Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Health and Social Care Bill:
Health and Social Care Board;
Local Commissioning Groups;
Northern Ireland Local Government Association

27 May 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Jonathan Buckley
Mr Gerry Carroll
Mr Alan Chambers
Ms Órlaithí Flynn
Ms Cara Hunter
Ms Carál Ní Chuilín

Witnesses:

Mr Paul Cavanagh	Health and Social Care Board
Dr Nicola Herron	Local Commissioning Groups Chairs' Forum
Ms Karen Smyth	Northern Ireland Local Government Association

The Chairperson (Mr Gildernew): I welcome, via video link, Dr Nicola Herron, who is chairperson of the local commissioning groups (LCGs) chairs' forum. Good morning, Dr Herron. Can you hear me OK?

Dr Nicola Herron (Local Commissioning Groups Chairs' Forum): Good morning, Colm. I can indeed. How are you?

The Chairperson (Mr Gildernew): Not too bad, thank you, Nicola. We are also joined by Mr Paul Cavanagh, who is the interim director of planning and commissioning at the Health and Social Care Board (HSCB). Can you hear me, Paul?

Mr Paul Cavanagh (Health and Social Care Board): I can. Good morning, Colm.

The Chairperson (Mr Gildernew): Good morning, Paul. We also have Ms Karen Smyth, who is head of policy and governance in NILGA, the local government association. Can you hear us OK, Karen?

Ms Karen Smyth (Northern Ireland Local Government Association): Yes, I can. Thanks very much, Chair. It is good to be with you this morning.

The Chairperson (Mr Gildernew): Thank you all for joining us. For sound quality purposes, if members have access to a headset, please use it, as that seems to help. Members should also try to remain on mute when they are not contributing directly.

I invite the witnesses to go ahead and give us some opening statements. I will go to Nicola first. Opening statements should last perhaps three or four minutes, and we will then go to members' questions. Nicola, can you go ahead?

Dr Herron: Yes, that is fine. Thank you very much for the invite to come to talk to you all. I was very reassured to hear the comments earlier, because, on the ground, we are totally reliant on the support of government bodies for the health and social care of the people of Northern Ireland.

I represent the local commissioning groups. For those of you who are not aware of our role, we are the committees of the Health and Social Care Board. As you will be aware, the situation is changing. It was agreed about five years ago that the Health and Social Care Board should close, but events overtook that decision, with the Executive's closing down and then the pandemic. We are now at the point of planning properly for the transition to the new arrangement, which will be called an integrated care system (ICS).

The integrated care system will be similar to the old system in some ways. It is still very much in the planning stages. It involves the various agencies that provide healthcare on the ground for the people of Northern Ireland. The beauty of the LCGs in the past was that they had representatives from a broad spectrum of service providers. I am a GP and have worked for 30 years in Derry, in the north-west. There are other GPs, pharmacists, dentists, allied health professionals (AHPs), and community and voluntary sector representatives on the group, The Public Health Agency (PHA) also has representation on it.

Like you, we have public meetings. Our role is to hear the voices of people on the ground to find out what their health needs are and then feed those needs back up through the statutory structures to where the decisions are made on healthcare commissioning. We thus hope that we have a responsive system. The transition to the new integrated care system will now involve the trusts as well. In the past, the Health and Social Care Board commissioned healthcare services from the trusts, but, in the new arrangement, the trusts will also be at the table, making decisions about healthcare and how best to provide it.

The pandemic has made an already unacceptable situation with waiting lists, which we have discussed already, absolutely intolerable at this stage. Certain areas of healthcare, such as scheduled operations and dementia care in particular, have gone from a bad to an even worse situation. Much of the focus in meetings has been on whether we can come up with a strategy to try to meet the population's needs in a better way.

What I see as a GP is that people used to be very focused on where they got their treatment. There was always a lot of pressure on local representatives to keep services local, be they operative services, operations, hospitals, outpatient services or casualty departments. There was a big push from the population to keep those services as local as possible and to have them on the doorstep. My recent experience, particularly since COVID, has been that people are much more concerned with when, as opposed to where, they will get their treatment. From that point of view, this is a good opportunity for, and ties in well with, a transition to an integrated care system, where we will be able to look much more strategically at the schedule of care and at things such as the hip, gall bladder or cataract operations that people desperately need. Those are life-enhancing but also life-saving operations for a lot of people. They need to be available, and they need to be available sooner rather than later. People are much less concerned that those services should be available to them on their doorstep and much more concerned that they should happen as soon as possible. When Mark Taylor was on the radio a couple of days ago, a guy came on who is waiting for hip surgery, and he said that he would crawl to Cork if that is what it took to get his hip operation done. I hear that on the ground as well.

Earlier, someone described a two-tier system when speaking about health inequalities. The old saying is that your health is your wealth. Unfortunately, in Northern Ireland at the minute, your wealth is your health. People pay for their procedure if they can afford to do so, because they are absolutely desperate. Something therefore needs to change. Something needs to improve. As a healthcare professional and as a representative of the LCGs, I say that we really need your support to ensure that health and social care is an absolute priority. We have seen from the pandemic that the whole economy and the well-being of the community depend on health being properly funding.

Health is a circular thing. Somebody said earlier that having difficulty accessing your GP affects other things. Equally, GPs are inundated with people who have been waiting five years for hip surgery, because they need ongoing and recurring care. They are coming to us for help with referral to physiotherapy, for more pain relief and for help with forms to be filled out for benefits. Those are people who, if they were to have their surgery, would be independently living in a much more pain-free way. Everything therefore has a knock-on effect on everything else.

The LCGs have been actively involved in community partnerships and in looking at ways in which to improve the pathways for patients through the care system as best we can with what we have. There is a project called No More Silos. I am not sure whether any of you are aware of that one.

The Chairperson (Mr Gildernew): We are.

Dr Herron: It has been looking at attendances at the emergency department, and some really good stuff is coming out of it. As much as anything else, it is good that there have been enhanced communications and relationships between primary and secondary care under No More Silos. We have ongoing educational sessions now. They had been fortnightly during the acute phase. We will now have monthly sessions at which consultants in the hospital and GPs will get together to look at interface issues and at areas in which we can improve the care of patients and ensure that they are not falling between two stools.

The LCGs have played a pivotal role. Over the past couple of months, we have been looking at how we will become involved in the planning processes for the new integrated care system, and we will be doing that on an ongoing basis. Various strategic groups are already set up, and Stevie Corr, who was the original chair of the LCG chairs' forum, is on the policy framework group. Over the next nine months, the chairs of the LCGs, plus members of the LCGs, will be becoming more actively involved in the planning. As I said, the LCGs are a broad church, with people from all different backgrounds, so that should ensure that we have local representation in the planning stages of the new integrated care system.

The Chairperson (Mr Gildernew): Thank you, Nicola. Paul, do you want to make a few opening remarks, please?

Mr Cavanagh: Sure, Colm, and thanks very much for the opportunity. As Nicola said, the way in which we have managed ourselves from the point of view of commissioning services in the past number of years has been through the local commissioning groups, as part of the Health and Social Care Board. The board will close in the next year, as we all know, and we are now very focused on a new planning model. We are working hard to develop that. I am co-chairing the new planning model project board, so we really are focused on what we want to retain. For example what has been good about the likes of local commissioning groups? Nicola has given you a flavour of the way in which they were able to integrate services locally and able to bring together the various players to create much more joined-up care for people. That is key in all of this.

We also want to think about the things that we need to strengthen. One thing that we certainly need to strengthen is our connection with community planning, and we are very keen to ensure that the new integrated care system links to community planning really closely. That is one of the areas on which we are working hard. We are working with NILGA, and we are talking to the Society of Local Authority Chief Executives (SOLACE) and various councils to get a good flavour of what we need to strengthen. The good thing is that we are already embedded in community planning, so we are talking to ourselves when talking about community planning as well, because we have put a lot of effort into it.

We know that we want to integrate the entire system. In doing that, we want to make sure that we do not create disparities across Northern Ireland. We are a small place, and it is about trying as far as possible to have as much consistency regionally as we can, but it is also about giving authority to local systems to allow them to make decisions that make best sense for their population. It is the 80:20 rule that always needs to be thought about there. A great deal of consistency is required. Our response to waiting lists needs to be consistent regionally, but there are a lot of things that we can do locally to build on the relationships that are there.

We have to engage with our local populations, understand their needs better and ensure that the system that we create makes sense. It is about having a much more communicative system. We are keen to ensure that, through that communication, people understand the decisions that we are making

as a system, that they have an opportunity to feed into the system and, indeed, that they can participate in decisions. The logic of some of this is therefore carried through from that.

It is a very challenging position. The discussion on waiting lists a moment ago is a reflection of that, Colm. We recognise, however, that the more that we can offer that local authority in each of our five areas, the more likely that it is that we will be more responsive and able to provide the kind of support and care that is required. I will stop at that point.

The Chairperson (Mr Gildernew): Thank you, Paul. Karen, go ahead, please.

Ms Smyth: Thanks for the opportunity to meet the Committee this morning, Chair. I understand that you have a massive agenda and significant issues that you are dealing with in addition to the Bill.

I will keep my comments brief. I will highlight the areas that are of most concern to local government, which Paul and Nicola touched on. We in NILGA fully support the Minister in his drive to improve health and social care provision across the North. We trust that the changes will not bring with them the unintended consequence of the exclusion of locally elected members from commissioning discussions. Paul articulated that there is very much a desire to make sure that there is better communication at local level to articulate need and move that discussion upwards. Councillors are fundamentally important to that part of the relationship. We are certain that the input and scrutiny that has been provided by councillors and LCGs for well over a decade now has been a positive influence in every trust. We look forward to discussions with the Department. Paul referred to working with NILGA. We have a meeting with Martina Moore and Paul in mid-June, at which we want to discuss how we can help co-design future working arrangements, in line with community planning priorities. The community planning process is currently under review, and reviews of the plans are due soon. That makes this a really good time to design in changes. We know that we need to contemporise that central/local relationship and evaluate how it impacts on people.

Our key priority today is to ensure that locally elected members are materially and meaningfully involved in health commissioning activity. We want to avoid any development of a vacuum in arrangements. When I met the elected members of the LCGs, there was concern, as they were not really sure about what was happening. Perhaps that is the case because this is at a very early stage and we need to work more closely together going forward, but we question the wisdom of any proposal or suggestion at this stage that would result in the formation of a separate forum for elected members as a sideline to the main conversations. There is a concern that they will be stuck in a room talking to one another and not involved in the substantive discussions.

As our health and social care provisions are transformed, councillors from across the 11 councils will play a vital civic leadership role and hopefully ensure that there is no disconnect among the health sector, councils and local communities at this important time. We want to add value to the picture and make sure that we can help improve it.

The Chairperson (Mr Gildernew): Thank you to all our panel. There are certainly a lot of things of interest and a lot of things around which consensus is emerging. I was struck by some of the things that were said about hearing the views of people on the ground — that is really important — and how their views should be not only heard but actioned and acted on. I note that Nicola said that the trusts will also be at the table. We want to ensure equality of arms and determine how local input will be managed, but the Committee is very conscious that, although the dissolution of the Health and Social Care Board is being taken forward in legislation, there is nothing in that legislation to demonstrate what exactly we will be moving to. In the context of our discussion about waiting lists, we should not see this as a technical process of enacting a decision that has been taken about the Health and Social Care Board. Rather, we need to see how we can add value and how the commissioning model can contribute to the concerted action that needs to be taken on waiting lists.

What are your views, panel, on how the legislation could be strengthened? I have said before that you would not move out of your home until you had seen your new house or knew that it was ready to move into. What are your views on how that process is to be managed in the Bill that we are discussing today?

Mr Cavanagh: I take your point. The past year has been challenging for us. We have really just got back to looking at the new planning model in recent months. I assure you that a lot of work is being taken forward on the model. We are developing proposals around it. It is not that we do not know what we are moving to, but I appreciate your point about the Bill. It is a technical requirement that the board

must close. The Bill is therefore needed to facilitate that and, as we know, a number of related issues. I assure you that we are working hard on the project board for the new planning model. We are talking to a lot of people — Karen mentioned our conversations with NILGA — to ensure that we understand people's views and construct something that genuinely brings us all together. As much as possible, it is about trying to find the right shape of things for the Health and Social Care family. Indeed, the wider family needs to work much more closely to maximise the resources that are available and to make sure that we provide the care that people require.

The Chairperson (Mr Gildernew): My second question is to Karen and picks up on her point about locally elected members having concerns about being in a separate forum in another room and coming late to the discussions. That is concerning. Can you flesh out what proposals they think should be considered to ensure that that does not happen and to ensure that we not only retain local input but strengthen it?

Ms Smyth: The value is in how the plans link with the community planning process. That is the local steer for directing priorities. Our community plans are evidence-based. There has been much more attention to detail paid at council level. There is much more maturity in conversations about health. We have moved from the position of fighting over where services are based to talking about the fact that we need to get services on the ground completely. At local level, there is an understanding that we cannot have every service everywhere. It is therefore about making sure that we have the ability to involve local members in discussions. There are a number of ways in which to do that, such as through community planning partnerships or through the integrated care mechanisms, which are yet to surface as a definite picture in local government circles. It is all quite nebulous for us at the moment, and that is one of the reasons that the conversation that we will have in June with Paul and Martina will be so valuable.

Earlier, you talked about a Northern Ireland Executive Committee approach to dealing with health issues. It is also about being aware of the fact that elected council members meet regularly with Northern Ireland Executive Ministers through the Partnership Panel. The Health Minister is a frequent attender, and Dr Michael McBride has also been at meetings. There are mechanisms for working very closely with councils regionally while still taking the local situation into account.

There are therefore already mechanisms for meeting with local government as a whole, and we encourage the Department to avail itself of those mechanisms and to maximise relationships with elected members at that level, rather than to duplicate any arrangements. It is about making sure that they are substantively and materially involved in the other mechanisms, whether those are subregional or regional. I am delighted that Councillor Corr and Councillor Mallaghan are both involved in the regional coordination of the local commissioning groups and the chairs' group. Unfortunately, they are unable to be with us today. They stood back because of a slight perception of a conflict of interests. That is why no elected representatives are with me this morning. That has put me in a bit of a difficult position, given that ours is a member-led organisation. Our members are keen to have the conversations and to work out the direction of travel. At the minute, planning may be at too early a stage to know that.

The Chairperson (Mr Gildernew): Thank you, Karen. Nicola was looking to comment as well.

Dr Herron: You talked about Executive involvement in all of this, and that is very important. A recurring theme in most of the discussions about trying to fix the broken system is the huge workforce issue in Northern Ireland. It is absolutely massive, and it has come about as a result of years and years of what seems to be lack of foresight planning when it comes to graduates from not only the medical profession but nursing and the allied health professions. Every time that we look at setting up a new service or improving a service, the stumbling block is the number of nurses, doctors, physiotherapists and all the other people who will be required to ensure that we have a good and vibrant health service in the years ahead. We are now at a point at which we have more jobs than we have people, and that is never a good place to be in, because it means that, if you advertise a post, you will be lucky to get an applicant for it, as opposed to being able to choose the best of the applicants who have applied for the job. It is almost impossible to future-plan a service if you cannot be assured that you will have the people to fill the posts.

We have a new medical school in the north-west, and that is fantastic. Over time, that will improve the situation for the medical workforce. There is a difficulty with GPs. We have, on average, 2,000 patients per full-time-equivalent GP. There are an increasing number of very complex patients, with a wide

variety of needs, some of whom may be seeing four or five consultants in hospital. We are having to try to work with all the different issues that patients have daily.

Moreover, GPs are also being expected to take on roles in order to ease the pressure on secondary care. We are really struggling with that. Without a vast increase in the number of GPs, we will have difficulty meeting the needs of the population and easing the pressure on secondary care.

There is no point in telling an organisation to provide a service if it is not given the fiscal power required to meet the needs of the people who need that service. We are talking not about wants here but about needs. The Executive have to be aware that the health needs of our population will increase over time.

We have an ageing population. Unfortunately, our young people are still leaving these shores, so our taxpayers are leaving. If we could encourage more of those people to stay, that would make a big difference to the overall health of our population. When we look at health inequalities, we see that the swathe of people living in rural environments tends to be at the sharp end of healthcare availability. There is also poverty and deprivation. One in three people in the population here could be defined as being in a deprived group, and that has a huge knock-on effect on our health.

The responsibility of the Executive is therefore huge. As GPs, we look at the Executive as one of the groups of people with even more responsibility than we have to try to ensure the health of the population. Fundamentally, the health of the people of Northern Ireland depends as much on their general well-being as on their blood pressure, blood sugar or anything else. The Executive have a huge responsibility to ensure that the general health and well-being of the population is improved by its having access to education and through there being enough people who are able to go through college and then stay here.

One of the ways in which we could improve the workforce quickly, as opposed to just looking at the number of people going into courses, is to incentivise our graduates to return. A huge number of our young people have left these shores to qualify as nurses, doctors, physios, occupational therapists and psychiatric nurses. They have gone. They have gone down South, gone across to England or Scotland or gone further afield, and they are not coming back. They are going out in a wave and coming back in drips.

In other parts of the UK, incentivising schemes are used to help pay off student loans or give people financial incentives. We have not looked in that direction, as doing that would need the support of the Executive. It is an innovative way of bringing back people who are already qualified and who can hit the ground running. If we really want to get on top of the waiting lists, we need to bring some of our qualified staff back to Northern Ireland, get them into our system and get them working in the hospitals.

The Chairperson (Mr Gildernew): Thank you, Nicola. There is also scope to get back some of our qualified staff who have not left here but simply left the health service as a result of, in some cases, life. We can potentially do more to attract and support some of those people back into positions that badly need to be filled. As I mentioned, over 5,750 vacancies in the health service are actively being recruited for, and that is unsustainable.

Before I go to members, I will pick up on something that Karen said. She mentioned that some of the picture is nebulous. That goes to the heart of the Committee's concerns. I say to Paul that the Department should look at that. The legislation in front of us is not nebulous in the least; it is clear. We have heard evidence that there is potential here for a situation in which people are marking their own homework with regard to performance and finances. I am conscious that it is something that, I think, the Department needs to look at. It is my view that the Committee may need to look at how it can add substantive planning into what is going to replace the HSC going forward and how that commissioning model will look.

I will leave it there at this point in time. A number of members are indicating. First, we will go to the Deputy Chair, Pam Cameron, then to Carál Ní Chuilín, Órlaithí Flynn and Paula Bradshaw, in that order. We will go to Pam first of all. Go ahead, Pam, please.

Mrs Cameron: Thanks to Nicola, Paul and Karen for your attendance at the Committee. My apologies: I was dumped out there for a bit, so if this has already been covered, I apologise in advance.

What consultation has there been between the Department and the chairs of the LCGs on the Health and Social Care Bill, or, maybe separately, in respect of any revised structures? What sort of conversations have been had? Does someone want to lead off on that, please?

Dr Herron: I suppose that Paul and I can both comment on that from two ends of it. We have had meetings with Martina Moore and Paul with regard to the structures that are currently up and running and in place. Stevie Corr, as one of the LCG chairs, has also been involved in the strategic framework planning group. Paul may have a better insight into the full extent of the interaction between the Department and LCGs.

Paul, you are on mute — oh, it is not.

Over the next nine months, members of all the different LCGs will be involved in the planning stages in the different groups. There are five different strategic groups. There are some, I suppose, in areas such as IT and communication where we may not have so much active input. However, the LCGs will have a proactive role in the groups on the actual planning of services on the ground and how they will be commissioned and provided. I am not sure whether Paul wants to come in.

Mr Cavanagh: Sorry, I am not sure what happened there, Colm. Can you hear me now?

The Chairperson (Mr Gildernew): I can hear you, Paul. It was probably because the system takes a few seconds to bring you up into the sound. We will just pause for a few seconds, if we need to, to see whether that improves. Go ahead, Paul.

Mr Cavanagh: So it is working now, Colm. Sorry. Maybe I clicked it too many times, Colm. I think that you were hinting at that as well.

The Chairperson (Mr Gildernew): Who knows? That could happen.

Mr Cavanagh: As Karen has already said, one of our chairs, Stevie Corr — he chairs the Belfast local commissioning group — is a member of the new planning project board. He represents all five LCG chairs on that project board. He has been a very active and helpful member. He has put a lot of his time into the framework that we are developing for the new planning model. The LCG chairs are well represented by Stevie, and also Martina. I attend all LCG chairs' meetings, so we have a constant conversation with them. From time to time, Martina joins me at those regular LCG chairs' meetings. Therefore, Pam, there have been lots of opportunities.

We have been keen to look at both the positives and the negatives with regard to LCGs. We do not want to lose the things that have been good in the past: integrated working, the partnership approach, the link with community planning and so on. However, we know that there have been limitations too: the limitation of authority, limited opportunities to bring more people into the decision-making process and so on. Colm, that has probably been an active and ongoing process with LCG chairs. There is a lot more to do. I am also keen that LCGs, in this final year, actually reach out to their constituencies, be it their councillor members, community and voluntary sector members and so on, to talk to them about what is to come as we develop the new planning model.

Mrs Cameron: Thanks for that. Which stakeholders who are represented on the LCGs now do you feel are most exposed to loss of input in the new structures?

Dr Herron: You are on mute again, Paul.

The Chairperson (Mr Gildernew): Just give it a second. Maybe it is taking —.

Mr Cavanagh: I did not touch it this time, Colm.

The Chairperson (Mr Gildernew): I think it is just taking a few seconds for the administration to bring you in. It is a slightly new tweak in the system we are using this morning, so there are probably wee bedding-in problems.

Mr Cavanagh: Apologies, Colm. I will be more patient.

I think, Pam, the intention is that all the constituencies currently around the table continue to be around the table, and we want to bring the likes of community planning into that as well. We are looking at how best to relate in general with local government, as Karen said. We are also thinking about not only that table but how we relate to our population and the variety of interests in our population. They may not be so directly involved with health and social care but will, as we all do, have an interest in health and well-being. So much of this is about trying to get upstream, rather than always focusing on the very big problems in elective waiting lists and unscheduled care. I do not want to minimise those in any way, but I think we also know that we have to look at that whole life of our population and how we can do our best to look at prevention and good health as much as providing services when people require them.

Ms Ní Chuilín: Thank you for all your comments and even some of the submissions that have been put in. They are very helpful. Unfortunately, however, as you know, we have been having these conversations for a long time. My concern is about that democratic and inclusive approach to going forward. For example, not all community planning is at the same level across each council area, and that is a concern. The other issue is how we can ensure that the whole-system approach takes into account the independence and the critical friend position. Where will the voice of the community and voluntary sector, and the voice of the democratic elected representative, be? That is one question.

The other question I have is that there is, for me, still an issue around social care that has not been resolved. Commissioning, as you will know, despite all the good work, should be implemented by need. How can we ensure that it is not part of a different direction, either by professionals within health and social care or by political direction, and that it is based on need? Those would be my two concerns around this.

Dr Herron: What you are saying is absolutely right, and it comes up in a lot of conversations. Even when we are looking at ED attendances, you would think, in some ways, that that is a long way removed from care packages, but it actually is not. When you talk to the casualty consultants, their problem is that they have people in the ED who cannot gets beds in the hospital because there are people in those beds who cannot get discharged because they need a care package. Suddenly, you just see that everything in healthcare and social care is interrelated. It is like it is married together, so there is a huge impetus and a huge focus in trying to improve those. It is vital that that is up there as one of the many, many competing priorities. I suppose that the difficulty on the ground in the past for health boards, LCGs and health trusts — really, all of us on the ground — has been trying to meet the needs of that full spectrum, realising that each has a knock-on effect on the other, within the budget that is provided for us. That is the struggle.

Colm, you are right: we need to be accountable. Yes, much as you say, we cannot mark our own homework, and that makes sense. However, what you do not want to do is make the system incredibly unwieldy because we spend all our time counting it. I qualified over 30 years ago, and there was much less counting and form-filling done back then. Is the system any better with all the form-filling and counting? I am not sure. I honestly do not know. I do know that, as you become more and more accountable, it means more and more counting. What we do not want is for that counting to take up such a big slice of the budget that it *[Inaudible owing to poor sound quality]* for the care on the ground. It is trying to trust professionals to be professional, but also have them accountable, without that accounting eating into our budgets for care. That is really important too.

Ms Smyth: The point that Ms Ní Chuilín made about community planning being at different levels is fair. Given her time as Communities Minister, she will be more than aware of the community planning review that is under way. We are approaching the end of that and anticipate that the draft review report will be presented to the permanent secretaries and chief executives group fairly soon. Just so that the Committee is aware, one of the issues with community planning has been resourcing and the ability to use resources effectively between the organisations that are involved. Hopefully, the review will go some way to addressing that issue and making community planning more effective.

At local level, we are talking about working across silos, and you are talking about working across silos within Health, which is a multiplication of factors in itself. At a local level, councils will look at how they can benefit their economies and communities. They will look at schools, transport links and how to attract people to their communities. Hopefully, in turn, that will attract people to work and live and stay in more rural areas like Fermanagh, which, as far as I am aware, is struggling with GPs. If we can do that in a more joined-up fashion through community planning and working with Health to look at what the shortages are, what we need locally and how to address those, it will be a win-win for everybody

Ms Ní Chuilín: Thank you for that.

Paul, the notion that we need to incentivise our health and social care staff needs to be part of this. We are losing staff to the private sector. If you talk to the staff side representatives and, indeed, the trade unions, you will find that they feel that they have not been looked after very well, despite them looking after us and putting their lives at risk. As part of local commissioning, are we looking at incentives and things like childcare vouchers, student loan arrangements and all the things that have been accepted by other bodies? I am not saying that it has to be something that the Minister makes a decision on, but how can we recruit staff and retain the staff that we have? That will be one of our biggest challenges around commissioning.

Mr Cavanagh: Yes. It is the biggest issue. I also agree with you that it is not just about recruitment. It is very much about retention. Colm, you made the point about bringing people back who worked in the health service some years ago. Perhaps they had a family and dropped out of the health service for a while, but we need them to come back and we need to support them to retrain and get their skills back up to where we need them to be. We are open to incentivisation. Why would we not be? To be frank, some of the agreements that we have in place with the staff side limit us a bit on that, but we have to do it, and Nicola has probably given us a good flavour of the benefits of it already. We are losing out not just to other parts of the UK but to countries across the world. We are losing a lot of people to places like Australia, Canada and so on. There have to be incentives. We also need to make it attractive to live here so that we can draw people in. All of us who live here know how attractive it is to live here and how good the work-life balance can be, but there are a lot of challenges for us to sell that internationally.

It is partly about recruitment, partly about retention and partly about drawing those people in internationally. We have gaps in our workforce that we will not be able to fill with people who are locally trained.

The Chairperson (Mr Gildernew): OK. Thank you.

Ms Flynn: I thank the panel for its presentation. I have a question for each of you, if you do not mind.

Nicola, in your opening remarks, you mentioned the good role that the LCG committees play, in the sense that they hear the voices from the people on the ground and feed those up through the system. However, the trusts will also be at the table now. How will that help or enhance the current structures? How will trust input at that level help that important process, which you laid out, of getting people's feedback on the ground and feeding that up? Do you want to cover that first, Nicola, or do you want me to —?

Dr Herron: I can do that, Órlaithí. No problem. The original arrangement was that the boards would commission the services from the trusts, and the trusts would deliver the services. A difficulty arose, however, when a trust was not able to deliver those services. What we all know is that the health needs are vastly increasing and that our staffing numbers — all the things that we have talked about have made it very difficult for certain areas of the service to be applied and rolled out and to function. The pandemic has obviously thrown so much of what should have been happening out the window, because priority had to be given to dealing with COVID.

It is interesting that, even amidst the pandemic, the No More Silos group that was set up involved the trusts and primary care working together. What was most apparent from that is that, when professionals get together round a table to figure out a problem and how to solve it, there is engagement from the start. What you do not meet, then, are objections or obstructions further down the line, because you are not telling somebody to go and do something; they have actually been part of the decision-making process. That has made a massive difference in smoothing the pathways of patients who need the service, because professionals right through the service have already made the decisions and agreed how the pathway looks, how it is shaped and how it works on the ground. My hope is that, in the integrated care system, because the trusts are at the table, they will have ownership of the decisions that are made, and that therefore you will get willing participation.

A tiny example of that is the monthly forums that are going to be set up for hospital consultants and GPs to get together in order to look at the different issues that we have getting our patients seen and sorted in the hospital. We will look at all those issues together, and they will probably tell us what we are doing wrong or what they see us doing wrong, and we can think, "Do you know what? It's easy for us to do this in a different way that will make life better for you". It is called No More Silos because it is

very easy, when you are in different silos, to judge the other silo more harshly than is fair, so, by coming together, we will hopefully open up pathways that actually do no take much more effort but work an awful lot better for patients.

Ms Flynn: That is really important. As you explained, the earlier you work together on an issue or a problem, the easier that it will, hopefully, be to rectify it. I know that this is slightly separate, but take the programme of work that the Department is carrying out on the Encompass system in terms of technology and IT. Sometimes you assume that these things are already linked up, but, hopefully, the reform of the IT system through Encompass will help if, physically and practically, GPs and the local commissioning groups are working more closely with the trusts. I hope that it works out as intended. Thanks for the answer, Nicola.

Paul, you spoke about the new planning model and the fact that a project board has been set up. What is the make-up — the membership — of the project board? You said that you are looking at the things that you hope to retain and the current strengths, as well as the weaknesses in the system and the things you want to strengthen. You mentioned community planning with the councils, but you also referenced understanding the needs of the population better. I think that one is massive. It is about how you do that in practical terms. We have been lobbying the Minister for a long time to carry out a full needs analysis of poor mental health, the mental health crisis and drug and alcohol addiction to help resource it and manage *[Inaudible]* in a better way. The Department told us recently that, for budgetary reasons, carrying out that needs analysis would not be the most sensible use of money. Is the project board looking at that really important issue? How do you intend to carry out that piece of work? Can you give us a flavour of the ideas or proposals that you are looking at try to address that?

Mr Cavanagh: Sure. I will deal with the project board first. It is quite a wide group of people, including people from the Department of Health, the Health and Social Care Board and the Public Health Agency. Northern Ireland Council for Voluntary Action (NICVA) is there to bring a community and voluntary sector perspective. We have LCG chairs, through Stevie Corr, who we have already mentioned; he is also a councillor in Belfast, as you know. It is about trying to get that mix of people and have all those constituencies come together. Sorry, I should have also mentioned said that the GPs are represented through the General Practitioners Committee. It is a very large group of people. As you know, meetings are great from a technology point of view, but it can be quite challenging to manage those meetings when you have as many as 40 people involved. At this stage, it is going as well as we can hope. As I have already said — Karen mentioned it — we are also reaching out because, at this stage, that project board is designed to start putting the framework in place and to start working through the various work streams that we need to take forward, but we need to widen that out quite soon, and we are hopeful that, over the next six months, we will begin to see those local groups being set up as well. If all goes to plan, that is our intention over the next number of months.

The point about the strengths and weaknesses is an important one. What is good about LCGs right now is that local intelligence, and Nicola gave some examples. That local intelligence is an opportunity for something to come from the ground right into the decision-makers, and that is a good way of beginning to spot where the problems are. It is also an early alert to where the problems are, because, at an early stage, we see things that can be done differently. We hope to strengthen that and improve on it, because the priorities of each of those people — the priorities of someone who is using a service will be quite different from the priorities of a consultant who is delivering a service, for example. It is about trying to put as much equity into that and begin to think about it. The experience of sitting in a hospital waiting room is as important in trying to resolve problems as is the challenge of seeing enough patients in a day and so on. That is why we are keen to create some kind of an equity in those local groups — those integrated care systems — so that people can begin to highlight the things that are most important to them and we can begin to work through them. That is part of the needs piece as well. It is not a sophisticated part of it, but it is about people talking together. Elected representatives are very good at that, as you know, because you talk to so many of your constituents and you bring forward a lot of issues that, to be honest, we are not sighted on because we are not close to some of the things on the ground.

I will pick up on your previous question to Nicola. One of the things that we hope is that we are moving towards collective accountability. That is a big challenge for the system, and I do not want to underestimate it. It comes back to the point that Nicola made about the silos. If these integrated care systems are to work, people need to share the problem and the solution and then actually be accountable for how that goes thereafter. That is where we are moving to. In the first year, we may not quite crack that, but we have to get there. Trusts have a very challenging job, as we all know, in providing such diverse services. They need to be held accountable for the services that they deliver, but the wider system also needs to work with the trusts and support the trusts to deliver the services

that they need. As Nicola said, there is pointing of fingers that goes on between trusts, GPs and so on. We need to get to a point where it is actually a shared problem. The challenges facing a GP today are the challenges that trusts also need to get their heads round, because, if the whole system does not function, you end up with people defaulting to an emergency department, as we know. That collective accountability comes with that authority, and the system still needs to be managed. I do not think that it is that people are talking to themselves and holding themselves to account — they also need to be held to account. The Minister will still have his prerogatives and the priorities that he wants to drive through the system, so they will also need to negotiate how they will deliver on that. It is very challenging.

There is a piece of work for us to do on needs assessment. We have done some of it in the past, with population plans and so on, so there are methods of doing it. We can talk to the King's Fund in London, which has a lot of experience in this space and is working with the integrated care systems in England. There are ways of doing this. Community planning has already worked through a lot of this, and we have a lot to learn and to draw on. Think about the engagement exercises that community planning partnerships went through a few years ago. I take Karen's point that we will have to get a great deal more consistency across the 11 areas. The flip side of the coin is that there is a huge amount of intelligence there already. How are we going to draw on that and draw it in? I do not think that it is always about starting from scratch again, going out and doing the big consultations. That is part of it, but it is also about using what we already know and beginning to put that into some kind of a shape where it actually makes a difference to the way that we provide health and social care.

Ms Flynn: That is great, Paul; thank you very much for that answer. And just, then —.

The Chairperson (Mr Gildernew): Órlaithí, I have to move on. I will try to come back to you for that last question, if I can, but I am going to have to move on to other members to ensure that everyone gets in.

Ms Flynn: No problem.

The Chairperson (Mr Gildernew): You can put your question in writing if I do not get back to you, and I am sure that the panel will come back to us on that. I will go to Paula and then Cara. Those are the last two indications that I have at this time. Go ahead, Paula.

Ms Bradshaw: Thank you, Chair, and I thank the members of the panel for their contributions this morning. My first question is to Paul, and it is really off the back of my comments at the start of the Committee meeting about the accountability for the money that flows from the Department of Health through the Health and Social Care Board into the trusts for the commissioned services. As taxpayers, we are paying for the trusts to deliver certain procedures and programmes etc. Where is the accountability to make sure that the money is spent correctly? What is the penalty if that is not done? How do you think the new Health and Social Care Bill will enhance and create that greater link between what we are paying for and what is actually delivered? That is my first question, thank you.

Mr Cavanagh: We currently have things that are called service and budget agreements (SBAs), Paula, which you may be aware of. They are designed every year to basically agree the volumes that we expect to receive in both elective care and social care in a number of aspects. They are quite wide-reaching. They are challenged by things like vacancies and so on. If the trusts had all of the staff in place that the money was designed for, they would be able to deliver to that level. However, because they do not, the reality is that we fall short of what we are capable of. That remains a big challenge for us. We have been looking in the trust rebuild plans, which you will be aware of, at how we can square that circle in some way with a COVID prism, because we know that, even on our best day, COVID is restricting the amount that we can deliver, although the good things that we have been doing — the virtual consultations and so on — have at least given us a bit more back.

Ms Bradshaw: Sorry, Paul, I want to go back a little bit, because I want to understand that. The services are commissioned and, as you say, broken down into numbers. Sometimes they do not hit those numbers because of vacancies. What happens to that money? Is it given back? "We have not been able to deliver 100. We only delivered 80, so there are 20 there", so they give the money back? What happens to the money?

Mr Cavanagh: It is not given back, because, sometimes, for example, the trust has to employ locums, who are a lot more expensive than what the money was designed for, Paula. It is a very difficult and

challenging picture, but the money does not really come back. Sometimes trusts will use the money that they have to maybe access a service in the private service to ensure that those patients receive care in as timely a way as possible. However, it is a challenging picture, and, because of those additional costs from the likes of locums and agency staff and so on, it limits the opportunity for us to say, "If you cannot deliver that, we will just take the money back". The reality is that the trusts are probably having to pay higher rates in some circumstances, and possibly higher rates with the private sector as well. It is a challenging picture, Paula. There is a process to scrutinise that, but, ultimately, penalties are challenging in this kind of space, because there are other costs to try to even deliver some of the capacity that we want to see delivered through the likes of locum and agency.

Ms Bradshaw: I appreciate that. I suppose it is not penalties per se; it is more about the fact that we have the waiting lists coming out this morning, so it is about commissioning services to actually meet the demand.

I will move on. My second question relates to the second part, and I think that it is directed towards Nicola. It is about the issue that you had raised about incentivising staff and the use of agency staff, as you mentioned, Paul. I declare an interest, as my daughter has applied to do occupational therapy in England, and we very much assume that she will not come back at the far side of it. I hope that she does. When the paediatric pathology unit service or that arrangement was moving over the Alder Hey, I asked the Health and Social Care Board, "Why can you not provide greater incentives and an enhanced salary etc?", and I was told that, in many ways, it was because of the coupling with the Agenda for Change national framework and other pay. In the interests of not paying so much for agency staff and other pressures, should we think about decoupling from the Agenda for Change network in Northern Ireland so that we can be more agile and not spend so much money on locums etc?

Dr Herron: It is funny; I was just looking at letters that I wrote a couple of years ago to members of the Executive regarding the medical school in Derry. At that time, £22 million a year was spent on locums in hospitals alone, and I am sure that it is even higher than that now. On average, if you include the cost of the agency, a locum will be two to three times the cost of a contracted doctor in the same position. I would say that you could extrapolate that to nurses and any other allied health professionals. So, not only is it more expensive to employ locums, you cannot plan a service based on locum cover.

You are absolutely right: if we really want to plan our services for the future, we need to have contracted staff working in our system. There is a domino effect as well. Once a department is short-staffed, it gets even harder to retain staff. So, it is already under pressure, then more people leave and, eventually, the department can collapse and the specialism can move elsewhere. One of the advantages of having a regionalised approach to elective care is that you can have a good body of staff in one specialism in one place. Trying to have that dotted around Northern Ireland is not working.

When I started 30 years ago, there were four surgeons in Altnagelvin, and between them, they did everything. Now, you have so much sub-specialisation, and surgeons are highly skilled. If I want my heart surgery done, I want a specialist to be doing it. Similarly, if your mother is having bowel surgery, you want the best possible surgeon in that area. That is the right direction to go, but it causes practical and strategic issues on the ground. Each of the surgeons needs a group of similarly skilled surgeons around them, not only to make sure that they keep up their skills to that high level but because they are on rotas at night. One of the issues that we are finding is that, if there are two or three sub-specialised surgeons in a hospital, they are reluctant to be on call for general surgery, and rightly so, because a bowel surgeon cannot be expected to operate on a vascular issue at 2:00 am. When you have those sub-specialities, you need to have a good number of those people together. That causes a problem in somewhere as small as Northern Ireland, but without that we will not have a service that is future-proofed or high-quality for our patients.

We need to incentivise people to come and work here and make sure that we have enough staff. The areas and departments that tend to do the best are those that, on the surface, seem to be over-recruiting. That way, you get a good, robust and healthy workforce that is happy to stay. In my experience of healthcare and primary care, every day is a busy day, but there is not really any such thing as an overwhelmingly busy day unless we are understaffed. As soon as you are understaffed, you start to feel overwhelmed and the problem in the health service is that when you are feeling overwhelmed or the work is too much for the staff, it becomes dangerous. Lives are at risk in that instance. It is bad in any line of work if you are too busy for the demand, because it is stressful, but in healthcare it is dangerous as well.

We need to make sure that our staff are supported so that they can go into work and feel that they are providing a safe service. Otherwise, people feel that, with the best of intentions and the best will in the world, the service that they provide is at times, because they are so busy, not safe. If you are sitting in an ED waiting room for 12 hours, that is inherently not safe. If the staff are so busy and run off their feet because they are looking after too many people, that is not safe. So, we have a responsibility to make sure that there are enough staff where acute care is happening.

Ms Bradshaw: Thank you.

The Chairperson (Mr Gildernew): I declare an interest as a former social worker. Even without staff vacancies or people going off, the caseload of the team that I worked with — the older people's team in the south Tyrone area — was increasing year-on-year by 5% and 6%. That was not being commissioned for at all. That was just incrementally going onto the staff, year on year. The issue of an ageing population is massive, and is something that we need to consider as well.

Dr Herron: Sometimes, there is an announcement of an increase in the Health budget. Obviously, that is always welcome. The difficulty is that, if there is an increase in wages at the same time, that is not ring-fenced. If £1 billion extra is put into the health service, people will expect £1 billion extra of care. However, if at the same time we increase wages, and that takes a big percentage of that money away, that reduces the care. Could money for wages be, in some way, ring-fenced aside from the care money? I know that the two are related, but it can muddy the waters when dealing with people's perception of what services can be provided.

We are all agreed that nurses need to be paid better. All the people who work in the health care service need to be paid adequately so that we can retain them. However, that pay budget needs to be ring-fenced apart from the service that is being provided for patients. Otherwise, the population suddenly feels, "Oh, my goodness. The health service got that extra billion. How come we're not doing so many extra operations and everything?" If the wages budget were separate from the service budget, it might clarify things for the population as regards where the service should be going.

Ms Hunter: Thank you to the panel. Good morning. I welcome your contributions and comments. I especially welcome your comments, Nicola, on staff psychological support and well-being. I know, from conversations that I have had, that there is certainly a feeling of being overwhelmed due to the events of the last year.

I am an MLA in a very rural constituency in the north-west. I have real concerns that rural people sometimes feel that their voices go unheard when decisions are being made already. As we look forward, what ideas does the panel have on the inclusion of rural voices; for example, the Rural Women's Network and the Rural Community Network? Oftentimes, they already feel overlooked. There is a fear that even rural representatives will have less of an input in the future.

Mr Cavanagh: I will give you an example, Cara, more than anything else because I fully agree with you. We have to strike a balance in reaching out to people. As you said, as a rural MLA, you know that it is challenging to provide services in rural areas. Increasingly, a lot of our services are being provided in urban areas, but we have to strike that balance, and that balance still has to make sense. We have to support people to live at home as much as we possibly can and provide the social care, in particular, to ensure that.

About a year ago, I was still the assistant director and commissioning lead for the western area, so rurality is something that I am very mindful of. Over the last number of years, we would always have worked with the rural community networks in the west. At various points, they would have reached out to community organisations on specific issues. Sometimes, it was older people's needs; sometimes, it was children's needs. There was a whole mix of issues that we were constantly trying to find ways to address.

We have to use intermediary bodies such as rural networks and rural community groups to reach out. We are too far away from the ground. I would like to say that I am really hooked in. I am not. However, I know a lot of people who are well hooked in, and we have to begin to work with those people. Yourselves as well, as elected Members, whether MLAs, councillors or MPs, are having constituency discussions. We have to draw on that intelligence in our decision-making.

We are very fortunate in Northern Ireland, as you know. We have a really strong community and voluntary sector. It is weak in some rural areas. I would not say that it consistent across the piece, but,

largely, we have a pretty strong, vibrant sector. We have to work with it and find ways for it to help us to reach out to people so that we fully understand the needs.

Ms Hunter: Thank you, Paul. I recognise the complexity of health issues, but that rural dynamic definitely makes them more difficult. Thank you for looking at that.

Ms Smyth: Councils, particularly Fermanagh and Omagh District Council and Derry City and Strabane District Council, are very attuned to issues that rural people face. With community planning arrangements and local working arrangements, there is attention paid to local district electoral areas that have that rural focus.

I will comment on the situation with COVID. We have seen an uplift in the way in which government bodies and councils work with individuals and communities at a local level in rural areas. Improvements to broadband communication have been instrumental in that. We have also seen councils work very closely with community groups and sports groups to have that local communication and community activity that assists with building health — particularly mental health — and well-being at a local level. Those conversations and relationships, whether over Zoom or directly, through a socially distanced litter pick, for example, are key to what Paul said about local knowledge and management and ownership of issues at a local level.

Earlier in the week, I was in a meeting with a planning officer from Highland Council in Scotland. We think that we have problems with rurality, but looking at a map of the population spread for the Highland Council was quite alarming. Reliance on and access to new technology will be key to how we go forward.

Ms Hunter: Thank you, Karen. I note that certain community groups in my constituency are trying to teach the elderly population digital literacy to help to combat loneliness, specifically in rural areas. That is a great point, thank you.

Dr Herron: Early in the pandemic, we discussed having outpatient appointments for everybody. It is a funny thing that there was more equality in rurality during lockdown because, even if you live in an urban development, it still felt like you were detached from the big centres. Some of the discussion was about facilitating the use of technology and broadband to have outpatient appoints and even to have consultant outpatient appointments. That is one thing that the pandemic brought to us. We can keep that for the longer term, so that somebody in rural Fermanagh does not have to travel 100 miles to see a doctor for an appointment that takes 10 minutes just for a medication review that could be carried out over the internet. Some positives have definitely come out of the pandemic for rural areas.

Karen mentioned the incentivising schemes in the Highlands. That is one thing that I know. My son is a doctor in England, and my daughter is a physio. I am raging; I would love to get them back. I could not believe it when my son said that he would come back to Northern Ireland if some of his student loan was paid off for doing that. I thought, "I'm going to kill you". It is about those little things. Sometimes we think of doctors in terms of "Sure, why would they need more money?", but they come out of college with £50,000 or £60,000 of student debt and do not earn that much for the first five or 10 years. It would not take much to make a big difference to them and to incentivise them to come home. The really good thing about those guys coming home is that they will stay. When we try to incentivise people who are not originally from here to come here, they come for a couple of years and then they go back home.

Rural areas always end up at the sharp end. In Fermanagh, the southern half of the Western Trust has seen more GP practice closures than anywhere in Northern Ireland. They are in an absolutely desperate place. If you have a big enough pot of people, everybody will get the benefit. If you can incentivise people to go to the rural areas, which are beautiful places to live, the chances are that, once they get settled, they will stay there. Initially attracting them to those areas is what is important. We now have multidisciplinary teams (MDTs) in primary care. During the pandemic there was a lot of interaction between them and the community and voluntary sector to bring food parcels to people's homes and that sort of bread-and-butter stuff on the ground. GP practices, pharmacies and all of those sorts of things are vital in rural areas. They are part of the network and the fabric of those societies.

Ms Hunter: Thank you, Nicola.

The Chairperson (Mr Gildernew): Thank you very much to the panel. We heard reference to Stevie Corr a few times. We were hoping to hear from Stevie this morning. It would be interesting to hear his and, potentially, Cathal Mallaghan's perspectives on their experience with the LCGs and how they could contribute the work in which we are engaged.

I am struck by the fact that there seems to be a great deal of harmony around what is going on at the minute. The review and the project board are looking into those things now, but it would have been more useful if that work could have been fed into the Bill. I think that we are all on the same page and that everyone is thinking the same things, but, unfortunately, an awful lot of it is not on the page that matters, which is in the legislation. In our part of the world, we have a saying that eaten bread is soon forgotten. I do not say that out of any sense of somebody doing something deliberately, but pressure takes over. We are dealing with a Bill that is removing some of the functions and then we do not see the clear picture. Something that should be considered is how that might be improved. You can make a quick comment on that. Will you commit to looking into that for us?

Mr Cavanagh: I assure you that, as soon as we can share that information with you, we will. We are working through it at pace. We are close to having a new planning model that will provide you with reassurance. We will come back to the Committee as soon as possible in relation to that. I do not think that the intention is to take down the current house without having the other house in place at the point at which we need it. Our hope is that, in the coming weeks, we will see that progressing at pace. I hope that that will provide you with the assurance that you require.

The Chairperson (Mr Gildernew): I appreciate that.

Ms Smyth: I urge a wee bit of caution, Chair. If you need to remain fleet of foot in the health sector, which we do at the moment, I am not sure that putting a definitive format for a new model into the legislation is the best thing to do. It is a primary Bill. It may be a case of having an associated document rather than putting the results of it in to a primary Bill.

Mr Cavanagh: We are doing that, Karen. That is my sense, Colm, but I agree with Karen.

The Chairperson (Mr Gildernew): OK. Your sound broke up a bit, Karen, but we got the gist of that. Come back to us. We certainly think that there is merit and value in looking at how we strengthen it in that regard, however that may be done.

Thank you all for attending this morning. I appreciate your insights and your answers to members' questions. I wish you all the best of luck in the time ahead. Thank you.