Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Health and Social Care Bill:
British Association of Social Workers NI;
British Dental Association NI;
Community Pharmacy NI

27 May 2021

NORTHERN IRELAND ASSEMBLY

Committee for Health

Health and Social Care Bill:
British Association of Social Workers NI; British Dental Association NI;
Community Pharmacy NI

27 May 2021

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:

Ms Carolyn Ewart	British Association of Social Workers Northern Ireland
Mr Andy McClenaghan	British Association of Social Workers Northern Ireland
Mr Tristen Kelso	British Dental Association Northern Ireland
Ms Caroline Lappin	British Dental Association Northern Ireland
Mr Gerard Greene	Community Pharmacy Northern Ireland

The Chairperson (Mr Gildernew): I welcome Ms Carolyn Ewart, director of BASW. Carolyn, can you hear us OK?

Ms Carolyn Ewart (British Association of Social Workers Northern Ireland): I can hear you. Can you hear me?

The Chairperson (Mr Gildernew): Yes, we are hearing you Carolyn. Thank you. We are also joined by Mr Andy McClenaghan, communications and public affairs officer for BASW. Good morning, Andy. Are you able to hear us OK?

Mr Andy McClenaghan (British Association of Social Workers Northern Ireland): I can, Chair. Good morning.

The Chairperson (Mr Gildernew): Thank you very much. We are also joined by Mr Gerard Greene, who is chief executive of Community Pharmacy NI (CPNI). Good morning, Gerard. Can you hear me?

Mr Gerard Greene (Community Pharmacy Northern Ireland): Good morning, Chair. Yes, I can hear you.

The Chairperson (Mr Gildernew): Thank you. We also have Ms Caroline Lappin, who is chairperson of the British Dental Association (BDA). Caroline, can you hear us?

Ms Caroline Lappin (British Dental Association Northern Ireland): I can indeed. Good morning, Chair.

The Chairperson (Mr Gildernew): Thank you. Finally, we have Mr Tristen Kelso, who is director of the BDA. Tristen, can you hear us OK?

Mr Tristen Kelso (British Dental Association Northern Ireland): I can indeed. Good morning.

The Chairperson (Mr Gildernew): Thank you all. Many of you have been with the Committee before in other roles. You are very welcome, and it is good to see you all back again. We appreciate your assistance in providing evidence to the Committee.

I remind all members that sound quality is improved by using a headset. I also remind them to ensure that they are on mute when they are not contributing. Panel, please also bear in mind that it may take a second or two before you are brought into the spotlight, so it will help if you delay for a second or two. I ask all who are attending the meeting to be conscious of background noise or typing; anything like that comes through quite clearly at times, so members should watch out for that.

We have a very experienced and expert panel. I want to be sure to get the best out of the time that we have with you, recognising the time that you have taken to be with us this morning. I ask all members to be as brief and focused as possible with their questions. We have eaten into our time with an earlier, very substantial discussion on waiting lists, about which we are all concerned, so I ask members to be very succinct with their questions. I also ask that one member of the panel, perhaps, identify the person who is best placed to answer a particular question and that other panel members only come in if there is something additional or essential to say. Indicate, and we will try to get you in. I will keep an eye on everyone as we go along. Members, please indicate if you feel that your question is not being answered directly and you want to cut it short; it is not always easy to know if the answer is on the track that you were seeking. I ask members to manage their time in that way, and we will try to get through as many questions as we can.

May I ask each of you to give as brief an introduction as possible, in light of time? For convenience, I will invite you in the order in which I brought you all in. I will go to you first, Carolyn. Go ahead, please.

Sorry, before you start, Carolyn, I declare an interest as having previously worked as a social worker. I am on a career break here from one of the trusts. I want to declare that up front. That is not why I am bringing you in first, Carolyn; it is because you are first on my list. Go ahead, please.

Ms Ewart: Thank you, Chair, and thank you for the opportunity to present the views of the British Association of Social Workers Northern Ireland (BASW NI) on the Health and Social Care Bill.

The BASW NI is the professional association of social workers. We have 22,000 members across the UK, employed in front-line, management, academic and research positions in all care settings.

I want to be clear from the outset that BASW NI does not oppose the Bill's intended aim of closing the Health and Social Care Board (HSCB) and transferring its functions to the Department of Health and the health and social care trusts. However, the association is concerned about the Department's lack of transparency concerning the plans and its failure to meaningfully engage with key stakeholders in relation to them. The association also questions the extent to which the closure of the board will succeed in delivering the reduction in bureaucracy, increase in accountability and improvements in efficiency that are noted as key drivers for the planned restructuring. As the explanatory and financial memorandum published to accompany the Bill explains, the then Department of Health, Social Services and Public Safety conducted a consultation during the period 15 December 2015 to 12 February 2016 on policy proposals to close the Health and Social Care Board. BASW NI has significant concerns about the consultation process and the use of the consultation findings to justify the closure of the board.

In the section of the 'Getting the Structures Right' consultation headed 'New Structures', the proposals made by the Department are unhelpfully vague. While the document stated former Minister Hamilton's intention to close the board, the Department did not provide specific detail concerning the options that

it intended to pursue, save for explaining that functions of the board would go to the Department, the Public Health Agency (PHA) or the trusts.

Of greatest concern, perhaps, is that, of the 151 responses to the consultation question asking whether consultees agreed with the proposed structural changes, 62% disagreed or strongly disagreed with the proposal, and only 19% agreed or strongly agreed. Despite BASW Northern Ireland's response to the consultation and the Department's acknowledgement, in its consultation analysis report, that it provided insufficient detail to enable stakeholders to adequately assess the appropriateness of the structures proposed to replace the board, the association has been involved in no further consultation on the matter and has received no additional information regarding the Department's plans.

BASW Northern Ireland is very concerned that the Department has since introduced the legislation that we are discussing today to radically alter health and social care commissioning and governance structures on the basis of that consultation. The association believes that that indicates a lack of regard for the views of the stakeholders involved.

The permanent transfer of functions currently delegated by the board to the trusts does not, in itself, lead to concern. Based on the available information, it is not expected that it will have any direct impact on the delivery of services. What is of concern in relation to the transfer of functions, however, is the Department's failure to communicate the implications of the draft legislation to the social work profession.

Engagement with BASW Northern Ireland members, including social workers in senior leadership positions, indicates a lack of transparency on the part of the Department about the transfer of functions. To ensure that any potential confusion is avoided, it is essential that the Department explain clearly and unambiguously precisely which functions will transfer and where they will go. Relying on social workers to unpick the content of draft legislation to find that clarity does not meet the standards of transparency that BASW Northern Ireland expects the Department to uphold.

The Department has also argued that the Bill's transfer to the Department of the duties and responsibilities previously held by the board will result in clearer lines of accountability and performance management and, therefore, a reduction in bureaucracy. While BASW Northern Ireland supports all possible improvements in oversight and efficiency, our members query whether the planned restructuring will yield the intended results.

Andy and I will be happy to provide further details on that, or any other, issue that I have raised in this introduction. Thank you for listening.

The Chairperson (Mr Gildernew): Thank you very much, Carolyn. You have spoken on behalf of BASW. I go now to Gerard Greene, chief executive of Community Pharmacy NI. Go ahead, Gerard, le do thoil.

Mr Greene: Good morning, Chair and members. Thank you for affording me, on behalf of Community Pharmacy NI, this opportunity to speak on our submission on the Bill. As most of you are aware, CPNI represents community pharmacy contractors in Northern Ireland in negotiations with the board and the Department on services and pharmacy contractual arrangements including remuneration and reimbursement.

Community pharmacy is one component of the family practitioner services (FPS) that is currently underutilised but has clearly demonstrated its central role in public health and primary care service provision, as has come sharply into focus with the community pharmacy response during COVID. That has been recognised by the current Health Minister, Mr Swann, and, indeed, is reflected by the very high level of public confidence in the sector. The proposed changes and their outworking must not, therefore, jeopardise the wider health service or the important community pharmacy service that we provide to patients. The transition must facilitate and support continued development in order to deliver further innovative services and maximise that key front-line health and social care resource at the level that is closest to patients and communities.

CPNI's overarching comment on the Bill is that, as has been widely articulated, there is not enough detail to fully understand what impact the Bill will have on pharmaceutical services as well as on wider health services. With regard to commissioning, the Health Minister referred in the Assembly to a new way of planning services. A key part of that process will be to take on the learning from local commissioning groups (LCGs) and bring forward a mechanism to ensure the continuation of local

input. We agree that the current commissioning model is not as effective as it could be and that it is too complex for a patient base of this size. It is essential that any new health and social care commissioning process is capable of understanding, appreciating and harnessing the strengths of community pharmacy to improve access and quality of services to patients. It is essential that the local voice and the expertise available to the process of commissioning primary care services will be retained and enhanced and that there will be appropriate access to experienced people to mediate inadvertent, ill-thought-out policies. CPNI asks for clarity on details of these new processes and mechanisms and requests that assurances are given that stakeholders, including CPNI, are fully consulted on any proposals in respect of these.

While the Bill does not deal with funding per se, CPNI is concerned that there is a possible risk of budgetary and service provision being delegated, in part, to trusts. Trusts can be detached from the primary care and preventative healthcare needs of patients and the need for services provided by community pharmacists. Additionally, trusts may see an opportunity to offset secondary care budgetary deficits through reduced FPS funding allocations to which they may have access. It will be critical that funds that are earmarked for community pharmacy are ring-fenced so as to protect them from reallocation elsewhere. It is critical that the Department is specific when giving directions to the HSC trusts regarding the allocation or use of funds for pharmacy services. The Bill indicates that market-entry appeals will be dealt with in future by a prescribed body. It will be essential that CPNI is consulted on the composition of that body.

In general, continuity of community pharmacy services and retaining the unique value of the Northern Ireland community pharmacy network in supporting patients and the health service must be maintained and enhanced in the transfer and transitioning of HSCB functions to the Department. We encourage senior Department officials, who will be charged with the responsibility of directing and overseeing health service provision, to draw on the experience and expertise of HSCB integrated care professionals with current responsibilities for pharmacy services and with stakeholders, including CPNI, to ensure that responsive community pharmacy services can continue to be developed, as witnessed throughout the COVID-19 period. Placing community pharmacy on the strategic bodies and structures in the Department, including the primary care directorate, the rebuilding boards and the various project and programme boards, will be important in helping to bring about a successful and inclusive transition. The Northern Ireland community pharmacy network acts as a buffer for the HSC and as a safety net for patients. It is an essential front-line healthcare provider, key to the rebuilding of Health and Social Care (HSC).

The Chairperson (Mr Gildernew): Thank you. Go raibh maith agat, Gerard. Caroline and Tristen, which of you are speaking on behalf of the dental association?

Mr Kelso: I am, Chair. Thank you to the Committee for inviting BDA Northern Ireland to present today. Members will have received our written submission. Our view is that the Bill creates a unique context to overhaul how dentistry and oral health is administered in the Department of Health. The Bill will have direct implications for dentists and oral health, as stated under clauses 2 and 3, but as significant are the indirect implications for dental administration that will follow from HSCB closure, which we urge the Committee to also consider.

The lack of dental administrative capacity in the Department of Health has, without question, constrained advances in the oral health of our population, not least on the strategic reforms required. It is the reason why our current oral health strategy dates back to when Tony Blair was Prime Minister. It is also why our general dental practitioners work off a general dental services (GDS) contract that is over 30 years old and largely activity-based rather than focused on prevention. It is why the Department of Health inequalities report can be published without any mention of oral health. The Bill needs to be about so much more than simply abolishing the regional board. For us, it is about ensuring that the right administrative structures are put in place to recognise the public importance of oral health in its own right and the wider contribution that oral health can make to general health.

In our response, we refer to information gaps and a complete lack of engagement thus far on how the Bill relates to dentistry. We can see, under clause 2, that over 1,100 general dental practitioner (GDP) contracts will transfer from the board to the Department next March, but we have yet to be consulted on what that might mean for independent dental contractors. We also have no clarity on what a future appeals process will look like. Furthermore, we have been given no insight into what the new chain of command will look like for dental administration and where dentistry will fit in. On the role of the Chief Dental Officer (CDO), after the Bill comes into force, will the CDO be the senior DH official to direct former board dental advisory staff brought into the Department, or could the CDO be under the direction of a senior civil servant? Will dentistry continue to be disenfranchised from the DH hierarchy

and departmental priorities by having no representation either on the Department boards or on the HSC management boards? Finally, what policy framework will guide the work of former HSCB dental staff and, indeed, other dental staff under the control of the Department?

As per our opening remarks, we need to seize this opportunity to fix how dentistry is administered in the Department. That is the precursor to being able to make much-needed progress on tackling our considerable oral health inequalities and ensuring that the public have continued access to health service dentistry by reforming health service dentistry to be financially viable in its own right and to achieve a reformed, refocused and outward-looking oral health system, comprising general, community and hospital dental services that can make a combined impact on some of the biggest public health challenges that we face.

BDA's preferred approach is to bring the administration of dentistry under a new dental unit to be created in the Department. That would be headed up by the office of the CDO, who would report directly to the permanent secretary and have a seat at the top HSC management board. Such a dental unit must be properly resourced, which is a particular concern at present. Those reforms would address the currently disjointed structures. They would help to streamline dental administration by bringing together strategy, policy and responsibility for dental services. Dental officials would work under a common direction set out in a revised oral health strategy, which would be aimed at embedding prevention in our population's oral health. That would be fully aligned with the outcomes-based approach set out in the Programme for Government.

We also want to see greater transparency and more opportunities for public engagement in the new commissioning process. Local engagement via the LCGs has been a useful watchdog in the past. We want to see a new vehicle to facilitate that, with continued dental involvement. Connected with that is defining a future role for our local dental committees, following on from their current consultative role with the board on local dental issues. Ultimately, whatever new structures are put in place must have improved patient outcomes at their core. It should not be an abstract process.

COVID has laid bare that the long-awaited reforms needed in dentistry in Northern Ireland simply cannot wait any longer. Morale among dentists has reached a new low, with just 4% having high or very high morale. A total of 89% of our GDPs feel financial uncertainty, and 62% of dentists cannot see a future in health service dentistry. With dental activity rates sitting at around 40% of pre-COVID levels due to infection prevention and control restrictions, including enhanced PPE, the Bill simply must deliver on dentistry. Thank you.

The Chairperson (Mr Gildernew): OK. Thank you. I thank all the panel for sticking to the time and for contributing some significant evidence, including your concerns, suggestions and ideas. Before I go to members, I would like to get clarification on the level of consultation with each of you on the new structures. I will touch base with each of you to see whether you have engaged on the new structures. We are somewhat concerned about the idea of removing one structure without knowing in greater detail what is replacing it. I will check with each of you in turn. Carolyn, where are you at with consultation on the new structures?

Ms Ewart: We have had no consultation on the new structures. We really have a blank page: we do not actually know what is proposed. We are, obviously, very concerned about that. We do not know what the move will be. We are calling for urgent consultation with us and our members on what is proposed.

The Chairperson (Mr Gildernew): Gerard, on behalf of CPNI, where are you at on the consultation process?

Mr Greene: Similarly, we have had no engagement. We have not been consulted. Indeed, this is our first interaction. After our submission to the original consultation and your request for our submission, this is the first engagement that we have had with the process.

The Chairperson (Mr Gildernew): Thank you, Gerard. Tristen?

Mr Kelso: There has been no consultation with BDA on this. After sending our submission to the Health Committee, we also wrote to the Health Minister. We have a meeting scheduled with Martina Moore, project director of the board migration project team, for next week. However, there has been nothing to date.

The Chairperson (Mr Gildernew): Thank you. I am concerned to hear that, because, as I noted in the previous session, while everyone is on the same page, it is crucial that we have clarity and detail. We need to ensure that we not only transfer responsibility and commissioning but improve the process, which is so badly needed across all our healthcare systems. I am concerned about that, I have to say.

I will go to members for questions. *[Pause.]*

The Committee Clerk: Sorry, Chair. There seems to be a wee bit of a delay. Hopefully, it is sorted now.

Mrs Cameron: That is it now. Thanks, Chair. I thank the panel for their interesting presentations. It is a bit worrying that there has been so little consultation from the Department.

How important is it that the dedicated arrangements for the commissioning of services in areas of primary care are retained? What are the risks of a one-size-fits-all approach?

Ms Lappin: Thank you very much, Pam, for your question and having us back in front of the Committee. It has become very clear — we knew it as professions before COVID, but COVID has laid it very bare — that a one-size-fits-all approach does not suit any sort of healthcare system, particularly ours with the health and oral health inequalities that we have in Northern Ireland. A one-size-fits-all approach will not suit anything, nor will it embrace the opportunity that we have to actually reform our services. This is a unique opportunity to change how things have been approached in the past.

For us, in dentistry, it is clear that the current system is not working for our patients or our professionals. Therefore, the outcomes for patients are just not as good as they could or should be. At the minute, we have a system that is designed around activity. It is designed around bean counting and filling teeth; it is not designed around a modern healthcare system that focuses on a preventative approach. Therefore, from a dental point of view, a one-size-fits-all approach — and, certainly, one that, to date, has not offered any consultation with the profession — is not in the interests of any patients.

Mr Greene: From a Community Pharmacy perspective, the transition and change here affords a tremendous opportunity. Community pharmacy has been in a difficult place for many years. We have been working closely with board and Department colleagues and, indeed, the Minister over the past year. We have agreed commissioning plans that are reflective of local need and a new direction of travel for services. We have seen the benefit of a much more engaged process with regard to our own regional services. We have been engaged in ICPs (integrated care providers) and LCGs as well. Through various initiatives, such as building the community pharmacy partnerships, we have seen the importance and value of working with stakeholders from the ground up to get solutions.

From a Community Pharmacy perspective, we have been, and still are, on a journey to a stabilised place. There are still a lot of challenges for community pharmacy. For us, the real concern is that when we introduce such a significant organisational or system change, while that can provide opportunities for enhancement and so forth, we must continue to manage safely the progress that has been made. There are parts of the health service that are working, and they must be carried forward in a way that does not compromise what has been achieved. It is about building on what is positive and looking at the areas that need further work. When you look at the reports on waiting lists, you see that there are many aspects of the health service that are problematic.

We touched on an important aspect earlier on the question about engagement. Understandably, there is a very medical approach to health service provision, but healthcare provision is wider than the medicalised model. It is very much about bringing the other stakeholders into that strategic planning. It is great that the Committee has reached out to some of the other professions. I think that that is where we want to be collectively, and certainly from a Community Pharmacy perspective: having a meaningful input at the strategic project board and programme board levels in the Department. Excluding our voices means that the full picture is not there and is not considered. That is to the detriment of the population and what the health service is trying to do. We are all here because we want to make a real, positive contribution. We interact with patients and the health service, and we can see where the issues are. Unless we are at the top table, making those informed contributions and being part and parcel of the service solution designs in the new system, there is a risk of repeating some of the issues that have afflicted the system to date.

Ms Ewart: I will add to that from a social work point of view. Some of the criticism from previous reviews has been that social work and social care have not been involved early enough. It is absolutely fundamental that we take on board the views of social workers and social care workers. A whole system approach needs to be adopted, and we need to be at the top table as well.

The important thing is that we are trying to get a blend. We want to have a regional approach that provides consistency at a regional level but is tailored to local need. That is a difficult thing to try to achieve, but if they engage with the professional bodies and our members, they will enhance that. Obviously, co-production by involving service users and carers is fundamental in that approach as well.

Mrs Cameron: Thank you all for those answers. How will the Health and Social Care Bill reduce administrative burdens on front-line staff?

Ms Ewart: Thank you, Pam. I will take that question. We have campaigned for a very long time about the need to reduce administrative burdens on social workers. As we see it, the system is broken; it is tremendously flawed. Over the years, we have done a number of reports that have highlighted that social workers spend 80% of their working day on paperwork and duplicative bureaucracy. Despite many efforts, nothing has changed. We are in a worse situation than we were when we first released our report in 2012.

We have a social work workforce review that is in draft form. We were working towards publishing it last March. World events overtook us, and it is now in draft form to go for approval. It is very unfortunate that the workforce plan, as it is, does not really mention bureaucracy. It does not tackle that issue head-on. We must be prepared to challenge that and say that it really must change. It is not good enough that social workers spend 80% of their working lives doing paperwork and duplicative bureaucracy. That is not acceptable. We would not accept it of lots of other professional groups. It needs fundamental reform. When the Assembly was suspended, we gave evidence to the Northern Ireland Affairs Committee at Westminster and asked for a task force on reducing bureaucracy. Unfortunately, that has not happened either. I think that, in transforming the service, the number-one request from any social worker would be that we strip out unnecessary bureaucracy. Lots of bureaucracy is necessary and fundamental to practice, but the duplication of paperwork is a major problem.

Mr Greene: In the previous session, Nicola Herron said that, over the past 30 years, she has seen increased levels of management in the health service. Health service provision requires accountability in the system without micromanagement. We, in community pharmacy, have seen, through COVID, the need for an agile system response. It needs to be responsive to regional and localised need. It is about striking a balance. Community pharmacies are extremely busy environments. We are taking up a lot of increased workload as a result of changes in access to health services and primary care. That is against the backdrop of some 50 million dispensing activities every year in community pharmacies. While there is a need for accountability, governance, etc — everybody understands that — it is about streamlining it and not overcomplicating things. It is about recognising the professionalism of the healthcare professionals in community pharmacy and the health service.

We, in community pharmacy, are very much front-line. That is where the benefit and added value of community pharmacy is: that interaction with the patient. The increase in bureaucracy, administration, etc that is associated with services takes us away from patients. That is to the detriment of the overall health service objective: looking after our patients and having a responsive, agile health service.

Ms Lappin: On the back of the remarks that Tristen made a short while ago, we, in dentistry, find ourselves in the unenviable position of having, at higher levels, very little administration and bureaucracy, which, ultimately, falls down to our clinical practitioners. In Northern Ireland, we have over 1,100 general dental practitioners. We also have dentists working in community services, like me, and in hospital services. Dentistry, like every other profession on the screen today, is full of bureaucracy. The lack of a dedicated dental branch in the Department of Health and the fact that there are very few dental advisers in the Health and Social Care Board, who are spread extremely thinly, means that we are feeling the impact of that on the ground, which, ultimately, will affect our patients and their care.

The one positive that we have had during COVID is engagement with our acting Chief Dental Officer and the Health and Social Care Board on the operational guidance for re-establishing general dental services in Northern Ireland. That was real co-production between our dental clinical practitioners, our

Health and Social Care Board and our Department. It showed that, between us, we could come up with evidence-based, effective prevention and control guidance to get our dental practices back up and running for patient care. That is one positive example, but it relied very much on goodwill with practitioners, clinicians, the board and the Department. We need some level of shared bureaucracy across our government and commissioning services with our clinical practitioners so that we, as clinicians, can get on with treating our patients.

Mrs Cameron: Thank you.

The Chairperson (Mr Gildernew): Thank you, Caroline. During this morning's waiting list debate, I was struck by the thought, which has been aired at Committee, that the main cause of admission of children to hospitals is tooth extraction. We are dealing with a strategy that is significantly out of date and is based on data that is even more out of date. If we could look at things like that, we could free up some pressure and some resource. Anyway, that is a slight digression.

Mr Carroll: Thanks, panel. I am very concerned about what I have heard this morning. You are all saying that there is a lack of transparency from the Department. I think that you have all used words to the effect that there is a lack of detail and a lack of consultation with you or consideration of you. That is very concerning, and the Department needs to address that. Hopefully the Committee can pressure the Department.

I have two quick points. I was at a picket yesterday involving education welfare officers (EWOs) who are employed by the Education Authority (EA). They are basically social workers under a different name, but they are paid £5,000 less than social workers, who I am sure BASW will tell me are not paid enough as it is. Those workers carry out essential work for vulnerable young people, people who are falling between the cracks, people who have problems in school and all sorts of issues and people in deprived communities. I just want to put that out there, and any comment on it is welcome. I have not really heard from either the Department or yourselves about how this new structure will deal with those issues. I know that they are essentially education workers, but they tie in with health issues. The approach seems to be to just move the furniture around rather than deal with the ongoing problems with staff, pay and waiting lists. I take the point that you have had limited consultation, but it would be useful to get clarity from you on how the Bill may deal with those issues.

I have a final comment to confirm or illustrate what Gerard said. It is conveyed to me quite regularly that the health service is top-heavy with management and senior management, which is in contrast to the fact that the health service is understaffed by several thousand. Those are general comments, but if anybody wants to pick up on them, that would be useful. That is me for now. Thanks.

Mr McClenaghan: Yes, I totally agree. Education welfare officers play a vital role. They are social workers every bit as much as social workers who work in the HSC. The Bill will not have any impact, because education welfare officers will be regulated in the same way as other social workers are — they are regulated by the Northern Ireland Social Care Council — but the governance will be taken forward by the Education Authority.

You talked about the staffing issues — there are massive staffing pressures; we know that. There are huge staffing pressures associated with the roll-out of multidisciplinary teams. We have been very much in favour of bringing social work back to community level, but the figures for the next 10 years are very significant. I think that, by the time that the multidisciplinary teams are fully rolled out, you will need an additional 380 band 7 social workers in those teams. At the moment, in the HSC, we have only 1,752 social workers in bands 7 to 9. Band 7 is the lowest grade and will probably be the largest part of that group, but it is a massive drain on HSC resources to fully staff those multidisciplinary teams. That is only one example. We are seeing huge increases in demand for looked-after children's services and older people's services. Those all need to be factored into proper workforce planning by the Department. That is absolutely essential and is where the focus needs to be in the next number of years.

Carolyn made a point earlier about bureaucracy. I remember that, in December 2016 — I think that Gerry and Paula are the only current members of the Health Committee who were on the Committee back then — I raised the issue of bureaucracy and how we are essentially wasting money by requiring highly trained social workers to do administrative work. Administrative work is incredibly important, but it is not the primary role of a social worker. If we are to get the best value out of the system, we have to make sure that social workers are doing social work and that we are not paying them to do the wrong type of work that involves unnecessary, duplicative bureaucracy. Staffing is a huge issue for us

at the moment, and we need additional resources. We know that we need more staff, but we also need staff to be doing the right work.

The Chairperson (Mr Gildernew): Thank you.

Mr Greene: Chair, may I come in?

The Chairperson (Mr Gildernew): Go ahead, Gerry.

Mr Greene: Gerry, I think that your point touches on something. It is almost as though there is an iceberg in the health service. Everybody knows that there are issues on the top, but it is what is underneath that is the real problem. That is why strategic planning and the inclusion of the various professions at a very senior level is critical to the success of the transition. I do not think that anybody opposes the transition, but it is about making sure that it is not just being done for the sake of it. We have to make a real effort to tackle some of the issues.

We talked about educational welfare officers having social worker qualifications and so forth. Being on the front line, day in and day out, in community pharmacy, we see the struggles that people have that are affecting their health in ways that are not necessarily about medicines. I have spoken with various members of the panel, and I know that there is particular interest in the mental health challenges that will come forward here.

There is a tremendous opportunity here, and we all want to play our part in getting a health service that moves in the right direction, does what it can for the public and addresses some of the deficiencies, such as the waiting lists etc. Again, my call is that we have to be at those strategic levels in order to input. The experience that we have — that skin in the game — makes it real. That is what is needed at the top levels. I have no issue whatsoever with the strategic people who are charged with the responsibility, but they have to draw on our experience. We tapped into that through the Chief Pharmaceutical Officer, the director of integrated care, the assistant director and so forth, and that helped to make progress over the last year. However, there is a lot more work to be done, and we need to be at that decision-making level to help with that.

Mr Kelso: May I add to that, Chair?

The Chairperson (Mr Gildernew): Go ahead, Tristen.

Mr Kelso: I echo exactly what Gerard said. Pharmacies are family practitioner services as we are. The perception and reality for dentists and dentistry are that there has been a break in the chain in the Department. We have an acting Chief Dental Officer, who is doing a remarkable job with very few resources. We do not know what that post will look like in the future. There are no deputy CDOs here, and the CDO does not get to report directly to the permanent secretary, so we feel that dentistry is not privy to or included in a lot of that high-level strategic decision-making. Primary care and dentistry then lose out. We are also really concerned about where the smaller community dental services (CDS) stand with getting rid of the board, for example.

We need to end the disconnect, to join up the system and the dots and to have the overarching policies in place to govern where we are going with things, with the appropriate targets and whatever else. We, in dentistry, certainly share and echo a lot of Gerard's views.

The Chairperson (Mr Gildernew): Thank you.

Ms Ewart: May I —?

The Chairperson (Mr Gildernew): Go ahead, Carolyn.

Ms Ewart: I just want to make one final point. Gerry, we absolutely support and stand behind the EWOs in their campaign for fair pay. As Andy said, what the Bill does not do is to offer any solutions to those issues. We have probation officers in Northern Ireland who must be social workers. The community and youth justice sector also employs social workers. The outgoing Chief Probation Officer, who will leave her post shortly, highlighted in a recent meeting that the probation service cannot employ staff in the probation service, youth justice and as EWOs because they are paid so much less. It is a fundamental issue that really needs to be sorted out. We need a strategic approach

that looks at and values our workforce as a whole. We need that strategic approach to sort that issue out.

The Chairperson (Mr Gildernew): Thank you. I appreciate that those are all important points, and we are focused on how that can be done via the Bill.

Ms Bradshaw: Thank you to the panel for coming here today. My first question picks up on the point that Caroline mentioned about having a dedicated dental branch. I raised that issue last week when the Committee met a representative from the Royal College of Nursing. It strikes me that the way to ensure full understanding of what dentists and, in turn, their patients face is to enhance the role of the Chief Dental Officer and the Chief Social Work Officer and so on, so that they have more of a branch. Last week, the witnesses were not so keen on that. They said that it was more of an advisory role. Can you expand on how we could have better accountability and commissioning of services across those disciplines if we had more expertise at the top of the Department of Health? Thank you.

Ms Lappin: Are you happy for me to go ahead and answer that, Tristen?

Mr Kelso: Absolutely.

Ms Lappin: Thank you very much, Paula. It is nice to see you again.

We have said all along that dentistry has been very much deprioritised in the Department of Health. The Chief Dental Officer has a very firm role in advising the Minister about dentistry in Northern Ireland. However, one thing that we have asked for clarity on is what the role of the Chief Dental Officer will be as a consequence of the Health and Social Care Bill. That is not clear to us. If that is not clear to us, as the dental professionals, that is worrying for the future of dentistry in Northern Ireland.

The other thing that has disappointed us, and on which we seek clarity, is how dentistry is integrated into or how it relates to the rest of the healthcare system. You were very much involved in our event in Stormont a couple of years ago. One of our key asks at that event was for recognition that dentistry is an integral part of wider and general health. If there is not a substantive role for the Chief Dental Officer within the Department, which goes beyond advisory and into strategic planning and allows our dental representation to be at the top table, there simply will not be integration of dental and oral health into the wider healthcare agenda. The people who will miss out on that are our population.

The Department of Health published the inequalities report. As the Chair indicated, the biggest reason for a child to be admitted to hospital is for dental care. I carry out work on those lists in my role within the trust. Believe me that the number of children is not reducing because of COVID; in fact, the situation is getting worse. Waiting lists are increasing. In my trust, we are extremely lucky that we have been able to get up to 50% capacity for our lists. That is the picture throughout Northern Ireland. Those inequalities will not improve while our dental representation within the Department does not have a strong voice that goes beyond being advisory. We are very much focused on the fact that the deprioritisation of dental and oral health within the wider healthcare agenda in Northern Ireland has not benefited anybody; in fact, it has had a negative impact on our profession and on our ability to hope that we will have a profession within health service dentistry as we move forward. We have hit crisis point.

Ms Bradshaw: Thank you. I may ask Gerard this, but it is equally relevant to dentists. Carrying on that point, as private contractors, you have to have dental plans or to carry out other income-generating activities that subsidise your public health service work. How could commissioning be improved so that community pharmacists, for example, are not dipping into their personal reserves to subsidise the making-up of blister packs and servicing of care homes? Gerard has talked to the Committee about that in the past. How could commissioning be improved as we move into the new potential lead from the Department of Health?

Mr Greene: Thank you, Paula. How can you improve the commissioning? I touched on that in my opening statement. I talked about the potential, as we transition to a new arrangement, for budgets to be, in part, managed by the trusts. At present, the HSCB commissions the community pharmacy service. In large part, that is the totality of community pharmacy's funding. Going forward, we would like certainty that the independent contract status is defined and ring-fenced so that the value and benefit of commissioned regional services is maintained.

By and large, 95% of the revenue of community pharmacies is funded by the health service. There is not the scope to dip into a lot of other aspects to subsidise. Our concern is that, where there is potential to look at area population and health care models etc that involve spanning the trusts and the secondary care and primary care sectors, if responsibility for the funding goes in part to the trusts, primary care practitioners could see that part of their funding is retained with the trusts, because the trusts are always in a deficit position.

First of all, it is about ring-fencing current budgets and then looking to stabilise and build those. Community Pharmacy just does not have the capacity to look to alternative revenue streams, so that is important. As I said, there has been quite a bit of work done in this last year and a half, but there is so much more to do, and this period of change is going to be critical.

I come back to the point, Paula, that you mentioned about the dedicated dental branch. Again, it comes back to my point about the influence and the ability to influence. I have been in this role for quite a while. I remember going up to the Department to see the director of primary care, who would have had responsibility for medicine, pharmacy, dentistry and optometry. I remember going up a few years ago and the director of primary care had responsibility only for medicine; for general medical services. Therein lies a difficulty. That is why you need an inclusive process. Part of what the Department does is to set the policy. However, if the policy is uni-professional, there is then the risk of the detriment cascading to the other professions. That is then picked up through loss of opportunity for wide healthcare for the population.

Our Chief Pharmaceutical Officer is engaged with the Department and in rebuilding the management board. However, CPNI feels that it has a role to play in that as well, and that is what we are calling for. It is about that safe handover of arrangements as they are at the minute, where pharmacies' funding is largely controlled and managed by the Health and Social Care Board, and that there is no risk to that. I think that all family practitioner services would have an uncertainty about the governance around the contractual arrangements that apply to independent contractors.

Ms Bradshaw: Thank you, panel.

Ms Ní Chuilín: *[Inaudible owing to poor sound quality]* raised are definitely related to the abolition of the Health and Social Care —.

The Chairperson (Mr Gildernew): Sorry, Carál, we just caught you midstream. Would you start again, please?

Ms Ní Chuilín: No bother. Apologies for that, Chair. First of all, thank you for the presentation. It strikes me that a lot of the issues that you raised are certainly linked to the abolition of the Health and Social Care Board and what will happen to commissioning. For me, listening to this is distressing. Fundamentally, we also need to deal with some of the other issues that you have raised. I am not saying that you are doing this, by the way, but I do not want those issues to get lost in this process either.

In relation to the Department's plans on tackling health inequalities, the fact that dentistry was not visible is alarming. Given the state of oral health, particularly with the number of extractions, and the fact that good oral health, like physical and mental health, is linked to finance and nutrition, it is a massive opportunity. Certainly, I imagine that we will be raising that as well.

Community Pharmacy has been given a lot of support by individuals on the Committee and, indeed, the parties. In fact, I think that we all support you.

How can we use the opportunities through this process to try to fix a lot of the bureaucracy, particularly in social work? I represent North Belfast and am in contact with a lot of good social workers. As Gerry Carroll pointed out, we also have good contact with education welfare officers, the Probation Board and those helping people to avoid having to go through the criminal justice system. I see a lot of people in the community and voluntary sector being asked to do more with less money. I appreciate that bureaucracy is needed, particularly for safeguarding. We all accept that. However, what would you do differently? How do you ensure that bureaucracy for social workers is reduced? How can we ensure that dentistry is part of tackling health inequalities and, indeed, part of the management board? Gerard talked about the need to be represented at that senior level. What else do we need to do through the Bill?

This is my last point, Chair, because I am conscious that time is running on. We need to, if we can, separate some of the issues that are in the Bill and are also part of transforming health and social care. Social care will be critical, particularly if we are to address the waiting lists. If we cannot get care packages and do not have social workers on the wards and working with families, there will be another backlog. What would you do in those circumstances? I am asking you to do more, and that is because we want to make sure that those issues do not slide. We want to give you as much support as possible without wedging everything into the process of abolishing the board. I will leave it there. Thank you very much.

Mr Kelso: Chair, I am happy to respond on the dental issues. Carál, thank you very much for your very favourable comments. The issue of oral health has been kicked down the road for many years. We have a policy vacuum, and I think that we *[Inaudible owing to poor sound quality.]* Oral health is linked with things like cancer, and the oral cancer reviews link in with the new cancer strategy and so on. We absolutely need the Department to take the issue on and to really accept that it needs to put in place the resources and the manpower at its end to be able to make the reforms needed. We need a new GDS contract or else there will not be health service dentistry post-COVID. Things were teetering and broken before COVID. It has now collapsed, and it is reliant on ongoing short-term support, so that needs to be sorted.

We also need to tackle the inequalities. We need a new oral health system to link, in dentistry, the various dental crafts, the GDS, the CDS and the hospitals. Again, it is about having that overarching policy. Where do we want to go? What can we do? Is that the new vision for oral health in Northern Ireland? We need to draw from the learning and best practice elsewhere. Finally, we need to integrate oral health with the contribution that it can make to wider health priorities and to address the broken link in the chain in the Department, given that dentistry feels that it does not have a voice. We heard today that, when it comes to family practitioner services, there is a disconnect between the big, high-level priorities being taken forward at a departmental level and the office of CDO. Where is that going? How will it have the strategic focus and capacity to be able to deliver and lead the reform agenda that is so badly needed in oral health and dentistry?

Ms Ewart: Carál, thank you for your comments. I think that you made a good point that a lot of the issues that we raise need to be separated out from the Health and Social Care Bill. That point is very well made.

On what we do about bureaucracy, we have so many ideas. At this stage, we need a task force that is headed up by the Chief Social Work Officer, is time-limited and is tasked with stripping out all the unnecessary duplicated paperwork that we use. If I could show you the plethora of forms that we have to complete, you would be gobsmacked. We need to, genuinely and from a strategic point of view, give permission to the practitioners, who are worried about not filling in forms. We need to strip out the unnecessary paperwork and to develop one referral form that is done by an agency. As opposed to the 20 or 30 forms that other people insist that we fill in, we need to say that we are going to have this form. I think that our aspiration is to switch that balance to 80:20. If we could say that our task is to get to a system, by reducing by increments, so that we spend 80% of the time working with people and 20% of the time doing paperwork, that would seem like a fair system to me. Looking at caseloads and satisfaction in social work is all interlinked, but I think that we need a task force.

Mr Greene: Very quickly, Carál, thank you very much. I think that you are right about separating the Bill and the operational aspects. There is this transition to come. The Bill should give the vehicle for the reformation to take place. When I look at community pharmacy, even in its recent response to COVID, I see that family practitioner services, independent contractors and certainly community pharmacy show that there is an agility in the sector.

Everybody is aware of bureaucracy in the health service and that it is more of an oil tanker, but I think that, when we are looking to change a system and we want to enhance and improve it, we must not go into the trap of thinking that the whole system is irreparably broken. We have to look at what is working well and to build on the positives. The agility that there is within the family practitioner professions and, certainly, community pharmacy has to be looked at. We have stolen a march a wee bit with our commissioning plans, over the past two years, in trying to accelerate some of the change, but, as I said, there is more work to be done.

Mental health, support for patients with medicines adherence, compliance trays and so forth was touched on, and we are working through trying to formalise services. Those are services where, if we get the service right, that will impact not just on the patient who gets the service coming in from the

pharmacy but around how that patient is managed through the whole journey of care. It is around domiciliary care support and so on. Those are examples of ways in which community pharmacy is innovating, and I think that it is about looking at what is working well in the system and trying to see how that model can be the template for going forward. We want to play our full part, and that is why there is the repeated call to be at those decision-making levels in the planning to avoid an over-medicalised approach to the solution. Reaching out to the other providers as well as the local communities is the right way to do it. It is about striking a balance but trying to move at pace.

The Chairperson (Mr Gildernew): Thank you. I do not have any other indications from members at this stage. Clerk, have you received anything?

The Committee Clerk: I have received no further indications, Chair.

The Chairperson (Mr Gildernew): That was a valuable session. Clearly, there are significant issues of interest that relate to the Bill and some that maybe go beyond the Bill that we are considering. All the information and the evidence will certainly be considered in full by the Committee. I thank every one of you for taking the time to provide us with your insights, experience, suggestions and all of that. Obviously, you are all key components of our entire health and social care service, and we are very much aware of that and are keen to ensure that your voices, your experiences and your expertise are heard and are able to provide the extra value that each of your fields of work represent. Thanks very much for that, and please all take care in the time ahead. I appreciate your attendance.