Witnesses:

Ms Claire Ronald, Chartered Society of Physiotherapy Northern Ireland
Ms Tanya Killen, Northern Ireland Committee - Irish Congress of Trade Unions
Ms Karen Murray, Royal College of Midwives
Mr John Patrick Clayton, UNISON
Ms Anne Speed, UNISON

COVID-19 Response: Trade Unions

The Chairperson (Mr Gildernew): I welcome, via audio link, Ms Anne Speed, chair of the NICICTU health committee and member of UNISON; Ms Claire Ronald, vice-chair of the NICICTU health committee and member of the Chartered Society of Physiotherapy (CSP); Ms Karen Murray from the Royal College of Midwives (RCM); and Ms Tanya Killen from NIPSA. In person, we have Mr John Patrick Clayton, policy officer for UNISON.

I welcome you all here this morning. We are very conscious that you play a crucial role in the design and delivery of healthcare. I now invite the witnesses to brief the meeting. Anne Speed will speak first, and she will then introduce other members of the panel. Anne, I invite you to give us your briefing, please.

Ms Anne Speed (UNISON): Good morning, Committee members and colleagues. I am sorry, but there is an echo on the line here. I am not —.

The Chairperson (Mr Gildernew): We are hearing you clearly, Anne. It may be difficult for you, but there is no echo here. It may be awkward for you, but we can hear you.

Ms Speed: Fine. Thank you. I will briefly tell you that the NICICTU health committee is composed of various unions affiliated to the Northern Ireland Committee, Irish Congress of Trade Unions. Our main focus is on policy development and implementation. In our work, we engage with the Department of Health; arm's-length bodies such as the Health and Social Care Board (HSCB) and the Public Health Agency (PHA); and healthcare trusts.

rise to during the COVID-19 pandemic, have underscored the importance of a partnership approach and our role in dealing with all the challenges.

When we entered the COVID-19 pandemic, we had been through a period of sustained austerity. We are aware that the cost of providing care services increases by around 6% annually, and that level of investment is just to allow services to stand still. In the past decade, investment has not been forthcoming. That has left our members working in a service that is under-resourced and under pressure. I can tell members that, in the past nine weeks, I have engaged substantially with the infrastructural initiative that has been undertaken by the Department of Health to support the preparation of the acute sector in developing COVID-19-focused care; dealt with the Regulation and Quality Improvement Authority (RQIA) in its role as an oversight and guidance body for the social care independent sector; engaged with the PHA to try to define and determine guidance for our workforce; and liaised with the health trusts regularly to ensure that engagement with the workforce is absolutely guaranteed.

We have therefore been working at a mile a minute. We have been pressed to deal with crisis issues as they emerge. We have had difficulties with complicated guidance or absence of guidance; problems relating to personal protective equipment (PPE), such as undersupply; and difficulty with there being a lack of conduits between the independent sector and the public sector. Eventually, after a period, we acknowledge, and this happened with a great deal of support from us, that the public sector was able to wrap its arms around the independent care sector, for both domiciliary care provision and nursing-home provision.

We are extremely concerned that the COVID-19 pandemic will further widen health inequality in our society. The virus is particularly dangerous for persons with underlying health conditions. I am sure that the Committee has heard a great deal of evidence from the health service about the concerns over the slowdown in provision of general healthcare and the increasing number of people who are now on waiting lists for critical care, coronary care and cancer care. We will play a major role in the restarting of services. We have had briefings with the critical care team at departmental level, and we have made submissions for its consideration.

There is anxiety across the workforce.

We believe that there is a lack of confidence in the community with regard to entering back into care across the health service. We discussed with employers this morning how to make the public more confident about taking care and seeking help.

2017, and, possibly during your questions, we can get into the detail of how that has operated since then. As Anne has alluded to, our concern is where TAB finds a place in those new arrangements. We do not yet have any clarity on that. It is not particularly clear from the Minister's announcement or, indeed, from the plan or from the proposed changes to the HSE framework document in relation to the creation of the management board. So, obviously, we have concerns in that regard.

Speaking from the UNISON perspective, as the policy officer with UNISON, the concern that we have around the management board is the potential that this may become another layer of bureaucracy in the health service. As Anne alluded to, we already have a split between commissioning and providing of services. We have a number of trusts and a variety of HSE structures. So, where the management board sits in that regard and where room will be found, particularly for the voice of the workforce and the representative trade unions, would be our primary concern in relation to the management board. Perhaps we will let Claire come in if she has anything that she would like to add, and then, we will be happy to take your questions.

Ms Claire Ronald (Chartered Society of Physiotherapy Northern Ireland): I do not want to add too much, because I want to give the Committee time to ask us any questions that you think are relevant. The only thing that I want to highlight is the fact that, often what we are told when we talk about staff engagement and staff involvement is that there is the strategic partnership forum. This is something that trade unions fought for for a long time. It has been in abeyance for quite a while, and it is important that it gets up and running. It will be interesting to see how it will run with social distancing, because it is quite a large group, and it is about facilitating discussion and collaboration. It is not about negotiation, and it should not take the place of negotiation. Instead, it is focusing much more on how we can influence the future strategic directions, so it is for looking at where we want to be in four or five years' time and at what decisions need to be made now. That does not replace the involvement of trade unions in decisions on what is happening here and now, so we need to be able to separate out the two of them. The strategic partnership forum is not the answer to trade union engagement in how we relaunch services post-COVID. That is the only thing that I want to add at the moment.

The Chairperson (Mr Gildernew): Thank you, Claire. We will now open up to members for a question-and-answer session. My first question is in relation to the management board. I have noted the comments about where the conversation would take place. Have there been any contacts to date at all in relation to that issue with NICICTU or with the unions?

conversation about that journey, involving the principles of co-design and co-production in a plan for the future, I cannot seem them being adhered to. This is not a blueprint for the future, and perhaps the Minister might agree with us. If that is the case, then we need to hear from him about how we will have that conversation and about how we will develop that strategic, new, innovative thinking, because everybody at the table on that management board are the existing deliverers of the service, and all we can see is that they have come together in a tighter managerial function. I will leave it to other colleagues to add to that.

Mr Clayton: Thank you for the question, Deputy Chair. All that I will add to what Anne has said is that what is not entirely clear from the change, particularly for the HSC framework, is around the future of commissioning in this new structure. One reading of the change to the framework would seem to suggest that commissioning is potentially being put on ice, so I think that some clarity is needed around that. There seems to be, on a reading of it, a suggestion that the commissioning plan that is in operation will effectively roll on for the next two years, and I think that there needs to be some clarity around that. That could be quite a significant change to how the system as a whole operates, because the Department currently issues the commissioning direction and then the Health and Social Care Board issues the commissioning plan and then the Trusts implement that. As trade unions, we have always taken the view that we wanted to see the abolition of the commissioner providers because we thought that was a layer of bureaucracy that was not the best use of the health service's resources. We wanted to see a much flatter structure across the board that would be much more around a public health model. Given the context of COVID-19, that is, arguably, even more important than it ever was. That might be an issue for the Committee to explore further with the Department, and with the Minister more specifically.

To add to Anne's point on engagement, as I said earlier, there is a lack of clarity about TAB. When it was established by Minister O'Neill under Delivering Together, it was to play an advisory role to the Minister. The Minister was to be at the TAB meetings, and at that time, we went through a period when there was no Minister. Minister Swann came in in January and, alongside other TAB members, we sought an engagement with the Minister as a meeting was agreed, and then, because of the pandemic, that meeting was postponed. Therefore, I think that clarity around the future role of TAB is very important. We feel that there is the potential for TAB to play a very constructive role, and it has not really had the opportunity to do that yet, in the fullest sense, because there was no Minister in post for several years. Therefore, I think that is very important going forward. It is also for the reasons that Anne has alluded to, as well, because on the management board structure, from what we can see, it does seem somewhat narrow in its construction; it is chief executives of trusts, senior officials from the Department and so on. Therefore, it is important to think about how the voice of the workforce can feed into those conversations, because that is integral to the principle of co-production and co-design, which is at the heart of Delivering Together.

the future.

The Chairperson (Mr Gildernew): OK. We can follow that up.

Mr McGrath: I thank the panel for the presentation. I reflect on where we are: we have Delivering Better Services, the Compton report, the Bengoa report, TIGs and TABs, and now we have a management board. If we hear "board", "forum", "panel" or "review" one more time, people's heads are going to explode with all the information. I feel that we end up being almost report- and board-heavy but action-light with the Department. The health structure itself has the Health and Social Care Board, trusts, the Department, the Public Health Agency and commissioning bodies. To me, it seems that there should be management, staff and public, and that the three should work together in what they are doing. We have this management board announcement, and it does not feel like the allied professions, for example, are represented on it at all. In my experience, when these boards are set up, it is sort of intra-departmental. All their little officials get together, and you have to fight to get the other agencies, the staff and the views on the ground onto it. Do you feel that this management board is going to be like that? Are we going to have to fight to make sure that the allied professions — which is, what, 13 different agencies that are being ignored — are on this management board? How are their views going to be heard? How are the views of those staff who have worked so hard through COVID going to be heard and reshaped? Or are we just going to end up with this being another management board report that goes on the shelf in a year's time? What are the trade unions' views on that?

Ms Tanya Killen (Northern Ireland Public Service Alliance): Chair, I suggest that Claire Ronald, who represents the allied health professions, respond to that question.

The Chairperson (Mr Gildernew): Yes. Go ahead, Claire.

Ms Ronald: Thank you for picking up on that huge gap that exists. As Anne and John Patrick have said, the framework document is something we are still working our way through. It is still quite new to us. Obviously, we only got it on Tuesday. However, as others have already said, it feels as though that management board is replicating existing structures and not looking at transformation.

Our allied health professionals have been front and foremost in the response to COVID, and they are going to be front and foremost in the next steps to rehabilitate COVID patients and the patients who have not had care while we have been dealing with the acute care of COVID, and yet they are nowhere on that board. The chief nursing officer (CNO) does a fantastic job, and allied health professions sit under her remit, but to

The Chairperson (Mr Gildernew): It is a missed opportunity in that sense. To do things differently, you need to have a broad input, including from service user voices and carers. There are lots of other perspectives that should and would be of value, so that is relevant.

Ms Bradshaw: I thank the panel for coming this morning. During the pandemic, MLAs have found it very useful to hear directly from front-line workers about their working conditions etc. In your briefing, Anne, you mentioned that you have had briefings on the rebuilding process and that you have made submissions off the back of that. Just step back a bit: how have you been able to communicate with the Department during the pandemic to feed in concerns about workers' welfare? Have your submissions been responded to positively or not?

Ms Speed: Thank you for the question. That probably brings us to the second part of our evidence, which is to do with the particular needs of the workforce. In our evidence, we highlighted a number of headings, and I would like to refer to them. First, to answer the member's question, we have had a weekly dial-in with the Department, which the HR directors have attended. As the issues emerged, we sought and received responses, although sometimes with delays. That allowed us to raise a number of questions under the headings that are in today's submission, such as testing, PPE, the impact of COVID on black, Asian and minority ethnic (BAME) workers etc. We also engaged — I did, in particular — with the external agencies that I mentioned earlier, like the RQIA, the PHA, the Chief Medical Officer and the Chief Nursing Officer.

As the surge emerged, there were a lot of questions to be answered. We had a portal for urgent responses which worked in some instances and did not work in others. It has been patchy, but that is how we have been able to engage. However, that only emerged after we insisted on having a quick access panel. We had to ask for that, and eventually we got it, but that is how we dealt with and have been dealing with all those issues. The workforce concern continued on from the dispute period that we had, where we had hundreds of vacancies. The challenges are that we have to convert temporary posts to permanent; safe staffing is a huge challenge, and we have not been able to progress that; and the reduction and elimination of exorbitant levels of agency spend.

Moving on, we have had to engage in extensive discussion around frequently asked questions, documentation that has to be cascaded to the workforce, risk assessments, strategies, health and safety concerns and testing. We had to press very hard to ramp up testing, particularly for workers in the independent sector. We had to meet many challenges on PPE. There were problems with its type and availability. There were some shortages. There are all those issues and, as I mentioned, the BAME concerns. They are the kind of workforce issues that we now have to get resolved. We have to get real

pandemic. Social workers and carers are extremely passionate about the role, and they are incredible in their

[Inaudible]

persistence and response to people in need. The jobs are already stressful, and these have been exacerbated tenfold by COVID-19. *[Inaudible.]*

The Chairperson (Mr Gildernew): Karen, I am sorry. I must interrupt you there. That feedback is back on the line. I ask all members who are not speaking to ensure that they are placed on mute. Karen, you were a little faint there anyway. Maybe you could hold the phone up a wee bit closer or something. It was just a little hard to hear.

The Committee Clerk: It is Tanya, Chair.

The Chairperson (Mr Gildernew): Tanya, sorry. My mistake.

Other members, please ensure that you are on mute, and, Tanya, please carry on.

Ms Killen: OK. COVID-19 has increased pressures on vulnerable children and families. It has also impacted the way in which social work and social care are able to interact with them. There is no doubt that social workers and social care workers have had to adapt and to make radical changes to the way in which they have carried out their duties. However, they have felt vulnerable and exposed by minimal safeguards when direct client contact has been limited, which has made assessment very difficult. They struggle with the knowledge that they are discharging patients from hospital without sufficient care packages or into homes that have had inadequate PPE; we are all aware of those issues. Sadly, the impact of this crisis for adult and child protection is likely to be felt long after the threat of the virus itself has receded.

Going forward, public acknowledgement is needed of the valuable work that those staff undertake, and there must be assurances that they are not left carrying responsibility for gaps in the system.

As the Committee will be aware, prior to the pandemic, the trade unions were engaged in industrial action on safe staffing. There were 500 social work vacancies and 1,000 admin vacancies. COVID-19 has in many ways masked those difficulties as services have been stepped down and activity has dropped. However, as Anne mentioned, as they are being re-established, those staffing issues will emerge with a

focus.

We also feel that the guidance does not address the issue of staff being required to do sleep-ins as part of their shift, which is a major oversight that further exposes staff.

Our views on that are very well known: there is a health and safety risk with sleep-ins.

When re-establishing services, it is critical that PPE, testing and social distancing are at the fore of dealing with the return of staff to the work environment. It is NIPSA's view that the health and well-being centres are not fit for purpose in that regard.

I will briefly mention childcare, which is not normally in the remit of trade unions. Childcare has been extremely challenging during this time. Older parents who had provided childcare may now be shielding, and daycare facilities have been closed. Going forth, and in preparation for people returning to the workplace, it is our view that childcare has to be addressed very seriously. For instance, 700 people in the Belfast Trust are off work shielding. Therefore, the numbers returning from working at home or schooling from home will be even more significant. The childcare issue will have to be addressed.

Mrs Cameron: First, I declare an interest: I have a family member who is a nurse.

Staff who were upskilled at very short notice and with very little training have been doing the most dangerous but vital work in, for example, the ICUs dealing with the most seriously ill COVID patients. What conversations, if any, have been ongoing with the Department and staff members to ensure that they are on the appropriate pay scale and band?

Ms Speed: Thank you for the question. NICICTU and the RCN have significant nurse membership, and there are parallel conversations about the utilisation of student nurses, the new intake, terms and conditions, contracts of employment and the skill levels required. That is an ongoing process. It is a bit slow-moving, but it is occurring, and we are keeping a very close focus on that.

Mrs Cameron: Does that include staff going from one band to another when moving from, for example, a high dependency unit to an ICU? I know that there is differentiation in the pay bands, but the work is very similar, or even the same, certainly during COVID.

If we do not get prompt responses from the Department, the restart will be delayed. Committee scrutiny of the length of time that it takes to get responses from the Department and whether it is responding promptly enough certainly could be of assistance to us.

Mr Clayton: I can think of several examples of transformation and workforce planning over the past three years — Claire may be able to think of some points on this as well — when the Department introduced major policy initiatives on the reorganisation of services such as stroke services and breast assessment services. From my perspective, those initiatives were not accompanied by a detailed analysis of workforce requirements and workforce planning.

Many reorganisations seem to be motivated by a general comment such as, "Our staff are spread too thinly across too many sites", "We don't have enough staff" or "We're not able to grow the workforce sufficiently". That goes back to the overall point about the lack of workforce planning over many years that got us to where we are. There is also a lack of real substantive analysis of the implications for the workforce of service reorganisation.

As Anne mentioned, that is being looked at through our bargaining structures, but it is also a major policy development issue. The Department tends to put itself in a position whereby it thinks about policy changes or service reorganisations, but the workforce piece gets a bit neglected or overlooked. That is vital and has to be at the initial stages of the conversation. That is what we have always impressed on the Department in those fora.

Mr Carroll: Good morning, panel, and thanks for your presentation. For the record, I am a member of Unite.

I want to talk about care homes. There is a lot of talk about the independent sector, but there is a view that the independent sector relies heavily on the state through getting finance from trusts and the Department. There is a concern about that generally.

I would like to ask, maybe Anne in particular, whether there is a concern about certain care homes not recognising or obstructing trade unions. How does that tie in to people being able to raise health and safety concerns safely?

When it comes to transformation or even a return to normal services, is there a concern that there may be

The Chairperson (Mr Gildernew): Yes. I think that it would be better to hear from them in the next session.

Gerry reminded me that I should have declared an interest. My previous career was as a social worker. I am a member of NIPSA and on a career break from one of the trusts.

Mr Easton: Thank you for your presentation. I am trying to get to the bottom of the Transformation Advisory Board. I note that a meeting to be held on 24 March was, understandably, cancelled because of COVID. Have there been any meetings of TAB since the Assembly got back up and running? Were there any meetings before or after the Assembly was suspended? I want to see how effective it was.

Correct me if you want, but I sense a great deal of frustration from you at the lack of engagement. On issues like PPE and testing, responses have been very slow to get to you. You also have concerns about the clarity on commissioning should the Health and Social Board close and the lack of a maternity strategy not being addressed. Am I correct in reading from your tone that there is huge frustration about the lack of consultation and engagement with you? I want to ensure that I am correct.

Mr Clayton: I will deal with the TAB issues, if that would be helpful, and Anne and her colleagues will come in more generally about engagement on PPE and the other issues that you raised.

By way of context, TAB was established by Minister O'Neill in 2017. The NICICTU health committee was invited to nominate a representative to that, which was me. TAB also has representatives from the community and voluntary sector and from the patient and service user experience. It is very much rooted in the idea of public and personal involvement — there is a statutory duty around that — as well as co-production and partnership.

TAB had one meeting with the Minister, the exact date of which eludes me right now. I think that it was in February 2017, when Minister O'Neill was still in post. Then, we went into an Assembly election in March 2017, and the Assembly did not sit for several years, as we all know. During the period when the Assembly was not sitting, departmental officials invited us to take part in meetings with them. Those meetings were, in a sense, more informal, in that they were generally an opportunity for officials to share information with us as TAB members and to hear our points of view on particular issues that they raised with us. We also had the opportunity to ask them about specific issues and raise specific agenda items.

As regards TAB and the transformation programme more generally, the transformation programme was

what we call the "bargaining issues", such as terms and conditions for the workforce and workforce planning, through the workforce directorate in the Department of Health. I think that they have problems getting responses from the policy leads and other parts of the Department of Health. I would like Claire to respond to that *[Interruption.]*

The Chairperson (Mr Gildernew): We have someone on the line. Maybe it is Claire who is not on mute, but we certainly are picking up on some of the childcare issues. We are all juggling with those.

Ms Ronald: There is someone else who needs to be on mute.

The Chairperson (Mr Gildernew): Absolutely. Go ahead, Claire.

Ms Ronald: To pick up briefly the issue of PPE and testing *[Interruption.]*

I will wait while others mute themselves.

The Chairperson (Mr Gildernew): We have a dog barking in the background. We are picking up on that. I am not sure that it is on Claire's line. If everyone presses hashtag 6, it will put your phone on mute. Sorry, it is star 6. That will put your phone on mute. Can everyone just check that your phone is on mute by pressing star 6? That sounds better now. Go again, Claire, please.

Ms Ronald: Can you hear me?

The Chairperson (Mr Gildernew): Yes, we can hear you OK.

Ms Ronald: When it comes to some of the PPE and testing, as Anne says, we have regular meetings as the negotiating group with the workforce department and with HRD. We have to be fair to them, because sometimes their answers are delayed because of the systems that we are working in. Some things are outwith our control. Take, for example, quarantine, which Westminster suddenly introduced. That will have an impact on us, and we are still trying to work through some of that. On the workforce side of things, we are building on those relationships and working through that.

As John Patrick was saying, it is wider as we transform, and that brings us back to the announcement on

policy development around what is going to happen with care homes in the future. We need access to that data. The RQIA is collecting data on what is happening for the PHA, but it has not shared that information with us. We have a right to that information because it is our workforce, and our members, and, indeed, our families and communities, who are in those care homes. It is an important question, and all of us will need the data to make the right judgement about what is required.

I was glad to see an increased emphasis on testing. I was involved in discussions with the RQIA a number of weeks ago and made various interventions about patients going from hospital to home and about the delay in test results for care home staff. Test results for staff were being returned in the trusts within 24 hours, but it was 72 hours for care home staff. Over time, all of that has improved. I acknowledge that. They were initial problems. If we are planning for the next phase, all of us need to see the data and the analysis.

Mr Chambers: The Commissioner for Older People is calling for a frequency of twice a week. Bearing in mind that the test is unpleasant and invasive, would you protect the right of the workers you represent if they were not happy to present themselves twice a week for such a test?

Ms Speed: Obviously, we would have to consult those in the workforce who are our members; we cannot ignore their concerns. We would also need to have access to the staff to have that conversation. That is where the issue of the closed doors and the care home owners comes into play. We will consult where we can, but some doors are closed, and they need to be opened.

The Chairperson (Mr Gildernew): Thank you, panel, for that session. It has been interesting, informative and useful.

There has been a suggestion that we write to the Minister in relation to gaps in engagement between the management group and some allied health professionals. Members are agreed that we do that. We will also engage on the responsiveness to issues that you raised and consider how they can be improved upon.

Members, I thank those of you who are leaving. We will take a short break in order to get the additional two members on to the line. We will return at noon.

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