Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Transformation of the Health Service: Department of Health

20 February 2020

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 Sinéad Bradley
Ms Paula Bradshaw
Mr Gerry Carroll
Mr Alan Chambers
Ms Jemma Dolan
Ms Órlaithí Flynn

Witnesses:

Mr Gearóid Cassidy	Department of Health
Ms Ciara Dolan	Department of Health
Ms Sharon Gallagher	Department of Health

The Chairperson (Mr Gildernew): I welcome to the Committee Ms Sharon Gallagher, deputy secretary for transformation and planning in the Department of Health; Ms Ciara Dolan, director of transformation; and Mr Gearóid Cassidy, transformation programme manager. Thank you very much. Would you like to brief the Committee?

Ms Sharon Gallagher (Department of Health): Thank you, Chair. I was just talking to the Committee Clerk, and she described me as a frequent flyer. I hope not; I hope that this is my last flight.

Good morning, members. Thank you for having us here today. I provided a short paper on the transformation of the health service in advance of today's meeting. I hope that it has given members a flavour of this complex issue. If you are content, I will share more detail with the Committee on this important matter.

I briefed you a few weeks ago on tackling unacceptable waiting lists. We discussed the work required to ensure that, alongside managing the backlog, essential new ways of working are put in place to allow us to meet future demand and prevent those backlogs recurring. Those new ways of working will be brought about through the transformation agenda.

You will all be aware of the numerous challenges facing health and social care services in Northern Ireland, not least our ageing population. People are living longer, but there are more long-term health conditions. That presents a huge and growing challenge for the system's capacity to meet demand. I am sure that you discussed that issue with the groups that you met in recent weeks. Health inequalities continue to persist in Northern Ireland between the most deprived and least deprived areas. There is growing evidence that children who experience adversity in childhood are more likely

to experience health issues in later life. There is also the significant challenge that is presented by our current service delivery model, which is no longer fit for purpose. Recruitment issues make attracting and retaining staff to prop up that outdated system even more challenging. It was those and other challenges in the system that led to the publication of the Bengoa report, 'Systems, Not Structures', in October 2016. The report spoke of the need for a long-term sustainable transformation of the health and social care system. In response, the Health Minister at the time published 'Health and Wellbeing 2026: Delivering Together', which laid down a road map for transformation over a 10-year period.

Delivering Together seeks to radically reform the way in which health and social care services are designed and delivered in Northern Ireland, with a focus on person-centred care rather than on buildings and structures. It is aligned with the aspirations set out in the Northern Ireland Executive's draft Programme for Government, and it aims to improve the health of our people, improve the quality and experience of care, ensure the sustainability of our services, and support and empower staff. It also recognises the challenges that need to be overcome if all that is to be achieved. Delivering Together recognises that transformation is a journey rather than a destination. It is an iterative process that will be co-produced to ensure that the needs of those who rely on and work in health and social care services inform and shape and are at the heart of that important change. Delivering Together is clear: how we plan, design, support and implement service transformation is as important as the changes that we wish to make. It therefore makes commitments to partnership working, to investing in our workforce, to improving quality, to driving collective leadership, and to making best use of technology and data. It also recognises that transformation cannot happen in isolation and that stabilisation, as well as reconfiguration, will complement, enable and support transformation to happen, and, importantly, that that will take time and money.

I will take a few minutes to highlight some of the developments that have been made possible in the last few years through the transformation agenda. I am conscious that I covered some of those the last time. Programmes such as Elevate, which is led by the Community Development and Health Network (CDHN), support communities to work collaboratively through making best use of local resources to reduce health inequalities and ensure that the next generation's health and social care outcomes are better. We have invested in training social workers in new ways of working, which has proven successful in empowering families to build on their own strengths and support their own well-being, with the right help and support available to them. Work is also progressing on the development of family support hubs for hard-to-reach families, the operation of a HIV prevention clinic, and the delivery of a new homelessness hub. Those are all successfully engaging with those in our communities who may otherwise not access the services that they need but that are available to them.

We introduced new multidisciplinary teams (MDTs) in primary care to increase services available in GP settings. I heard that you had a briefing on that from colleagues. That new model of care has introduced first-contact physiotherapy, social work, mental health practitioners and enhanced levels of district health nursing and health visiting into GP practices. Those disciplines are all working together for the first time to ensure that the right services are available at the right time to those who need them. We have also undertaken a programme of service reviews, including public consultations on stroke services and breast assessment services. Those are being analysed and will be considered by our Minister. Prototype day-case elective care centres for cataracts and varicose veins were introduced in December 2018 and are being piloted. We invested about £28 million in building our workforce and empowering them to undertake the roles that they are skilled to do.

Investment to address waiting lists over the last two years allowed an additional 120,000 people to be seen or treated in 2018-19, with 70,500 in 2019-2020 proposed for the end of the year. Importantly, we are organising ourselves to deliver in a more efficient and effective way, with work progressing on the legislative provision to give effect to the closure of the Health and Social Care Board (HSCB). Work is also ongoing to scope a future planning model for health and social care services.

As I said, co-production is at the heart of how we develop and implement new ways of working, and we have invested in building capacity and capability to embed new ways of working. We are moving forward with our digital health agenda, encompass, which will transform the way health and social care services are accessed and delivered. Good progress has been made, but the task ahead is significant and will require additional investment.

In 2016, Delivering Together was agreed by the Northern Ireland Executive with cross-party support and recognition that the transformation of health and social care in Northern Ireland would require a period of double running, which is additional recurrent investment over and above what it takes to run existing services. Given the broader financial position, double running has not been possible. However, £200 million was made available through the confidence and supply agreement for the two-

year period 2018-19 and 2019-2020. While this money was non-recurrent, it provided an important injection of funding to begin the transformation process through the on-boarding of over 170 projects across the entire span of health and social care.

As we move forward, the financial position remains challenging. The Department's budget, as it stands, is insufficient to meet current demand and rising pressures or to systematically tackle the growing waiting lists backlog, and there are the added pressures of effecting in-year savings. While the confidence and supply funding has been a positive enabler, the result of the investment has impacted on the financial position for 2020-21, with an estimated £150 million needed next year to sustain and grow the initiatives that began over the first two years.

The pace and scale of transformation will undoubtedly be influenced by the finance available, but, as in previous years, we will work hard to ensure any investment is maximised to improve health and social care services.

The renewed commitment to health and social care transformation through New Decade, New Approach has reaffirmed Delivering Together as the road map for change. Importantly, transformation is now moving into a new phase, from planning and foundation laying to implementation and building a new, modern and sustainable system. Those changes will present challenges to all of us: operational, strategic and emotional. Transformation is complex and multifaceted, and it will take time and resource. It will impact on all of us, but to stay still is simply not an option. Thank you, Chair.

The Chairperson (Mr Gildernew): Sharon, thank you for the presentation. We all acknowledge that a huge amount is being done. We had a very good discussion this morning with the Royal College of General Practitioners (RCGP) and the BMA about multidisciplinary teams.

You mentioned health inequalities, which have a serious impact on parts of our community. How are you linking improvement in health inequalities to transformation? How are you measuring that?

Ms Gallagher: Health inequalities are a key part of the overall transformation agenda. We recognise that we have to stem the flow into primary and secondary care services by supporting people to look after their own health. We invested in pilots in a number of areas — for example, the Healthy Places pilots in Lisnaskea, Ballycastle and Belfast — which enable local communities to better understand how they can look after themselves for the future, mentally and physically. There is a broad range of initiatives in the Community Development and Health Network, which I mentioned, and it works with people at local level in individual communities to help them to maximise the resources they have available and support themselves. The Public Health Agency (PHA) is key in this work and is coordinating the effort by looking at the available resource and the ongoing initiatives in order to allow us to focus on what works to support people at community level.

The Chairperson (Mr Gildernew): I hear what you are saying about putting in resources. What I am asking is: how are you going to evidence that health inequalities are being addressed in the way that we want them to be addressed?

Ms Gallagher: I beg your pardon.

The Chairperson (Mr Gildernew): What are the metrics?

Ms Gallagher: There are two levels. Each intervention that we bring forward will have metrics or outcomes that are measurable. We are coming to the end of our two-year programme, so there is a broad ongoing programme of evaluation to decide which initiatives need to be brought forward. Most of those are short-term and have been on the ground for only a year or a year and a half max.

There are a couple of points. First, health and social care outcomes are not primarily the determinant of what we do in Delivering Together. They are part of the broader draft Programme for Government outcomes and will require working right across government. Secondly, that needs to be measured over the long term and in line with the draft Programme for Government outcomes. You will know that a range of indicators underpin the Programme for Government outcomes, and the Delivering Together programme and the initiatives feed into them. It will be an ongoing longitudinal evaluation of what works well on health inequalities and on a range of other areas.

The Chairperson (Mr Gildernew): I take it that, in real time, it will feed into what has worked well and, therefore, where we put additional resources. I understand that there is objective need centrally in the

Programme for Government — that is important — and that Health plays its role, but what actual things do you measure to see whether health inequalities are being addressed?

Ms Gallagher: I do not have that information with me. As I say, at an intervention level, we will evaluate every project to ensure that it delivers what we intended it to deliver.

The Chairperson (Mr Gildernew): Is that about delivering so many hours of resource or whatever, or is it about outcome?

Ms Gallagher: Outcome.

The Chairperson (Mr Gildernew): How do you measure outcome? I am trying to figure out how you actually measure a good outcome.

Ms Gallagher: Every intervention is different. With the Community Development and Health Network, for example, we look to a range of outcomes at the end of the programme to evaluate whether it did what it was intended to do. The work that I referred to on Healthy Places in areas such as Lisnaskea and Ballycastle will have a different set of outcomes. It will be a mixture of outcomes and outputs depending on the nature of the work, because some of the work will be research work or early development work, but each will be assessed based on the business case that is set out, which will say, "Here is what we intend to achieve", in order to make a decision on rolling them forward. I am not answering your question, I suspect.

The Chairperson (Mr Gildernew): I am still trying to understand. If necessary, you can come back to us. How are we measuring that that is having an impact on health inequalities?

Ms Gallagher: I am trying to look at the short term and the long term. Long term, that is tied into our Programme for Government and the indicators that underpin the Programme for Government. I am not able to tell you today, Chair, specifically what those indicators are. I am more than happy to provide those, but anything that we do feeds into that long-term aspiration under the Programme for Government and the process there for measuring outcomes.

The Chairperson (Mr Gildernew): I would appreciate it if you come back to us because, for the Committee, it is essential that what gets measured gets done. If we are not taking those measurements, we are not understanding what is working and what is delivering in tackling health inequalities, and it might just be things that feel right or whatever. We need to have the evidence so that we can tailor the budgets into areas, can demonstrate that it is working and know that it is lifting people out of those health inequalities over time. We are not expecting a short-term fix but, if we are to guide the journey, we need to know what is happening in real time.

Ms Gallagher: I agree with that absolutely, and that is one of our challenges in bringing forward new initiatives. None of these acts in isolation and the work, together with a number of initiatives, means that many things feed into people's outcomes in health inequalities, including housing, employment and the economy. It can be difficult to measure a single intervention and how that impacts on the overall health outcomes for the population. It is multilayered and multi-complex and I am trying to describe that, for each area and intervention that we funded, we will have a clear evaluation, but it is a much more complex position when you put everything together to understand what the big levers are. We think that we have a fair understanding of where we should invest money, but your point is absolutely correct: we have only a limited amount of money and there is much that we can do, and we need to make sure that we invest it in the right things.

The Chairperson (Mr Gildernew): It is essential for all those services in the longer term that we deal with inequalities and all the other areas, but our principal focus is on how Health is contributing to that. I recognise that there is a cross-departmental job of work to be done in our society and all that.

The briefing refers to 735,000 people having access to MDTs once the roll-out is complete. Earlier, we heard concerning figures about how long the roll-out will take to complete. Is there a target date by which all patients will have access to an MDT?

Ms Gallagher: It depends on additional money and resource but, over five years, we hope to roll out to all areas of Northern Ireland. That is the plan, but it is based on many assumptions, including available workforce and additional funding.

The Chairperson (Mr Gildernew): Under key deliverables, you refer to ensuring that every GP practice has a named district nurse, health visitor and social worker. The target date was March 2017, and it is described as being complete. However, it then states that multidisciplinary teams are being rolled out in three areas. How is it complete if it is being rolled out?

Ms Gallagher: It was the wording of the action: "We will begin that process". It depends on having the workforce and the money to roll out. It is challenging to roll out new models as well as providing the resources. That really is double running. At one level, you are continuing with the service that you have and adding something on top of that. We have maximised what we can roll out on MTDs at this point. We have had challenges with recruitment in different areas, and the model for MDTs is slightly different depending on your area. Some of it is tailored towards the needs of the population in that area, but some of it is about challenges with recruitment in areas such as mental health. As I say, the plan on paper looks at a five-year roll-out, but that is based on many assumptions.

The Chairperson (Mr Gildernew): Does every GP practice have a named district nurse and social worker? Is that complete?

Ms Gallagher: It is not complete for every GP practice.

The Chairperson (Mr Gildernew): We want to see a timeline for making sure that it is complete, given that it is a key deliverable. Will you come back to us with more information and a better breakdown? It is clearly not complete so we need more information.

Ms Bradshaw: It is good to see you again. You quite rightly said that all the parties were in favour of transformation and signed up to the Bengoa principles. I want to focus on the consultation that took place on breast assessment centres during the three-year hiatus.

The expert panel that was commissioned by the Department did not visit all the sites, including Belfast City Hospital, where the regional Cancer Centre is. The expert panel did not reach a consensus about which of the Belfast urban settings would go. Who took the decision on the consultation paper to move the service to the Ulster Hospital from the City Hospital?

Forgive me, members, but this is my constituency. At least 30% of people who go for assessment in the City Hospital are from other trust areas. Why on earth would you move that one part of screening from the regional Cancer Centre, from the Centre for Cancer Research and Cell Biology (CCRCB), from the PHA-funded NI Biobank (NIB) and from where there are surgeons who are breast surgeons and do not have any other caseload? Why on earth would you have a bit of political ground sharing to move it from there when there is no discernible change in what the service will look like? Who took those decisions?

Ms Gallagher: Over 4,600 people responded to the consultation on breast assessment. We had a number of consultation events around the Province, and I was at a couple of them. It is fair to say that we heard, loud and clear, what people had to say, and that will be reflected in our consultation response to the Minister.

At this point, I am not sighted on the level of detail underpinning who made those multiple decisions that you describe. The main point that I want to convey today is that, through the consultation process, we heard what people said, and that is reflected in the report to the Minister.

Ms Bradshaw: I will just leave it there, but we would like an update as soon as possible because there is obviously concern. We do not want the transformation process to be discredited because we think that the decision-making and the lead-up to the decision-making have been flawed. I want to see a reconfiguration. I want to see regional specialisms and all of that. Obviously, as an urban MLA, I would want that, but, in this case, there are serious issues, and I welcome the fact that you will reflect on the response.

Mr Carroll: Thanks for your presentation. I welcome the fact that your submission recognises that the NHS is under-resourced. That is true, and I assume that everybody will support that. The current budget is not sufficient to meet demand, and a serious injection of cash is required.

I am also concerned because, with that accepted, and in your submission, there is a logic that follows that we have to strip back our services in the NHS. There is not only an admission that we are

underfunded but a logic that we have to cut back in our health service, and that is very worrying. It presents all sorts of problems for people's health and weakens the NHS generally. I am very concerned about the issue.

Sharon, you said that we need to ensure that those who rely on the health service inform and shape its transformation, and that is true. Following on from Paula's point, it has to be done with everything, but especially the breast assessment clinics. I am concerned because there has been a pattern of behaviour in the last few years where, essentially, decisions were made by the Department and presented to the public as being done and dusted, and you have to like it or lump it. That is the fundamental problem. It does not engage or include people, and it presents things as being a fait accompli.

You said that there were 4,000-odd responses to the consultation on the breast assessment clinics, but I am aware that there was a petition with between 10,000 and 20,000 signatures. Has a decision been made? It beggars belief that, especially in west Belfast, there is a 76% detection rate of stage 1 and stage 2 cancer, which is 2% higher than the national average. That is working for people in west and south Belfast and other areas, so why is there a proposal to close, reduce and downplay that assessment centre in the City Hospital and move it to Dundonald or elsewhere, when there is no guarantee that people will attend? It is very concerning for me and for others. If it is not broken, why would you try to change it? It is important that people are not excluded when decisions are being made.

The briefing paper refers to 1,600 extra staff for transformation. Can I get a breakdown of where they are?

Ms Gallagher: There are three points, Gerry, if you bear with me. The first is on cutbacks. Transformation is absolutely not about cutting back on staff or services. As you know, the Bengoa report states clearly that the way in which our buildings are structured does not lend itself to a modern service for this century. We are trying to look not only at the model of services in order to develop new ways of working but at new roles for people working in health and social care. This is absolutely not about having fewer people in health and social care but developing, empowering and changing the workforce to meet the needs of people moving forward rather than the needs of 20 or 30 years ago. That being the case, transformation is about sustainability because you could put all the block grant into Health over the next couple of years and it would not be enough. We need to change something. It is about sustainability rather than cost efficiency. Where the policymaking and the process of consultation are concerned, I am sorry there is an impression that the Department makes decisions that do not take account of people's views. That is something that we will need to try harder to mitigate. I was at a meeting a couple of years ago on the criteria for reconfiguration of services, and we heard that loud and clear from constituents in the Newry area. They said, "You come and ask questions, but we never hear anything, and then you make your own decisions". We hear that loud and clear.

I will just say to Paula that we heard what people said about the breast assessment clinics, and that will be reflected in the position report for the Minister to make a decision, so we are back into the appropriate policymaking, and the Minister will make a decision on the way forward.

Mr Carroll: I know you do not have the report in front of you, but, briefly, what is in it? What is the recommendation to the Minister?

Ms Gallagher: That is for the Minister, first, to consider. It is in draft form at the minute. It has not been presented to the Minister, so it would be wrong for me to indicate what is in it.

Mr Carroll: Is there a time frame for it to be presented to the Minister?

Ms Gallagher: It is still being finalised, but it is nearing completion.

On the last point —. You give me a list every time I come here.

Mr Carroll: That is a short list; I could ask you more questions, but I know what the Chair would say.

Ms Gallagher: If you are referring to the number of people who have been funded through the transformation over the two years, I think it is just over 1,100 people.

Mr Carroll: It states 1,600 in the report.

Ms Gallagher: Is it 1,600? I beg your pardon. We can give you a breakdown of those.

The Chairperson (Mr Gildernew): Can you come back to the Committee with that breakdown, please?

Ms Flynn: The criteria for transformation, if I am correct, are yet to be published after consultation. I think the criteria being used are those in the Health and Social Care Board's change or withdrawal of services policy from 2014. If the criteria for transformation are yet to be decided, does that risk any of the work on transformation that has been done so far? If the criteria change, will any of the projects that are going through the transformation process have to be reviewed? You mentioned the £150 million for the roll-out of existing projects and services. Is that £150 million over and above the £100 million that is being spent to start the projects?

On a positive note, going back maybe two or three years ago, our Sinn Féin team met yourself and Gearóid at the beginning of this process, and I am delighted to see some of the schemes that have been rolled out, particularly around mental health, with street triage and the pilot custody suites. We are getting really good feedback from service users, the police and the Ambulance Service, so it is good to see that those projects are working. Long may they continue, hopefully. Thank you.

Ms Gallagher: We share that sentiment. We are delighted with some of the projects that have been rolled out, and we very much want to keep them.

I think I mentioned the reconfiguration criteria when I was talking about going to the Newry consultation. They have been signed off and are published on our website. I can provide a copy for the Committee. They did not change very much from those that were put forward. They take into account things like outcomes, alternative provision and all the things that Professor Bengoa and the expert panel set out as issues. That is agreed and on our website.

The £150 million is the amount required to sustain what we have and to grow for the next year. It is to keep what we have going and to grow it a little bit.

Ms J Dolan: I have a couple of questions. Paragraph 15 of your paper states that the 18 initial actions have been completed, and the table shows that all are at a green and complete status. Does that mean that the Department has no further action on transformation? What does the green status mean? Just like the breast assessment consultation, can I have an update on the reshaping stroke services consultation to find out where it is at? You sounded cautious when saying that the MDTs could be established within five years. Dr Black was at the Committee and said that, within 10 years, we could have a serious crisis in Fermanagh, where you are bussing people up to a GP. I just want you to see the urgency. I am not saying that MDTs will solve every problem that we have, but I would welcome some urgency on that.

Paragraph 37 refers to decisions having to be made. Can you provide examples of what sort of decisions those could be?

Ms Gallagher: I wish that it was the case that the Department felt it had finished its transformation on the 18 actions.

Ms J Dolan: So do I. I am just wondering.

Ms Gallagher: Minister O'Neill, as Health Minister, did not want to publish a strategy without an action plan, and her initial action plan contained 18 actions. That action plan was really important because, soon after that, the Executive were no longer in place. We were able to continue that work on the back of the strategy and the action plan. Those actions may be completed or are coming to a conclusion, but, behind that, we have a range of other work, so each year, we enter into another phase of transformation based on the amount of money that we have available and the priorities that we see at that time. Those priorities, in the absence of an Administration, have been discussed and agreed by the transformation implementation group, which is chaired by the chief executive and has all the heads of the health and social care trusts and the top management group in the Department. It is very early days, and we have only just dipped our toe in transformation, even though some of the work has had a really good outcome. There is much more ahead.

I will come to your last question now, Jemma, which is about decisions to be taken. The big decisions that we are talking about are things like where breast assessment and stroke assessment services are located and how they will be delivered. We have spent the last two years working busily, I hope, in developing options, in engaging, in co-producing and in consultations in order to form views and opinions and to bring to a Minister some considerations. Going back to the fact that Delivering Together was agreed on a cross-party basis, some of these decisions will need Executive support. They are significant for local communities, and, as I mentioned in my opening remarks, they will impact on all of us.

While we had 4,600 responses on breast assessment services, we had 19,000 on stroke. That, I think, says a lot about people's engagement with the process and how they feel about transformation and services local to them. Similar to the work on breast assessment, we are pulling that together. It has taken some time, obviously, both with breast assessment and with stroke, to consider all those responses and put together a report that can advise the Minister.

On Dr Black's view on the GP system being in crisis within 10 years, I could not agree more with Dr Black. What I am talking about is not a lack of aspiration; it is a reality based on the staff that we have available and the funding that we have available over the next period to implement multidisciplinary teamworking.

Mrs Cameron: Thank you for your presentation. We absolutely recognise the severe challenges ahead, and it is very welcome that the 18 priority actions in that 'Delivering Together' document have got the green light. I commend the work that has been done to date in very challenging circumstances. Obviously, consultation is incredibly important, and we are all very aware that there will be very unpopular decisions to be made in the future. Across the Assembly, we have to support the Minister and the Department in making the decisions that will allow transformation to happen. I think it is very important to state that.

What technology is available now, and what is the Department looking at going into the future with artificial intelligence? We know that Encompass is coming on board as well. Is there more to be done, or are you actively looking at new, innovative ways of changing how we operate systems and how we diagnose? What help is there to push ahead with transformation?

Ms Gallagher: It is a really important point, Pam. Encompass is not an IT system as such. It will actually drive transformation. The point that we are making about systems not structures is not just about our buildings; it is about the use of artificial intelligence and all the things that banks and other people use. In many ways, they are way ahead of Health and Social Care, and we need to get up front and upstream on some of that so that we can allow people to check their blood pressure from their phone or laptop or whatever. Encompass as a programme is still in its infancy, but, over the period that we are talking about, it will lead transformation. I keep talking about allowing people to access services in a different way and us delivering services in a different way. I am very happy if the Committee would like a presentation, particularly on Encompass and what it can deliver, but, having had presentations on this, I know that it is incredible what we do not have and what is available. Pam, you are absolutely right, and that is where we want to be with the Encompass programme. We want to maximise it so that it is not just an IT system that underpins what we do every day but that it leads the way in how we transform our services. As I say, I am more than happy to follow up with colleagues in the Department on getting a presentation, if that would be helpful.

Mrs Cameron: That would be a really good thing to have, especially if it is of that importance. It would be good to have some more understanding of the Encompass programme.

The Chairperson (Mr Gildernew): It would be useful if we could get a written briefing in advance, and then we can feed it into where it fits into forward work.

Ms Gallagher: Of course.

Ms S Bradley: Thank you for your presentation. I want to go back to the breast and stroke proposals that are being presented to the Minister. How developed are they? Are they in reports, or are they recommendations? Do they include options for the Minister to select from with a background read? I would like to know the nature of just what is being presented to the Minister. Have they been completed at this stage on both topics?

Ms Gallagher: As part of any policymaking, you have your consultation and then you have your consultation report, which will draw out the key points from people who were in favour and people who were not and any options on those. They are quite specific recommendations, particularly for the breast assessment one, so there will be a view on people's acceptance of that, and a Minister will basically consider what people said about the proposals that have been put forward to them.

Ms S Bradley: You mentioned the Newry event, which I was at. We talk about the outcomes and indicators on health inequalities, and we need to be specific about that. One of the huge issues that came up, certainly from the Mournes area, was access to services. It just seems to odd to me that, on one hand, we are having conversations about the difficulties that exist in trying to recruit people to more rural areas and to services beyond Belfast, yet, when we have services that have achieved that, we are considering stripping them down to some degree or taking them back into the Belfast remit. I just think that sometimes we are doing one thing this week and undoing it in another week. I would like an assurance that regional access to services and the infrastructure, or lack of infrastructure, that exists is heavily weighted against the options and that the clarity of communication that I certainly received is reflected in any report or recommendations brought to a Minister.

Ms Gallagher: With regard to the spectrum of Health and Social Care, we are trying to invest in communities, primary care and multidisciplinary teamworking so that people can access more services without going outside their local area. There is an absolute commitment to that in Delivering Together.

As regards regionalisation or a Belfast focus, research shows that where you can have specialist services, or centres of expertise, if you like, that deal with many people, you have a more experienced workforce who are more satisfied in their job, retention is better and people actually get an improved service in terms of the quality and timeliness. It is a balance between those. Certainly, where we site future models will be up for consultation, and we will use the reconfiguration criteria in considering all those options, like access, infrastructure and people's ability to travel. We have done some work on that with regard to breast assessment services, but more needs to be done. Before we site or redeploy any service, there will be a full consideration of the impact on the population in line with any policy.

The Chairperson (Mr Gildernew): How many projects and key deliverables are in development or being rolled out?

Ms Gallagher: Delivering Together — this sounds as if I am going to fudge the issue, and maybe I am a little bit — is huge. There are some centrally managed projects that are overseen by the transformation implementation group, and we can absolutely give you a list of them, but the one thing that I would say is that transformation is also about enabling people in their local trust to make change, because it cannot simply be centrally driven. I can give you quite a comprehensive list of what has oversight by the transformation implementation group and what is being funded through the £200 million, but there are many other examples of change, quality improvement and transformation, if you like, that are not under the purview of the programme within the £200 million. I just want to give you that caveat, but I can provide you with what is in the £200 million.

The Chairperson (Mr Gildernew): What we would want then to do is start to look at specific projects, because that is obviously very high-level with regard to detail. I know that £150 million has been outlined for next year. Rolling forward to 2026, what budgetary forecasts are being made for transformation in the following years?

Ms Gallagher: Roughly around £100 million, but, because of the way we are bringing transformation forward through co-production, those are very indicative costs. We are putting a marker that we will definitely need additional money of in and around £100 million. That may not even be enough, because, if you recall, transformation is built on the premise that double running needs to exist, and we do not have enough money to run our business at the minute. There is a 3% gap moving forward into next year in what we need to run our business. We have £100 million as a marker, but it will become clearer as we start to co-produce and understand where we are bringing the transformation projects. For example, only when there is a decision on stroke services and how they will work moving forward can we really work through the cost associated with it.

The Chairperson (Mr Gildernew): That is £100 million per year.

Ms Gallagher: It is £100 million per year, as a conservative estimate.

The Chairperson (Mr Gildernew): In the light of some of the issues that we have already discussed about the consultations, what lessons have been learnt about how co-production is done from this point forward?

Ms Gallagher: We are always learning about co-production. We have a lead in our Chief Nursing Officer, who has developed the guidance. We have invested in enabling and building capacity and capability in co-production. However, I think it is fair to say that co-production is a difficult way of working. It takes time. It takes people to absolutely listen. It takes proper engagement, not lip service. It takes a bit of time for all of us, as a system, to work in a different way. I think that there is an absolute — not ambition, because it is more than that. We really do want to co-produce services. We want to listen and respond accordingly, because we know that, unless we do that, things will start to unravel. We have no option but to make change that will be sustainable in the future. There are lessons to be learnt now, and I suspect that, if I am back in front of you next year, I will say that there are more lessons to be learnt, but our ambition is to get there.

The Chairperson (Mr Gildernew): I have one final question, and we have a few minutes, if members want to come in on anything else. Workforce issues are coming up time and again on stabilising the service, never mind transforming it. There are constant workforce issues. We are all aware of the headline figure on nursing shortages, but there are lots of other staff. Part of the workforce issue is to make sure that nurses work to the top of their experience and ability and all that. The same is true for social workers, for that matter. I declare an interest as having previously worked a social worker, and my wife is a nurse. There are a lot of other support staff. In terms of the workforce strategy, what are the detailed breakdowns of the staff grades or occupations that are missing in the system across the, I think, 7,000 posts at the moment?

Ms Gallagher: I think that you are getting a briefing on the workforce strategy next week. I do not have that detail available to me, but it is fair to say that quite a significant piece of work has been done against each discipline to understand what the gaps are and what the future requirement is. I think that I mentioned new roles coming into play and the impact of them in allowing people to work at the very top of their grade and starting to change the way we deliver the services. I hope that the presentation next week will give you the detail you need on that, Chair.

The Chairperson (Mr Gildernew): Are the 1,600 employed in transformation projects in new roles? Are they working on transformation, or are they delivering transformation in the front-line services?

Ms Gallagher: They will be a mixture of people, because what we said was that, for transformation, we need to stabilise, reconfigure and transform. Many of those will be in stabilisation. We funded waiting list initiatives through the transformation fund. That may be new people coming on board to deliver services. There are not that many people who are unemployed in Health and Social Care, so people have been redeployed from elsewhere and have applied for jobs under transformation. That is part of our challenge now. The transformation money comes to a drop-dead end on 31 March. People have moved into those new roles, and it is an uncertain time for them. We need to evaluate those new initiatives to see whether they need to continue. In the main, most of them are showing that they are delivering what they said they would, and that will need to continue. We have a real challenge in funding those posts moving forward.

The Chairperson (Mr Gildernew): Thank you for your presentation and responses. It is similar to some of the other issues that we have come across; we will want to drill down into some more of the detail. We appreciate that you will be coming back to us with some information. On behalf of the Committee, thank you very much for your assistance today.