Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

First-day Brief: Department of Health

15 February 2024

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Liz Kimmins (Chairperson)
Mr Danny Donnelly (Deputy Chairperson)
Mr Alan Chambers
Mrs Linda Dillon
Mrs Diane Dodds
Miss Órlaithí Flynn
Miss Nuala McAllister
Mr Colin McGrath
Mr Alan Robinson

Witnesses:

Mr Chris Matthews	Department of Health
Mr Peter May	Department of Health
Mr Peter Toogood	Department of Health
Mr Jim Wilkinson	Department of Health

The Chairperson (Ms Kimmins): I welcome the permanent secretary of the Department of Health, Mr Peter May, who will provide the Committee with an introductory briefing. With him are senior officials from the Department: deputy secretaries Mr Chris Matthews, Mr Jim Wilkinson and Mr Peter Toogood. Thank you all for attending. Apologies that we are slightly behind time. We have had quite a lot to get through. I will hand over to you and will open for questions afterwards.

Mr Peter May (Department of Health): Thank you for giving me the opportunity to attend today's Committee meeting with my colleagues. Let me start by welcoming you to your new roles and welcoming the return of a Minister of Health, an Executive and an Assembly to reinstate the proper democratic decision-making and accountability arrangements. I am joined by three colleagues: to my left, Peter Toogood, group lead for social care and public health; to the extreme right, Chris Matthews, group lead for corporate and resource management; and, to my immediate right, Jim Wilkinson, group lead for healthcare policy. In addition to those three colleagues, you will meet other members of our senior leadership team in the coming days and weeks.

I have been asked to focus my comments on the key challenges facing Health and Social Care (HSC). You will know that they are many and various, but the key theme that is likely to underpin them all is resource availability. You will know that, before the £3·3 billion package was agreed with the UK Government (UKG), we were on course to have an overspend of approximately £135 million and that that overspend did not take account of an estimated HSC public-sector pay bill of many hundreds of millions of pounds, meaning that, in total, we estimated an overspend of over £500 million in 2023-24. For an accounting officer, that is an extremely uncomfortable place to be in. I reassure you that I

believe that we have taken all the decisions that are in our power to reduce the overspend, including setting out a rigorous efficiency approach across the Department and its arm's-length bodies (ALBs).

I advise the Committee that the budgetary pressures facing not just Health but all Departments are at a higher level than I have witnessed at any point in my Civil Service career. Alongside a severely constrained financial position, we have multiple and compelling demands for additional funding and a range of public services that are clearly in need of greater investment. In such a situation, something has to give. Last November, I publicly warned that we will never have enough money in Health and Social Care to do everything that we want. The competing demands for extra funding cannot all be met — not now and not in the foreseeable future.

Looking ahead, if we had to work on a flat-cash basis from this year's settlement and not take account of the £3·3 billion deal with the UK Government, we would face a pressure of approximately £1 billion for 2024-25. The main components of that are this year's pay rise; the projection for next year's pay rise; the overspend this year, which, we believe, would run through into next year; and additional and new pressures resulting from the likes of inflation, increased drug prices and growth in demand. In the coming weeks and months, we will clarify that budget situation, and I hope that the outcome of the Executive exercise will significantly reduce or, indeed, eliminate the problem. The other thing to stress is that those numbers are based on simply continuing provision as it is, which, we know, is under extreme pressure, and not on introducing new or better arrangements. That means continuing only with those aspects, for example, of the cancer and mental health strategies or the multidisciplinary team (MDT) roll-out that we have already commenced and not starting the implementation of new things.

Allied to the financial challenges are those experienced by our workforce in all parts of our system. I pay tribute to everyone who works in health, social care and public safety and to my colleagues in the Department for keeping the service running in the most challenging of circumstances. Following the extraordinary efforts during the pandemic, our people now face an environment in which demand outstrips capacity in nearly all areas. That is what is driving the increase in waiting lists in secondary care, the increase in the number of unmet packages in social care and the pressures that our GPs experience in primary care.

We have grown the workforce in recent years in medical, nursing and allied health professional (AHP) terms, but we also face a higher proportion of patients who are over 75, many of whom suffer from multiple conditions and are therefore more complex to treat. Demographics tell us that that trend will continue.

We recognise that we need to do more to meet the health and social care needs of the community. In our primary and community care sector, we are seeking to maximise the service that we can provide. That has included not only MDTs in some areas, which I have mentioned, but having a range of pharmacy-first initiatives, harnessing the role that our community pharmacists can play in meeting demand. A social care collaborative has been formed. Again, that very much explores what we can do collaboratively with the resources that we have to maximise impact. The reality remains, however, that the demand and challenges that we face across the system will require more than maximising what we do: it will need transformation and investment.

Given those challenges, we are clear that we need to demonstrate that we are maximising the use of the resources that we have. Alongside the efficiency programme that I mentioned, there is a major drive to enhance productivity. Measures such as the introduction of day-procedure centres at Lagan Valley Hospital and Omagh Hospital, overnight stay centres in the South West Acute Hospital, Daisy Hill Hospital and the Mater Hospital and the rapid diagnostic centres at Whiteabbey Hospital and South Tyrone Hospital are all part of the approach to create centres of excellence that can drive high-volume, low-complexity cases to maximise the impact on the public.

I am sure that you will want to explore in greater detail and question some of the challenges facing the Health and Social Care system. However, I am only too aware that those challenges can appear overwhelming and depressing. I offer the hope that there is a way through. My colleagues and I are clear that the challenges facing our system can be addressed over time, provided that a number of things come together and work on a strategic and long-term basis. I suggest that the key aspects that required are, as I said, first, a look internally at what we can do. We need systems to draw the best out of the many skilled and committed members of our workforce. Health, social care and public safety employ many tens of thousands of people and contracts for services that employ tens of thousands more. Those people know many of the ways to improve the way that our system works. It is through maximising what they can deliver that we will be most effective. Secondly, as the reality is that internal

improvements alone will not be enough, we need a clear and sustained approach to investment over a number of years that provides the certainty needed to underpin proper planning and delivery, including growing the workforce in the areas where we have a deficit. Thirdly, I would suggest that we need consistent and strategic political decision-making that enables the reconfiguration of our services to create sustainable and efficient delivery. I know that all of you have constituencies and will take a close interest in how services in your locality are affected, but I ask you to do that with an eye on the big picture. The challenge is to ensure that we can deliver for all our people and provide the most timely care that we can on a regional basis.

We have to be realistic about the fact that our hospital estate is fragmented in comparison with that in many countries. As a result, while we need all the hospitals that we have, we need to avoid delivering too many services in too many places. One of the consequences of that is that you end up with very small teams where even one or two people leaving can throw a service into crisis. I want to be clear that no one in the Department is dismissive of the natural fears that communities have about whether the greater distance travelled to a service could impact on their chances of survival. We are also driven, however, by a strong commitment to ensure that, when individuals receive a service, it is of a high quality and that that quality does not differ depending on where it is delivered. The consequence of small teams trying to deliver a range of services is that they do not gain the range of experience that they need to deal with each of those conditions; therefore, risks can grow over time. In addition, there is the reality that doctors vote with their feet. They want to be part of large teams in which they can grow their skills to the greatest extent and feel that they are working in a safe environment, so smaller teams generally find it harder to attract doctors, not least because rotas are often smaller as well. What we have seen, therefore, is unplanned service change in a range of areas, which, everybody agrees, is undesirable.

That will be the continued pathway unless decisions are taken to reconfigure services to build strong teams in centres of excellence that deliver high-quality care to our population. The challenge is in ensuring that the most effective pathways are in place to allow citizens to access those services and that those pathways work. Part of that is about enhancing our primary care and community health functions to shift the balance of care from a hospital-based care model. Acute hospitals should be only for acute episodes of care. Strong primary care and community health and social care improves outcomes for people and gatekeeps the impact on secondary care. Alongside that, we need to maximise the full potential of our workforce by introducing new roles, extended and advanced roles, to ensure that we have the workforce to sustain services, meet the changing demands on our service and improve outcomes for people in Northern Ireland now and for the future.

I will conclude with three final observations. First, we have had a lot external reviews conducted, from the Bengoa review around the need for transformation across our system to specific reviews in areas such as cancer and mental health. As a result we have a good idea of what is needed to make change happen. We need the time, people and resources to deliver on that, and, in return, we should expect to be held to account for the extent to which we succeed. A key part of that is being really clear about which things we will prioritise to deliver at any one time, because, if we try to deliver on everything at once, given the scale of the challenge that we face, we will almost certainly fall over and fail to achieve in any area. Prioritisation will mean agreeing that some things do not get attention immediately. That will be difficult, because there will always be individuals or interest groups who would like to see their area prioritised. That is entirely understandable, but it is a practical constraint, and it will be easy to identify the areas not being given attention.

Secondly, we need to encourage and enable those who deliver services to work together, optimising resources to reduce health inequalities and deliver the best outcomes for all. Similarly, joining up Health with the work of the rest of government better could yield significant health and well-being outcomes. We have a public health agenda under 'Making Life Better' and a new approach to how we deliver services through the integrated care system (ICS) framework. Both will provide a good platform to support shared and collaborative efforts, but there is more to do to build community and individual engagement with their health and with the system of health.

Thirdly and finally, I want the Committee to know that we will seek to respond in a timely fashion to your requests, but I highlight that we face major challenges at the moment in meeting the demands of three statutory inquiries — COVID, Muckamore Abbey and urology — and we are implementing two others that have reached conclusions. The COVID inquiry is a particular challenge with multiple modules, and we are investing significant amounts of money and people in meeting the requests required of us. I ask that you bear that in mind if, at any time, we struggle to meet one of your deadlines.

Thank you for listening. I will hand over to you for your questions.

The Chairperson (Ms Kimmins): Thank you, Peter. That was a comprehensive overview of what is undoubtedly a huge amount of work. I am sure that members will have lots of questions. Obviously, we have limited time as well, so I will open up now to questions from members. Without constraining anyone, we should be conscious that we want to get through as much as possible. Responses should also be kept as succinct as possible. We have a lot to get through in the course of the mandate.

I will kick off with a couple of questions of my own. Obviously, we have all been very focused on public-sector pay. I am glad to see that today there has been a positive announcement on funding for it. Have you any indications of what that will mean for Health and Social Care staff at this stage? Will it settle the pay dispute, and where is that with the Department?

Mr May: Thank you for the question. Yes, we have opened negotiations with the Agenda for Change unions. There have been two meetings so far, and there will be a further meeting next week. We will use the Agenda for Change settlement in England as our benchmark, taking account of previous settlements that there have been here as well. There was also a first meeting today with the British Medical Association (BMA) in relation to doctors' pay. Again, there is a report by the Review Body on Doctors' and Dentists' Remuneration, which we will use as our guide. We have started that process. You would not ask me to give you a detailed summary in the middle of those negotiations, but we all hope that we will be able to reach a satisfactory position sooner rather than later. It is probably worth noting that doctors in England or, at least, junior doctors and consultants have not settled on the basis of the offer that was made to them, so that may prove more difficult for us. We will have to see.

The Chairperson (Ms Kimmins): On the back of that, domiciliary care is a huge issue across the board and is linked to the pay issues that we are seeing in terms of recruitment and all of those things. I note that, according to the first-day brief that has been provided to members, the Department is looking at options for how we tackle that. There is a knock-on impact when we look at the capacity in our hospitals, and trying to get people out of hospital is one of the biggest issues that we face. Is there any further detail on those proposals, and when can we expect to see them?

Mr May: I will just comment on the specifics to do with pay, and then I will ask Peter Toogood to say a little more about the detail. On pay, one of the changes in relation to a significant increase in the national living wage from 1 April will likely have a significant impact on the social care workforce. It is certainly one of the things that we factored into the sums of money that I was talking about in my statement about the pressures that we face in 2024-25. Peter has been leading some work on the adult social care side and the children's social care side. Do you want to say something specifically about domiciliary care, Peter?

Mr Peter Toogood (Department of Health): As Peter said, we recognise that home care or domiciliary care is probably one of the key challenges immediately presenting to us in the adult social care arena. For the past year, as Peter mentioned, I have been leading the social care collaborative forum, where we have tried to bring together colleagues across the independent sector, which provides 70% of our home care services, along with representatives from the trusts, the voluntary and community sector and, indeed, unpaid carers, because they provide valuable social care services. We made a lot of good progress last year in understanding each other's worlds better.

In order to meet the need, the two sectors need to work seamlessly together. If we are honest, we are not there yet, but, over the past year, we have been providing the context and the environment in which an improved pay settlement will, hopefully, thrive. We are focusing on fair work as a particular challenge at the moment, and we have established a fair work forum, which is looking at the issue of fair work and improving terms and conditions across the sector. Whereas the initial focus is around fair pay and terms and conditions, we also want to look at what fair work means in the broadest sense, because fulfilment is a big issue. We want a situation where workers in that sector are heard and represented and feel secure and can feel the need to progress in a healthy and inclusive environment where their rights are heard. We are looking at a holistic package in the context of looking at what that immediate pay context looks like.

Alongside the pay stuff, we have tried to look at how we increase the capacity for domiciliary care provision with what we have, which is very much along the lines of the broader thrust across all our services. For example, we are putting early review teams into the trusts, and we have funded some to look at the domiciliary care packages between two and eight weeks after they have been given at the

point of discharge to see whether the package still meets the needs of the individual or whether we can recycle some of that capacity back into help.

So, pay is important and is at the forefront of our considerations. We are working it up in the context of fair work, and we are putting into the context of the broader piece, which is the need to plug the gaps that, we know, are there.

The Chairperson (Ms Kimmins): Thank you. We talk about transformation and so on, and — I am being a bit parochial — the 'Getting it Right First Time' report on gynaecology and maternity services was published recently. We know that transformation is needed, but the interpretation of some of the report can cause a lot of fear and concern. One of the issues raised with me was fear about the future of the maternity service in Daisy Hill Hospital. Can I get some feedback from the Department? It is only a report, but where is it going? The Minister referenced the report in the debate on the women's health strategy this week.

Mr May: The key focus for us with that report will be on the recommendations that are reached and not necessarily on the commentary, which is, I think, what you are referring to. Our focus will be on trying to work through those recommendations so that we can improve the service in those areas, because one of the reasons why we commissioned that report is that we were aware that we were facing severe challenges in that area, and getting some experts from England who, essentially, have the chance to compare with provision elsewhere is one of the ways in which we can short-circuit and get to the best answer as quickly as we can. Do you want to add anything, Jim?

Mr Jim Wilkinson (Department of Health): We have been using the 'Getting it Right First Time' team as our process to give us some information about how we might improve the efficiency of services. As Peter said, our focus is on the recommendations and creating an action plan to implement those recommendations to improve patient pathways and improve efficiency. However, it is a report by clinicians, and they are free to make comments. The Southern Trust has already referenced that commentary and indicated that it has no intention of changing services there.

The Chairperson (Ms Kimmins): That is reassuring, and I hope that it will allay people's fears. Certainly, at the minute, there is no capacity to lose services that are already in the system, so it is about looking at how to make improvements. It is reassuring to hear that at this stage.

I have a couple of other questions, and then I will open up to the rest of the members. The report talked about some of the capital projects. Can we get an update on the Newry community treatment and care centre and the electricity upgrades for Daisy Hill and Craigavon?

Mr May: We committed some money in-year for electricity. There is a multi-year requirement of a certain amount each year, and we expect to meet that requirement as we go through. From memory, the Newry community care project is on our plan, but it will be subject to the availability of capital, which, like resource, will be under significant pressure next year at least. We will need to see the outcome of the Budget before we can reach any conclusions.

The Chairperson (Ms Kimmins): Thank you. That is all from me. I will hand over to Linda.

Mrs Dillon: The Chair has covered some of my questions. My main question was this: what does today's announcement mean? Can we get a bit of detail on that as soon as possible? You have given us what you can today, and I understand that you will not have a detailed outline of what it looks like, but it is important that we get that as soon as possible.

You talked about the priorities, and I understand that we cannot do everything, but can we get, as soon as possible, a list of the priorities, the rationale behind how they were reached and how the plan will be worked out?

Mr May: On the priorities point, the logic is that priorities should be set alongside a budget being set, because you need to know that you have the wherewithal to deliver them. While we have a returning Minister, a Minister has not been in post for some time, and it is reasonable to give the new Minister a little time to decide which priorities he wishes the Department to focus on in the immediate period. I agree that, within a reasonably short period, we need to be able to set those out. I do not have much to add on the pay points. We are all pleased that the way is clear to try to resolve the pay dispute, and we are working hard to do that as quickly as possible.

Mrs Dillon: Pay is important, obviously, but so are conditions. I think specifically about the domiciliary care workers who do not have assurance about their contracts and hours of work. We need to deal with all that, because, if we do not have that assurance, we will lose people.

In relation to that, can we have a bit of assurance about where we are with workforce planning in terms not only of recruitment but of retention? In thinking about not just the immediate future but what will happen, can we have a bit of information on planning ahead? The papers give percentages on staff in the HSE showing not only the rise from 2022-23 but some figures from 2018 up to 2022. Is the rise in the staff percentage in nursing and midwifery in particular due to additional staff or to a reduction in bank staff? Have we stayed stable in that we have not had any great increase in the numbers of staff but there are more permanent or full-time staff than bank staff?

Mr May: There are some new roles. I mentioned multidisciplinary teams, which are in 30% of Northern Ireland. Workers in those are employed by the trusts and count against the trusts. Similarly, as a result of the industrial action that was concluded in early 2020, decisions were made about changes to nursing arrangements in hospitals. That will have had some impact. There is certainly additionality. We are looking to reduce reliance on agency staff. That is a core part of our agenda and has been for the last 12 months. We have made really good progress with social work agency, and, with nursing agency, we have made good progress with using the off-contract use of agency, which, as you know, is the more expensive element. We have more to do with the core agency.

Mr Wilkinson: The overall workforce has grown. You asked whether that was offset by a reduction in the use of agency or bank staff. During the same time, we have been spending more on agency and bank staff, so, overall, there has been more investment in the system. Part of that is to do with the increase in nursing places that we have had over the last three years through student nurses, but there are still a lot of vacancies in the system. For us, the priority is to try to move into a having full-time workforce rather than agency or bank staff. However, the other part of that equation, which Peter has referenced before, is to make sure that we are able to design the work and the process to make maximum efficiency of what we have got to allow people to do the jobs that they need to do.

You also mentioned welfare. We have a workforce strategy and a workforce plan, and a big feature of that is well-being. Alongside the number of people, we have quite high numbers of sick absences. That depletes the workforce as well. Therefore, we want to work across all fronts: recruitment; training; and a reduction of agency staff in order to increase the numbers of permanent staff and of well-being as well.

Mrs Dillon: I agree with that, but this is us getting a sense of where that is. Again, I am not asking you for that today, but we definitely need to have it, because it is such an important part of everything that we are doing.

My last question is on capital, which Liz alluded to. Again, I know that this will all be dependent on budget and that you cannot give us this today, but the Committee will want, as soon as possible, to get a sense of the priorities for the capital budget and where that will go. We know that there are areas that definitely have been left in a deficit and where the least money has been spent on capital over a long, long number of years. I will not mention the areas, because I do not want to be parochial, but the truth of it is there and is laid bare to see. It does not matter whose area or constituency it is; if it is the truth, it is the truth, so we need to deal with it. Can we get a sense of that? I am not asking you for that today because I do not want to take up the time of other members who could ask questions that might need answering today. Those are the things that I would like to see as soon as we can get them.

Mr McGrath: Peter, I thank you and your team for the work that you have done in the last period of time, and I thank your predecessors and the directors who have been in place. For five of the last seven years, we have not had a Government or an Executive in this place, and it has been left to you, as officials, to effectively run our health service. Can you give us a flavour of the difficulties that that has caused you? What have you had to face, and what decisions have you not been able to take? Will you give us a sense of how close to collapse the health service has come? I see collapse as the service not being able to provide a timely service for patients, resulting in them dying. Is that happening, and what can we do to stabilise things going forward?

Mr May: Thank you for the question. Obviously, I was not in the Health Department during the first period without Ministers, but this last period has been extremely difficult. It has been the most difficult

in my time in the Civil Service because of the financial challenges and the challenge of taking decisions on the basis of what the legislation sets out.

What is lacking in an environment without Ministers is that there is no Programme for Government and no universally set Budget, so there is no set of priorities against which all of government can pull. Inevitably, within the Department, I can take some decisions, at least, but a Minister coming in tomorrow or next month could easily want to take a different direction from the one that I have adopted. That makes long-term planning much more difficult, and that has been one of the things that have been most challenging in recent times.

Everyone will use their own language, but I would say that all parts of our Health and Social Care system are under severe pressure, and there are always risks that something might go significantly wrong as a result. The system is resilient. Often, people have said, "This is so bad. We cannot allow it to get any worse", and then it does, unfortunately, get a little worse because circumstances do not permit people to do the things that they would like to do. There is no doubt that the risk envelope, as it were, is more stacked than, I suspect, it has ever been in health and social care, which is why it is so important that we are able to take some of the steps that I have tried to set out. I know that there is broad political consensus on the need to invest in and transform our health services and on how important it is that we try to begin to make those moves sooner rather than later so that we can begin to mitigate some of the greatest risks.

Mr McGrath: We continue to reiterate that we would love to see a commitment that nobody will collapse the institutions in the period ahead, to give the stability that you and your senior management team need to deliver healthcare. In an echo of your remarks, we hear from the ground that the envelope is stacked and that people are having lots of difficulties. If we can find resolutions and solutions, that would be much more helpful.

In the previous Health Committee, we got close to producing legislation on safe working practices to provide a legislative base that would provide the comfort for staff of knowing that they are going to work in a safe environment where they will not be under considerable pressure or have vacancies that cause pressure. Can you give us a sense of where we are now that we are, essentially, in a new Assembly? Is that still on the table, or do we have to go back to the start? Does the Minister decide on whether that is a priority, or can the Committee help to press for that?

Mr May: We will talk to the Minister about legislative priorities for this and future years. Work has been done on safe staffing, which was a commitment after the nursing strike that ended in 2020. My recollection is that we hope to be in a position to go out to a public consultation later this year. That will provide the Committee with an opportunity to engage on that legislation and bring legislation forward thereafter. Is there anything that you want to add, Jim?

Mr Wilkinson: No, that is the sort of timetable that we are working to. We would rather progress that work so that is not a case of going back to the start. We have been engaging closely with the relevant trade unions and hope to bring forward a public consultation later in the year.

Mr May: Obviously, that is subject to ministerial input.

Mr McGrath: Thank you.

Mrs Dodds: Thank you for the information. I am new to the Committee —

Mr May: You are very welcome.

Mrs Dodds: — so forgive me if I ask questions that you have probably heard 100 times before. I think that some of it is important to put on the record. You referred to the £3·3 billion financial package, which is important. In that financial package, about £34 million is set aside to try to reduce waiting lists. We know that we have the worst waiting lists across the board in the whole of Europe. If we think of nothing else, prioritising people on waiting lists who are in pain is a huge issue that we all must tackle, and, to me, £34 million seems a small amount. What is your estimation of the amount that is actually needed to bring waiting lists down to a more manageable level, and how do you see that happening?

Mr May: I am glad that you are not starting with the easy questions. You are right that £34 million is a small amount to invest in waiting lists. We can give you illustrations — I do not have them here — of what sorts of things that would enable to happen or not happen.

I will give you some context. Until this year, in recent years, we have been investing £96 million each year in something called a "waiting list initiative". In practice, a substantial part of that money has been used to deal with cancer and red-flag referrals that were not being dealt with in our system. That gives you some sense of the order of magnitude. This year, I took a decision to reduce that amount, given the budgetary challenges.

The £34 million will not go anywhere near addressing the waiting list problem. It would require many hundreds of millions. I do not have a number that I can give you today. It depends on the parameters that you set for what you are aiming to get to. It is a bit more complicated than it looks. It is not simply a question of clearing the people who are currently on waiting lists; you have to accept that new people will come on to the waiting lists all the time as well. A core part of what, we believe, is necessary is to get to a place where our system can cope with that level of new referrals on an ongoing basis, and then there is some investment that helps to clear the backlog that exists. I suggest to the Committee that it is important not to look at that in just a secondary care context. Actions taken, for example, in relation to enabling the discharge of people who are in hospital but with no medical reason to be there would free up space in hospitals to deal with more elective care than they do at the moment. Equally, by investing in public health and multidisciplinary teams in primary care, it should be possible to have a focus on people who are in cohorts that make them more rather than less likely to come into hospital at some point in the future and to take action to reduce the levels coming in.

We need to take a systemic approach to waiting lists rather than just a narrow one of how much money we can throw at a problem at any given point, welcome though a sum of money would be.

Mrs Dodds: I accept that there is a big, rounded conversation around waiting lists. We are, however, in a position where, when I speak to friends who are GPs, they tell me that one of the most traumatising things that they face is having to red-flag a potential cancer patient while knowing that that patient will not be seen for a long time. I want to know that, as well as the conversation around waiting lists, the Department will place some priority on waiting lists. That is massively important.

Mr May: To be clear, it is the focus of a huge amount of work and effort in the policy part of the Department, which is based in Castle Buildings. Also, since the Committee last met, the Health and Social Care Board has ceased to exist, and the people who worked there are now part of the Department's strategic performance and planning group, and they, too, have a huge focus on reducing waiting lists for a range of things.

You mention cancer particularly. We face challenges to meet the 14-day breast target, the 31-day and 62-day targets, but it is certainly not the case that people are waiting for very long periods. We are doing our very best to —.

Mrs Dodds: I suspect that, if you are a woman who has been called back in about a mammogram, any length of time is a very long period. I want us to have a particular focus on that so that we understand that these things are hugely important. Maybe someone could write to me about that, or I would be happy to have direct conversations about it, because it is a massively —

Mr May: You can be assured that it is, and I am happy to follow up.

Mrs Dodds: If I may, Chair, I will ask about a couple of other things. Lots of stuff from the presentation jumped out at me as being important. Again, it would be useful to get an overview of the capital needs of the whole health estate and to look at that. I will be parochial: after Belfast, Craigavon Area Hospital serves one of the widest and biggest trusts in Northern Ireland, and some parts of the hospital are in very poor shape. We need to look at the capital budget priorities.

On workforce priorities, will recruitment of student nurses into Queen's University Belfast (QUB) and Ulster University continue to be suspended? I know that you did it this year and that those places were offered out. Will we try to reinstate that? It seems that, if we do not bring on new nurses, we will never meet the workforce challenge.

Lots of people talk about multidisciplinary teams, and I see the value of them. Has any appraisal been done of the work of multidisciplinary teams and how effective they are for the areas in Northern Ireland that have them?

Finally, I have a question for Peter about domiciliary care. I appreciate that sorting out the workforce — paying the workforce properly — is really important, but the sustainability of the private sector is a massive issue, and we need to look at it. I am also interested in the views of the people who receive the care. I speak to a lot of people who get a maximum care package of 15 minutes, four times a day. It is very little. In an ideal world, we would all like to provide more. That is also important.

I look forward to engaging with you. Perhaps we could have some brief answers. Thank you, Chair, for your forbearance.

Mr May: On workforce numbers and trainees, not just for nursing but more generally, I am afraid that the only answer that I can give at this stage is that a decision needs to be taken in the context of the Budget outcome. I am sure that the Minister — the Department, certainly — would like to increase numbers of trainees in a range of areas, but we need to wait and see.

Some analysis of multidisciplinary teams has been done, and we can provide that to the Committee in due course. Another important dimension to multidisciplinary teams is that we believe that they help to stabilise primary care in the areas where they are in place. We have not seen the same levels of contract hand-back in areas where multidisciplinary teams are in place. That is an important consideration, but, in addition, you are right to want to see the benefit in terms of health outcomes.

Mr Wilkinson: We can certainly share some information on the outcomes of multidisciplinary teams. To date, we have that for physiotherapy, mental health and social work interventions and on the impact of multidisciplinary teams on GP time. As Peter said, the evidence shows that they provide a better service. Our challenge, because we have been limited by funding, is that they only provide a better service where they exist, so it is about how we spread that better service more widely.

Mrs Dodds: If only 30% of Northern Ireland is covered by multidisciplinary teams — is that what we are saying?

Mr May: Yes.

Mrs Dodds: — we have an enormously long way to go to provide that service. There is an inequality straight away in how people are treated across Northern Ireland. I know some GPs who have them; I know some GPs who would love to have them; and I know other health professionals who tell me that they are not terribly sure whether they work.

Mr May: Indeed. I have heard all those voices as well. Peter, do you want to say something about the social care aspect that the member raised?

Mr Toogood: Sure. Yes, you are absolutely right. We have put in place a forum, and the key members of that are the independent sector providers, including individuals and representative organisations such as Independent Health and Care Providers, for example. The voice of service users is also a key voice on that forum, because, in anything that we do, we are here for that reason. We can be better at that and are looking at how we can improve the voice of those service users on that forum. Those two key voices are there and are informing the work, because, again, such is the scale of the challenge that you have outlined, we cannot do it all in the statutory sector, and nor do we claim to. For me, it has been about trying to put that into practice. "Partnership working" and "working together" may sound twee, but the reality is that we need to involve everybody collectively to get a solution.

One of the key areas that we are looking at — the work will take a wee bit longer to deliver — is a new model for home care or domiciliary care. The time-and-task model that we have at the moment poorly serves the people who use the service, and we recognise that. There are some pockets of good practice that have been trialled in some trust areas, but we are looking to see what that would look like, and we have commissioned some work in that regard. That is one of the key areas of work that we would like to see come to fruition. The sustainability of that sector is key, and it comes back to the points that Peter made about pay and terms and conditions and how we can invest in that sector.

The Chairperson (Ms Kimmins): That is helpful in terms of the flexibility around domiciliary care. In my experience, you find that, as time goes on, there is less and less that staff are even allowed to do, compared with many years ago when people were going in and setting fires for older people and things like that. That is changing rapidly, and people are not getting what they would like out of it. Any flexibility around that would be welcome, and we should listen to service users and their families and find out how that is impacting in reality.

Ms Flynn: Thanks very much to the panel for coming to today's Committee meeting. You will know that, the other day in the Assembly Chamber, we had a debate about the women's health strategy. It is referenced in the first-day brief, as is the review of maternity services. I want to ask specifically about looking at a refreshed maternity strategy. I know that that work had to be paused due to COVID, and the latest response from the Department was that the work would recommence as soon as possible. My first question is this: has the work on the maternity strategy started up again? I know that Professor Mary Renfrew is also carrying out a review and that you might be waiting until that work is complete. That is my first question.

Mr May: That review is pretty well on now, and we expect to see the outcome shortly. I do not think that the maternity services strategy has kicked off yet.

Mr Wilkinson: No. As you identified quite rightly, things have moved on. We are aware of the need to refresh and renew the strategy, but the priority for us was looking at the safety of maternity services as are and responding to local and national reports to see what we could do. That was really the basis of the work that we commissioned. When that report comes in, we will want to check that we have all the actions necessary in terms of our maternity services, and that will provide a platform for the strategy. However, in terms of commitment and resource, our priority is the safety of maternity services and the development of an action plan, and that will then lead us into the refresh of a more holistic strategy. It is tied up in a similar position to the women's strategy, but it is looking at maternity services.

Ms Flynn: All that makes complete sense. I understand that the important thing is to action the recommendations that come out of those reviews and reports. That will hopefully give you a good basis to look at a future strategy, but you need to keep it on a list of high priorities because there is no sense in talking about having this great women's health action plan or working towards a women's health strategy when our maternity services are, like the wider health service, they are under severe pressure. I just wanted to make that point and get some detail on it, so thanks for that. My second question is about the first-day briefing paper. I do not know whether I missed it, but I could not see any detail about or reference to addiction, and I wonder why that is. I know that you cannot put everything in your first-day brief, and the 10-year mental health strategy, the MDTs and the perinatal stuff are all in it, but it worries me that addiction is not there substantially. The reason that I worry is the massive cost that addiction places on the health service; it is probably closer to £1·5 billion when drug deaths and alcohol deaths are included. Both of those have almost doubled over the past 10 years. I think that the figures for alcohol deaths came out yesterday.

There might have been some changes to your leads in the Department. When we last met at Committee, I think that you, Peter Toogood, were head of mental health services. I know that the directors recently changed, with Heather Stevens taking over from Gavin Quinn. Where does addiction fall as regards priorities and the first-day brief? Does Heather's role take in mental health and addiction? It is just so that I know who my point of contact is among the senior officials in the Department who are dealing with those serious matters.

Mr May: Let me talk to the first-day brief, and I will then ask Peter to say something about the organisational approach. I take full responsibility for things not being in the first-day brief. In the past, a large volume was produced that, I felt, was unreasonable to ask any Minister to read on day 1, so I took the decision to remove some things that were offered for inclusion in the first-day brief, and I think that that was one of them. That does not mean that it is not important; it is just that there is a limit to what you can give a Minister on day 1. A lot of work has been done on addiction. Do you want to speak to that, Peter?

Mr Toogood: Sure. You are right, Órlaithí: there has been a range of changes since I was last here. There has been some recent reorganisation in the Department as well. As things sit, in my broader group, I still have responsibility for the mental health strategy, which is Heather's role. I also have responsibility for the substance use strategy, which Liz Redmond heads up as Heather's equivalent. Gary Maxwell is a lead on that.

You are right: in one version of the first-day brief, the substance use strategy for alcohol and drugs is referenced at a high level. One of my new responsibilities is chairing the substance use programme board, which the Chief Medical Officer (CMO) did previously. That is part of a broader reorganisation that we have done in the Department that has brought some of the public health policy areas that used to sit under the CMO into my group alongside some of the related policy areas, most notably mental health.

Substance use, alcohol and drugs sits with Liz Redmond and Gary Maxwell, but they work closely with Heather on the implementation of the mental health strategy. For example, they have put together the two pots of money that we have for those strategies to fund a coordinating post. There are some actions that are common to those strategies, so there is no point in two separate bits of the Department doing them separately. They are absolutely hand in glove in making sure that there is a join-up and that we maximise what we have to the best effect of both strategies. It is helpful that it sits under one policy responsibility as well. That means that Liz and Heather talk regularly as part of my broader team: they are fully sighted on what is going on in each other's world, so, hopefully, nothing falls between the gaps.

Ms Flynn: I appreciate that update. I completely appreciate from doing our own first-day briefs that you cannot put everything in them and that you have to prioritise. The issue of addiction overlaps with mental health, suicide prevention and all the rest — it cuts across all Departments — but it needs to be up there as a health issue, because we are seeing an increase in the number of people dying through drugs and alcohol. It is a really serious issue that is impacting on, I am sure, the constituencies of everyone around the table.

Mr May: I take your point about the first-day brief. Let me be clear, however, that no difference has been made to what is happening in the Department as a result of whether or not something is in the first-day brief. I do not want you to run away with the idea that some change has been made to the level of resource or effort that is being put into those matters as a result of that: it has not.

Ms Flynn: That is grand — no problem. I will raise that with the Minister, as well, since he heads up the Department.

This is my final question. You mentioned that there may be some pressures on your resources as a result of the COVID inquiry, other inquiries that you are involved in and the amount of work that you have on overall. As regards your resources, staff and teams, do you still have a dedicated team working on transformation and health inequalities?

Mr May: A number of teams are working on that in different ways across the policy areas that Jim Wilkinson and Peter Toogood work on. Jim, do you want to say something about transformation and then Peter can say something about inequality?

Mr Wilkinson: Yes. I am on transformation on the healthcare side as opposed to population health. The closest part of health transformation is helping people to live healthier lives, but it goes right the way to looking at how we make the acute system work as effectively as it can.

We have teams. We talked about secondary care teams, the GIRFT reviews and the service reviews. Those look at how we improve and organise services. We have also been doing some work on the construction of the acute sector — how a hospital system works. We talked about some of the service collapses. That work looks at how the system should operate as a network and how people should be able to access that care. Primary care is all about the area of multidisciplinary teams but also GP contracts.

Transformation work is progressing across all those fronts in an attempt to move this forward and deliver at pace, if we can. Although funding and the pressures that we face are critical, we have maintained focus on transformation being one of the answers to help to address some of those problems.

Mr Toogood: The health inequalities piece is part of the broader population health policy remit. Liz Redmond and Gary Maxwell, whom I mentioned, have responsibility for that. That is in the context of the Making Life Better strategy, which is the Executive's overarching strategy for addressing health inequalities. That work is being taken forward by Liz Redmond's team. It includes reaching out to other Departments, because health is only one part of health inequalities; a load of other social

determinants have an impact on people's health. We have a dedicated team looking after that Making Life Better programme of work.

Ms Flynn: Thank you, Peter. Chair, I think it would be a good idea if the Committee were to get an update from those two teams — transformation and health inequalities — at some stage, if members are content to do that.

The Chairperson (Ms Kimmins): Yes.

Miss McAllister: Thank you very much for the presentation. We have had sight of the first-day briefing for a few days, which was helpful in informing today's discussion. Obviously, it is a long time since any Health Committee has sat, so we all have a number of questions, but I want to stick to what is pertinent to today. I recognise the difficulties that have been placed on civil servants for the past two years by the difficulties with resources, so I want to thank you for the work that you have done in the absence of an Executive. Moving forward, now that we have an Executive, we will hopefully be able to make the necessary changes, but I recognise that we cannot do everything at once and that it would be unrealistic to make those promises.

I have a question that follows on from the discussions about the budget. Of course things have to be budgeted and decisions need to be made. Those decisions are often quite difficult. Peter, you spoke quite a number of times about maximising the resources that you have. Unfortunately, we have seen cuts to services over the past months, particularly to charities and services such as cancer support services and mental health support services. We have not, however, seen mitigations to that. When there is a cut to a service that does the work that any other statutory health body should do, that will just transfer the workload back to statutory services.

On recent decisions that have been made, in what context are mitigations to the impact on the health service looked at? I recognise that there is a need to work within the resources and the budget that you have, but where are the mitigations and at what point do they come into play? We see a lot of contact from community and voluntary organisations and umbrella groups that essentially is being shifted now onto the statutory sector. Where do the mitigations come into play?

Mr May: Thank you for the question. The two examples that you gave differ in nature. It might be worth saying to start with that, during COVID, a number of funds were established for cancer, mental health and carers. Those funds are projected to end at the end of this financial year; in other words, at the end of March 2024. Therefore, there has not been a reduction yet, but, clearly, there is a budget-related risk in relation to those funds. I met the community fund and one of the providers of those services only a few weeks ago, just before it was clear that the Executive were returning, as it happens. That was a COVID-related fund: it was established for a particular purpose and a particular time. It was always time-limited in nature.

The other example that you offered was core grant funding to the community and voluntary sector. This year, I took a decision that there would be a 50% reduction in that core grant funding. I do not have the numbers in front of me, but around £1·75 million in total was reduced. That was in a context where we were facing a significant overspend as a Department. We did not cut the services that the community and voluntary sector provides directly. They amount to many tens of millions, both in the Department and in trusts. In answer to a number of MLAs, we provided some of that figure work. As a proportion of the overall spend on the community and voluntary sector, it is very small. I receive a lot of representations from that sector about the impact that that has, because the core grant is one of the ways in which they are able to meet their corporate responsibilities and to engage in public consultations and other things. I suppose that I am saying is that I tried to mitigate it as best I could. There was not an additional mitigation that I could identify on top of that, which is why that decision was taken. I was clear at the time and have been since that it is a decision that I would rather not have had to take.

Miss McAllister: Thank you for that, and I respect that it was a decision that you should not have had to make. Unfortunately, we were in a situation that we could not control. Regarding the budgetary pressures, the Committee would look forward to seeing those mitigations in place in terms of shuffling people around the health system. It happens when there are cuts to any services, statutory or not. Those mitigations are important.

I move to my next question, which is supplementary to a question asked by another member — I cannot remember who. It is about services provided under the domiciliary care packages. I respect the

fact that a lot of work is going on there. Can you give us a quick response on whether you are reviewing the 15-minute packages? It was Diane Dodds who asked the question. It was not clear whether the expansion, removal or individual nature of that was part of any review. The 15-minute house call is brought up by constituents as being insufficient. I appreciate that it might be a quick response.

Mr May: On the mitigations point, I agree that, where mitigations are available, we should look for them. However, it is unrealistic to think that there will always be a mitigation; in other words, that you can make a cut but it does not have any impact on the service user or the service to be provided. We need to be honest about that. That is the risk environment that we operate in. We have reduced the spend in all sorts of areas in order to try to live within the envelope that was provided this year, and we have not succeeded in that. I do not want the Committee to run away with the idea that there was always something that could have been done that meant that it would not have an impact, because I do not believe that that is realistic.

Peter, I think that you were clear that there is a review going on.

Mr Toogood: Yes. Work on the design of a new model for home care is part of that broader work that is happening under the social care collaborative forum. Members of the forum felt that it was important that we looked at that area of work, while appreciating that it is not a quick fix. I suppose that we have to ride the challenge of meeting the here and now and the system that are working in now to maximise what we can get out of it — we have some initiatives in place to try to do that — whilst saying, "OK. This is the direction that we are going in, and that is where we want to head to". I think that the South Eastern Trust has piloted an outcomes-based domiciliary care package model. Again, it is more intensive and is in a small area, but it is producing good results. The questions have to be these: would that work more broadly, what would it cost, and how would we get to that whilst dealing with the here and now? That is the challenge that we face: dealing with the here and now and planning and making change for the future. That is part of ongoing work. We are using the Innovation Lab in DOF, I think, at the moment to help us with our thinking around that and putting it all together.

Miss McAllister: I would be interested to hear more at another time about the South Eastern Trust. Was it the one that you mentioned?

Mr Toogood: It was.

Miss McAllister: I would be interested to hear about it.

Mr Toogood: We can confirm that for you, but I think that it was, yes.

Miss McAllister: I have another question from the first-day briefing about children's social care services and the Ray Jones report. I noted that the consultation closed in December. Can I get an update on whether what is brought forward will include an action plan for implementation, so that we do not have yet another report that sits on the shelf and nothing is done about it? Will it include an action plan? Again, I understand that resources are an issue, but some of the recommendations are policy- and practice-based. Some things could move more quickly than others. Is that due imminently, and will it include an action on implementation?

Mr May: There were an awful lot of responses — over 130, I think. Peter, do you want to talk through that? There are certainly things that we are looking to do more quickly, and we did not consult on some things on that basis. It takes a bit of time to make sure that we review properly all the responses that we have received.

Mr Toogood: As Peter said, we had 134 responses to the review. That was due in part to, I suppose, a recognition of the challenges that face children's social care and, it is not unfair to say, the charismatic engagement by Professor Jones. He was widespread in how he engaged with the stakeholders. We are going through that at the moment. We asked 66 questions on about 50 of those recommendations. Yes, I can see the pain on your face about having to respond to that. We have done some number crunching on the quantitative piece around that, but, as you can imagine, a lot of the responses were quite hefty; some running to 50 pages of narrative. That is where time is being taken at the moment. We are analysing those responses. The aim is to have that consultation report, which will include an implementation plan, finished by the end of March.

When I say that, we are not sitting doing nothing. We know that the issues in children's social care are significant and serious. Similarly to what was said about adult social care, we have put a children's social care reform programme in place, again with the aim of bringing together people who can influence some of the challenges that are well known in the system. Ray Jones was good at engaging with us throughout his review, so we knew what his emerging findings were. We will have an implementation plan. We know that it will include things around residential placements for looked-after children; doing a needs analysis, for example, and then considering how we meet that need. There will be stuff around the fee framework for fostering, because we know that it is a particular pressure in recruiting and retaining foster carers. There are also workforce issues in children's social care that we want to take forward. Picking up on your point about the voluntary and community sector organisations, we recently engaged with the Reimagine Children's Collective, which is about eight voluntary and community sector organisations that have come together in response to Ray Jones's review. He recommended that the voluntary and community sector should be more joined up in its engagement with us, and, either last week or the week before, we had a good engagement with those organisations. We want to formalise how we engage with that sector when delivering, so that will be one of the key actions that we want to see coming forward.

That is a flavour of what I anticipate coming through, subject to what comes out of our analysis of the recommendations.

Miss McAllister: Thank you. There seems to be a lot going on there at the minute.

Mr May: Some of the recommendations were very much for Ministers and the Executive to consider. It may take longer to address those issues. It is obviously subject to our Minister's views.

Mr Toogood: There are probably two recommendations that a lot of people had views on: whether there should be a separate arm's-length body for children in social care, and, in conjunction and tandem with that, whether there should be a Minister for children. That is a longer-term matter that we will need to bring to our Minister and the Executive in due course.

Miss McAllister: Thank you. On social care again, can you give the Committee — because it has been some time, and it was in the first-day brief — an update on the Muckamore resettlement? In particular, can you expand on the adult safeguarding Bill? I was one of the respondents. The brief mentioned the exploration of mandatory CCTV. In particular, a lot of families said that had the CCTV not been in place, they would not know the extent to which their loved ones had suffered. Can you expand on where we are at the minute?

Mr Toogood: On Muckamore, as you are aware, Peter took a decision last year that the hospital would close by June of this year. Currently, there are 24 patients still in the hospital. We anticipate that 14 will be resettled before the summer. We are less sure of the timescales for the remaining 10 patients, but we have a dedicated oversight resettlement board that is chaired by Patricia Donnelly, who is working closely with the trusts to source resettlement options. Liaising between the trusts and the voluntary and community sector providers that are providing those resettlements is an important job. That work is under way.

The drafting of the adult protection Bill is well developed and is almost complete. We are looking at the costings for the Bill at the moment, and that plays into what we said earlier: when the business case for that comes out, we will need to consider it in the context of our budget settlement.

On the CCTV aspect, you are right: when we consulted on the adult protection Bill, that was not part of the consultation, but it came through very strongly as part of it and with the members of the oversight board in the Department who oversaw the development of the Bill. The Bill, as drafted, will need to be put to our Minister, because he did not see it when it was consulted on. The proposal is not about mandating the use of CCTV but giving the Executive the power to legislate to regulate CCTV in settings where vulnerable people are being housed. Again, we need to take that to the Minister, and he will need to take it through the Executive because that was not part of the original consultation. That Bill is well developed. Again, we are now in the affordability consideration as to when we bring it forward.

Miss McAllister: Thank you. I am sure the Chair wants me to move on. I have 10 more questions.

The Chairperson (Ms Kimmins): Danny and Alan might want in. Danny and then Alan Chambers.

Mr Donnelly: Thank you for coming in today for the presentation of the first-day brief. It was incredibly comprehensive, and you have touched on a lot of different issues. In fact, a lot of the questions that I was going to ask have been asked by other members, which is very encouraging. It seems that we have a Committee with a lot of shared priorities.

The waiting lists are causing unnecessary suffering. We see predominantly older people suffering in their homes, and it is unacceptable. It is horrendous, unnecessary suffering. It is great to hear that the way is clear for a resolution on the pay deal. A lot of us have stood on picket lines with the healthcare staff, freezing and pushing for fair pay. That is something that they are very loud about. It affects their daily lives, so it is great to see that moving forward.

As a nurse, I think that the domiciliary care package will be transformative across the whole system, in that there will be a lot more patient flow through the hospital, reducing impacts on A&E departments and even on GPs. There is a lot with the domiciliary care package that will relieve pressures on other areas, and it is great to hear your comments that that is being taken forward seriously.

Colin, I think, mentioned safe staffing. It is a key issue for nurses. The pressure that they are under when they have increased numbers of patients is incredible for patient safety and the working conditions of the nurses involved I am grateful that that is being taken forward, and I hope to see it delivered during the mandate. As I said, I have personal experience of the pressures in the health service. It is worsening, and we have had cases of burnout. Nurses have left the profession because they simply cannot do their job any more; it is affecting their health. That is the situation that they are in. Despite working through breaks and doing extra hours when they are asked, there is a lot of pressure on them.

We had a situation in November 2022 where an A&E in the Northern Trust closed its doors. As Colin said, it was on the verge of collapse. That A&E stopped taking patients on the Saturday night. It was an incredibly frightening prospect for the people in the area that their A&E could not service them if they needed it. The system is incredibly overloaded.

We have covered quite a lot today, which is absolutely great. It was great to hear Órlaithí mention addiction services. We have a shared interest in it as part of the all-party group. It has a huge impact on many families across Northern Ireland.

I have one question about something that I did not see mentioned in the first-day brief, which is unpaid carers, but you have mentioned it today, Peter. I understand that we have around 290,000 unpaid carers across Northern Ireland who are doing a lot of work looking after loved ones in their homes. That equates to around £5·8 billion of work. Care strain is a real thing. They can find themselves under a lot of pressure financially, and they can find themselves strained as well. My first question is this: what are we doing for those carers? A recent survey from Carers NI stated that one in three carers have said that they have not had a break in years. Legislation is going through in Scotland at the minute to try to have a protected right for carers to be afforded a regulated, protected break and respite for the person that they are caring for in order to relieve the strain of caring for somebody. Has the Department considered that? What else are we doing for those unpaid carers?

Mr Toogood: You are absolutely right, Danny. We recognised early on, when we put the collaborative forum together, that unpaid carers were key to delivering social care, and I am familiar with the figures quoted by Carers NI. We are delighted that Craig Harrison from Carers NI has joined the forum to be the representative who will articulate the views and needs of that sector. He has taken that role on our forum as a representative not just of Carers NI but of the broader collective that they have put together in that sector.

Craig and a colleague from the Department head up one of our key workstreams under that forum around unpaid carers. Craig is working with our colleague to develop what needs to be done. Well, we know what needs to be done: there is stuff around the carers' register, respite and support etc. As we have heard today, we are operating in that resource-constrained environment, so that workstream is bringing forward what can be done within those constraints. There is some immediate work around improving the carers' register as a first-order issue, but we are aware that the carers' strategy is way out of date. I think that it is from 2006. That will be a key piece of work that we want to look at to take it forward. We can come back to you about the priorities of that particular work stream. I assure you that unpaid carers are at the table playing at active role. I am delighted that they are doing so. We are trying to get some immediate actions that can be taken forward within the resource constraints. Again, we are mindful that we need to look at that broader strategy, which is well out of date.

Mr Donnelly: Thank you very much. I have a second question about a different service. The GP elective surgical services had quite a cut recently; I think that it was in August. Recently, the GP vasectomy scheme was cut completely. As Nuala said about mitigations, all those people who would have been taken up by the system and been through it and for whom the procedure would have been done cheaply in a GP's surgery will now not be able to do that. They will end up on a hospital waiting list for years. Cutting that service, through which the procedure was done cheaply at a GP surgery, will now relate to people being added on to longer waiting lists for years and years, unless they pay privately, for a procedure that is more expensive for secondary care to deliver. Is there something to look at about long-term potential savings like that? Personally, I thought that that scheme was a great example of how you can do a cheap procedure and relieve pressures on hospital services and waiting lists. Are there any thoughts of looking at that again in order to help to bring the waiting lists down and take costs away from secondary care?

Mr May: Thank you for that question. We will look at all issues in context when we know what the budget is as we go forward. There was a reduction in the amount of funding for GP elective services this year. While it is an important service, as you say, for those who receive it, that decision was based on looking at prioritisation overall. At that time, we were reducing the amount of funding being put into the waiting list initiative, which deals largely with more serious cases in which the intervention would be more life-changing in nature for people. It was a decision that I felt obliged to take, given the legal responsibilities placed on me. I had to take some account of the seriousness of the issue in that context.

I met the GPs who are responsible for the service. They impressed on me the importance of the GP elective service, not least for GPs. It is a motivating factor for them to feel that they are also able to keep a hand in doing some of that elective work alongside the day-to-day work that they do when seeing patients in primary care. That is why we arrived at our decision not to end it entirely but to retain some of it. The vasectomy service has been paused, and a decision will need to be taken about whether to restart it. That is in the context of the fact that vasectomies are not delivered in all parts of the UK. That decision needs to be taken, and it will now be taken at a political level.

Mr Chambers: Peter, I place on record my appreciation of the briefings that you gave during the suspension of the Assembly. They were very helpful.

In your opening comments, you said something along the lines that we would fall over and fail if we tried to do everything at once. That is a very fair and accurate comment. We may need to harness expectations going forward. With transformation, the elephant in the room is that there can be local resistance to major change. If we are going to use the Bengoa model or an updated version of it to go forward, we have to recognise that it will not be an overnight project. There will be structured implementation as that process happens and is delivered in the greater public interest. We may see local campaigners out with their placards, and I get that, but is there a case for the Department to mount a robust and widespread public education exercise to explain what transformation is about and what the benefits for everyone in the long term will be?

Mr May: Thank you for the question. You referenced the briefings. For members who may be wondering which briefings you are referencing, I had offered briefings to the five main parties' spokespersons. Three individuals who attended are on the Committee, and other parties were represented at those briefings. We held those every four to six weeks during the period.

The second point that you made was about not being able to do everything. It picks up, partly at least, on what Danny said about how it is great that we are doing work in all these areas. If we start adding up what would be needed for implementation in all those areas, however, we would have to be realistic and say that there is no prospect, not only in money terms but in skills and capacity terms. Danny, as someone who has worked in health and social care, will understand that there is only so much change that people can take at any one time, so we need to be really careful and thoughtful.

Your fundamental question, Alan, was about engaging the public on transformation. That is really important. Jim, do you want to say something about the work that we have been doing and about how, if the Minister chooses, we might be able to take it forward?

Mr Wilkinson: Yes. Members will be aware from some of the briefings that we have been looking at aspects of transformation. As we describe it, transformation, as per Bengoa, was not only about how to organise hospital services but about how to organise care in the community and primary care, looking in particular at how the acute sector is organised and what transformation might mean for it.

We have been working closely with clinicians and trusts to understand, beyond Bengoa, what we mean when we talk about "transformation". The narrative that is coming out is that we need sustainable services that meet the needs of the population. Some of that will involve creating elective centres, about which we have talked. Some of it will be about specialist centres, which may happen only at a regional level. Some will be about the core services that a hospital needs to provide to meet the needs of its community.

The real challenge is to determine how that will work. How it will work is more about cooperation, workforce deployment, pathways and understanding patient pathways. That debate and that thinking has moved forward to the extent that, subject to the Minster's views, we are in a position to start engaging with the public on what their hospital provides, how it fits in with the network and how that network works effectively in a transformed system.

We will take those thoughts to the Minister shortly, and that may well start the opportunity. It is about a narrative, about engagement and about the public supporting that view of transformation, not a transformation that does not mean anything. That really is a critical phase of it.

Mr Chambers: The public aspect is very important.

Diane asked about the unacceptable length of waiting lists. We have to recognise that the length of waiting lists was not helped by the five years of suspension that the Assembly underwent, nor was it helped by the COVID epidemic. Diane mentioned the £34 million to try to address the waiting list issue. I realise that it is not all about money, as there are all sorts of aspects involved, but, when you were pressed, Peter, you said that it would take hundreds of millions to bring waiting lists down to what would be considered normal levels. If somebody were to transfer those hundreds of millions into your account tomorrow, what would be your best estimate of the timescale for bringing waiting lists back to acceptable and normal levels?

Mr May: It depends on how you define "acceptable and normal levels". I do not want to give an answer off the cuff without having worked it through. A lot of work is being done in the Department on how we could make it that no one currently on a waiting list would need to wait for more than a year. We offered a projection last year, but I will need to check that that is an extant projection, because it was some time ago that I last saw the number, and I do not want to mislead the Committee. We need to understand that there is always some scope to flex resource within the system to invite people to work different patterns, longer patterns or additional shifts. You are often then looking at the independent sector as the second way in which to flex capacity. Anecdotally at least, the independent sector is a lot busier now, because some people seek private care even if they can marginally afford it. That is unfortunate, and we would like to be in a position to meet that demand through the health and social care system.

I suppose that I am saying that, in addition to doing a piece of work that says that you can do x amount, you need to be sure that you have the people who can deliver that x amount. A scaling-up would therefore be needed. That is why I am reluctant just to offer you a date off the cuff.

Mr Chambers: I talked about harnessing expectations. Are you talking months or years?

Mr May: Not months. It is definitely years.

Mr Chambers: It is a period of years.

Mr May: Yes.

Mr Chambers: OK. Finally, will you give us a quick update on the challenges that our trusts are facing owing to the introduction of free car parking on their sites?

Mr May: Chris nearly got away without having to comment today. I will ask him to talk about that one. Is that OK, Chris?

Mr Chris Matthews (Department of Health): Sure. The biggest challenge on the car parking side of things will be the logistics of managing a free car parking service. You can imagine that if you make something free, it will attract a lot of people who want to use it. Hospitals are near the places where

people work, so we will need traffic management systems. We have estimated that it will cost something like £9·5 million a year to manage the flow of traffic in car parks across the system.

We are having some issues with procuring the systems, because they are quite unique. At the minute, the procurement is being challenged by two potential providers, so we will have an issue even with getting the systems in place before the legislation goes live. The trusts may be in a position of having to find people to put on high-vis jackets, go out into the car park and manage the cars as people park. There are some pretty significant logistical challenges involved, essentially to make sure that the free car parking provision goes to patients and staff members as opposed to people who just want to use free car parks.

The Chairperson (Ms Kimmins): Last but not least is Alan. I know that Linda and Diane have small points to raise at the end.

Mr Robinson: It seems a long time since Diane posed the question to you, Peter, about the cost of tackling waiting lists. You talked about hundreds of millions of pounds. I am looking at a Northern Ireland Audit Office report that indicated that the cost of a 2017-22 plan was estimated to be £909 million. I assume that we are talking about telephone numbers now.

Mr May: Waiting lists have certainly got a lot worse since that report was written.

Mr Robinson: Peter, when you and your officials speak, we all listen. When you talk about transformation, there is not anybody in this room — there is not anybody in this Building — who does not recognise and agree that we need it.

To get down into the politics of it all, messaging is sometimes involved. Take Causeway Hospital, for which a negative message is constantly in the headlines. For example, a maternity hub is to be created at Antrim Area Hospital. As a wise old owl once said, the road from the Causeway to Antrim, Belfast or beyond is a two-way road, but the traffic unfortunately tends to go only one way. When you get down into the politics of it all, it can be difficult for us to argue the importance of transformation to people when they see a one-way road — a one-way system — whereby services are being diluted or being lost to other hospitals. Someone made reference to the messaging. It is important that, when we talk about services, we talk about services that can be gained and boosted and enhanced in hospitals as well.

Mr May: You have made a really powerful point, which I fully agree with. For me, this is about what each hospital will be known for — for the services that it will deliver for its local community and for the region. For example, the elective overnight stay centres introduced in the South West Acute Hospital and in Daisy Hill Hospital have been indications that those hospitals will have a future. There is a range of services that they will continue to deliver for their local communities, and they will provide regional services for those high-volume, low-complexity cases at those elective overnight centres. That is the sort of thing that those hospitals, which are perhaps not as large as the big area hospitals, can undertake.

The challenge with those hospitals is that, if you try to deliver all the services on one site with small teams, the risk of unplanned collapse is greater. That is, I think, the thing that strikes the greatest fear into the local population, if they feel that a service is being removed without planning and careful thought.

In the case of Causeway Hospital, Jennifer Welsh, chief executive of the Northern Trust, did a presentation to Causeway Coast and Glens Borough Council the other week, setting out her vision for Causeway for the future, for example. A lot of this is about joining up the work that is done regionally with what it will mean for each locality in a way that makes sense for the people in that locality. However, the point you make is a powerful one, so thank you.

The Chairperson (Ms Kimmins): On the back of that, I could have said a lot of what Alan said about Daisy Hill Hospital in my area, but it is important that we do not confuse transformation with service collapse, and that is what we have been seeing, particularly in recent years. We know that there are lots of really positive things happening. You mentioned elective care hubs, but, because of the trajectory, people's fears are always high around these things.

We talked about the pay settlement at the beginning of the meeting. The crux of a lot of the issues is workforce. Until we can resolve those issues, we will never get to the point where we are not seeing

this. If we can focus on a proper workforce plan, that will help to deal with so many more of the issues that we see across the board.

Sorry, Peter. I did not mean to interrupt you.

Mr May: No, that is fine.

The Chairperson (Ms Kimmins): I know that we have been talking for a long time. It is our first meeting back, and I am very conscious of officials and the time that you have been here, but I have Linda, Diane and Danny with just three small points, if they can keep them as brief as possible.

Mrs Dodds: This really just ties in with what we have been talking about. Our local communities feel that hospital services are under threat. They see the negative; they do not see any positive. That is because we do not see a plan. We have had the Bengoa report. We have had numerous iterations of all the plans, but we now need to see a plan from the Department and the Minister that sets it out: if we do A, somebody does B. That will be contentious and difficult — I genuinely know that — but what we have seen so far, and I am loath to use the word, is rationalisation through collapse, as the Chair said. What we really want for the future is a proper plan for the hospitals that we can all buy into and say, "This is what we need to do". That is a powerful and important point. I am looking for lots of plans from you today. A plan for waiting lists is really important.

Peter is smiling. I will be after him for a plan for children's services too. *[Laughter.]*

Mr May: Jim has already talked a good bit about the work that we have done in preparation. We have seen some planned changes in recent times. Maternity at Causeway Hospital is one such example. The minor injury unit moving from Ards Community Hospital to the Ulster Hospital is another example. It is possible, therefore, to make planned change. If we do not make planned change, the risk of collapse grows in some areas, I am afraid. That is the risk that we are always managing.

Mrs Dillon: On the back of that, the three things that need to be in that plan are: will you get a better service?; will you have a better outcome?; and will there be accessibility? For people in a rural area, it is about how they get there. It is different for everybody. I have a car, so I can jump in it. I have family, so, if I cannot drive, they can take me. What about those people who do not have support around them and do not have access to transport? I am not asking you to answer that. I am saying that, for me, those are the three things that are needed. If I can go and tell somebody, "Here are the three things that will definitely happen for you: you will have accessibility; you will have a better outcome; and you will have a better service", I think that they will get it, but we need to give them those guarantees.

My question is about inquiries. A trust pays for the inquiries that are in its area. Are those paid for out of the trust budget, or is a separate business case made to the Department to finance them? I am talking about the likes of the urology inquiry, which would be paid for by the Southern Trust. I know that some may be departmental, but some are, certainly, trust.

Mrs Dodds: The cervical smear one.

Mrs Dillon: The cervical smear one, yes.

Mr May: It is the Department that establishes public inquiries and pays for the running of those. That is my clear understanding. There will be a demand on trusts or other organisations that need to give evidence to a public inquiry. The Southern Trust will have been heavily involved in the urology inquiry in terms of giving evidence; providing exhibits; giving senior time to attend the inquiry; giving evidence at inquiry hearings; and the need for legal support for witnesses and for writing statements. It is similar to what, as I described, the Department had to do for the COVID inquiry. Those are the costs that are incurred by individual trusts, but they are not for the actual running of the inquiry.

Mrs Dillon: Can they come with a business case for those costs? On the cervical smear one, for example, those were unforeseen costs, and, yes, the trust failed those women — I accept that — but so did the PHA. Is the Southern Trust carrying all the cost, and are the PHA and the Department getting away with it?

Mr May: I would need to go and look at the cytology example. It is not quite the same as public inquires —

Mrs Dillon: I get that.

Mr May: — because it is a different equation. What we have said to the trusts so far is that they need to bear their own costs, just as the Department has had to bear very substantial costs for participating in inquiries. That is the position that we have adopted.

Do you want to add to that?

Mr Matthews: I will just add that, where those costs go over the trust budget, they will appear as pressures, for which it will come back to us to seek additional funding.

Mr Wilkinson: There is not only the cost of the inquiry but the cost of doing the work to address the problem that has arisen. The answer to that is, yes, it is the trust's responsibility to do the work. However, that is like all work. If a trust needs assistance and support with that, it can go to our performance group and say, "How do we mitigate this? How do we get the list to go down?".

For example, when the trust was doing its look back in urology, it still had to continue to deliver urology services, so it had to look at what mitigations it could put in place. As Chris says, where that exceeds its budget, or where it has to put additional resource to that, it will appear as a cost. It is responsible for doing that work.

Mrs Dillon: I would appreciate somebody coming back to me on the cervical smear one, because there were a number of failures.

Mr May: Yes, I am happy to look into that one.

Mr Donnelly: In one of the presentations — I think that it was yours, Jim — you mentioned harnessing the power of community pharmacies. We have all been written to recently by community pharmacy representatives. In fact, I visited one of my community pharmacists yesterday, on their request. They have sent us urgent letters about the clawback, saying that the increase in clawback in January had gone from 9·75% to 18·4% and that that had created significant financial pressures right across Community Pharmacy. They see that making a lot of community pharmacists unsustainable, particularly in rural areas. Were you aware of what that was going to mean for community pharmacists? What is the reason for the increase?

Mr May: We have received a significant number of letters from community pharmacies. The Minister will meet the representative body, Community Pharmacy Northern Ireland, next week. That will be an opportunity to engage on the issues. So, as ever, Community Pharmacy looks to quite a complex cocktail of funding and different funding arrangements, whether it be the fees that it receives for the work that it does or the profit margin that it is able to accrue or whether any clawback arrangements should apply if there are excess profits and so on. There have also been some complicating factors with money that was loaned to Community Pharmacy during COVID. That money is being recouped, and we are nearly at the end of that process.

It would be worth having a more detailed conversation about that, rather than trying to answer a specific question about it here, because there is not just one issue; it is more complicated than that. Community Pharmacy itself would say that there is not just one issue that is of concern.

Mr Donnelly: OK, I appreciate that. Perhaps that is something that we can follow up. Thank you.

The Chairperson (Ms Kimmins): OK. This has been a detailed discussion, but I am sure that you expected that, especially as it is our first Committee meeting. We appreciate it, and we know that there is huge amount of work ongoing and to be done. I am sure that we will pick up on a lot of that going forward. Thank you all.