Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Briefing by Mr Robin Swann MLA, Minister of Health

14 March 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 Swann	Minister of Health
Mr Chris Matthews	Department of Health
Mr Jim Wilkinson	Department of Health
Ms Brigitte Worth	Department of Health

The Chairperson (Ms Kimmins): In attendance today, we have the Minister of Health, Robin Swann MLA; Jim Wilkinson, deputy secretary of the healthcare policy group; Chris Matthews, deputy secretary of the resource and corporate management group; and Brigitte Worth, the director of finance. You are all very welcome. To date, we have appreciated the very positive engagement that we have had with departmental officials in formal and informal meetings. Moreover, the receipt of papers and responses to any letters have been prompt, and we are grateful for that. I invite the Minister to make his opening remarks.

Mr Swann (The Minister of Health): Thank you very much, Chair. I hope that that positive engagement continues throughout the day. I thank you and Committee members for the opportunity to attend today's meeting. I look forward to having a constructive relationship with the Committee throughout my time in office, because I value and appreciate the work and role of Committees. They are central to the vitality of the Assembly. Of course, you would expect me, as a former Committee Chair, to say that. I also place on record my appreciation of the Health Committee in the previous Assembly mandate. It conducted its affairs during a very difficult period, as we all remember.

I am conscious that I will place early legislative asks on the Committee, but, sadly, that is unavoidable, given that we have come through two years without an Executive or an Assembly. I trust, however, Chair, that the Committee and my Department will strike the correct balance between providing democratic scrutiny of legislation and, as you have said, avoiding delays and backlog pressures.

An early priority for me on the legislation front will be to ensure that Northern Ireland is covered by the terms of the UK Government's tobacco and vapes Bill. I believe that the Committee is to have a briefing on the Bill after this session. That planned legislation will make it illegal to sell tobacco products to anyone born on or after 1 January 2009. It will also provide powers to allow for further regulatory measures to address youth vaping. The Bill offers a significant opportunity to tackle a public health scourge, and I do not want Northern Ireland to be left behind.

In year 1 of the legislative programme, I also want to bring forward a new health protection legislative framework for Northern Ireland in the form of a public health protection Bill, which will replace the Public Health Act (Northern Ireland) 1967. That Bill will include emergency powers that, alongside similar legislation already in place in England, Scotland and Wales, will enable us to better manage 21st-century public emergencies.

I will now turn to wider issues. Today, I want to outline my vision for the future of health and social care services. I think that we can all agree that we are at a critical juncture. It is, of course, important to emphasise that our health service and its staff still do amazing work every day. In our own lives, we all have good reason to be eternally grateful for the compassion and excellence that they provide, and we can reflect on how the health service has developed over its 75-year history. Routine treatments that would have been unimaginable back then are now commonplace, and there has been a remarkable increase in life expectancy.

Nevertheless, we now have a system that is in deep trouble. I will not sugar-coat that, because I owe it to patients and staff to be honest and frank. Some of our pressures are experienced in other jurisdictions: the double whammy of budgetary constraints on the one hand and the growing demand for care from an ageing population on the other is not unique to us. We do, however, have our own deep-seated problems as well. Our system was already in trouble long before 2020, through political stagnation, the stop-start nature of the Executive and the Assembly, repeated failures to agree multi-year Budget settlements and the associated short-term, totally counterproductive decisions that were sometimes subsequently taken. There were those broader financial pressures, missed opportunities to reform and, of course, growing waiting lists.

Then came the pandemic, with all that that involved for patients, services and staff, and the further, growing backlogs of care that it created. It did not stop there either. The subsequent cost-of-living crisis did not just impact on households and businesses. There has been a cost-to-government crisis too, with pay and other running costs inevitably climbing sharply as inflation has soared. That brings us to the point at which I now find myself, in common with other Executive Ministers. I am looking down the barrel of an inadequate budget for 2024-25 while also facing growing need and demand. That is why I warned publicly in recent weeks that the next year will be largely about damage limitation. That is the reality, and it would be wrong for me to pretend otherwise. As I stated, the risks of service breakdown are real and are growing in a range of areas. By that, I do not mean that we will wake up one morning and the health service will have simply toppled over. It will be more gradual and more insidious than that. It will be a slow-motion slide that, in reality, is already in play.

I know that the Committee Chair has already heard from departmental finance officials and that that engagement will continue, but I want to make two points about the budgetary situation before I move on. First, the need for productivity and efficiency savings has never been more present. That will be a relentless focus for my Department and is an absolute priority for me. The Committee has already heard from our trust chief executives about the pressures that they are facing to make savings, and, as part of the drive for efficiencies, my Department will be supported by NHS-wide expertise. That is coming in the form of a Getting It Right First Time (GIRFT) review. I look forward to its assessment of whether and where further savings may be identified. I believe, however, that it needs to be shouted from the rooftops that productivity and efficiency savings alone will not be enough to bridge the funding gap. They are part of the answer but far from the whole answer, and anyone who suggests otherwise is in denial, because successive Health Ministers from different parties will have sat in front of Health Committees and set out how health funding needs to increase significantly annually. Next year and beyond, we will also have the recurrent costs from this year's pay settlements, and, as members will know, pay settlements are for life, not just for the moment when an Executive is re-formed and Ministers walk back in from the wilderness.

Secondly on the Budget, I fully understand that other Ministers and Departments are also facing severe financial pressures. They will be making competing bids for additional resources, and I am sure that their party colleagues will be naturally sympathetic to those bids, because I would expect nothing less. There will, however, be an unavoidable real-life consequence for patients, staff and services if the Department of Health is left with an entirely inadequate budget. There would also be an irony if

Assembly Members were to vote through such an outcome and were then to continue to fill my mailbag with more demands for more spending across all parts of Health and Social Care (HSC) or, indeed, if they were to grab a placard and join rallies against cutbacks. Irony would be one word for that, and others are available.

Let us now turn to the longer term and to how we can turn around the great ship that, I believe, is Health and Social Care. With the right combination of ambition, funding and joined-up political leadership, I believe that it is doable. Let me repeat that: I believe that it is doable. We know what is needed, and I will set out in conclusion three key component of that.

The first is to prioritise primary and social care, because, without doing that, our citizens will not get the support that they need to live healthy and independent lives. Our hospitals will continue to struggle more and more each year, and the more we increase pressure on our hospitals, the less capacity we will have to bring down our waiting lists.

Secondly, it is important that we have route maps in place for the future. We will need to not just continue but accelerate our progress along them. The route maps include the cancer, mental health and urgent and emergency care strategies, which I have published alongside the elective care framework. We are already beginning to see an impact. Its pace and scale, however, will be impacted on by the budget that we have available. Our elective care framework, for example, has already produced some welcome results, with an emphasis on service reviews and improvements and on creating centres of elective activity through our establishment of elective care hubs. That includes day procedures and overnight care centres.

For inpatient and day-case patients, the latest published waiting list shows a reduction for the sixth successive quarter. That is the longest sustained reduction since at least 2008. Overall, there has been a 6·4% reduction in patients waiting for inpatient and day-case admissions compared with 30 September 2023, and a 12·7% reduction since 30 December 2022. That is 14,259 fewer patients. I am confident that improvements can and will continue in some areas. Since taking up office five weeks ago, there are other areas that I have tasked officials to consider. As Committee members, you are probably aware of the specific ask that I sent to Executive colleagues about targeted waiting-list initiatives for next year. We have, of course, still a very long way to go.

In the workforce too, we have seen some concrete results from continued investment. Our focus on workforce development has supported a 15·7% increase in whole-time equivalent staff in post across Health and Social Care in Northern Ireland between March 2018 and December 2023. That includes an 18·4% increase in medical and dental staff, a 16·8% increase in registered nursing and midwifery staff, and a 21·5% increase in professional and technical staff. The latest published figures for Health and Social Care vacancies, as of 31 December last year, still showed, unfortunately, 5,906 vacancies actively being recruited for. That is still an overall vacancy rate of 7%, and, since 31 December, the number of active HSC vacancies in need of recruitment has also seen a downward trend, decreasing by 2,410 vacancies. That is down to 5,906 as of 31 December last year.

Chair, that brings me on to the third and final part of mapping out a better long-term future, and that is reform. You will be aware, I hope, of the scale of the Encompass programme for creating a digital record for patients. That is crucial to so much of what we hope to achieve across our system. Moreover, my Department is finalising the acute system blueprint, which I commissioned, for the future shape of our hospital network. That will set out how we can best make use of our entire hospital estate and the role that each hospital can play within that and work effectively as a whole system network, both locally within the trust areas and, increasingly, regionally. It will not set out precise locations for each medical speciality at this point. That will require ongoing clinical-led processes. I believe, however, that the blueprint will provide greater clarity to the public and staff on what hospital reconfiguration will look like and what it can achieve. The key outcome will be clarity for citizens about the services that they can expect and clear patient pathways, with a focus on the safety, quality and efficiency of those pathways and on how services can assessed.

As I have said, transforming our health service is doable. There are priorities, such as primary and social care, driving forward our strategic plans and delivering a reconfigured hospital system, all underpinned by advancing our technology and workforce agendas. The pace and, indeed, scale of transformation will be heavily dependent on funding, however.

In conclusion, I return to my warning about a year of damage limitation and comparing the health service to a great ship. When a ship is battered by a dangerous storm, the overriding focus is, inevitably, on keeping it afloat and away from the rocks. That is what I fear that 2024-25 is mainly

going to look like. There are limited opportunities mid-storm to debate how we got here, or whether we should build a better mast or sails. Instead, we must plan ahead for calmer waters while accepting that, although we are not there yet, we can get there.

Chair, thank you for allowing me to make that opening statement about where we currently are. When I return to the Committee, I will not be as lengthy.

The Chairperson (Ms Kimmins): Thank you, Minister. I do not think that any of us is under any illusion about just how challenging the situation is. Everything that we have discussed so far in Committee reflects what you have said. There are, however, a number of issues that we will want to tease out. You mentioned in your opening statement the workforce issue. That is crucial to any reform and to tackling the issues instead of having the constant firefighting that we see every day.

I will ask a number of questions, and then I will open the meeting up to members. We are conscious of time, so, hopefully, we can keep responses succinct so that everybody can get the most out of this. We appreciate your time, Minister.

Pay and conditions for our health and social care workers is a key issue. I am very pleased to see today that there has been an agreement for negotiations to start with junior doctors in the next fortnight. That is very positive. Hopefully, we can reach a positive settlement. We are waiting on some other sectors, such as nursing, to ballot their staff on what has been offered. On the back of that, particularly for the junior doctors, has there been any engagement at this stage with your counterparts in England? The Department said that you are waiting on some developments before seeing how things will move forward. Do you expect a Barnett consequential to come to assist with some of the pressures here?

Mr Swann: That is a fair point, Chair, about pay, terms and conditions. It is about the Barnett consequential. Unlike in England and Wales, part of our health pay pressure is our social care, which does not fall under the same remit as it does in England. When England gets an uplift and we get the Barnett consequential, it is not a direct percentage carry-across, and that always presents us with pressures. I met Victoria Atkins, the Secretary of State for Health and Social Care, on Monday morning about that. The Department for Health and Social Care (DHSC) has ongoing engagement with junior doctors. It is hopeful about where it has got to with consultants. That will give us a read-across as well.

Like you, I welcome the response from junior doctors that they will engage and look initially at pay, terms and conditions for 2024-25. I have always been clear that I want to look at the wider package, including contract reform. Compared with England, we have an imbalance in Northern Ireland with junior doctors' base salary and what they get as percentages, allowances or bonuses. We could work productively on that mismatch. I hope to engage with them on that. The fact that we are willing to engage and that we will meet again over the next fortnight is a positive sign. I had offered to bring in the Labour Relations Agency (LRA), as you are aware, should that be necessary, but, at this stage, both sides have had positive engagement and do not think that we need to do that, but that offer remains on the table.

The Chairperson (Ms Kimmins): It is good to hear you talk about the contract. That is a big part of the issue that the doctors have highlighted.

I will move on quickly, because I am conscious that members will have a number of questions. You will be aware that, this morning, the BDA presented to the Windsor Framework Democratic Scrutiny Committee. Dental contracts are a huge issue. They are probably more critical than we have realised. We are going to have a very diminished NHS dentistry service if some of the issues are not addressed soon. Where is that? It is clear to me that it costs dentists to deliver NHS dentistry services. That is a very important issue, primarily for the dentists but also for people who are reliant on a NHS dentists, as they will be affected most. It would be helpful to get an update on that, Minister, as well as on dentists' contracts, because I know that they are seeking a new contract.

Mr Swann: The Chair mentioned the engagement that took place this morning on amalgam and the change to what can be supplied here. We are still operating under EU regulations, so, when the transfer away from mercury-based fillings comes in, we will have to follow the EU directive. My reading of that, and the advice that I have had, is that the issue has not been agreed or settled in the European Union, so there is still some scope available. It will then be about how we apply the directive in Northern Ireland. It is one of those strange issues. The decision has been taken because mercury

affects the environment, so it falls under the remit of DAERA and DEFRA. Those are the two lead Departments, although the outworkings directly affect the Department of Health, and not just NHS dentistry but across dentistry.

We are engaging on the issue. The BDA has met my officials about having conversations about what the ban on amalgam will look like, should it happen. I have departmental officials looking into what could happen if we are taken down the route of having to follow the EU in having to use — I cannot remember the term — white fillings, which are about five times more expensive than amalgam fillings. Pieces of work are therefore ongoing, should we unfortunately have to follow the EU time frame for the ban rather than the rest of the UK.

I am due to meet the BDA about specific contract negotiations within the next fortnight. That will be a national meeting, now that I have taken up office again. I have moved to apply the recommendations of the Review Body on Doctors' and Dentists' Remuneration (DDRB) on payment for dentists and where they sit within the general dental services (GDS) contract. I am considering investment proposals for further support for our general dental services contract for next year. Those proposals will be shared with the BDA as soon as possible, through my officials' engagement with it.

The Chairperson (Ms Kimmins): It is important to say that, although the ban on amalgam will drive up costs further, it is long-term underfunding that has led us to where we are.

Some of the papers provided to the Committee contain information on the Government Actuary's Department (GAD) advising about updating its analysis of the cost of the GP indemnity scheme. Are we any closer to identifying options for the indemnity scheme?

Mr Swann: We have identified a number of options and are talking to GPs about them. We are due to meet GPs shortly to put the offers to them. The briefing that I had just before this Committee meeting involved some talk about what we can do within the financial pressures that we are already looking at for 2024-25. We were able to put in place small recompense for GPs' indemnity costs at the end of last year. I want to see how we can further support them. That will be a key issue in the negotiations. I am also looking at doing a wider piece on how we can better shape our general medical services (GMS) contract with GPs. It even includes looking at having a co-authored framework. Good progress is being made with GPs and the BMA on that.

Mr Jim Wilkinson (Department of Health): The indemnity issue is very complex. We will first focus on seeing what we can do within the parameters of the current arrangement. You referred to there being a significant business case to look at what might happen with a future indemnity scheme, but the small approach taken last year was to recognise that indemnity costs were increasing, identify where they were increasing and intervene to see whether they could be offset. That was primarily focused on winter pressures — the additional hours that we were asking GPs to work — and the consequences of that for indemnity. That, however, pointed to a direction of travel whereby we would try to focus on indemnity as a single issue, rather than as a part of all the costs.

The Chairperson (Ms Kimmins): OK. We will perhaps continue to engage on that in order to monitor progress.

I have three more questions. I will ask them together, because I am conscious of time. First, you will be aware that representatives from Community Pharmacy briefed the Committee last week. Community pharmacies are still in a space in which things are not progressing as we had hoped. That is similar to some of the other issues that we have talked about. We are seeing the real pressures that that critical issue is placing on Community Pharmacy, and that will also have an impact on our wider community. Can we get an update on the drug tariff issues? English drug tariffs are being used here, but community pharmacists are very strong in their view that the tariffs do not work well for the service that they deliver. Will you also give an update on the review of the cost-of-service analysis? That is one of the key issues.

Secondly, I want to see some work done on reviewing the Children's Hospice's funding model for the longer term. There are some varying perspectives on what the model is and what is being implemented. I am keen to hear about the hospice, because it is the only one of its kind in the North.

Thirdly, do you have any update on whether the Department is reviewing the childcare ratios for registered childminders and childcare providers? Childcare is an Executive priority, and it informs part of the discussion that comes under the Department's remit.

Mr Swann: I will start with your final question. It is probably the easiest one. Yes, I have an update. I hope to have recommendations towards the end of next month about potentially reviewing the ratios, and I will share those with the Committee. We have to go out to consultation. If I can, I will make it the shortest consultation that we can legally have, because we are aware of the differences in the childcare ratios between us and England and Wales. That piece of work is ongoing. We are in a place in which we can soon publish a consultation. We have been actively looking at doing that.

We are in a challenging situation with Community Pharmacy. While there was no sitting Executive or Assembly, there was financial pressure around what moneys it could receive for investment and even for the application of DDRB recommendations and other funding models. I met Community Pharmacy representatives in the middle of last month. I was able to progress a £10·1 million advance payment to try to get it to the end of the financial year and to get that surety. That meant bringing forward £6·1 million for the DDRB recommendations and an additional £4 million for service pressures. That brings its overall funding allocation this year into the region of £145 million.

We are looking at the drug tariff piece. I committed my officials to engaging with Community Pharmacy NI about what that piece of work should look like. It is not as simple as lifting another jurisdiction's model and applying it here without looking at the other costs and payments involved. We are making sure that we get a fully rounded package.

I am clear, and I have always been clear, when I meet its representatives that Community Pharmacy is a critical part of our overall health network, given the services that it supplies and, I believe, the services that it can supply. It is an untapped resource, but what I get it to do it through engagement all comes back to the funding pressures.

There are challenges at the minute with the drug tariff that, I believe, we can work through. My Department is receiving ongoing assurances that the pricing by suppliers to Northern Ireland remains on a par with that in other parts of the UK. If evidence is provided about individual issues in the Northern Ireland market, we have mechanisms for considering an adjustment. The overall consideration will be whether there is an impact on the delivery of the profit margin. We are engaging on those models. I will have to manage matching the expectations of large parts of our sector to the financial capability that I have. As I said in my opening comments, it is not that we do not want to do it; it is about what we have the ability to do within our funding envelope.

The Chairperson (Ms Kimmins): That will not be particularly welcome news. From looking at the capacity of Community Pharmacy, I note that if any pharmacies are to close, which, we hope, will not happen, there is no capacity in the system for patients to go elsewhere, given all the issues that there are with accessing drugs. From the Committee's perspective, we urge that whatever can be done is done, because we are aware of how critical the situation is.

Mr Swann: Chair, we are not on opposite sides. I do not think that we are on opposite sides from Community Pharmacy either. It is just about where we currently are in regard to the support that we can give. I firmly believe that Community Pharmacy is a crucial part of our network and a key partner, and I believe that we have a good working relationship with that body. I know the financial pressures that it is under, which is why I moved to give it £10·1 million in this financial year to give it breathing space until we get to the end of this financial year and see what further we can do.

You mentioned the funding model for the Children's Hospice. Again, it is about the conversation that we have not just with the Children's Hospice but with hospices in general about the 50:50 funding model that was committed to by Des Browne back in 2005. There has always been a mismatch between perception and understanding of the 50%: is it 50% of the running cost of their model or what we in the Department, or even in the Health and Social Care Board, believe is 50% of a baseline cost of supplying a palliative care bed? We are having that engagement. Chris, do you want to comment?

Mr Chris Matthews (Department of Health): That has been an ongoing conversation for a number of years with the hospices. As the Minister says, our ideal outcome is that we provide a fair settlement to keep those services running. The challenge that we have had, as the Minister said, is that we have very limited room to manoeuvre, so any increases in expenditure in one area will mean taking money from somewhere else. We have to try to make these decisions in the round as opposed to thinking of them individually. That means trying to balance the decisions and trying to gain an understanding of the general perspective and the general scope of the issues that we are dealing with. However, that is not to say that we are unsympathetic to any of these particular services. It is really to say that we have a number of extremely difficult funding issues in front of us and we know that we will not have enough

resources to cover them all, so that means making decisions around how to get the best value and the best impact for the citizen. That requires us to think about more than just one particular service. That is very difficult for anyone to hear, and it is very difficult for us to have to deal with and think about, but that is the nature of the situation that we are in.

Mrs Dillon: Thank you to the Minister and the departmental officials. I will pick up on that last point. I accept what you are saying, Chris. I understand the position that you are in. We have all been very clear that we understand that you are in a difficult financial position, but we also need to look at this question: where do you think these people will go if the hospice service collapses? They will end up in the health service anyhow, so we need to establish whether there is a saving by having the hospice service. I think that there can be no doubt on this earth that there is.

I am sure that plenty of people around this table help their local hospice. I certainly collect for the Southern Area Hospice, which covers my area, and it does an awful lot of fundraising. Hospices are very much reliant, in the first instance, on themselves. Having to top that up is much better and much more efficient for the health service. Also, the service is different. The service is absolutely exceptional and outstanding, but it is very different to what you get in a hospital setting, because those people are very specifically trained. The setting is made to ensure that families and the people who are ill are looked after in a very specific way. I do not think that you can even compare them. If people end up in the health service rather than a hospice, they will not get the same care.

Mr Swann: We recognise that, and that is why we moved to reinstate the £84,000 for the Children's Hospice. As the Committee, the Assembly and the Children's Hospice recognised, that did not allow the hospice to fully address what it wanted to do. We value and work in partnership with all our hospice providers, and you mentioned a number of them, Linda. That is why, during COVID, the Finance Minister at that time, Conor Murphy, and I put additional moneys into hospices. We realised that what we were able to supply financially was not being matched because there was no fundraising going on at that time, so we gave them that extra support.

I do not want to commit, but if I can find moneys towards the end of this year, hospices will be one of the areas I will look at. I am not making any commitments or promises because I do not if I will have money left, but I do value hospices. You made a point about the challenges in regard to fundraising, and that goes back to my opening comments, Chair, about the financial situation that we all find ourselves in, because any organisation that relies on fundraising is also getting it tight, no matter where they are across the board.

Mrs Dillon: I appreciate that, Minister. You are right to not make false promises but at least give some hope that, should money become available, those conversations will happen. That is really important.

I will ask a few questions about other areas. We know — you have said it — that primary care and social care will be a priority for you. What is the plan for social care? All the trust executives were in front of us a few weeks ago, and every one of them said that the most important thing for them was, without exception, dealing with care packages and releasing people from hospital settings back into their homes, whether that is a nursing home, a residential care home or their own home. Can you give some sense of what the plan is? I understand all you that said about having to stabilise things — I get that — but we will not stabilise anything in the hospitals without dealing with how to get people out of hospital and, more importantly, keep them from going into hospital in the first place.

Mr Swann: That is why I have identified primary care and then social care as one of my priorities. I am fully aware of the pressures that domiciliary care faces. That is why, before I left my post the last time, I set up the collaborative work forum that brings together providers, trade unions, trusts and the Department to look at how to increase packages. We were able to increase the regional rate to £18·54 an hour, and some provision will be paid at higher rates, depending on the level of care provided. It is about getting people into the workforce. That is about how we not only support them in a career pathway but give them value and make them feel valued. We do that by recognition, not just through the pay packet but by acknowledging that the work they do is critical to what we are trying to achieve.

The longer-term work is about a reformed model of domiciliary care. What I would like to see — the forum is looking at this — is a move away from the time and task approach of the past to the outcome delivery model. That model will, ultimately, be more expensive to deliver, as we have to pay more people to do it, so the challenge comes in recruitment, but it provides a certain quality of service. Where we currently sit, our biggest problem with packages is providing people to supply them, so it is about getting people into the workforce. That is the challenge that we face in health and social care in

regard to domiciliary care, so it is about how we work across the forum to make sure that pay and terms and conditions are recognised and that people have the opportunity to progress on a career pathway if they want to.

Mrs Dillon: We look forward to seeing those plans come forward. That is really important, because all this is exactly what I want to hear, but it is about seeing how we will actually do it and — we had the same conversation last week — how we will see it working out.

My final question — if that is OK, Chair; I am conscious of other members — is about children's services. A section of our meeting next week will be dedicated to those services. We know that children's services are, at this moment, a complete — I do not think that you can use any other word — disaster. We are not serving families well; we are not keeping families together; we are not preventing children from going into care; and we are not doing enough to support families. What is the plan? I know that we have to deal with all the other stuff — children go into care, and it is then about how we support them and their families and anybody else who has to care for them — but what are we doing to prevent children from ending up in care in the first place? What are we doing to keep families together and to put those support services in place? Some brilliant organisations are doing fantastic work, but they are doing it in spite of the challenges rather than because of any support that they get. What are we going to do? Will something come forward from Ray Jones's recommendations? What is the plan?

Mr Swann: That is why I commissioned Ray to look at what we can do about the larger children's social services piece. It is about what we can do together. I met the Justice Minister this morning on another issue, but the conversation came around to Ray Jones and how my Department, the Department of Justice, the Department for Communities and the Department of Education can work together. There is a larger piece on children's services in general. Looking to the Ray Jones' piece of work, especially the engagement piece that he did in finalising his report and making those recommendations, you see that it is about how Northern Ireland is of a size that we could do this together right and start to break down the different silos that we have, looking at the different parts of children's social services or just children's services, because we all want to gain the same output.

We are currently working through the consultation responses to Ray Jones's independent review. We had 134 responses, and we hope to work our way through those in the next month to six weeks to see where we go with that. It sets a direction of travel, but it is also a longer-term piece in regard to what we need to do. In the here and now, it is about is how we make best use of the current working between, as I say, us and those other Departments, especially Justice and Education.

Mrs Dillon: I appreciate that. Another important element — I am sure that you will not ignore this, given the efforts of Ray Jones to ensure that it happened — is engaging with the organisations that support those children and young people, because they have an awful lot to offer and an awful lot that they can input into the process, probably more than anybody else.

Mr Swann: That is a valid point. What came out of Ray's work was just how deeply he engaged with those young people and how much — I know this from talking to them when the report was published — they saw their input in what he had produced.

Of the 53 recommendations, some will be cross-cutting across all Departments. I will need the Executive to take those on board in order to be able to progress the review to its full outcome and what it can achieve.

Ms Flynn: Thanks, Robin, for the briefing today. I have two questions. First, do you have any update on the implementation of the regional mental health crisis service? Where is that sitting?

Secondly, in the longer-term 10-year mental health strategy, does the Department have any plans on how it can engage, involve and incorporate our community and voluntary sector in the roll-out of the regional mental health crisis service? During the week, we met representatives of The Well, which is in the Kilkeel area and saves the lives of people. When people are in crisis, that local community group calls out to their homes and de-escalates the crisis there and then. It does brilliant work on mental health crisis and suicide prevention.

There is the community navigators pilot project in the Belfast Trust. Again, that is helping with the pressures on staff in emergency departments, and it is helping people who are in crisis. I know that the work of the regional service is really important. Is there any update on the roll-out of that? How can

we ensure that those critical community and voluntary groups that help to save people's lives are part of the roll-out of that regional service?

Mr Swann: Thanks, Órlaithí. I will take your last point first. I do not know whether this has been communicated to those community navigators yet, but we are going to extend their work and evaluate that as a pilot, so we need to keep it in place while we do that. There is an opportunity there, as you say, to roll that out across our other EDs.

Our need for, and support of, the voluntary and community sector, especially when it came to the development and delivery of the mental health strategy, is about partnership, because we cannot do this on our own. We do not have the internal resource to do so; our trusts do not have the internal resource; and GPs do not have the capacity. As I talked about earlier, we need the engagement of Community Pharmacy as well. Our voluntary and community sector, working on the ground, is crucial to this.

The challenge that I have — this goes back to my opening comments — is how we can support them financially to do what we need them to do. The focus is around the challenges that I have with the budget. I am not even sure whether I will have the budget in 2024-25 to do what I need to do, never mind what I want to do. However, I do not want to take away any hope or encouragement from our voluntary and community sector, because it is crucial to what we do. It does fantastic work. When I was able to re-establish the mental health fund, which was a time-specific fund, especially coming out of COVID, we could ask those organisations to actually step in and do some of that work. The money will not be there to continue that work. It is about how we look at other funding streams and, again, work collaboratively with other Departments to see who is funding who to provide what service. It is not just about duplication but about ensuring that the best Department or arm's-length body (ALB) is actually supporting the best organisation to deliver those outcomes, rather than having organisations looking for a cocktail of funding from a number of pots. Again, that is a wider piece of work, but, as each Department finds itself squeezed further financially, we have to be more interlinked about what we want to.

Ms Flynn: Before I come on to my second, final question, I want to mention some budget stats that Brigitte kindly produced in the correspondence. We had asked about the percentages that mental health and addictions were sitting on. We know that mental health spending is 7% of the overall budget, and addictions spending is 9% of that 7%. I know that your budget is under extreme pressure, but, again, I will just make the case that we really need to get that figure for mental health spending up, Robin, or we will not be able to do the transformative 10-year mental health strategy, continue with Protect Life 2 and tackle substance use. I know that you are in a difficult position, but, again, I make the plea that we get some additional funding.

Mr Swann: The target that was set and recognised in the 10-year mental health strategy was to move to 10% comparative funding. That is already there, but it is 10% of what? I do not mean to keep repeating this and sound like a broken record, but I need a decent budget for 2024-25 to be able to do the things that I want to do. That will be the challenge.

Ms Flynn: OK. My final question is about the recent outbreak of measles and whooping cough. I know that the PHA has already done a wee bit of work, and that there has been some publicity on it to raise awareness. Some of those stats were really worrying, especially on the whooping cough. It jumped from two cases within the past two years up to 72 cases already this year. What plans does the Department have in place to try to ensure that we get a handle on such outbreaks?

Mr Swann: We are working on that through the PHA. It is contact tracing again where necessary. Going back to measles, we identified a case that had actually come in on a flight from Abu Dhabi that landed in Dublin. Again, both public health agencies have been able to work together on that. We were able to share the passenger manifest yesterday, so that any Northern Ireland resident travellers who were on that flight have been or will be contacted by PHA to ensure that they are aware of possible challenges, where they should go for support and vaccines and the PHA phone number. The PHA put out an all points notice last night, I think, but now that we have the manifest it will be more targeted.

On whooping cough, measles and all the rest, it is about vaccine uptake. It is about engaging with a younger cohort of parents and convincing them of the benefits of vaccination for young children, especially for measles, whooping cough, rubella and all those diseases for which people of our generation took vaccination for granted. They ensured that they got vaccinated and that children were,

too. It is about that re-engagement and reassurance piece, and engaging with family GPs to ensure, not that they are aware but that they are making the best opportunities to deliver those as well. Publication, education and promotion are where we currently are.

Ms Flynn: Hopefully, the public listens to the public health message on vaccinations for babies and young kids, rather than, sometimes, rumours on social media. That is part of the problem and why levels are dropping.

Mrs Dodds: Thank you, Minister. I think that everyone on the Committee knows and understands the difficulties with the health budget. We wish you well. We want to have a positive working relationship with the Department on those issues. That said, me being me, I know that you expect me to ask you some questions. I start with two or three random ones. A quick flick through the European Council website this morning told me that the regulation on mercury had been finalised and that the trialogue had taken place between the Commission, the Council and the European Parliament. That has been finalised. It is important that we get to grips with the impact of that for dentistry in Northern Ireland. Representatives of dentistry sent in a briefing paper today. I will just read it to you, because it is really important.

> *"An amalgam ban, if directly applied here, will have an irreparable and long-lasting damage to provision of dental services, not least at a time when health service dentistry is on its knees."*

Has the Department done any work on what the ban will cost Northern Ireland dentists, and how you are going to bridge that gap? That is the first part. The second is: have you sought conversations with the Departments in London so that there can be some conversation on this at the Joint Committee on the risks and costs to Northern Ireland?

Mr Swann: If you share that document with us —

Mrs Dodds: It is on the website.

Mr Swann: — we will pick that up. We have, as I said, I think, in answer to the Chair, started internal work on those specific costs. We are aware that the replacement that dentists will have to use will cost five times as much as amalgam. That work has commenced. As for engagement with the Joint Committee, as I said earlier, our lead is still with the —. The cost of implementing the outworkings of an act listed in annex 2 of the Windsor framework that relates to general dental services and the prohibition of amalgam fillings from January 2025 has been costed at somewhere in the region of £236,000. That is what it will cost.

Ms Brigitte Worth (Department of Health): We stress that those figures have been updated more recently. As part of the Budget process, we have submitted a bid to the Department of Finance under the Windsor framework. We have been invited to submit bids for the additional costs of the Windsor framework and its outworkings, and that is one of the bids that we have submitted. As I said, that was the figure we had at the time. As recently as early this week, Minister, you cleared a further update on those figures, so that number may be out of date, but we certainly have —.

Mrs Dodds: So, the cost is in that region; that is the general ballpark figure.

Mr Swann: We will get you that updated figure.

Mrs Dodds: Thank you. There are a few other points. Yesterday, NHS England announced that it was going to stop the use of puberty blockers for young children. It said that there was not enough evidence to support the safety or clinical effectiveness of them. Do you intend to follow that position?

Mr Swann: Yes.

Mrs Dodds: That is excellent: sharp and to the point. I hope that you do that as quickly as possible.

These questions require only very quick answers. There has been a compensation scheme for mesh-damaged women in the rest of the United Kingdom. Will you be bringing forward a similar scheme to Northern Ireland?

Mr Swann: We are not looking at a similar scheme; we want to be part of the same scheme. I look to Brigitte on that.

Ms Worth: I have no additional detail on that. Sorry, Minister.

Mr Wilkinson: We are aware of the scheme. We are in contact with officials in England and understand the nature of the scheme. For us, there are three elements to it. First, understanding what the finalised scheme will be because it is still a work in progress. Secondly, understanding the quantum and potential impact on Northern Ireland, and, thirdly, the best way of implementing it. As the Minister said, that may well be through extending every part of the UK scheme or mirroring the scheme here. However, we are very much aware of the proposals and developments.

Mrs Dodds: That sounds like a long process, Jim.

Mr Wilkinson: We will endeavour to make the progress as quick as we can, and at similar pace and quantum. We will need to devote our own resources to understand the nature of the scheme in England, but our officials have been in initial contact with DHSC officials and are part of that debate.

Mrs Dodds: Just two quick things to finish. I could talk about the budget, but maybe others are going to do that. Thank you for agreeing to meet the group from the Southern Trust area, the ladies with letters. They are looking forward to meeting you. I was with them the other night.

If you do not know this figure, it is fine if someone even just writes to the Committee about it. How many serious adverse incidents (SAIs) have there been across all the trusts of women whose smears were missed and they went on to develop cancer?

Mr Swann: I do not have that figure with me, Diane, but I will respond to you in writing.

Mrs Dodds: That is a very important one. Finally, I remember a briefing on this in the last mandate generally to parties on the issue of a duty of candour for staff. Can you update us on where that piece of work is?

Mr Swann: We have a wider piece of work ongoing regarding a structural framework on candour, SAI reform, and all those strands of work that we were pulling together under that. That should be out — I do not know. *[Pause]*

Mr Matthews: I am honestly not sure. *[Laughter.]*

Mr Wilkinson: We hope to publish the framework. We have been working on a framework on open and just culture. The duty of candour is the legislative end of it, but once we concluded the consultation, it was clearly pointing to the culture being as important as the duty. We are doing a lot of work on developing an open-and-just-culture framework. That is near the final stages of development, and we hope to be in a position to go out to consult on that fairly shortly and publish that framework. That is part of that whole gamut of patient safety, openness and duty of candour. It all forms part of that process.

Mr Swann: Thanks, Jim. It is the wider, overarching piece that will probably bring in the review of SAIs, recommendations from the inquiry into hyponatraemia-related deaths (IRHD), the neurology inquiry and all the inquiries that we have running on duty of candour all together under one piece of work so that we are not continually going out to consultation or back out to the workforce with different strands.

Mrs Dodds: That makes sense.

Mr McGrath: Minister, welcome back to the Health Committee and to your role as Health Minister for a few months.

In terms of the service, we can get lost in a lot of detail. Community pharmacy is short of money. Dentists are short of money. Domiciliary care is under pressure. Nursing homes are waiting in the wings for their funding models, and they are being too short. The waiting lists are getting longer and longer. The pay for nurses was short but sorted for this year. Junior doctors and other doctors: short.

Then there is next year. GPs are struggling to deliver their services. The multidisciplinary teams (MDT) roll-out has stalled. Consultants are eyeing up jobs in other jurisdictions because the pay is much higher. There is no resolution to safe working legislation. The mental health strategy is short of money, the cancer strategy is short of money, and the community and voluntary sector funding has decimated much of that.

If the system is not at collapse and in the process of collapsing, is mighty close to it. We can talk about our individual issues and individual bits and pieces and where the work is being done, and your staff must be pushed to the extreme trying to keep the ship afloat, as you referenced earlier. We need to see a high-level plan that we can examine to see where we are going to go overall, rather than a specific plan here and there. I know that if I write to you about an issue, you are going to come back and tell me that you do not have the money. Is there a point where we need to make this a wider Executive conversation so that it is not just you as the Health Minister sitting there with not the right amount of money to deliver the service that is needed? How do we get to that point? There is no point in spending the next three or four years writing to you or to whomever is the Health Minister, for them to say that they do not have the money. The Executive need to take decisions, and those decisions have to be held to account one way or another. Some will be supported, and some will not. The sector needs to know, and it is unfair that every time we complain about an issue, we are accused of complaining. Of course we are going to complain because, right across the board, just about every facet of the health service is short of funding. The logical conclusion is that we fund a number of the services and restrict and cut back others. Those are the political decisions that have to be taken in any other democratic place. Will we get to that stage?

Mr Swann: Yes, we will. On the Executive making those decisions, I have been very clear that I need an additional £1 billion on top of what I currently have. We have been asked, and we are taking forward a projection of service on a flat cash basis. That means we have looked at what we were given last year on a flat cash basis and tried to map that into next year's services. We are in the invidious position of being two to three weeks from the end of this financial year with a budget process that has not started. Normally, as Members are well aware, we would know our budget for next year, rather than looking to see what it may be. I am still in the situation, like every other Minister, of waiting to see what the allocation will be for 2024-25.

I said that I needed £1 billion, and I will break that down into three specific blocks. Of that, £300 million is a recurrent consequence of this year's pay negotiations and uplifts. As I said in my opening statement, a pay award is not just for when we come in the door. This year, I have committed to the Agenda for Change, the DDRB recommendations and the associated costs, which is the £300 million knock-on effect. I then have an additional £550 million for additional pressures, such as health inflation, which is always higher than other inflation due to the pressures arising from non-pay inflation and the growth in demand. We have an aging population, higher costs for drugs, unavoidable increases those things that we have to pay, such as holiday pay and employer pension contributions, and the recognition that, unfortunately, a large portion of our workforce is on the national living wage, so when that goes up we have additional pressures there as well. Even within that, there is a £150 million estimate to start to look at the pay lift we expect to fund in 2024-25. That is not about doing anything additional or new; that is the standstill period that we find ourselves in.

As Health Minister, when I negotiate with the Finance Minister to put forward our case, as you are all fully aware, it will be a very challenging position. I have said that I have a challenging job. In the next four to five weeks, the Finance Minister in Northern Ireland will be equally challenged, because she will have to make the call. That will go to the Executive. The Executive will decide if those allocations are just and fair for what we have to do. At that point, we have to look at what we are going to do with the money we have been provided with. Do we look towards some of the transformational pieces that need additional funding in primary and social care? If I do that without the additional money to do it, where do I take it from?

Of the £3·3 billion that was promised, there is £49 million per year of transformational funding. I could spend that day in, day out on what I want to do in Health. People talk about Bengoa, and the report was very clear: transformation needs a ring-fenced budget that is set aside from the operational budget. It is not about transforming with the small pot you have; it is about being given the resource to transform. When that £49 million is there as transformation money, it is how we bid into that as well. Of the additional £850 million that the Executive have indicated on top of what we had last year, I am saying that we need £1 billion of it. That is for the real-life pressures to stand still. When I say we look to efficiencies, that will not make the cost savings that we need. I noticed, from reading transcripts this morning, that that was the same message that the Finance Minister, the permanent secretary and the Department of Finance told the Finance Committee yesterday. We can tighten our belts so far but, at

some point, we will have to say that we are going to have to stop something. As Chris said, it is not because we want to stop it; it is because we can no longer make it viable. When we see that budget, that is when we are going to have to come back and have those real discussions with the Committee.

I talked earlier about parties and individuals voting through a Budget and then asking me to spend more. People need to be realistic that the budget that is allocated to the Department of Health is what the Department of Health has to spend. There has to be an expectation of what you get for your money.

Mr McGrath: Chair, I just have a final comment. Minister, I agree with you 100% because, if you do not get that full £1 billion from the Executive, every single one of those issues that I have read out and every issue that members have mentioned is not going to change — not substantially. There may be a tweak to the edge, but there will be no substantial change if there is not any cash to actually deliver that work. It is a fair point. We will have to observe who is complaining about the lack of spending if they have gone through the Lobbies to give you a budget that does not give you the money to do anything.

Mr Swann: In saying that, with regard to funding, it is also about the Opposition and the amendments that they bring forward to Budget proposals from the Executive, where we can look to see what the Opposition will do when it comes to Health. I know what commitments other parties have made with regard to that additional £1 billion. There will be a large expectation, and that is why I talked about 2024-25 in my opening comments because of the financial period being a year of stability and doing what we can.

When I was in this post before, I do not think a member or a party around this table did not agree that Health needed a recurrent budget so that we could see the changes being made were for the long term, rather than for a six-month funding period, because that is money that we did not know we were going to have on 1 April next year. That recurring budget is important to us. The size of the budget is vital, but a recurring budget gives us the stability to do the work that we want to do.

The Chairperson (Ms Kimmins): I think we had an opportunity for that in 2022 but, unfortunately, it did not happen.

Mr Chambers: Minister, normally, when a politician takes up office, the media wait for 100 days before they write their performance pieces. You have only been in office for five to six weeks, although it may feel like 100 days. Political expectations across the Assembly, probably from day one, are growing, and that is evidenced by your AQW postbag. Maybe we all need to just step back and take a more realistic approach to our expectations. I am reassured by your comments that improvements are doable. That is what we all aspire to, but we have to recognise that it may be a long-term journey. I believe that future multi-year Budgets will get us to our destination an awful lot quicker.

I have three questions about funding. First, how important is it for you to receive clarity on next year's funding outcome? Secondly, what difference would it make, in terms of impact, receiving that clarity early in the financial year compared to later in the year? Lastly, if you are kept waiting for clarity, what will be the impact on the delivery and scale of the waiting list initiative?

Mr Swann: I thank the member for his comments and his questions. It is about looking at what we have been able to do in the meantime, even with the pressures that we have been under and the financial pressures. We have looked at what we can do from a service point of view. We have established those two dedicated day procedure centres in Lagan Valley and Omagh hospitals and three elective overnight stay centres at Daisy Hill, the Mater Hospital and the South West Acute Hospital. We have had the expansion of our post-anaesthetic care unit beds, two rapid diagnostic centres at Whiteabbey Hospital and South Tyrone Hospital, as well as those ongoing service reviews. We have been able to do those small pieces, but they are not on the wider scale that we need. That is the challenge presented by not having that recurrent budget that the member asked about. We are making those small changes and establishing those sites, but we could do more if we knew that there would be funding for next year and the following year. That would also give staff the reassurance they need to make transitions into new roles and reassurance that the new service that we are establishing will be there and that pathways can be established and secured for who is going into that service, when they will get access to it and the rest of it.

This planning round is in the context of another one-year Budget and, as I said to Colin, we do not know what we will have on 1 April. If we do not get a budget until June or even September, and we

then find out that our budget is dramatically short of what we are spending, the action that we will have to take to balance our books will be more dramatic. The sooner we have an indication of what we can do and what we have, the less impactful some of the decisions will be. If we are waiting until the last quarter and then have to make significant budget cuts or amendments, that will have more of an impact on what we are doing.

At this minute in time, I do not have additionality for waiting list initiatives. In the package that was presented by the Government at the start of the year, it was indicated that there would be £34 million for a waiting list initiative. I have asked for that but, as yet, have not received it. The challenge, come 1 April, will be whether I spend that £34 million, thinking that it is the only waiting list initiative money that I will get for 12 months, or do I spend it as if it is additional to the £138 million that I have asked the Executive for. Without clarity, I am left at a disadvantage as to what I can plan for and go forward with. It all depends on what the financial package is; when we know what that will be, that will start to shape the plans for what we have to do, as Colin was talking about.

Mr Chambers: Minister, there has been a lot of collective noise around a collegiate approach to health and health funding. I certainly hope that all of those promises fall into place.

Mr Swann: So do I.

Mr Donnelly: Thanks, Minister, for coming. We have already hit on quite a lot of the topics that I wanted to talk about, so thank you for your answers in relation to those.

I have a couple of questions. One thing that I have noticed over the last couple of years relates to morale in the health service. Since COVID, there has been a decrease in morale. People feel undervalued, overworked and strained; we are getting more and more burnouts, and people are leaving the profession to go to other jurisdictions and other professions. People are not being attracted to nursing, or even to medicine. There is an issue with retaining staff as well. I absolutely welcome your prioritising transformation and completely agree that we have to do that, but we cannot transform the system without having staff. We need to keep the staff in the system. To go back to your analogy, a ship needs sailors, so you absolutely need to keep that together.

I will go through a couple of things. I was going to talk about the duty of candour, but that was raised by Diane. I am glad that that was mentioned. We are seeing increased numbers of GPs not being able to deliver services and handing back their contracts. I know that you are aware of the situation in Glenarm a couple of years ago and of how that has progressed and had an impact on the East Antrim area. We see further situations. I understand that other GP services are under extreme pressure, so I would like to hear how you are going to support struggling GP practices to prevent them from having to hand their contracts back.

From my background as a nurse, I know that safe staffing is incredibly important to the staff across the system. Nurses are certainly very keen to see that; it is one of the asks that they had during industrial action and things like that. Certainly, nurses want to deliver safe and effective care. It is very stressful for people working in the health service who feel that they cannot deliver safe and effective care due to the burdens placed on them, and that they cannot deliver for their patients. That is impacting on people's stress levels and their health and encouraging them to leave the profession. What are your plans to progress a safe staffing Bill? I am sure you are aware of recent concerns that were raised in the Belfast Trust over the last couple of days about pressures in the system and patients being treated in corridors and things like that. It happens everywhere, and more and more so over the last few years. We have seen constant pressures. They used to be known as winter pressures, as I am sure you are very aware, but they are not winter pressures any more, they are all-year pressures. We have corridor beds and pressures in A&E throughout the year.

On A&E, you attended the Royal College of Emergency Medicine (RCEM) event two weeks ago. We have seen a huge increase in patients waiting longer than 12 hours and 24 hours in our A&E departments. It is something that should never happen: no patient should wait longer than 12 hours, and certainly not ever 24 hours. In September 2016, seven people waited for longer than 24 hours, and by September 2023, the number was 3,927. There has been a huge increase in 12-hour and 24-hour waits in our departments. It puts pressure on the ambulance services and throughout the system as well. What are your plans for reducing pressures in emergency departments? How will that help ease pressures on the rest of the system? *[Pause.]* Go.

Mr Swann: OK, go. *[Laughter.]* I will start with safe staffing. I hope to progress that Bill this year. My officials have had good engagement with the trade union side on that, and it was one of the topics we discussed with the Royal College of Nursing (RCN) yesterday and NIPSA the day before. I hope to have that ready for consultation by the end of the year, because it is a comprehensive piece of work. We have co-produced and co-designed it with the trade union side, because it is important that it is not imposed on them but is something that is worked in partnership with them so there is an understanding of what it means.

I will just go through some of your points. You can remind me if I miss anything. On the pressures in our emergency departments and the length of stays, again, that goes back to my initial points about priorities in primary and domiciliary care. If people are being treated and supported in the community, the flow through hospital is a lot easier. We see those numbers for long stays in our ED departments because we do not have the flow of patients going through our system, to both prevent them coming into EDs by being seen by GPs but also getting them out of the hospital setting through support with domiciliary care packages.

I commissioned a Getting It Right First Time report on urgent and emergency care before I left office. It is due to publish its recommendations shortly. One of the useful things about GIRFT is that it is brings in systems specialists who know what they are talking about. Where they have come in before, their recommendations have pointed out difficulties that we already knew, but because we used professionals to do that, they give us solutions. For example, the GIRFT report on orthopaedics has made a massive change. The urology report will set a direction of travel for us. I am hopeful that the GIRFT review of urgent and emergency care will show us a way to manage our patients and our emergency flow and will make sure that we have an information system to show people where to go, such as an ambulatory minor injuries unit. Urgent and emergency care is not always the right avenue, but that is where a lot of people see the front door of the health service, and that is where they are going now. It is about how we use those other avenues as well. On staff morale, I agree with you as to where we are. As to engaging with staff, the biggest impact on them was a year and half of this place not being here to listen to them and engage with them. That has had serious implications. Because of the frustrations that they have in the system, in their own support networks, they did not have that avenue to access decision-makers. They were able to talk to departmental officials and engage with work programmes that were already started, but they saw that change. I am not saying that the Assembly being back here has seen every healthcare worker celebrate where they are now, but it shows them that there is somebody willing to engage in support through you, the Health Committee, through local MLAs and also by having a Minister back. Having that local accountability, we were able to look at the pay reviews that the Secretary of State was unwilling to do when there was no Assembly. Those small things make a difference. We will not sort out morale overnight, but we need to make sure that we are providing a service that staff feel safe working in. That is where the bonus of the safe-staffing legislation comes forward with union support and union buy-in.

Contract hand backs by GP practices has been an ongoing issue. At this point, we have not seen a GP practice close, and that is important. People talk about contracts being handed back, but it does not mean that the practice has shut down. In a number of cases, we saw other GPs step in and take on that contract. GP federations have stepped in, and there have been other models of taking over the running of a practice. In extremis, we have seen trusts step in to ensure that a GP practice continues to function in the location as it has done.

When one GP practice hands back its contract for legitimate reasons and concerns, we have seen a destabilising effect on some of the GP practices around. There is a fear that, if that practice were to fold, they would end up picking up all the patients that were going to be transferred across. Work is going through my Department, with officials engaging with GPs as to what the contract looks like and how we work our way round to making it a better contract for 2024-25.

Going back to points that members have raised, we do not see contracts being handed back in the same numbers where we have multidisciplinary teams. Therefore, this is about how we finance and staff our multidisciplinary team model. This is something that I have always believed in, as to how we support our GP practice but also how we support wider health provision closer to people at home. That is what I continue to do, and I have asked officials to look at it.

What did I miss?

Mr Donnelly: I think that was it. *[Laughter.]*

Miss McAllister: Thank you, Minister for your answers so far. I have a couple of questions supplementary to those already asked. I will start with them. The first is on the junior doctor talks that you mentioned. I noticed a tweet from the junior doctor committee that there had been an offer to enter talks. Can you clarify whether that is a negotiation? If it is, has money been found for it?

Mr Swann: I have not seen the tweet. I received an update from officials that the junior doctors are coming back in to engage about 2024-25 pay. When we get them in, I hope to have a wider conversation, but we have not finalised the terms of that meeting yet, Nuala. We are at a stage where we are back, talking again, negotiating how we take that back. Junior doctors are a crucial part of our workforce. I want to support them and make sure that there is a mechanism there that we support. One of the issues they raised — I think it was raised in the Chamber by Linda — was about the conditions in which junior doctors work. It is not just about the pay; it is about how they are treated and the staff rooms that they have access to. There are other pieces of work that I think we can engage on as well.

Miss McAllister: Thank you, although it is my understanding — from those who currently sit on the committee, those who have been on the committee before and various organisations — that previous Health Ministers, including you, have already engaged on working conditions. It has already been put to the Department many times what those conditions are, and they have not yet been changed or agreed to. It is important that we do not raise expectations where we are not going to deliver. It is not always about resourcing and financing, but it is about listening and actioning. It is important that, if you are going to commit to talking about working conditions, you actually implement those changes. It is important not to raise expectations around the pay negotiations.

Mr Swann: No. I have never raised expectations when it comes to any negotiations or even when it comes to addressing the Committee on what I believe we can currently deliver.

Miss McAllister: Thank you. I look forward to hearing that and seeing how that goes after the first two weeks.

My other question is a supplementary question about the surgical hubs. Last week, the Committee had a brief update on how they are doing. We have heard from a number of health professionals that they are progressing well. Do you feel that the outputs are as high as they could be? Do you have enough ring-fenced beds, workers and resources? Are enough elective surgeries taking place in the hubs versus in hospitals that should be focusing on other non-elective or specialised procedures?

Mr Swann: That finding actually came out of the Bengoa report, but we really saw it through COVID, when we tried to establish what we called green sites that looked at elective surgeries. If we look at what we have been able to produce in that short space of time, as I said earlier, we see the two dedicated day procedure centres at Lagan Valley and Omagh hospitals and the three elective overnight stay centres at Daisy Hill Hospital, the Mater Hospital and South West Acute Hospital.

A crucial piece of that work relates to our post-anaesthetic care unit (PACU) beds, where a patient can have an operation. Previously, we would have had to put them into ICU for intensive care, but the PACU beds are the form of support that they need. Professor Mark Taylor worked to promote those. We also see our three speciality centres for cataracts at the Downe Hospital, South Tyrone Hospital and the Mid Ulster Hospital and the orthopaedic day procedure unit at the Duke of Connaught unit. Those small units are now in place, but it is about how we start to expand capacity.

I talked about the blueprint review of our hospitals that I am looking at. It looks at how we identify what we are currently doing in hospitals as local sites and how we expand that regionally. There is always the line, "You are going to close hospitals", but I need every square foot of every hospital that I currently have. That is why, even during the previous term, we expanded and invested in the Duke of Connaught unit. We invested in other facilities, such as Whiteabbey Hospital, but we do not have the current staffing ratio. It is about making sure that we have those balances, which, I think, was your point.

Miss McAllister: Each week, the Committee hears about the staffing issues, not only in the hubs but across the workforce. I will stay on the issue of surgical hubs. When it comes to transformation, it is about not only staffing but the public. Would it be beneficial to enter a communication strategy that says to the public, "Look, do you want to get your surgery in your closest hospital in two or three years or to travel a bit further?" and to engage with other Departments around the need for community transport?

Mr Swann: That is the message that I have put out. Going back to COVID times, one of our biggest challenges was getting the workforce to travel to those sites. We got through that issue, and then we started to get patients who were willing to travel. As you pointed out, it is about identifying whether someone is willing to travel or to wait. That level of choice is still in the system. Most people in Northern Ireland are willing to travel.

There is a third cohort to whom we need to get the message across. Some of our Assembly colleagues still see the removal of a service from a local hospital as a reason to protest and complain rather than as part of looking at how we can best use that hospital as part of a wider strategy of what we need to do to change.

Miss McAllister: I agree with your last point, but, unfortunately, Minister, members of your own party have often protested when there have been changes. It is important that every single party gets on board and —.

Mr Swann: There have been members from yours as well, I believe.

Miss McAllister: One thing that I do want to ask—.

Mr Swann: Sorry, I want to go back to the last point. I didn't finish it.
Before the end of the previous mandate, when John O'Dowd was Infrastructure Minister and, I think, Edwin Poots was Agriculture Minister, we looked at whether we could pool community transport so that we were making best use of all those resources, across the three Departments, to make sure that people who were willing to travel were supported to do that.

Miss McAllister: That is really helpful and important for moving forward under transformation. Otherwise, it will not be successful in the long term. You mentioned that the workforce travels now. Is there a heavy reliance on locums? In particular, do any of the hubs have a heavy reliance on locums, and does that use more resources in the longer term, which we would not want to see?

Mr Swann: I am not sure about the workforce skill utilisation in regard to the use of locums. Through those transformational pieces, we have tried to stabilise posts and make them long-term investments. Again, the one-year, non-recurrent budget has posed challenges.

Mr Wilkinson: There is a challenge. You are quite right. The centres that we do have are up and running. The key is making sure that we are using all the lists and that we have the staff to run the lists. Primarily, it is about using HSC resources as far as possible. That is about staff moving and doing those lists, particularly consultants, and using a staff mix — using the staff who are there, plus, perhaps, a different consultant; or it is about purchasing additionality, under waiting-list initiatives, through the HSC.

When you talk about transformation in the future and moving forward, there are things that will have to be done to enable it. One of those will be looking at the workforce. It is about not just the gaps in the workforce but how much we can lever in a HSC workforce as well as the individual trust workforce. The idea is that there is a dual role, where a trust employee is also part of the HSC workforce. Those are some of the messages that are coming through in that blueprint work.

The physical locations are important, but the more important stuff, as you said, is about communication and understanding the public's interest in where they would go for treatment and understanding how that is enabled through the workforce. There are lots of challenges in all those areas, but those are the key enablers — workforce, messaging and delivery. The Minister mentioned productivity: that is about looking at theatre utilisation and consultant time across every location and not just the elective centres.

Miss McAllister: Thank you. I have a few more questions; is that OK? May I ask supplementaries?

The Chairperson (Ms Kimmins): I will take Alan Robinson, and I will let you in if we have a wee bit of time at the end. A couple of people have asked to come in.

Miss McAllister: May I ask him one?

The Chairperson (Ms Kimmins): Yes.

Miss McAllister: I was timing myself.

The Chairperson (Ms Kimmins): I am timing everybody. *[Laughter.]* I want to make sure that everybody gets in.

Miss McAllister: It is supplementary to what Linda Dillon said about Ray Jones's report and social services. You are still considering those recommendations. One of the recommendations was around a new children's directorate. We understand the resources issue, but sometimes there are a lot of issues around bureaucracy too and how to cut through that and make the right decisions, with the trusts working together to say, "OK, who has respite services in one trust and who does not have them in another?". We need to ensure that they can work together. At the moment, we are hearing too many negative issues around respite. It is the worst it has ever been for families who are already struggling.

In particular, I do not know whether the Minister is aware of it or can update us on whether the Department is still paying for Rainbow Lodge, even though it currently has no patients in it for respite services. It cannot get a workforce. It is my understanding — maybe it has changed — that it does not have any patients in for respite services, but it is still getting £300,000 a year as a respite unit, and people are not able to access it. I do not know whether that comes down to trusts not working with the private organisations that run respite units, or whether it is because there are not enough collaborative work going on. Something has gone wrong there: a service is currently being run, but there are no patients in it, nor have there been for a number of years. It would be worth the Minister and his team checking out whether that is still the case.

Mr Swann: I will check up on the specifics of that, and I will get back to the Committee.

Mr Robinson: You are very welcome, Minister. Everybody has pitched their questions at a very high level, but nobody has taken the opportunity to bring their questions down a tier. You will know about Causeway Hospital. We have heard for some years now about a vision for Causeway Hospital and about it being a potential elective hub on the north coast. We have heard a lot from you today and from previous contributors who have made presentations to the Committee about transformation and reform.

At what point will we see that vision for Causeway Hospital? Whatever the vision and whether an elective hub is situated there, that will have an impact not only on my constituents — your constituents — but potentially on all Committee members and our constituents. I am keen to know at what point we will see that in place, because it will give a bit of confidence to the staff and will help the Department of Health to attract staff, because that is one of the key issues. We are consistently told that, for various reasons, Causeway struggles to attract staff. Forgive me for bringing it down to that tier, Minister, but I never miss an opportunity.

Mr Swann: Look, Alan, it would be remiss of me to think that you would do so, because you — I do not mean this in a bad way — have followed in your father's footsteps in representing the population in East Londonderry. Any time that he spoke to me, it was about Causeway Hospital — what a fantastic facility it is, with the people who work in it and the service that they provide.

In regard to your specific point on the vision, I spoke earlier about the blueprint for our hospital service, and I am sure that you will have engaged with Jennifer Welsh, the chief executive of the Northern Trust. The trust has an ambitious but deliverable vision for Causeway Hospital as the next generation of a surgical hub. The trust also recently opened an ambulatory unit to support the elderly population up there. That investment in and dedication to the Causeway is shared by the Department, the Northern Trust and the Northern Trust board as to how the Causeway serves not only the trust but, as you said, the wider population across the north coast. We are working in collaboration with the Northern Trust on how that work goes forward.

On your point about recruitment, I go back to meetings with your father and Tony Stevens, when he was chief executive and recruitment was beyond a challenge for Causeway; it just could not manage to get anybody there. That has changed dramatically in the past couple of years due to the vision that has been supplied. It comes down to the way in which the narrative around Causeway has changed. Causeway used to be one of those hospitals that always seemed to be under threat of closure, whereas now, it is an integral part of our entire hospital system. I appreciate the support that our local elected reps give to the Northern Trust management in promoting Causeway not just as a place to go to but as part of the future of our health service and what it can deliver.

Mr Robinson: I am not being mischievous when I ask — we have heard about reform multiple times today — have there been any discussions, conversation or thinking, given that we have a single education trust, about a single health trust for Northern Ireland?

Mr Swann: Alan, as that is part of Ulster Unionist Party policy, I am glad that you are maybe on message.

Mr Robinson: I am not advocating it; I am only asking. *[Laughter.]* I caveat that heavily now.

Mr Swann: No, sorry, I do not mean to be facetious, or mischievous, as you put it, Alan. There is opportunity in looking at the more regional approach to some of our services. We are starting to see it in mental health, with trusts breaking down their artificial borders within Northern Ireland. There is a bigger piece of work on whether to look at our acute hospitals in that regard — the blueprint — at how they manage the services that they deliver, where they deliver them and where their catchment area is. It is maybe not about the step to a single trust but how our trusts work better together. I look to Jim, because he will remember the term that the five trusts have developed for how they work together.

Mr Wilkinson: I wish I could, Minister. *[Pause.]* They are looking at "provider collaboratives" as a way of trying to formalise arrangements. As we look at the blueprint document and at initiatives such as elective hubs and we talk about staff and patients moving and about regional services, we need to ask, "How do we underpin that with more formal arrangements and structures?". The trusts themselves are looking at provider collaboratives, and, recently, just before Christmas, they produced a collaborative approach to a central control centre to look at urgent care pressures across the system. There is scope to look at that in other matters.

At the same time, as part of the work that is being done on the blueprint, we are looking at approaches in Scotland, where there are commitments and, almost, service level agreements and memorandums of understanding about how trusts and providers will operate and support each other. If we say that there is a network and part of the system is a network as well as an individual trust area, as members have said, a failure in one part of the network will eventually have a repercussion somewhere else in that network. Therefore, we are looking at much more formal arrangements to try to cement those collaborative approaches.

The Chairperson (Ms Kimmins): We have been round everyone at this stage, Minister. Linda and Nuala have indicated that they have two quick follow-up questions. I would like to conclude as well because, as the discussion has gone on, some of the issues that I raised at the start have come up. For me, the message is very clear that, if we invest in our workforce and value our workforce, a lot of the issues that we are dealing with today will be, hopefully, in a much better place. Others have touched on the fact that we are currently spending quite a lot of money on plugging gaps with agency and locum staff. If we can get to a point where that is not needed to the same extent, which will not be easy, we will definitely be in a very different position.

In addition to that, we talked about transformation and reform. I met RCN representatives yesterday, following your meeting, and we were talking about the safe-staffing legislation. That co-production and co-design is so important to everything that we do. If it is being led by clinicians, those are front-line staff who know exactly what they are talking about and dealing with. That should also include the wider community, and I think that there is a huge role in particular for unpaid carers, who know best for their loved ones. I think that that is very important in the piece. By working with the community to bring that forward, hopefully, we will not be dealing with protests and people opposing things. A lot of what we have seen, in fairness, is around service collapse, not transformation, because we have not got to that point yet.

I have one very quick point on dentistry. I talked about the cost-of-service analysis review for Community Pharmacy. Have you any plans to do something similar with dentistry because of those rising costs?

Mr Swann: We are looking at the general dentist service contract in regard to where that currently sits. What stage that is at, I do not have off the top of my head.

Mr Wilkinson: We have been looking specifically at this in 2023-24. The Minister has made some comments about the funding that has been made available. We are also looking at the general uplift. Members have made points about changes that have happened elsewhere across the UK in approaches to the general dental contracts. I know that you heard today about the Scottish contracts.

We are looking at those developments to see the benefits and the impacts that they have had and what that might mean for Northern Ireland in trying to stabilise and sustain dental services here.

Mr Swann: On agency staff, one of the things that we did was to remove off-contract agency staff. We hope and estimate that, towards the end of this financial year, we will see our agency bill reduced by £20 million because of the actions that have been taken there as well as having the additional staff that we have been able to get in through the health and social care workforce. If that figure stays true and we see a reduction in our agency spend, not only will it be a first for a number of years here in Northern Ireland but we will be the first across the four nations to see a start in the reduction of that. One of the things that we were also able to do and which was an early indicator from Ray Jones's report was to remove agency social workers as part of the workforce. We did that to the extent that we were able to offer a place in our health and social care workforce to every graduate that came out. It is a challenging piece of work because it takes a lot of input from trust management, ward management and trade union side. We were able to do that off-contract piece, and I think that there is more that we can do on agency staff. If you met the RCN yesterday, you will know that the recent pay uplift goes some way to narrowing the gap between what agencies were paying and core salaries. It does not fully close the gap. It is work that needs to be ongoing.

The Chairperson (Ms Kimmins): That is positive about agency staff. I declare an interest as a social worker. We met the chief executives a number of weeks ago. Some of the figures that we heard regarding vacancies in social work teams were frightening. Hopefully, we can start to fill those vacancies. It was said to me that our spend on locums here is, proportionately, higher than that in England, Scotland and Wales. I am very conscious of that. If we are able to get a good pay settlement, we can start to eliminate some of that.

Mrs Dillon: This is a follow-on from what Nuala said about adults with learning disabilities, including those in my constituency, and the respite care that is, or, rather, is not, in place for them. It goes back to other points that were made about unpaid carers and all of that. There is a cost to not only the health and well-being of the young person, who, in some cases, needs respite from their family and needs to see other people outside of their home, but carers. There is a financial cost, and a cost to their health and well-being because of how they are looked after. We have a responsibility to them.

I had a meeting with your officials specifically on the issue, as you will be aware, but it really needs a regional focus. We need to make sure that every single family right across the North has decent access to respite care. I know that that will not happen overnight, but we need to see a plan in place that has, at its centre, carers and the adults and young people who use the service. It needs to be co-designed. It must be about what people actually need; let us not put in place a service that does not meet their needs in any way whatsoever. It is about really reaching out to carers. I know that, sometimes, that is difficult, but that is because we are dealing with people who have been fighting for years for every single thing for the people whom they love. We need to put some kind of plan in place. I accept all of the issues around finances, but it is not all about finances. In some cases, we have the facilities and the staff and are just not using them well.

Mr Swann: Our trusts can work on that collaboratively to get the provision back up to where it used to be. It is about expectation management as well.

Miss McAllister: Thank you, Minister, for your previous answer. I hope that, when looking at the overall structure of respite, you will look at delayed discharge and why some children wait for over five years to be discharged from hospital settings. If that is how we treat our young people and families, that is a really damning indictment of where we are.

You gave a one-word answer earlier to a question about puberty blockers. That will be very damaging for a very small number of people in Northern Ireland. Will puberty blockers now be paused or banned for all under-18s, not just trans kids? It should not have been a single-word answer.

Mr Swann: Sorry. I apologise for any upset that that may have caused to anybody who has been listening. I answered Diane's specific question about what was being followed. I apologise. The member is right. I was going to finish by clarifying that point. I answered Diane's question in a way that needed more explanation about the additional supports that are already out there, current provision in Northern Ireland and how it meets National Institute for Health and Care Excellence (NICE) guidelines and the concerns that have been raised in England.

Miss McAllister: It is important that the Minister meets LGBT+ organisations in Northern Ireland, which are only too aware of the acute needs of the young people in Northern Ireland who are left waiting for years and then transfer to the adult wait. It is really important that we are careful in our —

Mr Swann: In my previous time as Minister, I had quite a lot of engagement and meetings with and support from those organisations. I apologise for any upset that may have been caused.

The Chairperson (Ms Kimmins): Minister, thank you very much. That was a useful discussion. I thank the officials as well for their attendance. It has certainly been very good. I hope that we can continue this engagement in the coming weeks and months.

Mr Swann: Congratulations, Chair, on your timing. *[Laughter.]*

The Chairperson (Ms Kimmins): Thank you. We started late, so we are not doing too bad, but we have a good bit still to get through.

Mr Swann: Thank you.