



Northern Ireland
Assembly

Windsor Framework Democratic
Scrutiny Committee

OFFICIAL REPORT (Hansard)

COM (2023)395 Proposal to Amend
Regulation (EU) 2017/852:
British Dental Association Northern Ireland

14 March 2024

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Members present for all or part of the proceedings:

Mr Philip McGuigan (Chairperson)
Mr David Brooks (Deputy Chairperson)
Dr Steve Aiken
Mr Patrick Brown
Mr Jonathan Buckley
Ms Joanne Bunting
Ms Sorcha Eastwood
Mr Declan Kearney
Ms Emma Sheerin

Witnesses:

Ms Ciara Gallagher	British Dental Association Northern Ireland
Mr Tristen Kelso	British Dental Association Northern Ireland
Ms Roz McMullan	British Dental Association Northern Ireland

The Chairperson (Mr McGuigan): I welcome Tristen Kelso, the director of the BDA in the North; Roz McMullan, the chair of the BDA in the North; and Ciara Gallagher, the chair of the NI dental practice committee (NIDPC). All three will give evidence to the Committee on the proposal to amend the regulation on mercury, which will phase out the use of dental amalgam by 1 January 2025, except when a dental practitioner considers its use necessary owing to a specific medical need. A derogation until 30 June 2026 has been provided for to help minimise any negative socio-economic impacts, in particular for low-income patients.

I remind everybody that the evidence session will be recorded by Hansard. Before I hand over to the witnesses, I remind Committee members that the meeting is part of an evidence-gathering exercise in anticipation of the Committee's being notified when the EU act is published in the Official Journal of the European Union (OJEU). If notified, the Committee will need to decide whether it wishes to conduct an inquiry, as is provided for in the regulations. Members should focus their attention on the key questions for us and on whether it appears likely that the proposed replacement EU act:

"would have a significant impact specific to everyday life of communities ... in a way that is liable to persist."

Thank you for coming. I will hand over to you to make your presentation.

Mr Tristen Kelso (British Dental Association Northern Ireland): Thank you, Chair, and the Committee, for inviting the BDA to brief you today. I will introduce my colleagues. Roz McMullan is the

chair of our BDA Northern Ireland council and is a former hospital consultant orthodontist in the Western Health and Social Care Trust (WHSCT). Ciara Gallagher is the chair of our dental practice committee and is a practice owner. She is representing general dental practitioners. I am the director of BDA Northern Ireland.

I will briefly set the scene on the policy direction to date and explain why direct application of the amended EU regulation on mercury could have such a detrimental impact here. The European Parliament vote earlier this year to ban dental amalgam from 1 January next year sent shock waves across the entire dental profession, nowhere more so than in Northern Ireland. As our position paper makes clear, we — dentists and government — have been working on the basis of a managed, phase-down trajectory for dental amalgam. A phase-down approach is recognised in the Department of Health's Northern Ireland plan to phase down the use of dental amalgam. The plan was published in 2019 and sits alongside similar national plans for England, Scotland and Wales.

Far from being an outlier, the phase-down approach is also recognised internationally. At COP-5, the UN Conference of the Parties to the Minamata Convention on Mercury, last November, a proposal to establish 2030 as the phase-out date was rejected. A phase-down approach was reaffirmed in order to respect differences in countries' capacity; to promote equity; to take an evidence-based approach to identifying alternatives to dental amalgam; and, ultimately, to safeguard the oral health of respective populations. The UK is a signatory to that convention.

The phase-down of dental amalgam at a rate appropriate for each country is the best and only option for public health, not least considering the immense strain that dental services are already under. It is also an environmentally responsible approach, which the BDA supports. Reducing dental amalgam use requires Governments to put in place the necessary supports to manage the move away from that material. Despite having a phase-down plan, we still have a long way to go to achieve the three key strands that are outlined in our national plan: prevention; research and new treatment techniques and materials to replace amalgam; and service delivery reform, specifically general dental services (GDS) contract reform and the development of the community dental service.

To be bound by the amended regulation to an arbitrary date of January next year for phase-out, when the required preparatory steps, of which we are fully supportive, have not been adequately progressed, is alarming. Deviating from the established phase-down policy that applies at UK level and that continues to be advocated by all four Chief Dental Officers (CDOs) poses considerable risk of irreparable and long-lasting damage to the provision of dental services here, not least at a time when health service dentistry is on its knees. That cannot be overemphasised.

Ciara will expand on the fact that, in dentistry, we have a vital public service that is grossly underfunded, in which the fees paid to dentists, as self-employed independent contractors, already barely correlate with the true cost of providing care. An example to illustrate that is this: under the NHS, dentists are paid £10-62 to place a single-surface amalgam filling. Replacing amalgam with alternative materials will come at considerable additional cost, owing to the much costlier materials and the longer time required to place them. Those are costs that the Department should fully mitigate. Based on recent history, however, there is little confidence in the profession that that will happen. Members of the Northern Ireland public already struggle to access NHS dental care because the service is so poorly remunerated. On financial grounds alone, the regulation, if directly applied here, will be the tipping point for health service dentistry.

We have shared with you feedback from dentists about the impacts, as they see them, of an amalgam ban being imposed. In the words of one of those dentists:

"Increase in expenses and the ban on amalgam are the perfect storm. I don't know any dentist who will be able to deliver any NHS work next year under the circumstances. NHS dentistry is about to collapse."

That is as stark as it gets, and there will be a direct impact on patient care. There are strong clinical arguments for why dental amalgam must remain available as one of the tools in the armoury of the dental profession, not least here, where we have a high-needs population. It is not simply a case of swapping dental amalgam for something else. Dentists are deeply concerned about their high-needs patients. They refer to teeth that could otherwise be restored having to be extracted. They speak of being fearful that an amalgam ban will add to existing staff stress levels and increase pressures on general dental services, ultimately resulting in increased referrals to the other dental services, which are also under immense strain.

The amended EU regulation shines a spotlight on the fragile state of NHS dentistry in Northern Ireland, a service that is already rapidly shrinking, with reduced health service activity that was underspent by £12 million in 2022-23 in comparison with 2019-2020. An amalgam ban poses a considerable additional risk that causes many in the profession to be genuinely fearful of its demise. As another of our members put it:

"Failure to mitigate will result in the loss of health service dentistry in Northern Ireland, leaving the vulnerable and less well-off in great difficulty."

We hope that that risk will be nullified by the work of the Committee and the Assembly to agree to hold an inquiry and to oppose direct application of the amended regulation. Why are we in Northern Ireland so unprepared for these changes and set to be impacted on so severely? The profession would point to a derogation of duty by authorities here to progress real reform and invest properly in modern dental services, by failing to roll out ambitious oral health prevention measures to improve oral health, failing to introduce a new GDS contract that properly and fairly incentivises NHS care, and failing to invest properly in the dental workforce. The service is so unstable, and the conditions have not been met to see a move away from amalgam, certainly not from January 2025, or even within the 18-month time frame that is envisaged by the derogation.

There are real concerns about the impact that the amended regulation could have on the ability of the most disadvantaged people in society to access dental services. The threat of an amalgam ban may well be the final straw for health service dentistry. Indeed, it may already be too late to avoid collapse of the service. An amendment that was passed by MEPs referred to members states endeavouring to:

"ensure appropriate reimbursement is made available for mercury-free alternatives"

to limit the socio-economic impact on costs of care for patients and dentists. Will the UK Government pick up the tab? It could easily be in the tens of millions of pounds.

We want to reach a point at which amalgam is no longer needed, but we are not there yet. Achieving that requires considerable reform and investment. Combined with the fragile state of health service dentistry, the issue represents a major risk. Above all, there is a collective duty to strive for the outcome that best reflects the needs and oral health profile of the local population.

Thank you for listening. My colleagues and I will be happy to answer any questions. Ciara will lead on general dental services issues, while Roz will lead on impacts across dental services and oral health more generally.

The Chairperson (Mr McGuigan): Thank you very much. As it happens, some of the issues are part of the wider scope of the Department of Health. I am aware that the Health Minister will be before the Health Committee this afternoon. Having had a conversation with my colleague who is the Chair of the Health Committee, I am pretty certain that the wider dentistry piece will be raised there. Essentially, you are saying that your profession is unprepared for this, and that this is the final act, as it were, given the impact that it will have on the dental profession.

I will refer to the issue that relates specifically to the Committee, which is the specific EU regulation. In February, a compromise text stated:

"To minimise any negative socio-economic effects, in particular for low-income patients, in those Member States, where phasing out the use of dental amalgam as of 1 January 2025 poses considerable difficulties because the transition to mercury-free alternatives will not be completed by that date ...a derogation until 30 June 2026"

will be introduced.

I suspect that NHS patients fall under that category of patients. You are labouring on the 2025 date. Specifically, what positive difference will the derogation until 2026 make?

Ms Roz McMullan (British Dental Association Northern Ireland): I will hand over to my colleague, Ciara, but I will start.

You are quite right. The EU regulation has given the option of the derogation. It does not come easily but rather with a lot of work. An evidence base that the population will be significantly impacted on by

such implementation has to be provided. It is not just a one-off thing, allowing you to go away for 18 months and start to work on your other plans. Rather, it has to be a continued process, as I understand it from reading the regulation. We are all in uncharted waters here, but it appears that it is ongoing work. It is not something that we should throw out, as it is certainly an option.

The three key legs of the stool that underpin the Minamata Convention on Mercury, which is a UN treaty, are prevention, contract or systems to deliver care, and research into alternatives, and those are not 18-month projects. They are much longer. I will now hand over to my colleague Ciara.

Ms Ciara Gallagher (British Dental Association Northern Ireland): When it was thought that the ban would be coming in in January 2025, our questions were always going to be whether a derogation would do and whether 18 months would be enough to stabilise the service. To elaborate on what Tristen said, I think that it is important to understand the backdrop that we are looking at here. Some 90% of dentistry is delivered to patients by high-street practices such as mine. We are stand-alone businesses, and like all businesses, we have faced massively increased costs over recent years. Unlike other businesses, however, we are not in a position to alter our fees to match those costs, because our fees are set by the Department of Health, and no business that is giving out more than it is taking in can survive. Dentistry is the same. Right now, we are in a very unstable situation, and that is even without the arrival of the amalgam ban. Dentistry is a public service, and we need to save it.

On your question about the 18 months, Chair, it will take time for us to get ready. We need time to develop a proper prevention strategy. Work has been done, but we are not there yet, and we will not be there in 18 months' time. When a prevention strategy is introduced, it has to be developed, it has to be rolled out, and people have to be trained. It then has to go into the population, and it takes years for those effects to come through for us to have less tooth decay and for there to be less reliance on fillings. We are talking about the removal of a core filling material. We have not got enough time to roll out a proper prevention strategy.

On the filling materials, we are not fighting to keep amalgam for ever. We are not fighting to keep it beyond 10 years. What we are saying is that we are not ready to get rid of it yet, because we have not got a suitable alternative for a lot of cases. Where amalgam scores very highly is when you have a nervous patient who cannot sit for too long for treatment. It scores very highly for patients who have special needs. It is a reasonably economic material, which means that it will be a good material for looking after patients from low socio-economic groups. For elderly patients who come in and find it difficult to sit for long periods, amalgam works better than anything else. For patients who gag during treatment, amalgam works better. It is a great workhorse material for dentistry. To remove it from use in 10 months or 18 months will mean that we will have patients who will not have teeth that we could have otherwise have looked after. Those are teeth that they would otherwise have kept for chewing and have been able to keep for speaking. Such patients would not have to wear dentures, and, in the case of children, they would not have to have a general anaesthetic. The ramifications will go on and on, all because we will have taken a core material out of our dentist toolkit.

A derogation will not do, because we will not be ready in 18 months. White fillings take longer to place than amalgam fillings. I know that placing a large white filling takes me three times as long as it does to place a large silver amalgam filling. We are not just saying that we will do this instead of doing that. We are trebling patients' treatment time, and, if we are trebling their treatment time, we are reducing our capacity and therefore cannot see as many patients. The natural answer to its taking more time is to have more clinicians, but it will take time to train clinicians. We can have dental therapists, who can do fillings. They do not do the whole remit of dentistry. We do not have a school of dental therapy here, however, so even if we were to start planning now, we would be talking about five years before the first dental therapist were to come on board to increase the workforce that we will need to meet the longer time that it will take to treat patients. That is a key reason that 18 months is not long enough.

Is there anything else? Have I answered that sufficiently?

The Chairperson (Mr McGuigan): Following on from your examples from people and the proposed derogation and who it will capture, what percentage of patients whom you treat in the community come under the category that will be included in the derogation?

Ms Gallagher: I can tell you how many fillings were placed last year. Last year, 182,000 silver amalgam fillings were placed. If we had had to do those 182,000 fillings in white filling material, we would not have been able to do so. I cannot give you a figure for the percentage of patients, but if you

look across the socio-economic picture, you will see that anybody who is coming from a socio-economically deprived background will be disproportionately affected by the ban.

The Chairperson (Mr McGuigan): I want to ask about the difference between the phase-down approach and the phase-out approach. There were 182,000 patients last year. How many patients were there the year before? How many are dropping off?

Ms Gallagher: I can answer that. We have statistics for how many amalgam fillings we placed in 2015 and how many we placed last year. We are down 43%. We are therefore placing 43% fewer amalgam fillings now than we did in 2015, so we are on our way.

Over seven years, we have reduced the amount of silver amalgam by 43%, but that is over seven years, so we are talking about just over 10 months, or even over 18 months, to go from 47% to zero. The service will break. Ultimately, patients will be suffering, because, clinically, they are not going to be able to get the right material to fill their teeth. Furthermore, they are not going to be able to access care. There are therefore two problems, in that it will mean the complete collapse of the service, with no NHS dentist having patients, but even if people can get NHS dentistry, a key material has been removed from our toolkit.

The Chairperson (Mr McGuigan): It is a ban not just on the use of amalgam but on its export and import. From where do dentists in the North get their amalgam? I presume that we do not manufacture it here.

Ms Gallagher: There are manufacturing sites all over Europe. At the moment, it is also manufactured in China and North America. I understand that Europe, obviously, is going to be winding down its manufacturing of amalgam. We will be able to access it, but it will go up in price. If the ban comes in, routine, basic NHS dentistry that we do with amalgam fillings will be more expensive anyway. If, however, you compare the cost of a large silver filling on the NHS with a white filling provided privately — we assume that the Government would cover the NHS cost — it is five times more expensive. If you stick with amalgam, the cost will go up. If you get rid of amalgam and switch to white filling material, the cost will be exponentially larger for the Department of Health if it has to cover those NHS patients.

The Chairperson (Mr McGuigan): Tristen mentioned, and you just alluded to it, that there is an implication that Westminster might reimburse dentists. Will you give us a full explanation of that? That is important.

Mr Kelso: We are in uncharted constitutional territory. All that we can say is that the EU Commission amendment that was passed by MEPs made the assumption that member states would step in. The concern and the question here is this: will they? It is not just about getting from a stable situation to offset the risk of amalgam. Reform should have happened years ago. Are the Westminster Government going to step in to bring us from where we are, on our knees, to the position of stabilising the service and offsetting the extra cost of amalgam use? One part of the member state is potentially covered by that but not other parts of the UK. That is our concern.

If it falls on the Department of Health, we know of the £1 billion black hole there. The concern is that the Department has not been able to meet the true cost of delivering NHS dentistry as it is, so where is the extra money going to come from? If it can get only a certain amount and is therefore not quite there, that is not going to cut it. That is the concern, and we do not have the answers. Those are big conversations that, hopefully, you will be able to take forward.

The Chairperson (Mr McGuigan): Thank you.

Dr Aiken: Thanks very much for your evidence so far. I have a couple of questions.

First, as a point of clarification, why did the EU shift the date from 2030 to 2025? What was the rush?

Mr Kelso: That is a very good question. In 2021, the 2030 date was there for phase-out. That did not happen. The EU had done an impact assessment, which was carried out pre-pandemic. We would say that the data bears completely no relevance to where dentistry is now compared with where it used to be. When we met the permanent secretary in November, there were suggestions that we were looking at a 2027 phase-out date. Suddenly, January 2025 happened, creating shock waves.

We cannot answer for the EU. All that we can say is that the BDA position would be in line with the United Nations Minamata convention, which ruled out a 2030 phase-out date and maintained phase-down, which is the policy that has been in place.

Dr Aiken: To clarify, your Scottish, Welsh and English colleagues continue with the phase-down approach —

Mr Kelso: Yes.

Dr Aiken: — for which there is good clinical and fiscal supporting evidence. Do we know what is happening in the Republic of Ireland?

Mr Kelso: Yes. We have close working relationships with our colleagues in the Republic. They, like us, are part of the Council of European Dentists (CED), which dentists are part of at a European level. It was very much about a phase-down approach and the need for greater prevention in the Republic of Ireland as well. So, there has been a common approach to the position that has been in place up until now. Obviously, as member states, they are directly implicated in this matter.

Ms McMullan: The Republic of Ireland is a lot further on than us in some aspects. Its water supplies have been fluoridated for many decades now, but it still has a deprivation issue and an oral health issue. I understand that its dentists will struggle, even with a derogation of 18 months, so they too are concerned. It has a completely different system for delivering dental care, as you are probably aware. To some extent, as with all groups, those who rely on the medical cards there or those who are affected by deprivation here in the North will be the ones who are impacted the most by such an implementation.

Dr Aiken: What have you heard through your links with the European dentists' movement? From my research, I am aware that dentist groups all over Europe are saying that they cannot do it.

Ms McMullan: I worked in Norway for six months. Norway has, ostensibly, been free from dental amalgams since 2005 or 2006. It gets fluoride to its young population through a schools project, so the decay rate there is low. However, decay is caused by diet, so those who are more prone to decay and the more vulnerable in society still experience decay. In Norway, unfortunately, research shows that the extraction rate has gone up. More teeth are taken out in Norway, and I saw that when I worked there.

Dr Aiken: The discussions that I have had with some of our friends in Europe show that they are in the same position, particularly those in the Baltic states and further down in eastern Europe – not so much France or wherever else — because they do not know how they will deal with the situation when amalgam is phased out. Thank you for that.

Ms Gallagher: One other point is that their dental services are not a house of cards like ours, because they are funded in a different and better way. They are starting from a better baseline with a less fragile dental service.

Ms McMullan: That is the same even for the UK. At the back end of last year, Scotland developed, as you are probably aware, a new contract system about which we can speak, if you wish. That certainly —

Dr Aiken: That is one for the Health Committee.

Ms McMullan: — stabilised their services. Even compared with others in the UK, we are in a very unstable situation. People have described the dental service as being on its knees. I would go further than saying it is on its knees.

Dr Aiken: I return to the specific issue for this Committee, which is to do with amalgam. Much like the people who are trying to sort out construction issues with their apartments, we have the rather bizarre situation where we are having to ask, "In which Department does responsibility for this issue lie?" It might sound bizarre to everybody who is watching the meeting, but it is a DAERA issue because it relates to mercury.

I understand that DAERA has been given the lead to try to sort the issue out. Have you had any interaction with that Department, or has it decided to push things forward? One of the Committee's purposes is to see whether any harm to the people of Northern Ireland will be caused through any changes that have come in. Another of its roles is to flag issues early so that we do not get to the situation where we have to use the Stormont brake. It is about saying, "Here is a problem, and we need to get it sorted." We need to be in communication with the joint working group to do that. That is supposed to be done by the relevant Department. Has DAERA engaged in any of that?

Mr Kelso: DEFRA has been the lead agency on behalf of the UK. The four UK Chief Dental Officers, including our Chief Dental Officer, led on a lot of that work on the impact on dentistry and clinical care. We have had no conversation with or contact from DAERA. My sense is that January's vote caught people unprepared.

Dr Aiken: This is my final question: is dentistry in the UK ready for the phasing down by 2030, or is there still an element of aspiration to that?

Ms McMullan: We are at a standing start. Although 2030 is more achievable than 2025, it will still be very tight with good and targeted prevention. We have an obesity strategy, which has finished its consultation, and oral health improvement strategies, which are in consultation, so the work has started. However, even if you started targeted prevention yesterday, a child born today will be five years old in five years' time, so you are not going to see the effect starting to push through until that length of time. We are now in 2024. Time seems to move so quickly, and 2030 is only six years away.

Dr Aiken: The question that we have to ask is whether there will be a detrimental effect on the people of Northern Ireland even with the derogation. Can we have a one-word answer? Yes or no?

Ms Gallagher: Yes.

Ms McMullan: Absolutely.

Ms Eastwood: Apologies: I cannot be there in person, as I am not very well. I wanted to touch base with you guys in BDA. Thank you so much for giving evidence today. I think that it was Tristen and Roz who said that we are in uncharted territory. Clearly we are. We, as a Committee, want to make sure that we do our job fully. This is almost a perfect storm. I know that we are very keen to remain within the tramlines of the responsibilities of our Committee, but, nonetheless, it is impossible to have a conversation about this without mentioning the wider impact and where NHS dentistry is at currently. You all very much have my sympathy and support because, clearly, much more support is needed.

I want to ask, very briefly, about conversations with the Department of Health. Steve referred to DAERA, which clearly has a very niche role due to the chemicals involved and regs around that. I am concerned that, no matter what we do here, there is going to be an onus to increase the training provision due to the needs that we will have in the future. Clearly, no matter what, we will be using more of the new white filling, which will require more training places. What conversations have there been on that?

Ms McMullan: I will start and then pass to my colleagues. You are quite right: training is very much highlighted as one of the needs. As Ciara pointed out, it does not have to be the dentist who places the fillings; we have therapists who can do that. Nurses also handle the material, which requires specialist training. Even those in the workplace at the moment will need to be trained. That will be in addition to increasing the workforce.

There are two strands to training. We have a brilliant training agency in the Northern Ireland Medical and Dental Training Agency (NIMDTA), which provides training to the profession. Conversations about the need for training have been had. I cannot speak for NIMDTA — I am sure that, as part of your inquiry, you will look to it — but I am quite sure that it is very well aware of, and anxious about, the training that will be necessary to fulfil the requirements. Training is very much part of the conversation that we have had. It is one important strand that we need to take into consideration, and it takes time.

Mr Kelso: A key part of the national plan was to grow and develop community dental services. A workforce review was done in 2018 but has only just been published. That said that, even pre-pandemic, because of the growing ageing population, the service needed to grow from a headcount of 80 up to 117. Instead of growing, the headcount has been reducing in recent years. Again, as with all

of these things, we understand the difficulties financially, but that growth needs to happen in order to meet the obligations that we face. The GDS deal with 90% of the care, so it is about trying to retain practitioners in NHS dentistry. The exodus is already well under way. The growth needs to happen. We have been pushing for workforce planning, but we really are not moving forward very quickly at all.

The Chairperson (Mr McGuigan): Sorcha, are you happy?

Ms Eastwood: Thank you, Chair. I have one last question. There was a brief discussion about finances at the start. If I have picked you up correctly and understood the briefing, there was almost an expectation that part of phasing down would involve covering some of the financial outlay for, basically, the cost of procuring the white fillings because there would be a price differential. Did you say that there had been an expectation, maybe not across the other devolved regions but in mainland Europe, and a period of crossover during which the purchase and procurement of white fillings and the associated costs had been partially subsidised? Did I pick you up right on that?

Ms McMullan: I will let Ciara answer some of that. Of course, there are different methods of providing and funding dental care throughout Europe. We have a fully funded NHS system that provides comprehensive care to the majority of our population. That is not the case for most other countries in Europe. There is a different situation for a dentist who is providing care in France, possibly under an insurance plan or on a pay-as-you-go private basis. The cost of that could be subsidised to help the transition. That is a different system and a different way of thinking to what we have in the UK.

Ciara has very clearly outlined — she will again, I am sure, because she deals with this day and daily — the difference between providing white fillings and silver amalgam fillings, both in time and in the cost of materials. We have to take into account that, as with any medicament, any producer of a dental amalgam has to go through a licensing process to license their product. That takes money and time, and that investment may not happen from certain companies that decide to withdraw from the market as the market shrinks in size. So, there will be less competition and a higher cost for amalgams. Ciara pointed that out, and she may want to expand on the costs.

Ms Gallagher: As I said at the beginning, what is being paid to dentistry does not cover the cost of care. There is a miscalculation at the moment in what we are paid to cover what we do. There is a huge lack of faith amongst the profession that the Government will accurately calculate the new costs of these materials. Our latest survey came out last week, in which almost 90% of dentists said that, if the ban comes into place, they intend to leave the NHS. There is a miscalculation at the moment, which is why the service is on its knees. What is to say that there will not be a miscalculation in the future? We know what it costs to run our businesses, and we know that the NHS fees do not cover that, so why would new NHS fees for a more expensive material and a more costly procedure be any different? They will not cover those costs, and there will be a bigger loss when providing NHS dentistry.

It is back to the issue of stabilising the service, and, because the service is so underfunded, we are really struggling. NHS-committed practices are really struggling to recruit dentists. There are multi-surgery practices in deprived areas that have only one dentist working in them to serve thousands and thousands of patients. That situation has come about because they cannot recruit, and the reason that they cannot recruit is that, as all the statistics show, a committed NHS dentist in Northern Ireland is the lowest-paid dentist in the UK. It is not all about money; it is about the survival of the service, and the service will not survive as it is. If this ban comes in, there is absolutely no chance that anybody who is limping on now will continue to do so. As I said, 90% of dentists have said that, if the ban comes in, they will leave. That will mean no care. There will be a significant impact on everyday life in communities in Northern Ireland if you cannot see a dentist.

Ms McMullan: I point the Committee to points 21, 22 and 23 in the position paper, which outline the extent of dental decay in Northern Ireland. It is a non-communicable disease and is very similar in its epidemiology to other non-communicable diseases that, I am sure, you have heard about. I will not go through those figures — you can read them — but we have high levels of decay and three times the rate of extractions under a general anaesthetic for our children pro rata. We also know — we have the statistics to show this — that the impact is highest in areas of deprivation. On every tick, we have a really important core population that needs dental treatment. I am speaking for them today, so that they continue to get the care that they so need, whether that means a white filling or a silver one; whatever the dentist feels is right after conversation with the child, parent or patient. That is something that happens in the dental clinic. We should protect that. Sorry, I get a bit passionate about it.

Ms Gallagher: I will come in briefly. We are talking about significant impact. If people cannot get to see the dentist, there is a knock-on effect on all the other services. For example, you will have people with toothache and swollen faces coming into A&E. GPs are already coming down with treatment requirements. We have patients who cannot get screened for cancer and, therefore, by the time they present, they will be later stage and have worse survival rates. The general anaesthetic services in hospitals for children who have more decay will be overwhelmed. The same goes for specialist oral surgery services, because, the more damaged a tooth is, the harder it is to take out. So those specialist services will be overwhelmed too. There will be a ripple effect on services throughout the community due to the impact on dentistry services. We could keep those services within our buildings and not have ramifications spreading throughout the whole of health care.

Ms McMullan: I will speak up for orthodontics briefly, being the orthodontist that I am. When you have a crowded mouth, often you try to avoid taking teeth out these days. However, sometimes you have no option but to take out teeth. It is much easier for the orthodontist and the patient — the treatment is shorter — if the right tooth is taken out rather than the tooth that is decayed and rotten and which the dentist tells us has no life. Certainly, from the point of view of orthodontic treatment, that approach improves the care of the child.

The Chairperson (Mr McGuigan): I am not being the harsh Chair. From an MLA point of view, we deal with constituents all the time who struggle to see a dentist. We are all aware of the crisis in dentistry. However, I want to keep everything focused on the issue of amalgam fillings and its impact. Otherwise, we will be having a conversation that, while good, is not really relevant to this.

Ms McMullan: Certainly, the orthodontic point relates to the amalgam issue. The wrong tooth will be coming out.

The Chairperson (Mr McGuigan): Absolutely. Sorcha, if you have finished, I ask Jonathan to come in.

Mr Buckley: Thanks very much to the British Dental Association for the presentation this morning. You have made a good job of simplifying something that can sometimes come across as complex. The real-life impact on citizens across Northern Ireland is very clear, and we can hear the sense of panic in your voices and in your correspondence.

You have been very clear with the Committee. That is probably not the way in which the Committee expects to have concerns brought to it. You believe that processes relating to the Stormont brake, such as the launch of an inquiry, should be applied now. What has your experience been of registering the concerns of dentists in Northern Ireland about the impact that this proposed change to EU law will have in Northern Ireland?

Mr Kelso: First and foremost, this is the Committee that is responsible for hearing concerns about any amended EU regulation or new act. In our focus, we respect and value that there are democratic structures here, including this Committee, to do that job. All we have done is engage with the Committee. Obviously, we have engaged with the Health Minister as well to lay out the concerns of the profession about the impacts we feel the change will have. We met officials and shared our briefing paper along those lines, and we have another meeting with the Minister scheduled. In terms of engagement, we have been watching carefully at a European level through our membership of the CED and we are part of an international group.

Stormont has only come back and we are in the early stages, but timing is the issue. The vote on the regulation happened before Stormont came back. Stormont is back now, and, to be quite frank, we sighed with relief that it is and that the Windsor framework institutions are here to, potentially, look at things. Obviously, we come at it from a dental public health perspective, whereas you will be looking at these things in the round. We just want to be as clear as possible about impact, and, hopefully, inform that job.

That is where we are at. It is early days, obviously, but we expect that the amended regulation could be with us very quickly.

Ms McMullan: We met the Department two weeks ago and shared the same position paper and concerns that we have.

Mr Buckley: I appreciate that. I can sense the frustration that something is coming down the tracks very quickly. I suppose the Committee's role is to look into whether or not it will have a detrimental impact. Following on from Steve's initial comment — maybe Ciara address this — in terms of the real-life impact on service provision for citizens in Northern Ireland, if this changed EU law applied to Northern Ireland, how quickly do you anticipate there being a breakdown in service provision?

Ms Gallagher: Almost immediately. As soon as the decision is made, dental practice business owners will have to rewrite their entire business plan for the year based on a whole new model of treatment delivery. Under the NHS, that cannot happen: when you put it into your spreadsheet, you will end up with a seriously negative number at the bottom. So, as soon as that decision becomes law in our country, which is where we were in January, there will be an immediate rewriting of business cases. The statistics from last week show that 90% of dentists said that they would reduce service provision and 50% said that they would leave completely. There would be an immediate collapse.

Mr Buckley: The EU has claimed that the manufacturing and import of dental amalgam can continue in limited circumstances, such as specific medical need. Is that pie-in-the-sky thinking? Is that possible? Where the dental amalgam comes from has been answered, but will the supply from GB to Northern Ireland be fettered by additional certification if it can only enter Northern Ireland for only strict medical purposes?

Ms Gallagher: The medical purposes have not been defined. Until we have a definition of how broadly we could use our dental amalgam — I said at the beginning that lots of people would be affected by not being able to have a dental amalgam. That has not been defined in terms of specific medical need, so it is something that we want some clarity on.

Mr Kelso: We have strayed into other arenas, such as health. The BDA is a UK-wide organisation. BDA Northern Ireland clearly sees the massive extra risk from the regulation. However, even in GB, our colleagues are extremely concerned about the indirect impact on the cost of, and access to, supply. Regardless, it looks as if the whole of the UK will be impacted, and there is the potential for extra impact. Those are the sorts of conversations that we are having.

Mr Buckley: How acute is, for example, the issue of tooth decay in deprived areas of Northern Ireland compared with the rest of the United Kingdom? I do not want to get too much into the debate on the lack of service provision or the difficulties facing the industry. I am just trying to get a picture of the material impact on deprived areas of Northern Ireland compared with the impact across the UK.

Ms McMullan: Dental decay, like any non-communicable disease, impacts on areas of deprivation. Surveys are carried out regularly throughout the United Kingdom, generally on five- and 12-year-olds and adults. They happen at various intervals. Without going into the details or a lot of figures, not only do we consistently come out as the region with the highest number of the population experiencing decay but, within the population experiencing decay, it is worse: there is more tooth decay, missing teeth or fillings within the group that has increased decay. That answers your question. It is a disease of deprivation and a disease that impacts a group at a higher level.

Mr Kelso: To add to that, in 2020, which was the last full financial year before COVID impacted, 21,000 teeth were extracted under general anaesthetic from children, which is, pro rata, roughly three times higher than in England. That gives you a sense of oral health, the links with deprivation and how we are at the bottom of the UK-wide league table on this one.

With regard to oral health improvement plans, the consultation has only closed on updating our 2007 oral health strategy. We have had a vacuum there. A lot of good work has been done by the Chief Dental Officer, but that needs to feed through. We are three times worse off, per head, than England.

Ms McMullan: Again, I just want to reiterate that figure: 21,000 teeth. That is at the end of the spectrum: general anaesthetic extraction. That does not include the extractions that are carried out in dental surgeries under local anaesthetic or sedation or those carried out by the community service under sedation. That is at the end of the spectrum. You know the population of children in Northern Ireland, so 21,000 teeth extracted under general anaesthetic is not a statistic that we are particularly proud of.

Ms Gallagher: You asked about our health in relation to England. Within Northern Ireland, children from deprived areas are three times more likely to have tooth decay than children from other areas

Mr Buckley: Those are startling statistics. I thank you very much for answering the questions very directly. I share your concerns and thank the BDA for bringing them to the Committee today.

Ms Bunting: Have any other member states of the EU signed up to the Minamata convention?

Mr Kelso: Something like 140 or 150 countries have signed up to the Minamata convention. We can get you that information after the meeting.

Ms Bunting: Thank you. I want to be clear and confirm that my takeaways from your evidence are correct. You indicated, in your briefing paper and orally, that there is no evidence that mercury from amalgam fillings has any harmful effects on health and that the inequalities that currently exist between the deprived and non-deprived will be significantly exasperated. This is me trying to establish the significant impact that will persist. You have indicated that we are nowhere near ready. The disparity in the statistics between those who live in deprivation and those who do not is fairly stark and shocking, to be honest. You have said that the number one reason for the hospitalisation of children is extraction. Yes?

Ms McMullan: Yes.

Ms Bunting: You said that, faced with the choice, people will extract teeth rather than fill them. It is also in the evidence that people will extract teeth because of fear of litigation. So far, those are all accurate and significant impacts. I noted the cost differential: the cost of an amalgam filling can range from £8.13 to £20.90, whereas, with a white filling, that increases to between £80 and £150. That is a stark difference. You have indicated that business decisions are being made now, so by the time all of this works its way through, it could, essentially, be too late to save NHS dentistry. So far, so good?

Ms McMullan: Yes. So far, so good.

Ms Bunting: That is fine.

Ms Gallagher: There is a solution, and it is a quick one, but that is for another Committee. It is the Scottish model. I will stop talking.

Ms Bunting: That is fair enough. I am trying to understand whether I have got the significant impact on Northern Ireland down. You said that the derogation will have a significant impact on the most disadvantaged in our society. You also said that, although the EU may well say that member states should reimburse appropriately, at this juncture you remain unclear on whether or not that will happen on the basis that current levels of service are not being adequately funded. Yes? OK. Philip already dealt with one of my questions, which was about the impact of the derogation. Let me work through this. Did I read, in your dossier, that the health impacts of replacements for amalgam have not yet been fully tested?

Mr Kelso: There is further research to be done. One big area that has been raised is the potential of microplastics. We are signed up to getting to a point where we do not need mercury — amalgam — fillings anymore, but we do not want to do a rush job and displace one environmental issue with another. The research has not been completed, and a suitable alternative material that does everything that mercury does has not yet been found.

Ms Bunting: Would you say that the EU appears to have jumped the gun considerably?

Mr Kelso: Yes.

Ms McMullan: Yes.

Ms Bunting: OK. You indicated that treatment time will treble and costs will double. In Northern Ireland, there are already significant impacts on the cost of living; dentistry already has an impact on people's costs. When faced with a choice of day-to-day essentials versus oral healthcare, people choose day-to-day essentials. Those increases will mean that they have to continue to make that choice. I see you nodding. OK.

You may not be in a position to answer this, so this may be pure speculation, but, from what you have seen, what is the likelihood of the EU moving, were its member states to say, "We can't make this deadline; it is not practical"? Presumably, we are not the only ones who are in financial difficulty over this.

Mr Kelso: We are a small player in a big game. The way we see it is that we need to put the panic button out to you. The role of these institutions and of this Committee, in particular, is to take up those issues. We are in no position to have direct conversations with European officials. There is no European Commission office in Belfast anymore and no MEPs to appeal to, but there is an important democratic role for this Committee to do what needs to be done for the local population. That is our appeal; that is why we are here.

Ms Gallagher: Joanne, I will briefly go back to the point about treatment costs doubling. That is an underestimate, because it is based on current underfunding. In certain situations, you can put white fillings in back teeth. That treatment is grossly underfunded; it is one of the worst funded of the treatments that we provide. We wanted to work on real-life figures, and those are the figures we worked on and that are printed. Treatment costs doubling is not a real-world figure; they are increasing much more than that. I wanted to put that on the record. We based that on inadequate fees. We have to come into line and recalibrate all the fees, and recalibrating the treatment fees that were used in those sums will result in a significantly higher figure for the cost for non-amalgam alternatives.

Ms Bunting: That is really helpful, Ciara, thank you. I have just one more question, Chair. Am I right to say that, presumably, research shows that there is a direct correlation between poor oral health and poor general health and that one exacerbates the other?

Ms McMullan: Yes. Quite a lot of research is going on at the moment, and has been done in the past, about interrelationships, even within the epidemiology of diseases. We have a lot of evidence around gum disease. We focused on decay, but the other thing that dentists see a lot of is gum disease in the gums and the bones around people's teeth. There is a lot of relationship between that and heart disease. We are learning more about the epidemiology of non-communicable diseases. Disease processes have not been particularly well researched. When they have been researched, they have been researched in silos, with everybody finding the same thing, but people are now coming together and seeing those interrelationships.

Ms Bunting: Essentially, when people make the choice between a dental service that will cost at least twice what it currently costs and feeding their children or heating their homes, they will not choose oral care. That speaks to a significant impact, which will persist.

Lastly, I think that there is something in your briefing paper that indicates that, were we to diverge from the rest of the UK, it would become difficult for practising dentists here to move to work elsewhere in the UK? Is that right?

Ms McMullan: Yes.

Ms Gallagher: It is because you are trained across the whole spectrum of materials. Therefore, if you are not trained in one aspect of it, it is harder to move into a different jurisdiction.

Ms McMullan: That may lead to a loss of our undergraduate trainees, whether in therapy or dentistry. It could lead to people moving outside the UK as well: remember, places like Australia, and Canada are still on a phase-down trajectory.

Ms Bunting: I will close on this point. It strikes me that the case for significant impact that will persist has been more than adequately made by this evidence. Bearing in mind the financial position that the bulk of people in Northern Ireland find themselves in, not to take action at this point would be a real dereliction of duty on the part of the Assembly. If we care about our constituents, their socio-economic position and the choices that they will have to make in those circumstances, the long-lasting impact of this could be horrendous. I do not think that any of us want to see National Health Service dentists crash and burn and for that to be lost to our society.

Mr Kearney: Thank you very much for coming here this morning. I know that we have gone outside the scope of the Committee, but nevertheless, the various observations and insights that you have provided have been very helpful. What you have mapped out, in quite stark terms, for me, is what I

would describe as the medical pathology of poverty and deprivation. This particular region, as you well know as professionals, presents with the worst mental health and well-being indices, with higher levels of child poverty. We are a low-wage, regional economy, and we have areas in the North which have not reduced their poverty and disadvantage indices in 25 years. They remain persistently and intractably high.

When you relate all of those factors together, it is very apparent how issues around oral hygiene and healthcare impact directly on other morbidities, or, indeed, become consequential to other morbidities, and Ciara made that point very well. What we are dealing with here is a perfect storm of cross-cutting issues. That is why it is also useful that Steve Aiken brought into focus the fact that there is a DAERA issue here. There is a very significant Department of Health issue here, which is outside the remit of this Committee. However, you are already engaged there.

As a society, we are dealing in multiple ways with the consequences of the Brexit decision in 2016. It never ceases to seize my perspective that, in so many different ways, these are not just economic issues. They have consequences that impact on social and health matters and in cultural and educational terms. In many ways, we are dealing with a big legacy here. It is notable that the British Government, in their negotiation around preparing for the exit from the EU, and then in anticipation of trying to manage the mitigations arising from that, did not identify this particular issue as one of the points on the horizon. We are where we are, however.

I come back to the point that we have a backdrop of a health service that is already deeply damaged and in endemic difficulties across the entire spectrum. I have always considered your profession in the health service to be, if I may use the term, one of the Cinderella elements of the system. I relate dental care and oral hygiene and your work as professionals to the challenges that we have with oncology, cancer research and adult learning disabilities and the extent to which so many of those aspects of health and well-being have been underfunded and underinvested in, and the result is vast pressures that have real-world consequences for broader society.

I have a couple of questions, and I want to come back briefly, at the end, to a point that Steve raised. I do not want to go over the same ground with the Twenty-six Counties, but I am interested the extent that the BDA has spoken to colleagues in the South about the levels and states of preparation for that, given that the Twenty-six Counties remains a member state. I put my question to the three of you. First, is our dental profession and the provision of oral and dental health care in crisis?

Ms McMullan: Yes.

Mr Kearney: Thank you. Would you agree that your testimony and presentation sets out a detrimental effect with very stark implications, but nevertheless, consequential to the chronic underinvestment in and instability of dental services in the North?

Ms Gallagher: If you had a steady dental service that was properly funded and dentists had faith in the planning for NHS dentistry, we could probably handle this issue a little bit better. Amalgam is a useful material, and it has an important place, but this would not be such a significant blow if our services were more stable. I will go back to the house-of-cards analogy: if this was on top of a solid house, the strain could be absorbed somewhere else.

Mr Kearney: You described that very well earlier, Ciara, as did Roz. We are dealing with a real-world consequence of a context, and therefore it has to be seen and understood in the context and perspective of a historic and current situation that has presented profound challenges and systemic crisis for our broader health and social care system.

Ms McMullan: You put it very well when you put it in the context — I worked in Derry — of the position with the oral health of our population at present and the work that we all need to do as a society to improve that. It is not necessarily the fault of the people; it is the system we put in place for them. It is about giving people access to care and healthy choices. People are in economic strife at the moment, as you and I well know, and they are making difficult choices. It is important not to blame society. It is about the systems to provide the care so that children do not miss school because they have sore teeth and people can go to work because they are not taking their child for a general anaesthetic to have a tooth out.

There is great work going on in the community service; I commend that. Again, we are straying beyond the issue, but the context is important. The community service does great work to provide

care, but, if patients are displaced into that service because of the amalgam issue, it will impact secondarily on the patients who receive good care in the community service.

Mr Kearney: My penultimate point is that the detrimental effect to society is not, therefore, in and of itself derived directly from this issue. The detrimental effect to society in the North is in the broader context of underfunding and underinvestment, as well as inadequate planning, preparing and policy relating to oral hygiene provision and dental healthcare services.

Ms McMullan: Yes.

Mr Kearney: Thank you for clarifying that.

My last point relates to the South, and the extent to which the Committee of European Dentists —

Mr Kelso: Council.

Mr Kearney: Has the committee conducted an assessment of the phasing out of amalgam — in any time frame — and its repercussions for the Twenty-six Counties, as you have done for here? Do we have a sense of the multiplier effects that will be challenged by your counterparts in the Twenty-six Counties and in England, Scotland and Wales?

Mr Kelso: I can talk to aspects of that. We are regularly in conversations with the Irish Dental Association (IDA). Its position, as part of the Council of European Dentists, is very aligned with ours. We are being bounced from a managed phase-down approach into an acceleration of the phase-out timetable to just next year. There are conversations, but we have not talked about the patient exemptions, which is another part of this. I am sure that Europe will talk to that and that it is not a case of, "Amalgam can't be used, and that's it". Those conversations had to be had at member-state level. That is probably the space that the IDA is in, but I do not speak for it.

The view at not just European but international level, at the FDI World Dental Federation, is that phase-down is the direction that we, as the profession, need to maintain. We are already making a certain level of progress. We need to maintain that trajectory, but we are being bounced into something different.

I do not see a lot of prevention in the Republic of Ireland. Again, as with us, if you improve oral health outcomes, you reduce the demand and need for those filling materials. That work should have been done. We have felt like a lone voice over many years, championing on behalf of NHS dentistry. A bit like the cancer strategy before it, there have been excuses for the delay, and reasons have been offered as to why we cannot do those things instead of going ahead and identifying what is in our gift to change. Look at the return on investment: if you spend a pound now, you achieve so much down the line. We are in a really poor position because that work was not done. However, we are not on our own; there are others.

Mr Brooks: A lot of the issues have been dealt with comprehensively in your presentation — thank you for that — and via questions from colleagues. It was probably clear before the Committee meeting today, although it has been given added emphasis, that action is needed urgently. It is something that demands our attention. We need to use all of the tools that are available to us to give protection to the dental sector.

A lot of the questions have already dealt with the issue comprehensively. Mine is a little more technical. It goes back to — Steve touched on it — the interface between Departments and the question of who is responsible for what. We understand that DAERA and, in the rest of the UK, DEFRA will be the lead on mercury and the chemical side of things. Do we have a clear picture of who is responsible for defining the medical exemptions that are provided for in the proposed Act? Is it appropriate for dentists to be put in the position where they have to decide what is "strictly necessary" in terms of medical exemptions from the use of amalgam?

Mr Kelso: I am not saying that we have a clear picture at this stage. To be quite frank, we do not have a clear picture of any of this. However, in terms of exemptions, our understanding of the amended EU reg is that that is done at member-state level. However, it is unclear as to how confined or free that will be. The original regulation gives a wide berth for clinical discretion to determine the medical needs, the types of patients and the exemptions. At European Parliament-level, there were some issues over

the wording of that, but we are unclear about that. In a Northern Ireland context, I presume that the Chief Dental Officer would input into that. However it is unclear whether she will have a free hand or whether there will be constraints for her to work within. We are not sure about that yet.

Ms Gallagher: It would be tricky at clinical level as well. If you have a set of criteria, but, let us say, the patient sitting in your chair does not fall into the right category, and you know that dental amalgam is going to work better than anything else, where do you sit as a health professional? Are you in breach because you did not match these regulations, or did you act in the best interests of your patient? It adds a real level of confusion, concern and stress when treating a patient.

Mr Brooks: Absolutely. That is probably the other point. It is a very difficult position for our dentists to be put in, to try to decide what is strictly necessary and what is not in relation to this legislation.

This might be something that you cannot answer. It may be a question for the Clerk, if she has any input in this. Who is responsible for articulating the case for delaying the implementation of the amalgam regs to the Commission, given that, under the proposed Act, your justification would have to be given? Where does it fall in terms of Departments? Does it fall, because of the chemical side of things, to DAERA, or is it to Health, with them explaining the medical issues?

Mr Kelso: In terms of the derogation, my reading is that, obviously, it is the impact. There seems to be a bit of confusion about the point at which those high-level conversations can be had at UK/EU-member-state level. Does the inquiry have to be held? If and when, then, does the Stormont brake need to be applied? Do those high-level conversations need to be had thereafter? I am sure that the various relevant Departments would be feeding into that process. That is my reading on it. DAERA would have a role in enforcement. That is another angle — the policing of this and what that would look like. There must be high-level conversations, and we look to this Committee, the Assembly and beyond to take those issues forward on behalf of the sector.

Mr Brooks: I agree. As we did in the last meeting, Committee members are all working out where the parameters are, what action we can take and when, and what is the most appropriate action to take. We are doing the right thing by essentially going through an investigation process, even if not formally. You are the starting point for that. I think, and my colleagues have expressed this already, that it is appropriate to take action in the process. This is a very clear case for those levers being pulled. That is my position; I suspect it is the position of my colleagues as well.

Mr Brown: Thank you all for your presentation. It is important that we do this piece of work at this stage, in the early stages of the Committee. Obviously, we are all still getting an understanding of the exact remit. Someone referred to the tracks of the Committee and the need to stay between the rails.

A few of the points that I was going to make have been made, but Joanne asked whether any wriggle room remains on the legislative side in the European Parliament, or whether it is a done deal. The documents in front of us, particularly given the vote in January, may suggest that it is a done deal, but, as you rightly identified, we have not totally ironed that out. It is important for the Committee to get a final opinion on that and on whether there are likely to be any changes, such as to the period of the derogation, that could buy us a little more time.

Declan made important comments about working within the context of this place; ultimately, it is the remit of the Committee to judge the potential impact of the new rules on life in Northern Ireland. We can judge a good or bad law on the prima facie evidence, but we have to work within the context of this place. A good law can have a bad impact if we are not ready to absorb the changes that the legislation lays out. At the same time, the context here may well change, and that is where any submissions that we receive from the Department of Health will be crucial. There is a chance that the situation will be the spark that lights a bit of change in the Department's response to the pressures and crises in your industry.

The Committee can play a valuable role in getting a clear idea of the Minister of Health's plans for the dental industry in Northern Ireland to enable it to cope. If the response says that he has minimal plans, that will be a serious consideration for the Committee. We cannot make the decision until we know what plans the Minister has to address the issues. There will obviously be an important submission from DAERA on the top-line regulation and enforcement of the use of the materials, but only decisions by the Department of Health will change the context in which the legislation applies.

Chair, it is really important at this stage that the Committee pushes both Departments but particularly the Department of Health to submit evidence on how they will respond to the legislation. Am I right in thinking that we can do that, if we have not already done so?

The Chairperson (Mr McGuigan): We can have a discussion about what to do after we have finished the session. Do you have any specific questions, Patrick?

Mr Brown: Most of them were asked —

The Chairperson (Mr McGuigan): Fair enough.

Mr Brown: — already. I am sorry, Philip.

The Chairperson (Mr McGuigan): You are grand.

That was very thorough and informative. We thank you very much for coming before us, for your presentation and for taking our questions. It is clear that we are all sympathetic, as members pointed out. The Committee will do its job in addressing the specific issues that are in front of us. Thank you very much.

Ms McMullan: Thank you.

Mr Kelso: Thank you very much.