HOUSE OF COMMONS

Northern Ireland Affairs Committee

Oral evidence: The funding and delivery of public services in Northern Ireland, HC 1165

Wednesday 24 May 2023

Ordered by the House of Commons to be published on 24 May 2023.

Watch the meeting

Members present: Simon Hoare (Chair); Stephen Farry; Mary Kelly Foy; Sir Robert Goodwill; Claire Hanna; Carla Lockhart; Jim Shannon; Bob Stewart; Mr Robin Walker.

Questions 79 - 113

Witnesses

I: Dr Tom Black, Northern Ireland Council Chair, British Medical Association; Dolores McCormick, Associate Director, Employment Relations and Member Services, Royal College of Nursing; Professor Mark Taylor, Northern Ireland Director, Royal College of Surgeons.

Written evidence from witnesses:

- [FPC0012] – British Medical Association
- [FPC0024] - Royal College of Nursing
- [FPC0005] – Royal College of Surgeons

Examination of Witnesses

Witnesses: Dr Tom Black, Dolores McCormick and Professor Mark Taylor.

Q79 **Chair:** Good morning, colleagues, and good morning to our first panel of witnesses today in our inquiry on the funding and delivery of public services in Northern Ireland, which is, as we know, a crucial and pressing topic. Our first session is going to be focused on health and our second on education. Time, as always, presses. There is a lot of ground to cover. Usually, I say that I am going to be strict and then find myself being incredibly lenient. I have put the leniency on eBay—that is gone—so now strictness is the only rule. I am going to ask for very short questions and for short and pithy answers. We have an hour for each section. We want to cover off as much as we possibly can. Witnesses, if what you wanted to say has already been said, we have heard it and Hansard has typed it down. It does not need to be repeated, but thank you.

I am going to kick off the questioning and hope that I can keep to my own strictures. Could we just have a thumbnail sketch of the situation as you see it with regard to financing of your sector?

Dolores McCormick: Thank you for the opportunity to provide this evidence today. As a thumbnail sketch, I would not be overdramatising it if I said that the state of our health service in Northern Ireland is beyond crisis. I would absolutely say that we have fallen off the cliff edge from the front door of our hospitals to the back, right out to our community primary care. We are facing incredible pressures.

I am here today speaking from the Royal College of Nursing. Nurses are facing moral distress daily as they strive to deliver care, which they feel, on many occasions, sadly, is not the level of care that they want to be delivering. They are unable to meet the needs of patients. To me, that is where we are at. We are underfunded, with a workforce that is stretched and broken, and with an inability to do what it is that we came into the profession to do.

Q80 **Chair:** That, I am going to guess, is as applicable to physical health as it is to mental health.

Dolores McCormick: Yes.

Professor Taylor: Thank you all very much for the opportunity to come here today. To set the scene, we have 122,000 patients waiting for surgery in Northern Ireland. We have 378,400 patients waiting to see a consultant for the first time. That is over 500,000 people in Northern Ireland currently waiting either to see a clinician or to have treatment. That is one in four of our population. We know from the time of Bengoa that there was a situation where we had to transform our health service but realised that we had a massive backlog. The difficulty with this current budget, and particularly reducing money that was addressing waiting list initiative work, is that all that that will do is simply add to the burden.

To set the context, our orthopaedic surgeons are seeing people whom they know they will never be able to give the treatment that they are designed to give them. An 80-year-old person waiting five to seven years for a hip will not get that hip replacement. A child on a waiting list waits so long that they are transferred to the adult waiting list, due to the length of time that they have waited.

Every single day, vascular surgeons are making decisions around, "Is it the person who needs the lifesaving aneurysm operation?" which is an operation in the abdomen, "or is it the person who needs their leg taken off?" The moral distress that Dolores has talked about is every single day in Northern Ireland's health and social care.

Dr Black: We do not need to tell you what the funding is like. You have seen the documents that came to you. The funding is the situation. You cannot run a health service on that funding. We have heard about the workload and the waits. Just to put it into context, in England they are working very hard on their 18-month waiting lists. That is the focus in England at the moment.

We are working very hard on our eight-year waiting lists, which is 96 months. In terms of comparison, how bad is it in England in terms of outpatients? 7 million patients are waiting. The equivalent number, when you take into account the population in Northern Ireland, would be in excess of 20 million.

In June 2022, the BMA held a press conference and said that we felt that, at that stage, the NHS in Northern Ireland was broken. We felt that there were 20 GP practices in crisis. We described the situation in terms of outpatient and inpatient waits. Since then, 16 of those 20 practices have closed. They have handed back their contracts. At this moment in time, we have 30 practices in crisis. How many of those will close? Which service is next to close? Is it going to be a surgical service in that hospital? Is it going to be medical or paediatric?

Q81 **Chair:** Just pausing there for a moment, does that manifest itself more in urban settings or in rural settings, or does it apply uniformly?

Dr Black: That is a very good point. As you can imagine, in terms of general practice, areas of high deprivation suffer most, because those patients have much higher needs and, therefore, it is more difficult to meet those with a constrained budget. In terms of the hospital service, you are looking at rurality and at the border areas. As we know, five out of the six counties could be represented as border counties. We see hospitals in the south-west and in the southern areas, for instance, suffering.

We are the clinicians and we are here saying that we cannot run the health service, given the workforce and funding constraints that we have at the moment, and patients are not getting the service that they need.

Q82 **Chair:** You have all referred to waiting lists and the enormous pressure on clinicians and healthcare practitioners in taking difficult daily decisions. Waiting lists are surely just going to accrue greater demands on the public purse for social care and those sorts of services. I am thinking of your 80-year-old lady waiting for her hip replacement. I declare an interest: I have had two hips replaced and would not want to be creaking around at the age of 53 on my two original hips. It was jolly painful. This is just storing up, and a big problem is going to get bigger, is it not, even if there was a rapid injection of cash to try to resolve the most pressing cases?

Professor Taylor: Yes, absolutely, and there are many examples of what you have just highlighted. There is the social budget burden on those people with immobility, but there are 5,000 people waiting for a gallbladder operation. We are playing Russian roulette with those people, because they are sitting on a waiting list, but they do not sit static on the waiting list. They present to ED with recurring flare-ups, and one complication of gallstone disease is acute pancreatitis.

You can spend one year in hospital with necrotising pancreatitis. I have lost count in my own practice and those of my colleagues of the number of people who were on a waiting list for a 30-minute operation and presented with a complication as a result of being on that waiting list. That has cost us much more in terms of funding to cater for that person in intensive care, so you are absolutely right.

Going back to Tom's point, we said in Bengoa that the stark option facing Northern Ireland's health service was to resist change and see services collapse. We see that in emergency general surgery in the South West Acute Hospital, we see that in emergency general surgery in Daisy Hill Hospital, and it will not be long before other hospitals are the same. The difficulty is that my counterparts and friends in England, Scotland and Wales have made some of the decisions that we should have made a decade ago.

Q83 **Chair:** That takes me to my final question of the opening session, which is on the politics of this. One appreciates that, notwithstanding the fact that health is devolved, Stormont does not have a magic wand. What is your assessment with regards to the impact that a bad situation, a non-functioning Executive, is having on the lives of ordinary people when it comes to health outcomes, access to treatment and the like?

Dr Black: Politics in Northern Ireland is very difficult. We understand that. Politics in Northern Ireland is not helped by the situation in London. We do not look to the DUP and say, "Oh, it is your fault this time", because we have had this problem before in other ways.

At the same time, there is a recognition that, if Stormont was in place, we would be able to make decisions that the civil servants cannot make. The civil service is constrained by its ability, its flexibility and its autonomy within its rules.

Chair: We have taken evidence from them on those points.

Dr Black: We also have constraints with regard to funding. We are workers in the health service. We look to you, the politicians, to provide the funding and to tax the people, and we go and look after the people. The people of Northern Ireland are not being well served.

We have a universal health service that is free at the point of need, but it is neither universal nor free. Just to take Mark's point and expand it, I work in an area of high deprivation. If you are 60 years old, you will not get your hip replacement, because your time of death will coincide with the time of your hip replacement—the 10 years that you will wait. Those patients are paying for that service at the moment.

I am not here to blame any particular party, or politics in general, in Northern Ireland, because, if I was in your place, I would find it just as difficult.

Q84 **Chair:** I was not seeking to apportion blame. I was trying to look to the future and to ask whether the resurrection of the Executive would help this issue for the benefit of patients.

Dr Black: Yes, absolutely.

Q85 **Chair:** You say "yes", Dr Black. Dolores McCormick, you were nodding as well.

Dolores McCormick: Yes, absolutely. Even if we look back over the last year or two, when we had our Executive up and running, a lot of initiatives were launched by the Health Minister. We had a time when we had someone who listened. We had a lot of strategies that had just been set running but are now halted. It is simple things like listening to the profession. We have a recruitment and retention strategy. We are now working on the agency reduction piece that was launched by the Minister when he was in post. We have a lot of examples of things from the nursing world that impact across healthcare, where, if we have our own Executive up and running, we can make things happen, by local people who understand.

Q86 **Jim Shannon:** First of all, it is lovely to see you, and thanks for coming. I have a couple of questions, but I will do the first one very quickly. The £297 million funding gap, which has been referred to, is to be paid back through the Barnett consequentials for 2023-24, which will put greater pressures upon the health system as we have it at this moment in time.

When it comes to the nurses' pay disputes, for instance, Unite over here has settled. Unite union members back home who I have spoken to have yet to get a pay increase coming through that is similar to what we have here. The Royal College of Nursing dispute is not settled. I have a large number of nurses in my constituency who tell me that they are way behind when it comes to meeting the wage structure.

Ever mindful of that, I then give the comparison of the agency staff who

are being heavily recruited and costing more to run than the nurses. It just does not add up economically. Financially, it looks like a really silly equation. If you paid all the nurses a wee bit more, the agency staff would be reduced and you would have more nurses. Therefore, the financial equation would work out to your advantage.

Dolores McCormick: I totally agree with everything that you have just said. We have an overwhelming nursing agency bill that has ran out of control. Why? We have to roll back the clock to when nursing numbers were cut some 10 years ago. We have heard just this week that we have lost 300 from next year's intake of our student nurses. If you lose 300 nurses, it is the long-term impact of that. That 300 is not coming out year in, year out.

We have approximately 3,000 vacancies among nursing staff and, to plug those gaps, this culture of using agency staff has crept in and spiralled. It has now spiralled to absolutely scandalous hourly rates that are being used for off-contract agency staff.

The first thing is that we need to pay our nurses fairly. They need to be rewarded for the job that they do. We need to work harder at retaining them within our health and social care system. This piece of work that we have just started on in relation to reducing the number of agency staff will not work overnight. That will be a long-term piece of work, because we need to get enough nurses into the system before we can adequately address that agency bill.

Q87 **Jim Shannon:** You referred to education. The fact that they have had to cut back on that means the potential of having more nurses to replace those is lost as well.

Professor Taylor, you were on TV one night some time ago during covid. You were in your scrubs. You put forward some fantastic ideas on how to restructure the health service back in Northern Ireland. Your thoughts were quite illuminating. I am not saying that to give you a big head, but that was my opinion at that time, and the opinion of many others who watched it on TV.

You were involved in Bengoa and, therefore, you had ideas on how we could change the system. I am keen to get your ideas on how that could happen in the short and long term. Dolores referred to the long term for nurses. There is a long term but there has to be a short term, and middle management is another thing that we need to be looking at.

On eyecare, early diagnosis stops the loss of eyesight, etc. The pressure on GP surgeries is my last point, because that is raising its head in many places across Northern Ireland; I am glad to say it is not in our area, but it is in some parts of North Down and further into the west as well.

Professor Taylor: The first thing is that, during the pandemic, we knew that operative activity plummeted throughout the country, because of the need to deal with the pandemic. At that stage, the concept of covid-green

or covid-light centres was devised in order to try to keep surgery going in protected environments.

The spin-off of that, and certainly something that we in the Royal College of Surgeons of England are really very much advertising along with GIRFT—Getting It Right First Time—is this concept of surgical hubs. I have to declare that I chaired the review of general surgery. At the moment, we are trying to set up standalone surgical hubs—in other words, ambulatory centres for day care surgery and overnight stay surgery.

What happens every winter, when the beds are at a premium because of emergencies, is that elective surgery is cancelled. The difficulty now is that we are seeing winter all year round, so elective surgery is always the casualty, whereas, in the infrastructure of Northern Ireland—forgive me for coming back to buildings—we have the opportunity for hospitals that are so precious to their local communities to stay open, not close, but under a different identity.

That identity is surgical hubs that do not need to worry about the pressures of emergencies. That will build up the capacity to meet the ever-rising demand that we currently find ourselves with. We have seen examples of that in Omagh and Lagan Valley. We are now seeing it in South West Acute Hospital and Daisy Hill Hospital. They were hospitals that were feeling vulnerable because the word "closure" was always close by.

Q88 **Jim Shannon:** In terms of early diagnosis in GP surgeries for eye surgery, we are losing GPs and, therefore, it is hard to replace those who are leaving.

Dr Black: We are using opticians a lot, and they can screen the eyes for various diseases. In that particular area, it is worth emphasising that, if you have a cataract in Northern Ireland, you will wait a very long time for it to be done. It is really important at that age to be able to see, to read and to watch your programmes. That is not being done. The waiting lists are huge. We have been trying out waiting list initiatives. We have seen that, due to the funding cuts, there will not be any waiting list initiatives. That was looked at as a medium-impact effect in terms of the cuts.

What is happening in my area is that families are bunching up, everybody is adding a bit in, and they are sending them off privately. There is limited private capacity within Northern Ireland, and so a lot of them are now going south to get their eyes done.

Q89 **Carla Lockhart:** Some parties are promising that healthcare will be fixed under a restored Executive. I do not believe that to be the case. I would be keen for you to inform this Committee whether there are the financial resources within the current Stormont budget to transform healthcare in the way that is needed. If not, what is your assessment of what is needed?

Professor Taylor: We know that, to deal with the backlog of the waiting lists, the last permanent secretary projected that it needed £700 million. That is close to £1 billion now just to eradicate the excessive waiting lists that we talked about earlier.

The answer is that Bengoa came out in 2016. I have learned to suppress my frustration over the last seven years and I have become patient, as have my colleagues. We know what we need to do and, in fact, there are some shoots of hope already starting: i.e. some of the multidisciplinary teams and some of the surgical hubs.

There is no doubt that, in order to transform and deal with the firefighting, we need much more resource and we need it to be recurrent over three to five years so that you can plan, rather than on a yearly basis with temporary contracts and temporary solutions—in other words, sticking plasters on the dam that is already bursting.

Q90 **Carla Lockhart:** For two weeks in a row, we have heard from both reviews that we need money for transformation.

My second question is around GP practices. One of the biggest frustrations, certainly out on the doors in the election, is face-to-face appointments. A lot of GPs still do them, but there are a number who do not. It is very frustrating for constituents who ring 300 to 400 times in the morning and cannot get through. People who are working cannot get through. What plans are there to reinstate face-to-face appointments in those places where they are not happening? Is it your assessment that, because GP practices may not be seeing patients as much, it is putting additional pressures on A&E within the services of the trusts?

Dr Black: You are right about all of that, Carla. It is worth reflecting that, since 2019, GPs in the United Kingdom are providing more appointments than they were at that time. Let us take my own practice. I have fewer doctors now than I did 30 years ago when I started. We provide twice as many appointments per head of population. The average number of consultations is now seven per patient per year. When I started, it was 3.5. I have fewer GPs. How do I cope with that? I cope with that by triaging those who request an appointment. If you want to get some paperwork from me, I do not need to see you. I will triage it and discuss it on the phone, and only bring in those sick children and those sick elderly. Everybody is still seeing patients. They are trying to see the ones who need to be seen. If you want to be able to accommodate seven appointments per patient per year, you will need more GPs.

We have a real problem at the moment. I am from the BMA, and my members expect services. My medical students have said to me, "Could you please develop guidance for applications for intern posts?" Interns is the name for F1s in the Republic of Ireland. My medical students want to go to the Republic, where they will be better paid and better treated. My consultants have asked me for guidance on how to apply for jobs in the

Republic of Ireland. They want to move to the Republic of Ireland, where wages are twice as high.

I declined both of their offers, on the basis that not only would they be outside the NHS, which would not be in the interests of the United Kingdom, but they would also no longer need to be BMA members if they moved to the Republic of Ireland. That is the problem that we have at the moment. It is not so much the funding. You are quite right, Carla, that we do not have enough funding to fix this at the moment. We need more funding, but it is not just the funding. We need more workforce. If our workforce is moving out of the jurisdiction, we have a real problem in the future.

Q91 **Claire Hanna:** I appreciate all the answers so far, and we could probably do this for many hours, including on issues like GP appointments. My understanding is that the pressure is on GPs because of the backlogs elsewhere in the system and because there is no one to refer to. They are under increasing pressure because they are having to manage things that are not being dealt with in acute services.

I wanted to come back to some of the workforce issues. In your written evidence, you raised continued reliance on temporary and agency staff, and the financial impact of that, which Jim has touched on. Are we doing sufficient work on the ground, so to speak, to transition people back to agency roles, or is that even possible, given that one of the drivers is the relentless pressure and the inflexibility? It is a bit of a chicken-and-egg scenario as more people leave for the flexibility of agency working, but are we putting anything in place and are we doing enough with the private companies that are probably doing quite well out of the dysfunction that has come to exist?

Dolores McCormick: The Department of Health recently launched the agency reduction working group, which the RCN is in discussions with. That is one piece that is going on. Are we doing enough on the ground? I would imagine that we could be doing more, because the trusts are absolutely trying to recruit and attract people at this minute in time. For example, we have nurses working for off-contract agencies, which we are trying to remove from the landscape, because of the extortionate costs and because it could arguably be seen as a misuse of public moneys.

Trusts are doing some work on the ground in relation to attracting people back, but, when we get under the skin of it, I do not know that we are doing enough. For example, we had a recruitment and retention strategy last year, and a number of recommendations came out of that. The piece behind that was asking nurses questions about their work, about their terms and conditions and about what would make it better for them. That has heralded a list of recommendations, which have not really been implemented.

Some of these are things such as, "Why would I go to an agency?" A lot of people go to an agency because of flexibility. Nurses are largely a

female workforce who have caring responsibilities. They can get that flexibility around childcare and school runs if they go and work for an agency, and be paid more money for the pleasure. It is about trusts being more innovative, and that piece of work has not really happened.

There are things in there like flexibility and annual leave. The elephant in the room is pay, terms and conditions, and we are, once again, settling out of parity with our colleagues in the UK. That will not make it easy for any trust to attract people back from an agency at this time, if we do not, somehow or other, retain that pay parity.

Q92 **Claire Hanna:** Is there anything that can be done at the other end? There are agencies that are profiting handsomely from this dysfunction. Is there anything that is happening in other parts of the NHS in England or Scotland in terms of initiatives to try to address it at source? You are outlining a very logical, ground-up way of improving the attractiveness of permanent positions, but is there anything that can be done in terms of tightening on the agencies themselves?

Dolores McCormick: The one thing that we have done is set that framework out. We call it the new agency framework, which has very much set the tariffs and has put out tenders. At this minute in time, it has been restricted to approximately 30 agencies, so that is really where we are at. I do not know what else we can do.

It is now about holding the line. It will not happen overnight. Even if we set a good framework with a good tariff in terms of what nurses' hourly rates will be through these agencies, the workforce gaps are still so wide that there has to be built into that some escalation. The approach that has been taken is very much risk-based.

Q93 **Claire Hanna:** On the training pipeline, another pressure is insufficient professionals. Just as an example, I was reading about physiotherapy, where we are running at a vacancy rate of about 12%. There are something like nine applicants for every funded place. What are the blockages to addressing the pipeline of professionally qualified people? Is it just a financial thing? Why are we not training enough people for the vacancies that we have?

Dolores McCormick: It is purely financial. In Northern Ireland, we have more than enough applicants for nursing and, I would imagine, physiotherapists. It is a funding issue, and we have just seen 300 being sliced off.

Q94 **Mr Walker:** On the funding issue, which everyone is talking about, is part of the problem the student numbers cap and that there are not enough places for training? In the rest of the UK, we have the same challenge in terms of attracting sufficient people into both nursing and medicine, and that is partly supplemented by international people being brought in. Is it not the case that you are seeing that picture in Northern Ireland?

Dr Black: In terms of the medical workforce, we have failed over the last decade to train enough GPs and to bring enough medical students through. We had one medical school until recently. We have a second one now, but, up until recently, we have sent as many medical students away to be medical students in England, Scotland and Wales as we have trained in Northern Ireland. As we know, 75% of them do not return.

We are on the cliff edge of a huge problem, which we have only intimated to this point, in terms of the medical workforce. That problem is Sláintecare, which is the investment programme in the Republic of Ireland. As we know, it seems to have a lot of funds at the moment, and it intends to increase its consultant cohort by 1,000 and its GPs by 2,000. That would take most of our doctors out of Northern Ireland, if that was the destination of doctors in Northern Ireland.

Will it be? It is worth reflecting that, in the report of the General Medical Council of the UK in 2022, the No. 1 destination for doctors from the GMC is Australia, as we know. The No. 2 destination, which very quickly ran up the rankings, is the Republic of Ireland. Nearly 400 doctors left the GMC register last year. We would expect that to become worse, because Sláintecare really only started handing out the contracts in March 2023. Those were anticipatory moves.

Mark Taylor is one of the few consultants who I have spoken to in the last few months who have not registered with the Irish medical council. They are all applying for jobs. They are looking at the rates. The rates are double those paid in Northern Ireland. You know Northern Ireland, Bob. I live 400 yards from the border and I could easily commute across, except I am not going to. There is the possibility for a lot of our consultants in the border counties to move. Nurses will do the same. Physios will do the same. Radiographers will do the same.

Q95 **Claire Hanna:** It raises questions that we are not going to be able to address here about the limits that we are placing on reform and rehabilitation of the health service within the strictures of the border as is. There are synergies and opportunities as well as threats, as you are legitimately outlining, in looking at the bigger picture in health, but that is a story for another day.

Professor Taylor: To join both Ms Hanna's and Mr Walker's questions, there is one other aspect of workforce, and it would be wrong of us to give the impression that this is all about money. One aspect of workforce and the over-reliance on locum agencies is that we are still trying to prop up many services in many places.

One of the things that we predicted in Bengoa is that you would need the entire block grant to keep all these inefficient and ineffective places open at all times, because of whatever the situations have been in the past. The medical locums were there to try to keep some of the acute surgical centres open until it became too bad and too unsafe.

The key for the workforce is that we must have not only the enhancement of the workforce and more funding for it, but a strategic reconfiguration of our health and social care in Northern Ireland. With every one of the 11 reviews, we have made some progress from the days of 17 hospitals for a population of 1.8 million. Each review has maybe brought us closer to what best looks like, and funding coming needs to be linked really carefully to change.

Chair: It is a very strong theme that is coming out, is it not? It is about not just blank cheques, but ringfenced, hypothecated transformation funding.

Claire Hanna: Investing to transform, essentially.

Chair: Carla has made the point, as have others.

Q96 **Claire Hanna:** Just to pick up on the issue of last year's overspend being recouped through Barnett consequentials and the impact that that is going to have on pay awards, I almost dare not ask—and we do not have time to answer—what the impact on morale is going to be. How is that going to be reconciled, particularly in the context of pay settlements in the NHS in Scotland and England, for example?

Dolores McCormick: Speaking from the Royal College of Nursing, I cannot find a word to describe what you have just said. The inability to offer a pay settlement to Northern Ireland has caused absolute anger and outrage across the nursing profession. It is just going to make all that we have been talking about more difficult.

I did want to say, just going back to workforce, following on from Mr Walker's question, it is about the agency and the need for that. We heard two weeks ago about a tighter cap. What is behind all of that is that we do not have a workforce plan for healthcare staff in Northern Ireland. We do not have a workforce plan that looks at population need and is tailored around that. That may sound unbelievable, but that is where we are at. There is no workforce plan in order to implement Bengoa and everything else that we need to do.

Chair: In shorthand, transformational funding, political bravery and professional flexibility have the potential to deliver improving outcomes for health, albeit from a very low baseline.

Mr Walker: Not if you cannot pay the existing workforce.

Q97 **Claire Hanna:** You mentioned a cross-border dimension. A scheme that previously ran allowed for relatively minor procedures under an EU directive that appears to be gone now. Anecdotally, they were relatively low-hanging fruit in terms of procedures. That seems to have had a big impact. Has it, or what has the loss of that scheme done to waiting lists? Is there the potential to recreate it?

Dr Black: It was brilliant, Claire. If you needed a hip replacement in Northern Ireland and the capacity was not there in the system—while we have only three private hospitals in Northern Ireland, there are 18 in the

Republic of Ireland—you could go to the Republic and get your hip done in Dublin, Navan or wherever, and come back up. You paid half the price yourself and they covered the other half of the price. Some of my patients went to other European Union countries. That is no longer the case. They would go to Latvia and come back the next day with their knee replacement. I do not know how they managed it, but they did it. That is not available now.

What my consultant colleagues tell me is that we do not have the capacity to mop up the 600,000 people who are on waiting lists. We simply do not have the capacity in the private sector or the public sector in Northern Ireland.

Doctors in the UK would tell you that 30% to 35% pay cuts across the board—junior doctors, consultants and GPs—have arrived. You understand the Barnett consequentials better than I do, but it is very clear that, if you are telling healthcare workers of all sorts in Northern Ireland that there will be no pay rise now because of the politics—let us call it that, for shorthand—what do you think the workforce is going to do? They are going to move to places, be it Australia for junior doctors or the Republic of Ireland for more senior doctors. They are going to leave the system, because they have lost hope in the system in Northern Ireland.

We have a very difficult year ahead of us. We are going to see GP collapses and hospital service collapses, and they are going to happen every month, if not every week.

Professor Taylor: Chair, can I come back to your comments? You hit the nail on the head.

Chair: I like you. You can come again.

Professor Taylor: Rafael Bengoa said that Northern Ireland could lead the rest of Europe and beyond in developing a sustainable health and social care model fit for a rising aged population with comorbidity, using new technologies and the management of cancers, as we are doing now with expensive drugs and machinery. With all of that, we can bring that about. The three pillars that you mentioned are exactly what can happen. Even though my glass is empty, my glass is still full, and I still believe that we can do it.

We can do it, but it requires all of us together to have political maturity and confidence, but with clinicians like myself and my panel colleagues standing shoulder to shoulder with our politicians. It is not fair that particularly our rural politicians are having to face their public to try to explain something around change, if we are not prepared to stand with them. We are in a situation now where good can come of all of this. I really believe that, but your three points are exactly what we can do to create sustainable health and social care that can be the envy of others.

Q98 **Bob Stewart:** Thank you so much for coming over. It is nice to see you.

I am absolutely appalled, listening to you and having read what I have read. There is an eight-year waiting list—that is what you are saying, Mark is it not—of 122,000 people waiting for operations.

My question has already been largely answered by all three of you in what you have already said, but could I then narrow it down? I have three things that I want to try to get an answer on. Tom, you mentioned that there were twice as many doctors when you started in the profession some time ago. Is that what you said, or did I get it wrong?

Dr Black: We had roughly the same number of general practitioners in terms of full-time equivalents, but the patients came 3.5 times on average per year. They now come twice as often. This is not me blaming them, Bob, because they need to come more often.

Did anyone see the statistic yesterday? It is the most horrific statistic, and this is a UK statistic. It is about the rate of diabetes in Northern Ireland. Remember that a diabetic patient requires about 12 times more care than every other patient, because of their blood pressure and their heart and so on. We have a rate of 6.9% of diabetes, and that is not counting the prediabetics, which is probably another 2% or 3%. There are some countries in the world with rates of 20% or 30% and, while we are not heading that way, you can see why, to some extent, the NHS is a victim of its own success.

We all live longer. Because of age, we accumulate more diseases. Patients come twice as often. If you have the same number of GPs seeing patients twice as often, there will be waits, will there not?

Q99 **Bob Stewart:** So we need more GPs, fundamentally.

Dr Black: Yes, we need more GPs. We need more hospital doctors. We need more nurses.

Q100 **Bob Stewart:** How many more GPs, roughly?

Dr Black: Northern Ireland has recently increased the GP training numbers to 121 per year. For more than a decade, it was about 60, which was inadequate. They think that we will need about 161. In the UK, the Government promised an extra 6,000, and they are struggling. Why? If you are going to get extra GPs, you need to improve the terms and conditions, and they are not good compared to Australia and so on.

Q101 **Bob Stewart:** Mark, you were talking about specialisation and doing these surgical hubs. I totally get that. Do you have surgical hubs now, and how many more do you want?

Professor Taylor: The important thing about surgical hubs is that they will allow elective surgery to take place seven days a week. That surgical presence in a building called a hospital will still allow that hospital to function as a hospital. While emergency general surgery or emergency surgical practice may come away from it, the fact that there is elective

practice in there will keep the hospital open, as well as their ED and their acute medical departments.

The success of creating these hubs is that we do not have to face the question, "Do we close hospitals?" for all of the emotive reasons that go with that. When we have the worst waiting lists in the UK, why would we want to close beds and hospitals when we need more capacity?

At this present time, we have two day surgical centres—Lagan Valley and Omagh. We have the start of an elective overnight stay centre in South West Acute Hospital and in Daisy Hill, and more will follow. In my own hospital, which is the Mater Hospital in Belfast, we also have an elective overnight stay centre.

The key to that is that that is for those patients who have diabetes or heart disease and cannot come in and go home that night after surgery, but need an overnight stay. Remember that 60% of our waiting list is ambulatory. It is day care surgery. It is only 40% that is the big, complex stuff, and that is why these surgical hubs could really revolutionise the capacity that is needed. We are also going to need the independent sector and waiting list initiative work to deal with a backlog. We cannot use a new, transformed system to start off first with this massive backlog and then start to try to develop capacity.

Q102 **Bob Stewart:** I know Altnagelvin Hospital quite well. It is a huge hospital. Would you make a surgical hub as an annexe to that? Is that how you would think of it? Would you put it somewhere like the Waterside or across the river?

Professor Taylor: Or even further, because we know from the census that our gracious public said that they will travel. If they know that they get the surgery by the right person in a timely place, they will travel.

Bob Stewart: When we visited Altnagelvin, I remember that people were coming there from the Republic, were they not? It is a sort of joint affair. My question has already been largely answered and these are just my own thoughts on it, so I will shut up.

Q103 **Sir Robert Goodwill:** Good morning, everyone. Interestingly, Mark, you mentioned the figure of £700 million to fix the problem, which, coincidentally, was the figure that the *Belfast Telegraph* suggested could be raised if charges for all sorts of things like water, elderly travel and tuition fees were brought in line with the rest of the country. Part of that would be charging for domiciliary care—I have seen a figure of £15 million for that—and prescription charges. Is that something that we should actively look at to bring more money into the health service, in the same way that people in England pay for prescriptions?

Professor Taylor: As a college and not a union, we do not have a position on revenue generation, as in what would be there to generate revenue. I wonder if I could pass to my learned colleagues to the left here.

Q104 **Sir Robert Goodwill:** Understandably, doctors and nurses are very keen to say, "We need more money", but the downside of that is that we need to either charge more tax or levy charges for some things that we could do, so it is politically very sensitive.

Professor Taylor: The discussion on a prescription charge has been occurring and, even during the Bengoa panel, we made various suggestions around that.

Dr Black: The BMA is a union. When we go into our union meetings, we are all great socialists. We have a bust of Aneurin Bevan in the headquarters in Tavistock Square, Bloomsbury. We feel that it should be universal, free at the point of need and funded by taxation. General taxation is the responsibility of politicians.

We do not think that prescription charges are a good idea, because they create health inequalities and we know that, in other countries that have them, there is a tendency to choose which medication you need.

There is also a practical aspect. When we had a prescription charge in Northern Ireland, there were so many exemptions that only 2% of the prescriptions that I issued in my practice attracted a charge; 98% did not pay the prescription charge. You run into problems of whether you are spending more on the system.

The answer to your question is this: please tax the people to pay for the health service, so that we can deliver as efficiently and as effectively as possible, but we would be against user charges within the health service.

Sir Robert Goodwill: There are a lot of other areas outside the health service where charges could be levied as well.

Professor Taylor: Yes.

Q105 **Mr Walker:** Professor Taylor has already answered many of my questions about Bengoa, but what has not been started from Bengoa that could be if the Executive were there, or if there were other decisions taken? What are the lowest-hanging fruit from what could be driven forward if the resource was made available?

Professor Taylor: That is an excellent question. What started with Bengoa and what its real success was is that we had five-party support. The first that was started was the multidisciplinary teams in primary care. What have we failed to achieve? We have failed to achieve the whole concept of shift left—in other words, population health, going back to eye checks preventing people from becoming blind, et cetera.

The difficulty now with Bengoa is that we have some who have multidisciplinary teams, whereby the GP practice has its own physiotherapist, its own pharmacist and its own psychologist, so people other than the GP. I know that Tom is very important, but there are other people who can provide the service. It does not have to be the GP. We have stalled that rollout of multidisciplinary teams. At the same time, we

are seeing our general practices in crisis.

The second issue is the whole issue of reconfiguration. In Bengoa, we called it rationalisation; that is a terrible term, but it was really saying there are services in Northern Ireland that are hanging there by a string. The difficulty is that it is sometimes a difficult political decision to say, "We are going to centralise from here", or, "We are going to withdraw the following services from there". We really need to come back to looking at rationalisation and reconfiguration.

That is where we are starting to see the low-hanging fruit, because the surgical hubs are giving hospitals a new identity. I will give you an example. Breast surgery is once again taking place in South West Acute Hospital. Our plastic surgeons are wanting to go there to treat cleft lips. Our paediatric surgeons from Belfast are going to Daisy Hill.

If I had said that three or four years ago, people would have laughed at the fact that a surgeon from the big specialties in Belfast was going to the rural hospitals to get theatres. Surgeons are creatures who want to be in an operating theatre, wherever that may be. That is not to say that every surgeon in Northern Ireland is going to travel all over the country, but there is no doubt that, if our patients are willing to travel, and it is effective for the surgeon to travel to get as much done on that list, that is the direction of travel.

We are getting there, but we need to turn Bengoa back on with power and with a full roll-out of multidisciplinary teams. Let us really practise the population health model that was there and rationalise and reconfigure those buildings called hospitals.

Q106 **Mr Walker:** In all of this conversation, we have been hearing pretty stark evidence across the board about the health service. We have heard very little about social care. In Northern Ireland, health and social care are much better integrated than in most of the rest of the UK. Do we take it from that that the system is working well? I see lots of shaking heads. What needs to be done on that front, in particular?

Professor Taylor: Certainly, social care is integrated. Unfortunately, one of the words that came through in Bengoa was "silos", and we still have those. There is no doubt that there is no point in Mark Taylor and colleagues fixing primary and secondary care, and leaving social care adrift, because it is all inextricably linked. That is another massive area, and Dolores and Tom may want to come in on that.

Dolores McCormick: Social care is certainly not in a good shape in Northern Ireland.

Q107 **Mr Walker:** Interestingly, in England, integration is often seen as part of the solution to social care not being in a good shape. You have a much more integrated system.

Dolores McCormick: It is sometimes more integrated in name. As an example, we privatised care for the elderly population in terms of their

needs for nursing and residential care. That is a system that is absolutely struggling at this minute in time to recruit and retain a workforce. The independent sector and domiciliary are both mixed economies of care, but that sector is experiencing the same problems as it is in England in terms of quality of care, continuity of care and recruitment for our most vulnerable. When that system is broken, poor and vulnerable people end up in our ED units, which are totally inappropriate places for them to be.

Mary Kelly Foy: I have a couple of questions that I am going to ask, but I just want to ask first about the state of NHS dentistry in Northern Ireland. Here in England, the British Dental Association has said that it is entering its "final act". It is nigh on impossible to find an NHS dentist, and there are tens of thousands of people on waiting lists.

Chair: Do not use all your Adjournment debate material, which I know you have this afternoon.

Mary Kelly Foy: I have, yes, and I had a question yesterday as well. It is something that is often missed out of health services, or it is at the bottom of the queue.

Chair: It has big health implications.

Q108 **Mary Kelly Foy:** We know that there is not a shortage of dentists. It is the way that the payment scheme is set up: it is not worth their while working for NHS dentistry when dentists can make a living going private. I just wondered whether it is a similar situation in Northern Ireland.

Professor Taylor: It is a very similar situation. To extend that even in terms of waiting lists, children waiting for dental extractions that require an anaesthetic are a massive problem. Our chief dental officer has been particularly vexed about trying to deal with that, because not only have you the dental problem, but you have the developmental problems that come with a child who has dental caries and cannot communicate; there is delayed communication.

When I talk about waiting lists being so long, the waiting lists that give us all moral distress are our paediatric waiting lists. It is not just the condition but the life that that person will lead, affected by delays and delays. Certainly, in terms of dental lists, there is a major problem in community dentistry.

Dr Black: It is really difficult to get an appointment, Mary. You cannot get one on the NHS. It is very difficult to get one even within the private sector.

I would just reflect that pharmacy also has huge problems. A billion prescriptions per year are issued in the United Kingdom through the national health service. It is a huge number. In Northern Ireland, it is about 22 million. The number of prescriptions in Northern Ireland is decreasing. Why? Because we do not have enough GPs within some areas, where practices are collapsing and being taken over by other contractors.

One pharmacist quoted to me a figure of 40% in terms of the drop in prescriptions. Imagine that, Carla—40% of prescriptions, many of which will be repeat prescriptions, not being issued. You think immediately of the patient. I mean no offence, because I am a union guy, but I start thinking, "How is the pharmacist going to keep open if they do not have enough prescriptions coming through?"

It could be dentistry, pharmacy, general practice, hospitals, our nursing colleagues or our physios. I will give you a quote. Robert Louis Stevenson said, "Sooner or later everyone sits down to a banquet of consequences". That is where we are now. We have done this not very well for the last decade and a half with respect to the NHS. We are sitting down to a banquet of consequences, unfortunately, right throughout the service.

Q109 **Mary Kelly Foy:** Children not seeing a dentist at the minute is the biggest reason why children are in A&E with tooth pain. That is one consequence. Oral cancers are also up, because they are not detected, going back to the prevention agenda.

Chair: It also has an educational output impact if you are off school. I see our education panel nodding at that.

Professor Taylor: It leads to time off school and educational and developmental delays.

Q110 **Mary Kelly Foy:** If there was a significant injection of cash now in order to fund the transformation project, would this mean that health services in Northern Ireland would cost less down the line? Do you have any specific examples of how this would work in practice?

Professor Taylor: The answer is, "Absolutely, yes". Going back to an earlier point, we know that the costs of sustaining a health service are rising in any part of the world. We are not alone. The rest of the world are trying to deal with increased elderly populations, modern technologies and so on. We have talked about locum agencies and trying to keep all services open and to keep places ticking along. We have to radically improve efficiency and productivity, and not sit back and accept that theatres and clinics are under-utilised and so on.

There is no doubt that the transformation will be cost-effective. The critical message is that it is not all about money. It cannot be all about money, because the NHS will consume and consume endless resource unless we are clever about prevention, such that we do not get to the cure, and that, when we get to the cure, we have it in specialist centres that are efficient and effective and there is not this disparity.

The difficulty for us at the minute is that there is such disparity depending on where you are. For example, in Northern Ireland, if you are a child under the age of five, it is a paediatric surgeon. If you are in Belfast over the age of 16, it is an adult surgeon. If you are in South Eastern Trust over the age of 13 and a half, it is an adult surgeon. In every other part of Northern Ireland, it is an adult surgeon operating on

your child over five. There are disparities even within a small place like Northern Ireland.

Dolores McCormick: Following on from the transformation question, Mary, we can definitely be much more efficient if we work more collaboratively. Where I am coming from is that we have been faced with stop-start politics and one-year funding that switches on and switches off. I know of so many nurse-led initiatives that start out but do not become regionalised. Sometimes, they do not become regionalised because the money flow stops or there is maybe one very interested person who moves on. The regions do not learn about good practice from each other, but there are so many examples of nurse-led initiatives that have cut down waiting lists and improved outcomes for patients across all of the spectrum, from mental health to children and right through. Those initiatives have to be embedded into any form of transformation that we take forward.

Dr Black: We can make it more efficient, and we can certainly increase our productivity. In terms of the natural history of health services, if you keep people living longer, they will develop diseases of old age. Dementia is a huge problem now; it did not used to be, because people died from a heart attack. Much fewer people die from heart attacks. Very few die in childbirth. Very few die from TB. We have cured all those diseases. Mortality rates for children used to be huge. They are very rare now, thankfully.

As we keep people living longer, we will need more resources. As a society, we can decide where that line is. We have decided that it is 9% of GDP. The Germans and the French are at 11% or 12%, and the Americans are at 18% of a bigger GDP. Is that sensible? Warren Buffett tells us that the healthcare industry in America is a "tapeworm in the American economy". He is probably right, but those are the choices that people make.

Q111 **Mary Kelly Foy:** People used to live longer. Would it not be great if we did not need hospitals, doctors and nurses because people were not ill in the first place? You have alluded to this, Dolores, but each of your organisations has emphasised the importance of multi-year budgets. What difference could that make to the health service? Is setting multi-year budgets a realistic proposition for Northern Ireland in the short term?

Dolores McCormick: It would certainly go a long way to proper workforce planning that meets the population across all parts of healthcare. Multi-year budgets would also allow Bengoa. Under New Decade, New Approach, we were promised sustainable funding, fair pay, safe and effective staffing, and the implementation of the mental health strategy, which looks like it might be shelved, because we do not have funding. On and on it goes. Multi-year budgets would allow all of that to happen.

Professor Taylor: At our college, we produced a document, "10 Steps, Not 10 Years". That was in response to our Health Minister at the time saying it might take 10 years. We felt that 10 steps was more important. An important part of that was the recurring budget. As Dolores said, that recurring budget means you do not have stop-start projects that leave you unable to scale projects up. There is nothing as frustrating as initiatives to try to bring about a change in Northern Ireland having to be abruptly stopped because that one-year budget funding stream has been cut off. Recurring budgets means there is a more permanent solution instead of a temporary solution.

Also, with a recurring budget you can address the issue, with people saying, "Look, we are going to put this aside to deal with backlog. We are going to put this aside to transform the buildings. We are going to put this aside to roll out our multidisciplinary teams throughout Northern Ireland". That recurring budget is critical as we go forward. Otherwise, what happens is that we get this rush to spend money at the end of the year. It is nearly a scattergun approach: "We have to spend the money. Where is it going?" That does not seem logical in terms of planning a successful outcome.

Dr Black: I agree.

Q112 **Mary Kelly Foy:** The final question is around the political instability in Northern Ireland. I know yourselves and other organisations in the health field have urged politicians to come together and form an Executive. What impact has that political instability had on health services?

Professor Taylor: It has had a massive impact. The reason I say that is because, when we had political stability, thank goodness it was during the pandemic, and the political stability during the pandemic allowed lots of decisions to be taken. We had a Minister in post who not only dealt with the pandemic but initiated the cancer strategy, the elective care framework and the review of general surgery. Those things happened when there was a collective Government in place. We had three years of political instability. Then we had a pandemic, and now we have a further period of political instability. The only way we are going to fix health and social care in Northern Ireland is together.

Q113 **Stephen Farry:** Mark has touched on the point about prevention. Perhaps you could just elaborate a bit more in terms of how counterproductive some of the cuts in the system are going to be down the line, such as the cutting of nursing places and the damage from that. Overall, there are opportunity costs that we are building up or losing from the lack of decision-making structures in place at present. Is it possible for the health service to live in the budget that is allocated this year, particularly with no clear decision-making structures? I am conscious that there was an overspend last year. Are we potentially looking at an inevitable further overspend this year?

Finally, if we get an injection of cash over the course of this year, how do

you balance fixing the current crisis that is there in terms of all the pressures, while at the same time not losing the opportunity for transformation? Where is the right balance between stabilisation and transformation?

Dr Black: What we have in Northern Ireland at the moment is difficulty getting a GP appointment and difficulty getting an ambulance. You can be quoted seven hours for an urgent ambulance. There is also difficulty getting an outpatient appointment. It is nearly impossible to get an outpatient appointment. This is despite the efforts of the nurses, doctors and healthcare workers, who are doing their very best.

I always read the civil servants' letters very carefully because they choose their words very carefully. When you read the civil servants' letters, what that means for the service in Northern Ireland is that they are coring down to the five basics that people will say you need if you go to a townhall: paediatrics, geriatrics, cancer services, maternity and ED. They always assume their GP will be there. That is where the civil servants are coring down to. They are looking at the five core services and saying, "We are going to have to maintain cancer services and red flag referrals", even though at the moment we are missing the 95% target, with 35% or 36% achievement for red flag referrals. You can imagine how difficult that patient that I have is when they get to Mark with their much more advanced cancer.

Everything we are doing at the moment is wrong, because we are constrained by the exigencies of funding and workforce. We could do an awful lot better. It will take planning. What you have heard this morning is a full appreciation of where we are and what needs to be done.

Professor Taylor: In terms of the short-term cuts, any impact on the waiting list initiative work will increase waiting lists even further. We have already gone into great depth on the consequences of the waiting lists. The other issue is that we have an increase in the surgical consultant workforce in Northern Ireland of 4.5%, but we are losing 25% who are coming to retirement age. Surgeons in the 51 to 55-year bracket, which I fit into, will all be retiring in the next three to four years. The short-term cuts blend into the long-term cuts as well, and it is back to the same recurring cycle of workforce. We have to realise that any changes at this time will have further mounting pressures in an already very perilous health service.

Dolores McCormick: Stephen, you mentioned the 300 cuts to the nursing profession. All I can say is that that is totally counterintuitive when you look at the yawning gaps within that workforce. If you go into our ED, you can speak to a district nurse who is meant to be in a team of eight but there are only two. That is the impact of the cuts on nursing. Remember that nursing is the biggest workforce. There is not one part of the health service that does not require a nurse. We need each and every one of them. The cuts are an absolute blow.

Chair: We could spend many, many hours on this. I am grateful to you for taking the time, for taking our questions and for confirming many of our fears and suspicions. I do not know why I look specifically to Professor Taylor, but it appears that the narrative has moved back to the transformational funding side of the debate. What might be helpful is some sort of triaged note as to what would get the biggest bang for the buck in short order. As a Committee, we would be very happy to then furnish the Secretary of State with that as, if nothing else, a discussion document.

We are grateful. Colleagues, I appreciate that we all have 101 more questions we want to ask but, in the interests of time, I am going to draw this session to a close. We are going to now switch our left-hand side of the brain on and move away from health and into education.