Written Ministerial Statement

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Department of Health

DEPARTMENT OF HEALTH PLANNED INITIATIVES

Published at 4.00pm on Wednesday 10 July 2024

Mr Nesbitt (Minister of Health): The purpose of this Written Ministerial Statement is to update Members on a series of important actions I am initiating as Health Minister.

There is a very heavy responsibility on me as Health Minister to strategically lead our health service towards recovery, to secure better outcomes for patients, and to improve working conditions for staff.

I hope Members will accept that this cannot be a solo operation. The health of our population is a responsibility we all share and improving services and outcomes will require cross-Governmental commitment and investment.

This is particularly the case with health inequalities. Members will recall that I identified health inequalities as a prime area of focus in my first speech to the House after taking office.

The other key areas I emphasised – health reform, waiting lists, cancer care and mental health – are all closely connected to health inequalities.

My Department recently published the 2024 annual report on health inequalities, detailing persistent and disturbing disparities between the most and least deprived areas in Northern Ireland. These included disparities in life expectancy, healthy life expectancy, drug misuse fatalities, alcohol related deaths and suicide.

Above all, my concern is about the impact this has on people in our communities.

Additionally, based on data from England, it is estimated that health inequalities cost Northern Ireland up to £1.7 billion every year, including health costs, lost productivity, economic inactivity, poor educational outcomes.

To give one shocking example, how can it ever be acceptable that women in our most deprived communities can expect to live 14 fewer years in good health than those in the least deprived communities?

Health inequalities are, of course, a symptom of the inequalities that exist in society. These must be a priority for the Executive as a whole.

That is not to underplay the responsibilities of my Department and the Health and Social Care (HSC) system.

I am pleased today to announce the first phase of a Live Better initiative, designed to bring targeted health support to communities which need it most.

This will build on the good work developed by the Public Health Agency and the HSC over the years and will seek to pull existing initiatives and programmes together so that they can be delivered intensively in communities to make a real and lasting difference. This won’t just rely on people coming to us. The initiative will provide information and initiatives directly in specific communities, as well as signposting to existing areas of support.

This will cover such areas as: increasing uptake of health screening and vaccination; mental health and emotional well-being support; blood pressure and cholesterol checks; building health literacy; improving social connections; providing nutritional advice; and providing opportunities to be more physically active.

The details of the programmes to be delivered under this initiative are still being developed, and the shape of the initiative will be informed by what communities themselves identify as requirements.

My intention is that the community and voluntary sector will be a key, and equal, partner in delivering and supporting this programme, as will the communities themselves.

My plan is to begin the initiative in the autumn in two locations, which will be announced in due course. The programme will then be rolled out and developed.

I trust the initiative will be supported and indeed actively promoted by Members from across the Assembly.

It is important to reiterate that the health service alone can only do so much to address health inequalities.

Research indicates that only about 20% of health outcomes are related to clinical care.

Other critical factors include economic disadvantage, environment, education and housing. For example, economic inactivity, the measure of those of working age who are neither in, nor seeking employment, stands at some 26% of the working age population. This requires a cross-departmental approach.

As the 2016 Bengoa report stated: “We can see that health and health inequalities are interrelated with the economy, economic inactivity, poverty, social isolation, educational underachievement, criminal justice, regeneration, and many other parts of government.”

I have already highlighted health inequalities to Executive colleagues, and I look forward to a co-ordinated and sustained focus across Government, under Making Life Better, the Executive’s public health framework.

Despite the large contribution to health inequalities of factors outside the control of the health system, it is vital to address the 20% contribution of clinical care to the health outcomes of our population.

I would emphasise that addressing health inequalities must be at the heart of health reform.

Unfortunately, the debate on health reform and health transformation has become increasingly distorted. Too often, it has been misconstrued as primarily a cost cutting programme, or a plan to close hospitals. This is damaging the real objective of reform, which is better outcomes, both for service users (patients) and HSC staff.

I recently told Members of my intention to reboot the public conversation around health reform.

To that end, I have invited Professor Rafael Bengoa to return to Northern Ireland in the autumn for a conference and series of other engagements. I am pleased to report that he has accepted.

This is not about yet another review of our health service. Professor Bengoa’s return is about helping us assess the important work already undertaken and underway and identifying the key strands of action now required. It is about helping to accelerate the process of change.

Most importantly, I believe Professor Bengoa will help refocus the public conversation on the whole health reform agenda.

This will be informed by the publication of two key documents.

Firstly, I will publish a proposal for hospital reconfiguration for public consultation over the summer. This document has been shared with Royal Colleges, trade unions and service users/carers, building on the detailed engagement undertaken with clinicians, health service leaders and other stakeholders during its development. The document will be shared with Executive colleagues for their consideration and hopefully endorsement, ahead of being issued publicly.

The proposal will provide the basis for current and future reconfigurations of hospital services. It will not set out precise locations for each medical specialty – that will require ongoing specific assessments including regional service reviews and HSC Trust led reconfigurations.

It will have a vital role in supporting engagement with clinicians, communities and society as a whole on why we need to reorganise hospital services and how we will manage our hospital system as an

integrated network. This requires a shift from viewing individual hospitals as discrete units to embracing the idea of a network of interdependent hospitals.

A central theme of the document is that while every existing hospital has a key role to play, every hospital cannot provide every service.

The proposal will therefore categorise our hospitals into four specific types, operating as an integrated whole. These are: local hospitals, general hospitals, area hospitals and regional centres.

I should also remind Members that health reform is about much more than hospital reconfiguration.

As the Bengoa Report stated: “While some rationalisation and concentration of specialist resources will be necessary to allow new delivery models to take effect, they are not ends in themselves.”

As the report made clear, meaningful transformation is about moving to a more patient centred, population health model, and supporting people to take more control of their own health and actively manage health conditions that may affect them.

This will be a core premise of the second document I am planning – a three-year strategic plan for health and social care, covering the remainder of the current Assembly mandate.

This strategic plan will focus on the three themes of Stabilisation, Reform and Delivery.

We obviously have to be realistic about what is attainable in the immediate future, given the 2024/25 health budget. That is why Stabilisation will be the dominant theme in the first year and, given the extent of the budget shortfall, in some cases, finances will limit ambitions for mitigation.

At the same time, we must not lose sight of our strategic objectives and priorities. That means, front and centre, prioritising primary care and social care. This is vitally important in its own right to help our citizens live healthy and independent lives in the community. It also has the massive additional benefit of easing pressure on our beleaguered acute hospital sector.

The overriding objective, as ever, will be better outcomes for patients and all those who use and depend on services.

I can inform Members that intensive work continues to secure greater efficiency and productivity across the HSC system.

I am currently assessing the latest position regarding my Department’s budgetary shortfall, taking on board Trust savings plans, the June monitoring round allocation and the wider UK public expenditure context.

I fully accept the requirement for significant savings but I again make clear there are lines I will not cross as Minister.

I hope I have assured Members of my profound ambitions for our health service, of my hope and indeed confidence that it can turn the corner.

It is the case that inadequate and short-term budgets are a major obstacle in our way. We must do better.

Along with the strategic plans and initiatives I will be developing, I shall continue making the case for sustained investment in the services that matter so much to us all.

In relation to social care, I can advise members that a 2023/24 End of Year Report and a 2024/25 Delivery Plan will be published next week for the Social Care Collaborative Forum.

The Forum is working collaboratively to implement proposals arising out of the public consultation on the Reform of Adult Social Care. Its membership includes providers, regulators, trade unions, service users, carers and Departmental officials.

The 2024/25 Delivery Plan will focus on key themes of: Building a Sustainable Workforce; Improving Commissioning and Contracting Arrangements; and Developing Improved Partnership Working.

I can also update Members in relation to my Department’s response to the Independent Review of Children’s Social Care Services in Northern Ireland.

My Department is today publishing a summary and analysis of the responses to public consultation held in response to this Review.

This will be followed in the autumn by publication of my formal response to the Review's recommendations.

Ahead of that, I will also be engaging with Executive colleagues on the Review's recommendations that are cross-cutting and relate to the policy responsibilities of other Departments. These include recommendations relating to the establishment of a Children and Families Arm's Length Body, the appointment of a Minister for Children and Families, the expansion of the Sure Start Programme and the Gillen Review of Civil and Family Justice.

In conclusion, I acknowledge all 90 of us who have the privilege of serving as MLAs are made aware on a daily basis of constituents who require and deserve better, in terms of waiting lists, access to services, and the capacity of our health and social care system. I am determined to inject more hope into healthcare.