Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Health and Social Care Bill: Department of Health

15 April 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Jonathan Buckley
Mr Gerry Carroll
Mr Alan Chambers
Ms Órlaithí Flynn
Ms Cara Hunter
Ms Carál Ní Chuilín

Witnesses:

Mr Allan Chapman	Department of Health
Mr Gareth McKeown	Department of Health
Mr John Millar	Department of Health

The Chairperson (Mr Gildernew): Members, I welcome the departmental officials, who are here to brief us on the Health and Social Care Bill. First, I welcome Mr John Millar, Health and Social Care Bill team manager. Good morning, John. Can you hear us?

Mr John Millar (Department of Health): Good morning, Chair.

The Chairperson (Mr Gildernew): You are very welcome, John. I also welcome Mr Gareth McKeown, who is the migration to closure project team manager. Can you hear us?

Mr Gareth McKeown (Department of Health): Yes.

The Chairperson (Mr Gildernew): Thank you. I also welcome Mr Allan Chapman, who is the future planning model team leader. Can you hear us?

Mr Allan Chapman (Department of Health): Yes, Chair. Good morning.

The Chairperson (Mr Gildernew): When we are doing the question and answer session, I will go to John to ask how he wants to handle the briefing element. One of you should lead on the substantive answer so that, if there is additional information only, rather than *[Inaudible owing to poor sound quality]* the others can add comments in order to facilitate the time in the meeting. We are already running significantly over time. Will members and the panel try to keep it as brief and succinct as possible?

John, I will come back to you. Will you outline how you will brief us? We can take the questions and answers after that.

Mr Millar: Thank you, Chair. The plan is to provide, hopefully, a relatively short opening statement. The briefing was provided, and we hope that it was useful to the Committee. Once the opening statement is done, we will be happy to take questions. I am happy to take the lead on most of them, depending on the question, but I will refer to Gareth or Allan if it covers their speciality.

The Chairperson (Mr Gildernew): OK. Thank you. Go ahead, John.

Mr Millar: Good morning, Chair, and thank you for the opportunity to brief the Committee about the Health and Social Care Bill. As you mentioned, I am the Bill team manager. As you also said, I am joined by departmental colleagues, Gareth and Allan. Gareth is team lead for the migration to closure project. He deals with many of the practical elements that are involved in the closure of the board. Allan is the planning model team lead and is responsible for the recently commenced work on future planning.

I hope that the briefing paper that we provided prior to the session was useful. To begin, it will be helpful to set out some high-level information about the Health and Social Care Bill. Its objective is simple: to facilitate the closure of the Health and Social Care Board (HSCB) and the transfer of responsibilities for its functions, in the main, to the Department of Health. The planning assumption is that the board will close on 31 March 2022. At that point, staff of the board will transfer to the Business Services Organisation (BSO) under a hosting arrangement, as illustrated in the appendix to the briefing paper.

Crucially, those staff will retain their Health and Social Care (HSC) terms and conditions and will continue to undertake their current roles and functions as before but as an integral part of the Department rather than an arm's-length body. They will be directed by the Department and led by a senior civil servant at deputy secretary level.

The Health and Social Care Bill seeks to provide the legislative framework for the closure of the Health and Social Care Board and the transfer of its functions. I will cover the essential elements of the proposed legislation and give an indication of what each will mean in practice.

Clause 1 provides for the dissolution of the Regional Health and Social Care Board, which consequently means that local commissioning groups (LCGs) will cease to exist. A statutory duty remains on the Department to secure the commissioning of Health and Social Care services and, in doing so, to set the priorities and outcomes that the system is expected to deliver on. Whilst the dissolution of the board will remove the requirement for local commissioning groups, it will not detract from the need for local intelligence and input into the planning process.

In practical terms, the Department is planning for the regional board closure on 31 March 2022. Local commissioning groups will remain in place until that date, which means that their input and influence will continue into the 2022-23 commissioning cycle. The need beyond 2022-23 for local input to and intelligence in the planning process is recognised. While the LCGs will cease to exist, the local commissioning teams that are in the board will remain in place. The local commissioning teams are staffed by regional board staff, and their role includes the gathering, compilation and input of local information to inform plans and the maintenance of effective working relationships with partners in their localities. Those roles will continue beyond the closure of the regional board and, as a consequence, will ensure that there is no decrease in the availability of local information to be considered in a commissioning cycle.

In addition, the Minister recently approved a programme of work to develop a new way of planning services based on an integrated care approach. A key part of the process will be to engage with local commissioning groups in order to ensure that key learning is incorporated in any new approach.

Clause 2 deals with the transfer of the regional board's functions. The clause introduces schedule 1, which is the core of the Bill. It details all the amendments that are required to existing legislation to achieve the transfers of powers, duties and responsibilities as a consequence of the board's closure. The amendment to health-specific Acts and orders results in duties and responsibilities that were briefly held by the board now being placed, in the main, directly in the Department. That includes commissioning, performance management and funding, for which responsibility will now sit with the Department. It will also include contracts for primary medical practitioners — that means GPs, dentists

and pharmacists etc — who will be the responsibility of the Department. The Bill will also provide the Department with regulation-making powers to ensure that primary medical practitioners have access to an independent appeal process in the event of contractual disputes or other specified issues arising between the Department and its primary medical practitioner contracts holders.

I will now turn to accountability in the new model. The senior civil servant directing former board staff will be accountable to the Department's permanent secretary for the delivery of functions by the former board staff. The permanent secretary is accountable to the Minister for the Department's performance. The performance of and accountability for the functions under the direction of the senior civil servant will be subject to the same scrutiny as the rest of the Department's business by the departmental board, which includes non-executive members.

In addition, the oversight of the audit and risk assurance committee will extend to include those functions that are under the direction of the senior civil servant. The Department's audit and risk assurance committee membership includes the two non-executive members of the departmental board and a further two independent external members. The senior civil servant will be a member of the Department's top management group, which will be chaired by the permanent secretary and will meet weekly to discuss the work of the Department.

Turning to the functions that will go to the trusts, a new article 10A of the Health and Personal Social Services (Northern Ireland) Order 1991 is detailed in the Bill. That article will provide a definition of what is included in social care and children's functions, and there is a list of the functions that currently are largely with the regional board or are already exercised by trusts through responsibility that is delegated from the regional board to trusts. The Bill will see these functions placed directly on trusts, but the oversight of the exercise of those functions is currently carried out in the social care and children directorate of the regional board. Following the closure of the board, oversight will continue to be undertaken by the same staff but as an integral part of the Department.

The Bill provides for the Department to be directly responsible for the oversight of the trusts' exercise of those functions. Oversight will be facilitated by regular and ongoing performance reporting by the trusts to the Department. In addition, the Bill provides that trusts must submit, annually at the very least, a scheme detailing how they are exercising social care and children functions for the Department's approval.

I will move on to clause 3, which concerns schemes for transfer of assets and liabilities. To help effect the dissolution of the board in practical terms, the clause places a duty on the Department to make one or more schemes for the transfer of the board's assets, including its staff and its liabilities. Transfer schemes for staff have been used on many occasions. In this case, all the staff of the board will be transferred to the Business Services Organisation. However, they will be directed by the Department and led by a senior civil servant. No former board staff will be dispersed to HSC trusts, the Public Health Agency or any other health body as a consequence of the closure of the board. That approach, while streamlining structures and reducing bureaucracy, will also provide flexibility for the work on the new planning approaches to evolve. Importantly, through their employment with the Business Services Organisation, the former board staff will retain their HSC terms and conditions and, further, no staff will be made redundant. Active engagement with board staff has been and continues to be a fundamental part of the transition process to closure. Consultation with staff and/or their representatives will be a key part of the development and operation of the transfer scheme for staff.

Clause 4 introduces schedule 3, which ensures an ordered wind-up of the board and provides mitigating legislative provision to address the potential risk to the continued operation of the health and social care system following the closure of the board. A power is included to provide for a regulation to be made, if required, in order to address any non-alignment of existing legislation that has not already been identified as a consequence of the closure of the board and commencement of the new arrangements. Again, that is not novel or contentious. It was evident in the Health and Social Care (Reform) Act (Northern Ireland) 2009, which provided for the dissolution of a number of health bodies and the transfer of their legislative functions at that time.

Schedule 3 will place a duty on the Department to make arrangements for a statement of final accounts of the board, and, together with a report from the Comptroller and Auditor General, those must be laid in the Assembly. It also makes provision for ensuring continuity in previous directions issued to and by the board. If that provision was not in place, every direction and issue to the regional board would cease to have effect from the closure of the board, leading to potentially significant implications for ongoing service delivery.

In addition, the Department may continue anything that is being done by or to the board, including legal proceedings following the closure of the board. It is important to highlight that fact. Anything that was commenced with the regional board before closure, including legal action relating to staff or assets and liabilities, becomes the responsibility of the Department upon closure.

Clauses 5, 6 and 7 are standard interpretation, commencement and short title clauses. Clause 5 provides interpretation for a number of references made in the Bill to what the terms, for example, "the Department", "the Regional Board" and "the 1972 Order" refer.

Clause 6 provides that the Department may appoint on which day some clauses of the Bill come into force. Provisions in the Bill will come into operation either on Royal Assent or will commence on a date that is to be decided by the Department. It is the Department's intention that clause 1, that is, the dissolution of the board, and clause 2 and schedule 1,which transfers the functions of the board, will be commenced from 31 March 2022. That is subject to the Bill successfully completing the legislative process.

The commencement date has been chosen to militate against a number of potential risks, such as complications that may be associated with a closure part way through a financial year, which could lead to a double running of systems and double accounting requirements. The proposed closure date will minimise any potential issues with governance and accountability arrangements as well. However, you will see that the date is not stated in the Bill. The alternative of including a fixed date in legislation provides an unnecessary element of risk. Those risks could include unforeseen delays in legislative progression leading to the Bill not securing all necessary approvals, including Royal Assent, by a fixed date.

Finally, clause 7 is the title by which the ensuing Act will be known. In this case, the title of the Act will be the Health and Social Care Act (Northern Ireland) 2021.

Moving on to new regulation-making powers, I have made a couple of references to powers being included in the Bill, specifically to powers to provide for regulations to be made if necessary to address any non-alignment of existing statutory legislation that is not already identified, and powers to allow the Department to ensure that primary medical practitioners have access to an independent appeals process.

The delegated powers memorandum, which was previously provided to the Committee, details in total six new departmental regulation-making powers. The other new regulation-making powers allow the Department to make regulations to amend the list of social care and children functions conferred directly on trusts; to make regulations so that a Department's power to give directions and guidance may apply to a substituted body or person to whom the Department has directed the exercise of social care and children functions should those functions be removed from a HSC trust; to make regulations to amend any statutory provisions as necessary to facilitate and safeguard the exercise of social care and children functions by a substituted body or person following the removal of those functions from a trust should that be necessary; and to make regulations to amend any statutory provisions as necessary to facilitate the exercise of functions delegated to trusts.

It will be clear to members at this point that the Bill is relatively straightforward in its objective. The closure of the board is a step forward as we seek to reduce the bureaucracy and complexity that is so keenly associated with the health and social care system. It is only a first step in enabling a better focus of resources and enabling the system to operate more effectively and efficiently.

Finally, I hope that you feel that the summary was useful. We are happy to take any questions that you might have.

The Chairperson (Mr Gildernew): Thank you, John. That was useful. First of all, you went into some detail on the local commissioning groups. Early in my time as an MLA, I attended a couple of the local commissioning group meetings that were taking place in my constituency. I found them useful, although there was huge room for improvement in co-production and co-design. For example, members of the public were entitled to attend the meetings but were not entitled to contribute, and there were very tightly defined speaking procedures and things like that that restricted debate, inclusion and co-production. However, there was a very welcome safeguard in that local councillors were represented as of right on the group and were entitled to speak, engage and represent their communities and their needs.

As a result of this change, I would have hoped that we would look at strengthening the local commissioning element in a way that would open it out to co-production with other people and provide communities with the ability to genuinely engage in the tough discussions about what is available, how you make finite budgets cover everything and what their priorities are. I am a bit concerned about some of the things that you said, but that is in the context of some concern that I have about the Minister's statement on Tuesday in the Assembly. I picked up that he stated that the cancer strategy had:

> *"been co-produced with the Health and Social Care Board and ... the health ... trusts." [Official Report (Hansard), 13 April 2021, p7, col 2].*

I contend that that is just necessary planning with the people who are directly involved; it is not co-production. Co-production should involve staff representatives, allied health professionals, if they are relevant, and community organisations. Co-production is not a chore; it is a prize in that the people who have many of the solutions want to be part of the conversations.

You said that local commissioning groups will continue until the 2022-23 cycle when the local commissioning teams in the Department will take over the function in discussion with the people who had sat on the local commissioning groups. That strikes me as bringing commissioning back in-house rather than opening it out more to the community. I have a concern about that. What will be the relationship between the local commissioning teams and the people that they are speaking to? What right will those people have to impact on decision-making, or will they just be consulted and have their views taken on board or not, depending on what the local commissioning team in the Department chooses?

Mr Millar: I also reflected on the fact that the Minister has commissioned work to take forward a new approach. A key part of that process will be to engage with local commissioning groups in order to ensure key learning from that new approach. The new approach will take account not only of key learning from the LCGs but of the changed landscape in which we are now operating with the creation of community planning partnerships and how we can better align ourselves to achieve improved outcomes for our local populations.

Mr Chapman: It is important to note that the future planning work that we are undertaking will look at what comes in place alongside, as John mentioned, the staff that will be retained from the board and that work in local commissioning groups and teams. It will be similar to what exists in the local commissioning group in that it will be a body that is representative of partners from across the sectors, including the voluntary and community sector and service users and carers. The idea is to build a broader system that allows for local input and local intelligence that are available not only from the likes of professionals and the statistics but from local communities and individuals on their health needs in order to ensure that we create a system where that information is fed into how priorities are determined and how services are planned and delivered. That is part of the future planning work that we are starting to take forward.

The Chairperson (Mr Gildernew): I accept that. I noted your reference to an integrated care approach, and it remains to be seen how all of that develops. What we know for sure, however, is that the local commissioning groups are going to be done away with, and I wonder whether that is necessary. Could they not have been retained, along with their expertise, which you are now seeking to consult on and capture. Why not retain them until such times as we can see what is going to replace them and how the system is going to be improved?

Mr Chapman: The intention is that the work on what comes behind the LCGs will start now. As John said, we are not doing it in isolation. We have established a project board, and it includes representation from LCGs. We will be working closely with them on how to make the move forward. We are looking to build on what they have done to date. As you say, and the previous review of commissioning hinted at this, there have been limitations to what the LCGs have been able to achieve, but they have also provided us with really good foundations on which to build. Although a fully fledged integrated system takes time and will require a phased approach, the intention is that, whatever we bring in under the future planning model, the mechanisms will be in place from the date of closure.

The Chairperson (Mr Gildernew): OK. What appeals process will be in place at that point for commissioning decisions, either those taken or not taken? What appeals process is being built into the Bill or into the future arrangements?

Mr Chapman: I am not sure whether there is anything specific in the Bill. I will need to come back to you about appeals, after I look at the mechanisms currently operating and at how they will possibly be brought forward and integrated into the new operating model.

The Chairperson (Mr Gildernew): Thank you. I would like you would come back to the Committee with that information, Allan.

Mr Millar: Chair, may I clarify something? The basic principles of the Bill are to close the board and transfer its functions, so the details that you have asked for about an appeals process are not included in the primary legislation. They will be for the work that Allan is doing on taking forward the arrangements.

The Chairperson (Mr Gildernew): Is there any reason that an appeals process could not be part of the Bill?

Mr Millar: An appeals process is not part of the scope of the Bill. If the Health Committee were to recommend it, however, I am sure that it would be something that the Minister would have to consider.

The Chairperson (Mr Gildernew): Thank you, John. My final question, before I open up the meeting to members, is about engagement with staff and unions about the transfer of staff. What engagement has there been with staff and unions about the future and how the move is going to be coordinated?

Mr McKeown: I will take this one. As John has set out, the vast majority of the work of the project is on the transfer of functions. This, however, is all about the people side of things. To set up the project, 16 strands cover the various functions. Within each strand, we have a trade union representative embedded. We have established a staff-side forum, and we meet every six to eight weeks. All the relevant trade unions are there, along with management side, involved in the project.

HR and communications are at the forefront of this. We have an ambition programme, which is to build capacity and capability amongst the staff. We have a people strategy in place to support them through the transition. We explain what we are doing, why we are doing it and how it impacts on them. That is all very clearly communicated to staff at various levels, from chief executive to all staff, and to smaller groups. There are also one-to-one sessions. Those communications are two-way engagements. For example, today we are running a session in which staff can input into the naming of the future group in the Department. Staff and trade union engagement is therefore absolutely hand in glove with the Department throughout.

The Chairperson (Mr Gildernew): OK. That is the right approach, and a valuable one. Thank you for that, Gareth. I will now open up the meeting to members' questions.

Ms Ní Chuilín: Thank you for outlining the scope of the Bill. I thank Allan in particular. The Chair has asked a lot of the questions, but, although I appreciate that this is a technical, seven-clause Bill dealing with the abolition of the board, the questions that were raised need to be reflected somewhere.

For example, when we are transferring the local commissioning groups, even though they will be there until 2022-23, what that means needs to be better explained. It could mean amending the explanatory and financial memorandum, but it definitely needs to be fed in somewhere.

This may already have been answered, but if clauses 1 and 2 are to go ahead, the other clauses that relate to the transfer functions — clauses 3 and 4 — are dependent on the dissolution of the board, yet the local commissioning groups will still be operational. That could perhaps be explained, or is it all going to be done in one fell swoop?

You mentioned talking to trade unions and staff-side representatives. I have noted some of the comments that I made when this was first announced. What are the current issues, given that BSO will retain all the Health and Social Care staff? What are the current arrangements to ensure that whatever is commissioned reflects the needs of that geographical area? That is not clear from what we have seen up until now.

Mr Millar: The member asked about the commencement of the Bill. From memory, only clauses 1 and 2 are at the discretion of the Department. The other clauses, which deal with having to have a transfer scheme in place and the transitional arrangements will come in on Royal Assent. As I hopefully

explained in my opening remarks, the plan is for the Department to commence clauses 1 and 2 on 31 March 2022. They are not in the Bill as having a fixed date because there are things to do with the legislative process and the period required to get Royal Assent that are outside the Department's control. If we were to have that date fixed in the Bill and anything were then to happen, it would have major implications for those provisions. That is a very technical explanation.

Ms Ní Chuilín: Yes, I appreciate that, John, but, at the end of the day, the principle should be that all the clauses are subject to whatever happens. Giving that kind of carte blanche authority to the Department is OK, but only up to a point, because, when it is too technical, it almost becomes confusing. We therefore need more clarity around that.

Ms Hunter: I thank the panel for appearing before the Committee. Chair, you raised the issue of staff and unions, so I thank you for raising that important point.

My question is about future planning. I raised this issue previously in Committee. Being based in a rural constituency, I have a real concern around regional imbalance, and I know that other MLAs are as well. What assurances will you give that services will be evenly distributed across the North in order to ensure rural and regional balance?

On the back of that, we know that accessibility to healthcare is vital, and there are a number of barriers to that, such as travel and transport. As we build a new system, what consideration has been given to accessibility, especially for more vulnerable groups, such as older people or those based in a rural community?

Mr Chapman: On the regional side of things, the whole purpose of having a future planning model is to go down the route of following the principles of local-level decision-making. As the model develops, and I stress that it will take time to develop, it will increase autonomy at a local-area level for it to make decisions around planning and services to meet the area's needs. It will be based on a population's health needs assessment. That will look at what we need regionally, in Northern Ireland as a whole, which will feed into and inform the objectives and priorities. We will also look to develop ways in which to drive that detail down into what is needed at a local level so that decisions can be made by local areas, whether rural, urban or wherever, on what services are needed to suit their population, and even what services are needed within segments of their population. There will always be a need to look at certain specialist services on a regional level, so that will be built into the future planning model as well. A bit of work will need to be done on what falls to the local area and what falls to the region. As the systems mature, we should find that decisions will increase at a local level, and the autonomy level will increase with that.

The transport issue links to getting down to local-area decision-making. The integrated care system approach has been developed elsewhere and is a model that is trying to be adopted across the world, but there is no blueprint for it. One of the key aspects is that it looks at breaking the local areas up into certain population sections. We will be looking to build a similar type of approach. Doing that would allow for the needs of a particular rural area to be met. It could then look at what is needed to get the service that it needs. That could include particular transport needs, which the rural area could build into its planning approaches.

Ms Hunter: That is great, Allan. That local expertise and insight is really important moving forward. I am happy with that. Thank you.

Mr Carroll: Thanks, Chair, and thanks to the panel. I have two main questions. The first is on the transfer of staff. John said that staff will retain their HSC terms and conditions. Will that be indefinitely? Has a time frame been put on that, or what is the process? Will staff who were previously employed by the board be employed by BSO, the Department or a combination of both? What is the fine detail of that?

Mr McKeown: On staff transferring and retaining their terms and conditions, I can say that, from 1 April 2022, BSO will take on their employment contracts as they are, with whatever the terms and conditions are. If they are fixed-term/permanent staff, those conditions will be carried over. There are no time frames attached. If they are permanent members of staff, they will therefore retain that status. There will be no change. It is a transfer from one organisation to another. All board staff will transfer to BSO via transfer schemes set out in the Bill's provisions.

Mr Carroll: OK. Thanks. I hope that their conditions will be maintained and that there is no thought process to rely on agency staff. At times, BSO has relied on agency staff too heavily, so I hope that there is not a repeat of that happening.

I have one final question. I do not know who will be able to answer it, but it is relevant to the discussion. There is a perception amongst a lot of people that the Department is top-heavy, with too many staff at senior management level. There is also a perception that, when patients are failed or questions are asked about issues in the many different inquiries, there is a culture of either not disclosing information or of not having transparency. People often feel that they are not being given the answers that they deserve. For taxpayers and people who are entitled to proper healthcare treatment, that is essential. What assurances are there that, with the Bill and the transfer of powers and functions to the Department of Health, there is not going to be a repetition of that approach? Where there are failings, which there are likely to be, as is the case with any organisation, is there an assurance that people's concerns will not be ignored and that, when it comes to asking questions, they will not be shut out?

Mr Millar: The functions transfer directly to the Department. The public will see that the delivery of services will largely continue as it is, with the trusts and with the primary medical practitioner contractors. They will not see any difference in the front-line delivery of services as a result of the transfer of functions. Complaints procedures, FOI requests and that kind of thing will remain as they for people looking to access information and raise complaints, queries and questions. MLAs will be happy to hear that, when you raise them, questions will come directly to the Department, and, hopefully, you will get answers a bit quicker than you do now, as we will not have to go to a board. They will instead all be captured in the Department.

Mr Carroll: Thanks, John. I hope that that is the case, and I hope that people get answers to their concerns and queries and that they are not ignored or met with a defensive approach, which, unfortunately, has happened too many times. I appreciate your answers, panel.

Ms Bradshaw: Thank you, panel, for the update. You have touched on some of the issues that I had raised previously about accountability and oversight. The audit and risk oversight committee is very much to be welcomed, especially the fact that it has two external people on it.

My questions relate to where there are failings in the commissioning of services at the minute, and I will link that to the trust. This week, for example, I got figures from the Department of Health stating that there are no endometriosis specialist consultants and that there is, I think, 0·8 of an endometriosis specialist surgeon. The trusts are failing in many ways, even when the services have been commissioned. How therefore is the new system going to improve that? I am concerned that the permanent secretary and his senior management board will be interested in the big-ticket items, such as cancers, strokes and diabetes, when some conditions are being failed. That is my first question.

Mr Millar: Initially, commissioning will be done by the Department, as those functions come in. The senior civil servant will be responsible for all the functions that come into the Department, including commissioning. Her link into the Department is through the top management group, which is made up of the permanent secretary and executive board members. It sits on weekly to discuss corporate business and the handling of emerging issues.

Ms Bradshaw: Thank you, but look at what happened with paediatric pathology a few years ago. Part of the reason that Northern Ireland lost the service — it is now at Alder Hey Children's Hospital — was that the vacancy was allowed to come about, and there were then delays in filling it. An endometriosis vacancy has now arisen in the past few weeks in the Belfast Trust. What penalties, safeguards or measures are going to be put in place so that, when services are commissioned from the Department of Health, we do not see those failings again in the trusts, resulting in services — especially those with limited numbers of staff, not the big-ticket stuff — being allowed to fester to the point of having to close?

Mr Millar: I cannot give the member an absolute guarantee — that would be foolish — but the Bill will take away the middleman, which is the board. Performance management will be directly between the trusts and the Department. Under the new arrangement, there will be no middleman, as the board will not be there, and those discussions will have to take place directly between the Department and the trusts.

Ms Bradshaw: OK. I will raise that issue directly with the Health Minister in the Chamber.

The second part of the information that I received this week about endometriosis is that trusts are recording their waiting lists differently, and we heard again this week the Health Minister talk about a regional prioritisation list. How can we have a list that is robust on clinical need when the five trusts are recording waiting lists for their patients differently? Is there an opportunity through this Bill to tidy that up so that we are dealing with apples and apples and not apples and oranges across the trusts?

Mr Millar: The primary legislation sets out the framework for where those functions lie. The detail will probably be in lower-level regulations, so that is possibly the avenue through which that kind of thing would have to be addressed. I do not have the facts and figures to address the detail of your question, but I am quite happy to take it away and respond at a later date.

Ms Bradshaw: I appreciate that. As you said, the Bill is at quite a high level, and my questions are possibly outside its scope, but those are the practical implications that need to be considered to ensure that, to go back to Carál's point, we do not have regional variations across the trusts and that, going forward, there is an opportunity to improve performance across the whole of Northern Ireland. I appreciate your time spent on the Bill and at the Committee today. Thank you.

Ms Flynn: Thanks to the panel. My first question is for Allan, and then I have one or two for John. I want to go back to the subject of the future planning team. The importance of that local input and intelligence from local communities has already been mentioned, and you said earlier that these things will take time to develop, but that is part of your future planning work. You said that you will start to take that type of work forward and engage with local communities. Allan, do you have a timeline for that engagement process or any structured programme of work for how you are going to get into the local communities and have that engagement to get their input?

Mr Chapman: We have been working on a communications and engagement strategy that will look at the broader projects going forward, at whom we need to engage with and at, at best, indicative timings for whom we will need to engage with at what stage. That is subject to change, depending on how things progress.

One of the key areas that we will be looking at is community engagement and how that will feed into the future planning model. That will be a bit of a longer-term consideration. Again, there is no specific timeline, because we have to start to look at how we go about doing that and what the right approach is.

We have a meeting today with the integrated care partnerships' third-sector steering group. We are therefore starting to have discussions with some organisations in that area to see how engagement will work for them, how we can facilitate and enable that and how we can perhaps utilise what is already in place, such as the steering group and its wider forum.

Similarly, community and planning partnerships have a voluntary and third-sector structure in place, and we need to consider how we do not overly burden that sector with another project coming along. We are looking to do something different, but we will perhaps look to utilise the options available to us there. A wider community engagement on planning services is the key to finding out how we embed those services. Doing that will take much longer, but it is useful to note that that type of thing does happen now, possibly not systemwise, which we hope to get to. An example of that is the work going on in the Western Trust. It has done a lot of engagement recently from community level up to determine needs and to look at multi-morbidities. Mechanisms have been developed, and there are examples of best practice, if you like, that we can build upon. There is no set timeline. Engagement on the development of the model will happen reasonably quickly, because, as I referred to before, we want that in place for closure. That will ramp up reasonably quickly, and it includes the meetings today.

The wider development of community involvement and engagement through the model itself will happen over the next 12, 18, 24 months. It will be a case of looking to constantly improve on that and to support the community to engage. That is because, as an example, the voluntary and community sector is broad and wide, and it is very difficult to turn around and say, "Give us one representative who can sit on this group and cover off all concerns, issues or expertise that you could bring to the table". We have to look at ways of trying to support them and what works for them as well.

Ms Flynn: OK, Allan. That is useful. I know that all those timings are indicative, but it would be useful if we could get regular updates on how you are getting on with the communication and engagement process. Thank you for that.

John, I want to take us back to one of the questions that, I think, the Chair raised earlier around whether there is any scope in the Bill to look at an appeals process for commissioning decisions. You answered that, currently, there is no scope in the Bill for that. In your earlier remarks, you mentioned that you are looking at an independent appeals process for the contracts of primary medical practitioners. Is there scope in the Bill for an appeals process for primary medical practitioners? If so, does that mean that there is a possibility that we could try to expand the scope to take in commissioning decisions?

Mr Millar: I would suggest at this point that they are two radically different things. There is an existing relationship with the primary medical providers, in that they are contracted, and that contract sits with the board. I will explain the process at the moment. If the board, in monitoring performance, decides that an individual practitioner is not living up to the service contract or is not delivering what they are supposed to be delivering, it will make a decision to, depending on the seriousness of the lack of delivery, either place a penalty on the payments out or seek to go further in terms of the inclusion of that practitioner on the list for practitioners in Northern Ireland. The initial decision is made by the board. Obviously, the practitioner, at that point, might not necessarily like that decision and has a right of appeal to, in most cases, the Department. In pharmacy, it is slightly different. With the new arrangements, it would not be fair for the Department to be — to use a phrase — judge, jury and executioner. That is why we are seeking to have the regulation powers to set up an independent body to make those second-stage decisions.

On commissioning — you will have to forgive me because I am not an expert in commissioning — I am not sure that there is an appeals mechanism in the current structure for any decisions made on commissioning, so we have not given a lot of thought to introducing an appeals mechanism for a new structure.

Ms Flynn: OK, John. That is fair enough. Thanks for that answer.

Finally, how does the Department intend to review the effectiveness of the legislation after it has been brought in?

Mr Millar: Like everything else, there will be a post-project evaluation internally in the Department, following completion of all the strands.

Ms Flynn: OK. John, thanks very much.

The Chairperson (Mr Gildernew): John, there is one other thing that I want to raise before we let you go this afternoon. I know that you mentioned that there is a requirement for an annual report on children's services. However, I have a concern about that particularly vulnerable or potentially vulnerable group, the organisational churn that may be a natural result of all the changes and the fact that people may not know that they do not know certain things. Is it possible for the review process to be early and often throughout the initial period of the transition into the new system, so that nothing can fall between the cracks and no child will be exposed or left vulnerable to harm as a result of the organisational change?

Mr Millar: Regarding the reports on the exercise of those social care and children functions, there is already a mechanism in place for a report to go to the board at least annually, which is then referred to the policy experts in the Department. We are taking that middle level away so that the report will go straight to the Department. With the way that it is worded, the Department can ask for a review of the scheme at any stage; it does not have to be done annually but can be done at any stage of the year depending on the Department's professional view of the service that is being provided.

The Chairperson (Mr Gildernew): It would be appropriate for that to happen early in the cycle and to be ongoing. That annual review could leave a lot of potential. I heard you say that the annual review is a minimum, but it is important, given that there will be a lot of organisational change and churn, that that is considered and has a very close eye kept on it.

Mr Millar: On the social care and children functions, I reiterate my point from the opening statement: the same staff who discharge those functions in the board will do it in the Department with the added value of having the policy colleagues closer at hand.

The Chairperson (Mr Gildernew): If that leads to improvement or streamlining, it is to be welcomed.

Mr McKeown: The loss of staff is one of the risks that we are closely managing. One of the reasons why we went for the hosting option was to allow staff to retain their terms and conditions so that there would be a retention of staff. In the board, we are doing work on succession planning and knowledge transfer to plan for staff churn that, as you say, is out of our control.

The Chairperson (Mr Gildernew): OK. That is everything as far as members are concerned. John, Gareth and Allan, thank you for your attendance today and for addressing us with your briefing and addressing members' questions. As Órlaithí indicated, we will be seeking to engage with you further on the detail of this as we expand our understanding and identify issues that may arise or that we could add value to in the Bill. Good luck to you all in the time ahead. I appreciate you coming today.

Mr Millar: Thank you.

Mr McKeown: Thank you.

Mr Chapman: Thank you.