Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Health and Social Care Bill: Health and Social Care Board

29 April 2021

NORTHERN IRELAND ASSEMBLY

Committee for Health

Health and Social Care Bill: Health and Social Care Board

29 April 2021

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 Leslie Drew	Health and Social Care Board
Ms Sharon Gallagher	Health and Social Care Board

The Chairperson (Mr Gildernew): I welcome to our meeting Mr Leslie Drew, who is chairperson of the Health and Social Care Board (HSCB). Are you able to hear us, Leslie?

Mr Leslie Drew (Health and Social Care Board): Yes, Chair, I can hear you.

The Chairperson (Mr Gildernew): Thank you, Leslie. We can hear you also. We have Ms Sharon Gallagher, who is the chief executive of the Health and Social Care Board. Are you able to hear us OK, Sharon?

Ms Sharon Gallagher (Health and Social Care Board): Morning, Chair. I am indeed.

The Chairperson (Mr Gildernew): Thank you both. I am glad to see you both using headsets; hopefully that will help with the sound. I remind the panel and Committee members: remain on mute when you are not speaking, please. That will hopefully help with the quality of the sound. Leslie, will you outline how you will brief us this morning? We can then move into questions and answers with members.

Mr Drew: Yes, Chair. I have a short introduction — an overview — and I will then hand over to the chief executive for some short comments, after which the Committee can ask questions.

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

Mr Drew: Good morning, Chair and members of the Health Committee. Thank you for the opportunity to be here today. As you said, I am accompanied today by my chief executive, Mrs Sharon Gallagher. My name is Les Drew. I was appointed as chairperson of the Health and Social Care Board approximately 13 months ago, on 1 April 2020. When I was appointed to this role, I expected to be focusing on the closure of the Health and Social Care Board and the migration of its team to a new operating model, in line with the recommendations of a number of expert panel review reports.

Like most people, I did not fully appreciate the impact that COVID-19 was going to have on all our lives, as well as on the health and social care system. The year 2020 was to become the most challenging year for the Health and Social Care Board in its entire corporate life. I am immensely proud of how the Health and Social Care Board team responded to the challenges of COVID-19, helping to deliver the Minister's priorities by working with colleagues in the Department of Health, the Public Health Agency (PHA), hospital trusts and the primary care sector. I have witnessed at first hand the incredible creativity and innovation of the Health and Social Care Board team as they not only responded to COVID-19 challenges but demonstrated a renewed sense of purpose and determination as they embraced the need for further reform of the current health and social care system.

For your information, during the past 12 months, I have been personally involved in the appointment of a new chief executive and five out of six members of the senior management team of the Health and Social Care Board, and I believe that those individuals are all totally committed to the new direction of travel that has been proposed for the Health and Social Care Board.

The objective of the Bill is to give effect to the decision to close the Health and Social Care Board, which was initially proposed by Simon Hamilton in November 2015 and has been endorsed by three separate Health Ministers. The Health and Social Care Board was established through primary legislation, namely the Health and Social Care (Reform) Act (Northern Ireland) 2009. Therefore, new primary legislation is required to effect the closure of the Health and Social Care Board and to transfer responsibilities for management of its functions to the Department of Health. The Bill relates solely to the regional Health and Social Care Board and has no material impact on other health and social care bodies. The purpose of the Bill is to dissolve the Health and Social Care Board and transfer responsibility for its functions to the Department of Health. These functions include the commissioning of services, the performance management of trusts and other providers, and funding allocation. The Bill contains only seven clauses and three schedules. I am confident that it contains sufficient safeguards to ensure that the assets and, most importantly, the staff of the Health and Social Care Board are transferred seamlessly and successfully into the Department of Health. The Health and Social Care Board may be closing as a corporate entity, but the Health and Social Care Board team will continue to play a vital role in the planning and design of a new fit-for-purpose health and social care system for the citizens of Northern Ireland.

The Bill also contains some necessary amendments to 69 Acts or orders dating between 1965 and 2020. That is mainly to remove the references to the old Health and Social Care Board name. I can confirm that the Health and Social Care Board's existing board of non-executive directors fully supports the direction of travel and is keeping a careful watch on the progress of that important piece of work. During the past year, the Health and Social Care Board's board of non-executive directors and I have continued to perform an important scrutiny role around business-as-usual activities. I assure you that, as part of our responsibilities for the Health and Social Care Board, we are committed to ensuring that this programme of work will successfully meet its conclusion. To that end, my chief executive is a member of the Department of Health oversight board that has been established to oversee that process. In addition, a progress report is provided by the project director, Martina Moore, as a standing item at our monthly board meetings. That has provided the Health and Social Care Board's non-executive directors with the opportunity to scrutinise and ask challenging questions about this complex project. I assure you that, until that responsibility passes to the Department, the current non-executive directors of the Health and Social Care Board will be fully engaged in the migration process and will provide scrutiny, challenge and clear guidance, support and advice where necessary. As I have said, those functions will transfer to the Department of Health. They will be subject to the Department of Health's internal scrutiny and governance arrangements.

I led many change initiatives in a past life in my career with Northern Ireland Electricity Networks. Based on that experience, I can advise the Committee that the programme of work to migrate the Health and Social Care Board into the Department appears to be being taken forward after having considered all of the obligations of the Health and Social Care Board and associated risks. The Health and Social Care Board staff and their trade union colleagues are integral to designing how the new arrangements will work. They are key players in the process and are able to bring to the table a wealth of knowledge and expertise about the current systems and all of the arrangements. The passing of the

Bill will bring to an end the current local commissioning group (LCG) structure. That is an area that I am particularly interested in; indeed, I regularly attend the local commissioning group chairs' forum. I have seen first-hand evidence of the commendable work that they have been doing. I am also conscious of the limitations that the current system arrangements have placed on their ability to make a real difference. The Bill provides us with a real opportunity to change how we plan services. I am particularly pleased that the local commissioning group members are engaged in the transition process and are represented on the project board. They are committed to playing a vital role in the design of the new way of working and supporting its implementation. They have valuable insight into both what has worked well and what has not worked well and needs to be addressed. The LCGs have historically provided a local voice. That voice must be clearly heard in whatever new model is put in place.

It is clear that the need for change has never been greater. We heard the Minister last week referring to the current dire situation regarding waiting lists. Those are not just numbers but individuals who could so easily be a member of our family, a work colleague or a neighbour. We must all play our part in arriving at a solution, part of which must be to look at how we plan our services, remove duplication and empower our local communities to plan and deliver services that they need for their population. I am pleased that that work to develop a new planning model is going forward jointly between the Health and Social Care Board team and Department of Health colleagues. This partnership approach recognises the need for joined-up thinking as we try to design a new approach.

In conclusion, the closure of the Health and Social Care Board and the migration of its team into a new operating model were first announced almost six years ago. It has been a long process, particularly for the staff involved. The passing of the Bill will be a significant milestone on the way to enabling a much larger transformation journey to be taken forward. During my short tenure, I have been able to build a strong and robust relationship with the new chief executive and senior management team. Through staff engagement, I have tried to engage with the Health and Social Care Board team at every level regarding closure. I am confident that we all share a common vision for the future in which the citizens of Northern Ireland will enjoy better health outcomes.

Chair, I will hand over to my chief executive to make a few comments, if that is appropriate.

The Chairperson (Mr Gildernew): Absolutely. Thank you, Leslie. Go ahead, Sharon.

Ms Gallagher: Thank you, Chair. I will get confused today, as I am working to two chairs: the chair of the board and the Chair of the Committee. *[Laughter.]*

The Chairperson (Mr Gildernew): Fair enough.

Ms Gallagher: I will keep it brief. As you know, I have been working on the transformation agenda — specifically on this area of work — since 2015, when the decision to close the board was initially made. Since then, that decision has been reaffirmed by subsequent Ministers. In September, I was appointed chief executive of the board, alongside my deputy secretary role in the Department. That is a unique position, in that I am leading the work to close the board on behalf of the Department but am also discharging the chief executive responsibilities of running the business of the board and managing the transition of its staff and functions into the Department. In essence, we are trying to shadow run or shadow form what the new model will look like, so that we can test it.

In taking forward the legislation, we have an opportunity to build a new way of working. We know that there are complexities and a level of bureaucracy in the system. We are trying to work against that being the case in the future. We are trying to make sure that resources are concentrated where they will have most effect. As Les said, it is fair to say that the uncertainty that has existed over recent years has had a detrimental impact on the confidence and morale of the workforce in the board. I have given a lot of my focus to that since my appointment last September. I wanted to provide clarity to staff and make sure that they are consulted, not just on the future model, but on the role that they will play in it. As you know, the decision to close the board was taken in the context of the current broader commissioning process not being fit for purpose. Importantly, as Les said, work is well advanced on developing a new model for commissioning health and social care services as we move forward. The blueprint for that is in the final stages of development and will soon be considered by the Health Minister.

Finally, in line with what Les said, I look forward to bringing this legislation through. I think that it will mark an end to the lack of certainty around moving forward, allow us to bring forward our

transformation journey and, more importantly, allay the concerns of staff and provide them with certainty for their future. Thank you.

The Chairperson (Mr Gildernew): Thank you to both the chair and the chief executive for those briefings. Leslie, I am struck by your reference to the fact that, in your view, sufficient safeguards are in place for assets and staff. That is welcome, and I get a sense that a fair degree of effort has been put into that. The Committee and I welcome the fact that staff are being prioritised, with this transition being managed in a way that reduces any anxiety and is as smooth as possible for them.

More generally, in relation to commissioning, I was struck by the analogy that you would not ever move house without first knowing what the new house is like, and also that the new house is ready before you move out of your old house. I am struck by the whole issue of local commissioning groups. We heard several references to the work on what will replace them being well advanced. Leslie, are you satisfied, in your role as chair, that there are sufficient safeguards around the protection of local involvement in the new commissioning model, and, indeed, that that can be enhanced, let alone stand still? Are you satisfied that enough preparation work has been done and that the Committee and everyone else can satisfy themselves that the system that is designed to be picked up will be available for us to scrutinise before this is all complete?

Mr Drew: As I said, I regularly attend the local commissioning chairs' forum, and I have been impressed by the level of engagement from it in this process. Clearly, work is still ongoing, and the entire commissioning model may not be ready for 1 April. However, the framework and the structure is certainly being thought through. Careful consideration is being given to where things have not worked and where they can be improved. Local commissioning groups currently do not have a close, integrated relationship with trusts, but integrated care partnerships (ICPs) have a close relationship, and they will also be involved in making decisions on the design of the future model. I am very confident that all the stakeholders involved are being consulted and that their views are being taken on board, and I think that that will lead to a much better population-based local commissioning model in the future, compared to what we have now. The local commissioning groups have done a tremendous job in terms of their expertise and knowledge, and I am certainly encouraged that that knowledge is being captured and brought into the process of developing a new model.

The Chairperson (Mr Gildernew): In your experience, how should the new model differ from the current model? Where is the added value?

Mr Drew: It has to be based on an integrated care system approach whereby representatives who are involved in community planning and integrated care partnerships at trust level and are close to their own populations will identify the health and well-being needs of those populations and design service delivery that is appropriate to meet those needs. It is about bringing the health and care system closer to the population so that there is not the same inequality or postcode lottery. It is about giving a voice to the local community on its health and social care needs.

The Chairperson (Mr Gildernew): Can you tell us any more about how that will be done in practice? What will replace the local commissioning groups?

Mr Drew: That is being worked through at the moment, and the chief executive may want to come in and add something. The local commissioning group chairs and members have been involved in the process, and what that will look in a number of months' time will unfold. The chief executive might be able to give a wee bit more detail on that.

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

Ms Gallagher: I have a couple of things. First of all, as you will have heard before, Chair, the closure of the board is just phase 1. Changing the way we commission services is a massive undertaking. It is a very complex system, and there are many players involved and a lot of money involved. The one thing that we want to protect is services. Reorganising ourselves cannot come at the cost of service delivery, as in either people resource or financial resource. The closure of the board is the first step. As of 1 April 2022, new networks will be formed at local level. At the minute, Martina and the team are working through what that will look like. As Les said, the local commissioning groups, ICPs and others are involved in determining what that will look like.

You asked about the biggest change in the end model — the aspirational model that we are going for in terms of the blueprint. On paper, it does not look that different because, on paper, we have an integrated health and social care model at the minute. ICPs and LCGs all do a really good job, but the feedback that we are getting, and what we know, is that they are not empowered sufficiently, so the new model needs to look at how we empower the networks more at local level. That means accountability, funding and allowing them to determine what is needed at local level. We have a process at the minute that nearly says that on paper but works against itself. The learning that Les has talked about again and again is listening to the voices of those people who have been involved and have said, "Here is what is working well", because not everything is wrong, and, "Here are the areas that we need to focus on to make it better".

The Chairperson (Mr Gildernew): I appreciate your answers to that, Sharon, but given that that is all known, and given what you said is a unique role in that you are chief executive of the board but you also have responsibility in the Department, to go back to my house analogy, you would not move out of your own house until you had seen the new house and knew that it was fit for purpose. Doing this in at least two stages or phases is a choice that the Department has made, so it is putting in front of us a proposal to close the board without showing us what the new arrangements will look like. Would it not make more sense for you to simultaneously present what you are proposing to replace it with?

Ms Gallagher: That is a fair point, Chair. We are doing it simultaneously, but the implementation will be staged. You will get a briefing from the team very shortly about what that looks like, and I will be more than happy to come back at that time. As I said, on paper, it will not look that different. This is about a change in accountability. It is a cultural piece and is a real investment at local level. It is about a more delegated authority, with trusts working with primary care and community care. When we consulted in 2015-16, we heard back that, "We agree that the board needs to close because it creates a layer of bureaucracy, but we are not quite sure how this integration will work in practice. Trusts are a big entity. Will other players get lost in that? Will all the finance go to the trust?" Those are the things that take more time. They need time to engage with people to build the trust and to move us into a different set of circumstances.

When I took this work on in 2015 and looked at the legislation — I have said this before — my first thoughts were, "What is wrong with that?" Any model can work on paper, but it is about how people come to the table, the maturity of the relationships and the trust within the relationships. We need to spend some time and effort in developing that.

The Chairperson (Mr Gildernew): I welcome the fact that we will get that briefing shortly on what will replace it and what the proposed new model is. Will you commit that we will receive that in advance of us completing our consideration of this Bill?

Ms Gallagher: I very much hope so, Chair. Yes is the short answer. It has not been to the Minister, but we are more than happy to come back and talk about that pending the Minister's consideration.

The Chairperson (Mr Gildernew): OK. The Committee will be keen to have that. Thank you for that, Sharon. I will move now to members.

Mrs Cameron: Thank you, Leslie and Sharon, for your attendance and evidence on this important subject. Are there aspects of the current complaints or appeals processes for service providers that could be addressed or improved under the Bill? Are there lessons from accountability models elsewhere that you believe are relevant when considering the provisions of this Bill?

Ms Gallagher: I am happy to take those questions, Les, if you are content?

Mr Drew: Yes, Sharon. Go ahead.

Ms Gallagher: On the appeals processes for service providers, at the minute the structure is that the Minister sets the priorities through a commissioning plan direction; the board and the PHA, alongside partners, create a commissioning plan; and the trusts commit to that plan through their trust plans. With regard to appeals on commissioning decisions, given that the Minister sets the priorities, the board and the PHA work in consultation with stakeholders about how those services can be commissioned. There is an ongoing engagement and consultation approach. There is an agreed agenda. I do not believe that there has been a case in respect of which an appeal process has been

needed. If you give an example, I could tease that out a little more. I am not sure that I have answered your question.
Mrs Cameron: No, that is fine. Thank you.

Ms Gallagher: On learning from other accountable or integrated care systems, we have done a lot of research and had conversations and considerations on what others are doing. There is no doubt that an integrated approach is the only way forward. We cannot have silos. Some of the learning, as I said to the Chair, is about relationships rather than what it says on a piece of paper. It is about trust. It is about supporting an integrated care structure with accountability, governance and funding and, importantly, it is about being clear about outcomes and understanding the needs of a local population. Those who work in a community and understand it know, from a health and social care perspective, what the best response is to their needs.

Mrs Cameron: Thank you for that, Sharon. The Chair touched upon the local commissioning groups. There is concern about losing that expertise with the abolition of those groups. How do we ensure that the commissioning of services does not create a monopoly for hospital services, for example?

Ms Gallagher: "Local commissioning groups" is a naming convention that sits with the current legislation. LCGs will close because the legislation is being changed, but we are working to enhance the local voice and local decision-making. The construct through which we do it might be called something other than an LCG or integrated care partnership (ICP), but it will not be that far away. Some of the same people will be involved. They are already involved in determining what that construct looks like. At the heart of what we are doing is an emphasis on local commissioning more broadly, local understanding of need, local planning of services and local delivery.

Mrs Cameron: That is great. Thank you.

The Chairperson (Mr Gildernew): Thank you, Pam. I ask members to go on to mute if they are not speaking. We are picking up some background noise. I will go on to Carál Ní Chuilín, Go ar aghaidh.

Ms Ní Chuilín: Thank you, Sharon and Leslie, for your presentation. You said, in response to Pam's question, that some of the descriptions, of the local commissioning groups and the integrated care partnerships, for example, might change, but, essentially, the functions will be the same. To go back to Colm's point, we need more definition at this stage. While we all supported the *[Inaudible owing to poor sound quality]* in terms of the Health and Social Care Board, a lot of clarity is still needed.

What role do trade unions and staff-side representatives have in the process?

Mr Drew: I will pick up on the first one, Chair. In my introduction, I said the staff and trade union representatives from all the trade unions have been involved in the process. The fact that they have been involved and are represented on the project board gives me some confidence in the safeguards around the Bill. Sharon, would you like to add to that?

Ms Gallagher: Thanks, Les. Carál, I mentioned that I have been involved in that work since 2015. In 2018, I set up the staff-side forum with trade unions including NIPSA, Unite, RCN, BMA and Unison. That forum still runs, and it meets every two months. You had a previous briefing about the structure of the programme board and the projects. Trade union representatives are embedded in that process as well. We have put a strong emphasis on engagement with staff representatives.

Since taking up the post of chief executive, I have spent a lot of time and energy engaging with the staff and the board about the closure. I have met every member of staff in zoom sessions to discuss what they do now and to try to understand their future. I have also developed a new, broader, people strategy, launched this week, called Ambition. It seeks to build the capacity, capability and morale of the staff in the board again, with a focus on the future rather than the past. The decision has been made to close the board, we are moving forward on that, and my whole focus is on supporting staff into that future. I am committed to engaging with the people. I keep saying that you can put any structure on paper, but if you do not bring the people with you, you are wasting your time. It is an absolute priority for me, the team and the board in the Health and Social Care Board.

Ms Ní Chuilín: I appreciate that, Sharon.

Leslie, you are right: it is a small enough Bill. My question relates to clause 4. We are looking at transitional arrangements and provisions, which are necessary to mitigate any potential risks arising from the closure of the Health and Social Care Board. What are the current risks? For example, some of these functions will go straight to the Department and then to the trust. For particular health scandals in hyponatraemics, neurology — we have another public inquiry coming, into urology — what other risks do you anticipate needing to mitigate as part of this Bill?

The Chairperson (Mr Gildernew): Just come off mute, please, Les.

Mr Drew: Sorry, Chair. I can reassure you that responsibility for management and coordination of all of the functions will pass to the Department of Health. The Department will be responsible for risk management relating to the closure. It will be part of its internal governance and control to ensure that the risks are properly managed.

Regarding other risks, in the COVID-19 world that we are all experiencing, that, in itself, could be a huge distraction from the day-to-day business of services. Each trust has its own board, which has a role in governance and accountability. The boards will watch the delivery of services from individual hospital trusts and other service providers carefully. I believe that there is sufficient governance and accountability built into the current system and what has been planned. That gives me a high level of confidence about being able to respond to any risk that may occur.

Ms Ní Chuilín: Who is the chair of the oversight project board at the minute?

Mr Drew: The chair is Martina Moore. Is that right, Sharon?

Ms Gallagher: For the oversight board, it is the permanent secretary.

Mr Drew: Sorry, the project director is Martina Moore. The chair is the permanent secretary.

Ms Ní Chuilín: OK, but there are no staff-side representatives on that board, are there?

Ms Gallagher: No, it is primarily the chief executives of the organisations affected.

Carál, may I add a couple of points in relation to the risks? You are right that the Bill sets out four risks, which are primarily associated with the transfer of the staff, the assets and the liabilities. There are many risks, as you know, in health and social care, and you have named just some of them. Regarding the risks more broadly, in my experience over the last number of months, when I have held both roles, it has already reduced bureaucracy and hand-offs. Because I sit on the top management group, because I sit on the rebuild management board and because I work, within the Department structure, to the Minister, there is a much closer interface between what the board does, how quickly it is engaged and how quickly it responds to that. So, there are not the handoffs that there had been previously. You will know that much of the learning on some of these things has been that too many organisations have been involved. I am already starting to see, as I hope that the broader system is, how the effect of bringing the board more directly under the responsibility of the Department is really making a change in the way that we do business.

Mr Drew: I think that what Sharon has said is very true. I think that there now will be a greater line of sight between the Department and the trusts. At the moment, with the Health and Social Care Board in the middle, it creates a certain level of bureaucracy. If that is removed, the Department can deal directly with trusts, which will speed up any processes that are involved and investigations and so on.

Ms Flynn: Thank you, Sharon and Leslie. My second question was answered in response to Carál. In talking about this whole process of streamlining the commissioning of services and this new structure, both of you touched on trying to cut out of some of the bureaucracy. Leslie, you talked about the Department and the trusts having a closer connection and things being done quicker. That all sounds really positive.

Earlier, Pam touched on the appeals process. We had a bit of a discussion around this a couple of weeks back, when we had a briefing from the Department and the Bill Office team. The issue around the appeals process came up. I know that the Bill contains a mechanism for an appeals process for the primary medical providers in relation to their contracts. I asked whether there could be scope in the Bill to look at an appeals process on the commissioning of services and how that might be challenged

or questioned if necessary. The response was that they were not sure whether an appeals process around commissioning was already in place in the board, so it was a bit difficult to continue the conversation on how we will look at that set-up in the revised structure that we will be working from. Can you confirm whether a mechanism is currently in place for that process?

Ms Gallagher: Órlaithí, the short answer is that there is no appeals process. In the commissioning process, I would need to understand better what you mean by appeals. When the Minister sets the priorities and issues those through the commissioning plan direction, there is a process in place that takes all of the stakeholders involved in order to develop the response to that. That is basically the commissioning plan, and, in that commissioning plan, there are sign-offs by the boards. So, the board of the PHA and the board of the Health and Social Care Board are all involved in that. That makes sure that it is line with the ministerial priorities and that it is in keeping with our commissioning process but also is within the budget that has been allocated. There is nothing in that commissioning plan that cannot be aligned back up to the Minister's priorities or be affordable within that.

Ms Flynn: OK. That is fair enough. I know, Sharon, that you mentioned earlier that there might not be the need for an appeals process on commissioning decisions, and you made a point about the approach being taken at the minute. For talk's sake, what would happen if certain stakeholders had an issue? That has come up in the past. I have certainly dealt with different groups when a commissioning decision has been made on an issue and not everyone has been content or happy with the approach.

Ms Gallagher: It is a fair point. In fact, there are many occasions on which a lot of people are not content, but that is perhaps not about the service that has been commissioned but about the amount of funding that we can apply to that commissioning. That is a challenging one. I know that you had a briefing from colleagues in the Department just before this. There is simply not enough money to go round, so there is always that conflict between the commissioning of the service itself and how much you can fund to bring forward the service in a meaningful way that meets demand. We would all say that, in most areas, there is just not enough money to meet demand at the minute.

Ms Flynn: To pick up on that, Sharon, how will the arrangements in place now for the involvement of stakeholders in the commissioning plans and in the decisions that are made change under the new structure? Hopefully, that will determine that there is not the need for an appeals process, if everyone is content that they are having an input and that their voice is being heard. Is there a big difference between the structure at the moment and the new one in terms of the input of stakeholders?

Ms Gallagher: The new model, which we talked about earlier, is aimed at giving more accountability and financial resources at a local level so that local groups can have a conversation, understand the local need, decide on the services needed, make an investment in those services and hold them to account, so there will be the same collaborative effect. There may still not be enough money, and there might still be a little bit of conflict. I am not suggesting for one second that everybody will be content after we move into this new arena, because there are still huge challenges facing all of us in health and social care. The key point is that the groups will have the wherewithal that is sometimes missing now because of our structure and our accountabilities.

Ms Flynn: Thanks for that, Sharon. You mentioned that the chair of the oversight board is the permanent secretary. What input or role does the Minister of Health have on that board? Is it the responsibility of the permanent secretary to communicate with the Minister, or can he play an active role in the new structure?

Ms Gallagher: The role of the oversight board is to oversee the closure of the Health and Social Care Board. It would act in a normal way, with the permanent secretary chairing the meetings, and any decisions falling from that will be a ministerial decision. In the main, up to now, we have dealt with the process of closing the board: dealing with the Bill, understanding the implications and responding to that. Ultimately, all decisions are made by the Minister.

Ms Flynn: OK. That is great, Sharon.

Mr Drew: I have a couple of points. Thanks, Sharon, for your responses. The words "delegation" and "empowerment" have come up a number of times, and, for me, it is extremely important that, whichever model is put in place, there is clear delegation and empowerment and that local populations

are given responsibility for finance and resources to provide the health and social care needs of the local population.

Ms Flynn: That is great, Leslie.

The Chairperson (Mr Gildernew): I do not see any other members indicating, but if someone wants to come in with a quick point, that is fine; I will touch base with them before we go.

Reflecting on this session and on the previous sessions, I think that a lot of the right things are being said, and the Committee fully supports the direction of travel that you set out. The problem is that there is a lack of detail and clarity. Whilst we want to see the removal of unnecessary bureaucracy and the system working as well as possible, we do not want to lose involvement, local input and inclusion in the system, accountability and that improvement. It is unfortunate that it is being done in a staged way, and I welcome the commitment that you have given us, Sharon. Given that the work is so well advanced, it is important that we see the actual detail. That is where we can look at the granular detail and assure ourselves, and everyone, that the replacement system is there, is robust and ready to go and not only meets the needs but improves local involvement, co-production and the accountability process. We are all on the same page about where we are trying to get to. However, given the timing, we need to see the detail coming forward.

I do not see any other indications from members wishing to speak. Les and Sharon, I thank you for your attendance today. It has been useful, and I am sure that we will continue our scrutiny of this process and consideration. Thank you for your contribution to that. Thank you and goodbye.