



Northern Ireland
Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Health and Social Care Bill: Department of
Health; Health and Social Care Board

10 June 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 John Millar	Department of Health
Ms Martina Moore	Department of Health
Mr Paul Cavanagh	Health and Social Care Board

The Chairperson (Mr Gildernew): I welcome back to the Committee Ms Martina Moore, director of organisational change at the Department of Health; Mr John Millar, Bill team manager for the organisational change directorate in the Department; and Mr Paul Cavanagh, director of planning and commissioning for the Health and Social Care Board. Can you all hear me OK?

Ms Martina Moore (Department of Health): I can, Chair.

Mr John Millar (Department of Health): I can, Chair. Thank you.

Mr Paul Cavanagh (Health and Social Care Board): Yes. Good afternoon, Colm.

The Chairperson (Mr Gildernew): Thank you. Martina, can you brief the Committee and we will take it from there?

Ms Moore: Thank you, Chair. I will start by briefing on the planning model. John will then pick up on the Bill issues.

Thank you, Chair and members for the opportunity to be here today. We are aware that the Committee has been very keen to see the detail of the proposed planning model. I know that the Minister wrote to the Committee on 26 May with a copy, and I hope that you found that useful. I will provide you with a brief outline of the background to the project, the work that we have undertaken to

develop that framework and what the model proposes in how we plan and manage services in the future.

We know from the various reports that we need to transform how we plan our services to meet the needs of our growing and changing population. Fundamentally, as we all know, our population is getting older. People are living longer, and that brings an increased risk of longer-term and complex health conditions. As has been raised quite often at the Committee recently, those health inequalities persist in our society. Obviously, that is against the background of the huge financial challenges and unacceptable waiting times. We were facing all those challenges pre COVID, and they have been further compounded by the pandemic.

As we are looking to the future to ensure that there is a sustainable system for Northern Ireland, we must look at how we plan our services. That is about meeting the needs of today's population but also those of the future population and taking account of the changing demographic. We must place the focus on prevention: keeping more people well in the first place with early interventions, and treating people earlier to make sure that fewer people need hospital care. Essentially, it is about getting the right care at the right place at the right time. As we know, 'Delivering Together' gives us the blueprint for transforming health and social care. It articulates the need for local communities and providers to come together to plan integrated, continuous health and care based on population need, appreciating that it will always be those services that we need to plan on a regional basis.

In line with that vision, the Minister approved the programme of work at the end of last year to develop the planning model. That is based on an integrated care system approach. That approach seeks to harness not just the strengths of Health and Social Care (HSC), but to look beyond our boundaries to what can be achieved when we work in partnership with the voluntary and community sector, local government, other statutory partners and, indeed, our service users. Integrated care is not a new concept. It already happens in pockets of the system. However, rather than let it emerge on an ad hoc basis or out of necessity rather than by design, we can take the steps now to put the systems and structures in place to embed that approach as our normal way of working. As mentioned, COVID really shone a stark light on the health inequalities that continue to persist in society and the impact that they continue to have. However, it has also shown what can be achieved when we break down traditional barriers and come together; again, not just in Health and Social Care but when we work with our partners beyond the system to deliver on a shared outcome. We must embrace fully that way of working. We believe that now is our opportunity to do so.

With regard to our approach, we established a project board, co-chaired by Paul Cavanagh and me. We have brought together wide representation from relevant policy and service leads in Health and Social Care and from other sectors, such as the voluntary and community sector and the Patient and Client Council (PCC). Key to that has been our members who represent the likes of local commissioning groups (LCGs) and integrated care partnerships (ICPs), who have brought their experience from those other sectors to the table. One of those work streams has, obviously, been the one that we are focused on now: development of the draft framework that you have in front of you.

The framework sets out the blueprint for the establishment of an integrated care system (ICS) in Northern Ireland. At its core, it is about partnership and collaboration between sectors and organisations, obviously, with the purpose of improving health and well-being. It is about delivering services in a joined-up way, so not in silos or isolation. A key aspect is that all those partners are involved and invested in delivering those improvement outcomes together. It is also about autonomy in enabling more decision-making at a local level. It gives local areas more control over the planning and funding of services in their area.

The proposal is that the model will be underpinned by a population-health approach; that whole-life approach from prevention and early intervention, through primary and secondary care to end-of-life care. A population-health approach recognises the factors that are beyond Health and Social Care that impact on health and well-being and provides the circumstances to bring all the partners together round the table to understand the needs of their population and what they can do collectively to meet them. Local intelligence, evidence, data and lived experience will all be necessary to provide the information to identify what is needed most and where it is needed most and to make sure that it is delivered by the most appropriate sector, organisation and professional.

The framework was informed by the move to integrated care systems that have been developed in other jurisdictions. As I said, we have worked closely with colleagues in local commissioning groups and ICPs. While we continue to look to the experience of those other areas, we have sought to design the framework to make sure that it works for Northern Ireland and takes into account our specific

needs. It is underpinned by the clear vision to deliver together to improve the health and well-being of the people of Northern Ireland and links us into the Programme for Government, which is about enabling the population to live long, healthy, active lives.

You will see that the document details the sets of values and principles to which partners must adhere. They reflect some of the key themes that emerged during the development process. However, fundamentally, it is about the person: the person is the centre of the model.

With regard to the strategic direction, it is proposed that the model is supported by a strategic outcomes framework. Again, that is outcomes-based accountability, and aligns that with the overarching 2021-26 Programme for Government. The outcomes framework will then inform the work at each level of the model and convey the ministerial and departmental strategic direction, obviously, in line with the health and well-being priorities and needs of those populations. Again, we are looking at that, informing it with quantitative and qualitative data, and building on current knowledge from existing strategies, such as Making Life Better. That goes back to the local input and intelligence that will be key to the whole process. In particular, that link with community planning will prove critical when we are looking to identify and address those wider determinants of health and well-being and to put greater focus on health improvement, early intervention, reducing health inequalities and delivering those services to people who are in need.

If you look at the framework, you will see that it reflects the different levels that exist in integrated care systems. Broadly speaking, there are regional and local levels to the model. Obviously, they are interlinked and dependent. With the closure of the Health and Social Care Board, its staff will inform a new, important group in the Department. It will be called the "strategic planning and performance group". That group will provide continuity of business and retention of expertise in the system and will provide oversight and guidance in the development of the ICS approach. Work is under way to ensure that there is clarity between what would constitute regional responsibility against what needs that local perspective. While, at regional level, it will provide the relevant coordination and governance over the local ICS, that planning and management of regional services at the heart of an integrated care system is really what happens at the local level. That is where you see those collaborative partnerships between sectors and organisations. The framework details how they are segmented depending on population size. What we have looked at is what we are calling "area, locality and community".

If you look at the framework, you will see that we have five local areas, each covering a trust's geographical area. We propose that, in each of those areas, an integrated partnership board is established, which will bring all the partners to the table to plan, manage and deliver services to the local population based on need. An important point to make is that those are not trust partnership boards. We are used to the geography of the trusts, but, from the outset, it is essential that it is about partnership. That message came through loudly in the consultation that took place in 2015-16.

The framework details the minimum required membership for the groups that will ensure that all key partners are involved. It does not preclude any other organisations, professionals or individuals being brought to the table, either on a full-time basis or whenever it is deemed appropriate. It is for each area to decide that. We wanted to set out the minimum membership that we expect to see. Those boards will have responsibility for planning and managing services in their area that meet the needs and priorities of their population and deliver against the high-level outcomes set by the system, making the best use of collective assets and resources. They are supported by locality and community groups, which are the best-placed groups for delivering those on-the-ground changes and providing local intelligence and expertise about what is needed. The partnership boards cannot work in isolation, so, as well as their alignment and interactions with the regional structures, we want them to work collaboratively, wherever it is appropriate and beneficial to do so. The experiences of existing systems and initiatives, such as LCGs and ICPs, have built and will continue to build upon the design of that.

I mentioned the importance of partnership working and collaboration a number of times. It is imperative that we take this opportunity to strengthen our partnerships and to develop new ways of working that will result in a better experience and better service for our population. Within that remit, Northern Ireland is not a large place, but a lot happens here. We are working to ensure that we do not create duplication in the system or replicate existing structures. We do not want to repeat what is being done well elsewhere; we simply want to support those efforts by building together on what is working well. The emergence of the community planning partnerships is an example of where we can come together in a more cohesive and joined-up way. A wide breadth of partners are already involved and engaged in our model of community planning partnerships, which looks at how we can work and align with them in a way that works best for everyone.

Partnership working is not new, but it requires leadership and support. Working across boundaries and sectors is not easy and will require us to think differently about how we do things and about our behaviours and culture. Achieving a sense of trust, equality and parity between partners will be key. We will look at ways that we can support those changes through the likes of training and development. Documents, guidance, frameworks and all those things are absolutely key and fundamental. As I said, those are totally necessary. At the end of the day, however, it will be down to all of us and the actions we take to deliver against the values and principles that we set out in the vision.

The development of a fully functioning integrated care system is complex. It will take us some time to develop that model. In the first instance, it will operate under the existing governance and accountability arrangements and funding, albeit reflecting the changes from the forthcoming closure of the board. There will be a continued need to have mechanisms in place to monitor the delivery of outcomes, performance and financial accountability within the existing structures and organisations. For example, trusts will continue to be held accountable for their normal business, and the strategic planning and performance group will have a key role in making that happen. Moving forward, the new model will need to include similar requirements. From the document, you may notice that we have placed some of those requirements on the groups from the outset, including the development of partnership agreements, decision-making frameworks and the need for plans and annual achievement and progress updates.

The vision for the model is for partnership boards in local areas to have autonomy of decision-making and funding in planning for local needs. We know that funding can be a barrier, so it is important that the system is supported by a funding model that supports the change and that is clear and transparent. It will take us some time to do that. We have started that. It will take time, but that should not stop us from moving forward now. From speaking to people who are involved in integrated care systems in other areas, and even from looking at what has happened during COVID, we know what we can achieve when we come together with a shared vision. Over the next few months, while we work on the new funding model, we will explore opportunities for working together within the funding and budgets of our existing arrangements.

One thing that came up recently is that looking at governance and accountability leads to questions about legislation. From the Bill and the draft framework, you will know that, at this point, there are no proposals for any specific legislative provisions. We have looked at what has come before and what has been done elsewhere. Northern Ireland has an integrated health and social care system in statute, which puts it in a different place from other jurisdictions. That aspect is really important and will give us a sound basis from which to develop integrated care. Not immediately placing statutory requirements around the model gives us and the system the ability to test what does and does not work and to respond to the lessons that we learn with agility and responsiveness. It will give us the opportunity to evaluate and consider what legislation may be required for that and what that would look like. That is not a new way of doing things. You may know that there is a White Paper and a list of proposals for how to underpin ICSs in England. However, that was developed only after they had been up and running for a number of years and built on the lessons learned. The legislative requirements must be given full consideration, but we believe that the right approach in these early stages is to allow the model to develop and to be informed by what works well.

Chair, that was quite a run-through of the overview, and there is more detailed information in the document. As far as next steps are concerned, we intend to launch a consultation. The framework is a blueprint for what we mean. It is a vision for the future to facilitate more informed and detailed debate and discussion, which we welcome. In broad terms, there is still a lot of work to do, and we want to engage with all those involved in that detailed design.

I take the opportunity to stress that this is the beginning of a process. As I said, we know that a fully functioning integrated care system, in which we have autonomy of funding and decision-making in local areas, will not be in place for April 2022. It will take time to do that. We will have some of the key elements in place, such as the local area groups and the outcomes framework, and will be working with the groups in assessing their population needs to allow the development of the plans. In the meantime, we are working very closely with Paul and his team, not just on the development of the model but in making sure that all necessary steps are being taken to ensure that there is service continuity after the closure of the board and the migration of staff. While you may not see any significant difference in how we plan our services in April 2022, we will have put in place the early steps and foundations for the model and will be able to build on those in the months that follow.

I hope that the document and our appearance today will give you a clearer understanding of the vision that we are setting. As I said, we are very much at the start of a journey, but it is one that, we believe, can provide us with a genuinely improved way of planning our services. I am not sure whether you want to ask questions on that or to ask John to talk about the Bill.

The Chairperson (Mr Gildernew): We will take John's presentation and then ask questions on both presentations or either presentation, whichever is the case. Thank you, Martina. Go ahead, John.

Mr Millar: Chair, thank you. Following the call for evidence and subsequent evidence sessions, a few queries were raised about the Health and Social Care Bill that I would like to address. Martina has talked about future planning, and I am sure that there will be questions about commissioning. The areas that I would like to cover are consultation, budget issues for pharmacy, safeguarding training for GPs and the rationale for the movement of staff to the Business Services Organisation (BSO). I will start with consultation.

Some representatives who gave evidence mentioned a lack of consultation. You were advised previously that the public consultation on restructuring was conducted from December 2015 to February 2016 and that the consultation report was published in March 2016. That consultation received over 180 responses from a wide range of stakeholders. It largely affirmed the need for change, with a number of responses highlighting that, whilst closing the board would not cure all the issues faced by our system, having more effective structures would allow for a better focus on resources and support the system to operate more effectively and innovatively. Once again, the need for change was broadly welcomed in the responses to the call for evidence and the oral evidence sessions that the Committee has had.

A number of responses to the consultation expressed concerns about how services will be commissioned in the future. Martina provided information about the plans for future commissioning, but I want to reiterate some high-level points. A programme of work that will look at how services could be planned and managed differently has started. The consultation responses will be considered in the context of that work. That work seeks to develop a new way of planning services, which, as you heard, is based on an integrated care approach that is founded on partnership and collaboration. Engagement with stakeholders will be key to that process. There is broad representation from the various sectors on the project board, and officials have engaged with various stakeholders at this early stage of development.

Engagement will be key in going forward. It is important to highlight that, while some things are changing, other things will remain the same, for instance, staff terms and conditions for staff who are moving from the board on its closure. Engagement channels with board staff regarding closure of the board include representative bodies attending regular staff site forum meetings. The staff site forum has been meeting regularly since 2018, with NIPSA, UNISON, Unite, the RCN and the BMA all represented on it. An external engagement plan is also in place. Existing communication channels, such as the board's e-zine and website, are useful means of stimulating engagement. In addition, meetings with key stakeholder groups are already being arranged.

For those areas that are changing, consultation will be carried out on individual matters, such as future planning, which Martina mentioned, and the independent appeals process for primary medical contractors that will be developed. We hope to be able to develop a paper on that consultation that will go to the Minister in the very near future. Hopefully, that consultation will go out in the next number of weeks. Unfortunately, the consultation may go out during recess, but we will make sure that the paper gets to the Committee in advance of that. Those consultations will help to inform debate and to encourage wider engagement. The consultations will seek the views of key stakeholders and help to broaden awareness and understanding of what we seek to do.

I move to community pharmacy. Another issue raised by Community Pharmacy NI (CPNI) during the oral sessions was the possible risk of budgetary and service provision being delegated to trusts. The analysis of consultation responses also showed a concern, particularly around the proposal to give trusts more responsibility for planning care in their areas. The Bill does not provide any additional responsibility for trusts. There are also no plans for the budgets of independent contractor services to go to the trusts. The need for a stable and sustainable network of community pharmacies is recognised. Work is ongoing with CPNI to develop a road map for the long-term future for the community pharmacy services. The work under way on the future planning model will see the roll-out of an integrated care system model that will be underpinned by a population-health approach that aims to plan and deliver services that will meet the health and well-being needs and priorities of the population.

The issue of safeguarding training for GPs was raised by GP representatives at one of the oral evidence sessions. The Bill was seen by some as an opportunity to clarify the lines of responsibility for management, training and safeguarding at primary care level. However, that is outside the remit of the Bill. The objective of the Health and Social Care Bill is simply to give effect to the decision to close the Health and Social Care Board. On safeguarding training, as independent contractors, GPs are responsible for keeping their professional skills up to date, including on safeguarding, as part of their continuing professional development. The other issue that was raised was representation on the Safeguarding Board. It is our understanding that the BMA represents doctors, including GPs, on that board.

On the rationale for the board's staff moving to the BSO, as mentioned during earlier evidence sessions, the former board staff will continue, in the main, to undertake the same functions, albeit they will be directed by a senior civil servant in the Department. They will become part of the new strategic planning and performance group. With the move, there will be no fundamental re-engineering of the processes.

In determining the operational model to be introduced upon closure of the board, extensive analysis and engagement took place across the HSC to determine the optimum approach. Among the key considerations taken into account were the need to deliver on the objective to close the board, to transfer responsibility for its functions to the Department, to make best use of the skills of the staff, to mitigate the risk to service delivery and to have flexibility to allow work on a new way of commissioning services to evolve. The hosted model, where staff are under the instruction of the Department but their human resource issues remain managed by BSO, was deemed to be the best solution to ensuring that the expertise of the board staff was fully utilised. That enabled staff to retain their HSC terms and conditions whilst allowing the work on a new planning model to be brought forward.

Clause 3 places a duty on the Department to make one or more schemes for the transfer of the board's assets and its liabilities. Schedule 2 contains details on what must be provided in any scheme under that clause. The content of schedule 2 as it relates to transfer schemes is not new or novel. Very similar provisions are evident in the Health and Social Care (Reform) Act (Northern Ireland) 2009. That provided for the dissolution of a number of health bodies and the transfer of those staff, other assets and liabilities to a number of new bodies at that point. Before making a scheme, the Department must consult employees or their representatives.

I hope that that was helpful. Along with Martina and Paul, I am happy to take questions.

The Chairperson (Mr Gildernew): Thank you, John. Martina, is that the presentations done, and will we go to questions?

Ms Moore: Yes, please, Chair.

The Chairperson (Mr Gildernew): OK. Thank you very much for that. That is very interesting. I raised the point before that you would not move out of your old home until you saw what the new place was like. In that respect, you highlighted the fact that this is a new build and a self-build, and that today we are getting a look at some of the draft plans. There is an awful lot in those that seems good and positive, and I welcome that. The issue remains that, until such times as there is something solid in place, they are only plans. That is not to undermine them, but it is about how they interact with the closure of the board.

I understand that the legislation is about the closure of the board, and John touched on that, but I welcome your mention of ambition and plans. For me, in the Committee's scrutiny, we will want to see maximum ambition in how we use this opportunity to put in place the correct elements. We will want to look at how that commitment is included. I recognise the issue of consultation and getting input. That is another valid element.

I want to focus on the integrated care system that you outlined and talked about, Martina. That system would need to be driven from the top down and the bottom up, so that both elements would be involved. The Department has invested considerable time and resources since 2013 in building and developing integrated care partnerships right across the region. Those already involve GPs, the community to some degree, health charities, trusts, service users and pharmacy, for example. Does the Department intend to retain and build upon the ICP experience to develop that middle tier, which would act as a bridge between the bottom up and the top down?

Ms Moore: We are looking at that locality level at the minute, and we are saying that that needs to be built upon the experiences to date. We have a piece of work ongoing that is looking at what needs to be at that locality. We are working with the current ICPs. It is very much about their experiences to date, what has worked for them and where, perhaps, there have been limitations. We are looking at how we can build on that experience.

Somebody from the board who has an ICP team is doing a focused piece of work for me on locality. What is it that we need at that locality level? What is it that we have with our ICPs? As you said, what is the gap that we need to bridge? She is interviewing a cross section of people to get a wide range of views on that, so that she can bring a paper to us at the start of July, and we can start to look at that. As you said, it is about building on what is working well. What limitations did they perhaps feel and what do we need to do about that? It goes back to what you said: the Bill provides a unique opportunity to do things differently and to learn from the lessons of the past. We, in the team, are invested in capitalising on the opportunity and, as you said, working with experts across the system and beyond in engaging with people about what matters to them.

Mr Cavanagh: ICPs were designed to be working at the coalface in developing integrated care pathways that were very much patient-centred. Their purpose was to give GPs greater access to secondary care and to allow secondary care to develop close working with GPs. If we could develop services within primary care with GPs, that was our direction. The integrated care systems are a considerable step up from that. They are strategic, system-wide and are about connecting with wider partners. ICPs are part of the engine room for the integrated care system, but there is a lot more that we need to do strategically, including a much more comprehensive understanding of each population's needs, a much more direct connection between those needs and the services and the approaches that we need to take in each of our local areas.

The Chairperson (Mr Gildernew): This model of population health will require a significant culture change in budgeting and participation processes if it is to be successful in implementing better outcomes. Have you learned from examples elsewhere? You mentioned England, Scotland and Wales, but are you looking at anywhere else across the world where this is being done to put in place things that could sustain and develop the model?

Ms Moore: We are. As you said, we have England, Scotland and Wales, and we have been speaking with the Republic quite a bit. More recently, we have looked at Canterbury, which is an area of New Zealand that has done this quite successfully. We have been trying to tap into some of the lessons that have been learned there. The key message from across the piece, from all those areas including New Zealand, is that it is about, as you said, culture, relationships and parity. It really necessitates a shift in mindset, looking at the whole-life approach, at the outcomes and at what everybody can bring to the table and the equal role that everybody can play.

More recently, we have engaged with a woman in New Zealand who is absolutely brilliant at explaining things; if I could bring her to you, I would. New Zealand has simplified it and stripped everything right back. They have created a persona — I cannot remember her name, but it is something like Nora — and every decision that they make and everything that they do comes back to what impact it has on her. As they said, beyond counting widgets, are we actually making a difference? What is the difference that we are making to the population? As you said, how are we tackling the health inequalities and how are we really starting to make a difference? We have tapped into that.

We have created a buddying system with West Yorkshire and Harrogate Health and Care Partnership. It has been up and running for four years and has the same population size as Northern Ireland. The director there speaks to our project board quite a lot as we go through this process. Interestingly, it now wants to learn from us, because it does not have the integration of health and social care, which is a struggle for it. Its officials said that there should be upfront investment in bringing people together and creating some sort of development programme and training in the new way of working. We are saying that everybody has an equal say, and, looking at who is around that table, it will be a shift for a lot of them; it will be like letting go. We are absolutely committed to investing in that, and we are looking at that work, particularly on what happened elsewhere and where we can get recommendations on working with the likes of a leadership centre to support everybody.

The Chairperson (Mr Gildernew): That is very good and welcome. I absolutely agree with you and am pleased to hear you say that you are looking at best practice across the world. Why do we not lead

the world in this? You are right that we have unique challenges, but we also have some unique benefits, such as the integrated system, and we know that we need to transform and get the pointed edge of health out into communities early: early intervention at a community level. That is all very welcome.

My last question follows on from where you finished off, Martina: equality of arms. Obviously, the trusts will be more centrally involved in commissioning and in primary care, so what are you doing to support, sustain and develop that community level and the integrated care partnerships to enable them to compete on equal terms and be able to share that power that we are hoping transfers down to communities over their health needs.

Ms Moore: We have started that work. Initially, during these phases, we had representation from the voluntary and community sector, but it is fair to say — we all know this — that no one person can represent the voluntary and community sector because it is so diverse. As we go out to consultation, we need to get into the trust areas and see what is there. Every area of Northern Ireland is different, as you know, so no one trust area will have the same voluntary and community set-up. For us, part of it is going out to see what exists and asking how we support people in those areas to come to the table and to feel that they are there not only as a voluntary or community person but as somebody with an equal say. That is very important for us at the outset.

We are in the early stages, but we want to set the direction of travel. We have been talking to representatives, but we need to move it on a step as we go out to consultation and really get into the areas and see what is needed and how to support them to play an equal part. That is fundamental. We cannot have somebody going into a room and feeling either that they are not being listened to or that they do not understand what people are talking about. From the outset, we need to invest in that to make sure that we support it. We can do that in different ways — sorry, I can see that Paul has his hand up — and we will look across them.

Mr Cavanagh: A quick point, Colm, is that we have champions in this space. People from the voluntary and community sector have been involved in local commissioning groups and ICPs, working with trusts and so on. We want to draw on their experiences and find out how they got up to speed. We do a lot of induction and learning with them as they go, so we are thinking about what the experience has been and learning from that, and, hopefully, we will do things differently based on that experience and use some of those champions to support us in bringing other people up to speed.

The Chairperson (Mr Gildernew): Integrated care partnerships bringing local communities forward and the commissioning group that applies local democracy and input and knowledge — they are all valuable. OK. I will bring in members to ask questions.

Ms Bradshaw: I want to follow on from the last point about community partners. When I look at the paper that you supplied — thank you for that, panel — with the indicators of health and well-being such as smoking cessation, obesity and eating, emotional well-being as triggered by isolation, oral health, breastfeeding etc, as someone who was in the community and voluntary sector for 19 years, I see that no body is better placed to do the work than those community organisations. As you said, Martina, there may be some differences in capacity, but brilliant work is going on, and it is delivered at a fraction of the cost of giving it to the private sector. I encourage that work.

The voluntary sector is the other aspect of this. I am thinking of Chest Heart and Stroke or the Stroke Association and the great work that they do on rehabilitation of people after a stroke or heart attack. Will you give more detail about how you imagine that they could be properly commissioned? I always hate the thought of their selling buns, taking money from one project to fund another project or scraping together pennies for projects that are saving the health service overall a lot of money in the long term. I want a wee bit more detail on how they will be properly funded.

Ms Moore: As I said, we are in the early stages. The key point of the funding model that we want to build is this: we envisage a funding pot for an area as an ICS fund that would go to an integrated care system to allocate as it sees fit, depending on its population need. Part of that is about looking not only at what is needed for that population but at who is best placed to deliver on it. It is not always necessarily, as you say, health and social care. Those voluntary or community groups could be part of that whole-life plan.

We need to build a funding system that will, more or less, allow us to say to the Belfast or Northern integrated care system, "That is your funding pot. These are the strategic outcomes that we are

looking for a system to deliver. Can you look at your population? We established work streams for data, intelligence and all that to support it, and here is what our intelligence tells us about what your population looks like. Will you now plan to make the improvement that you collectively need in those areas?"

Again, it is, as I said, about not just automatically saying, "That is the health and social care pot, so that is for health and social care". It is about looking across an integrated care system. That will necessitate new funding models, which will be quite complex for us to do. That is why we say that we know that that will probably take us a bit longer. That is the vision, however, and that is what we want to consult on. That is the vision around that table: a collective resource to make a difference to the local population.

I do not know whether Paul wants to add anything from the commissioning side.

Mr Cavanagh: Like you, Paula, I spent half my career in the community and voluntary sector before coming to the health service, so I understand intimately the value that the community and voluntary organisations bring to health and social care, and I am deeply committed to community development approaches. We have to say from the outset that the community and voluntary sector needs to be a key partner in the integrated care system. We also need to recognise that, as Martina said, there are opportunities to do things differently. Rather than defaulting to giving the money to health and social care trusts, we need to think differently about what the community and voluntary sector brings to the table.

We need to ask the community and voluntary sector how best it wants to be represented. As Martina said, no one person in such a diverse sector can represent it. We have to give the sector opportunities to think about how it can be best represented. We need to think about how we can be much more creative in communicating and working with the sector. That is also why we are embedding this process with community planning. Community planning has already cracked some of it; it does not have all the answers but it certainly has some of them, and it is ahead of us in some of these things. That will also help us to get the intelligence right and draw on all that experience. As Martina said, we also have to look at ways to do things differently through the community and voluntary sector in future.

Ms Bradshaw: I want to reflect on two emerging themes in our evidence session, the first of which is the specialist regional approach, especially coming out of COVID. Mention was made of this trust area and that trust area, so I wonder how you will marry that together. Obviously, Belfast and Derry are central [*Inaudible owing to poor sound quality*] roll out that need for regional centres where it is possibly the best solution.

The other issue that was raised is around the roles of the Chief Medical Officer (CMO), the Chief Nursing Officer (CNO) and the Chief Dental Officer etc and how the teams around them will, potentially, be supported in order to make sure that [*Inaudible owing to poor sound quality*] broader public health role, just to see what the Department will do in terms of reconfiguration around those two issues.

Ms Moore: I am sorry, Paula, I lost most of that. I do not know whether Paul picked it up.

Mr Cavanagh: I got it, Martina, so I will kick off. It is important to emphasise that, Paula, as you know only too well, we have very specialist services, which will continue to be provided at a regional level. We then have regional services that are coordinated at a regional level but are delivered locally. However, we want, as much as possible, to ensure that we have equalisation of waiting lists and so on — things that the Committee is very familiar with.

We are committed to creating five local systems, but how will they work together at a regional level to ensure that we do not create all kinds of issues around postcode differentials and so on? Our focus over the next number of months will be to think that through a bit more. Colm, you said in your initial comments that things were top down and bottom up. We all know that that is easily said but is a lot more challenging to do. We need to recognise that there are political priorities that need to be taken forward across the whole system, but we also need to ensure that what we are learning on the ground from our population needs assessment and our delivery of services is feeding up as well, so that the Department, the Minister and so on are getting a sense of what is happening on the ground.

That is much easier said than done, Paula. I do not underestimate the challenges, but that is where our heads are at. That is our commitment: to try to make this different. If we make it different, it should

mean that the things that are coming from the top down are already informed from the bottom up. Our hope is that it should be a much more cohesive system.

Ms Bradshaw: The other question was about the role of the Chief Medical Officer —

Mr Cavanagh: I am sorry; that is in that same space, Paula. If we are doing top down and bottom up, that should also include the needs and priorities of the CMO and the CNO. They are very involved in the process of developing the model, as Martina knows. We have to bring that professional expertise to bear across the system from those senior people in the Department and, indeed, from our clinicians, our social care professionals and those people who are working in health and social care. It is about trying, as much as possible, to draw on the best evidence and practice that we are aware of and on those very skilled people in our health and social care system, in our community and voluntary sector and so on, so that, as Colm said, we can genuinely create a system that will be the envy of others, rather than our always looking to others to learn from them.

Ms Bradshaw: I thank Paul and the panel.

Ms Ní Chuilín: I thank the panel for its presentation this afternoon. A couple of my questions may have been answered, but I do not think that they were answered fully. Who appoints a regional group over the area integrated partnership board? Who appoints the members of the area integrated partnership board? It might be a Minister or a permanent secretary. That is one question.

The other question is more of a comment. You will know better than most that regional disparities and inequalities are still prevalent. They are evident in community planning and integrated care partnerships as well. How will those disparities be closed with the dissolution of the Health and Social Care Board? The consultation that happened in 2015 and closed in 2016 was very significant, but that was four or five years ago. Has there been or will there be an equality impact assessment done on that process in relation to those regional inequalities?

Ms Moore: The regional group is what was the Health and Social Care Board. That is the strategic planning and performance group and also the Public Health Agency (PHA). They will have that regional role of coordination across those area integrated partnership boards. As I said at the outset, the vision is that those areas will have autonomy. The regional group's role in that is about quality of care and, going on to your second question, about making sure that we do not end up creating inequality in doing this. It is about having that across the system as a whole to make sure that quality of care is maintained.

The membership of the area integrated partnership board will come from within the system. One thing that we are now considering during the consultation is how best to nominate members, as you say. There is no decision on that as yet. We are looking at whether it can copy the same sort of process as an LCG or whether there is a different way. We hope to have that secured and rounded up so that, when we come out of the consultation, we can move on that very quickly.

I am sorry, I missed the end of your last point.

Ms Ní Chuilín: It was about equality impact assessments. Given that the first consultation happened four or five years ago and knowing the regional inequalities in health and social care, what will we do to ensure that the services are given to everybody at the point of need?

Ms Moore: As part of this process, we will do all the required screening. We are starting that now in order to go out with the consultation, and we are doing the equality screening. We are looking at the health inequalities that you talk about. As I mentioned, we have set up a data and intelligence work stream. In that, we are really looking to pull in all the data that we can, and, again, that is not just from health and social care. There is a wealth of data outside health and social care, so we are looking at our other partners to see where we can build that picture. As you said, that will then allow us to look at what those inequalities are, and there may be disparities between areas. That is fundamental to this. We need to be able to allow those areas to plan based on those inequalities and the need and to make sure that we start to reduce them.

We have a massive piece of work. We know that it is complex. Health and social care is awash with data, but we need to bring it together in a meaningful way so that we start to understand what it is. Part of that is not about data; it is the other side of it. Data can tell you so much, but the interaction with those communities is also important. What is behind the data that shows what it means to the

people on the ground? Figures can tell one story, but you need to get it in and speak to the people to see what it means to them. What are their priorities? We can take the data and put together a list of what we think are the priorities for the system, but you need to engage with the people whom it is impacting to see what matters to them. We have a massive piece of work to do around that, but we have started it. That work stream is up and running, because, at the end of the year, we want to be in a position to pull that together for the integrated care systems and have the comprehensive knowledge that they can build on.

Ms Ní Chuilín: Chair.

Ms Moore: Screening is absolutely —

Ms Ní Chuilín: It is the full equality impact assessment rather than screening.

Ms Moore: Yes. Sorry. We will do the screening, and the impact assessments will follow.

Mr Cavanagh: Briefly, Carál, health inequalities are a key issue for us and always have been. We have been doing work on that area. In my work with local commissioning groups, for example, we have identified that certain conditions are more prevalent in urban areas, particularly Belfast and Derry. A lot of work has been done around respiratory conditions, for example. There are high levels of chronic obstructive pulmonary disease (COPD) in Belfast and Derry, and we have looked at targeted initiatives there. They are, however, in pockets, Carál. I am honest enough to say that. If we are serious about population needs, we have to understand our populations more closely and begin to address those health inequalities. Some of them relate to urban poverty, some to rural isolation and so on. It is about trying to strike the balances.

The Chairperson (Mr Gildernew): Thank you for that. There are no more questions. All of that direction of travel is very good. It is welcome, and it is good work — I acknowledge that — and, in some ways, it is exciting that we have this opportunity to build on it, but I am concerned that, unfortunately, none of it is in the Bill that we are dealing with. John, you dealt with some of the issues that have been raised throughout about the scope of the Bill being to close the HSCB, or something along those lines. However, it could have been about replacing the HSCB, which, in my mind, would have been a much clearer approach. How can the Committee and the Assembly ensure that there is commitment and buy-in to delivering on what are very positive messages?

Ms Moore: The Minister has approved the direction of travel, but we are a programme work strand within the rebuilding management board, which, as you know, has senior leaders from across HSC, all of whom have committed to, and approved, this as the direction of travel. I am totally committed to delivering on the project, and I know that Paul is too. A key part of that has to be the consideration of the legislative requirements. One thing that we ask is that that process be allowed to evolve so that we can see what works, rather than our putting something around it now that, perhaps, pigeonholes us in a space where we cannot learn from the lessons. Part of the process always has been, and will be, that consideration. We talk to other areas about that. We talk about where they have used statute, where they have not, the reasons why they did or did not, and their experience of what they did. It is about letting us examine that in more detail. It goes back to what you said at the start: it is exciting. There is an opportunity to do something and to build something that could make a difference. We have to make sure that we capitalise on that and look to do something that will make a difference, and then, perhaps, look at what statute needs to be put around it. There is a commitment to this direction of travel in the Department. As Paul said, we have engagement from across the piece, even on our project board. We have a commitment from all of the areas that sit on that board and who, obviously, have responsibility for delivering on it.

The Chairperson (Mr Gildernew): Thank you all for attending, for presenting those issues and for taking members' questions. We will continue our scrutiny process. Thank you for your assistance. Take care.