Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Health and Social Care Bill: Department of Health

9 September 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Ms Paula Bradshaw
Mr Gerry Carroll
Mr Alan Chambers
Ms Cara Hunter
Ms Carál Ní Chuilín

Witnesses:

Mr Allan Chapman	Department of Health
Ms Martina Moore	Department of Health
Mr Vincent Ramirez	Department of Health

The Chairperson (Mr Gildernew): I welcome first, by video link, Ms Martina Moore, who is director of organisational change. Good morning, Martina. Can you hear us?

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

The Chairperson (Mr Gildernew): Thank you.

Secondly, I welcome Vincent Ramirez. Vincent is involved in the organisational change directorate. Can you hear us, Vincent? *[Pause.]* We are not hearing from you, Vincent. I will just check. I think you are hearing us, but we did not hear you. You appear to be on mute, Vincent. We will come back to you in any case, but you appear to be on mute at the moment.

Thirdly and finally, I welcome from the Department Allan Chapman, who is also from the organisational change directorate. Good morning, Allan. Are you able to hear us?

Mr Allan Chapman (Department of Health): Good morning, Chair. Yes, I can hear you.

The Chairperson (Mr Gildernew): Thank you. I will just check back quickly. Vincent, can you hear us? No, we are still not hearing you. Anyway, Vincent, we will proceed to the briefing and, hopefully, that sound issue on your end can be resolved.

I welcome all three witnesses to the meeting and thank them for coming. I will go back to you, Martina. Is it you who will lead the briefing, and then we will go to members' questions? Am I correct in that?

Ms Moore: Actually, Chair, Allan will lead the briefing. Unfortunately, I have had a few connection problems, so, just to make sure you get a full briefing, Allan will take you through it.

The Chairperson (Mr Gildernew): OK. That is no problem at all. Allan, it is over to you. Go ahead and present us with your briefing. Go raibh maith agat.

Mr Chapman: Thanks, Chair and members, for the opportunity to be here today. I am aware that the Committee recently wrote to the Department and raised some queries about the proposed future planning model in the context of the Health and Social Care Bill. I know the Minister wrote to you on 22 July, and I hope that you found that useful and that it will help to inform our discussion.

I will begin with a brief update on our ongoing targeted consultation on the draft framework and the ongoing work that has been undertaken to date, and I will provide an overview of the response from the Minister to your recent correspondence. As you will be aware, the draft framework is undergoing a targeted consultation process, which launched on 19 July and will close on 17 September. The documentation was distributed to a wide range of stakeholders. We have held two workshops in order to help raise awareness of the consultation, improve people's understanding of the development of the model and encourage formal responses.

Early indications suggest that the workshops have been well received. Over 200 attendees were registered across both sessions. Initial feedback has been positive, with the majority of attendees agreeing that the proposed approach to integrated care set out in the draft framework is the right approach to adopt in Northern Ireland.

We have received a few formal responses to the consultation already. From the level of interest and engagement we have seen to date, we hope to receive substantial and useful feedback from across the system and beyond. In addition to the two workshops organised by the Department, we have supported and engaged with additional events that have been hosted by other organisations and stakeholders where possible. The responses to the consultation will be collated and analysed to further inform discussion and identify any changes that may be required to the framework. A summary response document will be produced and published in due course.

Work has also continued to progress on other aspects of the project. Work is ongoing on defining the best approach to providing the ministerial and departmental strategic direction to the model. That will take the shape of a strategic outcomes framework, which will be designed in such a way as to be reflective of the health and well-being needs of the population of Northern Ireland. The strategic outcomes framework will consist of a set of high-level outcomes that are fully aligned to those of the Programme for Government (PFG) and designed on the basis of evidence derived from latest official statistics and complemented with thorough qualitative intelligence, both from existing sources and a series of engagement events that are being planned. The engagement process, along with findings from the current consultation, will provide not only insight to understanding people's needs and priorities but key feedback on how to best capture that local intelligence on a continuous basis once the model is implemented.

A work stream has also been established comprising senior system leaders from across Health and Social Care (HSC) to consider regional services in the new integrated care system (ICS). The criteria for the regional commissioning of services requirements are being explored. Reasons that have been outlined to date include highly specialised services; small population numbers who require services; services delivered by one or more trusts for the region; and services delivered outside Northern Ireland. The direction remains that, as the ICS model matures, all services that can be planned and delivered locally should be. That is foremost in the work stream development process.

I will now move to the key issues raised in the most recent correspondence. In respect of the delivery timeline of the future planning model and when we anticipate local engagement structures being put into regulation, it is always important to remain cognisant of the pressures in the system currently as a consequence of the ongoing COVID-19 pandemic and the scale of the task at hand.

The development of a fully functioning integrated care system is a complex undertaking that will take time, and we are only at the beginning of the journey. However, I reassure members that the ICS model is being developed in order to provide the structure and mechanisms that will ensure that local input and intelligence continue to inform the planning processes; in fact, the model is seeking to expand that local input in a way that will see it further embedded in how we do things. To that end, the draft framework sets out that five local area integrated partnership boards will be established by 1 April 2022. Whilst we include indicative dates in the framework for certain other elements, such as

partnership agreements, we will, of course, be informed by the feedback from the consultation and ongoing engagement with stakeholders and by any specific timelines associated with such aspects.

We acknowledge that what will be in place on 1 April 2022 will not be the end point. Much work will be needed beyond that date to continue to support the model to develop. For example, the model will operate within existing financial and governance arrangements in the first instance, but those are areas that will be further explored over time as we come to identify what the most appropriate approach is for those aspects of the model and as the partnerships mature. It is important to stress that such developments will occur in partnership with those involved in the model; indeed, we will look to those involved to identify the right solutions for their local areas rather than impose the wrong ones.

Moving on to when we anticipate legislating for the new arrangements, there is no current set time frame or deadline for that aspect of the model. We believe that it is important that the model is afforded the time and opportunity to develop and mature before being bound or formalised within specific legislative requirements. Allowing that time ensures that any legislative requirements identified as necessary will be the right ones and that the model is not constrained by legislation in any stages before the right structures, processes and working practices are in place. The lack of specific legislation will not inhibit the ICS model from operating successfully; rather, it will maximise the opportunity for flexibility in its development. That is not an uncommon approach, and it has been adopted elsewhere. For example, in England, legislation is only now being brought forward on its ICS model after being under development for the last five years.

It is important to reiterate that consideration of the future legislative requirements to underpin the model is absolutely part of the development process. In the past, we have had a tendency to legislate first and then implement in line with that legislation. That has not necessarily provided the outcomes that were desired. In adopting our approach, we believe that the model and any future legislation will be much more effective in delivering integrated working within and beyond the HSC system.

The Committee's recent correspondence also sought consideration of an amendment to the Bill that would allow local commissioning groups (LGCs) to continue until the integrated care framework is in place. As I touched on, new arrangements, including the developing ICS model, will come into operation on 1 April 2022. Whilst a fully developed ICS model will not be in place at that date, the structures will provide the means to secure local input. They will be in place, and that will ensure that local input and intelligence continue to be an important part of the planning cycle.

It is also important that we recognise that there are potential hurdles that could present when attempting to retain LCGs given that such an amendment could not be easily or quickly drafted. Retaining LCGs beyond the closure of the Health and Social Care Board (HSCB) would require resources that are currently working on the development and establishment of the ICS model to be diverted to support the development of any necessary legislative amendments. That would have a significant impact on the time frame for bringing forward an ICS model in Northern Ireland. A new statutory basis would have to be developed and drafted for inclusion in the Bill, given that LCGs or committees are constituted under the HSC Board. The complexities involved in doing that are unknown at this point and would require careful consideration by the Office of the Legislative Counsel (OLC) and legal advisers and would entail significant work to set the details of the policy position and give effect to that in the legislation. By way of example, before any amendment to retain LCGs could be taken forward, there are a number of factors for consideration, such as identifying who would have responsibility for LCGs. In each case, the primary legislative duties, powers and responsibilities of any organisation would need to be considered and amended. The type of consultation required and with whom is another factor that would need to be considered, including the impact that could have on the timescales of the passage of the Bill.

Given the approaching end of the mandate, it is unclear if there is sufficient time to get any additional legislative requirements across the line. Adding to those policy decisions, it is also important to recognise that current members of LCGs have the skills, knowledge and experience that will be sought for membership and participation in the various levels of the ICS model. We risk diminishing the talent pool available to the ICS model, creating confusion around roles and responsibilities and, ultimately, undermining the successful development and evolution of the model. Having the existing structures retained whilst trying to champion and implement the shift to a new way of working will be challenging. It will be difficult for individuals to give the necessary time and focus that are required to extend LCGs and to commit to the development of the ICS model. In the push for retaining the existing system in statute, we could inadvertently risk replicating the system we already have and move no further move towards improving integration and the way we plan, manage and deliver our services and interventions. We could, in fact, create a status quo. The end goal of the ICS model is to expand and

give greater weight to local input in the planning process and not to reduce or devalue its importance any way. We wish to build on the foundations that the LCGs and others have provided. Overall, the retention of LCGs in statute would pose significant challenges to the development of a new way of working, but, importantly, it would also pose a genuine risk to the passage of the Bill in this mandate and, therefore, a real risk to the proposed closure of the HSC Board. Given the significant amount of time, effort and work that has been undertaken to get to this point, particularly with the HSC Board staff in order to provide certainty and clarity on their future and roles, the Department will not be supportive of such an amendment.

I will move now to Committee oversight. The recent correspondence from the Committee also suggested a possible amendment to the Bill that would allow the Committee a role in the scrutiny of transitional arrangements. I take this opportunity to assure members that we are committed to ongoing engagement with the Committee throughout the process. We suggest that an agreed schedule be drawn up for that engagement that meets the Committee's needs and that would, hopefully, negate any need for specific legislative provision in that regard. We are, of course, happy to explore that further in the session.

I move now to governance, which the Committee raised. It is useful to note that the current commissioning processes will largely remain the same on 1 April 2022, albeit they will reflect the closure of the HSC Board. Following the closure of the board, the existing statutory duty for the Department to set strategic priorities and objectives will remain as a coordinator response *[Inaudible owing to poor sound quality]* whilst the Bill will remove the requirement for a commissioning plan to be developed by the board. A plan setting out how the strategic priorities and outcomes *[Inaudible owing to poor sound quality]* required, and work is ongoing to review and improve the current process. There will, of course, be a continued need to monitor outcomes *[Inaudible owing to poor sound quality]* where accountability *[Inaudible owing to poor sound quality.]* That work will be undertaken and led by the strategic performance and planning group in the Department and will comprise the former board staff. Their skills and experience will not be lost in the process, and they will continue to carry out their duties and functions, albeit under the direction of the Department. As noted in previous correspondence and briefings, the groups will be directed by a senior civil servant of the Department and subject to departmental governance arrangements. The statutory duty will remain with the Department to prepare the framework documents that describe the roles and functions of the various health and social care bodies and the systems that govern their relationship with each other and the Department. The current HSC framework document that details those governance arrangements will be updated to reflect the closure of the board. All the HSC bodies will ultimately remain accountable to the Department and the Minister for the discharge of the functions set out in the final legislation, and the changes introduced by the Bill will not detract from that fundamental accountability.

Engagement with the Office of the Legislative Counsel has advised that the development of a suitable amendment to strengthen the governance framework, as suggested by the Committee, would require clear articulation of the Committee's expectations of what it envisages is required. That would be the starting point in the development process. Following that, the Office of the Legislative Counsel would have to be provided with a very detailed proposal about what strengthening governance and accountability across the HSC would mean if it were to draft any relevant legislative amendments. Only then would we be in a position to fully understand the impact of that and the time required to draft such an amendment. As with the amendment on the retention of LCGs that was discussed and depending on the proposed scope or complexities involved in drafting, there is the potential that the amendment could put at risk the passage of the Bill in the current mandate.

The Committee has also sought further clarification on the production of reports on commissioning and on what those reports could contain. As I mentioned, following the closure of the board, the existing duty for the Department to set the strategic priorities and objectives will remain. While there will be no statutory requirement for the board to have a commissioning plan, a plan setting out how the strategic priorities and outcomes will be met will still be required, and work is ongoing to consider how the current process can be improved. Work streams are in place to consider each step in the process, including reporting frequency and the mechanisms that monitor the performance of the system against its delivery of strategic outcomes. The Committee suggested that reports could include information on local engagement and health inequalities. That suggestion will be taken on board and further explored as part of the development process.

I will move now to the last element of your recent correspondence. The Committee requested further information on the key differences in the pay scales and terms and conditions that prevent staff coming to the Department. It is very much recognised that current board staff have important skills and knowledge and that they must be available to support the Department and the wider HSC system,

post closure. Options for the specific arrangements post closure were considered and included the hosting model and transfer of the board staff into the Department. The hosting arrangement, as members have appreciated, provides a practical solution to ensuring that the skills and expertise of board staff are retained and builds on the close working relationship with the Department *[Inaudible.]* It also enables board staff to retain their existing terms and conditions and supports a more flexible basis for further redistribution of resources as we move forward.

There were a number of factors militating against the alternative option of transferring staff into the Department. Those included clear articulation from board staff that they wished to retain their existing terms and conditions and a desire to continue their careers in the HSC. That option increased the potential risk of losing key staff and with them their knowledge and expertise, which will be critical for the present and in the future. It also did not offer the same flexibility as the hosting arrangement in allowing the work on a new planning model to evolve.

A very limited consideration of possible impacts undertaken on those at bands 8A to 8D in the board concluded that if transferred into the Department, they were likely to be placed on marked time in terms of salary for a number of years. Counterparts in the same bands in the wider HSC would not have had that restriction. That, again, would have amplified the potential risk of those staff seeking to leave current posts.

A comprehensive analysis of the key differences in the pay scales and terms and conditions between staff on the board and Civil Service pay scales and terms and conditions was not undertaken. To undertake such work would have been highly resource intensive, and it was ultimately considered unwarranted given the significance of the other reasons outlined in the selection of the hosting option.

I hope members found that briefing useful and it helped to inform your scrutiny of the Bill. We are making strides forward, and we are receiving positive feedback from stakeholders that this approach and direction for Northern Ireland is, indeed, the correct way forward. We are happy to take questions. Thank you.

The Chairperson (Mr Gildernew): OK. Thank you, Allan. I note the Department's position as set out in the letter. However, it is important to reference the fact that we had an evidence session with people who have been involved or are currently involved with some of the LCGs, and they expressed concern about the level of uncertainty about what would replace the board. I have been contacted separately by others with experience of and who work in LCGs who have a similar concern.

We are aware that the new system will include the trusts as part of the commissioning process. In recent meetings I had with GPs, I heard them express concern at the roll-out of the multidisciplinary teams. There are clearly difficulties for everyone concerned in that the skilled staff who would fill those roles are at a premium. The words used to describe it were that people are "fishing out of the same pool".

If we are in a new situation with the new ICS, where the trusts, community groups and GPs and primary care are part of the conversation, how will those differences be managed? What governance will be in place? What will be the system of checks and balances in order to provide a fair discussion? Would you agree that element of it is very uncertain and is the basis of an awful lot of the concerns about stepping off the side of the platform without knowing where you are going? How would you address that? How will this be governed?

Ms Moore: One of the things we recognise and talk to people about is that, as Allan set out, this is an evolving model. By April 2022, we want to have in place the structures and those partnerships, but we will still be undertaking the same commissioning processes in that initial phase that we are now. That is really because there is a lot of work to do in an integrated care system to make it work properly. Part of that is bringing those people together and working with them through the system. They are part of the process from the outset of putting in place the governance arrangements and funding model, so it is about how they are truly partners and have that equitable voice around the table.

A lot of the feedback we are getting is concern that the trusts will be there. The trusts are seen as a major power base, so how can we really change the culture in Health and Social Care? How do we then make sure that we have that equity and parity so that we have a framework in place so that when there are, as you say, decisions that are contentious, we have a framework that will allow those decisions to be made?

That will take time, and we understand that, but we think we can have the structures in place for April. We can work with our commissioning teams in the board, who will continue to work with the new ICS on local intelligence and planning. We will concurrently go into each of those five areas, work with those groups and put in place the support and structures that build an effective partnership and put the framework around how decisions are made, because we cannot really fall back to where we were in the past. We cannot let this become a body in which, as you say, there are big players around the table who have the say. We need to make sure that we build the space, the time and the development with everybody around the table so that this becomes a partnership, and the focus of that partnership always has to be this: what outcome are we trying to achieve? It is back to the whole population-based approach. In any decisions that are made, it has to always come back to its very simplest, which is what is best for the person at the centre of the system.

I understand your concerns, and we understand the feedback. We are running those sessions at the minute. We are asking for people to, in some ways, maybe take a leap of faith with this, but we will have the structures in place, we will have those people and we will work with them to get that local input and intelligence. We hope to go out towards the end of this month, in the strategic outcomes framework, to really talk to people about what matters to them. However, we know that we will have to put partnership agreements and decision-making frameworks in place. If a person on an ICS is not actually adhering to the partnership approaches, we would need to think about what we do about that. We are doing a lot of learning at the minute, as I said, from other systems, but we are working to make sure that the structures are in place. If we can, we will start to have those governance arrangements in place, because we cannot actually devolve the funding to those bodies until we have governance arrangements in place that can support that devolution and until we have very clear accountability and a funding system that gives the funding to that area and allows the bodies to make those decisions. It should be a simple funding system; at the minute, it is complex. We need to be quite clear about where the money is going, what it is being spent on and what outcome it is delivering for the people of an area.

The Chairperson (Mr Gildernew): I recognise the benefit of flexibility in developing. In common across the people who are involved in this, that is, community representatives, elected representatives and medical and health professionals, everyone wants to see the system improve. I do not think anyone is afraid of change in that respect. In my opinion, it probably would be better had the time been put in to developing the model before the HSC Bill was brought forward. It seems a bit like putting the cart before the horse in that respect. I accept that you acknowledge the concerns and are aware of them. It is just about how, along with flexibility, we get certainty and oversight in a way that delivers a better health system with real citizen and community involvement.

Ms Moore: One thing we are getting from people in the feedback is the need for some kind of certainty. At the minute, we are saying that this is a phased timeline because we need to develop a new funding model. There is absolutely no doubt about that. When it comes to funding Health and Social Care, we need a new model that will underpin this system. One of the takeaways we are looking at is on trying to give a bit more certainty around the timeline. As I said, under phase 1, the area integrated partnership board structure will be in place in April, but we will work over the coming weeks to try to put, as much as we can, indicative time frames around the other parts so that people have clarity about how we are moving through this journey.

If we had the time to do this again — you are right, absolutely — we would maybe develop this at the same time as the Bill. When we took this on, obviously, we had been working on the Bill. Unfortunately, as you will know, we were all redeployed to deal with COVID for a significant time last year, and that has impacted on our timeline. However, I take your point. If we had the time again and did not have those other factors that impacted against us, we would have this far further developed down the line and would be in a better position today with you.

The Chairperson (Mr Gildernew): Thank you. Reporting will be a huge job of work for this Committee for the remainder of the term, as it will be for any incoming Committee. Your paper states:

> *"I can assure you that I am content that Officials will continue to provide regular updates ... and suggest that an agreed schedule for the provision of written or oral briefing be established and agreed and finalised with the Committee in due course."*

What is the time frame for that, Martina?

Ms Moore: We want to work with the Clerk, and we are more than happy to sit down with him after this meeting and put in a complete schedule of when we will come to give you regular updates, if you are happy with that. We are happy to work with the Clerk after this meeting and will make sure that we schedule him in so that you will know at regular intervals when we are coming.

Where our timeline is concerned, we are working on implementation and comms at the minute. We are highlighting key delivery points in the system. We can do a schedule of briefings and, hopefully, identify when there are key decision points, documents or whatever so that we can make sure we bring them to you before we move forward. For example, we could probably come back to you on the strategic outcomes framework in the next couple of weeks, if you have time, obviously. We can work with the Clerk to make sure that we get a robust schedule in place.

The Chairperson (Mr Gildernew): The Committee also indicated that it felt it was important to have certain things in those reports, including, critically, health inequalities and how commissioning is addressing those inequalities.

Thank you for that, Martina. I will go to other members now. First, I will go to Carál and then to Paula. Those are the indications that I have at present.

Ms Ní Chuilín: Thank you, Chair, and thank you to the officials for the presentation. Martina, you touched on one of the points that I was going to raise about the strategic outcomes framework, which is critical. I look forward to an update on that.

We have consistently raised a concern about dealing with the gap that is in services and workforce planning now before moving into a new model. Where are our trade unions, our staff-side representatives and, indeed, our partners in the community and voluntary sector in the process? That is my first question, if you want to answer that, and then I will come back to two other small points.

Ms Moore: In the initial phases, we had a Northern Ireland Council for Voluntary Action (NICVA) representative join our project board, and in the work streams that worked on the draft framework, we had community and voluntary sector representatives from our existing integrated care partnerships (ICPs) and LCGs. We have been working with the community and voluntary sector over the last number of weeks on the framework. We had a very specific consultation session, which NICVA facilitated for us. We are looking at and setting in place a forum to look at how the community and voluntary sector directly inputs into the project, which it feels it needs. It is OK for us to perhaps say, "Would such and such work on our work stream for the community and voluntary sector?" The representatives said they could not represent the sector, so they wanted a forum where they could report on the work they were taking on, gather views and feed that back to us. We also need a forum that looks at how the community and voluntary sector is supported when its representatives are part of those area integrated partner boards. We are reflecting on that. If we have two, three or four, or whatever the number is, voluntary and community sector representatives around the table, how can they be supported at that table so that they can represent a sector? What do they need in the background? It perhaps may be a forum that they can go to with the issues.

At the minute, there is the ICP third-sector forum, which was established as part of the ICPs that are in place. That grew quite significantly over COVID. I am not sure of the latest figure, but I think it maybe has 99 voluntary and community groups or something like that. We spoke to it, because that is a mechanism that is already in place. Its representatives said that they are willing to widen the scope of that group, should any other organisation that is not involved in ICPs at the minute want to join. We are meeting them in the next couple of weeks, and we will use that forum as a basis whereby they can directly input into the work streams. When we are starting to set those up, we will look at what mechanisms they need to make sure they can represent the voluntary and community sector in their local area when they are sitting around the table and at the support, learning and development and so forth that comes with those that they will need for that work.

We have been briefing trade unions. Up to now, that has been sporadic. We are making sure that we have a staff-side forum set up that reflects the want for HSCB migration and is specific to future planning. We have been updating it about future planning. We have been meeting some trade unions separately about future planning, but we recognise now that it is a massive change that will impact across the system and that it needs to be wider than the staff-side forum that we have set up at the minute. We are working with the trade unions to put a mechanism in place whereby we have regular engagement on those detailed issues.

Was there something else, Carál?

Ms Ní Chuilín: No, that was it, Martina, on that point.

Chair, I want to mention two other small points. I appreciate that update. The feedback I received over the summer is at variance with the information you have given. It is just that people are aware of things that may happen. They know that discussions are ongoing, but they do not have a grasp of what is going to happen. The concern, which you have already mentioned, is that, when the Health and Social Care Board closes on 31 March, the framework for a fully functioning ICS model will not be in place on 1 April. That is from your own briefing. That is what has grabbed the headlines. You have a job of work to do in working with your partners in the trades unions because a lot of staff out there are unsure.

There are some additional points that I wanted to raise, Martina. The workforce planning issue has been persistent and will remain so. The other issue is addressing persistent health inequalities. The concern is that consultants have a greater say than care in the community representatives, particularly given the focus on social care at the moment and the privatisation of social care. What gaps are going to be filled to ensure that social care and care to address, if not eradicate, some of the health inequalities, can be developed, and how will that be done with the same level of equity and equality around those tables? That is, for me, one of the biggest neuralgic issues. Those are my two points.

Ms Moore: We are getting feedback. When we did the initial work on this and looked around the table at the integrated partnership boards, we were trying to make sure that we got representation from everybody who should be round that table, but without making it too big and too burdensome. A lot of the feedback that we are getting — we had it in the last couple of sessions — is probably very akin to what you are saying about the balance and that we are moving into health inequalities in an outcomes-based way. We very much predicate that on the fact our system, as it is currently designed, does not meet the needs of today's population. We need to look at a different way of doing this, and a lot of that, as you say, is about what care can be provided in the community and what the level of prevention is. That is something that we are going to have to consider very carefully over the next couple of weeks. We are going to have to look back at that table again and see how that membership needs to work.

Likewise, the issue of the chair of the group has come up as well, which is another thing that we need to look at. There has been feedback, again, probably aligned to what you are saying, that it is very Health-heavy, yet a lot of the determinants that have an impact on our health and well-being are outside the Health remit. There is so much expertise and knowledge in the community, so we are looking at that. I have engaged with the Social Care Council and we need to continue to do that to see how we can best do this.

There is a new director of workforce planning in the Department, and we have been engaging. The whole point of this is population health planning — planning for the needs of your population. If you are planning your services to meet the needs of your population, your workforce planning should all come together. We are looking to see how we can really start to factor that. When you start to look at this, when you are looking at planning for population need and planning to improve outcomes — those strategic outcomes are key — it is clear that those outcomes are beyond the Health remit.

We need to grasp that the responsibility of those groups is that wider health outcome, and we need to look at how we can start to do everything differently. It is so big and it encompasses everything. That is why we are starting to filter that out ourselves, even into the likes of workforce planning. I will be honest: at the outset, I would not necessarily have thought that I must get workforce planning in. However, you are absolutely right; it is key. If we have to plan for the future needs of the population, workforce planning must be a part of that. We are picking those points up.

Ms Ní Chuilín: Thank you.

Ms Bradshaw: Thank you, panel, for the update this morning. My questions relate to expert input and patient input, which you have touched on. Is there any more that you can say about it? I have had ongoing concerns about the removal of the board and the external expertise and years of experience that it brings to the public sector in the area of health. Can you talk a bit more about that and whether the Patient and Client Council (PCC) will have an enhanced role?

My second question is about the Health and Social Care Board's deficiency over the last 10 years in getting an ME clinical lead specialist and a regional service in place. How will the new dispensation improve that situation? More broadly, we know that there are a number of rare diseases that should have a care pathway, and we do not have the specialist clinicians and care pathway in place for those because the numbers are relatively low. How will rare diseases be picked up?

My final point is on engagement with independent contractors. I am doing some work regarding community dentists, for example, who are lobbying because they are concerned about the future of the sector and the need for their members, dentists, to move more into private work because their contractual arrangements with the Health and Social Care Board on behalf of the Department of Health are not sustainable. The issue is about the wider engagement across so many sectors.

Ms Moore: We have engaged with the PCC; it has been part of the process from the outset. For example, its chief executive sits on our project board. That is the other group that we are working with.

The situation that has been raised with us, and it is the same situation in the community and voluntary sector, is: how do we ensure that we have patients' — and carers are the other sector that has come up — input into the process? How do we get their input into the work streams without creating a burden? How do they represent views? If they are around the area integrated partnership board table, how do we support them? We want them to be around the table, to be supported there and not to feel that they are there just because the framework document says that they should be there, if that makes sense. We have therefore set up another group, which is also just starting. We worked with the PCC and the personal and public involvement (PPI) leads, and we spoke to service users who were involved in such things as No More Silos. They were adamant that we have to be clear about how it will work for patients and carers. The group, which Allan is taking now, has just been established, and we will work with it to come up with a model in which people can input directly to our project and we can support them as part of the area integrated partnership boards.

On professional staff, may I check — did you mean the professional staff of the board?

Ms Bradshaw: No, I was talking about the membership of the Health and Social Care Board — that committee —.

Ms Moore: The non-executive?

Ms Bradshaw: Yes, sorry.

Ms Moore: I suppose that the closure of the board and the transfer of its responsibilities to the Department mean that it is subject to departmental governance arrangements. The Department's board, as you know, has non-executive members as well. One of the things that we will probably have to look at, as the area integrated partnership boards and the ICS model that has been brought in develop, is the need for independent chairs. We will have to work our way through that and look at it as part of this process. We have seen it happen in England recently. I do not know if you have been following the ICS journey over there, but they have moved to put in independent chairs. That is part of our consideration. It will be important, when we develop a funding model that will allow devolution of funding to those areas, that we have those kinds of governance arrangements in place. That is all part of the journey. In the first instance, as I said, we will not have devolution of funding to build that model, but it is definitely a key consideration for us.

We also recognise the need for regional planning of specialist services, such as those you mentioned, and what we need to improve it. The basis of the integrated care system is that, as far as possible, you should allow local areas to plan. There will always be those instances, however. We are looking at what plans we need to put in place regionally to make sure that we can provide the care needed for services such as the ones you mentioned. In that space, too, we do not want the group to be completely removed from local areas, so we are looking at setting up a regional forum. It will have responsibility for delivering those services, but the areas will come in on it. A lot of the aftercare needs to be delivered close to home, so we are trying to pull it all together. We have just started that work, but it can all form part of our briefings to the Committee as we move through the process.

On the independent contractors —.

Ms Bradshaw: Before you move on to independent contractors, you are right in the sense that carers also need to have an input into the process. With rare diseases, and, because of the complexity of the

patients' circumstances in many cases, for their carers it is 24 hours a day; they do not have the time to attend or, even virtually, get involved. I am concerned that they are probably not even aware of the area groups — I am not aware of the vast majority of rare diseases — and that we would be reliant on people who are already stretched because of their domestic and pastoral responsibilities at home. As long as my concern is noted, I am happy for you to move on to the last issue that I raised. Thank you.

Ms Moore: We had an engagement session last Friday with a number of carers. We are picking up on that, and that is where it came to the fore for them. They said, "Don't rely on voluntary and community to represent us, because we are not always engaged". As you said, someone caring for someone with rare condition could be quite isolated, particularly if their time is taken up. It has become a key point for us, and we are looking at how we make sure that carers are supported.

The question about independent contractors has been raised, particularly in relation to dentists. On the membership at the table, you will have noted that they were not at the table in its initial iteration. That was not to say that they would not be at the table, but part of the consideration by the work stream was to put in a core membership that would need to be there every week. In discussing population health and prevention work, oral health is a key aspect, and the thinking of the work stream was that we would bring them on as and when, but we take the point that is coming through again from the dentists themselves about the key role that they have played, in the independent sector in particular. That is the other piece that we have to pick up and work through. Hopefully, we will get a schedule of updates, and we can work through that and take your feedback as we move through the process.

Ms Bradshaw: Thank you very much. That is very helpful.

The Chairperson (Mr Gildernew): Thank you. Picking up on Paula's point and your response, Martina, we are acutely aware of the difficulties in dentistry and the huge inequalities in the North. The key thing is that, although you say that dentists will be brought on as and when needed, if they are not in the room, you do not know what it is that you do not know; that is the problem. That is why, as far as possible, all the professions, expertise and knowledge need to be in the room.

The other thing that strikes me about that conversation is that it is about what are referred to as "rare cancers", yet half of all the deaths in the North are from what are termed "rare cancers". It is a complex situation, and therefore it is vital that we get it right.

There are no other indications from Members. Thank you very much to our panel for presenting the evidence and dealing with the questions and answers and for the written response that we will also consider. You talked about a leap of faith, Martina, and we have got a clear sense from you of genuine will to build and develop a better system across the board. Our concern emanates from the size, scale and complexity — the huge behemoth that it is — of Health and from events and inertia. Large organisations tend towards inertia, and that, more than faith, is a concern. It is about practicality and ensuring that there is oversight.

We will continue our consideration. I thank you and wish each of you the very best of luck in the time ahead. Thank you.