Committee for Health

Report on the Health and Social Care Bill

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Report: NIA 87/17-22

Contents

Powers and Membership

The Committee for Health is a Statutory Departmental Committee established in accordance with paragraphs 8 and 9 of Strand One of the Belfast Agreement 1998 and under Assembly Standing Order 48. The Committee has a scrutiny, policy development and consultation role with respect to the Department for Health and has a role in the initiation of legislation.

The Committee has power to:

- consider and advise on Departmental budgets and annual plans in the context of the overall budget allocation;
- consider subordinate legislation and take the Committee Stage of primary legislation;
- call for persons and papers;
- initiate inquiries and make reports; and
- consider and advise on matters brought to the Committee by the Minister of Health.

The Committee has nine members, including a Chairperson and Deputy Chairperson, and a quorum of five. The membership of the Committee is:

Colm Gildernew MLA (Chairperson)
Pam Cameron MLA (Deputy Chairperson)[1]
Paula Bradshaw MLA
Jonathan Buckley[2]
Gerry Carroll MLA
Alan Chambers MLA[3]
Órlaithí Flynn MLA
Cara Hunter MLA[4]
Carál Ní Chuilín MLA[5]

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[1] Gordon Lyons MLA replaced Pam Cameron as Deputy Chairperson of the Committee between 21 June and 6 July 2021.
[2] Jonathan Buckley replaced Alex Easton MLA with effect from 2 November 2020.
[3] Alan Chambers replaced John Stewart MLA with effect from 10 February 2020.
[4] Cara Hunter replaced Colin McGrath MLA with effect from 14 December. Colin McGrath previously replaced Sinéad Bradley MLA with effect from 23 March 2020.
[5] Carál Ní Chuilín replaced Pat Sheehan MLA with effect from 1 February 2021. Pat Sheehan previously replaced Jemma Dolan MLA with effect from 16 March 2020.

Executive Summary

1. This report sets out the Committee for Health's consideration of the Health and Social Care Bill.

2. The Health and Social Care Bill was introduced to the Northern Ireland Assembly on 8 March 2021 and was referred to the Committee for Health for consideration.

3. The purpose of the Bill, which contains seven clauses and three schedules, is to give effect to the decision to close the Health and Social Care Board.

4. The Committee received a total of nine responses to its public call for evidence on the Bill. In addition to the Department, the Committee took oral evidence from nine organisations, including the Chair and Chief Executive of the Board and representatives of the Local Commissioning Groups.

5. During its consideration of the Bill, the Committee highlighted a number of concerns to the Department. These included:

   - a lack of clarity/detail about the new arrangements and in particular, on what will replace Local Commissioning Groups;
   - the Department's lack of engagement with stakeholders on future arrangements;
   - a desire on the part of stakeholders to have input into the development of the future planning arrangements;
   - concerns about a diminished local input to commissioning;
   - reporting arrangements; and
   - whether the transfer of functions would deliver increased transparency and accountability and reduce bureaucracy.

6. The Committee was concerned that, with the removal of Local Commissioning Groups, there would be a gap in local engagement and input into health and social care commissioning decisions.

7. The Committee also raised concerns in relation to openness and transparency and the need for more detail on the reporting mechanisms for the new system/framework. The Committee also wanted to see any report include sections on local engagement/input and on how commissioning decisions address health inequalities. The Committee believes that having a robust and transparent reporting mechanism will provide the Assembly and the wider public, with the confidence that decisions are made according to the needs of the community.

8. The Committee welcomes the work undertaken by the Department on the new system and notes that initial proposals are out for consultation. The Committee looks forward to ongoing engagement with the Department on this issue as the new system is developed. The Committee notes that the work on the new system should have been conducted in advance of the Bill being introduced and appreciates that the pandemic may have caused a delay in this work being carried out.

9. Following consideration of written and oral evidence and discussions with the Department, the Committee remains concerned that the Bill, as currently drafted, does not include any statutory underpinning for the new health and social care commissioning system that will be in place upon the closure of the Health and Social Care Board.

10. The Committee agreed that it wished to see the Bill amended to include provision for legislative powers to place a statutory duty on the Department of Health to bring forward regulations on the new ICS Model/Framework to be laid in the Assembly and for such regulations to be approved by affirmative procedure. The Committee agreed that any regulations should include the reporting mechanism of the new model.

11. In addition, the Committee outlined its concerns in relation to a possible loss of local input during the transitional arrangements. The Committee agreed that the Bill should be amended to reflect an additional requirement that Local Commissioning Groups are retained. It was the Committee's view that an amendment of this type would allow the retention of the that Local

Commissioning Groups until regulations are approved by the Assembly to ensure there is no gap in local engagement and input.

12. At its meeting on 23 September, the Committee agreed amendments to the Bill (as outlined at paras 61-66) that would provide the Committee and the Assembly with the necessary assurances.

13. The Department of Health did advise the Committee that it was considering possible amendments to the Bill to alleviate the Committee's concerns. The Committee will consider those amendments in detail when/if they are provided in advance of Consideration Stage.

Introduction

1. The Health and Social Care Bill was introduced to the Northern Ireland Assembly on 8 March 2021 and was referred to the Committee for Health for consideration in accordance with Standing Order 33 (1) on completion of the Second Stage of the Bill on 16 March 2021.

2. At introduction the Minister of Health made the following statement under section 9 of the Northern Ireland Act 1998: '*In my view the Health and Social Care Bill would be within the legislative competence of the Northern Ireland Assembly*.'

3. The purpose of the Bill, which contains seven clauses and three schedules, is to provide for the closure of the Health and Social Care Board (the Board) and the transfer of its functions and staff.

4. Further information on the background and policy objectives of the Bill can be found in the Bill's accompanying Explanatory and Financial Memorandum.[6]

Committee Approach

5. The Committee was briefed by Department of Health (Department) officials on the principles of the Bill at its meetings on 4 March and 15 April. A Minute of Evidence of the pre-introductory briefing session of 4 March is not available, however a link to the recording of the meeting can be found at Appendix 2. The Minutes of Evidence of all the other evidence sessions held with departmental officials can also be found at Appendix 2.

6. A public notice inviting written submissions on the Bill was placed in the Belfast Telegraph, Irish News and Newsletter. In addition, the Committee invited views from a number of key stakeholders. The Committee received nine written

[6] Available: http://www.niassembly.gov.uk/assembly-business/legislation/2017-2022-mandate/primary-legislation---bills-2017---2022-mandate/health-and-social-care-bill/efm---as-introduced/

submissions in response to its call for evidence. Copies of the written submissions are included at Appendix 3.

7. During the period covered by this report the Committee considered the Bill and related issues at 16 meetings. The related Minutes of Proceedings are included at Appendix 1 of this report.

8. At its meeting on 25 March 2021, the Committee agreed a motion to extend the Committee Stage of the Bill to 1 October 2021. The extension was sought to ensure that there was sufficient opportunity to take oral evidence and carry out robust scrutiny of the clauses and schedules of the Bill while also ensuring there was time for the Bill to complete its passage before the end of the mandate. The motion to extend Committee Stage was supported by the Assembly on 19 April 2021.

9. The Committee heard oral evidence from seven of the nine organisations who provided written evidence. In addition, the Committee invited and heard evidence from representatives of the HSCB and the Local Commissioning Groups (LCGs). The Minutes of Evidence for these sessions are included at Appendix 2 and a list of witnesses who gave oral evidence is included at Appendix 5.

10. The Committee would like to place on record its thanks to the organisations who responded in writing and provided oral evidence on this Bill.

11. The Committee explored the issues raised in the evidence it received with the Department both in writing and in further oral evidence sessions. Memoranda and papers from the Department, including its response to the issues raised in written submissions on the Bill are included at Appendix 4. Minutes of Evidence of all briefing sessions with the Department officials including the (10 June) session on the Department's plans to develop future commissioning arrangements are included at Appendix 2.

12. The Committee sought advice from the Examiner of Statutory Rules in relation to the range of powers within the Bill to make subordinate legislation. The Examiner was satisfied that the delegation of legislative powers presently provided for in

the Bill was not inappropriate and that the exercise of these legislative powers was, in each case, subject to an appropriate Assembly scrutiny procedure.

13. The Committee carried out informal deliberations on the Clauses of the Bill at its meetings on 1 July, 9 and 16 September. The Committee undertook its formal clause by clause scrutiny of the Bill on 23 September 2021.

14. At its meeting on 30 September 2021, the Committee agreed its report on the Health and Social Care Bill and ordered that it should be published.

15. The next section of the report sets out the Committee's consideration of the provisions of the Bill and outlines the amendments the Committee wishes to see made to the Bill.

Consideration of the Bill

16. The purpose of the Health and Social Care Bill is to dissolve the Regional Health and Social Care Board; to make provision for and in connection with the exercise by the Department and Health and Social Care (HSC) Trusts of the functions of the Board; and for connected purposes.[7] The Bill contains seven clauses and three schedules.

17. The Committee's consideration of the clauses and schedules of the Bill was informed by the written and oral evidence it received. The Committee received nine written submissions in response to its call for evidence and heard oral evidence from seven of those organisations. In addition, the Committee invited and heard evidence from representatives of the HSCB and the LCGs. The Committee also had ongoing engagement with Departmental officials throughout its consideration of the Bill and explored the issues raised in evidence during departmental evidence sessions and by correspondence.

18. A summary of the evidence received on each clause and the Committee's consideration of the issues raised in this evidence is set out below.

19. The Department's response to the issues raised in the written submissions the Committee received from stakeholders can be found in correspondence of 3 June 2021 (Appendix 4).

General remarks

20. All of the organisations that provided evidence to the Committee on the Bill acknowledged the need for the reform of the health and social care structures and a number of those organisations welcomed the Bill as part of that ongoing transformation process. The Regulation and Quality Improvement Authority

[7] The Health and Social Care Bill, as introduced by the Minister of Health on 8 March 2021. Available: http://www.niassembly.gov.uk/globalassets/documents/legislation/bills/executive-bills/session-2017-2022/health-and-social-care-bill/health-and-social-care-bill---as-introduced---full-print-version.pdf

(RQIA) advised that it was wholly supportive of the Bill, citing the potential benefits of achieving more streamlined and responsive decision making and planning functions to support the delivery of safe, effective and accessible services for the population of Northern Ireland. The Royal College of Nursing Northern Ireland (RCN) stated its support, in general terms, for the purpose of the Bill.

21. The Committee shared stakeholders' views on the need for reform and acknowledged the Department's assertion that the closure of the Board was an important first step on a wider transformation journey. The Committee also acknowledged that the closure of the Board has been the policy position of the Department since 2015 and has been a position endorsed in turn by three Health Ministers, including Minister Swan.

Clause 1: Dissolution of the Health and Social Care Board

22. Clause 1 of the Bill provides for the dissolution of the Board and its respective committees including LCGs.

23. The main issues raised in evidence in relation to Clause 1 related to:

- a lack of clarity/detail about the new arrangements and in particular, on what will replace LCGs;
- the Department's lack of engagement with stakeholders on future arrangements;
- a desire to have input into the development of the future planning arrangements; and
- concerns about a diminished local input to commissioning.

Lack of clarity on what will replace LCGs

24. LCGs were established under Section 9 of The Health and Social Care (Reform) Act (Northern Ireland) 2009. Within the current arrangements, the five LCGs are aligned to the boundaries of the five HSC Trusts in Northern Ireland. With the

devolved authority of the Board, LCGs are responsible for the commissioning of health and social care by addressing the care needs of their local population. LCGs also have responsibility for assessing health and social care needs, planning health and social care to meet emerging needs, and securing the delivery of health and social care to meet assessed needs.[8] The effect of the dissolution of the Board removes the statutory requirement and basis for LCGs.

25. A number of the submissions received by the Committee agreed that that the current commissioning model was not as effective as it could be and was too complex for a patient base of this size and there was general agreement that the operation of future commissioning arrangements should be redesigned. However, many of the organisations expressed concern regarding the absence of detail on what will replace the existing commissioning arrangements.

26. In its written submission, the Royal College of General Practitioners Northern Ireland (RCGPNI) expressed concern about the lack of detail regarding commissioning structures with the dissolution of the LCGs. The Northern Ireland Local Government Association (NILGA) concurred, advising that the overarching issue for its members was the current lack of clarity on replacement arrangements. The Chartered Society of Physiotherapy Northern Ireland (CSP) also stated it was concern about the abolition of LCGs, the transfer of their functions to the Department, the fundamental impact this will have on commissioning and the lack of detail regarding how the commissioning process will operate in the future.

27. The British Dental Association (BDA) said it had not been provided with sufficient information to have a clear picture of what the full implications of the Bill are likely to be for dentistry and dentists. This view was echoed by Community Pharmacy Northern Ireland (CPNI) regarding the impact of the Bill on pharmaceutical services. BDA has asked for clarity on the future role of Local Dental Committees (LDCs) after the Bill comes into force, specifically in relation to their

[8] NI Assembly RaISe Briefing Paper (2011) Local Commissioning Groups: History, Establishment, Functions and Operation. Available: Local Commissioning Groups: History, Establishment, Functions and Operation (niassembly.gov.uk)

current consultative role with the Board on local issues and advised that local dental input should continue after dissolution of the Board.

28. The British Association of Social Workers Northern Ireland (BASW) stated that a lack of clarity and detail on the new structures was evident in the consultation[9] that informed the Bill and was acknowledged in the Department's later consultation analysis report.[10] BASW believed that the introduction of legislation based on that consultation showed a lack of regard for the views of the stakeholders involved. In addition, BASW highlighted that the Department has not explained how the independent expertise of the Board's Chair and non-executive Directors would be replaced. BASW added that it was also uncertain how the closure of the Board would improve efficiency and decision-making.

Engagement with stakeholders and input on future arrangements

29. Much of the evidence received by the Committee expressed frustration at the lack of engagement with stakeholders on the design of future arrangements. Without exception, the evidence received by the Committee indicated a willingness on the part of stakeholders to be involved and provide input into the development of future commissioning structures.

30. BASW advised the Committee that it has not been involved in any consultation or engagement with the Department on its future plans since the 2015 consultation.

31. BDA advised that there had been no direct engagement/consultation with BDA on the Bill and the implications for dentistry and dentists. BDA stated that the Bill presented a unique opportunity to completely overhaul how dental/oral health services are administered in Department must not be wasted.

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[9] DHSSPS (2015) Health and Social Care: Reform and Transformation, Getting the Structures Right. Available: https://www.health-ni.gov.uk/consultations/health-and-social-care-reform-and-transformation-getting-structures-right

[10] DHSSPS (2016) Health and Social Care: Reform and Transformation, Getting the Structures Right Consultation Analysis. Available: https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsc-transormation-analysis-report.pdf

32. Similarly, CPNI asserted that it is essential that the new commissioning process harnesses the strengths of community pharmacy to improve access and quality of service to patients. CPNI stated that it was critical that assurances are given that stakeholders are fully consulted on the new processes and mechanisms.

33. In its written submission to the Committee, RCN stated that it was important for the Department to define the principles that will govern the reconfiguration process and recommended a number of principles for the consideration of the Committee during its scrutiny of the Bill (see RCN's submission in Appendix 3 for further detail).

34. CSP also provided its views on how the future commissioning model should work and recommended the competencies identified by the programme of world class commissioning.[11] CSP asserted that the redesign of the commissioning process should provide an opportunity to redefine the relationship between the public sector, provider organisations (private, public and voluntary), individuals and their communities.

35. In its written submission, BASW outlined its support for a regional approach to the provision of services and cited the example of the planning mental health services outlined in the most recent draft strategy[12] as a key example. BASW advised that as new mechanisms are developed to replace the LCGs, it is vital that lessons are learned and services are not planned solely on local commissioning arrangements. RCN also asked, in response to concerns relating to growing health inequalities, for assurances from the Department that the new arrangements will more effectively deliver the commissioning of health and social care services on the basis of assessed need across Northern Ireland.

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[11] Available: https://webarchive.nationalarchives.gov.uk/ukgwa/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_080952.pdf

[12] DoH (2021) Mental Health Strategy 2021-2031: Consultation Draft. Available: https://www.health-ni.gov.uk/sites/default/files/consultations/health/doh-mhs-draft-2021-2031.pdf

36. Contrary to the lack of engagement experienced by some organisations, other organisations described both ongoing and planned engagement with the Department. RQIA advised that it was working closely with colleagues on the Health and Social Care (HSC) Migration Project Team to ensure that going forward there are clear principles of co-operation to sustain the effective working relationships that support RQIA in its work. The Southern Health and Social Care Trust (SHSCT) advised that it will play an active role in supporting the development of new commissioning arrangements and emphasised the importance of ensuring that local need and input to the process is maintained.

37. NILGA also confirmed, in its written submission, that currently LCG chairpersons are involved in discussions within a 'Draft Framework Group' on a new planning model for Trusts, refocussing direction and outputs. NILGA did however ask for increased engagement, particularly on the development of replacement mechanisms and structures. NILGA also advised that departmental officials have been meeting with the council Chief Executives, and trusted that as local services and community plans align, local elected members would be materially involved in influencing change.

Local input

38. The importance of maintaining the input of local voices in the commissioning process going forward was highlighted by many of the contributors to the Committee's call for evidence.

39. CSP advised that it was concerned that the knowledge, expertise and diversity of views on LCGs would be lost with the transfer of functions to the Department. CSP was further concerned that the structures within the Department would not facilitate the inclusion of all representative clinical groups in the commissioning process given, what in its view are, the structural inequalities that currently exist within the Department.

40. In its written submission, BDA stated it was concerned that the transfer of functions from Board/LCGs to the Department may result in less opportunity to influence and input into the process. BDA asked that mechanisms are put in

place to ensure the Department becomes more accountable going forward, with increased local input, not less.

41. CPNI shared concerns about the removal of LCGs, fearing that the local voice will be diminished, which will contract the expertise available to the process of commissioning primary care pharmaceutical services, and that this will reduce the access to experienced people to mediate ill-thought-out policies. CPNI has requested clarity on the detail of the new processes and mechanisms which will ensure that the learning of the local commissioning groups is utilise and to ensure the continuation of local input.

42. When briefing the Committee on 20 May, RCGPNI advised the Committee that its General Practitioners (GPs) currently have good representation on LCGs. In its written submission, it stated that it was vital that the development of new commissioning services would continue to include primary care voices bringing important insight into local population health need particularly at this time of Multi-Disciplinary Team (MDT) development and integration with community and 3rd Sector services.

43. NILGA provided its view, that the inclusion of local councillors in commissioning discussions and decisions added value and would ultimately assist the Minister and his officials in achieving their aims, acting as a counter to the centralisation which, in NILGA's view, seemed to be the current direction of travel. NILGA emphasised the willingness of councils to work closely with HSC partners to ensure that the eventual commissioning delivery models put in place are appropriate and maintain meaningful democratic input. NILGA advised that its elected members currently involved in LCGs are concerned that a separate forum will be created for councillors, with minimal value, to pay lip service to their role and are keen to ensure that this is not the outcome of the change brought by the Bill.

Committee deliberations and Department of Health response

44. The Health Committee shared stakeholder concerns regarding the lack of clarity on future commissioning arrangements and questioned how local input would

continue to inform commissioning decisions in the future model. The Committee was also concerned about the lack of engagement reported by stakeholders on the future planning model.

45. The Department advised the Committee that a programme of work was underway to develop the future planning model that will replace existing commissioning arrangements and processes. The Department confirmed that this work would see the development of a new Integrated Care System (ICS) model in Northern Ireland whereby local providers and communities would be empowered to come together to plan, manage and deliver care for their local population based on a population health approach, managed and delivered at a local level.

46. The Department advised the ICS model reflected the importance of ensuring local input and intelligence remain key to the shaping of HSC services that will meet the needs of the population. The Department further assured the Committee that the expertise and experience of the LCGs, in particular their role in gathering local intelligence and in informing the planning and delivery of services based on identified need, would be built upon in the design of those groups. Moreover, those groups would have the autonomy and flexibility to call upon any local partner or organisation in order to seek out the required relevant expertise in the planning and delivery of those services that will meet their population's needs and priorities.

47. The Department confirmed that a phased approach would be taken to the development of the future planning model and that the development of an integrated care system approach was a complex undertaking which would take time to develop.

48. The Committee remained concerned that it did not have enough information on the future planning model and on what would replace the work of the LCGs and following the briefing session with the Chairperson and Chief Executive of the HSC Board on 29 April asked the Department to provide further detail and briefing on the new commissioning structures.

49. The Department provided the Committee with an advance copy of the draft Framework on 26 May (see Appendix 4) and advised of its intention to engage with key stakeholders. The Draft Framework document provided information on what the ICS model will look like which will include provision for a Regional (level) Group, five Area (level) Integrated Partnership Boards (AIPBs), and locality and community level structures. The Framework document also sets out the Department's views on the development of governance, accountability, finance and budgetary arrangements.

50. The Department undertook a targeted consultation[13] on the future planning model draft framework document between 19 July and 17 September 2001. As the outcome of the consultation was not available at the time of writing this report the Committee was unable to draw upon the consultation responses to inform its consideration of the Bill.

51. The Committee welcomed the consultation on the Draft Framework, and additionally the consultation on the development of a new independent appeals process for Family Practitioner Services (FPS) contractors, as an important first step in garnering the views of key stakeholders and looks forward to seeing further and ongoing engagement work undertaken by the Department. The Committee values the important contribution that HSC stakeholders can make to the future planning arrangements and encourages the Department to continue to adapt a collaborative approach to this work going forward.

52. At its meeting on 1 July, the Committee began its informal deliberations on the Bill. The Committee remained unsatisfied about the lack of certainty and detail on the future commissioning arrangements and agreed to write to the Department to ask for:

- clarification on the timeline for when the new Future Planning Model Framework will be in place and when the Department would expect the new local engagement structure to be put within regulation;

[13] https://www.health-ni.gov.uk/consultations/future-planning-model-targeted-stakeholder-consultation

- consideration of an amendment that would allow the LCGs to continue until the new Integrated Care Framework was in place; and
- consideration of an amendment and/or process that would allow the Committee a role in the scrutiny of transitional arrangements.

53. In correspondence of 22 July and at the Committee meeting on 9 September, department officials confirmed that a fully functioning ICS model would not be in place on 1 April 2022 as the associated funding and governance arrangements would take time to develop however the structures through which local input will be provided will be in place including the establishment of the Regional Group and the five AIPBs.

54. The Department advised that the ICS model should be provided with the time and opportunity to develop and mature before being bound or formalised in specific legislative requirements. The Department's view was that it would be unhelpful to commit to a specific date for the primary or secondary legislation which may constrain the development of a final functioning ICS model.

55. In response to the Committee's suggestion that LCGs should continue until the new Framework is in place, the Department advised that although a fully functioning ICS model would not be in place on 1 April 2022, the structures through which an avenue for local input to be provided would be in place. The Department set out its reservations for the introduction of an amendment that would allow the continuation of LCGs citing the impact on finite resources within the Department and pointing out that it was likely that the individuals currently involved in LCGs would be those sought to participate in the various levels of the ICS model.

56. The Department also asserted that the Committee's suggestion would require a new statutory basis for LCGs to be developed and drafted for inclusion in the Bill and that the delivery of a satisfactory amendment would require a significant degree of development to become a coherent legislative provision. In its 22 July correspondence the Department set out the policy decisions that would need to be fully developed and agreed for such an amendment to be brought forward. The Department advised that the work and time necessary to develop such an

amendment would place the passage of the Bill within the remaining mandate and the closure of the Board at risk and confirmed that the Minister was not supportive of such an amendment.

57. At its meeting on 16 September, the Committee considered the Department's response and was still of the opinion that it would be difficult for the Committee to support this clause un-amended. The Committee maintained their concerns that the Bill, as currently drafted, does not include any statutory underpinning for the new health and social care system that will be in place upon the closure of the Board. The Committee agreed that it wished to see an amendment to the Bill to include provision for legislative powers placing a statutory duty on the Department to bring forward regulations on the new ICS Model/Framework to be laid in the Assembly and for such regulations to be approved by affirmative procedure. It is the Committee's view that such an amendment would ensure that the Committee and the Assembly would have oversight of the new ICS Model/Framework and a higher level of scrutiny would be afforded to the Assembly.

58. In addition, the Committee outlined its concerns in relation to a possible loss of local input during the transitional arrangements. The Committee agreed that the amendment should reflect an additional requirement that LCGs are retained. It was the Committee's view that an amendment of this type would allow the retention of the LCGs until regulations are drafted and would ensure there is no gap in local engagement and input. The Committee also agreed that the LCGs should cease to exist once the regulations on the new model is approved. This should prevent the Department from having to double run the two systems.

59. At the meeting on 23 September, the Committee instructed the Bill Clerks to draft amendments in respect of:

- an amendment to include provision for legislative powers placing a statutory duty on the Department to bring forward regulations on the new model for the delivery of health and social care in Northern Ireland, to be laid by way of affirmative procedure; and
- an amendment that would allow for the retention of the LCGs until such time as the Department bring forward regulations on their replacement, by way of the draft affirmative procedure.

60. At its meeting on 23 September, the Committee was briefed by the Bill Clerks on two possible options for taking forward amendments in relation to the concerns that the Committee had raised. One option was in relation to scrutiny through secondary legislation and the second option was through primary legislation.

Option one – secondary legislation

61. The Committee considered the following amendments that would provide a statutory underpinning, through regulation, for the new system. This option also included the LCGs remaining in place until the regulations on the new system are agree by the Assembly. The following amendments were considered:

Amendment 1 New Clause - New Model

After Clause 1 insert-

'New Model for Health and Social Care

(1A) (1) The Department must, before the first anniversary of this Act coming into operation, lay before the Assembly regulations to —

(a) establish a new model for the planning, management and delivery of health and social care in Northern Ireland, and

(b) set out the governance and reporting arrangements for the new model.

(2) If it is not reasonably practicable for the Department to comply with section 1A(1), the Minister must make a statement to the Assembly on why it is not reasonably practicable to do so.

(3) Regulations under this section are not to be made unless a draft of the regulations has been laid before, and approved by a resolution of, the Assembly.'

62. The inclusion of a new clause, as outlined above, would allow the Board to close but places a statutory duty on the Department to produce secondary legislation to make provision for a model for health and social care (subsection (1)(a) and (b)), using the draft affirmative procedure (subsection (3)). Subsection (2) of this new clause places a statutory duty on the Minister to make a statement to the Assembly if the Department is unable to lay said regulations before the first anniversary of the Act coming into operation.

63. The terminology in respect of the new model, namely the Integrated Care System has been referred to at a higher level ('new model for delivery of health and social care') in order to avoid any future difficulties if there are any changes to the way in which the model is referred to /named. The new clause also provides that the regulations should set out the governance and reporting arrangements for the new model.

Amendment 2 - Repeal of the LCGs

Clause 4, page 2, line 14

At end insert -

'(4) The Department may by regulations repeal section 9 (Local Commissioning Groups) of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

(5) The regulations provided for under section 4(4) must not specify a date which is earlier than date on which the regulations provided for under section (1A) of this Act are approved by a resolution of the Assembly.

(6) The regulations provided for under section 4(4) are not to be made unless a draft of the regulations has been laid before, and approved by a resolution of, the Assembly.

(7) Regulations under section 4(4) may make such amendments to the Health and Social Care (Reform) Act (Northern Ireland) 2009 and this Act as are necessary or appropriate in consequence of the repeal made by the regulations.'

64. Amendment 3 allows for the continuation of the LCGs while Amendment 2 provides the Department with a mechanism to allow for the closure of the LCGs by repealing section 9 of the 2009 Act and will ensure the LCGs and any replacement do not run concurrently.

Amendment 3: Continuation of the LCGs

Schedule 1, Page 5, Line 3

In paragraph 11 leave out "and (b)"

Schedule 1, Page 42, Line 35

In paragraph 232, leave out "7 to 11" and insert "7,8,10 and11"

Schedule 1, Page 42, Line 35, at end insert-

232(A) In section 9(1) —

(a) for "Regional Board" substitute "Department"
(b) omit "in accordance with paragraph 7 of Schedule 1"

232(B) In section 9(3)(b), for "Regional Board may, with the agreement of the Department," substitute "Department may"

232(C) Omit section 9(6)(b)

232(D) Omit section 9(7)

Schedule 1, Page 42, Line 37 Leave out "and Local Commissioning Groups"

Schedule 1, Page 42, Line 38

Leave out paragraph 233(b)

Schedule 1, Page 42, Line 39

Leave out paragraph 233(c)

Schedule 1, Page 43, Line 38

Leave out "and Local Commissioning Groups

65. This will allow the Department to repeal section 9 by regulations subsection (4), using the draft affirmative procedure in respect of the LCGs (subsection (6)) which are retained by way of Amendment 3. Subsection (5) assures that the repeal of section 9 cannot take place on a date before the regulations on the new model for health and social care (provided for under the new clause (1A) have been approved by the Assembly.

66. This amendment seeks to allow for the continuation of the LCGs by amending paragraph 232 of the Bill in order to retain section 9 of the 2009 Act which legislated for the LCGs. The additional amendments are all consequential amendments that need to be made as a result.

Option 2 – Primary Legislation

67. The Committee also considered amendments that would provide a statutory underpinning, through primary legislation, for the new system. This option also included that the Board remaining in place until the primary legislation was laid. Therefore, LCGs would remain in place until the primary legislation is laid. The following amendments that would make this provision were considered:

New Clause - New Model (Primary legislation)

After Clause 1 insert-

'New Model for Health and Social Care

(1A) (1) The Department must, before the second/third/fourth anniversary of this Act coming into operation, bring forward to the Assembly legislation to —

(a) establish a new model for the planning, management and delivery of health and social care in Northern Ireland, and

(b) set out the governance and reporting arrangements for the new model.

(2) If it is not reasonably practicable for the Department to comply with section 1A(1), the Minister must make a statement to the Assembly on why it is not reasonably practicable to do so.'

68. This new clause would place a statutory duty on the Department to produce primary legislation to make provision for a model for health and social care (subsection (1)(a) and (b)). Subsection (2) of this new clause would place a statutory duty on the Minister to make a statement to the Assembly if the Department is unable to bring forward legislation before the (agreed) anniversary of the Act coming into operation.

New Clause Delay the commencement of Clause 1/dissolution of the Board

Oppose the question that Clause 6 stand part of the Bill and insert new Clause 6

After Clause 5 insert-

'Commencement

6. — (1) Section 1A of this Act comes into operation on Royal Assent.

(2) The other provisions of this Act come into operation on such day or days as the Department may by order appoint.

(3) An order by which section 1 comes into operation may not be made unless the legislation provided for under section 1A of this Act is laid before/approved by the Assembly.'

69. This new clause would delay the dissolution of the Board and commencement of Clause 1. Subsection (1) allows for the new clause (1A) to come into operation upon Royal Assent with the other provisions (subsection 2) on day(s) the Department appoint. Subsection (3) provides that the Board cannot be dissolved unless the legislation is laid/approved. This amendment would mean that the Board could not close until primary or secondary legislation on the new model for the delivery of health and social care has been laid.

Committee consideration of options

70. At the meeting on 23 September, the Committee considered the two options and discussed the benefits and possible drawbacks of the amendments. The Committee agreed that there was consensus that the Board should close and option 2 would mean that the Board would not be able to close until primary legislation was laid, which could take a considerable amount of time. The Committee came to the decision that option 1 amendments, through regulation, would provide flexibility while underpinning the Committee's and Assembly's role in approving any new system. The Committee noted that this would not prevent the Department from bringing forward primary legislation once the new structures have bedded in.

71. Option 1 amendments would also provide continuity for the LCGs until the new regulations are approved by the Assembly, this will ensure that there is continuity in local engagement on health and social care decisions.

72. The Committee agreed to take forward amendments 1-3 of option 1. The Committee noted that the Department has advised that it is considering amendments on this clause of the Bill to address the Committee's concerns. The Committee agreed to consider those amendments when they are available.

73. The Committee also agreed that it would not table the agreed amendments in the Business Office until it had considered the Department's proposed amendments or the Department schedule consideration stage.

Clause 2: Transfer of the Health and Social Board Legislative Functions

74. Clause 2 of the Bill introduces Schedule 1 which provides for the transfer of the Board's functions to the Department and the Trusts. Most duties and responsibilities previously held by the Board will go the Department, while social care and children functions are placed with the Trusts. The Department will retain oversight responsibility for the functions exercised by the Trusts.

75. The main issues raised in evidence in relation to Clause 2 related to:

- the rationale for the transfer of functions to the Department and Trusts and requests for further detail relating to the transferred functions;
- Engagement and input on future arrangements; and
- Whether the transfer of functions would deliver increased transparency and accountability and reduced bureaucracy.

76. The Department's response to specific issues raised in the written submissions can be found in the Department's correspondence of 3 June 2021 (Appendix 4).

Transfer of functions detail and input on future arrangements

77. Some organisations highlighted in their submissions to the Committee that there was insufficient detail in relation to the transfer of the functions from the Board and that the rationale for the transfer was not clear. Others, such as RCGPNI, stated its support for the clarity provided in the Bill regarding the transfer of responsibility for primary care contracts to the Department of Health.

78. In its written submission, BASW stated that there has been a lack of transparency concerning the functions that will transfer to the Department and those that will transfer to the Trusts and requested that the Department provide further detail. In its later oral evidence to the Committee on 27 May, BASW advised that the permanent transfer of functions currently delegated by the Board to the Trusts did not lead to concern and was not expected to have any direct impact on the delivery of services. What did concern BASW was the Department's failure to communicate the implications of the draft legislation to the social work profession.

79. BASW asked for clarity relating to changes that Schedule1 of the Bill will make to the Health and Personal Social Services (Northern Ireland) Order 1991 in respect of the functions to be exercisable by the Trusts on behalf of the Department and queried whether there will be substantive changes to the liability of the Trusts concerning the exercise of delegated functions. BASW also requested further detail on changes that will be made to the Health and Personal Social Services (Northern Ireland) Order 1972 and the Health (Miscellaneous Provisions) Act (Northern Ireland) 2008.

80. While RCN argued that it is was not clear why the current functions of the Board in relation to social care and children's services would, as defined at clause 2, transfer to the Trusts, RCGPNI considered the transfer of responsibility for social care and children to the Trusts as appropriate.

81. RCGPNI did however identify that there was an opportunity to clarify the lines of responsibility for management and training in safeguarding at primary care level. RCGPNI advised that since the establishment of the Safeguarding Board for NI, there has been confusion over the representation for primary care physicians and

lines of responsibility for oversight of training and support of safeguarding in primary care. RCGPNI believe that the bill offered an opportunity to revisit the issues inherent in the current structures affording an opportunity to strengthen links with the Trust's safeguarding processes.

82. In its written submission, CPNI stated it was concerned that there was a possible risk of budgetary and service provision being delegated to the Trusts. CPNI is concerned that under such a delegated arrangement, Trusts may see the opportunity to off-set secondary care budget deficits through reduced FPS funding allocations. CPNI state that it is critical that funding for community pharmacy is ring-fenced. CPNI has also request clarity on the changes the Bill makes to the Health and Personal Social Services (Northern Ireland) Order 1972 in respect of the arrangements for additional pharmaceutical services.

83. In its written submission to the Committee, BDA advised it was concerned at the lack of communication from the Department on the transfer of responsibility for independent General Dental Practitioner (GDP) contracts and want an opportunity to input and be consulted on these new arrangements.

84. BDA cited similar concerns about the lack of consultation and input in relation to the new independent appeals process referred to in Clause 2. This was a concern echoed by CPNI, who also requested that it is consulted on the composition of the "prescribed body" that will deal with appeals.

85. It is important to note that the Department has since launched a consultation[14] on the development of a new independent appeals process for FPS contractors upon the closure of the Board. The 8-week targeted consultation closes on 24 September 2021. The Committee looks forward to considering the outcome of that consultation.

[14] Available: Family Practitioner Services Independent Appeals Consultation | Department of Health (health-ni.gov.uk)

Increased transparency/accountability and reduced bureaucracy

86. In its written submission, the SHSCT advised that it will be important to have transparent accountability arrangements within the system to deliver the benefits anticipated from the Bill. BDA stated that full transparency around the new commissioning process, including who is ultimately responsible and accountable for budgets, and the policy they are working towards needs to be an important consideration of the Bill.

87. In its submission, BASW stated that it did not believe that the transfer of duties and responsibilities to the Department would have any demonstrable impact in terms of enhancing accountability and in fact it believed that the transfer could effect a reduction in transparency. By way of example BASW pointed out that currently the Board's meeting papers are published which allows for scrutiny of decision making, but advised that this level of transparency is not replicated by the Departmental Board which publishes minutes but not the associated papers. In the interests of maintaining existing accountability, BASW stated that it is essential that the Department continues to publish information on the statutory functions delegated to the Trusts on an annual basis following the closure of the Board.

88. RCN highlighted similar concerns, stating that it was not convinced that transferring the functions and associated processes of the Board to the Department would result in a reduction in bureaucracy. RCN advised that it was not convinced that simply transferring the functions of the Board to the Department constitutes a streamlining of bureaucracy and nor does it automatically render more efficient the key processes of commissioning, performance management, and financial management.

89. CPNI expressed a similar view, stating that the current HSC administrative structure needs reworked, but that the aim should be to remove layers of bureaucracy, not simply transfer these from the Board to the Department.

90. CSP stated in its written submission that with the transfer of functions to the DoH, a governance framework for the oversight of health service commissioning in Northern Ireland should be published. CSP set out that this should define how the

commissioning process will operate within the Department's current structures, its leadership, its membership and its relationship to the wider health and social care system. It should be clear within the governance framework how the commissioning process will operate, how decisions will be made, including managing conflicts of interest, and how it will engage with stakeholders and exercise financial control and risk management. CSP also want to see the retention of the requirement for commissioning plans to be approved by the Public Health Agency (PHA) in future arrangements.

91. RCN supported this call for a proper governance structure and in oral evidence to the Committee (20 May) stated this would enable transparency around accountability and responsibility.

92. In oral evidence to the Committee, RCN highlighted that in addition to commissioning, the Board has important performance and financial management functions. RCN said it was concerned that the transfer of these functions to the Department may lead to a lack of independent scrutiny as the Department will be responsible for both commissioning and assessing performance.

Committee deliberations and Department of Health response

93. During its deliberations on the Bill the Committee remained convinced of the importance of ensuring openness and transparency in the decision making process for the commissioning of services and wanted to be assured that there would be a strong governance framework within the new structures.

94. The Committee wrote to the Department to ask how the governance framework could be strengthened to enhance the transparency of decision making and asked the Department to consider what amendments could be made to the Bill that would provide the Committee with that assurance.

95. The Department responded[15], advising the Committee that the current commissioning processes will remain largely the same on 1 April 2022 and when

[1515] DoH correspondence of 22 July 2021 (Appendix 4).

the Board closes there will be a continued need to monitor the delivery of outcomes, performance and financial accountability and that mechanisms will be in place to achieve this. The Department advised that this work will be undertaken by the Strategic Performance and Planning Group within the Department and will comprise the former Board staff. This Group will be subject to departmental governance arrangements. The Department confirmed that the current HSC Framework document will be updated to reflect the closure of the Board and governance arrangements.

96. The Department further advised that in relation to the ICS model, the draft framework for the model does set out the requirement for each local area to develop partnership agreements and decision-making frameworks to provide transparency and clarity on the approach to collaborative working and decision making. The development of new governance and funding mechanism will take time and therefore the model will operate within the extant arrangements initially. The ICS model will reach maturity at the point that new governance mechanisms are in place facilitating devolved funding and decision making powers to ICS, at this point, the HSC Framework will be updated accordingly.

97. The Department advised that the development of a suitable amendment as suggested by the Health Committee would be problematic and the Minister was not minded to make such a commitment, however commitment that officials would provide the Committee with ongoing updates and briefings on the development of the ICS Governance Framework was confirmed.

98. The Committee welcomes the commitment from Departmental officials to provide a schedule of briefings over the coming period which will allow the Committee to be kept informed of progress on the ICS model and associated governance framework. The Committee is keen to ensure that openness and transparency is at the core of the framework and will provide everyone with the assurance that decision making is evidence based.

99. The Committee is content that the governance framework for the new model will form part of the proposed regulations on the new structures and therefore how performance will be monitored and reported will be subject to scrutiny by the Committee and the Assembly.

100. Another matter that concerned the Committee was that Schedule 1 will end the statutory requirement by the HSCB to prepare and publish each financial year a commissioning plan in respect of Health and Social Care. At present the Commissioning Plan is developed and agreed in consultation with the PHA.

101. It was the Department's view that as the responsibility of the functions of the former Board will transfer to the Department the process of developing a Commissioning Plan in response to a Commissioning Direction is no longer practicable as both areas would now be within the Department's responsibility. However the Department also acknowledged the input, expertise and role of the PHA in the planning of services and advised this would continue within the new operating model. [16]

102. The advance copy of the Draft Framework document provided to the Committee in May set out the Department's proposals to replace the commissioning plan direction and commissioning plan:

- The Minister and Department will set out a clear strategic direction with expected outcomes. This will replace the current Commissioning Plan Direction and will provide a high-level overview of the key priorities that must be delivered by the wider system.
- The Regional Group will be responsible for the production of an annual Regional Population Health and Wellbeing Plan in response to the strategic direction. This will set out how the wider system will deliver against the priorities and improve outcomes for the population. It will include detail on the financial and budgetary position as well as how performance and success will be monitored, and effectively replaces the existing Commissioning Plan.
- Each AIPB will develop a work plan / joint delivery plan for their area in line with the strategic direction. This will look to deliver against the key priorities and will take account of local population needs. This will be reported to, and require approval from the Regional Group.

[16] DoH briefing paper 12 April 2021 (Appendix 4)

103. At its meeting on 1 July the Committee agreed to ask for further clarification from the Department on how often the reports on commissioning would be produced by the Department and if those reports could contain information on areas such as local engagement and how decisions address health inequalities.

104. In response[17] the Department advised the Committee that specific work streams are in place to consider each step of the process including reporting and frequency and the mechanisms which will monitor the performance of the system and its delivery against the strategic outcomes. The Department advised that it would consider the Committee's suggestion that the reports contain local engagement and health inequalities information as part of the development process.

105. The Committee is content to allow the Department time to consider the responses to its current consultation on the new system and that the Department will bring forward proposals and how it will report on monitoring of performance and delivery of strategic outcomes. However, the Committee is clear that any report should provide transparency in the decision making process and include what local engagement has taken place and how health inequalities have been addressed in decisions made.

106. During its consideration of Clause 2, a number of Committee Members queried whether there was merit in developing an appeals process relating to commissioning decisions and explored this idea with stakeholders during the oral evidence sessions.

107. RCGPNI advised that any appeals process should be robust, appropriate and timely, while RCN stated that if the commissioning process is right, with co-production and co-design, an appeals process would not be necessary.

108. In response to the Committee's discussions on the potential for a commissioning appeals process, the Department confirmed that there was no appeals process in relation to commissioning decisions within the current system.

[17] DoH correspondence of 22 July 2021 (Appendix 4)

The Department advised that the Board engage the Trusts in the planning process to ensure there is a general consensus on the services to be commissioned to deliver against the commissioning direction. The Department went on to advise that should a Trust feel that other services should be commissioned then they have an number of ways of taking this forward with the Board, either via correspondence or through the regular Trust/Board meetings.[18]

109. The Department confirmed that it had no plans to develop a specific appeals process for commissioning decisions. It was the Department's view that an appeals process in relation to commissioning decisions would not be within the scope of the Bill.

110. The Committee was satisfied that a robust, transparent and accountable commissioning process would not require a separate appeals process and that a clear and concise governance framework and reporting schedule should provide the openness and transparency that is necessary.

Clause 3: Schemes for Transfer of Assets and Liabilities

111. Clause 3 of the Bill places a duty on the Department to make one or more schemes for the transfer of all the assets and liabilities (including employed staff) of the Board to another relevant health body.

112. Clause 3 also introduces Schedule 2 which provides for continuity in terms of providing that a transfer scheme does not affect the validity of anything done by or to the Board (including legal proceedings) before the transfer date.

113. Issues raised in evidence in relation to Clause 3 related to: the rationale for the transfer of the employment of staff to the Business Services Organisation (BSO) under a hosting arrangement; clarity on staffing structures within the Department; and questions whether the transfer of staff would reduce bureaucracy and improve efficiency.

[18] DoH correspondence 28 April 2021 (Appendix 4)

114. RCN stated that there was no clear rationale for the decision to transfer the employment of Board staff to BSO but the same staff becoming operationally accountable to the Department. RCN argued that the phenomenon of staff being operationally accountable to one organisation while their line management accountability resided with an entirely different organisation was a recipe for confusion.

115. BASW stated that it was not clear how the transfer of staff of the Board to BSO would have any demonstrable impact in terms of reducing bureaucracy.

116. BDA requested clarity on management responsibility for the Board's dental staff when they move to the Department and asked for clarity on the office of the Chief Dental Officer (CDO) within the new arrangements. BDA also highlighted, both in its written submission and in its oral evidence to the Committee, its concerns regarding the fragmented administration of dentistry in NI; the absence of an up to date oral Health Strategy and the need for reform of the General Dental Services (GDS) contract. BDA also questioned whether oral health policy was given sufficient priority within the Department and highlighted its concern about the downgrading of the role of the CDO within the Department.

117. BDA set out its preferred approach to bring the administration of dentistry under a new dental unit to be created within Department, headed up by the a CDO, reporting directly to the Permanent Secretary and would have a seat at the top Departmental Management Board. This would address, in BDA's view, the previously disjointed structures between the Board/the Department and CDO, and would help streamline dental administration by bringing together policy, strategy and dental services together under a common aim of improving the population's public health.

Committee deliberations and Department of Health response

118. The Committee noted the Department's confirmation that existing employees of the Board will transfer to BSO on the same terms and conditions as they currently have and was reassured by the Department that there had been regular engagement through a staff engagement forum to keep staff and unions sighted

and involved in the development of proposals. The Department also advised the Committee that no major issues or concerns have been identified. The Department further confirmed that no former Board staff would be made redundant as a result of the closure and there would be no movement/dispersal of staff to other parts of the Department, the Trusts or the PHA.

119. The Department further advised that when the Board closes, the staff will continue in the main to undertake the same functions, under the direction of a senior civil servant within the Department. In this step there will be no fundamental reengineering of process. This model gives effect to supporting the movement of the current functions of the Board to the Department, strengthening decision making and accountability and utilising fully the skills, knowledge and experience of existing Board staff.

120. When carrying out its deliberations on the Bill the Committee wanted to understand the key differences in the employment terms and conditions that prevented staff from transferring directly to the Department and asked for clarification from the Department.

121. The Department advised[19] in response that it had considered a number of options for the transfer of Board staff including transferring into the Department, however a number of factors mitigating against transfer to the Department were identified. These included: Staff of the Board wish to retain existing terms and conditions and the opportunity to continue their careers within HSC; the potential risk of key staff seeking to leave; less flexibility than the hosting arrangement; and advice that costs could not be quantified without significant resource intensive detailed work being undertaken in terms of a TUPE type exercise for each individual affected.

122. The Department confirmed that it did not undertake a comprehensive analysis of the key differences in the pay scales and terms and conditions as it considered this work nugatory given the significance of the other reasons for the selection of the hosting arrangement.

[19] DoH correspondence 22 July 2021 (Appendix 4).

123. The Committee accepted the Department's explanation of the transfer of the Board's staff under the hosting arrangement, but agreed to seek further information on this issue.

Clause 4: Transitional provision

124. Clause 4 of the Bill introduces Schedule 3 which contains provisions that require the Department to make arrangements for the preparation of the final accounts and report of the Board. Further, the Auditor and Comptroller General must examine and provide a report to the Department. The Department must provide these reports to the Assembly.

125. Part 2 of Schedule 3 provides General Provisions and Specific Provisions to ensure continuity in terms of previous directions issued, and how references to the Board in statutory provisions or statutory documents are now to be read. In addition, the Department may continue anything being done by or to the Board (including legal proceedings) following its closure.

126. The Committee did not receive any views or comments relating to Clause 4 of the Bill.

127. At its meeting of 23 September, the Committee agreed to amendment number 2 (at para 64). This amendment provides the Department with a mechanism to allow for the closure of the LCGs by repealing section 9 of the 2009 Act and will ensure the LCGs and any replacement do not run concurrently. This amendment is a paving amendment for amendment 3 which retains the LCGs.

Clause 5: Interpretation, Clause 6: Commencement, and Clause 7: Short title

128. Clauses 5, 6 and 7 are standard interpretation, commencement and short title clauses respectively.

129. Clause 5 defines certain terms used in the Bill, including applying the Interpretation Act (Northern Ireland) 1954 to the expressions “statutory document” and “statutory provision”.

130. Clause 6 stipulates that the provisions of the Act will come into operation either on Royal Assent or on a date subsequently decided by the Department.

131. The Department has indicated that the anticipated closure date of the Board is 31 March 2022, with the new arrangements coming into place from 1 April 2022. The Department advised that these dates have been chosen to mitigate against a number of potential risks, such as complications associated with a closure part-way through a financial year, double running of systems and double accounting requirements. It is the Department’s view that the proposed closure date will minimise any potential issues with governance and accountability arrangements.[20]

132. While it is the Department's intention that the commencement of clauses 1 and 2 will take effect from 31 March 2022, this date has not been included in the Bill. The Department believe that including a fixed date in legislation provides an unnecessary element of risk, including unforeseen delays in the progression of the legislative process.

133. Clause 7 sets out the title of the Act.

134. The Committee did not receive any views or comments in respect of Clauses 5, 6 and 7.

[20] DoH Briefing Paper 12 April 2021 (Appendix 4)

Regulatory Making Powers in the Bill

135. The Bill contains six new departmental regulation making powers. These regulation making powers will:

- provide for regulations to be made (if necessary) to address the potential risk of any non-alignment of existing statutory instruments not already identified as a consequence of the closure of the Board and commencement of new arrangements;
- provide the Department with the power to make regulations to establish a body independent of the Department to deliver a transparent independent dispute resolution process in the event of contract disputes arising in relation to Primary Medical providers such as GPs and Dentists etc.;
- provide a power for the Department to make regulations to amend the list of Social Care and Children functions conferred directly on the HSC trusts;
- provide a power to the Department to make regulations so that the power of the Department to give directions and guidance, etc. to a HSC trust outlined in paragraph 6(2) to paragraph 8 of Schedule 3 may apply to a substituted body or person to whom the Department has directed to exercise Social Care and Children functions should the exercise of those functions be removed from a HSC trust;
- provide the Department with a power to make regulations to amend any statutory provisions as may appear to the Department as necessary, to facilitate and safeguard the exercise of those Social Care and Children functions by a substituted body or person following the removal of Social Care and Children functions from a HSC trust, should that be necessary; and
- provide the Department with a power to make regulations to amend any statutory provisions as may appear to the Department necessary to facilitate the exercise of functions delegated to HSC trusts.

136. The Committee sought advice from the Examiner of Statutory Rules in relation to the range of powers within the Bill to make subordinate legislation. The Examiner was satisfied that the delegation of legislative powers presently provided for in the Bill was not inappropriate and that the exercise of these

legislative powers was, in each case, subject to an appropriate Assembly scrutiny procedure.

137. The Examiner did however advise the Department that there was an omission in the content of the Memorandum. The omission related solely to the non-inclusion of the powers provided in Clause 6 (1) of the Bill that allows the Department to bring into operation on such day or days as it may appoint by (Commencement) Oder the provisions identified in section (1) of Clause 6.

138. In response, the Department updated the Delegated Powers Memorandum to reflect the omission identified by the Examiner. The Department advised the Committee that the remainder of the Delegated Powers Memorandum remains unchanged.

139. The Committee proposed an amendment for a new Clause at 1A, will provide the Department with additional regulation making powers in relation to the new system.

Clause by clause consideration of the Bill

140. Having considered the written and oral evidence received on the Bill, the Committee undertook its formal Clause-by-Clause consideration at its meeting on 23 September 2021. The related Minutes of Proceedings of the Committee's clause by clause consideration are in Appendix 1 and the Minutes of Evidence of the proceedings are in Appendix 2.

141. Information on the Committee's deliberations on the individual Clauses in the Bill can be found in the previous section of this report.

Clause 1: Dissolution of the Regional Health and Social Care Board

142. **Agreed:** The Committee agreed that it was content with Clause 1 as drafted.

New Clause 1A: New Model

143. The Committee considered its proposed amendment to insert a new Clause 1A: New Model, to place a statutory duty on the Department of Health to produce secondary legislation to make provision for a model for health and social care using the draft affirmative procedure:

After Clause 1 insert –
'New Model for Health and Social Care
(1A) (1) The Department must, before the first anniversary of this Act coming into operation, lay before the Assembly regulations to —

(a) establish a new model for the planning, management and delivery of health and social care in Northern Ireland, and

(b) set out the governance and reporting arrangements for the new model.

(2) If it is not reasonably practicable for the Department to comply with section 1A(1), the Minister must make a statement to the Assembly on why it is not reasonably practicable to do so.
(3) Regulations under this section are not to be made unless a draft of the regulations has been laid before, and approved by a resolution of, the Assembly.'

144. **Agreed:** The Committee agreed that it was content with the new Clause 1A as drafted.

145. **Agreed:** The Committee agreed to recommend to the Assembly that the proposed new Clause 1A be added to the Bill.

Clause 2: Transfer of the Regional Board's Functions

146. **Agreed:** The Committee agreed that it was content with Clause 2 as drafted.

Clause 3: Schemes for transfer of assets and liabilities

147. **Agreed:** The Committee agreed that it was content with Clause 3 as drafted.

Clause 4: Transitional provision

148. The Committee considered its proposed amendment to Clause 4 on the repeal of Local Commissioning Groups:

Clause 4, page 2, line 14
At end insert
'(4) The Department may by regulations repeal section 9 (Local Commissioning Groups) of the Health and Social Care (Reform) Act (Northern Ireland) 2009.
(5) The regulations provided for under section 4(4) must not specify a date which is earlier than date on which the regulations provided for under section (1A) of this Act are approved by a resolution of the Assembly.
(6) The regulations provided for under section 4(4) are not to be made unless a draft of the regulations has been laid before, and approved by a resolution of, the Assembly.
(7) Regulations under section 4(4) may make such amendments to the Health and Social Care (Reform) Act (Northern Ireland) 2009 and this Act as are necessary or appropriate in consequence of the repeal made by the regulations.'

149. **Agreed:** The Committee agreed that it was content with the amendment as drafted.

150. **Agreed:** The Committee agreed that it was content with Clause 4 as amended.

Clause 5: Interpretation

151. **Agreed:** The Committee agreed that it was content with Clause 5 as drafted.

Clause 6: Commencement

152. **Agreed:** The Committee agreed that it was content with Clause 6 as drafted.

Clause 7: Short title

153. **Agreed:** The Committee agreed that it was content with Clause 7 as drafted.

Schedule 1: Transfer of the Regional Board's functions

154. The Committee considered its proposed amendments to Schedule 1 to allow for the continuation of Local Commissioning Groups:

Schedule 1, Page 5, Line 3
In paragraph 11 leave out "and (b)"

Schedule 1, Page 42, Line 35 In paragraph 232,
leave out "7 to 11" and insert "7,8,10 and11"

Schedule 1, Page 42, Line 35, at end insert
232(A) In section 9(1) —
(a) for "Regional Board" substitute "Department"
(b) omit "in accordance with paragraph 7 of Schedule 1"

232(B) In section 9(3)(b), for "Regional Board may, with the agreement of the Department," substitute "Department may"
232(C) Omit section 9(6)(b)
232(D) Omit section 9(7)

Schedule 1, Page 42, Line 37
Leave out "and Local Commissioning Groups"

Schedule 1, Page 42, Line 38
Leave out paragraph 233(b)

Schedule 1, Page 42, Line 39
Leave out paragraph 233(c)

Schedule 1, Page 43, Line 38
Leave out "and Local Commissioning Groups"

155. **Agreed:** The Committee agreed that it was content with the amendments as drafted.

156. **Agreed:** The Committee agreed that it was content with Schedule 1 as amended.

Schedule 2: Transfer of assets, etc

157. **Agreed:** The Committee agreed that it was content with Schedule 2 as drafted.

Schedule 3: Transitional provision

158. **Agreed:** The Committee agreed that it was content with Schedule 3 as drafted.

Long Title

159. **Agreed:** The Committee agreed that it was content with the Long Title as drafted.

Appendix 1: Minutes of Proceedings

4 March 2021

11 March 2021

18 March 2021

25 March 2021

15 April 2021

29 April 2021

6 May 2021

20 May 2021

27 May 2021

10 June 2021

1 July 2021

9 September 2021

16 September 2021

23 September 2021

28 September 2021

30 September 2021

Appendix 2: Minutes of Evidence

Date	Evidence Session
4 March 2021	A briefing from the Department of Health on the principles of the Bill took place at the meeting on 4 March 2021. A Minute of Evidence for the session is not available, however a link to the recording of the meeting can be found here: https://niassembly.tv/committee-for-health-meeting-thursday-4-march-2021/
15 April 2021	Briefing from the Department of Health.
29 April 2021	Briefing from the Health and Social Care Board.
20 May 2021	Oral evidence from CSP, RCGPNI and RCN NI.
27 May 2021	Oral evidence from BASW, BDA and CPNI.
27 May 2021	Oral evidence from NILGA and the Chairperson of the LCG Chairs' Forum.
10 June 2021	Briefing from the Department of Health on the future planning model and response to stakeholder submissions on the Bill.
9 September 2021	Briefing from Department of Health responding to Committee's suggested amendments to the Bill.

Appendix 3: Written Submissions

1. British Association of Social Workers NI (BASW)
2. British Dental Association NI (BDA)
3. Chartered Society of Physiotherapy NI (CSP)
4. Community Pharmacy NI (CPNI)
5. NI Local Government Association (NILGA)
6. Regulation and Quality Improvement Authority (RQIA)
7. Royal College of General Practitioners NI (RCGP)
8. Royal College of Nursing NI (RCN)
9. Southern Health and Social Care Trust (Southern Trust)

Appendix 4: Memoranda and papers from the Department of Health

Date	Paper / Memoranda
1 March 2021	Department briefing paper outlining the purpose and content of the Bill
3 March 2021	Health and Social Care Bill Delegated Powers Memorandum
15 April 2021	Department briefing paper
28 April 2021	Department briefing paper on commissioning
11 May 2021	Correspondence from the Department advising that information on the future planning model will be provided before Consideration Stage
28 May 2021	Advance copy of DoH NI Future Planning Model - Integrated Care System NI Draft Framework
3 June 2021	Department response to the written submissions the Committee received on the Bill
3 June 2021	Updated Delegated Powers Memorandum for the Health and Social Care Bill
19 July 2021	Department letter to stakeholders on Future Planning Model consultation
22 July 2021	Department response to Committee proposed amendments to the Bill

Appendix 5: List of Witnesses

4 March 2021

John Millar, Head of Health and Social Care Board Closure Project Branch, Department of Health

Martina Moore, Director of Organisational Change, Department of Health

15 April 2021

Allan Chapman, Future Planning Model, Planning Team Lead, Department of Health

Gareth McKeown, Migration to Closure Project Team Manager, Department of Health

John Millar, Health and Social Care Bill Team Manager, Department of Health

29 April 2021

Leslie Drew, Chairperson, Health and Social Care Board

Sharon Gallagher, Chief Executive, Health and Social Care Board

20 May 2021

Dr Laurence Dorman, Chairperson, Royal College of General Practitioners NI

Rita Devlin, Associate Director of Nursing Policy and Practice, Royal College of Nursing

Tom Sullivan, Public Affairs and Policy Manager, Chartered Society of Physiotherapy NI

27 May 2021

Session 1

Paul Cavanagh, Interim Director, Planning and Commissioning, Health and Social Care Board

Dr Nicola Herron, Chairperson, Local Commissioning Group Chairs' Forum

Karen Smyth, Head of Policy and Governance, NILGA

Session 2

Carolyn Ewart, Director, British Association of Social Workers NI

Andy McClenaghan, Communications and Public Affairs Officer, British Association of Social Workers NI

Caroline Lappin, Chairperson, British Dental Association NI

Tristen Kelso, Director, British Dental Association NI

Gerard Greene, Chief Executive, Community Pharmacy NI

10 June 2021

Martina Moore, Director of Organisational Change, Department of Health

Paul Cavanagh, Interim Director, Planning and Commissioning, Health and Social Care Board

John Millar, Health and Social Care Bill Team Manager Department of Health

9 September 2021

Martina Moore, Director of Organisational Change, Department of Health

Allan Chapman, Organisational Change Directorate, Department of Health

Vincent Ramirez, Organisational Change Directorate, Department of Health

Appendix 6: List of abbreviations and acronyms used in the report

Abbreviation / Acronym	Full Meaning
AIPBs	Area Integrated Partnership Boards
BASW	British Association of Social Workers Northern Ireland
BDA	British Dental Association Northern Ireland
Board	Health and Social Care Board, sometimes referred to as HSCB
BSO	Business Services Organisation
CDO	Chief Dental Officer
CPNI	Community Pharmacy Northern Ireland
CSP	Chartered Society of Physiotherapy Northern Ireland
Department	Unless specified otherwise, all mentions of 'the Department' refer to the Department of Health
FPS	Family Practitioner Services
GDP	General Dental Practitioner
GDS	General Dental Services
GPs	General Practitioners
HSC	Health and Social Care
ICS	Integrated Care System
LCGs	Local Commissioning Groups
LDCs	Local Dental Committees
Minister	Minister of Health
MDTs	Multi-Disciplinary Teams
NILGA	Northern Ireland Local Government Association
PHA	Public Health Agency
RCGPNI	Royal College of General Practitioners Northern Ireland
RCN	Royal College of Nursing Northern Ireland
RQIA	Regulation and Quality Improvement Authority
SHSCT	Southern Health and Social Care Trust
Trust(s)	Health and Social Care Trust(s)

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