

PROPOSALS FOR HEALTH AND SOCIAL CARE REFORM IN NORTHERN IRELAND: A COMPARATIVE PERSPECTIVE

This briefing paper will highlight a number of key issues around the current proposals put forward by the DHSSPS to continue the reform of the Health and Social Care system in Northern Ireland. In doing so, the paper will provide comparative information relating to the organisational structures in each of the other health systems within the UK.

Review of Public Administration and the 'direct rule' model

Launched by the Stormont Executive in June 2002, the Review of Public Administration (RPA) represented the most far-reaching reform of the system of public administration in Northern Ireland for decades. The Review was a comprehensive examination of the processes and institutions associated with the administration and delivery of public services in Northern Ireland. It focused on 150 bodies, including 26 district councils, the Health and Social Services Boards and Trusts, the Education and Library Boards, and approximately one hundred other public bodies and organisations. Following suspension in October 2002, the RPA was progressed by Direct Rule Ministers until restoration of the devolved institutions in May 2007.

As a central component of the wider RPA, the direct rule Minister for Health announced on 22nd November 2005 the reorganisation of Northern Ireland's health and social services. The main *raison d'être* for the overhaul of the health system was to improve efficiency and performance to deliver a high quality service which focused on the health needs and well-being of the individual patient and wider population. A key element in the strategy was the significant reduction in the number of organisations within the health and social care system contributing towards a leaner and streamlined service.

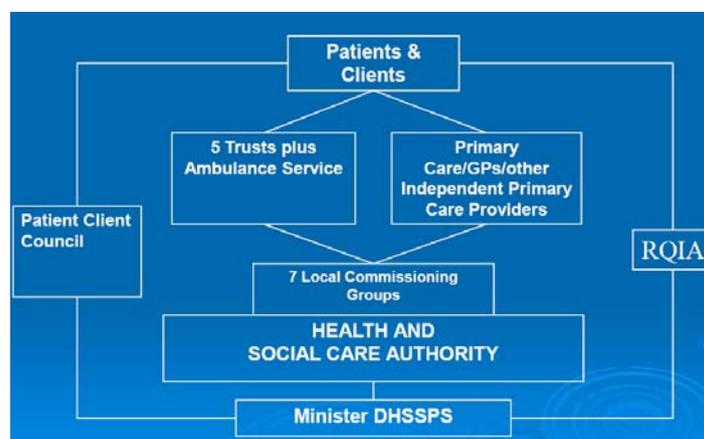
The central recommendations of the former Health Minister's new organisational structure for the health and social care system, which are illustrated in Figure 1 below, included:

- a smaller government Department for Health, Social Services and Public Safety to develop strategic policy and set long term targets, lead the drive for better performance and efficiency and performance manage the Health and Social Services Authority;
- a Health and Social Services Authority to replace the four health and social services boards and take on some functions currently within the Department.

This body would be responsible for commissioning and performance-managing the health and social services;

- five new integrated health and social services trusts, plus one ambulance service trust to replace the current 19 trusts. These trusts would be larger and fully integrated and would strengthen the linkages between hospital and community based services;
- seven local commissioning bodies to take on some roles from the four health and social services boards and some roles from the 15 local health and social care groups. These bodies would act as local offices of the Health and Social Services Authority and will work in conjunction with GPs and other local primary care practitioners to commission services from the trusts. The plan is to remap the 26 district councils into seven larger new district councils which would be conterminous with the seven proposed Local Commissioning Groups. Councils would have a new and enhanced role in a number of areas, including planning, conservation, local economic development, tourism, regeneration, community planning, environmental health, community development and emergency planning. A new power of well-being would also be introduced which would allow councils greater flexibility and power in implementing community planning and development;;
- one patient and client council to replace the four health and social services councils.¹

Figure 1: Direct rule model for new Health and Social Care structures²



There were two major phases for implementation of the RPA within health and social care. The first phase involved the establishment of the 5 new integrated Health and Social Care Trusts and the retention of the Northern Ireland Ambulance Trust with effect from 1st April 2007. The second phase was scheduled for completion by April 2008 and included establishing new organisational arrangements to replace the

¹ European Observatory on Health Systems and Policies (2006) *Health Systems in Transition: the Northern Ireland report*, European Observatory on Health Systems and Policies: 14-15.

² Illustration taken from presentation by Nigel Carson, (former Director of Equality and Public Safety), 16th March 2007.

present four Health and Social Services Boards, four Health and Social Services Councils and a number of other Agencies.

Revised post-devolution model – ‘going back to first principles’

Shortly following appointment as Minister for Health, Social Services and Public Safety in May 2007, Michael McGimpsey ordered a reappraisal/review of the raft of proposals for reform of the Health and Social Care in Northern Ireland put forward as part of the Review of Public Administration. Indeed, the decision to reconsider all the plans devised during suspension is one which the Minister has highlighted since coming into office. In his speech to the Assembly on 4th February 2008, the Minister stated that:

...the return of devolution, with a local Minister and a local Assembly scrutinising their work presents a real opportunity to deliver a local solution that meets our local needs. I have said it before, and I shall say it again: I make no apology for having taken the time to consider the organisational changes that are required to put in place arrangements that are fit for purpose, both now and in the future and that will deliver the best possible outcome for patients and clients. To do otherwise would be to fail the people of Northern Ireland.³

Within the review, the Minister decided to ‘go back to first principles’ in order to have the clarity about potential benefits as well as the essential attributes of any new structure. Since 8th May 2007, the Minister has been involved in substantive engagement to determine the future structures for health and social care taking cognisance of the views of a wider range of people including patients, clients, carers and health social care staff, to agree the scope of the review and communicate this with key stakeholders. The original RPA proposals were examined and a set of key guiding principles agreed as follows:

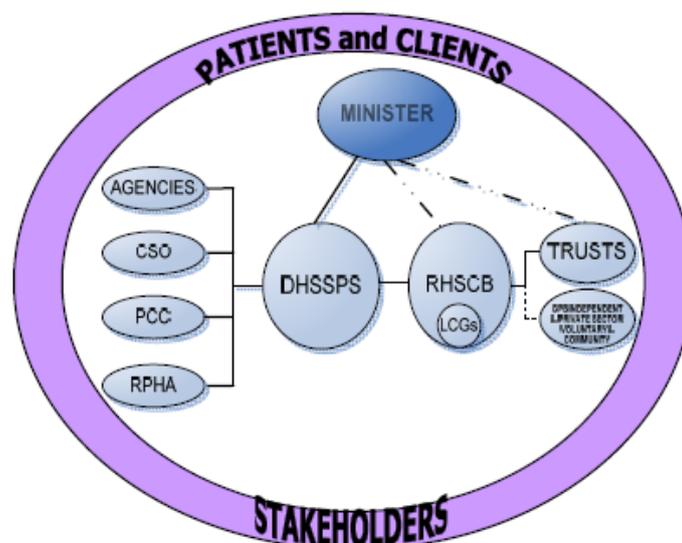
- The Service must be centred on the needs of patients, clients and carers.
- Services must be efficient, with fair but challenging savings targets and all unnecessary waste and duplication eliminated. Value for money is crucial and therefore the delivery of services and all the supporting activities must be focussed on maximising benefits to patients, clients and carers.
- Forward looking, innovative health and social care organisations will be encouraged delivering the services that they are commissioned to provide, adhering to priorities, meeting targets and ensuring that performance is always being improved.
- Patients, clients and carers must be given the opportunity to voice their concerns and be sure that they are being listened to. – dignity, respect, equality and fairness for patients, relatives and staff are at the core of the health and social care system.

³ Ministerial statement to the Northern Ireland Assembly – 4 Feb 2008.

- Quality and standards will continually be driven up without compromise.⁴

The product of the current Health Minister's review was the development of a new model, set out in Figure 2 below, which builds substantially on the previous model proposed during suspension but with a number of significant amendments.

Figure 2: Proposed Structures for Health and Social Care from 1st April 2009⁵



--- reflects direct access by the Minister on issues of performance management

CSO – common services organisation
PCC – Patient Client Council
RPHA – Regional Public Health Agency
RHSCB – Regional Health & Social Care Board
LCGs – Local Commissioning Groups

The main elements of the proposal model are:

- A streamlined Regional Health and Social Care Board (RHSCB) focused on commissioning, performance management and improvement and financial management which both encourages and ensured access to quality services responsive to need;
- Dynamic Local Commissioning Groups (LCGs) with the active involvement of GPs, professionals within social work, public health, nursing and Allied Health Professionals; other primary care practitioners; and community representatives;
- A smaller Department more sharply focused on its responsibilities for serving the devolved administration, bringing forward legislation, and determining and periodically reviewing policy, standards, priorities, and targets;

⁴ DHSSPS (2008) Proposals for Health and Social Care Reform, DHSSPS: 3.

⁵ DHSSPS (2008) Proposals for Health and Social Care Reform, DHSSPS: 12.

- The establishment of a 'common services organisation' to provide a broad range of support functions for the health and social care service;
- A new Regional Public Health Agency (RPHA) to create better inter-sectoral working to tackle health promotion and inequalities and help realise the shared goal of a better and healthier future for all our people, which would incorporate the functions of the existing Health Promotion Agency;
- Action to reinforce the independence of the Health and Social Services Councils and strengthen the regional aspects of patient, client and carer representation while maintaining a strong focus; and
- Increased democratisation through local government representation on key bodies and improved partnership and local government and other stakeholders in the commissioning and delivery of health and social care.⁶

Structures in the other UK health systems

Since the establishment of the devolved administrations in Scotland, Wales and Northern Ireland, the NHS in each of these jurisdictions has been organised and operated separately. Indeed, political devolution within the UK has created the possibility of each country's NHS addressing governance issues in different ways, creating something of a natural laboratory in which ideas can be tested. Divergence in the governance of the NHS is increasingly apparent, even though all of these systems adopt 'partnership' and 'collaboration' as the key concepts in their organisational designs. Points of divergence include: the degree to which a 'purchaser-provider' separation has been abolished; the mechanisms for primary care doctors to influence secondary care; the approach to 'localisation' of the health system; and the flow of funds within the NHS.⁷

Broadly speaking, since devolution Scotland has moved furthest away from the structure of the English NHS, especially by abolishing the 'purchaser-provider split' originally introduced in Scotland in the early 1990s as part of the internal market. The NHS in Scotland is now once again an integrated system, with a single body – the Scottish Department of Health – responsible for planning and providing all healthcare services.

In contrast Wales has adopted a model more similar to England's, local bodies analogous to England's PCTs (Primary Care Trusts) are responsible for overseeing the provision of primary care services and for commissioning or 'purchasing' hospital and community health services from NHS trusts. Wales has not however, followed England in creating foundation trusts, or in commissioning more services from the private sector.

Meanwhile, Northern Ireland has seen the least change in the organisation of its NHS, since devolution, and has a structure similar to that of the NHS internal market

⁶ DHSSPS (2008) Proposals for Health and Social Care Reform, DHSSPS: 12-13.

⁷ Woods, K. (2002) A Critical Appraisal of Accountability Structures in Integrated Health Care Systems, *Paper prepared for the Scottish Executive Health Department Health Department Review of Management and Decision Making in NHSScotland*, September: 20.

in England. Regional bodies and their sub-committees commission or 'purchase' the full range of health services for their populations. On the other hand, in Northern Ireland, unlike all other countries of the UK, it is the NHS, not local authorities, which provide social care services.⁸

Figure 3: The structure of the NHS in England⁹

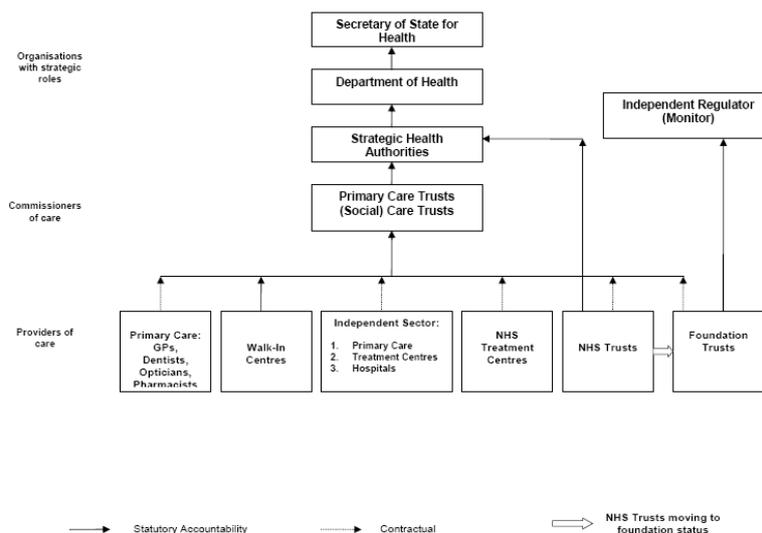


Figure 4: The structure of NHS Scotland¹⁰

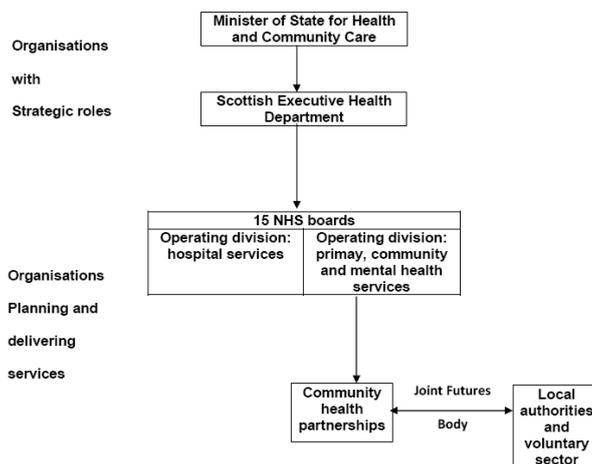


Figure 4 illustrates how the 15 Health Boards, which replaced 29 self-governing trusts in 2004, plan and deliver both primary and secondary care services. Most

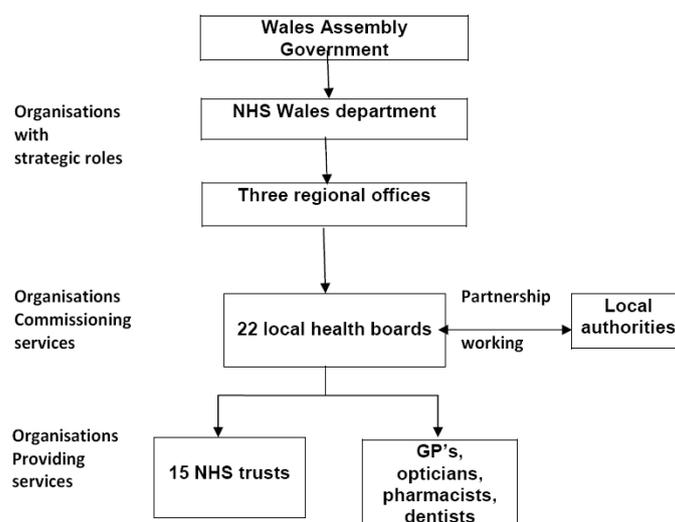
⁸ Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge: 156.

⁹ Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge: 8.

¹⁰ Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge: 158.

boards have one operating division which provides secondary (hospital) care services, and one which provides community and mental health care services and oversees the provision of family health services. Local flexibility is allowed. For example, Dumfries and Galloway health board each have just one operating division, which provides all elements of healthcare.¹¹

Figure 5: The structure of NHS Wales¹²



Similar to the English NHS, the organisational structures supporting the health systems in Wales and Northern Ireland continue to operate a clear division between commissioners and providers of health services. In Wales, twenty-two Local Health Boards (LHBs) are responsible for improving the health of their local communities. They are responsible for commissioning primary and community healthcare services from mainly GPs as well as other medical practitioners including dentists, pharmacists and opticians. Additionally, LHBs also commission or 'purchase' hospital or secondary care services predominantly from the 15 NHS trusts.

Meanwhile, in Northern Ireland both health *and*¹³ personal social services are organised around the purchaser-provider split. The commissioning (planning and purchasing) of health and social services is currently the responsibility of the four Health and Social Services Boards. Moreover, since April 2002, 15 Local Health and Social Care Groups (LHSCGs) have been responsible for planning *and* delivering primary and social care services in their areas. Replacing GP fundholders, they operate as 'committees' of the local health and social services board, and are based on groups of GP practices, serving populations ranging from 60,000 to 200,000. LHSCGs are responsible for planning and delivering both health and social care services *outside*¹⁴ the hospital setting, including those provided by GPs, dentists, community pharmacists and optometrists. They are intended to facilitate partnership

¹¹ Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge: 159.

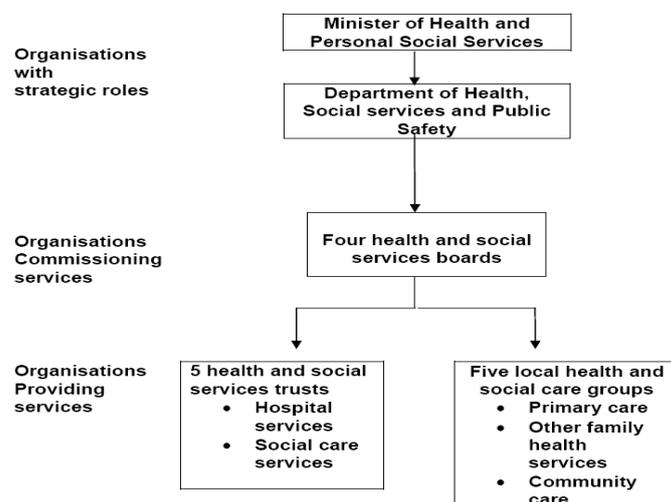
¹² Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge: 165.

¹³ My emphasis.

¹⁴ My emphasis.

working between health and social care organisations, and enable community involvement in the planning and delivery of services.¹⁵

Figure 6: The current structure of the Northern Ireland Health and Social Care system¹⁶



It is important to note that while the purchaser-provider split is a prominent operating mechanism within the health systems in Northern Ireland, Wales and England, the English NHS stands alone due to the centrality of the market and the introduction of the 'payment by results' regime in 2002. Under this new financial framework, hospitals are paid on a 'per case' basis, with prices fixed nationally (according to a 'national tariff') in advance.

It should also be noted that as a direct result of the Labour government's policy of actively expanding the role of the private sector into the provision of clinical services in the English NHS in recent years that increasingly commissioning organisations i.e. the Primary Care Trusts are purchasing or contracting from private health corporations. Crucially, a Department of Health White Paper¹⁷ in 2006 outlined the government's plans to contract out to the private sector the commissioning functions and budgets of Primary Care Trusts through practice-based commissioning. Under practice-based commissioning providers of GP services will hold the budgets and commission all medical services, including primary care, community health services and hospital care.¹⁸

¹⁵ Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge: 173.

¹⁶ Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge: 171.

¹⁷ Department of Health (2006) *Our Health, Our Care* – document accessible electronically at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453

¹⁸ Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge: 178.

Coterminosity

One of the key themes within the Department's proposals for reform of the Northern Ireland Health and Social Care system is for local commissioning groups to work more closely with local government. In his Assembly speech, the current Health Minister highlighted the 'missed opportunity' within the previous 'direct rule' proposals which 'did not include any input from elected representatives'. He went on to state that, 'there are benefits in tying commissioning arrangements to defined population areas; in particular having coterminosity with local government'.¹⁹

One of the characteristic features of the Welsh health system is its strong partnership with local authorities. It has been noted that 'the dominant thrust in post-devolution Welsh health services organisation is localism: the creation of a locally responsible health service that formulates its understanding of needs in local communities in partnership with local government'.²⁰ The new organisation of the Welsh health system, which was created in April 2003, established the 22 Local Health Boards coterminous with the existing twenty-two unitary local authorities. This meant constructing twenty-two commissioning bodies (for a Welsh population of approximately 3 million) with populations ranging from 55,983 (Mrthyr Tydfil) to 305,340 (Cardiff)²¹, and close connections with (including representation from) local government.²²

Issues relating to 'Proposals for Health and Social Care Reform' (2008)

Performance Management

One of the notable deficiencies within the NI health service identified by the 2005 Appleby review was the distinct absence of an explicit performance management system. Such a system within the health service was regarded as pivotal to achieving improvements in efficiency, effectiveness and responsiveness. Appleby was critical of the existing performance management structures in place at the time of the review contributing to an impression of 'a system lacking urgency, of general drift, and a consequent frustration amongst many in the services – at all levels – with the relative lack of improvement in performance'.²³ He contended that the current performance management system was devoid of the clear and effective structures, information and most importantly incentives – both rewards and sanctions – at individual, local and Northern Ireland organisational levels to encourage innovation and change.

To some extent Appleby was dismissive of the proposed organisational reforms outlined within the RPA in relation to generating improvements in performance management across the health service. The review noted that despite the RPA

¹⁹ Ministerial statement to the Northern Ireland Assembly – 4 Feb 2008.

²⁰ Greer, S. (2004) *Territorial politics and health policy – UK health policy in comparative perspective*, Manchester, Manchester University Press: 147.

²¹ Please note these figures are to provide an approximate indication of population size only as they form part of Greer's research published in 2004.

²² Greer, S. (2004) *Territorial politics and health policy – UK health policy in comparative perspective*, Manchester, Manchester University Press: 147.

²³ Appleby, J. (2005) *Independent Review of Health and Social Care Services in Northern Ireland*, August: 10.

acknowledging the importance of ensuring clear lines of accountability to the Department and the Minister for expenditure, quality and performance, and while noting that performance management remains the remit of the Department, it was still not apparent how the new model would facilitate performance improvements within the system. In particular, the review argued that 'it remains to be seen how providers are to be held account for their performance...[and that] while 'partnership and integration' can generate good things for patients and users, there is a distinct danger that the performance model implied by the RPA's structural reform could fail to provide the necessary incentive and sanctions – or 'bite' to encourage providers of services to continually seek out new ways to improve their performance.'²⁴

Appleby recommended that given the specific circumstances within Northern Ireland including its small population size and distribution and its political governance structures etc. there was a need to further investigate the 'most appropriate form of separation' between purchasers (i.e. the four health boards) and providers (essentially the Trusts) within the health service.

The review provided a number of recommendations relating to the introduction of possible incentive mechanisms which would need to be specifically tailored to the distinctive organisational structures in NI including 'an activity-based prospective reimbursement system for providers' (similar to the Payment by Results (PbR) regime in England). Another key policy strategy introduced within the English NHS to engender greater competition between service providers that was recommended by Appleby was the 'careful expansion of patient choice'. While the review cautioned against its suitability within a relative small health system like that in Northern Ireland, they equally highlighted the potential benefits of enhancing patient choice, particularly in the provision of certain operating procedures where there are a number of service providers.

Local Accountability

Ensuring local accountability within the Northern Ireland Health and Social Care system is a major recurrent theme contained within the Department's proposals. Under the proposals there is an identifiable chain of accountability between the main organisations. In terms of the key commissioning bodies i.e. the Regional Health and Social Care Board (RHSCB) and Local Commissioning Groups (LCGs), the Chair of each of the proposed 5 LCGs would be accountable to the Chair of the RHSCB. Meanwhile, the RHSCB is accountable to the Minister for DHSSPS who in turn is answerable to the Assembly.

Meanwhile, the composition of the proposed RHSCB will seek to enhance local accountability through the appointment of 4 elected local representatives

Patient-Public Involvement

There a number of bodies across the four health systems in the UK which represent the interests and concerns of patients and the public. Furthermore, there are arrangements in place which inform the requirements of key statutory organisations to ensure the representation of patients and the non-statutory sectors. For example,

²⁴ Appleby, J. (2005) *Independent Review of Health and Social Care Services in Northern Ireland*, August: 10.

as in the English NHS, the involvement of patients and the public is an important part of the accountability of health services in Scotland and Wales.

In Scotland, NHS Boards are required to have 'lay' non-executive members on their boards of directors, while there is a statutory duty to ensure the involvement of patients and the public in the planning and delivery of services. The duty to involve patients and the public also extends to 'community planning partnerships'. They are required to engage with their local communities through local 'public partnership forums' and to have at least one member of these forums on their committee. 'Public partnership forums' are 'networks' or 'virtual groupings' of existing voluntary organisations, user and carer groups, and 'interested individuals'. They are intended to provide a mechanism for the two-way flow of information between community health partnerships and patients and the public – to inform people about local services and to gather their views and opinions on how to improve them, and to ensure that the views of local people are represented in planning and decision-making.²⁵

Similarly, in Wales the Local Health Boards and the NHS trusts are required to ensure that the views of local voluntary organisation and local residents are considered as part of working in partnerships to develop health, social care, and well-being strategies. Public representation is achieved not only through representation of local voluntary groups and local or 'lay' people on their boards of directors, but also through the work of the 20 Community Health Councils.²⁶

In responding to Assembly questions regarding health and social reform on 4th February 2008, the Minister stated that he 'remains to be convinced that the excellent work being carried out by the health and social services councils would be improved by establishing one large organisation, which was suggested by the direct rule Administration.'²⁷

Subsequently, within the Department's proposals 'two options' are put forward both of which are planned to ensure integration with the NHS Trusts and 'are well placed to engage with service providers and are well equipped to articulate the public voice and promote and represent the public interest.'²⁸

The two options proposed are:

1. A single, independent, regional body along the lines previously suggested for the proposed PCC, but required by statute to establish five groups/committee operating within the same geographical areas as the five integrated HSC Trusts.
2. Five separately constituted independent local bodies each operating within the same geographical areas as Option 1. These local bodies would be required by statute to work together on a collaborative basis, to provide a

²⁵ Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge: 163.

²⁶ Talbot-Smith, A. and Pollock, A. (2006) 'Devolution: the NHS in Scotland, Wales and Northern Ireland' in *The New NHS – A Guide*, London, Routledge: 169.

²⁷ Ministerial statement to the Northern Ireland Assembly – 4 Feb 2008

²⁸ DHSSPS (2008) Proposals for Health and Social Care Reform, DHSSPS: 40.

more effective regional focus where appropriate to represent the interests and promote the involvement of the patients, clients and carers.

According to the proposals, 'in order to ensure that the new consumer body or bodies are and are seen to be independent, it is proposed that they would be funded by and directly accountable to the Department.'²⁹

The lessons of organizational reform

Dr Kevin Woods, the current Chief Executive of NHS Scotland published a paper in 2002 relating to the development of the devolved health systems within the UK. He concluded the paper by stating that

It is evident... that huge organizational change and uncertainty is at play in the UK's health services. Most of it is driven by political philosophy, local circumstance, and experience rather than evidence, not least because hard empirical evidence of what works and what does not is difficult to assemble. At best, most evaluations of the changes that have occurred are a combination of informed commentaries, and partial analyses of particular components of rapidly evolving health care systems. [In] conclusion, it is only possible to summarise some of the main themes that have emerged from a decade of health care reform and suggest some of the ideas that are currently guiding the development of administrative structures and accountabilities. They are:

- It is difficult to find hard evidence that any of the whole system reforms of administrative accountabilities have secured, independently of other actions, the improvements they were intended to achieve; at best they have made a contribution.
- Partial implementation of reform is the norm, reflecting the complexity of whole system change and the pressures of political accountability on publicly funded systems.
- Internal markets and managed competition has left an enduring legacy that continues to inform the structure and administrative accountabilities of health care systems.
- Most countries have retained a separation of 'commissioning' and 'providing' but have attempted to replace competition with collaboration.
- There is some experimentation with new organizational models *within* hitherto wholly public systems, e.g. Foundation status but these are in their infancy; the distinctions between public provision, independent not for profit, and private provision in countries where these have been strong in the past are increasingly unimportant to public funders of health care.
- The unanticipated consequences of markets and managed competition have had some of the most profound effects, notably the changed role of the State

²⁹ DHSSPS (2008) Proposals for Health and Social Care Reform, DHSSPS: 40.

as a regulator of health care actors, and growth in primary care organizations as new entities in health care systems.

- Health care integration, both horizontally and vertically, is now the objective of much health care policy in many countries.
- Devolution of decision-making power within health care systems is a stated intention of policy in some countries but is difficult to achieve in the face of strong upward accountability pressures to support political accountability.
- ‘Sticks’ outnumber ‘carrots’ as motivators in post market systems, as it is proving difficult to identify appropriate ‘carrots’ to replace economic rewards. There also appears to be growing recognition of the contribution of personal accountabilities to health care improvement.

In conclusion, it is perhaps worth highlighting the following comment from an academic on the impact of reform on health care improvement.

As different countries have gone different [reform] routes, a hard reality has emerged: there are no ‘magic bullets’ to be had in health care reform. One conclusion - which may be taken as depressing, liberating, or a bit of both – appears to be that improvements in health care are not contingent on the drafting of grand blueprints or the ability of politicians and public servants to pull big policy levers. Health care improvement starts from the ground up. It requires tenacious work to understand what does and does not work in real life and the engagement of countless providers [clinicians] and patients, institutions and communities. Similarly, most policy movement seems to be incremental, driven by experience and evidence, rather than theory or ideology.³⁰

February 2008

³⁰ Woods, K. (2002) A Critical Appraisal of Accountability Structures in Integrated Health Care Systems, *Paper prepared for the Scottish Executive Health Department, Health Department Review of Management and Decision Making in NHS Scotland*, September: 22-23.