

Health and Social Care: Reform and Transformation

Getting the Structures Right

Table of Contents

[1. Ministerial Foreword 3](#_Toc437867699)

[2. Current System 5](#_Toc437867700)

[DHSSPS 5](#_Toc437867701)

[HSC Board 5](#_Toc437867702)

[Public Health Agency 6](#_Toc437867703)

[HSC Trusts 6](#_Toc437867704)

[Family Practitioner Services 7](#_Toc437867705)

[3. Health and Social Care across the UK 8](#_Toc437867706)

[England 8](#_Toc437867707)

[Scotland 9](#_Toc437867708)

[Wales 9](#_Toc437867709)

[Social Care Commissioning 9](#_Toc437867710)

[4. The Case for Change 11](#_Toc437867711)

[5. Reforming the System 14](#_Toc437867712)

[Questions 14](#_Toc437867713)

[I. Less Red Tape 15](#_Toc437867714)

[ii. More Responsive to Innovation 15](#_Toc437867715)

[iii. Accountability and Performance Management 16](#_Toc437867716)

[iv. Commissioning & Planning 16](#_Toc437867717)

[v. New Structures 17](#_Toc437867718)

[6. How to respond 19](#_Toc437867719)

# 1. Ministerial Foreword

Health and Social Care is unique in the public and private sectors in that it impacts on everyone. Every single one of us will use these services at some point in our lives. I consider it a tremendous honour and a great responsibility to serve as Minister for Health, Social Services and Public Safety in the Northern Ireland Executive, but I am also aware of the scale of the challenges we face.

As in many developed countries, we are facing the multiple challenges of:

* a growing and ageing population;
* a population with high levels of disability and mental health problems;
* a rise in the number of chronic conditions people are living with;
* unhealthy lifestyles contributing to increases in obesity and diagnoses of type 2 diabetes; and,
* developments in medical technologies and medicines which, whilst opening up new opportunities for treatment, are pushing up costs.

This is also all happening at a time when we are facing unprecedented financial pressures. It is the accumulation of these challenges that threatens the future of our Health and Social Care (HSC) system, and which makes the current way in which health and social care is delivered unsustainable.

In a speech last May, I set out my ambition for a world class Health and Social Care Service in Northern Ireland, drawing on the innovation and excellence of staff in the HSC. We are fortunate to have a health and social care service full of highly trained, committed and skilled staff and I want to make sure that we have the right administrative structures in place that will enable them to carry out their work to the best of their ability.

I have already made clear my own view that our current structures are too big and too bureaucratic, that they have led to a system that controls and constrains, rather than one that supports and enables innovation. I want to de-layer our Health and Social Care system by moving away from the current commissioning model and replacing it with a more streamlined, more accountable and above all more responsive service.

Finally, I should be clear that these changes are about structures, not people. The Health and Social Care Board has talented people working within it, who have consistently performed to a high standard. However, the administrative structures created during the last Assembly term do not serve the HSC, and more importantly the public, well enough and it is clear to me that without removing some of the layers in our system and improving accountability and responsibility, we will not be able to deliver the transformation we need.

Of course, I cannot achieve this transformation without the support and participation of stakeholders across the system. I am looking forward to hearing your views on my proposals and to working in partnership to create a new, more responsive, more accountable and, above all, more effective Health and Social Care system.

# 2. Current System

The current structure of the Health and Social Care system in Northern Ireland has its origins in the Review of Public Administration (RPA) which was initiated by the Northern Ireland Executive in June 2003. The Health and Social Care (Reform) Act (Northern Ireland) 2009 (“the Reform Act”) provides the legislative framework within which the Health and Social Care structures operate and establishes the high level functions of the various HSC bodies as follows.

## DHSSPS

The Reform Act places a statutory duty on the Department to promote an integrated system of:

1. Health care designed to secure improvement:
   1. In the physical and mental health of people in Northern Ireland, and
   2. In the prevention, diagnosis and treatment of illness; and
2. Social care designed to secure improvement in the social well-being of people in Northern Ireland.

Under the direction of the Minister, the Department discharges this duty by developing policies and associated legislation, determining priorities, allocating resources and setting standards.

The Department has retained responsibilities for HSC pay, terms and conditions, workforce planning, estate management and asset management.

## HSC Board

The Health and Social Care Board (HSCB) is a non-profit making statutory body responsible for the commissioning of health and social care services for the population of Northern Ireland. The role of the Health and Social Care Board is broadly contained in the following functions:

1. To arrange or ‘commission’ a comprehensive range of modern and effective health and social services for the 1.8 million people who live in Northern Ireland.
2. To performance manage Health and Social Care Trusts that directly provide services to people and support service improvements in pursuit of optimal quality and value for money, in line with relevant government targets.
3. To effectively deploy and manage its annual funding from the Northern Ireland Executive, currently around £4 billion – to ensure that this is targeted upon need and reflects the aspirations of local communities and their representatives.[[1]](#footnote-1)
4. To act as the legal authority for the discharge of a range of statutory functions in relation to children and people with mental health difficulties.

In discharging its commissioning function, the HSCB is required to produce an annual commissioning plan, in full consultation and agreement with the Public Health Agency (PHA), in response to a Commissioning Plan Direction issued by the Department. This process is intended to ensure the translation of the strategic objectives, priorities and standards set by the Department into a range of high quality, accessible health and social care services and general improvement in public health and wellbeing.

## Public Health Agency

The PHA - through its input to the commissioning process, by securing the provision of specific public health programmes, and by supporting research and development initiatives – is responsible for improving and protecting the health and social wellbeing of, and reducing health inequalities between, people in Northern Ireland.

The HSCB is required to consult with the PHA in the development of the annual commissioning plan and cannot publish the plan unless it has been approved by the PHA.

## HSC Trusts

HSC Trusts are the main providers of the health and social care services commissioned by the HSCB. The HSCB agrees Service and Budget Agreements (SBAs) with HSC Trusts, which detail the services to be provided and associated volumes, costs and outcomes, and approves individual Trust Delivery Plans (TDPs) which set out what Trusts will achieve, how they will meet Ministerial targets and standards, and the resources that they will use in delivering services. In addition to agreeing SBAs and TDPs, individual service developments may be subject to the completion of Investment Proposal Templates (IPTs).

Monitoring Trust performance against the agreed objectives and targets, along with the financial break-even requirement, is the responsibility of the HSCB. In discharging this responsibility, the HSCB is required to work with the PHA, particularly where activity relates to the key priorities and targets of the PHA. In addition to performance monitoring, the HSCB and PHA will also work together to support Trusts on improving performance.

Separately to the lines of responsibility between Trusts and the HSCB, Trust Chairs and Chief Executives are accountable to the Minister and DHSSPS, reflecting the accountability arrangements between a parent Department and its arm’s length bodies.

This division of responsibilities requires the HSCB, PHA, Trusts and the Department to work closely to ensure services which are to be commissioned can be delivered within the resources available.

## Family Practitioner Services

Family Practitioner Services (FPS) – that is GPs, dentists, community pharmacists and opticians - are central to the health and social care system. Family practitioners and those who work with them in extended primary care teams act as the first point of contact for patients and service users and as a gateway to a wider variety of services across the HSC. The HSCB manages the various contracts with family practitioners, not only in terms of pay and performance monitoring but also in terms of quality improvement, adherence to standards and delivery of departmental policy. The HSCB is accountable to the Department for the proper management of FPS budgets. The PHA also commissions a range of health improvement services from FPS.

# 3. Health and Social Care across the UK

Only Northern Ireland has an integrated system of health and social care. In England, Scotland and Wales responsibility for social care rests with local authorities, although it is clear that all UK regions currently recognise the need to better integrate the planning and provision of health and social care and are taking forward a number of initiatives with that aim.

The idea of separating the purchasing of healthcare from the provision of healthcare – the purchaser provider split – was first proposed in the 1989 UK White Paper *Working for Patients*. These reforms were implemented from 1991 with separate purchasing and provider organisations established in all four UK regions. However, since devolution both Scotland and Wales have moved to reintegrate these functions, and only Northern Ireland and England have retained separate commissioning and provider organisations.

## England

In England, the Department of Health is responsible for strategic leadership and funding of both health and adult social care in England. The Department of Education holds responsibility for children’s social care. NHS England is an independent body, at arm’s length from government, with responsibility for providing leadership for improving outcomes and driving up the quality of care, overseeing the operation of clinical commissioning groups (CCGs), allocating resources to CCGs, and commissioning primary care and specialist services.

The main providers of health services in England are NHS Trusts, NHS Foundation Trusts and Family Practitioner Services such as GPs, dentists, opticians and pharmacists.

In addition to the main commissioner and provider organisations, there are a number of other NHS bodies. Public Health England has responsibility for protecting and improving health and wellbeing, and reducing health inequalities. Commissioning Support Units, Strategic Clinical Networks and clinical senates have been established to support CCGs in their work. Health and Wellbeing Boards bring together bodies from the NHS, public health and local government to plan how to meet local health and social care needs, and to commission services accordingly. A number of regulatory and monitoring organisations are also in place, including Monitor, the Trust Development Authority (currently being combined into NHS Improvement), the National Quality Board, Ofsted and the Care Quality Commission.

## Scotland

The Scottish Government, through its Health and Social Care Directorate, sets the strategic direction and allocates resources for health and social care. Unlike England and Northern Ireland, the NHS in Scotland does not have separate commissioning and provider organisations. Instead, 14 regional NHS boards are responsible for planning and providing health services to meet the needs of their populations. Regional boards are also responsible for the protection and improvement of their populations’ health.

In addition to the 14 regional boards, seven special NHS boards provide a range of specialist and national services for the whole of Scotland – these include NHS24 and the Scottish Ambulance Service. Healthcare Improvement Scotland is the national healthcare improvement organisation.

Whereas in England and Northern Ireland, responsibility for monitoring and managing performance against government health targets sits outside of central government, this function is retained by the Scottish Government.

## Wales

Like Scotland, there is no separation of the commissioning and provider functions in NHS Wales. The majority of healthcare services in Wales are planned and delivered by seven local health boards. In addition, three NHS Trusts provide specialised services on a nationwide basis – these are the Welsh Ambulance Service Trust, the Velindre NHS Trust which provides specialist cancer services, and Public Health Wales.

## Social Care Commissioning

Social care is both funded and commissioned differently from healthcare in all administrations across the UK including Northern Ireland. Unlike healthcare, personal social services are subject to assessment of need and means testing of the person’s capacity to pay. In England, Scotland and Wales, Local Authorities are responsible for meeting the social care needs of their eligible populations which they do through a mixture of direct provision and services commissioned from third party providers. Since the introduction of the Health and Social Care Act 2012, Local Authorities in England have also been responsible for the provision of Public Health Services.

In Northern Ireland social care is commissioned primarily by the HSCB and the HSC Trusts although in recent years there has been some limited commissioning of social care by the PHA in relation to family support services. This provides a combination of contracts for significant volumes of social care services and smaller locally based services. The social care market is, in general, more complex and diverse than the healthcare market with two thirds of services being provided by third party providers: it spans a range of activities from setting regional tariffs to commissioning individual packages of care to meet the assessed needs of a single person.

# 4. The Case for Change

Prior to the Review of Public Administration, health and social care services were commissioned by four Health and Social Services Boards and provided by 18 Health and Personal Social Services Trusts and one Ambulance Service Trust. The current structure of the HSC was designed to be more streamlined and accountable, and aimed at maximising resources for front-line services and ensuring that people have access to high quality health and social care.

There were two major phases for implementation of the RPA changes: the establishment of the five new integrated HSC Trusts and the retention of the NI Ambulance Service with effect from 01 April 2007; and the establishment of the HSCB and PHA on 01 April 2009. It was proposed that the HSCB would focus on commissioning, financial and performance management and would be supported by five local commissioning groups (LCGs coterminous with HSC Trusts) to assess the needs of local populations and commission services to meet these needs. The PHA would focus on health improvement, health protection and would provide public health support to commissioning.

As an optimised model, these structures were intended to provide a robust, balanced and informed approach to strategic planning, commissioning, performance management and service improvement.

The diagram below shows the current structure of the Health and Social Care system along with the lines of accountability and funding flows between the different organisations:****

It can be seen clearly from this that the current model has multiple layers, intricate layers of decision making and unclear lines of accountability. The Donaldson report and the Department’s own review of commissioning both received consistent feedback from those working across the HSC that the system is not working as effectively as it should – and that it is not working as envisaged in 2009[[2]](#footnote-2)[[3]](#footnote-3).

In general, there are a number of key points that have emerged throughout this work:

1. There is a lack of clarity regarding the chains of accountability and responsibility across the various HSC organisations;
2. The current structures are seen as overly complex and bureaucratic, and are disproportionate to the size of Northern Ireland;
3. There is a perception of ineffective communication within and across organisations, and that the complexity of existing structures does little to foster and support strong, collaborative working relationships across the health and social care system;
4. The complexity and bureaucracy of the current structures is seen to stifle reform and innovation, and make it difficult to implement meaningful change;
5. The annual nature of the financial and service commissioning planning cycle inhibits long-term, strategic planning. A longer planning period would seem appropriate for an organisation managing a budget of £4.6 billion;
6. There is a need for greater stakeholder involvement in the planning and design of services – in particular clinical and professional expertise, members of the public and service users, and the community and voluntary sector;
7. Local commissioning is not operating as envisaged in the 2009 reforms. There was a view that LCGs do not have the necessary information and autonomy to perform their function;
8. While there are certainly examples of good practice and effective working relationships, these seem to have been achieved largely in spite of the administrative structures rather than because of them.

The current structures provide for a complex decision making process (for instance, from LCG, with decisions then considered by HSCB and then PHA professional staff, and sometimes by the Department). It is also clear that responsibility – and therefore accountability – has not always been effectively shifted to provider organisations.

Donaldson and others have made the point that administrative structures are only one component of the wider health and social care system, and not a panacea for the issues facing health and social care. Changing the structures will not in itself reverse the growing challenge that we face in meeting demand. However, having more effective structures will allow us to focus resources, avoid duplication and allow those working in the system to operate more effectively.

Maintaining a commissioning approach in Northern Ireland was intended to ensure there was appropriate challenge to providers. However, it seems the current model is hampered by short-term planning, a focus on process rather than outcomes, a system that controls and prescribes, rather than one that enables and supports. It seems clear from consideration of the Scottish and Welsh models that effective challenge can be created – and change driven – without relying on a commissioner/provider split. It is also clear when we look at Scotland and Wales that we could design a simpler system of health and social care planning and management for Northern Ireland.

While there is not currently a consensus on what the most effective model is for Northern Ireland, there is a clear message from those working in and those using the system that it is not working as well as it should. Our current structures are simply not lean or agile enough to allow us to keep up with the pace of change in health and social care. This consultation is intended to stimulate debate about these structures, to ensure that everyone has the opportunity to have their say and, ultimately, to build agreement on what are the best health and social services structures for Northern Ireland.

# 5. Reforming the System

The Minister has stressed that this is about structures, not people. The HSC Board has many talented officials working within it, carrying out many important roles, and to a high standard. However the current administrative structures do not work as effectively as they might and have a number of weaknesses.

Through the work of Donaldson and the Department’s Review of Commissioning, we know there is a perception that the current administrative structures carry too much complexity and have too many layers of authority. Those working within the system feel that the number of stages in decision making, often involving several bodies, can slow things up and may make the whole system less responsive. This has caused some frustrations among staff and managers across the system, many of whom feel the emphasis has been placed more on transactions rather than enabling transformation.

This complexity may also have contributed to a situation where lines of accountability are perhaps weaker than they should be, with a lack of clarity about where responsibility for decisions sits. Moving forward, it has been argued that we need to shift the balance between management and leadership.

It is therefore proposed to de-layer the health and social care system by moving away from the current commissioning model and closing down the HSC Board. This will allow the Department to take firmer strategic control of the health and social care system. It will also allow Trusts to take control of planning the delivery of local services more effectively. The PHA will be retained in order to ensure a renewed focus on early intervention and prevention.

We know that structural change will not resolve all of the issues facing health and social care. The experience in Wales, England and Scotland confirms that they face many of the same challenges we do despite the differences between our systems. Nevertheless, as public servants engaged in delivering a vital service, it is crucial that we have the right structures in place to enable the system to be as responsive, efficient, flexible and effective as possible.

## Questions

In his speech of 04 November 2015, the Minister announced his vision for reform and transformation of Health and Social Care in Northern Ireland. In this section, we provide some of the key points from the Minister’s speech and ask for your views.

### I. Less Red Tape

***“The administration of Health and Social Care suffers from a common Northern Ireland public sector problem. It is too big. It is too bureaucratic and it doesn’t deliver best value.”***

There is a perception that the current administrative structures carry too much complexity and have too many layers of authority. Those working within the system feel that the number of stages in decision making, often involving several bodies, can slow things up and may make the whole system less responsive. This has caused some frustrations among staff and managers across the system, many of whom feel the emphasis has been placed more on transactions rather than enabling transformation.

**Q. Do you agree that there is too much complexity in the current system and that it is not working to its optimum capacity?**

### **ii. More Responsive to Innovation**

***“Essentially it has been a model that controls and constrains, rather than one that supports an exceptionally talented and committed group of professionals to achieve the best possible outcomes for the people of Northern Ireland.”***

The Review of Commissioning identified that the complexity of the current structures may have had a negative impact on reform and innovation by making it more difficult to implement meaningful change.

We need to achieve a more sustainable balance between overall strategic direction and operational practice. We believe the proposed reforms would enable the HSC to focus more on care delivery and reform, rather than getting caught up with oversight and process. Removing a layer of bureaucracy would also help to speed up decision making and allow the overall system to become more responsive.

**Q. Do you share the Minister’s view that the system needs to be better at enabling and supporting innovation?**

**Q. Would reduced bureaucracy in terms of HSC structures allow the system to respond more quickly to changing demands?**

### iii. Accountability and Performance Management

***“Our work must be focused on meaningful improvements, supporting Trusts in achieving their performance targets and taking a lead on transformation and driving innovation. Above everything else, it is about driving delivery.***

***I want to see the Department being much more active in ensuring that reforms are implemented, that issues are addressed when they arise, that services are delivered consistently, and that Trusts are more directly accountable to the Minister.”***

Sir Liam Donaldson’s review pointed to a lack of clarity around accountability in health and social care in Northern Ireland. This point was also made in the Review of Commissioning. It was felt that the existing lines of accountability across the various HSC bodies are blurred – for example, while the HSCB is accountable for performance and financial breakeven across the HSC, Trusts are ultimately accountable to the Permanent Secretary of the Department. There was a sense that the HSC needs to clarify roles, responsibilities and lines of accountability.

**Q. Will bringing performance management into the Department help to improve lines of accountability?**

### iv. Commissioning & Planning

***“The review highlights that our commissioning model isn’t as effective as we need it to be.”***

***“What I am signaling is an end to the current way we commission healthcare in Northern Ireland.”***

The concept of a commissioner/provider split within Health and Social Care is associated with a desire to improve performance by increasing competition between providers. However, the Review of Commissioning found that the experience here in Northern Ireland has been that there is little real competition between healthcare providers, with LCGs tending to commission services primarily from their local Trust.

Furthermore, Donaldson believed that the population of Northern Ireland is too small to justify the complexity of a full healthcare commissioning system. He concluded that we have created a system where we have the complexity of commissioning without the benefits of the most sophisticated commissioning models.

**Q. The Donaldson report and the Department’s Review of Commissioning both concluded that a full, competitive commissioning process is too complex and transactional for an area as small as Northern Ireland. Do you agree?**

***“I want our Trusts to be responsible for the planning of care in their areas and have the operational independence to deliver it.”***

It is proposed that Trusts should take on responsibility for planning the bulk of health and social care services delivered in Northern Ireland. This should strengthen operational independence, simplify and streamline the existing system significantly and allow us to build on our existing strength – integration of health and social care. It should also help create a stronger sense of a single HSC, working together, and provide more scope for professional engagement, leadership and reform. Importantly, this will mean that Trusts will be responsible for assessing and meeting the health and social care needs of people in their area.

Moving away from a regional structure with a separate commissioning function to Trust-led planning for local services will necessitate changes at a local level, including ending the role of LCGs. But work will need to continue to better integrate services – including ensuring a strong voice for primary and community care, service users and the third sector.

**Q. Do you agree that Trusts are best placed to assess local needs and should therefore have a greater level of responsibility and autonomy for planning services in their area?**

### v. New Structures

***“I…propose that we close down the Health and Social Care Board. I believe we no longer need a standalone organisation like the Board.”***

***“I want to see the Department take firmer, strategic control of our Health and Social Care system.”***

***“I will retain a Public Health Agency that renews its focus on early intervention and prevention.”***

***“My proposals would mean that many of the Board’s existing functions, and staff, would revert back to the Department. Some would move to the new Public Health Agency, whilst others, especially those in respect of planning for need, will move to our Trusts.”***

It is proposed that at a regional level Northern Ireland should move away from a structure with a separate performance management and commissioning function. Instead, the responsibility for performance and financial management should be brought into the Department. This would focus lines of accountability, clarify the currently somewhat confused perception of leadership within the system, and would create the right conditions for a genuinely strategic approach to driving performance, planning and reform.

It is likely that this approach would see the current functions of the HSC Board go either to the Department, the PHA or Trusts. Further detailed work will of course be needed to consider the finer details of how these revised structures would operate. This would include where functions would sit most effectively and how changes should be implemented. Legislation will be necessary for some major structural changes but it may be possible to carry out some smaller reforms more quickly.

This is a substantial set of changes for the HSC to make – which must be accompanied by a shift in culture and practice as we move to a system focussed on greater autonomy and accountability. Nonetheless, we believe the approach to be one that is deliverable. We understand that this may initially be unsettling for those currently working in the system, however the Department will make every effort to ensure there is full engagement with HSC bodies and staff throughout this process.

**Q. Do you agree that these are the right structural changes to make to streamline and simplify the Health and Social Care system?**

# 6. How to respond

You can respond to the consultation document by e-mail, letter or fax using the accompanying questionnaire on the Department’s website ([www.dhsspsni.gov.uk/consultations](http://www.dhsspsni.gov.uk/consultations)).

If this document is not in a format that suits your needs, please contact us and we can discuss alternative arrangements.

Before you submit your response, please read Annex A of the consultation questionnaire about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises.

Responses should be sent to:

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**The closing date for responses is 12 February 2016**

1. HSCB Annual Accounts 2013/14 [↑](#footnote-ref-1)
2. Review of HSC Commissioning Arrangements - Final report, DHSSPS 2015. Available at: <https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/review-hsc-commissioning2015.pdf> [↑](#footnote-ref-2)
3. The right time - the right place: An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland, DHSSPS 2014. Available at: <https://www.dhsspsni.gov.uk/publications/right-time-right-place> [↑](#footnote-ref-3)