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Northern Ireland Assembly

Research and Information Service
Briefing Paper

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Transforming Health and Social Care in Northern Ireland – Services and Governance

This briefing paper aims to provide the new Health Committee with an overview of a number of issues from the 2011-16 Committee's legacy report. It focuses on key aspects of health and social care reform in Northern Ireland over the past decade or so, including the 20-year strategy for primary care; 'Transforming Your Care' (TYC); the Donaldson Report; and the recently established expert panel, chaired by Professor Bengoa. The paper also includes key points from the previous Committee's scrutiny of TYC, including workforce planning and care for older people.

Executive Summary

In many countries, including Northern Ireland (NI), governments are striving to transform health and social care services in the context of increasing demands placed on services by ageing populations; increased numbers of people living with multi-morbidities; constrained resources; technological advances and rising patient expectations.

In NI, over the past decade at least, policy direction has aimed to shift service provision away from hospitals and towards care in the community, as close to home as possible.

This paper focuses on key aspects of health and social care service and governance reform in NI, over the past decade or so.

Primary care is recognised as central to health and social services in NI, acting as a first point of contact and a 'gateway' to secondary care and a wider variety of services within primary care itself.

In 2005, the former Department of Health, Social Services and Public Safety published *Caring for People Beyond Tomorrow* - a 20-year strategic framework for primary care, recognising the need for wider development of community-based alternatives to hospital admission.

The key aspect was **'integrated working'** and the introduction of **Primary Care Partnerships,** with a new role for GPs in the development of these voluntary alliances of health and care professionals and voluntary and community sector bodies working together. The aim was to improve integration between primary and community care, hospital specialists and social services.

The reform agenda gathered pace in June 2011, when the then Minister for Health, Social Services and Public Safety, Edwin Poots MLA, announced a review of the provision of health and social care services.

The Review, known as 'Transforming Your Care', focused on changes that would make the greatest difference to outcomes.   It proposed a new **integrated model** of health and social care, with population-based planning of services.

The key drivers included care to be provided as close to home as practical, a **shift of resource** from hospitals to enable investment in community health and social care services and a changing role for general practice working in 17 **Integrated Care Partnerships (ICPs)**, building on the previous Primary Care Partnerships.

The ICPs have focused on improving how services are organised for frail older people and those with specific long-term conditions, aiming to preventing hospital admissions.

The service model for primary care was a "Hub and Spoke" approach, with the hubs providing services which do not require a hospital bed but are too specialised to be provided in a local GP surgery.

This direction of travel pre-dates TYC as the 2005 strategic framework for primary care, had already described such 'hubs', for example, The Arches Health and Social Care Centre was completed in 2005 and the Grove Wellbeing Centre opened in 2008.

In 2014 the focus of reform moved to 'governance', when Professor Sir Liam Donaldson advised on governance arrangements across health and social care with ten recommendations in his report *The Right Time, The Right Place*.

The reform process to date has been hampered by the financial situation of the Department in recent years. HSC Trusts have fought to maintain existing services while being required to make efficiencies. The Department has relied on Monitoring Round monies to fund aspects of reform and as bids were not always successful, the implementation of TYC has been slow.

His report recognised that TYC contained good ideas for developing alternatives to hospital care and called for 'action not words' with a new costed, timetabled implementation plan and an impartial international panel of experts to review the configuration of HSC services, whose recommendations would be binding on government in NI.

In 2016, the then Health Minister, Simon Hamilton MLA, stepped up reform by appointing an expert, clinically-led panel (somewhat based on the Donaldson recommendation) to consider, and lead debate on, the best configuration of services for NI. The panel is a mix of local, national and international expertise and will report in the summer of 2016.

He also announced the creation of a ring-fenced £30million Transformation Fund to be invested in order to realise the vision set out in TYC.

In January 2016, the Public Accounts Committee (NI Assembly) noted a key challenge for reform was to put the HSC Trusts on a sustainable financial footing, highlighting that as the Trusts have no authority to move money from one year to the next, this impedes their ability to undertake longer-term financial planning.

Since becoming Health Minister in May 2016, Michelle O'Neill has stated that she intends to refocus efforts to reshape the HSC, with the report of the expert panel leading the debate.

During the 2011-16 mandate monitoring the progress of reform and the implementation of TYC was key for the Committee for HSSPS.

Its Workforce Planning Review (September 2015) provided the Committee with an opportunity to engage with stakeholders regarding the overall progress of TYC as well as the specific impact on HSC staff. A number of key issues emerged:

- The status of TYC - the Committee became concerned that the Department were not working to a measurable, costed plan and that this raised questions in terms of monitoring, governance and funding.

- Tracking the planned shift of £83 million from hospital services to primary/community services – It became clear that the Department's financial circumstances over the past number of years were delaying implementation of TYC, by not permitting funding for new service developments. Although bids had been made in the Monitoring Rounds to help achieve the £83 million they had not always been successful.

- New service models - The Committee concluded that there was a lack of clarity as to who was responsible for developing new service models under TYC; and

- Regional workforce planning - The Committee was concerned about the time taken to produce the Regional Workforce Planning Framework, given its importance to TYC. Its recommendations included that;

  - o the Regional Workforce Planning Group should take a wider approach to workforce planning, making 'strenuous efforts' to avoid 'silo-based' approaches and focused instead on patient need; and

  - o The Department should consider how primary care services can be reconfigured regarding staff to deal with the increasing demands for GP appointments and also produce an estimation of the percentage increase or decrease in the size of the workforce required to implement TYC.

The Health Committee understood that the 'shift left' of services outlined in TYC also encompassed supported living options for older people as an alternative to residential care. It was in this context, the Committee carried out its review into supported living options for older people in 2014. The Committee's recommendations included that the relevant departments needed to work together in terms of developing housing options for older people which will have the best health outcomes for older people, based on the evidence available.

Glossary

HSCB: Health and Social Care Board
ICP: Integrated Care Partnership
PAC: Public Accounts Committee
PCP: Primary Care Partnership
PHA: Public Health Agency
LCG: Local Commissioning Group
TYC: Transforming Your Care

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1 Context – Health and Social Care in Northern Ireland

The Department of Health sets the policy and legislative context for health and social care in Northern Ireland (NI). An annual Commissioning Plan Direction sets out Ministerial priorities, key outcomes and objectives and related performance indicators.

The Health and Social Care Board (HSCB), in conjunction with the Public Health Agency (PHA) then produces a Commissioning Plan. The 2016/17 Commissioning Plan is currently being drafted by the HSCB.

At its simplest, commissioning is about securing and monitoring health and social care services for the population of NI. The diversity and complexity of the services delivered is immense, with some local services being designed and secured for a population of a few thousand, while for rare disorders, services need to be considered regionally or even nationally.

Since the devolution of powers to the Northern Ireland Assembly in 1999, the NI health and social care (HSC) system has remained organised around a formal functional split between service commissioning (purchasing) and service provider functions. The *Health and Social Care (Reform) Act (Northern Ireland) 2009*[1] provided the statutory basis for the rationalisation of these bodies:

- **Commissioning** – from four health and social care boards to the one regional HSCB,[2] working in conjunction with the PHA, to commission services to meet assessed need and promote good health. The 2009 Act also established five local commissioning groups (LCGs)[3], which function as committees of the HSCB. Each LCG is co-terminus with its respective HSC Trust area and is responsible for assessing needs and commissioning health and social care for its local population.

- **Service Providers** – from nineteen trusts[4] to the present five health and social care trusts and one ambulance trust.

- **Future Changes to Commissioning** - On 4 November 2015 the then Minister, Simon Hamilton, announced his intention to close the HSCB in order to reduce bureaucracy and ensure the Department retains strategic control, with increased focus on the financial and performance management of the Trusts[5]. This has not yet happened and discussion is currently ongoing on the future structure of health and social care in NI.

NI's model of integrated governance for health and social care sets it apart from other jurisdictions within the UK. In England, Scotland and Wales the provision of social care

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[1] Health and Social Care (Reform) Act (Northern Ireland) 2009, http://www.legislation.gov.uk/nia/2009/1/contents
[2] Health and Social Care Board, http://www.hscboard.hscni.net/
[3] Local Commissioning Groups, http://www.hscboard.hscni.net/LCG/index.html
[4] Seven hospital trusts, 11 community and social services trusts plus one ambulance trust
[5] Hamilton outlines ambitious vision for health and social care in Northern Ireland, DHSSPS Press Release, https://www.health-ni.gov.uk/news/hamilton-outlines-ambitious-vision-health-and-social-care-northern-ireland

is the responsibility of local authorities.[6] Integration in the delivery of services in NI is mainly achieved through the division of care into nine 'programmes of care' to which resource procurement and finance are assigned - acute services; maternity and child health; family and child care; elderly care; mental health; learning disability; physical and sensory disability; health promotion and disease prevention; and primary health and adult community.[7]

Health and social care services in NI are largely government funded and almost entirely free at the point of care for primary, hospital, community care and prescription pharmaceuticals. 'Out of pocket' expenses exist for dental care but these are capped and exemptions exist for certain groups.[8]

General Practitioners (GPs) play a main role in primary care and operate as independent contractors, funded by the Department of Health, through a combination of capitation and fee for service.[9]

2 Overview of the Drivers and Direction of Health and Social Care Reform

In many countries, governments are transforming how they deliver and manage health and social care services fit for a modern context. That context includes the increasing demands placed on these services by ageing populations, constrained resources, technological advances and rising patient expectations.

As a result of dramatic improvements in healthcare over the second half of the 20th century and continuing into the 21st century the number of people living with disease, often multi-morbidities, and needing years of support from the health and care system, has increased enormously.

Multimorbidities are often defined as the co-existence of two or more long term conditions. Multimorbidity increases markedly with age, but it is also found in younger people, especially in socially deprived areas where the co-existence of physical and mental health problems is common. It is associated with poor quality of life, disability, psychological problems and increased mortality. It is also associated with increased frequency of health service use including emergency hospital admission.[10]

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[6] United Kingdom, Raising Standards, OECD Reviews of Health Care Quality, OECD, (2016), page 242, http://www.oecd.org/health/health-systems/oecd-reviews-of-health-care-quality-united-kingdom-2016-9789264239487-en.htm

[7] Ham, C. et.al. (2013). Integrated care in Northern Ireland, Scotland and Wales, Lessons for England, The Kings Fund,

[8] United Kingdom, Raising Standards, OECD Reviews of Health Care Quality, OECD, (2016), page 241, http://www.oecd.org/health/health-systems/oecd-reviews-of-health-care-quality-united-kingdom-2016-9789264239487-en.htm

[9] As above

10 National Institute for Health and Care Excellence, Scope (2016), Guideline Title – Multimorbidity: assessment and management, https://webcache.googleusercontent.com/search?q=cache:ZcgV_9n6xj0J:https://www.nice.org.uk/guidance/gid-cgwave0704/resources/multimorbidity-final-scope2+&cd=3&hl=en&ct=clnk&gl=uk

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NI has not been immune to these factors and to the realisation of the need for real strategic change in delivery and suitable governance of its health and social care services.

A key theme for health and social care reform in NI over the past decade or so has been the recognition of the over-reliance on the hospital sector and the aim of shifting service provision away from hospitals and towards care in the community, closer to home. Primary care is recognised as central to health and social services acting as a first point of contact and a 'gateway' to secondary care and a wider variety of services within primary care itself.

Over a decade ago it was already recognised that a clear sense of direction for primary care was needed. Consequently, in 2005, the former Department of Health, Social Services and Public Safety published a 20-year strategic framework for primary care, *Caring for People Beyond Tomorrow.*[11] The framework noted the need or a much wider development of community-based alternatives to hospital admission.

This direction gathered pace in June 2011 when the then Minister for Health, Social Services and Public Safety, Edwin Poots MLA, announced a review of the provision of HSC services in NI and subsequently appointed the Review panel in August 2011.[12] It became known as 'Transforming Your Care' (TYC).

In recent years the HSC system has been subject to repeated scrutiny both formal and by the media, regarding[13]:

> *the quality and safety of care provided, amidst sustained economic pressures and ongoing concerns over adequate access to acute hospital care.*

This has ensured that latterly, the focus of reform has also included the governance structures with the publication of *Right Time Right Place* in 2014 (the Donaldson Report).[14] Its subsequent out-workings, include the establishment of an expert panel (chaired by Professor Rafael Bengoa)[15] to lead debate on the best configuration of health and social care in NI.

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[11] Caring for People Beyond Tomorrow, DHSSPS, October 2005, https://www.health-ni.gov.uk/publications/caring-people-beyond-tomorrow-strategic-framework

[12] Poots publishes details of Health and Social Care Review, HSC Review Press Release, 25th August 2011, http://www.hscboard.hscni.net/hscreview/News/08-25-2011%20-%20Poots%20publishes%20details%20of%20Health%20and%20Social%20Care%20Review.html#TopOfPage

[13] United Kingdom, Raising Standards, OECD Reviews of Health Care Quality, OECD, (2016), page 240, http://www.oecd.org/health/health-systems/oecd-reviews-of-health-care-quality-united-kingdom-2016-9789264239487-en.htm

[14] The Right Time, The Right Place, an expert examination of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland, Review team – Sir L. Donaldson, Dr P Rutter and D r M Henderson, December 2014, https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf

[15] Hamilton appoints Expert Panel to lead debate on delivering world class Health and Social Care for Northern Ireland, Department of Health, press release, 7/01/16, https://www.northernireland.gov.uk/news/hamilton-appoints-expert-panel-lead-debate-delivering-world-class-health-and-social-care

In January 2016, the NI Assembly Public Accounts Committee (PAC) noted that a key challenge for reform was to put the HSC Trusts on a sustainable financial footing[16]:

> *the financial strength of HSC Trusts has continued to decline despite the fact that they receive additional resources year-on-year to shore up their financial position.*

The PAC noted that HSC Trusts have no authority to move money from one year to the next and this impedes their ability to undertake longer-term financial planning[17]:

> *The decline in the financial stability of HSC Trusts is mirrored in widespread breaches of key waiting times targets for elective, emergency and outpatient care… Transforming Your Care is heralded as the great transformational saviour for health and social care, but the pace of change has been at best mediocre.*

The PAC recommended that the Department approach the Department of Finance to explore the options for introducing three-year budgets for the Trusts to enhance longer-term planning and also called on the Department to clarify the time period over which it expects the benefits of TYC to be realised. The former Health Minister, Simon Hamilton MLA, responded that the PAC report reaffirmed the need for "far reaching and radical reform".[18]

3 Transforming Service Delivery

3.1 A New Direction for Primary Care

In the 20-year strategic framework for primary care, *Caring for People Beyond Tomorrow* (2005),[19] the starting point was the recognition that demographic trends towards a larger and older population combined with lifestyle factors would have a large impact on the demand for primary care services[20]:

> *This will require the much wider development of community-based alternatives to hospital admission…*

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[16] Report on General Report on the Health and Social Care Sector 2012-13 and 2013-14, Public Accounts Committee, NI Assembly, 33rd Report NIA 282/11-16, January 2016, http://www.niassembly.gov.uk/assembly-business/committees/archive/public-accounts-committee/reports-2011-2016/

[17] Report on General Report on the Health and Social Care Sector 2012-13 and 2013-14, Public Accounts Committee, NI Assembly, 33rd Report NIA 282/11-16, January 2016, http://www.niassembly.gov.uk/assembly-business/committees/archive/public-accounts-committee/reports-2011-2016/

[18] PAC Report supports need for ambitious reform of health and social care, Department of Health, Press Release, 20/06/16, https://www.health-ni.gov.uk/news/pac-report-supports-need-ambitious-reform-health-and-social-care

[19] Caring for People Beyond Tomorrow, DHSSPS, October 2005, https://www.health-ni.gov.uk/publications/caring-people-beyond-tomorrow-strategic-framework

[20] Caring for People Beyond Tomorrow… DHSSPS, sections 2.10-2.11, https://www.health-ni.gov.uk/topics/health-policy/primary-care-strategy#toc-0

The outcomes envisaged from its implementation included[21]:

- Making primary care services more responsive and accessible - by providing a wider range of services in the community and by way of time to see practitioners in a greater number of locations;

- Developing more effective partnerships and team working across organisational and professional boundaries;

- More proactive engagement with service users about service planning, design and delivery; and

- Improved premises and infrastructure, harnessing new technologies and clinical advancements.

In June 2006 the steering committee published an improvement programme for commissioners to take forward with providers, including integrated working, nurse-led discharge, intermediate care and non-medical prescribing[22].

The most fundamental aspect was **'integrated working'** – a new role for GPs in the development of population-based primary care teams. Clinically-led pilot projects known as **Primary Care Partnerships** (PCPs) were initiated in 2010 to promote new approaches to commissioning care. The PCPs were established by the 'parent' LCG and consisted of voluntary alliances of health and care professionals and voluntary and community sector bodies working together to inform the commissioning decisions of the LCGs.

There were 15 PCP pathfinder pilots addressing issues as diverse as dermatology, ultrasound diagnostics, medicines management and mental health. The objectives were to improve integration and co-ordination between primary and community care, hospital specialists and social services and to identify alternative care pathways.[23]

The achievements of the PCPs have been described as 'modest' but they appear to have provided a basis for future service developments regarding **Integrated Care Partnerships** under TYC (see Section 3.2).[24]

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[21] Primary Care Strategy, *Caring for People Beyond Tomorrow* (2005), https://www.health-ni.gov.uk/topics/health-policy/primary-care-strategy#toc-0

[22] Reform programme for primary and community services (June 2006), https://www.health-ni.gov.uk/publications/reform-programme-primary-and-community-care-services

[23] Primary Care Partnerships, NI Assembly Official Report, Hansard, Committee for Health, Social Services and Public Safety, November 2011, http://www.niassembly.gov.uk/assembly-business/official-report/committee-minutes-of-evidence/session-2011-2012/november-2011/primary-care-partnerships/

[24] United Kingdom, Raising Standards, OECD Reviews of Health Care Quality, OECD, (2016), page 250, http://www.oecd.org/health/health-systems/oecd-reviews-of-health-care-quality-united-kingdom-2016-9789264239487-en.htm

3.2 – Transforming Your Care (TYC)

Despite positive local improvements in 'integrated care' being driven by the PCPs, the reform agenda for primary care appeared to lose some momentum in the years following the initial drive from *Caring for People Beyond Tomorrow*,[25]

Reform gathered pace again in June 2011, when the then Minister for Health, Social Services and Public Safety, Edwin Poots MLA, announced a review of the provision of HSC services in NI and subsequently appointed a Review panel in August 2011.[26]

The Review focused on what changes would make the greatest difference to outcomes for patients, users and carers and it became known as 'Transforming Your Care' (TYC). It engaged with over 3000 members of the public, clinicians, providers and interest groups and reviewed evidence within NI and internationally.

3.2.1 TYC Principles and Recommendations

A range of principles were identified to underpin a new **integrated model** of health and social care, the main ones being:

- To placing the individual at the centre of the model - a better outcome for the service user, carer, and their family;
- To provide the right care in the right place at the right time;
- **Integrated care** – working together with population-based planning of services;
- A focus on prevention and tackling inequalities;
- Promoting independence and personalisation of care; and
- Realising value for money;

TYC proposed a total of 99 recommendations, with the key drivers including[27]:

- Care to be provided as close to home as practical.
- **Shifting resource** from hospitals to enable investment in community health and social care services.
- A changing role for general practice working in 17 **Integrated Care Partnerships** (ICPs) across NI.
- Quality and outcomes to be the determining factors in shaping services; and
- Prevention and enabling individual responsibility for health and wellbeing.

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[25] Caring for People Beyond Tomorrow, DHSSPS, October 2005, https://www.health-ni.gov.uk/publications/caring-people-beyond-tomorrow-strategic-framework

[26] Poots publishes details of Health and Social Care Review, HSC Review Press Release, 25th August 2011, http://www.hscboard.hscni.net/hscreview/News/08-25-2011%20-%20Poots%20publishes%20details%20of%20Health%20and%20Social%20Care%20Review.html#TopOfPage

[27] Transforming your Care – A Review of Health and Social Care in Northern Ireland, December 2011, Executive Summary, http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf


TYC did not refer specifically to the previous framework for primary care, *Caring for People Beyond Tomorrow*. It simply referred to the fact that in recent years, an emphasis had been placed on increasing the role of primary care and the community supporting those with Long Term Conditions, and that this role could be expanded and based around the principle of 'home as the hub of care'.[28]

TYC further alluded to the previous framework in that the 353 GP practices (at that time) would work within networks of the already established PCPs forming part of new ICPs, along with representatives from other HSC bodies.[29]

TYC referred to NI's historical over-reliance on hospital services and that following the Review, and over time, there are likely to be 5-7 major 'hospital networks' each serving a population of some 250,000 to 350,000. It acknowledged that 'rurality' has historically influenced the number of hospitals and that this would be taken into consideration.[30]

3.2.2 The Integrated Care Model

The **Integrated Care Model** was illustrated as follows:
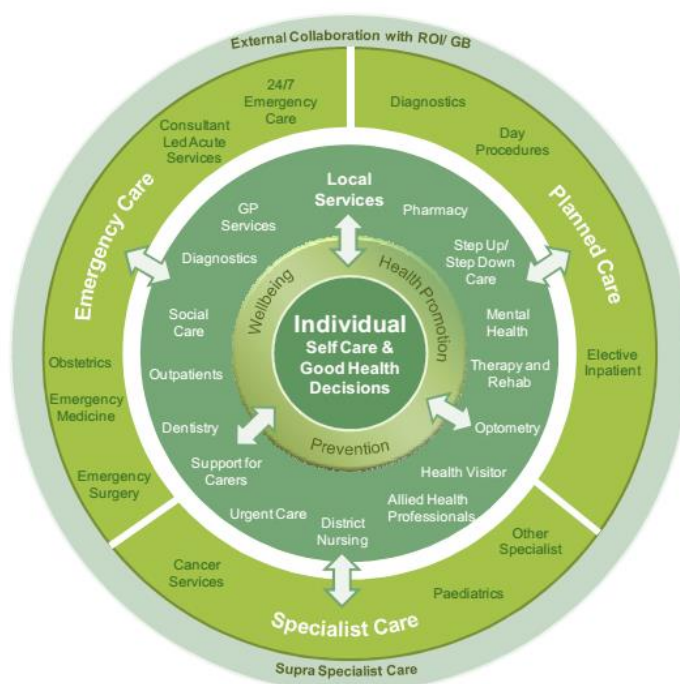
Source: Figure 4 of Transforming Your Care[31]

The model was generally envisaged to operate as follows[32]:

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[28] Transforming your Care – A Review of Health and Social Care in Northern Ireland, December 2011, page 72
http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf

[29] As above, page 115

[30] As above, pages 8 and 26

[31] As above, Figure 4, page 6,

[32] As above

- The HSC would provide the tools/support to allow individuals to maintain good health and wellbeing;

- Services would be enabled to regard home as the 'hub' of care to ensure people can be cared for at home as far as possible, including at the end of life. Most services will be provided locally, for example diagnostics, outpatients and urgent care, and local services will be better joined up with specialist hospital services; and

- HSC professionals would work together in a much more integrated way and if specialist hospital care is required it will be available but would plan to discharge patients into the care of local services as soon as their needs permit.

Case studies were developed to explain how the model would impact on ten major areas of care[33]:

> Population Health and Wellbeing - Older People - People with Long-Term Conditions -
>
> People with a Physical Disability - Maternity and Child Health - Family and Child Care -
>
> People using Mental Health Services - People with a Learning Disability - Acute Care -
>
> Palliative End of Life Care

At the heart of the new model is the transition to local population based service planning and integrated local service provision via the ICPs[34]:

> *The review sensibly places general practice central to this reform looking for general practitioners to form geographical networks… and assume critical leadership roles in Integrated Care partnerships (ICPs), the successors to PCPs.*

3.2.3 The TYC Model for Primary Care

The service model for primary care was to support the 'shift-left' based on a "Hub and Spoke" approach - the hubs providing services which do not require a hospital bed but are too specialised to be provided in a local GP surgery (a spoke), for example, outpatient assessments for long term conditions, minor surgery and diagnostics such as x-ray and ultrasound. [35]

Local GP surgeries will include practitioners such as GPs, practice nurses and Trust services where there is localised demand.[36]

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[33] Transforming your Care – A Review of Health and Social Care in Northern Ireland, December 2011, Executive Summary, http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf

[34] United Kingdom, Raising Standards, OECD Reviews of Health Care Quality, OECD, (2016), page 251, http://www.oecd.org/health/health-systems/oecd-reviews-of-health-care-quality-united-kingdom-2016-9789264239487-en.htm

[35] Health and Social Care Board, Transforming Your Care, Health and Care Centres, http://www.transformingyourcare.hscni.net/tyc-in-action/delivering-services-closer-to-home/health-and-care-centres/

[36]

In April 2013, two planned new 'Health and Care Centres' in Lisburn and Newry were announced to be a "*pivotal part of the reform of health and social care, as set out in Transforming Your Care*".[37] By then work was already underway on similar centres across NI, for example in Omagh, Banbridge and Ballymena. The Banbridge Health and Care Centre opened only recently at the end of January 2016.[38]

Belfast has seven such centres: Arches Centre (East Belfast), Beech Hall Centre (West Belfast), Bradbury Centre (South Belfast), Carlisle Centre (North Belfast), Grove Wellbeing Centre (North Belfast), Knockbreda Centre (Castlereagh) and Shankill Centre (West Belfast). These are described by the Belfast Trust as 'Health and Wellbeing Centres' – 'one stop shops' for treatment, care and information, which had previously been provided from a number of sites.[39]

This direction of travel for primary and community care is not new and pre-dates TYC. For example, the Grove Wellbeing Centre opened in 2008 and the Arches Centre was completed in 2005. The 2005 strategic framework for primary care, *Caring for People Beyond Tomorrow* (already discussed in Section 3.1) had already envisaged such centres:[40]

3.2.4 Consultation Process

In the years following 2011, the planning and a consultation process around TYC took place (October 2012 to January 2013, *Vision to Action*[41]). The HSCB and the HSC Trusts implementation plans and the Local Population Plans for each LCG were in finalised form by October 2013.[42] Five key overarching messages that emerged from the consultation process on how TYC should be taken forward[43]:

1. Sufficient investment to make change happen with alternatives in place before change occurs to current services;

2. A focus on support for carers as a key partner in care provision;

3. Support for staff who are the key enabler to implementing TYC;

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[37] Poots announces two new £40million health centres, DHSSPS News Release, 11th April 2013, http://www.northernireland.gov.uk/news-dhssps-110413-poots-announces-two

[38] Health Minister opens new £16million Banbridge Health & Care Centre, Department of Health, Press Release, 27th January 2016, https://www.health-ni.gov.uk/news/health-minister-opens-new-%C2%A316million-banbridge-health-care-centre

[39] Belfast Health and Social Care Trust, Health and Wellbeing Centres, http://www.belfasttrust.hscni.net/contact/WellbeingTreatmentCentres.htm

[40] Caring for People Beyond Tomorrow, DHSSPS, October 2005, paragraph 2.14, https://www.health-ni.gov.uk/publications/caring-people-beyond-tomorrow-strategic-framework

[41] Transforming your Care, Vision to Action Consultation Document, http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/TYC-Vision-to-Action-Consultation-Document.pdf

[42] Transforming Your Care, DHSSPS, Background to Transforming Your Care, https://www.dhsspsni.gov.uk/topics/health-policy/transforming-your-care#toc-4

[43] Transforming Your Care, Vision to Action Post Consultation Report, March 2013 http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/03/Transforming-Your-Care-Vision-to-Action-Post-Consultation-Report.pdf

4. Engagement with the voluntary and community sector in designing services and in developing their capacity to be key partners in the delivery of TYC; and

5. Need for greater cross governmental / agency working to address health inequalities and implementation of TYC.

3.2.5 Focus of Integrated Care Partnerships

The types of services that were proposed to be delivered within the community, through ICPs, were to include[44]:

> GPs with enhanced services - 24/7 Urgent Care including GP, mental health crisis response and minor procedures – Pharmacy – Outpatients – Diagnostics- Optometry - Dentistry - Access to therapy and rehabilitation - Beds used for step-up/ step-down from hospital managed by GPs - Reablement - Social support - Cross Departmental working groups to support social needs - Links to Voluntary and community organisations to support care - Support to carers - Advocacy services - Antenatal and postnatal care - Health and Wellbeing Advice.

The initial focus of ICPs has been on improving the way services are organised for frail older people and those with specific long-term conditions, with the aim of preventing hospital admissions.[45] For example:

- In November 2015 an integrated Community Respiratory Team was launched in the Western area. The multidisciplinary teams, based at Altnagelvin, Tyrone County and South West Acute hospitals, have developed services to improve care offering clinical support, monitoring, education and advice on self-management to patients and their families. Patients can be seen in a range of settings, including their own homes, healthy living centres, clinics and GP practices[46]; and

- The 'Acute Care at Home' team was launched in Belfast in October 2015 and is a team of healthcare professionals, led by a Consultant Geriatrician, working to help older people manage conditions such as chest infections, urinary tract infections, cellulitis and dehydration without the need for attending the emergency department, or hospital admission.[47]

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[44] Transforming your Care – A Review of Health and Social Care in Northern Ireland, December 2011, page 115, http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf

[45] Ham, C. et.al. (2013). Integrated care in Northern Ireland, Scotland and Wales, Lessons for England, The Kings Fund, http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/integrated-care-in-northern-ireland-scotland-and-wales-kingsfund-jul13.pdf

[46] Health and Social Care Board (NI), ICP News, http://www.hscboard.hscni.net/new-community-respiratory-team-a-breath-of-fresh-air-for-patients-in-the-west/

[47] Health and Social Care Board (NI), ICP News, http://www.hscboard.hscni.net/new-1-7m-hospital-home-service-older-people-belfast/

3.3 Reform of Governance - The Donaldson Report

In April 2014 the focus of reform moved to 'governance', when the former Minister, Edwin Poots MLA, commissioned the former Chief Medical Officer of England, Professor Sir Liam Donaldson, to advise on the governance arrangements across the HSC. His report *The Right Time, The Right Place* was published on 27 January 2014:[48]

> *The analysis in the report was based on extensive input from, scrutiny of, and discussion with people across the health and social care system in NI.*

The ten recommendations, although focused on governance, did include specific reference to TYC, recognising that TYC contained many good ideas for developing alternatives to hospital care but that now "few believe it will ever be implemented or that necessary funding will flow to it".[49] The recommendations are extracted and summarised from the report as follows:[50]

1. **Coming together for world class health care** - An impartial international panel of experts to review the configuration of HSC services. (Controversially, the report recommended that all politicians and the public accept 'in advance' the recommendations of this panel) (see section 4.2 for more detail on the expert panel);

2. **Strengthened commissioning** – the commissioning system in NI should be redesigned to make it simpler and more capable of reshaping services.

3. **TYC – action not words** – a new costed, timetabled implementation plan for TYC should be produced but with two projects to be immediately enabled as they have the potential to reduce the demand on hospital beds - expanded roles for pharmacists and paramedics in pre-hospital care;

4. **Self-management of chronic disease** - a programme should be established to give people with long-term illnesses the skills to manage their own conditions – piloted in one disease area first;

5. **Better regulation** - the regulatory function to be more fully developed by exploration of options around expanding the role of the Regulation and Quality Improvement Authority versus the outsourcing of this function;

6. **Making incident reports really count** – The report highlighted that the way the system of incident reporting works within the HSC "is falling well below its potential"

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[48] The Right Time, The Right Place, an expert examination of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland, Review team – Sir L. Donaldson, Dr P Rutter and D r M Henderson, December 2014, Chapter 2, https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/donaldsonreport270115_0.pdf
[49] As above, paragraph 4.2.4
[50] As above, Chapter 6

– the recommendation was that the system of Serious Adverse Incident and Adverse Incident reporting should be retained with some modifications, including:

   a. introduction of a clear policy and some re-shaping of the system of Adverse Incident reporting so that the lessons emanating from cases of less serious harm can be used for systemic strengthening;

   b. a duty of candour should be introduced in NI consistent with similar action in other parts of the UK;

   c. a portal for patients to make incident reports should be created and publicised; and

   d. a limited list of Never Events should be created.

7. **A beacon of excellence in patient safety** – the report recommended the establishment of a NI Institute for Patient Safety, after highlighting that:

   there is currently a complex interweaving of responsibilities for patient safety amongst the central bodies responsible for the health and social care system in Northern Ireland. The Department of Health, Social Services and Public Safety, the Health and Social Care Board, and the Regulation and Quality Improvement Authority all play a part….

8. **System-wide data and goals** - the establishment of systems metrics that can be aggregated/disaggregated from regional level to individual service level for the HSC system – according to the report, the NI HSC system has no consistent method for the regular assessment of its performance on quality and safety at regional-level, Trust-level, clinical service-level, and individual doctor level - in contrast to the best systems in the world.

9. **Moving to the forefront of new technology** – the establishment of a small Technology Hub to identify the best technological innovations that are enhancing the quality and safety of care internationally; and

10. **A much stronger patient voice** - a number of measures should be taken to strengthen the patient voice, including:

   a. more independence in the patient complaints process;

   b. the Patient and Client Council should have a revised constitution making it more independent and its Board should be reconstituted to include a higher proportion of current or former patients or clients of the HSC system; and

   c. the organisations representing patients and clients with chronic diseases should be given a more formal role within the commissioning process.

4 Current Direction of Reform

4.1 Updates on Reform

Simon Hamilton MLA became Health Minister in May 2015 until the end of the previous mandate and initiated a series of reforms building on TYC and the Donaldson Report, including:

4th November 2015 – Based on a Donaldson Report recommendation - the Minister signalled the end to the current way healthcare is commissioned, by planning to close the HSCB and creating a specific directorate within the Department with greater focus on the financial and performance management of the Trusts. The plan was to retain the PHA with renewed focus on early intervention and prevention.[51] Work is currently ongoing on the future commissioning structures.

7th January 2016 –- He appointed a clinically focused expert panel to lead debate on the best configuration of HSC services for NI (see section 4.2). The panel is chaired by Professor Rafael Bengoa.

2nd March 2016 – He announced the creation of a ring-fenced £30million Transformation Fund to be invested in projects/initiatives focused on innovation, prevention and collaboration within the sector, in order to realise the vision set out in TYC.[52]

Since becoming Health Minister on 25th May 2016, Michelle O'Neill MLA has highlighted that she intends to refocus the efforts to reshape the HSC. Among her priorities are further development of all-island networks for cooperation on health and social care; reducing health inequalities and mental health[53]:

> we must have a firmer grip on the strategic direction of health care delivery….Professor Bengoa's report…will lead the debate on how we deliver a world-class health service and will form a key part of any change agenda.

On 14th June 2016, the Minister welcomed an extra £72million for health and social care services through June Monitoring but said she remains focused on long-term reform[54]:

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[51] Hamilton outlines ambitious vision for health and social care in Northern Ireland, DHSSPS Press Release, https://www.health-ni.gov.uk/news/hamilton-outlines-ambitious-vision-health-and-social-care-northern-ireland

[52] Hamilton launches £30million Transformation Fund, DHSSPS New Release, 2nd March, 2016, https://www.dhsspsni.gov.uk/news/hamilton-launches-ps30million-transformation-fund

[53] Reshaping services top priority for new Health Minister, Executive News Service, DoH News Release, 26 May 2016, https://www.health-ni.gov.uk/news/reshaping-services-top-priority-new-health-minister

[54] Extra funding welcome but reform is long-term priority: O'Neill, Executive News Service, DoH News Release, 14th June 2016, https://www.northernireland.gov.uk/news/extra-funding-welcome-reform-long-term-priority-oneill

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> *it is only through longer-term structural reform that we will secure an efficient and effective health and social care service.*

4.2 The Expert Panel

4.2.1 The Panel Members

The expert panel is clinically-led and the focus is to draw on the experience of those working in or using HSC services, but also to ensure there is an international perspective. The panel comprises six members drawn from a range of specialties and backgrounds:[55]

Chair - Professor Rafael Bengoa who has practiced as a doctor for seven years in both hospital and primary care.

Key to his role in this panel - from 2009 to 2012 he was Minister for Health and Consumer Affairs in the Basque Government in Spain and during that time "implemented a transformation of the region's health service during a period of even harsher austerity than we now face in Northern Ireland".[56]

Other panel members:

Mairead McAlinden - Chief Executive of Torbay and South Devon NHS Foundation Trust in England, formerly Chief Executive of the Southern HSC Trust between 2010 and 2014;

Professor John Øvretveit - Director of Research and Professor of health care innovation implementation and evaluation at the Medical Management Centre, The Karolinska Institute, Stockholm;

Bronagh Scott - deputy chief nurse for NHS England London region, having held a number of senior management posts and executive directorships in health and social services in NI and London;

Dr Alan Stout - GP principal in East Belfast, based in the Arches Centre and deputy chairman of the NI General Practitioners Committee and assistant secretary of Eastern Local Medical Committee (BMA); and

Mark Taylor - Consultant in General and Hepatobiliary Surgery and lead clinician at Belfast's Mater Hospital.

It has been noted that this is not what Professor Donaldson had envisaged when he recommended an international panel whose findings would be binding on government:

> *because he believed that a combination of populist stances by local politicians, and media coverage were preventing necessary reform.*[57]

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[55] Hamilton appoints Expert Panel to lead debate on delivering world class Health and Social Care for Northern Ireland, https://www.northernireland.gov.uk/news/hamilton-appoints-expert-panel-lead-debate-delivering-world-class-health-and-social-care

[56] The former Basque Minister charged with sorting out our health service, Scope NI, NICVA Newsletter, 8 January 2016, http://scopeni.nicva.org/article/the-former-basque-minister-charged-with-sorting-out-our-health-service

[57] As above

The then Health Minister instead opted for a panel comprised of both local clinicians, national and international healthcare professionals. Dr Stout of the panel highlighted that the panel will not be seeking to implement direct copies of other models, for example the Basque initiatives that Professor Bengoa implemented in that region, but that[58]:

> *elements of other programmes that have been successful will be considered. We don't need to completely discard what we have at present….Many of the key principles of TYC are still very valid….The problem with TYC wasn't the principles, more implementation…*

The panel's recommendations are expected in the summer of 2016.[59]

4.2.2 The Working Principles

Within a month of its formation, the panel held a cross-party health summit and outlined a set of draft principles. After feedback from local political parties, the agreed 13 working principles were published on 23rd March 2016[60]:

> *The principles call for a planning-based health service focusing on patient need, illness prevention and one that builds on the current integrated nature of Northern Ireland's health and social care system.*

The principles are summarised below as taken directly from the Working Principles document[61]:

Ethos
1. The system should be collaborative, not competitive – (i) organisations must work together to provide high quality care, (ii) unwarranted variance in care across the system should be minimised, (iii) the HSC should continue to work in partnership across government, with industry, academia, the community and voluntary sector, staff and patients to deliver new models of care.

2. The system should adopt a population health and well-being model with a focus on prediction and prevention rather than reaction - this principle acknowledges that HSC resources and service developments are often "locked into reactive disease care" and there should be an increased emphasis on prevention and health promotion, particularly for those experiencing inequalities.

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[58] The Big Interview: Dr Stout talks to VIEW about new NI health expert panel, by Brian Pelan, 11 April 2016, http://viewdigital.org/2016/04/11/big-interview-dr-alan-stout-talks-view-new-ni-health-expert-panel/

[59] Reshaping services top priority for new Health Minister, Executive News Service, DoH News Release, 26 May 2016, https://www.health-ni.gov.uk/news/reshaping-services-top-priority-new-health-minister

[60] Brinkley, G, The Bengoa Principles, BMA Northern Ireland Blog, 25th April 2016, https://www.bma.org.uk/connecting-doctors/bma_northern_ireland_community/b/bma_northern_ireland_blog/posts/the-bengoa-principles

[61] Working Principles for HSC Remodelling, Department of Health, https://www.health-ni.gov.uk/publications/working-principles-hsc-remodelling

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3. Patients should be active participants in their own care, not passive recipients - patients should be supported to take greater ownership of their own health outcomes. The principle acknowledges that the:

> *public rightly expects access to safe, sustainable and high quality health and social care services; however….the public should also be enabled to take greater responsibility for their own health and well-being, and to use services appropriately.*

Delivery Model

4. Health and Social Care is already integrated in NI. Remodelling must build on this strength and take a whole system perspective – building on the integration that already exists to allow patients to be able to transition smoothly between social care, community care and hospital care.

5. Only people who are acutely unwell need to be in a hospital – the principle is backed by research showing that hospital use is affected by deprivation, with people in poorer areas more reliant on emergency services, and making insufficient use of planned elective services, and studies showing positive feedback from patients who were treated in community settings.

6. Very specialist services can be based anywhere in Northern Ireland - it is proposed that any acute hospital in NI has the potential to become a regional centre and that the HSC should:

> *continue to explore and realise the mutual benefits of collaboration with other jurisdictions in ensuring patients have access to high quality, sustainable services.*

7. The location and composition of resources should be based on meeting patients' needs and achieving the best outcomes - co-ordinated workforce and service planning should be carried out on the basis of the population's need rather than to maintain services which are not sustainable in the long term.

8. The real value of Health and Social Care is in its people, not its buildings - local initiatives should be encouraged and best practice should be shared across the region with HSC staff given the freedom to innovate and deliver services in a way that best meets people's needs.

Implementation

9. Whole system remodelling is a medium to long term process:

Reform and remodelling on this scale will take time and must be supported by an evidenced, costed and resourced implementation plan. This will need policy and political commitment in the long term.

10. The system must be supported to implement change with pace and scale:

Service developments and investment from this point should be geared towards supporting and complementing a long term strategy for sustainable and quality care.

11. Technology should be developed and adopted where it can support and enable transformation - it was acknowledged that NI has one of the most advanced electronic care record systems in Europe:

Innovation and new technologies should be embraced in collaboration with industry where they offer the potential to deliver better or more efficient services.

Leadership and Culture

12. The panel will engage constructively with elected representatives when designing and communicating a remodelled HSC. The Panel will also engage openly with HSC staff and the public:

Without change, the Northern Ireland Health and Social Care system is not sustainable in the medium to long term. Elected officials will play a key role in analysing proposals and enabling the public to understand the need for change.

13. Northern Ireland can be a world leader in transforming health and social care – this principle highlights that NI can be a pioneer in "designing and delivering health and social care services fit for the 21st Century".

4.2.3 Transforming health care – the Basque approach

Although it has been stated in a recent interview with the panel member, Dr Stout, that the panel will not copy any one model of reform[62], it is likely that Professor Bengoa's

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[62] The Big Interview: Dr Stout talks to VIEW about new NI health expert panel, by Brian Pelan, 11 April 2016, http://viewdigital.org/2016/04/11/big-interview-dr-alan-stout-talks-view-new-ni-health-expert-panel/

system-wide reform of the Basque healthcare system from 2009 (for a population of over 2.3 million people), will feature in its considerations.

The reforms of the Basque system followed, to an extent, the Chronic Care Model, with additional emphasis on (i) developing a favourable policy environment, (ii) stimulating thinking with new models of care, (iii) aligning 'bottom-up' and 'top-down' integrators and (iv) promoting a distributed leadership approach.[63]

Further detail is found in Appendix 1.

5 Monitoring Progress of Service Reform – Health Committee

During the last mandate monitoring the implementation of TYC was a strategic priority for the Committee for HSSPS, including a review of workforce planning – encompassing the overall progress of TYC and a review of supported living for older people.[64]

5.1 Review of Workforce Planning – Overall Progress of TYC

The Workforce Planning Review (September 2015) provided the Committee with an opportunity to engage with stakeholders regarding the overall progress of TYC as well as the specific impact on HSC staff. The Committee discovered that TYC 'in its broadest iteration' still had the general support of the health and social care sector[65]:

> *All of the organisations…believed that the general principles of TYC were reasonable and provided a sensible direction for how future services would be provided.*

However, concerns from stakeholders included a lack of clear performance indicators and implementation detail with no real outline of how the HSC is going to get to where it wants to be. There was no disagreement over a shift from acute care to community based services but that the shift was not being properly funded. There were a number of key themes that emerged from this particular Committee Review:

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[63] Bengoa, R. (2013), Transforming health care: an approach to system-wide integration, International Journal of Integrated Care, http://www.ijic.org/articles/10.5334/ijic.1206/

[64] Committee for Health, Social Services and Public Safety, Reports – Workforce Planning (23/09/15); Supported Living (22/09/14); and Learning Disability (18/7/14), http://www.niassembly.gov.uk/assembly-business/committees/health-social-services-and-public-safety/reports/

[65] Committee for Health, Social Services & Public Safety, Review of Workforce Planning in the Context of Transforming Your Care, NIA 268/11-16, paragraph 30, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2015-2016/review-of-workforce-planning-in-the-context-of-transforming-your-care-final-report-.pdf

- The status of TYC within the Department;

- Tracking the TYC planned shift left of £83 million from hospital based services to primary/community based services;

- Development of new service models; and

- Regional workforce planning.

RaISe supported the review with two research papers. The first briefing[66] summarised how the issue of HSC workforce planning had been dealt with in the series of official relevant TYC publications. It also highlighted some challenges to medical workforce planning as identified by the British Medical Association (BMA) and introduced the NHS Scotland Everyone Matters: 2020 Workforce Vision as a good practice example of workforce planning for the Committee's consideration.

The second paper provided a baseline and an introductory review of HSC staff numbers and trends in a selection of staff groups likely to be impacted by TYC. The aim was to stimulate discussion around potential areas for further investigation by the Committee at that time.[67]

With regard to overall progress of TYC, the Committee conducted a review of the Department's Benefits Management Framework for TYC in 2014. In November 2014 the Committee appointed an Expert to advise on[68]:

- Whether the benefits framework has the capacity to effectively track how the implementation of TYC impacts on the levels of health inequalities in NI; and

- What examples of best practice existed in relation to the use of benefits/outcomes frameworks in health settings in other countries or regions and whether such approaches could be usefully applied to TYC.

The expert identified a total of 14 challenges and the Committee referred the report to the Department. In response the Department agreed to address a number of the challenges including: to conduct a review of the full Benefits Strategy, including the governance, roles, responsibilities and reporting; to give more consideration to the identification of disbenefits and reflect this in the next iteration of the Benefits Strategy; and to make the outcome profile more robust in design.

5.1.1 The Status of TYC

The Committee was keen to establish the status of TYC in the Department's planning. In an evidence session on 24 June 2015, the Department explained that in its view

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[66] Thompson J. (May 2014), Transforming Your Care – Workforce Planning, NIAR 277-14, NIA Research and Information Service (not published)

[67] Thompson J. and Todd D (February 2015), Transforming Your Care (TYC) Workforce Planning 2 – Trends in HSC Staff Numbers, NIAR 928-15, http://www.niassembly.gov.uk/assembly-business/committees/archive/health-social-services-and-public-safety/archive/research-papers/research-papers-2015/

[68] Committee for Health, Social Services and Public Safety End of Session Report 2014/15

TYC was not a 'plan' to be completed, but an ethos to inform commissioning decisions. Regarding new service models to implement TYC, the Department stated:

> *I am not sure that it has a beginning and an end. It is a live issue all the time. It is not the case that we have to produce 10 service models when we produce those, the job is done. It is a way of thinking. It is a context for the way in which we think. It is about trying to work from a patient's point of view…there is never an end to this.[69]*

The Committee were concerned that this approach to TYC (i.e. not working to a measurable, costed plan) raised questions in terms of monitoring, governance and funding and that this approach had caused confusion at a local level, particularly with regard to the development of new workforce models.   For example, organisations were unclear on whether a new model operating in one HSC Trust was going to be replicated across all the Trust areas.[70]

5.1.2 Shift of Funds from Hospital Based Services to Community Based Services

In 2014, the Committee conducted a review into the Department's approach to Budget 2015/2016. The report contained 12 main findings, including a concern that the Department's emphasis appeared to be on using the budget to maintain existing services, rather than reflecting the Department's stated top two strategic priorities – namely, the provision of high-quality front line care and the **implementation of TYC**.[71]

When TYC was published in 2011/2012, the Department estimated that £70 million would be required for its implementation over a '3 to 5-year period'. One of the objectives was, by 2014/2015, to have shifted £83 million from hospital based services to community/primary based services. At the time of the Committee's review, the Department estimated that by the end of 2014/2015 financial year, £38 million would have been spent to that end.[72]

In a more recent briefing to the Committee (March 2015) the Department advised the Committee that[73]:

> *we estimate that, by the end of 2015-16, some £45·3 million will have been shifted left from hospital to community services and invested in community*

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[69] Committee for Health, Social Services & Public Safety, Review of Workforce Planning in the Context of Transforming Your Care, NIA 268/11-16, pages 10, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2015-2016/review-of-workforce-planning-in-the-context-of-transforming-your-care-final-report-.pdf

[70] Committee for Health, Social Services & Public Safety, Review of Workforce Planning in the Context of Transforming Your Care, NIA 268/11-16, pages 10-11, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2015-2016/review-of-workforce-planning-in-the-context-of-transforming-your-care-final-report-.pdf

[71] Committee for Health, Social Services and Public Safety Legacy Report 2011 – 2016 Report: NIA 311/11-16 (Committee for Health, Social Services and Public Safety), http://www.niassembly.gov.uk/assembly-business/committees/archive/health-social-services-and-public-safety/reports/

[72] Committee for Health, Social Services and Public Safety: Response to Draft Budget 2015/2016, http://www.niassembly.gov.uk/assembly-business/committees/archive/health-social-services-and-public-safety/reports/

[73] Committee for Health, Social Services and Public Safety, OFFICIAL REPORT, (Hansard), Budget 2015-16 Spending Plans:DHSSPS Briefing '11 March 2015.

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*services to avoid hospital admissions and reduce time in hospital in line
with the TYC vision.*

In February 2015, the then Minister, Jim Wells MLA, acknowledged the pressure of the Department's financial circumstances on TYC. He stated that he and his predecessor had been clear that "ideally we are working to a three- to five-year implementation. That, of course, is dependent on financial circumstances".   He noted that the financial plan for 2015-16 was developed to[74]:

*deliver a balanced position for 2015-16. However, that financial plan does
not permit funding for any new service developments, including those that
might support the delivery of Transforming Your Care (TYC). That said, the
delivery of TYC remains a priority for my Department…*

The Minister continued to say that John Compton, the author of 'Transforming Your Care', "could not have envisaged the present financial backdrop". He noted that the Department had made bids, mostly in the Monitoring Rounds, to achieve the £83 million and they had not always been successful.[75]

The Public Finance Scrutiny Unit of RaISe produced the following table regarding the bids made by the Department in the Monitoring Rounds, clearly showing that the Department did not receive the amount of money it needed in those years to implement TYC[76].

Monitoring Round	Capital/ Resource	Value Bid £ million	Value Met £ million
June 12-13	Resource	18	0
June 13-14	Resource	28	9.4
June 13-14	Capital	10	0
October 13-14	Resource	18.7	0
January 13-14	Resource	5	30
June 2014-15	Resource	21.3	0
Total		101	39.4

When the Committee queried with stakeholders the 'shift left' of monies, and its impact on the workforce, most organisations appeared to be unaware of how this had improved staffing on the ground. Stakeholders highlighted that, for example there had been a decline in the number of community nurses over recent years in NI. The HSC

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[74] Transforming Your Care: Costs, Oral Answers to Questions, HSSPS, in the NI Assembly, 17/02/15,
    http://www.theyworkforyou.com/ni/?id=2015-02-17.4.2
[75] As above
[76] Table complied by Public Finance Scrutiny Unit, NI Assembly Research and Information Service, (June 2016), based on DFP
    Monitoring Round Statements

Trusts were able to provide some examples, particularly regarding staff affected by learning disability and mental health resettlements.

A lack of wider communication across the health and social care sector, particularly with professional and staff side bodies at a regional level seemed to be a key issue.

5.1.3 New Service Models

The Regional Workforce Planning Group (RWPG), chaired by the Department of Health, was established in August 2012 to consider the implications of TYC for the workforce and to ensure that this was reflected in the workforce planning programme. The RWPG finalised a Regional Workforce Planning Framework (RWPF) in April 2015.

The Committee felt that there was a lack of clarity as to who is responsible for developing the new service models under TYC. During the evidence session with the Regional Workforce Planning Group (RWPG) on 24 June 2015, the Department stated:[77]

> *…It is the role of the Board and the PHA as commissioners to determine and agree the various models of service delivery, including the outworking of TYC; to challenge the trusts or providers to ensure that they have identified their workforce needs to be able to deliver the commissioned services…*

However, the Trusts all advised the Committee that, in some instances, they are taking the initiative for developing new local service models and then bringing these to the HSCB to bid for them to be funded.[78]

5.1.4 Regional Workforce Planning

The specific workforce planning elements within TYC include key proposals 79, 95 and 97A[79]:

- 79: Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements;

- 95: Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is co-ordinated at home or close to home; and

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[77] Committee for Health, Social Services & Public Safety, Review of Workforce Planning in the Context of Transforming Your Care, NIA 268/11-16, pages 10, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2015-2016/review-of-workforce-planning-in-the-context-of-transforming-your-care-final-report-.pdf

[78] Committee for Health, Social Services & Public Safety, Review of Workforce Planning in the Context of Transforming Your Care, NIA 268/11-16, pages 10, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2015-2016/review-of-workforce-planning-in-the-context-of-transforming-your-care-final-report-.pdf

[79] Transforming Your Care, A Review of Health and Social Care in Northern Ireland, DHSSPS, 2011, http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf

- 97A: More formal integration of workforce planning into the commissioning process to drive the financial transformation.

The Committee welcomed the publication of the RWPF, but was concerned about the time taken for its production. The Department highlighted that other streams of work had been progressed in parallel, including a programme of medical specialty reviews; additional uni-professional reviews; and a pilot workforce review for domiciliary care for older people - in the context of a programme of care rather than in a particular profession.

Based on the evidence it took during its review, the Committee made a number of recommendations regarding workforce planning, including[80]:

- The RWPG should:

  o take a wider approach to workforce planning and make 'strenuous efforts' to avoid 'silo-based' approaches which focus primarily on staffing groups rather than patient need;

  o take note of the workforce needs within the private/independent sector – particularly in terms of the staff required for nursing and residential homes, day-care and domiciliary care;

- The Department should:

  o consider how primary care services can be reconfigured regarding staff, to deal with the increasing demands for GP appointment;

  o produce an estimation of the percentage increase or decrease in the size of the workforce required to implement TYC;

  o consider how the RWPG can be made more inclusive of staff side and professional bodies and look at other ways of engaging with these groups;

  o consider taking a longer-term approach to workforce planning by engagement with other jurisdictions, for example, Scotland (as referred to above in RaISe paper NIAR 277-14) in terms of understanding the merits and challenges involved in taking a longer- term view; and

  o prioritise the development of policies on recruitment and retention of healthcare staff.

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[80] Committee for Health, Social Services & Public Safety, Review of Workforce Planning in the Context of Transforming Your Care, NIA 268/11-16, page 7-8, http://www.niassembly.gov.uk/globalassets/documents/reports/health/session-2015-2016/review-of-workforce-planning-in-the-context-of-transforming-your-care-final-report-.pdf

The HSCB and PHA Commissioning Plan 2015/16 set out a number of workforce initiatives and services as follows[81]:

- Integrated service - the regional workforce planning framework will drive the practical implementation and improvement of workforce planning across the HSC.

- Profession specific - there will continue to be workforce planning and development through profession specific activities, including:

    o a workforce planning review for Nursing and Midwifery services in NI - *Delivering Care: Nurse Staffing in Northern Ireland;*

    o Trusts to increase working practices which support 7 day services;

    o a range of workforce plans across different specialties have been developed or are underway;

    o the implementation of the Social Work Strategy, which includes workstreams such as workload, job rotation, extended hours and flexible working;

- Capability Development Initiatives to support the reform agenda
  These include:

    o change Management and core skills programme for those involved in TYC or transformation projects;

    o effective partnership working and skills programmes for those on ICP Committees or supporting their operation;

    o development of a HSC Knowledge Exchange open to all those involved in the design, commissioning or provision of health and social care services across NI; and

    o investment in 'Organisation Workforce Development and Service Improvement' skills to support staff in their roles.

- The *Delivering Care: Nurse Staffing in NI* Project:
  a framework to determine staffing ranges for the nursing and midwifery workforce in a range of specialities*:*

    o phase one set out the nursing workforce required for all general and specialist medical and surgical hospital services – the HSCB has agreed an implementation plan;

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[81] Commissioning Plan 2015/16, HSCB and PHA,
http://www.hscboard.hscni.net/download/PUBLICATIONS/COMMISSIONING%20PLANS/Commissioning%20Plan%2020
15-2016.PDF

      o   three further phases were at development stage:

        •   phase two focuses on nurse staffing within Emergency Departments;

        •   phase three focuses on District Nursing; and

        •   phase four focuses on Health Visiting.

5.2 Review of Supported Living for Older People - in the context of TYC

In NI, between 2010 and 2025, the number of people over 65 is expected to increase by 40%, and the very elderly (people over 85) is expected to almost double. This means that more people will be living with long term illnesses and disabilities, which has implications for how, and where, people will be cared for.

The majority of older people wish to remain living in their own homes. The policy direction of TYC for older people was to support them to maintain independence and manage daily living in their own home or in assisted housing, as opposed to in an acute setting or long term care, as long as possible.[82]

The Health Committee understood that the 'shift left' outlined in TYC also promoted supported living options for older people in their own community as an alternative to residential care. It also noted that within the TYC Implementation Plan there was an acknowledgement that these alternatives are not widely known about by the public. It was in this context the Committee carried out its review into supported living options for older people in 2014.[83]

The TYC Implementation Plan stated that for older people, one of the significant benefits of TYC would be the increased availability of community-based alternatives to residential care. Due to improved availability of these types of community-based alternatives, it was expected that the demand for statutory residential homes would decline. [84]

During its review, the Committee considered the structure and availability of supported living options for older people in NI, assessed the capacity of supported living options to support TYC in terms of reducing the need for residential home places; and identified examples of best practice in supported living in other countries/regions.

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[82] TYC Strategic Implementation Plan, DHSSPS, Section 4.3.2, October 2013, http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf

[83] Review of supported living for older people in the context of Transforming Your Care, Committee for Health, Social Services & Public Safety, Report Number 193/11-16, http://www.niassembly.gov.uk/globalassets/Documents/Reports/Health/session-2014-2015/Report-on-Review-of-Supported-Living-for-Older-People-in-the-context-of-Transforming-Your-Care.pdf

[84] TYC Strategic Implementation Plan, DHSSPS, Section 4.3.2, October 2013, http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf

As part of its evidence, it considered two papers from RaISe entitled[85]:

- *Caring for an ageing population: TYC proposals* (NIAR 69-14) – the paper highlighted that the majority of older people want to remain living in their own homes but that the concept of supporting this is not new, with previous publications like *People First* (DHSSPS, 1990) and the *Bamford Review* (DHSSPS, 2007) also reflecting this vision. It concluded that whilst TYC advocates the home as the hub of care and support, there was little evidence of what the costs for this will be in terms of older people or if there will be better health outcomes by keeping older people at home or in supported living places.

- *Specialised grouped housing for older people: introductory briefing* (NIAR 108-14) - the focus of this paper was the policy around, and examples of, this type of housing in NI and also the out-workings of the Housing our Ageing Population: Panel for Innovation (HAPPI). HAPPI was established in June 2009 to investigate what reform was needed in the UK to ensure that new build specialised housing meets the needs and aspirations of older people.

In its final report, the Committee made a number of recommendations in this area including those summarised below:[86]

1. The HSCB should:

   a. require each of the Trusts to produce an action plan for raising awareness of supported living options for older people;

   b. review the criteria the Trusts use in terms of proposing supported living for an older person in the context of their needs assessment.

2. Promoting supported living should be carried out by government departments and/or their relevant arms-length bodies, as part of existing responsibilities;

3. More joint planning between the Trusts and housing associations before decisions are made to commission new facilities;

4. The Department should begin:

   a. forecasting the need and demand for supported living places over a 10-year period - forecasts kept under review and reassessed when decisions are being taken to build new facilities;

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[85] Review of supported living for older people in the context of Transforming Your Care, Committee for Health, Social Services & Public Safety, Report Number 193/11-16, Appendix 4, http://www.niassembly.gov.uk/globalassets/Documents/Reports/Health/session-2014-2015/Report-on-Review-of-Supported-Living-for-Older-People-in-the-context-of-Transforming-Your-Care.pdf

[86] Review of supported living for older people in the context of Transforming Your Care, Committee for Health, Social Services & Public Safety, Report Number 193/11-16, http://www.niassembly.gov.uk/globalassets/Documents/Reports/Health/session-2014-2015/Report-on-Review-of-Supported-Living-for-Older-People-in-the-context-of-Transforming-Your-Care.pdf

       b.   collecting data on numbers of older people supported in their own home through domiciliary care who would be suited to supported living; and

5. The relevant departments to work together in terms of housing options for older people which will have the best health outcomes, based on the evidence available.

The Department accepted the majority of the Committee's recommendations and work is ongoing in relation to their implementation.

6 Concluding Comments

For at least the past decade the policy direction for health and social care in NI has aimed to shift resources and service provision away from hospitals and to increase care being provided in the community as close to home as possible. The new model of care places the patient at the centre with home as the 'hub' of care as far as possible.

This change has been driven by the increasing demands placed on services by ageing populations; increased numbers living with multi-morbidities; constrained resources; technological advances and rising patient expectations. Also the recognition of NI's historical over-reliance on hospital services has played a key part in reform plans.

Although TYC has been the key driver in this regard, the direction of travel started at least five years before then with the 20-year strategy for primary care recognising the need for wider development of community-based alternatives to hospital admission and planning for 'one-stop' shops for health and social care in the community such as The Arches Centre and The Grove Health and Wellbeing Centre. Such centres are now in place in many towns across NI.

At the heart of TYC reform is the drive to build on NI's already integrated health and social care systems with enhanced integration on the ground via the transition to local population based service planning and the central role for GPs in the development of population-based primary care teams via the 17 Integrated Care Partnerships (ICPs) across NI.

Again, this direction is not entirely new as the forerunners of the ICPs were in essence the Primary Care Partnerships (PCPs) initiated as an outworking of the 20-year primary care strategy. They were clinically-led pilot projects established by the 'parent' LCG and consisting of voluntary alliances of health and care professionals and voluntary and community sector bodies working together to inform the commissioning decisions of the LCGs.

A main focus of scrutiny for the Committee in the 2011-2016 was to make every effort to track the impact of reform on the ground for front-line services and staff. Given the

scale of reform this was an immense task. Some of the key issues that came to light are now discussed.

Later in the mandate, the Department appeared to alter how it viewed TYC and referred to it as an 'ethos' driving commissioning decisions rather than a plan to be implemented. The Committee were concerned at this approach in terms of the ability to resource or monitor the reform without a costed, measurable plan. Professor Sir Liam Donaldson, in his review of governance of health and social car, also called for a new costed, timetabled implementation plan for TYC.

The Committee concluded that there was a lack of clarity as to who is responsible for developing the new service models under TYC and was particularly concerned at the pace of workforce planning for the HSC workforce. The Regional Workforce Planning Group did not finalise a Regional Workforce Planning Framework until April 2015. The 'shift left' of service delivery particularly impacts on HSC staff requiring development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is co-ordinated at home or close to home.

Overshadowing the reform process to date has been the constrained financial situation. In the years following the implementation plans for TYC the necessary finance to fulfil service reform on the ground was not forthcoming.

HSC Trusts have struggled to maintain existing services while being required to make efficiencies. The Department has relied on Monitoring Round monies to shore up the reform agenda and as bids were not always successful, the implementation of TYC has been slow. The £30million Transformation Fund announced in March 2016 is a boost to realising the vision of TYC.

The future of health and social care transformation has now taken on an enhanced clinical focus with the establishment of a clinically-led Expert Panel in January 2016, due to report in the summer of 2016. It is clear from the recent history of health and social care service reform that models of service delivery, for example, the Integrated Care Model of TYC, are not enough on their own to change day-to-day clinical practice. It also requires processes and resources to help local managers and health professionals to change practice on the ground and a suitable mix of bottom-up or clinically-led interventions to engage clinical and nursing leadership in the change process and top-down interventions that needed to be standardised across the entire health care system.

Appendix 1 – The Basque Approach to Reform

Reform of health care in the Basque Country focused on the Chronic Care Model. The MacColl Centre for Health Care Innovation, Seattle, US, developed the Chronic Care Model to tackle the many deficiencies in the current management of diseases such as diabetes, heart disease, depression, asthma and other chronic illnesses. Those deficiencies include:

- Rushed practitioners not following established practice guidelines;
- Lack of care coordination and planned care;
- Lack of active follow-up to ensure the best outcomes; and
- Patients inadequately trained to manage their illnesses.

The Chronic Care Model is not new, being originally designed in the mid-1990s and subsequently refined in 2003.[87] It:

> *identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise.*

(i)   Developing a favourable policy environment

A key aim in the Basque reforms was to explicitly raise 'chronicity' to the policy level as it was widely recognised that pilot programmes for tackling chronic illness are frequently not transferable to different contexts and "therefore, a sufficient scale of change is not reached in a community or a country"[88].

(ii)   Stimulating thinking with new models of care

The reform agenda was centred on three main models of care (a) the Chronic Care Model, already described, (b) the Triple Aim and (c) Risk Stratification.

These models/frameworks were not new but was different was their relevance to stimulate 'system' thinking towards a population health perspective.

Risk stratification - the whole population of the Basque Country being stratified according to their risk of hospitalisation. This has allowed interventions to prevent hospital admissions to be more accurately targeted on certain groups.[89]

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[87] The Chronic Care Model, The Macoll Centre for Healthcare Innovation, http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18

[88] Bengoa, R. (2013), Transforming health care: an approach to system-wide integration, International Journal of Integrated Care, http://www.ijic.org/articles/10.5334/ijic.1206/

[89] Bengoa, R. (2013), Transforming health care: an approach to system-wide integration, International Journal of Integrated Care, http://www.ijic.org/articles/10.5334/ijic.1206/

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) (Massachusetts, US) that describes an approach to optimising health system performance. It is IHI's belief that new designs must be developed to simultaneously pursue three dimensions, called the "Triple Aim"[90]:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

(iii)   Aligning 'bottom-up' and 'top-down' integrators

It was recognised that the use of the models were not enough on their own to change day-to-day clinical practice and that the Basque system did not have the elements required for coordinated or integrated care. So "a battery of management processes" ('integrators') were developed to help managers and health professionals to change practice on the ground.

Both 'top-down' and 'bottom-up' interventions were implemented[91]:

- Bottom-up interventions engaged clinical and nursing leadership in the change process; and
- Top-down interventions were those that needed to be standardised across the entire health care system and followed a more traditional formal planning approach. For example, the:

   resource allocation system was actually financing fragmentation…We therefore launched a new approach to joint commissioning (bundled payments across primary and hospital care) geared to encourage coordinated work at the provider level and to incentivise innovation in local care delivery".

(iv)   Promoting a distributed leadership approach

In view of the complexity of the reform process, it was considered unlikely that a traditional management approach which tries to enforce these improvements onto the organisation would work.[92]

Reform started with clinical integration to promote doctors' commitment to improvement initiatives. In the first year, 150 'bottom-up' projects were initiated in this way, which encouraged other health care professionals. It was recognised that with 'top–down' projects the probability of those projects "fading

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[90] Institute for Healthcare Improvement, Triple Aim, http://www.ihi.org/Topics/TripleAim/Pages/Overview.aspx
[91] Bengoa, R. (2013), Transforming health care: an approach to system-wide integration, International Journal of Integrated Care, http://www.ijic.org/articles/10.5334/ijic.1206/
[92] Bengoa, R. (2013), Transforming health care: an approach to system-wide integration, International Journal of Integrated Care, http://www.ijic.org/articles/10.5334/ijic.1206/

away with their political promoters" is high, but on the contrary, with many projects 'bottom-up' they are 'owned' locally and it was believed that they would tend to better survive 'political turnover'.