

# **REVIEW OF HSC COMMISSIONING ARRANGEMENTS FINAL REPORT – OCTOBER 2015**

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## LIST OF ABBREVIATIONS

BSO	Business Services Organisation
CCGs	Clinical commissioning groups (NHS England)
DfP	Department for Finance and Personnel NI
DHSSPS	Department of Health, Social Services and Public Safety NI ('the Department')
FPS	Family Practitioner Services
HSC	Health and Social Care
HSCB	Health and Social Care Board
ICPs	Integrated Care Partnerships
IPTs	Investment Proposal Templates
LCGs	Local Commissioning Groups
NIGPC	Northern Ireland GP Committee (British Medical Association NI)
OECD	Organisation for Economic Cooperation and Development
PCTs	Primary Care Trusts (NHS England)
PHA	Public Health Agency
RPA	Review of Public Administration
RQIA	Regulation and Quality Improvement Authority
SBA	Service and Budget Agreements
TDPs	Trust Delivery Plans
TYC	<i>Transforming Your Care</i>

## CHAPTER 1 – INTRODUCTION AND CONTEXT

### The Review of Commissioning

Commissioning in the context of health and social care can be defined as the process of securing the provision of services to meet the needs of a population. This encompasses assessing a population's health and social care needs, planning services to meet these needs, working with providers of services to agree the services to be delivered, monitoring delivery of services against agreed standards, and evaluating the impact of the services that have been commissioned (DHSSPS, 2011).

The current arrangements for Health and Social Care (HSC) commissioning in Northern Ireland were established in 2009, following the Review of Public Administration (RPA). Six years on from their establishment the Department of Health, Social Services and Public Safety (DHSSPS) has undertaken a review of the commissioning process.

This review was prompted by the need to assess whether the structures used to ensure the delivery of health and social care services in Northern Ireland remain the most appropriate ones. The review can be set in the context of:

- the need to ensure continued improvements in the health and wellbeing of the population and address health inequalities;
- the need to ensure continued improvements in the quality, safety and value of health and social care services;
- rising demand, resulting from an older population and the growth of chronic diseases;
- financial pressures set by both the constrained fiscal environment and rising demand;
- the increasing pace of technological change;
- as a result of these pressures, ongoing challenges in meeting key performance targets across the HSC.

Sir Liam Donaldson's review of the quality of health and social care provision in Northern Ireland also highlighted concerns about the effectiveness of the current arrangements in Northern Ireland. In response to the recommendation that the commissioning system should be redesigned, the then Minister initiated a review of commissioning arrangements in Northern Ireland. The Terms of Reference are included at Appendix 1. The review commenced in May 2015.

### Review Arrangements

The review was led by DHSSPS. A project steering group was established to provide leadership and direction to the review. This group was chaired by the DHSSPS Permanent Secretary and included members of the Department's Top Management Group, the Chief Executive of the Health and Social Care Board (HSCB), the Chief Executive of the Public Health Agency (PHA) and a representative of the six HSC Trust Chief Executives. The review was carried out by a small project team, comprising Departmental officials and experienced commissioners from the HSCB and PHA.

Expert advice and guidance to the review was provided by Derek Feeley, Executive Vice President of the Institute for Healthcare Improvement, and Tony Hunter, Chief Executive of the Social Care Institute for Excellence.

### Inputs to the review

In undertaking this review the project team carried out a series of interviews with a wide range of stakeholders. In all, more than 50 interviews were conducted including with senior officials in the Department, the HSCB and PHA; the Chair and a non-executive Director from both the HSCB and PHA; members of Local Commissioning Groups (LCGs) and Integrated Care Partnerships (ICPs); Chief Executives and senior executives from the HSC Trusts; the Patient and Client Council; professional bodies, including a number of Royal Colleges; and representatives from the voluntary and community sector. Written contributions to the review were invited from a number of other government departments, district councils, trade unions and other bodies that it was not possible for us to meet in the

time available. A full list of meetings and written submissions is provided at Appendix 2.

Views in this report have not been attributed to individuals, given the importance of ensuring open and honest dialogue. Each meeting that we had and submission that we considered added value and helped to challenge our thinking – all those we met with were extremely generous with their time.

The review also considered a wide range of inputs, including:

- responses to the consultation on Sir Liam Donaldson's report;
- a stocktake undertaken by the HSCB, with support from Ernst and Young, of their commissioning approach;
- a draft case study on health and social care commissioning in Northern Ireland, produced by the OECD as part of its wider review of public sector reform;
- a literature review commissioned by DHSSPS from Ulster University, considering evidence for the effectiveness of alternative models for planning and resourcing health and social care services in other UK countries and internationally;
- input from the HSCB and PHA outlining their approaches to commissioning, providing case studies and key facts/ statistics; and
- relevant research papers and previous reviews, as detailed in the bibliography accompanying this report.

### Review of Public Administration

Prior to RPA, health and social care services in Northern Ireland 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 Northern Ireland Executive launched the RPA in June 2002 with a view to putting in place modern, accountable and effective arrangements for public service delivery. Within health and social care, there were two major phases for implementation of the RPA changes -

the establishment of the 5 new integrated HSC Trusts and the retention of the NI Ambulance Trust as providers of services, with effect from 1 April 2007; and the establishment of the HSCB and PHA on 1 April 2009.

In arriving at the final form of the current structures, various options were considered. One of these was to move away from separate commissioner and provider functions, and instead combine both functions in a number of sub-regional health agencies. However, this option was ultimately rejected on the basis that it may have lacked the tension that was perceived as necessary to bring about improvements in performance and productivity. Instead, a decision was taken to retain a commissioner/ provider split through the establishment of a regional commissioning function. It was initially proposed that a Strategic Health and Social Services Authority should be established that would have responsibility for commissioning, performance management and health promotion, along with five HSC Trusts and one Ambulance Service Trust as providers of services.

However, following the restoration of the devolved Assembly in 2007 the then Health Minister outlined concerns that the planned regional Authority would be too cumbersome and add unnecessary bureaucracy. Instead, in 2008 the Minister announced plans to establish a smaller regional HSC Board with no more than 400 staff, to focus on commissioning, financial management and performance management; five local commissioning groups (coterminous with HSC Trusts) to assess the needs of local populations and commission services to meet these needs; and the establishment of a new regional Public Health Agency to focus on health improvement, health protection, and to provide public health support to commissioning.

### Aims and Goals of the NI Health and Social Care System

The Department's statutory responsibility is to promote an integrated system of health and social care designed to secure improvement in:

- the physical and mental health of people in Northern Ireland;
- the prevention, diagnosis and treatment of illness; and
- the social wellbeing of the people in Northern Ireland.

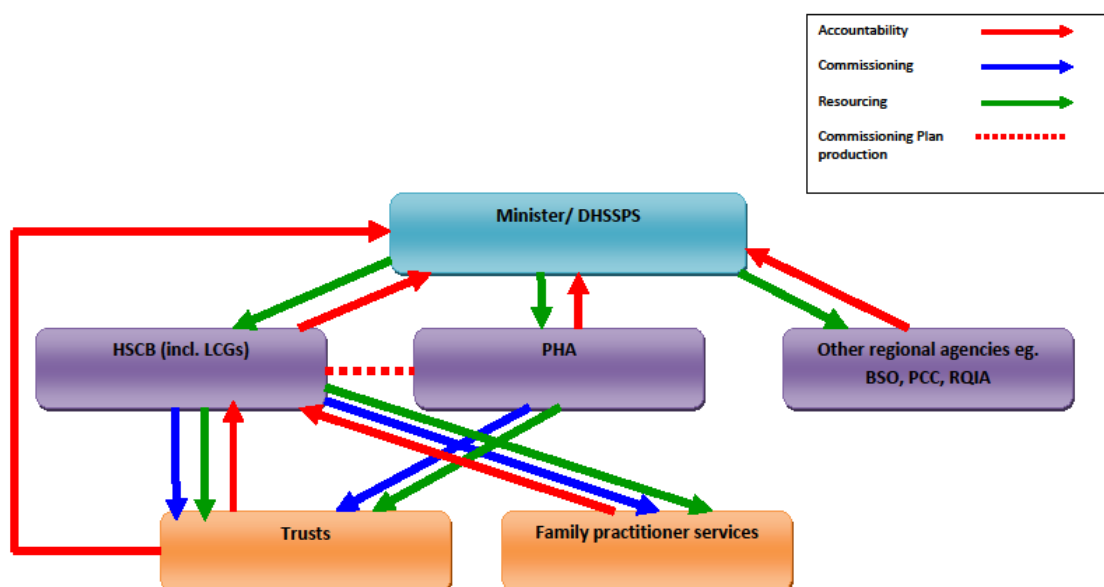


These responsibilities are carried out by direct departmental action and through the Department's arm's length bodies. The following are the Department's key strategic priorities:

- to improve and protect population health and wellbeing, and reduce health inequalities;
- to provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient satisfaction; and
- to ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

### Current Health and Social Care Structures

This current structure of the Northern Ireland HSC, along with the lines of accountability and funding flows between the different organisations, is represented in the following diagram:



The roles and responsibilities of the various HSC bodies, along with their relationships with each other and the Department, are set out in a Framework Document (DHSSPS, 2011) and are summarised below.

### *HSC Board*

The HSCB, including five LCGs as sub-committees of the Board, is responsible for commissioning health and social care services to meet the needs of the population of Northern Ireland; managing the performance of HSC Trusts; acting as the named authority for the discharge of a range of delegated statutory functions including those specified under the Children (Northern Ireland) Order 1995; and ensuring the best possible use of resources of the health and social care system.

In discharging its commissioning function, the HSCB is required to produce an annual commissioning plan, in full consultation and agreement with the 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.

The Department has retained responsibilities for HSC pay, terms and conditions, workforce planning, estate management and asset management. This division of responsibilities requires the HSCB, PHA, Trusts and Department to work closely to ensure services which are to be commissioned can be delivered within the resources available.

### *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 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.

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

### *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.

### Commissioning Arrangements

As set out in the Department's 2011 Framework Document, the purpose of HSC commissioning is to improve and protect the health and social wellbeing of the people of Northern Ireland and reduce inequalities in access to good health and quality of life. Commissioning aims to achieve a progressive improvement in services through investment based on evidence of effectiveness, compliance with quality and efficiency standards and a focus on addressing the determinants of poor health and wellbeing. The involvement of public, patients, clients, carers and communities and engagement with other partners has a central role in the commissioning process.

The Department sets the policy and legislative context for health and social care in Northern Ireland. It also determines the standards and targets by which quality, access and outcomes should be measured and provides the strategic direction for the health and social care professions therefore ensuring that quality, safety and patient experience are considered the drivers in commissioning and service provision.

The commissioning process, which includes resource and performance management and is led by the HSCB working with the PHA, aims to translate the agenda set by the Department into a comprehensive, integrated commissioning plan for health and social care services.

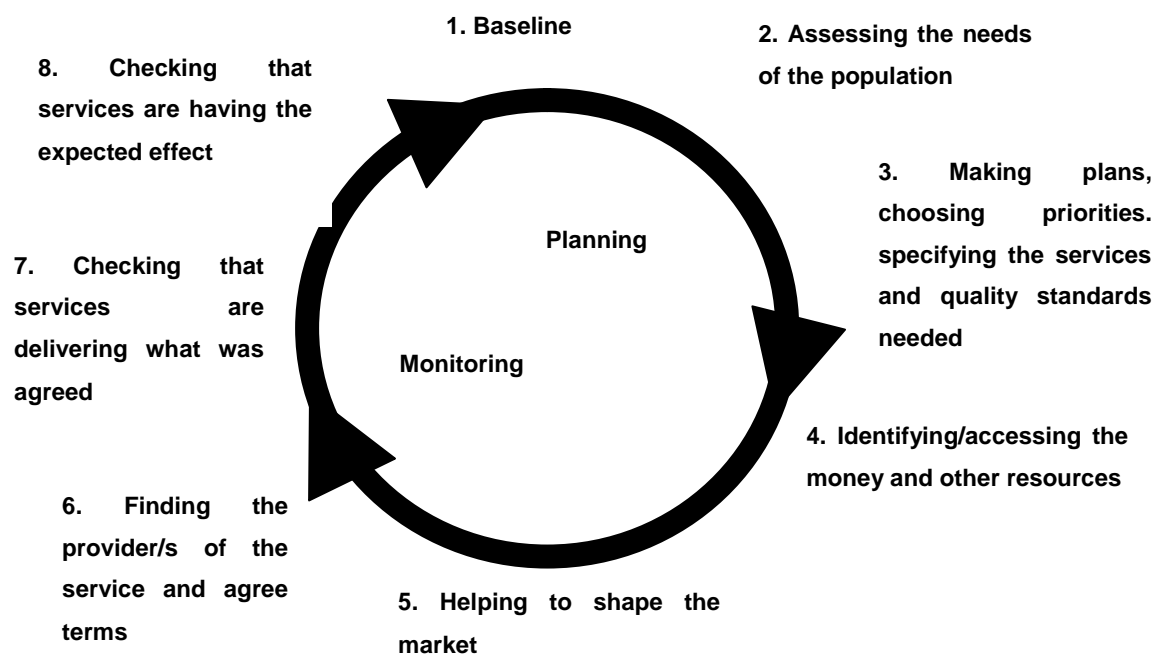
### The Commissioning Cycle

Commissioning includes the following activities:

- i assessing the health and social wellbeing needs of groups, populations and communities of interest;
- ii prioritising needs and investments within available resources;
- iii building the capacity of the population to improve their own health and social wellbeing by partnership working on the determinants of health and social wellbeing in local areas;

- iv engaging with the public/patients/clients/carers/families and other key stakeholders and service providers at local and regional level in planning health and social care services to meet current and emerging needs;
- v engaging with clinical and social care staff, service managers and providers to design and reform services;
- vi securing, through SBAs, the delivery of value for money services that meet standards and service frameworks for safe, effective, high quality care;
- vii safeguarding the vulnerable; and
- viii using investment, performance management and other initiatives to develop and reform services.

In the context of Northern Ireland’s integrated health and social care system commissioning should be seen as a cyclical process involving the full range of health and care services and needs, as set out in the diagram below. Activities are organised around a commissioning cycle that moves through from assessing needs, strategic planning, priority setting, securing resources to address needs, agreeing with providers the delivery of appropriate services, monitoring that delivery, evaluating impact and feeding back that assessment into the new baseline position in terms of how needs have changed.



In delivering on its role as Commissioner the HSCB (and PHA) also needs to facilitate a more integrated provider system by managing the interfaces between providers (statutory, independent and voluntary), developing capacity in those provider networks and acting as 'guardians' of the care pathway. The range of providers in the marketplace varies and for social care provision is generally more developed than is the case for healthcare (for example, 100% of nursing home care is provided by independent and voluntary sector providers). The development of a social care market place was driven by the Griffith's report of 1988 and the subsequent community care reforms of the early 1990's which have resulted in a large proportion of adult social care services moving from in-house provision to third party providers.

#### Commissioning and Performance Management

As represented in the above diagram monitoring performance of providers against the agreements they make in relation to service delivery is a key part of the commissioning cycle and should be at the core of the interface between the Commissioner and the Provider. In this regard the HSCB (including LCGs) and PHA are required to maintain appropriate monitoring arrangements in respect of provider performance in relation to agreed objectives, targets, quality and contract volumes. In the case of social care there are an increasing number of contracts where service user outcomes form part of the contract.

#### Summary of health and social care systems in other UK regions

In developing the options and recommendations within this report, the review team has considered the current system in Northern Ireland and the different systems in place across the UK. It is therefore worth taking some time here to give a broad overview of these systems. In doing so, it should be noted that 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 concept of “commissioning” in the healthcare context stems from the Conservative government’s NHS reforms of the early 1990s and efforts to introduce an internal market into the National Health Service with the aim of driving service efficiency. The idea of separating the purchasing of healthcare from the provision of healthcare – the purchaser provider split – was first proposed in the 1989 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 social care in England. 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.

In March 2013, the implementation of the reforms set out in the 2012 Health and Social Care Act replaced Primary Care Trusts with 211 CCGs. CCGs are led by clinicians and have responsibility for planning and commissioning the majority of health services for their local area.

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 was established in 2013, and 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 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 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: 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.

### Structure of the Report

Chapter 2 of this report provides an analysis of the current commissioning arrangements, drawing on the key findings from the stakeholder engagement conducted by the review team as well other materials. The analysis will be structured around a number of themes which reflect the agreed terms of reference:

- needs assessment, prioritisation and planning;
- quality, safety, patient experience and user engagement;
- funding mechanisms and market management;
- performance management and service evaluation;
- leadership, accountability and clinical/professional engagement;
- organisational structures and processes; and
- delivering reform and driving innovation.

Chapter 3 then considers the action that can be taken to strengthen the planning of health and social care services in Northern Ireland, including options for structural changes.

## CHAPTER 2 - ANALYSIS OF CURRENT NI COMMISSIONING ARRANGEMENTS

Sir Liam Donaldson's review of health and social care governance arrangements in NI noted that the "quality of the commissioning process is a major determinant in the quality of care that people ultimately receive" (Donaldson, 2014: 44). However, before moving on to consider the strengths and weaknesses of the present commissioning system in NI, it is important to make the point that commissioning – and indeed the structures in place to perform that function – while a key component, is only one part of the wider health and social care system. A paper produced by the University of Birmingham's Health Services Management Centre in 2008 recognised the complexity of healthcare commissioning and noted that the impact of commissioning will be affected by the way in which other elements of reform of health and social care systems are taken forward – the additional factors identified included payment systems, market management and regulation, and the degree to which commissioners are given the authority to exercise leverage and make necessary, if at times politically difficult, decisions. The paper concluded that "even if world class commissioning is developed, it may fall short of its potential in the absence of other changes in system design" (Ham, 2008: 7).

Similarly, a recent study of integrated care in Northern Ireland, Scotland and Wales found that whatever structures are in place, the delivery of seamless integrated care is challenging (Ham et al, 2013). Another comparative study of the four UK regions suggests that the different health policies adopted since devolution have had little impact on performance against key indicators (Bevan, 2014: 8).

This point is reiterated in a recent comparison of the four UK health systems, which found that "despite hotly contested policy differences between the UK health systems since devolution on structure, competition, patient choice and the use of non-NHS providers, there is no evidence linking these policy differences to a matching divergence of performance". This might suggest that the quality of the people in the system and their relationships is the most important factor. The report also highlights improvements in population health and the increased resources available for health services across the four countries since the late 1990s, the study notes that the performance gap between England and the rest of the UK has

narrowed in recent years and that Northern Ireland has improved performance against the majority of indicators assessed (Bevan et al, 2014: 1-2). Input provided by the HSCB to the review team also points to increased efficiencies in health and social care services in NI in the five years since 2009/10. For example, it notes that while spend on inpatient treatment has decreased by 2%, activity has increased by 11%. Overall, spend on hospital services decreased by 4% between 2009/10 and 2013/14, while the percentage of total spend on community and personal social services increased by 4%. The gap in reference costs between NI and England has also narrowed, from £152.5m in 2009/10 to £98m in 2013/14, a reduction of £67.4m (41% saving) in real terms.

However, despite these improvements, the Donaldson report concluded that the existing commissioning arrangements in NI are not operating as effectively as they could. Donaldson recommended that the NI commissioning system should be redesigned to make it simpler and more capable of reshaping services for the future, and that a choice must be made to adopt a more sophisticated tariff system or change the funding flow model altogether (Donaldson, 2014: 44). Respondents to the recent consultation on Donaldson's recommendations were overwhelmingly in agreement that the commissioning system should be redesigned – 92% of respondents either agreed or strongly agreed with this recommendation. These responses consistently emphasised the need to simplify the current process, make it more transparent, and ensure greater involvement from clinical/ professional staff as well as service users. Academic research has also questioned the effectiveness of commissioning in Northern Ireland (Birrell, 2015: 11-13).

During stakeholder interviews, and on considering the written inputs to the review, the review team encountered a number of differing views on the current commissioning arrangements. The team heard from some of those interviewed that a separate commissioning function provided the necessary tension and balance in the system, to ensure that the interests of one sector did not outweigh others and, where necessary, to take difficult decisions based on the best available evidence. Others considered that the separation of the commissioner/ provider function - and the bureaucracy perceived to surround it - hampered reform and innovation and reduced the autonomy and decision-making powers of providers.

However, despite the differing views on the effectiveness and impact of the commissioner/ provider split, some key messages emerged fairly consistently across all stakeholder groups regarding the current system:

- there is a lack of clarity regarding the chains of accountability and responsibility across the various HSC organisations;
- the current structures are overly complex and bureaucratic, and are disproportionate to size of NI population;
- the annual nature of the planning cycle has a negative impact on long-term, strategic planning;
- there is a need for greater stakeholder involvement in the planning and design of services – in particular clinical/ professional expertise, public/ service users, and the community and voluntary sector.

A more detailed summary of the key points made to the review team, and drawn from the additional inputs to the review, is set out below. These are organised under a number of broad headings, largely in line with the agreed terms of reference for the review.

#### Needs assessment, prioritisation and planning

The University of Birmingham's 2008 study on *Healthcare Commissioning in the International Context* noted that "health needs assessment is not routinely carried out in many systems, and when it is it may not be incorporated into purchasing decisions" (Ham, 2008: 2). Similarly, the OECD case study contends that the health and wellbeing needs of the NI population are unevenly articulated to the commissioning process (OECD, 2015).

This statement reflects the views of many of those who were interviewed by the review team or who provided written inputs to the review. While some respondents suggested that the system was getting better at assessing and responding to need, the majority considered that there was scope to do more in this area. It was suggested that the role of LCGs in assessing local needs has not been realised, in

part because of a perceived lack of data to support meaningful needs assessment. There was also a broad sense that commissioning teams do not always have access to – or do not fully utilise - the specialist skills and expertise required to adequately assess population health and care needs. For example, clinical and professional respondents to the review highlighted the knowledge among those engaged in delivering services regarding the specific health and care needs of patients and clients. There was also a clear message from voluntary and community sector respondents that they are uniquely placed to provide intelligence on need, but that this expertise is seldom sought – though we were also given details of an exception to this in the operation of and infrastructure for Children and Young People’s Strategic Planning. In Children and Young People’s Strategic Planning there are multi agency forums which seek to engage local people to identify and assess need and plan services. A number of district councils and the NI Local Government Association responded to the review, and all pointed to the role that new councils can play in assessing the health and care needs of local populations through the development of community plans. Finally, there was a sense that more could be done to engage the public and service users in determining health and care needs.

A common view expressed by stakeholders was that the priorities for health and social care services should be evidence-based, focused on outcomes across the entire patient pathway and developed in consultation with clinical/ professional staff, service users, and other stakeholder groups (for example, Royal Colleges). A number of respondents indicated that where the commissioning system has been most effective is when commissioning frameworks, service specifications and care pathways have been developed in partnership between clinicians, professionals and managers, based on evidence and in response to identified needs. For example, the screening programmes for abdominal aortic aneurysm and bowel cancer screening have been cited as responding to a clearly articulated need and having a robust evidence base drawn from both local and national intelligence. The review team was advised that the commissioning model employed by the HSCB’s Social Care Directorate is outcome-focused and based on service improvement methodology. The model is framed around personalisation and user/ community engagement, and is aimed at improving outcomes and user experience through the application of evidence-based best practice. Work to establish a new radiotherapy service at the

Altnagelvin hospital site has also been cited as an example of a service developed through effective collaboration between all relevant parties, in response to a clearly identified need (i.e. growing demand for radiotherapy services provided at the regional Cancer Centre at Belfast City Hospital). The business case for this service has now been approved and the new facility, due to open in October 2016, is expected to enhance access to radiotherapy services and improve the patient experience.

There was a clear consensus across all inputs to the review that the annual nature of the planning cycle is problematic, resulting in a reactive system with a short-term focus. The OECD case study reports a view that “the commissioning process is poorly designed to deliver strategic planning that prioritises assessed needs within available resources” and notes an “almost universal consensus” that there is a need to shift to a longer term planning and commissioning horizon. Based on this, OECD proposes a move to a five to 15 year planning cycle (OECD, 2015). Certainly, among those interviewed by the review team, there was broad agreement that a three to five year planning cycle, perhaps accompanied by an underlying, longer-term strategic plan, would be more effective.

In this regard, it is worth noting recent developments in England, Wales and Scotland where there has been a move to three to five year planning processes, with plans reviewed and, if necessary, updated during that time:

- in England, commissioners are required to develop strategic plans covering a five year period, with the first two years being at an operational level (this reflects the fact that in December 2013, NHS England published CCG funding allocations for 2014/15 and 2015/16).
- in Wales, there is a new requirement that Health Boards (the planning and provider organisations in Wales) develop integrated medium term plans (IMTPs) covering a three year period. Subject to agreement of a satisfactory three year plan by DHSS Wales, Health Boards are given some flexibility over how they use resources over the period covered by the plan.
- in Scotland, legislation introduced in 2014 aimed at promoting greater integration between health and social care placed a duty on Health Boards

and Local Authorities to develop strategic plans. These plans can cover a longer period than three years, but must be reviewed and revised at least every three years.

A number of interviewees and respondents considered that there was a need for greater consultation on priorities and strategic plans, with stakeholders inside the HSC as well as with external parties such as district councils, community and voluntary sector organisations, and patients and service users.

There was also a clear view from respondents that there is a need for a whole systems plan incorporating workforce and capital planning. The OECD report notes anxieties expressed by interviewees regarding a potential “workforce crisis” and recommends that commissioning needs to be better joined up with other parts of the system, in particular with workforce planning.

#### *Summary of key points*

- need for longer term, strategic planning cycle.
- need for more effective collaboration between managerial, clinical and professional teams in assessing health and care needs; developing evidence-based, outcome-focused priorities that span the entire patient pathway; and contributing to the development of strategic plans.
- need for better integration of workforce and capital planning with broader strategic planning.
- scope for greater involvement of other stakeholders - including community and voluntary sector organisations, district councils, and service users – in assessing need, developing priorities and planning services.

#### Quality, safety, and patient/ service user experience and engagement

The Francis report into the events at Mid-Staffordshire was clear that commissioners of services have a duty to ensure that the services they commission are provided safely, and emphasised the importance of meaningful engagement with patients and service users throughout the commissioning process. There was a perception



among some stakeholders consulted during the review that the focus of the commissioning process (and indeed the wider HSC system) is on finance, activity, performance targets and processes, rather than quality of services and patient outcomes. However, in its input to this review, the HSCB provided the review team with examples of service specifications and commissioning frameworks. These set out the aims and objectives of services to be commissioned, and showed a focus on the safety and quality of services and on improving patient/ service user outcomes and experience. In benchmarking services to inform future commissioning decisions, it is also clear that consideration is given to quality indicators, as well as to financial and access data. In addition, it is important to note that the Donaldson report found no evidence of fundamental safety problems within the HSC in Northern Ireland, and indeed it emphasised that services here are likely to be no more or less safe than in other part of the UK. Nonetheless, the clear perception among stakeholders is that too much emphasis is placed on monitoring activity.

The review team was provided with a number of examples of areas where patient and service user engagement has informed the commissioning process. For example, in commissioning the Lifeline service (a crisis response helpline), we understand the PHA consulted with a range of stakeholders including users of the existing service and families bereaved by suicide. Proposals to reconfigure inpatient addiction services were the subject of a programme of extensive public and service user consultation and were revised in response to the views expressed during this process. The development of the 2015/16 Commissioning Plan was informed by the views and opinions of service users and carers, facilitated by a workshop hosted by the HSCB and PHA, and commissioning intentions have been developed in response to issues identified by patients, in areas such as chronic pain and endometriosis. Nevertheless, there was a sense from some respondents to the commissioning review, as well as from the OECD study, that efforts to engage users in the planning of services are sometimes perceived as a “tick box” exercises, and that more could be done to engage more meaningfully with patients and service users.

In addition to the need for greater engagement with patients and service users in developing plans for specific services, a number of stakeholders suggested that

there was scope for a more wide-ranging process of public engagement regarding the longer-term configuration of services and the prioritisation of health and social care needs within available resources.

### *Summary of key points*

- need to address the perception that safety and quality of services and patient experience are not given sufficient priority in the commissioning process.
- potential for greater engagement with the public on the design and delivery of services, and on longer-term plans for the future of health and social care services.

### Funding mechanisms and market management

In his 2005 review of the health and social care system in NI, Appleby suggested that further consideration should be given to the introduction of some form of activity-based reimbursement in NI, in order to drive increased efficiency and enhanced performance (Appleby, 2005: 172). Sir Liam Donaldson's report, while noting that the costs of running a tariff system would be difficult to justify in NI, recommended that a choice be made between a more sophisticated tariff system or to change the funding flow model altogether (Donaldson, 2014: 15, 44).

During the development and implementation phase of RPA, a programme of work was undertaken to explore the feasibility of implementing an activity-based funding model in NI. However, drawing on learning that had emerged from the operation of “payment by results” in the NHS in England and taking account of the integrated nature of Northern Ireland’s health and social care system, it was decided that such an approach would not be appropriate for full implementation in NI. It is important to note that the English commissioning model is not entirely tariff-based, with around 70% of NHS funding allocated via block contracts (NHS England, 2014: 10). Published information such as CHKS and HES which compare costs across the UK are used when setting block contracts in Northern Ireland. As elsewhere in the UK, the level of sophistication and specificity in the contracts tends to fall as you move away from acute procedures and into community based activity. It has been argued that public services in England are generally moving away from activity based

funding to capitated models measured against outcomes (Jupp, 2015: 11) and the empirical evidence for the impact of payment by results is limited (Birrell, 2015: 29).

While interviewees recognised that the current funding mechanisms in NI are not ideal, and suggested that money tends to be allocated on the basis of historical activity rather than in line with assessed needs or agreed priorities, there was broad agreement that the introduction and operation of a tariff system here would result in high transactional costs that would outweigh any likely benefit. In addition, it was pointed out that such systems tend to incentivise hospital activity, rather than the necessary shift of services out of the hospital sector.

While there was little support for a move towards an activity-based funding model, there was a sense that more could be done to align financial pathways with care pathways and adopt payment mechanisms that would incentivise improved outcomes and patient experience across these pathways.

The short-term nature of the financial planning cycle was also reported as problematic, hindering long-term, strategic planning and reducing any flexibility for providers to innovate. Respondents noted the tendency of the HSC system to focus on the small amount of additional annual income, rather than a longer-term, strategic focus on the use of recurrent resources.

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 it is clear that (at least with the health sector here) there is little competition between providers, with LCGs tending to commission services primarily from their local Trust (HSCB/PHA, 2015: 66). The OECD case study found that at present commissioning is neither geared towards lowest cost for delivery or best practice, that available data is poorly suited to identify and end inefficiencies and decommission redundant services, and that there is little competition between providers (OECD, 2015).

It is important to note that the review team heard evidence of the different landscape in both health improvement and social care where services are currently

commissioned from a large field of potential providers. However, respondents to the review from the community, voluntary and independent sector were often negative about the commissioning and procurement processes, perceiving them to be overly bureaucratic, time-consuming, and not conducive to the development of innovative service models.

### *Summary of key points*

- need for longer-term financial planning focusing on recurrent resources rather than non-recurrent annual allocations.
- lack of financial flexibility impacts on ability to make long-term investment decisions.
- no consensus as to whether commissioning is the right model for NI, given the size of its population and limited market of health service providers.
- broad agreement that an activity-based funding model is not right for NI, but that alternative approaches should be explored that would incentivise reform, innovation, more collaborative working and ultimately improved patient/ client outcomes.

### Performance management and service evaluation

A number of interviewees expressed a view that performance management, rather than commissioning, is the primary focus of the current system. Some considered that the approach to performance management was adversarial and focused on numbers and activity rather than service improvement, quality of care, or patient outcomes. There was a sense that key stakeholders – in particular clinical and professional staff – are becoming increasingly disengaged from the process and that there was a need to secure greater “buy-in” from all stakeholders to the targets and priorities set for the HSC.

The lack of sanctions for poor performance and incentives for strong performance were also raised as issues. Although there was no clear view as to what form such sanctions or incentives might take, the onus on the HSCB to ensure financial breakeven means that imposing financial sanctions on providers is counter-

productive. A number of stakeholders considered that the current performance management system was too hands-on and micro-managed, and that greater autonomy and flexibility could prove to be an incentive.

While it is clear that providers should be held to account for the services they provide, there may be lessons to be learnt from the model in place in Scotland where a robust performance management system is complemented by a separate service improvement function. In addition, the Scottish government has in place a clear “ladder of escalation” which sets out the specific circumstances when performance concerns about a provider would merit an intervention from government, and outlines the form such interventions take.

In relation to service evaluation, there was broad agreement that more could be done to routinely evaluate the effectiveness and impact of commissioned services. However the review team did also hear specific examples of formal evaluations that have taken place, and where new service models have been commissioned that have resulted in real improvements in patient experience and quality of care, as well as increased efficiency. For example:

- Transforming Cancer Follow Up programme – developed by the HSCB and PHA in partnership with Macmillan Cancer Support and HSC Trusts. An evaluation of the programme has recently been completed and the 2015/16 Commissioning Plan includes steps aimed at building on this evidence base and consolidating the approach for all eligible patients. Similarly the review team was provided with reports monitoring the impact and outcomes of the breast and bowel cancer screening programmes;
- Mental health and learning disability services – in addition to the regular feedback received from service user and carer representatives on the Bamford Monitoring Group, in 2012 the HSCB and PHA used the Sensemaker Audit tool to measure service user/ carer specific outcomes and experience of mental health services. It is intended to repeat this evaluation in 2015/16.

### *Summary of key points*

- lack of sanctions and incentives to drive improvements in quality and performance – in particular, the use of financial sanctions has proved problematic because of the HSCB’s overall responsibility for the financial breakeven of the HSC.
- need to strike a balance between accountability, responsibility and autonomy, and between performance management and service improvement.
- in terms of targets and priorities, a balance must be struck across the three key aims of the HSC – improving health and wellbeing; safety, quality and patient experience; and achieving value for money in terms of both resources and outcomes (the ‘Triple Aim’ approach).
- need to ensure that key stakeholders have a sense of ownership of performance targets – scope for greater engagement with clinical and professional staff, and with service users and their representatives, to develop a range of evidence-based and, where possible, outcome-focussed targets.

### Leadership, accountability and clinical/ professional engagement

Sir Liam Donaldson’s review pointed to a lack of clarity around who is ultimately in charge of health and social care in Northern Ireland (Donaldson, 2014: 11, 16). This point was also made to the review team on numerous occasions. Stakeholders considered that the 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, a number of stakeholders noted that Trusts are accountable to the Permanent Secretary of the Department, rather than the Chief Executive of the HSCB. There was a strong sense that the HSC needs to clarify roles and responsibilities and identify an individual leader of the system.

A number of stakeholders expressed a view that the level of political and media interest in the health and social care service here is more intense than in other parts of the UK. This point has not always been borne out in the review team’s discussions with colleagues in other regions. Nevertheless, it is clear that implementing necessary reforms in the HSC is likely to generate intense public and

political scrutiny. There was a strong sense from a number of stakeholders that there needs to be an element of freedom to make these decisions, where there is clear and demonstrable evidence that they are necessary for improved services.

In relation to clinical and professional engagement, a number of interviewees were of the view that the location of public health expertise in the PHA, separate from the main commissioning organisation, has not been helpful in this regard. While numerous stakeholders emphasised that public health, clinical and professional input is critical to the commissioning process, it was suggested that this is often not supported by the current structures. This point was reiterated to the OECD team (OECD, 2015).

The review team heard some examples where public health experts and clinical and professional teams have successfully been engaged in the commissioning process, from the assessment of need, through to service design and implementation. For example:

- expansion of radiotherapy services to the Altnagelvin site - plans developed through close working between the HSCB, PHA, the Western Trust and RoI colleagues. Clinical staff have led on the development of workforce, training and recruitment plans for the service as well as the development of a clinical service profile, detailing those radiotherapy components that can be delivered at the Altnagelvin site and those that will continue to be delivered at the cancer centre;
- stroke services – ongoing clinical engagement in the development of detailed service specifications;
- mental health and learning disability services – clinical and professional staff involved in the development of commissioning frameworks, service models and care pathways for each of the specialist areas in the Bamford Action Plans;
- drug and alcohol services – clinical staff were consulted on commissioning priorities and service models. In addition, drug and alcohol coordination

teams (multi agency partnerships at Trust level) were involved in the process of identifying local needs and gaps in service provision.

The commissioning of screening and immunisation programmes was also cited by a number of stakeholders as an example of when the commissioning process has worked well. Again, the reasons stated for this include a solid evidence base for a service, the input of public health expertise, and consultation with clinical staff and other stakeholders, including patients.

A number of interviewees expressed the view that the commissioning process operated more effectively in social care than in health. The reasons cited for this tended to include a clearer understanding of roles and responsibilities across the system, the involvement of professional teams in the commissioning process, the formalised arrangements and principles governing the delegation of statutory functions, and the use of evidence-based objectives to inform commissioning frameworks and service specifications. However, it should be noted that respondents to the review from the community and voluntary sector were particularly critical of the procurement and commissioning processes in the social care sector.

Previous reviews of the NI health and social care system (e.g. *Fit for the Future*, *Acute Hospitals Review*, Appleby report), and the RPA proposals, have recognised the need to secure the involvement of GPs and other primary care practitioners in planning and designing services that respond to local need. LCGs, and latterly ICPs, represent the outworking of this in the current system. However, some stakeholders interviewed during the review considered that the commissioning process, and the wider HSC system, remains too focused on acute services at the expense of both primary and community care – a point that was also made to the OECD team (OECD, 2015). A number of stakeholders emphasised the role of clinical networks - drawing on expertise from across health and social care, across the primary, secondary and community sectors, and across disciplines e.g. mental health as well as physical health - in planning and coordinating care across the whole patient pathway.



### *Summary of key points*

- whatever option is agreed, strong sense from stakeholders that there is a need to identify a clear point of leadership within the system, and clarify roles and responsibilities of – and lines of accountability between - the various HSC bodies.
- greater autonomy and delegation of authority to reform and innovate. Strong sense that people want to get on with the job, but that they're being prevented from doing so.
- separation of HSCB and PHA has not been helpful in securing public health and clinical input to the commissioning process. Some good examples of when clinical and managerial teams have worked together with other stakeholders to develop commissioning frameworks and service specifications, but sense that this approach happens in spite of, rather than because of, structures.
- need for greater involvement of clinical and professional staff from beginning to end of commissioning process.

### Organisational structures and processes

There was a strong sense from interviewees and respondents to the review that there is a need for leaner, simpler structures than exist in the current system. Stakeholders in general cited the separation of the HSCB and PHA, the five LCGs and 17 ICPs – as well as the duplication of some functions across the Department and HSC organisations - as creating a complex system, with too many layers of bureaucracy.

There is also a question as to whether the costs associated with the commissioning process represent value for money. Whereas the HSCB was limited to a maximum of 400 staff when it was established in 2009, it currently employs 584 staff with salary costs of £29m (this increase is in part due to additional functions that the HSCB has been tasked with since its establishment). The commissioning directorate within the HSCB accounts for £4.8m of this total, though staff across the organisation

will also be involved in commissioning – for instance, those in the social services and finance directorates. The PHA currently employs 338 staff, at a cost of £16.9m.

In particular, interviewees expressed the view that there were too many layers of approval required before a decision to invest is taken. This point was echoed by respondents to the recently completed ICP evaluation survey, who expressed frustration that plans for innovative, multi-disciplinary care pathways have to go through multiple levels of approval before investment is confirmed. Respondents to the survey expressed the view that this approval process was impacting on the ability of ICPs to operate effectively.

Similarly, a number of respondents to the review from the community and voluntary sector expressed the view that the complexity of existing structures and processes made it difficult for them to engage with the system, despite being in a strong position to identify health and social care needs and contribute to the design of services and outcome measures.

Interviewees pointed to poor communication within and across organisations, and suggested that the complexity of existing structures does little to foster and support strong, collaborative working relationships across the health and social care system. The OECD team's case study adds an important corollary to this point – that in fact the size of the NI system has meant that good, productive working relationships have developed across a number of organisations. Importantly, some contributors to the OECD case study noted that “the quality of these relationships explained how the system continued to function despite resource constraints and organisational challenges” (OECD, 2015).

The OECD study notes that “support for the existing system of commissioning came from only a very small minority” (OECD, 2015). However, the Departmental-led review team heard from a number of interviewees that there was a need for some regional function to undertake the key elements of commissioning – assessing population need, planning and securing services to meet these needs, and evaluating the effectiveness of those services – and to ensure consistency of service models and standards across NI. While this could be undertaken at provider level

for the majority of services, there are some services for which a regional approach is most appropriate. In addition, consideration would need to be given as to how to secure primary care involvement to any provider-led process, how to ensure that services are provided consistently across NI and to ensure the necessary shift from acute care.

Colleagues in Scotland have advised that these issues have been addressed by setting clear targets and outcomes, requiring Health Boards to develop plans outlining how these will be achieved, and holding Boards to account on performance against plans. In addition, a range of managed clinical networks have been developed to improve standards of patient care through integration of services and collaboration across professional and organisational boundaries.

A point made consistently by interviewees was that local commissioning was not operating as envisaged in the 2009 reforms. There was a strong sense that LCGs do not have the necessary information and autonomy to perform their function. While some stakeholders were of the view that some form of local function should remain to assess population need and secure input from local health economies (including primary care practitioners), others considered that for a country of NI's size all services could be planned on a regional basis.

#### *Summary of key points*

- need for leaner, simpler structures and processes.
- need to consider nature of regional and local structures.
- important to strike a balance between responding to local needs, while at the same time ensuring consistent standards and quality of service across NI.

#### Delivering reform and driving innovation

Some stakeholders considered that a regional commissioner provides the tension needed to implement reform and that recent changes to service models such as PPCI and paediatric cardiac surgery would not have been possible without a neutral, regional commissioning function. There was also a sense that the complexity and

bureaucracy of the current structures stifle reform and innovation, and make it difficult to implement meaningful change. Certainly the empirical evidence for the impact made by commissioning seems limited (see Birrell, 2015: 11-13) with the suggestion that providers often defined the service they wanted to be commissioned. This idea of 'reverse commissioning' was also highlighted by stakeholders.

While much of the focus of discussions with stakeholders was on the way in which services are commissioned, there was also a recognition that de-commissioning is equally important to drive reform. However, there was a strong sense that the various issues identified above - the need for more meaningful engagement with the public on the future of health and social care services; the lack of long-term planning; the need for clarity on roles and responsibilities; and the complexity and bureaucracy of existing systems and processes - have impacted on the ability to take difficult decisions to reconfigure the way services are delivered.

The role and extent of localism in any future system will also have a bearing on the ability of the system to deliver reform and drive innovation. While there is an argument for a consistent service delivery model for a population of 1.8m people, the majority of stakeholders recognised the need to strike a balance in the system so that providers have flexibility to respond to local needs, but at the same time ensuring that innovative practices are evaluated and embedded consistently across the region as appropriate.

#### *Summary of key points*

- options for future systems will need to be assessed against their ability to facilitate sometimes difficult decisions necessary to deliver reform.
- the balance between local responsiveness and regional consistency will need to be a key consideration.

## **CHAPTER 3 - CONCLUSIONS AND RECOMMENDATIONS**

In undertaking this review we have heard a wide range of views and comments. There was a clear and consistent message that the system is not working as effectively as it should – and that it is not working as envisaged in 2009. While there were some issues that were cited frequently there is little consensus on how to make the current system work better nor on what the most effective model is for Northern Ireland. Despite this general view that the system was not working effectively, it is also clear there are some areas of good practice.

It is clear that we can improve the structure of the HSC and the way the functions work – but the pressures and challenges that the service faces will continue to remain and grow no matter what changes we make. Improvements to systems and structures will not reverse the growing challenge that we face in meeting demand.

There are also risks: changes to structures and functions create uncertainty and soak up time and energy; structural change could simply see problems which are behavioural moved rather than solved.

Despite this, the previous chapter of this review sets out a clear case for why avoiding change is not an option. In particular, it is clear that our current structures – with multiple layers – are simply not nimble enough to allow us to keep up with the increasing pace of change in health and social care.

### Structure of the recommendations

Within the scope of this review there are a large number of issues and a plethora of options. We have sought to structure our conclusions in a way that allows people to navigate the various decision points, accepting that more detailed design work will need to follow.

We start by addressing the approaches that could be taken at a regional level – strengthening commissioning, moving away from the commissioner/ provider split or having a mixed model.

There are then a series of options for dealing with different elements of the system which could exist under any of the regional models. This includes an assessment of local approaches to commissioning or planning for services, approaches to family practitioner services and public health, different funding models and performance management. More effective performance management levers will be key to making whichever system we use work effectively.

There are some areas where action can be taken to improve the current system with or without structural change. We set out some principles and approaches that should be pursued within the current system, to make it work better.

### The case for structural change

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

Maintaining a commissioning approach in Northern Ireland was intended to ensure there was appropriate challenge to providers. However, it is clear to us that we have a top down system without any teeth – and one in which the lack of clear lines of accountability make it easy for people to criticise and hard for people to take responsibility. 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.

But the question of whether to maintain a ‘commissioning’ system is not one of clear contrast. Both the Scottish and Welsh systems have commissioning functions within them. In Wales the Specialised Services Committee commissions or plans more specialised services; while in Scotland the Joint Boards which will be responsible for both health and social care funds will explicitly employ a commissioning model. In making performance interventions, all systems need to be able to draw a distinction

between services that are under-funded against genuine need and those which are under-performing.

Any change should be judged against some criteria to assess the likelihood of the making a positive impact. We suggest proposed changes should be considered against:

- How well they balance clear strategic direction at a regional level with operational independence
- Whether they improve accountability and responsiveness
- Whether they can deliver a focus on care delivery and reform, rather than oversight and process
- Whether they help to simplify and streamline the existing system
- Whether they allow us to build on our existing strengths
- How deliverable any changes would be.

The final section of this chapter draws on these criteria in coming to conclusions, though we have not sought to formally score options against them, given the possible variations within each option.

## **Changes to regional structures - options**

### **Option 1 – strengthen the current commissioning process**

There must be serious doubts about whether a full commissioning model is appropriate for Northern Ireland, given the overheads generated for a relatively small population group. However, we could seek to implement this model more effectively.

Assuming we are seeking a commissioning process that involves some element of competition, there is a choice about whether that competition should be internal between HSC organisations or include external competition from the private sector.

#### *Competition*

There seems to be a consensus that Northern Ireland is too small for there to be an effective private market in many areas of healthcare. We note some evidence from those involved in GP fundholding to suggest that some competitive tension can be created in elective care between HSC organisations where they are required to actively compete for work. Equally there is clear evidence from other countries in the UK that vibrant markets for social care can be built in relatively small constituencies – and there are good examples of this in Northern Ireland.

Generating effective competition across a reasonable range of services in Northern Ireland might necessitate a broader range of provider bodies. Returning to a greater number of Trusts in order to build competition is clearly not a wise option. However, the development of GP Federations (groupings of GP Practices) creates a body which could potentially provide an alternative to the Trust for the provision of a number of services.

More broadly, there could be a much stronger focus on building and managing private markets – as there currently is in England. This might involve more focus on encouraging new entrants to service provision and greater stability for third sector and private sector partners – potentially with multi-year agreements. Work with Federations and the private and third sectors could identify areas where greater competition to hold service delivery contracts could be built.



However, a stronger focus on creating competition, whether internal or external, would also mean the acceptance of the friction and waste that this can create, with effort expended on bidding for services. Some forms of competition and competitive tension may involve people having to travel further for their care – and as in England may involve staff being TUPE'd between employers when an incumbent service provider loses the contract for the service they are running. Thought would also need to go into planning for the failure of providers outside the state sector – though this would simply be an expansion of the risks that are already carried in areas like domiciliary care where there is a heavy reliance on private and third sector partners. It will also be challenging to ensure that service specifications drive quality as well as volume and cost. Nonetheless, there is likely to be learning from England and elsewhere that could be drawn on.

This approach would only be successful if there was a greater willingness to accept the financial impact on Trusts of losing service provision. The requirement on the commissioner to seek to achieve financial break-even would therefore need to be reconsidered.

This approach could involve:

- Holding competitive procurements for a far greater range of services.
- Creating a 'right' for community organisations to challenge provider organisations to outsource services for which they could bid.
- A stronger focus within the commissioning body on managing a market, alongside managing individual contracts (for instance, producing documents such as the Market Position Statement required by England's Health and Social Care Act 2014 and building relations with a wider range of providers). Different skills may be needed by the commissioner, if there is to be a greater focus on drafting and managing commercial contracts.
- Strengthening the 'choice' agenda to ensure patients can go to the provider who they see as likely to provide them with the best service.

- Policy changes may also be necessary, to ensure a greater proportion of services are competitively commissioned in order to help build markets.

Without some attempt to generate greater competitive tensions, we find it hard to see a compelling argument for the continuation of a commissioning model.

<b>Pros</b>	<b>Cons</b>
Could drive up quality and drive down cost	Could lead to a fragmentation and the loss of the integrated nature of our providers
	Greater risk of service failures, as organisations push down costs
	Difficult to maintain focus on quality as well as price
	Greater overheads from managing competitive procurements and regular engagement with a wider range of organisations
	Need to manage transition where services are taken over by different providers, including e.g. TUPE

### *Strengthening the Commissioner*

Alongside, or instead of, focussing on introducing a stronger competitive element to our system we could focus on strengthening the commissioning function in other ways. This could allow the commissioning body/ies to drive better performance from Trusts and make it better able to plan on a system wide basis, taking difficult decisions where needed. This would also help to ensure there was a strong, independent voice in the system able to make the technical case for system-wide changes. To strengthen the current commissioning function a range of changes could be considered.

Greater influence in senior appointments:

- Give the commissioning body/ies a formal role in appointing members of Trust Boards and their Chief Executives. However, Trusts should not become directly managed units of the commissioning body/ies if we are to continue to attract the best talent to run our Trusts. This would need to be combined with changes to see the commissioning body/ies feeding into Trust governance reviews and a clearer regional approach to talent management.

Ensuring the right expertise exists:

- Providing the commissioning body/ies with its own dedicated clinical and public health expertise to improve clinical engagement and input.

Further simplifying the regional decision making structure:

- By either merging the HSCB and the PHA or separating their functions, so Northern Ireland has two distinct commissioners with separate responsibilities.
- Considering the role of LCGs and ICPs (see section below on local models).

Strengthening performance and financial levers:

- Commissioning is likely to be most effective where some form of tariff is implemented for at least some services.
- A broader range of performance levers is made available, with a clearer 'ladder' of intervention.

Putting all the relevant functions in one place:

- Transferring workforce planning and capital functions to the commissioning body/ies.

However, there is also an argument that the effectiveness of the commissioning function could be strengthened by stripping it back and ensuring it becomes more strategic in nature and focussed purely on the core commissioning process and the skills needed for this. This could still involve, for instance, merging the PHA and the

HSCB – but it could also involve moving some functions to other regional agencies or to the Department.

Strengthening the current commissioning arrangements may simply reinforce some of the weaknesses of the current system and potentially increase the costs of the commissioning function.

<i>Pros</i>	<i>Cons</i>
Provides a strong organisation to challenge Trusts and other providers, ensuring value for money	Uncertain whether enough competitive tension and challenge could be created to justify the overheads in this model
	Hard to reconcile collaborative approach with need to challenge and create competition
	Could add to uncertainty around system leadership

**Option 2 – abolish regional healthcare commissioning, making Trusts responsible for assessing their population needs, planning to meet those needs and delivering appropriate services.**

This option would broadly follow the model used in both Scotland and Wales, with local health boards (equivalent to our Trusts) responsible for planning their services against a capitated budget. Board plans are assessed and agreed by the Scottish and Welsh Governments. In both systems, it is recognised that some services need to be planned at a regional level – with a collaborative approach taken to identifying which services. In Scotland, managed clinical networks provide consistency in clinical approaches rather than a single central body.

This system avoids the transactional costs of seeking to track relatively small amounts of money through the system, which seems to be a characteristic of the

Northern Ireland system. This approach helps ensure delivery bodies take full responsibility for the delivery of care. We would also argue that this approach creates the space for a genuinely strategic regional function to have an impact in driving performance, delivering reform and ensuring consistency.

One decision in setting up this model is whether the capitated budget is top sliced for regional services – or whether the ‘whole’ budget for the population is given to the Trust who would then purchase services from other Trusts. The former approach would give the Trust body ownership for their population health – and inject the tension of a commissioner/provider function. However, it could lead to counter-strategic decisions (for instance different Trusts coming to different views on where and how specialist services should be commissioned) and the over-provision of specialist services.

As with Scotland and Wales there would need to be some planning, and in some instances procurement, of services that could only be considered at a regional level. This could include, for instance family and child protection services and those acute services currently dealt with by Specialist Service Commissioning Team – though a mechanism would need to be in place for deciding what should be planned at regional level (and what could be passed back to the local level, as technology develops to allow services to be delivered locally). As discussed below, there are choices about whether remaining regional functions sit independent of the Department or within its remit.

Mechanisms would also need to be in place to ensure consistency in approach to care pathways. In Scotland, this is done in a collaborative manner through Managed Clinical Networks. The HSCB and PHA currently oversee collaborative clinical networks in some areas and this approach could be expanded as part of a central regional function – as an alternative to an approach based around separate managed clinical networks. Performance management and service improvement would also need to be located at a regional level – with decisions to be made about public health and family practitioner functions (on which, see below).

One of the principle risks in this approach could be that central Government lacks the strong levers to drive reform. In particular, there is likely to be a concern that without a commissioning organisation Trusts' attention may be drawn to acute services (given the greater public profile these often hold). As well as strong performance management and service improvement functions, financial levers could be used to help achieve its aims (e.g. ring-fencing blocks of funding by programme of care).

Thought may also need to be given to whether internal governance arrangements for Trusts would need to change to reflect a broadened role – and what additional skills and knowledge senior managers would need.

Both the Scottish and Welsh systems demonstrate that strong levers can exist to drive performance and reform, even without a commissioning function. Indeed, it might be argued that without some of the transactional overheads associated with a commissioning regime, there could be a stronger central function. Well-defined performance criteria focussed on outcomes may be even more critical in models which devolve a lot of power to providers.

Both the Scottish and Welsh models are healthcare models. However, we see no reason why the approach could not apply as effectively to social care as to health.

<b>Pros</b>	<b>Cons</b>
Would remove some of the transactional overheads	Mechanisms would be needed to ensure Department could still deliver regional priorities, including reform
Should provide Trusts with more ownership and responsibility and emphasise collaboration	Would involve Trusts taking on a new function which would need to be resourced and properly overseen
Would simplify decision making structures	

**Option 3 - take a split approach, commissioning some services and giving Trusts responsibility for planning in others.**

It was clear through our engagement that some services in Northern Ireland are commissioned more effectively than others – and in some services there is more scope for competition than in others. As noted above, in any system some specialist acute and community services (such as statutory children’s homes) will need to be planned at a regional level. A commissioning approach could be maintained for these services.

There may be other areas where the volume and transferability of services would enable a commissioning approach that could drive better value – for instance some elective procedures. There may be other services such as some community health services where the value added by a commissioning process is likely to be more limited.

We could therefore seek to pursue a mixed system – with some services planned by Trusts or a local body and others commissioned by a regional body/ies. A clear set of criteria would need to be developed against which to decide whether services were commissioned or locally planned.

<i>Pros</i>	<i>Cons</i>
May best enable us to build on what currently works well	Added complexity
Would ensure the most effective mechanism is applied to each service area, potentially helping to improve outcomes	Impossible to define the edges of some services
Would ensure limited commissioning resource was focussed where it could make most impact	Could create perverse incentives to deal with conditions through one route and not another

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Potential for confusion and difficulty  
reconciling different approaches within  
one relationship

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## **Other structural considerations**

### Where should regional functions sit?

One of the key decisions on the structures we use is whether the system is managed from within DHSSPS or by an arms length body. A decision was made in 2009 to have separate functions in arms length bodies, with the HSCB and the PHA responsible for managing providers and ensuring delivery. England has a similar model – with NHS England working with other bodies to manage delivery. However, Scotland and Wales have incorporated the performance management function into their Departmental structures – with a role such as Chief Operating Officer in place.

#### *A separate body*

There are strong arguments for maintaining a separate function. Separation enables independence in operational decision making, helps draw a clear line between strategic decisions and the operation of the system, and may make it easier to draw in the specialist operational skills necessary by providing different terms and conditions.

#### *An integrated body*

There are equally strong, if not stronger, arguments for the incorporation of this management and performance function in the department. It would recognise that, ultimately, the Minister and the department are responsible for performance and delivery. It may also make it easier to ensure delivery informs policy and allow for better coordination of strategy and delivery. This system also has the benefit of simplicity and reduces the scope for friction between different bodies, different agendas or communication failures. It would also make it easier to pool some functions and create a bigger pool of clinical expertise to draw on. However, this approach would see a significant expansion in the Department's headcount and could be seen to run counter to the broad approach pursued in 2009 and implemented by most other departments.

Many of those with the operational expertise necessary to undertake some of these functions would not view themselves as potential civil servants. Nevertheless, use of

secondments and maximising the flexibility in civil service terms and conditions could address some of the potential challenges around terms and conditions.

### Local models

Whether we have a system based on a commissioning approach, or one based on integrated local planning and delivery functions, there is still a question about how the need for local variances in care are identified and delivered.

We heard clear views that the current LCG model was not working effectively and that change is needed. At the minute we have not fully committed to a localised model and are carrying some of the costs with little of the benefit. We were impressed by the enthusiasm and dynamism of ICPs – but also heard questions about the need to put effort into varying care pathways for a population of 1.8m people.

If the commissioning based approach in Northern Ireland is to continue, there is an argument for strengthening local commissioning by devolving more power and resources to LCGs. However, this function could also be incorporated into the regional commissioning body and be administratively led. Either of these models could be combined with an approach which seeks to strengthen the local health and social care economy and drive greater cooperation amongst providers. Some funding could be offered on the basis of outcomes being achieved across a local 'health economy', with providers agreeing amongst themselves how best to deliver those outcomes.

If Northern Ireland moves away from a commissioning based model, the need for local variation and input could be reflected through the Trust's planning process. Further thought would need to be given to ensuring that primary care, third sector and other voices are fully reflected in a Trust-led local planning model.

Whichever approach is taken, care should be taken to pursue more effective coordination and collaboration between different partners involved health and social care delivery locally – whilst avoiding unnecessary administrative overheads and complex leadership structures.

### Other regional functions – Public Health and Family Practitioner Services

These services are currently commissioned centrally by the Department and managed by the HSCB. Given the size of Northern Ireland, this makes sense and ensures there is no duplication in administrative function. However, in the other UK countries while contracts are centrally negotiated the management of those contracts and additional services agreed through, for instance, Local Enhanced Services with GPs, are negotiated and set at a local level. We can see some benefits in localising this function in Northern Ireland – principally it would give greater local ownership of primary care services as a whole and could help to address the join between primary and secondary care. It might also give a stronger voice to primary care services – with a Board-level executive in Trusts responsible for a broader range of primary care services.

Other parts of the UK devolve some of their health improvement functions to local units (such as the Health Boards in Scotland). England, Scotland and Wales also retain a regional/national public health body. A number of PHA functions – such as vaccination programmes – would only ever make sense being commissioned or planned on a regional basis but, as with family practitioner services, there is a case that could be made for devolving more responsibility for health improvement.

A decision on the approach to managing both family practitioner services and public health functions will need to weigh the potential for greater responsiveness and closer integration with other services from a devolved approach against the likely greater overheads and the loss of regional consistency.

### Funding and performance management

As noted, a tariff based approach was carefully considered by the Department in 2007 as part of an exercise on payment mechanisms. It was decided at that time not to pursue activity based funding. While tariffs have driven up efficiency they have also encouraged hospital based procedures and driven a focus on activity rather than quality of outcome. In some cases they have also driven increased budgets, as

hospitals have over-delivered against expected numbers. A tariff based system is also likely to increase the administrative costs for Northern Ireland, both in setting tariffs and tracking delivery.

What a tariff based system can bring is a greater discipline within hospitals for understanding their costs. Tariff systems continue to develop with results or outcome based tariffs being developed in some areas.

An integrated system without a central commissioner would necessarily rely on capitated budgets – but a proportion of funding could be retained to support innovative new schemes, with results based payments in some cases, until they become mainstream business. In particular, novel financial approaches could be explored to help drive collaboration and integration across bodies.

A capitated system may also be beneficial in helping Trusts plan for long term savings – provided there were clear multi-year financial planning assumptions. There was a general belief that savings from improvement and innovation were drawn back to the centre. This is not the case – but the setting of regionally defined efficiency targets has helped create this impression. Full ownership of their budgets by Trusts could help incentivise innovation and reform.

Overall we think a capitated approach is the right one for Northern Ireland – but with some constraints around how those funds are used in order to ensure that, for instance, funding is not switched from community to acute services. Oversight mechanisms to ensure the appropriate resourcing of delegated statutory functions discharged by Trusts will be required alongside this approach. There may also be scope for the deployment of payment by results agreements (including innovative new models such as ‘gainshare’ agreements and social impact bonds) in certain areas – for instance in some aspects of elective care. The use of these financial mechanisms needs to be more fully explored – with a judgement made about whether the additional complexity and overhead is justified.

Whatever structures are chosen going forward, stronger performance management levers are necessary. In particular, if we are to focus on devolving decision making, whether to Trusts or local commissioning mechanisms, increased accountability must follow that funding.

We heard that in other UK countries, there is a sense of earned autonomy: if the performance of your Trust or Board is generally good (both in clinical/social care and financial terms), then you are left to get on with the job. Where performance deteriorates there is a clear and tried and tested escalation process in place. We should look to create a similar system here – with freedoms and flexibilities as an incentive for performance.

More broadly, we should seek to create alternatives to the current process of withholding funds for poor performance. While that should remain as key lever, taking back funds where services have not been delivered only makes it more difficult to meet performance targets and could ultimately impact on the service provided to patients and clients. These alternatives could include focussing on greater transparency, greater choice and more rewards (both financial and non-financial – including ‘earned autonomy’).

## **Changes to begin work on immediately**

### *Longer term strategic plans*

Multi-year planning should free up effort that is currently trapped in an annual cycle, enabling a quicker and less resource intensive update process to take place each year. Multi-year planning will allow a stronger focus on long terms issues, such as population health, and should allow a better linkage with workforce planning and capital spend (which focus on longer time horizons). It should also create the capacity and the time to strengthen public engagement in the commissioning / planning process.

As noted, the Scottish Government require their Health Boards and Local Authorities to develop strategic plans covering at least a 3 year period, with a built in review every 3 years. Wales have attempted this approach but we understand not all of the Health Boards there have managed to develop and agree the 3 year plans required of them.

In Northern Ireland, the yearly budget cycle is likely to prove a constraint. Nonetheless:

- 3-year plans should form the basis for work across the HSC, driven by the objectives set in the Programme for Government.
- These 3-year plans should be underpinned by stronger and more robust assessments of need.
- The Department should consult more widely both within the HSC and outside it on the priorities and targets it sets, which should be more outcome focussed.
- The planning process should more effectively integrate priorities for primary and secondary care and priorities for workforce planning and capital investment.
- Working with DfP, the Department should provide a set of financial planning assumptions upon which these plans can be based.
- The scope for moving to multi-year negotiation processes with for e.g. GP contractual negotiations should also be explored.

- A sharper package of incentives and sanctions should be developed to incentivise the delivery of long term plans.

### *Leadership*

In Scotland, there is a clear sense of 'NHS Scotland'. In Wales, we understand the Welsh Assembly Government is seeking to build further a similar sense of joint enterprise. In England, there is a strong focus on building 'systems leadership', focussed on collaboration to deliver transformation. While the core values of the NHS are strong across the HSC in Northern Ireland, more could be done to strengthen this sense of separate organisations but with a single purpose and ethos. The creation of a Strategic Leadership Group for the HSC in Northern Ireland is a positive step in this direction. In addition there should be:

- Continued operational independence for HSC bodies – but there must be greater clarity around lines of accountability.
- Greater collaboration amongst Trusts in delivering and developing services. In particular, more must be done to share and roll-out innovation from one Trust to another. We suggest that a repository of innovative change be developed to ensure that Trusts are, as a first step, able to check and identify what approaches have been tried and tested elsewhere – and that alongside this the scope for a regional hub to help drive a culture of quality improvement is considered.
- Trusts should expect that they will need to devote a proportion of their senior management time and energy to engaging with and leading regional projects and programmes in order to build collaboration and integration across organisations.
- Peer leadership should also be used more often when there are performance challenges. Failures in performance should be addressed collectively.
- Opportunities should be sought to bring clinical and professional staff together across specialities on a Northern Ireland basis more regularly, to build clinical and professional communities.

### *Delivering Transformation*

One of the strong themes that came through in the review was the fact that the system focussed on the 'fly not the elephant', with significant energy expended every year on bidding for any additional funds that were allocated. This is not a challenge unique to Northern Ireland. We heard that the current system worked best when there was a multi-disciplinary team set-up, with a clear objective.

- The focus of the system should be on getting the best possible value from the £4.7bn we spend on health and social care. This could involve a programme of rolling thematic reviews across service areas to consider how services can be reconfigured and re-shaped to better meet demand within existing resources – and ensure the appropriate level of consistency in models of care across Northern Ireland.
- In-year funding should be allocated as far as possible against a list of agreed service priorities. Trusts should plan on the basis that additional funding will not become available in year.
- Any demography funds secured at the start of the year should be allocated where additional service capacity can be demonstrated through reform. Consideration should also be given to a dedicated reform fund.

### *Financial flexibility*

If we are to move to a longer term planning horizon, we need to consider the financial flexibilities we give to provider bodies. Without some flexibility across years Trusts will not have the discretion to make longer term investment decisions. Northern Ireland seems unique in the UK in not providing this flexibility to its providers. Often this flexibility is used as a reward for good provider performance and / or is linked to the completion and sign off of longer term strategic plans. The Department will need to engage with DfP to make the case for any necessary changes.



### *Focussed on both service quality and access*

There was a strong sense that the focus of performance management was heavily skewed to access targets for acute care, such as the 4 hour Emergency Department access target. There needs to be a better balance struck between ensuring access and driving quality.

- Performance management discussions with Trusts should encompass the whole range of Trust services.
- A clear ladder of intervention should be developed, so Trusts know in advance what response can be expected if and when performance starts to deteriorate.
- 'Earned autonomy' should be the key principle that underpins this approach.
- Greater emphasis should be placed on service improvement support.

### *Streamline decision making and strengthen accountability*

Balancing coordinated decision making with devolved decision making is often a challenge. Without cutting across requirements to develop more consistent care pathways and ways of working across Northern Ireland, clearance processes need to be made clearer and slimmed down to allow for quicker decision making. Clarity on the roles and responsibilities of different decision makers is critical if we are to achieve this.

### *Community engagement*

As well as creating the capacity for greater engagement with communities and service users by moving to a longer term planning horizon, new approaches are needed to gather views from the wider public around issues of relative prioritisation and forms of service delivery. Digital means of engagement provide new opportunities to engage more of the public in discussion.

## **Conclusions**

It is clear that the current system of commissioning carries too much complexity and too many layers of authority, with too many interactions between different bodies slowing up decision making, blunting responsiveness and creating tensions as each organisational layer seeks to influence decisions. This has sapped the considerable energy and talents of those working in the system, with the focus on transactions rather than transformation.

This complexity has also meant that accountability is weaker than it should be, with a lack of clarity about where responsibility for decisions sit and a feeling of disempowerment at all levels. Instead of focussing on collaboration to drive change effort has been directed into transactional interactions. Moving forward we need to shift the balance between management and leadership. The current system is not uniform however – and as noted by this report there are some clear examples of good practice on which we should build.

While the scope for improvement is clear it is also transparent to us that it is impossible to build the perfect system. Conversations with Wales, England and Scotland confirm that they face many of the same challenges we do despite the differences between our systems. Nonetheless, there are clear lessons for us in the rest of the UK – particularly when it comes to both streamlined structures and collaborative cultures. The Scottish and Welsh systems also demonstrate that strong leadership and performance management is not synonymous with a commissioner/provider split.

Further detailed work will be needed to consider the finer details of how changes are implemented. Legislation will be necessary for some structural changes. Close engagement with HSC bodies and staff affected will be necessary to ensure the success of any changes. In particular we heard that the HSC was weakened by a loss of talent and experience when enacting previous structural reforms. Focussed efforts will need to be made to retain (and attract) talent as part of managing change. This is likely to be easier if there is a clear timeline for change, a commitment to moving swiftly and dedicated resource and oversight focussed on managing change.

At a regional level Northern Ireland should move away from a structure with a separate commissioning function. Instead, Trusts should take on responsibility for planning the bulk of services delivered in Northern Ireland. This should strengthen operational independence, shorten lines of accountability, simplify and streamline the existing system significantly and allow us to build on our existing strength – integration. It should also help create a stronger sense of a single HSC, working together and provide more scope for clinical engagement and leadership. Scotland and Wales provide templates from which to learn. This approach should increase the focus on care delivery and reform, rather than oversight and process, and should simplify and streamline the system. We would also argue that it builds on Northern Ireland’s existing strength – the integrated nature of our health and social care system.

A stronger, more strategic core should be based within DHSSPS, again building on learning from Wales and Scotland. This should create a better balance between clear strategic direction and operational independence. This strategic core should have a clear focus on reducing unjustified variation, driving reform and overseeing financial management, performance management and the commissioning / planning of services that can only be effectively planned at regional level. The PHA should remain as a separate organisation, though the functions for which it is responsible must be considered further. Putting a clear focus on one regional body will address the core issue we heard – confused lines of accountability and leadership. Nonetheless, structural change will need to be accompanied with a focus on changing behaviours and ways of working.

Further thought should be given to how Family Practitioner Services are organised, given ongoing work to consider the delivery of GP services. There is merit, in our view of ensuring Trusts play a more active role in primary care – but adopting some of the approaches being trialled in England to bring together providers across an ‘economy of care’ should be considered alongside the devolution of greater responsibility to Trusts.

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 care, service users and the third sector. Further work is needed to define and refine how these structures will operate and how integration will be incentivised within the new structure.

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.

While we heard arguments for changes to Trust boundaries and numbers we doubt that these changes would have a significant impact on the effectiveness of the system. Structural change should therefore be focussed on the areas where it is likely to have greatest impact.

The conclusions and recommendations set out above represent only a very broad framework for change, considered against the criteria set out at the beginning of this chapter. Further detailed work will need to be undertaken to refine the model, clarify structures, responsibilities and staffing issues.

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## Appendix 1

### Review of Health and Social Care Commissioning Arrangements in Northern Ireland

#### Terms of Reference

To ensure that the commissioning of health and social care services is fit for purpose to meet the changing and growing needs of the citizens of Northern Ireland into the future, the Department has instigated a review of commissioning to identify opportunities for improvement.

This review will:

1. Undertake an assessment of how the commissioning process facilitates the delivery of high quality and efficient health and social care services in Northern Ireland, with particular reference to:
  - **Assessing** the health and social wellbeing **needs** of the population of Northern Ireland.
  - **Strategic planning** to prioritise needs within available resources, including the use of financial and other levers, to reshape services to meet future needs.
  - **Engaging** patients, users, carers / families and other key stakeholders at a local level in the commissioning of health and social care services.
  - **Securing, procuring, incentivising and agreeing** high quality, value for money service provision to meet the assessed and prioritised needs of the population.
  - **Ensuring** the delivery and outcomes from services commissioned.
  - **Evaluating** impact of health and social care services and **feeding back** into the commissioning process in terms of how needs have changed.
  
2. Bring forward recommended options to improve the effectiveness of the delivery of health and social care services in Northern Ireland.

It is expected that the review will report in the summer of 2015.

## Appendix 2

### List of stakeholder meetings and written inputs

#### Meetings held:

Abigail Harris, Director of Planning, Cardiff and Vale University Health Board
Alex McMahon, Director of Strategic Planning, Performance and Information, NHS Lothian
Alex Morton, Director of Commissioning System Change and Public Health Transition, NHS England
Allied Health Professions Federation NI
Belfast HSC Trust Chief Executive and senior management team representatives
Belfast LCG representatives
Bernard Mitchell, Chair of the Northern Ireland Guardian Ad Litem Agency, former member of SMT at the HSCB and former senior civil servant DHSSPS
Brian Slater, Scottish Government policy lead, strategic commissioning policy for health and social care integration
British Medical Association, Chair, NI Council
British Medical Association, Chair, NI General Practitioners Committee
Bronagh Scott, Deputy Chief Nurse, NHS England, London Region and North-West London Director of Nursing, formerly Director of Nursing at the Northern Health and Social Care Trust
BSO Chief Executive
Catherine Underwood, Director of Integrated Commissioning for Adult Social Care Services, Norfolk County Council
Chair, Antrim and Ballymena ICP
Chair, Craigavon and Banbridge ICP
Chair, East Antrim ICP
Chair, Mid-Ulster ICP
Chair, North Down ICP
CO3 health and social care special interest group
Colm Donaghy, Chief Executive of Sussex Partnership NHS Foundation Trust and former Chief Executive of Belfast Health and Social Care Trust
Daniel Phillips, Director of Planning, Welsh Health Specialised Services Committee
David Geddes, Head of Primary Care Commissioning, NHS England
David Sissling, Chief Executive of Kettering General Hospital NHS Foundation Trust, former Chief Executive of NHS Wales, former Programme Director for Healthcare London and

former Chief Executive of the Northern Ireland Health and Social Care Authority
DHSSPS top management group
HSCB Chair and non-Executive Director
HSCB Executive Directors
Independent Health and Care Providers (IHCP)
Ivan Ellul, Director of Commissioning Policy and Planning, NHS England
John Compton, former Chief Executive of the Health and Social Care Board
John Connaghan, NHS Scotland Chief Operating Officer
Mairead McAlinden, Chief Executive of South Devon Healthcare NHS Foundation Trust and former Chief Executive of Southern Health and Social Care Trust
Martin Farran, Executive Director of Adult and Community Services, Barnsley Local Authority
NI Ambulance Service Trust Chief Executive
NI Association of Social Workers
NI Council for Voluntary Action
NI Faculty of Public Health
NI Practice and Education Council for nursing and midwifery
NI Social Care Council
Northern HSC Trust Chief Executive and senior management team representatives
Northern LCG representatives
PCC Chief Executive and Head of Operations
PHA Chair and non-Executive Director
PHA Executive Directors
Ray Martin, former DHSSPS civil servant
Rob Bellingham, Director of Commissioning (Greater Manchester), NHS England Lancashire and Greater Manchester
Robert Williams, Scottish Government policy lead, performance management
Royal College of GPs
Royal College of Midwives
Royal College of Nursing
RQIA Chief Executive and Executive Team representatives
South Eastern HSC Trust Chief Executive and senior management team representatives
South Eastern LCG representatives
Southern HSC Trust Chief Executive and senior management team representatives
Southern LCG representatives

Tim Davison, Chief Executive, NHS Lothian
Tom Coffey, Clinical Lead and Chair of Mental Health Clinical Commissioning Group, Wandsworth CCG.
Western HSC Trust Chief Executive and senior management team representatives
Western LCG representatives

### **Written submissions received**

Action for Children
Antrim and Newtownabbey Borough Council
Association for Real Change
Brain Injury Matters
British Heart Foundation
CO3
College of Occupational Therapists
Craegmoor NI
Department for Social Development
Department of Agriculture and Rural Development
Derry City and Strabane District Council
Family Mediation NI
Homecare Independent Living
Lisburn and Castlereagh City Council
Mid and East Antrim Borough Council
Mid Ulster District Council
Newry, Mourne and Down District Council
NI Local Government Association
Office of the First Minister and Deputy First Minister
Praxis
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal College of Psychiatrists
Royal College of Surgeons
Triangle Housing Association

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