# GETTING IT RIGHT FIRST TIME

# Northern Ireland Efficiency Programme Report

## January 2025

*This report has been produced by the Getting It Right First Time (GIRFT) Project Team at the Royal National Orthopaedic Hospital (RNOH/GIRFT). It aims to identify areas which could deliver potential efficiencies in systems, provide a sense of where efforts might best be focused to realise savings (cash releasing or otherwise) and productivity gains in the short, medium and long term.*

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## Executive Summary

The HSC in Northern Ireland is facing financial challenge. We were asked to deliver a high level review of efficiency in specific areas across the HSC in Northern Ireland. The areas of focus for the review were estates, litigation, procurement, business and corporate services functions, existing efficiency programmes, organisational and reporting structures and commercialisation opportunities across the region. However, part way through the review we were asked to pause our review of existing, department led efficiency programmes as it was felt it was too early in most of these programmes to have a meaningful review. We also did not receive some of the data and information requested which limited some of our work, for example, we were unable to complete our work on organisational and reporting structures as information was not easily available in a format that would allow comparisons to be made and conclusions drawn.

We are grateful to all those who participated in the review and for the open and honest views provided.

We have identified opportunities and changes to practice that should improve efficiency through maximising the use of existing resources and assets and in taking a more regional approach in some areas.

Since the review, we have presented our findings to Mike Nesbitt, the Northern Ireland Health Minister and Peter May, Permanent Secretary at the Department of Health, who were both keen to see these recommendations taken forward.

In total, there are **37 recommendations** in this report. We hope that these are a catalyst to introduce positive change to improve efficiencies and notably in seeing a more cohesive approach to working across the region. We understand that implementation of some of our recommendations has already commenced. For example, a business case has been developed for a new DLS Case Management System / database to support better utilisation of litigation data and a working group has been established to take forward work on medical staffing. The HSC is also working with the Department and the RNOH/GIRFT team on a pilot project to drive savings in procurement.

## 1. Introduction

Getting It Right First Time (GIRFT) is a national programme, under the direction of Professor Tim Briggs, designed to improve the treatment and care of patients by in-depth review of services, benchmarking, and the presentation of data-driven evidence to support change.

The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis, with the input and professional knowledge of senior clinicians, to examine how things are currently being done and how they could be improved.

GIRFT Projects at the Royal National Orthopaedic Hospital (RNOH/GIRFT), also under the chairmanship of Professor Tim Briggs, was commissioned by the Northern Ireland Department of Health (NI DoH) to undertake a review of efficiency opportunities and savings across Northern Ireland in some specific functions.

To date RNOH/GIRFT have worked with the Northern Ireland Department of Health to undertake reviews in Orthopaedics, Gynaecology, Urology, Emergency Medicine and Paediatric Trauma and Orthopaedics.

The aim of this Programme is to identify potential efficiencies in systems, provide a sense of where efforts might best be focused to realise savings (cash releasing or otherwise) and productivity gains in the short, medium and long term.

## 2. RNOH/GIRFT Efficiency Programme

The objectives of the RNOH/GIRFT Efficiency Programme were to:

- Identify opportunities for efficiencies and savings across Northern Ireland.
- Provide a landscape view of current services.
- Identify opportunities for savings and rank those in order of opportunity to be addressed in further phases.

The themes we were asked to review:

- Estates;
- Litigation;
- Procurement;
- Business and corporates services;
- Existing efficiency programmes*;
- Organisational and reporting structures**; and
- Commercialisation opportunities.

** Please note that part way through our review we were asked to pause our meetings around Existing Department led Programmes as it was felt it was too early in most of these programmes to have a meaningful review so we have not reported any findings against this part of the scope.*

*** Please note we were unable to complete our work on organisational and reporting structures as information was not easily available in a format that would allow comparisons to be made and conclusions drawn.*

The approach was as follows:

- We looked at a broad range of areas for potential efficiencies.
- We used data to provide a robust evidence base to give the case for change.
- We benchmarked against other systems where possible.
- We identified the areas we have reviewed which may provide the best opportunities for efficiency savings.

- We presented the evidence using metrics that are meaningful to executive, clinical and operational teams.

The timeframe of the review is detailed in **Table 1.**

**Table 1: Timeframe**

| Activity | Date |
|---|---|
| Refine approach and gain agreement of provider participation | March 2024 |
| Service agreement negotiated, finalised and signed | March 2024 |
| Programme kick-off | March 2024 |
| Communication and engagement with the Trusts | April 2024 |
| Data and information gathering | May 2024 |
| 2-day visit and workshop | 21st and 22nd May 2024 |
| Draft report issued | June 2024 |
| Wrap up meeting | June 2024 |
| Ministerial meetings | September 2024 |
| Final draft report issued | November 2024 |
| Final report issued | January 2025 |

## 2.1 Data gathering and analysis

The RNOH/GIRFT team analysed and compared data from various data sources:

1) **Corporate services (financial year 2023-24);** to benchmark costs in the following areas: Finance, HR, Digital & Technology, Payroll, Governance & Risk and Procurement. *This was completed by the Directors of Finance.*
2) **Litigation high level data request (financial year 2018/19– 2022/23);** to benchmark the number of clinical negligence claims along with associated costs at specialty level along with the incident type. ***We did receive some data from the Business Services Organisation (BSO) Directorate of Legal Services (DLS) but data from Trusts was variable*.**
3) **Questionnaire;** to give us a better understanding of the governance in the following areas: corporate services; procurement and estate. ***Corporate Services for HSC NI are largely provided through Shared Services so information was not available to Trusts.***
4) **Pre-visit questionnaire,** which queried staffing costs for bank, agency and contractors; revenue for services and organisational structure chart. *This* ***was not completed*** *by the majority of Trusts as the data requested was not easily available, but data was provided centrally.*
5) **Procurement data** for some specific products. ***This was provided by BSO.***

## 2.2 Workshop

A workshop was held on the 22nd May 2024 to provide all key stakeholders with an overview of the emerging themes and recommendations identified during the various meetings and the data gathering exercises. It was also an opportunity for all key stakeholders to provide comment and feedback on our early findings.

Following the RNOH/GIRFT presentation, the group were asked to provide us with their top 3 priorities for improving efficiency, the most popular priorities were:

1. Reducing the costs associated with the high number of medical locums.
2. Development of clear action plans with time bound deliverables, whilst holding people to account.

3. Reducing the costs associated with procurement, ensuring that Trusts are getting the best value for money.

Other areas were discussed including Independent Sector Tariffs Enhanced Care and Nurse Stabilisation.

# 3. Estates Findings and recommendations

## 3.1 Governance and Leadership

A strategic Estates Board has been established since our visit which is chaired by the Department's Health Estates Director, we support this positive step.

There is an Estates Leadership Group which meets occasionally and draws together estate leads across Trusts and this is used to discuss key issues, share good practice and develop policies.

**It was apparent that there is an inconsistency in accountability and reporting mechanisms across the region, leading to silo working and an insufficient level of collaboration.**

Each Trust manages and governs its estate individually and this leads to different ways of doing things, which is not necessarily the most efficient and effective way of working across the region.

As a result of this, there seemed to be little collaboration and sharing of best practice across Trusts. Some efforts to address this were shared, but the Department needs to take a lead with the Trusts to address this and utilise the significant knowledge and experience to deliver improvements with a regional focus.

**The Trusts evidenced some good quality information within their Property Asset Management (PAM) plans but it was unclear how these are being used as part of overall Estates governance.**

It requires a significant effort and resource in developing and submitting PAM plans, but to no obvious benefit. Again, these reports are produced but there is no central governance to manage the issues arising from these reports.

## 3.2 Estates Rationalisation

**The disposal of Trust surplus estate is taking too long.**

Reducing the size of estates saves money, where estate is surplus or not fit for purpose. There were 103 vacant properties which are reported as costing around £0.5M per annum to run. It was reported that overall, the region achieved only 18 disposals in last 5 years against a target of 30. The disposal process in its current form, seems to be 'aiming for perfection' and is not supporting speedy disposal. We have therefore recommended that disposal activity needs to be a properly resourced, centrally coordinated and a time-limited piece of work.

**There are a significant number of leasehold properties but there is also significant unused space.**

There are 214 third-party leases costing £4M per annum, yet 30% of the estate is underutilised with 103 vacant properties. There is little evidence that there is a focus to reduce leaseholds or reduce lease costs across the region.

**Our review suggested that there is poor utilisation of space across a number of sites with insufficient site data in terms of space utilisation, running costs etc.**

We found it hard to find data of the actual annual running costs of buildings and how space is being utilised. There was very little benchmarking between like for like sites helping to drive efficiency and effectiveness.

**Agile and hybrid working was not fully adopted across the region.**

We saw evidence of some pockets of agile and hybrid working but this was not being driven consistently across all sites or Trusts.

The latest data seen suggested that space utilisation standard is only adequate across 70% of sites. Increased adoption of agile and hybrid working would help to improve space utilisation and provide greater flexibility to staff where used appropriately.

**Physical medical records storage is taking up a significant amount of space across the region. Our review suggested there was limited consolidation of the use of training, warehousing and storage facilities across the region.**

Some sites reported using up to 20% of space to store medical records which could be used for better purposes and there seemed to be no strategic approach to the provision of storage, warehousing and training facilities across the region.

## 3.3 Other issues

**There is clear evidence that the backlog maintenance (BLM) issue is progressively deteriorating year on year.**

We were provided with data showing the on costs needed to bring the regional estate up to standard (referred to as Back Log Maintenance). The region has significant 'High risk' back log maintenance valued at £249M. The total of all backlog maintenance is valued at £1.4B (which is 38% of the total value of estate). Capital does not appear to be effectively used to deliver space optimisation.

**The Region has a number of expensive capital projects requiring too much rework, leading to cost overruns and unplanned, high expense maintenance costs.**

Major capital projects were reported to be running late and over-budget and in some cases requiring significant rework adding to the BLM burden. Two examples given which were Belfast Maternity and Children's Hospital (with an overrun of 3 years, with costs doubled) and the Critical Care Centre at Royal Victoria Hospital, Belfast (over 10 years late, with a cost increase of 70%).

## 3.4 Estates Recommendations

| | Estate - Leadership and Governance Actions/Recommendation |
|---|---|
| 1. | Build upon existing governance and establish an overarching Health Property Asset Management (PAM) Board which will meet regularly and draw together the key estate leads from Trusts and Health ALBs and work together to deliver the key deliverables of the property strategy and drive improvements to overall property efficiency and effectiveness. |
| 2. | Ensure that the main duties of the PAM Board are to provide strategic planning for health estates, monitor performance of properties, sharing of expertise and good practice, estate investment decisions, oversight of property maintenance, risk management and reporting on estate efficiency to the Department of Health Board. |
| | **Estates – Rationalisation Actions/Recommendation** |
| 3. | To enable more collaboration and sharing of expertise bring together expertise and resource from across the region to create a dedicated team to deliver property disposals more effectively. |

| | |
|---|---|
| 4. | Conduct a review of all leasehold properties and (if not already in place) establish a lease control process ensuring any new leases are regularly reviewed and endorsed by the PAM Board before any new leases are put in place. |
| 5. | Begin a process of benchmarking sites to measure and compare at site level space utilisation, annual running costs, sustainability etc. Start with the most expensive sites with poor utilisation. |
| 6. | Mandate agile and hybrid working throughout region, measure compliance through a benchmarking process and understand the impact on the overall estate. |
| 7. | Scope out a project to deliver more effective medical storage solutions to include consolidation of warehousing and training facilities. |
| | **Other issues Actions/Recommendation** |
| 8. | Ensure sustainability activity is managed and monitored through the PAM Board. Benchmark sustainability data to help drive improvements in utility, waste etc. Exploit more widely any 'invest to save' initiatives that can be accessed by the Region. |
| 9. | Look at re-establishing multi-year budget setting to support more effective delivery of projects that will deliver efficiency savings. |
| 10. | Use capital allocations to support projects that will deliver space optimisation. |

# 4. Litigation Findings and recommendations

## 4.1 Litigation Background

**Why we look at litigation in England and how a litigation focus can support Northern Ireland.**

For a number of years there has been a litigation GIRFT programme in England promoting better use of data, sharing of good practice and learning from claims. This has led to reductions in the number of claims received. The following information shows some of the improvements in England from running the programme.

**Table 1** Shows the reduction in Trauma and Orthopaedic litigation claims in England.

**Table 1: Reduction in T&O (Trauma and Orthopaedic) claims**

| Year of claim Notification | No. of claims | % change in claim volume | Estimated cost of claims end of 2019/20 | % change in cost of claims |
|---|---|---|---|---|
| 2012/13 | 1467 | | £173.0 M | GIRFT VISITS BEGAN |
| 2013/14 | 1617 | 10.22 | £175.9 M | 1.65 |
| 2014/15 | 1519 | -6.06 | £147.7 M | -16.04 |
| 2015/16 | 1395 | -8.16 | £146.3 M | -0.92 |
| 2016/17 | 1268 | -9.10 | £163.5 M | 11.71 |
| 2017/18 | 1206 | -4.89 | £138.7 M | -15.16 |
| 2018/19 | 1144 | -5.14 | £139.6 M | 0.62 |
| 2019/20 | 1253 | 9.53 | £166.3 M | 19.17 |

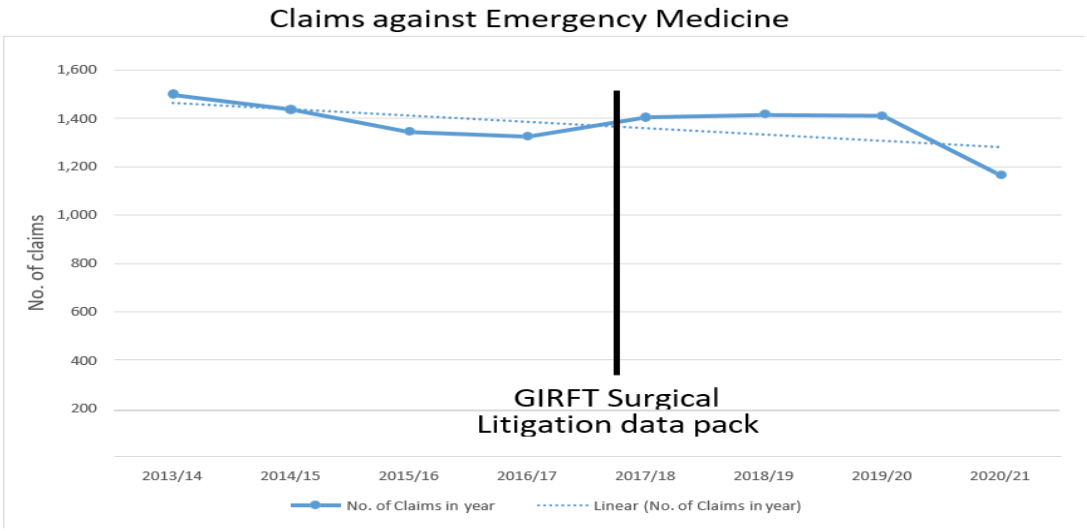
The NHS Resolution 2020 report – Shows a reduction in T&O litigation claims since 2014.

- T&O dropped from No1 to No2 as the most litigated speciality.
- T&O dropped from 10% to 5% of costs.
- Bucking the trend in other specialities – the overall cost of clinical claims rising by 95% to £2.3bn.
- New estimated cost saving of £145.4m since 2013/14 (reduction in claims number of 1174 claims).
- A rise in all clinical claims in Clinical Negligence Scheme for Trusts (CNST) of 9.35% in 2019/20.

- NHS Resolution premium 2017/18 – in RNOH was down by £650,000.

The following specialties with a trend of decreasing claim volume are: Anaesthesia, Breast Surgery, Dermatology, Emergency Medicine, General Medicine, General Surgery, Maternity, Oral Maxillofacial Surgery, ENT, Paediatric Medicine and Trauma and orthopaedics.

**Figure 1** Shows the line of claims trend against Emergency Medicine in England.




**England Trust Pilot:** One Trust in England conducted a pilot using a forensic accountant to review their claims. The effect on their NHS Trust premium compared to the national annual Collect which increased every year was immediate and positive, as shown below in **Table 2** below.

| | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 | 2018/2019 |
|---|---|---|---|---|---|
| National Collect increase | 5% | 35% | 17% | 17.5% | 11.8% |
| NHS Trust increase | 19% | 34% | 10% | 9.5% | **(8%)** |

Had this NHS Trust continued to be charged at national Collect rate (and historically this Trusts were higher shown in red) their premium would now be £35m compared to current £13.2m. Green shows were Trust managed to reduce costs compared to the rest of England. This method works and provided a saving of £22.8m in one year.

## 4.2 Litigation in Northern Ireland

In Northern Ireland there is no regional programme for learning from clinical negligence claims to improve patient safety across the region. There is no parity with incident learning even though only about a third of claims have been raised as incidents.

It is recognised that learning from claims has an immediate patient safety benefit and can improve the efficiency of the clinical service to provide a mid-term saving in cost by reducing complications through getting patient care right first time. The significant financial gains would be a long-term benefit from reduced claims. There is scope for the annual review of the SLA between Trusts and DLS to evolve to focus Trusts on the benefit of learning from and managing claims well.

For an incentive system to work, Trusts need to be receive a charge proportional to the costs they incur, this would be regarded as an experience charge. In addition, there could be an exposure charge based of the actuary calculated risk of the clinical services provided by each Trust. To protect an individual Trust with an increase in volume or cost of claims having their finances effected beyond what can be tolerated operationally actuary support would be required to cap costs before they become devastating. This is achieved by a shared scheme where support from the pool of Trusts is provided. There are concerns that as Northern Ireland is a smaller system than England it might not be able to manage a full incentive scheme including both legal costs and damages and as a consequence an incentive scheme might only reflect legal costs with damages continuing to be paid by DoH. Further exploration of an incentive scheme would need to be carried out working alongside the government actuaries department to benefit from the knowledge gained from running the system in England.

There was no best practice guidance in existence for claims handling or claims learning or any measure for hospital performance or incentives for best practice in place. There was no guidance for front line clinicians to avoid litigation (such as awareness, feedback and learning opportunities).

There is a need to improve these protocols for the benefit of patient safety and to reduce costs both in direct patient care with fewer complications and in any resulting cost of litigation.

Unfortunately, neither DLS nor the Trusts were able to provide any better data than has been published in the Clinical / Social Care Negligence Cases in Northern Ireland (2022/23) (A report produced by the Department of Health). We met with the DoH report authors who receive data from Trusts directly in a National Data Collect and do not involve DLS.

During the last five years, the amount paid on clinical / social care negligence cases has significantly increased by £12.5 million (42.9%), from £29.2 million in 2018/19 to £41.7 million in 2022/23. Even acknowledging the growing costs of administering and defending legal processes, as well as the increases in the value of settlements awarded, this is a significant increase.

**Table 3:** Shows the amount paid on clinical / social care negligence cases, by the HSC Trust / Legacy HSS Board (2018/19- 2022/23).

| HSC Trust / Legacy HSS Board | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | Change Since 2018/19 | % Change Since 2018/19 |
|---|---|---|---|---|---|---|---|
| Belfast | £15,230,342 | £10,103,777 | £7,057,538 | £10,111,212 | £8,624,656 | **-£6,605,685** | **-43.4%** |
| Northern | £2,157,461 | £5,271,022 | £4,737,589 | £4,634,885 | £8,110,145 | **£5,952,684** | **275.9%** |
| South Eastern | £1,147,087 | £5,612,118 | £4,580,300 | £7,483,858 | £9,775,090 | **£8,628,003** | **752.2%** |
| Southern | £2,912,103 | £5,918,173 | £2,739,764 | £3,847,967 | £6,870,725 | **£3,958,622** | **135.9%** |
| Western | £3,766,075 | £3,847,470 | £1,779,476 | £10,588,093 | £7,465,734 | **£3,699,658** | **98.2%** |
| Legacy HSS Boards | £3,989,029 | £1,851,585 | £934,659 | £3,568,144 | £894,295 | **-£3,094,734** | **-77.6%** |
| NIAS / NIBTS | £7,437 | £223,832 | £22,448 | £33,442 | £919 | **-£6,518** | **-87.6%** |
| **Northern Ireland** | **£29,209,533** | **£32,827,978** | **£21,851,773** | **£40,267,602** | **£41,741,564** | **£12,532,031** | **42.9%** |

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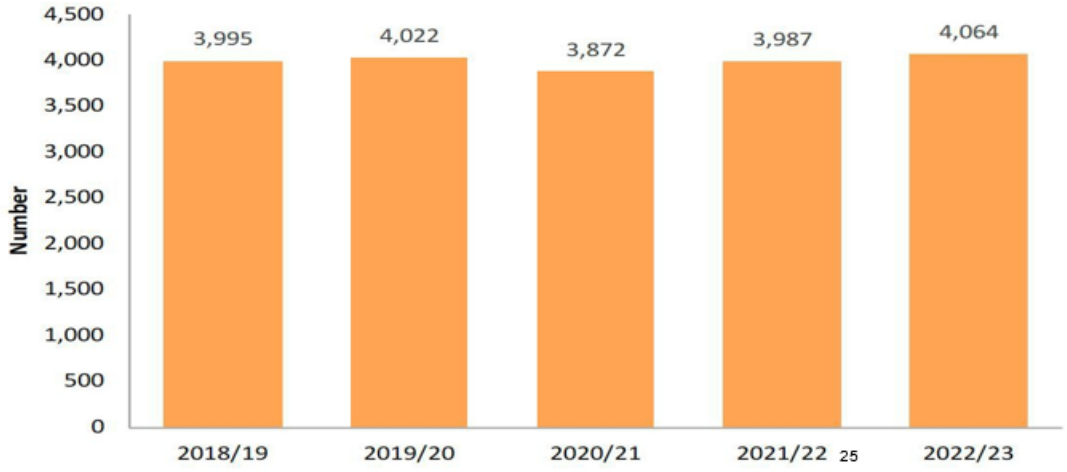
The number of claims open remains high during 2022/23, 4,064 clinical / social care negligence cases were open at any stage, 69 (1.7%) more than in 2018/19 (3,995).

**Figure 2:** Shows the number of cases open at any stage during year, by HSC Trust / Legacy HSS Boards (2018/19-2022/23).




Almost half (45.7%, 1,857) of all cases open in 2022/23 related to four specialties.

**Figure 3:** Shows the number of cases by four largest specialties (2022/23).

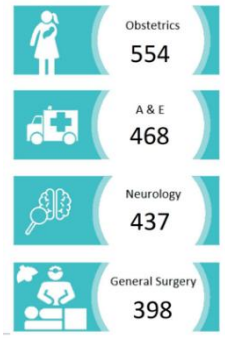



**Figure 4:** Shows cases open at any stage, by specialty (2018/19-2022/23).

| Specialty | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|---|---|
| Accident & Emergency | 670 | 645 | 577 | 456 | 468 |
| Anaesthetics & Pain Mgt. | 50 | 47 | 41 | 37 | 35 |
| Burns, Plastic & Max. Surgery | 28 | 25 | 23 | 26 | 26 |
| Cardiac Surgery | 23 | 17 | 15 | 18 | 19 |
| Cardiology | 47 | 49 | 49 | 49 | 52 |
| Children & Young People | 114 | 122 | 130 | 123 | 133 |
| Dentistry | 21 | 16 | 15 | 17 | 18 |
| Ear, Nose & Throat | 43 | 47 | 42 | 39 | 44 |
| General Medicine | 209 | 187 | 163 | 258 | 251 |
| General Surgery | 413 | 368 | 328 | 386 | 398 |
| Gynaecology | 259 | 275 | 284 | 337 | 283 |
| Mental Health Acute | 71 | 71 | 65 | 64 | 73 |
| Neurology | 107 | 261 | 333 | 407 | 437 |
| Neurosurgery | 27 | 24 | 22 | 18 | 21 |
| Obstetrics | 712 | 671 | 628 | 564 | 554 |
| Oncology | 43 | 52 | 52 | 55 | 54 |
| Opthamology | 51 | 54 | 49 | 46 | 51 |
| Paediatrics | 91 | 92 | 88 | 93 | 98 |
| Radiology | 60 | 61 | 62 | 64 | 69 |
| Trauma & Orthopaedics | 369 | 328 | 284 | 268 | 264 |
| Urology | 66 | 63 | 62 | 57 | 60 |
| Other | 459 | 445 | 420 | 445 | 494 |
| Unknown | 62 | 102 | 140 | 160 | 162 |
| **Total** | **3,995** | **4,022** | **3,872** | **3,987** | **4,064** |

Almost three fifths (59.9%, £136.1 million) of the amount paid out on cases open at any stage in 2022/23 related to the 'Obstetrics' specialty, of which 82.7% (£112.6 million) had been paid in damages.

**Figure 5**: Shows the amount paid on the 10 largest specialties**.**

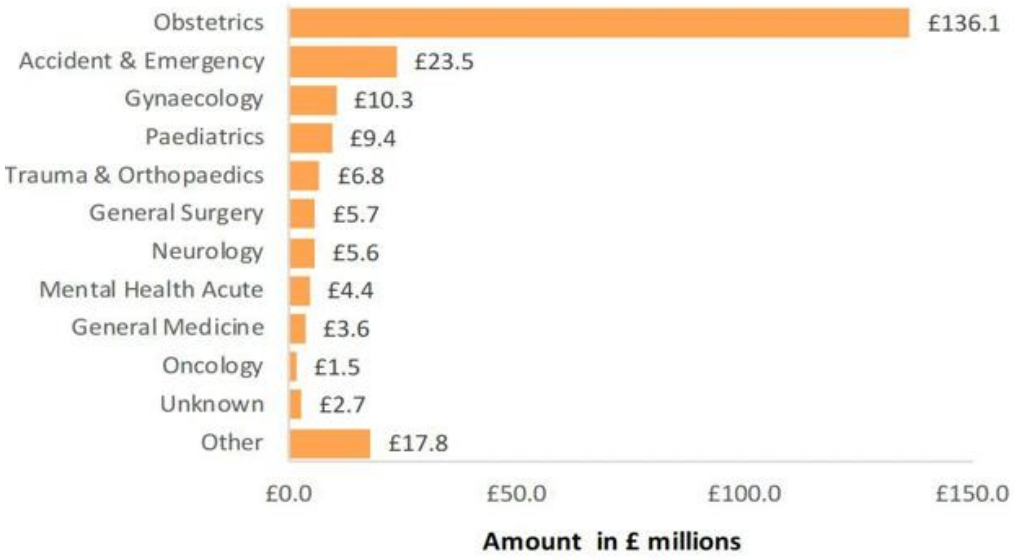
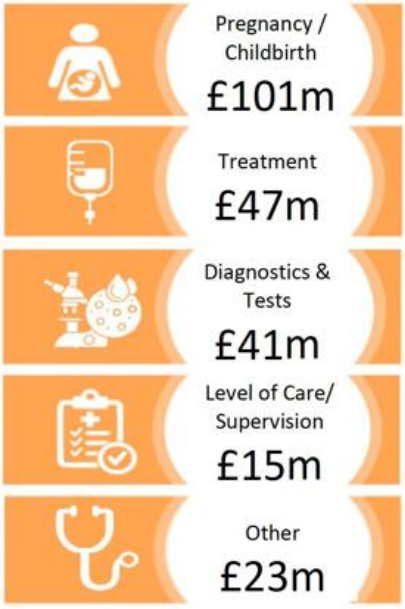



**Figure 6:** Shows the total amount paid by the largest "nature of alleged incident" categories (2022/23).




## 4.3 Observations from the Litigation review

We were pleased to note some examples of good practice seen within both Trusts and in DLS.

**Workforce**

We know that Trusts range in size and structure and we heard and observed varying skill sets within Trusts with some excellent workforce as well as opportunities for improving Trust performance and minimising litigation impact.

We saw varying levels of clinical input into Litigation practices with one good example of a medical lead/Associate Medical Director having 1-2.5 PAs for litigation focus.

**Process**

We saw variation in how claims are handled between Trusts. There should be a focus in all Trusts on Clinical negligence, employers / occupier's and general litigation which are core areas of focus. We were told there was variable resource coverage for activity such as Judicial Reviews, Information Governance and Coroner's Inquests across Trusts.

We would recommend a uniform protocol for implementing a set process of handling claims across all Trusts including a pre-action protocol and good processes for working with DLS.

**Funding**

Funding is provided via a block contract for DLS, whereby each Trust pays a contribution under an SLA which is reviewed annually. This appears to be top-sliced from each Trust budget. We are unclear what incentives for Trusts are in this model.

## 4.4 Learning from claims

There is some activity around litigation in Trusts at varying levels. We suggest that consistent all Trust approach to litigation is adopted to maximise the opportunity for improving patient safety, cost burden to the Region and improve shared learning for all.

An updated Datix system is in the process of being implemented. We were told that there are issues linking claims, serious adverse incidents (SAIs), complaints and inquests in Datix and we feel that Trusts may benefit from a cloud-based version. There is a Monthly Trust Claims Advisory Group meeting which considers cases including Solicitor and Counsel learning.

There is also a quarterly Regional Litigation Forum with DLS. Trusts report this as useful but it has a claims handling focus. This group meeting could include more shared learning & analysis and reporting of trends by theme or specialty.

Overall, there appears to be variable mechanisms for sharing learning in Trusts and it is unclear whether all learning reaches each clinical team. The Learning Summaries/outcome report from DLS is of variable quality.

The DLS savings report is a saving based calculation with the assumption of settlement being reached at the maximal reserve costs. This is a saving forecast based on the worst case scenario and so does not represent a true saving for Trusts.

## 4.5 Examples of good practice

We saw evidence of good practice in Trusts as outlined below;

- The Northern Ireland Ambulance Trust has Clinical Support Officers to provide training and support to clinical staff following an investigation of claim/complaint/SAI/Inquest.
- The Northern Ireland Ambulance Trust has a litigation manager who has a 'Power BI' tool to track claims.
- Belfast Trust has a Medical lead who produces learning summaries for each claim.
- Belfast Trust has thematic reviews for example, for sharps injuries.
- Northern Trust's Medical director ensures learning from claims is shared at morbidity and mortality meetings.
- Southern Trust has weekly risk meetings reviewing new and ongoing claims.
- Southern Trust have an Adept fellow reviewing coroner's inquests for learning.
- South Eastern Trust have a shared learning policy with quarterly reports being shared with clinical directors.
- Western Trust shares a post-case report analysis with involved staff.

- DLS have previously provided useful training for example, for coroner's inquests and witness statement, it was noted that these have decreased post-COVID, however DLS plan to increase training when capacity allows.
- DLS are fast tracking medical negligence claims with SAIs.

## 4.6 Areas of concern raised by the Trusts

We asked the Trusts to share their priority list of concerns which is as follows;

1. Maternity.
2. Emergency Medicine.
3. Consent.
4. Cauda equina syndrome.
5. Delay in ambulance responses (small number of claims against NIAS overall).
6. Employers Liability and Occupiers Liability (ELOL) – an increase in bullying and harassment claims.

**Current Reported themes**

- No lessons learned.
- Failure to follow protocol/records keeping.
- Failure to follow protocol.
- Risk assessment/Failure to follow Protocol.
- Risk assessment/Failure of Prevention.
- Records keeping/staff training/ failure to follow.
- Protocol.
- Equipment Related, Estate Management.
- Consent.
- Communication.
- Medication Error.
- Dysfunctional Patient Flow/Pathway.
- Misinterpretation or Mishandling of results.
- Resource Issue.
- Individual Clinical Error.

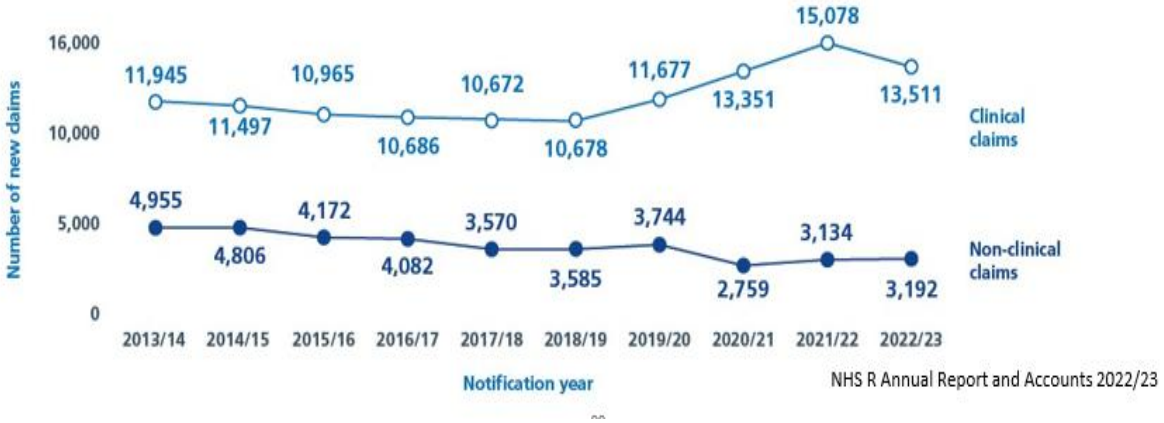
**Legal Aid**

Legal aid is still active in the Region and there is concern that there are disproportionate number of clinical claims as a result.

RNOH/GIRFT has not been provided with relevant data to make a reliable comparison between Northern Ireland and England.

Legal aid was cut as part of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LAPSO) in England in April 2013. The claims data in England demonstrates that there was an initial slight fall (due to an artificial rise in claims as solicitors sort to execute claims before LAPSO ended, but overall claims have risen since 2020 (this is not related to COVID-19 pandemic) as the 'no win no fee' system has ensured that patients still have excellent access to legal services regardless of financial status. We know that litigation is higher in less affluent regions.

We have evidence from England as shown in **Figure 7** below.




## 4.7 Litigation recommendations

| | BSO/DLS Actions/Recommendations |
|---|---|
| 11. | Improve the utilisation of the clinical and ELOL litigation data by introducing a new DLS Case Management System / database to allow interrogation of data to easily identify claims based on causal themes, clinical specialties and allow Trust comparison (benchmarking) in claims handling and learning. Business intelligence options will allow easy tracking of claims to identify trends of open claims within casual themes and specialties. |
| 12. | Undertake thematic reviews of litigation data targeting high volume and value to learn from claims. Central DLS department litigation manager to lead on regional "Learning from Claims". |
| 13. | Nominate a central clinical lead to advise DLS on learning claims. |
| 14. | DLS to re-introduce training for witness statements and increase the availability of the training for coroner's inquests. |
| 15. | Develop an early notification system for birth injury and fast tracking of claims where there is clear liability. |
| 16. | Establish regional programmes to recommend 'saying sorry', a 'just and fair' culture for staff, working in partnership with patients, families and carers and involve them with safety investigations, ensure openness and candour, signpost to support and commit to share learning. |
| 17. | Appoint an ELOL forensic accountant to review patterns and trends e.g. millions of pounds saved in one Trust in England. |
| | **Trust Actions/Recommendations** |
| 18. | Develop a regional set process for best practice in learning from claims across all Trusts:<br>- Allowing triangulation against learning from Claims, Complaints, Serious Adverse Incidents and Inquests<br>- Upgrade Datix to a cloud based version.<br>- Re-introduce theming of incidents to support triangulation.<br>- Introduce clear standardised processes across NI for each Trust to feedback learning of claims from litigation managers to frontline clinical staff through morbidity and mortality meetings, departmental meetings etc. |
| 19. | Ensure that clinical staff with formal roles have dedicated sessions incorporated into job plans to assist legal departments with enquiries and communication with other clinical staff. This work to be given protected time without detrimental effect on clinical services. This would be separate to a medical director who has overall responsibility for clinical negligence. Often best suited to high value and volume specialties where it can be of the most benefit. |

| | |
|---|---|
| 20. | Consider a mechanism to incentivise and provide benefit to Trusts investing in learning from litigation claims (current centrally funding from the Department of Health provides no financial incentive/benefit). |

### 4.8 Financial impact of recommendations

The initial increase in costs to realise benefits would be:

1) **Centrally**
    a. New DLS claims database.
    b. Employment of a DLS litigation manager with a pure focus on Safety and Learning from claims to drive improvement rather than the management of claims.

2) **Trust level**
    a. The payment of PAs to clinicians in Trusts as part of adapting their existing job plan.

## 5. Procurement findings and recommendations

### 5.1 Procurement background

We undertook a high level review of potential opportunities to achieve savings from improving the effectiveness of medical device procurement. Our understanding is based on interviews with BSO's procurement team as well as views from Trusts. We were provided with some data, described below, to get a sense of the likely scale of possible procurement savings.

The principal mechanism for ensuring value for money on device spend is BSO's procurement framework. BSO asks Trusts to outline the medical devices they may wish to use and organises a framework contract where suppliers bid a unit price and this becomes the framework price that is used for any business conducted through the framework.

Consequently, the framework includes many manufacturers and distributors offering a wide range of devices at a wide range of prices. Many of these will be substitutes for one another. It is left for Trusts to decide which devices they procure through the framework.

BSO believe that unit prices in the framework are competitive, although routine benchmarking is not regularly undertaken to ensure this is the case. Benchmarking is sometimes used e.g. for specific product groups or when prices are moving significantly.

Procurement controls appear to be effective in the sense that Trusts are required to buy through the framework. We did not hear of examples where Trusts are procuring devices outside the framework.

Whilst medicines procurement was not a big focus in this work, our understanding is that some hospital medicine procurement follows a similar process to devices.

In relation to pharmacy, we also did not focus on inventory management, but this was mentioned as an area of possible savings particularly in relation to stocks held in hospital pharmacies.

### 5.2 Procurement observations

Whilst BSO's procurement framework appears to be an effective mechanism for organising procurement, we believe there are opportunities to achieve significant additional savings. These savings will come from:

- Narrowing the range of devices being procured (subject to clinical needs) to keep the scope of procurement manageable. We saw examples where suppliers have products listed on the framework, but no purchases are made.
- Introducing an element of competition, whereby suppliers are bidding to earn a place on the framework in return for a guaranteed or likely volume. Currently suppliers are bidding a price but a) they are not excluded for submitting high prices and b) volume discounts are likely being foregone because suppliers aren't bidding against an agreed or target volume.
- Having stronger controls in place to encourage clinical teams to use devices that represent the best value for money.

## 5.3 Procurement data

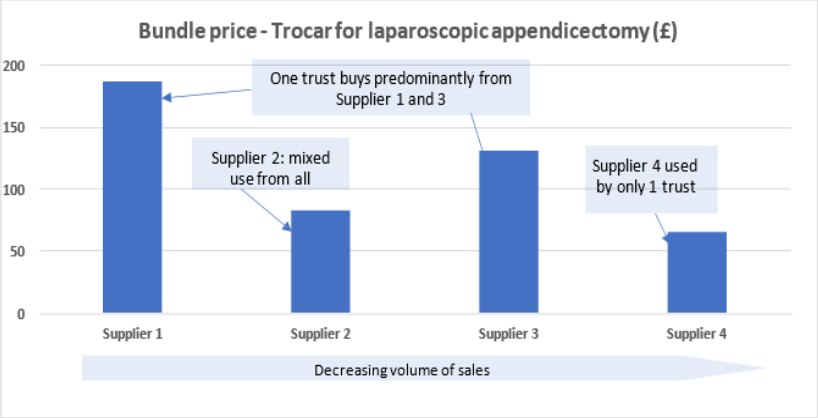
Data suggests there is significant scope for switching to lower cost suppliers: For example, our case study of trocar devices for laparoscopic appendicectomy.

BSO provided data on Trust usage of trocar devices from four suppliers. We analysed the framework prices of the bundle of trocar devices required to perform laparoscopic appendicectomy.

We found:

- The supplier with the highest volume is the most expensive.
- Only one Trust uses the least cost supplier.
- Moving all purchases to the 2nd cheapest supplier would save 41% (53% if all purchases shifted to the cheapest).
- Additional volume discounts may be achievable.

**Figure 8:** Shows the bundle price for trocars used for laparoscopic appendicectomy.



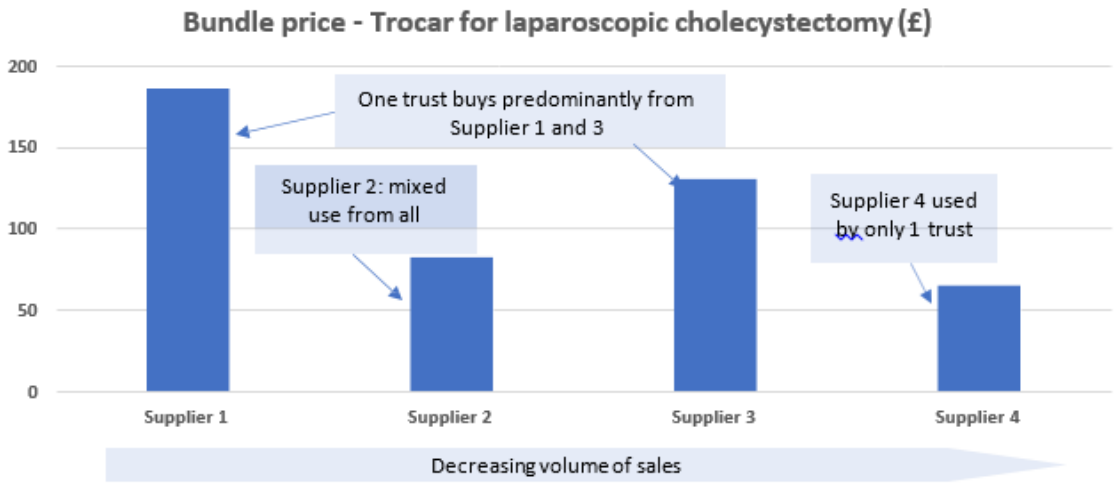

*Source: based on information provided by BSO. Savings should be treated as indicative because of limitations with the data.*

We found similar opportunities in relation to trocar devices for laparoscopic cholecystectomy. Using the same data, we also reviewed the bundle price of devices required to perform a laparoscopic cholecystectomy.

We found:

- Very similar findings in the mix of suppliers used by Trusts.
- Moving all purchases to the 2nd cheapest supplier would save 38% (53% if all purchases shifted to the cheapest).
- Additional volume discounts may be achievable.

**Figure 9:** Shows the bundle price for Trocars used for laparoscopic cholecystectomy.




Source: based on information provided by BSO. Savings should be treated as indicative because of limitations with the data.

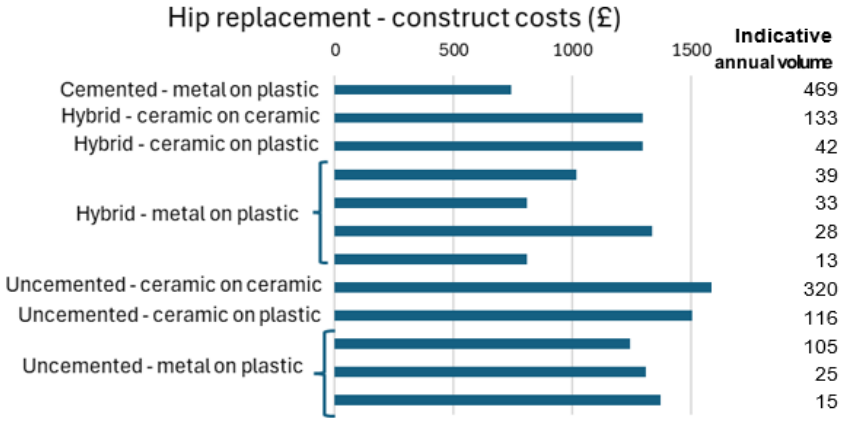
**Data suggests these conclusions will hold for other clinical areas.**

One Trust involved in this review has involved clinicians in an exercise to assess the potential savings from switching to better value paediatric intubation devices. The Trust worked with clinicians to identify paediatric intubation devices that were acceptable substitutes for one another. They identified a potential saving of 75%.

BSO provided us with data on the pricing for devices used in hip replacements. The data shows variation in the cost of different constructs being used.

Whilst indicative (we cannot identify the precise volumes and combinations being used in practice), the data suggests variation within the same construct costs and significant scope to consolidate the range of constructs in use. **See Figure 10 below.**

**Figure 10** Shows hip replacement construct costs.




Source: based on information provided by BSO. Savings should be treated as indicative because of limitations with the data.

**A high level review suggests there may be additional savings by using more competitive procurement processes.**

We have highlighted opportunities from reducing the range of devices available and encouraging clinical teams to use a small range of clinically acceptable products that provide

the best value for money. In addition, we think additional savings are possible through using competitive procurement processes (e.g. where the price bid by a supplier determines whether or not it makes it on the framework agreement). Data suggests there is scope for additional discounts.

**Table 4** looks at a selection of energy devices and compares prices in Northern Ireland with the best achieved in England.

**Table 4: Energy devices comparisons**

| Item | Approx. annual NI spend | % savings based on lowest England price |
|---|---|---|
| Curved shears (1 product) | £200k | 11% |
| Nano-coated sealer/divider | £260k | 17% |
| Impact instrument | £350k | 20% |

## 5.4 Procurement recommendations

Trusts currently spend (2022-23) £403m on clinical supplies and services and £75m on general supplies and services. Our work found that there are significant potential procurement savings which could be identified against this spend.

| | Procurement Actions/Recommendations |
|---|---|
| 21. | Reduce the spread of products that clinicians are able to routinely choose from.<br>- This removes the ability for clinical teams to use higher-cost suppliers when lower-cost alternatives are available.<br>- This will require significant engagement from clinical teams to agree scope, to build confidence that clinical quality will not be impacted, and to identify (and overcome) barriers to switching.<br>- Trusts to raise awareness of the costs of the products to those who are selecting them.<br>- This could generate immediate savings and does not require any retendering activities via BSO.<br>- Trusts could action this on their own right away, but co-ordination across organisations likely to be more effective longer- term. |
| 22. | Move away from the current open framework agreement to a more competitive approach where suppliers actively compete for a place on BSO's framework.<br>- Involve clinical teams in agreeing appropriate product bundles that are substitutes for one another.<br>- BSO runs a tender exercise where suppliers compete to supply a product bundle against an indicative volume.The number of successful suppliers is limited – so being competitive matters.<br>- Regular re-tendering to test the market, ensure pricing remains competitive and allow other suppliers to re-compete for a place on the framework.<br>- A phased approach means this could be rolled out quickly (e.g. using some of the bundles and product areas defined in the recommendation above).<br>- Undertake regular benchmarking against other sources to give confidence that Northern Ireland prices represent value for money.<br>- Short term: Investigate scope to work alongside e.g. the mechanisms used in England to benchmark prices.<br>Long-term: May be value in coordinating procurement with approaches in England (requires further investigation to establish whether this is possible and appropriate). |

| | |
|---|---|
| 23. | Open dialogue with suppliers about the potential for more innovative approaches to contracting.<br>- This is a longer-term goal. Suppliers are increasingly value-added services alongside product (e.g. stock management, services to support more efficient theatre operation etc.).<br>- Procurement and Supply Chain Partnership Board could be asked to take this forward, beginning with reviewing experience and lessons in other countries (e.g. there are examples in the NHS in England) and then opening dialogue with suppliers on the potential for value-added services. |

## 6. Business and corporate services findings and recommendations

As part of a wider drive in NI public service to consolidate business and corporate services, HSC went through a major programme 10 years ago with a view to consolidating some of these services and introducing shared services where possible. We support this approach to delivering efficiencies, however we have made the following observations.

### 6.1 Spend on corporate services

We received information for each Trust (including Northern Ireland Ambulance Service) on headcount for three central corporate services functions;

1. Finance (note some of this – notably accounts payable and accounts receivable – is outsourced to BSO (Business Services Organisation).

1. Human resources (note some of this – notably recruitment and payroll – is outsourced to BSO).
2. Risk and governance.

We have benchmarked against values for England, but note the difficulties of comparability, particularly given the different scope of an English Trust versus a Northern Ireland Trust.

Data suggests some variation across Trusts in headcount by corporate service area (after controlling for Trust size). For example, the headcount in risk and governance looks low by England standards. Training provision was also often run in silos across the region, again creating inefficiencies.

**Figure 11:** Shows comparable data of Finance staff across Northern Ireland.

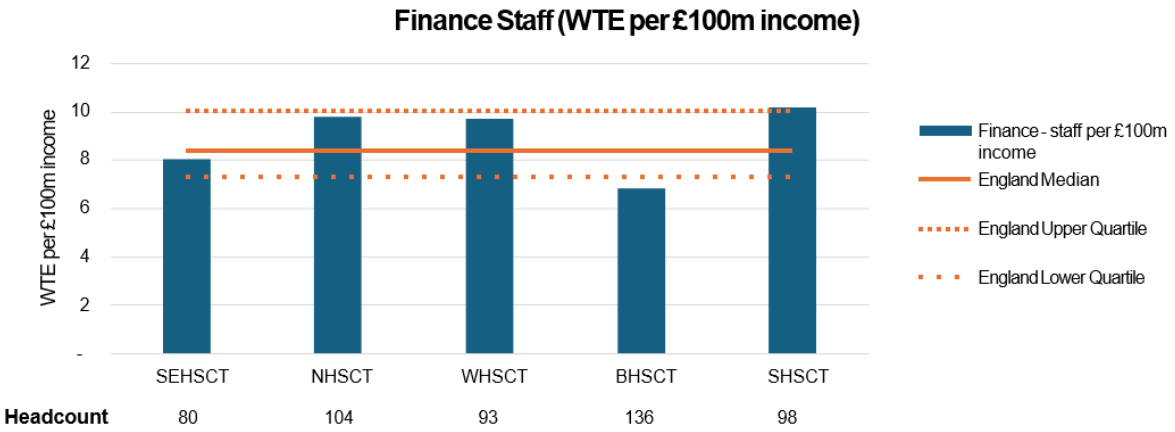


**Figure 12:** Shows comparable data of HR staff across Northern Ireland.

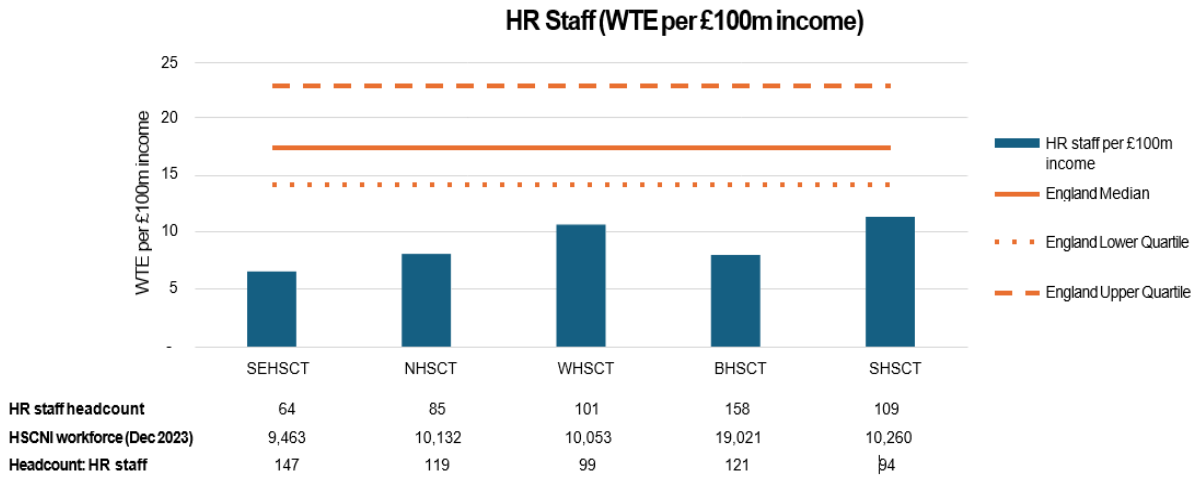
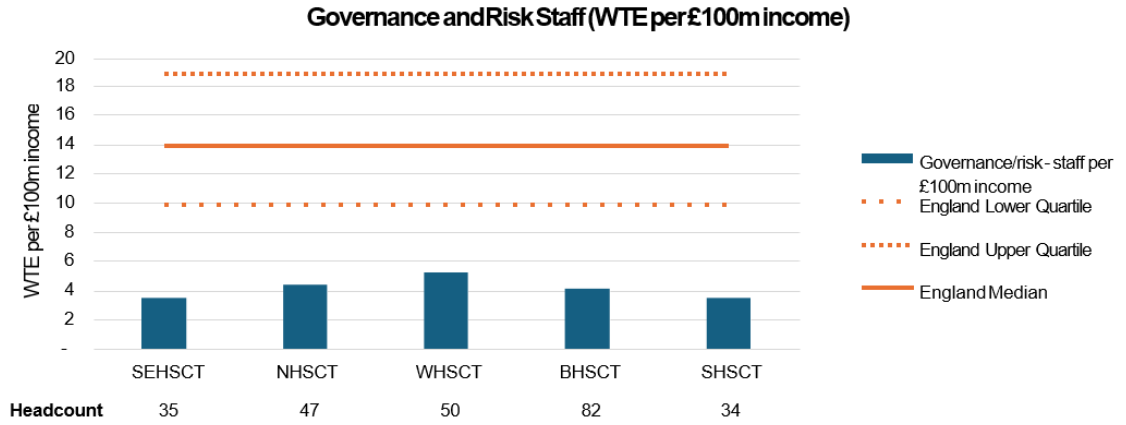



**Figure 13:** Shows comparable data of Governance and Risk staff across Northern Ireland.




## 6.2 Corporate services recommendations

| | Actions/Recommendations to target for corporate services savings |
|---|---|
| 24. | Take action to benchmark corporate services in Trusts to examine opportunities for further consolidation of some corporate services (e.g. within finance and HR) to take advantage of economies of scale. |
| 25. | Review opportunities to develop a regional approach to training delivery to release space in Trusts and consolidate delivery, reduce costs and develop a regional strategy for training and development. |

## 6.3 BSO recommendations

A strategic review of BSO was delivered by PA Consulting in 2021 – this set out a number of recommendations. We consider that BSO need to set out which of these 2021 recommendations are progressing, when they will be delivered and share this with their client base.

| | BSO Actions/Recommendations |
|---|---|
| 26. | Clarify roles, responsibilities and accountabilities between BSO and Trusts for those services currently provided by BSO e.g. procurement. |
| 27. | Agree KPIs and benchmarks and for all services currently delivered by BSO and use these transparently with Trusts through monthly reporting. |

| | |
|---|---|
| 28. | Develop a full suite of KPIs focusing on BSO's role in delivering savings and efficiency across the Region which are reported against to the Department of Health and bring more of a commercial and efficiency driven perspective to their service delivery and costs, including better use of data. |

## 7. Commercial opportunities findings and recommendations

We met with leaders from BSO, Department of Health and the Trusts in Northern Ireland. There was limited interest in developing additional income streams.

Leaders were concerned that managing several small contracts may take away energy and focus from the main mission of providing health and social care to the population of Northern Ireland.

| | Commercial opportunities Actions/Recommendations |
|---|---|
| 29. | Trusts should explore the scope to renting vacant estate to retail outlets on their sites. |
| 30. | Trusts should explore opportunities to develop income streams from research including industry sponsored studies. |
| 31. | BSO should explore opportunities to provide business services to other public sector bodies e.g. salary services. |

## 8. Cross-cutting themes

### 8.1 Working as One Region to secure best value

There needs to be a regional approach to procuring services from 3rd party providers:

- Agreed tariffs/tiered approach for high cost/complex social care placements.
- A single Northern Ireland approach to procuring locums and agency staff.
- Review non-emergency patient transport.
- Imaging and Pathology networking.

Trusts should use their considerable expertise and capability to drive down costs which will not impact directly on patient services. If Trusts do not have this capability they should identify resource gaps to address this.

- Develop a coordinated recruitment strategy for Northern Ireland. To deliver a cohesive approach so that Trusts aren't working against one another.
- Develop a regional strategy for home working and hybrid working. There needs a standardised approach across Health and Social Care to fully realise these benefits.

### 8.2 Medical staffing findings and recommendations

Job planning processes are of variable maturity between Trusts. We found variable mechanisms for job planning with paper versus electronic options. There are high rates of locum usage across Trusts which is a high cost burden and does not offer patients continuity of care. Smaller departments with high frequency on call are particularly vulnerable and this affects performance, morale and potentially patient safety.

We understand there to be difficulties in recruitment which is exacerbated in some specialities and localities. We understand that International recruitment is managed separately by individual Trusts.

| | Medical Staffing Actions/Recommendations |
|---|---|
| 32. | Develop an overarching regional medical staffing strategy. |
| 33. | Establish regional cap for agency medical staff with associated escalation process and accountability framework. |
| 34. | Develop a regional job planning framework to harmonise practice across Trusts and link this to the annual business cycle and demand and capacity programmes. |
| 35. | Consider the regional procurement of job planning software for all Trusts. |
| 36. | Develop a regional approach to international fellows and CESR programme. |
| 37. | Consider an SLA for selected services in hard to recruit localities with a single provider Trust e.g. dermatology & neurology. |

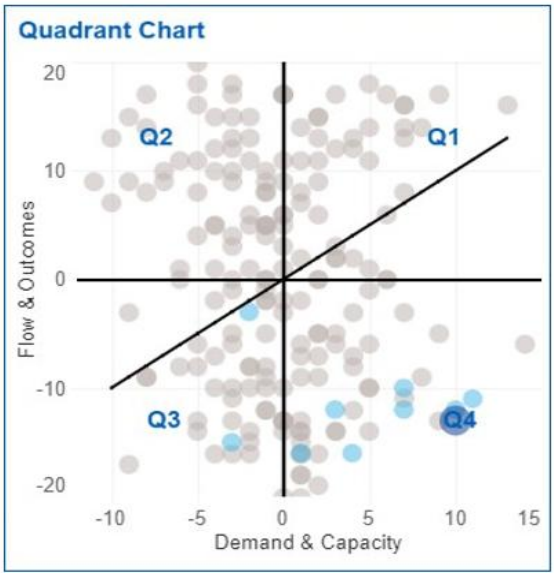
## 8.3 Using data to identify, track and report against improvement goals in the region

During interviews, we found little evidence of data being used consistently within or across organisations to support clinical and operational improvement. We would expect to see more use of operational tools to support day to day planning and workflows (e.g. theatre dashboards). Some of the tools to help with this are:

- ✓ CHKS available to all Trusts (and centrally)
- ✓ SEDIT tool available to all Trusts

There is scope to do more with what is currently available and draw on experience in neighbouring systems (e.g. GIRFT metrics in England). Trust leaders should have the capability to achieve finance targets by utilising data more to drive efficiency and improve productivity.

**Figure 14:** The chart below is taken from the **Summary Emergency Department Indicator Table (SEDIT).**




It compares data on and flow and outcomes against demand and capacity across Trusts in Northern Ireland and England. The blue dots show Northern Ireland Trusts and suggests that these Trusts are facing less demand and capacity pressures relative to their England counterparts but score worse on flow and outcome measures.