# *Chapter 4*

# Health care quality in Northern Ireland

*Northern Ireland has established a robust strategic agenda for quality of care, but faces a difficult challenge in maintaining public confidence amidst sustained economic pressures and ongoing concerns over access. While the small scale of the system promotes a culture of trust, it is over-burdened by a governance structure that may benefit from further consolidation. Amidst an array of grassroots initiatives there exists a need to further promote effective learning and sharing across services and scaling-up of good practices. More metrics to drive benchmarking across services along with a strengthened role for the regulator are indicated. The integration of health and social care governance has been poorly exploited to date, with funding and service arrangements still in silos and a lack of incentives to encourage change. Further integration and development of general practice as a principal agent for co-ordinating community responses to health and wellbeing needs will help drive reform.*

Northern Ireland has the smallest population of the four countries in the United Kingdom. Political power was devolved from Westminster to the Northern Ireland Assembly in 1998, although it was suspended during the period between 2002 and 2007. The Assembly is responsible for a range of devolved powers, including the administration of the health and social services system in Northern Ireland. This chapter provides an overview of the key institutions, policies and arrangements in place in Northern Ireland to ensure the provision of high quality health care and promote ongoing improvement.

Section 4.1 of this chapter provides an overview of the structure of the health and social care system in Northern Ireland and sets out the key contextual factors for considering the quality and safety system, including the centrality of primary care policy and reform. Section 4.2 considers quality governance issues and sets out the role of key governance bodies. Sections 4.3 to 4.10 cover specific components of the quality and safety system including professional training and certification, authorisation of medical devices and pharmaceuticals, use of standards and guidelines, regulation and inspection of health care facilities, patient and public involvement in health care quality, use and public reporting of quality indicators and use of financial incentives. Section 4.11 identifies and considers key patient safety initiatives. Finally, Section 4.12 provides some concluding comments along with the key messages and recommendations from the OECD on the review.

## 4.1. The planning, financing and delivery of health care in Northern Ireland

Since devolution some 17 years ago, the Northern Ireland health and social care system has maintained a number of distinctive features throughout this period of evolution and reform. The system remains organised around a formal functional split between service commissioning or purchasing and provider functions. While the number and configuration of commissioning bodies and provider based trusts has been rationalised over time, the structural framework to promote choice and competition between providers remain. An enduring and unique feature of the system is the integration of health and social care governance, which has been in place for over 40 years. The health and social care portfolio is the largest service sector in Northern Ireland and accounts for more than 45% of total government expenditure.

The system currently faces a difficult challenge in maintaining public confidence in the quality and safety of the care provided, amidst sustained economic pressures and ongoing concerns over adequate access to acute hospital care. A central theme for health and social care reform in Northern Ireland over the past decade has been to rebalance the provisions of services away from hospitals and towards care and support in the community. The

*Transforming Your Care* strategy underpins the policy and planning agenda for reform in this respect.

## *Organisation and financing of health care in Northern Ireland*

Northern Ireland has a population of approximately 1.8 million people with two-thirds of these people located in and around Belfast the capital. It has the smallest population of the four countries in the United Kingdom, representing only 3% of the total population (see Table 4.1).

**Table 4.1. Population Estimates for the United Kingdom by Country, 2012**

| | Millions | % |
|---|---|---|
| England | 53.5 | 84 |
| Scotland | 5.3 | 8 |
| Wales | 3.1 | 5 |
| Northern Ireland | 1.8 | 3 |
| United Kingdom | 63.7 | 100 |

*Source*: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency.

Health and social care services are largely government funded and almost entirely free at the point of care, including hospital, primary and community care and prescription pharmaceuticals. While statutory user charges exist for dental care, these are capped and exemptions exist for young, low income and other groups (O'Neill et al., 2012).

Most health services are provided by public entities. There are only two small private hospitals and private health insurance uptake is low. Aged care and other care home places are largely privately provided and over half of domiciliary care services are provided by the independent sector (Northern Ireland Statistics and Research Agency, 2012). General Medical Practitioners and general dental practitioners (GDPs) are generally self-employed.

General Medical Practitioners play a key role in the primary care system in Northern Ireland. They operate as independent contractors and are funded by the department through a combination of capitation and fee for service payments. The Department for Health, Social Services and Public Safety is responsible for agreeing the contract with general practitioners while the Health and Social Care Board oversees the management of the contract including additional services. General practice is generally organised around single practices though Practices have recently started to form themselves into Federations of around 20 practices with a geographic population focus.

Dentists are generally self-employed, although some are employed by private organisations providing services funded by the department and others in the provision of services, for example, for children through the community dental service. Unlike nearly all other health and social care services provided in Northern Ireland, out of pocket expenses exist for some dental services.

A structural characteristic that sets Northern Ireland apart from the others countries of the United Kingdom is the model of integrated governance that has existed for health and social care services for over 40 years. While in Northern Ireland, the Department of Health, Social Services and Public Safety (DHSSPS) has strategic oversight of both health and social care, in England, Scotland and Wales the provision of social care still remains the responsibility of local authorities.

The DHSSPS is by far the largest government department in Northern Ireland, with an estimated budget in 2014-15 of over GBP 4.7 billion (EUR 6.3 billion) – the second largest being Education with just under GBP 1.9 billion (EUR 2.6 billion). Health and social care currently accounts for over 45% of total estimated recurrent expenditure (see Figure 4.1) by government in Northern Ireland (Northern Ireland Executive Budget, 2014).

**Figure 4.1. Northern Ireland Public Services Budget,[1] 2015-16**


1. Equates with the Non Ring-Fenced Resource specified in NI budget papers which covers the total ongoing costs of providing services.

*Source*: Northern Ireland Executive (2014), *Budget 2015-16,* available at http://www.northernireland.gov.uk/budget-2015-16.pdf, accessed on 4 February 2015, p. 40.

The Northern Ireland Executive launched the Review of Public Administration (RPA) in June 2002 with the final outcome announced by the Secretary of State in November 2005. Its purpose was to review Northern Ireland's system of public administration with a view to putting in

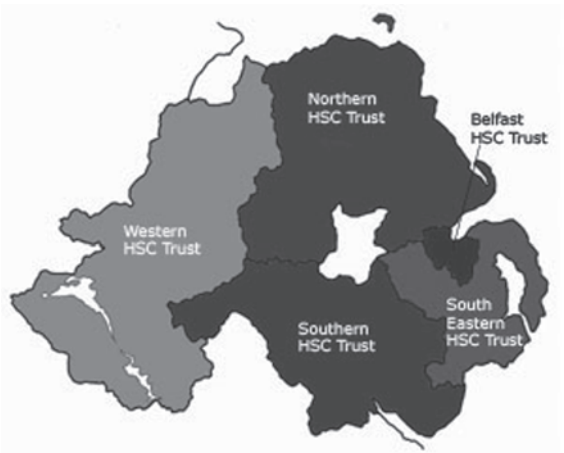
place modern, accountable and effective arrangements for public service delivery in Northern Ireland. A major restructure to the system was introduced following the Review of Public Administration and was aimed at maximising economies of scale and improving outcomes (Ham et al., 2013).

The Health and Social Care (Reform) Act (Northern Ireland) 2009 provided a statutory basis for the restructuring of the administration of health and social care, resulting in the consolidation of the number of organisations involved in the administration, commissioning and delivery of care, including:

- *Commissioning*: from four health and social service boards to one regional board and five local commissioning groups, which act as committees of the board.
- *Provision*: from nineteen trusts (eleven community and social services, seven hospitals and one ambulance) to six trusts (five health and social care and one ambulance).
- *Public involvement*: one patient and client council replaced four health and social services councils (Ham et al., 2013). The Reform Act also placed a statutory obligation on health and social care (HSC) organisations and the department to involve the public and consult with them in relation to their health and social care.

The geographic boundaries of Local Commissioning Groups and Trusts are aligned (see Figure 4.2.)

**Figure 4.2. Geographic boundaries of Health and Social Care Local Commissioning Groups and Trusts in Northern Ireland**




*Source*: Northern Ireland Statistics and Research Agency (2013), *NIRA Geography Fact Sheet*, available at: http://www.ninis2.nisra.gov.uk/public/documents/NISRA%20Geography%20Fact%20Sheet.pdf, accessed on 4 February 2015.

### *Key policy developments aimed at improving quality of care in Northern Ireland*

Late in 2005 the DHSSPS released *Caring for People Beyond Tomorrow* a strategic framework for primary health and social care which sought to establish the vision for primary care service policy and development in Northern Ireland. The Minister's foreword amplified the central objective of the strategic framework:

> *"Too much reliance is placed on the hospital sector: a more responsive and dynamic primary care sector could provide the necessary care close to home. Therefore, we need to develop a much more responsive system which is fully integrated and joined up with the wider health and social care network", "Foreword" in Department for Health, Social Services and Public Safety (2005)* Caring For People Beyond Tomorrow: A Strategic Framework for the development of Primary Health and Social Care for Individuals, families and Communities in Northern Ireland.

The framework identified a vision for primary care and a set of high level goals to be achieved in the first five years of the 20 year strategic horizon, including improved access to a wider range of primary care services, more effective and integrated team work, greater community involvement in service planning and infrastructure development for integrated services. A steering committee was established to oversee the implementation of strategies to meet the goals, with an emphasis on reducing reliance on hospital services, improving discharge arrangements and achieving service efficiencies. In June 2006 an improvement programme was announced for commissioners to take forward with providers, including integrated working, nurse-led discharge, intermediate care, case management and non-medical prescribing.

*Transforming Your Care*, a wide ranging review of the Northern Ireland health and social care system, was initiated in 2011. In announcing the review, the Minister emphasised the overriding need to drive up the quality of care, improve outcomes and enhance patient experiences of care. The focus of the review echoed the central objective of the strategic vision for primary care six years earlier, to see a shift in care currently carried out in hospitals into the community.

The review was undertaken by the Health and Social Care Board Review Team. The Team undertook research, consultation, analysis, drafting of reports and recommendations. An expert panel provided challenge on the progress of the review; the methodology used; the quality of information assembled and analysis undertaken, and finally the robustness and

appropriateness of the findings, proposals and recommendations. The expert panel was led by the Chief Executive of the Health and Social Care Board in an ex officio capacity supported by independent experts, including the Chief Executive Officer of The King's Fund, the Executive Chair of SSE Ireland, a general practitioner, academic and retired civil servant. The review covered all health and social services, involved significant stakeholder consultation and provided recommendations and implementation plans for future configuration and delivery of services. It explicitly excluded changes to the existing governance structures, namely the configuration of the Health and Social Care Board and Trusts and the level of the budget resources available.

The key principles and model for reform put forward by the review team focuses on creating greater involvement and control for individuals in care decision making and the provision of services closer to home. The model was applied to a variety of population groups, including those with chronic conditions and the elderly to illustrate how it might work in practice. Around 100 proposals flowed from this work, with many picking up similar themes to the 2005 strategic framework for primary care, including population based multi-service teams with a central role for GP leadership (to be known as Integrated Care Partnerships) and workforce reform. The review understandably went further and made proposals around consolidation of acute services, continuation of the closure of institutional disability and mental health facilities (as recommended in the Bamford Review in 2007) and shifting resources from acute care back into the community.

*Quality 2020* is the principal policy document on quality and safety for the Northern Ireland system of health and social care services. The document was launched in November 2011 by the DHSSPS to provide a strategy and clear directions over the subsequent ten years for the quality and safety of health and social care services in Northern Ireland. The strategy was released at a time when the system, while still grappling with the financial challenges resulting from the global financial crisis and in response to recognition that longer term strategies are needed to meet ongoing challenges and maintain high quality services (DHSSPS, 2011).

The strategy aligns with the conceptual framework for quality adopted by the OECD, defining three quality dimensions – safety, effectiveness and patient and client focus. The document sets out a bold vision for the system, that it "be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care" (DHSSPS, 2011). In considering how to achieve the vision emphasis is placed on leadership, resources, a learning culture and quality measurement.

Five strategic goals with related key actions are identified for the ten-year period:

1. Transforming the culture
2. Strengthening the workforce
3. Measuring the improvement
4. Raising the standards
5. Integrating the care

In 2012 an implementation plan was subsequently developed. Together the strategy and implementation documents provide a sound blueprint for a robust and comprehensive approach to building a quality and safety focus across the health and social care services in Northern Ireland. A number of the key initiatives set out in the implementation plan are identified in this report and highlighted for priority action by the DHSSPS as it proceeds with the implementation plan for the strategy, including:

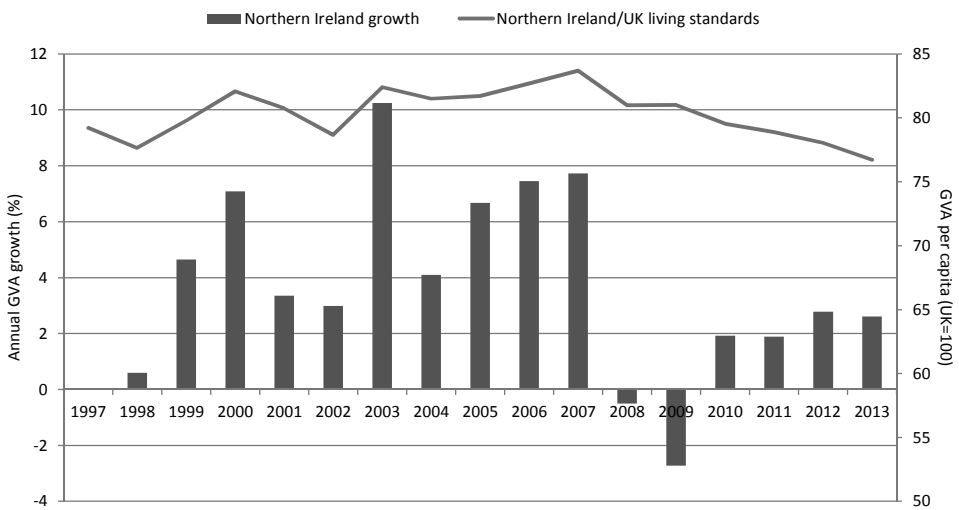
- The promotion of a culture of learning and innovation through strengthened opportunities for benchmarking across trusts and services.
- The clarification of responsibilities and strengthening of accountabilities for quality improvement at all levels in the system.
- The adoption of clinical care standards to promote delivery of appropriate care and reduce unwarranted variation.
- The development of a robust suite of quality and safety performance indicators, including clinical indicators.
- The establishment of targets with regular quality review and reporting at the trust and whole of system level.

The economic context for the health and social care system in Northern Ireland was relatively robust in the years leading up to the global financial crisis. In 2005 Professor John Appleby undertook a review of the provision of Health and Social Services in Northern Ireland to consider scope for resources devoted to health and social care to be used more effectively, particularly in relation to improving service waiting times. While much of the review was taken up with budget considerations, the main conclusion from the review was that the issues for the NI system relate more to the use of resources than the amount of resources available. Appleby pointed strongly towards the need for more robust performance management arrangements with long term targets coupled with rewards and sanctions to encourage service improvements by providers.

The onset of the global financial crisis from 2008 significantly changed the operating environment for the health and social care system in Northern Ireland. The impact of the crisis is clearly evident in the official economic figures of the Northern Ireland Executive (see Figure 4.3), with negative economic growth recorded in both 2008 and 2009.

While there has been positive growth in recent years, it lags behind the UK average. Provisional results for 2013 indicated that the Northern Ireland economy grew by 1.2%, below the UK average of 3.3%. Although more recent data show signs of further limited growth, living standards in Northern Ireland remain below the UK average. In 2013 the living standards index indicated NI was at 76% of the UK level (Northern Ireland Executive).

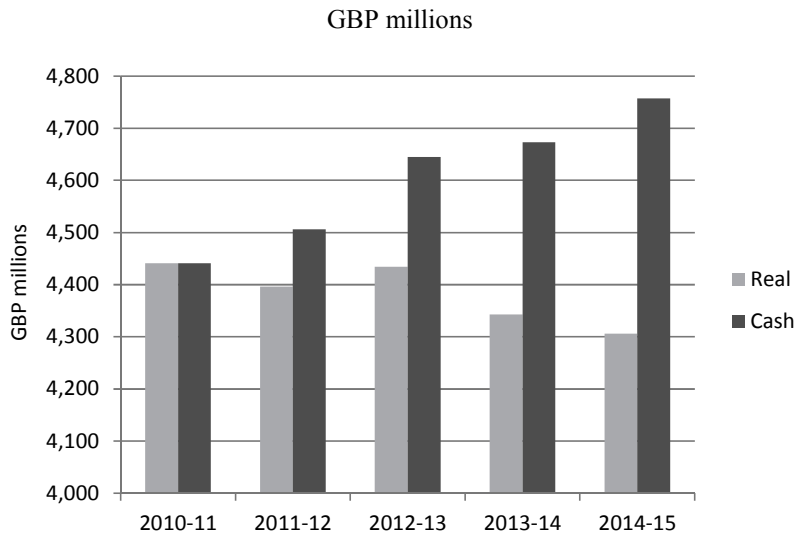
**Figure 4.3. Northern Ireland economic growth and living standards**




*Source:* Northern Ireland Executive (2011) *Budget 2011-15*, available at http://www.northernireland.gov.uk/revised_budget_-_website_version.pdf, accessed on 4 February 2015.

In 2011 Professor John Appleby completed an update review on resource needs and opportunities for improved productivity, in light of the implications of the global financial crisis. In his report, Appleby clearly identifies that the need to manage down national debt and to realign government income and expenditure will have significant impact on public spending. Whilst acknowledging that Northern Ireland's proposed budget settlement was relatively favourable and health and social care were relatively better off than other sectors, he identified projected real reduction in spending over the five years to 2014-15 (see Figure 4.4).

**Figure 4.4. Northern Ireland Health & Social Care Budget: Projected cash and real change 2010-11 to 2014-15**




*Source*: Appleby, J. (2011), "Rapid Review of Northern Ireland Health and Social Care Funding Needs and the Productivity Challenge; 2011/12-2012/15", Belfast, DHSSPS.

The official budget outcome for the portfolio from 2011-12 to 2014-15 confirm real reductions in total planned spending, estimating reductions of over 5% per annum (Northern Ireland Executive Budget 2011-15). There are indications that these budget pressures are significantly impacting on the portfolio's spending plans and ability to respond to service demands. In late 2014 in an address to the Assembly the Minister stated that his:

> *"Department has been experiencing significant financial pressures, most notably since autumn 2013, and that these have yet to be recurrently resolved. These pressures are in a wide range of areas including children's' services, quality and safety of services, elective care and unscheduled care and they reflect the ever increasing demands on health and social care and the technological and treatment advances that can now be provided" (Oral Statement to the Assembly by Health Minister Jim Wells MLA – 14 October 2014 – Outcome of October Monitoring Round and Paediatric Congential Cardiac Services, available at:*
> http://www.dhsspsni.gov.uk/print/index/statements-minister/statements-minister-2014/oralstatement141014.htm, accessed 2 October 2015).

The budget position and economic outlook for Northern Ireland provides a challenging policy landscape for the country. The flow-on implications for population health, service demand and health system sustainability are significant.

### *The quality of care in Northern Ireland has been repeatedly questioned in recent years*

In recent years, the health and social care system has been subject to repeated scrutiny in relation to concerns over the standard of care. Separate reports on an inquiry into deaths from Clostridium difficile in hospitals of the Northern Trust and the recall of over 100 dental patients by Belfast Trust after a review of the clinical performance of a senior doctor were released in early 2011. Later that year, a report by the RQIA examining delays in the reporting of x-rays in the system was also released. During 2012, the system also began responding to the 32 recommendations related to the findings of an investigation into an outbreak of Pseudomonas aeruginosa infections in neonatal units which had resulted in five neonatal deaths. More recently, a review of unscheduled care was undertaken by the RQIA, in response to concerns about access to hospital care in the Belfast Trust and media reporting on extended waits in emergency departments.

While strategies to address these issues may have brought improved care quality through better co-ordination of acute and primary and community care, there is a risk the intensity and urgency of the responses required by such reviews detract from longer term strategies for quality and safety improvement and the pursuit of system reforms, such as those under the *Transforming Your Care* agenda. Senior officials consulted during the review repeatedly reflected on the disproportionately high level of scrutiny the media places on health and social services provision in Northern Ireland and expressed concern over the level of resources and attention required to manage public expectations.

Other commentators have noted the "high, perhaps unrivalled, level of media coverage" in Northern Ireland and the impact of the shocks to the system that have been brought about by various reports from the recent raft of formal reviews. They observe "it often paralyses the organisation under scrutiny" with opportunities for learning lost through the organisation being overwhelmed by the burden of recommendations (Donaldson, 2014).

### *Priorities for health service reform in Northern Ireland are well established but progress with system change has been slow*

A central theme for health and social care reform in Northern Ireland over the past decade has been to rebalance the provisions of services away from hospitals and towards care and support in the community.

In 2005, amidst recommendations to sharpen the incentives in the system to improve health resources use, the Appleby review recommended greater attention be given to practical involvement of GPs in the purchasing of care as a way of both strengthening the involvement of general practitioners in the system and as part of a devolution strategy for commissioning secondary care services.

Later in 2005 the DHSSPS released *Caring for People Beyond Tomorrow* a strategic framework for primary health and social care which sought to establish the vision for primary care service policy and development in Northern Ireland.

The most fundamental aspect of this change agenda lay in the notion of integrated care, namely the establishment of a central role for GPs in the development of population based primary care teams. A central recommendation, reflective of the Appleby review, was to develop a managerial partnership between Trust and GP practice leadership. The planning and successful integration of other key elements of the reforms, including better community based-case management, non-medical prescribing, changes in skill-mix, information system and capital infrastructure development and intermediate care are identified as being pivotal on the establishment and leadership of the new primary care teams or bodies.

While GP leadership was evident on the boards of governance of trusts and the planning for clinically led pilot projects (known as Primary Care Partnerships) to promote new and innovative approaches to commissioning care was initiated in 2010, evidence of progress on concrete reform to the service system in the early years after the change agenda was established was limited. The Primary Care Partnerships consisted of voluntary alliances of health and care professionals and voluntary and community sector bodies working together to inform the Local Commissioning Groups of agreed areas in which services could be provided more effectively and efficiently around the needs of patients (Northern Ireland Assembly, 2012). While the achievements of the partnerships would seem modest, they appear to have provided a basis for future service developments under the *Transforming Your Care* reform agenda established in 2011-12.

The *Transforming Your Care* review echoed the central objective of the strategic vision for primary care six years earlier, to see a shift in care currently carried out in hospitals into the community. The review was undertaken at a time when a number of incidents and inquiries into the standards of care were causing public concern over care quality and safety (e.g. inquiry into deaths from Clostridium difficile in hospitals of the Northern Trust). It would also appear that the reform agenda for primary care had lost momentum in the preceding years, most likely as a consequence of the greater policy attention to system sustainability required during the early aftermath of the global financial crisis.

The review provides a robust blueprint for service reform, with the transition to local population based service planning and integrated local service provision at the heart of the new system model. The review sensibly places general practice central to this reform looking for general practitioners to form geographical networks (referred to as federations of practices) and assume critical leadership roles in Integrated Care Partnerships (ICPs), the successors to PCPs. The 17 ICPs are collaborative networks of health care providers, statutory, community & voluntary and independent, who seek to ensure the co-ordination and effectiveness of care for local service users across acute and community based health and social care services.

The *Transforming Your Care* review identifies the need for a transition period for the system in building the new partnership model, before the anticipated dividends to better patient outcomes and economies in the system enabled financial sustainability. To this end, the review identified transitional or "hump" funding over the first three year of GBP 70 million. Although challenging to achieve, given the current budgetary context for health and social care portfolio, the allocation of such funding recognised the significant upfront investment required to provide well targeted incentives to providers, build information systems to enable care and performance monitoring and establish operational capacity of any new organisations. For example, the review identified the potential for Integrated Care Partnerships to form the basis for a multidisciplinary mutual organisation or to have social firm status. In addition, there is planned development of federations of general practice (DHSSPS, 2011). This form of investment would appear consistent with plans in Scotland to make available additional resources of up to GBP 100 million in 2015-16 to support government plans to further integrate health and social care.

Progress with the transition to this new system since the release of the *Transforming Your Care* review would appear modest, particularly given the long lead-time for the preliminary development with Primary Care Partnerships in the five years prior to the review. While 17 Integrated Care

Partnerships have been established, they are still in early stages of service planning and development. At a workshop for the members of the committees for the Integrated Care Partnerships in mid-2014, while participants reported improvements in communication between services, relationship building and a clearer vision for improving services there were frustrations raised over the pace of change, the adequacy of transitional funding and the lack of clarity over the longer term commitment to change (Integrated Care Partnership, 2014).

The partnership models vary across the region and in many instances are initially of relatively small scale and address different aspects of care for specific population groups or care issues rather than take a broader-based systematic service approach to addressing the needs of the local community. For example, in one Local Commissioning Group (LCG) area a falls clinic for the elderly is being piloted, while in another LCG area improved support for palliative care is being explored and in another a specialist clinic for respiratory conditions is being tested. Mechanisms have been established to disseminate lessons learnt from each project. While a number of these initiatives may prove after evaluation to be valuable innovations, plans for diffusion and system-wide application of best practice models are required for large-scale system reform. With a view to addressing this issue, DHSSPS entered into an agreement with the Institute for Healthcare Improvement (IHI) in October 2014. This sought to utilise IHI's "Triple Aim" methodology, initially in two prototype sites with a view to scaling up throughout Northern Ireland.

Clarification of the role of general practice in the Integrated Partnerships now and as they evolve in the future is critical. General practitioners would appear to have robust opportunities for input into deliberations on changes to service provision in the community through their membership on the Partnership Committees of the Integrated Care Partnerships (ICPs) and LCGs. However, the central role of general practice in the design and delivery of the new models of care has not been fully exploited at this point. Liam Donaldson goes further in asserting that the "frustrations of the general practitioner community in Northern Ireland that *Transforming Your Care* has not worked, is not properly planned nor funded, has led them to take matters into their own hands and form federations" (2014).

The BMA Northern Ireland's GP Committee is co-ordinating the establishment of a Federation of GP practices. Each Federation comprises of around 20 general practices and delivers services to local populations of around 100 000, aligned with the population coverage of the ICPs. The plan was for all GP practices in Northern Ireland to be incorporated into not-for-profit Federations during 2015 (BMA, 2015). While these Federations may provide potential for a greater focus on population health and enable a scale

of service that could support further service integration, careful integration will be required to ensure that these non-government bodies align with ICPs and the ongoing evolution of organisation and governance of community care and support services.

There are indications that insufficient funding support has been dedicated to this endeavor. The current financial pressures and urgent service access issues facing the portfolio are likely have impacted on this situation. In a recent oral presentation to the Northern Ireland Assembly regarding the budget, it is noted that GBP 8 million in additional funding was being earmarked for progressing the Transforming Your Care agenda in 2015-16, which falls well short of the level of funding originally identified to effectively enable service system transition.

Further, clearer specification of the operational model of service integration to apply across Northern Ireland through the 17 partnerships is warranted. This work could involve greater encouragement of GP leadership, through well targeted incentives and alignment of performance expectations, for example through the Quality Outcome Framework, and the identification of the core elements of a primary care model that should be evident across each region, to enable consistent coverage and access by the community. This could be informed by consideration of the characteristics and implementation strategies for models being pursued in other countries including Medical Homes and Accountable Care Organisations in the US and the transition to Family Health Units in Portugal (see Box 4.1) and to Primary Health Networks in Australia.

While the key elements for reform in the health and social services system in Northern Ireland have been specified and the case for change has been established, bold and sustained political and clinical leadership is required, along with progressive funding transitions, to generate system-wide change of the scale required to bring the vision to full fruition.

**Box 4.1. Primary Care Reform in Portugal**

The primary health care reform agenda in Portugal led to the development of a new organisational model for primary health care known as Family Health Units (FHUs) in 2006. FHUs are self-organising multi-professional teams that are formed by general practitioners, nurses, managers and other professionals to deliver primary care together. The average FHU has around 12 000 patients, with 7 doctors and 20 professionals in total. These teams have functional and technical autonomy enabling them to define their own working processes and to negotiate goals with their local authorities (Fialho et al., 2011) and a payment system sensitive to performance that is designed to reward productivity, accessibility and quality. A comprehensive performance indicator set is tied to the payment system.

The 350 Primary Health Care Centres that existed in Portugal during 2006 have been rapidly transitioning into the new FHU model. By 2010, about 300 FHUs were in place and by 2014 the growth in this model of care had reached coverage of around half of the Portuguese population, noting the FHU model had evolved somewhat since 2005.

The funding of FHUs can vary according to different models. One model, known as Model B, supplements a small salary component with capacitation payments, payment for negotiated additional services, a premium for negotiated goals and a fee-for-service for house calls. The possibility to negotiate with the purchasing/commissioning agency the achievement of certain goals that can lead to further institutional incentives is a distinctive feature of this model.

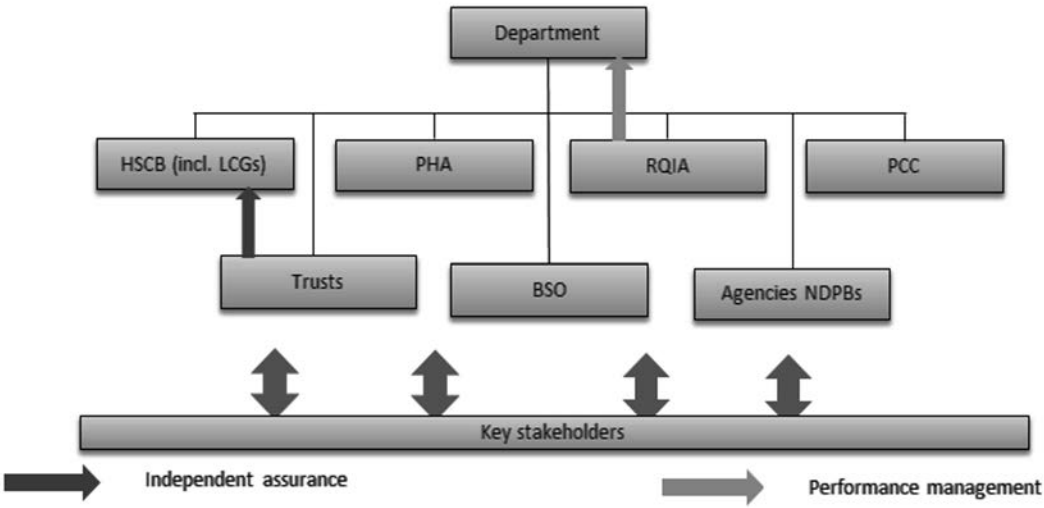
## 4.2. Governance of health care quality monitoring and improvement

This section sets out the key organisations and bodies in the structure of the health and social care system in Northern Ireland, along with the lines of accountability and reporting (see Figure 4.5). Each has an integral role to play in the overall governance of the system and the overall assurance and improvement of the quality and safety of services. However while integration of health and social care is a structural strength of the system, this has not been well exploited to achieve service reform.

### *The key agencies and stakeholders involved in quality of care in Northern Ireland*

Responsibility for the administration and management of health-related matters in Northern Ireland lies with the Minister of Health, Social Services and Public Safety who is part of an eleven person executive led by a First Minister and a Deputy First Minister (O'Neill et al., 2012). The Programme of Government sets out the Executive's budget and investment across departments.

**Figure 4.5. Structure of Health and Social Care System in Northern Ireland**




BSO = Business Service Organisation; HSCB = Health and Social Care Board; NDPB = Non-departmental public body; PCC = Patient and Client Council; PHA = Public Health Agency; RQIA = Regulation and Quality Improvement Authority

*Source:* Department for Health, Social Services and Public Safety (2011) *Framework Document,* DHSSPS available at http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf, accessed on 11 June 2015.

The Department of Health, Social Services and Public Safety leads on the Programme of Government commitments relevant to the portfolio. The department has strategic control of care and issues to the Social Care Board each year:

- A Commissioning Plan Direction (CPD), which sets out the Minister's priorities and details specific standards and targets that should be delivered by health and social care.
- An Indicators of Performance Direction, which sets out a range of performance indicators intended to improve Health and Social Care Trust performance (see Section 4.8).

The department is responsible for Policy on Safety and Quality, including standards and guidelines, professional regulation and adverse incident reporting and learning.

The Health and Social Care Board is responsible for commissioning care, performance management, service improvement and resource management. The Health and Social Care Board consults with the PHA to produce an annual Commissioning Plan that responds to the higher level Commissioning Plan Direction and Indicators of Performance Direction. The Commissioning Plan and its associated service and budget agreements are agreed between the Public Health Agency and Health and Social Care Board. The board is assisted by five Local Commissioning Groups that are aligned geographically to the Health and Social Care Trusts. The Groups assess the needs of their local populations, identify priorities and secure the delivery of services to meet those needs within the overall remit of the board to undertake the commissioning of care for the region.

The six Health and Social Care Trusts (five geographic and one regional ambulance) are the key bodies responsible for providing health and social care in Northern Ireland. They may also commission some aspects of social care, including domiciliary care services. Although the quality and safety of health and social care services have been the responsibility of the Health and Social Care Boards and Trusts in Northern Ireland for some time, the Health and Personal Social Services Order 2003 placed a statutory duty of quality on these bodies. The Order requires that these bodies establish and maintain arrangements for the purpose of monitoring and improving the quality of the health and personal social services they provide and the environment in which they are provided.

The primary operational responsibility for public health in Northern Ireland rests with the Public Health Agency. Activities undertaken by the Agency include the promotion of health and well-being by working with other agencies on particular initiatives aimed, for example, at promoting healthy lifestyles, supporting commissioning activities with public health advice, responding to threats posed by infectious diseases and supporting research and development on new interventions. The Agency also maintains a register of professionals across the range of specified allied health professions such as dietetics, radiography, speech and language therapy, and physiotherapy and podiatry. The intention is to help maintain standards and protect the public (O'Neill et al., 2012). The PHA has a central role in the promotion of patient and client involvement in health and social care.

The Quality, Improvement and Regulation (NI) Order (2003) established the role and functions of the Regulation and Quality Improvement Authority (RQIA) which plays a central regulatory role in the health and social services sector in assuring and improving quality of care in Northern Ireland. The Authority has a broad range of powers in relation to conducting reviews and carrying out inspections and investigations and reporting on arrangements by statutory bodies for the purpose of monitoring

and improving the quality of the health and personal social services for which they have responsibility.

Under the order, the Department of Health, Social Services and Public Safety is able to prepare and publish statements of minimum standards, which are required to be taken into account by the Regulation and Quality Improvement Authority in determining extent of compliance. Statements of minimum standards of care have been published for the following bodies:

- Nursing homes
- Residential care homes
- Nursing agencies
- Domiciliary care agencies
- Residential family centres
- Day care settings
- Child-minding and day care for children
- Children's homes
- Independent healthcare establishments.

The RQIA may serve an Improvement Notice to a person or organisation that the Authority believes is failing to comply with any statement of minimum standards. A notice is required to specify in what respect there is a failure to comply with a statement of minimum standards and what improvements the Authority considers necessary.

The Order also provides for the regulation of health and social care services by the Authority, including registration and inspection of nursing homes, domiciliary care agencies, children's homes and private hospitals. Although Health and Social Care Trusts (including public hospitals and general practices) lie outside of the RQIA regulatory powers, the Order places no limit on what standards the DHSSPS may issue and the frequency by which the RQIA can inspect Trusts.

The department publishes overarching standards to support good governance and practice in the health and social care services sector, which the RQIA use to assess the quality of services when conducting clinical and social care governance reviews. The Quality Standards for Health and Social Care, published in 2006, reflect five themes:

1. Corporate leadership and accountability of organisations
2. Safe and effective care
3. Accessible, flexible and responsive services
4. Promoting, protecting and improving health and social well-being
5. Effective communication and information.

### *Integration of health and social care is a structural strength of the system that has not been well exploited to achieve service reform*

Northern Ireland has an enviable structural advantage over many OECD countries, with a well-established system of integrated governance for health and social care services. Despite this structural advantage, Northern Ireland does not appear to have vigorously pursued and realised significant advances in integrated models of care and achieved shifts in resources from the acute sector to strengthen care in community settings. While pockets of innovation were identified, and recent initiatives such as the Integrated Care Partnerships show promise, Northern Ireland has not fully capitalised on this structural strength to its system with some commentators asserting that "Northern Ireland represents a missed opportunity to demonstrate on a system-wide basis what can be achieved when the organisational barriers to integration of health and social care are removed" (The King's Fund, 2013).

It would appear that the funding and purchasing of acute care, general practice and social care remains largely in silos, with little real exploration of innovative funding models to promote new service delivery arrangements or incentive programmes to promote quality improvement. While stakeholder concerns to safeguard social care funding allocations from redistribution to acute care are appreciated, the existing integration of health and social care governance provides a basis for funds pooling and explicit redistributions, at least at the margins, to help drive more integrated and primary care oriented models of care. For example, in relation to general practice, a review of the alignment and effectiveness of the Quality Outcomes Framework settings and incentives with overall policy objectives and priorities for team-based primary care and changes in skill-mix may generate opportunities for development of mixed payments models that underpin sound business models for the promotion of planned integrated care models.

### *Quality governance requires simplification and further clarification of responsibilities to improve coherency*

Stakeholders consulted during the review expressed concerns over the current arrangements for improving quality and safety in the health and social system, with Trusts communicating a sense of being "swamped by directives" with no clear communication of priorities by the DHSSPS. Notwithstanding DHSSPS documentation on the roles and functions of key bodies (DHSSPS, 2011), they expressed that they experienced confusion at times over the respective roles of central bodies in setting the quality and safety agenda, particularly in relation to DHSSPS, HSCB, PHA and RQIA. For example, stakeholder comment suggested there is ambiguity over system expectations for adhering to NICE standards and who in the system is responsible for co-ordination, priority setting and how compliance is resourced and monitored. The authority of the RQIA in Trust matters is also considered unclear, particularly in relation to the outcome of reviews and further DHSSPS related advice.

The Appleby review in 2005 concluded that more robust performance management arrangements were required in the health and social services system in Northern Ireland. Clear lines of accountability to the department and the Minister for expenditure, quality and performance were seen as prerequisites for further building the commissioning capacity of the system.

As previously mentioned, the Health and Social Care (Reform) Act (Northern Ireland) 2009 provided a statutory basis for the restructuring of the administration of health and social care. It is clear that Northern Ireland has invested in reforming its structure to improve economies and effectiveness in managing the performance of the health and social care system. The number of previous bodies have been rationalised (19 trusts to 6), commissioning processes have been consolidated (four boards to one) and new regulatory and consumer bodies established. The responsibilities of each are either established in the legislation or codified in a variety of standards, policies and guidelines. A great deal of effort has been made to build a better structure and create a well-functioning system. However, while it would appear many of the right ingredients are in place, there is a need to consider rationalisation of the "top to bottom" chain of governance in quality and more clearly identify, and build the capacity, of central leadership and authority on the direction and priority for quality improvements. There are signs that through the establishment of the Health and Social Care Board and the Regulation and Quality Improvement Authority the lines of authority and accountability for quality and safety in the system have become more blurred and complicated.

There are concerns that the current governance structure of the Northern Ireland health and social care system may be over-engineered and burdensome. As noted later in this report, little action has been taken to lever off the commissioning function to drive innovations in service funding and service design, through the application of innovations and structural incentives. Further, given the nature and scale of the system, reconsideration of the value of maintaining a clear split between "commissioning" and "provision" functions is highlighted.

Countries maintaining a formal separation between providers and purchasers of services seek to benefit from the creation of "market forces" and through sharpened incentives improve quality and value. The private hospital sector in Northern Ireland is very limited and the scope for public hospital competition and choice is both geographically and structurally limited.

## 4.3. Professional training and certification

The regulation of health professionals working in Northern Ireland is largely undertaken on a UK-wide basis through national regulatory bodies. The UK regulator for doctors, along with more recent consideration by the UK regulator for nurses, is overseeing an agenda for revalidation where practitioners are required to participate in an annual appraisal. Agencies within Northern Ireland are responsible for managing and supporting post graduate education and ongoing professional development and training for doctors, nurses and allied health professionals.

### *Regulation and education of health professionals is largely UK-wide*

Jurisdiction for bodies involved in health professional regulation are largely UK-wide. There are nine principal regulators of health and social care professionals in Northern Ireland, seven are national health regulators and two are regional regulators, covering:

- Chiropractic
- Dental
- Medical
- Optical
- Osteopathic
- Nursing and midwifery

- Allied health (e.g. physiotherapy, speech therapists, dieticians, podiatrists)
- Pharmaceutical (Northern Ireland only)
- Social care (including social workers, Northern Ireland only)

The regulators each keep professional registers, set standards for education and practice, and ensure that professionals are fit to practice.

Within this overall approach, the national regulators have significant input from each country. For example, the General Medical Council has offices in Northern Ireland, Scotland and Wales which provides for greater capacity to respond to devolution and works to ensure regulation remains appropriate, in light of the different evolution of health policies and structures across the countries. The Nursing and Midwifery Council has at least one member from each of the countries on its council. The Northern Ireland Public Health Agency also reports having responsibilities in relation to professional regulation, education, workforce planning and development activities for nurses.

It is noted that the Pharmaceutical Society of Northern Ireland and the General Pharmaceutical Council (the regulatory body for pharmacists for the rest of the United Kingdom) have established a memorandum of understanding with the primary purpose of the two organisations working together as efficiently and effectively as possible, "so that the principles of regulation remain consistent and public confidence and safety is maintained in Northern Ireland and Great Britain" (2011).

The regulation of social care professionals falls within the legislative competence of each country. England, Scotland, Wales and Northern Ireland have all now introduced separate arrangements for the regulation of social workers and other social care staff (Law Commission, 2014). The regulator for the social care workforce in Northern Ireland is the Northern Ireland Social Care Council.

### *Education and Training is undertaken both on a UK-wide basis and by agencies within Northern Ireland*

The General Medical Council (GMC) is the regulator for doctors in the United Kingdom. In 2012 regulations were established to allow the GMC to proceed with medical revalidation, which requires all medical practitioners to participate in an annual appraisal that considers all areas of their practice and provide the GMC with supporting information on quality improvement activity, review of significant events and feedback from colleagues and patients for every five-year revalidation cycle.

The Northern Ireland Medical and Dental Training Agency (NIMDTA) is responsible for managing and supporting post graduate education for doctors and dentists in foundation, core and specialist training programmes. NIMDTA also delivers Continuing Professional Development courses for general practitioners, both medical and dental, as well as dental care practitioners. The Agency allocates the funding to service providers for the salary and training of newly graduated doctors participating in the foundation programme and partial funding of more experienced doctors participating in specialist training programmes.

The Agency has a role in determining the distribution of specialist training posts commissioned by the DHSSPS and ensuring each post meets standards set by the GMC. There is scope for strengthening and better aligning longer-term workforce planning functions with year on year allocations and distribution of training posts for specialty training in Northern Ireland, particularly in relation to responding to emerging priorities or gaps and accommodating transitions to new models of care.

Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPECNM) and the Northern Ireland Social Care Council is responsible for managing and supporting post-graduate education and ongoing professional development and training for nurses, midwives and social care workers respectively. In late 2014 the Nursing and Midwifery Council announced it is partnering with Northern Ireland and bodies in the other countries of the United Kingdom to test a system of revalidation, with a view to introduction by the end of 2015.

The NIPECNM undertakes regional co-ordination and commissioning of training with a view to ensuring best-value and a system-wide approach. Concerns exist over differences in required training and capacity to practice across the service system and the NIPECNM is working to reduce training duplication and improve workforce mobility by promoting uniform training programmes across the system.

The NIPECNM is also developing metrics to monitor nursing staffing levels, staff experiences and care outcomes to enable better understanding of the impact of staffing policies on service costs and outcomes.

### *Workforce and leadership development is orientated towards skills building for quality improvement*

There is recognition in Northern Ireland that while excellent arrangements are in place for leadership development across health and social care providers, there is a significant deficient in leadership skills for quality improvement and safety across the system. To help address this

situation the *Leadership Attributes Framework* was announced in November 2014.

The purpose of this framework is to:

- Assist individuals in assessing their current attributes (knowledge, skills and attitudes) in relation to leadership for quality improvement and safety and their learning and development needs for their current role or for future roles.
- Help organisations to build the capability and capacity of the workforce to participate in and lead, initiatives which develop quality care and services.

The framework provides a sound basis from which to build distributed leadership capacity across frontline care staff, management, commissioners and policy leaders. Funding commitments to support staff development and provide incentives to acquire further skills and competencies in quality and safety will be required. In the shorter term, incentive programmes to attract and retain skills and expertise in strategic leadership areas of need may be required, including organisational culture, clinical benchmarking and new business development. The *Transforming Your Care* agenda presents an opportunity to establish additional primary care workforce capacity through the development and implementation of safe and effective workforce innovations, including extended roles for nurses and possible expansion of community pharmacy.

## 4.4. Inspection and accreditation of health care facilities

The regulation and registration of health services in Northern Ireland is undertaken by the Regulation and Quality Improvement Authority (RQIA). While a system of health service accreditation does not exist, the RQIA does undertake routine inspections of services in reference to relevant standards and conduct thematic reviews as part of overall efforts to provide assurance on and improve health care quality. There is scope to strengthen the role of the RQIA in promoting diffusion of innovation and sharing of practices to improve quality across the system, including primary care.

### *The role of the RQIA should be strengthened and expanded*

As previously outlined, the regulation of a wide range of health and social services in Northern Ireland is undertaken by the Regulation and Quality Improvement Authority (RQIA). The Health and Social Care Trusts, including public hospitals services, and general practice are not registered by the RQIA and not subject to the same standard setting and inspection

regime applied to the independent sector, including the limited number of private hospitals in Northern Ireland. While Trusts are subject to various accountability processes, there may be justification to review the existing legislative framework for the RQIA to ensure consistent powers and arrangements exist for all health and social care services.

The Health and Social Care Board (HSCB) has principal responsibility for the performance of the Health and Social Care Trusts and Primary Care, including general practice. Services provided by general practitioners are separately contracted by the board through the General Medical Services Contract, with the Quality Outcomes Framework applied as the principal mechanism for performance accountability. The HSCB maintains a register of general practitioners providing services in Northern Ireland; the Primary Medical Performers List. NIMDTA plays a central role in the annual appraisal of general practitioners on behalf of HSCB who provide the Responsible Officer for GP revalidation.

The RQIA has a role in assuring the quality of services provided by the Health and Social Care Trusts. The Authority undertakes ad hoc thematic reviews, either at the request of the Minister or through self-initiation, and it would appear this is the main avenue through which the Authority currently contributes to the improvement in various aspects of the services provided through the Trusts. These reviews are wide ranging and require considerable expertise and understanding on often quite specific and specialised issues, particularly in relation to clinical care in acute hospital settings.

Although the RQIA does not currently undertake regular inspection of public hospitals as part of its programme of inspection of regulated bodies (except in relation to hygiene and mental health services), the Minister recently announced that from 2015 the RQIA will commence a rolling programme of unannounced inspections of the quality of services in all acute hospitals in Northern Ireland (Donaldson, 2014). While this should reduce the call on thematic reviews, this will have implications for the capacity and expertise of the authority in seeking to carry out this role change competently. The RQIA has also had a limited purview of general practice quality, with only a few reviews on such issues as revalidation readiness and after hours care noted.

A ubiquitous role in health and social care regulation for the RQIA should be considered, including public and private hospitals, aged care, mental health and primary and community care and support, that creates a uniform platform for regulation and common standards for quality and safety across government and non-government providers. This would provide coherency to the system of regulation, inspection and assessment and offers up greater opportunities to comment and influence on the

system's ability to respond in co-ordinated ways to the health and social care needs of the community.

In addition to the scope of regulation, inspection and assessment functions of the RQIA consideration should be given to the approach taken by the regulator in undertaking an extended assessment role. Significant expertise and capacity development will be required to take on this broader role and an expert review of international inspection methods and processes would enable "best practice" approaches to acute and primary care accreditation and external inspection to be considered and appropriately integrated.

In Australia, the Australian Council on Healthcare Standards (major non-government health care accreditation agency) established the Clinical Indicator Program over 20 years ago. Over time the organisation has developed a robust suite of clinical indicators and a database of member indicator data. The service provides an analysis and reporting service to member health care organisations and facilitates national clinical benchmarking using comparative information on the processes and outcomes of health care. Data are aggregated and analysed twice yearly and results are provided in the form of comparative reports. These reports compare results across all contributing organisations as well as providing a comparison with "peer" organisations based on a number of variables (ACHS, 2013). The Health Roundtable is another non-government organisation in Australia that provides executive opportunities for benchmarking and sharing health care intelligence and innovation.

### *Greater efforts to create whole of system learning and performance improvement are required*

The current governance structure for the health and social services system in Northern Ireland provides for coherency and alignment of population based planning, commissioning and service delivery functions. However, there are signs this structural coherency has fostered the development of five relatively self-sufficient and somewhat separate care systems. Without careful corrective policy action, there is a risk this structure will increasingly work against system-wide consistency in quality performance and the sharing and learning on innovation that is vital for strong quality improvement.

A lack of standardisation of approach to learning and performance improvement across the system was evident, with high levels of performance variability between trusts, lack of standardised reporting and limited opportunities and incentives to move beyond individual trust boundaries and services to compare and improve quality and safety. Sir

Liam Donaldson in considering current service configurations in his recent review of quality governance noted that despite its small size, "there is less co-operative working across Northern Ireland than might be expected. Silos reign supreme" (2014).

While support of local solutions to common challenges is a considered strength of the Northern Ireland system, there are indications that a greater focus on a whole of system framework for quality and safety improvement and more rigorous standardised performance monitoring across the system is required. This issue is picked up in more detail in Section 4.8. This would present opportunities for greater comparison of performance across trusts and facilitate benchmarking of services to better understand what is driving differences in performance and broaden uptake of innovative local practices.

There is significant scope for the RQIA to take a stronger role in quality improvement, and in conjunction with the development of greater quality and safety intelligence function, could provide the basis for a robust benchmarking programme across health and social services for Northern Ireland. Such a programme, would routinely bring trusts together to consider data and other information to identify good performance and then undertake collaborative activities to understand and share underlying success factors and promote the potential for diffusion across the system.

## 4.5. Authorisation of medical devices and pharmaceuticals

The regulation of medicines and medical devices is UK-wide. As the UK competent authority, the Medicines and Healthcare Products Regulatory Agency co-operates with the devolved administration in Northern Ireland in carrying out its functions. Medical device management policy exists at the trust level to provide a systematic approach to the acquisition, deployment, maintenance, repair and disposal of medical devices. The Medicines Regulatory Group is responsible for medicines control in Northern Ireland.

### *Well-established legislative and regulatory processes exist to ensure medical device and medication safety in Northern Ireland*

The Medicines and Healthcare Products Regulatory Agency (MHRA) regulates medicines and medical devices across the United Kingdom. The agency is responsible for ensuring that medicines and medical devices meet applicable standards of safety, quality and effectiveness and that the supply chain is made safer over time. The Agency supports research and helps educate the public and health professionals about the risk and benefits of medicines and medical devices in efforts to improve safety and effective use.

As the UK competent authority, the Agency ensures manufacturers meet relevant UK legislation by monitoring adverse incidents, approving clinical trials, auditing relevant bodies, registering classes of medical devices and undertaking compliance and enforcement action. Investigation of adverse incidents may result in the issue of safety warnings and the provision of advice and guidance on safety and quality issues. The MHRA co-operates with the devolved administration of Northern Ireland in carrying out its functions. For example, The Northern Ireland Adverse Incident Centre, a functional arm of the DHSSPS, acts as a regional centre for reporting and investigating adverse incidents involving medical devices and non-medical equipment.

Medical device management policy exists for the Health and Social Care Trusts to provide a systematic approach to the acquisition, deployment, maintenance, repair and disposal of medical devices and medical device training. The monitoring of organisational performance on medical device management is important to minimise or eliminate risks to patients and staff. The Northern Ireland DHSSPS has established a suite of 22 standards, known as the Controls Assurance Standards, to support the embedding of organisation-wide risk management in health and social care bodies. In addition to issues relating to environmental management, emergency planning and financial management, the Controls Assurance Standards cover medical devices and equipment and medicines management.

Compliance with the standards is measured by a system of annual self-assessment by health and social care bodies within the parameters issued by the health and social care bodies. Where self-assessment indicates compliance is below the threshold set down by the DHSSPS, action plans indicating how the body plans to improve and attain a sufficient level of compliance are requested.

The Medicines Regulatory Group is responsible, on behalf of the Minister of Health, Social Services and Public Safety, for medicines control in Northern Ireland, including the monitoring of the production, import/export, possession, supply and administration of controlled drugs and other medicinal products. DHSSPS has a statutory obligation to ensure compliance with legislative requirements in all areas of medicines control as applies to health and social care.

DHSSPS, through the Medicines Regulatory Group, has key responsibility under all medicines related legislation in Northern Ireland. The legislative responsibility concerns achieving compliance with national and international legislative requirements including those imposed by the Single Convention on Narcotic Drugs 1961, the Convention on Psychotropic Substances 1971 and EC Marketing Authorisation Medicines directives

namely "The Rules Governing Medicinal Products in the European Community".

The principal national medicines legislation under which the department acts is the Medicines Act 1968 and the Misuse of Drugs Act 1971 together with their attendant subordinate legislation. Other legislation includes the Pharmacy (Northern Ireland) Order 1976, the Poisons (Northern Ireland) Order 1976 and the Controlled Drugs (Supervision of Management and Use) Regulations (Northern Ireland) 2009. It also embraces joint responsibility with the Department of Agriculture and Rural Development (DARD) for the Veterinary Medicines Regulations 2011 and with the Medicines Healthcare Products Regulatory Agency (MHRA) in ensuring compliance with codes of practice and works closely with the Police Service of Northern Ireland in enforcing the precursor chemicals legislation.

## 4.6. Development and use of standards and guidelines

Northern Ireland has a wide range standards and guidelines for the health and social care system that are generated from a variety of sources and intended for a number of purposes. There is scope to strengthen the objectives for clinical and quality standards in the system, including clarification of priorities for implementation and adherence and expected levels of accountability.

### *Clearer system expectations for adherence to clinical standards and more effective performance monitoring required*

The DHSSPS has a wide range of interwoven standards and guidelines that are generated from a variety of sources and intended for a number of purposes, including:

- *Minimum care standards*: focus on safety and quality of care of regulated organisations. They are designed to address unacceptable variations in the standard of care and improve quality. These standards are used by RQIA in carrying out its regulatory functions.
- *Quality standards*: focus on overarching standards of good governance and best practice across health and social care services. These standards are used by RQIA in carrying out clinical and social care governance reviews.
- *Controls assurance standards*: focus on embedding risk management in HPSS bodies, including key areas of risk for patient safety (e.g. infection control, medicines management).

- *Service frameworks*: focus on care standards for broad health priorities (e.g. cardiovascular health, mental health). They reflect the relevant evidence base, together with the view of frontline staff and stakeholders on best practice. These standards are used by RQIA, HSCB and providers to commission care, evaluate performance and monitor care.
- *NICE guidance*: focuses on clinical guidelines for individual conditions developed by National Institute for Health and Care Excellence and adopted by the DHSSPS.
- *GAIN guidance*: focus on regional guidance by the Guidelines and Audit Implementation Network (GAIN) where no clinical best practice guidance is available or planned (see Section 4.7).

Stakeholders expressed confusion over responsibilities and accountabilities for compliance with the existing range of standards in the system. Further, in the face of feeling overburdened with requirements, the need for clearer indications of the priorities for improvement was indicated. Particular clarification was sought over the status and priority of NICE guidance, in relation to other standards in the system.

As indicated elsewhere in this report, Northern Ireland could strengthen the central leadership role of the DHSSPS in quality and safety governance for the system, by identifying stronger central performance accountability for quality policy implementation and outcomes and building capacity to routinely monitor and assess quality and safety performance improvement.

A high priority task for the department is policy development to further clarify and amplify the objectives for clinical and quality standards for NI, the process of adoption of the standards, priority setting for the system and levels of accountability for adherence, for example through routine clinical indicator monitoring, GAIN audit and/or the RQIA review processes. There would appear scope for greater articulation and strategic framing of the current range of standards and guidelines in the system, to facilitate a more co-ordinated approach to overall standard configuration, endorsement and monitoring. A core set of quality and clinical and social care standards should be established, with clear expectations regarding compliance and reporting communicated to providers as a matter of priority.

Sweden has a well-established programme for quality guidelines that links priority setting in the system to the guideline agenda. Implementation and regular evaluation of compliance is an integral part of the programme (see Box 4.2).

**Box 4.2. National Guidelines in Sweden**

There are a number of evidence based national guidelines produced by the National Board of Health and Welfare. The guidelines are intended to help health care providers to use resources efficiently, allocate resources where they are needed and make systematic and transparent decisions about setting priorities. In Sweden the development of guidelines is not just the activity of single professional disciplines but a system-wide effort to incorporate notions of evidence-based medicine, cost-effectiveness, multi-disciplinary perspectives and priority setting.

The emphasis is on developing guidance rather than issuing standards. In this respect this part of the work of the National Board bears similarities with the guideline and technology assessment programmes of National Institute of Health and Care Excellence (NICE) in England and the Haute Autorité de Santé (HAS) in France. The idea is that these assessments form the basis for the setting of priorities within Swedish health care, acknowledging the local decision-making freedom. There is also a national model for the transparent setting of priorities in health care.

For some activities recommended in guidelines, the government provides grants intended, among other things, to stimulate implementation of the guideline and encourage broader quality development in the particular clinical area addressed. New guidelines on dementia and schizophrenia, for example, were accompanied by such grants, disbursed to local government who were then free to use the additional funds as they best saw fit. The National Board of Health and Welfare conducts regular evaluations of compliance with the national guidelines, repeated after around three to four years and focused on those aspects of care deemed to have major need for improvement. The results of these evaluations are presented in the form of recommendations to the county councils, regions, hospitals and municipalities, and the goal is that the recommendations form the basis for local initiatives to improve the quality of care (OECD, 2013).

## 4.7. Audits and peer review

The Guidelines and Audit Implementation Network (GAIN) is responsible for clinical audit, some regional guidance and medical device evaluation in Northern Ireland.

### *The role and status of the GAIN in clinical audit needs to be clarified*

Clinical audit is the systematic review and evaluation of current practice against research based standards with a view to improving clinical care for service users. Clinical audit is a multi-disciplinary activity involving clinicians and managers responsible for the care and services being reviewed, with patients, consumers and carers fully involved wherever possible. Clinical audits should follow the patient journey which may require working across sectors, for example within primary, secondary and tertiary health and social care organisations (Healthcare Quality Improvement Partnership, 2009).

The Guidelines and Audit Implementation Network (GAIN) is responsible for clinical audit, some regional guidance and medical device evaluation in Northern Ireland. The organisation was established in 2007. Previously clinical audit had been the remit of a number of disparate bodies in the health and social care system including the Clinical Resource Efficiency Support Team, Northern Ireland Regional Audit Advisory and Regional Multi-professional Audit Group. The GAIN has published a number of clinical audits since its inception and provides clinical audit training to health and social care staff.

Although GAIN is funded by the DHSSPS the outputs of the organisation are not formally endorsed by the department. It is also not clear how the role of the RQIA and audit activities of the GAIN articulate. For example, the recent review of stroke services by the RQIA adopted a methodology that is well aligned with a clinical audit approach, perhaps with the exception of detailed clinical record review, and involved an assessment of services in line with the DHSSPS *Strategy – Improving Stroke Services* in Northern Ireland (RQIA, 2014a). The status and role of GAIN in auditing compliance of their regional guidance requires clarification, noting (for example) the RQIA recent review of the implementation of GAIN guidelines for people with a learning disability (RQIA, 2014b).

From 1st April 2015 GAIN was transferred to the RQIA following an independent review of its functions. This should provide a basis for clarifying the status of the role of the GAIN.

## 4.8. Public reporting of quality and performance

Northern Ireland has established a process whereby the performance objectives of the government for health and social care services are translated into performance measures and indicators for providers, including quality and safety of care. The development a more robust set of quality and safety indicators for inclusion in the core performance monitoring functions of the system is indicated. While the core set of indicators may require marginal changes to reflect emerging longer term strategic priorities for the portfolio, they should be relatively stable in order that for longer term targets and monitoring to be established at both the system and trust level. A range of reports and data on system and service performance are provided in the public domain, but there is scope for greater coherency in reporting and a stronger focus on quality and outcomes. Development of a dedicated public reporting website with user friendly access to relevant information at system and local provider levels would improve system transparency.

### *Stable core set of quality and safety indicators needs to be integrated into the performance framework of the department*

The Department of Health, Social Services and Public Safety leads on the Programme of Government commitments relevant to the portfolio. The department has strategic control of care and issues to the Health Services and Social Care Board each year:

- A Commissioning Plan Direction (CPD), which sets out the Minister's priorities and details specific standards and taets that should be delivered by health and social care.
- An Indicators of Performance Direction, which sets out a range of performance indicators intended to improve Health and Social Care Trust performance.

The Health & Social Care Board, including the five Local Commissioning Groups (LCGs), and the Public Health Agency (PHA) are tasked with commissioning the services to improve the health and social wellbeing of local populations, to meet the assessed needs of those populations, and deliver Ministerial Standards and Targets. This is achieved through the Commissioning Plan, which sets out how available resources will be used equitably to meet the relative health and social care needs of local populations and commission services to meet needs and deliver on ministerial priorities. The HSCB, working with Trusts, manages performance and service improvement against ministerial priorities.

The HSCB monitors performance through a series of monthly meetings with the HSC. The DHSSPS, in addition to its on-going sponsorship role, convenes formal accountability and assurance meetings with each of its Arm's Length Bodies twice a year. The extent to which these discussions integrate consideration of quality, budget and access performance and are referenced to an assessment of performance across the Commissioning Plan Standards and Targets and/or Indicators of Performance Direction is not clear. However, together, the indicators and targets do provide a sound basis for developing a stable and robust high-level performance dashboard for the health and social care system and for the DHSSPS to structure a performance review process.

While it is recognised that Commissioning Plan Direction confines itself to key areas of focus for the year in question and the Indicators of Performance represent a wider suite of measures to gauge performance across the full range of domains the department is responsible for, greater articulation and alignment between shorter term priorities and broader performance measures is required. In 2014-15 indicators and targets were included in the Commissioning Plan Direction on areas that were not

included in Indicators of Performance Direction (e.g. bowel screening, health care acquired infections) and indicator specifications existed that did not align (e.g. patient and ambulance turnaround times). While Northern Ireland has sought to separate its systems of performance management from quality improvement, it is unclear why key quality and safety indicators reflected in both the Indicators of Performance Direction and the Quality Reports of the Trusts (e.g. Hospital Standardised Mortality Ratio) are not more closely aligned and supported through appropriate performance targets in the annual Commissioning Plan Direction.

A review of the existing indicators and targets is required to ensure they are:

- limited to high priority strategic issues
- manageable in number for regular executive review
- appropriately balanced across key performance domains
- responsive to strategic operational performance, including general practice
- able to be reported regularly and in a timely manner.

While the performance dashboard may require marginal changes to reflect emerging longer term strategic priorities for the portfolio, they should be relatively stable in order that for longer term targets and monitoring to be established at both the system and trust level. DHSSPS should manage the development of standardised suites of indicators that cascade down from the dashboard to assist service level performance monitoring and facilitate more detailed comparisons across trusts and primary care providers.

Priority should be given to developing a more robust set of quality and safety indicators for inclusion in the dashboard, including priority indicators requiring information systems development. Consideration should be given to further clinical indicators to support clinical guideline uptake. Reference could be made to developments internationally. For example, the National Indicator Project in Denmark has developed clinical indicators for nine conditions (including stroke, heart failure, lung cancer, COPD and schizophrenia) and publishes these on an e-portal by hospital and an annual report on each condition is provided in the public domain (RAND, 2011, p. 28). The annual Quality Reports that have recently been published by trusts provide a good initial basis to build quality reporting.

As part of a broader review of the quality governance arrangements, the role of the Quality2020 Steering Group should be strengthened to include consideration of the system-level performance dashboard, identification of

opportunities for learning and sharing good practices and receipt of reports on internal reviews and action taken to address systemic issues of concern.

### *Early developments in public reporting are promising but greater coherency and improved access is required*

The public access to data and information on the quality and safety of their health and social care services is principally achieved through the DHSSPS and the Health and Social Care Trust websites, along with some annual reports.

The development of "Health and Social Care Trust Annual Quality Reports" has flowed from the implementation plan of the *Quality 2020* strategy with the initial publications by trusts occurring in 2014. Although the reports vary in presentation, they all provide a range of data and information across a standard set of themes of:

- effective health and social care
- delivering best practice in safe health and social care settings
- protecting people from avoidable harm
- ensuring people have positive experience of service
- staff health and wellbeing.

While these documents mark a significant step in providing public access to quality of care information in Northern Ireland the relative lack of comparisons in performance across the system, the significant lag time in publication and the frequency of reporting detract from the usefulness of the reports at this early stage. Review of these reports by the Patient and Client Council to assess consumer views on the understandability and usefulness of these reports, if not already carried out, would be a worthwhile exercise to guide ongoing development.

A wide range of data and information is also available from the Information and Analysis portal on the DHSSPS website, including social, health inequalities, family health services, hospitals, lifestyle choices and behaviours, the Quality and Outcomes Framework, workforce, mental health and learning disabilities, quality and safety and trust performance.

The data and information on safety and quality is very limited providing some data and reports on negligence, patient satisfaction, complaints and patient experience. More meaningful data is located in the trust performance section of the portal, where an interactive atlas of performance across the trusts enables access to data on approximately 40 performance indicators in five domains that appear to be reflective of the DHSSPS Indicator of Performance Direction, although this was difficult to verify.

Although many of the indicators pertain to access issues and there is a preponderance on waiting times for care, the indicators include some more centrally relevant quality and safety indicators including hip fracture treatment within 48 hours, bowel cancer screening uptake rates, timely commencement of treatment of suspected cancer patients and proportion of stoke patients who receive thrombolysis. For most indicators 2012-13 monthly data is provided by trust, enabling capacity for (albeit limited) system-wide comparisons. Data are not presented by hospital or service and variation data by provider are not available.

While it is difficult to determine whether this data form the basis of stable and central dashboard of indicators, there are indications they are considered in executive performance review meetings at least twice a year. It is noted that the safety and quality indicators in this suite of indicators do not align with the metrics presented in the Quality Reports prepared by the trusts and in this way the collective information provided by the system is both confusing and relatively difficult to appraise.

There is an urgent need for the DHSSPS to develop a robust suite of quality and safety indicators that can be integrated into a stable dashboard of indicators for the system, that at least reflect cost, quality and access issues. These indicators should draw on the key databases available to the DHSSPS including adverse event monitoring, complaints, hospital administrative databases clinical registries (e.g. hip surgery), patient experiences to provide a balance of indicators across effectiveness, safety and patient responsiveness domains.

System performance framework development that articulates with frameworks for each of the services sectors would help guide the establishment of this dashboard, and open up opportunities to monitor performance in relation to quality improvement related to service integration. The inclusion of general practice data will be critical to this process, particularly in regards to management of chronic conditions in the community. Other countries, including Canada (Canadian Institute for Health Information, 2012) have been developing systems-based performance frameworks to guideline indicator data collection and reporting.

Northern Ireland should consider the development of a dedicated public reporting website, providing well organised performance data and reports on a suite of indicators that cover cost, quality and access. In Canada the *Your Health System* (see Box 2.6, Chapter 2), Australian *My Hospital* and the US (see Box 4.3) the *Hospital Compare* websites provide examples of how countries have developed public access to comparative system performance data.

**Box 4.3. Public Reporting of Hospital Performance in the United States**

The US Hospital Quality Initiative uses a variety of tools to help stimulate and support improvements in the quality of care delivered by hospitals. The main objective is to distribute easy to understand data on hospital performance, quality information from the consumer perspectives, and payment and volume data. As part of this initiative, Hospital Compare (www.medicare.gov/hospitalcompare/search.html) provides a dedicated user-friendly website to enable the public to directly compare hospitals performance over 80 indicators. The indicators presented on the website are reflective of contemporary dimensions of hospital performance including:

- patient centredness (patient experiences measures based on the Hospital Consumer Assessment of Healthcare Providers and Systems Survey)
- effectiveness (both clinical process and outcome indicators for specific conditions including AMI, heart failure, stroke, surgical care, preventative care)
- appropriateness (medical imaging utilisation rates including MRI, mammography, CT and cardiac imaging)
- safety (postoperative complications including DVT or PE, accidental puncture)
- timeliness (emergency department waiting times)
- continuity or co-ordination of care (readmission rates)
- activity and expenditure (including Medicare payments and discharges for selected DRGs).

## 4.9. Patient and public involvement in improving health care quality

Northern Ireland has established a legislative basis for personal and public involvement in health and social cares services, which requires services to involve the public and consult with patients in service development and provision. A network of involvement groups exists across the system to help improve service responsiveness and the *10,000 Voices* survey has been conducted to better understand the experiences of patients, carers and families in receiving care. A well-established system for patient complaints exist that could be more effectively used to monitor performance and inform quality and safety improvements. The Patient and Client Council is responsible for ensuring a strong patient and client voice at both regional and local levels and for strengthening public involvement in decisions about care. The further development of patient and public involvement in health and social care is being explored through the *Transforming Your Care* reform agenda, including personalised budgets and self-directed support.

### *Patients in Northern Ireland have a legislative right to be involved in the care system*

Northern Ireland established a legislative basis for personal and public involvement in health and social cares services in 2009 through the Health and Social Care (Reform) Act (Northern Ireland). It places a statutory obligation on health and social care organisations and the DHSSPS to involve the public and consult with them in relation to their care and requires them to develop a consultation scheme that sets out how the organisation involves and consults with patients, clients, carers and the Patient and Client Council. Each organisation has published a consultation scheme. For example, the Belfast Health and Social Care Trust hosts on its website a publication entitled *Involving You* which sets out their framework for community development and user involvement.

The Public Health Agency co-ordinates a network of personal and public involvement groups that have been established in each health and social care organisation with representation from patients, clients, carers and community organisations and senior trust staff. While the potential of this network to improve service responsiveness is evident, it is not clear how the network's activities link with other patient-centred initiatives (e.g. Improving the Patients and Client Experience Standards, Patient and Client Council, 10,000 Voices, PROMS, Friends and Family Test and complaints intelligence) and reports through to the DHSSPS to build a coherent approach to service improvement.

The Public Health Agency has been conducting the *10,000 Voices* survey to better understand the experiences of patients, carers and families of the health and social care services in Northern Ireland. The survey commenced in mid-2013 and provides consumers an avenue to express what they liked and did not like about their service experiences. The insights from this survey, along with the evaluation of similar surveys in other countries, could have significant value for guiding service improvement and developing ongoing consumer feedback mechanisms. The interim results of this survey have not been published to date and it is not clear what feedback is planned for respondents, in terms of being informed of the overall findings from the survey.

The application of patient reported outcomes (PROMS) in Northern Ireland is still at early stages of development, with ongoing work currently focused on initial survey development. PROMS are intended to calculate health outcomes, as measured from the patient's point of view. Countries like Sweden have been pioneering the use of PROMS for specific procedures such as hip and knee replacements and groin hernia and varicose vein repair. Care should be taken to ensure the progression of work on PROMS in Northern Ireland is integrated into the overall quality and safety strategy for the system, given its significant potential to provide an

additional perspective on service quality that can be brought together with clinical indicators and measures of patient experience to provide a richer intelligence for service improvements.

### *Public reporting and systematic use of complaints data could be improved*

Northern Ireland has well-established complaints policies and procedures which require health and social services to have effective processes and procedures in place to facilitate the making of a complaint (including their right to complaint to the Northern Ireland Ombudsman), resolve complaints locally where possible, enable organisational learning and provide regular performance reports through the Health and Social Care Board to the DHSSPS.

Quarterly reporting to the DHSSPS includes data on the number of complaints, the nature of the complaint by category, response times and learning outcomes. All health and social care services and the Health and Social Care Board must publish an annual report on complaints and provision is made for copies to be provided to the RQIA and Patient and Client Council. While a regional breakdown of complaints statistics is to be provided via the DHSSPS website (DHSSPS, 2009) on an annual basis the visibility of this information could be improved through greater integration and amplification in overall system performance reporting.

The Health and Social Care Board plays a central role in monitoring trends in complaints and ensuring the proper functioning of the complaints systems within the trusts. In line with other recommendations in this report to strengthen the leadership role of the DHSSP in quality and safety and the development of a central intelligence function, the development of a more robust central complaints database with enhanced capacity to monitor patterns and trends is required. The development of key performance indicators (e.g. outcome and resolution rates, response times, number of complaints by category) and integration into overall system performance safety and quality performance accountabilities could allow greater triangulation for identification of emerging patient safety issues and give greater impetus for improvements in responsiveness of services to patients concerns.

The Patient and Client Council is the main health and social care consumer organisation in Northern Ireland. It is responsible for ensuring a strong patient and client voice at both regional and local levels and for strengthening public involvement in decisions about care. The Council is supported by five local offices that operate within the same geographical areas as the Local Commissioning Groups and Health and Social Care Trusts.

A particular priority for the organisation is to improve the timing and nature of feedback to patients. There are concerns that complaints resolution is too inward looking, catering more to deal with staff issues and organisational learning than being focused on the patient's needs for feedback and the community's needs for information on the quality of services. While significant support exists for DHSSPS efforts to capture patient experiences through initiatives such as 10,000 Voices and the Family and Friends Test, a stronger feedback loop on the results and implications for assessing local services is required back to the community.

The further development of patient and public involvement in health and social care is being explored through the *Transforming Your Care* reform agenda. For example, personalised budgets or self-directed support are being considered to better enable care to be designed to deliver the outcomes patients and their families want. This would extend beyond the existing model for social care clients where the Direct Payments system in Northern Ireland promotes and supports people in managing their own budgets to purchase services or employ support staff (DHSSPS, 2011). This is a particularly interesting development and one that could potentially drive significant changes in service delivery arrangements in segments of the health and social care system.

## 4.10. Use of financial incentives to improve quality

The commissioning process for health and social care services in Northern Ireland provides the principal avenue for developing and applying financial incentives to improve the quality and outcomes of the services provided through the trusts. Pursuance of Pay for Performance and other value-driven payment approaches have not been extensively explored in Northern Ireland to date. Scope exists to consider funding alignment and incentives to support resource reallocations and service development in primary care to support the *Transforming Your Care* agenda.

### *Commissioning process needs to explore brave and innovative funding incentives to support primary care reform and hospital quality improvement*

The use of financial incentives to improve quality in the Northern Ireland health and social services system are largely framed through the annual commissioning process of the Health and Social Care Board. The HSCB has responsibility for the commissioning arrangements with Health and Social Care Trusts and managing the contract for General Medical Services (which provides funding for general practice) in providing the health and social care services of the system.

The DHSSPS provides strategic direction and identifies priorities for service delivery each year through a Commissioning Plan Direction. This is

accompanied by an Indicators of Performance Direction, which sets out a range of performance indicators intended to improve Health and Social Care Trust performance. The HSCB then translates these directions into an annual Commissioning Plan, which sets out the system-wide programmes and initiatives and financial allocations and performance requirements of the five regional Health and Social Care Trusts.

The Commissioning Plan for 2014-15 is nearly 600 pages long and provides a comprehensive reflection of the demographic, social and economic factors impacting on the system, along with a descriptive account of key government policies and programmes in health and social care. Strategies and actions for the current year are identified along with financial allocations at the system level and for individual Trusts. While this document lays transparent the rationale and details of the current allocations and deliverables expected on the system, it does convey a rather complex and crowded set of priorities and relies on a high degree of programmatic specification rather than accountability for broader outcomes. While the indicators specified in the Indicators of Performance Direction are mentioned there is no apparent articulation with the commissioning outcomes being sought or specification of specific targets in the plan.

Three key observations are made in relation to incentives for improving quality. First, incentives to improve clinical quality data, care processes or outcomes through targeted payment arrangements are not specified. Second, opportunities to shift resources from the acute sector to the community sector are identified and quantified but fall short of firm targets for systemic reallocation and clear system-wide strategies for liberating funding from acute, general practice and community care, including for example, through funds pooling arrangements to support the business model for Integrated Care Partnerships. Thirdly the differing population share of resources across Trusts is identified but strategic incentives to bring resource requirements in line with population targets were not evident, including targeted service developments and acute pricing policy to incentivise convergence of unit costs.

Funding for acute, primary care and social care are largely managed in silos with historical allocations and only marginal consideration of opening up funds for contestability at the margins. Further, primary care funding to general practice is taken up in separate arrangements and while central to the *Transforming Your Care* agenda, reforms to the payment methods and funding arrangements along with other primary and community care providers is not evident. The Commissioning Plan tends to be more descriptive than strategic in configuring the funding and purchasing of services to deliver on the governments priorities.

A number of OECD countries have been exploring innovative payment systems over recent years to harness greater service value from the resources

devoted to health and social care, including a wide variety of Pay for Performance, Bundled Payment and Practice Incentive arrangements. For example, in Australia the Western Australian Government provides incentive payments to increase appropriate use of hospital stroke units (see Box 4.4). The existing Quality Outcomes Framework and blended payments system for general practice across the NHS is an example of these arrangements, and one Northern Ireland should review to consider alignment with current policy directions under the Transforming Your Care agenda.

### Box 4.4. Australian Pay for Performance Programs

The Western Australian Department of Health introduced the Performance-Based Premium Payment Program in 2012-13 to improve sustainability of clinical practice improvements within the over performance management and funding framework.

The programme has been designed to:

- recognise and reward services which provide a very high level of best evidence-based care
- reimburse service providers for any additional costs and tasks associated with participation in the scheme, including data collection and submission.

Clinical areas are selected for inclusion in the programme using the following criteria:

- A strong evidence base and clinical consensus on the characteristics of best practice
- High impact, i.e. variation in practice, gap between best evidence and current practice, high volumes or significant impact on outcomes
- Availability and quality of data.

The programme is open to hospitals funded by the Department of Health. Participation is not mandatory and hospitals are only eligible for payment if the required data is submitted.

Each year, the performance-based premium payments and incentive models are reviewed and assessed for their effectiveness in creating and maintaining clinical practice improvements in high priority care areas. This review will result in adjustments to existing payments, and the introduction of new payments for priority clinical areas (Department of Health Western Australia, 2013). Key areas that have been targeted to date are hip fracture, stroke and healthcare associated infection.

For example: An AUD 200 payment is awarded to hospitals for each patient admitted into a designated stroke unit and where the unit treats at least 65% of stroke patients at any time during their admission in a quarter.

The aim of this payment is to ensure appropriate admission to a designated stroke unit for patients suffering stroke. The National Stroke Audit in Australia revealed that in Western Australian hospitals with a stroke unit, only 56% of patients were on the stroke unit on the day of survey, compared to a national rate of 71% (Department of Health Western Australia, 2012, p. 19)

Similar quality based payments systems are continuing to being explored in in other parts of Australia. For example, Queensland has trialled the withholding of payments for "never events", financial penalties for adverse events (i.e. infections, pressure ulcers) and quality improvement payments for improved access to quality care (e.g. stoke care).

## 4.11. Patient safety initiatives

The Public Health Agency has primary operational responsibility for patient safety. The Health and Social Care Safety Forum was established to support health and social care organisations in providing safe, high quality care. A well-established adverse incident monitoring system exists and in conjunction with the Public Health Agency, the Health and Social Care Board is responsible for management and follow up of serious adverse incidents in accordance with documented guidance. Strategies for improved safety in priority areas also exist, for example, *Changing the Culture 2010* is Northern Ireland's strategy and action plan for the prevention and control of health care-associated infections. There is recognition that a significant deficit in leadership skills for quality improvement and safety exists across the system. To help address this situation the *Leadership Attributes Framework* has been developed.

### *A more central role for the department would further strengthen Northern Ireland's robust approach to patient safety*

The Public Health Agency has primary operational responsibility for patient safety. The Chief Medical Officer established the Health and Social Care Safety Forum in 2007 to support health and social care organisations in providing safe, high quality care. It became part of The PHA on the latter's establishment in 2009. The HSC Safety Forum:

- works collaboratively with stakeholders to assist improvement in safety and quality in health and social care
- helps service providers build and develop their quality improvement capability in line with internationally recognised theory and practice
- facilitates engagement between patients, clients, commissioners and service providers in order to promote safety and quality.

The HSC Safety Forum uses a variety of facilitative approaches, which include:

- enhancement of knowledge on safety, quality and improvement science within the system
- providing exposure to nationally and internationally recognised experts in the field
- acting as a conduit for the sharing of best practice
- hosting collaborative working
- directly supporting improvement initiatives within health and social care organisations.

The responsibility for HSC Safety Forum and the broader safety and quality activities of the PHA, including patient involvement and experiences work, lies with the Director of Nursing, Midwifery and Allied Health Professionals. Notwithstanding the quality and dedication of staff working in the PHA, a clearer integration point is required for quality and safety in the system, where data and intelligence are brought together (including adverse events, complaints, clinical indicators, clinical audit and review and patient experiences) to monitor performance and identify emerging patient safety and quality issues. This needs to be coupled with a strong system of advice and support for health services and frontline staff to assist in learning, diffusion of innovations and improve practice.

As indicated earlier in this report the existing roles and responsibilities across the DHSSPS and other key bodies, including the HSCB, PHA, RQIA and GAIN, are confusing and require review. For example, the respective roles of the Chief Medical Officer, Chief Social Services Officer as professional advisors to the government in the DHSSPS and the responsibility of the Directorate of Nursing and Allied Health Professions within the governance framework on quality and safety in Northern Ireland should be clarified, given the operational role played by the Public Health Agency presently. Further, while effective collaboration between the HSCB and PHA is noted (for example, on Serious Adverse Incidents), current legislative responsibility for service performance lies with the HSCB, which may further confuse responsibility for quality and safety governance for key stakeholders in the system.

Recommendations in this report seek to create greater visibility and capacity to the DHSSPS for quality and safety vis a vis other bodies in the system. The need for clear and strong leadership is vital for improvement and greater involvement and accountability for these functions centrally will reduce existing ambiguity concerns of stakeholders. Further coherency to this direction could also be achieved by clarifying and strengthening the role of the Chief Medical Officer and/or the Chief Nursing Officer in the DHSSPS, including greater visibility over regional leadership on quality and safety.

### *System-wide aggregation of adverse incident data would improve system surveillance on safety issues*

Health and social care bodies have well-established adverse incident monitoring systems and in conjunction with the Public Health Agency, the HSCB is responsible for management and follow up of serious adverse incidents in accordance with documented guidance. The HSCB works to ensure the learning from trends in incidence data and investigations with a regional application are effectively disseminated, including the issuing of

safety alerts. Health and social services in each trust have established Mortality and Morbidity Meetings as a basis for bringing people together from different disciplines to consider incidents and complaints and further generate and share system learning.

The use of adverse incidence data for performance reporting purposes is challenging. As with other countries, Northern Ireland is looking to improve overall incident reporting levels whilst being assured that through system learning and the application of safe practices, the quality and safety of care is improving. Accountability systems based on adverse incidents tend to be mandatory and limited to defined serious events (also known as sentinel events) such as unexpected death, transfusion reaction, and surgery on the wrong body part. These systems typically prompt improvements by requiring an investigation and root cause analysis of the event (WHO, 2005, p. 17).

The OECD Health Care Quality Indicators Project has been actively developing and reporting indicators of hospital care safety based on administrative dataset, including adverse events related to surgical complications and obstetric trauma (OECD, 2013, pp. 116-119) and countries are further developing systems to use such data to build system intelligence and integrate into reporting processes on safety issues. For example, the CHADx taxonomy developed by researchers at the University of Queensland in Australia and subsequent developments by the Australian Commission on Safety and Quality in Health Care (see Box 4.5).

Strategies for improved safety in priority areas have been developed for health and social care services in Northern Ireland, and include patient safety. For example, *Changing the Culture* 2010 is Northern Ireland's strategy and action plan for the prevention and control of health care-associated infections and commits the system to action in five key areas:

- making the patient environment safer
- surveillance of health care-associated infections
- tackling antimicrobial resistance
- improving accountability and public engagement
- research.

Since 2007 targets for the system have been set to reduce Clostridium difficile and MRSA and these targets are specified in the annual Commissioning Plan Direction, with each Health and Social Care Trust required to have an action plan in place for reducing health care-associated infections. As mentioned earlier in this report Controls Assurance Standards

(as part of organisational risk-management) exist for specific patient safety issues, including infection prevention. Heightened priority to learn from major incidents and improve infection control has been generated as a result of special investigations and public enquiries, including an inquiry into deaths from Clostridium difficile in hospitals of the Northern Trust in 2011.

**Box 4.5. Use of Administrative Data to Capture Adverse Events in Australia**

CHADx is taxonomy developed by researchers at the University of Queensland in Australia that allows hospitals to classify adverse events captured in administrative datasets, as markers of patient safety. The occurrence of a hospital-acquired complication is identified using the condition onset flag.

The tool was developed for use within hospitals and not as a means for external monitoring of hospital activity and holding hospitals to account (Utz et al., 2012). It is indicated for use at the local level, to provide a broad safety screen to stimulate further investigation, as one component of a more comprehensive hospital safety monitoring programme.

A statistical analysis of the CHADx commissioned by Queensland Health concluded that the tool provides a comprehensive classification of hospital-acquired conditions that facilities can use to keep track of inpatient harm (Utz et al., 2012, p. 11). The reviewers indicated that through further development work the potential use of the tool could be expanded. Key developments include:

1. Risk adjustment to enable valid comparisons over time and across services,
2. Improved quality of Condition Present on Admission to ensure reliable reporting
3. Clinical review of the tool to evaluate the validity of conditions in relation broader application.

Although the clinical utility of the tool has recently been questioned, the CHADx represents a valuable advance in developing hospital-based patient safety information capacity based on routinely collected administrative data.

Further development work, under the auspice of the Australian Comission on Safety and Quality in Health Care and Independent Hospital Pricing Authority in Australia has recently led to the creation of an alternative classification scheme for "high priority hospital complications" that through further validation and development, including reliable risk-adjustment, could potentially enable it to be used in cross-facility and longitudinal comparisons.

## 4.12. Conclusions

Since devolution some 17 years ago, the Northern Ireland health and social care system has put in place many of the key institutions, policies and arrangements to enable sound assessment, assurance and improvement of quality and safety. To improve its effectiveness, the system now requires greater strategic leadership and a simplification of its governance structures

to ensure the priorities for improvement and key strategies are clearly identified and communicated through the system. In line with its population, the system is small and displays an intimacy and trust in personal relationships that seem to prevail despite the intense scrutiny the health and social services provided face from the media and the steady flow of major reviews and investigations. There are indications the system comes together to address key safety and quality issues but more needs to be done to create a system-wide approach to performance. The five Health and Social Care Trusts have developed systems in quite different ways and there are limited opportunities for sharing and scaling up innovations and greater standardisation is needed to enable priorities for attention to be identified and performance monitored.

The Regulation and Quality Improvement Authority is well respected in its provision of a broad range of regulatory functions, including registration, inspection and review of health and social care services. However, there is scope to clarify and strengthen the role of the RQIA in the quality and safety governance landscape in Northern Ireland and build a more consistent regulatory approach across all health services, including those provided by Health and Social Care Trusts (particularly public hospital services) and general practice. It is not sufficient that central leadership capacity for quality and safety standards and improvement be boosted alone. Leadership skills and capabilities need to be distributed through the system from policy, commissioning, service management to frontline care providers. This needs to be well resourced and appropriate incentives for skills identification and acquisition provided. Additionally, clarifying quality and safety governance, creating greater system thinking, strengthening the role for the regulator, placing primary and community care more central to the *Transforming Your Care* agenda and workforce development and reform are key priorities for Northern Ireland to strengthen quality monitoring and improvement.

There is also a need to bring the clinical community, particularly general practitioners, into a more central place in leading primary and community care reform and informing further primary care policy development and service commissioning. It will be necessary to ensure continued development of robust business models and incentive schemes to encourage and sustain new models of primary care in the community that promote joined–up service provision and inter-disciplinary care. Strategic development of information systems needs to be aligned with developments under the *Transforming Your Care* agenda to support the clinical planning and delivery needs of the care team and improve accountability and performance monitoring. Primary care workforce capacity building is also required to enable the significant reforms to the service system envisioned in the *Transforming Your Care* strategy. There are opportunities to further

explore innovative workforce models to cost-effectively transition the service system and build care capacity in the community. Care needs to be taken to ensure these models safeguard confidence in the quality of care.

### Policy recommendations for Northern Ireland

To ensure high quality health care at every encounter and continuously improving care across the system, Northern Ireland should:

**1. Clarify quality and safety governance**

- Strengthen the central voice of the DHSSPS on quality by underlining its responsibility for the overall development of health care quality and safety policy and outcomes in the Northern Ireland health and social care system, along with a stronger public face and executive mandate to ensure alignment of policy priorities with operational outcomes through performance accountability mechanisms and enhanced central quality monitoring and intelligence capacity;
- A priority task for the DHSSPS is to ensure clear and unambiguous communication of the objectives for clinical and quality standards for the health and social care system;
- Clarify the responsibilities for performance governance of the DHSSPS and the Health and Social Care Board, and strengthen the accountability of health and social care organizations for delivering the changes and outcomes envisioned in *Quality 2020* and the subsequent development of related implementation priorities and policy outcomes, including a robust suite of quality and safety indicators integrated into an overall system performance dashboard;
- Undertake a review of the governance of quality and safety at commissioning, trust and individual service levels to identify opportunities to simplify existing arrangements, improve their consistency across services and agencies and strengthen channels of communication;
- Establish and publish a simple unambiguous framework for quality and safety governance that clarifies the core roles and responsibilities, improves vertical alignment of accountabilities and promotes sharing and learning across the system. The governance structure for *Quality 2020* could form the basis from which to develop the framework.

**2. Strengthen the system-wide approach to quality and safety**

- Establish a more robust suite of quality and safety indicators for integration into the overall system performance dashboard, including budget compliance, activity and access indicators;
- Embed the suite of indicators in the performance governance functions of the DHSSPS and the Health and Social Care Board, and in the key accountabilities of health and social care organizations to provide the principal basis to monitor and assess safety and quality performance at the system level;

**Policy recommendations for Northern Ireland** *(cont.)*

- Specify core standardised indicator sets that support and articulate with the system dashboard and more directly align with operational priorities, including indicators aligned to primary care QOF;
- Mandate routine monitoring and reporting at the trust and regional primary care level through more frequent *Quality Reports*;
- Establish clear system level thresholds that can trigger internal service review and facilitate peer service benchmarking activities across the system. Opportunities for further comparison with other UK countries should be explored;
- Build upon the role of the Quality2020 Steering Group, as part of the reviewed governance arrangements, to strengthen its consideration of the system level performance dashboard, identification of opportunities for learning and sharing good practices, and receipt of reports on internal reviews and action taken to address systemic issues of concern;
- Establish formal reporting expectations between frontline services (for example, through Mortality and Morbidity Meetings) and the Quality and 2020 Steering Group.

**3. Develop more robust and improvement-oriented regulation of core health services**

- Amend legislation to extend and strengthen the regulatory powers of the RQIA:
  - Bring trusts and primary care into the central scope of the health service inspection and review functions of the RQIA, along with the existing range of health, aged care and social support services;
  - Establish a cycle of regular review and inspection of health services, according to assessed relative risk and impact on quality and safety of services;
  - Provider a stronger orientation to promoting continuous improvement and facilitating information sharing and learning across the system, including establishment of benchmarking forums and diffusion of innovations to improve quality and safety.
- Undertake a comprehensive review of the inspection and assessment framework of the RQIA giving consideration to approaches internationally that give greater emphasis to promoting continuous quality improvement, incorporate robust forms of self-assessment and involve benchmarking of clinical quality and safety metrics;
- Identify resource requirements to extend and strengthen the RQIA role including expanded capacity for inspections, specialised expertise in acute care and general practice and development and broader access to performance related datasets, clinical quality indicators and QOF. Opportunities for partnering arrangements with other regulators in the United Kingdom could be considered as part of this process;

**Policy recommendations for Northern Ireland** *(cont.)*

- Clarify reporting relationships with the DHSSPS central safety and quality function and clearly communicate the role of the RQIA to service providers and the public, to avoid ambiguity over central governance of safety and quality and align communication of key priorities for service improvement across the system.

**4. Pursue greater structural integration in primary care**

- Continue to develop a more prominent role for primary care and in particular seeking high-level input from the general practice community in the central policy and planning functions of the portfolio through the expansion of Integrated Care Partnerships and support for Federations of General Practice;
- Explore the potential to liberate funding within acute, primary and social care for use in scaling up innovative funding and service models aligned with the Transforming Your Care agenda, including stronger incentive programmes aimed at targeted patient population outcomes and promoting team based multidisciplinary care;
- Business models should be developed and seed funding made available for the evolution of GP Federations into comprehensive and sustainable multidisciplinary primary care services, leveraging and integrating the QOF into broader primary care priorities along with enhanced blended payment arrangements;
- Strengthen the capacity and focus of the information management functions on data linkage and electronic health record developments to better support the health information needs of clinicians and enable monitoring of service utilisation across acute, primary and community sectors.

**5. Strive for greater development and innovation of the health workforce**

- Build on the initial work for the Attributes Framework to establish greater distributed leadership capacity for quality and safety and overall system innovation and performance;
- Establish incentive programmes to attract and retain skills and expertise in strategic leadership areas of organisational culture, clinical benchmarking and new business development;
- Progress development of innovative workforce models, particularly extended roles for general practice based nurses and community pharmacists to enhance accessibility and sustainability of developments in integrated care and support services across the community.

# *References*

Appleby, J. (2005), *Independent Review of Health and Social Care Services in Northern Ireland*, Belfast, DHSSPS, http://www.dhsspsni.gov.uk/appleby-report.pdf, accessed 10/02/2015.

Appleby, J. (2011), "Rapid Review of Northern Ireland Health and Social Care Funding Needs and the Productivity Challenge; 2011/12-2012/15", Belfast, DHSSPS.

Australian Council on Healthcare Standards (2013), *Clinical Indicator Program Information 2013*, ACHS, Sydney.

BMA Northern Ireland (2015), "General Practice in Northern Ireland: The Case for Change", British Medical Association, http://bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-members/northern-ireland-general-practitioners-committee, accessed 10/06/2015.

Canadian Institute for Health Information (2013), *A Performance Measurement Framework for Canadian Hospitals*, Canadian Institute for Health Information, Ottawa.

Care Quality Commission (2014), "Changes to the Way We Regulate and Inspect NHS GP Practices and GP Out-of-hours Services: Final Regulatory Impact Assessment", CQC, London, http://www.cqc.org.uk/sites/default/files/20141008_final_pms_ria_final.pdf, accessed 13/02/2015.

Connolly, S., G. Bevan and N. Mays (2010), *Funding and Performance of Healthcare Systems in Four Countries of the UK Before and After Devolution*, Nuffield Trust, London, accessed on 10 February 2015 at http://www.nuffieldtrust.org.uk/publications/funding-and-performance-healthcare-systems.

Department of Health Western Australia (2013), *Annual Performance Management Framework 2013-14: Activity Based Funding and Management Program*, Department of Health, Western Australia.

Department of Health Western Australia (2012), *Health Activity Purchasing Intentions2012-13*, Department of Health, Western Australia.

Department for Health, Social Services and Public Safety (2015), *Oral Statement to the Assembly by Health Minister Jim Wells MLA – 27 January 2015 – Quality of Care in Northern Ireland*, DHSSPS, Belfast, http://www.dhsspsni.gov.uk/index/statements-minister/statements-minister-2015/statement270115.htm, accessed 13/02/2015.

Department for Health, Social Services and Public Safety (2012), *Quality 2020 Governance Model*, DHSSPS, Belfast, http://www.dhsspsni.gov.uk/quality_2020_governance_model.pdf, accessed 22/02/2015.

Department for Health, Social Services and Public Safety (2011a), *Transforming Your Care: A Review of Health and Social Care in Northern Ireland*, DHSSPS, Belfast, http://www.transformingyourcare.hscni.net/wp-content/uploads/2012/10/Transforming-Your-Care-Review-of-HSC-in-NI.pdf, accessed 11/02/2015.

Department for Health, Social Services and Public Safety (2011b), *Framework Document*, DHSSPS, Belfast, http://www.dhsspsni.gov.uk/framework_document_september_2011.pdf, accessed 11/06/2015.

Department for Health, Social Services and Public Safety (2009), *Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning*, DHSSPS, Belfast, http://www.dhsspsni.gov.uk/hsc_complaints_-_revised_standards_and_guidelines_for_resolution_and_learning__amdts_.pdf, accessed 12/02/2015.

Department for Health, Social Services and Public Safety (2005), *Caring For People Beyond Tomorrow: A Strategic Framework for the Development of Primary Health and Social Care for Individuals, Families and Communities in Northern Ireland*, DHSSPS, Belfast, http://www.dhsspsni.gov.uk/primarycare05.pdf, accessed 11/02/2015.

Donaldson, L., P. Rutter and M. Henderson (2014), *The Right Time, The Right Place: An Expert Examination of the Application of Health and Social Care Governance Arrangements for Ensuring the Quality of Care Provision in Northern Ireland*, DHSSPS, Belfast.

Fialho, A.S., M.D. Oliveira and A.B. Sa (2011), "Using Discrete Event Simulation to Compare the Performance of Family Health Unit and

Primary Health Care Centre Organizational Models in Portugal", *BMC Health Services Research*, Vol. 11, No. 274.

Ham, C. et al. (2013), *Integrated Care in Northern Ireland, Scotland and Wales: Lessons for England*, The King's Fund, London.

Integrated care Partnerships (2014), "Report from the Regional ICP Workshop 4th June 2014", http://www.transformingyourcare.hscni.net/wp-content/uploads/2014/10/ICP-Regional-Workshop_4-June_Report.pdf, accessed 27/03/2015.

Law Commission, Scottish Law Commission and Northern Ireland Law Commission (2014), *Regulation of Health Care Professionals Regulation of Social Care Professionals*, Controller of Her Majesty's Stationary Office, London.

Northern Ireland Assembly (2012), *Official Report* (*Hansard) for Committee for Health, Social Services and Public Safety: Primary Care Partnerships*, http://www.niassembly.gov.uk/globalassets/documents/official-reports/health/2011-2012/primary-care-partnerships-29.11.11.pdf, accessed 16/03/2015.

Northern Ireland Executive (2014a), "Economic Strategy Priorities for Sustainable Growth and Prosperity", http://www.northernireland.gov.uk/ni-economic-strategy-revised-130312.pdf, accessed 04/02/2015.

Northern Ireland Executive (2014b), *Budget 2015-16*, http://www.northernireland.gov.uk/budget-2015-16.pdf, accessed 04/02/2015.

Northern Ireland Statistics and Research Agency (2013), "NIRA Geography Fact Sheet", http://www.ninis2.nisra.gov.uk/public/documents/NISRA%20Geography%20Fact%20Sheet.pdf, accessed 04/02/2015.

Northern Ireland Executive (2011), *Budget 2011-15*, http://www.northernireland.gov.uk/revised_budget_-_website_version.pdf, accessed 04/02/2015.

OECD (2013), *Health at a Glance 2013*: OECD Indicators, OECD Publishing, Paris, http://dx.doi.org/10.1787/health_glance-2013-en.

O'Neill, C., P. McGregor and S. Merkur (2012), *United Kingdom (Northern Ireland): Health System Review. Health Systems in Transition*, Vol. 14, No. 10, pp. 1-91,

http://www.euro.who.int/__data/assets/pdf_file/0007/177136/Northern-Ireland-HiT.pdf, accessed 12/02/2015.

"Oral Statement to the Assembly by Health Minister Jim Wells MLA – 14 October 2014 – Outcome of October Monitoring Round and Paediatric Congential Cardiac Services", http://www.dhsspsni.gov.uk/print/index/statements-minister/statements-minister-2014/oralstatement141014.htm, accessed 2 October 2015.

Public Health Agency and Health and Social Care Board (2015), *Draft Commissioning Plan 2014-15*, DHSSPS, Belfast, http://www.hscboard.hscni.net/publications/2015/%2026-01-2015%20Draft%20Commissioning%20Plan%202014-15%20PDF%205MB.pdf, accessed 12/02/2015.

Regulation and Quality Improvement Authority (2014a), *Review of Stroke Services in Northern Ireland*, RQIA, Belfast, http://www.rqia.org.uk/cms_resources/Review%20of%20Stroke%20Services%20in%20Northern%20Ireland%20%2D%20Report%20Dec%2014%5FISBN%2Epdf, accessed 15/02/2015.

Regulation and Quality Improvement Authority (2014b), *Review of Implementation of GAIN Guidelines on Caring for People with a Learning Disability in General Hospital Settings*, RQIA, Belfast, http://www.rqia.org.uk/cms_resources/Gain%20LD%20in%20Gen%20Hosp%20setting%2016%20Dec%2014%5FISBN%2Epdf, accessed 15/02/2015.

Utz, M., T. Johnston and R. Halech (2012), *A Review of the Classification of Hospital-Acquired Diagnoses (CHADx)*, Technical Report No. 12, Queensland Government, Brisbane, http://www.health.qld.gov.au/hsu/tech_report/techreport_12.pdf, accessed 16/02/2015.

World Health Organisation (2005), *World Alliance for Patient Safety – WHO Draft Guidelines for Adverse Event Reporting and Learning Systems*: *From Information to Action* Geneva, WHO, http://www.who.int/patientsafety/events/05/Reporting_Guidelines.pdf, accessed 16/02/2015.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