



HEALTH AND SOCIAL CARE (REFORM) BILL

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The Health and Social Care (Reform) Bill was introduced to the Northern Ireland Assembly on 23 June 2008. The main purpose of the Bill will be to provide the legislative framework within which the proposed new health and social care structures can operate.

To facilitate Members' consideration of the Bill this paper seeks to identify any potential gaps in the legislative provision specifically in relation to the functions and responsibilities of the key health and social care organisations proposed within the Bill.

EXECUTIVE SUMMARY

The Health and Social Care (Reform) Bill represents one of the most significant pieces of legislation affecting the Northern Ireland health service in recent decades. The current provision of health and social care in Northern Ireland is provided by the Health and Personal Social Services (Northern Ireland) Order 1972. This piece of legislation has been significantly amended over the years. The Health and Social Care (Reform) Bill will deliver a major overhaul of the existing structures underpinning the health and social care system. The Bill contains legislative provision for the reconfiguration of a number of key organisations including the creation of a smaller Department, an amalgamation of the four existing Health and Social Services Boards into one Regional Board accompanied by 5 Local Commissioning Groups, the creation of a new Regional Agency for Public Health and Social Well-Being and the amalgamation of four existing Health and Social Services Councils into one body – the Patient and Client Council.

This paper provides an overview of the legislative provisions in the Bill, focusing on the functions and responsibilities of the key health and social care organisations. The paper also seeks to identify potential changes to the legislation and has considered the multitude of views expressed within the considerable number of responses to the consultation exercises conducted by the DHSSPS on their HSC reform proposals and the HSSPS Committee on the Health and Social Care (Reform) Bill itself. In examining the proposed legislative framework within the Bill, a key observation is that the DHSSPS has chosen to advocate the retention of a highly centralised approach to health and social care delivery in which power cascades down from the Department and the Regional Board. Despite the contention of the Department to ‘support democratisation within the system’, there is evidence that in the configuration of powers of the Local Commissioning Groups there is insufficient levels of autonomous decision-making and budgetary control.

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1. BACKGROUND TO THE HEALTH AND SOCIAL CARE (REFORM) BILL

Shortly following appointment as Minister for Health, Social Services and Public Safety in May 2007, Michael McGimpsey ordered a review of the raft of proposals for reform of the Health and Social Care in Northern Ireland put forward as part of the Review of Public Administration (RPA). Indeed, the decision to reconsider all the plans devised during suspension is one that the Minister has supported since coming into office. In a speech to the Assembly on 4th February 2008, the Minister stated that:

...the return of devolution, with a local Minister and a local Assembly scrutinising their work presents a real opportunity to deliver a local solution that meets our local needs. I have said it before, and I shall say it again: I make no apology for having taken the time to consider the organisational changes that are required to put in place arrangements that are fit for purpose, both now and in the future and that will deliver the best possible outcome for patients and clients. To do otherwise would be to fail the people of Northern Ireland.¹

1.1 RATIONALE FOR THE BILL

The purpose of the Bill will be to provide the legislative framework within which the proposed new health and social care structures can operate. The Bill seeks, either within the body of the Bill or by securing sufficient power to make subordinate legislation, to establish the parameters within which each health and social care body will be permitted to operate and to establish the necessary governance and accountability arrangements, which will support the effective delivery of health and social care in Northern Ireland.²

1.2 CONSULTATION EXERCISES

A formal consultation exercise on the DHSSPS's policy proposals to inform the draft Health and Social Care (Reform) Bill was undertaken during the period from the 18th February 2008 until the 12th May 2008. By the end of the consultation process the DHSSPS received over two hundred responses from various stakeholders including other Health and Social Care (HSC) organisations, the medical profession, the voluntary and community sector, academia and the trades unions.

Meanwhile, at their meeting on the 3rd July 2008, the Committee for Health, Social Services and Public Safety authorised the commencement of a consultation exercise on the Health and Social Care (Reform) Bill. The consultation exercise ended on the 22nd August 2008. Throughout this paper, clear indication will be made between those responses received throughout the Department's consultation exercise on their HSC reform proposals and the HSSPS Committee's consultation exercise on the HSC (Reform) Bill.

A concern expressed by the organisation Children in Northern Ireland (CiNI) relates to how the responses received during the DHSSP's consultation process are used by them to inform the draft legislation. According to CiNI, their concerns have 'been

¹ Ministerial statement to the Northern Ireland Assembly – 4 Feb 2008.

² Health and Social Care (Reform) Bill (2008) *Exploratory and Financial Memorandum*, paragraph 4.

considerably heightened by confirmation that it is not the Department's intention to consult on the draft reform legislation which will be laid before the Assembly.³ The response raises an important issue regarding the timing of the DHSSPS's consultation process and the publication of the Health and Social Care (Reform) Bill. With the consultation exercise ending in mid May 2008 and the Bill published several weeks later in mid June 2008 it supports the concern expressed by CiNI regarding the extent to which the DHSSPS took cognisance of the responses in the drafting of the HSC (Reform) Bill. It is also worth noting that the DHSSPS's response to the submissions received during the consultation exercise is due to be published in early to mid September 2008. In this regard, the timetabling of the different stages between the ending of the consultation exercise and publication of the Bill seems incongruous with the Minister's initial commitment to 'go back to first principles' and allow adequate time for serious consideration of the structural reform proposals and drafting of the legislation.

1.3 OVERVIEW OF THE BILL

The Bill comprises 35⁴ clauses and 7 Schedules and is divided into 10 broad headings:

- *Restructuring of administration of health and social care* – covers the restructuring of health and social care bodies;
- *Department's role in promoting and providing health and social care* – consists of 5 clauses and outlines the general duties, powers and priorities of the Department of Health, Social Services and Public Safety (DHSSPS)
- *The Regional Board* - consists of 5 clauses and provides for the establishment of the Regional Health and Social Care Board. It also covers the functions of the Regional Board and outlines its objectives;
- *RAPHSW* - consists of 2 clauses and provides for the establishment of the Regional Agency for Public Health and Social Well-being;
- *RSSO* - consists of 2 clauses and provides for the establishment of the Regional Support Services Organisation;
- *Patient representation and public involvement* – establishes the Patient and Client Council, covers the functions of the Patient and Client Council (PCC) and deals with the need for health and social care bodies to consult with service users and produce consultation schemes;
- *HSC trusts* – places a duty on HSC trusts in relation to the improvement of health and social well-being;
- *Public-private partnerships* – provides for the Department of Health, Social Services and Public Safety, the Regional Health and Social Care Board, the Health and Social Care trusts, the RSSO, special agencies and the RAPHSW to form, or participate in forming, public-private partnerships;

³ Children in Northern Ireland (CiNI) Consultation Response.

⁴ A list of the headings of the 35 Clauses is provided in the Annex.

- *Transfer of assets, liabilities and functions* - deals with the dissolution of various health and social care bodies and the transfer of assets, liabilities and functions;
- *Supplementary* – provides for the Department to make supplementary provisions as it thinks necessary and makes general provisions in respect of subordinate legislation, amendments and repeals. It also sets out the title and commencement dates and includes interpretation provisions.⁵

2. FUNCTIONS OF KEY HEALTH AND SOCIAL CARE ORGANISATIONS

The following section identifies the functions and powers of the key organisations at the heart of the Northern Ireland Health and Social Care system. Through identifying the specific clauses in the HSC (Reform) Bill, a number of pertinent issues are raised relating to how the legislative provisions could potentially affect the different organisations' execution of their functions and the interaction between the bodies in delivering HSC services.

Clauses 2-6 Department of Health Social Services and Public Safety (DHSSPS)

Clauses 2-6 within the Health and Social Care (Reform) Bill set out the general duties, powers and priorities of the DHSSPS. For instance, clause 2 delineates the Department's general duty 'to promote...an integrated system of health care designed to secure improvement in the physical and mental health of people in Northern Ireland.'⁶ Moreover, clause 2, subsection 3 also states that the Department must among other things,

...develop policies to secure the improvement of the health and social well-being of, and to reduce health inequalities between, people in Northern Ireland.⁷

...allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way.⁸

...secure commissioning and development of programmes and initiatives conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between people in Northern Ireland.⁹

...monitor and hold to account the Regional Board, RAPHSW, RSSO and HSC Trusts in the discharge of their duties.¹⁰

A primary objective within the DHSSPS's proposals to restructure the health and social care system is the significant reduction in size, including personnel of the DHSSPS. The aim is to create a smaller organisation to support the Minister 'in advising on and reviewing policy, legislation, standards, priorities and targets and in

⁵ Health and Social Care (Reform) Bill (2008) *Explanatory and Financial Memorandum: 2.*

⁶ Clause 2, subsection 1, Paragraph (a), Sub-Paragraph (i).

⁷ Clause 2, subsection 3, Paragraph (a).

⁸ Clause 2, subsection 3, Paragraph (c).

⁹ Subsection 3, Paragraph (g)

¹⁰ Subsection 3, Paragraph (h).

all aspects of business in the Assembly, the Executive, the North-South Ministerial Council and the British Irish Council.¹¹

The intention is to ensure that the Department becomes,

...more sharply focused on its responsibilities for serving the devolved administration...driving performance primarily by setting strategic targets, tracking outcomes and applying strategic change levers to ensure that the health and social care system maintains a focus on delivering those outcomes, rather than being involved in the day-to-day operational management, which would be the role of the new RHSCB.¹²

Commenting on the Health and Social Care (Reform) Bill, Children in Northern Ireland (CiNI) highlight the need for the DHSSPS to include the commitment to reduce health *and* 'social well-being' inequalities between people in Northern Ireland. Currently within the HSC Bill there is only a commitment to reduce health inequalities.¹³ Consideration may be given to the inclusion of legislative provision to commit each of those HSC organisations responsible for the commissioning and delivery of health and social care services to the reduction of health and social well-being inequalities between people in Northern Ireland.

It is worth noting that, as the Bill stands, the Department, amongst other things has a duty to develop policies to reduce health inequalities rather than to actually reduce these inequalities themselves.

Meanwhile, CiNI's response also raises an issue around the need for clarity relating to the DHSSPS's general duty under clause 2, section 3, paragraph (c) to allocate resources in the most economic, efficient and effective way. CiNI contend that it is unclear as to whether a hierarchy exists in relation to these important criteria and argue that 'primary consideration must be given to ensuring that **effective** health and social care services are available to all.'¹⁴

- Departmental interference

Complementing the DHSSPS's responsibility to 'monitor and hold to account' the other key organisations within the health and social care system, there is a legislative requirement set out in clause 5 for the Department to prepare a "framework document". Significantly, this document sets out the main priorities, objectives, guidance and other matters for each health and social care body in connection with the carrying out of its functions. Under the same clause, the Department must keep the framework document under review and if required, revise it.

Consequently, the legislative provision within clause 5 raises a number of questions around the Department's potential to intervene in the functions of other key health and social care organisations. Naturally, the DHSSPS retains the statutory authority to intervene in the execution of the responsibilities of key organisations such as the RHSCB, the RAPHSW, the Trusts and the RSSO – without consultation in instances where urgent action is required.

¹¹ DHSSPS (2008) *Proposals for Health and Social Care Reform*, DHSSPS: 23.

¹² DHSSPS (2008) *Proposals for Health and Social Care Reform*, DHSSPS: 23.

¹³ See clause 2, section 3, paragraph (a).

¹⁴ Children in Northern Ireland's (CiNI) consultation response to the Health and Social Care (Reform) Bill.

However, the Department's power to prepare a "framework document" 'setting out in relation to each health and social care body the main priorities and objectives of the body in carrying out its functions'¹⁵ raises concerns around the potential for the DHSSPS to unnecessarily intervene in the operation of other HSC organisations. While clause 5, subsection 5 states that, 'in preparing the framework document, or any revision of it which appears to the Department to be significant', the legislation could clarify the Department's responsibility to ensure that the document cannot be employed simply as a controlling mechanism on the activities of other HSC organisations.

One HSC organisation where the unnecessary interference of the DHSSPS would be particularly concerning is the proposed Patient and Client Council (PCC). In its important role providing the 'patient voice' within the HSC system, representing the interests of the public and seeking redress from the DHSSPS, the RHSCB and the Trusts, it would be helpful for the legislative provision within the Bill to be clarified around the preparation of the framework document in relation to the PCC.

- Capital Investment

In relation to the wider issue of capital development and investment, it is worth considering the view expressed within the consultation response submitted by the Southern Health and Social Care Trust,

The Department's role in capital investment is not clearly defined...The Trust believes that the relationship between public, private and independent sector in developing capital schemes need closer working between the Department, RHSCB, the Strategic Investment Board, Health Estates and the Trusts.¹⁶

Without an explicit reference to the DHSSPS's function in the area of capital development, consideration may be given to the inclusion of legislative provision within the HSC (Reform) Bill, which clearly defines the role of the Department, and its relationship with the other agencies mentioned above in the procurement of capital assets.

Clauses 7-8 Regional Health and Social Care Board (RHSCB)

Clauses 7 and 8 provide for the establishment and functions of the new Regional Health and Social Care Board, which effectively will assume the powers of the existing 4 Health and Social Services Boards (whose dissolution and transfer of functions is provided for under Clauses 1 and 24 respectively) as well as 'any other functions which the Department directs it to exercise.'¹⁷

It is important to note that there is also legislative provision for the RHSCB within Schedule 1 of the Bill setting out the constitution of the body.

The core functions of the RHSCB in relation to the performance management of the trusts and the commissioning of health and social care services is provided for within clause 8, subsection 2:

The Regional Board must exercise its functions with the aim of-

¹⁵ Clause 5, subsection 1, paragraph (a).

¹⁶ Southern Health and Social Trust consultation response.

¹⁷ Health and Social Care (Reform) Bill (2008) *Explanatory and Financial Memorandum: 4*

- (a) improving the performance management of HSC trusts, by reference to such indicators of performance as the Department may direct; and
- (b) establishing and maintaining effective systems-
 - (i) for managing the performance of HSC trusts;
 - (ii) for commissioning health and social care;
 - (iii) for ensuring that resources are used in the most economic, efficient and effective way in commissioning such care¹⁸

Additionally, in relation to the RHSCB's commissioning function, clause 8, section 3 outlines the following provision:

The Regional Board must in respect of each financial year prepare and publish a document ("the commissioning plan") setting out such details as the Department may direct concerning-

- (a) the health and social care which the Board is to commission in that year;
- (b) the costs to be incurred in that regard;

and in drawing up the commissioning plan the Board must consult RAPHSW and have due regard to any advice or information provided by it.¹⁹

Reflecting the close working relationship between the RHSCB and the DHSSPS, subsection 6 states that,

It is the duty of the Regional Board to carry out its functions in the manner which it considers is best calculated to discharge the Department's general duty under section 2(1).²⁰

It is also worth noting that clauses 10 and 11 make provisions for the Regional Board in relation to conferring powers to give directions and guidance to HSC trusts and the provision of information by the RHSCB to the trusts.

- Managing performance of non-state/private sector providers

A potentially significant omission in the clauses providing for the core functions of the RHSCB is the management of performance in relation to service providers other than HSC trusts. As the primary organisation responsible for commissioning services within the health and social care system, it would seem logical for the Regional Board to monitor the performance of non-state providers. This is particularly salient within the current health policy environment where the Department are increasingly considering employing the services of private sector companies (including construction and facilities management) in the area of capital development and healthcare companies in an effort to reduce waiting times in key treatment areas.

¹⁸ Clause 8, subsection 2 (a) and (b).

¹⁹ Clause 8, subsection 3.

²⁰ Clause 8, subsection 6.

- Duplication

There are a number of recurrent issues that emerged from the DHSSPS's HSC reform proposals relating to the establishment and functions of the new Regional Board. One overriding point highlighted throughout a number of responses was that there should be clarity of roles, responsibilities and governance arrangements throughout the new health and social care system. In relation to the Bill, there is evidence of possible duplication in the area of commissioning responsibilities performed by the DHSSPS and the RHSCB. For instance, clause 2, subsection 3 states that,

The Department must-

...secure the commissioning and development of programmes and initiatives conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland.²¹

In comparing this key responsibility of the DHSSPS with the RHSCB's core function to 'establish and maintain effective systems for commissioning health and social care' it is possible to argue that the proposed legislation could produce duplication in this key area of service commissioning.

Clause 9 Local Commissioning Groups

Reflecting the Department's HSC reform proposals, the Bill provides for the RHSCB to be responsible for the appointment of Local Commissioning Groups (LCGs). Clause 9, subsection 1 states that, 'The Regional Board shall in accordance with paragraph 7 of Schedule 1 appoint a prescribed number of committees to be called "Local Commissioning Groups".'²²

Under the Department's proposals, the RHSCB 'would be ultimately accountable for the outcomes of commissioning functions discharged by LCGs. This includes the statutory responsibility to contain expenditure within allocated resources. The Chair of each of the LCG would be accountable to the Chair of the RHSCB.'²³

In relation to the functions of the LCGs, Clause 5 states that,

Each Local Commissioning Group must exercise its functions with the aim of-

- (a) improving the health and social well-being of people in the area as regards which the Local Commissioning group exercises its functions;
- (b) planning and commissioning health and social care to meet the needs of people in that area;
- (c) securing the delivery to people in that area of health and social care is efficient, co-ordinated and cost-effective;
- (d) improving the availability and quality of health and social care in that area.²⁴

²¹ Clause 2, subsection 3, paragraph (g).

²² Clause 9, subsection 1.

²³ DHSSPS (2008) *Proposals for Health and Social Care Reform*, DHSSPS: 21.

²⁴ Clause 9, subsection 5.

It is also important to note that, 'in connection with the exercise of these functions [each] Local Commissioning Group must consult RAPHSW and have due regard to any advice or information provided by it'.²⁵

- Greater autonomy in executing commissioning function

A significant number of the responses to the DHSSPS's HSC reform proposals supported the role of the RHSCB in establishing the Local Commissioning Groups. These proposals included,

- The RHSCB would ultimately be accountable for the outcomes of commissioning functions discharged by LCGs;
- The Chair of each LCG would be accountable to the Chair of the RHSCB;
- The RHSCB would approve each LCGs Annual Commissioning Plan and would be responsible for monitoring their performance.²⁶

Conversely, Professor Derek Birrell, University of Ulster commented that,

Local Commissioning Groups are proposed which have no independent status or autonomy. They can be overruled by RHSCB and are really local advisory groups in terms of public administration systems. They are not commissioning organisations in the sense of primary care trusts in England and the actual term is misleading.²⁷

Meanwhile, in their submissions to both the DHSSPS and the HSSPS Committee's consultation exercises, the Eastern Health and Social Services Board (EHSSB) stated that,

With devolved responsibility must come devolved budgets to allow the LCGs to address the needs of the local population within coherent regional policy and strategy frameworks. To that end, there should be a Senior Finance Office on the Board of the LCG. LCGs could then properly assure the Board of financial propriety and regularity.²⁸

Consideration may be given to inserting more detail around the specific functions including areas of commissioning responsibility under the control of Local Commissioning Groups. Greater clarity could assist in improving partnership working between the RHSCB and the LCGs and ensure that LCGs are fully engaged and consulted in regional decisions which affect their local area of responsibility. Providing more detail within the proposed legislation could provide a stronger platform enabling LCGs to develop into effective local commissioning organisations and support the objective of enhancing the devolution of health and social care in Northern Ireland.

²⁵ Clause , subsection 4, paragraph (b), sub-paragraph (i).

²⁶ DHSSPS (2008) *Proposals for Health and Social Care Reform*, DHSSPS: 20-21.

²⁷ Professor Derek Birrell Consultation response.

²⁸ Eastern Health and Social Services Board Consultation response to the DHSSPS's HSC reform proposals and the HSSPS Committee's consultation exercise on the HSC (Reform) Bill.

- Consultation

While there is an obligation for the LCGs to consult with the RHSCB and the RAPHSW in developing and finalising local commissioning plans coupled with a duty to cooperate with the PCC, there is no requirement on the part of LCGs to consult with the people within their locality and for whom they commission health and social care services. Therefore, consideration may be given to the inclusion in the Bill of legislative provision making it a statutory requirement for LCGs to engage in consultation exercises as an integral component in the coordination of local commissioning plans.

- Membership

Within the HSC (Reform) Bill there are two significant references in relation to the membership of Local Commissioning Groups. These are located within clause 9, sub-sections 6 and 7. According to sub-section 6, paragraph (a):

Regulations may-

Make provision for the membership of Local Commissioning Groups.²⁹

Meanwhile, section 7 states that,

Before making regulations under subsection (6), the Department must consult the Regional Board.³⁰

The HSC (Reform) Bill lacks detail in relation to the composition of the membership of the LCGs including the number of representatives from the health professions or the number of publicly elected figures. Consideration may therefore be given to the inclusion of legislative provision to clearly state the number of representatives from the health professions, elected local representatives and other groups as outlined within the DHSSPS's proposals.³¹

In their response to the HSSPS Committee's consultation exercise, the Pharmaceutical Society of Northern Ireland (PSNI) expressed their view that given the significant 'breath and strength of stakeholder opinion concerning the constitution of Local Commissioning Groups' the proposed legislation could be reworded as follows:

Before making regulations under subsection 6, the Department must consult the Regional Board, stakeholders and the public.³²

Meanwhile, the BMA(NI) in its response to the HSSPS's Committee's consultation exercise have voiced their opinion that 'elected local representatives should not be included on Local Commissioning Groups.' According to the organisation,

This is not to minimise the importance of elected local representatives as the BMA(NI) fully supports the principle that Local Commissioning Groups and local government should work jointly on local health

²⁹ Clause 9, sub-section 6, paragraph (a).

³⁰ Clause 9, sub-section 7.

³¹ See DHSSPS (2008) *Proposals for Health and Social Care Reform*, DHSSPS: 19-20.

³² Pharmaceutical Society of Northern Ireland (PSNI) Consultation response to the HSC (Reform) Bill.

improvement plans. The BMA(NI) believes that the strong scrutiny and accountability role of Local Councils, working alongside the new PCC, may be eroded if elected council representatives are on the LCGs. There is also a concern regarding the practicality of having four local representatives on each of the LCGs. If for instance the Northern Trust has one LCG, it will cover eight current local government areas.³³

Clauses 12-13 The Regional Agency for Public Health and Social Well-Being (RAPHSW)

Clauses 12 and 13 provide for the creation of the Regional Agency for Public Health and Social Well-Being (RAPHSW) and sets out its key functions, which include health promotion and protection and a responsibility to cooperate with other key HSC organisations. These include working with the RHSCB and the LCGs in the commissioning of services at a regional and local level. The provisions within the Bill reflected the 3 key functions of the RAPHSW as delineated within the Department's HSC proposals – health improvement, health protection and public health support to commissioning and policy development.

Clause 13, subsection 1 states that,

RAPHSW shall exercise on behalf of the Department-

- (a) the health improvement functions mentioned in subsection (2), and
- (b) the health protection functions mentioned in subsection (3).³⁴

Subsection 2 outlines the health improvement functions as

- (a) developing and providing, or securing the provision of, programmes and initiatives designed to secure the improvement of the health and social well-being of, and reduce health inequalities between, people in Northern Ireland; and;
- (b) health promotion.³⁵

Subsection 3 states that, 'Those health protection functions are the protection of the community (or any part of the community) against-

- (a) communicable disease, in particular by the prevention or control of such disease;
- (b) other dangers to health and social well-being, including dangers arising on environmental or public health grounds or arising out of emergencies.³⁶

Significantly, subsection 5 affirms that, 'The Department may by order amend subsection (1) to (4) for the purposes of altering the functions of RAPHSW.'³⁷

- Sharing responsibility for the local public health agenda

³³ BMA(NI) Consultation response to the HSC (Reform) Bill.

³⁴ Clause 13, subsection 1.

³⁵ Clause 13, subsection 2.

³⁶ Clause 13, subsection 3.

³⁷ Clause 13, subsection 5.

A considerable number of responses to the DHSSPS's reform proposals support the creation of a dedicated public health agency reflecting the Minister's intention to place the public health agenda at the heart of the Health and Social Care system. Equally there are concerns that in creating one body it could result in the centralisation of the key functions of health promotion and health protection which according to Professor Derek Birrell, University of Ulster 'is contrary to structures in the rest of the United Kingdom'.³⁸

In their response, the Northern Ireland Council for Voluntary Action (NICVA) have expressed concern around the new Public Health Agency incorporating the public health functions and responsibilities that currently rest with the Boards and Trusts. They have pointed out that, consequently,

...responsibility for work on health improvement, health inequalities and community development will not lie with organisations commissioning and providing services. The LCGs and Trusts will have a responsibility to consult the RPHA on their plans but we would be concerned that this separation might weaken these areas of work because commissioners and providers will feel less obliged to mainstream health improvement and health inequalities issues into all their work. This would detract from, rather than strengthen, the public health agenda, especially at local level where good relationships and good practice current exist.³⁹

These sentiments were shared in a number of the responses submitted by the different trusts. For example, the Southern Health and Social Care Trust (SHSCT) commented that,

It is important that in the design of the Regional Public Health Agency that it retains a locality sensitive model of working that can respond quickly and effectively to the needs of local communities to a more centrally driven strategic model that is driven largely by Departmental priorities.⁴⁰

It goes on by highlighting the considerable expertise and experience built up in recent years within the trust in the delivery of public health services and promotion. Emphasising concern around the impact of removing the Specialist Health Improvement functions currently cited within the trusts the SHSCT response stated that,

The Trust has invested in the development of a high profile, integrated Promoting Well Being Department, which incorporates the specialist health improvement function combined with that of community development, the Health Action Zone and user involvement. The Trust believes that this unique combination of agendas add significant strength and value to the work of improving health and well being and reducing health inequalities.⁴¹

There is a statutory requirement on both the RHSCB and LCGs to have 'due regard' to the advice or information provided by the RAPHWS in the execution of their

³⁸ Professor Derek Birrell's Consultation response to the DHSSP's HSC reform proposals.

³⁹ NICVA Consultation response.

⁴⁰ Southern Health and Social Care Trust response to the DHSSP's HSC reform proposals.

⁴¹ Southern Health and Social Care Trust response to the DHSSP's HSC reform proposals.

commissioning functions. However, there is no reference in the Bill with regard to direct cooperation between the trusts and the RAPHSW. To ensure the trusts' considerable experience in public health service delivery is not jeopardised and to enhance collaborative working between regional and local HSC bodies, consideration may be given to include legislative provision requiring the RAPHSW to work closely with the trusts in the execution of its responsibilities.

Additionally, the Royal College of Nursing (NI) in their response to the HSC Bill highlight their concern that current legislative provision is 'insufficiently robust and should be strengthened' in relation to 'partnership working' between the commissioning bodies and the RAPHSW. They contend that,

...requiring the commissioning authorities merely to consult and have due regard to advice and information provided by RAPHSW may not secure the full integration of public health and commissioning that will be essential in order to give effect to the Minister's objectives [to put the public health agenda at the heart of the HSC system].⁴²

In their submission, they suggest that the wording of the relevant phrase within clause 8, section 3 should be amended to, "the Board must work in partnership with RAPHSW and be able to demonstrate that its commissioning plan reflects the priorities determined by RAPHSW." In relation to Local Commissioning Groups, the RCN suggest amending clause 9, section 1 to ensure that LCGs "work in partnership with RAPHSW and be able to demonstrate that the exercise of its functions reflects the priorities determined by RAPHSW."⁴³

By making these changes the RCN argue that the relationships between the RAPHSW and the RHSCB and the LCGs will 'become one of strategic partnership rather than simply consultation and advice...ensuring that public health is at the forefront of service design and delivery.'⁴⁴

Clauses 16-17 The Patient and Client Council (PCC)

Clauses 16 and 17 reflect the Department's decision to choose Option 1⁴⁵ within their HSC reform proposals to establish 'a body corporate to be known as the Patient and Client Council'.⁴⁶

According to Clause 17, subsection 1,

The Patient and Client Council has the following functions as respects the provision of health and social care in Northern Ireland-

- (a) representing the interests of the public;
- (b) promoting involvement of the public;
- (c) providing assistance (by way of representation or otherwise) to individuals making or intending to make a complaint relating to health and social care for which a body to which this section applies is responsible;

⁴² Royal College of Nursing (NI) Consultation response to the HSC (Reform) Bill.

⁴³ Royal College of Nursing (NI) Consultation response to the HSC (Reform) Bill.

⁴⁴ Royal College of Nursing (NI) Consultation response to the HSC (Reform) Bill

⁴⁵ See DHSSPS (2008) *Proposals for Health and Social Care Reform*, DHSSPS: 40.

⁴⁶ Clause 17, subsection 1.

- (d) promoting the provision by bodies to which this section applies of advice and information to the public about the design, commissioning and delivery of health and social care;
- (e) such other functions as may be prescribed.⁴⁷

In addition to the functions of the PCC, clause 18 of the Bill provides for a duty on other health and social care organisations to cooperate with the PCC in the execution of its responsibilities.

- Strengthening the powers of the PCC

Clause 18, section 2, paragraph (a) states that ‘a body must consult the Patient and Client Council with respect to such matters, and on such occasion, as the body considers appropriate, having regard to the functions of the Council.’⁴⁸

Children in Northern Ireland (CiNI) have raised concerns around the potential scope of HSC organisations to ‘significantly undermine the spirit of cooperation, leaving it entirely to the discretion of the health and social care bodies to decide on what and when they will cooperate with the Council.’⁴⁹ Given these concerns, consideration may be given to the rewording of clause 18 to include ‘due regard’ in relation to cooperating with the PCC thus placing a greater obligation on all the HSC organisations.

3. OTHER RELEVANT CLAUSES AND ISSUES

Public Private Partnerships (Clause 22)

Clause 22 enables the Department, and certain health and social care bodies to form, or participate in forming, public-private partnerships to provide facilities or services for the promotion or provision of health and social care.⁵⁰

Performance Management

One of the notable deficiencies within the Northern Ireland health service identified by the 2005 Appleby review was the distinct absence of an explicit performance management system. Such a system within the health service was regarded as pivotal to achieving improvements in efficiency, effectiveness and responsiveness. Appleby was critical of the existing performance management structures in place at the time of the review contributing to an impression of ‘a system lacking urgency, or general drift, and a consequent frustration amongst many in the services – at all levels – with the relative lack of improvement in performance’.⁵¹ He contended that the current performance management system was devoid of the clear and effective structures, information and most importantly incentives – both rewards and sanctions – at individual, local and Northern Ireland organisational levels to encourage innovation and change.

⁴⁷ Clause 17

⁴⁸ Clause 18, section 2, paragraph (a).

⁴⁹ Children in Northern Ireland (CiNI) response to the HSC Reform Bill.

⁵⁰ Health and Social Care (Reform) Bill (2008) *Explanatory and Financial Memorandum*: 6.

⁵¹ Appleby, J. (2005) *Independent Review of Health and Social Care Services in Northern Ireland*, August: 10.

Beyond the provision for the Regional Board to achieve the aim of 'improving the performance of HSC trusts, by reference to such indicators of performance as the Department may direct' and 'establish and maintaining effective systems for managing the performance of HSC trusts' – very little information is provided regarding clear performance enhancing mechanisms or structures. The importance of ensuring robust performance management structures, clear information and effective incentives are embedded within the HSC system is highlighted in the consultation response submitted by the RQIA.

It is essential that a performance management framework is developed and put in place [which] clarifies the duties of the DHSSPS, RHSCB, RAPH (RAPHSW), HSC Trusts, Agencies and other bodies (including RQIA)...Clarity on the arrangements for the commissioning, performance management and governance arrangements for primary care family practitioner services is also required.⁵²

Those recommendations that emerged from the Appleby review which feature in the proposals and the HSC (Reform) Bill include the operation of a form of separation between commissioners and providers of services and the establishment of 'a single pan-Northern Ireland commissioner' in the form of the proposed RHSCB. The Appleby review also highlighted a number of other mechanisms or 'performance levers' which could underpin a more robust performance management regime within the HSC system. These included,

- serious, long-term target setting coupled with rewards and sanctions at organisational and individual levels;
- an 'activity-based prospective reimbursement system' for providers (similar to 'Payment by Results' currently employed within the English health system) with tariff setting used to drive improvement in efficiency and selective increases in activity to meet pan-service goals;
- careful expansion of patient choice - not similar to the way choice between Trusts competing within a market-based system in England but 'from the patient's point of view, a more formalised and embedded process of choice (not just hospital, but over the myriad of decisions that are taken throughout the system which affect a patient's care) can improve patient satisfaction and service responsiveness;
- General Practitioner (GP) involvement – despite previous rejection of GP fundholding, ways of both strengthening the involvement of General Practitioners in the system and as part of a devolution strategy for commissioning secondary care services, thought should be given to the practical involvement of GPs in the purchasing of care.⁵³

The development and implementation of a robust performance management regime integrated into the commissioning functions of the Regional Board and LCGs will be critical within the new HSC system. Better monitoring of contract performance and the imposition of financial sanctions in the event of organisational failure on the part of the service provider would help to focus the attention of Trust management.

⁵² Regulation Quality and Improvement Authority (RQIA) Consultation response.

⁵³ Appleby, J. (2005) *Independent Review of Health and Social Care Services in Northern Ireland*, August: 11-12.

ANNEX

35 Clauses of the Health and Social Care (Reform) Bill

- Clause 1: *Restructuring of administration of health and social care*
- 2: *Department's general duty*
- 3: *Department's general power*
- 4: *Department's priorities and objectives*
- 5: *The framework document*
- 6: *Power of Department to give direction to certain bodies*
- 7: *The Regional Health and Social Care Board*
- 8: *Functions of the Regional Board*
- 9: *Local Commissioning Groups*
- 10: *Power of Regional Board to give directions and guidance to HSC trusts*
- 11: *Provision of information, etc. to Regional Board by HSC trusts*
- 12: *The Regional Agency for Public Health and Social Well-Being (RAPHSW)*
- 13: *Functions of the RAPHSW*
- 14: *The Regional Support Services Organisation*
- 15: *Functions of RSSO*
- 16: *The Patient and Client Council*
- 17: *Functions of the Patient and Client Council*
- 18: *Duty to co-operate with the Patient and Client Council*
- 19: *Public involvement and consultation*
- 20: *Public involvement: consultation schemes*
- 21: *Duty on HSC trusts in relation to improvement of health and social well-being*
- 22: *Public-private partnerships*
- 23: *Schemes for transfer of assets and liabilities*
- 24: *Transfer of functions of Health and Social Services Boards*
- 25: *Transfer of functions of the Mental Health Commission*
- 26: *Transfer of functions of Central Services Agency*
- 27: *Amendment of statutory and other references to dissolved bodies, etc*
- 28: *Dissolution of special agencies*
- 29: *Orders, regulations, guidance and directions*
- 30: *Further provision*
- 31: *Interpretation*
- 32: *Minor and consequential amendments*

33: *Repeals*

34: *Commencement*

35: *Short title*