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# Change or collapse

## Lessons from the drive to reform health and social care in Northern Ireland

Mark Dayan and Deirdre Heenan

nuffieldtrust

## About this report

The health and social care system in Northern Ireland has seen seven fundamental reviews setting out major changes of direction in the last 20 years. Each has delivered a similar verdict: the country needs to reduce its reliance on hospitals, centralise some services for a critical mass at a smaller number of sites, and focus more on prevention and keeping people healthy.

This report examines the factors that may be helping or hindering efforts to improve the health and social care system in Northern Ireland today. It considers four main themes that emerged from our interviews as consistent and important factors: the level of ambition; centralisation and the space for initiative; public leadership and taking difficult decisions; and openness to learning and scrutiny.

It aims to be of interest to health leaders across different countries, especially in the rest of the UK, which shares the history, remit and funding mechanism of Northern Irish health and social care services. It forms the second in the Nuffield Trust's series of reports looking at what UK health systems can learn from one another, following *Learning from Scotland's NHS* in 2017.

## Acknowledgements

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# Key points

- There is determination in the leadership tier of the Northern Irish health and care system, and among front line staff, to make the changes in Rafael Bengoa's 2016 review a reality. Some improvements and important initiatives are happening – but change on the ground so far is at an early stage and patchy.

- The political vacuum in Northern Ireland is exacerbating chronic problems in taking difficult decisions. Although the civil service is doing its best to provide leadership, its role and culture limit what is possible. Without the legal powers and legitimacy held by a political leader, several very important processes of change face the end of the road.

- This is a lesson for services elsewhere in the UK which may also face a lack of stable government or a focus on constitutional issues. While politicisation has its problems, a lack of public leadership creates serious barriers.

- There is a lack of ambition around tackling waiting times for planned care, despite strikingly poor standards compared to other UK countries.

- There is little sign so far of the intended shift of care and resources into care outside hospital. Despite notional integration of health and social care, there are signs that the latter remains overlooked.

- Many people described a high degree of centralisation of power in health and social care in Northern Ireland. This is difficult to reconcile with the initiative and experimentation necessary for complicated change where the answers are not fully known.

- Centralisation, and the exposure of the service without political leadership, seem to foster a 'bunker mentality' culture where openness about problems and difficulties is discouraged, removing opportunities for the system to learn.

# Introduction

The health and social care system in Northern Ireland has seen seven fundamental reviews setting out major changes of direction in the last 20 years. Each has delivered a similar verdict: the country needs to reduce its reliance on hospitals, centralise some services to achieve a critical mass at a smaller number of sites, and focus more on prevention and keeping people healthy.[1]

These culminated in the detailed and wide-ranging 2016 review by Spanish health care leader Rafael Bengoa, *Systems not structures*. Bengoa's report concluded that:

> "The stark options facing the HSC system are either to resist change and see services deteriorate to the point of collapse over time, or to embrace transformation and work to create a modern, sustainable service."[2]

The review's specific recommendations were then used as the basis of a 10-year plan in 2016, *Delivering together*, an ambitious and detailed programme of change.[3]

This report examines which factors may be helping or hindering efforts to achieve these goals in Northern Ireland. It aims to be of interest to health leaders across different countries, especially in the rest of the UK which shares the history, remit, and funding mechanism of Northern Irish health and social care services. It forms the second in the Nuffield Trust's series of reports looking at what UK health systems can learn from one another, following *Learning from Scotland's NHS* in 2017. Northern Ireland's system also faces its own unique context, and we hope to reflect back an external view to leaders within the country on those particular dynamics and how they affect health care.

Throughout this report we look at what is helping and hindering the system from delivering four broad goals indicated in the Bengoa review and set out in detail in *Delivering together*:

- Shifting care out of hospital, so that greater use is made of services that treat people in their neighbourhoods or their own home
- Greater focus on prevention rather than curative services, and a focus on the health of the population as the essential task of health and social care
- Increasing public trust in the system by reducing waiting times to an acceptable level
- The centralisation of hospital services where this improves quality or safety by concentrating key staff.

The report considers four main themes which emerged from our interviews as consistent and important factors: the level of ambition; centralisation and the space for initiative; public leadership and taking difficult decisions; and openness to learning and scrutiny. There are of course many other important determinants of success – from medical and clinical discoveries and changes, to the economic and social situation in Northern Ireland. Our four were selected because interviewees described them as having deep and broad implications, and because they are within the control of Northern Irish political or operational leaders.

## Methods

Our question is fundamentally qualitative, seeking to understand different helpful or unhelpful factors. In order to gather a range of perspectives from across the system and outside it, the Nuffield Trust held an event in Belfast in 2018 in which attendees explored four themes – politics, leadership, workforce and innovations at the front line. We then conducted a series of interviews through the course of 2018 with leaders within the system, outside experts, and clinicians. A list is provided in Appendix A.

Quantitative analysis around finance, workforce and waiting times was also carried out where an objective benchmark was needed against which to assess the levels of success and pressure in Northern Ireland compared to other UK countries.

# 1 Level of ambition

The Bengoa report emphasised that an aligned commitment to change, from head offices to the front line, would be needed to drive the transformation it lays out. Themes of engagement and ambition – or the lack of these – emerged often in our interviews.

## A difficult beginning

Our interviewees described how the history of health and social care in Northern Ireland had built up considerable scepticism, frustration and inertia. Direct rule from Westminster, which ran until 1998 and from 2002 to 2007, was viewed as a short-term expedient until such time as a more permanent solution could be found. That meant a focus on keeping things ticking over, rather than large-scale reform.

During periods of devolution, especially since 2007, repeated independent reviews described the need to radically transform the system if it was to be sustainable and fit for the future. Each repeated the stark warnings of the previous one, and was followed by a period of momentum. But in many cases this faded away as action and detailed plans failed to materialise, reinforcing a sense of scepticism.

## Ambitions for transformation at the centre and in senior ranks

At the highest levels we found widespread commitment to a fairly radical overhaul of the aims and systems of health and social care in Northern Ireland, in line with the Bengoa review and its predecessors. This was present among both system insiders and those outside it.

There was a consensus that the Transformation Implementation Group in charge of overseeing change and the Department had genuinely adopted and prioritised a shift to doing more outside hospital; focusing on improving health outcomes rather than just indirect measures of performance; and making better use of non-medical staff. The decision to use the money secured by the Democratic Unionist Party under their Westminster 'confidence and supply' agreement largely to fund new initiatives along these lines reflects this.[4]

Senior figures we spoke to outside the Transformation Implementation Group felt a reorientation of aims and expectations in line with this. "I think the quality of the debate in Northern Ireland has hugely improved in the last two to three years", one told us.

But acceptance of the problems and solutions in theory did not necessarily translate into an appetite for fundamental change. We heard a realisation that a wholesale overhaul of the system would require accepting short-term pain for long-term gain. Centralisation, risk aversion, and political pressures all still pulled against these difficult trade-offs, as explored below.

## Do ambitions reach reality yet?

There are some signs of increased commitment and interest being associated with greater and more widespread improvement in the direction Bengoa suggested over the last two to three years. For example, we heard about continuous and wide-ranging changes to ophthalmology services to make better use of optometrists working with hospital doctors, using them to expand the capacity to deliver care and identify problems earlier. There has been an ambitious and expanding programme of medicine optimisation led by pharmacists.[5]

The creation of two pilot sites for 'multidisciplinary teams' around general practice was pointed out by several interviewees as a concrete and positive development. These have been initially rolled out in County Down and County Londonderry, supported by £5 million each in funding from the confidence and supply agreement.[6] They will make greater use of physiotherapists and mental health staff working alongside GPs, adding a wider range of skills.

Modelling from the English context suggests these steps have the potential to help deliver more of the care patients need outside hospital despite GP shortages, though hard evidence is not yet fully available.[7]

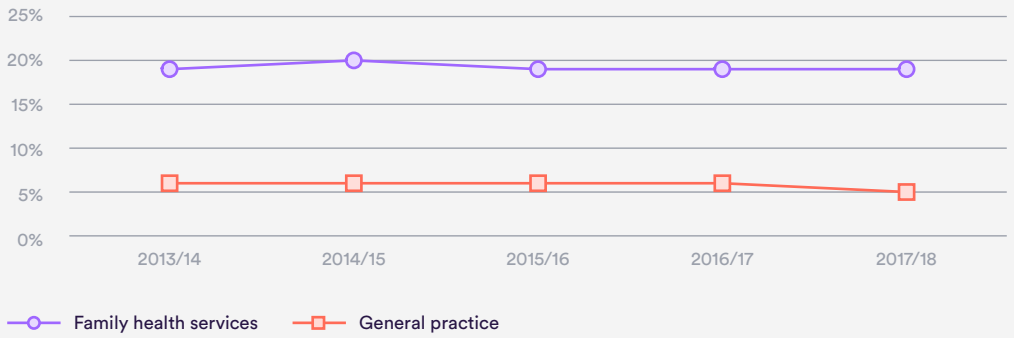
However, the level of commitment these changes reflect is clearly not present everywhere and conflicts with other powerful drivers in the system. "It's patchy, it's in certain specialties more than others, and it's not across the region", one leader told us.

Intertia and apathy were still described and expressed: one clinician told us it was "all just words". We heard that while individuals may be committed to improvement and working hard to achieve it in their own sector, they have little sense of other parts of the system less directly linked to their aims. Where this did exist it could be less than positive: there was a prevailing view that people at the front line were committed to change but the centre or the system actually worked against innovation.

There was common concern that at a local level, GPs and trusts did not always share the same goals and could not be held jointly accountable. Several senior figures had a strong hope that the introduction of GP federations, which bring together on average 17 practices,[8] would improve this situation. Nuffield Trust research within England suggests that while larger-scale organisations in general practice do gain advantages in their ability to change how they work, expectations need to remain realistic.[9]

It is important to note that health and social care trust accounts suggest any reorientation in what matters has not so far carried over into hard cash. At a national level, analysis of the annual accounts of the Health and Social Care Board, shown in Figure 1, shows no increase in spending on primary care, or specifically on general practice.

**Figure 1: Health care spending on primary care services as a proportion of health and social care spend**

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While the classifications used vary, trust accounts also suggest no shift in their budgets from acute, episodic care towards ongoing care for chronic illnesses outside hospital.

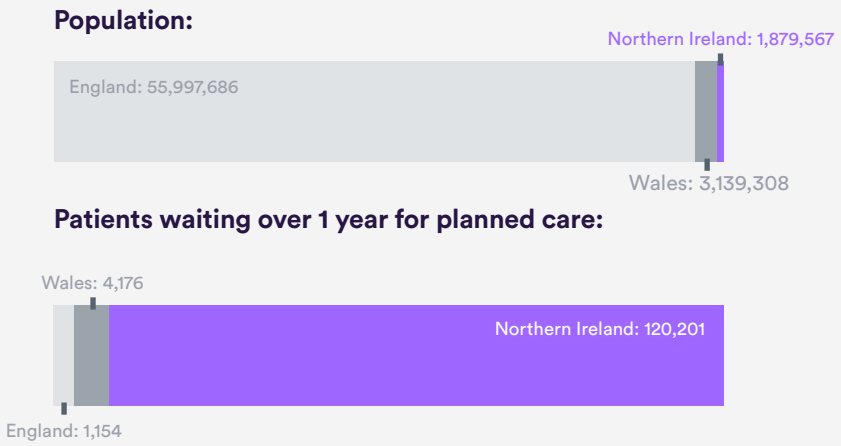
That the pattern of commitment to reform in the centre and parts of the front line seem to exist alongside pockets of intertia and alienation might be an inevitable stage in a process of change. However, it is not clear that there is an effective mechanism to change this. In Scotland and England, national bodies have aimed more publicly to promote new types of 'system leaders' – local executives who focus on managing change and working across different bodies.[11] In Scotland a similar concept is formally codified through the statutory creation of integration authorities with their chief officers, who combine the specific role of achieving this with important operational competencies.[12] Northern Irish integrated care partnerships have some similarities, but play a much less executive role.

## Waiting times and access

There is a low level of ambition around elective waiting times. Northern Ireland's health service is exceptionally slow at providing patients with planned care, compared to health services elsewhere in the UK. As Figure 2 shows, a person in Northern Ireland is at least 48 times as likely as a person in Wales to wait more than a year for care. This is despite Wales being the worst performer otherwise in the UK, and the Welsh method of measurement

capturing more stages of the journey for patients who are admitted to hospital – effectively starting the clock slightly sooner.

**Figure 2: Population sizes in England, Wales and Northern Ireland compared with number of patients waiting over a year for planned care in their respective country in March 2019**

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Note: Data for Scotland were not available. Northern Irish waiting lists may be relatively somewhat understated, as for waits in some areas the 'clock' starts later in the patient journey than in Wales or England (Northern Ireland counts from the point of the decision to admit, rather than referral).

Despite the Bengoa review warning that "reducing waiting times to an acceptable level" was necessary to maintain public confidence, the situation has, if anything, been deteriorating in recent years.

One interviewee gave their perspective on the role of culture as follows:

> "In the private sector, heads would roll, people would be expected to take responsibility for poor performance. In this system going the extra mile is not rewarded. Indeed it is viewed with suspicion if not hostility. Poor performance is excused or condoned with no sanctions. It's hardly conducive to continuous improvement."

Interviewees within the system argued that the shift in focus to doing more outside hospital had to come at the expense of waiting times performance. However, it is not clear that any shift in services radical enough to explain the

exceptionally poor performance has actually occurred yet. Poor performance, relative to other UK countries, far predates the Bengoa review. Interviewees outside the system leadership were less likely to have this perspective, and often agreed with the Bengoa review that a decent standard of access was part of the change needed. One leader in a representative body's summary judgement on change was "not quick enough, not quick enough for patients who can't access diagnosis and treatment".

The situation in Northern Ireland provides a possible warning to health care leaders in England and Scotland, where key recent policy documents have tended to emphasise clinical outcomes and preventative care over pure access to services.[14,15] While there is a clear case that these are more fundamental objectives, the situation in Northern Ireland is a warning that it is entirely possible within an NHS-style system for waiting times to deteriorate to such an extreme degree that this becomes a qualitative difference in the system with widespread implications.

## Does underfunding account for Northern Ireland's poor waiting times?

We consistently heard that money or staffing constraints ruled out addressing the situation regarding waiting times. But while funding has undoubtedly been tightly constrained compared to rising need in recent years, it is not clear that Northern Ireland is radically more underfunded relative to other UK countries, in particular Wales which has lower funding per person and a similar legacy of deindustrialisation. Previous analysis by the Healthcare Financial Management Association has suggested that Northern Ireland's health service may have much higher funding needs than England's, despite receiving only 3% more funding per capita.

However, our own analysis supports a similar conclusion only if the rate at which people receive Disability Living Allowance (DLA) is used as an indicator. We produced two models which predict funding at English CCG level based on a range of local measures of deprivation, age and geography, then applied these to Northern Ireland. Essentially, the models try to predict what the English NHS's complex allocation formula, which relies on individual

patient diagnoses, would say if it were applied to Northern Ireland (see Appendix C for further detail on these models).

Using rates of DLA – which is a very strong predictor of funding in England – as a predictive factor, Northern Ireland's predicted funding was 29% above the English average. This is because in 2016, the latest year for which all relevant data was available, Northern Ireland had extremely high rates of DLA recipients – three times that of England.

However, the potential for different political and welfare choices rather than differences in need to affect DLA rates is underlined by the fact that DLA rates subsequently fell by more than half in Northern Ireland, from 213,000 to 103,000 recipients.[16]

An alternative model used 2016/17 jobseekers' allowance rates, income support, house prices, healthy life expectancy and the numbers of men and women over the age of 65 to explain variation in funding within England. This was roughly as successful in predicting funding in England. On this model, Northern Ireland's predicted funding was only 2% higher than England's, within the margin of error of the actual figure of 5%. Among other factors, this reflects that while Northern Ireland has higher indicators of deprivation, it has a lower proportion of women over the age of 65 – a group associated with higher assessed need in England.

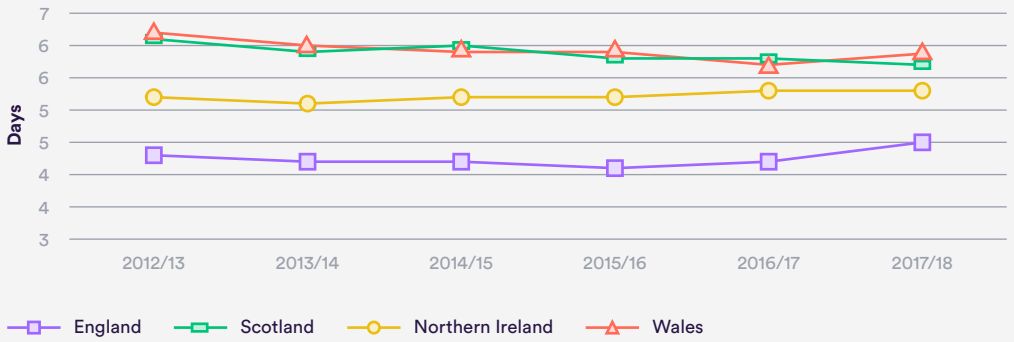
Yet it is almost impossible to overstate the gulf in waiting times between the two countries. In early 2019, the list of people waiting over one year in England was equivalent to one person per 48,524 inhabitants. In Northern Ireland, it was equivalent to one person in 16.

The problem is not simply a case of Northern Ireland admitting fewer people to hospital: admission rates are similar to other countries in the UK. Comparing indicators of hospital capacity and efficiency across the UK countries is difficult, because the six programmes of care into which Northern Ireland is divided do not map easily to divisions in the other nations.

As Figure 3 shows, the average length of stay in hospital, often considered an indicator of how efficiently patients are treated, is middling in Northern

Ireland compared to the other countries and notably shorter than in Wales or Scotland. However, it has risen very slightly in the past five years where it has fallen elsewhere.

**Figure 3: Length of hospital stay in UK countries (excluding maternity and mental health)**

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Northern Ireland again has an intermediate number of beds per person: more than England, significantly fewer than Wales, and roughly the same as Scotland. The proportion of beds that are occupied has been consistently slightly lower in Northern Ireland than in the other countries. However, it would be simplistic to see this as a measure of inefficiency, as bed occupancy in other UK countries is generally held to have reached excessive and even dangerous levels.[18]

## Social care

Another topic where there seemed relatively less impetus to progress was social care. We were made aware of important examples of better joint working across health and social care, but many primarily focused on the potential for managing health problems and their aftermath, such as steps to improve the ability to safely discharge people with ongoing illnesses[19]. We were aware of relatively fewer centrally promoted initiatives to address what few would dispute are important changes and serious problems within social care itself – especially social care for older adults.

Published information from Transformation Implementation Group meetings for the first five months of 2019 suggests social care for older people was discussed as a topic in its own right, rather than as a support to health care, only once when a member asked whether it was included in an integration initiative.[20,21]

Uniquely across the UK, Northern Ireland has a nominally fully integrated command structure for health and social care. The reality, as one individual with experience at a very senior level reflected, is that the latter has been "the poor relation". Another told us that integration could simply mean social care had its "pocket picked" to support local health services, with cuts to domiciliary care one of the primary means to deliver savings. They tended to agree that the drive for change and improvement had been much less marked: "at least there have been a lot of reports in health care".

A figure outside the system's leadership argued that Northern Ireland is "lagging behind in the whole area of social care which is ironic given that we [are the] only region with an integrated system". They noted that Northern Ireland was the only UK country not to have refined the legislation underpinning social care in recent years, while countries like Scotland[22] and England[23] have taken measures like standardising eligibility and granting new rights to carers. A domiciliary care workforce review is forthcoming, and this will provide an important opportunity to signal some solutions and ambitions.[24]

There is an important lesson here for Scotland, Wales and England that combining health and social care within the same organisation does not necessarily result in social care being accorded a higher priority or in smoother working across the sectors. Factors such as the higher political profile of health care, its very visible local presence, and its larger total budget can easily make it dominant within as well as across organisations. As each of the other three countries has moved or is moving to increasingly shared leadership across the sectors, it will be important that incentives and scrutiny ensure that local leaders do not mirror the historic pattern in Northern Ireland.

# Workforce planning

Many interviewees felt that one shortcoming historically had been poor workforce planning resulting in shortages of key staff groups, a costly reliance on temporary staff, and a misfit between the workers available and those that would be needed if the service were to meet its aspirations to change. The Northern Ireland Audit Office recently counted annual locum doctor spend as £83 million in 2017–18. This accounted for more than 10% of all spending on doctors in every area of Northern Ireland, and over 20% in the Northern and Western Trusts, which were the most affected.[25] These particular trusts have been disproportionate spenders on temporary medical staff for years, yet we are aware of no proposals to review this situation.

The Department published a workforce strategy in May 2018. Many of our interviewees were pleased with this development and felt it represented a real, positive change, especially in terms of the engagement with staff groups that fed into it. "It's fantastic and it is now starting to bear fruit", a leader in a representative body told us.

But many still felt that the system was a long way from successfully and consistently securing the right numbers of the right staff. "Northern Ireland has never had a long-term strategy for workforce planning: we lurch from one crisis to the next", one senior medic told us. Despite a recent increase in contrast to trends elsewhere in the UK,[26] few disputed that general practice was experiencing a severe and chronic shortage that was having real impact on the functioning of services.

The workforce strategy is a far-reaching and aspirational document, with an impressive level of ambition around bringing new types of staff into the workforce and expanding people's skills. However, it contains little discussion of the exact numbers of key staff groups needed and the exact mechanisms by which these will be secured. A process to come up with indicators is mentioned, but it is unclear to what extent this will include strategic planning as nothing appears to have been published.[27]

# 2 Centralisation and the space for initiative

In his 2014 review of the Northern Irish health service, Sir Liam Donaldson memorably observed that the people he interviewed had no consistent answer as to who was in charge of or ran the health system. We found a strikingly different picture. A typical response was that "everything is controlled by the Department", and this perception was shared among insiders and outsiders.

While this clarity was welcome in a sense, it sat alongside a widespread perception that centralisation, tight command and control and an aversion to letting people take responsibility for their own initiatives were impeding change.

## Leading from the top

Interviewees tended to perceive the power of the Department as having been intensified by the ongoing abolition of the Commissioning Board, regardless of their views on the merits of that decision. This practically added specific powers of commissioning services from trusts to the strategic and policy-setting powers the Department already held, and informally removed the only competing power centre.

Views on the level of autonomy really held by trusts varied. Interviewees outside trusts, including those who had previously held senior roles, tended to believe that "the trust chief executives think they run their empires but they don't." Those within the system saw things differently, viewing the relationship more as one of alignment than hierarchical control.

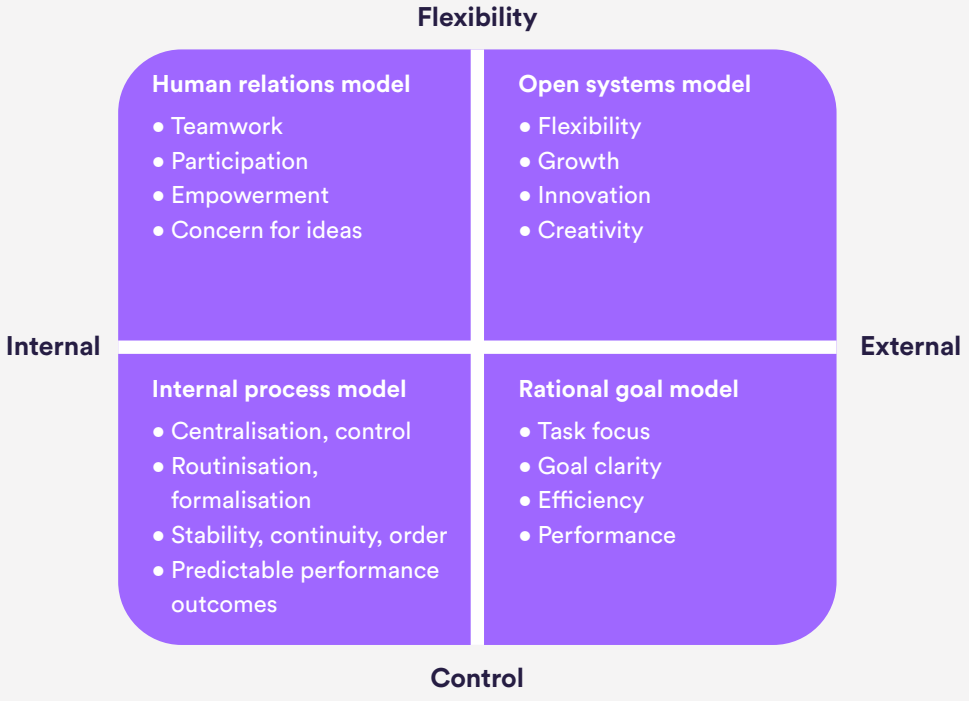
The political vacuum created by the collapse of power sharing was another factor in increasing the centrality of the Department. But many interviewees emphasised that these dynamics were not new, with a technocratic culture stretching back to direct rule and continuing through the period

of devolution. There was some sympathy for the fact that the permanent secretary was operating in the absence of a health minister, making it difficult to move beyond a risk-averse approach or to fundamentally change management structures.

## A culture ready for change?

The Competing Values Framework is a conceptual tool used to categorise culture in workplaces, especially in health care. The example below was tested on a sample of managers and clinicians. The axis running from top to bottom represents whether organisations are led flexibly, from across the organisation and with organic leadership, or through control from the centre from a few formal leaders. The axis from left to right represents whether their aims and values are internal, reflecting what people within the system want and value, or external, focusing what customers or patients want. In the Nuffield Trust's previous report on the Scottish NHS[28], we noted that it appears more "flexible" than the English and Welsh services. Our interviewees depicted a Northern Irish system, by contrast, that is more controlled.

**Figure 4: The Competing Values Framework on organisational culture in health care**



The problem is that while there is no universally right answer as to where a health system should be, academic literature suggests that quality improvement and change work best at the flexible end of the spectrum.[30]

## The difficulties of a centralised system

Our interviewees illustrated several overlapping problems that, in terms of the process of change, seemed to be connected to this model of culture and leadership.

The first was the discouraging effect it had on local organisational experimentation and innovation. "Organisations in NI look up to the Department rather than coming up with solutions themselves", one interviewee noted. "In this culture and context, paralysis and lack of decision-making becomes the norm. There is no confidence within the system to take ownership of innovation and creativity", another told us. The leadership style was described as autocratic and hierarchical and, despite commitments to a shared or devolved leadership style, there was widespread agreement that this had not translated into practice.

In one sense, a case could be made that this was positive in that it pulled power towards institutions that were relatively committed to the agenda of transformation – the Department and the Transformation Implementation Group.

However, academic literature emphasises that change programmes in health care need to take close account of the complicated realities of how care is delivered, and are more likely to succeed by accumulating small improvements. Initiatives at a large scale led far from the front line have a high failure rate.[31]

At an individual and professional level, a sense of separation and lack of agency relative to the centre was replicated. Bengoa said that the necessary type of leadership would be "a 'high involvement culture' with health care professionals. They are the key agent of change".[32] But although we spoke to some clinicians who were very engaged in change and found assistance in the wider system, many told us the prevailing culture did not encourage nor facilitate this type of clinical leadership.

Our interviewees described interpersonal dynamics which illustrate some of the difficulties, with fear and mistrust stifling open communication and reinforcing the status quo. There was a culture of "them and us" between upper tiers of the hierarchy and those working "at the coal face". Participants were cynical about the "fixation" on "white boards and targets" – a serious indictment of cultural negativity given the lack of achievement against targets during this period.

This mistrust was perceived to be reciprocated, with the centre itself "confusing fear with respect" and adopting a forcible manner towards those lower down the hierarchy. This type of management system tended to incentivise a focus on completing set tasks and avoiding attention from management, rather than initiating difficult and potentially risky changes. One leader told us the lesson learnt for staff who wanted to make improvements locally was to "keep their heads down and get on with it".

Low trust appeared to be horizontal as well as vertical: GPs voiced suspicions of trust leaders as empire-builders who were slow to work cooperatively, and vice versa. One senior clinician told us that in his judgement the prevailing culture was "the polar opposite of what was required to manage a change programme".

This issue has been recognised by leaders in the service. An approach of "co-production" was anticipated in *Delivering together*, and the Department has since produced a guide to this.[33] This envisages decisions being taken by staff, patients and leaders working "together in partnership to improve health and wellbeing outcomes". Some suggested that the moves towards co-production were evidence that the system was responsive and listening to the views of service users.

However, interviewees generally did not see this as an achieved reality. "Co-production is not a party of equals. It is a pretence. It pretends to alter the balance of power and create a partnership", one told us, saying that while emphasising the theory, the Department was "actually too short-sighted to see how it's most relevant to them".

## Lessons for other countries

The impact of centralisation in Northern Ireland's health and social care system may hold lessons for England and Wales. The central command structure of the Welsh NHS was criticised by an OECD review for a relative lack of "concrete levers" deployed to drive change and improvement from local boards.[34] The Northern Irish example shows how the concentration of powers in one body, coupled with a role as the gate-keepers of major decisions, can rapidly create an unambiguous power centre capable of driving significant changes if it has a clear culture and remit focused on this. However, it also illustrates that this carries significant risks if it is allowed to crowd out a more flexible leadership style.

In England, with the combination of the national bodies NHS Improvement and NHS England and the weakening of clinical commissioning groups in favour of 'integrated care systems', there is some potential for an analogous concentration of power at the top. There are reasons to be concerned about this if it leads in the direction of Northern Ireland's way of working: for England, the OECD review in 2016 already saw tensions around an excessively centralised approach and called for "greater emphasis on bottom-up approaches".[35]

## Short-term priorities

A more specific criticism was that the Department tended to have short-term, financially focused priorities. This has been identified as a widespread feature of the UK civil service, and can be linked to positive traits like departmental focus and political responsiveness.[36] However, it sits uneasily with a long-term process of ambitious change in a public service.

Interviewees often highlighted workforce decisions here, in the context of concerns about the standards of strategic planning as discussed above. One frequently mentioned example was the eventually reversed decision to cut nurse training. This was described as a "perfect illustration of the lazy thinking that pervaded through the Department – always look for an easy target regardless of the impact".

Others mentioned the recent instance when trusts were asked to find significant savings and responded by cutting domiciliary care packages, directly against the agreed direction of travel. One frustrated interviewee told us: “The bottom line is money, the system is all about balancing the books, not interested in doing things differently.”

# 3 Public leadership and taking difficult decisions

One of the mostly widely cited necessities for change was a political willingness to take difficult decisions. With some notable exceptions, this was felt to be lacking due to historical and social factors in Northern Ireland, with long-term change often being avoided due to public or political opposition.

## A problem with deep roots

Interviewees described short-term problems due to the collapse of power sharing; longer-term problems which had existed even when power sharing was in place; and some instructive examples where difficult decisions actually had been taken with public involvement.

The long-term factors were structurally rooted in politics and culture. Several interviewees saw Northern Ireland as having an especially strong tendency to local "parish pump" politics, where incentives pushed away from any decision to sacrifice a service in a particular area for the wider good. Interlinked with this was what one interviewee with experience working both outside and inside Northern Ireland described as a "lack of confidence that people will do what is best for the province".

Meanwhile, the health and social care system's engagement with communities was felt to have been consistently poor, or at least inconsistent over a long period of time. Interviewees criticised the emotional intelligence of the way engagement was often approached. They told us that technocratic language focused on "reconfiguration, transformation, reshaping" had failed to gain buy-in.

> "Health is an emotive issue and stakeholders need to be engaged on an emotional level. How to win hearts and minds is with a simple explanation… Policy reform is possible when underpinned by an appropriate vision and sold as something that can make a tangible difference."

These problems stretched back through periods of power sharing and direct rule. One event attendee remarked that if devolved government "came back tomorrow, it wouldn't solve our problems". Similar tensions have emerged elsewhere in the UK even where political institutions are in place and relatively supportive. Successive national and local reforms in England have been badly undermined by poor public engagement – with prominent recent examples including changes to Chase Farm hospital in London, and the national sustainability and transformation plan programme.[37]

However, it does appear that the collapse of power sharing has worsened political barriers. It has also added legal barriers. In 2018 the Northern Ireland Court of Appeal found that the civil service did not have the right to take a contentious decision regarding a waste incinerator in County Antrim,[38] a case many of our interviewees saw as having serious implications for difficult health care decisions. The Northern Ireland Act 2018, passed by the UK Parliament, aimed to give civil servants wider powers during the period without an Executive[39] – but guidance under it makes clear that there are still very real limits to their remits, especially in decisions that might be seen as constituting a policy change.[40]

## Real-world effects of political barriers and inertia

The exact breadth of projects felt to be held up by the immediate political situation varied widely, suggesting a broad but nebulous chilling effect. Elective care centres, for example, are a high priority initiative to centralise planned care for a higher concentration of staff and patients, with the potential to help address the situation in waiting times discussed above. Some felt that they could proceed more or less as planned, and indeed a first wave began operation in 2018 for two relatively less sensitive areas – varicose

veins and cataracts.[41] Others saw the more difficult decisions involved in concentrating services – and taking them away from some sites – as being near impossible without political leadership.

A longstanding but intensified issue was the tensions over attempts to centralise A&E services where this left smaller towns or rural areas with less extensive services. The fate of services at Daisy Hill hospital in Newry, which has struggled to gain a safe level of staffing but has been reprieved with a bailout[42], is a clear case in point. An interviewee suggested that the system was simply chronically failing to convince people in more rural areas of the benefits of concentrating staff for larger specialised services, relative to the tangible loss to their local areas.

Interviewees much nearer the front line, trying to carry out quite specific changes, described a sense that "important decisions need to be made and there is no-one to hold the pen".

Centralising stroke services was especially widely cited as something being blocked by an inability to take difficult decisions intensified by the lack of a devolved government. One attendee at our event noted that Northern Ireland currently has more than twice as many stroke centres as London, which has around five times the population. There is good evidence that dispersed services lead to higher rates of mortality for people suffering strokes.[43]

In 2019, the Department opened a consultation on stroke centres proposing a reduction from eight full-service sites to between five and three.[44] The Department carried out media publicity around this and made the Permanent Secretary available for interview – a departure from the general norms of civil service governance.[45] This is a positive step, both in terms of showing a willingness to lead without devolved government and in terms of the openness to engagement with the medical profession and the public that it suggests.

However, it is obviously at the point at which final decisions are put forward and particular sites are identified as losing services that the potential for political tension is greatest. The process of centralising trauma services in Scotland, for example, saw a high profile review[46] lead only to very delayed action, with the envisaged number of sites rising from one to four.[47]

As one very senior figure told us, "I don't think there's any question that aspects of this will require ministerial decisions… when it comes to changing the nature and scale of institutions or services then we will start to feel the impact of the political void".

## Possibilities for change

Because not all the causes stem from the immediate political situation, there is still scope for progress. Alongside the initial stages of stroke consultation, some local initiatives such as the Western Trust's Pathfinder programme have included highly visible public engagement processes even in the absence of political leadership – although whether this will carry through to buy-in for difficult decisions again remains to be seen.[48]

But it is notable that some cases picked out as being successful examples in Northern Ireland, like the changing of obstetrics at the Mater Hospital in Belfast, had required a degree of political leadership for a successful outcome. Interviewees widely cited the late 2016 decision of Michelle O'Neill as health minister to work with other parties in giving detailed backing to the Bengoa report as an important moment. It seems likely that this contributed to the extent to which interviewees described these initiatives as genuinely being taken up in the Northern Irish system, more so than earlier reviews. It is unfortunate that power sharing collapsed at a point when there may have been the potential for stronger political leadership.

One person who had worked on a high profile review of the Northern Irish system felt that, counterintuitively, difficult decisions had been broached in the reconfiguration of services like stroke, but less so when it came to joining up services where a more narrative and less technical approach was needed for leadership.

Social care was also seen as an area where difficult decisions were being postponed due to political stalemate. "The decisions needed for a firm financial footing need to be taken with a degree of political legitimacy… the willingness of politicians to tolerate a part of the UK with no government is astonishing", one leader with experience at a senior level inside the system told us.

There is no way around these formal and informal roadblocks as long as the political vacuum continues. The civil service in Northern Ireland has taken on an increasingly dominant role in managing and trying to change health and social care. This is to its credit, even as it raises issues around the centralisation of control.

But in the United Kingdom's legal and political tradition, which focuses on civil service impartiality, discretion and fiscal control, it is very difficult to see how the Department is best suited to lead the process of securing legitimitacy over contentious choices. One interviewee in a senior position warned that without political leaders, the limits of what had been set out by Michelle O'Neill in 2016 were "the end of the road".

## Lessons for other countries

The NHS in all four countries of the UK is subject to extensive politicisation and political control, and studies have often identified the problems that this causes. The Nuffield Trust report on Scotland's NHS, for example, noted that a "polarised political culture" where the Scottish National Party and opposition parties competed fiercely over health care issues "could make contentious decisions on shifting resources away from hospital care seem almost impossible". [49]

The situation in Northern Ireland illustrates that there are also risks from a lack of political engagement and leadership. Politicians responsible for health care issues often face powerful incentives not to provide cover for difficult or unpopular decisions. But in their absence, there is nobody else who can easily fill this role in providing democratic and legal legitimacy. With the Welsh Assembly, Scottish Parliament and House of Commons all currently having no majority party[50,51] and facing deep divisions on constitutional issues, this may become a problem more widely in the United Kingdom.

## The capacity to act across the border

Geographically, there is considerable logic to many health services operating across Northern Ireland and the Irish Republic. However, there are clearly institutional gaps to be bridged in making this a reality, and considerable political sensitivities.

One source of external funding and legitimacy for change has been programmes funded by the European Union across Northern Ireland and the border counties of the Irish Republic. These relating to health are largely held by the Cooperation and Working Together initiative, a partnership between national and local health bodies across the two countries which holds many of the health-related projects backed by these funds.[52] These include mental health support for vulnerable children, and cross-border services for medical acute specialties patients starting with dermatology.

There is a risk that the UK's departure from the EU will end these initiatives in their current form, putting these services into a difficult position and in time removing funding and international legitimacy from future initiatives.[53] The Political Declaration agreed between the UK and EU, subject to ratification, includes a commitment to a future 'Peace Plus' successor to be managed after Brexit.[54] However, a 'no deal' departure would mean these negotiations do not proceed as envisaged.

# 4 Openness to learning and scrutiny

Underlying all specific issues of improvement and change is the question of whether the Northern Irish system is well set up to learn about what works and does not work. Our interviewees largely did not view the health and social care system as one which valued learning nor evidence-based research, but rather one that was slow to adopt to changing demands and that at times had an instinct to avoid scrutiny.

## Evaluation and performance indicators

Attendees at our event reflected that formal evaluation of initiatives was relatively scarce, and that there was not necessarily good awareness of evaluations elsewhere in the UK and Ireland. They mentioned a lack of independent spaces in which to discuss and critique policy.

A tender has been opened for the rigorous evaluation of multidisciplinary teams in County Londonderry/Derry and County Down,[55] which is a promising step. However, this appears to have come well into the process and after a decision to roll out more widely.

The various iterations of Northern Ireland's 'Q2020' plan for quality improvement explicitly aim to "foster a culture of openness and learning" around serious negative incidents. They reference innovations like Schwartz rounds which aim to give staff time to discuss problems and experiences. However, there is limited emphasis on either formal evaluation or the kind of ongoing quantitative feedback and monitoring associated with quality improvement initiatives in Scotland.[56]

The highest-profile quantitative indicators of success that do exist are waiting times and performance targets. But as elsewhere in the UK, the risk of these distorting priorities was widely recognised – we "measure what we value

and we value what we measure". This led to perverse incentives within the system and a crowding out of more strategic aims, with hospital departments described as being fixated with "clearing their own whiteboards" rather than seeing the bigger picture.

## Training

We heard widespread concerns that training was neither keeping up with changes nor equipping employees to do so. It had changed little in two decades and there was little attempt to drive change and engagement. Employees rarely had the opportunity to reflect on their skills needs and address gaps in their competencies. There was broad agreement on the need to foster a culture of collaborative learning. Continuing training courses for those in employment were perceived in terms of legal requirements: one respondent described them as a "complete waste of time".

It was suggested that the structure of the health and social care trusts was not one which facilitated the exchange of information and knowledge. Training initiatives did not address needs around innovation and there was no platform where knowledge was shared.

## External scrutiny and oversight

Where scrutiny does exist from the media or outside bodies, it can be received in an oppositional fashion. "The centre is a bunker" with a "siege mentality", one senior doctor told us.

The authors of this report experienced repeated and explicit refusals to engage with our work from senior officials. This went far beyond anything we have ever experienced in often challenging and critical research in the English NHS, extending to circular emails to discourage large groups of senior figures from participating.

During the period of devolution the Assembly health committee offered one possible source of independent scrutiny. However, two interviewees commenting on this were sceptical about the Committee's capacity,

describing MLAs (members of the Legislative Assembly) being out of their depth and lacking the knowledge to ask the appropriate questions.

Several interviewees were pessimistic about how open the culture of the system was to criticism and learning from within. "Curious minds are thought to be difficult minds", one senior doctor told us.

These issues are hardly unique to Northern Ireland. The English NHS, for example, has repeatedly tried to foster a greater 'learning culture' internally, while in Scotland there has been interest in whether enough policy scrutiny exists externally.[57] However, because of size and history Northern Ireland has fewer strong and independent bodies than either. Risks created by this and by what can feel like an especially top-down culture, as discussed above, need to be taken seriously.

## A learning culture?

These issues add up to a large gap between the well-informed and responsive culture likely to drive change and the reality on the ground. The lack of this has real consequences. In some respects health and social care trusts were viewed as being in competition with each other and guarding information on innovation rather than disseminating and sharing. The excellent and innovative initiatives that do exist are not as widely disseminated, reflected on and understood as they might be. And there is a risk that well-intentioned but ineffective initiatives carry on without any source of scrutiny to identify them – something a system facing a real shortage of money and staff cannot afford.

It seems plausible that these traits are linked to two of the dynamics discussed above. Centralisation and an oppositional dynamic between the centre and the periphery are likely to enable and encourage an aversion to making problems or failures widely known. The political vacuum risks further incentivising this, by removing some of the system's capabilities to shape narratives that fold criticism or bad news into a constructive process of improvement.

Other UK countries may illustrate how a greater emphasis on learning and close monitoring of performance can be encouraged without creating a

negative or punitive impression to staff. In Wales and Scotland, high profile initiatives in recent years have promoted monitoring and discussion of hard measures of performance by emphasising the value of learning to improve outcomes. The Welsh 1000 Lives programme[58] began with a focus on public health, whereas the Scottish Patient Safety Programme[59] began with an emphasis on improving safety in hospitals. Both have tended to expand, applying similar models to other areas.

# Conclusion

The history of grand reviews and reality falling short in Northern Ireland's health and social care service leaves us with a simple question. In a decade's time, will we look back on the present day as an inflection point towards rapid progress? Or will we be reading another review which lays out again the possible future for a service that is struggling more than ever?

There are some signs consistent with the more positive version of the future. People at the centre of the system have genuinely reorientated towards trying to make services change what they do, not simply managing decline. Health trusts do now have new, formal and deeper co-ordinated relationships with general practice and the wider system.

Many staff have worked hard and imaginatively to come up with new and better ways of working on the ground. At its best, as with multi-disciplinary team pilots in general practice, local enthusiasm and central support have come together to create significant improvements.

But there are also major barriers to change within the service, and some of these are not getting better.

We heard again and again about a relatively centralised culture, which some see as closing the space for experimentation and critique. This is not well suited to a system that is trying to undertake truly complex change, where no one person in the centre truly knows what is possible or what will work.

Unfortunately, this way of working appears rooted in the power centres which have in some ways been a motivating force for improvements. This implies a danger that the top-down achievement of immediate changes is baking in fundamental flaws which will slow progress in the future.

Meanwhile, the length of time patients wait for planned care remains a stain on the system. The situation is frustrating for staff who know they could do better and is on full display to a public who are expected to trust that difficult changes are for the best.

Northern Ireland's health and social care system is also faced with a formidable range of external problems – some shared with many others, others truly unique.

Nobody could doubt that money is very tight, and more would make it much easier to address both waiting times and deeper change. But the reality is that a squeeze on health and social care as rising demand meets strained public funds is a reality not only across the UK but across the developed world, from the United States to Japan. It is a problem that will not go away soon.

A small population of 1.8 million means specialist services are innately difficult to fund and maintain. Solutions across all of Ireland are one promising answer, but they are politically sensitive: the vacuum of leadership and the implications of Brexit risk making them more difficult. The lack of a devolved government also creates daunting legal and political roadblocks to difficult decisions about centralising services within Northern Ireland. The civil service have been brave to begin controversial processes here, but they know they do not have the powers or the public position to finish them.

Despite the best of intentions, it is far from clear that health and social care in Northern Ireland has reached escape velocity from the cycle of falling short from high aspirations.

# Appendixes

## Appendix A – list of interviewees

Claire Armstrong, National Director, British Medical Association

Augusto Azuara-Blanco, Clinical Professor, School of Medicine, Dentistry and Biomedical Sciences, Queen's University Belfast

Rafael Bengoa, formerly chair of *Systems not Structures* report

Derek Birrell, Professor, University of Ulster

Tom Black, British Medical Association GP Committee

John Compton, former Chief Executive, Health and Social Care Board

Colm Donaghy, Former Chief Executive, Sussex Partnerships NHSFT, and previously Belfast Health Trust

Jim Dornan, Professor of Obstetric Medicine

Martin Dillon, Chief Executive, Belfast Health Trust*

Sean Holland, Chief Social Care Worker, Department of Health

Hugh McCaughey, Chief Executive, South Eastern Health Trust*

Aoife McDermott, Cardiff Business School

Lorna McKee, Emeritus Professor, University of Aberdeen

Heather Moorhead, Director, Northern Ireland Confederation

Michelle O'Neill, MLA, Sinn Fein

Siobhan O'Neill, Professor of Psychology, University of Ulster

Edwin Poots, MLA, Democratic Unionist Party

Carol Scoltock, Head of Discharge Services, Altnagelvin Hospital

Bronagh Scott, Director of Nursing, Policy and Practice, Royal College Of Nursing; and former panel member of *Systems not Structures* review

Janice Smyth, Director, Royal College of Nursing Northern Ireland

Tony Stevens, Chief Executive, Northern Health Trust*

Mark Taylor, former panel member of *Systems not Structures* review

* Interviewed collectively

# Appendix B – attendees at 2018 event

Dr Tom Black, BMA GP committee

John Compton, Former Chief Executive, Health and Social Care Board

Colum Conway, Chief Executive, Social Care Council Northern Ireland

Colm Donaghy, Former Chief Executive, Sussex Partnerships NHSFT, and previously Belfast Health Trust

Dr Grainne Doran, Chair, Royal College of GPs, Northern Ireland

Professor Keith Gardiner, Chief Executive, Northern Ireland Medical & Dental Training Agency

Dr Sara Hedderwick, Deputy Chair of Council, British Medical Association

Maeve Hully, Patient Client Council

Olive MacLeod, Chief Executive, Regulation and Quality Improvement Authority

Sean McGovern, Surgeon, Royal College of Emergency Medicine Northern Ireland

Dr Karl McKeever, Royal College of Paediatrics and Child Health

Ruth Miller, Lead Research Pharmacist, Western Health Trust

Dr George O'Neill, GP

Siobhan O'Neill, Professor of Mental Health Science, School of Psychology, University of Ulster

Richard Norris, Seconded from Scottish Health Council, University of Edinburgh

Mark Regan, Chief Executive, Kingsbridge Private Hospital

Janice Smyth, Royal College of Nursing

Tom Sullivan, Public Affairs and Policy Manager, Chartered Society of Physiotherapists

Professor Andrew Thompson, Chair of Public Policy and Citizenship, University of Edinburgh

# Appendix C – details of CCG-based funding model

In order to illustrate the factors which might determine whether Northern Ireland has higher or lower funding needs than other parts of the United Kingdom, we constructed two simple multiple linear regression models which examine what factors affect the distribution of health care expenditure within England.

Clinical commissioning groups (CCGs) in England receive funding based on an allocation formula, the details of which can be seen here: www.england.nhs.uk/allocations. This is highly sophisticated, taking into account a wide range of factors affecting health need and costs, including data on the actual usage of health care at an anonymised individual level, and unmet need indicated by the rate of age-adjusted mortality.

England was chosen as a comparator because its health service is divided into so many CCGs (209 at the time from which data was taken) with highly varying levels of deprivation and age distribution, providing the richest set of examples on which to base calculations.

Our regression models aim to simplify the determining factors to those which are also available for Northern Ireland. We tested a wide range of plausible demographic, economic and social indicators for their possible relationship to CCG funding. Only those with a significant relationship were used: where a relationship disappeared entirely in the context of other variables, the relevant variable was removed. All data was taken from the 2016/17 financial year, the last year in which all relevant data was available at CCG level at the time when this calculation was carried out.

It is important to note that the results of these models should not be interpreted as a definitive statement of how much health care spending is needed in Northern Ireland, or how much Northern Ireland would receive under the English formula. This is firstly because they are much cruder than the actual allocation formula, secondly because actual allocations do not correspond perfectly to what the formula suggests, and because CCG allocations did not at this time include general practice or specialised commissioning expenditure.

The model using Disability Living Allowance Rates also used:

- Jobseekers' Allowance rates
- Income Support rates
- Median house prices
- Female Healthy Life Expectancy
- The ratio of male to female inhabitants
- The proportion of female children aged 0–5
- The proportion of men over the age of 65
- The proportion of women over the age of 65

This model had an adjusted R-squared of 0.79. When applied to Northern Irish data, it predicted a spend of £2063, 29% higher than the weighted average CCG allocation in England per person, with a lower confidence interval of £1947 (22% higher) and an upper confidence interval of £2179 (36% higher). The upper and lower confidence intervals represent 95% certainty.

The model discounting Disability Living Allowance rates used:

- Jobseekers' Allowance rates
- Income Support rates
- Median house prices
- Male Healthy Life Expectancy
- Female Healthy Life Expectancy
- The proportion of female children aged 0–5
- The proportion of men over the age of 65
- The proportion of women over the age of 65

This model had an adjusted R-squared of 0.76. When applied to Northern Irish data, it predicted a spend of £1632, 2% higher than the weighted average CCG allocation in England per person, with a lower confidence interval of £1947 (22% higher) and an upper confidence interval of £2179 (36% higher).

These figures compare to real expenditure in Northern Ireland that was £2243 in 2016/17 as compared to £2137 in England (5% higher) and £2306 compared to £2168 the following year in England (6% higher). These figures are taken from HM Treasury's Country and Regional Analysis.

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**59 New Cavendish Street**
**London W1G 7LP**
**Telephone: 020 7631 8450**
**www.nuffieldtrust.org.uk**
**Email: info@nuffieldtrust.org.uk**

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