Fit for the Future

Summary of Responses to the Consultation
Department of Health and Social Services - March 1999

Contents

Foreword

The publication of this report fulfils a commitment made by the Department of Health and Social Services to produce a summary of the responses which it received to the Fit for the Future consultation paper, which invited views on the future of the health and personal social services in Northern Ireland. The report has been prepared following a careful examination of all the responses received during the consultation exercise. It attempts to summarise the comments and views offered on the extensive range of issues which were raised in the consultation paper. Every effort has been made to ensure that this is an objective summary of the responses, without any further interpretation, colouring or qualification by the Department.

Obviously it has not been possible to record every comment made by every respondent on every issue. What we have tried to do is reflect some of the recurring themes and important messages which came through in the responses. However, it is worth repeating that all the consultation responses to Fit for the Future have been read and considered carefully.

The Department would wish to take this opportunity formally to thank all those individuals and organisations who took the time and effort to submit responses to Fit for the Future. It is apparent that a great deal of work and careful thought went into making the submissions which have been received.

New Approaches Unit
Department of Health and Social Services

1. Introduction

1.1 On 30 April 1998 the Department of Health and Social Services (DHSS) published Fit for the Future, a consultation paper about the future of the health and personal social services (HPSS) in Northern Ireland. The paper set out the Government's vision for reforming and modernising the HPSS, identified the Government's view of the key changes required to achieve that vision and invited views on how those changes might best be implemented.

1.2 Over 15,000 copies of the full consultation paper and over 60,000 copies of a summary version were distributed to organisations and individuals across Northern Ireland and further afield. The bulk of these were sent out on the day of publication, but over 900 callers also used a special telephone helpline to get copies of the paper throughout the course of the five month consultation period, which ended on 30 September 1998. In order to make the document as accessible as possible, versions were made available in Chinese, in Braille, in large print and on audio cassette.

1.3 During the consultation period, officials from the Department were involved in more than 70 seminars, workshops and meetings across Northern Ireland to discuss with interested parties and individuals the issues arising from Fit for the Future. This included groups from within the HPSS, community and voluntary sector groups, patient and client representative groups and

district councils. In addition, the Department supported two outside bodies to facilitate discussion and consultation. The Institute of Health Services Management organised a series of workshops for HPSS staff and professionals at five locations across Northern Ireland and produced a comprehensive report of the comments made at those workshops. The Community Development and Health Network for Northern Ireland organised a consultation exercise for community and voluntary sector bodies in Northern Ireland and also provided a report of the views expressed.

1.4 Almost 250 responses have been received to Fit for the Future. The majority of these were from groups or organisations representing HPSS interests. Voluntary and community organisations and district councils also submitted a large number of responses. Very few responses were received from individual members of the public. A full list of those who responded to Fit for the Future, and who have no objection to their responses being made public, is at Annex 1. A copy of any response on this list may be obtained by contacting the New Approaches Unit helpline - telephone 01232 524752 - or by writing to:

The New Approaches Unit
Department of Health and Social Services
Room 121, Dundonald House
Upper Newtownards Road
Belfast, BT4 3SF.

1.5 The next chapter of this report highlights some of the recurring themes which featured in responses to the consultation. The subsequent chapters deal in more detail with what the responses said about the main issues raised in Fit for the Future. These chapters are organised to follow broadly the same order as the chapters in Fit for the Future. The final chapter of the report reflects comments made about the Department's handling of the consultation process.

1.6 Additional copies of this document, including a Chinese version, a British Sign Language video version and versions for people with a visual impairment, can be obtained by contacting the above address or telephone number. This document is also available on the Northern Ireland Civil Service (NICS) website at http://www.dhssni.gov.uk or on the HPSS intranet at http://hpssweb.n-i.nhs.uk

2. Overview of Responses

2.1 Together all the responses to Fit for the Future represent a comprehensive body of opinion about how the health and personal social services in Northern Ireland should be organised in the future. Predictably, the responses show that there is a very wide range of views on the matter. While there is broad agreement on some issues, particularly on the general principles and objectives for change set out in Fit for the Future, there is no clear consensus about taking forward many of the more practical issues, in particular matters regarding structures and organisations. This chapter of the report briefly highlights some of the recurring themes which emerged from the consultation exercise.

2.2 Many respondents commented on the prospect of devolution in Northern Ireland and suggested that final decisions about the future of the HPSS should rest with the new Northern Ireland Assembly. It was pointed out that the Assembly might wish to examine the overall structure of public services in Northern Ireland and that any changes to the structure of the HPSS should take account of such wider considerations.

2.3 There was a general endorsement of the principles underpinning the main aims and objectives of Fit for the Future. In particular, there was widespread support for:

* the abolition of the internal market and the introduction of arrangements which would promote partnership and co-operation between HPSS bodies;
* the maintenance and development of Northern Ireland's integrated system of health and social care;
* a new and stronger focus on quality issues in the HPSS;
* the move to more localised, team-based commissioning of health and personal social services, involving primary care professionals; and
* involving the public in shaping services and greater accountability to the public in planning, commissioning and providing services.

2.4 Many respondents commented on the excellence of our health and personal social services and the disruption to those services which could be caused by major organisational change. There was a view that any changes contemplated must bring demonstrable real benefits to the people who use the services and should not be undertaken simply for the sake of change. Many also argued that change should be taken forward one step at a time, in an open way, involving those concerned from the outset.

2.5 There were a number of more negative messages expressed about Fit for the Future, including the following:

* many people found Fit for the Future difficult to understand and to comment on. They felt that the language used was often too technical;
* many respondents felt that the consultation paper was heavily biased towards health care and dealt inadequately with social care;
* many respondents said that there was not enough information given about the proposed models to allow them to make a judgement; and
* the consultation paper was heavily criticised for failing to reflect the emphasis on community development which featured in Well Into 2000, which was published by the Department in December 1997.

2.6 The proposal that new arrangements for the commissioning of services should be centred around primary care was seen by many as a significant change for primary care professionals. It was argued that they would need proper training and development to be able to undertake the new roles expected of them effectively. Careful preparation would be needed to avoid any disruption of services to the public. Care would also be needed to ensure that any new arrangements for primary care-centred commissioning should take proper account of Northern Ireland's integrated health and social services.

3. The Government's Vision - The New HPSS

What Fit for the Future said

The new HPSS will keep the things which work, and discard those which do not. They will be built on seven key principles:

* Equity - a consistent standard of service for the whole of Northern Ireland, with equal access for equal need.
* Promoting health and well-being - including tackling inequalities.
* Quality - quality of care will be the driving force for decision-making.
* A local focus - services will be shaped by primary care professionals who know what patients and clients need.
* Partnership - the HPSS will work together with other organisations to improve health and well-

being.
* Efficiency - through performance management, and a drive to cut unnecessary bureaucracy.
* Openness and accountability - to local communities.

Achieving this vision means changing the way the HPSS are run. The internal market will be replaced by new arrangements based on co-operation rather than competition, and driven by quality and performance.

The Government has set the following targets for improving the HPSS:

* better and faster access to specialist cancer services;
* hospital waiting lists will be reduced by the end of the current Parliament; and
* better use of information and information technology.

What the Responses said

3.1 General Points

3.1.1 Most respondents commented on the chapter setting out the Government's vision for the HPSS. There was widespread support for the seven key principles underpinning the proposals for change and for the commitment to replace the internal market with new arrangements based on co-operation rather than competition. Many people strongly welcomed the commitment to keep the things which work, and discard those which do not.

3.1.2 A number of respondents suggested that the key principles needed to be developed further into operational objectives which would guide change. It was suggested that it was unclear how the proposals for new structures outlined in Fit for the Future were derived from these principles.

3.1.3 A number of respondents expressed the view that the vision, and indeed the rest of Fit for the Future, was heavily dominated by health care issues and largely ignored social care. One respondent suggested that the vision presented an illness model rather than an holistic health and well-being model.

3.1.4 There was considerable disappointment amongst many voluntary and community organisations about the absence of any specific reference to community development in the vision, and indeed throughout the consultation paper. Attention was drawn to the description under the heading A Local Focus, which was interpreted as being professionally driven and ignoring the role of local communities and community development in making a contribution to the planning and commissioning of services. The absence of any reference to community development was seen as inconsistent with two earlier policy documents published by the Department, Health and Well-being: Into the Next Millennium and Well Into 2000.

3.2. Specific Points

3.2.1 Some of the specific comments made on the Government's vision included the following.

The Seven Principles

* One respondent suggested that the seven principles should be supplemented by an additional principle covering human resources issues, reflecting the need to value and optimise the contribution of HPSS staff.
* Another respondent suggested the addition of a principle concerning the need to foster a

common identity and common sense of purpose within the HPSS.
* 'Best Value' was suggested as a possible additional principle.
* Several respondents representing social services interests suggested that, in addition to the existing seven principles, recognition should be given to the unique value base underpinning social care.
* A number of respondents highlighted the potential for tension between some of the seven principles. For example, the principle of 'equity' could be undermined by varying rates of progress in the development of new forms of primary care-centred commissioning which was implied by the principle 'a local focus'. There might also be tension between the principles of 'quality' and 'equity' in terms of accessibility to services.
* The lack of any specific reference to Targeting Social Need (TSN) was highlighted as inconsistent with the high profile given to TSN in Well into 2000.

Targets for Improvement of Services

* The targets for improvements in services were generally welcomed. In particular, there was very strong support for further investment in information and information technology, and in particular the development of a unique patient and client identifier, as a means of improving quality in the HPSS.
* However, a number of respondents considered that the targets were too narrowly focused and medically dominated, and should have included targets for community services and public health.
* One respondent commented that the emphasis on waiting lists was inappropriate and that more attention should have been paid to waiting times. It was also suggested that tackling hospital waiting lists should be part of a co-ordinated, continuing strategy rather than a series of individual initiatives.

4. The Need for Change

What Fit for the Future said

Things which will change include:

* more co-operation;
* ending unfairness;
* ending fragmentation;
* local commissioning;
* ending inefficiency;
* ending instability;
* ending secrecy; and
* reducing bureaucracy.

Things which will not change include:

* separate commissioning and providing functions;
* allocating resources on the basis of need;
* value for money;
* greater influence of primary care;
* integrated health and social services; and
* inter-sectoral co-operation.

What the Responses said

4.1. General Points

4.1.1 There was widespread comment on this chapter of Fit for the Future, with broad acceptance of the areas suggested for change and for retention. Many respondents welcomed the commitments to end the internal market, encourage greater co-operation between HPSS bodies, introduce greater stability in commissioning agreements and retain the split between commissioners and providers.

4.1.2 There was virtually unanimous endorsement of the retention of Northern Ireland's integrated system of health and social care. Some respondents felt that the consultation paper should have taken the opportunity to celebrate to a greater extent the benefits and successes of integrated services and to consider how integration could be enhanced further. The Department was cautioned against doing anything which might undermine integration.

4.1.3 In considering change, the Department was asked to take account of the need for the HPSS to work closely with the many organisations and interests outside the HPSS which have a role to play in promoting health and well-being, and to ensure that any organisational changes would support such multi-agency working through, for example, co-terminosity of administrative boundaries.

4.1.4 A recurring theme in the responses was that the HPSS has been subjected to change for many years and that a period of stability would be desirable. Any further changes to the structure of the HPSS should be based on a rigorous analysis of the costs and benefits of change compared with the current arrangements. Importantly, any changes should be assessed against their ability to provide demonstrable benefits to the health and well-being of the people of Northern Ireland and to secure improvements in the delivery of services. Some respondents suggested that, just as the Government's current policy is to promote clinical and social care practice based on evidence, there should also be research and evidence to back up proposals for organisational change.

4.1.5 The Department was reminded that structural change is only a means to an end. Changes should not undermine the continuity and development of services, and structural change should not be viewed as a solution to particular problems and pressures in the delivery of services.

4.1.6 Attention was drawn to the advent of a local Assembly and the need to examine any proposals for organisational change within the context of the Assembly's views on the wider governance of Northern Ireland and arrangements for the delivery of public services. Changes should not be made which might subsequently be undone by an Assembly.

4.1.7 A recurring theme from a number of respondents representing social work interests was that some of the arguments in favour of change failed to give proper consideration to the distinctive nature of social care. They argued that many of the problems associated with the HPSS described in Fit for the Future did not necessarily apply to social care, and many health care colleagues could usefully learn from the way social services currently operate in terms of partnership and co-operation with others.

4.1.8 There was a broad, though in many cases guarded, welcome for the proposal that in future all primary care professionals should play a more central role in the commissioning of services. Many respondents drew attention to some of the practical issues which would be associated with arrangements based on primary care-centred commissioning, for example with regard to the commissioning of statutory social care functions. These issues are covered in more detail in the next chapter of the report.

4.2. Specific Points

4.2.1 Some of the specific comments on this chapter of Fit for the Future included the following.

* One respondent commented that policy decisions had been taken to abolish the internal market and the GP Fundholding Scheme without any apparent analysis of the costs and benefits of these arrangements relative to the new options being proposed.
* It was suggested that the Government should commit itself to a programme showing how it would monitor the effectiveness of any proposed changes.
* There were concerns that putting primary care professionals in the lead on commissioning, with a single unified budget, would mean that rationing decisions were being pushed onto primary care professionals.
* Fears were expressed that, within a single unified budget, some services could lose out to the growing cost of drugs.
* A number of respondents suggested that arrangements for local commissioning should be genuinely inclusive of all primary care professionals and not dominated by General Practitioners (GPs).
* A number of interests representing General Practitioners argued strongly that any commissioning arrangements centred on primary care should involve real budgets.
* Change will need to be adequately resourced, otherwise the process will fail.
* Several respondents commented that the statement 'New primary care-centred local commissioning arrangements will give all professionals who make prescribing and referral decisions the opportunity to make financial decisions in the best interests of their patients and clients' seemed to restrict decisions on commissioning to a small group of primary care professionals.
* It was pointed out that significant organisational and professional development would be needed to prepare primary care professionals for their new role in commissioning.
* Any changes should produce more simplified structures, with clear lines of financial and statutory accountability.
* A number of respondents expressed scepticism that the savings in administrative costs of £25 million proposed in Fit for the Future could be achieved in the light of the models for change set out at chapters 6 and 7 of that document. It was pointed out that it was difficult to make an assessment of the prospects for savings in the absence of any detailed costings of the models.
* A number of professional representative bodies regretted that the role of secondary care clinicians in advising primary care professionals on appropriate referral and investigative patterns had been ignored in the proposals for primary care-centred commissioning.

5. Improving Quality

What Fit for the Future said

Quality will be at the heart of the new HPSS.

DHSS will consult separately on the development of a new quality framework to measure quality and performance throughout the HPSS.

DHSS will consider how new quality improvement measures to be introduced in the NHS in England should be applied in Northern Ireland, including:

* evidence-based Service Frameworks;
* the National Institute for Clinical Excellence;

* the Commission for Health Improvement; and
* a statutory duty for NHS Trusts to ensure quality of care through sound clinical governance arrangements.

DHSS will consider the need for similar arrangements in Northern Ireland to those which will be set out in a White Paper in England to ensure the quality of social care, including:

* the regulation of the social care workforce and training through the establishment of a General Social Care Council;
* arrangements for developing and maintaining the competence of the workforce; and
* the registration and inspection of day and domiciliary care.

The Northern Ireland Charter for Patients and Clients will be reviewed in conjunction with a similar review in Great Britain.

What the responses said

5.1 General Points

5.1.1 Just under half of all the responses received commented on the issues raised in relation to quality. Within this figure, however, virtually all the responses from HPSS interests had something to say.

5.1.2 There was almost universal support amongst those who commented for the emphasis placed on quality and the concept of clinical governance. The proposal that the Department would consult further on detailed proposals was also welcomed.

5.1.3 There was general consensus that quality should be central to any proposals for reforming and modernising the HPSS and should be a driving force for change. A number of respondents went further and indicated that quality improvements should be the main motivation for any changes to the structures and organisation of the HPSS and should precede any radical restructuring proposals. It was suggested by one respondent that major re-organisation was not at all necessary to deliver quality improvements. Others suggested that developing a new quality strategy should be the first stage of the programme emerging from Fit for the Future.

5.1.4 The links between quality and other issues raised in Fit for the Future were highlighted, in particular the need for a human resources strategy and new investment in Information Management and Technology (IM&T). Quality could only be improved if these issues were taken forward hand in hand.

5.1.5 In view of the fact that quality related issues will have the greatest impact on the way care is delivered to people, there was some disappointment at the failure of Fit for the Future to give even greater prominence to quality and at the decision to address the subject in detail only at a future date in further papers.

5.1.6 There was concern from some respondents that the chapter on quality concentrated too much on health and did not say enough about social care. It was pointed out that, although the proposals on quality being developed in England would be useful and influential, careful thought would have to be given to how best to apply those proposals to Northern Ireland to reflect our integrated service. This would mean more than simply bolting together the various changes being introduced in the NHS and social services in England.

5.1.7 Considerable disappointment was expressed by a number of respondents, particularly training and professional representative bodies, at the absence of any references to continuing and lifelong professional development and undergraduate and postgraduate education and training. These were considered essential to improving quality in the HPSS. Equally, the point was made that quality would depend on a robust research and development strategy. The Department was urged to rectify these omissions in its subsequent proposals on quality.

5.1.8 Many respondents highlighted the resource implications of putting in place a new quality strategy. Amongst other things, this would require significant investment in training and development and in IM&T.

5.2 Specific Points

5.2.1 The specific comments made on the issues raised in the chapter on quality included the following.

* A number of respondents suggested that a Minister for Public Health should be appointed in the New Assembly to oversee quality and ensure that all Government departments take account of the impact of their policies on health and well-being.
* It was suggested that any new arrangements for promoting quality should facilitate effective integration with cross-border and European agencies.

New Quality Measurement Framework

* There was a small number of responses on the proposals for a new framework for measuring quality in the NHS in England. Most respondents endorsed the six key themes listed.
* Some respondents advised that it would be important to concentrate on measures which genuinely focused on outcomes, and not on measuring things simply because they were measurable.
* A number of professional representative bodies highlighted the need for HPSS professionals to have a role in determining meaningful indicators of performance.

Clinical Governance

* It was suggested that a clear definition of 'clinical governance', as it applied to the HPSS, would be needed. The word 'clinical' is often perceived as synonymous with 'medical', and Northern Ireland may need a new definition to ensure that the concept covers all aspects of our integrated service.
* A number of respondents argued that clinical governance should apply to those providing primary care, as well as to Trusts.
* Several respondents suggested it would be necessary for the chief executives of any new primary care commissioning groups to have a statutory duty of quality imposed on them.
* The point was made that putting in place clinical governance arrangements and making them effective will be a long-term developmental process.

National Institute for Clinical Excellence/ Commission for Health Improvement

* Most respondents who commented on these new bodies were of the view that the HPSS should link into their work.
* There were different views as to how this should be done. Some suggested that Northern Ireland should have its own independent regional body which would link with the national bodies and tailor their work to the particular circumstances in Northern Ireland. However, it was generally felt that it would not be cost-effective for Northern Ireland to attempt to set up similar bodies to the National Institute for Clinical Excellence or the Commission for Health Improvement.

* Attention was drawn to existing work in the HPSS in relation to quality, such as the Clinical Resource Efficiency Support Team (CREST) and multiprofessional audit. The Department was urged to build on this.
* Some respondents suggested that local consumer interests should be represented on any body set up in Northern Ireland to have responsibility for quality.

Social Care White Paper

* There was a general welcome for the proposal to regulate social work and the social care workforce and training through the establishment of a General Social Care Council.
* Charter for Patients and Clients.
* It was suggested that, in reviewing the Northern Ireland Charter for Patients and Clients, attention should be paid to the responsibilities of patients and clients as to well as those of HPSS bodies.

6. New Arrangements - An Overview

What Fit for the Future said

Strategic planning

The Government wishes any new arrangements to have a much stronger strategic planning focus, so that the strategic changes signalled in 'Well into 2000' can be delivered effectively.

Primary care-centred local commissioning

The lead role in commissioning will move from Health and Social Services Boards to new, local, primary care-centred commissioning arrangements which should:

* offer all GPs and other primary care professionals an opportunity to participate;
* cover all health and social services;
* be based on areas or populations which are small enough to be 'local' but large enough for efficient and effective commissioning;
* not add to bureaucracy;
* be based on a single budget covering all types of care and treatment; and
* involve partnership with other organisations whose work impacts on health and well-being.

The new local commissioning arrangements will replace the GP Fundholding Scheme, which will end on 1 April 2000.

Provider organisations

The Government intends to re-examine the number and configuration of provider organisations with the aim of producing a more effective and efficient configuration.

What the responses said

6.1 General points

6.1.1. Many respondents supported the overall aims set out in chapter 5 of Fit for the Future, but there was little consensus on how they might be achieved. There were also a number of concerns about the practicalities of some of the proposed changes, with many suggestions about key features and safeguards which would need to be built in.

6.1.2 A recurring message was that decisions about new structures for the HPSS should be taken by the Northern Ireland Assembly.

6.1.3 There was considerable concern from many respondents that Fit for the Future had been based on policies developed for health services in England, and said very little about social services. In particular, it was argued that the proposals did not adequately address issues such as the safe, effective delivery of the broad range of statutory social services functions.

6.1.4 A number of respondents said that the case for some of the changes proposed in Fit for the Future had not been proven, particularly the proposals for changes to organisations and structures. Responses pointed to:

* the lack of detailed information about possible new arrangements;
* the absence of figures on the running costs of new arrangements and the costs of the changeover;
* the absence of any detailed analysis of the strengths and weaknesses of the current arrangements, or comparisons with what was proposed; and
* the lack of information on the improvements in services for patients and clients which the changes are supposed to bring about.

Strategic planning

6.1.5 Many respondents said that more effective strategic planning arrangements are needed for the HPSS, with a single, strong, Northern Ireland-wide organisation responsible for strategic planning, accountable to the Northern Ireland Assembly. There was no consensus on whether such an organisation should be part of the DHSS, or separate from it, although there were more responses in favour of a separate body, staffed mainly by HPSS professionals and managers rather than by civil servants.

6.1.6 Some respondents expressed concern that a single regional body would not be sensitive to the needs of rural parts of Northern Ireland. It was argued by some that any new strategic planning arrangements would need to have input from local communities and local HPSS organisations.

Local commissioning

6.1.7 There were more responses made about local commissioning than about any other issue raised in Fit for the Future. There was strong support for the proposal to develop new local commissioning arrangements, but a very broad range of views on what the new arrangements should look like, and some significant concerns expressed.

6.1.8 Responses from GPs and organisations representing them tended to suggest that local commissioning arrangements should be based on the building block of GP practices or groups of practices, and involve GPs, community nurses, social care professionals and other professionals where appropriate. Some GP responses suggested that there should also be local community representation. Many of these responses said that any new arrangements should be professionally led, with GPs reserving the right to have the controlling influence. GPs tended to argue that local commissioning organisations should hold their own budgets for commissioning services.

6.1.9 Responses from other professions, for example nursing, social work and professions allied to medicine, and HPSS organisations stressed the need for a partnership approach involving all primary care professionals. These responses tended to suggest that the various professionals involved should have equal rights or 'parity of esteem', with no single professional group having an automatic controlling majority. They put more emphasis on the need for community involvement than those from GPs, and tended to suggest that new arrangements should be based on communities or natural populations rather than GP practices.

6.1.10 Many responses from district councils and community and voluntary sector organisations expressed concern about professionally-led commissioning organisations, and stressed the need for arrangements based on equal partnership involving: the full range of primary care professionals; partner organisations in the statutory, community and voluntary sectors; local community representatives; and local elected representatives.

6.1.11 The prospect of local commissioning did raise some concerns. Some respondents described local commissioning as a 'medical model' imported from England, which may not be suitable for integrated health and social services in Northern Ireland. Others said that some particular services should not be part of local commissioning arrangements, including: statutory social services functions; mental health services; learning disability services; and family and child care services. A number of voluntary sector organisations said they were concerned that the services which they provide would not be given a high priority by local commissioners.

6.1.12 A number of respondents warned that local commissioning could increase costs, bureaucracy and fragmentation within the HPSS because of the larger number of bodies which would be involved. A large number of local commissioners could militate against strategic planning. Some respondents questioned whether GPs would have the necessary skills to take on responsibility for commissioning the full range of HPSS services, or indeed whether they would wish to do so given their extensive responsibilities for delivering services. Many respondents said that a great deal of training and support would be required for people involved in local commissioning to equip them to perform this role effectively.

6.1.13 Attention was drawn to the potential problems associated with allocating resources to local commissioning groups. The robustness of the method used to allocate resources tends to decrease as the size of the population covered by the commissioning organisation reduces.

Provision of services

6.1.14 Many respondents said that there are too many provider organisations in Northern Ireland, but there was no consensus on how they might be re-organised. Most respondents supported the idea of integrated health and social services, but there was no clear consensus on whether provider organisations should deliver hospital and community care services, or whether providers should deliver either hospital or community services only. Strong arguments were presented in support of both combined and separate providers. Those supporting combined providers pointed to the benefits they offered in terms of achieving better integration of care. Those supporting separate providers pointed out that combining the two types of services, particularly in the case of a large acute trust, would result in too broad a span of control and a loss of management focus.

6.2 Specific points

6.2.1 The following are examples of specific points made in responses.

* A number of respondents said that Health Improvement Programmes (see Glossary) are a key element in replacing the internal market with a partnership approach elsewhere in the United

Kingdom, and should be introduced in Northern Ireland.
* The Department was reminded of the importance of ensuring that any new arrangements would have access to the skills and expertise to enable public health functions to be carried out effectively both locally and regionally.
* Many respondents said that it was difficult to comment on the new arrangements, because Fit for the Future did not contain enough information about the roles and responsibilities of the various organisations which currently exist, or any evaluation of the strengths and weaknesses of the current arrangements.
* Questions were raised about whether the DHSS and the HSS Executive should be responsible for considering issues in relation to Fit for the Future because they are included in the scope of the review.
* Many respondents said that there should have been more information provided in Fit for the Future on where and how savings could be made.
* Some respondents said that the new arrangements would need to be sensitive to the needs of ethnic minorities and marginalised groups in society, and that there is a need for cultural awareness and anti-racist training for all HPSS staff.
* Many respondents emphasised the importance of education, training and research, and expressed disappointment that Fit for the Future did not make it clear how they would be commissioned and provided in the future.
* Some respondents said that local commissioning has a number of potential limitations including:
- a lack of expertise in needs assessment and commissioning among primary care professionals;
- the risk of neglect of services such as those for mentally ill or elderly people;
- the potential threat to specialised services; and
- difficulty in bringing about strategic change.
* Responses from social care professionals expressed particular concerns about local commissioning. For example, the following points were made:
- New organisational arrangements should not impose structures on social care functions which are essentially designed for health care functions. Social care works closely with primary care, but is distinct from it. Social care must avoid being shoe-horned into a GP-led model based on principles which have been developed to address health service concerns.
- It is difficult to visualise how, for example, child protection services, taking account of the close collaboration which is required with police and other agencies, can either be commissioned or delivered by a primary care framework. For this reason the proposal to incorporate funding for social care within a unitary budget held by primary care commissioners does not make sense.
* Attention was drawn to the complex range of statutory functions discharged by social care professionals. New arrangements must have safe, appropriate accountability arrangements for the discharge of these functions.
* Some respondents said that local commissioning could mean that the inequalities of fundholding would continue because of the possibility of different rates of development in local commissioning arrangements.
* A small number of responses from GPs said that some or all social services should not come within local commissioning arrangements.
* Many respondents - especially from community and voluntary sector organisations - said that any new arrangements should involve elected representatives, community and voluntary sector representatives, and representatives of patients, clients and carers in equal partnership with HPSS professionals.
* Some secondary care professionals supported primary care-centred commissioning arrangements, but said that there should be input from secondary care so that commissioning organisations would be aware of what would be feasible/best for patient care in secondary care settings.
* A number of respondents highlighted the need for clear accountability arrangements for primary care-centred commissioning arrangements. It was pointed out that the independent contractor status of some primary care professionals would make this issue complicated.
* A number of GPs or organisations representing them said that funding for General Medical Services should not be part of a unified budget, or should be ring-fenced within it.

* There was concern that unified budgets could mean that hospital services would dominate at the expense of social services.
* Many people pointed out that local commissioning would mean a lot of extra work for primary care professionals, and that they should be appropriately paid for their time and effort.
* Some respondents said that local commissioning arrangements should be piloted before being implemented fully, or that changes should be evolutionary. Other respondents said that new arrangements should be put in place as soon as possible to end the uncertainty which is damaging staff morale.
* Any reconfiguration of provider organisations should ensure consolidation in line with natural local communities.
* It was pointed out that some of the primary care professionals who would be involved in local commissioning arrangements might be employees of the organisations from which services were being commissioned. There may therefore be conflicts of interest.

7. Options for New Arrangements - Models A and B

What Fit for the Future said - Models A and B

Model A

Health and Social Services Boards would have a more strategic role, including the lead responsibility for improving overall health and well-being and reducing inequalities. The number and configuration of Boards would be kept under review.

Local commissioning would be carried out by Primary Care Groups in which the full range of primary care professionals could be involved. Primary Care Groups could serve populations of typically between 50,000 and 100,000. Primary Care Groups could move along a continuum of development, eventually combining with community Trusts to form Primary Care Trusts.

The number and configuration of Trusts would be reviewed.

The Government would welcome views on Model A generally, and on the following issues in particular:

* Scale of Primary Case Groups - what size of population should be served by Primary Care Groups?

* Form of Primary Care Groups - what form should Primary Care Groups take, and should they be expected to progress along the continuum of options described in the consultation paper?

Model B

The main elements would be Local Care Agencies, consisting of Primary Care Partnerships and providers.

Local Care Agencies would replace Health and Social Services Boards and some or all Health and Social Services Trusts. They would have two operational elements - Primary Care Partnerships and provider bodies, which would be part of - and accountable to - the Local Care Agency. There would be 6 to 8 Local Care Agencies with populations of 200,000 to 300,000.

Primary Care Partnerships would serve populations of 25,000 to 50,000. They should eventually evolve to the stage where they are commissioning most health and social services.

The configuration of providers could be streamlined, for example:

* one integrated provider for each Local Care Agency;
* one community provider for each Local Care Agency with a small number of separate acute hospital providers; and
* a mixture of integrated providers, community-only providers, and hospital-only providers, some of which could remain separate from Local Care Agencies.

Under model B, certain functions would best be carried out at a regional level, including:

* regional strategic planning;
* specialist commissioning;
* functions which need to be carried out independently of local commissioning;
* promoting regional quality standards and bench-marking, including registration and inspection; and
* holding Local Care Agencies and providers to account for their performance.

It is suggested that these functions would best be discharged by a single regional organisation. There would be a strong case for such an organisation to be combined with the HSS Executive to form a single organisation, operating within the DHSS.

The Government would welcome views on model B, and in particular on:

* the appropriate population coverage of Local Care Agencies and Primary Care Partnerships;
* the possible configuration of provider bodies;
* relationships between Local Care Agencies and their constituent Primary Care Partnerships and povider bodies;
* the nature, role, functions and configuration of future regional arrangements for the HPSS under model B and, in particular, the establishment of a single regional organisation which would operate within the DHSS; and
* the services which should be commissioned regionally.

What the Responses said

7.1 General points

Both models

7.1.1 Many respondents commented in detail on structures and organisations, particularly those from HPSS organisations and professionals. However, community and voluntary sector organisations and district councils tended to say less about numbers or types of organisations, but more about how they should be run, who they should be accountable to and what services they should provide.

7.1.2 There was no consensus on the overall type of new arrangements which should be introduced for the HPSS, and certainly no clear preference for either of the two models suggested in Fit for the Future - models A and B. Many respondents tended to concentrate on part of a model, and say little about the remainder. This was especially true of model B.

7.1.3 A particular problem for many respondents was that there was not enough information provided about the proposed models and the current arrangements to enable a choice to be made. In particular, many respondents said that a choice could not be made without detailed information comparing the costs of the proposed models and the current arrangements.

7.1.4 Many respondents said that the models were too theoretical, and that a choice of new arrangements should be based on hard evidence of what works and what does not work.

7.1.5 As well as commenting on the models set out in Fit for the Future, a number of respondents described alternative models in some detail.

Model A - general

7.1.6 Support for model A was strongest amongst GPs and organisations representing them, and weakest amongst community and voluntary sector organisations. The reasons given for supporting model A included:

* it is centred on primary care and patients and clients;
* it would meet the objectives for change set out in Fit for the Future;
* it would allow for evolutionary change and permit Primary Care Groups to find their own most appropriate level of operation;
* there would be less disruption to services than under the more radical model B;
* the arrangements would be similar to those in Great Britain and this would allow comparisons to be made; and
* there would be a clear separation between commissioning and provision.

7.1.7 Criticisms of model A included:

* it is a 'professional' model which deals with treating illness and providing care, rather than a 'social' model which recognises the wider factors affecting health and well-being;
* it is based on English proposals for health services only and will not work for Northern Ireland's integrated health and personal social services;
* there would be more bureaucracy than under model B, with the potential for a large number of separate commissioning bodies;
* there would be too little scope for community or user involvement;
* setting up Primary Care Groups/Trusts would increase bureaucracy and weaken the commissioner/provider split;
* there would be duplication between the roles of Boards and Primary Care Groups/Trusts; and
* it failed adequately to address the need for changes to structures at a regional level.

7.1.8 A number of changes to model A were suggested. The change most often suggested was that the number of Health and Social Services Boards should be reduced to 3, 2, or 1, either immediately, or after Primary Care Groups were up and running. Other suggested changes included forming Primary Care Groups around existing community trusts.

Model A - scale of Primary Care Groups

7.1.9 The sizes of population coverage suggested for Primary Care Groups ranged from as small as 25,000 to as large as 200,000, but with the largest number of responses in the range 50,000 to 100,000. Many respondents said that Primary Care Groups should be based on natural local communities, and that there should be flexibility of size to take account of differences between urban and rural areas.

7.1.10 The reasons given in favour of smaller groupings included:

* they would be more sensitive to local need;
* they would be easier to set up and keep together - larger groups would tend to break up;
* there would be better working relationships among the professionals involved;
* there could be evolutionary development - smaller groups could merge to form larger groups as they gained in experience; and
* there is evidence from Total Purchasing Pilots (see Glossary) that smaller groups are more effective than larger groups.

7.1.11 The reasons given in favour of larger groupings included:

* there would be less bureaucracy than with smaller groups because there would be fewer of them;
* larger groups would be more coterminous with key partner organisations;
* larger groups would be more effective in bringing about strategic change;
* capitation-based budgets would be more robust for larger groups; and
* there is evidence from multi-funds (see Glossary) that larger groups are more effective than smaller groups.

Model A - form of Primary Care Groups

7.1.12 Most respondents who supported model A said that there should be flexibility over the form of Primary Care Groups so that they could start at the point on the scale of development which suited them best, depending on the experience and expertise of the professionals involved. Most respondents also said that Primary Care Groups should be able to evolve along the scale of development as far as they wanted. However, a number of respondents suggested that the Groups should not be permitted to develop into free-standing Primary Care Trusts, as this would increase bureaucracy.

Model B - general

7.1.13 Support for model B was strongest amongst community and voluntary sector organisations and weakest amongst GPs. The reasons given for supporting model B included:

* it would reduce bureaucracy more than model A;
* the arrangements at regional level would be stronger than under model A, especially in relation to strategic planning and the commissioning of specialised services; and
* there would be more opportunities for community involvement and partnership.

7.1.14 Criticisms of model B included:

* it would involve revolutionary change, with too much disruption of services;
* the 4 Health and Social Services Boards would be replaced with 6 to 8 similar bodies (Local Care Agencies);
* there would be a return to the pre-1991 'command and control' arrangements, which stifled innovation and decision making at local level;
* Local Care Agencies would be dominated by providers, especially acute providers;
* the model is not centred on primary care or patients and clients;
* the benefits of having fewer organisations overall may be outweighed by the fact that the new organisations would be much more complex and difficult to manage; and
* the model would fudge the distinction between commissioning and providing.

7.1.15 Some respondents suggested variations to model B, such as replacing the regional body with a regional forum comprising DHSS and representatives of Local Care Agencies.

Model B - scale of Local Care Agencies and Primary Care Partnerships

7.1.16 As with model A, there was little consensus on the best population sizes for new arrangements. The sizes suggested for Local Care Agencies ranged from 200,000 to 500,000, and the sizes suggested for Primary Care Partnerships ranged from 25,000 to 300,000. However, most responses suggested sizes within the range 200,000 to 300,000 for Local Care Agencies, and 50,000 to 100,000 for Primary Care Partnerships. The arguments in favour of larger or smaller groups were similar to those described above for model A.

Model B - configuration of provider bodies

7.1.17 Many respondents said that there should be fewer provider organisations in Northern Ireland. However, there was no consensus on the best configuration for provider organisations. Many respondents argued for organisations providing both acute and community services. Reasons given in support of integrated providers included:

* there would be less bureaucracy;
* it would be easier to deliver seamless, integrated health and social services, especially for people with complex needs; and
* separate acute and community providers would fragment some services, for example speech and language services, and mental health services.

7.1.18 The arguments against integrated acute and community providers tended to centre on fears that acute services would dominate at the expense of community services. There was also concern that combined acute and community providers would require too broad a spread of responsibilities for management.

7.1.19 There was no consensus on whether some or all providers should be part of Local Care Agencies or separate from them.

7.1.20 A number of respondents suggested that the five Health and Social Services Agencies (see Glossary) should be brought together into a single body. However, other responses - notably from the Agencies themselves - said that, given the diversity of their roles and functions, there was no valid reason for doing this, and that the Agencies should remain as they are.

Model B - relationships between Local Care Agencies and their constituent Primary Care Partnerships and Provider bodies

7.1.21 Few respondents addressed this issue in any detail. Amongst those who did comment, there was a view that Primary Care Partnerships should be strongly represented on the boards of Local Care Agencies. Some people commented that the complexity of Local Care Agencies was such that the relationships between the various types of bodies within the models were very unclear.

Model B - regional arrangements

7.1.22 There was general agreement with the list of functions which Fit for the Future suggested should be carried out at regional level. Many respondents supported the suggestion for a single regional organisation to carry out these functions, but there was no consensus as to whether such a body should be part of the DHSS, or separate from it. Some respondents disagreed with

the suggestion for a regional body. They tended to suggest that any functions which could not be carried out by the DHSS should be carried out by consortia of local commissioning bodies acting together.

7.2. Specific points

7.2.1 Specific comments made about the models included the following.

* Fit For the Future made the mistake of putting 'form before function', concentrating on structures before it had developed a clear picture of the functions to be carried out at each level.
* A number of respondents commented that the statement made under model A that 'the number of Health and Social Services Boards would be kept under review' would perpetuate uncertainty and concern, and suggested that some key decisions were simply being put off.
* It was argued by some that the configuration of providers should match the configuration of services needed by local communities.
* Concern was expressed about the use of capitation formulae to allocate resources to organisations serving small populations, stating that the degree of confidence falls and the financial risk rises as the size of the population covered falls.
* Some social care professionals and HPSS organisations said that populations of 50,000 to 100,000 were too small for effective commissioning of social services.
* Some respondents said that the independent contractor status of GPs would make accountability complex under either model.
* Attention was drawn to the decision in England to give GPs the right to be in charge of local commissioning arrangements, and to the risk that local commissioning arrangements in Northern Ireland would be similarly dominated by doctors.
* It was argued by some that the building blocks for the new arrangements should be self-forming and not created artificially, because arrangements are much more likely to be successful if they are based on groups of primary care professionals with shared views and objectives who come together voluntarily.
* There were some additional suggestions for the types of services which should be commissioned regionally, including: neonatal intensive care; psychiatric services; learning disability services; specialist cancer services, neurosurgery; nephrology; and some laboratory services.
* Some GPs were concerned that their independent contractor status was under threat, and that some of the proposals in Fit for the Future represented the first step towards a salaried GP service.
* GPs tended to stress the need for Primary Care Groups or Primary Care Partnerships to have control of resources and to be accountable for their use, but also emphasised the need for risk sharing or risk management arrangements to cope with overspends.
* Many respondents said that in any local commissioning arrangements, proper management and administration arrangements would be required, and that this may make it difficult or impossible to reduce administrative costs.
* It was pointed out that the term 'primary care' is often used as if it means primary health care only. The general understanding of primary care does not encompass significant and distinctive aspects of social care, for example: empowering individuals and communities; addressing social exclusion; protecting the most vulnerable in society; working with neighbourhoods and communities to strengthen health and well-being; and working with other agencies.

8. Accountability

What Fit for the Future said

The Government would welcome views on:

* how the membership of HPSS organisations can be made representative of local communities, for example, by including elected representatives and representatives of community organisations;
* the type of arrangements needed to ensure independent oversight of the new HPSS;
* how the public can be empowered to engage effectively with commissioners and providers in the planning, delivery and evaluation of services;
* how the perspective of patients and clients can be harnessed to influence policy and service development positively in the future; and
* the scope and frequency of surveys of patient, client and carer experiences to give them a voice in shaping the HPSS.

What the Responses said

8.1 General Points

8.1.1 About half of all the responses received commented on the subject of accountability. Responses from those representing community and voluntary sector organisations commented on this issue in particular detail. The five specific questions asked in the document received different numbers of responses. Most of those who commented on the subject dealt with how the membership of the boards of HPSS organisations might be made more representative and how the views of the public, patients and clients could be obtained. There were fewer responses about arrangements for independent oversight of the HPSS, and there were very few comments about the subject of surveys.

8.1.2 Some issues generated broad agreement across all responses, whilst there were differing views on others. For example, most people strongly welcomed the overall aim of making the HPSS more accountable to the public. There was very strong support for involving elected representatives on the boards of HPSS bodies. There was also considerable support for having community and voluntary sector representatives directly involved in HPSS bodies. However, there was less agreement on the specific types of arrangements needed to oversee the HPSS, or on surveys of patients' and clients' views.

8.1.3 There were differences between the views of different groups of stakeholders. For example, many community and voluntary sector organisations thought that making the HPSS more accountable to local communities was just as important, if not more important, than questions about the numbers or types of organisations. Community and voluntary sector organisations tended to stress the importance of involving elected representatives and community representatives directly in running HPSS bodies. In contrast, organisations representing GPs tended to emphasise the accountability of GPs to their patients rather than to elected or community representatives.

8.1.4 A number of respondents commented that the creation of a devolved Assembly, with full executive and legislative responsibility for HPSS matters, would change the whole environment within which issues of accountability should be considered. For the first time in many years, locally elected politicians will be responsible for HPSS policy and legislation, and it was pointed out that this will considerably enhance the public accountability of services.

8.2 Specific Points

8.2.1 The specific comments made in response to the questions posed in Fit for the Future included the following.

Making HPSS Organisations More Representative

* Many respondents said that the HPSS should be accountable to the new Northern Ireland Assembly, with the Assembly's Health and Social Services Committee playing an important role, or to the Civic Forum. While some people said that this would be enough, many more responses stressed the need for local accountability as well.
* Most of those who commented on the subject said that locally elected representatives, community and voluntary representatives and representatives of patients, clients and carers should be included on the boards of HPSS organisations. Most people were not specific about whether this meant all HPSS organisations, or just some. One respondent suggested that elected and community representatives should be members of commissioning organisations only, and not provider organisations.
* Some respondents said that women and people from ethnic minority groups are under-represented on public bodies and suggested that special efforts should be made to support and encourage their participation on HPSS bodies. In this regard, one response said that, as women are under-represented in local government in Northern Ireland, care would be needed in suggesting that district councillors should be members of HPSS organisations.
* Many people said that elected representatives, community and voluntary sector representatives and patients', clients' and carers' representatives who are members of boards of HPSS bodies should have the same status and rights on those boards as professional members.
* The point was made that the ability of elected and community representatives to play an effective part on the boards of HPSS organisations would be significantly enhanced if they had:
- access to good quality information about the HPSS;
- relevant training; and
- practical support to allow them to take part in board meetings through, for example, help with childminding costs, transport or help with transport costs, interpreting services for people whose first language is not English, and ensuring that meetings are held at convenient times.
* There was some debate over whether elected representatives on the boards of HPSS bodies should be drawn both from the Northern Ireland Assembly and from District Councils, or whether they should be drawn only from one or the other. One respondent pointed out the potential tension which might arise if the HPSS, which will be accountable to the Northern Ireland Assembly, also had Assembly members on boards.
* A small number of responses challenged the statement made in Fit for the Future that 'primary care staff know what patients and clients need'. They commented that organisations led by primary care professionals would not necessarily be accountable to local communities.
* Several respondents pointed to the work of District Partnership arrangements in the EU Special Programme for Promoting Peace and Reconciliation, and suggested this as a useful model for making the boards of HPSS bodies more representative of local communities.

Arrangements to ensure independent oversight

8.2.2 There were relatively few responses on this subject and certainly little consensus. The main comments were as follows.

* There were mixed views about the effectiveness of Health and Social Services Councils. Some felt that they were doing an excellent job, whilst others questioned whether they had the power to effect any real change.
* A number of respondents suggested that a new single, strong, statutory body should be created to oversee the work of the HPSS representing all the people of Northern Ireland. Such a body might be supplemented by more local organisations in different parts of Northern Ireland.
* Differing views were expressed about the membership of Health and Social Services Councils or any bodies which might replace them. Some respondents said that these bodies should include elected representatives, community and voluntary representatives and representatives of patients, clients and carers. Others said that they should include consumer representatives only.
* One respondent pointed out the potential tensions which might arise among elected

representatives if they were members of Health and Social Services Councils on the one hand, and members of the boards of HPSS bodies on the other. This could result in one group of elected representatives holding another group of elected representatives to account.
* Some respondents said that having elected representatives and community representatives as members of the boards of HPSS organisations would provide sufficient oversight, and that no other arrangements would be needed. Indeed some suggested that sufficient independent oversight could be provided by the Northern Ireland Assembly, the Assembly's Health and Social Services Committee or the Civic Forum.

How the public can be empowered/how the perspective of patients and clients can be harnessed

8.2.3 Most responses took these issues together.

* Many people pointed out that the key to involving the general public and patients and clients in the HPSS is to make sure that there is better access to high quality, easy to understand information about services and proposals for changes to services. Some suggested that the information currently provided is often incomplete, or difficult to understand because of the technical nature of the language used.
* Many respondents pointed to the good work already being carried out by Health and Social Services Boards, Health and Social Services Trusts and other HPSS bodies and professionals in involving the public, and said that this should be built on. There were a number of suggestions for how this might be done, including:
- user panels;
- focus groups;
- public workshops;
- public meetings;
- citizens' panels or juries; and
- neighbourhood planning meetings run by community development groups and local churches.
* A number of barriers to involving the public were identified, including:
- a lack of publicity about ways of getting involved;
- public apathy;
- a feeling that decisions have already been made, and that the public's input will be ignored;
- the use of technical or expert language which is difficult to understand;
- the timing of meetings, which makes it difficult for some people to attend; and
- a lack of full information.
* The suggestion was made that more research needed to be done to establish what is effective in involving the public, and that staff working in the HPSS need specific training in how to involve the public and empower patients and clients.
* Many responses said that the key to involving the public is to ensure that all HPSS organisations adopt the principles of community development.

The Scope and Frequency of Surveys

8.2.4 There was very little comment on the subject of surveys. Of those who offered a view, most supported the suggestion for regular surveys of patients' and clients' views, provided that these views would be noted and acted upon. Some of the comments made were as follows:

* Some respondents pointed out that having surveys every year would be expensive and time consuming.
* There should be a rolling programme of surveys looking at different issues from year to year, permitting a picture to be built up over time of different issues affecting the public.
* If surveys are carried out, the results should be analysed and published quickly so that there is no time lag.

* The NHS is proposing to conduct surveys of patients and clients in Great Britain. Some people said that surveys in Northern Ireland should be carried out in the same way as surveys in the rest of the United Kingdom so that proper comparisons could be made and Northern Ireland could benchmark its performance against the best of the rest.
* It was suggested that any surveys should be carried out by an independent body.

9. The Management of Change

What Fit for the Future said

The process of change must be properly managed. This means:

* involving staff from across the HPSS;
* fostering an atmosphere of openness and honesty;
* communicating clearly with staff throughout the process;
* evaluating the costs and benefits of proposed changes, not only in financial terms, but in terms of their effect on patients and clients and staff; and
* piloting change where feasible or phasing its implementation.

A human resources strategy must be developed to support the change process, covering:

* slotting in arrangements;
* competition for senior posts;
* re-deployment within the organisation/within the HPSS;
* protection of pay and terms and conditions of service;
* redundancy arrangements;
* appeals;
* mergers - variations in terms and conditions; and
* PAFT implications.

The Government would welcome views on the management of the process of implementing new arrangements, including a human resources strategy.

What the Responses said

9.1 General Points

9.1.1 Just under half of those who responded to Fit for the Future commented on this issue. Within that, virtually all HPSS bodies, professional representative organisations and trade unions offered comments.

9.1.2 There was widespread welcome for the inclusion of a chapter on the management of change in Fit for the Future and for the guiding principles to which the Government has committed itself in dealing with the human resource implications of change. It was widely acknowledged that an effective human resources strategy will be a vital component of any change process and should be put in place at an early stage.

9.1.3 Almost everyone who commented on this subject emphasised the need for careful and sensitive management of the change process to reflect the needs and concerns of staff. Open communication and consultation with staff in deciding, planning and implementing change would be of the utmost importance. Many pleas were made for realistic timescales for change. While a

small number of respondents indicated that change should be decided and acted on quickly, the more general view was that change should be evolutionary, with appropriate lead times to ensure proper preparation and smooth implementation of change to minimise disruption to patients and clients and to staff.

9.2 Specific Points

9.2.1 Some of the specific comments made in relation to the management of change included the following.

* One respondent, commenting on the references in Fit for the Future to Policy Appraisal and Fair Treatment (PAFT), said that PAFT should not merely be 'kept in mind' as stated in the paper, but should be central to any human resources strategy which includes equality and equity in its guiding principles.
* It was suggested that Staff Councils, which already exist in many Trusts, should play an important part in the change process.
* The Department was urged to use the specialist expertise in human resource management which exists at Board and Trust levels in the HPSS in preparing a human resource strategy.
* Managing a change process will absorb enormous amounts of management time and will require significant investment to achieve successfully.
* Several respondents argued for the creation of an independent Staff Commission for the HPSS to deal with any staff transfers or restructuring issues.
* It was suggested that the Central Services Agency's Redeployment Unit should be reactivated to assist in the management of staff movements. It was also suggested that a Clearing House mechanism should be established in Northern Ireland, as in England, to assist the redeployment of staff who may be made redundant by the abolition of the GP Fundholding Scheme.
* If it is decided to change structures and organisations, the reasons for and benefits of change should be clearly and carefully explained to staff in the HPSS.

10. The Consultation Process

10.1 This chapter summarises a number of comments which respondents made on the process of consultation adopted by the Department. It is important that the Department learns from such exercises in order to improve future performance in this area.

10.2 Many respondents welcomed the fact that they were offered an opportunity to give their views on how the HPSS should be developed in Northern Ireland. However, whilst recognising the importance and complexity of the issues involved, a large number were unhappy that they were not in a position to make an informed assessment of and comment on the key issues because of the presentation of the paper. Particular difficulties included:

* the difficult and technical language used in the paper, aggravated by the absence of a glossary of terms in the summary version;
* the lack of detailed information in the paper about existing HPSS structures and arrangements, against which to measure the proposed changes;
* the lack of detailed supporting information about future organisational arrangements; and
* the absence of any diagrams or charts showing how the proposed arrangements might operate.

10.3 It was pointed out that a consultation exercise which straddled the summer months was not the best time of the year to encourage the widest possible response.

10.4 A number of special versions of the paper were produced, and this was welcomed by the groups at which they were directed. However, it was pointed out that efforts could have been made to make the document more accessible to other groups, such as people with learning disabilities.

10.5 Some people felt that the Department did not invest enough effort in bringing the consultation exercise to the general public or to people with special needs through a structured programme of seminars, workshops and face-to-face meetings across Northern Ireland. Some thought that the messages in Fit for the Future could have been spread more widely through television, radio, newspaper articles and public meetings. When undertaking future similar exercises, the Department was encouraged to prepare a detailed communications strategy with stakeholders, designed to ensure that the publication has the best chance of reaching its target audience.

10.6 The summary of Fit for the Future prepared by the Ulster People's College was commended by a number of community groups as very helpful in enhancing their understanding of the issues.

10.7 Finally, a number of respondents suggested that it would be helpful to have a second stage consultation process, once proposals on key issues have been further developed and can be explained in more detail with supporting financial and organisational information.

Glossary

Acute services - health care and treatment provided mainly in hospitals.
Acute Trusts - Health and Social Services Trusts which provide acute hospital care only.
Benchmarking - a process whereby organisations identify the best performers in particular areas and measure themselves against the best, with a view to securing improvements in their own performance.
Cash limit - the amount of money the Government proposes to spend or authorise on certain services or groups of services.
Central Health Index - a list of all patients registered with a GP in Northern Ireland.
Clinical governance - the organisation of services in line with set standards together with the minimisation and appropriate handling of adverse events.
Commission for Health Improvement - a new body proposed by the Government to oversee the quality of clinical governance and of clinical services.
Commissioning - the process of identifying local health and social care needs, drawing up plans to meet those needs, making agreements with service providers to deliver services, and monitoring outcomes.
Community care - health or social care provided outside hospital.
Community nurses - nurses who work in GP practices, district nurses, health visitors and school nurses.
Community Trusts - Trusts which provide community health and social services, but not acute hospital services.
Contract - an agreement between a purchaser and a provider specifying the type and amount of services to be provided, their costs, and the required quality standards.
Cost effectiveness - a measure of the effectiveness of a particular type of care or treatment compared with its cost.
Department of Health and Social Services (DHSS) - the Government Department responsible for health and social services in Northern Ireland.
Family Health Services - services provided by family doctors, dentists, pharmacists, opticians, community nurses, midwives, health visitors and professions allied to medicine.
General Medical Services - services provided by family doctors (GPs) and their staff.

GP Fundholding Scheme - a scheme which allows some GPs to manage budgets for certain services.
Health and Personal Social Services (HPSS) - includes hospital services, community health services, personal social services and general medical services.
Health and Social Services Agencies - organisations which provide a range of specialised services. There are 5 such agencies:
the Central Services Agency;
the Health Promotion Agency;
the Regional Medical Physics Agency;
the Blood Transfusion Agency; and
the Guardian ad Litem Agency.
Health and Social Services Boards - organisations responsible for commissioning health and social services for their resident populations. There are 4 Health and Social Services Boards.
Health and Social Services Councils - organisations responsible for representing the views of health and social services users, and for providing an independent oversight of the activities of Health and Social Services Boards. There are 4 Health and Social Services Councils, one for each Health and Social Services Board area.
Health and Social Services Trusts - organisations responsible for providing health and social services, and for exercising certain statutory functions on behalf of Health and Social Services Boards. There are 19 Trusts.
Health Improvement Programme - an action programme to improve health and healthcare locally, led by the Health Authorities (England and Wales), Health Boards (Scotland) and involving HSS Trusts, primary care commissioners/professionals, local authorities and other local interest groups.
HPSS Intranet - the means by which HPSS organisations can exchange information via computer.
HSS Executive - the part of the DHSS which is responsible for policy and legislation covering health and social services matters, and for managing the HPSS.
Integrated health and social services - health and social services which are commissioned or delivered together by one organisation.
Integrated Trusts - Trusts which provide both health and social services.
Internal market - the arrangements under which commissioners purchase services from providers in a competitive environment.
Local Care Agency - a possible new type of HPSS organisation which would bring together both commissioning and provision.
Multifund - a number of GP Fundholding Practices which have combined their management allowances(for the additional work involved in fundholding) to establish a single, centralised administration to manage their collective funds.
National Institute for Clinical Excellence - a new Institute which will be set up to promote clinical and cost-effectiveness and the production and dissemination of clinical guidelines.
Northern Ireland Charter for Patients and Clients - the document which sets out the rights of patients and clients in relation to the HPSS, and certain standards which the HPSS must meet.
Personal social services - personal care services for vulnerable people, including those with special needs because of old age or physical or mental disability, and children in need of care and protection.
Policy Appraisal and Fair Treatment (PAFT) - a requirement to test new policies or initiatives to ensure that they do not disadvantage or unfairly discriminate against individuals or groups on the basis of religion, gender, political affiliation, marital status, number of dependants, ethnicity, disability or sexual orientation.
Primary care - includes family health services (see above) and major components of social care.
Primary Care Groups - new local commissioning organisations which would bring together groups of GPs and other primary care professionals to commission care for their resident populations.
Primary Care Partnership - part of a Local Care Agency (see above). Primary Care Partnerships would bring together groups of GPs and other primary care professionals to commission care for their resident populations.

Providers - organisations which provide health and/or social services.
Public health - how society is organised to prevent disease, prolong life and promote health.
Secondary care - specialist care, typically provided in a hospital setting or following referral from a primary or community health professional.
Service framework - a means of bringing together the best evidence of clinical and cost effectiveness with the views of service users to determine the best ways of providing particular services.
Social Services - see personal social services.
Total purchasing pilots - groups of GPs who purchase hospital and community care services not covered by the Fundholding Scheme on behalf of their patients and clients. Legal responsibility for these services remains with the relevant Health and Social Services Board.

Annex 1: Fit for the Future - Consultation Responses

ACTPAM (Advisory Committee for the Professions Allied to Medicine)
Age Concern (NI)
Altnagelvin Hospitals Health and Social Services (HSS) Trust
Alzheimers Disease Society (Fermanagh Branch)
Alzheimers Disease Society (NI)
Antrim Borough Council
Ards Borough Council
Area Medical Advisory Committee, Northern Health and Social Services Board
Area Nursing Advisory Committee, Western Health and Social Services Board
Armagh and Dungannon HSS Trust
Armagh City and District Council
Armagh Diocesan Board of Social Responsibility
Association of British Pharmaceutical Industry
Association of Directors of Social Services
Association of Speech and Language Therapy Managers
Association of Trust Directors of Social Work
Association of Trust Directors of Social Work, South and East Belfast HSS Trust
Ballymena Borough Council
Ballymoney Borough Council
Banbridge Community HSS Forum
Banbridge District Council
Barnardos Child Care Office
Barnardos Chinese Health Project
Belfast City Council
Belfast City Hospital HSS Trust
Belfast City Hospital Medical Staff Committee
Belfast Link Laboratories
Belfast Travellers Education and Development Group
Boots the Chemists
British Association of Medical Managers
British Association of Social Workers
British Deaf Association (NI)
British Dental Association
British Diabetic Association NI
British Dietetic Association - Ulster Branch
British Medical Association (NI)
British Medical Association, Western/Londonderry Division
British Orthoptic Society (NI)
Brook Advisory Centres

Bryson House
Capitation Funding Review Group
Carrickfergus Borough Council
Causeway HSS Trust
CBI (Confederation of British Industry) (NI)
CCETSW (Central Council for Education and Training in Social Work) (NI)
CEMPSAC (Clinical Engineering and Medical Physics Services Advisory Group)
Central Medical Advisory Committee
Central Personal Social Services Advisory Committee
Central Pharmaceutical Advisory Committee
Central Services Agency
Chiropractic
Church of Ireland Board for Social Responsibility (NI)
Clinical Directors of Community Dental Services Group
College of Occupational Therapists
Commission for Racial Equality
Committee on the Administration of Justice
Community Development and Health Network (NI)
Community Development Centre North Belfast
Community Development Support Services Agency
Community Development Working Group
Community Practitioners and Health Visitors Association
Consult Older People Group
Co-operation and Working Together
Core Four Total Purchasing Pilot
Craigavon and Banbridge Community HSS Trust
Craigavon Area Health Forum

Craigavon Area Hospital HSS Trust
Craigavon Borough Council
Derry City Council
Derry Well Women
Down Lisburn HSS Trust
Dr C McKinstry, Royal Victoria Hospital (RVH)
Dr Devaney, Clinical Director, Homefirst Community Trust
Dr Doherty, Belfast City Hospital (BCH)
Dr Fulton, Medical Director, Altnagelvin Trust
Dr J Andrews, Ballycarry, Antrim
Dr M Reid, BCH
Dr Montgomery, Mater Hospital
Dr O Shanks, Muckamore Abbey Hospital
Dr R Ingram, Down Lisburn Medical Staff Committee
Dr S Cooke, RVH
Dr T Black, Western Local Medical Committee
Dungannon District Council
Dungannon District HSS Community Forum
Dunmurry Community Services Patient Participation Group
East Down Rural Community Network
Eastern Area Dental Advisory Committee
Eastern Area Pharmaceutical Advisory Committee
Eastern Board GP Forum
Eastern Health and Social Services Board
Eastern Health and Social Services Council
Eastern HSS Board Citizens Jury
Eastern Multifund
Equal Opportunities Commission for Northern Ireland

Faculty of Medicine, Queen's University Belfast (QUB)
Fermanagh District Council

Fold Housing Association
Foyle HSS Trust
Glaxo Wellcome
Greenpark HSS Trust
Guardian ad Litem Agency
Guild of Healthcare Pharmacists
H A Brown, Centre for Podiatric Medicine, QUB
Health Promotion Agency
Health Promotion Specialists, Down Lisburn Trust
Healthcare Financial Management Association
Help the Aged
Hill Medical Group
Homefirst HSS Trust
Industrial Therapy Organisation
Institute of Directors NI Division
Institute of Health Services Management
Institute of Health Services Management, Divisional Council
Institute of Healthcare Engineering and Estate Management
John Semple, Head of the Northern Ireland Civil Service
Lagan Valley Hospital Medical Staff Committee
LEAD - NI Coalition on Learning Disability
LINK Group (GPs)
Lisburn Borough Council
Lower North Belfast Carers Group
MacMillan Cancer Relief
Mater Hospital HSS Trust
Medical Physics Agency
Medical Research Council
MENCAP (NI)
Milltown Community Trust

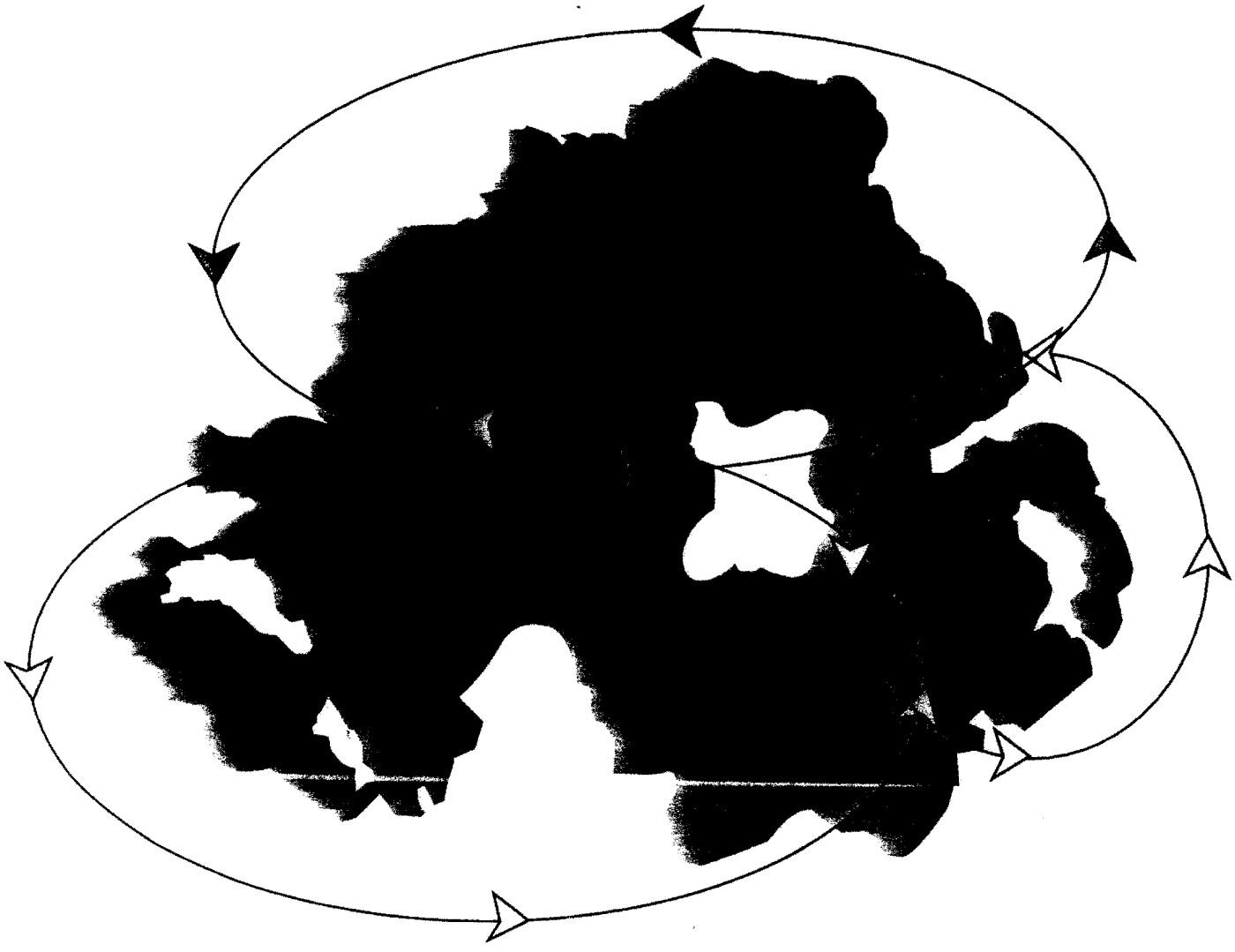
Mr Mercer-Gibson, for Bangor Health Centre GPs
Mr P Brady, 145 Glengesh Road, Temple
Mr R Common, 26 The Green, Dunmurry
Mrs M McKittrick, Belfast
Ms G Williams, 12 Lisnawery Road, Augher
MSF (Trade Union)
National Association of Inspection and Registration Officers
National Association of Primary Care
National Board for Nursing, Midwifery and Health Visitors (NI)
National Schizophrenia Fellowship (NI)
Newpin (Family Support Organisation)
Newry & Mourne HSS Trust
Newry and Mourne Carers Association
Newry and Mourne District Council
Newry and Mourne Mental Health Forum
NHS Confederation
NI Affairs Committee of Faculty of Public Medicine
NI Ambulance HSS Trust
NI Association for Mental Health
NI Association of Fundholding Practices
NI Blood Transfusion Service

NI Child Health Group
NI Council for Postgraduate Medical and Dental Education
NI Disability Committee
NI Economic Council
NI Forum of People with Disabilities
NI Fostercare Association
NI General Practice Managers
NI Hospice
NI Intermediate Treatment Association

NI Optometric Society
NI Prescribing Advisers
NI Royal College of Physicians
NIPSA (Northern Ireland Public Service Alliance)
North and West Belfast HSS Trust
North Belfast Partnership
North Down Borough Council
North Down Total Purchasing Pilot
North West Community Network
North West Independent Hospital
Northern Area Pharmaceutical Advisory Committee
Northern Health and Social Services Board
Northern Health and Social Services Council
Northern Ireland Voluntary Trust
Northlands
Nurse Leaders Network (NI)
Omagh District Council
Pharmaceutical Contractors Committee (NI)
Pharmaceutical Society of Northern Ireland
Professor D Marsh, QUB Orthopaedic Research Unit
Professor G McClure, RVH
Provider Estates Forum - United Hospitals Trust
Randalstown Health Centre
Royal College of Nursing, Treatment Room and Practice Nurses Forum (NI)
Regional Medical Services Consortium
Regional Orthopaedic and Trauma Committee, Greenpark HSS Trust
Royal College of General Practitioners - NI Faculty
Royal College of Midwives
Royal College of Nursing (NI Board)
Royal College of Ophthalmologists
Royal College of Pathologists
Royal College of Psychiatrists (NI)
Royal College of Speech and Language Therapists
Royal Group of Hospitals and Dental Hospital HSS Trust
Royal National Institute for the Blind
RUC
Rural Area Partnership in Derry
SHALOM Care (Community Group)
Social Democratic and Labour Party
South and East Belfast HSS Trust
South and East Primary Care Alliance
South Eastern Education and Library Board
South Tyrone Action Committee
Southern Area Medical Advisory Committee
Southern Area Pharmaceutical Advisory Committee
Southern Health and Social Services Board

Southern Health and Social Services Council
Southern Travellers Early Years Partnership
Speech and Language Therapy Agency - Down Lisburn Trust
Sperrin Lakeland Community Practitioners and Health Visitors Association
Sperrin Lakeland HSS Trust
Sperrin Lakeland HSS Trust Medical Staff (Psychiatry)
Springfield Road Surgery
Strabane District Council
The Cochrane Collaboration
Traveller Movement (NI)
Ulster Society of Pathologists
Ulster Unionist Party
UNISON (Trade Union)
United Hospitals HSS Trust
United Hospitals HSS Trust - Staff Side
Voluntary Organisations Forum
West Belfast Partnership Board
Western Area Dental Advisory Committee
Western Area Social Services Advisory Group
Western Health and Social Services Board
Western Health and Social Services Council
Women and Health Group (Bryson House)

Acute Hospitals Review Group



REPORT

June 2001

This volume is dedicated
to the memory of
Professor Gary Love,
a wise counsellor,
a fine physician and a good friend,
in recognition of his lifelong contribution
to health care in Northern Ireland
and as a major influence on the thinking in this report.

LETTER FROM THE CHAIRMAN TO THE MINISTER

Dear Minister

In August of last year you appointed me to Chair the Acute Hospitals Review Group. I now have much pleasure, on behalf of my colleagues, to submit our report and recommendations.

We are grateful to you for giving us the opportunity to serve in this way, and to all those in the health service and the wider community who helped us to do so.

We have tried to make the review an iterative process and have made strenuous efforts to ensure the widest consultation. As our findings have emerged, we have revisited a number of locations and professional groups. However, we were prevented from doing as much of this as we would have wished by the onset of the Foot and Mouth epidemic and the announcement of the general election. However, we are reassured by your undertaking to consult widely on our recommendations and to carry out impact assessments before implementing them.

We were fortunate in our support staff and especially in our Secretary, Richard Buchanan to whom we pay particular tribute.

We have, unusually for an official document, dedicated this report to our colleague, Professor Gary Love who, until his untimely death, committed himself with great enthusiasm and energy to the work of the Group. Many of his seminal ideas have carried through into our report.

In the course of our discussions, we found that more than anything else the service was crying out for decisions, for an end to drift and uncertainty.

I appreciate that you are now going to enter an extended period of consultation on our recommendations, and that after that, final decisions are a matter for you. I hope that you can do so as quickly as the procedures allow and that there is a general consensus that once you have taken them, decisions should be implemented rapidly.

The service also needs leadership and a sense of strategic direction in a period of turbulence and unprecedented change. We hope that in this respect these recommendations will have helped you to provide these.

I would personally like to thank you for the honour of being allowed to chair this Group, and my colleagues and support staff for their knowledge, their experience, their energy and their unfailing good humour.

Dr Maurice Hayes
Chairman

We were asked to make recommendations about the profile of acute hospital services in Northern Ireland. It soon became clear that we could not do so in isolation from what was going on in primary care and social care. Patient care is best seen as a system, a continuum in which the acute episode is an event in an unfolding, and ideally seamless, pattern of care. We had, therefore, to try to form a view of the likely fluidity of the boundary between primary care and the acute hospital sector, and between acute and continuing care, and the changes which appear to be taking place between the roles of doctors, nurses, professionals allied to medicine and others.

Patient care is best seen as a system in which the acute episode is an event in an unfolding, and ideally seamless, pattern of care.

It also seemed sensible to view the system, not as a solid construct, fixed for years ahead, but as a dynamic process continuously in transition.

We thought it sensible, too, to think in terms of services of high quality to which patients had access rather than buildings, although buildings are, of course, required as the location in which services can be delivered. We were attracted by the concept which was put to us by some clinicians of a virtual hospital, or a 'hospital without walls'.

We wished to approach the task as one involving not the closure of institutions but change, not the curtailment of services, but an improvement, not the restriction of access, but the readier availability to all of services of the highest quality, safely delivered, in the most appropriate setting.

We were attracted by the concept of a virtual hospital, or a hospital without walls.

We wished to define a seamless service in which access to services would be determined by patient and clinical needs rather than by arbitrary lines on a map. For this reason, we quickly decided that we should ignore all existing boundaries of Boards and Trusts, and, indeed, the border with the Republic, where this was relevant to our remit. This enabled us to think outside existing frameworks, to take account of patient choice and human geography, and to contemplate models which were three-dimensional, flexible and responsive to a variety of needs and demands rather than contorted to fit into the strait-jacket of Board or Trust boundaries.

it soon became clear, too, that the public were suspicious of change because they did not know where it was all leading, or because proposals appeared to have been forced piecemeal by events or as an ad hoc response to the crisis of the day. Change would be easier to understand and accept if it could be presented as part of a planned and rational process. Change there must be, if services are to be maintained and improved. The status quo is not an option. Yet change, if it is to be meaningful, should a be rational, planned-for, part of an overall design, and should command sufficient acceptance to enable all to move forward together towards an agreed goal.

The status quo is not an option.

7. There is little disagreement about what that goal should be: a service of quality which is safe, accessible, effective and efficient within the limits of the resources likely to be available. Disputes generally arise about the best route to be taken to this desirable objective and the timing and the rate of change. Change which is agreed and which can be managed as an orderly process is much to be preferred to that which is merely reactive to events or is created by accident or forced by uncontrollable external forces.

8. This suggests to us that it would be helpful to set out a vision of where the health service might be in 15 or 20 years time and the role of the acute hospital service in it. We chose this time-frame because of the long lead-in time for capital projects, and more particularly, because of the extended period needed to train the necessary staff and to ensure that they have the experience necessary to prepare them for their various tasks.

9. Attempting to forecast the future is a risky business, and more so in the health service than almost anywhere else. There have been quite revolutionary changes in the treatment, care and cure of very many conditions over the past decade and a half. New ways have been found of managing a wide range of debilitative diseases. At the same time, new and terrible maladies, hitherto unknown or unsuspected have emerged as major threats to health and wellbeing. There have been rapid and effective, if sometimes expensive, developments in treatment and equipment, new skills and techniques have been developed and new resources uncovered. It would be foolish to assume that change would be any less dramatic in the next couple of decades.

"What we see is a system of care which is complete in itself and which is accessible through many portals. Wherever accessed, the outcome for the individual patient should be the same – the knowledge and the certainty that he or she is in safe hands and will receive the appropriate treatment in the right place by people or teams with the relevant skills and experience."

10. The challenge is to design (or adapt) a system which can cope with change, which can accept or adopt the new dynamic while holding on to the basic principles which we have expressed. It may be difficult to do so if we see it only as a problem of buildings and where to put them, of institutions and who controls them, or management structures and who runs them.

11. What we see is a system of care which is complete in itself and which is accessible through many portals. Wherever accessed, the outcome for the individual patient should be the same - the knowledge and the certainty that he or she is in safe hands and will receive the appropriate treatment in the right place by people or teams with the relevant skills and experience. We have at times defined equity of access as meaning that a person should not have a worse prospect of recovery from a medical emergency whether in a remote rural area or the centre of a city. We see the health service as a resource, available to all, and equally accessible from a unit in a smaller town as in a large city hospital.

12. This vision is not far removed from that outlined in 'Fit for the Future', which we largely endorse. Where we differ from that document is in systematising the

process of change, and in timing. Development is not primarily about closure, but change, not about withdrawing services from local communities, but providing them more effectively. It is about making sure that new and improved arrangements are in place, that a better alternative can be offered before the old ones are withdrawn, and it is about keeping faith with people and with communities once the process to which they have agreed has begun.

13. Planners should not dismiss lightly the importance to communities of 'their' hospital, but it is clear that the public's ambitions for services that are both of the highest quality and close at hand are not always compatible. Hospital amalgamations may be necessary, but hospitals do not always need to exist on a single site, no matter how administratively tidy this may be. To provide access to hospital services in smaller, less populated areas, there may be a need to sustain hospitals that are smaller than the ideal - in such cases imagination will be required to ensure that the caseload of the hospital and its staff are maintained at an acceptable level. The answer to the problems of many small units is close working with a nearby unit so that strengths can be shared and weaknesses lessened.

14. In our longer-term vision, we have assumed that several well-observed trends will continue. The first is a shift in the centre of gravity of the whole system towards primary care. This will continue and should be encouraged. Part of the objective of our exercise is to keep people out of acute hospitals who should not, or need not, be there.

"Part of the objective is to keep people out of acute hospitals who should not, or need not, be there."

15. We were not charged with a review of the arrangements for primary care, but it is clear to us that reorganisation of the acute hospital system can only sensibly take place in the context of substantial and planned changes to the organisation and delivery of primary care. The aim should be to give primary care a more prominent role, and to take advantage of new developments in treatment and technology which increasingly make it possible to treat in a primary care setting conditions which previously required an extended period in hospital.

16. We see no alternative to the general trend towards sub-specialisation as a means of ensuring excellence and consistently good outcomes for patients. However, we note that the Royal College of Physicians is rethinking the extent to which complete sub-specialisation is either attainable or desirable. The possibility of ensuring that a greater number of patients can be safely and satisfactorily treated by primary care teams is one means of ensuring an equitable balance between access and quality, between centralisation and dispersal.

This will best be achieved by treating the hospital services as a system or a series of systems within the general health care system. This will facilitate interdependence, the optimum use of scarce resources, especially of skill and experience and the development of managed clinical networks. The day of the stand-alone institution

attempting to do everything from its own resources, acting in isolation from the wider system is already gone. Co-operation, co-existence and mutuality point the way to sustainable and accessible services in the future.

...of the ...alone ...institution ...to do ...from its ...resources, ...in isolation from the wider system is already gone. Co-operation, co-existence and mutuality point the way to sustainable and accessible services in the future.

18. In our view it will increasingly be seen as appropriate for acute medical and surgical care in hospitals to be consultant-delivered instead of, as at present, consultant-led. This may well lead to the emergence of a new role for consultant staff, which is already happening, to some degree. There will progressively be far less dependence on junior doctors working excessive hours to keep services going. There will also be a re-gearing of the relationship between training needs and service delivery, with trainees becoming largely supernumerary, with training being organised in parallel with clinical networks. This will provide opportunities for training in a variety of settings and offer the necessary range of experience and volume of casework.

19. Implementing change will take time: health services are provided by people. A skilled, trained and dedicated workforce is the greatest asset of the present services. They deserve to be cherished and sustained. Yet, at times, the debate tends to be dominated by issues of capital investment in buildings and equipment. Health care is a labour-intensive activity, and will always be so. The greatest capital lies in the staff. There needs to be a comprehensive approach to workforce planning as a matter of urgency.

20. It is important for the services to be able to respond quickly and effectively to an emergency, but a system which does not respond within a reasonable time to the need for elective treatment can scarcely be called either equitable or efficient. People on waiting lists for elective treatment may not be in immediate danger of dying, but they can suffer a substantial depreciation in the quality of life, they can become a burden on family carers, and some may indeed die while waiting for the promised treatment. It is entirely inequitable that access to treatment should be determined on the basis of a post-code. Ideally, waiting times for assessment and for treatment should be reasonable, known and maintainable. This could well result in a separation of the modes of delivery for emergency and elective care, with some hospitals doing mostly elective work, with protected staff and budgets for non-emergency care.

21. We have assumed for planning purposed that the resources likely to be available in Northern Ireland will represent a proportionate share of spending on the National Health Service in the rest of the United Kingdom - weighted as may be necessary to take account of local health-status and social deprivation. We are assuming, too, that spending on health care in the UK, expressed as a proportion of GDP, will equate with the mean for the EU. This implies significant medium term growth.

A service such as we envisage is predicated on effective systems for the transfer both of information and seriously ill patients. The first requires an effective and co-ordinated system of communication, making full use of developments in IT and tele-medicine, the second an efficient, well-resourced ambulance service - staffed by appropriately trained people - directed from a central control that is capable of making judgements about the needs of individual patients in emergency situations. These are urgent pre-requisites to any change.

What we are providing in this report is not a set of specifics or a detailed blueprint, which could well become quickly out of date, overtaken by new developments or changes to the external environment. We have also tried to avoid the risk of replacing one set of arbitrary boundaries with another. What we hope we have provided is a sense of direction and common purpose, an indication of a desirable destination and a route map to get there by way of systems and process. It will not happen overnight. Progress may be uneven and patchy, depending crucially, as it will, on building relationships and on leadership, but the goal is desirable and should be attainable.

"What we hope we have provided is a sense of direction and common purpose, an indication of a desirable destination and a route map to get there by way of systems and process."

We envisage a service in which quality and safety are paramount and standards are maintained by retraining and revalidation, by audit, inspection and public accountability, a service where the voice of the patient and the community are heard at the planning stage and in determining the arrangements for the delivery of services, where there is lay participation in decision-making at all levels, and where complaints are dealt with quickly, frankly and effectively.

Throughout the report we have tried to say that clinical services should not be confined by existing administrative boundaries, and this includes the border also. We envisage a system where complementary emergency and elective services can be developed for the benefit of patients on either side of the border, where it is sensible to do so. We also took forward the provision of services that require a population base of five million and which cannot be provided separately North or South for smaller populations, on an all-Ireland basis.

Report Structure and Recommendations

The structure of this report and our detailed recommendations are set out below.

- Chapter 1 - Introduction. In this chapter we describe how we tackled the review and what we heard during the public consultations.
- Chapter 2 - Context. In this chapter we provide information on the population of Northern Ireland, its health needs and the current provision of health services.

- **Chapter 3 - Pressures facing the Service.** In this chapter we set out a range of pressures, including increasing demands for health care, the trend towards concentrating services, and the continued pressure on resources.

- **Chapter 4 - Resource Availability and Utilisation.** In this chapter we compare the resources available to the HPSS in Northern Ireland with resources available in other parts of the UK and Ireland, and we examine whether resources in Northern Ireland are being used effectively. We make the following recommendations:

  (i) The DHSSPS, Department of Finance and Personnel and Northern Ireland Assembly should take steps to ensure that the funding of Hospital and Community Health Services in Northern Ireland is on a par with comparable regions in Britain.

  (ii) The DHSSPS should establish new targets to reduce waiting times with a view to ensuring that by 2010 no-one should have to wait more than three months for treatment.

  (iii) The number of acute hospital beds should be kept under close review. There may be justification for increasing capacity at a very small number of hospitals for example, the Ulster Hospital and Craigavon Area Hospital and, in due course, Antrim Hospital, but this would need to be justified by improvements in efficiency and at least offset by reductions elsewhere. All future investment or development proposals should be reviewed with this recommendation in mind.

  (iv) There should be rigorous scrutiny of activity and performance across the entire acute hospital sector with a view to optimising the use of existing resources. Thresholds for referral and admission should be carefully reviewed, taking account of criteria used elsewhere. There should also be a thorough investigation into delays in discharge from hospitals, including the scope for making better use of the private nursing home sector.

- **Chapter 5 - Vision for the Future.** In this chapter we describe a profile of the services we would like to see provided 15 to 20 years from now.

- **Chapter 6 - Access to Key Hospital Services.** In this chapter we set out our view of what represents reasonable access to emergency care services and maternity services.

- **Chapter 7 - Future Configuration of Hospital Services.** In this chapter we propose a configuration of acute hospital services that should ensure that the entire population of Northern Ireland has reasonable access to key hospital services. We make the following recommendations:

  (v) To ensure that the entire population of Northern Ireland has reasonable access to key hospital services, we propose that

emergency care services and inpatient maternity services should be provided, as a minimum, at the following nine sites:

- Altnagelvin Hospital;
- Antrim Area Hospital;
- Belfast City Hospital*;
- Causeway Hospital;
- Craigavon Area Hospital;
- Daisy Hill Hospital;
- Royal Victoria Hospital;
- Ulster Hospital; and,
- A new hospital for the South West.

(* The Belfast City Hospital would not provide inpatient maternity services because of the proposal to develop the Royal Jubilee Maternity Unit.)

The range of emergency care and inpatient maternity services (and other acute services) provided at each location will vary according to local need, but all of the nine locations should have ready access to a psychiatric opinion.

(vi) Every effort should be made to ensure the sustainability of all nine sites, in particular those serving smaller populations, namely Causeway Hospital, Daisy Hill Hospital and the new hospital for the South West. In relation to the three smaller hospitals the following opportunities should be fully explored:

- the transfer to them of day surgery and routine elective surgery from larger neighbouring hospitals;
- the potential for Daisy Hill to take on some of Craigavon Hospital's non-elective workload (in addition to some of its elective work); and,
- the potential for Daisy Hill and the new hospital for the South West to take on additional work from across the border.

(vii) The new hospital for the South West should be located in Enniskillen on the existing Erne site, or on an alternative site to the north of Enniskillen. During the period prior to the completion of the new hospital (which we would hope would be no more than five years), every effort must be made to sustain the existing 'one hospital on two sites model'.

(viii) When the new South West hospital is completed, work should begin on a modern local hospital facility in Omagh providing a wide range of local hospital services and a local emergency unit.

(ix) The Mater Hospital should continue to provide emergency care services for the foreseeable future, but its A&E department should be replaced with a local nurse-led emergency unit providing a comprehensive minor injury and illness service and linked to primary

care and one of the A&E departments in Belfast. Inpatient maternity services should only be maintained at the Mater on the basis of the continuation and development of existing links with the Royal Jubilee Maternity Unit, including close networking and adherence to joint clinical protocols. More generally, the Mater Hospital should build on its links with Whiteabbey Hospital to provide services to the populations of North Belfast, Newtownabbey and Carrickfergus.

(x) Emergency care services should be phased out at Whiteabbey. A modern local hospital facility should be developed, providing the full range of local hospital services and a local nurse-led emergency unit, complementing the services provided at the Mater Hospital.

(xi) Emergency care services should be phased out at Lagan Valley Hospital, with the hospital evolving into a specialist centre for elective treatment. As part of this change process, the hospital's A&E department should be replaced with a local nurse-led emergency unit providing a comprehensive minor injury and illness service and linked to primary care and one of the A&E departments in Belfast. Inpatient maternity services should be phased out at Lagan Valley, but the scope to provide all other maternity services, including the possibility of a variant of the domino delivery service, should be fully explored.

(xii) Services at the Downe Hospital should be developed along the lines proposed by the Downe Hospital Working Group with emergency medical services (including coronary care), accident and emergency and elective surgical services being provided in a new hospital. Inpatient maternity services should be phased out at the Downe, but the scope to provide all other maternity services, including the possibility of a variant of the domino delivery service, should be fully explored. An early start should be made on the construction of a new hospital in Downpatrick.

(xiii) Emergency care services should be phased out at Mid Ulster Hospital, as soon as alternative arrangements are in place at Antrim Area Hospital and the Toome bypass is complete. As part of this change to the function of the Mid Ulster, the hospital's A&E department should be replaced with a local nurse-led emergency unit providing a comprehensive minor injury and illness service and linked to primary care and the A&E departments in Antrim Area Hospital. Inpatient maternity services should be phased out at the Mid Ulster Hospital, but the scope to provide all other maternity services, including the possibility of a variant of the domino delivery service, should be fully explored. A new modern local hospital facility should be constructed in or around Magherafelt providing a wide range of local hospital services and a local emergency unit.

(xiv) A modern local hospital facility should be developed on the South Tyrone site providing a wide range of local hospital services and a local nurse-led emergency unit.

(xv) No change should be made to the existing services at any hospital until appropriate arrangements have been made to provide these services elsewhere.

Chapter 8 - **Future Organisational Structures**. In this chapter we propose new organisational structures comprising a Strategic Health and Social Services Authority and three Health and Social Care Systems. We make the following recommendations:

(xvi) Three new integrated Health and Social Care Systems should be developed for Northern Ireland, replacing the existing acute, community and combined Trusts. The systems are as follows:

- **the Northern Health and Social Care System**, including Altnagelvin Hospital, Antrim Area Hospital, Causeway Hospital and the local hospital at Mid Ulster;
- **the Southern Health and Social Care System**, including Craigavon, Daisy Hill, the new hospital for the South West at Enniskillen and the local hospitals at Omagh and South Tyrone; and,
- **the Greater Belfast Health and Social Care System**, including the Royal Victoria, Belfast City, Mater, Ulster, Lagan Valley and Downe Hospitals and the local hospital at Whiteabbey.

(xvii) As a first step in the process of creating the Greater Belfast Health and Social Care System, we recommend the immediate merger of the Royal Group of Hospitals Trust, Belfast City Hospital Trust and the Green Park Hospital Trust.

(xviii) A new Northern Ireland Strategic Health and Social Services Authority should be established to replace the four Health and Social Services Boards. The prime functions of this organisation would be strategic planning, capital planning, resource allocation, strategic planning of ICT, workforce planning and control and the commissioning of regional hospital services. Our strong preference would be for the Authority to be established as a new HPSS organisation rather than as part of the DHSSPS. It should conduct its business in public with regular public meetings. Its membership must include representatives from primary care organisations, the three Health and Social Care Systems as well as leading clinicians and community representatives.

(xix) Primary care organisations should be given responsibility for the commissioning of community services and non-regional hospital

services from the three systems, in the context of a strategic plan agreed with the Strategic Authority.

(xx) A single statutory consumer body should be established to monitor the operation and policies of both the Strategic Health and Social Services Authority and the three Health and Social Care Systems.

(xxi) Consideration should be given to the potential to organise support services such as finance and personnel on a regional basis.

- **Chapter 9 - Primary Care**. In this chapter we examine opportunities to develop the role of primary care to achieve greater integration of service delivery with secondary care. We make the following recommendations:

(xxii) Opportunities to develop the role of primary care to achieve greater integration of service delivery with secondary care should be fully explored and properly resourced. Potential areas for development include:

- a more prominent role for GPs in the provision of emergency, life-saving services, particularly in remote rural areas;
- involvement of primary care professionals in the planning and delivery of services in local hospitals;
- the co-location of GP out of hours co-operatives adjacent to A&E departments or local emergency units;
- an expansion in the availability of home-based care initiatives, if they are shown to provide safe, effective and economic treatment in a patient's own home; and,
- an expansion in the availability of one stop shops.

(xxiii) A telephone helpline service for Northern Ireland should be introduced, along the lines of NHS Direct in England. Initially this helpline should be piloted on an out-of-hours basis and linked to a GP co-operative covering a dispersed rural community.

(xxiv) The workforce planning exercise recommended below (at xxvii) should reflect the additional staff needs in primary care that will emerge through an expansion of the role of the sector of the type we envisage.

(xxv) The development of teaching Primary Care Trusts in England should be followed closely. Consideration should be given to establishing additional training facilities of this sort in Northern Ireland, perhaps in association with the Mater as a teaching hospital with strong links with the community, located in an area of high multiple deprivation, chronic illness and poor health status.

(xxvi) The research base in primary care should be expanded to provide additional information on effective treatments and interventions.

- **Chapter 10 - Workforce Issues**. In this chapter we examine a range of workforce issues that must be addressed to ensure there is the properly

prepared and motivated workforce required to deliver our vision. We recommend that:

(xxvii) A major workforce planning exercise should be undertaken as a matter of urgency. The plan should cover of the whole health and social services workforce, looking across sectors (primary, secondary, tertiary), employers (public, private, voluntary) and staff groups (nurses, doctors, dentists and other professions and other staff). The plan should consider the need to increase the current number of training places for doctors, nurses and other staff groups.

(xxviii) A detailed review of the working hours and practices of junior doctors in Northern Ireland should be undertaken to identify opportunities to broaden the role of nurses and other care professionals and identify other actions required to implement the EC Working Time Directive.

(xxix) Arrangements for the approval of consultant posts and training arrangements should be centralised as a matter of urgency.

(xxx) Action should be taken to ensure that Northern Ireland keeps pace with proposals to increase medical student numbers in England and elsewhere.

(xxxi) Consideration should be given to the potential to locate support services and other services such as the ambulance control centre and the local variant of NHS Direct outside Belfast in provincial towns. This would provide an opportunity to minimise the impact on local employment of changes to the configuration of hospital services.

- **Chapter 11 - Supporting the Delivery of Care: Essential Infrastructure.** In this chapter we examine the current position and future resource requirements in relation to the health estate, information and communications technology, the ambulance service, and radiology and pathology services. We recommend that:

(xxxii) A 10 year estate development plan should be prepared, setting out spending priorities for the period 2002 to 2012. These priorities should include:

- the current major capital development projects that are at various stages in the planning and construction cycle;
- the new major capital development projects proposed in this report; and,
- the backlog of routine estate maintenance.

(xxxiii) A task force should be established to produce an ICT strategic development plan. Until this plan has been agreed there should be a moratorium on all investment in new systems over £50k. The task force should also be asked to advise on future arrangements for developing, maintaining and investing in ICT.

(xxxiv) The recommendations for the development of the Northern Ireland Ambulance Service, as set out in the Strategic Review, should be implemented as a matter of urgency. Particular focus should be given to:

- the procurement of new and additional vehicles;
- the identification of a suitable location for the proposed new communications control centre;
- the urgent implementation of a training programme to allow ambulance crews to enhance their skills to higher paramedic standards; and,
- the development of the 'first responder' scheme to introduce a first tier response for communities in remoter areas of Northern Ireland.

(xxxv) The Clinical Imaging Strategy Sub-group should cost and prioritise their proposals for the development of imaging services in Northern Ireland. One priority should be to expand the range of radiology services that can be directly accessed by GPs as a means of achieving greater service integration between primary and secondary care. Another priority should be the installation of Magnetic Resonance Imaging (MRI) units at all of the designated cancer units (Altnagelvin Hospital, Antrim Area Hospital, Craigavon Area Hospital and Ulster Hospital) and the Belfast City Hospital to support its Cancer Centre role. The time that patients have to spend waiting in hospitals for CT scans should be investigated fully.

(xxxvi) A rolling programme of equipment replacement should be established for all capital-intensive services, in particular radiology and pathology. Radiology and pathology services should, in future, be planned on a regional basis.

- **Chapter 12 - Cross-border Co-operation in Hospital Services.** In this chapter we examine the potential for co-operation in the planning and delivery of hospital services at a local and all-Island level. We recommend that:

(xxxvii) Efforts should be made to enhance the existing level of co-operation in the vicinity of the border. Assistance and encouragement should be provided to the three CAWT projects exploring this issue. In addition consideration should be given to the scope to plan jointly and, where appropriate, deliver services for the populations on either side of the border. This applies in particular to emergency services and disaster planning.

(xxxviii) A study should be undertaken to establish the feasibility of a joint helicopter service covering an area north of a line from, for example, Castlebar to Drogheda (and therefore including all of Northern

Ireland) to be run initially possibly in conjunction with air-sea rescue or other such service.

(xxxix) There should be a thorough assessment of the potential for all-Island co-operation in the planning and delivery of supra-regional specialties such as transplantation services, paediatric cardiac surgery and the treatment of rare cancers.

- **Chapter 13 - Affordability**. In this chapter we consider the affordability of our recommendations in the context of resources likely to be available to the HPSS. We recommend that:

  (xl) A detailed review of the entire HPSS estate should be undertaken to identify surplus land and buildings for resale and development.

  (xli) Consideration should be given to the potential to access private finance on the basis of system-wide schemes.

- **Chapter 14 - Making it Happen**. In this chapter we set out a phased action plan for the implementation of our recommendations.

Background

In August 2000 Bairbre de Brún, the Minister for Health, Social Services and Public Safety, announced the establishment of an independent Review Group to examine acute hospital services in Northern Ireland. The Group - the Acute Hospitals Review Group (AHRG) - was chaired by Dr Maurice Hayes and comprised members from a wide range of professional, community and user backgrounds. Full details of the AHRG's membership are at Appendix A.

Terms of Reference

Our Terms of Reference were:

"To review the current provision of acute hospital services and, taking account of the issues of local accessibility, safety, clinical standards and quality of services, to make recommendations to the Minister on the future profile of hospital services."

We were also required:

"To take into account the views of individuals, organisations and groups with an interest or involvement in the provision of hospital services and to assess the scope for co-operation in the provision of local services with hospitals in other parts of the island."

Process

From the beginning we attached a very high value to consultation. We were anxious to ensure that no significant body of opinion would go unheard and that we would hear the particular needs and aspirations of a broad and diverse range of groups in society in relation to health care. Local accessibility was cited high on our terms of reference and we wished particularly to listen to the views of people who lived furthest away from the main acute hospitals. We have also taken into account the Northern Ireland Executive's commitment to regenerate the rural economy and, in particular, to ensure access to public services such as schools, hospitals and transport. Advertisements were placed in all the regional and local newspapers seeking representations. The Chairman appeared on all the local television and radio channels to publicise the exercise. In addition 411 letters seeking views or submissions were addressed to elected representatives, District Councils, Health and Social Services Boards and Trusts, to trade unions and professional organisations, to the churches, to statutory and voluntary bodies connected with the health service, to consumer groups and representatives, to local Health and Social Services Councils, to the Universities, and to individuals with experience in the service.

We were anxious to ensure that no significant body of opinion would go unheard

"We received over 300 substantial submissions and met 200 individuals or groups."

1.5 We received some 300 submissions and met with 200 individuals or groups. Details of the individuals or organisations consulted and the submissions received are at Appendices B and C respectively. Larger representations were heard by the full group, but in order to make ourselves more widely accessible and to maximise the number who could make direct representations in the time available, we split into smaller groups and carried out visits or discussions in parallel.

1.6 We visited every acute hospital in Northern Ireland, some more than once, and had detailed and helpful discussions with staff at all levels. We also met all the Health and Social Services Boards and all the Hospital and Community Trusts, the Northern Ireland Ambulance Service, the four Health and Social Services Councils as well as the various bodies associated with training. We also received briefings from Departmental officials and various advisory groups and working parties. We met a number of District Councils who had asked to see us and we also met representatives of political parties. We had a fruitful exchange of views with the Assembly Health, Social Services and Public Safety Committee at the beginning of our work and again during the course of our discussions. These we found extremely helpful as an expression of the concerns of local populations in different parts of Northern Ireland.

1.7 Because of the volume of interest shown, and because there was particular concern about the maintenance of local acute hospital services, we held public meetings in six centres: Downpatrick, Dungannon, Enniskillen, Magherafelt, Omagh and Whiteabbey. In each case the format was the same: a visit to the local hospital, consultation with staff, meetings with voluntary organisations, the District Council and action groups ending with a widely publicised public meeting. These meetings were well attended (average 400) lively and informative. We heard from them a very cogent message of the concerns and fears of the local communities, especially in areas where the local hospital was under threat of closure, of being run-down, or even in one case of having acute services withdrawn.

1.8 The message especially in the West was very clear. There was concern that five of the six main hospitals were East of the Bann and within 30 miles of Belfast, or perceptions that services were inexorably being run down, withdrawn and made more inaccessible. There was a great sense of inequity, and a fear of being left without services, of dying before help came or on the way to hospital, of being left with a sick child in the middle of the night, or of a woman being taken in labour miles away from the nearest maternity unit in an area with very poor roads and an inadequate public transport service. There was a concern too that changes which had taken place had been ad hoc, in response to crisis and that too often services had been withdrawn before a satisfactory alternative had been provided. A common complaint was that reductions in service that had been presented as temporary invariably turned out to be permanent and were then sometimes used as a basis for a further reduction.

We were left in no doubt that what concerned people most was access to accident and emergency, coronary care, medical emergency and maternity services.

People were not generally unreasonable in their expectations. There was a clear request that services should be safe and of high quality. There was, it appeared to us, a willingness to travel some distance to specialist centres for complex, expensive or rare treatments and a realisation that these could not be provided at more than a limited number of centres. This was balanced by an argument that routine treatment, or care which had to be received regularly, and day procedures, diagnosis and after-care should be available locally.

As we became aware of the importance of the linkages with primary and community care we spent time in discussion with GPs and primary care teams and with Community Trusts. We also visited local GP practices, GP co-operatives and organisations representative of general practice and primary care.

We found the primary care system in a high degree of uncertainty as preparations were being made to move from fundholding to some other arrangement. There were differences of view between those whose involvement of fundholding had given them experience of working together and a perception of the opportunities offered by commissioning, and those who took a more conservative, and indeed sceptical view of future developments. Here too we found a system under stress resulting from the difficulty of securing admissions for patients who needed acute hospital care, new demands for screening and preventative medicine and uncertainty about the future. As in the hospital service, some of those working in general practice or in the community felt overburdened and undervalued, unsupported and isolated in conditions that were increasingly difficult.

We informed ourselves on developments in Scotland and Wales, and in the case of the former received a briefing from one of the officers who had contributed to the Scottish Review.

In England we visited the Honiton community hospital in Devon and were impressed by the innovative design of the hospital and the comprehensive range of services provided in a modern building. While in England, we also observed the operation of an NHS Direct centre in London.

We drew, where possible, on existing research, whether carried out in Northern Ireland or elsewhere. We examined in detail the reviews of acute services undertaken by the four Boards and by the Department. Of particular importance were the Department's 'Regional Strategy for Health and Wellbeing 1997-2002', 'Fit for the Future' and 'Putting it Right'. We reviewed the surveys, evaluations and impact studies commissioned by the Department, Boards, Trusts and Health Councils. We also studied relevant reports by the Northern Ireland Audit Office and

We were left in no doubt that what concerned people most was access to accident and emergency, coronary care, medical emergency and maternity services.

"From the beginning, we decided that a radical review required us to ignore all administrative boundaries"

Health Services Audit, and by the National Audit Office and Audit Commission. We also commissioned research into bed numbers and bed utilisation in Northern Ireland, into waiting lists, and on resource allocation and comparative funding.

1.16 We were conscious of the need to be aware of wider Government policy and reviewed key documents such as the Regional Development Strategy, the Regional Transportation Strategy, the Rural Development Programme, the New Targeting Social Needs policy and the Section 75 Equality Scheme.

1.17 We were greatly helped in this work by Dr Jim Jamison, an experienced health researcher with a deep understanding of the local health and social services who had also carried out an evaluation of the impact of some cross border initiatives, and by Mr Dean Sullivan, a management consultant with PA Consulting Group.

1.18 We tried to carry out the review as openly and transparently as we could and with as little formality as possible. We are grateful to all those who approached it in this fashion. We regarded the review as an iterative process and tested our views as they emerged with different groups. We held all-day workshops with representative groups of administrators and clinicians, which we used as reference groups to whom we could turn from time to time for validation as our conclusions developed.

1.19 From the beginning, we decided that a radical review required us to ignore all administrative boundaries, whether of Board or Trust, and even the border between Northern Ireland and the Republic, where it was relevant to do so. We found a ready welcome for this approach from clinicians, administrators and local communities. Although the systems on the two sides of the border are different, the needs of the communities are similar and this should act as a spur to sensible collaboration.

"We found staff, of whatever grade and wherever we went, dedicated to a high standard of care"

1.20 In general, in our visits to hospitals and to other areas of the service, we were impressed by the care and dedication of staff at all levels. We found staff, of whatever grade and wherever we went, dedicated to a high standard of care, and frustrated by their inability to deliver this whether through over-load, lack of staff, shortage of resources or the pressure of increasing demand. Many buildings were in poor condition and badly maintained. Morale was universally low - people felt isolated, under stress and undervalued. We were told repeatedly that hospital services had been cut to the bone, and that successive cuts had resulted in a lack of elasticity. Hospitals which operated to nearly full capacity were unable to cope with sudden surges in demand, pressures which had previously only been experienced in the winter months were now apparent throughout the year, and patients, especially elderly patients, were waiting unreasonably, and in some cases impossibly long times for elective treatments which would transform the quality of their lives. We saw patients on trolleys waiting for admission, outliers in beds all

over hospitals, others inappropriately occupying acute beds that should have been used for elective procedures. Some hospitals were so busy that they were not taking referrals from GPs and the only means of entry was through presenting at the accident and emergency department. Most importantly, there was a need for a clear sense of direction, certainty about what was happening in and to the service, and confidence that things would get better.

"there was a need for a clear sense of direction, certainty about what was happening in and to the service, and confidence that things would get better."

1.21 We were particularly interested in the views of patients, conveyed through the Health and Social Services Councils and other local groups, and those of the rural population conveyed through the Rural Community Network and otherwise. They made very clear to us the fear that services were being withdrawn from rural areas to the extent that these would become non viable, that the concentration of hospital services in a few large urban centres (especially since five of the six main hospitals were in the East) would leave them unprovided for, at risk and unable to access services easily, given poor roads, poor public transport and low car ownership. They were particularly concerned by the plight of the increasing number of elderly and very elderly patients, often being cared for by family members who were themselves old, and the difficulty of arranging family visits at a distance.

1.22 In keeping with our brief to consider the potential for co-operation with health care systems in the South, we received briefings on arrangements there and held discussions with Departmental Officials and with the Minister. We also held discussions with health professionals in Dublin and informed ourselves of the work of Comhairle na nOspidéal. We visited hospitals in Monaghan, Cavan, Sligo and Letterkenny and met Health Board officials and members and public representatives who had asked to see us. Our plan to visit hospitals in Dundalk and Drogheda had to be called off because of the foot and mouth outbreak.

1.23 We had a useful exchange of views with representatives of the Royal College of Physicians in London and the Royal Colleges of Physicians and Surgeons in Ireland. We were glad to hear from the President of the Royal College of Physicians in London that they were aware of the problems of maintaining services that were safe and of high quality for dispersed and isolated rural communities. In view of the fears that had been expressed to us in the public meetings and elsewhere, we found our discussions with the officers of the Royal Colleges both helpful and encouraging. They share with us the objectives of putting the patient first. We found no indication that service needs were consistently being subordinated to the demands of training. What we did recognise in the Royal Colleges was a concern to maintain quality in the interest of the patient and to ensure that the training and experience afforded to our doctors should also be of the highest standards. We would find it hard to dissent from these requirements. What we did find was a recognition that the special problem of maintaining quality services, in smaller hospitals in remote locations required special consideration. The Colleges indicated

that they would favourably consider hospitals working together in networks as a basis for meeting training requirements of volume, variety and quality of clinical experience, and that (provided there was an overall strategy to develop services through networks) they would work sympathetically and constructively with health authorities to ensure the maintenance of services while new arrangements were being put in place.

1.24 The Joint Consultants Committee (JCC) - an organisation representing many senior hospital doctors in the UK - has pointed out[1] that the public is ambivalent in wanting the highest standards of clinical care but in opposing the closure of even the smallest hospitals where adequate quality standards can be difficult to sustain. As the JCC acknowledges, it is important to retain flexibility in local service provision to reflect the specific geography, the catchment population and special areas of skill, at the same time as maintaining the principles required for best patient care. The JCC has recognised that in small, less populated areas, access to secondary care would necessitate the continuance of hospitals which do not meet the ideal conditions and need to be staffed by exceptional means. The answer to the problems of many small units is seen to be close working with a nearby unit so that strengths can be shared and weaknesses lessened.

[1] Organisation of Acute General Hospital Services, JCC (July 1999)

Chapter 2 - Context for the Review

Introduction

2.1 This chapter sets out the context for the Acute Hospitals Review. It provides information on the population of Northern Ireland, its health needs, recent changes in hospital services and how needs and services here differ from those in neighbouring jurisdictions.

Our Population

2.2 The population of Northern Ireland has increased from about 1.60 million in 1990 to almost 1.70 million in 2000. A further increase of about 100,000 is projected by 2015. Approximately 73% of people live east of the River Bann, with 27% living to the west. The population in the west is expected to increase more quickly than that in the east during the next 15 years, but this will have only a small impact on the relative sizes of the two parts of the population.

2.3 The proportion of elderly people in Northern Ireland's population is also increasing: 5.8% are aged 75 and over compared with 5.5% in 1990. By 2015 6.9% of people will be over 75 and 4.0% will be over 80, compared with 3.1% over 80 in 2000. The fact that people are living longer is partly the result of better living standards and partly because of greater understanding of disease and the development of better means of diagnosis and new treatments. It has been estimated[1] that three of the seven years' increase in life expectancy since 1950 can be attributed to better medical care. The same study estimated that improved medical care also provides, on average, five years of partial or complete relief from the poor quality of life associated with chronic disease.

2.4 The increase in life expectancy has been accompanied by improvements in health among older people. Nevertheless although people over 75 represent only 5.8% of the population, they consume 18% of resources devoted to acute hospital care[2]. This means that an increase in the number of elderly people will have a disproportionate impact on funding requirements for hospital services.

2.5 Although the annual number of births has been falling gradually (from 33,000 in the 1960s to fewer than 23,000 in 2000) this is more than compensated for by the increase in the number of older people. It is not until after 2031 that the decline in the number of children[3] is projected to outstrip the expansion in older people and for the first time in a number of decades the population is expected to begin to contract.

"an increase in the number of elderly people will have a disproportionate impact on the funding requirements for hospital services"

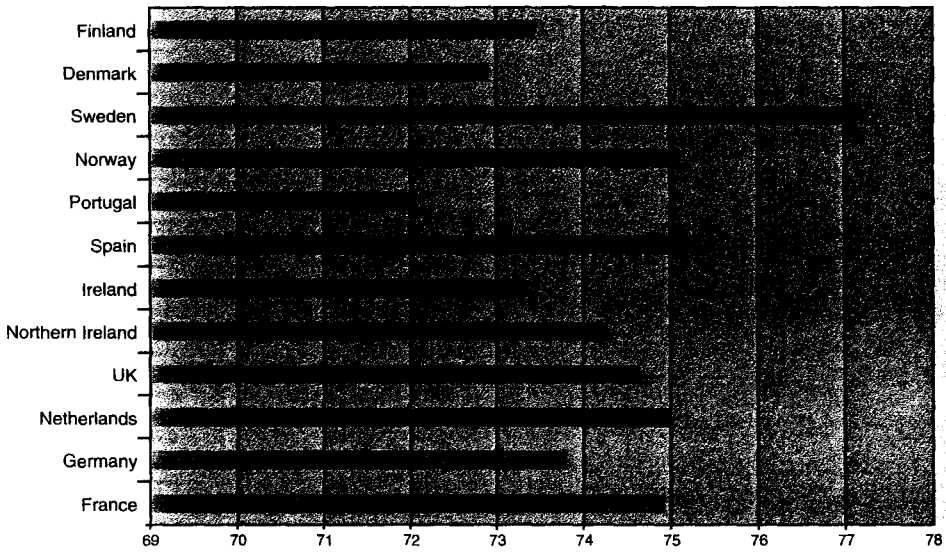
Bunker JP. Medicine matters after all. J R Coll Physicians Lond 1995 Mar-Apr;29(2):105-12

age-sex cost estimates taken from HSCRU report on needs indicators for acute hospital services along with the estimated effect of migration

Causes of Death in Northern Ireland

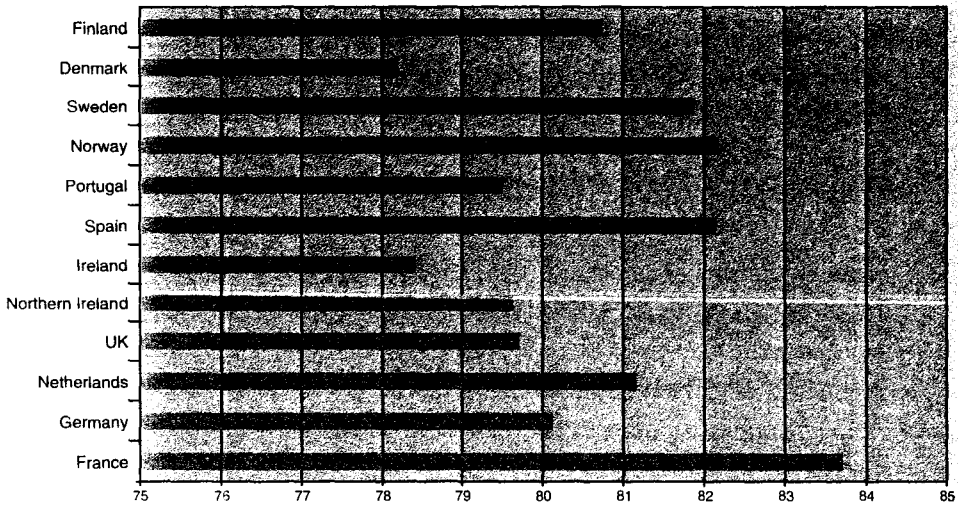
2.6 Over recent years there has been a small but steady increase in life expectancy for Northern Ireland people. Figures 2.1 and 2.2 show that while life expectancy remains slightly below that in the rest of the UK, for men it is now roughly in the middle and for women in the bottom half of a group of northern and western European countries.

Figure 2.1 Life Expectancy at birth (Males) European countries 1999



Sources: WHO, NISRA

Figure 2.2 Life Expectancy at birth (Females) European countries 1999



Sources: WHO, NISRA

2.7 Coronary heart disease (CHD), stroke and cancer are the main causes of death in adults. In recent years deaths from heart disease and stroke in men and women

under 75 years have been falling and are expected to continue to do so, but the standardised mortality rate for CHD in Northern Ireland is still one of the highest in Europe. Cancer deaths and suicides on the other hand are slightly lower than in Great Britain. While deaths from heart disease have been falling, those from cancer have been increasing and it has been predicted that cancer will overtake heart disease as the main cause of death in Northern Ireland by 2007.

2.8 Within Northern Ireland there are significant variations in life expectancy, with (as elsewhere in the developed world) people in affluent areas living longer than those in deprived areas. Infant death rates are almost 50% higher in the most deprived groups of our population than in the least deprived. Children from deprived areas have higher rates of death due to accidents: they are 15 times more likely to die as a result of a house fire than those from the most affluent areas and seven times more likely to die as a result of a road traffic accident.

2.9 A measure of the *overall* mortality in a population that is often used as a proxy for morbidity, and need for health services, is the Standardised Mortality Ratio (SMR). This is the ratio of the actual number of deaths to that expected if mortality rates by age group had been the same as in a standard or reference population (in this case the UK as a whole). Table 2.1 shows SMRs for UK regions along with values of a similar index reflecting self-reported limiting long-standing illness which has also been shown to be closely related to need for hospital services. Although Northern Ireland's mortality and morbidity levels are higher than the average for the UK they are now both less than in three English Regions. Mortality is much lower in Northern Ireland than in Scotland, and morbidity much lower than in Wales.

Table 2.1 Standardised Mortality and Limiting Long-standing Illness Ratios 1998/99 (UK=100)

Region	SMR (1998)	SLLIR (1998/99)
England	98	98
North East	114	116
North West	109	111
Yorkshire and the Humber	103	113
East Midlands	100	99
West Midlands	101	103
East	93	91
London	95	93
South East	91	83
South West	89	88
Scotland	116	97
Wales	101	130
Northern Ireland	101	105

Source: Regional Trends 2000

Hospital Provision

2.10 There are 15 acute hospitals in Northern Ireland, each of which provides a range of acute inpatient and outpatient services together with the necessary support services. There is also a specialist elective (non-emergency) centre at Musgrave Park in Belfast. There are significant differences in size of hospitals, the range of services available and their ability to deal with complex cases. Catchment populations range from less than 50,000 to 200,000. Hospitals elsewhere in the UK generally serve larger populations. For example, district general hospitals in England typically serve populations of 250,000 to 300,000, and recent studies suggest that a catchment population of about 500,000 may be required to allow the full range of services to be delivered effectively. Table 2.2 below shows the number of beds (including acute beds) available in each of Northern Ireland's acute hospitals.

"a catchment population of about 500,000 may be required to allow the full range of services to be delivered effectively."

Table 2.2 - Northern Ireland's Acute Hospitals and Bed Numbers (1999/2000)

Hospital/ Board	Acute Beds*	All Beds
Antrim Area Hospital	366	376
Coleraine Hospital	180	180
Route Hospital, Ballymoney	68	68
Mid Ulster Hospital, Magherafelt	180	180
Whiteabbey Hospital	100	163
Northern Board Total	**894**	**967**
Belfast City/Jubilee Hospitals	621	738
Downe Hospital, Downpatrick	112	125
Lagan Valley Hospital, Lisburn	141	198
Mater Infirmorum Hospital, Belfast	190	246
Musgrave Park Hospital, Belfast	184	256
Royal Group of Hospitals, Belfast	816	922
Ulster Hospital, Dundonald	444	573
Eastern Board Total	**2,508**	**3,058**
Craigavon Area Hospital	370	374
Daisy Hill Hospital, Newry	219	274
South Tyrone Hospital, Dungannon	80	98
Southern Board Total	**668**	**746**
Altnagelvin Hospital, Londonderry	408	456
Erne Hospital, Enniskillen	184	240
Tyrone County Hospital, Omagh	89	106
Western Board Total	**680**	**802**
Northern Ireland Total	**4,751**	**5,573**

* Programmes of Ca e 1 (Acute) and 2 (Maternity and Child Health)

Local Hospitals

2.11 There are a number of smaller local or 'community' hospitals: Ards, Armagh Community, Banbridge, Bangor, Braid Valley, Carrickfergus, Dalriada, Loane House, Lurgan, Mourne, Moyle, Mullinure, Omagh General, Roe Valley, Robinson Memorial, South Tyrone, Spruce House and the Waveney.

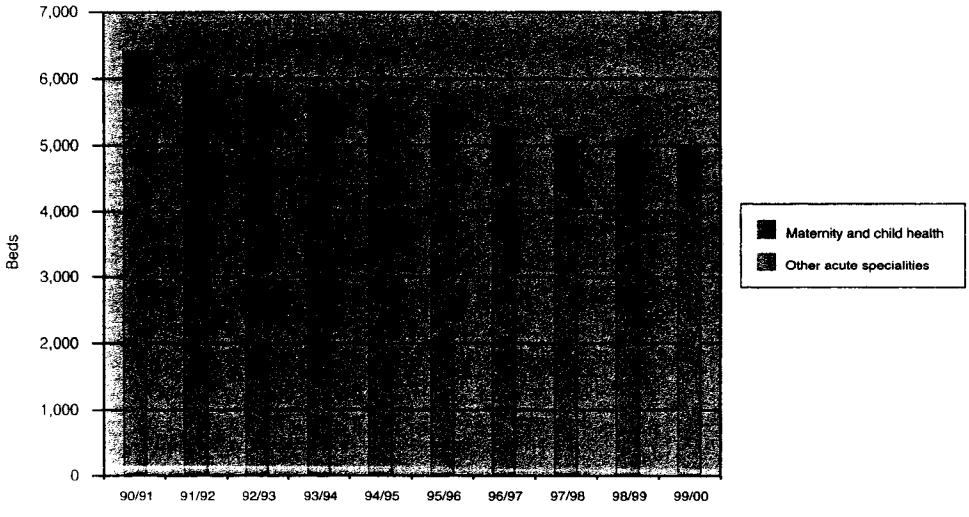
2.12 The range of services provided at community hospitals is narrower than that provided at acute hospitals. None of the community hospitals in Northern Ireland is able to deal with medical or surgical emergencies but they may provide intermediate care beds (sometimes overseen by GPs), out-patient clinics for surgery and medicine, day surgery, and a minor injuries unit.

Hospital Beds and Activity

(i) Inpatient Services

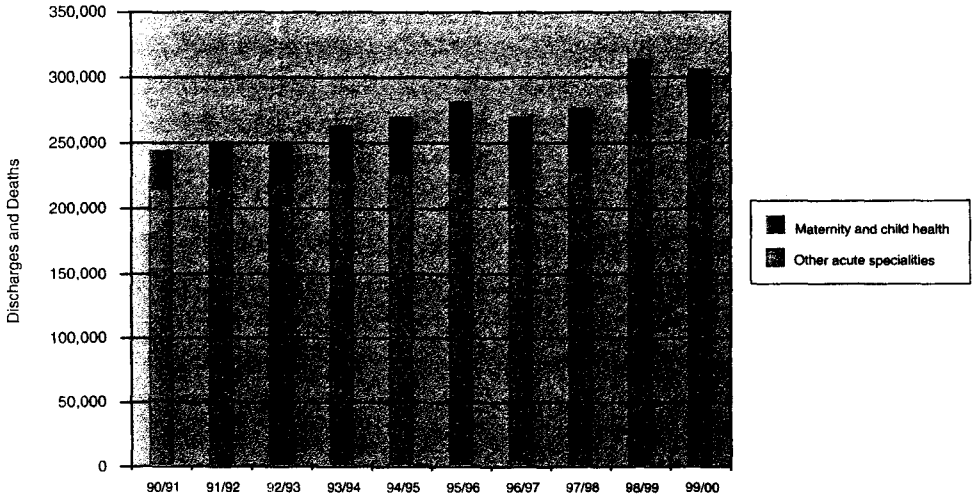
2.13 Since 1990/91 there has been a reduction of 1,400 (21%) in the number of acute hospital beds in Northern Ireland (Figure 2.3).

Figure 2.3 Available acute beds 1990/91-1999/2000



2.14 Over the same period there has been a 25% increase to over 300,000 in the number of inpatients treated each year (Figure 2.4).

Figure 2.4 Inpatients Treated 1990/91-1999/2000



2.15 This has been made possible by a reduction of 31% in average length of stay across all acute specialties Over the same period, the proportion of inpatients treated as day cases has increased from 18.5% in 1990/91 to 31.6% in 1999/00. Trends in length of stay and throughput during the last 10 years are shown in Figures 2.5 and 2.6. These are two of the most important factors in comparing the efficiency of acute hospital services and in enabling more patients to be treated. The trends noted here are comparable with those being achieved nationally and internationally.

Figure 2.5 Average Length of Stay 1990/91-1999/2000

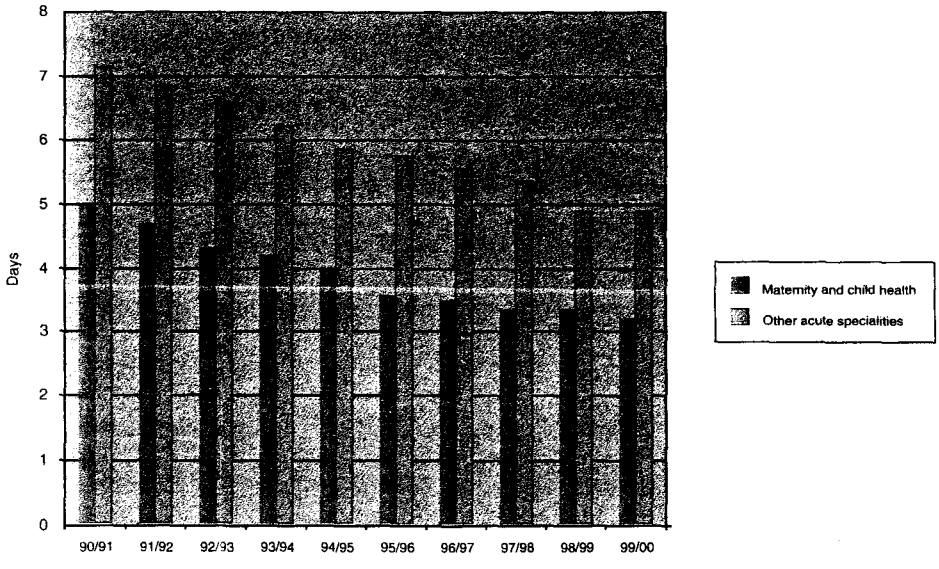
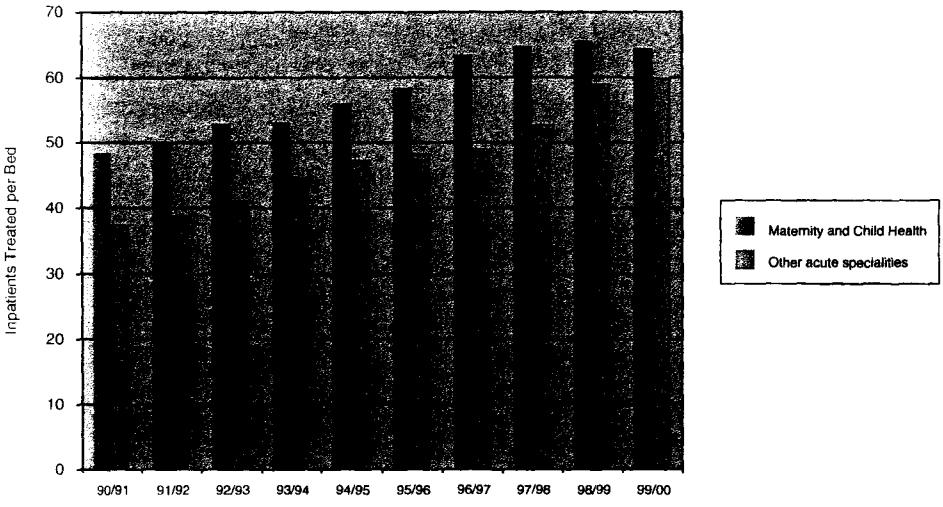


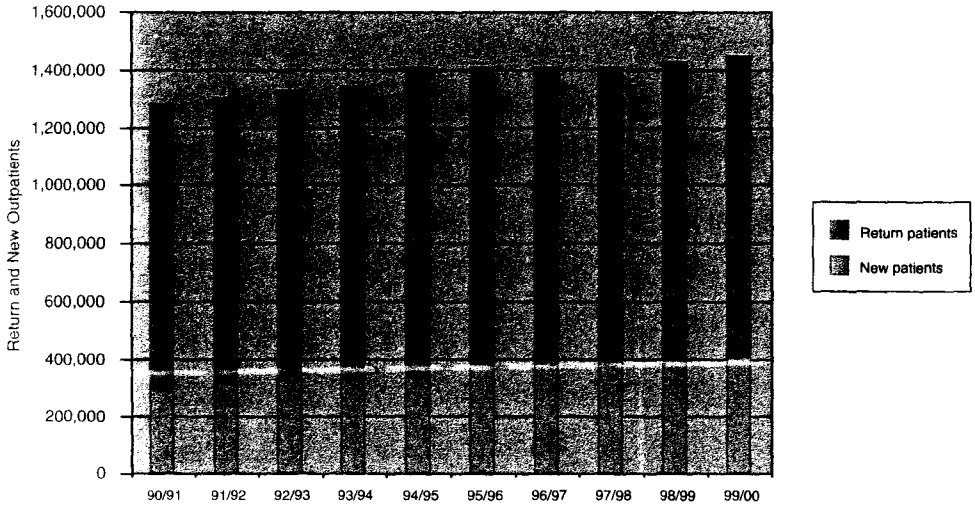
Figure 2.6 Inpatients Treated per Bed 1990/91-1999/2000



(ii) Outpatient Activity

2.16 In 1999/00, 1.435 million outpatients were treated in Northern Ireland hospitals, a 10% increase on the number treated in 1990/91. The number of new attendances has increased by 29% over that period, with return attendances increasing by just 4%. The ratio of return to new attendances has fallen from 3.1 to 2.5 as shown in Figure 2.7 below.

Figure 2.7 Outpatient Attendances 1990/91-1999/2000

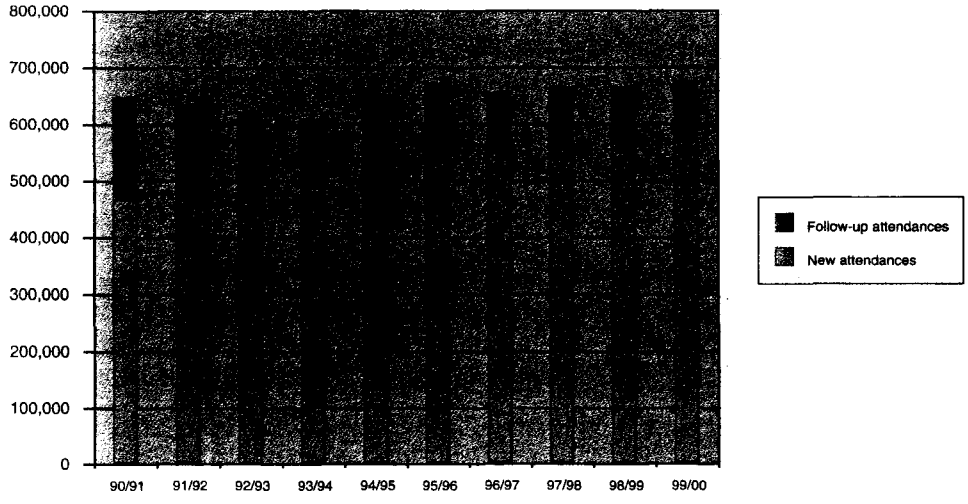


2.17 In 1999/00, 217,000 patients with an outpatient appointment did not attend, representing 13.1% of all scheduled appointments. In the same year 8,923 scheduled clinic sessions were cancelled (8.8% of all clinics), up from 6,256 (6.7%) in 1995/96.

(iii) Accident and Emergency Department Activity

2.18 In 1999/00, there were some 671,000 attendances at Accident and Emergency Departments, a rise of 3% on 1990/91. First attendances have risen by 23% while follow-up attendances have fallen by 47% (which is a significant improvement in performance). Trends in A&E attendances over this period are shown in Figure 2.8.

Figure 2.8 A&E attendances 1990/91-1999/2000



Hospital Workforce

2.19 At March 2000, some 22,200 whole time equivalent (WTE) staff were employed in hospitals in Northern Ireland, a reduction of just over 1% compared to March 1996. Doctors, nurses and midwives account for more than half of all of the staff employed in hospitals. A breakdown by main staff category is provided in Table 2.3.

Table 2.3 Hospital Based Staff at March 2000

Staff Category	WTEs at 31 March 1996	WTEs at 31 March 2000	Percentage Change
Medical and Dental	1,977	2,191	+10.8%
Professional and Technical	2,000	2,102	+5.1%
Nursing and Midwifery	12,215	11,637	-4.7%
Social Services	40	44	+10.0%
Administration and Clerical	3,049	3,342	+9.6%
Ancillary and General	2,693	2,497	-7.3%
Works and Maintenance	511	424	-17.0%
Total	22,486	22,237	-1.1%

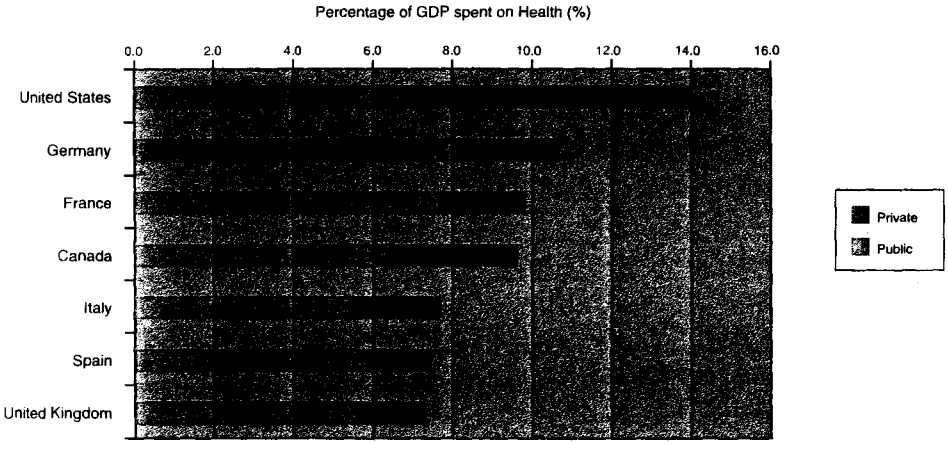
2.20 There have been increases in all staff groups with the exception of Nursing and Midwifery and two others (Ancillary and General and Works and Maintenance) where functions have been contracted out.

Comparisons with Health Services in Other Countries

International Comparisons

2.21 The UK spends less on health care than most other developed countries as shown in Figure 2.9 below.

Figure 2.9 Health spending as % of GDP 1997



2.22 The lower level of health care provision in the UK relative to other countries in Europe is highlighted by the number of doctors in each country. In 1996, while the UK had 175 consultants per 100,000 population, Germany had 341, France had 303 and Sweden had 280.

National Comparisons

2.23 The DHSSPS provided us with comparative data for England, Scotland, Wales, Northern Ireland and, where available, the Republic of Ireland on resource availability and utilisation such as beds, staffing, etc. These data are shown in Tables 2.4 to 2.7 below.

Table 2.4 Comparative Bed Numbers and Activity Levels (1999, other

Beds and Activity	Northern Ireland (1999)	England (1999)	Scotland (1999)	Wales (1999)
All beds / 1000 pop	5.0	3.8	7.1	5.1
Acute beds (incl maternity) / 1000 pop	2.8	2.4	3.1	3.3
Acute discharges/ 1000 pop	169.9	154.8	170.8	161
Acute discharges/bed	60.1	64.9	55.2	48.6
Day cases/1000 pop	65.8	69.1	85.5	111
A&E attendances/ 1000 pop	392.6	288.5	305.9	33[illegible]

*All specialties in publicly funded acute hospitals

Table 2.5 Comparative Staffing Levels per 1,000 Population (1999)

Staff Group	Northern Ireland (Staff/ 1,000 Population)	England (Staff/ 1,000 Population)	Scotland (Staff/ 1,000 Population)	Wales (Staff/ 1,000 Population)	[illegible]
Acute consultants - surgery	0.097	0.085	0.112	0.072	[illegible]
Acute consultants - dental	0.007	0.009	0.015	0.013	[illegible]
Acute consultant physicians	0.079	0.072	0.101	0.079	[illegible]
Acute consultants - other	0.201	0.166	0.207	0.172	[illegible]
All acute consultants (PoC 1)	0.386	0.332	0.434	0.336	[illegible]
O&G consultants	0.029	0.020	0.028	0.020	[illegible]
All health service consultants	0.482	0.418	0.545	0.416	[illegible]
Total medical & dental staff	1.44	1.21	1.59	1.29	[illegible]
Nursing, midwifery etc	8.69	7.27	10.04	8.60	[illegible]
Scientific, PAMs etc	2.48	2.15	2.76	2.36	[illegible]
Total direct HCHS care staff	12.61	10.64	14.38	12.25	[illegible]
Management & support staff* and ambulance staff	9.33	5.08	6.52	6.16	[illegible]
Total HCHS staff*	21.94	15.72	20.90	18.41	[illegible]
GPs	0.63	0.56	0.72	0.60	[illegible]
Population per GP	1,597	1,794	1,385	1,666	[illegible]

* Northern Ireland data include management and support staff for personal social services

Table 2.6 Comparative Inpatient Waiting lists (2000)

Waiting List Measure	Northern Ireland	England	Scotland	Wales
Number of people on inpatient waiting lists/ 1000 population	28.0	20.7	16.1	27.2
Number of people waiting more than 12 months/ 1000 population	5.62	0.97	0.23	3.85

Table 2.7 Comparative Provision of Community Care (1999)

Service Area	Northern Ireland (per 1,000 population >75 years)	England (per 1,000 population >75 years)	Scotland (per 1,000 population >75 years)	Wales (per 1,000 population >75 years)	RoI (per 1,000 population >75 years)
Nursing home beds	99.5	54.9	68.1	49.2	35.6
Residential places	71.4	93.7	70.7	72.9	62.8
Total care home places	170.9	148.6	138.7	122.0	98.4
Supported in nursing homes	51.9	19.9	35.5	22.1	n/a
Supported in residential homes	34.0	50.8	20.2	48.3	n/a
Total supported	85.9	70.8	55.8	70.4	n/a
Total home help recipients	285.7	121.1	214.7	126.6	n/a
Total meals recipients	44.4	43.8		69.2	n/a

2.2-1 In the main, Northern Ireland has higher hospital utilisation rates, particularly in A&E, than other parts of the UK and Ireland. It has more acute hospital beds and staffing resources than England but appears to use them less intensively, whereas Scotland, with more bed resources, uses them less intensively still. The disparity with other jurisdictions is however most marked in respect of community care services, where Northern Ireland has considerably higher levels of public and private provision and of state-funded utilisation of both institutional and domiciliary care. Reliance on nursing home, as distinct from residential home, provision is particularly high in Northern Ireland.

Summary

2.25 The population of Northern Ireland is increasing, and in the future an increasing proportion of the population will be elderly. Over recent years there has been an improvement in the overall health of the population, but there continue to be variations in health status in different parts of the region. More patients are now being treated in fewer beds, but Northern Ireland still has a greater number of beds than England, Wales and the Republic, and there is scope for further efficiency improvements. Northern Ireland has considerably higher levels of public and private provision and of state-funded utilisation of both institutional and domiciliary care.

Chapter 3 - Pressures Facing the Service

Introduction

3.1 This chapter sets out a number of pressures that we believe will demand significant change to the pattern of hospital services in Northern Ireland. The status quo is not an option. There are increasing demands from the public for high quality, effective and accessible health care. There are changes taking place in the patterns of illness and disease in an increasingly elderly population. There are pressures for greater concentration in the delivery of clinical services and developments that will enable services to be delivered in local settings, nearer to home. Finally, there continues to be significant pressure on the resources available to the service.

"The status quo is not an option"

Changing Care Needs

3.2 We noted in Chapter 2 that the population of Northern Ireland is expected to increase by 100,000 to some 1.8 million by 2015. The proportion of elderly people in Northern Ireland's population is also projected to rise. People are now living longer as a result of the greater understanding of disease and the consequent development of earlier diagnosis, new treatments and new drugs. The ageing population will present increasing demand for care in hospital and in the community. Although there is evidence that elderly people are staying healthy longer than in the past, there is likely to be a substantial rise in the incidence of diseases and accidents commonly associated with old age - fractures of the hip, dementia, kidney disease, stroke, heart disease and cancer, for example.

3.3 At the same time the number of births in Northern Ireland has been falling and is expected to continue to do so for the foreseeable future. This will have a significant impact on the demand for maternity services and services for children.

3.4 The framework for the future organisation of hospital services in Northern Ireland will need to reflect these fundamental changes to our demands for services.

Public Expectations

3.5 People are becoming better informed about new developments in health care through newspapers, television, the Internet and other sources. As levels of service in other parts of the economy rise, they will demand improvements in quality, convenience and effectiveness, at the same time placing value on ready access to services. People will be increasingly reluctant to accept services that are merely on a par with those historically provided in the UK; they will want services at least as good as those in the best European countries.

3.6 Our consultation exercise highlighted that what concerned people most was access to emergency care services (including coronary care) and maternity services. People told us that they were prepared to travel some distance to specialist centres for complex, expensive or rare treatments, and they acknowledged that such services cannot be provided at more than a limited number of centres. But they expect routine treatment, or care that has to be received regularly, to be available locally.

3.7 It is important that these expectations are reflected in the framework for the future organisation of hospital services in Northern Ireland.

Demand for Services

3.8 Demand for health services in Northern Ireland is very high, certainly in comparison with other parts of the UK and Ireland. We consider in the paragraphs below the two main components of this demand, namely, demand for elective (planned) care and demand for emergency care.

Demand for Elective Care

3.9 Northern Ireland has the longest per capita hospital waiting lists in the UK. In March 2000 there were over 47,000 people waiting for elective treatment, an increase of nearly 11,000 compared to March 1996. More significantly, there has been a huge increase in waiting *times*, with the number of patients waiting 18 months or more for treatment increasing from 632 in March 1996 to 5,200 in March 2000.

"there has been a huge increase in waiting times, with the number of patients waiting 18 months or more for treatment increasing from 632 in March 1996 to 5,200 in March 2000"

3.10 Although there is some doubt as to the accuracy of the data, the number of people recorded as waiting for an outpatient appointment has also increased significantly, from 59,000 in March 1996 to over 102,000 in March 2000. Of these patients, the number waiting six months or more for an appointment has increased from 7,300 to 26,700.

3.11 We believe that the current waiting times for treatment and outpatient consultations are totally unacceptable. We welcome the recent target set by the Minister to reduce the number of people waiting for treatment to 39,000 by March 2004 and to eliminate entirely all people waiting for more than 18 months by March 2003. But even these targets, challenging as they may be, do not go far enough. We do not see why an elderly patient should have to wait for a cataract operation (the current average waiting time is over six months) or a joint replacement (currently six to eight months) that could transform the quality of their remaining years of life.

3.12 We therefore recommend that new more challenging targets to reduce waiting times be established, with a view to ensuring that by 2010 no one should have to wait more than three months for treatment. In working towards this target, we would not wish to see average waiting times reduced other than on the basis of the clinical priority of individual patients, as determined by their GP and/or hospital consultant.

3.13 Better performance will require significant change to the current arrangements for undertaking elective work. In particular, planned operations must be protected from the disruption and uncertainty caused by emergency admissions.

"We believe that the current waiting times for treatment and outpatient consultations are totally unacceptable"

Demand for Emergency Care

3.14 In 1999/2000, A&E departments and minor injury units in Northern Ireland saw some 670,000 patients. This represents a slight fall compared to the number seen in 1995/96, but this fall is attributable to a reduction in return attendances; first attendances have continued to rise. Attendance rates in Northern Ireland are 37% higher than in England, 29% higher than in Scotland, 18% higher than in Wales and 20% higher than in the Republic. In England 20% to 30% of A&E attendances are regarded as 'inappropriate' (in the sense that they could have been adequately dealt with in another setting and more conveniently for the patient). The number of inappropriate attendances is likely to be at least as high in Northern Ireland. The high level of 'inappropriate' A&E attendances may indicate there is a useful role for a GP presence in A&E departments and there is some evidence that this is likely to improve appropriateness of treatment. We believe that there is also scope for greater use of nurse consultants and nurse practitioners. Alternatively, it may be possible to locate primary care centres or out-of-hours facilities close to A&E departments or local emergency units.

3.15 The overall number of emergency admissions to hospitals in Northern Ireland has also remained fairly constant during the last five years, but again our admission rates are high relative to other parts of the UK and Ireland. The proportion of emergency surgical admissions not resulting in an operation is also markedly greater than elsewhere, lending weight to the view that thresholds for admission to hospital in Northern Ireland may be lower than they might be.

3.16 While the overall annual number of emergency admissions has remained fairly constant, this conceals surges in the number of emergency medical admissions during the wintertime, when infections from the flu virus and related conditions are at their peak, which have at times threatened to overwhelm the service. We have seen evidence too, that emergency pressures are no longer only a problem in winter months. Pressure is now being felt in some hospitals into March and April, and later.

3.17 Pressures were particularly severe during the winter of 1999/00. These pressures were detailed in the DHSSPS report 'Facing the Future - Building on the lessons of winter 1999/2000'. The report describes how, over a six week period, hospitals and community services were put under sustained pressure as vulnerable people, particularly older people and children, sought treatment for severe flu-related and other respiratory illnesses, and hospital staff themselves succumbed. Hospitals and other services struggled to cope with the volume of demand for care and treatment. The provision of emergency care services had to take precedence and, inevitably, this compromised the level and quality of other services and placed great pressure on staff. All but the most urgent operations were suspended to make space for treating emergency admissions, and with surgical beds filled with patients from medical wards, normal hospital services were badly disrupted. At peak periods, acute and intensive care beds were being used to their full capacity and some very ill patients had to receive care in inappropriate settings. Some patients also had to lie on trolleys for long periods awaiting admission. At the same time, many community services were coming under severe pressure and patient discharges from hospital were delayed, further increasing the pressure on beds.

"While the overall annual number of emergency admissions has remained fairly constant, this conceals surges in the number of emergency medical admissions during the wintertime which have at times threatened to overwhelm the service."

3.18 In an effort to learn from the experiences of the winter of 1999/00, the Minister commissioned reviews by the Chief Medical Officer and the Chief Social Services Inspector, and asked the four Boards for reports. The actions to be taken as a result of this work include the phased expansion of intensive care and high dependency beds, the recruitment by Trusts of additional staff in key areas, and better communication between hospital and community care services.

3.19 As with elective care, the framework for the future organisation of hospital services in Northern Ireland will need to ensure that emergency care services are effectively managed. It will be particularly important to ensure that patients are treated in a hospital or primary care setting appropriate to their needs.

Advances in Medical Technology

3.20 Developments in medical technology in recent years have opened up new opportunities for diagnosis and treatment. Modern medicine is able to do things that were only dreamt of a generation ago. There are demands for new technology and equipment from almost all specialties, but particularly from pathology, radiology and the major admitting specialties. Much of this new equipment is very sophisticated and expensive. It also requires the skills of specially trained staff to operate it and interpret the results. This makes it inappropriate to try to provide much of this equipment on a large number of hospital sites. To do so would mean that scarce resources may be spent on under-utilised equipment and that specialist staff would have difficulty in maintaining and developing their skills. It is important, therefore, that the range of equipment at various hospitals is appropriate for the

types of services provided, and that there is complementarity of equipment and services between different hospitals.

3.21 At the same time, developments in medical technology have also created possibilities for some investigations and treatments to be delivered in local settings, nearer to our homes. One example is telemedicine, which enables timely specialist opinion to be accessed remotely, whether from a primary care setting or between hospitals.

Impact of New Technology on the Provision of Services

The Tyrone County Hospital in Omagh has established a tele-link with the Royal Victoria Hospital which has significantly improved access to Neurology services for patients in the Omagh area. Prior to the establishment of the link, all patients requiring a neurological opinion had to travel to Belfast or to Altnagelvin Hospital in Londonderry. With the establishment of the tele-link, patients at the Tyrone County Hospital can be reviewed remotely by a neurologist in the Royal Victoria Hospital who will then take a decision on their care needs.

Increasing Specialisation

3.22 The advances in medical technology referred to above require doctors, nurses and other staff to develop their expertise in increasingly narrow fields and specialisms to keep abreast of the pace of change. Consultant physicians and surgeons are increasingly specialising in the management and treatment of specific groups of illnesses. In surgery, for example, individual consultants now concentrate on the treatment of different cancers and in medicine there are specialists in old age (geriatricians) and the young (paediatricians). Further sub-specialisation has developed in many areas, for example, within paediatrics, neonatologists specialise in treating ill, newborn babies. This is reflected in the training of new doctors which is placing greater emphasis on developing specialists. Consequently, while the number of doctors may increase, there will be fewer general physicians and general surgeons.

3.23 Specialisation has created significant pressure for services to be concentrated on a reduced number of sites, serving larger populations. During the course of our review we were told of a number of reasons - many directly related to increased specialisation - why services should be concentrated in a smaller number of large hospitals:

- The medical Royal Colleges, in pursuit of better quality medical education, are laying down increasingly stringent accreditation standards. It is more difficult for smaller hospitals to meet these standards because the number of patients and the range of symptoms presenting for diagnosis can be too small to make training realistically possible.
- The EC Working Time Directive places a legal requirement on the United Kingdom and other Member States to reduce the working time of junior doctors to an average of 48 hours a week by 2010. This reduction in hours, and the need to meet training requirements, dictate the need to rationalise the deployment of junior doctors and will make it increasingly difficult to provide 24-hour services on a large number of sites.
- Consultant medical staff prefer to work in larger centres where they have the support of colleagues when dealing with complex cases, where specialist teams have caseloads that are adequate to maintain their level of expertise, and on-call rotas that are not unreasonably onerous.
- General physicians and surgeons, who have traditionally been the clinical backbone of smaller hospitals, are no longer being trained in the same way. Once the present generation retires, it will be difficult to find generalists to replace them.
- Primary care practitioners are already under pressure and, unless they receive additional resources, will find it difficult to stretch themselves further by providing additional support to smaller hospitals.

3.24 However, the evidence on whether concentrating services in a reduced number of specialist centres results in improved patient outcomes is not clear cut. The Joint Consultants Committee (JCC) report 'The Organisation of Acute General Hospital Services' (1999) notes that *"Evidence is emerging from volume quality relationships that improved clinical outcomes can be achieved for some treatments by concentrating activity into specialist centres although some of the evidence to date is conflicting. While professional expectation and public perception are inclined to favour larger specialist units, particularly for surgical conditions, many medical patients are probably best handled by general (internal) medical specialists practising in smaller hospital units, where the numbers are more manageable. The problem lies in identifying those who can be cared for in such units without undue compromise. Where doubt exists, the patient should first be admitted to a unit where all resources for diagnosis are available."*

3.25 The JCC report identifies examples of service areas where there are probable benefits from concentrating services, namely *"the development of cancer centres, supra-district neonatal intensive care units, renal transplantation units and trauma centres, and also in the management of vascular surgical conditions and head and major injuries."*

5.26 We were also helped in our consideration of the potential benefits of concentrating services by the University of York report 'Concentration and Choice in the Provision of Hospital Services' (1997). It examined the evidence to support service concentration on the basis of improved patient outcomes and reduced costs. In relation to patient outcomes, the report concludes that the evidence available does not support the view that larger volumes inevitably lead to higher quality but there are strong indications that for some conditions and procedures very low volumes can be associated with higher risk.

"larger volumes do not inevitably lead to higher quality, but for some conditions and procedures very low volumes can be associated with higher risk."

5.27 In relation to costs, the York report reaches the following conclusions: economies of scale appear to be fully exploited at a relatively low level (in the range 100-200 beds); diseconomies of scale may be expected to begin to rise in hospitals with more than 300-600 beds; and the extent or size of any diseconomies of scale cannot be reliably estimated from available literature.

5.28 These conclusions relate to individual hospitals. We found no evidence in relation to networks of hospitals but such networks may have the potential to generate efficiency improvements, particularly where they bring together in a single organisation a number of relatively small hospitals (i.e. those with less than 200 beds).

"networks may have the potential to generate efficiency improvements, particularly when they bring together in a single organisation a number of relatively small hospitals."

Resource Constraints

5.29 The escalating costs of capital development, new technology and equipment, new techniques and new drugs emphasise the need to ensure that hospital services are provided in the most cost effective manner if the current level of service is to be maintained, let alone enhanced. It is clear from the financial position of a number of Trusts in Northern Ireland that they are struggling to maintain services within the available resources: in 1998/99 the Trusts incurred a combined deficit of £6.8 million and in 1999/00 the deficit was £15.6 million. The pressure on resources within Trusts has contributed to the significant increase in waiting lists referred to above. The significant under-investment in the health estate and in essential new equipment and technology is a longer standing problem.

5.30 Our proposals for the future organisation of hospital services in Northern Ireland must be affordable within the resources likely to be available. While undoubtedly there is a need for a substantial injection of funding, it is of even greater importance that existing resources are used as effectively as possible.

"proposals for the future organisation of hospital services in Northern Ireland must be affordable within the resources likely to be available."

Summary

3.31 There are many pressures that will require significant change to the pattern and organisation of hospital services in Northern Ireland. We see no alternative to the trend towards specialisation as a means of ensuring excellence and consistently good outcomes for patients, but this must not be at the expense of reasonable access. The challenge is to secure the benefits of specialisation without concentrating services to such an extent as to make them inaccessible to the patients who need them.

3.32 Demand for services in Northern Ireland is very high and the system is struggling to cope, particularly during the winter. The future vision for the organisation of hospital services must ensure that this demand is met by deploying scarce resources and exploiting them fully to provide the maximum benefit for patients. Different parts of Northern Ireland will require local solutions that reflect local circumstances. But the quality and safety of the care provided must be uniformly excellent.

3.33 To do nothing is not an option. The status quo is unlikely to remain viable in the foreseeable future. The pressures we have identified will not go away and, as we have seen, services in smaller hospitals cannot be sustained unless changes are made that are planned, systematic and radical.

"To do nothing is not an option. The status quo is unlikely to remain viable in the foreseeable future. The pressures we have identified will not go away and, as we have seen, services in smaller hospitals cannot be sustained unless changes are made that are planned, systematic and radical."

Chapter 4 – Resource Availability and Utilisation

Introduction

4.1 In the previous chapter we noted that over the next 15 years there are likely to be further marked increases in pressure on the acute hospital sector in Northern Ireland. Although (as we saw in Chapter 2) there is no evidence that our population has markedly greater overall health needs, demand is already considerably higher than elsewhere in these islands. Waiting lists for elective treatment have been rising for some years and are unacceptably high by any standard, indicating that existing demand is not being accommodated. It was clear to us that one of the most pressing problems facing the service is how to manage this apparently inexorable increase in demand.

"One of the most pressing problems is how to manage an apparently inexorable increase in demand."

4.2 Our consultation exercise showed that there was a common belief among staff and public alike that health services in Northern Ireland were chronically under-funded. It was taken as axiomatic by many that the problems detailed in Chapter 3 (excessive waiting lists for elective treatment, difficulties coping with peaks in emergency medical admissions, etc.) were directly attributable to a shortage of resources, both in hospitals and in community services

4.3 Such problems can indeed be a result of under-funding, but they can also be the result of not using resources efficiently and effectively. There will never be 'enough' resources for health care in a publicly funded system, in the sense that additional funds could always be used to beneficial effect. Some 20 years ago the report of the Merrison Commission on the NHS[1] noted that the capacity of health services to absorb resources "is almost unlimited". It is difficult to argue for additional resources for hospital and community health services against other national and regional priorities if we cannot also demonstrate that existing resources are being used to the best effect by generally accepted levels of comparison.

4.4 We decided that it was not possible to undertake a thorough review of acute hospital services without also considering the appropriateness of funding levels and the extent to which these funds are being used efficiently. To assist with our examination of these two issues, we commissioned comparative studies in the following areas:

- Appropriateness of current and projected funding levels.
- Surgical activity rates and waiting times.
- Acute bed requirements.

4.5 The full results of these studies are available on the Internet (www.dhsspsni.gov.uk/hss). We consider the findings of each of the studies in the following paragraphs.

[1] Report of the Royal Commission on the National Health Service (1979) Cmd. 7615

Appropriateness of Current and Projected Funding Levels

4.6 The objective of the study was to inform debate about current revenue funding levels for hospital and community health services (HCHS) in Northern Ireland and to estimate the investment required in future to keep pace with regions of broadly similar need. We were concerned to find answers to the following:

- How does Northern Ireland compare with other regions in terms of funding for hospital and community health services?
- Have funding levels diverged over recent years and if so by how much?
- Have the additional funds provided to the NHS in England been reflected in Northern Ireland?

4.7 The regions and countries included in the study were Northern Ireland, the North East of England, parts of the North West of England, parts of the South West of England, Merseyside, Scotland, Wales and the Republic of Ireland.

Current Expenditure by Region

"Northern Ireland spends a greater proportion of hospital and community health resources on acute hospitals than most other regions"

4.8 Table 4.1 compares current *per capita* expenditure on hospital and community health services and, separately, acute services across the regions studied. HCHS expenditure in Northern Ireland in 1999/00 was £557 per head, a higher level of expenditure than most of the other regions studied. This may partly reflect the higher cost of providing regional services to a relatively small population, and the number of Boards and Trusts. Spending on acute services is higher than any other region apart from Scotland. This reflects the fact that we spend a greater (and, unusually, an increasing) proportion of HCHS resources on acute hospitals than most other regions.

Table 4.1 Current per Capita Expenditure by Region (1999/2000)

Region	HCHS £/head	Acute £/head	Acute as % of total HCHS spend
N Ireland	557	329	59.1%
NE England	587	321	54.7%
NW England	477	239	50.1%
SW England	522	288	55.1%
Mersey	459	254	55.3%
Scotland	629	336	53.4%
Wales	539	326	60.4%
RoI	605	315	52.0%

As we noted in Chapter 2, both the population of Northern Ireland and the proportion of elderly people are expected to increase. These factors together mean that over the next eight years Northern Ireland will experience one of the highest rises in the cost of providing acute services (which, as we saw above, accounts for almost 60% of all HCHS spending). Of the regions and countries studied only the Republic of Ireland is likely to have a greater need for increased acute hospital funding.

"These factors together mean that over the next eight years Northern Ireland will experience one of the highest rises in the cost of providing acute services"

Historical Expenditure Trends by Region

Although the 1999/00 HCHS funding figure in Northern Ireland of £557 per head was greater than most other regions, a number of these regions have enjoyed higher rises in recent years. For example:

- In 1996/97, HCHS expenditure per head in Northern Ireland was similar to that in the North East of England, and around 8% lower than that in Scotland.
- By 1999/00, HCHS expenditure per head in Northern Ireland was 5% lower than that in the North East of England, and 13% lower than that in Scotland.

These lower annual increases in Northern Ireland, combined with the increases in demand, have contributed to the feeling of pressure in the HCHS over recent years. This is not to discount the fact that the funding base of the NHS as a whole is now under increasingly critical scrutiny, and the Government has been committing substantial new resources. It would, however, be unwise to ignore the extent to which problems of under-funding may be compounded by not making best use of existing resources.

Future Expenditure Projections by Region

According to DHSSPS plans, HCHS expenditure in Northern Ireland is projected to increase to £1,270 million in 2003/04, or £737 per head of population. However, Northern Ireland would require an additional £141 million to match the 2003/04 projected expenditure level of £819 per head in the North East of England, and an additional £214m to match the projected Scottish level of £861 per head.

"Northern Ireland would require an additional £141 million in 2003/04 to match the North East of England and an additional £214m to match Scotland"

If current trends were to continue in all three regions, by 2009/10 HCHS expenditure in Northern Ireland would have risen to £1,851 million, or £1,052 per head of population. Spending in the North East of England by this time would be £1,207 per head and in Scotland would be £1,260 per head. Northern Ireland would need an extra £273 a year million to match spending in the North East of England by 2009/10 and an extra £366 million to match spending in Scotland.

Surgical Activity Rates and Waiting Times

4.14 The objective of the study was to examine:

- Comparative admission and operation rates for major surgical specialties.
- Comparative waiting times for elective surgery.
- Comparative staffing levels for surgical specialties.

Comparative Admission and Operation Rates for Major Surgical Specialties

4.15 This part of the study examined comparative hospital admission and operation rates (for both emergencies and non-emergencies) in Northern Ireland and England for a group of inter-related major surgical specialties, namely, general surgery, urology, trauma and orthopaedics, and accident and emergency[2]. Comparative admission and operation rates for 1999/00 are shown in Table 4.2 below.

Table 4.2 Surgical Admission and Operation Rates (Emergency and Non-emergency) in Northern Ireland and England, 1999/2000

Activity Rates*	N. Ireland Activity (Episodes per 1,000 population)	England Activity (Episodes per 1,000 population)	Difference (%)
Admission Rates:			
Emergency	27.3	21.3	28%
Non-emergency	39.2	37.2	5%
Total	66.4	58.5	14%
Operation Rates:			
Emergency	10.5	10.2	3%
Non-emergency	35.3	34.1	3%
Total	45.8	44.3	3%

* Rates shown are for general surgery, urology, trauma and orthopaedics, and accident and emergency.

[2] Unlike England, in Northern Ireland some urological and trauma problems are dealt with by general surgeons. This makes it necessary to look at the group of specialties together for comparative purposes.

4.16 Table 4.2 shows that the number of admissions per head of population is 14% higher in Northern Ireland than England for the surgical specialties examined. The disparity is much greater for emergency surgical admissions (28% higher in Northern Ireland) than non-emergency surgical admissions (5% higher). The table also shows that the differences in operation rates are much lower than the differences in admission rates, with Northern Ireland undertaking only 3% more operations per head of population than England.

4.17 For emergencies, the research findings suggest that the difference in admission rates is mainly attributable to admissions that do not result in operations. Local analysis would be required to establish definitively whether these admissions are always appropriate, but the results of this research, particularly at diagnosis level, strongly suggest that many patients are being admitted in Northern Ireland who would be dealt with outside hospital elsewhere. This is confirmed by the variations in admission rates by both geographical area and GP practice that exist within Northern Ireland, and by the results of studies of the appropriateness of admissions carried out in some hospitals locally.

"the results strongly suggest that many patients are being admitted in Northern Ireland who would be dealt with outside hospital elsewhere."

Comparative Waiting Times for Elective Surgery

4.18 This part of the study examined trends in inpatient activity and waiting lists for surgical specialties. We were particularly keen to understand the long-term impact on surgical waiting lists of a 3% reduction in HPSS expenditure in 1996/97.

4.19 The study showed that for virtually all surgical specialties, 1996/97 did indeed see a marked reduction in elective admissions (and in GP written referrals) although in most specialties activity levels have now returned to their original levels. Since 1996/97 there has also been a major increase in the proportion of elective work carried out on a day-case basis.

4.20 In general surgery, Northern Ireland's per capita current waiting lists are longer than in England in relation to the number of elective admissions, and the proportions of patients that wait for long periods are much greater than in England. As we said in Chapter 3, this is wholly unacceptable. It cannot be right that people, many of them elderly, should have to wait such long periods in increasing pain and discomfort for common procedures that have the potential greatly to increase their quality of life.

4.21 The study noted that long wait patients have not been targeted in Northern Ireland, and average waiting times are also considerably higher than in England. The fairly constant size of the list between March 1997 and March 2000 suggests that a waiting list initiative could result in a stable waiting list at a lower level. We were told by the Department that a targeted, appropriately resourced initiative of this sort successfully reduced waiting lists for a period in the early 1990s.

Comparative Staffing Levels for Surgical Specialities

4.22 The study highlighted that Northern Ireland has a much higher provision of general surgeons than England, but fewer specialist surgeons such as orthopaedic surgeons and urologists. It suggested, for example, that there may be scope for appointing a further two to three specialist urologists to take all of the urological work from general surgeons, releasing capacity to help general surgeons maintain lower waiting times. We recommend that the balance of staffing between the various sub-specialties in both surgery and medicine is an important issue for workforce planning, along with the need for adequate support from the other professional groups.

Acute Bed Requirements

4.23 The purpose of this study was to establish the appropriateness of the current number of acute hospital beds and to consider how many beds might be required in the future, taking account of factors including population changes and potential improvements in productivity. The study methodology was based on that used by the National Beds Inquiry in England.

4.24 For comparability purposes the study was confined to a sub-set of acute specialties referred to in the study as 'defined acute' (the acute specialties included within this definition are provided in the detailed study). Using this definition, Northern Ireland currently has some 4,500 acute beds.

Appropriateness of Current Acute Bed Numbers

4.25 The study first examined the number of acute beds that Northern Ireland hospitals would, in theory, require at present if levels of efficiency (average length of stay, day-case rate and percentage bed occupancy) were the same as the average currently being achieved by hospitals in England. All other things being equal, shorter lengths of stay, higher day-case rates and higher bed occupancy rates will result in a lower requirement for beds. Improving efficiency in this way need not have any adverse effect on the quality of care provided to patients.

4.26 Comparing average efficiency levels in Northern Ireland in 1999/00 with those in England, the study found that:

- The average length of stay in Northern Ireland's 4,500 acute hospital beds is 5.8 days, compared with 5.3 days in England.
- The percentage of treatment undertaken on a day-case basis in Northern Ireland is 62.6%, compared with 66.2% in England.

- Acute bed occupancy levels in Northern Ireland (80.5%) are almost the same as in England (81.1%)

The study concluded that, if in 1999/00 Northern Ireland had achieved the same average length of stay, day-case rate and occupancy level as those achieved in England, some 600 fewer acute beds would have been required. We prefer to look at this conclusion in another way: between 10% and 15% more patients could have been treated in the same number of beds, provided that the necessary additional resources in terms of manpower and theatre time could be available. If this increase in activity were confined to elective surgery the entire impatient/day case waiting list could be cleared in just over a year.

Future Acute Bed Requirements

This study also projected the number of acute beds that Northern Ireland might require in 2013, the last year for which population projections within Northern Ireland were available. The study used Northern Ireland's existing relatively high admission rates as the starting point for projecting bed requirements in 2013 for a range of scenarios.

Depending on the assumptions made on future levels of emergency activity, if by 2013 hospitals in Northern Ireland were able to move to the levels of efficiency anticipated by that time in England, the study concluded that expected demand in Northern Ireland could theoretically be dealt with in 3,300 to 4,100 acute beds. This represents a reduction to the current acute bed complement of between 400 and 1,200 beds.

Commentary on Study Findings

The main question we identified at the beginning of this chapter was how the acute hospital sector in Northern Ireland can cope with projected increases in demand and at the same time reduce the unacceptable length of time that people have to wait for elective treatment.

Our short to medium term assumption is that exchequer funding for hospital and community health services in Northern Ireland will rise at the same rate as in similar regions in Great Britain, particularly the North East of England. We recommend that every effort be made to ensure that this increase in funding is secured.

This is not to imply that we regard the general level of public funding for health services Great Britain, and particularly in England, as in any sense ideal. In the

longer term, we would hope to reach the EU average in terms of the proportion of GDP devoted to health care - this would involve an increase over current plans of about £200m a year and would provide the foundation for a step-change improvement to the quality of health care provided.

"Ultimately we would hope to reach the EU average in terms of the proportion of GDP devoted to health care - this would involve an increase over current plans of about £200m a year"

4.33 We believe that people in Northern Ireland and elsewhere in the United Kingdom will be increasingly unwilling to accept levels of health care that are below those available in other European countries. They will be able to compare the impact of new treatments and procedures on survival rates for a range of conditions such as cancer and heart disease, and see improvements in the quality of life in the aged and disabled across a range of European countries. This increased awareness will inevitably create pressure for politicians to raise the quality of health care provision to a level comparable with the best in Europe.

4.34 To plan *solely* on the basis of a substantial increase in funding however, and in the meantime to eschew the possibility of increasing the numbers of patients treated with the existing or a reduced number of beds, would not in our view be prudent. Year-on-year funding increases are clearly necessary, but it will be important to ensure that available resources are used efficiently and effectively. It will also be important to ensure that any savings from efficiency improvements are available for re-investment in the service.

4.35 In Chapter 2 we saw that, in the main, hospitals in Northern Ireland have higher activity rates per head of population than elsewhere in the UK. Both accident and emergency attendance rates and emergency surgical hospital admission rates appear high. Most patients seeking unscheduled or emergency health care already consult their GP: one study has suggested that three quarters of such patients in the UK contact GPs and only 12% of them attend A&E departments. This illustrates the importance of ensuring that emergencies are treated in primary care where appropriate. If a means could be found to encourage a slightly greater number of patients requiring 'unscheduled' care to consult their GP instead of attending A&E, this could result in a substantial reduction in A&E attendances and a concomitant fall in unnecessary emergency admissions. To illustrate this, a 15% reduction in A&E attendances could be achieved with a 1.6% increase in GP consultations (incidentally bringing both the A&E attendance rate and the GP consultation rate in Northern Ireland to about the average in the NHS in Great Britain). We recommend that thresholds for referral and admission to hospital should be carefully reviewed, taking account of criteria used elsewhere.

4.36 We do not regard comparisons with the English NHS or elsewhere as necessarily prescriptive. We are fully aware of the extent to which levels of service provision in England are being challenged by the public and by professional bodies. But this does not mean that it is inappropriate to aspire to current levels of efficiency in the NHS (in particular length of stay and day case rates) as a benchmark. Improving

efficiency in this way opens up the possibility of a realistic and affordable way of tackling backlog problems such as waiting lists while coping with the needs of an increasing and ageing population. There would, however, need to be corresponding improvements in the infrastructure for diagnostic services such as CT scanners and MRI units.

4.37 Although there has been a significant reduction in acute hospital beds during the last 10 years, Northern Ireland still has more acute beds and staffing resources than regions in England, but appears to use them less intensively. There is a great degree of disparity too in community care services, where Northern Ireland has much higher levels of provision and utilisation of both institutional and domiciliary care. This is hard to reconcile with evidence of the 'blocking' of acute beds by patients waiting for transfer to residential and community care. This could be as much as 10-15% of all acute beds. If the prevalence of bed blocking could be reduced (which could be effected if funds were available), this would have a substantial effect on the number of acute beds required. We therefore recommend an immediate and ongoing review of the efficiency of discharge arrangements from acute to community care, including the appropriateness of use of institutional provision, particularly in the private nursing home sector. Every effort should be made to keep people out of hospital and shift the 'centre of gravity' towards care in the community, properly resourced and supported.

"Northern Ireland does not need more acute beds"

4.38 There is enough evidence from our examination of recent trends in bed numbers, both locally and internationally, to lead us to the conclusion that Northern Ireland does not need more acute beds. As we saw in Chapter 2, the last 10 years have seen a reduction of 1,400 acute beds in Northern Ireland, while the number of people treated has continued to increase. Comparisons with international data suggest that it should be feasible, and it would be more advantageous, to invest additional money in doctors and nurses and in modern equipment and medicines rather than in maintaining or adding to the current number of acute beds. Interestingly, most of the additional expenditure identified in the NHS Plan for England is earmarked for improving medical and nursing staffing levels rather than infrastructure such as beds.

4.39 There is obviously a limit to the extent to which the reductions in acute bed numbers can be continued in the future, but we feel confident in recommending a planned reduction of at least 500 in the number of acute beds, to be achieved over the period to 2010. This would require a reduction in acute beds of little more than 1% each year. Every investment or development proposal should be viewed with this objective in mind. We would expect this reduction to be achieved through a combination of progressively lower average lengths of stay and increases in the proportion of treatment undertaken on a day-case basis. We would not argue for any significant increase in bed occupancy rates over their current levels. There may be justification for increasing capacity at a very small number of hospitals, for

example, the Ulster Hospital, Craigavon Area Hospital and, in due course, Antrim Area Hospital, but this would need to be offset by reductions elsewhere.

Summary

4.40 In this chapter we have examined the appropriateness of current and projected levels of hospital and community health service funding in Northern Ireland and the extent to which these funds are being used efficiently. We conclude that, in the short to medium term, increases in the funding of hospital and community health services in Northern Ireland should at least keep pace with those in Scotland and the North East of England. This will require a substantial uplift to current funding projections.

4.41 Notwithstanding any future increase in funding, we accept that there appears to be scope for improvements in efficiency. Clearly difficult decisions lie ahead for those with responsibility for Northern Ireland's hospital services. We do not underestimate the difficulties of proposing a reduction in acute beds against a public and professional perception that there are not enough at present. However bed numbers have been falling for many years and we are confident there is scope for further reductions. Such a trend is in keeping with our philosophy of moving the 'centre of gravity' towards primary care. This cannot be effected without a shift in the balance of expenditure in a context where Northern Ireland traditionally spends a greater proportion of its resources on acute hospital services than other regions. The principle is not in question; the issue is the rate at which change should occur.

Chapter 5 – Our Vision for the Future

What we have learned from our information gathering process, both from professionals and the public, has informed our vision for health care 15 to 20 years from now.

The pattern of acute hospitals has changed dramatically over the last 20 years. In 1981 there were 24 acute hospitals; today there are 15. Some professionals view this as a welcome trend which should continue. The public, however, particularly in rural areas where the impact of rationalisation has been greatest, often see it as a trend which will severely curtail their access to acute services. Our vision aims to *build* on what we currently have; to *adapt* hospitals rather than close them; and to *improve* rather than reduce access to services.

"Our vision aims to build on what we currently have; to adapt hospitals rather than close them; and to improve rather than reduce access to services."

The health care system of the future must continue to strive to improve the health of the population and reduce the need for acute hospital services. In particular, it must reduce inequalities in standards of health between the rich and the poor, and meet the needs of an increasing elderly population. At one extreme, through advances in medical science, the health care system will increasingly reduce mortality and improve the quality of life for survivors. At the other, it will offer the possibility of treating the vast majority of conditions in local community settings with minimum inconvenience to patients. Services at both ends of the scale will be equally valued as will the people who deliver them.

The value of people's time will be respected and a high premium will be attached to the need to reduce anxiety about medical conditions: patients will receive prompt attention and will not have to wait for long periods for diagnosis and treatment. They will be involved in making choices about their own health and that of their children, including where and from whom they receive care. And when it is proposed to change the nature or location of services in an area, there will be full engagement with the local community before decisions are taken. There will not be any change in the location of services before it can be demonstrated that the proposed new location has the capacity to deliver those services. The elderly will receive care that is properly adjusted to their needs with an emphasis on providing long-term care as close as possible to the patient's home. Care will not necessarily be synonymous with acute hospital care and will comprise a blend of models which will include intermediate care in community hospitals and treatment and rehabilitation in patients' own homes.

To make this happen will require a seamless service, through greater integration of primary and secondary care, supported by a modern and efficient information and communication system. There will be greater emphasis on interdependence; on optimum use of scarce resources; and on co-operation, co-existence and mutuality to achieve quality, safety, sustainability and accessibility. Skills and competencies within primary care will be exploited to the full and the boundaries of its activity will extend well into what is currently the domain of acute hospitals. Those services

that must be provided in acute hospitals will be delivered rather than me consultants. The viability of smaller hospitals and the range of services the will be determined by the needs of the communities they serve rather tha training requirements of the professionals who staff them. They will be sus by services provided through managed clinical networks which will link the larger acute hospitals. They will be complemented by a properly resourced equipped ambulance service with highly trained staff and a modern vehicle

5.6 We do not envisage a blank cheque to fund all this. But we are assuming th resources likely to be available here will represent a proportionate share of spending on the NHS in the rest of the UK. To achieve this vision will requi and flexible management and resourcing structures, designed to support se delivery unencumbered by administrative boundaries. It will require culture among those who will deliver the service and those who will administer it. It require imagination and innovation. Most of all it will require leadership.

5.7 In summary, we envisage a system that:

- Offers a seamless service focused on the needs of the individual patient.
- Delivers services as conveniently as possible for the patient, mainly in a primary care setting, in the home or an easily accessible local facility.
- Delivers services that are accessible to all people, including those from different ethnic backgrounds and those with disabilities.
- Promotes procedures that are designed to keep people out of hospital wh do not need to be there.
- Provides rapid and effective response to accidents and medical and surgic emergencies.
- Balances the centralisation required for complex, expensive or rare treatments and procedures with the decentralisation made possible by information technology and telemedicine, and by diagnostics, day procedures, ambulatory care, review and rehabilitation.
- Provides for the needs of a growing elderly population living longer, throug support in the home, intermediate care and respite beds and support servic for the treatment of chronic illnesses in a local setting.
- Makes available to all and localises the facilities required for an effective rehabilitation service for those who have suffered trauma, strokes or disease of ageing.
- Ensures the delivery of services through managed clinical networks - some regional, some locally centred. This will require consultants to adopt a more flexible approach to working patterns.
- Provides acute hospital services that are consultant-delivered rather than consultant-led, with a corresponding increase in the number of consultant level posts.
- Changes the relationship between service and training so that doctors in training are largely supernumerary and therefore the delivery of services in

local hospitals is not dependent on trainees. Training will be organised through the network to the best advantage of the trainee.

- Accommodates a substantial increase in the number of Nurse Specialists, Nurse Consultants and Advanced Nurse Practitioners, and also in Professions Allied to Medicine.
- Strengthens and supports primary care teams to take on the additional responsibilities they will face.
- Provides new local hospitals delivering most of the needs of a local population in bright, modern, attractive buildings.
- Reduces to an acceptable minimum the time needed for an appointment and for elective procedures.
- Incorporates a safe and efficient ambulance service.
- Includes sensible arrangements for co-operation across the border with the Republic to facilitate appropriate patient transfers and to maximise the use of scarce resources.
- Utilises the population base of the whole island in order to secure the provision of some scarce and expensive procedures.
- Locates services so that facilities in one part of the island can be used as a back-up for those in another, or in case of emergency.

We believe that the recommendations we have made in this report represent building blocks towards the construction of our vision. In essence, they are designed to secure hospital services that are:

- **High quality**, which through clinical governance, involving audit and quality assurance processes, ensure the best outcomes for patients.
- **Accessible** to everyone, taking full account of the urgency, nature and frequency of patients' needs.
- **Patient-centred**, and planned to ensure the best balance of safety, quality and convenience for patients.
- **Cost-effective** and offering value for money.
- **Professional**, delivered by staff with the appropriate skills and experience, working under appropriate conditions, and in a well equipped environment.
- **Integrated**, as part of a seamless system including primary and secondary care allowing treatment care plans to be developed for individual patients.

Chapter 6 – Access to Key Hospital Services

Introduction

6.1 As noted earlier in this report, while people are willing to travel for certain specialised services, our consultation exercise left us in no doubt that what concerned people most was access to emergency care services (including coronary care) and maternity services. It is crucially important, therefore, that any future configuration of hospital services in Northern Ireland ensures adequate access to each of these key services, while at the same time ensuring quality and providing value for money.

6.2 In this chapter we examine both emergency care services and maternity services to establish some broad parameters which we can use to guide our recommendations on the future configuration of services.

Access to Emergency Care Services

6.3 Emergency care services are characterised by complexity of provision. The components can include:

- GP services.
- Ambulance services.
- Out-of-hours services.
- Local emergency departments.
- Accident and Emergency departments.
- NHS Direct (although this service is not yet available in Northern Ireland).

6.4 With such diversity it is difficult for patients (and often for those working in the system) to know which service should be approached in what circumstances. The main issues concern how best to distribute available resources to provide a pattern of care that most often leads to the right patients getting to the right services at the right time, and how to achieve greater clarity about what services are most appropriate in what circumstances.

6.5 Accessibility is an issue of over-riding importance in relation to emergency medical care, and in particular the need for A&E services to be within a minimum distance or travelling time of where people live.

6.6 There were frequent references throughout the consultation exercise to the 'golden hour' which most people understood to mean the critical period between injury or onset of illness and the initiation of appropriate treatment. This was of particular concern in relation to the treatment of chest pain where access to emergency medical treatment within one hour was generally regarded as crucial. However, the provenance of the arguments surrounding the 'golden hour' was difficult to establish. The view amongst the professionals we consulted was that the

concept of a crucial period of around one hour between illness and treatment was well founded. While the significance of the hour diminishes in the context of the transfer of major trauma patients to an appropriately staffed and equipped hospital, there was a clear consensus that, for conditions such as heart attacks, it was important that treatment should be administered as quickly as possible.

6.7 The following represents a sample of the professional advice we have received on this subject:

- *Accessibility is of crucial importance to survival and patients should not have to travel more than 30 miles to an Accident and Emergency Department.*[1]
- *Accident and Emergency Departments should be accessible within one hour for all the population and preferably within 30 minutes.*[2]
- *If two units are within 10 miles of one another, rationalisation into one should be considered subject to an evaluation of travelling time, availability of community based emergency services and local transport.*[3]
- *People with suspected heart attacks should receive professional assessment and, where appropriate, be treated with thrombolytics (clot dissolving drugs) within an hour of calling for medical help or of dialling 999.*[4]

"There is clearly substance to people's concerns about being able to access emergency care services within a reasonable timescale"

6.8 There is, therefore, clearly substance to people's concerns about being able to access emergency care services within a reasonable timescale. We believe that a period of one hour represents a reasonable benchmark of accessibility. Indeed, we recommend that Northern Ireland should have a configuration of hospitals providing emergency care services which ensures that the whole population can normally expect to access those services within one hour.

Access to Maternity Services

6.9 Maternity services, like emergency care services, are characterised by complexity of provision, particularly at the time of delivery when options can include:

- Home delivery by midwife or GP.
- Delivery in a midwife-led unit, either locally or on the campus of a larger hospital.
- Transfer of mother and her midwife from home to a fully staffed unit for delivery only (the Domino system).
- Delivery in larger units, consultant staffed round the clock with cover from paediatricians and obstetric anaesthetists available at all times.
- Delivery in a regional unit capable of dealing with the most complex cases.

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[1] Submission to AHRG from NI Accident and Emergency Consultants.
[2] Professor J. Nicholl, Sheffield University.
[3] By Accident or Design: Improving A&E Services in England and Wales, Audit Commission.
[4] Department of Health (England) - National Service Framework of Coronary Heart Disease.

6.10 There is a particular recognition in maternity services of the primacy of patient choice and of the importance of affording women as much choice as possible in the place of delivery. This has been emphasised in a succession of policy documents from consumer, professional and government sources. Childbirth is a natural event and should be a joyful and fulfilling experience for mother and partner.

6.11 It has been recognised for some time that the quality and accessibility of hospital care is only one of a number of influences on pregnancy outcomes, and by no means the most important. Nevertheless for several years there has been lively debate among consumers, potential consumers, professionals and the general public about the optimal pattern of maternity services.

6.12 The debate about organisation of services reflects an underlying uncertainty about the optimal place of delivery following a normal pregnancy. On the one hand, fully equipped and staffed hospitals are thought to be the safest place for all deliveries, as no antenatal screening procedure can guarantee an uncomplicated delivery. On the other hand, there are those who maintain that a delivery with no known risk factors may actually be put at risk by the increased medical attention of technologically advanced maternity units, and low risk deliveries may benefit from the minimal intervention approach in small units. In addition there are concerns that concentrating services in a smaller number of units may endanger the health of women and babies by reducing accessibility and may also result in a service that is less 'woman friendly'.

6.13 Debate has centred on the appropriate balance between accessibility and safety, and has included the following key questions:

- Is midwife-led care as safe as a consultant obstetric unit?
- Are small units as effective/cost-effective as large ones?
- What is the importance of neonatal/paediatric and anaesthetic cover?

Midwife-led Maternity Units

6.14 The potential for developing midwife-led care was considered in detail by a multi-disciplinary study group established by the DHSS in the early 1990s. In its report[5] the group supported the development of midwife-led units on acute hospital sites to extend the range of care options available to women in Northern Ireland. It rejected the idea of stand-alone midwife and/or GP led maternity units on sites without acute hospital services.

[5] Delivering Choice: Midwife and General Practitioner Led Maternity Units. Report of the Northern Ireland Maternity Unit Study Group, August 1994.

6.15 The Department accepted the study group's conclusions and recommendations and in a 1996 Circular[6] endorsed the concept of a woman-centred service and emphasised the importance of quality of care and safety (including 24-hour consultant cover in obstetrics, anaesthetics and paediatrics in fully-staffed units). The Circular also noted the importance of communication and of women's choice and called for new models of care to be introduced (essentially midwife-led units) as set out by the study group.

6.16 We recognise the value of midwife-led units as a means of broadening the options available to women, and we support the provision of such units on sites where they have the support of consultant-led obstetric, paediatric and anaesthetic services.

Consultant-led Maternity Units

6.17 In February 2001 the Scottish Executive Health Department issued a Framework for Maternity Services in Scotland. This document established a number of principles for maternity services, which we largely endorse. As far as consultant-led inpatient units are concerned, it recommends:

- *Small consultant-led maternity units without on site neonatal services should develop and maintain close links with a specified larger maternity unit. Immediate neonatal care in such units should be provided by appropriately trained professionals.*
- *Consultant-led maternity units with on site neonatal services should care for women with low risk pregnancies and the majority of women with higher risk pregnancies. There should be short-term intensive care facilities available before transferring women to a specialist maternity unit.*
- *Consultant-led maternity units providing a full range of services appropriate to women with high risk pregnancies should have the following services available: obstetrics; anaesthetic services and access to adult intensive care; neonatal resuscitation, stabilisation and access pathways to neonatal intensive care; midwifery; radiology and imaging; laboratory; blood transfusion.*

6.18 More generally, the overwhelming weight of professional advice is that inpatient obstetric services should be provided only where there is access to 24-hour paediatric and anaesthetic cover. We endorse this view.

6.19 Interpreting the above principles in the light of the evidence and professional guidance, we consider that in the case of consultant-led maternity units:

- The entire population should be within one hour of the nearest consultant-led maternity unit.
- All units should have 24-hour consultant paediatric and anaesthetic cover.

[6] The Commissioning and Provision of Maternity Services: Policy Guidelines, June 1996.

- All units should have a sufficiently large caseload to justify a full consultant team, either on its own or in conjunction with another unit. Where units are networked in this way each one should have dedicated on-call consultant cover available within 30 minutes.

20 The need for round-the-clock anaesthetic and paediatric cover, coupled with the importance of maintaining skills and the effective use of scarce resources, suggests that it is not possible to sustain an inpatient unit for fewer than 2,000 deliveries a year. This has implications for the viability of the inpatient maternity units at a number of hospitals in Northern Ireland. We consider this issue further in Chapter 7.

Summary

21 In this chapter we examined two key services - emergency care services and maternity services - to establish some broad parameters which we can use to guide our recommendations on the future configuration of services. We have concluded that the entire population of Northern Ireland should normally expect to be within one hour's travel time of emergency care services and a consultant-led maternity unit. We also concluded that these units should have 24-hour consultant paediatric and anaesthetic cover and should have a sufficiently large caseload to justify a full consultant team. We support the development of midwife-led units on sites where there is also a consultant-led obstetric unit and paediatric and anaesthetic support services.

"the entire population of Northern Ireland should normally expect to be within one hour's travel time of emergency care services and a consultant-led maternity unit"

Chapter 7 - Future Configuration of Hospital Services

Introduction

7.1 In Chapter 6 we established the critical importance of ensuring adequate access to high quality emergency care and inpatient maternity services. We concluded that the entire population of Northern Ireland should normally expect to be within one hour's travel time of such services. In this chapter we apply this principle to determine the future configuration of inpatient acute services at hospitals in Northern Ireland.

7.2 Inevitably this process required trade-offs: whilst access was our most important consideration, other issues such as quality and safety, affordability and sustainability were also relevant. There is no simple formula that can be applied to produce an optimal solution, balancing all of these factors perfectly. A degree of judgement is required, and we readily acknowledge that others may conscientiously and in good faith arrive at conclusions that differ from ours. There is probably no single 'right answer'.

"There is no simple formula that can be applied to produce an optimal solution. There is probably no single right answer"

7.3 Over time, we believe that the current importance attached to the location of our acute hospitals will reduce. We expect advances in medical science to allow many of what we now term as 'hospital services' to be delivered in a much wider range of care settings, nearer to the home. Increasingly we will use acute hospitals only to access the most specialist forms of care. In Chapter 8 we propose new organisational structures - integrated Health and Social Care Systems - that will facilitate a shift from the planning and management of acute hospital services within stand alone institutions, each providing a comprehensive range of services, to a position where comprehensive services are provided by multi-disciplinary teams in a diverse range of facilities operating as a single inter-dependent network.

7.4 Nonetheless, hospitals will continue to play a key role and this chapter sets out our proposals for the future configuration of emergency care and inpatient maternity services at hospitals in Northern Ireland. We begin by recommending the provision of these services at nine hospitals that we believe will ensure acceptable access for all of the population of Northern Ireland. We go on to set out our view on the most appropriate location for the new hospital for the South West of Northern Ireland. Finally, we set out our view on the pattern of services to be provided at other existing hospital locations.

7.5 We have not attempted to set out in this chapter the full range of services that might be provided at each hospital location, beyond the core services of emergency care and inpatient maternity. Nor have we sought to identify other locations (beyond existing hospital sites) at which it might be appropriate for a local hospital to be established. We believe that these are issues that will be best examined by our proposed Health and Social Care Systems.

Measuring Accessibility

7.6 To compare access to emergency care and maternity services provided by different hospital configurations, we used a transportation model developed by the then Department of the Environment for Northern Ireland in 1996, updated with contemporary population and traffic volume data. The model allowed the calculation of journey times between any two locations in Northern Ireland based on average travel times during peak hours (7.00am to 9.00am weekdays). These travel times in turn allowed us to measure the number of people falling inside (or outside) 45 minute and 60 minute travel time bands (isochrones) for various configurations of acute hospitals as set out below.

Option 1: Emergency Care and Maternity Services Provided on 15 Sites

7.7 We begin by considering the access to services provided by the current configuration of 15 acute hospital sites in Northern Ireland (for the purpose of this analysis we have excluded the specialist elective centre at Musgrave Park which does not provide emergency care or maternity services). This configuration fully meets our access principle in that it would provide all of the population of Northern Ireland with access to emergency care and maternity services within one hour, as shown in Table 7.1 below.

Table 7.1. Option 1: Services Provided on 15 Sites - Access Times

Hospitals (15) located at:	Access Times	Population without access	%
Antrim, Causeway, Mid Ulster, Whiteabbey, Belfast City, Downe, Lagan Valley, Mater, Royal, Ulster, Craigavon, Daisy Hill, Altnagelvin, Erne and Tyrone County	<45 mins	3,000	0.2
	<60 mins	0	0.0

7.8 We have discussed in Chapter 3 the pressures that increasingly make it impossible to maintain the current configuration of services on 15 hospital sites. We now propose an evolutionary process that is aimed at moving health care towards our vision for the future. It is designed to provide a configuration of services based on total need in a way that better meets the requirements of the entire community and protects quality, while continuing to satisfy our standard of access to emergency care and maternity services in a sustainable and cost-effective way.

Option 2: Emergency Care and Maternity Services Provided on Six Sites

We felt it was unrealistic to consider a future hospital configuration by starting from an entirely blank sheet. Had we done so, we would at the very least have challenged the location of Antrim Hospital. Our feeling, and that of many of those we consulted during the review, is that a decision to locate the hospital in Ballymena would have better met the needs of the population of County Antrim including those in the more remote areas around the Glens. A Ballymena location would also have obviated the need for the Causeway Hospital, at least in its present form. However, given the extent of investment in what have, unfortunately to our minds, been described as the 'golden six' hospitals - Antrim, Belfast City, the Royal Group, Ulster, Craigavon and Altnagelvin - we have planned on the basis that it is unlikely to make good economic sense to replace them elsewhere and that these will continue well into the future.

If emergency care and inpatient maternity services were to be provided from only the six largest hospitals in Northern Ireland, our standard of access would clearly not be met. As Table 7.2 below shows, nearly 60,000 people would fall outside our one hour travelling time criterion with this configuration of hospitals. Such a configuration would significantly disadvantage rural communities and would clearly not satisfy the 'rural proofing' process which the Northern Ireland Executive Committee requires to be applied to new policies.

"We felt it was unrealistic to consider a future hospital configuration by starting from an entirely blank sheet."

Table 7.2. Option 2: Services provided on Six Sites - Access Times

Hospitals (6) located at:	Access Times	Population Without access	%
Antrim, BCH, Royal, Ulster, Craigavon and Altnagelvin	< 45 mins	245,000	14.5
	< 60 mins	58,000	3.4

Option 3: Emergency Care and Maternity Services Provided on Nine Sites

Access times are improved considerably by providing services at sites located around the periphery, at Daisy Hill (Newry), Causeway (Coleraine) and a new hospital for the South West as shown in Table 7.3 overleaf.

Table 7.3. Option 3: Services Provided on Nine Sites - Access Times

Hospitals (9) located at:	Access Times	Population Without access	%
Antrim, BCH, Royal, Ulster, Craigavon, Altnagelvin, Daisy Hill, Causeway and a new hospital for the South West	< 45 mins	35,000	2.1
	< 60 mins	0	0.0

7.12 The table shows that this configuration of services on nine sites should ensure that the entire population has access to key hospital services within our one hour threshold, and 98% of them within 45 minutes. We therefore recommend this configuration of services as the minimum necessary to provide acceptable access to emergency care and inpatient maternity services for all of the people of Northern Ireland. Although one or both of these services will continue to be provided at other locations (details of our proposals in this regard are set out later in this chapter) the strategic location of the nine hospitals means that they will be the anchorage points for our proposed Health and Social Care Systems and every effort must be made to ensure their long term viability.

"this configuration of services on nine sites should ensure that the entire population has access to high quality emergency care and inpatient maternity services within our one hour threshold, and 98% of them within 45 minutes"

7.13 We will explain in detail in Chapter 8 our proposals for Health and Social Care Systems but in outline we envisage three systems delivering the full range of emergency care, maternity and other services for their population, namely:

- **The Northern Health and Social Care System** which would provide services at Altnagelvin Hospital, Antrim Area Hospital, Causeway Hospital and other locations.
- **The Southern Health and Social Care System** which would provide services at Craigavon Area Hospital, Daisy Hill Hospital, at a new hospital for the South West and other locations.
- **The Greater Belfast Health and Social Care System** which would provide services at the Royal Victoria Hospital, Belfast City Hospital, Ulster Hospital and other locations.

7.14 We recognise that sustaining services will present a significant challenge for those sites serving smaller populations, namely Causeway, Daisy Hill and the new hospital in the South West. In each case the hospital's catchment population is likely to be lower than that ideally required to sustain full teams of consultants, particularly in relation to surgery. One solution may be to transfer day surgery and routine elective work from larger neighbouring hospitals. In this way these hospitals could secure additional workload and at the same time provide a valuable resource to reduce the current unacceptable waiting times for elective treatment.

15 There may be wider opportunities for Daisy Hill, both in the medium and longer term, to take on some of Craigavon Hospital's workload that has increased significantly since the change to the function of South Tyrone Hospital. In relation to both Daisy Hill and the new hospital for the South West, there may also be the potential to take on additional work from across the border, building on existing links. Our proposals for Health and Social Care Systems, set out in Chapter 8, will provide an appropriate vehicle for considering these and other opportunities to maximise the workload of the nine hospitals and ensure their long term sustainability.

16 We recognise that in order to satisfy our one hour standard it is neither necessary nor appropriate for the same range of emergency care and maternity services (or other acute hospital services) to be provided at every location. We envisage emergency care services being provided at three levels:

- Level One - an accident and emergency centre that can take major trauma and those emergencies specifically defined as appropriate for highly specialised care, for example, serious head and spinal injuries and major burns. It would provide the base for the Northern Ireland Critical Care Transfer Service, which ensures the safe retrieval of critically ill injured patients who have been stabilised at a local hospital, to appropriate intensive care facilities in a major hospital. There would be one centre of such expertise in Northern Ireland, based at the Royal Group of Hospitals. It would have A&E Consultants available at all times with full back-up.
- Level 2 - a centre that can deal with all emergencies (except those specifically defined as appropriate for level one). Level two centres would be capable of responding to major incidents on a 24-hour basis, would be staffed by A&E consultants with appropriate back up and would provide resuscitation, assessment and treatment of acute illness and injury 24 hours a day for patients of all ages by appropriately trained and experienced staff. We envisage level two units at Altnagelvin, Belfast City (although by agreement, ambulance borne trauma would be taken directly to the Royal), Antrim, Craigavon and the Ulster.
- Level Three - a centre serving a smaller catchment population, operating in a managed clinical network with a level two service. The range of services available in each centre will vary according to local circumstances. They would have physicians, surgeons and anaesthetists available during the day and a full A&E service. We envisage level 3 units at Causeway, Daisy Hill and the new hospital in the South West.

Given the increasing incidence of overdoses, suicides and depression presenting to A&E departments, we believe that it is vital that each of the nine locations has ready access to a psychiatric opinion. In due course, we would recommend that acute inpatient psychiatric services should be co-located with other acute services.

7.18 In relation to maternity services, we recognise that, as with other specialities, there is a need for some central concentration of provision with a caseload of 5,000+ deliveries a year to provide the base for a regional referral service and to support training and research. The Royal Jubilee Maternity Unit provides this regional service.

7.19 At each of the other eight sites (other than Belfast City Hospital, given the proposal to establish the Royal Jubilee Maternity Unit), we envisage a consultant-led maternity unit with 24 hour consultant paediatric and anaesthetic cover. As far as possible, each unit should try to secure the caseload (2,000+ births per annum) that is sufficiently large to justify a full consultant team. Where this volume of work cannot be achieved, smaller units must network with a larger unit and ensure that each one has access to dedicated on-call consultant cover within 30 minutes. We would support the provision of midwife-led units at the new Royal Jubilee Maternity unit or any of the other seven sites.

The Location of a Hospital for the South West

7.20 Earlier in this chapter we explained why we believe that a hospital in the South West of Northern Ireland is necessary in order to provide access to core acute services. The issue that remains to be addressed is where the hospital should be located to maximise accessibility to the South West's dispersed population of some 115,000 and ensure that it attracts sufficient patients (critical mass) to sustain the safe delivery of the necessary range of high quality services.

7.21 In our initial consideration of this issue we addressed the potential for retaining the two existing hospitals in their current forms. While this appeared an attractive option in terms of satisfying the desire of both communities to have a hospital in their area, it was clear that this was not viable because the population of the South West is insufficient to support key specialties on two sites; there is not enough work to maintain the skills of consultants or meet the training needs of junior doctors. This was borne out by the professional views we received and by the Western Board's own deliberations on this issue.

7.22 The Board has proposed that the Erne and Tyrone County hospitals should be replaced with a new hospital for the South West on a 'green-field' site. The Board declined, however, to suggest a location for the new hospital, noting that a decision on both this and the full configuration of services in the hospital must be considered by the Minister within the context of the overall strategy for the development of acute services in Northern Ireland. In the meantime, the Board has acknowledged that the implementation of its recommended single site model will take some time to achieve, and it is therefore necessary to secure an effective 'bridge to the future' based on the maintenance of the current 'one hospital on

two sites model'. This model involves the provision of a range of inpatient services shared between the Erne and Tyrone County hospitals, together with emergency care services, some day services and most outpatient clinics on both sites.

7.23 We considered whether the current one hospital on two sites model might be an appropriate long term solution for the population of the South West, but concluded that the model would inevitably result in some duplication of services with the corresponding question over long term sustainability associated with the two hospital arrangement, as referred to above. We strongly believe, therefore, that a new hospital on a single site, linked with others as part of a larger Southern Health and Social Care System, represents the best way forward for sustaining the safe delivery of the necessary range of high quality services for the population of the South West.

7.24 This led us to consider the options of a single hospital in Enniskillen, Omagh, or on a 'green-field' site somewhere between the two. Our examination of the 'green-field' option indicated that a location at or near a population 'centre of gravity' for the South West of Northern Ireland offered the potential to maximise both accessibility and critical mass. However, from studies commissioned by the Department, it appears that such a 'centre of gravity' would be located well outside any significant conurbation. This raises significant questions about whether a location well outside Enniskillen or Omagh, or any of the smaller conurbations in the South West, would be capable of providing the necessary physical and economic infrastructure to support a hospital of some 300 beds and the people necessary to staff it. A 'green-field' location would also seem to run contrary to the Regional Development Strategy that would not favour a proposal to locate such a major development outside a centre of employment and services for urban and rural communities. For these reasons we concentrated our attention on a single site option at either Enniskillen or Omagh.

7.25 There were strong arguments for each. Sites would be available at both locations and each town would offer the necessary economic and physical infrastructure (the Water Service has confirmed that the necessary water and sewerage infrastructure is available at either location). Although an Omagh location would provide a slightly larger catchment, Enniskillen would provide better access for the relatively small, dispersed population to the west of Lower and Upper Lough Erne. We have also considered the potential for Sligo General Hospital to complement a hospital located in Omagh in meeting the needs of this small population but have concluded that the condition of the road between Blacklion and Sligo involves travelling time in excess of an hour. While there are plans to improve some small stretches of this road, it is unlikely that they will make a significant difference to travelling times.

7.26 The issue is very finely balanced: there is no difference in the quality of service provided on either site; Omagh would provide a slightly larger caseload, but would leave a larger number of people outside acceptable access times. Following the principles we set out in Chapter 5, therefore, we conclude that Enniskillen offers the better location for a hospital providing emergency care and inpatient maternity services. This conclusion was not reached lightly, but we believe that a location in or around Enniskillen provides cover for a wider geographic albeit thinly populated area and ensures that the people to the west of Lough Erne are not disadvantaged through impaired access to services. Our conclusion reflects the human geography of the area, the fact that travel tends to be easier on an east-west axis, with Enniskillen midway on a strategic communication corridor between Belfast and Sligo. We recommend, therefore, that the necessary preparatory work should begin as soon as possible to identify a suitable location either at the existing Erne Hospital site or at an alternative site to the north of Enniskillen. In the shorter term the Board and Trust should spare no efforts in securing arrangements for the maintenance of acute services across the two sites, drawing on assistance from both Altnagelvin and Craigavon hospitals as appropriate.

7.27 We also recommend that a modern local hospital facility should be developed in Omagh, to provide the population in and around the town with access to a wide range of local hospital services. A template for the services that might be available in such a facility is provided at the end of this chapter.

7.28 For the majority of services, we would expect the new local hospital at Omagh to link into the new hospital for the South West at Enniskillen. This will be important as a means of ensuring the viability of the new South West Hospital as part of the Southern Health and Social Care System. But we see no reason why the new local hospital at Omagh should not also develop linkages with Altnagelvin where it is appropriate to do so.

Services at Other Locations

7.29 The first part of this chapter identified a configuration of nine hospitals that we believe will normally ensure that the entire population has adequate access to high quality emergency care and inpatient maternity services. While these nine hospitals will provide the anchorage points for the future delivery of acute inpatient services (as part of our three integrated Health and Social Care Systems), we envisage that, for the foreseeable future, services will also continue to be provided at other locations. The remainder of this chapter sets out our proposals in relation to the pattern of services at these other locations, namely:

- Mater Hospital.
- Whiteabbey Hospital.
- Lagan Valley Hospital.
- Downe Hospital.
- Mid Ulster Hospital.
- South Tyrone Hospital.

Mater Hospital

7.30 The Mater Hospital is a teaching hospital, providing the population of North Belfast with emergency care, inpatient maternity and other acute services. In 1999/00 some 45,000 patients attended the hospital's A&E department, it admitted some 6,000 medical and surgical emergencies and there were some 1,000 births at the hospital.

7.31 We do not believe that it is realistic to assume that the level of emergency activity undertaken by the Mater could be absorbed by one of the neighbouring Belfast Hospitals without significant and unjustifiable upheaval to patients and staff. We therefore propose that the Mater Hospital should continue to provide emergency care services for the foreseeable future. At the same time, however, we do not think that a 24 hour consultant led A&E service can be justified at the Mater, given that a similar service is provided at the Royal Victoria and Belfast City hospitals. Steps should be taken, therefore, towards replacing the existing A&E service at the Mater with a local emergency unit that would provide a comprehensive minor injury and illness service for a large part of each day, serving the needs of the vast majority of patients (over 75%) who currently attend the hospital's A&E department. This unit would be nurse-led with links to primary care and to one of the A&E centres in Belfast.

7.32 In relation to maternity services at the Mater, our attention has been drawn to the Deed of Arrangement entered into in 1972 by the then Northern Ireland Government which guaranteed the continuation of the hospital's character and ethos. We were told by the Trustees that this had particular relevance to the provision of maternity services. However, the workload of the hospital (some 1,000 deliveries in 1999/00) is significantly below the 2,000 deliveries per annum which we judged in Chapter 6 is the minimum necessary to sustain an inpatient unit with 24 hour anaesthetic and paediatric cover. We therefore conclude that inpatient and other maternity services should only be maintained at the Mater on the basis of the continuation and development of existing links with the Royal Jubilee unit, including close networking and adherence to joint clinical protocols. This would involve rotation of the consultants, midwives and junior medical staff in the two maternity units who would effectively act as a single clinical team.

7.33 More generally, we see the Mater developing an increasingly strong relationship with Whiteabbey Hospital, providing high quality services to the population of North Belfast, Newtownabbey and Carrickfergus as part of the Greater Belfast Health and Social Care System. This would be a logical relationship given that the Mater and Whiteabbey already serve a common, overlapping area, and the 'gravitational' attraction of the people from Newtownabbey and Carrickfergus towards Belfast.

Whiteabbey Hospital

7.34 Whiteabbey Hospital provides the population of Newtownabbey with emergency care and a range of other acute services. The hospital does not provide inpatient maternity services. In 1999/00 some 32,000 patients attended the hospital's A&E department and the hospital admitted some 3,000 medical and surgical emergencies.

7.35 The future of the hospital as an acute facility has been in doubt for some time. Proposals to change the status of the hospital were most recently confirmed in the Northern Board's acute strategy which proposed that a local hospital would be developed at Whiteabbey providing a range of non-emergency, local hospital services and a minor injuries unit. Following consultation, the Board confirmed this as its preferred option and forwarded its recommendations to the Minister in September 1998. In discussions at both Whiteabbey and Antrim hospitals, it was suggested to us that the implementation of the Board's proposals would see up to 80% of Whiteabbey's inpatients gravitate towards Belfast and the remainder towards Antrim.

7.36 Whiteabbey Hospital has a position of strategic importance and is ideally located to provide a range of services to its local community. It is an important resource, the full appreciation of which we feel has been prejudiced by the fact that its management structures are linked to Antrim Area Hospital rather than to a hospital in Belfast. It serves a catchment population which is relatively close to the major Belfast hospitals and our access standard suggests that it does not justify a full emergency care service. However, it has an important role to play in providing a wide range of local hospital services to its local population, in the context of the Greater Belfast Health and Social Care System. We therefore recommend that a modern local hospital facility should be developed at Whiteabbey. Our vision of the range of services that might be provided in such a hospital is set out at the end of this chapter.

7.37 As noted above, we believe that Whiteabbey offers the potential to complement the services provided by the Mater to the people of North Belfast, Newtownabbey and Carrickfergus. Also, as some local GPs have already demonstrated the will and the

capacity, there is scope for the hospital to develop its links with primary care in the provision of step-down or intermediate care beds.

Lagan Valley Hospital

7.38 The Lagan Valley Hospital provides the population in and around Lisburn with emergency care, inpatient maternity and other acute services. In 1999/00 some 39,000 patients attended the hospital's A&E department, it admitted some 3,000 medical and surgical emergencies and there were some 1,150 births at the hospital.

7.39 The hospital's location means that it plays an important role in providing extra capacity for emergency cases that might otherwise be admitted to one of the Belfast hospitals. However, we believe that over time the value of the hospital to patients in the Greater Belfast System would be greater if its role evolved from being a provider of general emergency services to a specialist centre for elective surgery. In this way it would provide the Greater Belfast System with much needed elective capacity which would be largely protected from short term emergency medical pressures. It will be important that this additional elective capacity is maximised, by fully exploring options such as longer working days, seven day working, etc.

7.40 To ensure that consultants, nurses and other staff groups continue to undertake a sufficient volume of emergency work to maintain and develop their skills, we would expect staff to be rotated into and out of Lagan Valley as part of the Greater Belfast Health and Social Care System.

7.41 As part of the change to the role of the Lagan Valley, we would expect the existing 24 hour consultant led A&E service to be replaced by a nurse-led local emergency unit linked to primary care and one of the A&E centres in Belfast. This unit would provide a comprehensive minor injury and illness service for a large part of each day, serving the needs of the vast majority of patients (over 75%) who currently attend the hospital's A&E department.

7.42 We envisage that the hospital would develop its rehabilitation role, particularly for elderly people living in and around Lisburn. The hospital might also provide state of the art outpatient and associated diagnostic services in all of the major specialities.

7.43 We recognise that the evolution of the Lagan Valley Hospital from a provider of general emergency services to a specialist elective centre will take time. We would emphasise that any change to the existing emergency care services should not be made until arrangements have been made to ensure that sufficient capacity is available within the Greater Belfast System.

7.44 In relation to maternity services, the workload of the hospital (some 1,150 deliveries in 1999/00) is significantly below the 2,000 deliveries per annum which we have identified as the minimum necessary to sustain an inpatient unit with 24 hour anaesthetic and paediatric cover. We do not envisage that it will be possible in the future to make arrangements that would maintain a viable and safe inpatient maternity unit in the hospital, and accordingly we recommend the phasing out of inpatient maternity services at Lagan Valley. However, we anticipate that there will continue to be a demand for a locally provided service in Lisburn and we believe that it should be possible to provide virtually the whole spectrum of maternity services with the exception of inpatient care at the time of the birth. These services might include:

- Routine antenatal care provided by consultant, GP and midwife.
- Ultrasound screening.
- Assessment of possible complications on a day case basis.
- Postnatal care for mother and baby.

7.45 The possibility of providing a variant of the domino delivery service to the patients served by Lagan Valley should also be investigated. Such a local service would, at the time of delivery, transfer the mother, along with her midwife, to an appropriately fully staffed and equipped centre, with mother and child returning as quickly as possible.

The Downe Hospital

7.46 The Downe Hospital provides the population of Downpatrick and South and East Down with emergency care, inpatient maternity and a range of other acute services. In 1999/00 some 23,000 patients attended the hospital's A&E department, the hospital admitted some 3,500 medical and surgical emergencies and there were some 550 births at the hospital.

7.47 Following a protracted period of uncertainty about the future of the hospital, in 2000 the then Minister (George Howarth) established a multi-disciplinary Working Group to make proposals for an appropriate package of services at Downpatrick. The Working Group recommended that the Downe should provide, among other things, a 24 hour A&E service and emergency medical service (including coronary care). The Working Group also recommended that the Downe provide an elective surgical service, but patients requiring emergency surgery would not be admitted to the hospital, but would instead be transferred to one of the Belfast hospitals. The Group assumed - on the basis of instruction from the Minister - that consultant-led inpatient maternity services would not be provided in any new hospital in Downpatrick. The Eastern Board confirmed in December that it would adopt the Working Group's proposals.

7.48 As detailed in the first part of this chapter, our standard of one hour for access to emergency care services will normally be satisfied regardless of whether such services are provided at the Downe. However, we acknowledge that travelling times between certain areas within the Downe's catchment area and the nearest alternative emergency care service are at the margins of that standard. We also acknowledge that travelling times to Belfast will increase in the future with growing volumes of traffic and further housing development, particularly around the Carryduff area. We have also noted that the Roads Service plans for the foreseeable future provide for no amelioration of traffic problems in that area.

7.49 The Downe Hospital Working Group, which included senior consultants in emergency and coronary care, has clearly expressed the opinion that, because transfer times in the area can be in excess of one hour, there is a necessity for the provision of a locally based resuscitation and stabilisation facility for certain types of surgical emergencies prior to transfer to hospitals in Belfast. While we do not challenge that assertion, we note that the delivery of the package of services proposed for the hospital depends on the development and maintenance of strong relationships with the Belfast hospitals. The viability and safety of the model, therefore, depends on the durability of the working arrangements that have been put in place, particularly in relation to the provision of 24-hour anaesthetic cover.

7.50 We have received assurance from the Down Lisburn Trust that the services at the Downe meet the necessary standards of quality and safety and have not exposed patients to undue risk. Specifically, the Trust said:

"The Trust is confident that the services it provides at the Downpatrick Hospitals are of the required standards of quality and safety and that patients at the Downe have not been exposed to undue risk. The Trust's network of care arrangements are currently working well and have the potential, if supported by Government, to endure into the longer term."

7.51 We have also received an assurance from the Eastern Board that the arrangements for the provision of anaesthetic cover are robust and should be sustainable in the longer term.

7.52 In relation to maternity services, the workload of the hospital - some 550 deliveries in 1999/00 - is significantly below the 2,000 deliveries per annum which we have identified as the minimum necessary to sustain an inpatient unit with 24 hour anaesthetic and paediatric cover. We do not envisage that it will be possible in the future to make arrangements that would maintain a viable and safe inpatient maternity unit in the hospital, and accordingly we recommend the phasing out of inpatient maternity services at Downpatrick. However, as at Lagan Valley and other hospitals where it is not possible to provide a viable and safe inpatient maternity service, we anticipate that there will continue to be a demand for a locally provided

service in Downpatrick and we believe that it should be possible to provide virtually the whole spectrum of maternity services with the exception of inpatient care at the time of the birth. We suggest that the opportunity to provide these services, including a domino delivery service, should be examined.

7.53 In conclusion, we believe that the package of services proposed by the Working Group now constitutes a sound basis for the development of the hospital as a facility providing a range of important health care services to its local community. We expect that our recommendation to phase out inpatient maternity services in Downpatrick should enhance the sustainability of the entire package of services, by making the anaesthetic rota much less onerous. At the same time, sustainability should be enhanced by our proposal to incorporate the Downe in an integrated Health and Social Care System for Greater Belfast. It is important that an early start is made on the construction of a new hospital in Downpatrick.

The Mid Ulster Hospital

7.54 The Mid Ulster Hospital provides the population in the Magherafelt area and surrounding district with emergency care, inpatient maternity and a range of other acute services. In 1999/00 some 22,000 patients attended the hospital's A&E department, the hospital admitted some 4,600 medical and surgical emergencies and there were some 700 births at the hospital.

7.55 Like the Downe, the future of the Mid Ulster as an acute hospital has been in doubt for some time. In 1998 the Northern Board proposed that the Mid Ulster should provide a range of non-emergency, local hospital services and a minor injuries unit in either a development of the existing Magherafelt site or in a purpose built local hospital. Emergency care services and inpatient maternity services would transfer to Antrim Area Hospital. The Board estimated that its proposals for the Mid Ulster would cater for some 85-90% of the patients who currently receive services on the site.

7.56 Travelling times from our isochrone study indicate that people in and around Magherafelt should normally be able to access emergency care services in a hospital other than the Mid Ulster within one hour. Yet we have ourselves witnessed the excessive delays which can often be a feature of the road at Toome during the morning and evening rush periods which are likely to put travelling times at the margins of or, on occasions, over our one hour standard. We also believe that a withdrawal of emergency services from the Mid Ulster at present would generate additional demand for Antrim Area Hospital with which it has not currently the capacity to cope.

We therefore recommend that, in due course, when appropriate alternative arrangements are in place, emergency care services should be withdrawn from the Mid Ulster Hospital and a new modern local hospital facility developed. We are anxious to avoid a repetition of the unsatisfactory situation that arose as a consequence of the closure of the South Tyrone Hospital where services were withdrawn before alternative arrangements were put in place, despite efforts by the staff at Trust, Board and Department level to prevent this. During the timescale required to achieve the transfer of emergency care services from the Mid Ulster, we have also been given to believe that the rush-hour traffic pressures at Toomebridge should be alleviated by the completion of the Toome bypass.

As part of the change to the role of the Mid Ulster Hospital, we would expect the existing 24 hour A&E service to be replaced by a nurse-led local emergency unit linked to primary care and the A&E centre in Antrim.

We acknowledge that the changes we propose for the Mid Ulster will take some years to achieve and the hospital is already struggling to maintain services. Every effort must be made in the interim to ensure that emergency care services are maintained at the Mid Ulster by drawing on all the resources available to the hospitals within our proposed Northern Health and Social Care System.

As with the Lagan Valley and Downe hospitals, we do not believe that the maternity workload of the Mid Ulster Hospital is sufficient to maintain a viable and safe inpatient maternity unit in the hospital. We therefore recommend the phasing out of inpatient maternity services at the Mid Ulster Hospital. As at Lagan Valley and Downe Hospitals, we believe it should be possible to provide at the Mid Ulster Hospital virtually the whole spectrum of maternity services with the exception of inpatient care at the time of the birth. We suggest that the opportunity to provide these services, including a domino delivery service should be examined.

South Tyrone Hospital

During the period 1994 to 2000, a succession of acute services was removed from South Tyrone Hospital and the hospital now provides a range of local hospital services. Inpatient maternity services were transferred to Craigavon Area Hospital in 1998, but more significant was the transfer to Craigavon of A&E and then general surgery in 1999. This left South Tyrone with minimal anaesthetics and radiology services and concerns were raised with the Northern Ireland Council for Postgraduate Medical and Dental Education and the Royal College of Physicians by clinicians at South Tyrone. Those concerns centred on the ability to continue to deliver emergency medical services in the absence of a surgical service. Subsequent visits by the Northern Ireland Council for Post Graduate Medical and Dental Education and the Royal College of Physicians concluded with the withdrawal of