training recognition, effective from August 2000. Clinicians from South Tyrone Hospital, together with colleagues from Craigavon Hospital, examined various models in which combined or single rotas might provide the required anaesthetic cover and surgical opinion (viewed as vital to the maintenance of medical inpatients) to South Tyrone. However, they were unable to come up with a workable arrangement and in August last year the hospital ceased to provide emergency medical services.

7.62 Our study of travelling times does not suggest that it is necessary to provide emergency care services at the South Tyrone Hospital in order to meet our standard of access. The proximity of Craigavon Area Hospital to Dungannon should ensure that people from the area are able to access emergency care within a reasonable timescale. We envisage in due course a modern local hospital being developed on the South Tyrone site providing a wide range of local hospital services and a local emergency unit, along the lines of the model set out at the end of this chapter.

7.63 The speed with which services had to be transferred from South Tyrone did not allow time for additional capacity to be developed at Craigavon. As a result, the hospital is struggling to provide an acceptable service. The difficulties being experienced at Craigavon Area Hospital were highlighted in a recent survey[1] of the hospital's A&E department that identified an unacceptable level of trolley waits. In one instance, 12 patients had been waiting on trolleys for up to 16 hours.

7.64 We note that efforts have been made to provide some additional capacity at Craigavon with the transfer of acute psychiatric inpatient services to St Lukes Hospital in Armagh. While we recognise that this action was taken in response to an urgent need for additional bed capacity at the hospital, we would wish to see the re-instatement of acute psychiatric services at Craigavon Area Hospital as a priority as part of a wider enhancement of facilities on the site.

7.65 The experience at South Tyrone Hospital highlights the difficulties that arise when services are withdrawn from one hospital before there is evident capacity in another nearby to absorb the resultant demand. Every effort must be made to ensure that this situation does not arise again anywhere else in the province.

The Local Hospital for the Future

7.66 We believe that, over time, the 'local hospital' will play an increasingly important role in the delivery of health and social care in Northern Ireland. With the development of integrated Health and Social Care systems, local hospitals will

[1] 'Casualty Watch', a quarterly report by the Southern Health and Social Services Council.

provide a facility where primary care, secondary care and community care professionals can come together to deliver key services to local populations. Local hospitals will increasingly not be seen as the poor relation to larger acute facilities. Rather, they will be bright, modern facilities providing the vast majority of hospital services required by the local communities that they serve. In the areas in which they are competent to provide services, we would expect them to be just as sophisticated as new larger hospitals.

There are examples of excellent local hospital facilities at a number of locations in England, and similar facilities are now being developed in Northern Ireland.

Case Study: The Local Hospital in Honiton

We visited the local hospital in Honiton during the course of our review. The hospital is recognised by professionals as a model of health care provision for smaller communities. The hospital provides a comprehensive range of services using the latest equipment in a modern, state of the art, facility.

The local hospitals we envisage for the future will provide a much wider range of services than that provided in traditional community hospitals. Because of this we considered the need to recommend a change of name to perhaps 'Local Health and Social Care Resource Centres'. We also wanted to demonstrate that our vision of the new local hospital is much, much bigger than a community hospital with a main focus on the elderly. These hospitals are vital cogs in the overall network of services. But, on balance, we decided that the term 'local hospital' would be more familiar and easily understood. Our vision of a local hospital of the future is provided overleaf.

Our Vision of the Local Hospital of the Future

The local hospital of the future will be a modern, state of the art facility. The precise range of services provided will vary according to local circumstances, but could include:

- **A Local Emergency Unit**, staffed by Emergency Nurse Practitioners and linked to a major Accident Emergency Centre for advice, support and training.
- **Outpatient clinics.** These could include both consultant-delivered clinics and clinics undertaken by GPs, specialist nurses and therapists.
- **Day case surgery.** Adult surgery could include removal of lumps and bumps, varicose veins, sterilisation and some laparoscopic procedures. Paediatric surgery could include hernia, circumcision, undescended testes, ENT, ophthalmology and dental work (for children with learning disabilities). Both adult and paediatric surgery [illegible] appropriate anaesthetic teams.
- **Ambulatory paediatric services**, including assessment, diagnosis and treatment with input from specialist paediatric [illegible]
- **Rehabilitation services**, including physiotherapy, [illegible] speech and language therapy and [illegible]
- **Diagnostic services** linked to a major centre. [illegible] fluoroscopy, ultrasound and endoscopic imaging. There could also be blood testing.
- **Maternity services.** These could include routine antenatal care, ultrasound screening, assessment of possible complications, and postnatal care for mother and baby.
- **Inpatient beds**, including:
  - Acute medical beds for patients not requiring 24 hour consultant oversight;
  - Step-down and convalescence beds for those patients requiring post-operative care following discharge from a larger acute facility;
  - Respite care beds for carers requiring respite for a number of weeks per year;
  - Palliative care beds for patients requiring this support; and
  - Rehabilitation beds including those for patients requiring rehabilitation following a stroke, accident or fracture, or who are suffering from the debilitation of old age and chronic rheumatoid conditions.
- **Diabetic Day Centre**, providing blood testing, examination, monitoring and education services.
- **Social Service advice and support services**, which could be based in and provided from the local hospital to support the ongoing care of people in the community.
- **Other services**, for example, equipment loan services, wheelchair services, hearing aid services, blood donation services, pharmaceutical services including retail chemists, optical services and patient libraries.

The hospital could also provide a base for the local GP co-operative, health visitors, district nurses, appropriate commercial outlets including specialist book shops. Also meeting facilities for local voluntary organisations and patient support groups, and training facilities for health staff.

Chapter 8 – Future Organisational Structures

Introduction

At the outset of this review we thought it unlikely that we would say much about statutory organisational structures but would concentrate instead on clinical services. We were aware too of the Minister's consultation paper on Primary Care and of the NI Executive's stated intention to undertake a comprehensive review of administrative arrangements in the wider public service. We were also concerned that a prolonged debate about structures might delay the changes in clinical services that we recommend. However, many of those to whom we spoke were insistent that we did form a view, because in their opinion the current structures were now a significant impediment to change. Almost everybody wanted to see a clearer vision for the future of Health and Social Services in Northern Ireland.

"Almost everybody wanted to see a clearer vision for the future of Health and Social Services in Northern Ireland"

The need for four Health and Social Services Boards was often questioned and a number of senior professionals described the problems that were generated when the Boards shaped services within their own boundaries and took different views on issues of priority. We do not criticise the Boards for this; their role is to form judgements about the needs of each of the communities they serve. What many of the people we spoke to thought to be missing was a strong central organisation that could plan sensibly for the future and ensure that investment was broadly targeted accordingly. Empowering primary care to commission local services for their communities received much support provided they did so within a broader strategic plan, which looked to the needs of the whole community.

"The need for four Health and Social Services Boards was often questioned"

The number of Trusts was thought by many to be excessive and to militate against effective collaboration in the planning and delivery of services.

"The number of Trusts was thought by many to be excessive and to militate against effective collaboration"

The integration of health and social care services in Northern Ireland was seen by the vast majority of people we spoke to as a strength. However, the need for further on the ground operational integration was recognised as a key requirement for the delivery of a truly seamless service.

A number of leading clinicians advised us of their concerns in relation to the standard of many regional services in Northern Ireland. A particular issue has been the lack of investment in specialised equipment. We were told that this situation has arisen predominantly because of inadequate funding - there is no arrangement for 'ring-fencing' funding for regional services. It was felt that that commissioners (Boards and fundholders) appear to have chosen to direct their funds away from these services to other areas that they perceive to be of a higher priority locally. The lack of funding available for regional services is compounded when the hospitals from which they are provided are coping with long term financial problems.

"We argue for one strategic planning authority and three clinical delivery systems"

Regional Specialties

Regional specialties are services that are best planned and, to a greater or lesser extent, delivered on a NI-wide basis. Some regional services are so specialised - because of the relatively small number of cases and the specialist skills and equipment required to treat them - that it is only appropriate to provide them at one or two hospitals in Northern Ireland. These services include cardiac surgery, neurosurgery, paediatric surgery and specialist paediatric medicine. There are other regional services such as cancer, where the delivery arrangements are more fluid. Relatively rare cancers requiring specialist care are most appropriately treated at one or two centres covering the whole of NI. Other cancers are more common and therefore can be provided effectively at a number of centres. Specialties such as cancer need an overall strategic framework within which their development can be managed.

The commissioning of most regional services is currently organised through the Regional Medical Services Consortium (RMSC). The RMSC comprises members from the four Boards, the DHSSPS and GPs (both fundholding and non-fundholding). The RMSC is not separately funded and therefore cannot commission regional services directly. Instead it provides a forum to co-ordinate planning and agree each Board's funding of service developments. Ultimately, responsibility for the commissioning of regional services remains with Boards and fundholders who consider the proposals of the RMSC in the light of other local priorities.

8.6 We concluded finally that if the above issues were to be addressed and our ideas for the future implemented, then the existing organisational structures would have to change. In essence we argue for one strategic planning authority and three clinical delivery systems based on natural patient flows and travel patterns.

Integrated Delivery of Health and Social Care Services

"What the patient wants is for the health and social care system to work for them so that they receive highly professional, seamless care"

8.7 One of the great challenges in the health field is to link together the complex network of services and specialist skills that individual patients need. Patient needs cannot be readily constrained within organisational boundaries. In modern health systems the patient who visits a GP will often find that he will call in the support of fellow professionals in developing diagnostic, treatment and care programmes. When a referral to hospital becomes necessary, the network extends and becomes significantly more complex. Some patients have conditions that require the skills of professionals based in more than one hospital. What the patient wants is for the health and social care system to work in effective harmony for them so that they receive highly professional, seamless care.

Making the system work effectively to meet the needs of individual patients is a prime challenge for the future. It was this search for seamless high quality care that led the Scottish Health Service to develop the concept of managed clinical networks that they described as: *"Linked groups of health professionals and organisations from primary, secondary and tertiary care working in a co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure the equitable provision of high quality clinically effective services throughout Scotland."*

"Making the system work effectively to meet the needs of individual patients is a prime challenge for the future."

Managed clinical networks provide a vehicle for the local delivery of quality assured care through the managed integration of hitherto separate clinical services. They can be of various types, concerned for instance with an individual specialty, such as neurology, or disease, such as cancer, both of which were proposed as pilots for the model in the Scottish Acute Services Review and are now in the process of implementation and evaluation.

Example of a Model Managed Clinical Network - Diabetes Services, Tayside

The managed clinical network for diabetes services in Tayside is one of the best developed of the networks in Scotland, reflecting its origins in advance of the Acute Services Review in Scotland that drew on its experience. The network serves 10,000 people in and around the City of Dundee (Tayside) and includes all general practitioners and hospital providers of care to diabetics. At the heart of the network's operation is a common database accessible to clinical members of the network who therefore have up to date information on individual patients. This has led the network to claim that "collaboration has created arguably the most comprehensive, validated information resource of all patients with diabetes anywhere". The advantages to continuity of care and to the implementation of evidence based clinical guidelines across the network are obvious.

For the most part these clinical networks build on existing professional relationships and referral patterns but make them more visible and capable of being effectively organised and supported. Concentration on the active management of the processes that connect the different component parts provides an improved service for patients.

"Managed clinical networks provide a vehicle for the local delivery of quality assured care through the managed integration of hitherto separate clinical services."

The management of emergency medical services as a single network offers the potential to smooth out peaks in emergency pressures at individual hospitals, thereby reducing the likelihood of trolley waits. Similarly, the management of elective services as a single network should help to ensure that all available capacity

is used to optimal effect, potentially increasing the overall level of activity and reducing waiting lists.

8.12 Another potential benefit of managed clinical networks is their ability to facilitate the concentration of specialist skills and complex diagnostic equipment, when appropriate, without necessarily having to close down local services which are so highly valued by local communities. We have good reason to believe that managed clinical networks would be acceptable to the medical Royal Colleges for professional training. This would allow the smaller, but nevertheless clinically demanding and stimulating, parts of the system to contribute to such training.

"We have reason to believe that managed clinical networks would be acceptable to the medical Royal Colleges for professional training. This would allow the smaller, but nevertheless clinically demanding and stimulating, parts of the system to contribute to such training"

8.13 It is in the field of cancer, with its need for a high level of reliable connectivity between services, that most progress has been made in network development. An interesting example of this is the South East of Scotland Cancer Network. This network comprises nine NHS Trusts located in four health board areas, providing a population of about 1.4 million people with integrated, multi-disciplinary services for a range of cancers. There are many other examples in other parts of the UK. In England the development of managed clinical networks for cancer services is now a requirement.

8.14 It is in the very essence of managed clinical networks that they can cross institutional and other organisational boundaries. Consequently they challenge existing planning and budgetary processes which are based on hospitals or geographical patches. In one sense the clinical networks rest on top of, or weave their way through, static components of the overall service. To work properly the networks demand information systems that support their role as well as that of the individual hospitals upon whose skills and services they draw. Clinical networks have to be managed. They demand high levels of partnership between all those within the system as well as shared professional rotas and common clinical protocols. They are not simply traditional 'hub and spoke' arrangements which, to some extent, have been devalued by over concentration at the hub; clinical life needs to flow evenly across the total network.

8.15 Developing managed clinical networks is not simple but the potential health gain is enormous.

The Challenge of Establishing Managed Clinical Networks

The Scottish Acute Services Review describes the challenge as follows: *"Establishing managed clinical networks and operating them effectively presents new challenges to cultures and attitudes, and the agenda for change requires flexibility and a developmental attitude on the part of those working within health care. Consultant staff will owe an allegiance to a clinical network (in some case more than one), which may not be contiguous with the area served by their employer Trust. Consultant appointments will have to be seen in the broader context of the skills and expertise needed by the network ...More mobility may be required of senior staff and a more effective electronic infrastructure will be needed to ensure information flow and support remote consultation or monitoring. Across the network, protocols will have to be developed to determine which clinicians should provide a given service to which patients and in which location(s). The agenda for change extends to patients and the general public, and requires a growing awareness and acceptance that all specialties and/or high technology clinical services cannot invariably be provided by their nearest local hospital."*

8.16 With the exception of highly specialist services (for which special arrangements are required), managed clinical networks operate for the most part within natural clinical communities or systems. In Wales these are referred to as health economies. It is within what we call these 'natural clinical systems' that interconnectivity needs to be secured. Each system needs to be large enough to provide the critical mass so essential to viability and clinical excellence. We describe our proposed systems for Northern Ireland below.

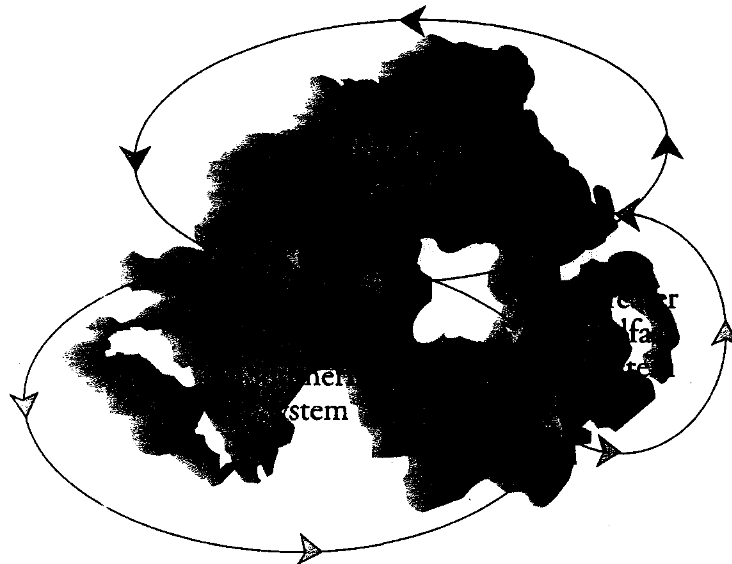
Three Integrated Health and Social Care Systems for Northern Ireland

8.17 Natural patient flows and travelling patterns in Northern Ireland point towards the development of three Health and Social Care Systems, each with at least one major hospital capable of dealing with serious emergency situations. The systems would be the employers of all staff involved in the delivery of services. They would not match the boundaries of the existing Boards, but in any case they are focused on service delivery and we make other recommendations later in this chapter in relation to the planning and commissioning of services. In addition, we envisage a regional specialty network that will link into each of our proposed systems.

"We do not wish to replace one set of arbitrary boundaries with another."

8.18 The existence of three systems should not inhibit the movement of patients between them. We do not wish to replace the existing set of arbitrary boundaries with another. Each system would serve a substantial population: the Northern and Southern Systems would each serve populations in the order of 400,000 to 500,000 with the Greater Belfast System serving some 700,000 people. As we noted in Chapter 2, 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; the populations of the three systems are consistent with this requirement. A broad illustration of the three systems is provided in Figure 8.1 below.

Figure 8.1 Illustration of the Three Health and Social Care Systems



"Partnership is not an option, it is a mandatory requirement."

8.19 In seeking to promote the management of clinical services we positively shift the managerial focus away from individual hospitals and community organisations. We recognise however the importance of sustaining the financial integrity of these institutions and organisations in the period of transition. Even in the long term they will retain their identities within a wider system. The detailed management arrangements within each system will need to recognise this. On-site or patch management will need to be blended with network management and both need to be mutually reinforcing. Partnership is not an option, it is a mandatory requirement.

8.20 Social care services, primary care services and community services will be an integral part of the three systems. We recognise that some social care services, such as adoption, will be best planned and perhaps delivered on a regional basis. Within each system we expect social care, primary care and community care to develop and thrive but in concert with developments in the rest of the system rather than separately. We envisage groups of primary care practices working together in

locality groups that would evolve into the primary care organisations of the future (various models for these organisations are under consideration as part of the Minister's review of primary care - 'Building the Way Forward in Primary Care'). These organisations will be an integral part of our three Health and Social Care Systems.

"We offer a sense of vision and direction, not a detailed blueprint"

8.21 The provider systems should in our view, be robust enough to blend together the contributions of directly managed clinical services with those provided by independent, voluntary and commercial providers in a mixed economy of provision.

8.22 If organisational change of the kind we have in mind is agreed we recommend a process of migration over a period of time. We offer a sense of vision and direction, not a detailed blueprint. Working out the detail will be an important means of drawing into the process of change health professionals and the staff of the existing organisations.

"We recommend a process of migration over a period of time"

8.23 Details of our proposed Health and Social Care Systems for Northern Ireland are set out in the following paragraphs.

The Northern Health and Social Care System

8.24 This system would include Altnagelvin Hospital, Antrim Area Hospital, Causeway Hospital and the local hospital at Mid Ulster. In this system Altnagelvin would represent the anchor point for secondary care although we would expect the specialist components of service to develop in a co-ordinated manner at both the Altnagelvin and Antrim sites. When looked at in the round, some adjustment to the balance of clinical work in each of these hospitals might be judged advantageous as might a higher degree of access to shared common services. We would see Altnagelvin developing as a provider of regional services to the population west of the Bann. Altnagelvin can expect developments in the foreseeable future in orthopaedics with Antrim developing its medical services. We believe there are opportunities for Altnagelvin to develop linkages with Letterkenny General Hospital in relation to orthopaedics and other services.

The Southern Health and Social Care System

8.25 This system would include Craigavon Area Hospital, Daisy Hill Hospital, the new hospital for the South West at Enniskillen and the local hospitals at Omagh and South Tyrone. In this system, the Craigavon Area Hospital would represent the anchor point for secondary care, supporting the development of managed clinical networks to sustain services through the hospitals in the South/South West area.

"We recommend the merger of the Royal Group of Hospitals Trust, Belfast City Hospital Trust and the Green Park Trust"

We believe that there are opportunities to develop linkages with Sligo Hospital, particularly in relation to orthopaedics services, south towards Cavan Hospital and south east towards Dundalk Hospital.

The Greater Belfast Health and Social Care System

8.26 This system would include the Royal Group of Hospitals, Belfast City Hospital, Ulster Hospital, Mater Hospital, Whiteabbey Hospital, Lagan Valley Hospital and Downe Hospital. As stage 1 in the process of creating this very large system, we recommend the immediate merger of the Royal Group of Hospitals Trust, Belfast City Hospital Trust and Trust Green Park Trust. This merger would allow a fresh look at the disposition of services (including regional services) across the two main Belfast sites as well as the potential for more sharing of common services and emergency rotas.

8.27 We commend the work that has been done in recent years in seeking to achieve complementarity and reduce duplication in the services provided on the Royal and Belfast City Hospital sites. The underlying logic of the McKenna report is that this should ultimately lead to a merger. We believe that the time has now come to take this final step, which had, indeed, been recommended in several reports and studies, over the last three decades, and has been urged on us by senior clinicians and by Queens University. The Belfast City and the Royal Victoria are the largest and most complex hospital communities in NI. They need to work as one clinical community and ensure their combined strengths are consolidated in an effective manner. We accept entirely the views we received from many sources that a deal of duplication and overlap could be avoided and the savings ploughed back into hard pressed services if the two hospitals were integrated as part of a wider network.

8.28 Musgrave Park Hospital too has important linkages with the Royal Victoria Hospital which is why it should be included in the same management framework. We believe that the potential of Musgrave Park to provide a regional centre for rehabilitation and to develop orthopaedic services would be greatly enhanced by the incorporation of the Duke of Connaught Unit (the RAMC hospital). We recommend that discussions on the feasibility of this proposal should be initiated.

8.29 As with other parts of the region, we are concerned that attention is paid to natural and traditional patient flows. To the north west of Greater Belfast lie the Whiteabbey, Mater and the Royal Victoria hospitals. To the south lie the Belfast City and Lagan Valley hospitals. To the south east lie the Ulster and the Downe hospitals. As the role of each changes, with the evolution of the proposed system of clinical networks, it is natural and desirable that links between these different hospitals should be managed to allow the development of effective arrangements for co-ordinating emergency care services, maternity services, elective surgery and

other clinical services. We believe significant benefits are possible from the re-alignment of services in the Mater and Whiteabbey Hospitals, in particular to provide acute medical cover and a geriatric medical service for the population in an area of multiple deprivation in North Belfast and along the north Lough shore. The Mater could also be the base for a small regional speciality such as ophthalmology.

The system must quickly identify dedicated beds for elective work.

One effect of these recommendations should be to provide space in the centre for highly specialised regional services by utilising capacity in the peripheral locations. The system must quickly identify dedicated beds for elective work including, crucially, those beds required to support regional specialities for the whole of Northern Ireland. As far as possible, routine elective work should be undertaken in the smaller hospitals within the system, such as the specialist elective centre we propose at Lagan Valley Hospital, to ensure that the Royal Victoria and Belfast City Hospitals can devote sufficient attention to more specialised services.

The central Belfast hospitals have several distinct but interconnected functions. As well as providing the general hospital services for the population of Greater Belfast, they are responsible for the provision of the great majority of the regional services for Northern Ireland while at the same time acting as the tertiary referral centres for the rest of the region. Concerns were expressed to us that these hospitals are finding difficulty in meeting the regional service needs of the population and this must be addressed as a matter of urgency.

There appear to be particular difficulties in relation to cardiac surgery. We understand that a review of cardiac surgery, including paediatric cardiac surgery, is currently underway which will include consideration of the needs of the whole island. We welcome this review and trust it will provide a clear way forward. Our own view is that the current number of patients being treated is clearly inadequate, there is scope for the service to be managed more effectively and there may be a need for increased capacity. It will be important also to consider the issue of paediatric cardiac surgery in light of the findings from the Bristol Enquiry.

The central Belfast hospitals also have responsibility for the majority of the undergraduate clinical teaching, the majority of post graduate training for specialist registrars, and are the centres from which the majority of the research carried out in Northern Ireland originates. During these times of change, and at a time when more undergraduate teaching is being provided beyond the sphere of Greater Belfast, it is nevertheless fundamental that there is a strong Greater Belfast Hospital sector to provide excellence in specialist services, in training and in research.

There is a considerable challenge in keeping a balance among the competing demands of regional and local services, teaching and research. It is important for the region that these hospitals are enabled to fulfil their different purposes, that

they keep pace with national and international developments in medicine, and that they can reinforce their positions in acting as centres of excellence.

Planning and Commissioning of Services

"The Health and Social Care Service needs a robust and clear strategic framework"

8.35 There was a broad consensus amongst all of those whom we met that the Health and Social Care Service in Northern Ireland needs a robust and clear strategic framework within which priorities can be set for development and services can be reshaped to meet changing patterns of clinical care. The conclusion that properly planned and organised cancer services can deliver substantial clinical benefits to patients applies to many other specialist services. It is important that these benefits are secured. Once the strategic framework is clear, local commissioning can proceed with confidence.

8.36 In our view a new Northern Ireland Strategic Health and Social Services Authority should be established to replace the four Health Boards. We see this organisation's prime functions as being:

- Strategic Planning.
- Resource Allocation.
- Capital Strategic Planning.
- Strategic Information System Planning.
- Workforce planning and control.
- Commissioning regional specialties.

8.37 The Strategic Authority would have no operational role in relation to service delivery. Whether this is a new HPSS organisation accountable to the Minister or part of a reshaped Department of Health we leave for the Minister to consider. Our strong preference would be for a new HPSS organisation to be established. Whichever option is selected, staff in the new organisation must be capable of handling complex clinical and managerial issues. It would be a small, sharply focused organisation with no responsibility for service delivery.

8.38 The Strategic Authority should conduct its business in public with regular public meetings. We would expect the policy papers that underpin its strategic decisions to be readily available to the rest of the health community and the public. The membership of the Authority must include representatives from primary care organisations and the Health and Social Care Systems, as well as leading clinicians and community representatives.

8.39 The Strategic Authority is the place where those charged with commissioning services and those providing service should come together to discharge their common obligations and duties to the whole community.

Commissioning of Community Services and Non-Regional Hospital Services

The commissioning of community services would be the responsibility of individual primary care organisations. We envisage these organisations coming together in system-wide partnerships or consortia to commission non-regional hospital services, predominantly, but not exclusively, within their provider system. The significant involvement of primary care organisations in the commissioning of services is crucial to ensuring that local accountability is secured.

Primary care organisations and partnerships will need significant freedom to be effective commissioners. Nonetheless, they must undertake this role within the policy framework and budgets set for them by the Strategic Authority to whom they would be accountable. We expect these primary care partnerships or consortia to be represented on the Strategic Authority and become in effect their operational arm for commissioning.

Regional Services

We strongly believe that all of the population of Northern Ireland deserves access to modern regional services. It is our view that this can best be achieved by giving one organisation responsibility for planning and commissioning these services for the whole of the region. In the short term, this could be the DHSSPS with a service based advisory group or board, or alternatively a consortia of HPSS organisations. In due course, we would expect responsibility for planning and commissioning regional services to be taken on by our proposed Strategic Health and Social Services Authority. It will be very important to involve the new primary care organisations in the planning and commissioning process for these specialties, through their membership of the Strategic Authority, but we do not think it appropriate to devolve the funding for the regional services to them individually. Clinical priority must remain the principal foundation for decisions about patient access but appropriate safeguards must be established to ensure that this is not influenced by patients' geographical proximity to regional specialty centres. Particular attention needs to be paid to the outreach and patient transport arrangements for patients who need to access these services.

"all of the population of Northern Ireland deserves access to modern regional services."

Each regional service should in our view have a designated Clinical Director who would be accountable to the commissioning organisation for ensuring that the specified clinical targets are met within the agreed planning framework. The Strategic Authority and the designated Health and Social Care System would agree the individuals concerned and ensure that their contract is adjusted to provide time for this vital leadership role. Each regional service would have detailed budget and service agreements with the hospital(s) from which the service is provided. In

time these services would form discrete regional clinical networks, but initially each would be based managerially at an appropriate Trust which would provide the Clinical Director with appropriate administrative support. The funding for these services would be precisely defined and over or under-spending and capital investment would be a matter for discussion between the Strategic Authority and the Clinical Director. The host Trust, or in due course system, should not use these funds for other purposes without explicit agreement. Once established we think it unlikely that the physical location of these services will change, although the nature of the service almost certainly will, as will the ability to outreach across the whole region.

8.44 The Strategic Authority should be required to publish an annual report on regional services detailing activity levels, sources of referral and cost, which would be available to the Assembly and the wider health community.

Consumer Representation

8.45 We envisage the creation of a single statutory consumer body to monitor the operation and policies of both the Strategic Health Authority and the three Health and Social Services Systems. This body would have the right to be consulted on the future policies of each of these organisations. It would bring together the views of patients and users of social services, and assist in making these views central to policy development and practice in the new structural arrangements. This Health and Social Services Consumer Body would study and report on the operation of the three systems as they plan and provide services across the region.

Common Services

8.46 There are a number of services that are being or could with advantage be managed on a regional basis through a common services agency, which could report either to the Strategic Authority or one or other of the three systems. These would include clinical services such as Blood Supply (which is already operating as a Northern Ireland-wide agency), and others such as Information Technology and Financial Services. Front line managers should be focused firmly on managing services to patients. The headquarters organisation and the service agencies need not be based in Belfast.

Summary

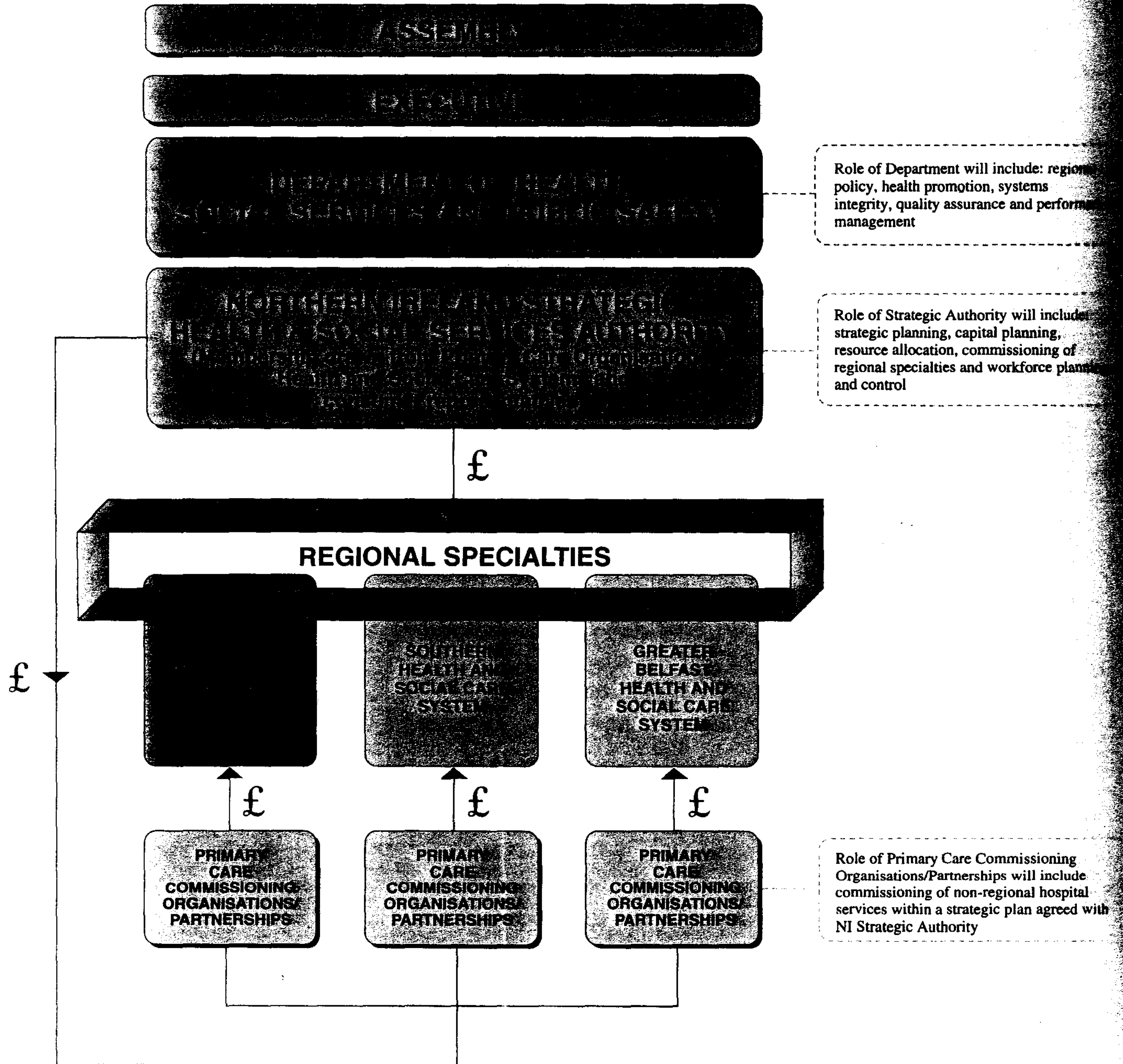
8.47 New organisational structures are crucial to the delivery of our vision for the future. Consumer views and needs will be heard through a new regional consumer body. A

new focus will be given to the planning and commissioning of regional hospital services with the establishment of a Strategic Health and Social Services Authority. This Strategic Authority will also provide a framework within which other hospital services can be commissioned by primary care organisations. At the same time, the establishment of three integrated Health and Social Care Systems will provide opportunities for staff from different professions, and from primary care and secondary care and social services to work together in multi-disciplinary teams delivering a seamless service to patients. 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.

In Figure 8.2 overleaf, we provide an illustration of our proposed organisational structure for the planning, commissioning and delivery of health and social care in Northern Ireland.

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.

Figure 8.2 New Organisational Structures



Chapter 9 - Primary Care

Background

9.1 From the outset, we were told of the pivotal role of primary care in addressing growing pressures in acute hospitals. We found confirmation of this in our analysis in Chapter 4 which highlighted Northern Ireland's relatively high rates of A&E attendance and emergency surgical admissions, and apparently low thresholds for referral and admission. Some of this may be due to cultural or structural differences, but our analysis strongly suggested that patients are being treated in hospitals in Northern Ireland who would be treated in the community elsewhere. There is, therefore, an opportunity to reduce pressure on the acute hospital sector by treating a greater proportion of patients in the community, provided that levels of resourcing, organisation and motivation in primary care are sufficient to the task.

9.2 In our background reading we noted that this seemed to be closely in keeping with current thinking. The DHSS document 'Fit for the Future' presented the HPSS as a single integrated service, "centred around primary care". 'Putting it Right' referred to the need for GPs to work more and more closely with hospital-based medical teams to extend their own skills and to enable more services to be developed in the community. The recent DHSSPS consultation paper 'Building the Way Forward in Primary Care' points out that close working links between primary care and hospital services are essential if people are to receive treatment in the right setting at the right time and are to be capable of moving easily through the whole system of health and social care. Those messages were reinforced throughout our consultation by people from a wide range of backgrounds. It rapidly became clear to us that although we were asked to conduct a review of acute hospitals, we could not perform that function without also considering the role of primary care and its interface with secondary care. This is because, as key components of an overall system, hospitals and primary care crucially depend on one another for their effective functioning.

"It rapidly became clear to us that although we were asked to conduct a review of acute hospitals, we could not perform that function without also considering the role of primary care and its interface with secondary care."

Primary Care - Context

9.3 The vast majority of contacts that people have with the health and social services are with primary care professionals. For example, every day in Northern Ireland 30,000 people see a doctor or a practice nurse, and each working day 120,000 people visit a local pharmacist.

9.4 Primary care covers a very wide range of services. It includes services provided by Family Health Service Practitioners - general medical practitioners (GPs), pharmacists, dentists, optometrists and the staff whom they employ. Details of Northern Ireland's GPs and the populations they serve are set out in Table 9.1. As we saw in Chapter 2, list sizes in Northern Ireland are 15% higher than in Scotland, though 11% lower than in England and 27% lower than in the Republic.

Table 9.1 - Northern Ireland's GPs

Board	Number of GP Practices	Number of GPs (WTEs)	Population Served
Northern Board	80	232	427,700
Eastern Board	148	396	673,300
Southern Board	79	182	309,400
Western Board	59	171	281,400
NI Total	366	981	1,691,800

9.5 Primary care services are also delivered by a range of staff employed by Heath and Social Services Trusts - community nurses, health visitors, community midwives, social services staff and the professions allied to medicine. In delivering these services Trust staff often work closely with GPs in their practices or in health centres. Together they provide a wide range of treatment and care in local communities, close to where people live.

"GPs are effectively the gatekeepers to the wider system of care"

9.6 GPs are, effectively, the gatekeepers to the wider system of care and have a key role in deciding what kind of treatment, support or advice is the most appropriate response to people's needs. Equally importantly, primary care is often the bridge back to normal health for those who have received more specialist care. The effectiveness with which patients are guided into and out of the hospital system, ensuring that they receive the right treatment at the right time, is crucially dependent on close working arrangements and effective communication links between the primary care and hospital sectors.

9.7 Recent years have seen increased opportunities for providing services in primary care settings. The development of new drugs, advances in treatment and care therapies and the use of information and communications technology mean that it is increasingly possible to treat people in their own communities for conditions that might previously have required a visit to hospital.

9.8 Demands on primary care will continue to grow, driven by policies such as: care in the community; health promotion; screening of high risk groups; demand for treatment and management of chronic disease arising from a growing elderly population; and diversification by primary care teams in areas such as twilight nursing, palliative care, hospital-at-home and minor surgery.

What We Heard

We met a broad spectrum of people from primary care including GPs, nurses and PAMs representatives. There were conflicting views about the capacity and the will of those working in primary care to extend the boundaries of their skills and practice into areas which have traditionally been within the domain of acute hospitals. On the one hand, we heard views which characterised primary care as a beleaguered sector and almost as a poor relation of secondary care which, without any form of consultation, planning or assessment of the implications, had been used as a repository of care to alleviate pressures in hospitals. We heard concerns about increasing demands for disease management, for example in Warfarin monitoring, which it was claimed had been moved to primary care without any additional resources.

On the other hand, we were encouraged by a great deal of enthusiasm from many people working in primary care for developing skills to enhance their capacity to provide a wider range of services in GP surgeries and other primary care settings. We saw examples of new and innovative practice that had invariably been inspired through primary care commissioning pilots.

"We were encouraged by a great deal of enthusiasm from many people working in primary care."

The Valuable Role of the Diabetes Nurse

We met a specialist diabetes nurse providing advice, support and treatment for patients showing symptoms of diabetes, generally on referral from their GPs. By providing a quick response to referrals and early diagnosis, this service can help to eradicate long delays in treatment and the consequential deterioration in health which patients would suffer if they had to wait for hospital treatment.

In this way, the service provided by the specialist diabetes nurse helps to avoid unnecessary hospital admissions through early intervention. Complemented by podiatrists and dieticians, continuing advice and support is provided for people with diabetes which helps them to enjoy greater mobility and independence and, of course, a better quality of life.

We saw the excellent facilities at the local hospitals in Bangor and Newtownards that offer a good model of co-operation between the primary and acute sectors in providing a range of important services for local people. The early success of these facilities is largely due to the imagination, drive and commitment of a small core of GPs who have worked hard to achieve their vision of how an extensive range of health care needs can be met in a local setting. The availability of appropriate funding for investment in staff, facilities and equipment has also been key.

Local Hospitals in Bangor and Newtownards

We visited the local hospitals in Bangor and Newtownards. Far removed from the cottage hospitals of the past, they are modern and dynamic facilities, providing services for which patients would otherwise have to travel to Belfast. The two hospitals are closely linked to the Ulster Hospital with medical services being provided by local GPs and Consultants from the main hospital.

This integration of medical care maximises the benefits of GPs' skills and knowledge of their patients, complemented by the provision of advice, specialist opinion and training from consultants. The two hospitals also include the first nurse-led peripheral minor injuries units in Northern Ireland. Using modern communications technology linked to the Ulster Hospital, these provide a casualty service for local people seven days a week with specialist back-up in the A&E department.

The local hospitals provide fast and convenient access to a range of services including diagnostics, outpatients clinics, therapy and rehabilitation. At Ards the day surgery service enables general surgical and gynaecological day procedures to be carried out, protected from the emergency pressures in a bigger hospital. The inpatient units of 20 beds on each site treat a wide range of conditions which would otherwise require admission to the Ulster Hospital. Patients can either be admitted directly by their GP or, with their approval, be transferred from the Ulster or another large hospital. Strict criteria, developed by the GPs and consultants, specify the types of condition appropriate for admission. As skills and confidence grow in line with training, so does the range of patients who can be treated at the hospitals.

There are plans for further developments at the two hospitals. Work on the establishment of inter-GP referrals is forming the basis for the development of specialist GP skills which can be expected to bring benefits to their patients and those of their colleagues. This development, together with technological advances, including digital x-ray which is shortly to be installed at Ards Hospital, followed by Bangor, will greatly enhance the range of services available to local people.

> **Some of the workload of hospitals could be managed by multidisciplinary teams working from primary care.**

9.12 Representatives of the Donard Primary Care Group told us of their efforts to involve local people and local health and social care staff in working together and with other agencies to achieve improvements in health and social well being in their area. To that end they had established a number of task groups to focus on issues such as elderly care, diabetes and mental health. Their view was that some of the workload of hospitals could be managed by multidisciplinary teams working from primary care or by hospital teams working within primary care. This view was echoed and amplified by other primary care representatives we met, including

representatives of the Royal College of General Practitioners. The predominant view in primary care was that the sector represented a highly skilled workforce which, given further investment in resources, training and an increase in staffing, could significantly improve the quality and diversity of services available at local level.

Achieving the Balance

It is difficult to be definitive about how best to enhance the effectiveness of primary care to achieve greater integration of service delivery with secondary care: the pattern of development will vary from one area to the next. Views are divided on which of the approaches described in 'Building the Way Forward in Primary Care' represents the best way forward. However it seems to us that a model which gives groups of multidisciplinary teams greater control over decisions about how services in their area should be planned, delivered and funded in order to provide patient-centred services, would provide the best catalyst for change. It would also allow the programme of change to be tailored according to local circumstances.

Prime Minister Tony Blair gave his vision for the future of primary care in a recent speech 'Empowering Primary Care and Supporting GPs in the NHS'. Much of his vision is consistent with the views of those in primary care that we spoke to. Below we suggest a number of areas in which it should be possible to make early progress.

Emergency Medical Care

We referred in Chapter 4 to Northern Ireland's uniquely high A&E hospital admission rates. Given the importance from the point of view of both the individual and the services of keeping people out of hospital whenever possible, these factors suggest that there may be scope for improvement in the effectiveness of the emergency services in this regard.

The high level of 'inappropriate' A&E attendances may indicate there is a useful role for a GP presence in A&E departments. Although this would not reduce the number of attendances, there is some evidence that it would improve the appropriateness of treatment. There may be scope for greater use of Nurse Practitioners and Nurse Consultants. Alternatively, it may be possible to locate A&E departments or local emergency units close to a primary care centre or out-of-hours facility.

Given the resources needed to ensure sufficient capacity and appropriate skills, primary care has the potential to take a more prominent role in relation to

emergency medical care. In more remote rural areas, where travelling times to the nearest hospital are greater, GPs could enhance the provision of life-saving services, for example, by providing defibrillation, thrombolysis and basic life support (BLS).

Local Hospitals and Intermediate Care

"Primary care can be the mainstay for the delivery of services in local care settings."

9.18 As demonstrated in the models of local hospitals described in Chapter 7, primary care can be the mainstay for the delivery of services in these local care settings. A significant feature of the facilities at the local hospitals at Bangor and Newtownards is the availability of intermediate care beds. Intermediate care has various interpretations and can mean different things to different people. In this context, we have used the term as defined by the Royal College of Physicians in a recent statement on the subject (RCP 5/10/2000). This commended the use of beds in the community to relieve pressure on costly acute hospital services. The Royal College guidance points out that good nursing care and active rehabilitation are vital components of intermediate care. It also notes that while intermediate care could be led by other practitioners, a medical presence is essential and, given the preponderance of elderly patients, care should be under the direction of geriatricians together with general practitioners with a special interest in the elderly. Importantly, the guidance also emphasises the need for strict admission criteria and that intermediate beds should not be used merely as a 'dumping ground' for the infirm: direct admission from the community should be subject to strict criteria.

9.19 As we have recommended in Chapter 7, local hospitals should be established at various locations to bring an extensive range of services to the local communities they serve. A critical success factor in these facilities is the involvement of primary care. We recommend that, pending the creation of our three proposed Health and Social Care Systems, representatives of local primary care are closely involved at an early stage in the planning and development of proposals in relation to the range of services to be delivered at these facilities.

Chronic Disease Management

9.20 GPs along with practice nurses and pharmacists have an increasing role in providing the care traditionally provided in hospital out-patient departments. Already much of the work to support people to manage chronic diseases such as asthma, diabetes and ischaemic heart disease takes place in primary care. The primary care practice will increasingly become the place where diagnostic tests and minor operations are carried out and where, as GP specialisms develop, one practice can provide a service to the patients of another. Chronic lung disease, mental health and care of the elderly are further examples of the many areas to be developed.

Out-of-Hours Co-operatives / Emergency Helplines

The establishment of GP co-operatives has been an important step towards the more effective co-ordination of out-of-hours services. Most GPs in Northern Ireland have joined co-operatives and they now cover the vast majority of the population. Co-operatives are in effect large rotas whereby the GPs on duty provide out-of-hours cover to all of the doctors participating. They operate from out-of-hours centres which patients who are assessed as needing to be seen urgently by a doctor can be invited to attend. Home visits are still made where doctors consider they are necessary.

Surveys undertaken in Northern Ireland to date indicate a generally high level of patient satisfaction with the service provided by co-operatives. Many callers are reassured by receiving telephone advice from a doctor. Patients who need an immediate consultation can be seen more quickly and in a clinical setting by travelling to an out-of-hours centre. For GPs, the co-operatives mean that they now generally have to work at nights and weekends much less frequently than before, leaving them better prepared for their daily surgeries. An evaluation of the DalDoc scheme in the Northern Board area[1] found that demand was higher than in a group of 16 co-operatives previously studied in Scotland, possibly reflecting the greater number of children in Northern Ireland. Telephone advice was more common in Northern Ireland than in Scotland, with fewer home visits. Patient satisfaction with the service was high, response times were regarded as excellent, there had been major improvements to GPs' quality of life, and no negative impact on other service providers was found. The available evidence, in Northern Ireland as elsewhere, is that these co-operatives work well. The effectiveness of GP co-operatives in keeping patients out of hospital may be enhanced by, wherever possible, locating co-operatives adjacent to A&E departments or in local emergency units along with other community based response services such as rapid response teams. Combined nurse triaging between GP co-operatives and emergency care services would help to ensure that patients most appropriate to primary care were directed accordingly.

In England and Wales, NHS Direct is another frontline service which enhances access to advice on healthcare and helps to ensure that people are directed to the most appropriate service taking account of the urgency and nature of their needs. Using a computer software system, nurses advise callers on the best course of action to take, which can include a recommendation to visit a pharmacist, to make an appointment with a GP or to go to the nearest A&E department. In Scotland a similar service, NHS 24, will soon be launched.

HSCRU, Queens University Belfast (1998)

West London NHS Direct

We visited the West London NHS Direct service at Southall in Middlesex. The service employs over 100 nurses and covers a population of over one million people. The service appears to be providing an effective form of reassurance to people who were anxious about health matters, particularly out of hours. It is highly valued by the GPs who see it as a major asset in helping to ensure that priority is given to those patients with the most urgent needs. A significant feature of the system is that it is linked to the GP co-operative in Southall, which means that the GP is provided with details of the patient's concerns and their case notes in time for their arrival at the surgery.

9.24 Although there is no evidence that NHS Direct helps in keeping pressure off acute hospitals, it may well have an important role in providing reassurance, particularly out-of-hours. We therefore recommend the introduction of a telephone helpline service to complement the service provided by out-of-hours co-operatives in providing an immediate and accessible source of advice and guidance on health care matters. We recommend that it should be introduced on a pilot basis, out-of-hours and linked to a GP co-operative covering a dispersed rural community. Such a service would have the potential to provide an important means of addressing people's concerns about health matters and help to ensure that where necessary, they had quicker access to the most appropriate form of care.

Home-Based Care Initiatives

"Rehabilitation schemes provide the option of safe earlier discharge from hospital."

9.25 There is increasing evidence from a number of pilot schemes that clinical outcomes in many cases can be as effective in a home environment with the added potential for enhancing quality of life. This applies to local pilots by Trusts of community-based rehabilitation and 'hospital-at-home' schemes. Rehabilitation schemes provide the option of safe earlier discharge from hospital with a period of skilled and intensive rehabilitation at home with a focus on helping elderly people to maintain as much independence as possible. These schemes rely on co-operation between hospital based and primary care (community) personnel to maximise their effectiveness. Rapid Response Services offer access to an urgent 24 hour domiciliary nursing service to patients, and other services including palliative care, which can avoid the need for admission to hospital. We recommend an expansion in the availability of such schemes to maximise the potential for providing safe, effective and economic treatment in a patient's own home.

Community Treatment and Care Centres

.26 The South and East Belfast Community Trust has recently received approval to provide three Community Treatment and Care Centres ('one stop shops') to provide a wide range of community services and a focal point for care and treatment. It is intended that the centres, each serving a population of 60,000 to 70,000 people, will be closely linked to all GPs in their area and will be co-located with a number of practices. Each centre will provide an opportunity for providing intermediate/ambulatory care services by GPs, Nurse Consultants, Nurse Practitioners, physiotherapists and other PAMs, and hospital consultants to the local population. With the emphasis on accessibility, they will be located adjacent to shopping facilities. These centres have the potential to complement or in some cases provide a substitute for a local (community) hospital particularly in an urban environment. We recommend that such schemes are closely monitored and evaluated with a view to considering the appropriateness of extending them to other suitable locations.

Resourcing Primary Care

.27 If the 'balance of care' is to shift significantly from secondary care there will be a need for more resources in primary care. There was a general consensus among those we met that an increase in GP numbers of up to 25% is needed to meet the existing demands in primary care and the increased responsibilities we have outlined above. Additional primary care resources will also be required to reflect the new commissioning responsibilities that we set out in the previous chapter. More Nurse Practitioners, Advanced Nurse Practitioners and practice nurses will be required and there will be a need to increase the local availability of training. We recommend that the Department's workforce planning process (see Chapter 10) should embrace the additional needs in primary care which will emerge through an expansion of the role of that sector into the areas we have indicated and appropriate resources be made available to support that expansion.

"If the balance of care is to shift significantly there will be a need for more resources in primary care"

.28 The Prime Minister's Speech 'Empowering Primary Care and Supporting GPs in the NHS' outlined the following ways to resource primary care:

- Structural change; using multidisciplinary primary care organisations to provide a strong framework for doctors and nurses to support each other.
- The need to recruit more GPs and free up their time for patients.
- A bigger role for pharmacists particularly in the area of medicines management.
- Upgrading and modernisation of GP premises with particular emphasis on ICT to enhance primary to secondary care communication, for example, hospital appointments, results and discharge letters.

9.29 The need to support and develop primary care training has also been recognised in England with proposals to establish three teaching Primary Care Trusts. Northern Ireland should follow these developments carefully and consider the need to supplement the community training provided at the Dunluce teaching health centre. One option might be to develop training capacity 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.

9.30 The development of a good research base in primary care locally should be encouraged. This would help to disseminate information on effective treatments and interventions in primary care as well as offer wider career opportunities. To do this, infrastructure for research in primary care and a research culture both need to be developed. This requires the setting up of research groups of GP practices, part-time research posts and infrastructure support. A network of primary care research would develop projects in association with academic departments, and be funded through the regional R&D Office.

Summary

9.31 There are clearly a number of opportunities to develop the role of primary care to achieve greater integration of service delivery with secondary care and remove some of the current pressures on the hospital system. In the future, primary care will have a key role to play in the commissioning of hospital services and in the delivery of services that previously have required a visit to hospital. We believe it is vital that the primary care sector is appropriately resourced to meet these and other challenges ahead.

Introduction

That our discussion has largely centred on services, facilities and systems should not detract from the importance we attach to the development of the health care system's main asset - a skilled, trained, dedicated, caring and motivated workforce. It would be negligent to ignore this. Health care is a highly labour-intensive enterprise. Salaries and wages, on average, account for some 70% of all expenditure. It would be impossible to begin to implement the changes and developments we have recommended without considering the impact on the existing workforce, the need to engage them fully in the process, their need for training and support, and the development of new skills and work-practices to meet the needs of a challenging and changing future.

The main asset is a skilled, dedicated, caring and motivated workforce.

We have been concerned at what appears to be the lack of any co-ordinated human resource strategy and the fragmented nature of workforce planning. This was a common response across all grades and disciplines, and was a cause of discontent and uncertainty. Much of this seems to have resulted from the devolution of responsibility to individual Trusts, which, however it might have made sense in terms of managing single institutions, made it more difficult to secure consensus on what should have been regional policies. Trusts have been competing for scarce resources, and sometimes this has led to the creation and filling of posts in a way which runs counter to regional policies and the strategic priorities of the service. We have been told of the need for a more co-ordinated response to workforce issues at a local level and the need for clearer direction at regional level, and we are concerned that these issues should be addressed as a matter of urgency.

We recognise the importance of a well prepared, highly motivated workforce to the realisation of the vision set out earlier in this report. We have identified a number of workforce issues in this chapter that will need to be addressed if this vision is to be achieved.

We recognise the importance of a well prepared, highly motivated workforce to the realisation of our vision.

Composition of the Workforce

The gender balance and age of the workforce is changing significantly. Historically, the medical profession was male dominated, but currently more than half of those entering medical schools are women. At the same time, other health and social services professional groups continue to be female dominated. The emergence of a largely female workforce must be reflected in future workforce planning, which should seek to be more flexible, more family friendly and more related to the life-styles and working preferences of women.

10.5 It has been suggested to us to that in future a growing number of consultants might choose not to remain in clinical practice up to the current age of retirement. It will be important that their skills and experience are not lost, and that senior doctors and other professionals are enabled to make a continuing contribution through teaching or management. In future, too, professionals will no longer be prepared to work the long hours of the past and there will be an emphasis on leading healthy, balanced lives, and this too along with other social pressures for change will have to be accommodated in workforce planning.

10.6 At the same time, professional roles within the workforce are changing. Some nurses, for example, are now taking on additional responsibilities as Nurse Practitioners and Nurse Consultants, providing a valuable additional resource and an opportunity to address deficits in medical staffing. Physiotherapists, radiographers, pharmacists and other clinical professionals are also performing tasks in primary and secondary care that were traditionally undertaken by doctors. We were told of innovative developments in England, where podiatric surgeons were able to treat patients on a day care basis, obviating the need for the patient to go to hospital. It will be important that such opportunities to develop the roles of all professional groups are identified and appropriate training, education and resources provided. At the same time, effective quality assurance arrangements must be in place to assure the public of a high quality, safe service.

10.7 The implementation of the EC Working Time Directive will reduce significantly the role of junior doctors in relation to service delivery. It will be important to minimise the impact of this change by ensuring that all opportunities for nurses and other care professionals to take on tasks currently undertaken by junior doctors are identified. As part of this process, we recommend a detailed review of the working hours and practices of junior doctors in Northern Ireland. The review should provide a reliable basis for the implementation of the Working Time Directive over the required 10 year timescale, with clearly defined milestones, responsibilities and accountabilities. The recommendations of the review should be reflected in the workforce planning of consultants and other care professionals.

The Medical Workforce

10.8 We were told during our visits to hospitals, and by professional bodies, of significant concerns in relation to the number of vacant consultant posts at Northern Ireland's hospitals. Of particular concern were the number of vacancies in radiology and pathology. More generally, we were told that even if all the existing consultant vacancies could be filled, the consultant complement for a number of specialties would still be significantly below that suggested by guidelines from professional bodies such as the Royal Colleges, the British

Association for Accident and Emergency Medicine and the Joint Consultants Committee. Among those specialties brought to our attention were:

- Accident and Emergency - the need to add 10-12 consultant posts to the current complement of 19 posts.
- Oncology - the need to add 9-10 consultant posts to the current complement of 14 posts.
- Paediatrics - the need to add 15-20 consultant posts to the current complement of 52 posts.
- Radiology - the need to add 35-40 consultant posts to the current complement of 61 posts.
- Pathology - the need to add 30-35 consultant posts to the current complement of 65 posts.
- Psychiatry - the need to add 45-50 consultant posts to the current complement of 74 adult psychiatry posts, and 7 to the current complement of child and adolescent psychiatry posts.
- Trauma and orthopaedics - the need to add 35-40 consultant posts to the current complement of 36 posts.

10.9 These and other shortages in consultant numbers were felt to be inhibiting the implementation of major strategies such as the Cancer Strategy, and restricting the extent to which specialist services can be made available outside the Belfast area. They were also felt, crucially, to be undermining the provision of key regional services.

10.10 These are substantial deficits to be made up, both in terms of the funding required, the funding of training posts, the provision of adequate clinical experience and finding the people.

"In the longer term we expect to see a substantial increase in the number of consultants"

10.11 In the longer term, we expect to see a substantial increase in the number of consultants, perhaps ultimately by a factor of two. An increase of this order will be required to provide the consultant-delivered service that we envisage and to reflect the reduced dependency on junior doctors for service delivery as the full impact of the EC Working Time Directive begins to be felt. Given that it takes 15 years from entry to medical school to reach consultant status, this is necessarily a long-term strategy which could take up to 20 years to implement. In the meantime, medical staffing in Northern Ireland should keep pace with changes already announced for the NHS, and subsequent developments. We welcome the recent proposal to increase consultant numbers in medicine by 3% per annum over the next 10 years as a first step in this direction but recommend that efforts be made to expedite the targeted increase.

10.12 We have earlier suggested the need for an increase of the order of 25% in the number of general practitioners. It is important too to monitor the trend towards subspecialisation, which could become excessive, and to reconsider the role of the

generalist on whom services in smaller isolated hospitals often depends. There is a need too to develop and sustain the role of the staff-grade doctor, so many of whom are playing a vital role in the maintenance of services here.

10.13 We are assuming that JHO and SHO training will be organised within each of the three systems we recommend, so as to provide doctors in training with a suitable range of experience in a way that will dovetail with service requirements. Such training would be planned and monitored centrally, as would the requirements for post-graduate and in-service training. We recommend an early review, along with the Post Graduate Medical Education Council and the Royal Colleges of these training arrangements.

"The required increase in the number of doctors will inevitably lead to a significant increase in the demand for medical school places."

10.14 The required increase in the number of doctors will inevitably lead, as in the rest of the United Kingdom, to a significant increase in the demand for medical school places. In England, new medical schools are being opened and others expanded. It seems to us that an increase in the number of medical school places in Northern Ireland is most likely to be achieved by an expansion of the QUB Medical School. We understand that the School has the capacity to increase the number of student places by 90 to 250. We recommend that urgent discussions take place to ensure that Northern Ireland keeps pace with proposals to increase medical student numbers in England. This, it must be appreciated, will place demands on the budget for Higher Education as an expansion of the medical school will require substantial capital investment in new buildings and facilities. It will also require additional recurrent revenue expenditure to fund the additional academic posts that will be required, to improve the present ratio of students to clinical staff (which are significantly higher than in comparable medical schools in other parts of the UK), and for research. As a matter of regional policy, and in order to build the capacity of Altnagelvin to accept some tertiary services, we would like to see some of this expansion of teaching and research located there.

The Nursing Workforce

10.15 It is quite clear to us that, for whatever reason, nurse training and recruitment figures have been underestimated. Recent figures suggest that there are 500 vacancies in the HPSS (4% of the workforce) and about 300 in the private sector. We were told of particular shortages of specialist nurses in theatres and intensive care. This is before any account is taken of the adequacy of the present nursing establishment, the need for specialist nurses and the expansion in numbers and roles that our recommendations imply. It has been suggested to us that the current complement of hospital nurses and midwives (11,600 whole time equivalents) should increase by as much as 20%.

10.16 There are obviously serious issues to be dealt with in relation to nursing numbers, training, staff retention, skill-mix and working conditions. These require urgent consideration.

10.17 We have seen figures which suggest that while between 1987/88 and 1997/98 entries into pre-registration nursing courses declined by 12% in England, 21% in Wales and 27% in Scotland, the reduction in Northern Ireland was 43%.

10.18 Again, between 1996 and 2000, in Northern Ireland, while medical numbers increased by 11% and numbers of administration by 10%, the number of nurses and midwives actually fell by 5%.

10.19 We support the Minister's recent decision to increase the number of nurse training places to 640, but recommend that the expansion be both increased and expedited. This will involve additional expenditure in the education sector, as well as additional costs for clinical placements and mentoring in the HPSS. Use should be made too of the private sector as a resource for clinical placements.

10.20 If there is not to be continued wastage to the private sector and abroad, it will be important to have regard to the needs of the predominately female nursing workforce for flexible and family friendly working arrangements. It will also be important to ensure that reward packages, especially for those in highly specialised and stressful areas of work are sufficient to attract and retain staff.

10.21 Training for nurse consultants and specialist nurses as well as consultant and specialist practitioners in the PAMs, and training for the emerging discipline of Clinical Practitioner should, as far as possible be made available in Northern Ireland. This is a case too where North/South co-operation could ensure the viability of training courses on the island. There must also be increasing potential for accessing training through distance learning (as is being done successfully in the South Eastern Health Board area in the Republic). In discussing training with nurses, we detected a general dissatisfaction that nurses coming off training courses were less well remunerated than their colleagues in England. It is important for the development of the services that personnel are not discouraged from undertaking training, and are suitably rewarded in the grading structure when they do so.

The Ambulance Workforce

10.22 Our recognition of the importance of an improved ambulance service as an integral part of the emergency service implies a requirement to substantially upgrade the skills of ambulance paramedics. We recommend the adoption of a two-year training course and a requirement that ambulance paramedics should

work on a regular rotation at a hospital emergency department in order to gain experience and to upgrade skills.

Workforce Planning

10.23 Workforce planning is a notably difficult exercise, depending on so many assumptions and variables that it can easily be got wrong. It is a limited exercise if it only takes account of the numbers likely to be required to fill posts falling vacant through retirement. We were told that planners in attempting to predict future workforce requirements have aimed at too perfect a balance, with no built-in contingency to ensure an adequate supply of suitably prepared staff at all times. Key to this attempt at precision has been a lack of financial resources to adequately fund training posts in all disciplines. The fear of over-production and consequent unemployment of trained staff has created difficulty in filling posts, and has removed the stimulus of competition for jobs.

10.24 The evidence is that rigidity in planning has resulted in difficulties for some Trusts in recruiting suitably qualified midwives, specialist nurses, clinical psychologists, PAMS professionals and medical consultants. Where there have been difficulties in meeting targets in the provision of regional specialisms, or in dealing with emergency admissions, these have related more to the shortage of specialist nurses than any other factor.

“Workforce planning should be an integral part of the overall planning process.”

10.25 Workforce planning, which appears not always to have taken sufficient account of policy development, changes in legislation, and the requirements of professional bodies should be an integral part of the overall planning process in the health and social services. There is a need to build in an adequate contingency, or even over supply the health care market with adequately prepared professionals so as to ensure that there is no repeat of the difficulties of the past in providing services to the population when they are required. Where new services have been introduced, as for example in cancer services and cardiology, it has not always been possible to ensure that there are sufficient professionals available, appropriately prepared, to deliver the requirements of the strategy. Similarly, when additional consultant posts have been approved, insufficient consideration may have been given to the ramifications for PAMs and nursing. These issues have resulted in less than optimum health outcomes for the population and frustration for those charged with commissioning and delivering these services.

10.26 We became aware, in the preparation of our report, of the publication of a Consultative Document on the Review of Workforce Planning for the NHS, and that regional versions have been provided in Scotland and Wales. We recommend that a similar workforce planning exercise should now be undertaken in Northern Ireland. The DHSSPS should take the lead, in consultation with the service, as a

matter of great urgency, and it should be possible to produce a consultative document for Northern Ireland within three months. A workforce plan is vital to ensure that even the present services are sustained and this work should therefore go ahead concurrently with consultation on our report. It may have to be amended subsequently to some degree, but at least a start will have been made on work that is urgently required.

Such a plan, following the model of the English document, should include a robust assessment of service needs, and the skills and staff required to deliver these services efficiently and effectively. The plan should cover 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 take account of evolving roles and reflect wider issues such as the EC Working Time Directive and the shift towards more flexible, family friendly working arrangements. The plan should examine service requirements, workforce issues and resources together to ensure that proposals for development are consistent and co-ordinated. Finally, the plan should ensure an appropriate balance between central (top down) and local (bottom up) planning, and should identify clear milestones, responsibilities and accountabilities.

“A workforce plan is vital.”

In developing the workforce to meet the new challenges, again following the English document, the emphasis should be on:

- **Team working** across professional and organisational boundaries.
- **Flexible working** to make the best use of the range of skills and knowledge that staff have.
- **Patient focused workforce planning and development**, stemming from the needs of patients, not professionals.
- **Maximising the contribution of all staff to patient care**, doing away with barriers that say only doctors or nurses can provide particular types of care.
- **Modernising education and training** to ensure that staff are equipped with the skills they need to work in a complex, changing health service.
- **Developing new, more flexible careers** for staff from all professions.
- **Expanding the workforce** to meet future demands.

The Impact of New Organisational Structures

In Chapter 8 we recommended the establishment of new organisational structures. Within these new structures, the Health and Social Care Systems would be the employers of all staff involved in the delivery of services.

10.30 The Northern Ireland Strategic Health and Social Services Authority would be responsible for the approval of all consultant posts. Our observation of the functioning of Comhairle na nOspideal in the Republic demonstrated the value of a multidisciplinary group of planners, commissioners, providers, educators and staff representative bodies in the planning and approval of new consultant and specialist registrar posts, and the filling of vacant positions. The development of a model of this sort in Northern Ireland as part of the Strategic Authority would enable all stakeholders to work together in partnership to address this important issue.

10.31 The centralisation of approval for consultant posts and of training arrangements is a matter of some urgency and should proceed forthwith. It need not wait for the full implementation of the structural changes that we have recommended.

10.32 We anticipate that managed clinical networks will generally be managed by clinicians who have been leaders in their field and who command the respect of their colleagues. They will also have to be able to work with colleagues in other professions and disciplines. They will need considerable training and support for the new role.

10.33 The new structures we recommend present a major challenge to health and social services managers. Those who have been managing institutions will now be asked to run systems. Those who have thought in terms of individual hospitals will be asked to think instead in terms of services. This represents a major cultural, behavioural and attitudinal change. The training needs of this group of staff should not be underestimated, nor should their need for continuing support and coaching through a long and difficult transitional period.

10.34 Training will also be required for those organising services on a new basis in primary care, and for those who are being asked to expand their professional horizons and to work in multi-disciplinary and cross-sectoral teams.

Wider Employment Issues

10.35 We received many and strong representations, particularly in provincial towns, about the importance of the district hospital to the local economy, as a generator of spending power to support the local commercial base and as a source of jobs in areas where alternative employment is hard to find. We were deeply impressed by these arguments and by the genuine concern that lay behind them on the part of District Councils, Chambers of Commerce, rural organisations and local communities. However, as we have pointed out throughout this report, our prime consideration has to be the welfare of patients and the provision of services, rather than with the creation or maintenance of employment in local areas.

This does not mean that we are deaf to the concerns expressed. We are fully aware of the fears, and the reality, that changes in hospital services could have a serious impact on employment locally. However we would argue that the configuration of services that we recommend does not envisage a decrease in employment overall. Indeed, we have pointed to the need to substantially increase the number of doctors, nurses and other staff. We see a major shift in the pattern of delivery of services towards primary and continuing care. These forms of care are, of their nature, labour-intensive. There will continue to be employment locally, perhaps not so much concentrated on single sites, but generally available to local people and bringing money into the local economy.

There is too, in the health care system, a wide range of jobs that do not provide direct clinical care, and which can be located anywhere. These include support services, agency and technical services that do not need to be in Belfast (where most are currently located) or in the eastern part of Northern Ireland. Centres for data processing, for the payment of accounts and other support services could just as well be sited in a provincial town, as could the ambulance control centre or a local variant of NHS Direct.

"All jobs do not need to be in Belfast"

This would seem to us to be in tune with Executive policies for rural development and key towns. We recommend that consideration should be given to the location of such agencies in a way that will minimise the impact on local employment of changes in the pattern of services at any local hospital.

Leadership and the Process of Change

The importance of leadership should not be underestimated. The human resources in the health and personal social services are its main asset. Staff are entitled to strong leadership from the centre and competent management locally.

"People deliver health and social services, and the quality of the service depends crucially on the extent to which they feel valued and motivated"

People deliver health and social services, and the quality of the service depends crucially on the extent to which they feel valued and motivated and part of the great enterprise. Some of the changes we recommend are radical with far-reaching implications for staff. It is imperative, therefore, that staff at all levels, and their representatives are consulted fully as part of the process of change, that where training or retraining is required, this is provided, and that the nature of the changes and the strategy behind them are fully explained. It is not our business to discuss terms and conditions of employment - these are matters for resolution between staff and their representatives and management at various levels. For change to take place smoothly, however, staff need to be reassured that their interests, too, will be taken into account, and protected where necessary, and that where changes in patterns of employment and working practices are required, these will be negotiated openly and fairly.

"Underpinning any change in professional roles and work practices is the need for a comprehensive workforce strategy"

Summary

10.41 The ability to recruit and retain an appropriately skilled and motivated workforce is crucial to the delivery of our vision. Issues such as the development of clinical networks, the reduction in junior doctor hours and changes to training will affect all professionals. There will be changes in the work people do, with the emergence of the Nurse Practitioner and Nurse Consultant, the development of the role of the radiographer, and similar changes in other professional roles. Staff will increasingly work as part of multi-disciplinary clinical networks to meet the needs of the population. Underpinning any change in professional roles and work practices is the need for a comprehensive workforce strategy that identifies service needs and the skills and staff required to meet these needs.

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Chapter 11 – Supporting the Delivery of Care: Essential Infrastructure

Introduction

11.1 The delivery of modern and effective health care requires access to appropriate facilities, equipment and support services. From a patient's perspective, the physical environment within which services are delivered is crucially important to their overall care experience. At the same time, it is important that staff providing health and social care have access to the necessary facilities and equipment and support services to allow them to do their job effectively.

11.2 In recognition of this, we examined the current position and future requirements in the following areas:
- The Health and Personal Social Services (HPSS) estate;
- Information and communications technology;
- The Ambulance Service.

11.3 We also examined two front line clinical services that support clinicians in all settings and that are very capital intensive, namely:
- Radiology;
- Pathology.

The HPSS Estate

11.4 Our discussions with Northern Ireland Health Estates and our own visits to hospitals in Northern Ireland highlighted the poor condition of a number of Northern Ireland's hospitals. As noted in Chapter 3, the pressure on resources within the service has resulted in significant under-investment in the health estate. Northern Ireland Health Estates told us that new major capital developments of some £600 million have been identified and are at various stages in the planning and construction cycle. In addition, a further £200 million to £250 million is required to address the backlog in essential maintenance expenditure necessary to improve other parts of the estate and ensure it complies with statutory standards (Fire, Health and Safety, etc.).

> **"£200-£250 million is required to address the backlog in essential maintenance expenditure necessary to improve the estate"**

11.5 The annual capital funding available to the HPSS is £50 million to £55 million (split roughly 50:50 between major works and minor works, including maintenance, equipment and ICT). It is clear that this level of capital funding is insufficient to meet the current needs of the service, let alone deliver our vision for the future of health care in Northern Ireland. It also makes poor economic sense to under-invest in the maintenance of buildings and equipment.

11.6 As a first step in addressing the urgent capital investment needs of the health estate, we recommend the preparation of a 10 year estate development plan, 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.
- The backlog of routine estate maintenance.

Information and Communications Technology

11.7 Information and communications technology (ICT) is another area that has suffered from prolonged under-investment as a result of other pressures on resources. There was a general sense of frustration from the doctors, other care professionals, administrators and ICT professionals we spoke to that the pace of development in ICT in the health service had lagged far behind the rapid pace of technological development in medicine. Archaic computer hardware and paper-based recording and communications systems were clearly incongruous in modern, hi-tech hospital environments like the new Royal Belfast Hospital for Sick Children. They stifled efficiency and undermined public confidence in the service.

11.8 There is a wide range of systems in use across Boards, Trusts, hospitals and among primary care organisations. A major concern is that these systems are incapable of communicating with each other with information being held, in effect, in 'silos' within GP surgeries, individual hospital departments, etc. As a result, clinicians, other medical staff and health administrators do not have a 'joined up' picture of patients, leading to unnecessary repetition of questions to patients on issues such as where they live and their medical history.

"It was the widely held view of those consulted that ICT had the capacity to improve significantly the standard of services and working practices"

11.9 It was the widely held view of those consulted during the review that ICT had the capacity to improve significantly the standard of services and working practices in a number of areas:

- *Primary care* - electronic access to up to date patient records, automated referral and discharge letter systems linked to secondary care, rapid on-line investigative test requests and results, e-mail, direct outpatient clinic booking, on-line prescribing and improved access to data on good practice and on mobility patterns.
- *Hospitals* - access to the latest research and guidance on the diagnosis, treatment and management of specific conditions, support for audit and clinical governance requirements, reliable and up to date patient information, tele-consultation, waiting list and admission management, automated discharge letter systems, electronic ordering of and reporting on diagnostic tests and performance management information.
- *The Public* - access to health promotion information, on-line appointment booking, electronic requests for repeat prescriptions for electronic transmission to a pharmacist, access to information about medical conditions and advice about treatment and care.

Although there are a number of ICT developments under way in Northern Ireland, investment in ICT has not been sufficient to keep pace with developments in the rest of the UK and the Republic. We accept the assessment of the DHSSPS that additional ICT investment of at least £10 million per annum is required, over and above current planned investment of £6 million to £7 million per annum.

ICT Developments in Northern Ireland

ICT projects currently under way in Northern Ireland include:

- Unique Patient Client Identifier Project (UPCI) - this project is aimed at establishing a UPCI for use across the HPSS. The UPCI database will hold a record for each member of the population that will contain information specific to the client, ie name, address, date of birth, GP but not clinical information. The project will go further than the corresponding NHS Number system in GB by providing for the automatic updating of any record from a single point regardless of where it is held within the health and social services.
- Person Centred Community Information System - this is a collaborative project involving 10 Trusts. Its aim is to provide information to support community professionals in improving healthcare provision to patients. This, in conjunction with UPCI, will provide the opportunity to enhance information transfers involving client data within and between acute hospitals, GPs and other community Trusts.
- HPSS Private Data Network - this currently links all Boards, Trusts and Agencies and is being extended to create a backbone network to link all GPs to the HPSS.

There is a need for a clear strategic vision and plan for ICT investment in the HPSS. This has been recognised by the DHSSPS and work is under way. In the light of the progress made to date we see no reason why it should not be possible to have the main elements of a framework for consultation available in six to nine months. A task force involving all of key stakeholders (including primary care representatives) might reinforce and support the efforts of the Department which, in our view, does not currently have the capacity in this area to handle change on the scale we believe is required.

"There is a need for a clear strategic vision and plan for ICT investment in the HPSS."

Until the strategic framework has been agreed it would seem appropriate to impose a moratorium on all investment in new systems valued at over £50k. Any urgent exceptions to this should require explicit agreement by the DHSSPS.

A decision needs to be taken about future management arrangements for developing, maintaining and investing in core ICT systems. We believe this cannot be left with individual systems and primary care providers. The three Health and Social Care Systems may provide an appropriate organisational focus for dealing with this matter within the context of an overall regional strategy.

The Ambulance Service

11.14 The ambulance service is a vital link in the emergency medical service chain. In the year 1999/2000, the Northern Ireland Ambulance Service (NIAS) responded to 68,000 emergency calls. During our public consultation, people generally applauded the dedication and commitment of ambulance service crews. But they were also concerned about the lack of investment in the ambulance service, reflected in the poor quality of much of the fleet and the out-dated equipment. People in the more remote rural areas were concerned about sparsity of cover and about the length of time it took ambulances to respond to emergency calls.

11.15 We visited the Knockbracken ambulance control centre where we heard at first hand from NIAS staff of some of the weaknesses in the current service. The communications system was particularly archaic, there were too few ambulances, some of the vehicles were in poor condition and there was no form of emergency call prioritisation system. These are all causes for concern but the last point is particularly worrying. It means that an ambulance can be dispatched in response to a call relating to a relatively minor condition, rather than responding first to a subsequent call relating to a more serious and potentially life-threatening one.

"The Department should give a high priority to the ambulance service"

11.16 These concerns were echoed in the Strategic Review of the Northern Ireland Ambulance Service ('Mapping the Road to Change', January 2000) which pointed to the challenges facing the Service in meeting emergency response times, particularly in large rural areas with dispersed populations. The Review recognised that, currently, rural areas of Northern Ireland had a lower probability than urban areas of meeting the Patient Charter Standard of 50% of all 999 calls being responded to within 8 minutes. The Review made a total of 64 recommendations and the NIAS has now prepared an implementation plan. To implement this plan, NIAS told us that they will require additional recurrent revenue and capital funding of £11.5m and £2.5 million per annum respectively, plus a one-off capital injection of some £10 million to £11 million. We understand that, to date, it has only been possible for the DHSSPS to commit an additional £2m to the NIAS for this purpose.

11.17 There is clearly an urgent need for improvements in the NIAS which has been historically under-funded. The five year timescale proposed in the Strategic Review for the implementation of the various recommendations is too long. We recommend that the Department should give a high priority to the implementation of the recommendations in the Strategic Review, and that there should be a significant increase in the proposed investment in the Ambulance Service in order to accelerate implementation. In particular:

- The procurement of new and additional vehicles should begin immediately.
- The scope to develop a common radio link with the fire and police services should be examined.

- Emergency care services should be separated from patient transport services.
- An early decision should be taken on the location of the proposed new communications control centre and its staffing which should include medical and nursing personnel. This location need not be in Belfast.
- A training programme should be implemented urgently to allow ambulance crews to enhance their skills to higher paramedic standards.
- The 'first responder' scheme should be developed now to introduce a first tier response for communities in remoter areas of Northern Ireland.

Radiology Services

11.18 Radiology services play an important role in the diagnosis, treatment and monitoring of patients. They are very capital-intensive and therefore costly to provide. Each of the 15 acute hospitals in Northern Ireland (and the specialist elective centre at Musgrave Park) has a radiology department, although there are significant variations in the range of services available. During our hospital visits it became clear that a number of radiology departments are finding it difficult to respond to the needs of hospital clinicians and general practitioners. One particular issue is the number of vacant radiologist posts. We also saw evidence of patients being kept unnecessarily in hospitals while they waited for a CT scan - given the pressure on hospital beds referred to in chapter 3, there is clearly a need for this issue to be addressed.

"patients are being kept unnecessarily in hospitals while they wait for a CT scan"

11.19 A recent report by the Clinical Imaging Strategy Sub-group (and an associated radiology manpower survey) set out proposals for the development of radiology services in different care settings in Northern Ireland. The key recommendations set out in these documents are as follows:

- There should be a significant expansion to the range of radiology services that can be directly accessed by GPs and available to clinicians in hospitals.
- Magnetic Resonance Imaging (MRI) units should be installed at all of the designated cancer units (Altnagelvin Hospital, Antrim Area Hospital, Craigavon Area Hospital, Ulster Hospital) and the Belfast City Hospital to support its Cancer Centre role. At present, the only hospitals with MRI scanners are the Royal Victoria and Musgrave Park. Waiting lists for a routine outpatient MRI scan at the Royal Victoria Hospital are 20 months (1 June 2000) and for an urgent outpatient scan three months.
- Urgent action should be taken to fill the current vacant consultant radiologist posts. There should also be an immediate increase in the training establishment of Specialist Radiology Registrars to address current understaffing and permit future expansion of services.
- Capital funds should be earmarked to ensure the implementation of a rolling programme of equipment replacement. Currently some 45% of radiology equipment in Northern Ireland is over 10 years old and would require £31 million to replace. This equipment may be exposing patients to higher levels of radiation than would be the case if more modern equipment was used.

- New technologies such as Picture Archiving Communication Systems and Teleradiology can enhance the service provided by radiology departments and should be developed as part of a NI-wide strategy.

"A key priority should be the provision to GPs of direct access to a range of radiology services."

11.20 In general we support the recommendations of the Sub-group but we note that no effort has been made to cost or prioritise their proposals. It will be important that this is done as quickly as possible. A key priority should be the provision to GPs of direct access to the full range of radiology services proposed by the Sub-group. In this way, GPs and secondary care staff will be encouraged to work more closely together in the provision of a 'seamless' service to patients. We would also fully support the Sub-group's proposal to increase the availability of MRI units given the length of the present waiting lists for this key service. There should also be urgent action to reduce significantly the time patients have to spend waiting in hospitals for CT scans.

11.21 Looking to the future, we would expect each of our three Health and Social Care Systems, in the context of a regional plan agreed with the Strategic Authority, to develop an efficient radiology service model involving an integrated and linked network of services. Radiology services in each system should be headed up by a Clinical Director. We recommend that a rolling programme for the replacement of radiology equipment should be established.

Pathology Services

11.22 Pathology services, like radiology services, play an important role in the diagnosis, treatment and monitoring of patients. They are also capital-intensive, although to a lesser extent than radiology services. In Northern Ireland, pathology services are provided from laboratories on 16 sites including 12 of the 15 acute hospital sites.

11.23 During the course of the review we consulted a number of senior pathologists in Northern Ireland. We also reviewed a recent Northern Ireland Audit Office (NIAO) report ('A Review of Pathology Laboratories in Northern Ireland', December 2000) and a recent study commissioned by the Chief Medical Officer ('Modernisation of Pathology: Scoping Study', February 2001). This process highlighted a number of issues being faced by the pathology service. These issues include:

- The volume and complexity of demand for pathology services from hospital clinicians and general practitioners is increasing as a result of increased demands from new cancer services, the greater emphasis on day care, increasing management of conditions in primary care, the demand for rapid diagnostic testing of medical emergencies on a 24 hour basis and, more generally the demand for a responsive pathology service outside normal working hours.
- Approximately 10% of consultant pathologist posts are vacant. More generally there is a need for greater numbers of pathology staff to meet the

increased demands referred to above, to deliver greater sub-specialisation and to achieve the reduction in working hours required by the EC Working Time Directive.

- There has been under-investment in laboratory equipment. A significant proportion is over 10 years old and would require approximately £4 million to replace. Newer equipment would allow for a greater proportion of analyses to be automated and would produce better and more standardised results. There is also a need for greater investment in information technology, including telemedicine.
- There has been under-investment in laboratory buildings. We were told that laboratories at the Royal, Craigavon, Antrim and Altnagelvin Hospitals have benefited from relatively recent investment, but the laboratories at the Belfast City Hospital are in urgent need of redevelopment.
- Quality standards are not being achieved - approximately one third of the laboratories in Northern Ireland have not yet obtained full or even partial accreditation with the voluntary national scheme for accrediting the organisation and performance of laboratories. It is likely that in the future there will be increasing pressure for laboratories to achieve accreditation as one objective way by which commissioners can be assured that services meet well defined quality criteria.

In England, pathology services have traditionally been organised to serve populations of around 250,000, but a number of services are now serving much larger populations. Concentrating services on fewer sites offers potential for economies of scale and for increased specialisation, both at a consultant level and for specific laboratories within the overall service.

"Quality standards are not being achieved - approximately one third of the laboratories in Northern Ireland have not yet obtained full or even partial accreditation with the voluntary national scheme"

In 1983, the DHSS adopted a policy for the provision of pathology services that recommended that they should, as far as possible be concentrated on six main sites. The NIAO study of pathology services in Northern Ireland highlighted that little progress has been made towards this goal, with Clinical Directors and other senior pathology staff tending to defend the need for their laboratories. The NIAO recommended that the DHSSPS, in conjunction with Boards and Trusts should *"consider the costs and benefits of their current configuration of laboratory services against an off-site service in some locations with on-line access to the laboratory systems of a major provider."*

The pathology study commissioned by the Chief Medical Officer also points towards the need to concentrate services on fewer sites serving larger populations. The study notes that *"Services need to consider whether the physical and organisational arrangements of pathology services allow them to meet the challenges of the future and the increased emphasis on improving, and demonstrating improvement, in quality. Larger systems of pathology are needed to manage this agenda, and services providing for half to one million or more are being developed elsewhere."*

We believe that the pressures on the pathology service to deliver a high quality cost effective service will make it increasingly difficult to sustain the current configuration of laboratories.

There has been significant under-investment in all of the key services necessary to support the delivery of care.

11.27 We believe that the pressures on the pathology service to deliver a high quality cost-effective service will make it increasingly difficult to sustain the current configuration of laboratories. It would seem sensible to us to organise pathology services around the core configuration of nine sites providing emergency care and inpatient maternity services set out in Chapter 7. This is not to say that all of these sites must have the full range of laboratory services, as it should be possible to develop effective on-line access to services, along the lines of the existing arrangements between Lagan Valley and Downe hospitals and the Belfast laboratories.

11.28 The precise configuration of laboratory services will be for our proposed Health and Social Care Systems to decide, in the context of a regional plan agreed with the Strategic Authority. Within each system we envisage a Clinical Director of Pathology who will be responsible for the development of an integrated network of services which will meet the demands from hospital clinicians, general practitioners and other service users throughout the system.

11.29 The capital investment required by the service will, to some extent, depend on the precise configuration adopted within each Health and Social Care System. But there is a clear need now for investment in new accommodation and equipment for the Belfast City Hospital laboratories. More generally, we recommend the establishment of a rolling programme for the replacement of pathology equipment.

Summary

11.30 It is clear that there has been significant under-investment in all of the key services necessary to support the delivery of care. While we have only looked in detail at two capital-intensive clinical services, we have little doubt that similar problems of under-investment exist in others. This cannot be allowed to continue and it is clear that a substantial increase in capital investment is required. There is a need to look closely at the present balance between capital and revenue funding. Access to capital will be important as a means of effecting change, but the rate of investment will determine to a large extent the rate of change. It will be easier to secure the public's support for change if they can see that something is actually being done - they are unlikely to be convinced of the merits of change that will take 20 years to realise. We believe, therefore, that change must be effected quickly and this will require a significant capital investment early in the change process. We consider the implications of this requirement, in the context of the overall funding needs of the service, in Chapter 13.

Chapter 12 – Cross-Border Co-operation in Hospital Services

Introduction

12.1 The Terms of Reference for the review included a requirement to consider opportunities for co-operation with hospital services in other parts of the island. In this, as in other parts of our review, our key concern has been the welfare and convenience of patients. We believe that this is the only basis on which development should be planned.

12.2 We decided to approach the issue of cross-border co-operation on two levels. First there is the local context in which as far as possible the border should not represent an impermeable clinical boundary. Patients should be helped to access treatment at the most convenient locations, irrespective of their having to cross a border to do so. At this level too, there is the possibility of securing local economies of scale and a critical mass. It may be possible through cross border co-operation between hospitals or hospital systems to secure sustainable rota arrangements, and to justify the use of equipment. It should also be possible to arrange for the location and disposition of ambulances so as to secure the maximum degree of emergency cover and to cut down on travelling. In a situation too where parts of Northern Ireland and the Republic are peripheral to systems centred in Belfast and Dublin respectively, it should be possible to use the resources of both countries to reduce the sense of isolation felt by rural communities.

“Patients should be helped to access treatment at the most convenient locations, irrespective of their having to cross a border to do so.”

12.3 At a broader, and potentially more exciting level, there is the possibility of securing the provision of services on the island which neither system on its own has a sufficiently large population base to sustain.

12.4 In this chapter we provide examples of current co-operation, we describe some of the obstacles to co-operation that have been identified and how these might be overcome, and we outline the potential for future co-operation at both a local level and a macro or all-Ireland level. We draw on material in two recently completed reports: one on an evaluation of the CAWT[1] organisation and the other on cross-border co-operation in health services generally.

“there is the possibility of securing the provision of services on the island which neither system on its own has a sufficiently large population base to sustain.”

Examples of Current Co-operation

12.5 Current North-South co-operation in acute hospital services takes a number of forms:

- Training/professional development.
- Purchasing or commissioning services from the other jurisdiction.
- Joint service development.
- Research and policy work.

[1] Co-operation and Working Together for Health Gain and Well-being in Border Areas.

Training/Professional Development

12.6 Professional co-operation has the longest pedigree, with the main bodies concerned with post graduate medical training - the Royal College of Physicians of Ireland and the Royal College of Surgeons in Ireland - operating on an all-Ireland basis. Although in the past the two Irish Royal Colleges have organised training only in the Republic, recently the Royal College of Surgeons in Ireland has co-ordinated basic surgical training in Northern Ireland in association with the UK Colleges. Joint training programmes for specialties where it is difficult to maintain a training programme in one jurisdiction, such as paediatric surgery and neurosurgery, have recently been put in place. Both Colleges conduct their examinations in Belfast, as well as centres in RoI.

12.7 Initiatives in the nursing field have included:

- Nurses from the Republic taking up distance learning opportunities at the University of Ulster.
- Joint conferences and research fellowships.
- The UK Central Council and the National Board for Northern Ireland have co-operated with An Bord Altranais on exchanges and educational standards.

Purchasing/commissioning Services

12.8 Cross-border co-operation in hospital services over the years has included a number of initiatives where Health Boards in the South and Health and Social Services Boards in the North have contracted with hospitals or boards in the other jurisdiction to provide elective treatments or diagnostic procedures. One early example of this was the arrangement the Royal Group of Hospitals in Belfast entered into in the mid-1990s with the Southern Health Board in the Republic to provide hip replacements in order to reduce the numbers waiting for surgery. A more recent example involves patients from the Southern Board in the North travelling to the Blackrock Clinic in Dublin (a private hospital) for diagnostic scans.

"There has been a number of co-operative service development initiatives, mostly under the *aegis* of CAWT."

Joint Service Development

12.9 There has been a number of co-operative service development initiatives, most under the *aegis* of CAWT. Recent examples include the joint appointment of a dermatology specialist by the North-Eastern Health Board and Craigavon Area Hospital which succeeded in reducing outpatient waiting lists in that specialty, and the provision by Daisy Hill Hospital of haemodialysis to renal patients in North Louth. Ear, nose and throat services for Donegal, Cavan and Monaghan are provided from Omagh, and the Mater Hospital in Belfast has provided ophthalmic services for some patients on waiting lists in the North Eastern Board area. We

were also told of the joint appointment of a Consultant Oncologist between Letterkenny Hospital and Belfast City Hospital, and of an interesting proposal by orthopaedic surgeons in Northern Ireland to secure orthopaedic services in North West Ulster by linking Letterkenny with Altnagelvin and Enniskillen with Sligo. The overall level of cross-border 'traffic' in hospital services remains quite low, however, and there is clearly scope for development.

Research and Policy Work

12.10 The Health Research Board in the South and the HPSS Research and Development Office in the North have introduced a grant funding scheme for cross-border research. Awards may be used for research scholars, small items of equipment, consumables and travel. Applications are assessed both on the quality of the research proposed and the quality of the cross-border collaboration. Although all areas of health and biomedical research are eligible, almost all the awards made to date have been in biomedical research.

12.11 A specific initiative in respect of cancer research has involved a memorandum of understanding between the Republic, Northern Ireland and the National Institutes of Health (on behalf of the US National Cancer Institute) in the USA. There are three elements to this:

- The underpinning and co-ordination of the two existing cancer registries.
- Scholar exchange where people from a range of professional and scientific backgrounds spend a short period of time at the National Cancer Institute to learn about scientific methods including how to organise cancer trials.
- The establishment of three-year cancer epidemiology fellowships for scientists from North and South, one year of which will be spent in the USA, one year in the Republic and one year in Belfast.

12.12 Cross-border co-operation in respect of policy development has been slower to develop, although there have been some notable recent advances in the areas identified in the Good Friday Agreement.

Obstacles to Co-operation

12.13 Attitudes to health care co-operation on both sides of the border are generally very positive. There are however recognised to be a number of obstacles to cross-border co-operation. The obstacles identified by the authors of the Altnagelvin/Letterkenny report include: policy differences, funding issues (including transaction costs), different methods of remunerating doctors, reciprocation, public acceptance, professional accreditation and insurance. We agree with the authors of this report that although the constraints identified above

> **“Attitudes to health care co-operation on both sides of the border are generally very positive.”**

are quite significant, they should not be viewed as insurmountable barriers but as challenges and opportunities to overcome in the interests of the population served.

Opportunities for Co-operation in the Future

12.14 We outline below a range of opportunities for future cross-border co-operation at both a local level and an all-Ireland level.

Local Co-operation

"...there is scope to enhance the existing level of co-operation in the vicinity of the border."

12.15 Notwithstanding the obstacles identified above, there is almost certainly scope to enhance the existing level of co-operation in the vicinity of the border. We recommend that encouragement and assistance should be given to the three CAWT projects exploring this (Altnagelvin/Letterkenny, Sligo/Monaghan/ Enniskillen and Craigavon/Newry/Dundalk).

12.16 There is scope for managed clinical networks to be established that would transcend the border. We anticipate that those networks we suggested in Chapter 8 will come into being when it makes good sense clinically, managerially, and economically.

12.17 Consideration should be given to including a cross-border element in all service reviews in either jurisdiction and health authorities or systems along the border should take account of what is being provided on the other side, and should develop joint planning procedures to enable them to do so. There should be an immediate assessment of how co-operation in emergency services close to the border might be enhanced, and how emergency and disaster planning in the two jurisdictions could be properly aligned.

12.18 The report on ambulance services in Northern Ireland concluded that an air ambulance or helicopter ambulance service was not justified. We do not, in general, disagree with this finding. However, in the light of our mandate to look at the potential for cross-border co-operation, we endorse the decision to revisit this issue within the framework for discussions on cross-border co-operation in health matters under the Good Friday Agreement. In particular, we believe there is a strong case for examining the feasibility of a joint 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.

All-Island Co-operation

12.19 This is, we believe, potentially the most exciting and beneficial area for co-operation. There are services which cannot be provided economically for a population of 1.7 million (the population of Northern Ireland). There are services, even, which cannot be sustained for a population of 3.5m (the population of the Republic). Some of these could be sustained at a tertiarv level for a combined population of 5 million (and it is interesting that in other parts of the UK health authorities are finding it increasingly difficult to provide some of the more sophisticated procedures below this threshold).

12.20 These procedures very often concern treatments for rare and complex conditions in children where the obligation to travel adds an additional burden and greatly disrupts family life. Children in both parts of Ireland have to travel out for these procedures and we would like to see some at least provided on the island. Similarly there are transplant operations for which patients have to travel, which could be performed more locally.

12.21 Of their nature, these procedures are unlikely in the short to medium term to be provided in more than a single centre on the island. There will be a need for balanced development to ensure that such supra-regional specialisms are not all concentrated in a single centre, and are evenly divided between Northern Ireland and the Republic.

12.22 We see merit too in joint planning which will ensure the complementarity of provision North and South. In particular this would provide a fail-safe mechanism whereby hospital systems providing regional services north and south could back each other up. This would particularly apply when a service had to be temporarily withdrawn for some reason (such as infection, fire etc) in one area and would obviate the need for total withdrawal of the service or for patients to travel abroad for treatment.

12.23 There are a small number of specialties where combining the 'critical mass' North and South might serve to justify the provision of supra-regional specialties on the island. These include:

- Transplantation services.
- Paediatric cardiac surgery.
- Treatment of rare cancers.

12.24 We recommend a thorough assessment of the potential for co-operation in relation to these and other potential supra-regional specialities.

12.25 In relation to the five areas for co-operation in health identified in the Belfast Agreement (A&E services, planning for major emergencies, co-operation on high

"There are services which cannot be provided economically for a population of 1.7 million. There are services, even, which cannot be sustained for a population of 3.5 million. Some of these could be sustained at a tertiary level for a combined population of 5 million"

technology equipment, cancer research and health promotion) we note that a number of working groups involving officials from both Departments have been set up to identify and take forward specific initiatives. We welcome this and would encourage those involved to build on their progress to date.

12.26 We believe there is the potential for much greater collaboration on the island in relation to evaluation and research to build the evidence base for health care decisions.

12.27 Consideration should be given to developing formal and reciprocal arrangements for peer review and audit. There is also scope to expand activities such as staff secondments, exchanges and development, and joint training programmes.

12.28 Efforts should be made to examine and seek to resolve 'barrier' issues such as structures/accountability, professional accreditation and medical insurance. Finally, economic research should be commissioned on, for example, the potential for economies of scale both locally and on an all-Ireland basis.

12.29 In all these cases progress is more likely to be made where a clear benefit to patients is identified, where there is a balanced provision and two way traffic. As in the past, these joint efforts where clinicians have taken a lead through their own professional networks are the more likely to succeed. Increasingly too these networks will include connections to those in the broader NHS and in other parts of Europe and the spread of change may well be dictated by changes and convergences within the framework of the European institutions and the North/South bodies.

12.30 Successful co-operation will also depend crucially on the development of ICT systems in Northern Ireland and the Republic that are compatible with each other and the ability to transfer information about patients swiftly and securely.

Summary

12.31 There is already a large amount of cross-border interchange, in most cases based on the common interests of professionals in the same field, by clinical need and by sound common sense. There is, we believe, considerable potential for the development of these initiatives to the benefit of patients and whole communities, but only on a basis of mutual respect and co-operation between individual clinicians and health care systems.

Chapter 13 - Affordability

Introduction

13.1 In the preceding chapters we have set out our proposals for the future provision of high quality, accessible health care services to all the population of Northern Ireland. It is clear that a number of these proposals will have significant cost implications for the HPSS. As noted in Chapter 3, Trusts are struggling to maintain even the existing level of service within available resources. It is vital, therefore, that our proposals to develop the service can be shown to be deliverable within the resources likely to be available over the next 10 years.

> **"It is vital that our proposals to develop the service can be shown to be deliverable within the resources likely to be available over the next 10 years"**

13.2 We consider the issue of affordability under the following headings:

- The current financial position.
- Future capital funding requirements.
- Future revenue funding requirements.
- Affordability of our proposals.

The Current Financial Position

13.3 The weak financial position of a number of Trusts and the significant under-investment in facilities and equipment indicate that we are struggling to afford even the current level of service provision. Although the funding of hospital and community health services (HCHS) in Northern Ireland is expected to increase by some £225m (20%) in cash terms during the next three years, it is unlikely that this increase will result in any significant improvement to services or facilities. Table 13.1 below shows the DHSSPS funding forecasts for HCHS to 2003/04.

Table 13.1: Forecast Funding of HCHS 2000/01 to 2003/04

Expenditure	2000/01 £m	2001/02 £m	2002/03 £m	2003/04 £m
Revenue expenditure	1,045	1,114	1,180	1,270
Capital Expenditure	52	54	40	50
Total Expenditure	1,097	1,168	1,220	1,320

Source: DHSSPS

13.4 All of the forecast increase in HCHS funding of some £225 million relates to revenue expenditure. We were told by the DHSSPS that this increase will not be enough to keep pace with the higher demands for services from an increasingly elderly population, and increases in costs in areas such as staff salaries, drugs, goods and services, let alone allow any improvement to service provision. The higher costs associated with running modern hospital facilities will also add to the

pressure on the revenue budget. Modern facilities tend to have a higher proportion of single bedded rooms which makes them significantly more expensive to operate than more traditional facilities because of the need nurses, higher cleaning costs, etc.

> **"the higher running costs associated with running modern hospital facilities will also add to pressure on the revenue budget.**

13.5 The DHSSPS budget for HCHS funding does not forecast any increase funding above its current level of £50 million to £55 million per annum roughly 50:50 between major works and minor works, including maint equipment and ICT).

13.6 As noted in Chapter 11, new major capital developments of some £600 have been identified and are at various stages in the planning and const cycle. It is clear, therefore, that annual funding of £25 million to £30 mill million to £300 million over 10 years) for major capital developments is significantly below what will be required during the next 10 years.

13.7 Similarly, the funding forecast of £25 million per annum for minor works equipment and ICT is clearly significantly below that which is required to health estate up to an acceptable standard and to replace existing, out of equipment. As noted in Chapter 11, some £200 million to £250 million is simply to address the backlog in essential maintenance expenditure requi the estate. This investment on its own would use up all of the current fund available for minor works, equipment and ICT.

13.8 On the basis of our analysis of existing HCHS funding we conclude that:

- The £225 million increase in HCHS revenue funding to £1,270 million 2003/04 is unlikely to result in any significant improvement to the cur level of service provision.
- HCHS capital funding of £50 million to £55 million per annum is signi below what is required for investment in new facilities, equipment and and to address the backlog of maintenance.

13.9 Against this background, we consider in the remainder of this chapter the ca and revenue implications of our proposals for investment in new facilities, equipment and ICT.

Future Capital Requirements

13.10 The major requirements for capital investment in facilities, equipment and ICT during the next 10 years are likely to be as follows:

- Existing proposals for major capital developments (£600 million).

- Other major capital developments - a new hospital in Enniskillen (£75 million), local hospitals for Omagh, Magherafelt, Whiteabbey and Dungannon (£20 million each).
- Investment in the existing estate to clear the backlog of maintenance. This will require additional capital investment of some £200 million to £250 million.
- Radiology services - all equipment more than 10 years old should be replaced as soon as possible, (£31 million), and MRI units installed at Altnagelvin, Antrim, BCH, Craigavon and Ulster (£1m each).
- Pathology services - all equipment more than 10 years old should be replaced as soon as possible (£4 million), and investment made in new facilities and equipment for Belfast Link Labs, over and above the £5 million requirement already identified (£10m).
- Information and Communications Technology - investment to replace existing outdated computer systems and other infrastructure components, and to buy in the expertise to secure early completion of the development work and implementation of the new strategy. This will require additional capital investment of some £10 million per annum.
- NIAS - investment to ensure the timely implementation of the recommendations contained in the Strategic Review. This will require additional capital investment of some £2.5 million per annum plus a one-off capital injection of some £11 million.

13.11 The total of the above requirements for capital investment in facilities, equipment and ICT during the next 10 years is some £1.1 billion at today's prices.

Future Revenue Requirements

13.12 The major requirement for revenue funding over the next 10 years will arise from the cost of increasing the number of health care professionals. In addition, some of our capital investment proposals will have revenue implications: each of the five MRI units will cost some £0.5 million per annum to operate and the NIAS requires additional revenue funding of some £11.5 million per annum.

13.13 In Chapter 10 we recommended that workforce planning exercises should be undertaken for each of the main health care professions to establish the investment in additional staff numbers required to deliver our vision. We do not wish to pre-judge the outcome of these exercises, but for the purpose of our consideration of affordability we have assumed that increases in health care staff numbers in Northern Ireland will generally follow the 2000 to 2004 trends announced for the NHS in England, extrapolated to 2010. On this basis we envisage in Northern Ireland that between now and 2010 there will be:

- 400 more consultants, an increase of 50% (the NHS Plan proposes an increase of 30% by 2004). This will require an increase in recurrent funding of some £40 million per annum (at today's prices) by 2010.
- 250 more general practitioners, an increase of 25% (the NHS Plan proposes an increase of 7% by 2004, but the Government has stated that this is only the start). This will require an increase in funding of some £25 million per annum by 2010.
- 2,300 additional nurses, an increase of 20% (the NHS Plan proposes an increase of 7% by 2004). This will require an increase in funding of some £60 million per annum by 2010.
- 1,000 additional therapists and other health professionals (the NHS Plan proposes an increase of 6% by 2004). This will require an increase in funding of some £25 million per annum by 2010.

13.14 In addition to the above direct staff costs, there will also be a need for funding to meet the cost of additional training places for each professional group.

13.15 The total of the above revenue requirements for investment in additional staff, the NIAS and new MRI units is some £160 million to £165 million per annum at today's prices.

Affordability of our Proposals

"Funding of hospital and community health services in Northern Ireland should be kept on a par with comparable regions in Britain, and over time brought into line with the EU average."

13.16 We have estimated above that the total capital funding requirement for the next 10 years is some £1.1billion at today's prices. This suggests a doubling of the existing level of capital funding for HCHS from £50-£55 million to £100-£110 million per annum. We believe there is some potential to offset this increase by a thorough review of the health estate to identify surplus land and buildings for resale and development, particularly in the Belfast area.

13.17 We have estimated that the total additional revenue requirement (i.e. over and above current revenue plans) is some £160 million to £165 million per annum (at today's prices) by 2010. To offset this increase, we envisage that significant revenue savings should be possible as a result of our recommended changes to organisation structures. We would expect savings in the order of £10 million to £15 million per annum to be available for re-investment, offset in the initial years by severance costs. We would also expect savings to be available from our recommended reduction of 500 acute beds by 2010.

13.18 We believe that step-change increases in capital and revenue funding of the order set out above are achievable if, as we recommend, the funding of hospital and community health services in Northern Ireland is kept on a par with comparable regions in Britain, and over time is brought into line with the EU average.

13.19 It will be important that, as far as possible, a significant increase in capital funding is secured early in the implementation process to allow change to happen and to be seen by the public to be happening. The pace of implementation of many of our recommendations will be determined, to a large extent, by the availability of capital.

13.20 Consideration should also be given to the scope for greater use of private finance, although recognising of course that this will have implications for the revenue budget. The Review of Acute Health Services in Wales suggested that individual 'health economies' (the equivalent of our Health and Social Care Systems) *"should produce an integrated business case for the complete redevelopment of the acute services network in its area. This should then form the basis of a PFI scheme within that health economy."*

13.21 The Welsh Review identifies a number of benefits from approaching PFI in this way:

- *It creates PFI schemes of a size and nature more likely to be attractive to the private sector.*
- *It provides capital funding at the front end [of the planning period], enabling the modernisation agenda to be taken forward quickly and providing the stimulus for changes in clinical practice.*
- *It focuses the PFI process into a more concentrated period of time, enabling management to develop and maintain the skills needed to work successfully in the PFI environment.*

13.22 The Welsh Review also noted that although 'health economy' wide PFI schemes would be larger than those previously undertaken in Wales, they would not be significantly different from those currently planned for the NHS in England.

13.23 It is clear that the proposed system-wide approach to accessing private finance in Wales could apply equally in Northern Ireland.

Summary

13.24 Our proposals for the future delivery of hospital services will clearly have significant revenue and capital implications. However, we believe they are affordable in the context of an increase in funding that will keep Northern Ireland on a par with comparable regions in Britain, along with off-setting savings from our recommended streamlining of organisation structures and rationalisation of the estate. We recommend that proper consideration be given to the potential to access private finance on the basis of system-wide schemes.

"Our proposals for the future delivery of hospital services will clearly have significant revenue and capital implications."

Chapter 14 – Making it Happen

Introduction

Many of those with whom we shared our emerging ideas expressed concerns about implementation. How could such a large and complex organisation safely undergo another bout of major change? We have given this matter some considerable thought because we did not want to make recommendations that might be fine in principle but unachievable in practice.

In our view the changes are manageable if handled with skill, care and urgency. We envisage four distinct phases.

Phase One (2001-2002)

This phase will give everybody (public, politicians, professionals, staff) the opportunity to digest and comment upon the ideas that lie behind the proposed changes and contribute to the thinking about implementation. In parallel with any public consultation, an opportunity should be created for the staff of the HPSS to play an active part in the process.

We held discussions during our work with many of the leading professionals and organisations that represented staff. On the basis of that experience we are confident they will respond constructively. A priority will be for the DHSSPS to establish a properly resourced implementation team, led by Department staff but also including leading health and social services professionals and managers, and people with experience in managing change in large and complex organisations. Their expert opinion might be reassuring to those who have doubts. The Northern Ireland Assembly will of course be extremely influential in these discussions and will have a key role to play in effecting any changes that have to be made to primary legislation as a result of our recommendations.

Phase Two (2002-2003)

This is the intermediate phase when existing organisations will begin to work and plan together in the new configuration. The proposed Strategic Authority will be working in shadow form and in each of the proposed systems a consortium of existing organisations will come together. Clear interim leadership will be very important. During this stage the crucial longer term Chair and senior officer appointments will be made both for the Strategic Authority and the three Health Care Systems. Discussions will be held with all interested parties about future management and professional structures. Senior staff in particular will need to be excited rather than threatened by the changes. The review of information systems will start, as will the preparation of detailed plans and business cases for those

“...nges are manageable if handled with skill, care and urg...”

“...staff need to be excited rather than threatened by the changes.”

capital investments targeted by the Minister for early priority. Partnership will be the watchword as will open communication processes. This phase might last for 12 months or so.

Phase Three (2003-2008)

14.6 During this phase the new structures will come into place and the swing from institutional to service management will begin to happen progressively over the months and years that follow. Clear lines of accountability will be essential at the commencement of this phase. Early on we would expect the new Strategic Authority to present to the Minister its medium and long term plans for reshaping services so that the public can see for themselves that the balance and sequencing of investment was as they would wish it. It is at this stage that the crucial service changes will begin to take place within the three provider systems.

Phase Four(2008 onwards)

14.7 This phase will be for consolidation and review of the new structures. In health and social services management, it is vital that organisations are ready to adapt and change in response to advances in medical and social sciences and the expectations of the public.

"the development of clinical networks should go ahead fairly quickly."

14.8 We believe these structural changes should be made carefully but quickly. Services to patients will have to be kept going during the changes and we would not want to see any unreasonable delay to development schemes that have already been agreed and which are consistent with our proposals (such as those for investment in ambulance services).

14.9 There are some changes, like the development of clinical networks, which should and could go ahead fairly quickly. It is more important to get clinical management right than to wait for the completion of administrative structures. The important thing is to reduce bureaucracy, to flatten structures, and to ensure that decisions are taken as near as possible to the patient and the professional.

"It is important that things are seen to happen."

14.10 It will be important, at this stage, that things are seen to happen and that the public, patients and staff are convinced that services can be improved and that action is being taken along the lines we suggest. Without that they will not sign up. There should be an early indication of investment in personnel, in ICT and in the ambulance service. It would help to build public confidence in the South West if the new hospital could be built in less than five years with services being provided from the new facility by 2006. Similarly the developments agreed for Downpatrick should be commenced as quickly as possible and steps taken to reduce pressure on Craigavon and the Ulster.

14.11 There will be a need for continuing research, and for a concurrent series of pilot projects relating, for example to:

- Developing linkages with primary care.
- The Northern Ireland variant of NHS Direct.
- The integration of primary and secondary care.
- The application of ICT and telemedicine to patient care.
- Managed clinical networks.
- The effective management of elective surgery.
- Waiting list reductions.
- The potential for utilising capacity in the private sector.
- Systems to ensure total quality control.
- Extended in-service training for all staff.

14.12 It will be important that the implementation team establishes effective arrangements to ensure that progress is taking place on all fronts concurrently, against an agreed timescale and set of objectives. Once a programme for change has been agreed, it should be published, and the team should be required to publicise progress reports at stated intervals.

14.13 The implementation of these recommendations will require a high level of leadership from the Minister down and can only be achieved by providing the necessary training and securing the commitment of staff at all levels.

14.14 We do not underestimate the challenges ahead. We have set out to provide not a detailed blueprint but a guide to the future. We have presented an achievable vision and expounded a set of guiding principles. It may be necessary to make change en route in response to developments in the economic or political environment, or other external events, but we hope that people will accept our vision, and hold fast to it. The detailed working out of the new arrangements should be in the hands of those responsible for the delivery of services. There is a need for decision making to be pushed as near to the clinicians and other care professionals as possible, and for them to take a lead in the development of services and the management of change. We hope that all of those who work in the health and social services will take ownership of our vision and work to implement it.

"The detailed working out of the new arrangements should be in the hands of those responsible for the delivery of services."

Appendix A: Membership of the Acute Hospitals Review Group

Dr Maurice Hayes
Chairman. He was formerly the Ombudsman and was Permanent Secretary of the Department of Health and Social Services from 1983 to 1987. Member of Seanad Éireann, Member Royal Irish Academy.

Dr Tom Black FRCGP
Is a practising GP in the Western Health and Social Services Board area. He is a fellow of the Royal College of General Practitioners and is currently Secretary of the Western Local Medical Committee.

Mrs Fionnuala Cook
Chairwoman of the Southern Health and Social Services Council.

Professor Brian Edwards
Professor of Health Care Development at the University of Sheffield.

Mrs Sue Hogg
Former Chair of the Western Education and Library Board and a former member and Vice-Chair of the Youth Council. She has had a long involvement with the Guide Association, and has been involved in work with community groups and people with special needs.

Ms Libby Keys
Chair of the Rural Community Network.

Prof Gary Love (deceased)
Retired consultant physician, responsible for maintaining academic standards within the Royal College of Physicians and was formerly Dean of the Faculty of Medicine at Queen's University Belfast. - (replaced by Dr Morrell Lyons January 2001)

Dr Morrell Lyons OBE, MD, FRCA (from January 2001)
Was a Senior Consultant in Anaesthetics at the RVH until his retirement in September 2000. He was President of the Association of Anaesthetists of GB and Ireland from 1994 to 1996 and was Chair of the Central Medical Advisory Committee of the Department of Health, Social Services and Public Safety from 1991 until his retirement.

Mr Donal O'Shea
Is Chief Executive of the Eastern Regional Health Authority in the Republic of Ireland.

Ms Rosemary Ryan
Is currently a Clinical Risk Manager and Nurse Consultant. She was formerly Director of Nursing at St James Hospital Dublin and at Altnagelvin Hospital.

Secretary
Mr Richard Buchanan

Research
Dr Jim Jamison
Mr Dean Sullivan, PA Consulting Group

Administration
Mrs Jane Armstrong
Mr Damien Kerr
Mr Brendan Seenan

Appendix B – Organisations and Individuals Consulted

A

Ad Hoc Hospital Group
Advisory Committee of the Therapeutic Professions Allied to Medicine
Altnagelvin Hospital HSS Trust
Ardglass Support Group
Area Medical Advisory Committee
Armagh District Council
Armagh & Dungannon HSS Trust

B

Ballymena Borough Council
Banbridge District Council, Health Care Sub-Committee
Banbridge Polyclinic
Belfast City Council
Belfast City Hospital HSS Trust
Belfast Link Laboratories
British Medical Association, Junior Doctors Committee, NI Consultants and Specialists Committee

C

Causeway HSS Trust
Cavan Hospital, RoI
Central Medical Advisory Committee
Central Nurses Advisory Committee
Chartered Institute of Physiotherapy
Chief Nurse Advisors from all Health and Social Services Boards in Northern Ireland
Chinese Welfare Association
Cookstown District Council
Craigavon Area Hospital Group HSS Trust
Craigavon Borough Council, Public Services Liaison
Craigavon & Banbridge Community HSS Trust
Crossmaglen Health Centre

D

Department of Health, London
Department of Health, Scotland
Department of Health, Social Services and Public Safety
Department of Health and Children, ROI
Department of Regional Development
Donard Commissioning Group
Down District Council
Down Lisburn HSS Trust
Downe Cardiac Support Group
Downe Community Health Committee

Downe Hospital Support Group
Downe Maternity Services Liaison Committee
Dublin Voluntary Hospitals
Dunadry Primary Care Group
Dungannon District Council
Dungannon District HSS Community Forum

E

Eastern Health & Social Services Board
Eastern Health & Social Services Council
Eastern Multifund
Eastern Regional Health Authority, ROI

F

Fermanagh Against Closure of the Erne
Fermanagh District Council
Fintona Concerned Residents Group
First Responders Scheme
Foyle HSS Trust
Friends of the Mid Ulster

G

Glens of Antrim Concerned Group
GP Commissioning Group
GPs consulted: Downpatrick; Dungannon; Enniskillen; Omagh; West Belfast; Whiteabbey
Green Park Healthcare Trust

H

Health Estates Agency
Homefirst Community HSS Trust
Honiton & Axminster Hospitals

I

Institute of Biomedical Science

J

Jones & Cassidy Solicitors

L

Larne Borough Council
Letterkenny Hospital, RoI
Lisburn Primary Care Commissioning Pilot

M

Magherafelt District Council
Mater Infirmorum HSS Trust
Monaghan Hospital, ROI
Moyle District Council

N

Newry & Mourne HSS Trust
NHS Confederation
NHS Direct
North & West Belfast HSS Trust
North Eastern Health Board, ROI
Northern Health & Social Services Board
Northern Health & Social Services Council
Northern Ireland Ambulance Service
Northern Ireland Council for Postgraduate Medical and Dental Education
Northern Ireland Nurses Association
Northern Ireland Public Sector Alliance
Northern Ireland Regional Medical Physics Agency
Northern Ireland Society of Anaesthetists

O

Oaklin Group
Office for Public Management
Omagh Chamber of Commerce & Industry
Omagh District Council

P

Peter Quinn Group
Public Meetings: Downpatrick; Dungannon; Enniskillen; Magherafelt; Omagh; Whiteabbey

Q

Queen's University Belfast

R

Royal College of GPs
Royal College of Midwives
Royal College of Nursing
Royal College of Physicians
Royal College of Psychiatrists (NI Section)
Royal College of Surgeons in Ireland
Royal Group of Hospitals and Dental Hospitals HSS Trust
Regional Medical Services Consortium

Rural Community Network
Rushe, Taylor & Simpson

S

Saintfield Health Centre
Save the Mid [Ulster Hospital] Group
School for Health and Related Research
SDLP, Health Committee
Sinn Féin
Sligo Hospital RoI
South & East Belfast HSS Trust
Southern Health & Social Services Board
Southern Health & Social Services Council
Sperrin Lakeland HSS Trust
Surgical Training Committee for Northern Ireland

U

Ulster Community and Hospitals HSS Trust
Ulster Unionist Party, Larne Health Committee, Health Review Group
UNISON
United Hospitals HSS Trust
University of Ulster

W

Western Health & Social Services Board
Western Health & Social Services Council
Whiteabbey Hospital Action Committee
Whiteabbey Hospital League of Friends
Whiteabbey Hospital Total Purchasing Pilot
Workers Party

Appendix C – Submissions Received during course of Review

AHRG Reference	Organisation / Individual
26	Colm Kelly, Downpatrick, Co. Down
27	St. Joseph's Convent Grammar School, Donaghmore, Co. Tyrone
29	Crossroads, Caring for Carers, Northern Ireland Ltd.
30	Mick Murphy, MLA, South Down
33	Dr. A. M. Jones, MB, FRCP
34	The Nuffield Department of Child Health, the Queen's University of Belfast
35	Councillor David Barbour, Coleraine Borough Council
45	Business and Professional Women UK Limited, Newcastle Club
46	The Passionist Community of Tobar Mhuire, Crossgar
47	Newcastle Chamber of Commerce
48	Dunsford Arts and Crafts Group
49	Downpatrick Women's Institute
50	The Ulster Wildlife Trust
51	The Research and Development Office (of the Northern Ireland Health and Social Services Central Services Agency)
53	East Down Rural Community Network
54	Strangford & District Playgroup Association
55	Action Cancer
56	Ballymena Borough Council
57	The Down' Syndrome Association
58	D P Nicholls, Consultant Physician, the Royal Group of Hospitals
59, 485, 557	Dr C H G Gould, Family Doctor, Whiteabbey Health Centre
61	Mr. A. R. Wray, FRCS, (Ed) ORTH, Consultant Orthopaedic Surgeon, Altnagelvin Hospitals HSS Trust
65 & 416	The Royal Hospitals
68	Councillor Nigel Dodds, MP, MLA, North Belfast
69	Craigavon Borough Council
70	Armagh City and District Health and Social Services Community Forum
71	Faculty of Public Health Medicine of the Royal College of Physicians of the United Kingdom
72	Clinical Imaging Strategy Subgroup
73	UNISON Northern Ireland
74	Causeway GP Forum
75	Castlewellan Downe Hospital Support Group
76, 213	Joint Consultant Medical Staff from South Tyrone Hospital, Mid-Ulster Hospital, Sperrin Lakeland HSS Trust
77	Convent of Mercy, Downpatrick, Co. Down
89	Western Education & Library Board

90, 465, 555	Sir George E Clark Metabolic Unit (Regional Centre for Endocrinology and Diabetes) The Royal Hospitals
91	Banbridge District Council
110	Council of the Royal College of Paediatrics and Child Health
112	Roads Service
114	W. Johnston, Ardlougher, Irvinestown, Co. Fermanagh
115	Omagh business woman
116	The Society for Mucopolysaccharide Diseases
118	The Royal College of Pathologists
120	The National Board for Nursing, Midwifery and Health Visiting for Northern Ireland
121	Medical Staff Committee Downe Hospital
122	Department of Anaesthetics, Downe Hospital
123 & 167	SDLP, Newry Branch
124	Northern Ireland Medical Forum
125	The Northern Ireland Society of Anaesthetists
126, 490, 536	Southern Health and Social Services Board
143	The British Deaf Association, Northern Ireland
144	Directorate of Ophthalmology, the Royal Victoria Hospital
145	Eddie McGrady MP MLA (South Down)
146 & 179	Green Park Healthcare Trust
147	The Royal Colleges of Physicians of London, Edinburgh and Glasgow
148	The Chartered Society of Physiotherapy, Northern Ireland Board
151	Northland Early Years Centre, Dungannon
152	The Royal College of Surgeons in Ireland
153	HPSS Trust Medical Directors
154	Altnagelvin Hospitals Health and Social Services Trust
159	Sperrin Lakeland Health and Social Care Trust
160	Southern Health and Social Services Council
163	Age Concern Newcastle
164 & 451	United Hospitals Trust
165	Omagh District Council
166	Glens of Antrim Concerned Residents Group
168	Betty Nicholl OBE MD FRCPath
169	Belfast City Council
172, 576, 596	Mrs Margaret Hoben, Newry, Co. Down
173	Ophthalmology & Vision Science, the Queens' University of Belfast Eye and Ear Clinic
174	The Alliance Party of Northern Ireland
176	Northern Ireland Regional College Advisor, the Royal College of Obstetricians & Gynaecologists
177	British Epilepsy Association
178 & 423	Down Cardiac Support Group
183	Royal College of Nursing, Northern Ireland

184	Representatives of Trauma and Orthopaedic Surgeons in Northern Ireland
185 & 186	Representatives of Accident and Emergency Consultants in the Royal Hospitals
188	Causeway Health and Social Services Trust
189	Sinn Féin
190	Northern Health and Social Services Council
191	North Down Borough Council, Health Committee
192	British Association of Dermatologists, Northern Ireland and Eire representative
193	Craigavon and Banbridge Community HSS Trust, and Anaesthetics and A&E staff at Craigavon Area Hospital Group Trust
194	Northern Ireland Music Therapy Trust
195	Co-operation and Working Together
196	Homefirst Community Trust
197	Southern Local Medical Committee
198	Save the Hospitals Committee, Newcastle representative
199 & 359	Newry and Mourne HSS Trust
200	Faculty of Medicine and Health Sciences, the Queen's University Belfast
201	Dungannon and South Tyrone Borough Council
202	Northern Ireland Regional Medical Physics Agency
203	Ulster Community and Hospitals Trust
205 & 540	Down Community Health Committee
206	Backcare - the National Organisation for Healthy Backs
207	Eastern Health and Social Services Council
209	Hazel Dunn, Co. Fermanagh
210	John Robb, Ballymoney, Co. Antrim
211	The Headmaster, Omagh High School
212	Dr. Norbert Lynch MB BCh MRCGP, Lisnaskea Health Centre
214	Gortin and District Historical Society
215	Owenkillew Community Centre, Gortin
216	Down District Council
217	Down Lisburn Health and Social Services Trust
219	Praxis
220	Clinical Director of Pathology Services, Altnagelvin Hospitals HSS Trust
223	Eastern Multifund
224	The Northern Ireland Optometric Society
225	Lisburn Borough Council
226	The Royal College of Psychiatrists, Northern Ireland Section
227, 495, 496	Armagh and Dungannon HSS Trust
228	Joint submission by Causeway, Newry & Mourne and Sperrin Lakeland HSS Trusts

229	Mrs J E Graydon, Co. Fermanagh
234	Omagh Chamber of Commerce and Industry
235	Gerry O'Doherty, Omagh, Co. Tyrone
236	Fermanagh District Council
238	Dr Bready & Partners, Newcastle, Co. Down
239 & 333	Mrs Rose Ferguson, Co. Fermanagh
240	Southern Health and Social Services, Geriatric Division
241	Physiotherapy Department, Tyrone County Hospital
242	Dr JMF Maginness MB BCH FFARCSI EDA Consultant Anaesthetist, Tyrone County Hospital
243	Belfast City Hospital Trust
244	Mrs Elizabeth Reid, Downpatrick, Co. Down
245	Director of Acute Hospital Services, Tyrone County Hospital
245	Miss Emma Smyth, Downpatrick, Co. Down
246	Mrs Ailish Hanna, Downpatrick, Co. Down
247	Miss Veronica Laird, Killough, Co. Down
248	Mr Liam Conlon, Downpatrick, Co. Down
249	Mrs Annie Gelsten, Downpatrick, Co. Down
251	Mrs Linton, Newtownabbey, Co. Antrim
253	Marian Tierney, Tempo, Co. Fermanagh
255	Antrim Borough Council
259 & 533	Councillor W. Mathews, FRCS, Coleraine Borough Council
260	Fermanagh GP Association
263	Mrs A E Jennings, Newtownabbey, Co. Antrim
264	Mrs S E Henry, Mr T J Henry, Newtownabbey, Co. Antrim
265	Dympna Foy, Tempo, Co. Fermanagh
266	Eamonn O'Neill, MLA South Down
268	Western Health and Social Services Board
271	Royal College of Psychiatrists, Northern Ireland Section
272	Larne Borough Council
273 & 353	Women in Agriculture, Fermanagh District Partnership (various)
274	Kathleen Barrett, Dromore, Co. Tyrone
275	Department of Health, Social Services and Public Safety
276	Downpatrick Maternity Services Liaison Committee
286	Speech and Language Therapy Manager's Forum in Northern Ireland
287	Joint submission by Cookstown District Council and Magherafelt District Council
288	Northern Ireland Ambulance Service
292 & 390	Rural Community Network (NI)
295	DHSSPS Advisory Group on Junior Doctors' Hours
296	Consultant Obstetricians and Gynaecologists at Belfast City Hospital and the Royal Maternity Hospital
297	Acting Dental Manager, South & East Belfast Trust

303	Councillor Oliver McMullan, Moyle District Council
304	Hearts of Down Support Group
306	North West Independent Hospital
308	T J W Crawford, Omagh, Co. Tyrone
309 & 310	United Hospitals HSS Trust
311	Brian P Ingram FIBMS M.Imgt, Dungannon, Co. Tyrone
312	Miss J Mossman, Dungannon, Co. Tyrone
314	Asadoc Ltd., GP Out-of-Hours Co-operative
315	Royal College of General Practitioners Northern Ireland Faculty
316	Pat McNamee, MLA for Newry / Armagh
317	Northern Ireland Council for Postgraduate Medical and Dental Education
318	David McClarty, MLA for East Londonderry
319	Paul McCormick, Downpatrick, Co. Down
320	The Committee of Downpatrick Presbyterian Church
321	Hillview Community Association
322	Dr John Porteous GP Lisnaskea, Co. Fermanagh
323	Ardglass and District Health Support Group
324	Dr MEH Cathcart, General Medical Practitioner, Enniskillen, Co. Fermanagh
325	Mater Hospital Trust
327	Brantry Women's Group
329	Caoimhghin O'Caolain, TD
332	John A Harkin, Co. Fermanagh
334, 335, 336,	Rushe Taylor and Simpson Health Campaigners Group, Omagh and Gortin
337	Mrs Dundee, Newtownabbey, Co. Antrim
340	Newry & Mourne District Council Health Services Working Group
343 & 405	Peter McGovern, Enniskillen, Co. Fermanagh
344	Newtownabbey Borough Council
345	Belfast City Council
346	ENT representative on the Hospital Service Sub-Committee of the Central Medical Advisory Committee, United Hospitals HSS Trust
347 & 558	Northern Ireland Chest Heart and Stroke Association
348, 349, 378	Ulster Farmers' Union, South East, South West & North Fermanagh Groups
350	NHS Retirement Fellowship, Northern Ireland Regional Committee
351	Clinical Director, Royal-Jubilee Maternity Service, the Royal Hospitals
353a	Mary Martin, Irvinestown, Co. Fermanagh
353a	Diana Carson, Enniskillen, Co. Fermanagh
353a	Mrs Eleanor Kerr, Lisnaskea, Co. Fermanagh
353a	Teresa McNulty, Irvinestown, Co. Fermanagh
353a	Sylvia Elliott, Irvinestown, Co. Fermanagh
353a	Alison Monaghan, Irvinestown, Co. Fermanagh

353a	Sandra Beatty, Irvinestown, Co. Fermanagh
353a	Hazel Manley, Florencecourt, Co. Fermanagh
353a	Deborah Coffey, Enniskillen, Co. Fermanagh
353a	Mrs Violet Breen, Fivemiletown, Co. Tyrone
353a	B P McElroy, Tempo, Co. Fermanagh
353a	Mrs Sheila Dunn, Brookeborough, Co. Fermanagh
353a	Carol Guy, Irvinestown, Co. Fermanagh
353a	Olive Bruce, Enniskillen, Co. Fermanagh
353a	Elizabeth Johnston, Newtownbutler, Co. Fermanagh
353a	Mary King, Trillick , Co. Tyrone
353a	Jayne Paget, Enniskillen, Co. Fermanagh
353a	Emily Hall, Enniskillen, Co. Fermanagh
353a	Mrs Anna M Kearns, Enniskillen, Co. Fermanagh
353a	Frances Rasdale, Enniskillen, Co. Fermanagh
353a	Mrs I E Wilson, Derrylin, Co. Fermanagh
356	North Western Health Board (ROI)
358	Senator Ann Leonard, MCC
361	Mary Curran, Omagh, Co. Tyrone
362	Trustees of the Mater Hospital
363	Dr. Eoin Bergin, Consultant Physician, Tyrone County Hospital
364	Councillor Edwin Poots, MLA Lagan Valley
365 & 366	Eastern Health and Social Services Board
369	Joint submission by a number of GPs from Newcastle, Killyleagh and Downpatrick, Co. Down
372	Dr J G McElroy, Hon Secretary British Geriatric Society NI
373	North and West Belfast HSS Trust
374	Advisory Committee of the Theraputic Professions Allied to Medicine
375 & 447	Donard Commissioning Group
381	Lisburn Primary Care Commissioning Pilot
384	Dorothy Fleming, Magherafelt
389	Mid-Ulster Primary Care Commissioning Pilot
394	Down Cardiac Support Group
396	Extra Care
401	Consultant ENT Surgeons, Sperrin Lakeland HSS Trust
403	Northern Ireland Public Service Alliance
406	South and East Belfast Primary Care Group
407	DA Adams FRCS, Clinical Director ENT, the Royal Victoria Hospital
409	Coleraine Borough Council
411	The Northern Ireland Confederation for Health and Social Services
414	Community Organisations of South Tyrone & Areas
417	Tyrone, Antrim, Down & Armagh Rural Network
424	Medical Committee of the Area Medical Advisory Committee of the Eastern Health and Social Services Board

429	Owenkillew Community Development Association
430	Consultant Dermatologists at the Royal Hospitals Trust
432	Western Health and Social Services Board
433	Consultant Gynaecologists, Belfast City Hospital Trust
452	Northern Health and Social Services Board
454	Connor Mulholland BSc FRCP FESC, Consultant Paediatric Cardiologist, the Royal Hospitals
459 & 517	Consultant Dermatologists, the Royal Hospitals and Belfast City Hospital Trust
461	Paediatric Directorate, the Royal Hospitals
472	Area Divisional Committee for Obstetrics and Gynaecology, Northern Health and Social Services Board Area
476	The Queen's University of Belfast
477	The Presbytery of Tyrone
478	The Northern Ireland Consultants and Specialists Committee
484	D Stafford, Omagh, Co. Tyrone
488	Regional Nutrition and Dietetic Managers Group
489	J Elliott, M Elliott, D Acheson, Aughnacloy, Co. Tyrone
500	Sam Foster, MLA Fermanagh and South Tyrone
501	A G Leonard FRCS, Lead Clinician in Plastic Surgery, Ulster Community and Hospitals Trust
503, 554, 579	The Ad-Hoc Group
515, 577	Trauma and Orthopaedic Surgeons in Northern Ireland
537	South & East Belfast HSS Trust
539	Hugh B Maxwell, Downpatrick, Co. Down
545	Chairman, Division of Paediatrics Northern Board
547	Dr T Johnston, Locum Consultant Psychiatrist, Down Lisburn Trust
553	Belfast Link Laboratories
569	The Planning Service
572	Strabane District Council
585	Officer for the Professions Allied to Medicine, Department of Health, Social Services and Public Safety
588	Mrs Joan Carson, MLA Fermanagh and South Tyrone
594	County Fermanagh Grand Orange Lodge
595	Ballinamallard District L.O.L.

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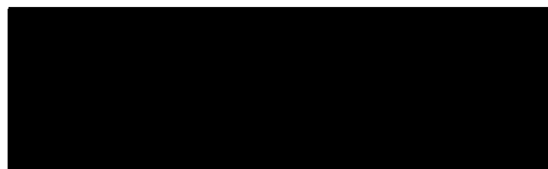

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Executive Summary

Introduction

1. The ability of acute hospitals here to deliver safe, effective and timely acute services has come under increasing strain. Pressures for change are coming from many and varied directions - new patterns of illness and disease, new medicines and treatments, new technologies, new skills and changes in how doctors, nurses and other health professionals train and work. These changes, combined with years of under-investment, are placing sustained pressures on hospitals and their staff.

Why Change is Needed

2. Our pattern of hospitals is based on an outmoded approach to acute care. As medical practice has developed, the trend has been for health professionals to specialise and become expert in particular aspects of treatment and care. This has resulted in great advances in treatments and improved outcomes for patients.

3. There is also a great deal of evidence to suggest that outcomes are better where treatments and care are delivered by specialist, multi-disciplinary, teams. But such teams must be large enough to work effectively. The teams need to care for sufficient numbers of patients to make best use of their skills, and to maintain those skills throughout a lifetime of practice. This is particularly important, as all health care practitioners will, in the future, be required to demonstrate their continued professional competence on a regular basis.

4. Smaller hospitals are now finding it increasingly difficult to deliver services to modern standards. They are beginning to lose recognition as training hospitals, as they do not provide sufficient opportunity for health professionals to develop the skills and experience necessary, and some are now finding it difficult to attract and retain staff.

What Kind of Change

5. If our hospitals are to provide patients with the full benefits of modern medicine, they must change to make best use of new technologies and to support new working practices. The further concentration of acute services for patients with more complex conditions will greatly improve the quality of care and the outcomes of treatment.

6. However, concentration must be balanced against the accessibility of services for patients and their families. Developments in medicine and medical technology are also opening up the way for smaller hospitals to provide high quality diagnostic

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services and a wider range of operations and medical procedures, often on an outpatient or day-case basis.

7. The effective delivery of services through managed clinical networks will, by supporting services across a number of sites, underpin a more convenient and accessible service for patients, without compromising standards of care or treatment.

Model for Future Hospital Services

8. Under the new model, none of the current hospitals delivering acute services will close - rather they will be adapted to support the new pattern of provision. The vast majority of people will be within 45 minutes, and everyone will normally be within one hour of emergency care and consultant-led maternity services. In the future, acute services will be more strongly patient-focused and organised around population groupings rather than facilities.

9. A number of new Local Hospitals will be established to deliver a wide range of services on a local basis. They will network with acute hospitals and local primary and community care to provide services that do not need to be delivered in a large acute hospital. The Local Hospitals will be the Mid-Ulster, South Tyrone, Whiteabbey, Downe, Lagan Valley, Mater and Tyrone County hospitals.

10. In view of the long journey times for some people, the Downe Hospital will be an Enhanced Local Hospital[1], and the provision of Enhanced Local Hospital services at Tyrone County Hospital is also proposed. As well as acting as a Local Hospital, Lagan Valley Hospital will become a specialist centre for planned (elective) surgery. Work will be undertaken to develop a second, protected elective centre in a Local Hospital west of the Bann.

11. There will be 9 acute hospitals at the Royal Group, Altnagelvin, Antrim, Belfast City, Causeway, Craigavon , Daisy Hill, the Ulster, and a new hospital in or to the north of Enniskillen. All of the 9 acute hospitals will support a broad range of acute services, each having their own characteristics and individual service profiles.

12. Consultant maternity in-patient services will be provided on 9 sites[2]. The development of midwife-led maternity units will be encouraged alongside consultant-led units, and 2 stand-alone midwife led units will also be piloted.

1 See paragraph 4.22
2 See paragraph 4.63

13. Opportunities for co-operation between the North and South on a range of healthcare issues will be developed to their full potential.

Changes in Administrative Structures

14. It is essential that the organisational structures support a partnership approach between all parts of the Health and Personal Social Services (HPSS) and reinforce the effective and efficient delivery of services. A number of options for reforming the HPSS structures have been identified. These include:

- replacing the 4 HSS Boards;
- creating a single Regional Authority with responsibility for strategic planning, workforce planning and commissioning of regional services;
- bringing together Local Health and Social Care Groups as commissioning bodies for local health and social services;
- combining HSS Trusts or replacing them altogether; and
- replacing the 4 HSS Councils with a single, statutory health and social care consumer body.

15. Following consideration of responses to the proposals for structural change set out in this paper, further consultation will take place before decisions are taken on final configurations.

Equality Implications

16. A preliminary assessment has been carried out as to whether the proposals would have an adverse or negative impact on people in the Section 75 equality groups. This involved examining travel times under the current pattern of 15[3] acute hospitals and comparing these to travel times under the proposed 9 site model for acute services. Overall, the 9 site model for acute services would not appear to have a significant differential impact on any of the equality groups.

Resources

17. Substantial investment is essential to implement the proposals. Around £1.2bn of capital at today's prices will be required over a 9-year development period. The capital funding gap between the capital expected to be available over the period and what is required is estimated as £842m at today's prices.

3 South Tyrone hospital has temporarily losts its acute services pending the outcome of the Acute Hospitals Review

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18. A significant increase in staffing will be needed to deliver these proposals: a 30% rise in the numbers of consultant medical staff; a 20% rise in qualified nurses; a 25% rise in other health professionals; and a 25% rise in doctors undergoing GP training. By 2010, the additional recurring funding required to support the increased workforce would be around £165m per annum at today's prices.

19. The new pattern of hospital services will lead to greatly improved performance, including reduced waiting times and the elimination of the problem of people waiting for admission and delayed discharges. While the Executive is committed to providing extra resources for hospital services, the extent and speed of that investment will be determined by the Executive, taking full account of available resources and relative priorities across all of its responsibilities.

Chapter 1: Introduction

1.1 The ability of acute hospitals here to deliver safe, effective and timely acute services has come under increasing strain in recent years. This reflects significant growth in the demands made on these services against a history of under-funding that has impeded service development over the past decade. At the same time, advances in medicine, medical technology, professional practice and standards of treatment have changed the nature of the services delivered by these hospitals.

1.2. It was against this background that the Minister for Health, Social Services and Public Safety commissioned an independent review of the current provision of acute hospital services.

1.3. The Acute Hospitals Review Group's (AHRG) report, published in June 2001, was subsequently issued for consultation. The report and the comments received covering its approach and conclusions have contributed to the proposals set out in this paper. The paper is structured as follows:

Chapter 2	Explains why change is needed.
Chapter 3	Explains what kind of change is required.
Chapter 4	Sets out a model for future hospital services.
Chapter 5	Sets out options for the changes in the administrative structures of the Health and Personal Social Services.
Chapter 6	Makes an initial assessment of the equality implications of the changes.
Chapter 7	Sets out the required resources and timing.

1.4. The proposals outlined in this paper have been discussed and agreed by the Executive for consultation. They will significantly affect the ways in which our hospital services are delivered, the ways in which staff do their work, the pattern of our hospitals, the range of services that they provide, and their accessibility.

Have your Say

1.5. The paper is being sent for comment to a wide range of organisations and individuals. It is also available direct to the public on request, and through libraries, health and social services premises and the Internet. The document is

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available in large type, braille, audio-cassette, Irish and Cantonese. Requests will be considered for translations into other minority languages.

1.6. If you want to express a view on the proposals set out in this paper, or on any of the issues it covers, you should write to, fax or e-mail the contact point below before 30 September 2002. In keeping with the Department's policy on openness, responses may be made available to the public. If you do not wish your response to be used in this way, or if you would prefer it to be used anonymously, please indicate this when responding.

1.7. Your views will help the Minister and Executive to reach final decisions on the future shape of hospital services and administrative structures. All the responses to the consultation along with any new information which might emerge out of, or during, the consultation, will be taken into consideration before final decisions are made on hospital services, around the end of November 2002, and before moving ahead with structural reform of the HPSS.

1.8. A telephone helpline for enquiries on how to obtain copies of the paper has been set up - the telephone number is (028) 9052 0210

1.9. Consultation meetings are being arranged at which people will have an opportunity to discuss the paper with representatives of the Department.

Contact Point

1.10. The central point of contact for all responses and copies of the paper is:
Department of Health, Social Services and Public Safety,
Modernisation Unit, Room C4.22, Castle Buildings,
Stormont, Belfast, BT4 3SG.
Tel: (028) 9052 2349
Fax: (028) 9052 0535
E-mail: modernisationunit@dhsspsni.gov.uk

Closing date for receiving comments

1.11. All comments should be submitted no later than 30 September 2002

CHAPTER 2: THE NEED FOR CHANGE

Background

2.1 Hospital services are facing critical and mounting problems. Too many people wait long periods for hospital treatment, and patients requiring emergency admission too often have to wait for a bed because hospitals are working to full capacity. With pressures on beds growing annually, peak pressures, previously associated with winter, are becoming a year-round problem.

2.2. It is also becoming increasingly difficult to keep services going in some hospitals, where the existence of small clinical teams means that services can be particularly vulnerable. Some services have failed in recent years; others are fragile and cannot be sustained much longer in their current form.

2.3. Hospital services have changed considerably in the past fifty years. However, the funding to match these changes has not kept pace and the necessary investment in these services has not been made. Too often, acute services are located in worn-out buildings, with staff doing their best to deliver 21st century treatments using outdated equipment and facilities.

2.4. This has led to the quality of some services falling. Hospital services must change radically if they are to achieve modern standards and to deliver the high quality care that people need. The following paragraphs outline the main pressures for change, the opportunities that are being created by new ways of working, and the drive to improve standards.

Pressures Facing Acute Services

2.5. Many of the pressures facing hospitals are inescapable and will, inevitably, affect the way future services are provided. Some fundamentally affect their ability to deliver safe and effective care.

Changing service needs

2.6. People are living longer. With advancing age, people are more likely to suffer from chronic diseases such as diabetes, heart disease or arthritic problems and may have two or more chronic health problems. They require continuing health care, co-ordinated and delivered by a wide range of health care staff in different places and at different times.

2.7. The expected growth in the number of elderly people here will give rise to substantial and increasing pressures on acute hospital services. Much more can be done for older people, who can now benefit from advances in medicine and

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surgery, including procedures such as renal dialysis, hip replacement or open heart surgery – treatments that would not have been available to them until relatively recently.

2.8. In addition to the increase in healthcare needs as a result of an ageing population, there are also more children and young people suffering from chronic diseases such as asthma and diabetes. Children today can also survive to adulthood with diseases such as cystic fibrosis. However, they may require regular and complex hospital-based treatments throughout their lives.

Developments in Health Care

2.9. New medicines to treat both chronic and acute illnesses are now available: chemotherapy for the treatment of malignant disease; advanced therapies, such as 'clot-busting' drugs, for the treatment of heart disease; and new medicines to relieve the symptoms of multiple sclerosis and rheumatoid arthritis. These treatments often replace older, less effective treatments, but usually at a higher price.

2.10. Many new treatments can now reduce short-term discomfort for patients or significantly improve their quality of life in the longer term. This is demonstrated by the significant increases in the number of hip replacements, cataract operations, coronary artery bypass operations, and organ transplants undertaken in recent years.

2.11. There have been many advances in surgical techniques. 'Key-hole' surgery has reduced post-operative pain and complications and accelerated recovery. Improvements in surgical techniques and anaesthesia have meant that more surgical procedures can be carried out on an outpatient or day-case basis, enabling patients to avoid long stays in hospital.

Developments in Medical Technology

2.12. Advances in medical engineering technology have also produced significant successes. For example machines (lithotripters) can generate shockwaves to smash stones in the kidney or urinary tract, and lasers can be used to destroy tumours and to eliminate clots in arteries. Medical imaging advances, such as CT and MRI scanners, and more recently PET scanners, will revolutionise diagnosis.

New ways of working

Specialisation

2.13. As medical practice has developed and widened it has become increasingly difficult, if not impossible, for doctors, nurses and other health workers to acquire knowledge and relevant skills in sufficient depth across the full range of health care services. As a consequence, they now train to develop narrower, more focused, interests in 'sub-specialties', in which they become expert.

2.14. Increased expertise has resulted in great advances in treatments and, most importantly, improved results for patients. For example, the advent of consultants specialising in spinal surgery, joint replacement or specialist hand surgery has directly improved outcomes for patients. However, it also means that the era of medical 'generalists', trained to span a wide range of specialties, is approaching its end. Such doctors have often provided the core of acute services in smaller hospitals here. As these doctors retire or move on, it is becoming impossible to replace them.

Information and Communications Technology

2.15. The information and communications technology revolution has the potential radically to improve medical diagnosis. It opens the way for much better use of information, through a greater integration of systems. This will mean that information held in different locations can be combined to gain a fuller understanding of the progression of illnesses and the effectiveness of treatments, thus supporting the development of new and more effective practice.

2.16. The developing ability to shrink distances through advanced communication systems will also transform how hospitals work. Telemedicine, for example, allows a GP to transmit a photograph of a patient's skin condition to, and receive advice from, a dermatologist who may be located hundred of miles away. Similarly, if a patient has severe chest pain, the technology to transmit a patient's heart tracing (ECG) to a cardiologist by cellular telephone for expert advice is already in use.

A Team Approach

2.17. People often seek help with healthcare problems that do not fit within a single specialist area. Patients with chronic diseases, affecting many body systems, are becoming more common. Health care practitioners of all types need to work in teams, pooling their knowledge and skills to provide the best available care for such patients.

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2.18. There is a great deal of evidence to suggest that outcomes are better if treatments and care are delivered by specialist multi-disciplinary teams. This is particularly so in the delivery of cancer services, but has also been shown to be the case for many chronic diseases. It is now accepted that services are better if they can be organised in a way that allows multi-disciplinary teams to develop.

2.19. Such teams must be large enough to work effectively and to provide reasonable working conditions for all the staff involved. They also need to care for sufficient number of patients to make best use of their skills and to maintain those skills throughout a lifetime of practice. This is particularly important, as all health care practitioners will be required to demonstrate their continued professional competence on a regular basis.

Training

2.20. The healthcare workforce is highly skilled, with one in five a graduate in their professional discipline. However, graduation is only the first rung on the ladder to specialist practice. Training takes place largely within the health service over several years. Traditionally this has mainly involved learning on the job. There have been significant changes to this approach throughout the past decade, which have recognised that it is not the most efficient way of equipping staff for specialist practice.

2.21. Increasingly, the jobs available to junior doctors, and other professional staff, do not provide the opportunity to develop the skills and experience necessary for modern practice. More stringent requirements covering the degree of supervision, the specific nature of the work undertaken by trainees and facilities for study available, are being applied by professional standard-setting bodies when considering, or reviewing, the suitability of a post for training.

2.22. The acute sector has been heavily reliant on staff in training to supplement the provision of patient care. This can no longer continue. At present, in hospitals which cannot meet training needs, the loss of training recognition has the potential to critically undermine service provision.

Supporting Hospital Staff

2.23. The hospital service depends on the commitment and motivation of its staff to deliver the quality of care achieved. Staff often work long hours, frequently beyond their contractual commitments, in the interest of their patients. They may work in a less than ideal environment, and find themselves dealing with situations

that can be harrowing and disturbing. They do so with professionalism and dedication.

2.24. It is important that the commitment and motivation of staff is built upon rather than undermined. If the current organisation of acute services does not provide staff with adequate support in an acceptable physical environment, there is a significant risk that:

- local recruitment of doctors, nurses and other health professionals will become increasingly difficult;
- staff will leave to find jobs elsewhere; and
- international recruitment will become progressively less fruitful.

Improving Standards

2.25. Improving the quality of hospital care, and the environment in which this care is delivered, is a major priority. The responsibility for quality has been addressed at both an individual and a corporate level. Individual doctors, nurses and other health professionals must now ensure that their professional development keeps their knowledge and skills up to date. At a corporate level the duty on Trusts to provide quality care will soon become a statutory responsibility. Accountability for the delivery of the services will be strengthened through the introduction of robust clinical and social care governance arrangements.

2.26. These requirements, along with new arrangements for the production and dissemination of standards, will ensure that individual members of staff will be kept fully up to date with guidance on new technologies and standards for treatment to be applied. All of this will be underpinned by a transparent and open system of independent monitoring of the quality of services within the HPSS. The principal vehicle for this will be the planned Health and Social Services Regulation and Improvement Authority, which will be established subject to the will of the Assembly, with legislation being brought forward this autumn.

Conclusion

2.27 There have been major changes in the needs of the population, and in medical knowledge, medical technology and the way doctors, nurses and other health professionals train and work to deliver acute healthcare. The public rightly expects the highest standards of services, and these need to continue to improve. All of these factors, taken together, will have a profound effect on the way hospital services can be provided in the future.

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2.28. The hospital service is constantly changing. Thanks to its highly skilled and committed workforce, hospitals continue to deliver good quality services, despite the growing pressures, and will continue to strive to do even better. However, it is increasingly difficult to deliver safe, modern and effective services in ageing hospitals, with outdated equipment and staffing complements that cannot support best clinical practice.

Pressures for Change

- Ageing population requiring increased treatment and care
- New medicines and new treatments
- Developments in medical technology
- New ways of working
- More stringent training requirements
- Improving standards

CHAPTER 3: WHAT KIND OF CHANGE

3.1 At present, there are 15 hospitals providing acute services here (see map at Appendix 1) and one further hospital that has temporarily lost its acute services, serving a population of around 1.7 million people. They range in size from large acute hospitals, such as the Royal Group and the Belfast City Hospitals, each serving the Belfast area and the whole population in some regional specialties, to the Downe hospital, serving a local population of around 55,000 people.

3.2. In order to meet the pressures for change outlined in the previous chapter, there needs to be a radical re-shaping of acute hospital services, with a greater differentiation between the roles of the current range of hospitals, concentrating specialised services where necessary, and decentralising other services where possible.

3.3. The trend internationally has been towards a greater concentration of hospital services on fewer sites. A number of professional medical bodies, including the Royal College of Surgeons, consider that an acute hospital, providing a full range of facilities and acute specialties, should be sufficiently large to serve a population of around 450,000-500,000 people. This would equate to three acute hospitals here. In practice, they recognise that most acute hospitals will continue to serve populations of around 200,000-300,000 for the foreseeable future.

3.4. It is their view that the specialist teams and technology necessary to treat acutely ill patients, and those with complex conditions, can only be maintained in large hospitals serving substantial numbers of patients. Such hospitals can be staffed to deliver complex modern treatments, ensure proper under-graduate and post-graduate professional training and raise clinical standards. Patients benefit by being treated by professional teams that treat enough patients to develop and maintain expert skills across a wide range of subspecialties.

3.5. Larger facilities are considered better able to use sophisticated diagnostic and other support services efficiently and economically, and support the number of clinicians necessary to provide 24 hour medical cover.

3.6. The Acute Hospitals Review Group and earlier reviews of acute services, conducted by the Health and Social Services Boards, have separately concluded that, to improve services for patients, a further concentration of acute services is necessary here.

Providing Local Services where Possible

3.7. Such reviews have also acknowledged that the improved quality of care and treatment arising from concentrating acute services must be balanced against the accessibility of these services to patients and their families. People want the best services available but prefer to have these in their own local area unless there is a good reason to travel further. They also want prompt and ready access to life-saving treatment in the event of an emergency.

3.8. Local hospitals foster the development of relationships with community and primary care services. Moreover, with developments in new technology such as telemedicine and teleradiology, local hospitals can now more easily link to specialist advice and support in larger acute hospitals. These developments in technology open the way for these hospitals to draw on medical and other expertise at a distance, and to provide patients with better diagnoses, of a potentially higher quality and with a minimum of delay.

3.9. The advances in medical treatment also mean that many more, formerly specialised, operations and medical procedures are becoming 'routine'. These can be more readily de-centralised and can often be treated on a day procedure basis.

Managed Clinical Networks – A New Way of Working.

3.10. In looking at how acute hospitals may change, it is important to take account of the advent of Managed Clinical Networks. Although still in its infancy, this approach to collaborative working opens the prospect of re-focusing services on populations rather than facilities.

3.11. The Acute Hospitals Review Group report noted the potential benefits of managed clinical networks and, in particular, *"their ability to facilitate the concentration of specialist skills and complex diagnostic equipment, when appropriate, without necessarily having to close down local services which are so highly valued by local communities"*.

3.12. Managed Clinical Networks have the potential to provide services to patients in a different way. They will support doctors, nurses and other health professionals, working together across different facilities and geographical/organisational boundaries to provide the right care for patients delivered from the most suitable location.

3.13. An effective clinical network for hospital based cancer services is already operational here. Staff at Cancer Units in Antrim, Craigavon, Altnagelvin and the Ulster hospitals work with the Belfast Cancer Centre to ensure that all patients receive high quality care. Regular multi-disciplinary meetings at the Cancer Centre and the Cancer Units provide the opportunity for health professionals to discuss an individual patient's diagnosis, and to agree the best medical or surgical care for that patient.

3.14. By providing services across a number of sites a more convenient and accessible service is provided for patients, without compromising standards of care or treatment. For example, a surgeon may provide outpatient clinics in a local hospital, carry out day-case surgery in a designated elective facility and perform major inpatient surgery at a large acute hospital.

3.15. Networks depend not just on individuals working across sites but on all the health professionals and their organisations working together to share good practice, communicate with one another, and provide a seamless service to patients. They offer the possibility of organising services differently, with the prime focus on the needs of the patient.

Conclusion

3.16. To support the development of modern hospital services, acute services here must change. Our pattern of hospitals is based on an outmoded approach to acute care. This does not facilitate the development of robust modern services that are sustainable and able to provide patients with both the full benefits and the level of quality of outcome which modern medicine can provide.

3.17. There is a limit to how much re-adjustment can be made to the current pattern of acute hospital services, and smaller hospitals are now finding it increasingly difficult to deliver services to modern standards. Consequently, they are beginning to lose training recognition and some are now finding it difficult to recruit and retain staff.

3.18. Action is needed now to identify where and in what ways services need to be concentrated to achieve higher quality; and where they can be decentralised, to make them even more accessible. A new pattern of services, supported by innovative managed clinical networks, will make an important contribution to transforming the quality and responsiveness of hospital services.

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Re-shaping Acute Services

- Concentrating services can bring considerable benefits
- Benefits of concentration must be balanced against accessibility
- De-centralisation of more hospital services now possible
- Managed Clinical Networks can support more convenient and accessible services

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Chapter 4: A Model for Future Hospital Services

Current Arrangements

4.1. At present, the acute hospitals here all deliver a wide range of acute inpatient, day-patient and outpatient acute medical and surgical services. All but one of the hospitals have an A&E department and thirteen of them provide in-patient maternity services, with the number of deliveries ranging from around 450 to 5000 each year.

4.2. Serving a population of around 1.7 million people, these hospitals each year treat around 380,000 in-patients, 150,000 of whom are emergency admissions, and 120,000 day-patients. They also manage 1,200,000 outpatient and 670,000 A&E attendances.

4.3. The factors outlined in previous Chapters underline the need for significant change in the way hospital services are delivered in the future. The challenge is to build on the strengths of the current service, and to develop a modern and effective hospital service that meets the needs of patients, and delivers the full benefits that modern medicine can offer.

4.4. To meet these requirements will require a shift away from stand-alone hospital facilities towards an integrated service that delivers a comprehensive range of treatment and care from a variety of hospital and primary care settings, all operating collaboratively as an inter-dependent care network.

Principles

4.5. In seeking to achieve the right relationship between quality, safety, accessibility, sustainability, equity, and affordability, the proposals in this Chapter are guided by the following principles:

- none of the current hospitals offering acute services should be closed – rather, they must be adapted to play their part in a new configuration of service provision;
- services should be decentralised wherever the opportunities created by service and technological developments make this possible and sustainable;
- the range and quality of hospital services should aim to match the best standards achieved in other parts of Europe;
- access times to emergency care and consultant-led maternity services, in an appropriate facility, should be the minimum achievable, with the vast majority of people within 45 minutes, and everyone normally within one hour, of these services; and

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- acute services must be re-focused, to achieve the concentration of expertise and experience required to deliver the highest possible levels of clinical care.

A systematic Approach to Hospital care

4.6. In developing these proposals, account has been taken of the AHRG report and the outcome of the public consultation on its findings. They follow a similar approach to the AHRG recommendations, in that they are built around a network of acute hospitals and Local Hospitals. However, the proposals go further than the AHRG recommendations in that they do not categorise acute hospitals into different levels and open the way for:

- the provision of a second Enhanced Local Hospital, in the West;
- the provision of a second protected elective centre, west of the Bann; and
- the piloting of two mid-wife led stand-alone maternity units, one in the East and the other in the West.

4.7. The hospital service has to be developed as an integral part of the total health system. Hospitals need to work as a dynamic element of that system, if they are to function effectively. The hospital service ultimately relies on primary and community care services, working effectively to channel the right patients to it and to re-integrate them back into the community at the end of their acute treatments.

4.8. The approach set out in this Chapter is based on the expectation that acute services will be patient –focused and organised around population groupings rather than facilities. This will require a much greater movement of staff within the system to support local activity and to ensure the proper decentralisation of services.

The Approach

- Closer integration of primary, community and secondary care
- Patient-focused acute services, organised around populations
- Greater movement of staff within system
- Local Hospitals a vital bridge in the new integrated health system

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Links to Primary and Community Care

4.9. The boundaries between primary and hospital care are becoming increasingly blurred. Primary Care Teams, which bring together GPs and community health and social care professionals, including pharmacists and general dental practitioners, are most often the first point of contact that people have with the Health and Social Services. They play an increasingly important role in sustaining vulnerable and chronically ill people in the community, and managing their access to appropriate levels of acute care.

4.10. This role is set to expand, with the development of Local Health and Social Care Groups providing a better focus for modernising primary and community care.

4.11. The further enhancement of primary care will directly support the localisation of services, with an increased emphasis on providing them as close as possible to the people relying on them. In addition to established relationships with existing community hospitals, such as Ards and Bangor hospitals, primary care teams will have the opportunity to work closely with Local Hospitals, which will form a bridge between acute and primary care.

4.12. Given proper investment, it is envisaged that primary care, secondary (hospital) care and community care professionals will work together, in modern facilities, to provide the vast majority of hospital and community services required by the local communities that they serve.

A New Model for Hospitals

- Strikes the right balance, proposing a network of acute hospitals and Local Hospitals, including:
  - 9 acute Hospitals
  - 2 Enhanced Local Hospitals
  - 2 protected elective facilities
  - 9 consultant-led maternity units
  - 2 pilot stand-alone midwife-led maternity units
- Links to primary and community care

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New Local Hospitals

4.13. In providing an effective health care system, local access to services is important. **Local Hospitals** will work directly in partnership with acute hospitals, forming a crucial bridge between hospital and primary and community care and helping to achieve cohesion between the different care sectors.

4.14. Local Hospitals are an important new concept, building on recent service developments here and elsewhere. They will be developed to provide the vast majority of services that people get in hospital settings (some 70%), and that do not need to be delivered in a large acute hospital.

4.15. Developments in clinical practice and technology are making more local treatment and care increasingly possible. Many investigations, treatments and procedures, previously requiring hospital admission, can now be carried out effectively and safely outside a major acute hospital.

4.16. Local Hospitals will provide increasingly sophisticated methods of investigation, diagnosis and day procedures that go considerably beyond what is currently available from Community Hospitals. They will provide a local base for expert clinicians, specialist nurses and other health professionals, who will relate to local populations rather than to individual facilities and provide a wide range of services, including:

- Extended-hours access to a minor injuries unit,
- an increased range of day case surgery,
- a wider variety of high quality diagnostic services,
- a wider range of outpatient clinics,
- pre and post natal maternity services,
- intermediate care, and
- rehabilitation and step-down beds, supporting people who require less intensively supported care as they complete their recovery from in-patient treatment.

4.17. The accessibility of Local Hospitals, their size and their local character, will ensure that they make a distinctive contribution to the overall provision of modern, high quality hospital services.

4.18. Developing Local Hospitals in this way will require considerable and continuing investment in modern equipment and in the training of staff. However, the proper

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development of Local Hospitals will greatly benefit the people who make use of their services.

4.19. The Mid-Ulster, South Tyrone , Whiteabbey, Downe, Lagan Valley, Mater, and Tyrone County hospitals will be developed as Local Hospitals. To take account of local circumstances, a number of these will have some additional services, as set out in the following paragraphs.

Downe Hospital

4.20. The AHRG report proposed that the Downe should provide, among other things, a 24 hour A&E service and emergency medical service, including coronary care. It should also provide planned (elective) day procedures but not emergency surgery.

4.21. This model raises a number of issues relating to the nature, extent and sustainability of the proposed services at the Downe. To address these, further clarification was sought regarding the detail of the model and the journey times in the Down area.

4.22. Journey times from some districts served by the Downe to the nearest acute hospital can be as much as 55 to 60 minutes. It is therefore proposed that the Downe should provide some additional services, as an **Enhanced Local Hospital**. The hospital will be linked to the acute hospital network and supported to maintain a 24 hour A&E unit, capable of providing resuscitation and emergency coronary care, and a consultant-led in-patient medical service, in addition to out-patient, diagnostic and day procedures.

4.23. In proposing this Enhanced status for the Downe as a Local Hospital, account has been taken of the particular problems of delivering emergency services to the dispersed rural population relying on this hospital. This approach builds on a model for the hospital previously developed by the Eastern Health and Social Services Board in collaboration with the Down Lisburn Trust, and the hospital consultants who provide current services at the hospital and in Belfast.

4.24. This hospital will have to work as part of a clinical network if it is to sustain these additional services. This will be challenging for staff at the Downe hospital and the acute hospitals working in partnership with it. The approach will be evaluated on a regular basis to confirm its continuing viability.

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4.25. The consultant-led inpatient maternity services provided by the Downe will be transferred, in line with proposals on Maternity services later at paragraph 4.61.

Tyrone County Hospital

4.26. A new Local Hospital is proposed for Omagh. Analysis of the journey times to an acute hospital in or to the north of Enniskillen shows that some people served by the Tyrone County Hospital would have journey times approaching 60 minutes.

4.27. Recognising that traffic volumes and other factors may also push journey times over the hour at certain times of the day, it is proposed to site an Enhanced Local Hospital in Omagh. The Western Health and Social Services Board will be asked to lead a process involving local Trusts, clinicians, other hospital staff, and other interested parties, including service users, to develop a model for such an enhanced service.

4.28. The model will need to demonstrate that any proposals are viable, sustainable and will not undermine the new acute hospital in the area.

Lagan Valley Hospital

4.29. Recognising the current capacity problems in Belfast, Lagan Valley Hospital will have to continue to provide a wide range of acute services for much of the period leading to the establishment of a new pattern of hospital services, pending its transformation to a modern Local Hospital.

4.30. As a Local Hospital, Lagan Valley Hospital will have a minor injuries unit linked to one of the Belfast A&E centres, and a rehabilitation role, particularly for local older people. It will also provide state of the art outpatient and diagnostic services for the major specialties.

4.31. Given its location and facilities, it is proposed that the Lagan Valley Hospital becomes a specialist centre for planned (elective) surgery for Greater Belfast , protected from short-term emergency pressures and developed so as to maximise its elective capacity. This would facilitate the development of elective beds, allowing the hospital to make a significant contribution to decreasing waiting times for surgery in the East.

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Other Protected Planned Admissions Provision

4.32. A single protected centre of this type, located adjacent to the Greater Belfast area, is unlikely to be sufficient to meet needs, reduce waiting lists, and ensure equality of access.

4.33. There exists a particular sense of inequity west of the Bann. Public concerns that services have been run down, withdrawn and made less accessible have generated understandable fears of being left without services.

4.34. Noting that accessibility is an important consideration, further work will be undertaken by the Department to identify a second major protected elective centre in a Local Hospital west of the Bann. In conjunction with other proposals in this paper, this centre will provide an important contribution to decreasing waiting lists in the West.

Mater Infirmorum Hospital

4.35. Recognising the current capacity problems in Belfast, the importance of making full use of the modern facilities of the Mater hospital is accepted. The Mater must therefore continue to provide a range of acute services for much of the period leading to the establishment of a new pattern of hospital services, pending its transformation to a modern Local Hospital. The Mater has a long and distinguished history as a teaching hospital. As a new Local Hospital, with good clinical links to the Royal Group of Hospitals and the Belfast City Hospital, and in close proximity to them, the Mater will be ideally placed to play an even more significant role in contributing to training of doctors, nurses and other health professionals of the future.

4.36. To enable the hospital to make this vital contribution, the Mater Hospital will be further supported in developing and expanding its role as a key institution in the fields of medical and nurse training. In particular the Department will formalise its role as a teaching hospital by putting its links with Queen's University on a statutory basis in the same way as the two main teaching hospitals. As a result the University would be given representation on the Trust board. These arrangements will be reviewed as necessary in the light of the decisions taken on HPSS structures.

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4.37. The Mater has been experiencing increasing difficulties in maintaining the existing maternity services. The Mater's close proximity to the new centralised maternity hospital[4] may, however, open up opportunities for sustaining the service on a close partnership basis.

4.38. The AHRG concluded 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, midwifes and junior medical staff in the two maternity units who would effectively act as a single clinical team.'*

4.39. It is proposed, on the basis of the approach suggested by the Acute Hospitals Review Group, that maternity services at the hospital will be maintained. This will be conditional upon the Mater Trust working with the new centralised Belfast maternity service, to show that robust networking arrangements can be put in place and sustained.

Modern Acute Hospitals

4.40. It is proposed to create a stable pattern of modern acute hospitals, comprising nine acute hospital sites. This approach will ensure that, regardless of where they live, most people will have access to acute services, effective emergency care and consultant-led maternity services within 45 minutes, and all the population will normally be within one hour of these services.

4.41. A core element of this approach is the establishment of a more integrated and mutually supportive network of acute and local hospitals. This will provide an inter-locking and seamless high quality care hospital network that links directly to primary and community care arrangements.

4.42. Some 'regional' services, such as chemotherapy, have already been decentralised from the Belfast hospitals. Future moves, such as the development of consultant-led fracture clinics in all acute hospitals, and full in-patient fracture services at Antrim and Craigavon, will also be brought forward.

[4] *A new Centralised Maternity Service will be sited on either the Royal Group or the Belfast City Hospital site. Maternity services at the Mater Hospital should link directly to this Service.*

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4.43. In addition Musgrave Park Hospital will continue in its role as a regional orthopaedic centre providing protected elective orthopaedic procedures. Steps will be taken to enhance services at the hospital, to facilitate a reduction in current long waiting times for operations.

4.44. Commissioners and providers of services will be expected to continue to pursue decentralisation opportunities as and when medical and technological advances permit.

4.45. Future acute services will be provided from nine hospitals: Royal Group, Altnagelvin, Antrim, Belfast City, Causeway, Craigavon , Daisy Hill, Ulster, and a new hospital in or to the north of Enniskillen, to serve the Fermanagh/Tyrone area. The rationale for the location of the new hospital for the Fermanagh/Tyrone area is addressed in paragraphs 4.51-4.60 below.

4.46. These acute hospitals will each have their own characteristics and individual service profiles. They should be seen as part of a mutually supportive network of complementary services. All of the nine acute hospitals will support a broad range of acute services. Each will have 24 hour A&E services, and a wide range of in-patient, outpatient and day procedures. Eight of the nine will have consultant led in-patient maternity services[5]. These services will meet most of the acute service needs of the population.

4.47. Additional specialist services, for the minority of patients with severe or complex conditions that require very specialist care, will be provided from some of the acute hospitals with larger patient volumes, for example inpatient fracture surgery. Where a patient requires services that are not provided in the acute hospital closest to their home, they will be admitted directly to, or transferred to, the nearest facility providing such services.

4.48. To provide patients with modern and effective treatments to the highest standards, specialist services need to be resourced accordingly. To deliver them, acute hospitals require the facilities, equipment and specialist medical, nursing, health professional and other support staff necessary to provide a multi-disciplinary approach to the management of complex clinical treatments.

[5] *A new Centralised Maternity Service will be sited either on the Royal Group or the Belfast City Hospital site.*

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4.49. There are a small number of services, such as neurosurgery or renal transplantation, which are distinguished by their highly specialised nature or by the relatively low number of patients, often with rare or complex conditions, that they treat. These will only be provided, on a region-wide basis, from one or two of the acute hospitals.

4.50. In addition, a number of Belfast hospital based specialties will be re-located, in line with the recommendations of the Eastern Health and Social Services Board's report: *Taking forward the Pattern of Acute Hospital Services in the Eastern Board Area, (December 2000).* These cover the future siting of specialties covering Plastics, Dermatology and Rheumatology. In the case of paediatric and adult ENT services, appropriate account will be taken of subsequent work by the Board with Trusts and clinicians on the separate siting of these services.

A New Fermanagh/Tyrone Acute Hospital

4.51. A new acute hospital in the Fermanagh/Tyrone area is necessary to provide accessible, high quality services to people in that area.

4.52. An acute hospital must have a workload sufficient to ensure its long-term viability. The Department's assessment is that a new acute hospital, at any of the locations considered, is sustainable, provided it is part of a larger managed clinical network. Potential partnership arrangements with acute hospitals in the South would further support the sustainability of an acute hospital in Fermanagh/Tyrone area.

4.53. The choice of locating the hospital in or to the north of Enniskillen, in Omagh, or in a location elsewhere, was finely balanced, and further analytical work was undertaken to guide this decision.

4.54. The over-riding concern was to ensure that the new facility meets the acute service needs of the population. The consultation on the AHRG report generated a number of detailed proposals as to the location of the new hospital and information was provided in support of each location.

4.55. To further inform the decision-making process, some additional analysis was undertaken in assessing journey times within Fermanagh/Tyrone and between the counties and adjacent hospitals in the South (See Appendix 5). An independent review and analysis of the reports supporting a number of locations/sites was commissioned; and activity and staffing data, covering Sligo, Cavan, Monaghan

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and Letterkenny hospitals, were analysed to help to establish the current potential of these hospitals to contribute to the provision of acute services here. Deprivation indices were also reviewed.

4.56. The results of these analyses can be summarised as follows:

(i) If the use of hospitals in the South is not taken into account and a new Fermanagh/Tyrone hospital is situated in or to the north of Enniskillen, around 8,744 people in the Fermanagh/Tyrone area would have travel times of over 45 minutes, of whom 2,131 would be between 50 and 55 minutes travelling time from the hospital. None would be more than 55 minutes away from the hospital. This compares with an Omagh location where 24,250 people in the Fermanagh/Tyrone area would be more than 45 minutes away, of whom 21,234 would be more than 50 minutes away, with 9,749 more than 60 minutes travelling time from the hospital. A location at Ederney, a location half way between the two towns, would place 17,802 people in the Fermanagh/Tyrone area more than 45 minutes away from the hospital, of whom 7,260 would be between 55 and 60 minutes travelling time away from it, and none would be more than 60 minutes away.

Site	Total no in Fermanagh/ Tyrone with journey time over 45 mins#	Of those with journey time over 45 mins		
		Journey time Over 50 min	Journey time Over 55 min	Journey time Over 60 min
Enniskillen*	8,744	2,131	0	0
Omagh	24,250	21,234	9,749	9,749
Ederney	17,802	7,260	7,260	0

** Times are calculated on the current hospital. If the new hospital was to the north of the town, journey times would be reduced.*

 # Calculations assume that people will travel to their nearest hospital in the North for treatment. While this may be the case for Accident and Emergency attendances, patients will travel to other hospitals for elective treatment, particularly for certain specialities

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(ii) If hospitals in the South were able to provide A&E and a full range of acute services to the population, and if this were factored into travelling times, no-one in Fermanagh or Tyrone would have to travel more than 55 minutes to an acute hospital, regardless of the location chosen. In this scenario, the differences between access times are much closer. If the hospital is located in or to the north of Enniskillen, around 6,525 people in the Fermanagh/Tyrone area would have travel times of over 45 minutes, none of whom would be more than 50 minutes away from the hospital. This compares with an Omagh location where 4,626 people would be more than 45 minutes away, of whom 2,365 would be between 50 and 55 minutes away from the hospital. A location at Ederney, which is half way between the two towns, would place 4,072 people more than 45 minutes away, none of whom would be more than 50 minutes travelling time away from the hospital.

Site	Total no in Fermanagh/ Tyrone with journey time over 45 mins#	Of those with journey time over 45 mins		
		Journey time Over 50 min	Journey time Over 55 min	Journey time Over 60 min
Enniskillen*	6,525	0	0	0
Omagh	4,626	2,365	0	0
Ederney	4,072	0	0	0

** Times are calculated on the current hospital, if the new hospital was to the north of the town, journey times would be reduced.*

 # Calculations assume that people will travel to their nearest hospital in the North or South for treatment. While this may be the case for Accident and Emergency attendances, patients will travel to other hospitals for elective treatment, particularly for certain specialities.

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4.57. There has been communication at a senior level between the Department of Health, Social Services and Public Safety and the Department of Health and Children concerning the potential of hospitals in the South to provide services to patients from the North. From this, it is apparent from the current stage of planning for hospital services that there is uncertainty as to whether the relevant hospitals in the South will deliver, over the longer term, the capacity and services equivalent to those provided by the nine acute hospitals in the North. This degree of uncertainty has to be taken into account in deciding the best location of the new hospital with a potential life-span of 60 or more years.

4.58. The revenue and capital costs of the new hospital would be largely the same whether it is located at Enniskillen, Omagh or a location somewhere between the two towns. However, some additional infrastructure costs, for example for services and road improvements, may be required if the hospital is located well outside the two main towns.

4.59. Given the difficulties that the Erne and Tyrone County hospitals are currently experiencing in maintaining acute services, it is essential that a decision on the location for the new hospital is reached as quickly as possible. In these circumstances and on the information available, the balance of advantage lies in locating the new hospital in or to the north of Enniskillen.

4.60. This proposal is firmly based on the available information, and any new information that emerges during the course of the consultation will be taken into consideration before reaching a final decision.

Maternity Services

4.61. Women want maternity services that are safe, provide high quality care, and offer real choice in the range of care available. They are particularly concerned about having to travel long distances during pregnancy or labour.

4.62. It is the intention that maternity services should be provided as close to people's homes as possible. Consequently, Local Hospitals, as well as the acute hospitals, will provide ante-natal care, ultrasound screening, assessment of complications and post-natal care for mother and baby.

4.63. Moreover, all mothers-to-be should normally be within one hour of the nearest consultant-led maternity unit. The safety of mother and baby is paramount, and women need to have confidence that safe and satisfactory arrangements are in

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place for their care and support in all maternity units. All of the 9[6] consultant-led maternity units will therefore provide cover, on a 24 hour basis, supported by teams of consultant obstetricians, consultant anaesthetists and consultant paediatricians.

4.64. It is clear that, in the future, the number of expectant mothers who will deliver their babies in the smaller maternity units will not be sufficient to enable staff in these units to maintain their expert skills. In such units, the small numbers of deliveries make it impossible to sustain the full team necessary to deliver a consultant-led maternity service.

4.65. Alongside the concentration of consultant-led maternity services, delivered on fewer sites, the development of midwife-led units, within or adjacent to a consultant-led maternity unit, will be taken forward. Such units can allow mothers with a low risk of having a complicated labour, to have a more natural birth in a safe but homely environment. The further development of these units will be actively promoted.

Midwife-led Stand Alone Units

4.66. The opportunities to move beyond this approach towards stand-alone midwife-led units are already being demonstrated in pilot schemes, in England, Wales and the South. Preliminary evaluations indicate that such units are capable of providing a safe, alternative option of care during delivery for mothers-to-be who are assessed as 'low risk', by putting in place appropriate and effective transfer arrangements to cover unexpected emergencies.

4.67. The opportunities for such developments here should be fully explored. It is proposed that the Department, in consultation with HSS Boards and Trusts, will arrange for local pilot projects to be established. Two initial pilot schemes are envisaged, one in the East and one west of the Bann. The proposed pilots will establish clear protocols to ensure that, where risks are identified at any stage, mothers-to-be are referred to a consultant-led maternity unit, which will be supported by the establishment of an effective region-wide neonatal transport service. The training and skills of midwives in the Stand Alone Units will also be enhanced.

[6] *A new centralised maternity service will be sited on either the Royal Group or Belfast City Hospital site. Maternity services at the Mater should link directly to this.*

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Supporting Rural Communities

4.68. The development of Local Hospitals, working with appropriately sited acute hospitals, will ensure that rural communities are not disadvantaged when it comes to accessing hospital services.

4.69. Recognising that, no matter how hospital services are arranged, dispersed rural communities will be some distance from them, early additional steps will be taken to put in place supporting measures. These will add to and complement the provision of hospital services and ensure that the needs of rural people are adequately addressed. These include:

- **Rapid Responder Schemes**– providing 24 hour cover within defined geographical areas. These are ambulance service paramedical staff, with pre-hospital trauma and life-support skills. Using rapid response vehicles, they will respond to emergency calls, assess the situation, and either deal with the incident themselves or provide support and care until an ambulance arrives;

- **First Responder Schemes** – these schemes provide a network of local people with the skills to respond to life-threatening emergencies;

- **Improved Ambulance Services** – the Department's plans will improve ambulance response times for many rural areas, and ambulance crews will be trained to provide thrombolysis (clot-busting drugs) for appropriate patients before they arrive in hospital;

- **Transport services** - a more flexible interpretation of 'clinical need' will be applied when considering eligibility for transport to and from hospital provided by the HPSS for people in rural areas; and

- **Innovative planning** –Boards and Trusts will set up task groups to develop imaginative ways of addressing the problems that people in rural areas face, especially those areas with long and difficult journeys. Examples include making greater use of vehicles other than ambulances for patients who do not require skilled ambulance aid, and enhancing services provided by primary care teams, drawing on the expertise of other emergency services.

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4.70. The aim is not to substitute local services for hospital-based care but to develop a range of pre-hospital support services, to ensure that the overall service available to rural communities is as good as that available to people living in communities closer to hospitals. The service for each area will be tailored to meet particular local circumstances.

Working in Partnership with the South

4.71. The AHRG recommended that collaborative working with health services in the South should be encouraged. This is fully in keeping with work already agreed and in progress.

4.72. For example, in 2000 the North South Ministerial Council (NSMC), established the North South Regional Hospital Services Group (NSRHSG) to consider the opportunities for developing partnerships covering the wider regional and supra-regional services. It has been tasked with identifying service areas/specialities where cross border or all-island co-operation can be of mutual benefit.

4.73. Cooperation and Working Together (CAWT) is an organisation formed in 1992 to promote cooperation in improving the health and social well-being of the populations of the North Eastern and North Western Health Boards in the South, and the Southern and Western Health and Social Services Boards in the North. A number of local cross-border initiatives are being developed by CAWT, which has been exploring opportunities for building greater collaboration between hospitals in border areas.

4.74. The Health Departments here and in the South are working collaboratively on A&E services, planning for major emergencies, co-operation on high technology equipment, cancer research and health promotion. For example, as part of work on planning for major emergencies, the NSMC has approved the joint commissioning of a feasibility study of an all-island Helicopter Emergency Medical Service and this is currently being taken forward. A joint contract is already in place for the disposal of clinical waste.

4.75. Such collaboration is in the best interests of patients North and South, and it is important that the full potential of such co-operation is realised.

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Conclusion

4.76. A number of new Local Hospitals will be established to deliver a wide range of services on a local basis. This will go considerably beyond what is currently available from Community Hospitals. They will network with acute hospitals and local primary and community care and provide the backbone of the new hospital service.

4.77. There will be greater differentiation between the roles of the current range of hospitals, concentrating specialised services where necessary, and decentralising other services where possible.

4.78. The nine acute hospitals, including a new acute hospital for Fermanagh/Tyrone, located in, or to the north of Enniskillen as outlined in this paper, represent a viable, robust and sustainable approach to delivering modern and accessible acute services.

4.79. Maternity in-patient services should be provided on nine sites. Midwife-led services should be further developed and two stand-alone midwife-led units will be piloted.

4.80. Opportunities for co-operation between the North and South on a range of healthcare issues should continue and be developed to their full potential.

Chapter 5: The Need for Change in Structures

Introduction

5.1. The HPSS is administered by the Department, 4 HSS Boards, 19 Trusts and 5 Special Agencies. There are also 4 Health and Social services Councils. The four Boards were originally set up to deliver the full range of health and social services, under the direction of the Department. With the creation of the internal NHS market in the 1990s, Boards were given responsibility for determining the needs of their population for health and social services. They became commissioners of services, purchasing them from a range of service providers

5.2. The main providers of services were the Trusts, which inherited the responsibility for the delivery of services from the Boards. The newly established Trusts were given a high degree of management autonomy, and competed with each other for contracts covering the delivery of health and social services.

5.3. Recognising the potential for GPs to influence the delivery of hospital services, the then government also established GP Fundholding practices. These were also given commissioning powers and were funded to buy a range of hospital and other services directly from Trusts.

5.4. At present, 19 Trusts and 5 Special Agencies deliver a wide range of hospital, community health and social care services . These consist of 7 Trusts that provide acute hospital services only, 5 Trusts that provide community health and social services only, 6 fully integrated Trusts providing both hospital and community health and social services, and one regional Ambulance Trust. The Special Agencies provide a number of services, including payments to independent practitioners, regional supplies, blood transfusion services, medical physics, guardian ad litem services for children, and health promotion.

5.5. The need for structural reform has been evident since moves to abolish the internal market began. The structures set up to promote the development of an internal market do not reflect the new emphasis on partnership and co-operation. Nor do they readily support the objectives of empowering local communities, targeting social need and removing inequalities, which feature strongly in the Executive's Programme for Government.

5.6. The competitive, internal market, approach has been replaced by a more collaborative approach. GP Fundholding has been abolished, and Local Health and Social Care Groups, (LHSCGs) are in the process of being set up, with the intention

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of bringing a much more inclusive approach to the identification of local needs and the commissioning of services.

5.7. The current roles of the Department, the 4 HSS Boards, the 19 HSS Trusts, the 5 Special Agencies, and the 4 HSS Councils all need to be reviewed, to determine whether they are appropriate in the new environment of partnership and cooperation signalled in the Executive's Programme for Government.

Relationship with Review of Public Administration

5.8. The Executive has announced its intention to launch a comprehensive review of all aspects of public administration in Northern Ireland. The draft terms of reference which are to be finalised shortly state that the intention is to *"review the existing arrangements for accountability, development, administration and delivery of public services in Northern Ireland, and to bring forward options for reform which are consistent with the arrangements and principles of the Belfast Agreement, within an appropriate framework of political and financial accountability."*

5.9. The review is to be launched in the coming weeks. It is anticipated that there will be a major consultation exercise in the autumn of 2002, with an initial report on progress being produced in spring 2003. It is envisaged that firm conclusions are unlikely to emerge before the end of 2003.

5.10. Clearly there will need to be a two-way inter-relationship between the Review of Public Administration (RPA) and work on structural reform within the HPSS. However, there is no question of this work being unnecessarily delayed because of the RPA. The Executive has agreed that work such as reforming the HPSS should be progressed, but decisions should be taken in a co-ordinated manner, taking account of the emerging principles/criteria from the RPA in determining the final configuration of HPSS structures.

5.11. Following consideration of the responses to the proposals for structural change a further consultation will be required before final decisions can be taken on structural reform.

The Acute Hospitals Review Recommendations on Structures

5.12. The Acute Hospitals Review Group, as part of its consideration of the need for change in the organisation of hospital services, looked at the current organisation of the HPSS and made a number of suggestions for streamlining its structures.

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The following paragraphs take account of these suggestions and set out for consultation a number of options for reforming HPSS structures.

5.13. The AHRG proposed that:

- the four HSS Boards should be replaced by a Regional Strategic Health and Social Services Authority outside the Department and by (possibly) three Commissioning Consortia or Partnerships, made up of local health and social care commissioning bodies,
- the 18 HSS Trusts (excluding the Ambulance Trust) should be replaced by 3 integrated Health and Social Care Systems for delivering services; and that
- the four HSS Councils should replaced by a single, statutory consumer body.

5.14. Responses to the initial consultation on the Acute Hospitals Review Group's report showed a general welcome for the proposal for a Strategic Health and Social Services Authority separate from the Department. Mixed views were expressed on the proposal to establish three Health and Social Care Systems.

5.15. Many of those who commented felt that any review should be considered as part of the Executive's proposed Review of Public Administration. However, the Assembly's Health, Social Services and Public Safety Committee felt that a review of the current structures should proceed as quickly as possible, and need not await the forthcoming Review of Public Administration (RPA).

Options for the Reform of HPSS Structures

5.16. The case for reform of HPSS structures is clear, and there is a strong public and professional expectation that Boards will be abolished and that the number of HSS organisations will be reduced significantly. In developing health and social care services for the 21st century, it is essential that the organisational structures support a partnership approach and reinforce the efficient and effective delivery of acute and other vital services. Proposals for reform are set out in the following paragraphs.

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Proposals for Reform of Structures

- Creating a single Regional Authority with responsibility for strategic planning, workforce planning and commissioning of regional services
- Replacing the 4 HSS Boards
- Bringing together Local Health and Social Care Groups as commissioning bodies for local health and social services
- Combining HSS Trusts or replacing them altogether
- Replacing the 4 HSS Councils with a single statutory health and social care body

A Single Regional Authority

5.17. It is proposed to create a single Regional Authority, which would have a strong strategic planning and accountability focus. The Authority would carry out key functions such as workforce planning and the commissioning of some regional services, and would have overall responsibility for managing change.

5.18. Following the launch of *"Investing for Health"* in March 2002, the Department is also undertaking a review of the Public Health function. This will be conducted in parallel with, and will take account of, the Review of Public Administration. As many of the functions within Public Health are delivered within the HPSS, this will also have a bearing on any structural reform.

Have your say:

Your views would be welcome on whether or not there should be a single Regional Authority, on the constitution, functions and location of this body, and whether it should be part of the Department or outside it.

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Commissioning bodies

5.19. With the disappearance of the four Boards, commissioning would be a major function for individual LHSCGs to handle. In order to share the burden, enhance commissioning power and ensure that there is a consistent approach to commissioning, it is proposed that this role should be exercised by groups of LHSCGs working in partnership. There are a number of ways in which this could be done. A key determinant in setting their number and constitution would be whether they would also deliver a range of community health and social care services.

5.20. Consideration of the options for bringing LHSCGs together will be shaped by the views of the public, staff and other interested parties on whether it is still seen as important to maintain an organisational separation between commissioning and delivery. It will also be influenced by views on whether fully integrated health and social care delivery bodies are the preferred model, in the light of the perceived success or otherwise of the three main types of Trust configuration in operation since the early 1990s.

5.21. Depending on the weight given to these factors, new models for commissioning bodies could include:

- LHSCGs coming together as Commissioning Consortia or Partnerships, with delegated budgets from the regional body, to commission the full range of health and social care services in the light of the assessed needs of their local communities. In this model, given the focus on commissioning, three bodies might be regarded as sufficient for this purpose.

- LHSCGs coming together as fully integrated commissioning and delivery bodies, in which case there would be no further need for Trusts, since responsibility for the delivery of services would pass to these new bodies. Given their responsibility for delivering a wide range of hospital, primary and community health and social services, there would be a case for more than three bodies.

- LHSCGs coming together as Commissioning Consortia or Partnerships, but also with responsibility for the delivery of primary community health and social services, but not acute, services. In this model, there would continue to be a reduced number of acute-only Trusts. Given the range of service delivery responsibilities which these combined LHSCGs would have, there would be a case for more than three bodies.

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5.22. Under any of these models, LHSCGs could be constituted either as statutory bodies in their own right, or as operational units of the Regional body.

Options for New Structures: Commissioning[7]

- LHSCGs as commissioning bodies
- LHSCGs as commissioning and delivery bodies
- LGSCGs as commissioning and delivery bodies with the exception of acute services

Have your say:
Your views would be welcome on whether Boards should be abolished, and on the constitution, functions and number of Commissioning bodies.

Trusts

5.23. Depending on the preferred commissioning bodies option, there are a number of different possibilities for Trusts. As a minimum, there should be a significant reduction in the number of HSS Trusts. This should aid effective networking between organisations in the delivery of services, and ensure resources are focused on service users rather than administration. The options include:

- A number of fully integrated Trusts delivering the whole range of hospital, community health and social care services.
- A number of separate acute Trusts and community health and social care Trusts.
- A number of acute only Trusts, with the delivery of community health and social care services being the responsibility of commissioning bodies.
- A number of LHSCGs coming together as fully integrated commissioning and delivery organisations, as described above, which would remove the need for Trusts.

[7] *The Regional Authority may have some regional commissioning functions*

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Options for New Structures: Delivery

These include:
- Fully integrated Trusts
- Separate acute and community Trusts
- Acute only Trusts
- LHSCGs as integrated commissioning and delivery organisations with no Trusts

Have your say:
- **Your views would be welcome on the constitution, functions and number of Trusts, and on whether there should continue to be Trusts.**
- **Any other options for delivery organisations**

A Consumer Body

5.24. It is proposed to match the functions of the 4 HSS Councils with the new structural arrangements. Should there be a new single Regional Authority, we would propose to replace the 4 Councils with a single statutory health and social services consumer body. This should enable the body to reflect the new organisational arrangements in the health and social services, and strengthen the voice of the service user on cross-cutting strategic policy issues. The new body would perform an important role in monitoring the work of the Regional Authority. It would also streamline current arrangements in relation to commissioning research, opinion surveys, and publishing information.

5.25. At the same time, it would be essential to ensure that this body would be constituted to enable it to keep in touch with the views of the public on local issues. There may be a number of ways of achieving this.

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5.26. The new LHSCGs have community representation, and this will help to ensure that issues of concern to local communities will be addressed. Nevertheless, should there be single Regional Authority, a strong regional consumer body, in touch with local opinion on local issues, is also required.

Have your say:

- **Your views would be welcome on whether the four HSS Councils should be replaced by a single statutory health and social services consumer body, in the event of a single regional authority.**

- **Your views would be welcome on other ways of achieving consumer representation.**

Conclusion

5.27. It is important that the new structures being proposed will support the close working of all parts of the HPSS, and facilitate the essential linkages which are needed between health and social services and education, housing and other key public services.

5.28. The views of the public, staff and other interested bodies, together with the emerging principles/criteria from the Review of Public Administration, will be pivotal in determining the final shape of these new structures.

5.29. Following consideration of the responses to the proposals for structural change, further consultation will be required before decisions can be taken on final configurations.

Chapter 6: Equality

Equality Implications

6.1. Under the statutory Equality obligations (Section 75 of the Northern Ireland Act 1998), due regard must be given to promoting equality of opportunity for the nine statutory equality groups specified in the legislation.

6.2. A preliminary assessment has been carried out of whether the proposals have an adverse or negative impact on people in the nine groups. (A summary of the assessment is at Appendix 2.) This has involved examining travel times using the current configuration of 15 acute hospitals and comparing these to travel times under the 9 site configuration. This was calculated for three possible locations for the new hospital in the Fermanagh/Tyrone area (Enniskillen, Omagh and a green field site half-way between the two at Ederney). The different access times were calculated under three categories, to show the number of wards and the affected population where the difference in travel time either:

(i) decreased, stayed the same or increased by less than 5 minutes,

(ii) increased by between 5 and 30 minutes, or

(iii) increased by more than 30 minutes.

6.3. The composition of each category of wards was then analysed to determine if there were any differences for each equality group living in the three categories of wards.

6.4. Overall the nine site configuration would not appear to have a significant differential impact on the Section 75 equality groups, wherever the new hospital in the Fermanagh/Tyrone area is located. The measures proposed on decentralising services, and those for ameliorating the problems that people face in rural areas, will contribute to promoting equality of opportunity for people in the nine equality groups.

6.5. Everyone cannot live close to an acute hospital but, for people who are geographically isolated, steps can be taken to minimise any risk and ensure that they are not disadvantaged because of where they live.

6.6. Living in a rural area should not prevent people from receiving the high quality care that they need.

Equality

- Effect on travel times of 9 site configuration assessed
- No significant differential impact identified
- Decentralising services and measures for rural areas will promote equality of opportunity

Conclusion

6.7. The proposed 9 acute hospitals should ensure that the vast majority of the population can normally access high quality acute hospital services, including emergency care and maternity services, within 45 minutes and all of the population normally within one hour. Local Hospitals, delivering a range of outpatient, diagnostic, day procedure will network with these hospitals and with local primary and community care. There would not appear to be a significant differential impact on the Section 75 equality groups.

Have Your Say

This Chapter covers a range of important areas. We would like to hear your views on all of the issues raised.

Specific Equality Issues

Can you identify any equality impacts which might occur as a result of these proposals for any of the following groups of people?

- persons of different religious belief,
- persons of different political opinion,
- persons of different racial group,
- persons of different age,
- persons of different marital status,
- persons of different sexual orientation,
- men and women generally,
- persons with a disability and persons without,
- persons with dependants and persons without.

Are there likely to be any specific impacts in terms of tackling deprivation; for example, in relation to the New Targeting Social Need initiative?

Chapter 7: Resources and Timing

7.1. Funding is critical to the achievement of the vision of modern, high quality services. Resources are limited, and any approach to the development of services must be based on sound planning and careful use of funds. These issues have been carefully considered in the development of these proposals for hospital services which are designed to be implemented over a 9-year period. Bids will have to be made for the necessary resources as part of the normal funding processes.

Capital costs

7.2. To implement the proposals, around £1.2bn of capital at today's prices will be required, over a ten-year development period. The capital funding gap between the capital expected to be available over the period and what is required is estimated as £842m, at today's prices. In seeking to identify sources for the funding required no single solution – be it borrowing, Public Private Partnerships, (PPP) or more traditional public expenditure – is likely to meet our need, and a full range of funding options will be considered.

7.3. The detailed capital assumptions underpinning the Acute Hospitals Review are attached at Appendix 3. The proposals reflect the need for a phased, comprehensive programme of modernisation for the acute sector over the period to 2010/11.

7.4. The proposals recognise that the current pattern of hospital services is not 'fit for purpose', and is ill-equipped to provide the standards of acute hospital care which people are entitled to expect.

7.5. A key ingredient in shaping a modernisation agenda is the need to address vigorously the deficiencies in the infrastructure inherited from Direct Rule. These relate to:

- The failure to maintain the basic estate and equipment inventory;
- The failure to invest in new technology; and
- The cyclical need to replace much of the core acute hospital estate, much of which is 40 years old and older.

Revenue Costs

7.6. The AHRG report indicated that the continuing funding needed to provide the numbers of staff required, will, by 2012, be approximately £165m at today's prices.

Resources, (all at today's prices)

- £1.2bn capital required over 9-year development period
- £842m estimated funding gap
- £165m revenue costs by 2012

7.7. The Department's assessment of future staffing needs mirrors the AHRG view that current services are significantly under-staffed and that this directly impedes the improvements in quality and performance that the hospital service needs to achieve. Its estimate of the projected revenue costs associated with the necessary service developments is consistent with the AHRG figure. These estimates are based on the following:

- A 30% rise in the numbers of Consultant medical staff - this would address current deficiencies and make significant progress towards a consultant provided service, with a greatly reduced dependency on doctors in training to deliver care to service users.
- A 20% rise in the number of qualified nurses - this would address severe workload pressures relating to current nurse staffing levels and enable them to cope with the greater numbers of patients that will be cared for in a modern service. It would also support the increasingly specialised nature of nursing.
- A 25% increase in the number of qualified therapeutic staff - this would provide additional staff to address a growing need for services from speech and language therapists, occupational therapists, physiotherapists etc. These services, which are currently chronically under-staffed, are particularly important in supporting the trend towards shorter stays in hospitals and more community based support.
- The numbers of doctors undergoing GP training will have to be increased, to provide a 25% increase in numbers. This would allow GPs to take on more responsibility for treatments currently provided in hospitals.

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- Investment in other staff to support the increases in clinical staff identified above.

Staffing

- 30% increase in consultants
- 20% increase in nurses
- 25% increase in therapeutic staff
- 25% increase in GPs

7.8. These further increases, building on those already in the pipeline, will ensure that there are suitably qualified staff available, to bring services close to self sufficiency in trained staff by the end of the development period.

7.9. To achieve these increases, which are broadly in line with trends elsewhere, the number of people entering pre-registration training across a range of professions will have to be significantly increased.

7.10. There should be no difficulty in attracting students. There is currently a surplus of applicants for available training places. In nursing there are currently four applicants for every place.

7.11. There will be a short-term need to make up the numbers of trained staff, as there will be a time-lag before numbers completing training can be increased. Until the additional professionals are trained and available, the extra posts will be filled by a combination of initiatives. These will include:

- continuing the successful return to practice initiative within nursing and extending this to other health professionals groups;

- taking action to increase the proportion of graduates who are recruited into HPSS when they have completed training;

- developing the role of unqualified staff and enhancing the skills of this group by providing investment in training;

- continuing to draw on the world-wide market for certain professions including nursing and medicine; and

- encouraging more staff to stay on, through initiatives such as investment in professional development and flexible working practices.

7.12. Other initiatives, such as the new consultant contract and the proposals set out in *Agenda For Change,* will also assist in retaining staff within the HPSS.

7.13. A breakdown of projected costs is provided at Appendix 4. These estimates must, of necessity, be revisited in the context of the impact of other policy and service development initiatives, particularly within the community and social services. They will also be affected by service-wide developments, such as compliance with the EU Working Time Directive.

7.14. The arrangements for workforce planning are being strengthened at a regional level. This will provide a mechanism for updating and reviewing the investment required across all HPSS services on a regular basis, as the acute hospital review strategy rolls out over the next 10 years.

Performance

7.15. The hospital service has continued to review its performance, which has improved significantly in recent years. Over the past 10 years, the number of patients treated annually has increased by 38% and, over the same period, there has been a 32% reduction in the number of hospital beds.

7.16. With the changes proposed in the organisation of hospital services, and the provision of additional staff to deliver modern acute care, the performance of the acute sector is expected to further improve, even when account is taken of the predicted growth in the number of very elderly people.

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7.17. Once the new pattern of hospital services is established, it should:

- **Eliminate the problem of people waiting for admission** in all hospitals – with all patients transferred to a staffed bed as quickly as possible. All emergency cases will be admitted straight to a bed and no patients will wait more than two hours for admission post-assessment.

- **Bring waiting times for outpatient appointments down** to a maximum of three months, with urgent cases prioritised and seen much more quickly.

- **Reduce waiting times** for elective procedures to a maximum of 3 months.

- **Speed the flow of patients** through the hospital service and ensure that many more will avoid hospital admission altogether.

- **Eliminate delayed discharges** from hospital, with patients moving out of acute hospitals as soon as their acute treatment is successfully concluded.

- **Meet peaks in demand** by flexing available capacity without having to cancel procedures or delay normal work.

Timing

7.18. While the Executive is committed to providing extra resources for hospital services, the extent and speed of that investment will be determined by the Executive, taking full account of available resources and relative priorities across all of its responsibilities.

Conclusion

7.19. This substantial investment is the key to necessary changes. The investment will need to be spread over the next decade to progressively up-grade and improve facilities and to support new clinical practice. This scale of investment is crucial to developing a modern and effective hospital service. It should be seen in the context of a service that has a strong history of increasing productivity and making the best use of resources in the interest of patients.

Glossary of Terms

Access Time - estimated time taken by road to the nearest acute hospital based on average speeds on different classes of roads

Acute Services – health care and treatment provided normally in hospitals able to manage planned and emergency procedures

Acute Trusts – Health and Social Services Trusts which provide acute hospital care only

Clinical and Social Care Governance – a framework within which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding standards of care and treatment

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 a hospital

Community Trusts – Trusts which provide community health and social services but not acute hospital services

Consultant-Led Maternity Unit - a maternity in which a consultant is responsible for the clinical care of patients

Consultant-Led Services - services in which a consultant holds responsibility for the clinical management of patients

Day-Case Surgery - surgery which does not require an overnight stay in hospital

Deprivation Indices - indicators used to identify people, groups and areas in greatest social need

Differential Impact - where a particular group would be affected differently by the proposals

Elective Surgery - non-emergency surgery taking place in a hospital and planned in advance

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Enhanced Local Hospital - a Local Hospital which provides services additional to those normally available in Local Hospitals

Health and Personal Social Services (HPSS) - includes hospital services, community health services, personal social services and general medical services

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

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

Integrated Trusts - Trusts which provide both hospital and community health and social services

Local Health and Social Care Groups (LHSCGs) - groups of providers of local primary and community services - there will be 15 LHSCGs

Midwife-Led Maternity Unit - maternity units in which the clinical is led by a midwife

Primary Care - care provided by the primary care team, normally led by a general practitioner

Protected Elective Centre - a centre where the surgical treatment is elective only, emergency cases being cared for elsewhere

Providers - organisations which provide health and/or social services

Regional Services - specialist services which are provided from one or two hospital sites for people throughout the region

Section 75 Equality Groups - the groups of people specified in Section 75 of the Northern Ireland Act 1998, in respect of whom public authorities, in carrying out their functions, are required to have due regard to the need to promote equality of opportunity and to have regard to the desirability of promoting good relations

Special Agencies - organisations which provide a range of specialised services. There are 5 such agencies: Central Services Agency, Health Promotions Agency, Blood Transfusion Agency, Guardian Ad Litem Agency and the Regional Medical Physics Agency

Sustainability - the viability of a hospital having regard to its ability to treat sufficient numbers of patients to maintain the expert skill base of its clinical teams.

Independent Review of Health and Social Care Services in Northern Ireland

Professor John Appleby

August 2005

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Executive summary

Dear Minister

In late 2004, I was asked by the then Northern Ireland Finance Minister, Ian Pearson, with the support of the Health and Social Services Minister, Angela Smith to conduct a Review into the provision of Health & Social Care Services in Northern Ireland. The Terms of Reference for the Review set out in Annex A are broadly similar to those for previous studies carried out by Derek Wanless into the health & social care sector in Wales and the UK as a whole.

The main objective of the Review was to examine the likely future resource requirements of the health & social care sector in Northern Ireland. I was also asked to consider the scope for the resources devoted to health & social care to be used more effectively. A particular area of concern was the lack of progress on waiting times despite significant additional resources. This was linked to the apparent inability to track funding through the system .

The Review began in January 2005 with a series of meetings with patient and staff representatives as well as community and voluntary groups, and local political parties. Meetings were also held with senior managers and departmental officials. Overall, the Review has been in contact with around 100 individuals from over 40 organisations. In these meetings I was struck by the desire to provide the best possible care to the people of Northern Ireland, but concern that this was being hindered by weaknesses in the system. There was a real openness for reform which, although evident in some specific areas, was not being driven forward on a widespread basis. The general perception was that political instability and a lack of leadership throughout the system had created an unstable environment where it took too long for decisions to be made and which in turn were too easily obstructed from being implemented by narrow local concerns.

As part of the Review I commissioned a survey of a sample of the Northern Ireland's population's health status , whilst GPs and the Chief Executives of health & social care trusts were also surveyed to garner their views on the management of waiting lists. However, given the short amount of time in which the Review was to be completed we relied heavily on existing data sources and policy documents. External expertise was sought in certain areas and I am most grateful to the Informal Reference Group of health policy academics for their advice and comments on the progress of the Review.

The Review covered a lot of ground and drew on extensive data - reflected in the length of this report. Three areas were dominant, however: Funding, the use of resources and the performance management system and findings in these areas are summarised below together with a number of recommendations for your consideration.

Funding

In common with the rest of the UK, significant additional resources have been devoted to the provision of health & social care in Northern Ireland in recent years. However, the short-term and uncertain basis on which funds have often been allocated has hampered the strategic planning of services. Around three-fifths of the additional funding has been absorbed by increases in staff costs, reflecting the labour intensive nature of the sector, although most of this has been in higher wages and salaries rather than more frontline staff. Whilst it is estimated that around a quarter of the additional funds have been spent on service delivery improvements, looking forward, cost pressures (such funding required to implement Agenda for Change and the new GP and consultants' contracts) mean that a much smaller share of future funds will be available for service improvements.

Despite the concerns of Ministers, it has been possible to track the additional resources allocated to the health & social care sector in recent years from a range of perspectives. However, whilst the linkage between Budget bids agreed by Ministers and actual out-turn expenditure was relatively clear for hospital services, it was less obvious with respect to community and social services. Although DHSSPS have taken steps to ensure stricter adherence to funding decisions there is also a need for sufficient flexibility to allow service providers to respond to local needs where appropriate.

Recommendation 1: In the light of suggested future funding (see Recommendation 3), in-year monitoring additions to health and social care budgets should cease other than in exceptional circumstances and solely on a one-off basis (Section 2.2.2).

Recommendation 2 : Over and above the need to track spending for reasons of financial probity, the main performance policy monitoring focus should be on tracking outcomes, not spending per se. A programme budgeting approach - as currently being developed in England for 23 disease/service groups- in addition to traditional accounting would be of help with this (Section 2.2.3).

In terms of future funding, the trends determining resource requirements in Northern Ireland are expected to be similar to those in the rest of the UK. Although an ageing population is likely to increase the demand for resources, changes in public expectations and in particular technological developments will have an even greater impact. On the other hand, improvements in public health behaviour such as smoking and diet will tend to reduce requirements, whilst increases in productivity will allow more to be delivered for a given level of resources.

In order to quantify future resource requirements we adopted the most straightforward approach of estimating Northern Ireland's appropriate share of the expenditure projections for the UK as a whole set out by Derek Wanless. Northern Ireland is currently funded on the basis of its population share of increases in spend in England by the operation of the Barnett Formula. However, this simplistic mechanism does not take into account the differences in the need for health & social care expenditure between Northern Ireland and England.

There have been a number of models developed to inform the allocation of funds between and within UK countries on the basis of need. However, the main focus of this Review has been on the HM Treasury Needs Assessment Model (NAS), and the subsequent methodological revisions to this model suggested by the Northern Ireland Executive in 2002. The main revision was to increase the importance of deprivation in estimating the relative need for health & social care expenditure. The overall impact of these revisions is to increase the relative need for health & social care spend in Northern Ireland from 4% higher than England per head of population to 13% higher. The respective formulae for allocating funds *within* Northern Ireland and England were also adapted to allow a cross country need relativity to be calculated as a further comparison. Whilst the results tended towards those of the Northern Ireland Executive revised NAS model, they were highly sensitive to changes in the assumptions underlying key factors. In addition, the results from using the original Treasury model are consistent with the results of the survey of health status which is considered to be a better direct measure of the need for health expenditure than the proxy type variables used in the NAS model.

Having considered the evidence base for the revisions and taken expert advice I have come to the conclusion that whilst neither model is without fault, the weight of evidence is not yet sufficiently robust for the Northern Ireland Executive revisions to be accepted by HM Treasury as the final arbiter in this respect. The judgement of this Review (to be confirmed or denied in the light of any subsequent results arising from a UK-wide allocation model) is that a reasonable need differential between England and Northern Ireland should be around 7%. The expenditure projections for the Northern Ireland health & social care sector set out below, based on a 7% higher level of need, suggest that a significant increase in resources is required in the coming years, but with slower growth thereafter.

Table 1: Health And Social Care Spending Projections for Northern Ireland

	2002-03	2007-08	2012-13	2017-18	2022-23
Total NI Health & Social Care Spending (£ billion 2004-05 prices)					
Solid Progress	2.7	3.7	4.7	5.5	6.2
Slow Uptake	2.7	3.8	4.9	6.0	7.1
Fully Engaged	2.7	3.7	4.6	5.3	6.0
Average annual real growth in NI Health and Social Care spending (per cent)					
Solid Progress		6.8	4.6	3.1	2.7
Slow Uptake		7.0	5.4	4.0	3.5
Fully Engaged		6.8	4.3	2.8	2.4

A key issue, however, is whether the 7% greater level of health & social care spending should come from other spending areas within Northern Ireland (including efficiency improvements from within health and social care services) or from additional allocations from HM Treasury. Given that health & social care accounts for over 40% of Government spend in Northern Ireland and the likelihood is that other areas of spend in Northern Ireland will have a higher need for spend than in England, it will be unsustainable for the additional resources for health & social care to be entirely sourced from within Northern Ireland.

Recommendation 3: Adopt HMT NAS model-based Wanless 'fully engaged scenario' projections as set out in Table 1 for now as best reasonable guide to future spending in NI (Section 2.3.4).

Recommendation 4: Further work is needed to investigate the usefulness of employing direct measures of health status (for example, as derived from instruments such as the EQ-5D) in resource allocation models (Section 2.3.4).

Recommendation 5: Future work on pan-UK resource allocation model would provide a more empirically-based answer to relative shares of resources. Such work should be open, and draw on extensive experience in the area of resource allocation models of research groups across the UK (Section 2.3.4).

Recommendation 6: If the future spending path suggested by this Review is accepted, then there needs to be some way round the implications of the Barnett Formula for health and social care if the general principle of Barnett are to be maintained and other public services in Northern Ireland are not to suffer (Section 2.3.5).

Use of resources

In addition to extra funding, it is critical that the resources available to the health & social care sector are used as efficiently as possible. As there is no single measure available that would allow a comprehensive comparison of performance both within Northern Ireland and with other countries, the Review considered a range of efficiency and productivity indicators.

Overall, health status in Northern Ireland as measured by the EQ-5D survey was found to be slightly worse than in the rest of the UK - linked to poorer diets, heavy smoking, lack of exercise and other lifestyle and environmental causes. As a result, hospital activity tends to be higher than in England. However, there appeared to be a number of areas where health care utilisation was substantially higher than health status would suggest, such as accident and emergency attendances, which are almost a third higher than in England.

Recommendation 7: Routine collection of self-assessed health status data at population level would yield useful comparative data on population health status. In addition, the potential for routine collection of patient related outcome measures in health care services should be explored (Section 3.2).

Recommendation 8: On the basis of current lifestyle data, the funding recommendations based on the Wanless 'fully engaged' scenario imply considerable effort will be needed to engage the Northern Ireland population through expanded public health services and other means (Section 3.2).

Recommendation 9: Further investigation is required of very high A&E use to explore reasons and find ways for reducing likely inappropriate use (Section 3.3.1).

Recommendation10 : Detailed analysis is needed into hospital activity trends as part of a broader analysis of the dynamics of waiting times and lists (Section 3.3.1).

Recommendation 11: DHSSPS should develop a more coherent strategy towards partnership with private sector (Section 3.3.2).

The most obvious indication of poor performance has been the large number of people on waiting lists and waiting times for treatment compared with the rest of the UK. Whilst there has been some limited progress in terms of inpatient waits, there continues to be an upward trend in the number of people waiting for outpatient appointments.

The main focus of analysis was on the extent to which there is variation in performance between trusts and specialties. Whilst significant variation would reflect avoidable underperformance, it would also highlight the scope for improvement. It was found that the overall Northern Ireland waiting list is accounted for by a small number of trusts and specialties. There are also significant differences in performance over time, with some trusts able to reduce the number of long waiters whilst others have not.

One common approach to the problem has been to set targets (coupled with rewards and sanctions) for reductions in waiting lists and waiting times - a strategy which arguably has been the key factor in driving down waiting times in England over the last few years. However, in Northern Ireland while targets have been set, very few have been met, whilst the target setting process has been somewhat erratic with few apparent long-term goals and intermediate milestones, and noticeable gaps in target setting, such as outpatients. However, there are some good examples where trusts have tackled the problem of waiting often using examples from the Modernisation Agency. The critical role of Northern Ireland GP's in managing the initial flow of patients into hospitals needs to be considered in greater detail than that which has been possible for this Review,

From our survey of GPs one of the main perceptions for the lack of progress in this area is the lack of a consistent commitment throughout the health & social care system to reducing waiting times, as well as the lack of incentives or sanctions in order to drive the effort to meet the targets. Overall, the conclusion of this Review is that excessive waiting is not inevitable, nor an intractable problem given the level of financial inputs to the system. Solutions to the problem require a "whole systems" perspective, involving all parts of the health & social care system, and with consistent commitment to reductions from the highest levels of management.

In practice, tackling excessive waiting will involve most if not all of the following:

- Efficient use of key resources
- Weekly monitoring of lists by chief executives
- Continual validation of lists

- Treat-in-turn, together with consistent urgency prioritisation
- Clear bottlenecks (e.g. bed blocking, ringfence elective beds)
- Set targets coupled with incentives/sanctions (for individuals and organisations)
- Manage the entire patient pathway - from GP to outpatient to diagnostic services to waiting list to admission to discharge.
- Publish performance data (by hospital, specialty and clinical team).
- Reduce variations through patient choice
- Contain and if possible reduce, other demands on the hospital system - especially accident and emergency attendances and emergency admissions.

Whilst the recent announcement by Shaun Woodward to introduce the Second Offer Scheme is welcome given its success in Wales in reducing Inpatient and day case waiting times, it will be important that care is taken in terms of the detail of how this scheme is to be implemented. In particular, that the second offer treatments still represent value for money whilst the Tier 2 Outpatient Services should not simply be a vehicle to keep those still waiting for treatment to be completed off the formal waiting lists.

Recommendation 12: Adopt a multi-pronged long term strategy to reducing waiting times, including long term targets (with milestones) backed by strong incentives (Section 3.6.8).

Whilst excessive waits for treatment can be the result of high levels of demand (which in itself may reflect inefficiency in other parts of the system), the extent to which services are delivered effectively is a factor that too often has been ignored, with debate focusing on the amount of resources available. The Review considered a range of performance indicators on this matter. Whilst all have their weaknesses, collectively they present a broad indication of overall performance. Our main findings were:

- Hospital activity per member of staff is 19% **lower** than the UK average.
- Hospital activity per pound of health spend is 9% **lower** than the UK average
- Hospital activity per available bed is 26% **lower** than in England
- The unit cost of procedures is 9% **higher** in NI than England with day case unit costs 9% **lower** and elective inpatient unit costs 12.6% **higher**.
- There are significant variations in unit costs between trusts
- Day case rates are **higher** than the UK average and have risen significantly since 1990/91.
- Length of stay has remained broadly unchanged over the past five years.
- Average unit prescribing costs are nearly 30% **higher** in Northern Ireland than in England

Overall, the picture that emerges is one of fewer outputs achieved per given level of input than in England, although some aspects of poor performance are shared with Scotland and Wales. Whilst there are a number of potential explanations for this in addition to simple inefficiency (such as better quality of provision, maintaining hospitals in rural locations, and higher costs of delivering services in deprived areas) it still needs to be recognised that such performance differences represent additional costs on the system that could be used to increase activity and address problems such as waiting lists.

Recommendation 13: Investigate ways to reduce unit cost variations through incentive mechanisms such as tariff-based activity payment/budget setting systems (Section 3.7)

Recommendation 14: Further investigation is needed to explore possible of reasons for high unit costs at the Royal and Green Park Trusts (Section 3.7).

Recommendation 15: Investigate scope for further reductions in length of stay and avoidance of admission to hospital (Section 3.7)

Recommendation 16: Aim in medium term to use outcome-based productivity measures (Section 3.7).

Although the main focus of this Review has been on hospitals, this is not to diminish the vital role of family and social services. Although GP list sizes are smaller in Northern Ireland, the number of consultations per head of population is higher. There appears to be a lack of integration between GPs and the rest of the primary care sector which needs to be improved through a change in attitude on both sides. In addition, it is not clear that the new payments contract for GPs represents good value for money. In terms of prescriptions, despite implementing various initiatives to reduce the problem, Northern Ireland still has a significantly higher level of spend on prescription drugs per head of population than the rest of the UK. As with the rest of the health & social care sector this can be linked in part to the absence of sanctions to discourage poor performance.

Recommendation 17: An assessment should be carried out on the implementation of the GMS contract in Northern Ireland to examine whether the actual improvements in quality outweigh the cost. In light of the finding, the GMS contract should be revised as far as practicable (Section 3.4)

Recommendation 18: New mechanisms involving greater use of sanctions are needed to tackle high prescribing costs and to encourage greater use of generic drugs (Section 3.4).

Social services is the area of the health & social care system where provision in Northern Ireland is considered to be the furthest behind that in England. Whilst the available evidence suggests that this is not necessarily the case, Northern Ireland still appears to be many years behind in England in terms of achieving the policy aim of providing social services in a community rather than hospital environment wherever possible. In addition, despite having lower unit costs than in England, there appears to be scope for services to be delivered more efficiently. Independent/voluntary organisations, which rely on the public sector for funding, but are also in competition in providing services and for resources, highlighted a number of aspects where the relationship with Government could improve.

Recommendation 19: The integration of health & social services should be re-examined with an initial first stage being the implications of ring fencing of funding for social services from the acute sector. There should however be scope for financial sanctions when inefficiency in one part of

the system impacts negatively on another e.g. lack of social services provision causing delayed discharge from hospital (Section 3.5).

Recommendation 20: Contracting for services from independent/voluntary organisations should be reviewed to consider whether it can be placed on a more strategic basis (Section 3.5).

A key element in the efficient delivery of services is the recruitment, retention and motivation of staff. Whilst there was concern expressed about staff shortages, Northern Ireland does not appear to be deficient in terms of the number of health & social care staff compared to the rest of the UK. In addition, in common with the rest of the UK, labour productivity in the health & social care sector appears to have fallen since 1998/99. The main impetus to improve productivity in the UK as a whole has been the Agenda for Changes pay reforms as well as changes to consultants' and GP contracts. However, there is little evidence so far that this will have a significant impact on productivity despite the additional cost involved.

An additional issue in Northern Ireland has been the Government's policy on local pay flexibility for public sector workers given that most health & social care staff groups follow national pay settlements despite not being part of the respective pay review bodies. In assessing the case for maintaining the current position, the Review found that the public sector pay premium for health care workers was larger in Northern Ireland than the rest of the UK, whilst the cost of living is significantly lower, Long-term vacancies rates were also lower, as was reliance on international staff, whilst there appeared to be relatively little problem in terms of recruitment. Therefore, there is a case for the argument that the main reason for past and predicted labour shortages being an insufficient number of training places rather than the level of pay.

Recommendation 21: Further investigation is required of possible reasons for relatively low labour productivity (Section 3.8.3)

Recommendation 22: Health and social care workers in Northern Ireland should formally come under the remit of the relevant GB Pay Review Bodies: this will enable the Government's local pay policy to be implemented on an equal basis in Northern Ireland to the rest of the UK (Section 3.8.4).

Performance management

Finally, of critical importance is the effectiveness of performance management arrangements to drive the system forward to improve efficiency, effectiveness and responsiveness.

The impression I have gained over the course of this Review is of a system lacking urgency, of general drift, and a consequent frustration amongst many in the services - at all levels - with the relative lack of improvement in performance.

Current performance management arrangements lack appropriate performance structures, information and clear and effective incentives - rewards and sanctions - at

individual, local and Northern Ireland organisational levels to encourage innovation and change.

The Review of Public Administration's recommendations for reconfiguring health and social care organisations - in particular, the creation of around five Health and Personal Social Services agencies - in effect reinvent a pre-1990 English NHS model in which health authorities received weighted capitation allocations, planned services and directly managed (and set budgets for) the hospital providers in their area. However, despite acknowledging that there *'must be clear lines of accountability to the Department and the Minister for expenditure, quality and performance*', and while noting that performance management remains the remit of the Department, it is not clear in this model how performance improvements are actually to be achieved. In particular, it remains to be seen how providers are to be held to account for their performance. While 'partnership and integration' can generate good things for patients and users, there is a distinct danger that the performance model implied by the RPA's structural reform could fail to provide the necessary incentives and sanctions - or 'bite' - to encourage providers of services to continually seek out new ways to improve their performance.

Overall, from the point of view of performance management, it is hard to see any difference between the RPA's recommendations and the way the current system operates.

In contrast, this Review would suggest that some form of separation between the providers of services and the funders/commissioners of services would be an important factor in sharpening up incentives in the system. Given the particular circumstances in Northern Ireland, its population size and distribution, the political governance structures etc, there needs to be further investigation of the most appropriate form of separation, however. While the four health boards have, in theory, acted as commissioner/purchasers, it is not clear that the full benefits of this arrangement have been achieved. It may be that a single pan-Northern Ireland commissioner would be more appropriate. This arrangement would not preclude some devolution of commissioning to GPs (see below). A crucial aspect of such arrangements however is the design of the rules of engagement and the framework in which commissioners are required to operate. In particular, commissioners would need clear objectives/targets in order to drive performance through their commissioning decisions. The regional level performance management system therefore needs to be reformed to take on serious, long term target setting

Moreover, the performance management system needs to be reformed to take on serious, long term target setting coupled with rewards and sanctions at organisational and individual levels and greater devolution to providers. In turn, providers themselves need to consider how to devolve functions within their organisations, in particular, ways in which to engage frontline staff with the incentives faced by the organisation as a whole - through, for example, devolution of budgets and associated responsibilities.

The nature of the rewards and sanctions need careful thought. The competitive economic environment - at least as it is currently being developed in England - is unlikely to be appropriate in Northern Ireland. However, this does not rule out, for example, the introduction of an activity-based prospective reimbursement system for providers (similar to Payment by Results) with tariff setting (not necessarily fixed at

average costs) used to drive improvements in efficiency and selective increases in activity to meet pan-service goals. Nor does it rule out the promotion of greater public and patient awareness of variations in performance in the system. The recent Ministerial initiative on waiting lists is a welcome first step in this direction although implementation will be key.

Further, it does not rule out careful expansion of patient choice. While in England choice is being rolled out mainly with a policy emphasis on the leverage it may have over providers (crudely, losing business will stimulate cost and quality improvements), from the patient's point of view, a more formalised and embedded process of choice (not just of hospital, but over the myriad of decisions that are taken throughout the system which affect a patient's care) can improve patient satisfaction and service responsiveness. This may be a weaker incentive than that being introduced in England, but the limits to what could realistically be offered by way of choice need to be recognised in what is a relatively small system. Nevertheless, there may be certain services, specialties, operations etc where options do exist for real patient choice and where patients would like to exercise greater choice.

In addition, and despite the previous rejection of GP fundholding, ways of both strengthening the involvement of general practitioners in the system and as part of a devolution strategy for commissioning secondary care services, thought should be given to the practical involvement of GPs in the purchasing of care. Again, Northern Ireland has an opportunity to develop its own approach to this form of devolved commissioning.

Finally, no system relies on just one or two performance levers. In England, for example, the new payment system and (managed) patient choice are going to run alongside continued use of targets (renamed 'standards') and, importantly, an evolving regulatory system at arms length from government which aims to promote the ultimate goals of the system - better quality of care, more efficient and cost effective use of resources. NICE, the National Patients Safety Agency, the Healthcare Commission etc, are important organisations which aim to promote better care. Much of these organisations' work and output are public goods available for any system to use and from which Northern Ireland could benefit and could inform development of the new HPSS Regulation and Improvement Authority.

Recommendation 23: There is a need to develop an explicit performance management system with rewards and sanctions which provide enough 'bite' to encourage change and innovation in the health and social care system. There are many options for the types of incentives that could be introduced and their design for Northern Ireland. There should however be a commitment to such reform coupled with further investigation of how incentives can be strengthened (Section 4.3).

Recommendation 24: Separation of the tasks of service provision and commissioning is an important factor in sharpening incentives. However, the most appropriate structures (e.g. single pan-NI commissioner; devolved GP commissioning etc) needs further investigation (Section 4.3).

Recommendation 25: Alongside changes in the performance management system, there is a need to explore the development of a more transparent priority setting process at national level, together with an explicit 'NHS Plan for Northern Ireland' which sets out outcome-based targets linked to new spending paths (Section 4.3).

In conclusion, although the Northern Ireland health & social care sector does not appear to have been significantly under-resourced up until now, looking forward it will come under increasing pressure to replicate the improvements in health outcomes envisaged for the UK by Sir Derek Wanless - but without a significant increase in funding. Notwithstanding this, however, it is clear that a significant underlying reason for current problems with the Northern Ireland health & social care sector relate to the use of resources rather than the amount of resources available. There is considerable scope for improvement in the provision of services conditional on appropriate incentive structures being in place that focus on improving health outcomes, whilst recognising that more efficient delivery means more resources available for service improvements. Although the timeframe for the Review has meant that certain aspects such as capital investment have not been covered and others have not been considered in the detail that I would have preferred, I hope that this Report will set a more realistic context in which the future strategic direction of the Northern Ireland health & social care sector can be set.

Professor John Appleby
July 2005

1: Introduction

1.1 Background to this Review

This Review was commissioned in late 2004, by the then Northern Ireland Finance Minister, Ian Pearson, with the support of the Health and Social Services Minister, Angela Smith. The background to this Review was two-fold. First, a growing feeling that despite many years of significantly higher per capita health and social care spending than, in particular, England, Northern Ireland was not enjoying the levels of outputs and outcomes that might be expected even allowing for a greater level of need. Secondly, over the last few years a number of wide-ranging reviews have taken place in other parts of the UK, starting with the first Wanless Review of future funding for health care across the UK, and followed by a second Wanless Review investigating ways to improve the public's health. Further efficiency and organisational reviews have also been conducted in Wales (again, under the auspices of Sir Derek Wanless), and now, most recently, in Scotland - the Kerr Review.

While somewhat different in nature, each of these reviews has attempted to tackle some similar issues, not least, how to ensure that the scarce resources society agrees to make available to health and social care services generates the best outcomes for patients and other users.

This Review most closely resembles that carried out in Wales - where similar concerns were felt about the ability of the system to deliver given its financial inputs. Apart from tackling this efficiency question, this Review has also examined what the future might look like with respect to the level of funding that should be made available for health and social care services.

Over the next few years, across the UK, spending on health and social care will absorb one pound in every ten in the entire economy, taking the UK into the upper half of the spending league in comparison to similar countries. And as a public service, funded from taxation, where every extra pound spent on health and social care is a pound not spent on other public services, there is therefore a growing need (if not an absolute requirement) to explore how funds are used and whether there are better ways to achieve the goals set for health and social care services.

1.2 Terms of Reference[1]

The overall aim of the Review is to look at the resourcing of health and social services and to consider how reforms leading to targeted and sustainable investment, effective and efficient delivery structures and appropriate incentive systems can result in improved service delivery. The specific objectives of the Review are based on those previously undertaken in Wales and at the UK-wide level. The Review will need to consider and make recommendations in the following areas:

[1] See Annex A

1. the current position in levels of demand in relation to the levels of funding available;
2. the demands of the population for health and social services in NI, taking account of its distinctive characteristics, in terms of long term and sustainable resourcing;
3. technological, demographic, medical and other trends over the next two decades that may have implications for the future resource needs of the HPSS sector in NI consistent, where possible, with the approach adopted in the Wanless Review;
4. the extent to which resources are being used effectively and efficiently and, if there is evidence of sub-optimal resource utilisation, the issues which are impairing the most efficient and effective use of resources;
5. the scope for a more effective use of resources (human, revenue and capital) to bring about a significant improvement in access to, and quality of, services in the HPSS and specifically the optimum balance between prevention, community-based care and acute hospital care;
6. ways in which the interactions between the health and social care systems can be improved to maximise performance and the use of resources
7. the effectiveness of the organisational and incentive structures, decision-making and accountability processes in health and social care in NI;
8. further measures to improve health and well-being which can reduce the demand for health and social services.

1.3 Methodology

The Review will need to consider the present distribution of resources and the outcomes achieved for the level of spend. Performance measures and indicators will be an important part of the issues to be taken into consideration, and the establishment of incentives to encourage best practice. The Review will take evidence from key stakeholders with a focus on gathering evidence of best practice and what works.

1.4 Structure of report

Section 2 of this report examines historic and current funding levels in Northern Ireland, tracks current spending from various perspectives and, importantly, adapts the approach and results employed by the first Wanless Review of future funding in the UK to suggest possible spending paths for health and social care services in Northern Ireland.

Section 3 then provides more in-depth analysis broadly bearing on the question of the efficiency with which services are currently delivered in Northern Ireland. This section focuses on the level of use of and activity provided by health and social care services, waiting lists and times, efficiency of provision and issues concerning workforce and pay.

Section 4 examines the current performance management arrangements in Northern Ireland, and suggests how these might be strengthened in order to improve performance.

1.5 Acknowledgements

This Review would not have been possible without important contributions from many people. In particular, I would like to thank the Chief Economic Adviser of the Northern Ireland Civil Service, Michael Brennan and his team for their analytical support and Sarah Benton for secretarial support to the Review.

Support also came from the DHSSPS in providing data, analysis and answers to our questions. In particular I would like to thank Denis McMahon - our main link with the DHSSPS, Clive Gowdy and Paul Simpson and their staff, with Michael McKibbin in particular providing valuable assistance on the survey work.

In the course of this Review we consulted as widely as we could with managers, doctors, nurses, allied health professionals and, not least, patients groups, in our attempt to get behind the often rather dry descriptive statistics. A full list of those we talked to is included in Annex B.

Finally, I would like to acknowledge the hard work and commitment of Paul Montgomery (assigned full time to the Review from the Department of Finance and Personnel) and for his tremendous support in carrying through the Review to its conclusion.

2: Funding: Now and for the future

2.1 Introduction

Levels of funding, both now and in the future, are of critical importance and serve to set the overall boundaries or constraints of what is possible in terms of the services and care that can be delivered. This first section therefore examines historic and current funding levels in Northern Ireland, tracks current spending from various perspectives and importantly, adapts the approach and results employed by the first Wanless Review of future funding in the UK to suggest possible spending paths for health and social care services in Northern Ireland.

Section Conclusions

This section of the report has examined the main factors expected to impact on the level of resources required in the Northern Ireland health & social care sector in the coming years. Although there are some variations, these factors broadly reflect international trends. The demand for health care is expected to increase with the expectations of patients and the general public for a high quality, responsive, patient centred service. In terms of supply, technological developments will raise costs.

To quantify future resource requirements, Northern Ireland's need adjusted share of the UK expenditure projections from the Wanless Review was estimated. A range of need factors were considered from the HM Treasury position of no adjustment for need to an optimistic needs adjustment suggested by DHSSPS. Whilst the current HM Treasury approach using the Barnett Formula is sub optimal - because the differing needs of the population in Northern Ireland are not recognised - the changes made to the needs assessment (NAS) model as part of the 2002 Needs and Effectiveness Evaluation could not be endorsed by the Review at this time as the supporting evidence required further development. Given this, the judgement of this Review (to be confirmed or denied in the light of any subsequent results arising from a UK-wide allocation model) is that a reasonable need differential between England and Northern Ireland should be around 7%.

This implies that additional real resources of between £3.3bn and £4.4bn will be required in the coming years to deliver a high quality service. The delivery of such a service is dependent not only additional resources but also how services are delivered. The level of public engagement and health seeking behaviour will also determine whether the resources required will be at the lower end of the range. In terms of immediate Northern Ireland Budget priorities, whilst the preferred need indicator would imply that the health & social care sector in Northern Ireland is currently over-provided relative to England, this does not mean that the health and social care services should receive anything less than its Barnet consequential. However, and as this review explores later, there is a concomitant commitment on the part of the health and social care services to explore ways in which current resources are used more effectively and efficiently to maximise the attainment of key goals for the benefit of patients, clients and users.

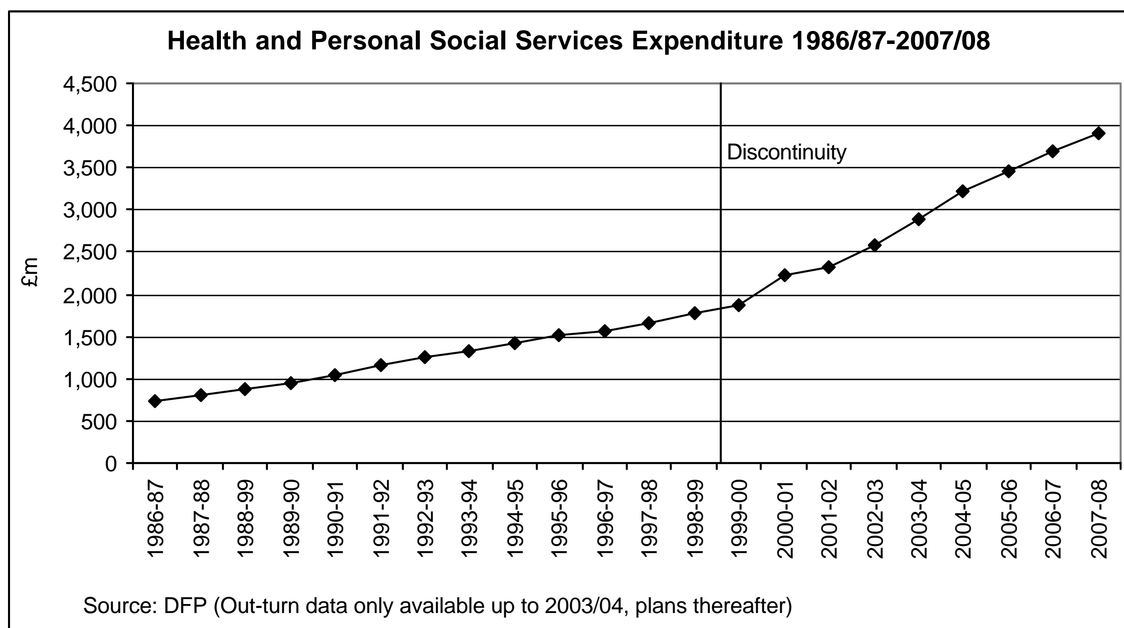
2.2 Historic trends in funding

To set some context for possible future spending on health and social care in Northern Ireland here we describe current and historic funding levels, making comparisons where possible with other regions and countries, outlining the global budget setting process for Northern Ireland, and analysing how recent increases in funding have been spent.

2.2.1 Funding levels

Figure 2.1 shows that the funding available for health and personal social services (HPSS) has increased significantly over the past twenty years. In addition, whilst comparison are made more complicated by changes in accounting practices there does appear to have been an increase in the growth rate of HPSS spend subsequent to 1999/00 which is expected to continue under current Government spending plans.

Figure 2.1: Health and Personal Social Services expenditure is expected to have increased by 8.4% a year on average over the twenty years since 1986-87 [2]

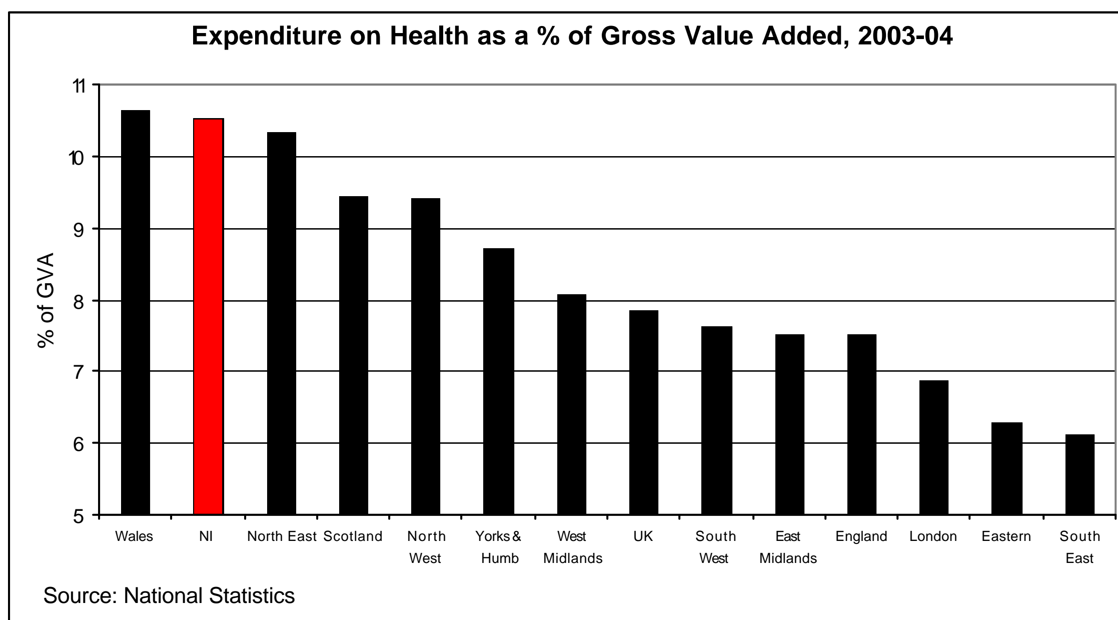


Comparing levels of health and social services expenditure between countries or regions is not an exact science; definitions of care vary and the way spending is accounted for can also differ. Further, it is unwise to assume that higher spending necessarily means better health outcomes or greater activity. And similarly, it should not be assumed that all spending differences are unjustified; differences in the need for health and social care and the efficiency with which different systems convert financial inputs into health care outputs and health outcomes often provide legitimate reasons for differences in levels of spending .

[2] Changes in accounting practices particularly in 2000/01 with the move from cash to accruals means that comparisons in spending over time need to be treated with care whilst the transfer of Preserved Rights and Residential Care Allowances from DSD resulted in a significant one-off uplift. Therefore the Figure is intended to be illustrative only.

Bearing these caveats in mind, there are a number of ways in which relative levels of expenditure on health and social care can be considered. The 2001 Interim Wanless Report presented health expenditure in the context of overall economic activity. On this basis, figure 2.2 shows health spend (excluding social care) as a proportion of Gross Value Added (GVA)[3] for the UK regions.

Figure 2.2: 11% of the value of all economic activity in Northern Ireland is devoted to health care (health excluding social care spending a percentage of GVA for UK regions, 2003-04)



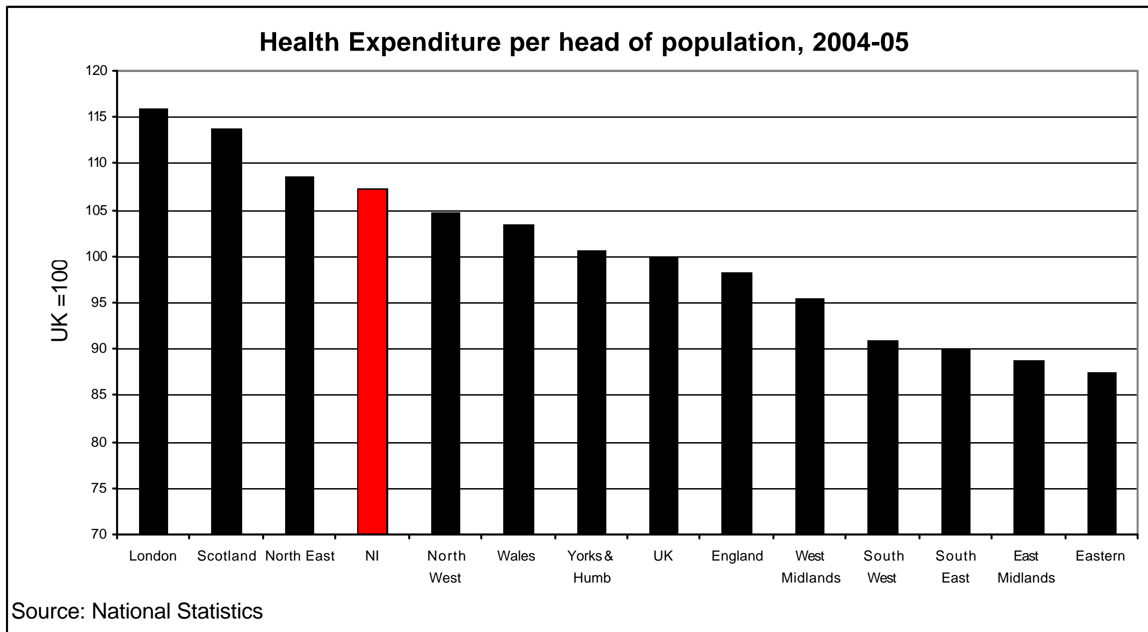
Although on this basis Northern Ireland has the second highest level of health spend, this is more a reflection of the region's relatively low level of GVA per head than its health spend[4].

A better measure of the relative level of health spend is on a per head basis - as shown in figure 2.3. Figures for 2004/5 show that Northern Ireland had the fourth highest level of spend per head on health of all the UK regions, and spending was 7.3% higher than the UK average. The general pattern revealed in the figure is to a large extent to be expected; per capita funding allocations in England, for example, are specifically designed to be unequal, being driven by the need health care as part of a general policy to improve equity of access to the NHS.

[3] Gross Value Added is the current preferred measure of economic activity for UK regions replacing Gross Domestic Product

[4] Around three-quarters of the difference in health spend as a % of GVA between NI and the UK as a whole can be accounted for by NI's lower level of GVA per head.

Figure 2.3: Northern Ireland spends 7% more per head of population on health care services (excluding social services) than the UK average(2004-05 (UK =100))

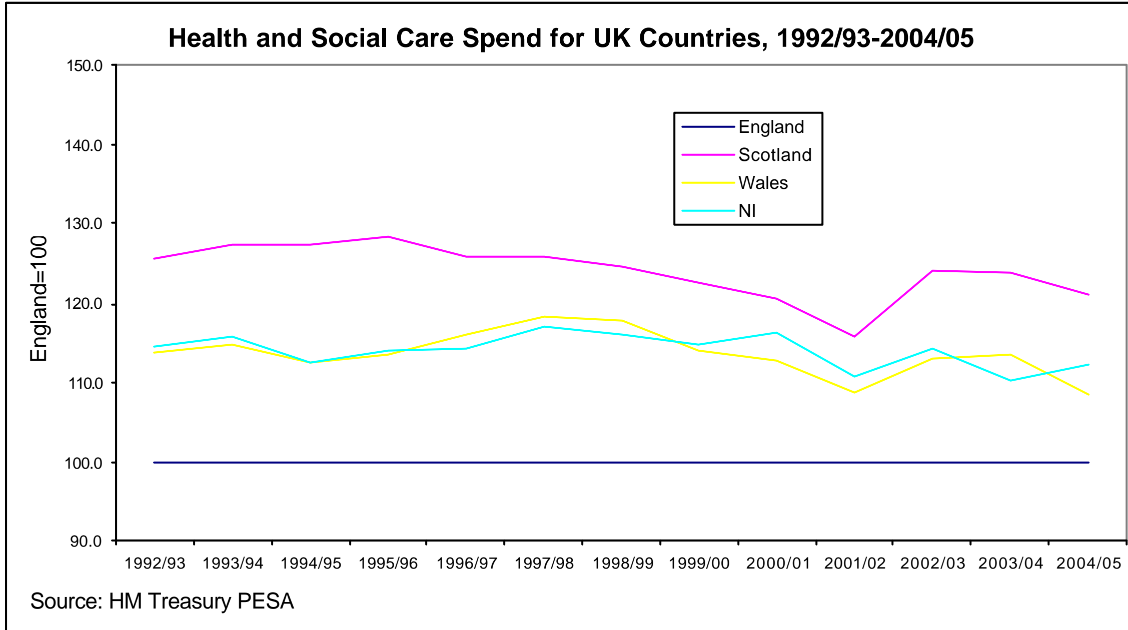


It is important to note, however, that there is no resource allocation mechanism across the whole of the UK; while differences in need may explain some or indeed all of the differences in per capita spend between Northern Ireland and the rest of the UK, this should not be assumed to be the case.

During the 1990's, per capita health and social care spending in Northern Ireland was consistently higher than in England (although lower than Scotland) in spite of the operation of the Barnett Formula[5](after the former Chief Secretary to the Treasury, Joel Barnett, who, in the 1970s, proposed it as a short term solution to Cabinet disputes over spending). However, in more recent years, the spend per head gap with England has narrowed (see figure 2.4). In the context of this trend continuing, it is important to have clarity as to the extent to which the need for health expenditure in Northern Ireland is higher than in England. This issue is addressed in Section 2.3.4

[5] The Barnett formula (discussed below) operates by allocating Scotland, Wales and NI its population share of growth in expenditure in England and as such is expected to lead to asymptotic convergence in spend per head levels between the UK countries. There are other minor adjustments to take account of the fact that some services are delivered on a UK wide basis and it would not be appropriate for the devolved administrations to receive a share whilst there is a VAT abatement factor applied specifically to Northern Ireland

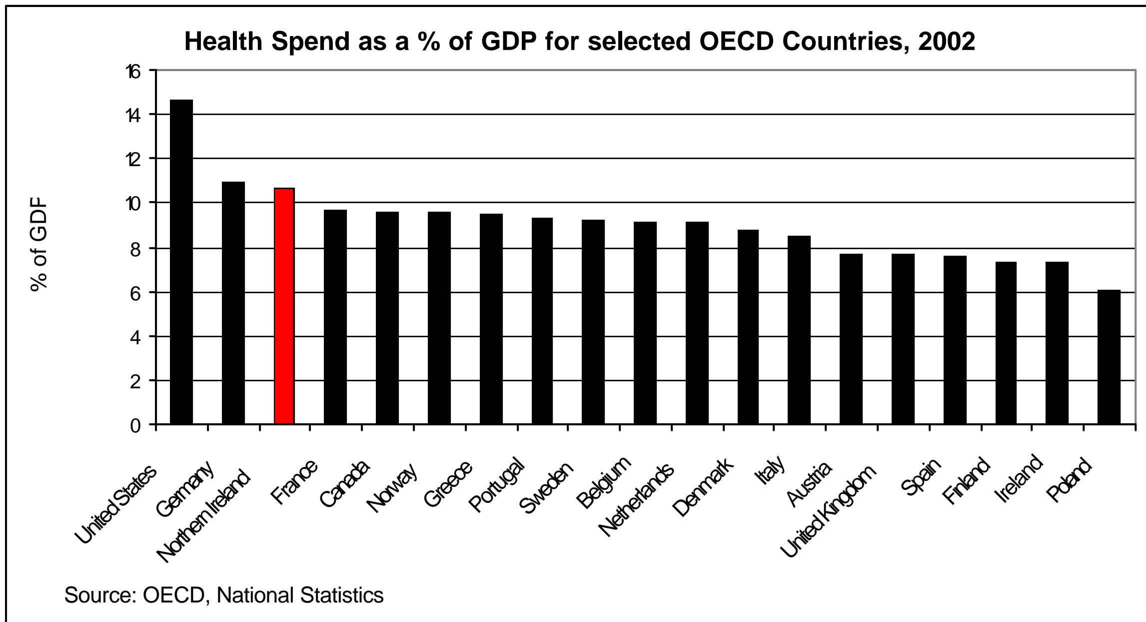
Figure 2.4: There has been some marginal convergence in the level of Health and Social Care spend per head for UK countries since 1992-93



Source: HM Treasury PESA

Internationally, figure 2.5 shows that expenditure on health care in Northern Ireland as a proportion of GDP is higher than all OECD countries with the exception of Germany and the United States.

Figure 2.5: Northern Ireland has a relatively high level of Health (excluding social care) Spend as a percentage of GDP compared to selected OECD countries ($PPP basis), 2002



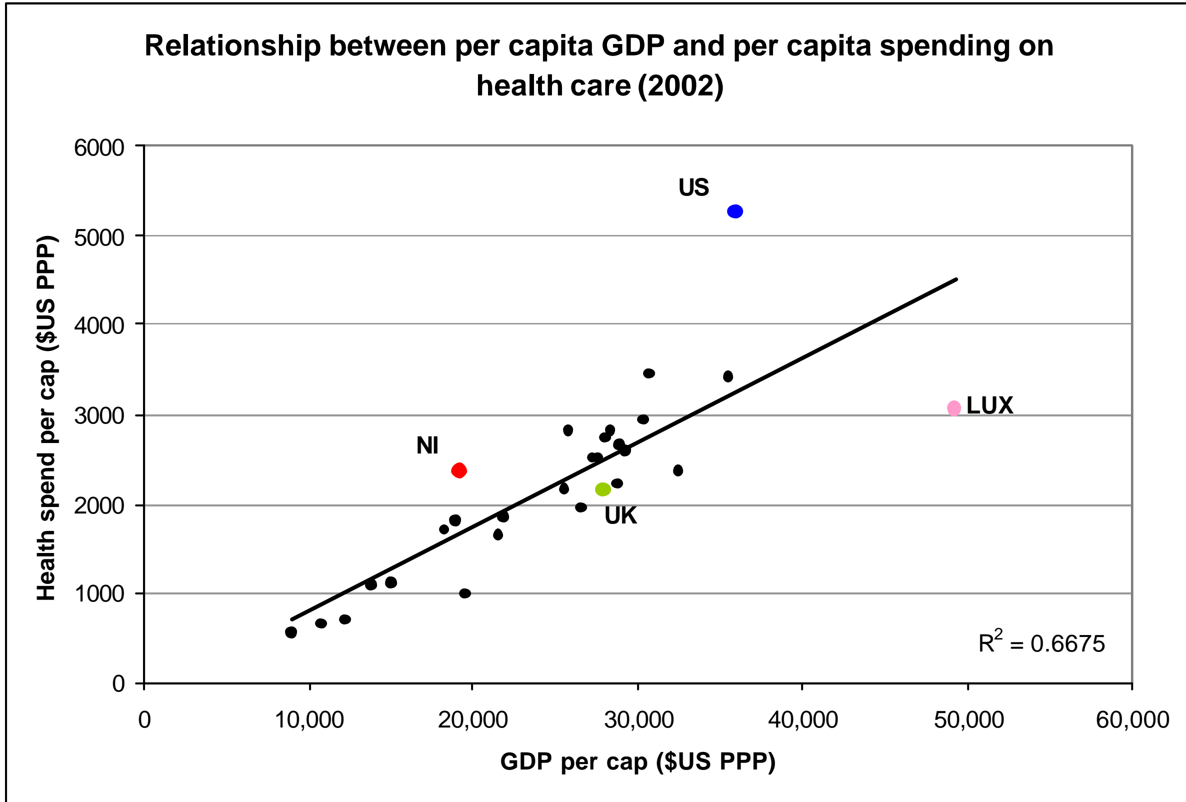
Source: OECD, National Statistics

However, as with spend as a proportion of GVA, the relatively high spend as a proportion of GDP is in part explained by the fact that Northern Ireland's per capita GDP is comparatively low. As figure 2.6 shows, Northern Ireland appears to spend more than might be expected given its per capita GDP. In fact, from this point of view, Northern Ireland appears to be spending nearly 30% more than expected. For

comparison, the UK as a whole is spending around 16% less than expected and the US 38% more.

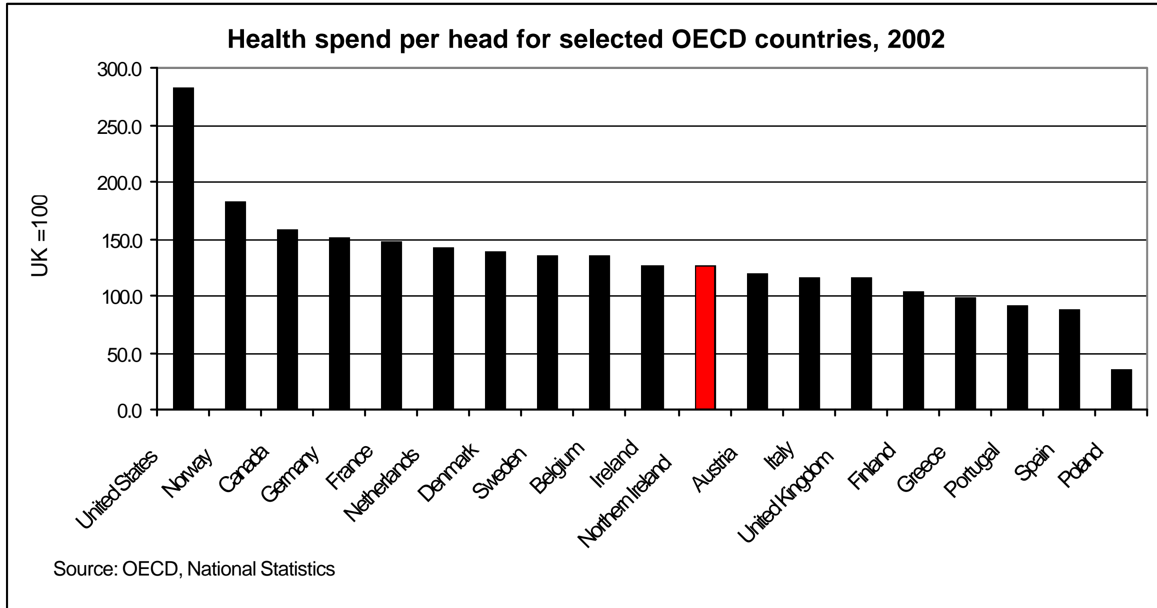
But this apparent position of overspending relative to its GDP is, as already noted, partly explained by Northern Ireland's relatively low level of GDP. In looking forward to what might be a reasonable and, in particular, an *affordable* level of spending we note in section 2.3.4 that international comparisons based on GDP are, for various reasons, problematic when considering Northern Ireland's position.

Figure 2.6: Northern Ireland appears to spend more on health (excluding social care) care than might be expected given its per capita GDP



The difficulty of using health spend as a share of national or regional wealth is highlighted when comparing Northern Ireland's spending on a per capita basis. As figure 2.7 shows, from this perspective, Northern Ireland slips down the international spending league table.

Figure 2.7: Health (excluding social care) spend per head for selected OECD countries ($PPP basis), 2002



Overall, while Northern Ireland currently has a higher level of health expenditure than most UK regions, in an international context, spending - in particular, per capita spending - is not particularly high

2.2.2 Setting global and local health and social care budgets

Since 1998, the Spending Review - announced bi-annually for public spending commitments three years forward[6] - has set the starting position for determining health and social care spend in Northern Ireland. With regard to the devolved territories, and health and social care spending in Northern Ireland in particular, the Spending Review produced by HM Treasury sets out spending in England, which forms the basis for a specific health and social care allocation through the operation of the Barnett formula.

The 'formula' is not sophisticated; it does not reflect differential health and social care needs or variations in the costs of providing services. In essence it uses the shares of total population to set the *change* in spending (not the total amounts) on certain public services in Scotland, Wales and Northern Ireland to ensure that decisions on spending (primarily in England) are reflected in other parts of the UK.

Currently, for example, a 10% increase in NHS spending in England would - via the formula - translate into an 8.9% increase in the equivalent allocation (from general taxation across the UK) for Northern Ireland[7]. Over the coming years, if the use of the Barnett Formula were to continue, this would suggest that spending increases will converge.

[6] The exception to this was the 5 year commitment to health spending set out by the Chancellor in the Spring of 2002 which was applied to England but not the rest of the UK. In practice DHSSPS have only been able to plan on a one-year basis.
[7] Based on the 12.2% higher level of HPSS spend in Northern Ireland than England in 2001-02

In practice, however, the actual health and social care services spend in Northern Ireland has been supplemented. Firstly, from decisions concerning the annual Northern Ireland Budget, which determines the shares of spending across all public services in Northern Ireland. And secondly, from in-year allocations (and occasionally subtractions (reduced requirements)) from (to) other budgets as a result of in-year monitoring of the state of budgets across the public sector. These latter sources of funding can be substantial, and have, between 2000/1 and 2003/4, accounted for a third of the total increase in Northern Ireland's spending on health and social care services (see Box 2.1)[8]

> **Recommendation 1: In the light of suggested future funding (see Recommendation 3), in-year monitoring additions to health and social care budgets should cease other than in exceptional circumstances and solely on a one-off basis.**

2.2.3 Tracking spending

Tracking funding from these different sources can be difficult, but it is vital not only to understand in accounting or financial probity terms where and on what budgets were spent, but also to provide policy makers and the public with information which connects up the tax-spend-outputs cycle and to monitor spending associated with policy commitments: in other words, how are the financial inputs connected to the health and social care outputs?

This section of the Review, therefore, attempts a broad audit of recent years' health and social care spending.

Total health and social care spending can be analysed from a number of points of view. Below we examine spending on the basis of:

- Global spending trends in HSPSS capital and revenue
- Cost pressures (for example, pay inflation)
- Trends by sector (such as hospital and community health services)
- Organisation
- Programme of Care (POC) - such as acute and mental health
- Hospital, social and community care
- Labour inputs - health and social care staff expenditure

[8] The DFP view is that In-year monitoring is to cater for unforeseen pressures – not an opportunity to bid for resources not obtained in the previous budget, although this is often the case.

Box 2.1: Sources of funding for health and social care services

The Northern Ireland Priorities and Budget process is an annual budget process which allocates the resources to central government departments and public bodies in Northern Ireland in line with local priorities and needs. Departments submit bids for additional resources detailing the specific purposes for which they are intended which are then analysed and prioritised by DFP. Recommendations on the level of funding, and the purposes for which it is intended, are submitted to the Finance Minister for consideration and discussion with ministerial colleagues. Following public consultation and further ministerial discussions and agreement, the Secretary of State approves the final Priorities and Budget outcome.

Departmental budgets are agreed by the Secretary of State at Unit of Service level (see Figure 2.11) and a detailed control annex listing specific allocations at Unit of Business level is notified to each department (neither of these are aligned with Programmes of Care). While departments have always been expected to adhere to the allocation detail included within the control annexes or to discuss any proposed reprioritisations with DFP, there is some concern that in some material cases, this was not happening. As a result, this year, for the first time, Settlement Letters have been issued to departments (with the associated control annexes), emphasising that departments must consult with DFP before using resources specified for particular purposes (as noted in the control annexes) for any other purpose. As regards HPSS spend, this is intended to provide an assurance that the wishes of Ministers are being respected.

Allocations to Boards represent the bulk of the HPSS budget and are distributed according to a capitation formula taking account of issues such as age, sex, poverty, sparsity of population etc. While DHSSPS ring-fence certain allocations prior to applying the capitation formula, Boards, in discussion with Trusts, determine how each share is allocated to meet the needs of local populations. The other significant element of the HPSS budget relates to the funding of Family Health Services which, on the whole, operates on the same basis as in England. The remainder is accounted for by an array of centrally managed programmes for example medical/dental education and training.

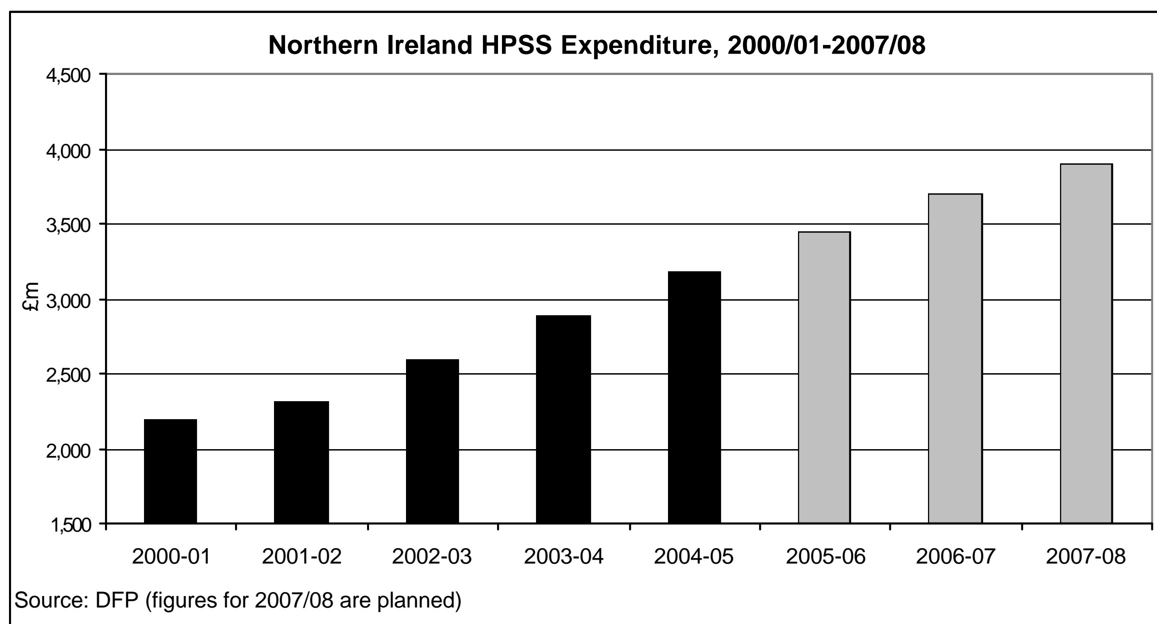
While the DHSSPS allocation is agreed by the Secretary of State at Unit of Service (and implicitly at Unit of Business) level, other than where certain allocations are ring-fenced, most of the allocations to Boards are made on a bulk capitation basis. Therefore, although the Department establishes PSA targets that are subsequently linked to the HPSS PfA, Boards' business plans, and Trusts' Delivery Plans, it has proved very difficult for DFP to track whether specific budget allocations have been used for the purposes intended.

Global spending trends

Expenditure data taken from the final out-turn Budget position held by the Department of Finance and Personnel[9] shows that between 2000-01[10] and 2004-05, health and personal social services expenditure increased by £981m or 9.5% per annum on average (figure 2.8). Over the next three years the pace of growth is planned to slacken to around 6.7% per annum, although this still represents an additional £700m of resources between 2004/5 and 2007/8 at a time when total planned allocations will increase by only 5.1% per annum.

[9] All data is final out-turn except for 2004-2005 where only February monitoring is available, consequently the expenditure for the current year may change between final expenditure as currently planned and the outcome as reported after the financial year has ended. Any changes should however be minimal and the data reported here should be broadly accurate.
[10] This data has been prepared from the final out-turn Budget position and exclude non-budget items and PSS accruals.

Figure 2.8: Northern Ireland HPSS spending has increased by nearly 10% per year in cash terms since 2000/1, but planned increases to 2007/8 will be around 7% per annum.



Cost pressures

Every year, a significant proportion of the cash allocated to HPSS is swallowed up by higher costs arising from increases in prices and pay. Here we examine these and other cost pressures over recent years and expectations for years up to 2007/8.

Figure 2.9 shows that almost half of the health and personal social services Budget allocation in Northern Ireland is, as expected for a labour intensive industry, spent on pay. The next largest share is on medical supplies, catering & cleaning which also includes hospital drugs, residential home costs, domiciliary care and foster care allowances.

Between 2001/02 and 2003/04 approximately a quarter of the additional funds allocated to HPSS were made available for additional services with around three quarters required for pay and price uplifts[11]. However, allocations from the Northern Ireland Budgets for 2002 onwards, imply that only 5.8% of the growth in spending between 2004/05 and 2007/08 is likely to go towards service developments

Most of the cost pressures relate to inflationary uplifts for pay and prices - as shown in figure 2.10. New contracts and staff reviews are also expected to increase HPSS expenditure between 2003/04 and 2007/08 by around £134m with £62m attributable to the implementation of Agenda for Change, £41.4m for the new GMS contract and £14.5m for the new consultants' contract[12].

[11] There is some disagreement between DHSSPS and DFP on this matter with DHSSPS arguing that only 14% of funds were available for service developments.
[12] Collectively pay reforms are expected to increase HPSS staff costs by 7.2% (i.e. £92.5m/£1,283m.) in addition to the general pay uplift for performance and cost of living

Figure 2.9 Pay is the largest single item of the Health and Personal Social Services Budget allocation, 2003/04

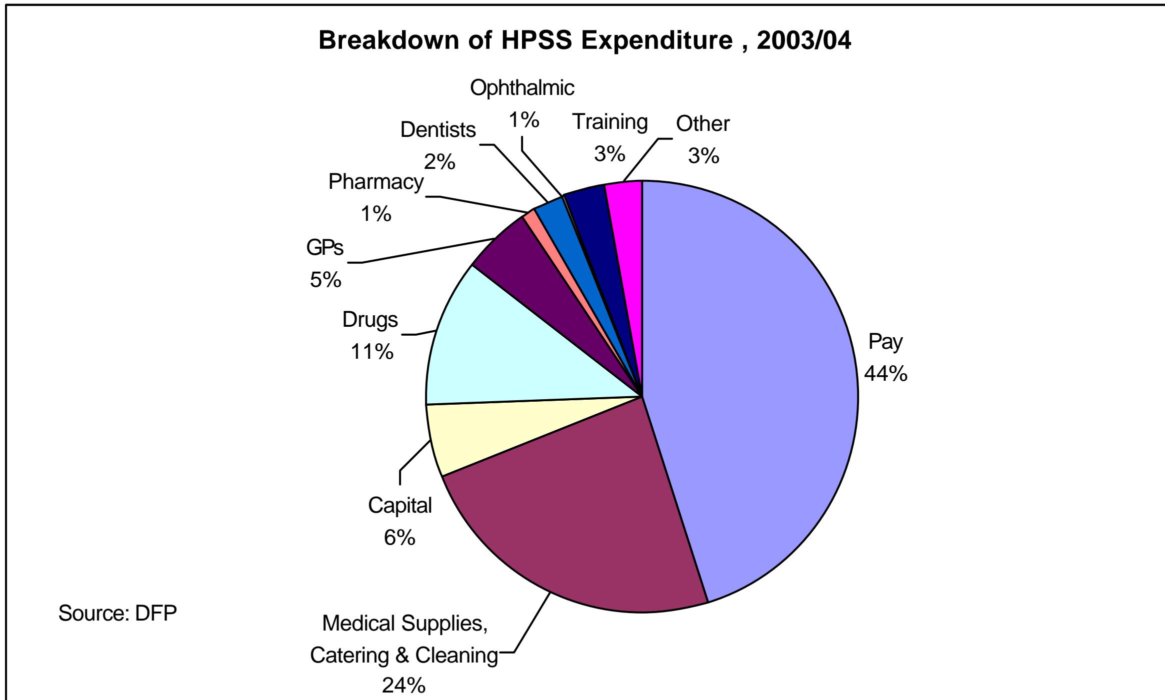
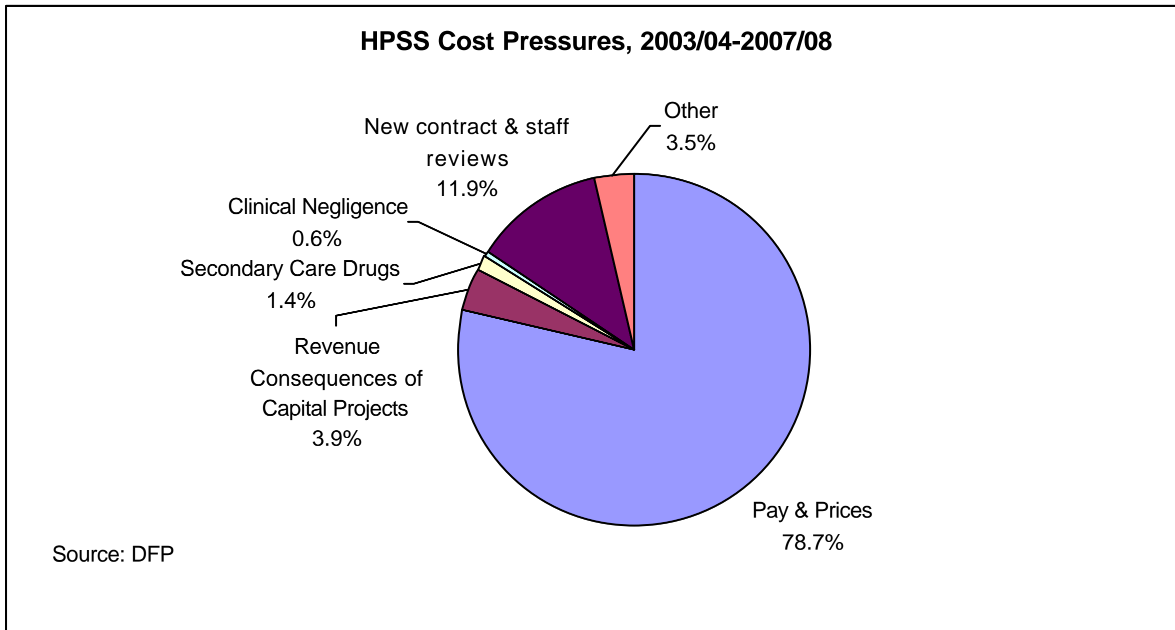


Figure 2.10: The most significant HPSS Cost Pressure over the period 2003/04-2007/08 will be pay & prices inflation[13].



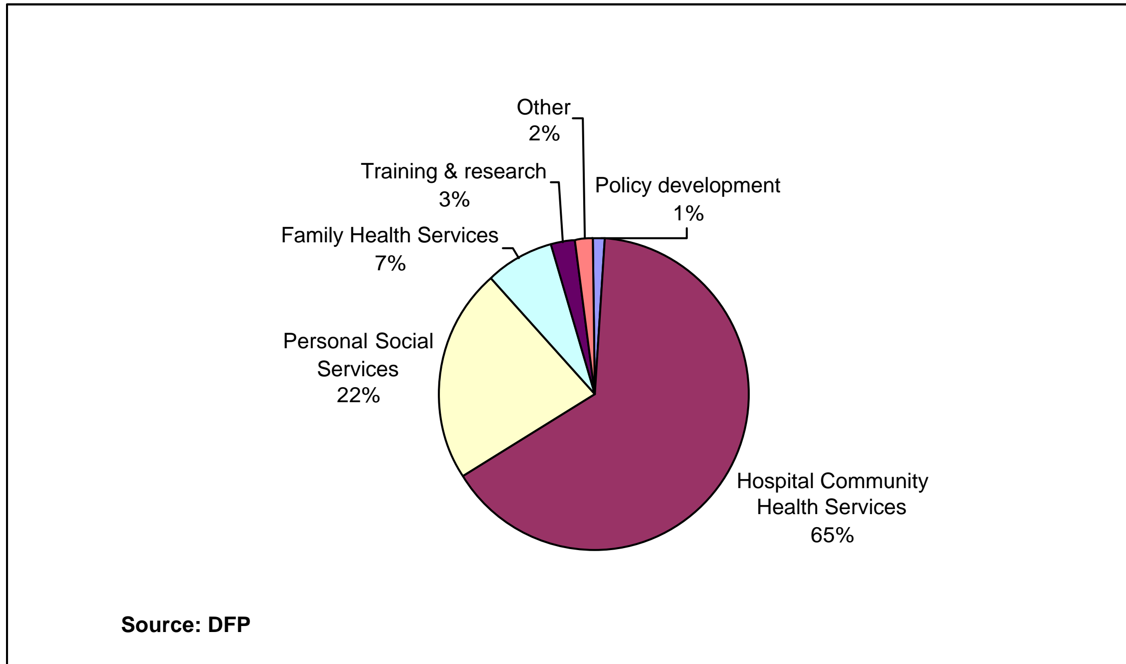
Trends by sector

The HPSS budget is agreed by Ministers in terms of the ten Units of Service, although figure 2.11 shows that the bulk of HPSS expenditure is concentrated in the Hospital and Community Health Services (HCHS), Personal Social Services (PSS), and Family Health Services (FHS). However, when the budget allocations are formally notified to DHSSPS, a more detailed description of what they are intended

[13] Pay and Prices cost pressure include an element of drugs.

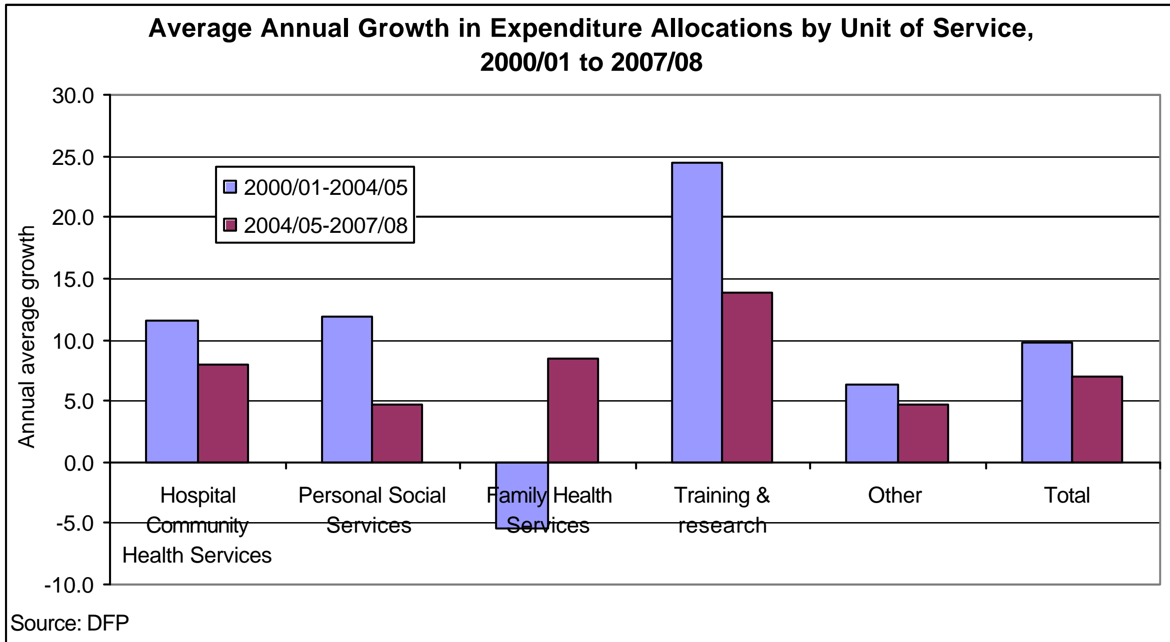
to be spent on is included in what is known as the budget control annex. In an effort to track allocations agreed by Ministers to actual spend, a settlement letter has been issued to each department for the first time this year, emphasising that departments must discuss with DFP before re-allocating any resources for purposes other than what was agreed as part of the budget process.

Figure 2.11 The majority of the HPSS Expenditure allocation by Unit of Service is expected to be spent on Hospital and Community Health Services, 2004/05



HCHS have absorbed an increasing share of total resources (a trend that is expected to continue) as shown in Figure 2.12. In 2007/08, HCHS is expected to account for nearly 70% of all spending - an increase of 6 percentage points since 2000/01. The higher growth in HCHS spend between 2000/01 and 2004/05 is in part due to the re-allocation of pharmaceutical spending from the FHS. The higher growth in HCHS spend appears to be inconsistent with general move to shift treatment from a hospital to a community/social setting where appropriate.

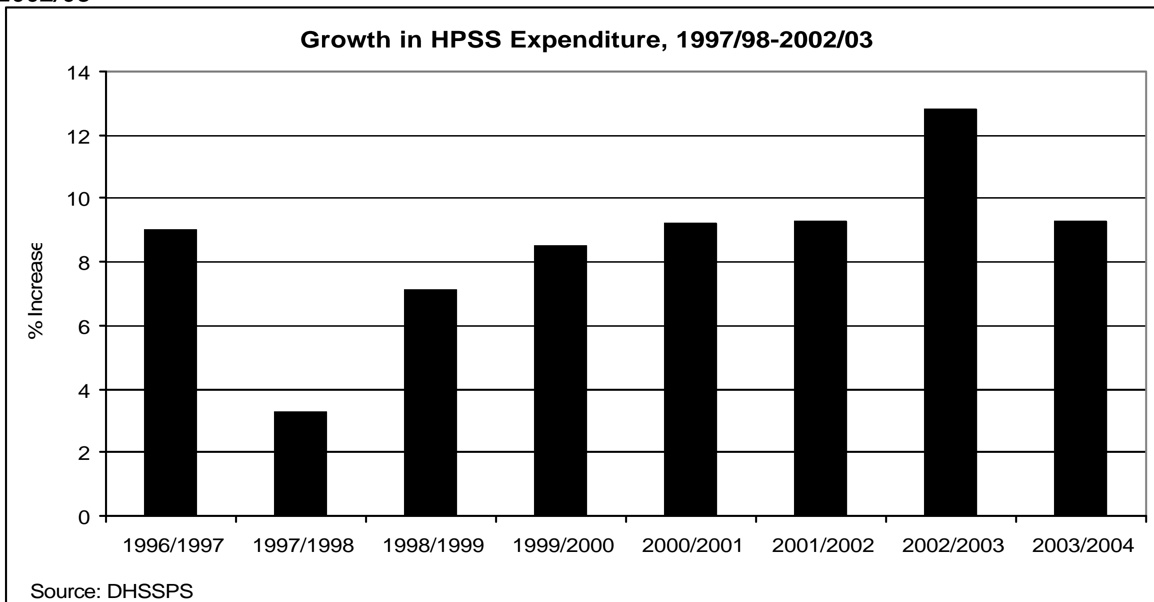
Figure 2.12: The annual average growth in spend for Hospital Community Health Services has been greater than that for Personal Social Services over the period 2000/01 to 2007/08[14].



Trusts

Around three quarters of the total HPSS spend is accounted for by trust spending with remainder carried out by GP's or centrally by DHSSPS. Expenditure by Trusts has increased by almost £950m - 8.5% per year - between 1995-96 and 2003/04 to stand at £2.0bn. Figure 2.13 shows that there was a steady increase in the growth rate of HPSS expenditure since up until 2002/03, whilst the slower level of growth in 2003/04 is expected to continue over the current budget period.

Figure 2.13: Growth in HPSS expenditure has increased year on year between 1997/98 and 2002/03



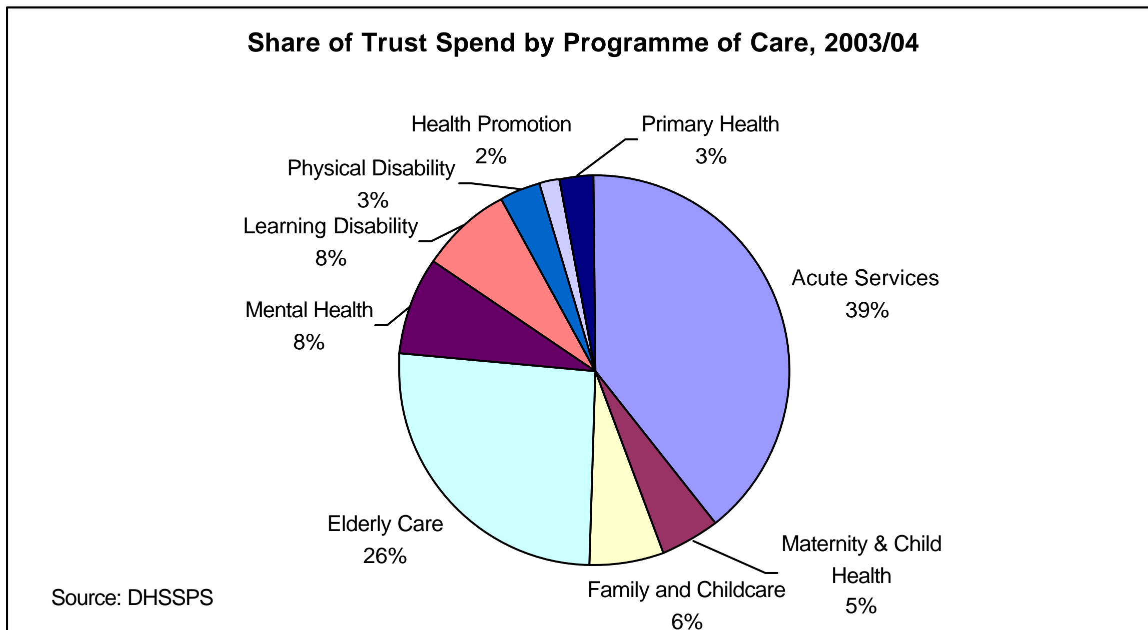
[14] However there appears to be a significant changes over time in the unit of service that particular items of expenditure are classified under. Whilst, DFP have provided as consistent a series as possible the chart should sill be treated as indicative only

Three trusts - the Royal Group, Ulster and City, located in the Greater Belfast area - collectively account for over a quarter of total HPSS spending in 2003/04. These trusts have also experienced growth in expenditure significantly higher than the average for Northern Ireland Trusts. For example, expenditure at the Royal Group of Hospitals increased by 10.7% per annum compared to the Northern Ireland average of 8.5% over the period1995/96-2003/04

Programmes of care

DHSSPS tracking of HPSS trust expenditure is currently available from 1995/96 to 2003/04. This allows trends in expenditure by Programme of Care[15] (POC). From this point of view, one of the consistent themes from the consultation process was the perception that funds were being diverted from other POC's towards the acute sector. Whilst DHSSPS bids for expenditure to DFP relate in many cases to specific POC's the block allocation of funding through the capitation formula would suggest that it is at the discretion of Boards and Trusts as to the distribution of expenditure between POC's. However, DHSSPS have indicated that in recent years there has been greater direction given by the Department to ensure that funds are used for the purpose intended. Although acute services dominate the HPSS sector - accounting for two-fifths of total spend (figure 2.14), at least over the period 1995/96-2003/04, growth in spend for the acute services was only slightly higher than the overall average (figure 2.15). However, its share of the total has increased slightly in recent years, and anecdotal evidence would suggest that this has continued in 2004 and 2005.

Figure 2.14: Acute services account for nearly two fifths of total spend….



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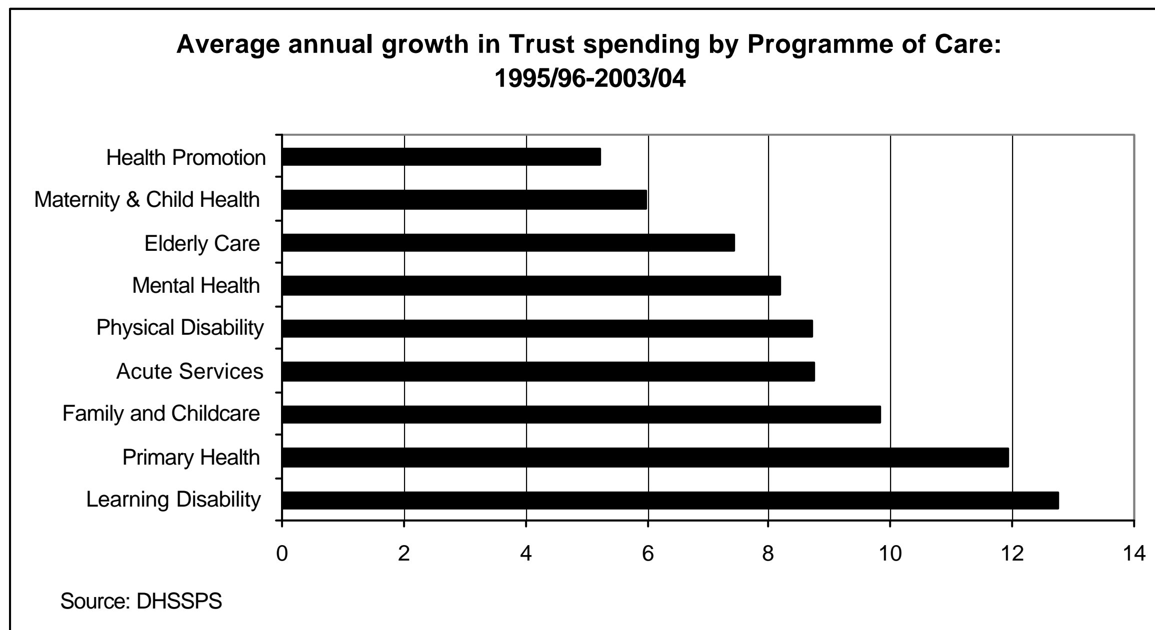
[15] Programmes of Care are divisions of healthcare, into which activity and finance data are assigned, so as to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. In total, there are nine Programmes of Care.

Figure 2.15....but acute services spending has grown more slowly than a number of other services.



Whilst the Learning Disability POC had the highest level of growth in expenditure over the period 1995/96-2003/04, its relatively small scale meant that it only accounted for a tenth of the overall growth. Given the demographic trends in Northern Ireland with a falling birth rate and ageing population it is to be expected that spend on Maternity and Childcare should have grown at a slower rate than the Northern Ireland average. However it is surprising that growth in spend on elderly care should be lower than the overall average whilst the low level of growth in expenditure on health promotion suggests a lack of investment for the future[16]. The dominance of the three largest Belfast Acute Trusts (Royal, City & Ulster) can be seen particularly with respect to the Acute POC where they account for 47% of total Northern Ireland spend in 2003/04 and 53% of spend growth since 1995/96.

In 2003/04 hospitals accounted for 54% of trust spend, reflecting the importance of the acute programme of care, followed by personal social services (33%) and community services (12%). Over the period 1999/00-2003/04 growth in hospital expenditure was less than both PSS and community services. The greatest contribution to the increase in trust spend over this period was from acute services (41% of total growth). More detailed analysis of Trusts Expenditure is set out in Annex C

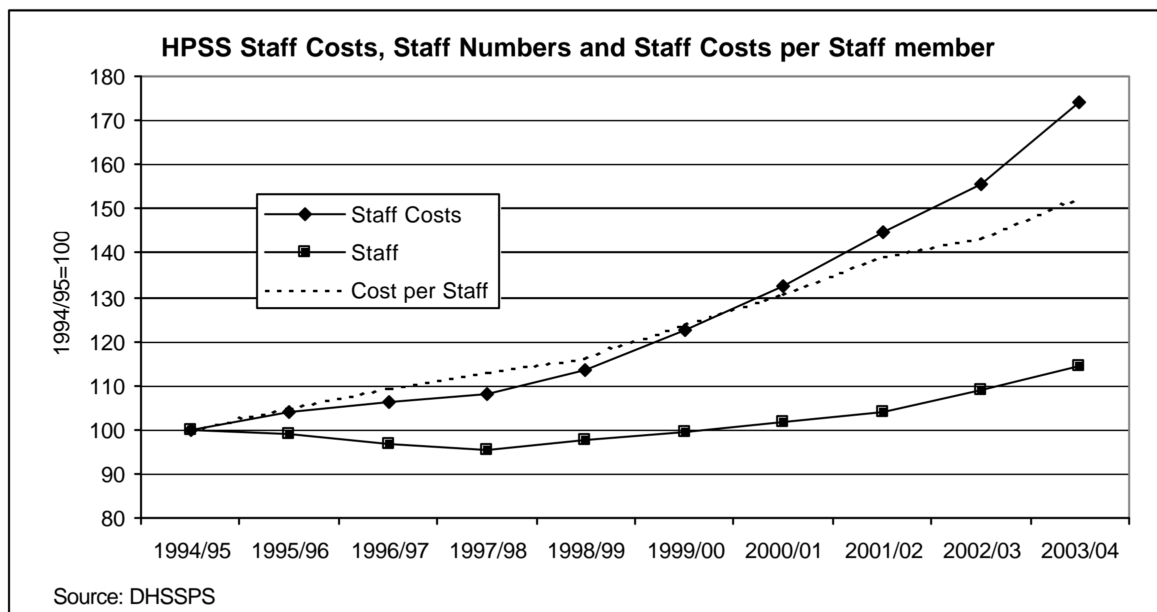
Health and social care staff

Current allocations (post initial implementation of Agenda for Change, Consultants' Contract and GMS Contract) show the proportion of all HPSS expenditure accounted for by direct pay and pension cost remaining stable at just over one half for the next number of years. In the entire period 2000-01 to 2007-08 just under 60% of the increase in HPSS expenditure will have been absorbed in pay costs.

[16] DHSSPS have suggested that the slower growth in the funding for elderly services may be due to previous over-funding of this POC. This raises the question as to whether DHSSPS should be more aware as to the appropriate level of funding across POCs.

Figure 2.16 shows that spending on staff costs by HPSS trusts has increased by 6.4% per annum from 1994/95 to 2003/4. Whilst wages and salaries have risen by 4.8% over this period, the number of staff has only increased in recent years, and at a slower rate (1.5% pa)[17].

Figure 2.16: Staff Costs have increased at a faster rate than the number of staff in the HPSS between 1994/95 and 2003/04



Over the period 1997/98- 2003/04, approximately 59% of the increase in HPSS expenditure was due to staff costs. This means that approximately 37% of the increase in HPSS expenditure over this period was due to increases in staff costs per head, with the remaining 23% due to increase in staff numbers[18]. However, there is significant variation in the rate of increase in staff costs per head between staff groups. Medical staff enjoyed growth of 7.6% per year in wages and salaries compared to the HPSS average of 5.1%, and 4.9% for trained nurses. The increase in wages and salaries within HPSS trusts was higher than those in the general economy (on a mean or median basis) as measured by the Annual Survey of Hours and Earnings.

Linkage between allocations and actual expenditure

As referred to above, a key concern regarding the health & social care sector in Northern Ireland has been the apparent lack of linkage between specific funding allocations to the department and subsequent service delivery. This has lead to the description of the health & social care sector as a financial black-hole where despite apparent significant additional funds there is little progress in resolving problem areas such as waiting lists. This phenomenon relates not only to Northern Ireland

[17] Between 1994/95 and 2003/04 the number of whole time equivalent staff in the HPSS has increased by just over 6,100 or 14.6%. The administration & clerical staff grouping experienced the largest increase in numbers (+2,400) whilst medical staff and trained nurses each increased by between 700-800.
[18] Between 1997/97 Total HPSS spend increased by £819m whilst staff costs increased by £487m with growth of 5.1%pa in staff costs per head and 3.0%pa in staff numbers.

but to the rest of the UK where the additional funds allocated do not appear to have resulted in a commensurate increase in activity. Whilst there are a number of reasons why the impact of additional funding has to date not been captured by headline indicators of performance there remains the concern that value for money has not been achieved.

In order to shed some light on this issue DHSSPS were asked to produce evidence linking as closely as possible their successful bids for expenditure with subsequent patterns of spend. Additional funds are allocated to the health & social care sector through a range of mechanisms including the outcome of Northern Ireland Budget Rounds, In –Year Monitoring, Northern Ireland Executive Programme Funds and European Funding. Whilst the largest share of additional funding comes from the Northern Ireland Budgets, the allocations from these sources are hardest to link to specific activities as they tend to fund general uplifts for pay and prices. It can be seen that additional funds are allocated for a broad range of services. For example, over the period 1999/00 to 2003/04 an additional £22.8m was allocated to dealing with Waiting Lists, £20.9m for Winter Pressures and £24.3m for Child Care services.

These additional funds were then linked to changes in spend for Hospital, Social and Community Services from Trust accounts data. Table 2.1 below shows that the increase in real Hospital spend for 2000/01 of £37m is equal to the associated budget bids.

In respect of hospitals, therefore, it does appear to be possible to track the funds through to actual expenditure. However, there are a number of caveats to this assertion, in particular that the correlation between bids and expenditure growth might have been achieved by simply allocating the large number of bids selectively to ensure the desired result.

Table 2.1: Reconciliation of Budget bids and real hospital expenditure growth 2000/01

	Budget Bids (£m)	Real Increase in Expenditure (£m)
Cancer Services	8.0	
Dependency Beds	2.4	
Fracture Services	1.0	
Medical Emergency	5.0	
Waiting List	1.3	
Winter Pressures	3.0	
Acute Services	5.0	
South Tyrone	5.5	
Causeway	0.5	
Clinical Waste	4.2	
Omagh	0.6	
MRI	0.5	
Hospital Total	37.0	36.4

In addition, the figures are insufficiently detailed to check whether, for example, the £8m allocated to Cancer Services was spent on those services rather than another aspect of hospital services. Indeed, even if there was an additional £8m spent on

Cancer Services this may have not have had the impact on actual outcomes for patients that would have been expected when the bid was agreed by Ministers.

In the case of community and social services, the transition was less transparent, mainly because funds tended to be allocated in the form of general funds to be shared across services and programmes of care. There were also a number of adjustments of significant scale such as the transfer of Preserved Rights which also distorted comparisons[19].

Further, as the actual expenditure data relates to trusts only there were a significant number of bids that were not allocated to a particular service such as equality and training.

Analysis of spend data has shown the difficulty of tracking expenditure throughout the system. Greater transparency would require more detail to be set out when putting forward bids in terms of the specific service/programme of care that the bid relates to and where possible what the resources will be used for in terms of staff, equipment or care packages. Whilst it is reasonable that there should be appropriate control on the use of public funds the cost of excessive micro-management particularly in the context of greater devolved decision making to frontline staff also needs to be recognised. There is however scope to tighten up the target setting process particularly with respect to Public Service Agreements to ensure that the objectives which resources are allocated to, lead to measurable improvements in service.

> **Recommendation 2: Over and above the need to track spending for reasons of financial probity, the main performance policy monitoring focus should be on tracking outcomes, not spending per se. A programme budgeting approach - as currently being developed in England for 23 disease/service groups - in addition to traditional accounting would be of help with this.**

Conclusion

The HPSS sector in Northern Ireland appears on initial analysis to be well funded in a UK context and reasonably funded in an international context. However, this is based only on analysis of the level of spend per capita and takes no account of the potential need for higher spend in Northern Ireland, which will be discussed at a later stage.

The decision making process when allocating health and social services expenditure appears to be convoluted. Although the expenditure bids agreed by Ministers include detail as to how the resources are to be used the subsequent block funding of Boards to distribute money to Trusts would suggest that decisions are also made at this stage based on local needs as to how funds should be allocated. Whilst there is direction from and monitoring by the DHSSPS as to the use of resources there remains considerable scope for confusion with same decisions being made at various stages in the process. There is a tension between the need for clear direction and control from the centre to ensure that the wishes of Ministers are

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[19] Whilst additional funds were transferred with Preserved Rights, the view of DHSSPS is that the cost of funding residential nursing care was in excess of these funds

implemented and the need for flexibility to ensure that local needs can be satisfied in the context of changing circumstances.

In terms of how the additional funds allocated to the HPSS sector have been used, the evidence available to date would suggest that the distribution of funds reflects past spending patterns, with the largest share going to the Acute Sector although not on a significantly disproportionate basis.

Since 1997/98 although the share of total expenditure accounted for by staff costs has declined, this item still accounts for a significant share of the overall growth in spend as has been the case in England. In particular, growth in wages and salaries accounts for over two-fifths of the increase in HPSS expenditure. Staff numbers have also risen with the largest increase in terms of administrative & clerical staff. Whilst it can be argued that wages are an important element in the recruitment, retention and motivation of staff and support to frontline services is also important, the relatively moderate increase in hospital activity over this period relative to England is of concern.

A key concern that was raised as part of the consultation process was that the funds allocated to the health & social care sector were not being used for the purpose intended. It has been shown, however, that there does appear to be a reasonable link between budgetary allocations and subsequent expenditure for Hospitals. For social and community services on the other hand, the link is much less clear although this is in part due to the way in which the funds are allocated.

2.3 Funding in the future

An important part of the terms of reference for this Review was to examine the:

'Technological, demographic, medical and other trends over the next two decades that may have implications for the future resource needs of the HPSS sector in Northern Ireland consistent, where possible, with the approach adopted in the Wanless Review.'

In approaching this aspect of the Review two points need to be kept in mind. First, there is no objectively correct answer to the question of how much should be spent on health and social care.

For health and social care in Northern Ireland, as for other publicly funded care systems, total spending levels are a matter of fiscal choice. This does not mean that such decisions have to be taken in a data-free environment; choices are not wholly subjective and can be informed by, for example, evidence of what benefits (in particular the value of these benefits) are likely to accrue from particular levels of spending, the opportunity costs of spending on health and social care and comparative benchmarking with spending levels in other countries and regions. Spending levels will also be informed by the values society wishes to pursue - for example, equal access for equal need in health and social care will not only imply a particular distribution of spending within Northern Ireland, but different levels of funding overall in comparison with other parts of the UK.

Secondly, while total funding levels - the *inputs* to health and social care - are important, of even greater significance are the *outcomes* from the system as experienced by patients and the population at large; if the system is inefficient at maximising outcomes for a given level of inputs, then it is not only money that is wasted, but lives too.

Bearing these issues in mind, the broad question we address here is: given multiple calls on limited public sector funding, what should Northern Ireland reasonably expect to devote to its health and social care system now and in the future?

Our approach has been to firstly adopt the assumptions and 'vision' underlying the original Wanless models used to produce spending paths for total (and NHS) spending paths into the future. Secondly, we have adapted the results from the Wanless Review to produce future shares of these UK totals for Northern Ireland.

The rationale for setting long-term projections of resource requirements holds equally for Northern Ireland as the rest of the UK in terms of allowing more effective long-term planning and management of the health & social care sector.

In projecting the future resource requirements for the UK, the approach of the Wanless Review was to focus on England and then use population uplifts for Scotland, Wales and Northern Ireland to produce a total for the UK. Whilst there are a number of areas where this assumption might be open to challenge, the responses to the Wanless Interim Report did not suggest that such an approach was unreasonable. An option that was considered early in our Review was to populate the Wanless (English/UK) model with Northern Ireland data. However, we were advised that this approach was not feasible, and instead decided to take the

Wanless UK projections as given and apply a range of population share adjustments to estimate Northern Ireland's future resource requirements.

Underlying Wanless's future vision were a number of factors that can be expected to increase the pressure to spend more on the health & social care sector in future years. In addition, whilst it would be unrealistic to assume that as spending increases, such pressures will reduce[20] given historical trends, there are actions that Government can take to ameliorate spending pressures. For example, public health promotion and improving the effectiveness of service delivery.

Key factors which drive the pressure to spend more on health and social care include:

- technological developments and medical advance
- higher expectations regarding the range and quality of health care provided,
- demographic and patterns of morbidity,
- extent to which resources are used efficiently

To these might also be added likely changes (increases) in the *value* society attaches to states of good health, with the implication that if the benefits (health) of the system are valued more highly, then this justifies higher costs (that is, spending)[21]

Although surveys suggest that the public are generally satisfied with the health service in the UK (and particularly in Northern Ireland - 79% satisfaction levels were reported for 2004 compared to 74% for 2003[22]), nonetheless, public pressure on services to provide increased responsiveness and quicker access to more effective care is evident.

Demographic changes over the next twenty years will clearly impact on demand for health and social care spending. However, as Wanless and others have noted, the relationship between need for health and social care and, for example, the proportion of the population who are elderly is not straightforward. Although those aged over 65 are among the main users of health services, it is proximity to death rather than age per se which is more important in modelling future health care costs. In terms of the sorts of health and social care problems services will have to deal with over the next twenty years, then the likelihood is that these will remain largely similar in type and scale to those they face now but in line with downward trends in overall mortality.

Although technological and medical advances may in some cases lead to reductions in unit costs, in general it is expected that by allowing more people to be treated for a wider range of conditions (and for a longer time and more effectively) these advances will put upward pressure on costs. Whilst there is considerable uncertainty regarding the future uses of existing technologies, as well as those that have yet to emerge, there is no reason to believe that the trend over the past thirty years (when

[20] Although this runs counter to the assumption at the institution of the NHS in 1948 that resource requirements would fall as the population became healthier.
[21] Jones CI (2002) Why have health expenditures as a share of GDP risen so much? NBER working paper 9325.
[22] DHSS&PS Public Attitudes to Health and Personal Social Services in Northern Ireland 2004

a significant proportion of the increase in health care costs was due to technological improvements) should not continue.[23]

The improved standard of care expected by public and patients will require a significant increase in the number of health care professionals. In addition, the roles and responsibilities of health care professionals will change, with changes in the skill mix within professions and changes in roles between professional groups.

2.3.3 Wanless expenditure projections for the UK

The projections of future health service resource requirements set out in the Wanless Review were based on the achievement of improved health services in the UK, with a high level of clinical standards to meet the rising expectations of patients and the public.

Some of the main costs of achieving this vision and identified by Wanless include:

National Service Frameworks: Whilst the present reality was considered to be far from this vision, it was anticipated that the NHS Plan will bridge this gap. A key element of the NHS Plan is delivery on the National Service Frameworks (NSFs) which set out national standards for service delivery. There are NSFs in place in England for the following areas; coronary heart disease, cancer, renal disease, mental health services and diabetes.

The Wanless Review projected that an additional £12bn would need to be spent by 2022/23 to deliver the NSFs for these areas. In addition, in recognition that the Government intends to extend the NSF approach to other disease areas it was assumed that similar growth in expenditure would be required to bring service in these areas up to and maintain the required standard. The cost of introducing NSFs to Northern Ireland would depend to a large extent on the level of morbidity for particular diseases and the current level of service provision and organisation.

Clinical governance: In order to provide continual improvements in the quality of service provided it is necessary for health care staff to have additional "protected time" devoted to clinical governance structures and schemes. The Wanless Review assumed that all healthcare staff will need to devote 10 per cent of their time to clinical governance compared to the current position of 5 per cent for medical staff and 2 per cent for other professional staff. Whilst this will increase costs in terms of additional staff it will also reduce hospital acquired infections, adverse incidents, avoidable emergency admissions and clinical negligence claims so that the additional net cost across the UK would be around £1.4bn by 2022-23.

Fast access: whilst waiting times in England are significantly lower than in Northern Ireland, the view of the Wanless Review was that substantial additional activity and hence resources would be required to match the outcomes in the best performing comparator countries. Overall it was estimated

[23] The general view of those who were consulted as part of the Wanless Review was that the nature, scope and pace of technological advance in the next ten years will not look radically different to the past ten years- P 173 on Wanless Interim Report.

that around an additional £12bn would need to be spent by 2022-23 to deliver such improvements.

In addition, given uncertainty regarding the impact of cost drivers such as the health needs and demands of the population, technological developments and workforce issues, and in particular the achievement of assumed productivity improvements, the Wanless Review built up three scenarios:

> ***'Solid progress*** – people become more engaged in relation to their health: life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. The health service is responsive with high rates of technology uptake and a more efficient use of resources;
>
> ***Slow uptake*** – there is no change in the level of public engagement: life expectancy rises by the lowest amount in all three scenarios and the health status of the population is constant or deteriorates. The health service is relatively unresponsive with low rates of technology uptake and low productivity; and
>
> ***Fully engaged*** – levels of public engagement in relation to their health are high: life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the health system and demand high quality care. The health service is responsive with high rates of technology uptake, particularly in relation to disease prevention. Use of resources is more efficient.'

It is worth noting here (and for reference in section 3.7 on efficiency) that the Wanless Review made assumptions about improvements in productivity in health care and which underpinned its final spending projections. Table 2.2 details the productivity assumptions made by Wanless and which, given this present Review's approach to projecting spending for Northern Ireland, also underpin our future funding requirements.

Table 2.2: Breakdown of productivity assumptions, per cent a year

	Unit cost reduction		Quality improvement		Quality-adjusted productivity	
	Lower	Higher	Lower	Higher	Lower	Higher
2003/04 - 2007/08	0.75	1	0.75	1	1.5	2
2008/09 - 2012/13	0.75	1.25	0.75	1.25	1.5	2.5
2013 - 2017/18	1	1.5	0.75	1.5	1.75	3
2018/19 - 2022/23	1	1.5	0.75	1.5	1.75	3

Source: Wanless Review Final Report

Wanless identified two components of productivity - cost-reducing and quality-improving. Over the twenty year period to 2022/23, feasible average annual quality-adjusted productivity improvements were assumed to lie between 1.5% and 3%.

Bringing together these scenarios, assumptions and vision for health services in the future through models to estimate, for example, activity needed to sustain very short waiting times, provided some broad estimates of possible spending levels for health care into the future for the whole of the UK (see table 2.3).

Table 2.3: UK Health Spending projections from Wanless Review

	2002-03	2007-08	2012-13	2017-18	2022-23
Total NHS Spending (£ billion 2002-03 prices)					
Solid Progress	68	96	121	141	161
Slow Uptake	68	97	127	155	184
Fully engaged	68	96	119	137	154
Average annual real growth in NHS spending (per cent)[1]					
Solid Progress	6.8	7.1	4.7	3.1	2.7
Slow Uptake	6.8	7.3	5.6	4.0	3.5
Fully engaged	6.8	7.1	4.4	2.8	2.4

Source: Wanless Review Final Report
Note: Growth figures are annual averages for the five years up to date shown (four years for 2002-03)

The table shows that under all scenarios the greatest growth in resources is required in the first ten years of the projections, as the UK ‘catches up’ with its European neighbours, with slower growth thereafter. As would be expected, the Fully Engaged scenario has the lowest cost whilst the Slow Uptake has the highest.

2.3.4 Application of Wanless projections to Northern Ireland

In estimating the long-term sustainable resource requirements of the health & social care sector in Northern Ireland, the approach involved taking the Wanless spend projections for the UK and estimating Northern Ireland’s need-adjusted share (see Annex D for further details). A key (and acknowledged) gap in the Wanless work was the exclusion of projections for social care services. With no future estimates for social care spending across the UK, for Northern Ireland projections it is assumed that social care receives increases in funding similar to health care.

There has been considerable debate as to Northern Ireland’s “fair share” of any growth in UK/England spend. Therefore, this analysis presents a range of outcomes based on alternative models embodying differing views as to the quantum of the fair share.

Our approach implies a set of criteria or objectives for the distribution of resources under devolution. In particular, that each country should receive resources that would *enable* it to provide the same standard and mix of services as the average for the UK as a whole, independently of local ability to pay. Whether an individual country chooses to provide higher or lower standards or a different mix is purely a local policy issue. It has long been accepted that differences in need will affect the cost of providing equivalent services and therefore must be incorporated into an estimate of “fair shares”. An implication of this approach is that the relevant “needs” factors and their weights must be those applied to the UK as a whole.

The main problem with this approach is that there is no pan-UK derived allocation formulae - that is, one using UK data to construct the appropriate weights for needs factors. However, there are a number of allocation formulae - for individual parts of

the UK , for example - which we examine in our analysis. However, it must be emphasised that in the absence of a UK-wide formula based on appropriate UK data, choosing between the results of our modelling work is, for now, more a matter of judgement than empirical fact.

Under current public sector funding mechanisms for the devolved administrations, changes in English spending departments' allocations drive changes in allocations in Scotland, Wales and Northern Ireland - primarily on the basis of population via the Barnett Formula as discussed in section 2.2. For example, as Northern Ireland's population is currently 3.4% of that in England, an increase in English public expenditure of £100m translates into an increase of £3.4m for Northern Ireland. There has been concern in Northern Ireland that the Barnett Formula is intrinsically unfair because it takes no account of the relative need for expenditure. In addition, the out workings of the Formula mean that when a Devolved Administration has a higher level of public expenditure per head of population than England (as is currently the case for Scotland, Wales and Northern Ireland), the growth in expenditure is lower than in England.

On this basis it is argued that Northern Ireland should receive funds *in addition to its population share*. In previous years, this has been accomplished through 'formula bypass', where Northern Ireland was allocated additional funding for specific areas - although more recently HM Treasury has adopted a stricter approach to the application of the Barnett Formula. As a result, Ministers in the previous Northern Ireland Executive lobbied for a review of the Barnett formula with a view to adopting a needs-based approach. On this basis, in the example above, if Northern Ireland's per capita need for expenditure was agreed to be10% higher than in England then it should receive an additional £3.74m.

Of course, critical in this respect is the extent to which the need for expenditure is actually higher in Northern Ireland than England. In 1979, and as part of preparations for greater devolution, HM Treasury conducted a Needs Assessment Study (NAS) to develop a model to estimate the public expenditure need factor (with England =1) for Scotland, Wales and Northern Ireland across a range of public services - including health and social services - although the analysis was never formally agreed. The NAS model was based on a weighted average of a range of factors including age structure, morbidity, deprivation, rurality and other cost drivers, and is in some ways comparable in approach to current weighted capitation allocation formulae used in England, Northern Ireland, Wales and Scotland to allocate NHS global budgets within countries.

In 2001, the Northern Ireland Executive commissioned a series of Needs and Effectiveness Evaluations (NEE) for five public expenditure areas. A significant part of each study was to update, where available, the existing HM Treasury NAS model and suggest evidence-based changes to the construct of the model. Whilst the results of the needs element of each study have not been published, the details of the models have been made available to this Review and updated for the latest available data. Three basic scenarios had been developed as part of the 2002 NEE:

NAS Update - based on updated data to populate the HM Treasury Model, this implies a need indicator of **1.0395** for the latest available data - that is, given the relative difference in the need for health care (based on factors such as

population structure and mortality) Northern Ireland should spend **3.95%** more per head of population on health services than England.

NI Executive Update - based on changes to the *structure* of the model, in particular, greater weight given to deprivation factors where Northern Ireland's need relative to England is high. This implies a need indicator of **1.132 (+13.2%)** for the latest available data.

NI Executive+ Update - based on the NI Executive update plus additional adjustments where the supporting evidence is less robust. These include adjustments to take account of differences in the ability to pay, private provision and community tensions. Overall, this implies a need indicator of **1.165 (+16.5%)** for the latest available data.

In addition to these modelling approaches, this Review has also looked at four further potential methods for arriving at a fair share for Northern Ireland of the Wanless UK projections:

EQ-5D health status model: The needs assessment models detailed above use a number of proxy variables for the need for expenditure on health & social care services which in reality relate primarily to the incidence of illness in a given population. The reason such proxy indicators are used is that there is generally very little data collected on the real factor of interest - *health*. However, the EQ-5D survey on health status discussed in Section 3.2.2 provides a direct measure of health status which can be compared with similar information for England. The results of the EQ-5D survey indicate that the average level of self-reported health in Northern Ireland is approximately 96% of that in England, implying a need indicator of **1.04 (+4%)**. This makes the strong assumption that there is a one to one relationship between the relative EQ-5D score and the need for spending.

A number of approaches were also considered based on the application of Northern Ireland data to the needs-based formulae for allocating health funding *within England, Scotland and Wales*. Unfortunately it was not possible, due to lack of available data, to use the models for Wales and Scotland, whilst the results set out below based on analysis carried out by DHSSPS using Northern Ireland and English allocation methods are subject to a number of caveats.

Northern Ireland allocation model: DHSSPS have populated the allocation formula for Northern Ireland with the latest data for England. This resulted in a set of need indicators for 11 programmes of care (POC) which ranged from **0.867 (-13.3%)** for the Elderly POC to **1.711 (+71.1%)** for the Physical & Sensory Disability, whilst Acute Services had a need indicator of **1.041 (+4.1%)**. Overall, the basic need indicator across all POCs was **1.095 (+9.5%)**. There are additional factors that are not material in an internal Northern Ireland formula but are significant when comparing with England. Including adjustments for rurality (+0.027) and resource costs increases the need indicator to **1.116 (+11.6%**)

English allocation model: DHSSPS have also populated the allocation formula for England with the latest available data for Northern Ireland. The

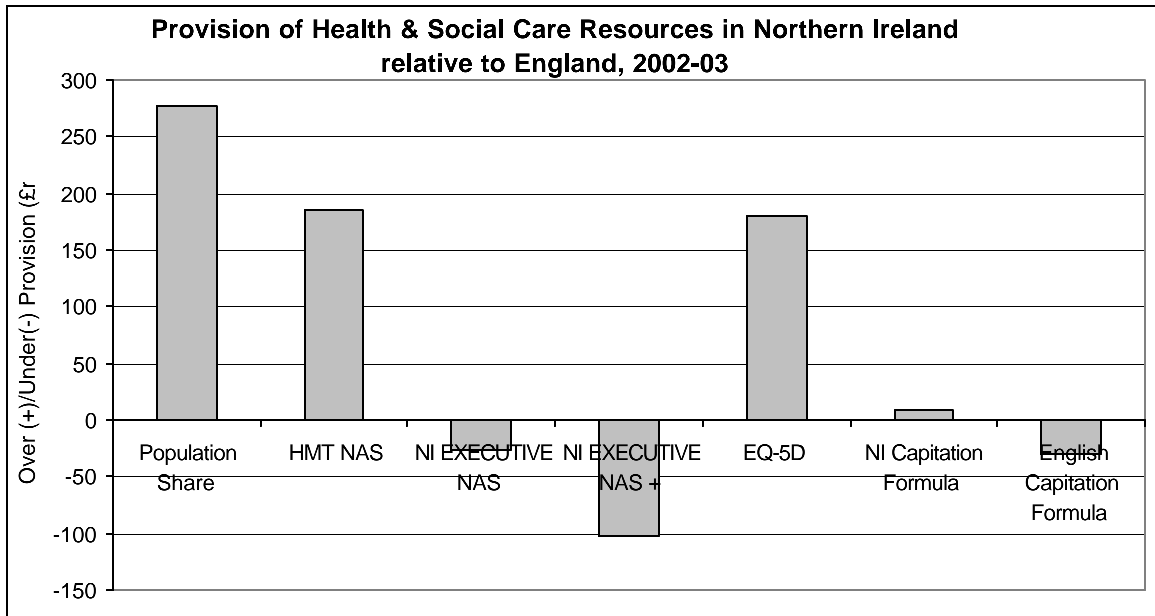
analysis was restricted to expenditure covered by hospital and community health services (HCHS) which accounts for approximately 77% of total spend. The main omission was social services which, if included, would have been expected by DHSSPS to increase Northern Ireland's relative level of need. The overall Northern Ireland age-need indices for Acute/Geriatric/Maternity and Mental Health are **1.065 (+6.5%)** and **1.541 (+54.1%)** respectively which translates into an overall need indicator of **1.133 (+13.3%)**.

International benchmarking: In order to provide a slightly different perspective - although one which in part reflects the Wanless Review's perspective concerning 'catch up' and 'keep up' - linkage between national per capita income and per capita health expenditure, which can be seen in an international context, was considered. Although the direction of causation may flow both ways, it is useful to estimate the level of health expenditure that Northern Ireland could afford given its level of economic activity without external financial support. On this basis, relative levels of economic activity (GDP) per head would suggest that Northern Ireland could only afford to spend 77% of the English level per head of head of population on public services.

Throughout the consultation process a consistent theme has been that health and social services in Northern Ireland are under-funded, and that, for example, initiatives in England cannot be replicated locally because of insufficient funds related to the lower growth in spend, or that activity growth necessary to tackle waiting times problems cannot be generated, again due to lack of funds.

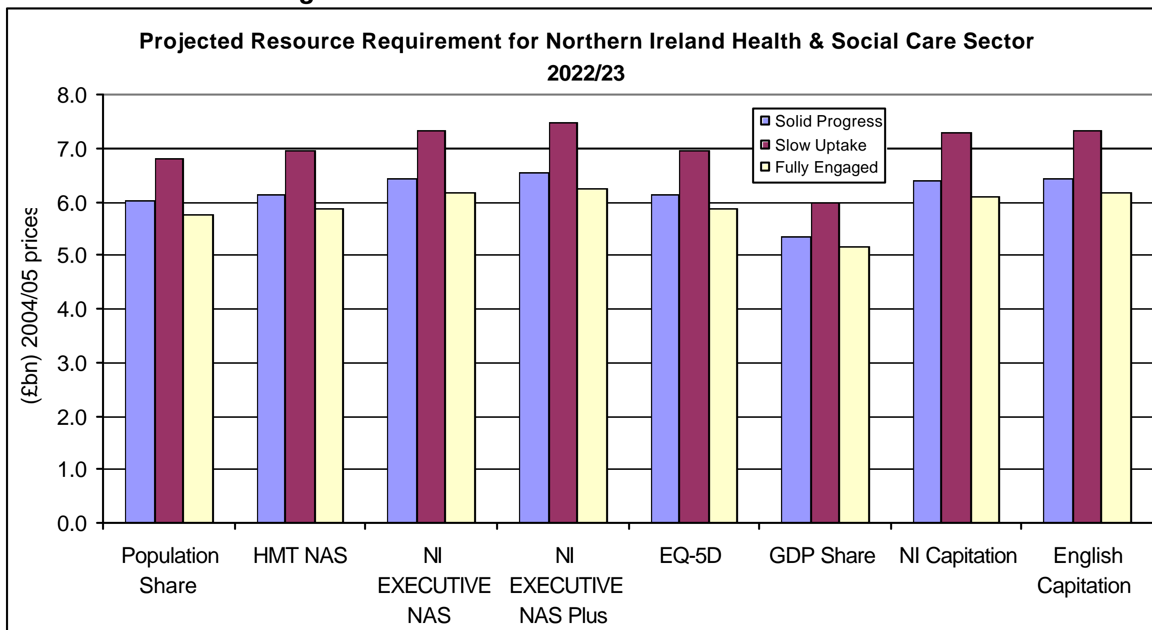
In order to assess the current position, figure 2.17 shows the results of applying each of the above spending models to the 2002/03 level of health & social care spend in Northern Ireland relative to England. For 'status quo' comparison, the figure also includes estimates based on application of the Barnett formula ('population shares'). It can be seen that the estimates range from an over provision of £276m, to an under provision of £103m. In addition, on the basis of its level of economic activity relative to England, it is estimated that expenditure on Northern Ireland's health & social care sector should be £800m *lower* than the current level (not shown on the figure). It should be noted however that these comparisons are based on HM Treasury figures which indicate that spend on health and social services per head of population is significantly higher in Northern Ireland than England, whilst it is the view of DHSSPS that there is parity in spending levels. The Review has been advised by DFP that as National Statistics, the HM Treasury figures should take precedence.

Figure 2.17: Estimates of Northern Ireland's current HPSS spend range from underprovision of £103 m to an over provision of £276 m.



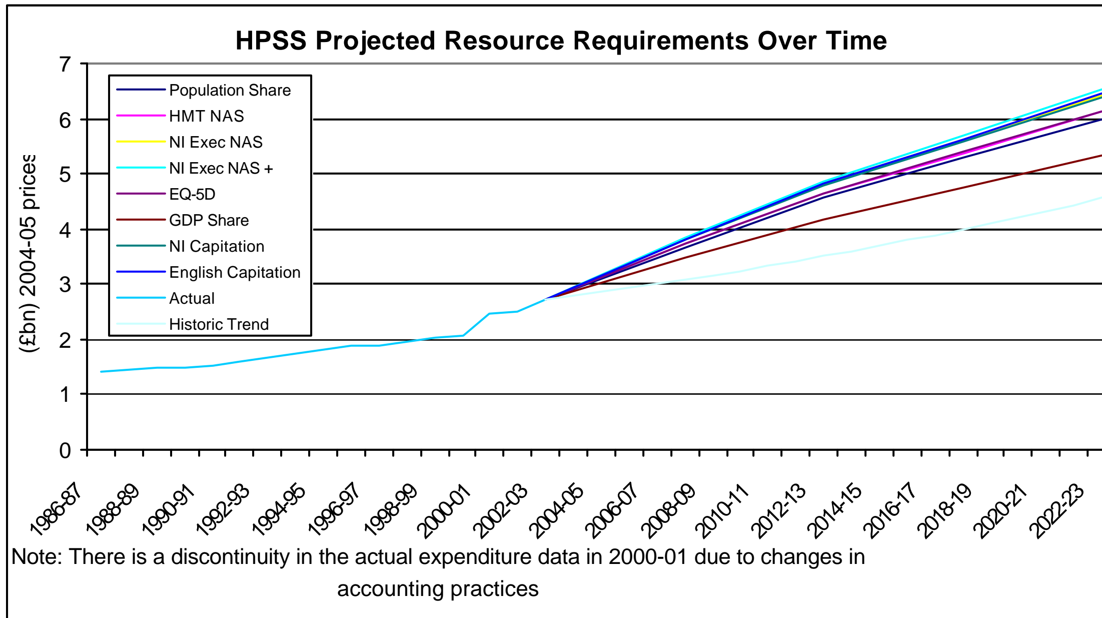
In examining future trends in spending, one option was to assume that under a needs-based approach, the adjustment would be applied to all expenditure initially, with the same growth in spend as England thereafter. However, this would have been unrealistic, as with some models which have suggested current overprovision, the changes in expenditure would have placed substantial resource pressures on the system. Instead, as with the Barnett Formula, the needs-based adjustment is assumed to apply *only to additional spend*. Figure 2.18 therefore sets out the range of projections for the resources required for the health & social care sector in Northern Ireland in 2022/23 under different modelling scenarios.

Figure 2.18: Wanless-based 2022/23 resource requirements suggests variations in spending under different modelling scenarios



Under the Solid Progress scenario, projected spending for 2022/23 ranges from £5.3bn to £6.5bn; That is, a real increase over twenty years of between £2.7bn to £3.9bn. Under the Slow Uptake scenario, additional resources of £3.3 to £4.8bn would be required, whilst under the Fully Engaged scenario additional real spending of £2.5 to £3.6bn would be required. However, as figure 2.19 shows, a significant increase in resources is projected compared to historic trends regardless of the assumption on relative need.

Figure 2.19: Although there is some variation in projected expenditure, all scenarios continue the significant growth in HPSS spend.

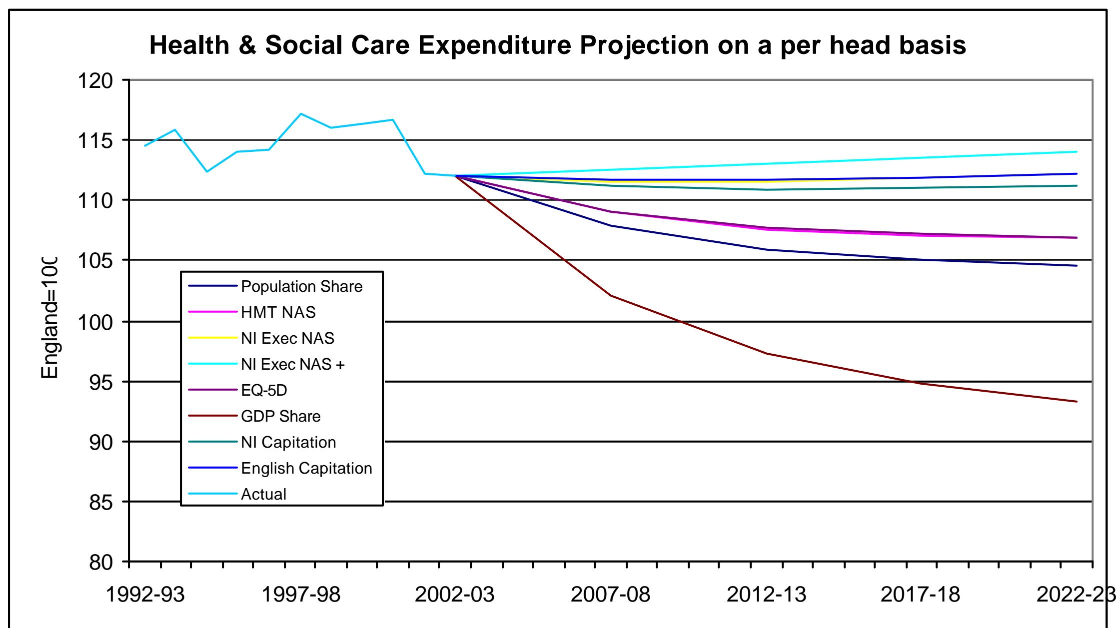


Note: There is a discontinuity in the actual expenditure data in 2000-01 due to changes in accounting practices

Figure 2.20 sets out the overall spend figures translated into spend per head relativities between Northern Ireland and England. If the assumed difference in need is greater than the 2002-03 difference in expenditure per head between Northern Ireland and England then expenditure per head relative to England is projected to rise over the next twenty years. It can be seen under the Northern Ireland Executive version of the NAS model with additional adjustments, spend per head is projected to rise to 114% of the English level by 2022-23 whilst under the GDP share scenario spend per head falls to 93% of the level for England. Under the Barnett formula spend per head is 4.6% higher than in England by 2022/23.

In many ways, these are somewhat pessimistic projections as, even under the Wanless 'fully engaged' scenario, they assume a continuation of the gap in relative need between Northern Ireland and England. It would be hoped that given efforts to meet the requirements of the fully engaged scenario, in the longer term the relative need gap would reduce.

Figure 2.20: Expenditure projections imply that Northern Irelands spend per head on Health and Social Services will range from 6.8% below the level in England to 14.1% above by 2022-23.



Although a range of estimates are set out above, it is important that the Review expresses a view as to which is the most appropriate.

International benchmarking (GDP share)

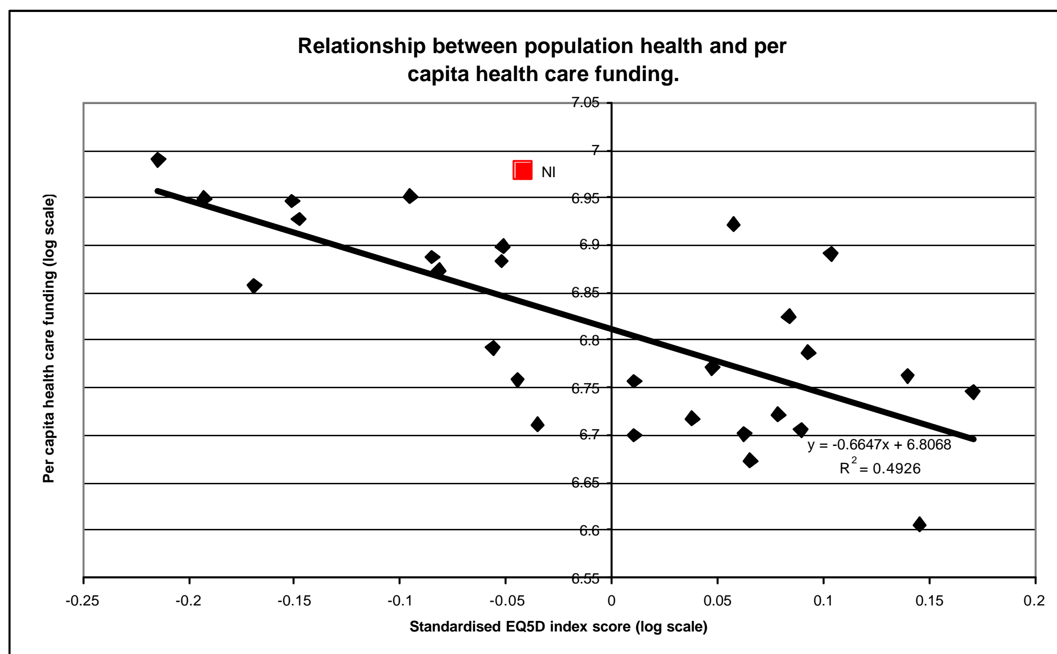
In its current constitutional state there is only a limited link between the amount of revenue raised by the Government in Northern Ireland and the subsequent expenditure on public services in the region. Therefore, the scenario based on a GDP share has been included for illustrative purposes only and does not represent a serious possible outcome.

EQ-5D health status model

Intuitively, sharing out health care resources on the basis of differences in population's health status is not only a more direct method than using proxies for health status, but a better approach too. Figure 2.21 below shows that there is a reasonably strong relationship between standardised EQ-5D scores for Strategic Health Authorities (SHAs) in England for 2003/4 (derived from the 2003 Health Survey for England) and SHA weighted capitation allocations (based on mortality and deprivation weighted populations) adjusted for differences in the cost of living, with a correlation coefficient of around 0.70 and an R^2 of 0.49[24]. In other words, variations in health explain around 49% of the variation in per capita funding between English SHAs.

[24] Including a dummy variable to take account of two outliers (North Central and North West London) further increases the R^2 to 0.68.

Figure 2.21: Northern Ireland receives significantly higher levels of health spending per head of population than would be expected given its health status relative to English SHA's.



In terms of funding implications, the trend line slope coefficient of 0.6647 suggests that the 4% poorer (self reported) health status in Northern Ireland relative to England should translate into a 2.8% higher level of spend per capita - considerably less than is the actual situation now.

This model is, however, simplistic, and could no doubt be improved with further work and the addition of other variables. As it stands, and even though there is an argument that the EQ-5D data is better than the available evidence on morbidity, judging Northern Ireland's relative expenditure need on the basis of relative needs as reflected by overall standardised EQ-5D scores provides at best a guide to spending. In the results summarised in figures 2.17-2.20 we have assumed a one to one relationship between EQ-5D score and spending.

Barnett Formula (Population shares)

The population share or Barnett Formula approach reflects current Government policy for funding Scotland, Wales and Northern Ireland. A key weakness of the Barnett formula is that it does not take into account the differing needs for expenditure between areas. Whilst Barnett might have been useful in the past as a means of narrowing the gap in levels of spending per head between UK countries (and acting as a rough rule of thumb to, in Joel Barnett's view, curtail wrangling over allocations) there is an argument for a more sophisticated approach to be adopted. All countries of the UK distribute the funding for services within their borders on the basis of needs-adjusted formulae; It is not clear why this principle cannot be extended to the allocation of funding between UK countries.

Northern Ireland allocation model

Populating the Northern Ireland allocation model with English data produced an overall basic need indicator across all POCs of **1.095 (+9.5%)**. However, this result is very sensitive to the need estimates for just two POC's (Learning Disability, and Physical & Sensory Disability) which together account for less than a tenth of overall spend. If the indicators for these POCs are set to one, then the overall need indicator falls to 1.04.

The very high relative level of need for these two POCs appears to be driven to a considerable extent by relative levels of benefit receipt. For example, a key driver for Physical & Sensory Disability is the percentage of 16-64 year olds in receipt of Disability Living Allowance, which is 141% higher than in England, whilst the proportion of people with a long-term illness is only 34% higher. Setting the benefit receipt element of the model to zero reduces the need indicator from 1.711 to 1.155 for this POC.

Moreover, given this model's implicit argument that there is much greater need for spending in the areas of learning, physical and sensory disabilities, it would be expected that this higher level of need would be reflected in a higher level of relative spend for these POCs. However, whist the need for expenditure in these two POCs is estimated jointly to be 63% higher than in England, the actual level of expenditure is only 36% higher. This is also the case with respect to the Mental Health POC, where need is estimated to be 43% higher, but actual spend per head is the same as in England[25]..

English allocation model

As with the Northern Ireland allocation model, the results of populating the English weighted capitation formula with data from Northern Ireland are sensitive to changes in a small number of factors. For example, in respect of the Acute/Geriatric/Maternity index, one element - the circulatory system morbidity factor - is based on 2001 data which indicates that Northern Ireland has a 7.3% higher rate of death from this group of diseases than England. However, between 2001 and 2003 the number of deaths from diseases of the circulatory system has continued to fall at a faster rate in Northern Ireland than England and Wales so that the gap is projected to have fallen to 3.4%[26]. On this assumption, the respective need indicator falls from 1.065 to 1.045.

The same principle applies to an even greater extent with respect to the mental health indicator which, at 1.541, is elevated by an estimate for a psycho-social morbidity index which was proxied using Northern Ireland survey data indicating that the proportion of those aged 16+ showing signs of possible mental health problems was considerable higher than in England. However, the EQ-5D survey carried out for this Review shows, for example, that mental health status in Northern Ireland is actually better than in England[27]. If this assumption is applied to the model then the mental health need indicator falls to 1.10.

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[25] Spend data taken from the 2002 Needs and Effectiveness Evaluation.

[26] The number of deaths caused by circulatory diseases fell by 6.5% in Northern Ireland over the period 2001-2003 compared to 3.0% in England & Wales- Table 9.6 Annual Abstract of Statistics.

[27] The proportion of respondents to the Northern Ireland EQ-5D survey (2005) reporting any problem with anxiety/depression was 15.2%; the equivalent proportion for England in 2003 was 19.2%

The need indicator quoted in applying Northern Ireland data to the English Capitation Formula does not include a market forces factor to take account of variations in the unavoidable cost of providing healthcare. Whilst it has not been possible to estimate a comparable market forces factor for Northern Ireland, data is available from National Statistics indicating that the cost of living is around 5% lower than in England.

Overall, adjusting for more recent changes in deaths from circulatory diseases and the differential cost of providing services has the impact of reducing the overall need indicator - based on the allocation formula for England - from 1.14 to 1.07.

DHSSPS have indicated, however, that these models do not include a number of factors that are relevant when comparing the relative need between Northern Ireland and England. For example, taking account of additional costs incurred in supporting services in areas of high community tension as well as the lower level of private provision in Northern Ireland compared to England increases the overall need indicator by 0.02.

It has not been possible in the time available to carry out the level of critique required to come to a final position on the relative level of need for health & social care expenditure in Northern Ireland relative to England based on the respective allocation formulae. Therefore, the results of applying these models (set out in figure 2.17-2.20) are based on the results of the initial update provided by DHSSPS.

Overall, therefore, whilst on first sight the capitation formulae for England and Northern Ireland would suggest that spend per head should be 10-14% higher in Northern Ireland, the results are highly sensitive to the data used. In particular, changes in the assumptions behind one or two key factors can significantly reduce the overall level of need. Depending on the assumptions used, in particular the choice of data used where no direct substitute is available, the formulae can be used to support the original HMT NAS model or the subsequent revisions made by the Northern Ireland Executive.

HM Treasury NAS Model

Whilst the HM Treasury NAS model has been used to inform funding decisions, it has not been used to allocate resources directly across UK countries, with the continued preference being the Barnett Formula. Since 1979 there have been some small changes in the methodology of the NAS model with the last completed update taking place in 1994.

In the subsequent period there has been a large amount of empirical analysis carried as part of the further development of the internal health resource allocation formulae of the four countries of the UK. In addition, there have been significant changes in some of the socio-economic indicators used in the model which means that it may no longer be appropriate for them to be included. For example, there has been significant progress in terms of housing conditions, with only 0.5% of households in England lacking or sharing the use of bath/shower and/or inside WC, so that it is unlikely to be as important a factor as it has in the past.

The main criticism put forward by the Northern Ireland Executive, however, was that insufficient weight was given to deprivation factors in the HM Treasury NAS model. For example, in the HCHS element of the model mortality has ten times the weight of deprivation. However the latest internal allocation formulae of England, Scotland, Wales in Northern Ireland all place significant weight on deprivation factors although it is difficult to estimate precisely a weighting factor relevant to the NAS model from this work because of differences in the way the formulae are constructed

NI Executive Update and NI Executive Update+ models

The University of York was commissioned to provide an initial assessment of the evidence used by DHSSPS to suggest changes to the HM Treasury NAS model. It was acknowledged that there were weaknesses in the NAS model and that there might be a case for increasing the weight of deprivation in assessing relative need. However, the evidence put forward (including background statistical work) was considered to be insufficiently robust for all the revisions to be accepted in full and that more research would be required for the argument to have sufficient weight to affect a change in the NAS model (see Annex E). These criticisms are endorsed by this Review. However, it should be emphasised that the criticisms relate to the standard of evidence reviewed. It may be that a UK-wide analysis to derive an allocation model could endorse the suggested updates of the NAS model. However, as things stand, it is not possible to endorse all the revisions.

In addition, as with the use of the English and Northern Ireland allocation models, the relative needs estimates obtained from the Northern Ireland Executive updates of the HMT NAS model are very sensitive to just a few health needs proxy variables.

For example, overall the need indicator for the Northern Ireland Executive revised NAS model is 1.132. However, this depends largely on factors relating to the number of Income Support recipients which are present in almost all elements of the model. Setting each of these factors to one reduces the overall need indicator to 1.023.

From a different perspective, at 65%, the differential between Northern Ireland and England in terms of Income Support recipients per head of population in the NAS model appears to be high. Across the UK, Northern Ireland has by far the highest level of Income Support recipients per head of population despite having generally more favorable labour market conditions. For example, the unemployment rate is equal to the UK average of 4.8% and is lower than in London (7.1%) and the North East (5.4%), whilst the number of jobs per resident population is higher than the North East and Wales. As a sensitivity, applying the IS per head relativity for the North East (1.34) to the NAS model results in the overall need indicator falling from 1.132 to 1.0796.

There may be an argument for giving greater weight, however, to the NAS deprivation factors - based on practice in Scotland and England. But, again, the

evidence to justify the particular additional weight suggested by the updates is not considered robust.

As noted earlier, in the absence of a UK-wide allocation formula based on UK data to derive appropriate weights for relative needs factors etc, choosing between the models examined above becomes, in part, a matter of judgement.

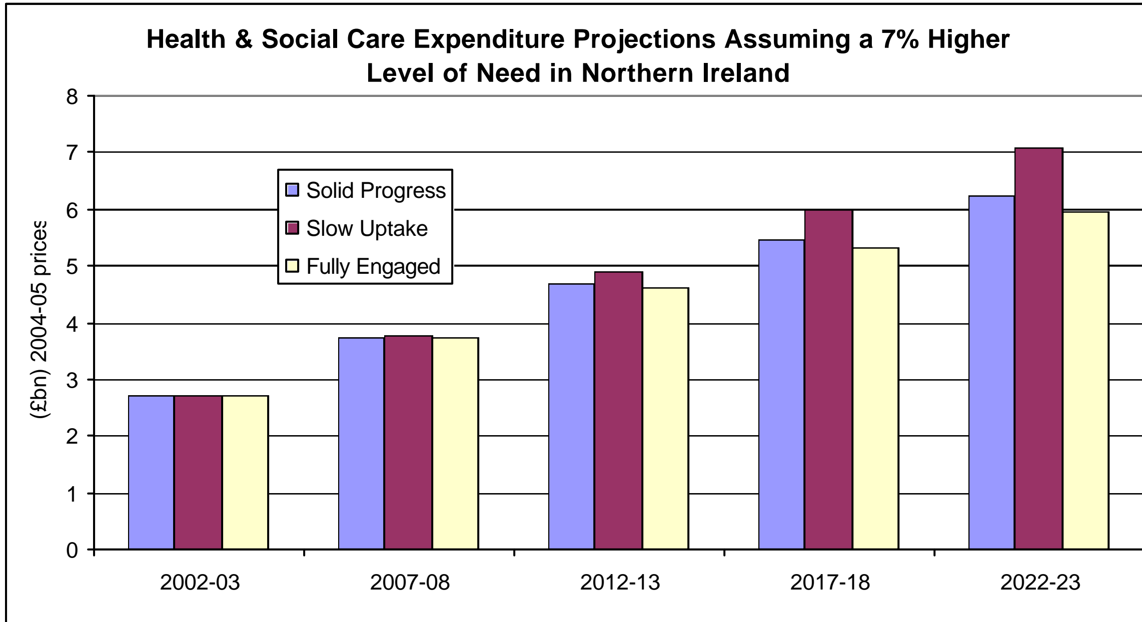
Given the criticisms and uncertainties noted above for the models tested, the two main candidates for a UK-wide formula are the NAS model, originally designed as an attempt at a UK-wide allocation guide, and the English capitation model populated with Northern Ireland data. The choice of the latter is based on the argument that it has relatively a stronger evidence base for the weights it employs and that in a UK-wide analysis to determine needs weights, English data would be likely to dominate, and that hence the current English weighted capitation formula is likely to get close to results that a UK-wide formula might produce.

However, as identified above, it has not been possible to perfectly populate the English capitation formula with Northern Ireland data, and the results are sensitive to changes in some of the factors underlying the model - to the extent that the additional per capita resourcing for Northern Ireland implied by the model could vary between 4% and 14% - the variation driven almost entirely by the very large (+59%) extra spend per head for mental health relative to England implied by the data used to populate this single needs factor.

Given this, the judgement of this Review (to be confirmed or denied in the light of any subsequent results arising from a UK-wide allocation model) is that a reasonable need differential between England and Northern Ireland should be around 7%. This is less than that implied by the English capitation model (due to the high sensitivity of the results from this model from just one needs factor - for mental health). But it is greater than that implied by the original NAS model, allowing for evidence from work carried out on the English and Scottish allocation formulae that the weight given to deprivation factors should be higher than 7.5%.

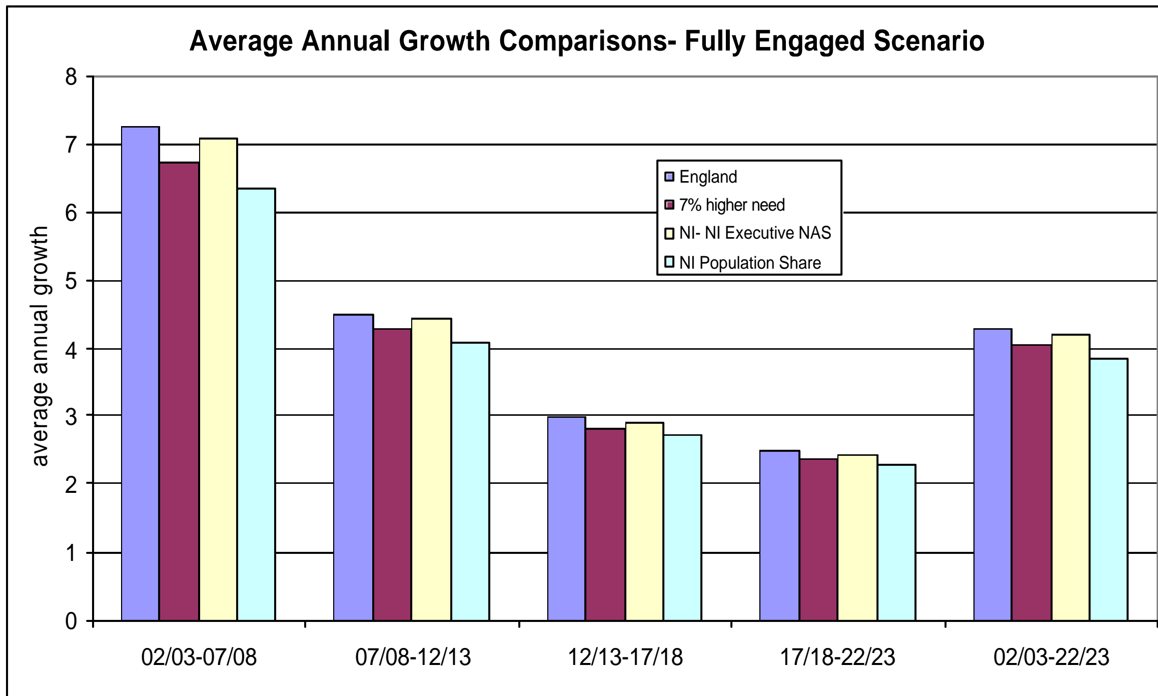
On this basis, the projected resource requirements for the health and social care sector in Northern Ireland over time under this assumed level of need are set out in figure 2.22 below.

Figure 2.22: Assuming a 7% higher level of need suggests real increases in Northern Ireland health and social care spending by 2022/23 of between £3.3bn and £4.4bn - percentage increases of between 121% and 162%



In terms of growth in expenditure, figure 2.23 below shows that there is a small difference in growth rates under the various scenarios, with the baseline position for England. The chart also highlights the extent to which the additional growth occurs in the 2002-03 to 2007-08 period with progressively slower growth in the five year periods thereafter.

Figure 2.23: Average Annual real growth Under the Fully Engaged Scenario is 4.0% for Northern Ireland assuming a 7% higher level of need compared to 4.3% for England.



Recommendation 3: Adopt HMT NAS model-based Wanless 'fully engaged scenario' projections as set out in Table 1 for now as best reasonable guide to future spending in NI.

Recommendation 4: Further work is needed to investigate the usefulness of employing direct measures of health status (for example, as derived from instruments such as the EQ-5D) in resource allocation models.

Recommendation 5: Future work on pan-UK resource allocation model would provide a more empirically-based answer to relative shares of resources. Such work should be open, and draw on extensive experience in the area of resource allocation models of research groups across the UK.

2.3.5 Implications of funding projections for the Barnett Formula

The projections detailed above imply that the health & social care sector in Northern Ireland will require an additional £210m in funding by 2022/23 compared to that which would be expected under the Barnett Formula, given the 7% higher level of need. There are two main mechanisms through which this funding could be secured:

(1) additional resources from HM Treasury (i.e. population share of English increases in spend, equivalent to an additional 7%)

(2) the re-allocation of resources from within Northern Ireland (i.e. reduce expenditure on other public services)

It is clear that option (1) would present significant difficulties for HM Treasury in terms of the potential repercussions for other parts of the UK and for other spending programmes.

The alternative is that the additional funds required for health & social care, over and above that received in the form of the respective Barnett consequentials, are obtained by diverting resources from other spending programmes within Northern Ireland. Under this scenario, for health spending per head to be 7% higher than in England would require spending in all other spending programmes to be 5% lower than in England, equivalent, for example, to a 15% fall in the Department of Education budget[28].

Such an outcome is clearly inconsistent with the "…long established principle that all areas of the United Kingdom are entitled to broadly the same level of public services and that the expenditure on them should be allocated according to their relative needs"[29]. In addition, the implication of the Barnett Formula - that public spending per head should be equalised across the UK - does not apply to the current position

[28] Alternatively if spending on schools was assumed to be in line with relative pupil numbers then spending in the rest of the NI departments would need to fall by almost a quarter.

[29] Para 2.9 Needs Assessment Study Report. The Report of an Interdepartmental Study co-ordinated by HM Treasury on the Relative Public Expenditure Needs in England, Scotland, Wales and Northern Ireland HM Treasury (1979)

within England where, for example, identifiable public expenditure is 15% higher per head of population in the North East than England as a whole[30].

Whilst additional work is required to assess with greater precision the UK wide variations in need for health and social funding, as an initial position it is the view of this Review that the second option for funding the spend projections detailed above are not feasible and are inconsistent with the parity of provision principle. Therefore, there should be some form of Barnett formula bypass, as has been the case in the past, to allow the same level of service to be provide in Northern Ireland as the rest of the UK.

> **Recommendation 6: If the future spending path suggested by this Review is accepted, then there needs to be some way round the implications of the Barnett Formula for health and social care if the general principle of Barnett are to be maintained and other public services in Northern Ireland are not to suffer.**

[30] 2004/05 figures from Table 8.11 in PESA 2005 (HM Treasury)

3: Health and Social Care in Northern Ireland Today

3.1 Introduction

The previous section provided an overview of current health and social care funding and allocations in Northern Ireland, and used the approach to future funding employed by the first Wanless Review to suggest a set of future spending paths for health and social care services. These implied a more than doubling in real terms of funding over the next twenty years. But setting the broad budget parameters only tackles part of the task of delivering a high quality health and social care service; health care needs, how services are used and the efficiency with which services are delivered all combine to determine the quality of the outcomes services can produce.

This section therefore reviews the implied demand for health and social care services arising from the current state of health of the Northern Irish population, the actual demand as revealed by the use of services and, crucially, the extent to which health and social care resources are currently being used effectively to address needs and provide acceptable levels of access to services.

In particular, we cover in some detail issues concerned with waiting lists and times, efficiency and productivity and workforce and pay.

Section Conclusions

In considering the health & social care system in Northern Ireland there has tended to be little analysis of performance, with the main emphasis being on funding as the main determinant of outcomes such as waiting times. Whilst to an extent this is understandable given the difficulty in measuring the efficiency with which public services are delivered, it is vital that the performance of the health & social care sector is monitored in support of a rigorous performance management system.

In this section, the performance of the Northern Ireland health & social care sector is compared with the rest of the UK across a range of indicators, collectively providing a broad indication of relative performance. In terms of waiting times the picture is unambiguous, with Northern Ireland having significantly longer waits than the rest of the UK. It is important to recognise however that there are significant variations within Northern Ireland between trusts and between specialties, with some areas making significant progress whilst in others, performance is less impressive. Therefore, long waiting times can be reduced by adopting a long term strategy, including long term targets backed by strong incentives,

Activity levels per head of population in Northern Ireland hospitals are found to be broadly similar to the rest of the UK, although A&E attendances are significantly higher, raising questions regarding demand management. In addition, given that there are significantly more resources used in the provision of health care in Northern Ireland, this implies that efficiency is lower in terms of inputs such as staff and beds as well as overall funding. Whilst the lower level of efficiency may in part be due to factors considered legitimate - such as the provision of services in rural or deprived areas - the full opportunity cost of such policy decisions needs to be fully appreciated.

In terms of staff, despite a general perception to the contrary, Northern Ireland appears to be reasonably resourced in a UK context with significantly higher levels of staffing than in England. In addition, the local labour market for health and social care staff appears to be relatively benign in terms of the recruitment and retention of staff with lower vacancy rates, use of international staff and cost of living whilst there is a larger public sector pay premium than is the case for the other UK regions. In terms of the Governments policy on public sector pay and the significant financial implications of recent pay reforms in the health sector, the continued maintenance of pay parity with the rest of the UK needs to be re-examined.

The issue of pay was also found to be relevant in terms of Family Health Services where it was not clear that the new payment contracts represented value for money. The relationship between GP's and the rest of the health & social care system appeared to be somewhat disjointed as a legacy from fundholding. In addition, despite implementing various initiatives to reduce the problem, Northern Ireland still has a significantly higher level of spend on prescription drugs per head of population than the rest of the UK. As with the rest of the health & social care sector this can be linked in part to the absence of sanctions to discourage poor performance.

Social services is the area of the health & social care system where provision in Northern Ireland is considered to be the furthest behind that in England. Whilst the available evidence suggests that this is not necessarily the case, Northern Ireland still appears to be many years behind in England in terms of achieving the policy aim of providing social services in a community rather than hospital environment wherever possible. In addition, despite having lower unit costs than in England, there appears to be scope for services to be delivered more efficiently.

3.2 Health

The health of any population is a complicated function of many economic, social, cultural, lifestyle, educational and other factors, as well as the level and consumption of health and social care services, provided and used over people's lifetimes. Although there is a conventional wisdom that health and social care contribute only marginally to improvements in population health, it is now increasingly recognised that once the big breakthroughs in public health measures have been achieved - proper sanitation, good housing, universal education and so on - organised health and social care services, at the margins, have a substantial impact on improvements in life expectancy and other measures of health.

While, in part, improvements in populations' health is attributable to the provision of health and social care services (and provide an indication of the success or performance of services), care needs to be taken in interpreting changes in, or comparative levels of, health either in terms of success or in terms of failure to fully meet needs (with the implication that too little is being spent on services).

Here we provide an overview of broad measures of the health of the Northern Irish population and report on a survey of a sample of the population carried especially for this Review and investigating people's self-reported health.

3.2.1 Mortality

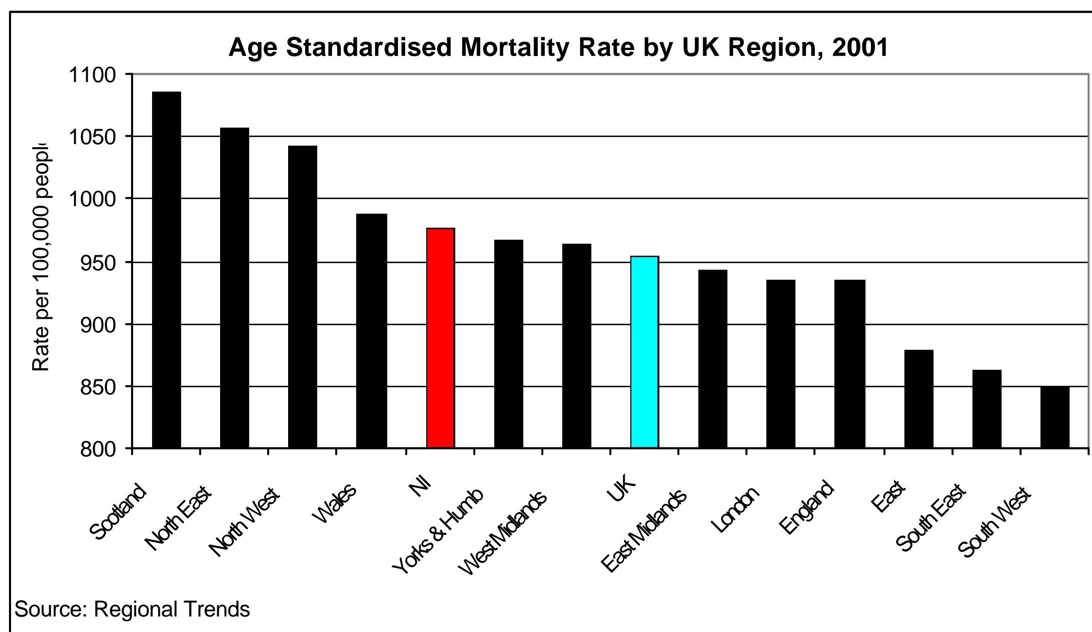
Age-standardised mortality rates per 100,000 population in Northern Ireland are comparable to Yorkshire and Humberside and around 2.4% higher than for the UK as a whole (figure 3.1). Although cancer mortality rates are lower than the UK average, Northern Ireland has significantly higher rates for respiratory diseases and the highest mortality from road traffic accidents. Infant mortality is also now close to the UK average having fallen from 13.2 per 1,000 live births in 1981 to 5.3 in 2004.

An issue that arose in the Review's consultation process was the assertion that the high number of suicides in Northern Ireland was a reflection of broader general mental health problems - and by implication, a need for greater investment in mental health services. However, mortality rates from suicides match the UK average.

As in many countries, however, over time, overall mortality in Northern Ireland has been falling. In fact, between 1996 and 2001, death rates have fallen by nearly 14% - faster than for the UK as a whole (9%)[31].

[31] However, in a historical context, during the 1960's NI had the lowest level of mortality of any UK region (Bardon J, A History of Ulster)

Figure 3.1: The age standardised mortality rate in Northern Ireland is 2.4% higher than the UK average in 2001



Source: Regional Trends

Falling mortality rates means that life expectancy improves. And over the last twenty years life expectancy at birth in Northern Ireland has increased by 4.2 years for females and 6 years for males - although females (80.6 years at birth) continue to have a significantly higher life expectancy than males (76.0).

Figures 3.2 and 3.3 show that over the past two decades life expectancy for both females and males has grown at a faster rate in Northern Ireland than the other constituent countries of the UK with the result that life expectancy is now higher than Wales although still slightly lower than England. Over the next fifty years, although the rate of growth in life expectancy is expected to tail off, by 2053 life expectancy in Northern Ireland is expected to have increased by a further 5.4 years for females and 6.1 years for males compared to 2003[32]. The DHSSPS aims to increase the life expectancy at birth of males and females in Northern Ireland by 3 and 2 years respectively by 2012; this represents an increase of 1.8 and 1.5 years over that projected by the Government Actuary.

[32] Source: Government Actuary Department

Figure 3.2: Female Life expectancy (at birth) in Northern Ireland is now close to the level in England.

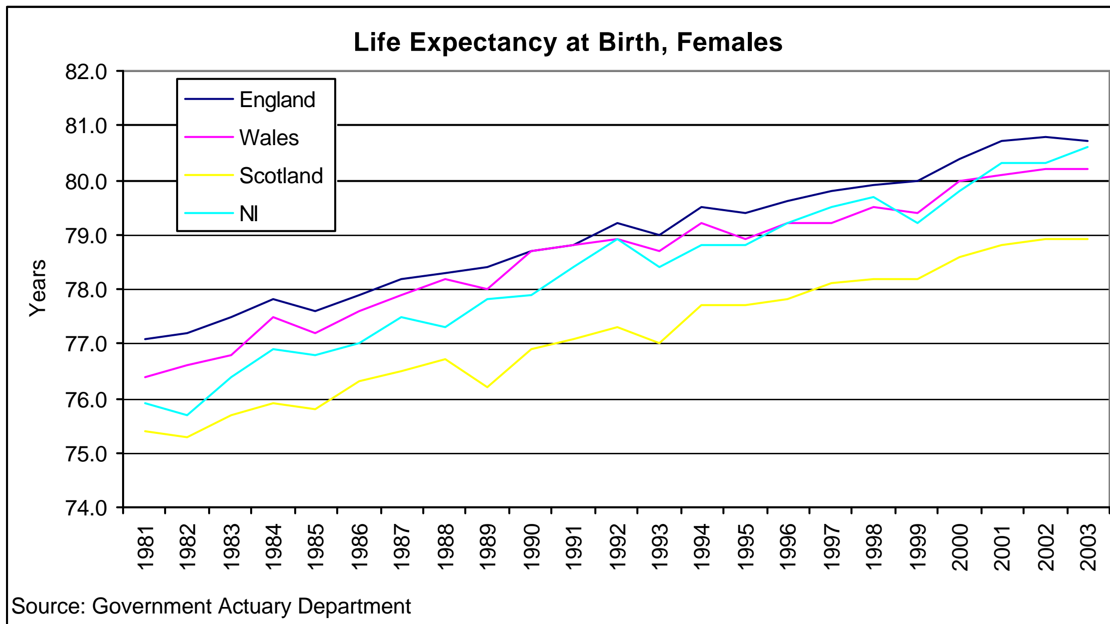
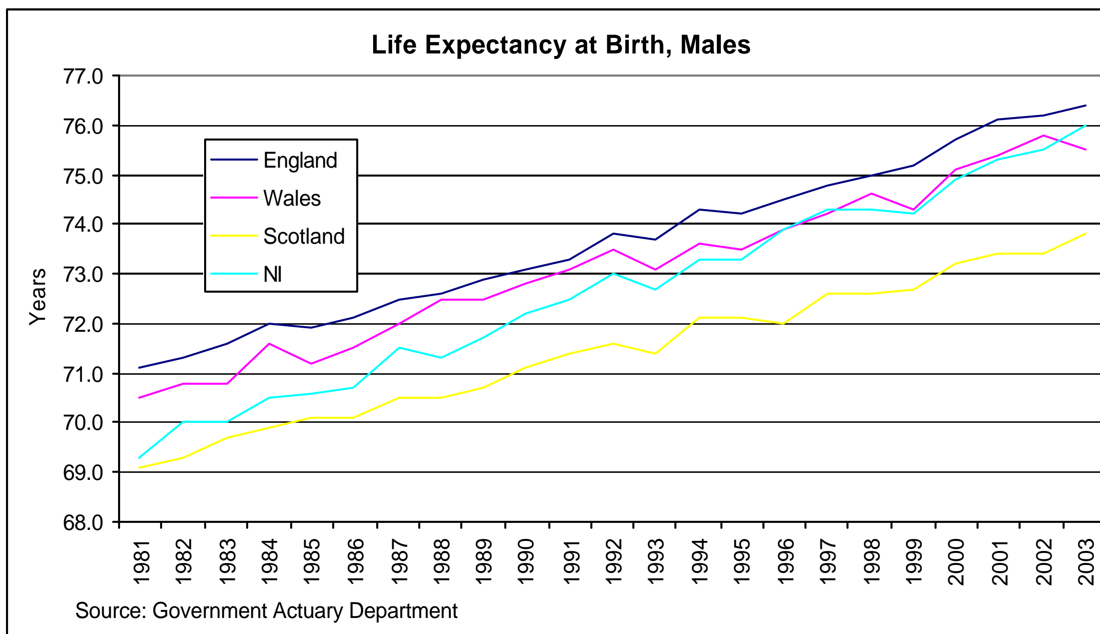


Figure 3.3: However, the rate of convergence with England has been greater for males.

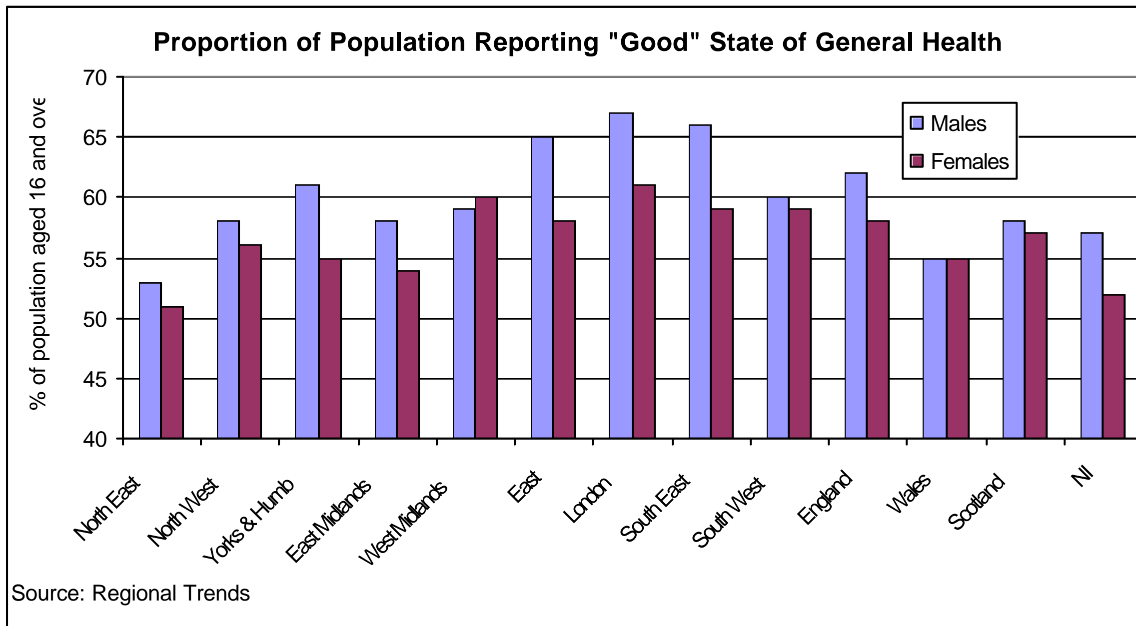


3.2.2 Self-reported health status

While mortality figures provide one perspective on the health of populations (and, with qualification, an indication of health service performance/need for investment), the vast bulk of the work and activity of health and social care services are directed at improving people's (health related) quality of life.

From this point of view, figure 3.4 - based on the General Household Survey - shows that the proportion of the population reporting themselves to be in good health is lower in Northern Ireland than most of the other regions of the UK (with the exception of the North East, and Wales with respect to males).

Figure 3.4: The proportion of population reporting "Good" state of general health in Northern Ireland is among the lowest in the UK in 2001



In order to expand on the information available on people's self-reported health status (and to provide data for the future funding modelling work detailed previously in section 2.3.4), the Review commissioned a special survey of 2,000 members of the public across Northern Ireland, using a generic, self-completed health status questionnaire - the EQ-5D[33].

One further reason for using this survey instrument was that the Health Survey for England also used the EQ-5D in its 2003 survey, enabling some direct comparisons to be made with the results from the Northern Ireland survey.

In the EQ-5D survey, respondents were asked the extent to which they have problems in various aspects of everyday life. Figure 3.5 shows that a higher proportion of people in Northern Ireland than England have problems with self-care and usual activities such as work and leisure activities. On the other hand, a lower proportion report problems with pain/discomfort or anxiety/depression.

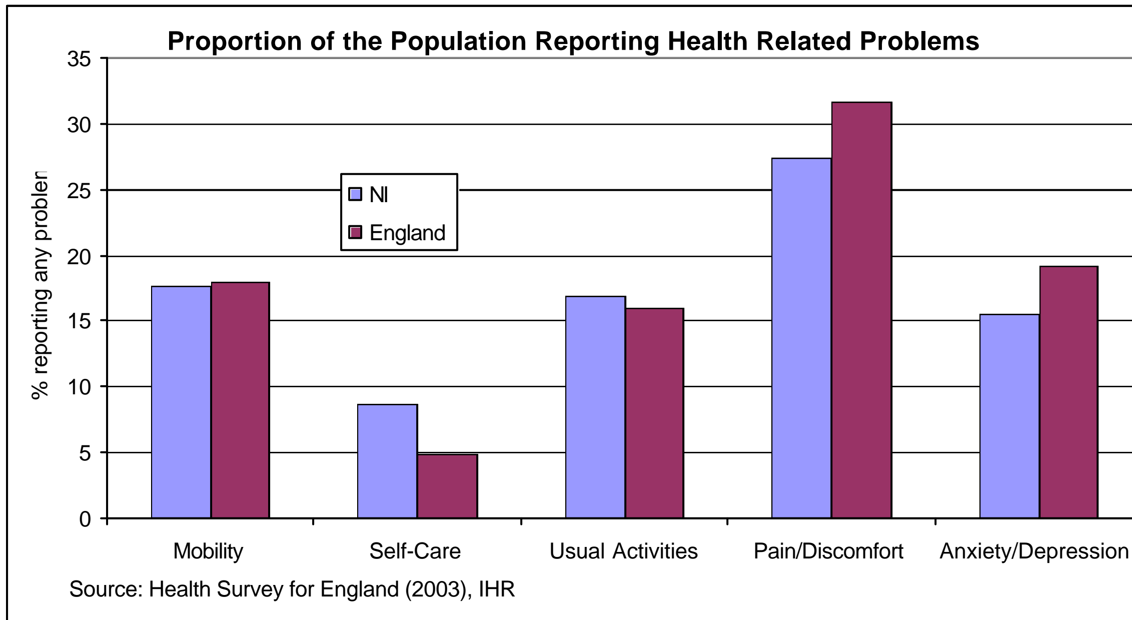
It is also possible to obtain an overall measure of health status by combining these five dimensions of the EQ-5D (details of the calculations used to construct the EQ5D index are contained in Annex F)[34]. On this weighted aggregate measure, overall the population sample for Northern Ireland reported a health status some 4% *lower* than that of an equivalent population group resident in England.

This average score masks significant variations within Northern Ireland (and across England) - as figure 3.6 shows.

[33] The EQ-5D is a well-tested instrument often used in clinical trials as well as across populations and designed to produce a single health score. Further details of the survey are contained in Annex F

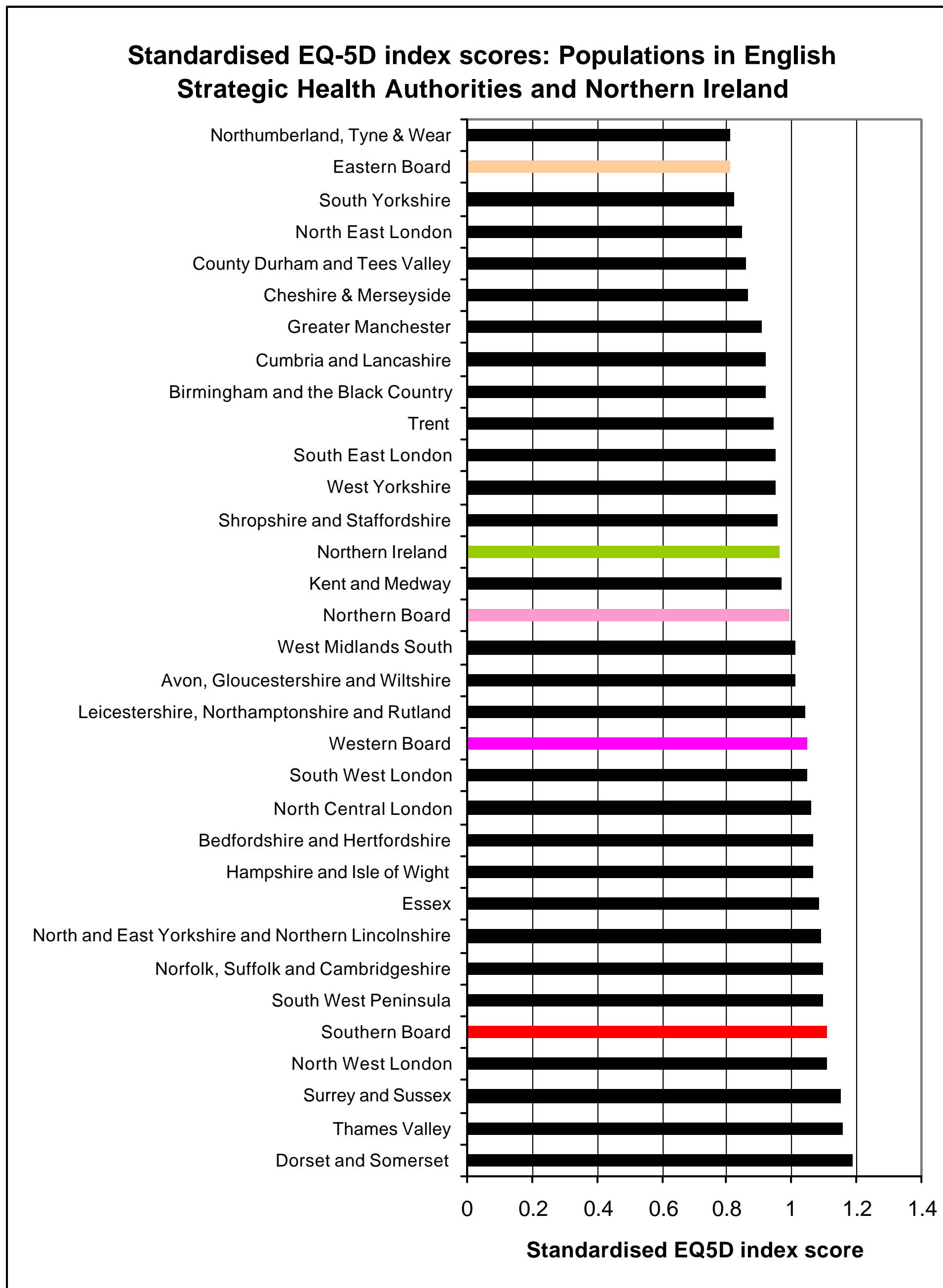
[34] When applied to subgroups of interest this index takes a value greater than 1 where health status is higher than that of an equivalent normative age/gender sample of the target comparative population. The index is lower than 1 where that health status is poorer.

Figure 3.5: Although the proportion of the population reporting health related problems is slightly lower in Northern Ireland than England on an unweighted basis, once adjustment is made for relative social values for the five dimensions, health status in Northern Ireland is lower than in England.



Within Northern Ireland, for example, there were found to be a significantly higher proportion of people reporting problems with health and a lower health status score in Belfast than the rest of Northern Ireland. Whilst the Southern Health and Social Services Board would have been ranked 5th out of the 28 Strategic Health Authorities in England, the Eastern Health and Social Services Board would have been the second lowest in terms of self-reported health status as measured by a standardised EQ-5D index (see figure 3.6).

Figure 3.6: Health Status of People Living in the Eastern Health Board Area is around 16% worse than the Northern Ireland average.

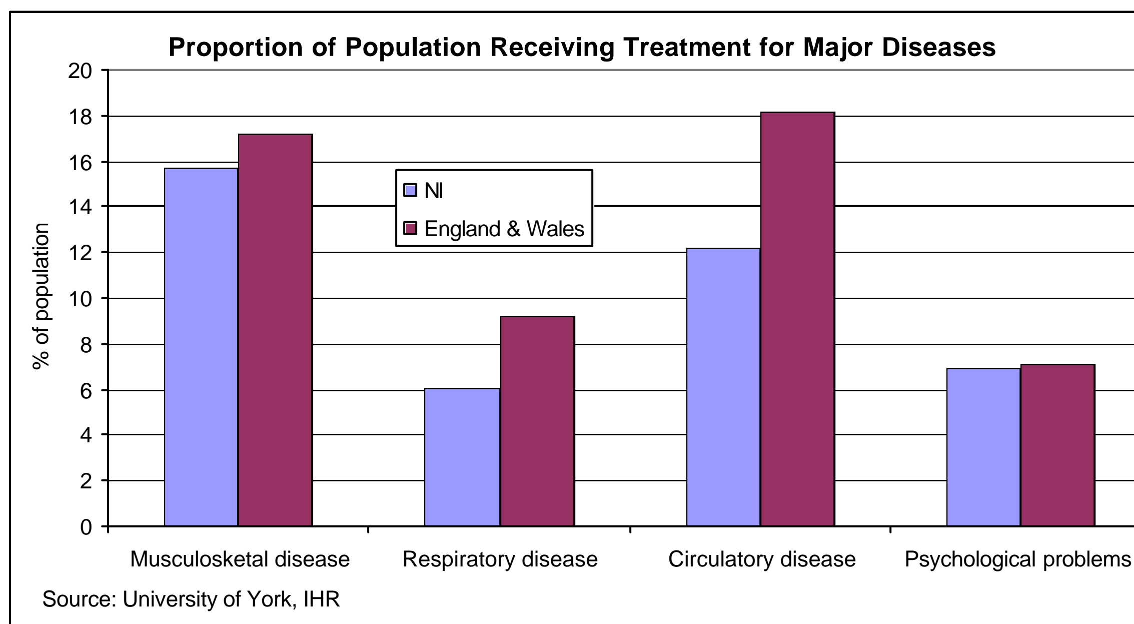


The EQ-5D survey also asked respondents to score their current state of health between 0 (representing the worst state of health) and 100 (the best possible state of health). The average score for Northern Ireland females was 76.2 compared to 76.8 for males. The overall score for people in Northern Ireland was around 3% lower than that found in previous studies for England, with the differential greater for males.

The survey also included questions relating to whether treatment was currently being received for a range of therapeutic areas. Figure 3.7 shows that there is a lower proportion of people in Northern Ireland than England & Wales currently receiving treatment. This result is somewhat surprising given that health status is worse in

Northern Ireland and is inconsistent with the data that will be presented in Section 3.3 which implies that hospital activity levels are close to the UK average in Northern Ireland.

Figure 3.7: People in Northern Ireland are less likely to be currently receiving treatment than in England & Wales for major diseases.



3.2.3 Distribution of health

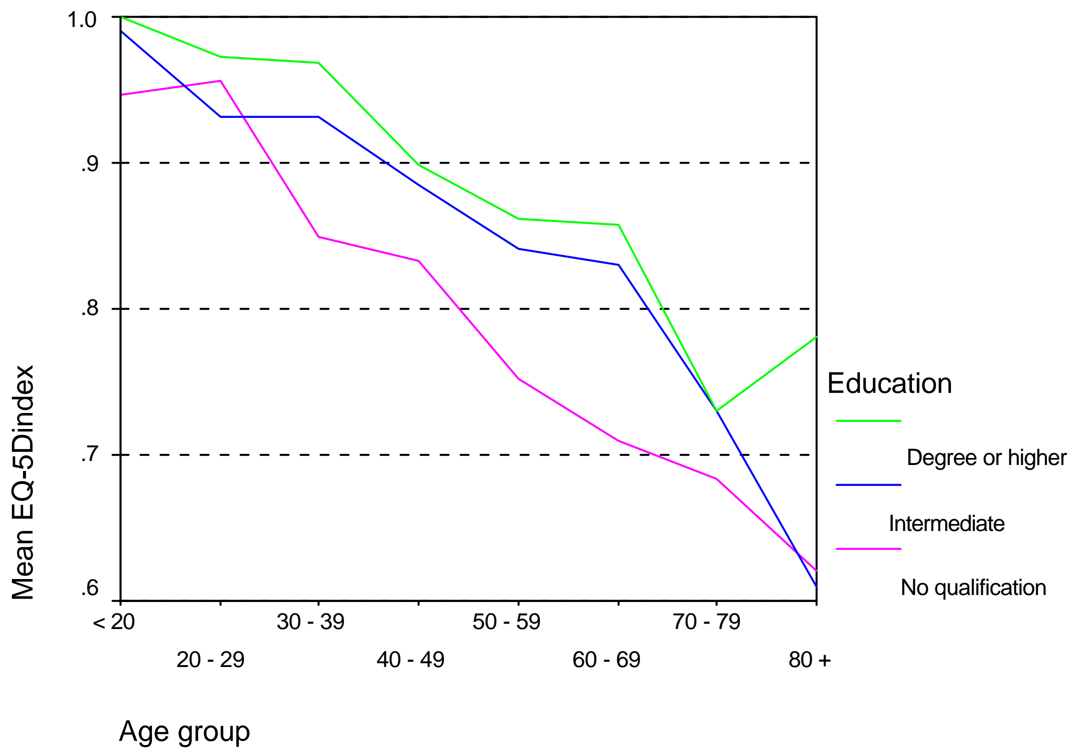
Although overall mortality rates are improving, there remain significant health inequalities within Northern Ireland. For example, data covering 1998 to 2002 show that mortality rates in the under 75s are 47% higher in socio-economically deprived than non-deprived wards. People in deprived areas are also more likely to be admitted to hospital - particularly as emergency admissions; admission rates for people living in deprived wards are 41% higher than in non-deprived wards, for example.

In terms of community background, 55% of those living in the fifth of wards with the worst premature mortality rates have a Catholic community background whereas 44% of the population are from this community[35].

Apart from the geographical variation in EQ-5D index scores across the four Northern Ireland health boards, the survey also recorded some characteristics of respondents - in particular, educational attainment. As figure 3.8 shows, EQ-5D index scores show a marked difference depending on educational attainment.

[35] Data source for this paragraph is DHSSPS report *Health and Social Care Inequalities Monitoring System: First Update Bulletin 2004*

Figure 3.8: People with higher educational attainments report better health across all age groups.



3.2.4 Lifestyles and health-seeking behaviour

As we note above, the determinants of a population's health are many and varied and while the level and distribution of health and social care services plays an important part in explaining changes in health, lifestyle factors - particularly for some diseases, for example, lung cancer - are also an important contributor to the general health well being of the population.

Table 3.1 sets out the main comparisons in terms of key lifestyle behaviours - diet, smoking, drinking, exercise and cancer screening. It can be seen that Northern Ireland has higher levels of fat intake and excessive drinking than England & Wales, whilst physical activity is below the rest of the UK. Although the proportion of people who smoke - around a quarter of the population - is similar to other parts of the UK, Northern Ireland has a higher percentage of heavy smokers. In terms of prevention, although the proportion of women screened for breast cancer is higher than in England & Wales.

Heavier drinking and smoking coupled with a high fat diet and a sedentary lifestyle add up to poorer health outcomes - regardless of the best efforts of the health services. But unhealthy lifestyles not only affect health outcomes but also place significant resource pressures on the health and social care system as they address the health consequences and with a consequential impact on the level of service provision (as shown in the UK Wanless Report[36]).

[36] The Final Report of the UK Wanless Review, Securing our Future Health: Taking a Long-Term View, projects under the solid progress scenario (which incorporates inter alia the meeting of public

Table 3.1: Prevalence of healthy lifestyle choices for UK countries

	England	Scotland	Wales	NI
Fat intake per day (grams)[1]	73	71	73	76
% of people who smoke[2]	26	28	27	26
Excessive Drinking (Males)[3]	21	29	23	27
Exercise (%)[4]	11.4	10.4	12.8	7.1
Cervical Cancer Screening (%)[5]	81.6	86.5	80.0	72.2
Breast Cancer Screening[6]	69.8	75.0	66.6	72.6

Source: National Statistics, NISRA
Notes:
1. 1999/2000 data
2. 2002/03 data for persons aged 16 and ov er
3. 2000/01 data for persons aged 16 and over relating to more than 8 units of alcohol in past week
4. 2000 data based on minutes per day spent on physical activity as a % of sedentary activity
5. March 2002 data as % of all aged 25-64
6. March 2002 data as % of all aged 50-64

Recommendation 7: Routine collection of self-assessed health status data at population level would yield useful comparative data on population health status. In addition, the potential for routine collection of patient related outcome measures in health care services should be explored.

Recommendation 8: On the basis of current lifestyle data, the funding recommendations based on the Wanless 'fully engaged' scenario (investigated in more detail in a subsequent report[37]) imply considerable effort will be needed to engage the Northern Ireland population through expanded public health services and other means.

health targets) a 12.5% lower need for expenditure by 2022/23 than under the slow uptake scenario where no change in public health behaviour is assumed.

[37] In April 2003, the Prime Minister, the Chancellor and the Secretary of State for Health asked Derek Wanless to provide an update of the challenges in implementing the fully engaged scenario set out in his report on long-term health trends. Derek Wanless' final report "Securing Good Health for the Whole Population" was published on 25th February 2004.

3.3 Utilisation and activity[38]

While the population's health is a central factor explaining the level of use of health services, it is important to bear in mind that the use of services is a reflection not only of the need for care, but also the availability of services; demand (need) is not always independent of supply. In this section we examine secondary care utilisation and activity (including the independent sector). Subsequent sections examine family health services and personal social services and contain a wider ranging discussion of funding and organisation of these sectors.

3.3.1 Hospital activity

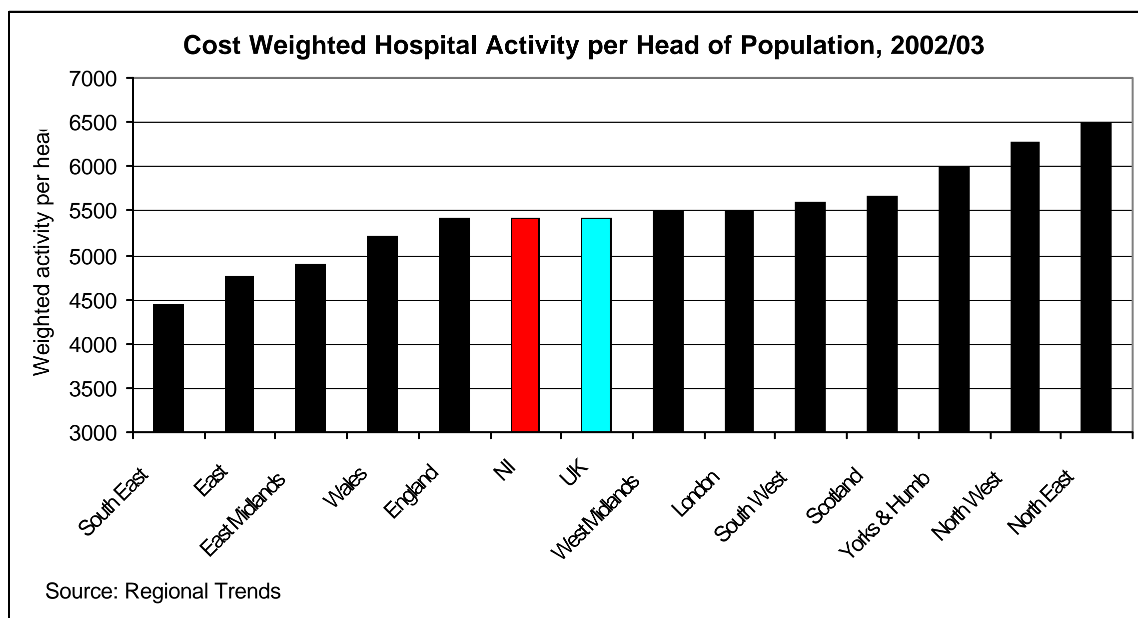
Figure 3.9 sets out an aggregate measure of secondary care activity in terms of inpatient, day case, out-patient and A&E attendances per head of population, weighted and summed on the basis of unit costs[39]. It can be seen that on this measure, Northern Ireland has a very similar level of aggregate hospital activity to England and marginally lower than the UK as a whole (see Box 3.1 regarding differences between published activity statistics and those used in this Review).

Box 3.1: Hospital activity data

Publicly available information on hospital activity has, from 1998/99, included data on renal dialysis treatments. These number around 33,000 deaths and discharges in 2003/04 - equivalent to around 10% of all inpatient cases across Northern Ireland. While these cases have been included in published statistics for hospital activity in Northern Ireland, here we exclude them as they distort comparisons (and time trends) as such cases are not included in the inpatient activity statistics for Great Britain. This exclusion has a significant impact on activity trends and productivity measures noted later in this review.

[38] In this section the terms utilisation and activity are used interchangeably.
[39] This is similar to the cost weighted activity index (CWAI) used in aggregate measures of efficiency and enables the aggregation of activities measured in different units - attendances, hospital stays etc.

Figure 3.9: Aggregate cost-weighted hospital activity per head of population in Northern Ireland is slightly below the UK average, 2002/03.

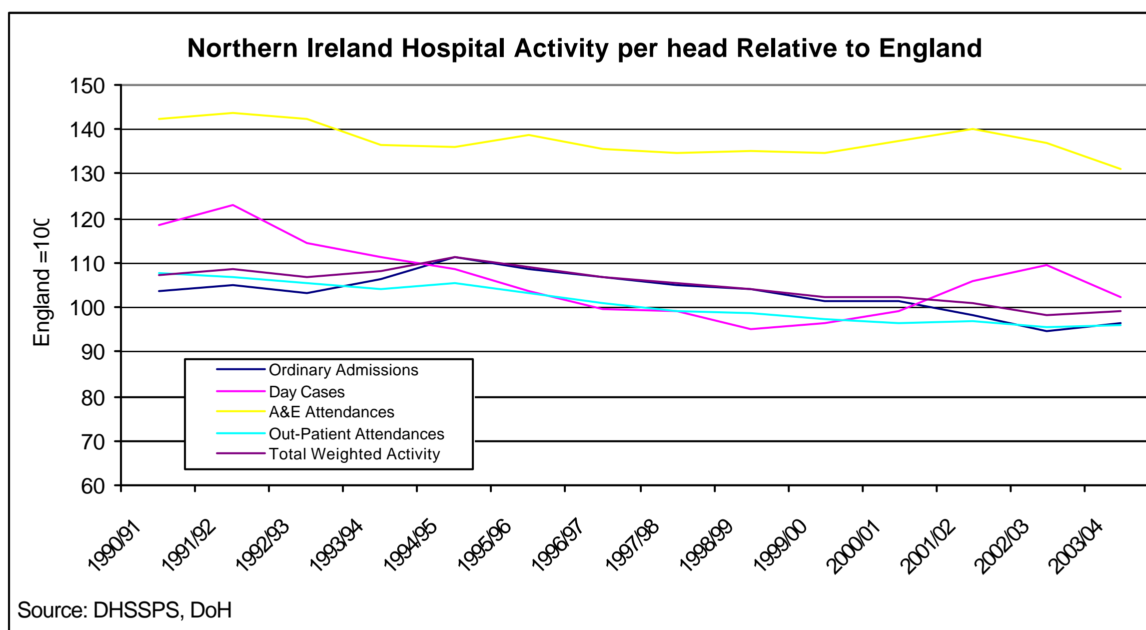


However, this aggregate measure of hospital activity masks an important difference with England. In particular, figure 3.10 shows that the level of accident and emergency attendances per head of population in Northern Ireland is 31% higher than in England[40]. Why this should be so (and indeed, why this has remained the case for many years) is not clear. Higher levels of provision and deprivation, a culture of using A&E in preference to general practice and problems with out of hours GP services have been offered as explanations, but to the knowledge of this Review there have been no in-depth studies or analysis to verify these explanations or explore the appropriateness of this level of A&E utilisation.

Recommendation 9: Further investigation is required of very high A&E use to explore reasons and find ways for reducing likely inappropriate use

[40] Provisional figures for 2004/05 indicate that the gap between Northern Ireland and England has fallen to 28% although A&E attendances in Northern Ireland still rose by 1.7% over the year.

Figure 3.10: The number of A&E attendances per head of population is 31% higher in Northern Ireland than England whilst there are 4% fewer out-patient attendances.



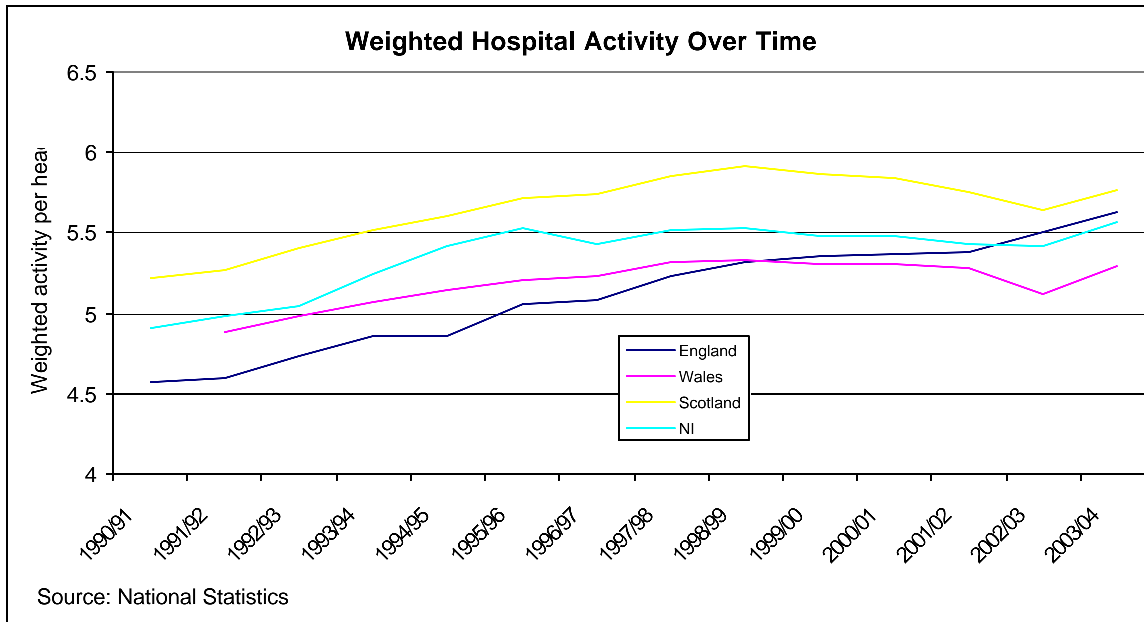
As for change in hospital activity over time, Table 3.2 shows that over the past decade there has been significant growth across the UK, with the rate of growth being highest in day cases and lowest in A&E. Unadjusted hospital activity in Northern Ireland has increased at a faster rate than in Scotland, but more slowly than England and Wales. However, once the higher weighting given to inpatient activity is incorporated, then Northern Ireland has had the second fastest growth in hospital activity

Table 3.2: Annual average growth in hospital activity, 1990/91-2003/04

	England	Scotland	Wales	NI
In-Patients	1.3	0.5	0.5	0.9
Day Cases	9.9	5.1	8.8	8.9
A&E	0.8	0.4	0.9	0.3
Out-Patients	1.7	0.1	1.6	1.0
Weighted total	1.9	0.7	0.8	1.5

Growth in utilisation and activity since 1990 has not been even, however. As figure 3.11 shows, most of the growth in activity occurred in the early part of the 1990's with slower growth subsequently. Since 1990/91, activity levels per head of population in Northern Ireland, Scotland and Wales have moved broadly in tandem, with little or no growth since 1997/98. However, levels of activity in England have been on a continual increase since 1996/7.

Figure 3.11: Scotland, Wales and Northern Ireland have not experienced significant growth in weighted hospital activity per head of population since 1997/98.



The trends in activity for Scotland, Wales and Northern Ireland show, as figure 3.11 indicates, a distinct change more recently, with sharp increases in 2003/4.

This increase in 2003/4 is also noticeable in trends for Northern Ireland in ordinary, and day case admissions and outpatient attendances (see figure 3.12). Figure 3.12 also shows that whilst the total number of ordinary admissions is now close to the level it was a decade ago, this has followed a nearly continuous decline since 1995/6.

Disaggregating ordinary activity further, shows, in figure 3.13, that the rise in ordinary activity in 2003/4 was wholly attributable to an increase in the number of emergency admissions to hospital. Importantly, the number of *elective* admissions - which include admissions from waiting lists - has been steadily falling since the mid 1990s and is now nearly a quarter lower than it was in 1994/5. This trend in elective admissions provides part of the explanation for the growth in waiting lists and times examined in more detail in section 3.6.

Recommendation 10: Detailed analysis is needed into hospital activity trends as part of a broader analysis of the dynamics of waiting times and lists.

Figure 3.12; There was a significant increase in all forms of hospital activity in Northern Ireland in 2003/04

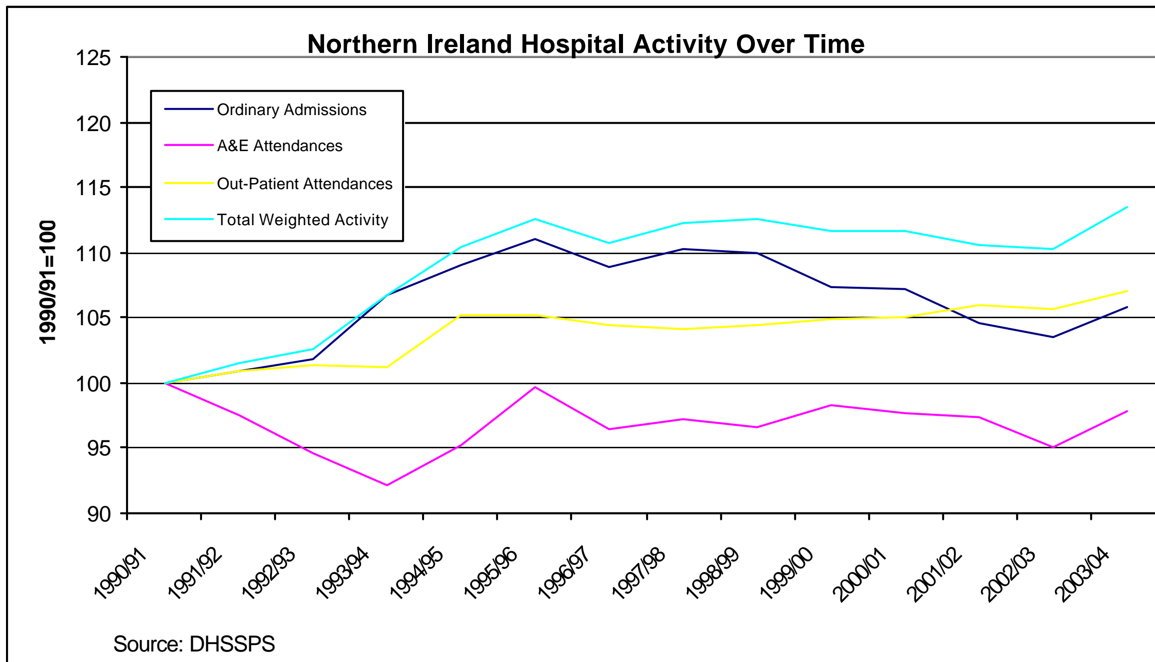
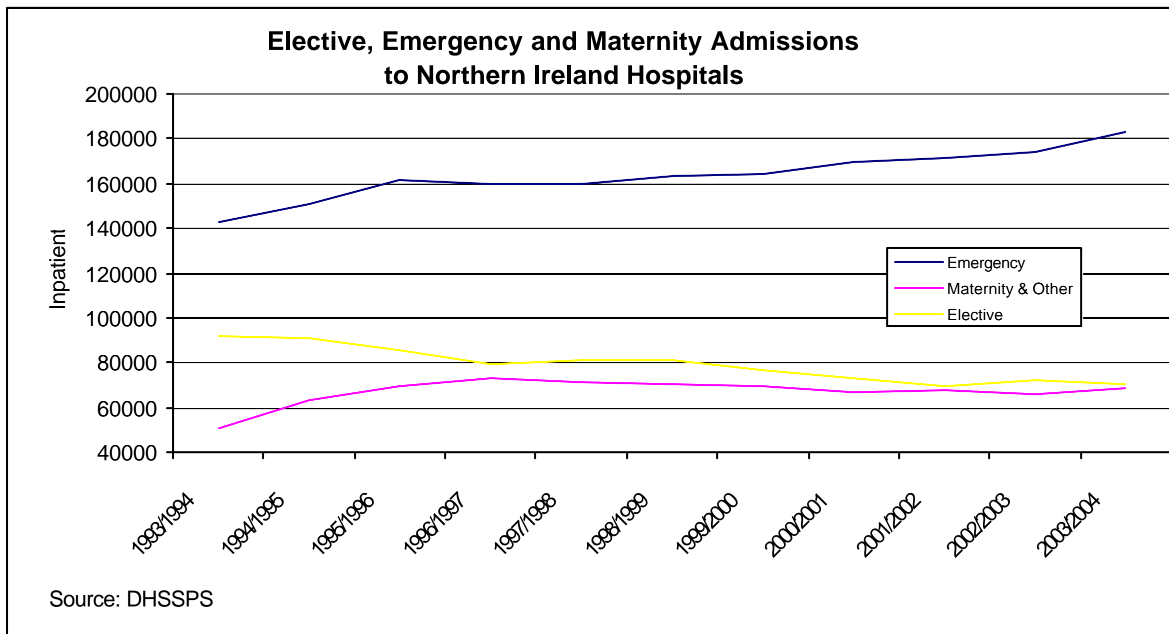


Figure 3.13: The number of emergency inpatient admissions has increased by 23% since 1993/94 whilst the number of elective admissions has fallen by 24%.



3.3.2 Private sector health & social care[41]

Despite recent growth, the private sector contributes only a small proportion of health care activity in the United Kingdom and an even smaller share for Northern Ireland. The private sector has the potential to benefit the health care system through raising

[41] Although the main focus here is on hospital activity, the private sector also has a significant role to play in the provision of nursing homes places as well as community/social care packages.

capacity, and, given a competitive economic environment, increasing pressure on public sector providers to improve performance by providing an alternative to the public sector[42]. However, private healthcare providers can also have a detrimental impact by exacerbating staff shortages in the public sector as well as creating financial uncertainty.

Prior to 2000, the Government's policy in England was to oppose any expansion of the use of the private sector to provide clinical services to NHS patients. However, with the publication of the NHS Plan and the identification of short term NHS capacity constraints as a hurdle in tackling waiting times targets set by the Plan, the purchase of private sector capacity by the NHS on behalf of NHS patients was seen as a way forward. By the end of 2005, private providers will carry out 4 per cent of publicly financed elective treatments in England, rising to 15% under Government plans[43]. There are no immediate plans for the Northern Ireland health & social care sector to follow such an approach, despite having longer waiting lists. Whilst acknowledging that in the coming years an increased number of patients will be treated in the private sector, the DHSSPS Regional Strategy for 2005-2025[44] raises concern regarding competition for staff.

The distinction between the public and private sector can be defined in terms of payment and provision. In terms of payment, 10% of all households in Northern Ireland have Private Medical Insurance whilst in Great Britain the range is from 8% in the North-East of England to 26% in the South-East, with a UK average of 17%[45]. In terms of provision, there are currently only two private hospitals in Northern Ireland with a total of 84 beds. This equates to approximately 0.05 beds per 1,000 population compared to 0.18 for the UK as a whole and 0.11 in Wales.

Private activity also takes place in public sector facilities. And in addition, Health Boards purchase treatments on behalf of the NHS from private health care providers not only in Northern Ireland but Great Britain and the Republic of Ireland as well.

Private activity in Northern Ireland's HPSS hospitals accounted for 1.4% of all finished consultant episodes in 2003/04, and 0.6% of out-patient attendances. Over half of all these outpatient attendances were for two specialties, gynaecology and cardiology.

[42] But this depends on how competitive the private sector is. For example, the NAO Wales report into NHS waiting times found that the average private sector costs for certain procedures was higher in the NHS whilst private treatment centres in England are being paid at rates above the national average.
[43] Source: The Economist 9-15 April 2005
[44] DHSSPS: A Healthier Future, A Twenty Year Vision for Health and Well-being in Northern Ireland 2005 – 2025
[45] Source: Family Resources Survey 2002/03

Table 3.3: Northern Ireland NHS hospitals treat a higher proportion of patients privately than in England or Wales. [1]

	In-Patients	Day Cases	Out-Patients
Northern Ireland	0.7	2.9	0.6
Wales	0.3	1.1	0.3
England		0.9	0.5

Source: DHSSPS, NAW, DoH
NI data is for 2003/04 whilst England and Wales are for 2002/03

Whilst this is a relatively small proportion, it is higher than in England and Wales (see table 3.3). However, the level of NHS income derived from private patients per head of population in Northern Ireland is less than half that for the UK as a whole[46]. This would suggest that either private activity in Northern Ireland hospitals is less costly than in Great Britain or that the HPSS is not charging the full economic cost for the use of facilities. Over the past five years, whilst the number of private day cases in Northern Ireland hospitals has fallen by 3%, the number of in-patients has increased by 13% and out-patients by 42%.

In 2003/04, Health Boards spent £10m on the treatment of 3,000 patients transferred to private health care providers - mainly as part of initiatives to reduce waiting lists[47]. This is equivalent to around 4.4% of the elective inpatient finished consultant episodes carried out in the HPSS in 2003/04. Whilst the number of patients treated under these initiatives has increased by 64% since 2001/02, expenditure has risen by 125%. The cost per treatment appears to be higher under these waiting list initiative than the unit cost for elective procedures in the HPSS. There is also some variation in cost between Boards[48]. Although this may simply reflect differences in case mix, in light of the concerns raised by the Welsh Audit Office[49] with respect to the use of private provision by the NHS in Wales it is important that this spending is audited for value for money.

Whilst the private sector remains a relatively insignificant provider in terms of the entirety of health service provision in Northern Ireland, at the margins it can make an important contribution to certain areas, in particular in tackling waiting lists[50]. However, while purchasing NHS care from the private sector can add a useful element of flexibility, value for money remains a stumbling block to any long term use of this capacity.

The impact on overall effectiveness of private activity in HPSS hospitals depends on the extent to which it represents additional capacity as opposed to an inequitable skewing of resources towards those who are willing and able to pay. In addition, whilst the treatment of HPSS patients in private health care facilities may represent a

[46] Laing's Healthcare Market Review estimate NHS income from private patients to be £408m in the UK in 2003/04 whilst HPSS income generated from private patients in NI for 2003 was £585k (Source: DHSSPS).

[47] Waiting list initiatives accounted for 98.2% but only 78.2% of spend as the remaining treatments were under Extra Contract Referrals where patients are referred to private healthcare providers as the specialist treatment they require is not available locally in a NHS hospital.

[48] In 2002/03 the cost per treatment under private health care Waiting List Initiatives was £2,600 (range £1,739-3,982 between Boards) whilst the unit cost per elective FCE was approximately £1,800.

[49] : NHS Waiting Times in Wales Volume 2 Tackling the Problem, National Audit Office Wales

[50] There were more people treated under private health care Waiting List Initiatives in 2003/04 (2,908) than there were Excess Inpatient Waiters in December 2004 (2,381)

pragmatic approach to supply constraints, it is important, as noted earlier, that value for money is achieved.

The level of private sector provision depends on a range of factors, including income levels, service provision in the public sector and Government policy. The current relationship with the private sector appears to have grown more out of necessity than design. It is important that there is clear direction from DHSSPS as to the role of private health care providers in the broader Northern Ireland health & social care sector so that their capacity and capabilities can, where appropriate, bring most benefit to patients.

Recommendation 11: DHSSPS to develop a more coherent strategy towards partnership with private sector

3.3.3 Cross Border Co-operation

The Republic of Ireland (RoI) has a different system of health and social care from that in Northern Ireland, with service users in the RoI having to pay for treatment provided free north of the border. For example, there are charges for GP appointments and hospital attendances - although around a third of the population are entitled to free health care and there are limits on the cost of services provided by the state. In addition, a large proportion of the population in the Republic of Ireland are privately insured (in which some Northern Ireland Hospitals participate[51]). Eligibility for care in both jurisdictions depends mainly on residency, although there are a number of exceptions under EU regulations, such a cross border workers.

In 2001/2, there were 2,430 RoI residents treated in Northern Ireland hospitals - under 1% of the total hospital activity in Northern Ireland. In comparison, 902 Northern Ireland residents were treated in RoI hospitals in 2002, equivalent to 0.17% of admissions. However, around 90% of the activity involving RoI residents in Northern Ireland hospitals is paid for either privately or through contracts between health boards. In addition, emergency treatment is covered by a reciprocal arrangement between RoI and Northern Ireland. Whilst Northern Ireland trusts do receive payment for non-emergency activity from the Republic of Ireland there is a question, as with private activity in general, as to whether the full economic cost is being charged.

The main cross border health and social care initiative is ‘Co-operation and Working Together’ (CAWT), which was established in 1992 by the four health boards located along the border between Northern Ireland and the Republic of Ireland, to facilitate cross border co-operation.

Through CAWT, the Southern and Western Health and Social Services Boards in Northern Ireland and the North Eastern and North Western Health Boards in the Republic of Ireland agreed to co-operate in order to improve the health and social well being of their respective populations. Recent projects have been taken forward in the area of emergency planning and pre-hospital emergency care.

However, the projects to date appear to have been rather small scale, not involving major issues such as the location of hospitals specifically to provide services on both

[51] Royal Victoria Hospitals, Altnagelvin and Daisy Hill.

sides of the border. Although this issue was considered by the Acute Hospitals Review Group in terms of the provision of hospital services in the south-west of Northern Ireland, there appears to have been very little in the form of joint planning of hospital services.

Given the relatively small scale of the health & social care system in Northern Ireland it is entirely sensible that services are provided on a cross-border basis where appropriate. This would ensure that as broad a range of services can be provided as close to patients as possible. Whilst there is reluctance on the part of some patients in border areas to access services in the Republic of Ireland, it does not make economic sense to, for example, have two small hospitals on either side of the border when one larger hospital could provide a better service to both communities.

3.4 Family Health Services

Primary care covers a wide range of services provided by a number of different health and social care professionals. It is an integral part of the whole system of care and is often the first point of contact for people who need help, support and advice from the health and social services.

There has been increased emphasis in recent years for primary care to take on more activity and direct fewer patients to other more expensive parts of the health & social care system. However, there is concern that that the resources required to facilitate this move have not been transferred. Concurrently, some of the clinical roles and responsibilities carried out by GPs are to be transferred to practice nurses, community pharmacists and other allied health professionals as part of a multi-disciplinary team, with more people being treated at home.

Family health services comprise: General medical, pharmaceutical, dental and ophthalmic services. The majority of expenditure is spent on the first two service areas; dental and ophthalmic services have not been covered as part of this Review. However it should be noted that the number of dentists and optometrists per head of population in Northern Ireland is the highest of the UK countries.

As in the rest of the UK, general medical services in Northern Ireland were delivered under the terms of the 1990 GMS contract. This allowed GP practices to operate a system of fundholding. While not all practices in Northern Ireland operated under fundholding, the majority did.

Under fundholding, individual GP practices were allocated a budget each year. Each practice controlled how this money was spent and what services were provided to their patients. Hospital costs for patients and practice staff costs were also met by each individual practice. Fundholders were also allowed to retain any savings made by the practice for reinvestment in future years.

There was a perception that fundholding contributed to an inequitable service. Following the abolition of fundholding in England and Wales and the establishment of Primary Care Groups (which evolved into Primary Care Trusts) a decision was taken to abolish fundholding in Northern Ireland. Fundholding was abolished in March 2002 and resulted in all GP practices being funded directly by Boards. Under the new system all hospital costs were also met by Boards as were practice staff costs and rents and rates of GP practices.

Local Health and Social Care Groups (LHSCGs) were established on the abolition of GP Fundholding. There are currently 15 LHSCGs based in local Trust areas and working across all areas of health and social care to address gaps in local service provision and to develop primary care services[52]. The Groups are required to develop links with their communities, all primary care stakeholders in their areas and other relevant agencies. It was envisaged that the LHSCGs would progressively receive larger budgets devolved from the health boards to allow them to develop a greater commissioning role[53].

[52] However, under the recommendations from the Review of Public Administration the number of LHSCGs will need to be reassessed.
[53] *Building the Way Forward in Primary Care*, DHSSPS Consultation Paper, December 2000.

However, amongst the 60% of GPs previously operating as fundholders there was significant resistance to the abolition of fundholding and a reluctance to become involved in the LHSCGs. There were two contrary views expressed by the groups and individuals we met as part of the consultation process on this matter. One was that the lack of GP involvement meant that LHSCGs were unable to develop and take on greater responsibility for the commissioning of services. The other was that the lack of responsibility and funding meant that LHSCGs were a step back for GPs, and that as a consequence there would be little point in becoming involved. The issue of GPs' involvement in allocation/purchasing decisions is returned to in Section 4 as part of suggestions for improving the performance management system.

A new national GP contract was implemented in April 2004. Its aims were to reward practices for higher quality care, improve GPs working lives and ensure patients benefit from a wider range of services in the community. In addition the news GMS contract is expected to lead to a fairer system of funding as well as the overhaul and modernisation of ICT infrastructure. The contract was negotiated and implemented on a UK wide basis. he new contract resulted in a 25% increase in spend on primary care between 2003-04 and 2004-05 when the new contract was implemented. In the first year this increased investment has resulted in practices achieving a significant proportion of the quality targets which had been set.

The new contract also meant that GPs could opt out of the responsibility for securing the provision of out of hours services and this would then transfer to Boards. Most, if not all GPs opted out of this responsibility and Boards have been responsible for re-provision with effect from 1 January 2005. The cost of providing this service was estimated at £21m. GPs who opted out of this responsibility were required to pay back a proportion of their funding designed to provide services to their patients and this amounted to some £5.5m in 2004-05. There is a question here of why the fall in income was not more in line with the cost of providing the transferred services.

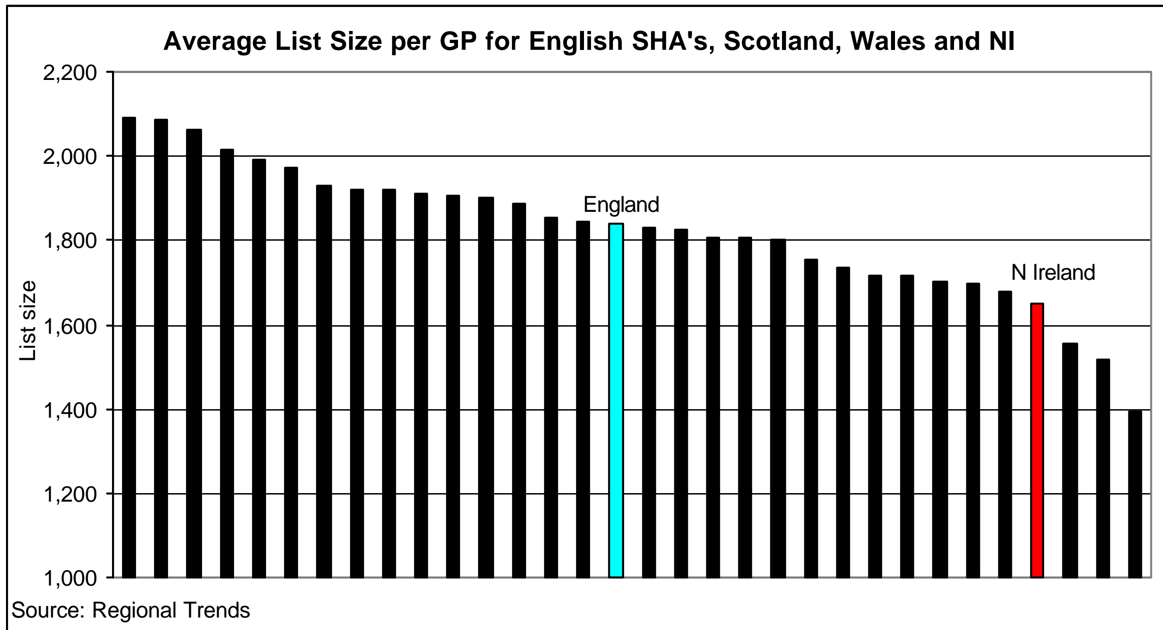
The new GMS contract delivers financial rewards for high quality care. The maximum quality points that can be achieved under the contract is 1050. In the original estimates for funding the contract, assumptions were made that approximately 75% of these points might be achieved but in practice GPs in Northern Ireland have achieved some 90%-95% of these targets which has resulted in an additional pressure of some £9m on the existing GMS contract envelope.

An important issue is that it is not clear that the better than expected performance in meeting targets reflects an improvement in quality of service or that the targets set were insufficiently challenging. If the former, then the ability of GPs to significantly improve quality outcomes in such a short period of time raises serious issues regarding past performance. DHSSPS have indicated that an objective of the new contract was to ensure that GPs are now remunerated for services they had previously provided in addition to their core terms of service but were not paid for. In other words, there was a 'deadweight' cost implicit in the new contract. However, it is unclear whether this phenomenon, common to many NHS employees, was significantly greater in respect of GPs.

There are currently around 1,100 GP's working in 366 practices in Northern Ireland. The number of GP's has increased by over a fifth in the past twenty years with the result that list sizes have fallen by over a tenth. Figure 3.14 below shows that GP list

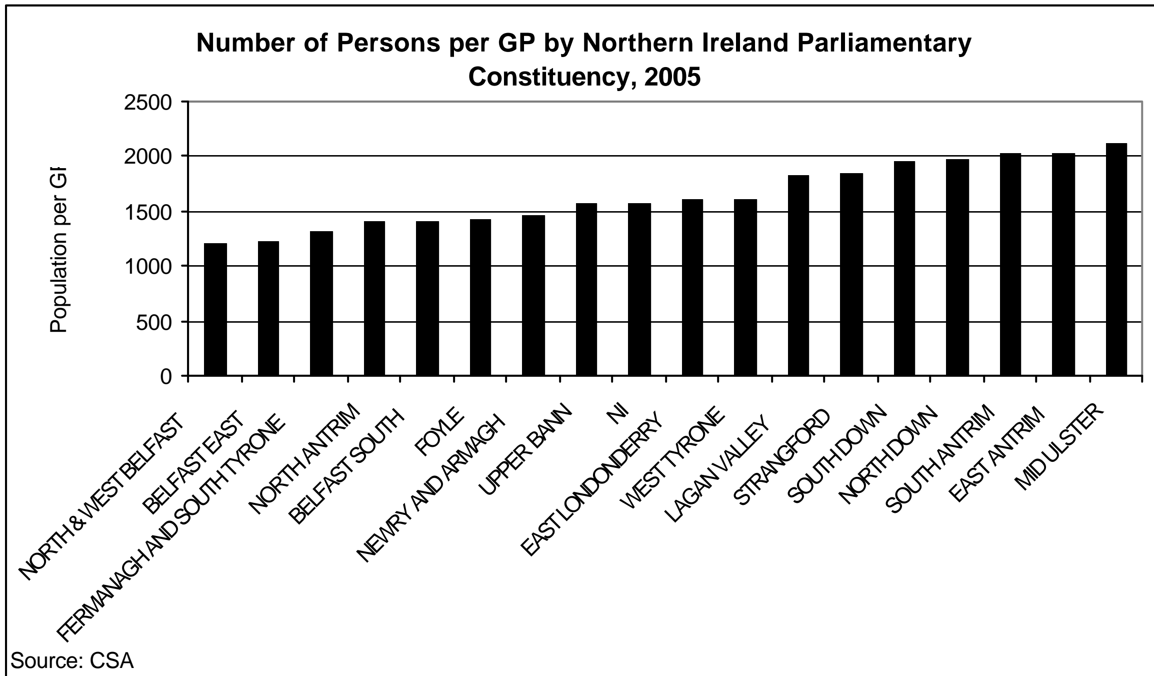
sizes in Northern Ireland are lower than the rest of the UK, with the exception of Scotland and the South-West of England.

Figure 3.14: GP List Sizes in Northern Ireland are 10% lower than in England, 2002



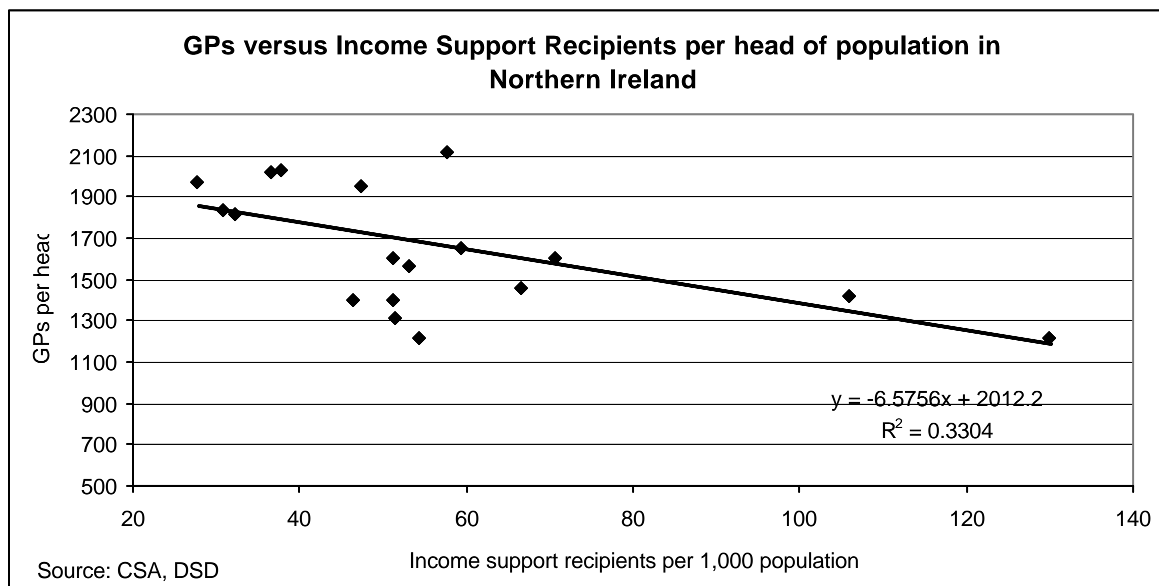
And figure 3.15 shows that there are significant variations within Northern Ireland in terms of the resident population per GP, with North & West Belfast having around 1,210 persons per GP compared to 2,110 for Mid Ulster.

Figure 3.15: The number of persons per GP is 74% higher in Mid Ulster than North & West Belfast



However, this appears to reflect the higher numbers of income support recipients - as shown in figure 3.16. The number of recipients is taken as an indicator of deprivation, and as those in deprived areas tend to have higher rates of illness it is assumed that they would require more attention per patient from GPs, necessitating smaller GP list sizes.

Figure 3.16: There is a negative correlation between Income Support recipients and GPs list sizes in Northern Ireland Parliamentary Constituencies .



In terms of work load, whilst figure 3.14 shows that GP list sizes are smaller in Northern Ireland than in most other areas of the UK, the number of GP consultations per head of population is higher.

Figure 3.17 shows that 18% of the Northern Ireland population had a GP consultation in the previous 14 days compared to 13% in Great Britain. In addition, whilst there appears to be a general downward trend in GP consultations in Great Britain since the mid 1990's, this has not been replicated in Northern Ireland. This raises the question of whether the higher rate of GP attendance reflects a greater level of need, or that alternative forms of treatment might be more appropriate.

A recent survey of GPs carried out by the Central Services Agency found that 48% of respondents reported that their morale as a GP was low, whilst 93% felt that too much is being asked of general practice. And nearly half stated that they would sacrifice some income in order to have less work - of concern given the increasing roles that are being expected of GP practices, and in particular the implications of the new GMS contract (with which, only a fifth were satisfied). Almost two-thirds felt that patients receive better care in general practice than five years ago. Surprisingly, only 58% of GPs agreed that a GP in a deprived area has to cope with more pressures and stress than a GP in a less deprived area.

Figure 3.17: The Proportion of the Population having a GP Consultation in the previous 14 days is nearly 40% higher in Northern Ireland than GB

3.4.1 Prescriptions

One of the main issues of concern with the provisions of health & social care services in Northern Ireland has been the relatively high level of GP prescribing[54]. In response, DHSSPS have introduced a variety of initiatives including the Prescribing Incentive Scheme which encourages GPs to make more effective and efficient use of prescribing resources by rewarding practices financially for achieving savings – practices were allowed to keep up to 60% of savings achieved in 2004/05.

GP prescribing is routinely monitored by prescribing advisers in each of the Health and Social Services Boards. Their role is to engage with GPs to encourage safe, rational and cost effective prescribing. The main method of communication with GPs and practice staff is by practice visits aimed at:

- Agreeing actions related to prescribing
- Discussion of evidence of change in prescribing
- Responding to queries on prescribing

A key objective of prescribing advisers is to increase the level and appropriateness of generic prescribing by for example compiling a list of generic switches and agreeing these with practices.

The COMPASS system provides on a quarterly and annual basis a range of prescribing reports and therapeutic notes to all GPs, Local Health and Social Care Groups, Boards' prescribing advisers and the Department. Each report provides an analysis of the prescribing at individual practice level, suggesting alternative approaches that might improve effectiveness, safety and patient care and showing

[54] However it may be that for example the quicker uptake of new drugs in Northern Ireland, whilst increasing the drugs bill, will lead to lower healthcare costs overall as other forms of treatment are required to a lesser extent.

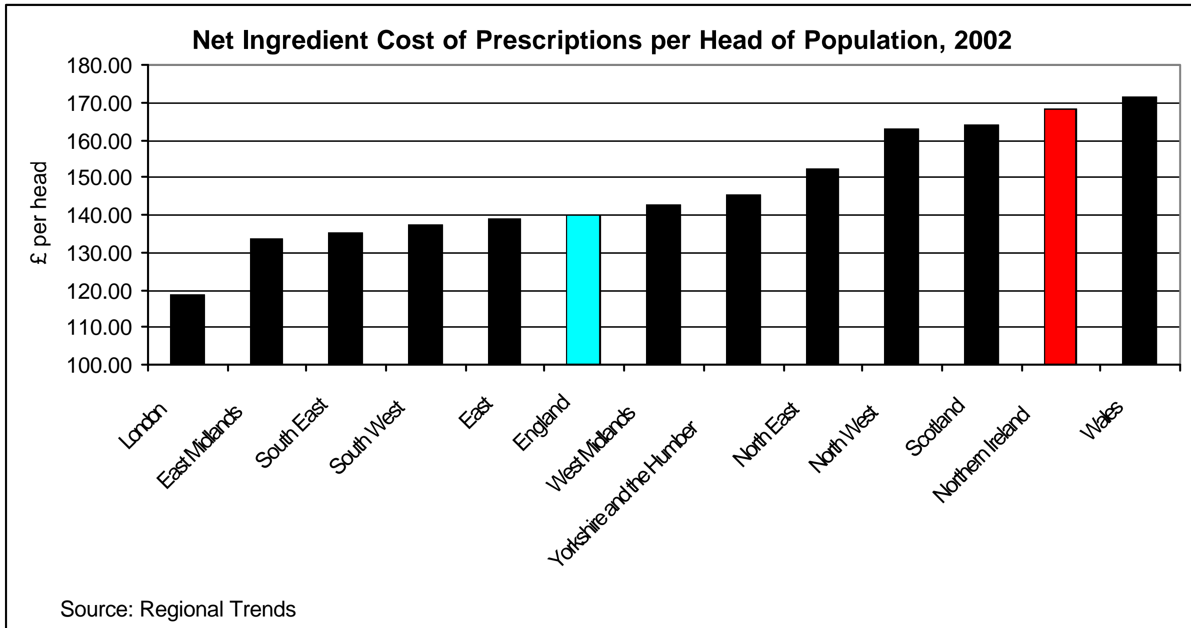
potential financial savings. The report allows practices to see how their prescribing compares to that of other practices in Northern Ireland and how they have changed compared to the previous year. The impact of using generic rather than proprietary drugs is emphasised.

All Boards have prescribing policies – these recognise any relevant regional strategic direction (e.g. a target in Priorities for Action) as well as Boards' own prescribing priorities. Once again, the Board prescribing advisers will take the lead in working closely with practices on these policies and may develop prescribing formularies for the practice to use as a tool to provide direction to practice prescribing where, for example, a problem has been identified with a certain type of medication

Overall, therefore, the interaction with GPs on prescribing is directed towards the provision of information and the application of persuasion and incentives as means of changing behaviour. There is currently no use of sanctions to influence prescribing practice. During the consultation process there were concerns expressed regarding this approach as GP's could make short-term improvements in order to obtain rewards and then return to past behaviour patterns before improving performance to receive further rewards in an ongoing cycle.

In 2003/04, £314m was spent on 26.6m prescriptions in Northern Ireland, 97% of which was paid for by the exchequer. Figure 3.18 below shows that Northern Ireland has the second highest spend per head on prescriptions of the UK regions

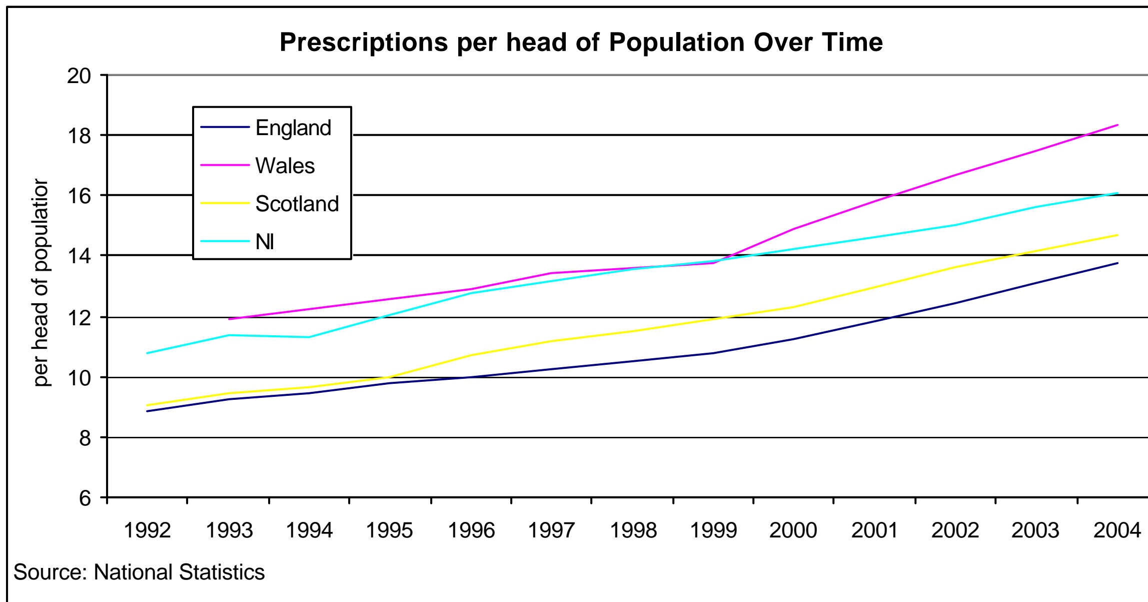
Figure 3.18: Net Ingredient Cost per Head of Population in Northern Ireland is the second highest of the UK regions.



In 2003, spend per head on prescriptions was 29% higher in Northern Ireland than England due to higher numbers of prescriptions being dispensed (+18%) and higher net ingredient cost per prescription item (+8%). It should be noted however that prescriptions in Northern Ireland tend to be in the less expensive forms of treatment,

so that the differential in unit costs is significantly higher than that suggested by the headline figure.[55]

Figure 3.19: The number of prescriptions dispensed per head of population has increased by 43% over the past ten years in Northern Ireland compared to 46% in England.



In addition, the number of prescriptions dispensed has increased by 48% over the past decade, so that the overall cost has increased by 131%. However, as figure 3.19 shows, Northern Ireland has had the slowest growth in prescriptions per head of the UK countries.

One of the main reasons for the higher unit cost of prescriptions in Northern Ireland relative to England is the greater use of proprietary drugs, which are on average over five times more expensive than generic drugs. In 2003, 41% of prescriptions dispensed[56] in Northern Ireland were for generic drugs compared to 55% in England. If Northern Ireland were to achieve the same generic dispensing rate as in England, this would reduce prescription costs by 18% equivalent to £55m. In terms of the number of prescriptions per head, over two-thirds of the differential with England is due to just five classes of drugs [57]

As part of the £474 DHSSPS Efficiency Programme [58] £83m is due to be saved over the period 2005/06-2007/08 by abating the growth in pharmaceutical costs through a

[55] Based on analysis of 2002/03 figures for NI and England Cost Weighted Activity Index which showed unadjusted unit costs to be 18% higher in Northern Ireland and 29% higher once adjusted for differences in prescribing distributions between different types of drugs.
[56] DHSSPS state that there is no data available on generic *prescribing*
[57] Based on 2002/03 data 68% of the differential in prescriptions per head can be accounted for by Analgesics, Antibacterial Drugs, Hypnotics And Anxiolytics, Antidepressant Drugs and Ulcer-Healing Drugs which collectively account for 35% of prescriptions in Northern Ireland.
[58] The Chancellor's Budget speech in Spring 2003 announced a cross–cutting review of efficiency in the public sector to identify the scope for efficiencies in public spending. In his 2004 Budget, the Chancellor announced that the Government would set targets to achieve cumulative efficiency gains of 2.5% per year over the SR2004 planning period. The Secretary of State has decided that parallel reform and efficiency programmes should apply to the public sector in Northern Ireland. To ensure delivery of this substantial efficiency programme is achieved, departments have produced Efficiency Technical Notes (ETNs) providing specific and quantified information on the actions departments will take over the next three years to deliver their efficiencies.

number of initiatives. These include therapeutic tendering[59], repeat dispensing projects as well as the roll-out of Integrated Medicines Management[60] across the HPSS which to date, inter alia, has had a significant impact in reducing length of stay and readmission rates.

Conclusion

The overall impression from the consultation process was a lack of integration between GPs and the rest of the primary care sector. There was also significant frustration on behalf of GPs, related to the fundholding issue, that the Department and Boards did not appreciate their work, communicate sufficiently, or consider the views of GPs when setting policy. On the other hand, GPs were viewed as too often operating independently of other parts of the system (for example, in not appreciating the treatments that could be provided by Allied Health Professionals). Whilst the Department would clearly wish for GPs to have greater involvement with LHSCGs and multi-disciplinary working in general, there is clearly a problem with the general relationship GPs currently have with the DHSSPS and Boards..

It is important that there is clear understanding and common purpose between GPs and the rest of the health & social care sector. GPs not only provide an important service to the public, but, in their role as gatekeepers, influence the commitment of a significant amount of health care expenditure. Given the high levels expenditure on prescription drugs and attendances at A&E, it is crucial that this interface operates effectively. At the same time it is not clear that one of the main opportunities to stimulate reform (the revised GMS contract) has been taken - for example, in terms of the role that GPs have in managing the flow of patients into hospitals. The initial impression is that there has been significant cost with little benefit in terms of patient outcomes or GP morale[61].

> **Recommendation 17: An assessment should be carried out on the implementation of the GMS contract in Northern Ireland to examine whether the actual improvements in quality outweigh the cost. In light of the finding, the GMS contract should be revised as far as practicable**

Despite implementing various initiatives to reduce the problem, Northern Ireland still has a significantly higher level of spend on prescription drugs per head of population than the rest of the UK. As with the rest of the health & social care sector this can be linked in part to the absence of sanctions to dissuade poor performance.

> **Recommendation 18: New mechanisms involving greater use of sanctions are needed to tackle high prescribing costs and to encourage greater use of generic drugs.**

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[59] Treatment is prescribed from a clinical specification for medicine rather than the availability of individual proprietary drugs.

[60] Integrated Medicines Management involves re-engineering the system for medicines management covering the patient care journey by applying a dedicated clinical pharmacy programme complimenting medical and nursing input and developing a scheme for product standardisation across the primary and secondary care sectors.

[61] Although payment for QOF achievement points may improve morale the January 2005 survey of GPs indicated that 48% would be willing to receive less pay for a smaller workload whilst only 21% were happy with the revised GMS contract.

3.5 Personal Social services

Personal social services incorporate a broad range of activity, from residential and nursing home care, to domiciliary care and day care, meals on wheels as well as field social care services. Social services differ fundamentally from the rest of the health & social care system in that they are delivered through a collaborative combination of statutory, voluntary and private sector organisations. In addition, informal carers provide a crucial input into the system which is often taken for granted. Demographic trends mean that carers will require more support in the future as they themselves become increasingly elderly whilst policies for dealing with young carers remain underdeveloped.

Spending on personal social services in 2003/04 accounted for around a quarter of total HPSS spend (£680m). Of this, services for the elderly accounted for just over half (52%), with around 30% devoted to mental health services and 18% to family and childcare services. The main areas of expenditure related to the elderly in terms of nursing home places (£144m), domiciliary care (£92m) and residential home places (£68m). In comparison, the main spend category for childcare was social work (£41m) whilst residential homes (£34m) was the main area of spend on services for those with a learning disability.

In comparison with England, per capita spending on personal social services has been on average 15% higher in Northern Ireland over the past five years[62]. This is close to the estimated need for spending of 13% higher than England based on HM Treasury NAS methodology but considerably less than the figure of 44% implied by the Northern Ireland Executive revisions to the Treasury model.

In terms of outcome based measures of performance, whilst the community services target set out in the DHSSPS Public Service Agreement covering the period 2003-2006 focused on the number of care packages[63] delivered, the main emphasis subsequently has been on increasing the proportion of support delivered in people's own homes to 40%[64]. In terms of children's services, the main focus has been on increasing the adoption rate for children in need to 7%.

The 40% target is interesting because although only 38% of care packages are currently delivered in a domiciliary setting, there appears to have been a downward trend over the past decade with 50% of care packages in 1995 being delivered in a domiciliary setting. Whilst the number of domiciliary care packages has increased over time, the growth in the generally more expensive alternatives (nursing and residential care) has been greater. There is also significant variation between Northern Ireland trusts, with the largest provider of care packages, Homefirst, also having the lowest proportion (22%) of care packages delivered in a domiciliary setting - if removed, the Northern Ireland average rises to 41% and the target is met.

[62] HM Treasury Public Expenditure Statistical Analysis .
[63] A care package is the main form of care that has been recommended for a client through the care management process. Care packages are provided in the form of places in nursing and residential homes as well as domiciliary care in persons own home. Separate services are also provided in terms of Home Help and Meals on Wheels as well as places at Day Care Centres.
[64] A 1999 study entitled "Attitudes and Aspirations of Older People: A Review of the Literature "for the Department of Work and Pensions found that 80% of older people would prefer to remain in their own home as long as possible.

Whilst the integration of personal social services is often perceived as being a key strength of the Northern Ireland system, this was not necessarily the view of those we consulted in the course of this Review[65]. In particular, it was felt that funding for social services was often diverted to shore up the acute sector. There was concern that this was creating longer term pressures as insufficient funding of social services would lead to delayed discharges from hospitals creating further problems in the acute sector.

These views are in line with the consultation responses detailed in the First Report of the Review of Community Care[66]. Whilst there was widespread commitment to the aspirations set out in the strategy "People First: Community Care in Northern Ireland for the 1990s"[67], which was introduced in 1993, there was concern regarding implementation. In addition, reservations were expressed regarding the considerable variations in service delivery across Northern Ireland whilst there were instances where the transition between hospital and care home was not as seamless as would be expected in an integrated system. Further, the decreasing share of domiciliary care was viewed as being the result of a perverse incentive as some of the cost of residential and nursing home packages can be offset be accessing social security benefits -which is not the case for domiciliary care[68].

The Review of Community Care highlighted that there were many good working examples of new and innovative practices in the area of community care. However, too much of this work was developed in isolation, and staff expressed frustration at the lack of collaboration between trusts. Fears were also expressed regarding the amount of resources available to community care - in particular, the fees paid to independent nursing homes.

The second phase of the Review of Community Care was to involve a number of projects taken forward on the basis of the "People First" objectives. In the three years since the publication of the first phase there appears to have been a significant amount of analysis and review carried out into particular aspects of the community care system. To date, however, with the exception of increasing the rate of payment to independent care homes, there also appears to have been few developments in terms of how services are actually provided. In addition, there is little to suggest that this position will change in the near future.

Given the variety of providers supplying personal social care, it might be expected that a degree of competitive pressure exists in the system. In practice, however, there is concern that the public sector is crowding out the independent sector. For example, although independent/voluntary providers are able to tender for contracts to deliver care packages, they have difficulty in recruiting sufficient amounts of staff because of the higher salaries and greater certainty of employment offered by statutory providers. Therefore, even where independent provision may be preferable

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[65] Views ranged from those who argued that any additional funds tended to go to the acute sector to those who suggested that funds were actually taken from social services.

[66] DHSSPS, 2002

[67] Objectives included, the development of services to enable people to live in their own homes wherever possible, provision of practical support for carers, proper assessment and good case management, promotion of the independent sector alongside good quality public services, clear delineation of the responsibilities of agencies, and securing better value for taxpayers money.

[68] In the UK, local authorities levy a charge for domiciliary care so there is less of an incentive to use the more costly care home alternative.

in terms of service and cost, the contract may be lost due to staffing shortages. There was also resentment expressed that independent providers incur the expense of training staff who then move to the more highly paid public sector.

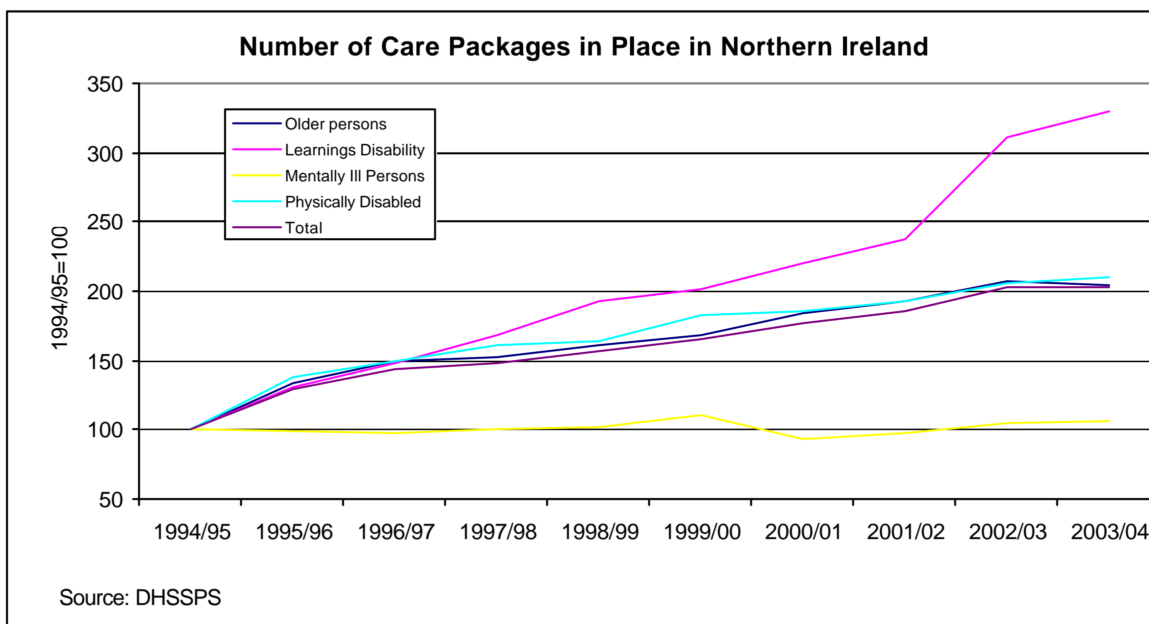
Assessing the efficiency of the delivery of social services is more difficult than for health care because the public sector is not the only provider, so inputs are less easily related to outputs. In addition, the comparability of data between jurisdictions is even more difficult than for healthcare. Therefore the analysis set out below is necessarily more tentative than in previous sections.

3.5.1 Adult Services

Adult services cover a wide range of service provision by trusts to a range of client groups, although services to the elderly dominates, accounting for three quarters of all care packages. Each trust decides the mechanisms for the delivery of social care. As at December 2004 there were 19,654 community care packages in effect, 38% of which were in nursing homes, 24% in residential homes and the remainder in the form of domiciliary care. The private sector provides the overwhelming bulk of nursing home packages (94%) and nearly half (47%) of residential home places. Over the past five years, whilst the number of care packages has increased by 29% overall, nursing and residential home packages have increased by over 40% whilst domiciliary packages have increased by only 12%.

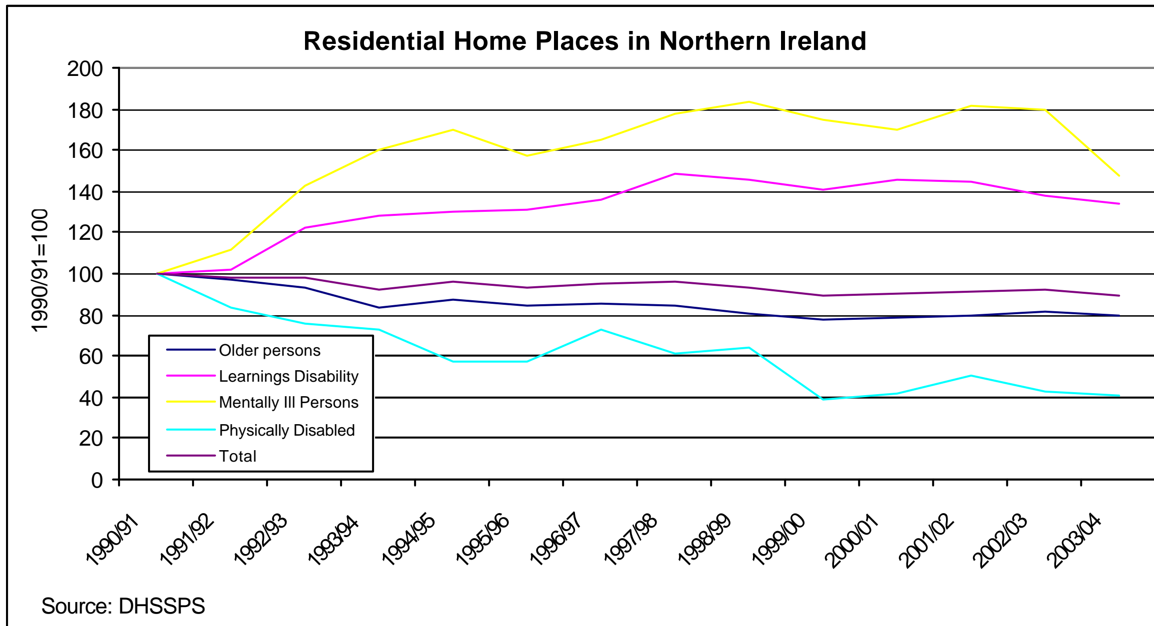
Figure 3.20 shows that over the longer term there has been even greater growth in the number of care packages provided with the exception of mental health where the level of provision has remained broadly stable over time. This is in line with the views those whom we spoke to representing mental health services who were concerned that mental health services were being left behind.

Figure 3.20: The number of care packages has more than doubled over the past ten years.



Although the number of residential care packages has risen over time, the number of places in residential homes has fallen as shown in figure 3.21:

Figure 3.21: There has been a 11% fall in the residential home places in Northern Ireland since 1990/91



The number of available places in residential homes in Northern Ireland has been on a gradual downward trend since 1990/91, and now stands at 6,282 (2003/04). Three quarters of places are in homes for older persons whilst places for persons with a learning disability account for 18% of the total. Figure 3.21 shows that the largest growth in places was in homes for the mentally ill and the greatest decline was in homes for physically disabled persons.

In comparison with other parts of the UK, there are 12.4 places in residential and nursing homes per 1,000 adult population in Northern Ireland compared to 13.8 in England, 12.0 in Scotland and 12.8 in Wales. However, given that the main client group for residential and nursing homes places are the elderly, the 2002 Needs and Effectiveness Evaluation quoted figures in terms of the population aged 65 and over which implied that there was 10% greater provision in Northern Ireland than England, whilst the 2002 Review of Community Care presented comparisons in terms of those aged 75 and over which implied that there were 15% more places in Northern Ireland than in England.

In terms of non-residential care, as of March 2004, 26,400 people in Northern Ireland were receiving home help, 4,650 meals on wheels services and 10,300 were registered at day care facilities. However, there is a downward trend in the numbers receiving home help, whilst numbers receiving meals on wheels and registered at day care facilities has risen over time. There are also significant variations between trusts with, for example, 59% of people aged 75 and over in the Armagh & Dungannon Trust receiving home help services compared to only 22% in the Ulster Community and Hospital Trust.

Those involved in mental health services raised a number of concerns with this Review that this form of care had a low priority in terms of resources, despite the

pressures that mental health problems have on patients and their families - it is only when a major incident occurs that mental health is considered. There was also difficulty in getting someone to take responsibility for a particular mental health issue as delivery of mental health services is spread across a range of organisations - this was a general point made by those representing the other forms of social services provision too.

In addition, despite the policy aim that long-term care should no longer take place in psychiatric hospital environments, the view of those we spoke to was that resources had not yet been transferred to the community sector to the same extent as in England. Although some progress has been made - with spend on the provision of mental health services in a community setting increasing at a faster rate than for psychiatric hospitals - the community share of mental health spend is still lower than was the case for England in 1999/00.

The Review of Mental Health and Learning Disability published a draft report in June 2004 and highlighted the higher level of need for mental health services in Northern Ireland (linked to social deprivation and political conflict). The draft report sets out a new Strategic Framework for Adult Mental Health Services for the next 15-20 years. Highlighting that there is insufficient investment in community services, leading to an inappropriate over-reliance on hospital services, the draft report makes recommendations covering the need for:

- better community and primary care for people presenting with a mental health problem;
- improved team working in community mental health services;
- improved services for those experiencing a crisis, with these services acting as a gatekeeper to hospital services;
- the location and quality of hospital provision;
- promotion of recovery and rehabilitation services to ensure people do not remain in hospital unnecessarily; and
- assertive outreach teams for those who remain vulnerable in the community.

Many of the themes expressed in terms of mental health can also be applied to learning disability and physical & sensory disability, in particular, the lack of progress in transferring provision from a hospital to community setting. Demand for services for the disabled is increasing due to rising survival rates of those with profound and multiple disabilities, whilst legislative requirements also have significant - in some cases disproportionate - resource implications. In addition, as with other social services, the view of those we spoke to was that policy initiatives in England were not being replicated in Northern Ireland.

The only significant indicator of the extent to which social services are delivered efficiently is unit costs. However, whilst variation in unit costs between trusts may provide an indication of relative efficiency, it may also reflect differences in underlying costs and quality of service. Overall, there appeared to be a significant variation in unit costs between trusts, for example, the cost of social work for the elderly in the North & West Belfast Trust was 220% higher than the Northern Ireland average whilst the cost of care homes for the elderly was significantly higher in the Causeway Trust.

3.5.2 Children's Services

Social services provided to children include child protection, care of looked after children (including fostering and residential care services), adoption services and day care facilities. Social work accounts for just over a third of total spend on children's services, with a fifth spent on residential homes and 15% on fostering and adoption services.

The key issue with respect to children's services is the level of funding relative to England. In particular, concern was raised with this Review that funding is to be terminated for the projects under the Children's Fund established by the Northern Ireland Executive. In addition, the perception was that policy decisions take longer to reach and implement than in England, with the result that service provision is often years behind in Northern Ireland - again, similar views were expressed in respect of the other social services.

However, from the activity statistics and evidence presented in the Needs and Effectiveness Evaluation, it appears that service provision is broadly similar Northern Ireland and England in terms of the proportion of children looked after by local authorities or on the child protection register - although it could be argued that that provision should be higher given deprivation levels in Northern Ireland.

Therefore, the main reason for the relative level of spend is lower unit cost of provision. Lower unit costs may reflect lower quality of provision or it may be that social services for children in Northern Ireland are provided more efficiently than in England. To the extent that the latter is the case, this raises questions as to whether similar levels of efficiency could not be derived for other parts of the health & social care sector.

There are currently around 2,500 looked after children in Northern Ireland (in the sense that a trust has parental responsibility for them). This is equivalent to 5.7 children per 1,000 population aged under 18 compared to 5.5 for England and 5.4 in Wales. Around 61% of children looked after are in foster care, 13% in residential care and the remainder placed with their families or elsewhere - the split in provision is similar to that in the rest of the UK. There are around 1,400 children on the child protection register - mainly as the result of neglect or physical abuse. A greater proportion of the population aged under 18 are on the child protection register in Northern Ireland (0.32%) compared to England (0.23%).

The quality of provision appears slightly better in Northern Ireland, with looked after children and young people experiencing more placement stability than in England or Wales, whilst in 2001/02 the proportion of young people aged 16 or over leaving care with at least one GCSE or a GNVQ was slightly higher in Northern Ireland (44%) than in England (41%)[69].

As with adult services however, there are significant variations across trusts in the level and type of provision. For example, there was a 124% higher rate of looked after children and 446% more children on the child protection register in the North &

[69] Five per cent of looked after children in NI had 3 or more separate placements during 2001/02 compared to 13% in Wales and 15% in England.

West Belfast Trust than the Craigavon & Banbridge Trust, whilst there were 137% more day care places in the South & East Belfast Trust than in Foyle. Such variations are largely explained by variations in need. However. there were also marked difference in the unit costs of residential care. For example if the unit cost of provision achieved by the South & East Belfast Trust was replicated across Northern Ireland, then the overall cost would fall by almost a quarter.

Conclusion

The main issue raised by those we consulted during this Review with regard to both adult and children's social services was a perception of too little funding, and, in the opinion of many, in large part due to resources being diverted to the acute sector. Whilst the evidence was mixed in terms of funding, the available data does not tend to suggest that there is a significantly lower level of social services *provision* in Northern Ireland relative to England. That is not to say that there are specific areas where there are insufficient resources or that a case could be made for a higher level of provision given relative levels of deprivation.

In addition, innovative projects tend to be resourced through non-recurrent funding so that they are more likely to be terminated in the face of overall funding pressures. There needs to be a more rigorous approach taken to ensure that if projects are discontinued, it is on the basis of relative effectiveness.

The funding issue was directly linked to the integrated nature of the service. Northern Ireland appears currently to be mid-position between full integration - where responsibility for both hospital and social services is shared - and the position in the rest of the UK where services are split. The findings of the Community Care Review would suggest that it is not only funding but also the movement of patients between services where the link is less than seamless. This Review has not been able to come to a conclusion as to whether the answer is to have greater integration or to formally split health and social services - whilst the link was considered worth maintaining by those to whom we spoke, in light of the associated problems it was not entirely clear why this was the case.

The above has been only a brief overview of the key issues associated with the provision of social services in Northern Ireland which, given the issues highlighted, merits a more fundamental consideration, with a focus on the services delivered and in particular the equity of provision between different parts of Northern Ireland.

> **Recommendation 19: the integration of health & social services should be re-examined with an initial first stage being the ring fencing of funding for social services from the acute sector. There should however be scope for financial sanctions when inefficiency in one part of the system impacts negatively on another e.g. lack of social services provision causing delayed discharge from hospital.**

> **Recommendation 20: the contracting of services from independent/voluntary organisations should be reviewed to consider whether it can be placed on a more strategic basis.**

3.6 Waiting and access

For public services free at the point of use, waiting has been one way of rationing or delaying access and hence aligning demand and supply. However, while waiting, in the absence of prices, may have a legitimate role in rationing scarce resources (given a fair waiting system), long waiting lists and times are not just a product of finite budgets. The existence of very long waiting times in Northern Ireland compared with England and Scotland, and variations in waiting times within Northern Ireland suggests considerable scope for improving Northern Irish patients' experience of waiting within current resource limits.

Although the numbers of patients waiting can be small in comparison to total activity in the health and personal social services, long waiting times can not only be damaging to patients' health but also increase costs of care. Conversely, the benefits of successfully reducing waiting times are not only reflected in better patient experience of their care (and better health) but also in more efficient health and social services.

In particular, we review data highlighting variations in waiting lists and times - between geographical areas, trusts and specialties. The existence of variations can be a sign of hope - long or excessive waiting may not be an inevitable consequence of the way the system is funded, for example. On the other hand, variations - for example, *within* a system - may suggest that resources are not being used optimally. Moreover, variations can also suggest that the problem is concentrated rather than dispersed across the whole system and hence suggest that particular policies will be more effective than others in tackling the problem.

3.6.1 Scale of the problem

Amongst the four parts of the UK, Northern Ireland has some of the longest waiting lists and times for inpatients and outpatients. Here we set out the scale of the problem, starting with waiting to see a specialist in an outpatient department through to waiting for admission to hospital and delays in discharges and waiting for other health and social care services.

Box 3.2: Measuring waiting times

How long patients wait can be measured in two different ways: a census (or snapshot) of the length of time patients still on the waiting list have waited; the actual length of time patients waited prior to seeing a specialist in outpatients or being admitted to hospital as an inpatient or day case.

Both ways of measuring waiting are valid, but provide different perspectives on waiting. However, from the patient's point of view, the main concern will be how long they waited having been seen at outpatients or having been admitted into hospital.

While patients who have been to outpatients or have been admitted may be seen relatively quickly, this may give a misleading impression of the way waiting lists are working or being managed.

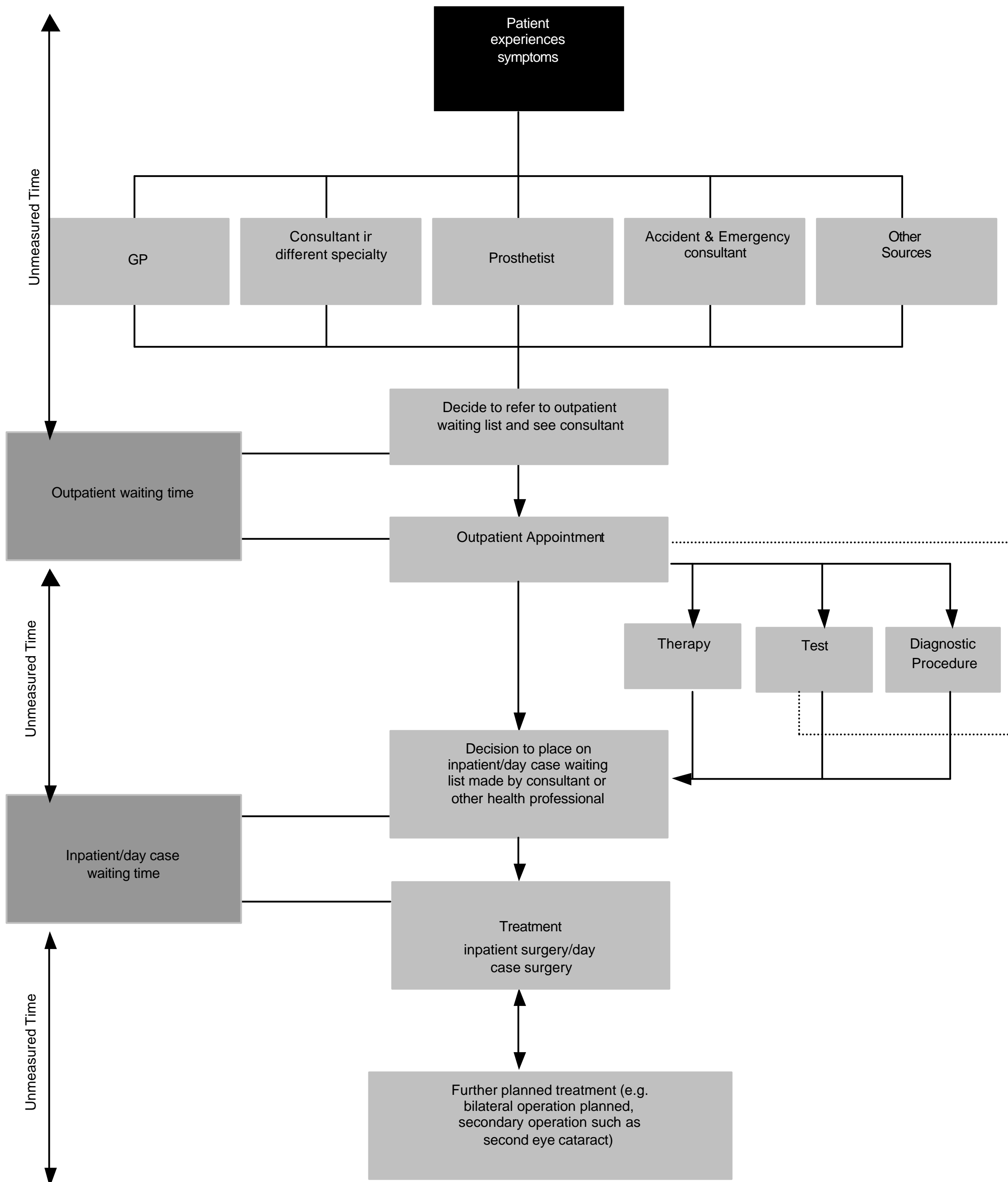
For example, as waiting lists do not operate as strict queues (on a first come, first served basis), but with patients moving around the list depending on changes in the urgency of their condition, the census view of waiting can reveal whether a group (of presumably less urgent cases) are continually bypassed by more urgent patients. The bypassed patients can end up as a 'mortlake' of patients who may never reach the head of the queue.

Box 3.3: The actual waiting experience.

Official waiting time statistics in Northern Ireland (and indeed in other parts of the UK) do not capture the full waiting time experienced by patients from the time they experience symptoms to the conclusion of treatment. The patient's journey through the health care system, for example, is illustrated in the chart below which shows where the gaps exist in official recording of waiting.

As noted in Box 1, above, the way that waiting lists operate within outpatients and inpatients can also have a significant impact on some patients overall waiting times.

The patient journey and reported waiting times

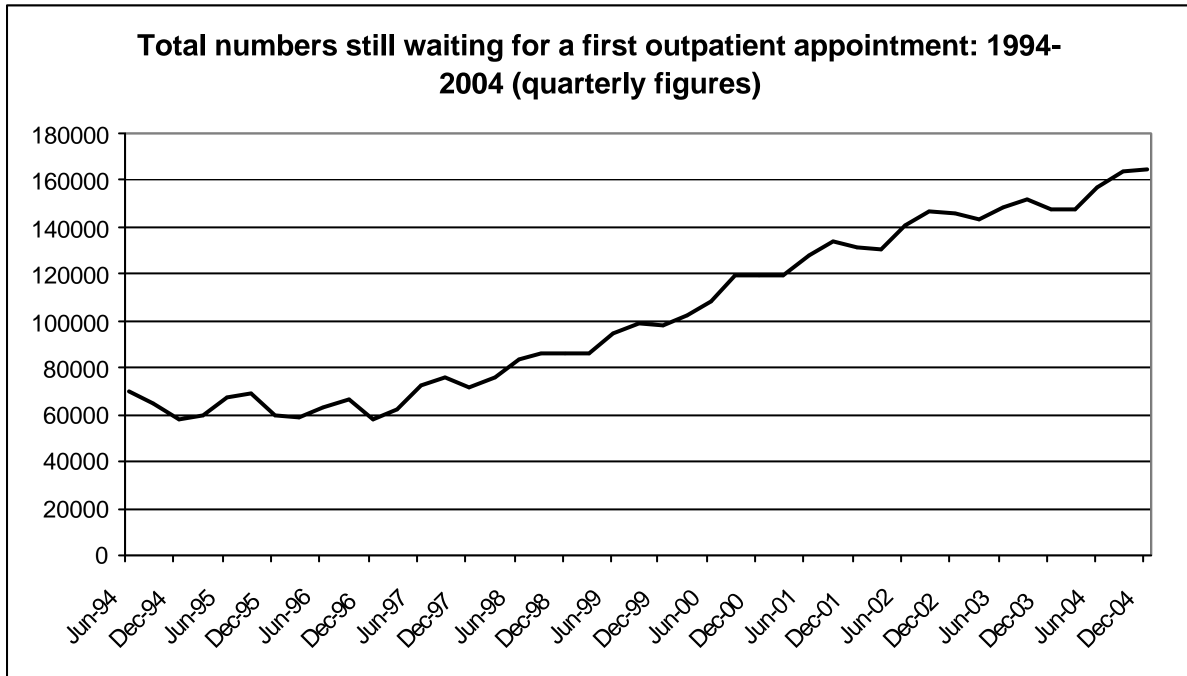


Source: NHS Waiting Times in Wales Volume 1 The Scale of the Problem, National Audit Office Wales

3.6.2 Outpatient waiting

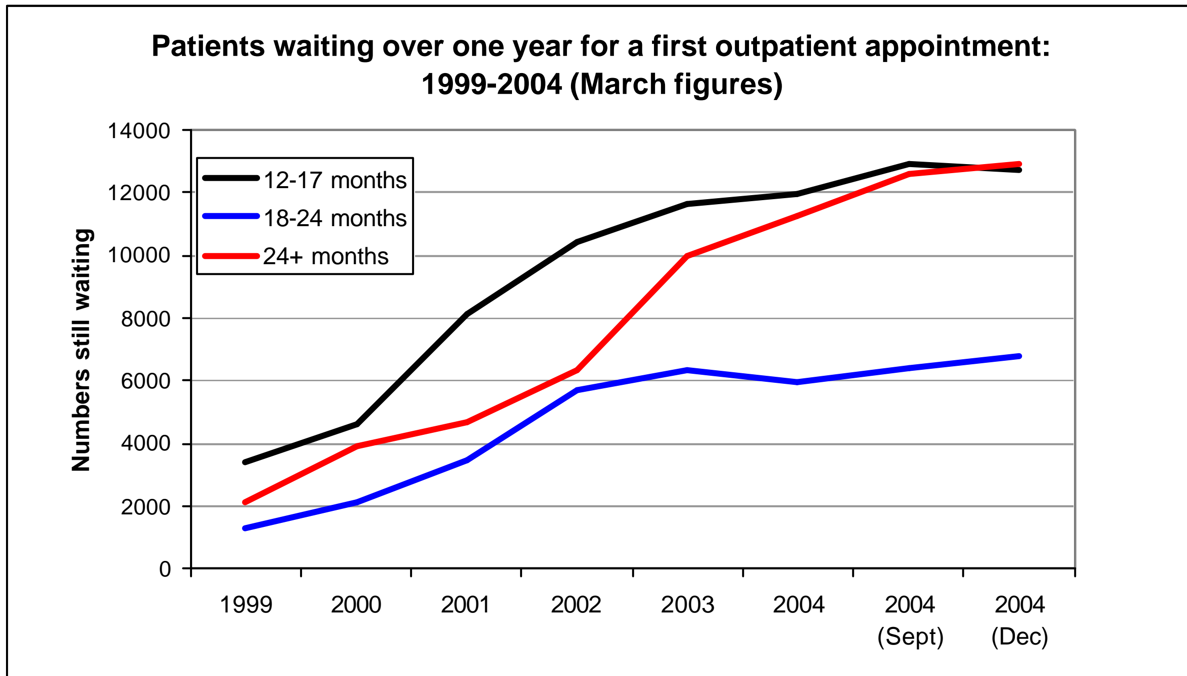
The total number of patients still waiting for an outpatient appointment in December 2004 stood at nearly 165,000. Trends over the last five years have been inexorably upward, and have risen by around 150% since 1994 (see figure 3.22). Nearly one in ten of the total Northern Ireland population is currently waiting to attend for a first outpatient appointment.

Figure 3.22: Total numbers of patients still waiting for a first outpatient appointment have increased by over two and a half times since 1994.



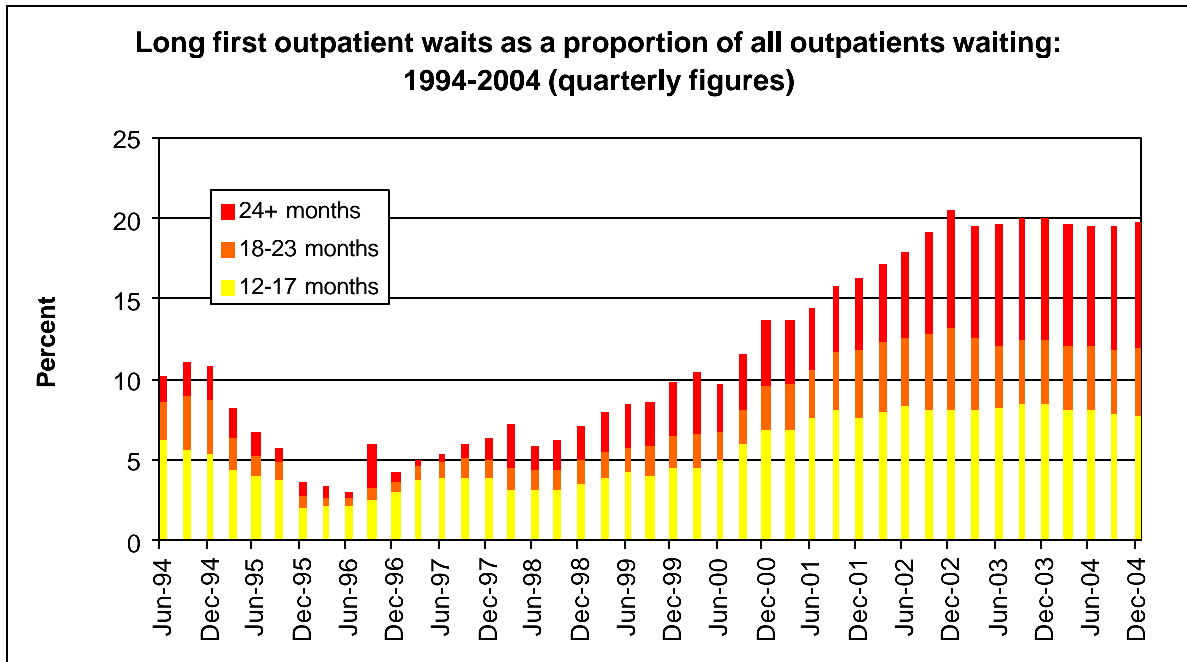
Of more concern to patients is how long they have to wait rather than the length of the queue in front of them. Over the last five years, 'excessive' waits (of more than a year) have risen. The number of people waiting 12-17 months has increased three-fold; those waiting 18 to 24 months four-fold, and those waiting over two years, six-fold (see figure 3.23).

Figure 3.23: Numbers of patients waiting over one year for a first outpatient appointment have risen over four-fold between 1999 and 2004.



While those waiting over a year have, since 2002, levelled off, there are no signs of any reductions in the numbers of excessive waits and 1 in 5 people are still waiting over a year for their first outpatient appointment (see figure 3.24.

Figure 3.24: Although the increase in the proportion of patients waiting over a year for a first outpatient appointment has levelled off recently, nearly one in five are still waiting more than a year and nearly 1 in 12 are waiting over two years.



The reasons *why* the number of long waits has increased over the last ten years are explored below. However, it seems unlikely that waits have increased either because of lack of funding - spending has increased considerably over the last ten years; or

due to increases in demand - between 1996 and 2002/3, total outpatient attendances rose by just 5% - around 0.5% per year on average.

3.6.3 Variations in outpatient waiting times

Apart from variations in waiting times over time, waiting times also vary among specialties, hospitals and in comparison to Wales, Scotland and England.

Variations by hospital

As figure 3.25 shows, there is considerable variation across hospitals in the share of the total outpatient waiting list across Northern Ireland. Of course, the main explanation for this is the variations in sizes of hospitals and workloads - bigger hospitals will have larger lists. However, as figure 3.26 shows, some hospitals - such as the Royal Group, Green Park and Ulster Community - appear to have a higher share of the total outpatient waiting list than might be expected given the number of GP referrals received.

Figure 3.25: Just three hospitals account for nearly half of the total number of patients still waiting for a first outpatient appointment

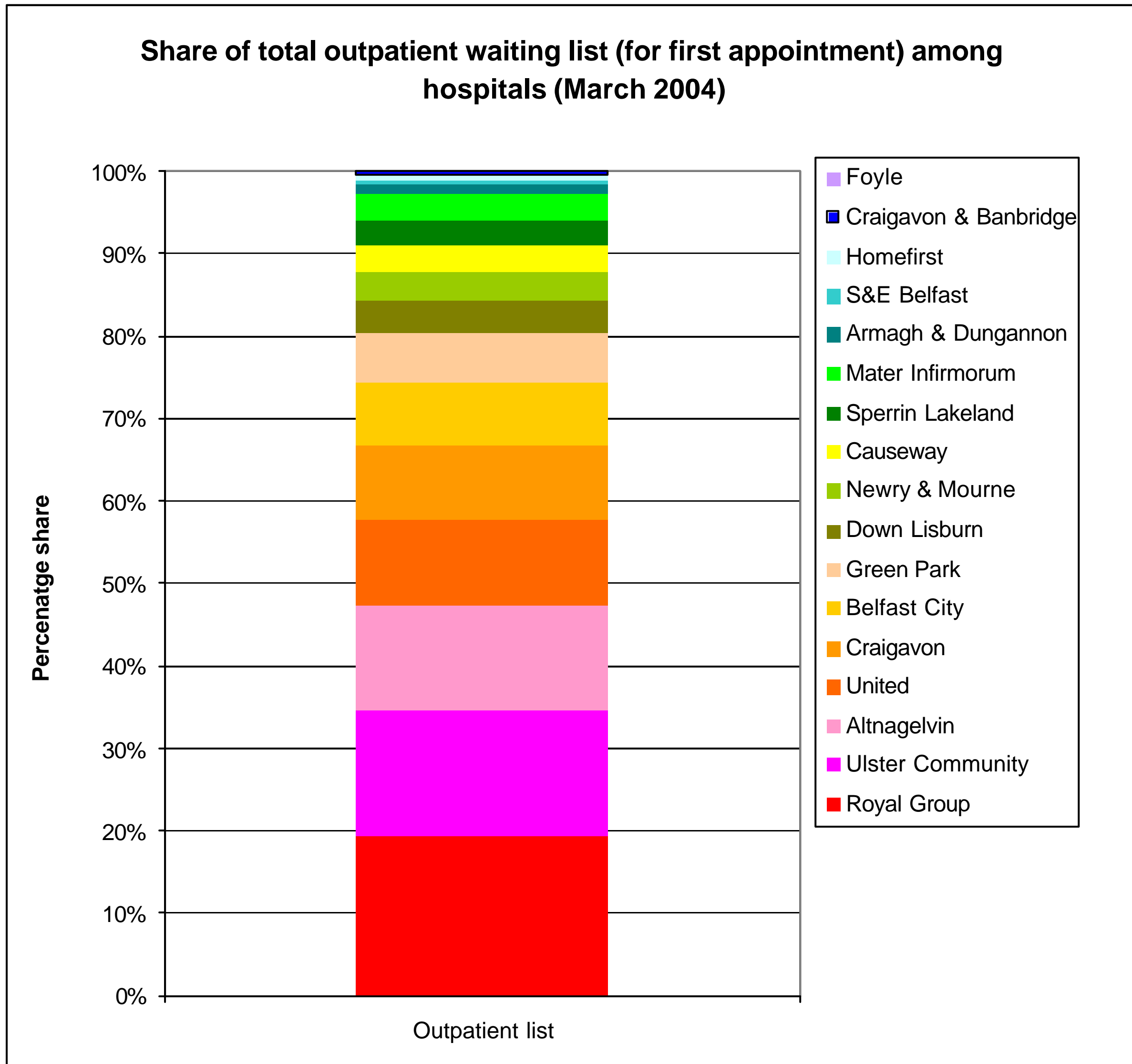
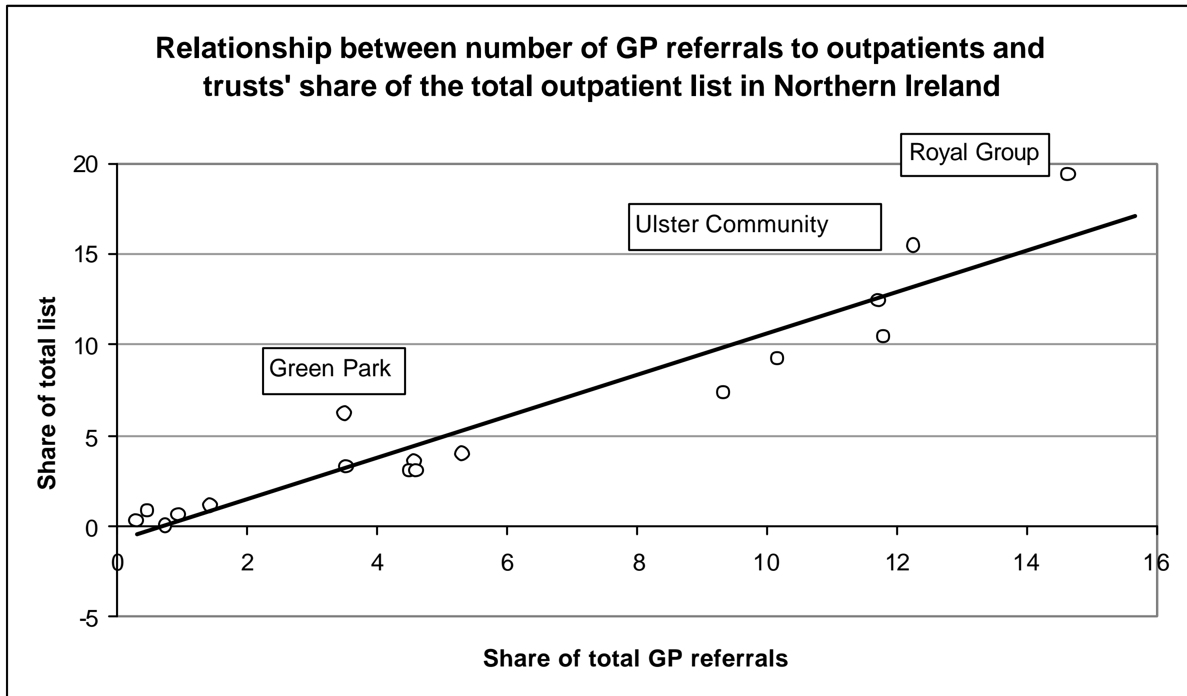


Figure 3.26: Some hospitals have a higher share of the total outpatient waiting list than might be expected given their share of total GP referrals to outpatients



As already stated, however, of greatest concern to patients is the time they have to wait rather than the total size of the list. And as figures 3.27 and 3.28 show, there are significant variations across hospitals in the proportion of those patients waiting over a year and over two years for admission.

Some variation is perhaps to be expected given differences in the sizes of hospitals, local pressures and circumstances. However, as figure 3.29 shows, there is a relationship between trusts' shares of total GP referrals to outpatient departments and their shares of the number of patients waiting over 12 months for a first appointment. However, some hospitals - such as Ulster Community, Green Park and the Royal Group - appear to have a greater share of long wait patients than might be expected given their share of referrals.

Figure 3.27: Over a quarter of patients in two hospitals are waiting more than a year for their first outpatient appointment

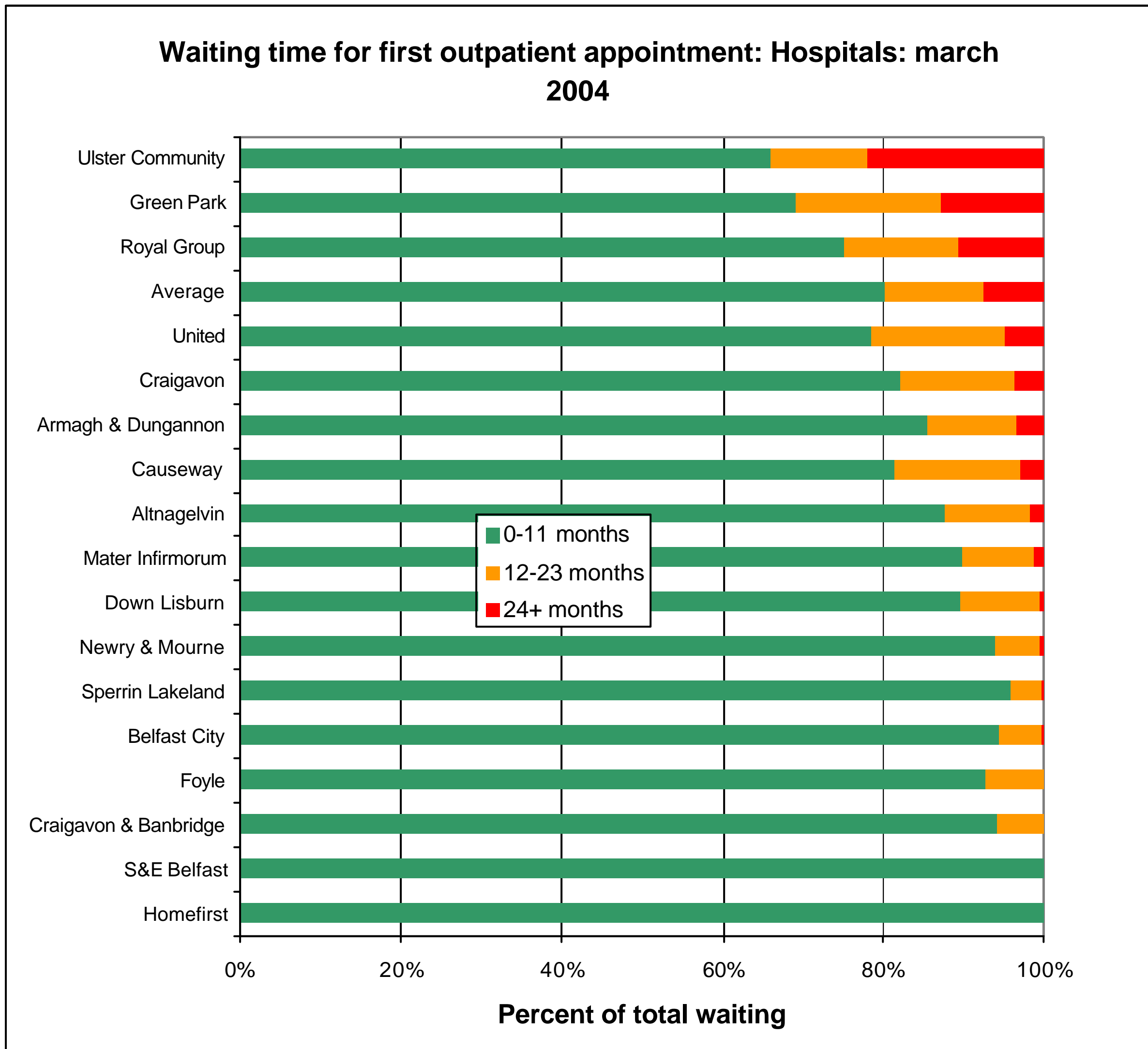


Figure 3.28: Just two hospitals account for 70% of patients waiting over 2 years; five hospitals account for 70% of patients waiting 12-23 months…

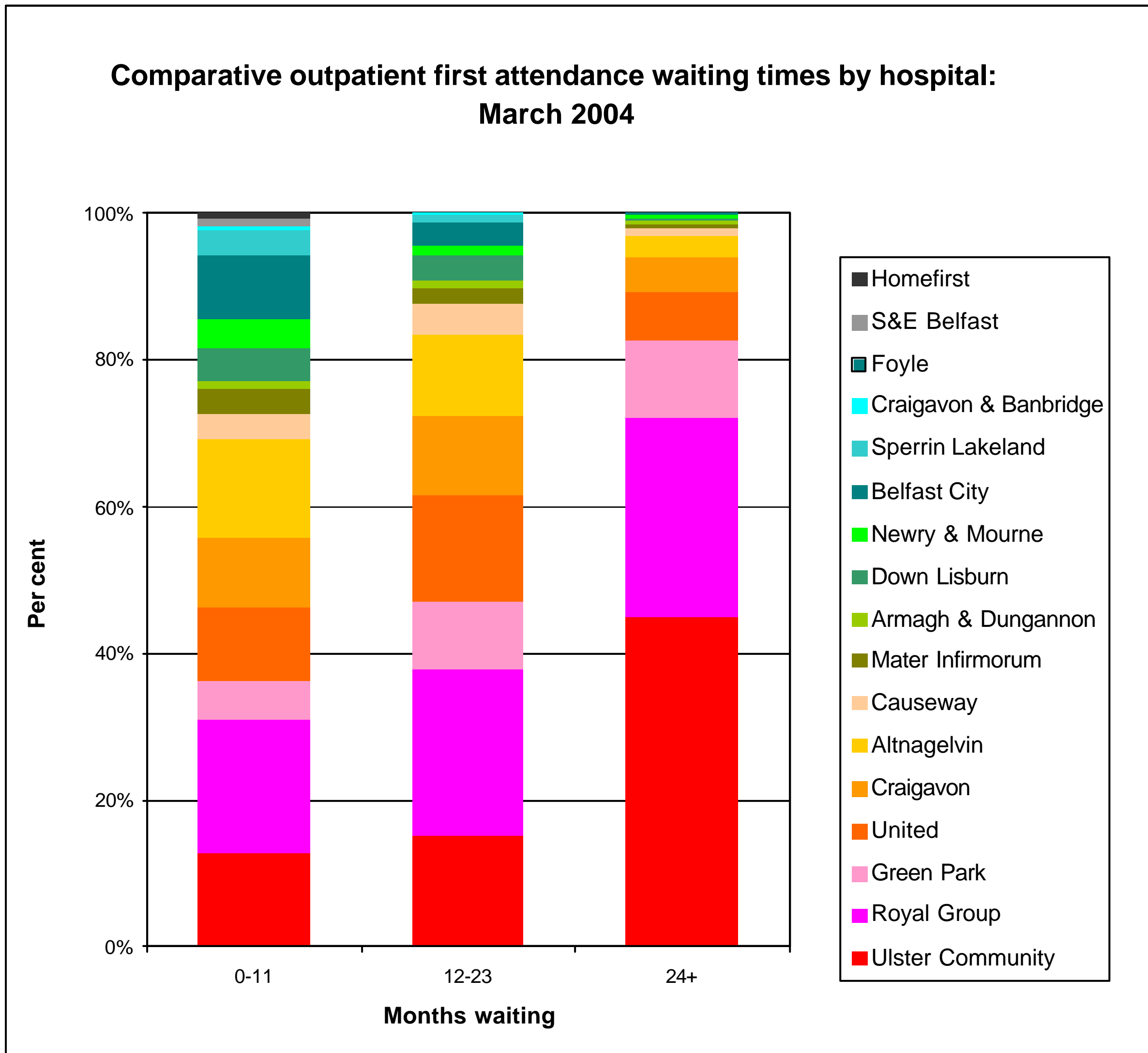
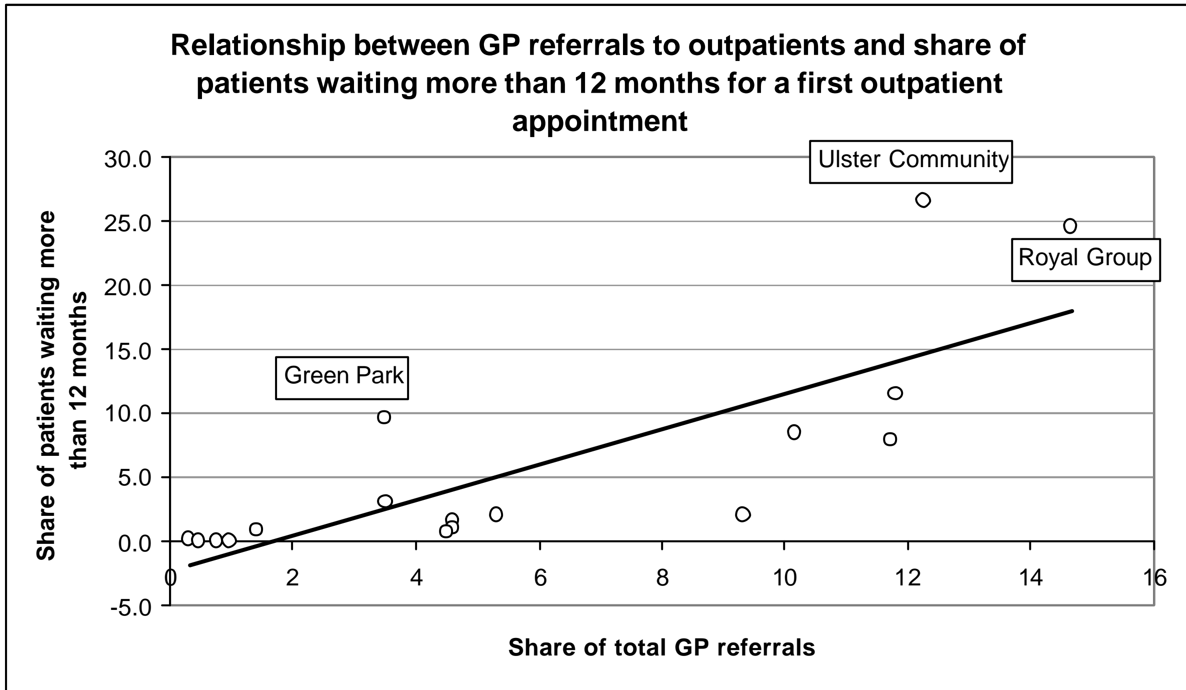
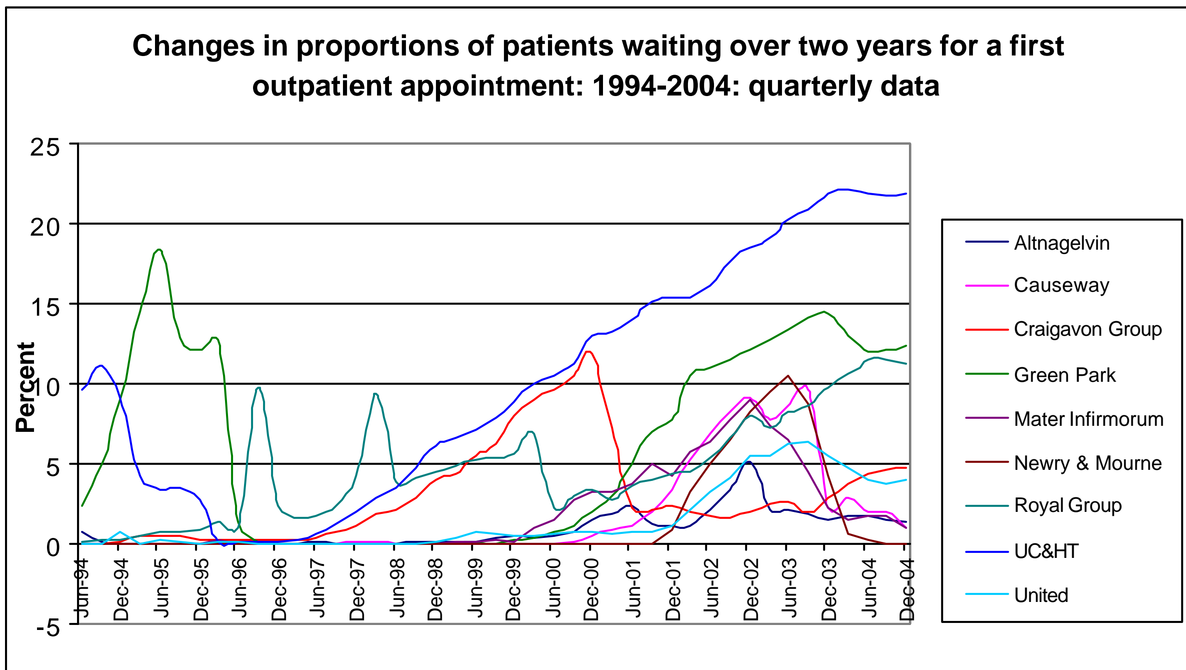


Figure 3.29: Some hospitals have a higher share of the total number of patients waiting more than one year for a first outpatient appointment than might be expected given their share of total GP referrals to outpatients



However, the fact that some hospitals have managed, for example, to virtually eradicate very long waits of over two years while others, with similar proportions waiting over two years in 2002, and although making big reductions over the last two years, have not, suggests that not all the variations in waiting times across hospitals are justified (see figure 3.30).

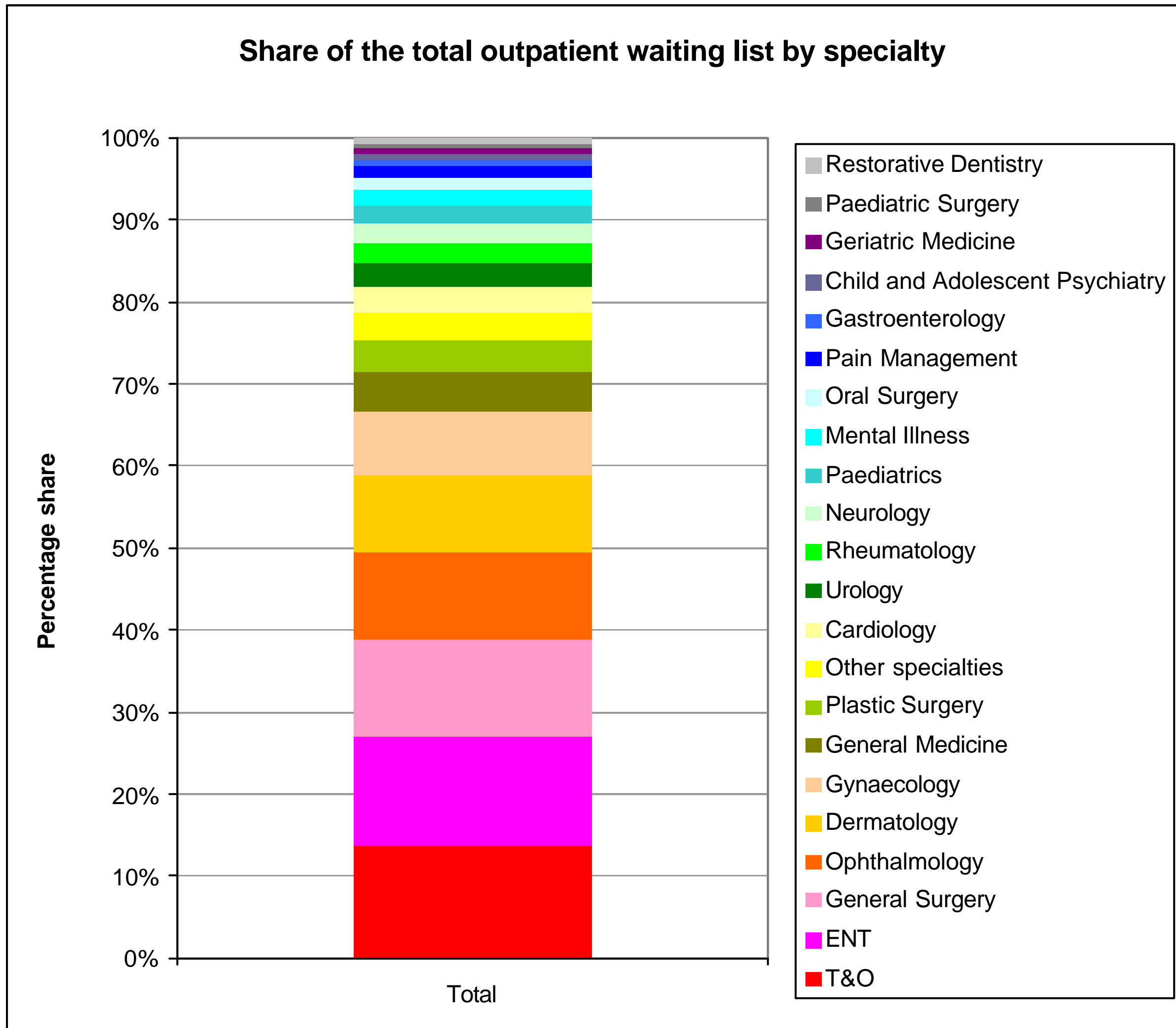
Figure 3.30: Some hospitals have reduced the proportion of very long waits for outpatient appointments; others have not.



Variations by specialty

Again, as might be expected, there are variations in waiting lists and times across specialties (see figures 3.31, 3.32 and 3.33). And again, much of this variation will be expected given variations in, for example, workloads.

Figure 3.31: Just four specialties account for almost half of all those waiting for a first outpatient appointment in September 2004



However, it is very noticeable that just two specialties - plastic surgery and trauma and orthopaedics - account for over six out of ten patients waiting more than two years for a first appointment in outpatients (see figure 3.32). For plastic surgery in particular, over 60% of patients are still waiting for a first appointment after two years (see figure 3.33).

Figure 3.32: Just two specialties account for over 60% of patients waiting over 2 years for a first outpatient appointment; five specialties account for two thirds of all patients waiting 12-23 months

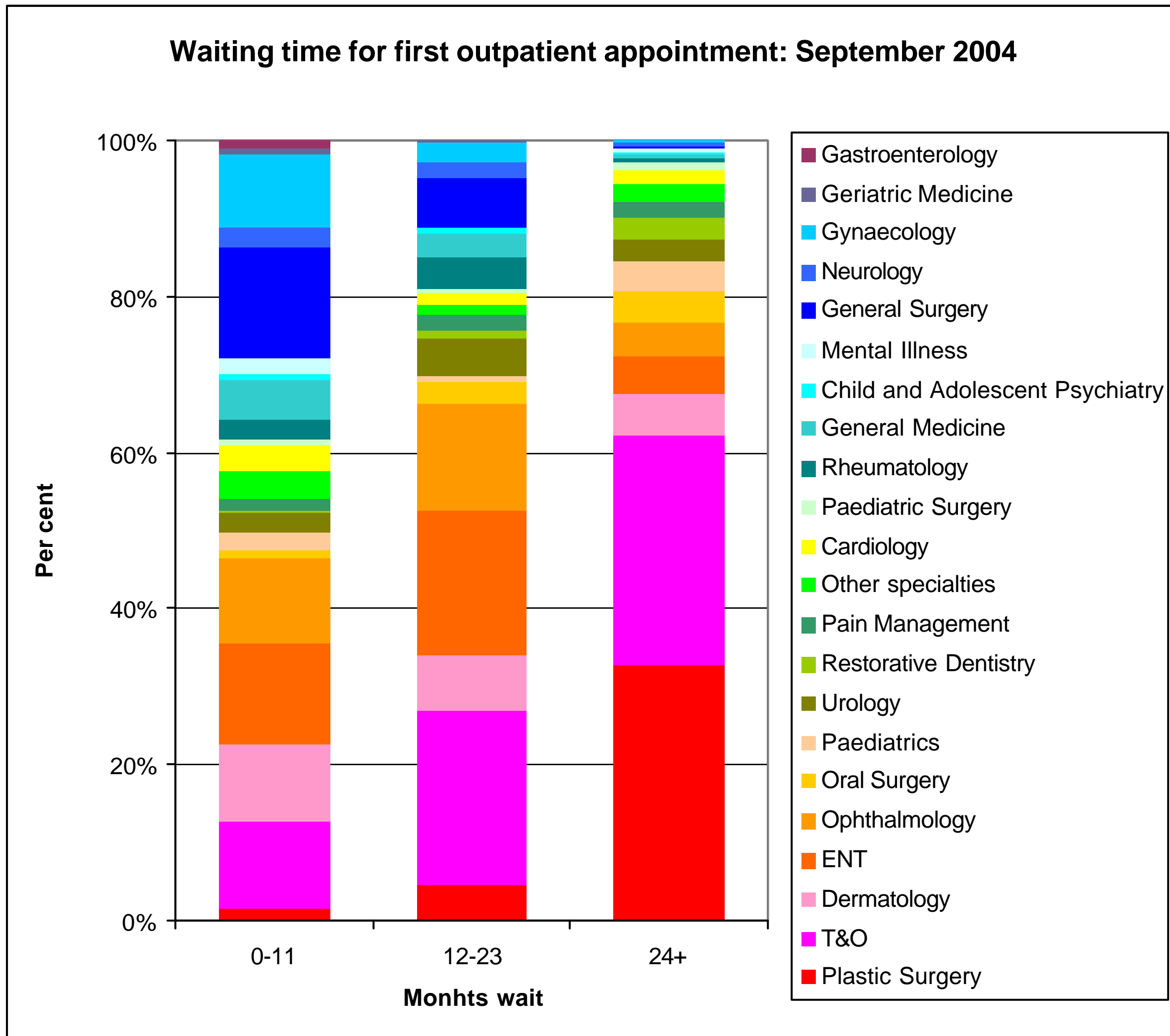
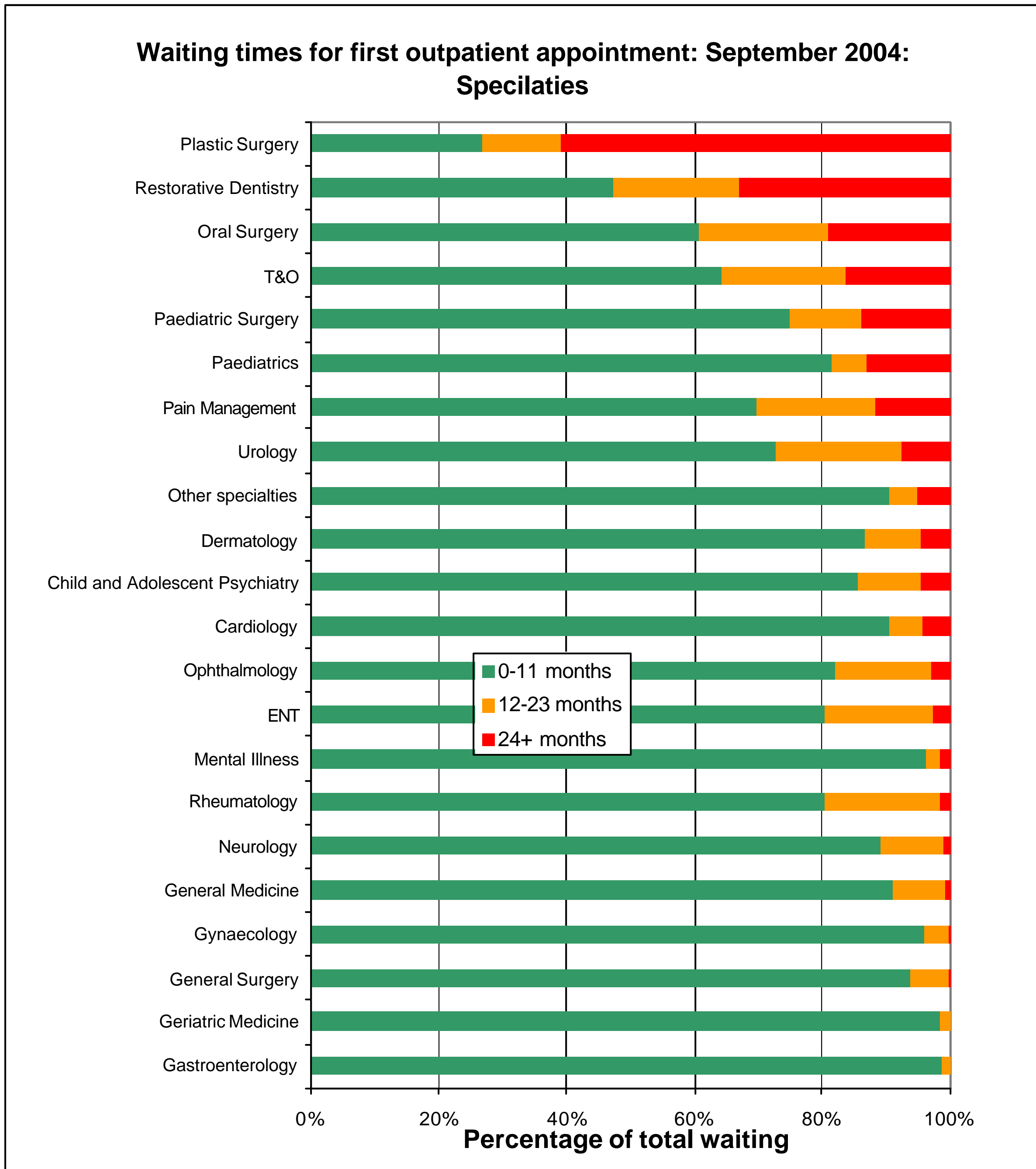
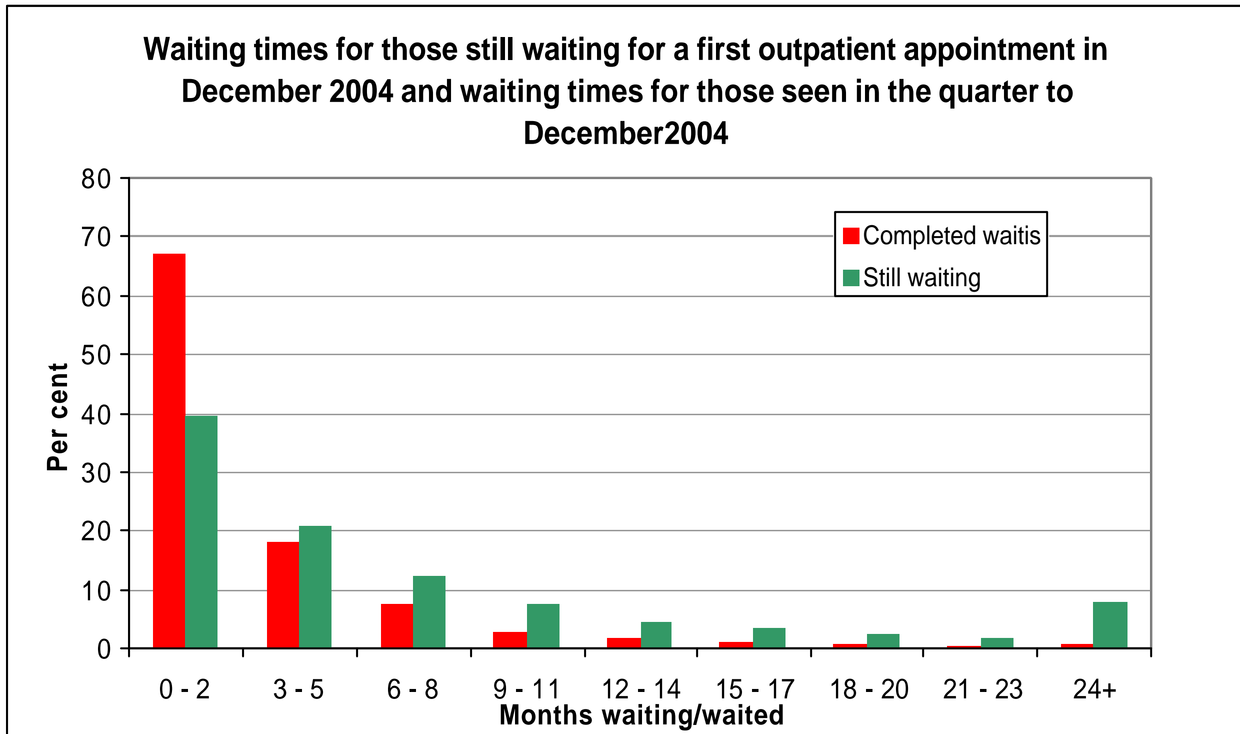


Figure 3.33: Six out of ten Plastic surgery patients are still waiting over two years for a first outpatient appointment; Outpatient waiting time variation among specialties



Another view of waiting is the length of time patients waited once they had had their first outpatient appointment. Figure 3.34 shows a marked difference in the waiting times distributions for those with ‘completed’ waits and those still on the waiting list. While just over 65% of those who did have an appointment only waited up to two months, the corresponding figure for those still waiting is 40%.

Figure 3.34: Patients who have had a first appointment tend to have waited less time than those still on the list. This is partly due to under 3 month waits being under-recorded by the quarterly census of those still waiting, but may also indicate a 'mortlake' of bypassed patients.



Variations across the UK

Comparisons of outpatient waiting lists and times across the UK are difficult to make due to lack of data. Scotland, for example, has no live outpatient list, rendering comparisons with Northern Ireland impossible. And no data is collected in England on the total numbers waiting.

However, figures 3.35 and 3.36 make what comparisons are possible - mainly with Wales. On all the comparisons that are possible, Northern Ireland has the poorest performance, with longer lists per head of population than Wales, proportionately more patients waiting longer than six months (38%) than either England (probably around 1%) or Wales (31%), and far more proportionately waiting over 18 months (12%) than Wales (3%).

Figure 3.35: Northern Ireland has more patients waiting for a first outpatient appointment per head of population compared with Wales and England

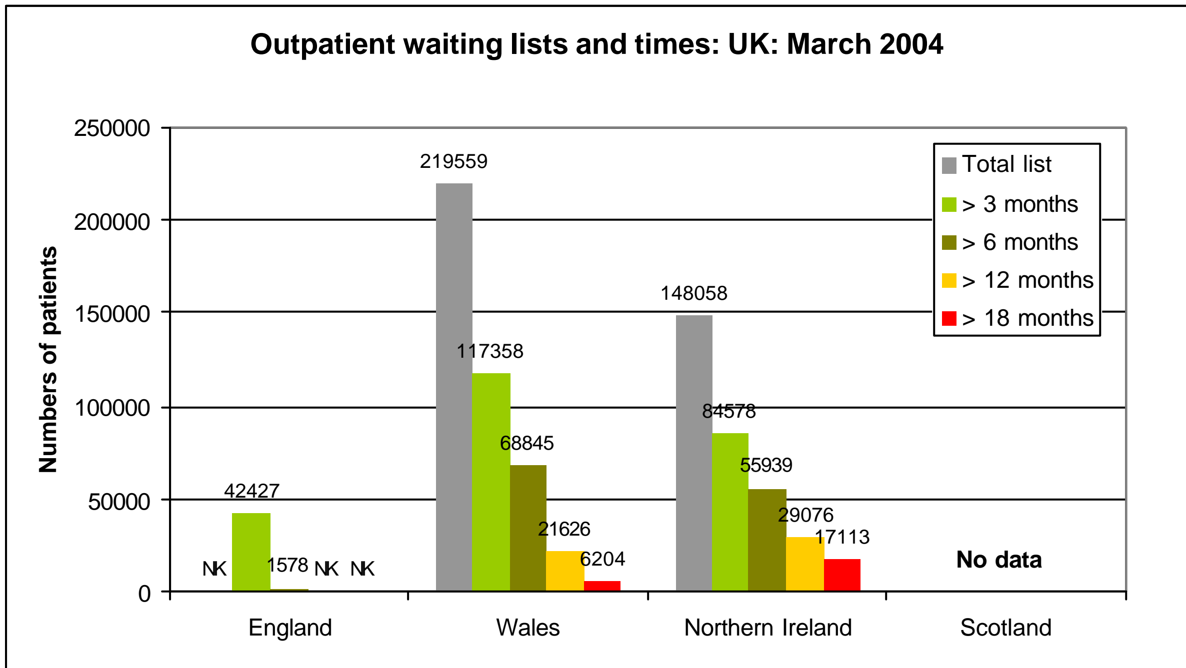
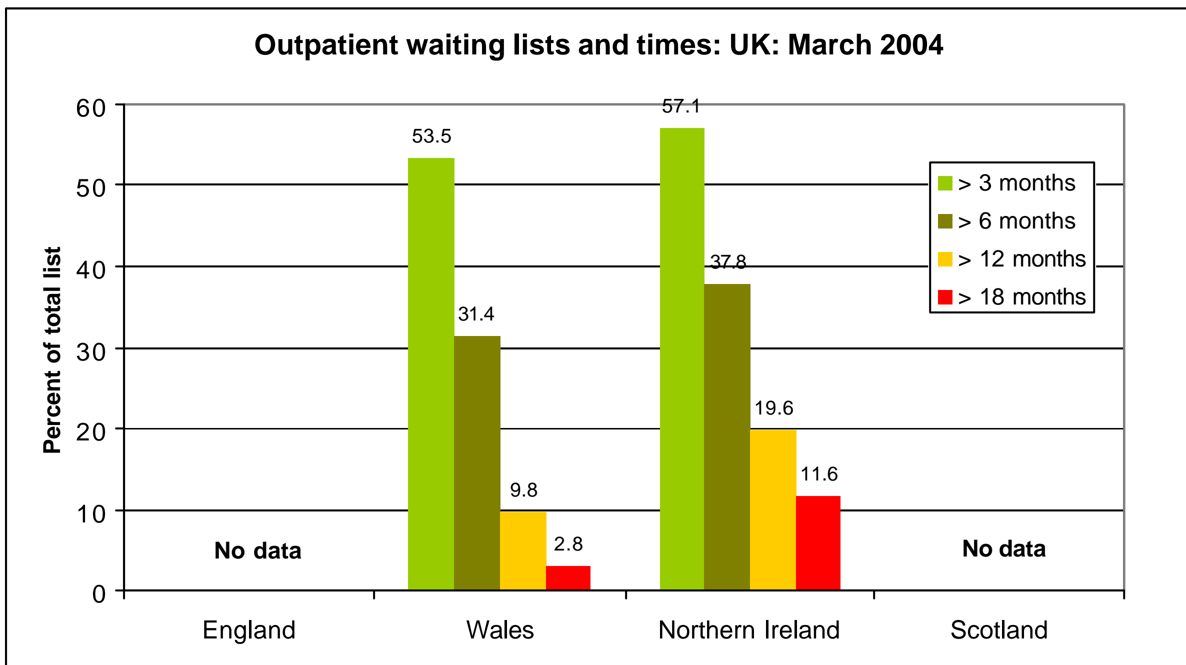


Figure 3.36: Northern Ireland performs poorly on outpatient waiting times compared with Wales

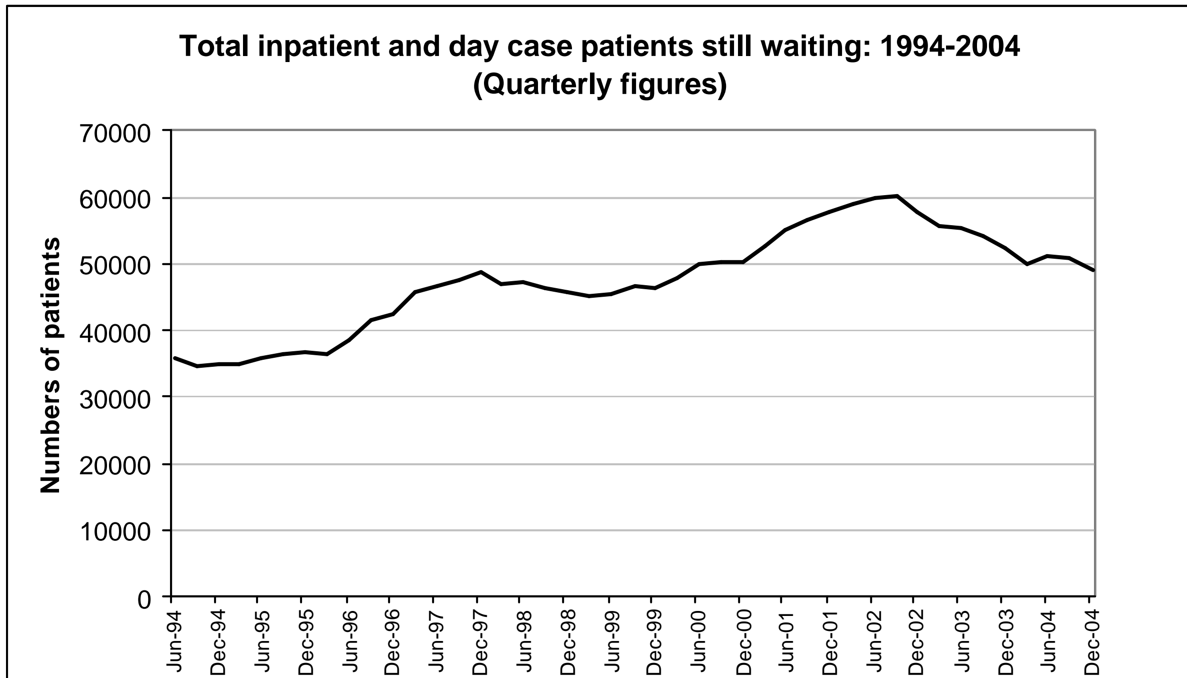


3.6.4 Inpatient and day case waiting

In December 2004, just under 50,000 people in Northern Ireland were waiting to be admitted to hospital for inpatient or day case care (see figure 3.37). The December 2004 reduction brings the total numbers of inpatient and day cases waiting to levels at the turn of the century

This represented 3% of the entire population - 15% more than Wales (2.6%), 36% more than Scotland (2.2%) and 67% more than England (1.8%).

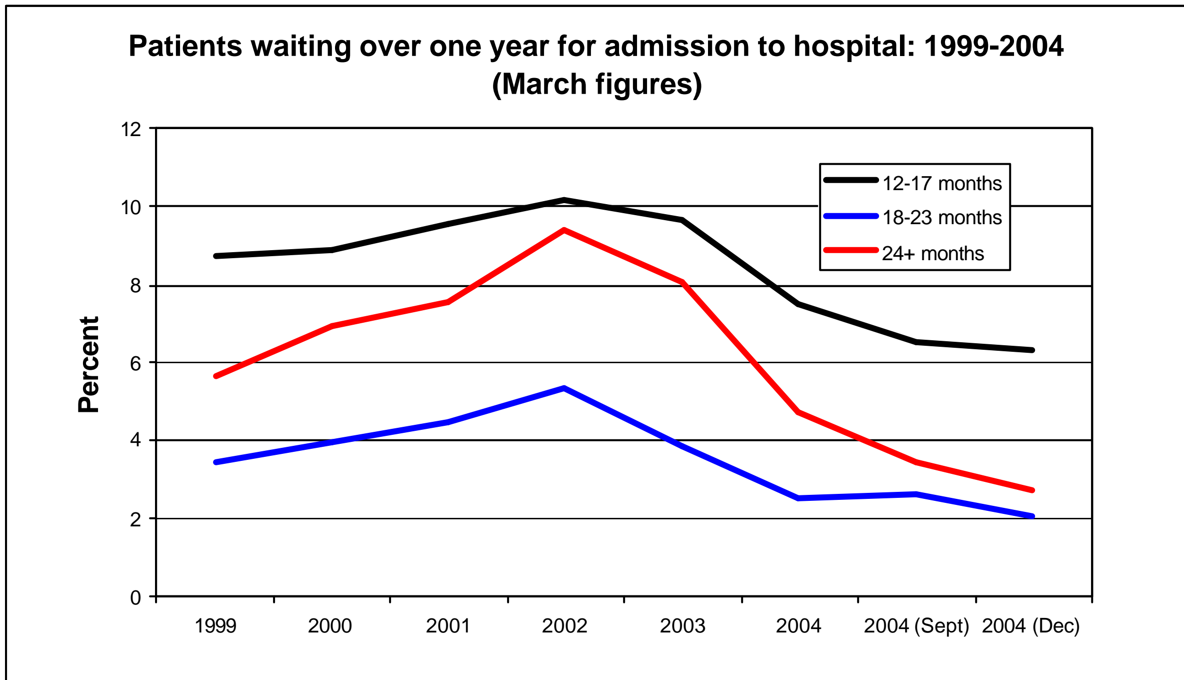
Figure 3.37: The total number of patients still waiting for admission to hospital has started to fall from its peak in 2002, but December figures show a levelling off at around 50,000



But while the total size of the waiting list for hospital admission can make headlines, of real concern to patients is how long they have to wait before admission.

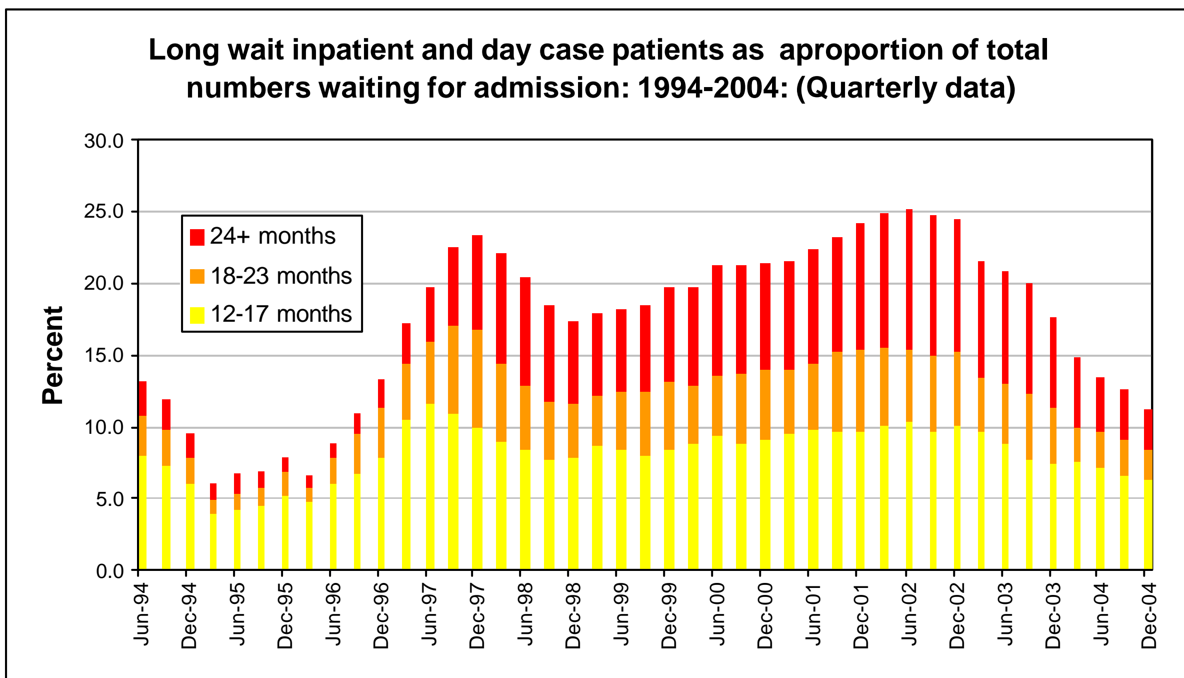
In terms of long waits - of which there is no definition, but over a year, might be a reasonable view of a long wait - there has been some progress over the last two years. Figure 3.38 shows that since March 2002, the numbers of patients waiting over a year have reduced considerably - although the rate of fall has slowed in recent quarters.

Figure 3.38: The numbers of patients still waiting over one year for admission to hospital have, since 2002, fallen to the level in 1999, and in December 2004 the number fell further, to 5,501.



These recent falls suggest that reducing long waits is not an intractable problem. However, looking back further over trends in long waits provides a mixed picture. As figure 3.39 shows, over the last ten years the proportion of the total inpatient list waiting over 12 months, has fluctuated between 6% and nearly 25%. There have been periods of significant reductions in long waits, but also subsequent periods where the proportion (and absolute numbers) have then built up again.

Figure 3.39: Since their peak in 2002, when a third of all inpatients and day cases were still waiting over 9 months for admission to hospital, the proportion of long waits reduced



Such trends raise the question of the sustainability of past attempts to reduce long waits and the effectiveness of actions and strategies to reduce waiting times. We return to these later on and in section 4 which looks at the performance management system.

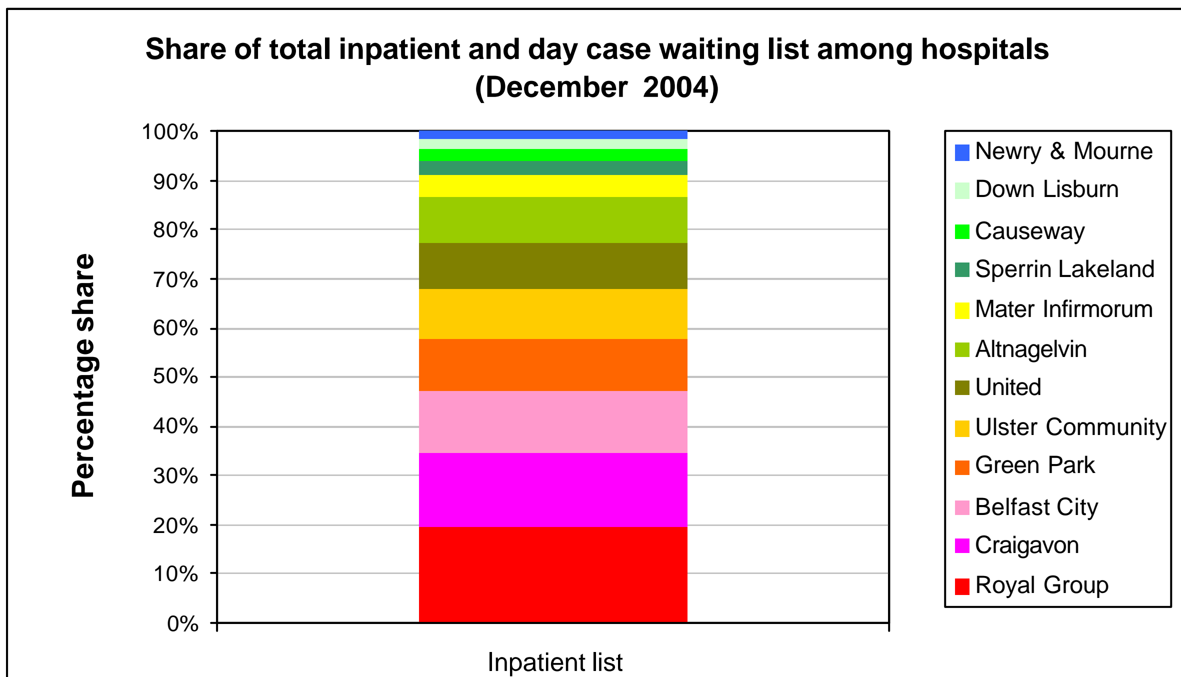
3.6.5 Variations in inpatient and day case waiting times

Apart from variations in waiting times over time, waiting times also vary among specialties, hospitals and in comparison to Wales, Scotland and England.

Variations by hospital

Figure 3.40, for example, shows that nearly 70% of all those on waiting lists are awaiting admission to five hospitals across Northern Ireland.

Figure 3.40: Just three hospitals account for nearly half of the total number of patients still waiting to be admitted to hospital



In part such variations in the share of the total list is explained by differences in the workloads of hospitals. Figure 3.43, for example, shows a relationship between trusts' shares of the total waiting list and their shares of total inpatient and day case activity (for 2003/4). Three hospitals, however, appear to have higher shares of the waiting list than might be expected given their workloads - the Royal Group, Craigavon Area and Green Park.

Figure 3.41: Over a quarter of patients in four hospitals are waiting more than a year for admission to hospital

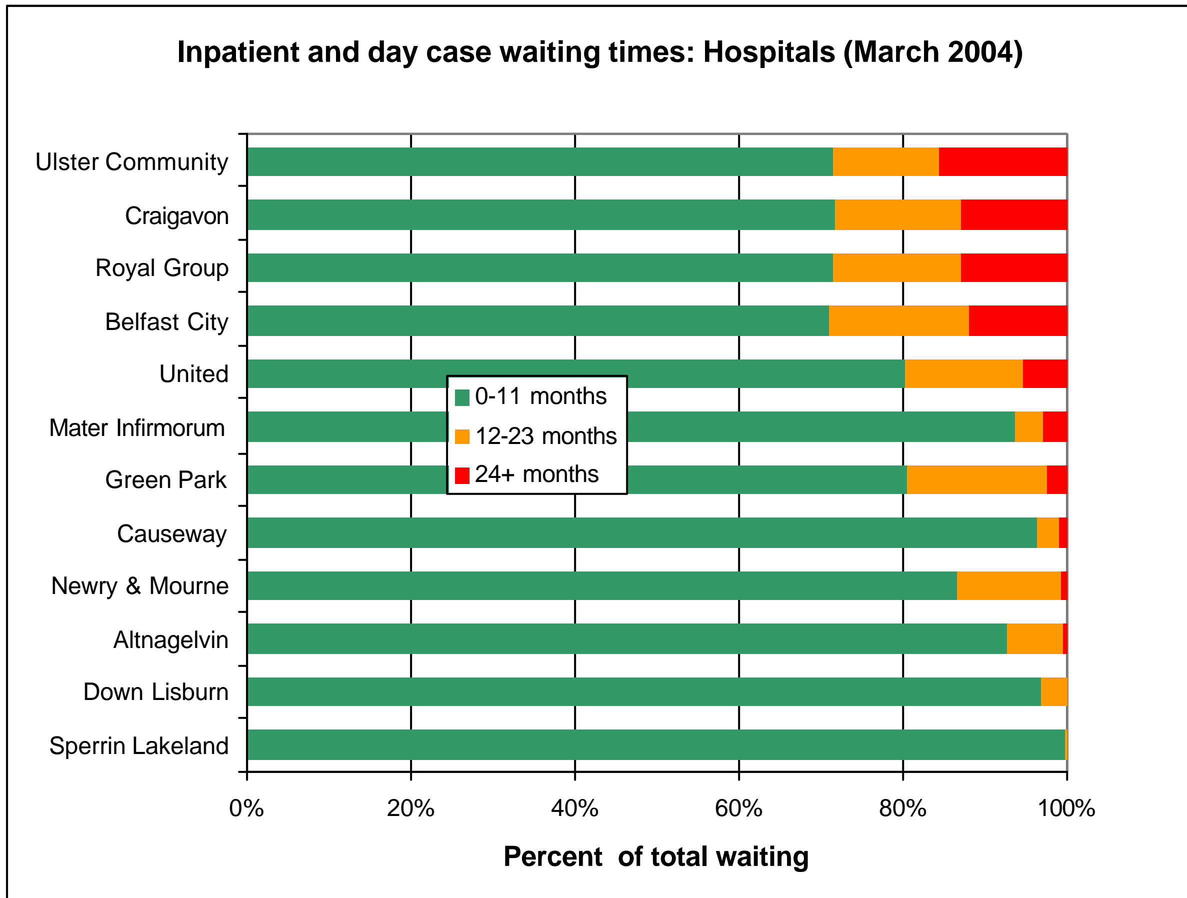
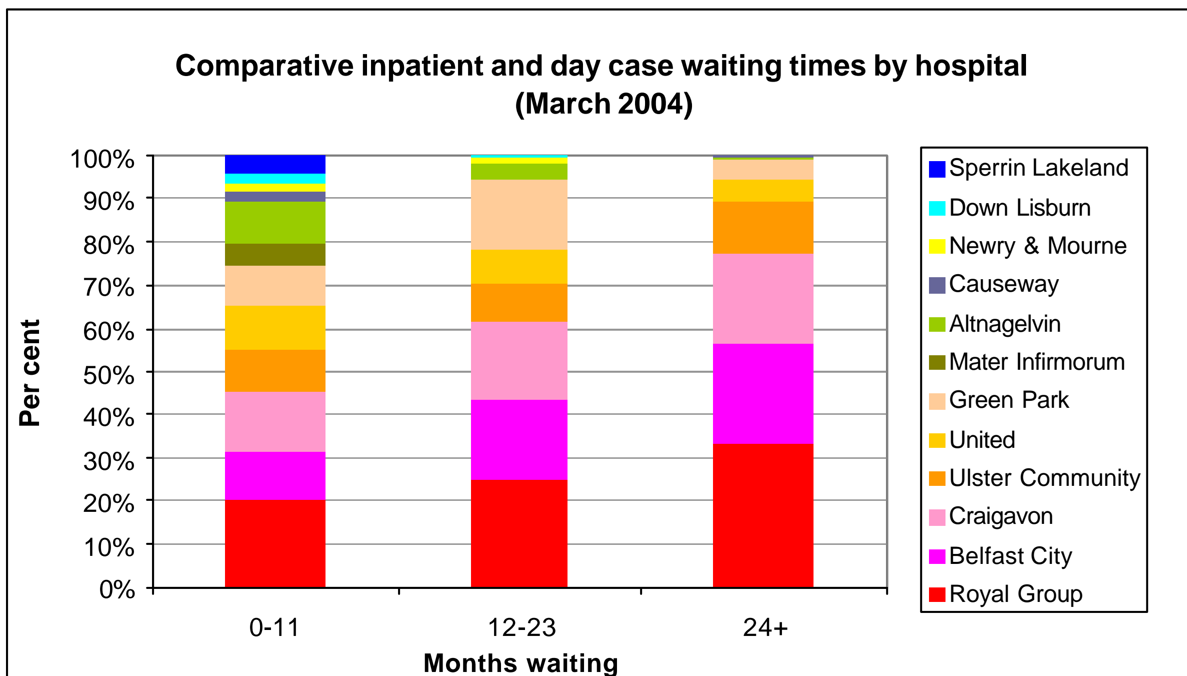


Figure 3.42: Just four hospitals account for nearly 90% of all patients waiting over 2 years for admission to hospital; five hospitals account for nearly 80% of patients waiting 12-23 months…



Variations in waiting times are also evident. And again, while these can in part be explained by differences in the workloads of hospitals, the relationship is not as clear

cut as with the size of lists, and further, the same three hospitals - the Royal Group, Craigavon Area and Green Park - are outliers, with a higher share of patients waiting over 12 months than might be expected given their activity levels.

Figure 3.43: Some hospitals have a larger share of the total waiting list than might be expected given their share of total activity

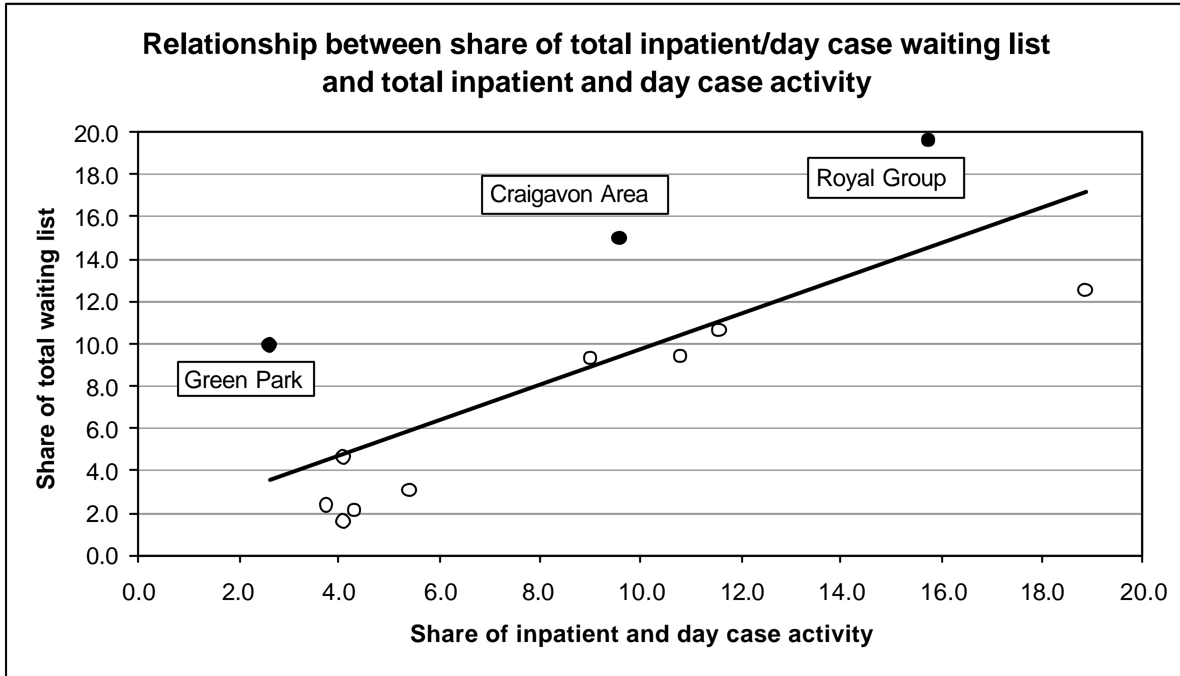
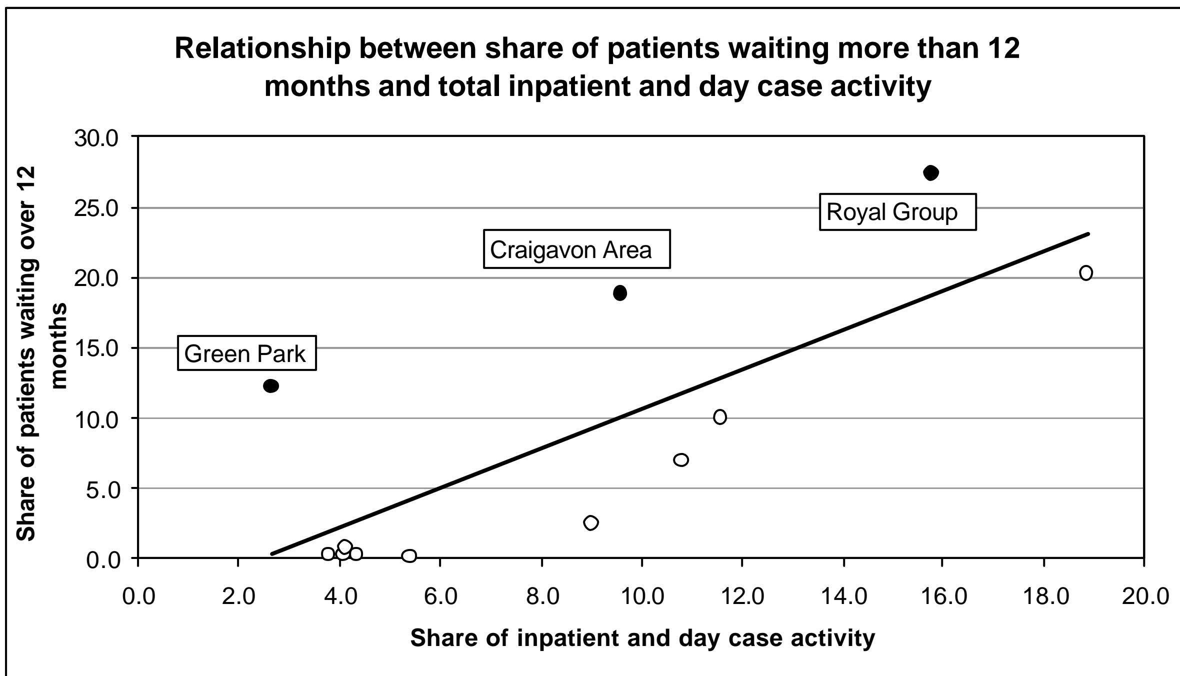


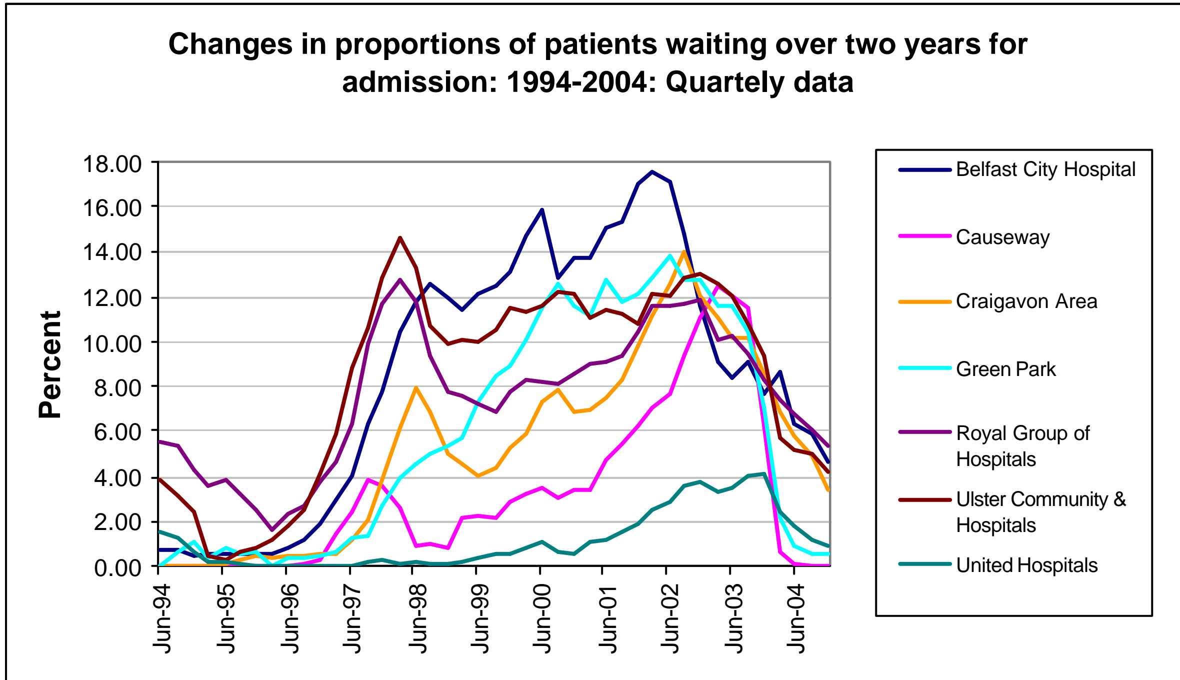
Figure 3.44: Some hospitals have a higher proportion of patients waiting over a year than might be expected given their share of total activity



However, the fact that some hospitals have managed, for example, to virtually eradicate very long waits of over two years while others, with similar proportions waiting over two years in 2002, and although making big reductions over the last two

years, have not, suggests that not all the variations in waiting times across hospitals are justified (see figure 3.45).

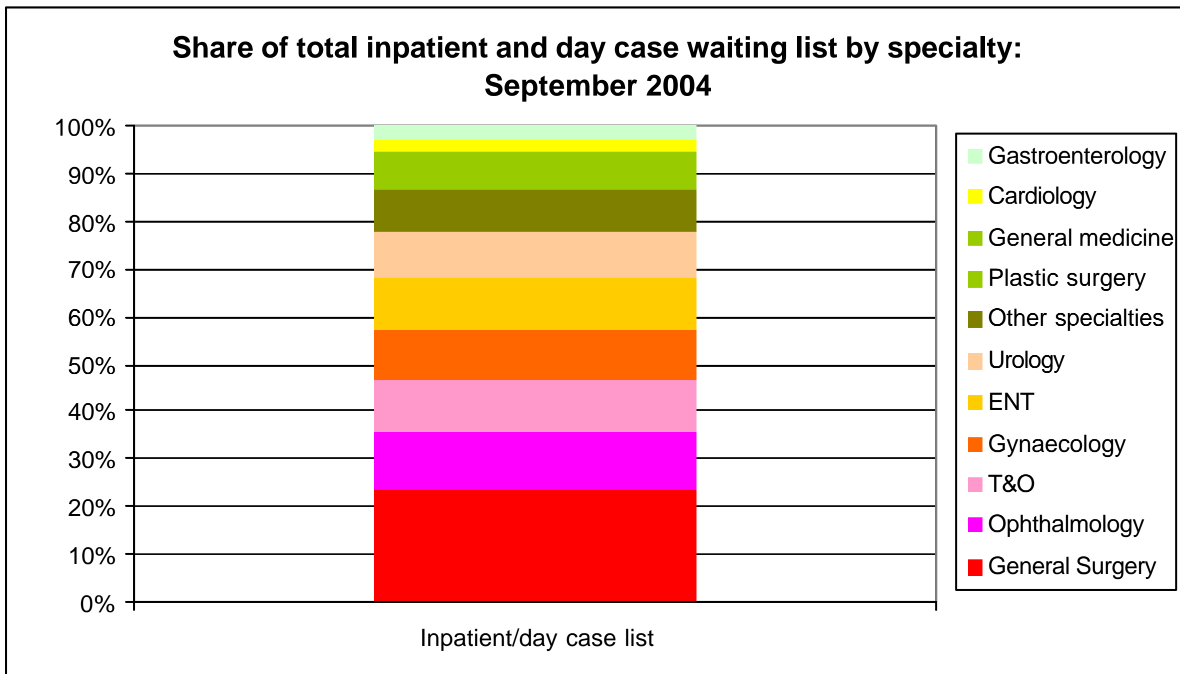
Figure 3.45: Some hospitals have managed to almost eradicate very long waits



Variations by specialty

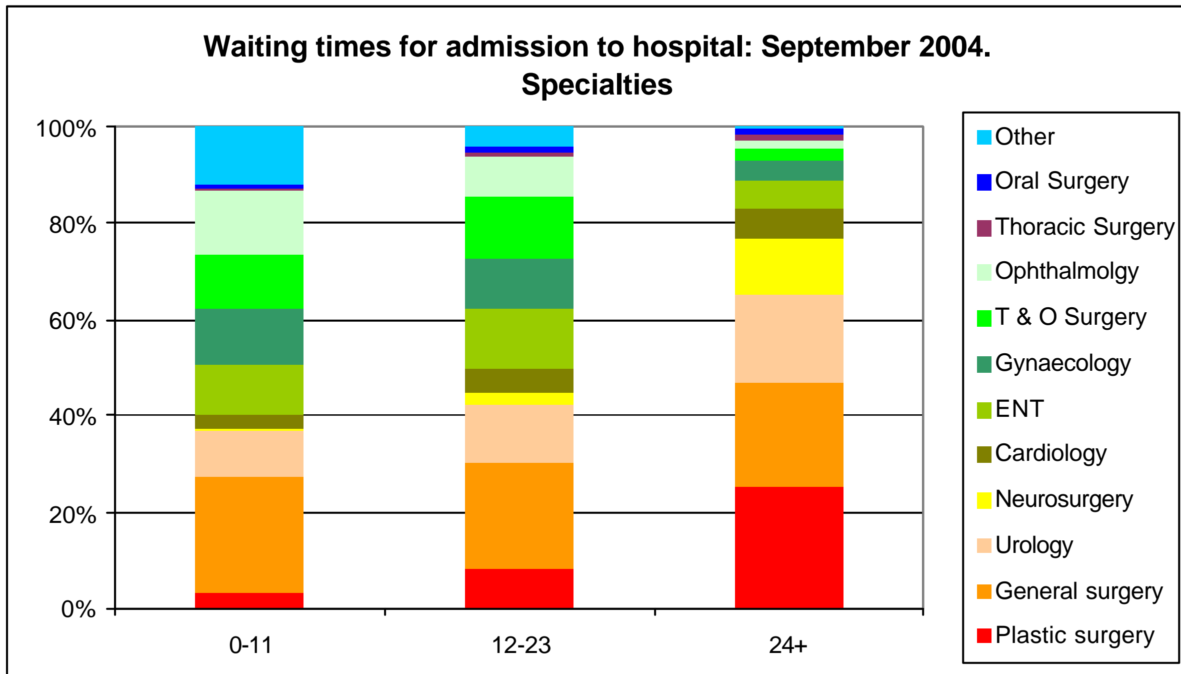
As with outpatient waiting lists and times, there are significant variations across specialties for inpatient and day case waiting lists (see figures 3.46 and 3.47).

Figure 3.46: Just four specialties account for nearly 60% of all p[patients on inpatient/day case waiting lists.



Again, as with outpatient waiting, the bulk of those waiting for admission to hospital are waiting in just a few specialties (general surgery, ophthalmology, trauma and orthopaedics…). And similarly, the majority of those waiting excessive times for admission are also concentrated in a handful of specialties - particularly, plastic surgery, general surgery and urology.

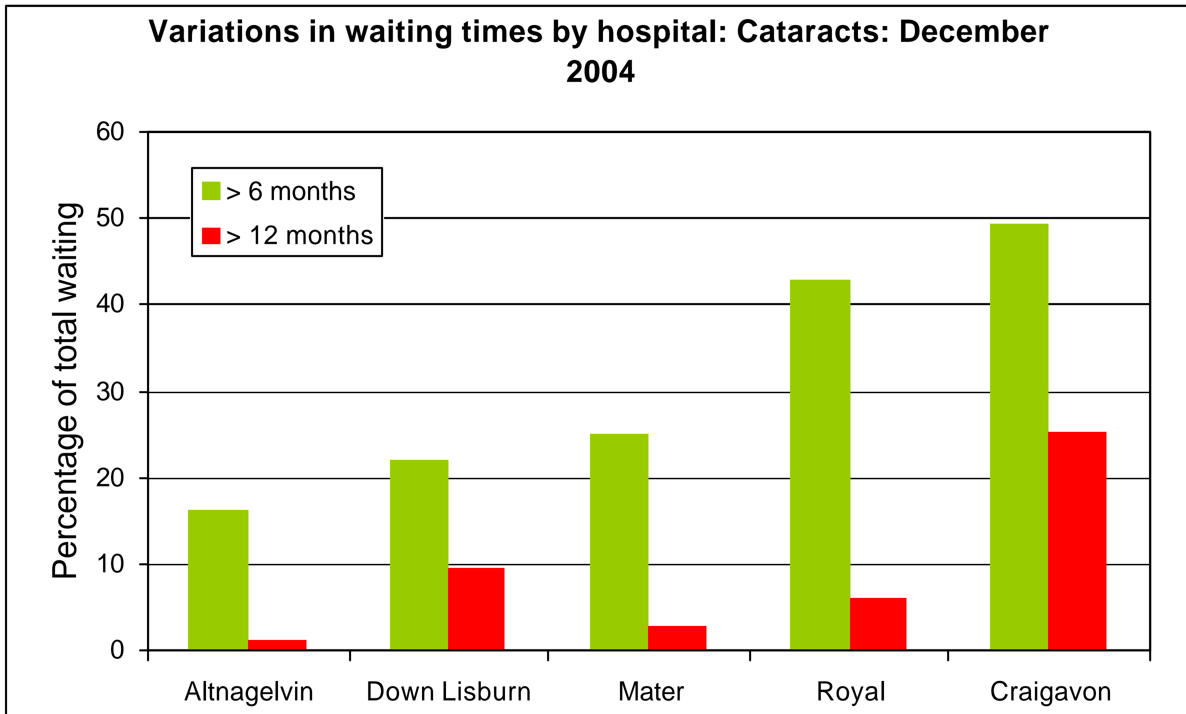
Figure 3.47: Just three specialties account for over 65% of patients waiting over 2 years; six specialties account for 60% of all patients waiting 12-23 months



Moreover, the majority of some specialty lists and waits are concentrated in just a handful of hospitals - sometimes, as in the case of trauma and orthopaedics, just one hospital - Down and Lisburn - accounts for over 82% of the total list. And in the case of ophthalmology, 62% of the total list is accounted for by the Royal.

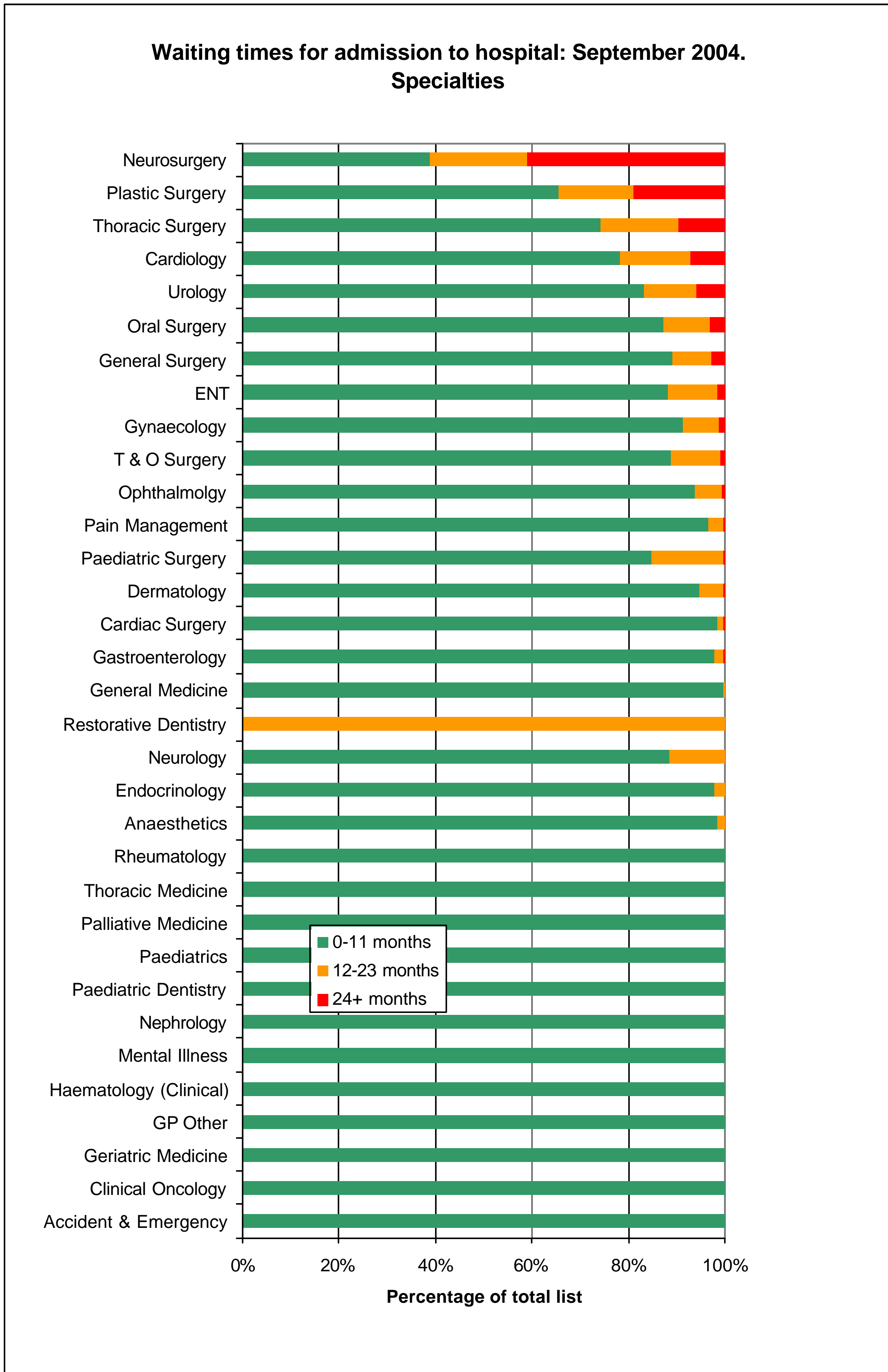
At the level of individual procedures there are also variations in waiting times, as figure 3.48 shows for cataract procedures.

Figure 3.48: Nearly half of all patients waiting for a cataract operation at Craigavon wait over six months; while at Altnagelvin only 16% do so.



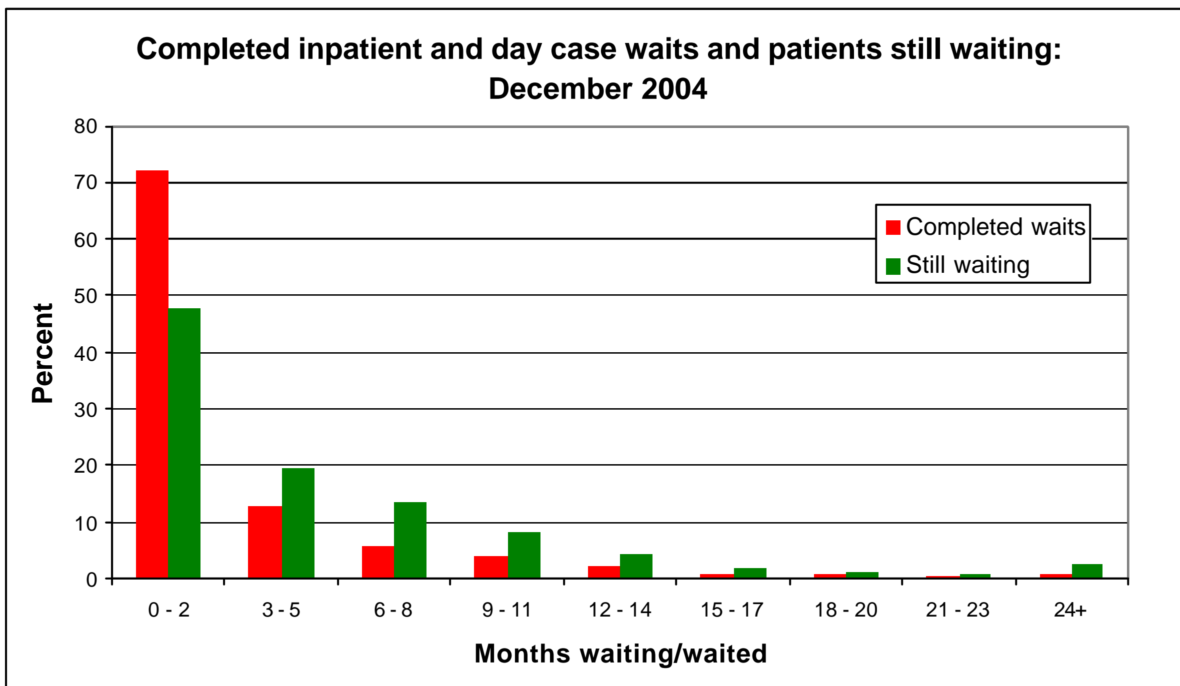
The reasons for very long waits in some specialties will depend on the nature of the specialty, the patients and the nature of the condition to be treated. For example, one reason for the very long waits in plastic surgery is undoubtedly the fact that much of the work carried out in this specialty is non-urgent and patients are rarely in pain.

Figure 3.49: 40% of those waiting for admission to neurosurgery have been waiting over two years.



As with the pattern of outpatient completed waits and those still waiting, patients who are admitted to hospital generally wait less time than those still on the list. In part this is a quirk of the data collection, but it can also be symptomatic of the dynamics of the way lists work in which a group of patients, considered by clinicians to be non-urgent, are bypassed by those deemed to be more urgent; some patients may find it very hard to move up and off the waiting list in this situation.

Figure 3.50: Patients who have been admitted to hospital tend to have waited less time than those still on the list. This is partly due to under 3 month waits being under-recorded by the quarterly census of those still waiting, but may also indicate a 'mortlake' of bypassed patients.



Variations across the UK

There are significant variations in waiting lists and waiting times across the four UK countries. Figure 3.51 shows that Northern Ireland has longer waiting lists per 1000 population and poorer waiting times than Wales, Scotland and England. And figure 3.52 clearly shows the shorter waiting time experience for patients in England and Scotland compared to Northern Ireland and Wales.

Figure 3.51: Compared with the rest of the UK, Northern Ireland has the greatest number of patients per 1000 population still waiting for admission to hospital. It also has the greatest number still waiting over one year for admission per 1000 population

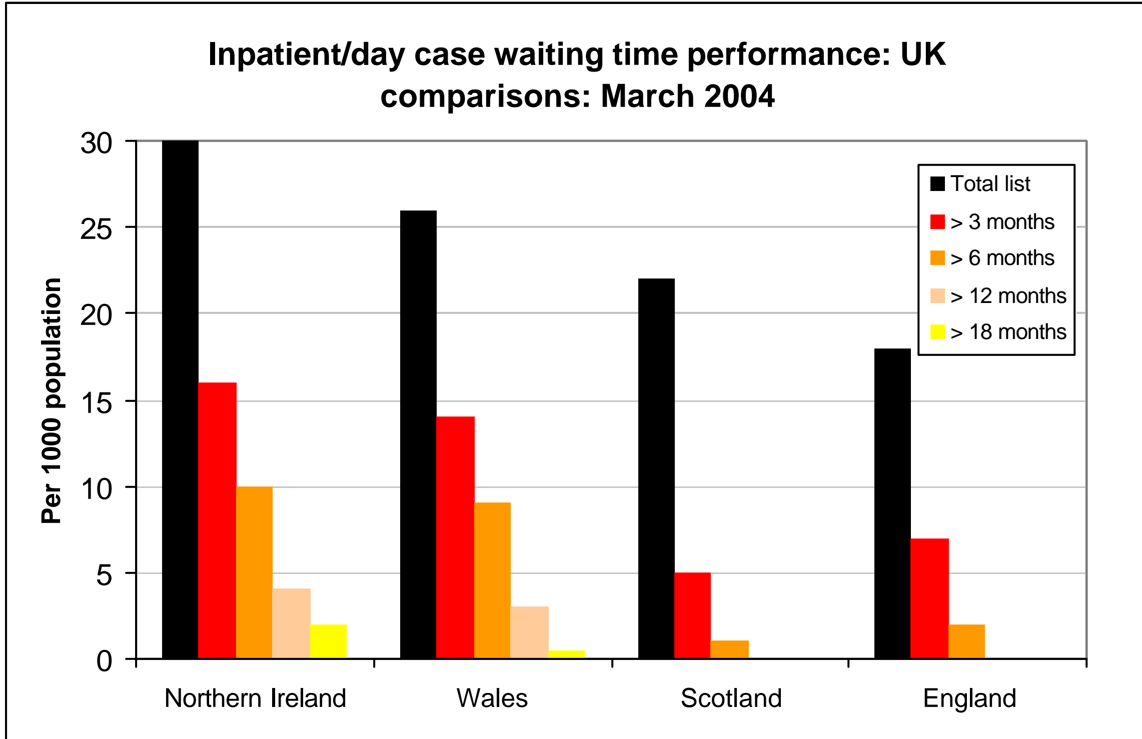
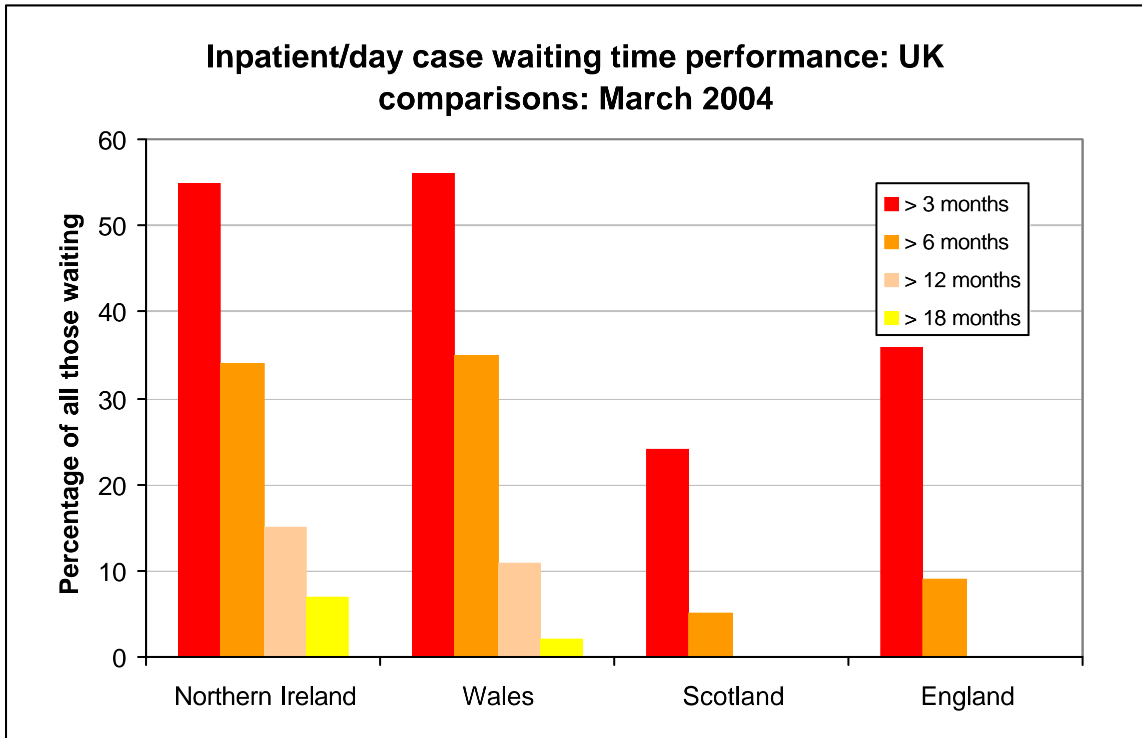
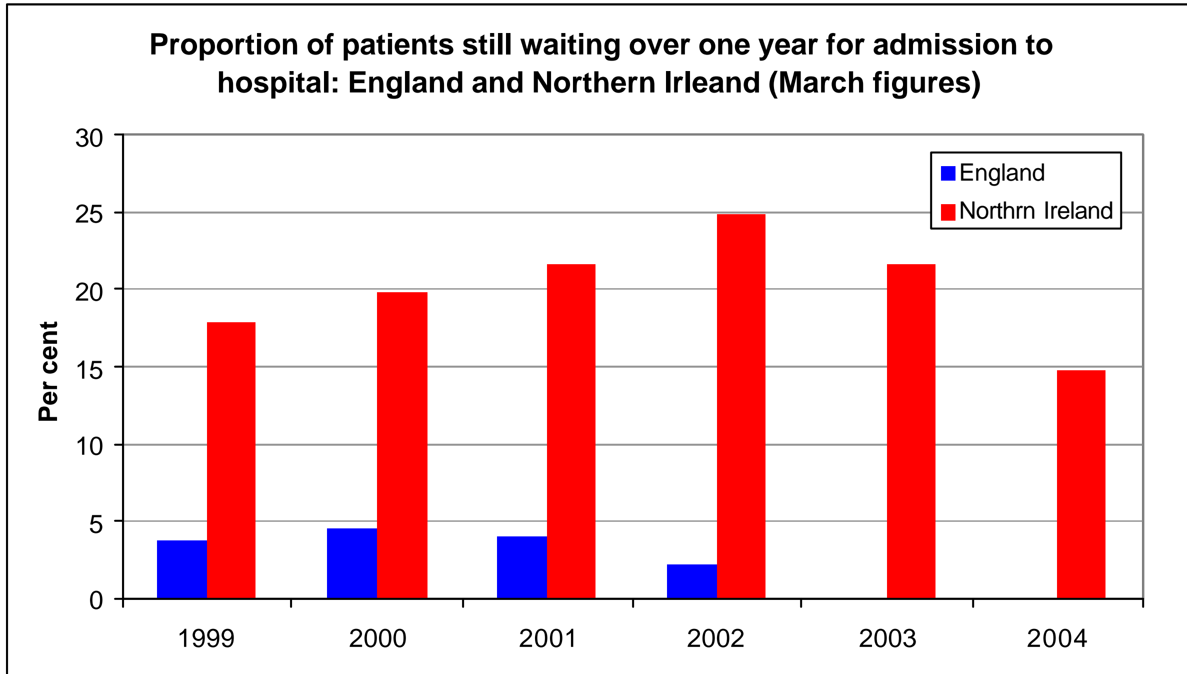


Figure 3.52: Northern Ireland currently has the worst waiting times situation for long waits for admission to hospital of any region of the UK.



The waiting times gap between, for example, Northern Ireland and England, is not a recent phenomenon; figure 3.53 shows that Northern Ireland is lagging someway behind England. Recent falls in the proportion of those waiting over a year are encouraging, but only take Northern Ireland to where England was in 1988 when a similar proportion of patients (15%) waited over a year.

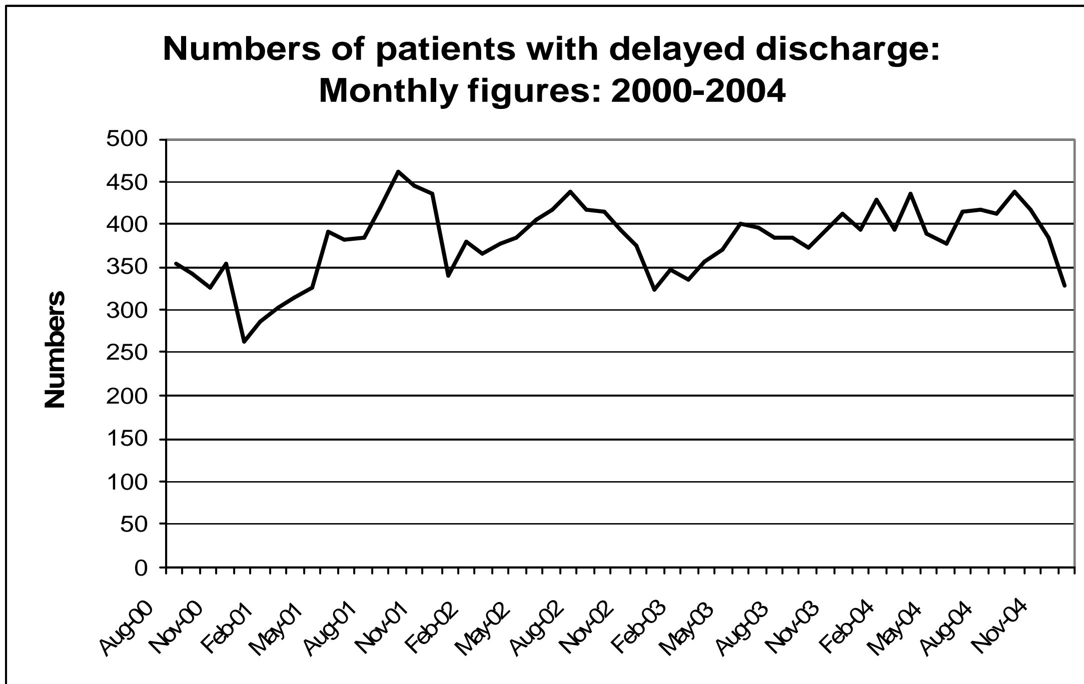
Figure 3.53: Compared with England, over the last six years Northern Ireland have performed poorly in reducing the numbers of patients waiting over one year for admission to hospital.



3.6.6 Waiting for discharge

As noted earlier, waiting occurs in many parts of a health care system. And potentially almost as distressing for patients as waiting to get into hospital, is waiting to get out - to be discharged - after treatment. Delays in discharges from hospital have remained at around 350 to 400 patients in any one month for the last four years (see figure 3.54); this is equivalent to a hospital the size of Altnagelvin Area Hospital occupied with patients (overwhelmingly over 75 years old) simply waiting to go home or on to other nursing or residential home accommodation.

Figure 3.54: Since 2000, the number of delayed discharges has remained around 350 to 400 - tying up 4% of all beds.

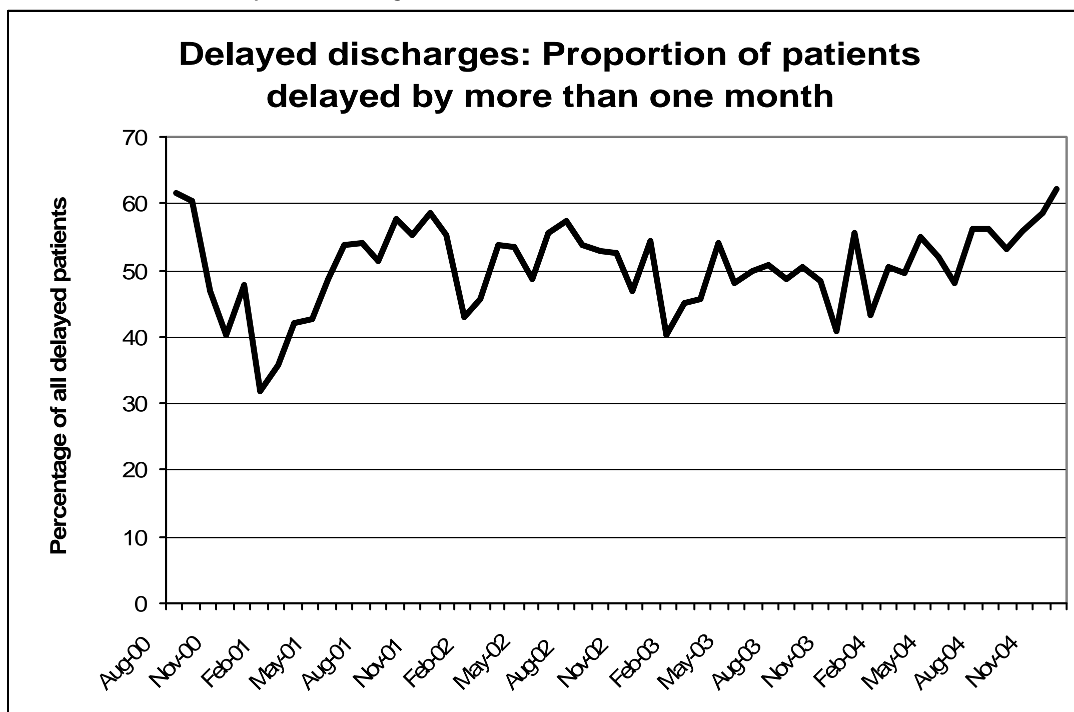


While the proportion of beds tied up with delayed discharges in Northern Ireland - 4% - is lower than in Scotland (6.2%) and Wales (5.1%), it is more than twice as high as in England, where significant reductions have been achieved over the last few years.

For those patients experiencing delays in discharge, waits can be considerable. Currently, as figure 3.55 shows, over 60% of all delayed discharge patients have been waiting over a month to leave hospital; and over a fifth are waiting more than three months, with over 6% waiting over six months.

The reported reasons for delayed discharges are most commonly 'lack of funding', waiting for an assessment of needs in hospital, and, the lack of an available and appropriate care package.

Figure 3.55: The proportion of patients delayed in hospital by more than one month has remained at around 50% of all delayed discharges since 2000



3.6.7 Targets to reduce waiting lists and times: a failed strategy?

It is clear that waiting times in most parts of the Northern Irish health system are, despite some improvements recently, very long - especially in comparison with England.

A significant minority of patients wait more than two years just to get a first outpatient appointment. A proportion of these patients who are then placed on the inpatient/day case waiting list will then go on to wait a further two or more years before being admitted to hospital. In total, some patients will have waited four or more years from the time they were referred by their GP until they get a bed in hospital - an intolerable length of time to have to wait for treatment. And, somewhat ironically, not only can it be difficult for some patients to enter hospital, it can also be difficult to exit; every year hundreds of patients find themselves unable to leave hospital for many weeks or even months due to discharge problems of one sort or another.

Dealing with the problem of (unnecessary and excessive) waiting in different parts of the health and social care system is not, as other countries have found, easy to do. One common approach has been to set targets for reductions in waiting lists and waiting times - a strategy which arguably has been the key factor in driving down waiting times in England over the last few years.

In Northern Ireland, targets, dealing with various aspects of waiting, have been in place (and promulgated by the Department's annual Priorities for Action documents) since the early 1990s (following the introduction of the Patient's Charter). However, as Box 3.4 details, since 1997, very few targets have been achieved. Moreover, as

can also be seen from Box 3.4, target setting has been somewhat erratic, with little apparent long term goals and intermediate milestones set, noticeable gaps (for example, no targets for reducing outpatient waiting times) and with many targets only appearing once over the last seven years despite not being achieved.

Box 3.4: Waiting time targets: 1997/8 to 2005/6

Centrally set targets for any aspect of waiting in the Northern Irish health and social care system have been abstracted from the Department of Health's annual Priorities for Action documents.

1. 2004/05

Target	Date to be achieved	Outcome?
No inpatient/day case to be waiting >6 months	2006/7 or 2007/8	This is a general indication of the timescale in which such a reduction should be reached. It is not, at present, considered by the DHSPSS to be a target as such.
95% of patients requiring hospital inpatient or day case treatment to be admitted within 12 months of being placed on a waiting list	March 2005	**Not on target?**: By December 2004, 11.1% still waiting >12 months. However, of those *admitted* in the quarter, 95% had waited 12 months or less.
Other than in exceptional circumstances, no patient to be waiting for inpatient or day case treatment >18 months	March 2005	**Target unlikely to be achieved**: By December 2004, 4.8% still waiting >18 months
No patient to be waiting for inpatient or day case treatment >15 months	March 2006	**On target?**: By December 2004, 6.9% still waiting >15 months
Number of delayed discharge days to be reduced by 10% compared to 2003/04 levels	March 2005	**Not on target:** Between March and December 2004 there were a total of 80,290 delayed discharge days, against a target reduction of 90,878 by March 2005.
Number patients waiting >2hours in A&E between a decision to admit and admission to a ward to be reduced by one third of 2003/4 levels	March 2005	**Not on target:** Between March and December 2004, 24,087 patients had waited more than two hours in A&E between a clinician's decision to admit and admission to a ward, against a target of 20,568 by March 2005.
Improve access to primary care services by ensuring that 90% of patients who request a clinical appointment (for other than emergencies) will be able to see a General Practitioner or an appropriate primary care	March 2005	**On Target** Boards anticipate meeting this target although the SHSSB has indicated some slippage will occur.

professional within the practice or provided by the practice within 2 working days		
85% of all people who are medically fit for discharge from hospital but who require access to community support to facilitate their discharge should wait no more than 8 weeks for such services to be provided	March 2005	**Unlikely to be Achieved** At December 2004, this standard was being met in the WHSSB area only. Elsewhere performance ranged from 66% to 73%.
To have made demonstrable progress towards achieving the strategic target of a 75% response rate within 8 minutes across all Board areas by 2007	March 2005	**On Target** Systems will not be place to enable the target to be measured until March 2006 but Boards record progress on track for delivery by 2007.

2. 2003/04

Target	**Date to be achieved**	**Outcome?**
Numbers of patients waiting longer than 18 months for hospital inpatient or day case treatment to be reduced by 50% from the level at June 2002	March 2004	**Target exceeded:** 61% reduction achieved
Number of patients waiting for hospital inpatient or day case treatment to be reduced by 5% from the level at June 2002	March 2004	**Target exceeded**: 16.7% reduction achieved.

3. 2002/03

Target	**Date to be achieved**	**Outcome?**
Constrain hospital waiting lists to the March 2002 level	March 2003	**Target exceeded**: total numbers fell by 2,767 (4.8%)

4. 2001/02

Target	**Date to be achieved**	**Outcome?**
Reduce waiting lists by a quarter, from 51,000 to 39,000, with a milestone reduction to 48,000 by March 2002	March 2004	**Not achieved:** waiting lists *increased* to 57,000 in March 2002, and were just under 50,000 by March 2004
No patient to be waiting >18 months, with a milestone reduction of 50% in those waiting >18 months by March 2002	March 2003	**Not achieved:** Numbers waiting >18 months and cardiac patients waiting >12months increased by 2,337 (+36%) over March 2001 levels; by March 2003 the number of 'excess waiters' was 6,659, an increase of 229 (+3.6%) over March 2001 levels.
No cardiac patient to be waiting >12 months, with a 50% reduction in those waiting >12 months by March 2002	March 2003	
No patient to wait >48 hours for surgery in fracture clinics	No date set	**Not Achieved.** Work was being addressed

		on a regional basis through the Fracture Crisis Working Group in which Boards participated. DHSPSS state that: “Winter pressures reduced the impact of the additional capacity introduced into the system.”
Reduce the number of people waiting for occupational therapy assessments for housing adaptations at April 2001 by 20%	March 2002	**Not achieved.** Northern Board reduced the numbers waiting by 19% and Western Board by 17%.

5. 2000/01

No specific targets set in this year. General exhortation from DHSPSS to maintain downward pressure on waiting lists and ensure that gains made were not lost: By March 2001, waiting lists rose by 16.7%

6. 1999/00

Target	Date to be achieved	Outcome?
Maximum wait for outpatient appointment no more than 3 months from time of GP referral	2000	**Not achieved**: 77% seen within 3 months
No patient to be waiting longer than 18 months for admission to hospital	2000	**Not achieved**: 96% admitted within 18 months; 12% still waiting > 18 months by March 2000
No cardiac patient to be waiting longer than 12 months for admission to hospital	2000	**Not achieved**: 8% admitted within 12 months;
No patient to wait longer than one month for admission following a cancelled operation	2000	**Not achieved**: 1% not admitted within one month

7. 1998/99

Target	Date to be achieved	Outcome?
Maximum wait for outpatient appointment no more than 3 months from time of GP referral	1999	**Not achieved:** 80% seen within 3 months
No patient to be waiting longer than 18 months for admission to hospital	1999	**Not achieved**: 95% admitted within 18 months
No cardiac patient to be waiting longer than 12 months for admission to hospital	1999	**Not achieved**: 85% admitted within 12 months
No patient to wait longer than one month for admission following a cancelled operation	1999	**Not achieved**: 0.7% not admitted within one month

8. 1997/98

Target	Date to be achieved	Outcome?
Maximum wait for outpatient appointment no more than 3 months from time of GP referral	1998	**Not achieved**: 80% seen within 3 months
No patient to be waiting longer	1998	**Not achieved:**

than 18 months for admission to hospital		95% admitted within 18 months
No cardiac patient to be waiting longer than 12 months for admission to hospital	1998	**Not achieved**: 83% admitted within 12 months
No patient to wait longer than one month for admission following a cancelled operation	1998	**Not achieved:** 0.3% not admitted within one month

End of Box 3.4

Despite the apparent lack of success in meeting waiting times targets - the reasons for which are discussed below, and in the next section on the performance management system - there are (recent) examples of successes in tackling the problem of waiting. Box 3.5, for example, summarises some of the approaches taken at local level - often using learning from the Modernisation Agency and experience of the National Patient Access Teams in England in reducing waiting times.

Box 3.5: Examples of success in tackling waiting lists and times in Northern Ireland

The following examples of success in reducing waiting times are taken from *Tried, Tested, Shared 2: Summaries from the Service Improvement projects 2003-04* (DHSSPS, 2004).

The Service Improvement Unit was set up in 2003 and aimed to improve patient and client access '…by engaging multidisciplinary teams in redesign to reduce waits and delays..'. This bottom up, micro approach has helped many trusts improve their waiting times performance.

Causeway Trust managed to completely eradicate over 12 month waiters in just eleven months through a combination of protecting elective beds from emergency use, regular validation of lists, eradicating bottlenecks along the patient pathway, use of a points system to forecast necessary theatre capacity and development of a common general surgery waiting list.

Foyle Trust reduced the waiting time for a first outpatient appointment for its family planning services from 18 weeks to 4 weeks, reduced the average wait within clinics from 85 to 30 minutes and cut its DNA rate by introducing a computerised booking system, providing one contact telephone number for patients, sending out reminders for appointments, introducing nurse-led clinics and extending clinic opening hours.

Craigavon and Banbridge Trust reduced DNAs from 22% to 10% and cut the longest wait for a new assessment from four months to two weeks for its Continence Clinic by validating lists, introducing a partial booking system and generally redesigning clinic structures.

A common outcome of these and many other initiatives has not just been the reduction in waiting times and lists, but improved staff morale and motivation, higher patient satisfaction, improved information systems, a greater understanding of the 'whole system' and how services interlink and the need to monitor performance on an ongoing basis.

3.6.8 Solutions to reducing waiting times?

One, understandable, reason for the lack of success in achieving centrally-determined targets could be that the targets set have been too ambitious. However, as the National Audit Office for Wales noted in its recent report on waiting times in

Wales, in comparison with England, Northern Ireland (and Wales) have historically set rather unambitious targets[70] .

While it has been put to the Review that lack of funding was a key reason for lack of progress in reducing waiting times, this view was contradicted by some senior trust managers and by most of the general practitioners to whom we talked. From our survey of trust chief executives, *lack of funding* was, on average not the main barrier to meeting waiting time targets. In addition, as table 3.4 shows, other barriers were often rated as more important within trusts.

Table 3.4[(a)]: Survey of trust chief executives: 'What are the main barriers to achieving waiting time targets?'

TRUST>	A	B	C	D	E	F	G	H	I	J	K	L	M	N	Average score [(d)]
Staff vacancies	3	2	3	2	2	1	2	2	2	4	3	2	2	2	2.3
Levels of urgent, but non-emergency work	1	3	4	2	2	3	2	2	3	2	1	3	4	3	2.5
A lack of funding	(b)	3	2	1	3	3	2	(c)	3	4	1	3	3	2	2.5
Higher than expected emergency admissions	1	1	3	4	4	3	4	2	3	2	na	4	5	3	3.0
Insufficient beds	4	1	3	4	4	2	4	2	1	2	na	3	5	4	3.0
An increase in GP referrals	1	3	3	1	4	2	3	3	3	2	3	5	5	2	3.1
Winter pressures	2	2	3	4	3	3	4	2	2	2	5	4	5	3	3.1
Delayed transfers of care	2	1	4	4	4	4	3	3	1	2	na	3	5	5	3.2
Shortage of theatres	3	1	4	3	3	4	4	3	2	2	na	4	4	5	3.2
Unrealistic targets	4	2	2	2	4	3	5	2	4	4	na	3	3	5	3.3
Skills shortage	4	2	3	4	1	5	3	5	4	4	3	5	5	1	3.5
Treating private patients	4	5	5	5	5	5	5	5	5	5	na	5	5	4	4.9

a Rating 1=extremely significant, 2=very significant, 3=significant, 4=slightly significant, 5=not significant at all.
b No score given: 'Varies by specialty'
c No score given: 'Recurring funds a problem'
d Average= sum of scores divided by number of trusts

A more important reason for the apparent failure of the target setting regime in Northern Ireland, and a key theme in the next section on the performance management system, was and remains the lack, as far as this Review could discern, of a consistent commitment throughout the health and social care system to the objective of reducing waiting times, and in addition, the lack of any system of incentives - rewards and sanctions at organisational or individual levels - absolutely necessary in order to drive efforts to meet targets.

Overall, the conclusion of this Review with regard to the issue of waiting is that evidence exists - for example, variations in waiting times across hospitals in Northern Ireland, examples of significant reductions in waiting times in some hospitals and the example of historic reductions in waiting times in England - that excessive waiting is

[70] See for example Figure 7 in Report by the National Audit Office Wales, NHS Waiting Times in Wales Volume 1- The Scale of the Problem.

not inevitable, nor an intractable problem given the level of financial inputs to the system.

Broadly, solutions to the problem require a ‘whole systems’ perspective, acknowledging that answers to the problem will involve, for example, not just the elective care system, but all parts of a hospital as well as the wider health economy. In addition, solutions necessarily need to adopt the viewpoint of the patient, coupled with a consistent commitment to solving the problem - from managers, clinicians and others concerned with patients’ welfare.

In practice, tackling excessive waiting will involve most if not all of the following:

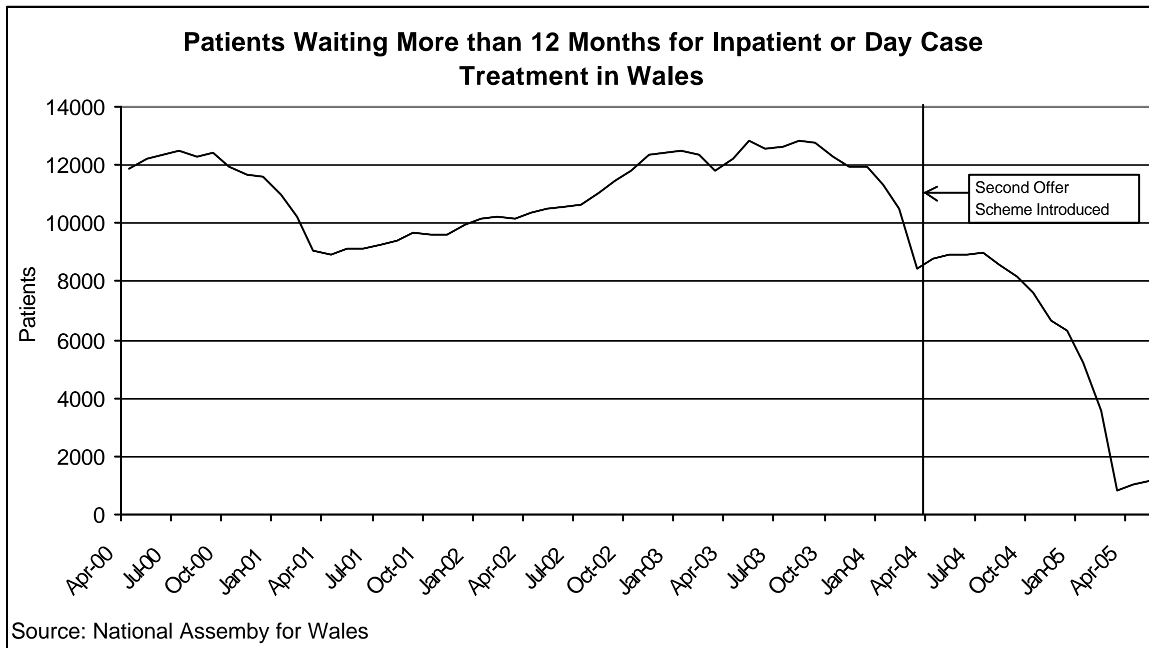
- Efficient use of key resources (theatres, beds, LOS, TOI etc)
- Weekly monitoring of lists by chief executives
- Continual validation of lists
- Treat-in-turn, together with consistent urgency prioritisation
- Clear bottlenecks (e.g. bed blocking, ringfence elective beds)
- Set targets coupled with incentives/sanctions (for individuals and organisations)
- Manage the entire patient pathway - from GP to outpatient to diagnostic services to waiting list to admission to discharge.
- Publish performance data (by hospital, specialty and clinical team).
- Reduce variations through patient choice
- Contain and if possible reduce, other demands on the hospital system - especially accident and emergency attendances and emergency admissions.

Recommendation 12: Adopt multi-pronged long term strategy to reducing waiting times, including long term targets (with milestones) backed by strong incentives.

A series of initiatives have recently been announced in relation to both inpatient and outpatient waiting lists following the work of Dr Martin Connor and colleagues at the Greater Manchester Strategic Health Authority. For those on inpatient waiting lists a ‘Second Offer’ system will be introduced similar to that introduced in Wales in 2004. Under this system, when a trust fails to treat patients within agreed time thresholds, they are offered treatment elsewhere and the original trust has to pay for the treatment in full. The corollary is that patient who refuse a reasonable second offer of treatment will be taken off the waiting list and referred back to their GP.

Figure 3.56 below shows that the Second Offer scheme does appear to have been successful in reducing the numbers on inpatient waiting lists in Wales. However, in their January 2005 report on waiting times, the National Audit Office of Wales raised a number of concerns with the scheme in terms of the impact on financial viability of trusts, disputes as to is responsible for delays in treatment as well as the reluctance of patients to travel.

Figure 3.56: The number of persons in Wales waiting more than 12 months for inpatient or day case treatment has fallen by 87% since April 2004[71].



The major concern of the Welsh Audit Office, however, was that the scheme did not constitute a clear and coherent overall strategy because it did not address the issue of outpatient waiting and may make the problem worse. In Northern Ireland, this is being addressed by improvements in the management of primary care. Instead of being sent directly to a consultant, non-urgent referrals will be passed to a central assessment service which will determine the most appropriate next stage of treatment. Whilst this scheme has the clear potential to reduce the burden on hospital consultants, this depends on the extent to which consultants are willing to devolve some of their responsibilities to others. In addition, this raises questions as to why GPs have been unable to manage demand effectively to date.

Overall, this Review welcomes the adoption of a more robust approach towards tackling the waiting list problem in Northern Ireland hospitals. However, as has been highlighted by the work in Wales, the detail of how the schemes will be implemented is crucial. In particular, care should be taken that the cost of providing an alternative source of treatment is not excessive and that the addition of, in essence, a triage tier to the referral process does not simply create increased bureaucracy .

[71] This includes those who declined a second offer-719 in May 2005

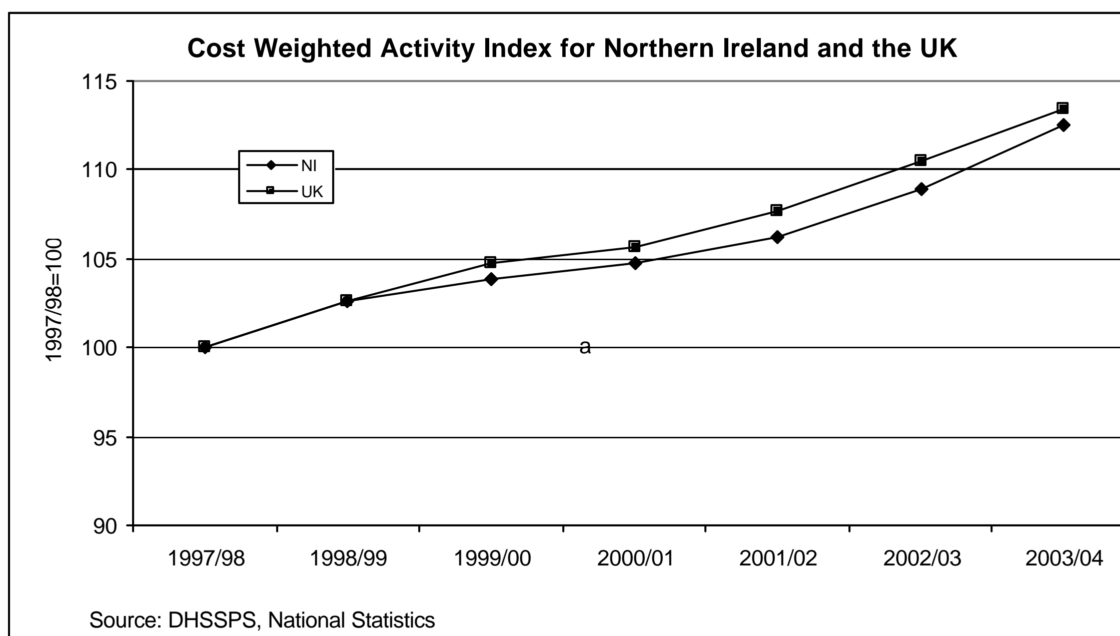
3.7 Efficiency and productivity

In common with most public services it is difficult to determine precisely the extent to which resources have been used efficiently in the health & social care sector. Although the inputs to the system are relatively easy to capture and measure (money, staff etc), the outputs present a more difficult task. For example, whilst population health measures such as age standardised mortality rates are often used as output indicators they are imperfect measures of health system performance as they reflect a range of determinants other than the effects of health and social care services, and often over individuals' entire lifetimes. Moreover, while such measures may capture one of the dimensions of health (in this case, death), other dimensions (quality of life) are just as important.

Unfortunately, health and social care systems do not routinely measure patients' and clients' quality of life, and, coupled with the attribution problem when using measures such as SMRs, traditionally, measures of efficiency have tended to rely on ratios of inputs (money) to outputs - usually measured in terms of activity (patients treated, operations performed etc).

Composite measures of health service activity (adding together different types of activity using share of expenditure as weights (cost weighted activity index - CWAI) divided by changes in real financial resources (the cost weighted efficiency index - CWEI) have been used by the English NHS to capture, in broad terms, the efficiency with which the NHS converts inputs into outputs. However, such measures are, as we note, imperfect (see Box 3.6).

Figure 3.57: The Cost Weighted Activity Index (CWAI) of Healthcare Services increased by 12.5% in Northern Ireland between 1997/98 and 2003/04 compared to 13.4% in England.

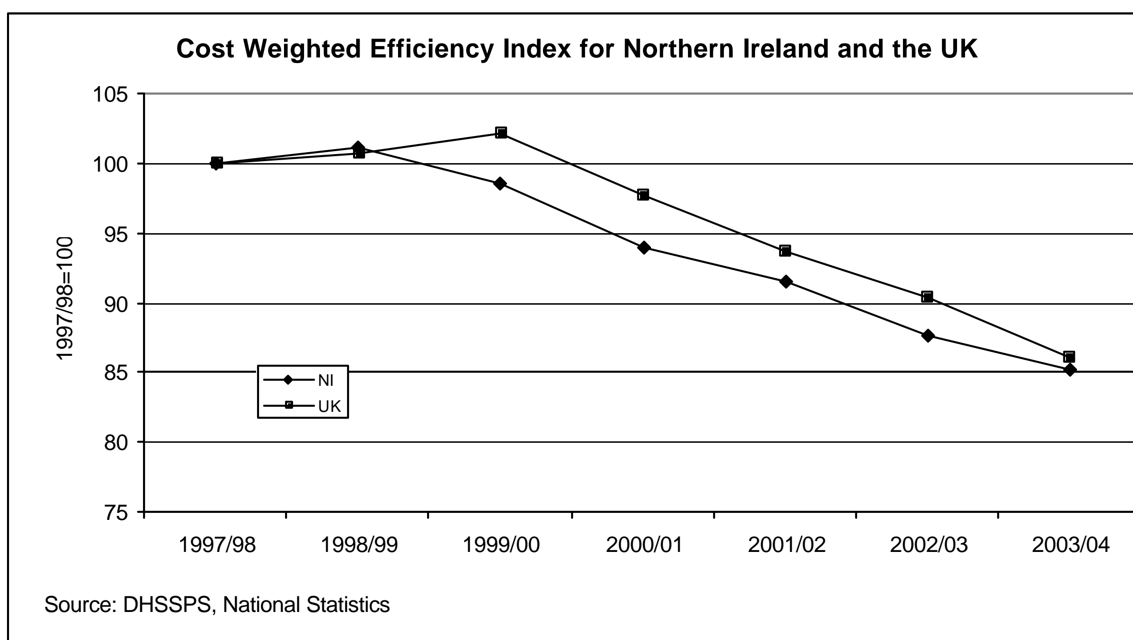


For illustrative purposes, figure 3.57 compares the increase in health service activity between Northern Ireland and the UK as a whole in terms of the CWAI. The CWAI includes hospital activity (e.g. inpatients, day cases), community activity (e.g. health visiting and district nursing) and family health services (e.g. GP consultations and

prescribing) weighted by their shares of total spending. It can be seen that on this measure, activity has risen at a slightly slower rate in Northern Ireland than England between 1997/98 and 2003/04. However, looking at the underlying data in more detail highlights the weaknesses of the indicator. In particular, the greatest contributions to the growth in activity in Northern Ireland come from inpatients and day case activity and GP prescribing activity[72]. In respect of the former, the main growth is mainly attributable to growth in day case activity, which, as these are on average less expensive than inpatient care, in the context of a constant weight suggests that growth is overstated. In addition, GP prescribing in Northern Ireland is not necessarily an area where more implies better.

In terms of efficiency, figure 3.58 shows that because health expenditure (in constant prices) increased at a faster rate than activity over this period, the efficiency index for both Northern Ireland and the UK as a whole followed a similar downward trend between 1999/00 and 2003/04. However, it should be highlighted that these charts are meant to be indicative of general trends and DHSSPS have significant reservations regarding their use.

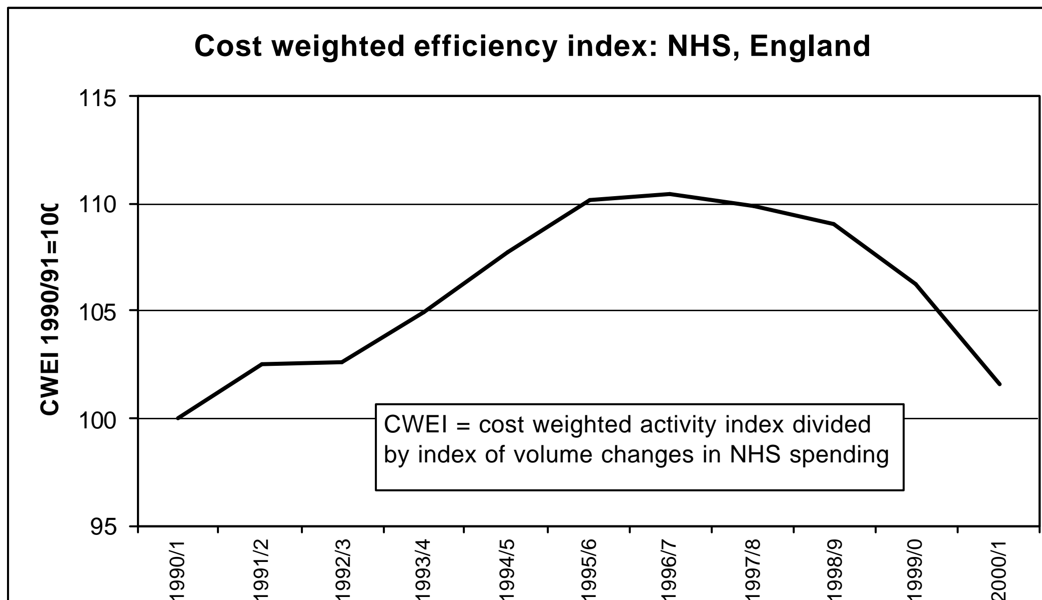
Figure 3.58: The Costs Weighted Efficiency Index (CWEI) of Healthcare Services fell by almost 15% in the UK and Northern Ireland between 1997/98 and 2003/04.



In response to problems with traditional measures of efficiency and productivity a review was commissioned by the ONS on the measurement of Government output. Although the review published its final report in January 2005 it is expected to be some time before useful results become available [73].

[72] Collectively they account for 78% of the growth in weighted activity excluding dental services for which data is not available over the entire period.
[73] Atkinson Review Final report: Measurement of Government Output and Productivity for the National Accounts, 2005

Box 3.6: Problems with traditional measures of health care productivity and efficiency



The reason for the falling trend in the above graph is straightforward: As the traditional productivity measure is a ratio of outputs (activity) to inputs (money), and as there have been relatively large increases in NHS spending since 1997/8 without similar increase in outputs, the ratio of outputs to inputs must fall. With spending rising even faster since 2000/01, this downward trend is likely to have continued in subsequent years.

Although the reason for the trend is straightforward, its interpretation is less so. There are essentially four reasons underlying the downward trend in efficiency:

Extra spending has in part been:

- **absorbed by higher costs (rather than higher outputs).**

  In other words, productivity has actually fallen in some areas

- **invested in services and activities which may take some years to be reflected in increased outputs.**

  Spending on preventative services such as smoking cessation classes or dietary advice, may not yield their full measurable results sometime after the year in which the spending on these services took place.

- **increasingly channelled into activities not captured by the productivity measure.**

  The cost weighted efficiency measure, for example, does not record clinics held in GP surgeries, which may often act as a substitute for activities usually carried out in hospitals.

- **used to increase the (unmeasured) *quality* rather than the (measured) *volume* of outputs.**

  Devoting more time to each patient improves the quality of care (and costs), but is not captured by current productivity measures.

It may seem somewhat paradoxical, but it is not always in the patient's interests for the NHS to always do more activity - even if this improves measured productivity. It is not, for example, necessarily desirable for the NHS to continually increase the number of admissions to its casualty departments; prevention is better. And as some drugs (and some operations and other interventions) are only of very limited benefit to patients it makes little sense for the NHS to strive to provide more.

For the NHS, improving productivity is not just about producing more of everything for each extra pound, it is about doing the right things in the right way as efficiently as possible.

Due to the weaknesses of the overall macro indicators, significant weight is often given to micro indicators of performance such as waiting lists and times, cancellation rates, GP referral rates, day case rates etc. However, each of these indicators needs to be considered in context. For example, high waiting lists may reflect high levels of demand rather than inefficient delivery, whilst a very high rate of bed occupancy may exacerbate the risk of hospital acquired Infections.
Here, using currently available data, we examine the efficiency of various sectors of the health and social care system in Northern Ireland, wherever possible and appropriate, making comparisons with other regions of the UK. As already noted, largely for historical reasons, there is a bias towards the acute health care sector in terms of the measures available to provide indicators of efficiency and productivity.
In considering the effectiveness of acute service provision in Northern Ireland, the 2002 Needs and Effectiveness Evaluation (NEE) presented evidence that unit costs were higher and productivity was lower in Northern Ireland than England, with part of the explanation for this being attributable to higher lengths of stay. However, little were made of these findings and it was also stated that Northern Ireland performed better in terms of other indicators of performance (such as readmission rates) but with little in the form of supporting data.

A key statement from the NEE was that, *"Productivity in the hospital sector has increased by almost 100% over the last 10 years"***.** This was based on growth in throughput (that is, day case and inpatient activity per available bed) - which increased by 97% in Northern Ireland between 1991/92 and 2000/01 compared to 71% in England. It is worth noting however, that despite this greater increase in throughput, by 2000/01 productivity in Northern Ireland was still 19% lower than in England. In addition, subsequent growth in throughput has averaged only 2.5% per year in Northern Ireland compared to 3.0% in England.

These calculations include renal dialysis treatments not included in GB data as referred to in Section 3.3.1. Excluding these treatments the growth in Northern Ireland throughput between 1991/92 and 2000/01 falls to 83% whilst 2003/04 throughput is 26% below the level in England.

3.7.1 Hospital activity and labour inputs

Throughput is one measure of the utilisation of a key resource - beds. However, there are other ways of looking at the efficiency with which a system uses the resources at its disposal.

For example, although Northern Ireland has higher levels of hospital activity than the UK average (see section 3.2.2), it also has significantly higher levels of staffing, and figure 3.59 shows that Northern Ireland, Wales and Scotland have significantly *lower* level of labour productivity than English regions, with hospital activity per staff member in the Northern Ireland health care sector approximately 19% lower than the UK average (and 16% below on unadjusted basis)[74].

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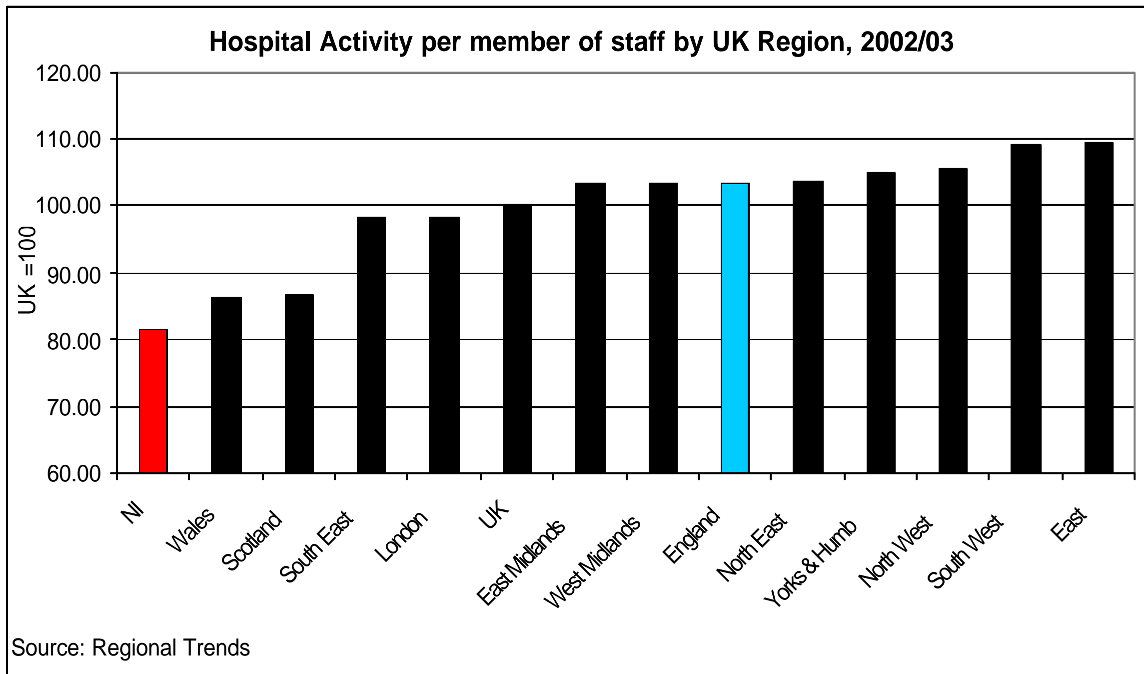
[74] Unweighted activity is simply the summation of the number of inpatients, outpatients, day cases and A&E attendances. Weighted activity is the sum of each activity weighted by the respective unit cost for England. Inpatients have a weighting of 20.9 compared to 7.1 for day cases and 1 each for outpatients and A&E.

Figure 3.59: Hospital activity (weighted) per member of staff in Northern Ireland is the lowest of the UK regions, 2002/03



Although it was not possible to split staff between activities, figures 3.60-3.63 below compare levels of inpatients, outpatients, day cases and A&E attendances with the total number of HCHS staff for each UK region as a broad indicator of labour productivity. It can be seen for inpatients, outpatients and day cases that HCHS labour productivity in Northern Ireland is significantly below the UK average. Whilst labour productivity in Northern Ireland is higher in terms of A&E attendances, the significant variation with other forms of activity raises questions as to whether the level of activity reflects actual need or that it might be better for treatment to be provided in an alternative form.

Figure 3.60: The number of inpatients treated per HCHS staff member in Northern Ireland is 21% lower than the UK average.

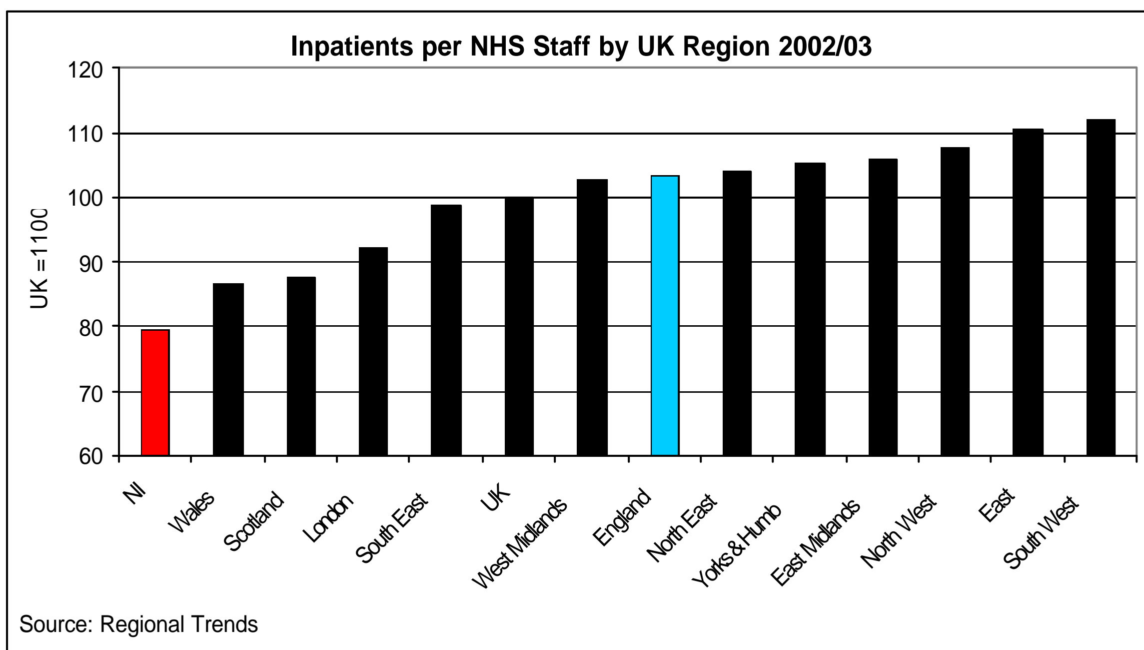


Figure 3.61: The number of day cases per HCHS staff member is 11% lower than the UK average.

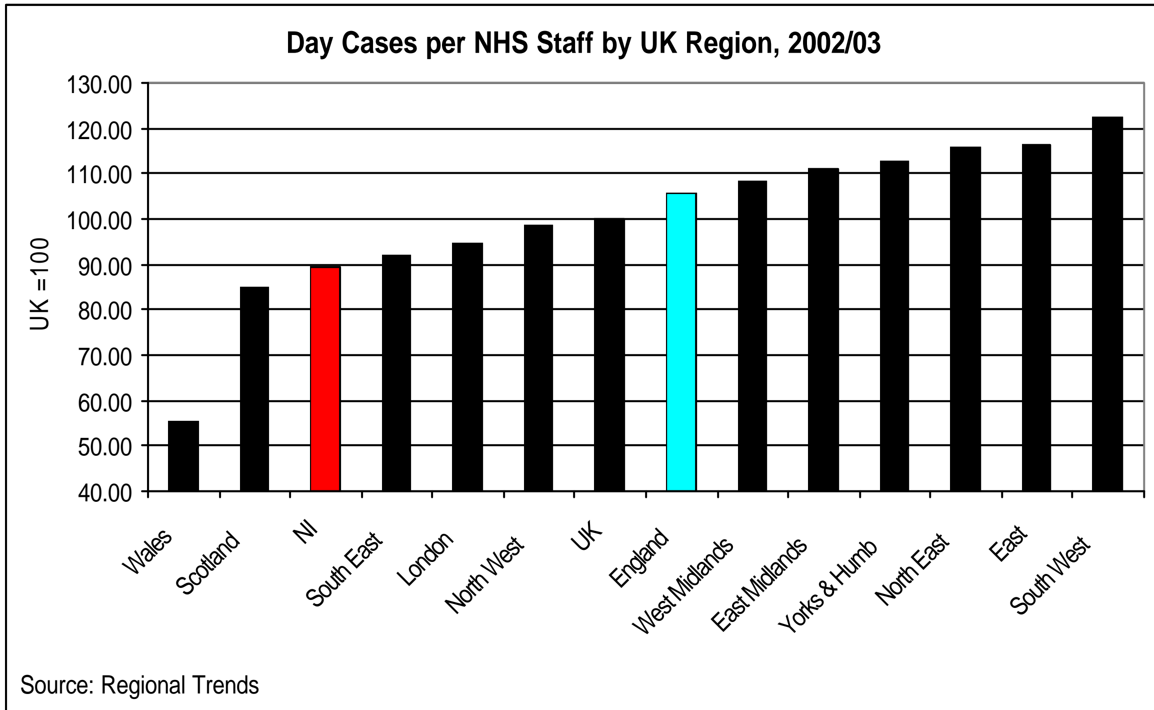


Figure 3.62: The number of outpatients treated per HCHS staff member is the lowest of all UK regions

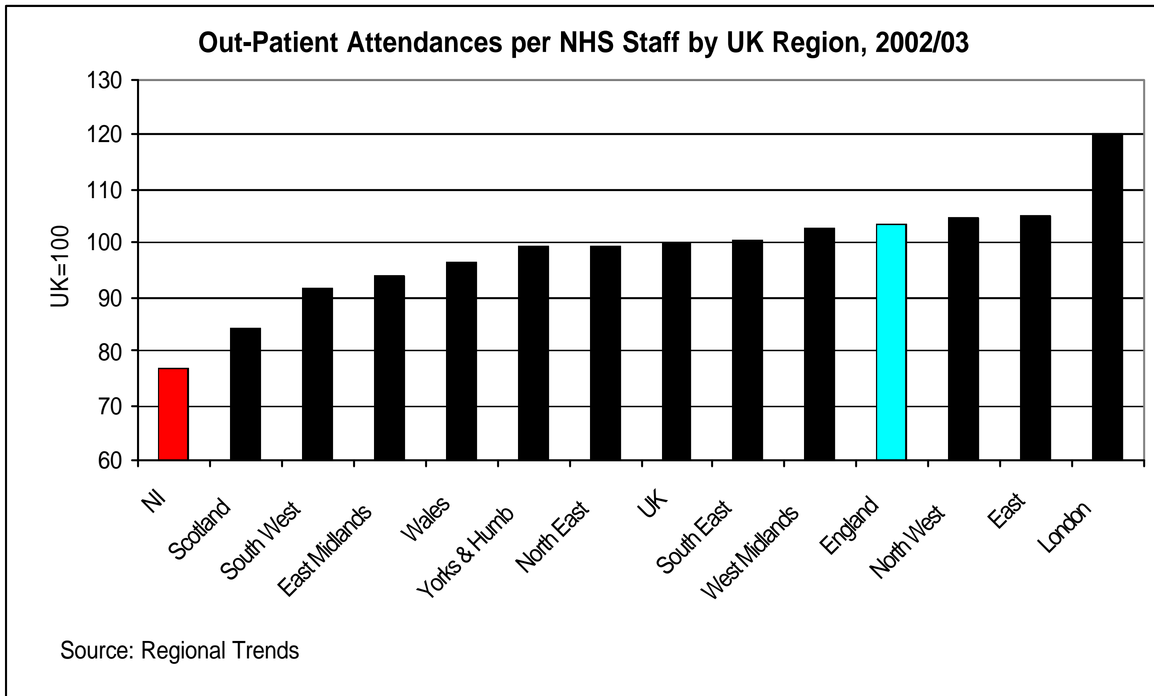
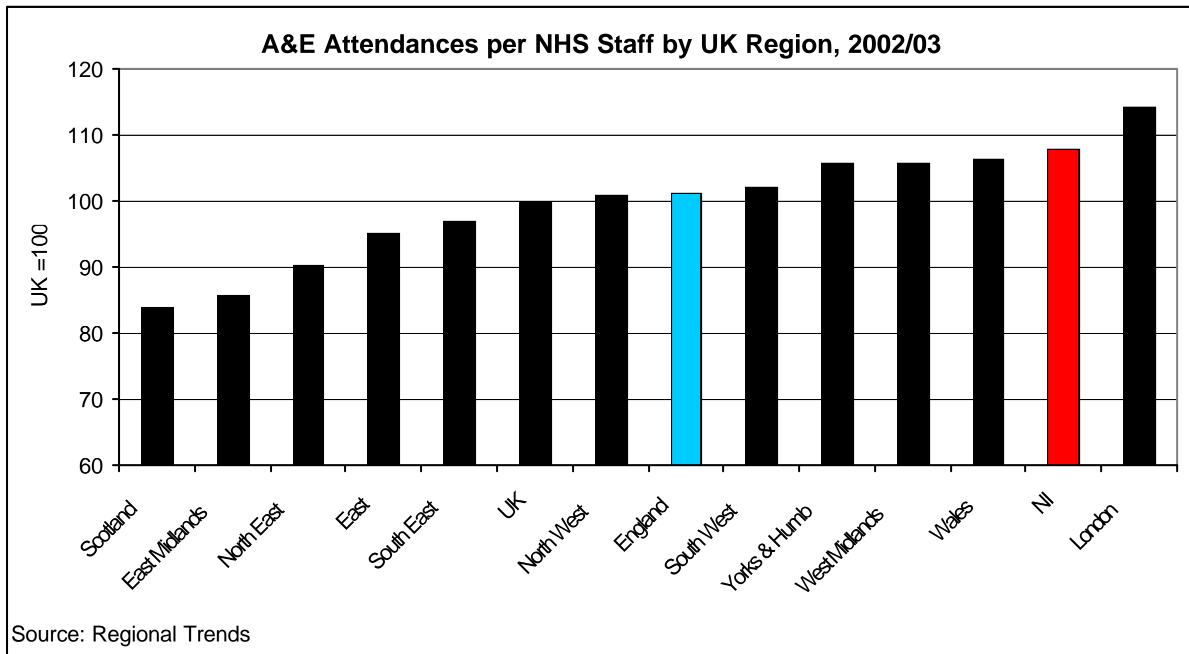
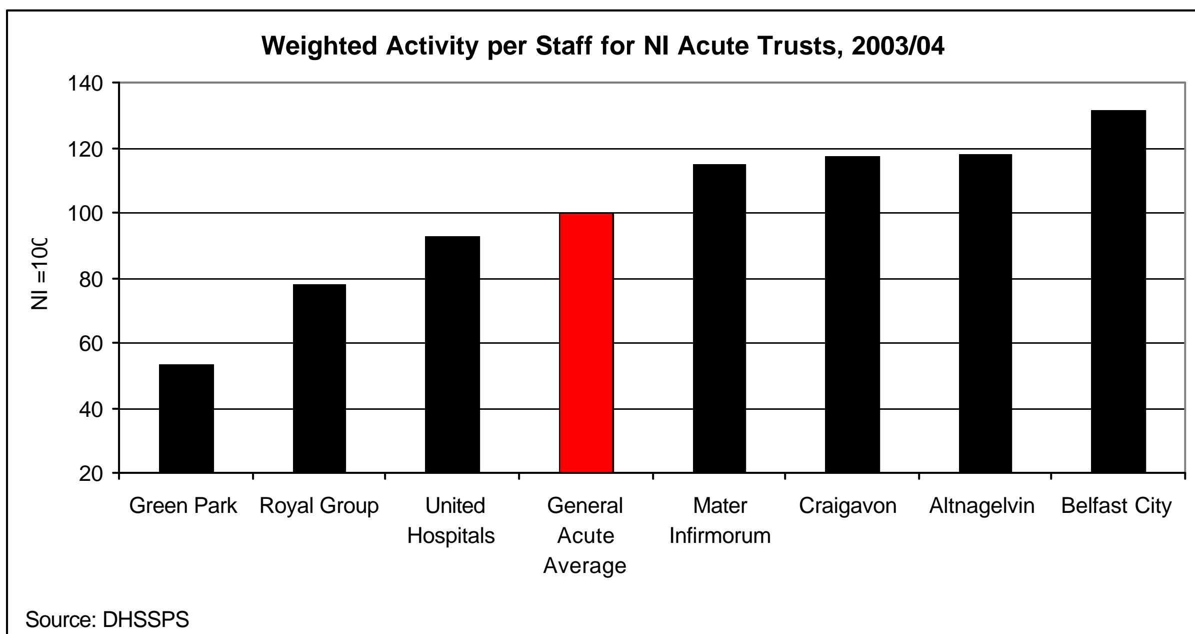


Figure 3.63: The number of A&E attendances per HCHS staff member is 8% higher than the UK average



There are also significant variations in the level of activity per staff member between Northern Ireland hospitals. Figure 3.64 compares the weighted level of activity for General Acute Hospitals in Northern Ireland. It can be seen that weighted activity per staff is 31% higher in the Belfast City Trust than the average for Northern Ireland whilst in the Green Park Trust labour productivity is 47% below the average. However, these comparisons need to be treated with care given differences in case mix with the Royal and Greenpark Trusts carrying out the main regional medical specialties.

Figure 3.64: There are significant variations in the level of weighted hospital activity per staff for Northern Ireland general acute trusts, 2003/04

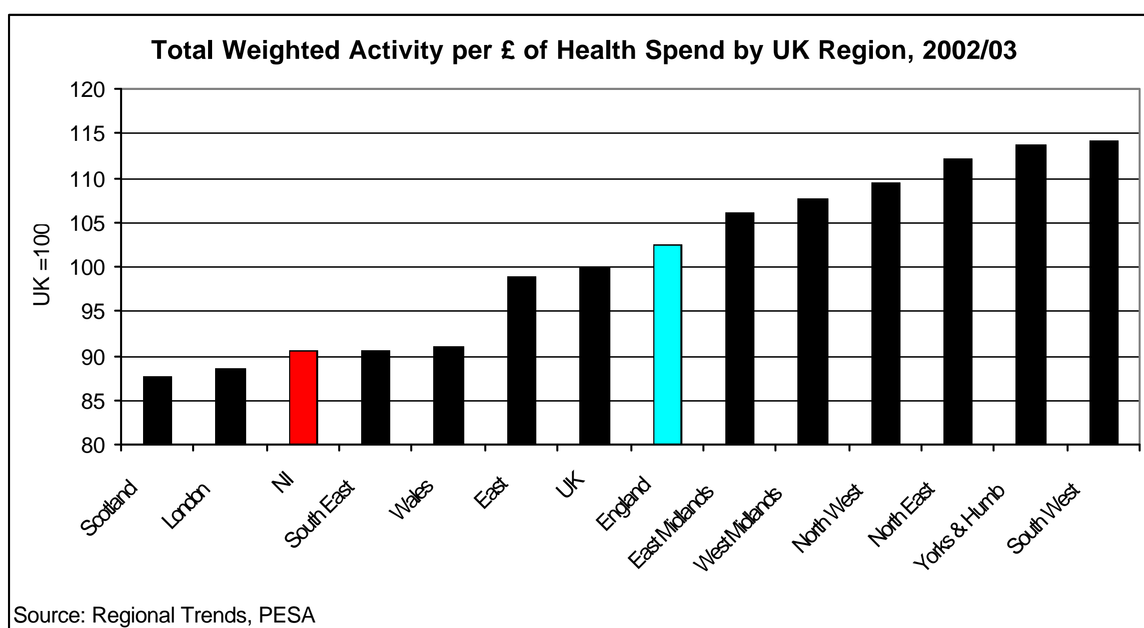


3.7.2 Hospital activity and total financial inputs

Whilst labour is a significant input into the provision of health care services, it is not the only one. In addition, variations in labour input mix across the different regions of the UK (which have not been taken into account above) can affect regions' relative positions.

A more general measure of inputs is the total financial resources devoted to health care. Figure 3.65, for example, shows that hospital activity per health care pound in Northern Ireland is 9% lower than the UK average (7% unadjusted for the different unit cost of activities). If Northern Ireland were to achieve the same level of efficiency as England, this would allow, for example, an additional 45,000 inpatients to be treated each year - equivalent to the entire inpatient waiting list[75].

Figure 3.65: Hospital Activity (weighted) per £ identifiable Health spend is 9% lower in Northern Ireland than the UK average, 2002/03



3.7.3 Unit costs of hospital activity

At a more micro level, it is also possible to examine the unit costs (also termed reference costs) of individual defined groupings of like hospital procedures that are considered to consume like resources- health care resource groups (HRGs).

Such data allows for comparison both at the level of trusts across Northern Ireland and with England. Figure 3.66 shows that the average cost per procedure (aggregated up from individual procedures into elective inpatients, non-elective cases and day cases) in the acute sector in Northern Ireland for 2002/03[76] was 6%

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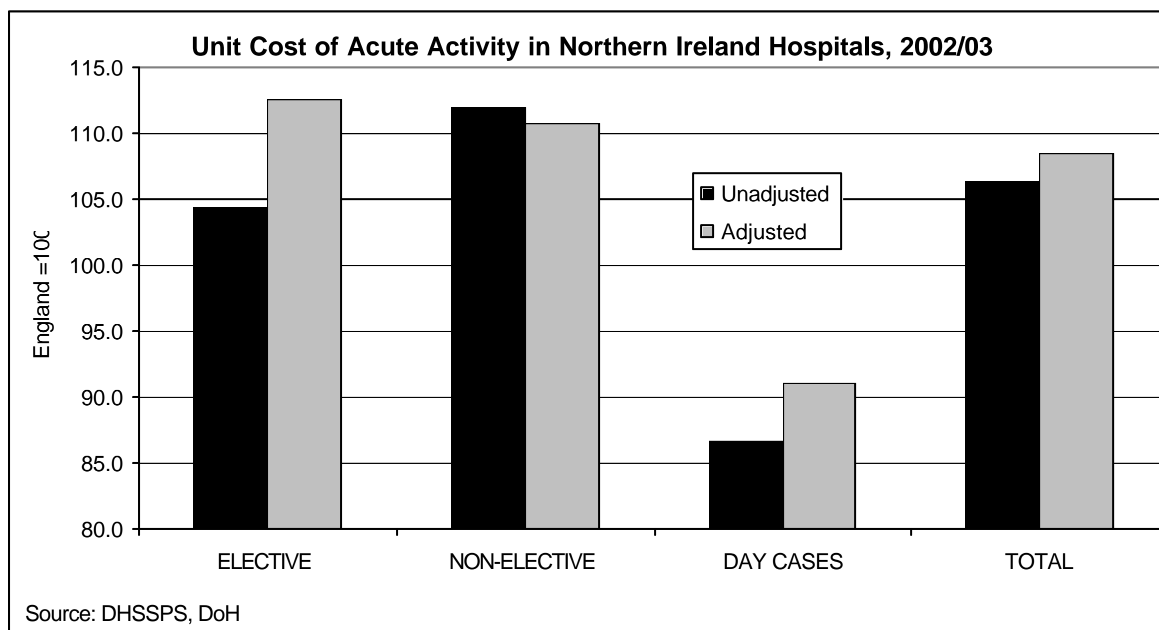
[75] Based on 9.4% of weighted activity divided by the weighting for inpatient activity (20.9)

[76] The unit cost data covers approximately £450m of the £708m acute budget in 2002/03. It is estimated that approximately £66m of the £450m could be saved if Northern Ireland matched the performance of England in terms of the HRGS where unit costs are currently lower in England. Whilst DHSSPS consider that only £25m could be saved this is on the basis that Northern Ireland matches England even in those areas where costs are currently higher ie unit costs would be allowed to fall which is clearly illogical.

higher than in England. However, given that the case mix in England tends to be distributed towards more expensive procedures, adjusting for case-mix results in unit costs being 9% higher in Northern Ireland compared with England[77].

There are significant variations within this overall figure. Day case unit costs are 9% lower than in England, while elective inpatient costs are 13% higher, with non-elective costs being similar. As the length of stay for elective procedures in Northern Ireland is 7% lower than in England (although later it will be shown that for all in-patient activity the length of stay is higher in Northern Ireland), this would indicate that per diem unit costs in Northern Ireland are even higher than this. In addition, in England unit costs are also adjusted when making comparisons between Trusts by a market forces factor to reflect differences in the underlying cost base of different areas. The lower level of costs in Northern Ireland would imply that unit costs are even further from the English than the figures above would suggest[78].DHSSPS have indicated that a significant element of the difference in unit costs is due to maternity provision which, the Department state, is of a higher standard in Northern Ireland than England.

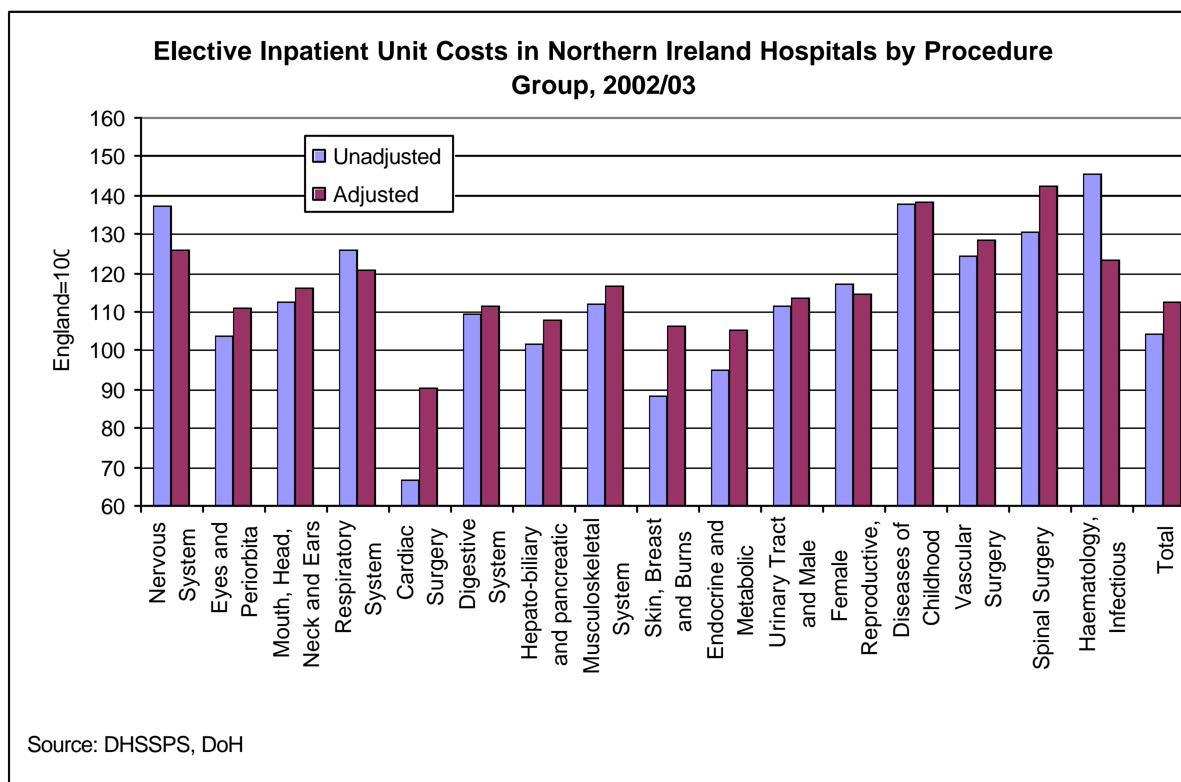
Figure 3.66: 2002/03 Unit Costs in Northern Ireland Acute Sector (England =100)



At a more disaggregated level, figure 3.67 shows average unit costs for Northern Ireland relative to the English average (=100) across groups of procedures. For nearly all groups, Northern Ireland has higher unit costs for elective procedures than England (with the exception of cardiac surgery, where unit costs are 9% lower). In contrast, spinal surgery costs are 42% higher in Northern Ireland than England.

[77] Adjusting for case mix involved weighting English unit cost data per procedure by the Northern Ireland distribution of FCE's between procedures.
[78] DHSSPS have indicated that some of the difference in unit costs is due to methodology rather than efficiency for example in respect of funding for older Specialist Registrar posts for junior doctors and the non exclusion of discrete coronary care units from NI HRGs.

Figure 3.67: Elective Inpatient unit costs are higher in Northern Ireland than England for most procedure groups, 2002/03

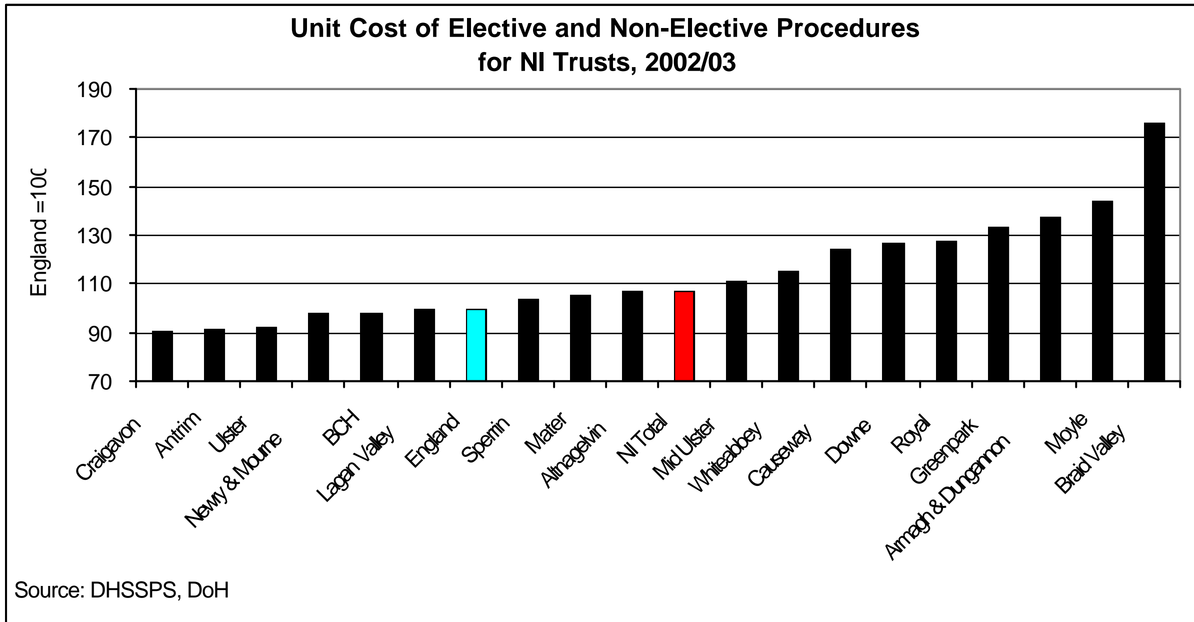


Within Northern Ireland there are also significant variations between trusts - but this appears to be mostly related to trust size. Figure 3.68 shows that there are a number of hospitals in Northern Ireland where the average unit cost of procedures is comparable to the average for England.

However, there are also trusts which have costs substantially higher than the Northern Ireland average. These tend to carry out only small amounts of acute activity. This corresponds to the view of some of the people we met who suggested that the continued provision of services in hospital below a certain scale was inefficient. However, given their relatively small scale, removing the three smallest Trusts[79] from the analysis only marginally reduces Northern Ireland's overall unit cost. In contrast, if the Royal Group of Hospitals and Greenpark Hospital Trust were excluded, this would be sufficient to remove the cost difference with England. DHSSPS have argued that these findings reflect those found elsewhere: that small and large hospitals tend to have higher unit costs. However, this begs the question of the appropriate size - both in efficiency and clinical terms - for Northern Ireland hospitals and the opportunity costs currently born as a result of maintaining the current configuration of hospitals.

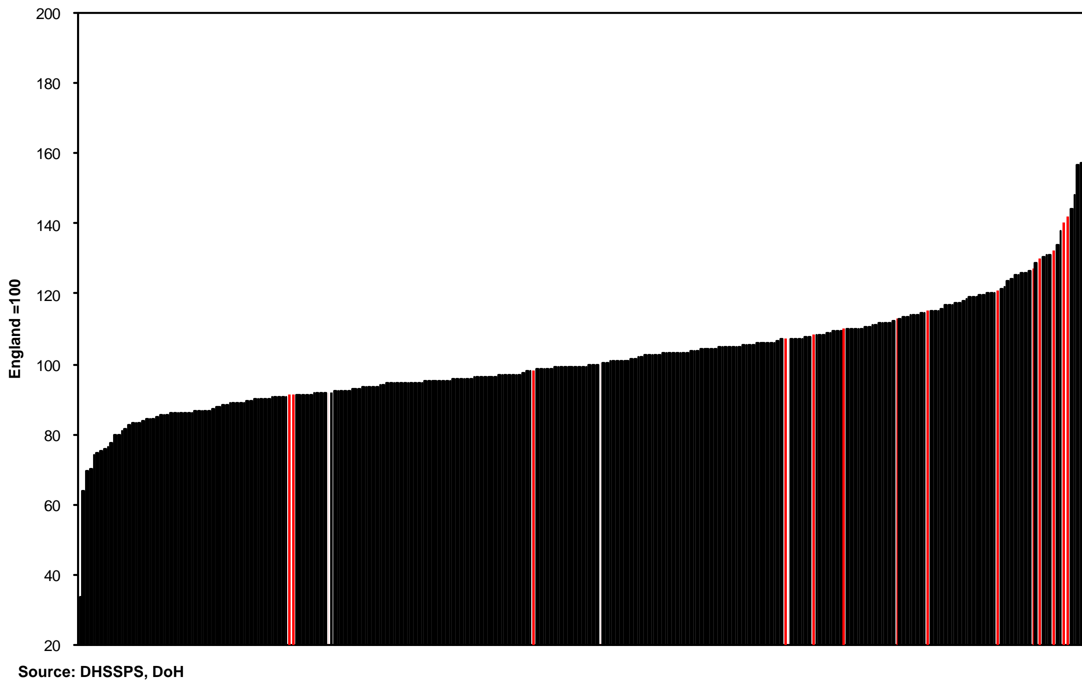
[79] Armagh & Dungannon , Braid and Moyle

Figure 3.68: The Unit Cost of Elective and Non-Elective Procedures for most Northern Ireland Acute Hospital Trusts is above the average for England, 2002/03



It is important to recognise that there is also significant variation in the unit cost of procedures for NHS trusts in England. Figure 3.69 highlights the performance of Northern Ireland acute trusts against the range of trusts in England. It can be seen that whilst a minority of Northern Ireland hospitals are below the English average, a majority are above - some in the top 10%.

Figure 3.69: Unit cost of procedures for Northern Ireland trusts compared to NHS Trusts in England, 2002/03



This section has shown that there are in general lower level of productivity and efficiency in hospitals in Northern Ireland than England although performance appears to be better than in Scotland and Wales. Section 3.83 will show that in recent years the level of activity has not risen to the same extent as staff in the

HCHS sector throughout the UK countries. There is therefore clear scope for efficiency gains if the performance in England could be matched particularly if reforms in England, such as payment by results, return productivity to the levels seen in the late 1990's. Whilst policy makers in Northern Ireland may decide that the required adjustments to the system here are not appropriate, for example reduced level of service for rural communities, the opportunity cost of such decisions need to be recognised.

Recommendation 13: Investigate ways to reduce unit cost variations through incentive mechanisms such as tariff-based activity payment/budget setting systems

Recommendation 14: Further investigation is needed to explore possible reasons for high unit costs at the Royal and Green Park Trusts.

3.7.3 Theatre Usage

A key resource within hospitals is operating theatres. A recent report from the Northern Ireland Audit Office[80] indicated that there was significant unused capacity in the system given that theatres were only intended for use (that is, available) 63% of the available time. DHSSPS have argued that because of the need to have theatres dedicated to particular specialties a better indicator is the proportion of *planned* hours that were used, and that on this measure the 2002 Healthcare Commission Acute Hospital Portfolio illustrated that the mean across Northern Ireland was 74% compared to 73% across English and Welsh trusts.

In addition , whilst the overall cancellation rate of 6.4% was within the bench mark target of 10%, there were significant variations between individual specialties. In particular, the cancellation rate for cardiac surgery was 36% whilst that for plastic surgery was 9% (2001/02 data)[81].

Over the past two years there has been general progress in this area, with a 6% increase in intended theatre sessions and a fall in the cancellation rate to 5% (although this still means that theatres are only used for 68% of the time). There has been progress too in reducing the cardiac surgery cancellation rate - now down to 24%. However, this appears to have been achieved largely by cutting the number of intended sessions by more than half[82]. In addition, cancellation rates for plastic surgery have increased to 32% whilst those for thoracic surgery have increased from 3% to 16% over the period.

3.7.4 Day case work

Where appropriate in terms of medical technology and patients' health status, many operations once requiring overnight stays in hospital as an inpatient are now carried out as day cases. This is not only a more efficient use of scarce hospital resources,

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[80] *The Use of Operating Theatres in the Northern Ireland Health and Personal Social Services*, NIAO, 2003

[81] A higher cancellation rate is to be expected for cardiac surgery due to the dependence on patients' fitness for surgery.

[82] DHSSPS have indicated that this was due to changes in cardiac procedure casemix, with less invasive procedures now available and only the more complicated cases resulting in operations.

but better for patients. As a result, rates of day case work have generally been increasing in all health care systems.

A 2001/02 DHSPSS commissioned report into value for money aspects of day case work in Northern Ireland[83] found that compared with England, a higher proportion of day case activity in Northern Ireland was *inappropriate* in terms of, for example, minor procedures that should be carried out in treatment rooms or outpatient departments. At the same time, too many patients were being treated as in-patients when treatment as a day case would have been more appropriate. Out of eighteen procedures investigated, there were only five for which Northern Ireland hospitals had the same or higher rates than in England and Wales. In addition, whilst the level of throughput per staff member was higher in Northern Ireland, at 6.5%, the rate of non-attendance was significantly higher.

In terms of more recent performance, figure 3.70 shows that day cases account for 66% of elective day and inpatient activity in Northern Ireland compared to 65% for the UK as a whole - although there does not appear to be significant variation across UK regions, with the exception of Wales.

Figure 3.70: Northern Ireland has the sixth highest day case rate of UK Regions, 2002/03

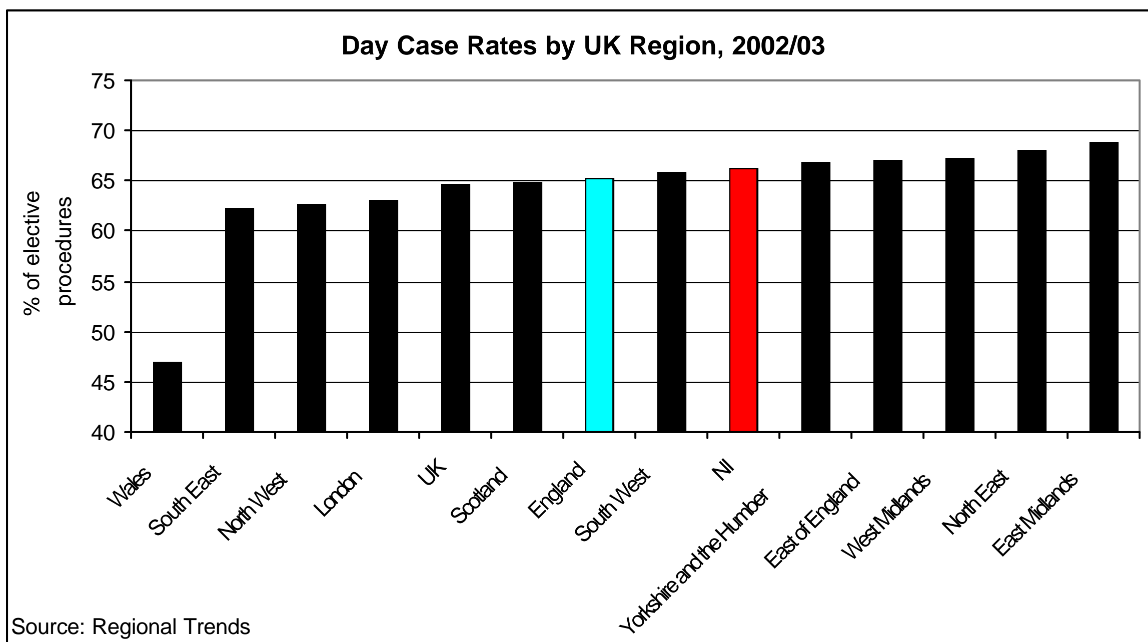
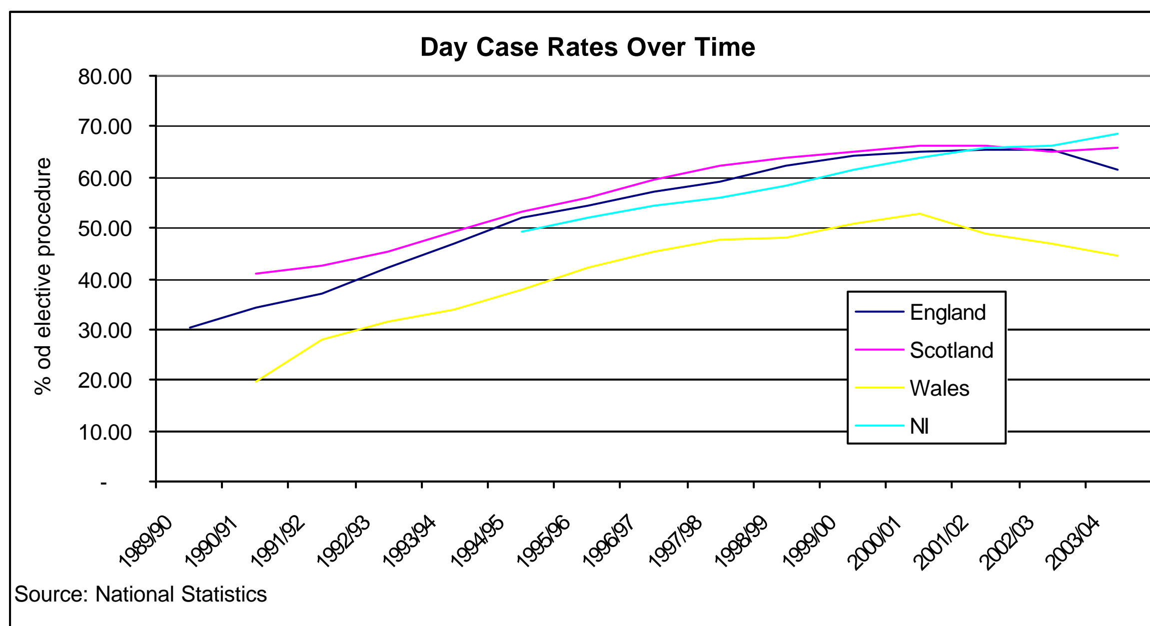


Figure 3.71 shows that there has been a significant increase in the day case rate across the UK in the past decade.

[83] *Day Surgery in Northern Ireland*, Regional Summary of Acute Hospital Portfolio, DHSSPS (October 2003)

Figure 3.71: Northern Ireland, England and Scotland have experienced broadly similar upward trends in day case rates.



However, day case rates in Scotland and England appear to have reached a plateau in recent years, although the fall in the English day case rate in 2003/04 was due to a substantial increase in elective inpatient activity[84]. In Northern Ireland, which previously had lower day case rates than in England and Scotland, the upward trend has continued although this has been due to a fall in elective inpatient activity. Wales is the clear outlier in terms of day case rates although it is not clear whether this reflects differences in activity or data collection.

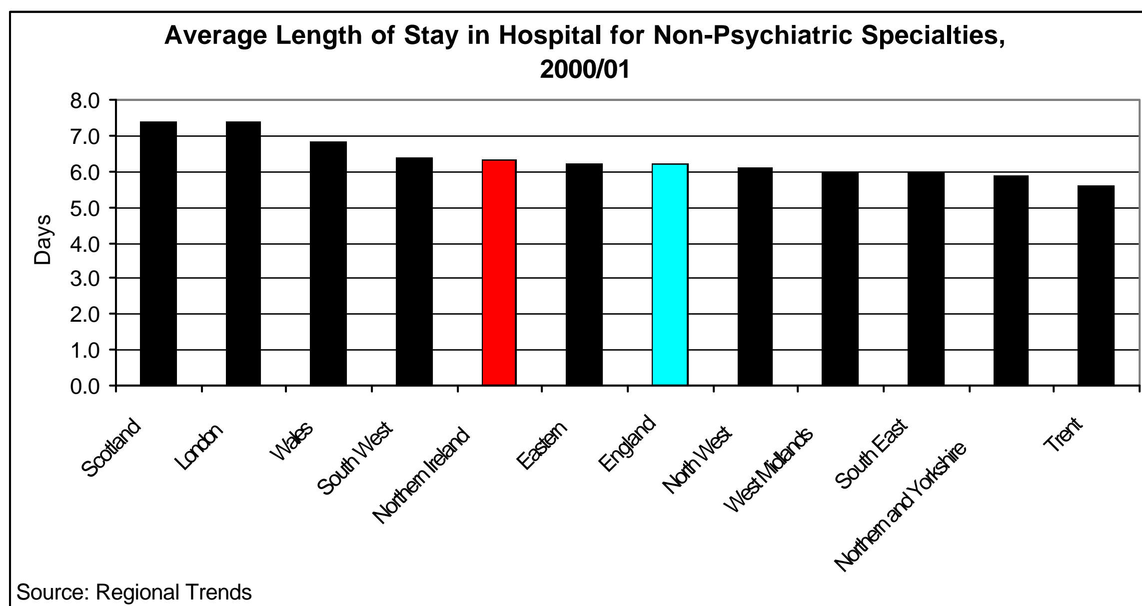
3.7.5 Length of Stay

Reductions in length of stay have been a long term trend across all health care systems and have been one of the main sources of improvement in efficiency and productivity. Length of stay is clearly important in terms of efficiency as the longer a person stays in hospital, the greater the cost.

The 2002 NEE recognised that the average length of stay in Northern Ireland hospitals was slightly longer than in comparative regions although this was in part explained by differences in measurement and policy. Figure 3.72 shows that although the average length of stay is higher in Northern Ireland than in England, it is lower than in Scotland and Wales.

[84] The increase in elective inpatient activity of 37.1%recorded for 2003/04 is higher than that which would be reasonably expected. It has however not been possible to obtain a definitive explanation for the increase.

Figure 3.72: Average Length of Stay in Hospital for Non-Psychiatric Specialties (Mean Days), 2000-01



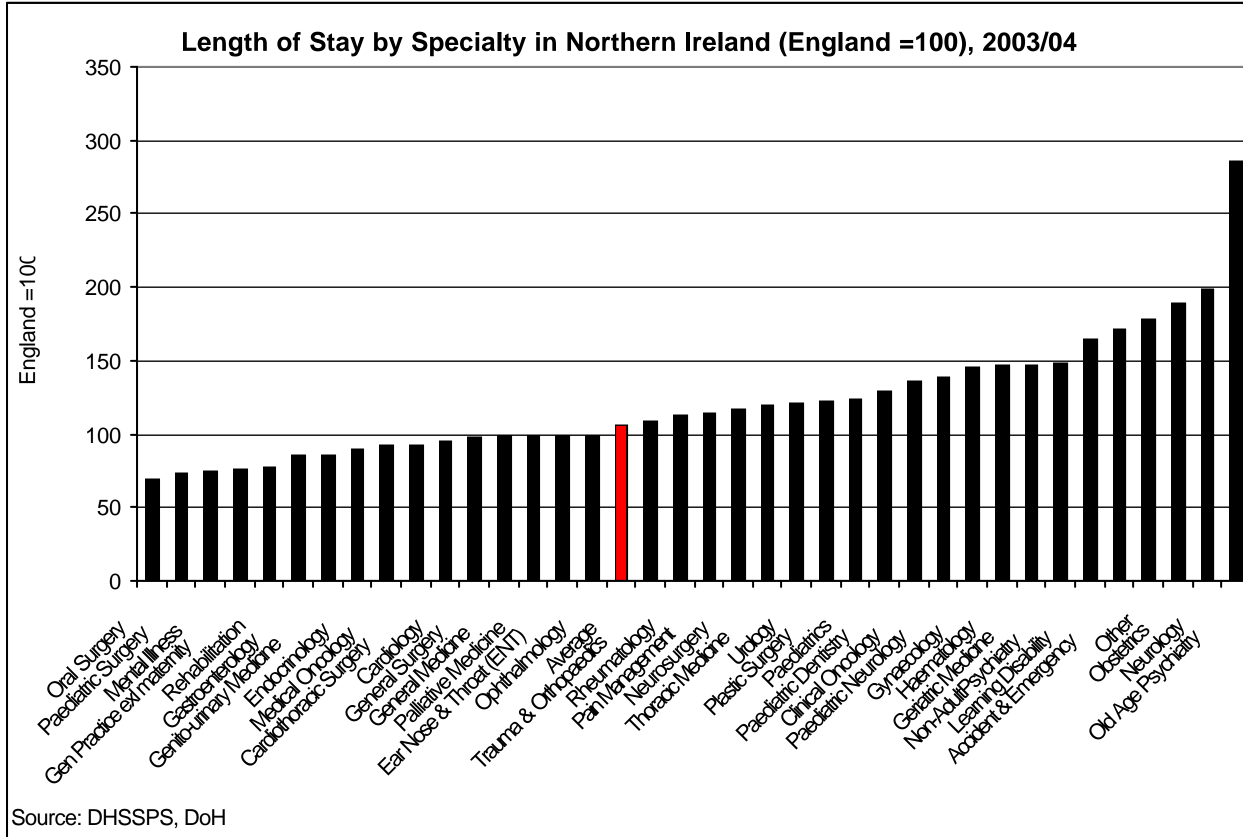
More recently, figure 3.73 compares the average length of stay in Northern Ireland with England for a range of specialties. Whilst the average length of stay of stay in Northern Ireland is 6% greater than in England it can be seen that there are significant variations between specialties. For example, for general medicine and general surgery, which together account for over a third of the deaths and discharges, Northern Ireland has a lower length of stay than England. In addition, geriatric medicine, in which the average length of stay is 32.3 days in Northern Ireland compared to 21.9 days in England, accounts for almost all the variation between the countries[85].

Overall, the average length of stay for treatment in Northern Ireland hospitals has fallen from 9.4 days in 1995/96 to 7.8 days in 2003/04. However, most of the decline occurred between 1995/96 and 1998/99, since when the average length of stay has remained broadly stable Whilst the average length of stay has fallen for all Programmes of Care over the past decade, figure 3.74 shows that the largest falls have been in Mental Health and Learning Disability.

A key factor determining length of stay is bed management. This issue was considered as part of the 2002 Acute Hospital Portfolio analysis[86]. It was found that a higher proportion of beds in Northern Ireland than England were occupied by patients who should have been in a different type of bed representing an inefficient use of resources as well as reducing quality of care.

[85] If the Geriatric Medicine Inpatient specialty in NI Trusts had the same level of length of stay as in England, this would reduce the average length of stay to 7.7, slightly above the 7.6 figure for England.
[86] Acute Hospital Portfolio Year 3 Draft Regional Report, DHSSPS

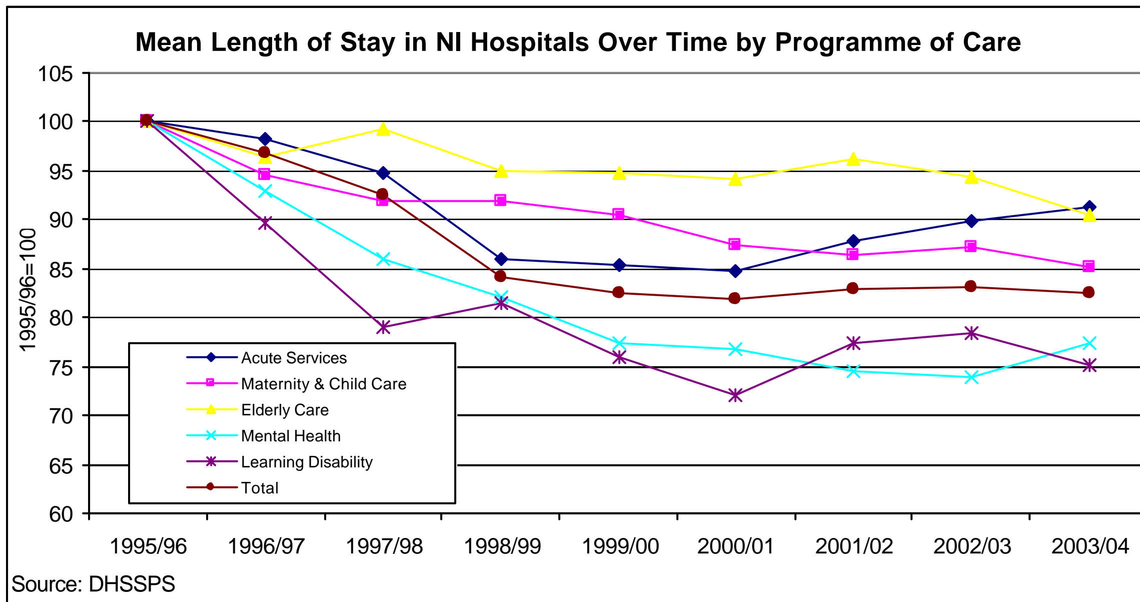
Figure 3.73: Mean Length of Stay by Specialty in Northern Ireland (England=100), 2003/04



Overall, there is scope for reductions in the average length of stay in Northern Ireland. If the average length of stay in England from figure 3.73 was matched in Northern Ireland this would potentially free up bed capacity to treat an additional 18,000 inpatients or perhaps more appropriately 700 more Geriatric medicine patients given that this appears to be the main cause of the differential[87]. It should be noted that the 2005/06 Priorities for Action contains a target that the average length of stay for patients should be reduced by 5% in 2005/06 and a further 5% in 2006/07 compared to 2004/05 levels.

[87] Calculated as current number of NI deaths and discharges minus NI occupied beds divided by length of stay in England.

Figure 3.74: Length of Stay in Northern Ireland Trusts has fallen across all by Programmes of Care.



Recommendation 15: Investigate scope for further reductions in length of stay and avoidance of admission to hospital

Recommendation 16: Aim in medium term to use outcome-based productivity measures.

3.8 Workforce and pay

A key element of health and social service delivery is the recruitment, retention and motivation of sufficient numbers of appropriately skilled staff. Health and social services are labour intensive sectors, with direct staff costs accounting for around two-thirds of total spending. Therefore, whilst the workforce is critical to delivery, it is also important to make every effort that the significant costs associated with this input are minimised as far as possible, while balancing the demands of the system, patients, taxpayers and staff.

The importance of workforce issues is reflected in the focus of a number of major reports and reviews recently. The Wanless Review[88], for example, indicated that a significant increase in health care staff will be required over the next 20 years to deliver a new 'vision' of care envisaged by the review. In addition, workforce issues were considered as part of the 2002 Needs and Effectiveness Evaluation[89]. More recently, the DHSSPS has published results from a series of uni-professional workforce reviews, whilst the Department of Finance and Personnel has produced a Pay and Workforce Strategy for the Northern Ireland Executive Departments with a major focus on health[90].

Here we consider the current availability and future requirements of staffing resource for health and social services in Northern Ireland and whether these resources could be used more effectively and efficiently. It is important to note at the outset that unlike other aspects of health and social care services where distinct Northern Irish policies are developed, in terms of the pay and conditions of staff, Northern Ireland tends to mirror the position in Great Britain.

3.8.1 Historic staffing trends and comparisons

Currently, there are around 110,000 people employed in health and social care in Northern Ireland, equivalent to nearly 6.4% of the entire population and around 28% more than in the UK as a whole[91]. In turn there are approximately 68,000 people employed directly as public servants in NHS Trusts in Northern Ireland[92]. In addition, of course, there are thousands of people providing care and support in the form of charities, friends and relations, without whom the formal health care system would be under unsustainable pressure.

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[88] Securing our Future Health: Taking a Lon-Term View, Final Report of the Wanless Review, April 2002

[89] Effectiveness Evaluation: Health and Social Care, DHSSPS

[90] Northern Ireland Pay and Workforce Strategy 2004, DFP

[91] There are 3 million employee jobs in SIC N (Health & Social Work) in the UK as a whole equivalent to 5.0% of the population.

[92] The main difference between the two figures are those employed in the provision of social services but not by the public sector, including those working in independent nursing and residential homes- however, to the extent that the public sector funds such services, these workers can be considered to be indirectly employed by the public sector. The latter figure also does not include GP,s, Pharmacists, Dentists and Opticians working in Family Practitioner Services. .

Figure 3.75: Trends in health service employment in Northern Ireland are similar to those in other countries

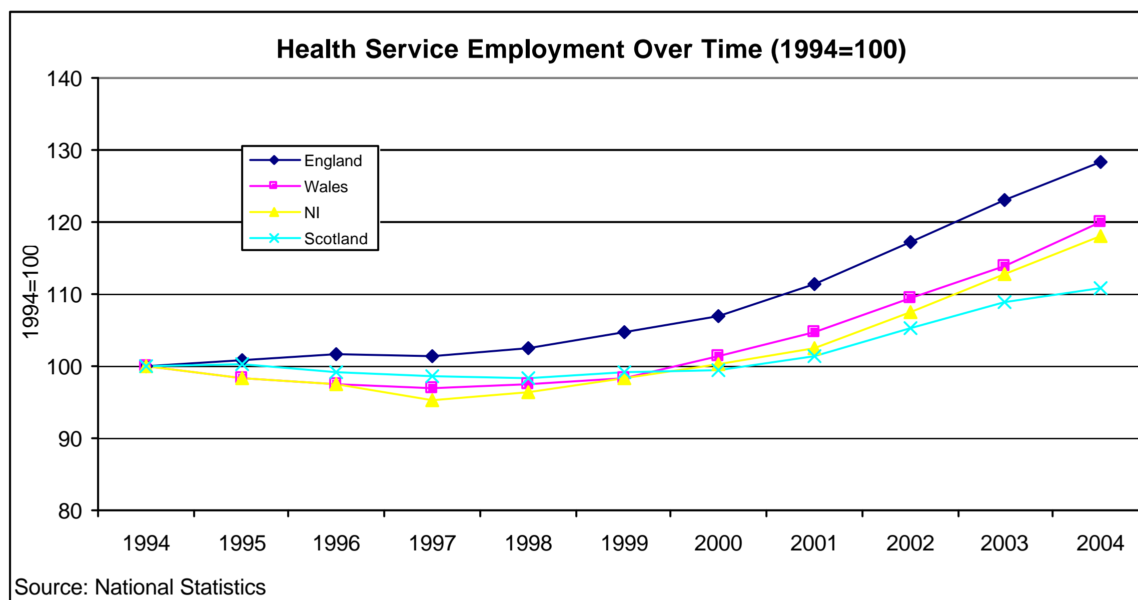


Figure 3.75 shows that in common with Wales and Scotland, Northern Ireland experienced a decline in NHS employment in the mid 1990's - possibly linked to the contracting out of services. More recently, all UK countries have experienced growth in numbers of health care staff, with England experiencing the fastest growth - although the base for England was, and remains lower.

Whilst differences in the coverage of workforce statistics for the UK countries makes overall comparisons of staffing levels difficult, Figure 3.76 compares the number of hospital and community health service (HCHS) staff, qualified nurses and medical & dental staff per head of population.

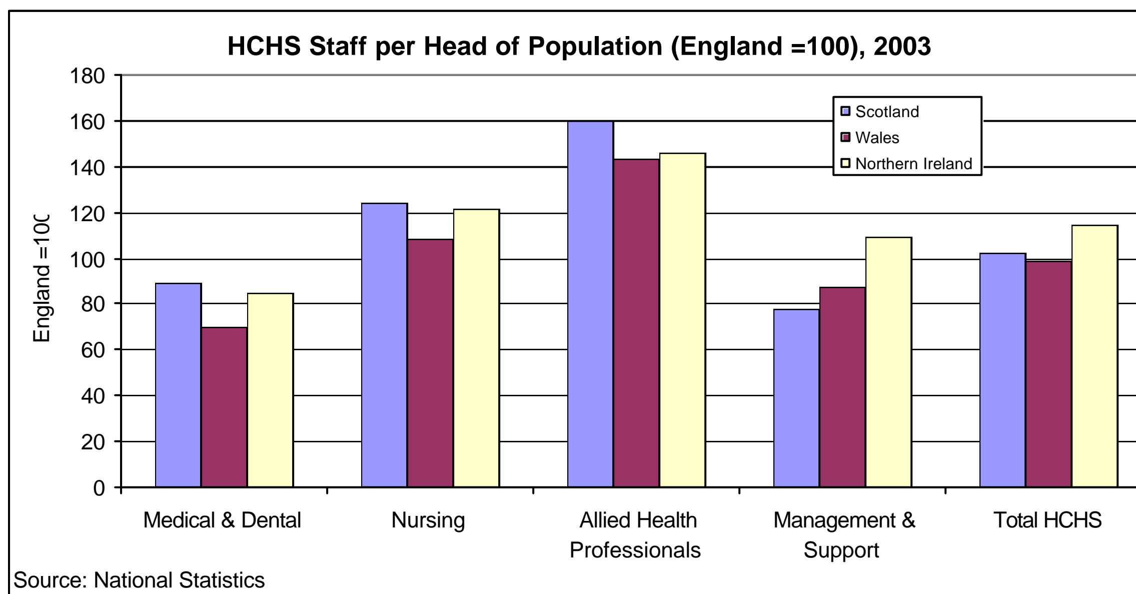
It can be seen that Northern Ireland has significantly higher levels of total HCHS staff per head of population than the rest of the UK. However, as the Interim Wanless Report highlighted, the UK as a whole has substantially fewer doctors and nurses than many other western industrialised countries[93]. Although it may be the case that England has too few health care staff rather than Northern Ireland having too many, the public sector funding parameters currently applying in the UK mean that it is the position in England that is most relevant when considering Northern Ireland's relative level of provision.

A particular issue in the Needs and Effectiveness Evaluation was the level of administrative & clerical staff in the Health & Personal Social Services (HPSS) sector. It was shown that this staff group accounted for broadly the same share of overall HPSS staff in Northern Ireland as England in 1999. However, between 1999 and 2003 the number of administrative & clerical staff increased by 20% in Northern compared to just under 3% in England - which meant that there were 43% *more* administrative & clerical staff per head of population employed in the HPSS sector in Northern Ireland than in England(although at least part of this difference may be due

[93] Paragraph 11.17, Wanless Interim Report, HM Treasury

to definitional differences in the way staff are catagorised between the two countries)[94].

Figure 3.76: Northern Ireland has over 10% more HCHS staff per head of population than England

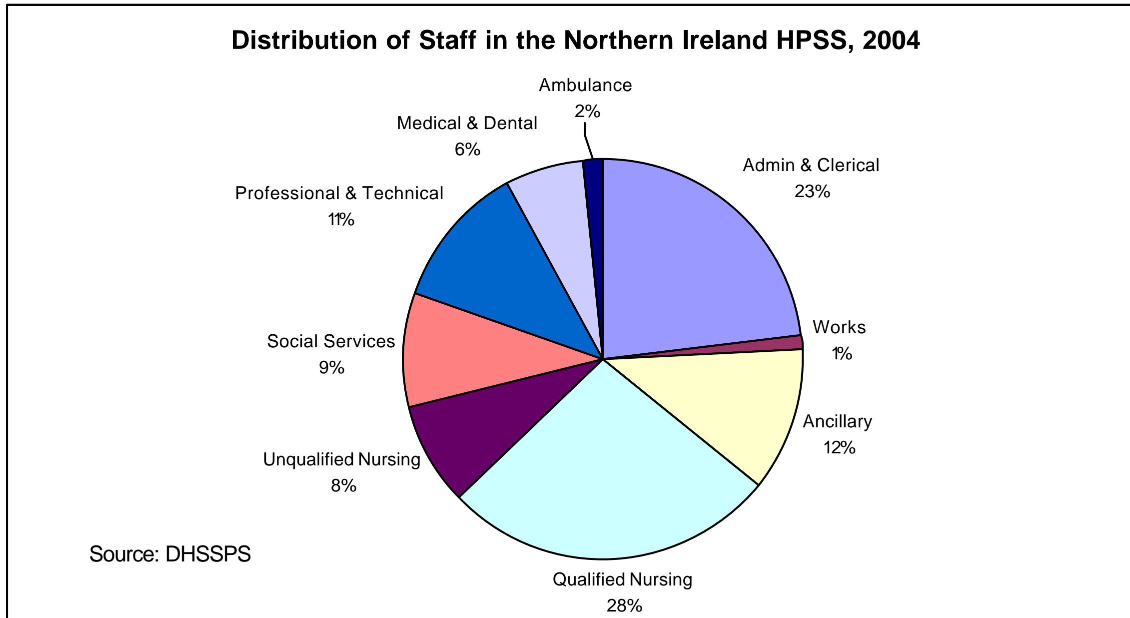


In terms of the major staff groups employed outside of the HCHS, there are 6% more GPs per head of population in Northern Ireland than England and 4% more personal social services staff. However, Northern Ireland's staffing compliment for both these groups per head of population is lower than in Wales and Scotland.

Figure 3.77 shows that the largest grouping in the health and social care workforce is qualified nursing & midwifery staff (28%), followed by administration & clerical staff (23%). However, since 1994, the fastest growth in staff numbers has occurred in the professional & technical staff grouping - which includes physiotherapists, radiographers and dieticians.

[94] In 2003 Administrative & Clerical staff accounted for 22.8% of Health and Personal Social Services staff in Northern Ireland compared to 14.5% in England.

Figure 3.77: Nurses and administration and clerical staff made up over half of the entire health and social care workforce in 2004.



3.8.2 Future staffing needs

For England, the Wanless Review projected a need for an additional 62,000 doctors, 108,000 nurses and 74,000 health care assistants over the next 20 years. If these large increases are translated to Northern Ireland, then even allowing for greater staffing now, Northern Ireland will also require a significant increase in staff to provide the same level of service (although given its higher starting point, the increases will not need to be as great). Northern Ireland's share (based on 7% higher level of need) of the Wanless projections would suggest an additional 2,200 doctors, 3,900 nurses and 2,700 health care assistants by 2022. However, taking into account Northern Ireland's higher starting point would suggest an increase of only 2,170 nurses for example[95].

A consistent theme raised by staff representatives in this Review's consultations was the need for better workforce planning. Given that around half of the staff employed in the health and social care sector in Northern Ireland are in regulated professions which require lengthy periods of training, it is essential that there is adequate workforce planning in place to ensure that supply meets demand. It is the role of the department - in conjunction with the local universities - to ensure that sufficient training places are made available in order to meet future staff requirements.

The Needs and Effectiveness Evaluation indicated that health and social care workforce planning in Northern Ireland had been somewhat underdeveloped in the past. In particular, during the 1980s poor planning meant that too many staff were

[95] The Wanless Projections would suggest that there will be approximately 413,000 nurses in England in 2022, or 7.62 per 1,000 population. Given that there are currently 7.42 nurses per head of population in NI, and adjusting for population change and need, this would suggest an additional 2,170 nurses.

being trained relative to the demand from the health and social care services (which are, in essence, a monopsonist for such labour). In response, during the 1990's there were reductions in the number of training places - with the result that there were perceived to be labour shortages. Whilst there is waste in funding training when there may not be the opportunity to use the skills developed, it is not clear why demand should exactly meet supply for certain public sector professions when it is not the case for most other professions. The additional cost of training is likely to be lower than the premium paid to health care professionals resulting from the tight labour market that has been a feature of the current system.

To improve the standard of workforce planning, in 2001 the DHSSPS commenced a series of uni-professional workforce reviews covering the main groups employed in health and social care - including the main clinical professions.

The main purpose of these workforce reviews was to provide medium term projections of the demand and supply for each profession. The need for staff was expected to increase if increasing health and social care demand were to be met (as a result of an ageing population, changing roles as well as service developments). Supply was expected to fall - due in general to the numbers entering the workforce not being sufficient to balance those leaving. Overall, the workforce reviews projected significant shortfalls in the supply of professional staff by 2006. However, the subsequent *Pay and Workforce Strategy* suggested that the former projections exaggerated the scale of shortfall and that there would be merit in considering the approach to workforce planning in England where there was greater emphasis on policies to ensure that supply met demand (for example, through changes in skill mix, retention policies etc). Whilst the recently produced revised workforce review for nursing has taken on board a number of these criticisms, the approach remains less pro-active than in England[96]. For example, it is assumed when modelling future supply that no progress will be made in reducing the attrition rate from degree courses whilst the anticipated productivity growth is less than in England.

Although there is likely to be a requirement for additional health & social care staff in the coming years, the increase needed may not be as great as that suggested by DHSSPS. Further, it is important to ensure that the existing staff resources are used effectively and efficiently before significantly increasing these inputs.

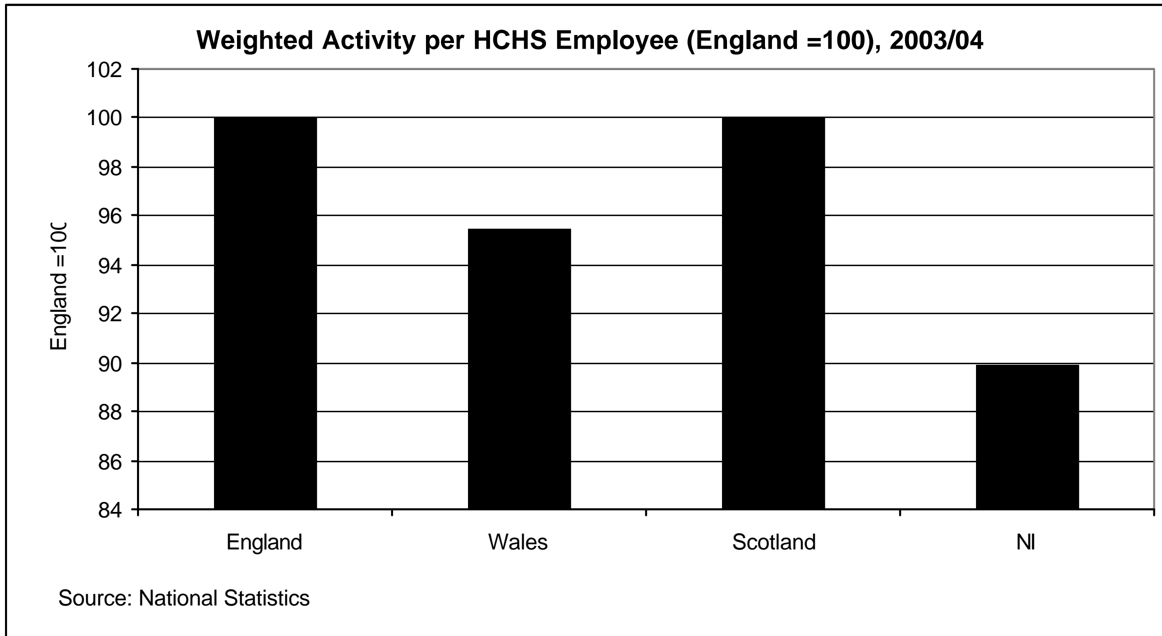
3.8.3 Effectiveness, efficiency and productivity

It is beyond the scope of this study to consider in great detail the extent to which staff are used effectively and efficiently in Northern Ireland as this would require detailed micro analysis of working patterns. However, as figures 3.60-3.63 in section 3.71 on Efficiency indicated, given that staffing levels are significantly higher than in England, whilst activity levels are slightly lower, this would suggest that productivity could be improved. Figure 3.78 below shows that weighted activity per HCHS employee is 10% lower in Northern Ireland than England. Whilst there are many arguments that could be employed to explain the lower level of productivity in Northern Ireland - such as policy decisions to reduce access times associated with the geography of Northern Ireland, increased health and social care demand arising from high levels

[96] Review of Workforce Planning for Nursing Midwifery and Health Visiting Final Report February 2005, DHSSPS

of deprivation, and poor development of ICT – it is not clear how significant each is in explaining the variation.

Figure 3.78: The level of weighted activity per HCHS Employee is 10% lower than in England, 2003/04.



Interestingly, figure 3.79 shows that the productivity of the health & social care sector in Northern Ireland has followed a similar trend to the rest of the UK in recent years. Productivity rose up until 1997/98, since when it has declined as activity has increased at a slower rate than the resources available. Overall, productivity in the health & social care sector has fallen at a faster rate in Northern Ireland than England and Scotland since 1994/95.

The productivity of consultants, as measured by the number of inpatient and day case finished consultant episode per consultant, follows a slightly different pattern. Figure 3.80 shows that the productivity of consultants was falling before 1997/98. Northern Ireland has experienced the smallest fal throughout the UK in productivity over this period so that the productivity of consultants is higher than in Scotland & Wales but remains (around 7.4%) lower than in England.

Figure 3.79: Northern Ireland has followed a similar trend over time to the rest of the UK in terms of HCHS labour productivity.[97]

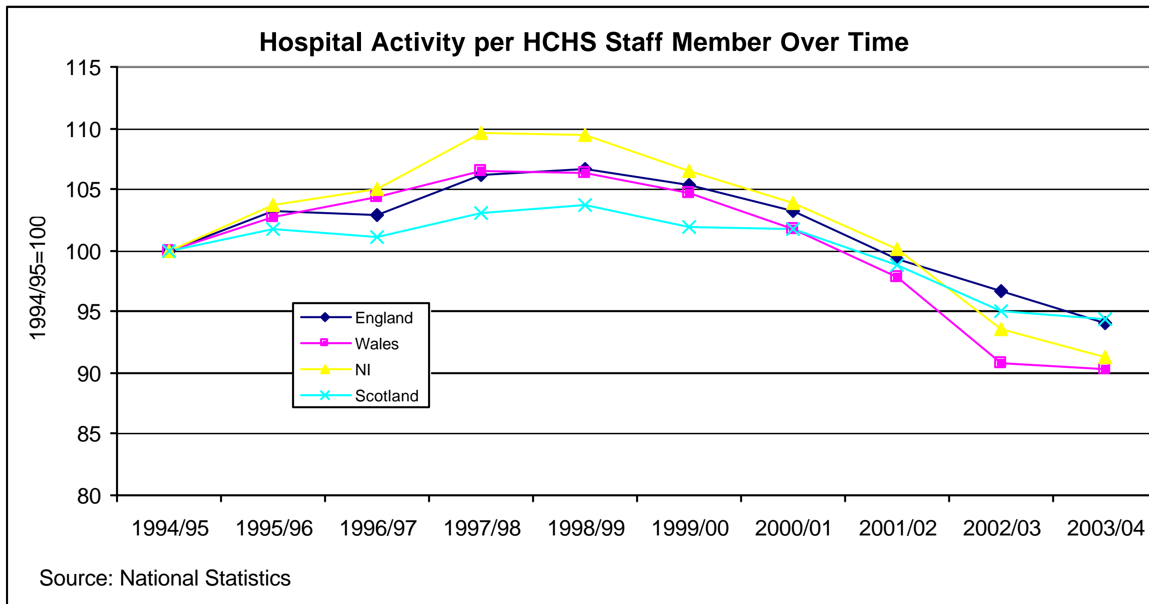
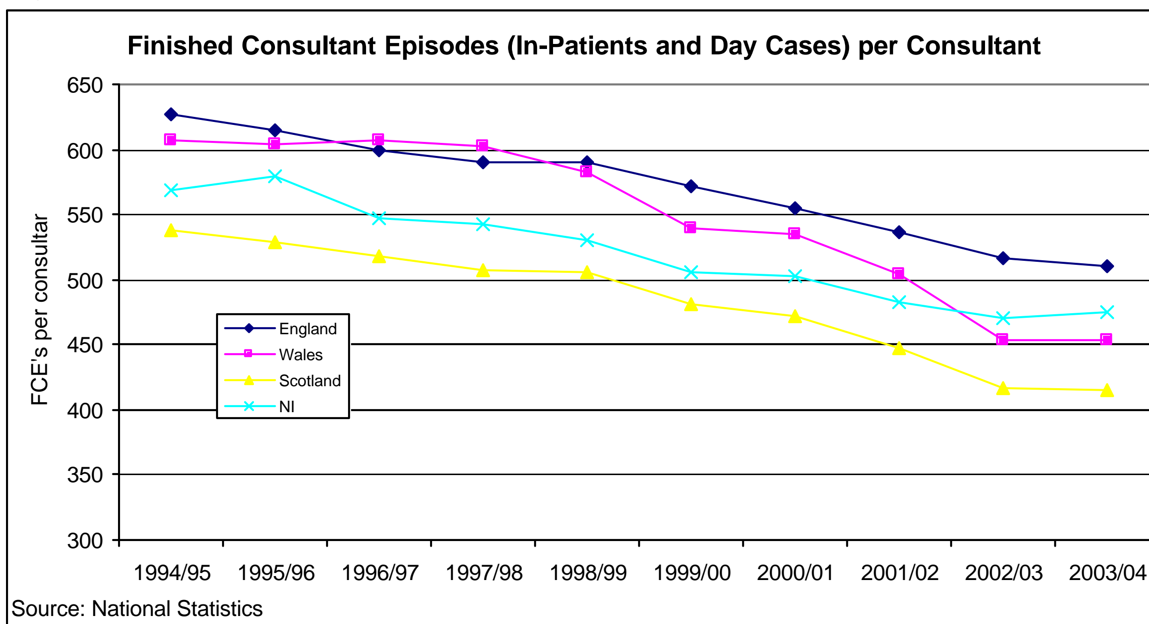


Figure 3.80: The number Finished Consultant Episode (In-patients and Day Cases) per consultant is currently higher in Northern Ireland than Scotland & Wales but lower than in England - but trends in all countries have been downward.



The need to improve labour productivity has been recognised. For example, Budget 2005-2008 indicated that £225m out of the £474.2m efficiency savings over the next three years will come from the more productive use of health and social care professionals' time. These savings would fund increases in front line capacity (costing £135m) and the quality of services (costing £90m). However, this Review would note that it is not clear from the information set out in the accompanying Efficiency Technical Notes how the improved service will be achieved. Indeed, the

[97] Labour Productivity Index is derived by index of total weighted activity (as set out in Figure 3.9) divided by index of NHS employment. Whilst differences in methodology mean that it would not be appropriate to compare levels of productivity the chart is intended to be indicative of general trends.

main activity appears to be the collection of data on performance which, although valuable, in itself will not directly lead to significant improvements.

The Northern Ireland Regional Strategy[98] indicates that productivity improvements in the health & social care sector are expected to come from reduced demarcation; nurses and allied health professionals taking on some of the roles and activity of doctors, and health care assistants taking on some of the roles of nurses. The main focus on implementation revolves around joint aspects of training for medical and nursing staff with the intention of changing behaviours and attitudes towards multi professional working.

The Needs and Effectiveness Evaluation indicated that the level of absenteeism in Northern Ireland Trusts ranged from 3% to 7%, with an estimated overall average of 6% compared to 5% in England. Despite a requirement in Priorities for Action there appears to have been little success in reducing absenteeism rates (which currently range from 4% to 8% for Northern Ireland Trusts compared to an average of 5% for England[99]). This issue was raised as part of the recent nursing workforce review, where the view was expressed that sickness policies need more rigorous enforcement, particularly after maternity leave.

Recommendation 21: Further investigation is required of possible reasons for relatively low labour productivity

3.8.4 Staffing costs

Although movement towards (lower) English staffing levels would result in higher productivity, this could be at the expense of quality of service. An alternative way to improve labour productivity and efficiency is to focus on the costs of staffing.

Health and social care staff in Northern Ireland generally enjoy the same terms and conditions as in the rest of the UK. It was argued in the Needs and Effectiveness Evaluation that this was necessary in order to recruit, retain and motivate staff. In addition, reducing the level of pay relative to the rest of the UK was expected to result in an increase in the number of staff leaving the system- no evidence has been produced to support these arguments.

Pay parity has become more critical in recent years due to the pay reforms initiated in England - such as Agenda for Change for non-medical staff and the new contracts for hospital consultants and general practitioners. These reforms have resulted in substantial increases in salaries, but with the prospect of changes in working practices, higher productivity and improved recruitment and retention of staff. A weakness of these reforms is that the costs are upfront and definitively set whilst the benefits in terms of service delivery tend to be more nebulous and longer term. Given the health and social care funding mechanism for Northern Ireland and a higher level of per capita staffing, implementing equivalent pay reform has placed significant resource pressures on spending in Northern Ireland - as noted earlier in section 2.2.3. Although Northern Ireland has, to date, managed to maintain pay

[98] *A Healthier Future- A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025*, DHSSPS

[99] NI figures are for October 03-March 04 whilst England figures are for 2003

parity whilst also maintaining higher staffing levels, recent pay reforms increasingly highlight the opportunity costs of maintaining such a policy.

Pay parity with the rest of the UK has been guaranteed for the past thirty years as a result of provisions in the 1971 Northern Ireland Finance Act, which indicates that the remuneration of persons employed in the health services in Northern Ireland correspond as close as possible with the rates for such services obtaining in Great Britain. In practical terms this has meant that whilst Northern Ireland was not covered under the remit of the relevant national Pay Review Bodies, the recommendations of terms and conditions from these bodies was taken up in Northern Ireland. This policy has continued, with the application of Agenda for Change reforms and changes to doctors' contracts applying equally in Northern Ireland as the rest of the UK. It needs to be recognised, however, that these particular reforms were designed and introduced in response to specific problems in England, problems which may not have occurred to the same extent in Northern Ireland.

Local pay flexibility

In 2003 the Government issued guidance[100] indicating that, within existing national bargaining frameworks, public sector pay should be based on local labour market conditions. In taking this forward, the terms of reference for the national Pay Review Bodies were amended to take into account local factors in their deliberations. Such local labour market conditions include vacancy rates, regional price indices and the pay gap between public and private sectors. Given that Northern Ireland is not covered under the remit of the Pay Review Bodies it is not clear how the Government's policy will be applied with respect to Northern Ireland. However to date there has been little progress in Great Britain, with local pay variations arising mainly in the form of additional payments for high cost areas, whilst the logic of the policy would be to have lower pay levels in low cost areas.

There has been considerable debate as to whether the 1971 Finance Act still implies a statutory requirement to retain pay parity. In particular, it has been argued that the change in policy means that in effect there is no longer a GB-wide settlement for Northern Ireland to retain parity with. However, the local pay policy guidance clearly indicates that national bargaining frameworks will remain. Until there is a break from parity for other regions of the UK, it is likely to be highly controversial to implement such a policy in Northern Ireland. Nevertheless, it is worth reviewing some of the evidence that bears on this issue:

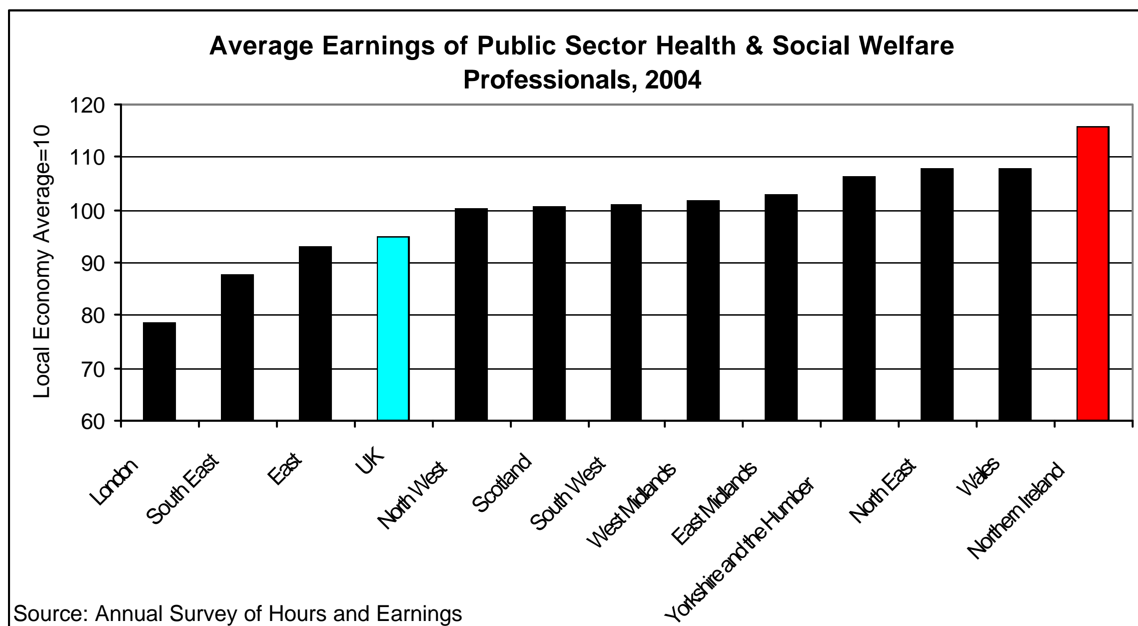
1. Public and private sector earnings gaps

The 2004 Pay and Workforce Strategy for the Northern Ireland departments set out analysis illustrating that the gap in earnings between the public and private sectors in Northern Ireland was higher than the rest of the UK. Whilst part of the gap could be explained in terms of the security situation in Northern Ireland and occupational structure, a significant differential remained. Figure 3.81, for example, compares the average earnings of Associated Health Professionals

[100] Government Guidance Note on Progressing Local Pay (October 2003), HM Treasury

with the economy average level of earnings for the UK regions[101]. It can be seen that for most UK regions the level of earnings for Associated Health Professionals working in the public sector is higher than the economy wide average. However, the differential is greatest for Northern Ireland, where average earnings are 16% higher than the economy average.

Figure 3.81: Average earnings of Health and Social Welfare Associate Professionals working in the public sector are 16% higher than for the economy as a whole in Northern Ireland.[102]



In terms of specific professions, the 2004 Annual Survey of Hours and Earnings (National Statistics) shows that the average weekly gross pay of female nurses is 23% higher than the average for full-time females as a whole in Northern Ireland whilst the earnings of medical practitioners are almost three times higher than the Northern Ireland average. Although not all people have the appropriate skills to become doctors or nurses it would appear that the health care sector is a relatively attractive career option in the Northern Ireland labour market.

2. Labour migration

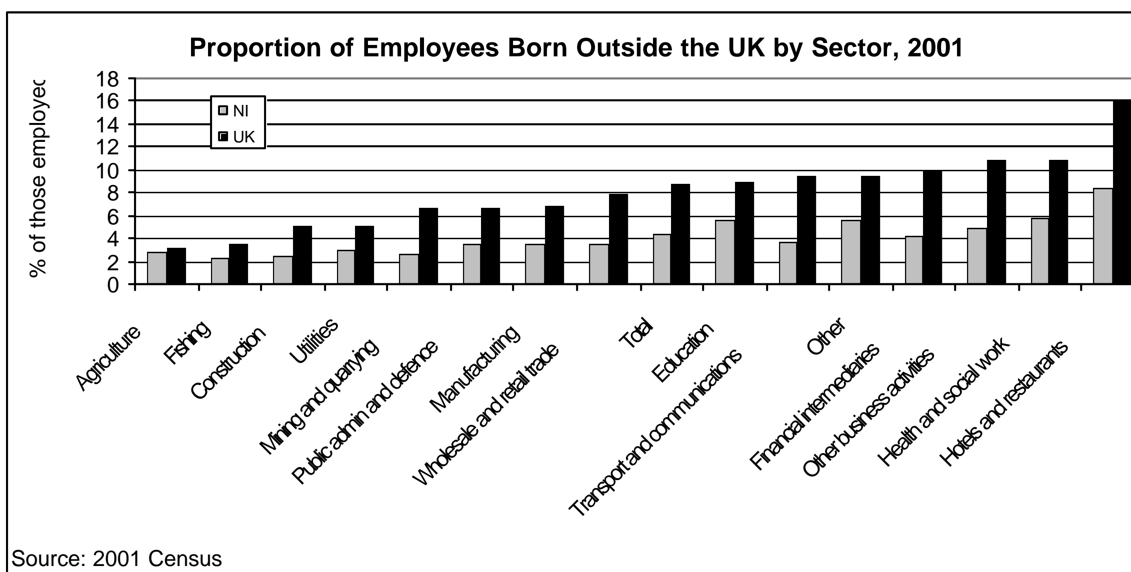
One of the main arguments against the break from pay parity is that it would result in significant numbers of staff migrating from Northern Ireland. In particular, most health care staff have transferable skills and might be considered more mobile than the rest of the population. Although it has been suggested that the increase in public sector salaries in the Republic of Ireland in recent years has lead to migration of public sector workers from Northern Ireland, there is little evidence to indicate the such transfers have been significant.

The main movement of staff in the health & social care sector has been from other countries into Northern Ireland. In 2002, approximately 3% of nurses registered in Northern Ireland were from overseas compared to 8% for

[101] Health and social welfare associated professionals include Nurses, Midwives, Paramedics and Radiographers but exclude Doctors
[102] Average (Mean) gross weekly earnings of full-time employees

England[103]. There are currently 812 nurses from overseas employed by Northern Ireland Health Trusts, equivalent to 5% of nurses compared to over 10% for the UK as a whole[104]. However, there is significant variation between Northern Ireland Trusts with overseas nurses accounting for a higher proportion of the total for the Mater, Royal and Ulster Hospitals.

Figure 3.82: Only 6% of those employed in the Northern Ireland health & social care sector were born outside of the UK compared to 11% for the UK as a whole



In terms of the overall number of health and social care staff, data from the 2001 Census indicates that 89% were born in Northern Ireland, 4% in England, 3% in the Republic of Ireland and 3% outside the British Isles. Figure 3.82 shows that whist a higher proportion of Northern Ireland health & social care staff were born outside of the UK than the economy average, the share is significantly lower than for the UK as a whole. In addition, the differential is even greater with respect to those born outside of the EU who account for over four times the share of staff in the UK as they do in the Northern Ireland health and social care sector.

Therefore, whilst Northern Ireland has an increasing reliance on overseas staff, this remains to a lesser extent than in the rest of the UK.

3. Pay and cost of living differences

A further argument is that it would be unfair for someone doing the same job in Northern Ireland to be paid less than in England. However, the cost of living is generally lower in Northern Ireland than the rest of the UK with the result that real wages are currently higher in Northern Ireland.

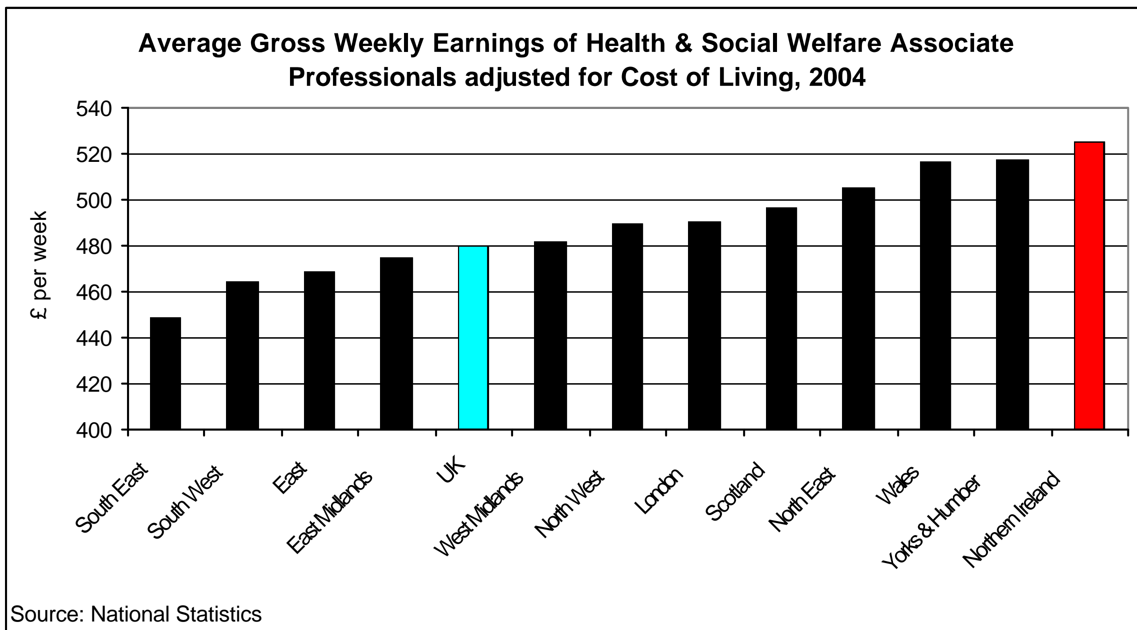
Whilst the 2004 Pay and Workforce Strategy indicated that the cost of living was nearly 10% lower than the UK average, more recent figures for 2004 indicate that prices are only 5% lower in Northern Ireland. Figure 3.83 below shows that the earnings of Associated Health Professionals working in the

[103] Here to Stay? International Nurses in the UK, RCN
[104] The February 2005 Review of Nursing Workforce Planning indicated that there were 42,000 overseas nurses currently working in the UK.

public sector in Northern Ireland are the highest of UK regions after adjusting for the lower cost of living.

However, these cost of living figures are an average across the whole economy; there are significant variations between income standards due to housing costs. For example, the required income for the lowest income standard is estimated to be 9% lower than the UK average in Northern Ireland, whilst that for the highest is 28% lower[105]. Therefore, for the more mobile health care staff there is likely to be a significant cost advantage from living and working in Northern Ireland relative to the rest of the UK.

Figure 3.83: The Average Gross Weekly Earnings of Health and Social Welfare Associate Professionals Adjusted for Cost of Living is highest of all UK regions



4. Vacancy rates

Whilst there are a number of complications in comparing vacancy rates for health care staff across UK countries, Table 3.5 provides a broad comparison.

Overall vacancy rates in Northern Ireland are lower than England and Wales - in particular, for nursing and medical & dental staff[106]. Significant progress has been made in reducing vacancies in recent years in part due to significant recruitment of overseas doctors and nurses.

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[105] Figures from Croner Reward Cost of Living Regional Comparisons March 2004
[106] More recent figures from the Nursing Workforce Review suggest that the 3 month vacancy rate for nurses rose to 1.5% in Northern Ireland in 2004.

Table 3.5: 3-month vacancy rates in Health Service for England, Wales and NI

Category	NI (Jun 04)	Wales (Mar. 04)	England (Mar. 04)
Medical and Dental of which consultant[107]	1.9 *3.2*	7.9 *8.8*	4.3 *4.4*
Nursing, Midwifery and Health Visiting	1.4	2.1	2.6
Social Services	0.9	N/a	N/a
Admin and Clerical	0.6	N/a	N/a
Professional and Technical	1.8	2.4	3.4
Other	0.9	1.4	1.3
All Staff excluding Social Services	1.3	2.1	2.2

Source: DHSSPS, NHS, NAW

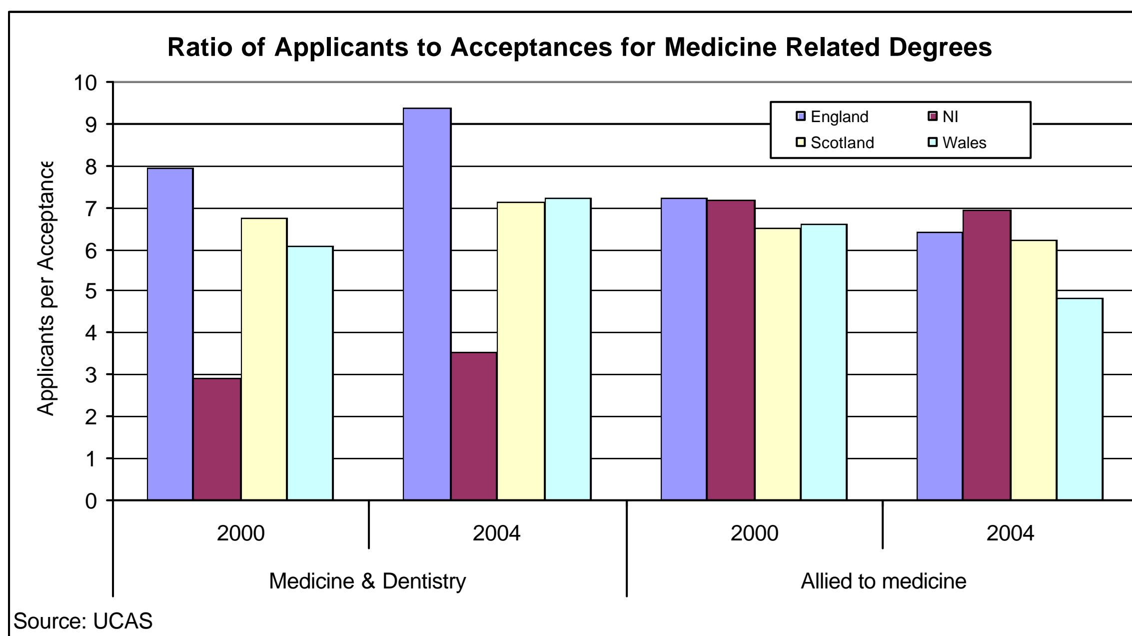
5. Labour supply and training

The picture in terms of recruitment is slightly more confusing, as the recruitment procedure begins when the choice is made for degree course. Figure 3.84 shows that the number of applicants per acceptance for degree courses for Professions Allied to Medicine was higher than that for the rest of the UK[108]. However, the ratio for medicine & dentistry courses at Northern Irish institutions was significantly lower than the rest of the UK[109]. This latter ratio of around 3:1 is not viewed by DHSSPS as being particularly low and the view from the consultation process was that recruitment was not a significant problem.

A possible reason for the lower ratio might be that Northern Irish students are selecting not to go into medicine because of the higher qualifications requirements. As a broad indication of this, 94% of successful Northern Irish applicants to medicine & dentistry degree courses had the equivalent of three 'A' Level passes at A grade or better, compared with 84% for the UK as a whole[110].

[107] Consultant data is for September 2003. DHSSPS have indicated that the rate is now in the region of 7%.
[108] There was some variation between the professions allied to medicine with Nursing (2.85) having a lower ratio than Physiotherapy (7.89), Dietetics (6.11), Occupational Therapy (7.10), Podiatry (7.07), Radiography (7.23) and Speech & Language Therapy (12.87)
[109] For Medicine alone the ratio was 3.73:1
[110] In terms of Allied to Medicine Degree Course which includes Nursing, Ophthalmics and Pharmacology the percentages were 35.2% for NI and 23.7% for the UK.

Figure 3.84: The Ratio of Applicants to Acceptances for Medicine Related Degree Courses is lower in Northern Ireland than the rest of the UK



6. General Labour Market Conditions

In terms of more general indicators of the public sector labour market. whilst there is a paucity of comparable data for the UK regions, the available evidence would tend to suggest that there is greater availability of labour for the Northern Ireland health and social care sector than the rest of the UK. Although unemployment has fallen towards the UK average, the employment rate remains the lowest in the UK, whilst Northern Irish schools are producing significant numbers of highly educated young people, suggesting that there is a greater potential supply of labour in Northern Ireland than the rest of the UK. Recruitment and retention issues are not likely to be more problematic in Northern Ireland than elsewhere, therefore.

Conclusion

Relative to England, the health & social care sector in Northern Ireland currently has a reasonable level of staffing capacity. Whilst Northern Ireland will require greater numbers of health care staff in the coming years, there is scope for using existing resources more effectively.

In looking to the future, an important issue, however, is whether Northern Ireland should continue to bear the opportunity costs of maintaining pay parity with the rest of the UK - particularly as the current system of public sector funding will make it increasingly difficult to both maintain parity and, for example, continue with higher staffing levels than elsewhere

Whilst there is scope for work patterns to be more efficient, there is also potential to more closely align the levels of pay for health & social care staff with local labour

market conditions (within existing national frameworks) without damaging the ability of the services to recruit and retain appropriate staff. Clearly, the issue of pay parity is sensitive, and it will be the case that any policy designed to tackle this will in turn need to be sensitive to staff morale and motivation; it may well be the case that for many professions in the services that it would be better to retain pay parity and that further, where, in the best interests of the system as a whole, parity is not retained, that alternative, non-financial benefits could be considered. However, from our consultations and consideration of the available evidence, there is a strong case that the main reason for past and predicted labour shortages has been an insufficient number of training places rather than the level of pay per se.

Recommendation 22: Health and social care workers in Northern Ireland should formally come under the remit of the relevant GB Pay Review Bodies: this will enable the Government's local pay policy to be implemented on an equal basis in Northern Ireland to the rest of the UK.

4. Performance management

4.1 Introduction

The previous section has shown that on broad efficiency measures, and in particular in terms of waiting times, there is room to improve the performance of Northern Ireland's health and social care system.

Northern Ireland is not alone. As the OECD have noted[111], almost regardless of funding levels or sources, health and social care systems around the world face common issues and problems when it comes to improving their performance. Despite high levels of commitment and professionalism from health and social care staff, best efforts to provide appropriate care in the most efficient way can be frustrated by the way systems are structured and organised. Poorly designed (or, indeed, the complete absence of) incentives and systems to promote improvements in performance at national, local and individual levels can significantly affect the way the health and social care system responds - to patients' needs, to the dynamic nature of medical technology and to changes in attitudes and values.

How health and social care systems are managed, the incentives and sanctions in place and the type and availability of performance information are critical to improving performance.

In order to set some context for the situation in Northern Ireland with respect to performance management this section first details some of the reform efforts being pursued in OECD countries. It then describes the current performance management system in Northern Ireland and recent suggestions for changes (mainly in structures) aimed in part at improving performance.

The key question this section addresses is whether current reforms and modernisation in Northern Ireland will be adequate to tackle the performance issues previously identified.

Section Conclusions

Current performance management arrangements lack the performance structures, information and clear and effective incentives - rewards and sanctions - at individual, local and national organisational levels - required to encourage innovation and change.

These criticisms were confirmed in our consultations with key stakeholders. It was clear, for example, that the current performance management system was adjudged to require further development, to deal with an absence of accountability in the system. This review does not feel that recommendations of the Review of Public Administration adequately addresses the weaknesses with the performance management system. And contrary to the RPA, this Review would suggest that some form of separation between the providers of services

[111] OECD (2004) Towards high performing health systems. OECD, Paris.

and the funders/commissioners of services would be an important factor in sharpening up incentives in the system.

Overall, the system needs to be reformed to take on serious, long term central target setting coupled with rewards and sanctions at organisational and individual levels and greater devolution to providers to give them the scope to respond. In turn, providers themselves need to consider how to devolve functions within their organisations, in particular, ways in which to engage frontline staff with the incentives faced by the organisation as a whole - through, for example, devolution of budgets and associated responsibilities.

The nature of the rewards and sanctions need careful thought. For example, mainly for reasons of scale (and efficiency), the competitive economic environment currently being developed in England is unlikely to be appropriate in Northern Ireland. However, this does not rule out, for example, the introduction of an activity-based prospective reimbursement system for providers (similar to Payment by Results) with tariff setting (not necessarily fixed at average costs) used to drive improvements in efficiency and selective increases in activity to meet pan-service goals. Nor does it rule out the promotion of greater public and patient awareness of variations in performance in the system.

Moreover, it does not rule out careful expansion of patient choice. While in England choice is being rolled out mainly with a policy emphasis on the leverage it may have over providers (crudely, losing business will stimulate cost and quality improvements), from the patient's point of view, a more formalised and embedded process of choice (not just of hospital, but over the myriad of decisions that are taken throughout the system which affect a patient's care) can improve patient satisfaction and service responsiveness. This may be a weaker incentive than that being introduced in England, but the limits to what could realistically offered by way of choice need to be recognised in what is a relatively small system. Nevertheless, there may be certain services, specialties, operations etc where options do exist for real patient choice and where patients would like to exercise greater choice.

In addition, and despite the previous rejection of GP fundholding, to both strengthen the involvement of general practitioners in the system and as part of a devolution strategy for commissioning secondary care services, thought should be given to the practical involvement of GPs in the purchasing of care. Again, Northern Ireland has an opportunity to develop its own approach to this form of devolved commissioning.

Finally, no system relies on just one or two performance levers. In England, for example, the new payment system and (managed) patient choice are going to run alongside continued use of targets (renamed 'standards') and, importantly, an evolving regulatory system at arms length from government which aims to promote the ultimate goals of the system - better quality of care, more efficient and cost effective use of resources. NICE, the National Patients Safety Agency, the Healthcare Commission etc, are important organisations which aim to promote better care. Much of these organisations' work and output are public goods available for any system to use and from which Northern Ireland could benefit and could inform development of the new HPSS Regulation and Improvement Authority.

4.2: Health care reform in OECD countries

Reducing costs, improving clinical and cost effectiveness, increasing public health, patient safety and patient responsiveness have been key issues for most OECD countries for more than two decades. Tactics and strategies to improve performance have drawn on economic, management and organisational theory as well as the results of experiments in many countries. The OECD have identified over twenty (at least) different areas where reform has or is being tried in order to tackle three broad performance concerns: Improving public health and clinical quality; Improving system responsiveness; and Improving efficiency and cost effectiveness.

Box 4.1 summarises the various reform strategies identified by the OECD; while not all of these are of relevance or applicability to the health and social care system in Northern Ireland, this list provides some structure in describing Northern Ireland's current performance management system and efforts to reform and modernise. It also illustrates the sheer range of possible reform tactics that could be considered in the Northern Ireland context.

Box 4.1: Reform strategies to improve performance

Improving public health and clinical quality

- Focused public health programmes
- New health care delivery arrangements
- Patient safety systems
- Public reporting of information on quality
- Targets and standards for improvement
- Technical assistance to improve quality and performance
- Aligning economic incentives with effectiveness incentives

Improving system responsiveness

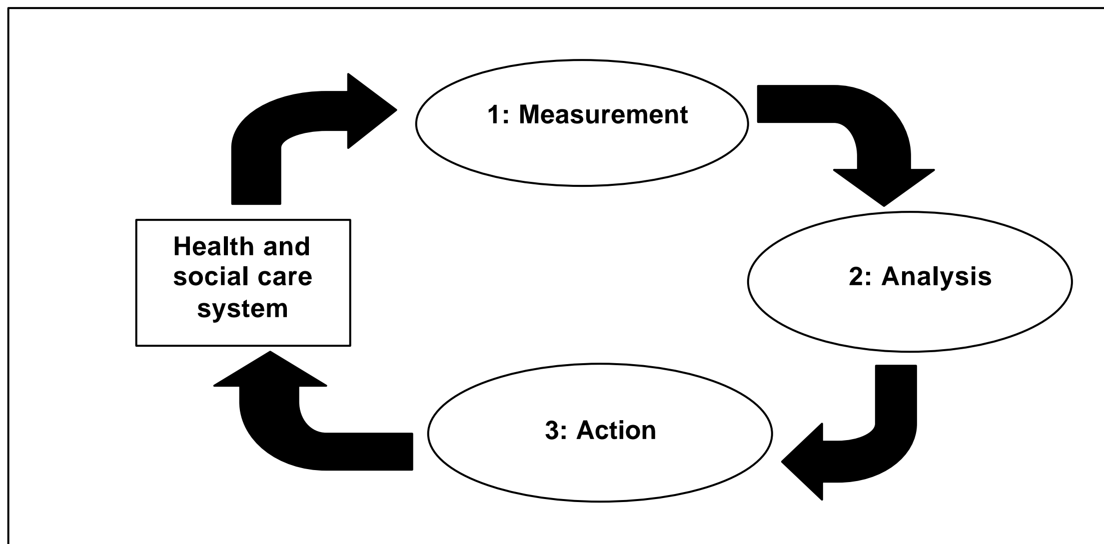
- Improving patients' rights to treatment
- Patient satisfaction and experience surveys
- Patient choice

Improving efficiency and cost effectiveness

- Control of wages and prices
- Budgetary caps
- Shifting costs to the private sector
- Shifting care to lower cost services within the system
- Incentives embodied in primary care provider payments
- Incentives embodied in secondary care provider payments
- Separation of purchasers and providers
- 'Earned autonomy' for providers
- Provider competition
- Assessing technological change
- Pharmaceutical regulation

Within the continuous performance management cycle (see figure 4.1), the majority of reform strategies pursued in OECD countries have focussed on the third performance management activity, *actions*. However, as noted later, of equal importance with respect to Northern Ireland are the prior stages of measurement and analysis (for example, key areas of performance are poorly described in official statistics and hence the reasons why changes in performance measures occur poorly understood).

Figure 4.1: The Performance Management Cycle



Drawing conclusions from the range of reform activity being pursued in OECD countries is difficult. However, some common strategies emerge which might be helpful in informing possible changes to the performance management system currently in operation in Northern Ireland:

- separate purchaser and provider functions,
- better align incentives with objectives through contracts,
- decentralise decision making,
- increase competition/contestability among providers
- benchmark performance against best-performing providers,
- use (carefully designed and run) output-related prospective payment systems

The OECD suggest that,

> *'While the positive impact of such policies has most often been weakened by continued central control, tight spending limits and tighter supply constraints than elsewhere, these policies generally have been sustained, despite subsequent reforms in many countries.*[112]

But the OECD go on to caution that,

> *'Experiments with competition among providers have been less successful and reforms have been reversed in those countries where they were*

[112] OECD, *ibid*

introduced. Failures partly reflected tight supply conditions and monopoly positions of providers in local health-care markets and lack of sufficiently skilled purchasers. Positive results from competition probably require establishing market conditions conducive to competition, better purchasing capacity, and the information base needed to appropriately set and monitor contracts.'

Reform and modernisation are, then, the norm rather than the exception in health and social care systems around the world. While there are few definitive explanations for observed successes and failures in different countries' reform strategies, in the face of clear evidence that systems are not achieving the best results given resource levels and the particular economic, social and other circumstances in which they operate, doing nothing is not an option.

Next we review current arrangements for performance management in Northern Ireland and, with reference to some of the reform strategies pursued elsewhere, suggest possible options for change.

4.3 Current performance management arrangements in Northern Ireland

Performance management systems are, in reality (and despite the simplified three-stage process described in figure 4.1) rather complex, and invariably difficult to describe. However, at a very broad level of description, the current performance management system in Northern Ireland could be characterised as centrally-driven within a hierarchically-managed organisation. However, the system lacks appropriate performance structures, information and clear and effective incentives - rewards and sanctions - at individual, local and national organisational levels to encourage innovation and change.

These criticisms emerged from our consultations with key stakeholders. It was clear, for example, that the current performance management system was adjudged to require further development, with an absence of accountability in the system. In particular, none of the individuals and groups we met were able to provide a clear description of the incentives and sanctions in place to ensure that the targets set by the Minister were achieved.

The general view was the system would benefit from less centralisation of control whilst it was unclear whether the Department or the Boards were in control of the Trusts. The view of DHSSPS officials was that the ‘hard line’ approach to performance management in England over the last few years had lead to disruption, uncertainty and a lack of confidence amongst management and hence would be inappropriate in Northern Ireland. Nevertheless, an internal DHSSPS/HPSS review of the current performance management system completed in January 2005 was critical of the system and has recommended various changes[113] (see Box 4.2), However, none of its recommendations address the key issue of *how* performance is to be improved.

Box 4.2: DHSSPS/HPSS review of current performance management system

A review of the performance management arrangements for the HPSS was concluded in January 2005 and concluded that the current system:

- is complex, unwieldy and very bureaucratic;
- not comprehensive in terms of being able to measure HPSS performance as a whole, often focusing on new initiatives rather than the totality of resources;
- lacks linkage between annual and strategic plans. As a result, there is a lack of continuity between the two and often a focus on short-term gains at the expense of longer-term achievements;

And that,

- targets do not always reflect the real priorities, particularly in terms of the outcomes for people who use the health and social services;
- data is often collected which is not put to any useful purpose; and
- equally, appropriate information is often not available to support the monitoring process.

The review recommended various changes - chiefly, a new set of performance indicators to capture the totality of the work carried out by the HPSS.

However, the review contained no criticisms or recommendations about the *effectiveness* of the current system to actually improve performance - in particular, no reference was made as to the process or mechanics by which performance is to be improved.

[113] HPSS Performance Assessment and Reporting Framework, Report and Proposals from Working Group, DHSSPS).

Below we examine this particular issue and other key elements of a performance management system - structures and processes, information and analysis, and standard/target setting.

4.3.1 Performance structures and processes

By performance structures we mean leadership, management and accountability arrangements in the health and social care system. In this respect, the Review of Public Administration (RPA)[114] has tackled a different aspect of performance structures and has made proposals for changing the number of health and social care organisations. However, the RPA's recommendations - drafted by the DHSSPS - also suggest a mode of working and interaction between health and social care organisations which touches on the way performance management systems might develop. In particular, the RPA rejects a competitive model in health and social care, and instead proposes an integrated commissioner/provider model. We pick up this issue in the conclusions to this section.

Pace the current recommendations of the RPA, the health and social care performance management system, as noted above, is centralised and hierarchical in nature; over 1,000 staff at the DHSSPS[115] and a further 800 staff in the four Boards control the flow of funding to service providers, develop and promulgate planning and strategy guidance and set performance goals - primarily through the annual Priorities for Action (PfA) document.

The DHSSPS develop the annual PfA based on their Public Service Agreement (PSA). Boards then respond with Health and Wellbeing Investment Plans (HWIPs) which set out how they will meet the PSA goals. Finally, individual trusts then have to produce Trust Delivery Plans (TDPs) which in turn set out how they will use their resources in pursuit of these goals.

In terms of monitoring and accountability for meeting PfA plans, as the 2004/5 PfA states,

> *'HWIPs and TDPs will continue to provide the focus for rigorous [Health and Personal Social Services] monitoring and accountability arrangements throughout the year. These arrangements include quarterly reporting to the Department by Boards and Trusts, meetings between Boards and Trust officials and the Department[116] and accountability review meetings involving Board chairs and the Minister.'*[117]

In effect, the Department runs the health and social care services in Northern Ireland along fairly traditional management lines and with accountability flowing upwards from trusts, to Boards, and finally to the Department. As is clear from descriptions of the performance management system supplied by DHSPSS to the review (see

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[114] An interim report is currently (May 2005) out for consultation
[115] DHSSPS have indicated that over 400 of these officials are providing direct operational services.
[116] Extracts from annual DHSPSS/Board accountability reviews are noted in Annex I.
[117] It is worth mentioning in passing that while it is fairly easy for members of the public to locate publications setting out DHSSPS, Board and Trust plans, priorities and targets for the following year, it is much harder to locate any publications succinctly summarising what targets had been achieved in previous years.

annex H), there is little account of how failure to meet targets or plans is dealt with and little on positive mechanisms and processes to encourage improvements in performance.

From our consultations, it was clear - as noted above - that this system is generally considered to be too centralised, too bureaucratic, and with a lack of clarity as to whom should be held responsible for performance improvement.

From our survey of chief executives of trusts and in relation specifically to the DHSPSS waiting time performance management arrangements and the role of incentives to meet targets, there was a split between those that felt current DHSPSS waiting time performance management arrangements were effective, and those that felt that they were either not very effective or ineffective (see table 4.1).

Table 4.1: Trust chief executive survey: 'How effective are the Department's external waiting time performance management arrangements?'

The Department's waiting time performance management arrangements are…	Number of responses
Very effective	0
Effective	10
Not very effective	3
Ineffective	3
It is too soon to comment	2

While there seems to be some contentment among chief executives regarding the effectiveness of a system that is meant to improve the performance of organisations they manage, we would observe that the outcome of this system with respect to waiting times does not appear to have produced significant improvements (see section 3.6 on waiting times).

We therefore suggest that serious consideration be given to ways to improve the structures governing the performance management system and the processes used to lever up performance.

4.3.2 Performance information and analysis

Any performance management system, whether hierarchical and management driven, or decentralised and driven through downwardly accountable mechanisms, requires timely and appropriate performance information on which to base future decisions and monitor the outcomes of past decisions.

The experience of this Review in its own attempts to draw together and analyse performance information confirms the DHSSPS/HPSS' s own review of the performance management system that the right information does not always exist or that information systems sometimes lack the ability to provide answers to basic performance questions. Asking, for example, a straightforward question such as whether or not waiting times targets had been met from year to year proved more difficult for this Review to clearly establish than should be the case[118]. And while the

[118] With current information systems, as the NI Audit Office have noted (*Waiting for Treatment in Hospitals*, NIAO, November 2004), it is impossible to know how long individual patients wait from GP

Review has presented various perspectives on tracking funds through the system, this was by no means easy or, indeed, directly addressed key performance questions concerning the benefits derived from recent spending increases.

But more than the collection of the right sort of information, there is the question of engaging in the right (or indeed, any) analysis of data to address performance problems and issues. For example, as far as this Review has been able to ascertain there has been little or no thorough analysis in or outside the DHSSPS of reasons why A&E attendance rates in Northern Ireland are so high (around 31%[119] higher than in England for example). Similarly, there is little or no analysis of the equally high rate of GP consultations, whether these are appropriate or indeed desirable from a clinical point of view (or indeed whether best use is being made of a valuable and expensive health care resource).

Finally, information on performance is not given the public prominence it deserves. As already noted elsewhere in this Review, performance information has been seen as part of the remit of the statistics section of the DHSSPS and by implication (and in practice) separate from the performance analysis/management system and somewhat buried from public view.

4.3.3 Standard/target setting

While the annual Priorities for Action documents have nominally set out goals and targets each year, as this Review noted with respect to waiting lists and times, the PfAs appear somewhat short term, with little connection across years or clear long term goals and appropriate targets. There is an overwhelming case in Northern Ireland for a new look at systematically setting short, medium and long term objectives and quantifiable standards/targets for the health and social care system.

There are clear dangers inherent in an over-reliance on targets as part of a performance management system, but in the (desirable) absence of a market-driven process, targets can act as the 'signals' to providers, helping to direct their priorities and energies into those areas, services and outcomes deemed desirable.

This, however, begs the question of what *is* desirable. The use of targets places a significant onus and responsibility on those setting the targets to balance, for example, the needs of individual patients or clients against those of the community as a whole; or to reach a balance in the often inevitable trade offs between desirable goals such as efficiency and equity. On this, there is a clear need for each 'level' in the system to be clear as to its role and responsibility with regard to the generality or specificity of targets. Overall strategy and priorities need to be set by government, with the DHSSPS translating these into more detailed targets.

4.3.4 Incentives: Rewards and sanctions

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referral to inpatient admission. Moreover, the lack of a patient record-based information system (such as the Hospital Episode Statistics system in operation in England for over a decade) at NI level also makes it virtually impossible to know waiting times for specific procedures.

[119] Provisional figures for 2004/05 indicate that the gap has fallen to 28%.

Targets are necessary, but not sufficient for improving performance, however. Of absolutely crucial importance is the system of incentives and sanctions associated with targets. The 2002 Wanless Review made some important observations about the role of incentives and sanctions in driving up performance in health and social care.

In particular, the review noted that:

> *'Appropriate processes must be in place to ensure that the nationally-set standards are delivered by the health service. There are many cases where this has not happened and standards of care delivered have fallen short. The vision of the health service in 20 years' time set out in this Report cannot permit this, so the processes of objective setting, incentivisation and targeting have to be sensitively designed to ensure they achieve the required results rather than distort resource allocation.*
>
> *There are a number of aspects to such 'processes'. They particularly relate to the way in which resources and information flow around the system and in which incentives and targets are used to direct the delivery of efficient and effective levels of care. The flows are vertical, between those setting standards nationally and those delivering them locally, and horizontal, between the different health and social care providers locally.*
>
> *There is a fine balance to be struck in deciding on the most appropriate way to ensure that central standards are achieved across the service. The setting and auditing of targets is one means which can be used. Financial incentives are another.' (Para's 6.23-6.25 Securing our Future Health: Taking a Long-Term View,* HMT 2002*)*

This Review agrees with these observations, and in particular with the need to design open and explicit incentive systems which reward success and penalise failure. A survey this Review conducted among trust chief executives to explore issues concerning waiting times performance revealed - at best - some ambivalence towards the current performance management system.

For example, just over half of chief executives stated that current performance management arrangements provided little or no incentives for their trusts to meet waiting times targets and just five out of sixteen that it provided sanctions if trusts fail to meet targets (see table 4.2). There was agreement that to some extent performance management arrangements would be more effective if they included stronger incentives and sanctions. The very fact that there appears to be disagreement between chief executives over whether the current system contains any incentives or sanctions at all is problematic, and suggests greater clarity and a shared understanding of the performance management system is needed.

Table 4.2: Trust chief executive survey: 'To what extent are there incentive for your trust to meet waiting times targets, and sanctions if you miss them?'

	Performance management arrangements provide **incentives** for the Trust to meet its waiting time targets…	Performance management arrangements provide **sanctions** if the Trust fails to meet its waiting time targets…	Performance management arrangements would be more effective if they included **stronger** incentives and sanctions for achieving waiting time targets
To a large extent	**2**	**1**	**2**
To some extent	**6**	**4**	**8**
To a small extent	**5**	**6**	**4**
Not at all	**4**	**5**	**1**

And for those chief executives who believed more incentives and sanctions were needed table 4.3 outlines their responses.

Table 4.3: Trust chief executive survey: 'What incentives and sanctions would be most effective in improving waiting time performance?'

Rewards	**Sanctions**
Rewards of investment funds to divisions	No service development for poor performing departments
Improved flexibility in being able to reward key individuals not covered by performance related bonus system	No staff development for poorly performing departments
Transfer services to departments which have good performance records and have genuine competition	Increased organisational and individual accountability for failure
Increase funding available for exceeding target	Money follows the patient reimbursement
Productivity payments for staff	'P45s' for failing managers and practitioners
Small amounts of funding to purchase equipment	League tables. Funding related to performance.
First priority for additional operating sessions	
Money follows the patient reimbursement	
Investment linked to performance	
League tables. Funding related to performance.	

These suggestions prompt a number of possible ways forward for addressing some of the deficits in the current performance management system identified above and noted by many of those we consulted during this Review.

Tariff-based provider budget setting/payment system

Healthcare Resource Group (HRG)-based reference costs form the basis for the reform of hospital reimbursement system (Payment by Results, PbR) in England. Although linked with patient choice (and money following the patient), a key independent aspect of PbR and one which embodies a powerful financial incentive to reduce variations in costs (and, over time, to drive down the mean) is the fact that individual HRG 'prices' are fixed. In England, and for the time being, HRG tariffs are fixed at the national average HRG cost. The implication of this is that hospitals providing HRGs at above-tariff cost will need to examine ways of reducing their costs.

Such a payment system could be used as a budget setting system for trusts, one which directly links reimbursement to activity and which, through the tariff setting process, embodies a direct incentive to address cost variations.

'Earned autonomy'

The reward from earned autonomy can be a combination of greater freedom from central control and diktat (earned on the basis of achieving goals set centrally) and access to financial rewards - for example, specific performance-related funding.

Patient choice

From the patient's point of view, a more formalised and embedded process of choice (not just of hospital, but over the myriad of decisions that are taken throughout the system which affect a patient's care) can improve patient satisfaction and service responsiveness. Moreover, choice based on more explicit information on performance - for example, waiting times - can help reduce performance variations.

GP commissioning

Although previously rejected, the idea of devolving the purchasing or commissioning of patient secondary care to general practice could provide an additional stimulus for secondary care providers to more actively respond to the concerns GPs have about the care their patients receive. The survey of GPs conducted by this Review to explore views on waiting lists and times produced some strong responses from GPs who often felt that the secondary care system was not always doing all it could to meet the access needs of their patients (see Annex G).

GP commissioning does not have to follow the model of fundholding in terms of, for example, the volume of services GPs commission. Commissioning could, for example, be based around specific services, specialties or even interventions.

The objective or focus would be to sharpen the incentives on the secondary care provider side to respond appropriately to the signals GPs would send as a result of the pattern of their commissioning.

Publishing performance information

The publication of performance information is not only a necessary aspect of public accountability, but can also provide information to inform patients' choices within the health and social care systems, make a public link between spending and outcomes, and highlight progress towards targets. Wide and prominent dissemination of performance information can also improve the quality and timeliness of information[120].

An independent inspectorate (see below) may consider publishing an annual overview performance report on the health and social care system which would collate all targets and associated information and reach an overall judgement on progress. Such assessments need to be seen to be independent and not feel obliged to pull their punches: It needs to be recognised that publishing performance information is not (and should not be) a comfortable thing for the health and social care system.

External support and advice

Support from an external source or agency can often help individual organisations successfully tackle performance problems and can act as a way to disseminate learning and new ways of doing things across the health and social care system. Support may be delivered in a formal way via some specific organisation (such as the Modernisation Agency) and as the result of a specific trigger (failure to meet a target or satisfy a regulatory inspection) or could be informally arranged and provided by another trust.

Independent inspection/regulation

Ensuring that the health and social care system not only reaches minimum standards of quality of care and minimises risk to patients, but also strives for improvements in quality can be enhanced through independent inspection and regulation. The newly established HPSS Regulation and Improvement Authority in Northern Ireland is currently developing ideas for its role and activities, but it could usefully examine the development of similar organisations (such as the former Commission for Health Improvement, now the Healthcare Commission in England). It could also explore the possibility of more formal connections to exploit economies of scale.

This Review has not had the time to work up how any or all of these options for injecting a greater sense of urgency and 'bite' into the performance management system might be developed in the context of Northern Ireland. By way of comparison, and to some extent evidence of what works and what does not, Box 4.3

[120] Currently, performance information is not only buried in the Statistics and Research section of the DHSSPS website, but is limited in scope and extremely user-unfriendly.

summarises the recent experience of developments in the English NHS performance management system.

Box 4.3: Recent experience of developments in the English NHS performance management system: there is no 'magic bullet'.

Over the last five years or so the English NHS has been subject to a barrage of changes in its performance management system in attempts to lever up performance and, in particular, to ensure that Ministerial and government commitments were met.

Between 1997 and 1999, the main focus of health policy was to explore alternative arrangements to the internal market which, in their 1997 manifesto, new Labour had promised to abolish. In place of fundholding, for example, GPs were offered influence via newly reformed health authorities - Primary Care Groups. Importantly, targets - and one target in particular, Labour's manifesto pledge to reduce waiting lists by 100,000 - emerged as a tool of performance management.

Ministerial changes, a commitment to large increases in funding and a perception that the new arrangements were not delivering change fast enough, lead to the drawing up of the NHS Plan in 2000 and a tougher, more centralist system and experiments in rewards and sanctions in relation to an expanded set of longer term targets. Franchising of top management, national performance funds, greater public dissemination of performance ratings ('naming and shaming') and star ratings emerged to increase pressure on the system to deliver.

And overall, the period from 2000 to 2004 was a time which saw remarkable reductions in waiting times and the achievement of other targets set by government. There were also costs. Complaints about micro management by Ministers, the distortion in clinical priorities arising from tactics to meet stringent targets and some evidence of managerial manipulation of performance data became more common. In part (although the NHS Plan flagged this next stage in the development of the performance system) this lead to greater emphasis on 'earned autonomy' - that is, less central interference earned by meeting targets. The creation of Foundation Trusts status embodied this devolutionary shift.

From 2004, the system entered a new phase - greater devolution, but also increased independent monitoring and regulation and the start of experiments in patient choice. Importantly, a new reimbursement system for hospitals began its phased implementation - Payment by Results. This system will not only enable money to follow the choices made by patients, but due to its fixed tariff, provides a very strong financial incentive on above-tariff trusts to reduce their costs. Despite this search for more 'automatic' or devolved mechanisms for levering up performance, the system still retains some tough targets - notably the goal of reducing maximum waiting times from GP referral to hospital admission to 18 weeks.

The current focus of policy is now on purchasing. Primary Care Trusts (formerly Primary Care Groups) have generally been felt not to have performed well, and experiments are now taking place with a form of GP fundholding - GP commissioning - as a possible way of sharpening the purchasing function.

Much in the system is still evolving and drawing hard conclusions about what works and what does not - or rather, what works, but at what cost - is difficult. However, the health system overall has probably learnt the habit of change and has gained a greater confidence in experimenting with new ways of doing things. Importantly, it has also learned the benefits of clinical engagement in the process of change (through, for example, the development of the national service frameworks, and clinical networks).

Given the record on recent and current progress on improving system performance in Northern Ireland, doing nothing would not appear to be an option and ways need to be explored for introducing some 'constructive discomfort' into the system

alongside greater devolution of responsibility and increased independence from government of some functions such as inspection and performance monitoring and reporting to government and the public in general.

Noted earlier was the fact that current recommendations from the Review of Public Administration explicitly rule out one option for sharpening the current performance management system - namely, competition. The RPA consultation document states that *'…the development of new structures will embrace the principle that the commissioning and delivery of services need not be separated organisationally.'* It then goes on to note that *'These principles point clearly to the development of structures characterised, not by the need to generate competition, but by the creation of partnerships between commissioning and delivery…'* (Para 5.10 *The Review of Public Administration Further Consultation*, March 2005)

The RPA's recommendations for reconfiguring health and social care organisations - in particular, the creation of around five Health and Personal Social Services agencies - in effect reinvent a pre-1990 English NHS model in which health authorities received weighted capitation allocations, planned services and directly managed (and set budgets for) the hospital providers in their area. However, despite acknowledging that there *'must be clear lines of accountability to the Department and the Minister for expenditure, quality and performance*' (Para 5.24 vii), and while noting that performance management remains the remit of the Department, it is not clear in this model how performance improvements are actually to be achieved. In particular, it remains to be seen how providers are to be held to account for their performance. While 'partnership and integration' can generate good things for patients and users, there is a distinct danger that the performance model implied by the RPA's structural reform could fail to provide the necessary incentives and sanctions - or 'bite' - to encourage providers of services to continually seek out new ways to improve their performance.

Overall, from the point of view of performance management, it is hard to see any difference between the RPA's recommendations and the way the current system operates.

Nevertheless, if the RPA's reconfiguration recommendations go ahead, *and* it is accepted that a more robust performance management system, with, for example, more explicit rewards and sanctions, needs to be developed, then serious and urgent thought needs to be given to methods for holding providers to account within these new, more integrated structures.

Overall, however, this Review would suggest that some form of separation between the providers of services and the funders/commissioners of services would be an important factor in sharpening up incentives in the system. Given the particular circumstances in Northern Ireland, its population size and distribution, the political governance structures etc, there needs to be further investigation of the most appropriate form of separation, however. While the four health boards have, in theory, acted as commissioner/purchasers, it is not clear that the full benefits of this arrangement have been achieved. It may be that a single pan-Northern Ireland commissioner would be more appropriate. This arrangement would not preclude some devolution of commissioning to GPs (see below). A crucial aspect of such arrangements however is the design of the rules of engagement and the framework

in which commissioners are required to operate. In particular, commissioners would need clear objectives/targets in order to drive performance through their commissioning decisions. The regional level performance management system therefore needs to be reformed to take on serious, long term target setting

In turn, providers themselves need to consider how to devolve functions within their organisations, in particular, ways in which to engage frontline staff with the incentives faced by the organisation as a whole - through, for example, devolution of budgets and associated responsibilities.

The nature and strength of the rewards and sanctions need careful thought. For example, mainly for reasons of scale (and efficiency), the competitive economic environment currently being developed in England is unlikely to be appropriate in Northern Ireland. However, this does not rule out the creative tensions that a separation of purchasing and providing can bring, and nor, for example, the introduction of an activity-based prospective reimbursement system for providers (similar to Payment by Results) with tariff setting (not necessarily fixed at average costs) used to drive improvements in efficiency and selective increases in activity to meet pan-service goals. Nor does it rule out the promotion of greater public and patient awareness of variations in performance in the system.

Moreover, it does not rule out careful expansion of patient choice. While in England choice is being rolled out mainly with a policy emphasis on the leverage it may have over providers (crudely, losing business will stimulate cost and quality improvements), from the patient's point of view, a more formalised and embedded process of choice (not just of hospital, but over the myriad of decisions that are taken throughout the system which affect a patient's care) can improve patient satisfaction and service responsiveness. This may be a weaker incentive than that being introduced in England, but the limits to what could realistically offered by way of choice need to be recognised in what is a relatively small system. Nevertheless, there may be certain services, specialties, operations etc where options do exist for real patient choice and where patients would like to exercise greater choice.

In addition to the separation of the tasks of provision and commissioning, ways of both strengthening the involvement of general practitioners in the system and as part of a devolution strategy for commissioning secondary care services, thought should be given to the practical involvement of GPs in the purchasing of care. Again, Northern Ireland has an opportunity to develop its own approach to this form of devolved commissioning which could build on the Local Health and Social Care Groups.

Finally, no system relies on just one or two performance levers. In England, for example, the new payment system and (managed) patient choice are going to run alongside continued use of targets (renamed 'standards') and, importantly, an evolving regulatory system at arms length from government which aims to promote the ultimate goals of the system - better quality of care, more efficient and cost effective use of resources. NICE, the National Patients Safety Agency, the Healthcare Commission etc, are important organisations which aim to promote better care. Much of these organisations' work and output are public goods available for any system to use and from which Northern Ireland could benefit and could inform development of the new HPSS Regulation and Improvement Authority.

Recommendation 23: There is a need to develop an explicit performance management system with rewards and sanctions which provide enough 'bite' to encourage change and innovation in the health and social care system. There are many options for the types of incentives that could be introduced and their design for Northern Ireland. There should however be a commitment to such reform coupled with further investigation of how incentives can be strengthened.

Recommendation 24: Separation of the tasks of service provision and commissioning is an important factor in sharpening incentives. However, the most appropriate structures (eg single pan-Northern Ireland commissioner; devolved GP commissioning etc) needs further investigation.

Recommendation 25: Alongside changes in the performance management system, there is a need to explore the development of a more transparent priority setting process at national level, together with an explicit 'NHS Plan for Northern Ireland' which sets out outcome-based targets linked to new spending paths.

Annexes

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Annex A

TERMS OF REFERENCE

Background

A1. Health and social services are essential to the health and social well-being of the people of Northern Ireland and it is important that they are resourced appropriately and that they are delivered efficiently and effectively. Inevitably, they are a major call on the resources available for public spending in Northern Ireland and, as such, it is important that the money allocated is used economically and that it properly reflects the levels of need.

A2. The need for health and social care resources is determined by the complex interplay of a number of factors including age, deprivation, spatial distribution of the population, the consequent economies of scale achieved in health and social care facilities, and ability to contribute towards health and social care costs. Northern Ireland has historically had higher levels of per capita public expenditure on health and social care than England (although less than Scotland and similar to Wales). However, there are contributing factors in terms of high levels of morbidity and mortality from major diseases, such as heart disease, a number of different forms of cancer, and respiratory illness. There are also higher levels of disability, social disadvantage, deprivation and structural issues such as rurality.

A3. The Government has sought to address these needs through continued priority for health and social services in public expenditure. In October 2004, the Northern Ireland Finance Minister, Ian Pearson, announced a substantial increase in health and social services spending when he published the 2005-2008 Draft Priorities and Budget. Between 2004-05 and 2007-08 the resources allocated to the Department of Health, Social Services and Public Safety are planned to increase by 25.1% (this compares with a 32.1% uplift in England over the same period).

A4. However, it is clear that the demand for services continues to rise and there are significant cost pressures facing the health and social services in the coming years. These pose considerable difficulty in relation to funding and the current levels of growth in funding cannot readily be sustained. It is also the case that there are a number of deep-seated problems in the provision of services, with lengthy waiting lists, trolley waits and difficulties in meeting the demand for care and treatment. There is therefore a need to examine both the resources available to health and social services and how these resources are actually utilised. Significant reform in service delivery (particularly in the acute sector) in England has resulted in improved performance and the study should assess how to apply these lessons to Northern Ireland.

A5. In April 2002, HM Treasury published an independent review (by Derek Wanless) of the long term resource requirements for the UK Health Service '*Securing Our Future Health: Taking A Long-Term View*'. Subsequently the National Assembly for Wales also commissioned a review (with Wanless acting

as adviser) to examine how the resources for health and social care in Wales could be reformed and services improved.

A6. Professor John Appleby, Chief Economist on Health Policy at the Kings Fund has been invited by the Finance Minister, Ian Pearson, to conduct an independent review of health and social care provision in Northern Ireland. The review will consider the implications of the Wanless studies and the developments in policy in hospital services, primary care and community care in Northern Ireland. The work carried out previously by Wanless will form an integral basis for the review. It will focus on helping to ensure that resources allocated to health and social care are being translated into improved and more cost effective service delivery.

Project Brief

A7. The overall aim of the review is to look at the resourcing of health and social services and to consider how reforms leading to targeted and sustainable investment, effective and efficient delivery structures and appropriate incentive systems can result in improved service delivery. The specific objectives of the review are based on those previously undertaken in Wales and at the UK-wide level. The review will need to consider and make recommendations in the following areas:

- the current position in levels of demand in relation to the levels of funding available;
- the demands of the population for health and social services in NI, taking account of its distinctive characteristics, in terms of long term and sustainable resourcing;
- technological, demographic, medical and other trends over the next two decades that may have implications for the future resource needs of the HPSS sector in NI consistent, where possible, with the approach adopted in the Wanless Review;
- the extent to which resources are being used effectively and efficiently and, if there is evidence of sub-optimal resource utilisation, the issues which are impairing the most efficient and effective use of resources;
- the scope for a more effective use of resources (human, revenue and capital) to bring about a significant improvement in access to, and quality of, services in the HPSS and specifically the optimum balance between prevention, community-based care and acute hospital care;
- ways in which the interactions between the health and social care systems can be improved to maximise performance and the use of resources
- the effectiveness of the organisational and incentive structures, decision-making and accountability processes in health and social care in NI;
- further measures to improve health and well-being which can reduce the demand for health and social services;

Methodology

A8. The review will need to consider the present distribution of resources and the outcomes achieved for the level of spend. It will also be instructive to consider service delivery in terms of comparison with leading practice in England. Performance measures and indicators will also be an important part of the issues to be taken into consideration, and the establishment of incentives to encourage best practice. The review wil take evidence from key stakeholders, including those with experience of delivering cutting edge reform in England, with a focus on gathering evidence of best practice and what works.

A9. The review will take written and oral evidence from the key stakeholders in health and social care provision in Northern Ireland and England including:

- Representatives of patients, clients, carers and service users
- The HPSS family of organisations
- Staff, professionals and unions
- Relevant independent and private sector organisations
- Local political representatives
- Community and voluntary Sector
- ‘Change implementers’ in England’s NHS

A10. This review will not revisit areas where reviews have already been conducted or a policy decision has already been made. The review will, however, seek to utilise the broad consultations and analyses which have been undertaken in support of this work. In particular, the review will build on recent work undertaken to develop a twenty year strategy for health and well-being.

A11. Professor Appleby will be supported in conducting the review by a small team of officials drawn from the DHSSPS, DFP and EPU. In addition, advice and guidance will be sought from a formal reference group including local stakeholders and individuals with direct operational experience of the HPSS sector in GB. An informal advisory group of respected academics in the field of health economics will also advise on the direction and outputs of the review.

Output

A12. The product of the review will be a report to the Finance Minister advising on the optimal use of financial resources to deliver and sustain whole system health and social care services for the people of NI over the next 10 years. The report will also highlight the performance indicators and information requirements needed for successfully monitoring delivery of health and social care services.

A13. It is intended that the review will report in late spring 2005 in time to inform the production of the Draft NI Budget.

Review Steering Group

Dr Andrew McCormick, DFP
Clive Gowdy, DHSSPS
Paul Simpson, DHSSPS

Review team

Prof John Appleby, Chief Economist, King's Fund
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Anne Tohill
Tadhg O'Briain
Leah Sloan
Sarah Benton

In addition, the team were able to call on help from other staff in the Department of Health, Social Services and Personal Safety and the Department of Finance and Personnel.

Informal Reference Group

Anthony Harrison, King's Fund
Prof Nancy Devlin, Department of Economics, City University
Prof David Parkin, Department of Economics, City University
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Prof Martin Knapp, Chair and Co-Director, LSE Health and Social Care
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Dr Nigel Rice, Centre for Health Economics, University of York.
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Prof Ciaran O'Neill Professor of Health Economics and Policy, School of Policy Studies, University of Ulster

Annex B

Respondents to consultation

Bryan Harty	Blackrock Clinic, Dublin
Brian Best	British Medical Association
Brian Patterson	British Medical Association
Helen Ferguson	Carers N Ireland
Alan Braden	Causeway Health & Social Services Trust
Brian Dornan	Causeway Health & Social Services Trust
Margaret Gordon	Causeway Health & Social Services Trust
Neil Guckin	Causeway Health & Social Services Trust
Dr Windsor Murdock	Causeway Health & Social Services Trust
Nevil Oliver	Causeway Health & Social Services Trust
Stephen Mathews	Cedar Foundation
Eileen Thompson	Cedar Foundation
Pip Jaffa	Childcare N Ireland
Pauline Leeson	Childcare N Ireland
Tonya McCormack	Childcare N Ireland
Elaine McElduff	Childcare N Ireland
Christine Best	Crossroads Caring for Carers
Jillian Anderson	DHSSPS
Professor David Bamford	DHSSPS
Clive Gowdy	DHSSPS
Andrew Hamilton	DHSSPS
Fiona Hodkinson	DHSSPS
Dorothy Jeffrey	DHSSPS
Jim Livingstone	DHSSPS
Dr Norman Morrow	DHSSPS
Nuala McArdle	DHSSPS
Denis McMahon	DHSSPS
Heather Robinson	DHSSPS
Paul Simpson	DHSSPS
Kevin Doherty	Disability Action
John Compton	Down Lisburn HSS Trust
Dr Paula Kilbane	Eastern Health & Social Services Board
Richard Black	Eastern Health & Social Services Board
Quentin Coey	Eastern Health & Social Services Board
Pam Garside	Eastern Health & Social Services Board
Patricia Gordon	Eastern Health & Social Services Board
Sean Donaghy	Eastern Health & Social Services Board
William McKee	Eastern Health & Social Services Board
Anne Lynch	Eastern Health & Social Services Board
Angela Paisley	Eastern Health & Social Services Board
Dr David Stewart	Eastern Health & Social Services Board
Hugh Connor	Eastern Health & Social Services Board
Cecil Worthington	Eastern Health & Social Services Board
Jane Graham	Eastern Health & Social Services Board
Dr Peter Beckett	General Practitioner
Dr Tom Black	General Practitioner

Dr Ian Buchanan	General Practitioner
Dr Ian Clements	General Practitioner
Dr Robin Crawford	General Practitioner
Dr Hubert Curran	General Practitioner
Dr Harold Jefferson	General Practitioner
Dr David Ross	General Practitioner
Joleen Connelly	Help the Aged
Duane Farrell	Help the Aged
Pamela McCreedy	KPMG
Norma Evans	Homefirst Community Trust
Alan Gilbert	NHS Confederation
Katherine McDonald	NHS Confederation
Terry Woodhouse	NI Audit Office
Pat McCartan	NI Confederation for Health and Social Services
Bernard Mitchell	NI Confederation for Health and Social Services
Michael Wood	NI Confederation for Health and Social Services
Pauline Stanley	NI Confederation for Health and Social Services
Dr George O'Neill	North & West Health & Social Care Group
Pat Cullen	North & West Health & Social Care Group
Ian Deboys	North & West Health & Social Care Group
Noel Graham	North & West Health & Social Care Group
Linda Wilson	Office of the First Minister and Deputy First Minister
Barney McNeany	Office of the N Ireland Commissioner for Children and Young People
Nigel Williams	Office of the N Ireland Commissioner for Children and Young People
David Finnegan	Review of Public Administration
Gordon Kennedy	Royal College of General Practitioners (NI)
Martin Bradley	Royal College of Nursing (NI)
John Knape	Royal College of Nursing (NI)
William McKee	Royal Group of Hospitals & Dental Hospital Trust
Jillian Anderson	Service Improvement Unit, DHSSPS
Breandan MacCionnaith	Sinn Fein
Stiofan Long	Sinn Fein
John O'Dowd	Sinn Fein
Carmel Hanna	Social, Democratic and Labour Party
Colm Donaghy	Southern Health & Social Services Board
Mairead McAlinden	Southern Health & Social Services Board
Sean McKeever	Southern Health & Social Services Board
Dr Anne Marie Telford	Southern Health & Social Services Board
Stella Cunningham	Southern Health & Social Services Board
Eleanor Hayes	Ulster Community & Hospitals HSS Trust
Alan McFarland	Ulster Unionist Party
Thomas McHaffy	UNISON
Patricia McKeown	UNISON
Dr John Jenkins	United Hospitals HSS Trust
Dominic Burke	Western Health & Social Services Board
Steven Lindsay	Western Health & Social Services Board
Peter McLaughlin	Western Health & Social Services Board
Maggie Reilly	Western Health & Social Services Council

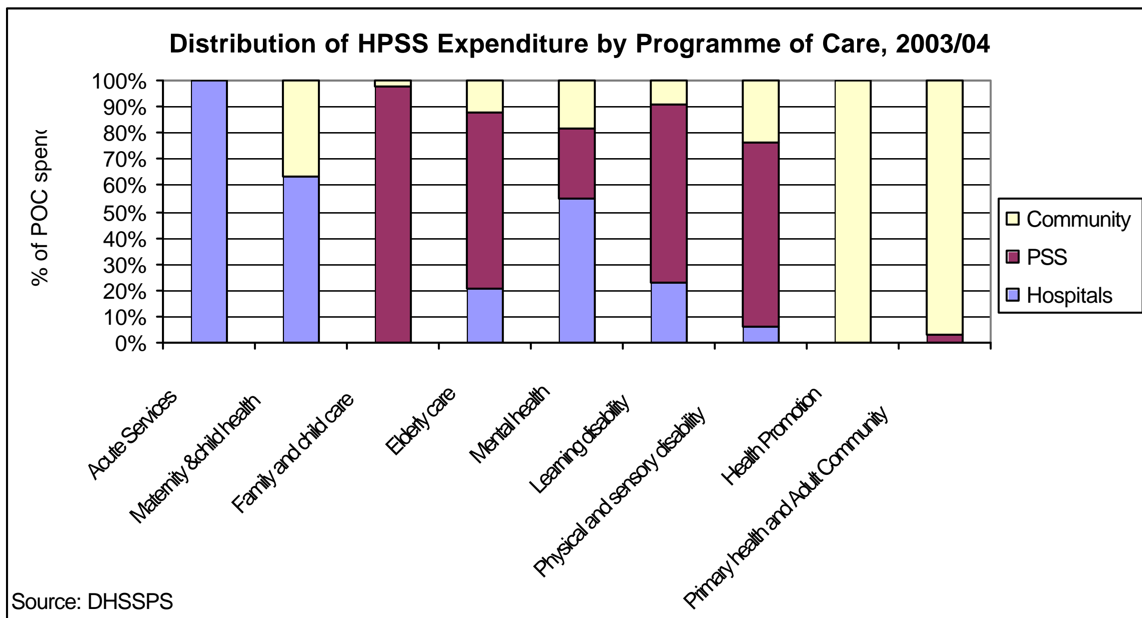
Annex C

TRACKING SPENDING

Hospital, social and community services

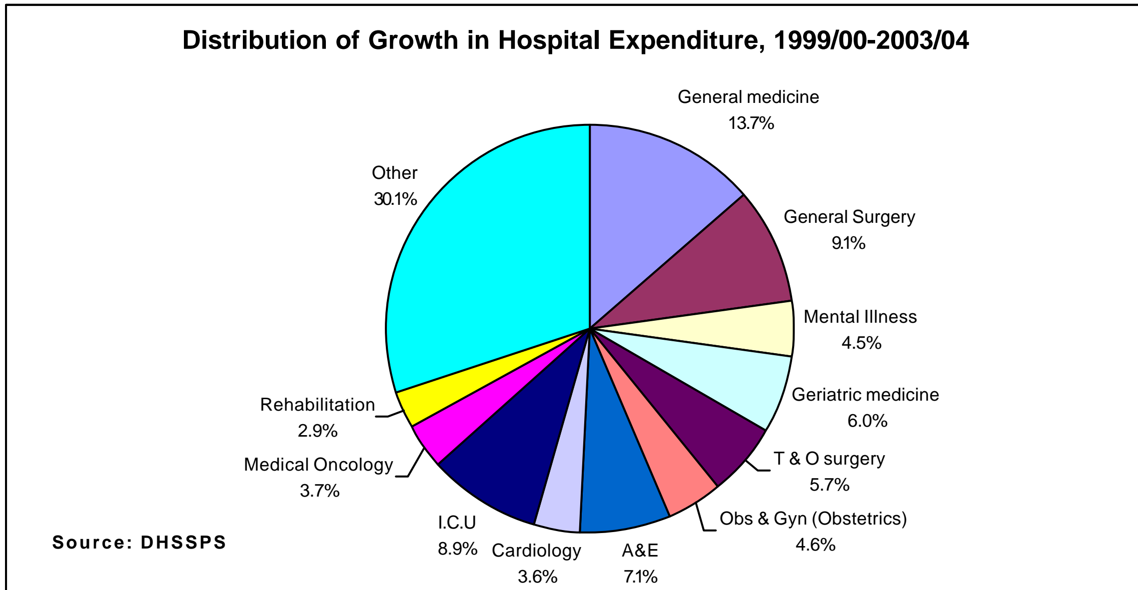
C1. In 2003/04 Hospitals accounted for 54% of Trust spend reflecting the importance of the Acute Programme of Care followed by Personal Social Services (33%) and Community Services (12%). However, Figure C.1 shows that for four POC's (Family and Child Care, Elderly Care, Physical & Learning Disability) the greatest amount of expenditure was in Personal Social Services whilst almost all expenditure for Health Promotion and Primary Health was through Community Services. Over the period 1999/00-2003/04 growth in Hospital expenditure was less than both PSS and Community Services. The greatest contribution to the increase in Trust spend over this period was from Hospital Acute Services (41% of total growth) followed by Social Services for the Elderly (17%) reflecting their overall importance in total spend.

Figure C.1: Whilst hospitals account for most of the HPSS expenditure, they make a relatively minor contribution in terms of most Programmes of Care 2003/04.



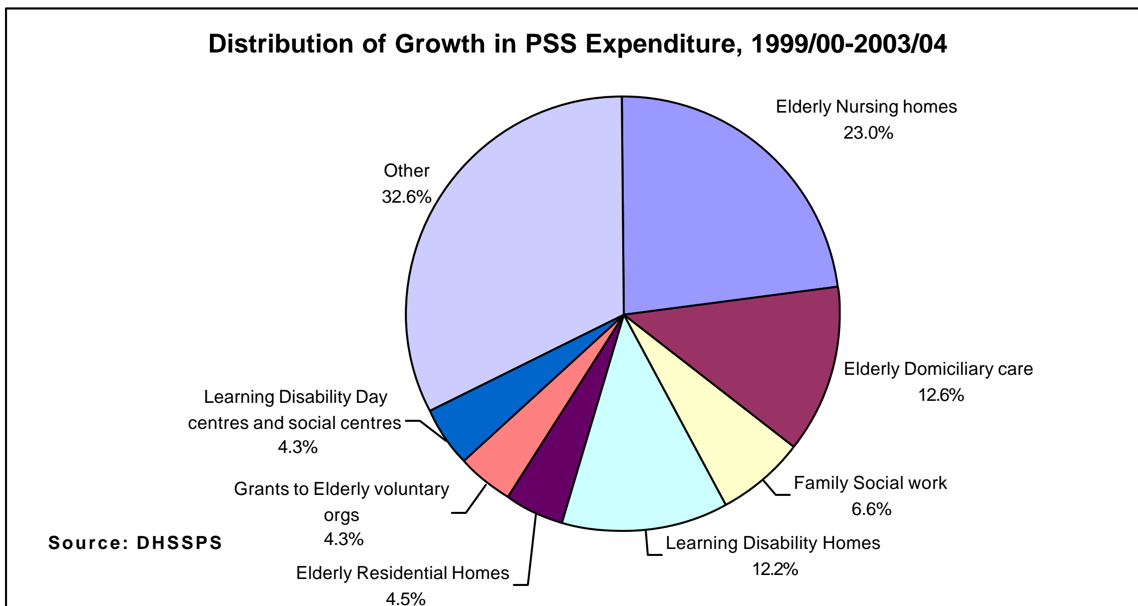
C2. Figure C.2 shows that the largest contributions to the increases in hospital spending during 1999/00-2003/04 came from general medicine and general surgery. Whilst mental illness and geriatric medicine also made a significant contribution to the overall growth, both these specialties experienced lower rates of growth in spend than the hospital average. In comparison, expenditure on A&E and intensive care units grew at a significantly faster rate than the hospital average.

Figure C.2: Contribution to Growth in Hospital Expenditure (+£316m) by Specialty, 1999/00-2003/04



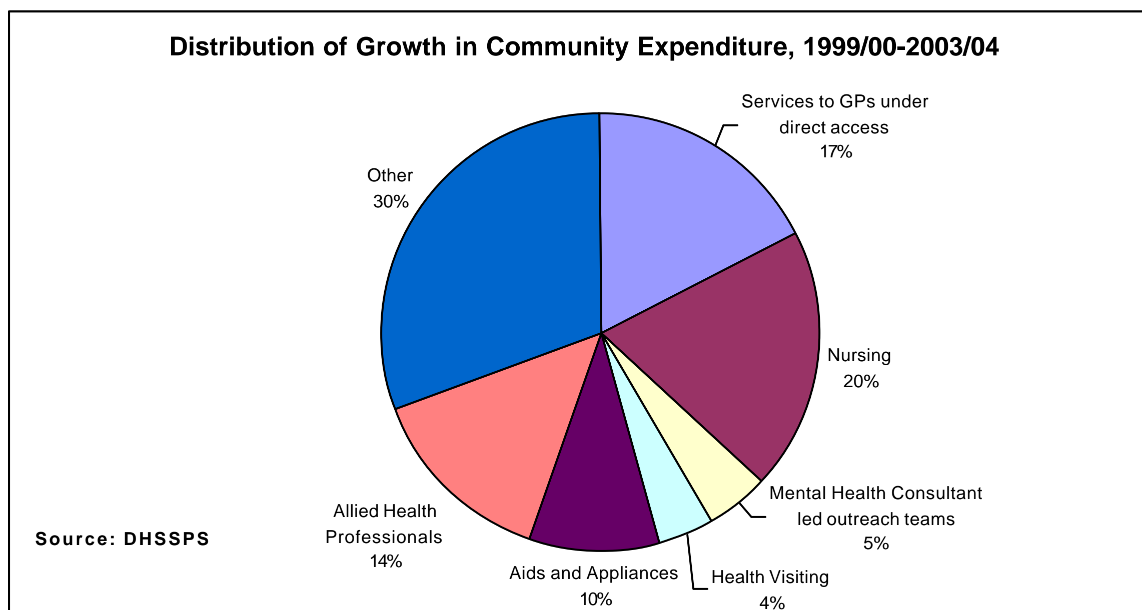
C3. Figure C.3 shows that the largest contribution to the growth in personal social services expenditure over 1999/00-2003/04 came from care for the elderly either in nursing/residential homes or in their own residence. Over this period elderly care expenditure increased on nursing homes (+56%) at a faster rate than residential homes (+16%) and own home (+45%). Indeed, the increase in spend on nursing homes (+£51.7m) was greater than that for general medicine (+£43.2m).

Figure C.3: Contribution to Growth in Personal Social Services Expenditure (+£225m) by Category, 1999/00-2003/04



C4. The growth in expenditure for community services is more widely distributed with only five categories individually accounting for more than 4 per cent of the total increase in spend. Figure C.4 shows that around a fifth of the increase in expenditure on community services went to payments to GP's with direct access payments increasing by 177% over the period compared to 60% growth for all community services.

Figure C.4: Contribution to growth in community services expenditure (+£92m) by category, 1999/00-2003/04



Annex: D

FURTHER DETAILS OF ASSUMPTIONS USED IN CALCULATING FUTURE RESOURCE REQUIREMENTS OF NI HEALTH & SOCIAL CARE SECTOR

D1. A number of options were considered in estimating the long-term sustainable resource requirements of the Health & Social care sector in Northern Ireland. At the extreme, the Wanless analysis could have been rejected completely and an entirely new model of future resource requirement been developed for Northern Ireland specifically. However, given the resource and time constraints on the Review this would not have been practical. It had been hoped to take the Wanless model which had been based on English data only and populate with Northern Ireland equivalents. Under advice from HM Treasury this approach was also rejected as the model was no longer fit for such a purpose.

D2. Therefore, it was decided that the approach would be to take the Wanless spend projections for the UK and estimate Northern Ireland's need adjusted share. One of the questions for consultation set out in the Interim Report of the Wanless Review related to whether health trends would effect different parts of the UK in different ways. In general, the consultation responses indicated that the impact of health trends would be similar throughout the UK but that there would be some differences related to population characteristics. In particular there were differences in population growth, age structure and morbidity. In terms of technology and workforce issues however, international trends were expected to dominate.

D3. The Wanless projections of health spend are presented in terms of both public spending and total health spending as a share of GDP i.e. including the private sector[121]. It could be argued that total health spending should be the focus of attention and that the public sector in Northern Ireland should receive additional funds for the relatively under-developed level of private provision. However, as shown in Section 3.3.2 it is not clear how far Northern Ireland is behind the rest of the UK in this respect, whilst the consultation process indicated that the private sector was growing in Northern Ireland.

D4. The first stage of the analysis was to calculate the baseline figure for England in 2002/03. Although Wanless produced figures for the UK as a whole, the subsequent 2002 Budget set out the comparable figures for England[122]. A further complicating factor is that subsequent Budgets in both Northern Ireland and the UK as a whole for the period up to 2007/08 have diverged from the expenditure projections sets out by Wanless. This could have been taken

[121] Private health spending is assumed in the Wanless Review to remain at 1.2 per cent of GDP throughout the forecast period although in figures presented as part of the 2004 Spending Review HM-Treasury increased the share to 1.4 per cent.
[122] The UK baseline figure was not used as this would have required the needs adjusted shares for Scotland and Wales to also have been calculated. In addition, the HM Treasury figures for England were used in preference of taking a simple population share to reflect that health spend per head is currently lower in England than in the rest of the UK. The HM treasury figures show however, that England's share of total UK spending was projected to increase by 0.1pp a year over period 2002/03 to 2007/08.

account of through, for example, assuming that growth would change in the subsequent periods to compensate, with the result that overall growth up to 2022/23 would have remained the same. However, given that the long-term perspective is being considered it was decided not to consider any short-term variations from the Wanless projections.

D5. The treatment of Personal Social Services was more complicated as the Wanless projections covered only 60% of total PSS expenditure. In addition, the projections presented in the Final Report represent core resource requirements on the basis of the present position adjusted for population and changes in the level of ill health. As a consequence, it is acknowledged that the projections under-estimate the additional resources required. In particular, they do not take into account the resources required to deliver a higher quality service. Whilst the growth rates for heath expenditure may be higher than that which would be expected for more fully developed social services spend projections it was considered reasonable to assume that the growth rate for social services expenditure would be the same as that for health services.

Annex: E

CRITIQUE OF NI REVISIONS TO NAS MODEL

In order to inform the Reviews examination of allocation models in the context of providing a guide to future spending on health and social care in Northern Ireland, an initial critique of the revisions to the NAS model was commissioned from Dr Nigel Rice, at the Centre for Health Economics, University of York.

The following report is based on material supplied by DHSPSS, including background statistical work in support of the revisions suggested.

SUMMARY

E1. The Northern Ireland Executive's Needs and Effectiveness Evaluation (NEE) study is an attempt to evaluate the assumptions underlying the Treasury Needs Assessment Study (NAS) model and to compare these to perceived current knowledge and evidence of the need for health care in Northern Ireland (NI). This exercise resulted in a set of suggested revisions to the NAS model that benefits NI compared to England.

E2. The Needs Assessment Study carried out by the Treasury in 1979 looked at how the need for health care in Scotland, Wales and Northern Ireland compared to England. This exercise resulted in a model (the NAS model) that has been used to inform thinking about the distribution of resources but has not thus far been used to set actual allocations. Since 1979 the NAS model has been updated, the last complete update related to November 1994.

E3. Currently, allocations to NI are based on historical allocation decisions augmented by the Barnett formula. The Barnett formula is a mechanism used to allocate new monies to the devolved administrations based on population shares. It is not weighted for need.

E4. Should the use of the Barnett formula be challenged as an appropriate mechanism to allocate monies then the NAS model would be a needs-based approach readily available to the Treasury. On the basis of the results from the 1994 update of NAS, Health and Personal Social Services (HPSS) in Northern Ireland was estimated to be *over-funded* by £74 million.

E5. The NEE contains two fundamental pieces of analysis. The first is a routine update of the NAS model. This simply updates the population, morbidity and deprivation data together with updates to the weights attached to these (based on evidence from English resource allocation). The assumptions behind the updates appear sensible. Updating the NAS model suggests that HPSS is *over-funded,* relative to its current funding position (based on the Barnett formula), by around £35million.

E6. The second analysis suggests fairly substantial revisions to the NAS model made on the basis of judgement informed by research evidence. A key component to the revisions is the change in emphasis away from morbidity and

towards deprivation as exerting influence on the need for health care and the percentage of total expenditures that should be weighted by these needs factors. A further important element is the suggested increased weighting afforded to sparsity which is intended to reflect the greater costs associated with providing services to rural and remote areas.

E7. Revisions to the model are more ambitious and result in HPSS being *underfunded* by an estimated £135 million relative to its current funding position.

E8. More speculative adjustments are also noted which if implemented would raise the estimated *underfunding* to as much as £233 million. However, it is stressed that further probing of these issues is required before these additional adjustments are recommended.

E9. The main difficulty is that the revisions offered to the NAS Treasury model are based largely on informed judgement and interpretations of research evidence. This is particularly the case for arguments made to shift the emphasis from morbidity towards deprivation factors. I am not of the opinion that the arguments presented are sufficiently well advanced to suggest these fundamental revisions to the model represent a serious candidate for an alternative needs based approach.

E10. At best, the arguments made would form the basis of initiating a dialogue with the Treasury about the most appropriate needs-based mechanism for allocating resources. This is not to say that the claims are without foundation but further evidence, backed by empirical analysis, would need to be presented to support the revisions offered before they can be taken seriously.

E11. Other fundamental revisions to the NAS model are supported by research evidence of a more robust nature and, there does appear to be prima facie evidence of a case for claiming the costs of providing health and social care services in remote and rural areas in NI is more expensive than England. However, I feel that further research is required to support these assertions.

E12. In its present form, it is difficult to see how the judgements underlying the revisions could be used to gain a consensus among interested parties that these offer a more appropriate means of assessing relative needs. In my view, should a needs based approach be adopted then an analysis of need supported by empirical evidence obtained through a statistical analysis of relative health care needs across the countries of the UK is required. However, it is recognised that such a study would be data intensive requiring information measured at a meaningful level of aggregation and of a comparable nature across each of the devolved administrations.

E13. While the evidence on NI comparative levels of morbidity and deprivation suggests a needs weighted approach as an appropriate mechanism to ensure an equitable allocation of resources, the evidence presented is not, in my opinion, of sufficient scientific quality and objectivity to suggest the revised model as a credible alternative to the NAS model. Ultimately both the NAS and the revised model are based on informed opinion and judgement and

arguments concerning the plausibility of the NAS model could just as easily be aimed at the revised model offered by the NEE exercise.

E14. In short, whilst the NAS model may itself be imperfect, it has the support of the Treasury as a needs based approach for potentially informing relative health care allocations across the devolved administrations. Convincing the Treasury that the revisions offered by the NEE exercise are a credible alternative to NAS would, in my opinion, prove difficult.

E15. In the absence of a thorough statistical analysis of the relationship between need and health care use across the devolved administrations, I would suggest that the *routine update* to the NAS model provides the most appropriate currently available method for NI to assess its potential funding position under needs weighting.

MAIN REPORT

Introduction

E16. An interdepartmental study on the relative public expenditure needs of England, Scotland, Wales and Northern Ireland was carried out by HM Treasury in 1979. The exercise, known as the Needs Assessment Study, resulted in a model, the NAS Model, which looked at how need for health care in each of the devolved administrations compared to England. It was not intended to measure absolute need. Since 1979 the NAS model has been updated, the last complete update related to November 1994. The model has been used to inform thinking about the distribution of resources but has not thus far been used to set actual allocations. The 1994 update of NAS indicated that, on the basis of the model assumptions, Health and Personal Social Services (HPSS) in Northern Ireland was over-funded by £74 million.

E17. The current system of allocations to Northern Ireland (NI) is based on historical allocation decisions augmented by the Barnett formula. During the 1960s and 1970s, public expenditure plans for Scotland, Wales and NI were settled collectively and by negotiation within the wider public expenditure framework.[123] This set the precedent for funding to the devolved administrations and forms the core of the budgets allocated. It has been claimed that this core reflects the higher needs, which it is argued the devolved administrations have, because it was, at least in part, determined by arguments over need relative to England[2].

E18. The Barnett formula is a mechanism used to allocate new monies for comparable (to England) programmes to the devolved administrations based on their population shares. It only applies to changes on spending plans and the underlying core remains unaffected.

E19. A criticism of a strict application of the Barnett formula is that it will result in convergence in per capita spending as the core is diluted by new monies which

[123] See Edwards, T. (2001) The Barnett Formula. *House of Commons Library, Research Paper 01/108*.

is allocated on a population basis alone. Presently there appears to be little evidence that convergence is taking place.[124]

E20. Should the use of the Barnett formula be challenged as an appropriate mechanism to allocate monies then the NAS model would be a needs-based approach readily available to the Treasury. The NI Executive's Needs and Effectiveness Evaluation (NEE) study is an attempt to evaluate the assumptions underlying the NAS model and compare these to perceived current knowledge and evidence of the need for health care in NI.

E21. The NEE contains two fundamental pieces of analysis. The first is a routine update of the NAS model. This simply updates the population, morbidity and deprivation data together with updates to the weights attached to these (for example by updating the cost-weights attached to population demographic data). The second analysis suggests fairly substantial revisions to the NAS model made on the basis of judgement informed by research evidence. A key component to the revisions is the change in emphasis away from morbidity and towards deprivation as exerting influence on the need for health care and the percentage of total expenditures that should be weighted by these needs factors. A second important element is the suggested increased weighting afforded to sparsity which is intended to reflect the greater costs associated with providing services to rural and remote areas.

E22. The simple update of the 1994 NAS model results in an estimated *over-funding* of HPSS of around £35m (needs index of 108 for NI compared to England index of 100). Revisions to the model are more ambitious and result in NI being *underfunded* by £134m (the needs index increases to 117). These revisions are based on what is termed "clear and objective evidence".

E23. More speculative adjustments are also noted which if implemented would raise the *underfunding* to as much as £233m. These adjustments are based on what is termed "professional judgement supported by research". However, it is stressed that further probing of these issues is required before these additional adjustments are recommended.[125]

E24. The purpose of this note is to assess the validity and robustness of the suggested revisions to the NAS model.

The NAS model

E25. The NAS model calculates NI expected need for health care compared to England on the basis of population size and structure, their health and social care needs and cost factors due, for example, to rurality. Each of the needs and population factors are expressed as a ratio to their equivalent English factor. For example, since SMRs are greater in NI compared to England this needs factor would attain a ratio greater than 1.

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[124] See Midwinter, A. (2002) *Northern Ireland's Expenditure Needs: A Preliminary Assessment.* Research Paper 81/02; Research and Library services, Northern Ireland Assembly.
[125] P A21.33: Appendix 2.5. Review of Needs Assessment Study (NAS) Model – Hospital and Community Health Services (HCHS), Family Health Services (FHS), Personal Social Services (PSS), and Capital.

E26. Individual factors may be given a weight between 0 and 1 to indicate its assumed influence on the need for health care. For example, SMR < 75 is weighted by 0.6 as a morbidity indicator for Health and Community Health Services (HCHS); composite deprivation indices are derived by weighting individual deprivation variables and summing across these.

E27. The individual indicators are then multiplied by the proportion of expenditure to which it is assumed to relate. For example, for HCHS morbidity factors are applied to 77% of expenditure, whereas population demographic factors are applied to 100% of expenditure. Accordingly morbidity is afforded less relative weight in determining putative allocations than demographics. These are then multiplied by each other to produce a composite needs, population and cost (rurality) factor. It is this composite factor that could form the basis of future allocations.

E28. Details of the NAS model for each of the programme components, HCHS, Family Health Services (FHS) and Personal Social Services (PSS) are provided in Appendix I.

E29. The NAS model methodology is *normative* and *judgemental*. It is assumed that the indicators chosen to reflect need have a causal relationship with expenditure or service use. These indicators were selected on the basis of plausibility and judgement and were not chosen or indeed weighted on the basis of a statistical analysis of the relationship between need and the use of health care. In this respect the NAS methodology departs from modern resource allocation models employed to distribute monies across trusts, regions and health boards within England, Wales, Scotland and NI.

Routine update to 1994 NAS Model

E30. The routine update to the 1994 NAS model consists of applying current or more recent data than those used previously. Accordingly, the population data and data on morbidity and deprivation indicators are updated. Also, the weights applied to the population demographics are updated to reflect recent evidence from HCHS work in England. The key routine updates are outlined below.

E31. The rationale for updating the population data from 1994 to 2001 (and maintaining updated data) is NI's faster growing population and changing age profile, such that (taken from Chapter 2[4]):

- By 2010 the population aged 65+ is expected to grow by 15%: the corresponding figures for England, Scotland and Wales are 8%, 7% and 7% respectively.
- Growth rates for the 85+ years age group are expected to show even greater differences between NI and the rest of GB (to 2025).[126]
- However, it ought to be noted that by 2025, older people will still make up a smaller proportion of the population in NI compared to the proportion of population in the rest of GB.

[126] Chapter 2 – Assessing the needs of the population.

- NI has a young population with 30% aged under 20 years compared to 25% in England. It also has a higher birth rate (11% higher), although this gap is narrowing.

E32. The population demographic structure has implications for needs assessment as the very young and elderly have higher than average health care expenditures. Based on expenditures per head in 1997/98 on HCHS, it is claimed that it would take a 1% increase in resources per year in real terms to meet the additional costs associated with demographic growth and change up to 2015 and at least as much thereafter.[127] Note that Midwinter points to similar calculations for Scotland resulting in an increase of only 0.23% over three years.[128]

E33. The second adjustment relates to the weights applied to the age profiles (paragraphs (iii) and (iv), pA2.82 of Appendix 2.5.). These are updated to reflect the weight used for HCHS resource allocation in England (using 1997-99 data). It is claimed that updating the cost-weights would lead to a reduction in the 1994 NAS calculated over-funding of NI.

E34. It is further claimed that UK wide weights should be applied (as opposed to weights from England only). This would increase allocations to NI (paragraph (iv)) due, it appears, to NI and Scotland having greater per head expenditures for the 45+ age groups compared to England (although weights for younger age groups would decrease).[129] However it is not clear what proposals are made to calculate UK weights. If these were calculated on the basis of a population-weighted average of England, Scotland, Wales and Northern Ireland then they would be heavily influenced by English cost weights due to the superior population and the benefit to NI of using UK weights may not be as great as assumed. However, in principle it appears sensible to base weights on a UK average rather than a single country alone.

E35. The simple update of data and age cost-weights is of little contention and appears to be a suitable way to proceed to gauge NI comparative level of need within the context of the NAS approach.

Model revisions

E36. Model revisions are based on the above routine updates to the 1994 NAS model together with various changes to the individual indicators within each of the expenditures programmes, changes to the relative weight that morbidity and deprivation factors are afforded and revisions to the amount of expenditure to which need is applied.

E37. The main features of the recommended revisions are outlined below.

[127] Appendix 2.2. Study 2 – Needs and Effectiveness Evaluation: Relationship between Age and Cost of Service. Section: Summary of Detailed Analysis: Hospital, Community and Health Services.
[128] P20, para. 63. Midwinter, A. (2002) *Northern Ireland's Expenditure Needs: A Preliminary Assessment.* Research Paper 81/02; Research and Library services, Northern Ireland Assembly.
[129] See Annex 1, Table 1: Expenditures (£) per head of population by age (HCHS excluding maternity services), Appendix 2: Detailed Papers on Factors Affecting Need.

Need in relation to morbidity and deprivation

E38. The major revisions with respect to need are:

- an adjustment to the proportion of expenditure to which needs factors are applied such that this becomes 100% for HCHS, FHS and all 3 PSS components. Currently the NAS model applies needs factors to 90.5% of expenditure for HCHS, 76% for FHS, 52% for PSS Elderly, 62% PSS Children and 32% PSS Other,
- a shift in emphasis within programmes such that expenditure factors for morbidity and deprivation are afforded equal weight. For example, for HCHS morbidity is given an expenditure weight of 77% and deprivation a weight of 13.5%. A shift to equal weight together with needs factors being applied to 100% of expenditure would necessarily imply weights of 50% and 50% respectively.

E39. Shifting the emphasis from morbidity factors towards deprivation and increasing the amount of expenditure to which needs factors are to be applied benefits NI due to it having higher levels of deprivation compared to England. For example, the following comparisons are noted:

- SMR < 75 – NI Standardised Mortality Ratio for those aged under 75 is 4% above the UK average (England is 3% below UK average).
- NI has the lowest proportion of the working age population in employment – 66% compared to 76% in England. Rates for the very long term unemployed (5 years or more) is higher in NI (18.3%) compared to England (highest figure across English regions is 11.7% in the North East).
- Income Support Benefit – The level of recipients is 68% higher in NI compared to England.
- Disadvantaged children – The proportion of lone parent households is higher in NI (12.6%) compared to England (9.1%).

E40. The overall effect of the revisions is that per capita spending in NI should be at least 17% higher than that of England. This is equated to an additional £190m for 2000-01.[130]

E41. The recommendations of applying needs factors to 100% of expenditure and shifting the emphasis from morbidity towards deprivation are based on a review of resource allocation models in the UK and how these have been implemented. The arguments are set out in the document "Health and social care needs: The impact of deprivation".

E42. For example, it is claimed that the mix of deprivation, morbidity, and mortality indicators in the Acute Needs Index for HCHS expenditures in England suggests that their relative influence is in the ratio 40%: 40%: 20%. The `Arbuthnott Index' used in Scotland comprises of a composite indicator of need consisting of three deprivation indicators and one mortality indicator (all of equal weighting) suggesting a ratio of 75% to 25% in favour of deprivation.

[130] Paragraph 8, page 5: Needs and Effectiveness Evaluation: Health and Social Care: Executive Summary, July 2002.

E43. The paper rightly states that "direct measures of ill-health or morbidity would be used within the HCHS and FHS components of the NAS model as the link between such indicators and this type of service need is clear and direct." (p1, paragraph 3.) It also notes that evidence on morbidity is often limited in routinely collected data sources and that the morbidity data collected is often problematic through biases inherent in self-reported measures. This is often the case when using small area statistics (the basis of many resource allocation models) where area socio-economic and deprivation data are by comparison more abundant.

E44. As a consequence, the majority of resource allocation models use, alongside limited morbidity data, mortality, socio-economic and deprivation data. These are often viewed as proxies for morbidity. However, they can also be seen as determinants of the underlying social causes of the need for health care.[131]

E45. Given that morbidity data is often in short supply and that socio-economic and deprivation data is relatively abundant it is not surprising that resource allocation models contain relatively more deprivation indicators compared to morbidity indicators.

E46. The approach often adopted in resource allocation models is to view both morbidity and socio-economic or deprivation variables as drivers of health care need. The relationship between these factors is derived from a regression model of service use on such indicators. Many factors combine to influence the outcome of such a process including the assumptions made in specifying the model, the degree of collinearity between the variables and the order in which variables are added to a model. The weight afforded to morbidity and deprivation is determined by the regression model estimates.

E47. The NAS model appears to view deprivation and morbidity as having distinct influences on the need for health care and on this basis they are provided with weights based on judgement. If it is assumed that deprivation influences the need for health care largely through its impact on morbidity, then a normative analysis would place greater weight on legitimate measures of morbidity. This appears in to be the case with NAS allocations for HCHS expenditures where mortality is applied to 77% and deprivation to 7.5% of expenditure.

E48. The basic problem with the revisions is that they are largely judgemental but based on interpretations of research evidence that employs a different (regression based) approach to assessing relative needs. In the absence of a statistical analysis of relative health care needs across the countries of the UK, it is difficult to see how the judgements underlying the revisions could be used to gain a consensus among interested parties that these offer a more appropriate means of assessing relative needs.

E49. While the evidence on NI comparative levels of morbidity and deprivation suggests a needs weighted approach is required to ensure an equitable allocation of resources, the evidence presented is not, in my opinion, of

[131] For example, the presence of carers in the home will influence demand for health care, or high earning households may have a greater predisposition to use private health care.

sufficient scientific quality and objectivity to support the revised model as a credible alternative to the NAS model.

E50. Ultimately both models are based on informed opinion and judgement and arguments concerning the plausibility of the NAS model could just as easily be aimed at the revised model offered by the NEE exercise.

E51. At best, the arguments made could form the basis of initiating a dialogue with the Treasury about the most appropriate needs-based mechanism for allocating resources to the devolved administrations. However, I am not of the opinion that the arguments are sufficiently well advanced to suggest the revised model is a serious candidate for an alternative needs based approach.

Sparsity

E52. The NAS model includes a `sparsity factor' to compensate for the additional cost of providing services in sparsely populated areas. The sparsity factor is calculated as follows:

- For HCHS sparsity is based on the proportion of people living in District Council areas with a population density of less than 1 person per hectare compared to the equivalent proportion in England. The factor weight afforded this variable is 12.5%. It is unclear what the rationale was applied to determine this weight.
- For FHS the sparsity is calculated by expressing total GMS expenditure including expenditure on Rural Practice Payments (RPPs) as a percentage of GMS expenditure without RPPs. This is then expressed as a ratio to the equivalent English figure.
- For PSS the same sparsity variable and weight as applied to HCHS is used.

E53. The sparsity factor is then applied to 12.5% of HCHS expenditures, 28% of FHS expenditures and 50% of each of the components of PSS expenditures. These sparsity expenditure weights are intended to reflect the travel-related elements of each of the health and social care components. For example, it is estimated that 12.5% of HCHS expenditure involves travel-related services (ambulance and community health services).

E54. The Executive's NEE study, drawing on research into the additional costs of providing health and social care to sparsely populated areas, suggests that a sparsity cost premium of 20%, rather than the 12.5% assumed for HCHS would by justifiable for NI. A more ambitious estimate of 30% is also suggested. For PSS the same estimate of 30% (again rather than 12.5%) is also suggested.

E55. These estimates are derived from a study by MSA Ferndale[132] that involves estimating the travel related costs that would be incurred if equality of access to services (independent of location) were to be achieved in all areas. The costs are then related, via regression based methods, to relevant characteristics of areas considered. This relationship between cost and area characteristics allows the researchers to impute the travel costs for other areas not included in the original research.

[132] MSA Ferndale. (2001) The Costliness of Rurality in the Provision of Health and Social Services, Internal Project Paper.

E56. This research provides evidence that the travel cost of providing health and social care to remote areas in NI is more expensive per head than in England. The research contains a couple of fundamental assumptions - for example, that NI Health Boards can be considered operationally equivalent to Districts in England, and that the ratio of travel costs for Home Care Services between NI and England can be applied to all other health and social care services - and it would be useful to assess the materiality of these assumptions. However, there does appear to be prima facie evidence of a case for claiming the costs of providing health and social care services to remote and rural areas in NI is more expensive than England.

More speculative revisions (to be further probed)

E57. These, more speculative, adjustments concern the influence that individual deprivation indicators exert on the overall deprivation index for each of the expenditure programmes. These are summarised in Appendix II.

E58. It is further suggested that NI should be compensated for the additional costs faced by the DHSS due to lower levels of provision of private health care in NI compared to England. The argument appears to be that in England the private sector releases the burden on the publicly provided health service (hence the public sector receives a greater allocation than it needs) and that this is not the case in NI, at least not to the same extent. It is claimed that an appropriate compensation could amount to £25m.

E59. A more detailed analysis of the comparative use of private nursing homes was provided as supporting evidence for the differential cost NI faces per capita compared to England. A survey of self-funding of nursing home places in NI suggests this represents 15% of all nursing homes places. The comparable figure for England is estimated at 33%. Reasons provided for the lower level of self-financing in NI include higher historical levels of unemployment, lower wages and lower property values. The analysis suggests there is prima facie evidence of a higher burden placed on the public sector in NI to provide nursing home care.

E60. A further adjustment is suggested to compensate for the perceived additional costs arising from the tensions in NI resulting in higher levels of stress and an increased burden on the health service. An estimate of £18m is claimed as an appropriate amount. This appears to be based largely on an analysis of anti-depressants and ulcer healing drugs. It is claimed that the higher use of these drugs in NI compared to England is related to the NI “Troubles”. It is unclear why these additional costs are not accounted for through increased levels of morbidity and why a separate adjustment as proposed is required.

E61. It is claimed that should the above factors be accounted for NI would currently be *underfunded* by as much as £233m.

E62. The proposed revisions are largely judgemental and not grounded on strong evidence. It is noted that the report[133] lists these revisions as "Other Issues to be Probed (identified through professional judgement supported by research)". Further research on these issues is required before firm recommendations for changes to the NAS model should be made.

Conclusions

E63. Currently the system of allocating HPSS funding to NI is based on the Barnett formula. This system allocates monies on the basis of a baseline that forms the core of the budget together with a formulaic element that applies to new monies. The baseline reflects historic allocations to devolved administrations while the formulaic element allocates on the basis of population shares alone. It only applies to changes on spending plans and the underlying baselines remain unaffected. The Barnett formula has been criticised on the grounds that is does not reflect needs, and that over time the formulaic element will ensure convergence in spending across the devolved administrations.

E64. The Treasury 1994 NAS model is suggested as a readily available alternative to the Barnett formula that has the benefit of containing a weight for need. Under needs weighting, it is argued that NI, which has higher levels of morbidity and deprivation, would benefit comparatively to England. However, an application of the 1994 NAS model indicates that NI is currently *over-funded* by £74m. A simple update of the model using currently available data suggests an *over-funding* of £35m. The revisions to the NAS model suggest that NI is *under-funded* by £135m.

E65. The suggested revisions to the NAS Treasury model are based largely on informed judgement and interpretations of research evidence. This is particularly the case for arguments made to shift the emphasis from morbidity towards deprivation factors. I am not of the opinion that the arguments presented are sufficiently well advanced to suggest these fundamental revisions to the model represent a serious candidate for an alternative needs based approach. At best, the arguments made would form the basis of initiating a dialogue with the Treasury about the most appropriate needs-based mechanism for allocating resources. This is not to say that the claims are without foundation but further evidence, backed by empirical analysis, would need to be presented to support the revisions offered before they can be taken seriously.

E66. Other fundamental revisions to the NAS model are supported by research evidence of a more robust nature and there does appear to be prima facie evidence of a case for claiming the costs of providing health and social care services in remote and rural areas in NI is more expensive than England. However, I feel that further research is required to support these assertions.

[133] P A21.31: Appendix 2.5. Review of Needs Assessment Study (NAS) Model – Hospital and Community Health Services (HCHS), Family Health Services (FHS), Personal Social Services (PSS), and Capital.

E67. Overall, while some elements of the proposed revisions are supported by empirical research providing prima facia evidence for a claim for increased funding support, there is a general lack of rigorous statistical analysis offered from which an independent analyst could assess with any great degree of certainty the validity of the claims made.

E68. In the absence of a thorough statistical analysis of the relationship between need and health care use across the countries of the UK, I would suggest that the updated NAS model provides the most appropriate available method for NI to assess its potential funding position under needs weighting.

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February 2005

Appendix I

The NAS model employs a similar methodology for HCHS, FHS and PSS components of expenditure but differs in the groupings used to define population demographics, the chosen indicators of need and the costs of delivering services. The key components to the NAS model are:

HCHS –

- Population structure - the population is broken down by births and 7 selected age bands (0-4 through to 85+) and weighted by English HCHS expenditure weights.
- Morbidity - measured using SMR < 75 with a weighting of 0.6.
- Deprivation – based on a composite indicator consisting of 3 equally weighted factors: Isolated Elderly, Housing Conditions, and Income Support.
- Fertility – a measure of the average number of children that women would have over child bearing years assuming age-specific fertility rates.
- Sparsity – Proportion of people living in District Council areas with a population density of less than 1 person per hectare.
- Resource cost differences – based on additional HCHS expenditure experienced in Thames regions of England compared to total English HCHS allocation.
- Teaching Expenses adjustment

The factors are applied to the following percentage of expenditure:
Population structure: 100%
Morbidity: 77%
Deprivation: 7.5%
Fertility: 6%
Sparsity: 12.5%

FHS –

- Population structure – Similar procedure to HCHS but using five age categories (0-4, 5-15, 16-64, 65-74, 75+) and weighted by English FHS expenditure weights.
- Morbidity – combination of SMR < 75 and an indicator of the percentage of population in physically demanding (manual) occupations. The two factors are weighted in ratio 0.8:0.2.
- Deprivation – based on a composite index consisting of the following factors: Isolated Elderly, Housing Conditions, IS recipients, Children in Lone Parent Families on IS, and Children in Lone Parent Families. The relative weightings applied to these are 0.3, 0.1, 0.4, 0.1, and 0.1 respectively.
- Fertility – as HCHS
- Sparsity - calculated by expressing total GMS expenditure including expenditure on Rural Practice Payments (RPPs) as a percentage of GMS expenditure without RPPs.

The factors are applied to the following percentage of expenditure:

Population structure: 100%
Morbidity: 40%
Deprivation: 30%
Fertility: 6%
Sparsity: 28%

PSS –
(1) Elderly (population aged 65+):

- Population structure – divided into 3 sub-groups (65-74, 75-84, 85+) and weighted using weights 1.0, 4.5 and 14.2 respectively.
- Deprivation – Composite index consisting IS recipients, Isolated Elderly and Housing Amenities. The three factors are weighted in ratio 0.3, 0.6, 0.1 respectively.
- Disability – prevalence of disability among adult population.
- Sparsity – as with HCHS
- Resource cost differences – based on comparison of average earnings of PSS professionals.

The factors are applied to the following percentage of expenditure:
Deprivation: 50%
Disability: 2%
Sparsity: 50%
An overall index is calculated by multiplying the following factors: Population; Deprivation, Disability and Sparsity; and Resource cost differences.

(2) Children (< 18):

- Population structure – single weight applied to under 18 age group.
- Deprivation – composite index consisting of IS recipients in under 60 age group, Children in Single Parent Families (2 versions of), Housing Conditions, Population density. These factors are weighted in ratio: 0.2, 0.125, 0.125, 0.05 and 0.5 respectively.
- Disability – as per PSS Elderly.
- Sparsity – as per PSS Elderly
- Resource Cost Difference – as per PSS Elderly.

The factors are applied to the following percentage of expenditure:
Deprivation: 60%
Disability: 2%
Sparsity: 50%
An overall index is calculated by multiplying the following factors: Population; Deprivation, Disability and Sparsity; and Resource cost differences.

(3) Other:

- Population structure – single weight applied to 18 to 64 year age group.
- Deprivation – composite index consisting of IS recipients in under 60 age group, Children in Single Parent Families (2 versions of), Housing Conditions. These factors are weighted in ratio: 0.5, 0.2, 0.2, and 0.1 respectively.
- Disability – as per PSS Elderly.

- Sparsity – as per PSS Elderly
- Resource Cost Difference – as per PSS Elderly.

The factors are applied to the following percentage of expenditure:

Deprivation: 30%
Disability: 2%
Sparsity: 50%

An overall index is calculated by multiplying the following factors: Population; Deprivation, Disability and Sparsity; and Resource cost differences.

An overall need factor for PSS is calculated by averaging the needs factors for the three sub-programmes using weights that are proportions of total PSS spending in England on each group. The weights are 46% for elderly, 34% for children and 20% for other adults.

Appendix II

These, more speculative, adjustments concern the influence that individual indicators exert on the overall deprivation indicators for each of the expenditure programmes.

These are summarised as follows[134]:

HCHS –
- Isolated Elderly – increase weight from 0.33 to 0.40
- Poverty – increase weight from 0.33 to 0.50
- Housing Conditions – reduce weight from 0.33 to 0.10

FHS-
- Isolated Elderly – reduce weight from 0.30 to 0.20
- Poverty – retain at 0.40
- Lone Parent Families – increase weight from 0.10 to 0.15
- Lone Parent Families in Poverty – increase weight from 0.10 to 0.15
- Housing Conditions – retain at 0.10

PSS –

Elderly
- Isolated Elderly –reduce weight from 0.60 to 0.30
- Elderly Poverty – increase weight from 0.30 to 0.60
- Housing Amenities – retain weight at 0.10

Children
- Population Density – reduce weight from 0.50 to 0.30
- Adult Poverty – increase weight from 0.20 to 0.30
- Lone Parent Families – reduce weight from 0.125 to 0.10
- Lone Parent Families in Poverty – increase weight from 0.125 to 0.20
- Housing Conditions – increase weight from 0.05 to 0.10

Other
- All weights remain unchanged

[134] P A21.31: Appendix 2.5. Review of Needs Assessment Study (NAS) Model – Hospital and Community Health Services (HCHS), Family Health Services (FHS), Personal Social Services (PSS), and Capital.

Annex: F

EQ-5D: Summary measurement of population health

F1. The Health Survey for England (2003) provides EQ-5D data for some 16,000 adults sampled as part of a national survey conducted in the recent past. The EQ-5D data in this survey are unfortunately limited to the reported problem levels on each of the dimensions of EQ-5D since the English survey omitted self-rated health status recorded on a 0-100 visual analogue scale (VAS). These data are available for the Northern Ireland survey however.

F2. To enable comparison of health status at a population level, EQ-5D data were first converted into an index form ($EQ\text{-}5D_{index}$). This index is computed by applying *social preference weights* to the self-reported level of problem on each of the five dimensions. These weights were previously established by surveying a representative sample of the UK population using Time Trade-Off (TTO) procedures as part of the Measurement and Valuation of Health (MVH) project commissioned in 1993 for the then Department of Health and Social Security. These TTO-based social preference weights have been widely reported and form part of the reference case methodology advocated for technology appraisals conducted by the National Institute for Clinical Excellence.

F3. Mean $EQ\text{-}5D_{index}$ values were computed separately for men and women in the HSE (2003) survey. Values were computed for successive 10-year age groups in each case. Hence for each cell in this 7 by 2 matrix it is possible to identify a mean $EQ\text{-}5D_{index}$ and its corresponding standard deviation. This process establishes a set of normative population values for EQ-5D, in effect defining the *expected* value for an individual of a given age and gender.

F4. The *observed* $EQ\text{-}5D_{index}$ for each respondent in the Northern Ireland survey was standardised using the normative population values obtained from the HSE(2003) survey using the following transformation

$$EQ\text{-}5D^* = 1.0 - [(EQ\text{-}5D_{obs} - EQ\text{-}5D_{exp}) / EQ\text{-}5D_{sd}\} \qquad \text{.... (I)}$$

Where:

$EQ\text{-}5D_{obs}$ is the observed value of EQ-5Dindex for an individual respondent
$EQ\text{-}5D_{exp}$ is the mean $EQ\text{-}5D_{index}$ for an individual of the same age/gender
$EQ\text{-}5D_{sd}$ is the standard deviation of that expected mean $EQ\text{-}D_{index}$

F5. When this standard transformation is applied to the HSE(2003) survey it yields a mean of 1 and a standard deviation of 1.0. A summary measure of population health (SMPH) can be constructed by computing the mean EQ-5D* for a given group of n individuals whose normative $EQ\text{-}5D_{index}$ values are known, that is SMPH = $\sum$ (EQ-5D*) / n.

F6. When applied to subgroups of interest this index takes a value greater than 1 where health status is higher than that of an equivalent normative age/gender

sample of the target comparative population. The index is lower than 1 where that health status is poorer.

F7. The SMPH index values for the four Northern Ireland Health Boards and the whole Northern Ireland survey is given in Table F.1

Table F.1 : Standardised summary population health by Health Board

Health Board	*Valid N*	*Mean*	*Standard Error of Mean*
EHSSB	674	0.809	0.052
NHSSB	396	0.991	0.055
SHSSB	333	1.107	0.052
WHSSB	348	1.045	0.055
ALL	1,952	0.959	0.026

F8. The SMPH index for the Northern Ireland survey data is 0.959 - indicative of a health status that is some 4% lower than that of an equivalent population group resident in England.

Table F.2 : Standardised summary population health by Strategic Health Authority (sorted by SMPH index)

Strategic Health Authority	*Mean*	*Count **
Dorset and Somerset	1.186	407
Thames Valley	1.157	703
Surrey and Sussex	1.150	827
North West London	1.109	542
South West Peninsula	1.097	528
Norfolk, Suffolk and Cambridgeshire	1.094	732
North and East Yorkshire and Northern Lincolnshire	1.087	524
Essex	1.082	595
Hampshire and Isle of Wight	1.068	528
Bedfordshire and Hertfordshire	1.065	586
North Central London	1.059	269
South West London	1.049	364
Leicestershire, Northamptonshire and Rutland	1.039	491
Avon, Gloucestershire and Wiltshire	1.011	667
West Midlands South	1.011	585
Kent and Medway	.965	449
Shropshire and Staffordshire	.956	543
West Yorkshire	.950	657
South East London	.949	370
Trent	.945	1,040
Birmingham and the Black Country	.922	678
Cumbria and Lancashire	.918	682
Greater Manchester	.909	878
Cheshire & Merseyside	.862	764
County Durham and Tees Valley	.860	473
North East London	.844	543
South Yorkshire	.825	372
Northumberland, Tyne & Wear	.807	522

* The number of observations per PCT recorded in the HSE(2003) survey

F9. The corresponding SMPH statistic computed for Strategic Health Authorities (SHA) using the HSE(2003) survey data are listed in Table F.2. The lowest SHA value (Northumberland, Tyne and Wear) corresponds to the value recorded for Eastern HB. The 4th highest SMPH index (North London) corresponds to that recorded for Southern HB. Three SHAs record SMPH index values greater than the best recorded for a Health Board. Given that that the managed population of an SHA is more likely to approximate the total Northern Ireland population rather than that of the individual Health Boards, a fairer comparison might be made by locating the Northern Ireland SMPH value within those seen in Table F.2. On this basis, Northern Ireland equates with Kent and Medway, which is ranked 16/28 amongst SHAs.

Annex G

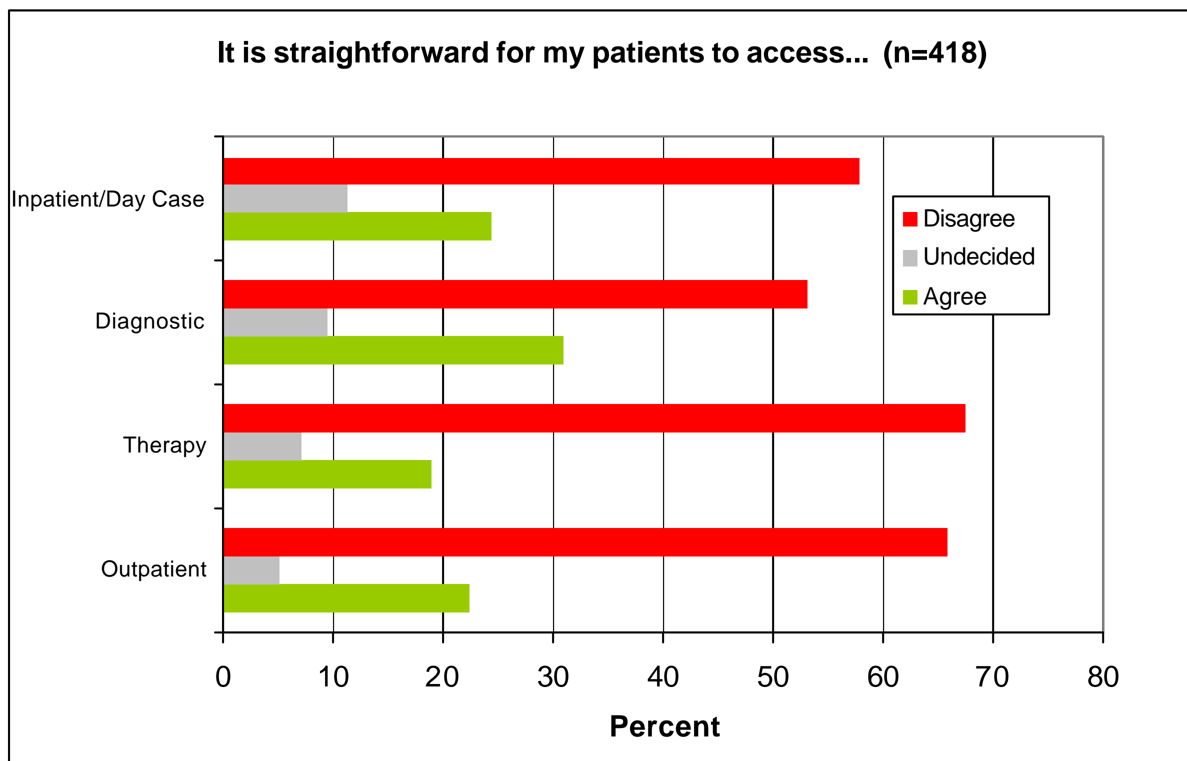
Survey of General Practitioner views and experience of waiting lists and times in Northern Ireland

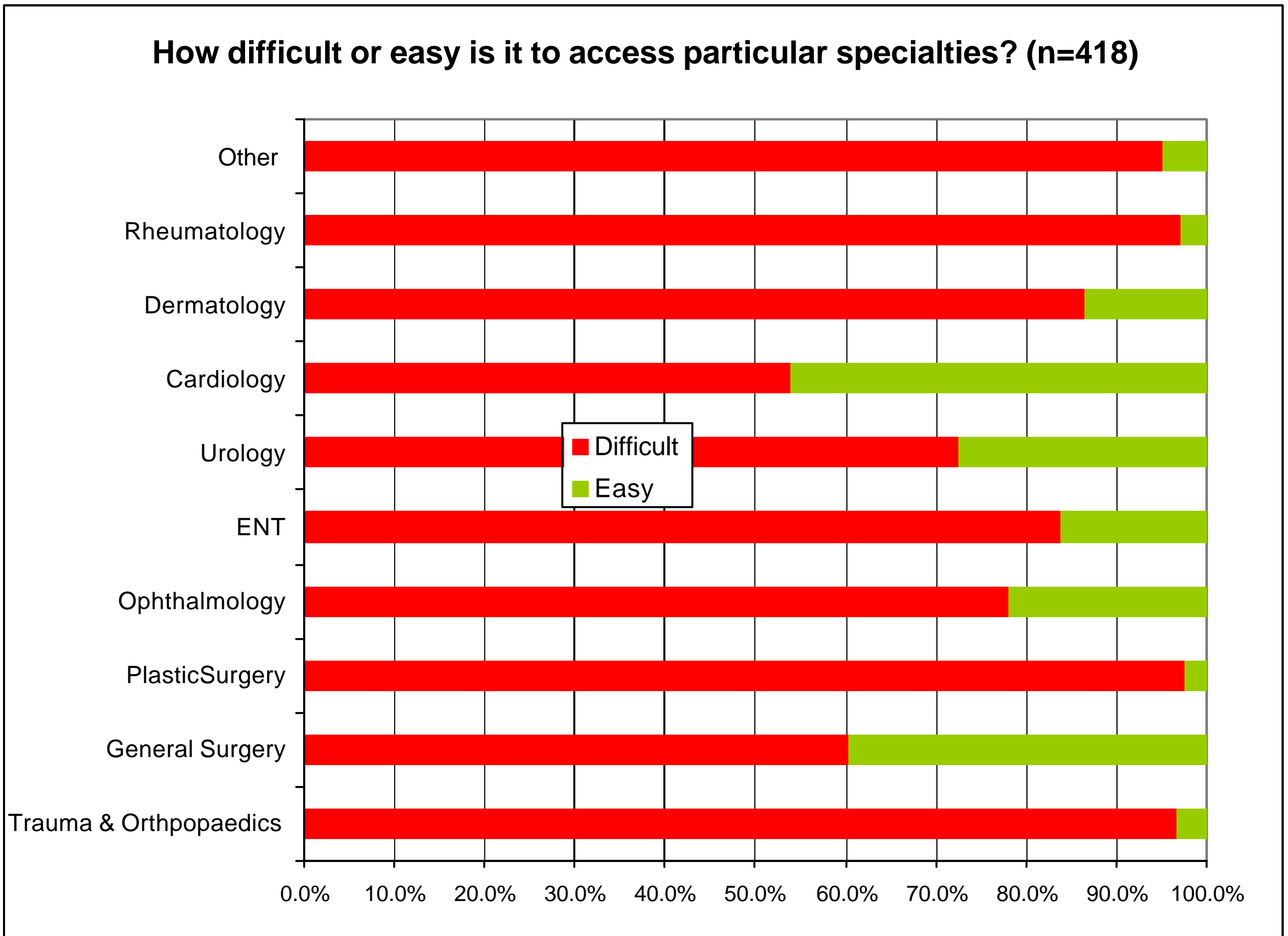
As part of this Review's investigation, a special survey was carried out by the Review team of GPs experiences and views of waiting times and lists. The questionnaire used was adapted from one used by the National Audit Office in Wales, for whom we are grateful for advice on the survey.

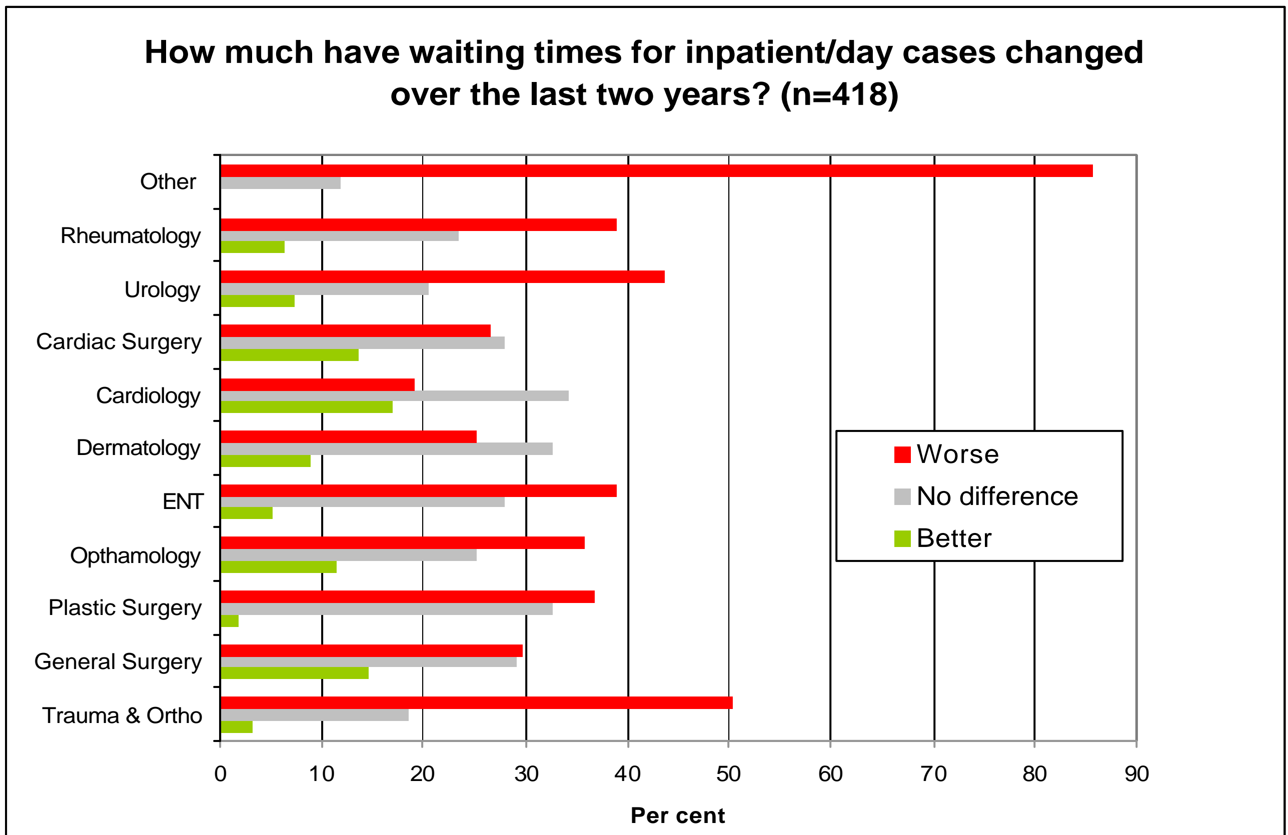
Over 400 GPs returned completed surveys - representing 39% of the total number practising in Northern Ireland.

Here we present a basic descriptive analysis of the results. We have not included additional written comment received by GPs. These will be available at a later date.

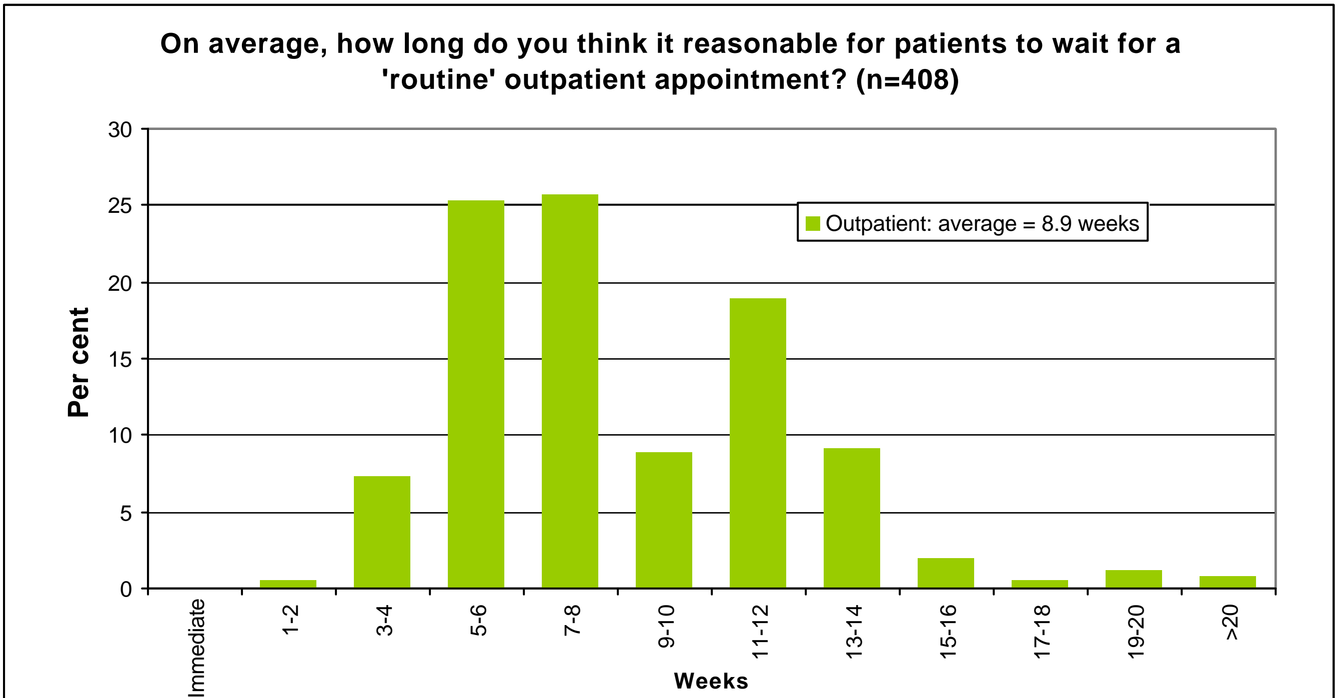
A: Ease of access

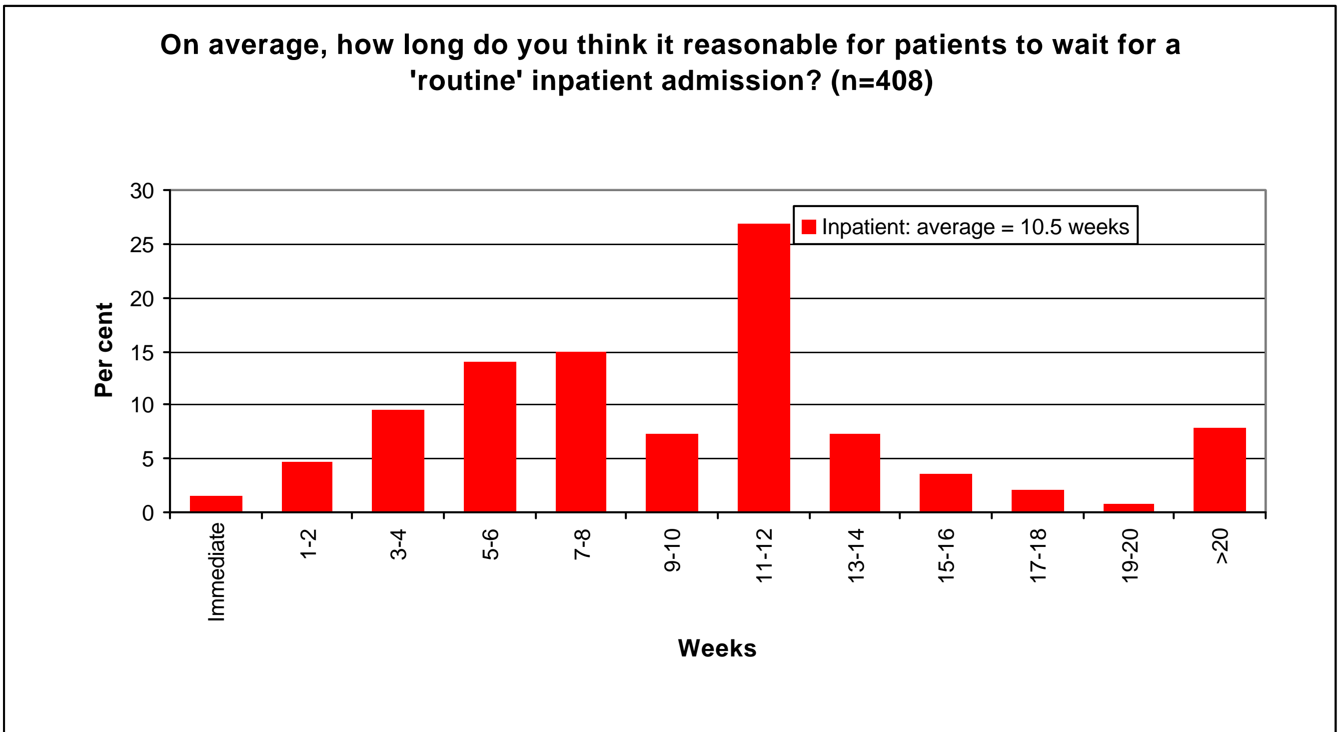


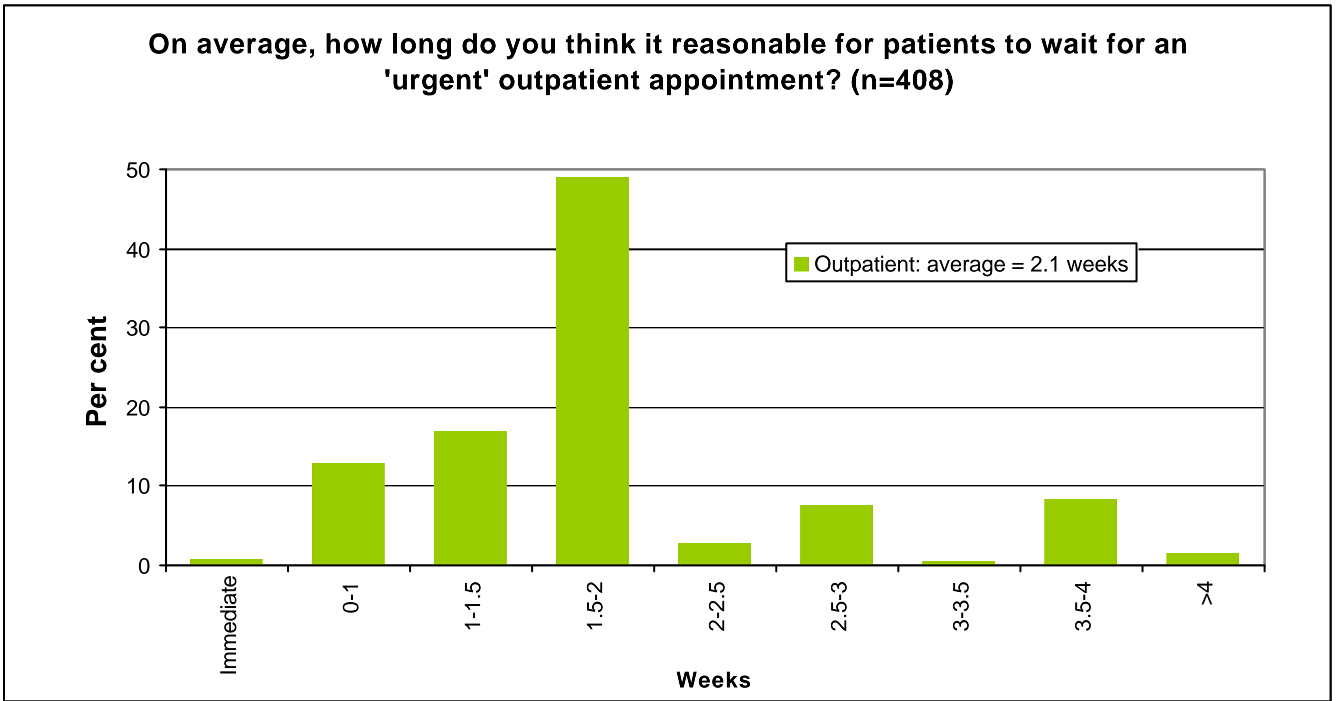

How difficult or easy is it to access particular specialties? (n=418)
Other
Rheumatology
Dermatology
Cardiology
Urology
ENT
Ophthalmology
PlasticSurgery
General Surgery
Trauma & Orthpopaedics
Difficult
Easy
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
80.0%
90.0%
100.0%

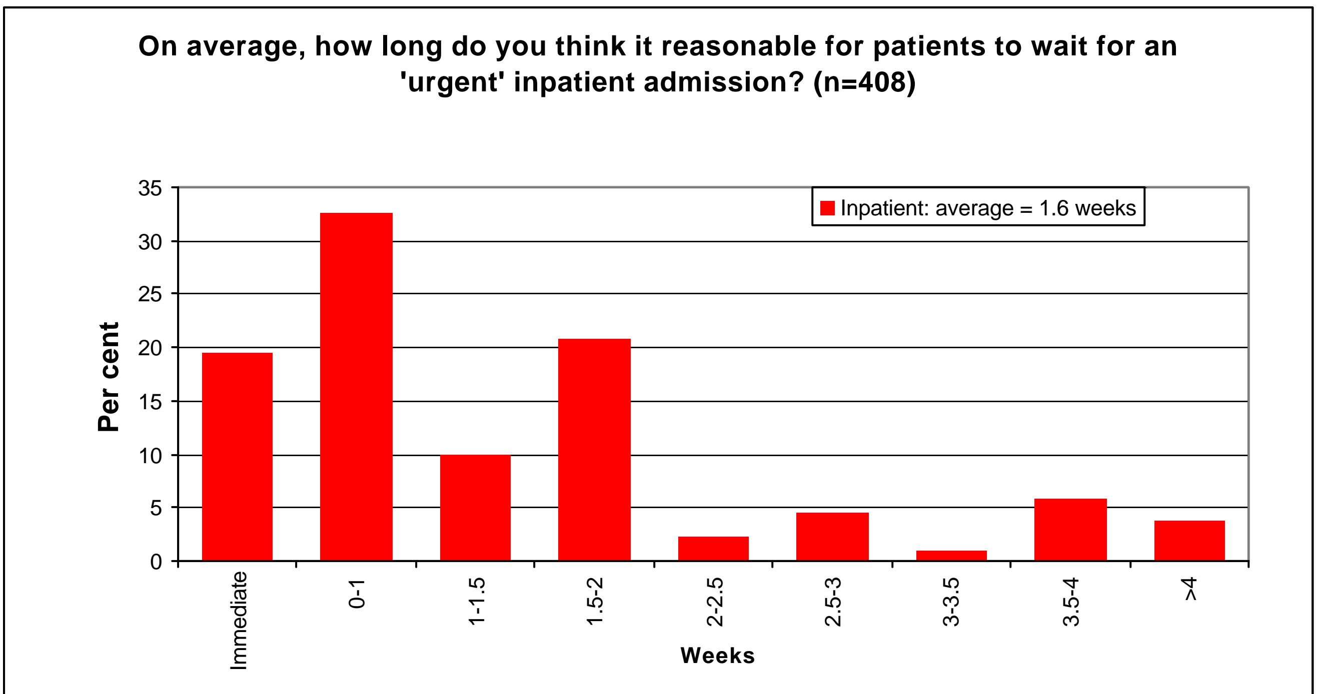

How much have waiting times for inpatient/day cases changed over the last two years? (n=418)
Other
Rheumatology
Urology
Cardiac Surgery
Cardiology
Dermatology
ENT
Opthamology
Plastic Surgery
General Surgery
Trauma & Ortho
Worse
No difference
Better
0
10
20
30
40
50
60
70
80
90
Per cent

B: 'Reasonable' waiting times

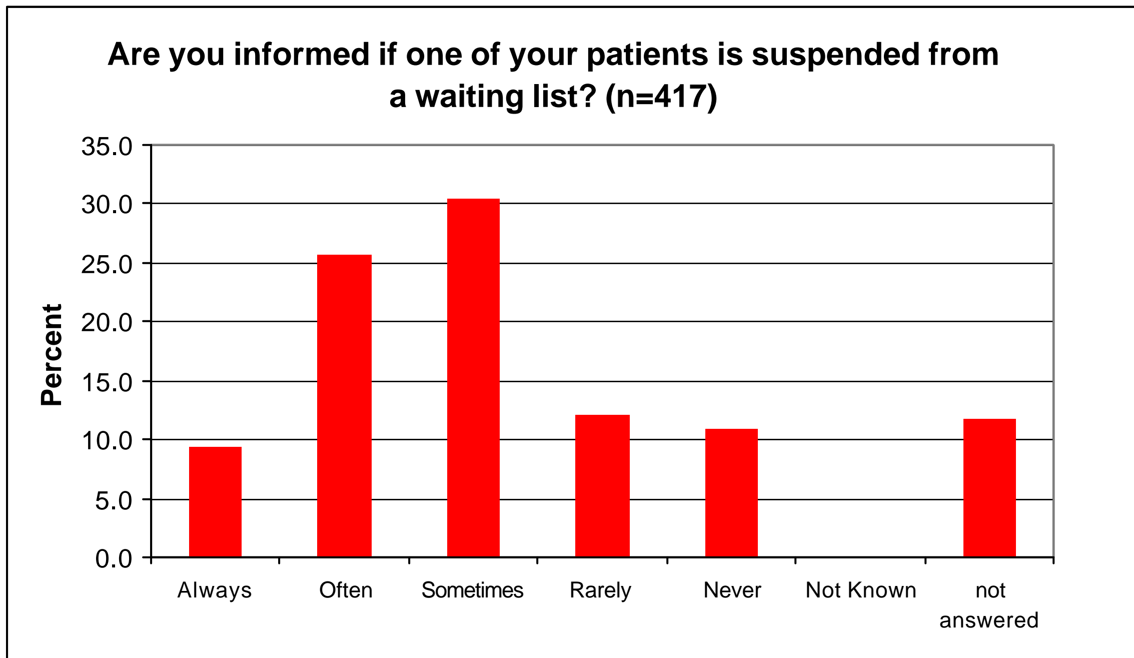


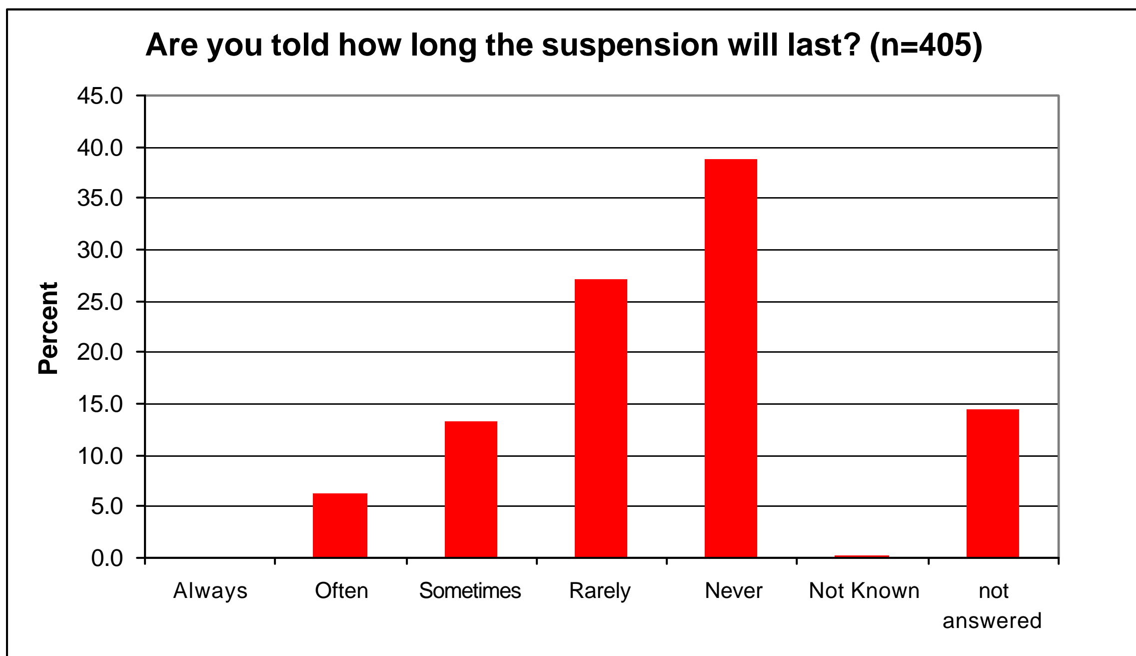


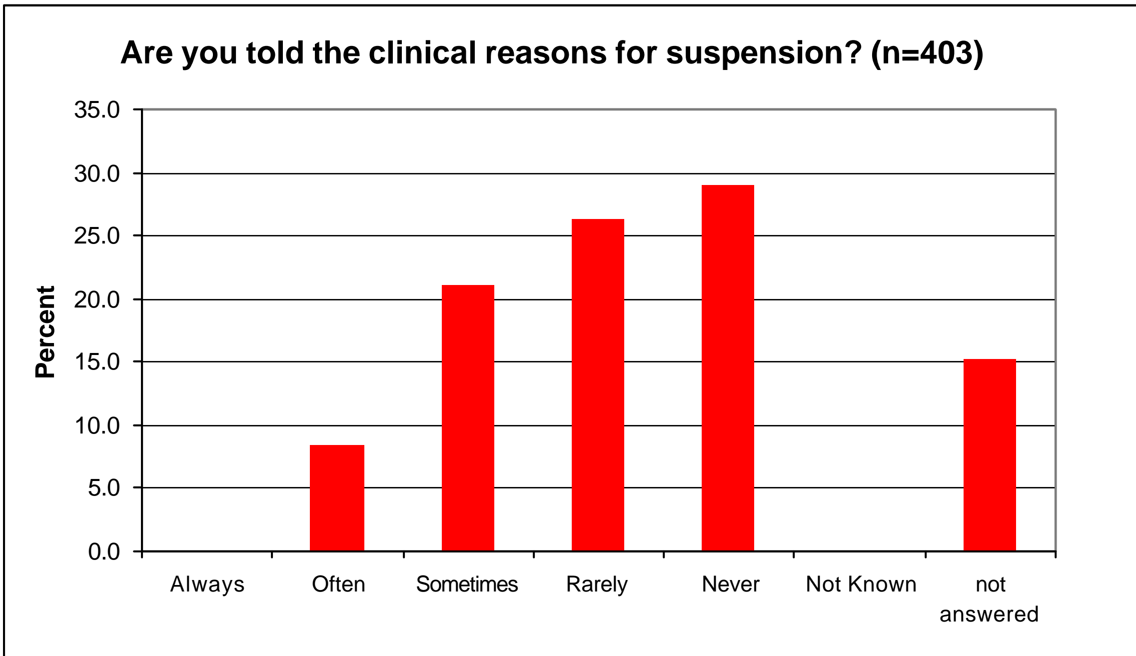

On average, how long do you think it reasonable for patients to wait for an 'urgent' outpatient appointment? (n=408)
Outpatient: average = 2.1 weeks
Per cent
50
40
30
20
10
0
Immediate
0-1
1-1.5
1.5-2
2-2.5
2.5-3
3-3.5
3.5-4
>4
Weeks

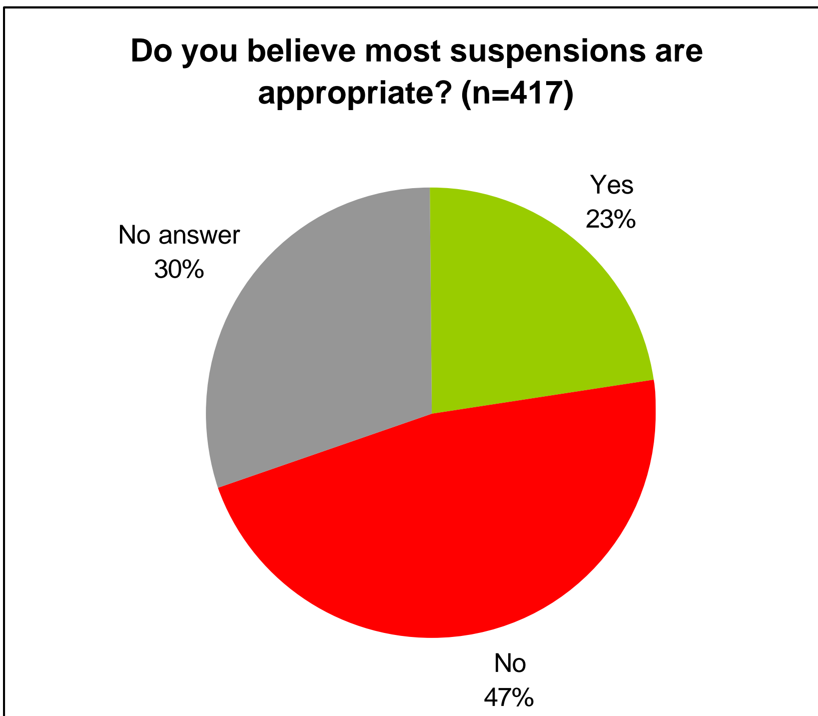

On average, how long do you think it reasonable for patients to wait for an 'urgent' inpatient admission? (n=408)
Inpatient: average = 1.6 weeks
Per cent
35
30
25
20
15
10
5
0
Immediate
0-1
1-1.5
1.5-2
2-2.5
2.5-3
3-3.5
3.5-4
>4
Weeks

C: Suspensions from lists

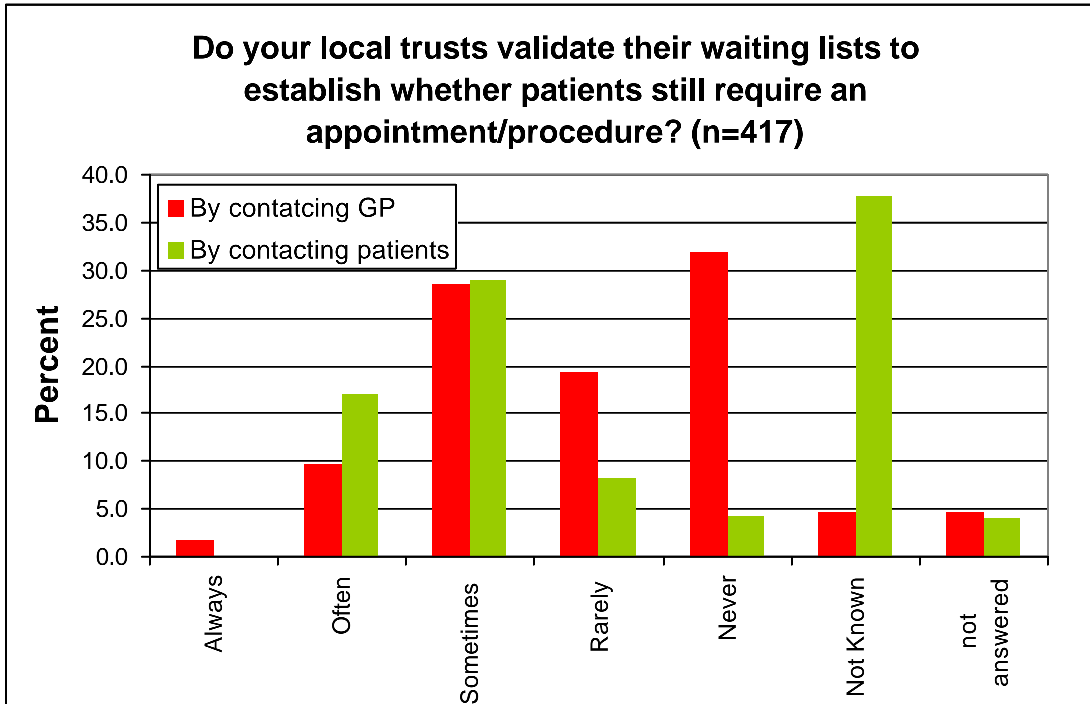




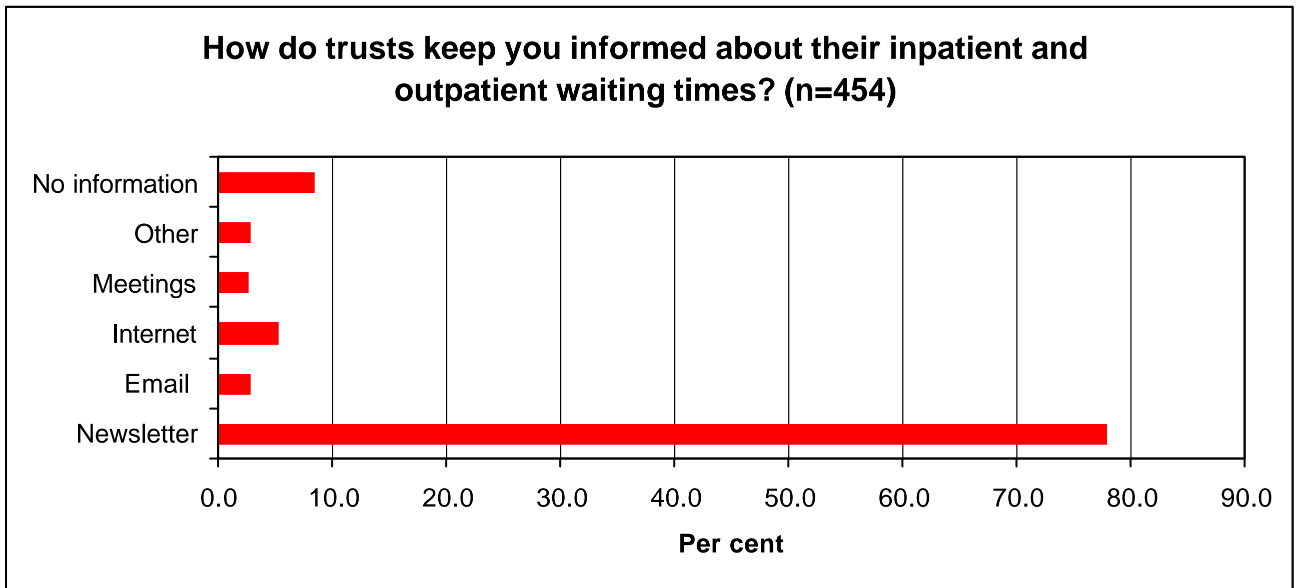

Are you told the clinical reasons for suspension? (n=403)
Percent
35.0
30.0
25.0
20.0
15.0
10.0
5.0
0.0
Always
Often
Sometimes
Rarely
Never
Not Known
not answered

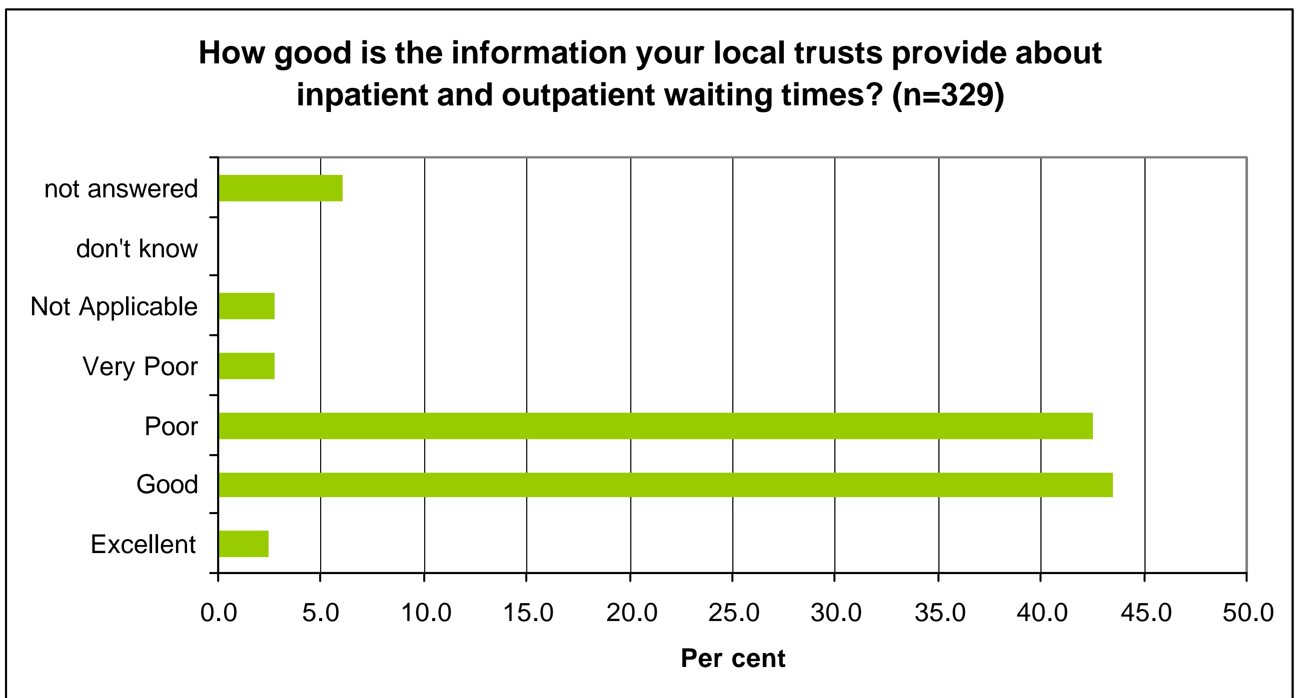

Do you believe most suspensions are appropriate? (n=417)
Yes 23%
No answer 30%
No 47%

D: Validation of waiting lists



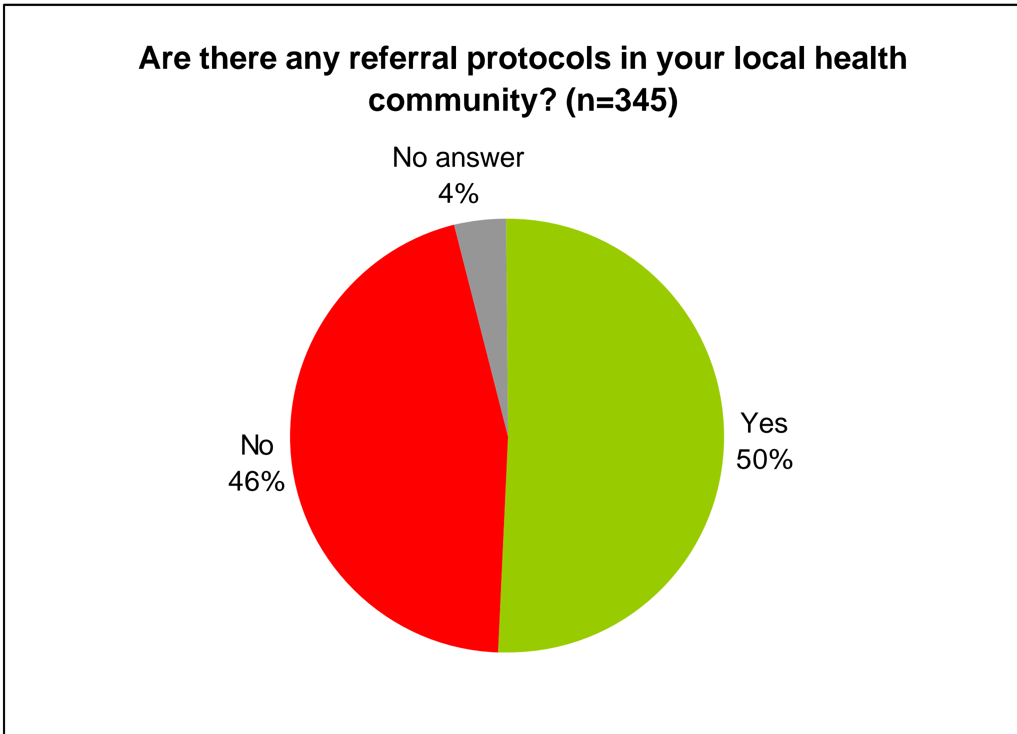
E: Information about waiting

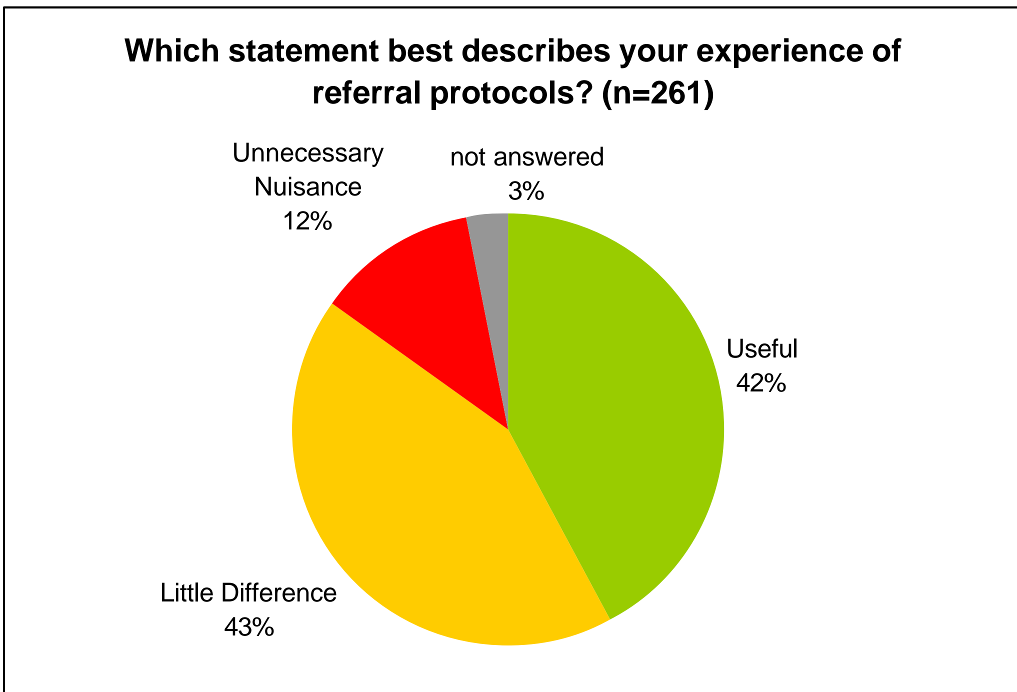




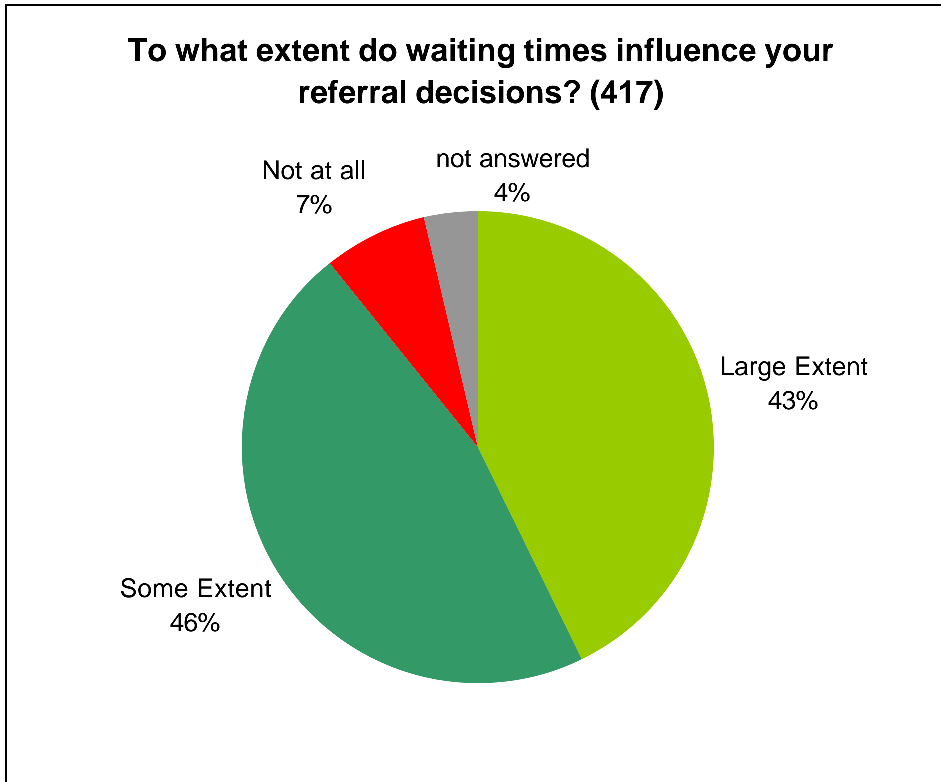
When referring for specialist consultation, do you tell your patients how long they are likely to wait?
not answered
don't know
Only if asked
Never
Rarely
Sometimes
Always
0.0
5.0
10.0
15.0
20.0
25.0
30.0
35.0
40.0
45.0
50.0
Per cent

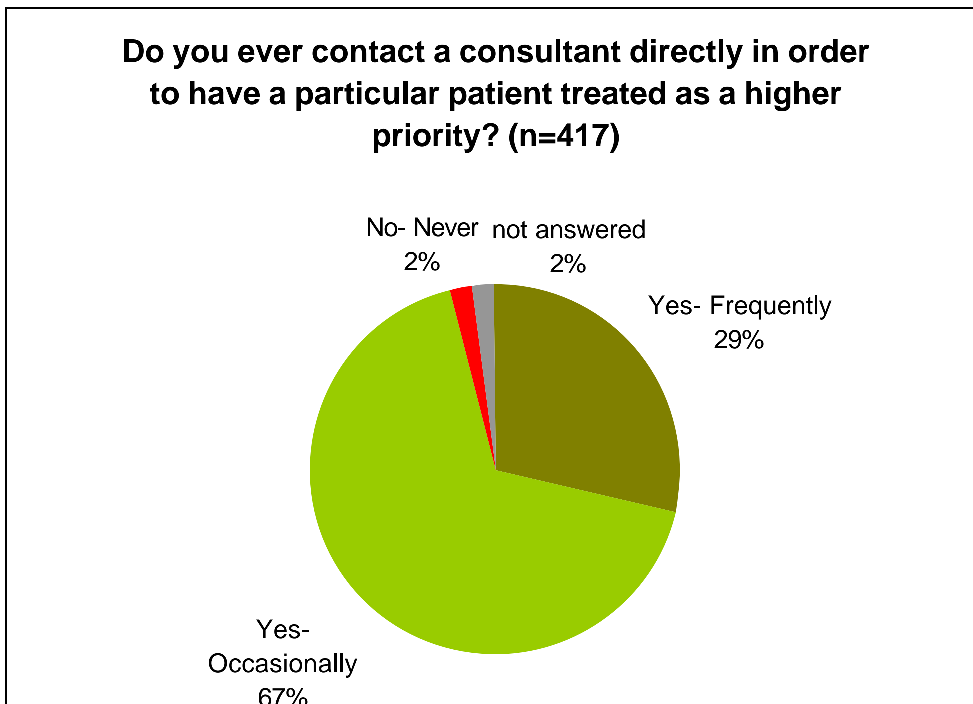
F: Referral protocols

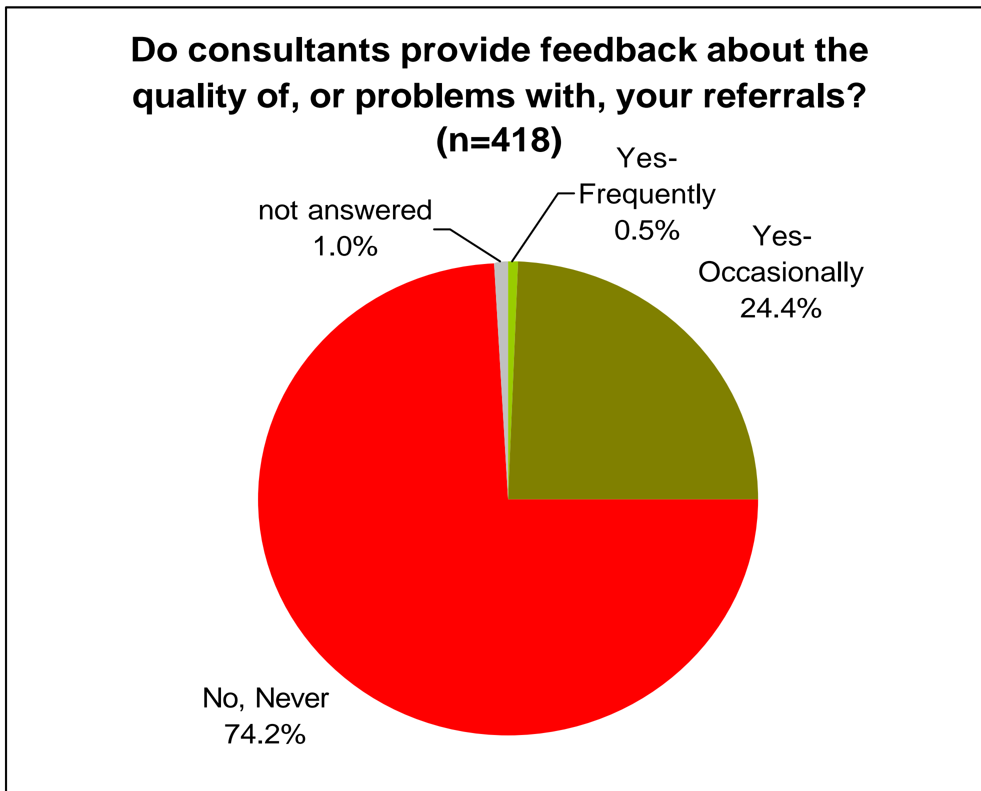




G: Referral decisions


To what extent do waiting times influence your referral decisions? (417)
Not at all 7%
not answered 4%
Large Extent 43%
Some Extent 46%


Do you ever contact a consultant directly in order to have a particular patient treated as a higher priority? (n=417)
No- Never 2%
not answered 2%
Yes- Frequently 29%
Yes- Occasionally 67%


Do consultants provide feedback about the quality of, or problems with, your referrals? (n=418)
not answered 1.0%
Yes-Frequently 0.5%
Yes-Occasionally 24.4%
No, Never 74.2%

Annex: H

PERFORMANCE MANAGEMENT ARRANGEMENTS

Description supplied by the DHSPSS:

Background

H1. In recent years, the Department has given priority to ensuring the development of effective arrangements for managing and monitoring service performance in the HPSS. In line with the Secretary of State's *Priorities and Budget* and the Department's Public Service Agreement (PSA) and Business Plan, the Department's main annual planning document for the HPSS is *Priorities for Action*. It translates the PSA into an annual working agenda for the HPSS which must be implemented in a context of financial stability.

Priority Setting and Performance Assessment

H2. On foot of *Priorities for Action*, Boards and Trusts are required to submit Health and Wellbeing Investment Plans and Trust Delivery Plans respectively, detailing how they intend to deploy their resources to meet the identified priorities. A range of measures are in place to monitor their progress against these plans and to provide a clear line of accountability to the Minister and Department. These include annual meetings at Ministerial level with each of the Boards, which provide an opportunity to review the delivery of services in the preceding year, to focus on priority areas for the year in question and to discuss key challenges facing the service.

H3. Departmental officials also conduct a series of progress review meetings with Boards and Trusts during the year, at which quarterly reports detailing progress against targets in *Priorities for Action* are reviewed.

H4. Earlier this year, the Department began a review of performance arrangements in place in the rest of the UK and elsewhere to inform the development of a new high-level performance assessment and reporting framework for the HPSS. The objectives of the framework will include:

- the broadening of the performance focus to embrace the totality of investment in the HPSS;
- the establishment of credible baselines for benchmarking across key areas of financial, organisational and clinical and social care performance; and
- the identification of areas for performance improvement and the development of suitable targets.

H5. Work to date has identified a pool of potential performance indicators, which are currently being evaluated by the Department. It is planned to bring forward proposals for Ministerial consideration in the near future.

Improving Standards

H6. The Department is at present implementing a programme of legislative and organisational change designed to address unacceptable variations in standards of treatment and care and to raise the quality of service provision. This includes:

- placing a statutory duty of quality on Boards and Trusts which will underpin accountability at local level for the quality of services. This duty has been in place since April 2003;
- devising minimum standards of care against which services will be inspected and monitored in the future. A range of standards are currently being developed in preparation for public consultation from autumn 2004; and
- the creation of a new and independent HPSS Regulation and Improvement Authority. The Authority, which is currently being established, will be operational from April 2005 and will be responsible for regulating services, conducting reviews and undertaking inspections.

Governance

H7. In March 2002, the Department adopted the internationally-recognised risk management standard AS/NZS 4360:1999 (already in use in the NHS in England) for itself and all of its associated bodies. The Department sees the adoption of a single model for risk management as an important step towards providing the right environment for the development of effective controls for the range of risks facing the HPSS.

H8. Controls assurance standards supplement this system of risk management by focusing on key areas of risk and providing HPSS bodies with a vehicle to report the extent to which those risk are being managed effectively. An initial six standards were published in 2003/04 and HPSS bodies are due to submit compliance reports against these standards in May 2004. A further 15 standards are being developed.

H9. In addition, the Department has been promoting the development of clinical and social care governance as a framework through which HPSS bodies are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment where excellence in clinical and social care will flourish. This process will be facilitated and supported by a Clinical and Social Care Governance Support Team.

Annex: I

PERFORMANCE MANAGEMENT ARRANGEMENTS

Selected extracts from 2004 Board/DHSPSS Annual Accountability Review meetings:

Northern Board

'The Board reflected that the continued development of good communication between the Department and the HPSS helped make Priorities for Action a successful way of establishing and pursuing key priorities.'

'The Department emphasised the continuing importance of action to reduce waiting lists and invited the Board to comment on its ability to meet the waiting list targets set out in Priorities for Action. The Board pointed to the value of central drive by the Department and urged consistency of focus on this [waiting times] area with trusts but said that it thought the targets were achievable, provided, of course, that trusts can deliver their part of the agenda. Given joint accountabilities for delivering the waiting list agenda, the Department encouraged the Board to continue to work collaboratively with trusts to effect improvements in this area.'

Western Board

'The Department asked the Board to comment on its performance. The Board highlighted 3 areas where progress had been difficult, the first of these was in relation to waiting lists where the total numbers of people had increased, causing the Board to miss its target for reduction in numbers waiting by 27. The Board explained that problems had arisen at Altnagelvin where efforts to tackle outpatient waiting in ENT and ophthalmology had had a knock-on effect on inpatient waiting numbers. The Department emphasised the need to maintain focus and momentum on hospital waiting and noted the efforts now being made by the Board and trust to tackle this problem in 2004/5.' [This is the full extent of minted discussions about waiting lists/times performance for this Board]

Southern Board

The Department underlined that the HPSS must aspire to the standards being delivered in England and Wales and emphasised that the Board and local trusts should not aim to simply satisfy the targets this year but should be creative in the use of resources to deliver the best outcome possible on waiting times and numbers. The Board undertook to work to exceed the targets wherever that was possible and provided the meeting with a copy of an internal Board report on the Secondary Care targets contained in Priorities for Action.'