Department of Health, Social Services and Public Safety

An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Review of the Medical Workforce

Final Report

June 2003

1. EXECUTIVE SUMMARY

1.1 Introduction

This review is one of a series of reviews which the Department of Health, Social Services and Public Safety (DHSSPS) is undertaking to inform the planning and provision of health and social services staff over the next five to ten years, and covers the professional medical staff group. This group includes Consultants, GPs, Non-consultant Career Grades and all grades of doctors in training.

The aim of the review was to investigate, within the context of workforce planning and deployment, current and future supply and demand factors that will impact on the delivery and development of professional medical services over the next 5 – 10 years.

The detailed terms of reference included:

- an analysis of the current medical workforce in Northern Ireland;
- an analysis of current and future recruitment and retention issues; and
- a prediction of the future supply of the workforce and demand.

The review set out the following key elements:

- the predicted number of medical professionals required over the next five to ten years;
- a model that can be applied to predict trends in the supply and demand of medical professionals;
- a model identifying the parameters that will impact on the supply and demand of these professionals within the context of developments both within the professions and in the wider operating environment including economic context and society's requirements; and
- identifies current and indicative future trends in the development of these services.

The review was overseen by a Steering Group established by the DHSSPS and chaired by Director of Human Resources (DHSSPS). The group approved the project approach, made recommendations as to involvement from the service and reviewed the initial findings and draft report prior to approval in its final form. This Steering Group also acted as a forum for discussion and debate around the assumptions to be used for the modelling to ensure they reflected the experiences of those in the service.

The work format consisted of key informant interviews, reviews of relevant literature and work to date and data modelling of current workforce data.

1.2 Context

This review was carried out against a background of continuous change and development in the service and took account of a number of key strategic issues and documents which will impact on the future delivery of service in Northern Ireland, including:

- The Acute Hospitals Review;
- Building the Way Forward in Primary Care;
- Priorities for Action 2002 / 03;
- European Working Time Directive;
- New Consultant's Contract;
- New GP Contract;
- New Deal for Junior Doctors.

1.3 Workforce Structure

The data used for the review was the HRMS Payroll Information as at September 2001 as supplied by the DHSSPS, supplemented by information supplied by the Northern Ireland Council for Postgraduate Medical and Dental Education (NICPMDE) and the Central Services Agency (CSA) . Whilst it was recognised that discrepancies exist with regards to how individual trusts have categorised staff, it was felt that for overall trends it was sufficiently robust and the most accurate available within the timescale of the project. All figures quoted are for headcount (as opposed to whole time equivalents).

1.3.1 Consultants

As at September 2001, there were 929 Consultants employed. 59% of them are aged 40 –55, with a further 17% over 55. Forty-nine Consultants are over 60 years of age. Only 22% are female, which is in marked contrast to the balance of current medical students where over 60% are female.

23% work part time, however, the information available does not distinguish between those staff who have part-time HPSS contracts due to shared posts, such as with the University, those with "maximum part-time" contracts and those who are "genuine" part-time.

1.3.2 Non-Consultant Career Grades (NCCG)

This group of 188 covers Associate Specialists and Staff Graders. Total numbers have risen by 38% in the last four years, all in Staff Graders. The group is relatively young (70% being under 45), predominantly female (60%), and 31% work part-time.

1.3.3 Specialist Registrars (SpR)

There were 471 Specialist Registrars and 42 GP Registrars in 2001. Of the Specialist Registrars, 90% are under 40, and 40% are female. The percentage that is female has risen by 6% from 34% in the last four years. Only 7% of the group work part-time.

1.3.4 Senior House Officers (SHO)

There were 720 SHO on the payroll in September 2001, of which 76% are under 30, with a small proportion (4%) being over 40. 45% of the group are female and only 3% work part-time.

1.3.5 Pre-registration House Officers (PRHO)

There were 188 in September, but this will rise to 212 in August 2002. 94% are under 30, and 57% are female.

1.3.6 Other

The "Other" group consists of staff classified as hospital practitioners, general / medical practitioners and medical officers, and are principally employed on a sessional basis reflected in the fact that 86% are part-time. The age range is wide and evenly spread, and 49% are female.

1.3.7 General Practitioners (GPs)

There are 1,069 GP principals, 75% of who are under 50, with 4% (48) currently over 60. 23% are female - of whom 41% work part-time. There are also approximately 160 – 180 registered GPs in Northern Ireland who are not working as GP principals, many of whom work on a sessional or locum basis.

1.4 Key Issues – Supply

During the key stakeholder interviews, a number of major supply issues were discussed.

1.4.1 Consultants

Many consultants are looking to retire early, or posts are proving difficult to fill, because they are no longer attractive work prospects. Factors contributing towards this include high levels of on-call, and the increasing pressure which changes to junior doctors' hours and the consequent lack of junior doctors are putting on consultants to make this on-call commitment even higher.

Poor infrastructure in some trusts, for example, the physical estate or lack of theatre time, or nursing support, and the lack of availability of private practice in many areas does not make working in Northern Ireland attractive to consultants from outwith the province. The opposite is also true in that posts in the rest of the UK are often more attractive to Northern Irish doctors than remaining in the province.

1.4.2 Vulnerability of small sites

Where small sites are struggling to cover with limited numbers of consultants, the loss of one person can have a major impact on the site's ability to maintain a service. It puts extreme pressure on the remaining consultants, making their posts even less attractive. Once several vacancies arise in one specialty, the ability to recruit is extremely limited, as no one wants to take on a short-handed service.

1.4.3 UK shortages and Strategic Overview

There are a number of specialties, such as radiology, anaesthetics and laboratory medicine, where there are significant shortages in consultant staff throughout the UK. The current systems in place in Northern Ireland result in a mixture of organisations determining posts and how they should be filled within each specialty. In these circumstances the most pressing service needs in the province as a whole may not be addressed or filled as a priority, nor does it enable staff to be readily moved around the province should a new pressure within a specialty arise. A more strategic approach could potentially reduce some of these problems and ensure priorities are addressed to the overall benefit of the service.

1.4.4 Capacity constraints – Queens University Belfast Medical School

In recent years the number of undergraduate places made available at Queens has been increasing. However, this has been at a steady but gradual rate, and the Medical School has now reached its current capacity. This applies to both teaching staff and facilities such as clinical simulation. A step change in investment is needed if undergraduate numbers are to continue to expand.

1.4.5 Capacity constraints – in service training

The current major constraint restricting the system in its ability to produce more consultants in the short-term is in relation to available capacity for in service training. This is particularly so for Specialist Registrars. Whilst this is the case for some specialties, it does not apply to all, and work needs to be carried out on a specialty basis to determine those areas where additional training posts can be established in the short-term.

1.4.6 Male / Female split

At present more than 60% of new undergraduate medical students are female, as opposed to 22% of current consultants. Unless there is a concerted effort made to facilitate more family friendly policies, with flexible training and more imaginative working patterns (and in some areas a change in attitude), this will contribute to a significant shortage of consultants across all specialties in the future, and a high proportion of the current investment in undergraduate medical students will be lost.

1.4.7 GPs - Availability of Trained Staff

In Northern Ireland there are approximately 160-180 trained GPs who are not working as GP Principals. Whilst some of these may be looking for a permanent position within a practice, a large number of them enjoy the benefits which locum or sessional work provides, particularly with regards to part-time working and family friendly hours. Many also do not wish to make the business commitment of becoming part of a practice, which a principal position requires.

At present there is not a shortage of GPs in the province. However, both the changes proposed to future GP contracts and the move to a more primary care focused pattern of service delivery are likely to have an impact on the number of GP posts (whether as principals or otherwise) required across the province. Expansion to the level envisaged in, for example, the Acute Hospitals Review of an increase of 25% will result in a shortage of GPs unless an increased number of trainees are planned for in the future.

1.5 Key Issues – Demand and Other Factors

1.5.1 Service Pressures

Acute services are experiencing increasing pressures, from changing demographics, increasing admissions, pressures on waiting lists, delays in discharging elderly patients to the community, increased public expectations, changing care needs, advances in medical technology or resource constraints. This is alongside changing legislation with regards to working conditions, including the European Working Time Directive, and qualitative aspects such as clinical governance.

Primary care and general practice are experiencing pressure from areas 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, diversification in areas such as palliative care, hospital-at-home and minor surgery. These are inextricably linked with the current drive 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, but this is in turn creating pressure elsewhere.

1.5.2 Service Configuration

It is clear that given the current and projected shortages of doctors, not just at consultant level, across a range of specialties, the present configurations of services are not sustainable. Irrespective of any other pressures, the service is unable to deliver on the European Working Time Directive or the New Deal for Junior Doctors, both of which are now legal requirements.

The outcome of the discussions on service configuration will have a significant impact on workforce planning and will enable detailed projections to be made at a site and specialty level. Models will require regular updating as progress is made in these discussions.

1.5.3 Changes to GP and Consultant Contracts

National negotiations are currently ongoing with regards to GP and Consultant's contracts and the outcomes of these are not yet finalised. However, they are likely to have an impact on the level of hours worked by senior staff and therefore the manpower requirements needed to compensate for potential reductions.

1.5.4 Specialisation vs. Generalisation

There is an increasing conflict within the service between specialisation and generalisation of doctors. The current pattern of training provision and the impact of clinical governance and quality standards are some of the factors driving the move towards increased specialisation. However, this is resulting in an increased difficulty in covering areas such as medical and surgical on-calls, where specialised staff are not willing to provide diagnosis or undertake procedures which they do not carry out on a regular basis. It is also resulting in a difficulty in providing cover at smaller sites where generalists are needed and there are not sufficient volumes of activity to justify specialist cover.

Whilst some of the professional colleges are recognising this as an issue, further work needs to be carried out to resolve it. It creates a tension between service providers and the medical and training bodies and this needs to be addressed. Consultation on the creation of a Medical Education Standards Board has been completed and proposals from this should enable the province to move forward in finding solutions to the problem.

1.5.5 Specialty specific

Every specialty and sub-specialty is different, and there are a large number to be considered. The broad-brush approach taken in this review can only be used as a starting point and more detailed work is needed at a much lower level to provide accurate projections. Each specialty will have varying requirements and the solutions for each will also differ.

1.5.6 Determination of Number of Posts and the Roles of Doctors in Training

At present the number of PRHO posts available per annum is primarily dictated by the need to ensure posts are available for all graduates from Queen's Medical School. This has recently been increased in recognition of the impact of the New Deal on Junior Doctors Hours.

The number of Specialist Registrar posts are centrally controlled and based on anticipated numbers of consultant vacancies as a result of factors such as service expansion and retirements. This means that there is no over-supply of consultant level staff in the province, but also means that increasing the number of consultant staff from within the system cannot be achieved quickly.

These factors have also resulted in a "surplus" of staff at SHO grade, with significant numbers of training doctors experiencing difficulties and time delays in securing a Specialist Registrar post with which to progress their training.

1.5.7 New Ways of Working

Significant work has taken place throughout the UK to look at new ways of working, primarily driven by the need to ensure compliance with the New Deal. Work in Northern Ireland is being taken forward by the Implementation Group, but there is still a significant amount of work to be done. Experience so far in Northern Ireland has shown that a major limiting factor in taking some of this work forward is the shortage of nurses and other healthcare professionals available to fulfil alternative or additional roles.

1.5.8 Non-consultant Career Grades (NCCGs)

Non-consultant career grade staff are increasingly being used to support consultant led services in hospitals. Whilst concerns have been expressed as to the professional linkages (e.g. with Royal Colleges) and the need to ensure requirements for Continuing Professional Development are met, these grades could make a significant contribution to helping resolve manpower issues.

1.6 Data Modelling

1.6.1 Assumptions

The baseline data used was supplied by the DHSSPS and was based on the annual Trusts' payroll download as at September 2001. This was supplemented by data provided by NICPMDE and CSA. A series of assumptions was developed with the Steering Group and applied to the data:

Retirements: Current retirement age of 62 dropping steadily to 59 after ten years.

Other Leavers: The DHSSPS completed an analysis of staff leaving in 2001 (excluding retirements) and a percentage estimate was calculated for each grade of staff. Most were considered realistic but the percentage for PRHO staff was dropped following discussion with the steering group. The final percentages were Consultants – 3%, NCCG – 5%, SpR – 4%, SHO – 4%, PRHO – 1%, Other – 8%, GPs – 1%.

Current Vacancies: Based on the DHSSPS annual review (Dr Woods), 8% was applied for Consultants. From discussions with the NICPMDE no vacancies were assumed for SpR and PRHO levels. On anecdotal evidence, 20 vacancies were included for SHO posts and none for GP principals.

Loss to Workforce Due to Work / Life Balance: This is to compensate for the number of staff wishing to move to part-time working, as a result of the increasing number of females entering the profession. For Consultants, GPs and SpRs it is assumed that an additional 1% of the workforce per annum wishes to move to part-time working, and that this percentage rises steadily to

2.5% per annum over ten years. For all other staff groups it has been assumed that there will be an increase of 1% per annum.

Working Time Directive: The impact of the WTD on Consultants and GPs is assumed to be included in the increase to workload (see below). For SpR, SHO, PRHO and full-time Staff Graders it is assumed that a 14% increase in staff are required from 2003/04 and a further 14% required from 2008/09. For SHO and PRHO it is also assumed that the impact of this increase will be reduced by a third as a result of a transfer of workload to non-junior doctor staff.

Workload Projections: An increase of 40% in Consultants and 25% in GPs over ten years has been assumed, along with a 30% increase in NCCG posts over the first five years. Sensitivity modelling has also been carried out on an increase of 60% of Consultants and 40% of GPs.

Annual Completion of Training Grades: It is assumed that it currently takes 1 year to complete PRHO training, 4 years to complete SHO training, 1 year for GP Registrar training and 5 years for SpR training.

1.6.2 Models

The following table sets out the results of the data modelling for each staff group. It shows the requirement for staff each year based on current posts and additional service requirements <u>within</u> each grade of staff:

Table 1.6.1

Projected Requirements for Staff per annum

	2002/03	**03/04**	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
Consultants	136	137	101	112	112	112	125	126	127	137
GPs	75	77	80	87	83	89	98	105	107	114
SpR	118	133	139	144	149	154	163	169	176	181
NCCG	34	32	29	23	20	15	20	17	17	21
GP Reg	75	77	80	87	83	89	98	105	107	114
SHO	226	243	241	246	251	256	265	271	277	283
PRHO	216	221	226	231	236	240	246	252	258	264

It is important to bear in mind that this is the number of staff required per annum and therefore covers staff leaving requiring replacement. Therefore for the training grades (SpR, SHO and PRHO), the above numbers do not equate to the number of qualified staff available each year to progress to the next stage of training.

Once the current staff structures were adjusted for all of the assumptions, comparisons were then made as to requirements for "newly qualified" staff versus staff coming through the system. The results are the following (principally shortfalls), in projected staff. (A positive figure denotes an "over-supply"):

Table 1.6.2

Shortfalls in Requirements for Staff per annum

	2002 /03	03/ 04	04/ 05	05/ 06	06/ 07	07/ 08	08/ 09	09/ 10	10/ 11	11/ 12
SpR	-42	-42	-2	-9	-5	0	-8	-4	1	-4
SHO	-47	-58	-56	-57	-50	-51	-69	-73	-76	-86
GP Reg	-33	-2	-3	-7	4	-2	-9	-7	-2	-7
PRHO	-38	-29	-22	-22	-22	-23	-27	-27	-27	-27
Graduates	-33	-48	-57	-62	-56	-60	-66	-72	-78	-84

This shows the projected shortfall in SpR available to fill consultant posts, SHO to fill SpR posts and so on. It is based on the assumption that the following additional posts will be funded and established each year and that any requirements from previous years are met, and these figures are therefore not cumulative. The following are required to cover additional posts for increased workloads, the WTD and additional GP Reg training posts.

Table 1.6.3

Projections for Additional Posts Requiring Funding per annum

	02/ 03	03/ 04	04/ 05	05/ 06	06/ 07	07/ 08	08/ 09	09/ 10	10/ 11	11/ 12	Total
Cons	37	37	37	37	37	37	37	37	37	37	**370**
GP	25	25	25	25	25	25	25	25	25	25	**250**
NCCG	19	15	11	8	4						**57**
SpR		13	13	13	13	13	16	16	16	16	**129**
GP Reg	33	2	3	7	0	2	9	7	2	7	**72**
Staff Grade		2	2	2	2	2	3	3	3	3	**22**
SHO		13	13	13	13	13	17	17	17	17	**133**
PRHO		3	3	3	3	3	4	4	4	4	**31**

(note – NCCG excludes Staff Grades, shown separately)

1.6.3 Sensitivity Analysis

By its very nature the modelling is based on a range of assumptions. Sensitivity analysis was carried out on three areas – age of retirement, length of time spent at each training grade and the increase in Consultants and GPs needed to cover increased workload. All of these had a significant impact on the numbers required at each grade and therefore highlighted the need for continuous review of the numbers as more accurate information emerges.

1.7 Conclusions and Recommendations

1.7.1 Complexity of Modelling and Overall Results

Modelling the flow and requirements for staff at each level in the training programme is complex and subject to significant variation depending on the assumptions used. However, all of the modelling indicates a need to immediately increase the number of graduates available to fill future posts, and (as is already known) an under supply of newly qualified SpR staff in the short term.

1.7.2 Shortfall in New Consultants

The current system in Northern Ireland is not producing sufficient qualified staff to meet the potential requirements for Consultant staff and work needs to be carried out in the short term to review potential ways to fill the gap in the intervening years before additional staff can be trained. Areas that should be considered include:

Retaining existing Consultants: Ways should be reviewed to encourage existing staff to remain in the health service beyond their current retirement plans. By being more imaginative with working patterns, some may be encouraged to stay. This also enables very experienced staff to be retained within the service to assist in training additional doctors. Work also needs to be carried out to ensure that NHS pension arrangements are such that consultants are not discouraged to take on different work patterns because of the potential impact on their pensionable salary.

International Recruitment: Northern Ireland should ensure it remains fully involved in UK wide initiatives to attract suitably qualified staff from abroad, either on a temporary or permanent basis.

Use of Funds: When funding becomes available to increase the number of consultant posts, this needs to be targeted sensibly, recognising where the most pressing service needs are, whilst also acknowledging that in some specialties consultant vacancies are proving difficult to fill in the short term due to the lack of candidates available.

NCCGs: There are a number of very experienced staff working at NCCG level, who may have the potential to be fast tracked to Consultant level, and this should be reviewed on a specialty basis. The future of NCCGs in Northern Ireland should also be reviewed as there is the opportunity to develop these roles into meaningful careers in their own right, with the potential to develop significant skill and experience with which to support Consultants. However, this needs to be balanced with the need to increase the number of Consultant staff in order to provide a "Consultant delivered" service.

Use of GPs: There may be opportunities to create jobs that combine a role in general practice with a role in hospital medicine as an NCCG. There are already a number of GPs working as clinical assistants or as hospital practitioners attached to a consultant. However, such doctors usually only work one or two sessions each week and often only in an outpatient department. The suggestion here is that such doctors would work more sessions in hospital, perhaps up to five each week, and provide care in a larger number of stages in the patient journey.

Use of Other Staff to Support a Consultant Delivered Service: Whilst it is recognised that there are difficulties in recruiting and retaining staff, especially nurses, in developing alternative roles to support the medical profession, this does not mean it is an impossibility. Lessons can be learnt from for example, successes in General Practice in terms of supporting the role of "lead doctors" (i.e. those who are ultimately responsible for the medical care of patients) in the provision of care, both face-to-face and over the telephone.

1.7.3 Infrastructure Development

The solution to the shortage of medical manpower does not lie only in increasing the number of doctors and changing the skill-mix of clinical teams. It will also require the development of the supporting infrastructure – principally the use of more clerical staff and IM&T – to reduce the burden of administrative tasks currently undertaken by clinical staff.

1.7.4 Training Numbers – Specialist Registrars

Work needs to be carried out at a specialty or sub-specialty level to determine where there is potential to increase training grade numbers, especially SpR numbers in the short term, whilst ensuring criteria for training are being met. Timescales and actions required to enable expansion in other areas then need to be determined.

1.7.5 Medical School

The requirements for expanding the capacity at Queens Medical School to 250 students per annum should be determined, including a potential timescale for delivery. The potential for attracting graduates to the PRHO programme from the rest of the UK and the Republic of Ireland should also be explored, especially given that many Northern Irish medical students study in Great Britain, and there is a planned expansion in student numbers across the UK as a whole.

1.7.6 Funding for Additional Teaching Capacity

Any additional investment in training grades requires a review of the cost and infrastructure available for teaching, not only in the educational system as mentioned above, but also in the health service, where additional funding will be required to support the necessary increase in in-service training provision.

1.7.7 Family Friendly Policies / Flexible Training

The availability of family friendly policies and flexible training patterns needs to be extended if we are to retain the high number of females currently coming through medical school. Reviews should be carried out to determine ways in which this can be achieved without significant financial penalty to the employing organisation.

1.7.8 Further Research

Further research would be useful to obtain definitive data to support future modelling assumptions, such as planned retirement ages, reasons for leaving (all grades), and requirements for additional posts to cover work / life balance.

1.7.9 Service Strategies

Workforce planning is very difficult to carry out with any degree of accuracy if the future shape and provision of services is unclear. The Acute Hospitals Review (Hayes Review) is undergoing further consultation and the final outcome of the consultations on Primary Care is also awaited.

In the short term, networking arrangements across the province should be encouraged to alleviate the most severe pressures. As potential plans and strategies emerge, workforce requirements will need to be continuously reviewed.

1.7.10 Further Workforce Planning at Specialty Level

As previously mentioned, this report is only a starting point for more detailed workforce planning. By its very nature it is a broad-brush approach, and more detailed planning should be carried out on a specialty basis (not necessarily on a trust or site basis). This would enable more detailed assessments to be made of the issues and allow alternative service configurations to be modelled.

To be effective, workforce planning in the HPSS must be a continuous process, with regular reviewing of assumptions and updating of the models to reflect ongoing changes.

2. INTRODUCTION

2.1 Background

A modern health service is one that delivers care to patients in a way that is sensitive to their needs and expectations. It is a service that offers advice, support, high quality clinical care and seamless provision across care organisations. To deliver this the health service depends on its staff. It needs a workforce which has the skills and flexibility to deliver the right care at the right time to those who need it – a workforce which has the right number of staff deployed in the right places and working to the maximum of their ability.

In order to address this issue the Department of Health, Social Services and Public Safety has commissioned a review of the current provision of medical staff across Northern Ireland. The aim of the review is to inform the Department's planning in the provision of training to facilitate service continuity and development over the next five to 10 years. This report is the result of that review.

This review considers a number of changes ongoing in the Health Service which are impacting on the roles and responsibilities of staff and which will have a bearing on planning the medical workforce required in the future. These include:

- the blurring of clinical and non-clinical roles with a greater scope for other staff to perform tasks previously undertaken by medical staff;
- changing employment patterns and policies relating to family friendly working, maternity and paternity rights;
- the impact of recent and forthcoming legislation such as the European Working Time Directive; and
- changes in new technology and the use of more expensive and increasingly complex medical equipment and testing procedures.

2.2 Terms of Reference

Against this background the aim of the review was to investigate, within the context of workforce planning and deployment, current and future supply and demand factors that will impact on the delivery and development of the medical profession over the next 5 – 10 years.

The detailed terms of reference included:

- an analysis of the current medical workforce in Northern Ireland;
- an analysis of current and future recruitment and retention issues;
- a prediction of the future supply of the workforce and demand;

The review should set out the following key elements:

- the predicted number of medical professionals required over the next five to 10 years;
- a model that can be applied to predict trends in the supply and demand of medical professionals;
- the model should identify the parameters that will impact on the supply and demand of these professionals within the context of developments both within the professions and in the wider operating environment including economic context and society's requirements; and
- identify current and indicative future trends in the development of these services.

2.3 Review Methodology

2.3.1 Steering Group

The approach taken within this project has been similar to that taken in other workforce reviews recently commissioned by the Department. The project has been overseen by a Steering Group (see Appendix A) established by the Department and chaired by the Director of Human Resources (DHSSPS). The Steering Group approved the project approach, made recommendations as to involvement from the service and reviewed the initial findings and draft report prior to approval in its final form. This Steering Group also acted as a forum for discussion and debate around the assumptions to be used for the modelling to ensure they reflected the experiences of those in the service.

2.3.2 Work Format

The format for the work carried out consisted of the following:

i. Key informant interviews with relevant personnel (see Appendix B for a list of personnel interviewed). These were held to identify the key issues affecting recruitment and retention within the profession, to gather information to inform predictions of future demand and to identify useful sources of relevant literature and data;

ii. Review of relevant literature and work carried out to date; and

iii. Data modelling based on centrally available workforce data and key assumptions, derived from the above review work, for projecting factors affecting supply and demand.

2.4 Structure of this Report

This report sets out the findings of the review of the medical workforce as follows:

- Section 3 – An overview of the context within which the review is taking place including key policy drivers;
- Section 4 - A breakdown of the current workforce, including current career structures and roles;

- Section 5 – Analysis of the current supply issues being faced by the profession;
- Section 6 – Analysis of the current major demand issues affecting the service and impacting on staff workloads;
- Section 7 – Modelling of the current workforce data to provide a prediction of future need against the projected supply within the workforce;
- Section 8 – Conclusions and recommendations arising from the report.

3. CONTEXT

3.1 Overview

The Health Service, by its very nature, is a continuously evolving organisation. Few aspects remain static for long, and in particular at the moment there are significant changes taking place that will affect the workforce required to deliver the service. These changes include, but are not limited to:

- Advances in medicine and clinical technology;
- Changes in the way doctors are being trained;
- Evolving roles for all staff groups;
- Increased specialisation alongside an increase in service provision in primary care;
- The balance of accessibility versus clinical governance and quality control;
- European legislation and the impact on available staff; and
- Changing expectations of service users.

This means that when considering workforce planning for the future a framework needs to be established which can be regularly and easily updated in line with evolving policies and strategies. This report therefore represents a starting point from which further work can be taken forward.

A number of associated principles for the development of workforce plans in England have been identified by the Department of Health:

- workforce development has to be built around the services and potential services the public need;
- this in turn needs to drive debate on the skills and competencies required to deliver this service;
- workforce planning needs to be integrated with service and financial planning;
- the use of a holistic approach, looking across primary, secondary and tertiary care, across staff groups, and between the health, social and voluntary care sectors;
- responsive to service changes and developments;
- supportive of multi-disciplinary training, education and working.

3.2 Northern Ireland

Whilst the above principles fully apply to any workforce planning, acknowledgement needs to be made of where the HPSS in Northern Ireland is at present with regards to its long-term service strategies. A number of key strategic documents have been developed, the outcomes of which will determine the way forward for the provision of services across the spectrum of the HPSS from primary care to tertiary services. Key elements of these strategies that impact on workforce planning are discussed below.

3.2.1 The Acute Hospitals Review

The Health Service in Northern Ireland is considering the recommendations of the Acute Hospitals Review led by Dr Maurice Hayes, which sets out proposals for the future shape of acute services in the province.

The review highlights the current pressures that the service is under, including:

- Changing care needs;
- Public expectations with regards to quality, convenience and effectiveness;
- Demand for services;
- Advances in medical technology;
- Increasing specialisation; and
- Resource constraints (personnel and finance).

The review recommends a restructuring of services delivered from hospital sites in Northern Ireland, whilst ensuring all members of the population can access such services within one hour. It also recommends the development of managed clinical networks and local health and social care resource centres.

The outcome of this review will clearly have a significant impact on the future shape and size of the workforce, across all staff groups.

3.2.2 Building the Way Forward in Primary Care

The DHSSPS has published "Building the Way Forward in Primary Care" which sets out proposals for the future of Primary Care beyond the cessation of GP Fundholding, and includes the proposed establishment of Local Health and Social Care Groups.

There is much discussion currently in the Health Service about the future role of Primary Care. Whilst it is clear that there is a strong drive towards greater delivery of care in the Primary Care setting, the future shape of these services has not yet been clearly articulated. There is also a strong view that this cannot be resolved in isolation and has to be taken forward in conjunction with the Acute Hospitals Review.

3.2.3 Priorities for Action 2002 / 03

The "Priorities for Action" sets out the Minister's expectations for the Health and Personal Social Services (HPSS) in the forthcoming year and the overall planning goals and key actions required to secure their achievement. Detailed priorities and actions are given for areas such as health development, primary care, workforce, winter planning and community care, acute hospital services, maternity and child health, the ambulance service, family and child care, care of older people, mental health, and learning, physical and sensory disability as well as areas such as estate and IT. These priorities will guide the detailed planning and direction that the service in Northern Ireland will take in the short-term.

3.3 UK Policies

3.3.1 European Working Time Directive

The European Working Time Directive requires that staff should not be working more than 48 hours per week. It also sets out recommendations for compensatory rest after working anti-social hours, and determines what (with regards to on-call) constitutes "work" versus "duty". It is a current legal requirement for the NHS to implement the directive in all areas, and with all staff groups. A timetable of staged implementation has been agreed by member Governments which means that the 48 hour week will not apply to doctors in training until August 2009, with an interim 58 hour week coming in to force in August 2004, along with significant changes in rest requirements.

3.3.2 New Consultant's Contract

National negotiations are currently ongoing with regards to a new Consultant's contract, and it is likely that the outcome may have a significant impact with regards to, amongst other issues, hours of work and meeting the European Working Time Directive.

The NHS Confederation has been working closely with the four UK health departments in the negotiations for a new consultant contract. Progress has been slower than it has been for a new GP contract (see section 3.3.3). In October 2000, the BMA Central Consultant and Specialist Committee and the government issued its own proposals, building on the *NHS Plan* in February 2001. According to a recent publication by the NHS Confederation,[1] the 'management side' seeks to address many of the concerns raised by employers about the need for a clear framework of accountability and responsibility for consultants in the new contract. More importantly, it also wants a new contract to 'help rather than hinder' NHS organisations in modernising and improving their services. The negotiations are also seeking to address the concerns of the BMA and the consultant body with regards to workload, on-call duties, emergency work, career progression and salary levels.

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[1] NHS Confederation, London 2002 "Consultant Contract Negotiations" Morgan G

The NHS Confederation reports that – at its present state of development – the new consultant contract may be expected to offer, for the NHS:

- greater control of the working week and a greater proportion of time devoted to direct clinical care;
- a new framework for job plans;
- an end to fixed and flexible sessions, with a time-tabled programme of commitments and an expectation that consultants will be on-site for all programmed activities;
- direct links between pay progression, commitment and delivery;
- clear rules on access to private practice.

Similarly, the NHS Confederation reports that it expects the new contract to offer, for consultants:

- a clear cap on workload growth through a time-tabled working week;
- monetary recognition of on-call and emergency work;
- an increase in basic pay, with a higher starting salary and access to further pay progression (including a substantial increase in lifetime earnings);
- a new concept of 'phased consultant careers' with career-long pay progression and different patterns of work and remuneration.

There is no set date for the implementation of this contract. This will depend upon progress in the remaining stages of negotiation.

3.3.3 New GP Contract

Since July 2001, the NHS Confederation has also been developing a new general medical services contract for GPs in negotiation with the General Practitioners Committee of the British Medical Association. This has been done on behalf of the departments of health of the four countries of the United Kingdom. The NHS Confederation published a 'framework document' for a new GP contract for consultation on 23 April 2002.

It is proposed that the new GP contract will be between primary care organisations (PCOs) and GP *practices* as opposed to a contract with individual doctors as at present. This is intended to enable primary care practices to employ a wider range of staff and to receive income related to patient workload rather than to the number of GP principals and their individual list sizes. This has the potential to enable more care to be provided without necessarily increasing the number of GPs in a practice.

Significantly, it is intended that GP practices will have the opportunity to receive income from a number of sources, including payments for providing enhanced services over and above the basic range of GP services; the provision of training and education levies; and private income. Payments will also be available through a 'quality framework' to allow practices to substantially increase their income by achieving a series of quality standards. The proposed contract is therefore intended to increase the profitability of general practice by creating additional personal earning opportunities for GPs. This will enable the expansion of services and allow individual GPs to control and manage their personal workload more effectively. The new contract is also expected to sustain a greater range of employment options, allowing GPs to work more flexibly and in family-friendly ways. These various changes should enable greater recruitment and retention by offering a more profitable career with a more varied, interesting and manageable workload.

Finally, a crucial point of the new contract is that it proposes to remove the formerly obligatory commitment for GPs to provide out-of-hours services to patients. This should prove very popular and, subject to its financial implications, should provide a major boost to recruitment and retention.

The Government is aiming for acceptance of the detailed contract in the autumn, with implementation across the UK to follow as soon as possible within each Health Department. Phased implementation will take place from April 2003, with the timescale for full implementation dependent on the legislative process and timetables within each country.

3.3.4 New Deal for Junior Doctors

The introduction of the new banded contract for junior doctors has produced a strong incentive to deliver New Deal hours and rest requirements. The hours and rest limits applied to junior doctors are now enshrined within their legally binding contract of employment. Hours of Actual Duty limits are included in contracts from 1st December 2000 for all junior doctors, with Hours of Actual Work and Rest limits included in the PRHO contract from 1st August 2001 and for all other junior doctors from 1st August 2003. Persistence of working patterns outside these limits constitutes a breach of contract, as well as attracting the financial penalty of the Band 3 multiplier.

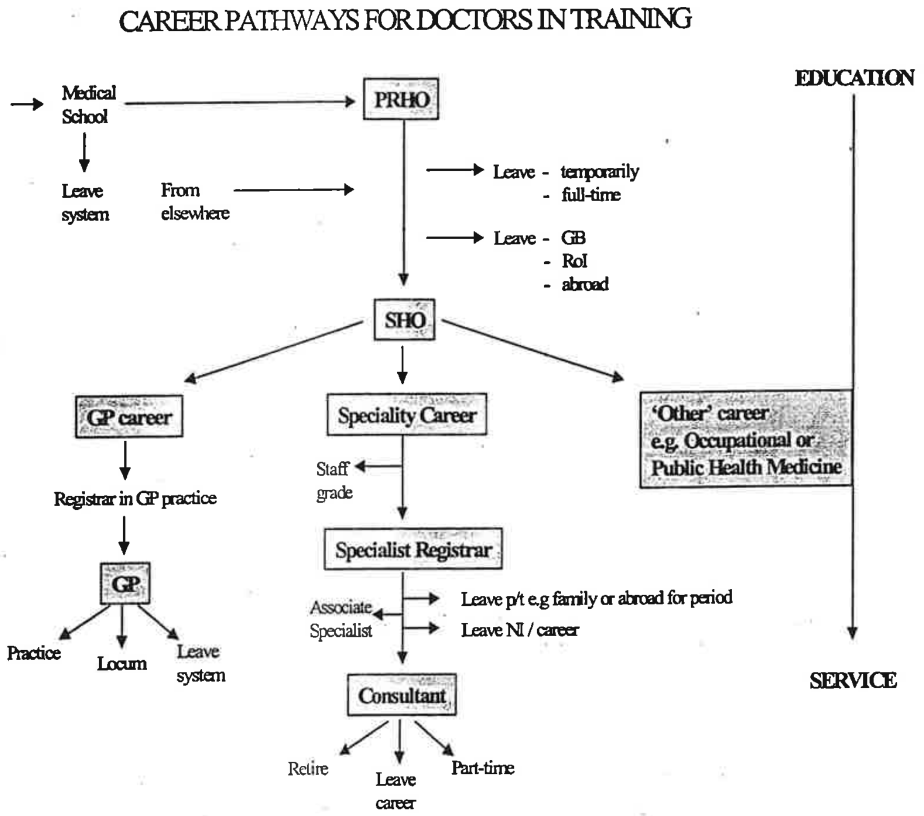
Compliance with the New Deal also ensures compliance at present with the European Working Time Directive.

4. THE MEDICAL WORKFORCE

4.1 Workforce Structure

The medical workforce is made up of a number of different grades, (based principally around the required training for doctors,) for GP, consultant or non-consultant career structures. The following sets out a brief resume of the available career structure for doctors and should be reviewed in conjunction with Figure 4.1.

Figure 4.1
Career Pathways for Doctors in Training



4.1.1 University Graduates

Students require 5 years at University before they are able to commence their pre-registration House Officer training. At present the Medical School at Queens University, Belfast (QUB) accommodates approximately 180 students per annum. Projected output of graduates at February 2002 is dropping, with 183 expected to graduate in 2002, 173 in 2003, and 169 in 2004 and 2005. Students from other accredited Medical schools in the rest of the UK and the Republic of Ireland are also able to continue their medical training in Northern Ireland.

4.1.2 Pre-registration House Officer (PRHO)

The Northern Ireland Council for Post Graduate Medical and Dental Education (NICPMDE) is responsible for the management of the establishment and placement into PRHO posts in the province. The NICPMDE (via the DHSSPS) fund the basic salaries, with trusts funding the additional pay supplements relating to the hours worked and intensity of workload which determine the pay banding applied. Additional posts will only be created and approved if they meet training requirements. An increase in posts has recently been agreed to help meet the requirements of the WTD, and 212 posts will be available from August 2002. Intakes are 6 monthly (August and February), with most students commencing in August.

Final year medical students are provided with information on the available PRHO posts and the Council provides a matching service. A PRHO normally takes one year to complete this stage including their general examination. The system ensures that there are sufficient PRHO places in Northern Ireland for all students graduating from Queens, and applications are also accepted from elsewhere. Given that the current number of posts now exceeds the number of graduating students, this is an increasing necessity.

The New Deal for junior doctors requires that irrespective of the shift pattern, total hours of work should not exceed 56 hours per week, with strict rules around levels of intensity and available hours of rest. For less intense specialties this means that a junior doctor's rostered hours may be more than 56 as long as these hours incorporate sufficient rest periods within them e.g. when on an overnight on-call.

A number of junior doctors (approx. 10 – 20) leave the system at the end of their PRHO year, for example to work in Australia or elsewhere, either on a temporary or permanent basis. However, their whereabouts once they have left are not tracked, so it is not known how many come back to continue their training in Northern Ireland at a later stage.

4.1.3 Senior House Officer (SHO)

SHO posts are, in the main, advertised and managed by the Trusts and are based on 6 monthly rotations. The length of time and range of specialties in which an SHO gains experience will be mainly determined by his or her future career aspirations, as each specialty will have a range of requirements and qualification criteria to be met before an SHO can apply for a Specialist Registrar (SpR) post. Generally 2- 3 years is the minimum level of experience required, with the majority of staff currently taking an average of four years at this grade.

Whilst the NICPMDE gathers information from Trusts with regards to their SHO posts, and funds 50% of their basic salary, the junior doctors are not tracked through the system in the same way as PRHO and Specialist Registrars, nor is the Council involved in their placements. However, again, new SHO posts require to be approved by the Council on the basis of their training content.

There is a central rotation scheme for basic surgery (64 posts from August 2002,) and psychiatry (15). For surgery this is an initial two-year (4 x 6 month) rotation scheme with appraisal for a potential third year. Candidates in Northern Ireland cannot apply for a SpR post in Surgery unless they have participated in this scheme, or a similar scheme elsewhere in the UK.

At present in Northern Ireland there is a surplus of experienced SHOs compared to the number of SpR posts available each year. A number of doctors are taking some time to secure a SpR post and many are working as locums or as "Trust Doctors" in the meantime. It is also likely that some are moving away from the province to work elsewhere, but unfortunately the current information systems do not enable this to be quantified.

4.1.4 Specialist Registrar (SpR)

SpR posts are again managed centrally by the NICPMDE. Previously the Council funded trusts for 50% of the basic salary, but that has now increased to 100% for new posts, with trusts funding any banding uplift applicable. On successful appointment to a SpR post the doctor is allocated a National Training Number (NTN) which is used to track them through the system.

Most specialties require at least 5 years experience (surgery 6 years) prior to obtaining the Certificate of Completion of Specialist Training (CCST) which entitles a doctor to apply for a Consultant post. A SpR can be interviewed for a consultant level post up to three months prior to their CCST, and is entitled to remain in their SpR post for 6 months after attaining their CCST. This can be extended for a further six months at the discretion of the NICPMDE to enable further sub-specialty experience to be gained or if there is particular difficulty in obtaining a consultant post. Beyond this period the doctor is required to find alternative employment (e.g. as a locum) to enable a new SpR to take up the training post.

The number of SpR posts available at present is primarily determined by the anticipated number of consultant vacancies in future years. The training and supervision required to ensure the post provides the relevant level of experience also imposes restrictions on the number of posts that can be created.

There are several types of SpR posts in the system. Type 1 posts lead to CCST and can be split between UK NTNs and Visitor Training Numbers (VTNs), who are overseas medics who do not have a right of residency. Type II posts are Fixed Term Training Appointments (FTTA) for overseas doctors which do not lead to CCST. At April 2002 the NICPMDE had 372 NTNs, 18 VTNs and 46 FTTAs (total 436). There are also a number of LAT (Locum Appointment for Training) posts (currently 33), where staff fill a locum post to allow other SpR to undertake, for example, time in a research post as part of their overall training programme. LATs may (if agreed individually in advance) be able to claim this time in post as relevant experience when progressing towards their CCST.

4.1.5 Non-consultant Career Grades (NCCGs)

These consist of Staff Grade and Associate Specialist posts and are generally taken up by staff who have completed part or all of their SpR training, or experienced SHOs. They are created and managed by trusts on the basis of service need. Many of these staff may not wish to continue to Consultant level, and these posts often offer better conditions with regards to working hours and requirements to participate in on-call arrangements.

These posts do raise concerns about the availability and requirements for Continuing Professional Development (CPD), professional accountabilities and linkages to the relevant Royal Colleges. Currently, trusts deal with these issues in a variety of ways, but the medical profession as a whole recognises that a more formal structure would be useful for these posts.

4.1.6 General Practitioner Training (GP)

All GP trainees must complete their PRHO year before undertaking two years on SHO rotations in relevant specialties and one year as a GP Registrar attached to a GP practice. This can either be as part of a 3 year integrated scheme managed by the NICPMDE (with 34 places available from Aug 2002) or as a 2-year self-constructed scheme followed by a year as a GP Registrar. There are currently 42 GP Registrar posts in N.I. and these are funded by the CSA (Central Services Agency) on behalf of the DHSSPS. The Royal College of General Practitioners and the Joint Committee on Post Graduate Training for General Practice consider that the GP registrar period of training should be expanded from 12 months to 18 months to enable registrars to be adequately trained.

4.1.7 Flexible Training

Flexible training is, in theory, available to junior doctors. For PRHO and SpR posts this is managed by the NICPMDE. Candidates must justify that training on a full time basis would not be practicable. Not surprisingly, the vast majority of flexible trainees are women.

At January 2002, there were no flexible trainees at PRHO level, 1 SHO and 22 SpR. There was also a waiting list of candidates (1 PRHO and 10 SpR) waiting for funding. Job shares are also encouraged e.g. in areas such as psychiatry.

At present flexible training sessions include participation by the doctor in on-call and emergency duties along with their colleagues at the same grade. The New Deal for junior doctors dictates that if a flexible trainee is participating in an illegal rota (and in NI most of the junior doctors rotas are still illegal), or working more than 40 hours a week, they are entitled to full pay irrespective of the actual hours which they are working. This can therefore make flexible trainees very expensive, but is also seen as unfair on their other colleagues working full time. Not surprisingly, trusts are currently reluctant to fund the additional costs not covered by the NICPMDE.

4.1.8 GP Retainer Scheme

A retainer scheme is centrally available to encourage qualified GPs back to work after a career break, and currently there are 45 places. It provides four fixed sessions a week and is available for five years. It also allows for an additional two sessions in General Medical Services (GMS) related work e.g. family planning if desired. Extensions are only available at the end of the five-year term if there are unfilled places, and this is not usually the case. Currently there are no males on the scheme.

4.2 Workforce Composition

Appendix C provides a series of tables showing the composition of the Consultant, Non-consultant Career Grade, Specialist Registrar, SHO, PRHO, GP and Other staff groups and key trends, in terms of:

- Department/speciality;
- Trust;
- Age;
- Gender; and
- Part-time/Full-time working.

For the purposes of this report, the specialties have been amalgamated into 15 major groups. Appendix D lists the specialties and groupings.

All of the information is based on the HRMS annual return to the DHSSPS as at September 2001, or information provided by the Central Services Agency (CSA) or NICPMDE.

Whilst it is recognised that there may be minor discrepancies in the payroll data e.g. differences between trusts in classification of staff to specialties, and that some changes will have occurred since September, the overall data is considered robust enough for the level of data modelling required.

The numbers represent headcount, not whole time equivalents (w.t.e.).

The key workforce trends are outlined below.

4.2.1 Total Workforce Numbers

Table 4.1 shows the total number in each workforce group in 2001:

Table 4.1
Medical Workforce (2001)

Workforce Group	Number in Workforce	Change 1998-2001	% Change 1998-2001
Consultants	929	+58	+7%
Non-consultant career grades	188	+52	+38%
Specialist Registrars	471	+39	+9%
Senior House Officers	720	+38	+6%
Pre-Registration House Officers	188	+4	+2%
Other	244	-65	-21%
General Practitioner Registrars	42		
General Practitioner Principals	1,069	+27	+3%

"Other" includes hospital / general / medical practitioners and medical officers on the HRMS payroll

Source: HRMS September 2001

4.2.2 Consultants

In 2001 there were 929 Consultants, the largest proportion of whom worked in medical specialties (18%) surgical specialties (19%) and anaesthetics (17%). Between 1998 and 2001, there was an overall growth of 7% (58) with the largest growth in absolute terms being in Pathology (14). Greatest Consultant numbers are present in the Royal Group of Hospitals and Belfast City Hospitals Trust which account for 312 (34 % of the total workforce).

59% of the 929 Consultants are aged 40 – 55, and 17% are over 55, with 49 consultants already over 60 years of age.

The gender split within the Consultant group has changed only slightly between 1998 and 2001, with a 1% increase in the proportion of females in the workforce. The balance in 2001 was:

- Female 22% workforce; and
- Male 78% workforce.

This is in marked contrast to the balance of current medical students where over 60% are female.

The number of Consultants working part-time has decreased slightly, from 216 in 1998 to 213 in 2001, 23% of whom are women. However, the information available does not identify between those staff who have part-time HPSS contracts due to shared posts, such as with the University, those with "maximum part-time" contracts and those who are "genuine" part-time.

4.2.3 Non-Consultant Career Grades

The non-consultant career grade workforce covers staff graders and associate specialists. Total numbers stood at 136 in 1998 but had risen to 188 by 2001 – a 38% increase, all in Staff Graders.

In 2001, the main work areas for non-consultant career grades were in A&E, Paediatrics, Community and General Medicine.

The group is relatively young, with 70% being aged under 45 in 2001. The workforce is predominantly female (60%), a percentage increase of 3 % since 1998.

Part-time working has increased in recent years – 26% of the group worked part-time in 1998 and 31% were working part-time in 2001, of whom 93% were women.

4.2.4 Specialist Registrars

The number of Specialist Registrars has grown by 9% since 1998 with a total workforce of 471 in 2001. This does not include 42 GP Registrars on the GP training scheme.

90% of the 471 SpRs are aged 26 – 40, and 40% of the workforce are female, an increase of 6% since 1998. The percentage of the workforce working part-time has remained steady at 7%, and 70% of these are women.

4.2.5 SHO

The number of SHO posts has also grown in the last four years, by 6% to 720, principally in Anaesthetics and A&E. 76% of the 720 SHOs are under 30, with 4% (36) being over 40. The fact that 24% are over 30 may reflect the difficulties that many are experiencing in obtaining SpR posts, and the length of time many of them are therefore spending at the SHO grade.

45% of the group are female and this has remained steady over the last four years. Only 3% work part-time.

4.2.6 PRHO

PRHO posts have remained fairly static over the last few years, with 188 in September 2001 although increases to 212 by August 2002 have been agreed. 94% are under 30 and 57% are female.

4.2.7 Other

The "Other" group consists of staff classified on the HRMS system as hospital practitioners, general/medical practitioners, and medical officers. They mainly work in community trusts in A&E, geriatrics, dermatology, community and family medicine and are principally employed on a sessional basis, and therefore not surprisingly 86% are part-time. The numbers have dropped from 309 in 1998 to 244 in 2001.

The age range is very wide and relatively evenly spread within ages 30 to 60 years and the percentage of females has remained static at about 49%.

4.2.8 General Practitioners (GPs)

There are 1,069 GP principals in Northern Ireland 75% of whom are under 50 with 4% (48) over 60.

Only 23% are female, 41% of whom work part-time.

However, it is known that there are also approximately 160-180 registered GPs in Northern Ireland who are not working as GP Principals. Many of these are working on a sessional or locum basis, but it is not known how many are actively looking for a principal's position.

5. KEY ISSUES - SUPPLY

Set out below are the major supply issues raised during the key stakeholder interviews.

5.1 Consultants

5.1.1 Unattractive posts

Many consultants are looking to retire early, or posts are proving difficult to fill, because they are no longer attractive work prospects. Factors contributing towards this include high levels of on-call, and the increasing pressure which changes to junior doctors' hours and the consequent lack of junior doctors are putting on consultants to make this on-call commitment even higher.

Poor infrastructure in some trusts, for example, the physical estate or lack of theatre time, or nursing support, and the lack of availability of private practice in many areas does not make working in Northern Ireland attractive to consultants from outwith the province. The opposite is also true in that posts in the rest of the UK are often more attractive to Northern Irish doctors than remaining in the province.

One third of respondents to the Royal College of Physicians, London, recent hospital consultant questionnaire[2] reported that at least one of their colleagues had opted out of the acute general medicine rota, and one third indicated that they too would like to opt out of on-take duties. And the Royal College of Surgeons of England's report[3] suggests that freedom from on-call duties may be required if senior surgeons are to be encouraged to stay in their posts beyond the current average retirement age of 60 years. This changing attitude towards work/personal-life balance (in part, probably a reflection of an increasing proportion of women doctors in senior positions) represents an irrevocable change in the health service.

One of the underlying problems is that all consultants are expected to perform in the same way. This is especially so with surgeons who are, for example, expected to undertake the same number of outpatient, operating and teaching sessions as their consultant colleagues, regardless of their age. However, according to the Royal College of Surgeons in England, most surgeons, especially those in their earlier years, would welcome more operating sessions than the average of 2-4 scheduled half-day elective operating lists per week. Standing for long periods at an operating table becomes less easy as one gets older, whilst one's overall clinical knowledge and experience becomes greater with age. Therefore, to improve clinical performance, provide more effective teaching and to increase staff retention rates beyond the average retirement age, it may be appropriate to enable more senior

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[2] Royal College of Physicians, London, 2002 "Coping with Pressures in Acute Medicine: 3rd RCP consultant questionnaire survey".

[3] Royal College of Surgeons of England. London 2001 "The Surgical Workforce in the New NHS"

surgeons to undertake proportionately more outpatient and teaching sessions and fewer operating sessions and for their younger colleagues to operate more.

5.1.2 Vulnerability of small sites

Where small sites are struggling to cover with limited numbers of consultants, the loss of one person can have a major impact on the site's ability to maintain a service. It puts extreme pressure on the remaining consultants, making their posts even less attractive. Once several vacancies arise in one specialty, the ability to recruit is extremely limited, as no one wants to take on a short-handed service.

5.1.3 UK shortages

There are a number of specialties, such as radiology, anaesthetics and laboratory medicine, where there are significant shortages in consultant staff throughout the UK. This results in trusts "robbing Peter to pay Paul" with organisations offering differing remuneration packages to encourage staff across, so resulting in a staff shortage elsewhere. Within the province, no strategic overview is taken as to where the key shortages are and which posts are priorities for filling, as appointments are generally managed on a trust rather than a wider basis.

5.2 Doctors in Training

5.2.1 Capacity constraints – Queens Medical School

In recent years the number of undergraduate places made available at Queens has been increasing. However, this has been at an incremental rate, and the Medical School has now reached its current capacity. This applies to both teaching staff and facilities such as clinical simulation. A step change in investment is needed if undergraduate numbers are to continue to expand.

5.2.2 Capacity constraints – in service training

Many interviewees cited that the current major constraint restricting the system in its ability to produce more consultants in the short-term is in relation to available capacity for in service training. This is particularly so for Specialist Registrars. Even though there is currently an excess of SHOs available for SpR posts, the changes to training (for example surgeons requiring increased supervision) and the need to ensure staff receive a sufficient level of exposure and experience mean that accreditation by the Royal Colleges for additional training posts may not be forthcoming.

Whilst this is the case for some specialties, it does not apply to all, and work should be carried out on a specialty basis to determine those areas where additional training posts can be established in the short-term.

5.2.3 Male / Female split

The following table shows the balance of males to females in the various staff groups in 2001 and 1998:

Table 5.2.3

Male / Female Split by Staff Group

	2001		1998	
Staff Group	**% male**	**% female**	**% male**	**% female**
Consultant	78	22	79	21
SpR	60	40	66	34
SHO	55	45	54	46
PRHO	43	57	56	44
New Undergraduates	40	60		
NCCGs	40	60	43	57
"Other"	51	49	52	48
GPs	67	33	70	30

At present more than 60% of new undergraduate medical students are female, as opposed to 22% of current consultants. Whilst recognising the long timescale for training a doctor to consultant level (approximately 15 years), and the improvement in ratio at, for example, SpR level, this raises a major issue. Clearly, unless there is a concerted effort made to facilitate more family friendly policies, with flexible training and more imaginative working patterns (and in some areas a change in attitude), this will contribute to a significant shortage of consultants across all specialties in the future, and a high proportion of the current investment in undergraduate medical students will be lost.

5.3 General Practitioners

5.3.1 Availability of Trained Staff

As previously mentioned, in Northern Ireland there are approximately 160-180 trained GPs who are not working as GP Principals. Whilst some of these may be looking for a permanent position within a practice, a large number of them enjoy the benefits which locum or sessional work provides, particularly with regards to part-time working and family friendly hours. Many also do not wish to make the business commitment of becoming part of a practice, which a principal position requires.

The current system of funding for GPs does not encourage practices to expand their number of partners when there are more financially beneficial ways of covering the workload, for example by employing locums, even though this inevitably has an impact on the quality and continuity of care delivered.

Therefore at present there is not a shortage of GPs in the province. However, it must be stressed that this is based on the current number of GP positions. Both the changes proposed to future GP contracts and the move to a more primary care focused pattern of service delivery are likely to have an impact on the number of GP posts (whether as principals or otherwise) required across the province. Expansion to the level envisaged in, for example, the Acute Hospitals Review Group of an increase of 25% will result in a shortage of GPs unless an increased number of trainees are planned for in the future.

6. KEY ISSUES – DEMAND AND OTHER FACTORS

6.1 Acute Services

Whilst the issues around the supply of staff vary by staff group, the factors dictating demand are relatively common to all. The key areas at present are:

- Increasing pressure on acute services, whether from changing demographics, increasing admissions, pressures on waiting lists, delays in discharging elderly patients to the community, increased public expectations, changing care needs, advances in medical technology or resource constraints; and
- Changing legislation with regards to working conditions, including the European Working Time Directive, and qualitative aspects such as clinical governance.

6.2 General Practice

Increased demand for staff is resulting from a variety of factors that are continuously evolving, 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, diversification in areas such as palliative care, hospital-at-home and minor surgery; and
- The potential 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.

6.3 Service Configuration

As previously mentioned, there are a number of strategic documents which have recently been published, the outcome of which may potentially have a significant impact on the configuration of services in the province in the future. What is already clear is that given the current and projected shortages of doctors, not just at consultant level, across a range of specialties, the present configurations are not sustainable. Irrespective of any other pressures, the service is unable to deliver on the European Working Time Directive or the New Deal for Junior Doctors, both of which are now legal requirements.

The outcome of the discussions on service configuration will have a significant impact on workforce planning and will enable detailed projections to be made at a site and specialty level. Models will require regular updating as progress is made in these discussions.

6.4 Changes to GP and Consultant Contracts

As previously mentioned, national negotiations are currently ongoing with regards to GP and Consultants contracts and the outcomes of these are not yet finalised. However, they are likely to have an impact on the level of hours worked by senior staff and therefore the manpower requirements needed to compensate for potential reductions.

6.5 Specialisation vs. Generalisation

There is an increasing conflict within the service between specialisation and generalisation of doctors. The current pattern of training provision and the impact of clinical governance and quality standards are some of the factors driving the move towards increased specialisation. However, this is resulting in an increased difficulty in covering areas such as medical and surgical on-calls, where specialised staff are not willing to provide diagnosis or undertake procedures which they do not carry out on a regular basis. It is also resulting in a difficulty in providing cover at smaller sites where generalists are needed and there are not sufficient volumes of activity to justify specialist cover.

Whilst some of the professional colleges are recognising this as an issue, further work needs to be carried out to resolve it. It creates a tension between service providers and the medical and training bodies and this needs to be addressed. Consultation on the creation of a Medical Education Standards Board has been completed and proposals from this should enable the province to move forward in finding solutions to the problem.

6.6 Specialty specific

Every specialty and sub-specialty is different, and there are a large number to be considered. For the purposes of this report we have grouped the 67 payroll categories used by the acute services into 15 groups. However, when reviewing workforce planning this broad-brush approach can only be used as a starting point and more detailed work is needed at a much lower level to provide accurate projections. Each specialty will have varying requirements and the solutions for each will also differ.

6.7 Determination of Number of Posts and the Roles of Doctors in Training

At present the number of PRHO posts available per annum is primarily dictated by the need to ensure posts are available for all graduates from Queen's Medical School. This has recently been increased in recognition of the impact of the New Deal on Junior Doctors Hours.

The number of Specialist Registrar posts are centrally controlled and based on anticipated numbers of consultant vacancies as a result of factors such as service expansion and retirements. The process has been designed to ensure that all Specialist Registrars should be able to secure a Consultant post within a short time period after achieving their CCST. This means that there is no over-supply of consultant level staff in the province, but also means that increasing the number of consultant staff from within the system cannot be achieved quickly.

These factors have also resulted in a "surplus" of staff at SHO grade, with significant numbers of training doctors experiencing difficulties and time delays in securing a Specialist Registrar post with which to progress their training.

6.8 New Ways of Working

Significant work has taken place throughout the UK to look at new ways of working, primarily driven by the need to ensure compliance with the New Deal. Work in Northern Ireland is being taken forward by the Implementation Group, but there is still a significant amount of work to be done.

Whilst some areas can be progressed quickly, the development of new forms of healthcare professionals, such as physicians assistants, will take longer to have an impact.

Experience so far in Northern Ireland has shown that a major limiting factor in taking some of this work forward is the shortage of nurses and other healthcare professionals available to fulfil alternative or additional roles.

6.9 Non-consultant Career Grades (NCCGs)

Non-consultant career grade staff are increasingly being used to support consultant led services in hospitals. In the opinion of the NHS Executive[4] these roles must be clearly defined and should be appointed only to recognised grades.

Whilst concerns have been expressed as to the professional linkages (e.g. with Royal Colleges) and the need to ensure requirements for Continuing Professional Development are met, these grades could make a significant contribution to helping resolve manpower issues.

6.10 Strategic Overview

The current systems in place in Northern Ireland result in a mixture of organisations determining posts and how they should be filled within each specialty. Particularly at consultant level, where vacancies and additional posts are managed by health boards and trusts, there have been examples of "robbing Peter to pay Paul" which have not helped the service overall. In these circumstances the most pressing service needs in the province as a whole may not be addressed or filled as a priority, nor does it enable staff to be readily moved around the province should a new pressure within a specialty arise. A more strategic approach could potentially reduce some of these problems and ensure priorities are addressed to the overall benefit of the service.

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[4] NHS Executive. Good Practice Advisory Document. "The Recruitment of Doctors and Dentists in Training" Dept. of Health, London 1998

7. DATA MODELLING

7.1 Source of Data

In developing a supply and demand model for each of the medical staff groups, a series of assumptions was developed based on the HRMS data and feedback from key informants. The assumptions are set out below.

7.2 Modelling Assumptions – Supply Factors

7.2.1 Retirements

Age information for each staff group has been provided in 5-year age bands (see Appendix C) and we have assumed a linear age spread within each band. While the average retirement age is thought to be dropping, some staff are still working well beyond 60. The average age of consultant retirements (excluding early retirements on the grounds of ill health) in 2001 was 62. Anecdotal evidence indicates that some doctors are intending to retire earlier, however, issues such as pension planning may impact on many doctors ability to retire as early as they would like.

Therefore, following discussion with the Steering Group we have assumed a current retirement age of 62 dropping steadily to 59 after ten years. The impact of this has been smoothed over the timescale covered by the model.

Table 1.6 in Appendix C shows a breakdown, by specialty, of the number of consultants over 50, and therefore who may potentially retire in the next ten years. This is compared to the current number of consultants in each specialty to give the percentage of potential retirements.

7.2.2 Other Leavers

Data has been supplied by the DHSSPS detailing, for the year 2001, the number of leavers for each grade broken down by category, e.g. personal reasons, ill health, job elsewhere etc. Categories such as transfers to other trusts and completion of training contracts have been ignored as it is assumed these staff have remained within the system. From this data, an annual percentage of leavers has been calculated and applied to the models. Bearing in mind that the data available only covers one year, following discussion with the Steering Group, the percentage for PRHO staff was dropped from 6% (11 per annum) to 1% (2 per annum). All other percentages remained the same. The percentages by grade used in the modelling are therefore:

Consultants	3%
Non-consultant career grades	5%
Specialist Registrars	4%
SHO	4%

PRHO	1%
Other	8%
GP	1%

7.2.3 Current Vacancies

For modelling purposes information on current consultant vacancies gathered by the DHSSPS for its annual review and projection of Specialist Registrar posts has been used. This equates to an overall 8% of total workforce. It is assumed these will be filled over the next two years.

No information is held centrally with regards to non-consultant career grades and other posts, but vacancies are assumed to be minimal. Anecdotal evidence indicates there are some vacancies for SHO posts, particularly in paediatrics and psychiatry, so 20 have been allowed for in the model.

From information provided by the NICPMDE there are no current Specialist Registrar and PRHO vacancies, although they are at present projecting 12 PRHO vacancies for the August intake.

It is assumed that, given there are currently no significant recruitment problems with GPs, that there are no current vacancies in the system.

7.2.4 Loss to Workforce Due to Work / Life Balance

It needs to be recognised that the increasing percentage of women entering the profession will result in a drive for greater availability of family friendly work policies and flexible training. It is also known that women are generally choosing to start their families at a later age, and therefore the major impact is expected within the Consultant, GP and Specialist Registrar grades. For the purposes of the model it has been assumed that there will be an annual increase in staff required to compensate for hours lost of 1 % rising to 2.5% per annum over ten years.

For all other staff groups it has been assumed that there will be an increase of 1% per annum.

7.3 Modelling Assumptions – Demand Factors

7.3.1 Working Time Directive

It is very difficult at this stage to quantify the potential impact of the WTD with regards to Consultants, and therefore the impact has been subsumed within the projections for increased workload.

It is assumed that there is no impact with regards to GPs, NCCGs except full time Staff Graders, and Other grades.

For SpR, SHO, PRHO grades and full time Staff Graders the following assumptions have been applied:

- they currently work an average non-compliant 64 hours per week;

- this will drop to 56 hours per week for the first six years – average loss = 8 hours per week = 14% increase in staff required;
- this will then drop to 48 hours per week – again average loss = 8 hours per week = a further 14% increase in staff;
- the implementation will take several years to complete;
- the above impact on SHO and PRHO grades will be reduced by 33% as a result of the transfer of workload to non junior doctor staff; and
- the already agreed increase to PRHO posts for August 2002 is included in the first year.

It is fully recognised that this is a very general approach and that the actual impact is dependent on a range of factors such as intensity of workload, and size of organisation. However, that requires working at a specialty or sub-specialty and site level and this level of detail was outwith the remit of this review.

7.3.2 Workload Projections

Taking into consideration the deliberations of the Acute Hospitals Review Group, service reconfigurations, the impact of an ageing population, the potential impact of the new GP and Consultants contracts, the findings of the Wanless Report[5], and professional guidelines, an increase in Consultants of 40% and GPs of 25% over the next ten years has been assumed. (Sensitivity analysis has also been carried out on an increase of 60% for consultants and 40% for GPs – see section 6.8.3).

In recent years, there has been a significant increase in the number of NCCG posts requested and established. These have been required for a number of reasons, principally to enable trusts to manage the impact of the working time directive on training grade posts, and partly to help alleviate other service pressures. It is likely that the rise in posts will continue in the short-term, however, the assumptions within the data modelling are that the requirements for meeting the WTD and increased service pressures will in the main be covered by the projected requirements for increasing training grade and consultant numbers, and therefore, after a period of time, the numbers of NCCG posts required to cover these factors will no longer continue to rise. Therefore, for the workload projection, an increase of 30% over current numbers has been projected over the next five years, based on a declining rate of increase.

No increase has been assumed for other staff groups other than those included above for the WTD.

7.3.3 Annual Completion of Training Grades

In order to project the planning numbers through all of the relevant grades we need to "annualise" the numbers of staff at each of the training grades. We

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[5] Securing our Future Health: taking a Long Term View, 2002

have therefore assumed that it takes 1 year to complete PRHO training, 4 years to complete SHO training, 1 year for GP Registrar training and 5 years for an SpR to complete training and be ready for a consultant's post.

The current workforce composition has 471 SpRs, equating to 94 per annum completing training. There are 720 SHOs, equating to 180 per annum and from August there will be 212 PRHO posts.

7.4 Summary of Assumptions

The following table summarises the assumptions to be applied for the data modelling:

Table 7.4

Summary of Assumptions for Data Modelling

	Cons	NCCG	SpR	SHO	PRHO	Other	GP
Supply							
Retirement	62 down to 59 after 10 yrs		n/a	n/a	n/a	62 down to 59 after 10 yrs	
Leavers / annum	3%	5%	4%	4%	1%	8%	1%
Current Vacancies – assumed filled over 2 yrs	8%	0	0	3%	0	0	0
Work / life balance increase per annum	1% to 2.5% after 10 yrs	1%	1% to 2.5% after 10 yrs	1%	1%	1%	1% to 2.5% after 10 yrs
Demand							
WTD - increase							
2002/03 to 2006/07	-	14%*	14%	10%	10%	-	-
2007/08 to 2011/12	-	14%*	14%	10%	10%	-	-
Workload increase	40% over 10 yrs	30% over first 5 yrs	-				25% over 10 yrs

* full time staff graders only

7.5 Models

Applying the above assumptions for each staff group results in the following data models. **NOTE - THESE MODELS ASSUME THAT ALL POSTS ARE FILLED EACH YEAR I.E. THE SHORTFALLS ARE NOT CUMULATIVE.** For a detailed description of how the models are calculated, see Appendix E.

7.5.1 Consultants

The table sets out the projected number of SpRs required to complete their training each year in order to meet the need for additional consultants on an annual basis, and how that compares with the current and projected annual supply:

Table 7.5.1

Projected New Consultant Requirements per annum

	2002 /03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/ 12**
Supply										
Retirements	25	24	22	30	28	27	39	39	39	49
Leavers	28	28	28	28	28	28	28	28	28	28
Current Vacancies	37	37								
Work / life balance	9	11	14	17	19	20	21	22	23	23
Demand										
Increased workload	37	37	37	37	37	37	37	37	37	37
Total per annum	**136**	**137**	**101**	**112**	**112**	**112**	**125**	**126**	**127**	**137**
SpR Supply	94	95	99	103	107	112	117	122	128	133
Over supply / -Shortfall	**-42**	**-42**	**-2**	**-9**	**-5**	**0**	**-8**	**-4**	**1**	**-4**

At present the system is producing approximately 94 new consultants (SpR completing their training) per annum, which will gradually rise over the next ten years. This results in a shortfall in available consultants against projected consultant requirements. Whilst future requirements are more closely met within the above model, it does not produce sufficient staff to cover the initial shortfall, nor does it allow any "over supply" of doctors in the future.

When reviewing anticipated retirements (Appendix C, Table 1.6), it is worth noting that for some sub-specialties a considerable percentage of consultant staff may potentially retire over the next ten years, for example 60% in Thoracic Medicine, 67% in Endocrinology and Diabetes, 75% in Paediatric Surgery.

7.5.2 Non-consultant Career Grades

The table sets out the projected number of new staff required to be available each year in order to meet the need for NCCG on an annual basis:

Table 7.5.2

Projected Non-Consultant Career Grade Requirements per annum

	2002/03	**03/04**	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
Supply										
Retirements	4	4	5	2	3	2	6	3	3	7
Leavers	9	9	9	9	9	9	9	9	9	9
Work / life balance	2	2	2	2	2	2	2	2	2	2
Demand										
WTD		2	2	2	2	2	3	3	3	3
Increased workload	19	15	11	8	4					
Total per annum	**34**	**32**	**29**	**23**	**20**	**15**	**20**	**17**	**17**	**21**

It is assumed for modelling purposes that the NCCGs are filled by experienced SHOs, and this is factored in to the following tables when looking at the requirements for SHO posts.

7.5.3 Specialist Registrars

The table sets out the projected number of staff required each year to fill SpR positions, combined with new staff required for NCCG and GP Registrar posts, on the basis that these three categories all require qualified SHO staff, so giving a total requirement for trained SHOs each year:

Table 7.5.3

Projected New Specialist Registrar Requirements per annum

	2002/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Supply										
Annual SpR intake	94	95	99	103	107	112	117	122	128	133
Leavers	19	19	19	19	19	19	19	19	19	19
Work / life balance	5	6	8	9	10	10	11	12	13	13
Demand										
WTD	0	13	13	13	13	13	16	16	16	16
Total SpR per annum	**118**	**133**	**139**	**144**	**149**	**154**	**163**	**169**	**176**	**181**
Requirement for NCCG	34	32	29	23	20	15	20	17	17	21
Requirement for GP Reg	75	77	80	87	83	89	98	105	107	114
Total SHO Requirement	**227**	**242**	**248**	**254**	**252**	**258**	**281**	**291**	**300**	**316**
Current SHO Supply (see below)	**180**	**184**	**192**	**197**	**202**	**207**	**212**	**218**	**224**	**230**
Shortfall	**-47**	**-58**	**-56**	**-57**	**-50**	**-51**	**-69**	**-73**	**-76**	**-86**

In order to do the above modelling it is necessary to calculate an annual intake into year 1 and graduation from year 5 of this part of the training programme. As a baseline the current number of SpR posts has been spread over five years (471/5 = 94). The annual total increase in posts required to meet the needs of the working time directive and the work/life balance for the whole SpR workforce are also assumed to be spread across the five years of training doctors in the group. Therefore the number of posts being created for each year of entry / graduation is increased annually by 1/5 of the increase in total posts each year.

The number of staff required each year will be greater than the number of posts available in order to take account of the leavers each year whose posts require refilling.

The requirement for increased GP registrars, principally as a result of the projected 25% increase in GPs, will result in a shortfall of SHO trained staff each year over the projected ten-year period.

7.5.4 Senior House Officers

The table below sets out the annual requirements for SHO staff, and how this compares to the current number of PRHO staff likely to be available:

Table 7.5.4

Projected New SHO Requirements per annum

	2002 /03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/ 12**
Supply										
Annual SHO intake	180	184	192	197	202	207	212	218	224	230
Leavers	29	29	29	29	29	29	29	29	29	29
Vacancies	10	10								
Work / life balance	7	7	7	7	7	7	7	7	7	7
Demand										
WTD	0	13	13	13	13	13	17	17	17	17
Total SHO per annum	**226**	**243**	**241**	**246**	**251**	**256**	**265**	**271**	**277**	**283**
Current PRHO Supply	**188**	**214**	**219**	**224**	**229**	**233**	**238**	**244**	**250**	**256**
Shortfall	**-38**	**-29**	**-22**	**-22**	**-22**	**-23**	**-27**	**-27**	**-27**	**-27**

As with the SpR group, an annual intake into year 1 and graduation from year 4 of this stage of training has been calculated, and increases in posts for WTD and work/life balance have been spread over the four years.

As can been seen, there is a small projected shortfall of PRHO trained staff on an annual basis. These staff would require to be resourced from outwith the province.

7.5.5 Pre-Registration House Officers

The table below sets out the projected requirement for PRHO posts based on current service need and how this compares to the anticipated number of graduating students:

Table 7.5.5

Projected New PRHO Requirements per annum

	2002/03	**03/04**	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
Supply										
Annual PRHO Intake	212	214	219	224	229	233	238	244	250	256
Leavers	2	2	2	2	2	2	2	2	2	2
Work / life balance	2	2	2	2	2	2	2	2	2	2
Demand										
WTD	0	3	3	3	3	3	4	4	4	4
Total PRHO needs	**216**	**221**	**226**	**231**	**236**	**240**	**246**	**252**	**258**	**264**
Student Supply	**183**	**173**	**169**	**169**	**180**	**180**	**180**	**180**	**180**	**180**
Shortfall	**-33**	**-48**	**-57**	**-62**	**-56**	**-60**	**-66**	**-72**	**-78**	**-84**

The above factors in the current anticipated graduate supply for the next four years are based on figures provided by the QUB Medical School and a return to current levels for future years. This assumes the only supply of students is via QUB Medical School and does not take in to account the availability of graduates from the rest of the UK or the Republic of Ireland.

7.5.6 Others

The following table sets put the requirement for new staff on an annual basis:

Table 7.5.6

Projected New "Other" Requirements per annum

	2002/03	**03/04**	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
Supply										
Retirements	6	7	7	13	8	9	15	8	7	24
Leavers	20	20	20	20	20	20	20	20	20	20
Total	**26**	**27**	**27**	**33**	**28**	**29**	**35**	**28**	**27**	**44**

Given that these are mainly sessional staff, for example GPs doing hospital sessions, it is assumed that staff already trained and available, including the additional GPs projected below will fill them.

7.5.7 General Practitioners

The following table sets out the requirements for newly qualified GPs per annum, and how that compares with the current supply of qualifying GP Registrars:

Table 7.5.7

Projected GP Requirements per annum

	2002/03	**03/04**	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
Supply										
Retirements	27	27	27	31	25	30	37	43	43	50
Leavers	12	12	12	12	12	12	12	12	12	12
Work / life balance	11	13	16	19	21	22	24	25	27	27
Demand										
Increased Workload	25	25	25	25	25	25	25	25	25	25
Total GP Reg Requirement	**75**	**77**	**80**	**87**	**83**	**89**	**98**	**105**	**107**	**114**
Supply	**42**	**75**	**77**	**80**	**87**	**87**	**89**	**98**	**105**	**107**
Shortfall	**-33**	**-2**	**-3**	**-7**	**4**	**-2**	**-9**	**-7**	**-2**	**-7**

The table assumes that the number of GP Registrar training posts are increased each year in line with previous year requirements, so resulting in an initial high shortfall, with lower shortfalls projected in future years.

7.6 Summary of Data Modelling

The following table sets out the results of the data modelling for each staff group. It shows the requirement for staff each year based on current posts and additional service requirements within each grade of staff:

Table 7.6.1

Projected Requirements for Staff per annum

	2002 /03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/ 12**
Consultants	136	137	101	112	112	112	125	126	127	137
GPs	75	77	80	87	83	89	98	105	107	114
SpR	118	133	139	144	149	154	163	169	176	181
NCCG	34	32	29	23	20	15	20	17	17	21
GP Reg	75	77	80	87	83	89	98	105	107	114
SHO	226	243	241	246	251	256	265	271	277	283
PRHO	216	221	226	231	236	240	246	252	258	264

It is important to bear in mind that this is the number of staff required per annum and therefore covers staff leaving requiring replacement. Therefore for the training grades (SpR, SHO and PRHO), the above numbers do not equate to the number of qualified staff available each year to progress to the next stage of training.

The following section sets out the number of staff completing each stage of training each year and compares this to the number required.

7.7 Projected Shortfalls in Available Staff

The following tables summarise the projected shortfalls in staff as set out in the data models. These are based on training timescales of 1 year at PRHO, 4 at SHO and 5 at SpR level. (NOTE – these are annual shortfalls, based on workforce requirements within each group, and assume that projections for previous years are met. This is not necessarily realistic and it is therefore important to bear in mind that some of these shortfalls may need to be added together to give a cumulative figure.):

Table 7.7.1

Projected Requirements for newly qualified SpR per annum

	2002 /03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/ 12**
Consultants Required	136	137	101	112	112	112	125	126	127	137
Available SpR	94	95	99	103	107	112	117	122	128	133
Over supply / (Shortfall)	**-42**	**-42**	**-2**	**-9**	**-5**	**0**	**-8**	**-4**	**1**	**-4**

For the next two years there will be a significant shortfall in staff available to meet Consultant requirements. Whilst the numbers available in the future more closely match need, they are not sufficient to cover the shortfall from previous years, nor do they allow for an over supply of qualified doctors.

Table 7.7.2

Projected Requirements for newly qualified SHO per annum

	2002 /03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/ 12**
SpR Required	118	133	139	144	149	154	163	169	176	181
NCCG Required	34	32	29	23	20	15	20	17	17	21
GP Reg Required	75	77	80	87	83	89	98	105	107	114
	227	242	248	254	252	258	281	291	300	316
Available SHO	180	184	192	197	202	207	212	218	224	230
(Shortfall)	-47	-58	-56	-57	-50	-51	-69	-73	-76	-86

As a result of the projected increase in GPs required (and therefore the knock-on effect on GP Registrar posts) there is an annual shortfall of qualified SHO staff to fill these posts and additional staff would need to be attracted in from elsewhere.

Table 7.7.3

Projected Requirements for newly qualified PRHO per annum

	2002/03	**03/04**	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
SHO Required	226	243	241	246	251	256	265	271	277	283
PRHO Supply	188	214	219	224	229	233	238	244	250	256
(Shortfall)	-38	-29	-22	-22	-22	-23	-27	-27	-27	-27

There is a small projected shortfall in qualified PRHO staff per annum, so again, staff would need to be attracted in from elsewhere.

Table 7.7.4

Projected Requirements for new Graduates per annum

	2002/03	**03/04**	**04/05**	**05/06**	**06/07**	**07/08**	**08/09**	**09/10**	**10/11**	**11/12**
PRHO Required	216	221	226	231	236	240	246	252	258	264
Graduate Supply	183	173	169	169	180	180	180	180	180	180
(Shortfall)	-33	-48	-57	-62	-56	-60	-66	-72	-78	-84

The shortfall in graduates over the next four years will need to be met by attracting graduates from elsewhere in the UK or the Republic of Ireland. Additional capacity will need to be developed at QUB immediately if the continuing shortfall is to be met from within Northern Ireland. An increase in capacity at QUB to 250 per annum would be sufficient.

As can be seen from the above, the level of shortfalls in available staff are not the same at each grade. The greatest levels of shortfall are for graduates and SHO. This is principally because experienced SHOs are required to feed in to the Spr, NCCG and GP career routes, and is therefore impacted by the expansion of both Consultant and GP posts.

In order to meet this need, a greater number of PRHO posts than is necessary for service requirements would have to be established, which would have major implications for the availability of sufficient training for this number of doctors.

7.8 Sensitivity Analysis

The above models are developed using a series of assumptions, some of which have a greater impact than others. Therefore sensitivity analysis has been carried out on several of the larger variables to assess their impact. The three areas reviewed are the age of retirement, the annualisation of the career grades and the assumed increase in workload.

7.8.1 Age of Retirement

The models assume a current retirement age of 62, dropping to 59 by year ten, resulting in an anticipated 701 retirements (322 Cons, 39 NCCG, and 340 GP). However, if this is adjusted to an assumed annual retirement age of 60 for the ten years, this reduces the number of retirements to 613 (269 Cons, 34 NCCG, 310 GP). This has an impact on the number of training posts required per annum as follows:

Table 7.8.1

Projected Requirements for newly qualified staff per annum

	2002 /03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/ 12**
Retire 62 - 59										
Consultants	136	137	101	112	112	112	125	126	127	137
Available SpR	94	95	99	103	107	112	117	122	128	133
Over supply / (Shortfall)	**-42**	**-42**	**-2**	**-9**	**-5**	**0**	**-8**	**-4**	**1**	**-4**
Retire 60										
Consultants	127	150	116	103	104	106	115	116	117	117
Available SpR	94	95	99	103	107	112	117	122	128	133
Over supply / (Shortfall)	**-33**	**-55**	**-17**	**0**	**3**	**6**	**2**	**6**	**11**	**16**

Table 7.8.1 (continued)

Projected Requirements for newly qualified staff per annum

	2002 /03	03/ 04	04/ 05	05/ 06	06/ 07	07/ 08	08/ 09	09/ 10	10/ 11	11/ 12
Retire 62 - 59										
GPs needed	75	77	80	87	83	89	98	105	107	114
GP Reg	42	75	77	80	87	87	89	98	105	107
Over supply / (Shortfall)	**-33**	**-2**	**-3**	**-7**	**4**	**-2**	**-9**	**-7**	**-2**	**-7**
Retire 60										
GPs needed	64	92	95	82	84	85	94	95	97	97
GP Reg	42	64	92	95	95	95	95	95	95	97
Over supply / (Shortfall)	**-22**	**-28**	**-3**	**13**	**11**	**10**	**1**	**0**	**-2**	**0**

Maintaining a working life to 60 years enables sufficient newly qualified SpR to be trained to meet future needs, but will not cover shortfalls in the early years. Gaps in the early years could be partially bridged by enabling medical staff to feel comfortable working beyond 60.

7.8.2 Annualisation of Training Grades

The models assumed that 4 years are spent at SHO grade and 5 at SpR, and the baseline for the numbers of training doctors per year has been calculated by taking the current number of staff and dividing it by the relevant number of years.

However, we know that the training structure is complex and the time spent at the SHO and SpR grade will vary by specialty and individual. Therefore the models have also been calculated using a 3-year term at SHO and 6 year term at SpR. This results in a very different pattern of over supply and shortfall at the various grades as follows:

Table 7.8.2

Projected over supply / -shortfall of newly qualified staff per annum

	02/ 03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/ 12**
SpR	-57	-57	-18	-25	-21	-18	-27	-24	-20	-25
SHO	29	19	23	25	34	36	21	19	20	12
PRHO	-98	-91	-86	-88	-90	-92	-97	-100	-102	-104

As can be seen, this gives a significant shortfall of qualified SpR staff against Consultant posts, an over supply of SHO staff for SpR posts each year and a shortfall of PRHOs to fill SHO posts.

There are currently 471 SpR, which equates to 94 per annum on a five-year programme, and 79 per annum on a six-year basis. For SHO, of which there are currently 720, a four-year programme equates to 180 per annum, whereas a three-year programme equates to 240 per annum, a significant difference.

It is also known that a number of SHO qualified staff are currently working as Trust Doctors or Staff Graders because there are insufficient SpR posts available, and this will be distorting the figures available for modelling.

7.8.3 Workload Projections

The models assume an increase of 40% in Consultants (280) over ten years and 25% in GPs (250). Modelling an increase of 60% in Consultants (560) and 40% in GPs (430) has the following effect:

Table 7.8.3

Projected Requirements for newly qualified staff per annum

	02/ 03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/12**
SpR Shortfall	-61	-61	-21	-28	-23	-19	-27	-23	-18	-22
GP Reg Shortfall	-50	-3	-3	-7	4	-2	-9	-7	-1	-8
SHO shortfall	-64	-76	-74	-74	-68	-69	-86	-91	-93	-104

7.9 Additional Posts Requiring Funding

The data models project the number of staff required for each grade of post each year. However, many of these are required to fill posts which are already funded but become available e.g. retirements, leavers and current vacancies. It is also assumed that increases in staff numbers required due to the development of more flexible working patterns (work / life balance) are already funded as they will generally involve full time posts converting to part time posts, but equally the same whole time equivalent (w.t.e.) e.g. 1 full time post converting to two part time posts.

Therefore the areas where new funding for additional posts each year will be required will be for service expansion (Consultants, GPs and NCCGs), the working time directive (SpR, SHO, PRHO, and full time Staff Graders) and increases in GP Reg training posts. These are summarised below:

Table 7.9.1

Projected Requirements for Funding of Additional Staff per annum

	02/ 03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/ 12**	**Total**
Consultants	37	37	37	37	37	37	37	37	37	37	**370**
GP	25	25	25	25	25	25	25	25	25	25	**250**
NCCG	19	15	11	8	4						**57**
SpR		13	13	13	13	13	16	16	16	16	**129**
GP Reg	33	2	3	7	0	2	9	7	2	7	**72**
Staff Grade		2	2	2	2	2	3	3	3	3	**22**
SHO		13	13	13	13	13	17	17	17	17	**133**
PRHO		3	3	3	3	3	4	4	4	4	**31**

(note - NCCG above excludes Staff Graders shown separately)

8. CONCLUSIONS AND RECOMMENDATIONS

From both the qualitative analysis and the detailed data modelling we can draw the following conclusions and recommendations (it is recognised that these are all based on the premise that additional funding will be available to expand numbers of posts, and that this is not a given);

8.1 Complexity of Modelling

As can be seen from the sensitivity analysis, modelling the flow and requirements for staff at each level in the training programme is complex and subject to significant variation depending on the assumptions used. Varying the assumptions result in different levels of potential over or under supply, with the SpR and SHO grades being the main areas effected. This is complicated by the fact that the time period spent at each grade will vary by specialty and individual.

It must also be borne in mind that the shortfalls are against a backdrop of increasing the number of medical posts (all grades excluding "others") by 965 (27%) over ten years, compared to recent expansion of 6% over the last four year period.

However, all of the modelling indicates a need to increase the number of graduates available to fill future posts, and (as is already known) an under supply of newly qualified SpR staff in the short term.

8.2 Shortfall in new Consultants

The current system in Northern Ireland is not producing sufficient qualified staff to meet the potential requirements for Consultant staff and work needs to be carried out in the short term to review potential ways to fill the gap in the intervening years before additional staff can be trained.

The new consultant contract is likely to go a long way towards addressing many of the problems identified by consultants. However, implementing the contract will require an increase in consultant numbers. It will also require a significant change in the way consultants work and, because there are insufficient doctors currently training to become consultants, it will require changes in skill-mix over the next few years. Other issues to be considered are;

8.2.1 Retain existing Consultants

Ways should be reviewed to encourage existing staff to remain in the health service beyond their current retirement plans. Many staff are retiring because they no longer wish to work the long hours or under the continued pressure which they currently experience. By being more imaginative with our working patterns, some may be encouraged to stay. This also enables very experienced staff to be retained within the service to assist in training additional doctors.

Work also needs to be carried out to ensure that NHS pension arrangements are such that consultants are not discouraged to take on different work patterns because of the potential impact on their pensionable salary.

8.2.2 International Recruitment

Northern Ireland should ensure it remains fully involved in UK wide initiatives to attract suitably qualified staff from abroad, either on a temporary or permanent basis.

8.2.3 Use of Funds

As and when funding becomes available to increase the number of consultant posts, this needs to be targeted sensibly, recognising where the most pressing service needs are, whilst also acknowledging that in some specialties consultant vacancies are proving difficult to fill in the short term due to the lack of candidates available.

8.2.4 NCCGs

There are a number of very experienced staff working at NCCG level, who may have the potential to be fast tracked to Consultant level, and this should be reviewed on a specialty basis.

Work also needs to be carried out to determine the future of NCCGs in Northern Ireland. There is substantial potential to develop these roles into meaningful career opportunities in their own right, with the potential to develop significant skill and experience with which to support Consultants. However, this needs to be balanced with the need to increase the number of Consultant staff in order to provide a "Consultant delivered" service.

If current consultant workload is to be reduced by the use of other staff then those staff must be sufficiently competent to require minimal supervision for the tasks they undertake – otherwise the consultants' work will switch from doing it themselves to checking that others have done the same job correctly.

8.2.5 Use of GPs

At the moment in Northern Ireland, there are more doctors trained as general medical practitioners than there are GP vacancies. The results of the review of primary care in Northern Ireland may result in an increase in the requirement for GPs, which, as modelled, will absorb the above over supply.

However, whilst the new GP contract is likely to make a career in general practice (even if not working as a principal) more attractive, not all newly qualified GPs immediately want permanent, full-time positions or to become GP principals with the various responsibilities this entails, such as running a practice and employing staff.

The current situation may provide an opportunity to create jobs that combine a role in general practice with a role in hospital medicine as an NCCG. This could help to address the need for highly trained doctors working in a hospital environment who would support a consultant-led service and need minimal supervision in doing so. It is recognised that many career hospital doctors neither have experience of general practice nor desire to go into it. However, all GPs have had experience of working in hospital and some would wish to continue to spend a significant proportion of their time in that environment. This could be an attractive option to those doctors who do not wish to (or cannot) take on the full responsibilities of being a consultant. It is also a potential way of providing a higher status to the non consultant career grade position in hospital.

Not all doctors wish to opt for a career that is either wholly hospital-based or general practice-based. This option is based on the well-established role of a number of GPs as clinical assistants or as hospital practitioners attached to a consultant. However, such doctors usually only work one or two sessions each week and often only in an outpatient department. The suggestion here is that such doctors would work more sessions in hospital, perhaps up to five, each week, and provide care in a larger number of stages in the patient journey.

8.2.6 Use of Other Staff to Support a Consultant Delivered Service

An increasing number of hospitals are employing other staff to support medical practitioners in on-take duties and in other work. Within the province this work is being taken forward by the Implementation Group on Junior Doctors Hours, and this should be supported and encouraged.

Whilst it is recognised that there are difficulties in recruiting and retaining staff, especially nurses, this does not mean it is an impossibility. Lessons can also be learned from successes in General Practice in terms of supporting the role of “lead doctors” (i.e. those who are ultimately responsible for the medical care of patients) in the provision of care, both face-to-face and over the telephone.

Any work taken forward should be carried out province wide to ensure effort is concentrated on the most urgent service needs first, rather than being taken forward by individual Trusts or Boards.

8.3 Infrastructure Development

The solution to the shortage of medical manpower does not lie only in increasing the number of doctors and changing the skill-mix of clinical teams. It will also require the development of the supporting infrastructure – principally the use of more clerical staff and Information Management and Technology (IM&T) – to reduce the burden of administrative tasks currently undertaken by clinical staff.

8.4 Training Numbers – Specialist Registrars

Work needs to be carried out at a specialty or sub-specialty level to determine where there is potential to increase training grade numbers, especially SpR numbers in the short term, whilst ensuring criteria for training are being met. Timescales and actions required to enable expansion in other areas then need to be determined.

8.5 Medical School

The requirements for expanding the capacity at Queens Medical School to 250 students per annum should be determined, including a potential timescale for delivery. The potential for attracting graduates to the PRHO programme from the rest of the UK and the Republic of Ireland should also be explored, especially given that many Northern Irish medical students study in Great Britain, and there is a planned expansion in student numbers across the UK as a whole.

8.6 Funding for Additional Teaching Capacity

Any additional investment in training grades requires a review of the cost and infrastructure available for teaching, not only in the educational system as mentioned above, but also in the health service, where additional funding will be required to support the necessary increase in in-service training provision.

8.7 Family Friendly Policies / Flexible Training

The availability of family friendly policies and flexible training patterns needs to be extended if we are to retain the high number of females currently coming through medical school. Reviews should be carried out to determine ways in which this can be achieved without significant financial penalty to the employing organisation.

8.8 Further Research

Further research would be useful to obtain definitive data to support future modelling assumptions, such as planned retirement ages, reasons for leaving (all grades), and requirements for additional posts to cover work / life balance.

8.9 Service Strategies

Workforce planning is very difficult to carry out with any degree of accuracy if the future shape and provision of services is unclear. As mentioned earlier, the report of the Acute Hospitals Review Group (Hayes Review) is now complete and the final outcome of the consultations on Primary Care is also awaited.

In the short term, networking arrangements across the province should be encouraged to alleviate the most severe pressures. As potential plans and strategies emerge, workforce requirements will need to be continuously reviewed. It is clear that the current service configuration is not sustainable with the workforce available.

8.10 Further Workforce Planning at Specialty Level

As previously mentioned, this report should act as a starting point for more detailed workforce planning. By its very nature it is a broad-brush approach, and more detailed planning should be carried out on a specialty basis (not necessarily on a trust or site basis). This would enable more detailed assessments to be made of the issues and allow alternative service configurations to be modelled.

This work is particularly imperative with regards to the implementation of the Working Time Directive, which is now European Law and requires to be complied with as soon as possible.

To be effective, workforce planning in the NHS must be a continuous process, with regular reviewing of assumptions and updating of the models to reflect ongoing changes.

APPENDIX A

STEERING GROUP MEMBERS

Membership of Steering Committee

Chair:	D. Bingham	HR Director DHSSPS
Steering Committee Members:	I. Carson	Royal Hospitals
	J. McFarland	UCHT
	G. Humphries	United Hospitals
	J. Kelly	Sperrin Lakeland
	L. McCaughey	Craigavon Hospital
	J. McCluggage	NICPMDE
	J. Orr	QUB Medical Faculty
	J. Jenkins	Implementation Support Group
	D. Stewart	EHSSB
	J. Peden	Mater Hospital
	M. Doherty	Altnagelvin Hospital
	P. Ramsay-Baggs	BMA
	P. Maguire	BMA
	P. Woods	DHSSPS
	J. Thompson	DHSSPS
	J. Cairns	DHSSPS

APPENDIX B

KEY INFORMANT INTERVIEWS

Table of Key Informant Interviews	
Dr.Paul Bell	S&E Belfast Community Trust
Dr.Ian Carson	Royal Hospitals Trust
Dr.Dennis Connolly	Green Park Trust
Dr.Ken Fullerton	BCH Trust
Dr. Jim McFarland	Ulster Community and Hospital Trust
Prof Bowman	United Hospitals Trust
Ms Jacinta Molloy	Causeway Trust
Dr.Jim Kelly	Sperrin & Lakeland Trust
Ms Nuala Sheerin	Foyle Community Trust
Dr.Stephen Best	Craigavon & Banbridge Community Trust
Dr.Paddy Loughrane	Newry&Mourne Trust
Dr.Harold McNeill	Armagh & Dungannon Trust
Dr.Liam McCaughey	Medical Director Craigavon Area Hospital
Dr.Robin McKee and Dr.Caroline Marriott	N&W Belfast Community Trust
Dr.Jim Biers	Down & Lisburn Trust
DrJack McCluggage	NI Council for Postgraduate Medical/Dental Education
Dr.Agnes McKnight	NI Council for Postgraduate Medical/Dental Education
Dr.J Jenkins	Implementation Support Group, Junior Doctors Hours
Dr.D Stewart / Ms Janet Little	EHSSB
Dr Stanton Adair	EHSSB
Ms Mary Hinds	Mater Hospital
Dr.Paddy Woods	Medical Workforce Planning Advisor to Dept
Dr Peter Maguire	BMA Junior Doctors Hours
Mr P Ramsay-Baggs	BMA
Dr K McConkey	BMA
Dr S Austin	BMA

APPENDIX C
WORKFORCE COMPOSITION

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1. CONSULTANTS

1.1 Consultants by Department

Table 1.1

Consultants by Department

Department	1998	1999	2000	2001	% Change 1998-2001
Medical Specialties	165	145	162	169	+2%
Anaesthetics	150	155	158	159	+6%
Psychiatry and Learning Disability	97	93	102	104	+7%
Surgical Specialities	91	98	99	101	+11%
Radiology	68	67	65	66	-3%
Non-clinical Oncology	7	9	12	12	+71%
Pathology	49	54	61	63	+29%
Obstetrics and Gynaecology	56	52	57	57	+2%
Medical Paediatrics	40	42	42	47	+18%
Other	39	16	35	34	-13%
Orthopaedics	30	30	35	33	+10%
ENT	23	24	23	24	+4%
Accident and Emergency	13	16	18	19	+46%
Ophthalmology	22	19	20	19	-14%
Neurosciences	12	13	16	17	+42%
Clinical Oncology	9	9	4	5	-44%
Total	**871**	**842**	**909**	**929**	**+7%**

Source: HRMS

1.2 Consultants by Department by Trust

Table 1.2

Consultants by Department by Trust

Department	Trust	1998	1999	2000	2001
Accident and Emergency	Altnagelvin HSS Trust	1	2	2	2
	Belfast City Hospital Trust	2	2	2	2
	Causeway	0	0	0	1
	C-avon/B-bridge Hospital	2	2	3	3
	Down & Lisburn Trust'	1	1	1	1
	Mater Infirmorum Trust	1	1	2	2
	RG Hospital Group Trust	3	3	3	3
	Ulster Hospitals	2	3	3	3
	United Hospital Group	1	2	2	2
Total		**13**	**16**	**18**	**19**
Anaesthetics	Altnagelvin HSS Trust	10	12	12	12
	Armagh and Dungannon	4	4	4	0
	Belfast City Hospital Trust	20	20	20	21
	Causeway	6	6	6	6
	C-avon/B-bridge Hospital	9	12	13	14
	Down & Lisburn Trust'	9	7	7	8
	Green Park Trust	5	3	5	5
	Homefirst Community	5	5	2	2
	Mater Infirmorum Trust	4	5	6	7
	Newry & Mourne	4	5	5	5
	RG Hospital Group Trust	40	43	44	42
	Sperrin/Lakeland HSS Trust	8	9	8	9
	Ulster Hospitals	15	14	15	16
	United Hospital Group	11	10	11	12
Total		**150**	**155**	**158**	**159**
ENT	Altnagelvin HSS Trust	3	3	3	3
	Belfast City Hospital Trust	2	2	2	2
	C-avon/B-bridge Hospital	3	3	4	4
	Mater Infirmorum Trust	1	1	1	1
	Newry & Mourne	1	1	0	0
	RG Hospital Group Trust	4	6	5	6
	Sperrin/Lakeland HSS Trust	3	3	3	3
	Ulster Hospitals	2	2	2	2
	United Hospital Group	4	3	3	3
Total		**23**	**24**	**23**	**24**
Medical Paediatrics	Altnagelvin HSS Trust	4	4	5	5
	Armagh and Dungannon	2	1	1	1
	Belfast City Hospital Trust	1	1	0	0
	Causeway	3	3	3	3

	C-avon/B-bridge Hospital	5	4	5	5
	Down & Lisburn Trust'	1	1	1	1
	Foyle HSS Trust	1	1	1	1
	Homefirst Community	1	1	1	2
	N & W Belfast Trust	0	1	1	1
	Newry & Mourne	3	3	3	3
	RG Hospital Group Trust	4	5	6	8
	S & E Belfast Trust	1	2	2	2
	Sperrin/Lakeland HSS Trust	4	5	4	5
	Ulster Hospitals	5	5	5	5
	United Hospital Group	5	5	4	5
Total		**40**	**42**	**42**	**47**
Medical Specialities	Altnagelvin HSS Trust	13	14	14	14
	Armagh and Dungannon	4	4	4	0
	Belfast City Hospital Trust	23	21	24	23
	Causeway	6	6	6	5
	C-avon/B-bridge Hospital	8	8	12	16
	Down & Lisburn Trust'	6	6	5	6
	Eastern Board HQ	13	0	7	7
	Green Park Trust	3	3	3	3
	Mater Infirmorum Trust	5	6	6	6
	Newry & Mourne	9	5	5	5
	RG Hospital Group Trust	32	32	33	38
	Sperrin/Lakeland HSS Trust	7	8	8	8
	Ulster Hospitals	14	15	17	17
	United Hospital Group	22	17	18	21
Total		**165**	**145**	**162**	**169**
Neurosciences	Belfast City Hospital Trust	1	1	2	3
	Green Park Trust	0	0	1	1
	RG Hospital Group Trust	12	13	15	16
Total		**13**	**14**	**18**	**20**
Obstetrics and Gynaecology	Altnagelvin HSS Trust	5	4	5	5
	Armagh and Dungannon	5	2	2	0
	Belfast City Hospital Trust	5	5	6	6
	Causeway	3	3	3	3
	C-avon/B-bridge Hospital	5	4	4	6
	Down & Lisburn Trust'	5	6	6	6
	Mater Infirmorum Trust	3	3	3	3
	Newry & Mourne	4	4	5	5
	RG Hospital Group Trust	6	6	8	8
	Sperrin/Lakeland HSS Trust	4	5	4	4
	Ulster Hospitals	5	5	5	5
	United Hospital Group	6	5	6	6
Total		**56**	**52**	**57**	**57**

Ophthalmology	Altnagelvin HSS Trust	7	4	5	5
	Mater Infirmorum Trust	2	2	3	3
	Newry & Mourne	0	1	1	0
	RG Hospital Group Trust	12	12	11	11
	United Hospital Group	1	0	0	0
Total		**22**	**19**	**20**	**19**
Orthopaedics	Altnagelvin HSS Trust	4	3	6	5
	Belfast City Hospital Trust	1	1	0	0
	Green Park Trust	16	16	15	15
	RG Hospital Group Trust	6	7	10	11
	Ulster Hospitals	3	3	4	2
Total		**30**	**30**	**35**	**33**
Other	Armagh and Dungannon	0	0	0	1
	Belfast City Hospital Trust	1	2	2	2
	Central Services Agency	1	1	1	0
	Down & Lisburn Trust'	1	1	2	2
	Eastern Board HQ	23	0	18	18
	Newry & Mourne	1	1	1	1
	Northern Board H Q	3	2	2	2
	RG Hospital Group Trust	1	1	2	1
	S & E Belfast Trust	1	0	0	0
	Southern Board H Q	6	7	6	6
	Ulster Hospitals	0	0	1	1
	Westcare Business Services	1	1	1	1
	Western Board HQs	1	1	1	1
Total		**40**	**17**	**37**	**36**
Pathology	Altnagelvin HSS Trust	10	8	7	8
	Belfast City Hospital Trust	10	13	16	17
	Blood Transfusion Service	2	3	2	2
	Causeway	1	1	1	1
	C-avon/B-bridge Hospital	8	9	9	10
	Green Park Trust	1	1	0	0
	Mater Infirmorum Trust	0	1	0	0
	NI Ambulance Trust	0	0	1	1
	RG Hospital Group Trust	14	14	15	14
	Ulster Hospitals	3	3	4	4
	United Hospital Group	8	9	8	8
Total		**57**	**62**	**63**	**65**
Psychiatry and Learning Disability	Armagh and Dungannon	6	6	8	7
	Belfast City Hospital Trust	4	4	4	4
	Causeway	3	3	3	4
	C-avon/B-bridge Comm	6	6	7	7
	Down & Lisburn Trust'	7	7	8	8
	Foyle HSS Trust	10	9	10	10

	Green Park Trust	1	1	1	1
	Homefirst Community	18	16	17	18
	Mater Infirmorum Trust	5	6	6	7
	N & W Belfast Trust	7	6	7	6
	Newry & Mourne	3	3	4	4
	RG Hospital Group Trust	2	2	2	2
	S & E Belfast Trust	10	8	8	8
	Sperrin/Lakeland HSS Trust	8	9	9	9
	Ulster Hospitals	6	6	6	7
Total		**96**	**92**	**100**	**102**
Radiology	Altnagelvin HSS Trust	6	6	6	6
	Armagh and Dungannon	1	1	0	0
	Belfast City Hospital Trust	10	10	9	13
	Causeway	2	3	3	3
	C-avon/B-bridge Hospital	5	5	6	5
	Down & Lisburn Trust'	3	3	3	3
	Green Park Trust	2	2	2	2
	Mater Infirmorum Trust	3	3	4	4
	Newry & Mourne	2	4	4	3
	RG Hospital Group Trust	14	12	10	11
	Sperrin/Lakeland HSS Trust	3	3	4	3
	Ulster Hospitals	7	8	8	9
	United Hospital Group	10	7	6	4
Total		**75**	**76**	**77**	**78**
Clinical Oncology	Belfast City Hospital Trust	7	9	12	12
Total		**7**	**9**	**12**	**12**
Surgical Specialities	Altnagelvin HSS Trust	6	6	7	7
	Armagh and Dungannon	3	3	3	0
	Belfast City Hospital Trust	11	13	15	16
	Causeway	3	3	3	4
	C-avon/B-bridge Hospital	6	7	6	8
	Down & Lisburn Trust'	6	6	6	6
	Mater Infirmorum Trust	3	4	4	4
	Newry & Mourne	3	4	4	4
	RG Hospital Trust	23	22	21	20
	Sperrin/Lakeland HSS Trust	7	7	7	8
	Ulster Hospitals	10	12	11	12
	United Hospital Group	10	11	12	12
Total		**91**	**98**	**99**	**101**
Grand Total		**871**	**842**	**909**	**929**

Please note – during the period, Craigavon / Banbridge Hospitals trust took over the acute care elements of Armagh and Dungannon.

1.3 Consultants by Grade

Table 1.3

Consultants by Grade

Grade	1998	1999	2000	2001	% Change
Lecturer/Consultant	1	0	1	1	0%
Consultant	866	840	901	921	+6%
Public Health Consultant	4	2	7	7	+75%
Group Total	**871**	**842**	**909**	**929**	**+6%**

Source: HRMS

1.4 Consultants by Trust

Table 1.4

Consultants by Trust

Trust	**1998**	**1999**	**2000**	**2001**	**% Change**
RG Hospital Group Trust	173	178	185	191	+10%
Belfast City Hospital Trust	98	104	114	121	+23%
Ulster Hospitals	72	76	81	83	+15%
United Hospital Group	78	69	70	73	-6%
Altnagelvin HSS Trust	69	66	72	72	+4%
Craigavon/Banbridge Hospital	51	54	62	71	+39%
Sperrin/Lakeland HSS Trust	44	49	47	49	+11%
Down & Lisburn Trust'	39	38	39	41	+5%
Mater Infirmorum Hospital Trust	27	32	35	37	+37%
Causeway	27	28	28	30	+11%
Newry & Mourne	30	31	32	30	0%
Green Park Trust	28	26	27	27	-4%
Eastern Board HQ	36	0	25	25	-31%
Homefirst Community	24	22	20	22	-8%
Foyle HSS Trust (Community)	11	10	11	11	0%
S & E Belfast Community Trust	12	10	10	10	-17%
Armagh and Dungannon	25	21	22	9	-64%
N & W Belfast Trust	7	7	8	7	0%
Craigavon/Banbridge Comm	6	6	7	7	+17%
Southern Board H Q	6	7	6	6	0%
Blood Transfusion Service	2	3	2	2	0%
Northern Board H Q	3	2	2	2	-33%
Westcare Business Services	1	1	1	1	0%
Western Board HQs	1	1	1	1	0%
NI Ambulance Trust	0	0	1	1	+100%
Central Services Agency	1	1	1	0	-100%
Group Total	**871**	**842**	**909**	**929**	**+7%**

Source: HRMS

Please note – during the period, Craigavon / Banbridge Hospitals trust took over the acute care elements of Armagh and Dungannon.

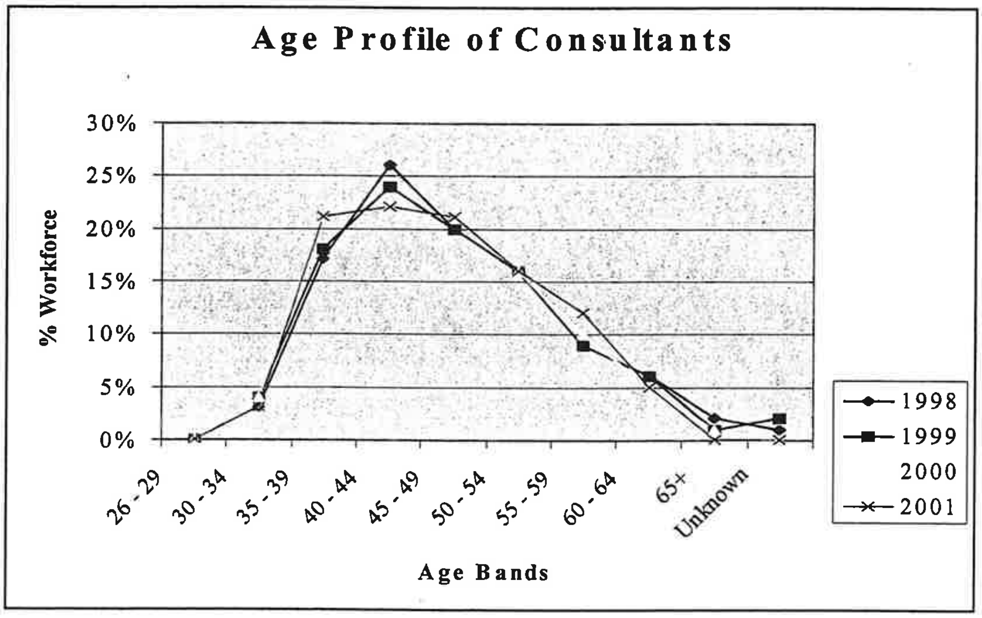
1.5 Consultants by Age

Table 1.5
Consultants by Age

Age Bands	**Number**	**Per cent**
26 - 29	0	0%
30 - 34	25	3%
35 - 39	192	21%
40 - 44	207	22%
45 - 49	199	21%
50 - 54	146	16%
55 - 59	107	12%
60 - 64	45	5%
65+	4	0%
Unknown	4	0%
Group Total	**929**	**100%**

Source: HRMS

Figure 1.1
Consultants by Age



Source: HRMS

1.6 Consultants 50 years and over by Specialty

Table 1.6

Consultants by Age Band over 50 vs Total Consultants in the Specialty

Specialty	**Age Bands**				**Total**	**Total**	**% of**
	50-54	**55-59**	**60-64**	**65+**	**+50**	**Cons**	**Total**
General Practice	2	1			3	3	**100%**
Community Medicine		2			2	2	**100%**
Other Depts		1	1	1	3	3	**100%**
Public Health Med.	2	1			3	23	**13%**
General Medicine	20	11	6		37	84	**44%**
Rheum – Rehab	1	1			2	7	**29%**
Infectious Diseases			1		1	3	**33%**
Thoracic Medicine	2	1			3	5	**60%**
Dermatology	4	2			6	12	**50%**
Cardiology	1	3	3		7	20	**35%**
Genito-Urinary Med	1				1	3	**33%**
Nephrology	3		1		4	8	**50%**
Geriatric Medicine	8		2		10	23	**43%**
Endocrin & Diabetes	1			1	2	3	**67%**
Neurology	1				1	8	**13%**
Clin Neuro-Physiol			1		1	2	**50%**
Neuro Surgery			2		2	5	**40%**
Neuropathology		1			1	2	**50%**
Radiotherapy	2				2	12	**17%**
Paediatrics	6	3	1		10	46	**22%**
Paediatric Surgery	1	2			3	4	**75%**
General Surgery	15	11	2		28	69	**41%**
Plastic Surgery		2			2	7	**29%**
Urology		2	1		3	9	**33%**
Vascular Surgery		1			1	2	**50%**
Card/Thoracic Surg	2	1			3	6	**50%**
ENT	3	4	2	1	10	22	**45%**
Orthopaedics	8	3	1		12	33	**36%**
A&E	4	1			5	19	**26%**
Ophthalmology	3	4			7	19	**37%**
Anaesthetics	14	20	9		43	159	**27%**
Radiology	9	3	4		16	65	**25%**
Mammography	1				1	1	**100%**
Gynae and Obs	7	14	6	1	28	57	**49%**
Mental Handicap	1	1			2	9	**22%**
Mental Illness	11	5	2		18	89	**20%**
Histo/Cyto	2				2	8	**25%**
Physiology		2			2	2	**100%**
Chemical Pathology	2				2	4	**50%**
Haematology	4	3			7	15	**47%**
Histopathology	2				2	13	**15%**
Med Microbiology	2	1			3	10	**30%**
Haematology	1				1	1	**100%**
	146	**107**	**45**	**4**	**302**	**458**	

1.7 Consultants by Gender

Table 1.7

Consultants by Gender

Year	Female	% Female	Male	% Male	Total
1998	183	21%	688	79%	871
1999	177	21%	665	79%	842
2000	194	21%	715	79%	909
2001	207	22%	722	78%	929

Source: HRMS

1.8 Part-time Working Among Consultants

Table 1.8

Part-time Working 1998-2001

	1998	1999	2000	2001
Number Working Part-time	216	178	202	213
% Total Workforce	25%	21%	22%	23%
% Part-time Workers who are Women	21%	20%	21%	23%
% Women in the Workforce Working Part-time	25%	20%	22%	23%

Source: HRMS

2. NON-CONSULTANT CAREER GRADE

2.1 Non-Consultant Career Grade by Department

Table 2.1

Non-Consultant Career Grade by Department 1998-2001

Department	**1998**	**1999**	**2000**	**2001**	**% Change**
Accident and Emergency	26	29	32	33	+27%
Anaesthetics	13	10	14	15	+15%
ENT	2	3	3	3	+50%
Medical Paediatrics	13	19	22	23	+77%
Medical Specialties	24	29	35	40	+67%
Clinical Oncology	1	1	1	1	0%
Obstetrics and Gynaecology	5	5	5	5	0%
Ophthamology	7	8	9	8	+14%
Orthopaedics	1	2	5	4	+300%
Other	11	20	22	23	+109%
Pathology	4	4	5	6	+50%
Psychiatry and Learning Disabilities	21	21	19	18	-14%
Radiology	2	3	3	1	-50%
Surgical Specialties	6	10	10	8	+33%
Total	**136**	**164**	**185**	**188**	**+38%**

Source: HRMS

2.2 Non-Consultant Career Grade by Department by Trust

Table 2.2

Non-Consultant Career Grade by Department by Trust

Department	**Trust**	**1998**	**1999**	**2000**	**2001**
Accident and Emergency	Altnagelvin HSS Trust	0	1	1	0
	Armagh and Dungannon	2	2	2	0
	Belfast City Hospital Trust	1	1	2	3
	Causeway	2	2	2	1
	C-avon/B-bridge Hospital	2	2	3	4
	Down & Lisburn Trust'	5	6	7	7
	Mater Infirmorum Trust	0	1	0	0
	Newry & Mourne	2	1	1	2
	RG Hospital Group Trust	1	2	1	1
	Sperrin/Lakeland HSS Trust	4	4	5	5
	Ulster Hospitals	3	3	4	6
	United Hospital Group	4	4	4	4
Total		**26**	**29**	**32**	**33**
Anaesthetics	Altnagelvin HSS Trust	2	2	3	3
	Belfast City Hospital Trust	1	1	1	1
	Green Park Trust	2	2	2	2
	Mater Infirmorum Trust	1	0	1	1
	RG Hospital Group Trust	3	2	1	4
	Ulster Hospitals	0	0	1	1
	United Hospital Group	4	3	5	3
Total		**13**	**10**	**14**	**15**
ENT	RG Hospital Group Trust	2	2	2	2
	United Hospital Group	0	1	1	1
Total		**2**	**3**	**3**	**3**
Medical Paediatrics	Altnagelvin HSS Trust	1	1	1	1
	Armagh and Dungannon	4	7	6	3
	Causeway	0	2	2	2
	C-avon/B-bridge Hospital	0	0	0	3
	Homefirst Community	0	1	2	3
	Newry & Mourne	0	0	1	1
	RG Hospital Group Trust	5	4	5	4
	Sperrin/Lakeland HSS Trust	1	1	2	3
	Ulster Hospitals	0	1	1	1
	United Hospital Group	2	2	2	2
Total		**13**	**19**	**22**	**23**

Medical Specialities	Altnagelvin HSS Trust	2	2	2	2
	Armagh and Dungannon	0	0	2	2
	Belfast City Hospital Trust	2	3	3	4
	C-avon/B-bridge Hospital	4	4	6	7
	Down & Lisburn Trust'	4	4	3	4
	Green Park Trust	0	0	1	1
	Mater Infirmorum Trust	1	1	1	2
	Newry & Mourne	1	2	2	2
	RG Hospital Group Trust	4	6	7	7
	Sperrin/Lakeland HSS Trust	1	1	2	2
	Ulster Hospitals	3	4	4	5
	United Hospital Group	2	2	2	2
Total		**24**	**29**	**35**	**40**
Obstetrics and Gynaecology	Armagh and Dungannon	1	1	1	0
	C-avon/B-bridge Hospital	0	0	0	1
	Newry & Mourne	1	1	1	1
	RG Hospital Group Trust	1	1	1	1
	Sperrin/Lakeland HSS Trust	1	1	1	1
	United Hospital Group	1	1	1	1
Total		**5**	**5**	**5**	**5**
Ophthalmology	Altnagelvin HSS Trust	1	0	0	0
	Armagh and Dungannon	0	0	1	0
	Causeway	1	1	1	1
	Mater Infirmorum Trust	1	3	3	3
	RG Hospital Group Trust	4	4	4	4
Total		**7**	**8**	**9**	**8**
Orthopaedics	Green Park Trust	1	2	3	2
	RG Hospital Group Trust	0	0	2	2
Total		**1**	**2**	**5**	**4**
Other	Causeway	2	2	3	3
	C-avon/B-bridge Comm	0	0	1	1
	Foyle HSS Trust	4	5	5	6
	Homefirst Community	0	4	3	3
	N & W Belfast Trust	0	1	1	1
	Newry & Mourne	0	4	4	4
	Sperrin/Lakeland HSS Trust	3	2	3	3
	Ulster Hospitals	2	2	2	2
Total		**11**	**20**	**22**	**23**

Pathology	Belfast City Hospital Trust	3	3	3	3
	Blood Transfusion Service	2	2	2	2
	C-avon/B-bridge Hospital	0	0	1	1
	Ulster Hospitals	0	0	0	1
Total		**5**	**5**	**6**	**7**
Psychiatry and Learning Disability	Armagh and Dungannon	2	2	2	1
	Causeway	1	2	1	1
	Down & Lisburn Trust'	0	1	1	1
	Foyle HSS Trust (Community)	6	2	2	2
	Homefirst Community	4	4	3	4
	Mater Infirmorum Trust	4	4	4	4
	N & W Belfast Trust	2	3	2	2
	Newry & Mourne	0	0	0	1
	S & E Belfast Trust	2	3	2	2
	Sperrin/Lakeland HSS Trust	0	0	2	0
Total		**21**	**21**	**19**	**18**
Radiology	Belfast City Hospital Trust	2	3	3	1
Total		**2**	**3**	**3**	**1**
Surgical Specialities	Altnagelvin HSS Trust	0	1	1	1
	Armagh and Dungannon	1	2	1	0
	Belfast City Hospital Trust	1	1	1	1
	Causeway	2	2	2	2
	C-avon/B-bridge Hospital	1	1	2	2
	Newry & Mourne	0	1	1	1
	RG Hospital Group Trust	0	1	1	0
	United Hospital Group	1	1	1	1
Total		**6**	**10**	**10**	**8**
Grand Total		**136**	**164**	**185**	**188**

Please note – during the period, Craigavon / Banbridge Hospitals trust took over the acute care elements of Armagh and Dungannon.

2.3 Non-Consultant Career Grades by Grade

Table 2.3

Non-Consultant Career Grades by Grade 1998-2001

Grade	1998	1999	2000	2001	% Change 1998-2001
Associate Specialist	45	45	46	46	+2%
Staff Grade	91	119	139	142	+55%
Group Total	**136**	**164**	**185**	**188**	**+38%**

Source: HRMS

2.4 Non-Consultant Career Grade by Trust

Table 2.4

Non-Consultant Career Grades by Trust

Trust	1998	1999	2000	2001	% Change 1998-2001
RG Hospital Group Trust	20	22	24	25	+25%
C-avon/B-bridge Hospital	7	7	12	18	+157%
Ulster Hospitals	8	10	12	16	+100%
United Hospital Group	14	14	16	14	0%
Sperrin/Lakeland HSS Trust	10	9	15	14	+40%
Belfast City Hospital Trust	10	12	13	13	+30%
Newry & Mourne	4	9	10	12	+200%
Down & Lisburn Trust'	9	11	11	12	+33%
Mater Infirmorum Hospital Trust	7	9	9	10	+43%
Causeway	8	11	11	10	+25%
Homefirst Community	4	9	8	10	+150%
Foyle HSS Trust (Community)	10	7	7	8	-20%
Altnagelvin HSS Trust (Hospital)	6	7	8	7	+17%
Armagh and Dungannon	10	14	15	6	-40%
Green Park Trust	3	4	6	5	+67%
N & W Belfast Community Trust	2	4	3	3	+50%
S & E Belfast Community Trust	2	3	2	2	0%
Blood Transfusion Service	2	2	2	2	0%
C-avon/B-bridge Comm	0	0	1	1	+100%
Total	**136**	**164**	**185**	**188**	**+38%**

Source: HRMS

2.5 Non-Consultant Career Grades by Age

Table 2.5

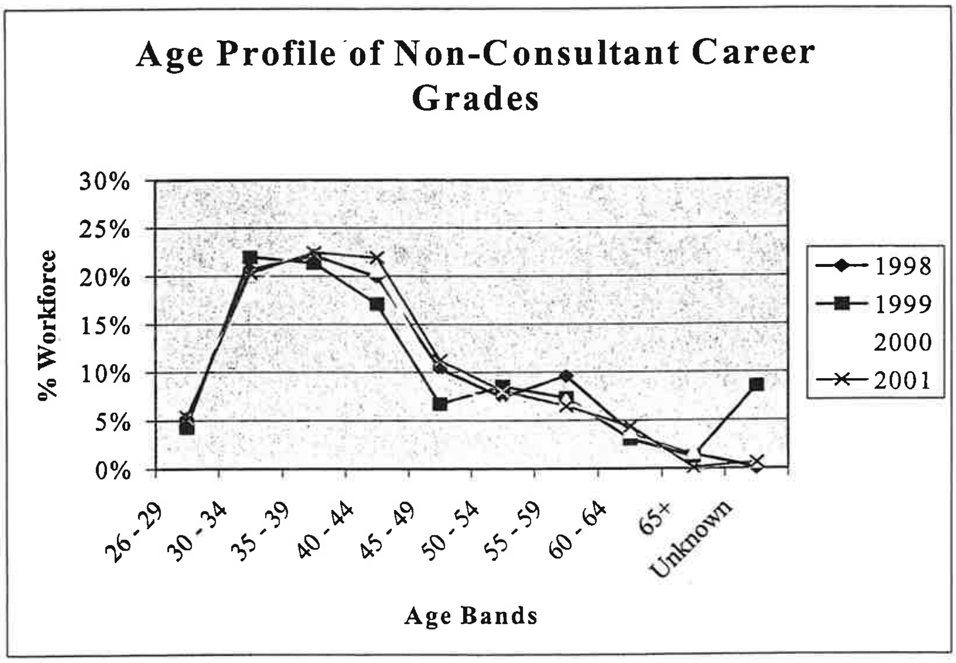
Non-Consultant Career Grades by Age

Age	Number	Per cent
26 - 29	10	6%
30 - 34	38	20%
35 - 39	42	22%
40 - 44	41	22%
45 - 49	21	11%
50 - 54	15	8%
55 - 59	12	6%
60 - 64	8	4%
65+	0	0%
Unknown	1	1%
Total	**188**	**100%**

Source: HRMS

Figure 2.1

Non-Consultant Career Grade Age Profile



Source: HRMS

2.6 Non-Consultant Career Grades by Gender

Table 2.6

Non-Consultant Career Grades by Gender

Year	Female	% Female	Male	% Male	Total
1998	77	57%	59	43%	136
1999	100	61%	64	39%	164
2000	106	57%	79	43%	185
2001	112	60%	76	40%	188

Source: HRMS

2.7 Part-time Working Among Non-Consultant Career Grades

Table 2.7

Part-time Working 1998-2001

	1998	1999	2000	2001
Number Working Part-time	36	49	52	58
% Total Workforce	26%	30%	28%	31%
% Part-time Workers who are Female	89%	96%	90%	93%
% Women in Workforce Working Part-time	42%	47%	44%	48%

Source: HRMS

3. SPECIALIST REGISTRARS

3.1 Specialist Registrars by Department

Table 3.1

Specialist Registrars by Department 1998-2001

Department	1998	1999	2000	2001	% Change 1998-2001
Accident and Emergency	9	11	12	10	+11%
Anaesthetics	47	40	50	55	+17%
ENT	12	10	12	9	-25%
Medical Paediatrics	32	32	33	36	+20%
Medical Specialities	79	90	82	93	+18%
Neurosciences	10	8	12	12	+20%
Obstetrics and Gynaecology	51	51	49	50	-2%
Ophthalmology	15	13	12	13	-13%
Orthopaedics	18	16	19	23	+28%
Other	5	4	4	3	-40%
Pathology	28	28	30	34	+21%
Psychiatry and Learning Disability	25	29	31	29	+16%
Radiology	24	21	17	28	+17%
Non-clinical Oncology	11	10	15	16	+45%
Surgical Specialties	64	62	66	60	-6%
Probity Department	1	0	0	0	-100%
Honorary	1	0	0	0	-100%
Total	**432**	**425**	**444**	**471**	**+9%**

Source: HRMS

3.2 Specialist Registrars by Department by Trust

Table 3.2

Specialist Registrar by Department by Trust

Department	Trust	1998	1999	2000	2001
Accident and Emergency	Altnagelvin HSS Trust	1	1	1	1
	Belfast City Hospital Trust	2	2	2	2
	C-avon/B-bridge Hospital	1	1	1	1
	Mater Infirmorum Trust		1	2	2
	Newry & Mourne		1	1	
	RG Hospital Group Trust	3	3	3	2
	Ulster Hospitals	2	2	2	2
Total		**9**	**11**	**12**	**10**
Anaesthetics	Altnagelvin HSS Trust	2	1	2	2
	Belfast City Hospital Trust	7	4	9	11
	C-avon/B-bridge Hospital	3	2	2	2
	Green Park Trust			1	1
	Mater Infirmorum Trust	2	2	2	4
	Newry & Mourne	2			
	RG Hospital Group Trust	23	25	28	27
	Ulster Hospitals	6	4	5	6
	United Hospital Group	2	2	1	2
Total		**47**	**40**	**50**	**55**
ENT	Altnagelvin HSS Trust	1	1	1	1
	Belfast City Hospital Trust	2	2	3	2
	C-avon/B-bridge Hospital	2	1	2	1
	RG Hospital Group Trust	3	4	4	3
	Sperrin/Lakeland HSS Trust	2	1	1	1
	United Hospital Group	2	1	1	1
Total		**12**	**10**	**12**	**9**
Honorary	RG Hospital Group Trust	1			
Total		**1**	**0**	**0**	**0**
Medical Paediatrics	Altnagelvin HSS Trust	4	4	4	3
	Belfast City Hospital Trust	1			
	C-avon/B-bridge Hospital	2	3	4	4
	N & W Belfast Trust	1	1	1	2
	RG Hospital Group Trust	16	17	17	19
	Ulster Hospitals	3	3	4	4
	United Hospital Group	5	4	3	4
Total		**32**	**32**	**33**	**36**

Medical Specialities	Altnagelvin HSS Trust	3	4	4	5
	Armagh and Dungannon	1	2	0	0
	Belfast City Hospital Trust	21	25	22	22
	Causeway			1	1
	C-avon/B-bridge Hospital	6	7	7	7
	Down & Lisburn Trust'	1	1	1	2
	Green Park Trust	1	1	1	2
	Mater Infirmorum Trust	2	2	2	2
	Newry & Mourne		1	1	1
	RG Hospital Group Trust	34	35	35	42
	Ulster Hospitals	5	6	4	4
	United Hospital Group Total	5	6	4	5
Total		**79**	**90**	**82**	**93**
Neurosciences	RG Hospital Group Trust	10	8	12	12
Total		**10**	**8**	**12**	**12**
Non-clinical Oncology	Belfast City Hospital Trust	11	10	15	16
Total		**11**	**10**	**15**	**16**
Obstetrics and Gynaecology	Altnagelvin HSS Trust	5	4	5	5
	Belfast City Hospital Trust	10	10	1	1
	C-avon/B-bridge Hospital	5	6	5	4
	Down & Lisburn Trust'	1	1	1	1
	Mater Infirmorum Trust	2	3	6	5
	Newry & Mourne	1	2	1	1
	RG Hospital Group Trust	19	15	21	25
	Ulster Hospitals	4	5	5	3
	United Hospital Group	4	5	4	5
Total		**51**	**51**	**49**	**50**
Ophthalmology	Altnagelvin HSS Trust	3	2	1	2
	RG Hospital Group Trust	12	11	11	11
Total		**15**	**13**	**12**	**13**
Orthopaedics	Altnagelvin HSS Trust	2	1	2	3
	Belfast City Hospital Trust	3	3		
	Green Park Trust	8	7	9	11
	RG Hospital Group Trust	3	3	6	7
	Ulster Hospitals	2	2	2	2
Total		**18**	**16**	**19**	**23**

Other	Eastern Board HQ	2			
	Northern Board H Q	1	1		
	RG Hospital Group Trust		1	2	1
	Southern Board H Q	1	1	1	1
	Western Board HQs	1	1	1	1
Total		**5**	**4**	**4**	**3**
Pathology	Belfast City Hospital Trust	11	11	10	18
	Blood Transfusion Service	1			1
	RG Hospital Group Trust	16	17	20	15
Total		**28**	**28**	**30**	**34**
Probity	Belfast City Hospital Trust	1			
Total		**1**	**0**	**0**	**0**
Psychiatry and Learning Difficulties	Belfast City Hospital Trust	4	4	5	4
	C-avon/B-bridge Comm		1	3	1
	Down & Lisburn Trust'	3	4	4	4
	Foyle HSS Trust		1	1	
	Homefirst Community	3	2	2	4
	Mater Infirmorum Trust	1	1	3	3
	N & W Belfast Trust	3	4	4	2
	RG Hospital Group Trust	2	1	1	
	S & E Belfast Trust	6	7	6	10
	Sperrin/Lakeland HSS Trust	2	2	1	
	Ulster Hospitals	1	2	1	1
Total		**25**	**29**	**31**	**29**
Radiology	Altnagelvin HSS Trust	1	2		2
	Belfast City Hospital Trust	4	4	4	6
	C-avon/B-bridge Hospital				2
	Green Park Trust	1	1		1
	RG Hospital Group Trust	15	12	11	13
	Ulster Hospitals	3	2	2	4
Total		**24**	**21**	**17**	**28**
Surgical Specialities	Altnagelvin HSS Trust	5	4	4	5
	Armagh and Dungannon	1			
	Belfast City Hospital Trust	9	12	12	11
	Causeway	1	2	2	2
	C-avon/B-bridge Hospital	8	5	6	5
	Down & Lisburn Trust'	2	3	2	3
	Mater Infirmorum Trust	1	3	4	3
	Newry & Mourne	3	2	2	2

	RG Hospital Group Trust	22	21	22	18
	Ulster Hospitals	9	7	9	8
	United Hospital Group	3	3	3	3
Total		**64**	**62**	**66**	**60**
Grand Total		**432**	**425**	**444**	**471**

Please note – during the period, Craigavon / Banbridge Hospitals trust took over the acute care elements of Armagh and Dungannon.

3.3 Specialist Registrars by Grade

Table 3.3

Specialist Registrars by Grade 1998-2001

Grade	**1998**	**1999**	**2000**	**2001**	**% Change**
Registrar	35	13	12	10	-71%
Senior Registrar	59	35	27	23	-61%
Specialist Registrar	338	377	405	438	+30%
Group Total	**432**	**425**	**444**	**471**	**+9%**

Source: HRMS

3.4 Specialist Registrars by Trust

Table 3.4

Specialist Registrars by Trust 1998-2001

Trust	1998	1999	2000	2001	% Change
Eastern Board HQ	2	0	0	0	-100%
Belfast City Hospital Trust	86	87	83	93	+8%
Green Park Trust	10	9	11	15	+50%
S & E Belfast Community Trust	6	7	6	10	+67%
Ulster Hospitals & Community Trusts	35	33	34	34	-3%
RG Hospital Group Trust	179	173	193	195	+9%
Mater Infirmorum Hospital Trust	8	12	19	19	+138%
N & W Belfast Community Trust	4	5	5	4	0%
Down & Lisburn Trust'	7	9	8	10	+43%
Blood Transfusion Service	1	0	0	1	0%
Northern Board H Q	1	1	0	0	-100%
Causeway	1	2	3	3	+200%
Homefirst Community	3	2	2	4	+33%
United Hospital Group	21	21	16	20	-5%
Southern Board H Q	1	1	1	1	0%
Armagh and Dungannon	2	2	0	0	-100%
C-avon/B-bridge Hospital	27	25	27	26	-4%
Newry & Mourne	6	6	5	4	-33%
C-avon/B-bridge Comm.	0	1	3	1	+100%
Altnagelvin HSS Trust (Hospital)	27	24	24	29	+7%
Foyle HSS Trust (Community)	0	1	1	0	0%
Sperrin/Lakeland HSS Trust	4	3	2	1	-75%
Western Board HQs	1	1	1	1	0%
Group Total	**432**	**425**	**444**	**471**	**+9%**

Source: HRMS

Please note – during the period, Craigavon / Banbridge Hospitals trust took over the acute care elements of Armagh and Dungannon.

3.5 Specialist Registrars by Age

Table 3.5

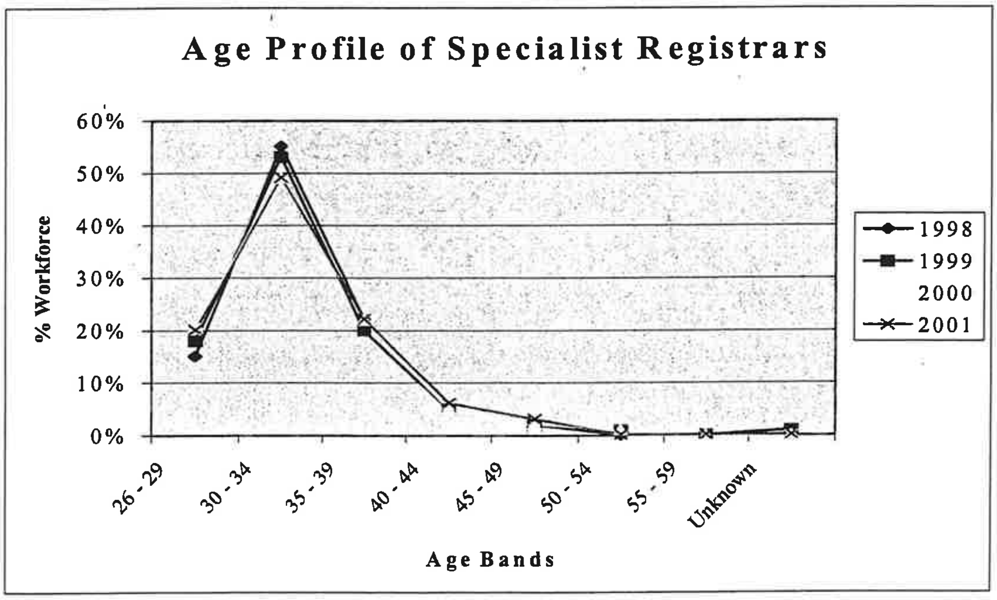
Specialist Registrars by Age

Age Band	Head Count	Percentage
26 - 29	93	19.7%
30 - 34	231	49.0%
35 - 39	99	21.0%
40 - 44	29	6.2%
45 - 49	14	3.0%
50 - 54	2	0.4%
55 - 59	2	0.4%
Unknown	1	0.2%
Total	**471**	**100%**

Source: HRMS

Figure 3.1

Age Profile of Specialist Registrars



Source: HRMS

3.6 Specialist Registrars by Gender

Table 3.6

Specialist Registrars by Gender

Year	Female	% Female	Male	% Male	Total
1998	148	34%	284	66%	432
1999	153	36%	272	64%	425
2000	163	37%	281	63%	444
2001	188	40%	283	60%	471

Source: HRMS

3.7 Part-time Working Among Specialist Registrars

Table 3.7

Part-time Working 1998-2001

	1998	1999	2000	2001
Number Working Part-time	29	25	31	33
% Total Workforce	7%	6%	7%	7%
% Part-time Workers who are Women	59%	76%	77%	70%
% Women in the Workforce Working Part-time	11%	12%	15%	12%

Source: HRMS

4. SHO'S

4.1 SHO's by Department

Table 4.1

SHO's by Department

	1998	1999	2000	2001	% Change
Surgical Specialities Total	83	89	82	84	+1%
Radiology Total	9	7	7	8	-11%
Psychiatry and Learning Difficulties Total	95	87	95	90	-5%
Pathology Total	11	10	10	15	+36%
Orthopaedics Total	12	18	12	14	+17%
Ophthalmology Total	11	11	10	10	-9%
Obstetrics and Gynaecology Total	72	75	74	73	+1%
Neurosciences Total	6	6	6	6	0%
Other Total	2	1	1	1	-50%
Medical Specialities Total	196	182	193	195	-1%
Medical Paediatrics Total	81	86	83	88	+9%
ENT Total	18	17	15	14	-22%
Anaesthetics Total	32	41	36	49	+53%
Accident and Emergency Total	54	55	66	73	+35%
Total	**682**	**685**	**690**	**720**	**+6%**

Source: HRMS

4.2 SHO's by Department by Trust

Table 4.2

SHO's by Department by Trust

Department	Trust	1998	1999	2000	2001
Accident and Emergency	Altnagelvin HSS Trust	6	5	5	7
	Belfast City Hospital Trust	8	8	6	7
	Causeway	4	4	4	6
	C-avon/B-bridge Hospital	5	7	10	9
	Down & Lisburn Trust'			3	4
	Mater Infirmorum Trust	5	5	6	7
	Newry & Mourne				2
	RG Hospital Group Trust	8	7	8	9
	Sperrin/Lakeland HSS Trust	2	4	3	3
	Ulster Hospitals	8	8	8	7
	United Hospital Group	8	7	13	12
Total		**54**	**55**	**66**	**73**
Anaesthetics	Altnagelvin HSS Trust	5	6	6	7
	Belfast City Hospital Trust	8	10	10	10
	C-avon/B-bridge Hospital	4	5	3	7
	Mater Infirmorum Trust	1	2	1	1
	Newry & Mourne	3	3	2	2
	RG Hospital Group Trust	4	6	6	9
	Ulster Hospitals	3	4	4	8
	United Hospital Group	4	5	4	5
Total		**32**	**41**	**36**	**49**
ENT	Altnagelvin HSS Trust	2	2	2	2
	Belfast City Hospital Trust	1	1	1	1
	C-avon/B-bridge Hospital	3	4	3	2
	Newry & Mourne	1	1	1	1
	RG Hospital Group Trust	3	2	2	2
	Sperrin/Lakeland HSS Trust	2	2	1	2
	Ulster Hospitals	2	2	2	1
	United Hospital Group	4	3	3	3
Total		**18**	**17**	**15**	**14**
Medical Paediatrics	Altnagelvin HSS Trust	7	10	8	9
	Belfast City Hospital Trust	5	3		
	Causeway	4	6	5	5
	C-avon/B-bridge Hospital	8	10	10	10
	Newry & Mourne	5	5	5	5
	RG Hospital Group Trust	26	25	30	35

	Sperrin/Lakeland HSS Trust	5	7	5	5
	Ulster Hospitals	10	9	9	10
	United Hospital Group	11	11	11	9
Total		**81**	**86**	**83**	**88**
Medical Specialities	Ulster Hospitals	18	18	16	17
	Altnagelvin HSS Trust	15	14	15	15
	Armagh and Dungannon	8	7	7	0
	Belfast City Hospital Trust	32	28	32	31
	Causeway	8	8	7	7
	C-avon/B-bridge Hospital	17	15	16	21
	Down & Lisburn Trust'	8	10	10	10
	Mater Infirmorum Trust	7	7	7	9
	Newry & Mourne	5	4	5	6
	RG Hospital Group Trust	33	28	32	36
	Sperrin/Lakeland HSS Trust	9	9	11	9
	United Hospital Group	36	34	35	34
Total		**196**	**182**	**193**	**195**
Neurosciences	RG Hospital Group Trust	6	6	6	6
Total		**6**	**6**	**6**	**6**
Obstetrics and Gynaecology	Altnagelvin HSS Trust	5	5	5	5
	Armagh and Dungannon	3	2	3	
	Belfast City Hospital Trust	5	5		
	Causeway	4	4	4	4
	C-avon/B-bridge Hospital	4	4	4	7
	Down & Lisburn Trust'	9	9	8	8
	Mater Infirmorum Trust	4	4	4	5
	Newry & Mourne	4	6	5	5
	RG Hospital Group Trust	12	13	20	18
	Sperrin/Lakeland HSS Trust	5	6	6	6
	Ulster Hospitals	7	6	6	5
	United Hospital Group	10	11	9	10
Total		**72**	**75**	**74**	**73**
Ophthalmology	Altnagelvin HSS Trust	3	3	3	3
	RG Hospital Group Trust	8	8	7	7
Total		**11**	**11**	**10**	**10**
Orthopaedics	Altnagelvin HSS Trust	2	3	4	4
	Belfast City Hospital Trust	3	6	0	0
	Green Park Trust	2	3	2	5
	RG Hospital Group Trust	3	4	5	3
	Ulster Hospitals	2	2	1	2
Total		**12**	**18**	**12**	**14**

Other	Newry & Mourne	2	0	0	0
	Southern Board H Q	0	1	1	1
Total		**2**	**1**	**1**	**1**
Pathology	Belfast City Hospital Trust	5	5	5	8
	C-avon/B-bridge Hospital	0	0	1	1
	RG Hospital Group Trust	6	6	4	6
Total		**11**	**11**	**10**	**15**
Psychiatry and Learning Difficulties	Altnagelvin HSS Trust	1	1	1	1
	Armagh and Dungannon	5	5	8	6
	Belfast City Hospital Trust	5	6	5	5
	Causeway	3	3	4	4
	C-avon/B-bridge Comm	6	5	6	7
	Down & Lisburn Trust'	14	10	11	10
	Foyle HSS Trust (Community)	7	7	9	8
	Belfast City Hospital Trust	18	17	18	17
	Mater Infirmorum Trust	4	8	6	7
	N & W Belfast Trust	3	3	3	3
	Newry & Mourne	3	3	4	4
	RG Hospital Group Trust	2	2		
	S & E Belfast Community Trust	12	6	8	7
	Sperrin/Lakeland HSS Trust	6	6	6	6
	Ulster Hospitals	6	5	6	5
Total		**95**	**87**	**95**	**90**
Radiology	Belfast City Hospital Trust	9	7	7	8
Total		**9**	**7**	**7**	**8**
Surgical Specialities	Altnagelvin HSS Trust	4	4	4	4
	Armagh and Dungannon	4	5	4	
	Belfast City Hospital Trust	4	4	5	9
	Causeway	4	4	4	4
	C-avon/B-bridge Hospital	5	6	5	8
	Down & Lisburn Trust'	8	8	7	6
	Mater Infirmorum Trust	4	4	4	4
	Newry & Mourne	4	3	4	5
	RG Hospital Group Trust 1	16	17	13	8
	Sperrin/Lakeland HSS Trust	8	10	11	10
	Ulster Hospitals	9	10	8	10
	United Hospital Group	13	14	13	16
Total		**83**	**89**	**82**	**84**
Grand Total		**682**	**686**	**690**	**720**

Source: HRMS

4.3 SHO's by Trust

Table 4.3

SHO's by Trust

	1998	1999	2000	2001	% Change
RG Hospital Group Trust	127	124	133	139	+9%
United Hospital Group	86	85	88	89	+3%
Belfast City Hospital; Trust	85	83	71	79	-7%
Ulster Hospitals & Community Trusts	65	64	60	65	0%
C-avon/B-bridge Hospital	46	51	52	65	+41%
Altnagelvin HSS Trust (Hospital)	50	53	53	57	+14%
Sperrin/Lakeland HSS Trust	37	44	43	41	+11%
Down & Lisburn Trust'	39	37	39	38	-3%
Mater Infirmorum Hospital Trust	25	30	28	33	+32%
Causeway	27	29	28	30	+11%
Newry & Mourne	27	25	26	30	+11%
Homefirst Community	18	17	18	17	-6%
Foyle HSS Trust (Community)	7	7	9	8	+14%
S & E Belfast Community Trust	12	6	8	7	-42%
C-avon/B-bridge Comm	6	5	6	7	+17%
Armagh and Dungannon	20	19	22	6	-70%
Green Park Trust	2	3	2	5	+150%
N & W Belfast Community Trust	3	3	3	3	0%
Southern Board H Q	0	1	1	1	+100%
Group Total	**682**	**686**	**690**	**720**	**+6%**

Source: HRMS

Please note – during the period, Craigavon / Banbridge Hospitals trust took over the acute care elements of Armagh and Dungannon.

4.4 SHO's by Grade

Table 4.4

SHO's by Grade

	1998	**1999**	**2000**	**2001**	**% Change**
House Off (Post-Reg)	1	0	0	0	-100%
Senior House Officer	681	686	690	720	+15%
Group Total	**682**	**686**	**690**	**720**	**+6%**

Source: HRMS

4.5 SHO's by Age

Table 4.5

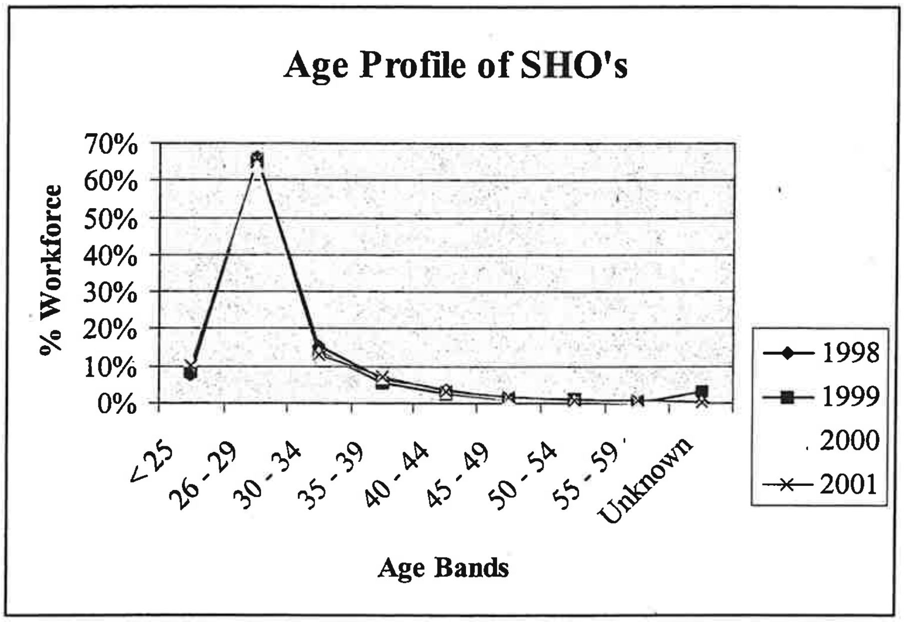
SHO's by Age

Age Bands	**Number**	**Per Cent**
< 25	70	10%
26 - 29	473	66%
30 - 34	93	13%
35 - 39	48	7%
40 - 44	23	3%
45 - 49	9	1%
50 - 54	2	0%
55 - 59	2	0%
Unknown	0	0%
Group Total	**720**	**100%**

Source: HRMS

Figure 4.1

Age Profile of SHO's 1998-2001



Source: HRMS

4.6 SHO's by Gender

Table 4.6

SHO's by Gender

	Female	% Female	Male	% Male	Total
1998	314	46%	368	54%	682
1999	291	42%	395	58%	686
2000	309	48%	381	52%	690
2001	327	45%	393	55%	720

Source: HRMS

4.7 Part-time Working of SHO's

Table 4.7

Part-time Working of SHO's 1998-2001

	1998	1999	2000	2001
Total in the Workforce	682	686	690	720
% Working PT	5%	3%	2%	3%
% Women Working Part-time	74%	58%	75%	72%
% Women Working Part-time in the Workforce	9%	4%	3%	4%

5. PRHO'S

5.1 PRHO's by Department

Table 5.1

PRHO's by Department

Department	1998	1999	2000	2001	% Change
General Medicine	71	65	74	77	+8%
Rheumatology And Rehab	2	2	2	2	0%
Cardiology	8	8	4	8	0%
Nephrology	2	3	3	2	0%
Geriatrics	10	10	11	12	+20%
Neurology	0	0	0	2	+200%
Endocrinology	2	2	3	1	-50%
General Surgery/Urology	67	70	63	72	+7%
Orthopaedic Surgery	10	8	3	6	-40%
Neuro Surgery	2	2	1	0	-100%
Radiology	1	1	1	1	0%
Haematology/Blood Transfusion	1	1	1	1	0%
Urology	4	4	4	3	-25%
Vascular Surgery	2	3	0	0	-100%
Cardiac Surgery	0	0	3	0	0%
Thoracic Surgery	2	2	10	1	-50%
Group Total	**184**	**181**	**183**	**188**	**+2%**

Source: HRMS

5.2 PRHO's by Department by Trust

Table 5.2

PRHO's by Department by Trust

Department	Trust	1998	1999	2000	2001
Medical Specialities	Altnagelvin HSS Trust	6	6	6	6
	Armagh and Dungannon	2	2	0	0
	Belfast City Hospital Trust	25	23	24	25
	Causeway	2	2	3	3
	C-avon/B-bridge Hospital	6	6	8	8
	Down & Lisburn Trust'	3	3	3	4
	Mater Infirmorum Trust	5	4	5	5
	Newry & Mourne	4	4	4	5
	RG Hospital Group Trust	16	15	16	17
	Sperrin/Lakeland HSS Trust	5	5	6	7
	Ulster Hospitals	11	10	10	11
	United Hospital Group	10	10	12	11
Total		**95**	**90**	**97**	**102**
Neurosciences	RG Hospital Group Trust	2	2	1	2
Total		**2**	**2**	**1**	**2**
Orthopaedics	Belfast City Hospital Trust	4	4	0	0
	RG Hospital Group Trust	4	2	1	6
	Ulster Hospitals	2	2	2	0
Total		**10**	**8**	**3**	**6**
Pathology	Belfast City Hospital Trust	1	1	1	1
Total		**1**	**1**	**1**	**1**
Radiology	Belfast City Hospital Trust	1	1	1	1
Total		**1**	**1**	**1**	**1**
Surgical Specialities	Altnagelvin HSS Trust	6	6	6	6
	Armagh and Dungannon	2	2	0	0
	Belfast City Hospital Trust	14	15	15	11
	Causeway	2	2	3	3
	C-avon/B-bridge Hospital	6	6	8	8
	Down & Lisburn Trust'	3	3	0	3
	Mater Infirmorum Trust	4	6	5	5
	Newry & Mourne	4	4	4	5
	RG Hospital Group Trust	10	12	15	10
	Sperrin/Lakeland HSS Trust	5	5	6	5
	Ulster Hospitals	8	8	8	10

	United Hospital Group	11	10	10	10
Total		**75**	**79**	**80**	**76**
Grand Total		**184**	**181**	**183**	**188**

Source: HRMS

Please note – during the period, Craigavon / Banbridge Hospitals trust took over the acute care elements of Armagh and Dungannon.

5.3 PRHO's by Grade

Table 5.3

PRHO's by Grade

	1998	1999	2000	2001	% Change
House Off (Pre-Reg)	184	181	183	188	+2%
Group Total	**184**	**181**	**183**	**188**	**2%**

Source: HRMS

5.4 PRHO's by Trust

Table 5.4

PRHO's by Trust

	1998	1999	2000	2001	% Change
Belfast City Hospital Trust	45	44	41	38	-16%
RG Hospital Group Trust	32	31	33	35	+9%
Ulster Hospitals & Community Trust	21	20	20	21	0%
United Hospital Group	21	20	22	21	0%
Craigavon/Banbridge Hospital	12	12	16	16	+33%
Altnagelvin HSS Trust (Hospital)	12	12	12	12	0%
Sperrin/Lakeland HSS Trust	10	10	12	12	+20%
Mater Infirmorum Hospital Trust	9	10	10	10	+11%
Newry & Mourne	8	8	8	10	+25%
Down & Lisburn Trust'	6	6	3	7	+17%
Causeway	4	4	6	6	+50%
Armagh and Dungannon	4	4	0	0	-100%
Group Total	**184**	**181**	**183**	**188**	**+2%**

Source: HRMS

Please note – during the period, Craigavon / Banbridge Hospitals trust took over the acute care elements of Armagh and Dungannon.

5.5 PRHO's by Age

Table 5.5

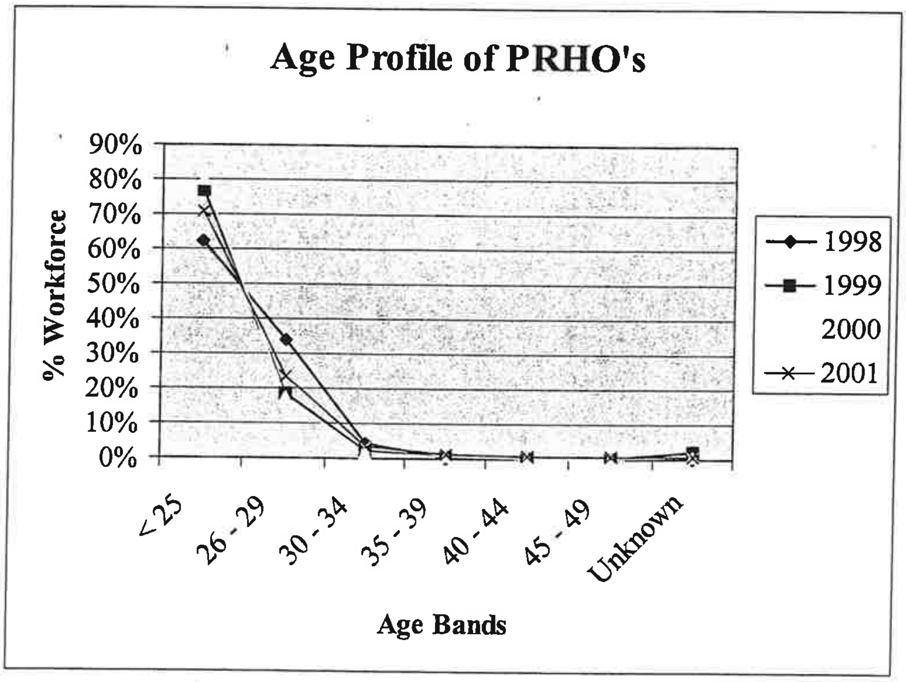
PRHO's by Age

Year	**Number**	**Per cent**
< 25	133	71%
26 - 29	44	23%
30 - 34	6	3%
35 - 39	2	1%
40 - 44	1	1%
45 - 49	1	1%
Unknown	1	1%
Group Total	**188**	**100%**

Source: HRMS

Figure 5.1

Age Profile of PRHO's



Source: HRMS

5.6 PRHO's by Gender

Table 5.6

PRHO's by Gender

Year	Female	% Female	Male	% Male	Total
1998	81	44%	103	56%	184
1999	95	52%	86	48%	181
2000	95	52%	88	48%	183
2001	107	57%	81	43%	188

Source: HRMS

6. OTHER MEDICAL PRACTITIONERS

6.1 Other Medical Practitioners by Department

Table 6.1

Other Medical Practitioners by Department

Department	1998	1999	2000	2001	% Change
Other	160	126	126	109	-32%
Medical Specialties	57	57	56	61	+7%
Accident and Emergency	40	27	22	22	-45%
Psychiatry and Learning Difficulty	9	9	9	9	0%
Medical Paediatrics	8	8	6	8	0%
Pathology	9	9	8	8	-11%
ENT	8	7	7	7	-13%
Ophthamology	4	3	5	5	+25%
Radiology	3	4	6	5	+67%
Anaesthetics	5	7	4	3	-40%
Surgical Specialties	1	2	3	3	+200%
Obstetrics and Gynaecology	2	2	2	2	0%
Neurosciences	1	1	1	1	0%
Orthopaedics	2	1	1	1	-50%
Total	**309**	**263**	**256**	**244**	**-21%**

Source: HRMS

6.2 Other Medical Practitioners by Department by Trust

Table 6.2

Other Medical Practitioners by Department by Trust

Department	Trust	1998	1999	2000	2001
Accident and Emergency	Armagh and Dungannon	2	2	2	1
	Belfast City Hospital Trust	6	6	2	5
	C-avon/B-bridge Hospital	20			1
	Foyle HSS Trust	1	1	1	1
	Mater Infirmorum Trust	2	13	8	7
	RG Hospital Group Trust	2		1	1
	Ulster Hospitals	5	5	8	6
	United Hospital Group	2			
Total		**40**	**27**	**22**	**22**
Anaesthetics	Altnagelvin HSS Trust	1	1	1	0
	Foyle HSS Trust	1	1	1	1
	RG Hospital Group Trust	3	3	2	1
	Ulster Hospitals	0	2	0	1
Total		**5**	**7**	**4**	**3**
ENT	Altnagelvin HSS Trust	1	0	0	0
	Belfast City Hospital Trust	1	1	1	1
	Down & Lisburn Trust'	1	1	1	1
	RG Hospital Group Trust	2	2	2	2
	Sperrin/Lakeland HSS Trust	1	1	1	1
	Ulster Hospitals	2	2	2	2
Total		**8**	**7**	**7**	**7**
Medical Paediatrics	Armagh and Dungannon	1	0	0	0
	Causeway	1	0	0	0
	Down & Lisburn Trust'	1	1	1	1
	Foyle HSS Trust	1	2	0	1
	N & W Belfast Trust	1	2	2	2
	Newry & Mourne	1	1	1	1
	RG Hospital Group Trust	2	2	2	3
Total		**8**	**8**	**6**	**8**
Medical Specialities	Altnagelvin HSS Trust	4	3	3	2
	Armagh and Dungannon		1	4	4
	Belfast City Hospital Trust	8	12	11	10
	Causeway	2	2	2	2
	C-avon/B-bridge Hospital	4	5	4	6
	Down & Lisburn Trust'	3	3	3	3

	Foyle HSS Trust	9	8	7	8
	Green Park Trust	4	3	3	3
	Newry & Mourne	4	0	1	2
	RG Hospital Group Trust	5	5	4	4
	Sperrin/Lakeland HSS Trust	2	3	2	3
	Ulster Hospitals	6	9	9	12
	United Hospital Group	6	3	3	2
Total		**57**	**57**	**56**	**61**
Neurosciences	RG Hospital Group Trust	1	1	1	1
Total		**1**	**1**	**1**	**1**
Obstetrics and	Causeway	1	1	1	1
Gynaecology	Ulster Hospitals &	1	1	1	1
Total		**2**	**2**	**2**	**2**
Ophthalmology	Altnagelvin HSS Trust			1	1
	Homefirst Community	1	1	1	1
	RG Hospital Group Trust	3	2	3	3
Total		**4**	**3**	**5**	**5**
Orthopaedics	Green Park Trust	2	1	1	1
Total		**2**	**1**	**1**	**1**
Other	Armagh and Dungannon	3	3	4	4
	Belfast City Hospital Trust	3	2	2	1
	Causeway	20	9	10	10
	C-avon/B-bridge Comm	12	6	5	5
	C-avon/B-bridge Hospital	1			
	Down & Lisburn Trust	11	13	12	12
	Eastern Board HQ	1		1	1
	Foyle HSS Trust	11	10	9	7
	Homefirst Community	18	13	14	9
	N & W Belfast Trust	31	31	30	29
	Newry & Mourne	10	6	6	4
	Northern Board H Q	4	3	2	1
	RG Hospital Group Trust	4	3	2	2
	S & E Belfast Trust	6	6	6	5
	Southern Board H Q	10	8	6	6
	Sperrin/Lakeland HSS Trust	3	5	4	4
	Ulster Hospitals	2	0	0	0
	United Hospital Group	2	2	4	2
	Westcare Business Services			1	1
	Western Board HQs	8	6	8	6
Total		**160**	**126**	**126**	**109**

Pathology	Belfast City Hospital Trust	1	2	1	1
	Blood Transfusion Service	7	7	6	6
	C-avon/B-bridge Hospital			1	1
	RG Hospital Group Trust	1			
Total		**9**	**9**	**8**	**8**
Psychiatry and Learning Difficulties	Armagh and Dungannon	1	1	1	0
	Belfast City Hospital Trust	2	2	2	2
	Homefirst Community	1	1	1	1
	N & W Belfast Trust	2	2	2	2
	S & E Belfast Trust	2	2	2	2
	Sperrin/Lakeland HSS Trust	1	1	1	2
Total		**9**	**9**	**9**	**9**
Radiology	Belfast City Hospital Trust	2	3	5	4
	C-avon/B-bridge Hospital	1	1	1	1
Radiology Total		**3**	**4**	**6**	**5**
Surgical Specialities	Belfast City Hospital Trust			1	1
	Ulster Hospitals		1	1	1
	United Hospital Group	1	1	1	1
Total		**1**	**2**	**3**	**3**
Grand Total		**309**	**263**	**256**	**244**

Please note – during the period, Craigavon / Banbridge Hospitals trust took over the acute care elements of Armagh and Dungannon.

6.3 Other Medical Practitioners by Grade

Table 6.3

Other Medical Practitioners by Grade

Grade	1998	1999	2000	2001	% Change
P/T Medical Practitioner	68	81	68	73	+7%
Clinical Medical Off	73	61	54	47	-36%
Hospital Practitioner	24	40	51	47	+96%
Sen Clinical Med Off.	21	19	19	18	-14%
General Med Prac/Gp	41	14	10	10	-76%
Medical Off	15	7	10	8	-47%
Gen Med Practitr/Hosp	30	7	9	7	-77%
Visiting Medical Off	9	7	7	7	-22%
Clinical Res Fellow	4	6	5	5	+25%
Dir Public Hlth/Camo	3	3	4	4	+33%
Clinical Assistant	2	2	3	3	+50%
Medical Adviser	4	3	2	3	-25%
Professor	3	3	3	3	0%
Sen Medical Advisor	1	2	3	3	+200%
Hosital Prac	4	3	2	2	-50%
Medical Assistant	2	2	2	2	0%
Asst Ch Adm Med Off	1	1	1	1	0%
Clinical Rep (Gp)	2	1	2	1	-50%
Sess Gp Adv Med Audit	2	1	1	0	-100%
Total	**309**	**263**	**256**	**244**	**-21%**

Source: HRMS

6.4 Other Medical Practitioners by Trust

Table 6.4

Other by Trust

Trust	1998	1999	2000	2001	% Change 1998-2001
N & W Belfast Community Trust	34	35	34	33	-3%
Belfast City Hospital Trust	23	28	25	25	+9%
Ulster Hospitals & Community Trusts	16	20	21	23	+44%
Foyle HSS Trust (Community)	23	22	18	18	-22%
Down & Lisburn Trust'	16	18	17	17	+6%
RG Hospital Group Trust	23	18	17	17	-26%
Causeway	24	12	13	13	-46%
Homefirst Community	20	15	16	11	-45%
Sperrin/Lakeland HSS Trust	7	10	8	10	+43%
Armagh and Dungannon	7	7	11	9	+29%
Craigavon/Banbridge Hospital	26	6	6	9	-65%
Mater Infirmorum Hospital Trust	2	13	8	7	+250%
Newry & Mourne	15	7	8	7	-53%
S & E Belfast Community Trust	8	8	8	7	-13%
Blood Transfusion Service	7	7	6	6	-14%
Southern Board H Q	10	8	6	6	-40%
Western Board HQs	8	6	8	6	-25%
Craigavon/Banbridge Community	12	6	5	5	-58%
United Hospital Group	11	6	8	5	-55%
Green Park Trust	6	4	4	4	-33%
Altnagelvin HSS Trust (Hospital)	6	4	5	3	-50%
Eastern Board HQ	1		1	1	0%
Northern Board H Q	4	3	2	1	-75%
Westcare Business Services	0	0	1	1	+100%
Total	**309**	**263**	**256**	**244**	**-21%**

Source: HRMS

6.5 Other Medical Practitioners by Age

Table 6.5

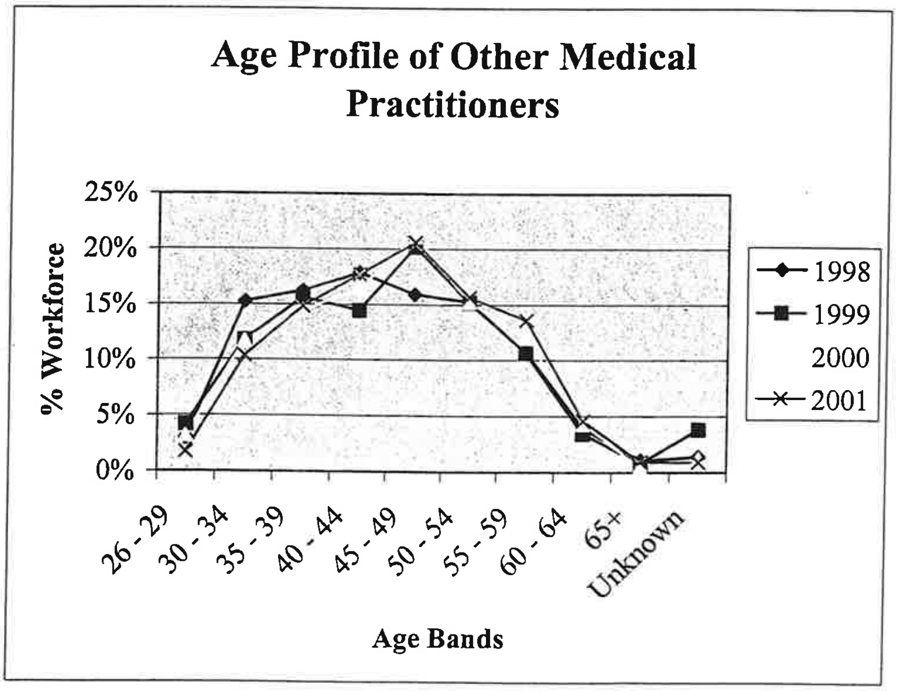
Other Medical Practitioners by Age

Age	Number	Per Cent
26 - 29	4	2%
30 - 34	25	10%
35 - 39	36	15%
40 - 44	43	18%
45 - 49	50	20%
50 - 54	38	16%
55 - 59	33	14%
60 - 64	11	5%
65+	2	1%
Unknown	2	1%

Source: HRMS

Figure 6.1

Age Profile of Other Medical Practitioners



Source: HRMS

6.6 Other Medical Practitioners by Gender

Table 6.6

Other Medical Practitioners by Gender

Year	Female	% Female	Male	% Male	Total
1998	148	48%	159	52%	307
1999	131	50%	132	50%	263
2000	127	50%	129	50%	256
2001	119	49%	125	51%	244

Source: HRMS

6.7 Part-time Working Among Other Medical Practitioners

Table 6.7

Part-time Working 1998-2001

	1998	1999	2000	2001
Number Working Part-time	261	223	221	209
% Total Workforce	85%	85%	86%	86%
% Part-time Workers who are Women	47%	50%	50%	49%
% Women in Workforce Working Part-time	40%	43%	43%	42%

Source: HRMS

7. GENERAL PRACTITIONERS

7.1 GPs by Board

Table 7.1

GPs by Board

Health Board	1998 GPs	1999 GPs	2000 GPs	2001 GPs	% Change 1998-2001
Eastern	425	427	429	432	+2%
Northern	239	244	245	251	+5%
Southern	198	199	199	204	+3%
Western	180	184	183	182	+1%
Total	**1042**	**1054**	**1056**	**1069**	**+3%**

Source: CSA – 1 Oct each year

7.2 GPs by Age

Table 7.2

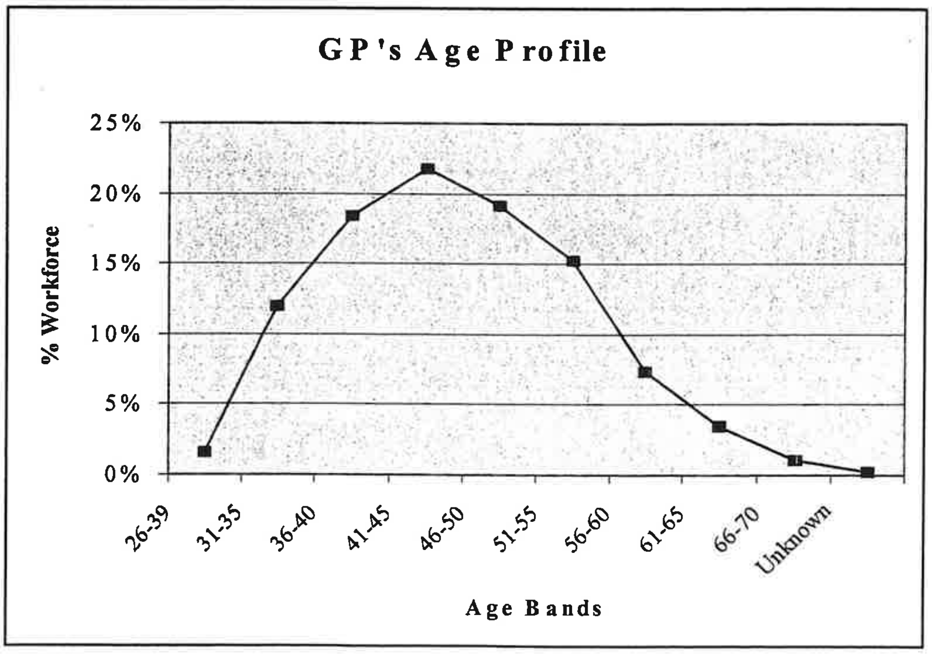
GPs by Age

Age Bands	Percentage	Number
26-39	2%	17
31-35	12%	128
36-40	18%	196
41-45	22%	232
46-50	19%	204
51-55	15%	163
56-60	7%	79
61-65	3%	37
66-70	1%	11
Unknown	0%	2
Total	**100%**	**1069**

Source: CSA – 1 Oct 2001

Figure 7.2

GPs by Age



7.3 GPs by Gender

Table 7.3

GPs by Gender

	Male	Percentage	Female	Percentage	Total
Eastern Health Board					
1998	282	66%	143	34%	425
1999	281	66%	146	34%	427
2000	279	65%	150	35%	429
2001	278	64%	154	36%	432
Northern Health Board					
1998	172	72%	67	28%	239
1999	175	72%	69	28%	244
2000	171	70%	74	30%	245
2001	174	69%	77	31%	251
Southern Health Board					
1998	140	71%	58	29%	198
1999	139	70%	60	30%	199
2000	132	66%	67	34%	199
2001	129	63%	75	37%	204
Western Health Board					
1998	140	78%	40	22%	180
1999	139	76%	45	24%	184
2000	134	73%	49	27%	183
2001	133	73%	49	27%	182
Total All Boards					
1998	734	70%	308	30%	1042
1999	734	70%	320	30%	1054
2000	716	68%	340	32%	1056
2001	714	67%	355	33%	1069

Source: CSA – 1 Oct each year

7.4 Full-time and Part-time Working

Table 7.4

Full-time and Part-time Working Among GPs by Gender

Eastern Health Board

	Male	Percentage	Female	Percentage	Total
Full Time	244	71%	98	29%	342
Part Time	34	38%	56	62%	90

Northern Health Board

	Male	Percentage	Female	Percentage	Total
Full Time	159	75%	52	25%	211
Part Time	15	38%	25	63%	40

Southern Health Board

	Male	Percentage	Female	Percentage	Total
Full Time	122	77%	36	23%	158
Part Time	7	15%	39	85%	46

Western Health Board

	Male	Percentage	Female	Percentage	Total
Full Time	130	84%	24	16%	154
Part Time	3	11%	25	89%	28

Total

	Male	Percentage	Female	Percentage	Total
Full Time	655	76%	210	24%	865
Part Time	59	29%	145	71%	204

Source: CSA – 1 Oct 2001

APPENDIX D
SUB-SPECIALTY GROUPING

Appendix D

Grouping of Specialties and Sub-specialties for Data Analysis

Main Group	Specialties / Sub-specialties	Main Group	Specialties / Sub-specialties
Radiology	Radiology Mammography	Medical Paediatrics	Paediatrics Child Health Community Paediatrics
A & E	A & E		
Anaesthetics	Anaesthetics Pain relief	Neurosciences	Clinical Neuro-physiology Neuro Surgery Neurology Neuropathology
Ophthalmology	Ophthalmology		
ENT	ENT Otolaryngology	Clinical Oncology	Medical Oncology Radiotherapy
Orthopaedics	Orthopaedics	Psychiatry & Learning Disability	Mental Handicap Mental Illness Child & Adolescent Psychiatry Forensic Psychiatry Psychiatry of Old Age Alcoholism / Drug Abuse Psychotherapy
Surgical Specialties	General Surgery Paediatric Surgery Plastic Surgery Urology Vascular Surgery Gastroenterology Renal Failure Surgery Cardiac Surgery Thoracic Surgery	Pathology	Clinical Genetics Physiology General Pathology Chemical Pathology Haematology Histopathology Medical Microbiology Immuno Pathology Histo / Cyto Clinical Chemistry
Medical Specialties	General Medicine Rheumatology/ Rehab Infectious Diseases Thoracic Medicine Dermatology Cardiology Genito-urinary Med Nephrology Geriatric Medicine Endocrinology and Diabetes Gen Med Spec. Int Geriatrics	Other	General Practice Community Medicine Other Depts Occupational Medicine Advisory Public Health Medicine Well Women Clinics GP Contracts Family Medicine Anatomy
Obs & Gynae	Obstetrics and Gynaecology Maternity		

APPENDIX E
BREAKDOWN OF CALCULATIONS FOR MODELLING

Consultants

Table 7.5.1

Projected New Consultant Requirements per annum

	2002 /03	03/ 04	04/ 05	05/ 06	06/ 07	07/ 08	08/ 09	09/ 10	10/ 11	11/ 12
Supply										
Retirements	25	24	22	30	28	27	39	39	39	49
Leavers	28	28	28	28	28	28	28	28	28	28
Current Vacancies	37	37								
Work / life balance	9	11	14	17	19	20	21	22	23	23
Demand										
Increased workload	37	37	37	37	37	37	37	37	37	37
Total per annum	**136**	**137**	**101**	**112**	**112**	**112**	**125**	**126**	**127**	**137**
SpR Supply	94	95	99	103	107	112	117	122	128	133
Over supply / -Shortfall	**-42**	**-42**	**-2**	**-9**	**-5**	**0**	**-8**	**-4**	**1**	**-4**

Consultant baseline = 929 (current employees at September 2001 per HRMS).

Basis of calculations;

Retirements: Using the 5 year age band profile in Appendix C, assume a retirement age of 62 in 2002/03 moving down to a retirement age of 59 by 2011/12.

Leavers: Based on the information provided by DHSSPS for 2001, and excluding age retirements – 3% applied to consultant baseline for leavers per annum. (929 x 0.03 = 28)

Current vacancies: Based on the DHSSPS annual survey for the projection of SpR posts for Sept 2001 – 74 vacancies, which, for the purposes of the model are assumed to be filled in the first two years (74 / 2 = 37).

Work / life balance: Number of additional staff required to compensate for staff wishing to move to part-time working. In 2002/03 it is assumed that 1% of baseline staff wish to move to part-time (929 x 0.01 = 9). This rises to 2% per annum by 2006/07 (929 x 0.02 = 19) and 2.5% per annum in 2011/12 (929 x 0.025 = 23)

Increased workload: 40% increase in the number of consultants employed, achieved over ten years (929 x 0.4 = 372 – over 10 years = 37 per annum).

Total per annum: Total of all of the above factors.

SpR Supply: This is the number of SpR projected to "graduate" each year, and is the annual SpR figure shown at the top of the SpR table below.

Over supply / shortfall: The difference between the projected SpR supply and the total per annum.

Non-Consultant Career Grades

Table 7.5.2
Projected Non-Consultant Career Grade Requirements per annum

	2002 /03	03/ 04	04/ 05	05/ 06	06/ 07	07/ 08	08/ 09	09/ 10	10/ 11	11/ 12
Supply										
Retirements	4	4	5	2	3	2	6	3	3	7
Leavers	9	9	9	9	9	9	9	9	9	9
Work / life balance	2	2	2	2	2	2	2	2	2	2
Demand										
WTD		2	2	2	2	2	3	3	3	3
Increased workload	19	15	11	8	4					
Total per annum	34	**32**	**29**	**23**	**20**	**15**	**20**	**17**	**17**	**21**

NCCG baseline = 188 (current employees at September 2001 per HRMS).

Basis of calculations;

Retirements: Using the 5 year age band profile in Appendix C, assume a retirement age of 62 in 2002/03 moving down to a retirement age of 59 by 2011/12.

Leavers: Based on the information provided by DHSSPS for 2001, and excluding age retirements – 5% applied to baseline for leavers per annum. (188 x 0.05 = 9)

Work / life balance: Number of additional staff required to compensate for staff wishing to move to part-time working. For this staff group it is assumed that 1% of baseline staff wish to move to part-time (188 x 0.01 = 2 per annum).

Working time directive: Within this staff group this applies only to full-time staff graders (98). The assumption is that a 14% increase in staff is required from 2003/04 and a further 14% from 2008/09. However, it is also assumed that the initial increase cannot be achieved in one year and is therefore spread over 5 years, with the second increase spread over four. (98 x 0.14 / 5 = 2 per year, 98 x 0.14 / 4 = 3 per year).

Increased workload: 30% increase in the number of NCCG employed, achieved over the first five years on a declining basis (188 x 0.3 = 56 – year 1 = 56 x 5/15, year 2 = 56 x 4/15 etc. to year 5 = 56 x 1/15) .

Total per annum: Total of all of the above factors.

Specialist Registrars

Table 7.5.3
Projected New Specialist Registrar Requirements per annum

	2002 /03	03/ 04	04/ 05	05/ 06	06/ 07	07/ 08	08/ 09	09/ 10	10/ 11	11/ 12
Supply										
Annual SpR	94	95	99	103	107	112	117	122	128	133
Leavers	19	19	19	19	19	19	19	19	19	19
Work / life balance	5	6	8	9	10	10	11	12	13	13
Demand										
WTD	0	13	13	13	13	13	16	16	16	16
Total SpR per annum	118	**133**	**139**	**144**	**149**	**154**	**163**	**169**	**176**	**181**
Requirement for NCCG	34	32	29	23	20	15	20	17	17	21
Requirement for GP Reg	75	77	80	87	83	89	98	105	107	114
Total SHO Requirement	227	**242**	**248**	**254**	**252**	**258**	**281**	**291**	**300**	**316**
Current SHO Supply	180	**184**	**192**	**197**	**202**	**207**	**212**	**218**	**224**	**230**
Shortfall	-47	**-58**	**-56**	**-57**	**-50**	**-51**	**-69**	**-73**	**-76**	**-86**

SpR baseline = 471 (current employees at September 2001 per HRMS). Assume five year training programme.

Basis of calculations;

Annual SpR: It is necessary to calculate an annual intake into year 1 and the output ("graduation") from year 5 of the SpR training programme. This gives you both the number of SpR posts available each year for incoming SHOs, and the number of "graduating " SpRs available to take up Consultant posts. It is assumed that the number of staff are spread evenly across the five years. Therefore, for 2002/03 the baseline number of SpR posts has been spread over the five years to give an initial annual intake / output of 471 / 5 = 94.

Each year, the total number of SpR posts will be increased by the additional posts required to meet the needs of the working time directive and the work/life balance. (Leavers have no impact on the overall number of posts, but do have an impact on the number of staff required.) These additional posts relate to the whole SpR workforce are therefore assumed to be spread across the five years of training doctors in the group. Therefore the number of posts in each training year is increased annually by 1/5 of the total increase in posts .

Applying this to the model, in 2002/03 the baseline is 471 SpR or 94 SpR per training year. There are 5 new posts created for work/life balance, giving a new baseline of 476 or 95 (476 / 5) SpR per training year. In 2003/04, 6 new posts are created for work/life balance and 13 for WTD giving an end of year baseline of 495 (476 + 6 + 13) or 99 (495 / 5) per training year. This pattern is followed throughout the rest of the model.

Leavers: Based on the information provided by DHSSPS for 2001, and excluding age retirements – 4% applied to baseline for leavers per annum. (471 x 0.04 = 19)

Work / life balance: Number of additional staff required to compensate for staff wishing to move to part-time working. In 2002/03 it is assumed that an additional 1% of baseline staff wish to move to part-time (471 x 0.01 = 5). This rises to 2% per annum by 2006/07 (5 x 2 = 10) and 2.5% per annum in 2011/12 (5 x 2.5 = 13)

Working time directive: The assumption is that a 14% increase in staff is required from 2003/04 and a further 14% from 2008/09. However, it is also assumed that the initial increase cannot be achieved in one year and is therefore spread over 5 years, with the second increase spread over four. (471 x 0.14 / 5 = 13 per annum, 471 x 0.14 / 4 = 16 per annum).

Total SpR per annum: Total of all of the above factors.

Requirement for NCCG: Total per annum from NCCG table above.

Requirement for GP Reg: Total per annum required from GP projections below.

Total SHO requirement: Total of SpR per annum + Requirement for NCCG + Requirement for GP Reg.

Current SHO Supply: This is the number of SHO projected to "graduate" each year, and is the annual SHO figure shown at the top of the SHO table below.

Over supply / shortfall: The difference between the current SHO supply and the total SHO requirement.

Senior House Officers

Table 7.5.4

Projected New SHO Requirements per annum

	2002 /03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/ 12**
Supply										
Annual SHO	180	184	192	197	202	207	212	218	224	230
Leavers	29	29	29	29	29	29	29	29	29	29
Vacancies	10	10								
Work / life balance	7	7	7	7	7	7	7	7	7	7
Demand										
WTD	0	13	13	13	13	13	17	17	17	17
Total per annum	226	**243**	**241**	**246**	**251**	**256**	**265**	**271**	**277**	**283**
Current PRHO Supply	188	**214**	**219**	**224**	**229**	**233**	**238**	**244**	**250**	**256**
Shortfall	-38	**-29**	**-22**	**-22**	**-22**	**-23**	**-27**	**-27**	**-27**	**-27**

SHO baseline = 720 (current employees at September 2001 per HRMS).
Assumed four year training programme.
Basis of calculations;

Annual SHO: It is necessary to calculate an annual intake into year 1 and the output ("graduation") from year 4 of the SHO training programme. This gives you both the number of SHO posts available each year for incoming PRHOs, and the number of "graduating " SHOs available to take up SpR, NCCG or GP Reg posts. It is assumed that the number of staff are spread evenly across the four years. Therefore, for 2002/03 the baseline number of SHO posts has been spread over the four years to give an initial annual intake / output of 720 / 4 = 180.

Each year, the total number of SHO posts will be increased by the additional posts required to meet the needs of the working time directive and the work/life balance, and the filling of vacancies. (Leavers have no impact on the overall number of posts, but do have an impact on the number of staff required.) These additional posts relate to the whole SHO workforce are therefore assumed to be spread across the four years of training doctors in the group. Therefore the number of posts in each training year is increased annually by 1/4 of the total increase in posts .

Applying this to the model, in 2002/03 the baseline is 720 SHO or 180 SHO per training year. There are 7 new posts created for work/life balance and 10 vacancies filled, giving a new baseline of 737 or 184 (737 / 4) SHO per training year. In 2003/04, there are a further 10 vacancies filled, 7 new posts are created for work/life balance and 13 for WTD giving an end of year baseline of 767 (737 + 10 + 7 + 13) or 192 (767 / 4) per training year. This pattern is followed throughout the rest of the model.

Leavers: Based on the information provided by DHSSPS for 2001, and excluding age retirements – 4% applied to baseline for leavers per annum. (720 x 0.04 = 29)

Current vacancies: Based on anecdotal evidence 20 vacancies, which, for the purposes of the model are assumed to be filled in the first two years (20 / 2 = 10).

Work / life balance: Number of additional staff required to compensate for staff wishing to move to part-time working. It is assumed that each year an additional 1% of baseline staff wish to move to part-time (720 x 0.01 = 7 per annum).

Working time directive: The assumption is that a 14% increase in staff is required from 2003/04 and a further 14% from 2008/09. However, it is also assumed that the impact of alternative patterns of care will reduce this increase by 33% and that the initial increase cannot be achieved in one year and is therefore spread over 5 years, with the second increase spread over four (720 x 0.14 x (1.0 – 0.33) / 5 = 13 per annum, 720 x 0.14 x (1.0 – 0.33)/ 4 = 17 per annum).

Total SHO per annum: Total of all of the above factors.

Current PRHO Supply: This is the number of PRHO projected to "graduate" each year, and is the annual PRHO figure shown at the top of the PRHO table below.

Over supply / shortfall: The difference between the current PRHO supply and the above total SHO per annum.

Pre-Registration House Officers

Table 7.5.5
Projected New PRHO Requirements per annum

	2002 /03	03/ 04	04/ 05	05/ 06	06/ 07	07/ 08	08/ 09	09/ 10	10/ 11	11/ 12
Supply										
Annual Intake	212	214	219	224	229	233	238	244	250	256
Leavers	2	2	2	2	2	2	2	2	2	2
Work / life balance	2	2	2	2	2	2	2	2	2	2
Demand										
WTD	0	3	3	3	3	3	4	4	4	4
Total PRHO needs	216	**221**	**226**	**231**	**236**	**240**	**246**	**252**	**258**	**264**
Student Supply	183	**173**	**169**	**169**	**180**	**180**	**180**	**180**	**180**	**180**
Shortfall	-33	**-48**	**-57**	**-62**	**-56**	**-60**	**-66**	**-72**	**-78**	**-84**

PRHO baseline = 188 (current employees at September 2001 per HRMS) August 2002 = 212 per NICPMDE.

Basis of calculations;

Annual Intake: The annual intake each year is increased by the number of posts created in the previous year for wtd and work/life balance.

Leavers: Based on anecdotal evidence - 1% applied to baseline for leavers per annum (212 x 0.01 = 2 per annum)

Work / life balance: Number of additional staff required to compensate for staff wishing to move to part-time working. It is assumed that each year an additional 1% of baseline staff wish to move to part-time (212 x 0.01 = 2 per annum).

Working time directive: The assumption is that a 14% increase in staff is required from 2003/04 and a further 14% from 2008/09. However, it is also assumed that the impact of alternative patterns of care will reduce this increase by 33% and that the initial increase cannot be achieved in one year and is therefore spread over 5 years, with the second increase spread over four (212 x 0.14 x (1.0 – 0.33) / 5 = 3 per annum, 212 x 0.14 x (1.0 – 0.33)/ 4 = 4 per annum).

Total PRHO needs: Total of all of the above factors.

Student Supply: This is the number of students projected to "graduate" each year from Queens.

Shortfall: The difference between the current student supply and the above total PRHO per annum.

Others

Table 7.5.6
Projected New "Other" Requirements per annum

	2002 /03	**03/ 04**	**04/ 05**	**05/ 06**	**06/ 07**	**07/ 08**	**08/ 09**	**09/ 10**	**10/ 11**	**11/ 12**
Supply										
Retirements	6	7	7	13	8	9	15	8	7	24
Leavers	20	20	20	20	20	20	20	20	20	20
Total	26	**27**	**27**	**33**	**28**	**29**	**35**	**28**	**27**	**44**

Other baseline = 244 (current employees at September 2001 per HRMS).

Basis of calculations;

Retirements: Using the 5 year age band profile in Appendix C, assume a retirement age of 62 in 2002/03 moving down to a retirement age of 59 by 2011/12.

Leavers: Based on the information provided by DHSSPS for 2001, and excluding age retirements – 8% applied to the baseline for leavers per annum (244 x 0.08 = 20 per annum)

Total per annum: Total of all of the above factors.

General Practitioners

Table 7.5.7
Projected GP Requirements per annum

	2002 /03	03/ 04	04/ 05	05/ 06	06/ 07	07/ 08	08/ 09	09/ 10	10/ 11	11/ 12
Supply										
Retirements	27	27	27	31	25	30	37	43	43	50
Leavers	12	12	12	12	12	12	12	12	12	12
Work / life balance	11	13	16	19	21	22	24	25	27	27
Demand										
Increased Workload	25	25	25	25	25	25	25	25	25	25
Total GP Reg Requirement	75	**77**	**80**	**87**	**83**	**89**	**98**	**105**	**107**	**114**
Supply	42	**75**	**77**	**80**	**87**	**87**	**89**	**98**	**105**	**107**
Shortfall	-33	**-2**	**-3**	**-7**	**4**	**-2**	**-9**	**-7**	**-2**	**-7**

GP baseline = 1,069 (current at September 2001 per CSA).

Basis of calculations;

Retirements: Using the 5 year age band profile in Appendix C, assume a retirement age of 62 in 2002/03 moving down to a retirement age of 59 by 2011/12.

Leavers: Based on the information provided by CSA for 1998 to 2001, and excluding age retirements – average over three years = 12 per annum

Work / life balance: Number of additional staff required to compensate for staff wishing to move to part-time working. In 2002/03 it is assumed that 1% of baseline staff wish to move to part-time (1,069 x 0.01 = 11). This rises to 2% per annum by 2006/07 (1,069 x 0.02 = 21) and 2.5% per annum in 2011/12 (1,069 x 0.025 = 27)

Increased workload: increase of 250 in the number of consultants employed, achieved over ten years.

Total GP Reg Requirement: Total of all of the above factors.

Supply: For 2002/03 this is the number of GP Registrars who will complete training (per NICPMDE). For future years it is assumed that the number of training posts has been increased to meet the previous year's needs.

Shortfall: The difference between the projected GP Reg training posts and the total GP requirement per annum i.e. the continuing increased requirement for training posts.

Department of Health, Social Services and Public Safety

An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Review of the Podiatry Workforce

Final Report

June 2003

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EXECUTIVE SUMMARY

In September 2001, the DHSSPS commenced a series of uni-professional workforce reviews, which, over the period of one year, would cover the main clinical professions within the HPSS. There were a number of drivers behind the initiative and these included, the publication of the Hayes Report on the future of Acute Hospital Services and the DHSSPS consultation document 'The Employer of Choice'. Both documents highlighted the urgent need to put in place structures that will support workforce planning within and across all of the HPSS Professions. While it was determined that the initiatives, at this stage, would be taken forward on a uni-professional basis, the information and recommendations from this work would provide an important baseline in terms of developing workforce planning within HPSS across service sectors and professions.

Introduction

The document presented sets out a comprehensive review of the HPSS Podiatry profession. The review was undertaken during the period April-September 2002 and was co-ordinated by a Project Group, which comprised of representatives of the DHSSPS, providers, education, commissioners and staff side. The content of the report includes background details (including terms of reference), the project methodology, and a detailed profile of the current Podiatry workforce, a projection of the supply and demand for podiatrists within the HPSS workforce over the 5-year period 2003-2007 and recommendations to address issues arising from the review.

Background

The principal focus of the review was to provide the DHSSPS and service providers and commissioners with information concerning recruitment and retention issues within Podiatry and a projection of supply and demand within the profession. This information is vital to assist the Department in developing strategies that will ensure that the correct numbers of professionals are trained, in place and working effectively to offer the maximum benefit to patients and clients.

In considering the above, it is also important to review the current health policy context for the delivery of health and social care services in the future. A number of strategic documents have been reviewed and highlight the focus now being given to the delivery of high quality accessible care, with the development of the HPSS workforce being key to achieving this.

Terms of Reference

1. Provide a profile of the current Podiatry workforce in Northern Ireland, including:

   - Numbers employed, specialism in which employed, grading distribution age and gender balance.
   - Working conditions and patterns, grading and distribution.
   - Continuing professional development opportunities.

2. Provide an analysis of current and future recruitment and retention issues, including:

   - Remuneration
   - Career development and specialisation
   - Career breaks / leaving the profession
   - Working arrangements

3. Provide a prediction of the future supply of podiatrists over the next 5 years within the workforce and demand, including:

   - Number of podiatrists required meeting service demands
   - Specialism distribution

   This review will focus on providing a qualitative report and was not required to examine economic issues or carry out detailed feasibility studies.

Methodology

The following methodology was employed:

- Audit of current workforce identifying the staffing profile and characteristics. This baseline information was primarily gathered from existing information held within the Department and at Trust level on the Human Resource Management Information Systems, and supplemented as possible by the respective professional bodies.

- Background research conducted to identify future and current trends impacting upon the staff and involved a keyword and heading search of relevant professional databases; policy document review; a review of Trust and commissioner strategies to identify proposed service developments or changes and a review of benchmark data sources.

- Consultation with stakeholders involving extensive consultation, through 14 key informant interviews and 7 focus groups.

- Analysis of data gathered to develop a workforce model to aid the prediction of supply and demand of the workforce over the period of 2003 - 2007.

Key findings of the review – supply and demand issues

Supply Issues

Current Staffing Profile

- The Podiatry workforce represents a total headcount of 179 in Northern Ireland (March 2002).

- The ratio of headcount to whole time equivalent for this work force is 1.2:1.

- 77% of the workforce is female with 23% male.

- The age profile of the Podiatry workforce shows that only 1% fall within the 55 + category and that 60 is the 'eligible' age for retirement within the general Podiatry profession.

- The data indicates that 95% of the workforce is under 50 years of age and 69% are below 40 years of age.

- The grade breakdown of podiatrists within Northern Ireland workforce identifies that 32% are at Senior I grade and 52% are at Senior II grade and only 1% at the basic grade level.

- The total number of current vacancies within this profession was identified as 7, which equates to 3.9% of the workforce.

Recruitment and Retention

- There are currently no issues with regard to recruiting to training places at the University of Ulster with the application to places ratio 5.5:1

- The attrition rate for Podiatry students is 22% based on a three-year period.

- On average 73% of new graduates do not enter the HPSS sector in Northern Ireland, due to a lack of posts. Data indicates that only 1 graduate in each of the last 2 years took up employment within the N.I HPSS due to the lack of posts available.

- Final year students expressed a strong desire to take up employment in the NIHPSS but indicated there were poor job opportunities.
- Staff requests are increasing for work-life balance practices and it is estimated that currently this accounts for a loss of 1% of the Podiatry workforce per annum and the trend is likely to increase.

Private Sector

- There is a demand for Podiatrists within the private sector and graduates often gravitate towards this employment when unable to gain employment within the HPSS.
- A considerable number of Podiatrists work in a dual role between the private sector and the HPSS.

Career Progression

- Lack of career opportunities and progression is a significant factor in demotivating the work force. There is a limited career path beyond Senior I level when often the only available promotional route after Senior I is into management, which has very limited opportunities.
- There are very few basic grade posts within the Podiatry workforce (a total of 6 at March 2002) and these numbers have decreased by 57% since 1998 (from 14 Podiatrists).
- The majority of Podiatry posts - 31%, are at a Senior I level, with 51% of posts at Senior II level, which in total accounts for 84% of the workforce.

Lifelong Learning

- Difficulties are encountered in ensuring Continual Professional Development for post-graduate staff both from a time and funding prospective. Time out often has a detrimental affect on contract and indicative volumes, which complicates workflow patterns and the ability of managers to release staff for training.
- There are current issues indicating the need for a change in the undergraduate clinical placement system and a requirement for Trusts to consider improved way of facilitating clinical placements.

Under representation

- There is a lack of representation at corporate and strategic levels for the profession, which correspondingly means a lack of inclusion in the decision and communication process within Boards and Trusts.

Demand Issues

Demands, which will alter services provision, have been identified within the context of the review.

Service Developments

- The development of a Diabetes specialist post Royal Group of Hospitals Trust.
- The delivery of a Podiatry Service within the context of Regional Brain Injury Unit.
- The provision of Podiatric Surgery within the HPSS.
- The Podiatry contribution to the Health and Social Care Groups.
- Role extension of the Podiatrists into both the clinical specialist and consultant role.

Skill Mix/Workforce Review

- A significant amount of podiatrist's time can be spent on administrative and clerical tasks.
- Some tasks undertaken by podiatrists do not require professional skills and there are opportunities to further allocate tasks to assistant grades eg decontamination of equipment.
- Podiatry assistants could be employed to meet some of the requirements identified as current demand in the clinical service.

Operational difficulties

- A considerable element of the clinical service time has now been allocated to "high risk" category patients. This prioritisation shifts the emphasis of service provision to leave a significant gap in the ability to deliver a clinical service to lower risk patients. These pressures have resulted in lengthening clinical waiting lists within the podiatry service.

- Pressures experienced within the Podiatry Service results in lengthening clinical waiting lists for new patients attempting to access the clinical service for the first time.
- An increase in patient awareness of Patients Charter, rights access to services, increasing expectations and complaints systems causes pressure on the operational service delivery.
- An ageing growing population with increased referral activity patterns, compounding clinical complications and increased dependency, are causing pressure on the clinical service.

Projected Supply and Demand Conclusions

Conclusions were drawn and assumptions made concerning the future profile of the workforce and supply and demand projections have been detailed in Section 7 of this report. They have been developed into a workforce model to predict the requirement of the Podiatry workforce over the period 2003 - 2007.

All data presented has been gathered from discussions with the project group, key informant interviews, HPSS Project Support Analysis statistics and current business cases.

Supply Conclusions

Supply conclusions are based on assumptions made during the consultation process and the projected supply of podiatrists has been calculated between 2003-2007. These are profiled in the table below:-

Table: Projected Supply of Overall Podiatry Workforce in NI (2003-2007)

Supply	2003	2004	2005	2006	2007
Total available to NIHPSS	12	15	15	15	15
Total leavers of NIHPSS	5	6	6	5	5
Total current/potential numbers in NIHPSS	172	179	190	201	211
Projected potential numbers in NIHPSS	179	190	201	211	221
Potential net increase (decrease)	**4%**	**5%**	**5%**	**5%**	**5%**

Demand Conclusions

The demand for Podiatry professionals has been presented at three category levels:

Category 1: This refers to capital and service development, which have already been agreed in which the workforce requirements have been identified, and have the associated funding approval.

Category 2: This refers to service developments that have been identified via the key informant interviews and project group that are likely to be supported over the next 5 years, although resources have yet to be identified. This includes educational requirements at both under and postgraduate's levels including continual professional development, time required to facilitate students on clinical placements, elements of health promotion, role development and meeting clinical governance.

Category 3: This refers to additional demands within the current and future services, identified via the key informant interviews and project group that do not have funding allocation. This includes referral waiting lists and clinical service demands that cannot be met within existing resources.

For the initial purposes of this workforce plan the combination of Categories 1 + 2 has been adopted. These categories include agreed resourced capital and service plans with identified workforce requirements and those that are likely to be resourced within the 5-year plan. The following table illustrates the impact of these demands including the current vacancies within the projected workforce.

Table: Projected Demand Figures in headcount over the 5-year workforce plan for Podiatry population within Northern Ireland.

Workforce requirements	2003	2004	2005	2006	2007
Vacancies	7	5	2	0	0
Category 1 (capital &service requirements, with identified resources)	0	2	-	-	-
Category 2 (current and future demand likely to be resourced	6	4	5	1	1
Total	**13**	**11**	**7**	**1**	**1**

Demand Category 3 has been explored in depth in Chapter 5 of the report.

Supply v Demand Conclusions

The following table illustrates the overall increase (decrease) in the numbers within the workforce over the 5-year plan.

Table: Profile of projected supply against demand by headcount for the 5-year plan.

Key Factors: Supply v Demand	2003	2004	2005	2006	2007
Potential additional numbers in NI HPSS	7	9	9	10	10
Potential total workforce in NI HPSS	186	195	204	214	224
Vacancies	7	0	0	0	0
Demand Categories 1&2	5	6	5	1	1
Total over (under) numbers in workforce	**(5)**	**3**	**4**	**9**	**9**

It can be seen from the above table that the supply of Podiatrists available to the NIHPSS should meet the demands of Categories 1&2 by year 2 of the workforce plan when taking into account the current vacancies (7).

RECOMMENDATIONS

The timescale for the implementation of the key recommendations outlined below is twelve months to coincide with the follow up review.

Workforce Planning

- Now that the workforce planning process is established it is recommended that the Project Board should be retained to review supply and demand on an ongoing basis. It should utilise the information gathered in the review building and expand on it, taking into account such factors as the impact on the workforce, of role extension, specialisation, capital plans and service development business cases.
- The Project Board should ensure that there is a consistent and targeted approach to gathering relevant supply and demand data and manpower recording processes.
- The Department should review the activity data collected from the Allied Health Professions at Trust level. Professional managers should review management data collection from the current information systems and ensure the systems are maximised to their full potential. The aim of these reviews will be to provide a more comprehensive management information collection, which will aid the workforce planning process.

Recruitment & Retention

- All employers should put in place policies to incorporate planned induction, consolidation and mentorship programmes for all new staff and review the effectiveness of these in a quantitative and qualitative manner.
- Employers and the profession should put in place a consistent approach to the implementation of work-life balance policies and procedures and this should be factored into workforce planning.

Utilisation of the available Workforce

- Trusts should carry out further work into the possibility of reallocating non-clinical responsibilities to other health care workers including Podiatry Assistants.
- A co-ordinated approach between the professions, employers and the DHSSPS should take place with regard to workforce planning of

Podiatry, particularly in relation to role extension and development issues.

- Commissioners should work closely with Trusts to clearly specify the required podiatry clinical service provision within the existing resources.
- Consideration should be given by Commissioners and Trusts to defining how patients access the service with the aim of achieving better control of demand and workflow focused through appropriate clinical channels.

Education & Development

- The UU and Trusts should work together to agree best practice for undergraduate clinical placements that ensures students are fully prepared for a clinical working environment
- All Trusts with Podiatry services have been surveyed (DHSSPS May 2002) with regards to the existing numbers of clinical placements and the maximum numbers that may be accommodated for each training year. Further discussions should take place between DHSSPS, Trusts and the University to establish a more comprehensive way of providing undergraduate clinical placements. There should be solutions found to the barriers identified to ensure Trusts can accommodate the number and quality of clinical placements required.
- Statistics indicate a high attrition rate and a high number of repeat year students within the undergraduate course. The reasons for these should be identified and explored with the view to improve outcomes and graduate numbers. These statistics should be monitored by the University of Ulster and reviewed on a regular basis by the DHSSPS.
- There should be an increased focus placed on Continuing Professional Development (including leadership development) and all employers should ensure that the recommended hours provision is accounted for through the workforce planning process.
- The Podiatry profession should become actively involved in the Centre for Postgraduate Continuing Professional Development for Allied Health Professional's. The NI Podiatry profession should identify its training requirements and contribute to planning for these needs.
- Employers should ensure training is available for all staff that will be required to provide mentorship or coaching support as part of their role.

- The Department should take forward the development of the AHP's Consultant role to acknowledge the high levels of clinical expertise within the profession.

Further Review of the Workforce

- The Project Group should be convened initially on an annual basis to review and update the workforce plan.

- Trusts should review the skill mix of their Podiatry workforce to ensure it has the most appropriate combination of staffing grades to meet the needs of the clinical service. This review should also ensure that entry-level posts are maintained so there is a continued flow into the workforce of new graduates.

- The Project Group should be mobilised to take forward where appropriate any recommendations emanating from the workforce review.

- Trusts should review with its Podiatry Service the demands of Category 3, as identified in this report, and ensure that any agreed increase in service is included in any future service development plans.

CONCLUSION

This Podiatry workforce review can by only viewed as a starting point, or baseline for further work to be carried forward. This includes the development of an action plan to take forward the recommendations outlined above. The models presented in the report will need updated and refined on a regular basis to continue to inform decision making and priorities concerning the investment in the NI HPSS Podiatry workforce over the five-year plan.

1. INTRODUCTION

An in-depth review of the Podiatry workforce in Northern Ireland took place between April and September 2002 and was co-ordinated by a Project Group, which comprised of representatives of the DHSSPS, HPSS commissioners and providers, education and staff side. The report includes:

- A background to the project
- The project methodology
- A summary of the recruitment and retention issues arising from the review and a projection of the supply and demand for podiatrists over the next five years within HPSS.

The report concludes with a list of recommendations, which seek to contribute to the addressing current and future workforce issues within the NI HPSS Podiatry workforce.

The Department of Health, Social Services and Public Safety Northern Ireland's aim of the review is to develop strategies that can assure the correct numbers of podiatrists are in place and working in the most effective way to offer optimal benefit to the overall healthcare team and the patient.

1.1 TERMS OF REFERENCE

The following specific terms of reference were applied when carrying out this review:

Provide a profile of the current Podiatry workforce in Northern Ireland, including:

- Numbers employed, grading, distribution, age and gender balance.
- Working conditions and patterns.
- Continuing professional development commitments.
- Provide an analysis of current and future recruitment and retention issues, including:
- Remuneration.
- Career development and specialisation.

- Career breaks/leaving the profession.
- Working arrangements.
- Provide a prediction of future supply over the next 5 years and demand for podiatrists, including:
- The number required meeting service demands.
- Specialism distribution.

The requirement for this piece of work was to review issues at a generic, strategic level and provide sound conclusions and recommendations relevant to the workforce as a whole. This review was not required to examine economic issues or carry out detailed feasibility studies.

The aim of the report is to provide a starting point and baseline for workforce planning which could then be built on and expanded through future analysis and focus using identified workforce representatives at all levels throughout the sector.

1.2 METHODOLOGY

The methodology for the review focused on consulting with those within the current workforce, across the geographical regions of Northern Ireland. The views of under graduate students were also sought as they represent a substantial part of the future supply of the workforce.

All representatives were identified by the Project Board, Appendix 1, set up to manage this review.

The methodology adopted for this review contained the following:

- Key Informant Interviews: Semi-structured in-depth interviews were carried out with 14 key representatives, Appendix 2.
- Focus Groups: 7 focus groups were held made up of a representative mix of disciplines, grades and primary and secondary sector employees, Appendix 3.
- Literature Review and Desk Research: A comprehensive literature review was undertaken and it was key that these references were utilised to inform the project, Appendix 4.

2. CONTEXT

It was important to set this review within an appropriate context before carrying out any data gathering to inform the design of pertinent survey tools and ensure relevancy of conclusions and recommendations. This necessitated looking at the current situation with regard to the wider Health Policy context and the roles that podiatrists could play within this.

Health Policy Context

The overall aim of the Department of Health, Social Services and Public Safety is to improve the health and well being of the people of Northern Ireland within the resources available. It seeks to achieve this in ways which:

- Are fair and equitable, targeting resources towards those in greatest need
- Listen to the views of users, carers and the public.
- Continuously improve the quality and clinical excellence of services
- Stimulate and support the formation of partnerships across all sectors to promote and improve health and well-being.

It must also seek to increase the effectiveness of clinical intervention. That is to maintain or improve health and to secure the greatest possible health gain from available resources. Those HPSS employees, which fall within the Allied Health Professions, specifically Podiatry, are key to achieving this overall clinical effectiveness and essential to develop strategies that can ensure the correct numbers of these skilled employees are in place, working on an integrated basis and in the most effective way, offering maximum benefit to the health care team and optimal patient and client outcomes. Sir Maurice Hayes has further reinforced this in the Acute Services Review consultation document (May 2001) (1) where he states that the DHSSPS, in consultation with the service, should as a matter of urgency undertake an assessment of service needs and the skills and staff required to deliver these services efficiently and effectively. The report also stressed that there is the need to build up adequate contingency or even over supply of adequately prepared professionals so as to ensure that there is no repeat of difficulties of the past.

It is within this context that the workforce review for Podiatry is set.

Great Britain and Northern Ireland Context

The strategic focus outlined above was first detailed in 'The New NHS – Modern and Dependable' (2) which set out the Government's vision for the National Health Service (NHS) in England. The Government plans for NHS modernisation are intended to ensure a high quality, national service that is clinically sound, cost-effective and equitable. This was emphasised by Alan Milburn, speaking at Farnborough Hospital on 13 October 1999, saying; "By the time we finish our 10-year programme of modernisation, the NHS of 1948 will be unrecognisable. It will remain true to its values but they will be delivered in new and modern ways". The NHS white paper (3) and subsequent quality consultation document (4) identified requirements for consistent, high quality care throughout the health service and all health organisations, including primary care. This will mean that all areas of healthcare, including Podiatry deliver care to the patient in the most timely and most cost effective ways possible.

In line with the above, the Northern Ireland Executive in its Programme for Government 2001-2004 (5) identified "Working for a Healthier people" as one of its priorities and has stated that "we will work to reduce waiting lists, implementing new management arrangements, and recruiting additional front line staff".

The Programme focuses specifically on the following:

- Reducing preventable diseases, ill health and health inequalities.
- Ensuring that the environment supports healthy living and that recreational facilities are improved.
- Modernising and improving hospital and primary care services to ensure more timely and effective care and treatment for patients.
- Enabling those who suffer from disability, chronic mental or terminal illness to live normal lives.

The Programme commits the Executive to the following actions, which affect podiatrists directly:

- Providing 40-50 extra specialist medical, nursing and other staff to improve treatment of people with breast, lung and colorectal cancers.
- Addressing workforce shortages in the health service.

The document 'Priorities for Action' (6) details the DHSSPS planning priorities for 2001-2002, in the context of the Programme for Government as outlined above. It states the objectives, and targets that will ensure their achievement. In meeting it's responsibility for setting strategic direction, overseeing the delivery of the health and social services, the DHSSPS has set targets for Boards and Trusts. These include:

- Increasing capacity, improving flexibility and responsiveness to meeting continued demand.
- Improving access to services, particularly reducing waiting lists.
- Tackling shortages of skilled staff, particularly in hard-pressed specialist areas. This includes not only increases in the supply of qualified staff but also measures to improve recruitment and retention of staff within the HPSS.
- Developing partnerships with other statutory and voluntary sector organisations.

Secondary Care

In the provision of secondary services, the Acute Hospital Review Group Report 2001(1) is the most recent document to address the structure of the HPSS as a whole in Northern Ireland. The Report highlights key recommendations, which include:

- To significantly shift the balance of care from secondary care to primary care.
- To provide acute hospital services that are consultant delivered rather than consultant led.
- Primary care organisations should be given the responsibility for the commissioning of community services and non-regional hospital services in the context of the strategic plan.

Quality and Primary Care

These principles outlined above have been reinforced in the context of Northern Ireland in the recent Consultation Paper, "Best Practice – Best Care" (7). This paper, published in April 2001, focuses on the three interlocking strands of setting standards (improving services and practice), delivering services (ensuring local accountability) and improving monitoring and regulation of the services. In addition, identifying new ways for health professionals to be involved in the delivery of NHS services has been a key principle identified in the Consultation Paper "Building the way forward in Primary Care" (8), which clearly sets out a number of priority areas for development in primary care relevant to this review.

In Northern Ireland these proposals have been supported by the 'Allied Health Professions', which includes Podiatry. The position paper 'Primary Care – Professions Allied to Medicine' (9), endorses the priority given to breaking down traditional boundaries so that all care professionals use their skills in the most appropriate way to treat and care for people, the development of new and innovative models of service delivery and the support of emerging new professional roles. However in order for this to happen it is argued that there must be greater representation of the Allied Health Professions to influence the decision making process in strategic planning, policy formulation, commissioning and in the general management of the HPSS (10).

Public Health

In the UK, public health strategies have recently been produced for Scotland (Working together for a Healthier Scotland 1998) (11), Wales (Better Health – Better Wales 1998) (12) and England (Saving Lives: Our Healthier Nation 1999) (13).

In Northern Ireland these key issues are reinforced in the strategic documents "Investing for Health" (14), and "Well into 2000: A positive agenda for Health and Social Well-being" (15) which underpin the government's vision for the Health Service. The proposals encourage professions to work with the community to promote health and well-being rather than focus on the treatment of ill health. Podiatry has a key role to play in health promotion starting from childhood on.

The Podiatry profession

The Society of Chiropodists and Podiatrists came into being in 1945 when 5 British chiropody organisations amalgamated. In 1954 the examinations of the Society were approved by the Ministry of Health for National Service appointments. The Society continued as the examining body for the purposes of State Registration when the United Kingdom Parliament formally acknowledged the professional status of Podiatry under the Professions Supplementary to Medicine Act 1960. This gives a considerable degree of professional autonomy to Podiatrists, enabling them to maintain their own professional discipline, set standards of conduct and Code of Ethics, and to set standards of education and training for entry into the workforce.

In 1993 the Society of Chiropodists added the name Podiatrist to its title reflecting the use of the term throughout the English-speaking world.

There are currently 8,500 members and students registered in the UK with the Society of Chiropodists and Podiatrists. (16)

SUPPLY ISSUES

The NI Podiatry Workforce has had minimal growth in recent years. Northern Ireland had 141.29 WTE podiatrists in posts at March 1998, a total of 149.8 WTE in March 2002, an increase of 5.7% over 4 years. The issues associated with the supply of podiatrists are detailed in subsequent paragraphs:

Remuneration

The pay structure for podiatrists provides Basic, Senior II, Senior I, Chief IV, Chief III, Chief II, Chief I and Area Chief Grades. Clinical grades are identified at Basic, Senior II and Senior I. From Chief IV to Area Chief as well as Senior Management II are considered to be at a managerial level. Often the Chief IV grade has a high clinical input with a managerial element. Agreement was reached however during 2001/2 on the introduction of Allied Health Professions Consultant Posts in England and Wales.

The salary structure is the same as that applied to the other Allied Health Professions of Occupational Therapy, Physiotherapy, Orthoptists, Dietitians and Radiographers with pay awards determined by the National Pay Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine. The Pay Review Body recommended a 3.7 per cent increase to basic pay and some allowances in 2001/2. Discretionary Points were consolidated into the pay scales, introduced as a mechanism for staff to achieve recognition for having developed their role and skills. Staff are eligible for discretionary points after serving one year at the top of the scale. (17)

Like other NHS professions, the remuneration of podiatrists will come under new arrangements proposed under Agenda for Change. The timeframe for introduction of these arrangements within NI HPSS has not yet been determined.

Recruitment

There is evidence to suggest that the recruitment issues for podiatry commence at undergraduate level within the UK as a whole. A report in Podiatry Now in May 2001 suggested "Schools across the UK are almost universally struggling to recruit students on the podiatry degree course and ultimately into the profession." (18) In its 1999 Annual Report, the Society of Chiropodists and Podiatrists documented the problem of falling numbers of applications to podiatry degree courses, concluding that between 1996 and 1999 there had been a 29% reduction in the total number of applications. (19) The situation led to the establishment of a Task Force who produced and distributed entirely new recruitment material. In addition, a careers speakers network was set up during 2001 for members attending careers conventions. In addition, podiatry was promoted as the NHS Career of the month for September 2001.

Statistics from the Department of Health Vacancy Survey indicated that at March 2001 there were 40 podiatry vacancies in the United Kingdom. This represents a vacancy rate of 1.5 per cent. In Northern Ireland at 31st March 2002 there were 7 podiatry vacancies (3.9%).

The shortfall in the number of podiatrists required was recognised beyond doubt in the NHS Plan. (20) The Plan highlighted a commitment to increasing PAMs numbers, suggesting that by 2004 there would be:

- Over 65,000 more therapists.
- 4,450 more therapists in training.
- New therapist Consultant posts.

Retention

Professional and occupational burnout is a recognised syndrome amongst health care professionals. A recent study of burnout and work stress in newly qualified podiatrists in the NHS indicated that 100% of the 172 sample exhibited high levels of emotional exhaustion and de-personalisation. The report indicated that the key work stressors identified were too much work, isolation, patients' lack of understanding of the job, and lack of career structure. (2000) (21)

A report published in Podiatry Now (February 2002) indicated that for podiatrists, a lack of recognition for their work and role within the NHS could be a frustrating and demoralising experience. (2002) (22)

The Role of the Private Sector

Evidence presented to the Select Committee on Health in England indicated that 5,000 State Registered Podiatrists are employed in the private sector. Over 50% of the nation's statutory regulated podiatric workforce therefore, is self-employed, (2000) (23). However there is a no accurate way of establishing the number of dual workers i.e. these staff that work both in the private and public sectors.

Education and Training

A number of strategic documents review education, training and development for health professionals in England and Wales (2001) (24). Educating and Training the Future Health Professional Workforce for England (2001) concluded that achieving the planned expansion set out in the July 2000 NHS

Plan depends on increased investment in teaching staff and accommodation at higher education institutions; achieving value for money in the provision of training courses; a reduction in student drop out rates and a larger number of good quality practice placements.

The reports also note the availability of suitable practice placements as a critical limiting factor on the number of training places that can be commissioned and that given current staffing levels, most hospital departments are close to or have already reached their capacity for supervising students. In England there have also been problems with recruitment and retention for undergraduate places, with an average 20% under recruitment against available places, and student attrition rates ranging from 6 to 10%. The NHS Executive's Human Resource Performance Framework (2000) (25) includes targets to reduce attrition rates, with the 2000/01-intake non-completion rate of pre-registration training not to exceed 10% for allied health professionals nationally.

In Northern Ireland the overall number of university places for podiatry is 18 per annum. In addition, the attrition rate is higher in Northern Ireland than in England and Wales, with average attrition rate of 22% per course (based on figures from UU over the last three years).

Family Friendly Policies

In England and Wales, this is documented in the third Report of the House of Commons Select Committee on Health (1999) (26). In considering NHS workforce issues the report details the government's commitment to introduce a range of family friendly policies including childcare facilities, flexible hours and job share opportunities and the fact that the NHS operates a comprehensive 24-hour service provides opportunities. There is therefore a need to be flexible so that an employer can assist staff to 'marry their work and out of work responsibilities'.

DEMAND ISSUES

Understanding the current and future demand issues within HPSS as they relate to podiatrists is essential in projecting future requirements for staff. The issues associated with the demand of podiatrists are detailed in subsequent paragraphs:

Societal Changes

The Department for Education and Employment, Employers Skills Survey Report (2000) (27) highlighted that there has been steady growth in demand that is expected to continue in the medium term, for the services of Professions Allied to Medicine. Factors contributing to this demand include ageing population, rising expectations of patients and government reforms including a move towards care in the community, more integrated multi-disciplinary services and the introduction of clinical governance. The report identifies that the picture within HPSS is one of changes in technology and ways of working requiring staff to have a greater range of skills and a higher level of skills. The NHS plan has recognised the above and sets out a clear commitment to AHP's staff, with over 6500 more therapists and other health professionals to be employed by 2004 and the introduction of new therapist consultant posts. The NHS Plan identifies the need for 250 Consultant therapist posts by 2005.

Legislative Changes

Special Education Needs and Disability Bill (2003/4) - This new legislation which is likely to be passed by the Assembly in 2003/04, will provide more opportunity for parents to opt to place their children in mainstream schools with the recommended support required, rather than within a special school. (The Bill will remove 'economic grounds' as a reason for Boards not recommending placement of special needs children in mainstream schools). This will potentially have logistical and resource implications for podiatrists specialising in podopaediatrics who may be required to provide services to children placed in scattered mainstream schools.

Service Demands

According to evidence presented to the Select Committee on Health, at any one time 3,700 full-time equivalent podiatrists maintain 2,250,000 active cases. At present access to podiatry varies widely across the UK. In many areas, only those at highest risk receive access to treatment. In other areas, podiatry care continues to provided along the traditional line of the 4 priority groups who retain the associated right of self-referral, pensioners, children under 18 in full-time education, expectant mothers and disabled. Both those at high risk and those who maintain the right to self-referral will impact upon the demand upon podiatry services in the future:

- **Ageing Population:** Their average life span is increasing by about 2 years every decade (28). OPCS data suggested that 16% of the population are aged 65 and over. The number of people in this age category has also increased by 16.15. % during the last 10 years. Nationally 87% of podiatry provision goes to pensioners. Furthermore, 45% of all pensioners receive NHS podiatry care. (2001) (29).

- **Diabetes:** The World Health Organisation's report 'The World Health Report 1997' indicated that by 2005 cases of diabetes will double globally (1997) (30). Where podiatrists are involved in the care of patients with diabetes, the number of amputations is reduced by 40%, saving the NHS at least £60,000 per patient. (2002) (23). The National

Service Framework for Diabetes (2001) (31) indicated that a core of highly skilled NHS podiatrists would be required. Standard 10 of the National Service Framework states that:
"All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes."

It goes on to indicate that:

- All young people and adults with diabetes should receive an annual surveillance for lower limb complications and should be managed in line with the latest evidence.

- All those identified as being at increased risk of developing lower limb complications should be referred to a foot protection programme;

- All those who develop swelling, redness, discolouration, pain or ulceration of their foot should be referred urgently (usually within 24 hours) to a multi-disciplinary foot care services.

CREST Guidelines for the management in Northern Ireland of the Diabetic foot (1998) (32) states that "early detection and surveillance for foot problems reduces the incidents of diabetic foot disease. Poor management can be implicated in 1/3 of the foot complications of diabetes mellitus, resulting in very significant morbidity and mortality. The Saint Vincent Declaration, (1989) includes targets for reducing the complications of diabetes. Systematic and regular foot care has been shown to reduce the risk of chronic ulceration and amputation in the lower limb by 50% or more. Admission for diabetic foot/leg disease is the single largest component of hospital bed usage by people with diabetes. Almost half of all diabetes related admissions are for lower limb disease". "In Northern Ireland 60% of all major amputations are related to diabetes".

- ➢ **Children's Services:** Research funded by the Department of Education and Employment identified those caseloads and waiting lists were highest for under 4's. This will include the increasing number of children diagnosed with autism and children with special needs. There is also increasing emphasis on the need for significantly more early intervention services within Podiatry, brought about by initiatives such. as Surestart.

- ➢ **Education Services:** The increased demand for podiatry services within educational settings is evidenced by figures provided by the South Eastern Education and Library Board. During the period 1985 to 2001, there was a 114% increase in the number of children attending special schools in the area (604 to 1291). Between 1997 and 2001, the number of children with a statement of special education needs increased by 14% (2592 to 2943). In addition, a significant number of children with special education needs do not receive a statement, but are supported through specialist inputs within mainstream education. The Warnock Report states that at any time 20% of school age population will have special needs and approximately 2% will have a statement.

Furthermore, the numbers of children in full-time education up to the age of 18 has increased. If the right of self-referral remains this will impact upon the demand for podiatry services.

- **Cancer Services:** The NHS Cancer Plan (2000) (33) and the Calman-Hine Report (1995) (34), in United Kingdom, were published with the aim to create a network of cancer care within England and Wales so that every patient wherever he or she lives, receive a uniformly high standard of care. In the Government's strategic document 'Investing for Health' Northern Ireland (2000) (14), it states that, as the second most frequent cause of death men have a 1 in 6, and a women as 1 in 8 chance of dying from the it before the age of 75yrs. The Campbell Report (1996) (35) was a key document as it showed that treatment by specialist, multi-disciplinary teams leads to better outcomes for patients. To ensure that all people with the disease have rapid access to cancer services the report also outlined for the need for current services to be re-organised. The implementation of the report will provide one regional cancer centre, at the Belfast City Hospital, and four additional cancer units, one for each Board area. To progress the development of Cancer Units and the Cancer Centre in line with the Campbell Report, is one of the key objectives within both the 'Acute Services Review' (2001) (1) and 'Priorities for Action' (2001) (6).

Service Developments

A number of service developments are likely to impact upon the demand for podiatric services. They can be outlined as follows:

- **Prescribing Rights:** The Health and Social Care Act 2001 contained enabling legislation to extent prescribing rights to other statutorily registered groups of healthcare professionals, including podiatrists.
- **Nail Surgery:** A recent survey published in Podiatry Now of 350 patients in a mixed urban-rural health board indicated that both the majority of GPs (63%) and users (81%) supported an expansion of podiatrists providing nail surgery. (29)
- **Podiatric Surgery:** According to the Society of Chiropodists and Podiatrists a 'growing number of Trusts are showing an interest in

setting up podiatric surgical units and NHS commissioning officers have been identified at regional level to progress developments.' (2001) (19)

- **Biomechanics/Gait Analysis:** In May 2002 the Health Services Audit commissioned a Review of Disability Equipment in Trusts in Northern Ireland. Podiatric Biomechanics and Orthotic provision was included in this review. Result indicated that in terms of NI Trusts, Causeway H&SS Trust and Homefirst Community Trust demonstrated innovative practice with regard to Podiatric Orthotic provision which included formal tendering in accordance with good practice guidelines and audit work that demonstrated clinical effectiveness. The report recommended that Trusts should liaise with Commissioners to determine the scope for the funding of future provision of Podiatric Orthotic Services that meet the needs of the local population in a timely manner.

- **Podopaediatric:** Podopaediatrics is a specialist service for children and involves assessing and detecting problems of the feet and lower limbs, which may affect children in later life. Referrals to this specialist service have grown over the past 10 years and successful outcomes have been identified in prospective Audits undertaken by Causeway H&SS Trust Podiatry Services since 1998. Results in the NI Review of Disability Equipment in 2001 recommended that Trusts should liaise with Commissioners to determine the scope for the funding of future provision of Paediatric Podiatric Orthotic Services that meet the needs of the local population in a timely manner.

- **Rheumatology:** As stated in the Guidelines for the Management of the Foot in Rheumatic Diseases (North West Podiatry Services, Clinical Effectiveness Group 2002), rheumatological diseases can be disabling, cause pain, deformity and loss of function. In rheumatoid arthritis, foot involvement has been reported to occur between 50-80% of patients (Michelson et al, 1994, Kerry et al, 1994) with the degree of disability progressing with the course of the disease. The majority of patients with systemic sclerosis often present with foot problems (Sai-Kousel et al 2001) and it is recognised that foot care is important in preventing major foot pathologies and amputations. The role of the Podiatrist in the orthotic management of other rheumatological diseases such as juvenile chronic arthritis has also been highlighted as being essential (Helliwell and Woodburn 1998) both for the reduction of pain and the improvement in foot function. Although at less risk from serious foot problems, patients with osteoarthritis may benefit from podiatry interventions (Keating et al, 1993).

The broad philosophy of podiatry management is to relieve pain, maintain function, prevent or minimise deformity and reduce the risk of ulceration. Podiatry services should provide a specific service for the diagnosis, assessment and management of foot problems associated with rheumatic diseases. The role of the Podiatrist in the Rheumatology team is recognised as a vital component in the integrated care given to patients by the multidisciplinary team (SIGN guidelines 2000, Widdow 1998). Increasingly Consultant Rheumatologists are requesting specialist foot care services for their patients (Williams 2001a) and it is suggested that the Podiatrist is a key practitioner in the management of patients with musculoskeletal disease (Beeson 1995, Jacobs 1984). However in both primary and secondary care less than 25% of patients with O/A and less than 45% of patients with RA are informed about podiatry as a possible treatment or service (BLAR Standards of Care 1999).

Currently in Northern Ireland there is only one full time dedicated podiatry clinical specialist in Rheumatology (at Senior I grade). This Podiatrist works as part of a multidisciplinary rheumatology team at Belfast City Hospital.

Continuous Professional Development

In the UK, although there has been no statutory requirement, the code of professional conduct makes it clear that all podiatrists must continue to maintain and advance their knowledge and skills throughout their careers. The Society of Chiropodists and Podiatrists Code of Conduct states 'Practising members must undertake continuing professional development in accordance with such guidance that is issued by the Society from time to time.' In February 2001 the Faculty of Podiatric Medicine, endorsed by the Council, introduced a new CPD framework for all members continuously to improve the quality of service to patients through encouraging the uptake of CPD. The policy recommends that members will be expected to complete 15 core credits and 15 general credits over a three-year period. One hour of activity equals one CPD point. It is the responsibility of the practitioner to maintain a record of CPD activity. (2000) (36). It is anticipated that this will eventually become a mandatory requirement with the establishment of the Health Professions Council (HPC) on 17 April 2002.

Evidence based practice through good quality audit and research is vital if podiatry is to develop as a profession. A recent report completed by the Research and Development Office in Northern Ireland found that the ratio of podiatry staff involved in research was 1:14, and only 1% of podiatrists surveyed had a master's degree. The report concluded that much more needs to be done to support PAMs in this area. (2001) (37).

Skill Mix

A recent survey published in Podiatry Now of 350 patients in a mixed urban-rural health board indicated that both GPs (59%) and users (61%) were supportive of the trained and supervised Foot Care Assistant grade to provide basic foot care (29).

3. KEY FINDINGS – DATA ANALYSIS

This section details the key findings of the analysis of the workforce profile information.

Workforce Demographic Profile

Available information was compiled of the current demographic profile of the Podiatry workforce of Northern Ireland to use as baseline information. The key sources utilised are highlighted below:

- The DHSSPS Project Support Analysis Branch sourced from-
    - HRMS – current HR system in use by the Trusts across Northern Ireland.
    - PMIS – current HR system in use by the Department at a regional level.
- DHSSPS – Workforce Questionnaire, May 2002.
- University of Ulster – Students statistics.
- Society of Chiropodists and Podiatrist Annual Report 2001.

3.1 CURRENT UK PROFILE OF THE PODIATRY WORKFORCE

Information contained in the Society of Chiropodists and Podiatrists Annual Report (2001) would suggest that nearly half of all registered Podiatrists work in NHS only. However approximately 27.05% work in private practice, with 12% working in both and NHS and private practice.

Table 3.1.1: UK Breakdown of Podiatry Employment Sources

Sector	**Headcount**	**Percentage**
Dual NHS & Private Practice	852	12.00
Private Practice & Community	475	6.7
NHS & Community	75	1.06
NHS & Private Practice & Community	200	2.82
Private Practice only	1919	27.05
Community	223	3.14
NHS Only	3351	47.23
Total	**7095**	**100**

Source: Society of Chiropodists and Podiatrists Annual Report (2001)

3.2. CURRENT REGIONAL PROFILE OF THE PODIATRY WORKFORCE

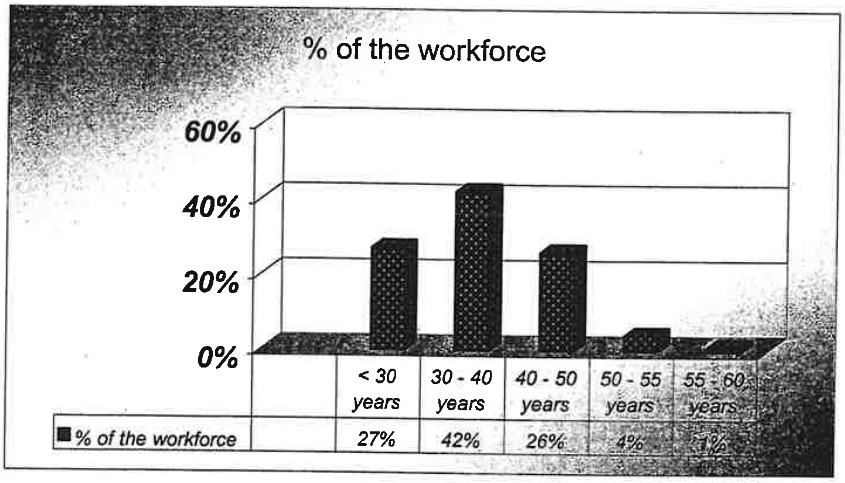
In Northern Ireland there are currently 179 state registered podiatrists working in the HPSS (13 Trusts) in N.I.

Of these 23% are male and 77% are female. There has been a slight decrease in the number of males within the workforce over the past 4 years (28% in 1998, compared to 23% in 2002).

In addition, 2 Trusts are recorded as employing 4 podiatrist bank staff (these staff may also be employed permanently within other Trusts).

The source of this information is the DHSSPS Data Base.

Graph 3.2.1: Age Profile: Podiatrists- March 2002



Source DHSSPSNI (March 2002)

The data indicates that the vast majority (95%) of the current workforce is less than 50 years of age and 69% are under 40 years.

3.3 FULL TIME/ PART TIME PROFILE

The number of podiatrists working part time has increased quite significantly over the past 4 years, from 49 in 1998 (30% of the total workforce) to 68 in 2002 (39% of the workforce). Overall the workforce has grown minimally by 5.7% (from 141.29 WTE to 149.8 WTE) over the period 1998 – 2002.

3.4 HEADCOUNT TO WHOLE TIME EQUIVALENT BREAKDOWN

Based on the available data, information can be presented on the ratio of current numbers of full time to part time podiatry staff, shown as actual headcount to whole time equivalent.

Table 3.4.1: Headcount to WTE ratio

Total Headcount	179
Total WTE	149.8
Headcount/WTE	Headcount = 1.2 WTE

Source: Trust Questionnaire

The figure indicates that for every WTE podiatry post, the equivalent of 1.2 are staff employed within the service.

3.5 WORKFORCE PROFILE BY GRADE

An analysis across all HSS Trusts of grade profile of the podiatry workforce is detailed in the table below.

Table 3.5.1: Grade Profile by Headcount

Grade	F/T	P/T	Total Headcount	% Of total
Basic	2	0	2	1%
Senior II	51	40	91	51%
Senior I	33	23	56	31%
Chief IV	10	3	13	7%
Chief 111	8	1	9	5%
Chief 11	3	0	3	2%
Area Chief 2	3	1	4	2%
Senior Management II	1	0	1	1%
TOTAL	111	68	179	100%

Source: HRMS

The table indicates that the highest proportion of staff is graded at the middle and upper clinical grades (i.e. Senior I and Senior II) 31% and 51% respectively.

In relation to support staff for the podiatry, only 2 assistants were recorded as working within HPSS throughout NI in March 2002.

3.6 VACANCY ANALYSIS

The workforce questionnaire forwarded to service managers provided details of the vacancy profile at March 2002. The analysis of the vacancies is detailed below.

Table 3.6.1: Vacancies by Headcount

BOARD	FULL TIME	PART TIME	TOTAL
EHSSB	2	1	3
SHSSB	0	0	0
NHSSB	0	3	3
WHSSB	0	1	1
Total	2	5	7

Source: Trust questionnaire

All of the seven identified vacancies at March 2002 were permanent posts.

Vacancy Analysis / Total Workforce Numbers

The information from the workforce questionnaire at March 2002 indicates current vacancy rate of 3.9% within the HPSS Podiatry workforce. This is calculated by headcount as follows:

Staff in post	172
Vacancies	7
Total workforce	179
Vacancy % rate	3.9

Source: Trust Questionnaire

3.7 RECRUITMENT AND RETENTION OF STAFF

Managers were asked within the questionnaire to identify the number of staff they had been able to recruit from universities or employers outside of N.I. The figures provided indicated that on average (across the last 3 years):

- ➢ 8 graduates from universities outside of N.I. was recruited to NI HPSS (average of 2 per year).

- ➢ 11 qualified staff returned to the N.I HPSS workforce after working as therapists elsewhere (average 3 per year), a number of these will have trained within N.I.

In relation to retention of staff, managers returned the following information:

- 13 staff left the HPSS workforce during 1999 – 2001. (This equates to approximately 7% of the workforce)
    - None of the above retired
    - 8% left for family reasons
    - 23% left to take up a post outside of N.I.
    - 31% left to take up a post in the private sector
    - 38% left for other reasons

Source: Trust Questionnaire

The DHSSPS has also been able to supply information on podiatrists leaving HPSS for reasons other than retirement during 2001. The figures provided have informed the development of the supply projections detailed in future sections of the report.

3.8 UNDERGRADUATE EDUCATION

The degree course for Podiatry is three years in duration and is located on the Jordanstown Campus of the University of Ulster in Northern Ireland. Qualification grades for entry into the course are a B, C and D at Advanced Level education. Applications to training places are a ratio of 5:5.1.

Based on information provided by the University of Ulster the table 3.8.1 provides details of anticipated number of undergraduates entering the degree course over the next 4 years.

Table 3.8.1: Estimates of students qualifying from UU over the next 5 years

Entry Year	Student Places	Graduation Year	Graduate Numbers
2000	18	2003	10
2001	18	2004	13
2002	18	2005	13
2003	18	2006	13
2004	18	2007	13

Source: University of Ulster

3.9 ATTRITION RATES AND DESTINATION OF GRADUATES

The University of Ulster have provided details of the attrition rate for each intake of students and the first employment destination of graduates.

The details indicate an average attrition rate of 22% based on figures produced over the last 3 years.

The following table details the occupation by destination of graduates 6 months post graduation from 1999–2001.

Table 3.9.1: Destination of University of Ulster Graduates

Destination	1999	2000	2001
NI HPSS	6	1	1
NHS	0	2	0
Private Practice	3	3	4
Commercial Sector	2	0	2
Education Sector	2	1	0
Others	2	1	0
Total Graduates	15	8	7
% Students not entering NI workforce	60%	77%	86%

Source: University of Ulster

The figures indicate that for 1999 only 40% of students joined the N.I. HPSS workforce immediately after graduating from the University of Ulster. This figure decreased to 13% in 2000, and increased slightly to 14% in 2001. In both 2000 and 2001 the highest number of graduates joined private practice, with 57% doing so in 2001.

These figures may well reflect the lack of job opportunities for newly qualified graduates within the NI HPSS.

The figures provided in this section will inform the future supply projections for the workforce.

4. KEY FINDINGS IN KEY INFORMANT INTERVIEWS AND FOCUS GROUPS

4.1 SUPPLY ISSUES

This section provides details of the views expressed throughout the 14 key informant interviews and the 7 focus groups, which involved 32 podiatrists and 5 University of Ulster podiatry final year students. Many of the issues raised by different individuals were consistent and provided valuable information, which has informed the development of the recommendations and conclusions, contained in the report.

4.1.1 University of Ulster Students and Graduates

Students involved in the undergraduate focus group raised a number of issues, which were of concern in the recruitment of students to the undergraduate course and the profession. The focus group participants highlighted the need to "raise the profile of the profession" both in secondary schools and within the service itself. As one student implied, "Not many people know about the course, or even the name 'podiatry'. If you say you're a podiatrist people think you cut toenails."

Participants in the University of Ulster focus group acknowledged the high attrition rate on the undergraduate course. They explained that the likely cause of this was factors to do with the course provision and structure. Students pointed to the fact that the course had moved location twice in the last 5 years. The majority of key informants also highlighted the lack of practical clinical placements as a major contributing factor. However, the students did not raise this as an issue.

Participants within the University of Ulster and professional focus groups indicated that the frustration upon graduating was the lack of full-time permanent posts in Northern Ireland. As one student suggested, "There is no work in the Health Service in Northern Ireland and when there is it is only maternity leave or part-time cover". The lack of full-time permanent positions resulted in students looking at the private practice option, employment in Boots, Scholl or employment in NHS in England or Scotland. One student highlighted this issue suggesting, "Because we can't get a job in the NHS, we look to private practice but we're just doing bits and pieces." The focus group participants highlighted the frustration that they felt with this. The feeling amongst the group was that there was demand for work for podiatrists but no jobs. One student said, "When you're out on clinical placement the service waiting lists are very long. There is work but no jobs."

4.1.2 HPSS Recruitment

Nearly all Trust Managers interviewed indicated that they had not been experiencing difficulties in recruiting staff over the last 1-3 years, largely because of the lack of new posts available. The majority of key informants highlighted a reduction in the number of applicants applying for posts at all levels and staff recruited were largely from Northern Ireland.

A minority of key informants indicated that difficulties might be experienced in the future in recruiting staff to specialist posts in renal and oncology, and recruiting staff to positions at Chief IV level, where it was perceived that staff were not keen to take on additional responsibility for no difference in salary to that of a Senior I.

4.1.3 Temporary Posts

Most Trusts were employing temporary staff for cover for secondments, maternity leave, acting up arrangements and pilot projects, such as those in primary care commissioning. Agency staff usage was non-existent.

4.1.4 HPSS Retention

The majority of Trusts did not have difficulty retaining staff, and reported that they had a stable workforce. A minority of Trusts reported difficulties retaining temporary and Basic Grade staff who left for reasons of a permanent contract or promotion. A small number of informants did envisage some difficulty retaining staff in the future because of the better terms and conditions offered by private companies such as Boots and Scholl, and the upgrades which had occurred in Homefirst Trust which, it was perceived, would draw staff to this Trust.

4.1.5 Family Friendly Policies/Career Breaks/Return to Practice

Many respondents in the key informant interviews reported increasing requests for flexible working. The average number of requests for flexible working, at each Trust, per annum, was two. Almost all of the key informants interviewed reported taking a flexible and positive approach to requests, provided the requirements of the service were met. The requests for flexible working were reported as relating in the main to reduced hours because of family commitments, staff were tired of the system, unpaid leave after maternity leave, term-time working or to take up some private practice.

Five out of 11 Trusts interviewed indicated that they had experienced requests for career breaks. Evidence from the interviews did however indicate that in the main staff returned to the Trust following a career break.

4.1.6 Private/Voluntary Sector

The majority of key informants indicated that there was a demand for staff to work in private practice. The majority of Trusts indicated that staff did not leave their HPSS post to work in the private sector, but instead operated a dual role, with some staff requesting a reduction in HPSS hours to do so. However, there is currently no means of collating evidence as to the numbers involved in private practice whose substantive employment is in the HPSS. The influence of private practice was reported in almost all of the focus groups sessions. The attraction of private practice was highlighted as the ability to increase income levels, as one participant suggested, "Verrucae have educated my son."

Three Trusts mentioned the growing influence of private companies such as Boots and Scholl to attract staff.

None of the Trusts reported the demand for podiatrists in the voluntary sector.

4.1.7 Working Hours, Terms and Conditions

Key informants indicated that staff worked 36.5 hours per week, with a minimal amount of evening clinics being provided. Fifty per cent of Trusts had staff who worked overtime on a regular basis, with half of these Trusts reporting paying overtime and the other half offering time off in lieu.

Many respondents in the interviews and focus groups indicated that working hours, terms and conditions was a key area of concern and impacted on the recruitment and retention of staff. Participants were particularly frustrated by the salary on offer and the current use of Discretionary Points as a means of extending the career structure of podiatrists.

The most common area of concern was the salary package on offer to podiatrists. Focus group participants highlighted the fact that they perceived that the level of pay did not reflect the level of responsibility and the level of risk associated with the work, for example, those patients at risk of amputation.

The current use of Discretionary Points to extend the career structure of podiatrists was seen by almost all participants in the focus groups as bureaucratic. Staff also reported distaste at having to prove on paper what they did, which was time-consuming in itself. As one participant in the focus group suggested:

"You had a lot of hoops to go through, a lot of paperwork…..An awful lot of people didn't bother."

4.1.8 Career Progression

The lack of career progression and a formal structure for promotion was perhaps the most vehemently expressed issue in both the key informant and focus group participants. The lack of career progression was noted at all levels. The reasons for this were documented as being three-fold: the lack of formal structure for promotion caused by the definitions of Whitley Council not being updated to meet clinical changes and the lack of recognition of clinical specialist (Chief III), the resulting static workforce, and the fact that there has been no new posts in podiatry for a number of years.

Focus group participants highlighted the limited opportunities for newly qualified graduates, because of both the lack of Basic Grade posts in the system. Focus group participants and key interview informants pointed to what they described as the resultant "temporary merry-go-round." Limited opportunities to progress to Senior I from Senior II were also highlighted. One focus group participant highlighted this issue in, "I've been sitting at Senior II for 22 years. I'm going downhill rather than uphill." Another participant suggested that the limited opportunities to progress to Senior I was because of the lack of appropriate infrastructure: "Senior I's have to become a Senior I for something, but we don't have something. It's through luck or spending time being trained privately. There is no investment in Senior II training."

The limited opportunity for career progression once at Senior I level was also highlighted. It was reported that an active decision was made at Senior I level as to whether staff wanted to leave the clinical route and become a Manager. It was highlighted that becoming a Manager was becoming less appealing because of the additional responsibility and the limited pay differential between Managerial and clinical grades.

Key informants also indicated that the creation of Clinical Specialist posts at Chief III level were required. The opportunity to continue along a clinical route would be more appealing, as one focus group participant suggested, "You're clinically dead after Senior I."

4.1.9 Continuing Professional Development (CPD) and Research

Both interview informants and focus group participants highlighted lack of resources for continuing professional development as a key concern. All staff acknowledged the importance of CPD in terms of ensuring their ability to perform and meet the demands of the service.
The main issue raised by both the key informants and the focus group participants was one of limited funding per person per Trust, and the lack of parity in funding across Trusts.

Staff also reported problems with getting time off to go on courses or to attend conferences which was often linked to lack of resources to ensure contracts and indicative volumes were maintained.

A further issue was the provision factor. Staff participating in the focus groups and the majority of key informants pointed to the lack of a co-ordinated, regional approach to training, and the lack of provision by both the Professional Body and School of Podiatry at the University of Ulster. Staff participating in the focus group highlighted the fact that the Managers had got together in a Forum to provide some Regional courses, which had improved the training situation.

Accessibility to relevant courses was also highlighted as an issue. Staff indicated that they were often required to go to England for specialist courses in areas such as diabetes and biomechanics.

The majority of key informants also made reference to the fact that the requirement for future re-registration will increase the demands for continual professional development and make it mandatory.

4.2 DEMAND ISSUES

All respondents expressed concern about the inability of HPSS to meet the demand for podiatry services both currently and into the future.

4.2.1 Current Services

The evidence from the interviews suggested that key areas of current unmet need/demand for podiatry services are as follows:

1. Diabetes
2. Renal
3. Vascular
4. Acute services
5. Podiatric surgery
6. Paediatrics
7. Rehabilitation
8. Health Promotion
9. Stroke Services
10. Elderly Care Services
11. Physical Disability
12. Learning Disability
13. Oncology

4.2.2 Administration

The majority of focus group respondents indicated that paperwork and administration were taking up more and more of qualified podiatrists time, which was reducing the amount of patient contact time. The amount of time spent on clerical tasks had evolved out of the increasing need to document all aspects of the podiatrist's work because of increasing legislation, litigation, Parliamentary questions and audit and performance review. Few podiatrists felt that they had access to adequate clerical support, and half of all focus group participants felt that a significant proportion of the administrative work could be reallocated to administration staff if there were appropriate numbers.

4.2.3 Increased Focus on CPD

Both the key informants and participants in the focus group sessions highlighted the increasing role of continual professional development, given the likely introduction by the new Health Professions Council of a requirement for a minimum number of CPD days to be undertaken by qualified staff, and the growing emphasis on clinical governance within HPSS organisations.

4.2.4 Provision of Undergraduate Clinical Placements

The current system of student clinical placements was one of the key concerns of Managers participating in the key informant interviews, with all of the Managers acknowledging practical clinical placements were a necessary pre-requisite to complete the educational cycle and transition into employment.

Eight out of the eleven Trusts interviewed provided observational clinical placements, although one Trust was not providing the placements in the current year. The majority of Trusts supported observational placements in the students' first and second years of the course, with only one Trust providing third year placements.

All of the key informant interviews expressed concern over the current clinical placement structure and organisation, and acknowledged that there was a need for a formal review. The key barriers to the provision of clinical placements were expressed as being the lack of practical placements, lack of funding for the placement providers, lack of funding for staff acting as supervisors, lack of training for staff acting as supervisors, the current workload of staff, and lack of accommodation for students.

Managers involved in the key informant interviews expressed concern that the current system reduced the clinical abilities of qualifying graduates. They recognised this system could be enhanced and improved upon. Although the graduates had a good theoretical foundation, the lack of practical clinical placements meant that they were less well equipped for working in the clinical setting.

Managers identified the value of the clinical tutor role if a new system was to be introduced for undergraduate clinical placements.

4.2.5 Increasing Patient Expectations

Both interview and focus group participants pointed to the fact that patients were more knowledgeable about their rights through increased availability and access to information. Focus group participants also indicated that patients were not well informed about the role of Podiatry, which caused particular frustrations for staff. This can be supported by a recent survey published in Podiatry Now of 350 patients in a mixed urban-rural health board, which indicated that only 5% of users were aware of the education level of Podiatrists, whilst only 17% were aware of the difference between State Registered and Non-State Registered Podiatrists. (2001) (25) Focus group participants highlighted however that patients were pleased by the outcome of the service of Podiatry, once they were aware of the service that a podiatrist could provide.

For the majority of focus group participants the main issue was the expectation of over 65 year olds of a right to a service, and the issue of self-referral. This is supported by a recent survey published in Podiatry Now of 350 patients in a mixed urban-rural health board, which indicated that 65% of users and 87% of GPs supported the abolition of self-referral. (2001) (25)

4.2.6 Role Extensions

Examples of where the role of Podiatry has had an impact or could in the future are detailed below:

- Podiatric Surgery
- Health Promotion & Prevention
- Teaching of students on clinical placements
- Clinical Specialist roles in wound care, biomechanics, podopaediatrics, falls clinic, rapid response, rheumatology, vascular, A&E nail surgery.

4.2.7 Skill Mix

Only one of the 11 Trusts interviewed employed Foot Care Assistants, this Trust employed 2 WTE Assistants. A second Trust also employed a technical instructor grade. Those employing assistants commented positively on the contribution they made to service delivery. Most of the respondents in the key informant interviews and focus groups welcomed the role of the assistant, with some presumptions. Staff indicated that the Foot Care Assistant role must not be employed instead of a qualified podiatrist, and that there must be clarity around the role and function of the assistant. Possible roles for the Foot Care Assistant were highlighted in the key informant interview and focus groups as charting, dressing/undressing patients, applying surgical dressings, basic foot care and hygiene, health promotion, decontamination/sterilisation of instruments and clerical and administrative tasks.

The issue of inappropriate skill mix was also highlighted for the professional staff. The issue most commonly expressed was that the majority of clinical specialist posts were graded at Senior I level, and should be graded at Chief III. In addition, a number of key informants also expressed concern at Senior II undertaking Senior I tasks. The fact that the profile of patients had altered in Trusts towards high-risk patients had also resulted in staff at Senior II performing at a higher level. It was expressed that as a result in one Trust was Senior II staff successfully requesting upgrades to Senior I and this may have a knock-on effect on other Trusts.

On the managerial front, Managers highlighted the fact that there was a flat managerial structure, therefore limiting the ability for deputisation, delegation of tasks, and succession training.

4.2.8 Changing Service Provision

Participants in both the key informant interview and focus group sessions highlighted ways in which they envisaged the provision of podiatry services changing and/or developing in the future. These can be outlined as follows:

- Changing the clinical profile to high risk cases – a recent survey published in Podiatry Now of 350 patients in a mixed urban-rural health board, indicated that both users and GPs supported increased priority status for people with diabetes (2001) (25)
- Reducing the number of domiciliary visits
- Educating carers
- Educating GPs with regards to inappropriate referrals
- Providing orthopaedic triage clinics
- Providing health promotion projects, such as the Delta Project for children in schools.

4.2.9 Societal Factors

The majority of respondents highlighted the following societal factors as necessitating an increase in demand:

- **Ageing Population** - advances in medicine have resulted in people living longer and this has resulted in an increase in demand for podiatry services.

- **Increased Dependency** - it is now recognised that those who receive the clinical care are generally more dependant than before and this brings about a more resource intensive podiatry service.

- **Medical Technology** - advances in medicine and technology have resulted in people with certain complex conditions surviving longer than previously and requiring an increased input from the podiatry service.

- **CREST guidelines** – in NI approximately 39% only of people with diabetes per 100,000 population on arrival receive assessment of their foot health as set out in CREST guidelines for Wound Management.

5. WORKFORCE SUPPLY AND DEMAND PROJECTIONS

The Project Board agreed a set of assumptions around key supply and demand factors that are and will affect the Podiatry workforce within the NI HPSS in the next 5-years. These assumptions were then used to formulate a model from which certain predictions around projected supply and demand could be calculated. The key assumptions utilised have been outlined.

5.1 SUPPLY PROJECTIONS

The supply figures have been gathered by reviewing trends over the past 3-4 year period, presented in the data supplied by the DHSSPS, University of Ulster and Podiatry Managers from within the service.

The supply of Podiatrists within the NI workforce is in the main determined by:

- The existing employees currently available in the workforce;
- Students graduating from the University of Ulster;
- Students returning to work in NI after graduating from a University outside of NI;
- Professionals leaving the workforce (through retirement, leaving for personal reasons, career breaks etc).

5.1.1 Supply assumptions for those Podiatrists entering the workforce

There is a total of 179 podiatrists within the current HPSS workforce. On average 10-13 students graduate each year. An attrition rate of 22% for students on the University of Ulster course for podiatrists has been included in the graduate statistics.

The supply of graduates entering the workforce in N.Ireland HPSS has been averaged at 26% of the final numbers qualifying. This is based on destination figures supplied by the University of Ulster over the three-year period 1999-2001. In real terms therefore 74% do not take up their first post within NI HPSS. However, in the last year (2001) only one graduate took up post within NIHPSS. This is an indication of the low number of available entry-level posts within Podiatry NI HPSS. It was the view of the Project Group that the employer of choice for graduates was the NIHPSS and it was only after failure to identify such a position that employment was sought elsewhere eg the private sector.

The view from Podiatry Managers in the Project Group and evidence gathered from the key respondents interviews indicated that there would be the equivalent of two qualified podiatrists p.a. entering the overall Northern Ireland HPSS sector from outside of Northern Ireland. This has been projected to remain static over the 5-year workforce projections included in the report.

5.1.2 Supply assumptions for those leaving the workforce

In regards to retirees, an assumption has been made by calculating the numbers retiring based on earliest eligible retirement age (ie 60 years). Therefore as all podiatrists over 55 years at present have been assumed as leaving the workforce over the next 5 years. This equates to 1 podiatrist. Evidence from the DHSSPS Project Support and Analysis Branch would support this assumption.

Included in the retirement figures will be a small number of staff retiring due to incapacity. This has been recorded as one over the period 1999–2002 Therefore the assumption has been made that 1 podiatrist over the course of the 5-year plan might retire due to incapacity.

Based on anecdotal evidence from the key informant interviews and feedback from the project group, it has been suggested that, at present, 1.75% of the total workforce capacity is lost over the 5-year period due to an increase in the uptake of part-time working and work-life balance policies. Evidence shows that podiatry is a young workforce with 69% of staff under 40 years of age. This is the age group in which more requests for life/work balance occurs.

Based on anecdotal evidence from the key informant interviews and feedback from the project group, it has been estimated that the number of podiatrists leaving the HPSS sector will be 4 each year [for reasons other than retirement/medical].

5.2 DEMAND PROJECTIONS

It is difficult to obtain accurate data concerning the exact future quantifiable demand for Podiatrists. This is mainly due to the fact that there is little specific information available on projected resource investment within the service over the next 5-years. The professional managers have expressed concerns regarding the lack of past growth and investment in podiatry posts balanced against the significant demand which was identified by the project group in terms of waiting lists, inability to meet clinical guidelines and clinical service areas which the profession recognise they cannot give a commitment.

5.2.1 Demand Assumptions Utilised

The demand projections for additional podiatrists required within the HPSS over the next 5 years have been identified in the following categories:-

Category 1

This refers to capital and service development, which have already been agreed in which the workforce requirements have been identified, and have the associated funding approval.

Category 2

This refers to service development that have been identified via the key informant interviews and project group that are likely to be supported over the next 5 years, although resources have yet to be identified. This includes educational requirements and both under and postgraduates level including continual professional development, time required to facilitate students on clinical placements, elements of health promotion, role development and meeting clinical governance.

Category 3

This refers to additional demands within the current and future services, identified via the key informant interviews and project group that do not have a funding allocation. This includes referral waiting lists and clinical service demands that cannot be met within existing resources.

Category 1
Capital and service requirements with identified workforce requirement, which have had funding approval.

Four posts were identified within this category over the 5-year plan:

- Diabetes specialist post RVH (1 WTE)
- Brain Injury Unit (1 WTE)

To meet the needs of **Category 1** a total of 2 WTE Podiatrists have been identified.

Category 2
Capital and service requirements identified by the project group that are likely to be resourced within the 5-year plan.

Within this category the project group identified the following demands over the 5-year plan:-

- it is suggested the time spent on Continuing Professional Development should equate to 36.5 hours per podiatrist per annum. This translates into an additional 3.5 WTE podiatrists.

- there is a requirement for protected time allocated to students by podiatrists during their clinical training in respect of adequate mentoring and support. It is suggested this should equate to 6 hours per week per student over the course of their clinical placements. This allocation will require an additional 0.5 WTE podiatrist.

- Areas of role extension and workforce requirements for podiatry were identified as:

    - Podiatric surgery development (2 WTE)
    - Clinical specialist in wound care, biomechanics, falls clinics, rheumatology, vascular – neurology, A&E nail surgery (4 WTE)
    - The Consultant Podiatrist role (2 WTE)
    - Participation in the newly established Health and Social Care Groups (2.25 WTE)

The total workforce requirement of **Category 2** is 14.25 WTE Podiatrists. It is important to use the figures presented in Category 2 as a baseline and to recognise the need for review to be carried out to refine them in order to provide the most accurate projection.

Category 3

Current and future demand/unmet need with no identified funding.

The professional podiatry managers considered the areas of clinical unmet need and current demand on Podiatry services throughout the NI HPSS. After exploring and identifying the requirements within Category 3 they prioritised the need. This report will only identify the prioritised need. This has been divided into three distinct areas:-

- **CREST Guidelines.** In 1998 CREST published guidelines on wound management, which clearly outlined good practice in the management of the diabetic foot. At present a Joint Diabetes Task Force is reviewing and developing the CREST guidelines on Diabetes. To achieve this aim, a strategy for the implementation of these multi-disciplinary guidelines has been developed. As part of this process the Task Force is identifying the workforce requirements to fully implement the strategy. A consultation document emanating from the Task Force's report on its findings by December of 2002. The implementation of both these CREST guidelines will have significant implications within NI Podiatry Workforce as it is estimated that it may require in total an additional 52 WTE Podiatrists. This estimate only takes into account the current diagnosed incidence rates of diabetes and not the predicted rise in these rates over the next 5-10 years. In NI currently there are 40,000 diagnosed diabetics with a possible additional 25,000 not yet diagnosed within the current population. Diabetes UK predict that these figures will double by 2010.

- **Clinical High Risk Patients** "High-risk" refers to people with a systemic disease process, which results in significant foot pathology. High risk conditions could lead to serious foot pathology and ultimately will impact on the person's morbidity and mortality. These conditions include:-
  - Vascular Disease
  - Renal Dysfunction
  - Diabetes
  - Neurological Conditions
  - Compromised Autoimmune Disorders

  The requirement for podiatry provision to these patients would be 8 WTE Podiatrists. This has been calculated using existing waiting lists statistics which are in excess of 10 weeks.

- **Patients with significant Podiatric Pathology.** Current Podiatric waiting list statistics indicate that some people with significant podiatric pathology in the absence of a medical condition wait an average two-three years to be seen. Based on current waiting list information the workforce requirement to address this clinical area would be 8 WTE.

The benefits of Podiatry treatment of these clinical groups are:

- decrease incidence of ulceration and infection
- allow developmental progress
- decrease in amputation rates
- reduction in further treatment/rehabilitation
- reduction in bed occupancy for these groups
- increased independence

- **Duties associated with staff side representation.** The group considered that the time spent regionally had substantially increased in recent years. This time spent reduces the provision of the clinical service which the group assessed as equating to 200 hours per annum (1 WTE)

To meet the prioritised clinical need in **Category 3**, as identified by the professional managers in the project group, a total increase of 69 WTE Podiatrists would be required.

5.3 SENSITIVITY ANALYSIS

In an attempt to explore the percentage growth and investment that would be required in the Podiatry Workforce to meet the prioritised clinical services of Category 3 a sensitivity analysis exercise was undertaken. The analysis consists of three scenarios, 10%, 30% and 40% growth levels of the Podiatry workforce.

The table below indicates the number of podiatrists that would equate to each scenario growth level.

Table 5.3:1: Scenario 1, 2 & 3 and percentage increase of Podiatrists indicated in each growth level.

Scenario	Current Head Count	Increase Head Count	Total increased Workforce
1. Increase by 10%	179	18	197
2. Increase by 30%	179	54	233
3. Increase by 40%	179	72	251

These percentage growths were applied to Category 3 (current demand and unmet need with no identified funding within the Podiatry Clinical Service).

Scenario 1

An overall increased growth of 10% to the existing podiatry workforce equates to a total of 197 staff, an increase of 18 podiatrists. At this level of growth the Podiatry Service would be able to provide clinical services for unmet need/current demand areas identified within Category 3 for patients with the following conditions:-

- vascular disease
- renal dysfunction
- diabetes
- neurological conditions
- compromised auto-immune disorders

It could also provide a limited clinical service for patients with significant podiatric pathology based on current waiting lists.

Scenario 2

An overall increase of 30% to the existing podiatry workforce would equate to an increase of 54 podiatrists giving a total of 233. At this level of growth a clinical service could be provided that would allow the podiatry service to meet all the CREST guidelines on wound management and diabetes care.

Scenario 3

An overall increase of 40% to the existing podiatry workforce would equate to an increase of 72 podiatrists giving a total of 251. At this level of growth a clinical service could be provided that would allow the Podiatry Service to meet all the CREST guidelines on wound management and diabetes care as well as providing a clinical service for high-risk patients with:

- vascular disease
- renal dysfunction
- diabetes
- neurological conditions
- compromised auto-immune disorders

It could also provide a clinical service for patients with significant podiatric pathology based on current waiting lists. The time identified by the Project Group associated with staff-side representation regionally would also be met within this growth.

In conclusion the Podiatry service would require a 40% growth to meet all the prioritised clinical requirements identified by the Project Group and the service managers within Category 3 (unmet need and current clinical demand).

6. CONCLUSIONS

6.1 PROJECTED SUPPLY OF PODIATRY WORKFORCE

In using the previous assumptions based on our consultation process the projected supply of podiatrists has been calculated between the years of 2003-2007. Highlighted are relevant podiatry supply issues table (6.1.1), which utilises elements of supply figures based on feedback from respondents and literature review. For the purposes of identifying actual numbers required in the workforce the figures have been converted to headcount based on the headcount to WTE ratio for the profession, which is 1.2:1.

Table 6.1.1: Projected Available Supply in Headcount of Overall Podiatry Workforce in NI (2003 - 2007). NB [ ] indicates a decrease

Supply	**2003**	**2004**	**2005**	**2006**	**2007**
Return to practice	0	0	0	0	0
University of Ulster Graduate Figures	10	13	13	13	13
Entering N.I. from elsewhere	2	2	2	2	2
Total supply available to enter NI Workforce	**12**	**15**	**15**	**15**	**15**
Those leaving the Workforce:- Retirees [inc. incapacity]	0	1	1	0	0
Family friendly lost capacity	1	1	1	1	1
Leaving Podiatry	4	4	4	4	4
Total leaving NI Workforce	**5**	**6**	**6**	**5**	**5**
Total current/potential workforce	172	179	190	201	211
Projected potential workforce	179	190	201	211	221
Potential Net Increase (Decrease)	**4%**	**5%**	**5%**	**5%**	**5%**

The number of graduates stated in this table equates to the total supply and not just those taking up employment within the NIHPSS. It should also be noted that although these Podiatrists may be initially available to the NI Workforce not all of them may wish to take up employment within the HPSS.

The graduate figures are based on the present average attrition rate during the course of 22%.

Areas that could have an effect on the supply equation have been noted:

- Euro/Pound Equilibrium - could have the effect of decreasing the supply of the Podiatry workforce in the Northern Ireland marketplace.

- Consideration should be given to the effect of the recently announced strategy for the health service in the Republic of Ireland.

- More effective utilisation of the available workforce - as the evidence in this report and historical data shows there is some potential for a more effective utilisation of the available workforce either by a re-allocation of certain duties to non-qualified staff, an increase in the whole time equivalent ratio, an increase in the amount of qualified podiatrists returning to the workforce.

- The University of Ulster increase its intake and subsequent output of graduates. At the moment all information suggests that the recently increased intake will remain static for the foreseeable future.

In conclusion, based on the above analysis and assumptions a prediction that the supply of the overall Podiatry workforce over the course of the next 5 years has the potential to increase by up to 20%.

6.2 DEMANDS FOR THE PODIATRY WORKFORCE

Based on information gathered during the project from key informant interviews, the Project Board, relevant policy documents, specific educational, capital and service developments, with associated staffing implications, have been identified over the 5-year plan (2003-2007). For the initial purposes of this workforce plan the combination of Categories 1&2 have been adopted. These categories include agreed resourced capital and service plans with identified workforce requirements and those that are likely to be resourced within the 5-year plan. In order to estimate the demand numbers of professionals these summary figures have been profiled on table 6.2.1.

Table 6.2.1: Projected Demand Figures in headcount for the Podiatry Workforce 5-year Plan

	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
CATEGORY 1 Capital and service requirements that have allocated resources:-						
Diabetes Specialist (RVH)	-	1	-	-	-	1
Brain Injury Unit	-	1	-	-	-	1
SUB TOTAL - HC	-	**2**	-	-	-	**2**
CATEGORY 2 Current demand that are likely to be resourced in 5-year plan Extended role:-						
Podiatric Surgery	1	-	1	-	-	2
Student Training	1	-	-	-	-	1
CPD	1	1	2	-	-	4
Clinical Specialist	1	1	1	1	-	4
Consultant Role	-	-	1	-	1	2
HSC Groups	1	2	-	-	-	3
SUB TOTAL - HC	**5**	**4**	**5**	**1**	**1**	**16**
CATEGORIES 1&2	**5**	**6**	**5**	**1**	**1**	**18**

The demand for additional podiatrists over the 5-year plan for Category 1 is a headcount of 2 and for Category 2 is 16. The total demand for categories 1&2

is 18 Podiatrists in headcount over the 5-year plan as identified by the project group.

6.3 SUPPLY V DEMAND FOR THE PODIATRY WORKFORCE

In order to estimate the numbers of additional professionals required over the course of the next 5 years the summary figures of supply and demand have been profiled.

Table 6.3.1: Profile of projected supply against projected demand over a 5-year period by headcount.

Key Factors	2003	2004	2005	2006	2007
Total Supply Available to NIHPSS	12	15	15	15	15
Total leavers in NIHPSS	5	6	6	5	5
Net Supply	**7**	**9**	**9**	**10**	**10**
Vacancies	7	-	-	-	-
Demand Category 1	-	2	-	-	-
Over (Under) Supply	**7**	**7**	**9**	**10**	**10**
Demand Category 1&2	5	6	5	1	1
Over (under) supply	**(5)**	**3**	**4**	**9**	**9**

From the previous tables it can be concluded that supply balances with demand for podiatry-staffing levels at each of the two categories presented apart from year one of the plan.

6.4 CONCLUSIONS ON SUPPLY AND DEMAND

It can be seen from the figures presented that the total supply of podiatrists available to the NIHPSS should meet the demands of categories 1&2 (agreed and resourced capital and service plans) by year 2 of the workforce plan when taking into account the current vacancies (7). These forecasts are made with the assumption that the supply available to the workforce remains constant. It should be noted the supply figures have the potential to be increased with an improvement in the attrition rate of the Podiatry Degree Course.

Table 6.4.1: Projected supply workforce numbers available in headcount after accounting for demand categories 1&2. NB ( ) indicates a shortfall

YEAR	2003	2004	2005	2006	2007
Project numbers over (under) supply	(5)	3	4	9	9

Subject to securing investment the provision of a clinical service for some of the identified needs of Category 3 could be considered in years 2, 3, 4 and 5 of the plan. This includes referral waiting lists and clinical service demands that can not be met within the existing resources eg meeting the standards of clinical practice identified within the Crest guidelines.

The figures identified by the Project Group should be taken as a first attempt and a baseline, which will require further in-depth discussion and challenge to refine and produce the most accurate statistics.

6.5 SENSITIVITY ANALYSIS SUMMARY

A number of scenarios have been presented to analyse their impact on the clinical service provision identified in demand Category 3 of prioritised unmet need/current demand, which has no identified funding.

Scenario 1: Increasing the percentage of Podiatry posts in Northern Ireland by 10% and considering which elements of the clinical service indicated in Category 3 could be achieved.

Scenario 2: Increasing the percentage of Podiatry posts in Northern Ireland by 30% and considering which elements of the clinical service indicated in Category 3 could be achieved.

Scenario 3: Increasing the percentage of Podiatry posts in Northern Ireland by 40% and considering which elements of the clinical service indicated in Category 3 could be achieved.

Table 6.5:1: Sensitivity Summary Impact of Increasing % of Podiatry Posts within NIHPSS

Scenario	**Additional Podiatrists Headcount**	**Potential Additional Clinical Service Provision**
1. Increase of 10%	18	Clinical "High Risk" patients within identified patient groups
2. Increase of 30%	54	Meet CREST guidelines on wound management and diabetes
3. Increase of 40%	72	Clinical "High Risk" patients within identified patient groups and meet CREST guidelines on wound management and diabetes.
Total existing Workforce (2002)	**179**	**Present service delivery**

The above table profiles and summarises the impact of increasing the workforce in the three scenario stages on the prioritised clinical service areas of unmet need and current demand identified by the Project Board in Category 3.

7. RECOMMENDATIONS

The timescale for the implementation of the key recommendations outlined below is twelve months to coincide with the follow up review.

Workforce Planning

- Now that the workforce planning process is established it is recommended that the Project Board should be retained to review supply and demand on an ongoing basis. It should utilise the information gathered in the review building and expand on it, taking into account such factors as the impact on the workforce, of role extension, specialisation, capital plans and service development business cases.

- The Project Board should ensure that there is a consistent and targeted approach to gathering relevant supply and demand data and manpower recording processes.

- The Department should review the activity data collected from the Allied Health Professions at Trust level. Professional managers should review management data collection from the current information systems and ensure the systems are maximised to their full potential. The aim of these reviews will be to provide a more comprehensive management information collection, which will aid the workforce planning process.

Recruitment & Retention

- All employers should put in place policies to incorporate planned induction, consolidation and mentorship programmes for all new staff and review the effectiveness of these in a quantitative and qualitative manner.

- Employers and the profession should put in place a consistent approach to the implementation of work-life balance policies and procedures and this should be factored into workforce planning.

Utilisation of the available Workforce

- Trusts should carry out further work into the possibility of reallocating non-clinical responsibilities to other health care workers including Podiatry Assistants.

- A co-ordinated approach between the professions, employers and the DHSSPS should take place with regard to workforce planning of

Podiatry, particularly in relation to role extension and development issues.

- Commissioners should work closely with Trusts to clearly specify the required podiatry clinical service provision within the existing resources.

- Consideration should be given by Commissioners and Trusts to defining how patients access the service with the aim of achieving better control of demand and workflow focused through appropriate clinical channels.

Education & Development

- The UU and Trusts should work together to agree best practice for undergraduate clinical placements that ensures students are fully prepared for a clinical working environment

- All Trusts with Podiatry services have been surveyed (DHSSPS May 2002) with regards to the existing numbers of clinical placements and the maximum numbers that may be accommodated for each training year. Further discussions should take place between DHSSPS, Trusts and the University to establish a more comprehensive way of providing undergraduate clinical placements. There should be solutions found to the barriers identified to ensure Trusts can accommodate the number and quality of clinical placements required.

- Statistics indicate a high attrition rate and a high number of repeat year students within the undergraduate course. The reasons for these should be identified and explored with the view to improve outcomes and graduate numbers. These statistics should be monitored by the University of Ulster and reviewed on a regular basis by the DHSSPS.

- There should be an increased focus placed on Continuing Professional Development (including leadership development) and all employers should ensure that the recommended hours provision is accounted for through the workforce planning process.

- The Podiatry profession should become actively involved in the Centre for Postgraduate Continuing Professional Development for Allied Health Professional's. The NI Podiatry profession should identify its training requirements and contribute to planning for these needs.

- Employers should ensure training is available for all staff that will be required to provide mentorship or coaching support as part of their role.

- The Department should take forward the development of the AHP's Consultant role to acknowledge the high levels of clinical expertise within the profession.

Further Review of the Workforce

- The Project Group should be convened initially on an annual basis to review and update the workforce plan.
- Trusts should review the skill mix of their Podiatry workforce to ensure it has the most appropriate combination of staffing grades to meet the needs of the clinical service. This review should also ensure that entry-level posts are maintained so there is a continued flow into the workforce of new graduates.
- The Project Group should be mobilised to take forward where appropriate any recommendations emanating from the workforce review.
- Trusts should review with its Podiatry Service the demands of Category 3, as identified in this report, and ensure that any agreed increase in service is included in any future service development plans.

CONCLUSION

This Podiatry workforce review can by only viewed as a starting point, or baseline for further work to be carried forward. This includes the development of an action plan to take forward the recommendations outlined above. The models presented in the report will need updated and refined on a regular basis to continue to inform decision making and priorities concerning the investment in the NI HPSS Podiatry workforce over the five-year plan.

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APPENDIX 1 - PROJECT BOARD MEMBERS

Workforce Planning Group – Members

NAME	TRUST/HOSPITAL
DAVID BINGHAM, DIRECTOR OF HUMAN RESOURCES	Department of Health Social Services & Public Safety
JOYCE CAIRNS, DEPUTY DIRECTOR OF HUMAN RESOURCES	Department of Health Social Services & Public Safety
DOROTHY JEFFREY, PROJECT DIRECTOR	Department of Health Social Services & Public Safety
FIONA HODKINSON	Department of Health Social Services & Public Safety
BRONAGH MONAGHAN, CHIEF PODIATRIST	Belfast City Hospital Trust
COLIN FULLERTON, CHIEF OF SCHOOL OF PODIATRY	University of Ulster, Jordanstown
MARGARET MOORE, PODIATRY MANAGER	Sperrin Lakeland Trust
MICHELLE TENNYSON, PODIATRY MANAGER	South & East Belfast Trust
SADIE SOMERVILLE, PODIATRY MANAGER	Armagh & Dungannon HSS Trust
ANNE CLARKE, SENIOR MANAGER, PODIATRY SERVICES	Causeway HSS Trust
COMMISSIONER REPRESENTATIVE – DR. PAMELA HANNIGAN	Northern Health & Social Services Board
JENA MUSTON	Beeches Management Centre
FRANK GALLAGHER	Regional Staff Side Representative
ROY HAMILL, PODIATRY MANAGER	Homefirst Community Trust. Braidvalley Hospital Site, Ballymena

APPENDIX 2 – KEY INFORMANT INTERVIEWS

Representative	**Organisation**
Mrs Julia Shaw	Royal Group of Hospitals Trust
Michelle Tennyson	South & East Belfast Trust
Mrs Shirley Blair	Homefirst Community HSS Trust
Margaret Moorehead	Ulster Communities & Hospital Trust
Margaret Moore	Sperrin Lakeland Trust
Mr Roy Hamill	Homefirst Community HSS Trust
Mr David Fenton	Down Lisburn Trust
Anne Clarke	Causeway Community Trust
Mrs Sadie Sommerville	Armagh & Dungannon HSS Trust
Mr Martin McLoughlin	Newry & Mourne HSS Trust
Bronagh Monaghan	Belfast City Trust
Mrs Joy Steenson	Armagh & Dungannon Trust
Mr Colin Fullerton	University of Ulster
Mr Frank Gallagher	Regional Staff Side Representative

APPENDIX 3 – FOCUS GROUPS

Group	Location
1	NHSSB-Homefirst Staff
2	NHSSB-Causeway Staff
3	WHSSB
4	SHSSB
5	EHSSB-Mater & BCH Staff
6	EHSSB-DLT, UCHT, SEBT, NWBT
7	Final year – UU Students

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Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

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Caring for People Beyond Tomorrow...

A Strategic Framework for the development of Primary Health and Social Care for Individuals, Families and Communities in Northern Ireland

MINISTERIAL FOREWORD

The desire to have and maintain good health and a positive sense of wellbeing is fundamental to us all. Throughout our lives we seek help from local health and social care professionals, through for example, a family doctor, nurse, pharmacist, social worker, dentist, carer or one of many allied health professionals. These people and many others who invariably provide a first point of contact and continued support through the health service, have demonstrated over time their dedication, professionalism, and a relentless pursuit to provide an excellent service.

Today, in primary care we do much very well, but the system can still let people down when they need it most. Provision of a high quality primary care service has been, and will continue to be subject to significant pressure as the demands placed upon our health service continues to grow. That is why we need to consider new ways of working, which will help meet both current and future needs. In many areas we still fail to meet the standard of care our population expects. Too much reliance is placed on the hospital sector: a more responsive and dynamic primary care sector could provide the necessary care close to home. Therefore, we need to develop a much more responsive system which is fully integrated and joined up with the wider health and social care network.

To this end, my Department has developed this Strategic Framework, which sets out a long-term vision, a policy position that will guide the development and delivery of future primary care services, but more importantly, an action plan that will contribute to real benefits.

I want to see our primary care service undergoing substantial reform, by way of structures, systems, and protocols – I want people to know that our healthcare system puts patients first – providing urgency and choice in treatment and care. More needs to be done to create effective high quality and modern primary care services, which will be responsive to people’s needs; provide greater access through a wider range of services delivered close to where people live and work; and be more integrated across hospital, regional, and community care providers, making the best use of the skills of our health and social care professionals.

I am determined that we can bring about these necessary changes. Some of these changes will involve adopting and adapting approaches from around the world, which will be used to deliver quicker access to assessment and treatment in local communities, leading to reduced waiting times for those requiring more complex treatments in hospital.

I will insist that change is brought about promptly and safely to ensure our primary care system meets the needs of the whole population, and its implementation will be closely monitored. However, to make a real success of this Strategic Framework, we all need to embrace and contribute to its delivery.

Shaun Woodward, MP

For Individuals,
Families and
Communities

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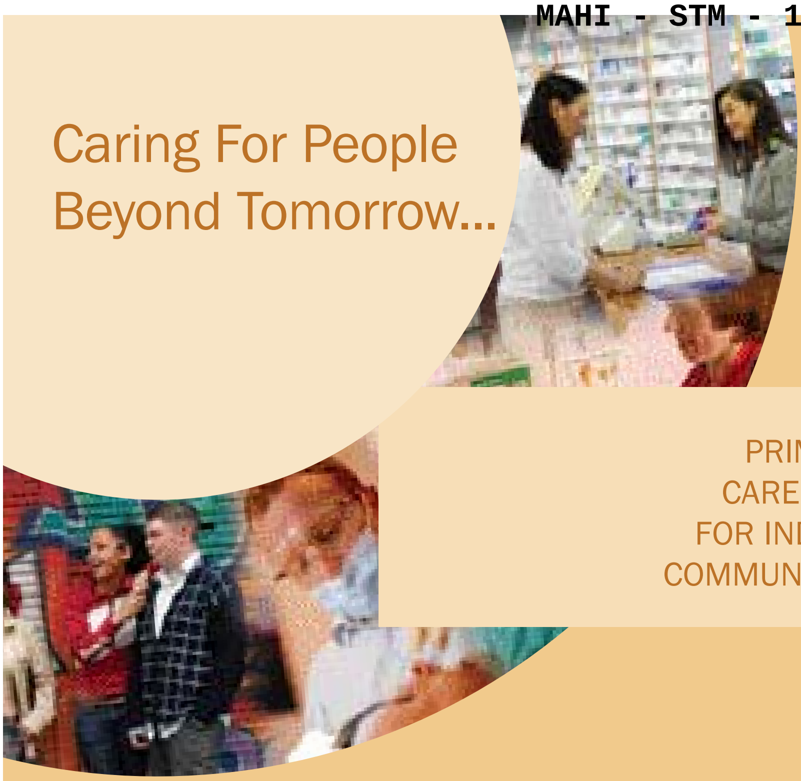
For Individuals, Families and Communities

Caring For People
Beyond Tomorrow...



PRIMARY HEALTH AND SOCIAL CARE: A STRATEGIC FRAMEWORK FOR INDIVIDUALS, FAMILIES AND COMMUNITIES

Section 1:
What Is Primary Care, And Why Is A Strategic Framework Needed?

1.1 Primary Care is the cornerstone of health and social care provision. Each day thousands of contacts take place between primary care professionals and individuals, families and communities, in a range of settings - in the high street, at home, in clinics and health centres or at more specialist facilities, and are delivered through public, private and voluntary sector organisations. The contacts are by people in their local community with family doctors, nurses, midwives, allied health professionals (physiotherapists, podiatrists, occupational therapists, speech and language therapists, dietetics, psychologists, etc.), social workers, care assistants, dentists, pharmacists, optometrists (ophthalmic opticians) and others. Most people look to primary care for help in a local setting near to where they live, with many consultations resulting in advice or straightforward effective treatment or care. Some are referred on for more specialised care or treatment outside the primary care sector, for example in hospital.

1.2 Primary Care is central to the range of health and social services provided to the local population. It acts both as a first point of contact and as a 'gateway' to a wide variety of services, both within the primary care system itself and to other parts of the wider health and social services system. It also has links with other agencies, for example in relation to housing and education.

In this document the use of the term **'Primary Care'** encompasses both primary health and social care, which is a reflection of the integrated service that we have in Northern Ireland. In other parts of the UK and internationally the term usually refers to health care systems only. When the term Primary Care therefore is used in this document, it is essentially short for 'Primary Health and Social Care' and refers to *"the many forms of health and social care and/or treatment accessed through a first point of contact provided outside hospitals".*

1.3 It plays a key role in the protection of vulnerable children and adults, it supports many community development projects and in the area of public health, it provides health education and information, and actively promotes health, and helps to protect us from and prevent disease. In this way it is fundamentally about helping to prevent people becoming ill or requiring care in the first place, and meeting their needs if they do.

1.4 In Northern Ireland typically everyday:

- 30,000 people see a family doctor or practice nurse;
- 120,000 people visit a community pharmacy where around 75,000 prescriptions are dispensed;
- 3,000 new courses of dental treatment are started;
- 1,000 eye-sight tests are performed;
- Over 2,000 people are visited by district nurses and health visitors;
- 33,000 people are looked after in their own home by some form of domiciliary care;
- 17,000 people are cared for in residential and nursing homes; and
- 2,400 children are looked after in some form of care.

1.5 At present, there are almost 20,000 people actively involved in the provision of primary care services across Northern Ireland. This includes some:

- 1,200 General Practitioners (GPs);
- 5,000 Nurses;
- 250 Midwives;
- 700 Dentists;
- 1,000 Community Pharmacists;
- 1,000 Allied Health Professionals;
- 500 Optometrists;
- 4,000 Social Workers; and
- 6,000 Home-helps.

The total annual expenditure amounts to just over £1 billion (2003/04 estimates).

1.6 Primary Care services and structures have evolved over many years and have generally served the local population very well. The advent of new treatments, new technologies, and many innovative services, have brought, and continue to bring, tremendous benefits to

individuals, families and communities. But, as for all services, there are many challenges to be met in the future and changes that will need to be made.

1.7 Looking to the future, it is essential that there is a clear sense of direction, and that the main priorities within the service are made explicit. Clarity of vision and purpose will ensure that all the people and organisations providing care or treatment know how they can contribute to securing maximum impact and benefits for all concerned. It will also assist people who use and benefit from these services to be aware of both the services available to them and how they can influence the planning of their care and the delivery of services generally.

1.8 Consequently, this Strategic Framework has been developed to provide:

- a vision for primary care services over the next twenty years;
- a framework of principles, values and high-level goals that will make clear the nature of the future primary care system we wish to see developed; and
- a policy framework that will steer and influence future development and delivery of services.

1.9 The Framework is designed to harness a number of related actions and strategies under one umbrella, in a way that will help deliver the overall strategic vision and associated goals. It is not therefore intended to set out here detailed plans for all aspects of primary care. That sort of detail will feature in strategies and plans to be developed in due course for component parts or aspects of primary care, all within the Framework, for example, the Community Nursing Strategy.

1.10 The Framework is intended to ensure that current and future plans for the many different aspects of primary care can be managed and developed in a way that is consistent with a common vision for an integrated service. Furthermore the Framework has been developed as an integral component of the new Regional Strategy, *A Healthier Future*, contributing to the overall development of health and social services across Northern Ireland.

Section 2:
What Changes Affect Primary Care?

2.1 Over the last twenty years and more there have been many major developments in our health and social care system. The system has coped with many challenges and has continued to provide services to the community throughout some difficult times in our society's recent history. Surgical intervention has become less invasive and much now can be done on a day-case basis. Lengths of stay in hospital have reduced. More people are being treated than ever before in our hospital system and, for many, advances in drugs and better health and social care in the community have helped avoid hospitalisation altogether. Trends over the last few years have seen a shift in workload from the acute hospital sector to the primary care sector. There have also been many new service developments offering alternatives to hospital admission or facilitating earlier discharge than used to be possible. Similar trends are evident in other areas of our health and social care system.

2.2 The expansion of our community mental health and learning disability services has meant that we are much less reliant now on our psychiatric and learning disability hospital services for the provision of support to people with a mental illness or learning disability and there are now many innovative examples of supported living in the community.

2.3 The development of new services for children with a disability has enabled many families to have a range of community and respite services provided for their children, reducing the amount of time spent in hospitals for non-medical reasons. Similarly, new partnerships involving the public, private and voluntary sectors, and changes to home care services, and the use of new equipment and technology, mean that a growing number of people, who previously have had to rely on residential care, are now being supported at home.

2.4 These changes have been brought about in response to a number of factors such as developments in best clinical and professional practice, population trends, new advances in medicine, and a desire to be more responsive and flexible in meeting the needs of people in their community.

2.5 Despite significant increases in resources in recent years and the sustained efforts of staff across the HPSS, our services remain under

enormous pressure. Volumes of activity have been rising substantially, but the level of demand continues to outstrip the capacity and capability of the system.

2.6 At the same time most people continue to rate their primary care services very highly. A survey of 1,500 people conducted by the Department in February 2003 showed that some 75% rated access to primary and community based care services as either excellent or good and at least 80% rated the quality of service delivered similarly. Importantly, however a significant minority of those surveyed indicated that they had difficulty accessing services. This included some of the most vulnerable people in the community.

2.7 A recent review of the needs and effectiveness of our current health and social care system noted the improvements in performance that had been achieved in recent years in meeting the needs of the population. It also pointed to the increased role that could be played by primary care, in dealing with immediate and critical need, by providing for a greater range of care options. The need for further concerted efforts in promoting public health and wellbeing was also stressed. At the same time it also emphasised the importance of the need to get the balance right between the primary care and hospital sectors if an effective health and social care system is to be achieved to meet future needs.

2.8 Strategies for the future clearly need to take such issues into account. Looking ahead 20 years, trying to anticipate service needs and demands, cannot be an exact science. However, we can expect that society in Northern Ireland will change and evolve in many ways. These changes will bring with them new expectations, on the part of the public and practitioners alike, around the nature and pattern of primary care services. Population trends, new advances in medicine and computer technology, new working practices, greater access to information, lifestyle issues, and increasing expectations of people will all have an impact.

Population trends

2.9 Drawing upon research information and the latest population projections, it is likely that by the year 2025 Northern Ireland will have a population which:

- is larger (1.8 million people by 2026 compared to just under 1.7 million today), potentially creating more demand generally;
- is older (around 350,000 people over the age of 65 by 2023 compared to 266,000 in 2002), and therefore likely to present additional challenges in respect of both health and social needs;
- is living longer, and may have greater levels of incidence of age related chronic conditions;
- is likely to exhibit increased prevalence of conditions such as obesity and diabetes due to some lifestyle factors evident today, such as smoking, alcohol misuse and bad eating habits;
- is better educated and informed, and so better able to access information, take a more proactive role in maintaining their own health and wellbeing, and more demanding (seeking a person-centred service operating to the highest standards); and
- is likely to be socially and ethnically more diverse, thus placing a premium on equality of opportunity and targeting of need, with consequences for the way health and social care is delivered.

2.10 So demographic and lifestyle trends will have a profound impact on the future demand for primary care services. The growth in the number of the very elderly, in particular, will present a considerable challenge. The over 85 population is expected to almost double over the next twenty years. Major change will be required if we are to respond adequately to the needs of this group alone, in maximising independent living and reducing reliance on hospital and residential care.

2.11 This in turn will require the much wider development of community-based alternatives to hospital admission, the establishment of flexible and

innovative 24-hour crisis response services, more supported-living opportunities and access to appropriately skilled, and resourced, community-based rehabilitation teams. Such an approach will make significant demands on our community nursing services. It will also need to draw much more heavily, than at present, on the skills of allied health professionals such as physiotherapists, occupational therapists and podiatrists, to name only a few.

2.12 There will also need to be an even greater emphasis than at present on health promotion, enhanced social wellbeing and disease prevention. This would provide support to people in making and sustaining lifestyle changes, helping to reduce future levels of chronic illness and, where necessary, supporting people to manage their own condition, again with less reliance on the hospital sector and practitioners generally. In this regard, multi-disciplinary primary care teams will need to be in place with greater specialisation in areas such as diabetes, respiratory illness and heart disease.

Advances in Medicine, Care Provision and Technology

2.13 In the future advances in medicine, care and technology will continue to drive change in the range of services that can be provided safely in the community. This will enable more people to be diagnosed, treated and cared for at home or close to where they live. Greater access to diagnostic services in the community for primary care professionals will enable them to treat people more quickly and avoid unnecessary referrals to hospitals. Also, new more effective treatments will continue to emerge, as advances in genomics, new gene therapies and antibiotics, etc., bring new products to the market capable of being deployed by practitioners in primary care.

2.14 This in turn will lead to greater specialisation in the primary care workforce. More sophisticated treatment and care will be capable of being delivered in communities. Care pathways will change, and for many conditions that currently require a hospital visit, individuals will attend specialists in a local primary care centre. These Health and

Care Centres in many cases would be organised on a “1-stop-shop” basis, such that, a range of health and care services would be available to people under one roof. For example, GP services, nurse practitioners, pharmacists, physiotherapists, social workers and dieticians. These enhanced services within the community will provide more convenient and quicker access to services, including for example x-ray and minor surgery, and it will reduce the need for hospital based treatment and consequently reduce waiting times for necessary hospital treatment.

2.15 To allow this to happen changes in working practices across the whole primary care team will be needed. The range of advice and health care management from community pharmacists, for example, will expand, taking account of their skills in managing medicines and their extended prescribing abilities. Similarly, primary care nurses will take on responsibility for an even wider range of activities such as prescribing, social care professionals will work more closely with General Medical Services practices through integrated primary care teams. These changes will improve access and increase patient choice, and provide family doctors with more opportunity to concentrate on more complex and medically specialised conditions.

2.16 The infrastructure supporting primary care will also need to change to accommodate, not only the new technology, but also the wider range of activity to be provided locally. New premises will be needed and technology links installed with the wider health and social care system. These could provide for the flow of records, or, for example, prescriptions, between different professionals, and allow access to test results or x-rays and images, as well as hospital in-patient and out-patient booking systems.

2.17 The individual’s journey across the primary care and hospital sectors will become more streamlined with greater interaction between the medical and nursing teams in hospital and the wider primary care team in the community – all facilitated by improved information flows. But if people are to fully benefit from such advances, a more joined up approach to the delivery of care and treatment will clearly be essential.

2.18 Access to the Internet will also without doubt impact on the way services are delivered and accessed. Already many people are using it as a source of information and advice about their condition. In the future it is likely to be more proactively used as a communication medium between people and their local primary care team. It would act not only as a source of general information about illnesses, but provide access to

advice on self-management of chronic conditions, infections, or communicable disease control within the local community. It could also be used as a communication vehicle for the transfer of test results directly to individuals and the provision of advice and even diagnosis and treatment between care professionals and individuals working together remotely from different locations – again reducing the need for face-to-face consultations.

A different focus

2.19 Partly in response to changes of this kind, a new contract for General Medical Services has been introduced from 1 April 2004. It is designed to provide real benefits for individuals and GPs and practice teams. It aims to reward practices for higher quality care, improve GPs' working lives and in turn ensure that people benefit from a wider range of high quality services in the community. It is planned that new contractual arrangements will similarly be put in place for dental practitioners and community pharmacists in the near future. These contracts will provide incentives for the provision of high quality care and treatment.

2.20 In relation to the community and social care workforce, "Agenda for Change" will contribute to enhancing practice and service standards, foster the potential for new ways of working and enable the development of a new career structure. This will assist with the retention of highly competent practitioners close to the front line of service delivery. This means that the public can have greater confidence in the quality of services provided. It will also help address the difficulty in retaining staff in some of the most challenging areas of work, for example, residential childcare. However, there is a need for further change to service structures and systems if we are to meet the needs of a changing Northern Ireland population over the next two decades.

2.21 There is growing evidence internationally that more efficient, and better quality services, can be delivered by closer co-operation among different professionals within primary care. The emergence of a multi-disciplinary team approach to service delivery in primary care is widely seen as the future way of working. This team approach is seen as better meeting peoples' needs by providing efficient and effective care packages that make best use of the skills and knowledge of a range of professionals for the benefit of individuals, families and communities. However, as professionals work more together in teams providing seamless services, their individual roles will need to change and evolve over time.

2.22 This evolution has already begun. For example in the nursing profession where nurses are taking on new specialist roles and extending their skills in areas such as sexual health, respiratory care and working with vulnerable groups such as the homeless and asylum seekers. The new General Medical Services contract also envisages development of specialist GPs, working in the community providing enhanced services to patients in their own and other practices. Thus professionals in primary care are already taking positive steps to develop the new skills needed to work in multi-disciplinary teams in line with the changing demands on the service as well as emerging best practice. In addition, it also enables primary care professionals to provide a wider range of services in the community, providing an enhanced capacity and alternative ways to meeting people's needs.

2.23 In parallel with these developments in the future, people will be encouraged and helped to take more responsibility for managing their own health and wellbeing through the provision of better information, advocacy and support services. From early years through to older age, people will be helped to actively participate in decisions affecting their health and wellbeing. With the right support and information, people will understand more about healthy lifestyles and understand the actions they need to take to reduce, or prevent, harm to their health and wellbeing. In addition, people will be helped to acquire basic skills to help them manage any chronic conditions. This can only be achieved if the primary care system is able to provide effective programmes of health and lifestyle education, disease prevention and support to individuals in the management of their own conditions.

2.24 This approach will need to be undertaken in partnership with people in the community. Primary care will have a proactive role in encouraging and supporting people to take greater responsibility for their own health and wellbeing. A recent example of this developing role is the 'Building the Community-Pharmacy Partnership' initiative which involves pharmacists

working with local community organisations to encourage community activity and self-help, increase local people's understanding of health issues and encourage local people to play a role in promoting health. It will also need to focus on those in greatest social need and seek to close the 'socio-economic health gap' between different groups within society. The challenge will be, through a combination of improved, better targeted, and expanded primary care services, allied with more effective self-care programmes, to reduce our dependency on general hospital referrals or residential care, as well as dependency on health and social care practitioners generally.

2.25 With so much change likely to lead to a totally different primary care service in the future it will be all the more important to ensure that there is absolute clarity in terms of public accountability. Decision-making at all levels in the system must be evidenced-based and people must be able to know and understand how and why services are to be delivered and to know who carries relevant responsibilities. In particular, robust systems to support effective clinical and social care governance within the primary care system as a whole and the wider health and social services must be developed and sustained to protect and reassure both practitioners and people using primary care services.

Section 3:
Meeting The Challenge – A Vision For The Future

3.1 The Department is committed to promoting and improving the health and social wellbeing of the people of Northern Ireland by ensuring the provision of appropriate health and social care services. Key to delivering on this commitment is meeting the challenges likely to arise in the future as we have seen in the previous section. Some of these challenges are more immediate and specific to the primary care system itself. Others will mean changing the way services are structured, and the way professionals work with each other and with service users. If these changes are not harnessed within an overall vision for the services of the future, there is a real risk of inconsistency in the quality, range and responsiveness of services that will be provided to people.

3.2 To help avoid this we have firstly set out below the key attributes of the type of system that we feel everyone would want to achieve. These are:

- a service focused on providing comprehensive person-centred care;
- a first point of contact that is readily accessible and responsive to meet peoples' needs day or night;
- a co-ordinated, integrated service employing a team approach with multi-agency linkages;
- an emphasis on engagement with people and communities about their care and the way services are designed and delivered; and
- a focus on prevention, health education and effective self-care.

3.3 Building on these attributes we have set out below a vision for 2025 for the future development of primary care. This vision is intended to provide direction and a common sense of purpose for the Department, its statutory bodies, health and social services professionals and all others involved in delivering health and social care. It also clarifies for the public what can be expected of primary care services and professionals in the

future. At the same time we must not be complacent in assuming that beyond 2025 we will not face other challenges. This will definitely be the case given the constant change in the environment, such as demographics and technology at the very least. This vision is simply a vehicle to aid planning and development by providing focus for our efforts and thinking.

Our Vision for 2025 is of:

A Primary Care system that achieves very high levels of health and social wellbeing, maximising care and treatment in the community convenient to where people live and work, minimising the need for hospitalisation or residential care, and is the cornerstone of health and social services generally, providing the great majority of services.

It will treat and care for people as the first point of contact in a comprehensive fashion and be highly responsive, providing immediate access to a wide range of services, day or night. In doing so it will foster new technology and information systems accessible by both citizens and practitioners.

It will provide consistently high quality and seamlessly integrated services, with an emphasis on prevention, safety and continuity of care. Service delivery will be based upon partnership working across the public, private and voluntary sectors. Services will be both proactive and reactive in meeting peoples' needs, with chronic conditions being predominantly managed in the community, and supported by specialised services in hospitals.

Services will be delivered by a highly skilled, well-motivated and fairly rewarded workforce, mainly working in teams, and operating from modern fit-for-purpose premises. They will employ the most modern equipment and advanced technology, previously only available in hospitals.

Primary Care will provide a service that will be well understood and used by citizens, and in which they, along with practitioners, will have an effective voice in planning and evaluating services.

Primary Care will engender pride among those who work in it and respect by those who use it.

3.4 This vision paints a picture of how primary care, in all its many and varied aspects, needs to be developed to benefit individuals, families and communities and ensure their health and wellbeing. It is challenging and demanding. It does not attempt to describe all the detailed workings of a system 20 years from now, but rather give a clear focus to the essence of what that system should be like from both the perspective of the citizen and the practitioner.

3.5 Furthermore, it is based on a set of ***design principles*** and ***core values***, which are set out in Annex 2. These ***design principles*** are the building blocks underpinning the vision. They serve as a means of defining the features of service delivery and the potential benefits accruing to the people of Northern Ireland for their future health and wellbeing. By working to these principles, and ensuring that they inform future practice in the primary care sector, it is expected that even higher quality care can better be secured for everyone. In a planning context, it is envisaged that future strategies or plans for component parts of primary care (e.g. community nursing, etc.) should embody these principles and thus ensure a greater consistency of approach in primary care policy, planning and service delivery generally. The ***core values***, also in Annex 2, describe the key attributes and enduring qualities of a primary care service that both citizens and those who work in the sector should be able to expect in the future as we strive towards attaining our shared vision.

Caring For People Beyond Tomorrow...

PRIMARY HEALTH AND SOCIAL CARE: A STRATEGIC FRAMEWORK FOR INDIVIDUALS, FAMILIES AND COMMUNITIES

Section 4:
Realising the Vision – First Steps Over The First 5 Years

4.1 Making a reality of the vision painted will require action on a number of fronts. The challenges cannot be met simply by an increase in capacity. Significant change to the way services are delivered is also needed. We need to develop better ways of team working and consider changes in the traditional roles of primary care practitioners and service providers, creating the opportunity to design new ways of working which will reshape the boundaries between primary care, hospital and other associated services. We need to improve our infrastructure to ensure that it effectively supports the changes envisaged.

4.2 We need to provide for more proactive engagement with individuals and local communities, not only in future planning and design of services, but also in the development of community safety initiatives, the protection of vulnerable individuals, the raising of awareness of lifestyle issues, and health promotion and disease prevention management programmes. More services need to be delivered at a local level, close to peoples' homes, or where they work, and be linked with and supported by services provided in other sectors such as hospitals as well as housing, education, environment and other voluntary, community and statutory agencies. This type of change will require much more effective working among all the main stakeholders: the health and social care organisations, practitioners and the public. In particular, the Department will wish to work closely with all of the relevant professions, and the public, in bringing about real and beneficial change, and indeed involve them in the change process.

4.3 All of this will take time. But a start must be made now in translating the vision into reality. This section sets out four High-Level Goals for primary care. These goals are designed to enable this vision to become a reality and, on the basis of current knowledge, it is expected that they will broadly remain relevant to the service over the next two decades.

4.4 The four **High-Level Goals are**:

Goal 1.
To make primary care services more responsive and accessible and encompass a wider range of services in the community;

Goal 2.
To develop more effective partnership working across organisational and professional boundaries to provide more effective and integrated team working;

Goal 3.
To facilitate more informed, proactive engagement and involvement of people in local communities and practitioners in the use, planning and delivery of services;

Goal 4.
To put in place a care infrastructure fit-for-purpose which provides integrated modern services.

4.5 Specific actions associated with each High-Level Goal have also been identified which should be addressed over the **first** 5 years of the 20-year strategic horizon to start the process of change.

Goal 1.
To make primary care services more responsive and accessible and encompass a wider range of services in the community.

4.6 Most people enjoy good health and wellbeing most of the time. When this situation changes they expect to be able to access the services they need in a timely way – in an emergency, if necessary. The new General Medical Services contract offers considerable scope for GPs and the wider primary care team to offer better quality and more responsive services in primary care within a specified quality, outcomes, and enhanced services framework. The Improved Access Schemes, introduced as part of the new General Medical Services contract in 2004, is aimed at ensuring that people can access GPs or an appropriate

primary care professional within 48 hours. Over time health and social service Boards will be expected to further develop services to ensure that they are designed to better meet peoples' needs and living circumstances. For example, from 1 January 2005 they are responsible for the delivery of primary care out of hours services. This offers significant potential for the development of a system of out of hours care which is more comprehensive in its coverage.Key objectives in terms of ***responsiveness and access*** over the first five years will be:

Objective 1.
to deliver to people within a minimum of 24 hours appropriate and equitable access to all primary care services;

Objective 2.
to provide a comprehensive primary care out of hours emergency care service providing access, as appropriate, not only to general medical, general dental and community pharmacy services, but also to community nursing, mental health, and other social care services.

4.7 In the absence of certain services in the community, the hospital service too often has to deal now with numerous conditions that could be managed more appropriately in local settings – if the right skills and services were available.

4.8 We need to look critically at all of the care pathways for people to ensure we offer the best possible configuration of expertise and use of available resources. This will involve managing referrals into hospital care efficiently and effectively, and providing services in the most appropriate setting, preferably as close as possible to the service user. For example, better access to physiotherapy or the skills of a podiatric surgeon would provide a real alternative to the lengthy waiting times associated with the hospital orthopaedic service and make services that are available to address some of the more painful conditions associated with old age more accessible and responsive. Similarly innovative and flexible response systems involving highly trained ambulance personnel and skilled care practitioners could transform the emergency care pathway.

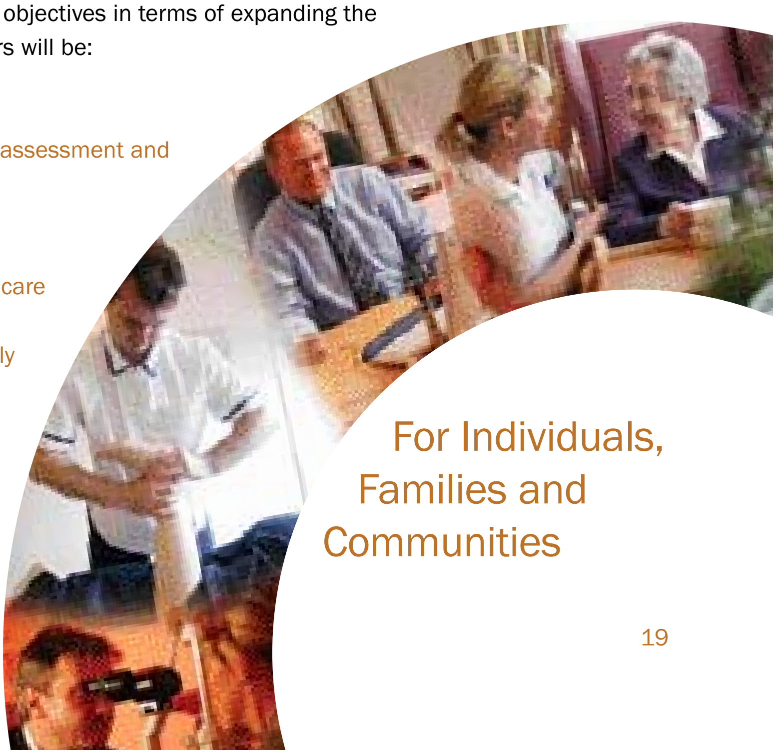
4.9 Multi-disciplinary mental health crisis response teams working in the community have been shown to provide an effective alternative to hospital admissions for dealing with exacerbations of mental illness. Such teams working in partnership with other agencies could help ensure active support and supervision of individuals allowing people with severe mental illness to maintain independent living in the community with much less reliance on specialist hospital services. Similar systems of care for people with a learning disability would also reduce reliance on specialist hospital services.

4.10 Many vulnerable people, suffering from a number of conditions have unfortunately to be admitted to hospital on a number of occasions each year. Evidence from the USA suggests that with proper community support, hospital admissions could be reduced by up to 50% for such client groups with high levels of patient satisfaction. The approach works by identifying patients most likely to require an emergency admission to hospital and providing for their effective 'case management' by appropriately trained primary care staff. This could involve a nurse or other practitioner with advanced skills working actively with these identified patients in the community to treat and stabilise their condition and co-ordinate the various inputs from other professionals needed to maintain the individual at home. The role could include ordering diagnostic tests and prescribing medication, issues that have, in the past, been the almost exclusive preserve of doctors.

4.11 We need to begin planning and implementing these types of approaches now if we are to successfully address the consequences of the population and lifestyle trends for the future. Enhanced primary care services that would equate to outpatient services, which could be delivered by GPs with a special interest, nurses and allied health professionals, will provide quicker access to a wider range of services close to where people live and work. Consequently key objectives in terms of expanding the ***range of services*** over the first five years will be:

Objective 3.
to develop a broad range of multi-disciplinary assessment and treatment services in primary care;

Objective 4.
to develop and implement a range of primary care strategies for community care, community pharmacy, community nursing, child and family support, general medical services, general dental services, optometric services, older people and carers services and services delivered by allied health professionals;



Objective 5.
to provide for improved management of chronic conditions in the community by developing and implementing plans for the increased deployment of multi-disciplinary care teams;

Objective 6.
to initiate new case management arrangements for at risk people involving multi-disciplinary primary care teams proactively working with and supporting individuals to help avoid unnecessary emergency hospital admissions;

Objective 7.
to develop and implement strategies to provide for effective, community based and person-centred services for people with learning disabilities and mental illness.

4.12 Health and Social Service organisations will be asked to bring forward primary care reform and modernisation plans demonstrating how services can be redesigned to better respond to emerging need and providing for a greater range of services and level of activity in the community. For example, in the area of mental health, stress, depression, and in particular suicide prevention, more needs to be done. A taskforce has recently been established to develop a suicide prevention strategy, based around a partnership approach involving health and social services organisations, statutory agencies, and voluntary and community organisations.

4.13 Chronic condition management programmes will be established to help treat a range of major chronic diseases and conditions. These programmes will be provided by primary and community care practitioners with support from hospitals. The Department will also want to give further consideration to potential policy and service developments associated with complementary and alternative medicines and therapies.

4.14 As these service developments become available, so patient choice will further broaden and become more effective.

Goal 2.

To develop more effective partnership working across organisational and professional boundaries to provide more effective and integrated team working.

4.15 Delays, bottlenecks and other constraints often impede individuals' progress into and through the health and social care system. Complex needs and the co-ordination of different types of care can sometimes result in care pathways being disjointed. Individual professionals often work in isolation of each other and there remain unnecessary obstacles and barriers between the different care sectors. This can lead to significant delays in referral and discharge arrangements and difficulties in mobilising all aspects of care packages needed to sustain individuals in their own homes. A greater emphasis on partnership working across organisational and professional boundaries offers considerable potential to achieve improved streamlined services to individuals.

4.16 We have to involve primary care practitioners in the process of changing how services are delivered. GPs and other primary care professionals with a special interest could take on new roles that have, until now, invariably been the domain of hospital based specialists – particularly in the areas of chronic conditions or long-term illness. Healthcare professionals working in primary care will see their responsibilities expand as they enter into new partnerships. For example, in the future community pharmacists, as well as dispensing medicines, will offer a range of services, including review of patient medication, monitoring and evaluating drug therapy, disease prevention programmes and managing patient care plans, as well as offering clinical pharmacy advice and guidance to GPs and other practitioners on prescribing practice.

4.17 The availability of properly resourced and appropriately skilled multi-disciplinary primary care teams could provide for much earlier discharge, allowing for example, post operative rehabilitation to be provided closer to, or at home and providing for a significant reduction in hospital lengths of stay. Within primary care Carers provide a major contribution, supporting and caring for people within their homes. Carers are vital partners in the effective provision of health and social care within our community. The Department will develop a Carers' Strategy which will foster an environment that both protects the interests and develops Carers to enable them to better provide high quality care. Key aspects of this strategy will focus on the identification of Carers, the development of information, and support and training for Carers.

4.18 The further development of partnership working with other Departments, Agencies and voluntary bodies offers considerable scope for the development and implementation of new holistic approaches to many intractable social issues such as homelessness, sexual violence and family breakdown, with the voluntary sector often being able to better engage with individuals beyond the reach of the statutory sector. The local voluntary and community sector has always contributed significantly to the effective delivery of health and social care. There is clear evidence that a community development approach to multi-disciplinary working helps deliver better health and social care outcomes. The voluntary and community sectors have extensive knowledge, skills and experience, which can help inform the development and delivery of services. The Department will develop plans for the voluntary and community sector to change the means by which the voluntary and community sector are engaged in the planning and delivery of primary care services. Key objectives for ***partnership working*** over the first five years will be:

Objective 1.
to develop and implement multi-disciplinary protocols and professional standards to ensure that people receive care and treatment in the place most appropriate to their needs by staff who are appropriately skilled;

Objective 2.
to develop community rehabilitation models of care, which help people to regain and maintain independence and achieve a better quality of life in their own homes and communities thereby avoiding long stays in hospital;

Objective 3.
to enhance and streamline home care and treatment processes to facilitate effective hospital discharge planning;

Objective 4.
to develop the role of the community pharmacist in the primary care team and establish an integrated and standardised medicines management framework between the primary care and hospital sectors;

Objective 5.
to develop multi-agency strategies and approaches to homelessness, social exclusion, sexual abuse and domestic violence that meet need at an early point to maximise the potential for positive change.

4.19 The cornerstone of an effective primary care service is its skilled staff. However, we do not always make best use of the skilled resources that we have at our disposal. Effective multi-disciplinary team working across organisational and professional boundaries, where appropriate, can do much to streamline the care process and provide for more effective care pathways with referral arrangements channelled through any member of the multi-disciplinary team as 'gate-keeper'. Key objectives in terms of effective ***team working*** over the first five years will be:

Objective 6.
to develop a workforce development and skills enhancement strategy for primary care professionals;

Objective 7.
to develop a single integrated multi-disciplinary assessment process for people with complex needs;

Objective 8.
to develop and implement plans that will promote the introduction of more specialist practitioners and provide for a higher skills base and greater capacity for community based care and treatment;

Objective 9.
to develop community action plans across the community statutory, voluntary and private sectors to make best use of existing capacity and to secure increased commitment of other sectors outside the HPSS (e.g. education, housing, etc.) to joint working.

Goal 3.
To facilitate more informed, proactive engagement and involvement of people in local communities and practitioners in the use, planning and delivery of services.

4.20 Effective user and community engagement in local planning decisions about the nature and design of services is essential if public confidence in the primary care system is to be maintained and strengthened. Public participation and engagement is a prerequisite to the achievement of our aim to develop a pattern of service that responds adequately to local needs and aspirations. The Department will develop an overarching policy to involve people in local communities to help build caring communities, which will develop further initiatives such as the Investing for Health Partnerships. The policy will promote a community development based approach to help encourage the involvement of people and communities with health and social services. Key objectives in terms of ***community engagement*** over the first five years will be:

Objective 1.
to establish innovative approaches and strategies to more effectively engage community and voluntary organisations with practitioners in service planning and delivery;

Objective 2.
to provide people in communities with access to information in order to facilitate a better understanding of the rationale behind, and therefore ownership of, decision making.

4.21 Key to improving access to services and engaging effectively with local communities is the provision of information. This is also of paramount importance to developing individual and community commitment to safeguarding the vulnerable, to healthy lifestyle choices, and to the health promotion and disease management programmes necessary to make a real difference over the next two decades to people's health and wellbeing. Key objectives in terms of ***information*** over the first five years will be:

Objective 3.
to develop an information and communications system that will inform service users and carers about the services available to them and how best to access and use them (including advice on social care issues, treatment and the ongoing management of chronic conditions).

4.22 In addition to the provision of information, there is a need to work with people to help them take greater control of their own conditions through for example provision of self-care support programmes. Primary care professionals will have a significant role in developing and promoting a culture of self-care, taking proactive steps to support and monitor effective self-care among people in the community. These programmes will place a greater emphasis on partnerships across agencies and the community and voluntary sector to provide joined-up action, as envisaged by the Investing for Health Strategy, in order to promote good health and wellbeing in a comprehensive and holistic manner. The aim is to reduce the numbers of people at risk and leading to fewer complications of chronic conditions or breakdown of individual or family functioning. Key objectives in terms of ***self-care*** over the first five years will be:

In this Document the term **self-care** refers to the steps taken that enables individuals to take ownership and make choices that will promote and maintain their good health and wellbeing, and preventing illness and harm. It also involves the support necessary to enable individuals, families and communities to manage long-term or chronic conditions. This might include teaching individuals how to monitor and understand their conditions, self administer care and therapies, and seek care early when problems are developing.

Objective 4.
to develop a strategy designed to strengthen the role of primary care professionals in contributing to improvements in emotional wellbeing, health promotion, health education and disease prevention;

Objective 5.
to develop self-care support programmes for a range of chronic conditions and self-help responses to avoid breakdown in individual or family functioning;

Objective 6.
to review the effectiveness of the direct payments system under which individuals assume responsibility for securing and managing their own care package, using direct funding made available by the HPSS.

Goal 4.
To put in place a care infrastructure fit-for-purpose which provides integrated modern services.

4.23 The vision of a locally based, user and community focused primary care system will only be fully realised when the most appropriate infrastructure is put in place to support it. As indicated earlier, the expansion of assessment, diagnostic, treatment and support services in the community will call for more sophisticated premises than are presently available providing for multi-disciplinary working and enhanced technological links with other areas of the care system. The Department will take forward a major programme of primary and community infrastructure development in the context of the Investment Strategy for Northern Ireland. The key objective in terms of ***physical infrastructure*** over the first five years will be:

Objective 1.
to establish and implement a service infrastructure investment plan to deliver modern fit-for-purpose premises with modern technology through, for example, a network of Primary Care Centres encompassing concepts like community care treatment centres, health and wellbeing centres, diagnostic and treatment centres, family assessment and day care centres, etc.

4.24 Modern integrated services, which use the most advanced equipment, techniques, and multi-disciplinary teams, will be highly dependent on access to prompt, high quality information. It is, therefore, essential to develop and exploit advances in computer and other new technology systems across primary care. Through the development of the current Information and Communications Technology Strategy for health and social services, a range of initiatives will be implemented to improve information links between services, including comprehensive care records, diagnostic and imaging information, and information and advice to people in the community about their health and social care. Those professionals practicing in primary and community care need information to help breakdown barriers between areas of care that can lead to delays in referrals and treatment. Further integration and modernisation of systems will be taken forward in support of primary care providers. The key objective in terms of ***technology infrastructure*** over the first five years will be:

Objective 2.
to develop and implement Information Communication Technology strategies and systems that better facilitate the efficient and effective delivery of primary care services across organisational and professional boundaries.

4.25 The most important asset of primary care is its staff; having the right people with the right skills and attributes is naturally essential to delivering an effective primary care system. Workforce plans designed to address projected capacity needs will be further developed to provide for the development of competencies and roles across all professions, as the service develops and expands integrated working of multi-disciplinary teams. The key objective in terms of ***workforce*** over the first five years will be:

Objective 3.
to put in place appropriately designed human resource policies and practices that allow for the recruitment and retention of sufficient numbers of skilled staff to support the key changes envisaged in the strategy.

4.26 Information to enable evidence based decisions and to inform thinking around future developments is necessary to ensure that primary care services continue to progress and meet future needs. Indeed, education and learning in the future, needs to be at the heart of policy and service development. This needs to be set in the context of the likelihood that an increasing element of education and training of all health and social care professionals will be delivered in a primary care setting. This highlights the need to ensure that there is a vibrant research culture supporting primary care. The key objective in terms of ***research and development*** over the first five years will be:

Objective 4.
to ensure appropriate emphasis is given to research in primary care to develop further evidence-based practice.

Section 5:
Making it Happen

5.1 This vision and policy framework sets out a challenging future agenda for the development of primary health and social care across Northern Ireland. The vision sets out a clear focus and the high-level goals make clear how the many stakeholders can contribute to, or influence, the development of a future primary care service.

5.2 In order to achieve this vision for primary care significant change will be required in:

- the ways in which people access our service;
- the range of services provided;
- how the services are delivered; and
- how services are supported.

5.3 In moving forward, the successful implementation of this Strategic Framework will require shared ownership among all stakeholders. There will be a wide variety of organisations involved and there is a need for shared commitment among all concerned to the common vision for primary care. To make this happen the Department will, for its part, work closely with all of the relevant professions, and the public, in making that vision become a reality.

5.4 In terms of future organisational structures in primary care, the current Review of Public Administration is addressing this matter in the wider context of health and social services generally. The current 15 Local Health and Social Care Groups, which bring together primary care professionals and community user representatives to help assess the needs of local communities and design local services to meet those needs, are, in organisational terms, committees of their Health and Social Services Board. With the abolition of the Boards, the role, number and membership of these Groups will need to be reassessed to ensure that local primary care professionals, local community and hospital staff, service users and local communities will continue to be able to contribute to the commissioning plans of the new Agencies and secure a primary care centred approach to service planning and design.

Financial Resources

5.5 The implementation of this Strategic Framework makes clear the immediate and longer-term changes needed. Delivery will involve the best use of existing as well as new resources to maximise health outcomes and improve the quality of our service.

5.6 Successful implementation will require changes to the way we currently work and how we use our existing resources. This may lead to some change in the way resources are allocated across the primary care and hospital sectors. But the likely future demands on our hospital system, given the technological, demographic and life-style changes referred to earlier, mean that the resources currently allocated to the hospital sector will continue to be required, if that sector is to respond to increasing morbidity and need in the population. It will be incumbent on all health and social services organisations to continue to work together in identifying and developing more efficient and effective ways of working across organisational and sectoral boundaries.

5.7 The direction set by this Strategic Framework means primary care teams will have a key role in ensuring that the hospital sector is utilised to meet demand only where it is appropriate to do so. To achieve this, primary care teams will clearly have to be developed and sufficiently resourced.

5.8 Significant resources are used to deliver health and social services, including primary care. Substantive funding has recently been invested through the new GP contract, and further additional investment in the many different health and social care professional groups working in primary care will also be required. Securing these additional resources in the context of public expenditure will not be easy, given the many challenges and competing priorities faced by Government across the public services generally. Nevertheless, with the assistance and support of those working in health and social services, and particularly primary care, the Department will endeavour to secure the additional resources required.

5.9 In line with existing Government policies, the provision of such additional resources will be conditional on real reform in the way existing resources are deployed and services delivered, with the implementation of integrated team-working being a pre-requisite for further development. Furthermore, in allocating resources the need to determine best value and ensure affordability will remain paramount in developing future services, and decision-making will aim to be evidence-based in order to help secure the most efficient and effective use of resources across primary care services. For example, Northern Ireland spends proportionately more on prescription drugs than the rest of the United Kingdom. We need to tackle this with a degree of urgency so that resources unnecessarily devolved to this area can be released to other priority service development.

Human Resources

5.10 Arguably the most important change required to bring about this Strategic Framework will not be systems but the people in them. The vision and its associated goals represent significant change. It will therefore require careful and sensitive management of the change process. New workforce plans to meet future needs will be required and the Department has already begun work in this important area, taking into account the need for a future to be characterised by a multi-professional approach to delivering health and social care. The work focuses on the recruitment, retention and continuous professional development of staff across the health and social services. A number of workforce reviews are ongoing, which look at the likely demand and supply in a range of medical and social care disciplines. These will help inform the development of multi-professional workforce plans. There will also be a need for professional groups to consider themselves how they develop in ways that place increased importance on working in multi-disciplinary teams.

5.11 In addition, to providing new disciplines with a range of new skills, continuous professional development programmes will need to be further developed for professionals and staff, and particular attention will also need to focus on the development of those that provide key support to professionals, such as care assistants, carers and volunteers – without whom service provision would inevitably falter.

Equality

5.12 A key objective of this Strategic Framework is to promote equality of opportunity for all: It addresses key issues of access and places emphasis on delivering services that meet the needs of all individuals and communities – the infrastructural development programme will benefit all areas, especially rural areas. It promotes, in particular, development of new services for those members of our society who are the most vulnerable or marginalised providing for more responsive services in the community. The elderly, people with disability, children and people living with social disadvantage will all benefit. The Framework embraces the New Targeting Social Need policy seeking to ensure that access to services are made available to all, and that where necessary specific steps should be taken to target those in greatest social need in our community. Actions and related strategies taken forward by the Department and other health and social services organisations will take account of poverty, deprivation and the ill effects of social exclusion.

5.13 In addition, the values that underpin the Strategic Framework should contribute to maximising equality in the widest sense. In accordance with best practice an equality screening of the Framework has been undertaken. In examining the Strategic Framework against the categories set out in Section 75 of the Northern Ireland Act 1998, the needs of rural communities were also considered. These screening processes have identified no potentially negative equality impacts. Particular attention will be paid to the access issues brought about within rural settings, and means to help address this identified, developed and implemented across the wide range of services provided through primary and community care.

Implementation

5.14 The vision, its principles and values, together with the high-level goals and related actions that make up this Strategic Framework have been developed through an open and participative process, drawing on the views of people who use and those who deliver health and social services. The Strategic Framework has been

crafted to integrate with the overall Regional Strategy and other key strategies, including Developing Better Services and Investing for Health.

5.15 The Department will establish a Strategic Framework Monitoring Group to help ensure the effective implementation of the Primary Care Strategic Framework. The Group will consider progress annually and provide advice to the Department on the implementation and review of the Framework. It will also seek to influence health and social services, and organisations with a contribution to make, to encourage the effective realisation of the vision for primary care services. Its membership will comprise representation of the key stakeholder groups associated with primary care.

5.16 An implementation plan which makes clear the Goals and related objectives and detailed actions to be achieved within the next five years have been set out in annex 1. The implementation plan will be monitored as actions and objectives are progressed. The implementation plan will be a flexible and evolving planning document, and future actions will be identified and developed to ensure that the change process is continuous, and that appropriate contributions are made to advance the achievement of the vision. The public, service users, people working in the health and social services will be encouraged to contribute to the process of determining future actions.

5.17 A key factor necessary to ensure progress is leadership. A vision for primary care, together with a policy framework that reflects the collective views of a wide range of people and organisations sets the direction. The implementation plan sets out a series of actions to be taken forward on a series of fronts, but real change will be dependent on change drivers and champions for change in primary care. Health service organisations, practitioners and people in communities need to take responsibility to help bring about the desired change, as well as Government. The Department will work to foster strong and effective leadership at all levels within primary care to better ensure successful outcomes.

Conclusion

5.18 An integral part of the change process will be the re-positioning of primary care in a way that acknowledges and reinforces its centrality to the provision of health and social services and raises its profile in the public mind. This in turn will require that effective action flows from the strategic and operational statements set out in this document and other related strategic plans.

5.19 The implementation of this Framework will involve very substantial change in the nature, scope and delivery of local primary care services. It will change current patterns of services and expenditure giving increased emphasis to educative, preventive and treatment programmes in the community rather than avoidable treatments in hospital or residential settings. This approach is consistent with international developments in health and social care.

5.20 The Department is determined that Northern Ireland should be an integral part of that positive movement and this Strategic Framework sets out a vision and a way forward to achieve this goal. The Department encourages individuals, communities and professionals to embrace the changes proposed, thereby securing for the whole population of Northern Ireland the quality of primary care services that individuals, families and communities deserve.

For Individuals,
Families and
Communities

GOAL 1.

To make primary care services more responsive and accessible and encompass a wider range of services in the community.

Objective 1. To deliver to people within a minimum of 24 hours appropriate and equitable access to all primary care services.	
Action 1.	Complete a review and evaluation of access to all primary care services by 2007.
Action 2.	Develop regional access standards for all primary care services by 2008.
Action 3.	Establish programme to deliver access standards by 2009.

Objective 2. To provide a comprehensive primary care out of hours emergency care service providing access, as appropriate, not only to general medical, general dental and community pharmacy services, but also to community nursing, mental health, and other social care services.	
Action 1.	Establish immediate project to develop a Regional Out-of-Hours service, which provides access to multi-disciplinary care and treatment.
Action 2.	By April 2007, implement programme to establish Regional Out-of-Hours service, as part of the Reform and Modernisation programme.

Objective 3. To develop a broad range of multi-disciplinary assessment and treatment services in primary care.	
Action 1.	By April 2006, to put in place a range of primary care based assessment and treatment services in appropriate specialties to provide speedier access to appropriate health and social care professionals.
Action 2.	By 2008, to extend the provision of primary care based assessment and treatment services which provide a comprehensive range of services that reflect the many specialties currently provided through hospital.

Objective 4. To develop and implement a range of primary care strategies for community care, community pharmacy, community nursing, child and family support, general medical services, general dental services, optometric services, older people and carers services and services delivered by allied health professionals.

Action 1.	Expand respite care services for Carers by March 2006.
Action 2.	Develop Community Nursing strategy by March 2006.
Action 3.	Continue implementation of the Community Pharmacy strategy and development of new contract for community pharmacists by March 2006.
Action 4.	Develop an Allied Health Professionals strategy for primary care by 2006.
Action 5.	Develop a Primary Medical Services strategy by 2007.
Action 6.	Develop Primary Dental Care strategy and new contract for primary care dental practitioners by March 2007.
Action 7.	Develop Ophthalmic Services strategy by 2008.

Objective 5. To provide for improved management of chronic conditions in the community by developing and implementing plans for the increased deployment of multi-disciplinary care teams.

Action 1.	By 2006, evaluate and review the provision of multi-disciplinary care pathways for a range of chronic conditions: diabetes, coronary heart disease, stroke recovery, arthritis and muscular-skeletal problems, chronic obstructive pulmonary disease, asthma, depression, stress and pain management.
Action 2.	Identify capacity needs for multi-disciplinary care pathways in respect of chronic condition management, by March 2007.
Action 3.	Develop strategies for enhancing multi-disciplinary team working to more effectively address chronic condition management, by 2008.

Annex 1

PRIMARY CARE STRATEGIC FRAMEWORK
IMPLEMENTATION PLAN 2005/6 - 2009/10

Objective 6. To initiate new case management arrangements for at risk people involving multi-disciplinary primary care teams proactively working with and supporting individuals to help avoid unnecessary emergency hospital admissions.

Action 1. Review and evaluate current case management arrangements for at risk people in primary care by March 2006.

Action 2. By 2007, develop and implement a programme to establish new case management arrangements.

Objective 7. To develop and implement strategies to provide for effective, community based and person-centred services for people with learning disabilities and mental illness.

Action 1. By 2006, evaluate findings of mental health review in respect of primary care services.

Action 2. Develop and establish a programme to implement review recommendations in primary care services by 2007.

GOAL 2.

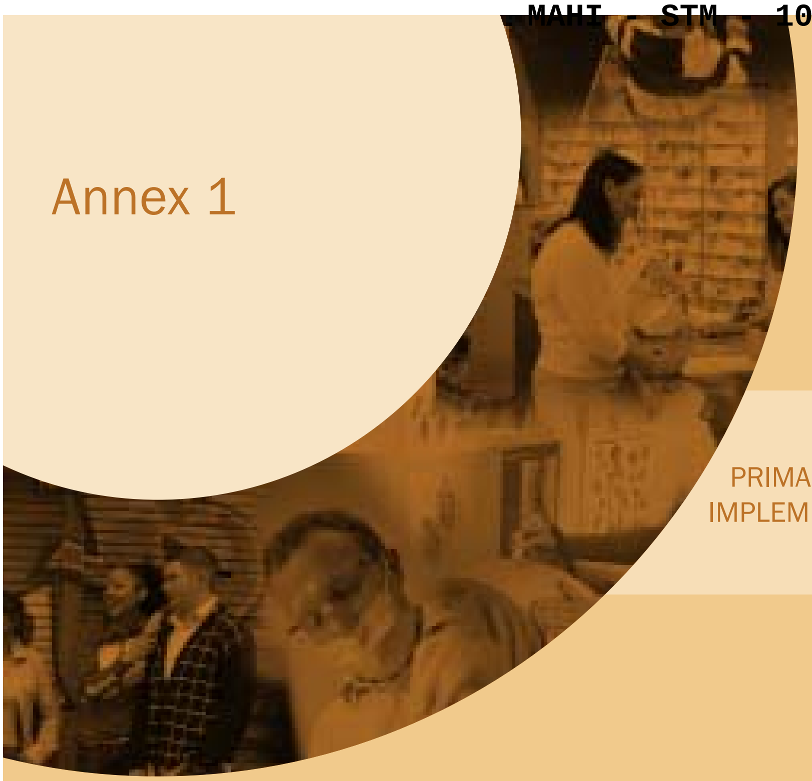
To develop more effective partnership working across organisational and professional boundaries to provide more effective and integrated team working.

Objective 1. To develop and implement multi-disciplinary protocols and professional standards to ensure that people receive care and treatment in the place most appropriate to their needs by staff who are appropriately skilled.	
Action 1.	Evaluate current multi-disciplinary approaches to care, particularly in the training of practitioners, by 2006.
Action 2.	Develop plans to deliver training and development standards to facilitate increased multi-disciplinary working by 2007.

Objective 2. To develop community rehabilitation models of care, which help people to regain and maintain independence and achieve a better quality of life in their own homes and communities thereby avoiding long stays in hospital.	
Action 1.	By March 2006, HPSS delivery agents should develop plans designed to ensure more effective use of intermediate care to support community based rehabilitation.
Action 2.	By 2007, monitor and evaluate measures taken to facilitate the early discharge of patients from hospital.

Objective 3. To enhance and streamline home care and treatment processes to facilitate effective hospital discharge planning.	
Action 1.	By 2006, establish mechanisms to identify patients with recurrent episodes of inpatient care, and develop a primary care managed care service within the community setting.
Action 2.	By 2007, establish procedures to provide alternative to hospital care packages, minimising hospital admissions, or providing for early discharge to care closer to, or at home.

Annex 1



PRIMARY CARE STRATEGIC FRAMEWORK IMPLEMENTATION PLAN 2005/6 - 2009/10

Objective 4. To develop the role of the community pharmacist in the primary care team and establish an integrated and standardised medicines management framework between the primary care and hospital sectors.	
Action 1.	Continue to implement the Community Pharmacy strategy.
Action 2.	Throughout the period, develop and extend the Building the Community Pharmacy Partnership programme as a model of good practice in community development between the professional services and voluntary and community sectors.
Action 3.	Establish new community pharmacy contract by April 2006.
Action 4.	Develop and implement pharmaceutical service improvement programme by October 2005.

Objective 5. To develop multi-agency strategies and approaches to homelessness, social exclusion, sexual violence and domestic violence that meet need at an early point to maximise the potential for positive change.	
Action 1.	By 2007, evaluate and review the implications for primary care identified in the multi-agency strategies to homelessness, social exclusion, sexual violence and domestic violence.
Action 2.	By 2008, develop and implement a programme to address the primary care aspects of the multi-agency strategies.

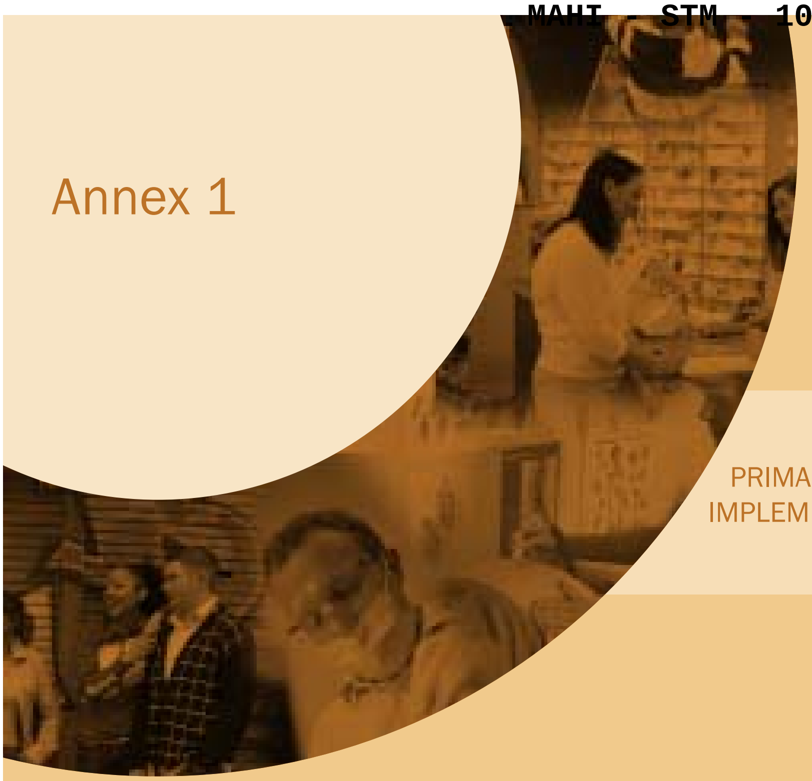
Objective 6. To develop a workforce development and skills enhancement strategy for primary care professionals.	
Action 1.	By 2007, review the training needs of primary care workforce.
Action 2.	By 2008, develop and implement a strategy to enhance the skills base in primary care workforce over 10-year period.

Objective 7. To develop a single integrated multi-disciplinary assessment process for people with complex needs.	
Action 1.	By 2008, develop a single assessment tool for the care of older people and implement across the HPSS.
Action 2.	By 2010, have piloted and published a new integrated assessment process.

Objective 8. To develop and implement plans that will promote the introduction of more specialist practitioners and provide for a higher skills base and greater capacity for community based care and treatment.	
Action 1.	By 2007, review and evaluate scope for increased specialisms in primary care.
Action 2.	By 2008, develop and implement a programme to provide for the strategic deployment of primary care specialist practitioners.

Objective 9. To develop community action plans across the community, statutory, voluntary and private sectors to make best use of existing capacity and to secure increased commitment of other sectors outside the HPSS (e.g. education, housing, etc.) to joint working.	
Action 1.	Develop a Community Development Strategy Action Plan, which promotes joint working with community, voluntary and private sectors in primary care.
Action 2.	By 2008, develop action plans and protocols for inclusive engagement of community, voluntary and private sector organisations in the provision of primary care services.

Annex 1



PRIMARY CARE STRATEGIC FRAMEWORK
IMPLEMENTATION PLAN 2005/6 - 2009/10

GOAL 3.

To facilitate more informed, proactive engagement and involvement of people in local communities and practitioners in the use, planning and delivery of services.

Objective 1. To establish innovative approaches and strategies to more effectively engage community and voluntary organisations with practitioners in service planning and delivery.	
Action 1.	In light of recommendations arising from the Review of Public Administration, determine structures and procedures to be implemented that will strengthen the role of community and voluntary organisations in service planning and delivery.
Action 2.	By 2007, develop an overarching policy for involving people in the identification of need, planning and delivery of primary care services.

Objective 2. To provide people in communities with access to information in order to facilitate a better understanding of the rationale behind, and therefore ownership of, decision making.	
Action 1.	Develop a proactive service user communication strategy by 2007, in accordance with Freedom of Information and Data Protection Act requirements.

Objective 3. To develop an information and communications system that will inform service users and carers about the services available to them and how best to access and use them (including advice on social care issues, treatment and the ongoing management of chronic conditions).

Action 1.	By March 2006, review and evaluate scope for different mediums to communicate services information to the public.
Action 2.	By 2007, develop and implement a primary care Information Strategy for delivering service information to the public.

Objective 4. To develop a strategy designed to strengthen the role of primary care professionals in contributing to improvements in emotional wellbeing, stable relationships, health promotion, health education, disease prevention, and the development of safe and caring communities.

Action 1.	By March 2007, complete review of Investing for Health strategy. (To ensure significant improvement in health and social wellbeing, and reduction in health inequalities is achieved by 2012).
Action 2.	By 2008, evaluate and identify scope for primary care professionals to contribute to promotion and maintenance of good health and social wellbeing.
Action 3.	By 2009, develop a programme for primary care professionals to establish proactive steps to promote and maintain good health and social wellbeing within local communities.

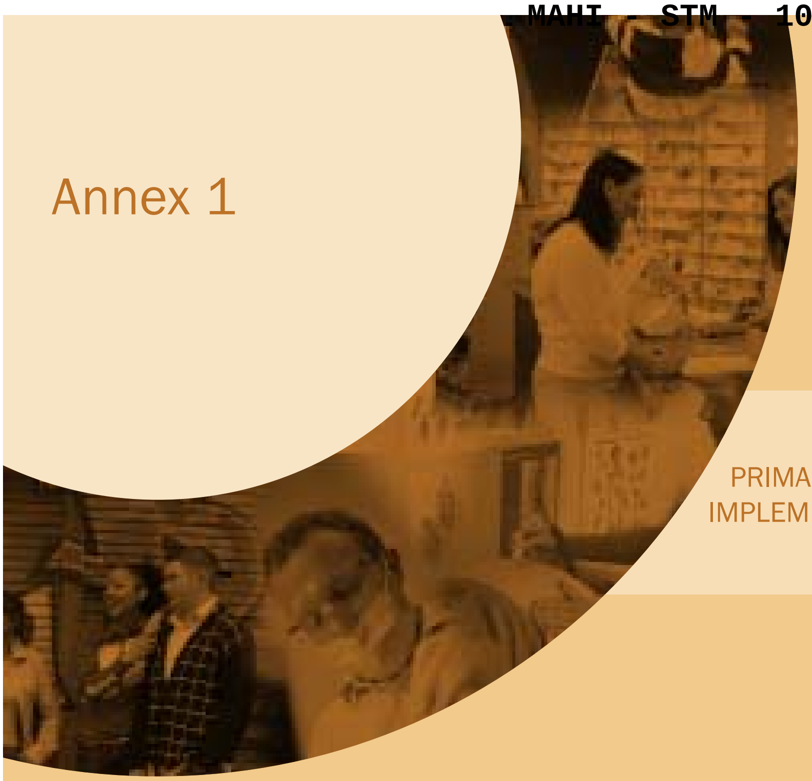
Objective 5. To develop self-care support programmes for a range of chronic diseases and conditions, and self-help responses to avoid breakdown in individual or family functioning.

Action 1.	Throughout the period, further develop direct care from the pharmacy, currently known as minor illness schemes.
Action 2.	By 2007, review and evaluate scope for the development of self-care support programmes across primary care services.
Action 3.	By 2008, develop a self-care support programme that facilitates and encourages primary care practitioners to take proactive action.

Objective 6. To review the effectiveness of the direct payments system under which individuals assume responsibility for securing and managing their own care package, using direct funding made available by the HPSS.

Action 1.	By 2008, review and evaluate the cost effectiveness of the direct payments scheme.

Annex 1



GOAL 4.

To put in place a care infrastructure fit-for-purpose which provides integrated modern services.

Objective 1. To establish and begin to implement a service infrastructure investment plan to deliver modern fit-for-purpose premises with modern technology through, for example, a network of Health and Care Centres encompassing concepts like community care treatment centres, health and wellbeing centres, diagnostic and treatment centres, family assessment and day care centres, etc.

Action 1.	Commence evaluation of Outline Business Cases for a major programme of primary and community care infrastructure development, in context with the Investment Strategy for Northern Ireland.
Action 2.	In line with Outline Business Case timescales, commence first traunch of approved capital development works.

Objective 2. To develop and implement Information Communication Technology strategies and systems that better facilitate the efficient and effective delivery of primary care services across organisational and professional boundaries.

Action 1.	By 2006, review and evaluate Information Communication Technology needs across primary care services.
Action 2.	By 2008, develop a primary care Information Communication Technology strategy and investment plan, to modernise systems in support of primary care service providers.
Action 3.	Implementation of the ‘Patient Centred Information System’, an electronic care records system, to be completed by 2010.
Action 4.	By 2010, modernise the Health and Social Services network infrastructure, providing links between the different health and social care services.

Objective 3. To put in place appropriately designed human resource policies and practices that allow for the recruitment and retention of sufficient numbers of skilled staff to support the key changes envisaged in the strategy.

Action 1.	Review and evaluate the capacity and workforce needs in primary care, to help deliver the key changes envisaged in the strategy, by 2007.
Action 2.	By 2008, develop a primary care human resources strategy to meet key changes envisaged in the strategy.

Objective 4. To ensure appropriate emphasis is given to research in primary care to develop further evidence-based practice.

Action 1.	By 2006, review and evaluate current research base in primary care.
Action 2.	By 2007, develop and implement primary care research programme.

Annex 2

DESIGN PRINCIPLES

1) Primary Care services will be focused on the needs of individuals, families and communities.

2) Primary Care services will be located and rooted in the local community it serves, and will work to understand and serve the needs of that community.

3) Primary Care services will, as far as possible and with service user agreement, manage and share information so that service users do not have to “tell their story” many times to different practitioners.

4) Primary Care services will be readily accessible, responsive, integrated, co-ordinated, flexible and innovative in the way they deal with the needs of individuals, families and communities.

5) Primary Care services will be holistic in nature, making the fullest possible assessment of population needs and bring to bear the most appropriate range of services to benefit citizens and their communities.

6) Primary Care services will not be constrained by traditional or perceived boundaries between those working in different sectors or disciplines and will maximise benefits of team approaches in providing support, care and treatment.

7) Primary Care services will proactively address the needs of the vulnerable, support individual’s and families’ functioning, support health promotion and disease protection and prevention and will help people to understand their own health and care needs and better manage these.

8) Primary Care services will streamline and co-ordinate care pathways between the primary care and acute sectors, seeking to maximise the extent to which people can be cared for at home.

9) Primary Care services will operate to high standards of quality, probity, professionalism and accountability.

CORE VALUES

We will promote and practice the following values in delivering primary care services -

- **Empowerment** – providing individuals with the opportunity to take greater responsibility for their own health and wellbeing, and putting people at the centre of service provision.

- **Respect** – treating people with dignity, and respect for all staff and practitioners involved in service delivery.

- **Partnership** – working collaboratively with service users and across all disciplines, sectors and specialisms in primary care to ensure an integrated team based approach, collaborating with agencies, outside primary care, and working with people in their local communities.

- **Excellence** – promoting excellence in service delivery and building on evidence-based best practice.

- **Community** – anchoring primary care in a community context, and to the maximum extent possible, enabling all members of that community to have a voice in service design, delivery and review.

- **Safety** – ensuring that practice and services are of the highest possible quality and in partnership with communities and other agencies ensuring that services safeguard vulnerable people by dealing with concerns about risk and harm sensitively and effectively.

- **Continuity** – ensuring a co-ordinated and integrated approach to health and social care within primary care, and with other Health Social Services and other sectors, and ensuring a safe and inhabitable environment as well as continuity of care within the system.

- **Value for Money** – ensuring that all services are affordable and delivered efficiently and cost effectively.

- **Equity** – consistency and fairness in service delivery to ensure equity of access and treatment for those in need of services.

Annex 3

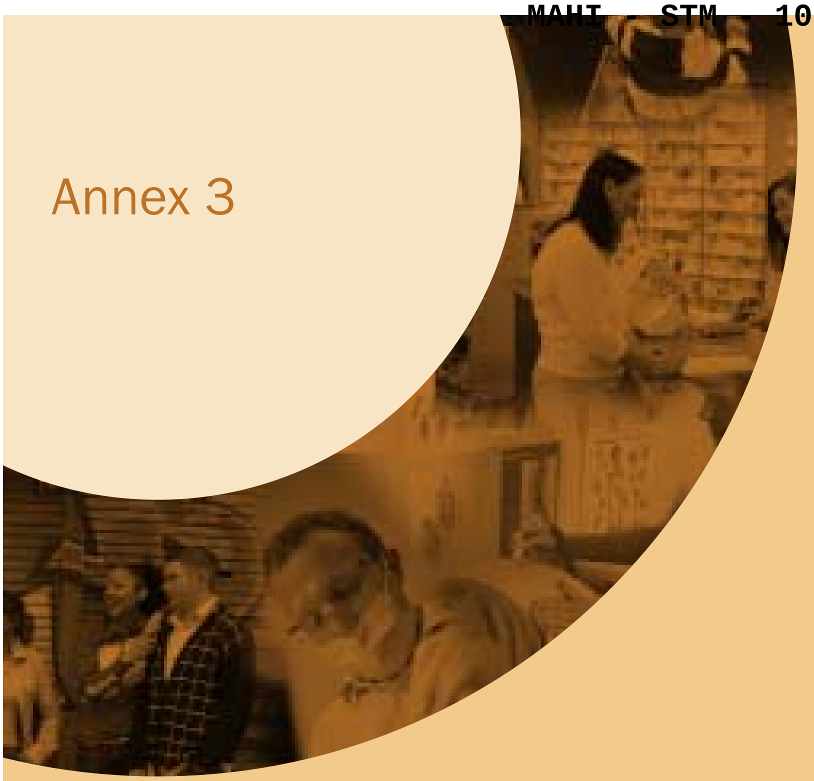
List of Consultation Respondents

The Department would like to thank the following people, groups and organisations in providing views and comments, which have helped to inform and shape the Strategic Framework for Primary Care.

North and West Belfast Training Team
Gosford Housing Association
Adult Mental Health Review
Breathe Easy Causeway
Ballymena Borough Council
Help the Aged
Westcare
Causeway Bereavement Support Group
Northern Ireland Optometric Society
British Lung Foundation
Mental Health Alliance Coordinator – Down Lisburn Trust
Family Information Group
East Down Rural Community Network
Homefirst Community Trust
Dr Henderson, Chair Eastern Area Local Dental Committee
Foyle Health and Social Services Trust
Podiatry Managers' Group (Northern Ireland)
Royal College of Nursing Northern Ireland (Agenda for Change)
John Clarke, Victims Unit, Office of the First Minister and Deputy First Minister
Lobbying, Activism and Research Group (Dungannon)
Joanne Black (Member of the Public)
Craigavon and Banbridge Community Health and Social Services Trust
Omagh 2010 Taskforce
Aware Defeat Depression
British Psychological Society Northern Ireland Branch

Health and Social Services Councils
Ann Spencer, Team Leader Physiotherapist Community, Newry and Mourne Trust
Sister Donna Keenan, Tyrone County Hospital
Omagh District Council
Anonymous Voluntary Group
Belfast City Council
Northern Ireland General Practitioners Committee
Epilepsy Action, Armagh Branch
Royal College of Midwives
Northern Ireland Housing Executive
Northern Ireland Practice and Education Council for Nursing and Midwifery
Belfast Health Initiative – Springhill
Royal College of General Practitioners Northern Ireland
Skegoneill Health Centre
Healthy Living Centre – Upper Springfield
South and East Belfast Trust
Simon Community Northern Ireland
West Belfast Partnership Board
Advocacy for Senior Citizens Coleraine
British Dental Association Northern Ireland
Eastern Local Medical Committee
Royal College of Nursing Northern Ireland
Central Nursing Advisory Committee
Craigavon Borough Council
Ulster and Community Hospitals Trust
North and West Belfast Health Action Zone – Travellers Action Group
Antrim Borough Council
Royal College of Psychiatrists
Newtownabbey Borough Council
Asthma UK Northern Ireland
Northern Ireland Affairs Committee, Royal College of Physicians United Kingdom, Faculty of Public Health
Green Park Healthcare Trust
North and West Belfast Health and Social Services Trust
Springhill Community House
Carers Northern Ireland
Helen Gilmore – Sperrin Lakeland Trust
Craigavon and Banbridge Health and Social Care Group
Royal Hospitals
Armagh and Dungannon Health and Social Care Group
Ophthalmic Committee – Central Services Agency

Annex 3



Springfield Road Surgery
Arthritis Care Northern Ireland
Northern Ireland Sessional Doctors Association
Katie McCormack (user)
Western Investing for Health Partnership
Altnagelvin Hospitals Health and Social Services Trust
Northern Ireland Women's Aid Federation
Community Mental Health Team (Ulster Community and Hospitals Trust)
Catherine McNally Environmental Health Officer, Coleraine Borough Council
Chartered Society of Physiotherapy Northern Ireland
Diabetes United Kingdom Northern Ireland
Eastern Health and Social Services Board
Northern Health and Social Services Board
Armagh and Dungannon Health and Social Services Trust
Foyle Health and Social Services Trust
Ards Borough Council
Nexus
Newry and Mourne Local Health and Social Care Group
Director of Primary Care, Southern Health and Social Services Board
Sinn Fein
Western Health and Social Services Board
Local Optical Committees in Northern Ireland

NOTES

Caring For People
Beyond Tomorrow...

For Individuals,
Families and
Communities

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TRA

Transforming Your Care

A Review of Health and Social Care in Northern Ireland

Transforming Your Care

A Review of Health and Social Care in Northern Ireland

December 2011

The Review Team would like to thank the Project Team:

Pamela McCreedy – Project Leader
Angela Hodkinson, Elaine Hunter, Seamus Carey – Project Managers
Ffiona Dunbar, Maria Higgins, Jonathan Houston – Project Support

1. INTRODUCTION

The task faced by the Review was both challenging and daunting. Health and Social Care is of interest to everyone in Northern Ireland and the team approached their task fully aware of the responsibility it had been given.

It was also aware that whilst it was important to look to best practice and examine data from outside the province the deliberations had, in the end, to make sense for Northern Ireland. Many drivers exist in this context: the importance of health and social care to the economic wellbeing of NI; the contribution staff make; the shadow of our recent history in NI, particularly in the mental well being of the citizenry; and the very powerful affinity the NI society has to the core NHS principles.

The team approached its task with that knowledge and these matters were reflected exhaustively in their deliberations. However, the overriding desire of the team was to describe and build a system of health and social care which would place the individual, family and community that use it at the heart of how things are done. That meant using evidence to explain why there needs to be change and concentrate on the outcomes that individuals could reasonably expect in a modern system of care and treatment.

The Review is therefore about change; not careless or haphazard change but planned change over a 5 year period that can and should improve care. The report may be contentious to some, but the Review team saw clearly that there are no neutral decisions as it looks to the future. It has taken the view that a managed and transparent change is better than unplanned, disorganised change.

Finally on behalf of the team I should like to thank the very many people, citizens, professionals and representatives of interest groups who gave freely of their time to help the Review. I should also like to extend thanks to the independent panel members for their honesty, challenge and contribution to the Review.

John Compton
Chair of the Review Team

December 2011

EXECUTIVE SUMMARY

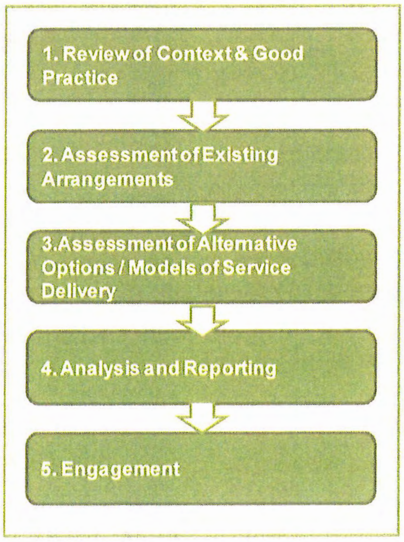
2. EXECUTIVE SUMMARY

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care (HSC) Services in Northern Ireland would be undertaken. The Review was to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met. Crucially it was to bring forward recommendations for the future shape of services and provide an implementation plan. The Review team was not asked to bring forward proposals which reduced the budget published by the Northern Ireland Executive, but was asked to ensure that it was used to best effect.

The Minister judged that at a time of considerable flux within health and social care and the wider economy it was prudent not to disconnect the service from the Review process. Therefore, he appointed John Compton, Chief Executive of the Health and Social Care Board, to complete the task in an ex-officio capacity. However, the Minister did want a strong independent overview to the process, helping to shape and providing challenge to any proposals. Therefore he also appointed an independent panel comprising: Professor Chris Ham (Chief Executive of the King's Fund), Professor Deirdre Heenan (Provost and Dean of Academic Development at the Magee Campus), Dr Ian Rutter (General Practitioner), Mr Paul Simpson (retired senior civil servant), and Mr Mark Ennis (Executive Chair of SSE Ireland).

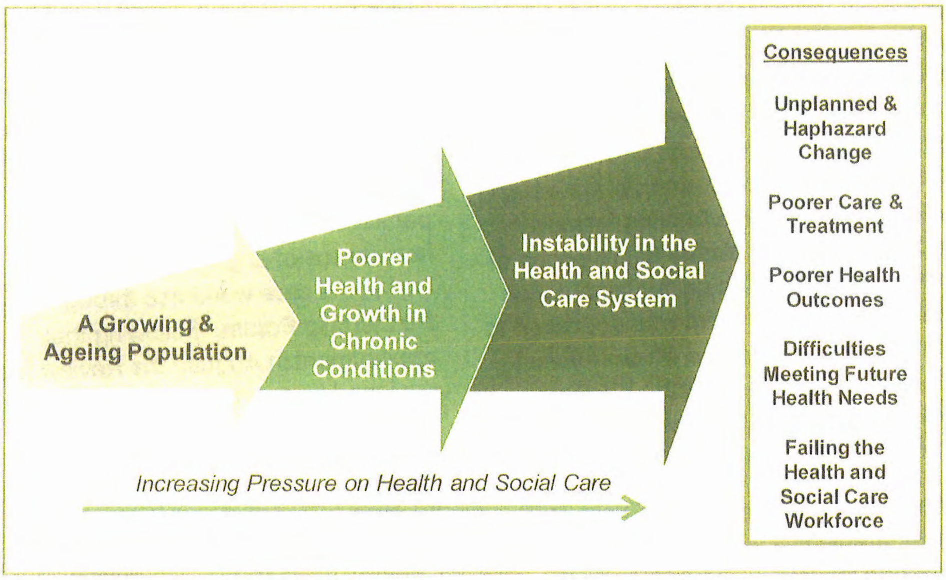
The Review was to complete by 30 November 2011. Within the timescale available, the Minister was keen to ensure maximum engagement with the public, clinical and professional leaders, health and social care organisations and stakeholders in the voluntary, community, private and independent sectors. In particular the Minister highlighted the importance of engaging with the health and social care workforce through the Partnership Forum. Following their appointment in August, the Review team designed its approach as shown below.

Figure 1: Overview of Approach



The Review concluded that there was an unassailable case for change. The figure below illustrates the core of the argument.

Figure 2: Future Model for Integrated Health and Social Care



Responding to these pressures, the Review identified eleven key reasons which support the need for change (summarised in the adjacent box) along with a model of health and social care which would drive the future shape and direction of the service.

Figure 3: Reasons for Change

To be better at preventing ill health

To provide patient-centred care

To manage increasing demand across all programmes of care

To tackle health inequalities

To deliver a high-quality, evidence-based service

To support our workforce in delivering the necessary change

In developing a new model, the Review engaged with over 3000 members of the public, clinicians, providers and interest groups. It also reviewed evidence to ensure that any changes required had at their heart better outcomes for patients and clients and their families.

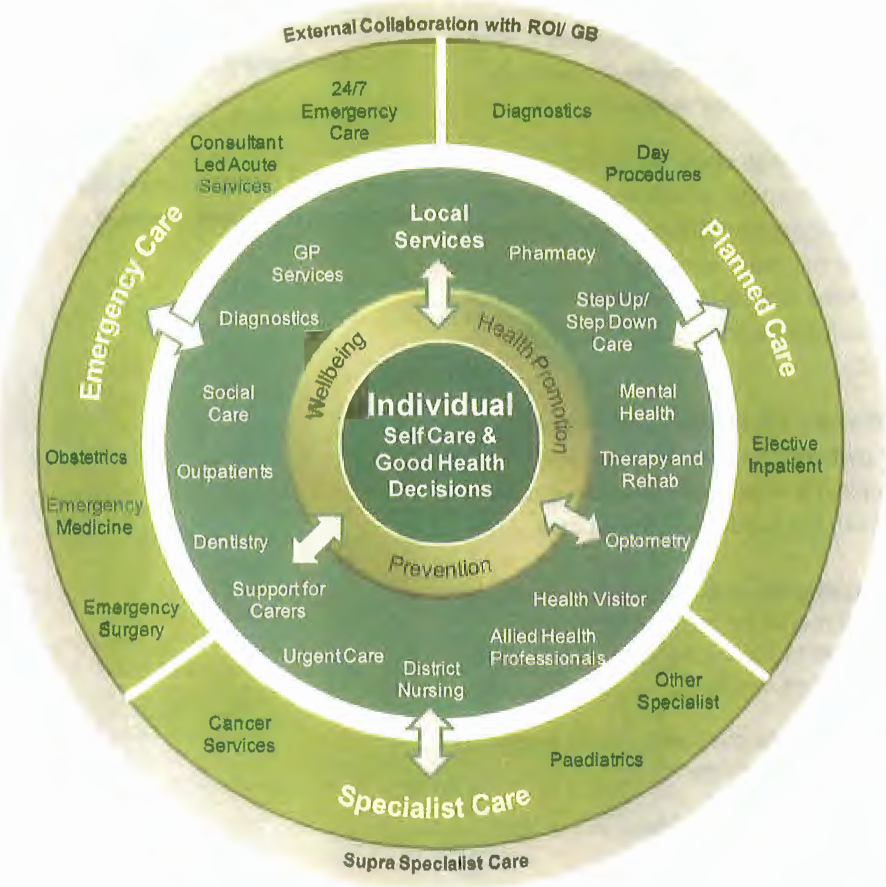
The Review was clear about the purpose of change namely, what changes would make the greatest difference to outcomes for patients, users and carers. In doing so the Review looked beyond the geographical boundaries of Northern Ireland.

The Review identified twelve major principles for change, which should underpin the shape of the future model proposed for health and social care.

1. Placing the individual at the centre of any model by promoting a better outcome for the service user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.
5. A focus on prevention and tackling inequalities.
6. Integrated care – working together.
7. Promoting independence and personalisation of care.
8. Safeguarding the most vulnerable.
9. Ensuring sustainability of service provision.
10. Realising value for money.
11. Maximising the use of technology.
12. Incentivising innovation at a local level.

The model devised by the Review team is shown in the figure overleaf.

Figure 4: Future Model for Integrated Health and Social Care



Briefly described the model means:

- every individual will have the opportunity to make decisions that help maintain good health and wellbeing. Health and social care will provide the tools and support people need to do this;
- most services will be provided locally, for example diagnostics, outpatients and urgent care, and local services will be better joined up with specialist hospital services;
- services will regard home as the hub and be enabled to ensure people can

be cared for at home, including at the end of life;

- the professionals providing health and social care services will be required to work together in a much more integrated way to plan and deliver consistently high quality care for patients;
- where specialist hospital care is required it will be available, discharging patients into the care of local services as soon as their health and care needs permit; and
- some very specialist services needed by a small number of people will be provided on a planned basis in the ROI and other parts of the UK.

To help illustrate what this would mean, case studies were developed to explain the model. In essence they show it to be simpler to use, clearer about the key worker, and crucially providing an improved outcome for those who use the service.

Following on from this, the impact on ten major areas of care was examined:

Population Health and Wellbeing

Older People

People with Long-Term Conditions

People with a Physical Disability

Maternity and Child Health

Family and Child Care

People using Mental Health Services

People with a Learning Disability

Acute Care

Palliative and End of Life Care

The model was applied to these service areas and each has a series of recommendations. The full list of 99 proposals is provided Section 19 of the report.

The key themes in the recommendations are summarised below.

Quality and outcomes to be the determining factors in shaping services.

Prevention and enabling individual responsibility for health and wellbeing.

Care to be provided as close to home as practical.

Personalisation of care and more direct control, including financial control, over care for patients and carers.

Greater choice of service provision, particularly non-institutional services, using the independent sector, with consequent major changes in the residential sector.

New approach to pricing and regulation in the nursing home sector.

7

Development of a coherent 'Headstart' programme for 0-5 year old children, to include early years support for children with a disability.

A major review of inpatient paediatrics.

In GB a population of 1.8million might commonly have 4 acute hospitals. In NI there are 10. Following the Review, and over time, there are likely to be 5-7 major hospital networks.

Establishment of a clinical forum to ensure professionals are fully engaged in the implementation of the new model.

A changing role for general practice working in 17 Integrated Care Partnerships across Northern Ireland.

Recognising the valuable role the workforce will play in delivering the outcomes.

Confirming the closure of long-stay institutions in learning disability and mental health with more impetus into developing community services for these groups.

Population planning and local commissioning to be the central approach for organising services and delivering change.

Shifting resource from hospitals to enable investment in community health and social care services.

Modernising technological infrastructure and support for the system.

Following from this, the Review considered and presented the methodology to make the change over a 5 year period.

This initially describes a financial remodelling of how money is to be spent indicating a shift of £83million from current hospital spend and its reinvestment into primary, community and social care services. It goes on to describe as integral the need for transitional funding of £25million in the first year; £25million in the second year; and £20 million in the third year enable the new model of service to be implemented

In conclusion, the Review reiterates that change is not an option. It re-affirms there are no neutral decisions and there is a compelling need to make change. The choice is stark: managed change or unplanned, haphazard change. The Review team commends its report to the Minister.

BACKGROUND TO THE REVIEW

3. BACKGROUND TO THE REVIEW

This part of the report explains the nature and purpose of the Review. It sets out who was involved and why, then describes the objectives set for the Review, the scope of the task and the approach taken to complete it.

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care Services in Northern Ireland would be undertaken, asking how it should change and requesting an implementation plan to manage the change. The full terms of reference is included at Appendix 1.

The key objectives of the Review were to:

- undertake a strategic assessment across all aspects of health and social care services;
- undertake appropriate consultation and engagement on the way ahead;
- make recommendations to the Minister on the future configuration and delivery of services; and
- set out a specific implementation plan for the changes that need to be made in health and social care.

The Review was not to be fully independent and Mr John Compton, Chief Executive of the Health and Social Care Board, was invited to lead the process. The Minister judged that at a time of considerable flux within health and social care and the wider economy it was prudent not to disconnect the service from the Review process. However he did want a strong independent overview to the process providing challenge to any proposals. Accordingly he appointed five independent panel members:

- Professor Chris Ham (Chief Executive of the King's Fund);
- Professor Deirdre Heenan (Provost and Dean of Academic Development at the Magee Campus, University of Ulster);
- Dr Ian Rutter (General Practitioner);
- Paul Simpson (retired senior civil servant); and
- Mark Ennis (Executive Chair of SSE Ireland).

The appointments reflected the desire to ensure proper scrutiny was applied to the process.

The Minister's over-riding concern is driving up the quality of care for clients and patients, improving outcomes and enhancing the patient experience. In initiating the Review, the Minister explained that he wanted it to ensure that health and social services are focused, shaped and equipped to improve the quality of care and outcomes for the population, and to provide value for money in financially challenging times. He wants to see a shift in care currently carried out in hospitals into the community with patients being treated in the right place, at the right time and by the right people.

The Minister also made it clear that in deciding to have a Review no criticism was implied about staff working in the current system. Quite the reverse, he concluded that the current model was unsustainable going forward and that he wanted to see a service which was developing not declining, a service which built upon the commitment and expertise of those working in health and social care.

OBJECTIVES

Accordingly the objectives of the Review were to:

- provide a strategic independent assessment across all aspects of health and social care services of the present quality and accessibility of services and the extent to which the needs of patients, clients, carers and communities are being met by existing arrangements in terms of outcomes, accessibility, safety, standards, quality of services and value for money;
- undertake appropriate consultation and engagement on the way ahead with the public, political representatives through the Assembly Health Committee, HSC organisations, clinical and professional leaders within the system, staff representatives through the Partnership Forum, and stakeholders in the voluntary, community, independent and private sectors;
- make recommendations to the Minister on the future configuration and delivery of services in hospital, primary care, community and other settings; and
- set out a specific implementation plan for the changes that need to be made in the HSC, including proposals in relation to major sites and specialities.

SCOPE

In delivering these objectives the Review was to take account of the following:

- extant policy and strategies approved by the Minister, in particular the aims of improving public health, the prevention of illness and of improving outcomes for patients and clients;
- statutory duties on the HSC to improve the quality of services provided, to improve the health and social wellbeing of the population and to reduce health inequalities; and

- primary care, community care, social care and hospital services.

Certain areas were deemed to be outside the scope of the Review:

- the new organisational structures created as a result of the RPA process within Health and Social Care; and
- the Review should work within the constraints of the current level of funding for the coming period. The current Performance and Efficiency Unit (PEDU) review of the scope to make savings in the health and social care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review.

However, the Minister indicated that if the Review felt it should comment on any of these areas, it should not feel constrained in doing so.

Public health and social wellbeing is at the heart of health and social care. The Review team is aware that there is a separate piece of work being undertaken by the Department of Health Social Services and Public Safety (DHSSPS) and the Public Health Agency (PHA) to create a new public health strategy, as set by the Executive and Minister. Notwithstanding this, the Review considered it appropriate to look at public health and wellbeing in its work.

The Terms of Reference had asked the Review to make recommendation on the future configuration of hospital, primary care, community care and other settings. During the course of the Review, the team proposed to the Minister that it was better to describe a framework for the future of care rather than including specific proposals in relation to sites and specialties. The rationale for this presented to the Minister was the critical need to enable professionals and communities to devise local solutions within a very clear framework and criteria for success. The Minister agreed to this approach to applying the Terms of Reference.

APPROACH

Giving consideration to the Terms of Reference set by the Minister (Appendix 1), a project plan was developed. The approach to the Review involved five key strands of activity, as shown in the figure below.

Figure 5: Overview of Approach

In particular the Minister highlighted the importance of engagement with stakeholders and a comprehensive engagement plan was developed. The objective was to enable informed debate and to present information to the public.

This resulted in more than 3,000 people engaging directly with the Review, and many more being exposed to debate on the key issues affecting health and social care provision through media coverage of the Review on TV, radio, online and by the printed media.

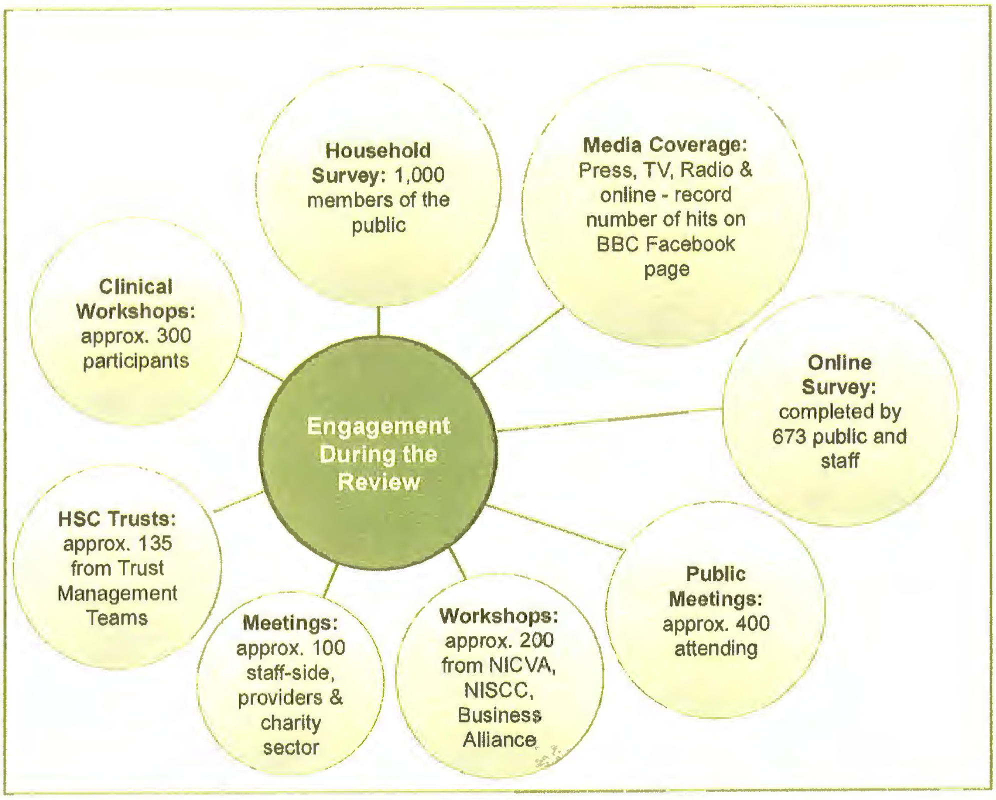
The engagement plan for the Review involved:

- An **online survey** completed by 673 individuals, of which 91% worked for an organisation providing health and social care (see Appendix 2 for a summary of results);
- Engagement with local **media** to promote press, television and radio features on the Review to raise public awareness of the issues involved and stimulate debate. The BBC e-panel received 641 views on aspects of the health and social care system;
- A **household survey** (completed by IpsosMORI) of 1,009 adults aged over 16, selected to be representative of the Northern Ireland population in terms of gender, age, social class and geography (see Appendix 3 for a summary of results);
- Six **public meetings** were held in Londonderry, Omagh, Ballymena, Belfast, Lisburn and Armagh. These were facilitated by the Patient and Client Council (PCC). (See Appendix 4 for details of the questions raised during the meetings);
- A series of **workshops with clinicians** from HSC Trusts, General Practitioners (GPs) and HSC managers to discuss current provision and future needs of specific service areas (see Appendix 5 for details of attendees and areas covered at each workshop);
- A series of **sector workshops**, with representatives from the voluntary and community sector (facilitated by the Northern Ireland Council for Voluntary Action), registered social care workforce (facilitated by the Northern Ireland Social Care Council), and private sector (facilitated by the Business Alliance) (see Appendix 6 for details of attendees);
- **Small group meetings** with a range of stakeholders including HSC arm's length bodies, trade unions (via the Partnership Forum), professional and regulatory bodies, voluntary and community sector organisations, political representatives, independent care providers, and colleagues within health and social care in other parts of the UK and the Republic of Ireland (see Appendix 7 for a full list of the stakeholders engaged with);
- Submission of **written responses** to the Review (see Appendix 8 for a list of written submissions); and
- Meetings with **HSC Trusts'** Senior Management Teams.

A Glossary is included in Appendix 9.

An overview of the stakeholders engaged with throughout the review is shown in the figure below.

Figure 6: Engagement during the Review



STRUCTURE OF REPORT

This report begins by outlining the reasons why our health and social care system needs to change, based upon the evidence that the Review has collected during the Review process. It then sets out the principles the Review considers should underpin this change.

A new model of care is described and contrasted with the existing model of care using case studies. The report details the impact of the new model across 10 areas of care.

Population Health and Wellbeing

Older People

People with Long-Term Conditions

People with a Physical Disability

Maternity and Child Health

Family and Child Care

People using Mental Health Services

People with a Learning Disability

Acute Care

Palliative and End of Life Care

It moves on to describe the implications for the health and social care system. This takes account of integrated working across health and social care, workforce issues and enhanced use of technology. Finally, an implementation roadmap outlines how this change will be implemented and delivered over a five year period.

THE CASE FOR CHANGE

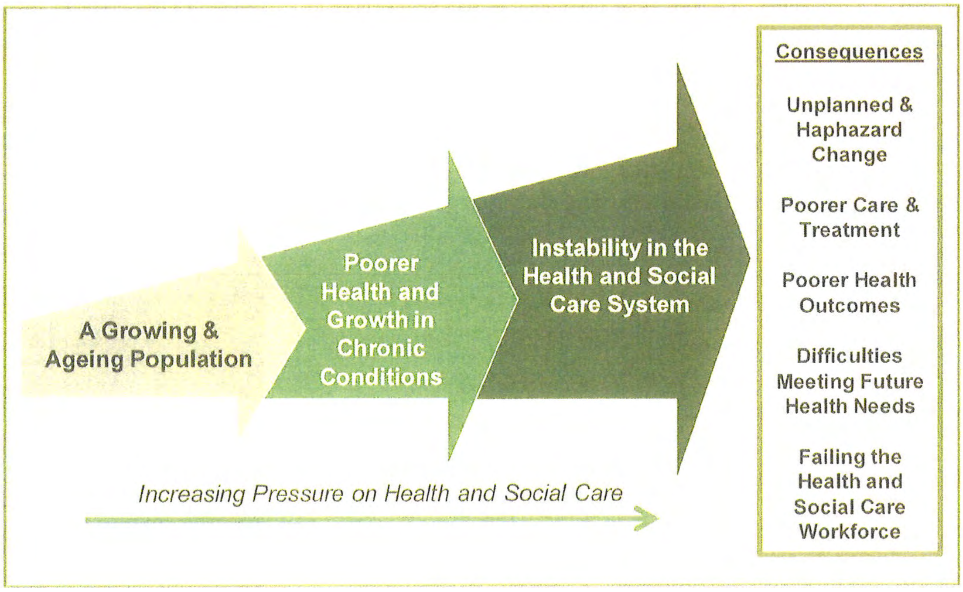
4. THE CASE FOR CHANGE

Making the case for change is at the centre of this Review. It is not a critique of the current provision but rather a fundamental recognition that the existing model of care is not fit for purpose as one looks to the future.

The figure below illustrates the pressures currently facing the system and the potential consequences of doing nothing.

There are no neutral decisions in this regard. If we do nothing, the system will not be able, in its current form, to continue to deliver a high quality service that will meet the needs of the population.

Figure 7: Pressure facing the system



The fundamental changes to our population in terms of age and need are clear. We must design a model which acknowledges this and is based on the needs of this changing population rather than its historic configuration. If we do not plan to change the system we will continue to be faced with unplanned changes that will not be in the best interest of the patient. This will result in a prioritisation of who gets care and a reduction in access to many important services for a large proportion of our population.

We have a highly skilled and dedicated workforce who are being failed by a system which is no longer fit for purpose. This has resulted in staff working within a system which does not deliver the quality of service to which they strive.

The Review also acknowledges that throughout this process everyone spoken to has asked the Review to promote the **'making it better'** principle and has affirmed that it **can be better**.

WHY DO WE NEED CHANGE?

Despite the many positive aspects of the current model of health and social care, compelling factors reflect the need for change:

- a growing and ageing population;
- increased prevalence of long term conditions;
- increased demand and over reliance on hospital beds;
- clinical workforce supply difficulties which have put pressure on service resilience; and
- the need for greater productivity and value for money.

Against this backdrop, the Review identified 11 keys reasons supporting change. In a new model, how these are responded to will be key to shaping the decisions for the future configuration of specific services.

Reason 1 – The need to be better at preventing ill health

Reason 2 - The importance of patient centred care

Reason 3 – Increasing demand in all programmes of care

Reason 4 – Current inequalities in the health of the population

Reason 5 – Giving our children the best start in life

Reason 6 – Sustainability and quality of hospital services

Reason 7 – The need to deliver a high quality service based on evidence

Reason 8 – The need to meet the expectations of the people of NI

Reason 9 – Making best use of resources available

Reason 10 – Maximising the potential of technology

Reason 11 – Supporting our workforce

Reason 1 – The need to be better at preventing ill health

The population of Northern Ireland can become a healthier society through prevention of ill health and the promotion of health and wellbeing. People wish to be responsible in taking decisions to support better personal health. In this regard it is important to communicate evidence to enable people to choose a lifestyle where healthier outcomes can happen.

Smoking - In Northern Ireland around 340,000 people aged 16 and over smoke. Smoking contributes to not only many cancers, heart disease, bronchitis and asthma, but other illnesses including stroke, which causes around 2,400 deaths per year. These deaths are avoidable. Around 86% of lung cancer deaths in the UK are caused by tobacco smoking and, in addition, the International Agency for Research on Cancer states that tobacco smoking can also cause cancers of the following sites: upper aero-digestive tract (oral cavity, nasal cavity, nasal sinuses, pharynx, larynx and oesophagus), pancreas, stomach, liver, bladder, kidney, cervix, bowel, ovary (mucinous) and myeloid leukaemia. Overall tobacco smoking is estimated to be responsible for more than a quarter of cancer deaths in the UK, that is around 43,000 deaths in 2007.[1] Half of all smokers eventually die from cancer, or other smoking-related illnesses.[2] A quarter of smokers die in middle age, between 35 and 69.

Obesity – in the most recent survey of Northern Ireland's health and wellbeing, 59% of all adults measured were either overweight (35%) or obese (24%)[3]. The impact of this increase has resulted in complications in pregnancy, increase in type 2 diabetes, coronary heart disease, stroke and a number of cancers. It is also known that obese children are more likely to become obese adults. We face a significant challenge in halting the rise in the proportion of the population who are overweight or obese.

Alcohol and drug misuse cost our society hundreds of millions of pounds every year. However, this financial burden can never truly describe the full impact that substance misuse has on many vulnerable individuals including children and young people, families, and communities in Northern Ireland.

Not to act on these facts will condemn the population and the system to failure.

Reason 2 – The importance of patient centred care

Evidence suggests that people are best cared for as close to home as possible. It is also what people have told us through the Omnibus survey - 81% of people

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[1] Cancer Research UK

[2] Mortality in relation to smoking: 50 years' observations on male British doctors, Doll et al, 2004

[3] NI Health and Social Wellbeing Survey 2005/06, DHSSPS

surveyed said that more health and social care services should be delivered in GP surgeries, local centres and in people's homes.

Inpatient hospital care will always be an important part of how care is provided, but it is only best for a patient with acute medical needs. There are many benefits associated with delivering care within people's homes and in their local communities. Providing patient choice about where they are cared for is critical. Integrated teams working together in the community provide this opportunity and would deliver better quality.

A central theme of 'Quality 2020 - a 10 year Strategy to protect and improve Quality in Health and Social Care in NI[4]' is to ensure the patient and client receives the right care, at the right time in the right place, with the best outcome. The 'High Quality Care for all NHS: Next Stage Review Final Report' also identified the need to bring care closer to home, to ultimately deliver better care for patients. This was also a central focus of the 2006 White Paper 'Our health, our care, our say', and it has become clear that a health and care economy-wide approach is needed for an effective and sustainable model of care that is more convenient for patients.

A bed utilisation audit of 2011 showed that, on the day in question, up to 42% of the inpatients reviewed should not have been in hospital.[5] Furthermore in 2009/10, 28% of the deaths of people admitted from a nursing home, occurred within 2 days of admission into hospital[6].

The care closer to home approach is not about challenging hospital provision, but about defining the role of hospitals in meeting the needs of the population. The real prize is to provide community alternatives which improve patient/ client care and experience. The evidence again points to a need for change.

Reason 3 – Increasing Demand

The evidence of increasing demand is compelling whether from a population or disease perspective.

Demography

Northern Ireland has a population of approximately 1.8m people. It has the fastest growing population in the UK and it continues to grow. The number of people over 75 years will increase by 40% by 2020. The population of over 85 year olds in NI will increase by 19.6% by 2014, and by 58% by 2020 over the 2009 figure (see the figure below).

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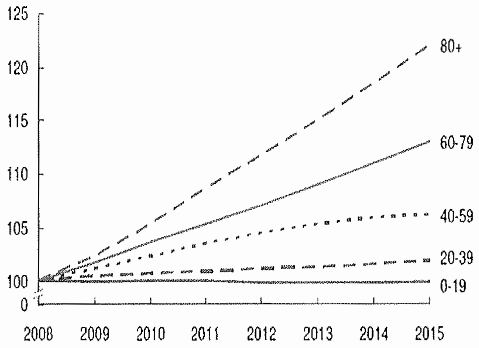
[4] Quality 2020, A 10-year Strategy to Protect and Improve Quality in Health and Social Care in NI, DHSSPS

[5] Bed Utilisation Audit of 8 acute hospitals in NI, April – September 2011

[6] HIB, DHSSPS, 2011

Figure 8: Northern Ireland Population Projections



Source: NI Neighbourhood Information Service

Longer life expectancy is something to celebrate. Many older people enjoy good health and continue to make a significant contribution to society as carers, learners, workers and volunteers. In particular, older people are identified as important social resources in rural areas, providing informal care and supporting the cultural and social lives of their communities.[7] The health and social care system has a role in enabling older people to live as full and healthy a life as possible and caring for the most vulnerable when needs change.

There is however, a high level of dependence on institutional and hospital care for older people, and inconsistencies in the quality and range of services provided across Northern Ireland. Services are not currently meeting expectations and, since they account for a large proportion of health and social care expenditure, defining a new model to successfully meet the needs of older people is an overwhelming priority. Older people have said they want care, support and treatment in or close to home. Services must therefore continue to reform and modernise to respond to growing demand with an increased emphasis on personal, community based services.

Disease Prevalence

There are increasing numbers of people with chronic conditions such as hypertension, diabetes, obesity and asthma. The disease prevalence levels reported via the Quality Outcomes Framework (QOF) are summarised below[8].

- QOF reported prevalence for hypertension has increased year on year across all UK regions, with the rates reported in NI lowest of the 4 UK countries at 12.54%, showing an absence of managing this condition.
- Diabetes is an increasingly common condition. Prevalence in the UK is rising. NI prevalence is 4%.

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[7] Commission for Rural Communities (2008) The Personalisation of Social Care

[8] Source: PHA Health Intelligence Briefing on QOF 2009/10).

- QOF reported prevalence of Atrial Fibrillation is increasing year on year across the whole of the UK. In NI, rates have increased from 1.25% in 2006/07 to 1.33% in 2009/10, equating to an additional 1,500 patients with AF.
- Stroke/ Transient Ischaemic Attack (TIA) reported prevalence has increased yearly across the UK. In NI prevalence has increased from 1.37% in 2004/05 to 1.71% in 2009/10, representing over 6,400 additional patients.
- NI has the lowest QOF reported prevalence of asthma at 5.86 per 1,000 patients compared to the rest of the UK. Notwithstanding this prevalence has increased in the last 5 years.
- QOF reported prevalence of Chronic Obstructive Pulmonary Disease has risen steadily since records began in 2004. The prevalence in NI was 1.63% for 2009/10.

All of this describes the unremitting increase in chronic conditions in NI. Individuals with long-term conditions very often have multiple conditions – around a quarter of those in the UK with a long-term condition have three or more conditions[9]. Our system often does not deal with multiple conditions in an integrated way, which for the individual can mean having to engage with multiple clinicians and services which are not well joined up. The consequent personal experience is often very frustrating.

Keeping Pace with Developments

Best practice in health and social care provision is developing all the time. There are new technologies, new care pathways, new partnerships, new drugs and new levels of regulation. Our population will expect access to these improvements. The need to understand demand patterns and work with providers in primary, community and secondary care to ensure more effective management of demand will be a central issue in the future.

It is estimated that the demand for services could grow by around 4% per year by 2015[10]. Examples of the potential consequences without change are listed below:[11]

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 8,000 extra nursing home weeks; and
- 40,000 extra 999 ambulance responses.

If we were to continue to deliver services in the way that we do today, we would

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[9] NHS Scotland (2005) National Framework for Service Change. Long Term Conditions Action Team Report.

[10] Reshaping the System (2010) McKinsey

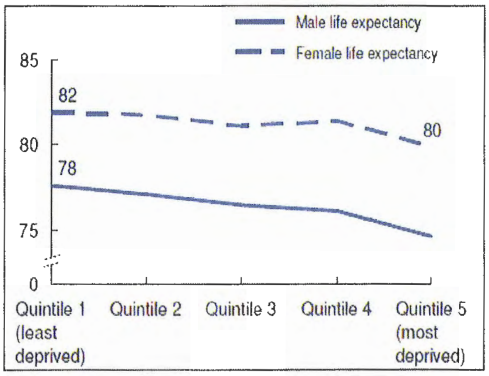
[11] NI Confederation for Health and Social Care: Areas for Action for Health and Social Care in Northern Ireland 2011-2015

quite simply fail the popula#tion as the system struggled to cope. The quality of outcome for the individual and their family would inevitably decline.

Reason 4 – Current inequalities in the health of the population

In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women. However, against this positive overall trend, inequalities are evident when mortality rates are compared across geographical areas. People who live in the 20% most deprived areas are 40% more likely to die before 75 than the NI average. Life expectancy against deprivation level is shown in the figure below.

Figure 9: Life Expectancy and Deprivation in Northern Ireland



Source – NISRA: Independent Review of Health and Social Services Care in Northern Ireland

For example, along the bus route from Donegall Square to Finaghy Road South, there is an increase in life expectancy of 9 years, as shown in the figure overleaf. Similar patterns exist in rural areas.

Across NI there is also variability in the health of the public. Belfast had the highest rate of births to mothers aged 19 or under in 2004 (25.9 per 1000) compared to other Local Government Districts in Northern Ireland. Indeed there is considerable variation even within the Greater Belfast area. In 2009, of the 349 births to teenage mothers in Belfast Trust 37% were in west Belfast, 28% in north Belfast, 15% in east Belfast, 11% in south Belfast and 8% in Castlereagh.

The most deprived group of the population has an admission rate to Neonatal Intensive Care of 19% above the regional average for Northern Ireland.

Some of the most common characteristics associated with being born into poverty rather than more affluent circumstances are highlighted below:[12]

- lower life expectancy;
- 23% higher rates of emergency admission to hospital;
- 66% higher rates of respiratory mortality;
- 65% higher rates of lung cancer;
- 73% higher rates of suicide;

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[12] NISRA Inequalities Monitoring Report 2010

Figure 10: Life Expectancy, Donegall Square to Finaghy Road South

	Donegall Square	Queen's University	Upper Malone Road	Finaghy Road South
Metro 8 Bus Route	●	●	●	●
Male Life Expectancy	71 years	71 years	79 years	80 years
Female Life Expectancy	77 years	81 years	82 years	83 years
NIMDM Ward Rank	22	237	328	550

- self harm admissions at twice the Northern Ireland average;
- 50% higher rates of smoking related deaths; and
- 120% higher rates of alcohol related deaths.

Health and Social Care alone cannot fully address the inequalities issue. If we are to deliver effectively on improving the health of our population, we need meaningful partnerships and a common agenda to be developed with local government, housing, education, the environment, and our local communities. Making joined up government more tangible is essential. However, it is incumbent on health and social care to look to change and how it can contribute to better outcomes for the citizen.

Reason 5 – Giving our children the best start in life

The 2007 Unicef review of Children and Wellbeing ranked the UK 21 out of 21 developed countries.[13]

There is growing evidence that a child's early years of development have a significant impact on their health in later life.

The Californian Adverse Childhood Experience study (1998) linked childhood maltreatment and later-life health and well-being.[14] The consequences for society include: adult mental health

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[13] UNICEF (2007) *Child Poverty in Perspective: An overview of child well-being in rich countries*, Innocenti Report Card 7, UNICEF Innocenti Research Centre, Florence.

[14] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS, 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med.;14(4):245-58

problems, poor physical health and high health expenditure.

Early Intervention: Good Parents, Great Kids, Better Citizens report argues 1 in 8 children are currently growing up in an environment of unacceptable risk.[15] Neglect and abuse in early years creates emotionally, mentally and physically damaged adults thus perpetuating problems into the next generation. An early intervention approach counteracts this outcome. The study identified the need to respond differently to the childhood years through structured early intervention.

The review of research found that targeted, intensive programmes such as the Family Nurse Partnership can help improve outcomes for vulnerable children and families, for example: reduced child abuse and neglect, reduced crime, reduced drug and alcohol abuse, and reduced school grade repetition.[16] These result in reduced victims' costs and increased earnings, highlighting a ratio of return of £3 for every £1 invested.

The Review noted that it has been acknowledged by several independent authors that the level of investment in Children and Families Services in NI is approximately 30% less than in other parts of the United Kingdom. It had been predicted that the number of births in Northern Ireland was to decline but in fact birth rates have remained broadly static. This overall position has led to an increased demand, particularly for family support services.

Given this evidence, failure to do better will prevent any opportunities to break the cycle of poor life outcomes for many in our society.

Reason 6 – Sustainability and quality of hospital services

Given the increasing and changing nature of the population, changing practices in medicine and increased expectations of the public, the gap between demand for services and current provision is widening. If we were to continue to provide services as they currently are, it would lead to unplanned and unmanaged collapse of key services. This would ultimately lead to detrimental impact on patients and clients. The choice is stark: it is not principally about money but about sustainability and clinical evidence. The conclusion is clear: plan and manage the transition or accept a more haphazard set of changes. In this regard there are no neutral decisions.

Historically, in Northern Ireland, there has been an over-reliance on hospital services. Given its rurality and based on recognised norms, a population the size of NI is likely to have between 5 and 7 major acute hospital networks, each

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[15] Good Parents, Great Kids, Better Citizens. Graham Allen MP and Rt Hon Iain Duncan Smith MP, Centre for Social Justice and Smith Institute 2008

[16] The Family Nurse Partnership Programme, Department of Health, http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128402.pdf

serving a population of some 250,000 to 350,000. Currently we have 10 hospitals for a population of 1.8million, in other words one per 180,000. The rurality of Northern Ireland has historically influenced the number of hospitals provided, and this must also be taken into consideration when developing a new model of care. There is however evidence to show that whilst important in a Northern Ireland context that travel per se does not create worse outcomes. For example the Rural Trauma Outcome Study in Scotland[17] showed that longer pre-hospital travel times did not increase mortality or length of stay.

The Royal College of Surgeons has stated that in a fragmented emergency surgical set-up a patient is four times more likely to have a poorer outcome than in a more organised model. It goes on to say that where the model is not organised, patients have prolonged hospital stays with significant cost implications, both physical and emotional to the patient and their family[18].

Trying to maintain acute services across the current number of sites has proved increasingly difficult. Scarce staffing and other resources are spread too thinly, making it impossible to ensure that permanent senior medical cover for emergencies is available at all sites, on a 24/7/365 basis (24 hours a day, seven days per week and 365 days per year). Currently, many sites rely on a combination of junior doctors and temporary locums to provide much of the cover required, particularly out of hours. This inevitably impacts on quality and cost. It also creates service fragility.

The Chairman of the British Medical Association's Council in Northern Ireland stated that "the present situation is untenable: we cannot maintain top flight A&Es in every town. Reconfiguration... is currently happening by crisis rather than by taking difficult decisions". He goes on to cite recent changes at the Mid-Ulster, Whiteabbey and Belfast City Hospital as examples of how reconfiguration is currently occurring by crisis rather than in a structured and planned approach.[19]

More people are admitted to our hospitals than in other areas of the UK and lengths of stay are significantly longer.

In simple terms, we know it is possible and better to provide services closer to home but we have continued to use hospitals. This is an unsustainable model which will deliver poorer outcomes for the patient in the future.

Reason 7 – The need to deliver a high quality service based on evidence

The responsibility of the HSC is to deliver a high quality, safe and accessible service

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[17] Scottish Urban v Rural Trauma Outcome Study, J Trauma September 2005

[18] The Higher Risk General Surgical Patient: Towards Improved Care for a Forgotten Group, Royal College of Surgeons of England and Department of Health

[19] News Letter, November 7 2011

to the population of Northern Ireland, with good outcomes. Currently there are indications that there is room for improvement in how things are done.

There are increasing numbers of people with chronic conditions such as hypertension, diabetes, obesity and asthma. Yet evidence suggests lower than appropriate access to general practice is achieved.

Although improving, daycase rates are lower when compared to England at 64.7% compared to the England average of 75.5%.

The number of registered suicides rose from 146 in 2005 to 313 in 2010. The rates per 100,000 of the population vary greatly across the region with a rate of 24.9 in the most deprived area compared to 7.6 in the least deprived area.

Treatment for cancer has been revolutionised over the past decade with survival rates improving across a range of cancers, but we still fall behind European survival rates in a number of cancers, so further work needs to be done. A study[20] funded by Cancer Research UK and the Department of Health, England was carried out by researchers from a number of institutions in Australia, Canada, Denmark, Norway and the UK that were the focus of the study. Survival rates were found to be "persistently lower" in Denmark, England, Northern Ireland and Wales.

In obstetric services, 55.6% of deliveries are normal, compared with 61.2% in England and 61% in ROI. Our caesarean section rate is high at 30.2% compared to 24.1% in England and 25% in ROI.

Investment in Mental Health, Learning Disability and Children and Family Services in NI is up to 30% less than in other parts of the UK because our model over consumes resource in hospital provision.

At March 2010 there were 2,606 looked after children in Northern Ireland, up by 6% (143) from 2009 (2,463). 11% (about 270) of these children were in residential care, where the outcomes are likely to be very poor, and 65% were foster care placements.[21] The recruitment of foster carers to meet rising demand continues to be a challenge to ensure choice and the matching of carer skill to the needs of the child.

Every year in Northern Ireland around 3,000 people suffer a stroke. Stroke is the third biggest killer and the leading cause of severe disability in Northern Ireland. Up to 40 per cent of strokes are preventable.[22]

The Royal College of Physicians, National Sentinel Audit 2010, found NI had a higher length of stay of 21.3 days (to

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[20] The study was published in the peer-reviewed medical journal The Lancet.

[21] Children Order Statistical Tables for NI 2009/10

[22] National Stroke Association 2005

discharge or death) compared to the National average of 19.5 days.[23]

Looking at general Surgery, the chance of a patient dying in a UK hospital is 10% higher if he or she is admitted at the weekend rather than during the week, where the service is not well organised. Provision of services, particularly of theatre access, critical care and interventional radiology, is often incomplete, and the correct location of patients after surgery is often not given sufficient priority. Furthermore, the clinical response for patients who deteriorate is often poorly thought through and, at times, ad hoc[24].

Dr Foster, a UK provider of comparative health and social care information, also reported that it found a worrying 10% spike in deaths at weekends compared with weekdays across 147 hospital trusts.[25] Too often our services do not respond to 7 day a week working.

PCI (Percutaneous Coronary Intervention) is a treatment to reduce or eliminate the symptoms of coronary artery disease including angina, dyspnea and congestive heart failure. A pilot carried out by the Belfast HSC Trust (Feb10 – Mar11) showed low mortality rates associated with PCI that were largely predictable and could be improved if PCI was better organised.

While significant improvements have been secured, NI continues to spend significantly more per head on prescription medicines than the rest of the UK at £232 per head of population, compared to Wales £194, Scotland £187 and England £165 (2009/10).

All this has informed the Review that the current model does not provide as high quality care as it could.

Reason 8 – The need to meet the expectations of the people of NI

Whilst the Review acknowledges it is difficult methodologically to get a full consensus on a population view, there are however factors which need taken into account.

A structured Omnibus survey to inform the Review was conducted in October 2011 in which 1009 people were surveyed from across Northern Ireland. This was supplemented by the online public survey. The online survey was completed by 673 persons, 91% of whom work for an organisation providing HSC services.

The high level results of the surveys are highlighted within this section with more detail throughout the body of this report and within Appendices 2 and 3.

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[23] RCP National Sentinel Clinical Audit of Stroke 2010

[24] Aylin P, Yunus A, Bottle A *et al.* Weekend mortality for emergency admissions. A large,multicentre study. Qual Saf Health Care 2010; 19: 213–217

[25] Dr Foster – Hospital patients ‘more likely to die at weekends’, November 2011

There were positive comments about the existing service, 22.6% of the people interviewed in the omnibus survey stated that they were very satisfied with health and social care provision in NI and 54.8% were fairly satisfied.

However, the Omnibus survey results went on to highlight dissatisfaction with:

- accessibility of services;
- the quality of services to older people; and
- the quality of services for people with mental health problems and learning disabilities.

A need for improvement was identified across each of these areas.

Access

- In regard to GP services: 65% felt that improvement is required including 23% who stated that a lot of improvement is required (22% in the online survey).
- Looking at assessment for home nursing or residential care: 79% felt that some improvement is required (including 21% who felt that a lot of improvement is required). This was supported by the online survey findings where 86% felt improvement is required (including 26% who felt that a lot of improvement was required).
- Appointment with a hospital consultant: 82% (and 91% in the online survey) felt some improvement is required, including 36% (30% in the online survey) who felt that a lot of improvement was required.
- Non emergency operations: 88% (91% in the online survey) felt some improvement was required including 36% (and 34% online) who felt that a lot of improvement is required.
- Time waiting in Accident and Emergency (A&E): 91% (96% online) felt improvement was needed, including 56% (and 47% online) who felt a lot of improvement was required.
- Access to Mental Health Services: 93% of people (online survey) stated that improvement was required to the availability of mental health services (43% stated that a lot of improvement was required).

Quality of Care for Specific Groups

- Older People: 89% (98% online) felt that improvement is required in the quality of care for older people, including 35% (35% online) who felt a lot of improvement is required.
- People with a Mental Health problem: 93% (88% online) felt improvement is required including 43% (28% online) who felt that a lot of improvement is required.
- People with learning disability: 70% (91% online) felt that improvement is required, including 30% (32% online) who felt a lot of improvement is required.

The online survey also highlighted the following:

- Quality of hospital services: this was not highlighted as an issue within the omnibus survey, but the online survey results showed that 92% felt there was some improvement required, with 18% feeling a lot of improvement is required; and
- Support for Carers: 97% of the online survey stated that improvement is required, including 45% who felt a lot of improvement is needed.

Further reinforcement of these results is expressed in the Patient and Client Council Priorities for HSC in Northern Ireland, November 2011. Some of the key priorities identified were:

- hospital care;
- care of the elderly (including domiciliary and community care);
- waiting times;
- cancer services;
- mental health and learning disability;
- health and social care staffing levels;
- access to GPs and primary care;
- children's services;
- reducing the costs of administration and management; and
- quality of care.

This evidence indicates strongly that the current system of health and social care is not meeting citizens' expectations.

Reason 9 – Making best use of resources available

This review is not about money per se and any discussion on resources produces strong views. It is, however, entirely valid to look at how we could use resources and the consequent productivity. In that regard it is difficult not to conclude that, with the overall level of resources available, we have the ability to provide a better service. The budget cycle has indicated annual expenditure of £4.65billion by the end of this Assembly period (2014/5). The Review was not asked to reduce this figure but knows that with annual pressure of 4% from residual demand and changing population,[26] change is non-negotiable. The challenge presented to the Review is simply how best to spend the resource to achieve maximum benefits.

Best Use of Estate: we currently have 10 acute hospitals, 5 local hospitals and 30 community hospital facilities, with 4,361 beds in acute and local hospitals, and 1,924 community beds. In addition there are 60 statutory residential and nursing homes for older people, 39 residential homes for children, as well as a range of daycare centres and health centres. There is an over reliance on buildings to

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[26] Reshaping the System (2010) McKinsey

provide care rather than support its delivery.

Any future models of care will have to take into consideration the best use of the estate that is currently available. It will not however concentrate on the preservation of the existing building stock but rather present a new service model which delivers care on a 24/7/365 basis.

Best Use of Staff: the HSC currently employs 78,000 people either full-time or part-time, which equates to 53,209[27] whole time equivalents across all specialties comprising:

- 33% nursing staff;
- 7% medical and dental;
- 12% social services;
- 5% Allied Health Professionals;
- 4% home helps;
- 2% ambulance services staff;
- 7% other professional and technical staff; and
- 26% admin and clerical staff (including medical secretaries ward clerks); and
- 4% managers (being Band 7 or above).

Our staff mix is primarily structured to support the existing care model which is institutionally based. For example, Northern Ireland has a higher proportion of qualified nursing staff (across all settings) compared with England, at 77% compared with 73%. Nursing care has 3.5 times the activity per weighted population than England and Wales. The driver appears to be elderly patients, with NI having 3 per 1000 weighted population compared to 0.16 per 1000 population in England.[28]

Appleby[29] stated that indicative data suggests Northern Ireland produces between 17% and 30% less inpatient, outpatient, day case and A&E activity per head of hospital and community staff than England and that hospital activity per member of staff is 19% lower than the UK average. These efficiency figures are very closely aligned to our current hospital model.

Best Use of Money: In the US, currently the care costs for 5% of the population account for 50% of health care spending.[30] This fact can be applied to any western health economy including Northern Ireland. Addressing the reason for this will require changes to be made which ensure resources are focused in the right areas.

If we were to continue providing health and social care in the same way as we do today, some suggest we would need £5.4

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[27] DHSSPS NI Health & Social Care Census, March 2011

[28] Reshaping the System, McKinsey 2010

[29] Independent Review of HSC Services in Northern Ireland, 2005

[30] Research in Action, Issue 19, 2006

billion of funding by 2014/15 to cope with this combination of growing demand for care and inflating costs. Given that this is unrealistic, from both an economic and delivery perspective, we need to reshape services. Adopting a new model which is efficient, patient centred and providing high quality evidence based services, would enable a legitimate debate in the future on how much funding health and social care should receive, compared with other public services.

Much of the significant management, administrative and overhead efficiency savings potential in health and social care has already been captured through the Review of Public Administration (RPA), and the potential for further savings is limited. Instead, fundamental change is required in how we deliver care in the future.

Reason 10 – Maximising the Potential of Technology

Technological change is both a driver and enabler for the future. The pace of change is incredible and our current model does not promote its absorption or benefit as it should. For example, NI has now one of the most sophisticated radiological systems anywhere but we need new ways of working to maximise the potential of this technology. The technology that enables 24/7 intervention in the care of strokes and coronary conditions can revolutionise the outcome for patients but to deliver it our current service pattern must change.

There is overwhelming evidence that organising emergency care separate from elective care makes better use of the infrastructure in hospitals. Information is key. As a system we have a huge amount of data but poor data analysis, preventing professionals from having the evidence that is central to their work. For example, information from patient records could be used more effectively to monitor our local health needs and to assess what treatments are working well. Data needs to be used in a more effective way to ensure it is translated into information that we can use to plan our services.

Communication with the public is not as modern as it should be, for example in arranging appointments, in explaining how to use the service and giving timely information. This leads at times to disorganisation in our response to the individual and inefficiency.

The technological infrastructure in NI is good and it can promote more care closer to home but our service has not yet fully embraced the opportunity that exists. Connected health projects exist but have emerged in an ad hoc manner. If the service is to derive maximum benefit in this regard, development of connected health needs to be more coherent. Changes therefore will need to build upon the existing Memorandum of Understanding between Invest NI and DHSSPS in relation to connected health. A clear commitment to maximising the technological potential to service provision will be essential.

Reason 11 – Supporting Our Workforce

Problems being experienced by staff trying to deliver services within the HSC were highlighted in the HSC Staff Survey carried out in 2009. Over 2 in 5 staff (43%) felt that they cannot meet all the conflicting demands on their time at work, and only 34% agreed that there are enough staff at their organisation to do their job properly. The most common reason stated for staff having been injured or feeling unwell in the last 12 months was work-related stress (31%). When the Review team met with staff to discuss the future there was not a single voice which argued for the preservation of the existing model of service.

The Review acknowledged the willingness of staff to make change and heard clearly that they wanted to be closely involved in how change should happen.

CONCLUSION

It is clear that we need to act now both to improve our system's quality and productivity, and to better manage the demand on our services. Fundamental change is required in how we deliver care in the future. There are no neutral decisions: every decision will have consequences and opportunity costs for patients and clients. More simply put, we need a new model of care.

We are not different. Whilst there are unique factors at play in Northern Ireland impacting on the demand for services, a number of the issues with the HSC in NI are common in other areas of the UK.

Healthcare for London, A Framework for Action was a review into the healthcare delivered to the population of London, led by Prof. Lord Ara Darzi. This review set out similar issues in terms of the need to focus on improving the quality of services delivered, meeting the expectations of the public, addressing the inequalities in the system, delivering the right care in the right place at the right time, issues with the configuration of specialist services and making better use of resources available, both in terms of the workforce, the infrastructure and taxpayers' money.

The Scottish Government's Shifting the Balance of Care framework set out a programme of changes across health and care systems intended to: bring about better health outcomes for people; provide services which reduce health inequalities; promote independence; and provide services that are quicker, more personal and closer to home.

NHS Wales also recently published a report setting out its 5 year vision for the NHS in Wales, Together for Health. This review identified largely common issues, including challenges with a rising elderly population, enduring inequalities in health, increasing numbers of patients with chronic conditions, rising obesity rates and a challenging financial climate.

Consequently NI cannot insulate itself from the need for change.

The Review presents an opportunity to consider a more integrated model for the HSC system that allows us to deliver an excellent health and social care service to the population of Northern Ireland.

THE PRINCIPLES FOR CHANGE

5. THE PRINCIPLES FOR CHANGE

The Review team has concluded that the Case for Change is unassailable. It highlights the pressures currently faced by our health and social care system and the demands that will be placed upon it in the future. If we continue to deliver services as we currently do, they will not meet the needs of our population and will not be sustainable for the years to come. Therefore, changes are needed to meet future health and social care needs.

In looking to recommend a new model, the Review has engaged widely with the public, clinicians, providers and interest groups, and reviewed research evidence to inform the changes that are required. It started with the 'user first' principle rather than considering the structures in our health and social care system. The aim throughout has been to consider what changes would make the greatest difference to outcomes for patients, users and carers.

The Review has developed a set of principles that will underpin the shape of the future model for health and social care. Later, in the document, when the implementation pathway is described, these principles will be important determinants in the change process. They build upon the three core objectives upon which the National Health Service (NHS) was founded:

- to meet the needs of everyone;
- to be free at the point of delivery; and
- to be based on clinical need, not ability to pay.

The Minister, in his statement on 27th September 2011, said that he believed the Assembly was fully committed to those principles, but had to recognise the fact that the rising level of need in health and social care services, the need to focus on outcomes and the constrained financial context made it increasingly difficult to hold onto those principles. The ability to continue to deliver these principles is only possible through the support of a radical programme of service change and reconfiguration.

The Review has concluded that there are twelve major principles that should guide changes to health and social care.

KEY PRINCIPLES

1. Placing the individual at the centre of any model by promoting a better outcome for the user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.

5. A focus on prevention and tackling inequalities.

6. Integrated care – working together.

7. Promoting independence and personalisation of care.

8. Safeguarding the most vulnerable.

9. Ensuring sustainability of service provision.

10. Realising value for money.

11. Maximising the use of technology.

12. Incentivising innovation at a local level.

WHAT DO THE PRINCIPLES MEAN?

1. Placing the Individual at the Centre of any Model

The individual must be at the centre of the health and social care system. The model must be built around what will produce the best outcomes for individual users, carers and families. Clarity about communicating this principle is essential.

2. Using Outcomes and Quality Evidence to Shape Services

All services should demonstrate that they are able to meet well understood measures of quality. This must include taking account of an evidence base of existing and emerging research on what produces the best outcome, both within Northern Ireland and beyond.

In NI, Service Frameworks[31] have been developed for 4 service areas, and a further 3 are under development. The Frameworks promote and secure better integration of service delivery along the whole pathway of care from prevention, diagnosis, treatment and rehabilitation, and on to end of life care. These include:

- cardiovascular services;
- respiratory services;
- cancer prevention, treatment and care;
- mental health;
- learning disability (under development);
- older people's health and wellbeing (under development); and
- children and young people's health and wellbeing (under development).

This is the best way to ensure that our limited human, financial and physical resources are used in the most effective way to produce the best possible patient and client outcomes.

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[31] Service Frameworks, DHSSPS

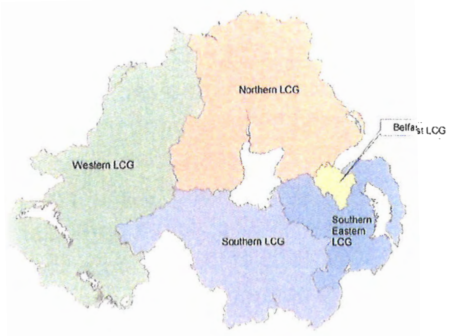
3. The Right Care in the Right Place at the Right Time

Care should be provided at home or as close to home as possible. Many of the services currently provided in an acute hospital or institutional setting should be provided in the community or in people's homes, making them more accessible. Where it is not safe and effective to provide services locally they should be provided more centrally or regionally. More simply put, the health and social care system should provide local services for local people, but safe, sustainable and accessible services for populations.

4. Population-Based Planning of Services

Services should be planned on the basis of the needs of a defined population or 'health and social care economy'. The Review team recognises population boundaries can be artificial but the starting point is to use the existing local health and social care economy populations, which are synonymous with the current Local Commissioning Areas (as in the figure below).

Figure 11: Local Commissioning Areas



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When necessary this should incorporate joint planning between these populations to deliver local or more central services. For some services this would require planning to take account of a NI wide perspective. However, with a population of 1.8million it is simply not feasible to provide every health and social care service that may be required, e.g. in these cases planning should be done jointly with other UK countries or the Republic of Ireland. The levels of planning are illustrated in the figure below.

Figure 12: Levels of Planning

5. A focus on Prevention and Tackling Inequalities

Prevention is always better than cure whether primary, that is avoiding the problem occurring, or secondary, that is arresting the problem. Such measures should be embedded into every service area. Services should support people to take good decisions about their health and wellbeing, with a particular focus on the needs of those groups that typically have poorest health outcomes. The factors impacting on health and wellbeing are diverse but well known and this will require partnership working across government and between the public and voluntary, community and independent sectors. Health economies will need to pay particular attention to achieving these outcomes demonstrating how in practice this approach expresses itself to the individual.

6. Integrated Care – Working Together

Services provided by different parts of the health and social care system should be better integrated to improve the quality of experience for patients and clients, safety and outcomes. This starts with making it simpler to use the system. It will require clinicians to organise care around the individual, with better communication and networking across primary, secondary and tertiary care, that is doctors talking to doctors, and professionals jointly reaching decisions about patients' and clients' care in partnership with them. Closer working together will be mandatory, illustrated by demonstration of full support of the various constituent parts of the service as to how services are organised. Underpinning this will be the requirement for improved technology and information sharing.

7. Promoting Independence and Personalisation of Care

Greater control by those in receipt of the service is a necessity. Flowing from this, as much diversity as practical should be available. To deliver this there should be a mixed economy of providers. In the majority of instances, this will be provided by statutory services but joint working with the independent sector will be expected. Services should aim to meet the needs of individuals, with care personalised in terms of their specific requirements. Patients, service users and their carers should be helped to take the important decisions about their own care, and importantly, enabled and empowered to take ownership of their own health. The vital contribution carers make to support the health and social care system should be recognised and carers' needs should be fully assessed and supported in this process.

8. Safeguarding the Most Vulnerable

Throughout the health and social care system, appropriate safeguards should be in place to protect the most vulnerable in society.

9. Ensuring Sustainability

Providing services requires significant attention to be spent in ensuring workforce sustainability. More simply put it means service models need to be robust. In this regard endorsement of regulatory and training bodies such as NIMDTA is essential. While locum and agency staff may be used to support a service where necessary and appropriate, they should not be inextricably linked to a service's ability to remain. Services organised this way are quite simply not sustainable.

10. Realising Value for Money

Any service models taken forward as a result of this Review must take cognisance of financial resources available to the HSC and secure value for money. Therefore there is a need for financial realism.

11. Maximising the Use of Technology

Changes should be supported by up to date technology to ensure vital information can be shared quickly among professional staff, duplication eliminated and that the latest diagnostic and treatment tools are available.

Changes should take account and build upon the Memorandum of Understanding between the DHSSPS and Invest NI on "Connected Health and Prosperity".

12. Incentivising Innovation at a Local Level

Making changes on the scale indicated in the following model will require devolved decision making and an incentive culture within health and social care, its workforce and the population. This is a direct response to the question 'why would I do it?'. Changes will need to show how they make things better, starting first with their positive impact on those using the service. The incentives of more local control in decision making, better training and development for the workforce and innovative ways of using resources will all be integral to the change process.

In this regard partnership working will be central, whether between populations in NI or with jurisdictions outwith NI. It will also be essential to explore in this context working with others, for example, the voluntary and independent sectors and the pharmacy industry to fully deliver the new model of care.

A FUTURE MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE

6. A FUTURE MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE

Following from the key principles outlined above and the Review's assessment of the opportunities that exist to do things better, a future model for integrated health and social care has been developed. This is illustrated in the figure below.

The future model is designed with the individual at the centre, with health and social care services built around them. Health and social care begins with the individual who is supported to care for themselves and make good health decisions.

Figure 13: Future Model for Integrated Health and Social Care

THE INDIVIDUAL

Every individual has a responsibility to make decisions that help maintain good health and wellbeing, prevent the onset of illness, and minimise deterioration as a result of any existing conditions they may have. People are supported to do this by health and social care professionals, their community, health and social care initiatives and regional health promotion, health protection and prevention initiatives. For example, this may include family support programmes run in community centres, smoking cessation programmes in pharmacies, screening in GP clinics (e.g. for cervical cancer), health visiting for newborns, healthy eating initiatives in community centres, and exercise programmes in local leisure centres. Fundamentally, people need to be supported to take responsibility.

LOCAL SERVICES

Integrated Local Services

For most people, much of what is needed from health and social care services will be increasingly accessible in their local area, either in their own home or in a local facility.

In many ways this may not seem much different to the way services are currently provided. The professionals providing local health and social care services, (for example GPs, district nurses, dentists and social workers) will continue to operate in local surgeries, health centres and high street practices, and to visit people's homes where needed. However, the way that they work with each other will be different.

GP practices will work together as federations of practices, enabling consistently high quality care for their patients. Additionally, Integrated Care Partnerships will be set up to join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent and voluntary sector. The Integrated Care Partnerships will have a role in determining the needs of local population and planning and delivering integrated services. Seventeen Integrated Care Partnerships will cover Northern Ireland.

For the individual, this will mean that GPs and all the other health and social care providers in an area, including from the voluntary and community sector, will be able to work together to deliver the services needed by their local population. As a consequence people will deal with fewer professionals and be at the centre of the decision making about their care and treatment.

Technology will support this integrated working. Electronic Care Records will allow health and social care teams to see patient records including details of medications, results of tests and any hospital treatment. This will help ensure that professionals have access to the information they need to treat a patient effectively, including in an urgent care situation. Patients will also have improved information on their personal circumstances.

More Services Provided In the Community

The public told the Review that there should be a greater range of services available in the community. Therefore, under the new model, more of the services that currently require a hospital visit will be available locally. This may include for example, X-rays and other diagnostic tests, and oral surgery. GPs will be enabled to undertake minor procedures in their surgeries. Outpatient appointments in many instances will be provided in the community rather than in hospital. In some specialties, care will be organised directly by the Integrated Care Partnership. New facilities will be developed to support this model, which may be similar to the health and care centres currently in some areas. This model will improve accessibility to health and social care services for the individual.

More specialist care will be provided in the community. Specialist hospital clinicians will support GPs and other community clinicians, working closely with them to plan how services are delivered. More specialists will also be employed in the community, for example, specialist nurses and GPs with a Special Interest. Providing outpatient appointments in the community will become the norm, with some of these being run by GPs and others by hospital specialists. This will reduce the number of follow-up visits to hospital required by patients.

These changes will be very important for people with long-term conditions, for example diabetes, cardiac illness or respiratory problems. For these patients, community-based support programmes will be put in place where multi-disciplinary teams work with patients to help them manage their condition. This will include:

- dedicated community-based clinics where patients can access a range of health and social care services, including inputs from community pharmacy, Allied Health Professionals such as podiatry and physiotherapy, nursing care and social work support as well as from GPs with a Special Interest and hospital specialists;
- better use of telehealth equipment to help people monitor their own conditions and alert health professionals when an individual's condition deteriorates;
- a named contact person for patients to call when they need assistance – this may be the GP, a specialist nurse or another member of the integrated care team; and
- direct admission to hospital care when needed as agreed between the GP and hospital specialist, with no need to

pass through the hospital emergency department.

Working in this way will also benefit groups who can face barriers in accessing care. For example, the new model will support the provision of enhanced community health services for people with a learning disability.

There will be a consistent approach to the provision of mental health services through the stepped care model, with most services being provided in the community by community mental health teams and voluntary and community sector partners.

More Support Available at Home

Throughout the Review people expressed their preference for care at home or as close to home as possible. In response to this, the new model will provide more support to help people who are sick or frail to maintain their independence and stay in their own homes for as long as possible. This applies whether that home is the family home, supported housing, a nursing home or residential home. However, there will be much greater emphasis on enabling people to remain in their chosen home. Providing care, treatment and support in this way will change the current model, perhaps most noticeably in terms of the number of residential homes.

As part of this approach, more tailored support will be provided to meet people's needs. People will have access to specialist equipment, nursing care, telehealth and telemonitoring support, and other therapeutic support at home, e.g. physiotherapy, podiatry or occupational therapy.

Social care will also be a central part of the support provided to enable independent living. This will include access to a diverse range of provision to meet people's social and emotional needs and tackle social isolation. Voluntary and community sector organisations will provide this support as well as community health and social care teams.

Virtual wards will also be developed. Under this model, individuals are admitted into the care of specialist teams, and provided with similar care as would be available in a hospital ward, but remain in their own home. Mental health treatment services will also be available at home, provided by Crisis Response and Home Treatment teams. This will result in reductions in inpatient care.

Intermediate care will be an important component of the new model, with greater provision of step-up and step-down beds in the community for people needing extra care for a short period of time. Step-up beds provide locally-based short-term support to avoid the need for individuals to be admitted into an acute hospital. Those leaving hospital may spend time in a step-down bed for rehabilitation before returning home. A reablement model will be introduced to provide people with the support they need to return to their homes following a stay in hospital, an accident or other crisis.

There will be a need to provide more respite care and short breaks in the community, to support individuals and carers. This will include accommodation and other short break options. All of this intervention is designed to respond to the patient's and carer's needs.

How people are cared for at the end of life is a key indicator of the values expressed by the HSC. Under the new model, services for those approaching the end of life will be provided that enable people to die at home, where that is clinically appropriate and consistent with their wishes. GPs and other community health services will provide in-reach to support people at end of life. This will apply in nursing homes as well as family homes.

Urgent Care

An urgent care model will be implemented in every area to provide 24/7 access to urgent care services. These services will be planned in accordance with local need. Whilst the model will take account of local circumstances, the outcomes will be consistent. The system of urgent care will ensure each community has local access to urgent health and social care services, variously provided by GPs, urgent care specialist nurses, mental health crisis response teams and emergency social workers.

EMERGENCY, SPECIALIST CARE, AND PLANNED CARE

Emergency care, specialist care, and planned care services will be provided in hospitals for people whose health and care needs cannot be met in their own homes or their own communities.

People needing specialist and acute care will be admitted to hospital. This may be on a planned basis, for example, for a pre-arranged procedure or as a result of an emergency.

The model aims for those admitted to hospital to be discharged to home or a community facility as soon as their health and care needs can be met there. Once individuals are discharged, follow-up care will be provided by the integrated care teams in the community with support from hospital specialists as required. As well as meeting the needs of patients and their families more effectively, this is a more efficient approach which will result in greater productivity.

Triage services and patient transport will be critical to ensuring that individuals access the care appropriate to their needs on a timely basis.

EXTERNAL COLLABORATION AND SUPRA-SPECIALIST CARE

Some services that are only needed by a very small number of people will be provided outside of Northern Ireland. This is necessary to ensure the quality of provision. Networks will be set up between the HSC in Northern Ireland and health and care providers in the ROI and other parts of the UK.

CONCLUSIONS

The proposed model has been designed to address the challenges presented in the Case for Change and the concerns expressed by those engaged with throughout the Review, both clinicians and the public.

The key differences between the current model of care and that proposed by the Review will be:

- care will be organised around the individual and not the institution;
- greater involvement in decision making will be afforded for the patient / client;
- the model provides a new way to look at the traditional model of GP and community health and social care services;
- home or close to home will be the centre of health and social care provision;
- there will be responsible access to emergency and hospital care; and
- new arrangements will be put in place to support provision outside the jurisdictions.

Overall, the model builds on evidence of what produces good outcomes, and supports the resilience and flexibility of the health and social care system for the future.

CASE STUDIES

The Review team considered it important to describe how it might be different for those using the service and offers the following examples to illustrate the change.

Older People

Current Model

Jean is a 79-year old woman, who lives alone in her house. She suffers from osteoarthritis, diabetes, bronchitis and heart disease. Because she is not as mobile she finds it difficult to get to hospital appointments. Jean was assessed on several occasions by various professionals, including a social worker, physiotherapist, occupational therapist, and a specialist diabetes nurse. She had to provide the same information each time she was assessed, which Jean found frustrating.

The outcome of the assessments deemed that Jean required support from a range of professionals and adaptations to the steps up to her house. Jeans gets confused who is coming to her each day. Furthermore, no-one noticed that she might have a cataract.

While Jean was waiting on the adaptations to her steps she fell and fractured her hip. She was taken to hospital and underwent emergency surgery. Jean had to stay in hospital while discharge planning was undertaken and a care package arranged. After some time, she was transferred to a rehabilitation ward where she underwent physiotherapy to assist her recovery, prior to returning home.

Jean now worries that she will not be able to cope in the longer term and that she may need to begin thinking about residential care.

Future Model

Jean's needs were assessed using the Northern Ireland Single Assessment Tool (NISAT), which allowed for all the information necessary to establish her health and social care needs to be collected in one assessment. All of those supporting Jean use this information so she doesn't have to provide the same information several times to various different professionals. Jean sees the specialist looking after her diabetes at her local which is more convenient.

Further to the NISAT, the adaptations were made to Jean's steps. The assessment also identified that Jean required a cataract operation – both these interventions happened quickly preventing her fall.

Jean was provided with details of the budget available to meet her care needs. The Trust explained that they could manage how this budget would be used or she could receive the budget via a Direct Payment and use it to purchase services herself. Jean chose not to take a Direct Payment, and instead to agree jointly with the Trust how her care budget would be used. They agreed that she would get support with going shopping and attending a local lunch club.

Case Study – Long Term Conditions

Current Model	Future Model
Tom is a 75 year old man suffering with heart problems. He lives on his own but is visited regularly by his daughter. He experiences regular breathing difficulties and his condition is exacerbated by regular chest pains which results in recurring episodes. After waiting in A&E to see a junior doctor and explained his circumstances he has been admitted to a ward where he receives the appropriate treatment required to treat his condition and symptoms. He does not require a referral to see cardiologists. He is discharged when stable after 5 days with appropriate advice on medications and life style. The next time he experiences the same symptoms he is worried and he phones his GP. His GP recognises that this is an exacerbation of his heart failure and sends an ambulance to take him to A&E where he is admitted again. This cycle is repeated again and again and Tom visits A&E 10 times that year.	Tom's GP referred him directly to the community heart failure team who contact him the day following discharge. The nurse arranges to come out to see him in a few days and ensure he understands all the medication he has been prescribed. His daughter is included in these discussions. They are educated about his symptoms and lifestyle and left a number to phone if the symptoms get worse. Tom visits the nurse in two weeks while his medications are increased in line with his clinical presentation. The Heart Failure nurse in secondary care provides specialist telephone advice as necessary. A referral to cardiology will be made if deemed necessary. The nurse takes every opportunity to educate Tom on his condition in order to ensure he knows how to manage his condition. If Tom feels that his symptoms are getting worse he can phone the heart failure nurse help line number who arranges to see him quickly. This proactive contact continues as appropriate for four years during which time Tom only needs to be admitted once to hospital for stabilisation of treatment. This admission is planned by the specialist heart failure team and Tom does not have to present to A&E.

Case Study – People with a Physical Disability

Current Model	Future Model
Gary is a 23-year old man who has cerebral palsy. As a result of his condition, Gary has been in a wheelchair for most of his life. Gary spends most of his time at home or at the local day centre. He has a care worker who visits his home for 30 minutes each morning to assist his mother getting him out of bed and dressed. He then goes to the local day centre. Each evening, his care worker returns to assist his mother in putting Gary to bed. Gary is concerned that he does not receive enough stimulation at the day centre and the activities which he participates in are very limited. Gary would be keen to spend more time with people of his own age group and expand his social networks, as the only people he truly engages with at present are his close family members.	Gary is a 23-year old male with cerebral palsy. His care worker visits his home for thirty minutes every morning and evening to assist his mother with getting him in and out of bed and getting dressed. Gary would prefer to have more control over his daytime activities. He decides to receive some of the budget available for his care in the form of a Direct Payment from the HSC Trust. He uses the Direct Payment to buy the support of a care-worker two days per week. Gary now attends the local college one day per week, where he has joined a committee for students with a disability. On another day his support worker helps him with leisure activities such as swimming. Gary still spends three day per week at the day centre. To help manage his Direct Payment, he receives help from a voluntary sector organisation on being an employer, including how to recruit and pay someone.

Mental Health

Current Model

Joe is an unmarried, 25-year old man who lives at home with his mother. He worked for three years as an engineer in a production factory, but unfortunately one year ago he was made redundant from his job.

Over the period since his redundancy, Joe has become increasingly depressed. He feels hopeless, experiences disturbed sleep, has lost interest in playing football and has become withdrawn from his friends. Joe's mother has encouraged him to visit his GP for some help, but Joe feels too embarrassed to do so.

Joe has also started to drink heavily in an attempt to self-treat his depression. When his mother would encourage him to stop drinking, he would become aggressive towards her, which made him feel guilty. Joe has started to self-harm and have suicidal thoughts.

The physical injuries caused by Joe's self-harming became so serious that he had to be admitted to hospital for treatment. Joe was also assessed by a psychiatrist at this time. Once the physical injuries had been dealt with, Joe was discharged from hospital and prescribed antidepressants to assist in the management of his illness.

Future Model

Joe feels increasingly depressed having been made redundant from his job. He feels disconnected from his friends and experiences disturbed sleep.

Joe picks up a booklet in a local takeaway produced by a local community organization. It encourages young men to look after their mental health and explains how to get help if necessary. Joe had been worried that there would be a social stigma attached to seeking help for mental health problems, but when he sees this advice he feels reassured that he could seek help.

Joe went to his GP who listened to his problems and advised that he should attend cognitive-behavioural therapy sessions. Joe now meets his therapist once per week at the local health centre, and also has regular review appointments with his GP to monitor his progress.

Joe was glad that he had heard the advice about seeking help with mental health problems at an early stage. He is now feeling much better and his illness is under control.

Case Study – Urgent Care

Current Model

Abby is 32 and is a keen cyclist. As she travelled home one afternoon, Abby was forced onto a curb by an oncoming car and crashed her bicycle which left her in considerable pain. On further inspection, Abby needed medical attention as her arm was bleeding badly and she was unable to move her wrist or put any pressure on it.

Abby called her husband who took her to the nearest A&E department. She explained her situation and gave her details and waited to see a consultant. A serious traffic accident requiring urgent attention meant that Abby waited 4 hours for an assessment while continuing to be in distress.

Eventually Abby saw a doctor where she was given stitches and some pain relief, as well as a splint to secure the arm and prevent any further damage. Abby was then referred for an X-ray to identify any fractures. After another lengthy wait of two hours for the X-ray and then the results the X-ray showed that no major damage had been caused.

Abby was free to return home and told to make an appointment with her GP to get her stitches removed.

Future Model

When Abby called her husband to tell him what had happened, he remembered the new number to call for all urgent care enquiries which he had learnt from a leaflet which had come in the post. After ringing the helpline, he was advised to take Abby to the local Health and Care Centre.

When Abby arrived at the Health and Care Centre she waited for a specialist nurse who saw her almost immediately. The nurse investigated the injury and identified that stitches were required but an X-ray would confirm whether further treatment was required. Abby received some pain relief and went for an X-ray which was taken in the same facility within half an hour.

The X-ray showed no fracture and Abby was free to return home after the nurse applied some stitches. Abby was advised to make an appointment with her GP to organise the removal of her stitches.

7. POPULATION HEALTH AND WELLBEING

INTRODUCTION

Prevention is integral to the delivery of sustainable health and social care. It enables individuals to make better health and wellbeing decisions. Additionally it is an important determinant in optimising health outcomes for the citizen. Investment in prevention also makes economic sense, for example, inequalities have been estimated in England to cost £5.5billion to the NHS alone.[32]

Total annual inpatient costs to health and social services in Northern Ireland as a result of smoking were estimated at £119million in 2008/9.[33]

Loss to the local economy as a result of obesity is estimated at £500million, with 59% of the population being either overweight or obese. This includes, for example, some £24.5million spent on prescribed anti-diabetic medication alone.[34]

The impact of alcohol on the health and social care system is estimated at some £250million. The additional social costs are estimated at almost £900million. Furthermore, it is estimated that alcohol is a significant factor in 40% of all hospital admissions, rising to 70% of Accident and Emergency attendances at weekends.

Given the significant impact of these issues on the health of the population and the costs of care, strategic and bold action is required. No system can withstand the pressure of doing nothing, and the HSC has a duty to address the health inequalities in our population.

THE CHALLENGES

The starting point is to acknowledge that population health and wellbeing is not just a matter for the health and social care system. It begins with the individual and the choices they make, but improving health and reducing health inequalities also requires joint action across government and partnership working. One area brought to the Review's attention was rural isolation and transport. The Review would suggest this is an area in which joint working could be piloted, including joint sharing and control of resources.

No-one disagrees with the concept of health and wellbeing, the challenge is to deliver a programme of change. Financial pressures will undoubtedly increase within HSC budgets, and often there is

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[32] NICE (2009) Using NICE guidance to cut costs in the downturn.

[33] RCP (2000) Nicotine Addition in Britain: A report of the tobacco advisory group of the RCP applied to 2008/9 HRG costs. In: Ten Year Tobacco Control Strategy for Northern Ireland Consultation Document.

[34] N Gallagher, Presentation QUB Centre of Excellence 2011, Source BSO.

consequent pressure to defer investment in prevention.

LIFESTYLE CHOICES

Alcohol Consumption in Northern Ireland

Given the link between alcohol consumption and harm, and evidence that affordability is one of the drivers of increased consumption, price has become an important feature of prevention strategies. Alcohol is now 44% less expensive in the UK than it was in 1980. It is possible today to exceed the maximum weekly recommended intake of alcohol for men (21 units) for around £4.

A University of Sheffield report, used by the Scottish Government, suggests that a minimum price of 45p and a complete ban on promotions would save about 50 lives in year one, rising to 225 lives in year ten. Moreover, it has been estimated for Scotland that the 45p per unit minimum price would have a total value to health, crime and employment in year one of more than £50million and over ten years of more than £700million.

The submission to the Review from the Royal College of Psychiatrists in Northern Ireland also highlights its view that alcohol price control could be the single biggest act that Government could undertake to improve health and wellbeing in Northern Ireland.

As NICE states: "There is extensive international and national evidence (within the published literature and from economic analyses) to justify reviewing policies on pricing to reduce the affordability of alcohol".

Over the last ten years, it has become increasingly socially unacceptable to drink and drive. This has been via a mixture of enforcement, education and diversion. In this context, it is proposed that a reduction in hazardous and harmful drinking becomes a priority for Northern Ireland with associated targets such as a reduction in A&E attendances helping to drive performance. This could be supported by focused media campaigns to change behaviours/ culture along with evidence based interventions for reducing harmful and hazardous drinking across Northern Ireland.

Smoking

As detailed in the Case for Change, around 340,000 people aged 16 and over smoke in Northern Ireland. Half of all smokers eventually die from cancer, or other smoking-related illnesses.[35] A quarter of smokers die in middle age, between 35 and 69. These deaths could be avoidable.

Reducing smoking is a high priority for public health and there is an ongoing programme of action to encourage people who smoke to stop and discourage people from starting to smoke. This includes public information campaigns and

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[35] Mortality in relation to smoking: 50 years' observations on male British doctors, Doll et al, 2004

smoking cessation services. The model of care proposed by the Review offers the opportunity to take an integrated, area-based approach to these actions, targeting groups facing particular risks, such as pregnant women, and locations where smoking rates are known to be higher, for example colleges.

Obesity

The Case for Change highlighted the rate of obesity in Northern Ireland and the challenges this presents. An estimated 59% of all adults are either overweight (35%) or obese (24%),[36] which has a very significant impact on our population's health and wellbeing. We face a significant challenge in halting the rise in the proportion of the population who are overweight or obese.

A regional Obesity Prevention Framework is being developed to set out the actions needed to reduce the rate of obesity. These include supporting the individual to take responsible decisions and helping to create an environment that supports healthy decisions about diet and physical activity.

In relation to the lifestyle factors of diet, physical activity, smoking and alcohol consumption, it is important that we provide citizens with good information and that we create environments which make it easier for people to make healthy choices.

To support this, the Review would encourage the Northern Ireland Executive to consider the wider role of the state in taking decisions impacting on health outcomes. In addition to considering the emerging evidence on the potential benefits of minimum pricing for alcohol (for example, taking account of the outcomes of the Scottish alcohol pricing initiative), the Executive may wish to consider the issue of pricing of alcohol and 'junk' food and further controls on tobacco usage.

SCREENING AND PREVENTION

Population screening programmes enable the early detection of disease. They involve testing people who do not have any particular symptoms of a disease to see if they have the disease or are at risk of getting it. Screening allows earlier intervention which contributes to improved outcomes for individuals. The current programmes include screening for breast, cervical and bowel cancers, diabetic retinopathy, antenatal infection screening and a programme of screening for newborns.

Immunisation is the most effective public health intervention for preventing ill health and saving lives. It provides people with vaccinations to protect them against serious infections. Many of these are provided in childhood, for example primary vaccinations for diseases including polio, whooping cough, diphtheria, and the MMR vaccine for measles, mumps and rubella. Uptake rates for childhood vaccination are very

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[36] NI Health and Social Wellbeing Survey 2005/06, DHSSPS

high in Northern Ireland and above the UK average. The uptake rates for the flu vaccination, which targets groups at risk of serious harm from the winter flu virus, are also higher than the UK average in Northern Ireland.

The Public Health Agency is responsible for screening and immunisation programmes. Key priorities are to maintain and expand existing programmes and to introduce new programmes where there is good evidence that they can be effective.

SOCIAL WELLBEING

The role of social support in preventing illness and enhancing individuals' quality of life is well recognised. For example, Section 8 which focuses on care for older people, describes how loneliness and social isolation have been proven to have a negative impact on physical health.

The voluntary and community sector plays a significant role in supporting the social needs of vulnerable groups, often working in partnership with health and social care, housing and other statutory services. This role should be expanded.

THE ROLE OF INTEGRATED CARE PARTNERSHIPS IN HEALTH PROMOTION

The Integrated Care Partnerships proposed under the new model, will have a leading role to play in promoting health and wellbeing. They should be incentivised to support evidence-based health and wellbeing promotion and embed prevention into health and social care services.

This should include:

- expansion of screening and immunisation programmes in the community where evidence exists to support them. Where possible, screening and immunisation should be provided in the community;
- an enhanced role for community pharmacists in health promotion, for example, in relation to information and advice around obesity and weight management, alcohol use and minor ailments;
- support for the role of Allied Health Professionals in secondary prevention, particularly as regards older people, for example, the role of podiatry care in falls prevention, and occupational therapy in rehabilitation;
- support from clinicians for community-based education programmes; and
- local community and voluntary organisations supporting the social and emotional needs of vulnerable groups.

SUMMARY OF KEY PROPOSALS

1. Renewed focus on health promotion and prevention to materially reduce demand for acute health services.

2. Production by PHA of an annual report communicating progress on population health and wellbeing to the public.

3. Maintenance of existing and implementation of new screening and immunisation programmes where supported by clinical evidence.

4. Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: in relation to pricing of alcohol and 'junk' food; and further controls on tobacco usage.

5. Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.

6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.

7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community.

8. Support for the health promotion and prevention role played by Allied Health Professionals, particularly with older people.

8. OLDER PEOPLE

INTRODUCTION

As highlighted in the Case for Change, Northern Ireland has the fastest growing population in the UK and it is an ageing population. By 2020, the number of people over 75 years is expected to increase by 40% from that in 2009, and the number of people aged over 85 is expected to increase by 58%.

Longer life expectancy is something to celebrate and many older people enjoy good health. However, among the 'older old', rates of ill health and disability increase dramatically. For example, dementia mostly affects people over the age of 70[37], and the rate of disability among those aged over 85 is 67% compared with only 5% among young adults[38]. The health and social care system cares for the most vulnerable when their needs change. Older people are significant users of health and social care services, and almost a fifth of the Health and Social Care budget (19% or £616million) is allocated to services for older people[39].

- Around 60% of acute hospital beds are typically occupied by people over 65.[40] Many arrive at hospital because there is no viable alternative in the community (more specific information on this follows later).
- Approximately 23,389 people receive domiciliary care, equating to some 233,273 hours of care each week.
- 9,677 people aged over 65 live in nursing or residential care.

Many excellent health and social care services are provided for older people by dedicated staff, volunteers and unpaid carers. But there is a high level of dependence on institutional and hospital care, and inconsistencies in the quality and range of services provided across Northern Ireland. Services are not currently meeting expectations in terms of quality and consistency. Too often they tend to focus on acute events and crises rather than providing the range of proactive and preventative support that can maintain the health and wellbeing of older people.

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[37] DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.
[38] DHSSPS (2010) Physical and Sensory Disability Strategy. A Consultation Document 2011-2015.
[39] HSCB Social Care Directorate Submission to the Review (October 2011)

[40] HSCB figures for 7/12/11 identified 60% of emergency and elective admissions excluding obstetrics, sick babies, the Children's Hospital and mental illness.

HOME AS THE HUB OF CARE FOR OLDER PEOPLE

Residential and Nursing Home Care

The proportion of older people in Northern Ireland living in nursing homes is 3.5 times higher than in England and Wales[41] and is increasing. Between 2007/8 and 2009/10, the number of nursing home places increased from 6,392 to 6,694. This reflects the growing complexity of needs and high dependency levels among some of the older population – for example the growth in cases of dementia where currently there are an estimated 19,000 cases. [42]

Meanwhile, the number of residential care places is slowly declining, reflecting the growth in supported housing schemes provided by Housing Associations which have replaced residential homes. Over the same period 2007/8 to 2009/10, the number of residential places fell from 3,096 to 2,983. Many of those using residential care are no longer permanent residents.

The policy aim for some time has been to shift care from institutional settings to home and community settings. The current Health and Social Care Board (HSCB) target (from April 2011) is for at least 48% of care management assessments to recommend a domiciliary care package rather than a nursing home or residential care. However, the majority of expenditure still relates to institutional care. In 2009/10 residential and nursing home provision accounted for £190million, with domiciliary care accounting for £138million and hospital care for £115million. Suggestions on how to improve care, from the online survey, included more community services, person centred care and in-reach services.

Following from the key principle that home should be the hub of care, the Review recommends that steps are taken to support greater provision of services for older people at home and in the community.

The Review supports the trend towards independent living – at home or in supported accommodation – and expects to see a very significant reduction in provision of long-term residential places in the next five years. This will inevitably

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[41] Reshaping the System, McKinsey 2010

[42] DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.

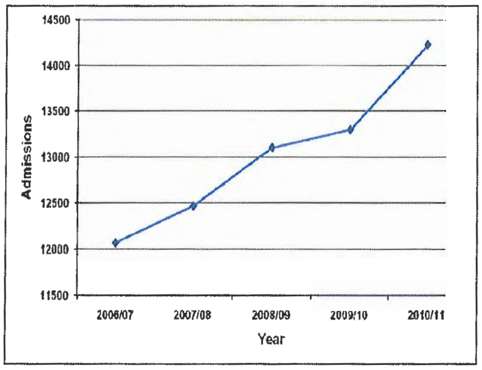
lead to the closure of existing facilities in a planned manner with resources transferred to home care or where appropriate to new models such as respite care.

Hospital Care

Increasing numbers of older people are being admitted to hospital on an unplanned basis and when they are admitted, older people tend to have longer stays and are more likely to face delays in waiting for discharge.

Over the five years to 2010/11, the number of admissions of older people into hospital increased by 18%, as shown below.

Figure 14: Total Admissions to HSC Hospitals in NI under the Elderly Care Programme of Care (2006/07 - 2010/11)



Source: NI Hospital Statistics: Inpatient Activity 2010/11

Many older people arrive at hospital because there is no viable alternative in the community, for example, due to lack of appropriate nursing and medical interventions available in nursing homes or at home.

Once admitted, older people tend to have longer stays in hospital. During 2010/11, the longest average length of stay across all specialties in Northern Ireland was under the rehabilitation specialty where admissions lasted for an average of 30.9 days. Longer lengths of stay for older people can be associated with cases involving a complex range of physical and mental health issues and therefore a requirement for a robust package of care to be agreed before discharge into the community.

Since April 2010, a target has been in place stating that the HSC Board and Trusts should ensure that 90% of complex discharges take place within 48 hours of the decision to discharge, with no discharge taking longer than seven days. As at the end of 2010/11, 86% (13,009) of complex discharges were within 48 hours regionally. The most common reasons for delay recorded were:

- no domiciliary package available;
- essential equipment / adaptations not available or assessment not completed; and
- no nursing home bed available in the chosen facility.

Research by the Alzheimer's Society found that people with dementia stay longer in hospital than other people undergoing the same procedure, and stays in an acute hospital environment can have a detrimental effect on the symptoms of dementia.[43] Admissions to hospital can also result in reduced confidence of older people and their families to live independently, and can lead to a move into residential and nursing care[44].

The Health and Social Care Board will begin to introduce a reablement model of care across Northern Ireland from 2012. This approach involves providing older people with intensive, time limited support with everyday tasks with the aim of enabling the individual to do the task as independently as possible at the end of the process. It has been shown to be an effective means by which to keep people independent for longer. The Southern HSC Trust has already begun implementing a streamlined assessment and care planning approach built around the reablement model.

It is also known that older people are often admitted to hospital at the end of life. A recent report by DHSSPS showed that 82% of people dying in hospital were over 65 years of age. Of these people, 18% (2010/11) had a length of stay of less than 2 days. The report also looked at the number of people dying in hospital within 2 days of admission who were admitted from a nursing home. In 2009/10, 28% of the deaths of people admitted from a nursing home occurred within 2 days of admission into hospital.[45]

Suggestions for improved care for people nearing the end of life, from the online survey, included more home support to allow people to die in their preferred location.

To help avoid unnecessary admissions of older people into hospital and encourage independence, the Review endorses the plan to introduce a reablement model across Northern Ireland. The Review also recommends that there should be better integration of hospital and community services. With the establishment of the 17 Integrated Care Partnerships there is a tremendous opportunity to:

- improve communication between GPs providing out of hours care and hospital specialists;
- provide in-reach into nursing homes by specialists and GPs;
- have clear specification of the care and interventions to be provided in a nursing home environment including, for example, administration of intravenous therapy and catheterisation;
- provide the management of end of life care in nursing homes – being transferred to hospital at the end of life can be distressing and the Review recommends that other than for sound

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[43] DHSSPS Dementia Strategy

[44] Stilwell and Kerslake (2003) What makes older people choose residential care, and are there alternatives?

[45] DHSSPS Hospital Information Branch (2011)

clinical reasons or family preference, nursing homes should manage end of life care;

- create greater provision of intermediate care, increasingly using the independent sector to provide:
    - step-down beds for short-term rehabilitation following a stay in hospital;
    - step-up beds that provide short-term support to prevent an admission into hospital; and
    - short-term reablement support to enable people to learn or relearn the skills necessary for independent living.

The Review suggests that whilst some intermediate care beds will be statutory, there will be an increased role for the independent sector in providing beds.

Patient and User Experience

The public place a high priority on the availability of good care for older people. In November 2011, the Patient and Client Council (PCC) engaged with its members on the future priorities for HSC in Northern Ireland. Of the top ten priorities identified, Care of the Elderly, including domiciliary care was second. Those consulted raised concerns about both the quality and quantity of social care provided, and the need for appropriate care in the community to help people live in their own homes. The need for better support for older people living in rural areas was identified.

Those consulted with by the PCC raised concerns with the PCC about the length of time that is allocated to those delivering domiciliary care.

Appropriate discharge planning for older people leaving hospital was also highlighted as a concern. Those consulted expressed a view that a holistic approach to discharge planning should be undertaken and that the patient, carers and community and primary care providers should all be involved in this process.

The quality and availability of respite care was highlighted as an issue, in particular for people with dementia. Consultees emphasised the importance of respite to support individuals and their families and carers.

The public survey conducted for this Review also found evidence of concerns with the quality and accessibility of care for older people:

- 35% of respondents felt that there was a 'lot of improvement' required in the health and social care services provided to older people overall;
- 24% of respondents stated that a 'lot of improvement' was needed in the quality of residential care for older people;
- 36% of respondents stated that 'a fair amount of improvement' or a 'lot of

improvement' was required in home help or home nursing care; and

- strong concerns were expressed about the waiting time for an assessment for home help, nursing or residential care - 33% felt that a 'little improvement' was needed, with 24% and 21% respectively, stating that a 'fair amount' or a 'lot of improvement' was required.

Workshops with clinicians confirmed public concerns in relation to care for older people. Clinicians highlighted the increasing demand for nursing and residential care due to the ageing population. They expressed the view that the capacity and capability of staff within nursing and residential care settings to provide care to the increasing numbers of patients with complex care requirements needs to be addressed. Quality issues were identified including poor nutrition of older people in hospital, nursing and residential care.

A 2008 UK-wide nutrition screening survey in hospitals, nursing homes and mental health units found that people in these care settings had a higher risk of malnutrition on admission and that the risk was much higher again for older people being admitted to care. For example, it estimated the rate of malnutrition for those aged 65 in the community at 14% compared with 32% for those being admitted to hospital and 42% for those being admitted to care homes[46].

Clinicians also highlighted a perceived lack of continuity and integration between hospital care and community based care. The limitations of IT and communications systems to support sharing of information between hospitals, primary care settings and residential and nursing homes was noted.

They expressed the view that greater rehabilitation and intermediate care is needed to prevent hospital admissions and support timely discharge.

The Review was persuaded of the need for, and its new model supports, a shift in services from hospital settings to closer to home. This will require more personalised care and diversity of service provision. Advocacy will be important in providing safeguards to vulnerable individuals. Telecare support will enable the greater management of risk and improving personal confidence.

PROMOTING HEALTHY AGEING

Throughout the Review, the public and clinicians expressed a desire for a more preventative model of care and one which enables better quality of life for older people. This is supported by research that suggests that preventative approaches can deliver better outcomes

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[46] DHSSPS - Promoting Good Nutrition A strategy for good nutritional care for adults in all care settings in Northern Ireland.

for older people, with fewer hospital admissions, shorter lengths of stay and greater satisfaction with service provision.

Preventative approaches aim to take a more holistic view of older people's needs, by addressing issues other than health which impact on wellbeing but require intervention from other areas of public service. The Joseph Rowntree Foundation's Older People's Inquiry[47] identified the areas that are valued by and thus important for the wellbeing of older people as:

- comfortable and secure homes;
- an adequate income;
- safe neighbourhoods;
- getting out and about;
- friendships and opportunities for learning and leisure;
- keeping active and healthy; and
- access to good, relevant information.

This emphasises the need for a more joined-up approach to assessing the care needs of older people, recognising the role of multiple providers of health and other services across the public, voluntary and community, and private sectors. The Northern Ireland Single Assessment Tool (NISAT) aims to provide a joined-up approach to assessing the needs of older people and carers, but rollout of the tool is at an early stage and it is not yet in use in all HSC Trust areas.

The Partnerships for Older People Projects (2009) in England tested more integrated approaches to supporting older people. Its evaluation suggests that low intensity practical support services that

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[47] Raynes, N et al (2006) Evidence submitted to the Older People's Inquiry into 'That Bit of Help.' York, Joseph Rowntree Foundation.

help older people to live well in their own homes (e.g. cleaning, care of pets, gardening, befriending, help with managing bills and DIY) had by far the greatest impact on health-related quality of life[48].

There is also good evidence of the effectiveness of interventions to reduce loneliness and social isolation and improve health and wellbeing. Social exclusion is associated with poor physical and mental health outcomes for older people, and social isolation has been identified as a particular risk for older people in rural areas.[49] A review of a rural intervention to address social isolation among older people in Northern Ireland concluded that health and wellbeing of older people can be profoundly influenced by geographical location and that interventions informed by local needs are likely to be more successful.[50]

A recent report by the Social Care Institute for Excellence (SCIE) illustrates the emerging evidence that one to one interventions such as befriending and outreach can reduce loneliness and depression, and are cost effective[51]. Such initiatives are often provided by community organisations. In this regard care services are more important than health services.

Ultimately, older people want to stay at home, living independently for as long as possible, and the current model of care does not always provide the support needed to do so. Too often this results in reliance on institutional care with crisis intervention as the order of the day. This is not consistent with a shift to the wellbeing model the public expects.

Personalised budgets refer to the greater involvement of those qualifying for health and social care services in how they are provided. Needs assessment identifies the amount of care funding available for each individual and a joint decision is taken between the service user and the provider on how that funding will be used.

This includes the option to access a Direct Payment which involves the provision of funding directly to patients and clients who then purchase directly the services they feel best meet their needs. Direct Payments are available to older people who need support, individuals with physical disabilities, learning disabilities or mental health issues.

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[48] Windle, K et al (2009) National evaluation of Partnerships for Older People Projects: final report. Canterbury, Personal Social Services Research Unit.

49 Commission for Rural Communities (2008) The Personalisation of Adult Social Care in Rural Areas.

[50] Heenan (2009) How Local Interventions Can Build Capacity to Address Social Isolation in Dispersed Rural Communities: A Case Study from Northern Ireland. Aging International, vol 36, no 4, 475-491

[51] Windle, Francis and Coomber (2011) Preventing loneliness and social isolation: interventions and outcomes. Social Care Institute for Excellence.

When people are provided with information and advice on the services that are available to them, they are in a position to make an informed choice as to the most appropriate care delivery for their particular needs. Those choosing to take a Direct Payments are able to choose who provides their care, when they deliver it and what they do to meet their particular needs. This may mean reduced uptake of core social care services provided directly by the HSC Trusts and uptake of a more diverse range of provision including that of the voluntary sector. Direct Payments users may also employer support workers directly.

Promotion of personalised approaches and the uptake of Direct Payments has been Government policy across the UK for some time. However, research has shown that there may be variation in the benefits experienced by patients and clients receiving direct payments, especially for older people and those with mental health problems. The most recent figures indicate that a total of 687 older people are in receipt of Direct Payments and 34 carers receive Direct Payments on behalf of an older person[52].

During the Review, the Direct Payments process was highlighted as being bureaucratic and of limited appeal to older people and their families. The need for independent provision of advocacy and coordination was identified as a method to facilitate and support service users in using personalised budgets.

Where individuals do not wish to take financial control, they should be given the option of advocacy to act on their behalf or a financial statement of the cost of their assessed support to enable greater choice on their part.

The Review concludes that there should be a focus on promoting healthy ageing, individual resilience and independence among older people.

Care for older people should be underpinned by a consistent assessment process, and a more holistic approach to planning and delivering support taking account of physical, social and emotional needs. Budgets within health and social care should be pooled, with joined up assessment and planning of needs using NISAT. The Review would also recommend pilots to explore budgetary integration beyond health and social care so as over time, the support funding managed by other parts of the public sector e.g. for housing support, could be integrated into a single care budget.

Support planning should take account of a diverse range of health, social and other support services appropriate to the needs of the individual, whether provided by statutory health and social care providers, the independent sector or voluntary and community sector providers. Service user involvement models for adult social care are being developed in other parts of the

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[52] HSCB Statutory Monitoring Returns May 2011

UK as a basis for more collaborative 'co-production' of services.[53]

The role of care users and their families as partners in care should be recognised, and support should be personalised to deliver the outcomes care users and their families want to achieve. This should include control over and clear information about budgets, whether through Direct Payments or involvement in personalised budgets where HSC procures services on behalf of and as directed by the individual. Advocacy and support should be available if needed to help make this a reality.

A diverse choice of provision should be available to meet the individual health and social care needs of older people, with appropriate regulation and safeguards in place to protect the vulnerable. The Review recommends overhauling the current financial model to drive this objective within the statutory, voluntary and private sector.

SUPPORTING CARERS

Informal care from family and friends is vital to enabling a large number of older people to continue to live in the community. Across the UK, this informal care is estimated to equate to £87billion per year[54]. Carers UK estimate that there are 207,000 carers in Northern Ireland (a substantial increase from the DHSSPS figure of 185,000 quoted in 2006) and that the value of the care they provide is more than £4.4billion per year.

Carers can suffer poor physical and emotional health themselves, either directly because of the strains of their caring role or because their caring role restricts their ability to access health care. Carers UK report that carers are twice as likely to be permanently sick or disabled than the average person. The Princess Royal Trust for Carers research 'Always on Call, Always Concerned' found that 69% of carers surveyed reported a negative impact on their physical health from their caring role, and the same percentage reported that caring had a detrimental effect on their mental or emotional health.

Frequently the Review heard from carers the centrality of their role and their sense of being taken for granted.

The Caring for Carers Strategy (DHSSPS 2006) was designed to recognise, value and support the role of carers. Each HSC Trust has a nominated carer co-ordinator and is developing new ways of supporting the needs of carers. An assessment of carer needs is an integral part of the NISAT approach which is beginning to be rolled out across all HSC Trust areas.

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[53] Needham and Carr (2009) Queen Mary University of London, SCIE Research briefing 31: Co-production: an emerging evidence base for adult social care transformation Social Care Institute for Excellence.

[54] Valuing Carers – Calculating the Value of Unpaid Care, Carers UK 2007.

Different carers are likely to need different types of support and their needs will change over time. Carer support interventions may include:

- programmes designed to educate carers about the care-recipient's condition and treatment;
- peer or professionally led carer support groups;
- respite services to provide carers with 'time away' from their caring responsibilities, including within the home, daycare or residential / inpatient provision;
- psychological therapy for carers; and
- care recipient training to promote confidence, self management and empowerment.

Evidence indicates that carer interventions such as these are effective in reducing carer depression and in some cases can have a positive impact on the condition of the care-recipient. Interventions which exist over a longer period of time have been found to be more successful than short-term initiatives[55]

The Review recommends a policy review to improve the outworkings of the carer assessment to better respond to their needs. There should be better recognition of carers' roles as partners in planning and delivering care for older people, and more practical support including, in particular, improved access to respite provision.

THE COSTS OF CARE FOR OLDER PEOPLE

Those engaging with the Review raised the issue of funding for adult social care and the potential future mix of funding sources including health and social care funding, social security benefits, and the patient or user's income. Current legislation in Northern Ireland enables charging of those being admitted to institutional care or receiving home care, but at present charging is not enforced for home care. The Review's role is not one of recommending charging but suggests it is a debate in which Northern Ireland society must fully engage.

The Review acknowledges that the independent sector is a major local resource in providing care for older people. It recognises that the relationship with government, particularly over pricing can be difficult. Consequently, the Review recommends the DHSSPS undertakes a policy review to consider:

- the benefits or otherwise of independent price regulation within the sector;
- the feasibility of the introduction of a certificate of need scheme ahead of

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[55] Tommis, Zinovieff, Robinson and Morgan (2009) Carer Interventions Assessed Final Report. All Wales Alliance for Research and Development in Health and Social Care

the development of new premises with upper size limits;

- much more due diligence checking on any organisation entering the market, including exploring the concept of a financial bond for new entrants to minimise risk on all sides; and
- ongoing financial appraisal to ensure the robustness of facilities in the sector.

SUMMARY OF KEY PROPOSALS

9. Home as the hub of care for older people, with more services provided at home and in the community.
10. A major reduction in residential accommodation for older people, over the next five years.
11. Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.
12. A greater role for nursing home care in avoiding hospital admissions.
13. More community-based step-up/step-down and respite care, provided largely by the independent sector.
14. A focus on promoting healthy ageing, individual resilience and independence.
15. More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.
16. A holistic and consistent approach to assessment of older people's needs across Northern Ireland and an equitable range of services.
17. A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.
18. Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.
19. A policy review of carers' assessments and more practical support for carers including improved access to respite provision.
20. An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.

9. LONG TERM CONDITIONS

INTRODUCTION

Long-term conditions (LTCs) refer to patients who have a condition that cannot, at present, be cured but can be controlled by medication and/or therapy for example diabetes, asthma or hypertension. These conditions affect both adults and children.

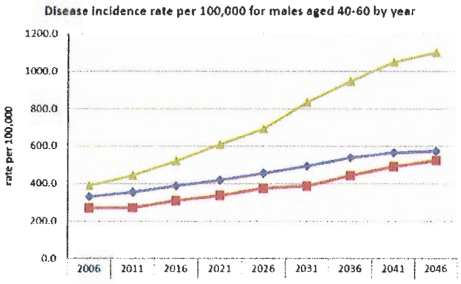
International studies have found that the cost of care for only 5% of the population makes up nearly 50% of the healthcare budget.[56] The majority of the 5% are made up of the elderly and people with long term conditions. Incidence of long-term conditions are on the rise.

A report[57] by the Royal College of GPs has identified that individuals with long term conditions account for more than 50% of all GP appointments, 65% of outpatient appointments and over 70% of in-patient beds in England. It also advocates that GPs are better placed to help individuals manage the issues associated with their condition.

It is clear that people with LTCs require high levels of care. It naturally follows that the health and social care system needs to focus its efforts on how to deliver high quality care to these individuals. The objective is to ensure better outcomes for patients. It is also important to understand that better organisation of care pathways will improve quality and value for money. The recent policy framework Living with Long-term Conditions[58] set out a number of principles and actions for the overall approach to the treatment and care of adults with LTCs.

The figure below illustrates the disease incidence rates for adult males.

Figure 15: Disease Incidence Rates



Source: National Heart Forum: Obesity Trends for Adults. Analysis from the Health Survey for England, (2010)

The Review recognises and celebrates advances made in modern treatments, but is also cognisant of the implications to future well-being. Major advancements in treatments for illnesses such as cancer have improved the life expectancy of sufferers. Increasingly cancers are becoming LTCs. Health and Social Care needs to ensure that it is ready to manage

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[56] Research In Action, Issue 19, 2006

[57] Care Planning: Improving the Lives of People with Long Term Conditions, 2011

[58] DHSSPS (2011) Living with Long-Term Conditions A Policy Framework Consultation Document

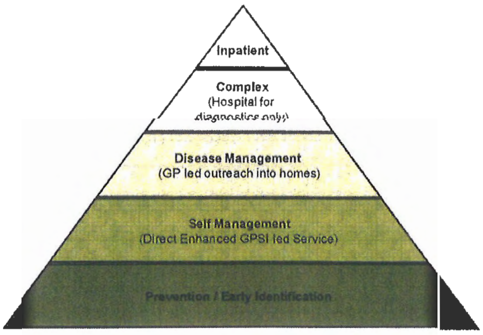
the LTCs that often develop as a result of progress in treatment.

The reality of the current system is that on many occasions individuals with a LTC are admitted to hospital after completing a complicated journey through A&E because there is no alternative.

In recent years, an emphasis has been placed on increasing the role of primary care and the community supporting LTCs. It is the Review's view that this current role can be expanded and based around the principle of 'home as the hub of care'.

The approach to the management of long term conditions should be based on the theory that the majority of effort is in prevention, early identification and self management with as little as possible care delivered within an inpatient setting, as shown in the following diagram.

Figure 16: Approach to management of Long Term Conditions



FOCUS ON PRIMARY AND SECONDARY PREVENTION

Whilst not all conditions are preventable, evidence indicates prevention has a key role in tackling:

- the increase in the percentage of children and adults who are overweight or obese;
- the increase in the number of people with long term conditions, such as diabetes;
- the higher frequency of risk factors for heart, stroke, vascular and respiratory diseases in more disadvantaged communities; and
- the higher death rates from conditions such as coronary heart disease, stroke, vascular and respiratory diseases in our society, particularly in more disadvantaged communities.

Although not all long term conditions are preventable, steps can be taken by individuals to decrease their chances of developing a condition. These include:

- promoting healthy lifestyles;
- reducing alcohol related problems;
- reducing overweight/ obesity levels;
- increasing a focus on psychological well-being; and
- decreasing incidences of falls among older people.

For many conditions, early case identification can be the key to limiting the effects of an illness.

There is a link between the prevalence of some conditions and deprivation, in particular for Chronic Obstructive Pulmonary Disease and asthma where rates are highest in the most deprived wards.[59]

The first focus is therefore to enable much greater self care to avoid chronicity. Integrated partnership working between clinicians in primary and secondary settings can produce real benefits for patients, for example in the treatment of diabetes. Support therefore begins with the GP, integrated community teams and community pharmacy.

The online survey included early intervention and use of community pharmacists as suggestions for better care for people with long term conditions and the Review supports this approach.

The Review considers Integrated Care Partnerships, that is professionals working together providing services for a population, as the way forward. In this regard the GP list acts as a building block for creating populations to enable this to happen. The data already known has the potential to be warehoused to inform best practice and intervention methods.

PERSONALISATION OF CARE PLANNING

At present personalised care planning is not practised in every area of NI. Consequently, care provision for people with a long term condition often lacks cohesion and consistency. This is a real source of frustration for the individual as they are managed simultaneously by a series of health professionals. This system results in the duplication of information reporting, which impedes analysis and treatment of the problem. All too frequently this results in overuse of hospitals.

Evidence shows that where information is readily available and accessible to all parties concerned with the treatment of LTCs, including the individual, patient experience outcomes are through a better managed system of delivery. This is enhanced even further if the individual has been involved in the planning of their care. Working in a more integrated system enables a more easily understood and straightforward care contract with individuals and their family to be created.

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[59] PHA Health Intelligence Briefing, QOF, 2011

Flexible care packages should make arrangements more responsive for individuals, particularly those with changing circumstances.

Evidence suggests that with the correct support, individuals suffering from a long term condition can have an important role in the management of their condition.[60]

Self management enables individuals to take control of their own care plan, acquiring the skills required to manage them through the education they have received.

The Stanford University Model designed by Professor Lorig, recognised that issues faced by individuals with chronic conditions were often exacerbated by a number of factors including pain management, stress, low self esteem and depression.

To tackle this, better planning of self-care management will need to be introduced and replicated across the region.

Social and emotional issues can be supported within the community by establishing links between the individual and clubs, societies, transport and other amenities which will have a direct impact to the overall well-being of the person.

The Expert Patient programme[61], led by fellow sufferers aims to empower people to:

- feel confident and in control of their life;
- manage their condition and its treatment in partnership with healthcare professionals;
- communicate effectively with professionals and be willing to share responsibility for treatment;
- understand how their condition affects them and their family; and
- use their skills and knowledge to lead a full life.

An important part of the individual's ability to manage their LTC will be the strength of the support they receive from family and friends. Carers should be respected as partners in care in regard to the overall provision of services.

Working within Integrated Care Partnerships, community pharmacies have an important role in the support of individuals with a LTC, particularly in medicines management as discussed below.

Predominately referring to diabetes care, but applicable to the management of all long term conditions, a 2007 report described how organised and proactive

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[60] Patient and family participation – What difference should it make to the quality of care?

[61] NHS England

services in partnership with engaged, empowered patients would ultimately provide better outcomes.[62]

One example of this in action has been the introduction of insulin pumps. The Public Health Agency reports the case of a 14 year old girl who was previously admitted to hospital 99 times from 2001-2010, but since the introduction of an insulin pump has had no diabetic related admissions. As a result her attendance at school and level of academic achievement has increased.[63]

The North West London Integrated Care pilot introduced greater use of multidisciplinary teams working within the community as well as having a direct link into secondary care.[64]

In the new model of care recommended by the Review, multidisciplinary teams will form the essential nucleus of health care professionals supporting patients in their own homes and community.

The integrated team is likely to include:

- General Practitioner;
- General Practitioner with a Special Interest (GPSI);
- Specialist Nurse;
- Occupational Therapist;
- Physiotherapist;
- Dietician;
- Social Worker; and
- Support Care Workers.

The composition of these teams should reflect the needs of the local population and be flexible to adapt to the nature of individual cases. All GP surgeries should indicate the lead professional for that practice. It may not always be that individual who treats or supports but they should be the first point of reference for patient and colleague professionals.

MEDICINES MANAGEMENT

People with LTCs often have multiple medicines to help manage their symptoms. Pharmacy errors are a very common risk factor for these patients. Compliance with the directions for use is key to the successful use of the medicines. The community pharmacy plays a key role is assisting people with LTCs.

The community pharmacist will form part of the multi-disciplinary approach to the management of LTCs. Pharmacies are ideally placed within local communities to provide advice without appointment. [65]

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[62] Roberts S, Working together for better diabetes care: Clinical case for change, Department of Health, 2007

[63] PHA, 2011

[64] North West London Integrated Care Pilot : Business Case, 2010

[65] Supporting people with long term conditions to self care: A guide to PCTs in developing local

This new model seeks to keep the focus on the patient, providing alternative options to being admitted to hospital, and providing opportunity to prevent such occurrences wherever possible.

In the new model General Practitioners with a Special Interest (GPSI), will assess the individual to determine the correct treatment needed and where the most appropriate setting is. Where an individual requires secondary care, the GPSI will contact a specialist directly for admittance to hospital. Case records will be fully available to the hospital which will improve efficiency and reduce length of stay.

Making the home the hub of care, multi-disciplinary teams would provide the primary source of intervention. These health care professionals will be known to the individual, and likewise to each member of the team, allowing quick response and effective treatment delivered locally.

Community led teams should also be responsible for helping individuals to prevent their condition worsening. Regular contact with the individual is essential, along with practical support and education.

DIRECT ADMISSIONS TO HOSPITAL FOR PEOPLE WITH LTCS

Early prevention and self managed care supported by multidisciplinary teams will help stem the demand for hospital care. However, there is still a real need for high quality, responsible acute care for those who need hospital care.

In the event of an individual requiring emergency treatment, there should be greater integration between community teams and secondary care clinicians.

The GPSI will be able to contact the hospital directly once it has been determined that acute care is required. Direct admission will ensure a better experience for the patient and ultimately a better outcome.

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strategies and good practice, Department of Health, 2006

TECHNOLOGY

A key enabler in the introduction of the new model is technology. Greater support can be given to individuals and health care professional through telehealth monitoring.

An individual will have the ability to better manage their own condition through a combination of assistive technology and access to information.

The current duplication along with poor patient records slows down the system and causes frustration to the individual when forced to continually relay their particular situation and treatment. A solution to this would be the creation of a single Electronic Care Record (ECR) which follows the individual through different care settings and Trust boundaries.

SUMMARY OF KEY PROPOSALS

21. Partnership working with patients to enable greater self care and prevention.

22. Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.

23. Patients to have named contacts for the multi-disciplinary team in each GP surgery to enable more straightforward communication.

24. Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.

25. A stronger role for community pharmacy in medication management for LTCs.

26. Development of admission protocols between secondary care specialist staff and those in the community.

27. Maximising the opportunities provided by telehealth in regard to LTC patients.

10.PEOPLE WITH A PHYSICAL DISABILIITY

INTRODUCTION

Between 17-21% of the Northern Ireland population have a physical disability and around 37% of households include at least one person with a disability[66]. While many disabled people have no greater need for health and social care support than the rest of the adult population, some draw on specific support services provided by the statutory and voluntary and community sectors. At March 2010 there were 7,527 people with a physical or sensory disability (aged up to 65 years) in contact with HSC Trust disability services. In budgetary terms, adult disability services account for a small proportion of health and social care spend - 2.8% of the HSCB budget or £91million.

PERSONALISATION AND PROMOTING INDEPENDENCE

Personalisation, independence and control are at the heart of the Review and for those with a physical disability. A Physical and Sensory Disability Strategy for Northern Ireland is in the final stages of development. It will formalise in policy terms the changes to the model of support for disabled people. Traditionally, a limited range of support services such as daycare and residential care have been provided for people with a disability.

The current service-led approach should be replaced by a more person-centred model in which statutory health and social care acts as an enabler, working in partnership with the disabled person and their family / carers to help people access the support that meets their individual needs. This may include some of the traditional residential and daycare services, but will increasingly reflect a wider range of needs. For example, a personalised support package might include:

- personal care support at home;
- specialist equipment such as a wheelchair or adaptations to the home;
- occupational therapy, speech and language therapy and physiotherapy;
- assistive technology; and
- assistance with day to day activities such as cooking, travel or work.

Voluntary and community sector organisations play a vital role in providing this much wider range of support and in acting as advocates for disabled people, promoting the control and independence agenda. Other parts of government have an important role to play in promoting independence for people with a disability,

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[66] NISRA 2007, referenced in DHSSPS Physical and Sensory Disability Strategy A Consultation Document 2011-2015. December 2010.

notably housing, education, employment, and culture, arts and leisure.

This approach is supported by the findings of the online survey conducted by the Review which recommended a multi-disciplinary and person centred approach.

PROVIDING THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME

As independent living options become more readily available there has been a gradual decline in the number of people with a disability living in long-term residential care (from 92 in 2005 to 80 in 2010) and there are only three statutory residential homes solely for people with a disability. However, the number of disabled people living in nursing homes has increased over the same period, from 284 in 2005 to 319 in 2010, reflecting the complex support needed by some which is not currently being met in the community.

There continues to be around 400 people with a disability living in long-term care settings. Care could be provided closer to home with more intensive treatment and rehabilitation when needed. Despite the drive to provide more home-based support, the number of people receiving a home-help service actually decreased by 30% between 2004/5 and 2008/9. This may reflect higher thresholds to access services and a focus on providing services for those with the highest level of need or the increase in uptake of Direct Payments which allow individuals to purchase their own support.

There is an increasing population of young disabled people with complex needs who are surviving into adulthood because of improvements in therapies and medical care and who require more intricate and costly packages of care, particularly during the transition to adulthood.

Provision of equipment is vital to allow people with a disability to live well at home. A third of the respondents to the Review's omnibus survey reported that 'a lot of improvement' was required to reduce waiting times for equipment such as wheelchairs and hoists. This issue was also raised at the clinical workshops where clinicians noted concerns surrounding the provision of adequate resources and equipment for patients and clients with physical disabilities. Clinicians also highlighted the need for inter-departmental working to address matters which patients and clients with physical disabilities experience, such as ensuring that housing is suitable for individual needs.

While it will be challenging to balance the increasing complexity of needs and requirement for significant nursing and personal care support, with more independent living, this is essential to promoting the rights of people with disabilities.

New service models will be needed to meet this challenge including continued development of respite and short break care to support disabled people and their families/carers. At present much of this continues to be provided in the traditional residential and daycare settings, but home-based respite services are beginning to be developed and should be further developed.

PERSONALISATION AND INDEPENDENCE

There has been little change in the number of people using statutory daycare facilities, although their role has changed somewhat, for example, provision of short-term respite support. Results from the omnibus survey indicated that 24% of respondents felt that 'a fair amount of improvement' was required with regard to the range of day provision for people with a disability, and a further 22% of respondents stated that 'a lot of improvement' was needed.

Participants at the clinical and voluntary sector workshops and many individuals engaging with the Review focused on the need to shift from a medical model of care and treatment for individuals with physical disabilities, towards a more user-centred care model, which delivers the right care to meet that patient or client's needs. The potential of personalised budgets to improve choice and control was highlighted by many as a means to ensure that the care patients and clients receive meets their particular needs i.e. addresses the question "what would make my life better?"

Direct Payments have been embraced by many people with a physical disability who welcome the greater control they allow. Between September 2007 and September 2010 the number of Direct Payment recipients within the Physical Disability programme of care increased from 312 to 587. Encouraging uptake of Direct Payments has been a target for several years and mechanisms have been put in place to promote uptake and support people with managing their own budgets to purchase services or employ support directly.

While the uptake of Direct Payments is growing, in particular among people with a physical disability, there is potential to grow this and other self-directed support approaches considerably within this group. Feedback from some indicates that bureaucracy is a barrier to uptake of

Direct Payments and a regional approach is needed to tackle this issue and encourage greater uptake.

Set against the endorsement of the forthcoming Physical and Sensory Disability Strategy, the Review proposes the following:

SUMMARY OF KEY PROPOSALS

28. Promoting independence and control for people with a disability, enabling balanced risk-taking.

29. A shift in the role of the health and social care organisations towards being an enabler and information provider.

30. Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a wide range of services across NI.

31. Better recognition of carers' roles as partners in planning and delivering support, and more practical support for carers.

32. More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support where required.

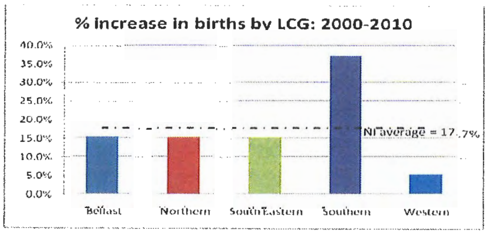
33. More respite and short breaks provision.

11.MATERNITY AND CHILD HEALTH

MATERNITY

The Review is cognisant of the current consultation on Maternity Services[67] and has factored that work into its thinking. In 2010 there were over 25,000 live births registered in Northern Ireland. During the last decade (2000-2010) the birth rate in Northern Ireland has increased by almost 18%. There are significant differences in birth rates across the province, as illustrated in the figure below.

Figure 17: Increase in births by LCG: 2000-2010[68]



Almost all births (99%) took place in hospital, and most mothers (91%) gave birth in their nearest consultant led unit.[69] Less than 1% of mothers are choosing to give birth at home. In recent years the proportion of births to teenage mothers has decreased (5.0% in 2010). Projections indicate that birth rates are likely to decrease over the next decade to approximately 23,500 by 2022/23.

There are a range of consultant led, co-located midwifery led, and freestanding midwifery units in NI. The capacity of the service to provide the recommended level of staffing cover for intra-partum care and to sustain inpatient paediatric services across all existing sites presents challenges, particularly for smaller units.[70]

Maternity care is of a high standard and according to recent surveys, women are happy with the standard of care they receive[71]. However there is increasing potential for variation in the provision of maternity care across Northern Ireland. In addition there are significant inequalities in maternal and infant outcomes, particularly amongst women from socio-economically deprived backgrounds.

The level of caesarean sections is generally higher than in the rest of the UK. There is increasing complexity arising from lifestyle for expectant mothers, most notably the increased rate of obesity, which provide both challenge and risk, across the population. Additionally many

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[67] Maternity Strategy for Northern Ireland, September 2011. DHSSPSNI, 2011

[68] NISRA in Health Intelligence briefing Trends in Northern Ireland Births and future projections, Public Health Agency 2011

[69] Births in Northern Ireland (2010), A Statistical Bulletin, Northern Ireland Statistics and Research Agency, March 2011

[70] Draft Commissioning Plan (Health and Social Care Board and the Public Health Agency – June 2011)

[71] Parental Views on Maternity Services. Parents' views on the Review of Maternity Services for Northern Ireland. Patient and Client Council, 2010.

women now choose to start their families later in life.

Challenges for maternity services into the future include:

- give a realistic choice of birth location for women;
- need for more continuity of care throughout pregnancy;
- reducing unnecessary interventions;
- dealing with the public health issues facing women of child bearing age to reduce ill-health and disability of mother and child; and
- supporting the expectant mother in her ante-natal care and connecting that support to the early years of parenthood.

The Review therefore expects change to follow the pattern set out in the forthcoming Maternity Strategy, from pre-conception, through pregnancy, birth and the post-natal period. In addition it recommends a specific regional plan for supporting the small number of mothers with serious psychiatric conditions.

CHILD HEALTH

Child health problems are often diverse in nature, severity and duration. The causes are often multi factorial and sometimes poorly understood. Effective interventions are often complex and time consuming, requiring a range of skills to be tailored to the needs of individual children.

Following the principle of care at or close to home, the Integrated Care Partnerships will be vital. However it was also clear to the Review that communities and the independent sector should be enabled to support families with ill children where appropriate.

When children need hospital care they need prompt access to skilled staff. There are challenges in providing a full range of paediatric sub specialties to a population of 1.8 million. Given this, there is a need to have clear pathways and consequent consistency of treatment.

In this field workforce issues and multiple service locations have the potential to threaten service resilience. Single handed specialties are difficult to sustain unless networked with other centres, whilst scarce skilled resources need carefully managed in the hospital setting. Notwithstanding this, community paediatrics should become a key resource working alongside integrated care partnerships enabling most care to be provided at or closer to home. The Review also saw potential for more formal links to larger centres in the UK or Republic of Ireland for this service area.

During its deliberations the Review team received a strong plea to examine, as a specific task, the nature, function and shape of in-patient paediatric services. The Review was persuaded this merited a separate piece of work. In this regard it also had drawn to its attention the very specific issue of palliative care for children.

Although there is a Children's Strategy for Northern Ireland there is no strategy for child health and no specific arrangements for palliative and end of life care for children. One of the Review proposals is that palliative and end of life care for children should be considered as part of the proposed review of Paediatric Services.

SUMMARY OF KEY PROPOSALS

Maternity

34. Written and oral information for women to enable an informed choice about place of birth.

35. Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.

36. Services in consultant-led obstetric and midwife-led units available dependent on need.

37. Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions.

38. Continuity of care for women throughout the maternity pathway.

39. A regional plan for supporting mothers with serious psychiatric conditions.

Child Health

40. Further development of childhood screening programmes as referenced in the Health and Wellbeing section.

41. Child health included as a component of the Headstart programme referenced in the Family and Childcare section.

42. Promotion of partnership working on children's health and wellbeing matters with other government sectors.

43. Close working between hospital and community paediatricians through Integrated Care Partnerships.

44. Completion of a review of inpatient paediatric care to include palliative and end of life care.

45. Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.

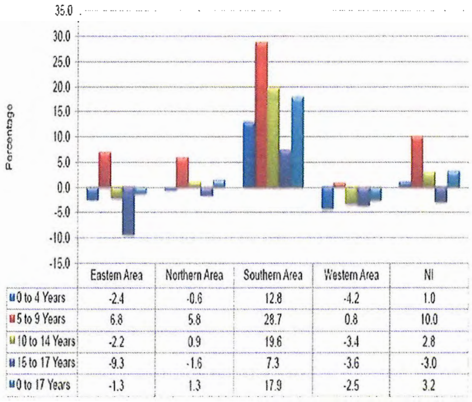
12.FAMILY AND CHILD CARE

INTRODUCTION

Approximately 24% of the Northern Ireland population is aged between 0 and 17 years. Population projections indicate this sector of the Northern Ireland population is set to increase by 3% by 2020. [72]

As the figure below illustrates, percentage increases between geographical areas is variable but the overall increase will bring increasing demands on family support services.

Figure 18: Percentage population change 2008-2023 by Area and Age Band



	Eastern Area	Northern Area	Southern Area	Western Area	NI
🟦 0 to 4 Years	-2.4	-0.6	12.8	-4.2	1.0
🟥 5 to 9 Years	6.8	5.8	28.7	0.8	10.0
🟩 10 to 14 Years	-2.2	0.9	19.6	-3.4	2.8
🟦 15 to 17 Years	-9.3	-1.6	7.3	-3.6	-3.0
🟦 0 to 17 Years	-1.3	1.3	17.9	-2.5	3.2

Source: NISRA 2008 Population Projections

Between 2005 and 2010 the number of Looked After Children per 1,000 children increased in Northern Ireland, England and Wales. The number of children on the child protection register per 10,000 children aged 0-18 is higher in Northern Ireland than in England, Scotland or Wales. Overall, the number of children on the child protection register has increased between 2006 and 2010 in all regions of the UK.

In 2010 there were 2,606 Looked After Children in Northern Ireland, up by 6% from 2009. The greatest proportion (65%) was in foster care. Between 2005 and 2008 the number of children in foster care decreased. Since then, this figure has increased by almost a quarter (23%) to 1,687. The total number of children on the child protection register has increased by almost 48% from 1,593 in 2005 to 2,357 in 2010.[73]

EARLY INTERVENTION

As discussed in Section 7, early intervention is an important focus in addressing population health and wellbeing.

It has been recognised by a number of independent reviews that, compared to other parts of the UK, there is a significant under investment in children's services

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[72] NISRA (2011) Population projections

[73] Social Briefing, Research and Information Service Briefing Paper, Northern Ireland Assembly, 83/11 NIAR 217/11, July 2011.

within Northern Ireland. Society will benefit from a coordinated effort to support and promote positive development of the intellectual, emotional and social skill of young children. There is a major incentive in getting this right. On a practical level, early engagement pays a very high rate of return. The dividend is 12%-16% per year for every £1 of investment – a payback of four or five times the original investment by the time the young person reaches their early twenties and the gains continue to flow throughout their life[74].

Key to this is promoting and supporting positive, engaged parenting particularly in those families where parenting skills are limited.

Children's services are heavily prescribed by legislation and associated guidance and regulations. These services operate within an infrastructure premised on the growth of partnerships which promote inclusivity and collaboration. These partnerships have enabled an increase in capacity and facilitated the improvement of outcomes.

The overarching principle set out within the Childrens (NI) Order 1995[75] that children are best cared for within the family of origin will continue to shape interventions and service delivery. The Review supports the development of advocacy, information services and training in the support of kinship care.

International best practice demonstrates that the health and social care needs of children and young people cannot be addressed by any single agency. A key example of this is the Children and Young People's Strategic partnership, which is a multi agency partnership whose purpose is to put in place integrated planning and commissioning aimed at improving the wellbeing of children in Northern Ireland.

The strategic direction over the past few years has recognised the importance of early intervention. The focus has been heightened through the publication of Families Matter[76], Healthy Child-Healthy Future[77] and the Family Nurse Partnership Initiative. The concept of Family Support Hubs is developing and the Family Support NI database provides an information and signposting resource for families, communities and professionals.

Child and Adolescent Mental Health Services (CAMHS)

The overall direction of Child and Adolescent Mental Health Services (CAHMS) will continue to be shaped by the Bamford Review of Mental Health and

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[74] (0-5): How small children make a big difference –The Work Foundation 2007

[75] The Children NI Order 1995, Legislation.gov.uk

[76] Families Matter: Supporting Families in Northern Ireland Regional Family and Parenting Strategy March 2009, DHSSPSNI

[77] Healthy Child, Healthy Future, A framework for the Universal Child Health Promotion Programme in Northern Ireland Pregnancy to 19 Years. DHSSPSNI, May 2010

Learning Disability. The needs of children with a disability remain a priority for commissioners and providers alike.

A Review of CAMHS in Northern Ireland was published in 2011 by the Regulation and Quality Improvement Authority[78]. A number of work streams are underway which will address many of that report's recommendations:

- progressing the Bamford Action Plan 2009;
- a review of Tier 4 services; and
- the appointment of a Commissioner for CAMHS.

Overall it is clear that child and adolescent services are continually improving and developing. However there is much work to do to develop and improve services further. It is estimated that to fully implement the RQIA recommendations may cost around £2million per annum. In the current financial climate this will require a prioritised approach.

Residential care

Approximately 11% of Looked After Children are in residential care. A number of issues have been identified:

- there is an increasing complexity of needs being presented by young people particularly in relation to mental health, drug and alcohol abuse, sexually harmful/vulnerable behaviours and criminality;
- it is difficult to provide flexible residential accommodation to meet the needs of a small number of young people; and
- young people aged 16+ are being excluded from their homes/ community as result of difficult behaviours.

Families

Families Matter: Supporting Families in Northern Ireland (Regional Family and Parenting Strategy 2009) moves parents into a central position in policy terms and strives to provide strategic direction on how best to assist parents in Northern Ireland to be confident and responsible in helping their children to reach their potential.

The wider vision of family support has been articulated in the Northern Ireland Family Support Model, which enables a 'whole system' approach to service planning. Its focus is on early intervention, ensuring that appropriate assistance is available to families at the earliest opportunity at all levels of need.

This model details four levels of need: all children and young people; children who are vulnerable; children who are in need and looked after children, illustrated in the figure below.

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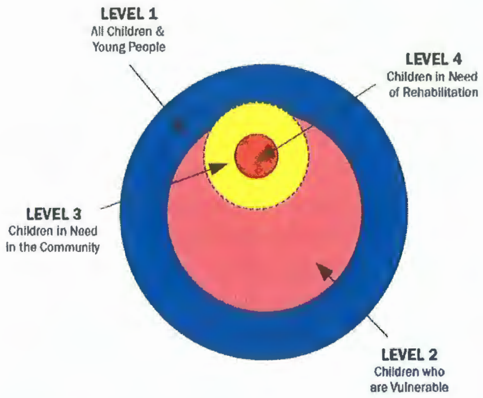
[78] RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland February 2011.

Figure 19: Northern Ireland Family Support Model[79]



It is widely acknowledged that early intervention produces positive dividends for children and families. The learning and experience from the Sure Start model which targets "children who will benefit most" and other similar initiatives here and elsewhere needs to be understood and extended where benefit can be demonstrated.

The Review acknowledges and endorses the streamlining and improving processes in regard to Children's Services as being taken forward through the Children's Services Improvement Board and Review on Co-operating to Safeguard Children. In addition the Review also makes the recommendations below.

SUMMARY OF KEY PROPOSALS

46. Re-structuring of existing services to develop a new 'Headstart' programme focusing on 0-5 year olds.

47. Exploration through pilot arrangements of budgetary integration for services to this group across Departments, under the auspices of the Child and Young People's Strategic partnership.

48. Completion of a review of residential care to minimise its necessity.

49. Promotion of foster care both within and outwith families.

50. Development of a professional foster scheme for those hardest to place.

51. Implementation of the RQIA recommendations in relation to CAMHS.

52. Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS services.

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[79] Families Matter: Supporting Families in Northern Ireland, Regional Family and Parenting Strategy. DHSSPS 2009

13.PEOPLE USING MENTAL HEALTH SERVICES

INTRODUCTION

Northern Ireland has higher mental health needs than other parts of the United Kingdom.[80] Based on the Northern Ireland Health and Social Wellbeing Survey (2001), 24% of women and 17% of men in Northern Ireland have a mental health problem – over 20% higher than the rates in England or Scotland.

Factors contributing to these rates include persistent levels of deprivation in some communities in Northern Ireland and the legacy of Northern Ireland's troubled history. For example, a recent study of the families of victims of Bloody Sunday found persistent effects of these traumatic events on the individuals concerned, with evidence of psychological distress still being found more than 30 years after the event.[81]

The incidence of suicide in Northern Ireland has been a particular concern in recent years. Suicide rates increased by 64% between 1999 and 2008, mostly as a result of the rise in suicides among young men. In 2008, 77% of all suicides were males and 72% were 15-34.

The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The Bamford Review, which completed its work in 2007, has set the agenda for the transformation of these services. The Review heard nothing which challenged Bamford but did hear frustration at the speed of implementation.

Although there is frustration there is also progress with actions that lay the foundations for modernising and improving services, for example the development of new strategies and agreeing new models of care for particular conditions. However, it remains the case that tangible services on the ground are the touchstone by which those using the service judge its success.

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[80] DHSSPS (2004) The Review of Mental Health and Learning Disability (Northern Ireland). A Strategic Framework for Adult Mental Health Services. Consultation Report.
[81] McGuigan, K., & Shevlin, M. (2010). Longitudinal changes in posttraumatic stress in relation to political violence (Bloody Sunday). Traumatology, 16, 1–6

PROMOTION AND EARLY INTERVENTION

Raising awareness of mental health issues and reducing the stigma associated with mental ill-health continues to be a key objective of the reform and modernisation programme. In terms of primary prevention, a suicide prevention strategy Protect Life[82] was launched in 2006 and is currently being refreshed. A new five-year Mental Health and Wellbeing Strategy is being developed to support the whole population to maintain good mental health. The Review endorses these actions.

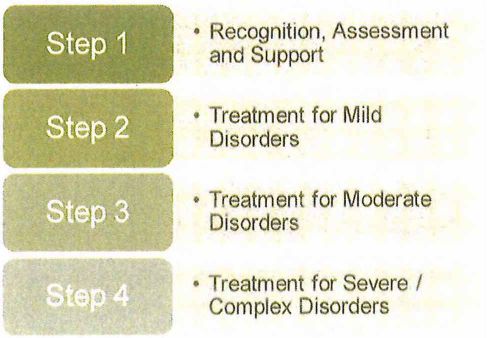
The Royal College of Psychiatrists' submission to the Review highlights that early intervention in psychoses can be effective and emerging evidence supports a similar approach for depression and anxiety. It therefore encourages development of a system capable of early intervention. The Stepped Care model (see figure below) promotes early intervention at the first stages of mental illness and the Psychological Therapies Strategy made recommendations as to how people with mild to moderate mental health problems could access psychological support. However, lack of investment has constrained the implementation of this strategy and feedback during the review suggested concern with the level of provision at Tiers 1 and 2.

Access to information about mental health services was raised by several of those with whom the Review engaged, including the Bamford Monitoring Group and registered social care workers. The Bamford Action Plan included plans to map available services and provide this information to service users, but progress has been slow in this regard. Users and carers told the Review how important it is to be able to easily access information on services that meet their particular needs.

PROVIDING THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME

The model of mental health care has evolved which promotes greater care at home and in the community rather than in hospital. A stepped care approach has been adopted, providing a graduated range of care to meet the patient's needs:

Figure 20: Stepped Care Model



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[82] Protect Life, A Shared Vision – The NI Suicide Prevention Strategy and Action Plan 2006-2011, DHSSPS

Each of the HSC Trusts has developed Crisis Response and Home Treatment models that provide services for acutely ill people at home and in the community rather than in psychiatric hospitals. The role, number and location of psychiatric inpatient units are also changing and Trusts are developing streamlined pathways for urgent mental health care.

However, these services have evolved differently in each area in terms of how people in crisis contact services, how they are triaged (by phone or in person at a hospital or other facility) and how they are treated in emergency departments. Whilst the Review acknowledges that there will be solutions for local areas, there is now a need to ensure that there is a consistent outcome for those who use the service. Additional home treatment services are still to be developed for particular client groups including children and young people, people with a learning disability and older people.

Despite the shift underway in care provision from the hospital to community setting, the Review noted that the objective to shift expenditure to a ratio of 60% community and 40% hospital has not yet been achieved.

PROMOTING INDEPENDENCE AND PERSONALISATION OF CARE

At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives. The Review strongly endorses this approach.

The voluntary and community sector plays a crucial role in providing the diverse range of support that may be needed. Recognising this, the Review recommends greater involvement of these organisations in planning provision for local populations. It also acknowledges this will be a challenge in some parts of the independent sector.

Provision of Direct Payments is one approach to support personalisation of care. However, among people with mental health issues, the uptake of Direct Payments has been lower than among other groups. At May 2011, a total of 81 people were in receipt of Direct Payments. The Review was told that perceived bureaucracy and inconsistent promotion of Direct Payments have been constraining factors.

A regional approach should be implemented to promote the uptake of Direct Payments among mental health service users including involvement of current recipients to share their experiences, and the provision of advocacy and support where needed should be considered. As a minimum, clear information on the financial package available should be given to those using the service.

INSTITUTIONAL CARE

A critical element in changing how things are done for this client group is to end long-term residency of people in mental health and learning disability hospitals. To date, 181 long-stay mental health patients have been discharged to the community. There are currently 150 long stay psychiatric inpatients who should be resettled into the community.

The model designed by the Review makes it clear that care should be provided at home or as close to home as possible. Fresh impetus into delivering the closure of long stay institutional care is required.

The Review urges an absolute commitment to completing the resettlement process by 2015 as planned, and ensuring that the required community services are in place to prevent the emergence of a new long-stay population. This should include developing models of treatment for children and young people, and those with specialist mental health needs, for example in the areas of learning disability and psychiatry of old age.

Attempts to shift the balance of spend between hospital and community expenditure should continue with reinvestment of any savings achieved in the hospital setting into community services.

The proposals below are set in the context of making tangible changes for mental health service users and their families and assessing the impact of that change on quality of life.

SUMMARY OF KEY PROPOSALS

53. Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.

54. Establishment of a programme of early intervention to promote mental health wellbeing.

55. Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.

56. A consistent, evidence-based pathway through the four step model provided across the region.

57. A consistent pathway for urgent mental health care including how people in crisis contact services, triage and facilities in emergency departments.

58. Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.

59. Further shift of the balance of spend between hospital and community, with reinvestment of any hospital savings into community services.

60. Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.

61. Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.

62. Close long stay institutions and complete resettlement by 2015.

14.PEOPLE WITH A LEARNING DISABILITY

INTRODUCTION

A learning disability is a lifelong condition and requires long-term support. Provision of services for people with a learning disability requires a multi-agency and integrated approach – it is not solely a health issue. The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland.

In regards to this care programme the Review heard nothing which challenged Bamford, but as with mental health services, did hear frustration at the speed of implementation. Despite this frustration there is progress, with actions being completed that lay the foundations for further change, for example, the development of new strategies and agreeing new models of care. Ultimately though, those who are supported judge it by changes to services on the ground. In this regard the Review heard of the need for more rapid progress.

EARLY INTERVENTION AND PROMOTION

The importance of early years intervention to support positive life outcomes was highlighted throughout the Review's engagements with the public, clinicians and others. While children with a learning disability and their families may be able to avail of early years support this is variable across the region. Consistent with the proposals set out in Section 12 on Family and Childcare, the Review considers that early years support for children with a learning disability should be part of a coherent and consistent programme of support for 0-5 year olds.

Many learning disabilities have associated physical health conditions, for example complex mobility or personal care needs, whilst the rates of early onset dementia are much higher among those with Down's Syndrome than among the general population. Evidence was presented to the Review on the challenges for people with a learning disability in accessing the full range of healthcare provision enjoyed by the general population. In particular, accessing health services such as occupational therapy, physiotherapy and speech and language therapy was highlighted as being important. People with a learning disability also identified a need for disability awareness training for clinical staff in the community who do not always deal appropriately with them, for example, not providing enough time and not speaking directly to the disabled person. The Review considered improvement in this area as fundamental.

Programmes are in place in each population area to enhance access to primary healthcare services for people with a disability including annual healthchecks and employment of health facilitators in the community. The Review endorsed this approach but was clear that a consistent outcome for all is important. In this regard it was made aware of particular problems in accessing Dentistry.

As services are planned Integrated Care Partnerships should be asked to ensure that clinicians are facilitated to respond more appropriately to the needs of people with a learning disability.

PROMOTING INDEPENDENCE AND PERSONALISATION

Promoting independence and personalisation is a key principle underpinning the model proposed by the Review. Feedback provided to the Review indicates that achieving this objective for people with a learning disability will require particular focus on the following areas:

- Day services - the diversity and age-appropriate nature of day services remains an issue for people with a learning disability. While there has been progress made in reforming the day centre-based model and providing more community based options, there is further work to be done in this regard. A one size fits all service will be less relevant in the future;

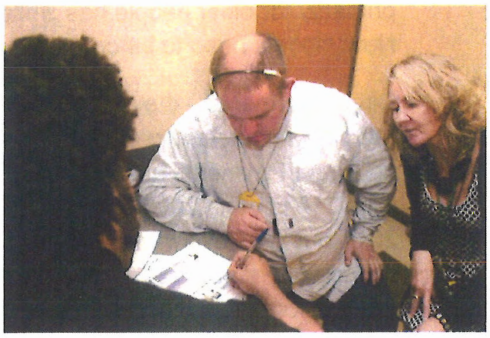
- Respite and short breaks - provision has increased but service users and carers indicate that much remains to be done to meet current needs. Services are frequently accommodation based. While these are important more flexibility in the home or local day placement should be explored. Respite care is not always age appropriate, for example, respite provision in nursing homes primarily for older people has limits. New models need to be created;

- Direct Payments – the number of people with a learning disability taking up Direct Payments has increased from 218 in June 2008 to 561 at May 2011 but the Review heard that service users and carers need more information and support with Direct Payments. Sharing the experiences of current recipients is recommended, along with provision of advocacy and support where needed. As a minimum clarity about the financial commitment should be available;

- Information – in general, users and carers consider it remains difficult to access information on the services available for people with a learning disability. Information on housing options was highlighted as an issue. Many carers are also unaware of their right to a carer's assessment and access to support to meet their physical and emotional needs; and

- Advocacy – people with a learning disability expressed the need for peer and independent advocacy to support them in making decisions and protecting their rights.

The Review considered voluntary and community sector organisations have a crucial role in providing support to people with a learning disability. In some instances these are organised and run by parent groups. This should be supported.



INSTITUTIONAL CARE

A critical element in changing the model of care and support for people with a learning disability is to end long-term residency in hospitals. Since 2008, 642 long-stay learning disability patients have been discharged to the community. There are currently around 200 long-stay inpatients in learning disability hospitals who should be resettled into the community.

The majority of learning disability services are already provided in the community as opposed to hospitals. The ratio of spend is 82% in the community to 18% in hospital. New community facilities are being developed for assessment and treatment for people with a learning disability which will support the resettlement programme. The Northern Ireland Housing Executive's Supporting People Programme also plays an essential role in developing a range of supported living options in the community for people with a learning disability. Supporting People has enabled 23,000 people (including both mental health and learning disability service users) to live independently.

The proposals below are set in the context of making tangible changes for people with a learning disability and their families and assessing the impact of that change on quality of life.

SUMMARY OF KEY PROPOSALS

63. Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)

64. Further development of the current enhanced health services on a Northern Ireland basis.

65. Support from Integrated Care Partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.

66. Better planning for dental services should be undertaken.

67. Further development of a more diverse range of age-appropriate day support and respite and short-break services.

68. Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.

69. Development of information resources for people with a learning disability to support access to required services.

70. Advocacy and support for people with a learning disability, including peer and independent advocacy.

71. Commitment to closing long stay institutions and to completing the resettlement process by 2015.

15.ACUTE CARE

Acute care is often perceived as synonymous with hospitals. However it also includes elements of primary care such as Out of Hours. This part of the report comments upon:

- unscheduled care;
- planned care;
- ambulatory care and diagnostics; and
- regional services.

UNSCHEDULED CARE

Unscheduled care includes such services as accident and emergency, emergency surgery, intensive care, coronary care, stroke services, urgent care and medical admissions. Trauma and orthopaedic services are integral to emergency care.

Ambulatory care, where patients can walk in and walk out on the same day can also be unscheduled care.

The Review does not propose to extensively define each component of service but considers it prudent to share its thinking about urgent care, emergency departments or A&E services. Three broad levels exist:

- Major trauma, which is dealt with regionally;
- Emergency intervention most commonly associated with the 999 ambulance service; and
- Urgent care/ Out of Hours care where a difficulty exists but it does not initially present as life threatening and includes minor injuries.

Unscheduled care is currently delivered via 10 Accident and Emergency Departments (9 of which are 24/7 consultant led), 8 Minor Injuries Units and 19 GP Out of Hours facilities and supported by the NI Ambulance Service.

Evidence suggests the system is increasingly not fit for purpose in the 21st century.

For example the HSC is failing to deliver acceptable A&E waiting times of 95% of patients waiting no more than 4 hours and no patients waiting for more than 12 hours. Overall, performance against these standards has been poor other than in the Southern Trust, both in relation to the 12-hour and four hour standards. Regionally, there were 7,386 breaches of the 12-hour standard in 2010/11 (compared to 3,883 during 2009/10) and cumulatively only 82% of patients were treated and discharged, or admitted within 4 hours of their arrival in A&E during 2010/11.

As discussed in the Case for Change, the Royal College of Surgeons' evidence is that better organised care equals better outcomes for the patient.

New treatments and associated technology for stroke and coronary care are a challenge to deliver in the existing model. Maintaining the supporting infrastructure necessary for high dependency or intensive care in our current model also presents a challenge. Additionally difficulties in retaining appropriately trained staff creates sustainability issues and remains a frequent challenge.

Organisational resilience is a recurrent problem. Each year the current model cannot appropriately staff its A&E service with all of the quality and financial issues that flow from this.

The public in a different way expresses similar problems:

- 91% of the people involved in the omnibus survey felt that improvement was needed to the time spent waiting in A&E, of which 56% stated that a lot of improvement is needed.
- 68% of people surveyed in the Omnibus survey agreed or strongly agreed that they would be prepared to travel a further distance for hospital services if it means they don't have to wait as long. There was no significant difference in the response from people from an urban area (67%) compared to those in a rural area (70%).

EMERGENCY SERVICES

Proximity to acute facilities is often perceived as the determining factor as to whether the local health and social care service will adequately provide for their needs. Increasingly, however, it is not only the distance to the appropriate facility that may determine outcome for the patient, but also the timeliness of the initial intervention.

For example, a person with a stroke needs to get access to the staff and technology to diagnose the stroke as quickly as possible, as explained:

Best Practice Guidance - Stroke Care

Evidence shows that people with an ischaemic stroke who receive thrombolytic treatment within 3 hours of onset are more than twice as likely to have favourable outcomes (such as reduced disability and lower mortality rates) after three months.[83] However, this treatment would harm people with haemorrhagic stroke. Therefore, it is essential that suspected stroke patients are transferred directly to an acute setting with the staff with appropriate skills and access to diagnostics which will allow accurate diagnosis (and therefore appropriate treatment) as quickly as possible.

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[83] Best Practice in Stroke Care 2007, Buchan, A (sourced from Healthcare for London: A Framework for Action report

The Omnibus survey showed that 70% of people surveyed agreed or strongly agreed that they would be prepared to travel a further distance for hospital services if it means they get the best treatment and 71% agreed or strongly agreed that ambulance staff should take seriously ill people to a hospital with the specialist services they need even if it is not the closest hospital.

The Rural Trauma Outcome Study in Scotland[84] showed that longer pre-hospital travel times did not increase mortality or length of stay.

The omnibus survey also highlighted the fact that the majority of the public are aware of where to attend in a number of circumstances, for example 74% of people said that they would attend the GP Out of Hours service if they had a child with a high temperature after 10pm.

However, it appears that the public do not actually attend the most appropriate setting for their needs. Of the activity recorded within the accident and emergency departments across NI, 50% of these are for conditions rated as standard cases without immediate danger or distress (Category 4 based on the Manchester Triage Categories). It can be assumed that a large proportion of these cases could be cared for in an urgent care setting without the need to attend an accident and emergency department.

Furthermore, for less common emergencies it is essential to maintain the required skills to enable the best patient outcome.

A model of care has been set out which delivers best outcomes to patients with major trauma and ensures a resilient service for the population of NI.

Regional Trauma Service

Major Trauma is the single biggest potential cause of death of people under 35 years of age. Due to the relatively small population of Northern Ireland (circa 1.8m) and the low incidence of major trauma cases (approximately 0.02% of the total population per annum), it is impractical to equip and staff all hospitals to the required level to provide optimal care for patients with major trauma.

The DHSSPS has recommended that the Royal Victoria Hospital becomes a regional trauma centre acting as the hub of the NI trauma network. Protocol dictates that patients should be transferred to the Royal Victoria Hospital directly, provided they are able to withstand the journey. If a patient is not able, they will be taken to the nearest major acute hospital within the network with the intention of transferring them to the Royal Victoria Hospital when they are able. Staff employed at the acute hospitals within the network receive appropriate training to maintain their skills.

This Review concluded that a similar model could be considered for other

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[84] Scottish Urban v Rural Trauma Outcome Study, J Trauma September 2005

emergency conditions which do not present in sufficient numbers for services to be maintained at all acute sites.

The result of networking services will be a model which includes a major acute hospital supported by a network of hospitals providing services to meet the needs of the local population. There are ten acute hospitals in Northern Ireland. In Great Britain populations of 1.8million are supported by maybe only four large hospitals. The Review accepted that by 2016/7 the model of major acute hospitals for Northern Ireland's more dispersed population will reconfigure to a more appropriate scale.

This will mean change at several of the current acute hospital sites, and the Review recommends that the key test for any future service configuration must be that it is sustainable and resilient in clinical terms. We recommend that each Local Commissioning Group should draw up specific proposals, taking account of the potential to provide service to the ROI. The Review's view is that it is only likely to be possible to provide resilient sustainable major acute services on five to seven sites, assuming that the Belfast Trust hospitals are regarded as one network of major acute services.

The Role of the Northern Ireland Ambulance Service

The role of the NIAS will be key in ensuring that people are treated in the right place at the right time. Patients should be transferred to the correct location first time where possible, to avoid further transfers at a later stage. It will be important that the NIAS can transfer people not only to Accident and Emergency Departments but also to Urgent Care Centres, Minor Injuries Units or GP Out of Hours. Bypass protocols will be required which clearly define which location patients should be transferred to for each type of condition.

Better management of unscheduled care in partnership between the HSC Trusts and the NIAS offers potential for improving care, patient flows efficiency and patient satisfaction.

Alongside all of this, it will be essential that the public are provided with information about the correct procedures in an emergency.

Quality of Outcome

Quality of outcomes requires that senior clinical decision makers are available at all accident and emergency departments 24/7/365. The model will be capable of delivering this outcome.

For the model to be successful it will need the support of urgent care centres, minor injuries units and GP in and Out of Hours services.

Delivering this model will require clinicians to be networked as one workforce pool for its population to ensure that training and good organisational opportunities are available to deliver a safe, high quality service.

URGENT CARE SERVICES

The clinical advances that result in a more specialised workforce create tension between local accessibility of urgent care services and the need to provide high quality services in acute hospital settings.

The current model includes a small number of Minor Injuries Units and GP Out of Hours to support Accident and Emergency Departments. Given the high volume of attendances at A&E which are Category 4[85] and below, there is potential to do things differently and achieve consistent outcomes. Accident and Emergency Departments can and should be supported more locally through an integrated urgent care model.

The urgent care model is not a 'one size fits all' approach. It is an approach which looks at the needs of the local people and tailors the provision to meet their urgent care needs. This model could, for example, look very different for an urban area compared to a remote rural area. Urgent care should be available on a 24/7/365 basis, including some on-call arrangements where necessary. The services to be provided to a population would be minor injuries, specialist nurses trained in urgent care, urgent care GPs, specialist teams such as mental health crisis response teams and urgent care social workers. The key is that these services are delivered in an integrated fashion.

These services will be supported by diagnostics available in the local community and the ability for GPs to directly admit patients into beds where necessary. Many of these services, other than beds, could all be available within a health and care centre setting, like the Health and Care Centre at Holywood Arches for example.

GP Out of Hours services are currently available for urgent care outside of the normal GP practice opening hours.

GP Out of Hours services should work as an integrated model of care with other urgent care services. A good local example of this working in practice is Downpatrick Hospital. In the UK the Shropshire approach has merit, as outlined below.

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[85] Cases without immediate danger or distress, Manchester Triage

Good Practice Example

Shropshire Doctors Co-operative Ltd (Shropdoc) provides urgent medical services for patients when their own surgery is closed and whose needs cannot safely wait until the surgery is next open, i.e. evenings, weekends and bank holidays.

The service also supported Out of Hours nursing arrangements. Shropdoc doctors carried 'Rapid Response Boxes' for palliative care, catheterisation, resuscitation, syringe drivers and controlled drugs and therefore undertook much of the night-time care that might otherwise have been referred to district nurses or resulted in patients being admitted.

Shropdoc also ran the Care Coordination Centre. This provided a single point of access for GPs to other services between 8am and 6pm and included physiotherapy triage for some referrals.

This model has been working well and has the potential further to develop.

CLEAR PROTOCOLS FOR THE POINT OF CONTACT FOR EMERGENCY AND URGENT CARE

There is evidence that the options available to the public in dealing with emergency and urgent cases are limited or not well known. As outlined above, it is important that people are referred to the place that is best suited to meet their medical needs. This will require clear communication with the public as to the types of facilities available, where they are located and under what circumstances they should be used.

To allow this, it will be important that the public can get access to the right advice at the right time. At present this is through the 999 emergency telephone number. The introduction of an urgent number to work alongside the emergency 999 number would allow people to talk to a trained professional who will be able to advise them on the best route for them, be that to an Accident and Emergency Department, an Urgent Care Centre, Minor Injuries Unit, GP Out of Hours service or to wait for a GP appointment the following day. The NIAS will play a pivotal role in managing unscheduled care into the future.

Dedicated Care pathways should be developed for children and people with long term conditions that will allow direct contact with a trained team available to support them in an emergency or when requiring urgent care. This should involve the ability to directly admit these patients to beds hospitals.

PLANNED CARE

INTRODUCTION

Planned or Elective care includes inpatient admissions which happen with prior planning, sometimes at relatively short notice. Often these services cover major treatments or interventions, for example cancer surgery, diagnostics, testing to assist diagnosis, for example blood tests or X-ray and planned ambulatory care, where patients can walk in and walk out on the same day.

Planned care is currently delivered largely from our 10 acute hospitals, 5 local hospitals and a number of community hospitals. There are approximately 6,646 (average 2010/11) hospital inpatient beds in NI (3,683 acute beds and 2,963 non acute beds).

Increasing demand has evidenced itself through rising numbers of inpatient Finished Consultant Episodes. This reflects the increasing subspecialisation as well as absolute demand.

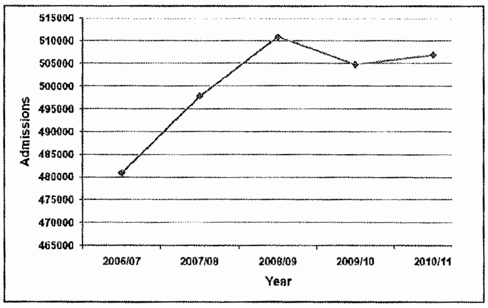
Some changes to service patterns have occurred, for example in cancer and urology, to improve outcomes. Whilst the role of some hospitals has also changed, more is required. However such change cannot happen without recognition of the impact on our current model. Partial change simply pressurises the existing system.

As stated in the Case for Change for both planned and emergency inpatient stays the length of stay is above UK levels.

During 2010/11, a total of 1,502,611 patients were seen at consultant led outpatient services within HSC hospitals in Northern Ireland.

The Total Admissions to HSC Hospitals in Northern Ireland under the Acute Programme of Care are shown in the figure below.

Figure 21: Acute Admissions



Source: DHSSPS Hospital Statistics

Our daycase rates are lower than they should be at 64% (2010/11) compared to the target of 75%. This means that the service is over reliant on inpatient beds when carrying out the procedures which could be carried out as a daycase.

The current target determines that at least 50% of inpatients and daycases are treated within 13 weeks and that all cases are treated within 36 weeks. At present, the current system is failing to meet these targets. Concern about increasing waiting times was highlighted as one of the

People's Priorities by the Patient and Client Council.

In the future planned care will be treating more older people. Planned care needs to be organised separately from emergency care. It gives better patient outcomes and enhances productivity. The Review therefore wishes to see better organisation of planned care.

Where there are planned specialist treatments, which are highly specialised, they will need to continue to be provided in one centre in Northern Ireland or via an agreement with a tertiary centre elsewhere (e.g. GB or ROI).

Diagnostics is an integral part of planned care. It assists the diagnosis of illness, for example blood tests, X-ray, MRI scans etc. These services are currently delivered within major acute hospitals and health and care centres. The review of Pathology Services in NI recommended there should be a managed clinical network for pathology. The Review strongly reinforces the expeditious implementation of this recommendation.

The current target determines that no patient waits longer than 9 weeks for a diagnostic test. In 2010/11 there were 23,518 breaches of this target.

Given all of this, it is impossible not to come to the conclusion that change needs to happen to improve outcomes for patients.

Evidence[86] shows that separating emergency and planned care improves outcomes in terms of continuity of care for patients, improved training for staff and faster access to senior opinion. The organisation of planned care should be clinically led and supported by the appropriate infrastructure.

Inpatient Activity

Key to the delivery of effective services is to ensure that people are given the right care in the right place at the right time. For planned care this means ensuring that people who need to be seen urgently are done so, that people who can wait do and that they are seen within a reasonable period of time.

Better organisation of planned services was supported by the Omnibus Survey which highlighted the following:

- waiting times for an appointment with hospital consultant: 82% felt some improvement is required, including 36% who felt that a lot of improvement was required; and

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[86] Separating Emergency and Elective Care: Recommendations for Practice, The Royal College of Surgeons of England, March 2007.

Delivering surgical services: Options for maximising resources. The Royal College of Surgeons of England, March 2007.

- waiting times for on emergency operations: 88% felt some improvement was required including 36% who felt that a lot of improvement is required.

In supporting the principle that care should be closer to home it will be important to ensure that referrals to acute hospitals and inpatient beds are for sound medical reasons.

Similarly when people are admitted as an inpatient, appropriate discharge protocols must be in place to ensure timely discharge.

This can be supported by multi-disciplinary teams in the community and the availability of intermediate care (care between home and hospital), including step-up and step-down facilities.

Outpatient and Diagnostics

Evidence suggests that GPs and nurses could carry out a proportion of outpatient appointments without the need for a consultant appointment. The location of these types of appointments does not need to be in an acute setting.

The National Primary Care Research and Development Centre[87] identified a number of approaches which resulted in effectively reducing demand for specialist outpatient treatment without impacting on quality or safety. These included primary care clinics for chronic diseases; discharging hospital outpatients to no follow up (patient initiated follow up only); and direct access by GPs to hospital-based diagnostic tests, investigations and treatments.

Case Study

In NHS Stracathro hospital in Scotland acute medical services are being concentrated in larger hospitals that have a full range of support services and technology. Smaller hospitals were reconfigured to provide a wider range of other services including: the management of chronic illness, community rehabilitation, provision of diagnostics and therapy and more local outpatient clinics delivered more locally than ever. The relatively small number of patients who require specialist inpatient treatment are managed in acute hospitals capable of meeting quality and safety standards.

A large proportion of diagnostics could be carried out within facilities closer to people's home. Diagnostics should be available alongside GP practices with the ability for GPs to directly refer patients.

Day cases where possible

Advances in surgical and medical techniques have meant that more procedures can be done as day cases. The Review recommends a better organised response to making sure the individual is referred to the most appropriate location for the best outcome.

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[87] Can Primary Care reform reduce demand on hospital outpatient departments? (March 2007)

The HSC should continue to work towards the 75% rates of day cases for surgical procedures for the basket of 24 procedures. This will assist the move away from inpatient care unless medically necessary.

While there is a strong argument for locally accessible services and care closer to home, this cannot be at the cost of quality and safety. There is recognition than any transfer of services must maintain the levels of both quality and safety.

HOSPITAL NETWORKS

To ensure good patient outcomes no hospital in the future can work other than as part of a network.

In order to provide complex healthcare safely and allow professionals to keep their skills and knowledge up to date they need to treat sufficient volumes of patients with particular conditions. Safe treatments are therefore difficult to deliver at every hospital because there are not enough patients to maintain the skills of the professionals.

Networks should be established to ensure that accessible and safe services are available to all citizens. For common conditions there will be sufficient demand to allow those services to be delivered as locally as possible, either through local hospitals or community facilities. For less common conditions, there will be a need to centralise services on major acute sites to ensure that a resilient workforce is available to support that service.

Planned services provided in hospitals should be organised to meet the needs of that population.

No facility or department should operate as a standalone unit. Professionals should work in networks across hospitals and Trusts to deliver the best care to the patient by working together. This can also help to sustain local services with staff in local hospitals networking with larger acute hospitals, or through provision of nurse-led facilities supported by appropriate medical backup and working with effective transfer protocols for patients requiring acute medical care.

Care Pathways

Care pathways are an important route map for how people will experience treatment and are clinically led.

While there has been some progress in developing tailored care pathways for specific conditions and to address the issue of resilience in the service, there needs to be more consistency of approach across the region to ensure the best quality care is provided, the service is resilient and sustainable and that people are treated in the right place at the right time.

Specialist Provision

The Review has already offered its thinking on the implications of the overall population size of 1.8million for sustaining the viability of specialist hospital services. Consequently this leads to vulnerable services which are difficult to attract staff to work in and if not effectively networked have the potential for poorer outcomes.

The sustainability of these services will best be delivered through networking with other tertiary centres, either in GB or ROI. This allows for consultants to gain the sufficient experience required and allows for multi-disciplinary team discussions on patients. Networks already exist for paediatric cardiac surgery (with the ROI), adult intensive care, cancer and pathology services.

The HSC sent 336 patients to hospitals in GB and ROI in the 6 months to September 2011 to be treated. Where services are so specialist the HSC cannot deliver these in NI, either in isolation or within a network. These types of specialist services will continue to be sent to specialist tertiary centres either in GB and ROI.

The Review recommends the development of joint planning arrangements with colleagues in the Republic of Ireland. In the first instance this would look at:

- shared opportunities in tertiary and specialist care,
- procurement,
- services in the New Hospital in the South West, and
- services which straddle the Border areas.

This would include a regular planning interface between the two jurisdictions to ensure areas of mutual interest are explored. These arrangements would be in addition to Co-operation and Working Together (CAWT), the existing partnership between the Health and Social Care Services in Northern Ireland and ROI, which facilitates cross border collaborative working in health and social care.

TECHNOLOGY

Technology will be a major enabler of networked working and care closer to home.

Investigations and treatment have become much more sophisticated requiring 24-hour access to increasingly complex technology – CT (Computerised Tomography) and MRI (Magnetic Resonance Imagery), sophisticated blood tests etc.

Technology will be required to support the changes in delivery of unscheduled care. Technology will allow all parts of the HSC to be linked in, allowing them to share live information on patients regardless of their location.

There is emerging evidence of the potential for telemedicine to support timely and appropriate inter-hospital transfer as well as better networking between hospitals. Some examples are shown below.

Example of Technology Working in the HSC

The Southern Trust currently operates a tele-dermatology service in which a specialist nurse sees the patient in an outreach clinic with a consultant remotely verifying the skin condition (via a high resolution photograph of the skin condition electronically sent to their location) and providing guidance on the most appropriate nurse or doctor-led pathway for the patient to follow.

The opportunities for technology to support the new model of care are explored further in the Implications section of this report.

CONCLUSION

All of this leads to a conclusion doing nothing is not an option and that planned and organised change is essential to achieve the following objectives:

- Right Care, Right Place, Right Time, Right Outcome;
- Organising Sustainable Inpatient Care;
- Improving Diagnostics;
- Engaging Primary Care;
- Creating a Sustainable Service;
- Being responsive to the public;
- Balancing local and central demand with quality and safety; and
- Providing clear information to the public about how to access services.

SUMMARY OF KEY PROPOSALS

72. Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document.

73. Over time, move to a likely position of five to seven major acute hospital networks in Northern Ireland.

74. Ensure urgent care provision is locally available to each population.

75. Set targets for the reduction of hospital admissions for long-term admissions and end of life care.

76. Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.

77. Ensure the transition takes full account of Service Frameworks and clinical pathways.

78. Expeditious implementation of a managed clinical network for pathology.

79. Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.

16. PALLIATIVE AND END OF LIFE CARE

INTRODUCTION

Palliative and end of life care is an important service in our system, expressing the essence of the values of the NHS. Palliative Care is defined as: "the active, holistic care of patients with advanced progressive illness". End of life care is a component of palliative care.

The Review heard no reason to challenge the Northern Ireland Palliative Care Strategy 'Living Matters, Dying Matters'[88], outlines an approach to improve the quality of palliative and end of life care for adults in Northern Ireland, irrespective of condition.

Approximately 15,000 people die in Northern Ireland each year. The main causes of death are circulatory diseases (35%), cancer related deaths (26%) and respiratory diseases (14%). Over two thirds of deaths occur in hospitals and nursing homes. The death rates in NI are falling and improving life expectancy means that the population of Northern Ireland is becoming 'older'. The profile of older people requiring care is becoming more complex, with many people now living with multiple chronic illnesses. Recent predictions suggest that one third of people over the age of 65 will be living alone by 2020.

Given that the prevalence of chronic conditions and dementia increases with age, demand for palliative and end of life care services is likely to increase.

As a society we need to have open and honest discussions with all age groups about the processes of dying, death and bereavement. We also need to understand the significance of planning ahead to avoid having to react in a crisis as well as planning for a death with dignity. Using some of the questions outlined in models such as in the Gold Standards model[89] can enable increased awareness and preparedness. We need to increase our understanding of when the palliative care phase ends and the end of life phase begins. These phases can move backwards and forwards and it may be difficult to determine when someone is dying. This can assist people in coming to terms with death and dying including the aspiration of planning for a good death.

Although the Palliative Care approach has traditionally been used for people mainly with a cancer diagnosis, it is applicable to other causes of death. The Review heard of a recognised inequity of access to palliative care for non cancer patients. General palliative care is delivered by a range of professional staff in primary, hospital and community settings.

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[88] Living Matters Dying Matters – A Palliative and End of Life Strategy for Adults in Northern Ireland - DHSSPS March 2010

[89] Gold Standards Framework

Specialist palliative care including complex psychosocial, end of life and bereavement issues is provided within HSC and by voluntary sector organisations that make a valuable contribution in this area of care.

It is estimated that two thirds of all deaths in Northern Ireland (9,570) would benefit from the palliative care approach in the last year of life, but do not receive it. 20,000 bed days are used in NI for people dying in hospital from cancer conditions alone. There is currently no strategy that directly addresses the palliative and end of life needs of children.

We correctly invest a large volume of resource in the last year of life, but often provide poor quality which does not meet patient and carer wishes. The Review concluded it can be improved with greater coordination of care in order to ensure that people die with dignity.

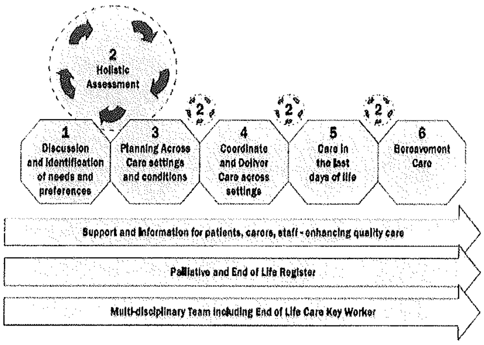
We also know that many more people than currently do would prefer to die at home. At the same time there are too many unnecessary, unwanted and costly end of life hospital admissions. We need to shift more care to the community where it can be more appropriately delivered.

Nursing homes are increasingly becoming the place where older people live and die with shorter average lengths of stay between 18-24 months. Complexity and higher dependency levels within nursing homes have implications for staff development to meet residents' end of life needs.

Frontline staff in general often lack training in delivering end of life care. There is a need to improve education and training for those providing palliative and end of life care.

The Review supports the model[90] below illustrating a continuous, holistic assessment of palliative and end of life care, co-ordinated by a key worker.

Figure 22: Palliative and End of Life Model



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[90] Living Matters, Dying Matters, An End of Life Care Strategy for Adults in Northern Ireland, DHSSPSNI, March 2010.

SUMMARY OF KEY PROPOSALS

80. Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.

81. Enhanced support to the Nursing Home Sector for end of life care.

82. Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.

83. Electronic patient records in place for the patient, their family and staff.

84. Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.

85. Palliative and end of life care for children considered as part of the proposed review of Paediatric Services as referenced in the Maternity and Child Health section.

IMPLICATIONS FOR THE SERVICE

17.IMPLICATIONS FOR THE SERVICE

The changing model of care which moves care as close to home as possible, will only work if the way in which we deliver services also changes.

With a change in the model of care delivered by hospitals, the support required to deliver services in the community and at home, there will be a shift of services that will impact on the type of facilities which we require and the workforce that will deliver the service.

This section sets out an overview of the guiding criteria to be used when considering the new model of service delivery:

- infrastructure;
- technology;
- workforce; and
- resources.

INFRASTRUCTURE

CARE AT HOME

As has been outlined in the sections above, there will be a major shift to care delivered within people's homes, throughout people's lives, whether it be management of long term conditions, support to people with mental health or learning disabilities or end of life care.

In some cases people's homes are nursing homes or residential facilities. The care delivered to individuals in these facilities should enable residents to remain in the facility provided their needs can be met there. The package of care will be based on personal needs, not based on location.

Personalised budgets will encourage diversity of service. Where there is reluctance to take charge through personalised budgets, advocacy and clear information on the financial implications of any assessment will promote this outcome.

An overview of the services that will be delivered in the home, through Integrated Care Partnerships, is as follows.

Services in your home

Access to specialist teams for long term conditions will be developed

Support for Specialist care for cancer

Rehabilitation services

Domiciliary Care, including home nursing

End of Life Care

Access to a range of support services for example daycare or respite

Health and Wellbeing support for vulnerable groups

Enabling good outcomes for those using the service - for older people this is best described as the reablement model. In mental health, the recovery model and in child care, the rescue model.

CARE IN THE LOCAL COMMUNITY

People will have access to a greater package of services within the community.

Services will be focused on the needs of the local population. Local planning will ensure that services are delivered that meet their needs and work towards tackling health inequalities, for example multidisciplinary teams to deliver a package of care to someone with a long term condition or more than one condition.

The types of services that will be delivered within the community, through Integrated Care Partnerships, will include:

Services in your local community

GPs with enhanced services

Pharmacy

24/7 Urgent Care including GP, mental health crisis response and minor procedures

Outpatients

Diagnostics

Access to therapy and rehabilitation

Social support

Links to Voluntary and community organisations to support care

Advocacy services

Antenatal and postnatal care

Health and Wellbeing Advice

Optometry

Dentistry

Cross Departmental working groups to support social needs

Beds used for step-up/ step-down from hospital managed by GPs

Support to carers

Re-ablement

Our 353 GP practices will work within networks based on the already established 17 Primary Care Partnerships. These should be on a formal basis as 'federations of practices'. This should result in GPs working together in a consistent manner.

The GPs currently within Primary Care Partnerships will form part of the Integrated Care Partnership along with representatives from other HSC bodies, as outlined above. Consideration should be given to the potential for these ICPs to form the basis for a multidisciplinary mutual organisation or to have social firm status.

Pharmacy will deliver an enhanced role in medicines management and health promotion to the local community and will be part of the multidisciplinary team supporting individuals with complex needs.

The ambulance service will have the ability to transfer patients to urgent care settings rather than defaulting to a major acute hospital if this is the most appropriate type of care required for the patient. The ambulance service will also be able to refer patients back to their GPs if they do not see the need to transfer the patient to other services such as urgent care or emergency care.

The focus of care will be reablement where possible. Support at home will be: increased availability of respite care; step up and step down beds between home and hospital; and rehabilitation beds. This will be supported by outpatients services, diagnostics and minor interventions being available closer to home.

The current decline in the demand for residential care homes will continue. In NI, we also have a higher use of supported accommodation than the rest of the UK. This trend is also likely to continue leading to a major reshape of this service.

People who require 24 hour nursing will be cared for within nursing homes.

The move away from residential care provision towards care at home will require a joined up approach to service delivery between the Department for Social Development and DHSSPS.

There will also be a move of dental services closer to home. For example, oral surgery can be carried out within the community at dental practices rather than within a hospital setting as is often the case.

The pathway for referral to hospital optometry services from practices has led to unintended high volumes of referrals. Clinical protocols for direct referral should be considered.

HOSPITAL SERVICES

Introduction

In the future hospitals will work as a system with each facility contributing to the provision of a total service to its population.

The Review is aware that there will be a considerable interest in the current hospital sites and their future role. However, as has been indicated early in the report, the final functionality of each of the facilities will be based on population need and the principles set out above.

The Review recommends that the commissioning system using its local communities should bring forward proposals for hospital services for each of the five populations by June 2012.

Evidence presented to the Review persuaded it that local populations and in particular professionals should design the way forward rather than impose a top down approach of specifying a function for each hospital.

In accepting this approach it wishes to make clear that there will be, as a consequence, change on all sites over a five year period. With change of this magnitude, the system and those working within it must enable, not disable, the change process. The following clearly articulates **what** should be provided. The **how** is for those working in the system.

Hospital Services

All current hospitals will have an integral role in the delivery of services to their localities. They will be essential in contributing to what a local population requires from a hospital service.

The Review is not prescriptive about the service configuration in these facilities but it is expected to include the following profile of services.

Services in your hospital

Urgent Care – doctor led assessment

Out of Hours – GP led

Elective Surgery – daycase and selective inpatient

Inpatient medical care on the basis of agreed pathways designed between primary and secondary doctors

Rehabilitation

Diagnostics

Midwife Led Obstetrics, where feasible based on demand

Hospitals will be networked with the GPs/ GPSIs and staff from the major acute centres. The preferred route for treatment is at home or within the community. Where people cannot be cared for in their own homes or within their community, they will be referred to hospital. Decisions on where to admit will be determined by clinical protocols and designed to ensure the best outcome for the patient.

Hospitals will be expected to separate elective surgical procedures from emergency procedures so that the system of care leads to better clinical outcomes and productivity, without one detrimentally affecting the other.

Patients may also be transferred within the network depending upon clinical need.

Major Acute Hospitals Services

Major acute hospitals provide care and treatment that requires centralisation to ensure that services are delivered by senior staff and that those services are resilient to demand pressures and provide the best outcomes for patients.

Each major acute hospital service must be capable of delivering and sustaining the following profile of services.

Services

24/7 Emergency Department

Emergency Surgery available 24/7

Complex Elective Surgery

Some non-complex elective surgery

Undifferentiated inpatient Medicine, e.g. coronary care and stroke

Paediatrics (Inpatient) available 24/7

Critical care available 24/7

Specialist Diagnostics available 24/7

Outpatients

Consultant led obstetrics

Midwife Led Unit, where appropriate

Since resilience is essential to the provision of hospital services, critical clinical staff will be employed to work in the hospital system and be a resource for each population working as necessary across hospital services and facilities.

Where inpatient provision is currently regional, such as cardiac surgery or sub regional, such as urology, clear clinical pathways which ensure equal access to populations will be required.

Specialist Services

Specialist hospitals will continue to deliver specialist services to the population of Northern Ireland including complex medicine, complex surgery and the associated outpatients service.

These services will be networked as necessary with ROI and GB to ensure that the highest quality services are delivered and that the staff are well trained and experienced.

Supra-Regional Services

Services which have such a low volume that they cannot be sustained to a high quality in NI, even without networking to other tertiary centres, should continue to be delivered outside of Northern Ireland. These include for example transplantations and rare disease management.

The Northern Ireland Perspective

The Review recognises that the future model must take into consideration the Northern Ireland dynamic. Given the rural nature of the West, and its close links to the ROI, the new model will require two major acute facilities in the West. The ROI has expressly indicated it wishes to maximise the opportunity for its population in the new hospital in the West.

Altnagelvin and Belfast hospitals have already well established working arrangements with ROI around some of its services which will continue.

There is currently a level of use of Daisy Hill Hospital by residents of the north east region of ROI. The future configuration of major acute services in Newry will be impacted upon by the potential demand for services from the ROI.

Conclusion

As a consequence of re-profiling services in this way there will be change on all existing sites.

The Review anticipates a major restructuring of how services are delivered by our current hospitals. As previously described, for NI this is likely to mean between five and seven major acute hospital facilities or networks.

The Review also wishes to make clear that maintaining an 'as is' model cannot be successful in delivering against the key principles or the guidelines already described. Furthermore, systems which are overly reliant on locum and agency staff are not acceptable.

Impact on the Northern Ireland Ambulance Service

The role of the NIAS is of central importance to the ability to deliver the new model of care. The NIAS has been going through some major changes in modernising its service to meet the needs of the HSC in the 21st century. This modernisation is planned to continue. The plans of the NIAS will support the implementation of the Review, in particular:

- supporting the new care pathways for unscheduled, in particular urgent care;
- training of NIAS paramedic staff to support the model;
- provision of an alternative to the 999 emergency number and availability of medically trained staff to triage patients to the most appropriate service;
- supporting the focus on prevention and wellbeing through information and advice; and
- continuing to support the move of care closer to home through diagnosis and treatment of minor illnesses and injuries in the community.

The NIAS will be involved in the planning and implementation process following the Review, alongside the representatives from across health and social care.

TECHNOLOGY

Technology is a key enabler of the delivery of the new model of care, in particular in supporting care closer to home and the ability of staff to work as an effective integrated multi-disciplinary team.

A forum should be established to take forward how technology will support the new model of care linking the service to industry and academia to ensure the optimum and best value for money solutions are taken forward and opportunities are identified and considered. Where appropriate, development of technological support will be through a collaboration approach with the Department of Enterprise, Trade and Investment (DETI) in line with the Memorandum of Understanding agreed between the Minister for Health, Social Services and Public Safety and the Minister for Enterprise, Trade and Investment.

The plans for technology to support the new model will come in the form of regional projects as well as technology solutions that will support the delivery of services to meet the specific needs of patients in a certain area. The population based planning approach will include plans for the use of technology to support how the model of care is delivered for that population.

Availability of Information at the Point of Care Delivery

Today, records are kept in all the places where you receive care. These places can usually only share information from your records by letter, email, fax or phone. At times, this can slow down treatment and sometimes information can be hard to access.

By making more health records electronic, there will be quicker ways to get important information to HSC healthcare staff treating patients, including in an emergency

Electronic Care Records (ECR) can be used to allow the sharing of information between the many systems currently used to store information across the HSC. This would result in all information held on each patient being available together through the use of the ECR platform.

An ECR pilot is currently underway. This has involved sharing of information within a Trust (i.e. acute, community and primary care information). The Review endorses the roll out of ECR across Northern Ireland with the ultimate aim of sharing information, not just within a Trust, but also across Trusts such that the service will provide an individual electronic care record for every patient in NI. Any patient could then attend any facility across NI and the health records and information will be available.

Information sources will include:

- GP records;
- Community Information Systems (also see below);
- pharmacy records (medicines management); and
- hospital records, including results of diagnostic tests.

Mobility of Staff

Mobile working by community staff allows for better use of resources.

With the shift of care into the community, consideration should be given to the merits of mobile technology to support staff working in the community.

The National Mobile Health Worker Project findings were that mobile devices loaded with office and clinical software allowed clinicians working within the community to make nearly 9% fewer referrals and avoid 21% of admissions.

GP Records

The Review also endorses the approach of developing a data warehouse for GP records in order to deliver information which is of a high quality and consistent across practices resulting in reduced variation and a safe and secure method of storing and sharing patient information.

The data warehouse will protect the confidentiality of patients and will provide timely, anonymised patient-based data and information for purposes other than direct clinical care, including:

- planning and commissioning;
- public health and research;
- clinical audit and governance;
- benchmarking; and
- performance improvement.

Data would be routinely extracted from GP systems and loaded into the data warehouse. The data warehouse would be used by staff at Trust, HSCB and DHSSPS levels. Access to the data would be strictly controlled and where necessary the data would be anonymised. Each "type" of user would have access only to the data for which they have authorised access.

Supporting People to Self-Manage their Care

Technology should be harnessed to support patients in managing their own care through, for example:

- supporting patient education;
- direct patient monitoring and support (telemedicine);
- clinical information and management systems; and
- promoting healthy living and disease prevention.

Telemedicine can be used to provide care closer to home such that the patient does not need to be in a hospital to receive care.

Connected Health

Connected Health is used to describe a model for healthcare delivery that uses technology to provide healthcare remotely. It provides a strategic opportunity for a different business model of procuring and delivering care around the needs of the patient. Through the use of technology patients are able to monitor their own condition, within the parameters set by their GP, thereby enabling them to take greater responsibility for managing their own health and well being. This should lead to a reduced need for patients to visit their GP Practices for monitoring of their condition. Variations to their clinical condition will be monitored remotely and they can be triaged to the relevant area of the health service as appropriate to their need at that time. This will result in patients visiting their GPs about their condition only when they need to and will lead to more appropriate and timely referrals to secondary care.

Connected Health sits well with government health strategies at many levels. It supports patient choice by allowing patients to remain within their own homes with effective self-management. It also supports the move of services from secondary to primary care settings and the ability to deliver a more cost effective, better quality service.

Supporting the principle of Right Care, Right Place, Right Time

One contact number for urgent care will allow triage of patients and ensure that they are directed to the best place of care as discussed in the NIAS section below.

A single robust community information system is required to support the increase in care to be delivered within the community.

WORKFORCE

The new model of service delivery requires a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated, integrated and at home or close to home.

New care model – Workforce implications

Some of the key implications include:

- more people will receive care in their own home, or close to home; which is more integrated with hospital clinicians working closely with GPs and other community staff to plan care delivery, along with increased clinical support provided in the home;
- multi professional community integrated teams will form the essential nucleus of health and social care professionals supporting patients in their own homes;
- increasing use of networks to coordinate care and share good practice and greater emphasis on partnership working within and across sectors; and
- the need to accelerate the pace of change.

The proposed changes will require staff to develop different skills and capacities. For example, GPs with Special Interests in emergency medicine or paediatrics, specialist long-term condition nurses and emergency care practitioners. It is likely that there will be more overlap and networking between services, and it is proposed that there will be an increase in outpatient follow-up appointments being carried out by GPs and nurses. Furthermore there is potential to explore new and extended roles as part of future care provision including the potential to introduce further multi-skilling alongside the use of assistive technologies to maintain older people in their homes.

Role change

Our expectations for what it means to be a health and social care professional are changing. They go beyond clinical practice itself, precisely because high quality care is delivered by a team in a system, not alone in a vacuum. To reach its full potential health and social care needs to harness the skills of professionals working together in making decisions in the clinical arena and bringing that expert judgement to bear on difficult resource and management decisions that impact on patients. Patients, the public and staff expect to see visible leaders making the case for those changes to services which evidence shows will improve patient care.

We need to be clear about what HSC organisations expect and need from tomorrow's clinicians and managers. Workforce planning and development is a critical building block in ensuring that staff are appropriately trained and confident in their roles. In light of the range of external factors likely to impact on health and social care our workforce planning needs to focus on demand signals from the local health economy and patients/ clients rather than just supply side inputs; linked to service planning and needs and underpinned by financial plans making it more robust and linked to patient needs. There needs to be close working between all education and training providers and the HSC to ensure continued high quality of education and training, based on service needs.

Extending GP leadership: Using the building block of Clinical Leads recently appointed to lead the recently formed PCPs, we need to identify and develop GPs will assume a critical leadership role in the new Integrated Care Partnerships. Clarity around roles and expectations will be critical to ensure they are able to engage with twin challenges of professional and management responsibilities.

Resilience

The ability to deliver good outcomes to patients is inextricably linked to workforce and in particular the medical workforce. In recent years the allocation of junior doctors has been problematic. Two matters are pertinent, access to good training and individual choice about workplace. Both will remain into the future. Failure to take full account of this has created many problems for the current model. It is likely that workforce availability over the next 3 years will be numerically less than required for the existing model but much more importantly the training experience that the current model provides, and ultimately the quality of outcome for patients, means that continuation of the current model is unsustainable. Any attempt to sustain the current model would simply flounder.

Engagement with staff organisations

Within the HSC a process of active engagement has been developed over a period of time, incorporating not only regular consultation on matters of concern to both HSC organisations and the staff representatives, but also partnership working on issues of joint concern to the service and the members they represent. It is vital that we remain committed to ongoing, close working with staff organisations and their representatives going forward.

NIAS

The Ambulance Service is a key part of the new service delivery model. Training

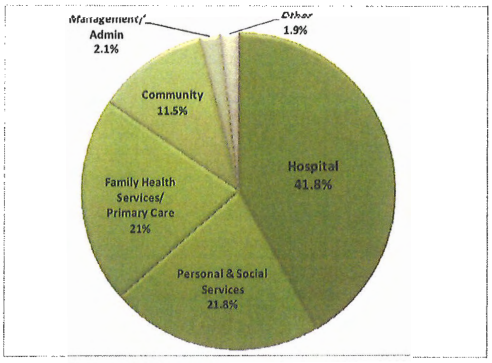
of ambulance staff in the new model and best location of care will be required as well as ensuring that bypass protocols are in place.

RESOURCES

Revenue Budget

The current revenue budget for DHSSPS in 2011/12 is £4,383million. The Health and Social Care element is £3,904million and is split as follows:

Figure 23: Current HSC Revenue Budget, 2011/12

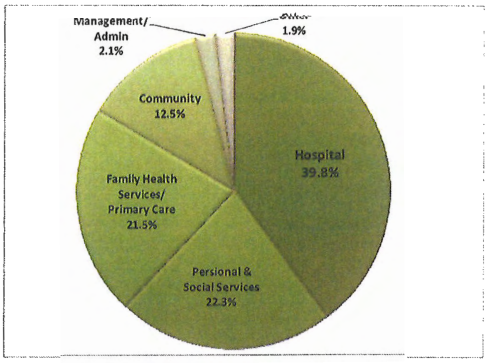


To allow the implementation of the new model of care the funding available for HSC services will be re-allocated. There will be a shift of care from hospital settings into the community. Some of the key changes that will be seen in the community will be:

- more care delivered in the home;
- changing care packages for people in nursing homes;
- increased role of the GP;
- increased role of Pharmacy in medicines management and prevention;
- a strong focus on prevention;
- increased use of community and social care services to meet people's needs; and
- outreach of acute services into the community.

The revenue budget for DHSSPS in 2014/15 is £4,659million. The Health and Social Care element is £4,150million. The projected allocation, applying the new model, is illustrated in the figure below.

Figure 24: Projected Allocation of HSC Revenue Budget, 2014/15

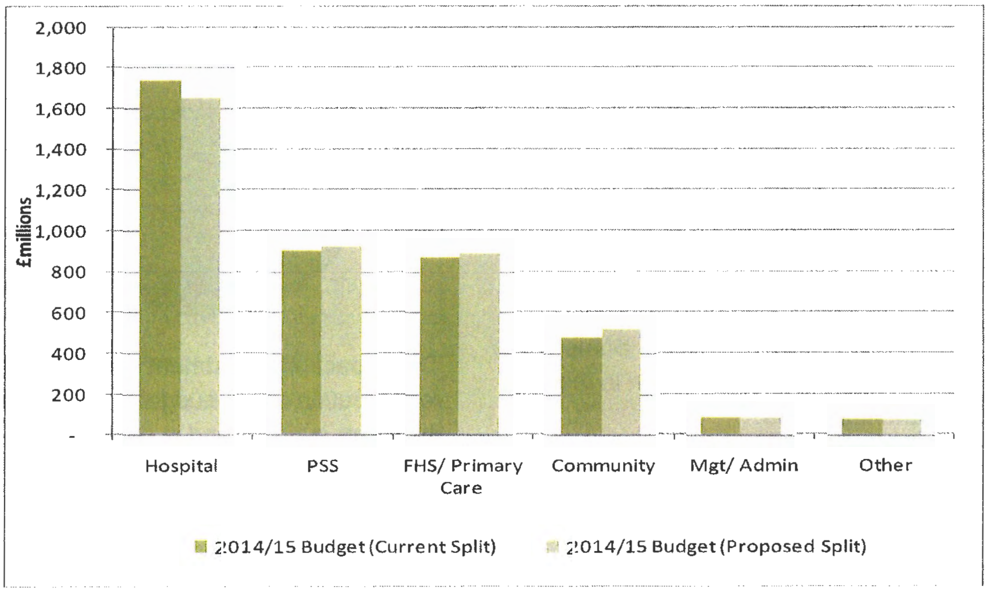


The impact on investment of the potential redistribution of the budget is illustrated in the figure overleaf and is as follows:

- reduction of the budget in hospital services, from £1,733million to £1,650million. This represents a £83million reduction, equating to 5% of the hospital services budget;

- increase in Personal and Social Services (PSS), from £903million to £924million. This represents a £21million increase, equating to a 2% increase in the PSS budget;
- increase in Family Health Services and Primary Care Services, from £871million to £892million. This represents a £21million increase, equating to a 3% increase in the FHS budget; and
- increase in Community Services, from £477million to £518million. This represents a £41million increase, equating to a 9% in the Community Services budget.

Figure 25: Projected Allocation of HSC Revenue Budget, 2014/15



A shift of care from hospital settings into the community reflects the principles, as outline in section 5, by which the Local Commissioning Groups will develop their population plans. The re-allocation of resource, illustrated in figures 23 and 24 is indicative; however it does reflect the anticipated level of change required to effect the change.

Consideration will also need to be given to the capital investment required to enable the change process to occur.

TRANSITION AND IMPLEMENTATION

This change will not be straight forward. It will require fundamental changes to the way we deliver services and will require substantial re-training of staff.

In addition it is estimated that transitional funding of approximately £25million in the first year; £25million in the second year; and £20 million in the third year will be required to enable the new model of service to be implemented.

We recommend this should be invested in:

- Integrated Care Partnerships, with a focus on older people and long term conditions;
- service changes; and
- voluntary early release scheme.

It is anticipated that after 2014/15 the model would be self-financing.

The principles for implementation are set out in section 18 overleaf. Detailed implementation plans will be developed following this review to reflect the complexity of changes required.

Income Generation

Often a parallel is drawn with other UK regions in regards to NI. Citizens contrast availability of services elsewhere with those that they have access to. This is sharply focused when there is discussion about income generation. Other regions have access to resources from charging which is not available in NI. The Review does not offer an opinion on how this should be addressed but would state there are no neutral decisions.

While income generation was not a matter for the Review, there needs to be a sensible debate about growing income within the spirit of the NHS principles. The Review recommends that this debate commences in NI in 4 areas:

- Non-emergency transport – for example car parking for visitors and staff and travel to day centres;
- Domiciliary care – DHSSPS has never applied the ability to charge for domiciliary care in the home;
- Prescriptions – consideration of a contribution towards the cost of prescriptions; and
- Social Bonds and their ability to support more diversity in community service provision.

The Review would wish to restate that it is not supportive of any move away from core NHS principles.

SUMMARY OF KEY PROPOSALS

86. Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.

87. Development of population plans for each of the five LCG populations by June 2012.

88. Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/AHPs, and social care.

89. Development of clear patient pathways for networked and regional services.

90. Establishment of a forum to take forward how technology will support the new model of care linking the service to industry and academia.

91. Full rollout of the Electronic Care Record programme.

92. Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.

93. Introduction of a single telephone number for urgent care.

94. Introduction of a single robust community information system.

95. Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home.

96. Development of GPs to assume a critical leadership role in the new integrated care teams.

97. More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.

98. Re-allocation of resources estimated to equate to a 4% shift of funds from hospitals into the community.

99. Initiation of a sensible debate about growing income within the spirit of the NHS principles.

ROADMAP FOR THE FUTURE

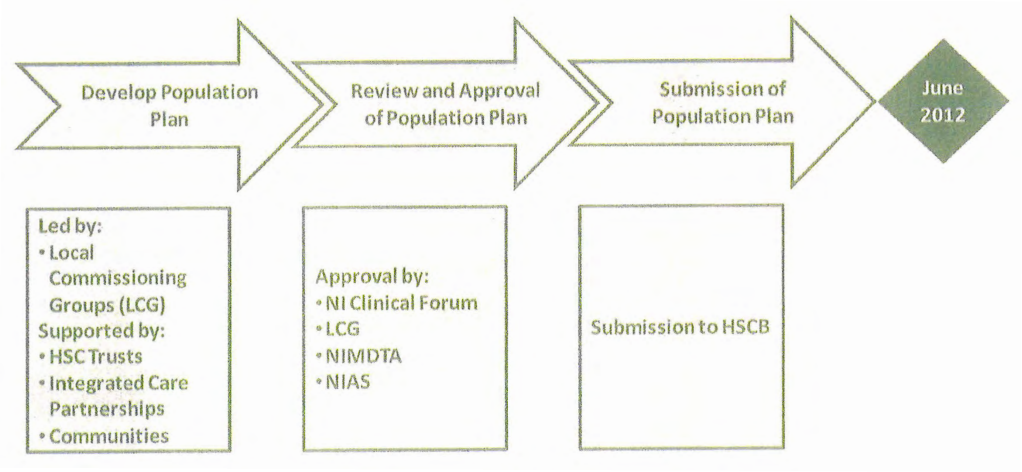
18.ROADMAP FOR THE FUTURE

Key to the successful delivery of the new model is a clearly defined roadmap for the future which sets out the steps needed to move from the current model of care to the new model of care. It is essential that a clear direction of travel is set out. This should be in the form of a clear implementation and engagement plan. The engagement plan will be an essential tool in setting out how the changes will affect users, families and staff. To support the implementation clear governance and reporting arrangements must be established. An answer to the 'who's in charge' question must be clear and accountabilities easily understood by all.

This section sets out a proposed response to this challenge. It comments upon governance arrangements for the programme, presents an approach to create an implementation plan and identifies the key actions and milestones for implementation of the recommendations of the Review. Additionally it describes a plan for engagement with staff and users. The Review recommends that detailed implementation and engagement plans are developed and published by June 2012 following this Review, as illustrated below.

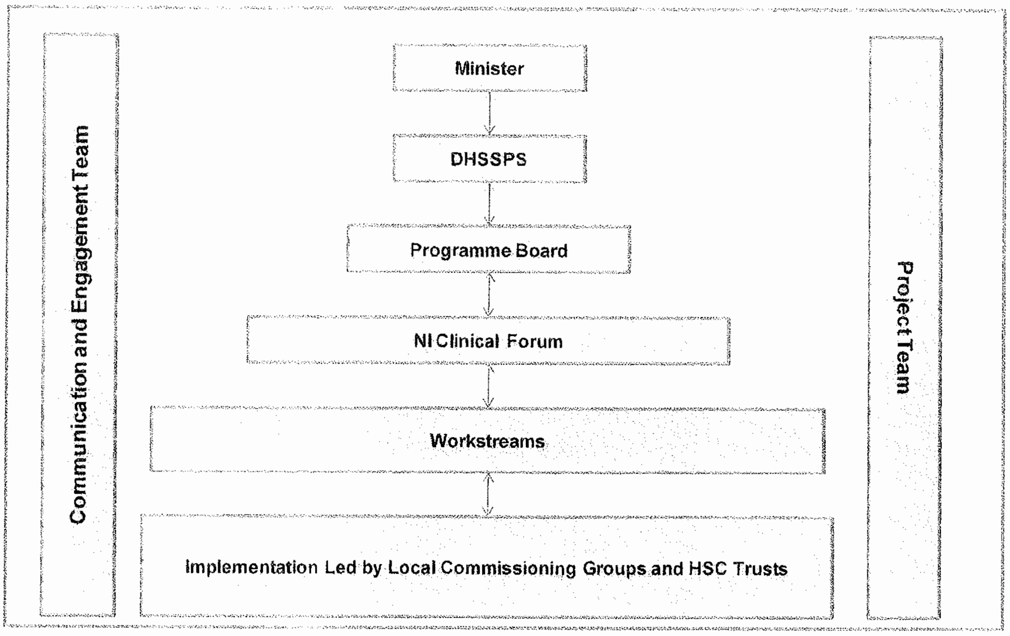
In addition, the Review recommends paying particular attention to achieving sign off from the 17 Integrated Care Partnerships, NIMDTA and the NI Ambulance Service when the Local Commissioning Groups put forward the models for their population.

Figure 26: Population Planning Process



PROGRAMME GOVERNANCE

Figure 27: Programme Structure



The programme of change will be led by the Minister for Health, Social Services and Public Safety. A Programme Board will be set up to report to the DHSSPS and Minister on the implementation of the Review. The Programme Board will be supported by the Northern Ireland Clinical Forum, a project team and workstream leads. The roles of each of the bodies included in the programme will be as follows.

Minister for Health, Social Services and Public Safety

The Minister is responsible for the roll out of the programme of change. The Minister will approve all major decisions about service changes, policy or legislation. The Programme Board will report to the Minister on progress of the implementation through the DHSSPS.

DHSSPS

The DHSSPS will advise the Minister on extant policy or new policy and will support the Minister in making decisions relating to the programme of change. In addition, the DHSSPS will ensure close collaboration with the Programme Board as it discharges its responsibilities.

Programme Board

The Programme Board will be chaired by the HSCB and made up of representatives from the HSCB and HSC Trusts. The Programme Board will be responsible for steering the implementation using the commissioning process. It will also be responsible for reporting to DHSSPS and the Minister on progress.

NI Clinical Forum

A NI Clinical Forum will be established in 2012 to provide strong professional advice to the Programme Board and give robust clinical advice in taking forward the changes. Additionally the Patient and Client Council will be invited to describe how best to ensure users and carers are engaged.

Workstreams

A number of workstreams will be set up for each area that is seen as key to leading the implementation. These workstreams will lead the implementation of the agreed plans for each population. They will report to the Programme Board on the progress under each workstream.

Delivery

The actual implementation of the changes agreed will be taken forward as a joint approach between commissioners and providers. The Local Commissioning Groups will work with the HSC Trusts and other providers in taking forward the plans. The LCGs will report to the Programme Board on the progress of the implementation.

Project Support

The Programme Board will be supported by a Project Team. The Project Team will use Project and Programme Management principles to monitor the progress of the implementation of the programme of change based on the plans approved by the Programme Board, the DHSSPS and the Minister. The Project Team will report directly to the Programme Board on the progress. The tools used to monitor progress will include:

- detailed Project Plan;
- key responsibilities for taking forward actions and associated timescales;
- actions and milestones;
- targets for measuring success; and
- development and management of project risks.

Communication and Engagement

The delivery of the programme will rely greatly on the ability to successfully communicate changes to the public and staff working in the HSC as well as successfully engaging with these groups and achieving their buy-in to the process. This will require communication and engagement support from a team with experience in taking forward major change programmes.

The suggested structure of the programme is shown in Figure 18 overleaf.

These arrangements should be in fully place by June 2012 to support the roll out of the population plans submitted at that time.

IMPLEMENTATION PLAN

A detailed implementation plan overleaf will be required to take forward the project. This will be based on population plans. Each of the population areas, led by Local Commissioning Groups, will be expected to produce population plans by the end of June 2012.

The figure overleaf sets out the high level actions associated with the recommendations of this Review.

The Review team acknowledge that many of the recommendations require policy change, as well as necessary equality, human rights and rurality impact assessments. In addition a number may also require legislative change to enable implementation. These will be taken forward in the implementation process.

ENGAGEMENT PLAN

The implementation of this programme of change is much more likely to deliver sustained transformational change through commitment than through compliance.

An engagement plan will be a key tool in taking forward the programme. The engagement plan will include:

- identification of the key stakeholders to be consulted with;
- how the stakeholders will be engaged with; and
- plan for engaging with stakeholders.

Stakeholders to be engaged with will include representatives from DHSSPS, HSC Board, HSC Trusts, Voluntary and Community Sector organisations, users and carers.

Stakeholders are expected to be engaged through a number of approaches, both targeted to specific stakeholders and those which are stakeholder wide. This will be via a number of methods which may include already established forums, workshops or one to one meetings.

Regular updates on engagement should be reported to the Programme Board.

COMMUNICATION PLAN

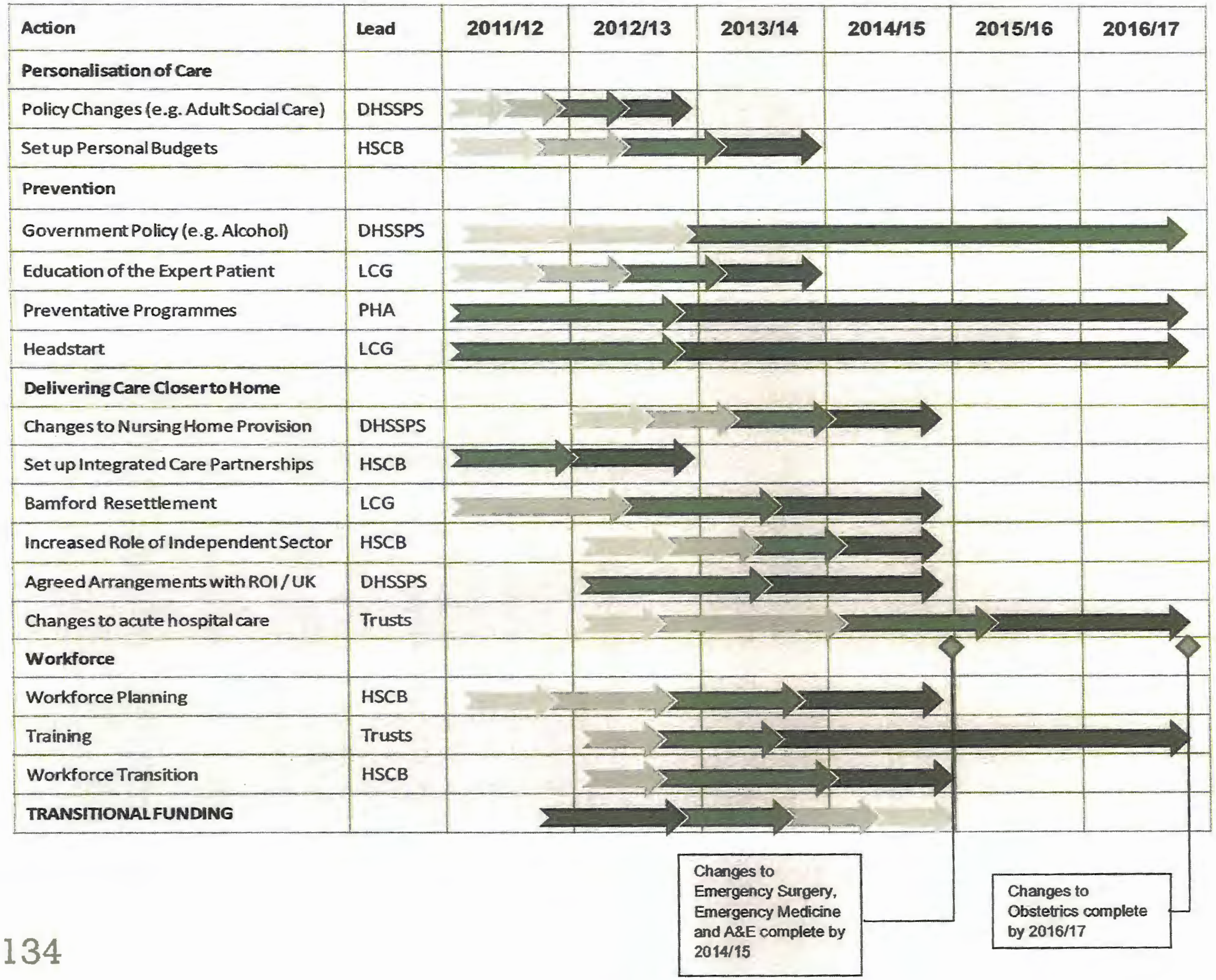
The major changes envisaged by this Review will impact on all residents of NI both those using the HSC service and those working in it.

To manage the effective implementation of the programme it will be essential that the changes are communicated effectively to those who will be affected, both from the perspective of understanding how the changes will affect care, changes in how to access care and a clear understanding of what is expected from the public in delivering the programme of change.

The communication plan should include details of:

- the key messages to be communicated;
- the target audience for communication;
- the approach to communication; and
- the forum and tools to be used when communicating with the groups identified.

Figure 28: Timeline for Completing Key Actions



Changes to Emergency Surgery, Emergency Medicine and A&E complete by 2014/15

Changes to Obstetrics complete by 2016/17

19.SUMMARY OF PROPOSALS

POPULATION HEALTH AND WELLBEING

1. Renewed focus on health promotion and prevention to materially reduce demand for acute health services.

2. Production by PHA of an annual report communicating progress on population health and wellbeing to the public.

3. Maintenance of existing and implementation of new screening and immunisation programmes where supported by clinical evidence.

4. Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: in relation to pricing of alcohol and 'junk' food; and further controls on tobacco usage.

5. Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.

6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.

7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community.

8. Support for the health promotion and prevention role played by Allied Health Professionals, particularly with older people.

OLDER PEOPLE

9. Home as the hub of care for older people, with more services provided at home and in the community.

10. A major reduction in residential accommodation for older people, over the next five years.

11. Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.

12. A greater role for nursing home care in avoiding hospital admissions.

13. More community-based step-up/step-down and respite care, provided largely by the independent sector.

14. A focus on promoting healthy ageing, individual resilience and independence.

15. More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.

16. A holistic and consistent approach to assessment of older people's needs across Northern Ireland and an equitable range of services.

17. A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.

18. Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.

19. A policy review of carers' assessments and more practical support for carers including improved access to respite provision.

20. An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.

LONG-TERM CONDITIONS

21. Partnership working with patients to enable greater self care and prevention.

22. Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.

23. Patients to have named contacts for the multi-disciplinary team in each GP surgery to enable more straightforward communication.

24. Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.

25. A stronger role for community pharmacy in medication management for LTCs.

26. Development of admission protocols between secondary care specialist staff and those in the community.

41. Child health included as a component of the Headstart programme referenced in the Family and Childcare section.

42. Promotion of partnership working on children's health and wellbeing matters with other government sectors.

43. Close working between hospital and community paediatricians through Integrated Care Partnerships.

44. Completion of a review of inpatient paediatric care to include palliative and end of life care.

45. Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.

FAMILY AND CHILD CARE

46. Re-structuring of existing services to develop a new 'Headstart' programme focusing on 0-5 year olds.

47. Exploration through pilot arrangements of budgetary integration for services to this group across Departments, under the auspices of the Child and Young People's Strategic partnership.

48. Completion of a review of residential care to minimise its necessity.

49. Promotion of foster care both within and outwith families.

50. Development of a professional foster scheme for those hardest to place.

51. Implementation of the RQIA recommendations in relation to CAMHS.

52. Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS services.

MENTAL HEALTH

53. Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.

54. Establishment of a programme of early intervention to promote mental health wellbeing.

55. Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.

56. A consistent, evidence-based pathway through the four step model provided across the region.

57. A consistent pathway for urgent mental health care including how people in crisis contact services, triage and facilities in emergency departments.

58. Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.

59. Further shift of the balance of spend between hospital and community, with reinvestment of any hospital savings into community services.

60. Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.

61. Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.

62. Close long stay institutions and complete resettlement by 2015.

LEARNING DISABILITY

63. Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)

64. Further development of the current enhanced health services on a Northern Ireland basis.

65. Support from Integrated Care Partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.

66. Better planning for dental services should be undertaken.

67. Further development of a more diverse range of age-appropriate day support and respite and short-break services.

68. Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.

69. Development of information resources for people with a learning disability to support access to required services.

70. Advocacy and support for people with a learning disability, including peer and independent advocacy.

71. Commitment to closing long stay institutions and to completing the resettlement process by 2015.

ACUTE CARE

72. Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document.

73. Over time, move to a likely position of five to seven major acute hospital networks in Northern Ireland.

74. Ensure urgent care provision is locally available to each population.

75. Set targets for the reduction of hospital admissions for long-term admissions and end of life care.

76. Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.

77. Ensure the transition takes full account of Service Frameworks and clinical pathways.

78. Expeditious implementation of a managed clinical network for pathology.

79. Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.

PALLIATIVE AND END OF LIFE CARE

80. Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.

81. Enhanced support to the Nursing Home Sector for end of life care.

82. Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.

83. Electronic patient records in place for the patient, their family and staff.

84. Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.

85. Palliative and end of life care for children considered as part of the proposed review of Paediatric Services as referenced in the Maternity and Child Health section.

IMPLICATIONS FOR THE SERVICE

86. Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.

87. Development of population plans for each of the five LCG populations by June 2012.

88. Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/AHPs, and social care.

89. Development of clear patient pathways for networked and regional services.

90. Establishment of a forum to take forward how technology will support the new model of care linking the service to industry and academia.

91. Full rollout of the Electronic Care Record programme.

92. Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.

93. Introduction of a single telephone number for urgent care.

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96. Development of GPs to assume a critical leadership role in the new integrated care teams.

97. More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.

98. Re-allocation of resources estimated to equate to a 4% shift of funds from hospitals into the community.

99. Initiation of a sensible debate about growing income within the spirit of the NHS principles.

20.CONCLUSION

The Review team was impressed and enthused by the opportunity offered by the Minister to bring forward coherent changes for HSC in NI. Change is always difficult, but in looking at change the Review was determined to keep the individual, their family and the evidence of what works at the fore-front of its deliberations.

Looking towards the next 5 years there is real potential with the implementation of the Review to see a service much improved and fit for the future. The Review cannot be impervious to the present wider economic climate and how that might impact on HSC. However the Review Team was firmly of the view that the best defence to such an eventuality was to be clear about the direction of travel, namely:

- starting with the individual;
- looking to a greater focus on prevention;
- maintaining care close to home;
- re-designing primary care; and
- re-shaping hospitals.

Planning for taking decisions and creating a new model for the future is at the core of the Review. The Review is convinced failure to plan will cause detriment to the health and wellbeing of the population

21.APPENDIX

1. Terms of Reference
2. Online survey summary of results
3. Household survey summary of results
4. Questions raised at public meetings
5. List of attendees at clinician workshops and areas covered at each event
6. List of attendees at sector workshops
7. List of stakeholders engaged with at small group meetings
8. List of written submissions
9. Glossary

Appendix 1
Terms of Reference

Review of the Provision of Health and Social Care services in Northern Ireland

1. **The Review should take account of:**

- the Minister's statement of vision and strategy for the HSC;
- the statutory duties on the HSC to improve the quality of services provided to individuals, and to seek to improve the health and social well-being of the population, and to reduce health inequalities;
- all extant statements of policy and strategy approved by the Minister, and in particular the aims of improving **public health**, the **prevention** of illness, and of improving **outcomes** for patients and clients. Other major themes of policy and strategy are the quest for better early intervention and chronic condition management, and the strategic shift of all suitable services towards a primary and community context;
- the organisational structure of the HSC as established in the 2009 Reform Act, and in particular the responsibility to secure a clear focus on public health, and increasingly effective local commissioning of services and to exercise good governance and provide clear accountability – the Review will need to ensure that its analysis and recommendations are practical and applicable within this statutory framework;
- the resources available in the Budget settlement for 2011-12 to 201415 approved by the Executive and the Assembly in March 2011, given the overriding obligation on all HSC bodies to manage services within the level of resources approved by the Assembly;
- best practice guidance of regulatory and advisory bodies affecting the provision of safe and effective services, notably the National Institute for Health and Clinical Excellence, the Social Care Institute for Excellence and the Royal Colleges;
- evidence of how arrangements for the delivery of health and social care in the Republic of Ireland and Great Britain and cooperation for mutual benefit with service providers there, might contribute to the objectives of the Review;
- the established framework of terms and conditions for HSC staff including Agenda for Change and the Consultants' Contract, and the contractual arrangements in respect of primary care;
- recent previous studies and analysis of the HSC including the Appleby Reports of 2005 and 2011, the McKinsey Report of 2010 and the forthcoming PEDU Review; and
- evidence-based good practice on the delivery of services from within Northern Ireland from elsewhere.

2. **On that basis, the Review is asked to:**

- Provide a strategic independent assessment across all aspects of health and social care services of the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met by existing arrangements, taking account of the issues of outcomes, accessibility, safety, standards , quality of services and Value For Money;

- Undertake appropriate consultation and engagement on the way ahead with the public, political representatives (primarily through the Assembly Health Committee), HSC organisations, clinical and professional leaders within the HSC, staff representatives (through the Partnership Forum), and stakeholders in the voluntary, community, independent, private and local government sectors;
- Make recommendations to the Minister on the future configuration and delivery of services in hospital, primary care, community or other settings. The essential task of the Review is to set out a specific implementation plan for the changes that need to be made in the HSC in the context set out above, including proposals in relation to major sites and specialties;
- To identify, at an early stage, potential areas of concern, specific priorities for Ministerial focus and potential issues of public/political/media concern;
- To prepare a Report incorporating its analysis, findings and recommendations.

3. The new organisational structures within Health and Social Care have delivered major efficiencies already. They are currently the subject of a further review as part of a wide ranging review by the Executive of all Arm's Length Bodies and are outside the scope of this Review.

4. The issue of overall funding levels available to meet the needs of Health and Social Care now and in the years ahead is also outside the scope of this Review as that is a matter for the Executive collectively drawing on the advice of DFP. The current PEDU review of the scope to make savings in the Health and Social Care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review.

5. Where the Review finds major tension, or contradiction, between its emerging view of the best way ahead and the extant constraints listed at paragraph 1 above, this should be raised for consideration by the Department as soon as possible, so that the Minister can be advised of the issue and give a specific steer as to how the Review should proceed.

6. The Review should complete its Report by 30 November 2011.

Appendix 2
Online Survey Summary of Results

Online Survey Results

In total there were 1107 responses.

However many of the responses were incomplete and in many cases only demographic information was captured.

The final sample was **673** responses although for some of the 'Quality' questions the sample was reduced further.

Summary of findings:

Demographic Profile

- **91%** of respondents said they work for an organisation providing health or social care services in NI
- **81%** said they work for an HSC Trust
- **95%** were providing the response on their own behalf

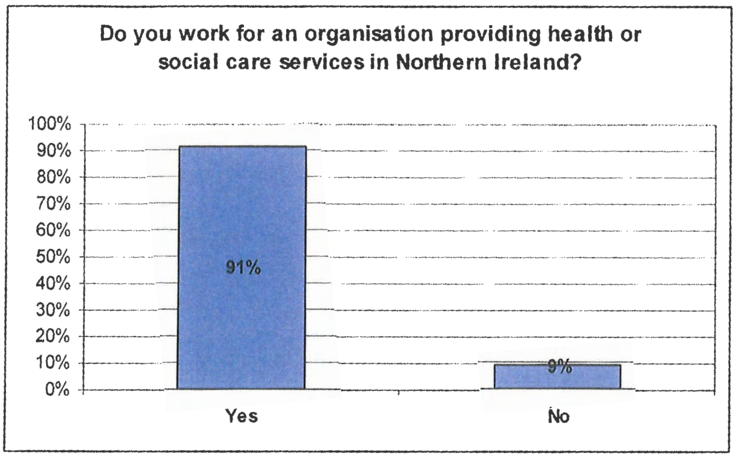
Service Usage in the last Year

Top 3 services reported by most respondents

- **94%** of respondents (or their families) have used GP services
- **54%** of respondents (or their families) have had an appointment with a hospital consultant
- **40%** of respondents (or their families) have used A&E services

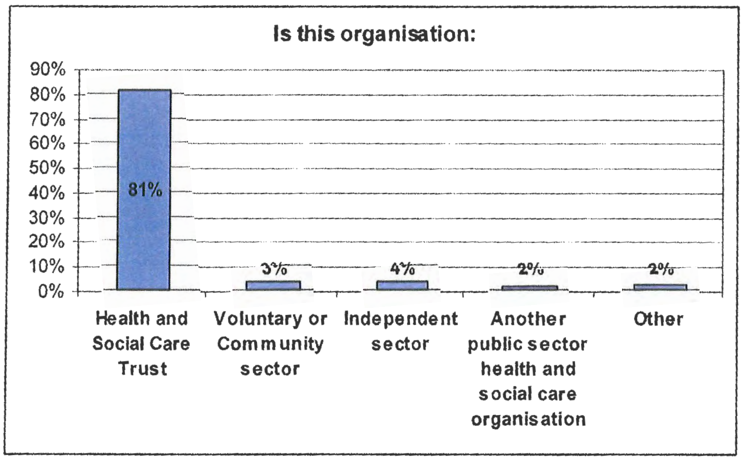
Profile

Do you work for an organisation providing health or social care services in Northern Ireland?

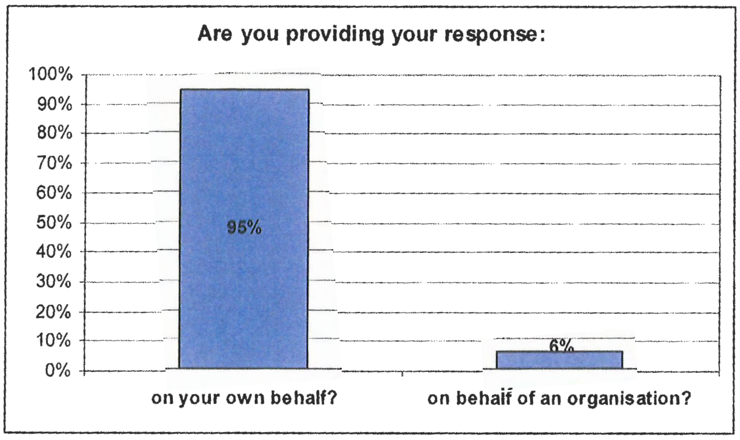


Is this organisation:

-A Health and Social Care Trust
-Another public sector health and social care organisation
-A voluntary or community sector organisation
-An independent sector organisation
-Other

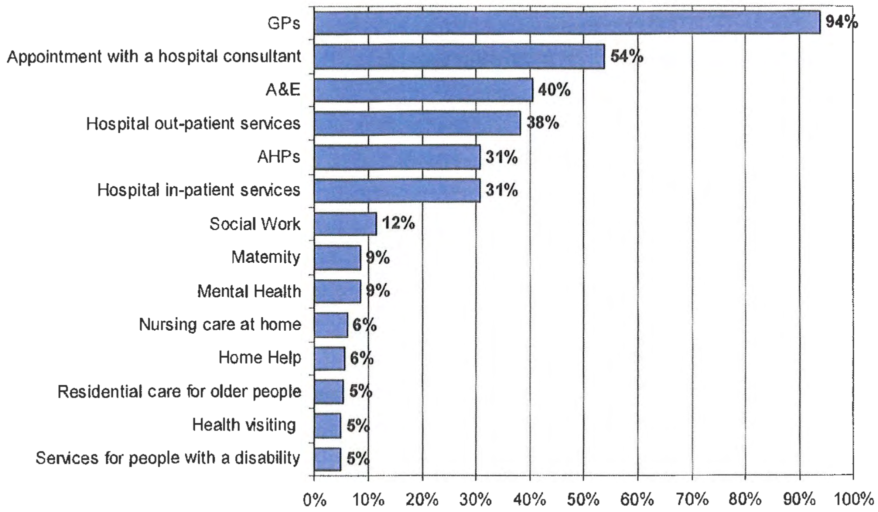


Are you providing your response
- On behalf of an organisation or
- On your own behalf?

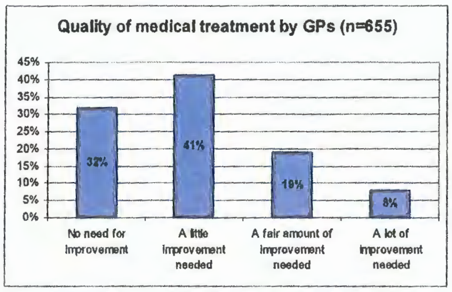


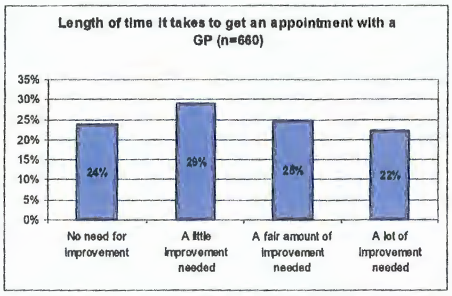
What is the name of the organisation you are sending your response on behalf of?
Action Mental Health
Autism NI (PAPA)
Bradleys Pharmacy
Castleview Private Nursing Home, Carrickfergus
Community Organisations of South Tyrone & Areas Ltd (COSTA)
Contact a Family
Dundela Pharmacy Ltd
FAITH HOUSE
Fermanagh Cardiac Support Group
Fold Housing Association
Foyle Parents and Friends Association
Home-Start Craigavon
Home-Start East Belfast
Home-Start In Northern Ireland
Kennedy's Pharmacy (Rasharkin and Dunloy)
Maria Mallaband Care Group Ltd
Mencap in Northern Ireland
MindWise New Vision for Mental Health
Newry & Mourne Carers Limited
Orchard House Private Nursing Home
Phoenix Healthcare
Shalom Care
Strandburn Pharmacy
The Dry Arch Children's Centre
The Stroke Association Northern Ireland
Wilson Group (Nursing Homes)

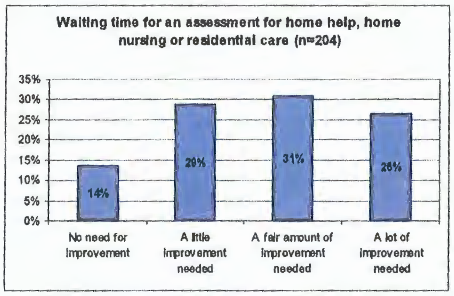
Have you or your family used any of these health and social care services in the last year?

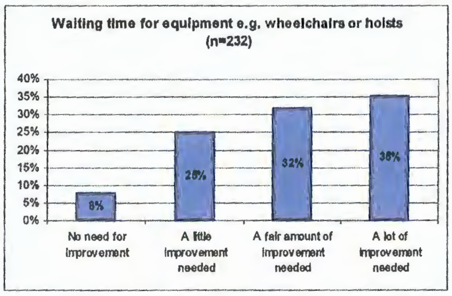


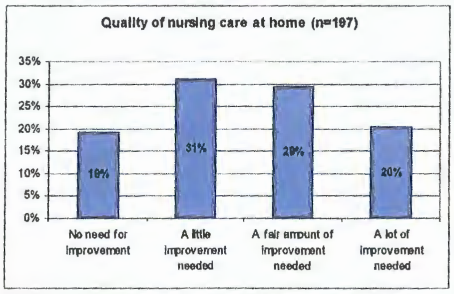
How would you rate the following aspects of Health and Social Care in Northern Ireland in terms of whether they require improvement or not?:

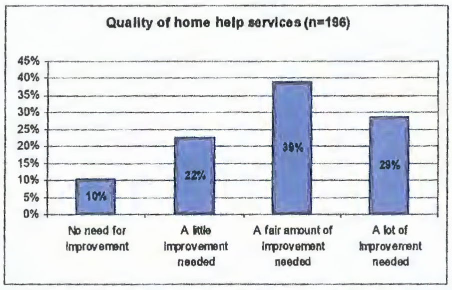

Quality of medical treatment by GPs (n=655)

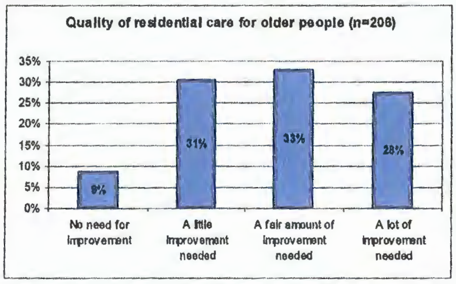

Length of time it takes to get an appointment with a GP (n=660)

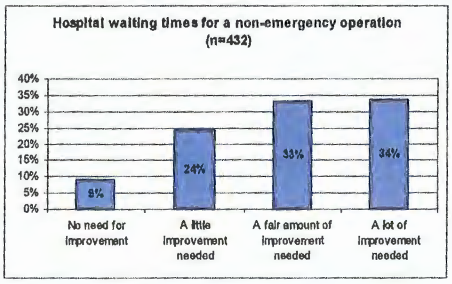

Waiting time for an assessment for home help, home nursing or residential care (n=204)

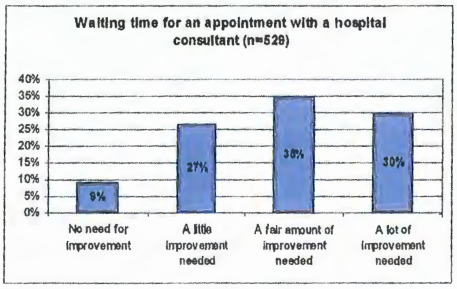

Waiting time for equipment e.g. wheelchairs or hoists (n=232)

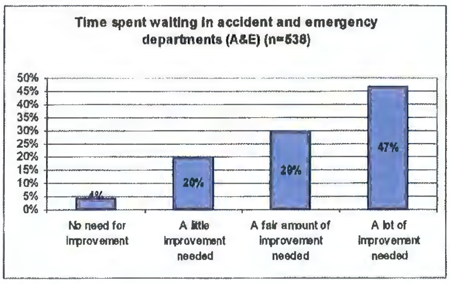

Quality of nursing care at home (n=197)


Quality of home help services (n=196)

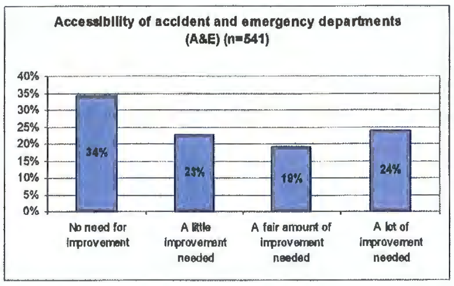

Quality of residential care for older people (n=206)


Hospital waiting times for a non-emergency operation (n=432)

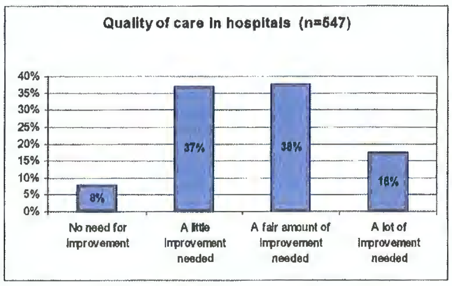

Waiting time for an appointment with a hospital consultant (n=528)



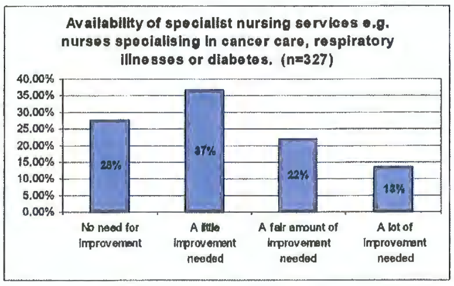
Time spent waiting in accident and emergency departments (A&E) (n=538)



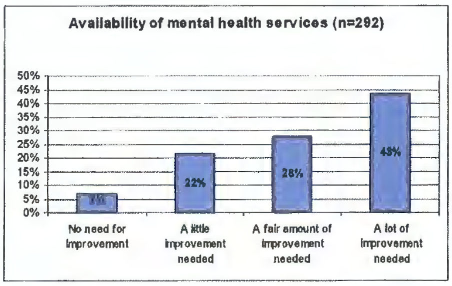
Accessibility of accident and emergency departments (A&E) (n=541)



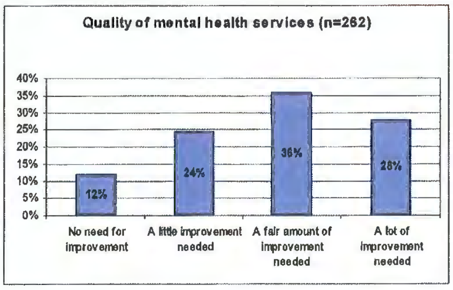
Quality of care in hospitals (n=547)



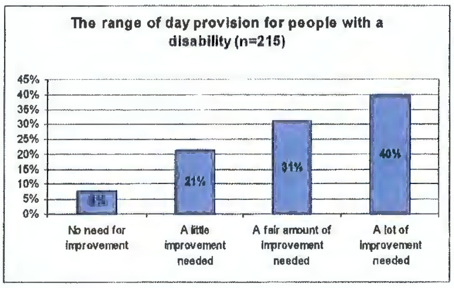
Availability of specialist nursing services e.g. nurses specialising in cancer care, respiratory illnesses or diabetes. (n=327)



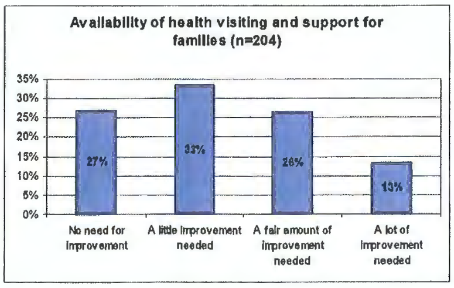
Availability of mental health services (n=292)



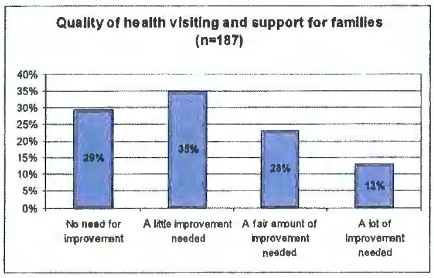
Quality of mental health services (n=262)



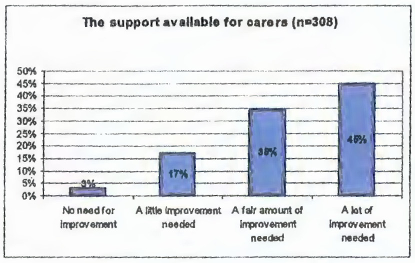
The range of day provision for people with a disability (n=215)

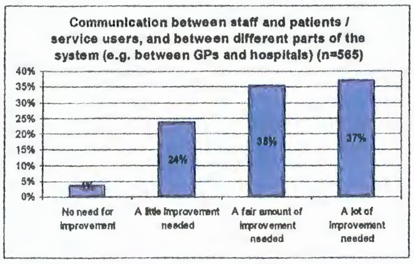


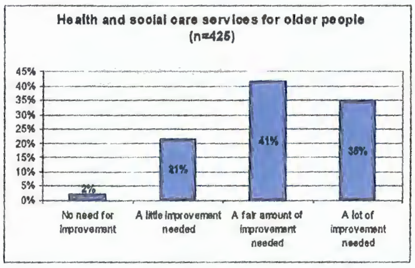
Availability of health visiting and support for families (n=204)

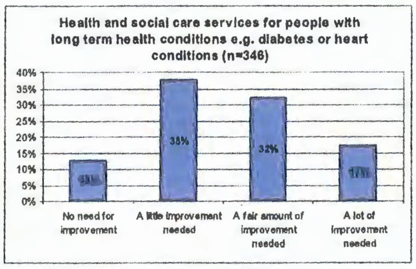


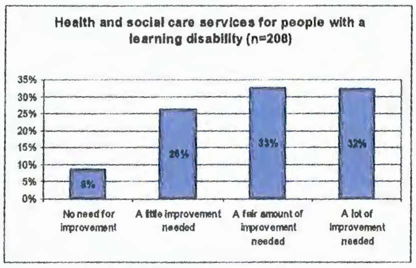
Quality of health visiting and support for families (n=187)

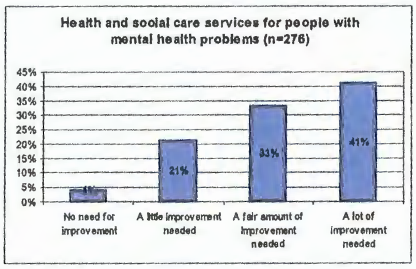

The support available for carers (n=308)

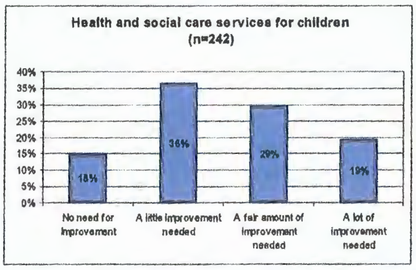

Communication between staff and patients / service users, and between different parts of the system (e.g. between GPs and hospitals) (n=565)

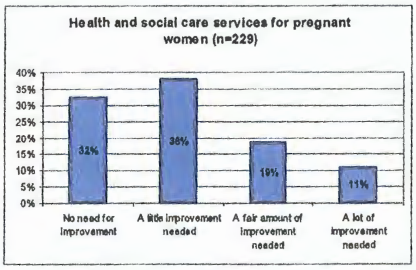

Health and social care services for older people (n=425)

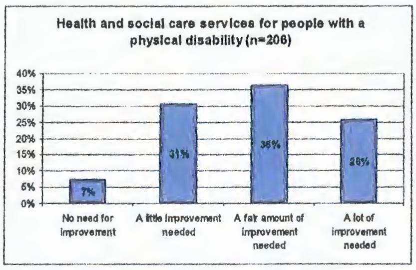

Health and social care services for people with long term health conditions e.g. diabetes or heart conditions (n=346)

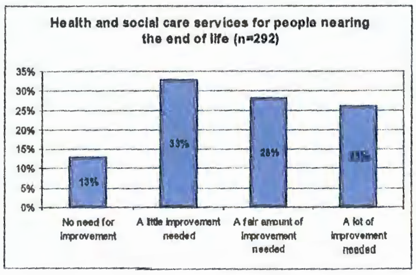

Health and social care services for people with a learning disability (n=208)


Health and social care services for people with mental health problems (n=276)


Health and social care services for children (n=242)


Health and social care services for pregnant women (n=229)


Health and social care services for people with a physical disability (n=206)


Health and social care services for people nearing the end of life (n=292)

Suggestions for Improvement

Quality of Medical Treatment by GPs

- Promote use of IT / access of information from other systems / electronic records for better decision making
- Improve communication across primary and secondary care / GP to GP / with patients & families
- Increase accessibility (extend opening hours) - evening and weekend clinics
- Training - skilling up especially in relation to Mental Health & Learning Disability, depression; keep skills up to date
- Improve interpersonal / customer care skills – especially listening skills, empathy
- More time for each appointment
- Continuity of GP
- More GPs
- Provide advice service - Use of other systems to provide advice e.g. telephone system, emails
- Use of Nurse to triage

Length of Time to get an appointment with a GP

- Increase accessibility (extend opening hours) - evening and weekend clinics
- Walk in Clinics (no appointments required)
- More GPs (and more Female GPs)
- Penalties for patients who ‘Did Not Attend’ (DNA) – use of reminder system
- Use of Community Pharmacist for minor ailments (German / Austrian Model)
- Provide help lines (may reduce demand for appointments)
- Increase role of the Practice Nurse / Triage Nurse / Triage service
- Improved system for making appointments (EMIS / online systems)
- Train receptionists re customer care skills
- Better sharing of information

Waiting time for assessment of home help home nursing or residential care

- Increase staff / resources / fill vacant posts
- More efficient use of resources
- Better process for assessment and implementation of services
- More funding
- Review ‘need’ – this may change / decrease
- Less bureaucracy
- Person centred / holistic approach

Department of
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QUALITY 2020

A 10-YEAR STRATEGY TO PROTECT AND IMPROVE QUALITY IN HEALTH AND SOCIAL CARE IN NORTHERN IRELAND

November 2011

Minister's Foreword

As Minister of Health, Social Services and Public Safety, the guiding principle for me, and I know for the vast majority of people working in health and social care, is to protect and improve the quality of our services. The strategy set out in this document is designed to provide a clear direction over the next 10 years to enable us to plan for the future while ensuring this principle is preserved, whatever the challenges we may encounter.

Clearly we face challenges in the immediate future on the financial front, but there are many other factors that we must also grapple with in the longer term which require that we plan now so as to be able to best address those challenges and maintain high quality services.

The people using Health and Social Care (HSC) services must be at the heart of everything we do. We will be measured by how we focus on their needs through delivering high quality as they deal with pain and distress. This means the services we provide must be safe, effective and focused on the patient.

HSC services in Northern Ireland are already internationally recognised for excellence in a number of areas, and these services are provided by thousands of staff who apply great skill with compassion to ensure the best possible outcomes and experiences of care for their patients and clients. Their continuing determination to deliver high quality care, whatever the constraints, is fundamental to achieving the right outcomes.

This strategy, therefore, has the great advantage of building on an already strong foundation. It gives a clear commitment to sustainable improvement and high standards, safe services and putting people first.

Edwin Poots, MLA
Minister of Health, Social Services and Public Safety

A VISION FOR QUALITY

Quality

Every day hundreds of thousands of people, old and young, are treated and cared for by highly skilled and dedicated professionals in our health and social care services. Some in their homes, some in hospitals, some in community settings, some because they are ill, some because they need care and support, some who need protection. Most of these people are in distress or pain. Some need urgent treatment. Some have to live with chronic conditions over many years. All of them deserve and seek one thing above all: to know that the service provided is of high quality.

But what is "*quality*", a word so often used but so little understood? The dictionary definition is "*degrees of excellence*". We know that quality can be high, low or somewhere in between. We also know that to make quality high normally requires a range of things to be present. Usually no one factor can define it. Whether it is holidays (facilities, food, comfort, service, etc) or cars (economy, power, safety, reliability, etc), the excellence is derived from how that product or service performs across a range of factors.

So how should we define quality for health and social care in Northern Ireland? One of the most widely influential definitions in healthcare was produced in the United States by the Institute of Medicine in 2001. It proposed six areas in which excellent results would lead to high quality or excellence overall: safety, timeliness, effectiveness, efficiency, equity, and patient-centredness.

"No one wants luxury; people just want to be safe and given the proper care." - a carer

The European Union describes high quality healthcare as care that is "*effective, safe and responds to the needs and preferences of patients*." Many other countries, including England, Scotland, Australia and the Republic of Ireland, have likewise focused on three key components, although not to the total exclusion of the others in the list of six above. Many countries have chosen to subsume those elements of timeliness, efficiency and equity under the heading of effectiveness. For Northern Ireland this 10-year quality strategy takes a similar approach defining quality under three main headings:

- **Safety** – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

- **Effectiveness** – the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome.

- **Patient and Client Focus** – all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Everyone expects the best care possible when they or a family member falls ill or needs social care support. In Northern Ireland this is provided by health and social care services, for the most part free at the point of use, and funded by the taxpayer at a cost of around £4 billion a year. It is different in one important aspect from the National Health Service (NHS) in Great Britain in that it provides integrated health and social care services.

It is a highly complex, sophisticated and increasingly technological service involving a wide diversity of some 70,000 people working together in multidisciplinary teams, providing services day and night, in all weathers, often dealing simultaneously with conditions that are very common as well as those that are very rare. They work in a compassionate and professional manner through more than 15 million engagements each year (hospital admissions, in-patient appointments, consultations, etc) with patients, clients, families and carers at times when they are suffering and vulnerable.

For all these people it is a fundamental expectation that the service provided will be as **safe** as possible. The fact is of course that in such a highly complex and stressful environment things will go wrong. The reasons are many and varied. Thankfully it is only in a tiny proportion of cases that things do go wrong. But a high quality healthcare service needs to protect and improve by learning from all such occasions and so minimising the chances of them happening again. There can never be room for complacency. Safety will always be an aspect of quality that needs to be guarded.

Equally, a high quality service should mean that the services provided are the right ones at the right time in the right place. In other words they are **effective** in dealing with the patient or client's clinical and social needs. Too often there is evidence that wasteful procedures or inefficient systems are being employed and internationally recognised best practice is not used where it can be.

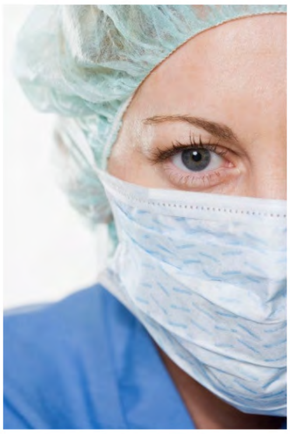
Thirdly, and just as importantly, services must have a clear **patient and client focus**. People are not just an element in a production process. There is abundant evidence that such an approach delivers improved health and wellbeing outcomes. There is also more than enough evidence, particularly in recent reports within the UK alone (and internationally), that when the dignity of the person is not respected, or people are not effectively involved in decision making about their health and wellbeing, or indeed listened to when they complain or raise concerns, quality suffers and declines.

Undoubtedly the amount of money available for health and social care services affects the quality of care, but other factors such as behaviours, attitudes and the way services are designed, are also very relevant. There is much evidence to show that money is not the only determinant of high quality. When some say "*we cannot afford higher quality at this time*" they overlook the fact that low quality, so often the result of inappropriate behaviours and attitudes, costs more.

Over the last decade, health and social care services in Northern Ireland have taken important steps forward in improving quality. The consultation paper *Best Practice – Best Care* (April 2001) made proposals for setting standards, ensuring local accountability and improved monitoring and regulation. New legislation in 2003 introduced a statutory Duty of Quality for Boards and Trusts. This also led to the establishment of the Regulation and Quality Improvement Authority (RQIA) as an independent body, one of whose main functions is to promote improvement in the quality of health and social care services. *Safety First* (March 2006) produced a framework for sustainable improvement.

In 2009 the HSC Reform Act introduced a new statutory Duty of Involvement for all the main HSC bodies. This required them to involve people at a personal and public level in making decisions about service design and delivery. Together these initiatives have made a positive impact on safety, effectiveness and patient/client focus. The object of this strategy is to build on that foundation so as to widen and deepen the impact over the next decade in terms of protecting and improving quality in health and social care.

As we face the next 10 years, with all its challenges and uncertainties – not least funding – this is when we most need a strategy to protect and improve quality across all health and social care.



Purpose of a quality strategy

How will a new quality strategy help to protect and improve quality and achieve excellence in the three areas described above? Fundamentally a strategy is simply a plan to achieve a result over the long term. In this case a period of 10 years has been selected to deliver results for quality because much of what needs to be done simply cannot be achieved overnight but will take time, regardless of money. The strategy is intended to provide a clear direction for all of us, taking account of the strengths and weaknesses of the present system, so that we can better tackle the future challenges and opportunities faced.

It will provide a vision of what we can achieve, a mission statement of how to get there, and specific goals and objectives to make that vision become a reality over the 10 years. It will give us the long-term perspective needed to plan and design future services and deliver outcomes to the highest quality possible.

There are already many examples, often recognised internationally, of high quality or excellence within health and social care in Northern Ireland. Such examples, based on recent evidence, include the focus on early years and early interventions, the treatment of cancer and head injuries, neurosurgery, innovative mental health facilities, the new health and care centres with their one-stop approach to treatment and care, and many others. But even more importantly, there are also thousands of individual staff who apply great skill with compassion, giving patients and clients the best possible outcome and experience of care at times of personal crisis. They show an unshakeable determination to deliver high quality care, whatever the constraints.

Consequently, this strategy has the great advantage of building on an already very strong foundation, while still recognising that no system is beyond improvement. There is a clear imperative to remain committed to continuous improvement, to maintain high standards and to achieve even higher degrees of excellence – in other words, to protect and improve quality.

How the strategy was developed

This strategy was devised by a project team convened by the Department. Over 100 people, some employed in health and social care and some users of these services, came together at four workshops to discuss priorities for safety, effectiveness and patient/client focus. The outputs from each workshop were referred to an international reference group made up of 18 highly respected professionals and academics for quality assurance. The essence of what was discussed at the workshops was also brought by the Patient and Client Council (PCC) to a wider public cross-section of almost 100 people in the community for comment, and focus group meetings were held with over 150 frontline staff working in health and social care at 10 venues around Northern Ireland. In all, some 350 people, from many different backgrounds, have contributed significantly to the development of this quality strategy (quotations from some of them are included in this document).

"We are already world leaders in some areas but in Northern Ireland we never talk enough about our successes." – a community nurse

The strategy was then published for public consultation in January 2011 and attracted 46 responses from a wide range of health and social care, voluntary and charitable organisations, as well as individuals. There was very broad support for the strategy and many helpful comments and suggested amendments, many of which have since been incorporated in this final version of the strategy. This consultation process, building on the highly inclusive development process, has further strengthened the integrity, purpose and focus of the strategy, reinforcing the underlying support for its implementation. It has also fundamentally confirmed that protecting and improving quality really is the first priority for all those concerned with achieving the best health and wellbeing outcomes.

Principles, values and assumptions

The strategy identifies a number of **design principles** that should continue to inform planners and practitioners over the next 10 years. A high quality service should:

- be holistic in nature.

- focus on the needs of individuals, families and communities.
- be accessible, responsive, integrated, flexible and innovative.
- surmount real and perceived boundaries.
- promote wellbeing and disease prevention and safeguard the vulnerable.
- operate to high standards of safety, professionalism and accountability.
- be informed by the active involvement of individuals, families and communities, HSC staff and voluntary and community sectors.
- deliver value for money ensuring that all services are affordable, efficient and cost-effective.

In delivering high quality health and social care this strategy also identifies the need to promote the following **values**:

- **Empowerment** - supporting people to take greater responsibility for their own health and social wellbeing, and putting people at the centre of service provision.
- **Involvement** - ensuring that service users, their carers, service providers and the wider public are meaningfully involved, and if necessary supported, at all stages in the design, delivery and review of services at an operational and a strategic level so that, as far as possible, services are personalised.
- **Respect** – showing respect for the dignity of all people who use the service, their carers and families and for all staff and practitioners involved in service delivery.
- **Partnership** - engaging collaboratively across all disciplines, sectors and specialisms in health and social care, including the voluntary and independent sectors, to ensure an integrated team-based approach, and working with people in their local communities.
- **Learning** - promoting excellence in service delivery and founded on evidence-based best practice to achieve improvement and redress.
- **Community** - anchoring health and social care in a community context.
- **Continuity** - ensuring a co-ordinated and integrated approach to health and social care in all health and social care sectors, and ensuring continuity of care across the system.

- **Equity and Equality** - fairness and consistency in service development and delivery.

While it is impossible to predict exactly what will happen over the next 10 years, the strategy also identifies eight strategic **planning assumptions** (which will be adjusted as circumstances change). These are:

- **Political** - health, social services and public safety will continue to remain the responsibility of a devolved Administration.
- **Structural** - the present Departmental and HSC organisational structures will remain broadly unchanged but delivery structures will continue to evolve.
- **Economic** – very significant resource constraints and challenges will continue to impact on services requiring a robust focus on efficiency and effectiveness of service design.
- **Social** - an ageing society will have greater need for health and social care; general demands and expectations on quality including involvement will continue to rise; there will be an increased focus on safeguarding vulnerable people and groups; there will be continued challenges in addressing the impact of obesity, deprivation, drugs and alcohol.

- **Technology** - the effective use of information and technology in health and social care will increase in importance.
- **Rights** - the need to promote and protect human rights and equality will increase in a diverse society.
- **Environment** - the pressure to minimise waste of all kinds and maximise the use of sustainable resources will increase.
- **Service Delivery** - there will continue to be advances and changes in the science underpinning treatment and care, as well as emphasis on prevention and self-managed care and a continued move towards caring for people in their own homes.

A strategic Vision for quality

Ultimately every patient and client, and their families and carers, wants to receive the best care at the time they most need it to achieve the best outcome possible. In order for this to be a reality for all the people of Northern Ireland, the 10-year quality vision for health and social care is:

"To be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care."

This is a bold statement and will require continuous improvement, concerted effort, commitment and determination if it is to be achieved by 2020. It must be acknowledged that many aspects of current services and many of the people working in health and social care are already world-class and worthy of celebration. So the strategy starts from a strong position. But high quality cannot be assumed to remain constant against the challenges that inevitably lie ahead. There is always room for learning, innovation and improvement.

This vision statement is intended to inspire and motivate all of us and give a shared sense of purpose and direction. As Abraham Lincoln said "*Far better to aim high and just miss the target, than aim low and just reach it.*"

"We need to identify who is best at providing high quality and see what they are doing. It is not good enough to settle for second place; we must aspire to be the best." - a GP

Mission statement

In terms of <u>how</u> the vision is to be achieved, the strategy mission statement is:

"In order to become an international leader for excellence in health and social care, the inherent motivation of staff to deliver high quality must be supported by strong leadership and direction at all levels, along with adequate resources, in order to:

- ***focus on improved health and social wellbeing for all;***
- ***provide the right services, in the right place, at the right time;***
- ***develop effective partnerships and communication between those who receive and those who provide services;***
- ***create a culture of learning and continuous improvement that is innovative and reinforced by both empirical and applied research;***
- ***devise better ways of measuring the quality of services; and***
- ***protect and enhance trust and confidence in the service provided."***

Succeeding in this mission will depend crucially on good leadership and partnership working. Excellence is something that should be obvious not only to professionals working within health and social care but to individual patients and clients and their families. There will be a need to embrace change positively and find innovative ways of dealing with problems with highly motivated, skilled and engaged staff and volunteers.

STRATEGIC GOALS AND OBJECTIVES

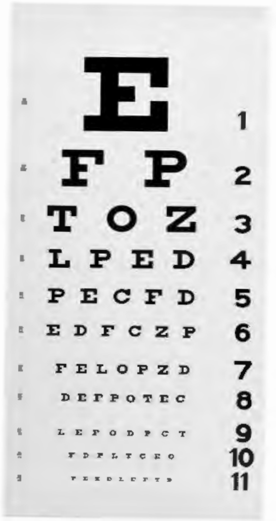
Setting strategic goals

The mission statement summarises how we can realise the vision of being an international leader in the excellence of health and social care. But it is the specific actions taken during the life of this 10-year strategy that will drive that positive change. To that end the strategy identifies five strategic goals to be achieved by 2020. Achieving them will help make the vision a reality.

1. **Transforming the Culture** - This means creating a new and dynamic culture that is even more willing to embrace change, innovation and new thinking that can contribute to a safer and more effective service. It will require strong leadership, widespread involvement and partnership-working by everyone.

2. **Strengthening the Workforce** - Without doubt the people who work in health and social care (including volunteers and carers) are its greatest asset. It is vital therefore that every effort is made to equip them with the skills and knowledge they will require, building on existing and emerging HR strategies, to deliver the highest quality.

3. **Measuring the Improvement** - The delivery of continuous improvement lies at the heart of any system that aspires to excellence, particularly in the rapidly changing world of health and social care. In order to confirm that improvement is taking place we will need more reliable and accurate means to measure, value and report on quality improvement and outcomes.



4. **Raising the Standards** - The service requires a coherent framework of robust and meaningful standards against which performance can be assessed. These already exist in some parts, but much more needs to be done, particularly involving service users, carers and families in the development, monitoring and reviewing of standards.

5. **Integrating the Care** - Northern Ireland offers excellent opportunities to provide fully integrated services because of the organisational structure that combines health and social care and the relatively small population that it serves. However, integrated care should cross all sectoral and professional boundaries to benefit patients, clients and families.

These five goals are developed in more detail below. Pairs of objectives for each goal are described in terms of why they are important, the actions to be taken, who might take the lead in each case, and, crucially, what will be the expected outcomes. Fundamentally, this sets out the difference this strategy can make for the future quality of health and social care.

TRANSFORMING THE CULTURE

Objective 1: We will make achieving high quality the top priority at all levels in health and social care.

Why is it important?

An emphasis on high quality will improve the experience of all those who use and work in health and social care services. It will also make those services safer for all.

What will be done?

- The delivery of high quality services will be central to the commissioning process.
- A consistent regional definition of what constitutes high quality in every service will be established and accountability for its delivery made part of governance arrangements.
- The use of best practice and improvement methods will be promoted and adopted across the health and social care system.
- Staff and service users' awareness of their individual roles and responsibilities in ensuring high quality outcomes for health and social care will be maximised.
- A culture of innovation and learning that creates more quality-focused attitudes and behaviours among HSC staff will be promoted.

> *"Often it's the little things that make a big difference to people's lives and make our own job worthwhile."* – a social worker

How will we know it is working?

- The number of adverse incidents and near misses reported will increase steadily reflecting a stronger reporting and learning culture – serious adverse incidents will decline in number.
- Increased evidence of more effective complaints resolution and learning.
- Improved levels of satisfaction by both staff and the public.
- Quality, embracing safety, effectiveness and patient/client experience, will be a standing top item on the agenda of all boards and top management teams within the health and social care system.
- Waste caused by inappropriate variations in treatment or care will reduce.

Objective 2: We will promote and encourage partnerships between staff, patients, clients and carers to support decision making.

Why is it important?

There is already a body of evidence from around the world that involving patients and clients in decisions about their care and treatment improves the outcome and their satisfaction with the services they receive and at the same time reduces demands on services. Workshops conducted in the preparation of this strategy also confirmed that this is an important issue for a wide range of service users.

What will be done?

- Best practice standards will be established for informing patients, clients and carers based on what has been successful elsewhere.
- Regular patient and client surveys as well as other creative approaches to getting feedback, such as ‘patient/client narratives’ will be conducted in collaboration with the PCC.
- Effective and meaningful partnerships to support shared decision-making for HSC staff, patients, clients and carers will be created, including the voluntary and independent sectors.
- Patients, clients and carers will be involved in the design and delivery of education and training to all staff working in health and social care.
- The needs and values of individuals and their families will always be taken into account.

How will we know it is working?

- There will be clear evidence of user involvement arising from effective implementation of Public and Personal Involvement (PPI) Consultation Schemes at all levels of decision making in health and social care from individual care to corporate management.
- There will be baseline information and regular monitoring on how involvement changes over time.
- Evidence on compliance by HSC bodies with all relevant equality and involvement standards.

STRENGTHENING THE WORKFORCE

Objective 3: We will provide the right education, training and support to deliver high quality service.

Why is it important?

No matter how good our systems and procedures are, they all rely on staff who are motivated, skilled and trained to implement them. This is fundamental to the delivery of safe and effective services. Increasingly these systems and procedures must include personal and public involvement in their design and operation.

What will be done?

- Opportunities for continuous learning by staff will be resourced and planned in order to continuously improve quality.
- Increased knowledge and skills in the principles of PPI will be promoted among all HSC staff.
- Arrangements will be made to involve service users and carers more effectively in the training and development of staff.
- A customised Healthcare Quality training package for all staff working in health and social care (with mandatory levels of attainment dependent on job responsibilities) will be developed, with possible links to regulation and dovetailed with existing and emerging training and development strategies across HSC.

"We need constantly to look for simpler and faster ways of disseminating learning to staff who need to know, to improve quality." - a hospital doctor

- Better use will be made of multidisciplinary team working and shared opportunities for learning and development in the HSC.
- Regular feedback from staff and service users and carers will be sought alongside commissioned research on quality improvement.

How will we know it is working?

- HSC service organisations will be recognised as employers of choice.
- Evidence for improved outcomes for patients and clients will be published.
- Increasing levels of competence among HSC professionals will be evidenced through professional revalidation and appraisal.
- There will be evidence from research of reducing errors in service delivery arising from "human factors".

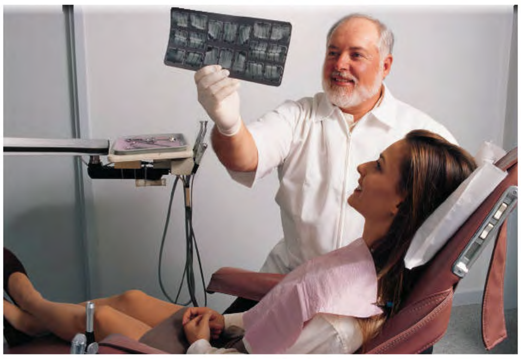
Objective 4: We will develop leadership skills at all levels and empower staff to take decisions and make changes.

Why is it important?

Strong leadership is the key to effecting change and we believe that giving frontline staff autonomy to take more decisions locally, provided this is balanced with clear accountability, is the best way to secure improved quality and productivity.

What will be done?

- Top management teams will be expressly accountable for quality improvement within their organisations.
- Each HSC organisation will produce an annual quality report and be responsible for making improvements year-on-year.
- Staff will be actively supported through service change programmes.
- Change champions will be trained and supported in the latest improvement techniques.
- A renewed emphasis will be placed on generating robust and relevant research to support innovation and quality improvement, building on links with local research organisations.



How will we know it is working?

- Evidence of increased authority being delegated to frontline decision makers wherever practical.
- Evidence of health and social care staff at all levels driving quality improvements.
- Every organisation or team will be involved in making their work safer, more effective and patient/client centred.

MEASURING THE IMPROVEMENT

Objective 5: We will improve outcome measurement and report on progress for safety effectiveness and the patient/client experience.

Why is it important?

Safety, effective treatment and a good experience of the care received, whether in hospital or the community, and whether provided by the public, voluntary or independent sectors, lies at the heart of a high quality service. We need to compile good baseline data and be able to measure that this is happening and let everyone have this information in as accessible a way as possible.

What will be done?

The HSC Board, Public Health Agency and Trusts will work with the RQIA, PCC and others to:

- Devise a set of outcome measures, with quality indicators, focused on safety, effectiveness and patient/client experience.
- Agree a set of effective quality performance targets, involving service users to drive improvement.
- Monitor quality improvement year-on-year and compare our performance with the rest of the UK, the Republic of Ireland and internationally.
- Publish a regional annual quality report that is widely available.

> *"We expect healthcare leaders and healthcare professionals to be intolerant of defects or errors in care and constantly seeking to improve, regardless of their current levels of safety and reliability."* - a doctor

How will we know it is working?

- There will be a set of effective and measurable quality targets agreed within the first year of the strategy implementation.
- All HSC organisations will meet quality performance targets.
- There will be evidence of steady improvement in the public's reported experience of health and social care.

Objective 6: We will promote the use of accredited improvement techniques and ensure that there is sufficient capacity and capability within the HSC to use them effectively.

Why is it important?

Within the large and complex health and social care system there is always scope for improvement. To achieve best outcomes it is important to review what happens and look for improvements with the aid of skilfully applied accredited techniques.

What will be done?

- A set of improvement methods and techniques for use in the HSC will be agreed and HSC staff will be trained and resourced to use them.
- Capacity and capability will be built up within the HSC to achieve the desired results.
- Audit techniques to measure how standards are being met will be further developed.
- Research and innovation will be encouraged.
- Benchmarking with other health and social care organisations outside Northern Ireland will be conducted to ensure that there is up-to-date information available on best practice.

How will we know it is working?*

- The number of avoidable deaths will decrease steadily.
- The number of healthcare associated infections will be reduced year-on-year.
- All HSC facilities will meet established standards for cleanliness.
- There will be 95% or higher satisfaction ratings from the public with the safety of care in the HSC.
- There will be 95% or higher satisfaction ratings from staff with the safety of care in the HSC.

(* These indicators will be further refined and developed during the implementation planning process.)

RAISING THE STANDARDS

Objective 7: We will establish a framework of clear evidence-based standards and best practice guidance.

Why is it important?

It is essential that we work to agreed standards that represent best practice and are clearly understood by staff, users and relatives alike. Standards should be authoritative and concise and help achieve high quality in the most cost effective way.

What will be done?

- Information on national and international standards will be gathered and standards developed, where necessary, to deliver best practice.
- A coherent regional framework for standards and guidelines will be established.
- A Web-based system will be established to allow easy access to the framework of standards and related information.

> *"Even though there is always change I think it is important that we ensure we are not seen to be stagnant, but an evolving organisation, always striving for the best."* – a public health consultant

How will we know it is working?

- Standards will be evidence-based and effectively applied.
- Standards will be kept up-to-date and easily accessible to all.
- The meeting of standards will demonstrate measurable improvements in the quality of services, becoming safer, more effective and more patient/client-centred.

Objective 8: We will establish dynamic partnerships between service users, commissioners and providers to develop, monitor and review standards.

Why is it important?

Increasingly standards should span both health and social care sectors and be developed by partnerships that include all those involved in providing and receiving a service. They should also be monitored periodically and reviewed if they are to continue to be fit for the purpose they were designed.

What will be done?

- An advisory group, representative of HSC organisations and including service user and carer representation, will be set up to harmonise processes in relation to the application of standards.
- A new structure will be created for drafting and agreeing standards and guidelines that gives meaningful inclusion to those affected by them.
- A performance management mechanism will be put in place to ensure standards are achieved by means of audit and compliance measurement within set timescales.

- An incentives mechanism will be created to better ensure compliance with quality standards in all health and social care settings.
- The use of Service Frameworks will be extended.
- Surveys of the public will be conducted to seek feedback on compliance with standards.

How will we know it is working?

- Quality targets published in Priorities for Action will be met.
- All parts of health and social care will be able to demonstrate compliance with the standards.
- Information on standards, and associated compliance information, will be easily accessible on-line.
- New standards will only be introduced after full and effective consultation.

INTEGRATING THE CARE

Objective 9: We will develop integrated pathways of care for individuals.

Why is it important?

Northern Ireland already has an integrated health and social care system, but in order to be truly effective there should be seamless movement across all professional boundaries and sectors of care. This has implications for the timely transfer of information and how data is held. Improvements in this area will make a significant contribution to raising the quality of care and outcomes experienced by patients, clients and their families.

What will be done?

- More effective and secure information systems will be established to record and share information across HSC structural and professional boundaries (and with other relevant Departments and agencies as appropriate).
- Service users will be given a greater role in, and responsibility for, information transfer (e.g. patient held records, patient smart cards, etc).
- Barriers to integrated multidisciplinary and multisectoral working will be identified and removed.
- Annual targets for use of personal care plans will be established.

> *"The first premise, indeed the whole point of a health service, is to deliver what its customer needs. In other words – put the patient first."*
> – a service user

How will we know it is working?

- Patients, clients, carers and HSC staff will collaborate in developing individual care pathways.
- Patients and clients will be able to move between different sectors and specialties within health and social care without undue delay or the transfer resulting in avoidable information errors or resultant harm.
- Patient and client information will be available to staff and carers when it is required.
- There will be evidence of consistent quality of care experienced by patients and clients across all settings.

Objective 10: We will make better use of multidisciplinary team working and shared opportunities for learning and development in the HSC and with external partners.

Why is it important?

It is increasingly recognised that the effectiveness of treatment and care given to patients and clients is enhanced by a holistic approach that encourages co-operation between all those involved at every stage. Failure to address this can produce an "us" and "them" mentality, which has the potential to be detrimental to outcomes and wasteful of resources.

What will be done?

- All disciplines should contribute to a single assessment through a shared assessment framework – NI Single Assessment Tool, and for children, Understanding the Needs of Children in Northern Ireland (UNOCINI).

- More integrated treatment and care teams will be established with innovative management approaches.

- Universities will further develop inter-professional education at undergraduate and postgraduate levels in health and social care.

- Pre-registration and post-registration training will be reviewed to enhance the use of multidisciplinary teams.

How will we know it is working?

- There will be a significantly more effective skills mix on teams.

- There will be increasing evidence of joint working across professional disciplines to improve quality.

- In-house organisational training will give primacy to multidisciplinary learning.

MAKING IT HAPPEN

Managing, advising and reporting

Implementing any new strategy requires good governance arrangements and structures to deliver results at every stage of the process. This is especially true of any strategy that covers a period as long as 10 years.

There are three important elements to implementing this strategy.

The first is **management**. A programme board, chaired by the Chief Medical Officer, will be responsible for overall control and will report on progress on the implementation of the strategy to the Minister. The board will include senior Departmental policy and professional representatives, senior executives from health and social care organisations, including the voluntary and independent sectors, and people who use health and social care services. Many others will be involved in working on individual projects reporting to the programme board in order to meet the objectives set out under each of the five goals. A senior official within the Department will be responsible for co-ordinating and overseeing the work of these project teams and will report to the programme board.

"We need to involve patients and their carers in both the design and implementation of the quality strategy." - a patients' representative

The second is **advice**. A Quality Advisory Forum will meet twice a year and include a wide range of "stakeholders", e.g. patients, clients, carers, trade unionists, relevant professional bodies, academics and HSC frontline staff (not senior executives) and representatives from the voluntary and independent sectors. The Forum will facilitate comment on regular six-monthly reports provided by the programme board and comment on progress against the objectives set. It will be able to suggest changes, voice concerns to the programme board and thus provide transparent accountability. This will help to reinforce the consensual and inclusive approach that has characterised the development of the strategy.

The third is **reporting**. It is proposed that each health and social care organisation will publish a freestanding Quality Report every year. These reports will state clearly the progress made in each organisation towards meeting the goals of the strategy and also comment on the improvement made to the quality of services commissioned, delivered or promoted within the previous 12 months by that organisation. The reports will make use of new "quality indicators" to be developed by the quality programme. The purpose of this report is to increase accountability against the Duty of Quality that health and social care organisations are required by law to meet. Furthermore, quality should be given the top position on the agenda for meetings of all senior management teams and boards within these organisations.

Engagement and Involvement

The relationship and exchange of information between the Department and health and social care organisations and the wider public will be important in driving this strategy forward. A new Quality Interface Group will be established with representation from all HSC bodies, and patient/client representation, to consider all proposals for new best-practice guidance, guidance under development and the dissemination and evaluation of guidance on all quality issues concerning safety, effectiveness and patient/client focus.

The Department will set up and manage a dedicated Quality Website to provide access to all relevant policy documents and guidance circulars. While this will be provided primarily for health and social care services, it would be available to everyone and the Department would take active steps to bring such guidance to the notice of a wide range of interests, including patient, client and carers' groups and the independent sector. The object would be to make information easily accessible and include links to related websites nationally and internationally.

The Implementation process

This strategy provides a clear vision of **where** we want to get to over the next 10 years in terms of quality healthcare; a high-level mission statement of **how** we plan to get there; and, most importantly, **what** we need to achieve in concrete terms to deliver that vision - the strategic goals.

Achieving those goals will require a detailed, rigorous and inclusive implementation planning process which is to be carried out over the next six months. We have established an implementation planning team drawing on a diverse range of interests including service users, commissioners, providers and led by a senior official in the Department. That team will finalise an implementation plan and submit it for Ministerial approval by February 2012 to enable the detailed work to follow that will secure those strategic goals, and thus our strategic vision.

It will obviously be necessary to keep the strategy under review so that it remains fit for purpose, not least because the nature and scale of challenges to be faced in the future are always subject to change. If we are not ready to adjust our plans to deal with changing circumstances, then we are likely to be blown off course and fail to realise our objectives.

It will also be essential that the people served by health and social care services, and those who work in the system, are kept fully informed of progress being made. Annual reports on progress in protecting and improving quality in health and social care will be widely accessible.

CONCLUSION

The 10-year Quality Strategy

This strategy is designed to protect and improve quality in health and social care over the next 10 years. During this period, services will undoubtedly face many great challenges. Some of those are already clear, such as funding for health and social care services, but some will only become clear as time passes.

In any event, there is a clear need to be prepared and ready to tackle those challenges strategically and effectively if the quality of services, so important to peoples' lives and wellbeing, are to be protected and improved. This is especially so because health and social care services are large and complex and can take time to change in ways that are safe and effective.

> *"The quality of services is inextricably linked to raising awareness and earning commitment."* - a hospital doctor

This strategy will aid our preparedness and readiness and provide an enduring framework within which policy and service design can better develop.

The Department will give leadership in its implementation. But leadership will also be required in all parts, and at all levels, of the Health and Social Care service, as well as through partnership with patients, clients, carers and communities.

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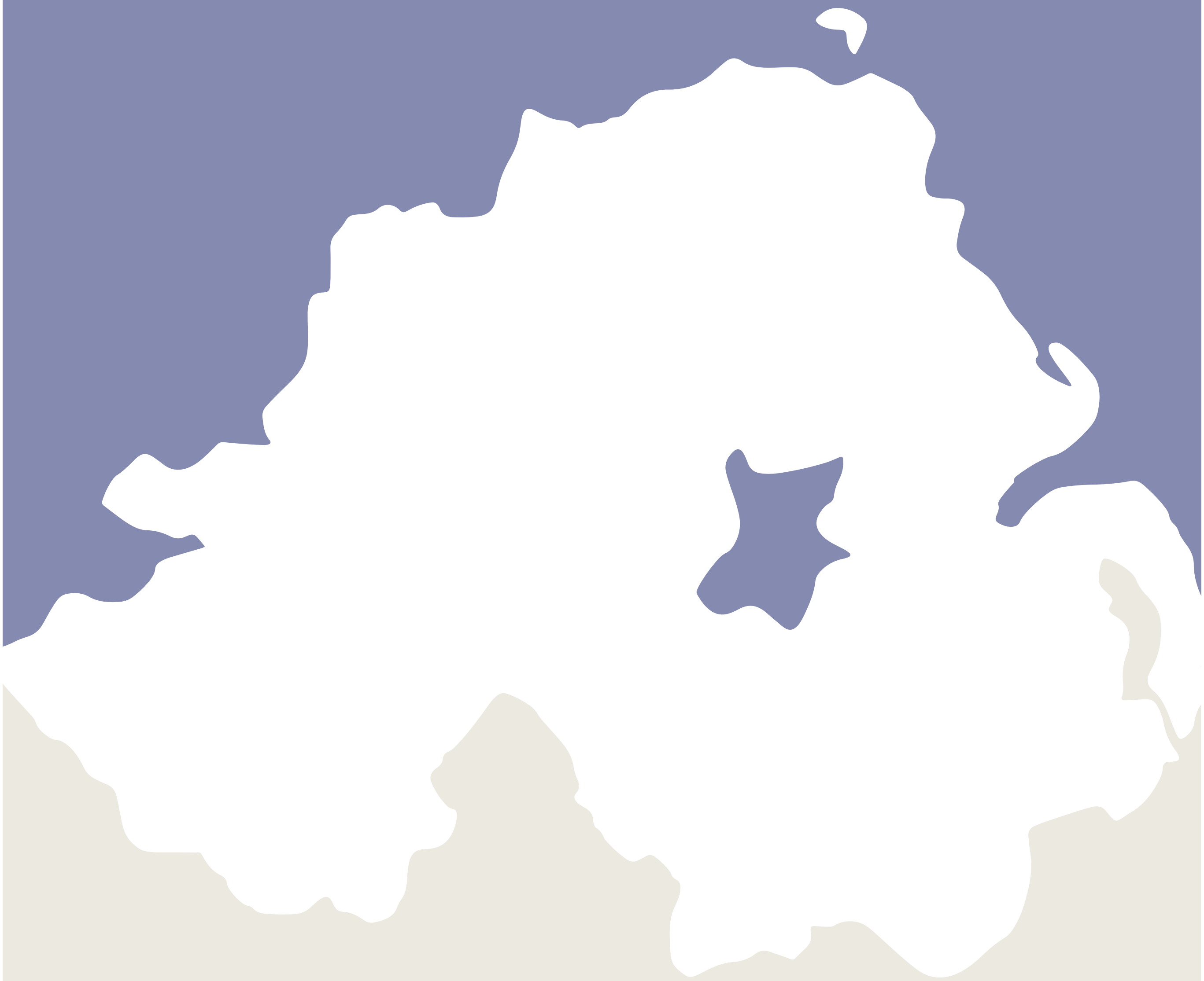
THE RIGHT TIME, THE RIGHT PLACE

An expert examination of the application of health and social care governance arrangements for ensuring the quality of care provision in Northern Ireland

DECEMBER 2014



Review Team | Sir Liam Donaldson | Dr Paul Rutter | Dr Michael Henderson

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1 CONTEXT

Throughout the developed world much healthcare is of a very high standard. The range of technologies and drugs available to diagnose and treat illness greatly increased during the second half of the 20th Century, and into the 21st, offering life and hope where patients' prospects were once bleak. As a consequence, the number of people living with disease and needing years or even decades of support from care systems has expanded enormously.

The ageing population of today is a central consideration in a way that was not foreseen when modern healthcare came into being in the aftermath of the Second World War. Today, people are living much longer and developing not just one disease but several that co-exist. In old age, the twin states of multi-morbidity and frailty are creating acute and long-term health and social care needs on an unprecedented scale.

Technology has continued its rapid and beneficial advance, opening up new opportunities for diagnosis and treatment but bringing even greater numbers through the doors of hospitals and health centres. Citizens experience the benefits of an advanced consumer society and when they encounter the health and social care system, they rightly expect it to be commensurate with this. Rising public expectations are a further driver of demand for healthcare. There are other, less predictable sources of pressure on services. For example, a change in the pattern of winter viruses can bring surges in demand that threaten to overwhelm emergency departments. In response to all of this, the size of budgets devoted to health and social care has had to expand dramatically.

At the epicentre of this complex, pressurised, fast-moving environment is the patient. The primary goal of the care provided must always be to make *their* experience, the outcome of *their* condition, *their* treatment, and *their* safety as good as it gets. Health and social care systems around the world struggle to meet this simple ideal. Evaluations repeatedly show that: variation in standards of care within countries is extensive; some of the basics such as cleanliness and infection are too often neglected; evidence-based best practice is adopted slowly and inconsistently; the avoidable risks of care are too high; there are periodic instances of serious failures in standards of care; and, many patients experience disrespect for them and their families, bad communication and poor coordination of care.

The health and social care system in Northern Ireland serves a population of 1.8 million. People live in urban, semi-rural or rural communities. Responsibility for population health and wellbeing, and the provision of health and social care, is devolved to the Northern Ireland Assembly from the United Kingdom government in Westminster. As in other parts of the United Kingdom, the Northern Ireland health service operates based on the founding principles of the National Health Service - the provision of care according to need, free at the point of access and beyond, funded from taxation. However, since the advent of devolved government, England, Scotland, Wales and Northern Ireland have adopted their own strategies for: promoting and protecting health; preventing disease; reducing health inequalities; and, planning and providing health and social care services. The countries have developed different structures and functions within their systems to meet these responsibilities. Thus, they vary in features such as: arrangements for planning and contracting of care; levels of investment in public health, primary and community care versus hospital provision; funding models; incentives; use of the independent sector; managerial structures; and, the role of the headquarters function.

Various agencies, groups and strategies populate the quality and safety landscape of Northern Ireland. Quality 2020 is the flagship ten-year strategy. Commissioned by the Minister of Health, Social Services and Public Safety in 2011, its vision is to make Northern Ireland an international leader in high quality, safe care. Quality 2020 is sponsored by the Chief Medical Officer and led by the Department of Health, Social Services and Public Safety. It has a steering group, a management group, an implementation team, project teams, and a stakeholder forum. These bring together representatives from across the statutory care bodies and beyond. Separately, a Health and Social Care Safety Forum convenes a similar group of stakeholders.

The Regulation and Quality Improvement Authority (RQIA) is the main regulator in Northern Ireland's care system. Many of the social care providers, and some healthcare providers, are registered with the Regulation and Quality Improvement Authority. However it does not register the Trusts, which provide the bulk of health and social care in Northern Ireland, or general practices. The Trusts' relationship with the regulator therefore has a somewhat softer edge than might be the case if they were formally registered, although an expanded role has been announced recently by the Minister.

Northern Ireland takes a keen interest in the work of quality and safety bodies elsewhere in the United Kingdom, and often implements their guidance and recommendations. The National Institute for Health and Care Excellence (NICE) and the former National Patient Safety Agency have been prominent in this regard.

Technical quality and safety expertise sits not in the Health and Social Care Board, but next door in the Public Health Agency. The Public Health Agency has a statutory role in approving the Health and Social Care Board's commissioning plans. Two executive directors are jointly appointed between the Public Health Agency and the Health and Social Care Board. There are therefore mechanisms through which quality and safety expertise should inform the Board's work. The Quality Safety Experience Group is jointly managed between these two agencies. It meets monthly and its primary focus is learning. It looks at patterns and trends in incidents and initiates thematic reviews.

In short, there is a good degree of activity in the sphere of quality and safety improvement. There are some unusual features of the landscape, which will emerge in some detail in this Review.

The way in which central bodies seek to achieve compliance with their policies and make broader improvement changes is based on a very traditional and quite bureaucratic management model. There is much detailed specification of what to do, how to do it, and then extensive and detailed checking of whether it has been done. This has strengths in enabling the central bodies and the government to demonstrate their accountability and give public assurances, but it can greatly disempower those at the local level. It can cause those managing locally to look up, rather than looking out to the needs of their populations.

The alternative is a style of leadership based on inspiration, motivation and trust that those closer to the front line will make good judgments and innovate if they are encouraged to do so. Perhaps the relationship needs a lighter touch, to liberate freer thinking on how to make services better for the future.

2 TERMS OF REFERENCE AND WORKING METHODS

The Review's formal Terms of Reference are available online[1]. The overall aim of the Review has been to examine the arrangements for assuring and improving the quality and safety of care in Northern Ireland, to assess their strengths and weaknesses, and to make proposals to strengthen them.

The analysis in this report is based on extensive input from, scrutiny of, and discussion with people across the health and social care system in Northern Ireland. Each of the main statutory organisations made formal submissions to the Review (including records of board meetings, policies, and plans). The Review put substantial emphasis on travelling around the system – both literally and figuratively – to see it from as many different angles as possible, and to come to a rounded view.

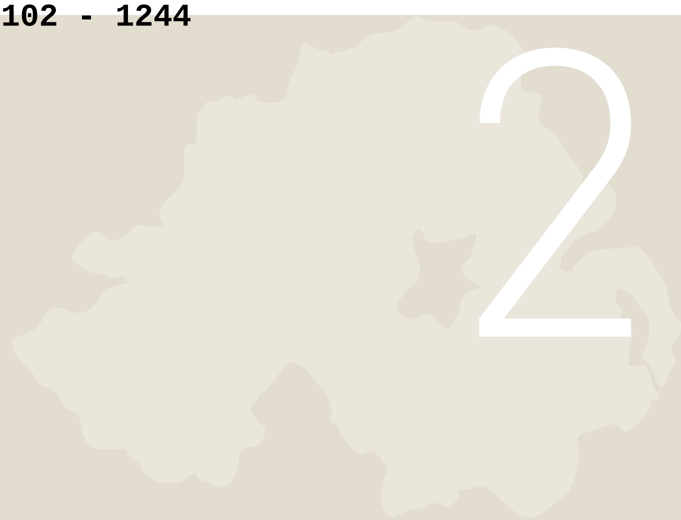
The Review Team visited the five Health and Social Care Trusts, the Northern Ireland Ambulance Service, the Department of Health, Social Services and Public Safety, the Health and Social Care Board (and its Local Commissioning Groups), the Public Health Agency, the Patient and Client Council, and the Regulation and Quality Improvement Authority. In each, the Review Team met with the executive team (Chief Executive and executive directors) and, in most cases, the Chair of the Board and other non-executive directors. The management team of each organisation gave a series of presentations covering the areas of interest to the Review, and Review Team members asked questions and led discussion.

During their visit to each Health and Social Care Trust and to the ambulance service, Review Team members also led focus groups discussions amongst frontline staff. In each of the five Health and Social Care Trusts, for example, the team met with separate groups of consultants, nurses, junior doctors, and other health and social care professionals. Senior managers were not present for these discussions. Participants were encouraged to speak openly, and generally did so. It was understood that no comments would be attributed to individuals. The focus groups centered on any concerns about quality and patient safety in their organisation and incident reporting, and other highly-related topics. The team also met with two groups of general practitioners.

The Review Team paid particular attention to the experiences of people who have come to harm within the Northern Ireland health and social care system. At each Trust, including the ambulance service, the team reviewed two recent Serious Adverse Incidents in detail, particularly considering the incident itself, the way in which patients and families were kept informed and involved, and the learning derived. The team later returned to two Trusts to review further incidents, this time selected by the Review Team from a list of all serious adverse incidents in the previous year. The Review Team met with people who have come to harm. Most of these meetings were in person; some were by telephone. In addition to people affected directly, the Review Team spoke to their family members and carers. We are particularly grateful to all of these individuals for giving of their time, and for graciously sharing their stories with us, which were often painful.

Finally, the Review Team met with a series of other individuals and groups that form part of the wider health and social care system in Northern Ireland, or have a strong interest in it. These were: the Attorney General, the British Medical Association, the Chest Heart and Stroke Association, the Commissioner for Older People for Northern Ireland, Diabetes UK, the General Medical Council, MacMillan Cancer Support, the Multiple Sclerosis Society, the Northern Ireland Association of Social Workers, the Northern Ireland Human Rights Commissioner, the Northern Ireland Medical & Dental Training Agency, The Honourable Mr Justice O'Hara,

http://www.dhsspsni.gov.uk/tor-080414.pdf



the Ombudsman for Northern Ireland, the Pain Alliance of Northern Ireland, Patients First Northern Ireland, the Royal College of Nursing, and the Voice of Young People in Care. Other patient and client representative groups were invited to meet with the Review Team, or to make written submissions.

To inform one aspect of the Review, the Regulation and Quality Improvement Authority oversaw a look-back exercise, reviewing the handling of all Serious Adverse Incidents in Northern Ireland between 2009 and 2013. Their report was received late in the Review process, but has been considered by the Review Team and reflected in this report.

Between starting and producing its final report, the Review Team has had a relatively short period of time. It has not been possible to undertake research, extensive data analysis, large-scale surveys of opinion, or formal evidence-taking sessions. However, the documents reviewed, the meetings held, the visits made, and the views heard have given a strikingly consistent picture of quality and safety in the Northern Ireland health and social care system. The Review Team is confident that a longer exercise would not have produced very different findings.

3 THE CHALLENGES OF DELIVERING HIGH QUALITY, SAFE CARE

Patients in hospitals and other health and social care services around the world die unnecessarily, and are avoidably injured and disabled. This sad fact has become well known since the turn of the 20th Century. Awareness of it has not been matched, unfortunately, by effective action to tackle it.

There is consistency in the types of harm that occur in high-income countries. In low-income countries, harm is mainly related to lack of infrastructure and facilities, as well as poor access to care. However, in North America, Europe, Australasia, and many parts of Asia and the Middle East, analysis of incident reports and the findings of patient safety research studies shows a different, strikingly consistent pattern. Between 3% and 25% of all hospital admissions result in an adverse incident, about half potentially avoidable. Within any health or social care service, there are many potential threats to the quality and safety of the care provided:

1. Weak infrastructure - the range and distribution of facilities, equipment and staff is inadequate to provide fair and timely access to required care.
2. Poor co-ordination - the components of care necessary to meet the needs of a patient, or group of patients, do not work well together to produce an effective outcome and to be convenient to patients and their families.
3. Low resilience - the defences in place, and the design of processes of care, are insufficient to reliably protect against harm such as that resulting from errors or from faulty and misused equipment.
4. Poor leadership and adverse culture - the organisation or service providing care does not have clear goals and a philosophy of care that it is embedded in the values of the organisation and visible in every operational activity.
5. Competence, attitudes, and behaviour - the practitioners and care-providers working within the service lack the appropriate skills to deal with the patients that they encounter, or they are unprofessional in their outlook and actions, or they do not respect other team members, nor work effectively with them.
6. Sub-optimal service performance - the way that the service is designed, organised and delivered means that it does not deliver processes of care to a consistently high standard so that over time it chronically under-performs often in a way that is not noticed until comparative performance is looked at.
7. Slow adoption of evidence-based practice - the service does not conform to international best practice in particular areas of care or overall.

The amount of each type of harm varies but the overall burden has changed little over the last decade despite the unprecedented priority that has been given to patient safety within these health systems. Little is known about the level and nature of harm in primary care, though more attention is now being given to it.

Although these threats are described in relation to health, they apply also to social care. Many are strongly related to the level of resources that is available to a health and social care system. The extent to which each problem is present varies hugely across the world, within countries, and even between different parts of the same service or area of care provision.

In some ways it is reassuring to believe that the problems of quality and safety of care are somehow universal, and that no country has the answers. This is dangerous thinking. The best services in the world show that even with the all the pressures of large numbers of patients, many with complex needs, excellence can be achieved consistently across all fields of care. The Northern Ireland health and social care service must not be satisfied with 'good enough.' With a clear recognition of the reasons for its current problems in quality and safety of care, and with everyone working together, it could be amongst the best in the world.

4 KEY THEMES ESTABLISHED BY THE REVIEW

The Review established six key themes. Each is set out in some detail below. Exploration of these themes provides the basis for the Review's conclusions (in section 5) and recommendations (section 6).

4.1 A SYSTEM UNDER THE MICROSCOPE

Northern Ireland's health and social care system is subject to a high, perhaps unrivalled, level of media coverage – much of it negative. Over recent years, it has also been the subject of a series of high profile inquiries. All have highlighted numerous failings in the leadership and governance of care. Many have made extensive recommendations and the extent to which these have been implemented has itself been controversial. The pressures of increasing demand for care have meant that access has been more difficult. There has been a focus on over-crowding and delays in emergency departments, the front door of the hospital service. All of this has meant that the last five years has been a period of unprecedented scrutiny of the way that health and social care in Northern Ireland is planned, provided and funded.

4.1.1 A stream of inquiries highlighting service failures

The number of recent major investigations and inquiries into shortfalls in standards of care in health and social care services in Northern Ireland is striking in relation to the size of its population. This does not necessarily mean that such occurrences are commoner than elsewhere in the United Kingdom. It may simply be that the level of public and media scrutiny is higher and the pressure from this triggers a statutory response by government ministers and officials. The end-result is that the profile of the service is more often one of failure rather than success.

In March 2011, Dame Deirdre Hine, a former Chief Medical Officer for Wales, issued the report of her inquiry into deaths from *Clostridium difficile* in hospitals in the Northern Trust area. She had been brought in to investigate 60 deaths that had been attributed to the organism. She found that the true figure was 31 deaths. She found management, organisational, clinical governance and communication failings. She made 12 recommendations. It took 23 months to complete.

In February 2011, the Belfast Trust recalled 117 dental patients following a review of the clinical performance of a senior consultant. An independent inquiry commissioned by the Minister was published in July 2013 and made 45 recommendations. An action plan developed by the Department of Health, Social Services and Public Safety identified 42 key actions including on staffing, training, supervision and clinical governance. In November 2013, the Regulation and Quality Improvement Authority conducted an assessment of implementation of those actions.

In December 2011, an independent report by the Regulation and Quality Improvement Authority examined delays in the reporting of plain X-rays in all Trusts after concerns were expressed about delays in two hospitals. The review found that serious delays had occurred and were caused by three main factors: a shortfall in consultant radiology staffing, a growth in numbers of x-rays to be reported after the introduction of digital imaging and the introduction of a new policy to report on all hospital chest x-rays because of worries about patient safety. The review found that there was little awareness at regional level that a serious backlog in reporting was developing with potential risks to patients due to delayed diagnosis. The review made 14 recommendations.

In May 2012, Doctor Pat Troop, former chief executive officer of the Health Protection Agency in England, issued her final report of the independent investigation into an outbreak of infections in neonatal units due to the organism *Pseudomonas aeruginosa*. Five babies had died in the outbreak and 32 recommendations were made covering technical matters, management, governance, communication, training, and outbreak management.

In April 2012, the Minister asked for special measures to be put in place to oversee the Belfast Trust because of major concerns about serious adverse incidents in the emergency department, recommendations from the Pseudomonas review, reviews of paediatric congenital cardiac surgery and recommendations of the dental inquiry.

In December 2012, the Minister appointed a Turnround and Support Team to go into the Northern Health and Social Care Trust because of concerns about the weakness of governance and quality assurance systems, the paucity of clinical leadership, and uncertainties about the reliability of mortality data. This particular Trust has had five chief executive officers in the last seven years.

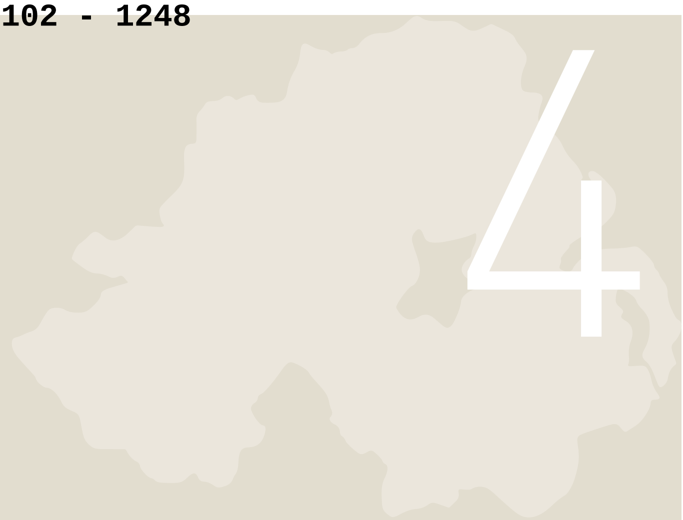
In June 2014, the Regulation and Quality Improvement Authority reported on its review of unscheduled care services in the Belfast Trust. The concerns that led to the review included: the declaration of a major incident, 12-hour waiting time breaches, dysfunctional patient flows and gross overcrowding of patient care areas. This triggered a fuller review that looked at matters region-wide. This produced 16 recommendations.

The dominant inquiry in recent times remains the *Independent Inquiry into Hyponatraemia–Related Deaths*. It is examining the deaths of children after being transfused in hospital with a fluid that was subsequently found to carry a significant risk. Concerns had been raised by the parents and others that this risk should have been identified much earlier, that action should have been taken to stop it being used, that there was a cover-up and that systems for monitoring safety were inadequate. It is being chaired by John O'Hara QC and was commissioned in 2003/4 but, because of other legal processes, was not able to hear full evidence until more recently. The report is expected in 2015.

The criticisms in inquiries like these have been largely justified and must be followed by action to improve the situations. Whether establishing formal, often lengthy, and costly inquiries is the right way to drive improvement is very debatable. Certainly doing so as the normative response to failure has important disadvantages. In particular, it often paralyses the organisation under scrutiny as its staff become pre-occupied with preparing evidence and supplying information. The learning is often put on hold - sometimes never to be returned to - until the inquiry is over. The burden of recommendations to be implemented and progress-checked can be overwhelming, so that the implementation becomes a bureaucratic exercise rather than a watershed moment for leadership, culture and the content of practice. It might be better to define a clear threshold for when a full-blown inquiry is initiated.

4.1.2 Intense political and media interest in service provision

Northern Ireland's health and social care system is subject to a high degree of political, as well as media, interest. This is a valid and expected feature of a publicly-funded system. Ironically, though, the way in which this interest becomes manifest often creates results that are counter to the true public interest. There have been many examples of local communities – and therefore their politicians – wanting to keep a local hospital open, contrary to the analysis of service planners. This has created



a situation in which Northern Ireland has more inpatient units than is really justified for the size of population, and the expense of maintaining them impedes provision of other services that would represent better value for money and more appropriately meet the needs of the population. Likewise, political pressure and media interest has prevented the salaries of top managers from being raised too substantially. However, senior executives in the Northern Ireland care system are now paid much less than their counterparts elsewhere in the United Kingdom. The public would be better served if their care system could compete to attract the very best managerial talent. The pressure to keep salaries down may be penny-wise and pound-foolish.

4.2 THE DESIGN OF THE SYSTEM HINDERS HIGH QUALITY, SAFE CARE

When a quality or safety problem arises somewhere within the Northern Ireland care system, the tendency is to point to the individuals or services involved, and to find fault there. As with so many other features identified in this report, this tendency is far from unique to Northern Ireland. But it represents, in the view of the Review Team, too narrow a focus. In reality, the greatest threats to the quality of care that patients receive, and to their safety, come from the way in which the system as a whole is designed and operates.

In short, the services that exist are not the services that the population truly requires. Political and media pressure acts to resist change, despite the fact that change is much needed. It is not clear who is in charge of the system, and the commissioning system is underpowered. All of this compounds the pressures, creating high intensity environments that are stressful for staff and unsafe for patients – particularly out of hours. These effects are explored further below.

The Northern Ireland care system has some elements in common with the other United Kingdom countries, and some that differ. Observers, asked to describe the Northern Ireland system, often point first to the integration of health and social care as its distinguishing feature. It is clear though from the findings of this Review that whilst the integrated design of the system has great advantages, it falls well short of perfection in promoting the highest standards of care and in preventing the dysfunctions in the co-ordination of care that are prevalent elsewhere.

4.2.1 Service configuration creates safety concerns

A striking feature of the provision of care in Northern Ireland is the wide distribution of hospital-type facilities outside the major city, Belfast, some serving relatively small populations by United Kingdom standards. This geographical pattern leads to specialist expertise being too thinly spread, and to the patchy availability of experienced and fully competent staff. It means that it is not possible everywhere to deliver the same quality of service for an acutely ill person at 4 a.m. on a Sunday as at 4 o'clock on a Wednesday afternoon. There is therefore a two-tier service operating in Northern Ireland - in-hours and out-of-hours - that is more pronounced in some places than in others. This is one of the biggest influences on the quality and safety of care. Delivery of services is too often higher risk than it should be in a 21st Century healthcare system because of the pattern of services.

Past analysts and observers have pointed to the current level and siting of provision not being in keeping with maintaining high standards of care. Some populations are just too small to warrant full-blown general hospital facilities yet they are kept in place because of public and political pressure. Amongst those who work within the system, there is deep frustration that the public are not properly informed about the higher risks of smaller hospitals and that the misapprehension that alternative forms of provision are in some way inferior to a hospital. These issues are illuminated by two wry comments made to the Review: "the word 'hospital' should be removed from the Oxford English Dictionary" and " Northern Ireland needs more roads not more hospitals."

Despite its small size, there is less co-operative working across Northern Ireland than might be expected. Silos reign supreme. The Health and Social Care Board runs regional commissioning teams, covering areas such as learning disability, mental health, prison health and a very broad category of 'hospital and related services'. However, particular scope exists to do more in improving standards in areas of clinical care where there is a strong evidence base for what is effective. In the cases where clinicians have worked together across organisational boundaries, remarkable transformations have occurred. This happened in cardiology where a regionally planned and coordinated service means that more patients with heart attacks get treated early, get less damage to their hearts, and more people live rather than die. The Ambulance Trust is the only one of the six Trusts organised on a regional basis. The Review Team was very struck by how much pressure this important service was under. This is consistent with the headline stories in other parts of the United Kingdom about ambulance services being unable to meet their service standards because of huge surges in demand. All parts of the service are taking the strain – from those in the control centre to those on the road. Yet when the detail of their situations is explored in depth, it is clear again that the problems stem from dysfunctional patient flows and pathways where different parts of the system are not working together.

4.2.2 Adverse consequences for primary and social care

The pressures on hospitals have consequences for primary and community services. There is a constant need for hospitals to discharge patients as soon as they possibly can to free-up beds for new admissions. Generally, this happens when an older person is judged medically fit for discharge. However, this does not necessarily mean that their physical and social functioning has reached a level where they can cope with a return to the community. The Review was told by general practitioners and social care staff that they often have to step in to provide unscheduled support in such circumstances and, because of inadequate communication at the time of discharge, they can be left in the dark about ongoing treatment plans and even be unclear about something as basic as a patient's medication regime. Some general practitioners spoke of spending long, frustrating hours trying to get to speak to a hospital doctor about their patient, without success.

Over the last decade, there has been a major increase in the dependency levels of people being cared for in the community. For example, the use of PEG feeding (directly into the stomach through a tube in the skin) is now commonplace in community settings, whereas it used to be a hospital treatment. As a result, community nursing staff have much more complex caseloads. There is also greater complexity in the other forms of disability, as well as in the treatments that people are receiving and other technologies that are supporting them.

The Review Team was very struck by the experience of one on-call pharmacist whom they talked to. He was responsible for preparing the discharge medication for patients leaving hospital on a particular Bank Holiday weekend. He reported filling a doctor's prescription for 20 different medications for each of four patients. This strongly illustrates several points. Firstly, it is not right that such an excessive amount of medication should be routinely prescribed. It should be rigorously reviewed and adjusted. Secondly, it again shows the complexity and multiple conditions affecting many patients, who move regularly between hospital and community. Thirdly, it highlights the opportunity for a much stronger role for under-appreciated disciplines like pharmacy on the boundary between hospital and population.

The integration of health and social care means that the Review Team's discussions within Trusts necessarily took account of the important role of social care staff, and particularly social workers. They are a vital part of the workforce and although under equal pressure to their healthcare counterparts, the Review was encouraged to hear about the strong emphasis on professional development in Northern Ireland and the particular expertise in specialist areas such as adult safeguarding.

The knock-on effects of pressures in the hospital system for community services are not restricted to post-discharge matters. Many hospital departments are so pre-occupied with urgent work and the high volume of patients that they do not have time to provide proper responses when patients or their doctors make contact to ask about progress with an outpatient appointment or test results.

4.2.3 High-pressure environments fuel risk to patients and sap morale

The demand from patients who need emergency care, as well as those who require planned investigations and treatments, is extremely high. The pressures on emergency departments and hospital wards are very great. Over-crowded emergency departments and overflowing hospital wards are high-risk environments in which patients are more likely to suffer harm. This is because delays in assessment and treatment occur but also because staff have to make too many important and difficult decisions in a short space of time - what psychologists call cognitive overload. That they will make mistakes and misjudgments is inevitable, and some of them will be in life-and-death areas. Experience in other safety-critical industries, and research, shows that high-pressure, complex, and fast-moving environments are dangerous. If inadequate staff levels are added to the mix, risks escalate further.

The Review met with many groups of health and social care staff, speaking on condition of anonymity. They are overwhelmingly conscientious people who feel deeply for their patients and want to excel in the care that they deliver. Yet, the workloads in some situations are unacceptably high; so too are stress levels. The stress comes not only from the large numbers of cases per se, but much more from the feeling of staff that they are not giving patients the quality of care they were trained to deliver. There is guilt too in knowing that they are forced to compromise their standards to levels that they would not accept for their own families. The phrase "doing just enough" was repeatedly used in the Review's meetings with front-line staff. There are extra pressures for some groups of staff. Doctors in training can find themselves in situations that are beyond their competence and experience. Sometimes they can call on back-up from senior staff, sometimes they have to do their best until the morning or Monday comes. Some nurses can find themselves dealing with an unacceptably large number of patients on a hospital ward at night. They too feel that they are having to lower their professional standards. This assessment is not based on isolated anecdotes but much more widespread and consistent accounts.

4.2.4 Transformation efforts are moving slowly

Transforming Your Care began as a substantial review of health and social care provision in Northern Ireland, commissioned in 2011. The review was led by the then-Chief Executive of the Health and Social Care Board, supported by an independent panel. It was a strong, forward-thinking piece of work.

The whole of the United Kingdom, like most developed countries, has a fundamental problem: the health and social care system that it has is not the health and social care system that it needs. The pattern of ill-health in the population has changed substantially since the systems were founded, and the systems have not changed to keep up. *The Transforming Your Care review* set out a convincing case for change. It described inequalities in health, rising demands, and a workforce under pressure. It particularly established that Northern Ireland has too many acute hospitals

- that elsewhere in the United Kingdom, a population of 1.8 million people would likely be served by four acute hospitals – not the 10 that Northern Ireland had.

Transforming Your Care set out a broad new model of care, which aimed to be tailored to today's needs and person-centered. In practical terms, its most substantial proposal was to move £83 million away from hospitals and give it to primary, community and social care services.

Those interviewed by this Review Team unanimously supported the need for this initiative. The widespread feeling, though, is that *Transforming Your Care* is simply not being implemented.

As a result of weak communication and little action, there is substantial skepticism about *Transforming Your Care*. The Review Team heard it variously referred to as "Transferring Your Care", "Postponing Your Care", and even "Taking Your Chances". One of its central concepts, 'shift left', is viewed particularly warily. Carers see it as a euphemism for dumping work onto them; general practitioners likewise. Those working in the community see their workload increasing, and worry that there is no clarity at all about what the overall care model is supposed to be.

The frustrations of the general practitioner community in Northern Ireland that *Transforming Your Care* has not worked, is not properly planned nor funded, has led them to take matters into their own hands and form federations. General practices themselves are financially contributing to these, in a move to establish community-centered care pathways.

The needs that *Transforming Your Care* sets out to address are becoming ever more pressing. Its implementation needs a major boost in scale and speed, and communication needs particular attention.

4.2.5 An under-powered system of commissioning

At 1.8 million, the population of Northern Ireland is relatively small to justify what is a quite intricately designed health and social care management structure. In addition to the Department of Health, Social Services and Public Safety, there are six Trusts, a Health and Social Care Board with five Local Commissioning Groups, a Public Health Agency, and several other statutory bodies.

A central feature is the split between care providers and commissioners, which increases the complexity of the system and its overhead costs. This began life as the so-called purchaser-provider split, introduced by Margaret Thatcher's government in the late-1980s. In various iterations, it has remained a feature of the NHS ever since. The introduction of a purchaser-provider split was originally intended to create a competitive 'internal market' to drive up quality and so increase value for money. However, the scope for genuine competition has always been very limited. The term 'commissioning' subsequently superseded 'purchasing'. Commissioning involves a wider set of functions – assessing need and planning services accordingly, and the use of financial incentives to intentionally drive the system's development relating to the type of services provided, their quality and their efficiency.

Within the United Kingdom, the English NHS has the most developed commissioning system. NHS England, the national commissioning board, is now separate from the central government Department of Health. It is a pure commissioning organisation, completely free from overseeing the performance of Trusts. Its only relationship with the provider side of the market is through the commissioning process. It devolves the vast majority of funds to local Clinical Commissioning Groups (of general practitioners) that make decisions about the allocation of money against a national framework of policies and goals. Services are priced under a tariff system. This tariff has become increasingly complex, to facilitate locally agreed variation and to incorporate pay-for-performance elements.

There are several contextual differences between England and Northern Ireland, of which the most obvious is population size. In England, the overhead costs associated with establishing and administering a complex tariff system are essentially divided between 53 million people. With a population one-thirtieth the size, the cost per head of running a similar system in Northern Ireland would be difficult to justify.

The problem for Northern Ireland is that it has gone just partially down the commissioning path. It does not have the benefits of a sophisticated commissioning system, yet has the downside of increased complexity and overhead costs. The worst of both worlds.

Northern Ireland has no service tariffs. The Health and Social Care Board allocates money by a process akin to block contracting. This approach was abolished years ago in England because it was considered old-fashioned, crude and not conducive to achieving value for money. Fully developed tariff systems reimburse providers on a case-by-case basis, with the amount paid dependent on the diagnosis or the procedure undertaken, the complexity of the patient and, in some cases, measures of the quality of care. In Northern Ireland, the funding system is far more basic. Staff the Review Team spoke to believed that it makes no distinction, for example, between a cystoscopy (a simple diagnostic procedure, usually a day case) and a cystectomy (a complex operation), a clear absurdity if true.

Northern Ireland's five Local Commissioning Groups are not like England's Clinical Commissioning Groups. The Local Commissioning Groups have a primary focus on identifying opportunities for local service improvement. They have very few resources and, in effect, are advisers and project managers rather than commissioners. England's Clinical Commissioning Groups, by stark contrast, have a high degree of control over resource allocation.

It is imperative, somewhere in the system, for needs to be assessed, services planned and funds allocated. Whichever part of the system is responsible for this must be sufficiently resourced to do it well – arguably, the Health and Social Care Board is currently not.

The Northern Ireland system would benefit from stronger thought- leadership from within. There is no established health and social care think-tank, and some key disciplines such as health economics are not strongly represented.

Northern Ireland could choose to go down any number of different routes. It could strengthen the current Health and Social Care Board, particularly to create a tariff that includes a strong quality component. Alternatively, it could devolve budgetary responsibility to the five Trusts, making them something akin to Accountable Care Organisations in other countries, responsible for meeting the health and social care needs of their local population. The Trusts would then buy in primary care services, and contract between themselves for tertiary care services.

Recommending a commissioning model is beyond the scope of this Review. It is clear, though, that the Northern Ireland approach to commissioning is not currently working well, and that this is surely affecting the quality of services that are being provided. For that reason, the Review Team must recommend that this issue be addressed.

4.2.6 Who runs the health and social care system in Northern Ireland?

It was instructive for the Review Team to have asked this question of many people. The question elicited a variety of answers, the common feature of which was that no one named a single individual or organisation. Indeed, most reflected their uncertainty with an initial general comment. Typical was a remark like: "The Minister has a high profile." When pressed to directly answer the question: who runs the service? Their answers included: "The Minister", " The Permanent Secretary in the Department of Health", " The Chief Executive of the Health and Social Care Board", and " The Director of Commissioning of the Health and Social Care Board."

These responses reflect the complexity of the governance arrangements at the top of the health and social care system in Northern Ireland. They show that ambiguity has been created in the minds of people – both clinicians and managers – throughout the system.

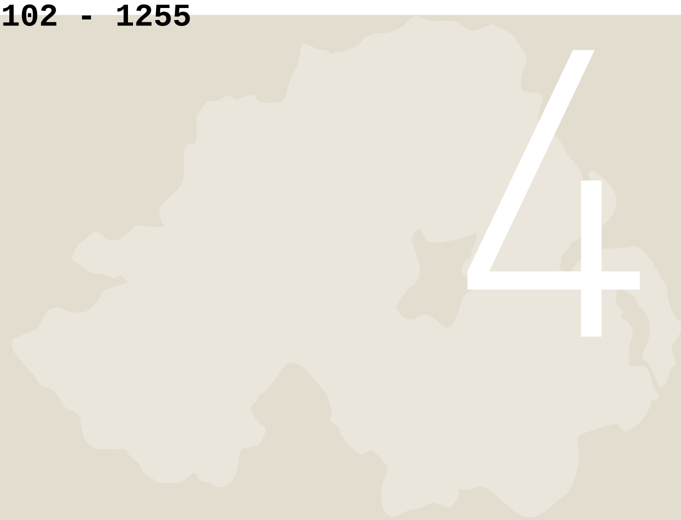
The question of who is in charge is both simple and subtle. Whilst overall accountability versus calling the shots versus making things happen are aspects of governance that would have a single leadership locus in many places, this is not the case in Northern Ireland. There is no single person or place in the organisational structure where these things come together in a way that everyone working in the service, the public and the media clearly understand.

The present arrangements have evolved over time but the Review of Public Administration in 2007 led to many of them. Prior to this the Department of Health, Social Services and Public Safety was larger and oversaw four Commissioning Boards and 18 Trusts. There were highly-centralised control mechanisms and the service was subjected to many and frequent circulars and directives. Since then there has been a smaller Department of Health, Social Services and Public Safety that is more focused on providing policy support to the Minister. A single Health and Social Care Board has been created from the previous four. The number of Trusts has been reduced from 18 to six, five organised to provide health and social care services by geographical area and the sixth an ambulance Trust for the whole region. Another important change has been the advent of a fully-devolved administration and the end of direct rule where power was in the hands of civil servants rather than elected local politicians. The lack of clarity about who is in charge is a major problem for Northern's Ireland care system. The difficulty is not that there is no figurehead, but that strategic leadership does not have the visibility of other systems. Without a clear leader, progress is piecemeal and change is hesitant and not driven through at scale – the Review Team was told "there are more pilots than in the RAF".

4.2.7 Clarifying the role of healthcare regulation

Aside from being commissioned by the Department of Health, Social Services and Public Safety to conduct occasional service-specific inspections, the Regulation and Quality Improvement Authority has until now conducted a program of thematic reviews driving more at quality improvement than at regulation.

From 2015, the Minister has decided that the regulator should undertake a rolling programme of unannounced inspections of the quality of services in all acute hospitals in Northern Ireland. The Regulation and Quality Improvement Authority is being directed in this task to examine selected quality indicators in relation to triage, assessment, care, monitoring and discharge. As a result of this change, the regulator will reduce its normal annual programme of thematic reviews.



These changes give the Regulation and Quality Improvement Authority a much stronger locus in the healthcare side of provision. However, this body has no real tradition of doing this kind of work, unlike its counterparts elsewhere in the United Kingdom. For example, in England, the various health regulators have evolved over a 15-year period with frameworks, methodologies, metrics and inspection regimes. For this reason, the Review is recommending that healthcare regulation in Northern Ireland is re-examined in the round, rather than approaching it piecemeal on an initiative basis.

4.3 INSUFFICIENT FOCUS ON THE KEY INGREDIENTS OF QUALITY AND SAFETY IMPROVEMENT

The recognition that quality and safety should be a priority in the planning and delivery of health and social care arrived late to this sector in developed nations. Until the early 1970s, services operated on the tacit understanding that doctors' and nurses' education, training, professional values and standards of practice ensured that most care was good care. It was not until measurement of quality became more commonplace that it was realised that faith in this ethos had been badly misplaced. A series of scandals blew apart public confidence in the NHS. There were many victims, and it became clear that trust alone was not sufficient. Often, such events depicted cultures in some health and social care organisations in the United Kingdom and other countries that had tolerated poor practice and even sought to actively conceal it.

Organised programmes to assure quality and improve it initially came into healthcare through approaches developed in the industrial sector, notably total quality management and continuous quality improvement. Until 1998, there had never been a framework to progress quality and patient safety in the United Kingdom's NHS. From that time, a comprehensive approach was introduced with: *standards* set by the National Institute for Clinical Excellence and in National Service Frameworks; a programme of *clinical governance* to deliver assurance and improvements at local level backed up by a statutory duty of quality; and, inspection of standards and *clinical governance* arrangements carried out by the Commission for Health Improvement. These roles have changed over time. Some still cover all, or most, of the United Kingdom, whilst others have been taken up differently in the four countries.

Much recent commentary on the NHS in the United Kingdom has focused on whether its leadership is really serious about quality and safety. There is a widespread view within the service that financial performance and productivity are what really matter to managers, despite what might be in the mission statements of their organisations. This came home to roost in the scandalous events at the Mid-Staffordshire NHS Trust in England where the Francis Inquiry heard that concerns about quality were down-played against financial viability in the pressure to gain Foundation Trust status.

A key consideration in quality and safety of healthcare is whether it is embedded in the mainstream at all levels. Up until the late-1990s, it was largely the domain of academics and enthusiasts. Since then, those who are fully committed to its underlying principles and goals have increased in number. However, it is still debatable what proportion of board members, management teams, and clinical leaders are 'card-carrying' quality and safety enthusiasts.

Prominent in international experience are four essential ingredients to improving the quality and safety of care. These are: clinical leadership, cultural change, data linked to goals, and standardisation. In Northern Ireland seeds of each can be found, but none is blossoming. This is substantially holding Northern Ireland's care system back from achieving its full potential.

4.3.1 Clinical leadership

A crucial test of the strength of the quality and safety system is the extent of clinical engagement. This is partly a question of hearts and minds but also a case of knowledge, skills and the philosophy of clinical practice.

The quality and safety of care will only get better if those who deliver the care are not only *involved* in improving it, but are *leading* the improvement effort. In the very best healthcare

systems in the world, clinicians are in the driving seat, supported by skilled managers. Traditionally, doctors, nurses and other health professionals have seen their duty to the patient in front of them. Rightly, this remains the important primary requirement for establishing a culture of good clinical practice. However, this is not enough to enable consistently high standards of care, nor to make care better year-on-year. This requires a paradigm shift in clinical practice, a different mission of practice, so that all healthcare professionals see the essence of their work not just in the care of individual patients but in ensuring that the service for all their patients reaches a consistently high standard and that opportunities for improvement are identified and taken. Accomplishing this is not easy. Clinicians will point out that their workloads are too heavy to make time to reflect on these wider considerations or that they do not have access to reliable data to allow them to compare their service to best practice or that they have not had training in quality and safety improvement.

Clinicians need to step forward to lead. This involves expanding their sense of responsibility beyond the individual patient in front of them to the system as a whole. When clinicians do step forward, they need to be supported. They need to be given responsibility and resources. They need to be given training, because leading improvement is technically and emotionally difficult.

In Northern Ireland, the Review Team met a small number of talented clinicians who have decided to step forward, and who are succeeding in leading positive change. The Review Team met many more clinicians who have tried to engage with 'management' in the past, have been knocked back, and have given up trying. There are many great ideas lying latent in the heads and hearts of clinicians, untapped by the system. The Review Team saw some effort, particularly in the South Eastern Trust, to provide clinicians with the skills that they need to lead improvement projects. Across the system as a whole though, the scale and scope of these is nowhere near what is needed.

4.3.2 Cultural change

Culture determines how individuals and teams behave day to day. It determines how clinicians view and interact with patients; whether they consider harm to be "one of those things", "the cost of doing business", or a feature of healthcare that, with effort, can be banished; whether they react to seeing problems in the system by complaining, or by taking on responsibility for fixing them.

All healthcare systems in the world realise the importance of culture. The difference between the best and the rest is what they do about this. The very best do not hope that culture will change; they put major effort into actively changing it. Their approach is not light-touch or scattergun; they see changing culture as a central management aim.

The Cleveland Clinic in the United States of America, for example, set out to improve patient experience, most of which is determined by how staff behave towards patients. The Clinic's management wanted all staff to better work as a team, and to see their role as being important for patient care – from doctors and nurses, to cleaners, receptionists and electricians. They designated them all 'caregivers'. All 40,000 caregivers attended a series of half-day training sessions, designed to build their practical communication skills and their awareness of self, others and team. They made patient experience scores widely available – ranked by doctor, by hospital, and by department. These efforts have continued for several years. In 2013, the Chief Executive's annual address to all caregivers included a powerful video about empathy. It has since been viewed 1.8 million times on YouTube. In short, the Cleveland Clinic made a major concerted effort to make patient experience important to all who work there.

It has paid off. With staff now more engaged than ever, the Cleveland Clinic has been able to move on to making safety and other elements of quality a crucial part of the culture too.

In Northern Ireland, as in many places, no effort has been made to influence culture on anything like this scale. Many people in the system are able to describe the culture, and many cite it as important. Scattergun efforts are made – a speech here, an awards ceremony there – but shifting culture is hard, and scattergun will not do it. Culture is viewed with a degree of helplessness – but the evidence from elsewhere is that it can be changed, and that doing so is powerful.

4.3.3 Data linked to goals

The importance of data and goals are news to nobody. Yet in Northern Ireland, as in too many other healthcare systems, data systems are weak and proper goals are sorely lacking.

Improving healthcare requires clear and ambitious goals. It requires a statement that preventable harm will be reduced to zero, or that the occurrence of healthcare associated infections will be cut in half within a year. Management guru Jim Collins would call these BHAGs – Big Hairy Audacious Goals. They are goals that are at once exciting and scary. They get people interested and motivated. They are the kind of goals that Northern Ireland should be setting for its care system.

If the goal is the destination, strong data are the sat nav. They show the current position in a form that provides useful information for action. Too often, data show where the system was over the last three months, or what performance has been across large units. They need instead to show the situation in real-time, or as near to it as possible. And they need to show performance at the very local level.

As with culture and leadership, data capability is an area that the best care systems in the world have invested in heavily. They have online dashboards that enable all aspects of the system to be measured, understood, and therefore managed. In comparison, Northern Ireland (and many other places) has a care system that is being managed as if through a blindfold. Investment in information technology is crucial and, if done intelligently, will pay dividends.

4.3.4 Standardisation

Doctors generally dislike standardisation (nurses warm to it more), but it is a crucial part of improving the quality and safety of healthcare.

One healthcare standardisation tool is the World Health Organization's Safe Surgery Checklist. Modelled after the checklists that pilots use throughout every flight, it lists a series of simple actions that should be taken before the patient receives anaesthetic, before the operation starts, and before the patient is moved from the operating theatre. Each item on the list is something blatantly obvious – checking the patient's identity, confirming the type of operation that is planned, and so forth. Without the checklist, each of these things is done most of the time – but not all of the time. The checklist ensures that they are done all of the time – to avoid the occasional instance, as happens, in which nobody properly checks the operation type, and the patient has the wrong operation.

Care bundles are a concept that in recent years have brought higher quality to the areas of care where they have been used well. They help clinicians to reliably give every element of best practice treatment for common conditions such as pneumonia. The evidence is clear: they save lives. Without them, patients get best, safest practice only some of the time and those who do not are the unlucky ones who can suffer greatly as a consequence.

Checklists and care bundles are not widespread in healthcare primarily, because they are counter-cultural. Doctors' training, in particular, emphasises the importance of retaining knowledge, of autonomy, and of variation between patients. All of these go against the idea of standardisation.

The concept of standardisation does not just relate to novel methods like checklists or care bundles. It is also concerned with all patients with a particular disease receiving a consistent process of care based on best practice internationally. The idea that people with conditions like bowel or oesophageal cancer should be receiving different treatment based on clinical preference or where they live is a disgrace. Healthcare should not be a lottery.

The best healthcare systems in the world have a high degree of standardisation. Not for everything – but for the areas of care where the evidence shows that it makes a difference. They have a substantial number of care pathways, checklists, and care bundles. This does not leave the clinicians without a job – far from it. Their judgement is vital in deciding which pathway, checklist or care bundle to use, and in spotting the cases in which a standard approach is not appropriate. They still spend the majority of their time working without reference to any of these things, but use them whenever they are needed.

Northern Ireland has some good examples of work in this area, including the rollout of a National Early Warning System for acutely ill patients, a care bundle for sepsis, an insulin passport, and regional chest drain insertion training. However, the opportunity for standardisation is much greater and needs to be applied at a more fundamental level, which influences the model of practice beyond this series of individual initiatives. There is not yet a critical mass of clinicians clamouring for more standardisation. There are multiple examples of different Trusts approaching the same clinical scenario in different ways, and wanting to retain their autonomy to do so. If Northern Ireland wants to be anything like as good on safety, clinical effectiveness and patient experience as the Cleveland Clinic and other centres of excellence, it needs to be more open to big change.

4.3.5 The recipe for success

There is little doubt that quality and safety are not fully embedded in the planning, design and delivery of services in Northern Ireland. More sleep is lost over budgets than about whether patients are treated with dignity and respect, whether outcomes of care are genuinely world class and whether patients are properly protected from harm when they are being cared for.

Four vital, and often superficially treated, ingredients for quality and safety improvement are: clinical leadership, cultural change, data linked to goals, and standardisation. They are highly inter-linked.

The Northern Ireland care system is not seeing the wood for the trees on these ingredients. The *Quality 2020* strategy cites them (and does set some big goals), but they are not held as central and are therefore somewhat lost. They need to be given far more prominence, because they form the bedrock on which all quality and safety improvement is built.

With focused effort, Northern Ireland could: build a cadre of skilled clinical leaders; develop a culture in which quality improvement is second nature; set big goals; establish the information technology systems required to measure quality locally and in real-time; and standardise processes substantially. If the care system makes these activities central to its quality and safety efforts, improvement will follow and will flourish. Without building this bedrock, no other efforts to improve quality and safety will gain any significant purchase.

4.4 EXTRACTING FULL VALUE FROM INCIDENTS AND COMPLAINTS

Most patient safety programmes have at their core a process to capture and analyse errors and accidents that arise during the provision of care. This is based on the long-established premise that only by learning from things that go wrong can similar events be prevented in the future. To some extent, this draws on the experience of other industries that have successfully reduced accidents and risk year-on-year. This thinking has led to the establishment of incident reporting systems in health services across the world, some operating only at the level of healthcare organisations, some encompassing whole countries and some restricting reports to those within one field of medicine (e.g. surgery).

It is not always appreciated that reporting of incidents (which can be voluntary or mandatory) is only one way of assessing harm in the care of patients. Numerous other approaches have been used, including: prospective observation of care processes; trigger tools involving retrospective case note review; expert case note review; Hospital Standardised Mortality Ratios (and similar metrics); and mining electronic hospital databases.

Alongside Northern Ireland's incident reporting systems runs a complaints system. Globally, surveys have consistently shown that what patients want from a complaints system are: an explanation, an apology, and a reassurance that improvements to the service will be made based on their experience. Other jurisdictions have found that the features of a good complaints system are: satisfactory local resolution of the majority of complaints; speedy response times; excellent communication with patients; good record keeping; apologies made in-person by the senior staff involved not on their behalf; accurate monitoring of the numbers and categories of complaint; effective learning at the local and systemic level.

All these systems have a common primary purpose: to improve the quality of care, and to reduce avoidable harm.

4.4.1 Incident reporting elsewhere

Globally, incident reporting systems vary greatly in: the nature of the data captured, the extent of public release of information, whether reporting is voluntary or mandatory, and the depth of investigation undertaken.

Most reporting systems start by defining in general terms what should be reported. Terminology varies; *adverse event, incident, error, untoward incident* are all in common use internationally. The epithet serious can be applied to any of the terms. The largest national system in the world was established in the NHS in England and Wales as a result of the report *An Organisation with a Memory.* From 2004 until recently, it was run by an independent body, the National Patient Safety Agency, and is called the National Reporting and Learning System. NHS staff are encouraged to make an incident report of any situation in which they believe that a patient's safety was compromised.

In this system, a *"patient safety incident"* is defined as *"any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS care."* Reports are first made to a local NHS organisation and then sent in batch returns by the local risk manager to the national level. Staff make a small number of reports electronically directly to the National Reporting and Learning System. The information required covers: demographic and administrative data; the circumstances of occurrence; a categorisation of causation; an assessment of the degree of harm as "no", "low", "moderate", "severe", or "death"; and action taken or planned to investigate or prevent a recurrence. These data are captured in a structured reporting form, but there is also a section of free text where the reporter is asked to describe what happened and why they think it happened. Data are anonymised to remove the names of patients and staff members.

In just over a decade, covering the NHS in England and Wales, nearly 10 million patient safety incidents have accumulated in this database. Since 2012, it has been mandatory to report all cases of severe harm or death. It remains voluntary to report all other levels of harm.

During the period of its existence, the National Patient Safety Agency in England and Wales issued 77 alerts and many other notices about specific risks, most of which had been identified by analysis of patient safety incident reports. New arrangements for issuing alerts are in place following the abolition of the National Patient Safety Agency.

This system of incident reporting in England and Wales holds a huge amount of data but only a small proportion of it is effectively used. It is currently being reviewed and is unlikely to continue in exactly the same way.

Worldwide, the problems associated with incident reporting are remarkably consistent, whatever system design is adopted. Firstly, under-reporting is the norm, although its degree varies. This seems to depend on the prevailing culture and whether incidents are seen as an opportunity to learn or as a basis for enforcing individual accountability and apportioning blame. It also depends on staff perceptions about the difference their report will make and how easy it is for them to convey the information that they are required to. Reporting rates are much lower in primary care services than in hospitals. Secondly, given the volume of reports made, there is often insufficient time, resource and expertise to carry out the depth of analysis required to fully understand why the incident happened. Thirdly, the balance of activity within reporting systems goes on collecting, storing, and analysing data at the expense of using it for successful learning. Indeed, there are relatively few examples worldwide of major and sustained reductions in error and harm resulting because of lessons learnt from reporting.

4.4.2 Incident reporting in Northern Ireland

Incident reporting began in the Northern Ireland health and social care system in 2004. Two categories of incident were established: *an adverse incident and a serious adverse incident.* The former were reported and investigated locally within each Trust. The latter were documented and investigated locally but also had to be reported to the Department of Health, Social Services and Public Safety. Staff make 80,000 to 90,000 adverse incident reports each year. Over 400 Serious Adverse Incident reports were made in 2013. In the five-year period from 2009, the number of Serious Adverse Incidents related to Emergency Departments rose from 8 to 36.

An adverse incident is defined as:

"Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation."

In 2010, major new guidance was issued passing responsibility for managing and further developing the serious adverse incident system to the Health and Social Care Board, where it remains to this day. Further guidance was issued in 2013 with new reporting rules.

To be regarded as a Serious Adverse Incident for reporting purposes, the incident must fall into one of the following categories: the serious injury or unexpected/unexplained death of a service user, staff member or visitor; the death of a child in health or social care; an unexpected serious risk to a service user and/or staff member and/or member of the public; an unexpected or significant threat to service delivery or business continuity; serious self-harm or assault by a service user, staff member, or member of the public within a healthcare facility; serious self-harm or serious assault by any person in the community who has a mental illness or disorder and is in receipt of mental health and/or learning disability services, or has been within the last twelve months; and, any serious incident of public interest.

Any staff member may report an adverse incident. The reporter is not asked to make a judgment about whether the incident meets the serious adverse incident criteria. A responsible manager makes it based on their reading of the incident and application of the guidelines. Any Serious Adverse Incident must be reported to the Health and Social Care Board within 72 hours. A subset of Serious Adverse Incidents must be simultaneously reported to the Health and Social Care Board and the Regulation and Quality Improvement Authority.

Trusts in Northern Ireland differ slightly in the procedure adopted for encouraging, receiving and investigating incident reports. Generally, all staff are encouraged to make reports as a way of making care safer. They complete an incident report and submit it to the Trust's risk management department so that it can be entered into the risk management database. Increasingly, more reports are being made on-line which cuts out the laborious form-filling which is an undoubted barrier to staff making a report and often leads to paper mountains in the risk management department. Trusts vary in the proportion of incidents that they investigate, the depth of that investigation and the extent to which action is agreed and implemented. Clinical governance committees (or their equivalents), sub-committees of the Trust board or the Board itself usually look at a selection of individual incident reports, at aggregated incident data or at both.

The number of Serious Adverse Incidents varies between Trusts (Figure 1). To some extent this reflects their differing number of patients. However, there is no way of knowing at present whether a higher level of incidents means that the organisation is less safe than others or that it is more safe and that its staff are more conscientious in making reports so that learning can improve patient safety. Whilst data are available on Serious Adverse Incident types, the categories and classifications used do not make it easy to aggregate data in a way that enables systemic weaknesses to be identified. Opportunities are therefore being lost for surveillance of patient safety across Northern Ireland.

The vast majority of Serious Adverse Incidents are reported by the five acute Trusts. Much smaller numbers are reported by the ambulance service and by primary care (Figure 2). The number of incidents reported has increased quite substantially from 2013 to 2014 (Figure 3). In part this is because of improved awareness of the reporting system. In part it is because the reporting criteria were changed – most notably, requiring that all child deaths be reported.

Figure 1. Serious Adverse Incident reports: by Trust

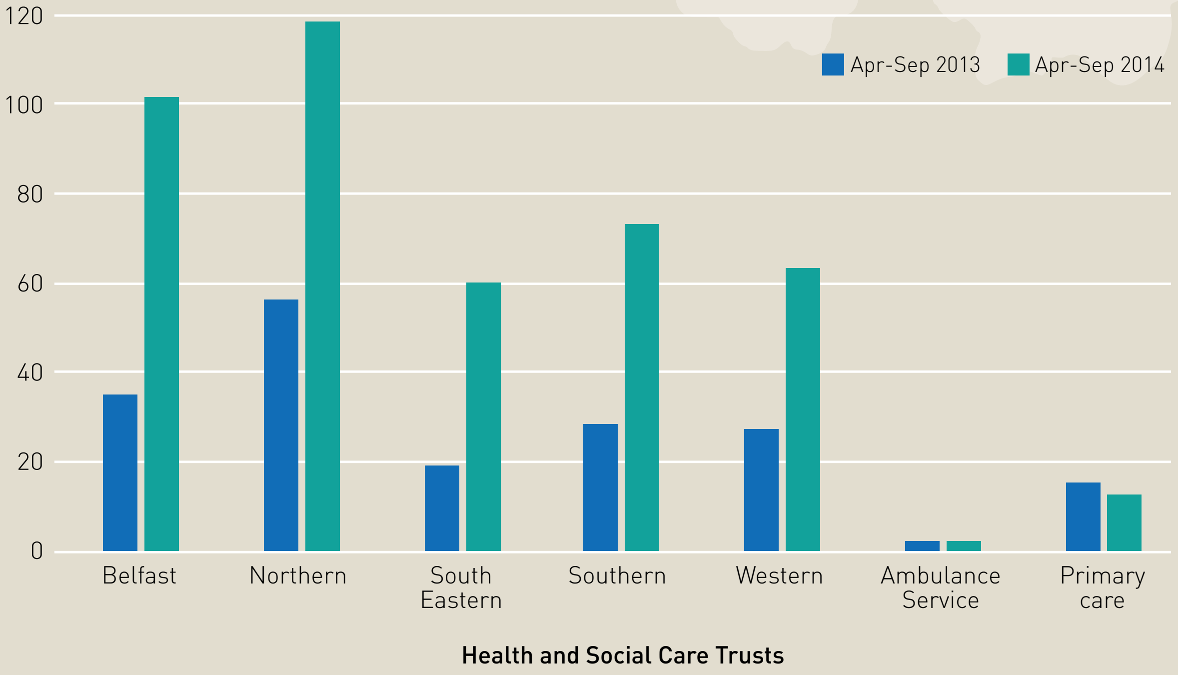
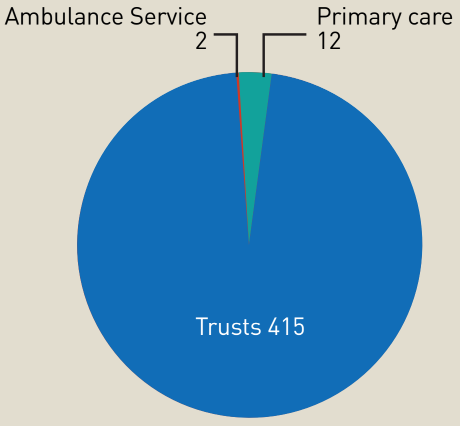
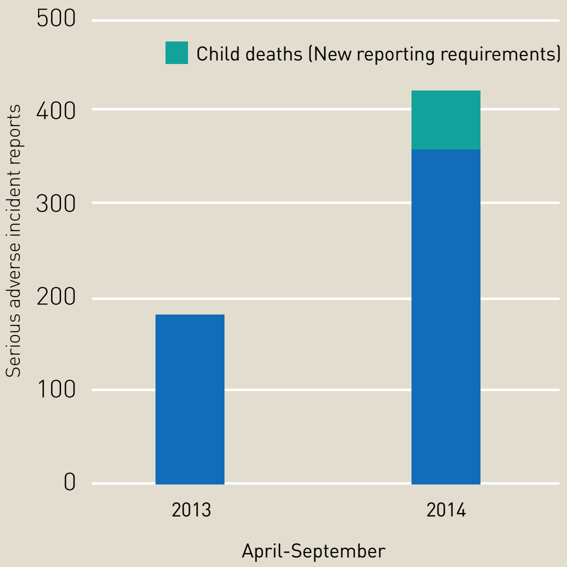


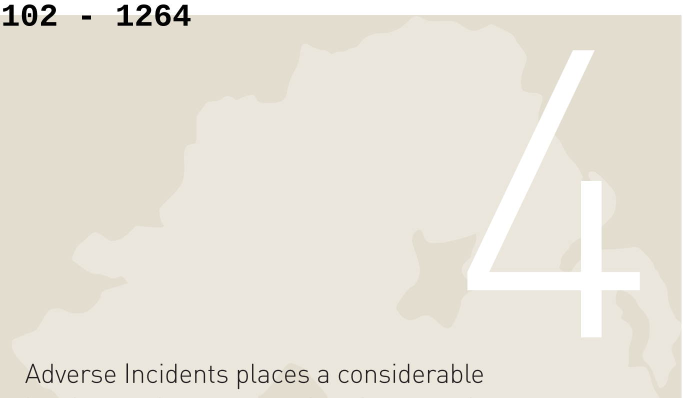
Figure 2. The great majority of Serious Adverse Incident reports are made by the Health & Social Care Trusts



Serious Adverse Incident Reports, Apr-Sept 2014

Figure 3. Serious Adverse Incident reporting increased between 2013 and 2014. Some of the increase was because reporting criteria changed, particularly introducing a requirement to report all child deaths.





All Serious Adverse Incidents are investigated. The type (and therefore intensity) of the investigation should depend on the severity of the incident, its complexity, and the potential to learn from it. Three levels of investigation are stipulated:

- *Level 1* involves a Significant Event Audit – a method of assessing what has happened and why, agreeing follow-up actions, and identifying learning.
- *Level 2* involves a Root Cause Analysis – a more detailed exercise to determine causation and learning, undertaken by a formal investigation team chaired by somebody not involved in the incident.
- *Level 3* involves a full-blown independent investigation.

Most Serious Adverse Incidents start at Level 1 investigation, and may proceed to Level 2 or 3 if the Level 1 investigation suggests that this is necessary or would be useful. A minority start at Level 2 or 3 immediately, bypassing Level 1.

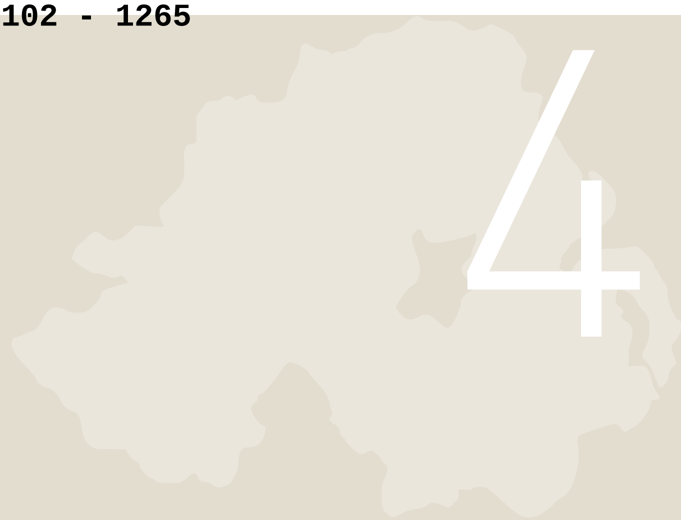
A Designated Review Officer, assigned by the Health and Social Care Board and Public Health Agency, provides independent assurance that an appropriate level of investigation has been chosen, and that it is conducted appropriately.

The process of dealing with Serious Adverse Incidents at the operational level of the service is very involved and highly regulated with little room for flexibility. There are a number of decision-making points at which important judgments must be made by staff on matters such as what level the incident falls into and whether to refer an incident to the coroner.

4.4.3 Frustrations with the incident reporting system

The staff who use the incident reporting system have concerns and frustrations. Firstly, at the policy level, the requirements to report Serious Adverse Incidents places a considerable burden on them to complete forms and meet deadlines, with very little flexibility to deviate from the proscribed procedure. There is an acceptance by staff that it is important to document and investigate Serious Adverse Incidents but the pressure to complete all the steps of the process often means that there is no time to reflect on what can be learned so as to reduce risk for future patients. One of the Serious Adverse Incidents that the Review Team discussed with Trust staff had involved interviews with 34 different people. It was by no means the most complex incident that the Review Team heard about.

There is an almost universal view that the requirement to report and investigate all child deaths in hospital as Serious Adverse Incidents has been a retrograde and damaging policy decision. The consequence of it has been that, if a child dies from a cause such as terminal cancer or a congenital abnormality, a grieving family must be advised that there is to be an investigation. Inevitably, this strongly implies that the service has been at fault. Such an approach is not kind to such families, puts staff in a very difficult position, and diverts attention from the investigation of genuinely avoidable incidents involving the care of children. In a separate aspect of incident policy, many staff working within the mental health field have concerns about the inflexibility of the Serious Adverse Incident scheme as it applies to suicide of their patients. Whilst the time-scales for investigation impose a necessary discipline on the process generally, the range of factors, individuals and agencies that need to be part of the determination of the root causes of the suicide of a mental health patient are very great indeed. The pressure to adhere to statutory deadlines can mean that the work in such cases can sometimes be incomplete and so has limited value in preventing recurrences.



Secondly, at the cultural level, some medical, nursing and social care staff are concerned that, in reporting an adverse incident, they will expose themselves to blame and possible disciplinary action. Junior doctors told the Review Team that making too many reports draws suspicion that they are trouble-makers and that an active interest in patient safety could damage their career prospects. They prefer to make their views on patient safety known through the medical trainee annual survey (Figure 4), where they can remain anonymous.

Figure 4. Percentage of medical trainees reporting concerns about patient safety and the clinical environment

Trust:	Belfast	Northern	South Eastern	Southern	Western
Patient safety	6.5%	6.8%	3.0%	4.7%	3.2%
Clinical environment	2.8%	3.6%	0.8%	1.4%	0.4%
Total	9.3%	10.4%	3.8%	6.0%	3.7%

Source: General Medical Council National Training Survey 2013. Numbers are rounded.

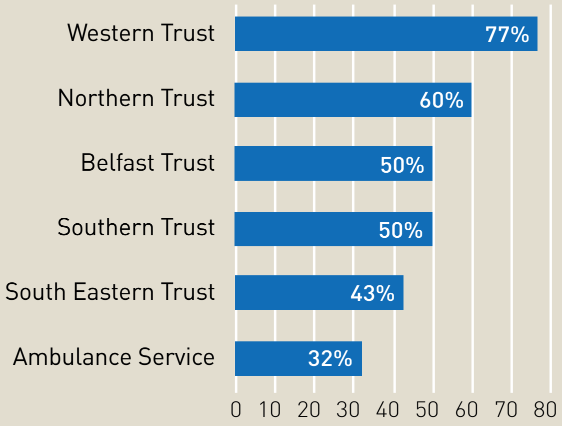
These cultural barriers to reporting and learning are not unique to Northern Ireland. Creating a culture where the normative behavior is learning, not judgment, is very much the responsibility of political leaders, policy-makers, managers and senior clinicians. This does not mean that no-one is ever accountable when something goes wrong but it does mean that a proper regard should be given to the overwhelming evidence that a climate of fear and retribution will cause deaths not prevent them.

Thirdly, at the operational level, staff frustrations with the incident reporting processes range from the very practical, such as not being able to find the form necessary to make the report, to the deeper de-motivating features of the system such as never receiving any feedback or information on the outcome of the report that they had made. Other weaknesses of the process perceived by staff include: having little training in how to investigate properly, reporting an incident then being asked to investigate it yourself, and a tendency for investigations to descend into silos even though there might have been a multi-specialty element to the patient's care.

4.4.4 The complaints system in Northern Ireland

Patients, their carers, and their families can make a complaint about the services received in person, by telephone or in writing. If the complaint concerns the health or social care services delivered by one of the six Trusts in Northern Ireland, a senior officer within the organisation will work with the staff involved in the person's care to investigate and produce a response. A letter from the chief executive officer of the Trust must go to the complainant within 20 working days. However, performance is suboptimal and very variable in this respect (figure 5).

Figure 5. All Trusts are failing to meet the standard 20-day substantive response time for complaints (% meeting standard shown; 2013-14)



The best outcome is for the complaint to be resolved locally to the complainant's complete satisfaction. This is not always possible and if the complainant is not satisfied with the response, the complaint can be re-opened and further investigation can be undertaken or external advice sought. If this still does not resolve the complaint, the complainant can make a submission to the Ombudsman. He will look at whether the process of responding to the complaint was undertaken appropriately. He can also investigate the substance of the complaint but under present legislation, he cannot make these reports public. This bizarre situation means that the public is unaware of where standards have fallen short and what the Ombudsman thinks should be done.

An increasing number of people who have complaints contact The Patient and Client Council asking for help. The Council does not have powers to investigate complaints, only to provide support. Nearly 2000 complainants contacted the Council last year. Many such contacts were from people who had tried to navigate the complaints system alone and had had difficulties. The Patient and Client Council's involvement often helps in facilitating resolution of the complaint, sometimes by arranging meetings of the two sides.

Complaints about primary care are handled somewhat differently. They are raised with the Health and Social Care Board directly. The number of complaints from primary care is lower than might be expected. This may reflect the reluctance of patients to complain about a service that they are totally reliant on.

4.4.5 Involvement of the coroner

Northern Ireland, like elsewhere, is still grappling with a difficult question: what is the appropriate role for the Coroner in the investigation of deaths that may have been caused, at least in part, by patient safety problems? This is not an easy question. It is difficult to create guidance that precisely defines which deaths should be investigated by the coroner and which should not. And Coroner's inquests have major pros and cons.

When somebody dies and their care may have been perceived as poor, some families call for a Coroner's inquest. The positive elements of this are that the Coroner is independent of the health and social care system, has clear legal powers, and is skilled in the investigation of deaths.

On the other hand, conducting an inquest into every Serious Adverse Incident that results in a death would be a resource-intensive undertaking. It also may not result in the most effective learning. Few could honestly say that the courtroom environment does not intimidate them. It is not the easiest place to build a constructive relationship between the clinicians involved in the care of the deceased and the deceased's family. It is not the most conducive environment to open, reflective learning.

In cases of negligence or gross breaches of standards of care, it is very clear that referral to the Coroner is the most appropriate course.

At the other end of the spectrum, in a few cases there is a Serious Adverse Incident at some point during a patient's care and this patient subsequently dies, but the death is entirely unrelated to the incident and so an inquest is really not warranted. In between these two extremes lies a substantial grey area, in which the relative merits of a Coroner's inquest and an internal Serious Adverse Incident investigation are debatable. This is not only the case in Northern Ireland, but across the United Kingdom as a whole (except that Scotland does not have a Coroner).

This is a complex issue. Currently only a subset of the deaths that could be the subject of a Coroner's inquest actually become so. Some are not reported to the coroner's office (largely appropriately, it seems) and some are discussed with the coroner's office but not listed for inquest. In other words, the judgments of clinicians and coroners' officers alike have a substantial bearing on which cases proceed to inquest. The subset of cases that end up in front of a coroner's inquest are also determined as much by family's wishes as by the content of the cases.

To some this may sound shocking but, given the complexity of the issues involved, the status quo is not entirely unreasonable and is in line with practice internationally. But the status quo is certainly not ideal. There is substantial room for improvement, so that the coroner can more optimally contribute to the system's learning.

4.4.6 Redress

The creation of financial, and other new, forms of redress would have to be linked to the handling of complaints, incidents and medical negligence claims in a whole systems manner. This is a highly complex area that was extensively examined in England in the report *Making Amends*. In the end, the central idea of introducing some payments for victims of harm and recipients of poor quality care, as well as potential litigants, was not taken forward. There were sound principles behind the proposals, but there was a leap-in-the-dark element too. Priority was given instead to action to improve the quality and safety of care and to improve responses to complaints. However, one of the other proposals of *Making Amends*, the introduction of a Duty of Candour, is finally being implemented in England. The Review Team considers that priority in Northern Ireland should be given to the areas covered by its recommendations, to making important changes to generate safer higher quality care, rather than embarking on new policies for redress, including financial compensation.

4.4.7 The nature of learning

The whole question of how *learning* takes place in healthcare through the scrutiny and analysis of incident reports or through their investigation has been little debated. Indeed, the term learning itself is very loosely applied in this context. Strictly applied, it would mean acquiring new knowledge from incidents about how harm happens. Yet, the way in which the word learning is repeatedly used in the context of patient safety is more than increasing understanding. It implies that behaviour will change or actions will be taken to prevent future harm. Unfortunately, although there are some exceptions, there is little evidence that major gains in the reduction of harm have been achieved in Northern Ireland or in many other jurisdictions through the so-called learning component of patient safety programmes.

In Northern Ireland, the main formally-identified processes for reducing risk or improving patient safety, aside from action plans derived at Trust level, are:

- the production of learning letters
- the bi-annual Serious Adverse Incident Learning Report
- the circulation of newsletters such as *Learning Matters*
- thematic reviews
- training and learning events

- implementing the recommendations of reviews and inquiries
- disseminating alerts and guidance imported from other parts of the United Kingdom or further afield.

On many, perhaps most, occasions when something goes wrong, the potential for learning from this is very rich indeed. This potential too often goes unrealised. This is a problem not just in Northern Ireland, but in care systems worldwide.

Three features determine the extent to which investigation of an adverse event results in risk being reduced:

- How deep the investigation gets, in understanding the true systemic issues that helped something go wrong
- How systemic the investigation's focus is, in considering where else a similar problem could have occurred beyond the local context in which it did occur
- How strong the corrective actions are in actually, and sustainably, reducing the risk of a repeat

The first of these, depth of investigation, is done reasonably well. A decade ago, harm was often put down to 'human error'. There is now far greater recognition that this is a superficial interpretation – that there are almost always problems within the system which not only allowed that harm to occur but made it more likely. The technique of root cause analysis is widely used in Northern Ireland, and helps to uncover some of the causal elements. Often, though, it does not find the deeper reasons. This is partly because of the time pressures to finish the investigation, partly because not all staff have had the necessary training to do this deeper analysis, and partly because of a lack of human factors expertise in the process. Also, many hospital incidents involve primary care in the chain of possible causation, yet primary care staff play a minor, or no, role in many investigations.

In relation to the systemic view, when a problem occurs, there is too great a tendency to investigate that specific problem, without looking for the broader systemic issues that it highlights. Problems are often addressed in the department where they occur, without asking whether they could have occurred in other departments, for example. Similarly, if a medication incident occurs, there is a tendency to fix the problem for that medication, without looking at whether there is a problem for similar medication or routes of administration.

This narrow, reactive approach fails to make full use of incident reports. In short, it reflects an erroneous assumption that the system as a whole is working fine, and that the problems that allowed the event to occur are specific, local ones. This is not the case. There are systemic problems through the health and social care system. Incidents of harm are distributed largely by chance – by location and by type. Fixing each specific problem is like playing "Whack-A-Mole" – it does not get to the nub of the issues.

The ultimate aim of investigation is to reduce the risk of harm, not simply to understand what went wrong. Corrective action is too often inadequate. There is no automatic link between understanding what went wrong and being able to reduce the risk of it happening again. Indeed, making the leap between investigation and risk reduction is really very challenging.

In Northern Ireland, the action lists that are generated by Serious Adverse Incident investigation commonly feature plans of the following kinds:

- Making staff aware that the incident took place
- Explaining to staff what went wrong
- Circulating a written description of the incident and actions taken to other parts of the health and social care system to share the learning

Such information sharing actions should form part of the plan but they do not amount to systemic measures that will reliably and significantly reduce the risk to patients.

Research and experience outside health care has shown that safety comes down to appreciating that big improvements are not made by telling people to take care but by understanding the conditions that provoke error.

Action plans often also feature some change to current paperwork or introduction of new documentation. This, too, is very reasonable but often has a weak impact on outcomes. It also has the important downside that mounting paperwork reduces the time for patient care and introduces complications of its own.

So what do strong corrective actions look like? Technological solutions have an important role to play. Electronic prescribing systems, patient monitoring systems, and shared care records can address multiple patient safety issues simultaneously (although their implementation and use is not without risk). Policies, rules, and checklists can also be useful, but are easy to implement badly and more difficult to implement well.

As discussed earlier in this Report, one area of high potential is the use of standardisation of procedure. It is underutilised in healthcare worldwide but where it is applied it has brought results. Standardisation of procedure is a mainstay of safety assurance and improvement in other sectors.

In large part, though, healthcare systems worldwide are not yet good at implementing solutions that will truly reduce risk. It is not the case that Northern Ireland is lagging behind – but that Northern Ireland is struggling with this problem alongside other countries.

Identifying the systemic issues and identifying strong corrective actions: each of these is tough; an art and a science in itself; an area in need of intense and rigorous study. Until these issues are tackled head on, in Northern Ireland and elsewhere, the system's learning when things go wrong will fall short.

When something goes wrong, patients and families ask for reassurance that it will not happen again. As it stands, nobody can honestly provide this reassurance. In fact, it is difficult even to say that the risk has been significantly reduced – let alone to zero. This needs to change.

4.4.8 Strengths and weaknesses of Northern Ireland's systems for incident reporting and learning

No system of reporting and analysing patient safety incidents is perfect. In an ideal world, all events and occurrences in a health service that caused harm or had the potential to cause harm would be quickly recognised by alert, knowledgeable front-line staff who would carefully document and communicate their concern. They would be enthusiastic about their involvement in this activity because they would have seen many examples of how such reports improved the safety of care. The resulting investigation would be impartial and multi-disciplinary, involving expertise from relevant clinical specialties but, crucially, also from other non-health disciplines that successfully contribute to accident reduction in other fields of safety. Investigation would be carried out in an atmosphere of trust where blame and retribution were absent, and disciplinary action or criminal sanctions would only be taken in appropriate and rare circumstances. Action resulting from investigation would lead to re-design of processes of care, products, procedures and changes to the working practices and styles of individuals and teams. Such actions would usually lead to measurable and sustained reduction of risk for future patients. Some types of harm would be eliminated entirely.

Very few, if any, health services in the world could come anywhere near to this ideal level of performance in capturing and learning from incidents of avoidable harm. This is so for all sorts of reasons ranging from an insufficiency of leaders skilled and passionate enough to engage their whole workforces on a quest to make care safer, through an inability to investigate properly the volume of reports generated, to the weak evidence-base on how to reduce harm.

The system of adverse incident reporting in Northern Ireland operates to highly-specified processes to which providers of health and social care must adhere. The main emphasis is on the Serious Adverse Incidents. The requirements laid down for reporting, documenting and investigating such incidents together with the rules for communicating about them and formulating action plans to prevent recurrence have created an approach that has strengths and weaknesses (Figure 6). In general, the mandatory nature of reporting means that there is likely to be less under-reporting than in many other jurisdictions. However, staff in Trusts must exercise judgment on whether to classify occurrences of harm as Serious Adverse Incidents. Whether they always make the right decision has not been formally evaluated. The Review did not find any evidence of suppression or cover-up of cases of serious harm.

Figure 6. Serious Adverse Incident reporting system in Northern Ireland: Strengths and weaknesses

Dimension	Strengths	Weaknesses
Accountability	Absolute requirement to report and investigate	Creates some fear and defensiveness
Coverage	Relatively high for serious outcomes	Less attention given to incidents with lower harm levels
Timescales	Clear deadlines for investigation and communication	Pressure to meet deadlines leaves little time for reflection
Investigation	Reasonable depth with frequent root cause analysis	Quality variable and little use of human factors expertise
Staff engagement	All appear to understand the importance of reporting	Do not often see the reports translating into safer care
Patient and family involvement	Requirement to communicate reinforced by checklist	Often creates tension and little ongoing engagement
Learning	Specified action plan required in every case	Not clear whether action is effective in reducing future risk

Tight time-scales are laid down for the various stages of handling a Serious Adverse Incident. These generally add a necessary discipline to a process that in other places can become protracted or drift off-track. There is a need, though, for some flexibility where an investigation requires more time. This is particularly so in the mental health field where the avoidable factors in a death can be very complex and are only discernible after interviewing very many people.

It is important to recognise that, whilst almost all of the experience and research literature is about patient safety, Northern Ireland has an integrated health and social care system. Social care in the United Kingdom has its own traditions in recognising, investigating and learning from episodes of serious harm involving those who use its services; the fields of child protection and mental health exemplify this. It is not entirely straightforward to integrate incidents in social care into the overall patient safety approach but the essential principles and concepts are little different.

The Northern Ireland health service falls short of the ideal just as do most other parts of the United Kingdom and many other places in the world. In all of these places, including Northern Ireland, patients are dying and suffering injuries and disabilities from poorly designed and executed care on a scale that would be totally unacceptable in any other high-risk industry.

The Northern Ireland approach to incident reporting and learning does not make its services any less safe than most of the rest of the United Kingdom or many other parts of the world. However, this should not be a reason for comfort, nor a cause for satisfaction.

The current requirement for all child deaths to be reported and managed as serious adverse incidents seems to be doing far more harm than good. It is distressing for families, burdensome for staff, and is not producing useful learning.

The ethos of improving safety by learning from incident investigations needs to shift:

- Away from actions that only make a difference in the particular unit where the incident occurred, towards actions that also make a difference across the whole of Northern Ireland
- Away from actions that only target that particular incident, towards actions that also reduce the risk of many related incidents occurring
- Away from weak actions such as informing staff, training staff and updating policies, towards stronger actions of improving systems and processes
- Away from long lists of actions, towards smaller numbers of high-impact actions

Less attention has been given in Northern Ireland to adverse incidents that do not meet the definition of a Serious Adverse Incident. They are reported, analysed and acted upon at Trust level. Only exceptionally are they considered centrally. The numbers are much greater so the logistics of analysing more would be considerable. However, there is much to be learned from situations when something went wrong in a patient’s care but they did not die or suffer serious harm.

4.5 THE BENEFITS AND CHALLENGES OF BEING OPEN

The health and social care system aspires to a 'no blame' culture, or a 'just' culture, in which staff can be open without fear of inappropriate reprisal. In reality, this is not the culture that currently exists. This is not primarily the fault of those delivering health and social care.

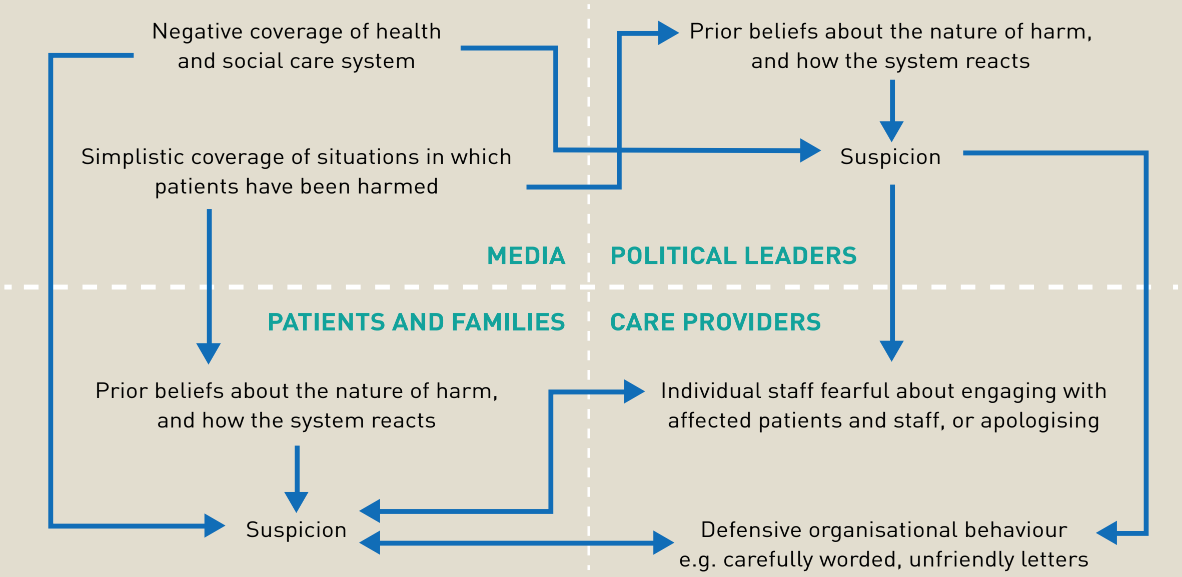
Openness is not something that can simply be demanded. It needs the right conditions in order to flourish. The enemy of openness is fear.

When something goes wrong, many patients' and families' first reaction is to want to know who is to blame. The situation often escalates, with the media coverage and political pressure that the detail of the story generates. In an ideal world, leaders of the system should be able to step in to paint a proper picture of the background to these complex events, and to build public understanding that few are a simple case of incompetence and carelessness. Instead, to remove the heat from the situation, approaches are announced that may not be the most effective way to achieve learning. On top of this, day-by-day the media portrays health and social care in a mainly negative light. There has been one inquiry after another. These are conditions conducive to blame and fear, not to transparency and openness.

Despite these adverse conditions, the Review Team found front-line staff willing to talk about problems, and to be open with families and patients when things go wrong. There is a willingness to be open – but there is blame, and there is fear.

Northern Ireland needs to increase the degree of openness and transparency in talking about harm, and decrease the degree of blame and fear. The responsibility cannot lie solely within the health and social care system. They are complex cycles.

Figure 7. The vicious cycle of suspicion and fear



Openness and transparency, blame and fear: these are multi-dimensional issues that cannot be improved directly by legislation, rules or procedures alone. As this Report has made clear, Northern Ireland is far from unique.

4.5.1 Governance arrangements to promote openness

Promoting openness and avoiding fear is about culture. Responsibility for this sits with many people, within and beyond the health and social care system. Governance may sound like a blunt tool and, used alone, it would be. But alongside other approaches, appropriate governance arrangements can promote openness and dispel fear.

The Serious Adverse Incident process currently requires Trusts to inform affected patients (or families) that their care is the subject of investigation. In general, they are invited to provide input and are provided with a copy of the investigation report. A checklist has been introduced to prompt investigators to take these steps. This is commendable, and represents a basic, but important, degree of openness with patients and families.

The nature of the involvement with patients and families in the aftermath of a Serious Adverse Incident cannot be shaped by a checklist alone. The Review Team heard from each of the Trusts how they handled this aspect of the policy. It is clear that this is a difficult area to get right. Early contact with the family in the event of a death is important but could come at a time when funeral arrangements are being made and perceived as intrusive or insensitive. The bureaucracy of the procedure can create an official feeling that opens up distance in the relationship with the family. It is important that staff in the Trust have the skill, experience and credibility to communicate with a family. It is helpful to have staff who deal with this situation regularly and have good inter-personal and counselling skills. They should be there with the clinical staff who may encounter the situation less frequently. Experience from elsewhere suggests that regular contact with the patient and family is important, not just a couple of one-off meetings with long silences in between. In the best services, the patient and family are fully involved in the process of learning and action-planning. Where this happens, it is empowering for everyone. This is only happening to a limited extent in Northern Ireland currently.

The Serious Adverse Incident process is also overseen by a Designated Review Officer within the Public Health Agency. This is also a welcome feature of the system although there is potential for these officers, or their function, to play a more substantial role.

Every Trust has appropriate arrangements for Serious Adverse Incidents to be discussed within the departments affected. The fact that these conversations are taking place usefully promotes a culture in which talking about harm becomes easier, and openness becomes the norm.

Every Trust also has arrangements for organisation-level oversight of this process. In most, this responsibility sits with a sub-committee of the Trust board. This too is good practice.

When something goes wrong, there is a tendency for the Department of Health, Social Services and Public Safety to deal directly with the Trust's Executive Team, bypassing the board. This happens partly from expediency – because the executive directors are present full-time, and are therefore available to take an urgent phone call from an official concerned about briefing the minister. But it serves to diminish the role of the board, and misses opportunities to build the board's familiarity with these issues and capability in dealing with them.

There is great concern and depth of feeling amongst staff in the system who have attempted to uncover poor standards of care and been denigrated. Their role as whistleblowers has placed them in an even more isolated position. This unsatisfactory situation needs to be resolved.

4.5.2 Perceptions of openness

The Serious Adverse Incident guidelines include some requirements intended to help openness and transparency. A recent look-back exercise, quality controlled by the Regulation and Quality Improvement Authority, suggests that patients and families are being appropriately informed when a Serious Adverse Incident occurs. This creates a substantially higher degree of openness than is the case in many countries worldwide. In the main, the Trust staff who are leading the investigation are willing to spend time meeting with patients and families.

However, several features of the investigation process too often give patients and families an adverse impression:

- The investigation process is frequently delayed beyond the stipulated timeline, and patients and families experience delays in getting responses to calls and emails. Such delays make people start to wonder, "what is going on?"
- When the investigation process starts, the degree of openness and transparency that the patient and/or family feel they are seeing is highly dependent on the communication skills of the Trust staff that they meet with. Some staff are highly skilled in these potentially difficult meetings; others are not.
- Standard practice is for patients and families to meet with the manager and/or clinician leading the investigation, and not to be asked whom else they would like to meet with. Many, for example, would find it helpful to meet with the staff directly involved in the incident, to put their questions directly, but this is not routinely offered. Such meetings have the potential to be intensely difficult; to be very useful if they go well, but harmful if they go badly.

4.5.3 Duty of candour

In 2003, the head of the Review Team (as Chief Medical Officer for England) issued a consultation paper, *Making Amends*, which set out proposals for reforming the approach to clinical negligence in the NHS. One key recommendation was that a duty of candour should be introduced.

As long ago as 1987 Sir John Donaldson (no relation), who was then Master of the Rolls, said "I personally think that in professional negligence cases, and in particular in medical negligence cases, there is a duty of candour resting on the professional man". There was, at the time of the *Making Amends* report, no binding decision of the courts on whether such a duty exists.

In November 2014, the General Medical Council and the Nursing & Midwifery Council issued a joint consultation document proposing the introduction of a professional duty of candour. Such a duty will give statutory force to the General Medical Council's Code of Good Medical Practice for doctors.

In the concomitant healthcare organisational measures introduced in England, a new "Duty of Candour" scheme will mean that hospitals are required to disclose information about incidents that caused harm to patients, and to provide an apology.

In Northern Ireland, it is already a requirement to disclose to patients if their care has been the subject of a Serious Adverse Incident report. There is no similar requirement for adverse incidents that do not cause the more severe degrees of harm. In promoting a culture of openness, there would be considerable advantages in Northern Ireland taking a lead and introducing an organisational duty of candour to match the duty that doctors and nurses are likely to come under from their professional regulators.

4.6 THE VOICES OF PATIENTS, CLIENTS AND FAMILIES ARE TOO MUTED

The best services in the world today give major priority to involving patients and families across the whole range of their activities, from board-level policy making, to design of care processes, to quality improvement efforts, to evaluation of services, to working on reducing risk to patients as part of patient safety programmes.

At the heart of the traditional approach to assessing whether a service is responsive to its patients and the public are surveys of patient experience and attitudes. This is still a very important part of modern health and social care. In many major centres whose services are highly rated, such surveys are regularly carried out and used to judge performance at the organisational, service and individual practitioner level, as well as, in some cases, being linked to financial incentives. Indeed, in the United States system, observers say that it was not until surveys of patient experience were linked to dollars that it was taken seriously. This is not a prominent feature of the Northern Ireland system, although there is some very good practice, for example the 10,000 Voices initiative, which has so far drawn on the experience of over 6,000 patients and led to new pathways of care in pain management, caring for children in Emergency Departments, and generally focusing on the areas of dignity and respect.

Looked at from first principles, the kind of questions a user, or potential user, of a service could legitimately require an answer to would include:

How quickly will I first be seen, how quickly will I get a diagnosis and how quickly will I receive definitive treatment?

If my condition is potentially life-threatening, will the local service give me the best odds of survival or could I do better elsewhere?

Will each member of staff I encounter be competent and up-to-date in treating my condition and how will I know that they are?

Does the service have a low level of complications for treatment like mine compared to other services?

How likely am I to be harmed by the care that I receive and what measures does the service take to prevent it?

If I am unhappy with a care-provider's response to a complaint about my care, will the substance of it be looked at by people who are genuinely independent?

Which particular service elsewhere in the United Kingdom, and other parts of the world, achieves the best outcome for someone like me with my condition? How close will my outcome be to that gold standard?

Very few of these questions could be answered reliably in Northern Ireland and other parts of the United Kingdom.

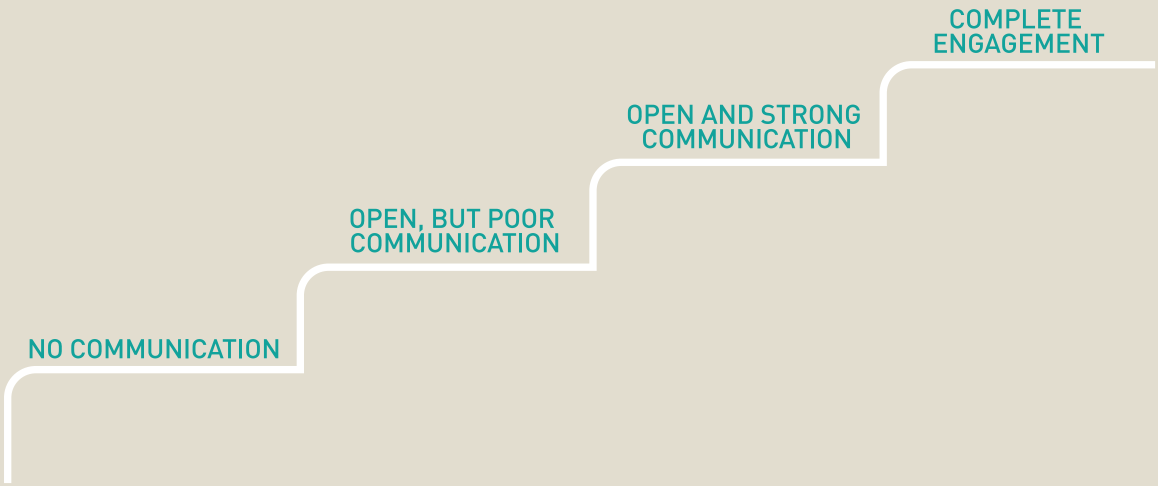
There are many potential themes for patient and family engagement in health and social care, for example:

- in shaping and designing services
- in measuring the quality of care
- in setting standards for consultation
- in shared decision-making
- in self-care of chronic diseases
- in preventing harm
- in giving feedback on practitioner performance

Few services do all of these, some only scratch the surface of genuine involvement, others do a few well. Overall, the Northern Ireland care system is engaged in some of these areas but certainly not in an organised and coherent way.

The terms of reference of the Review put particlar emphasis on harm. Globally, there is a spectrum in how well health and social care systems interact with patients, clients and families when things go wrong (figure 8). The ideal approach is to engage patients and families completely in the process of learning. They often find this hugely beneficial, because it allows them to play an active part in reducing the risk for future patients. It is also immensely powerful for staff, to hear patients' stories first-hand and to work with them to improve things.

Figure 8. Levels of engagement with patients and families when something goes wrong



Northern Ireland should aim for level three as an absolute minimum, but strive for level four.

The system is too often falling down to level two because:

- Staff who communicate with patients and families during the Serious Adverse Incident investigation process have variable communication skills – some are excellent, but some are less good. Little formal effort has been made to train staff to manage these difficult interactions well.
- Patients and families are often not offered the opportunity to meet with those who they would like to – the staff directly involved in the incident. Instead, they tend to meet with managers, and with clinicians who were not involved.
- There are frequently delays in the process of investigating a Serious Adverse Incident.
- Patients and families are too often sent letters filled with technical jargon and legalese.

When something goes wrong, the harm itself is intensely difficult for patients and families. Poor communication compounds this enormously.

5 CONCLUSIONS

5.1 RELATIVE SAFETY OF THE NORTHERN IRELAND CARE SYSTEM

5.1.1 There is some perception amongst politicians, the press and the public that Northern Ireland's health and social care system:

- Has fundamental safety problems that are not seen elsewhere
- Is less safe than other parts of the United Kingdom, or comparable countries
- Suffers from lack of transparency, a tendency to cover-up, and an adverse culture more broadly.

5.1.2 The Review found no evidence of deep-seated problems of this kind. Northern Ireland is likely to be no more or less safe than any other part of the United Kingdom, or indeed any comparable country globally.

5.1.3 This does not mean that safety can be disregarded, because it is clear from reading the incident reports and accounts of patients' experience that people are being harmed by unsafe care in Northern Ireland, as they are elsewhere. Northern Ireland, like every modern health and social care system, must do all it can to make its patients and clients safer.

5.2 PROBLEMS GENERATED BY THE DESIGN OF THE HEALTH AND SOCIAL CARE SYSTEM

5.2.1 There are longstanding, structural elements of the Northern Ireland care system that fundamentally damage its quality and safety. The present configuration of health facilities serving rural and semi-rural populations in Northern Ireland is not fit for purpose and those who resist change or campaign for the status quo are perpetuating an ossified model of care that acts against the interests of patients and denies many 21st Century standards of care. Many acutely-ill patients in Northern Ireland do not get the same standard of care on a Sunday at 4 am as they would receive on a Wednesday at 4 pm and, therefore, a two-tier service is operating. It may be that local politics means that there is no hope of more modern care for future patients and if so this is a very sad position.

5.2.2 The design of a system to provide comprehensive, high quality, safe, care to a relatively small population like Northern Ireland's needs much more careful thought. This applies to almost all aspects of design including: the role of commissioning, the structuring of provision, the relationship between primary, secondary and social care, the distribution of facilities geographically, the funding flows, the place of regulation, the monitoring of performance, and the use of incentives. Nowhere is the old adage: "I would not start from here" truer than in the Northern Ireland care system today.

5.2.3 There is widespread uncertainty about who is in overall charge of the system in Northern Ireland. In statutory terms, the Permanent Secretary in the Department of Health, Social Services and Public Safety is chief executive of the health and social care system but how this role is delivered from a policy-making position is not widely understood or visible enough.

5.2.4 In the specific domain of quality and safety itself, whilst it is reflected in the goals and activities of boards and senior management teams in Northern Ireland, it is not yet fully embedded with the commitment and purpose to make a real difference. The Review was most impressed with the work of the South Eastern Trust in this regard. The Review Team could not assess each Trust in depth, but its judgment on the South Eastern Trust is backed up, for example, by the national survey of trainee doctors.

5.3 FOCUS ON QUALITY AND SAFETY IMPROVEMENT

5.3.1 *Quality 2020* is a ten-year strategy with a bold vision – that the health and social care system should "be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in health and social care". Three years on, there is good evidence of the strategy being implemented. An influential steering group oversees the work.

5.3.2 The Review Team judged that *Quality 2020* represents a strong set of objectives, and that there is clear evidence of extensive work and of some successes in implementation. However, this does not amount to quality and safety improvement being given the primacy of focus that it needs, and Northern Ireland is not seeing the wood for the trees about the need to establish crucial aspects of quality and safety improvement which are not well represented at present: clinical leadership, cultural change, data linked to goals, and standardisation.

5.4 THE EXTENT TO WHICH SERIOUS ADVERSE INCIDENT REPORTING IMPROVES SAFETY

5.4.1 The system of Serious Adverse Incident reporting in Northern Ireland has been an important way to ensure that the most severe forms of harm that are inadvertently caused by care processes are recognised and investigated.

5.4.2 The Serious Adverse Incident process fulfils five main purposes:

- a public accountability function
- a response to the patients and families involved
- a communications alert route
- a barometer of risk within health and social care
- a foundation for learning and improvement

5.4.3 The kinds of incidents reported into this system appear little different to other parts of the United Kingdom and are similar to many other parts of Europe, North America and Australasia. Many harmful events are potentially avoidable and the human cost to patients and families in Northern Ireland is of grave concern, as it is in other jurisdictions.

5.4.4 Good practice elsewhere in the world suggests that patients who suffer harm and their families should be fully informed about what has happened, how it happened and what will be done to prevent another similar occurrence. More than this, they should be fully engaged in working with the organisation to make change. Patient and family engagement is a good and established feature of Serious Adverse Incident reporting in Northern Ireland but it often falls short of this fully engaged scenario. The extent to which it is valued and trusted by patients and families appears to vary, depending on the staff communicating with them.

5.4.5 The design for the specification, and recording, of information on each Serious Adverse Incident is sub-optimal particularly in gathering appropriate information on causation; this hinders aggregation of data to monitor trends and assess the impact of interventions.

5.4.6 The process for investigating Serious Adverse Incidents is clearly set out and involves root cause analysis-type methods. In many cases, it lacks sufficient depth in key areas such as human factors analysis. The degree of oversight by supervisory officials (the Designated Review Officers) is variable in extent and timeliness. Local health and social care staff generally approach the task of investigation conscientiously but many lack the training and experience to reach a standard of international best practice in unequivocally identifying the cause and specifying the actionable learning. They get little expert help and guidance in undertaking this activity.

5.4.7 The most important test of the capability of a patient safety incident reporting system is its effectiveness in reducing future harm of the kind that is being reported to it. Unfortunately, there are few places around the world where there is a powerful flow of learning that moves from identifying instances of avoidable harm, through understanding why they did or could happen, to successful elimination of the risk for future patients. Northern Ireland is no exception to this regrettable state of affairs.

5.4.8 There are two main levels of learning from Serious Adverse Incidents in Northern Ireland. The first is local. The lack of a consistently high standard of investigation and action-planning are barriers to effective risk-reduction within health and social care organisations. Another barrier is the limited degree to which front-line staff are involved in discussing and seeking solutions to things that have gone wrong. Experience elsewhere suggests that this practical and intellectual engagement, if well-led, often sparks great interest and commitment to patient safety amongst front-line staff. This is not really happening in Northern Ireland at present, for a number of reasons. Firstly, staff do not have the time and space to do it and the leadership of Trusts is not consistently creating and facilitating such opportunities. The Regulation and Quality Improvement Authority has established training in Root Cause Analysis for front-line staff, and this will help. Secondly, the specified rules of the Serious Adverse Incident system mean that Trusts are under a great deal of pressure to meet the time-scales laid down and are often dealing with many such cases simultaneously. As a result, the activity is too often slipping into an incident management role or worse a necessary chore that 'feeds the beast'.

5.4.9 The second level of learning is across the Northern Ireland health and social care system as a whole. The main role is played by the Health and Social Care Board working with the Public Health Agency (and the Regulation and Quality Improvement Authority where appropriate). These bodies have established a multi-disciplinary Quality Safety and Experience Group that undertakes much of the work in assessing patterns, trends and concerns arising from the analysis of locally-generated Serious Adverse Incidents and deciding what action needs to be taken on a Northern Ireland-wide basis. It does so by issuing learning letters, reports, guidance, newsletters and other specified action that the service needs to take. This is a valuable function from which considerable action aimed at improvement has flowed. Experience of improving patient safety elsewhere has shown that specifying action on a particular safety problem is not the same thing as implementing the change required. The latter is often much more difficult and depends on factors such as the systems, culture, attitudes, local priorities and leadership in the organisation receiving the action note. In the Northern Ireland care system more skill needs to be added to the implementation process. This is closely linked to the difficulties that arise when local services feel overloaded with central guidance and requirements for action. They only have enough management and clinical leadership capacity to implement a small number of changes at a time.

5.4.10 General practitioners, and others in primary care, report their Serious Adverse Incidents directly to the Health and Social Care Board, not through any of the Trusts. Levels of reporting of patient safety incidents in primary care services around the world are very low and much less is known about the kinds of harm that arise in this setting compared to hospitals. It is not surprising that the same is so in Northern Ireland. Another aspect of the primary care dimension is that many of the incidents that the Review discussed with the Trusts in Northern Ireland had a primary care element in the key areas of the care processes that had failed, yet general practitioners seemed to be less frequently involved in the investigation and planning of remedial action.

5.4.11 There are two particular aspects of the criteria for Serious Adverse Incident reporting in Northern Ireland that are not working in the best interests of a successful system. Firstly, the requirement that every death of a child in receipt of health and social care should automatically become a Serious Adverse Incident is causing major problems. A proportion of such deaths every month are due to natural causes. Some of the conditions concerned - for example, terminal cancer and serious congenital abnormalities - are particularly harrowing for the parents. After the death of a child, in such circumstances, for a family to be told that their child's death has been categorised as a Serious Adverse Incident carries the clear implication that the quality or safety of care was poor and at fault or even that the death could have been avoided. This can be enormously distressing for families and is grueling for staff. It is cruel, unnecessary and liable to undermine public confidence in children's services.

5.4.12 Secondly, using the same time-scales for investigating Serious Adverse Incidents in mental health as in in other fields of care is also causing major problems. The complexity of many mental health cases, the long past history of many such patients and clients, and the number of people and organisations who may be able to contribute relevant information to the investigation mean that a longer period is necessarily required to get to the truth than is currently permitted.

5.4.13 Overall, the system of Serious Adverse Incident reporting in Northern Ireland, in comparison to best practice, scores highly on securing accountability, reasonably highly on the level of reporting, does moderately well on meaningful engagement with patients and families, and is weak in producing effective, sustained reduction in risk. Also, the climate of accountability and intense political and media scrutiny does not sit easily with what best practice has repeatedly shown is the key to making care safer: a climate of learning not judgment.

5.4.14 The Review concluded that front-line clinical staff are insufficiently supported to fulfill the role of assessing and improving the quality and safety of the care that they and their teams provide. The lack of time, the paucity of reliable, well-presented data, the absence of in-service training in quality improvement methods, and the patchiness of clinical leadership are all major barriers to achieving this vital shift to mass clinical engagement.

5.5 OPENNESS WITH PATIENTS AND FAMILIES

5.5.1 The Serious Adverse Incident investigation system contains, in the view of the Review Team, sufficient checks and balances to ensure that affected patients and families are informed that something went wrong, except in exceptional circumstances.

5.5.2 Such mechanisms are part of good governance, but alone are insufficient. It will be culture – not accountability – that increases the reporting of harm, and staff's comfort in talking openly about harm.

5.5.3 Those conducting investigations are committed to rigorous investigation, and to being open with patients and families about what is found. But whilst some communicate well in person and in writing, others are less strong. This can come across to families as a lack of openness.

5.5.4 High-profile inquiries and negative media coverage have led some to believe that there is widespread cover-up of harm in the health and social care system. This is simply inconsistent with what the Review Team observed, which was a system trying, as many others in the world are, to get to grips with the difficult problem of patient safety.

5.5.5 Fear and suspicion powerfully inhibit openness. The health and social care system needs to rise to the challenge of tackling these threats head on. Perception is important – even simple delays and communication weaknesses can fuel suspicion. And if staff hear more from the media than direct from their leaders, this does not dispel fear.

6 RECOMMENDATIONS

Recommendation 1: Coming together for world-class care

A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standard of care required to meet patients' needs 24 hours a day, 7 days a week. Proposals to close local hospitals tend to be met with public outrage, but this would be turned on its head if it were properly explained that people were trading a degree of geographical inconvenience against life and death. Finding a solution should be above political self-interest.

We recommend that all political parties and the public accept in advance the recommendations of an impartial international panel of experts who should be commissioned to deliver to the Northern Ireland population the configuration of health and social care services commensurate with ensuring world-class standards of care.

Recommendation 2: Strengthened commissioning

The provision of health and social care in Northern Ireland is planned and funded through a process of commissioning that is currently tightly centrally-controlled and based on a crude method of resource allocation. This seems to have evolved without proper thought as to what would be most effective and efficient for a population as small as Northern Ireland's. Although commissioning may seem like a behind-the-scenes management black box that the public do not need to know about, quality of the commissioning process is a major determinant of the quality of care that people ultimately receive.

We recommend that the commissioning system in Northern Ireland should be re-designed to make it simpler and more capable of reshaping services for the future. A choice must be made to adopt a more sophisticated tariff system, or to change the funding flow model altogether.

Recommendation 3: Transforming Your Care – action not words

The demands on hospital services in Northern Ireland are excessive and not sustainable. This is a phenomenon that is occurring in other parts of the United Kingdom. Although triggered by multiple factors, much of it has to do with the increasing levels of frailty and multiple chronic diseases amongst older people together with too many people using the hospital emergency department as their first port of call for minor illness. High-pressure hospital environments are dangerous to patients and highly stressful for staff. The policy document Transforming Your Care contains many of the right ideas for developing high quality alternatives to hospital care but few believe it will ever be implemented or that the necessary funding will flow to it. Damaging cynicism is becoming widespread.

We recommend that a new costed, timetabled implementation plan for *Transforming Your Care* should be produced quickly. We further recommend that two projects with the potential to reduce the demand on hospital beds should be launched immediately: the first, to create a greatly expanded role for pharmacists; the second, to expand the role of paramedics in pre-hospital care. Good work has already taken place in these areas and more is planned, but both offer substantial untapped potential, particularly if front-line creativity can be harnessed. We hope that the initiatives would have high-level leadership to ensure that all elements of the system play their part.

Recommendation 4: Self-management of chronic disease

Many people in Northern Ireland are spending years of their lives with one or more chronic diseases. How these are managed determines how long they will live, whether they will continue to work, what disabling complications they will develop, and the quality of their life. Too many such people are passive recipients of care. They are defined by their illness and not as people. Priority tends to go to some diseases, like cancer and diabetes, and not to others where provision remains inadequate and fragmented. Quality of care, outcome and patient experience vary greatly. Initiatives elsewhere show that if people are given the skills to manage their own condition they are empowered, feel in control and make much more effective use of services.

We recommend that a programme should be established to give people with long-term illnesses the skills to manage their own conditions. The programme should be properly organised with a small full-time coordinating staff. It should develop metrics to ensure that quality, outcomes and experience are properly monitored. It should be piloted in one disease area to begin with. It should be overseen by the Long Term Conditions Alliance.

Recommendation 5: Better regulation

The regulation of care is a very important part of assuring standards, quality and safety in many other jurisdictions. For example, the Care Quality Commission has a very prominent role in the inspection and registration of healthcare providers in England. In the USA, the Joint Commission's role in accreditation means that no hospital wants to fall below the standards set or it will lose reputation and patients. The Review Team was puzzled that the regulator in Northern Ireland, the Regulation and Quality Improvement Authority, was not mentioned spontaneously in most of the discussions with other groups and organisations. The Authority has a greater role in social care than in health care. It does not register, or really regulate, the Trusts that provide the majority of healthcare and a lot of social care. This light-touch role seems very out of keeping with the positioning of health regulators elsewhere that play a much wider role and help support public accountability. The Minister for Health, Social Services and Patient Safety has already asked that the regulator start unannounced inspections of acute hospitals from 2015, but these plans are relatively limited in extent.

We recommend that the regulatory function is more fully developed on the healthcare side of services in Northern Ireland. Routine inspections, some unannounced, should take place focusing on the areas of patient safety, clinical effectiveness, patient experience, clinical governance arrangements, and leadership. We suggest that extending the role of the Regulation and Quality Improvement Authority is tested against the option of outsourcing this function (for example, to Healthcare Improvement Scotland, the Scottish regulator). The latter option would take account of the relatively small size of Northern Ireland and bring in good opportunities for benchmarking. We further recommend that the Regulation and Quality Improvement Authority should review the current policy on whistleblowing and provide advice to the Minister.

6

Recommendation 6:
Making incident reports really count

The system of incident reporting within health and social care in Northern Ireland is an important element of the framework for assuring and improving the safety of care of patients and clients. The way in which it works is falling well below its potential for the many reasons explained in this report. Most importantly, the scale of successful reduction of risk flowing from analysis and investigation of incidents is too small.

We recommend that the system of Serious Adverse Incident and Adverse Incident reporting should be retained with the following modifications:

- **deaths of children from natural causes should not be classified as Serious Adverse Incidents;**
- **there should be consultation with those working in the mental health field to make sensible changes to the rules and time-scales for investigating incidents involving the care of mental health patients;**
- **a clear policy and some re-shaping of the system of Adverse Incident reporting should be introduced so that the lessons emanating from cases of less serious harm can be used for systemic strengthening (the Review Team strongly warns against uncritical adoption of the National Reporting and Learning System for England and Wales that has serious weaknesses);**
- **a duty of candour should be introduced in Northern Ireland consistent with similar action in other parts of the United Kingdom;**
- **a limited list of Never Events should be created**
- **a portal for patients to make incident reports should be created and publicised**
- **other proposed modifications and developments should be considered in the context of Recommendation 7.**

Recommendation 7:
A beacon of excellence in patient safety

There is currently a complex interweaving of responsibilities for patient safety amongst the central bodies responsible for the health and social care system in Northern Ireland. The Department of Health, Social Services and Public Safety, the Health and Social Care Board, and the Regulation and Quality Improvement Authority all play a part in: receiving Serious Adverse Incident Reports, analysing them, over-riding local judgments on designation of incidents, requiring and overseeing investigation, auditing action, summarising learning, monitoring progress, issuing alerts, summoning-in outside experts, establishing inquiries, checking-up on implementation of inquiry reports, declaring priorities for action, and various other functions. The respective roles of the Health and Social Care Board and the Public Health Agency are clearly specified in legal regulations but seem very odd to the outsider. The Health and Social Care Board has no full-time officers of its own who lead on quality and safety and no in-house medical or nursing director. These functions are grafted on from the Public Health Agency. The individuals concerned have done some excellent work on quality and patient safety and carry out their roles very conscientiously. However, symbolically, and on grounds of organisational coherence, it appears strange that the main body responsible for planning and securing care does not hold these functions in the heart of its business. The Department of Health, Social Services and Public Safety's role on paper is limited to policy-making but, in practice, steps in regularly on various aspects of quality and safety. The Review Team thought long and hard before making a recommendation in this area. In the end, we believe action is imperative for two reasons: firstly, the present central arrangements are byzantine and confusing; secondly, the overwhelming need is for development of the present system to make it much more successful in bringing about improvement. Currently, almost all the activities *(including those listed above) are orientated to performance management not development. There is a big space for a creative, positive and enhancing role.*

We recommend the establishment of a Northern Ireland Institute for Patient Safety, whose functions would include:

- **carrying out analyses of reported incidents, in aggregate, to identify systemic weaknesses and scope for improvement;**
- **improving the reporting process to address under-reporting and introducing modern technology to make it easier for staff to report, and to facilitate analysis;**
- **instigating periodic audits of Serious Adverse Incidents to ensure that all appropriate cases are being referred to the Coroner;**
- **facilitating the investigation of Serious Adverse Incidents to enhance understanding of their causation;**
- **bringing wider scientific disciplines such as human factors, design and technology into the formulation of solutions to problems identified through analysis of incidents;**
- **developing valid metrics to monitor progress and compare performance in patient safety;**
- **analysing adverse incidents on a sampling basis to enhance learning from less severe events;**
- **giving front-line staff skills in recognising sources of unsafe care and the improvement tools to reduce risks;**
- **fully engaging with patients and families to involve them as champions in the Northern Ireland patient safety program, including curating a library of patient stories for use in educational and staff induction programmes;**
- **creating a cadre of leaders in patient safety across the whole health and social care system;**
- **initiating a major programme to build safety resilience into the health and social care system.**

Recommendation 8:
System-wide data and goals

The Northern Ireland Health and Social Care system has no consistent method for the regular assessment of its performance on quality and safety at regional-level, Trust-level, clinical service-level, and individual doctor-level. This is in contrast to the best systems in the world. The Review Team is familiar with the Cleveland Clinic. That service operates by managing and rewarding performance based on clinically-relevant metrics covering areas of safety, quality and patient experience. This is strongly linked to standard pathways of care where outcome is variable or where there are high risks in a process.

We recommend the establishment of a small number of systems metrics that can be aggregated and disaggregated from the regional level down to individual service level for the Northern Ireland health and social care system. The measures should be those used in validated programmes in North America (where there is a much longer tradition of doing this) so that regular benchmarking can take place. We further recommend that a clinical leadership academy is established in Northern Ireland and that all clinical staff pass through it.

Recommendation 9:
Moving to the forefront of new technology

The potential for information and digital technology to revolutionise healthcare is enormous. Its impact on some of the long-standing quality and safety problems of health systems around the world is already becoming evident in leading edge organisations. These developments include: the electronic medical record, electronic prescribing systems for medication, automated monitoring of acutely-ill patients, robotic surgery, smartphone applications to manage workload in hospitals at night, near-patient diagnostics in primary care, simulation training, incident reporting and analysis on mobile devices, extraction of real-time information to assess and monitor service performance, advanced telemedicine, and even smart kitchens and talking walls in dwellings adapted for people with dementia. There is no organised approach to seeking out and making maximum use of technology in the Northern Ireland care system. It could make a big difference in resolving some of the problems described in this report. There is evidence of individual Trusts making their own way forward on some technological fronts, but this uncoordinated development is inappropriate - the size of Northern Ireland is such that there should be one clear, unified approach.

We recommend that a small Technology Hub is established to identify the best technological innovations that are enhancing the quality and safety of care around the world and to make proposals for adoption in Northern Ireland. It is important that this idea is developed carefully. The Technology Hub should not deal primarily with hardware and software companies that are selling products. The emphasis should be on identifying technologies that are in established use, delivering proven benefits, and are highly valued by management and clinical staff in the organisations concerned. They should be replicable at Northern Ireland-scale. The overall aim of this recommendation is to put the Northern Ireland health and social care system in a position where it has the best technology and innovation from all corners of the world and is recognised as the most advanced in Europe.

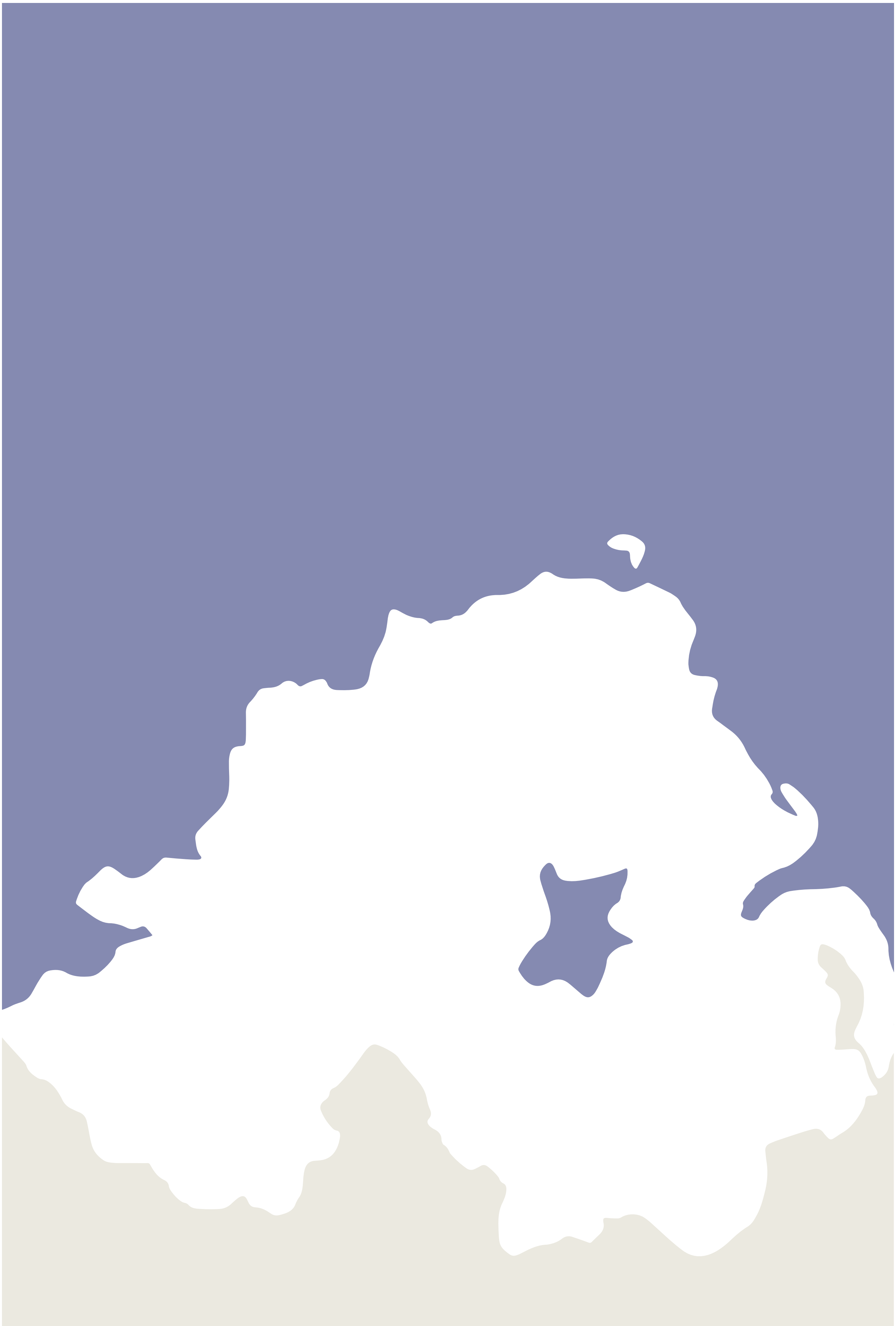
Recommendation 10: A much stronger patient voice

In the last decade, policy-makers in health and social care systems around the world have given increasing emphasis to the role of patients and family members in the wider aspects of planning and delivering services. External reviews – such as the Berwick Report in England - have expressed concern that patients and families are not empowered in the system. Various approaches have been taken worldwide to address concerns like these. Sometimes this has been through system features such as choice and personally-held budgets, sometimes through greater engagement in fields like incident investigation, sometimes through user experience surveys and focus groups, and sometimes through direct involvement in the governance structures of institutions. In the USA, patient experience data now forms part of the way that hospitals are paid and in some it determines part of the remuneration of individuals. This change catalysed the centrality of patients to the healthcare system in swathes of North America. Observers say that the big difference was when dollars were linked to the voice of patients. Northern Ireland has done some good work in the field of patient engagement, in particular the requirement to involve patients and families in Serious Adverse Incident investigation, the 10,000 voices initiative, in the field of mental health and in many aspects of social care. Looked at in the round, though patients and families have a much weaker voice in shaping the delivery and improvement of care than is the case in the best healthcare systems of the world.

We recommend a number of measures to strengthen the patient voice:

- **more independence should be introduced into the complaints process; whilst all efforts should be made to resolve a complaint locally, patients or their families should be able to refer their complaint to an independent service. This would look again at the substance of the complaint, and use its good offices to bring the parties together to seek resolution. The Ombudsman would be the third stage and it is hoped that changes to legislation would allow his reports to be made public;**
- **the board of the Patients and Client Council should be reconstituted to include a higher proportion of current or former patients or clients of the Northern Ireland health and social care system;**
- **the Patients and Client Council should have a revised constitution making it more independent;**
- **the organisations representing patients and clients with chronic diseases in Northern Ireland should be given a more powerful and formal role within the commissioning process, the precise mechanism to be determined by the Department of Health, Social Services and Public Safety;**
- **one of the validated patient experience surveys used by the Centers for Medicare and Medicaid Services in the USA (with minor modification to the Northern Ireland context) to rate hospitals and allocate resources should be carried out annually in Northern Ireland; the resulting data should be used to improve services, and assess progress. Finally and importantly, the survey results should be used in the funding formula for resource allocation to organisations and as part of the remuneration of staff (the mechanisms to be devised and piloted by the Department of Health, Social Services, and Public Safety).**

In implementing the above recommendations, the leaders of the Northern Ireland health and social care system should be clear in their ambition, which is in our view realistic, of making Northern Ireland a world leader in the quality and safety of its care. Northern Ireland is the right place for such a transformation, and now is the right time.



HEALTH AND WELLBEING 2026

DELIVERING TOGETHER

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
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FOREWORD

The World Health Organisation defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. That is the health outcome I want to deliver for all our people.

But without new approaches and in the face of ever growing demand - often driven by successful interventions and improving life expectancy - we will increasingly struggle.

Change is quite simply essential to deliver the world class service - free at the point of delivery and based on need - that is our collective commitment.

We must move beyond simply managing illness and instead ensure that our health service supports people to stay well; physically, mentally and emotionally.

In other words, we need to rethink how we deliver our health and social care service.

My predecessor, Simon Hamilton, asked a panel led by the internationally recognised expert, Professor Rafael Bengoa, to help us identify how to tackle the challenges in our Health and Social Care system.

Their report tells us clearly that we need to re-organise how we do things - and that we need to do this in partnership with the people who use the service and those who work in it. Critically, we must prioritise prevention and early intervention to ensure that people stay well. This approach will produce better health and wellbeing outcomes and it will reduce demand on our over stretched acute services. It will also help us tackle what the Expert Panel Report calls “striking health inequalities” in our society.

This document, Health and Wellbeing 2026: Delivering Together, is the outworking of the Expert Panel’s recommendations. It sets out a commitment to tackle the issues we face in our Health and Social Care system through decisive political leadership. We are determined to move beyond short-term approaches and crisis management.

This Executive is united as never before in its commitment to take the right, perhaps difficult, decisions. But we know this is the only way to deliver better outcomes for our people.

We are facing into a time of change for our health system but it is change that must happen. This document sets out a direction of travel that I hope all of our society can embrace and support in the challenging but exciting time ahead.

Michelle O’Neill, MLA
Minister of Health

1

THE CHALLENGE

My desire for world class health and social care is based on firm foundations - we have a health and social care system staffed with many talented and dedicated people working extremely hard to deliver high quality services to those in need. But increasingly those efforts are frustrated by a system which is clearly under mounting pressure. This is impacting on both those within the system and those it serves. Without radical change there is no doubt the situation will further deteriorate. That is why I am convinced that change is needed now.

Before I set out the case for change, it is important to acknowledge and celebrate where Health and Social Care, in collaboration with wider government, is making a real difference to our health and wellbeing.

Standardised
CIRCULATORY DEATH RATE
in under 75s
decreased by a fifth over the last 5 years

ENGAGEMENT WITH EDUCATION TRAINING OR EMPLOYMENT FOR THOSE AGED 16-21 WHO ARE IN CARE OR HAVE LEFT CARE HAS RISEN 5.7% IN THE PAST YEAR

SMOKING PREVALANCE FELL
from 26% in 2004/05
to 22% in 2014/15

7677
CARERS RECEIVED SUPPORT FROM TRUSTS IN 2015 COMPARED TO
1414
IN 2011

Over **1 in 3** adults (36%) reported that they ate the recommended
5 PORTIONS
of fruit & veg a day (2014/15)
increased by a third over the last 10 years

FAMILY SUPPORT HUBS
In 2015/16, **4522 families with children** were referred to Family Support Hubs, a **72% increase** on the previous year. Of the 5346 children referred to Hubs in 2015/16, **around 18% were children with a disability**

BOWEL CANCER DECREASE
Since **bowel cancer screening** was introduced, the percentage of people diagnosed with early stage disease has increased from **14% to 22%** thereby **improving their life chances**

LOOKED AFTER CHILDREN
achieving Key Stage 1: Level 2 or above

in English
7.5% INCREASE

in Maths
7% INCREASE

INCREASE IN ADOPTIONS
Between 2014/15 and 2015/16, there has been a **24% INCREASE** in the adoptions of Looked After Children

LIFE EXPECTANCY
over the last 5 years life expectancy has increased

1.3 YEARS
for males
(78 years)

1 YEAR
for females
(82.3 years)

Standardised
RESPIRATORY DISEASE DEATH RATE
in under 75s
decreased by a fifth
over the last 5 years

MMR VACCINE
over 95% of children received the MMR Vaccine which means we have not seen the outbreaks of measles that have occurred elsewhere

At the heart of the many successes of the Health and Social Care (HSC) system is the hard work and dedication of all staff, in every grade and role, who are delivering care at higher levels than ever before.

However, while there is much to celebrate, we must recognise the challenges in the current system. The reality is that we increasingly cannot properly meet people's needs with our current structures. In the past, and for a range of reasons, it has not been possible to achieve the whole system transformation at the scale and with the pace we need to meet the evolving health needs of our people. More and more the impact of this is felt on a daily basis and takes its toll on both those who use services and those working in the sector.

Our Health and Social Care System faces a number of significant challenges:

Organisational

In many past reviews, professionals and staff have expressed their frustration at the limitations of our current arrangements and their desire for change, most recently in the Expert Panel report. The 20th century configuration of our services is simply not optimised to meet the needs of 21st century care.

The point has now been reached where maintaining the current delivery models is having increasingly negative impacts on the quality and experience of care for many service users, while constraining the ability of the system itself to transform to meet today's health needs.

While staff work increasingly hard to mitigate these structural issues, the overall impact is experienced by service users and their families every day, in every part of the system. Regrettably, delays in accessing services and unacceptable waiting times for treatment are commonplace. The quality of our service, and the experience of those providing and receiving it, is not as good as it should be.

Modern research shows that outcomes for patients requiring complex or specialist treatment improves where high levels of specialist expertise is available and these teams are able to keep pace with innovation. The current spread of such HSC resources, too often committed to buildings rather than outcomes for patients, is a central challenge we must address.

If we persist with our current models of care, even with the best efforts of all staff and more investment year on year, waiting lists will continue to grow, our expertise will continue to be diluted, and the best possible outcomes for patients will not be realised. This is both unsustainable and unacceptable.

In addition, the way we are organised means that opportunities are being missed to create sustainable employment, drive economic investment, and maximise the contribution of the HSC to the economic goals of the Executive. For example, the life and health sciences sector provides 10% of all of the North's exports. Closer working between the HSC, our world class universities and life and health science organisations and maximising the potential for growth in this high value sector, is fundamentally dependent on centres of clinical excellence with the right level of expertise and the necessary capacity.

Workforce

A further challenge relates to the workforce itself. People who work in health and social care are its greatest strength, working ever harder to provide the care needed by patients and service users. Year on year, investment has been directed to front line services in an effort to meet the ever growing need for treatment and care.

However, if we accept, as a whole range of reviews have, that our services are not best configured for our needs, then it follows that recruiting additional staff alone to prop up outdated service models, is not the answer. We must be able to provide safe and high quality care which keeps up with the fast pace of innovation and health and social care developments. I recognise that staff need the opportunity to develop their skills and expertise in an environment which allows for a greater degree of specialisation, whilst maintaining personalised compassionate care.

It has also become clear that even when resources are made available to recruit additional staff, it has simply not been possible to fill all vacant posts. This in turn puts additional pressure on already hardworking staff and has seen our service become increasingly reliant on short term solutions such as locums and agency staff. This creates additional expense with negative implications for the quality of care. It has become a vicious circle which we must stop.

We must invest in our staff and provide the environment to allow them to do what they do best - provide excellent high quality care. This means providing opportunities to develop their skills and find suitable career paths at all levels. Where necessary, we will increase the numbers we train and consider ways of delivering care more effectively through the development of new roles and skills.

I am determined that we will make the health and social care system an employer of choice in the north of Ireland.

The Needs of a Rapidly Changing and Ageing Population

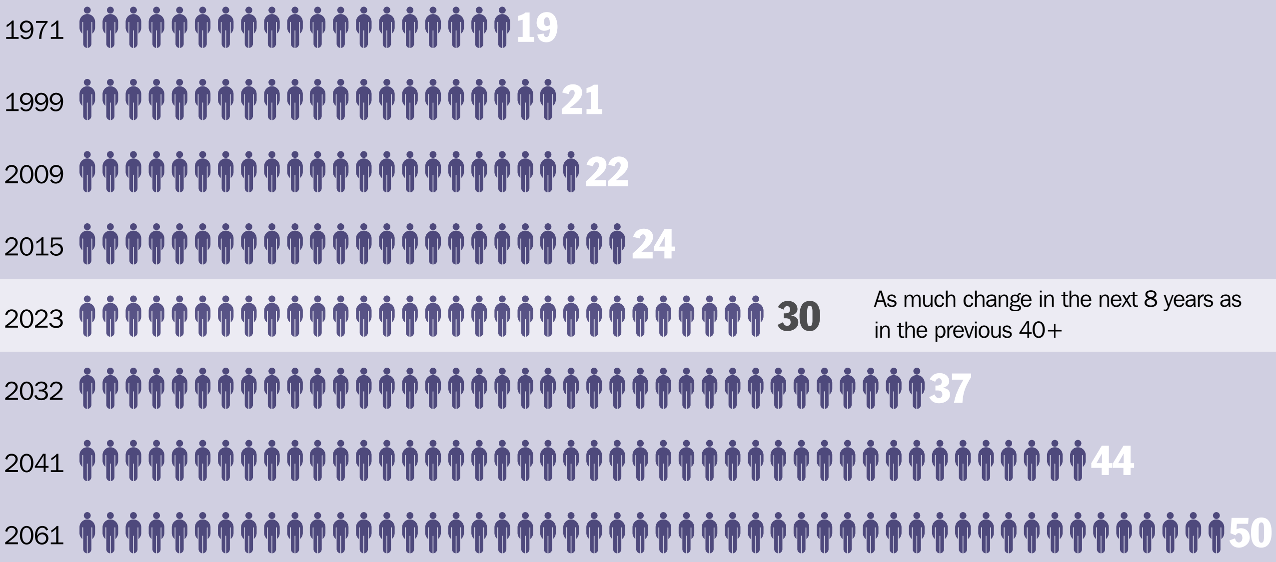
Our society is getting older: people are living longer, often with long-term health conditions, and we are having fewer children. Estimates indicate that by 2026, for the first time, there will be more over 65s than under 16s.

By 2039, the population aged 65 and over will have increased by 74% compared to the position in 2014. This will mean that one in four people will be aged 65 and over.

Similarly, the population aged 85 and over will increase by 157% over the same period, which will see their share of the population increase from 1.9 % to 4.4%.

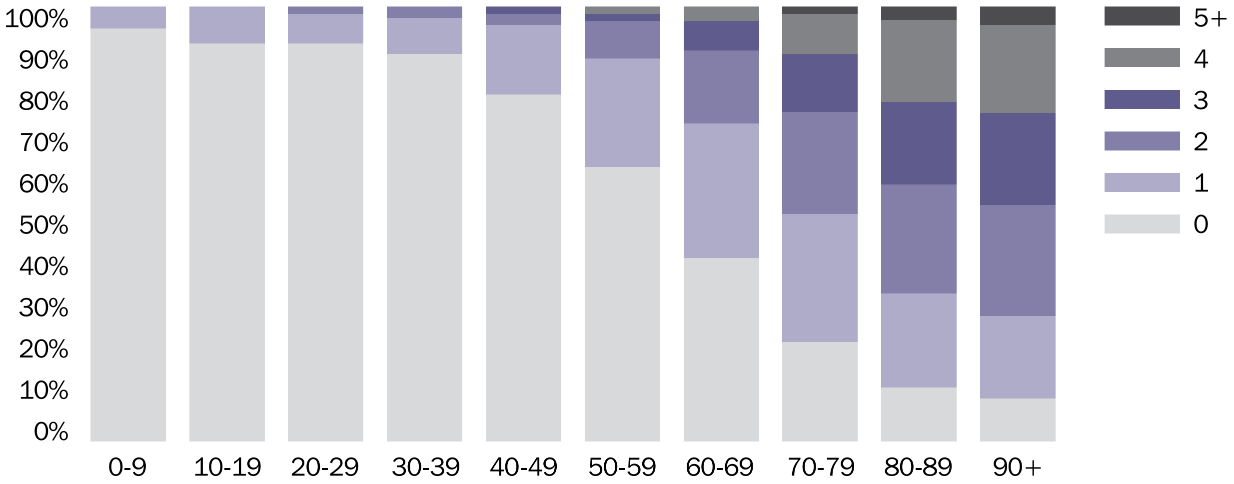
By any analysis, this is a massive success to which our health and social care service has made a significant contribution. That said, it does present a huge and growing challenge in terms of the demands and pressures on health and social care services.

An ageing population - number of older people (65+) per 100 aged 16-64



As much change in the next 8 years as in the previous 40+

Percentage of patients in each age band with the indicated number of morbidities



Developments in how conditions can be treated and managed mean that as we get older we are much more likely to develop and live with one or more long term conditions. The table above demonstrates that as we get older, the likelihood of having more than one condition at the same time increases dramatically, and with that the care and treatment that we require becomes much more complex.

Furthermore, people's health and social care needs have changed, and their expectations are rightly higher than at any other time before. In the past, for many conditions, where there was an effective treatment available, it often required hospital attendance or an in-patient stay. Increasingly, such treatments are available in the community, or can be provided on a day care basis; which in many instances is more appropriate to the needs of people with longer-term chronic conditions.

People today want to lead full and productive lives, staying independent for longer. In line with wider societal changes, we all expect improved access, choices and control when it comes to public services.

Health Inequalities

Despite people living longer, health inequalities continue to divide our society. The differences in health and wellbeing outcomes between the most and least deprived areas are still very stark, and completely unacceptable.

For example, men in the least deprived areas live 7.5 years longer than men in the most deprived areas. For women, the difference is over four years. In the most deprived areas, 30% of people report a mental health problem - double the rate in least deprived areas. Rates of suicide are also higher, and leave a devastating impact on people, families and those communities.

Birth weight is an important indicator of foetal and neonatal health, and a low birth weight has a strong association with poor health outcomes in infancy, childhood and throughout someone's life. Between 2010 and 2014, the proportion of babies born at a low birth weight was 44% higher in the most deprived areas than in the least deprived areas.

In 2013/14, the rate of obesity among children in Primary 1 was 71% higher in the most deprived areas than those in the least deprived areas. 42% of Looked After Children (LAC) come from the most deprived areas in the North. Being looked after is associated with poorer socio-economic outcomes in adulthood.

It is clear that economic, social and environmental factors, and experiences early in life, play a major role in determining not just the health outcomes at an individual and community level, but also their social, educational, economic and other outcomes. There is also growing evidence that children who experience adversity in childhood are far more likely to experience health issues in adult life. Specifically, these children are more likely to adopt health harming behaviours during adolescence which can lead to mental health illness and diseases such as cancer, heart disease and diabetes later in life. Adversity in childhood also means that children are more likely to perform poorly in school, more likely to be involved in crime and more likely to experience poverty and disadvantage in adult life.

Our future health and social care system needs to not only treat people who become sick or need support now, but also needs to do much more to ensure that the next generation is more healthy with more equitable life opportunities for all.

Our Opportunity

The problem and the compelling case for change is not in itself new, and has been made repeatedly by experts, staff and patients over many years. The Expert Panel's Report "Systems, not Structures: Changing Health and Social Care" once again reaffirms this. But despite the overwhelming evidence, the opportunity has thus far not been grasped. However, both as Minister and as an Executive we believe there is now no alternative but to transform how we design and deliver health and social care services.

The political summit hosted by the Expert Panel in February 2016 secured a political mandate for the need for change and the principles to underpin it, and I look forward to all parties engaging with and supporting the HSC to make the difficult decisions required to improve our population's health, and build a sustainable health and social care system. This is the time for political leadership.

The advent of a new outcomes based approach in the draft Programme for Government puts an onus on us all to work together, across traditional silos and boundaries to deliver the best outcomes for the people of the North. Now is the time for us to work collectively to deliver a world class health service.

Across this island, the health and social care fabric of both jurisdictions face the same challenges. We have the opportunity to work more collaboratively with colleagues to address those challenges, and deliver services in a way that improves care for our population as a whole. There are many good examples of where this is already working well, such as cancer and cardiac services in the north west or the partnership with Dublin for children's heart surgery. There are many more such opportunities, including the transplantation of organs and rare diseases, and we have developed a programme of work with the Department of Health in the South to identify areas of mutual benefit.

Staff, clinicians and professionals from right across our health and social care system are telling us loud and clear that change is now necessary. If we do not grasp this opportunity change will happen anyway but in a reactive and unplanned way, with more potential for detrimental impacts on those who use and deliver our services.

In addition, the HSC itself is a huge contributor to the economy in many ways, through skills development, spending power and employment practices.

As the single biggest employer in the North, we have a real opportunity and responsibility to make a tangible and positive contribution to the health and wellbeing of our staff, and society as a whole. We will be an employer of choice, leading by example and investing in the wellbeing of our staff. Despite the demand, resource and service pressures being experienced, I am committed to ensuring the wellness dimensions of being an employer of this scale will be better achieved across the HSC.

In the way we operate, we have the opportunity to promote a new way of working with the community and voluntary sectors through the innovative use of social procurement clauses, and commissioning services based on social value rather than simply on the basis of lowest cost.

Working with our world class universities, skilled graduates and world leading companies, we can grow our life and health sciences sector, creating new jobs. This will mean access to cutting edge technology and therapies, and the dual benefit of improving care and economic growth. To do so requires further collaboration between HSC, academia and industry. The HSC can only play its part if it can provide the centres of expertise and excellence that will continue to attract partners, and support the recruitment and retention of experts in their fields.

2

THE AMBITION

Health is a human right. I am deeply committed to the principle of universal health care, free at the point of delivery to those in need.

Aligned with the aspirations the Executive set out in the draft Programme for Government, my overarching ambition is for every one of us to **lead long, healthy and active lives**.

Improving the health of our people

Supporting and empowering staff

Improving the quality and experience of care

Ensuring sustainability of our services

Therefore, we want to see a future in which:

- people are supported to keep well in the first place with the information, education and support to make informed choices and take control of their own health and wellbeing;
- when they need care, people have access to safe, high quality care and are treated with dignity, respect and compassion;
- staff are empowered and supported to do what they do best; and
- our services are efficient and sustainable for the future.

All of these aims are of great importance and must be addressed if we are to meet the future needs for our population.

They will underpin a new model of **person-centred care** focussed on prevention, early intervention, supporting independence and wellbeing. This will enable the focus to move from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

We will create the circumstances for people to stay healthy, well, safe and independent in the first place. We will anticipate the needs of individuals for support and care and this new model of person-centre care will intervene early to avoid deterioration.

This model will be designed for and with people and communities rather than by organisations and services. Instead of thinking about buildings and hospitals as the only place to deliver services, we will deliver care and support in the most appropriate setting, ideally in people's homes and communities. In most instances people should only have to go to hospital when they need treatment that can't be provided in their community.

The way we design and deliver services will be focussed on providing continuity of care in an organised way. To do so we will increasingly work across traditional organisational boundaries, to develop an environment characterised by trust, partnership and collaboration.

3

THE CHANGE NEEDED

If we are to support everyone to lead long, healthy, and active lives, we need to change the focus of our services, and how and where those services are delivered. The Expert Panel has clearly said that 'something very different has to happen at the delivery of care level'.

We must:

- **Build capacity in communities and in prevention** to reduce inequalities and ensure the next generation is healthy and well;
- **Provide more support in primary care** to enable more preventive and proactive care, and earlier detection and treatment of physical and mental health problems;
- **Reform our community and hospital services** so that they are organised to provide care when and where it is needed;
- **Organise ourselves to deliver** by ensuring that the administrative and management structures make it easier for staff to look after the public, patients and clients.

Build capacity in communities and in prevention

We will work with communities to support them to develop their strengths and use their assets to tackle the determinants of health and social wellbeing.

We will support the development of thriving and inclusive communities, through the work of the HSC working closely with Executive colleagues and other providers such as councils, schools, police, housing and transport.

In particular, the HSC will become better at tapping into the innovative ideas and energies in communities themselves, and in the community and voluntary sectors. In all communities, every child and young person should have the best start in life, people should have a decent standard of living, and all citizens should be supported to make healthier and better informed life choices.

We will invest in HSC community development resources to work alongside all communities to enable social inclusion and tackle health inequalities and the underlying contributory factors including poverty, housing, education and crime.

It will take time to realign and grow the community development resource, and as a first step we will review existing capacity and then invest to meet any gaps, including a programme of training.

Alongside this, we will link social care more strongly with improving and safeguarding the wellbeing of individuals, families and communities. We will strengthen the social work profession by fully implementing my Department's Improving and Safeguarding Social Wellbeing Strategy.

To give every child and young person the best start in life, we will further increase the support we provide to children, young people and families from before birth to adulthood. The universal Health Visiting and School Nursing service will enable and support children and young adults to be successful healthy adults through the promotion of health and wellbeing; this will include the full delivery of the Healthy Child, Healthy Future programme. This will support the implementation of the Executive's Public Health Framework "Making Life Better" and its ambition to give every child the best start.

I will work with other Ministers to build on the success of the Early Intervention Transformation Programme and enhance early intervention services and the Family Support Hub network by exploring ways to build on the capacity of the hub model. This would include both better coordination of existing early intervention services and increasing the assessment capacity of the Hubs. This will enable us to respond quickly and flexibly to meet the needs of families early on before the problems they face become more intractable and severe. By increasing our early support to families we will reduce the need for later intervention, such as the need for children to come into care.

For children who are in the care system we will work to improve their life chances. Looked After Children experience much worse health, social, educational, and employment outcomes than other children. We will honour our corporate parenting responsibilities to the fullest extent and will be as ambitious for children in care as we are for our own children.

The range of placement options available to Looked After Children will be expanded. Through service redesign and, if necessary, new legislation we will better meet the individual needs of each child and put in place more effective supports for their caregivers, including kinship carers and families who adopt children from care. By working with the courts we will secure permanence for them more quickly helping their mental and emotional wellbeing, educational attainment and health in particular. Support will also be extended so that they are better prepared for independent living in adult life.

FAMILY SUPPORT HUBS

Family Support Hubs provide an accessible, flexible and responsive point of contact for families in need of support.

As of June 2016, 29 family support hubs were operational, providing full regional coverage across the North.

The engagement of local communities in the planning and commissioning of local services has been a key component to the successful delivery of Family Support Hubs.

In 2015/16 there were 4522 families referred through family support hubs, an increase of 1887 compared with 2014/15.

In 2015/16 a total of 5346 children were referred, 953 of which were children with a disability.

PRACTICE BASED PHARMACISTS

This initiative will see pharmacists working as an integral part of the GP surgery practice team. This means we can use their skills and experience to improve patient outcomes through reviewing their medication and reducing errors.

Practice Based Pharmacists (PBP) can help to alleviate some of the pressures faced by general practice through triaging patients to appropriate services and in some instances undertaking the diagnosis and initiation of treatment and follow-up appointments in patients with long term conditions.This will enable GPs to spend more time with patients with complex needs.

By December 2016, it is anticipated that 54 PBPs will have been placed in GP practices across the North with further PBPs appointed and in place over the period January-May 2017.

Enhancing support in primary care

Primary care is the bedrock of our health and social care system and provides around 95% of the care people need throughout their life. General Practitioners (GPs) and multidisciplinary primary care teams have a key role to play in improving population health and wellbeing, as well as developing care pathways and services to meet the population needs.

Our primary care service is still largely based on GPs working independently with some input from other disciplines. In future, the focus of our system will be increasingly on keeping people healthy and well in the first place. The World Health Organisation defines good health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. In the future we need a model that provides fully integrated multidisciplinary care, not just medical or nursing care.

Our future model of primary care is to be based on multidisciplinary teams embedded around general practice. The teams will work together to keep people well by supporting self management and independence, providing proactive management of high risk patients. They will identify and respond earlier to problems that emerge whether related to health or social circumstances or the conditions in which people live, providing high quality support treatment and care throughout life.

These teams will include GPs, Pharmacists, District Nurses, Health Visitors, Allied Health Professionals and Social Workers, and new roles as they develop, such as Advanced Nurse Practitioners and Physician Associates. There will be capacity and skills to proactively support individuals to address the lifestyle choices that impact upon their health and wellbeing. They will have the right tools and skills to diagnose, treat and coordinate the majority of care for their practice. They know the people they serve, and understand their needs better than anyone.

These teams will work in a more integrated way with all other community services and development work in their area, including Community Pharmacy. Community Pharmacy is an important part of primary care and can help to reduce pressure on other parts of the HSC. We must use them better, especially to support improved public health and engaging in with the public to ensure medicines are being used appropriately.

This model is radically different from what we have at present. It will require significant change in the way staff across the HSC are organised and deployed, and in the way GPs and other members of the new teams work together. This new model will therefore be rolled out incrementally over the next 5 years, learning and addressing gaps in staffing as we proceed. The roll-out of Practice Based Pharmacists will be completed by March 2021. GP surgeries will have named health visitors and named district nurses to work with by the end of March 2017. In addition, the way that core district nursing is delivered will be transformed, and a District Nursing Framework will be published by the end of this year.

We will maximise the potential for developing social prescribing models in the multidisciplinary primary care teams, through the embedding of social workers and building linkages to the range of early support services available to service users, such as Mental Health Hubs and other early help initiatives.

Additional funding for primary care will be focussed on developing these teams, with more funding for mental health interventions in primary care and funding to test the impact that specialist allied health professionals, such as physiotherapists, can have when working alongside the primary care team. Training for the first Advanced Nurse Practitioners for primary care and a new Physician Associate post-graduate degree programme have been developed and will start in early 2017. We will work closely with GPs and other professionals on the roll-out and evaluation of this model.

Together, the enhanced community capacity, the focus on prevention based approaches and the multidisciplinary teams in primary care will provide much greater capability to keep individuals and communities well.

Reforming our community and hospital services

Sometimes, the primary care or community care teams cannot fully meet a patient's needs but it isn't appropriate for them to be admitted to a hospital.

With developments in treatments and technology, we are able to do so much more without the need to admit people to hospital. Therefore in future we want to build on new services and models which are already emerging, and ensure that these are implemented across our health and social care system, working in partnership with those who deliver and use these services.

Acute Care at Home is an example of this type of service. Patients, often frail and elderly, are treated in their own homes by doctors, nurses and other staff. Conditions such as chest infections, urinary tract infections and dehydration can all be safely treated without the need to go to hospital, which can be a worrying and anxious experience for many. Patients have, within their own home environment, the same access to specialist tests as hospital inpatients and receive consultant led assessment and treatment.

We will make Acute Care at Home available to the whole population. We will better integrate it with social care and ensure it is supported by other services, including short stay hospital services, GPs and palliative care. This new model of care will be rolled out to all areas within the next three years.

We are committed to the further development of **Ambulatory Assessment and Treatment Centres**, to provide a more joined up, 1-stop service. Evidence from here and elsewhere shows there are significant benefits to be gained from this approach. Our current model is based on the traditional outpatient model of care where a GP refers a patient to the specialty the GP believes most closely relates to the possible cause of the person's symptoms. But as people live longer and develop more problems, diagnosis and treatment becomes more complex. So the traditional model is no longer fit for purpose.

Over the next 12 months, we will start to design these centres in partnership with clinicians and patients. They will provide simpler and easier access to the healthcare professionals and diagnostic equipment (such as X-Rays, CT scanners) needed to assess and diagnose conditions. Importantly, if a treatment or procedure is needed this will be possible on site with the aim of getting patients safely home the same day.

This avoids multiple outpatient visits and enables earlier diagnosis and appropriate treatment, and is therefore much better for those who use our services, and makes better use of our resources. Staff will have all the facilities they need to make the right diagnosis there and then, and to provide high quality care.

Elective Care Centres will be established to provide a dedicated resource for less complex planned surgery and other procedures. Evidence from elsewhere shows that such centres can reduce waiting times for planned care, and provide a better experience for both patients and staff. The current approach of delivering both planned and unplanned care using the same facilities and the same resources, means that waiting times can be adversely affected when the demand for urgent and emergency care is very high.

By making better use of our existing resources, and organising these in a different way, we will be able to provide larger volumes of activity, to a higher quality and in a more timely manner. The centres will be a resource for the region and the way they operate will be designed around the needs of patients. The number and location of these centres will be developed in partnership with clinicians and patients, and I expect proposals to be brought forward in the next 12 months.

Acute inpatient care will change. By changing the way preventive care, primary, community and less complex elective care is provided, and by looking after people in settings that are more appropriate to their needs, the nature of acute inpatient care will change.

Acute inpatient care will therefore focus on complex planned surgery and emergency care of patients who need an acute inpatient setting, for example, patients who have had a stroke, heart attack, or trauma, and those needing obstetric, neonatal or paediatric services or those with a significant worsening of a long term health condition. Multidisciplinary working will be a key feature of good quality inpatient care.

Across many different services there is very strong evidence that concentrating specialist procedures and services in a smaller number of sites produces significantly better outcomes for patients, as well as a much better and more supportive environment for staff

The role of our hospitals will therefore fundamentally change as they will focus on delivering the highest quality of specialist and acute care. However, not every service will be available in every hospital.

In the past few years we have seen the successful development of region-wide and cross-border **networks for highly specialist services** such as cancer, neonatology or cardiology as well as the development of the first truly all-island service in children's congenital cardiology. These are delivering innovative, world class services and we will seek to maximise opportunities to expand this approach and deliver more services on an all-island basis, where clinically appropriate to do so.

This is about changing the way that services are delivered, improving safety and quality, and making the best use of the resources we have. The Expert Panel, working with clinicians, has developed criteria which will help us to assess the sustainability and future of how services are provided, and this provides us with a route-map to work in partnership with those who use and deliver our services.

Mental Health

The North has a particular challenge with mental health, having the highest rates of mental illness in these islands. There are many talented and hardworking professionals in the system and the voluntary and community sector, who do excellent work in the services they provide. It is clear that our services need to continue to evolve and improve, building on the Bamford reforms from the last decade.

Mental health is one of my priorities as Minister of Health, and it is an issue that I will champion at every opportunity. I want better specialist mental health services. This would include further support for perinatal mental health and inpatient services for mothers, with potential to address the need that exists across the island. We will expand services in the community and services to deal with the trauma of the past. Underpinning all of this, I am committed to achieving a parity of esteem between mental and physical health to ensure that we are tackling the true impact of mental health on our communities.

Carers

Families and friends take on most of the caring responsibilities for their loved ones and this makes an enormous contribution both to the HSC and to society as a whole. I fully recognise that carers are an equal partner in providing care, and they need our support to be carers. They also need support to enable them to do the things that those without caring responsibilities take for granted such as working, going out socially, having a break or going on holidays. In the case of young carers, they need help and support just to do the things that young people do. I am committed, along with other government departments and their agencies, to providing that support.

We know that the needs of carers are changing, this means the type of support we need to give them is also changing. We need to encourage greater take up of carer's assessments and expand the options for short breaks, as well as enabling the greater use of personalisation and personal budgets where appropriate. We need to ensure carers can access up to date information and crucially consider how we can support carers to live their own lives. The role of carers and how we can better support them will be central to the Review of Adult Care and Support and I encourage everyone to make their views known when we bring proposals forward for consultation in spring 2017.

DELIVERING ACUTE CARE AT HOME

This service enables this vulnerable patient group to retain their independence and dignity and prevents unnecessary and stressful hospital admissions.

It was designed and implemented by East Belfast Integrated Care Partnership (ICP) and subsequently rolled out across Belfast. Similar services are available in some other Trust areas.

In the Belfast area, the average length of stay for Acute Care at Home patients is 6 days compared to 11 days in hospital. Over 1084 referrals have been received for the extended service in the Southern area.

Organising ourselves to deliver

To deliver care in a different way, it is clear that the way we plan and manage health and social care will also need to change. Therefore, in line with the recommendations of the Expert Panel's Report, we need to empower local providers and communities to work in partnership, including health and social care trusts, independent practitioners such as GPs and voluntary providers.

Embracing new models of care has the potential to harness the strengths of different parts of the system, across traditional organisational boundaries, across sectors and beyond what is traditionally considered to be the health and social care sector.

Working together, they will be expected to plan integrated and continuous local care for the populations they serve. I will set the outcomes we expect them to deliver, and the frameworks within which they need to operate, and hold them to account accordingly. For the first time, they will have the autonomy to make rapid and sustainable changes to improve services and address health inequalities in their area.

Where services are highly specialised, they will be planned and delivered on a region-wide basis. Building on the programme of work currently underway with Department of Health counterparts in Dublin, we will continue to explore opportunities to plan and deliver services on an all-island basis.

The recent consultation on HSC structures supported the need to reduce bureaucracy and put in place a more effective streamlined mechanism for how we plan health and social care services.

Starting now, we will work with the wider HSC system to design the new partnership approaches to the planning and management of HSC services, which moves away from competition towards collaboration, integration and improvement.

PRIMARY PERCUTANEOUS CORONARY INTERVENTION (pPCI)

This service, based in Belfast and in Derry, means that patients having a particular type of heart attack are taken from anywhere across the North straight to a specialised centre which can undertake this life saving procedure on a 24/7 basis.

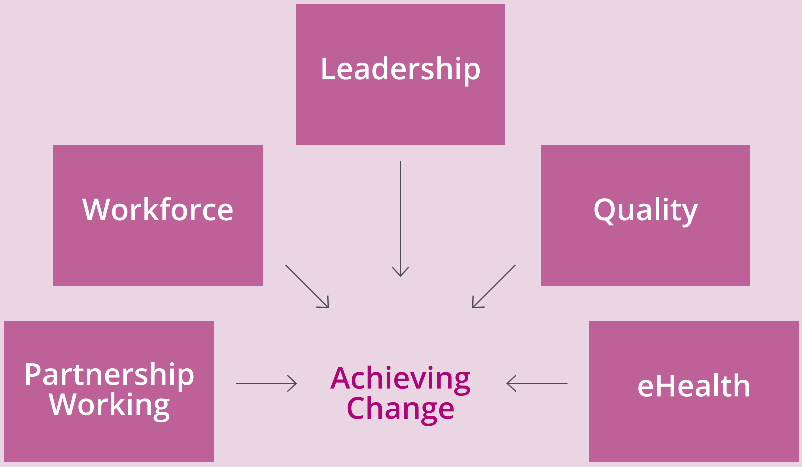
On average a total of 66 pPCI procedures are being carried out per month and from May 2016, Donegal patients have access to the Derry based service.

4

THE APPROACH

How we plan, design, support and implement service transformation is as important as the changes we wish to make.

Only by taking the right approach will these changes be the best ones for our population as a whole, and be sustainable in the long run.



Partnership Working

With people who use and deliver services
Our Health and Social Care system belongs to all of us and we all bring valuable insights to how it can improve. We must work in partnership - patients, service users, families, staff and politicians - in doing so we can co-produce lasting change which benefits us all. Everyone who uses and delivers our health and social care services must be treated with respect, listened to and supported to work as real partners within the HSC system.

Building on the good practice which already exists in the HSC, such as the Mental Health Recovery Colleges, we will work collaboratively in the spirit of openness and trust to deliver agreed outcomes.

When we embark on a change to our system or services, all relevant individuals or groups will be brought together, including those who use and those who deliver our services. A clear terms of reference will be developed collaboratively, ensuring all parties are clear about the task at hand, and how we will work together.

We will adopt creative and innovative ways to maximise involvement. All views and opinions will be received with equal merit. In the past the system has been criticised for delays in bringing forward change, we will support teams to work at pace.

Co-production will empower patients, service users and staff to:

- **design the system** as whole to ensure there is a focus on keeping our population well in the first place and ensuring that when people need support and help they receive safe and high quality care;
- work together to **develop and expand specific pathways of care and HSC services** which are designed around people and their needs, including setting outcomes to measure impact;
- be partners in **the care they receive** with a focus on increased self-management and choice, especially for those with long-term conditions.

A move to this model will not happen overnight. However, I am fully committed to this approach and will support this new way of working across the HSC. In order to start this process in November I will embark on a period of engagement about my proposals for the model of health and care for the future.

I am making a commitment that the design of new and reconfigured services will be taken forward on the basis of co-production and co-design.

We will strengthen the capacity of both those who use our services and those who deliver them to bring about positive change for and by themselves. This includes continued investment in initiatives such as Expert-by-Experience programmes, which provides training and development for users who work with the HSC to improve our services. We will also train staff to support the continued roll-out of the Quality 2020 Attributes Framework.

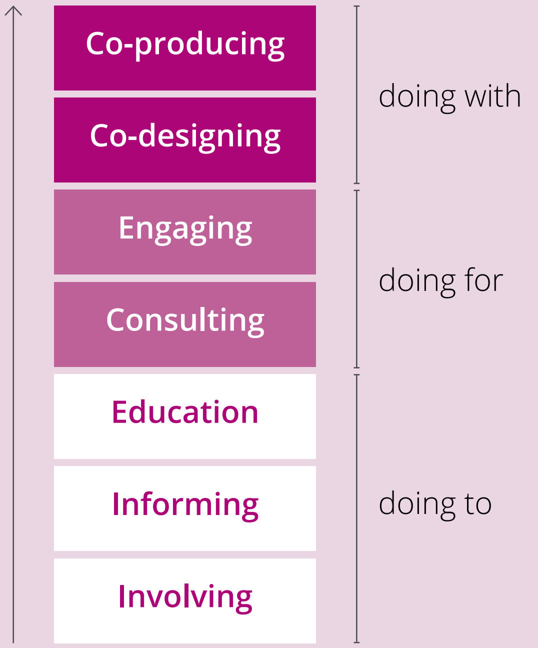
In addition, I intend to maximise the patient voice across our system, and align it much more closely to the quality improvement, and inspection and regulation. I also want to hear the voice of staff particularly those on the ground closest to those who use our services. In early 2017, I will consult and design a new feedback platform open to all those who both use and deliver our services. This will enable users and staff to tell us what matters to them in terms of their health and social care and to raise issues in as timely a manner as possible, so that they can be addressed early before they escalate to a complaint.

Co-production - a new approach to the design and development of mental health services

An example of how co-production can make a big impact on our services is the design and delivery of Mental Health Recovery Colleges. This is an innovative model that assists individuals in their personal and collective journey of recovery. This recovery focussed approach creates opportunities for those with lived experience to contribute as volunteers and in paid roles. These peer educators assist those with mental health problems to discover personal talents and develop life skills which can help them enter the labour market.

A number of people with lived experience have and continue to be developed to become peer educators and are now making a contribution to care delivery. Over 236 sessions of peer education have been delivered.

An alternative ladder of participation



With other providers
Partnership with other providers of care and other service providers is key to improving and safeguarding social, emotional and physical wellbeing. Health and social care has a strong tradition of working with other professions and sectors including the voluntary, community, criminal justice, education, housing and private sectors. These partnerships will be maintained and strengthened to maximise the impact we can make on improving people's health, social wellbeing and quality of life, as well as making the best use of resources.

Improving Quality and Safety

In the design and delivery of health and social care, quality and safety will always be a fundamental priority. The Expert Panel said "any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this".

It is clear to me that, in order to achieve our ambition for health and social care, we need to establish an infrastructure capable of supporting, enabling and driving the improvements we seek, with people at its heart. There needs to be a greater alignment between quality improvement, partnership with those who use our services, and how we regulate those services.

Like many healthcare systems, there has been a gradual increase in improvement capability across our health and social care service. One example is the Regional Mortality and Morbidity Review System, which supports the review of all hospital deaths by multidisciplinary 'frontline' teams to identify learning to improve the quality and safety of care. The system is well embedded in two Trusts at present and will be fully embedded across all Trusts by April 2017. Another example is the Medicines Optimisation Quality Framework which is supporting improvement by scaling up good practices for the appropriate, safe and effective use of medicines across health and social care.

We now need to fully integrate quality improvement into the work of every HSC organisation and provide real support for local and regional improvement work. That will mean improving our capacity to foster local innovation and to implement what works at scale. It also requires us to be able to proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs. Developing the science of improvement can be done at the same time as making improvements.

To deliver a sustainable and world class service into the future will require of all of us to work together very differently. We need an infrastructure that makes this possible.

For that reason, I intend to establish an Improvement Institute that will better align existing resources to enable improvement in our system of care. These include resources currently devoted to patient safety, regulation, evidence gathering, data analytics, information and, critically, those with experience of using our services. My aim is to establish a strong and integrated infrastructure to support improvement wherever it needs to happen across our system of care. This aim will only be achieved with the support and engagement of all leaders across the HSC system.

I have asked my Department to convene a group of local clinicians, professionals and service users with experience in improvement to advise on the design of that infrastructure. This will not be a new HSC organisation but will align existing resources and functions. The design work will be complete by February 2017 and I expect the Institute to begin to test how it will operate by May 2017.

Investing in our Workforce

The Expert Panel has re-affirmed that effective workforce engagement and planning are key enablers to HSC transformation. I believe the far-reaching transformation journey we are about to embark on needs the commitment and engagement of workers across the HSC at every grade if it is to succeed. I am confident that working together we can succeed.

The increasing pressure on services has contributed to difficulties in attracting and retaining experienced staff and the vacancy rate in a range of disciplines continues to grow. These factors have led to an escalation in the costs of maintaining safe service provision through the use of expensive agency and locum staff, as well as longer hospital stays than necessary.

Clearly, this is unsustainable and workforce planning cannot continue to be used simply as an exercise to ensure that existing rotas are filled. It has to be a vehicle for supporting the implementation of a new and sustainable model of care. It has to take account of increasing demand as a result of demographic trends, be informed by robust and accurate workforce information and analysis, and map to the new configuration of services in secondary care and the increased focus on primary care. It also has to address the factors that enhance the attractiveness of key jobs, such as domiciliary care.

However, effective workforce planning is only one aspect of what is needed. We want to ensure that we are harnessing the skills and experience of the 72,000 individuals working in the wider HSC family.

As stated earlier, I want the HSC to be an employer of choice, leading by example and investing in the health and wellbeing of its staff. We will explore ways to build on and consolidate the health and wellbeing services we provide for our staff.

I recognise the fears and anxieties about job security, role and job location that any change process will create. Based on their lived experience, HSC staff at all grades are all too well aware of the unintended day to day impact on their own teams of previous change initiatives. Too many of these experiences to date have not been positive.

I am determined that the unique store of knowledge, commitment and public service ethos that the HSC workforce represents will be listened to, engaged and nurtured at all levels. It is the single most important resource we have to achieve lasting change.

In collaboration with stakeholders, we are committed to ensuring a Workforce Strategy is developed by spring 2017 which will cover all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles and of reskilling and upskilling initiatives. This will require investment but we are convinced that investment in every area of our workforce is critical in delivering this new model of sustainable care.

But it is clear that some action needs to be taken now to address current workforce challenges. Therefore, we will continue to invest in training by expanding GP and nurse training places. I have asked for a number of areas to be looked at in detail, including the appointment of a Nursing and Midwifery Task group which will report within 12 months with recommendations for how we can maximise the contribution nursing and midwifery can make to improved outcomes for the population.

The forthcoming Reform of Adult Social Care and Support will consider the nature, size and skills of the social care workforce needed to deliver social care in the future. I will consider carefully the findings of the Domiciliary Care Workforce Review, which is due to be completed by the end of 2016. I am committed to taking steps to improve the recruitment and retention of this critically important group of staff.

Leadership and Culture

If we are to develop a culture of quality improvement and partnership working, this must be underpinned by a new approach to collective and system leadership. We are fortunate to have some of the most capable, committed and enthusiastic people making up our health and social care workforce. Many leading edge research and reports provide evidence that having continuous learning cultures and team working in health and social care organisations is crucial to ensuring safe high quality care.

Rather than concentrating power at the top, I want all those working in health and social care to feel able to effect change and improvement in care. This means developing leadership at all levels, a truly collective leadership model. I will flatten and remove unnecessary hierarchy, eliminating those policies which inhibit innovation and improvement. If we are to move towards a model of care powered by multidisciplinary teams, we need to empower all teams to deliver care, not micro-manage them. Working in partnership with our staff, I believe this is achievable.

This will require a major programme of cultural change and it will not happen overnight. But we need to start now.

As part of this we need to enhance our clinical leadership. The Expert Panel said that change *"will be more successful if… implemented in a setting which encourages clinical and professional engagement"*. I want to see our structures have more professionals directly engaged in the management and leadership of our services, effecting the change supported by skilled and able managers.

I have recently re-established the Strategic Health Partnership Forum and see this as an important contribution to the development of a new culture of partnership, involvement and listening.

Over the next 6 months, an HSC-wide Leadership Strategy will be developed to support this aim. Resources will be directed over the next 3 years and beyond to develop the right staff and leaders, with the skills, behaviours and values that will be so crucial in developing the compassionate, collaborative and high performing culture we seek.

eHealth and Care

Making better use of technology and data is essential if we are to move to a model focussed on service users, on improving the health and wellbeing of the population and on getting beyond organisational and professional silos. I am determined to realise the potential and opportunities presented by modern information technology to improve outcomes for service users and free up time for front line staff. To do so, co-production must underpin our approach, and we must learn the lessons and build on the experience of current and past HSC IT initiatives.

We will expand the range of information and interaction available to citizens, service users and those providing services both online and through apps. This will include building a new patient portal which will allow secure online access to their own health and care information where service users want this. This new patient portal will be in place for dementia patients next year and rolled out across the North by 2021.

To ensure our staff can focus on supporting individuals, the right information must be available to the right professionals, at the time they need it. Our award-winning approach to sharing information across different IT systems (the Electronic Care Record) has significantly changed the way care is delivered and improved safety. However, we still have too many different systems across the HSC making it difficult to join up data and focus on the service user.

We are currently assessing the best way to achieve a much more consolidated and common patient and user record, with fewer separate IT systems. This will be a major undertaking. We will aim to liberate time for care by equipping our community based workforce with new technology that will increase the time that doctors, nurses, therapists and social workers have to spend with patients. If we can realise a 15-minute increase in care time by reducing bureaucracy this equates to over 1,000 additional care professionals working with service users. These initiatives will also allow more staff in the HSC to work remotely, saving travel to and from hospitals, care centres and offices.

Moving to a more consolidated health record across the North will allow us to make better use of information about our population - designing new ways to intervene early and support people in managing their conditions. A programme of work to improve our use of health analytics, focussed on dementia patients, will start in 2017.

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THE ACTIONS

In this document I have set out my commitment to change but I recognise that much work is needed to develop, design and deliver the building blocks that will enable sustained improvement. I am committed to achieving the change required using a process of co-production.

The task is challenging and will take sustained and incremental effort over the next ten years to achieve real transformation.

But we start now. In the next section I have set out my actions for the next 12 months. These will be taken forward to make a positive and ambitious start towards stabilisation, reconfiguration and transformation.

As I have said, to deliver real and meaningful change will require an extension of the political goodwill and cooperation given to the Expert Panel. Moreover significant investment will be required. I believe this shared investment will not only improve people's health and wellbeing but have a positive impact on every aspect of their lives.

I fully believe that it is only by working together we can deliver a world class health and social care system.

Stabilisation

1	Develop a comprehensive approach for **addressing waiting lists** which takes account of the ongoing work of the Health and Social Care Board, as well as the recommendations from the Expert Panel.	*January 2017*
2	To improve access and resilience, and support the development of new models of care, make **significant investment in primary care** to ensure there is a multidisciplinary team focussed on the patient and with the right mix of skills. This will be supported by: - increased GP training places; - continued investment in Practice Based Pharmacists; - ensuring every GP practice has a named District Nurse, Health Visitor and Social Worker to work with; - supporting the development of new roles such as Physician Associates and Advanced Nurse Practitioners; and - further roll-out of the AskMyGP system. Bring forward a public consultation on the role of GP Federation and whether they should become HSC bodies.	*March 2017*
3	Bring forward proposals relating to the extension of placement options for **Looked After Children**.	*October 2017*
4	Following the completion and evaluation of a pilot project, roll-out access to the electronic care record (NIECR) to **community pharmacists** and establish a pilot to test access to the record for **independent optometrists.**	*October 2017*
5	Begin development of a new framework to fully realise the potential of **community pharmacy services** to support better health outcomes from medicines and prevent illness.	*November 2016*

Reconfiguration and service change

6	Embark on a consultation on the criteria set out in the Expert Panel Report and start a programme of **service configuration reviews**. These will be clinically led, working in partnership with those that use the services.	*November 2016*
7	As part of this process, my immediate priorities are:	
	• following extensive review and engagement, launch a public consultation on proposals to modernise and transform **Pathology** services designed to improve service and workforce sustainability ensuring a high quality pathology service for the future;	*November 2016*
	• move forward with the implementation of the new **Diabetes** Strategic Framework, which has been, and will continue to be, developed through partnership with patients and their representative groups;	*November 2016*
	• launch and commence implementation of the **Paediatric Strategies** (2016-2026) designed to modernise and further improve the standard of treatment and care provided in hospital and community settings, and palliative and end of life care for children and their families; and	*November 2016*
	• launch a public consultation on proposals to develop sustainable **Stroke** services and further improve the standard of treatment and care provided to stroke patients.	*February 2017*
	• following a recent review, launch a public consultation on the configuration of **Imaging** services, taking account of advances in technology, demographics and demands, and looking to both national and international best practice;	*February 2017*
8	Bring forward proposals for the location and service specification for **Elective Care Centres**, and **Assessment and Treatment Centres.**	*October 2017*
9	Develop design for new structures and approaches to support the **reform of planning and administration** of the HSC	*March 2017*
10	Identify current **innovative HSC projects** at the local level and develop a rolling programme and implementation plan to scale up these projects across the region.	*April 2017*

Transformation

11	Embark on a **period of engagement** with staff and service users to build a collective view of how our health and social care services should be configured in the future, and encourage a much wider public debate.	*November 2016*
12	Establish and seek members for a **transformation oversight structure** with membership drawn from within and outwith the HSC.	*November 2016*
13	Consult on proposals for the reform of **adult social care and support**, to consider different approaches to ensuring the long-term sustainability of the adult social care system.	*April 2017*
14	Consult on proposals for and complete design of a **new user feedback platform** open to all those who both use and deliver our services.	*October 2017*
15	Complete the initial design work for the **Improvement Institute.**	*February 2017*
16	Develop a **Workforce Strategy** covering all aspects of the HSC workforce, including retention and recruitment; opportunities for introducing new job roles; and upskilling initiatives.	*May 2017*
17	Develop a **HSC-wide Leadership Strategy** to consider a 5 year approach and plan for development of collective leadership behaviours across our system.	*May 2017*
18	Expand the range of information and interaction available to citizens online and development of a **patient portal** for dementia patients.	*October 2017*