SYSTEMS, NOT STRUCTURES:

CHANGING HEALTH & SOCIAL CARE

Expert Panel Report

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The Panel would also like to record their gratitude to the many organisations and individuals from across the HSC who gave of their time and expertise to informing this work. The report would not have been possible without their involvement.

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SECTION 1

THE PANEL'S REMIT AND THE POLITICAL SUMMIT

In his speech of 4 November 2015, the then Minister for Health, Simon Hamilton MLA, announced that in response to recommendation 1 of **The Right Time, The Right Place** report by Sir Liam Donaldson, he would appoint an expert, clinically led panel to consider and lead an informed debate on the best configuration of Health and Social Care services in Northern Ireland.

Sir Liam's report stated:

"A proportion of poor quality, unsafe care occurs because local hospital facilities in some parts of Northern Ireland cannot provide the level and standards 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".

The Panel was appointed in January 2016 and comprises local and international members. The Panel was given the remit to:

- Produce a set of principles to underpin reconfiguration of health and social care services.
- Support and lead debate including at a political summit to be held in early 2016 to agree the principles.
- Use the results of the political summit to develop a clinically informed model for the future configuration of health and social care, which will ensure world class provision for everyone in Northern Ireland.
- Clearly quantify the specific benefits in health outcomes that will be derived from the new model, both for individuals and the Northern Ireland population as a whole.

Political Summit: 17th February 2016

The panel along with MLAs and advisors from the DUP, Sinn Fein, UUP, SDLP and Alliance met for a one day health summit to discuss the need for change and agree a set of principles that would guide the panel in structuring a New Model of Health and Social Care for the people of Northern Ireland. Each party provided both verbal and written comments to a 'draft set of principles'. In turn the panel considered all comments and revised the principles to take as many of these on board as possible.

The final set of principles is attached at Annex A.

Engagement

The Panel has engaged extensively with stakeholders across health and social care, and the following key messages were heard consistently:

- The unsustainable nature of the 'status quo'. Major workforce gaps in all areas of the current model of service requiring significant investment in agency staff to maintain the current distribution of acute care.
- Underinvestment in primary and social care, the very services that can prevent hospital admission, because of over-investment in the current hospital model.
- Even with the funding used to purchase independent sector and 'in-house' waiting list initiatives, there are increasing delays for elective care.
- The contribution of unpaid carers and the voluntary sector, and the desire for the voluntary sector to be a trusted partner in care.
- Independent providers are delivering significant elements of care in domiciliary and residential care home settings and are struggling to cope with current funding levels.
- The need to invest in improving the health of our population and to take a more co-ordinated approach to supporting people with complex needs.

SECTION 2

THE BURNING PLATFORM – AN UNASSAILABLE CASE FOR CHANGE

Context

In the course of its work, the Panel has heard repeated references to 'review fatigue'. In essence, there seems to be a sense that the Health and Social Care (HSC) system has repeatedly spent significant time and resources analysing the challenges it faces, identifying the weaknesses in the current model, making recommendations for change, but subsequently failing to enact the necessary transformation to make these happen. The timeline at fig. 1 gives a sense of the main reforms and reviews that the system has experienced since the 1970s.

Across the system, there has been a broad consensus among those the panel has spoken to that there is a need for transformational change in the way services are delivered and the way our system is organised. It is important to fully understand the nature of the challenges and demands that health and social care services face, and also the reasons why the model that is currently in place is outdated and is not the one that Northern Ireland needs. Many of these issues will not come as a surprise to those working across the system or those who use its services. Indeed, many of these issues were plainly articulated to us from a number of different sources, who made clear their concerns with regard to factors such as rising demand, changing demographics and patterns of illness, financial sustainability, workforce planning and vulnerable services. Although there are committed and talented people at all levels of the system, the system itself is not making the most effective use of the available public funds to meet service users' needs.

Northern Ireland is not alone in facing these challenges. Health and social care systems across the developed world are currently struggling with the question of how to adapt their services to deal with continuously rising and changing patterns of demand. Most countries also recognise that simply adding more money and resources to tackling these issues is not enough to make services higher quality and sustainable, radical transformation is required. This is not an easy thing to do; change and transformation are always difficult, they create uncertainty and they require us to give up what we have in exchange for something new. This is particularly difficult when it involves something that is very important to us, such as the health and social care services that we and our families will all need to call on at some point in our lives.

Fig. 1 – Reviews and Reforms of Health and Social Care in Northern Ireland

1973	The HPSS (NI) Order provided for the establishment of four Health and Social Services Boards, responsible for administering and arranging provision of services.
1989	A Government white paper introduced the concept of an internal market. In Northern Ireland, this led to the establishment of 19 Trusts.
1998	Fit for the Future proposed the abolition of the internal market with commissioning decisions taken as close as possible to patients and clients and centred on primary care.
2001	The Acute Hospitals Review suggests the establishment of a single Strategic Health and Social Services Authority to replace the four HSS Boards. It also recommends moving to a service with 9 acute hospitals
2002	Developing Better Services supports significantly reducing the number of HSC organisations, including the creation of a single regional authority. Also recommends the 15 Local Health and Social Care Groups (LHSCGs) should be brought together.
2002	GP fundholding abolished. Arrangements for LHSCGs, as committees of the four HSS boards are put in place to assess need and design services. 15 were in place by 2005.
2005	The Appleby Review focuses on the need for rigorous performance management and greater incentivisation of strong performance.
2007	The then Minister decides against a regional Health Authority. Instead, he confirms the creation of 5 new integrated Trusts, 5 Local Commissioning Groups, a smaller Health and Social Care Board focused on commissioning, financial and performance management, and a Public Health Agency.
2011	Transforming Your Care sets out a broad new model of care, moving away from hospitals and into primary, community and social care services. Recommends 5-7 hospital networks
2014	Sir Liam Donaldson endorses the policy behind TYC but recommends the appointment of an impartial panel of experts to deliver the right configuration of HSC services.
2015	Following the Donaldson report and an internal review of commissioning, the then Minister launches a consultation on a review of the HSC administrative structures. The review recommends abolition of the HSCB.
2016	The appointment of an international expert panel to develop a clinically informed model for the future configuration of health and social care.

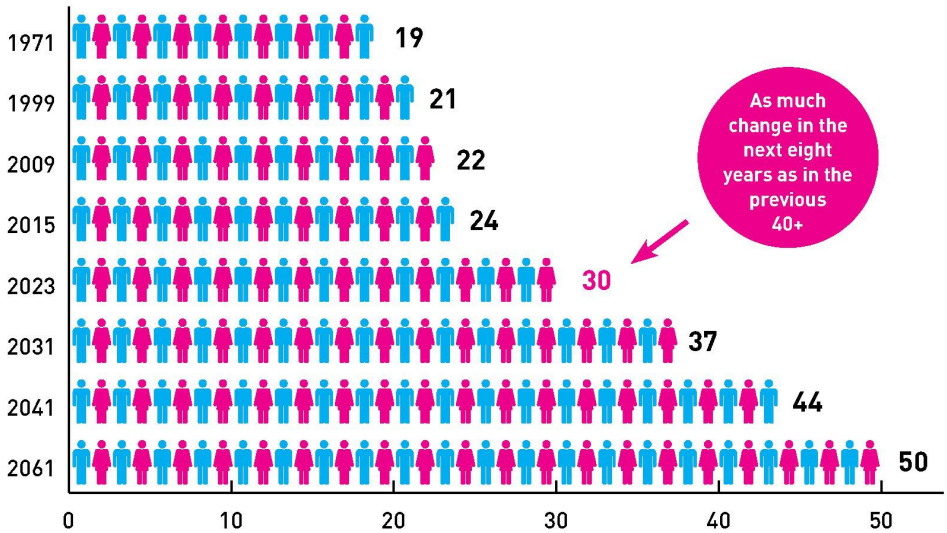
However, it is important that the case for change is clearly understood by those who use and those who deliver these services, and also the risks of not making these changes in a planned and transparent way. In this section of the report, the evidence that the existing system is already struggling to sustain services in the face of these changing circumstances is set out and the case made for new service models. Without systematic and planned change, already stretched services will undoubtedly be forced into unplanned change through fire-fighting and crisis.

The stark options facing the HSC system are either to resist change and see services deteriorate to the point of collapse over time, or to embrace transformation and work to create a modern, sustainable service that is properly equipped to help people stay as healthy as possible and to provide them with the right type of care when they need it. This report presents an opportunity that must be seized and acted upon.

Demographic Change

As a population, we are living longer than ever before and, for most of our lives, are healthier than ever before. When the NHS was created in 1948, life expectancy was 65.8 years for men and 70.1 years for women. It is now 78.1 for men and 82.4 for women. The number of older people in our community is also increasing as a proportion of the overall population. In 2013 there were estimated to be 279,000 people aged 65 and over, with 33,000 of them over 85 years. This is projected to increase considerably in the next 20 years to 456,000 and 79,000 respectively. As the graph below demonstrates, the demographic shift for the period from 2015-2023 will be equal to the demographic shift in the preceding 40 years.

Fig. 2 – Population Projections (2015-2061)



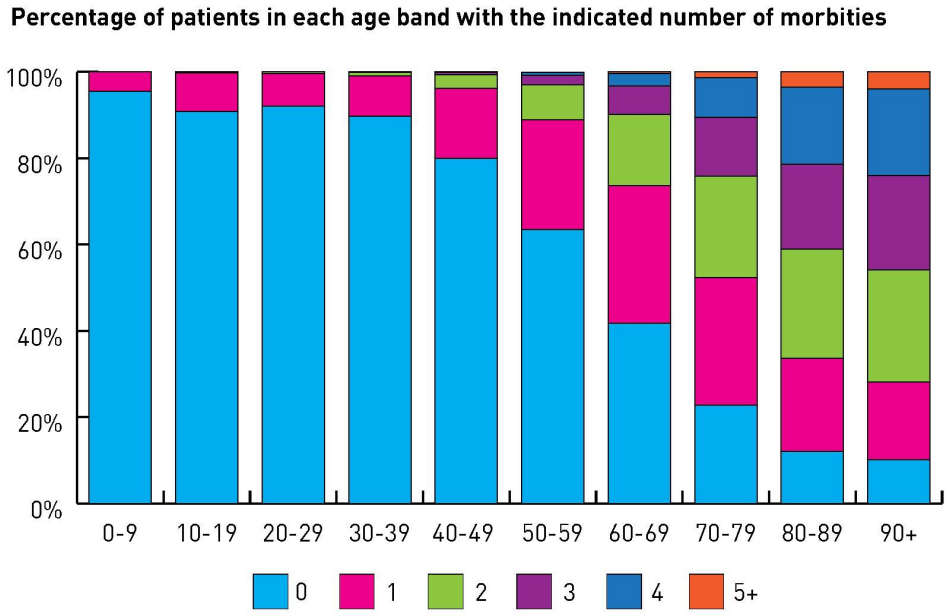
An ageing population: Number of older people (65+) per 100 aged 16-64

It is a similar picture across the UK and Ireland. However, out of all the UK countries, at 43.1% Northern Ireland had the largest percentage growth of people aged 85+ between mid-2004 and mid-2014. This is projected to continue over the 25 year period between mid-2014 and mid-2039.[1]

This increase in life expectancy is a great achievement, but it signals a major shift in demography and in patterns of demand for health and social care services. Ageing brings an increased likelihood of some degree of disability, dependency and illness, and older people are now the main users of Northern Ireland's health and social care services. The rate of disability among those aged over 85 is 67% compared with only 5% among young adults.[2] Dementia is also a growing issue for our older population, with 60,000 people projected to be suffering from the condition by 2051.[3] In addition, the profile of older people requiring care is becoming more complex, with many people now living with multiple chronic illnesses.

As well as living longer, developments in how we are able to treat and manage conditions mean that we are all much more likely to develop and live with one or more long term conditions. The table below[4] clearly demonstrates that as we get older, the likelihood of multiple morbidities increases dramatically, meaning that the care and treatment that we require becomes much more complex.

Fig. 3 – Co-morbidities by Age Band



1. NISRA Statistical Bulletin: 2014-Based Population Projections for Northern Ireland (published 29 Oct 2015)
2. Transforming Your Care, Health and Social Care Board, December 2011
3. Dementia Strategy, DHSSPS, 2010
4. Source – Health and Social Care Board, 2016

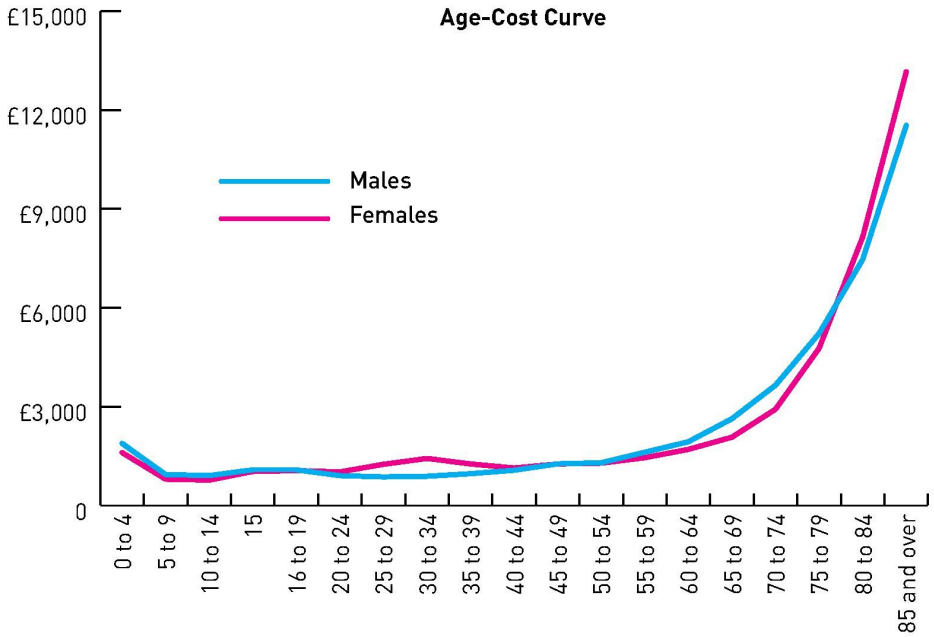
Impact on the HSC system

According to the latest figures, currently in Northern Ireland:

- Two thirds of acute hospital beds are currently occupied by people aged over 65;
- 9,670 people over 65 live in residential care or nursing homes;
- Approximately 23,400 users weekly receive domiciliary care.

In terms of costs, users aged over 65 account for more than two-fifths of HSC spending – 42%, compared to their population share of 14%. Whereas the average cost of treating a 55-59 year old stands at £1,970 per head, this rises to over £6,000 for 75-79 year olds and £14,000 for the over 85s.[5]

Fig. 4 – Age/Cost Curve



Ultimately, all of these figures and statistics illustrate a significant success story for Health and Social Care. As a population, we are seeing a marked reduction in acute life-threatening illnesses, but in their place we are now dealing much more commonly with long term conditions and disability as a result of the population's increased longevity.

The pressure that this is placing on the HSC's finite resources cannot be resolved by continuing to rely on the current acute care model. The change in the nature of the demand facing the system is not reflected in the ways services are designed

5. Source – Department of Health

and delivered. The vast majority of care is provided in the person's home or in local communities by unpaid carers, primary and community care teams, and the voluntary and independent sector. Acute hospitals are designed to deal with acute illness, not chronic conditions, and yet the beds in acute wards are filled with those whose needs may well be met more effectively and more efficiently elsewhere. The question that needs to be posed is whether the current system, which was set up to meet the needs of the mid to late 20th century, is still the right one to meet the changing patterns of illness and demand that we face in the 21st century.

Health Inequalities

While overall people are living longer and healthier lives, health inequalities continue to be a major issue. Life expectancy for males in the most deprived areas of NI is on average 7.5 years less than their counterparts in the least deprived areas. For females, the differential is 4.3 years.[6]

Fig. 5 – Deprivation & Life Expectancy

6. Source – Department of Health

The healthy life expectancy of people in the most and least disadvantaged areas differs dramatically. On average males live 58. 7 years in good health, females 62.2 years. However, female healthy life expectancy in the most deprived areas is 14.2 years lower than in the least deprived areas; and comparable figure for male healthy life expectancy is 11.8 years.

These inequalities also have a detrimental impact on the HSC system.

- There are 9 admissions to hospital for every 20 people in the most deprived areas compared to 6 admissions for every 20 people in the least deprived areas;
- Emergency admissions to hospital are 74% higher in most deprived communities than in the least deprived;
- Elective admissions to hospital are 25% higher in most deprived communities than least deprived;
- Hospital day cases are 21% higher in most deprived communities than least deprived.

Evidence from Marmot's review of health inequalities in England indicates that addressing health inequalities requires co-ordinated action across the wider determinants of health.[7] Action is required across government, to do more to improve universal public services as well as more targeted services for those with greater need.

In fact, research shows that only about 20% of health outcomes are related to clinical care: 10% is related to physical environment (air and water quality, built environment, etc); 40% is related to socio economic factors (education, employment, social support, community safety); and 30% is related to behaviours.[8] The diagram below shows some of the key indicators highlighting the gaps between most and least deprived.[9]

Fig. 6 – Health Inequality Indicators

Indicator	Baseline Year	Unit of Difference	Simple Gap
Male Life Expectancy	2009-11	Years	7.2
Female Life Expectancy	2009-11	Years	4.4
Infant Mortality[20]	2007-11	Deaths / 1,000 live births	0.8 (16%)
Smoking during Pregnancy	2012	Percentage	22 (280%)
Breastfeeding	2012	Percentage	30 (52%)
Key Stage 2 - Communication	2011/12	Percentage	20 (24%)
Key Stage 2 - Mathematics	2011/12	Percentage	21 (24%)
GCSE	2011/12	Percentage	22 (35%)
Alcohol-related Admissions	2009/10 - 2011/12	Admissions / 100,000 population	1,246 (452%)
Teenage Births	2011	Births / 1,000 Females	3.9 (570%)
Suicide	2009-11	Deaths / 100,000 population	21 (244%)

7. Fair Society, Healthy Lives, Marmot, 2010
8. http://www.countyhealthrankings.org/our-approach, County Health rankings and roadmaps, Robert Wood Johnson Foundation
9. Source – Department of Health

We can see that health and health inequalities are interrelated with the economy, economic inactivity, poverty, social isolation, educational underachievement, criminal justice, regeneration, and many other parts of government.[10]

Access to health and social care services is of course an essential component for the population's health outcomes, but as mentioned above, there is evidence that it is not in itself as important as lifestyle and environment – the circumstances in which people live, work and bring up their children.

While much of this is beyond this panel's terms of reference, it is clear that the Department of Health needs to continue to work in partnership with other departments and sectors to tackle the underlying social, economic and environmental determinants of health across the population. Local health and care partnerships, if properly organised, can also do much through local initiatives and shared budgets to address these fundamental determinants of health and wellbeing. As a major employer, the HSC has much to contribute to 'pathways to employment' through apprenticeships and other schemes to improve employability, and the estate owned by the HSC can provide opportunities for affordable housing. The HSC can also be a leader in the 'green economy' and improve the environment in local areas.

Rising Demand

As mentioned above, the demand for health services is growing and will continue to grow, driven by demography, an increase in chronic conditions, emergence of new technologies and changing practice in health care.

Currently in Northern Ireland:

- 1 in 5 people have a long-standing health condition;
- 60% of people are overweight (37%) or obese (23%);
- Almost one in five adults in Northern Ireland shows signs of a mental illness;
- 10.3% of the population claim Disability Living Allowance;
- The population is getting older;
- People have higher expectations.

These factors are creating pressures across the system and putting increasing demands on an already stretched system.[11]

10. Marmot, 2010

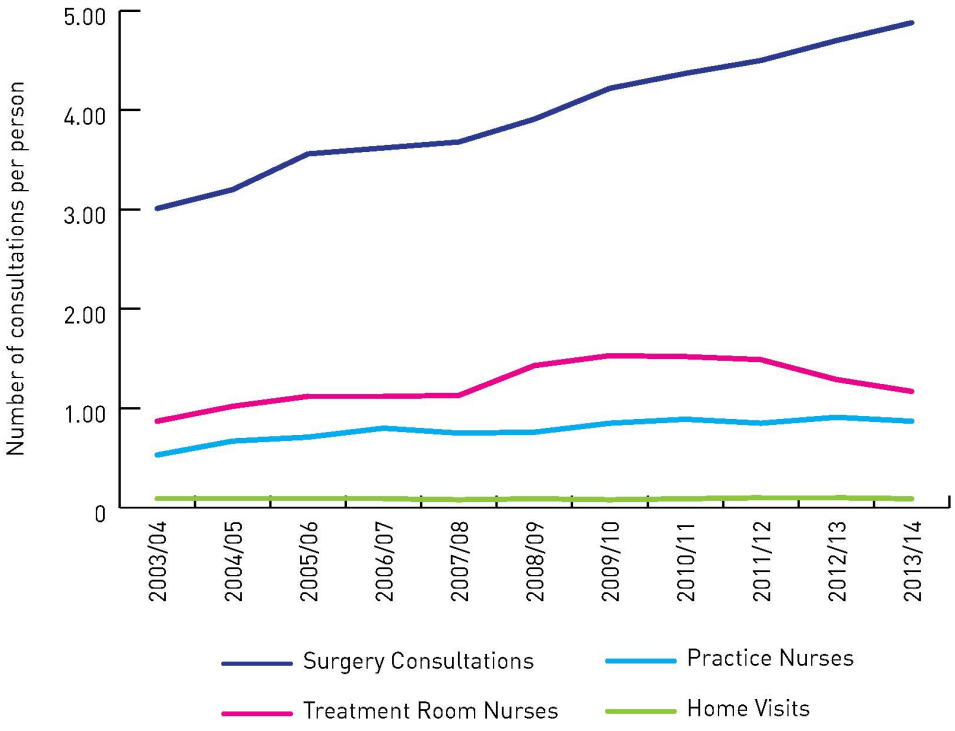
11. Source – Department of Health

Primary Care Service

Primary Care, as provided by General Practitioners (GPs), is the entry point to the Health and Social Care system for the majority of clients. Over the period 2008/9 to 2013/14, the demand for access to GP surgeries has increased on average by 21.5% whilst over the same period demand for GP Out of Hours (OOH) services has increased by 18%.

As the figure below shows[12], since 2003, there has been a steady and persistent rise in consultation rates for GPs. In 2008/9, 10.2 million consultations were undertaken by GP Practices; in 2012/13, 12.4m consultations were undertaken. This equates to an average of 6.9 consultations per patient per year in NI which is at the very high end of the spectrum compared with other OECD countries. In the south of Ireland the figure is 3 consultation per patient per year.

Fig. 7 – Consultation Rates



In conjunction with the rise in the number of consultations, there is also a growing number of complex patients who are more likely to have several co-morbidities.

12. Ibid

This rising demand cannot be resolved by the existing reactive model of care.

Hospital Services

People who require more specialist care are referred by their GP to the acute hospital sector. In addition to this, Emergency Departments provide a 'front door' to people who either self refer or who are assessed by primary care as needing urgent care. In 2011, **Transforming Your Care** forecast that the demand for acute services could grow by around 4% per year by 2015 and suggested that without change this would require:

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 40,000 extra ambulance responses.

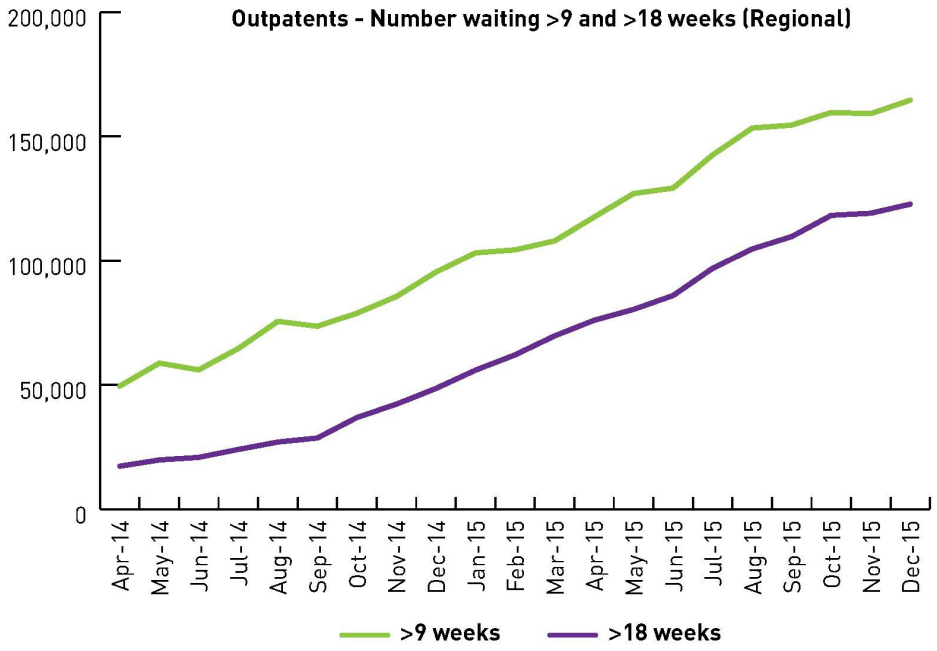
In fact, these estimates have proved to be a significant underestimate. The Department of Health's figures show that:

- The number of outpatient appointments, including appointments in the independent sector, increased by almost 121,000 between 2010/11 and 2013/14.
- The number of inpatient and day case hospital admissions, including those in the independent sector, increased by almost 48,000 by 2013/14.
- The number of Category A, B and C ambulance responses increased by almost 52,000 between 2010/11 and 2014/15.
- There has been a 5.7% increase in the number of inpatient admissions to hospital over the period. However, within the overall figures, there has been a 13.3% increase in non-elective admissions.
- In 2014/15, more than three-quarters (77.9%) of inpatient admissions were non-elective compared to 72.6% in 2010/11. Such an increase in emergency and urgent admissions can impact on hospitals' capacity to meet the demand for elective care, meaning more cancelled operations and appointments, and longer waiting times as priority is given to responding to the increasing demand for urgent care. This has been a major factor in the rise in waiting lists and waiting times for elective care in Northern Ireland.

13. Source - HSCB

In 2014/15 the financial constraints on the public sector led to a reduction in both in-house and independent sector waiting list initiatives. As a result, the number of outpatient appointments and hospital admissions dipped slightly (although still remaining significantly higher than 2010/11) while demand continued to increase. This resulted in sharp increases in waiting times and waiting lists (see table below[13]).

Fig. 8 – Outpatient Waiting Times



These figures more accurately reflect activity rather than demand. The increase in elective care waiting times indicates that there is further, unquantified demand for care.

As the growing waiting lists clearly show, the existing model is not addressing these challenges effectively.

200000

Social Care Services

>18 weeks

>9 weeks

150000

Although health and social care services are integrated in terms of delivery organisations in Northern Ireland there are differences between them. Provision of social care is often determined by different legislation. Unlike healthcare it is not universally free at the point of delivery with adults receiving social care being subject to means testing.

100000

There is a far greater diversity of providers of social care than health care with very significant amounts of social care being delivered by the private and voluntary sectors. How to deliver adult social care on a sustainable basis in ways that reflect people's preferences for how they want to lead their lives is an important challenge but this has not been the focus of this report and it is understood that the Department of Health is undertaking a separate exercise to consider these issues. They are however related. The purpose of social care is to promote social wellbeing including protection from abuse, reducing social isolation and the

50000

Apr-14 May-14 Jun-14 Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15

promotion of independence. Poor social wellbeing can have a negative impact on the quality of people's lives, including their health and in turn can have an impact on other public services, including healthcare, criminal justice and the benefits system. Social care can be particularly important in helping prevent people from being admitted to hospital and in facilitating their discharge when medically fit. Pressures on social care will inevitably have an impact on healthcare.

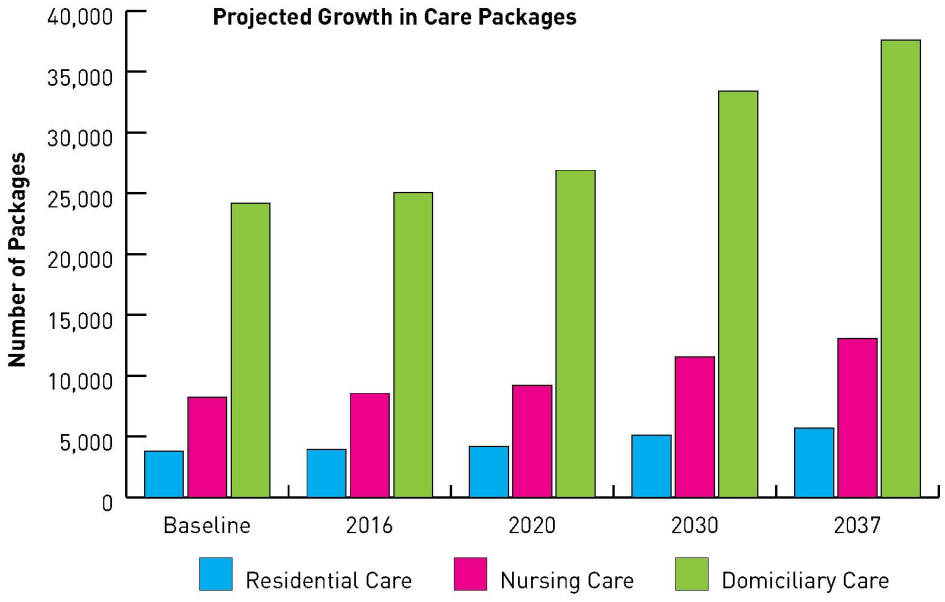
Expenditure on the Elderly Programme of Care amounts to 62% of total expenditure on adult social care services, with £543m of a total £873m being spent in this area.[14] Therefore, it is clear that an increase in the older population will require more support from the adult social care system and will require significant additional resources to adequately provide for people in need of care and support.

Using NISRA 2014 based population projections the Department of Health has carried out a crude projection of future demand for domiciliary care, residential care and nursing home care following the same growth rate as the population (18-64 and 65+).[15] The projections indicate that:

- an additional 4,050 care packages will be required in 2020 compared to current levels, an increase of 15%;
- an additional 20,101 care packages will be required in 2037 compared to 2016, an increase of 68%.

The graph below demonstrates the projected growth in the numbers of packages required:

Fig. 9 – Projected Growth in Care Packages (estimate)



14. Source – Department of Health

15. NISRA 2014-Based Population Projections, Projections by sex and single year of age (published 29 Oct 2015)

Demand and the Patient/User Experience

Of course, none of the preceding three service areas exists in isolation and any increase in demand, or lack of capacity to deal with this demand, in one part of the system has significant implications for the others.

This can be demonstrated most clearly by the impact caused by unmet demand for social care at both the front end (i.e. admission to hospital) and back end (i.e. discharge from hospital) of the system. The level of care people receive in their own community increasingly plays an important role in supporting people to live in their own homes and reducing the need for medical interventions either in a primary or secondary care setting. It also plays a fundamental role in the way the system operates by providing a way out of hospitals and a route back to the community or to an individual's home.

The sum of all this pressure is building to create a perfect storm for the entire Health and Social Care system. Patients are admitted to hospital unnecessarily because they can't access the treatment they need in their community, and, once admitted to hospital, are forced to stay longer than they need to because of the absence of domiciliary care packages to support them at their homes. This immediately causes:

- Pressures on the number of available beds;
- Unnecessarily busy Emergency Departments;
- Reduced capacity for dealing with elective/scheduled care;
- Poorer patient experience;
- Increased pressures on health and social care staff.

Ultimately, if there is insufficient capacity in social care to meet demand, this has a serious impact across the system in terms of increased GP appointments, Emergency Department attendances, higher rates of hospital admission and delayed discharges for patients who are well and ready to leave the hospital setting.

Workforce

The HSC's workforce is its biggest resource, its biggest strength and its biggest cost. Our health and social services cannot function without the commitment and skills of the people who work in them. These are also the people who have to cope at the coalface with the impact of the enormous pressures caused by rising demand.

Health and social care systems in Northern Ireland and in other jurisdictions, are reporting severe difficulties in recruiting and retaining staff. There is a growing doomsday scenario of not having enough GPs, hospital consultants and junior doctors, nurses, Allied Health Professionals, and social care staff that will inevitably lead to people not receiving the care they need.

There is also a recognised frustration among the highly educated and experienced workforce at all levels of the system with the lack of opportunities to work to the full level of competence to which they are trained.

Current health and social care models and the workforce designed to provide and implement those models are not sustainable in the long term and focus too much on a paternalistic approach based on ill health rather than working with patients towards a model of self care that is based on maintaining the health of the population. Breaking down the professional boundaries between staff and creating new generic roles is critical to providing an integrated, sustainable model of care for the population.

The transformation required in workforce will require a significant mind shift from the traditional, hierarchical and often professional silo approach to roles and responsibilities. It will require the relaxing of some of the strong and restrictive professional regulatory barriers that often delineate one professional role from another. For a workforce that maintains patient safety, professional regulation will always remain a prerequisite to protect the public from rogue professional practice.

A key message from the preparatory phase of producing this report was that without a radical review of the workforce in Northern Ireland the ambition to deliver co-ordinated care around patient need at population health level, local community level and individual level, the required transformation will not be possible.

Some of the issues and challenges facing workforce development currently in NI, as in the rest of the UK, have been highlighted in the Nuffield Trust report - Reshaping the Workforce to Deliver the Care Patients Need, 2016. They include:

- Lack of role clarity
- Lack of regulation and competency framework
- Understanding the implications of nurse staffing ratios
- Fragmentation of care
- Professional resistance[16]

16. Imison C, Castle-Clarke S, Watson R, (2016) Reshaping the Workforce to Deliver the Care patients Need, Research Report, Nuffield Trust

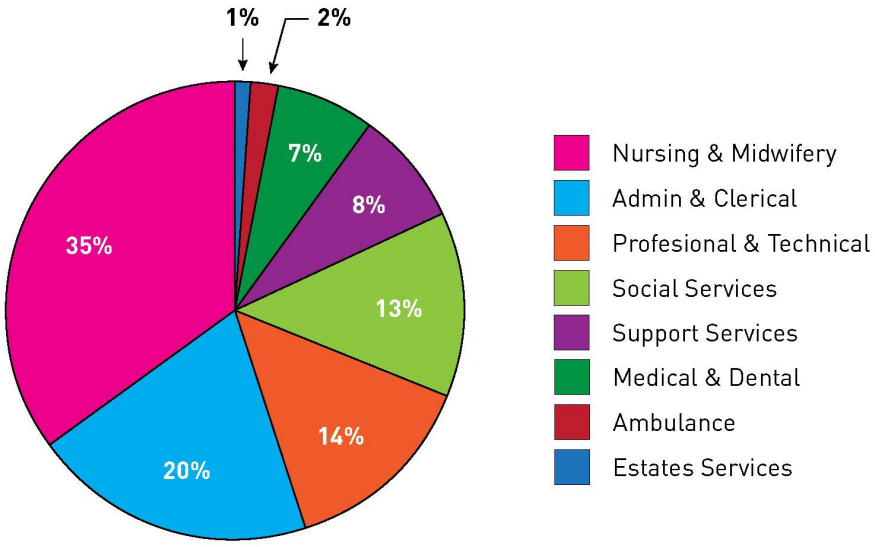
Recent reviews of the service in NI (TYC, the Donaldson Review, Quality 20/20 etc.) have identified that in order to transform services fundamentally, it will require a modern health and social care workforce that can work collaboratively to meet the needs of the population.

An approach to a workforce that responds to a population health model requires one of a blended nature where staff, professional and unregistered/unregulated, are recognised for the combined expertise they bring to a health and social care team that is built around the needs of patients. This will require a real shift from the current, sometimes narrow professional boundaries, to one that recognises that nurses, doctors, allied health professionals, and Health Care Assistants all have a role to play and one that focuses on having the right people in the right place at the right time to provide/contribute to the best care pathway for patients.

The success of any new service model will be absolutely dependent on staff being employed and deployed in such a way that makes the best use of their skills and which allows them to continue to develop as professionals while providing the services that users and patients need. The patient experience, and their perception of the quality of care they receive, depends in a very significant way on having well-trained, experienced and motivated frontline staff.

The HSC currently employs 54,637 whole time equivalent members of staff. The mix of staff is primarily driven by the need to support the existing care model, which is institutionally based. Comparing the most recent data with the mix of staff set out in TYC, it would appear that there has been little progress in attempting to shift resources away from this model. (See chart below)

Fig. 10 – Workforce Mix



The Panel has found that one of the major flaws of the current medical workforce mix is that it is focused on filling rotas and maintaining existing services, even where there are clear signs that these are not sustainable, rather than on detailed forecasting of demography and need. As one professional put it, "we are currently papering over the cracks in the current system, rather than investing in long term strategic change".[17]

As a case in point, it is proving extremely difficult to recruit and retain junior medical staff to deliver services where they would be unlikely to get the experience they need in terms of volumes and case mix in order to maintain their skills and develop new skills. This is reflected in the current, highest ever level of vacancies in training posts.[17]

Locum/Agency Costs

In recent years there have also been stark increases in costs associated with locum and agency staff to provide a safe service where it is not possible to recruit to permanent positions. The Northern Ireland HSC currently spends almost £77 million on locum and agency staff across the HSC workforce and these costs have been steadily rising. This is more than it spends on the entire GP OOH service.

Fig. 11 – Locum/Agency Spend 2010/11-14/15[18]

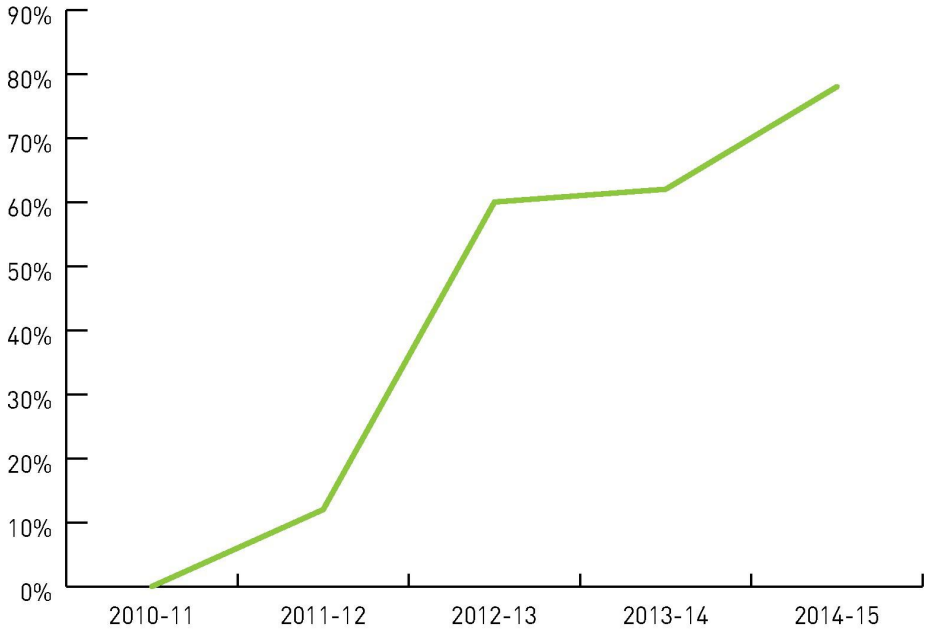
Agency Spend (includes locums)	2010/11	2011/12	2012/13	2013/14	2014/15
Medical & Dental	23,644,956	23,093,817	32,439,996	32,558,600	38,506,733
Nursing & Midwifery	6,916,885	8,641,658	9,852,129	11,116,340	12,094,055
Prof & Tech	1,217,178	2,388,060	4,940,249	3,978,227	3,039,152
Admin & Clerical	5,002,680	6,618,493	10,915,492	10,830,821	10,561,767
Support Services	2,033,150	2,882,374	4,725,091	5,273,308	6,312,881
Estates & Maintenance	0	0	10,084	601	19,945
Social Services	4,082,394	4,620,066	5,529,989	5,819,582	5,811,160
Ambulance	140,208	89,451	140,436	101,210	135,929
Other	0	22,429	124,726	0	26,988
Total	43,037,451	48,356,348	68,678,192	69,678,689	76,508,610

17. Source - NIMDTA

18. Source – Department of Health

In only five years, the amount the HSC spends on agency and locum cover has increased by 78%. The panel has even been presented with anecdotal evidence that for some junior doctors, the benefits of taking on locum work have superseded the benefits of having a permanent position.

Fig. 12 – Total Annual Locum/Agency Spend Increase from 2010 Level



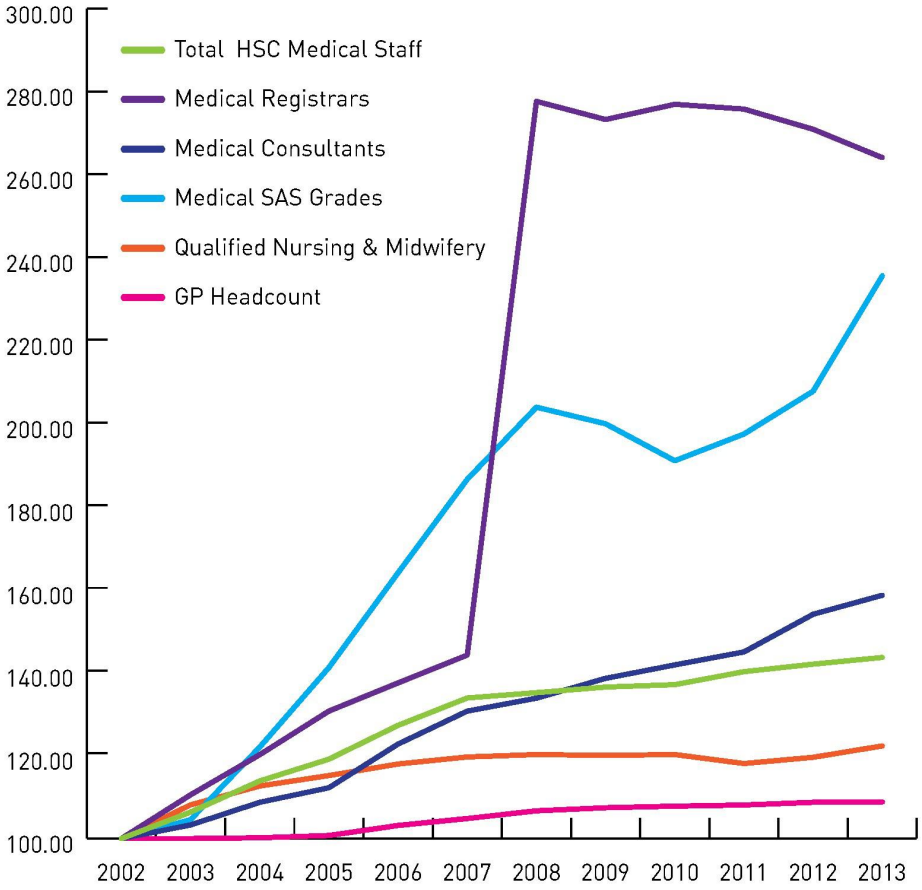
Much of the marked increase shown above is due to the high cost of filling rotas and propping up services where there is little or no chance of recruiting staff into permanent positions. It is also worth highlighting that what the system spends on locums or agency staff is money that is not available for investing in other parts of the HSC. Locums are expensive to employ and this money could be much more effectively invested in developing services that are sustainable in the long term. This would also have real benefits for staff, who would have improved professional development and job satisfaction, and for patients, in terms of the quality of care they receive and the continuity of the people delivering that care.

The locums themselves are of course not the problem, but their presence on this scale is a symptom of the structural problems facing the service. The answer is not providing more funding to try to fill these vacancies. This hasn't worked. The answer is changing the model of care to make sure that we create the right kinds of posts for all health professionals working in the system – posts that give our workforce the opportunity to use and develop their skills as part of wider teams, working together to best meet patients' needs. Many permanent staff have highlighted continuity and consistency issues in a service that relies on transitory locum and agency staff.

Primary Care Workforce

There are 347 General Practices in Northern Ireland, which are staffed by 1279 GPs. Data produced by the Department of Health suggests that the growth in the GP medical workforce has not kept pace with demand, or indeed with the growth in hospital medical staff. Furthermore, the average list size of 1641 patients per GP is the highest in the UK.

Fig. 13 - Index of Northern Ireland Medical and Nursing Workforce 2002 – 2013 (base 100)[19]



19. BMA Northern Ireland, General Practice in Northern Ireland: The case for change, February 2015

20. Ibid

The age profile of the general practice workforce also shows that just under a quarter of GPs here are aged 55 or older, which means that many will be planning to retire in the near future.[20]

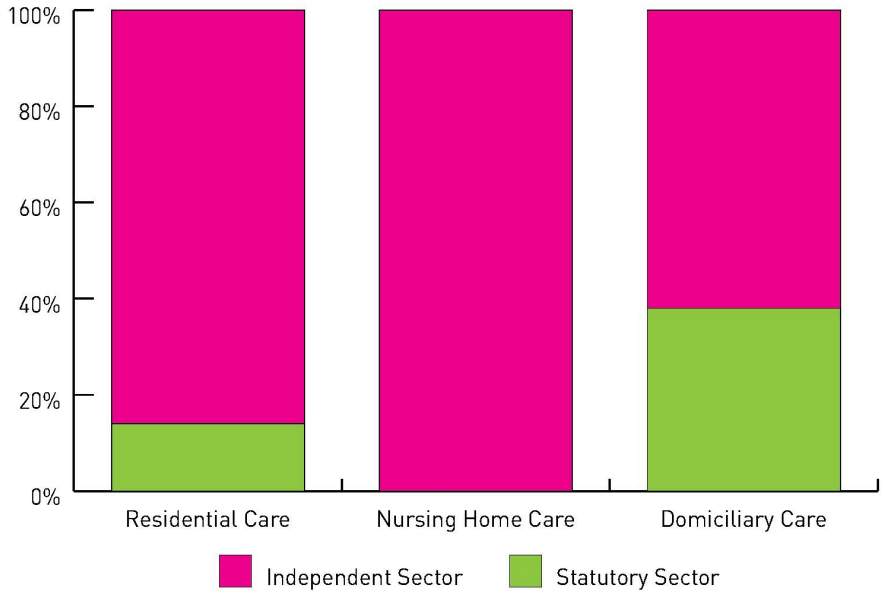
Fig.14 – GP workforce by age band

AGE BAND	% OF GPs
29-34	11
35-39	18
40-44	14
45-49	16
50-54	17
55-59	16
60-64	6
65 and over	2

Social Care Workforce

Social care is different from the other parts of the system insofar that it is largely commissioned by the HSC from for-profit and voluntary sector providers. The independent sector now provides 100% of nursing home care, 83% of residential care and 62% of domiciliary care. There is also still a significant proportion of care that is provided in-house by Health and Social Care Trusts and they and the independent sector are often put in the difficult position of competing for the same pool of staff.

Fig. 15 – Sectoral Distribution of Care Providers



Approximately 12,000 people are employed in the residential, nursing home and domiciliary care sectors.[21]

21. Can we trust the trusts? (ICHP, UKHCA) 2013

There are some significant concerns about the availability of an adequate future workforce to meet growing demographic demand. In England, for example, it is estimated that an additional one million care workers will be required by 2025.[22]

Recruitment and retention difficulties may, in part, be due to terms of employment including the use of zero hours contracts and staff being paid below the minimum wage.[23] The Commissioner for Older People has also identified the need for a well trained and registered social care workforce which is respected, valued and properly remunerated with opportunities for career progression.

In recent years, some providers have argued that the fees paid by the HSC are insufficient to attract and retain staff and that this risks creating instability, threatening the economic viability of their services. Indeed, some domiciliary care providers have already withdrawn from the market, citing affordability as the reason. Similarly, in the residential and nursing home market there have been some high profile closures, with the potential for more in the coming year.

This is a great, and growing, risk to the entire HSC. As we have stated above, if the social care sector fails to meet demand this will place enormous pressure across the rest of the system – particularly in relation to hospital admissions and discharges.

In the context of the demographic challenges outlined above, it must always be remembered that the most important, and the largest group by far, of staff delivering care services in Northern Ireland is unpaid.

Carers NI estimate that carers save the government some £2.4 billion and it is clear that the support of carers is absolutely essential in order to ensure the sustainability and viability of the system. Engaging and supporting carers is a fundamental aspect of maintaining service users within their own home and it is essential that the HSC improves its performance in this area.

22. The Future Care Workforce (ILC) 2014

23. The scale of minimum wage underpayment in social care (Resolution Foundation) 2015

Nursing and Midwifery

There are in excess of 16000 registered nurses and midwives employed by the HSC in Northern Ireland. This constitutes almost one third of the health and social care workforce in a variety of settings.

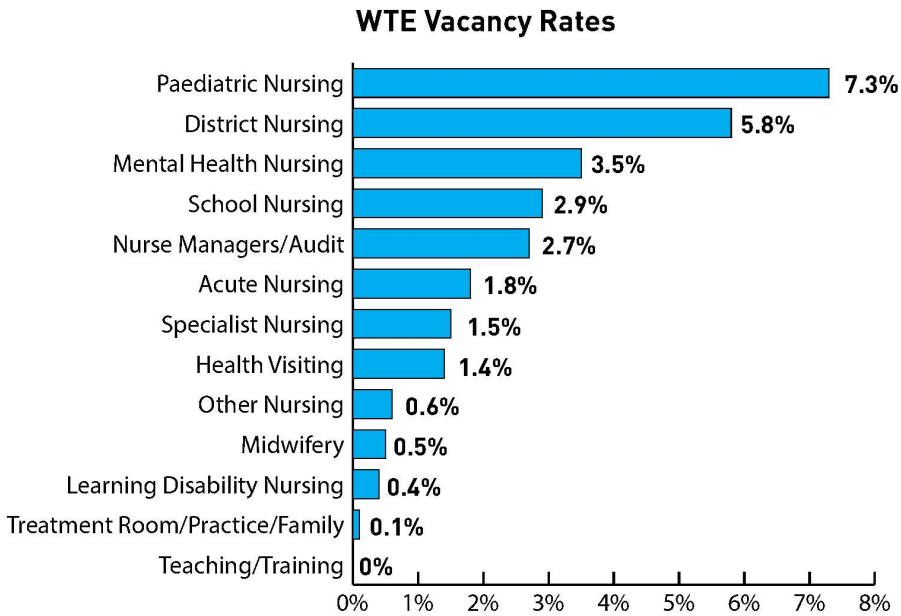
Fig. 16 – HSC Registered Nurses & Midwives as at 31st March 2014[24]

Combined Grades	Staff in Post Headcount (HC)	Whole-time Equivalent (WTE)
Registered Nurses	15,319	13,286.2
Midwives	1,327	1,042.5
Total	16,646	14,328.7

Figures from 1st October 2015 show that there were 531 (480 whole time equivalent) vacancies.

A vacant post is defined as a post '**actively being recruited to**'. The Department of Health collects data on vacancies via a survey twice a year. The figure below presents the available vacancy rates of permanent posts (based on whole-time equivalent) as at 30th September 2013.[24]

Fig. 17 – Available Vacancy Rates of Permanent Posts (based on whole-time equivalent) as at 30th September 2013

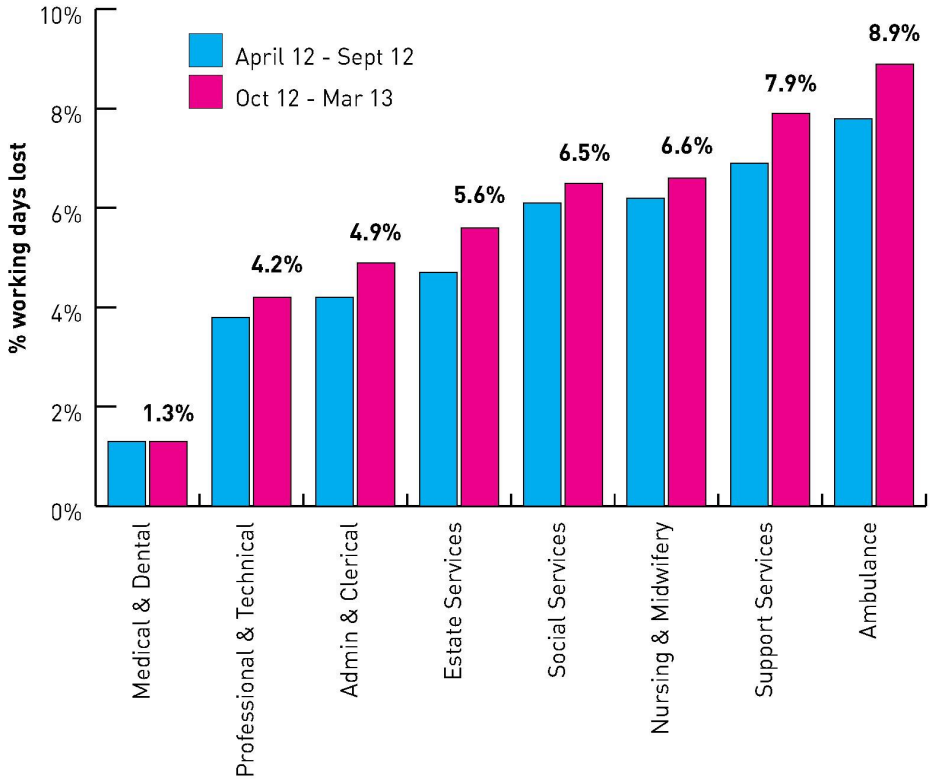


24. Source – Department of Health

Organisations reported that they did not expect to be able fill all these vacancies. In particular, they noted difficulties at a local level in recruiting to a number of specialties, including mental health services, care of older people, non-acute hospital care, theatres, critical care, general medicine, community, learning disability and prison health. However the composition of difficult to recruit specialities varied from Trust to Trust.

In addition, the graph below shows absence rates by occupational family across the HSC. We can see that absence rates are rising across all areas.[25]

Fig. 18 – Absence Rates by Occupational Family

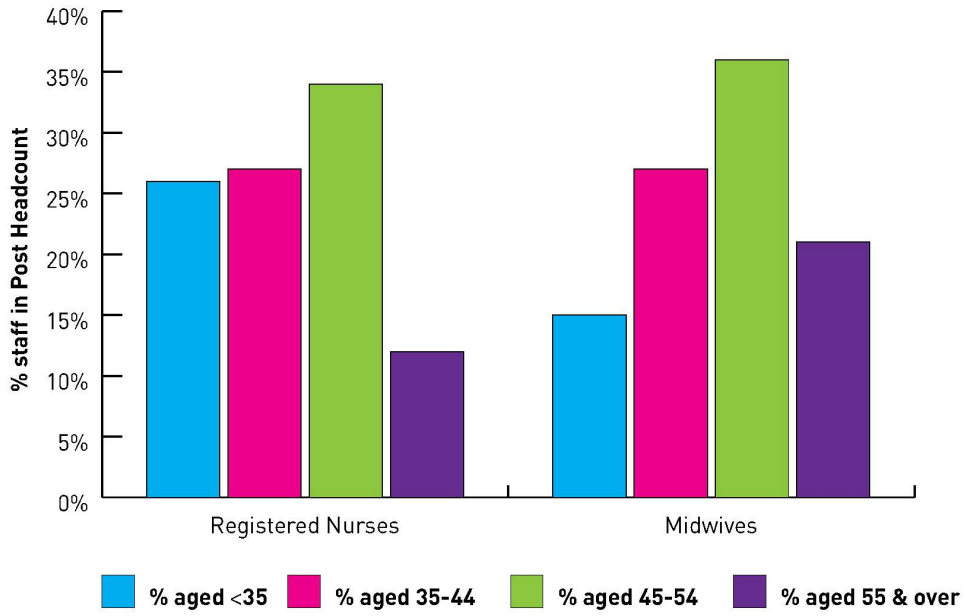


25. Source – Department of Health

26. Source – Department of Health

Furthermore the age profile of the nursing workforce shows the majority of the qualified staff to be above 45 years old, within a 10 -15 year period of average retirement age. The graph opposite shows the nursing and midwifery workforce broken down by age.[26]

Fig. 19 – Nursing and Midwifery Workforce by Age



Working patterns have also changed significantly. Almost half of qualified nurses are now working part time and almost two thirds of midwives.

Earlier this year, the then Minister took action to address these recruitment issues by increasing the number of commissioned student nurse places in Northern Ireland universities by 100 for the 2016/17 intake. This is very positive, but it will not impact on the service until 2019/2020. Steps are currently being taken to support a region wide recruitment process for nurses from EU and Non-EU countries.

Staff Morale

These issues are also reflected in the reported experience of staff in the HSC. In the most recent HSC staff survey, only 35% of staff felt that there were enough staff in their team to carry out the work and a significant proportion (36%) reported having experienced injury or illness as a result of work related stress. HSC Occupational Health Consultants have noted an increase in the number of staff presenting with stress related illness.

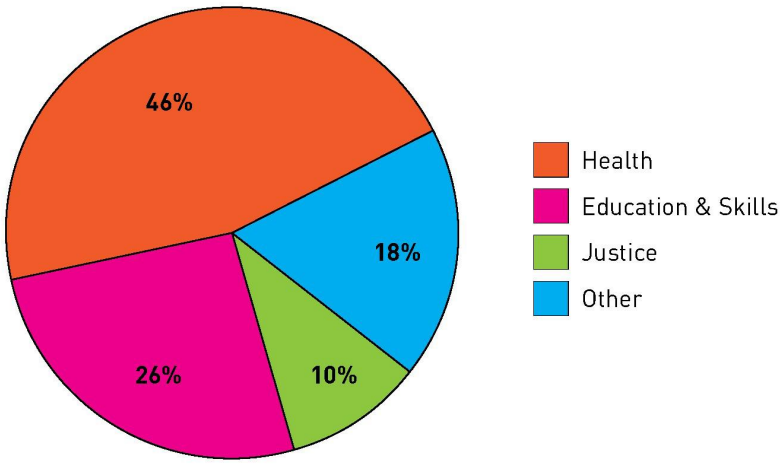
The cumulative effect of staff vacancies is ever-increasing workloads, higher risk of illness and a constant focus on the short term over the strategic. This risks creating a culture that exists by 'fire fighting' only. Innovation, learning from best practice and implementation of new systems are the unfortunate casualties of such a system. In all the encounters with stakeholders, from every part of the health and social care system, the panel have received the same message in terms of the need to invest properly in the staff that provide health and social care in voluntary, community, primary and secondary care settings.

The demands facing the current service model are putting severe pressures on the workforce. This is not fair to them or to the people who rely on them for care. Resolving this is not about money, it is about creating an environment in which staff are enabled and empowered to do the jobs they have been trained to do in a way that meets patients' needs. As the evidence above demonstrates, the current model has the patients in the wrong place and at the wrong time; this brings organisational de-motivation as staff feel unable to provide the highest quality of care to those they serve.

Financial Sustainability

As can be seen in the chart below, the Department of Health's budget is the largest among the Executive departments by some distance, with a budget of almost £4.6 billion, or 46% of the entire NI Executive spend.[27] The next largest sector in terms of budget is Education & Skills, with a little more than half of the health and social care budget.

Fig. 20 – Northern Ireland Budget by Sector



If we accept a conservative estimate of inflation at 1%, new medical developments at 1% and demand rising at 4%, then the Health and Care system as currently configured would require at least a 6% budget increase each year simply to stand still.[28]

Using this rationale, if the system continues in its current form, we can expect costs to double by 2026/27 simply to maintain current levels of performance.

Other

Justice

Education & Skills

27. OECD Reviews of Health Care Quality: United Kingdom 2016, p242

28. http://www.nuffieldtrust.org.uk/node/4190)

Fig. 21 – HSC – Projected Costs 2014/15 – 2020/21

Year	Total (£billion)	Year	Total (£billion)
2014/15	£4.6	2021/22	£6.92
2015/16	£4.87	2022/23	£7.34
2016/17	£5.17	2023/24	£7.78
2017/18	£5.48	2024/25	£8.25
2018/19	£5.81	2025/26	£8.75
2019/20	£6.16	2026/27	£9.23
2020/21	£6.53	2027/28	£9.83

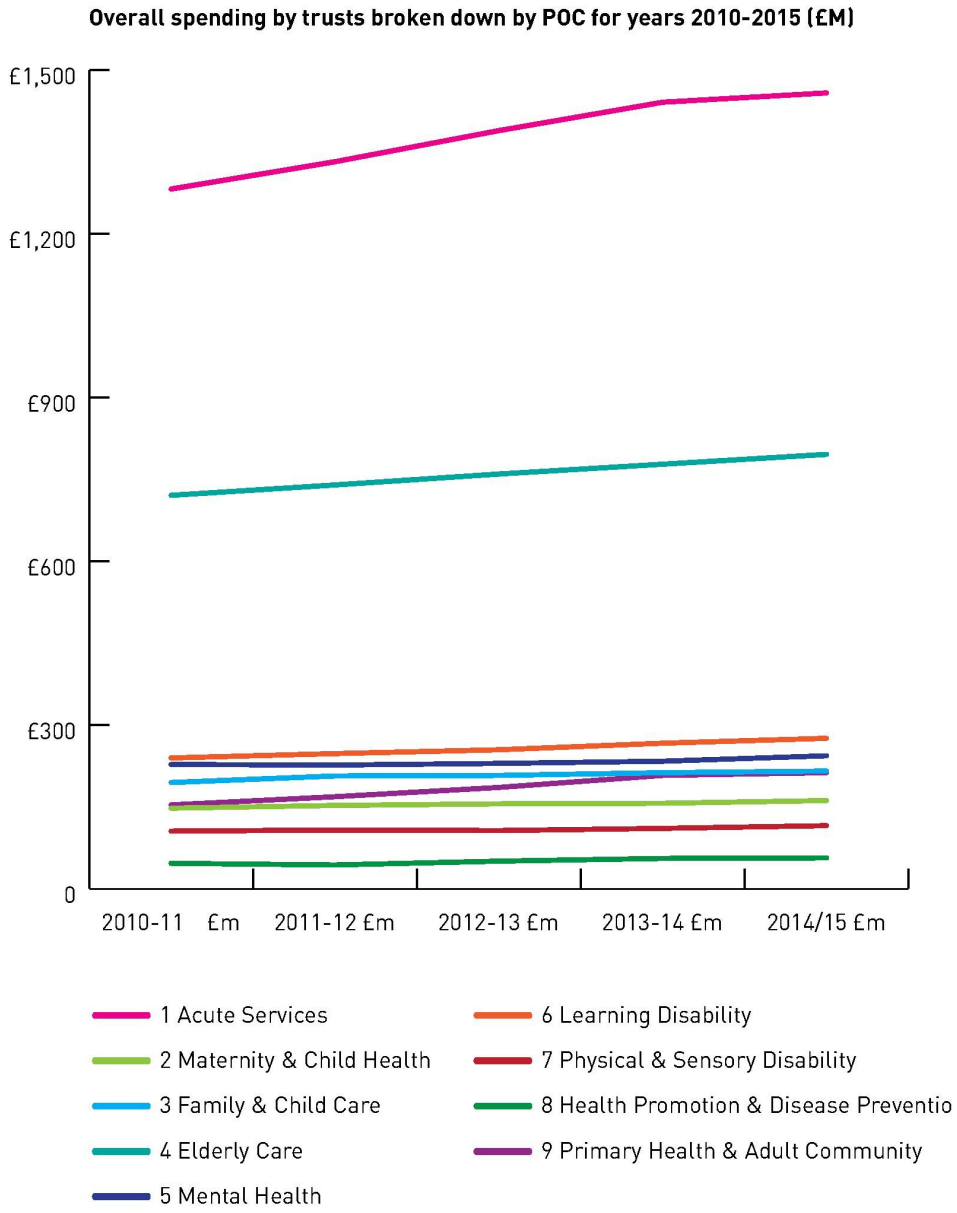
Although it is now more than ten years old, Professor John Appleby's 2005 review was an exhaustive look at how resources were being used across the system, with a particular focus on elective care and waiting times. Appleby updated his own results in 2011 and found that per capita spend in Northern Ireland was roughly 11.5% higher than in England, but that there is an 11.6% higher level of need. We can therefore draw the conclusion that the system is as well funded as other UK jurisdictions, with perhaps a very slightly lower level of funding per head once local levels of need and deprivation are taken into account.

However, Appleby's review also found significant disparities in some programmes of care. For example, according to his figures, mental health needs in Northern Ireland were estimated to be nearly 44% higher than in England, while actual per capita spending on these services was in fact 10-30% lower.[29]

These findings would support the argument that it is not the level of funding that it necessarily the problem, rather than how it is used to deliver services. If we consider the division of funding within the system by programme of care, it can quickly be seen that the majority of resources are invested in the acute hospital sector, which dwarfs all of the other programmes of care in scale.

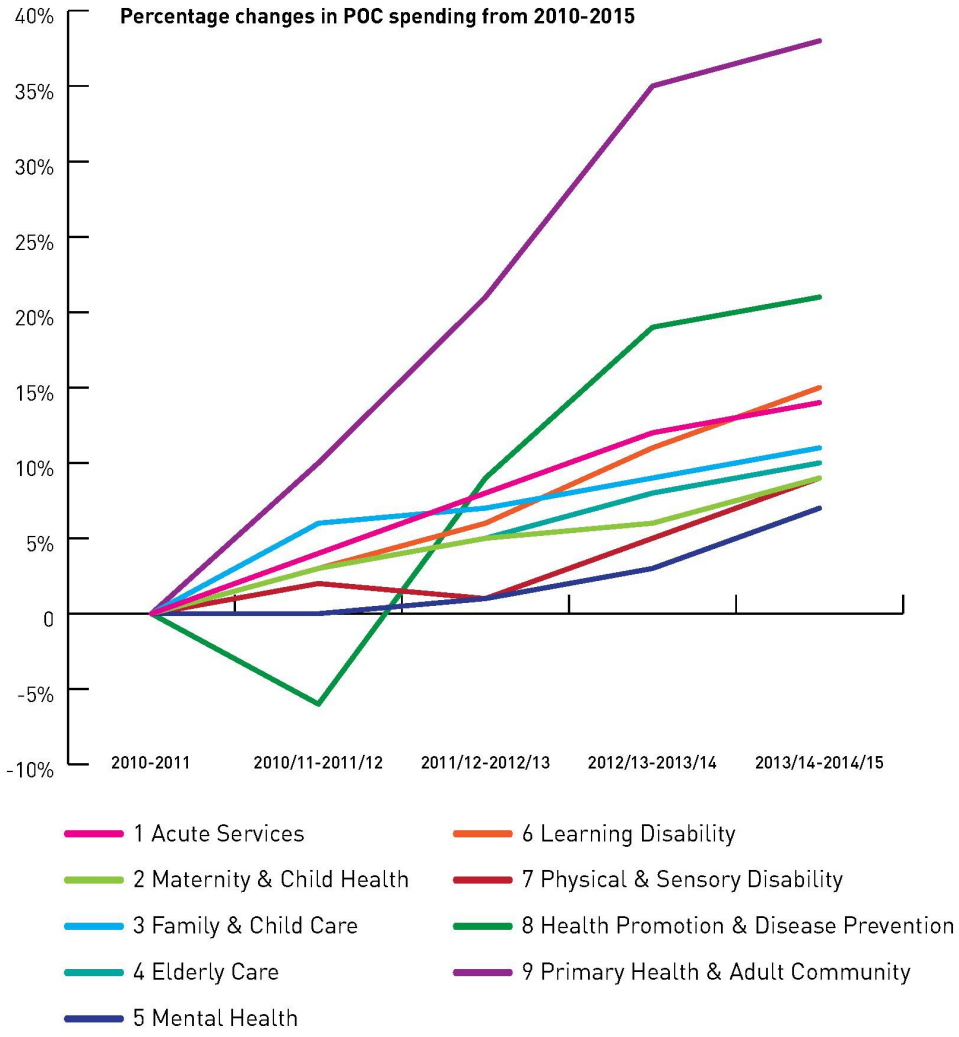
29. Appleby, J (2011) Rapid review of Northern Ireland Health and Social Care funding needs and the productivity challenge: 2011/12-2014/15, Department of Health

Fig. 22 – Funding by Programme of Care 2010/11-2014/15



As we can see from the graph above, spending on the acute sector continues to grow, although it is reassuring to note that the rate of increase has slowed down when compared to other programmes of care. While this may be indicative of a push by the system towards community based services, it also illustrates clearly that there is still a long way to go in making the shift from acute to community real and meaningful.

Fig 23 – Rate of Increase of Spending by Programme of Care 2010/11 – 2014/15



The OECD's report on Healthcare Quality across the United Kingdom, published in 2016, concluded that while there were examples of good practice in shifting resources from the acute sector to the community sector, there was no evidence that this was being managed systemically or strategically. Their report also concluded that funding was largely managed in silos and was often based on historical funding arrangements rather than an assessment of population need.

For a budget this size, the current one year commissioning cycle is also far too inflexible and short term to allow for any sustained investment or innovation. The Panel has heard from many sources that this prevents long term strategic planning and encourages a short term 'sticking plaster' approach to services, perpetuating the status quo rather than enabling transformation.

A real strategic approach to this will require a greater level of inter-sectoral funding, longer term commissioning cycles, and increased work across government to address the wider health determinants.

SECTION 3

VISION FOR A NEW MODEL FOR HEALTH AND SOCIAL CARE – ORGANISING FOR SUCCESS

There is an unassailable case for change. If we do not change the way we provide health and social care, the situation will only continue to get worse – the demand will continue to increase, activity will remain static and waiting times will continue to lengthen.

Following on from the evidence above, it is clear that:

- Given the challenges of today, business as usual, even if optimally managed, will not be enough to meet future demand.
- Transformation will require key cultural and operational changes in health care systems and in the way these systems are accessed by the public.
- Something very different has to happen at the delivery of care level.
- The funding mechanisms are not currently sufficiently aligned with the need to integrate care at the provider level.
- Health and social care are not working together as effectively as they might. If they were, there would be better outcomes and reduced waste.
- Front line improvements and innovation at the provider level need to be encouraged, sustained and scaled up where they can demonstrate three outcomes of the Triple Aim.
- The workforce needs to be empowered and engaged in designing the new models of care.
- The public should be honestly informed about why change is needed. Service users should be supported and encouraged to become 'informed and expert patients' who take individual action to manage their own health and well-being.

Given the challenges of today, business as usual, even if optimally managed, will not be enough to meet future demand.

The Panel has heard a strong sense of frustration among those working in the system, particularly from those on the front line, that the current pattern of investment which is prioritised to maintaining the current configuration of hospital

care would be better utilised in a new model of care outside hospital which better supports improved population health and well-being. The Donaldson report also identified the need to rationalise hospital infrastructure as a key part of reform.

Put simply, this work is not about closing hospitals. It is about fundamentally changing the way the HSC provides services.

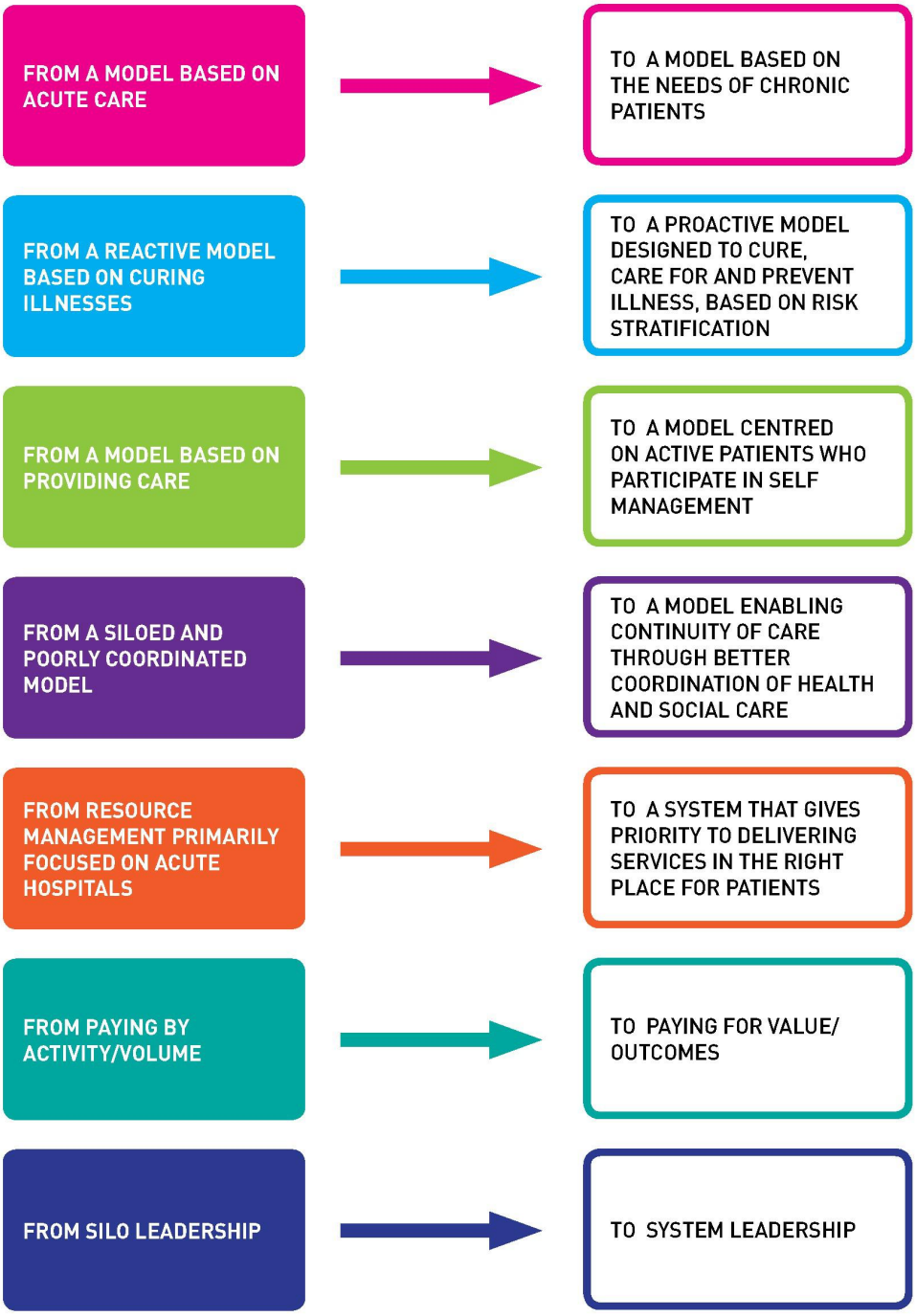
As a panel, we agree that it will absolutely be necessary to rationalise the provision of some specialist acute services as part of changing the service delivery model. As identified by Hayes, Compton and Donaldson, the current configuration of acute services is simply not sustainable in the short to medium term. As part of the transformation process, it will be necessary to reorganise services in such a way that resources are freed up from some parts of the existing model in order to allow them to be used for implementing new models that will offer higher value care. With respect to how this rationalisation is achieved, we will come back to this later in the report.

However, rationalising services is not the same as transforming the health and care system and the two should not be confused. The current overreliance on acute infrastructure is a contributory factor to the challenges facing the sector rather than their sole cause. While some rationalisation and concentration of specialist resources will be necessary to allow new delivery models to take effect, they are not ends in themselves. The meaningful transformation is in moving to a more patient centred, population health model, delivered at a sustainable cost.

Put simply, this work is not about closing hospitals. It is about fundamentally changing the way the HSC provides services. In some cases this may mean that some buildings/hospitals will close; in others it may mean that these buildings are used in different ways to provide a more effective and responsive service to meet the local population's needs.

The table opposite shows the main ways in which the system needs to change.

Fig 24 – Transformation



The Triple Aim

There are numerous health care systems in the world facing similar pressures and undertaking similar reforms in health and social care. These are the most important reforms in decades and an increasing number of them build around the Triple aim as a framework.

Although health care systems internationally are different from each other in many ways, they all have the same fundamental challenges:

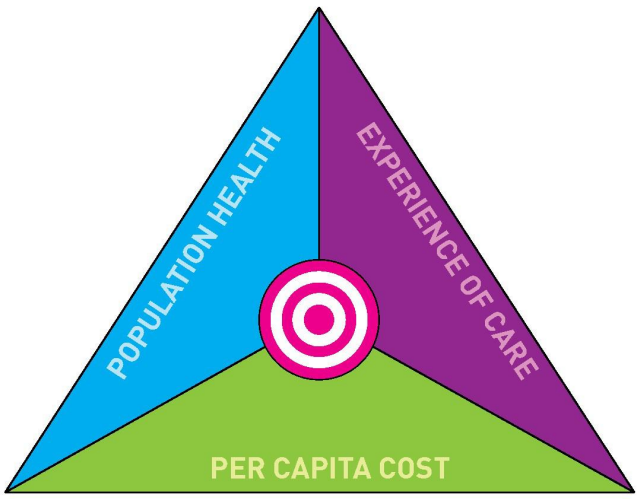
- All have sub-optimal organisation of care;
- Most are paying for volume and not for value;
- All use about 50% of expenditure on only 5% of the population;
- All have key challenges in prevention, quality and patient safety;
- Chronic patients receive fragmented and non continuous care; and,
- All could do more to reduce costly hospital admissions and readmissions.

There are numerous health care systems in the world facing similar pressures and undertaking similar reforms in health and social care. These are the most important reforms in decades and an increasing number of them build around the Triple aim as a framework.

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI). It is characterized by a simultaneous focus on three objectives:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and,
3. Achieving better value by reducing the per capita cost of health care.

Fig. 25 – The Triple Aim



The Triple Aim is perceived by many as a key framework to improve services, but it will not happen at scale unless there is a powerful policy intervention regionally as well as empowered innovation at a local level. The Panel proposes to use this framework to move forward on the broader health and social care transformation.

Of course, all of the policies and strategies in the world will not succeed if they do not pay attention to the people who deliver services on the front line. On this basis, the panel recommends including a fourth dimension (sometimes called the quadruple aim) based on improving the work life of those who deliver care.

RECOMMENDATION 1

The Panel recommends using the dimensions of the Triple Aim as a framework for reform, including an increased emphasis on the experience of those who deliver care.

The ongoing economic crisis in Europe has made the numerous vulnerabilities of all health care systems more visible. The immediate reaction in many countries has been cost containment. Senior leaders have reacted to this difficult immediate context by seeking efficiencies and, as a result, day to day crisis management has been centred on taking some major cost containment decisions, especially regarding human resource salaries, the pharmaceutical budget and co-payments.

However, there is a growing acknowledgement that these interventions do not correct the main problem of health care – its basic design around reactive episodic care and a weak focus on population health.

In other words, even if these crisis decisions are handled in an effective way, they do not create in themselves the capacity for health systems to cope with the future challenges of demography, chronicity, prevention, fragmentation, sustainability and patient centeredness.

Today in Europe, as well as elsewhere, most of the policy decisions in health care are not about having to decide whether to ration or to transform. Rather it is about finding the right balance of both and not letting rationalisation dominate the broader transformation. This document considers both agendas, and the Panel would recommend progressing and managing them both simultaneously.

The Triple Aim provides a new framework for a strategic response. While it may sound theoretical, it is practical in its application and has already been used to guide a number of prototypes in Northern Ireland which are already showing powerful results. We will cover some of these projects later in the document.

Advancing towards a Local Accountable Care System

The present model of care is not delivered on a population agenda. It is not providing continuity of care in an organised way and the organisations delivering care are still operating as silos.

The Panel has heard consistently and agrees that care should be personalised, preventative, participative and predictive. However none of those objectives can be achieved in the present reactive and fragmented system. The HSC therefore requires a new organisational form at the local delivery level, an organisational arrangement which will allow those approaches to be embedded in the culture of everyday health care.

The present model of care is not delivered on a population agenda. It is not providing continuity of care in an organised way and the organisations delivering care are still operating as silos. We need to move away from this hospital centred model of care to a more integrated model.

The Panel has heard of changes to the provider sector that are already being carried out to achieve the size and scale required to better manage, and indeed change, the current demand for services. General Practice is moving from the 'small business' approach to bring together Practices within larger geographies as 'Federations'. By working more collectively, it is hoped these Practices can share skills and services, manage workforce pressures, operate more efficiently and more effectively meet the rapidly increasing demand for primary care services. Services within Trusts are increasingly networking on a cross-Trust, cross-profession and indeed NI-wide basis where these services are specialised and there is a need to collaborate to meet demand. Trusts sub-contract with the community, voluntary and independent sectors for health and social care provision. There is a mix of provider models for GP OOH services.

So the provider sector – Primary Care, Trusts, 3rd sector and independent sector – is already becoming increasingly integrated and inter-dependent without structural reform. However, this is happening in the absence of strategic intent, and is operating under traditional contract models and output targets that do not support the system transformation which is required to address the challenges set out in section 2. This report proposes the development of Accountable Care Systems to integrate – by agreement, and without the need for structural reform – the provider sector to take collective responsibility for all health and social care for a given population and with a joint capitated budget linked to population based outcomes under agreement with the commissioning system to be decided by the Minister.

There are models where this collective provider model is starting to emerge. For example, the Sustainability & Transformation Plans (STPs) in England, where 44 planning and delivery systems have been set up based on geographical footprints, and charged with planning and delivering system-wide change. This will include a more integrated approach to health and well-being, self care, more proactive care for those with the most complex needs, and a smaller, more efficient hospital sector. This is all intended to both improve care outcomes and drive out collective financial deficits in their areas. Accountable Care Systems will also provide a structure for better patient engagement, empowering people to become active participants in their own care.

There are lessons learned from Accountable Care Systems elsewhere that provide evidence of the key components that can be put in place to drive more integrated working without structural reform. These are:

- Size and scale – the population footprints must be of sufficient size to manage the majority of population's care needs, to take accountability for managing variations in demand and expenditure, and to take 'internal decisions' to change the delivery of care, but also importantly to support local partnership working and risk sharing;
- A defined population where the new model of care can be delivered at pace, focusing on the stratified risk of that population – already available in General Practice if this information is collated and shared;
- New working arrangements, including shared leadership, shared accountability and devolved budgets, development of new roles to push the boundaries of the skilled but not qualified workforce and the 'generic professional case manager', and a partnership approach with the 3rd sector to deliver a more standardised service offering within local communities to reduce loneliness and isolation, improve well-being and to provide high quality care;
- New support tools, including shared information, accessible patient and client records, and a capitated funding system that incentivises an integrated provider response;
- Service user engagement, at population, service and individual level;
- Cost and quality measures which are measurable, comparable and outcome based.

Under an ACS, providers would collectively be held accountable – under a shared leadership model – for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target, with agreed risk share arrangements and incentives. They would also need to have maximum autonomy to make rapid and sustained changes to improve care and outcomes for the population they serve.

Of course, not all services will be amenable to this model. Some services are so specialist that they must be delivered at a Northern Ireland level. These will require a different commissioning or provider model – set at a regional level – to ensure specialised resources are concentrated on a small number of high volume sites, that they are sustainable in the long term, that inefficient duplication is avoided, and that they can be supported and incentivised to innovate and to develop world-class treatment.

Some services are so specialist that they must be delivered at a Northern Ireland level. These will require a different commissioning or provider model — set at a regional level

Transformation to deliver the Triple Aim will also require a new approach to the commissioning and delivery of care. The Department of Health carried out a review of commissioning in 2015 and found that the current system was complex, slow to take strategic decisions, unresponsive and with too much emphasis placed on

activity/volume over value/quality. The current commissioning model has also failed to effectively shift accountability to the provider level and this has led to an overly transactional approach. It is worth highlighting that the lack of a devolved budget and insufficient autonomy have been identified in other jurisdictions as key reasons why some population based models have not achieved their potential.

RECOMMENDATION 2

The Panel recommends that the HSC should move to:

- Formally invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and,
- Regionalised planning for specialist services.

Northern Ireland already has many of the building blocks to move towards Accountable Care Systems — perhaps even more so than many other nations.

Building on Existing Foundations

Northern Ireland already has many of the building blocks to move towards Accountable Care Systems – perhaps even more so than many other nations. The Panel believes that many of the key elements of a more integrated organisation, such as Integrated Care Partnerships as 'learning labs' for what will make integrated delivery systems work best and the emerging GP Federations, are already in place, but these building blocks need to be taken to the next level and be fully enabled with devolved autonomy and incentivising funding mechanisms linked to measurable population outcomes in order to truly become local Accountable Care Systems.

Furthermore, Northern Ireland has already made real progress in establishing an array of management and organisational processes, all of which help to provide the tools needed to move forward quickly. However these need to be further developed and strengthened in the following ways:

Adding Depth to Structural Integration of Health and Social Care

The formal integration of health and social care should be a key strength of the existing system and will provide a strong foundation to pursue reform. However,

in practice, the benefits of integration have not been fully exploited and it would seem that there are still significant administrative silos that prevent this happening. Integration in name only is not enough and if the Panel's proposed model is to be successful there has to be better integration between all parts of the health and social care system. This level of integration will require a great deal more work on how the system plans, funds and purchases care across acute care, general practice and community health, and social care provided by statutory, independent and community , voluntary and charitable providers.

The development of the Accountable Care Systems suggested in this report will greatly reinforce the necessary health and social integration on the ground.

The primary function of social services is to improve and protect people's social wellbeing when it is vulnerable. Social wellbeing refers to the extent that people are socially connected, engaged in purposeful activity, in control of their own lives and are protected from abuse and exploitation. The primary reasons to promote and protect people's social wellbeing are because it is essential to people's quality of life and it safeguards people's human rights. However not surprisingly there is also a strong relationship between people's social wellbeing and their health. This is one of the main reasons integration between health and social care services is seen as a desirable feature of healthcare systems.

The health impact of better integration between health and social care services is reinforced by more and more studies. The impact of social factors such as income, educational attainment, access to nutritional food, good quality housing and employment status is well documented. There is a growing evidence base and literature about the importance of social determinants of health in improving the health of populations. The relative contributions of genetics (20%), health care (20%), and social, environmental and behavioral factors (60%) are well documented.[30]

Northern Ireland is better placed than others to continue reinforcing the combined action of health and social services. The move to local integrated systems of care will provide an even better platform for this happen. However it can also present challenges.

When difficult funding decisions need to be made it can be difficult to secure investment in social services when faced with competing demands for healthcare investment. However there is a strong economic rationale for investing in social interventions.

The increasing use of new commissioning models (payment models) will be a key lever towards improved health and social integration. New payment models that hold these local integrated care organisations accountable for people's health and the cost of treatment can be used to maximise the benefits of integration. A focus on holistic outcomes that includes the promotion of social wellbeing and penalises outcomes that undermine it, such as unnecessary hospital readmissions, will make the health and social care system more sustainable and more importantly improve people's quality of life.

30. Chiu, G. et al. (2009) Relative contributions of multiple determinants to bone mineral density in men. Osteoporos Int, 20(12), 2035-2047

Payment schemes such as these would give these local organisations an economic logic to incorporate social interventions into their approach to care.

Targeted programmes can link individuals with chronic conditions to social support schemes. For example, community health workers can conduct home visits to low--income families with children with uncontrolled asthma. There are examples in which this type of intervention has reduced the use of emergency care by two thirds.[31] Managerially the children in such a scheme would be identified by a risk stratification approach in a community. This type of intervention is a practical example of targeting inequalities in a community as the targeted group are children of low income families.

Furthermore it makes economic sense as unmet social needs are associated with higher rates of emergency care, hospital admissions and readmissions. A recent study found that the 10 health conditions that accounted for the highest health care expenditure are linked to unmet social needs. These include heart disease, mental disorders, asthma, diabetes and hypertension.[32]

There are therefore numerous reasons for this integrated approach to become progressively the standard of care in Northern Ireland.

Expanding and investing in eHealth infrastructure

eHealth is a broad concept, defined as the use of electronic means to deliver information, resources and services related to health.

Data and enabling technologies are vital components of a modern healthcare system. We hold large amounts of information on behalf of our patients and we need to look after this, but we also need to use it as effectively as possible to deliver improved outcomes for individual patients, for the wider population, and for society as a whole.

31. Greineder, DK, Loane KC, Parks P (1999) A randomized controlled pediatric asthma outreach program. J Allergy Clin Immunol March 1999;103(pt 1):436-440

32. Agency for Health Care Research and Quality. DHHS . USA . 2011 - Medicla expenditure panel survey

The introduction of the Electronic Care Record (NIECR) has revolutionised the way health and care can be delivered by providing care staff with an up-to-date record that avoids duplication of tests and information gathering, and allows information to be used in ways that can lead to better decisions on prevention, treatment and care.

However, while a great deal of good work has already been carried out, much of the data that is held on patients is inaccessible to other systems within the HSC; it exists in data silos that do not communicate with other core datasets. More work needs to be done in terms of linking these systems and increasing interoperability. The Department of Health and the network of Chief Clinical Information Officers are in an ideal position to lead in setting the direction for eHealth, and in ensuring engagement from the wider clinical community.

Northern Ireland should continue to invest in this area, with the ultimate aim of providing patients with ready access to their own records. A conversation with patients and their representatives may also need to occur to discuss how the system uses HSC data and linked public sector datasets in medical research, population health planning and infrastructure development.

Patients should also have the right to see their own data and the system should move towards greater openness and access. This would allow patients to see this information and use it in managing their own health needs.

Advances in telecare, telemonitoring and electronic assistive technologies are also making a significant difference to the way services are delivered. Used effectively, they can make a valuable contribution to the quality of services by improving coordination of services, overcome geographical distances between patients and providers, enabling patients to live independent lives for longer, and engaging patients in their own health and well-being.

In a population health model such as that proposed by the panel, data, analytics and new technologies are key enablers in driving clinical innovation, and also in supporting patient self management and health ownership.

Northern Ireland is in an ideal position to take advantage of opportunities in eHealth, and position itself as a global leader in this field. There is a single HSC system, a collaborative network of organisations, engaged patients, two high quality universities and a thriving commercial IT sector. The Health and Social Care Board's eHealth strategy, which was published earlier this year, sets out how the HSC will work with industry, academia, the community and voluntary sector, other public sector bodies and government departments, and international partners to further develop uses of e-Health as a driver to improve health, well-being, prosperity and job creation.

Developing the Workforce

In addition, the health and social care system here has a powerful and expert workforce.

Despite the challenges, Northern Ireland already performs strongly in many aspects of health and social care delivery and, building on the strong foundation of its integrated workforce, has the existing capacity and capability to continue to lead the way in developing and implementing new and modern care pathways.

However, reconfiguring health and social care services will depend on the ability to reshape the workforce to support the new models of care.

An effective workforce where skills and competence are aligned and support new service models needs to have as its key aims:

- The improvement of quality;
- Financial efficiency;
- The long term health and wellbeing of communities.

Having the right number of appropriately skilled staff is a critical determinant of the quality and efficiency of the health and social care system, yet there is a growing and recognised gap between patient needs and the skills and knowledge of the workforce that cares for them.

While across health and social care systems here, as in other countries, organisations are reporting severe difficulties in recruiting and retaining staff, it is also recognised that there is a frustration among the highly educated and experienced workforce, of the inability to progress to the level of competence to which they are educated.

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There is also a clear need to invest not only in the immediate and short term future workforce but also on the pipeline for the longer term.

In Northern Ireland there is a real opportunity to adapt the current nonclinical workforce to meet the growing needs for patients to remain at home in local communities. There is an emerging body of evidence that shows that integrated workforce models configured around defined populations support improved population health outcomes, a better care experience, and also a reduction in the per capita cost of health care.

Immediate actions need to be taken to support the workforce to continue to deliver high-quality care to patients, clients and carers through this period of transformation. The Panel suggests that work is commenced to remove the artificial governance barriers that make role developments difficult to achieve and therefore the transferability referred to above difficult to attain.

For this to be successful, the HSC will need to:

- Put in place strong supporting systems and governance structures, including supervision of new and extended roles;
- Create a culture that supports experimentation and change; and
- Cultivate good relationships with local workforce and training bodies.[33]

33. Imison C, Castle-Clarke S, Watson R, (2016) Reshaping the Workforce to Deliver the Care patients Need, Research Report, Nuffield Trust

Within primary care in Northern Ireland there is a need to move from the predominantly GP led model of care to a more blended approach that accommodates the rich range of professionals working in partnership to meet the needs of the practice population. This can create a robust, extended primary care team serving a local population level, including Nurses, Doctors, Allied Health Professionals, Health Care Assistants, Pharmacists, Mental Health Professionals and Social Care workers all have a role to play in improving the service offering delivered by primary care, with an increased focus on prevention and early intervention and the active management of complex patients to support them to better manage their conditions.

In order to achieve this, it will be necessary for those at the head of the HSC to create a safe environment for local innovation. This means the workforce is not only engaged for clinical purposes, but also organisational and managerial innovation.

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A recent Vanguard document **"New Care Models and Staff Engagement: All Aboard"** draws out an approach to ensure staff are at the heart of decisions about new models of care.

This approach includes:

- Enabling different groups of staff across organisations to "break down the barriers" – to allow them to break out of old working patterns and think differently.
- Recognising that those on the front line of care have the best ideas about how to improve it – but also that they need to feel empowered to do so.
- Recognising that if staff feel that their contribution is valued, they will want to do all they can to make new care models a success.

The panel strongly believes it will be essential to reinforce this work and to invest heavily in staff engagement.

Improving Quality – Frontline Innovation

Quality improvement has taken on increased importance internationally in recent years. Drawing on the successful practice of 'improvement science' which was first applied in manufacturing and industry, a number of countries have sought to adapt this and apply the principles to health and social care services. To date, there have been some impressive results with this approach in areas such as Qulturum, in Sweden, Ko Awatea, in New Zealand, and Healthcare Improvement Scotland.

In Northern Ireland, the Panel has seen impressive examples of innovation and improvement going on across the HSC. However, it is also clear is that there is a lack of capacity and capability to scale these projects up and to sustain them across the system. While the Quality 2020 strategy shows that there is a clear

While the Quality 2020 strategy shows that there is a clear commitment to quality improvement at the top of the organisation, it is not clear that this has pervaded the HSC to the extent that it can be considered to be part of everyday business.

commitment to quality improvement at the top of the organisation, it is not clear that this has pervaded the HSC to the extent that it can be considered to be part of everyday business. The Panel was told that "quality improvement is still viewed as peripheral, an activity for a small number of HSC staff". This may be a reflection of the operational pressures in the current system, which restrict opportunities for staff to become informed and experienced in improvement methodology.

A new approach may be required to support staff across the system to adopt a 'right fit' methodology dependent on their need for improvement, whether this is to:

- Do it right – standardising/removing variation to improve efficiency;
- Do it better – improving existing systems to achieve better performance;
- Do it differently – innovate and change existing systems to improve outcomes.

The previous Minister announced that the Department of Health would develop plans for an Improvement Institute to drive forward innovative improvements in how health and social care services are delivered. The intention is that this would be able both to build on the emerging improvement and innovation hubs in each Trust and to bring them together regionally, but also to support individual professional and managerial staff to develop their skills and expertise in leading and delivering innovation and quality improvements and to share these skills and expertise with others.

The Panel would endorse this approach – any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user voice represented as part of this. The purpose of the Institute should be to create the conditions in which this improvement becomes the norm, from the bottom of the organisation up and the top of the organisation down.

Health and the Wider Economy

Health and social care is a significant part of Northern Ireland's Gross Domestic Product and it accounts for a sizeable proportion of jobs and public spending. A report by the Economy and jobs initiative task and finish group found that:

- Annual spend in the sector is £4.5 billion, with capital expenditure of £200 million.
- Staff employed within the Health and Social Care sector account for 9% of all employee jobs in Northern Ireland.
- The Health and Social Care sector creates approximately 10% of the total economic output of Northern Ireland.

Economic discussions about the HSC most commonly focus on the cost of running it. However, we should also recognise the enormous contribution it makes to the Northern Ireland economy.

Northern Ireland has previously been described as "small enough to be agile but big enough to matter." If the health and social care sector here can lead the way in transforming how services are delivered, then it has the potential to be a world leader in developing innovative services and products. The proposed new model, based around Triple Aim, would help to support healthcare market opportunities for Northern Ireland going forward, particularly in terms of the range of enabling technologies and processes that need to be developed to meet modern patterns of demand.

Any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user voice represented as part of this.

RECOMMENDATION 3

The Panel recommends that the HSC should continue its positive work to invest in and develop the areas listed above.

There should be particular focus on the three key areas of workforce, eHealth and integration:

- As a key enabler of Accountable Care Systems, the HSC should continue to invest in eHealth to support improved self management, care at home and use of information to drive better population health outcomes.
- The HSC should immediately develop innovative primary care based models that will allow non-medical staff to work in a way that makes the most of their skills. (For example, these could be based on the community nurse-led care models being implemented in the Netherlands, or the use of pharmacists in community development here in Northern Ireland).
- Work should be carried out to identify which social interventions are most cost effective in addressing the social needs and improving health for Northern Ireland.
- Any new approach to commissioning should be aligned with the need to build integrated health and social organisations on the ground which target specific inequalities and social groups.

Emerging Practices

In addition to these areas where work is already ongoing, there are some emerging processes which the HSC may wish to explore and adopt.

Value Based Care

This Panel considers the present resources would be better used in a value based care model. This report strongly recommends Northern Ireland should start taking this route as the short term changes will in themselves be insufficient to provide a high quality and sustainable health and social care system.

A value based model in Northern Ireland would need to reinforce an integrated primary and community health and social care delivery model so that more can be done out of hospitals, encouraging work across organisational boundaries, as well as strengthened primary care sector in order to effect a shift in the balance of care. This will involve paying for value instead of simply paying for activity, accelerating home care technological support schemes, and improving coordination with the voluntary, community and independent sector as true partners in care.

This process has the potential to harness the strengths of different parts of the system, across organisational silos, across sectors and beyond what is traditionally considered to be the health and social care sector.

Co-Production

The relationship between health and social care professionals has changed significantly in recent years. There has been an increasing acceptance that people who use services and have healthcare needs will have views on how they should be treated as individuals and as groups who have interests in services. It is now recognised that people should be treated with respect and listened to and that major changes to services should be consulted upon.

Co-production describes an approach that takes this changed relationship to a new level. Co-production involves breaking down barriers between professionals and the people they serve, recognising people who use services as assets with unique skills. It involves a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities.

There is a difference between co-production and participation: participation means being consulted while co-production means being equal partners and co-creators. The benefits of adopting co-production include delivering change that is owned by service users rather than being resisted by them and designing services that reflect the knowledge and expertise that comes from using services.

SECTION 4

ROADMAP FOR IMPLEMENTATION

Creating a Compelling Vision

Together, all of actions set out above will strengthen services in the community so that more can be done out of hospitals, encouraging work across organisational boundaries, as well as with strengthened primary care in order to effect a shift in the balance of care.

This is of course the strategic direction of travel that was outlined in Transforming Your Care – and it is still the direction that the system needs to move in. However, as the previous pages indicate, the Panel feels that we need to go much further. There is now a significant body of evidence internationally to show the elements that are necessary to achieve this kind of transformation, and also to demonstrate that this kind of strategic shift can produce better outcomes for local populations.

However, in order for this to happen, all these approaches need to be aligned around a common vision of transformation and not be a series of isolated initiatives. The Panel has concluded that at least part of the reason that TYC has not been the success many hoped, is that it became just one initiative among many and not the overriding strategy guiding the entire organisation's decision making.

For these reforms to be successful, they have to become the strategy for health and social care. It will not be enough for senior managerial and clinical leaders to pay lip service to the concepts outlined here, they must underpin every decision that is made and every new policy that is developed. The Minister will need to take some time to consider what this vision will be and how it will be communicated to staff and to the public. The Panel hopes that this report will help to provide the foundations for this vision.

However, in order for this to happen, all these approaches need to be aligned around a common vision of transformation and not be a series of isolated initiatives.

RECOMMENDATION 4

The Minister should create, communicate and lead a clear, powerful, long term vision for the Health and Social Care system as a first step in the implementation process.

Components of Transformation

Transforming the HSC is an enormous and complex task that will need to be progressed steadily over at least the next ten years and which will require a combination of change strategies. The Panel has identified three separate components for practical implementation:

1. **Driving the system towards Accountable Care Systems**
2. **Aggressively scaling up good practice**
3. **Rationalisation and stabilisation**

The HSC operates within a parliamentary democracy and as the political context cannot be avoided, it must therefore be managed.

While each of these stages has a different lifespan, they are all urgent, they are all connected, and they should all be launched simultaneously.

The mid-term goal is to establish new accountable care systems. The second component helps to create the conditions for the new delivery model by scaling up good practice where it is consistent with the overall vision. The third component does not change the model of care, but it is necessary to free up resources to allow the system to transform.

1. Driving the system towards Accountable Care Systems

This is a mid-term agenda, but it must start now.

The political context is of critical importance in any transformation process, as is the impact of politics on shaping the environment governing large-scale change. The Panel has frequently heard that there is a need to remove health from politics but in reality the importance of politics is a feature of all health systems and can ultimately determine whether and how far large-scale change succeeds or not. To paraphrase Tip O'Neill, the former House Speaker in the USA, all politics is local and this is nowhere more apparent than in decisions about local health services. The HSC operates within a parliamentary democracy and as the political context cannot be avoided, it must therefore be managed. Those seeking to introduce change, need to provide compelling evidence for why the change is necessary and a clear sense of the benefits the new model will offer.

The longer term demands of transformation are especially acute since electoral cycles often militate against long-term change. Results are looked for in the short term and this is especially evident in the type of change favoured which tends towards short term impact rather than long term reform.

If a health system transformation is going to thrive, it will require supportive policies that incorporate longer time horizons[34] with regular milestones to build confidence in the direction of travel. The work on the Principles carried out with the local political parties in a political summit earlier in the year was intended precisely to help future implementation and help to get beyond those short timeframes that drive output targets (principles at annex 1) by demonstrating the need for long term and sustained reform that will deliver improvements in population outcomes.

The Principles helped to create the right environment but much more needs to be done to reinforce and strengthen that environment.

As stated above, one absolutely fundamental component in creating this environment is the development and communication of a clear vision for health and social care and a robust implementation plan to deliver it.

The task in the mid-term is to transform the model of care in Northern Ireland. This has been indicated in previous reviews. All stakeholders interviewed by the Panel agreed with the need to drive towards new models of care but they called for a stronger implementation agenda.

To this end this Panel offers an approach to implementation for these mid-term changes. These actions should start now. Northern Ireland is investing a considerable amount of resources into health care but the present payment and delivery system will not create the organisation of the future.

Northern Ireland is investing a considerable amount of resources into health care but the present payment and delivery system will not create the organisation of the future.

Northern Ireland has the scale and capacity to do this. However this transformation will not happen at scale unless there is a powerful policy intervention. It needs to be conceived and implemented as an integrated package.

We therefore propose a series of time bound actions linked to the three dimensions of the Triple Aim framework which will take the health and care system in Northern Ireland to a population based model of care. Following on from the work of Sikka, Morath and Leape, we also suggest adding a fourth component – that of the health and care professional's experience.[35]

RECOMMENDATION 5

Alongside the Minister's vision for health and social care, the Panel recommends that plans, costs and timescales for introducing each of the following actions should be prepared within the next 12 months. It is vital that the implementation of these actions is led by health and care professionals and managers.

34. Halfon N & Conway P (2013) The Opportunities and Challenges of a Lifelong Health System N Engl J Med 2013; 368:1569-1571

35. Sikka, R, Morath, J, & Leape, L (2015) The Quadruple Aim: care, health, cost and meaning in work

Population Health

- Some work on risk stratification has already been carried out at General Practice level. This should be built on to introduce a comprehensive, system wide approach to risk stratification in of the entire NI population.

- Governance arrangements to be developed for new Accountable Care Systems (ACS), including integrated capitation budgets based on the services (excluding the most specialised services) required by the population served by the ACS to be devolved to these new autonomous and accountable provider partnerships.

- Starting immediately, progressively phase in early adopter accountable care systems, bringing together the provider sectors for a defined population into a single accountable leadership. The ACS would be responsible for utilising a capitation based budget across organisational and professional boundaries including local infrastructure to achieve agreed improvements in population outcomes.

- The Programme for Government is moving towards outcome based measures to judge the impact of political decisions and the use of public funding on the population, and the success measures for the new ACS should also be outcome focused, and should be measures of population health with priorities for improvement. The Panel recommends the development of a relatively small set of outcome based metrics which set the challenge for the new Accountable Care Systems.

Patient Experience of Care

- The use of co-production as an approach should be mandated in accountable care systems and service redesign.

- Provide the population with individual access to their health and care information.

Per Capita Cost

- Introduce new cost and quality measures which are measurable, comparable and outcome based.

- Start the process of paying for value and not only paying for activity. By the year 2020, 50% of the budget should be commissioning value.

- As new value based commissioning approaches are implemented and local integrated organisations take form, ensure that the metrics being used include combined social and health indicators.

- Move to a rolling three year budget cycle to allow for more strategic commissioning/planning of services.

Staff Experience

- The Department to lead on the development of an 8-10 year workforce strategic framework, aimed at identifying immediate workforce challenges and planning the workforce to meet the demands of the new delivery model.

- New workforce models to be designed around defined populations and associated care functions. This should include enhanced roles for the skilled but not qualified workforce.

RECOMMENDATION 6

Many of these recommendations will require additional, transitional funding. The Panel recommends that the Minister should establish a ring fenced transformation fund to ensure this process is appropriately resourced.

The transformation process will take years, and must be sustained over the longer term. The political administration can expect some short term results from the process but must create a mid-term strategy which is sustainable over time.

RECOMMENDATION 7

For this purpose, the panel recommends the creation of a transformation board, supported by the Department, linked to the Executive's health and well-being strategy.

- This board would set the mid-term strategy, oversee the transformation process and would be tasked with creating the right conditions for the local system of care to develop successfully.

- It should help to transform organisational structures and management processes by promoting local decision making, local innovation and scaling up of best practices among the local systems of care.

2. Aggressively Scaling up Good Practice

Not only does Northern Ireland have many of the elements that are necessary to allow it to move forward, it has numerous examples of good practice that are consistent with the overall vision described above. Many of these could simply be scaled up and implemented on a regional basis where they will drive the system change and improved population outcomes set out in this report.

Targeting Mental Health

Implementation of the Rapid Assessment Interface and Discharge Project

This project was developed in recognition of the fundamental role that mental health plays in promoting and sustaining positive physical health. There are strong relationships between presenting physical ill-health and underlying mental health problems and by addressing these needs we can support better health outcomes and recovery rates.

The Rapid Assessment, Interface and Discharge Team (based on the Birmingham RAID model) is a multidisciplinary mental health team based in an acute hospital setting. It brings together diagnosis, treatment, psychosocial and psychological based approaches to ensure the best outcomes for patients. The service is a specialised multidisciplinary liaison psychiatry and psychological medicine team that provides rapid, timely and high quality interventions to promote the recovery and well-being of patients who present at Emergency Departments and/or are admitted to general hospitals.

The service replaces the multifaceted approach to mental health referrals with a single point of contact for all mental health referrals. The team operates 7 days per week and over 24 hours, responding within 2 hours to all Emergency Department referrals and within 24 hours to routine ward based referrals or quicker if deemed necessary.

Whilst the Northern Trust RAID is a hospital based service, one of the key benefits of the service is its ability to outreach into the community and to act as a conduit to mental health services. Improved communication with community teams such as community mental health teams and Older Persons Teams have supported discharge planning within wards and support earlier discharge from Hospital. There is enhanced communication with Primary Care and GP's are provided with a report, in respect to RAID involvement.

This innovative model has required a new way of thinking and approach to service delivery. It has required staff who previously worked on their own to adopt a different way of working which included; working as part of a strong cohesive team, working across organisational boundaries, and working shifts for previous 9am-5pm workers.

The RAID concept has been evaluated by the London School of Economics in Birmingham. This has shown reduced length of stay and enhanced discharge processes. Early indications show similar emerging patterns in Antrim Area Hospital. RAID input has also contributed to the reduction of emergency hospital readmissions within 30 days, thus reducing the overall cost of care.

Dealing with Chronic Conditions

An Integrated Respiratory Service

Within the Western Health and Social Care Trust in 2013, deaths due to respiratory diseases accounted for 16.2% of the total number i.e. 2% higher than the NI average. In addition, the majority of deaths occur in the elderly population and this is therefore expected to rise. This has implications for service provision, including an increased need for social and emotional support, especially for those patients with chronic respiratory diseases and their families and carers.

Having mapped existing services and reviewed good practice elsewhere, it was decided to create a WHSCT Integrated Respiratory Service that would enable patients with a chronic respiratory condition to be cared for in the most appropriate setting, by the most appropriate person, with access to specialist respiratory advice to enable the patients to achieve maximum health and improved health outcomes.

Previously patients with a chronic respiratory disease may have received care from a diversity of core services and this contributed to confusion for patients, duplication of services, inconsistency of approach, and inequity of access.

A new Community Respiratory Team (CRT) ensured that the patient population and their carers would receive a high standard of co-ordinated care, be better informed and educated about self-management, have improved functional ability, and have enhanced access to other services e.g. palliative care, pulmonary rehabilitation, oxygen services, support networks and voluntary agencies.

A single point of contact was put in place at each of the three sites. Referral processes were streamlined to an electronic referral system. A new operational framework was developed and communicated to all services that refer and work with the CRT. To support the CRT, a respiratory consultant rota was established as well as a monthly multi-disciplinary team meeting for complex patients managed by the CRT in the home setting. Direct referrals from GPs to the team were introduced as well as from the Northern Ireland Ambulance Service. Databases to record data were developed for all sites.

This team provides a streamlined service for GPs, hospital staff and patients. This model ensures a more coordinated and responsive service and acts as the interface between the acute hospitals, the community service, primary care and the

community and voluntary sector. Referrals are accepted from Hospital Discharge Service, GPs, NIAS, self-referral (patients previously with the service), Out of Hours and Respiratory Outpatients Service.

The programme has delivered great benefits in terms of patient experience, reduced waiting times, improved self management, reduced admissions to hospital, and, above all, better outcomes for patients.

Providing Alternatives to Hospitalisation

Acute Care at Home

The Southern Health and Social Care Trust (SHSCT) has the fastest growing over 65 years population in Northern Ireland and is set to grow by 35% from 2012 to 2023, with the over 85 year old population set to grow by 73% in the same period.

Emerging evidence from models in Torafen and Lanarkshire indicated that a consultant led community Acute Care at Home (AC@H) service was proving to be an effective way of caring for acutely ill older patients in their home as an alternative to an admission to an Acute hospital.

Following 18 months of planning, Phase 1 of the consultant led AC@H service commenced in September 2014 aiming to assess patients within 2 hours of referral. The primary focus of the service is to maintain older people at home in the event of an acute illness or unexpected deterioration in health through the prevention of inappropriate admission or facilitation of early discharge. The service provides medical triage, assessment, diagnosis and treatment as an alternative to in-patient care specifically to those at risk of or potentially requiring admission to hospital, i.e. in the absence of such care, they would otherwise require inpatient treatment.

The patients have the same access as patients in an acute hospital ward to laboratory results and to diagnostic appointments (for CT scans, Ultrasound scans, X-ray, MRI scan).

The Team consists of Consultant Geriatricians, Speciality Doctor, Specialist Occupational Therapist, Specialist Physiotherapist, Specialist Nurses, General Nurses, Pharmacist, as well as Healthcare Rehabilitation Assistants and Clerical support. Clinical and managerial leadership provided strategic direction and inspired confidence in other stakeholders.

In the 19 months from 22/9/2014 to 30/4/2016 the service has safely cared for over 830 acutely unwell patients in the community who otherwise would have been admitted to an acute hospital. Consultants and other professionals report that older people are recovering much quicker, the risk of acquiring a hospital acquired infection is eliminated and risk of falls is greatly reduced, with little or no incidence of delirium, than if they had been in an inpatient setting.

The Trust worked in partnership from the outset with the Local Commissioning Group and the Integrated Care Partnerships throughout the development and implementation of the service. Working with the LCG enabled agreement on a service model with key performance indicators. The ICP were key to developing strong interfaces with primary care and community pharmacy.

The service could be replicated across the regions however it will be slow to develop fully at scale due to workforce issues.

Better Aftercare for Patients

Transforming Cancer Follow Up (TCFU)

TCFU is a strategic partnership between Macmillan, DoH, HSCB, PHA and NICaN which commenced in 2011. The TCFU project team and wider multidisciplinary cancer teams across all five Trusts have striven for transformational change to the follow-up and survivorship needs of patients on completion of cancer treatment. TCFU is a large scale, complex, service improvement programme testing new models of cancer follow up that has begun to transform how after care services are delivered. It was initiated through a patient workshop in 2009 where key messages were heard from people affected by cancer.

More people are now living with a cancer diagnosis which is an indication that things are improving and that the cancer landscape is changing for the better. Services need to adapt to those changes.

It's widely acknowledged that the current system of review and follow-up is not sustainable – it is not efficient and it does not fully meet the supportive care needs of patients.

TCFU allows patients to be provided with information tailored to their specific needs, provided in a format that signposts them to self-management support services and provides guidance on life style changes to maximise health and well-being and get their lives back on track; while at the same giving reassurance and a clear point of access back into the system if required.

The TCFU project team and wider multidisciplinary cancer teams across all 5 Trusts in NI have delivered transformational change to the follow-up and survivorship needs of patients on completion of cancer treatment.

TCFU has shown that by taking full account of the views of patients and by carefully adapting the services we provide it is possible to develop better more patient centred services whilst at the same time working more efficiently to meet increasing demand for scarce resources.

In the interests of space, each of these projects is only briefly summarised here, a full case study of each project is included at the end of this report.

International Good Practice

Other countries and regions are heading in the same direction using best practice examples as an approach to change the model of care. They indicate both better health outcomes and higher efficiency in the use of resources.

These are a few examples.

- Pharmacist Consultations for High-Risk Patients. Pharmacists meet with high-risk patients and their caregivers at primary care clinics or in their homes to provide medication management and education. Pharmacist consultation programmes have demonstrated a 30% reduction in 30-day readmissions.

- Nurse led models of care. In the Netherlands, ongoing financial pressures within the health sector led to home care providers cutting costs by employing a low-paid and poorly skilled workforce who were unable to properly care for patients with co-morbidities, leading to a decline in patient health. Giving district nurses far greater control over patient care broke this lose-lose approach and is demonstrating significant care improvement as well as an overall reduction in cost.

- This community nurse-led care model sees management functions shared between staff and ensures at least 60% of time spent is with patients. The Buurtzorg – or "neighbourhood care" – model uses teams of district nurses to deliver care in people's homes. These teams are self-managed and co-ordinate care with other healthcare professionals, such as GPs and Allied Health Professionals. They work within guidelines including the requirement to use 3% of their turnover for training, have a diversity of nurse specialisms, and to share eight defined management and administrative responsibilities between them. The nurses have access to coaches for wider support and a central back office that processes their billing, but are responsible for their team's own finances and use of time.

- Reinforce Tele-Primary Care Visits consultations with primary care physicians (also known as Virtual Primary Care or Tele-Outpatient Visits) decrease total cost of care and help patients avoid more complex interventions. Studies comparing e-visits with face-to-face care demonstrated net savings.

RECOMMENDATION 8

The system should identify and scale up at least two innovative projects per year where there is clear evidence of improved outcomes for patients or service users.

RECOMMENDATION 9

The Panel recommends that the Minister should adopt a continuous improvement methodology to support the reform of health care towards local systems of care.

To make this actionable, it is necessary to continue with plans to create stronger quality improvement systems. While the exact remit for this will need to be decided by the Minister, the Panel feels that it should be locally owned and tasked with providing support and intelligence to enable new projects at the provider level.

There is clear and unambiguous evidence to show that specialised procedures concentrated on a smaller number of sites and dealing with a higher volume of patients, will improve outcomes.

3. Rationalisation and Stabilisation

Rationalisation

One key aspect of this is the need to rationalise services to liberate resources that can be invested in transformation. The majority of resources in the HSC are still invested in delivering acute care, and within this some services are being delivered sub-optimally in terms of both quality and value. There is clear and unambiguous evidence to show that specialised procedures concentrated on a smaller number of sites and dealing with a higher volume of patients, will improve outcomes.[36 37 38 39]

Continuing to invest large sums of money in trying to keep unsustainable services in place will only serve to delay their collapse and represents a significant opportunity cost to reforms elsewhere in the system. More importantly, it is also contributing to variation in terms of the quality of care received by those using services in different Trust areas. In a population the size of Northern Ireland, this is unacceptable. In changing the way services are provided, it will be important that decision makers clearly demonstrate the evidence for, and benefits of, change.

Given the importance of this process as an enabler for wider reform, it is dealt with separately in the following section.

Stabilisation

The significant rises in waiting lists and waiting times in the past year have received significant media coverage. While clinicians and managers have made every effort to ensure that the clinical impact on patients has been kept to a minimum, it is clear that this mismatch between demand and capacity has had a negative impact on the public's confidence in the HSC. While the longer term transformation must

36. Bilimoria, K et al (2008) Directing surgical quality improvement initiatives: comparison of perioperative mortality and long-term survival for cancer surgery, J Clin Oncol

37. Morris, S, (2014) Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis, BMJ

38. Crawford, R & Greenberg, D (2012) Improvements in survival of gynaecological cancer in the Anglia region of England: are these an effect of centralisation of care and use of multidisciplinary management? BJOG: An international Journal of Obstetrics and Gynaecology

39. Meyer, J et al (2014) Assessment of Cardiology and Cardiac Surgery for Congenital Heart Disease in Northern Ireland and the Republic of Ireland

be progressed, it will also be important to increase public trust in the system by reducing waiting times to an acceptable level.

The Department of Health and the Health and Social Care Board are currently developing an elective care plan which will set out proposals for dealing with this issue in the short and longer term. Although the plan is still being developed, the Panel has been briefed on the direction of travel. In the Panel's view, this is consistent with the vision articulated in this document and should be implemented as a matter of urgency. It is expected that the elective care plan will be ready by the time that this report is published.

RECOMMENDATION 10

The Panel recommends that the Minister takes steps to address elective care performance. However, while this is important, it should not be allowed to overshadow the need for long term transformation.

Leadership for Implementation/Organisational Culture

This report signals the need to rationalise services as well as to implement transformational change. Both of these are extraordinarily difficult and will require a planned approach to change. Furthermore, the requirement to accelerate the development of local integrated care organisations implies a new profile of leadership both locally and centrally.

It has been estimated that the success of any transformational change initiative is likely to result largely from a mix of politics and context.[40] The Panel has tried to create a positive and constructive political context for these changes by holding a political summit at the beginning of the process, providing a safe space for discussion and debate on these important and contentious issues. We have also been engaging with the political parties both before and after the elections in NI. The continued involvement of the political representatives will be an important factor in the process from now on.

Based on previous analysis (Ovreveit 2012) the Panel believes that transformational change can be successfully implemented if senior management leans on:

- the growing evidence on community based integrated networks;
- the development of the right implementation competence;
- a favorable financial and regulatory context.[41]

40. Hunter D et al (2015) Doing transformational change in the English NHS in the context of "big bang" redisorganisation : Findings from the North East transformation system, Journal of Health Organization and Management 2015 29:1 , 10-24

41. Ovretveit J &Klazinga N (2012) Learning from large-scale quality improvement through comparisons Int J Qual Health Care, 24(5):463-9

The Panel sees no reason why these conditions cannot be created in Northern Ireland. One can see from the existing building blocks explained above that Northern Ireland has an at least as good, and probably better, chance than others to move forward successfully.

The Panel believes that one key element of that implementation competence is to develop a balanced top down/bottom up approach to leadership.

That balanced approach of top down and bottom up leadership will be key to implementation. It is people, not strategies, that bring about change and it is relationships, not systems, which make it work. The model of care proposed for the future in this report will require a new form of system leadership in order to achieve integration of care and true networking among delivery organisations.

This requires an environment where staff can innovate on organisational issues that improve delivery of care

A planned approach to a transformative process needs some form of 'system leadership' at a senior level and most likely a combination of approaches such as 'push' which could imply top down policies, targets and timescales, and 'pull' which is more focused on shared values, empowerment and vision. At this level, health care transformation seems to be best achieved by a 'channeling' leadership, i.e. people who facilitate and direct the organisation's energy in a way that gets the most out of people.

This implies avoiding pushing policies onto the system. Rather, it implies developing a vision and creating the conditions for local improvement as a key mechanism to facilitate implementation.

A key component of this channeling leadership will be to develop a "high involvement culture" with health care professionals. They are the key agent of change.

That is to say that the one key predictor of positive patient outcomes and satisfaction is the level of employee engagement. Evidence indicates that staff engagement is also linked to improved financial performance in an organisation.[42]

This approach to "high involvement cultures" requires an environment where staff can innovate on organisational issues that improve delivery of care (and not only on clinical issues).

Command and control from above will not accomplish this and it will fail to exploit the energy in the organisation. The changes required by the Triple Aim approach will be more successful if they are implemented in a setting which encourages clinician and health professional engagement.

In this sense change is everybody's business.

Finally, if these difficult decisions are going to be made, they must be taken and supported by leaders at all levels of the HSC. Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to

42. West M & Dawson J (2012) Employee engagement and NHS performance, Kings Fund

Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

This can only work if every part of the system is moving in the same direction and working towards a common goal. Clinicians must identify the evidence for change, managers must ensure that the correct processes are followed, and the Minister, supported by the Executive, must act quickly to take the final decision. **All three groups will need to be prepared to defend the decision publicly.**

This approach will not happen spontaneously. It has to be made **actionable**.

One key approach for this will be to continue eliminating regulatory obstacles and simplifying the structures which block local innovation. The focus on health and social integration implies local networking and local leaders building partnerships. Local innovation is key to achieve integration of delivery organizations.

RECOMMENDATION 11

The Panel recommends that at the strategic leadership level, the HSC should:

- Foster new system leaders by protecting and empowering clinical leaders who take on leadership roles.
- Analyse and eliminate regulatory obstacles which may get in the way of implementing the new networked local health and social care organisations.
- Take the formal decision to empower leadership close to the front line.

Starting the Conversation

If we are to fully support transformation, as well as reconfiguration of services, there is a potential to more fully engage the power of our staff, partners and the public. The new "social movement" approach, currently being adopted in the NHS, provides helpful context.

These new approaches, often underpinned by social media, can act as catalysts for discussion and a way of mobilising communities and individuals to become more involved in the way health and social care is delivered. They offer greater connectivity with voices that might otherwise be hard to reach, opportunities for collaboration, thought diversity, and a culture of openness.

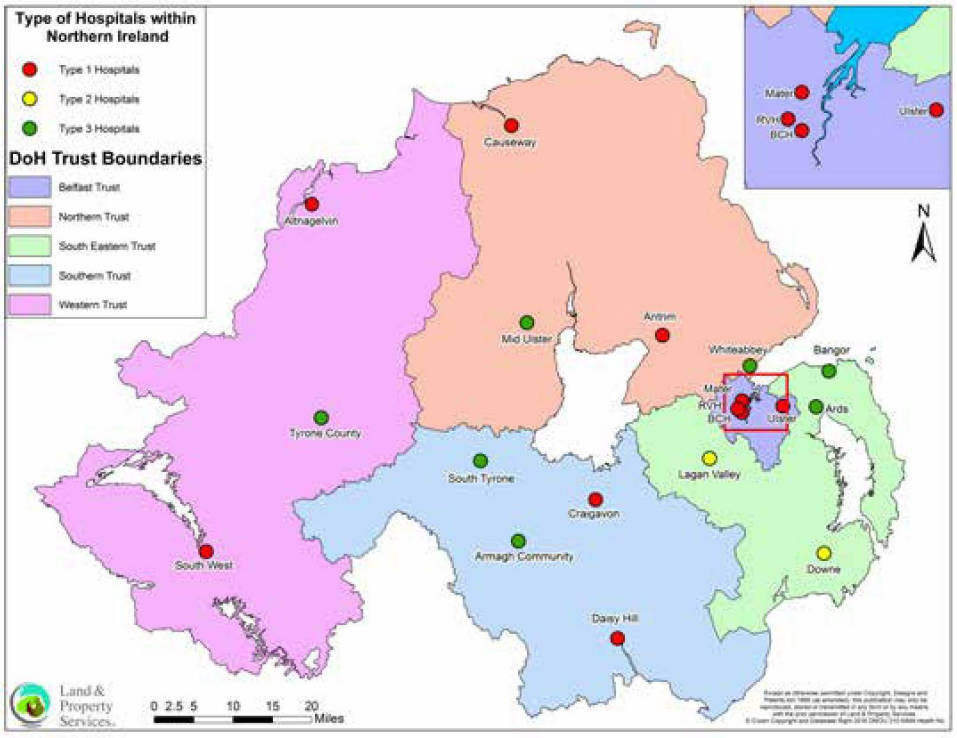
Some existing projects in the HSC are leading the way on this type of work. The Safety, Quality and Experience programme (SQE) in the South Eastern Trust, the HSC Knowledge Exchange, NICON and HSC Change Day are all good examples of initiatives that try to engage with staff or service users beyond the traditional, more formal processes.

At the 2016 NICON conference, more than 450 delegates expressed their support for the panel's final principle – that Northern Ireland could be a world leader in health care transformation – and these people were joined by over 2 Million people on social media, who were in some way able to be part of the conversation. There is significant opportunity to build on this approach and use new forms of media to communicate far more widely than has been possible in the past.

RECOMMENDATION 12

The Panel recommends that the HSC should consider whether there needs to be a platform for a more open and immediate conversation with staff and service users.

Fig. 26 – HSC Hospitals by type and HSC Trust



SECTION 5

RATIONALISATION

Through the extensive engagement held by the Expert Panel, we heard many common messages. These included:

- That previous reports over many years had signalled the need to rationalise acute services in Northern Ireland, but that implementation was slow due to resistance to change and the absence of a strong strategic approach to transformation.

- That some hospital services were increasingly vulnerable because of workforce shortages and junior doctor training requirements.

- That much needed investment in community services development was hindered because of the high costs of maintaining the current configuration of hospitals, particularly for these vulnerable specialties where often expensive locum and agency staffing was the only option for safe staffing, thus preventing development of those services that would provide an effective alternative to hospital-based care – a vicious circle resulting in ever increasing pressure on all parts of our health and social care system and increasing concerns about the quality and safety of some services.

- That the system is inconsistent from site to site.

Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis.

Earlier in this report we referred to the sense of frustration among clinicians and senior leaders at the slow pace of change up to this point. Indeed, we have heard the view expressed that unless this report contains a detailed list of hospitals and services that should close, then it will be judged to have failed.

If the model proposed in this report is to be successfully implemented, then it is inevitable that the way services are currently provided will need to change. The evidence contained in the burning platform shows the clear impact of inaction. Furthermore, changing these services is not optional; it is inevitable. The choice is not whether to keep services as they are or change to a new model. Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis.

Implementing these changes is not about making savings, it is about how we use the money we have to deliver the highest possible quality and value of care to patients and service users. The money that is currently being used to prop up

The difficulty does not lie in deciding what needs to be done. The difficulty lies in doing it.

unsustainable services does not deliver good value or the best quality of care for patients and could be reinvested in other parts of the system, particularly in areas such as general practice and primary care, mental health, learning disability and community care.

Focusing resources on specialist sites means that:

- Patients are seen in the right place and by the right person as soon as possible. Evidence shows that having all the services available on the same site improves the care delivered to the patient and the clinical outcomes;
- Staff have the necessary support and equipment to allow them to deliver the highest quality care to patients;
- It is possible to attract and recruit sufficient staff to deliver a safe, high quality, 24/7 service;
- The services are more stable and there is a better environment for patients and staff;
- There are the right conditions for professional development, quality improvement, leadership, teaching and other activities that are essential to a vibrant workforce expert in delivering care to acutely unwell patients;
- There is capacity for research and a greater ability to engage with academia and industry in generating new solutions and accelerating testing, adoption and introduction of existing solutions; and,
- This achieves the Triple Aim of better population health, better quality care and better use of resources.

However, as a panel we do not agree either that a prescriptive list should form part of this report. Changing the delivery of services is not like flicking a switch; they cannot simply be turned on and off at will. Hospital and community based services do not exist in isolation from each other and decisions in one area will inevitably have implications for the others. Decisions such as this must be taken carefully; they must be evolutionary; and, they must be carried out service by service, understanding the connectivity between clinical services that form the infrastructure of a hospital.

Furthermore, in the course of the many meetings, seminars, events and visits that the Panel has held and attended, it has become clear that clinicians and managers here already have a strong vision of what needs to be done to make services sustainable. The difficulty does not lie in deciding what needs to be done. The difficulty lies in doing it.

Process

While it is not appropriate for this report to dictate to people in different parts of Northern Ireland what services they should and should not expect to be located in their area or local hospital, it can provide a basis for a process within which these difficult but necessary decisions can be made.

1. Rationale for Reviewing Services

If we are serious about improving services and instituting large scale transformation, then these kinds of decisions:

- Must only be made in order to improve services – to create a more stable, sustainable service, to reduce waste and increase value;
- Must contribute to the overall vision – they should help to achieve the Triple Aim of better population health, better quality care, and better use of resources;
- Must be evidence based and clinically led – to ensure that the service meets patient and user needs more effectively, and that it can attract and retain high quality staff;
- Must be transparent – to include open communication and discussion with affected communities; and,
- Must contribute to the overall vision – they should help to achieve the broader model of integrated, community based care networks.

2. Criteria for Assessing Sustainability

This panel has developed a set of criteria for assessing the sustainability of services. We believe that those taking the decisions on the sustainability of a service should apply the following criteria:

- There is clear evidence that the outcomes for patients using these services are below acceptable levels either in the services as a whole or in particular hospitals, or where there are safety concerns.
- There is a clear clinical pathway for the patient population. Co-produced with patient groups.
- The service cannot meet professional standards or minimum volumes of activity needed to maintain expertise.

- The permanent workforce required to safely and sustainably deliver the service is not available/cannot be recruited or retained, or can only be secured with high levels of expensive agency/locum staff.
- The training of Junior Doctors cannot be provided to acceptable levels.
- There is an effective alternative 'out of hospital' care model or an alternative 'shared care' delivery model.
- The delivery of the service is costing significantly more than that of peers or of alternative 'out of hospital' alternatives due to a combination of the above factors.

3. Centralising Services – Case Studies

The use of the above criteria implies the centralisation of certain services. This section provides some examples of its benefits when carried out by clinicians and managers working in partnership. The examples show how services can be changed in ways that benefit patients, improve quality and make more efficient use of resources whether they are at local, regional or international level.

A. London Stroke Services

The English Department of Health's National Stroke Strategy identified that care in a stroke unit was the single most important factor in improving patients' outcomes after stroke. Based on these findings, in 2010 acute stroke services were centralised across in London. Prior to this, acute stroke services were provided in 30 hospitals. After reconfiguration, specialist care was provided in eight designated hyperacute stroke units 24/7.

Following the reforms, there was a significant reduction in mortality at 3, 30 and 90 days after admission. There was also a significant reduction in length of hospital stay.[43]

43. Morris, S, (2014), Impact of centralising acute stroke services in English metropolitan areas on mortality and length of hospital stay: difference-in-differences analysis, BMJ

B. Trust Level – Stroke Services in the Southern Trust

In 2012, the RQIA carried out a review of stroke services. Overall the key findings were that stroke services in NI were too fragmented between hospital sites, many patients were not being cared for in optimal environments, community services were underdeveloped and new time-critical interventions, such as thrombectomy, were not always available on a 24/7 basis. The review also highlighted the need for progression of clinical competencies and training relating to stroke and the establishment of clearly defined stroke units and dedicated stroke wards. This has proved difficult to achieve and sustain in smaller hospitals where recruitment and retention of specialist staff is a recognised problem.

In 2014, following public consultation, a decision was taken to create a single specialist stroke inpatient unit within the Southern Health and Social Care Trust, at Craigavon Area Hospital. The Trust is proposing to provide a consistent and specialist service 24/7 in one centre rather than spreading the specialist team of staff across four sites. Daisy Hill Hospital will continue to provide ongoing rehabilitation and support through community stroke teams working to a regionally agreed care model.

The proposals are consistent with clinical evidence which shows that patients are 25% more likely to survive or recover from stroke if treated in a specialised centre. Other benefits will include:

- High quality medical care
- Improved levels of Stroke Care in line with National Audit (SSNAP) recommendations – appropriate staffing levels to allow early assessment, observation and early rehabilitation input.
- The highest quality medical care in hospital (more concentrated levels of specialist medical, nursing and AHP care).
- Patients being admitted to a Stroke Unit as a ward of first admission. Latest medical evidence demonstrates that where patients are treated in specialist stroke units they achieve best outcomes.
- Better rehabilitation outcomes - a specialised service which will bring community and hospital based staff together as an integrated team providing care to Stroke patients. This will provide more focused care and continuity of service provision throughout the patient's pathway.

Reduced length of stay in hospital - more focused community based rehabilitation to allow Stroke patients to be discharged from hospital earlier and recover at home.

C. Regional level – Primary Percutaneous Coronary Intervention

Heart attack is a leading cause of mortality and morbidity in Northern Ireland. Approximately 40% of hospitalised heart attack patients have the more serious ST Elevation Myocardial Infarction (STEMI) heart attack. Traditionally a STEMI heart attack was treated by giving patients a clot-busting drug (thrombolysis). Patients then went a few days later to a catheterisation laboratory (cath lab), while still in hospital to have a metal stent inserted.

Primary Percutaneous Coronary Intervention (pPCI) involves the patient being taken immediately to a cath lab to widen the artery, clear the blockage and have a stent inserted, instead of using clot-busting drugs. Primary PCI reduces the mortality, complication rates and length of stay in hospital. A pPCI service needs direct admission to a designated centre with dedicated cath lab facilities capable

of undertaking the procedure 24/7. Running this requires many highly skilled staff, including interventional cardiologists, clinical physiologists, nurses and radiographers. Each centre needs to do a minimum number of cases each year to maintain standards.

The best fit which gave maximum geographical coverage for the NI population within an agreed travel time, while having enough caseload to maintain team skills, was to have 2 pPCI centres, one in Belfast (RVH) and one at Altnagelvin.

Making this work required commitment, coordination and agreement from senior clinical staff and managers in all six Trusts. A regional group was set up, chaired by a Consultant in public health from PHA, supported by the regional cardiac network coordinator, senior commissioner and finance officers from HSCB.

Obtaining agreement on clinical pathways and protocols was relatively straightforward. What was more difficult was trying to recruit the right number of trained interventional cardiologists to provide a sustainable out of hours rota for the Altnagelvin service, while ensuring sufficient workload to maintain their skills.

The group explored options to provide the night-time rota cover by consultants who would have daytime commitments in other hospitals, crossing Trust boundaries. The same approach was used for the Belfast pPCI service, seeking to offer opportunities to interventionalists working in other hospitals who wished to join the pPCI rota. In tandem, where there were other known gaps in cardiology services, such as in outpatient clinics, or cardiac MRI, if options were available to sort those within the overall configuration of new consultant posts then that was considered.

New IT systems were also agreed to share important patient information, both for patients waiting a daytime cath lab procedure and those waiting for cardiac surgery.

This regionally coordinated process ignored organisational boundaries when seeking the best solution for the population. Rather than focussing solely on pPCI, it used the opportunity to improve other aspects of cardiology services, with the end result that local services were strengthened as well as providing a new regional service. Primary PCI was centralised into 2 locations, because that was the best way to achieve a sustainable high quality service for patients, but others such as cardiac MRI and non-complex pacemaker implantation were able to be decentralised. This required close cooperation between clinical and management teams in all six Trusts. All had to make compromises to deliver a better, stronger cardiology service for the people of Northern Ireland.

D. Cross-Jurisdictional Level – Children's Congenital Heart Surgery

In recent years the regional Paediatric Congenital Cardiac Surgical (PCCS) Service, provided by the Belfast Trust, developed vulnerability in its surgical service due to new international safety and quality standards which could not be met because

of our relatively small population size. As evidenced by clinical reviews neither surgical centre (Belfast or Dublin) had been delivering a service which meets current international standards of both institutional case volume and consultant staffing: the service in Belfast did not meet the surgical case volume threshold, and the Dublin service has a medical staffing level in both intensive care and cardiology that is significantly lower than in comparably sized UK and European centres.

By December 2014 Belfast could not continue to provide an emergency and elective surgical service, and by April all interventional cardiology procedures ceased in Belfast (as these require the presence of a surgeon).

An International Working Group (IWG), led by Dr John Mayer from Boston Children's Hospital recommended the establishment of an all-island congenital heart disease (CHD) service, with a single surgical centre in Dublin capable of meeting international standards for surgical practice volumes, supported by specialist cardiology hubs in Belfast and other locations. The 'hub and spoke' network would involve all stakeholder groups including patient representative organisations in its governance structure, and be supported by enhanced telemedicine links, improved transportation, and a clinical research programme.

The all-island CHD Network was established in April 2015, following a public consultation on the recommendations of the expert group. In endorsing the IWG's recommendations, commitment was also given to the development of a specialist Children's Heart Centre in Belfast, enhancing existing facilities at the Clark Clinic within the current footprint of the Royal Belfast Hospital for Sick Children and making it fit for purpose until the new Children's hospital opens in 2021/22. This will secure the role of RBHSC as an integral part of the in the all-island 'hub and spoke' network, functioning as a 'Level 2' cardiology centre, i.e. providing the full range of non-surgical care required by CHD patients until they are ready to transition into the adult service.

The all-island CHD Network involves the two Health Departments, commissioners, service providers (management and clinicians) and patient representatives in a collaborative non-statutory structure to deliver an all-island CHD Service in line with the relevant legal and accountability arrangements that apply in each jurisdiction.

4. Maintaining Momentum

While criteria were previously developed as part of TYC, there is little evidence of these being applied in a systematic way to services or conditions. The panel believes that the Department should consider formal endorsement of these criteria and that a timetable for applying these should be developed, prioritised by specialty.

Based on the evidence the panel has received, the specialties that are currently in most need of reform would seem to be:

Priority 1

- EMERGENCY & URGENT CARE
- STROKE SERVICES
- PRIMARY CARE INCLUDING GP OUT OF HOURS
- GENERAL SURGERY
- PATHOLOGY
- VASCULAR

Priority 2

- PAEDIATRICS
- PALLIATIVE CARE
- OBSTETRICS
- RADIOLOGY
- NEONATAL SERVICES[44]
- TRAUMA
- UROLOGY
- REHABILITATION
- COMMUNITY BASED ELDERLY CARE
- BREAST SERVICES

RECOMMENDATION 13

The Panel recommends that the Department should formally endorse the criteria and apply them to five services each year to set out the future configuration of services to be commissioned (or not) from the Accountable Care Systems.

If applying the criteria leads to the conclusion that the service is vulnerable, plans for reconfiguration should be developed and actioned within this twelve month period.

44. Paediatrics, obstetrics and neonatal services are clinically linked and should be considered together.

5. Seeing the Big Picture

Having heard from many different leaders in different parts of the system, the Panel is in no doubt that local clinical leaders know exactly what they would like to do to optimise delivery of services for their patients and service users. However, it is also clear that in the interests of patients across the whole of Northern Ireland, decisions that will have a significant impact regionally or across Trust boundaries, must be taken in a regional context and must be consistent with the long term vision.

We therefore recommend the establishment of an appropriately resourced transformation business unit, based in the centre of the system. This unit should be tasked with providing a strategic view on projects with a regional impact – joining local and regional considerations while firmly focused on delivering better outcomes for patients. We are not advocating an expansion of bureaucracy and the past tendency to create unwieldy process management in taking forward change must be avoided.

The projects themselves would still be clinically/locally led and the role of the unit would be to bring a regional perspective to such decisions ensuring that patients' requirements are fully met. Given the inter-connections between medical conditions, this would also ensure that all the related regional impacts arising from proposed change are not being taken in isolation of the wider vision.

RECOMMENDATION 14

The Panel recommends the identification of a senior leader to lead this process at a regional level.

This process should be collaborative and inclusive and based on the criteria above.

6. Change is Everybody's Business

In taking these decisions, it is of course vitally important that there is clear engagement with communities both at a local level and regionally. People will need to be able to understand why a service is changing and what will take its place. The Panel considers this to be a fundamental component of any changes. Health professionals must support local representatives in explaining the rationale for change and the alternatives which will provide better care. Where the centre is leading and co-ordinating changes to hospital services, this should be led by professional leaders with support from clinical leaders in those services.

Finally, if these difficult decisions are going to be made, they must be taken and supported by leaders at all levels of the HSC. Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

When developing the criteria above, the Panel met with clinical leaders from across the Health and Social Care system and was struck by the support for and commitment to driving these difficult changes and wider transformation forward.

This can only work if every part of the system is moving in the same direction and working towards a common goal. Clinicians must identify the evidence for change, managers must ensure that the correct processes are followed, and the Minister, supported by the Executive, must act quickly to take the final decision. All three groups will need to be prepared to defend the decision publicly and openly, and to honestly communicate the need for change with local politicians, the public and individual service users.

SECTION 6

LIST OF RECOMMENDATIONS

Recommendation 1

The Panel recommends using the dimensions of the Triple Aim as a framework for reform, including an increased emphasis on the experience of those who deliver care.

Recommendation 2

The Panel recommends that the HSC should move to:

- Formally invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and,

- Regionalised planning for specialist services.

Recommendation 3

The Panel recommends that the HSC should continue its positive work to invest in and develop the areas listed above.

There should be particular focus on the three key areas of workforce, eHealth and integration:

- As a key enabler of Accountable Care Systems, the HSC should continue to invest in e-health to support improved self management, care at home and use of information to drive better population health outcomes.

- The HSC should immediately develop innovative primary care based models that will allow non-medical staff to work in a way that makes the most of their skills. (For example, these could be based on the community nurse-led care models being implemented in the Netherlands, or the use of pharmacists in community development here in Northern Ireland).

- Work should be carried out to identify which social interventions are most cost effective in addressing the social needs and improving health for Northern Ireland.

- Any new approach to commissioning should be aligned with the need to build integrated health and social organisations on the ground which target specific inequalities and social groups.

Recommendation 4

The Minister should create, communicate and lead a clear, powerful, long term vision for the Health and Social Care system as a first step in the implementation process.

Recommendation 5

Alongside the Minister's vision for health and social care, the Panel recommends that plans, costs and timescales for introducing the actions detailed in the main body of the report should be prepared within the next 12 months. It is vital that the implementation of these actions is led by health and care professionals and managers.

Recommendation 6

Many of these recommendations will require additional, transitional funding. The Panel recommends that the Minister should establish a ring fenced transformation fund to ensure this process is appropriately resourced.

Recommendation 7

For this purpose, the panel recommends the creation of a transformation board supported by the Department, linked to the Executive's health and well-being strategy.

- This board would set the mid-term strategy, oversee the transformation process and would be tasked with creating the right conditions for the local system of care to develop successfully.

- It should help to transform organisational structures and management processes by promoting local decision making, local innovation and scaling up of best practices among the local systems of care.

Recommendation 8

The system should identify and scale up at least two innovative projects per year where there is clear evidence of improved outcomes for patients or service users.

Recommendation 9

The Panel recommends that the Minister should adopt a continuous improvement methodology to support the reform of health care towards local systems of care.

To make this actionable, it is necessary to continue with plans to create stronger quality improvement systems. While the exact remit for this will need to be decided by the Minister, the Panel feels that it should be locally owned and tasked with providing support and intelligence to enable new projects at the provider level.

Recommendation 10

The Panel recommends that the Minister takes steps to address elective care performance. However, while this is important, it should not be allowed to overshadow the need for long term transformation.

Recommendation 11

The Panel recommends that at the strategic leadership level, the HSC should

- Foster new system leaders by protecting and empowering clinical leaders who take on leadership roles.
- Analyse and eliminate regulatory obstacles which may get in the way of implementing the new networked local health and social care organisations.
- Take the formal decision to empower leadership close to the front line.

Recommendation 12

The Panel recommends that the HSC should consider whether there needs to be a platform for a more open and immediate conversation with staff and service users.

Recommendation 13

The Panel recommends that the Department should formally endorse the criteria and apply them to five services each year to set out the future configuration of services to be commissioned (or not) from the Accountable Care Systems.

If applying the criteria leads to the conclusion that the service is vulnerable, plans for reconfiguration should be developed and actioned within this twelve month period.

Recommendation 14

The Panel recommends the identification of a senior leader to lead this process at a regional level.

This process should be collaborative and inclusive and based on the criteria above.

APPENDIX A

THE EXPERT PANEL'S PRINCIPLES FOR HSC REMODELLING

Vision Statement

"To create a fair and sustainable, including financially sustainable, Health and Social Care system that delivers universal, high quality, safe services that meet the Northern Ireland population's needs and which deliver world class outcomes for patients and service users."

Ethos

1. **The system should be collaborative, not competitive.**
   There are several components to this principle. Firstly, even in the short term it will not be safe or effective to deliver all services locally. Organisations must work together to provide high quality care to patients. Secondly, unwarranted variance across the system should be minimised. Patients should be able to receive the same standard of care anywhere in the region. Thirdly, the HSC should continue to work in partnership across government, with industry, academia, the community and voluntary sector, staff and patients to deliver new models of care. Finally, remodelling of the system should be a transparent and collaborative process.

2. **The system should adopt a population health and well-being model with a focus on prediction and prevention rather than reaction.**
   Like many health services worldwide, HSC resources and service developments are often locked into reactive 'disease care', which focuses on increasingly expensive diagnostics and treatment. It must be acknowledged that there should be an increased emphasis on investment in prevention and health promotion, particularly for vulnerable communities who are at highest risk of experiencing inequalities. It must also be acknowledged that addressing wider health determinants requires a cross-sectoral approach, although there is much that the HSC can do in terms of designing new models of care.

3. **Patients should be active participants in their own care, not passive recipients.**
Patients should be treated with respect and empowered to stay healthy and care for themselves where possible. Patients should also be supported and encouraged to take greater ownership of their own health outcomes. The public rightly expects access to safe, sustainable and high quality health and social care services; however, as part of the relationship between the HSC and citizens, the public should also be enabled to take greater responsibility for their own health and well-being, and to use services appropriately.

Delivery Model

4. **Health and Social Care is already integrated in Northern Ireland. Remodelling must build on this strength and take a whole system perspective.**
The HSC in Northern Ireland is an integrated system, to the envy of many countries. Remodelling must ensure that different parts of the system are connected, interdependent, that they talk to each other and that they form an integrated whole. Patients should be able to transition smoothly between social care, community care and hospital care.

5. **Only people who are acutely unwell need to be in a hospital.**
Hospital is often not the right answer. There is evidence that for patients who do not need acute care, being in an acute hospital can be harmful. Research also indicates that hospital use is affected by deprivation, with people in poorer areas more reliant on emergency services, and making insufficient use of planned elective services. Studies have shown extremely positive feedback and satisfaction levels from patients who were treated in community settings and the HSC must continue to develop strong community care models.

6. **Very specialist services can be based anywhere in Northern Ireland.**
In the face of increased specialisation and ever rising demand, it is not practical or desirable to try to deliver specialist services everywhere. However, it is true that specialist services could be delivered anywhere. Any acute hospital in Northern Ireland has the potential to become a regional centre. Furthermore, the HSC should continue to explore and realise the mutual benefits of collaboration with other jurisdictions in ensuring patients have access to high quality, sustainable services.

7. **The location and composition of resources should be based on meeting patients' needs and achieving the best outcomes.**
Co-ordinated workforce and service planning should be carried out on the basis of the population's need rather than with the aim of maintaining services which are not sustainable in the long term.

8. **The real value of Health and Social Care is in its people, not its buildings.**
HSC staff should be given the freedom to innovate and deliver services in a way that best meets people's needs, safely, quickly, and with respect and compassion. This implies more local autonomy and innovation within a defined policy framework. Northern Ireland has a wealth of knowledge and expertise that should be harnessed and developed to allow us to provide the highest quality services to patients. Local initiatives should be encouraged and best practice should be shared across the region.

Implementation

9. **Whole system remodelling is a medium to long term process.**
Funds will continue to flow into the health and social sector but simultaneously there must be significant gains in productivity. New care models allow for increased productivity. Reform and remodelling on this scale will take time and must be supported by an evidenced, costed and resourced implementation plan. This will need policy and political commitment in the long term.

10. **The system must be supported to implement change with pace and scale.**
Change is inevitable and must be embraced. There is an appetite and a will to implement planned change among staff. Service developments and investment from this point should be geared towards supporting and complementing a long term strategy for sustainable and quality care.

11. **Technology should be developed and adopted where it can support and enable transformation.**
Northern Ireland has one of the most advanced electronic care record systems in Europe. New technologies offer enormous potential for improved self-management, telemedicine, information sharing and communication across sub-systems. Innovation and new technologies should be embraced in collaboration with industry where they offer the potential to deliver better or more efficient services. This will bring benefits to patients, the HSC and the economy.

Leadership and Culture

12. **The panel will engage constructively with elected representatives when designing and communicating a remodelled HSC. The Panel will also engage openly with HSC staff and the public.**
Implementation will require strong political and technical leadership. Without change, the Northern Ireland Health and Social Care system is not sustainable in the medium to long term. Elected officials will play a key role in analysing proposals and enabling the public to understand the need for change.

13. **Northern Ireland can be a world leader in transforming health and social care**
Many countries are facing the same challenges and difficult choices as Northern Ireland. This process is an opportunity for Northern Ireland to be a pioneer in designing and delivering health and social care services fit for the 21st Century.

APPENDIX B

LIST OF ENGAGEMENT MEETINGS

CO3

DOH

NIASW

RCN

BMA

Patient & Client Council

PPI Seminar event

Sinn Fein

DUP

UUP

SDLP

Alliance

BHSCT

NHSCT

Meeting with representatives from all HSC Trusts

HSCB

PHA

Dr George O'Neill, GP

QUB

Clinical leaders seminar event

NIPSA

RQIA

Pathology Network NI

NICON

Royal College of Surgeons

Royal College of Paediatricians

Age NI

NHS England

Greater Manchester Health & Devolution

ICP & LCG Delegation

AHP Delegation

Senior Nurse Delegation

ABPI

Contact NI

Commissioner for Older People for NI

Chief Clinical Information Officers

Unison

BMA – NI GPC

Safety Forum

Institute for Healthcare Improvement

Community Pharmacy NI