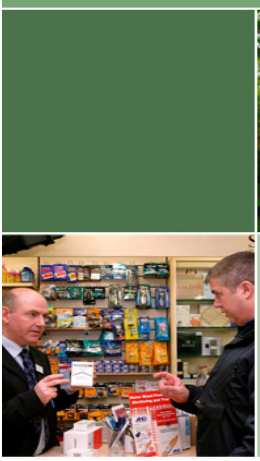
Transforming Your Care

A Review of Health and Social Care in Northern Ireland





Transforming Your Care

A Review of Health and Social Care in Northern Ireland

December 2011

The Review Team would like to thank the Project Team:

Pamela McCreedy – Project Leader

Angela Hodkinson, Elaine Hunter, Seamus Carey – Project Managers

Ffiona Dunbar, Maria Higgins, Jonathan Houston – Project Support

1. INTRODUCTION

The task faced by the Review was both challenging and daunting. Health and Social Care is of interest to everyone in Northern Ireland and the team approached their task fully aware of the responsibility it had been given.

It was also aware that whilst it was important to look to best practice and examine data from outside the province the deliberations had, in the end, to make sense for Northern Ireland. Many drivers exist in this context: the importance of health and social care to the economic wellbeing of NI; the contribution staff make; the shadow of our recent history in NI, particularly in the mental well being of the citizenry; and the very powerful affinity the NI society has to the core NHS principles.

The team approached its task with that knowledge and these matters were reflected exhaustively in their deliberations. However, the overriding desire of the team was to describe and build a system of health and social care which would place the individual, family and community that use it at the heart of how things are done. That meant using evidence to explain why there needs to be change and concentrate on the outcomes that individuals could reasonably expect in a modern system of care and treatment.

The Review is therefore about change; not careless or haphazard change but planned change over a 5 year period that can and should improve care. The report may be contentious to some, but the Review team saw clearly that there are no neutral decisions as it looks to the future. It has taken the view that a managed and transparent change is better than unplanned, disorganised change.

Finally on behalf of the team I should like to thank the very many people, citizens, professionals and representatives of interest groups who gave freely of their time to help the Review. I should also like to extend thanks to the independent panel members for their honesty, challenge and contribution to the Review.

John Compton
Chair of the Review Team
December 2011

EXECUTIVE SUMMARY

2. EXECUTIVE SUMMARY

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care (HSC) Services in Northern Ireland would be undertaken. The Review was to provide a strategic assessment across all aspects of health and social care services, examining the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and communities are being met. Crucially it was to bring forward recommendations for the future shape of services and provide an implementation plan. The Review team was not asked to bring forward proposals which reduced the budget published by the Northern Ireland Executive, but was asked to ensure that it was used to best effect.

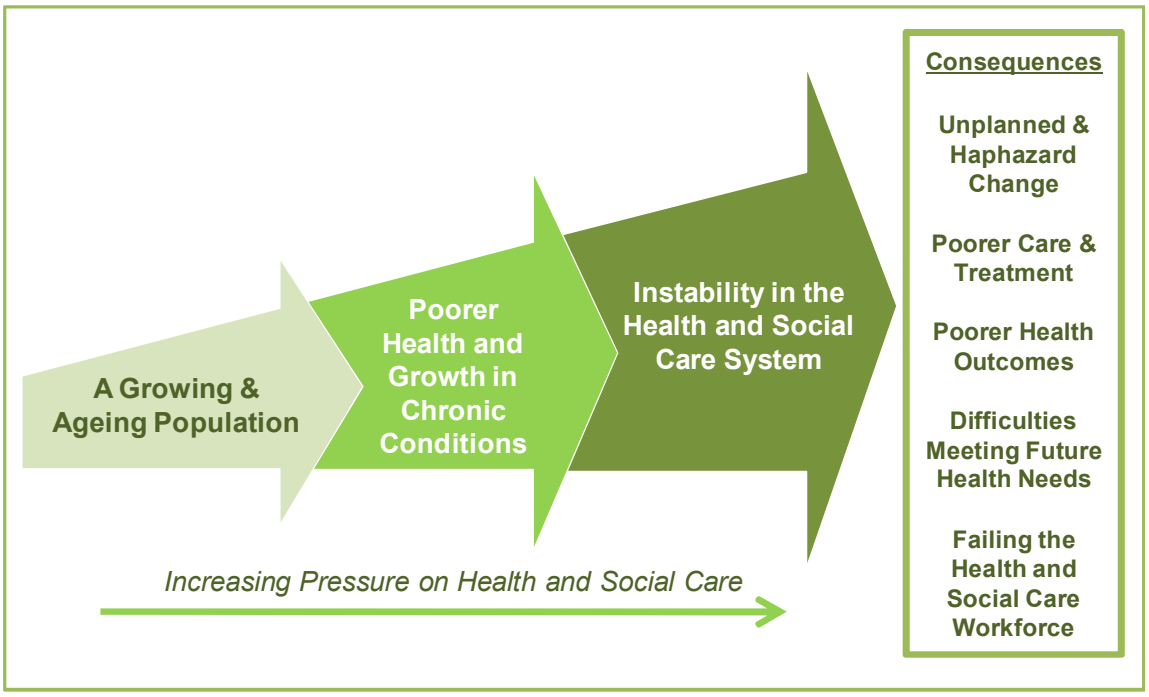
The Minister judged that at a time of considerable flux within health and social care and the wider economy it was prudent not to disconnect the service from the Review process. Therefore, he appointed John Compton, Chief Executive of the Health and Social Care Board, to complete the task in an ex-officio capacity. However, the Minister did want a strong independent overview to the process, helping to shape and providing challenge to any proposals. Therefore he also appointed an independent panel comprising: Professor Chris Ham (Chief Executive of the King's Fund), Professor Deirdre Heenan (Provost and Dean of Academic Development at the Magee Campus), Dr Ian Rutter (General Practitioner), Mr Paul Simpson (retired senior civil servant), and Mr Mark Ennis (Executive Chair of SSE Ireland).

The Review was to complete by 30 November 2011. Within the timescale available, the Minister was keen to ensure maximum engagement with the public, clinical and professional leaders, health and social care organisations and stakeholders in the voluntary, community, private and independent sectors. In particular the Minister highlighted the importance of engaging with the health and social care workforce through the Partnership Forum. Following their appointment in August, the Review team designed its approach as shown below.

Figure 1: Overview of Approach

The Review concluded that there was an unassailable case for change. The figure below illustrates the core of the argument.

Figure 2: Future Model for Integrated Health and Social Care



Responding to these pressures, the Review identified eleven key reasons which support the need for change (summarised in the adjacent box) along with a model of health and social care which would drive the future shape and direction of the service.

Figure 3: Reasons for Change

To be better at preventing ill health
To provide patient-centred care
To manage increasing demand across all programmes of care
To tackle health inequalities
To deliver a high-quality, evidence-based service
To support our workforce in delivering the necessary change

In developing a new model, the Review engaged with over 3000 members of the public, clinicians, providers and interest groups. It also reviewed evidence to ensure that any changes required had at their heart better outcomes for patients and clients and their families.

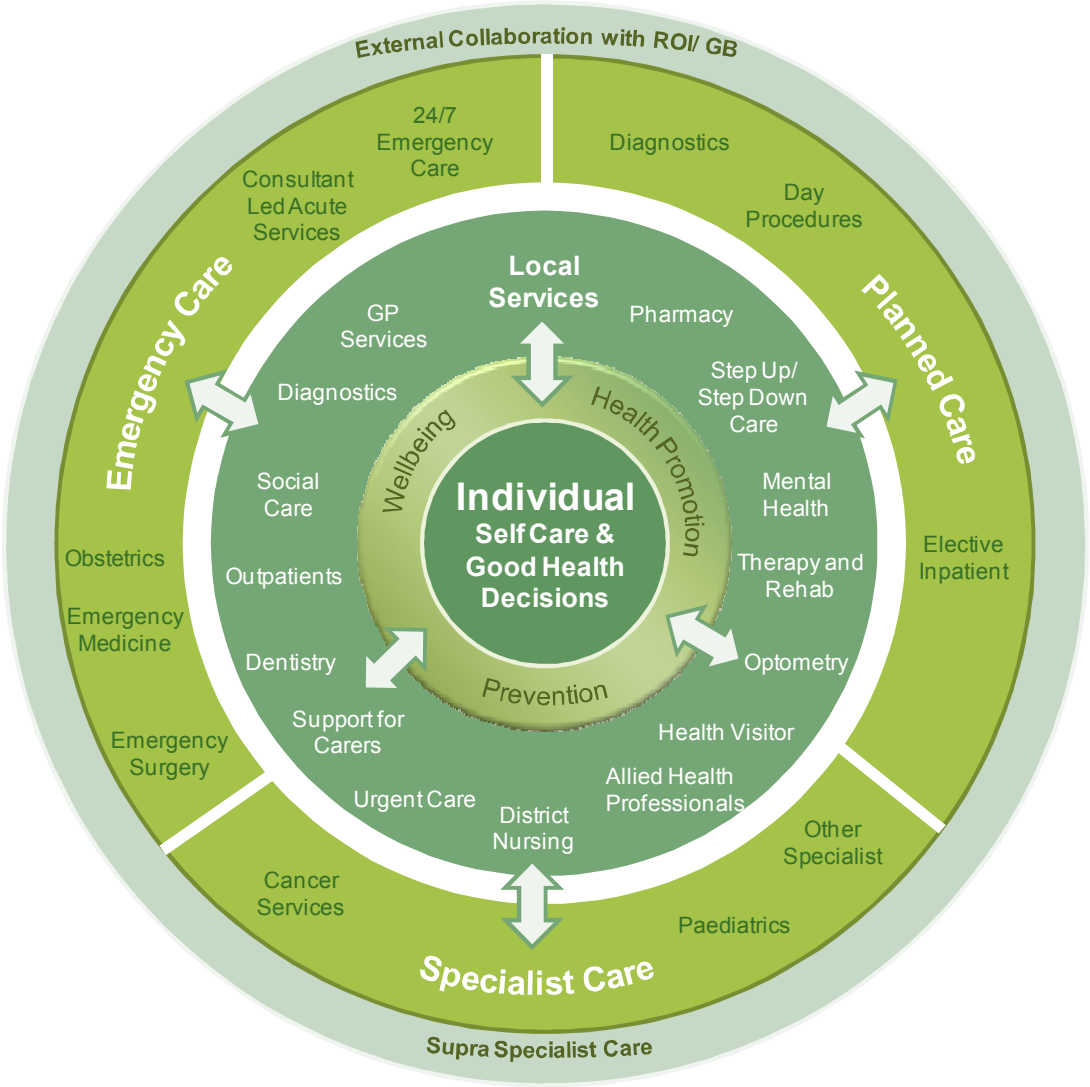
The Review was clear about the purpose of change namely, what changes would make the greatest difference to outcomes for patients, users and carers. In doing so the Review looked beyond the geographical boundaries of Northern Ireland.

The Review identified twelve major principles for change, which should underpin the shape of the future model proposed for health and social care.

1. Placing the individual at the centre of any model by promoting a better outcome for the service user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.
5. A focus on prevention and tackling inequalities.
6. Integrated care – working together.
7. Promoting independence and personalisation of care.
8. Safeguarding the most vulnerable.
9. Ensuring sustainability of service provision.
10. Realising value for money.
11. Maximising the use of technology.
12. Incentivising innovation at a local level.

The model devised by the Review team is shown in the figure overleaf.

Figure 4: Future Model for Integrated Health and Social Care



Briefly described the model means:

- every individual will have the opportunity to make decisions that help maintain good health and wellbeing. Health and social care will provide the tools and support people need to do this;
- most services will be provided locally, for example diagnostics, outpatients and urgent care, and local services will be better joined up with specialist hospital services;
- services will regard home as the hub and be enabled to ensure people can

be cared for at home, including at the end of life;

- the professionals providing health and social care services will be required to work together in a much more integrated way to plan and deliver consistently high quality care for patients;
- where specialist hospital care is required it will be available, discharging patients into the care of local services as soon as their health and care needs permit; and
- some very specialist services needed by a small number of people will be provided on a planned basis in the ROI and other parts of the UK.

To help illustrate what this would mean, case studies were developed to explain the model. In essence they show it to be simpler to use, clearer about the key worker, and crucially providing an improved outcome for those who use the service.

Following on from this, the impact on ten major areas of care was examined:

Population Health and Wellbeing
Older People
People with Long-Term Conditions
People with a Physical Disability
Maternity and Child Health
Family and Child Care
People using Mental Health Services
People with a Learning Disability
Acute Care
Palliative and End of Life Care

The model was applied to these service areas and each has a series of recommendations. The full list of 99 proposals is provided Section 19 of the report.

The key themes in the recommendations are summarised below.

Quality and outcomes to be the determining factors in shaping services. Prevention and enabling individual responsibility for health and wellbeing.
Care to be provided as close to home as practical.
Personalisation of care and more direct control, including financial control, over care for patients and carers.
Greater choice of service provision, particularly non-institutional services, using the independent sector, with consequent major changes in the residential sector.
New approach to pricing and regulation in the nursing home sector.

Development of a coherent 'Headstart' programme for 0-5 year old children, to include early years support for children with a disability.	Shifting resource from hospitals to enable investment in community health and social care services.
A major review of inpatient paediatrics.	Modernising technological infrastructure and support for the system.
In GB a population of 1.8million might commonly have 4 acute hospitals. In NI there are 10. Following the Review, and over time, there are likely to be 5-7 major hospital networks.	Following from this, the Review considered and presented the methodology to make the change over a 5 year period. This initially describes a financial remodelling of how money is to be spent indicating a shift of £83million from current hospital spend and its reinvestment into primary, community and social care services. It goes on to describe as integral the need for transitional funding of £25million in the first year; £25million in the second year; and £20 million in the third year enable the new model of service to be implemented In conclusion, the Review reiterates that change is not an option. It re-affirms there are no neutral decisions and there is a compelling need to make change. The choice is stark: managed change or unplanned, haphazard change. The Review team commends its report to the Minister.
Establishment of a clinical forum to ensure professionals are fully engaged in the implementation of the new model.	
A changing role for general practice working in 17 Integrated Care Partnerships across Northern Ireland.	
Recognising the valuable role the workforce will play in delivering the outcomes.	
Confirming the closure of long-stay institutions in learning disability and mental health with more impetus into developing community services for these groups.	
Population planning and local commissioning to be the central approach for organising services and delivering change.	

BACKGROUND TO THE REVIEW

3. BACKGROUND TO THE REVIEW

This part of the report explains the nature and purpose of the Review. It sets out who was involved and why, then describes the objectives set for the Review, the scope of the task and the approach taken to complete it.

In June 2011, the Minister for Health, Social Services and Public Safety, Edwin Poots, MLA, announced that a Review of the Provision of Health and Social Care Services in Northern Ireland would be undertaken, asking how it should change and requesting an implementation plan to manage the change. The full terms of reference is included at Appendix 1.

The key objectives of the Review were to:

- undertake a strategic assessment across all aspects of health and social care services;
- undertake appropriate consultation and engagement on the way ahead;
- make recommendations to the Minister on the future configuration and delivery of services; and
- set out a specific implementation plan for the changes that need to be made in health and social care.

The Review was not to be fully independent and Mr John Compton, Chief Executive of the Health and Social Care Board, was invited to lead the process. The Minister judged that at a time of considerable flux within health and social care and the wider economy it was prudent not to disconnect the service from the Review process. However he did want a strong independent overview to the process providing challenge to any proposals. Accordingly he appointed five independent panel members:

- Professor Chris Ham (Chief Executive of the King's Fund);
- Professor Deirdre Heenan (Provost and Dean of Academic Development at the Magee Campus, University of Ulster);
- Dr Ian Rutter (General Practitioner);
- Paul Simpson (retired senior civil servant); and
- Mark Ennis (Executive Chair of SSE Ireland).

The appointments reflected the desire to ensure proper scrutiny was applied to the process.

The Minister's over-riding concern is driving up the quality of care for clients and patients, improving outcomes and enhancing the patient experience. In initiating the Review, the Minister explained that he wanted it to ensure that health and social services are focused, shaped and equipped to improve the quality of care and outcomes for the population, and to provide value for money in financially challenging times. He wants to see a shift in care currently carried out in hospitals into the community with patients being treated in the right place, at the right time and by the right people.

The Minister also made it clear that in deciding to have a Review no criticism was implied about staff working in the current system. Quite the reverse, he concluded that the current model was unsustainable going forward and that he wanted to see a service which was developing not declining, a service which built upon the commitment and expertise of those working in health and social care.

OBJECTIVES

Accordingly the objectives of the Review were to:

- provide a strategic independent assessment across all aspects of health and social care services of the present quality and accessibility of services and the extent to which the needs of patients, clients, carers and communities are being met by existing arrangements in terms of outcomes, accessibility, safety, standards, quality of services and value for money;
- undertake appropriate consultation and engagement on the way ahead with the public, political representatives through the Assembly Health Committee, HSC organisations, clinical and professional leaders within the system, staff representatives through the Partnership Forum, and stakeholders in the voluntary, community, independent and private sectors;
- make recommendations to the Minister on the future configuration and delivery of services in hospital, primary care, community and other settings; and
- set out a specific implementation plan for the changes that need to be made in the HSC, including proposals in relation to major sites and specialities.

SCOPE

In delivering these objectives the Review was to take account of the following:

- extant policy and strategies approved by the Minister, in particular the aims of improving public health, the prevention of illness and of improving outcomes for patients and clients;
- statutory duties on the HSC to improve the quality of services provided, to improve the health and social wellbeing of the population and to reduce health inequalities; and

- primary care, community care, social care and hospital services.

Certain areas were deemed to be outside the scope of the Review:

- the new organisational structures created as a result of the RPA process within Health and Social Care; and
- the Review should work within the constraints of the current level of funding for the coming period. The current Performance and Efficiency Unit (PEDU) review of the scope to make savings in the health and social care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review.

However, the Minister indicated that if the Review felt it should comment on any of these areas, it should not feel constrained in doing so.

Public health and social wellbeing is at the heart of health and social care. The Review team is aware that there is a separate piece of work being undertaken by the Department of Health Social Services and Public Safety (DHSSPS) and the Public Health Agency (PHA) to create a new public health strategy, as set by the Executive and Minister. Notwithstanding this, the Review considered it appropriate to look at public health and wellbeing in its work.

The Terms of Reference had asked the Review to make recommendation on the future configuration of hospital, primary care, community care and other settings. During the course of the Review, the team proposed to the Minister that it was better to describe a framework for the future of care rather than including specific proposals in relation to sites and specialties. The rationale for this presented to the Minister was the critical need to enable professionals and communities to devise local solutions within a very clear framework and criteria for success. The Minister agreed to this approach to applying the Terms of Reference.

APPROACH

Giving consideration to the Terms of Reference set by the Minister (Appendix 1), a project plan was developed. The approach to the Review involved five key strands of activity, as shown in the figure below.

Figure 5: Overview of Approach

In particular the Minister highlighted the importance of engagement with stakeholders and a comprehensive engagement plan was developed. The objective was to enable informed debate and to present information to the public.

This resulted in more than 3,000 people engaging directly with the Review, and many more being exposed to debate on the key issues affecting health and social care provision through media coverage of the Review on TV, radio, online and by the printed media.

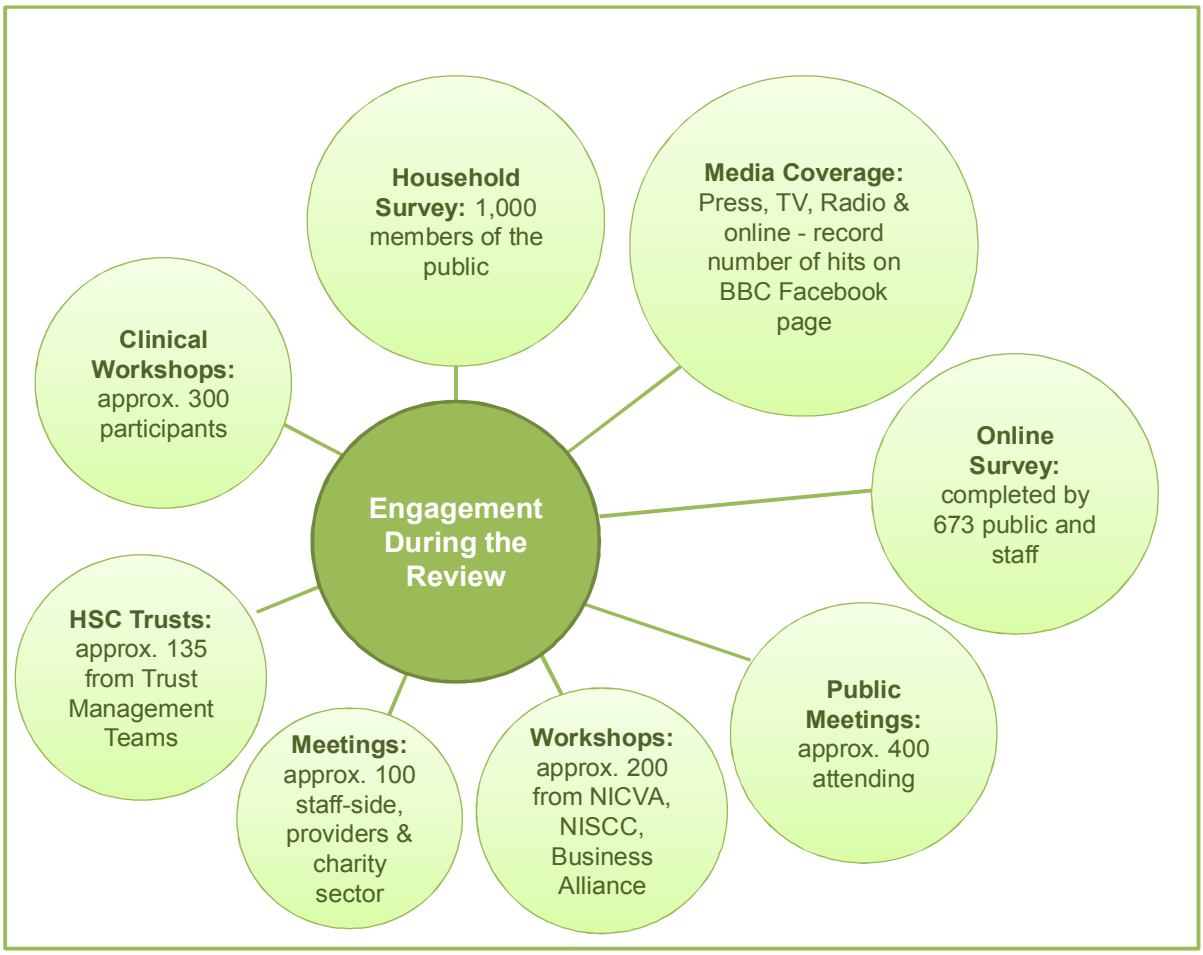
The engagement plan for the Review involved:

- An **online survey** completed by 673 individuals, of which 91% worked for an organisation providing health and social care (see Appendix 2 for a summary of results);
- Engagement with local **media** to promote press, television and radio features on the Review to raise public awareness of the issues involved and stimulate debate. The BBC e-panel received 641 views on aspects of the health and social care system;
- A **household survey** (completed by IpsosMORI) of 1,009 adults aged over 16, selected to be representative of the Northern Ireland population in terms of gender, age, social class and geography (see Appendix 3 for a summary of results);
- Six **public meetings** were held in Londonderry, Omagh, Ballymena, Belfast, Lisburn and Armagh. These were facilitated by the Patient and Client Council (PCC). (See Appendix 4 for details of the questions raised during the meetings);
- A series of **workshops with clinicians** from HSC Trusts, General Practitioners (GPs) and HSC managers to discuss current provision and future needs of specific service areas (see Appendix 5 for details of attendees and areas covered at each workshop);
- A series of **sector workshops**, with representatives from the voluntary and community sector (facilitated by the Northern Ireland Council for Voluntary Action), registered social care workforce (facilitated by the Northern Ireland Social Care Council), and private sector (facilitated by the Business Alliance) (see Appendix 6 for details of attendees);
- **Small group meetings** with a range of stakeholders including HSC arm's length bodies, trade unions (via the Partnership Forum), professional and regulatory bodies, voluntary and community sector organisations, political representatives, independent care providers, and colleagues within health and social care in other parts of the UK and the Republic of Ireland (see Appendix 7 for a full list of the stakeholders engaged with);
- Submission of **written responses** to the Review (see Appendix 8 for a list of written submissions); and
- Meetings with **HSC Trusts'** Senior Management Teams.

A Glossary is included in Appendix 9.

An overview of the stakeholders engaged with throughout the review is shown in the figure below.

Figure 6: Engagement during the Review



STRUCTURE OF REPORT

This report begins by outlining the reasons why our health and social care system needs to change, based upon the evidence that the Review has collected during the Review process. It then sets out the principles the Review considers should underpin this change.

A new model of care is described and contrasted with the existing model of care using case studies. The report details the impact of the new model across 10 areas of care.

- Population Health and Wellbeing
- Older People
- People with Long-Term Conditions
- People with a Physical Disability
- Maternity and Child Health
- Family and Child Care
- People using Mental Health Services
- People with a Learning Disability
- Acute Care
- Palliative and End of Life Care

It moves on to describe the implications for the health and social care system. This takes account of integrated working across health and social care, workforce issues and enhanced use of technology. Finally, an implementation roadmap outlines how this change will be implemented and delivered over a five year period.

THE CASE FOR CHANGE

4. THE CASE FOR CHANGE

Making the case for change is at the centre of this Review. It is not a critique of the current provision but rather a fundamental recognition that the existing model of care is not fit for purpose as one looks to the future.

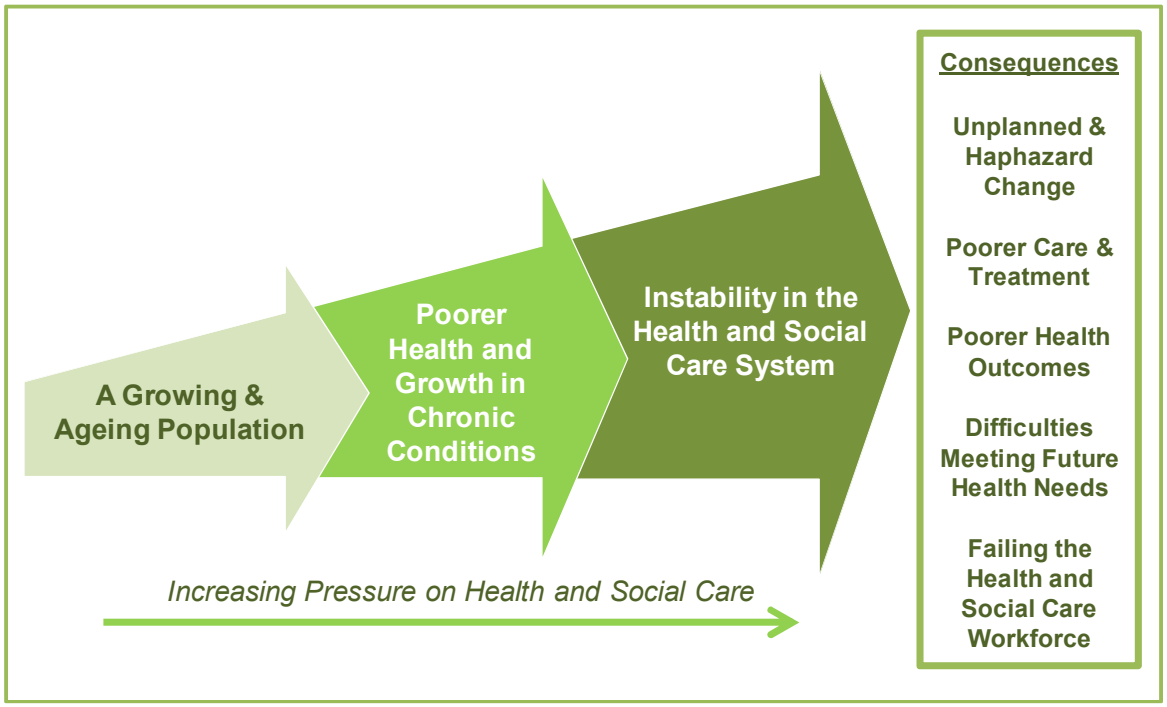
The figure below illustrates the pressures currently facing the system and the potential consequences of doing nothing.

There are no neutral decisions in this regard. If we do nothing, the system will not be able, in its current form, to continue to deliver a high quality service that will meet the needs of the population.

Figure 7: Pressure facing the system

The fundamental changes to our population in terms of age and need are clear. We must design a model which acknowledges this and is based on the needs of this changing population rather than its historic configuration. If we do not plan to change the system we will continue to be faced with unplanned changes that will not be in the best interest of the patient. This will result in a prioritisation of who gets care and a reduction in access to many important services for a large proportion of our population.

We have a highly skilled and dedicated workforce who are being failed by a system which is no longer fit for purpose. This has resulted in staff working within a system which does not deliver the quality



of service to which they strive.

The Review also acknowledges that throughout this process everyone spoken to has asked the Review to promote the **'making it better'** principle and has affirmed that it **can be better**.

WHY DO WE NEED CHANGE?

Despite the many positive aspects of the current model of health and social care, compelling factors reflect the need for change:

- a growing and ageing population;
- increased prevalence of long term conditions;
- increased demand and over reliance on hospital beds;
- clinical workforce supply difficulties which have put pressure on service resilience; and
- the need for greater productivity and value for money.

Against this backdrop, the Review identified 11 keys reasons supporting change. In a new model, how these are responded to will be key to shaping the decisions for the future configuration of specific services.

Reason 1 – The need to be better at preventing ill health

Reason 2 - The importance of patient centred care

Reason 3 – Increasing demand in all programmes of care

Reason 4 – Current inequalities in the health of the population

Reason 5 – Giving our children the best start in life

Reason 6 – Sustainability and quality of hospital services

Reason 7 – The need to deliver a high quality service based on evidence

Reason 8 – The need to meet the expectations of the people of NI

Reason 9 – Making best use of resources available

Reason 10 – Maximising the potential of technology

Reason 11 – Supporting our workforce

Reason 1 – The need to be better at preventing ill health

The population of Northern Ireland can become a healthier society through prevention of ill health and the promotion of health and wellbeing. People wish to be responsible in taking decisions to support better personal health. In this regard it is important to communicate evidence to enable people to choose a lifestyle where healthier outcomes can happen.

Smoking - In Northern Ireland around 340,000 people aged 16 and over smoke. Smoking contributes to not only many cancers, heart disease, bronchitis and asthma, but other illnesses including stroke, which causes around 2,400 deaths per year. These deaths are avoidable. Around 86% of lung cancer deaths in the UK are caused by tobacco smoking and, in addition, the International Agency for Research on Cancer states that tobacco smoking can also cause cancers of the following sites: upper aero-digestive tract (oral cavity, nasal cavity, nasal sinuses, pharynx, larynx and oesophagus), pancreas, stomach, liver, bladder, kidney, cervix, bowel, ovary (mucinous) and myeloid leukaemia. Overall tobacco smoking is estimated to be responsible for more than a quarter of cancer deaths in the UK, that is around 43,000 deaths in 2007.[1] Half of all smokers eventually die from cancer, or other smoking-related illnesses.[2] A quarter of smokers die in middle age, between 35 and 69.

Obesity – in the most recent survey of Northern Ireland's health and wellbeing, 59% of all adults measured were either overweight (35%) or obese (24%)[3]. The impact of this increase has resulted in complications in pregnancy, increase in type 2 diabetes, coronary heart disease, stroke and a number of cancers. It is also known that obese children are more likely to become obese adults. We face a significant challenge in halting the rise in the proportion of the population who are overweight or obese.

Alcohol and drug misuse cost our society hundreds of millions of pounds every year. However, this financial burden can never truly describe the full impact that substance misuse has on many vulnerable individuals including children and young people, families, and communities in Northern Ireland.

Not to act on these facts will condemn the population and the system to failure.

Reason 2 – The importance of patient centred care

Evidence suggests that people are best cared for as close to home as possible. It is also what people have told us through the Omnibus survey - 81% of people

[1] Cancer Research UK

[2] Mortality in relation to smoking: 50 years' observations on male British doctors, Doll et al, 2004

[3] NI Health and Social Wellbeing Survey 2005/06, DHSSPS

surveyed said that more health and social care services should be delivered in GP surgeries, local centres and in people's homes.

Inpatient hospital care will always be an important part of how care is provided, but it is only best for a patient with acute medical needs. There are many benefits associated with delivering care within people's homes and in their local communities. Providing patient choice about where they are cared for is critical. Integrated teams working together in the community provide this opportunity and would deliver better quality.

A central theme of 'Quality 2020 - a 10 year Strategy to protect and improve Quality in Health and Social Care in NI[4]' is to ensure the patient and client receives the right care, at the right time in the right place, with the best outcome. The 'High Quality Care for all NHS: Next Stage Review Final Report' also identified the need to bring care closer to home, to ultimately deliver better care for patients. This was also a central focus of the 2006 White Paper 'Our health, our care, our say', and it has become clear that a health and care economy-wide approach is needed for an effective and sustainable model of care that is more convenient for patients.

A bed utilisation audit of 2011 showed that, on the day in question, up to 42% of the inpatients reviewed should not have been in hospital.[5] Furthermore in 2009/10, 28% of the deaths of people admitted from a nursing home, occurred within 2 days of admission into hospital[6].

The care closer to home approach is not about challenging hospital provision, but about defining the role of hospitals in meeting the needs of the population. The real prize is to provide community alternatives which improve patient/ client care and experience. The evidence again points to a need for change.

Reason 3 – Increasing Demand

The evidence of increasing demand is compelling whether from a population or disease perspective.

<u>Demography</u>

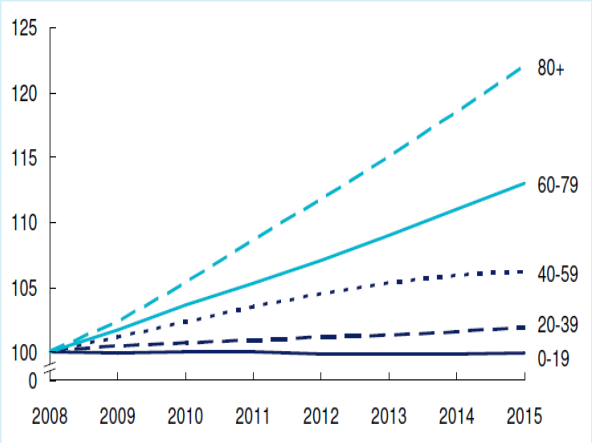
Northern Ireland has a population of approximately 1.8m people. It has the fastest growing population in the UK and it continues to grow. The number of people over 75 years will increase by 40% by 2020. The population of over 85 year olds in NI will increase by 19.6% by 2014, and by 58% by 2020 over the 2009 figure (see the figure below).

[4] Quality 2020, A 10-year Strategy to Protect and Improve Quality in Health and Social Care in NI, DHSSPS

[5] Bed Utilisation Audit of 8 acute hospitals in NI, April – September 2011

[6] HIB, DHSSPS, 2011

Figure 8: Northern Ireland Population Projections



Source: NI Neighbourhood Information Service

Longer life expectancy is something to celebrate. Many older people enjoy good health and continue to make a significant contribution to society as carers, learners, workers and volunteers. In particular, older people are identified as important social resources in rural areas, providing informal care and supporting the cultural and social lives of their communities.[7] The health and social care system has a role in enabling older people to live as full and healthy a life as possible and caring for the most vulnerable when needs change.

There is however, a high level of dependence on institutional and hospital care for older people, and inconsistencies in the quality and range of services provided across Northern Ireland. Services are not currently meeting expectations and, since they account for a large proportion of health and social care expenditure, defining a new model to successfully meet the needs of older people is an overwhelming priority. Older people have said they want care, support and treatment in or close to home. Services must therefore continue to reform and modernise to respond to growing demand with an increased emphasis on personal, community based services.

Disease Prevalence

There are increasing numbers of people with chronic conditions such as hypertension, diabetes, obesity and asthma. The disease prevalence levels reported via the Quality Outcomes Framework (QOF) are summarised below[8].

- QOF reported prevalence for hypertension has increased year on year across all UK regions, with the rates reported in NI lowest of the 4 UK countries at 12.54%, showing an absence of managing this condition.
- Diabetes is an increasingly common condition. Prevalence in the UK is rising. NI prevalence is 4%.

[7] Commission for Rural Communities (2008) The Personalisation of Social Care

[8] Source: PHA Health Intelligence Briefing on QOF 2009/10).

- QOF reported prevalence of Atrial Fibrillation is increasing year on year across the whole of the UK. In NI, rates have increased from 1.25% in 2006/07 to 1.33% in 2009/10, equating to an additional 1,500 patients with AF.
- Stroke/ Transient Ischaemic Attack (TIA) reported prevalence has increased yearly across the UK. In NI prevalence has increased from 1.37% in 2004/05 to 1.71% in 2009/10, representing over 6,400 additional patients.
- NI has the lowest QOF reported prevalence of asthma at 5.86 per 1,000 patients compared to the rest of the UK. Notwithstanding this prevalence has increased in the last 5 years.
- QOF reported prevalence of Chronic Obstructive Pulmonary Disease has risen steadily since records began in 2004. The prevalence in NI was 1.63% for 2009/10.

All of this describes the unremitting increase in chronic conditions in NI. Individuals with long-term conditions very often have multiple conditions – around a quarter of those in the UK with a long-term condition have three or more conditions[9]. Our system often does not deal with multiple conditions in an integrated way, which for the individual can mean having to engage with multiple clinicians and services which are not well joined up. The consequent personal experience is often very frustrating.

Keeping Pace with Developments

Best practice in health and social care provision is developing all the time. There are new technologies, new care pathways, new partnerships, new drugs and new levels of regulation. Our population will expect access to these improvements. The need to understand demand patterns and work with providers in primary, community and secondary care to ensure more effective management of demand will be a central issue in the future.

It is estimated that the demand for services could grow by around 4% per year by 2015[10]. Examples of the potential consequences without change are listed below:[11]

- 23,000 extra hospital admissions;
- 48,000 extra outpatient appointments;
- 8,000 extra nursing home weeks; and
- 40,000 extra 999 ambulance responses.

If we were to continue to deliver services in the way that we do today, we would

[9] NHS Scotland (2005) National Framework for Service Change. Long Term Conditions Action Team Report.

[10] Reshaping the System (2010) McKinsey

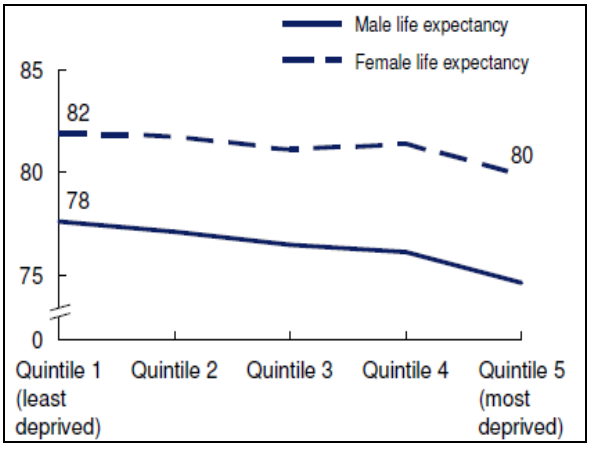
[11] NI Confederation for Health and Social Care: Areas for Action for Health and Social Care in Northern Ireland 2011-2015

quite simply fail the popula#tion as the system struggled to cope. The quality of outcome for the individual and their family would inevitably decline.

Reason 4 – Current inequalities in the health of the population

In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women. However, against this positive overall trend, inequalities are evident when mortality rates are compared across geographical areas. People who live in the 20% most deprived areas are 40% more likely to die before 75 than the NI average. Life expectancy against deprivation level is shown in the figure below.

Figure 9: Life Expectancy and Deprivation in Northern Ireland



Source – NISRA: Independent Review of Health and Social Services Care in Northern Ireland

For example, along the bus route from Donegall Square to Finaghy Road South, there is an increase in life expectancy of 9 years, as shown in the figure overleaf. Similar patterns exist in rural areas.

Across NI there is also variability in the health of the public. Belfast had the highest rate of births to mothers aged 19 or under in 2004 (25.9 per 1000) compared to other Local Government Districts in Northern Ireland. Indeed there is considerable variation even within the Greater Belfast area. In 2009, of the 349 births to teenage mothers in Belfast Trust 37% were in west Belfast, 28% in north Belfast, 15% in east Belfast, 11% in south Belfast and 8% in Castlereagh.

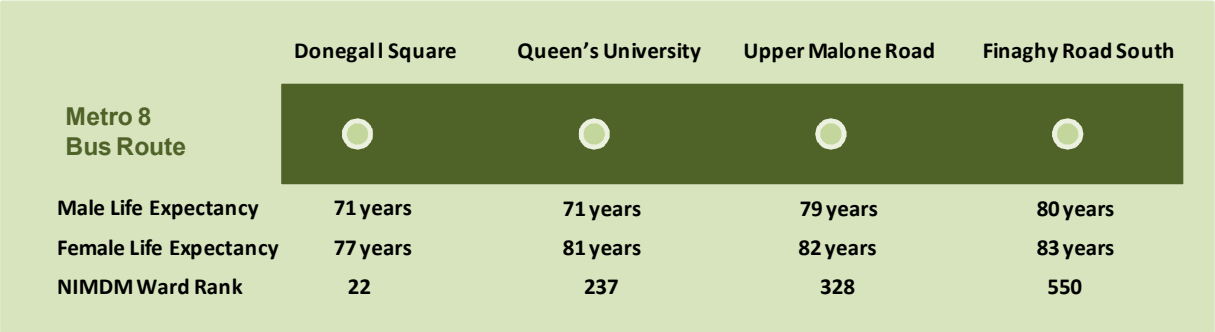
The most deprived group of the population has an admission rate to Neonatal Intensive Care of 19% above the regional average for Northern Ireland.

Some of the most common characteristics associated with being born into poverty rather than more affluent circumstances are highlighted below:[12]

- lower life expectancy;
- 23% higher rates of emergency admission to hospital;
- 66% higher rates of respiratory mortality;
- 65% higher rates of lung cancer;
- 73% higher rates of suicide;

[12] NISRA Inequalities Monitoring Report 2010

Figure 10: Life Expectancy, Donegall Square to Finaghy Road South



- self harm admissions at twice the Northern Ireland average;
- 50% higher rates of smoking related deaths; and
- 120% higher rates of alcohol related deaths.

Health and Social Care alone cannot fully address the inequalities issue. If we are to deliver effectively on improving the health of our population, we need meaningful partnerships and a common agenda to be developed with local government, housing, education, the environment, and our local communities. Making joined up government more tangible is essential. However, it is incumbent on health and social care to look to change and how it can contribute to better outcomes for the citizen.

Reason 5 – Giving our children the best start in life

The 2007 Unicef review of Children and Wellbeing ranked the UK 21 out of 21 developed countries.[13]

There is growing evidence that a child's early years of development have a significant impact on their health in later life.

The Californian Adverse Childhood Experience study (1998) linked childhood maltreatment and later-life health and well-being.[14] The consequences for society include: adult mental health

[13] UNICEF (2007) *Child Poverty in Perspective: An overview of child well-being in rich countries*, Innocenti Report Card 7, UNICEF Innocenti Research Centre, Florence.

[14] Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS, 1998. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med.;14(4):245-58

problems, poor physical health and high health expenditure.

Early Intervention: Good Parents, Great Kids, Better Citizens report argues 1 in 8 children are currently growing up in an environment of unacceptable risk.[15] Neglect and abuse in early years creates emotionally, mentally and physically damaged adults thus perpetuating problems into the next generation. An early intervention approach counteracts this outcome. The study identified the need to respond differently to the childhood years through structured early intervention.

The review of research found that targeted, intensive programmes such as the Family Nurse Partnership can help improve outcomes for vulnerable children and families, for example: reduced child abuse and neglect, reduced crime, reduced drug and alcohol abuse, and reduced school grade repetition.[16] These result in reduced victims' costs and increased earnings, highlighting a ratio of return of £3 for every £1 invested.

The Review noted that it has been acknowledged by several independent authors that the level of investment in Children and Families Services in NI is approximately 30% less than in other parts of the United Kingdom. It had been predicted that the number of births in Northern Ireland was to decline but in fact birth rates have remained broadly static. This overall position has led to an increased demand, particularly for family support services.

Given this evidence, failure to do better will prevent any opportunities to break the cycle of poor life outcomes for many in our society.

Reason 6 – Sustainability and quality of hospital services

Given the increasing and changing nature of the population, changing practices in medicine and increased expectations of the public, the gap between demand for services and current provision is widening. If we were to continue to provide services as they currently are, it would lead to unplanned and unmanaged collapse of key services. This would ultimately lead to detrimental impact on patients and clients. The choice is stark: it is not principally about money but about sustainability and clinical evidence. The conclusion is clear: plan and manage the transition or accept a more haphazard set of changes. In this regard there are no neutral decisions.

Historically, in Northern Ireland, there has been an over-reliance on hospital services. Given its rurality and based on recognised norms, a population the size of NI is likely to have between 5 and 7 major acute hospital networks, each

[15] Good Parents, Great Kids, Better Citizens. Graham Allen MP and Rt Hon Iain Duncan Smith MP, Centre for Social Justice and Smith Institute 2008

[16] The Family Nurse Partnership Programme, Department of Health, http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128402.pdf

serving a population of some 250,000 to 350,000. Currently we have 10 hospitals for a population of 1.8million, in other words one per 180,000. The rurality of Northern Ireland has historically influenced the number of hospitals provided, and this must also be taken into consideration when developing a new model of care. There is however evidence to show that whilst important in a Northern Ireland context that travel per se does not create worse outcomes. For example the Rural Trauma Outcome Study in Scotland[17] showed that longer pre-hospital travel times did not increase mortality or length of stay.

The Royal College of Surgeons has stated that in a fragmented emergency surgical set-up a patient is four times more likely to have a poorer outcome than in a more organised model. It goes on to say that where the model is not organised, patients have prolonged hospital stays with significant cost implications, both physical and emotional to the patient and their family[18].

Trying to maintain acute services across the current number of sites has proved increasingly difficult. Scarce staffing and other resources are spread too thinly, making it impossible to ensure that permanent senior medical cover for emergencies is available at all sites, on a 24/7/365 basis (24 hours a day, seven days per week and 365 days per year). Currently, many sites rely on a combination of junior doctors and temporary locums to provide much of the cover required, particularly out of hours. This inevitably impacts on quality and cost. It also creates service fragility.

The Chairman of the British Medical Association's Council in Northern Ireland stated that "the present situation is untenable: we cannot maintain top flight A&Es in every town. Reconfiguration... is currently happening by crisis rather than by taking difficult decisions". He goes on to cite recent changes at the Mid-Ulster, Whiteabbey and Belfast City Hospital as examples of how reconfiguration is currently occurring by crisis rather than in a structured and planned approach.[19]

More people are admitted to our hospitals than in other areas of the UK and lengths of stay are significantly longer.

In simple terms, we know it is possible and better to provide services closer to home but we have continued to use hospitals. This is an unsustainable model which will deliver poorer outcomes for the patient in the future.

Reason 7 – The need to deliver a high quality service based on evidence

The responsibility of the HSC is to deliver a high quality, safe and accessible service

[17] Scottish Urban v Rural Trauma Outcome Study, J Trauma September 2005

[18] The Higher Risk General Surgical Patient: Towards Improved Care for a Forgotten Group, Royal College of Surgeons of England and Department of Health

[19] News Letter, November 7 2011

to the population of Northern Ireland, with good outcomes. Currently there are indications that there is room for improvement in how things are done.

There are increasing numbers of people with chronic conditions such as hypertension, diabetes, obesity and asthma. Yet evidence suggests lower than appropriate access to general practice is achieved.

Although improving, daycase rates are lower when compared to England at 64.7% compared to the England average of 75.5%.

The number of registered suicides rose from 146 in 2005 to 313 in 2010. The rates per 100,000 of the population vary greatly across the region with a rate of 24.9 in the most deprived area compared to 7.6 in the least deprived area.

Treatment for cancer has been revolutionised over the past decade with survival rates improving across a range of cancers, but we still fall behind European survival rates in a number of cancers, so further work needs to be done. A study[20] funded by Cancer Research UK and the Department of Health, England was carried out by researchers from a number of institutions in Australia, Canada, Denmark, Norway and the UK that were the focus of the study. Survival rates were found to be "persistently lower" in Denmark, England, Northern Ireland and Wales.

In obstetric services, 55.6% of deliveries are normal, compared with 61.2% in England and 61% in ROI. Our caesarean section rate is high at 30.2% compared to 24.1% in England and 25% in ROI.

Investment in Mental Health, Learning Disability and Children and Family Services in NI is up to 30% less than in other parts of the UK because our model over consumes resource in hospital provision.

At March 2010 there were 2,606 looked after children in Northern Ireland, up by 6% (143) from 2009 (2,463). 11% (about 270) of these children were in residential care, where the outcomes are likely to be very poor, and 65% were foster care placements.[21] The recruitment of foster carers to meet rising demand continues to be a challenge to ensure choice and the matching of carer skill to the needs of the child.

Every year in Northern Ireland around 3,000 people suffer a stroke. Stroke is the third biggest killer and the leading cause of severe disability in Northern Ireland. Up to 40 per cent of strokes are preventable.[22]

The Royal College of Physicians, National Sentinel Audit 2010, found NI had a higher length of stay of 21.3 days (to

[20] The study was published in the peer-reviewed medical journal The Lancet.

[21] Children Order Statistical Tables for NI 2009/10

[22] National Stroke Association 2005

discharge or death) compared to the National average of 19.5 days.[23]

Looking at general Surgery, the chance of a patient dying in a UK hospital is 10% higher if he or she is admitted at the weekend rather than during the week, where the service is not well organised. Provision of services, particularly of theatre access, critical care and interventional radiology, is often incomplete, and the correct location of patients after surgery is often not given sufficient priority. Furthermore, the clinical response for patients who deteriorate is often poorly thought through and, at times, ad hoc[24].

Dr Foster, a UK provider of comparative health and social care information, also reported that it found a worrying 10% spike in deaths at weekends compared with weekdays across 147 hospital trusts.[25] Too often our services do not respond to 7 day a week working.

PCI (Percutaneous Coronary Intervention) is a treatment to reduce or eliminate the symptoms of coronary artery disease including angina, dyspnea and congestive heart failure. A pilot carried out by the Belfast HSC Trust (Feb10 – Mar11) showed low mortality rates associated with PCI that were largely predictable and could be improved if PCI was better organised.

While significant improvements have been secured, NI continues to spend significantly more per head on prescription medicines than the rest of the UK at £232 per head of population, compared to Wales £194, Scotland £187 and England £165 (2009/10).

All this has informed the Review that the current model does not provide as high quality care as it could.

Reason 8 – The need to meet the expectations of the people of NI

Whilst the Review acknowledges it is difficult methodologically to get a full consensus on a population view, there are however factors which need taken into account.

A structured Omnibus survey to inform the Review was conducted in October 2011 in which 1009 people were surveyed from across Northern Ireland. This was supplemented by the online public survey. The online survey was completed by 673 persons, 91% of whom work for an organisation providing HSC services.

The high level results of the surveys are highlighted within this section with more detail throughout the body of this report and within Appendices 2 and 3.

---

[23] RCP National Sentinel Clinical Audit of Stroke 2010

[24] Aylin P, Yunus A, Bottle A *et al*. Weekend mortality for emergency admissions. A large,multicentre study. Qual Saf Health Care 2010; 19: 213–217

[25] Dr Foster – Hospital patients 'more likely to die at weekends', November 2011

There were positive comments about the existing service, 22.6% of the people interviewed in the omnibus survey stated that they were very satisfied with health and social care provision in NI and 54.8% were fairly satisfied.

However, the Omnibus survey results went on to highlight dissatisfaction with:

- accessibility of services;
- the quality of services to older people; and
- the quality of services for people with mental health problems and learning disabilities.

A need for improvement was identified across each of these areas.

Access

- In regard to GP services: 65% felt that improvement is required including 23% who stated that a lot of improvement is required (22% in the online survey).
- Looking at assessment for home nursing or residential care: 79% felt that some improvement is required (including 21% who felt that a lot of improvement is required). This was supported by the online survey findings where 86% felt improvement is required (including 26% who felt that a lot of improvement was required).
- Appointment with a hospital consultant: 82% (and 91% in the online survey) felt some improvement is required, including 36% (30% in the online survey) who felt that a lot of improvement was required.
- Non emergency operations: 88% (91% in the online survey) felt some improvement was required including 36% (and 34% online) who felt that a lot of improvement is required.
- Time waiting in Accident and Emergency (A&E): 91% (96% online) felt improvement was needed, including 56% (and 47% online) who felt a lot of improvement was required.
- Access to Mental Health Services: 93% of people (online survey) stated that improvement was required to the availability of mental health services (43% stated that a lot of improvement was required).

Quality of Care for Specific Groups

- Older People: 89% (98% online) felt that improvement is required in the quality of care for older people, including 35% (35% online) who felt a lot of improvement is required.
- People with a Mental Health problem: 93% (88% online) felt improvement is required including 43% (28% online) who felt that a lot of improvement is required.
- People with learning disability: 70% (91% online) felt that improvement is required, including 30% (32% online) who felt a lot of improvement is required.

The online survey also highlighted the following:

- Quality of hospital services: this was not highlighted as an issue within the omnibus survey, but the online survey results showed that 92% felt there was some improvement required, with 18% feeling a lot of improvement is required; and
- Support for Carers: 97% of the online survey stated that improvement is required, including 45% who felt a lot of improvement is needed.

Further reinforcement of these results is expressed in the Patient and Client Council Priorities for HSC in Northern Ireland, November 2011. Some of the key priorities identified were:

- hospital care;
- care of the elderly (including domiciliary and community care);
- waiting times;
- cancer services;
- mental health and learning disability;
- health and social care staffing levels;
- access to GPs and primary care;
- children's services;
- reducing the costs of administration and management; and
- quality of care.

This evidence indicates strongly that the current system of health and social care is not meeting citizens' expectations.

Reason 9 – Making best use of resources available

This review is not about money per se and any discussion on resources produces strong views. It is, however, entirely valid to look at how we could use resources and the consequent productivity. In that regard it is difficult not to conclude that, with the overall level of resources available, we have the ability to provide a better service. The budget cycle has indicated annual expenditure of £4.65billion by the end of this Assembly period (2014/5). The Review was not asked to reduce this figure but knows that with annual pressure of 4% from residual demand and changing population,[26] change is non-negotiable. The challenge presented to the Review is simply how best to spend the resource to achieve maximum benefits.

Best Use of Estate: we currently have 10 acute hospitals, 5 local hospitals and 30 community hospital facilities, with 4,361 beds in acute and local hospitals, and 1,924 community beds. In addition there are 60 statutory residential and nursing homes for older people, 39 residential homes for children, as well as a range of daycare centres and health centres. There is an over reliance on buildings to

[26] Reshaping the System (2010) McKinsey

provide care rather than support its delivery.

Any future models of care will have to take into consideration the best use of the estate that is currently available. It will not however concentrate on the preservation of the existing building stock but rather present a new service model which delivers care on a 24/7/365 basis.

Best Use of Staff: the HSC currently employs 78,000 people either full-time or part-time, which equates to 53,209[27] whole time equivalents across all specialties comprising:

- 33% nursing staff;
- 7% medical and dental;
- 12% social services;
- 5% Allied Health Professionals;
- 4% home helps;
- 2% ambulance services staff;
- 7% other professional and technical staff; and
- 26% admin and clerical staff (including medical secretaries ward clerks); and
- 4% managers (being Band 7 or above).

Our staff mix is primarily structured to support the existing care model which is institutionally based. For example, Northern Ireland has a higher proportion of qualified nursing staff (across all settings) compared with England, at 77% compared with 73%. Nursing care has 3.5 times the activity per weighted population than England and Wales. The driver appears to be elderly patients, with NI having 3 per 1000 weighted population compared to 0.16 per 1000 population in England.[28]

Appleby[29] stated that indicative data suggests Northern Ireland produces between 17% and 30% less inpatient, outpatient, day case and A&E activity per head of hospital and community staff than England and that hospital activity per member of staff is 19% lower than the UK average. These efficiency figures are very closely aligned to our current hospital model.

Best Use of Money: In the US, currently the care costs for 5% of the population account for 50% of health care spending.[30] This fact can be applied to any western health economy including Northern Ireland. Addressing the reason for this will require changes to be made which ensure resources are focused in the right areas.

If we were to continue providing health and social care in the same way as we do today, some suggest we would need £5.4

[27] DHSSPS NI Health & Social Care Census, March 2011

[28] Reshaping the System, McKinsey 2010
[29] Independent Review of HSC Services in Northern Ireland, 2005
[30] Research in Action, Issue 19, 2006

billion of funding by 2014/15 to cope with this combination of growing demand for care and inflating costs. Given that this is unrealistic, from both an economic and delivery perspective, we need to reshape services. Adopting a new model which is efficient, patient centred and providing high quality evidence based services, would enable a legitimate debate in the future on how much funding health and social care should receive, compared with other public services.

Much of the significant management, administrative and overhead efficiency savings potential in health and social care has already been captured through the Review of Public Administration (RPA), and the potential for further savings is limited. Instead, fundamental change is required in how we deliver care in the future.

Reason 10 – Maximising the Potential of Technology

Technological change is both a driver and enabler for the future. The pace of change is incredible and our current model does not promote its absorption or benefit as it should. For example, NI has now one of the most sophisticated radiological systems anywhere but we need new ways of working to maximise the potential of this technology. The technology that enables 24/7 intervention in the care of strokes and coronary conditions can revolutionise the outcome for patients but to deliver it our current service pattern must change.

There is overwhelming evidence that organising emergency care separate from elective care makes better use of the infrastructure in hospitals. Information is key. As a system we have a huge amount of data but poor data analysis, preventing professionals from having the evidence that is central to their work. For example, information from patient records could be used more effectively to monitor our local health needs and to assess what treatments are working well. Data needs to be used in a more effective way to ensure it is translated into information that we can use to plan our services.

Communication with the public is not as modern as it should be, for example in arranging appointments, in explaining how to use the service and giving timely information. This leads at times to disorganisation in our response to the individual and inefficiency.

The technological infrastructure in NI is good and it can promote more care closer to home but our service has not yet fully embraced the opportunity that exists. Connected health projects exist but have emerged in an ad hoc manner. If the service is to derive maximum benefit in this regard, development of connected health needs to be more coherent. Changes therefore will need to build upon the existing Memorandum of Understanding between Invest NI and DHSSPS in relation to connected health. A clear commitment to maximising the technological potential to service provision will be essential.

Reason 11 – Supporting Our Workforce

Problems being experienced by staff trying to deliver services within the HSC were highlighted in the HSC Staff Survey carried out in 2009. Over 2 in 5 staff (43%) felt that they cannot meet all the conflicting demands on their time at work, and only 34% agreed that there are enough staff at their organisation to do their job properly. The most common reason stated for staff having been injured or feeling unwell in the last 12 months was work-related stress (31%). When the Review team met with staff to discuss the future there was not a single voice which argued for the preservation of the existing model of service.

The Review acknowledged the willingness of staff to make change and heard clearly that they wanted to be closely involved in how change should happen.

CONCLUSION

It is clear that we need to act now both to improve our system's quality and productivity, and to better manage the demand on our services. Fundamental change is required in how we deliver care in the future. There are no neutral decisions: every decision will have consequences and opportunity costs for patients and clients. More simply put, we need a new model of care.

We are not different. Whilst there are unique factors at play in Northern Ireland impacting on the demand for services, a number of the issues with the HSC in NI are common in other areas of the UK.

Healthcare for London, A Framework for Action was a review into the healthcare delivered to the population of London, led by Prof. Lord Ara Darzi. This review set out similar issues in terms of the need to focus on improving the quality of services delivered, meeting the expectations of the public, addressing the inequalities in the system, delivering the right care in the right place at the right time, issues with the configuration of specialist services and making better use of resources available, both in terms of the workforce, the infrastructure and taxpayers' money.

The Scottish Government's Shifting the Balance of Care framework set out a programme of changes across health and care systems intended to: bring about better health outcomes for people; provide services which reduce health inequalities; promote independence; and provide

services that are quicker, more personal and closer to home.

NHS Wales also recently published a report setting out its 5 year vision for the NHS in Wales, Together for Health. This review identified largely common issues, including challenges with a rising elderly population, enduring inequalities in health, increasing numbers of patients with chronic conditions, rising obesity rates and a challenging financial climate.

Consequently NI cannot insulate itself from the need for change.

The Review presents an opportunity to consider a more integrated model for the HSC system that allows us to deliver an excellent health and social care service to the population of Northern Ireland.

THE PRINCIPLES FOR CHANGE

5. THE PRINCIPLES FOR CHANGE

The Review team has concluded that the Case for Change is unassailable. It highlights the pressures currently faced by our health and social care system and the demands that will be placed upon it in the future. If we continue to deliver services as we currently do, they will not meet the needs of our population and will not be sustainable for the years to come. Therefore, changes are needed to meet future health and social care needs.

In looking to recommend a new model, the Review has engaged widely with the public, clinicians, providers and interest groups, and reviewed research evidence to inform the changes that are required. It started with the 'user first' principle rather than considering the structures in our health and social care system. The aim throughout has been to consider what changes would make the greatest difference to outcomes for patients, users and carers.

The Review has developed a set of principles that will underpin the shape of the future model for health and social care. Later, in the document, when the implementation pathway is described, these principles will be important determinants in the change process. They build upon the three core objectives upon which the National Health Service (NHS) was founded:

- to meet the needs of everyone;
- to be free at the point of delivery; and
- to be based on clinical need, not ability to pay.

The Minister, in his statement on 27th September 2011, said that he believed the Assembly was fully committed to those principles, but had to recognise the fact that the rising level of need in health and social care services, the need to focus on outcomes and the constrained financial context made it increasingly difficult to hold onto those principles. The ability to continue to deliver these principles is only possible through the support of a radical programme of service change and reconfiguration.

The Review has concluded that there are twelve major principles that should guide changes to health and social care.

KEY PRINCIPLES

1. Placing the individual at the centre of any model by promoting a better outcome for the user, carer and their family.
2. Using outcomes and quality evidence to shape services.
3. Providing the right care in the right place at the right time.
4. Population-based planning of services.

5. A focus on prevention and tackling inequalities.
6. Integrated care – working together.
7. Promoting independence and personalisation of care.
8. Safeguarding the most vulnerable.
9. Ensuring sustainability of service provision.
10. Realising value for money.
11. Maximising the use of technology.
12. Incentivising innovation at a local level.

WHAT DO THE PRINCIPLES MEAN?

1. Placing the Individual at the Centre of any Model

The individual must be at the centre of the health and social care system. The model must be built around what will produce the best outcomes for individual users, carers and families. Clarity about communicating this principle is essential.

2. Using Outcomes and Quality Evidence to Shape Services

All services should demonstrate that they are able to meet well understood measures of quality. This must include taking account of an evidence base of existing and emerging research on what produces the best outcome, both within Northern Ireland and beyond.

In NI, Service Frameworks[31] have been developed for 4 service areas, and a further 3 are under development. The Frameworks promote and secure better integration of service delivery along the whole pathway of care from prevention, diagnosis, treatment and rehabilitation, and on to end of life care. These include:

- cardiovascular services;
- respiratory services;
- cancer prevention, treatment and care;
- mental health;
- learning disability (under development);
- older people's health and wellbeing (under development); and
- children and young people's health and wellbeing (under development).

This is the best way to ensure that our limited human, financial and physical resources are used in the most effective way to produce the best possible patient and client outcomes.

[31] Service Frameworks, DHSSPS

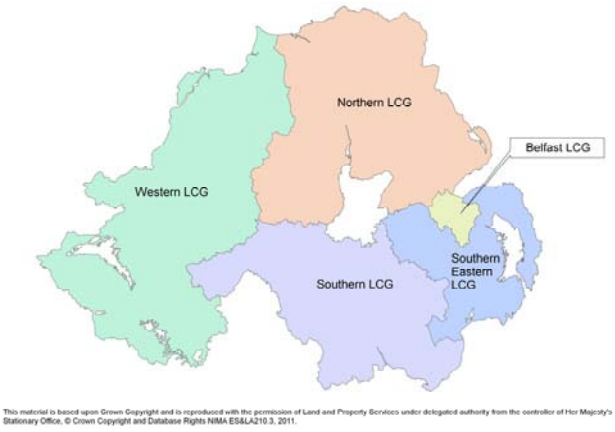
3. The Right Care in the Right Place at the Right Time

Care should be provided at home or as close to home as possible. Many of the services currently provided in an acute hospital or institutional setting should be provided in the community or in people's homes, making them more accessible. Where it is not safe and effective to provide services locally they should be provided more centrally or regionally. More simply put, the health and social care system should provide local services for local people, but safe, sustainable and accessible services for populations.

4. Population-Based Planning of Services

Services should be planned on the basis of the needs of a defined population or 'health and social care economy'. The Review team recognises population boundaries can be artificial but the starting point is to use the existing local health and social care economy populations, which are synonymous with the current Local Commissioning Areas (as in the figure below).

Figure 11: Local Commissioning Areas



When necessary this should incorporate joint planning between these populations to deliver local or more central services. For some services this would require planning to take account of a NI wide perspective. However, with a population of 1.8million it is simply not feasible to provide every health and social care service that may be required, e.g. in these cases planning should be done jointly with other UK countries or the Republic of Ireland. The levels of planning are illustrated in the figure below.

Figure 12: Levels of Planning

5. A focus on Prevention and Tackling Inequalities

Prevention is always better than cure whether primary, that is avoiding the problem occurring, or secondary, that is arresting the problem. Such measures should be embedded into every service area. Services should support people to take good decisions about their health and wellbeing, with a particular focus on the needs of those groups that typically have poorest health outcomes. The factors impacting on health and wellbeing are diverse but well known and this will require partnership working across government and between the public and voluntary, community and independent sectors. Health economies will need to pay particular attention to achieving these outcomes demonstrating how in practice this approach expresses itself to the individual.

6. Integrated Care – Working Together

Services provided by different parts of the health and social care system should be better integrated to improve the quality of experience for patients and clients, safety and outcomes. This starts with making it simpler to use the system. It will require clinicians to organise care around the individual, with better communication and networking across primary, secondary and tertiary care, that is doctors talking to doctors, and professionals jointly reaching decisions about patients' and clients' care in partnership with them. Closer working together will be mandatory, illustrated by demonstration of full support of the various constituent parts of the service as to how services are organised. Underpinning this will be the requirement for improved technology and information sharing.

7. Promoting Independence and Personalisation of Care

Greater control by those in receipt of the service is a necessity. Flowing from this, as much diversity as practical should be available. To deliver this there should be a mixed economy of providers. In the majority of instances, this will be provided by statutory services but joint working with the independent sector will be expected. Services should aim to meet the needs of individuals, with care personalised in terms of their specific requirements. Patients, service users and their carers should be helped to take the important decisions about their own care, and importantly, enabled and empowered to take ownership of their own health. The vital contribution carers make to support the health and social care system should be recognised and carers' needs should be fully assessed and supported in this process.

8. Safeguarding the Most Vulnerable

Throughout the health and social care system, appropriate safeguards should be in place to protect the most vulnerable in society.

9. Ensuring Sustainability

Providing services requires significant attention to be spent in ensuring workforce sustainability. More simply put it means service models need to be robust. In this regard endorsement of regulatory and training bodies such as NIMDTA is essential. While locum and agency staff may be used to support a service where necessary and appropriate, they should not be inextricably linked to a service's ability to remain. Services organised this way are quite simply not sustainable.

10. Realising Value for Money

Any service models taken forward as a result of this Review must take cognisance of financial resources available to the HSC and secure value for money. Therefore there is a need for financial realism.

11. Maximising the Use of Technology

Changes should be supported by up to date technology to ensure vital information can be shared quickly among professional staff, duplication eliminated and that the latest diagnostic and treatment tools are available.

Changes should take account and build upon the Memorandum of Understanding between the DHSSPS and Invest NI on "Connected Health and Prosperity".

12. Incentivising Innovation at a Local Level

Making changes on the scale indicated in the following model will require devolved decision making and an incentive culture within health and social care, its workforce and the population. This is a direct response to the question 'why would I do it?'. Changes will need to show how they make things better, starting first with their positive impact on those using the service. The incentives of more local control in decision making, better training and development for the workforce and innovative ways of using resources will all be integral to the change process.

In this regard partnership working will be central, whether between populations in NI or with jurisdictions outwith NI. It will also be essential to explore in this context working with others, for example, the voluntary and independent sectors and the pharmacy industry to fully deliver the new model of care.

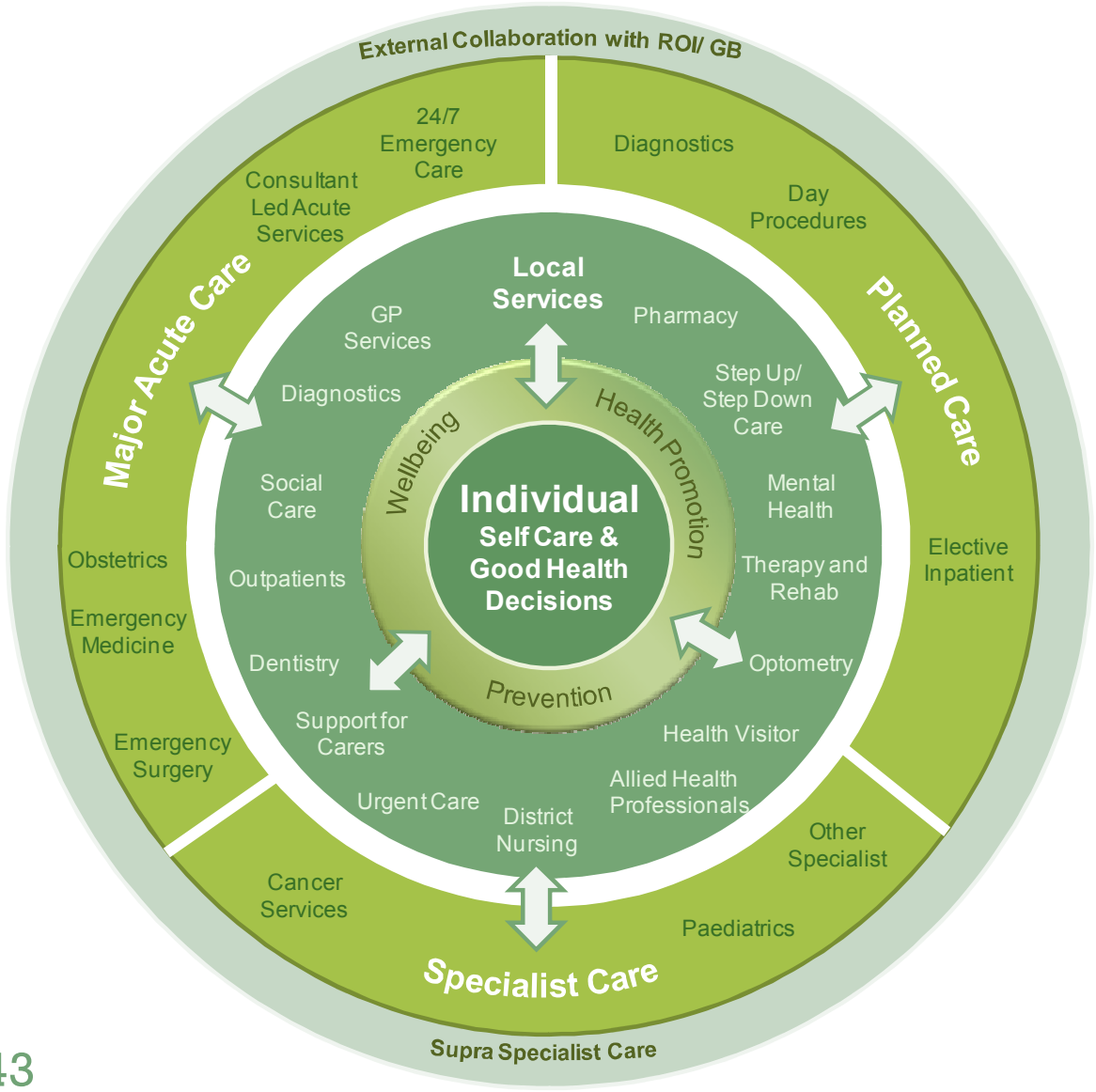
A FUTURE MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE

6. A FUTURE MODEL FOR INTEGRATED HEALTH AND SOCIAL CARE

Following from the key principles outlined above and the Review's assessment of the opportunities that exist to do things better, a future model for integrated health and social care has been developed. This is illustrated in the figure below.

The future model is designed with the individual at the centre, with health and social care services built around them. Health and social care begins with the individual who is supported to care for themselves and make good health decisions.

Figure 13: Future Model for Integrated Health and Social Care



THE INDIVIDUAL

Every individual has a responsibility to make decisions that help maintain good health and wellbeing, prevent the onset of illness, and minimise deterioration as a result of any existing conditions they may have. People are supported to do this by health and social care professionals, their community, health and social care initiatives and regional health promotion, health protection and prevention initiatives. For example, this may include family support programmes run in community centres, smoking cessation programmes in pharmacies, screening in GP clinics (e.g. for cervical cancer), health visiting for newborns, healthy eating initiatives in community centres, and exercise programmes in local leisure centres. Fundamentally, people need to be supported to take responsibility.

LOCAL SERVICES

Integrated Local Services

For most people, much of what is needed from health and social care services will be increasingly accessible in their local area, either in their own home or in a local facility.

In many ways this may not seem much different to the way services are currently provided. The professionals providing local health and social care services, (for example GPs, district nurses, dentists and social workers) will continue to operate in local surgeries, health centres and high street practices, and to visit people's homes where needed. However, the way that they work with each other will be different.

GP practices will work together as federations of practices, enabling consistently high quality care for their patients. Additionally, Integrated Care Partnerships will be set up to join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent and voluntary sector. The Integrated Care Partnerships will have a role in determining the needs of local population and planning and delivering integrated services. Seventeen Integrated Care Partnerships will cover Northern Ireland.

For the individual, this will mean that GPs and all the other health and social care providers in an area, including from the voluntary and community sector, will be able to work together to deliver the services needed by their local population. As a consequence people will deal with fewer professionals and be at the centre of the decision making about their care and treatment.

Technology will support this integrated working. Electronic Care Records will allow health and social care teams to see patient records including details of medications, results of tests and any

hospital treatment. This will help ensure that professionals have access to the information they need to treat a patient effectively, including in an urgent care situation. Patients will also have improved information on their personal circumstances.

More Services Provided In the Community

The public told the Review that there should be a greater range of services available in the community. Therefore, under the new model, more of the services that currently require a hospital visit will be available locally. This may include for example, X-rays and other diagnostic tests, and oral surgery. GPs will be enabled to undertake minor procedures in their surgeries. Outpatient appointments in many instances will be provided in the community rather than in hospital. In some specialties, care will be organised directly by the Integrated Care Partnership. New facilities will be developed to support this model, which may be similar to the health and care centres currently in some areas. This model will improve accessibility to health and social care services for the individual.

More specialist care will be provided in the community. Specialist hospital clinicians will support GPs and other community clinicians, working closely with them to plan how services are delivered. More specialists will also be employed in the community, for example, specialist nurses and GPs with a Special Interest. Providing outpatient appointments in the community will become the norm, with some of these being run by GPs and others by hospital specialists. This will reduce the number of follow-up visits to hospital required by patients.

These changes will be very important for people with long-term conditions, for example diabetes, cardiac illness or respiratory problems. For these patients, community-based support programmes will be put in place where multi-disciplinary teams work with patients to help them manage their condition. This will include:

- dedicated community-based clinics where patients can access a range of health and social care services, including inputs from community pharmacy, Allied Health Professionals such as podiatry and physiotherapy, nursing care and social work support as well as from GPs with a Special Interest and hospital specialists;
- better use of telehealth equipment to help people monitor their own conditions and alert health professionals when an individual's condition deteriorates;
- a named contact person for patients to call when they need assistance – this may be the GP, a specialist nurse or another member of the integrated care team; and
- direct admission to hospital care when needed as agreed between the GP and hospital specialist, with no need to

pass through the hospital emergency department.

Working in this way will also benefit groups who can face barriers in accessing care. For example, the new model will support the provision of enhanced community health services for people with a learning disability.

There will be a consistent approach to the provision of mental health services through the stepped care model, with most services being provided in the community by community mental health teams and voluntary and community sector partners.

More Support Available at Home

Throughout the Review people expressed their preference for care at home or as close to home as possible. In response to this, the new model will provide more support to help people who are sick or frail to maintain their independence and stay in their own homes for as long as possible. This applies whether that home is the family home, supported housing, a nursing home or residential home. However, there will be much greater emphasis on enabling people to remain in their chosen home. Providing care, treatment and support in this way will change the current model, perhaps most noticeably in terms of the number of residential homes.

As part of this approach, more tailored support will be provided to meet people's needs. People will have access to specialist equipment, nursing care, telehealth and telemonitoring support, and other therapeutic support at home, e.g. physiotherapy, podiatry or occupational therapy.

Social care will also be a central part of the support provided to enable independent living. This will include access to a diverse range of provision to meet people's social and emotional needs and tackle social isolation. Voluntary and community sector organisations will provide this support as well as community health and social care teams.

Virtual wards will also be developed. Under this model, individuals are admitted into the care of specialist teams, and provided with similar care as would be available in a hospital ward, but remain in their own home. Mental health treatment services will also be available at home, provided by Crisis Response and Home Treatment teams. This will result in reductions in inpatient care.

Intermediate care will be an important component of the new model, with greater provision of step-up and step-down beds in the community for people needing extra care for a short period of time. Step-up beds provide locally-based short-term support to avoid the need for individuals to be admitted into an acute hospital. Those leaving hospital may spend time in a step-down bed for rehabilitation before returning home. A reablement model will be introduced to provide people with the support they need to return to their homes following a stay in hospital, an accident or other crisis.

There will be a need to provide more respite care and short breaks in the community, to support individuals and carers. This will include accommodation and other short break options. All of this intervention is designed to respond to the patient's and carer's needs.

How people are cared for at the end of life is a key indicator of the values expressed by the HSC. Under the new model, services for those approaching the end of life will be provided that enable people to die at home, where that is clinically appropriate and consistent with their wishes. GPs and other community health services will provide in-reach to support people at end of life. This will apply in nursing homes as well as family homes.

Urgent Care

An urgent care model will be implemented in every area to provide 24/7 access to urgent care services. These services will be planned in accordance with local need. Whilst the model will take account of local circumstances, the outcomes will be consistent. The system of urgent care will ensure each community has local access to urgent health and social care services, variously provided by GPs, urgent care specialist nurses, mental health crisis response teams and emergency social workers.

EMERGENCY, SPECIALIST CARE, AND PLANNED CARE

Emergency care, specialist care, and planned care services will be provided in hospitals for people whose health and care needs cannot be met in their own homes or their own communities.

People needing specialist and acute care will be admitted to hospital. This may be on a planned basis, for example, for a pre-arranged procedure or as a result of an emergency.

The model aims for those admitted to hospital to be discharged to home or a community facility as soon as their health and care needs can be met there. Once individuals are discharged, follow-up care will be provided by the integrated care teams in the community with support from hospital specialists as required. As well as meeting the needs of patients and their families more effectively, this is a more efficient approach which will result in greater productivity.

Triage services and patient transport will be critical to ensuring that individuals access the care appropriate to their needs on a timely basis.

EXTERNAL COLLABORATION AND SUPRA-SPECIALIST CARE

Some services that are only needed by a very small number of people will be provided outside of Northern Ireland. This is necessary to ensure the quality of provision. Networks will be set up between the HSC in Northern Ireland and health and care providers in the ROI and other parts of the UK.

CONCLUSIONS

The proposed model has been designed to address the challenges presented in the Case for Change and the concerns expressed by those engaged with throughout the Review, both clinicians and the public.

The key differences between the current model of care and that proposed by the Review will be:

- care will be organised around the individual and not the institution;
- greater involvement in decision making will be afforded for the patient / client;
- the model provides a new way to look at the traditional model of GP and community health and social care services;
- home or close to home will be the centre of health and social care provision;
- there will be responsible access to emergency and hospital care; and
- new arrangements will be put in place to support provision outside the jurisdictions.

Overall, the model builds on evidence of what produces good outcomes, and supports the resilience and flexibility of the health and social care system for the future.

CASE STUDIES

The Review team considered it important to describe how it might be different for those using the service and offers the following examples to illustrate the change.

Older People	
Current Model	**Future Model**
Jean is a 79-year old woman, who lives alone in her house. She suffers from osteoarthritis, diabetes, bronchitis and heart disease. Because she is not as mobile she finds it difficult to get to hospital appointments. Jean was assessed on several occasions by various professionals, including a social worker, physiotherapist, occupational therapist, and a specialist diabetes nurse. She had to provide the same information each time she was assessed, which Jean found frustrating. The outcome of the assessments deemed that Jean required support from a range of professionals and adaptations to the steps up to her house. Jeans gets confused who is coming to her each day. Furthermore, no-one noticed that she might have a cataract. While Jean was waiting on the adaptations to her steps she fell and fractured her hip. She was taken to hospital and underwent emergency surgery. Jean had to stay in hospital while discharge planning was undertaken and a care package arranged. After some time, she was transferred to a rehabilitation ward where she underwent physiotherapy to assist her recovery, prior to returning home. Jean now worries that she will not be able to cope in the longer term and that she may need to begin thinking about residential care.	Jean's needs were assessed using the Northern Ireland Single Assessment Tool (NISAT), which allowed for all the information necessary to establish her health and social care needs to be collected in one assessment. All of those supporting Jean use this information so she doesn't have to provide the same information several times to various different professionals. Jean sees the specialist looking after her diabetes at her local which is more convenient. Further to the NISAT, the adaptations were made to Jean's steps. The assessment also identified that Jean required a cataract operation – both these interventions happened quickly preventing her fall. Jean was provided with details of the budget available to meet her care needs. The Trust explained that they could manage how this budget would be used or she could receive the budget via a Direct Payment and use it to purchase services herself. Jean chose not to take a Direct Payment, and instead to agree jointly with the Trust how her care budget would be used. They agreed that she would get support with going shopping and attending a local lunch club.

Case Study – Long Term Conditions	
Current Model	**Future Model**
Tom is a 75 year old man suffering with heart problems. He lives on his own but is visited regularly by his daughter. He experiences regular breathing difficulties and his condition is exacerbated by regular chest pains which results in recurring episodes. After waiting in A&E to see a junior doctor and explained his circumstances he has been admitted to a ward where he receives the appropriate treatment required to treat his condition and symptoms. He does not require a referral to see cardiologists. He is discharged when stable after 5 days with appropriate advice on medications and life style. The next time he experiences the same symptoms he is worried and he phones his GP. His GP recognises that this is an exacerbation of his heart failure and sends an ambulance to take him to A&E where he is admitted again. This cycle is repeated again and again and Tom visits A&E 10 times that year.	Tom's GP referred him directly to the community heart failure team who contact him the day following discharge. The nurse arranges to come out to see him in a few days and ensure he understands all the medication he has been prescribed. His daughter is included in these discussions. They are educated about his symptoms and lifestyle and left a number to phone if the symptoms get worse. Tom visits the nurse in two weeks while his medications are increased in line with his clinical presentation. The Heart Failure nurse in secondary care provides specialist telephone advice as necessary. A referral to cardiology will be made if deemed necessary. The nurse takes every opportunity to educate Tom on his condition in order to ensure he knows how to manage his condition. If Tom feels that his symptoms are getting worse he can phone the heart failure nurse help line number who arranges to see him quickly. This proactive contact continues as appropriate for four years during which time Tom only needs to be admitted once to hospital for stabilisation of treatment. This admission is planned by the specialist heart failure team and Tom does not have to present to A&E.

Case Study – People with a Physical Disability	
Current Model	**Future Model**
Gary is a 23-year old man who has cerebral palsy. As a result of his condition, Gary has been in a wheelchair for most of his life. Gary spends most of his time at home or at the local day centre. He has a care worker who visits his home for 30 minutes each morning to assist his mother getting him out of bed and dressed. He then goes to the local day centre. Each evening, his care worker returns to assist his mother in putting Gary to bed. Gary is concerned that he does not receive enough stimulation at the day centre and the activities which he participates in are very limited. Gary would be keen to spend more time with people of his own age group and expand his social networks, as the only people he truly engages with at present are his close family members.	Gary is a 23-year old male with cerebral palsy. His care worker visits his home for thirty minutes every morning and evening to assist his mother with getting him in and out of bed and getting dressed. Gary would prefer to have more control over his daytime activities. He decides to receive some of the budget available for his care in the form of a Direct Payment from the HSC Trust. He uses the Direct Payment to buy the support of a care-worker two days per week. Gary now attends the local college one day per week, where he has joined a committee for students with a disability. On another day his support worker helps him with leisure activities such as swimming. Gary still spends three day per week at the day centre. To help manage his Direct Payment, he receives help from a voluntary sector organisation on being an employer, including how to recruit and pay someone.

Mental Health	
Current Model	**Future Model**
Joe is an unmarried, 25-year old man who lives at home with his mother. He worked for three years as an engineer in a production factory, but unfortunately one year ago he was made redundant from his job. Over the period since his redundancy, Joe has become increasingly depressed. He feels hopeless, experiences disturbed sleep, has lost interest in playing football and has become withdrawn from his friends. Joe's mother has encouraged him to visit his GP for some help, but Joe feels too embarrassed to do so. Joe has also started to drink heavily in an attempt to self-treat his depression. When his mother would encourage him to stop drinking, he would become aggressive towards her, which made him feel guilty. Joe has started to self-harm and have suicidal thoughts. The physical injuries caused by Joe's self-harming became so serious that he had to be admitted to hospital for treatment. Joe was also assessed by a psychiatrist at this time. Once the physical injuries had been dealt with, Joe was discharged from hospital and prescribed antidepressants to assist in the management of his illness.	Joe feels increasingly depressed having been made redundant from his job. He feels disconnected from his friends and experiences disturbed sleep. Joe picks up a booklet in a local takeaway produced by a local community organization. It encourages young men to look after their mental health and explains how to get help if necessary. Joe had been worried that there would be a social stigma attached to seeking help for mental health problems, but when he sees this advice he feels reassured that he could seek help. Joe went to his GP who listened to his problems and advised that he should attend cognitive-behavioural therapy sessions. Joe now meets his therapist once per week at the local health centre, and also has regular review appointments with his GP to monitor his progress. Joe was glad that he had heard the advice about seeking help with mental health problems at an early stage. He is now feeling much better and his illness is under control.

Case Study – Urgent Care	
Current Model	**Future Model**
Abby is 32 and is a keen cyclist. As she travelled home one afternoon, Abby was forced onto a curb by an oncoming car and crashed her bicycle which left her in considerable pain. On further inspection, Abby needed medical attention as her arm was bleeding badly and she was unable to move her wrist or put any pressure on it. Abby called her husband who took her to the nearest A&E department. She explained her situation and gave her details and waited to see a consultant. A serious traffic accident requiring urgent attention meant that Abby waited 4 hours for an assessment while continuing to be in distress. Eventually Abby saw a doctor where she was given stitches and some pain relief, as well as a splint to secure the arm and prevent any further damage. Abby was then referred for an X-ray to identify any fractures. After another lengthy wait of two hours for the X-ray and then the results, the X-ray showed that no major damage had been caused. Abby was free to return home and told to make an appointment with her GP to get her stitches removed.	When Abby called her husband to tell him what had happened, he remembered the new number to call for all urgent care enquiries which he had learnt from a leaflet which had come in the post. After ringing the helpline, he was advised to take Abby to the local Health and Care Centre. When Abby arrived at the Health and Care Centre she waited for a specialist nurse who saw her almost immediately. The nurse investigated the injury and identified that stitches were required but an X-ray would confirm whether further treatment was required. Abby received some pain relief and went for an X-ray which was taken in the same facility within half an hour. The X-ray showed no fracture and Abby was free to return home after the nurse applied some stitches. Abby was advised to make an appointment with her GP to organise the removal of her stitches.

7. POPULATION HEALTH AND WELLBEING

INTRODUCTION

Prevention is integral to the delivery of sustainable health and social care. It enables individuals to make better health and wellbeing decisions. Additionally it is an important determinant in optimising health outcomes for the citizen. Investment in prevention also makes economic sense, for example, inequalities have been estimated in England to cost £5.5billion to the NHS alone.[32]

Total annual inpatient costs to health and social services in Northern Ireland as a result of smoking were estimated at £119million in 2008/9.[33]

Loss to the local economy as a result of obesity is estimated at £500million, with 59% of the population being either overweight or obese. This includes, for example, some £24.5million spent on prescribed anti-diabetic medication alone.[34]

The impact of alcohol on the health and social care system is estimated at some £250million. The additional social costs are estimated at almost £900million. Furthermore, it is estimated that alcohol is a significant factor in 40% of all hospital admissions, rising to 70% of Accident and Emergency attendances at weekends.

Given the significant impact of these issues on the health of the population and the costs of care, strategic and bold action is required. No system can withstand the pressure of doing nothing, and the HSC has a duty to address the health inequalities in our population.

THE CHALLENGES

The starting point is to acknowledge that population health and wellbeing is not just a matter for the health and social care system. It begins with the individual and the choices they make, but improving health and reducing health inequalities also requires joint action across government and partnership working. One area brought to the Review's attention was rural isolation and transport. The Review would suggest this is an area in which joint working could be piloted, including joint sharing and control of resources.

No-one disagrees with the concept of health and wellbeing, the challenge is to deliver a programme of change. Financial pressures will undoubtedly increase within HSC budgets, and often there is

[32] NICE (2009) Using NICE guidance to cut costs in the downturn.
[33] RCP (2000) Nicotine Addition in Britain: A report of the tobacco advisory group of the RCP applied to 2008/9 HRG costs. In: Ten Year Tobacco Control Strategy for Northern Ireland Consultation Document.
[34] N Gallagher, Presentation QUB Centre of Excellence 2011, Source BSO.

consequent pressure to defer investment in prevention.

LIFESTYLE CHOICES

Alcohol Consumption in Northern Ireland

Given the link between alcohol consumption and harm, and evidence that affordability is one of the drivers of increased consumption, price has become an important feature of prevention strategies. Alcohol is now 44% less expensive in the UK than it was in 1980. It is possible today to exceed the maximum weekly recommended intake of alcohol for men (21 units) for around £4.

A University of Sheffield report, used by the Scottish Government, suggests that a minimum price of 45p and a complete ban on promotions would save about 50 lives in year one, rising to 225 lives in year ten. Moreover, it has been estimated for Scotland that the 45p per unit minimum price would have a total value to health, crime and employment in year one of more than £50million and over ten years of more than £700million.

The submission to the Review from the Royal College of Psychiatrists in Northern Ireland also highlights its view that alcohol price control could be the single biggest act that Government could undertake to improve health and wellbeing in Northern Ireland.

As NICE states: “There is extensive international and national evidence (within the published literature and from economic analyses) to justify reviewing policies on pricing to reduce the affordability of alcohol".

Over the last ten years, it has become increasingly socially unacceptable to drink and drive. This has been via a mixture of enforcement, education and diversion. In this context, it is proposed that a reduction in hazardous and harmful drinking becomes a priority for Northern Ireland with associated targets such as a reduction in A&E attendances helping to drive performance. This could be supported by focused media campaigns to change behaviours/ culture along with evidence based interventions for reducing harmful and hazardous drinking across Northern Ireland.

Smoking

As detailed in the Case for Change, around 340,000 people aged 16 and over smoke in Northern Ireland. Half of all smokers eventually die from cancer, or other smoking-related illnesses.[35] A quarter of smokers die in middle age, between 35 and 69. These deaths could be avoidable.

Reducing smoking is a high priority for public health and there is an ongoing programme of action to encourage people who smoke to stop and discourage people from starting to smoke. This includes public information campaigns and

[35] Mortality in relation to smoking: 50 years’ observations on male British doctors, Doll et al, 2004

smoking cessation services. The model of care proposed by the Review offers the opportunity to take an integrated, area-based approach to these actions, targeting groups facing particular risks, such as pregnant women, and locations where smoking rates are known to be higher, for example colleges.

Obesity

The Case for Change highlighted the rate of obesity in Northern Ireland and the challenges this presents. An estimated 59% of all adults are either overweight (35%) or obese (24%),[36] which has a very significant impact on our population's health and wellbeing. We face a significant challenge in halting the rise in the proportion of the population who are overweight or obese.

A regional Obesity Prevention Framework is being developed to set out the actions needed to reduce the rate of obesity. These include supporting the individual to take responsible decisions and helping to create an environment that supports healthy decisions about diet and physical activity.

In relation to the lifestyle factors of diet, physical activity, smoking and alcohol consumption, it is important that we provide citizens with good information and that we create environments which make it easier for people to make healthy choices.

To support this, the Review would encourage the Northern Ireland Executive to consider the wider role of the state in taking decisions impacting on health outcomes. In addition to considering the emerging evidence on the potential benefits of minimum pricing for alcohol (for example, taking account of the outcomes of the Scottish alcohol pricing initiative), the Executive may wish to consider the issue of pricing of alcohol and 'junk' food and further controls on tobacco usage.

SCREENING AND PREVENTION

Population screening programmes enable the early detection of disease. They involve testing people who do not have any particular symptoms of a disease to see if they have the disease or are at risk of getting it. Screening allows earlier intervention which contributes to improved outcomes for individuals. The current programmes include screening for breast, cervical and bowel cancers, diabetic retinopathy, antenatal infection screening and a programme of screening for newborns.

Immunisation is the most effective public health intervention for preventing ill health and saving lives. It provides people with vaccinations to protect them against serious infections. Many of these are provided in childhood, for example primary vaccinations for diseases including polio, whooping cough, diphtheria, and the MMR vaccine for measles, mumps and rubella. Uptake rates for childhood vaccination are very

[36] NI Health and Social Wellbeing Survey 2005/06, DHSSPS

high in Northern Ireland and above the UK average. The uptake rates for the flu vaccination, which targets groups at risk of serious harm from the winter flu virus, are also higher than the UK average in Northern Ireland.

The Public Health Agency is responsible for screening and immunisation programmes. Key priorities are to maintain and expand existing programmes and to introduce new programmes where there is good evidence that they can be effective.

SOCIAL WELLBEING

The role of social support in preventing illness and enhancing individuals' quality of life is well recognised. For example, Section 8 which focuses on care for older people, describes how loneliness and social isolation have been proven to have a negative impact on physical health.

The voluntary and community sector plays a significant role in supporting the social needs of vulnerable groups, often working in partnership with health and social care, housing and other statutory services. This role should be expanded.

THE ROLE OF INTEGRATED CARE PARTNERSHIPS IN HEALTH PROMOTION

The Integrated Care Partnerships proposed under the new model, will have a leading role to play in promoting health and wellbeing. They should be incentivised to support evidence-based health and wellbeing promotion and embed prevention into health and social care services.

This should include:

- expansion of screening and immunisation programmes in the community where evidence exists to support them. Where possible, screening and immunisation should be provided in the community;
- an enhanced role for community pharmacists in health promotion, for example, in relation to information and advice around obesity and weight management, alcohol use and minor ailments;
- support for the role of Allied Health Professionals in secondary prevention, particularly as regards older people, for example, the role of podiatry care in falls prevention, and occupational therapy in rehabilitation;
- support from clinicians for community-based education programmes; and
- local community and voluntary organisations supporting the social and emotional needs of vulnerable groups.

SUMMARY OF KEY PROPOSALS

1. Renewed focus on health promotion and prevention to materially reduce demand for acute health services.
2. Production by PHA of an annual report communicating progress on population health and wellbeing to the public.
3. Maintenance of existing and implementation of new screening and immunisation programmes where supported by clinical evidence.
4. Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: in relation to pricing of alcohol and 'junk' food; and further controls on tobacco usage.
5. Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.
6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.
7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community.
8. Support for the health promotion and prevention role played by Allied Health Professionals, particularly with older people.

8. OLDER PEOPLE

INTRODUCTION

As highlighted in the Case for Change, Northern Ireland has the fastest growing population in the UK and it is an ageing population. By 2020, the number of people over 75 years is expected to increase by 40% from that in 2009, and the number of people aged over 85 is expected to increase by 58%.

Longer life expectancy is something to celebrate and many older people enjoy good health. However, among the 'older old', rates of ill health and disability increase dramatically. For example, dementia mostly affects people over the age of 70[37], and the rate of disability among those aged over 85 is 67% compared with only 5% among young adults[38]. The health and social care system cares for the most vulnerable when their needs change. Older people are significant users of health and social care services, and almost a fifth of the Health and Social Care budget (19% or £616million) is allocated to services for older people[39].

- Around 60% of acute hospital beds are typically occupied by people over 65.[40] Many arrive at hospital because there is no viable alternative in the community (more specific information on this follows later).
- Approximately 23,389 people receive domiciliary care, equating to some 233,273 hours of care each week.
- 9,677 people aged over 65 live in nursing or residential care.

Many excellent health and social care services are provided for older people by dedicated staff, volunteers and unpaid carers. But there is a high level of dependence on institutional and hospital care, and inconsistencies in the quality and range of services provided across Northern Ireland. Services are not currently meeting expectations in terms of quality and consistency. Too often they tend to focus on acute events and crises rather than providing the range of proactive and preventative support that can maintain the health and wellbeing of older people.

[37] DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.
[38] DHSSPS (2010) Physical and Sensory Disability Strategy. A Consultation Document 2011-2015.
[39] HSCB Social Care Directorate Submission to the Review (October 2011)

[40] HSCB figures for 7/12/11 identified 60% of emergency and elective admissions excluding obstetrics, sick babies, the Children's Hospital and mental illness.

HOME AS THE HUB OF CARE FOR OLDER PEOPLE

Residential and Nursing Home Care

The proportion of older people in Northern Ireland living in nursing homes is 3.5 times higher than in England and Wales[41] and is increasing. Between 2007/8 and 2009/10, the number of nursing home places increased from 6,392 to 6,694. This reflects the growing complexity of needs and high dependency levels among some of the older population – for example the growth in cases of dementia where currently there are an estimated 19,000 cases. [42]

Meanwhile, the number of residential care places is slowly declining, reflecting the growth in supported housing schemes provided by Housing Associations which have replaced residential homes. Over the same period 2007/8 to 2009/10, the number of residential places fell from 3,096 to 2,983. Many of those using residential care are no longer permanent residents.

The policy aim for some time has been to shift care from institutional settings to home and community settings. The current Health and Social Care Board (HSCB) target (from April 2011) is for at least 48% of care management assessments to recommend a domiciliary care package rather than a nursing home or residential care. However, the majority of expenditure still relates to institutional care. In 2009/10 residential and nursing home provision accounted for £190million, with domiciliary care accounting for £138million and hospital care for £115million. Suggestions on how to improve care, from the online survey, included more community services, person centred care and in-reach services.

Following from the key principle that home should be the hub of care, the Review recommends that steps are taken to support greater provision of services for older people at home and in the community.

The Review supports the trend towards independent living – at home or in supported accommodation – and expects to see a very significant reduction in provision of long-term residential places in the next five years. This will inevitably

[41] Reshaping the System, McKinsey 2010
[42] DHSSPS (2011) Improving Dementia Services in Northern Ireland. A Regional Strategy.

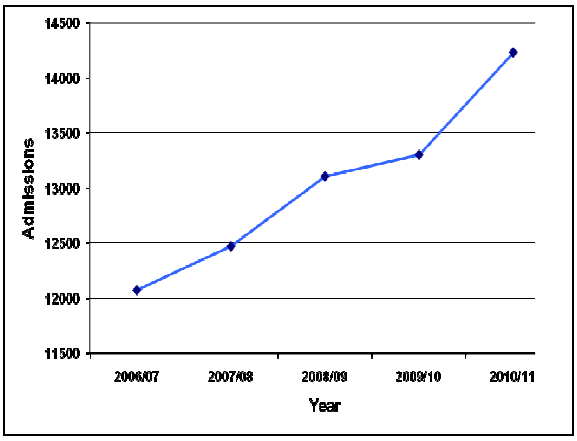
lead to the closure of existing facilities in a planned manner with resources transferred to home care or where appropriate to new models such as respite care.

Hospital Care

Increasing numbers of older people are being admitted to hospital on an unplanned basis and when they are admitted, older people tend to have longer stays and are more likely to face delays in waiting for discharge.

Over the five years to 2010/11, the number of admissions of older people into hospital increased by 18%, as shown below.

Figure 14: Total Admissions to HSC Hospitals in NI under the Elderly Care Programme of Care (2006/07 - 2010/11)



Source: NI Hospital Statistics: Inpatient Activity 2010/11

Many older people arrive at hospital because there is no viable alternative in the community, for example, due to lack of appropriate nursing and medical interventions available in nursing homes or at home.

Once admitted, older people tend to have longer stays in hospital. During 2010/11, the longest average length of stay across all specialties in Northern Ireland was under the rehabilitation specialty where admissions lasted for an average of 30.9 days. Longer lengths of stay for older people can be associated with cases involving a complex range of physical and mental health issues and therefore a requirement for a robust package of care to be agreed before discharge into the community.

Since April 2010, a target has been in place stating that the HSC Board and Trusts should ensure that 90% of complex discharges take place within 48 hours of the decision to discharge, with no discharge taking longer than seven days. As at the end of 2010/11, 86% (13,009) of complex discharges were within 48 hours regionally. The most common reasons for delay recorded were:

- no domiciliary package available;
- essential equipment / adaptations not available or assessment not completed; and
- no nursing home bed available in the chosen facility.

Research by the Alzheimer's Society found that people with dementia stay longer in hospital than other people undergoing the same procedure, and stays in an acute hospital environment

can have a detrimental effect on the symptoms of dementia.[43] Admissions to hospital can also result in reduced confidence of older people and their families to live independently, and can lead to a move into residential and nursing care[44].

The Health and Social Care Board will begin to introduce a reablement model of care across Northern Ireland from 2012. This approach involves providing older people with intensive, time limited support with everyday tasks with the aim of enabling the individual to do the task as independently as possible at the end of the process. It has been shown to be an effective means by which to keep people independent for longer. The Southern HSC Trust has already begun implementing a streamlined assessment and care planning approach built around the reablement model.

It is also known that older people are often admitted to hospital at the end of life. A recent report by DHSSPS showed that 82% of people dying in hospital were over 65 years of age. Of these people, 18% (2010/11) had a length of stay of less than 2 days. The report also looked at the number of people dying in hospital within 2 days of admission who were admitted from a nursing home. In 2009/10, 28% of the deaths of people admitted from a nursing home occurred within 2 days of admission into hospital.[45]

Suggestions for improved care for people nearing the end of life, from the online survey, included more home support to allow people to die in their preferred location.

To help avoid unnecessary admissions of older people into hospital and encourage independence, the Review endorses the plan to introduce a reablement model across Northern Ireland. The Review also recommends that there should be better integration of hospital and community services. With the establishment of the 17 Integrated Care Partnerships there is a tremendous opportunity to:

- improve communication between GPs providing out of hours care and hospital specialists;
- provide in-reach into nursing homes by specialists and GPs;
- have clear specification of the care and interventions to be provided in a nursing home environment including, for example, administration of intravenous therapy and catheterisation;
- provide the management of end of life care in nursing homes – being transferred to hospital at the end of life can be distressing and the Review recommends that other than for sound

[43] DHSSPS Dementia Strategy
[44] Stilwell and Kerslake (2003) What makes older people choose residential care, and are there alternatives?

[45] DHSSPS Hospital Information Branch (2011)

clinical reasons or family preference, nursing homes should manage end of life care;

- create greater provision of intermediate care, increasingly using the independent sector to provide:
    - step-down beds for short-term rehabilitation following a stay in hospital;
    - step-up beds that provide short-term support to prevent an admission into hospital; and
    - short-term reablement support to enable people to learn or relearn the skills necessary for independent living.

The Review suggests that whilst some intermediate care beds will be statutory, there will be an increased role for the independent sector in providing beds.

Patient and User Experience

The public place a high priority on the availability of good care for older people. In November 2011, the Patient and Client Council (PCC) engaged with its members on the future priorities for HSC in Northern Ireland. Of the top ten priorities identified, Care of the Elderly, including domiciliary care was second. Those consulted raised concerns about both the quality and quantity of social care provided, and the need for appropriate care in the community to help people live in their own homes. The need for better support for older people living in rural areas was identified.

Those consulted with by the PCC raised concerns with the PCC about the length of time that is allocated to those delivering domiciliary care.

Appropriate discharge planning for older people leaving hospital was also highlighted as a concern. Those consulted expressed a view that a holistic approach to discharge planning should be undertaken and that the patient, carers and community and primary care providers should all be involved in this process.

The quality and availability of respite care was highlighted as an issue, in particular for people with dementia. Consultees emphasised the importance of respite to support individuals and their families and carers.

The public survey conducted for this Review also found evidence of concerns with the quality and accessibility of care for older people:

- 35% of respondents felt that there was a 'lot of improvement' required in the health and social care services provided to older people overall;
- 24% of respondents stated that a 'lot of improvement' was needed in the quality of residential care for older people;
- 36% of respondents stated that 'a fair amount of improvement' or a 'lot of

improvement' was required in home help or home nursing care; and

- strong concerns were expressed about the waiting time for an assessment for home help, nursing or residential care - 33% felt that a 'little improvement' was needed, with 24% and 21% respectively, stating that a 'fair amount' or a 'lot of improvement' was required.

Workshops with clinicians confirmed public concerns in relation to care for older people. Clinicians highlighted the increasing demand for nursing and residential care due to the ageing population. They expressed the view that the capacity and capability of staff within nursing and residential care settings to provide care to the increasing numbers of patients with complex care requirements needs to be addressed. Quality issues were identified including poor nutrition of older people in hospital, nursing and residential care.

A 2008 UK-wide nutrition screening survey in hospitals, nursing homes and mental health units found that people in these care settings had a higher risk of malnutrition on admission and that the risk was much higher again for older people being admitted to care. For example, it estimated the rate of malnutrition for those aged 65 in the community at 14% compared with 32% for those being admitted to hospital and 42% for those being admitted to care homes[46].

Clinicians also highlighted a perceived lack of continuity and integration between hospital care and community based care. The limitations of IT and communications systems to support sharing of information between hospitals, primary care settings and residential and nursing homes was noted.

They expressed the view that greater rehabilitation and intermediate care is needed to prevent hospital admissions and support timely discharge.

The Review was persuaded of the need for, and its new model supports, a shift in services from hospital settings to closer to home. This will require more personalised care and diversity of service provision. Advocacy will be important in providing safeguards to vulnerable individuals. Telecare support will enable the greater management of risk and improving personal confidence.

PROMOTING HEALTHY AGEING

Throughout the Review, the public and clinicians expressed a desire for a more preventative model of care and one which enables better quality of life for older people. This is supported by research that suggests that preventative approaches can deliver better outcomes

[46] DHSSPS - Promoting Good Nutrition A strategy for good nutritional care for adults in all care settings in Northern Ireland.

for older people, with fewer hospital admissions, shorter lengths of stay and greater satisfaction with service provision.

Preventative approaches aim to take a more holistic view of older people's needs, by addressing issues other than health which impact on wellbeing but require intervention from other areas of public service. The Joseph Rowntree Foundation's Older People's Inquiry[47] identified the areas that are valued by and thus important for the wellbeing of older people as:

- comfortable and secure homes;
- an adequate income;
- safe neighbourhoods;
- getting out and about;
- friendships and opportunities for learning and leisure;
- keeping active and healthy; and
- access to good, relevant information.

This emphasises the need for a more joined-up approach to assessing the care needs of older people, recognising the role of multiple providers of health and other services across the public, voluntary and community, and private sectors. The Northern Ireland Single Assessment Tool (NISAT) aims to provide a joined-up approach to assessing the needs of older people and carers, but rollout of the tool is at an early stage and it is not yet in use in all HSC Trust areas.

The Partnerships for Older People Projects (2009) in England tested more integrated approaches to supporting older people. Its evaluation suggests that low intensity practical support services that

[47] Raynes, N et al (2006) Evidence submitted to the Older People's Inquiry into 'That Bit of Help.' York, Joseph Rowntree Foundation.

help older people to live well in their own homes (e.g. cleaning, care of pets, gardening, befriending, help with managing bills and DIY) had by far the greatest impact on health-related quality of life[48].

There is also good evidence of the effectiveness of interventions to reduce loneliness and social isolation and improve health and wellbeing. Social exclusion is associated with poor physical and mental health outcomes for older people, and social isolation has been identified as a particular risk for older people in rural areas.[49] A review of a rural intervention to address social isolation among older people in Northern Ireland concluded that health and wellbeing of older people can be profoundly influenced by geographical location and that interventions informed by local needs are likely to be more successful.[50]

A recent report by the Social Care Institute for Excellence (SCIE) illustrates the emerging evidence that one to one interventions such as befriending and outreach can reduce loneliness and depression, and are cost effective[51]. Such initiatives are often provided by community organisations. In this regard care services are more important than health services.

Ultimately, older people want to stay at home, living independently for as long as possible, and the current model of care does not always provide the support needed to do so. Too often this results in reliance on institutional care with crisis intervention as the order of the day. This is not consistent with a shift to the wellbeing model the public expects.

Personalised budgets refer to the greater involvement of those qualifying for health and social care services in how they are provided. Needs assessment identifies the amount of care funding available for each individual and a joint decision is taken between the service user and the provider on how that funding will be used.

This includes the option to access a Direct Payment which involves the provision of funding directly to patients and clients who then purchase directly the services they feel best meet their needs. Direct Payments are available to older people who need support, individuals with physical disabilities, learning disabilities or mental health issues.

---

[48] Windle, K et al (2009) National evaluation of Partnerships for Older People Projects: final report. Canterbury, Personal Social Services Research Unit.

49 Commission for Rural Communities (2008) The Personalisation of Adult Social Care in Rural Areas.

[50] Heenan (2009) How Local Interventions Can Build Capacity to Address Social Isolation in Dispersed Rural Communities: A Case Study from Northern Ireland. Aging International, vol 36, no 4, 475-491

[51] Windle, Francis and Coomber (2011) Preventing loneliness and social isolation: interventions and outcomes. Social Care Institute for Excellence.

When people are provided with information and advice on the services that are available to them, they are in a position to make an informed choice as to the most appropriate care delivery for their particular needs. Those choosing to take a Direct Payments are able to choose who provides their care, when they deliver it and what they do to meet their particular needs. This may mean reduced uptake of core social care services provided directly by the HSC Trusts and uptake of a more diverse range of provision including that of the voluntary sector. Direct Payments users may also employer support workers directly.

Promotion of personalised approaches and the uptake of Direct Payments has been Government policy across the UK for some time. However, research has shown that there may be variation in the benefits experienced by patients and clients receiving direct payments, especially for older people and those with mental health problems. The most recent figures indicate that a total of 687 older people are in receipt of Direct Payments and 34 carers receive Direct Payments on behalf of an older person[52].

During the Review, the Direct Payments process was highlighted as being bureaucratic and of limited appeal to older people and their families. The need for independent provision of advocacy and coordination was identified as a method to facilitate and support service users in using personalised budgets.

Where individuals do not wish to take financial control, they should be given the option of advocacy to act on their behalf or a financial statement of the cost of their assessed support to enable greater choice on their part.

The Review concludes that there should be a focus on promoting healthy ageing, individual resilience and independence among older people.

Care for older people should be underpinned by a consistent assessment process, and a more holistic approach to planning and delivering support taking account of physical, social and emotional needs. Budgets within health and social care should be pooled, with joined up assessment and planning of needs using NISAT. The Review would also recommend pilots to explore budgetary integration beyond health and social care so as over time, the support funding managed by other parts of the public sector e.g. for housing support, could be integrated into a single care budget.

Support planning should take account of a diverse range of health, social and other support services appropriate to the needs of the individual, whether provided by statutory health and social care providers, the independent sector or voluntary and community sector providers. Service user involvement models for adult social care are being developed in other parts of the

[52] HSCB Statutory Monitoring Returns May 2011

UK as a basis for more collaborative 'co-production' of services.[53]

The role of care users and their families as partners in care should be recognised, and support should be personalised to deliver the outcomes care users and their families want to achieve. This should include control over and clear information about budgets, whether through Direct Payments or involvement in personalised budgets where HSC procures services on behalf of and as directed by the individual. Advocacy and support should be available if needed to help make this a reality.

A diverse choice of provision should be available to meet the individual health and social care needs of older people, with appropriate regulation and safeguards in place to protect the vulnerable. The Review recommends overhauling the current financial model to drive this objective within the statutory, voluntary and private sector.

SUPPORTING CARERS

Informal care from family and friends is vital to enabling a large number of older people to continue to live in the community. Across the UK, this informal care is estimated to equate to £87billion per year[54]. Carers UK estimate that there are 207,000 carers in Northern Ireland (a substantial increase from the DHSSPS figure of 185,000 quoted in 2006) and that the value of the care they provide is more than £4.4billion per year.

Carers can suffer poor physical and emotional health themselves, either directly because of the strains of their caring role or because their caring role restricts their ability to access health care. Carers UK report that carers are twice as likely to be permanently sick or disabled than the average person. The Princess Royal Trust for Carers research 'Always on Call, Always Concerned' found that 69% of carers surveyed reported a negative impact on their physical health from their caring role, and the same percentage reported that caring had a detrimental effect on their mental or emotional health.

Frequently the Review heard from carers the centrality of their role and their sense of being taken for granted.

The Caring for Carers Strategy (DHSSPS 2006) was designed to recognise, value and support the role of carers. Each HSC Trust has a nominated carer co-ordinator and is developing new ways of supporting the needs of carers. An assessment of carer needs is an integral part of the NISAT approach which is beginning to be rolled out across all HSC Trust areas.

[53] Needham and Carr (2009) Queen Mary University of London, SCIE Research briefing 31: Co-production: an emerging evidence base for adult social care transformation Social Care Institute for Excellence.

[54] Valuing Carers – Calculating the Value of Unpaid Care, Carers UK 2007.

Different carers are likely to need different types of support and their needs will change over time. Carer support interventions may include:

- programmes designed to educate carers about the care-recipient's condition and treatment;
- peer or professionally led carer support groups;
- respite services to provide carers with 'time away' from their caring responsibilities, including within the home, daycare or residential / inpatient provision;
- psychological therapy for carers; and
- care recipient training to promote confidence, self management and empowerment.

Evidence indicates that carer interventions such as these are effective in reducing carer depression and in some cases can have a positive impact on the condition of the care-recipient. Interventions which exist over a longer period of time have been found to be more successful than short-term initiatives[55]

The Review recommends a policy review to improve the outworkings of the carer assessment to better respond to their needs. There should be better recognition of carers' roles as partners in planning and delivering care for older people, and more practical support including, in particular, improved access to respite provision.

THE COSTS OF CARE FOR OLDER PEOPLE

Those engaging with the Review raised the issue of funding for adult social care and the potential future mix of funding sources including health and social care funding, social security benefits, and the patient or user's income. Current legislation in Northern Ireland enables charging of those being admitted to institutional care or receiving home care, but at present charging is not enforced for home care. The Review's role is not one of recommending charging but suggests it is a debate in which Northern Ireland society must fully engage.

The Review acknowledges that the independent sector is a major local resource in providing care for older people. It recognises that the relationship with government, particularly over pricing can be difficult. Consequently, the Review recommends the DHSSPS undertakes a policy review to consider:

- the benefits or otherwise of independent price regulation within the sector;
- the feasibility of the introduction of a certificate of need scheme ahead of

[55] Tommis, Zinovieff, Robinson and Morgan (2009) Carer Interventions Assessed Final Report. All Wales Alliance for Research and Development in Health and Social Care

the development of new premises with upper size limits;

- much more due diligence checking on any organisation entering the market, including exploring the concept of a financial bond for new entrants to minimise risk on all sides; and
- ongoing financial appraisal to ensure the robustness of facilities in the sector.

SUMMARY OF KEY PROPOSALS

9. Home as the hub of care for older people, with more services provided at home and in the community.
10. A major reduction in residential accommodation for older people, over the next five years.
11. Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.
12. A greater role for nursing home care in avoiding hospital admissions.
13. More community-based step-up/step-down and respite care, provided largely by the independent sector.
14. A focus on promoting healthy ageing, individual resilience and independence.
15. More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.
16. A holistic and consistent approach to assessment of older people's needs across Northern Ireland and an equitable range of services.
17. A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.
18. Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.
19. A policy review of carers' assessments and more practical support for carers including improved access to respite provision.
20. An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.

9. LONG TERM CONDITIONS

INTRODUCTION

Long-term conditions (LTCs) refer to patients who have a condition that cannot, at present, be cured but can be controlled by medication and/or therapy for example diabetes, asthma or hypertension. These conditions affect both adults and children.

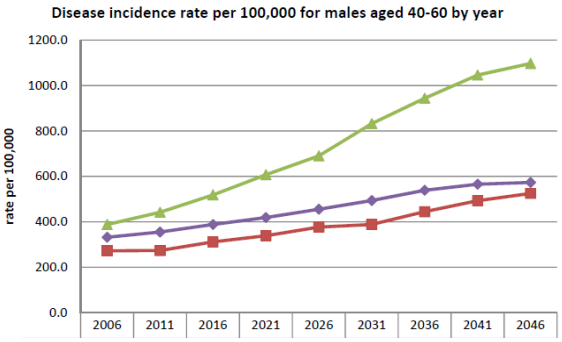
International studies have found that the cost of care for only 5% of the population makes up nearly 50% of the healthcare budget.[56] The majority of the 5% are made up of the elderly and people with long term conditions. Incidence of long-term conditions are on the rise.

A report[57] by the Royal College of GPs has identified that individuals with long term conditions account for more than 50% of all GP appointments, 65% of outpatient appointments and over 70% of in-patient beds in England. It also advocates that GPs are better placed to help individuals manage the issues associated with their condition.

It is clear that people with LTCs require high levels of care. It naturally follows that the health and social care system needs to focus its efforts on how to deliver high quality care to these individuals. The objective is to ensure better outcomes for patients. It is also important to understand that better organisation of care pathways will improve quality and value for money. The recent policy framework Living with Long-term Conditions[58] set out a number of principles and actions for the overall approach to the treatment and care of adults with LTCs.

The figure below illustrates the disease incidence rates for adult males.

Figure 15: Disease Incidence Rates



Source: National Heart Forum: Obesity Trends for Adults. Analysis from the Health Survey for England, (2010)

The Review recognises and celebrates advances made in modern treatments, but is also cognisant of the implications to future well-being. Major advancements in treatments for illnesses such as cancer have improved the life expectancy of sufferers. Increasingly cancers are becoming LTCs. Health and Social Care needs to ensure that it is ready to manage

[56] Research In Action, Issue 19, 2006
[57] Care Planning: Improving the Lives of People with Long Term Conditions, 2011
[58] DHSSPS (2011) Living with Long-Term Conditions A Policy Framework Consultation Document

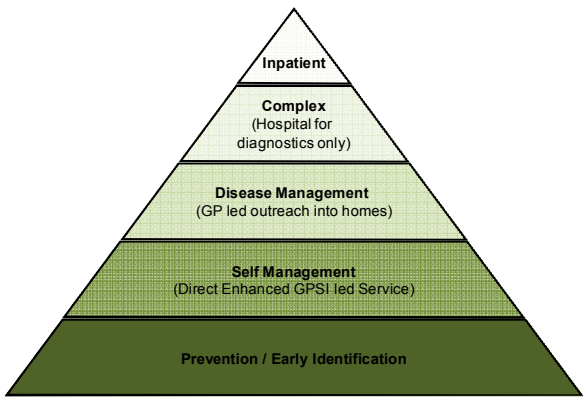
the LTCs that often develop as a result of progress in treatment.

The reality of the current system is that on many occasions individuals with a LTC are admitted to hospital after completing a complicated journey through A&E because there is no alternative.

In recent years, an emphasis has been placed on increasing the role of primary care and the community supporting LTCs. It is the Review's view that this current role can be expanded and based around the principle of 'home as the hub of care'.

The approach to the management of long term conditions should be based on the theory that the majority of effort is in prevention, early identification and self management with as little as possible care delivered within an inpatient setting, as shown in the following diagram.

Figure 16: Approach to management of Long Term Conditions



FOCUS ON PRIMARY AND SECONDARY PREVENTION

Whilst not all conditions are preventable, evidence indicates prevention has a key role in tackling:

- the increase in the percentage of children and adults who are overweight or obese;
- the increase in the number of people with long term conditions, such as diabetes;
- the higher frequency of risk factors for heart, stroke, vascular and respiratory diseases in more disadvantaged communities; and
- the higher death rates from conditions such as coronary heart disease, stroke, vascular and respiratory diseases in our society, particularly in more disadvantaged communities.

Although not all long term conditions are preventable, steps can be taken by individuals to decrease their chances of developing a condition. These include:

- promoting healthy lifestyles;
- reducing alcohol related problems;
- reducing overweight/ obesity levels;
- increasing a focus on psychological well-being; and
- decreasing incidences of falls among older people.

For many conditions, early case identification can be the key to limiting the effects of an illness.

There is a link between the prevalence of some conditions and deprivation, in particular for Chronic Obstructive Pulmonary Disease and asthma where rates are highest in the most deprived wards.[59]

The first focus is therefore to enable much greater self care to avoid chronicity. Integrated partnership working between clinicians in primary and secondary settings can produce real benefits for patients, for example in the treatment of diabetes. Support therefore begins with the GP, integrated community teams and community pharmacy.

The online survey included early intervention and use of community pharmacists as suggestions for better care for people with long term conditions and the Review supports this approach.

The Review considers Integrated Care Partnerships, that is professionals working together providing services for a population, as the way forward. In this regard the GP list acts as a building block for creating populations to enable this to happen. The data already known has the potential to be warehoused to inform best practice and intervention methods.

PERSONALISATION OF CARE PLANNING

At present personalised care planning is not practised in every area of NI. Consequently, care provision for people with a long term condition often lacks cohesion and consistency. This is a real source of frustration for the individual as they are managed simultaneously by a series of health professionals. This system results in the duplication of information reporting, which impedes analysis and treatment of the problem. All too frequently this results in overuse of hospitals.

Evidence shows that where information is readily available and accessible to all parties concerned with the treatment of LTCs, including the individual, patient experience outcomes are through a better managed system of delivery. This is enhanced even further if the individual has been involved in the planning of their care. Working in a more integrated system enables a more easily understood and straightforward care contract with individuals and their family to be created.

[59] PHA Health Intelligence Briefing, QOF, 2011

Flexible care packages should make arrangements more responsive for individuals, particularly those with changing circumstances.

Evidence suggests that with the correct support, individuals suffering from a long term condition can have an important role in the management of their condition.[60]

Self management enables individuals to take control of their own care plan, acquiring the skills required to manage them through the education they have received.

The Stanford University Model designed by Professor Lorig, recognised that issues faced by individuals with chronic conditions were often exacerbated by a number of factors including pain management, stress, low self esteem and depression.

To tackle this, better planning of self-care management will need to be introduced and replicated across the region.

Social and emotional issues can be supported within the community by establishing links between the individual and clubs, societies, transport and other amenities which will have a direct impact to the overall well-being of the person.

The Expert Patient programme[61], led by fellow sufferers aims to empower people to:

- feel confident and in control of their life;
- manage their condition and its treatment in partnership with healthcare professionals;
- communicate effectively with professionals and be willing to share responsibility for treatment;
- understand how their condition affects them and their family; and
- use their skills and knowledge to lead a full life.

An important part of the individual's ability to manage their LTC will be the strength of the support they receive from family and friends. Carers should be respected as partners in care in regard to the overall provision of services.

Working within Integrated Care Partnerships, community pharmacies have an important role in the support of individuals with a LTC, particularly in medicines management as discussed below.

Predominately referring to diabetes care, but applicable to the management of all long term conditions, a 2007 report described how organised and proactive

[60] Patient and family participation – What difference should it make to the quality of care?

[61] NHS England

services in partnership with engaged, empowered patients would ultimately provide better outcomes.[62]

One example of this in action has been the introduction of insulin pumps. The Public Health Agency reports the case of a 14 year old girl who was previously admitted to hospital 99 times from 2001-2010, but since the introduction of an insulin pump has had no diabetic related admissions. As a result her attendance at school and level of academic achievement has increased.[63]

The North West London Integrated Care pilot introduced greater use of multidisciplinary teams working within the community as well as having a direct link into secondary care.[64]

In the new model of care recommended by the Review, multidisciplinary teams will form the essential nucleus of health care professionals supporting patients in their own homes and community.

The integrated team is likely to include:

- General Practitioner;
- General Practitioner with a Special Interest (GPSI);
- Specialist Nurse;
- Occupational Therapist;
- Physiotherapist;
- Dietician;
- Social Worker; and
- Support Care Workers.

The composition of these teams should reflect the needs of the local population and be flexible to adapt to the nature of individual cases. All GP surgeries should indicate the lead professional for that practice. It may not always be that individual who treats or supports but they should be the first point of reference for patient and colleague professionals.

MEDICINES MANAGEMENT

People with LTCs often have multiple medicines to help manage their symptoms. Pharmacy errors are a very common risk factor for these patients. Compliance with the directions for use is key to the successful use of the medicines. The community pharmacy plays a key role is assisting people with LTCs.

The community pharmacist will form part of the multi-disciplinary approach to the management of LTCs. Pharmacies are ideally placed within local communities to provide advice without appointment. [65]

[62] Roberts S, Working together for better diabetes care: Clinical case for change, Department of Health, 2007
[63] PHA, 2011
[64] North West London Integrated Care Pilot : Business Case, 2010

[65] Supporting people with long term conditions to self care: A guide to PCTs in developing local

This new model seeks to keep the focus on the patient, providing alternative options to being admitted to hospital, and providing opportunity to prevent such occurrences wherever possible.

In the new model General Practitioners with a Special Interest (GPSI), will assess the individual to determine the correct treatment needed and where the most appropriate setting is. Where an individual requires secondary care, the GPSI will contact a specialist directly for admittance to hospital. Case records will be fully available to the hospital which will improve efficiency and reduce length of stay.

Making the home the hub of care, multi-disciplinary teams would provide the primary source of intervention. These health care professionals will be known to the individual, and likewise to each member of the team, allowing quick response and effective treatment delivered locally.

Community led teams should also be responsible for helping individuals to prevent their condition worsening. Regular contact with the individual is essential, along with practical support and education.

DIRECT ADMISSIONS TO HOSPITAL FOR PEOPLE WITH LTCS

Early prevention and self managed care supported by multidisciplinary teams will help stem the demand for hospital care. However, there is still a real need for high quality, responsible acute care for those who need hospital care.

In the event of an individual requiring emergency treatment, there should be greater integration between community teams and secondary care clinicians.

The GPSI will be able to contact the hospital directly once it has been determined that acute care is required. Direct admission will ensure a better experience for the patient and ultimately a better outcome.

---

strategies and good practice, Department of Health, 2006

TECHNOLOGY

A key enabler in the introduction of the new model is technology. Greater support can be given to individuals and health care professional through telehealth monitoring.

An individual will have the ability to better manage their own condition through a combination of assistive technology and access to information.

The current duplication along with poor patient records slows down the system and causes frustration to the individual when forced to continually relay their particular situation and treatment. A solution to this would be the creation of a single Electronic Care Record (ECR) which follows the individual through different care settings and Trust boundaries.

SUMMARY OF KEY PROPOSALS

21. Partnership working with patients to enable greater self care and prevention.

22. Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.

23. Patients to have named contacts for the multi-disciplinary team in each GP surgery to enable more straightforward communication.

24. Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.

25. A stronger role for community pharmacy in medication management for LTCs.

26. Development of admission protocols between secondary care specialist staff and those in the community.

27. Maximising the opportunities provided by telehealth in regard to LTC patients.

10. PEOPLE WITH A PHYSICAL DISABILIITY

INTRODUCTION

Between 17-21% of the Northern Ireland population have a physical disability and around 37% of households include at least one person with a disability[66]. While many disabled people have no greater need for health and social care support than the rest of the adult population, some draw on specific support services provided by the statutory and voluntary and community sectors. At March 2010 there were 7,527 people with a physical or sensory disability (aged up to 65 years) in contact with HSC Trust disability services. In budgetary terms, adult disability services account for a small proportion of health and social care spend - 2.8% of the HSCB budget or £91million.

PERSONALISATION AND PROMOTING INDEPENDENCE

Personalisation, independence and control are at the heart of the Review and for those with a physical disability. A Physical and Sensory Disability Strategy for Northern Ireland is in the final stages of development. It will formalise in policy terms the changes to the model of support for disabled people. Traditionally, a limited range of support services such as daycare and residential care have been provided for people with a disability.

The current service-led approach should be replaced by a more person-centred model in which statutory health and social care acts as an enabler, working in partnership with the disabled person and their family / carers to help people access the support that meets their individual needs. This may include some of the traditional residential and daycare services, but will increasingly reflect a wider range of needs. For example, a personalised support package might include:

- personal care support at home;
- specialist equipment such as a wheelchair or adaptations to the home;
- occupational therapy, speech and language therapy and physiotherapy;
- assistive technology; and
- assistance with day to day activities such as cooking, travel or work.

Voluntary and community sector organisations play a vital role in providing this much wider range of support and in acting as advocates for disabled people, promoting the control and independence agenda. Other parts of government have an important role to play in promoting independence for people with a disability,

[66] NISRA 2007, referenced in DHSSPS Physical and Sensory Disability Strategy A Consultation Document 2011-2015. December 2010.

notably housing, education, employment, and culture, arts and leisure.

This approach is supported by the findings of the online survey conducted by the Review which recommended a multi-disciplinary and person centred approach.

PROVIDING THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME

As independent living options become more readily available there has been a gradual decline in the number of people with a disability living in long-term residential care (from 92 in 2005 to 80 in 2010) and there are only three statutory residential homes solely for people with a disability. However, the number of disabled people living in nursing homes has increased over the same period, from 284 in 2005 to 319 in 2010, reflecting the complex support needed by some which is not currently being met in the community.

There continues to be around 400 people with a disability living in long-term care settings. Care could be provided closer to home with more intensive treatment and rehabilitation when needed. Despite the drive to provide more home-based support, the number of people receiving a home-help service actually decreased by 30% between 2004/5 and 2008/9. This may reflect higher thresholds to access services and a focus on providing services for those with the highest level of need or the increase in uptake of Direct Payments which allow individuals to purchase their own support.

There is an increasing population of young disabled people with complex needs who are surviving into adulthood because of improvements in therapies and medical care and who require more intricate and costly packages of care, particularly during the transition to adulthood.

Provision of equipment is vital to allow people with a disability to live well at home. A third of the respondents to the Review's omnibus survey reported that 'a lot of improvement' was required to reduce waiting times for equipment such as wheelchairs and hoists. This issue was also raised at the clinical workshops where clinicians noted concerns surrounding the provision of adequate

resources and equipment for patients and clients with physical disabilities. Clinicians also highlighted the need for inter-departmental working to address matters which patients and clients with physical disabilities experience, such as ensuring that housing is suitable for individual needs.

While it will be challenging to balance the increasing complexity of needs and requirement for significant nursing and personal care support, with more independent living, this is essential to promoting the rights of people with disabilities.

New service models will be needed to meet this challenge including continued development of respite and short break care to support disabled people and their families/carers. At present much of this continues to be provided in the traditional residential and daycare settings, but home-based respite services are beginning to be developed and should be further developed.

PERSONALISATION AND INDEPENDENCE

There has been little change in the number of people using statutory daycare facilities, although their role has changed somewhat, for example, provision of short-term respite support. Results from the omnibus survey indicated that 24% of respondents felt that 'a fair amount of improvement' was required with regard to the range of day provision for people with a disability, and a further 22% of respondents stated that 'a lot of improvement' was needed.

Participants at the clinical and voluntary sector workshops and many individuals engaging with the Review focused on the need to shift from a medical model of care and treatment for individuals with physical disabilities, towards a more user-centred care model, which delivers the right care to meet that patient or client's needs. The potential of personalised budgets to improve choice and control was highlighted by many as a means to ensure that the care patients and clients receive meets their particular needs i.e. addresses the question "what would make my life better?"

Direct Payments have been embraced by many people with a physical disability who welcome the greater control they allow. Between September 2007 and September 2010 the number of Direct Payment recipients within the Physical Disability programme of care increased from 312 to 587. Encouraging uptake of Direct Payments has been a target for several years and mechanisms have been put in place to promote uptake and support people with managing their own budgets to purchase services or employ support directly.

While the uptake of Direct Payments is growing, in particular among people with a physical disability, there is potential to grow this and other self-directed support approaches considerably within this group. Feedback from some indicates that bureaucracy is a barrier to uptake of

Direct Payments and a regional approach is needed to tackle this issue and encourage greater uptake.

Set against the endorsement of the forthcoming Physical and Sensory Disability Strategy, the Review proposes the following:

SUMMARY OF KEY PROPOSALS

28. Promoting independence and control for people with a disability, enabling balanced risk-taking.

29. A shift in the role of the health and social care organisations towards being an enabler and information provider.

30. Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a wide range of services across NI.

31. Better recognition of carers' roles as partners in planning and delivering support, and more practical support for carers.

32. More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support where required.

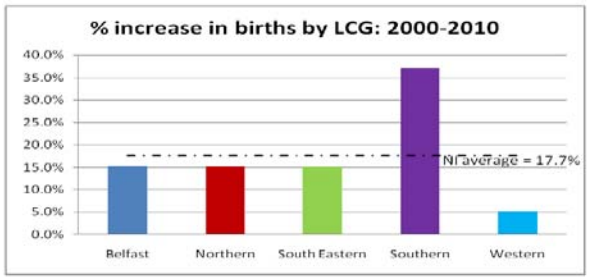
33. More respite and short breaks provision.

11.MATERNITY AND CHILD HEALTH

MATERNITY

The Review is cognisant of the current consultation on Maternity Services[67] and has factored that work into its thinking. In 2010 there were over 25,000 live births registered in Northern Ireland. During the last decade (2000-2010) the birth rate in Northern Ireland has increased by almost 18%. There are significant differences in birth rates across the province, as illustrated in the figure below.

Figure 17: Increase in births by LCG: 2000-2010[68]



Almost all births (99%) took place in hospital, and most mothers (91%) gave birth in their nearest consultant led unit.[69] Less than 1% of mothers are choosing to give birth at home. In recent years the proportion of births to teenage mothers has decreased (5.0% in 2010). Projections indicate that birth rates are likely to decrease over the next decade to approximately 23,500 by 2022/23.

There are a range of consultant led, co-located midwifery led, and freestanding midwifery units in NI. The capacity of the service to provide the recommended level of staffing cover for intra-partum care and to sustain inpatient paediatric services across all existing sites presents challenges, particularly for smaller units.[70]

Maternity care is of a high standard and according to recent surveys, women are happy with the standard of care they receive[71]. However there is increasing potential for variation in the provision of maternity care across Northern Ireland. In addition there are significant inequalities in maternal and infant outcomes, particularly amongst women from socio-economically deprived backgrounds.

The level of caesarean sections is generally higher than in the rest of the UK. There is increasing complexity arising from lifestyle for expectant mothers, most notably the increased rate of obesity, which provide both challenge and risk, across the population. Additionally many

[67] Maternity Strategy for Northern Ireland, September 2011. DHSSPSNI, 2011
[68] NISRA in Health Intelligence briefing Trends in Northern Ireland Births and future projections, Public Health Agency 2011
[69] Births in Northern Ireland (2010), A Statistical Bulletin, Northern Ireland Statistics and Research Agency, March 2011
[70] Draft Commissioning Plan (Health and Social Care Board and the Public Health Agency – June 2011)
[71] Parental Views on Maternity Services. Parents' views on the Review of Maternity Services for Northern Ireland. Patient and Client Council, 2010.

women now choose to start their families later in life.

Challenges for maternity services into the future include:

- give a realistic choice of birth location for women;
- need for more continuity of care throughout pregnancy;
- reducing unnecessary interventions;
- dealing with the public health issues facing women of child bearing age to reduce ill-health and disability of mother and child; and
- supporting the expectant mother in her ante-natal care and connecting that support to the early years of parenthood.

The Review therefore expects change to follow the pattern set out in the forthcoming Maternity Strategy, from pre-conception, through pregnancy, birth and the post-natal period. In addition it recommends a specific regional plan for supporting the small number of mothers with serious psychiatric conditions.

CHILD HEALTH

Child health problems are often diverse in nature, severity and duration. The causes are often multi factorial and sometimes poorly understood. Effective interventions are often complex and time consuming, requiring a range of skills to be tailored to the needs of individual children.

Following the principle of care at or close to home, the Integrated Care Partnerships will be vital. However it was also clear to the Review that communities and the independent sector should be enabled to support families with ill children where appropriate.

When children need hospital care they need prompt access to skilled staff. There are challenges in providing a full range of paediatric sub specialties to a population of 1.8 million. Given this, there is a need to have clear pathways and consequent consistency of treatment.

In this field workforce issues and multiple service locations have the potential to threaten service resilience. Single handed specialties are difficult to sustain unless networked with other centres, whilst scarce skilled resources need carefully managed in the hospital setting. Notwithstanding this, community paediatrics should become a key resource working alongside integrated care partnerships enabling most care to be provided at or closer to home. The Review also saw potential for more formal links to larger centres in the UK or Republic of Ireland for this service area.

During its deliberations the Review team received a strong plea to examine, as a specific task, the nature, function and shape of in-patient paediatric services. The Review was persuaded this merited a separate piece of work. In this regard it also had drawn to its attention the very specific issue of palliative care for children.

Although there is a Children's Strategy for Northern Ireland there is no strategy for child health and no specific arrangements for palliative and end of life care for children. One of the Review proposals is that palliative and end of life care for children should be considered as part of the proposed review of Paediatric Services.

SUMMARY OF KEY PROPOSALS

Maternity

34. Written and oral information for women to enable an informed choice about place of birth.

35. Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.

36. Services in consultant-led obstetric and midwife-led units available dependent on need.

37. Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions.

38. Continuity of care for women throughout the maternity pathway.

39. A regional plan for supporting mothers with serious psychiatric conditions.

Child Health

40. Further development of childhood screening programmes as referenced in the Health and Wellbeing section.

41. Child health included as a component of the Headstart programme referenced in the Family and Childcare section.

42. Promotion of partnership working on children's health and wellbeing matters with other government sectors.

43. Close working between hospital and community paediatricians through Integrated Care Partnerships.

44. Completion of a review of inpatient paediatric care to include palliative and end of life care.

45. Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.

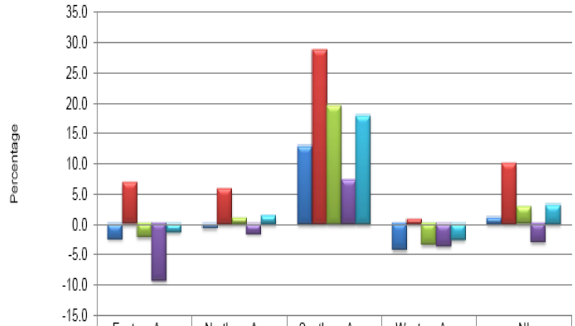
12.FAMILY AND CHILD CARE

INTRODUCTION

Approximately 24% of the Northern Ireland population is aged between 0 and 17 years. Population projections indicate this sector of the Northern Ireland population is set to increase by 3% by 2020.[72]

As the figure below illustrates, percentage increases between geographical areas is variable but the overall increase will bring increasing demands on family support services.

Figure 18: Percentage population change 2008-2023 by Area and Age Band



	Eastern Area	Northern Area	Southern Area	Western Area	NI
0 to 4 Years	-2.4	-0.6	12.8	-4.2	1.0
5 to 9 Years	6.8	5.8	28.7	0.8	10.0
10 to 14 Years	-2.2	0.9	19.6	-3.4	2.8
15 to 17 Years	-9.3	-1.6	7.3	-3.6	-3.0
0 to 17 Years	-1.3	1.3	17.9	-2.5	3.2

Source: NISRA 2008 Population Projections

Between 2005 and 2010 the number of Looked After Children per 1,000 children increased in Northern Ireland, England and Wales. The number of children on the child protection register per 10,000 children aged 0-18 is higher in Northern Ireland than in England, Scotland or Wales. Overall, the number of children on the child protection register has increased between 2006 and 2010 in all regions of the UK.

In 2010 there were 2,606 Looked After Children in Northern Ireland, up by 6% from 2009. The greatest proportion (65%) was in foster care. Between 2005 and 2008 the number of children in foster care decreased. Since then, this figure has increased by almost a quarter (23%) to 1,687. The total number of children on the child protection register has increased by almost 48% from 1,593 in 2005 to 2,357 in 2010.[73]

EARLY INTERVENTION

As discussed in Section 7, early intervention is an important focus in addressing population health and wellbeing.

It has been recognised by a number of independent reviews that, compared to other parts of the UK, there is a significant under investment in children's services

[72] NISRA (2011) Population projections

[73] Social Briefing, Research and Information Service Briefing Paper, Northern Ireland Assembly, 83/11 NIAR 217/11, July 2011.

within Northern Ireland. Society will benefit from a coordinated effort to support and promote positive development of the intellectual, emotional and social skill of young children. There is a major incentive in getting this right. On a practical level, early engagement pays a very high rate of return. The dividend is 12%-16% per year for every £1 of investment – a payback of four or five times the original investment by the time the young person reaches their early twenties and the gains continue to flow throughout their life[74].

Key to this is promoting and supporting positive, engaged parenting particularly in those families where parenting skills are limited.

Children's services are heavily prescribed by legislation and associated guidance and regulations. These services operate within an infrastructure premised on the growth of partnerships which promote inclusivity and collaboration. These partnerships have enabled an increase in capacity and facilitated the improvement of outcomes.

The overarching principle set out within the Childrens (NI) Order 1995[75] that children are best cared for within the family of origin will continue to shape interventions and service delivery. The Review supports the development of advocacy, information services and training in the support of kinship care.

International best practice demonstrates that the health and social care needs of children and young people cannot be addressed by any single agency. A key example of this is the Children and Young People's Strategic partnership, which is a multi agency partnership whose purpose is to put in place integrated planning and commissioning aimed at improving the wellbeing of children in Northern Ireland.

The strategic direction over the past few years has recognised the importance of early intervention. The focus has been heightened through the publication of Families Matter[76], Healthy Child-Healthy Future[77] and the Family Nurse Partnership Initiative. The concept of Family Support Hubs is developing and the Family Support NI database provides an information and signposting resource for families, communities and professionals.

Child and Adolescent Mental Health Services (CAMHS)

The overall direction of Child and Adolescent Mental Health Services (CAHMS) will continue to be shaped by the Bamford Review of Mental Health and

[74] (0-5): How small children make a big difference –The Work Foundation 2007
[75] The Children NI Order 1995, Legislation.gov.uk
[76] Families Matter: Supporting Families in Northern Ireland Regional Family and Parenting Strategy March 2009, DHSSPSNI
[77] Healthy Child, Healthy Future, A framework for the Universal Child Health Promotion Programme in Northern Ireland Pregnancy to 19 Years. DHSSPSNI, May 2010

Learning Disability. The needs of children with a disability remain a priority for commissioners and providers alike.

A Review of CAMHS in Northern Ireland was published in 2011 by the Regulation and Quality Improvement Authority[78]. A number of work streams are underway which will address many of that report's recommendations:

- progressing the Bamford Action Plan 2009;
- a review of Tier 4 services; and
- the appointment of a Commissioner for CAMHS.

Overall it is clear that child and adolescent services are continually improving and developing. However there is much work to do to develop and improve services further. It is estimated that to fully implement the RQIA recommendations may cost around £2million per annum. In the current financial climate this will require a prioritised approach.

Residential care

Approximately 11% of Looked After Children are in residential care. A number of issues have been identified:

- there is an increasing complexity of needs being presented by young people particularly in relation to mental health, drug and alcohol abuse, sexually harmful/vulnerable behaviours and criminality;
- it is difficult to provide flexible residential accommodation to meet the needs of a small number of young people; and
- young people aged 16+ are being excluded from their homes/ community as result of difficult behaviours.

Families

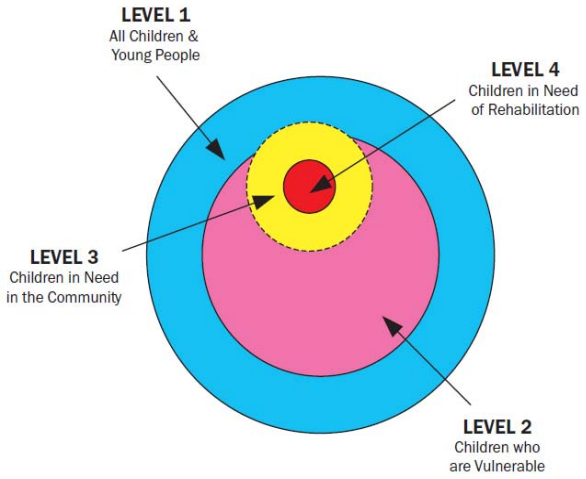
Families Matter: Supporting Families in Northern Ireland (Regional Family and Parenting Strategy 2009) moves parents into a central position in policy terms and strives to provide strategic direction on how best to assist parents in Northern Ireland to be confident and responsible in helping their children to reach their potential.

The wider vision of family support has been articulated in the Northern Ireland Family Support Model, which enables a 'whole system' approach to service planning. Its focus is on early intervention, ensuring that appropriate assistance is available to families at the earliest opportunity at all levels of need.

This model details four levels of need: all children and young people; children who are vulnerable; children who are in need and looked after children, illustrated in the figure below.

[78] RQIA Independent Review of Child and Adolescent Mental Health Services (CAMHS) in Northern Ireland February 2011.

Figure 19: Northern Ireland Family Support Model[79]



It is widely acknowledged that early intervention produces positive dividends for children and families. The learning and experience from the Sure Start model which targets "children who will benefit most" and other similar initiatives here and elsewhere needs to be understood and extended where benefit can be demonstrated.

[79] Families Matter: Supporting Families in Northern Ireland, Regional Family and Parenting Strategy. DHSSPS 2009

The Review acknowledges and endorses the streamlining and improving processes in regard to Children's Services as being taken forward through the Children's Services Improvement Board and Review on Co-operating to Safeguard Children. In addition the Review also makes the recommendations below.

SUMMARY OF KEY PROPOSALS

46. Re-structuring of existing services to develop a new 'Headstart' programme focusing on 0-5 year olds.

47. Exploration through pilot arrangements of budgetary integration for services to this group across Departments, under the auspices of the Child and Young People's Strategic partnership.

48. Completion of a review of residential care to minimise its necessity.

49. Promotion of foster care both within and outwith families.

50. Development of a professional foster scheme for those hardest to place.

51. Implementation of the RQIA recommendations in relation to CAMHS.

52. Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS services.

13. PEOPLE USING MENTAL HEALTH SERVICES

INTRODUCTION

Northern Ireland has higher mental health needs than other parts of the United Kingdom.[80] Based on the Northern Ireland Health and Social Wellbeing Survey (2001), 24% of women and 17% of men in Northern Ireland have a mental health problem – over 20% higher than the rates in England or Scotland.

Factors contributing to these rates include persistent levels of deprivation in some communities in Northern Ireland and the legacy of Northern Ireland's troubled history. For example, a recent study of the families of victims of Bloody Sunday found persistent effects of these traumatic events on the individuals concerned, with evidence of psychological distress still being found more than 30 years after the event.[81]

The incidence of suicide in Northern Ireland has been a particular concern in recent years. Suicide rates increased by 64% between 1999 and 2008, mostly as a result of the rise in suicides among young men. In 2008, 77% of all suicides were males and 72% were 15-34.

The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The Bamford Review, which completed its work in 2007, has set the agenda for the transformation of these services. The Review heard nothing which challenged Bamford but did hear frustration at the speed of implementation.

Although there is frustration there is also progress with actions that lay the foundations for modernising and improving services, for example the development of new strategies and agreeing new models of care for particular conditions. However, it remains the case that tangible services on the ground are the touchstone by which those using the service judge its success.

---

[80] DHSSPS (2004) The Review of Mental Health and Learning Disability (Northern Ireland). A Strategic Framework for Adult Mental Health Services. Consultation Report.

[81] McGuigan, K., & Shevlin, M. (2010). Longitudinal changes in posttraumatic stress in relation to political violence (Bloody Sunday). Traumatology, 16, 1–6

PROMOTION AND EARLY INTERVENTION

Raising awareness of mental health issues and reducing the stigma associated with mental ill-health continues to be a key objective of the reform and modernisation programme. In terms of primary prevention, a suicide prevention strategy Protect Life[82] was launched in 2006 and is currently being refreshed. A new five-year Mental Health and Wellbeing Strategy is being developed to support the whole population to maintain good mental health. The Review endorses these actions.

The Royal College of Psychiatrists' submission to the Review highlights that early intervention in psychoses can be effective and emerging evidence supports a similar approach for depression and anxiety. It therefore encourages development of a system capable of early intervention. The Stepped Care model (see figure below) promotes early intervention at the first stages of mental illness and the Psychological Therapies Strategy made recommendations as to how people with mild to moderate mental health problems could access psychological support. However, lack of investment has constrained the implementation of this strategy and feedback during the review suggested concern with the level of provision at Tiers 1 and 2.

Access to information about mental health services was raised by several of those with whom the Review engaged, including the Bamford Monitoring Group and registered social care workers. The Bamford Action Plan included plans to map available services and provide this information to service users, but progress has been slow in this regard. Users and carers told the Review how important it is to be able to easily access information on services that meet their particular needs.

PROVIDING THE RIGHT CARE IN THE RIGHT PLACE AT THE RIGHT TIME

The model of mental health care has evolved which promotes greater care at home and in the community rather than in hospital. A stepped care approach has been adopted, providing a graduated range of care to meet the patient's needs:

Figure 20: Stepped Care Model

[82] Protect Life, A Shared Vision – The NI Suicide Prevention Strategy and Action Plan 2006-2011, DHSSPS

Each of the HSC Trusts has developed Crisis Response and Home Treatment models that provide services for acutely ill people at home and in the community rather than in psychiatric hospitals. The role, number and location of psychiatric inpatient units are also changing and Trusts are developing streamlined pathways for urgent mental health care.

However, these services have evolved differently in each area in terms of how people in crisis contact services, how they are triaged (by phone or in person at a hospital or other facility) and how they are treated in emergency departments. Whilst the Review acknowledges that there will be solutions for local areas, there is now a need to ensure that there is a consistent outcome for those who use the service. Additional home treatment services are still to be developed for particular client groups including children and young people, people with a learning disability and older people.

Despite the shift underway in care provision from the hospital to community setting, the Review noted that the objective to shift expenditure to a ratio of 60% community and 40% hospital has not yet been achieved.

PROMOTING INDEPENDENCE AND PERSONALISATION OF CARE

At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives. The Review strongly endorses this approach.

The voluntary and community sector plays a crucial role in providing the diverse range of support that may be needed. Recognising this, the Review recommends greater involvement of these organisations in planning provision for local populations. It also acknowledges this will be a challenge in some parts of the independent sector.

Provision of Direct Payments is one approach to support personalisation of care. However, among people with mental health issues, the uptake of Direct Payments has been lower than among other groups. At May 2011, a total of 81 people were in receipt of Direct Payments. The Review was told that perceived bureaucracy and inconsistent promotion of Direct Payments have been constraining factors.

A regional approach should be implemented to promote the uptake of Direct Payments among mental health service users including involvement of current recipients to share their experiences, and the provision of

advocacy and support where needed should be considered. As a minimum, clear information on the financial package available should be given to those using the service.

INSTITUTIONAL CARE

A critical element in changing how things are done for this client group is to end long-term residency of people in mental health and learning disability hospitals. To date, 181 long-stay mental health patients have been discharged to the community. There are currently 150 long stay psychiatric inpatients who should be resettled into the community.

The model designed by the Review makes it clear that care should be provided at home or as close to home as possible. Fresh impetus into delivering the closure of long stay institutional care is required.

The Review urges an absolute commitment to completing the resettlement process by 2015 as planned, and ensuring that the required community services are in place to prevent the emergence of a new long-stay population. This should include developing models of treatment for children and young people, and those with specialist mental health needs, for example in the areas of learning disability and psychiatry of old age.

Attempts to shift the balance of spend between hospital and community expenditure should continue with reinvestment of any savings achieved in the hospital setting into community services.

The proposals below are set in the context of making tangible changes for mental health service users and their families and assessing the impact of that change on quality of life.

SUMMARY OF KEY PROPOSALS

53. Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.

54. Establishment of a programme of early intervention to promote mental health wellbeing.

55. Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.

56. A consistent, evidence-based pathway through the four step model provided across the region.

57. A consistent pathway for urgent mental health care including how people in crisis contact services, triage and facilities in emergency departments.

58. Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.

59. Further shift of the balance of spend between hospital and community, with reinvestment of any hospital savings into community services.

60. Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.

61. Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.

62. Close long stay institutions and complete resettlement by 2015.

14.PEOPLE WITH A LEARNING DISABILITY

INTRODUCTION

A learning disability is a lifelong condition and requires long-term support. Provision of services for people with a learning disability requires a multi-agency and integrated approach – it is not solely a health issue. The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland.

In regards to this care programme the Review heard nothing which challenged Bamford, but as with mental health services, did hear frustration at the speed of implementation. Despite this frustration there is progress, with actions being completed that lay the foundations for further change, for example, the development of new strategies and agreeing new models of care. Ultimately though, those who are supported judge it by changes to services on the ground. In this regard the Review heard of the need for more rapid progress.

EARLY INTERVENTION AND PROMOTION

The importance of early years intervention to support positive life outcomes was highlighted throughout the Review's engagements with the public, clinicians and others. While children with a learning disability and their families may be able to avail of early years support this is variable across the region. Consistent with the proposals set out in Section 12 on Family and Childcare, the Review considers that early years support for children with a learning disability should be part of a coherent and consistent programme of support for 0-5 year olds.

Many learning disabilities have associated physical health conditions, for example complex mobility or personal care needs, whilst the rates of early onset dementia are much higher among those with Down's Syndrome than among the general population. Evidence was presented to the Review on the challenges for people with a learning disability in accessing the full range of healthcare provision enjoyed by the general population. In particular, accessing health services such as occupational therapy, physiotherapy and speech and language therapy was highlighted as being important. People with a learning disability also identified a need for disability awareness training for clinical staff in the community who do not always deal appropriately with them, for example, not providing enough time and not speaking directly to the disabled person. The Review considered improvement in this area as fundamental.

Programmes are in place in each population area to enhance access to

primary healthcare services for people with a disability including annual healthchecks and employment of health facilitators in the community. The Review endorsed this approach but was clear that a consistent outcome for all is important. In this regard it was made aware of particular problems in accessing Dentistry.

As services are planned Integrated Care Partnerships should be asked to ensure that clinicians are facilitated to respond more appropriately to the needs of people with a learning disability.

PROMOTING INDEPENDENCE AND PERSONALISATION

Promoting independence and personalisation is a key principle underpinning the model proposed by the Review. Feedback provided to the Review indicates that achieving this objective for people with a learning disability will require particular focus on the following areas:

- Day services - the diversity and age-appropriate nature of day services remains an issue for people with a learning disability. While there has been progress made in reforming the day centre-based model and providing more community based options, there is further work to be done in this regard. A one size fits all service will be less relevant in the future;
- Respite and short breaks - provision has increased but service users and carers indicate that much remains to be done to meet current needs. Services are frequently accommodation based. While these are important more flexibility in the home or local day placement should be explored. Respite care is not always age appropriate, for example, respite provision in nursing homes primarily for older people has limits. New models need to be created;
- Direct Payments – the number of people with a learning disability taking up Direct Payments has increased from 218 in June 2008 to 561 at May 2011 but the Review heard that service users and carers need more information and support with Direct Payments. Sharing the experiences of current recipients is recommended, along with provision of advocacy and support where needed. As a minimum clarity about the financial commitment should be available;
- Information – in general, users and carers consider it remains difficult to access information on the services available for people with a learning disability. Information on housing options was highlighted as an issue. Many carers are also unaware of their right to a carer's assessment and access to support to meet their physical and emotional needs; and
- Advocacy – people with a learning disability expressed the need for peer and independent advocacy to support

them in making decisions and protecting their rights.

The Review considered voluntary and community sector organisations have a crucial role in providing support to people with a learning disability. In some instances these are organised and run by parent groups. This should be supported.

INSTITUTIONAL CARE

A critical element in changing the model of care and support for people with a learning disability is to end long-term residency in hospitals. Since 2008, 642 long-stay learning disability patients have been discharged to the community. There are currently around 200 long-stay inpatients in learning disability hospitals who should be resettled into the community.

The majority of learning disability services are already provided in the community as opposed to hospitals. The ratio of spend is 82% in the community to 18% in hospital. New community facilities are being developed for assessment and treatment for people with a learning disability which will support the resettlement programme. The Northern Ireland Housing Executive's Supporting People Programme also plays an essential role in developing a range of supported living options in the community for people with a learning disability. Supporting People has enabled 23,000 people (including both mental health and learning disability service users) to live independently.

The proposals below are set in the context of making tangible changes for people with a learning disability and their families and assessing the impact of that change on quality of life.

SUMMARY OF KEY PROPOSALS

63. Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)

64. Further development of the current enhanced health services on a Northern Ireland basis.

65. Support from Integrated Care Partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.

66. Better planning for dental services should be undertaken.

67. Further development of a more diverse range of age-appropriate day support and respite and short-break services.

68. Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.

69. Development of information resources for people with a learning disability to support access to required services.

70. Advocacy and support for people with a learning disability, including peer and independent advocacy.

71. Commitment to closing long stay institutions and to completing the resettlement process by 2015.

15.ACUTE CARE

Acute care is often perceived as synonymous with hospitals. However it also includes elements of primary care such as Out of Hours. This part of the report comments upon:

- unscheduled care;
- planned care;
- ambulatory care and diagnostics; and
- regional services.

UNSCHEDULED CARE

Unscheduled care includes such services as accident and emergency, emergency surgery, intensive care, coronary care, stroke services, urgent care and medical admissions. Trauma and orthopaedic services are integral to emergency care.

Ambulatory care, where patients can walk in and walk out on the same day can also be unscheduled care.

The Review does not propose to extensively define each component of service but considers it prudent to share its thinking about urgent care, emergency departments or A&E services. Three broad levels exist:

- Major trauma, which is dealt with regionally;
- Emergency intervention most commonly associated with the 999 ambulance service; and
- Urgent care/ Out of Hours care where a difficulty exists but it does not initially present as life threatening and includes minor injuries.

Unscheduled care is currently delivered via 10 Accident and Emergency Departments (9 of which are 24/7 consultant led), 8 Minor Injuries Units and 19 GP Out of Hours facilities and supported by the NI Ambulance Service.

Evidence suggests the system is increasingly not fit for purpose in the 21st century.

For example the HSC is failing to deliver acceptable A&E waiting times of 95% of patients waiting no more than 4 hours and no patients waiting for more than 12 hours. Overall, performance against these standards has been poor other than in the Southern Trust, both in relation to the 12-hour and four hour standards. Regionally, there were 7,386 breaches of the 12-hour standard in 2010/11 (compared to 3,883 during 2009/10) and cumulatively only 82% of patients were treated and discharged, or admitted within 4 hours of their arrival in A&E during 2010/11.

As discussed in the Case for Change, the Royal College of Surgeons' evidence is that better organised care equals better outcomes for the patient.

New treatments and associated technology for stroke and coronary care are a challenge to deliver in the existing model. Maintaining the supporting infrastructure necessary for high dependency or intensive care in our current model also presents a challenge. Additionally difficulties in retaining appropriately trained staff creates sustainability issues and remains a frequent challenge.

Organisational resilience is a recurrent problem. Each year the current model cannot appropriately staff its A&E service with all of the quality and financial issues that flow from this.

The public in a different way expresses similar problems:

- 91% of the people involved in the omnibus survey felt that improvement was needed to the time spent waiting in A&E, of which 56% stated that a lot of improvement is needed.
- 68% of people surveyed in the Omnibus survey agreed or strongly agreed that they would be prepared to travel a further distance for hospital services if it means they don't have to wait as long. There was no significant difference in the response from people from an urban area (67%) compared to those in a rural area (70%).

EMERGENCY SERVICES

Proximity to acute facilities is often perceived as the determining factor as to whether the local health and social care service will adequately provide for their needs. Increasingly, however, it is not only the distance to the appropriate facility that may determine outcome for the patient, but also the timeliness of the initial intervention.

For example, a person with a stroke needs to get access to the staff and technology to diagnose the stroke as quickly as possible, as explained:

Best Practice Guidance - Stroke Care

Evidence shows that people with an ischaemic stroke who receive thrombolytic treatment within 3 hours of onset are more than twice as likely to have favourable outcomes (such as reduced disability and lower mortality rates) after three months.[83] However, this treatment would harm people with haemorrhagic stroke. Therefore, it is essential that suspected stroke patients are transferred directly to an acute setting with the staff with appropriate skills and access to diagnostics which will allow accurate diagnosis (and therefore appropriate treatment) as quickly as possible.

[83] Best Practice in Stroke Care 2007, Buchan, A (sourced from Healthcare for London: A Framework for Action report

The Omnibus survey showed that 70% of people surveyed agreed or strongly agreed that they would be prepared to travel a further distance for hospital services if it means they get the best treatment and 71% agreed or strongly agreed that ambulance staff should take seriously ill people to a hospital with the specialist services they need even if it is not the closest hospital.

The Rural Trauma Outcome Study in Scotland[84] showed that longer pre-hospital travel times did not increase mortality or length of stay.

The omnibus survey also highlighted the fact that the majority of the public are aware of where to attend in a number of circumstances, for example 74% of people said that they would attend the GP Out of Hours service if they had a child with a high temperature after 10pm.

However, it appears that the public do not actually attend the most appropriate setting for their needs. Of the activity recorded within the accident and emergency departments across NI, 50% of these are for conditions rated as standard cases without immediate danger or distress (Category 4 based on the Manchester Triage Categories). It can be assumed that a large proportion of these cases could be cared for in an urgent care setting without the need to attend an accident and emergency department.

Furthermore, for less common emergencies it is essential to maintain the required skills to enable the best patient outcome.

A model of care has been set out which delivers best outcomes to patients with major trauma and ensures a resilient service for the population of NI.

Regional Trauma Service

Major Trauma is the single biggest potential cause of death of people under 35 years of age. Due to the relatively small population of Northern Ireland (circa 1.8m) and the low incidence of major trauma cases (approximately 0.02% of the total population per annum), it is impractical to equip and staff all hospitals to the required level to provide optimal care for patients with major trauma.

The DHSSPS has recommended that the Royal Victoria Hospital becomes a regional trauma centre acting as the hub of the NI trauma network. Protocol dictates that patients should be transferred to the Royal Victoria Hospital directly, provided they are able to withstand the journey. If a patient is not able, they will be taken to the nearest major acute hospital within the network with the intention of transferring them to the Royal Victoria Hospital when they are able. Staff employed at the acute hospitals within the network receive appropriate training to maintain their skills.

This Review concluded that a similar model could be considered for other

[84] Scottish Urban v Rural Trauma Outcome Study, J Trauma September 2005

emergency conditions which do not present in sufficient numbers for services to be maintained at all acute sites.

The result of networking services will be a model which includes a major acute hospital supported by a network of hospitals providing services to meet the needs of the local population. There are ten acute hospitals in Northern Ireland. In Great Britain populations of 1.8million are supported by maybe only four large hospitals. The Review accepted that by 2016/7 the model of major acute hospitals for Northern Ireland's more dispersed population will reconfigure to a more appropriate scale.

This will mean change at several of the current acute hospital sites, and the Review recommends that the key test for any future service configuration must be that it is sustainable and resilient in clinical terms. We recommend that each Local Commissioning Group should draw up specific proposals, taking account of the potential to provide service to the ROI. The Review's view is that it is only likely to be possible to provide resilient sustainable major acute services on five to seven sites, assuming that the Belfast Trust hospitals are regarded as one network of major acute services.

The Role of the Northern Ireland Ambulance Service

The role of the NIAS will be key in ensuring that people are treated in the right place at the right time. Patients should be transferred to the correct location first time where possible, to avoid further transfers at a later stage. It will be important that the NIAS can transfer people not only to Accident and Emergency Departments but also to Urgent Care Centres, Minor Injuries Units or GP Out of Hours. Bypass protocols will be required which clearly define which location patients should be transferred to for each type of condition.

Better management of unscheduled care in partnership between the HSC Trusts and the NIAS offers potential for improving care, patient flows efficiency and patient satisfaction.

Alongside all of this, it will be essential that the public are provided with information about the correct procedures in an emergency.

Quality of Outcome

Quality of outcomes requires that senior clinical decision makers are available at all accident and emergency departments 24/7/365. The model will be capable of delivering this outcome.

For the model to be successful it will need the support of urgent care centres, minor injuries units and GP in and Out of Hours services.

Delivering this model will require clinicians to be networked as one workforce pool for its population to ensure that training and good organisational opportunities are available to deliver a safe, high quality service.

URGENT CARE SERVICES

The clinical advances that result in a more specialised workforce create tension between local accessibility of urgent care services and the need to provide high quality services in acute hospital settings.

The current model includes a small number of Minor Injuries Units and GP Out of Hours to support Accident and Emergency Departments. Given the high volume of attendances at A&E which are Category 4[85] and below, there is potential to do things differently and achieve consistent outcomes. Accident and Emergency Departments can and should be supported more locally through an integrated urgent care model.

The urgent care model is not a 'one size fits all' approach. It is an approach which looks at the needs of the local people and tailors the provision to meet their urgent care needs. This model could, for example, look very different for an urban area compared to a remote rural area. Urgent care should be available on a 24/7/365 basis, including some on-call arrangements where necessary. The services to be provided to a population would be minor injuries, specialist nurses trained in urgent care, urgent care GPs, specialist teams such as mental health crisis response teams and urgent care social workers. The key is that these services are delivered in an integrated fashion.

These services will be supported by diagnostics available in the local community and the ability for GPs to directly admit patients into beds where necessary. Many of these services, other than beds, could all be available within a health and care centre setting, like the Health and Care Centre at Holywood Arches for example.

GP Out of Hours services are currently available for urgent care outside of the normal GP practice opening hours.

GP Out of Hours services should work as an integrated model of care with other urgent care services. A good local example of this working in practice is Downpatrick Hospital. In the UK the Shropshire approach has merit, as outlined below.

[85] Cases without immediate danger or distress, Manchester Triage

Good Practice Example

Shropshire Doctors Co-operative Ltd (Shropdoc) provides urgent medical services for patients when their own surgery is closed and whose needs cannot safely wait until the surgery is next open, i.e. evenings, weekends and bank holidays.

The service also supported Out of Hours nursing arrangements. Shropdoc doctors carried 'Rapid Response Boxes' for palliative care, catheterisation, resuscitation, syringe drivers and controlled drugs and therefore undertook much of the night-time care that might otherwise have been referred to district nurses or resulted in patients being admitted.

Shropdoc also ran the Care Coordination Centre. This provided a single point of access for GPs to other services between 8am and 6pm and included physiotherapy triage for some referrals.

This model has been working well and has the potential further to develop.

CLEAR PROTOCOLS FOR THE POINT OF CONTACT FOR EMERGENCY AND URGENT CARE

There is evidence that the options available to the public in dealing with emergency and urgent cases are limited or not well known. As outlined above, it is important that people are referred to the place that is best suited to meet their medical needs. This will require clear communication with the public as to the types of facilities available, where they are located and under what circumstances they should be used.

To allow this, it will be important that the public can get access to the right advice at the right time. At present this is through the 999 emergency telephone number. The introduction of an urgent number to work alongside the emergency 999 number would allow people to talk to a trained professional who will be able to advise them on the best route for them, be that to an Accident and Emergency Department, an Urgent Care Centre, Minor Injuries Unit, GP Out of Hours service or to wait for a GP appointment the following day. The NIAS will play a pivotal role in managing unscheduled care into the future.

Dedicated Care pathways should be developed for children and people with long term conditions that will allow direct contact with a trained team available to support them in an emergency or when requiring urgent care. This should involve the ability to directly admit these patients to beds hospitals.

PLANNED CARE

INTRODUCTION

Planned or Elective care includes inpatient admissions which happen with prior planning, sometimes at relatively short notice. Often these services cover major treatments or interventions, for example cancer surgery, diagnostics, testing to assist diagnosis, for example blood tests or X-ray and planned ambulatory care, where patients can walk in and walk out on the same day.

Planned care is currently delivered largely from our 10 acute hospitals, 5 local hospitals and a number of community hospitals. There are approximately 6,646 (average 2010/11) hospital inpatient beds in NI (3,683 acute beds and 2,963 non acute beds).

Increasing demand has evidenced itself through rising numbers of inpatient Finished Consultant Episodes. This reflects the increasing subspecialisation as well as absolute demand.

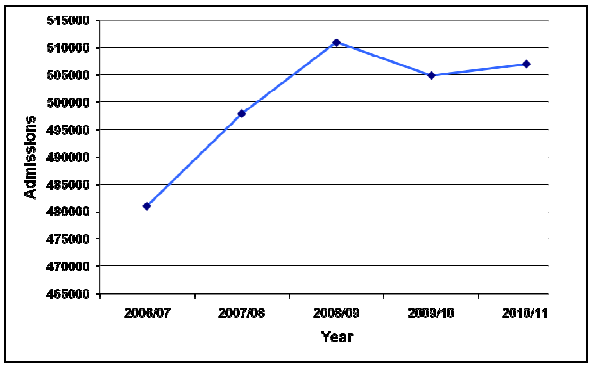
Some changes to service patterns have occurred, for example in cancer and urology, to improve outcomes. Whilst the role of some hospitals has also changed, more is required. However such change cannot happen without recognition of the impact on our current model. Partial change simply pressurises the existing system.

As stated in the Case for Change for both planned and emergency inpatient stays the length of stay is above UK levels.

During 2010/11, a total of 1,502,611 patients were seen at consultant led outpatient services within HSC hospitals in Northern Ireland.

The Total Admissions to HSC Hospitals in Northern Ireland under the Acute Programme of Care are shown in the figure below.

Figure 21: Acute Admissions



Source: DHSSPS Hospital Statistics

Our daycase rates are lower than they should be at 64% (2010/11) compared to the target of 75%. This means that the service is over reliant on inpatient beds when carrying out the procedures which could be carried out as a daycase.

The current target determines that at least 50% of inpatients and daycases are treated within 13 weeks and that all cases are treated within 36 weeks. At present, the current system is failing to meet these targets. Concern about increasing waiting times was highlighted as one of the

People's Priorities by the Patient and Client Council.

In the future planned care will be treating more older people. Planned care needs to be organised separately from emergency care. It gives better patient outcomes and enhances productivity. The Review therefore wishes to see better organisation of planned care.

Where there are planned specialist treatments, which are highly specialised, they will need to continue to be provided in one centre in Northern Ireland or via an agreement with a tertiary centre elsewhere (e.g. GB or ROI).

Diagnostics is an integral part of planned care. It assists the diagnosis of illness, for example blood tests, X-ray, MRI scans etc. These services are currently delivered within major acute hospitals and health and care centres. The review of Pathology Services in NI recommended there should be a managed clinical network for pathology. The Review strongly reinforces the expeditious implementation of this recommendation.

The current target determines that no patient waits longer than 9 weeks for a diagnostic test. In 2010/11 there were 23,518 breaches of this target.

Given all of this, it is impossible not to come to the conclusion that change needs to happen to improve outcomes for patients.

CARE CLOSER TO HOME

Evidence[86] shows that separating emergency and planned care improves outcomes in terms of continuity of care for patients, improved training for staff and faster access to senior opinion. The organisation of planned care should be clinically led and supported by the appropriate infrastructure.

Inpatient Activity

Key to the delivery of effective services is to ensure that people are given the right care in the right place at the right time. For planned care this means ensuring that people who need to be seen urgently are done so, that people who can wait do and that they are seen within a reasonable period of time.

Better organisation of planned services was supported by the Omnibus Survey which highlighted the following:

- waiting times for an appointment with hospital consultant: 82% felt some improvement is required, including 36% who felt that a lot of improvement was required; and

[86] Separating Emergency and Elective Care: Recommendations for Practice, The Royal College of Surgeons of England, March 2007.

Delivering surgical services: Options for maximising resources. The Royal College of Surgeons of England, March 2007.

- waiting times for on emergency operations: 88% felt some improvement was required including 36% who felt that a lot of improvement is required.

In supporting the principle that care should be closer to home it will be important to ensure that referrals to acute hospitals and inpatient beds are for sound medical reasons.

Similarly when people are admitted as an inpatient, appropriate discharge protocols must be in place to ensure timely discharge.

This can be supported by multi-disciplinary teams in the community and the availability of intermediate care (care between home and hospital), including step-up and step-down facilities.

Outpatient and Diagnostics

Evidence suggests that GPs and nurses could carry out a proportion of outpatient appointments without the need for a consultant appointment. The location of these types of appointments does not need to be in an acute setting.

The National Primary Care Research and Development Centre[87] identified a number of approaches which resulted in effectively reducing demand for specialist outpatient treatment without impacting on quality or safety. These included primary care clinics for chronic diseases; discharging hospital outpatients to no follow up (patient initiated follow up only); and direct access by GPs to hospital-based diagnostic tests, investigations and treatments.

Case Study

In NHS Stracathro hospital in Scotland acute medical services are being concentrated in larger hospitals that have a full range of support services and technology. Smaller hospitals were reconfigured to provide a wider range of other services including: the management of chronic illness, community rehabilitation, provision of diagnostics and therapy and more local outpatient clinics delivered more locally than ever. The relatively small number of patients who require specialist inpatient treatment are managed in acute hospitals capable of meeting quality and safety standards.

A large proportion of diagnostics could be carried out within facilities closer to people's home. Diagnostics should be available alongside GP practices with the ability for GPs to directly refer patients.

Day cases where possible

Advances in surgical and medical techniques have meant that more procedures can be done as day cases. The Review recommends a better organised response to making sure the individual is referred to the most appropriate location for the best outcome.

[87] Can Primary Care reform reduce demand on hospital outpatient departments? (March 2007)

The HSC should continue to work towards the 75% rates of day cases for surgical procedures for the basket of 24 procedures. This will assist the move away from inpatient care unless medically necessary.

While there is a strong argument for locally accessible services and care closer to home, this cannot be at the cost of quality and safety. There is recognition than any transfer of services must maintain the levels of both quality and safety.

HOSPITAL NETWORKS

To ensure good patient outcomes no hospital in the future can work other than as part of a network.

In order to provide complex healthcare safely and allow professionals to keep their skills and knowledge up to date they need to treat sufficient volumes of patients with particular conditions. Safe treatments are therefore difficult to deliver at every hospital because there are not enough patients to maintain the skills of the professionals.

Networks should be established to ensure that accessible and safe services are available to all citizens. For common conditions there will be sufficient demand to allow those services to be delivered as locally as possible, either through local hospitals or community facilities. For less common conditions, there will be a need to centralise services on major acute sites to ensure that a resilient workforce is available to support that service.

Planned services provided in hospitals should be organised to meet the needs of that population.

No facility or department should operate as a standalone unit. Professionals should work in networks across hospitals and Trusts to deliver the best care to the patient by working together. This can also help to sustain local services with staff in local hospitals networking with larger acute hospitals, or through provision of nurse-led facilities supported by appropriate medical backup and working with effective transfer protocols for patients requiring acute medical care.

Care Pathways

Care pathways are an important route map for how people will experience treatment and are clinically led.

While there has been some progress in developing tailored care pathways for specific conditions and to address the issue of resilience in the service, there needs to be more consistency of approach across the region to ensure the best quality care is provided, the service is resilient and sustainable and that people are treated in the right place at the right time.

Specialist Provision

The Review has already offered its thinking on the implications of the overall population size of 1.8million for sustaining

the viability of specialist hospital services. Consequently this leads to vulnerable services which are difficult to attract staff to work in and if not effectively networked have the potential for poorer outcomes.

The sustainability of these services will best be delivered through networking with other tertiary centres, either in GB or ROI. This allows for consultants to gain the sufficient experience required and allows for multi-disciplinary team discussions on patients. Networks already exist for paediatric cardiac surgery (with the ROI), adult intensive care, cancer and pathology services.

The HSC sent 336 patients to hospitals in GB and ROI in the 6 months to September 2011 to be treated. Where services are so specialist the HSC cannot deliver these in NI, either in isolation or within a network. These types of specialist services will continue to be sent to specialist tertiary centres either in GB and ROI.

The Review recommends the development of joint planning arrangements with colleagues in the Republic of Ireland. In the first instance this would look at:

- shared opportunities in tertiary and specialist care,
- procurement,
- services in the New Hospital in the South West, and
- services which straddle the Border areas.

This would include a regular planning interface between the two jurisdictions to ensure areas of mutual interest are explored. These arrangements would be in addition to Co-operation and Working Together (CAWT), the existing partnership between the Health and Social Care Services in Northern Ireland and ROI, which facilitates cross border collaborative working in health and social care.

TECHNOLOGY

Technology will be a major enabler of networked working and care closer to home.

Investigations and treatment have become much more sophisticated requiring 24-hour access to increasingly complex technology – CT (Computerised Tomography) and MRI (Magnetic Resonance Imagery), sophisticated blood tests etc.

Technology will be required to support the changes in delivery of unscheduled care. Technology will allow all parts of the HSC to be linked in, allowing them to share live information on patients regardless of their location.

There is emerging evidence of the potential for telemedicine to support timely and appropriate inter-hospital transfer as well as better networking between hospitals. Some examples are shown below.

Example of Technology Working in the HSC

The Southern Trust currently operates a tele-dermatology service in which a specialist nurse sees the patient in an outreach clinic with a consultant remotely verifying the skin condition (via a high resolution photograph of the skin condition electronically sent to their location) and providing guidance on the most appropriate nurse or doctor-led pathway for the patient to follow.

The opportunities for technology to support the new model of care are explored further in the Implications section of this report.

CONCLUSION

All of this leads to a conclusion doing nothing is not an option and that planned and organised change is essential to achieve the following objectives:

- Right Care, Right Place, Right Time, Right Outcome;
- Organising Sustainable Inpatient Care;
- Improving Diagnostics;
- Engaging Primary Care;
- Creating a Sustainable Service;
- Being responsive to the public;
- Balancing local and central demand with quality and safety; and
- Providing clear information to the public about how to access services.

SUMMARY OF KEY PROPOSALS

72. Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document.

73. Over time, move to a likely position of five to seven major acute hospital networks in Northern Ireland.

74. Ensure urgent care provision is locally available to each population.

75. Set targets for the reduction of hospital admissions for long-term admissions and end of life care.

76. Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.

77. Ensure the transition takes full account of Service Frameworks and clinical pathways.

78. Expeditious implementation of a managed clinical network for pathology.

79. Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.

16. PALLIATIVE AND END OF LIFE CARE

INTRODUCTION

Palliative and end of life care is an important service in our system, expressing the essence of the values of the NHS. Palliative Care is defined as: "the active, holistic care of patients with advanced progressive illness". End of life care is a component of palliative care.

The Review heard no reason to challenge the Northern Ireland Palliative Care Strategy 'Living Matters, Dying Matters'[88], outlines an approach to improve the quality of palliative and end of life care for adults in Northern Ireland, irrespective of condition.

Approximately 15,000 people die in Northern Ireland each year. The main causes of death are circulatory diseases (35%), cancer related deaths (26%) and respiratory diseases (14%). Over two thirds of deaths occur in hospitals and nursing homes. The death rates in NI are falling and improving life expectancy means that the population of Northern Ireland is becoming 'older'. The profile of older people requiring care is becoming more complex, with many people now living with multiple chronic illnesses. Recent predictions suggest that one third of people over the age of 65 will be living alone by 2020.

Given that the prevalence of chronic conditions and dementia increases with age, demand for palliative and end of life care services is likely to increase.

As a society we need to have open and honest discussions with all age groups about the processes of dying, death and bereavement. We also need to understand the significance of planning ahead to avoid having to react in a crisis as well as planning for a death with dignity. Using some of the questions outlined in models such as in the Gold Standards model[89] can enable increased awareness and preparedness. We need to increase our understanding of when the palliative care phase ends and the end of life phase begins. These phases can move backwards and forwards and it may be difficult to determine when someone is dying. This can assist people in coming to terms with death and dying including the aspiration of planning for a good death.

Although the Palliative Care approach has traditionally been used for people mainly with a cancer diagnosis, it is applicable to other causes of death. The Review heard of a recognised inequity of access to palliative care for non cancer patients. General palliative care is delivered by a range of professional staff in primary, hospital and community settings.

[88] Living Matters Dying Matters – A Palliative and End of Life Strategy for Adults in Northern Ireland - DHSSPS March 2010

[89] Gold Standards Framework

Specialist palliative care including complex psychosocial, end of life and bereavement issues is provided within HSC and by voluntary sector organisations that make a valuable contribution in this area of care.

It is estimated that two thirds of all deaths in Northern Ireland (9,570) would benefit from the palliative care approach in the last year of life, but do not receive it. 20,000 bed days are used in NI for people dying in hospital from cancer conditions alone. There is currently no strategy that directly addresses the palliative and end of life needs of children.

We correctly invest a large volume of resource in the last year of life, but often provide poor quality which does not meet patient and carer wishes. The Review concluded it can be improved with greater coordination of care in order to ensure that people die with dignity.

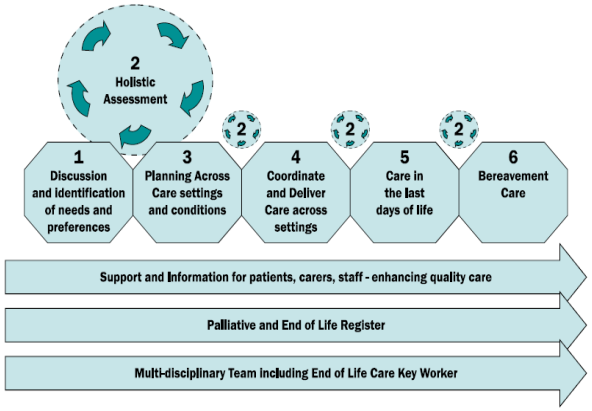
We also know that many more people than currently do would prefer to die at home. At the same time there are too many unnecessary, unwanted and costly end of life hospital admissions. We need to shift more care to the community where it can be more appropriately delivered.

Nursing homes are increasingly becoming the place where older people live and die with shorter average lengths of stay between 18-24 months. Complexity and higher dependency levels within nursing homes have implications for staff development to meet residents' end of life needs.

Frontline staff in general often lack training in delivering end of life care. There is a need to improve education and training for those providing palliative and end of life care.

The Review supports the model[90] below illustrating a continuous, holistic assessment of palliative and end of life care, co-ordinated by a key worker.

Figure 22: Palliative and End of Life Model



[90] Living Matters, Dying Matters, An End of Life Care Strategy for Adults in Northern Ireland, DHSSPSNI, March 2010.

SUMMARY OF KEY PROPOSALS

80. Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.

81. Enhanced support to the Nursing Home Sector for end of life care.

82. Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.

83. Electronic patient records in place for the patient, their family and staff.

84. Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.

85. Palliative and end of life care for children considered as part of the proposed review of Paediatric Services as referenced in the Maternity and Child Health section.

IMPLICATIONS FOR THE SERVICE

17.IMPLICATIONS FOR THE SERVICE

The changing model of care which moves care as close to home as possible, will only work if the way in which we deliver services also changes.

With a change in the model of care delivered by hospitals, the support required to deliver services in the community and at home, there will be a shift of services that will impact on the type of facilities which we require and the workforce that will deliver the service.

This section sets out an overview of the guiding criteria to be used when considering the new model of service delivery:

- infrastructure;
- technology;
- workforce; and
- resources.

INFRASTRUCTURE

CARE AT HOME

As has been outlined in the sections above, there will be a major shift to care delivered within people's homes, throughout people's lives, whether it be management of long term conditions, support to people with mental health or learning disabilities or end of life care.

In some cases people's homes are nursing homes or residential facilities.

The care delivered to individuals in these facilities should enable residents to remain in the facility provided their needs can be met there. The package of care will be based on personal needs, not based on location.

Personalised budgets will encourage diversity of service. Where there is reluctance to take charge through personalised budgets, advocacy and clear information on the financial implications of any assessment will promote this outcome.

An overview of the services that will be delivered in the home, through Integrated Care Partnerships, is as follows.

Services in your home
Access to specialist teams for long term conditions will be developed
Support for Specialist care for cancer
Rehabilitation services
Domiciliary Care, including home nursing
End of Life Care
Access to a range of support services for example daycare or respite
Health and Wellbeing support for vulnerable groups
Enabling good outcomes for those using the service - for older people this is best described as the reablement model. In mental health, the recovery model and in child care, the rescue model.

CARE IN THE LOCAL COMMUNITY

People will have access to a greater package of services within the community.

Services will be focused on the needs of the local population. Local planning will ensure that services are delivered that meet their needs and work towards tackling health inequalities, for example multidisciplinary teams to deliver a package of care to someone with a long term condition or more than one condition.

The types of services that will be delivered within the community, through Integrated Care Partnerships, will include:

Services in your local community
GPs with enhanced services
Pharmacy
24/7 Urgent Care including GP, mental health crisis response and minor procedures
Outpatients
Diagnostics
Access to therapy and rehabilitation
Social support
Links to Voluntary and community organisations to support care
Advocacy services
Antenatal and postnatal care
Health and Wellbeing Advice
Optometry
Dentistry
Cross Departmental working groups to support social needs
Beds used for step-up/ step-down from hospital managed by GPs
Support to carers
Re-ablement

Our 353 GP practices will work within networks based on the already established 17 Primary Care Partnerships. These should be on a formal basis as 'federations of practices'. This should result in GPs working together in a consistent manner.

The GPs currently within Primary Care Partnerships will form part of the Integrated Care Partnership along with representatives from other HSC bodies, as outlined above. Consideration should be given to the potential for these ICPs to form the basis for a multidisciplinary mutual organisation or to have social firm status.

Pharmacy will deliver an enhanced role in medicines management and health promotion to the local community and will be part of the multidisciplinary team supporting individuals with complex needs.

The ambulance service will have the ability to transfer patients to urgent care settings rather than defaulting to a major acute hospital if this is the most appropriate type of care required for the

patient. The ambulance service will also be able to refer patients back to their GPs if they do not see the need to transfer the patient to other services such as urgent care or emergency care.

The focus of care will be reablement where possible. Support at home will be: increased availability of respite care; step up and step down beds between home and hospital; and rehabilitation beds. This will be supported by outpatients services, diagnostics and minor interventions being available closer to home.

The current decline in the demand for residential care homes will continue. In NI, we also have a higher use of supported accommodation than the rest of the UK. This trend is also likely to continue leading to a major reshape of this service.

People who require 24 hour nursing will be cared for within nursing homes.

The move away from residential care provision towards care at home will require a joined up approach to service delivery between the Department for Social Development and DHSSPS.

There will also be a move of dental services closer to home. For example, oral surgery can be carried out within the community at dental practices rather than within a hospital setting as is often the case.

The pathway for referral to hospital optometry services from practices has led to unintended high volumes of referrals. Clinical protocols for direct referral should be considered.

HOSPITAL SERVICES

Introduction

In the future hospitals will work as a system with each facility contributing to the provision of a total service to its population.

The Review is aware that there will be a considerable interest in the current hospital sites and their future role. However, as has been indicated early in the report, the final functionality of each of the facilities will be based on population need and the principles set out above.

The Review recommends that the commissioning system using its local communities should bring forward proposals for hospital services for each of the five populations by June 2012.

Evidence presented to the Review persuaded it that local populations and in particular professionals should design the way forward rather than impose a top down approach of specifying a function for each hospital.

In accepting this approach it wishes to make clear that there will be, as a consequence, change on all sites over a five year period. With change of this magnitude, the system and those working within it must enable, not disable, the change process. The following clearly articulates **what** should be provided. The **how** is for those working in the system.

Hospital Services

All current hospitals will have an integral role in the delivery of services to their localities. They will be essential in contributing to what a local population requires from a hospital service.

The Review is not prescriptive about the service configuration in these facilities but it is expected to include the following profile of services.

Services in your hospital
Urgent Care – doctor led assessment
Out of Hours – GP led
Elective Surgery – daycase and selective inpatient
Inpatient medical care on the basis of agreed pathways designed between primary and secondary doctors
Rehabilitation
Diagnostics
Midwife Led Obstetrics, where feasible based on demand

Hospitals will be networked with the GPs/ GPSIs and staff from the major acute centres. The preferred route for treatment is at home or within the community. Where people cannot be cared for in their own homes or within their community, they will be referred to hospital. Decisions on where to admit will be determined by clinical protocols and designed to ensure the best outcome for the patient.

Hospitals will be expected to separate elective surgical procedures from emergency procedures so that the system of care leads to better clinical outcomes and productivity, without one detrimentally affecting the other.

Patients may also be transferred within the network depending upon clinical need.

Major Acute Hospitals Services

Major acute hospitals provide care and treatment that requires centralisation to ensure that services are delivered by senior staff and that those services are resilient to demand pressures and provide the best outcomes for patients.

Each major acute hospital service must be capable of delivering and sustaining the following profile of services.

Services
24/7 Emergency Department
Emergency Surgery available 24/7
Complex Elective Surgery
Some non-complex elective surgery
Undifferentiated inpatient Medicine, e.g. coronary care and stroke
Paediatrics (Inpatient) available 24/7
Critical care available 24/7
Specialist Diagnostics available 24/7
Outpatients
Consultant led obstetrics
Midwife Led Unit, where appropriate

Since resilience is essential to the provision of hospital services, critical clinical staff will be employed to work in the hospital system and be a resource for

each population working as necessary across hospital services and facilities.

Where inpatient provision is currently regional, such as cardiac surgery or sub regional, such as urology, clear clinical pathways which ensure equal access to populations will be required.

Specialist Services

Specialist hospitals will continue to deliver specialist services to the population of Northern Ireland including complex medicine, complex surgery and the associated outpatients service.

These services will be networked as necessary with ROI and GB to ensure that the highest quality services are delivered and that the staff are well trained and experienced.

Supra-Regional Services

Services which have such a low volume that they cannot be sustained to a high quality in NI, even without networking to other tertiary centres, should continue to be delivered outside of Northern Ireland. These include for example transplantations and rare disease management.

The Northern Ireland Perspective

The Review recognises that the future model must take into consideration the Northern Ireland dynamic. Given the rural nature of the West, and its close links to the ROI, the new model will require two major acute facilities in the West. The ROI has expressly indicated it wishes to maximise the opportunity for its population in the new hospital in the West.

Altnagelvin and Belfast hospitals have already well established working arrangements with ROI around some of its services which will continue.

There is currently a level of use of Daisy Hill Hospital by residents of the north east region of ROI. The future configuration of major acute services in Newry will be impacted upon by the potential demand for services from the ROI.

Conclusion

As a consequence of re-profiling services in this way there will be change on all existing sites.

The Review anticipates a major restructuring of how services are

delivered by our current hospitals. As previously described, for NI this is likely to mean between five and seven major acute hospital facilities or networks.

The Review also wishes to make clear that maintaining an 'as is' model cannot be successful in delivering against the key principles or the guidelines already described. Furthermore, systems which are overly reliant on locum and agency staff are not acceptable.

Impact on the Northern Ireland Ambulance Service

The role of the NIAS is of central importance to the ability to deliver the new model of care. The NIAS has been going through some major changes in modernising its service to meet the needs of the HSC in the 21st century. This modernisation is planned to continue. The plans of the NIAS will support the implementation of the Review, in particular:

- supporting the new care pathways for unscheduled, in particular urgent care;
- training of NIAS paramedic staff to support the model;
- provision of an alternative to the 999 emergency number and availability of medically trained staff to triage patients to the most appropriate service;
- supporting the focus on prevention and wellbeing through information and advice; and
- continuing to support the move of care closer to home through diagnosis and treatment of minor illnesses and injuries in the community.

The NIAS will be involved in the planning and implementation process following the Review, alongside the representatives from across health and social care.

TECHNOLOGY

Technology is a key enabler of the delivery of the new model of care, in particular in supporting care closer to home and the ability of staff to work as an effective integrated multi-disciplinary team.

A forum should be established to take forward how technology will support the new model of care linking the service to industry and academia to ensure the optimum and best value for money solutions are taken forward and opportunities are identified and considered. Where appropriate, development of technological support will be through a collaboration approach with the Department of Enterprise, Trade and Investment (DETI) in line with the Memorandum of Understanding agreed between the Minister for Health, Social Services and Public Safety and the Minister for Enterprise, Trade and Investment.

The plans for technology to support the new model will come in the form of regional projects as well as technology solutions that will support the delivery of

services to meet the specific needs of patients in a certain area. The population based planning approach will include plans for the use of technology to support how the model of care is delivered for that population.

Availability of Information at the Point of Care Delivery

Today, records are kept in all the places where you receive care. These places can usually only share information from your records by letter, email, fax or phone. At times, this can slow down treatment and sometimes information can be hard to access.

By making more health records electronic, there will be quicker ways to get important information to HSC healthcare staff treating patients, including in an emergency

Electronic Care Records (ECR) can be used to allow the sharing of information between the many systems currently used to store information across the HSC. This would result in all information held on each patient being available together through the use of the ECR platform.

An ECR pilot is currently underway. This has involved sharing of information within a Trust (i.e. acute, community and primary care information). The Review endorses the roll out of ECR across Northern Ireland with the ultimate aim of sharing information, not just within a Trust, but also across Trusts such that the service will provide an individual electronic care record for every patient in NI. Any patient could then attend any facility across NI and the health records and information will be available.

Information sources will include:

- GP records;
- Community Information Systems (also see below);
- pharmacy records (medicines management); and
- hospital records, including results of diagnostic tests.

Mobility of Staff

Mobile working by community staff allows for better use of resources.

With the shift of care into the community, consideration should be given to the merits of mobile technology to support staff working in the community.

The National Mobile Health Worker Project findings were that mobile devices loaded with office and clinical software allowed clinicians working within the community to make nearly 9% fewer referrals and avoid 21% of admissions.

GP Records

The Review also endorses the approach of developing a data warehouse for GP records in order to deliver information which is of a high quality and consistent across practices resulting in reduced variation and a safe and secure method of storing and sharing patient information.

The data warehouse will protect the confidentiality of patients and will provide timely, anonymised patient-based data and information for purposes other than direct clinical care, including:

- planning and commissioning;
- public health and research;
- clinical audit and governance;
- benchmarking; and
- performance improvement.

Data would be routinely extracted from GP systems and loaded into the data warehouse. The data warehouse would be used by staff at Trust, HSCB and DHSSPS levels. Access to the data would be strictly controlled and where necessary the data would be anonymised. Each "type" of user would have access only to the data for which they have authorised access.

Supporting People to Self-Manage their Care

Technology should be harnessed to support patients in managing their own care through, for example:

- supporting patient education;
- direct patient monitoring and support (telemedicine);
- clinical information and management systems; and
- promoting healthy living and disease prevention.

Telemedicine can be used to provide care closer to home such that the patient does not need to be in a hospital to receive care.

Connected Health

Connected Health is used to describe a model for healthcare delivery that uses technology to provide healthcare remotely. It provides a strategic opportunity for a different business model of procuring and delivering care around the needs of the patient. Through the use of technology patients are able to monitor their own condition, within the parameters set by their GP, thereby enabling them to take greater responsibility for managing their own health and well being. This should lead to a reduced need for patients to visit their GP Practices for monitoring of their condition. Variations to their clinical condition will be monitored remotely and they can be triaged to the relevant area of the health service as appropriate to their need at that time. This will result in patients visiting their GPs about their condition only when they need to and will lead to more appropriate and timely referrals to secondary care.

Connected Health sits well with government health strategies at many levels. It supports patient choice by allowing patients to remain within their own homes with effective self-management. It also supports the move of services from secondary to primary care settings and the ability to deliver a more cost effective, better quality service.

Supporting the principle of Right Care, Right Place, Right Time

One contact number for urgent care will allow triage of patients and ensure that they are directed to the best place of care as discussed in the NIAS section below.

A single robust community information system is required to support the increase in care to be delivered within the community.

WORKFORCE

The new model of service delivery requires a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated, integrated and at home or close to home.

New care model – Workforce implications

Some of the key implications include:

- more people will receive care in their own home, or close to home; which is more integrated with hospital clinicians working closely with GPs and other community staff to plan care delivery, along with increased clinical support provided in the home;
- multi professional community integrated teams will form the essential nucleus of health and social care professionals supporting patients in their own homes;
- increasing use of networks to coordinate care and share good practice and greater emphasis on partnership working within and across sectors; and
- the need to accelerate the pace of change.

The proposed changes will require staff to develop different skills and capacities. For example, GPs with Special Interests in emergency medicine or paediatrics, specialist long-term condition nurses and emergency care practitioners. It is likely that there will be more overlap and networking between services, and it is proposed that there will be an increase in outpatient follow-up appointments being carried out by GPs and nurses. Furthermore there is potential to explore new and extended roles as part of future care provision including the potential to introduce further multi-skilling alongside the use of assistive technologies to maintain older people in their homes.

Role change

Our expectations for what it means to be a health and social care professional are changing. They go beyond clinical practice itself, precisely because high quality care is delivered by a team in a system, not alone in a vacuum. To reach its full potential health and social care needs to harness the skills of professionals working together in making decisions in the clinical arena and bringing that expert judgement to bear on difficult resource and management

decisions that impact on patients. Patients, the public and staff expect to see visible leaders making the case for those changes to services which evidence shows will improve patient care.

We need to be clear about what HSC organisations expect and need from tomorrow's clinicians and managers. Workforce planning and development is a critical building block in ensuring that staff are appropriately trained and confident in their roles. In light of the range of external factors likely to impact on health and social care our workforce planning needs to focus on demand signals from the local health economy and patients/ clients rather than just supply side inputs; linked to service planning and needs and underpinned by financial plans making it more robust and linked to patient needs. There needs to be close working between all education and training providers and the HSC to ensure continued high quality of education and training, based on service needs.

Extending GP leadership: Using the building block of Clinical Leads recently appointed to lead the recently formed PCPs, we need to identify and develop GPs will assume a critical leadership role in the new Integrated Care Partnerships. Clarity around roles and expectations will be critical to ensure they are able to engage with twin challenges of professional and management responsibilities.

Resilience

The ability to deliver good outcomes to patients is inextricably linked to workforce and in particular the medical workforce. In recent years the allocation of junior doctors has been problematic. Two matters are pertinent, access to good training and individual choice about workplace. Both will remain into the future. Failure to take full account of this has created many problems for the current model. It is likely that workforce availability over the next 3 years will be numerically less than required for the existing model but much more importantly the training experience that the current model provides, and ultimately the quality of outcome for patients, means that continuation of the current model is unsustainable. Any attempt to sustain the current model would simply flounder.

Engagement with staff organisations

Within the HSC a process of active engagement has been developed over a period of time, incorporating not only regular consultation on matters of concern to both HSC organisations and the staff representatives, but also partnership working on issues of joint concern to the service and the members they represent. It is vital that we remain committed to ongoing, close working with staff organisations and their representatives going forward.

NIAS

The Ambulance Service is a key part of the new service delivery model. Training

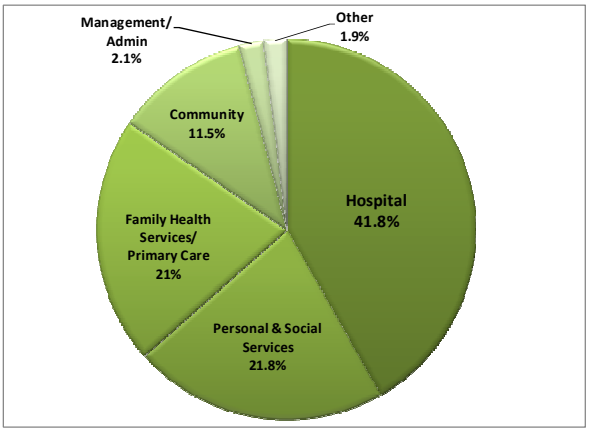
of ambulance staff in the new model and best location of care will be required as well as ensuring that bypass protocols are in place.

RESOURCES

Revenue Budget

The current revenue budget for DHSSPS in 2011/12 is £4,383million. The Health and Social Care element is £3,904million and is split as follows:

Figure 23: Current HSC Revenue Budget, 2011/12

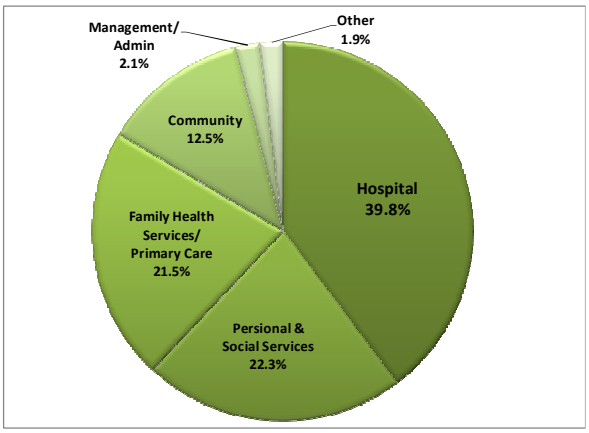


To allow the implementation of the new model of care the funding available for HSC services will be re-allocated. There will be a shift of care from hospital settings into the community. Some of the key changes that will be seen in the community will be:

- more care delivered in the home;
- changing care packages for people in nursing homes;
- increased role of the GP;
- increased role of Pharmacy in medicines management and prevention;
- a strong focus on prevention;
- increased use of community and social care services to meet people's needs; and
- outreach of acute services into the community.

The revenue budget for DHSSPS in 2014/15 is £4,659million. The Health and Social Care element is £4,150million. The projected allocation, applying the new model, is illustrated in the figure below.

Figure 24: Projected Allocation of HSC Revenue Budget, 2014/15



The impact on investment of the potential redistribution of the budget is illustrated in the figure overleaf and is as follows:

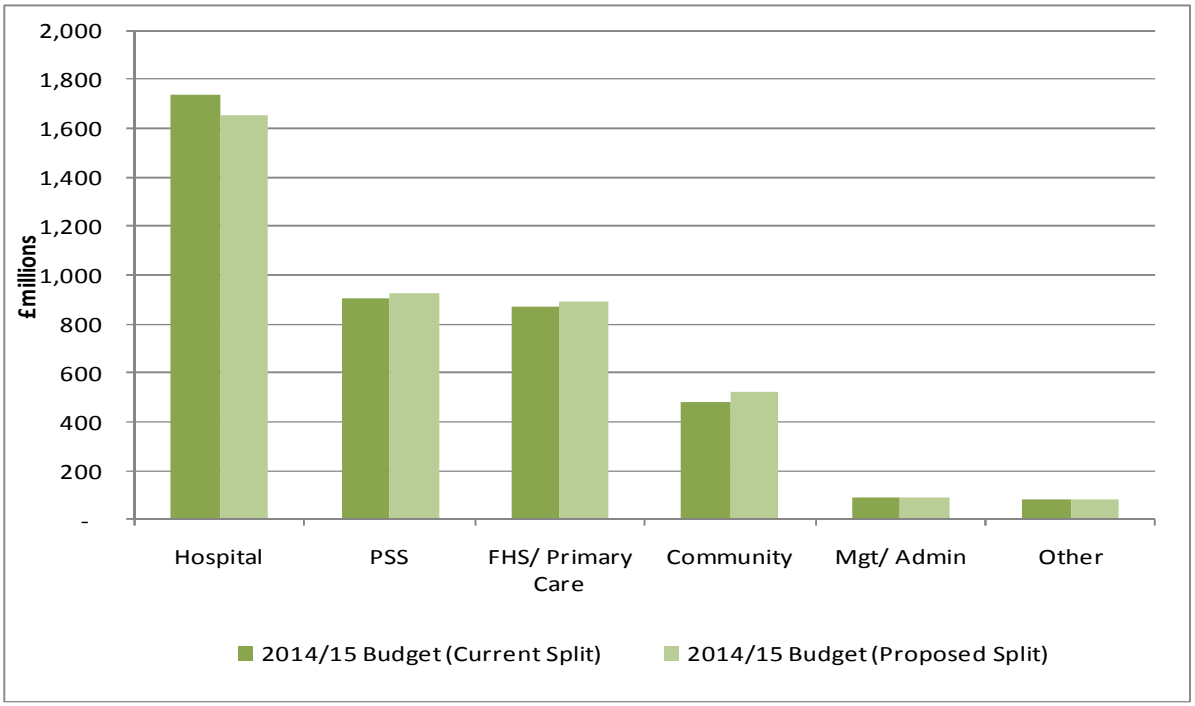
- reduction of the budget in hospital services, from £1,733million to £1,650million. This represents a £83million reduction, equating to 5% of the hospital services budget;

- increase in Personal and Social Services (PSS), from £903million to £924million. This represents a £21million increase, equating to a 2% increase in the PSS budget;
- increase in Family Health Services and Primary Care Services, from £871million to £892million. This represents a £21million increase, equating to a 3% increase in the FHS budget; and
- increase in Community Services, from £477million to £518million. This represents a £41million increase, equating to a 9% in the Community Services budget.

A shift of care from hospital settings into the community reflects the principles, as outline in section 5, by which the Local Commissioning Groups will develop their population plans. The re-allocation of resource, illustrated in figures 23 and 24 is indicative; however it does reflect the anticipated level of change required to effect the change.

Consideration will also need to be given to the capital investment required to enable the change process to occur.

Figure 25: Projected Allocation of HSC Revenue Budget, 2014/15



TRANSITION AND IMPLEMENTATION

This change will not be straight forward. It will require fundamental changes to the way we deliver services and will require substantial re-training of staff.

In addition it is estimated that transitional funding of approximately £25million in the first year; £25million in the second year; and £20 million in the third year will be required to enable the new model of service to be implemented.

We recommend this should be invested in:

- Integrated Care Partnerships, with a focus on older people and long term conditions;
- service changes; and
- voluntary early release scheme.

It is anticipated that after 2014/15 the model would be self-financing.

The principles for implementation are set out in section 18 overleaf. Detailed implementation plans will be developed following this review to reflect the complexity of changes required.

Income Generation

Often a parallel is drawn with other UK regions in regards to NI. Citizens contrast availability of services elsewhere with those that they have access to. This is sharply focused when there is discussion about income generation. Other regions have access to resources from charging which is not available in NI. The Review does not offer an opinion on how this should be addressed but would state there are no neutral decisions.

While income generation was not a matter for the Review, there needs to be a sensible debate about growing income within the spirit of the NHS principles. The Review recommends that this debate commences in NI in 4 areas:

- Non-emergency transport – for example car parking for visitors and staff and travel to day centres;
- Domiciliary care – DHSSPS has never applied the ability to charge for domiciliary care in the home;
- Prescriptions – consideration of a contribution towards the cost of prescriptions; and
- Social Bonds and their ability to support more diversity in community service provision.

The Review would wish to restate that it is not supportive of any move away from core NHS principles.

SUMMARY OF KEY PROPOSALS

86. Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.

87. Development of population plans for each of the five LCG populations by June 2012.

88. Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/AHPs, and social care.

89. Development of clear patient pathways for networked and regional services.

90. Establishment of a forum to take forward how technology will support the new model of care linking the service to industry and academia.

91. Full rollout of the Electronic Care Record programme.

92. Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.

93. Introduction of a single telephone number for urgent care.

94. Introduction of a single robust community information system.

95. Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home.

96. Development of GPs to assume a critical leadership role in the new integrated care teams.

97. More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.

98. Re-allocation of resources estimated to equate to a 4% shift of funds from hospitals into the community.

99. Initiation of a sensible debate about growing income within the spirit of the NHS principles.

ROADMAP FOR THE FUTURE

18.ROADMAP FOR THE FUTURE

Key to the successful delivery of the new model is a clearly defined roadmap for the future which sets out the steps needed to move from the current model of care to the new model of care. It is essential that a clear direction of travel is set out. This should be in the form of a clear implementation and engagement plan. The engagement plan will be an essential tool in setting out how the changes will affect users, families and staff. To support the implementation clear governance and reporting arrangements must be established. An answer to the 'who's in charge' question must be clear and accountabilities easily understood by all.

This section sets out a proposed response to this challenge. It comments upon governance arrangements for the programme, presents an approach to create an implementation plan and identifies the key actions and milestones for implementation of the recommendations of the Review. Additionally it describes a plan for engagement with staff and users. The Review recommends that detailed implementation and engagement plans are developed and published by June 2012 following this Review, as illustrated below.

In addition, the Review recommends paying particular attention to achieving sign off from the 17 Integrated Care Partnerships, NIMDTA and the NI Ambulance Service when the Local Commissioning Groups put forward the models for their population.

Figure 26: Population Planning Process

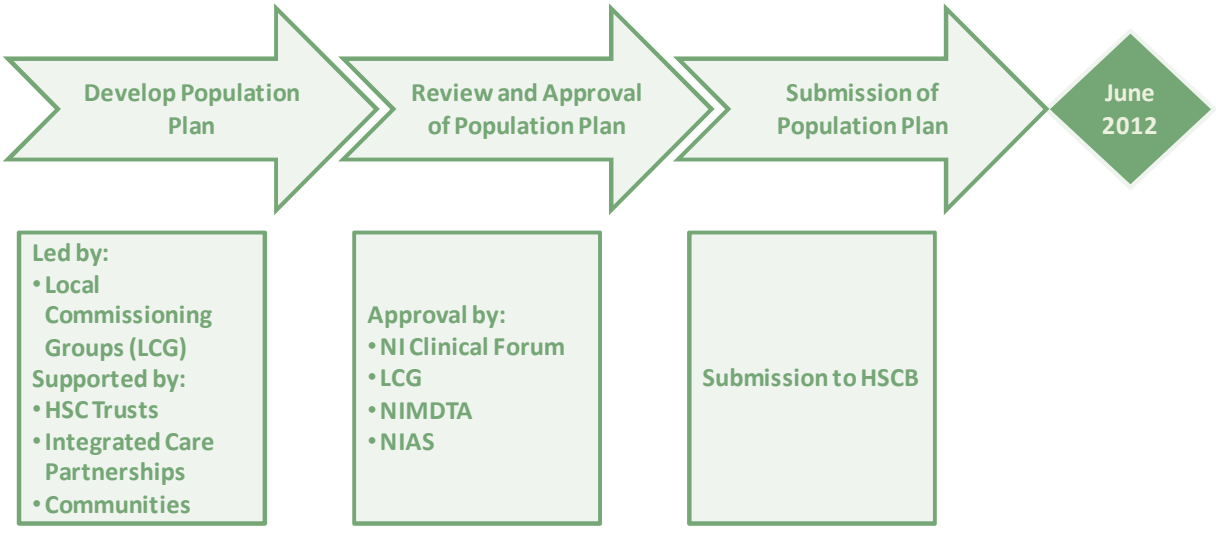
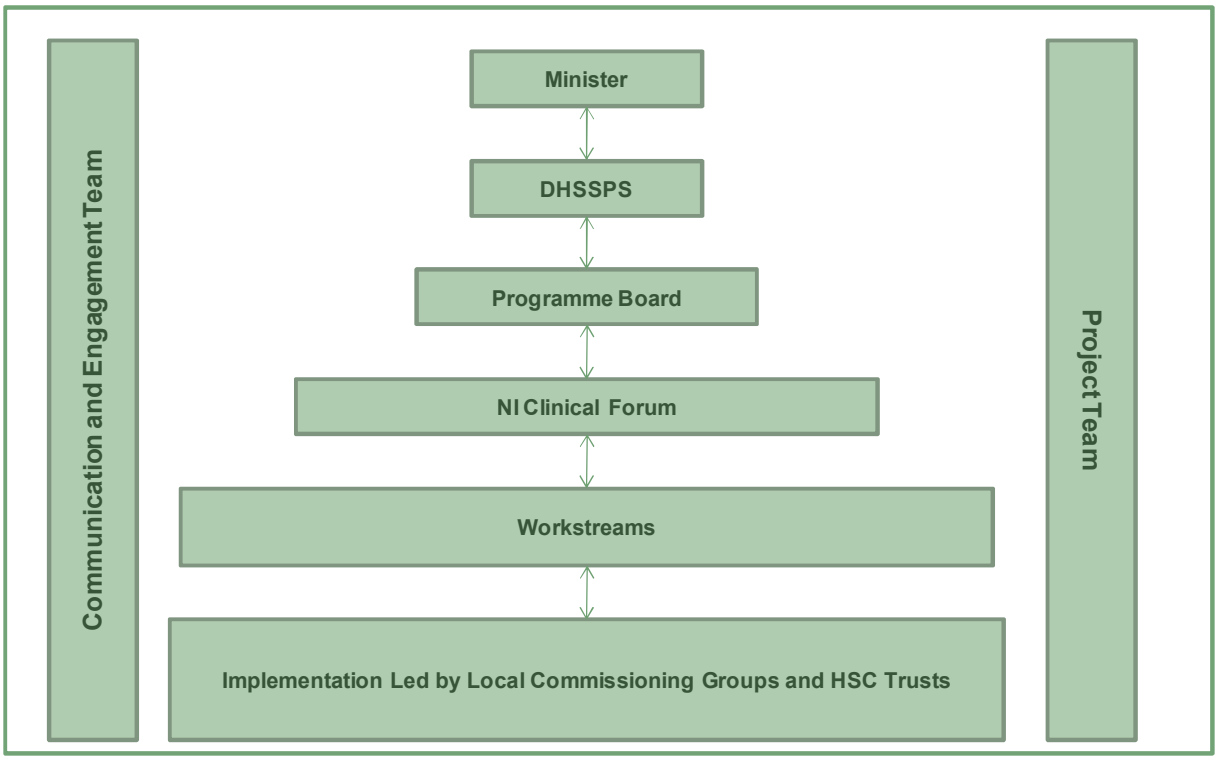


Figure 27: Programme Structure



The programme of change will be led by the Minister for Health, Social Services and Public Safety. A Programme Board will be set up to report to the DHSSPS and Minister on the implementation of the Review. The Programme Board will be supported by the Northern Ireland Clinical Forum, a project team and workstream leads. The roles of each of the bodies included in the programme will be as follows.

Minister for Health, Social Services and Public Safety

The Minister is responsible for the roll out of the programme of change. The Minister will approve all major decisions about service changes, policy or legislation. The Programme Board will report to the Minister on progress of the implementation through the DHSSPS.

DHSSPS

The DHSSPS will advise the Minister on extant policy or new policy and will support the Minister in making decisions relating to the programme of change. In addition, the DHSSPS will ensure close collaboration with the Programme Board as it discharges its responsibilities.

Programme Board

The Programme Board will be chaired by the HSCB and made up of representatives from the HSCB and HSC Trusts. The Programme Board will be responsible for steering the implementation using the commissioning process. It will also be responsible for reporting to DHSSPS and the Minister on progress.

NI Clinical Forum

A NI Clinical Forum will be established in 2012 to provide strong professional advice to the Programme Board and give robust clinical advice in taking forward the changes. Additionally the Patient and Client Council will be invited to describe how best to ensure users and carers are engaged.

Workstreams

A number of workstreams will be set up for each area that is seen as key to leading the implementation. These workstreams will lead the implementation of the agreed plans for each population. They will report to the Programme Board on the progress under each workstream.

Delivery

The actual implementation of the changes agreed will be taken forward as a joint approach between commissioners and providers. The Local Commissioning Groups will work with the HSC Trusts and other providers in taking forward the plans. The LCGs will report to the Programme Board on the progress of the implementation.

Project Support

The Programme Board will be supported by a Project Team. The Project Team will use Project and Programme Management principles to monitor the progress of the implementation of the programme of change based on the plans approved by the Programme Board, the DHSSPS and the Minister. The Project Team will report directly to the Programme Board on the progress. The tools used to monitor progress will include:

- detailed Project Plan;
- key responsibilities for taking forward actions and associated timescales;
- actions and milestones;
- targets for measuring success; and
- development and management of project risks.

Communication and Engagement

The delivery of the programme will rely greatly on the ability to successfully communicate changes to the public and

staff working in the HSC as well as successfully engaging with these groups and achieving their buy-in to the process. This will require communication and engagement support from a team with experience in taking forward major change programmes.

The suggested structure of the programme is shown in Figure 18 overleaf.

These arrangements should be in fully place by June 2012 to support the roll out of the population plans submitted at that time.

IMPLEMENTATION PLAN

A detailed implementation plan overleaf will be required to take forward the project. This will be based on population plans. Each of the population areas, led by Local Commissioning Groups, will be expected to produce population plans by the end of June 2012.

The figure overleaf sets out the high level actions associated with the recommendations of this Review.

The Review team acknowledge that many of the recommendations require policy change, as well as necessary equality, human rights and rurality impact assessments. In addition a number may also require legislative change to enable implementation. These will be taken forward in the implementation process.

ENGAGEMENT PLAN

The implementation of this programme of change is much more likely to deliver sustained transformational change through commitment than through compliance.

An engagement plan will be a key tool in taking forward the programme. The engagement plan will include:

- identification of the key stakeholders to be consulted with;
- how the stakeholders will be engaged with; and
- plan for engaging with stakeholders.

Stakeholders to be engaged with will include representatives from DHSSPS, HSC Board, HSC Trusts, Voluntary and Community Sector organisations, users and carers.

Stakeholders are expected to be engaged through a number of approaches, both targeted to specific stakeholders and those which are stakeholder wide. This will be via a number of methods which may include already established forums, workshops or one to one meetings.

Regular updates on engagement should be reported to the Programme Board.

COMMUNICATION PLAN

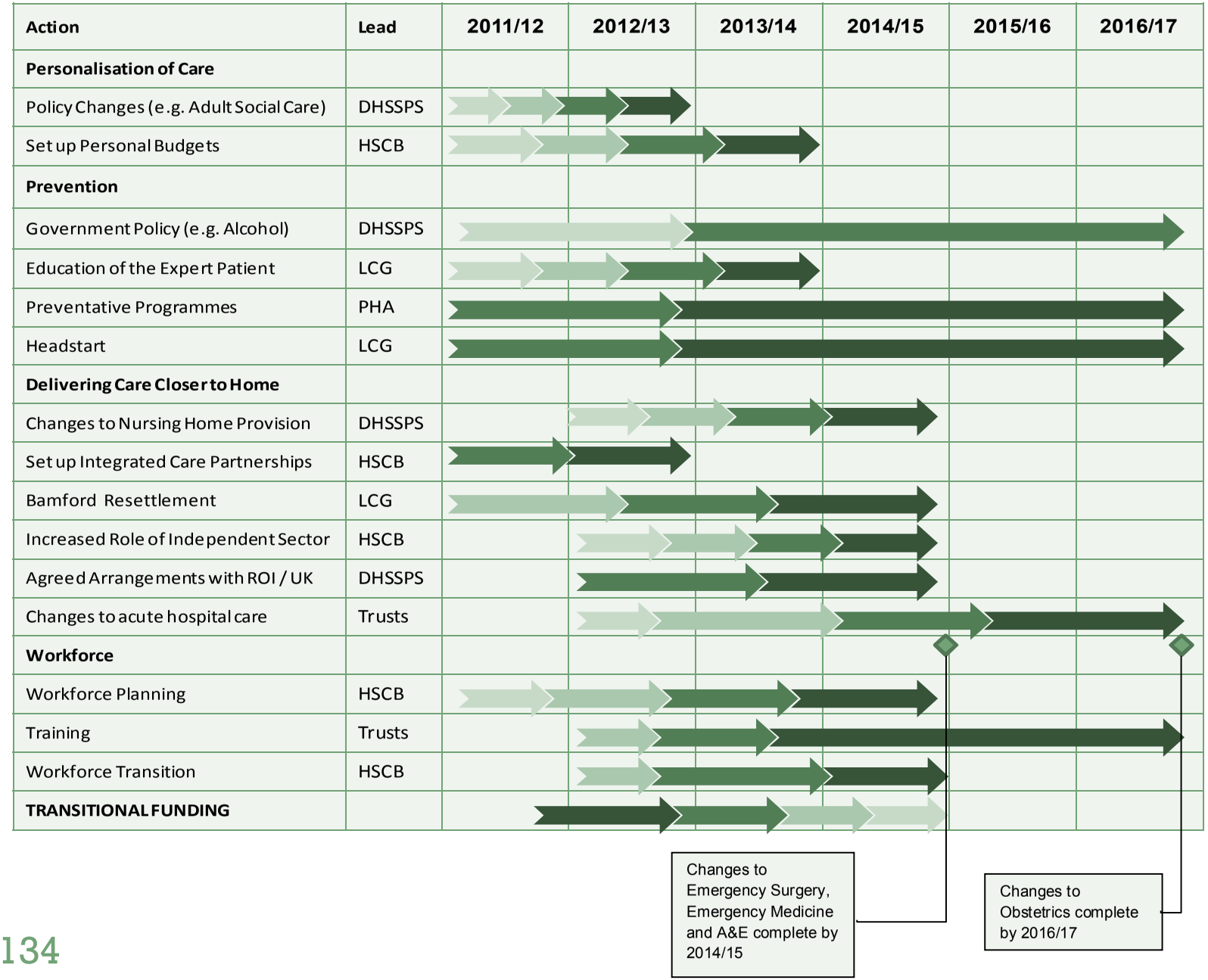
The major changes envisaged by this Review will impact on all residents of NI both those using the HSC service and those working in it.

To manage the effective implementation of the programme it will be essential that the changes are communicated effectively to those who will be affected, both from the perspective of understanding how the changes will affect care, changes in how to access care and a clear understanding of what is expected from the public in delivering the programme of change.

The communication plan should include details of:

- the key messages to be communicated;
- the target audience for communication;
- the approach to communication; and
- the forum and tools to be used when communicating with the groups identified.

Figure 28: Timeline for Completing Key Actions



19.SUMMARY OF PROPOSALS

POPULATION HEALTH AND WELLBEING

1. Renewed focus on health promotion and prevention to materially reduce demand for acute health services.
2. Production by PHA of an annual report communicating progress on population health and wellbeing to the public.
3. Maintenance of existing and implementation of new screening and immunisation programmes where supported by clinical evidence.
4. Consideration by the Northern Ireland Executive of the wider role of the state in taking decisions impacting on health outcomes, for example: in relation to pricing of alcohol and 'junk' food; and further controls on tobacco usage.
5. Incentivisation of Integrated Care Partnerships to support evidence-based health promotion, for example, clinician-led education programmes in the community.
6. Joint working pilot projects with other Government departments that enable resource sharing and control, for example in rural isolation and transport.
7. An expanded role for community pharmacy in the arena of health promotion both in pharmacies in the community.
8. Support for the health promotion and prevention role played by Allied Health Professionals, particularly with older people.

OLDER PEOPLE

9. Home as the hub of care for older people, with more services provided at home and in the community.
10. A major reduction in residential accommodation for older people, over the next five years.
11. Introduction of reablement to encourage independence and help avoid unnecessary admissions of older people into hospital.
12. A greater role for nursing home care in avoiding hospital admissions.
13. More community-based step-up/step-down and respite care, provided largely by the independent sector.

14. A focus on promoting healthy ageing, individual resilience and independence.

15. More integrated planning and delivery of support for older people, with joined up services and budgets in health and social care, and pilots to explore budgetary integration beyond health and social care.

16. A holistic and consistent approach to assessment of older people's needs across Northern Ireland and an equitable range of services.

17. A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.

18. Personalised care designed to deliver the outcomes care users and their families want, with increasing control over budgets, and access to advocacy and support if needed.

19. A policy review of carers' assessments and more practical support for carers including improved access to respite provision.

20. An overhauled financial model for procuring independent and statutory care, including exploring the potential for a price regulator, a certificate of need scheme and financial bonds for new entrants.

LONG-TERM CONDITIONS

21. Partnership working with patients to enable greater self care and prevention.

22. Personalised care pathways enabling home based management of the LTC with expanded support from the independent sector.

23. Patients to have named contacts for the multi-disciplinary team in each GP surgery to enable more straightforward communication.

24. Improved data warehousing of existing information to support care pathways and enable better outcomes to be more closely monitored.

25. A stronger role for community pharmacy in medication management for LTCs.

26. Development of admission protocols between secondary care specialist staff and those in the community.

27. Maximising the opportunities provided by telehealth in regard to LTC patients.

PHYSICAL DISABILITY

28. Promoting independence and control for people with a disability, enabling balanced risk-taking.

29. A shift in the role of the health and social care organisations towards being an enabler and information provider.

30. Joint planning of services for disabled people by the statutory, voluntary and community health and social care providers, and other relevant public services (e.g. housing) to ensure a wide range of services across NI.

31. Better recognition of carers' roles as partners in planning and delivering support, and more practical support for carers.

32. More control for service users over budgets, with continued promotion of Direct Payments, and a common approach to personalised budget with advocacy and brokerage support where required.

33. More respite and short breaks provision.

MATERNITY AND CHILD HEALTH

Maternity

34. Written and oral information for women to enable an informed choice about place of birth.

35. Preventative screening programmes fully in place to ensure the safest possible outcome to pregnancy.

36. Services in consultant-led obstetric and midwife-led units available dependent on need.

37. Promotion of normalisation of birth, with midwives leading care for straightforward pregnancies and labour, and reduction over time of unnecessary interventions.

38. Continuity of care for women throughout the maternity pathway.

39. A regional plan for supporting mothers with serious psychiatric conditions.

Child Health

40. Further development of childhood screening programmes as referenced in the Health and Wellbeing section.

41. Child health included as a component of the Headstart programme referenced in the Family and Childcare section.

42. Promotion of partnership working on children's health and wellbeing matters with other government sectors.

43. Close working between hospital and community paediatricians through Integrated Care Partnerships.

44. Completion of a review of inpatient paediatric care to include palliative and end of life care.

45. Establishment of formal partnerships outside the jurisdiction for very specialist paediatric services.

FAMILY AND CHILD CARE

46. Re-structuring of existing services to develop a new 'Headstart' programme focusing on 0-5 year olds.

47. Exploration through pilot arrangements of budgetary integration for services to this group across Departments, under the auspices of the Child and Young People's Strategic partnership.

48. Completion of a review of residential care to minimise its necessity.

49. Promotion of foster care both within and outwith families.

50. Development of a professional foster scheme for those hardest to place.

51. Implementation of the RQIA recommendations in relation to CAMHS.

52. Exploration of joint working arrangements outside the jurisdiction, with particular regard to CAMHS services.

MENTAL HEALTH

53. Continued focus on promoting mental health and wellbeing with a particular emphasis on reducing the rates of suicide among young men.

54. Establishment of a programme of early intervention to promote mental health wellbeing.

55. Provision of clearer information on mental health services should be available to those using them and their families, making full use of modern technology resources.

56. A consistent, evidence-based pathway through the four step model provided across the region.

57. A consistent pathway for urgent mental health care including how people in crisis contact services, triage and facilities in emergency departments.

58. Review the approach to home treatment services for children and young people, learning disability and psychiatry of old age.

59. Further shift of the balance of spend between hospital and community, with reinvestment of any hospital savings into community services.

60. Greater involvement of voluntary and community sector mental health organisations in planning provision as part of Integrated Care Partnerships.

61. Promote personalised care promoting the uptake of Direct Payments among mental health service users with involvement of current recipients to share their experiences, and advocacy and support where needed.

62. Close long stay institutions and complete resettlement by 2015.

LEARNING DISABILITY

63. Integration of early years support for children with a learning disability into a coherent 'Headstart' programme of services for 0-5 year olds as referenced in the Family and Childcare section (Section 12)

64. Further development of the current enhanced health services on a Northern Ireland basis.

65. Support from Integrated Care Partnerships to improve clinicians' awareness of the needs of individuals with a learning disability.

66. Better planning for dental services should be undertaken.

67. Further development of a more diverse range of age-appropriate day support and respite and short-break services.

68. Greater financial control in the organisation of services for individuals and carers, including promoting uptake of Direct Payments with involvement of current recipients to share their experiences, and advocacy and support where needed.

69. Development of information resources for people with a learning disability to support access to required services.

70. Advocacy and support for people with a learning disability, including peer and independent advocacy.

71. Commitment to closing long stay institutions and to completing the resettlement process by 2015.

ACUTE CARE

72. Reinforce the full development of the Regional Trauma Network set out in the DHSSPS document.

73. Over time, move to a likely position of five to seven major acute hospital networks in Northern Ireland.

74. Ensure urgent care provision is locally available to each population.

75. Set targets for the reduction of hospital admissions for long-term admissions and end of life care.

76. Set targets for the reorganisation of outpatient and diagnostic services between hospitals and Integrated Care Partnerships.

77. Ensure the transition takes full account of Service Frameworks and clinical pathways.

78. Expeditious implementation of a managed clinical network for pathology.

79. Make necessary arrangements to ensure critical clinical staff are able to work in a manner which supports the new arrangements.

PALLIATIVE AND END OF LIFE CARE

80. Development of a palliative and end of life care register to enable speedy transfer of information required by those providing palliative and end of life care.

81. Enhanced support to the Nursing Home Sector for end of life care.

82. Individual assessment, planning, delivery and co-ordination of end of life care needs by a key worker.

83. Electronic patient records in place for the patient, their family and staff.

84. Targets to reduce the level of inappropriate hospital admissions for people in the dying phase of an illness.

85. Palliative and end of life care for children considered as part of the proposed review of Paediatric Services as referenced in the Maternity and Child Health section.

IMPLICATIONS FOR THE SERVICE

86. Creation of 17 Integrated Care Partnerships across NI enabling closer working between and within hospital and community services.

87. Development of population plans for each of the five LCG populations by June 2012.

88. Establishment of a clinical forum to support the implementation of the new integrated care model, with sub-groups in medicine, nursing/AHPs, and social care.

89. Development of clear patient pathways for networked and regional services.

90. Establishment of a forum to take forward how technology will support the new model of care linking the service to industry and academia.

91. Full rollout of the Electronic Care Record programme.

92. Development of a data warehouse for GP records to high quality information on care across practices, resulting in reduced variation.

93. Introduction of a single telephone number for urgent care.

94. Introduction of a single robust community information system.

95. Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated and at home or close to home.

96. Development of GPs to assume a critical leadership role in the new integrated care teams.

97. More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.

98. Re-allocation of resources estimated to equate to a 4% shift of funds from hospitals into the community.

99. Initiation of a sensible debate about growing income within the spirit of the NHS principles.

20.CONCLUSION

The Review team was impressed and enthused by the opportunity offered by the Minister to bring forward coherent changes for HSC in NI. Change is always difficult, but in looking at change the Review was determined to keep the individual, their family and the evidence of what works at the fore-front of its deliberations.

Looking towards the next 5 years there is real potential with the implementation of the Review to see a service much improved and fit for the future. The Review cannot be impervious to the present wider economic climate and how that might impact on HSC. However the Review Team was firmly of the view that the best defence to such an eventuality was to be clear about the direction of travel, namely:

- starting with the individual;
- looking to a greater focus on prevention;
- maintaining care close to home;
- re-designing primary care; and
- re-shaping hospitals.

Planning for taking decisions and creating a new model for the future is at the core of the Review. The Review is convinced failure to plan will cause detriment to the health and wellbeing of the population

21.APPENDIX

1. Terms of Reference
2. Online survey summary of results
3. Household survey summary of results
4. Questions raised at public meetings
5. List of attendees at clinician workshops and areas covered at each event
6. List of attendees at sector workshops
7. List of stakeholders engaged with at small group meetings
8. List of written submissions
9. Glossary

Appendix 1
Terms of Reference

Review of the Provision of Health and Social Care services in Northern Ireland

1. The Review should take account of:

- the Minister's statement of vision and strategy for the HSC;
- the statutory duties on the HSC to improve the quality of services provided to individuals, and to seek to improve the health and social well-being of the population, and to reduce health inequalities;
- all extant statements of policy and strategy approved by the Minister, and in particular the aims of improving **public health**, the **prevention** of illness, and of improving **outcomes** for patients and clients. Other major themes of policy and strategy are the quest for better early intervention and chronic condition management, and the strategic shift of all suitable services towards a primary and community context;
- the organisational structure of the HSC as established in the 2009 Reform Act, and in particular the responsibility to secure a clear focus on public health, and increasingly effective local commissioning of services and to exercise good governance and provide clear accountability – the Review will need to ensure that its analysis and recommendations are practical and applicable within this statutory framework;
- the resources available in the Budget settlement for 2011-12 to 201415 approved by the Executive and the Assembly in March 2011, given the overriding obligation on all HSC bodies to manage services within the level of resources approved by the Assembly;
- best practice guidance of regulatory and advisory bodies affecting the provision of safe and effective services, notably the National Institute for Health and Clinical Excellence, the Social Care Institute for Excellence and the Royal Colleges;
- evidence of how arrangements for the delivery of health and social care in the Republic of Ireland and Great Britain and cooperation for mutual benefit with service providers there, might contribute to the objectives of the Review;
- the established framework of terms and conditions for HSC staff including Agenda for Change and the Consultants' Contract, and the contractual arrangements in respect of primary care;
- recent previous studies and analysis of the HSC including the Appleby Reports of 2005 and 2011, the McKinsey Report of 2010 and the forthcoming PEDU Review; and
- evidence-based good practice on the delivery of services from within Northern Ireland from elsewhere.

2. On that basis, the Review is asked to:

- Provide a strategic independent assessment across all aspects of health and social care services of the present quality and accessibility of services, and the extent to which the needs of patients, clients, carers and

communities are being met by existing arrangements, taking account of the issues of outcomes, accessibility, safety, standards , quality of services and Value For Money;

- Undertake appropriate consultation and engagement on the way ahead with the public, political representatives (primarily through the Assembly Health Committee), HSC organisations, clinical and professional leaders within the HSC, staff representatives (through the Partnership Forum), and stakeholders in the voluntary, community, independent, private and local government sectors;
- Make recommendations to the Minister on the future configuration and delivery of services in hospital, primary care, community or other settings. The essential task of the Review is to set out a specific implementation plan for the changes that need to be made in the HSC in the context set out above, including proposals in relation to major sites and specialties;
- To identify, at an early stage, potential areas of concern, specific priorities for Ministerial focus and potential issues of public/political/media concern;
- To prepare a Report incorporating its analysis, findings and recommendations.

3. The new organisational structures within Health and Social Care have delivered major efficiencies already. They are currently the subject of a further review as part of a wide ranging review by the Executive of all Arm's Length Bodies and are outside the scope of this Review.

4. The issue of overall funding levels available to meet the needs of Health and Social Care now and in the years ahead is also outside the scope of this Review as that is a matter for the Executive collectively drawing on the advice of DFP. The current PEDU review of the scope to make savings in the Health and Social Care sector is separate from the HSC Review and the development of an implementation plan to deliver savings will continue in parallel with this Review.

5. Where the Review finds major tension, or contradiction, between its emerging view of the best way ahead and the extant constraints listed at paragraph 1 above, this should be raised for consideration by the Department as soon as possible, so that the Minister can be advised of the issue and give a specific steer as to how the Review should proceed.

6. The Review should complete its Report by 30 November 2011.

Appendix 2
Online Survey Summary of Results

Online Survey Results

In total there were 1107 responses.

However many of the responses were incomplete and in many cases only demographic information was captured.

The final sample was **673** responses although for some of the 'Quality' questions the sample was reduced further.

Summary of findings:

Demographic Profile

- **91%** of respondents said they work for an organisation providing health or social care services in NI
- **81%** said they work for an HSC Trust
- **95%** were providing the response on their own behalf

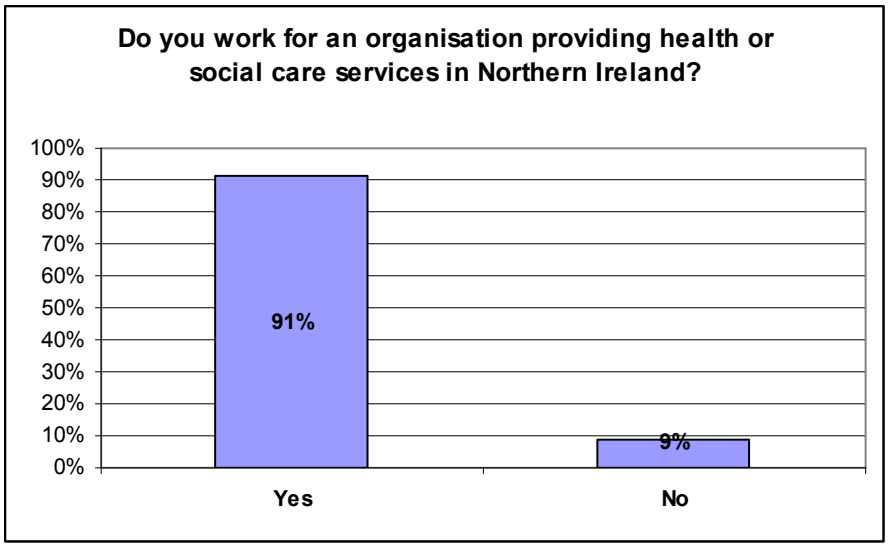
Service Usage in the last Year

Top 3 services reported by most respondents

- **94%** of respondents (or their families) have used GP services
- **54%** of respondents (or their families) have had an appointment with a hospital consultant
- **40%** of respondents (or their families) have used A&E services

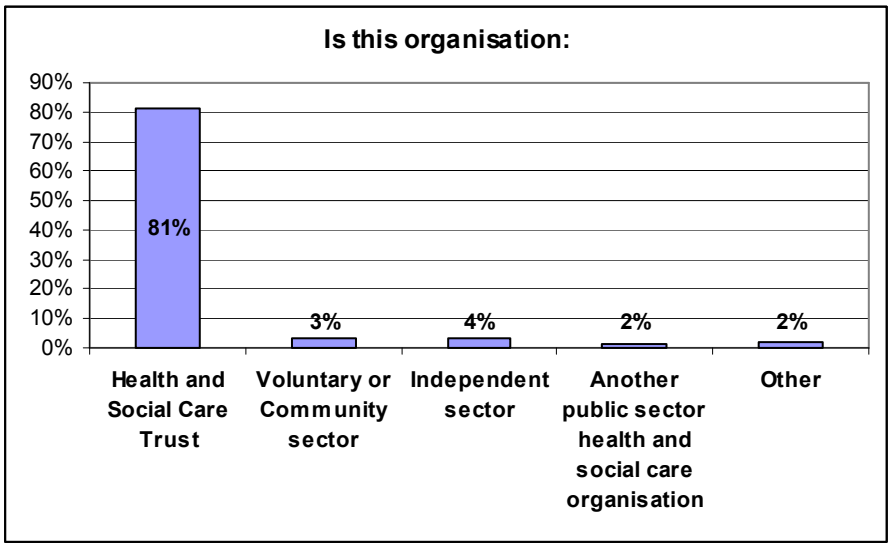
Profile

Do you work for an organisation providing health or social care services in Northern Ireland?

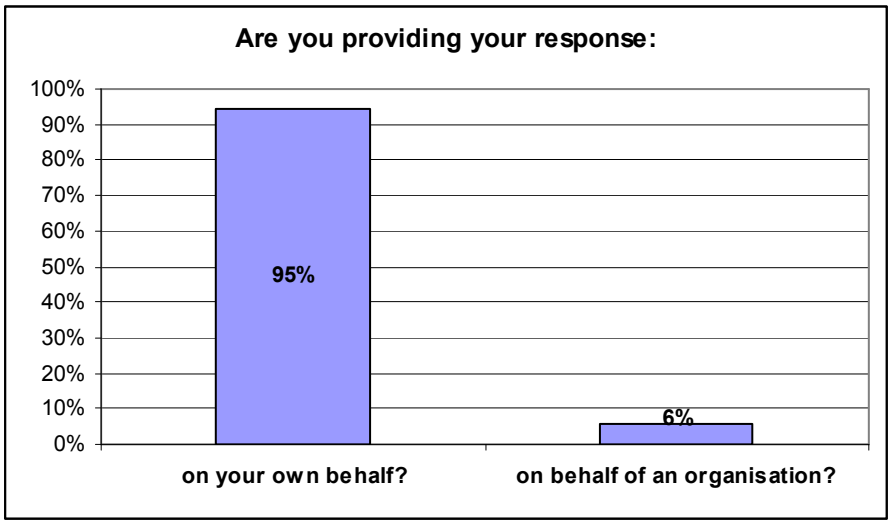


Is this organisation:

-A Health and Social Care Trust
-Another public sector health and social care organisation
-A voluntary or community sector organisation
-An independent sector organisation
-Other

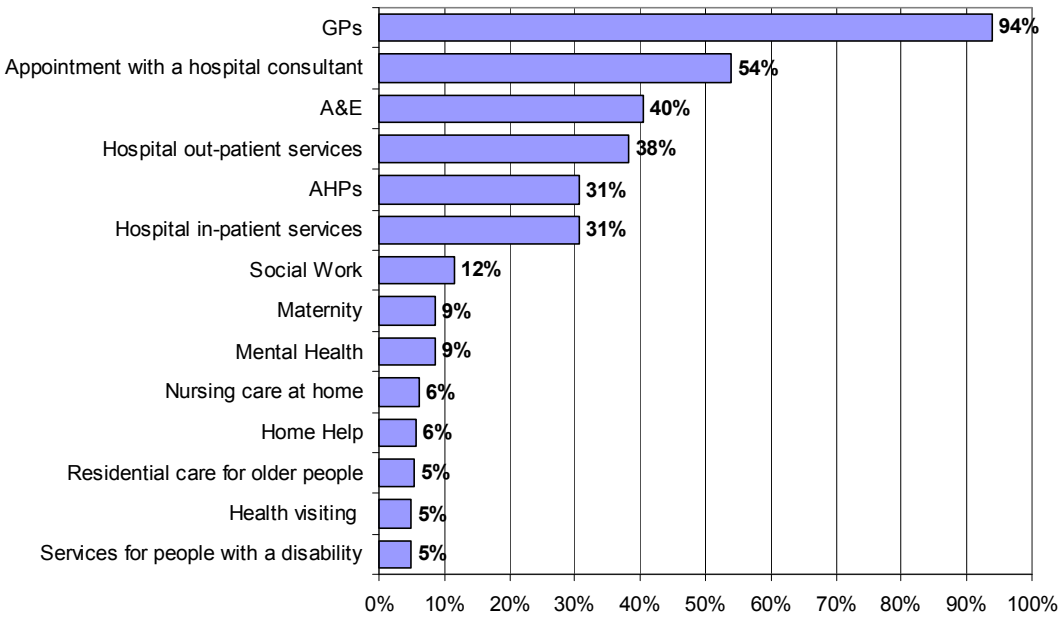


Are you providing your response
- On behalf of an organisation or
- On your own behalf?

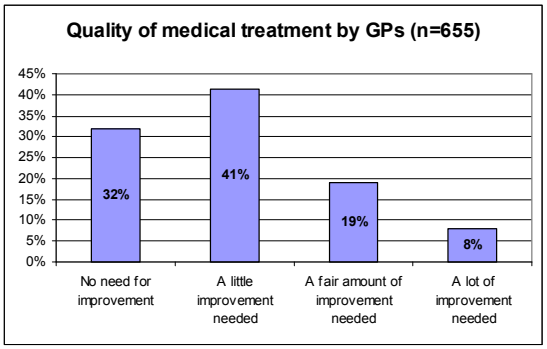


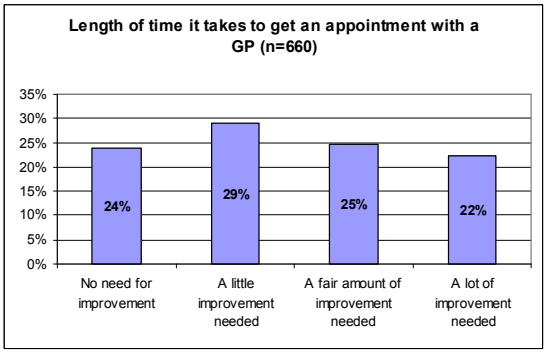
What is the name of the organisation you are sending your response on behalf of?
Action Mental Health
Autism NI (PAPA)
Bradleys Pharmacy
Castleview Private Nursing Home, Carrickfergus
Community Organisations of South Tyrone & Areas Ltd (COSTA)
Contact a Family
Dundela Pharmacy Ltd
FAITH HOUSE
Fermanagh Cardiac Support Group
Fold Housing Association
Foyle Parents and Friends Association
Home-Start Craigavon
Home-Start East Belfast
Home-Start In Northern Ireland
Kennedy's Pharmacy (Rasharkin and Dunloy)
Maria Mallaband Care Group Ltd
Mencap in Northern Ireland
MindWise New Vision for Mental Health
Newry & Mourne Carers Limited
Orchard House Private Nursing Home
Phoenix Healthcare
Shalom Care
Strandburn Pharmacy
The Dry Arch Children's Centre
The Stroke Association Northern Ireland
Wilson Group (Nursing Homes)

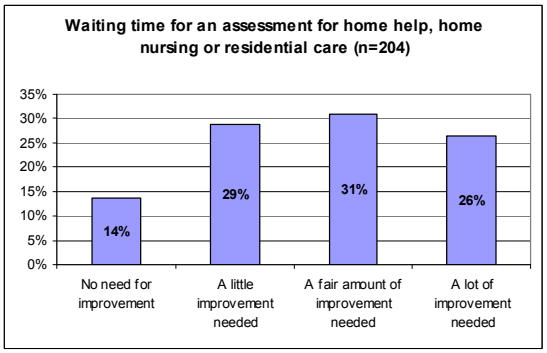
Have you or your family used any of these health and social care services in the last year?

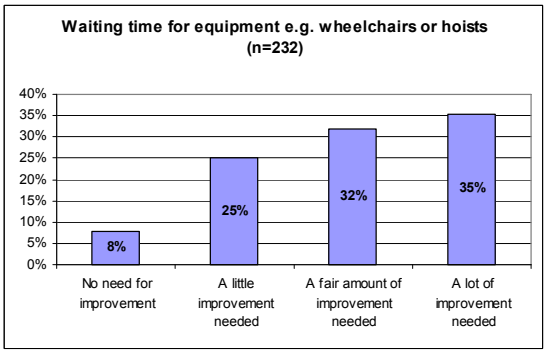


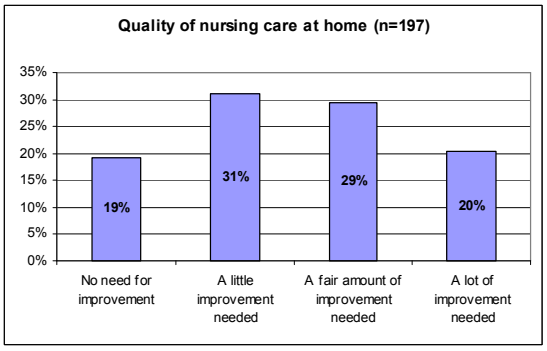
How would you rate the following aspects of Health and Social Care in Northern Ireland in terms of whether they require improvement or not?:

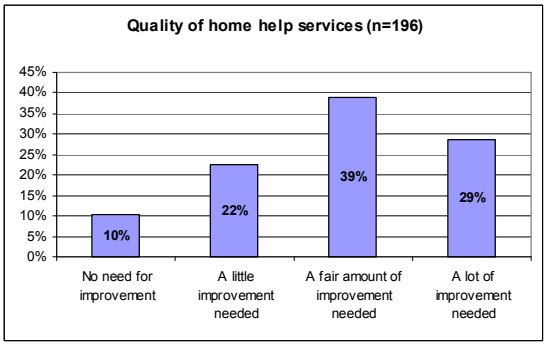


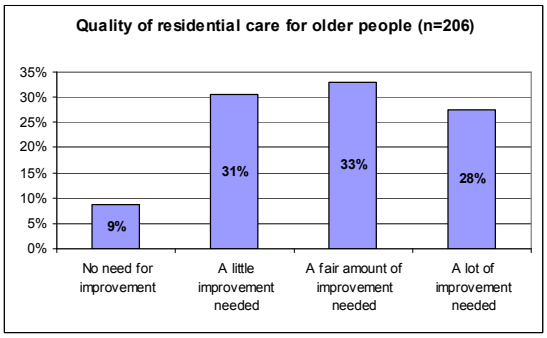


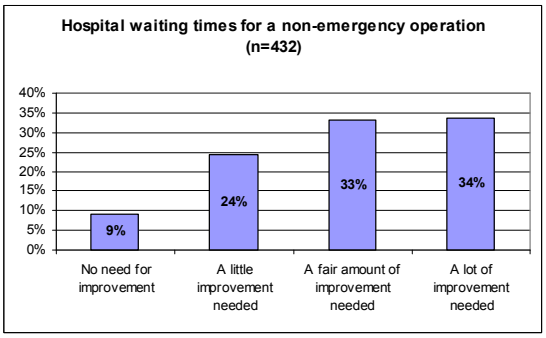


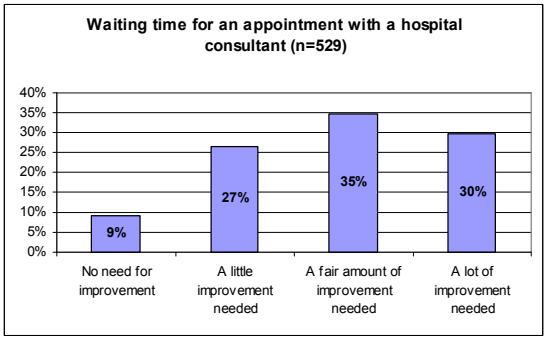


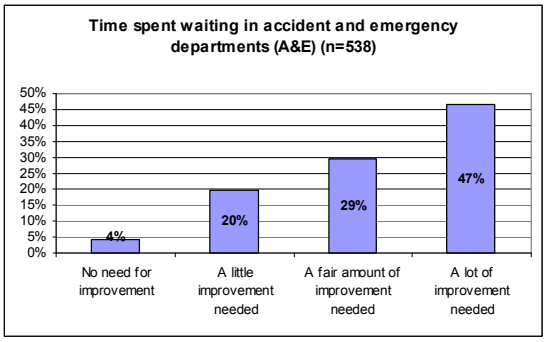


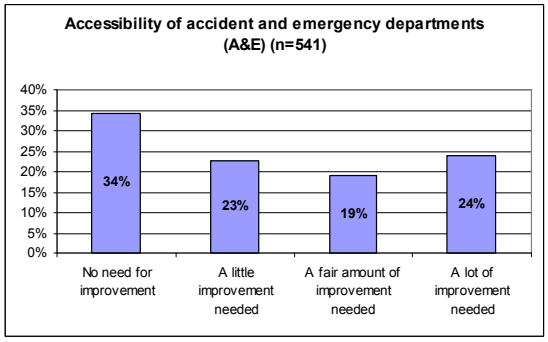


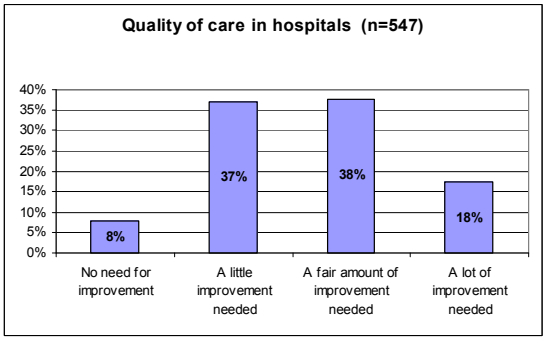


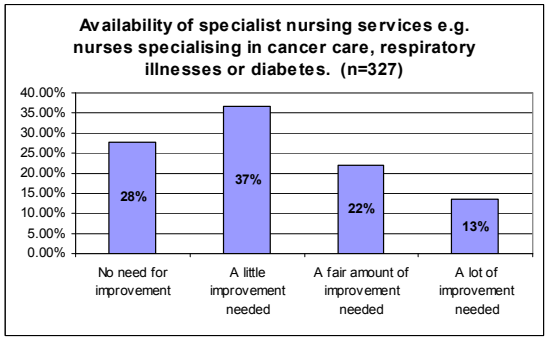


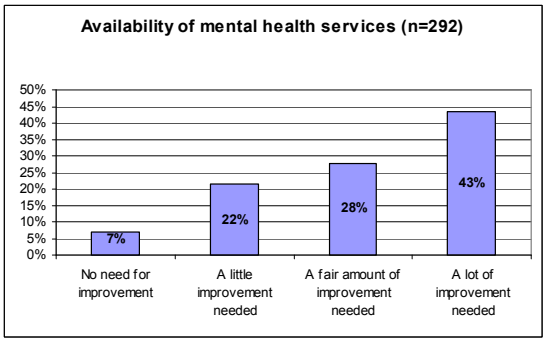


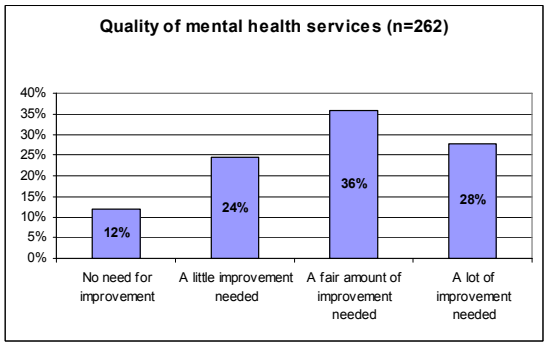

Time spent waiting in accident and emergency departments (A&E) (n=538)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
4%
20%
29%
47%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

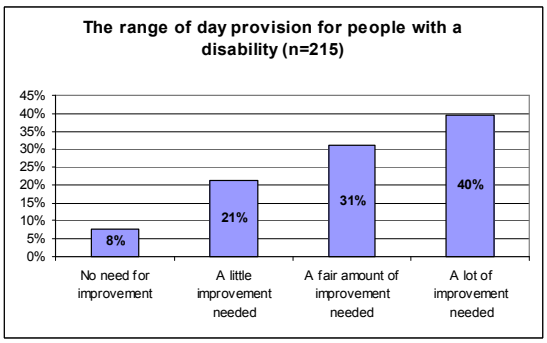

Accessibility of accident and emergency departments (A&E) (n=541)
40%
35%
30%
25%
20%
15%
10%
5%
0%
34%
23%
19%
24%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

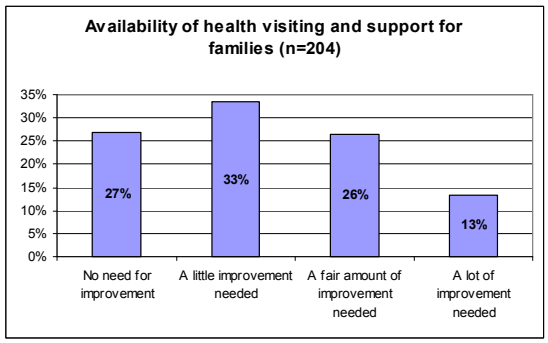

Quality of care in hospitals (n=547)
40%
35%
30%
25%
20%
15%
10%
5%
0%
8%
37%
38%
18%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

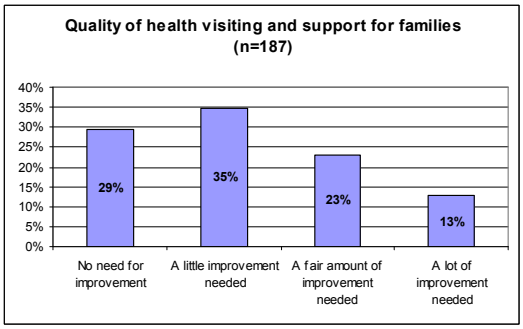

Availability of specialist nursing services e.g. nurses specialising in cancer care, respiratory illnesses or diabetes. (n=327)
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
28%
37%
22%
13%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

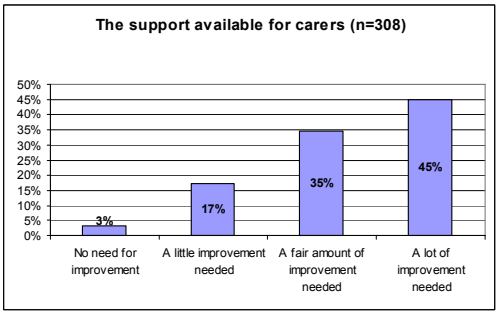

Availability of mental health services (n=292)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
7%
22%
28%
43%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

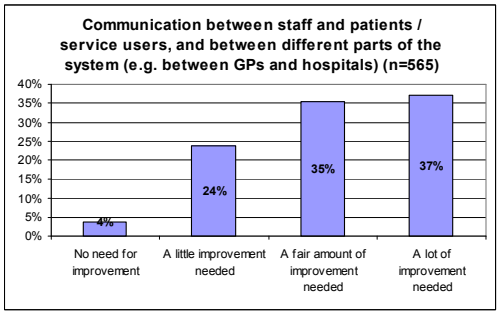

Quality of mental health services (n=262)
40%
35%
30%
25%
20%
15%
10%
5%
0%
12%
24%
36%
28%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

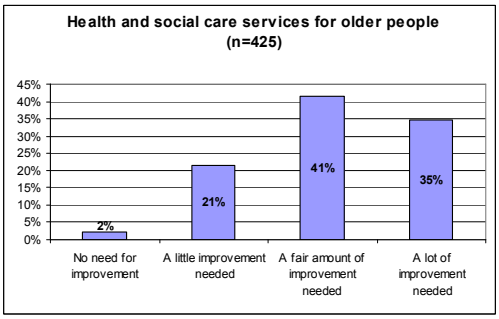

The range of day provision for people with a disability (n=215)
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
8%
21%
31%
40%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

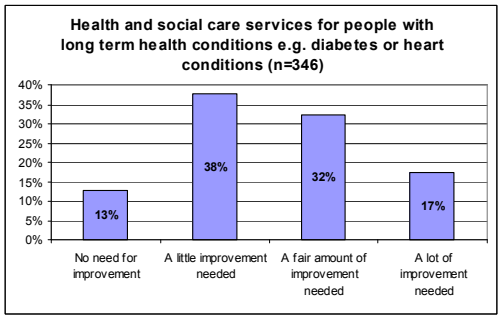

Availability of health visiting and support for families (n=204)
35%
30%
25%
20%
15%
10%
5%
0%
27%
33%
26%
13%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

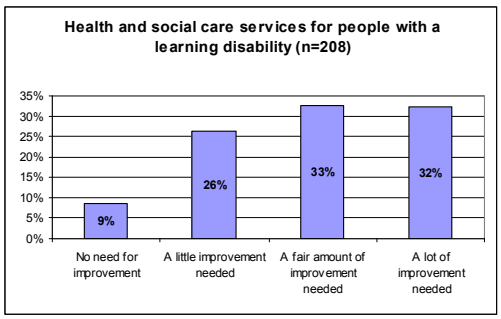

Quality of health visiting and support for families (n=187)
40%
35%
30%
25%
20%
15%
10%
5%
0%
29%
35%
23%
13%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

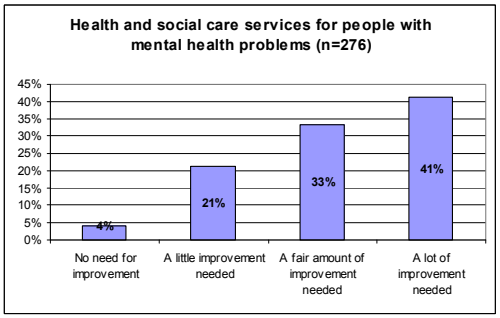

The support available for carers (n=308)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
3%
17%
35%
45%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

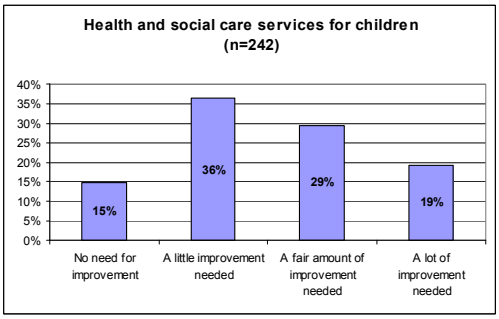

Communication between staff and patients / service users, and between different parts of the system (e.g. between GPs and hospitals) (n=565)
40%
35%
30%
25%
20%
15%
10%
5%
0%
4%
24%
35%
37%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

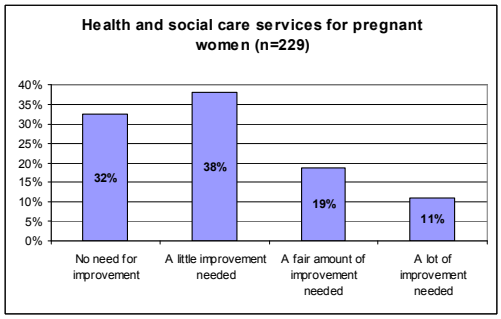

Health and social care services for older people (n=425)
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
2%
21%
41%
35%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

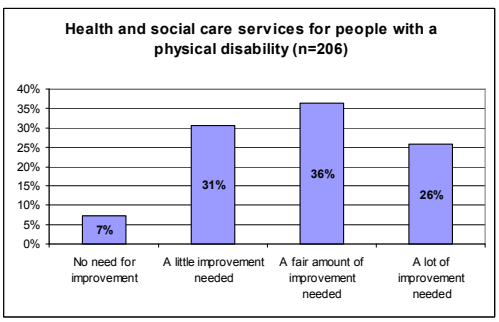

Health and social care services for people with long term health conditions e.g. diabetes or heart conditions (n=346)
40%
35%
30%
25%
20%
15%
10%
5%
0%
13%
38%
32%
17%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

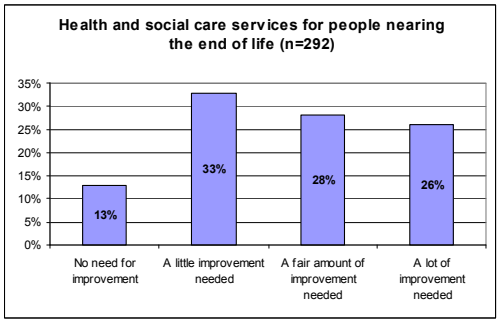

Health and social care services for people with a learning disability (n=208)
35%
30%
25%
20%
15%
10%
5%
0%
9%
26%
33%
32%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed


Health and social care services for people with mental health problems (n=276)
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
4%
21%
33%
41%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed


Health and social care services for children (n=242)
40%
35%
30%
25%
20%
15%
10%
5%
0%
15%
36%
29%
19%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed


Health and social care services for pregnant women (n=229)
40%
35%
30%
25%
20%
15%
10%
5%
0%
32%
38%
19%
11%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed


Health and social care services for people with a physical disability (n=206)
40%
35%
30%
25%
20%
15%
10%
5%
0%
7%
31%
36%
26%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed


Health and social care services for people nearing the end of life (n=292)
35%
30%
25%
20%
15%
10%
5%
0%
13%
33%
28%
26%
No need for improvement
A little improvement needed
A fair amount of improvement needed
A lot of improvement needed

Suggestions for Improvement

Quality of Medical Treatment by GPs

- Promote use of IT / access of information from other systems / electronic records for better decision making
- Improve communication across primary and secondary care / GP to GP / with patients & families
- Increase accessibility (extend opening hours) - evening and weekend clinics
- Training - skilling up especially in relation to Mental Health & Learning Disability, depression; keep skills up to date
- Improve interpersonal / customer care skills – especially listening skills, empathy
- More time for each appointment
- Continuity of GP
- More GPs
- Provide advice service - Use of other systems to provide advice e.g. telephone system, emails
- Use of Nurse to triage

Length of Time to get an appointment with a GP

- Increase accessibility (extend opening hours) - evening and weekend clinics
- Walk in Clinics (no appointments required)
- More GPs (and more Female GPs)
- Penalties for patients who 'Did Not Attend' (DNA) – use of reminder system
- Use of Community Pharmacist for minor ailments (German / Austrian Model)
- Provide help lines (may reduce demand for appointments)
- Increase role of the Practice Nurse / Triage Nurse / Triage service
- Improved system for making appointments (EMIS / online systems)
- Train receptionists re customer care skills
- Better sharing of information

Waiting time for assessment of home help home nursing or residential care

- Increase staff / resources / fill vacant posts
- More efficient use of resources
- Better process for assessment and implementation of services
- More funding
- Review 'need' – this may change / decrease
- Less bureaucracy
- Person centred / holistic approach

Waiting time for equipment

- Better procedures required for tracking and return of equipment e.g. central register of equipment; Trusts set target for return / recycling; patients pay deposit or application of financial sanctions for damage / non return (seems to be big issues with respect to trying to return equipment)
- More staff required particularly Occupational Therapists (OTs) and improved management of teams
- More resources for equipment purchase
- Faster appointment process

Quality of nursing care at home

- More time allocated per call
- More staff / resources
- Training of staff
- Increased use of Community Pharmacy
- Continuity
- Random audits / inspections and better regulation required
- Sign posting

Quality of home help services

- More time allocated per call – 15 minutes is not enough
- Training – a wider skills remit by staff and care plans to be held at home to indicate what carer has to do
- Increased use of Community Pharmacy
- Continuity
- More staff/ more resources / better pay = better service
- Increased funding – possibility of patient contribution
- Regulation
- Implement a register of carers - Trust service better than private.

Quality of Residential Care for Older People

- Improve regional standards of care especially for Dementia
- More staff
- Person-centred / holistic approach to provision including assessment on admission
- Random inspections
- More space / activities including crafts, stimulation to keep minds active etc
- Staff training especially re stroke
- More homes
- More money
- Better facilities including hygiene
- Direct payments – enable patient to make own decisions re care

Hospital waiting times for a non emergency operation

- Increased use of Community Pharmacy
- More staff (= more appointments) / more investment in staff to do scans etc
- Increased funding / use of Integrated Clinical Assessment and Treatment Services (ICATS)
- Prioritise waiting list using emergency and non emergency
- Up-skill staff
- Use/make better use of cancellation lists; deposit system (fines for DNAs)
- Improve, maximise theatre efficiency (including number of slots / evening and weekend appointments)
- NHS do NHS work - stop NHS consultants doing private work
- Employ Cardiac Paediatrician and stop sending to Birmingham and Dublin
- Improve communication
- Implement IEAP properly
- Bigger A&E departments and less of them
- St Thomas's

Waiting times for an appointment with a hospital consultant

- More consultants / specialists/ clear backlogs / increased training for these; more staff generally
- No private work
- More appointments (evening and weekends)
- Improved coding on new/review system / clarity on partial booking system
- Use of ICATS
- Expand Nurse led appointments /clinics
- Penalties for DNAs
- Improve communication
- Training for community specialists
- Telemedicine

Time spent waiting in A&E departments

- Reduce inappropriate referrals / attendances - educate public re appropriate use of A&E
- Use of specialist teams for improved triage – redirect to community as appropriate
- More staff and resources
- Improve communication re how long can expect to wait
- Long waiting times may be ameliorated through use of walk in centres / extended GP hours
- Use of a nurse led helpline to signpost public to correct department

Accessibility of A&E departments

- Improve local accessibility - stop closing local A&E Departments
- Address car parking including for disabled
- 24/7 opening hours including for Minor Injury Units
- Delivery of X-rays etc in other settings

Quality of care in Hospitals

- Improve hygiene
- Person centred care – more assistance with basic care e.g. eating, drinking, (dieticians), toileting
- Bring back matrons, senior nursing staff
- Address staffing shortages / more frontline staff doing the 'nursing'
- Ensure all are treated with dignity and compassion – improve staff attitudes and morale
- Improve communication
- No mixed wards
- Look at OASIS system in South Australia for IT

Availability of specialist nursing services e.g. nurses specialising in cancer care, respiratory illness or diabetes

- More specialist nurse are required – more training
- Ensure equity of access geographically and for conditions – same as for cancer, and 24/7
- Roll out concept of Expert patient

Availability of Mental health Services

- Implement Bamford
- Investment needed for respite services
- Home treatment teams
- Improve access (for all age groups; 24/7; Learning Disabled) and signposting
- More resources (in the community) & staff
- Increased co-ordination
- Targeted resources
- Enhance understanding by GP

Quality of mental health services

- More investment & staff (Community Psychiatric Nurses (CPN), Cognitive Behavioural Therapists, Psychologists etc))
- Bamford
- Continued emphasis on recovery
- Holistic, multidisciplinary approach must be adopted
- Increased role of Community Pharmacy

- Improve Child and Adolescent Mental Health Services (CAMHS) and Older People's services
- More community initiatives
- Early intervention
- Reduce waiting times

The range of day provision for people with a disability

- Improve the range of activities including daily living skills / increased provision and more choice / appropriate activities
- Remove the age link with this service / increase the opportunity for younger people / for those aged over 65yrs
- Increase capacity provision and choice
- Person-centred
- More availability for brain injury
- Alternatives to daycare e.g. employment schemes; day therapy sessions / community development approaches
- Personalised budgets

Availability of health visiting and support for families

- Need for more health visitors
- Need for more resources
- Increase support provided by health visitors especially in first few weeks for new mums
- More links with Surestart
- Targeted approach for those in need (or at risk) of the service
- Health visitors directly employed by GPs

Quality of health visiting and support for families

- More staff, resources, training
- Provision of more support for families with young children and families, families with disabled children
- Improve communication

The support available for Carers

- More respite opportunities (more respite, regularly) / more funding for respite that is adequate and suited to needs
- Implement carers strategy
- Training for Carers
- Befriending schemes
- Financial reward
- Use of a key worker / advocate
- Use of voluntary sector to provide support
- Bank staff to cover illness
- Increase the awareness of support available to carers

Communication between staff and patients / service users, and between different parts of the system (e.g. between GPs and hospitals)

- Greater use of Technology and electronic methods for communication, prescribing etc
- Use of central information systems (1 system) / files / online patient notes
- Use of patient passports for some conditions
- Electronic Care Record
- Timely communication / openness and honesty
- System link up
- Proactive sharing of information
- User forums

Health and social care services for older people

- Increased use of private sector
- More community services
- Proactive in reach services
- More Nursing homes (to cope with changing demographics); more home help / care packages
- Explore cross border models
- More staff / more resources / more funding
- Person-centred care
- Community development / healthy lifestyles
- Right service, right time, right place

Health and social care services for people with long term health conditions e.g. diabetes or heart conditions

- Self management
- Education on risk management / healthy lifestyles and choices
- Early intervention
- Use of Community Pharmacists (for blood tests/fasting glucose etc)
- Specialist clinics, management by GPs, patients and Nurses in community / 24/7 availability
- Incentives such as paid gym memberships, slimming world etc
- Use of / explore alternative drugs
- Same level of services as for Cancer
- More community based rehab teams
- Rapid access to tests, treatments and surgery to prevent co-morbidities

Health and social care services for people with a learning disability

- Forward planning for individuals with a Learning Disability
- Use of Community Pharmacy

- Review of services for Learning Disability required including those provided by private sector
- More resources including rehabilitation, OT, and respite
- Improve communication and listening
- Multi-disciplinary and person-centred approach
- Implement Bamford
- Training for staff
- More community based services, including day care opportunities, befriending schemes, domiciliary care, training schemes and workshops.
- More support for families and carers
- Improved provision of supported housing for independent living

Health and social care services for people with mental health problems

- Improved access to services generally (24/7) and with respect to Clinical Psychology services
- Involve family
- Involve community services including Pharmacy and CPN
- Better training for mental health nurses
- More resources and staff (including specialists and CBT therapists), to aid early diagnosis and prevention, and continuity of care
- Better acute care provision
- Improved communication
- Implement Bamford – more funding
- More support for 18-25 year olds

Health and social care services for children

- Education / accessibility
- OT in CAMHS services
- Early intervention / prevention
- Inclusive policies /services
- Acknowledge extra support needed for disabled children /more services for Autistic children
- Listen to children and families / Involve parents
- More money/staff
- More school nurses
- More support through Allied Health Professionals (AHPs)
- Locally available services

Health and social care services for pregnant women

- Provide more comprehensive advice e.g. risk behaviour / health improvement / healthy choices – smoking cessation campaigns / alcohol / breast feeding etc
- Continuity of care for individual; consistency across region

- Support for women in general, and for those with mental illness
- More Midwives /direct access in community
- Targeted services for young expectant mothers
- Tailored accessible services for women with a learning disability
- Customer care training for Midwives
- Regular timely access to scanning throughout pregnancy – women should not be allowed to go over due dates
- Patient choice – but safety comes first.
- A little negativity re Midwife led units

Health and social care services for people with physical disability

- Multi-disciplinary and client-centred approach
- Care / Care teams should cater for individuals not age groups / consider children aged 14-18 who sits between paediatrics and adults
- Improved access to AHPS
- More resources / more respite services
- More accessible appointments
- Look at good practice / models e.g. Cedar Model

Health and social care services for people nearing the end of life

- More home support e.g. care packages to die at home or preferred place
- Open honest debate / listening to needs / wishes of patients / choice / allow patients to be part of the end of life plan
- More resources including hospice beds, District Nurses
- Use of Pharmacists
- Provision of Palliative Care teams to all people and allow to die with dignity
- Multidisciplinary approach /Specialist Nurses
- Palliative care for Learning disability
- Training for all involved
- More support for families / bereavement
- Same level of services as is for cancer
- Signposting – who to contact
- More staff –e.g. Palliative nurses
- More co-ordination –palliative nurses used as key workers

If you could make 3 changes to improve health and social care in Northern Ireland, what would they be?

Main themes

- More staff generally, more nurses and AHPs
- Reduce waiting times
- Improve communication
- Improve access to GPs
- Focus on health promotion / prevention; address alcohol as a public health issue
- Improve communication
- Increase local accessibility of services
- Improve hospital and community services for older people
- Reduce the number of managers and reduce paperwork
- Introduce charges for prescriptions, other services including meals in hospital, missed appointments,
- Improve services for learning disabled and their families carers including respite care
- Improve mental health services
- Staff training
- Better use of technology
- Bring back matrons
- Community Pharmacy
- Improve roads infrastructure
- More money
- Educate people to support themselves
- Fewer managers and less bureaucracy
- Decentralise where possible
- Enhance staff morale
- Interworking - enhance cross border working
- Increase involvement of community and voluntary sector
- Family support services
- More hospice and palliative care

Do you have any other suggestions for the future provision of health and social care services in Northern Ireland? For example this may relate to how accessible services are, the quality and safety of services, or the health outcomes achieved.

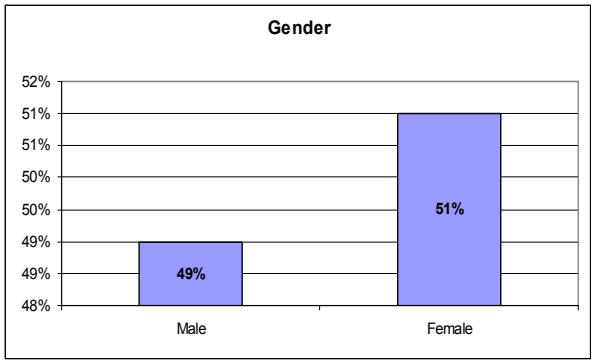
The responses given were variable and quite detailed. A very high level summary of some of the emerging themes are listed below:

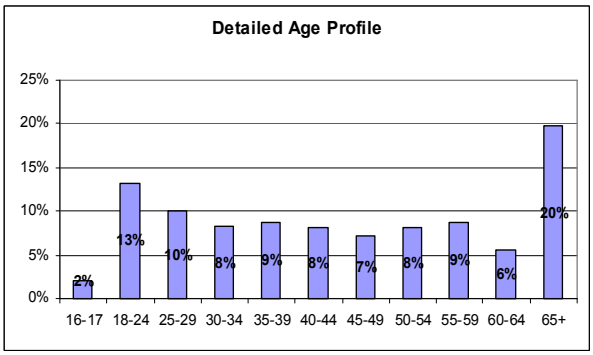
- Improve services for learning disabled and their families /carers
- Address alcohol as a public health issue
- Promote the use of Independent sector
- Reduce waiting lists
- Better use of Community Pharmacy services; more funding for Community Pharmacy services
- Better use of available services and facilities
- Promote / establish links within communities to combat loneliness
- Investment in resources / equipment
- More local services
- Introduction of charges (e.g. prescription charges)
- Equality of access for all in NI
- Invest in carers
- Invest in health promotion / prevention – make public responsible for their own health, start early; educate in schools to get public health message across
- Increase range of services offered by GPs / GP practice teams
- Stop closing A&E departments
- Reduce emphasis on targets and re focus on patient
- Fewer Managers
- Health care planning at local level
- Improve roads infrastructures thereby improve access to a range of services
- Enhance skills mix
- Improve GP accessibility
- Provision of quality training and communication
- More OTs
- Optimise use of technology
- Reconsider current location of some hospitals
- National health service for older people and those with disabilities
- Improve reporting times for diagnostic tests
- Less focus on waiting lists targets / find better ways to monitor waiting lists
- Reduce waste; reduce wastage with regard to pharmaceuticals
- Utilise skills in the community such as GPs, Pharmacists
- Better utilisation of AHPs
- More use of voluntary sector / community based services who can do the job for less
- Improve appointment systems
- More money needed

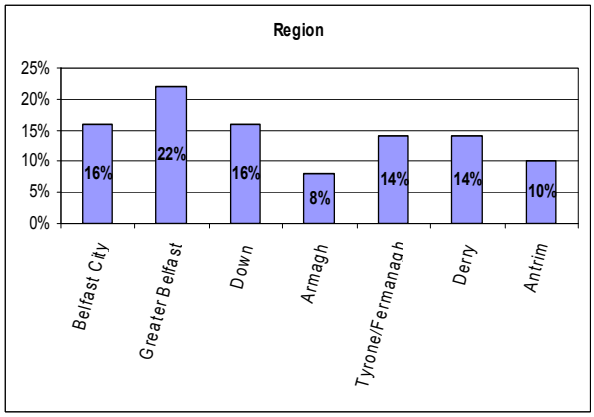
- Improve access to services for at risk youth
- Longer home help sessions
- Mobile clinics for hard to reach areas

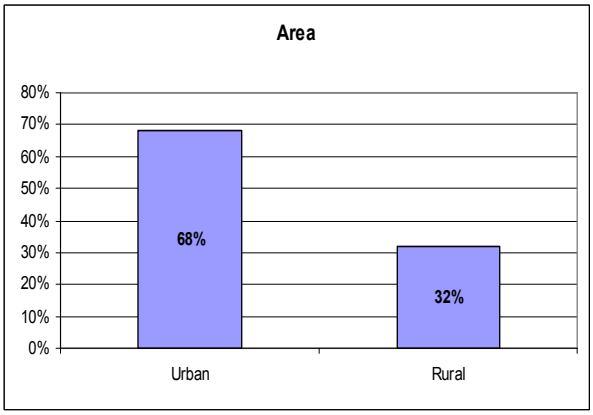
Appendix 3
Household Survey Summary of Results

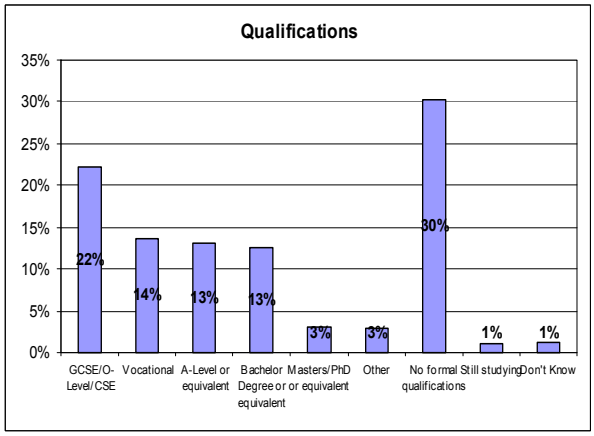
Profile Data

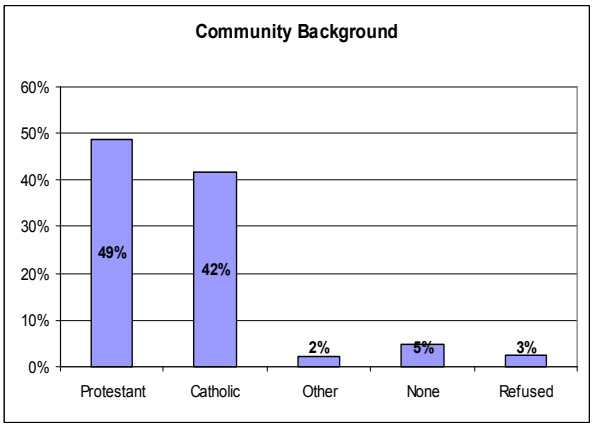


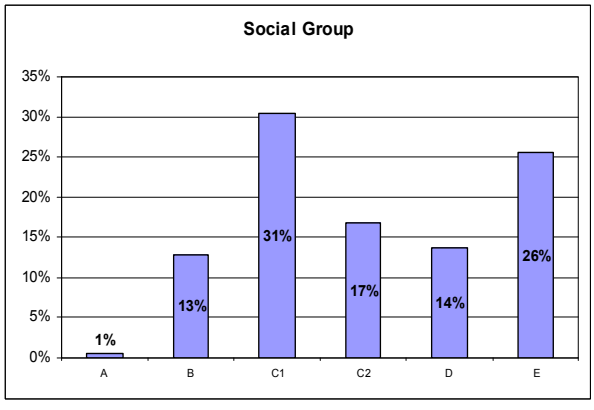


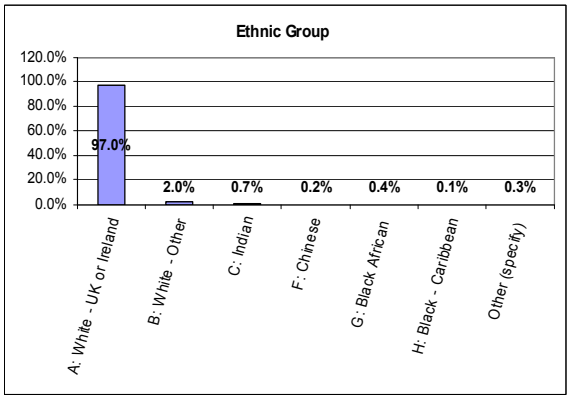






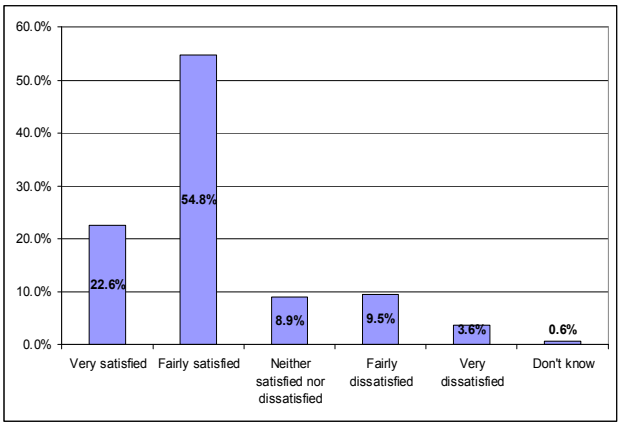


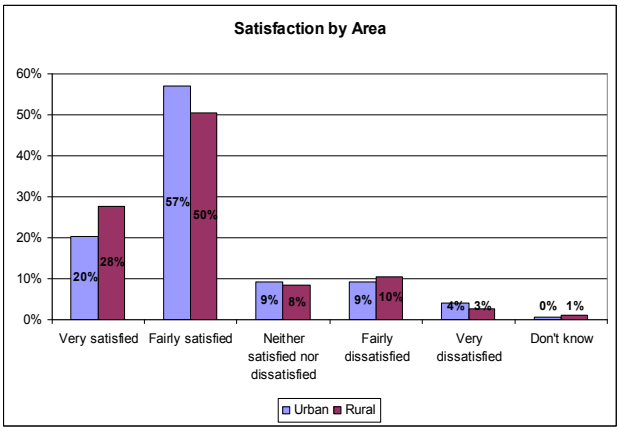


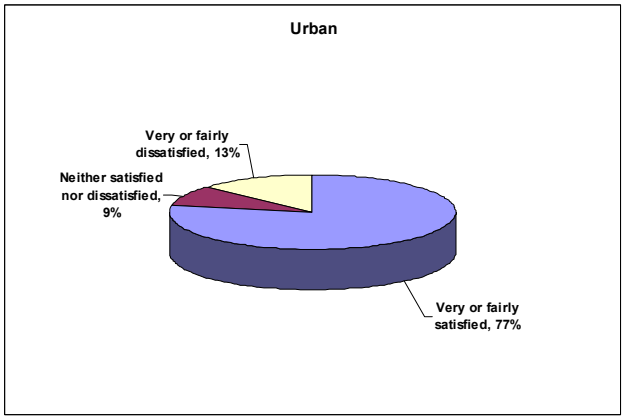


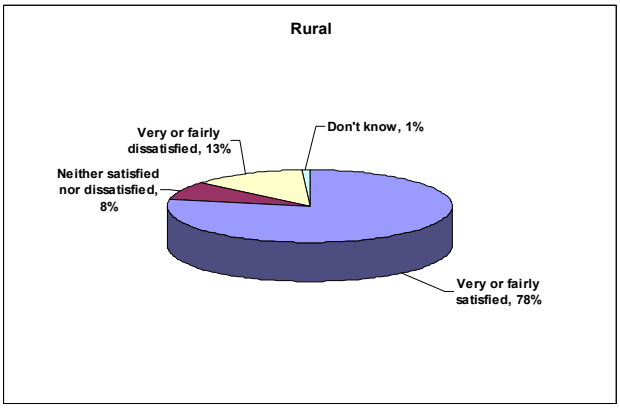
Question Responses

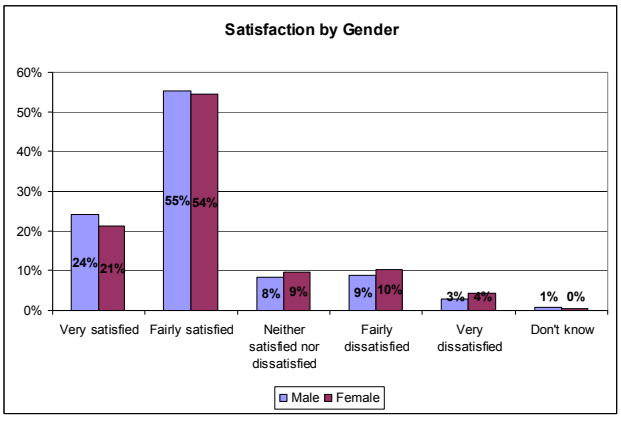
1. Overall, how satisfied or dissatisfied are you with health and social care provision in Northern Ireland at present?

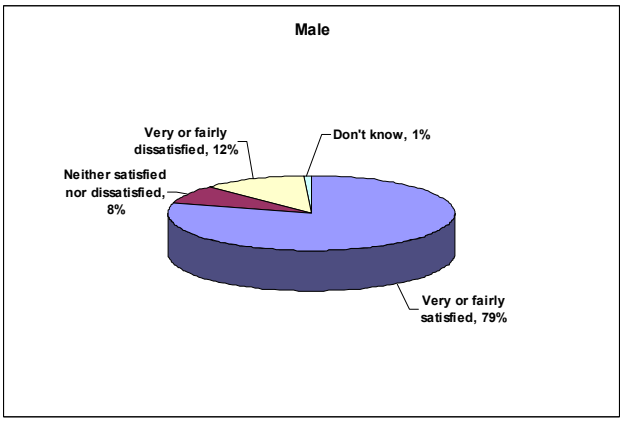


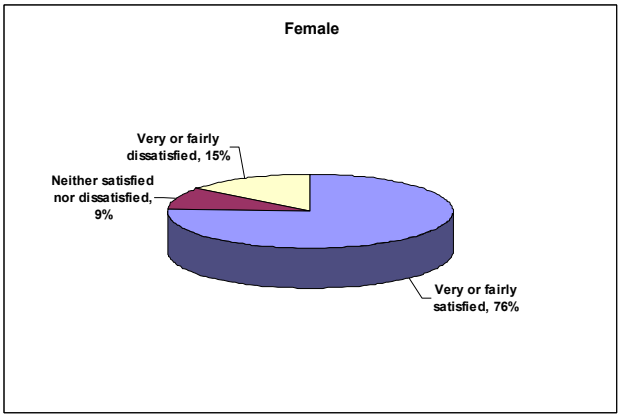


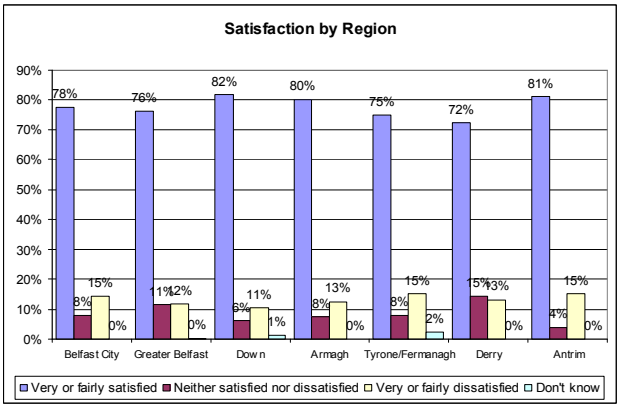




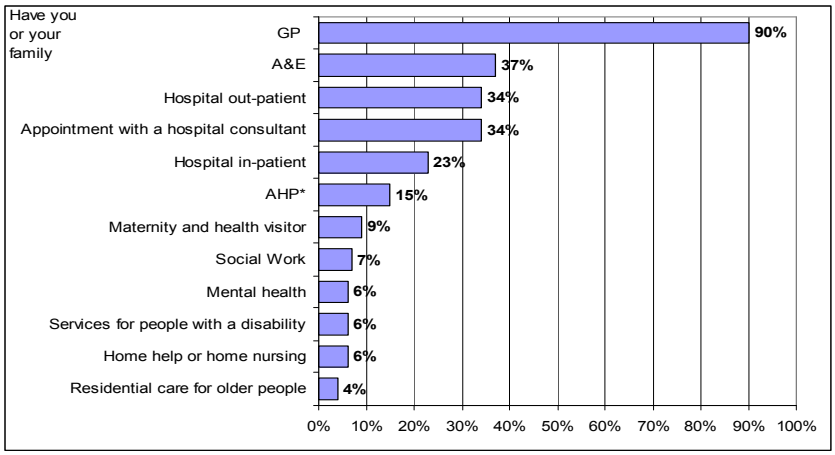




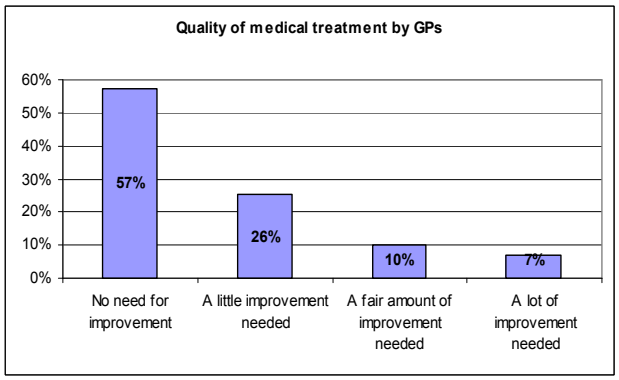


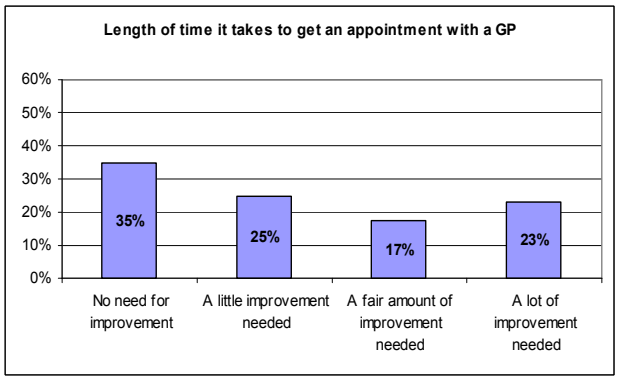


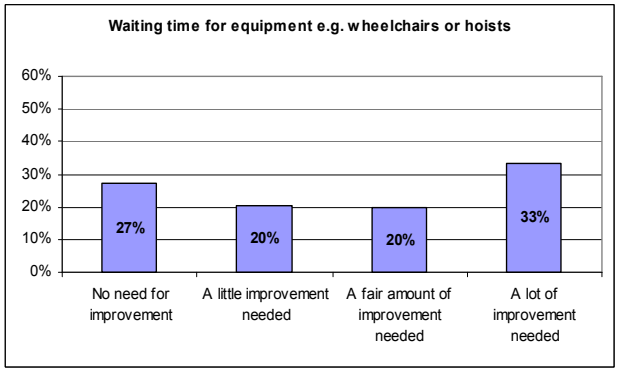
2. Have you or your family used any of these health and social care services in the last year?

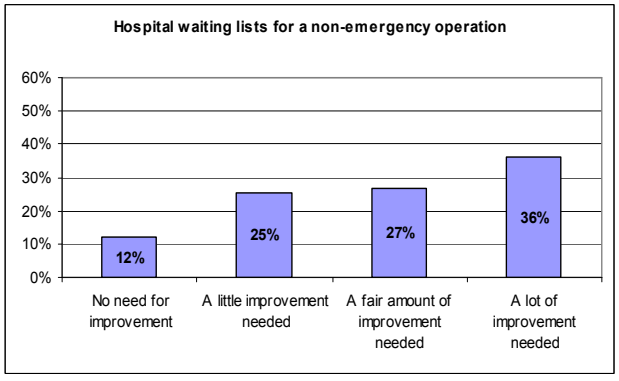


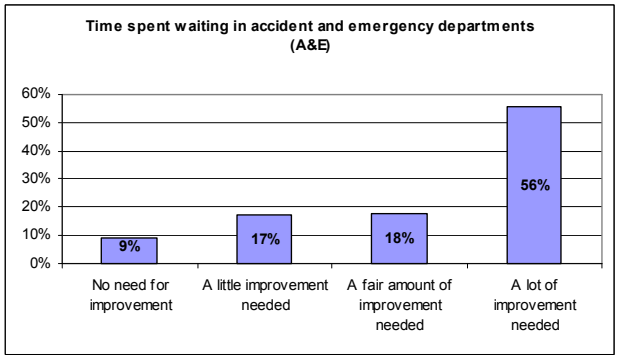
3. How would you rate the following aspects of Health and Social Care in Northern Ireland in terms of whether they require improvement or not?

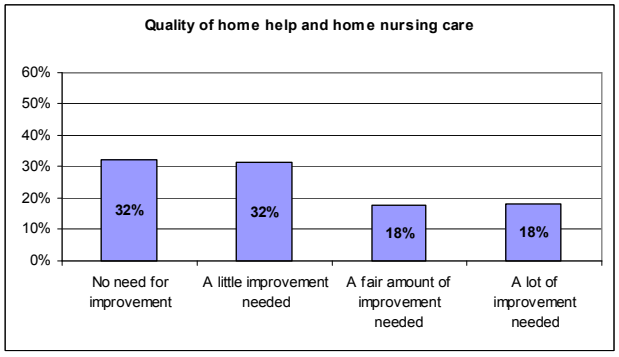


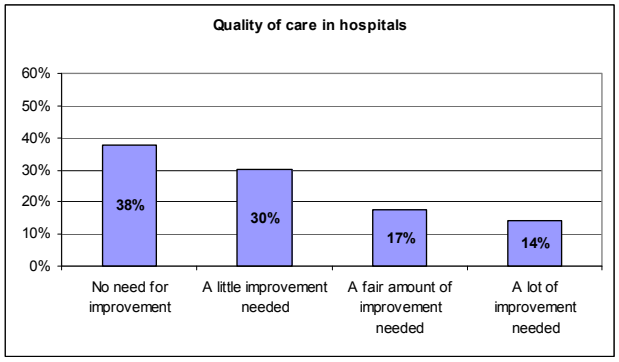


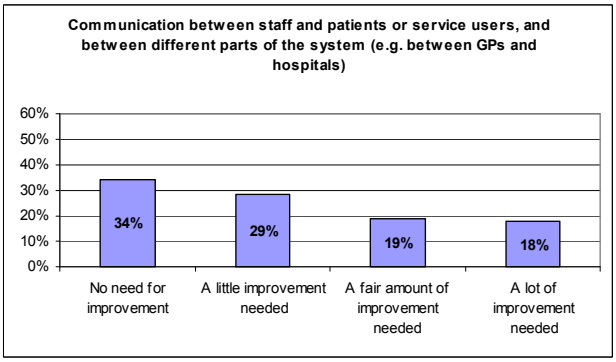


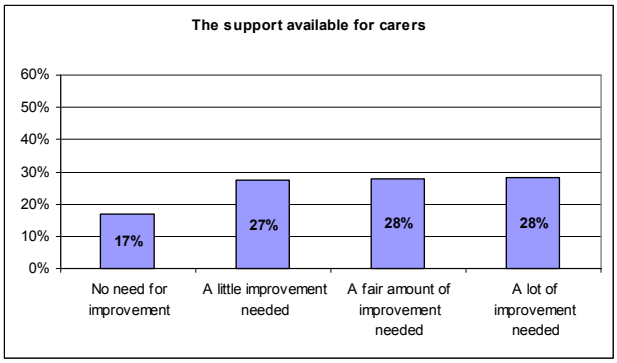




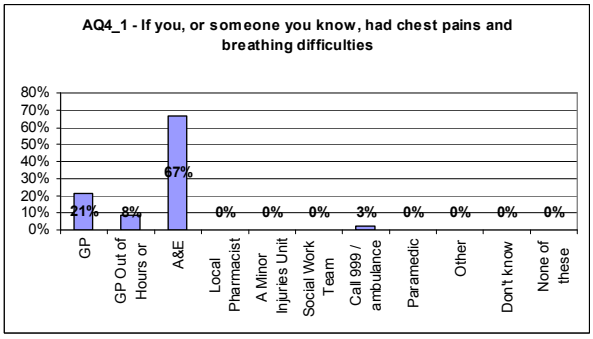


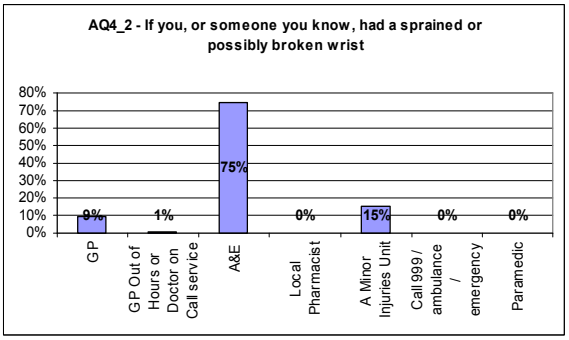


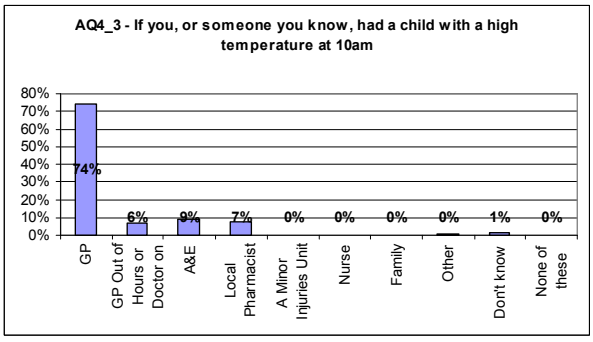


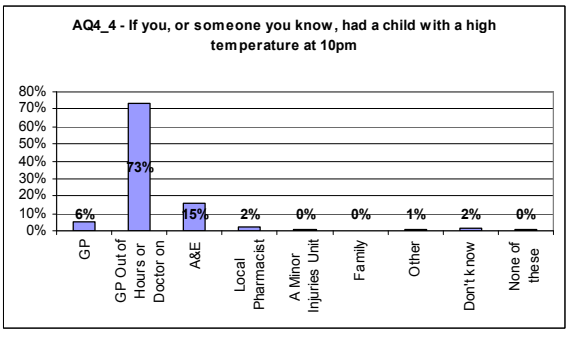


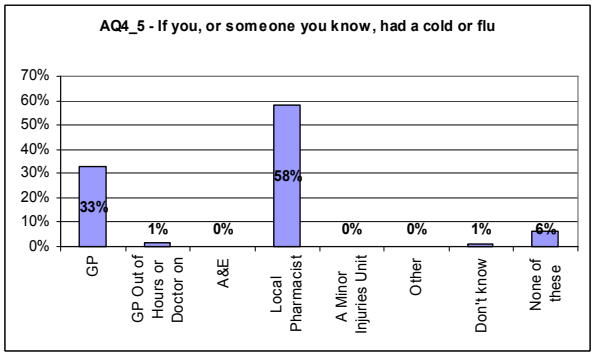
4. Which one of these services would you be most likely to go to in the following circumstances?

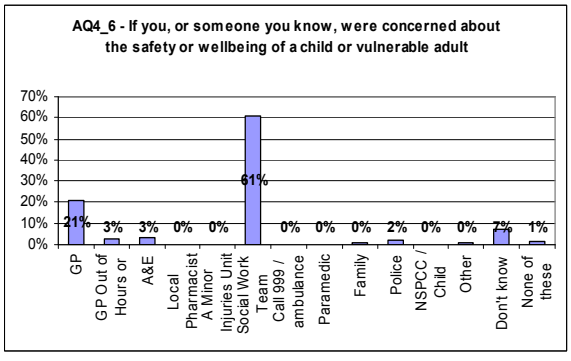




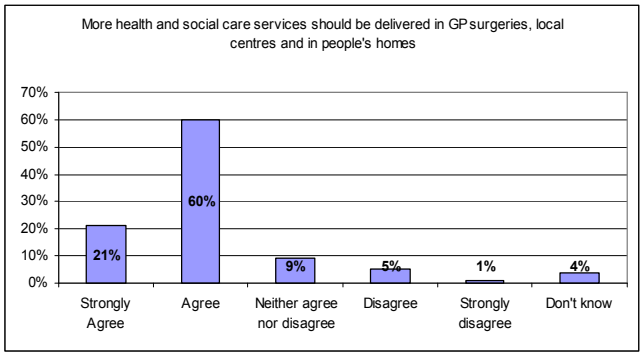


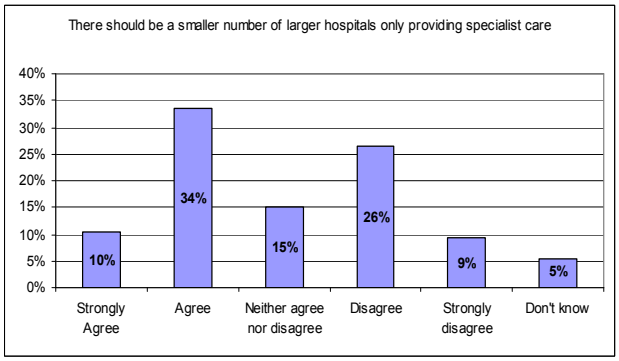


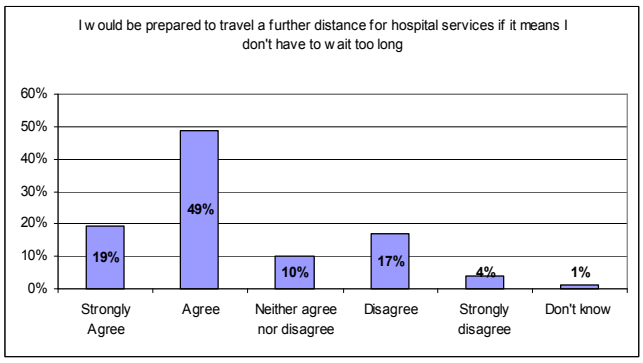


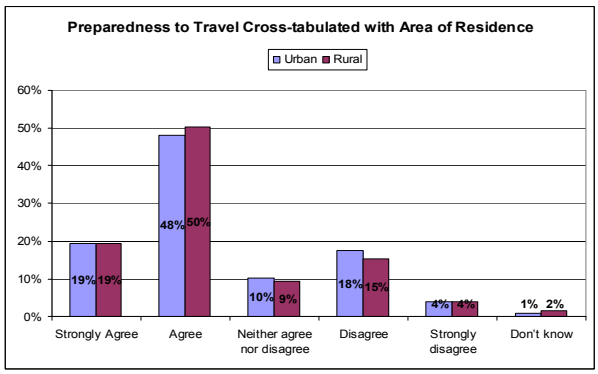


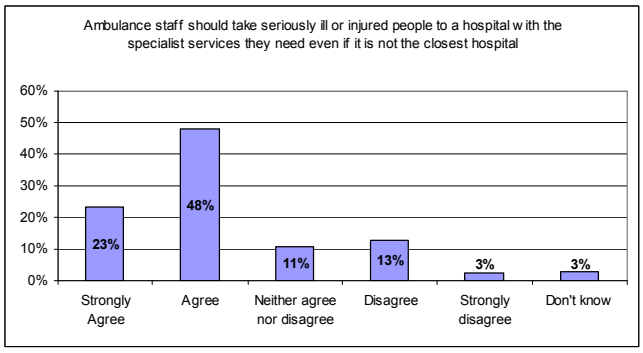
5. To what extent do you agree or disagree with the following statements?

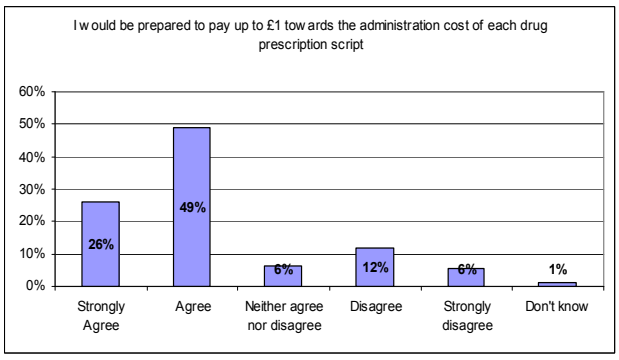




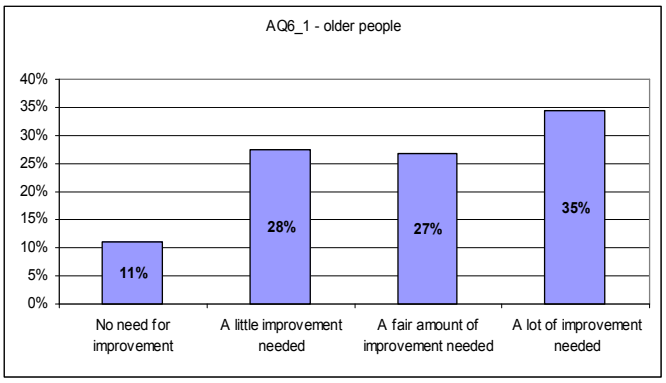


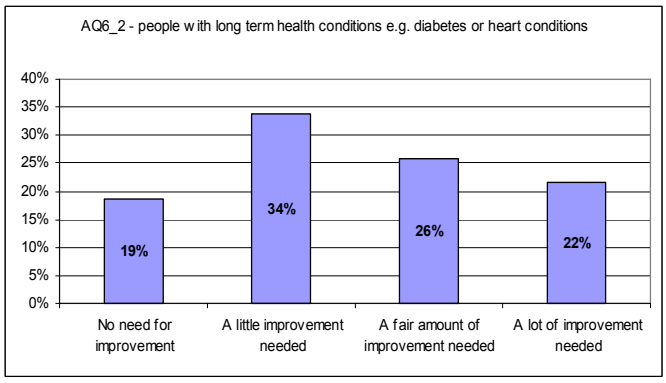


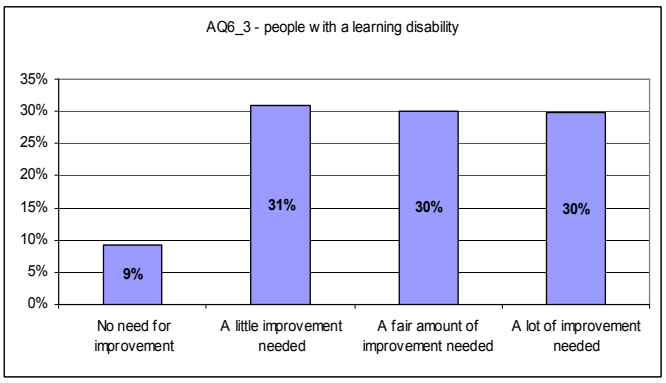


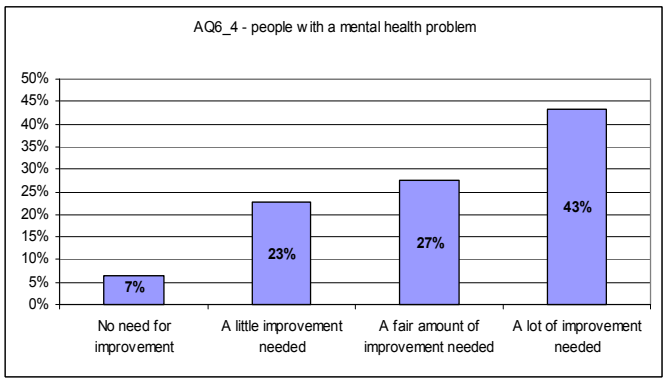


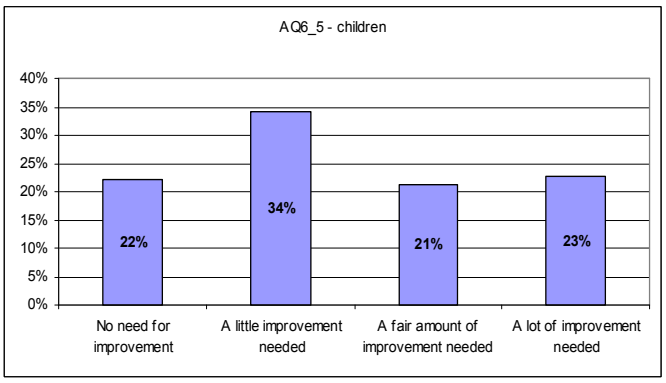
6. How would you rate the health and social care services provided for these groups in terms of whether they require improvement or not? Health and Social Care Services for:

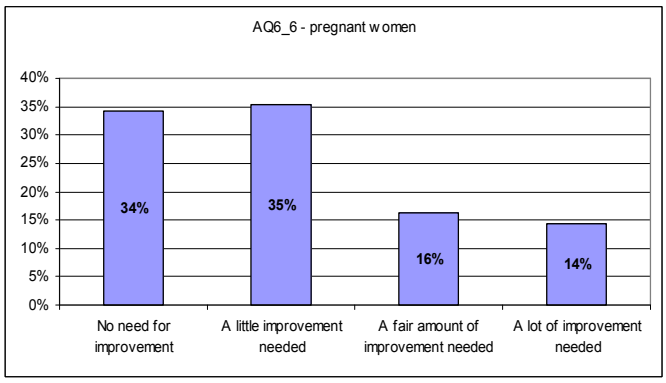




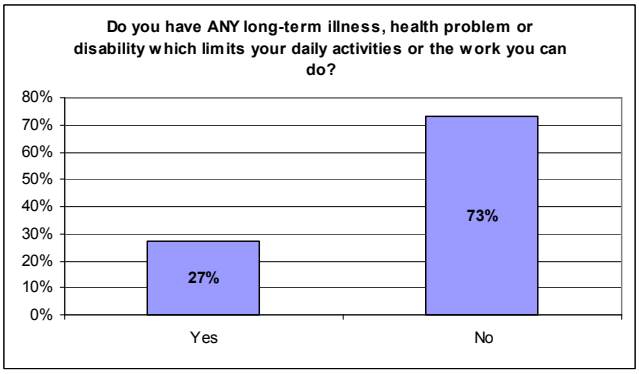


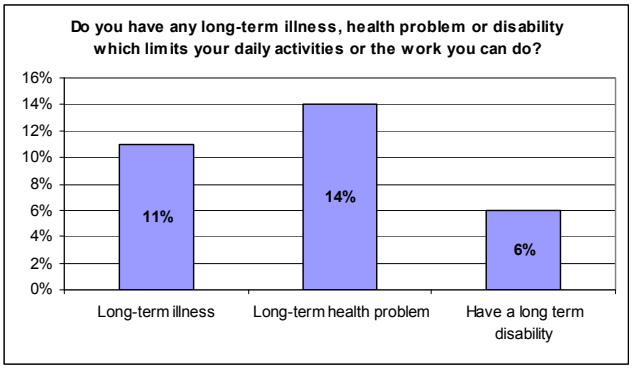




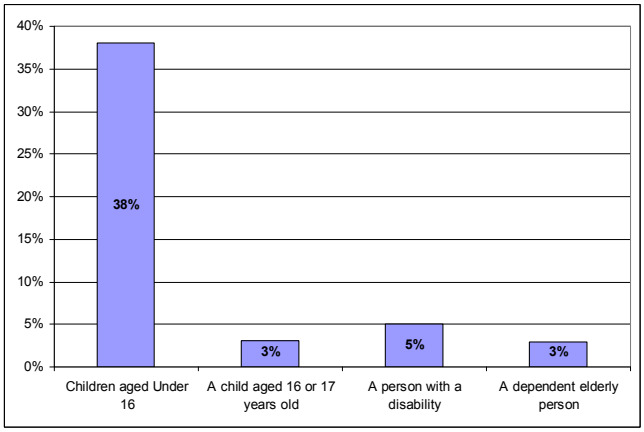


10. Do you have any long-term illness, health problem or disability which limits your daily activities or the work you can do?

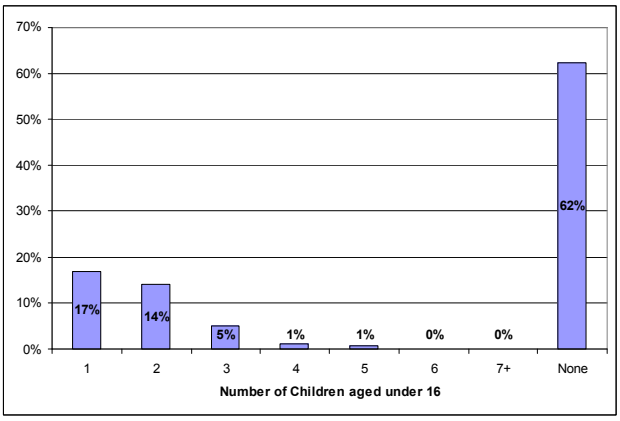




11. How many Children aged under 16 are there in your household, and do you have personal responsibility for the care of any of the following:



How many children aged under 16 are there in your household?



If you could do one thing to make health and social care services better what would it be?

Theme	No of responses	% of Total
More staff / no cutbacks on staff	126	11%
Don't know	120	11%
More money / spend money more wisely	81	7%
Shorter waiting times for GP / hospital appointments	77	7%
Reducing waiting times (general)	77	7%
Other	64	6%
Nothing	62	6%
Cut back on managers	41	4%
Keep services local / accessible	37	3%
Shorter waiting times at A&Es	34	3%
Better care for the elderly	29	3%
Improved care	24	2%
Cut down on bureaucracy / admin	23	2%
GP/doctor more accessible	23	2%
Better communication with patients / more information	22	2%
Better qualified staff / improve training	21	2%
Better mental health provision	17	2%
More flexible / longer opening hours for GPs	16	1%
More / better equipment / services	15	1%
Improve pay for nurses/doctors	14	1%
Improve A&E services	14	1%
Improve efficiency	14	1%
Keep hospitals open / more hospitals	13	1%
Bring back matrons	13	1%
Improve communication between GPs and other departments	11	1%
Cleanliness of facilities	11	1%
Making people more aware of services	10	1%
More services for children	10	1%
Keep A&Es open 24/7	9	1%
Longer opening hours for hospitals	8	1%
More beds in hospitals	7	1%
Access to specialists	7	1%
Penalties for missed appointments	6	1%
More community care / voluntary services	6	1%
Avoiding further cuts	6	1%
Consult with the public	5	0%
Fee for prescriptions / money wasted on prescriptions	5	0%
Open A&E at Lagan Valley	5	0%
More coverage in rural areas	4	0%
Improve follow-up care	4	0%
The way HSCNI is run	4	0%
Consistency of care	3	0%

Improve ambulance services	3	0%
Improving services for people with disabilities	3	0%
More time spent with patients	3	0%
More call outs	2	0%
Access to medical records	2	0%
Better working conditions	1	0%
Best practice in other countries	1	0%

Appendix 4
Questions Raised at Public Meetings

Questions Raised at Public Meetings

Tuesday 8th November 2011 at 7pm
Great Hall, Magee Campus, University of Ulster

- Mental health services have always been the "Cinderella" and are currently ten years behind UK funding levels. Will the Review Panel bring this to the notice of the Minister?

- How can the Review Team ensure relevant follow-up after care for services which take place elsewhere and are not sustainable in NI e.g. follow up for transgender people who have had surgery in other parts of the UK?

- The necessity for provision of respite care to go someway to alleviate massive carer stress and in order to allow carers to continue looking after loved ones in the community.

- How can you ensure quality of care with continual use of locum/agency staff when so many qualified practitioners/service providers are desperately seeking employment?

- Does the Panel feel that it may be time for a shift to a more social, rather than medical model of care, due to the ageing population?

- What consideration will the Health and Social Care Board be giving to building working relationships with the Health Service Executive in the Republic of Ireland in order to secure efficiencies in Service Delivery?

- Does the Panel have a view on the impact of the poor infrastructure in NI (i.e. lack of adequate rail link) on health care provision for people in the North West?

- How should the Department commission services for uncommon/rare conditions?

- Is there any recognition that we have just come out of 'conflict' and that health (especially mental health) is affected?

- Regarding mental health services, are there any plans to shift some of the budget to address the "Cinderella" service?

- Why do mental health patients go through A&E – why not have a mental health emergency room?

- How can commissioners support research to gauge the effectiveness of community interventions, which often do the most to promote inclusion but struggle to attract secure resources?

Wednesday 9th November 2011 at 7pm
Omagh Enterprise Centre, Omagh

- Why are there going to be hospital cut backs – particularly when new ones are being built but there is no money to run them?

- There is a growing emphasis on children's rights at the expense of the wishes and consent of parents. What protection will there be for the rights of parents?

- In the light of funding being withdrawn from the A5 (Derry – Aughnacloy Rd), can the Review Team use its influence to transfer the funding to the Omagh – Enniskillen (Hospital) Rd?

- Transport services to and from hospital is very poor. Older people refuse to go into hospital as they have no service to bring them home once discharged. Are there any plans to address this?

- What will the Review do to address Mental Health services as funding at present is inadequate?

- What are your greatest frustrations as a GP in a rural area (Dr. Gallagher) and what anxieties have you for our services over the next 5 years?

- The Review Team suggested a further shift of care from secondary into primary/ community care. How are planning to address the issue that primary care is already absorbing the bulk of care and there is no slack to be taken up?

- Why do we need a Board, and why do we need Trusts which have been allowed to become too powerful?

- Hospitals are not placed in the correct areas or take into account hospital across the border.

- How are hospitals going to be run? For example, the Erne has had its services cut back from what was promised.

- Communication is inefficient everywhere in the system. How does the Review plan to address this?

- Why are we not looking to innovation to reduce costs?

- Why don't the Patient and Client Council get a report from every patient after they visit a hospital?

- Can we have a nurse led midwifery stand alone unit at Enniskillen hospital?

- The Review should be carried out for the right reasons and not for an easy option. For example, safeguarding services to put another service in danger.

- Can the Review look at equity of service provision? For example, maternity services.

- Will the Review be based on an identified needs approach?

- Can we have assurances that our Health Service will remain public and free?

- Will all new initiatives be equality checked?

- Can we have assurances that the UK Health and Social care Bill will not be introduced?

- Will the Review look at statistics from the Trust Delivery Plans?

- How does the Review plan to reduce hospital bed waiting times at A&E?

Monday 14th November 2011 at 7pm
Ballymena Showgrounds, Ballymena

- There is a lack of good transport links for rural areas. How can equality be achieved for the socially poor who are left with no access to acute hospitals?

- How can HSC and society do more to protect the most vulnerable people e.g. victims of domestic violence, young and old?

- Has the Review looked at oral surgery services in primary and secondary care?

- Have there been any pilots set up to trial the emerging themes?

- How do you tackle resistance from consultants who use waiting lists to fund private practice?

- In the Northern Trust, the number of attendances and review attendances has dropped while there has been a massive increase in inpatients and daycases. We want to know what services are being given to us rather than taken away.

- The recommendations from the Comprehensive Spending Review were found to be untrue. How will you ensure this will not happen again?

- Has the Review Team engaged with community pharmacy and will it give a commitment to do so?

- With the planned closure of 100 pharmacies across the Province, how will this fit with the proposed move to primary care? What additional roles will community pharmacy have to take on?

- Will the Mid Ulster hospital receive the build and services it requires as stated in Developing Better Services?

- Are acute hospitals in the correct location to best serve patient need?

- Does the Review Team belie that a Rapid Response Vehicle is sufficient to fill the gap left by the closure of acute services in the Mid Ulster Hospital?
- Is it inevitable that fund shortages equal longer waiting times?

- What improvements can be made to case waiting times and welfare reports in relation to child abuse and acrimonious parental separation?

- Will the Review recommend making social workers give evidence under oath?

- Are there any plans to change the Dalriada Doctor on Call services within the Northern Trust i.e. move them to hospital sites?

Tuesday 15th November 2011 at 7pm
Assembly Buildings Conference Centre, Belfast

- What provision is in place in the Ulster Hospital, should it have to close, due to a super bug outbreak?

- What is the status of the McKinsey Report on/within the Review?

- Does the Panel see an expanded role for Multiple Sclerosis carers and would they be prepared to allocate some funding or shift in resources?

- The mandate is growth of domiciliary care. Is there any development in the funding?

- Do you feel that day care within the HSC Trusts is too cheap at £1.35 per day? Private day care is priced at £8 per hour.

- Out of 100 young people with severe learning disabilities leaving school each year in Northern Ireland, 20% with more complex needs have no choice but to attend a day centre – where is their choice for lifelong learning?

- Do the Panel feel that the cutting of jobs from Learning Disability services and not replacing day care workers is correct?

- Does the Review Team plan to address the short fall in Mental Health, as it is already underfunded by 44%?

- As an adult who has been diagnosed with a personality disorder, where is the promised help that the Bamford Report said was coming?

- During the Review is any thought given to the fact that we have 30% less cars here than the UK mainland and a transport system that stops at 9pm?

- What is the point in having a centre of excellence if it is located in an area unattainable to the public?

- What principles is the Review Team considering for the number of hospitals in Belfast and the services they provide? Will their funding be cut?

- What will be the acute status of all Belfast hospitals after the Review?

- Is the right to a second opinion still available?

- When one is a patient, can they be provided with a card that shows relevant standards for the service/treatment at issue? Patients don't generally know what they can expect.

- Pharmacy is not mentioned in the Review. Has the Panel considered the benefits and quality outcomes that could be achieved in Primary Care by fully engaging with Community Pharmacy?

- As the Minister has indicated he wants to close 100 Pharmacies, how will that impact on Community Pharmacy's ability to play its part in Primary Care?

- The Minister is on record of saying that there are 100 too many Pharmacies in NI. Has any consideration been given by this Review Team on the impact to the public if this was enacted?

- Why has Community Pharmacy not been covered by the Review?

- As Community Pharmacy is an integral part of the Primary Care team, has the Review Team any plans to engage with their representatives to obtain their view?

- Will the Review Team follow the Health Minister's stated intention of privatising social care services?

- You discussed ‘evidence’ of health inequalities in our society. Do you have plans as to how to address these in lower socio-economic groups with shorter life expectancy? What does that mean in relation to services?

- Does the panel believe in the principles of the NHS i.e. free at the point of need for all?

- What criteria is the there for the quality of care for the elderly in nursing homes where business people are requesting staff to cut incontinence pads?

- There is often mentioned ‘interdepartmental working/interagency working’. Describe what that would look like if it were being done successfully across all government departments. What needs to change to make it happen?

- How innovative is this Review going to be e.g. in other parts of the UK there have been introductions for playgrounds for over 60s. Will this Review be as far ranging and looking at a whole systems approach to tackling health and social care?

- When you say the workforce needs to be ‘less professionally driven’ and be shaped more towards services, what do you mean?

- What are the plans to ensure that OT services should be developed as a core element of Child and Adolescent Mental Health provision as recommended by Bamford in 2006?

- Has the Review recognised the need to resource an already stretched frontline service with the means to treat individuals ‘in the right place, at the right time and by the right people’?

Thursday 17th November 2011 at 7pm
Lagan View Enterprise Centre, Lisburn

- Who cares for the carers with health?

- How is the Downe A&E organised overnight? Is this a model that could be adopted for Lisburn?

- If the City hospital is going to become a specialist centre for chronic conditions within Belfast, could Lagan Valley become a specialist centre in the South Eastern Trust area in the same way?

- Do the panel agree that transparency is key to any planned changes and what is being done to ensure this takes place?

- What are the likely outcomes of the Review for (a) patients/users and (b) health care professionals?

- What preventative measures can be taken to reduce the obesogenic nature of our environment?

- Providing screening and enhanced services in community pharmacy can reduce NHS costs through early detection and treatment. This can remove pressure from our secondary care sector. Does the Review agree?

- Will the Review take account of the work of voluntary sector organisations and the value for money that these organisations provide?

- The N.I Assembly budget ensured that there would be no cut to Learning Disability budget. Can you confirm that this review completely safeguards this?

- Can the Review Team ensure that the recommendations made in the Bamford Review will be implemented?

- With nursing posts not being replaced and sick leave and maternity leave not being covered – how can we ensure delivery of patient-centred care?

- Why are hospitals still run on a Monday to Friday basis with skeleton staff working at weekends?

- In other parts of the UK (e.g. Scotland), community pharmacy plays a much greater role in the provision of both core and enhanced pharmaceutical services. Does the Review envisage this as the way forward in N.I?

- There is clear evidence that O.T. led reablement services deliver positive outcomes. Can the Review Team ensure that such services will be available to all service users in N.I?

- What is the potential for 24hr cover again in Lagan Valley A&E? Can local GPs help to ‘man’ the department?

- How is the RVH coping with the extra patients from LVH and BCH?

- With an annual intake of 135 medical students in QUB, where have all the doctors gone?

- Is it possible to use GP trainee doctors to staff local A&E departments as part of their training?

- There must be concern at the much lower resource spend on children in NI than elsewhere in the UK. Can the Review identify ways to increase the priority of services for children?

- How will the system deliver a more caring service to cancer patients who are terminally ill and at home? Will you work collaboratively with other depts. e.g. DSD for better housing conditions?

- What interventions can be made to ensure much needed improvements in the delivery of home care packages?

- Does the Lagan Valley hospital have a future?

Wednesday 23rd November 2011 at 7pm
St Patrick's Trian, Armagh

- How many more reports do we need? What are you going to do differently?

- The Department of Education is planning a 0-5 Early Years' Strategy – will the Review seek to link in the Department of Health, Social Services and Public Safety's pregnancy-5years provision with the Department of Education strategy?

- Are LCGs fit for purpose and how much money has been used to date? Are we getting Value for Money?

- Is there an assurance that Allied Health Professions staff will still be valued as integral to the process of effective/safe discharge planning from the acute setting into community care, as the focus appears primarily to be on community sector?

- There is a lot of talk on radio of proposed Pharmacy closures – what is the timescale for these closures?

- Would the Panel consider it a missed opportunity that the role Community Pharmacy could play in bringing health to the community is not mentioned in the Review?

- Will the Review recommend extended roles for Community Pharmacy in managing patients in the community, services to prevent ill health, health promotion etc?

- What plans are in place for more supported living accommodation in Newry? It is badly needed within the next two years.

- Are there any plans in place to build more long-term accommodation in the Newry area?

- Carers are for many the backbone of the health and social care system. In return the system has promised to deliver support to carers when it is needed. This is supposed to be achieved by offering each qualifying carer a Carers Assessment. This requirement is one of the statutory functions of the HSC Trusts. However, many Trusts do not fulfil this requirement and many carers continue to carry out their caring role without adequate support. How will the Review ensure that Trusts will no longer be able to neglect this statutory duty and how will the Board guarantee widespread compliance with this duty?

- Should service users, carers and members of the public have more say in how health and social care budgets are spent, via the use of scrutiny committees or citizen juries to ensure the public have real and meaningful input to service provision? The welcome initiative of Patient and Personal Involvement was introduced without direct funding for the development of this strategy. Will the initiative fail if health and social care fails to properly fund its development across the sector?

- What is your opinion of the proposals which include 'older people' receiving funds to pay their carers? Will this not further confuse the elderly?

- The BBC carried an article on the huge predicted increase in elderly population and the demand this will place on domiciliary care and social services. What is the Panel's view on the impact this will have on acute services for hospital admissions?

- Following speculation in the press – do you plan to close Accident and Emergency and acute services in Daisy Hill Hospital?

- With less acute hospitals how will service users access treatment from rural areas with insufficient public transport?

- Where is the infrastructure that will support a reduced number of hospitals, which is widely rumoured to be the outcome of the Review? There is no use modelling ourselves on urban environments without appropriate support and access.

- What impact will this Review have on jobs within the HSC?

- In light of the recent publicity in the press, radio and TV, is there any point in this meeting as the Review has already been written?

- What would you do to encourage appropriate restructuring of resettlement teams to include Occupational Therapists with unique skills to assess and advise on support needs equipment and adaptations in line with a number of Bamford recommendations?

- Would the Panel agree that GPs should be left to treat their patients thus leaving the complex range of other care to Trusts and other staff?

- Do the Panel believe that the independent/private sector can run services better and/or cheaper than the Trusts currently do?

- The shift in community based care – is this not more idealistic than realistic? Are the people/relatives expected to do this because of economic resources?

- Can Mr Compton give an assurance that A&E and emergency surgical services will be maintained at Daisy Hill Hospital?

- Leaks about the downgrading of Daisy Hill Hospital have already affected staff morale – can you reassure us about the future of Daisy Hill Hospital and that the level of services will be maintained?

- Commenting on a leaked report of 29/06/2011, will the Review result in: 2000 jobs lost; £40 cut from locum doctors and doctors; £30million cut from Pharmacy budget; a recruitment freeze; and the number of acute hospitals cut by 50%?

Appendix 5
List of Attendees at Clinical Workshops & Areas Covered

Workshop 1: Unscheduled Care, Specialist Services (including Cancer), Elective Care
Wednesday 12th October 2011 at 4pm
Ballymena Showgrounds, Warden Street, Ballymena, BT43 7DR

Name	Organisation
Jennifer Welsh	BHSCT
Dr Patricia Donnelly	BHSCT
Dr Dermot Maguire	GP
Dr Garth Logan	GP
Dr Sloan Harper	HSCB
Beth Malloy	HSCB
Jeff Featherstone	HSCB
Louise McMahon	HSCB
Paul Leyden	NHSCT
Tom Morton	NHSCT
Margaret O'Hagan	NHSCT
Stephanie Greenwood	NHSCT
Dr Olivia Dornan	NHSCT
Joanne McKee	NHSCT
Sean Donaghy	NHSCT
Martin Sloan	NHSCT
Jackie Elliott	NHSCT
Brenda McConville	NHSCT
Denise Quinn	NHSCT
Valerie Jackson	NHSCT
Liam McIvor	NIAS
Dr David McManus	NIAS
Liz Henderson	NICAN
Eleanor Ross	PHA
Dr Miriam McCarthy	PHA
Paul Kavanagh	PHA
Kevin McMahon	PHA
Dr Janet Little	PHA
Chris Allam	SET
Joe Toner	SET
Sean McGovern	SET
Mark Armstrong	SET
Dr Tim Harding	SET
Stephen Hall	SHSCT
Dr John Simpson	SHSCT
Seamus O'Reilly	SHSCT
Robert Carlile	SHSCT
Gillian Rankin	SHSCT
Heather Trouton	SHSCT
Charlie McAllister	SHSCT
Dr Bassam Aljarad	SHSCT

Paula Clarke	SHSCT
Phillip Murphy	SHSCT
Robin Brown	SHSCT
Ron Thompson	WHSCT
Geraldine Hillick	WHSCT
Dr Padhraig Conneally	WHSCT
Dr Brendan Devlin	WHSCT
Dr Paul McSorley	WHSCT
Stephen Clanaghan	WHSCT
Dr Caroline Mason	WHSCT
Dr Fergal McNicholl	WHSCT
Gerard Daly	WHSCT
Michael Riley	
Gloria Mills	

Workshop 2: Long Term Conditions, Care for Older People, Physical Disability, End of Life Care
Thursday 13th October 2011 at 4pm
Lisburn Civic Centre, Lagan Valley Island, Lisburn, BT27 4LR

Name	Organisation
Dr Ken Lowry	BHSCT
Dr Alister Taggart	BHSCT
Dr John McCann	BHSCT
Denise Killough	BHSCT
Dr Bernie Corcoran	BHSCT
Una McAuley	BHSCT
Bernie Kelly	BHSCT
Dr Grainne Bonnar	GP
Dr Paul McGerrity	GP
Iain Deboys	HSCB
Dr Sloan Harper	HSCB
Margaret O'Brien	HSCB
Fiona Gilmour	NHSCT
Yvonne Duff	NHSCT
Wendy Longshawe	NHSCT
Ann Orr	NHSCT
Fergal Tracey	NHSCT
Patrick Graham	NHSCT
Wendy Magowan	NHSCT
Hazel Winning	NHSCT
Adele Kennedy	NHSCT
Sean Falls	NHSCT
Melanie Phillips	NHSCT
Brian Serplus	NHSCT
Debbie Gillespie,	NHSCT
Liz Knight	NHSCT
Liam McIvor	NIAS
Brid Farrell	PHA
Siobhan McIntyre	PHA
Dr Walter Boyd	SELCG
Charlotte McArdle	SET
Janice Colligan	SET
Sarah Browne	SET
Bridie McKeating	SET
Bria Mongan	SET
Ray Elder	SET
Dr Simon Coulter	SET
Paula Clarke	SHSCT
Angela McVeigh	SHSCT
Francis Rice	SHSCT
Pat McCaffrey	SHSCT

Miceal Crilly	SHSCT
Roisin Toner	SHSCT
Cynthia Cranston	SHSCT
Dr Angela Garvey	WHSCT
Mr John McGarvey	WHSCT
Mr Brendan McGrath	WHSCT
Mr Garry Hyde	WHSCT
Dr Joe McElroy	WHSCT
Alison Cook	

Workshop 3: Family and Child Care, Maternity and Child Health
Friday 14th October 2011 at 4pm
Malone House, Barnett Demesne, Belfast, BT9 5PB

Name	Organisation
Brian Barry	BHSCT
Ann Moffett	BHSCT
Liz Bannon	BHSCT
John Growcott	BHSCT
Lesley Walker	BHSCT
Clifford Mayes	BHSCT
Paul Jackson	BHSCT
Dr Brian Patterson	GP
Dr Reggie McAuley	GP
John Duffy	HSCB
Dr Ursula Brennan	HSCB
Louise McMahon	HSCB
Mary Maxwell	NHSCT
Brenda McConville	NHSCT
Dr Michael Ledwith	NHSCT
Ian Allen	NHSCT
Martin Sloan	NHSCT
Sean Donaghy	NHSCT
Grace Edge	NHSCT
Heather Reid	PHA
Denise Boulter	PHA
Deirdre Webb	PHA
Fiona Kennedy	PHA
Joanne McClean	PHA
David Glenn	SET
Marian Robertson	SET
Heather Crawford	SET
Jackie McGarvey	SET
Ian Sutherland	SET
Elaine Madden	SET
Zoe Boreland	SET
Marian Campbell	SET
Paul Morgan	SHSCT
Geraldine Maguire	SHSCT
Patricia McStay	SHSCT
Peadar White	SHSCT
Colm McCafferty	SHSCT
Julie McConville	SHSCT
Michael Hoy	SHSCT
Janet McConville	SHSCT

Appendix 6
List of Attendees at Sector Workshops

Review of Health & Social Care Services in Northern Ireland
Northern Ireland Council for Voluntary Action Workshop
Tuesday 1st November at 10am
NICVA, 61 Duncairn Gardens, Belfast, BT15 2GB

Name	Organisation
Claire Armstrong	Addiction NI
David Barnes	Royal National Institute for the Blind NI
Paula Beattie	Trauma Recovery Network
Bernadette Best	Action Mental Health Central Office
Patricia Boyd	Shankill Women's Centre
Myrna Brown	Northern Ireland ME Association
Pauline Brown	British Red Cross (NI) Belfast
Ann Cooney	Southern Area Hospice Services
Carmel Costello	Carers UK Belfast Central Branch - Newtownabbey
Judith Cross	Age NI
Chris Deconink	East Belfast Community Development Agency
Karen Diamond	NI Music Therapy Trust
Geraldine Fennell	Carers UK Belfast Central Branch – Newtownabbey
Helen Ferguson	Carers Northern Ireland
Pauline Ferguson	Positive Futures for People with A Learning Disability
Dolores Finnerty	Caring Breaks Limited
Kate Fleck	Arthritis Care Northern Ireland Regional Office
Nicola Gault	Compass Advocacy Network Limited
Nigel Hampton	Enable NI
Claire Anne Irvine	Stratagem (NI) Limited
Dympna Johnston	Greater Shankill Partnership
Neil Johnston	NI Chest Heart & Stroke
Tom McEneaney	Aware Defeat Depression Belfast Office
Joe McGrann	Bryson Charitable Group
Joseph McKane	Forum for Action on Substance Abuse – Belfast HQ
Linda McKendry	Compass Advocacy Network Limited
Esther McQuillan	Parkinson's UK
Brian Mullan	North Belfast Partnership
Iain Neill	MACS Supporting Young People
Mary O'Hagan	Community Development Health Network
Ronnie Orr	Public Health Agency
Caitlin Reid	TinyLife
Kirsty Richardson	Greenway Womens Centre
Eddie Rooney	Public Health Agency
Mark Shepherd	Stratagem (NI) Limited
Patricia Short	Open College Network Northern Ireland
Alicia Toal	Voice of Young People in Care Ltd HQ
Anne Townsend	CRUSE Bereavement Care NI
Clare Watson	MS Society NI
Heather Woods	Dundonald Family & Community Initiative
Trevor Wright	Extern

Review of Health and Social Care Services
Business Alliance Event
Thursday 3rd November 2011 at 3pm
Boardroom, Equality Commission, Equality House, 7-9 Shaftesbury Square, Belfast, BT2 7DP

Name	Organisation
Mr John Compton	Review HSCNI
Mr Mark Ennis	Review HSCNI
Mr Mark Gibson	BT
Mr Mark Hopkins	BT
Mr Alan Irwin	BT
Ms Anne McGregor	NICC
Mr Mark Regan	Kingsbridge Private Hospital
Mr Michael Caulfield	Connected Health
Mr Nevin Ringland	Praxis Care
Mr Roger McMillan	Carson McDowell
Ms Aoife Clarke	CBI NI
Mr Bob Barber	Centre for Competitiveness

Northern Ireland Social Care Council
Registrant Engagement Event
Tuesday 8th November at 2pm
The Pavilion, Stormont, Upper Newtownards Road, Belfast, BT4 3TA

Name	Organisation
Norma Blair	Ardmonagh Family & Community Group
Avery Bowser	Centre for Effective Services
Margaret Burke	BHSCT
Clare Burke	Care Circle
Veronica Callaghan	NHSCT
Lynne Calvert	BHSCT
Janet Carter Anand	Queen's University Belfast
Martin Creed	BHSCT
Julie Cunningham	Community Nurse
Patrick Curry	NHSCT
Sharron Cushley	Salvation Army
Martin Doran	Care Circle
Rosemary Edgar	
Lorraine Gibson	NHSCT
Nuala Gorman	SHSCT
Alan Hanna	Autism Initiatives NI
Michaela Herron	Salvation Army
Linda Hook	Salvation Army
Marita Magennis	SHSCT
Fiona McCartan	Youth Justice Agency
Valerie McConnell	HSCB
Siobhan McCormac	Ardmonagh Family & Community Group
Margaret McCrudden	Newington Day Centre
Gillian McGalliard	NHSCT
Ann McGlone	Willbank Community Resource Centre
Zara McIlmoyle	NHSCT
Mary McIntosh	SHSCT
Joyce McKee	HSCB
William McKnight	BHSCT
Kerry McTeague	NHSCT
Margaret Monaghan	BELB
Seaneen Pettigrew	NHSCT
Gail Saunders	Homecare Independent Living
Joan Scott	SEHSCT
Paula Smyth	Leonard Cheshire Disability
Janene Swain	Rodgers Community Care

Northern Ireland Social Care Council
Registrant Engagement Event
Thursday 10th November at 10.30am
MDEC Building, Altnagelvin Area Hospital, Glenshane Road, Londonderry, BT47 6SB

Name	Organisation
Linda Beckett	Glen Caring Services
Fiona Devlin	NHSCT
Jean Doherty	WHSCT
Marian Doherty	WHSCT
Kitty Downey	Slievemore House
Sheena Funston	WHSCT
Vanessa Hegarty	WHSCT
Louise Horner	Leonard Cheshire Disability
Jonny Hoy	Simon Community NI
Moia Irvine	WHSCT
John Jackson	Slievemore House
Geraldine Jones	Limavady Community Development Initiative
Robin Kennedy	WHSCT
Bryan Leonard	Leonard Cheshire Disability
Elizabeth Logan	Partnership Care West
Martina McGuinness	Extra Care
Paul McLaughlin	WHSCT
Pat McMenamin	WHSCT
Dolores Moran	WHSCT
Rhonda Murphy	Action for Children
Sinead Murphy	Leonard Cheshire Disability
Stephen O'Connor	Seymour Gardens Residential Home
Michelle O'Neill	Praxis Care
Lorraine O'Kane	Slievemore House
Liam Quigley	Northern Ireland Association for Mental Health
Carol Scoltock	WHSCT
Paul Sweeney	Extern
Teresa Sweidan	WHSCT
Anne Weir	Probation Board for Northern Ireland

Appendix 7
List of Stakeholders Engaged with at Small Group Meetings

List of Stakeholders Engaged with at Small Group Meetings

Age NI
Alliance Party
Assistant Director of Allied Health Professions and Public Involvement, Public Health Agency (PHA)
Assistant Director of Human Resources, Business Services Organisation (BSO)
Assistant Director of ICT, Health and Social Care Board (HSCB)
Assistant Director of Integrated Care, Head of General Medical Services, HSCB
Assistant Director of Social Care and Children, Mental Health, HSCB
Assistant National Director for Disabilities, Health Service Executive (HSE), Republic of Ireland
Assistant National Director for Mental Health Services, HSE, Republic of Ireland
Assistant National Director for Older Persons, HSE, Republic of Ireland
Assistant National Director for Primary Care, HSE, Republic of Ireland
Bamford Monitoring Group
Belfast Health and Social Care Trust (BHSCT)
British Medical Association
Business Services Organisation
Department of Health, Social Services and Public Safety (DHSSPS)
Chair & Chief Executive, Patient and Client Council
Chairman, HSCB
Chartered Society of Physiotherapists
Chief Dental Officer, DHSSPS
Chief Economist, Health Policy, The King's Fund
Chief Executive, BSO
Chief Executive, PHA
Chief Legal Adviser, BSO
Chief Medical Officer, DHSSPS
Chief Nursing Officer, DHSSPS
Chief Pharmaceutical Officer, DHSSPS
Chief Social Services Officer, DHSSPS
Chief Officers 3rd Sector
College of Occupational Therapists
Community Pharmacy Northern Ireland
Communications Manager, HSCB
Democratic Unionist Party
DHSSPS Partnership Forum
Bishop of Down and Connor, Diocese of Down and Connor
Director General, Department of Health and Children, Republic of Ireland
Director General, Department of Health, Social Services and Children, NHS Wales
Director of Cabinet Operations, Scottish Government
Director of Commissioning, HSCB
Director of Finance, HSCB
Director of Human Resources, DHSSPS

Director of Integrated Care, HSCB
Director of Nursing and Allied Health Professionals, PHA
Director of Performance Management and Service Improvement, HSCB
Director of Planning and Redevelopment Services, BHSCT
Director of Social Care and Children, HSCB
Disability Social Care Forum
Equality Commission for Northern Ireland
Equality Manger, Business Services Organisation
Four Seasons Health Care
Head of Corporate Services, HSCB
Head of Information and Analysis Directorate, DHSSPS
Health and Social Care Board Members
Health Service Executive, Republic of Ireland
Independent Health and Care Providers
Junior Ministers, Office of the First Minister and Deputy First Minister
Law Centre – Rights in Community Care Group
Medical Adviser, HSCB
Northern Health and Social Care Trust
Northern Ireland Ambulance Service
Northern Ireland Association for Mental Health
Northern Ireland Confederation for Health and Social Services
Northern Ireland General Practitioners Committee
Northern Ireland Human Rights Commission
Northern Ireland Social Care Council
Northern Ireland Practice and Education Council for Nursing and Midwifery
Northern Ireland Public Sector Alliance
Northern Ireland Medical and Dental Training Agency
Open University
Pharmaceutical Society of Northern Ireland
Professor the Lord Darzi of Denham PC
Programme Director, European Centre for Connected Health, PHA
Regional Director of Operations, HSE, Republic of Ireland
Regulation and Quality Improvement Authority
Royal College of General Practitioners
Royal College of Midwifery
Royal College of Nursing
Senior Adviser, Special Delivery Unit, Department of Health and Children, Republic of Ireland
Sinn Fein
Social Democratic and Labour Party
South Eastern Health and Social Care Trust
Southern Health and Social Care Trust
Trust Chief Executive Forum
Trust Directors of Social Work
Ulster Unionist Party
UNITE
Western Health and Social Care Trust

Appendix 8
List of Written Submissions

List of Written Submissions

Age NI
Aisling Centre
Alliance for Choice
Alzheimer's Society
Association of the British Pharmaceutical Industry
Belfast Health and Social Care Trust (BHSCT)
British Medical Association
British Red Cross
Business Services Organisation
CBI Northern Ireland
Centre for Effective Services
Centric Health
College of Occupational Therapists
Consultant Paediatric Surgeons, Royal Belfast Hospital for Sick Children, (BHSCT)
Co-operation and Working Together
Craigavon Lipreading Class
Cyclist Touring Club Right to Ride Network
Diabetes UK
Domestic Care
Dr Julian Kennedy
Fermanagh District Council
General Practitioners in Fermanagh (collective response)
Global Diagnostics Ireland and Ennis General Hospital
Health and Social Care Board
Independent Health and Care Providers
Intelesens Limited
Lisburn City Council
Macmillan Cancer Support
Mater Hospital Community Forum
Mencap
Mr Ian Houston
Mrs Valerie Rosenberg
National Confidential Enquiry into Patient Outcome and Death
Neurological Conditions Service User and Carer Reference Group
Northern Health and Social Care Trust
Northern Ireland Ambulance Service
Northern Ireland Confederation for Health and Social Services
Northern Ireland Hospice
Northern Ireland Practice and Education Council for Nursing and Midwifery
Omagh Hospital Campaign Group
Pharmaceutical Society for Northern Ireland Professional Forum
Princess Royal Trust for Carers
Professor AP Passmore, Professor of Ageing and Geriatric Medicine, Queen's University Belfast
Regulation and Quality Improvement Authority
Royal College of Nursing

Royal College of Psychiatrists
Save the Mid Campaign
South Eastern Health and Social Care Trust
Southern Health and Social Care Trust
Sustrans
TF3 Consortium
Trust Chief Executives Forum
United Kingdom Homecare Association
Volunteer Now
Western Health and Social Care Trust

Appendix 9
Glossary

Glossary

A&E – Accident and Emergency

CAMHS – Child and Adolescent Mental Health Services

DETI – Department of Enterprise, Trade and Investment

DHSSPS – Department of Health, Social Services and Public Safety

ECR – Electronic Care Record

GP – General Practitioner

GPSI – General Practitioner with Specialist Interest

HSC – Health and Social Care

HSCB – Health and Social Care Board

LTCs – Long-term conditions

MLA – Member of the Legislative Assembly

MRI – Magnetic Resonance Imaging

NHS – National Health Service

NIAS – Northern Ireland Ambulance Service

NICE – National Institute for Health and Clinical Excellence

NISAT – Northern Ireland Single Assessment Tool

PCC – Patient and Client Council

PCI – Percutaneous Coronary Intervention

PHA – Public Health Agency

QOF – Quality and Outcomes Framework

RQIA – Regulation and Quality Improvement Authority


HSC
Health and
Social Care