

Executive summary

Dear Minister

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

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

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

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

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

Funding

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Use of resources

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

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

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

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

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

Recommendation 10 : Detailed analysis is needed into hospital activity trends as part of a broader analysis of the dynamics of waiting times and lists (Section 3.3.1).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Performance management

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



**Professor John Appleby
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