

## ***DEVELOPING BETTER SERVICES*** **MINISTERIAL ANNOUNCEMENT**

In June 2002 my predecessor, Bairbre de Brún, issued the consultation document *Developing Better Services: Modernising Hospitals and Reforming Structures*. It contained a range of proposals for modernising acute hospital services, building on the recommendations from the Acute Hospitals Review Group report and setting out proposals for new organisational structures to manage health and social services.

The consultation period for *Developing Better Services* ended on 31 October. A substantial number of responses were received, including nearly 8,000 reports, letters, postcards and e-mails as well as petitions bearing some 40,000 signatures. The responses came from a variety of organisations and individuals, including voluntary and community bodies, local councils, professional bodies, health and social care professionals, political parties and Health and Social Services bodies.

I want to thank all of those who took the time to make their contribution to the consultation process. They have played a valuable part in helping me come to my decisions.

On 27 January I put into the public domain further information which had been received after the end of the consultation period and which

might have influenced my decision. I did so as I felt it was important that everyone should see, and should have the opportunity to comment on, all of the material which could form part of my consideration of the issues. The necessary publication of that information unfortunately delayed the decisions for a short period of time.

Since taking on the Ministerial responsibility for Health, Social Services and Public Safety on 14 October 2002, I have met with a range of elected representatives and interest groups and I have visited and talked to staff in hospitals about the proposals in *Developing Better Services*. I have also met with Dr Maurice Hayes, the Chair of the Acute Services Review Group.

While different views exist on the decisions to be taken, everyone I have met has pressed on me the urgent need to end further deliberation and to announce as soon as possible my decisions on these proposals. They were right to do so. My announcement today signals the beginning of a long overdue programme of modernisation of hospital services in Northern Ireland.

## **THE DRIVERS FOR CHANGE**

My starting point in considering the issues is to do what is best for patients throughout Northern Ireland

Thirty years ago we could not have foreseen the enormous changes in health treatment and care or the increased demand for hospital services that we face today. Nor could we have anticipated the pressures that have arisen because of the success of the Health Service in treating patients

Some of these pressures are the result of population changes. Apart from the normal growth in the population, the proportion of elderly people is set to rise dramatically over the next decade or two and this will lead to a substantial increase in demand for health and social care and treatment. Happily, people are living longer, but this also means an increased demand for hospital and community care.

There is also a much greater expectation of high quality care by a better informed public. Demands for emergency care and treatment, which used to give rise to particular pressures in the winter months are now an all year round pressure on hospital resources. This in turn is placing more pressure on waiting times for elective surgery.

At the same time, medicine is now able to do so much more in the treatment of serious illnesses. In addition a whole range of developments in medical technology has opened up opportunities for both diagnosis and treatment, unheard of a generation ago.

Developments in medical technology have also created the possibility for some investigations and treatments to be delivered locally, nearer peoples' homes. Telemedicine for example, allows expert medical opinion to be accessed remotely between hospitals or by a local GP.

To keep pace with all of these developments, medical staff must develop their expertise in particular specialisms. The days of the general physician or surgeon are coming to an end. Training for new doctors no longer provides general skills, but places greater emphasis on developing knowledge and expertise in particular specialties.

Everyone is agreed that these advances in medical treatment and care are welcome and should be embraced, but they have a significant impact on our acute hospital system.

At present we have 15 acute hospitals in Northern Ireland serving a population of 1.7 million people. Most of the population is concentrated in the East and to the North with much of the remainder living in rural areas. Our existing hospital network has developed accordingly, with the larger hospitals around the centres of population and smaller acute hospitals serving local, mainly rural communities.

With the changes in medicine I have mentioned, this profile of hospitals is no longer appropriate. All of our hospitals are under pressure, but it is the smaller hospitals that are at the greatest risk,

since they cannot meet the standards of the specialties that are the essential core of acute care. This is a matter of safety and the quality of services and we cannot compromise on it.

Everyone is agreed that we must take the steps necessary to develop a modern, efficient and patient centred hospital service fit for the 21<sup>st</sup> century; that we must develop and utilise to the full, the benefits of new treatments, new technology and modern professional skills.

While at the same time, that we must not lose sight of the value of keeping services wherever possible at the heart of local communities.

*Developing Better Services* noted the view of the Royal College of Surgeons and other professional bodies that an acute hospital, providing a full range of facilities and acute specialities should be sufficiently large to service a population of between 450,000 – 500,000. For Northern Ireland this would mean three or at the most four acute hospitals. Given Northern Ireland's population distribution that is plainly not enough. Realistically a minimum population of between 100,000 and 150,000 is needed to provide the volume of patients necessary to sustain a modern acute hospital and to allow the types of advances in treatment, medical technology and specialist skills I have mentioned to be properly developed. Accordingly Northern Ireland needs around 9 or 10 acute hospitals to serve its population. This is what *Developing Better Services* proposed and the responses to the consultation have endorsed that level of provision.

But modernising our hospital system is not about centralisation or the belief that ‘bigger is best’; it is about getting the best fit of services designed around the patient.

At the heart of our modernisation programme is the recognition that service and workforce redesign offer the potential for a wider range of safe effective, high quality care to be offered in smaller hospitals than had previously been thought possible. Patients want more, not fewer local services, including the opportunity to benefit from the increasingly sophisticated medical links to larger hospitals that can be supported by clinical networking and telemedicine facilities. The responses to the consultation once again endorsed this approach.

*Developing Better Services* also rightly emphasised the need to develop primary care so that professionals working in the community can work more closely with their colleagues in hospitals. The creation of Local Health and Social Care Groups has provided a strong local focus for this. This principle has the support of all primary care professionals, including GPs. The implementation of a new GP Contract, with its guaranteed increased investment of up to 33% in primary care over the next three years, will also provide powerful support for the new pattern of hospital services which I am announcing today.

## THE NEW HOSPITAL NETWORK

As I have said, *Developing Better Services* proposed that the present configuration of fifteen acute hospitals should be replaced by a network of nine acute hospitals, supported by seven local hospitals, two of which, because of issues of access, should have a range of enhanced services. This approach was endorsed by the responses to *Developing Better Services*, but understandably concern was voiced over the status of a number of individual hospitals where a reduction of acute services was proposed.

What I am announcing today is the new pattern of hospital services for Northern Ireland, however before I can do that I need to deal with the two most contentious issues which arose.

Firstly, the proposal that the Mater should become, in time, a Local Hospital caused particular concern. I was left in no doubt of the very special relationship of the Mater with the whole community of North Belfast who campaigned tirelessly for the retention of acute services there.

I considered these arguments and, as I signalled in the House of Commons on 5 December, I have concluded that the Mater should continue to deliver a full range of acute services for a considerable period ahead. This remains my view, but in the context of a changing

world of health treatment and care, I will expect the Mater to evolve and to develop clinical networks with other hospitals, in particular Whiteabbey.

## **NEW HOSPITAL IN THE SOUTH WEST**

Secondly, by far the most difficult decision facing me has been the site of the new acute hospital for the South West. The arguments are finely balanced and all of those who have campaigned for the hospital to be built near Omagh or Enniskillen or at a mid-way point near Ederney, have argued their case strongly.

I have met with all of the main interest groups and I have visited both the Tyrone County and the Erne hospitals, to meet staff and hear first hand of their concerns. I have also met a range of elected representatives who have spoken passionately about the need for a new hospital in their respective areas.

One message above all has remained with me - the lack of any decision on this issue has already had a destabilising effect on services at both the Erne and at Tyrone County and without an early decision on the matter the damage to both hospitals may very quickly become irreversible.

While uncertainty continues we have great difficulty in attracting qualified medical and other hospital staff to fill posts and the fear is that inevitably services will have to be withdrawn. I have been assured that once a decision is made, irrespective of the location, clinicians within the respective communities will support my decision, knowing that to do otherwise, and to protract this debate further will almost certainly mean the demise of acute services in both Omagh and Enniskillen within a very short time.

I have considered carefully the evidence and information put before me, including the responses to the information put into the public domain on 27 January and, amongst other things, I have looked carefully at the issues of sustainability, equity of access, deprivation, opportunities for networking, the use of hospitals in Ireland and technical infrastructure issues such as regional planning and infrastructure costs, for all three options at Enniskillen, Ederney and at Omagh.

I believe that an acute hospital, if developed on any of the three sites, could be sustained and would attract the numbers of patients required to enable clinicians to develop and maintain the specialist skills required to deliver a range of acute services. I have also noted that the preliminary assessment of the equality implications of the proposal for 9 acute hospitals concluded that there would not appear

to be a significant differential impact on different equality groups wherever the new hospital in the South West were to be located.

I have considered the information on deprivation supplied to me and I have considered that information against the proposed new pattern of acute and local hospitals and the question of access to them, to assess what effect this might have on populations living in the most deprived areas in the South West. I believe that I have given proper and due regard to this issue in reaching my conclusions.

There was considerable debate around the application of average speeds for different types of roads and journey times used by the Department to calculate access times. As a result I put into the public domain further information on average speeds for different types of roads supplied by the Department of Regional Development and used by them. I am satisfied that whatever model or information is used, if applied correctly, the journey time speeds do not alter to such a degree that one model or method of calculation can be held above another.

I have also considered very carefully the use of hospitals in Ireland, for the population living along the border in Fermanagh, should they choose to use them. *Developing Better Services* concluded that on the basis of the information available in June 2002, uncertainty remained as to whether relevant hospitals in the South, close to the border with

Fermanagh, could deliver over the longer term, the capacity and services equivalent to those provided by the nine acute hospitals proposed in Northern Ireland.

During the course of the consultation my predecessor Bairbre de Brún and Micheál Martin in the Department of Health and Children in Dublin, met to discuss the future plans for acute hospital provision in the South and the opportunities to develop North-South co-operation on hospital services in the future. Bairbre de Brún also wrote to Micheál Martin in October 2002 seeking further clarification on these issues.

I have placed Mr Martin's response of 23 January 2003 in the public domain. It indicates that in aggregate terms, the future acute capacity at the Cavan/Monaghan Hospital Group and at Sligo Hospital is considered likely to be able to meet the possible scale of cross-border demand "for people who are willing to avail of services there." It also indicates that, "it would be necessary to look at the caseload likely to be involved in terms of specialty and complexity in more detail in order to make a definitive commitment in this regard".

In the longer term there can only be benefit for continued development of networking between hospitals in Northern Ireland and in Ireland. I fully endorse and welcome this development.

However, my first duty as a Minister is to provide hospital services for all of the people of Northern Ireland, irrespective of where they might choose to live. This is a fundamental point. I am very grateful to Micheál Martin for his response, but whatever we might have been prepared to consider, the caveats in his letter mean that the use of hospitals in Ireland can only be considered as an **additional element of choice** for the provision of acute hospital services for people living in Northern Ireland.

Taking all of these things into account I consider that the mid-way point option submitted by the Ederney Community Development Trust is the least sustainable. While some of the infrastructure is in place to develop an acute hospital, the remaining infrastructure needed to develop a green field site in the area is not. The development of the roads system alone to ensure ready access to a hospital at Ederney would add a substantial extra cost and the location of a major acute hospital there would be inconsistent with the current Regional Development Strategy for Northern Ireland. I have therefore not chosen Ederney as a location for this hospital.

When I considered the remaining choices of Omagh and Enniskillen, I had to weigh in the balance the opportunities for access to acute hospitals in Northern Ireland, for those people living in both Omagh and Enniskillen, and exclude from that analysis, for the reasons given, the use of hospitals in Ireland, in relation to this decision.

In doing so I have looked carefully at the travel assumptions and journey times presented in the responses and the further information on average travel speeds provided by the Department of Regional Development. I have concluded that the assumptions of road speeds used to calculate average journey times provided in *Developing Better Services* are still valid, even after a degree of sensitivity analysis has been applied.

The responses suggest that, in the absence of a local acute hospital, the natural pathway for acute hospital services for the population living around Omagh would be towards Altnagelvin or to Craigavon hospitals, with some of the population south of Omagh likely to travel to Enniskillen for treatment. All these travel times are well within one hour of an acute hospital. The converse is not true for a small but significant population living south of the Fermanagh lakes - almost 10,000 people whose journey time to their nearest acute hospital, if it were to be located in Omagh, would be in excess of one hour. If they chose to go to Craigavon the journey would be considerably longer.

I have therefore concluded that the interests of both Fermanagh and Tyrone are best served by siting the new acute hospital to the north of Enniskillen. This solution I believe gives the best overall configuration of acute hospitals and allows the greatest spread of

choice and equity of access to acute services for the population of both Fermanagh and Tyrone.

Let me stress again this was a finely balanced decision taken after careful consideration of all the options. I know this will be a significant disappointment for the population living around Omagh and Ederney, but I firmly believe it is the right decision and I would ask all those involved not to look at it in terms of winners and losers, but as a very significant opportunity for developing sustainable, modern acute services for all of the population of the South West.

## **THE NEW PATTERN OF HOSPITAL SERVICES**

In the light of what I have said about the Mater and the new hospital for the South West, I have decided that the new network of acute hospitals will be provided at the Royal Group of Hospitals, the Belfast City Hospital, the Mater Hospital and the Ulster Hospital, serving the greater Belfast area and providing a range of regional specialties. Altnagelvin, Antrim and Causeway Hospitals will provide acute services in the North and West, with Craigavon and Daisy Hill Hospitals serving the South, and a new acute hospital to the north of Enniskillen serving the South West.

Within Belfast, there have been some long-standing issues about the future location of some key specialties. These were Plastics, Dermatology and Rheumatology. *Developing Better Services* proposed that these should be relocated in line with the recommendations of the Eastern Board in 2000, and I have decided to endorse this.

*Developing Better Services* also referred to the continuing role of Musgrave Park Hospital as a regional orthopaedic centre whose services will continue to be enhanced and I am happy to endorse that. Outside Belfast, it will be important to improve the current provision of fracture services, and I will expect to see the development of consultant led fracture clinics in all acute hospitals, and full in-patient fracture services at Antrim and Craigavon Hospitals.

The new pattern of acute hospitals will provide support and network closely with local hospitals situated at Whiteabbey, Mid Ulster at Magherafelt, Lagan Valley Hospital in Lisburn, the Downe in Downpatrick, South Tyrone Hospital in Dungannon and Tyrone County in Omagh.

I am aware of the difficulty in access times to acute services for people living in the area of the Downe Hospital. *Developing Better Services* suggested that this hospital should have an additional range of services to support a 24 hour Accident and Emergency unit,

capable of providing resuscitation and emergency coronary care and a consultant led in-patient medical service. I have considered the proposals for the Downe carefully and I am persuaded that these proposals are necessary to provide a level of service appropriate to the needs of the area.

It is unlikely that any two Local Hospitals will be entirely the same, but the core of their services will include minor injuries units, high quality diagnostic services, outpatient clinics, day procedures, pre and post natal maternity services, intermediate care and rehabilitation and step down beds. These services will help to relieve the pressure on acute beds, but more importantly, they will give people local access to a wider range of hospital services than ever before and, where needed, allow them to recuperate much nearer home.

I have been persuaded to this view by the excellent work carried out by the Western Board and Sperrin Lakeland Trust to develop a local hospital model for the South West. This model places the emphasis on linking hospital services at local level with primary, community and social care professionals to provide a portal for a full range of community and hospital care, based on local community need, once again, placing the patient first. This model will be adopted in developing the future hospital services to be delivered at the Tyrone County in Omagh.

I recognise that *Developing Better Services* did not address the future of smaller hospitals such as Braid Valley in Ballymena, or the Moyle Hospital in Larne, and there has been concern about the future provision of services in these hospitals. I will therefore look to the Northern Board to bring forward proposals for the development of local hospital services in Ballymena and Larne based on the consultations it has already carried out with local interests, and which I am satisfied are consistent with the vision for local hospitals set out in *Developing Better Services*.

## **MATERNITY SERVICES**

I want to turn now to maternity services. *Developing Better Services* proposed that consultant led maternity services either in, or adjacent to an acute hospital should be delivered from the new configuration of acute hospitals. The birth rate in Northern Ireland is decreasing and it is becoming more difficult to maintain the expert skills required in smaller hospitals with declining numbers of births.

The responses to the consultation concurred with this view. I therefore endorse the proposals in *Developing Better Services* that consultant led maternity services should be delivered in future at the network of acute hospitals I have announced.

It is clear that the long overdue development of a Central Maternity Hospital in Belfast will have a significant impact on where mothers-to-be in the greater Belfast area choose to give birth. In this respect, if consultant led maternity services are to continue at the Mater I will expect to see strong networks developed between the Mater and the Royal Group of Hospitals, and ultimately the Central Maternity Hospital, wherever that is sited. This is not the responsibility of the Mater alone and I will expect the Royal to work in partnership with the Mater to network maternity services, for so long as it remains viable and safe to do so.

The opportunities to increase the choice of mothers-to-be was further increased by the proposal to develop midwife led maternity units adjacent to a consultant led unit, where expectant mothers could benefit from giving birth in more homely surroundings, but beside consultant led care should an emergency arise. There was a broad approval for this proposal in the responses and I would endorse and encourage this approach wherever possible.

*Developing Better Services* also proposed that, as an extension of this approach, two stand-alone midwife led units should be piloted. In these units mothers-to-be, already assessed as low risk could, if they chose to do so, give birth in these settings, provided effective transfer arrangements were put in place in the event of an emergency.

Preliminary evaluations in England and Wales and elsewhere suggest that such units can be a safe alternative to consultant led care.

The responses to the consultation showed no consensus on the proposal. While midwife representatives were in favour of such pilots a number of clinicians were not and there was little enthusiasm from mothers for this proposal. However, I am satisfied that there has been a degree of misunderstanding about the role of such units, with many people interpreting the proposal as an alternative to consultant led care, rather than an additional tier of choice.

I therefore wish to increase understanding and gauge reaction to this proposal in more detail, by issuing for consultation a detailed model specification for midwife led stand-alone maternity units, soon after this announcement. On the basis of the outcome of that consultation decisions will be made as to whether we should proceed with pilot schemes.

## **PROTECTED ELECTIVE CENTRES**

In considering the future profile of acute services, a major concern is the numbers of people waiting for hospital treatment. The numbers waiting for planned surgery in Northern Ireland are the highest in Europe. I am confident that we have made a good start in managing

patient waiting times, but much more effort will be required to provide services within a reasonable waiting time for patients.

*Developing Better Services* proposed that two centres for planned or elective surgery, protected from the demands of emergency medical surgery, should be established, one at Lagan Valley and one west of the Bann.

The consultation responses indicate that there is agreement on developing protected elective centres. However, there is also concern that such centres, if placed away from an acute hospital, will diminish the range of elective surgery that can safely be done at a distance from acute backup, should an emergency arise. Some concern has also been expressed that a protected elective centre located away from an acute hospital will undermine, rather than support, the range of services an acute hospital can provide.

I note that a protected elective facility already operates successfully in Altnagelvin Hospital and that South Tyrone Hospital has developed proposals to use its modern theatre equipment to provide a range of elective surgery. I therefore see value in the concept of protected elective centres and wish to see them developed.

I endorse the proposal in *Developing Better Services* that Lagan Valley Hospital should be developed as a protected elective centre,

providing elective surgery for the greater Belfast area and networking with the Greater Belfast hospitals.

The current proposals for a protected elective facility at South Tyrone should also be taken forward, and the new acute hospital to the north of Enniskillen should be designed to include a protected elective centre for the South West.

Clearly, this approach does not preclude any acute hospital from seeking to provide planned surgery protected from the peaks of emergency treatment and care.

I have therefore asked the Department, in conjunction with the four Health and Social Services Boards, to work up an overall approach to the development of protected elective facilities in order to maximise the potential for reducing patient waiting times.

## **CAPITAL INVESTMENT**

The decisions I have outlined today carry with them significant funding implications and will require detailed planning and committed implementation to see through.

It is absolutely clear that in order to reconfigure services on the scale I have outlined today, very significant investment will be required to

develop our hospital network. This includes pressing ahead with the new acute hospital in the South West, and building the new Downe hospital.

At the same time we need to begin to refurbish or renew the fabric of those hospitals which will become local hospitals sitting at the heart of their community.

*Developing Better Services* proposed a reconfiguration of services covering some 10 years and costing around £1.2 billion in capital expenditure at today's prices.

We have already made a significant start with the construction of phase 2 of a major development programme at the Royal Group of Hospitals which will include a new accident and emergency department as well as a new imaging centre; the first phase of the redevelopment of Altnagelvin Hospital, including the modernisation and extension of ward accommodation; the cancer centre at Belfast City Hospital due to be completed in 2005/6; and phases 3 and 4 of the Ulster Hospital Strategic Development Programme. Together these programmes, costing around £217 million, will significantly develop the acute hospital network.

I am very pleased to be able to confirm that the investment needed for this major development of services will now be delivered through the Reinvestment and Reform Initiative.

As my colleague, Ian Pearson, announced last Wednesday, the Strategic Investment Programme includes investment projects to the value of over £300 million for health and personal social services. These will be mobilised with the support of the Strategic Investment Board.

Over £70 million of this will be made available by the end of 2005/6 to take forward the commitments I have announced today. These include: £11m for the upgrade of Altnagelvin Hospital; £11m for the restructuring of Craigavon Hospital; £8m for an extension of Antrim Hospital; £6m for a new Plastics and Day Procedure Unit at the Belfast City Hospital; and £5m for Phase 3 of the Mater Hospital redevelopment.

Some £23 million will be provided to initiate the development of local hospitals beginning in 2004/05. I am pleased to announce this figure includes £13 million over two years to begin the rebuilding of the Downe Hospital, which I consider to be a capital priority.

I have also secured £5million to cover the early procurement and development costs of the new acute hospital to the north of

Enniskillen so that there should be no delay in taking this project forward. The new hospital itself will be among the significant projects which may be taken forward on a PPP basis with the support of the Strategic Investment Board.

Effective hospital services are also dependent on a modern ambulance service which can respond quickly to emergency situations and provide vital clinical care before a patient can reach hospital. I am therefore very pleased that the new Strategic Investment Programme includes provision for some £29 million for the development of Ambulance Services.

Assisting with the development of these projects will be among the few top priorities for the Strategic Investment Board. Through the Strategic Investment Programme, we will be able to deliver this demanding programme of change. This underlines the value of the changes which are now possible by a new approach to reinvestment, accompanied by reform, as secured by the Prime Minister, the Chancellor, David Trimble and Mark Durkan.

## **STAFFING**

*Developing Better Services* recognised the need for a significant increase in staffing numbers in medical, nursing and allied health professional staff to support the changes envisaged in hospital

services. The responses to *Developing Better Services* supported this and suggested that the numbers should be even higher.

The Department is already considering the staffing consequences of delivering the scale of change required. It is clear that without sufficient numbers of qualified staff coming on stream at the right time the effects of the changes I have announced today will be severely hampered. We have however started on a major programme of investment to increase the numbers of training places in these professions. These issues will be kept under review as part of the Department's manpower planning system.

It is also very clear that this new pattern of hospital services will require significant change in the way staff are deployed. Much more flexible patterns of working will be needed to ensure that clinical networks can flourish, and that expensive facilities can be used more exhaustively than is sometimes the case at present.

*Agenda For Change* will provide exciting new opportunities to change the way people work. While the new Consultants contract has not been accepted in Northern Ireland, the Department will want to work with doctors and their representatives to identify changes to the way consultants work which will help to ensure that the new hospital system works effectively and efficiently.

## **ORGANISATIONAL STRUCTURES**

*Developing Better Services* did not just concentrate on modernising hospital services. It recognised that to deliver the type of change I have outlined would require new forms of organisational structures to be in place. Following on from the Acute Hospitals Review Group report, *Developing Better Services* made a number of proposals for the reform of organisational structures.

The consultation responses generally supported the view that HPSS structures needed to change and that the number of bodies needed to be reduced broadly in line with the proposals. However, there was concern that any regional bodies would be centred around Belfast and that other areas would lose the benefit of a local voice on health issues.

I am also mindful of the very real concerns of both Boards and Trusts as to how both the modernisation of hospitals and the reform of structures will be implemented while trying at the same time to deliver a full range of health care services. The enormity of this task over the next number of years should not be underestimated.

*Developing Better Services* made clear that this was an initial consultation that, together with the emerging findings of the Review of Public Administration, would be used to frame firm proposals on

organisational structures. In December I expressed the intention to have further work on these proposals completed around April this year. As far as my Department is concerned we are still on track.

## **CONCLUSION**

The decisions I have set out today for the modernisation of hospital services in Northern Ireland will, I hope, bring to an end a long period of consultation and remove speculation over proposed changes to hospital services. I am very much aware that not everything I have announced today will be well received or accepted in every part of Northern Ireland, but I am convinced that unless we start to implement the changes I have announced we run the very real danger of seeing acute services in our smaller hospitals decline to the point of collapse.

No-one today should be in any doubt of our determination to deliver the modernisation vision I have set out today, a vision which places patients at the centre of our hospital and health care system. This is not just a challenge to the health service but to all of us throughout Northern Ireland to work together to achieve this vision.

## ANNEX A

### DEVELOPING BETTER SERVICES PROJECTS

#### **Altnagelvin Hospital Redevelopment**

- This project completes a major mid-life upgrade of the mechanical and engineering infrastructure of the main hospital tower, to extend the life of the 40-year old building by a minimum of 25 years. The redevelopment includes reconfiguration, modernisation and extension of ward accommodation, with a Services Centre providing laboratory and pharmacy support services.

#### **Downe Enhanced Local Hospital**

- Replacement of the Downe Hospital will provide a modernised service model for local hospital needs in the Downpatrick area, linking to the main acute hospital network. Facilities will include 24-hour accident & emergency services with resuscitation facilities, general medicine and coronary care inpatient services, with diagnostic support services and a wide range of day-surgery and outpatient clinics. Facilities for acute psychiatry and dementia will also be provided.

#### **Antrim Hospital Nucleus Extension**

- An additional nucleus template at Antrim will enable acute provision for the East and South Antrim area to be consolidated and concentrated on the Antrim Hospital site. The proposed development will include ward accommodation and out-patient facilities, with upgrading of site services to meet the additional demand on support services and infrastructure.

#### **BCH Plastics/Day-Procedures Unit**

- This project will allow Plastics and Maxillo-Facial services to be relocated from the Ulster Hospital to the BCH site. Provision will include additional main theatre and day-

surgery capacity, with new full-time day-surgery facilities which will undertake adult ENT work. New Critical care services will also be provided.

### **Mater Hospital Redevelopment Phase 3a**

- This development will complete a modernisation and upgrading project providing 42 additional in-patient beds. The main building will be modernised and upgraded to provide modern standards for a full range of clinical support services for the additional beds. Administrative accommodation and educational facilities will also be included.

### **Craigavon Hospital Restructuring Phase 1**

- This is the first stage of a major redevelopment of Craigavon Hospital site. It will re-provision acute psychiatry services on the site and provide additional theatre, intensive care and day-procedures capacity. Upgrading of diagnostic imaging and outpatient services will be included.

### **RVH Redevelopment Phase 2**

- This is a continuation of a major redevelopment programme for the RVH. It will include a new centralised imaging department, with MRI and PET scanning services, a new Accident & Emergency department, a 20-bed intensive care unit, 20 bed high dependency unit, four new theatres, and a new burns unit. A new outpatients' unit and medical education centre, together with a new receipt and distribution facility will also be included.

### **Ulster Hospital Strategic Development Plan**

- A 4-phase development plan was announced in July 2001. The Phase 1 replacement programme for critical medical equipment has been completed. Phase 2 comprises a redevelopment programme to provide additional ward capacity, expand and modernise laboratory and Central Sterile Services departments, upgrade diagnostic imaging, theatres, high dependency and maternity services, and renew site engineering services.

DEVELOPING BETTER SERVICES

ANNEX B

Investment Programme (*Developing Better Services Appendix 3*)

<b>Current Projects</b>	<b>Estimate £m*</b>
Altnagelvin Redevelopment Stage 1	16
BCH Cancer Centre	58
RVH Redevelopment Phase 2	87
RVH Imaging Centre	12
Ulster Hospital Strategic Development Phases 3-4	44
<b>Sub-Total</b>	<b>217</b>
<b>Strategic Investment Programme</b>	
Altnagelvin Redevelopment Completion	71
Antrim Nucleus Extension	17
BCH Plastics/Day-Procedures Unit	14
Belfast Maternity Hospital	47
Craigavon Hospital Restructuring Phase 1	13
Downe Enhanced Local Hospital	34
Mater Hospital Redevelopment Phase 3a	14
South-Western Hospital	101
Local Hospitals	10
<b>Sub-Total</b>	<b>321</b>
<b>Remaining Developments</b>	
Altnagelvin Site	24
BCH Site	23
Belfast Ophthalmology/Gynae Services	17
Craigavon Hospital Redevelopment Completion	76
Daisy Hill Redevelopment	12
Local Hospitals	42
Musgrave Park	35
RBHSC Phase 2	20
Royal Hospitals	21
Ulster Hospital Strategic Development Phases 3-4	58
<b>Sub-Total</b>	<b>328</b>
Backlog Maintenance	135
General Equipment	127
Major Equipment	89
<b>TOTAL</b>	<b>£1217m</b>

**Note\* Rounded to nearest £m**

**DEVELOPING BETTER SERVICES**

**ANNEX C**

PROJECT	ESTIMATED TOTAL COST	PROGRAMME 2003 – 06		ON – SITE	COMPLETED
		EXPENDITURE 2003- 06	ACTIVITY		
<b>Current Projects</b>					
Altnagelvin Upgrade Phase 1	£16.2m	£13.7m	Decant provision, site infrastructure and engineering, enabling works	Mid-2003	2005-06
BCH Cancer Centre	£57.9m	£45.4m	Construction, equipment programme, commissioning	Mid-2002	2005-06
RVH Redevelopment Phase2	£87.2m	£38.6m	Design & planning, construction of A&E, ICU/HDU, theatres, burns unit, out-patient and Education departments	Early-2003	2007-08
RVH Imaging Centre	£11.9m	£11.9m	Construction and commissioning	Mid-2003	2005-06
Ulster Hospital Strategic Development Plan Phase 2	£43.8m	£40.3m	Construction programme for theatres/ICU/HDU, wards, CSSD, maternity, laboratories and site services	Early-2003	2005-06
<b>Total</b>	<b>£217.0m</b>	<b>£149.9m</b>			
<b>Strategic Investment Programme</b>					
Altnagelvin Upgrade Completion	£ 70.8m	£10.6m	Construction	Mid-2003	2011-02
Antrim Hospital Nucleus Extension	£ 16.9m	£7.8m	Project appraisal, detailed design & planning, procurement, enabling works	Late-2005	2005-06
BCH Plastics/DPU	£ 13.6m	£6.2m	Project appraisal, detailed design & planning, procurement, enabling works	Late-2005	2005-06
Belfast Maternity Hospital	£46.8m	£4.0m	Project appraisal, detailed design & planning, procurement		
Craigavon Hospital Restructuring Phase 1	£13.1m	£10.8m	Project appraisal, detailed design & planning, procurement and construction	Mid-2005	2006-07
Downe Enhanced Local Hospital	£ 33.5m	£12.5m	Project appraisal, detailed design & planning, procurement and construction	Late-2004	2007-08
Mater Redevelopment Phase 3A	£ 14.1m	£4.9m	Project appraisal, detailed design & planning, procurement and construction	Early-2005	2007-08
South-West Hospital	£ 101.0m	£5.0m	Project appraisal, detailed design & planning, site acquisition, procurement, enabling works		
Local Hospitals	£ 10.0m	£10.0	Project appraisal, detailed design & planning, procurement		
<b>Total</b>	<b>£319.8m</b>	<b>£71.8m</b>			

