

**OVERVIEW OF THE
HEALTH AND SOCIAL CARE
NEEDS AND EFFECTIVENESS
EVALUATION**

Department of Health Social Services and Public Safety
Department of Finance and Personnel
Office of First Minister and Deputy First Minister

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INTRODUCTION

- 1 The aim of the Department of Health, Social Services and Public Safety is to improve the health and well-being of the people of Northern Ireland. Its key health and social care objectives are:-
 - to develop and promote policies, the efficient economic and effective implementation of which will lead to good health and wellbeing, a reduction in preventable disease and ill-health and greater social justice, minimising inequalities and ensuring greater equality of access to health and social services; and
 - to ensure the delivery of effective high quality health and social care.

- 2 Annual expenditure of DHSSPS amounts to some £2.5bn representing some 40% of the total Assigned Budget for Northern Ireland. Despite year on year real terms increases in spending, the money available is not sufficient to enable the Health and Personal Social Services to cope adequately with the range of rising demands impacting upon them. In addition to issues such as a growing elderly population, greater morbidity and higher levels of deprivation, public expectations are continuing to rise. Services consequently continue to operate under extreme pressure as manifested particularly by long waiting lists for hospital care and increasingly for community services.

- 3 This needs and effectiveness evaluation presents a comprehensive and systematic analysis of the health and social care needs of the local population and assesses the effectiveness of the HPSS response in addressing those needs. It embraces all care programmes. As such it provides a robust analysis of current needs and performance thereby providing a sound body of evidence to inform future decisions.

Terms of Reference

- 4 The overall purpose of the Review is to provide an assessment of the needs for and effectiveness of the resources provided for the HPSS in Northern Ireland. (See full Terms of Reference in Annex 1)
- 5 The review encompassed, improving population health and wellbeing, Acute and maternity services, services for older people, family and child care services, mental health services, services for people with disabilities, Family Practitioner Services, workforce issues and capital investment and infrastructure requirements.

The Policy Context

- 6 Northern Ireland has one of the worst public health records in Western Europe with coronary heart disease, cancer and respiratory disease accounting for over 65% of all deaths among both sexes. Many of these deaths occur under 65 years of age and are potentially preventable. The death rate from heart disease is one of

the highest in Europe, and is significantly higher than England. Lung cancer kills approximately 800 people here each year and accounts for about one quarter of cancer deaths in people under 75; the overall death-rate is among the middle range of European figures, however for women, the death rate is high in comparison with others in Europe. Our death rate from breast cancer is amongst the highest in Europe and accounts for one in three cancer cases in women and almost one sixth of cancer deaths in women.

7 The number of accidental deaths here is the highest in the UK and we have a worse road safety record on child fatalities than most European countries. Our child pedestrian fatality rate is particularly bad when compared to the EU average. Breast-feeding rates are the lowest in the UK and amongst the lowest in the developed world, while the rate of teenage pregnancy here is one of the highest in Europe. The levels of dental disease in children remain unacceptably high and are much greater than those in GB and Ireland.

8 Whilst there have been improvements in many areas in recent years and many examples of effective intervention, too many of our population die early from preventable illnesses and there are significant inequalities in the health status enjoyed by the population. Many of these are related to poverty and deprivation.

- 9 The dominant cost driver for HPSS services is the rapidly rising needs, expectations and opportunities of the population for treatment and services that are essential to basic health and an acceptable quality of life. Improvements in treatment options are expected and needed, indeed, the public expect to receive the best possible range and standards of treatment and, with the rapid advances in technology, these improvements are occurring with increasing frequency. There is little willingness to accept that cost considerations prevent these needs and expectations being met.
- 10 Over 70% of Health and Social Services Boards' budgets are consumed by pay related costs, and almost all of those turn on pay awards, terms and conditions, professional standards issues etc, which are decided in London. The other major block of HPSS spending is on the Family Health Services, which makes up some 21% of the overall budget. Here again, costs are determined in London for example, national negotiations govern GPs' remuneration and drugs costs and these impact directly on the scale of expenditure. While it is open to the Administration here to depart from the recommendations of the relevant Pay Review Bodies, it is clearly evident that any proposal to set pay at lower levels than in England or strike lower rates of remuneration for GPs, would simply lead to a major loss of skilled personnel, given the recruitment difficulties in parts of England. Already 40% of graduates in professions allied to medicine go to GB or the ROI to work and difficulties are being experienced in filling other posts e.g. hospital pharmacists where pay has not kept pace with the

private sector, and there is a recognised (national) shortage of nurses.

- 11 The fundamental point is that these cost-drivers which apply in England set universal pricing and cost structures which, in practice, must then be applied, in Northern Ireland.
- 12 The recent *Securing Our Future Health: Taking a Long Term View* (Wanless Report) concluded that UK health expenditure excluding personal social services needed to grow at an average annual real rate of between 7.1% and 7.3% above pay and price inflation over the next five years.

Report Structure

- 13 In the sections that follow, key factors concerning the health and social care needs of the population are highlighted, benchmarked where possible against the characteristics of the UK population as a whole. Their implications for the future development of local services are also drawn out.
- 14 Key indicators of performance are also identified and details of arrangements for securing improved efficiency and effectiveness are described, and achievements to date highlighted. Areas for further work and investigation are also identified.
- 15 Health and Personal Social Services represent a complex interplay of multi-professional services which ideally operate in a seamless

way to address the health and social care needs of the population. The individual services – whilst very different – are inter-dependent with constraints or investments in one area impacting on another. The inter-active nature of the various services is illustrated and the importance of adopting a ‘whole systems’ approach in securing optimal effectiveness of service delivery is a key conclusion of the work.

Note: It should be noted that a substantial proportion of the information contained in this Report and its Appendices was correct as of the end of March 2002.

ASSESSMENT OF NEEDS

- 16 Everyone aspires to have appropriate and high quality treatment and services when they are required. In today's society the public is much more informed about health issues and has increasingly high expectations of what should be available for them. This is having a very significant effect on the demand for services but there is also a range of factors which impact, often disproportionately, on the need for health and personal social services.

Population Issues

- 17 It is now accepted internationally that the key determinants for health care resources lie in the demographic and socio-economic profile of the population. Children and older people need greater access to health and social services than the rest of the population and high levels of morbidity are closely correlated with deprivation.
- 18 With regard to the population profile:-
- a Northern Ireland has a slightly younger population than the rest of the UK, but the differences are narrowing.
 - b Fertility rates in Northern Ireland – although reducing overall – are the highest in the UK, and are some 11% higher

than in England.

- c While NI has a proportionately smaller elderly population it is increasing at a faster rate. Projections suggest that the elderly population will increase by 54% over the next 25 years. For the most elderly (85+ years) the projected increase is most marked – 72% over the next 25 years compared to 47% in England. Over the next 10 years the over 65 and over 85 populations are projected to increase by 14.5% and 21.2% respectively, significantly greater increases than the rest of the UK.

- d The slightly younger population in Northern Ireland would, other things being equal, suggest a relatively lower level of need for health and social care than the rest of the UK. This however is more than offset by the implications of the level of deprivation.

- e The higher levels of fertility and faster growing elderly population will mean that for the foreseeable future those age groups in the population which consume most resources (children and the elderly) will continue to exert considerable pressure on existing service profiles and resources. Given the existing relationships between age and cost, it has been calculated that adequately responding to these demographic pressures alone will require a year on year real terms increase in funding of 1%.

- f The increasing needs associated with a larger elderly population will have significant implications for the number of hospital admissions, and demands for community services and residential provision. These pressures will continue to increase as advances in medicine and surgery enable much more to be done to improve the health and lifestyle of older people.

19 Key issues include:

- a the hospital and community sectors are currently operating at or above capacity as demonstrated by growing waiting lists and in some specialties, (e.g. general medicine) occupancy rates are dangerously high;
- b there are already significant levels of unmet need as demonstrated by long waiting lists for Acute and community services, some 3,000 older people are currently waiting for some form of community package or service;
- c the hospital waiting lists are the highest in the UK, and are 60% higher than in England, despite the fact that Northern Ireland treats proportionately more patients;
- d increases in emergency admissions are producing year round pressures on key services and directly affecting these services' ability to deliver elective treatments. There is insufficient capacity to deal adequately with demand;
- e there is evidence of increasing recruitment and retention problems within the HPSS which has implications for service continuity and quality. This has necessitated the

widening of the recruitment process beyond Northern Ireland, and also requires greater investment in training of skilled staff, which given the time required, needs to start now. Increasing specialisation in the medical arena renders difficult the replacement of general physicians or surgeons particularly in smaller hospitals and this brings with it particular problems for securing service continuity in a cost effective way;

- f domiciliary care is spread across users more thinly than in GB;
- g the private residential home sector is facing significant financial difficulties and there are signs that the market is becoming unattractive to investors as demonstrated by some suppliers withdrawing from the market;
- h fewer of our population are able to meet the full cost of their nursing home care (15% here compared to 31% in England) and there is much lower access to private health care. This means that public funding has to meet a greater proportion of total needs than elsewhere.

Morbidity and Deprivation Issues

20 Northern Ireland has relatively high levels of deprivation as measured by a range of important indicators:-

- a proportion of the population on income support (68% higher than England);

- b lone parent households – the number of single parent families - (38% higher than England);
- c overcrowding – measured as the percentage of households with one or more persons per room - (double the English level);
- d under 75 Standard Mortality Ratio – the ratio of actual to expected deaths which is highly correlated with morbidity - (7% higher than England);
- e long term unemployment (18.3% here compared to a range of 5.2% to 11.7% in England);
- f overall employment rates (66% here compared to 76% in England).

21. Health and Social Care needs are closely related to levels of deprivation in the community. This is the case in virtually all programmes of care. Higher levels of morbidity create increased demands on Family Practitioner Services (higher levels of prescribing), higher rates of hospital admission and heavier demands on our social care system. Emergency admissions to hospital are particularly linked with high levels of deprivation reflecting the link between deprivation and ill health. Higher levels of deprivation in the older population lead to higher dependency levels and demands on services at a younger age. And there is a close correlation between deprivation and poor mental health. Most notably there is an exceptionally strong relationship between deprivation and the need for childcare and family support services.

22 The analysis has further demonstrated:-

- a. expenditure in England is 35% higher on children's social services, despite Northern Ireland having significantly higher need and proportionately more children;
- b. this has severely restricted the service response to particular needs such as those for family support services, secure accommodation and child and adolescent psychiatric services;
- c. foster care allowance needs to be increased in order to attract more foster carers to address needs. Currently they are set at a lower level than GB.

23 With regard to Mental Health:-

- a. there is an estimated 25% higher level of mental illness here than in England;
- b. research confirms the serious impact that the 'Troubles'¹ continue to have on psychological wellbeing;
- c. prescription costs for anti-depressants are 37% higher, those for psychoses and other disorders are up to 75% higher than in England;
- d. there are almost 600 patients in long stay wards in hospitals. Many of these are waiting for a permanent residential placement in the community. Inpatient bed numbers per 1,000 population are significantly higher than GB – 6.4 for

¹Northern Ireland's Troubles – The Human Costs; The Costs of the Troubles Study, 1999(COTT);

Northern Ireland compared to 3.2 in England and 4.5 and 3.4 for Scotland and Wales respectively;

e at October 2000 there were over 1,000 children on child and adolescent psychiatric waiting lists;

f there are significant service gaps particularly in the primary and community sectors and in some specialist areas such as forensic psychiatric services where people as a result are detained in inappropriate facilities;

g overall, despite higher levels of need in the community, the service is over reliant on the hospital sector.

24 Deprivation is also linked with higher levels of many of the important risk factors in the lower socio-economic groups. Poverty, smoking, lack of physical activity, poor nutrition and alcohol misuse are risk factors common to the major diseases which account for the majority of the spending in the health service today. Smoking, lack of exercise, obesity and alcohol misuse together account for 50% of preventable life years lost².

25 To improve health it is necessary to tackle the underlying causes that are contributing to the development of illness as well as treating people when they are ill. *Investing for Health* will seek, through a cross-departmental, multi-sectoral framework for action, to improve health and wellbeing here and tackle health inequalities. It will focus particularly on the determinants of health within our social, economic, physical and cultural environment – for example,

² Wanless D(2001) Securing our Future Health: Taking a Long-Term View. Interim Report; London: HMT

ensuring we can live in a safe and healthy environment with a good standard of housing, having educational opportunities and the opportunity to gain the skills to work. In particular, although immunisation programmes currently achieve better uptake rates than England and Wales, there are significant gaps in the development of screening services, and these will require continued investment.

- 26 The question of how best to determine the most effective balance between spending on prevention and the ever increasing demands for treatment and care is difficult to answer. However, with an increased focus on prevention, the entire society and economy here would stand to gain. Research has shown that an extra five years life expectancy increases the annual growth rate for GDP per head by 0.3-0.5 per cent.³ Using 0.4 per cent as an average applied to GDP data here between 1998 and 1999, we can estimate an extra £66 million of GDP to our economy.

³Bloom DE and Canning D (2000) "The Health of Nations" Science February 18;287:1207-1209 cited in Wanless D(2002) Securing our Future Health: Taking a Long-Term View. Final Report; London: HMT

Disability

- 27 Deprivation also impacts on the level of disability in a population. Congenital issues (inherited conditions) also influence this and in Northern Ireland the 'Troubles' have also added to the numbers of people with disabilities who require life long care.
- 28 Relevant statistics pertaining to the Northern Ireland population include:-
- a a 20% higher level of disability than England;
 - b for more severe disability, the level is some 40% higher than England;
 - c the evidence of congenital malformation, depending on the specific condition, is 3 to 9 times higher than England and Wales;
 - d the number of people with a disability is growing as a result of increased survival rates of people with profound and multiple disabilities; and
 - e longevity is increasing for the adult population;
 - f in addition Northern Ireland has a higher rate of road traffic accidents resulting in long term disability.
- 29 These trends have major implications for the care programmes provided for people with learning disability or a physical or sensory disability. Survival, rehabilitation and support require increasingly sophisticated and expensive care packages. Some of these can cost up to £0.2m per annum. Increasing demand for

housing adaptations is adding to pressures on occupational therapy services. Changing social structures and smaller extended family networks are impacting on families' abilities to provide long-term support and there is increasing demand for respite care for Carers.

- 30 As needs are increasing so too are expectations – underpinned by legislation and prompted by announcements of new initiatives in GB which it has not been possible to replicate here.
- 31 Specifically with regard to the Learning Disability programme:-
 - a Some 390 long stay hospital patients are waiting for permanent care in the community;
 - b Services in the community are underdeveloped with significant service gaps in residential care, day support, respite and multi-disciplinary community support teams.

Regarding services for those with a physical and sensory disability, there are a range of needs which are sub-optimally met for example wheelchair service provisions, digital hearing aids, and services for children with disabilities. The Disability Discrimination Act also has significant implications for services both in terms of ensuring accessibility of services for those with a disability and in prompting additional demands for effective evidence based interventions.

Rurality

- 32 Population sparsity impacts on the costs of care. The provision of services to rural communities costs more than urban communities as a result of additional travel costs and more lost time due to travelling longer distances. This impacts directly on the ambulance service where specific initiatives are necessary to improve response times and social care and community health services. Additional payments are also made to Family Practitioners to ensure continuity of service to small catchment populations and diseconomies of scale are experienced in providing access to services at a greater number of (smaller) facilities. Given that Northern Ireland has a much more rural population base than England, estimates based on statistical modelling suggest that additional resources (of up to £38m) are required to meet similar levels of need.

Ability to Pay

- 33 The ability of a population to contribute to the cost of care has a significant impact on the purchasing power of Health and Social Care allocations. This is particularly the case for nursing home provision for which individuals contribute on an ability to pay basis. Twice as many people in England (31%) meet the full cost of nursing care themselves compared to Northern Ireland (15%). If similar levels applied here, a further £20m would be available for investment in services to meet other needs.

Private Health Care

- 34 The level of privately funded health care has a direct impact on the totality of need to be met by the statutory sector. This is particularly the case for elective surgery – where as much as 13% of total elective work was undertaken privately in GB in 2000. In total the value of the private Acute Health Care market in 2000 amounted to some £3.2bn, with the NHS generating some £340m directly from this source.
- 35 In Northern Ireland the contribution of the private sector health care market is negligible whereas a pro rata contribution would amount to some £90m. This means that the burden of care relative to England, falls disproportionately on the statutory sector here. It also means that the HPSS does not have access to the same level of private funding (which can be deployed against other needs). Nor does it have access to the additional capacity offered by the private sector.
- 36 The differential access to private health care and the rurality and ability to pay factors could account in gross terms for a purchasing power impact of £148m per annum or a per capita spend of some £88 per person. Even if only 50% of this manifested itself as additional need falling on the HPSS here, it considerably reduces the differential spend per head on health and social services between here and England.

Capital

- 37 The quality of the NI hospital stock is poor and there is a greater backlog of maintenance compared to England. A significant number of hospitals are at an age where they need substantial redevelopment or replacement. This increases the resources required in NI compared to England. Hospital equipment over 10 years old, such as imaging and laboratory equipment, needs to be replaced, in order to improve quality and effectiveness and to reduce unproductive staff time and patient delays.

Technology

- 38 Technology is one of the most important drivers of health spending and over the past 20 years technological change is estimated to have contributed around 2% to annual health spending increases. This is projected to cost significantly more as radical new technologies such as genomics and stem cell therapy are developed. These escalating cost pressures apply equally to Great Britain and here but Northern Ireland has fallen far behind Great Britain in the use of information technologies. As the Acute Hospitals Review confirms, significant investment is required to improve efficiency and effectiveness across the HPSS.

EFFECTIVENESS IN THE USE OF RESOURCES

- 39 The starting point for any consideration of the overall effectiveness of the HPSS must be to acknowledge that services here are under enormous pressure – both financially and also in terms of their ability to address adequately the needs that are presenting. Given these pressures, and the proportionate higher level of need in NI when compared to GB, the result has been that the HPSS has been unable to cope adequately with the numbers requiring care and treatment, and the quality of service has suffered.
- 40 Whilst significant increases in resources have been made available, the bulk of these have simply gone to meet inflationary pressures and the remaining amounts have been insufficient to keep pace with increasing needs. The position has been exacerbated by the need to supplement the baseline through annual cost improvement plans. This severely restricted management's options in covering unforeseen in-year costs. In today's terms some £195m recurrent annual funding has been extracted from the HPSS baseline in year on year efficiency and cost improvement targets by successive administrations over the last 15 years. A further £12m savings is targeted to be achieved by the end of the current year.

41 The HPSS are now providing annually for:-

673000	A & E attendances
23m	prescription items
1.4m	outpatient attendances
456000	inpatient and day cases
16000	nursing or residential homes places
2400	children looked after at any one time
173000	Social Services related contacts (for Elderly, Mental Health and Disability programmes) in the community.

42 The sheer volume of these figures means that marginal improvements in service are virtually unnoticeable, and those that are achieved are often masked by the increasing demands of demographic trends. Consequently the numbers waiting for care or treatment remain either unchanged or increase.

43 Notwithstanding this, although headlines have focussed on long waiting times and delayed discharges from hospital, some 7000 more patients were treated in the year to December 2001 compared to that to December 1999. Three out of 4 patients receive their treatment within 3 months and some 95% within one year. On the community side in the same period there has been an increase of almost 2000 care packages delivered, providing for reduced risk and improved quality of life for the recipients.

44 It should also be emphasised however that resources alone will not address the problems facing the HPSS. Major changes are necessary in a number of areas:-

- individuals must take greater responsibility for maintaining healthier lifestyles;
- too many people are inappropriately referred to hospital and should be supported within primary care;
- co-ordination and co-operation between services need to be improved;
- existing hospital structures are outdated and inefficient;
- there are significant variations in the costs of treating patients which need to be explored;
- while the costs of administration are broadly similar to GB there is a need for restructuring to improve the overall effectiveness of the service, and some modest cost savings could be produced over time.

The sections below outline the steps the Department has taken to improve effectiveness and overall performance and identify areas where further work is necessary.

Departmental Management Processes

45 Rigorous management and accountability processes to further assure the provision of effective and efficient services have been

put in place. In recent years a greater level of central direction has been introduced for the HPSS and this has imposed a greater degree of control over the operation of Trusts. This has been accompanied by a move away from the competitive behaviour characterised by the “Internal Market” towards a co-operative, whole-system response to the goals set by the Executive and the Minister. The strengthened accountability arrangements, set out below, reflect these changes.

Performance Management and Accountability

- 46 *Priorities for Action* – Drawing from the Programme for Government, the Public Service Agreement, and the Service Delivery Agreement, this sets out a clear, challenging but deliverable agenda that demonstrates how given resources will be deployed for the benefit of the local community. It also provides the basis for monitoring and accountability to the Department, to the Minister and elected representatives.

- 47 *Health and Wellbeing Investment Plans (HWIPs)* - These are submitted by Boards in response to Priorities for Action, setting out how they intend to take forward their overarching responsibilities to secure effective health and social services for their local populations, improve health and social well-being and reduce inequalities. HWIPs are the core vehicle for HPSS planning and accountability. Progress against the HWIPs is formally monitored quarterly and is reviewed in progress meetings and at the annual accountability meetings.

48 *Trust Delivery Plans (TDPs)* - The purpose of these is to demonstrate that the totality of a Trust's resources is being deployed in the most effective way in pursuit of the Priorities for Action. In addition to financial performance, TDPs must include the Trusts' development strategies for other key areas such as estate, workforce, ICT, governance and the user experience. Trusts are also required to set out the steps they are taking to benchmark their performance against good practice elsewhere. Trusts are also held accountable for service delivery issues, through their Service and Budget Agreements with HSS Boards.

Clinical and Social Care Effectiveness

49 Standards and service performance are currently monitored at Departmental, HSS Board and HSS Trust levels. Groups including the Social Services Inspectorate; Pharmaceutical Inspectorate; Dental Referral Service; Registration and Inspection Units; the Regional Multi-professional Audit Group (RMAG) and the Clinical Resource and Efficiency Support Team all make a significant contribution to support monitoring in the HPSS.

50 Under the "Best Practice - Best Care" proposals, arrangements will be put in place subject to resources being available in 2003-04 for setting clear consistent standards for services, putting clinical and social care governance arrangements in place, extending regulation to cover a wider range of services, and establishing more independent monitoring and inspection arrangements against the standards set.

- 51 The introduction of clinical and social care governance arrangements will mean that staff will receive the proper support to train and continuously keep up with new developments. By placing a statutory duty of quality on Chief Executives of HPSS organisations the quality of services delivered will be assured, in the same way that financial probity is adhered to. Progress will be monitored and organisations held accountable for the findings of the new independent 'Regulation and Improvement Authority'.

Financial Management

- 52 The financial performance of Trusts and Boards is monitored monthly by the Department, based on returns provided by each body. If emerging pressures cannot be met, contingency plans to recover the deficit and regain financial stability must be developed and implemented. The Department's detailed monitoring process ensures that potential deficits are addressed at the earliest opportunity.

HPSS Performance

53 Significant improvements in performance have been made in virtually all service areas in recent years as demonstrated below.

Hospital Services

- bed availability has reduced by 13% in the last 5 years and the number of patients treated has increased by 14% representing a 32% increase in productivity;
- in the same period length of stay has been reduced in the Acute sector by 16% and bed occupancy levels have increased from 75% to 81%;
- over the last 10 years the change is even more stark. Since 1991-2 there has been a 30% reduction in hospital beds coupled with a 39% increase in the number of patients treated annually – an overall productivity improvement of some 97%;
- outpatient attendances have increased by 1.7% over the last 5 years;
- the number of first attendances at A & E units has increased by 5.4% in the same period;
- despite the higher birth rates here, the overall downward trend does have a potential impact on the existing pattern of maternity services.

54 Regarding benchmarked performance with the UK:-

- the average length of stay in NI is marginally longer than elsewhere. Excluding a small number of specific conditions however performance is generally comparable;
- day case rates are similar to levels in GB although there may be scope for extending the range of day case procedures in line with GB;
- Northern Ireland is comparable or better on pre-operative lengths of stay and quality indicators such as the absence of surgical deaths or re-admission rates are also comparable;
- unit cost comparisons that are available suggest broadly similar costs.

55 A number of constraints to further improved performance have been identified as follows:-

- a further productivity gains in the Acute sector have been inhibited by delayed discharges which have reduced capacity to undertake elective work contributing to higher than necessary waiting lists and less than optimal use of operating theatres;
- b further investment in the introduction of assessment centres and patient transport services could speed up throughput;
- c further investment around the Acute sector could facilitate earlier discharge or avoid unnecessary admissions; (see paragraphs 82 - 87)

d the analysis and research undertaken for this study indicated that a wider range of care and treatment facilities was available in GB for people with longer term care needs.

Community and Primary Care Services

56 Since 1995 there have been very significant increases in activity across all programmes of care. Whilst these have been largely accessed through the purchase of additional places from the independent sector, the additionality has led to increased caseloads for assessment and fieldwork staff. More complex cases are also being managed in community settings. In overall terms there has been:-

- A 34% increase in people receiving support in their own homes and an additional 116% increase in the numbers supported in residential and nursing homes, and
- a reduction of 21% in hospital bed occupancy in elderly, mental health and learning disability beds.

57 Benchmarked comparisons with GB indicate that unit costs of service provision here are lower or similar for family and childcare, mental health, learning disability and physical disability programmes. This is also true for independent sector residential care places, although the costs of statutory residential care here are somewhat higher (£409 per week here compared to £394 in England). There is however less reliance on the statutory sector here.

58 With regard to Family Practitioner Services, expenditure on general medical services (the family doctor service) is lower in Northern Ireland but service quality and accessibility are comparable. Expenditure on ophthalmic services is also in line with that in GB relative to need. However on dental services and pharmaceutical services expenditure is higher than GB. Registration with dentists is higher in NI and there are recognised differences in need, reflecting deprivation and the non-fluoridation of water. A number of steps have been taken recently by the HPSS to improve the quality consistency and cost-effectiveness of prescribing. This has included the provision of incentives to GPs to achieve savings, the expansion of the number of professional pharmacists engaged to advise on prescribing practice, the greater use of generic (rather than branded) drugs, reviews of repeat prescribing and measures to reduce illegitimate claims for exemption from charges. As a consequence year on year increases are lower here relative to GB and the gap is narrowing. More research however is needed to explain fully the differences in prescribing expenditure.

59 Comparison with GB across the various programmes also revealed that:-

- despite higher levels of need a similar proportion of children are in the care system;
- there is an over reliance on hospital care in the mental health and learning disability programmes, reflecting the

underdevelopment of community and primary care services in these programmes;

- management and administrative costs are comparable; indeed a recent study by the NHS Confederation indicates that a significantly smaller proportion of expenditure is devoted to management here than in GB;
- there is greater reliance on nursing home care here, and significantly higher levels of domiciliary care, but there are less hours of domiciliary care assistance offered per person in Northern Ireland;
- although the service has recently introduced many initiatives to facilitate early discharge from hospital and avoid unnecessary admission, these initiatives are more prevalent in GB.

Securing Improved Effectiveness

60 The Department and HPSS have been active in promoting and securing improved effectiveness in the provision of services both strategically and at the operational level.

61 Major strategic reviews of services have been undertaken in recent years, which are currently being taken forward. Examples include:

- Investing for Health;
- Building the way forward in Primary Care;
- Community Care Review;
- Acute Hospitals Review;

- Review of Cancer Services;
- Strategy for Learning Disability Services;
- Review of Cardiology and Cardiac Services;
- Review of Critical Care Services;
- Residential Child Care Strategy;
- Strategic Review of Ambulance Services;
- ICT Strategy;
- Mid term evaluation of the oral health strategy;
- Review of adult neurology services;
- Review of renal services.

62 All of these reviews are designed to improve the effectiveness of services and provide for better health and social care outcomes, reflecting best international practice.

63 At a local level there are many examples where services have been rationalised or changes introduced to reduce risks and increase standards of care. These include:-

- a rationalisation of Acute services in the NHSSB area centralising services at new hospitals at Antrim and Coleraine and closing older smaller facilities at Ballymena, Larne, Antrim, Ballymoney and Coleraine;
- b the development of plans to centralise maternity services at either the Royal or Belfast City Hospital (BCH) sites;

- c the opening of cancer units at Altnagelvin, Antrim and Craigavon in support of the regional cancer centre to be located at BCH;
- d the reorganisation of Acute services between the BCH and RGH;
- e the implementation of the renal services strategy with the provision of new or expanded dialysis provision at key centres;
- f the re-alignment of Acute services at Craigavon Hospital following the temporary closure of services at South Tyrone;
- g the development of operational protocols governing for example guaranteed access to specialist fracture and paediatric services.

64 Within the community sector there has been a similar focus on securing an effective pattern of service delivery. Examples include:-

- a the development of professional assessment protocols governing access to residential and nursing home care;
- b the development of local service strategies by Boards covering the main care programmes and providing a strategic framework within which local investment decisions are taken;
- c the implementation of resettlement programmes for people in mental health and learning disability hospitals providing effective support in the community;

- d individual service reviews encompassing increasingly the views of service users and resulting in more effective and responsive services on the ground – e.g. the development of rapid response service, community rehabilitation programmes;
- e major improvements in the quality of residential child care services;
- f implementation of the Children Order providing for more effective support for families and children in need; and
- g the development and implementation of numerous initiatives and protocols governing professional and clinical intervention with service users;
- h immunisation up-take rates are generally higher than in England and Wales.

Quality and Safety Issues

- 65 Provision of a high quality and safe service lies not only at the heart of departmental policy, it is also the driving force in the development of the care professions. The accepted standards of clinical, nursing and social care are constantly increasing as the boundaries of human knowledge and scientific understanding are extended and best practice subsequently applied throughout the Service.
- 66 There have been major developments in this area in recent years as public expectations rise, and as unacceptable standards are tackled, increasingly in the public domain, through increased access to

litigation or through reference of individual cases to the professions' governing bodies. Issues of clinical and social care governance are now at the forefront of professional debate and are increasingly driving change on the ground.

- 67 Staff involved in delivering care seek to provide that care to the highest quality circumstances allow. There are nevertheless concerns that systemic issues militate against the achievement of highest standards. For example the high levels of activity place a relentless stress on the staff complements which are not sized to work at peak demands for continuous periods, leading to less time being available for standard nursing or clinical interventions. Junior Doctors still have to work longer hours than they should and Consultant rotas are in some areas too intensive. High levels of occupancy bring with them higher levels of clinical risk associated for example with higher risk of cross infection. Although claims for negligence here are comparable with England, there have been significant increases in the numbers raised in recent years, and action needs to be taken to reverse these trends. In addition there are concerns over increasing case loads in the social care sector.
- 68 Frameworks are being established to take the issue forward to ensure consistent application of standards throughout the NHS and to provide for better regulation and compliance. These are being reflected in Northern Ireland following the recent consultation exercise in "Best Practice - Best Care".

- 69 Responding to the quality agenda has major implications for the HPSS, not merely in responding to the resource requirements that follow in its wake, but also in securing the operational service changes that are necessary.
- 70 This agenda has prompted change in a range of Acute services as organisations struggle to meet professional accreditation for training posts and other service standards. It has also led to greater centralisation of some services to provide for effective professional cover on a 24 hour basis and increasing specialisation. It has also called into question the continued provision of Acute inpatient services at certain locations as the practice of safe medicine calls for access to the full range of services on a 24 hour basis.
- 71 In the Acute sector these issues are being addressed for example through the Acute Hospitals Review and associated consultation exercise, and strengthened appraisal and revalidation arrangements for the medical profession. There are also similar trends in social care governance which require attention to be paid to the implementation of appropriate supervisory structures and caseload review and management.
- 72 The quality agenda has very significant resource implications, with a need to invest in a wide range of services simply to improve standards. This will not address growing demand. It is however, required to sustain current levels of service and if not pursued would lead to the unplanned withdrawal of services from some

localities, the loss of public confidence in core facilities and higher levels of litigation and compensation.

Securing Improved Efficiency

- 73 In addition to the major cash releasing and cost improvement programmes pursued over the last two decades, which in today's terms have provided annual savings of some £195m, the HPSS continues to pursue efficiency opportunities to maximise the care that can be delivered within available resources. Initiatives include:-
- a further cash-releasing savings or income generation initiatives through for example more effective procurement, implementation of energy conservation schemes, introduction of car parking charges;
 - b securing productivity improvements through the systematic analysis of performance against peer groups, analysis of constraints to patient flows, and technical developments enabling more intensive use to be made of facilities;
 - c systematic review of unit costs through the annual production of 'reference costs' for Acute and community activity;
 - d a continuous programme of value for money studies. Recent studies commissioned by Health Services Audit covered the Diabetic Services, Regional Supply Services and a number of Acute Hospital issues;

- e review of individual services, encompassing not only support services but also clinical and community services e.g. reviews of nursing and other health profession services, case mix reviews etc.

Interdependency of Care Services

- 74 The Health and Personal Social Services constitute a complex interplay of different services which are heavily interdependent, offering choices regarding the appropriate route through the care system for specific illnesses and conditions dependent on severity. The inter-relationship of these services is illustrated at Annex 3, which demonstrates the different entrances to, processes through and exits from the health and social care system.
- 75 As for any system there are gateways, constraints and bottlenecks governing access to and flows through the system. Ensuring an effective system necessitates a holistic approach. For example there is little point in increasing activity in the hospital sector, if attention is not paid to ensuring effective discharge arrangements, otherwise the additional investment in the Acute sector merely results in the silting up of expensive Acute capacity.
- 76 The analysis of the various interdependencies immediately focuses attention on the interface areas between the primary Acute and community services. Ensuring that these interfaces operate in an integrated way is critical to the smooth and effective operation of the whole system.

- 77 There is evidence however of some disequilibrium between the various component parts, as manifested by long waiting times to gain access to the system, and delayed discharges from the system. Such issues compound the problems associated with lack of resources.
- 78 Although the HPSS has been developing its approaches to managing these interface issues, through for example the development of home from hospital schemes, and the provision of intermediate care, the range and scale of such initiatives here have been less well developed than in GB.
- 79 Avoidance of delayed discharges will maximise hospital capacity to address increasing emergency admissions and enable elective capacity to be protected.
- 80 Investment in assessment centres will help avoid unnecessary admissions and incentivising primary care teams to take on more responsibility for the management of conditions traditionally managed in the hospital environment will further release hospital capacity.
- 81 These issues apply not only to the Acute hospital model, but also to the interaction of services for those with mental illness and learning disabilities.
- 82 In a scenario where resources are fully committed and beds are intensively used to address current demands, the major difficulty is

identifying sufficient additional resources for investment ‘around’ the hospital to make a real difference, at a time when significant demands are also presenting on individual specialties in the hospital environment and on specific services in the community. To date it has only been possible to take some specific targeted action in this area.

- 83 There is a need to recognise that there exist constraints to the wide-ranging implementation of such an approach. The residential and nursing home sector is already operating at high capacity levels and there are doubts regarding whether current fee rates are sufficient to attract new private investment or maintain existing levels. Out of hours medical and professional cover will be expensive, and the general tightening of the labour market means the pay rates for domiciliary care are becoming less competitive.
- 84 Whilst the analysis has demonstrated broadly comparable or better performance than elsewhere, there were, nevertheless, a number of areas identified which require further examination and which may offer opportunities for further improving overall effectiveness. These are:-
- a the benchmarked performance of the hospital sector demonstrated broadly comparable performance with UK peers, but further investigation needs to be undertaken at Trust level to examine performance which lies outside the range of normal performance for individual specialties;

- b particularly, there is a need to ensure that appropriate provision is in place to address the needs of people with longer term care requirements such as those relating to MS, Strokes, Traumatic Brain Injuries, and Rehabilitation, so that Acute beds are not inappropriately occupied;
- c there is also a continuing need to ensure best clinical practice is applied so that all clinical interventions are evidence based, and the treatments offered represent the most appropriate response to conditions presenting;
- d a number of conditions are amenable to treatment on a day case basis, avoiding more expensive overnight care. Although the rates of day case work are broadly comparable with GB, there remains scope for increasing these;
- e unit cost comparisons have demonstrated broadly comparable costs with GB. There is a need however to extend the range of activity for which reference costs are available, to provide for a comprehensive and systematic evaluation of cost competitiveness with GB;
- f at individual Trust level, where benchmarks have shown costs to be out of step with comparators action needs to be taken to seek explanation of variations and reduce these;
- g the analysis indicated that the average length of stay in maternity wards is longer in smaller hospitals and the variation can not be wholly explained by differential need. High rates of caesarean procedures were also noted and these no doubt are contributing to longer lengths of stay;

- h in addition, population trends demonstrate a falling birth rate overall, and this will have implications for the future profile of maternity services;
- i although structures here, unlike GB, provide for the integrated delivery of health and social care services, there remains scope for more partnerships working across the different professions;
- j the analysis has demonstrated significantly higher levels of access to Domiciliary care provision – yet the service still is not able to fully meet assessed need. The underlying reason for this needs to be explored further, and the Community Care Review should include the assessment of the potential for greater use of sheltered housing with care, which is less well developed here;
- k notwithstanding the higher levels of investment in domiciliary care, there remains greater reliance on the nursing home sector here than in GB. Constraints to the effective delivery of the objective of maintaining people in their own homes needs to be explored;
- l there remains an over-reliance on hospital provision in the mental health and disability programmes;
- m Northern Ireland’s costs of prescribing are higher than GB, although the steps taken by the Department to contain costs have ensured that the rate of increase is lower than elsewhere. But there is a need to undertake more general research into expenditure trends to obtain a better understanding of the factors underlying the differences in costs and prescribing patterns here and in GB;

- n management and administrative costs have been shown to be comparable with GB. Indeed a recent study by the NHS Confederation indicates that a significantly smaller proportion of expenditure is devoted to management here compared to GB. However, it is acknowledged that there is scope for limited savings in the longer term from restructuring the HPSS. Subject to investment in new technology and systems, recent developments suggest there may be scope for providing support services for e.g. financial and personnel systems in a more cost-effective way.
- o although analysis indicates that there are broadly similar levels of clinical negligence claims here compared to the rest of the UK, nevertheless there have been a significant increase in the numbers raised in recent years.

85 Work is already underway to address many of these issues. An agreed action plan is in place to roll out the reference cost initiative across all specialties. As a result comparative cost information covering all inpatient and day case treatments should be available by January 2004.

86 Boards as commissioners of services are increasingly focussing on the performance of individual Trusts using management information to challenge them to attain higher levels of throughput and treat more patients within existing capacity.

- 87 Strategically the Acute Hospitals Review and consultation process will provide a framework for a more effective pattern of Acute services, within which, inter alia, the issues identified in maternity services will be addressed. Implementation of the second phase of the Community Care Review will allow different approaches to be tested for maintaining people in their own homes. The new arrangements envisaged for primary care will also involve health and social care professionals from a wide variety of backgrounds in decisions about service profiles both within the primary and community sectors, and the interface of these sectors with the hospital service. This will provide for the profession to work in a more integrated way than has been achieved to date.
- 88 A key objective of Local Health and Social Care Groups will be to ensure cost-effective prescribing and action plans are being developed to address the issue providing for GPs, pharmaceutical advisors and community pharmacists to work together to secure improvements. Research has been commissioned to explain the differential use of ulcer healing drugs between here and GB.
- 89 A public consultation process has just been undertaken on the structures of the HPSS, and the Department is actively monitoring developments in GB regarding the provision of support services on a shared basis with a view to bringing forward business cases for the replacement and reprofiling of financial systems and services. The Department is also currently working on the development of a central database for clinical negligence, which will enable lessons learnt from individual cases to be applied across the region. A

major initiative is also being taken to strengthen risk management across all services.

CONCLUSIONS AND KEY ISSUES

90 This section summarises the main findings and conclusions of the analysis and identifies key issues which have emerged.

Needs Assessment

91 The key factors determining need are associated with the age and socio-economic profile of the population. The key findings are:-

Population

- Northern Ireland's population is younger than that of GB, however;
- it has higher birth rates and is growing older more rapidly;
- the rate of increase in the elderly population particularly has major implications for the services ability to respond adequately to the demands of old age;
- already services are operating at capacity levels and there are high levels of unmet need as demonstrated by hospital and community waiting lists.

Morbidity and Deprivation

- Northern Ireland is significantly more deprived and as a consequence suffers higher levels of morbidity than other parts of the UK;
- the health status of the population is generally poorer;
- there is a close correlation between levels of deprivation in a population and need for health and social care - this applies to all programmes but the relationship is particularly strong for child care and mental health;
- in both of these programmes the level of investment is not commensurate with the level of needs and as a result there are important gaps in service provision.

Disability

- there are higher levels of disability in the Northern Ireland population compared to elsewhere in the UK;
- as a result of improved survival rates and increased longevity the disabled population is increasing, and this has major implications for the care programmes provided for people with learning disability or physical or sensory disability;
- the disability services are not responding adequately to the needs of the disabled population.

Other Factors

- the population of Northern Ireland is more rural than England and as the costs of delivering care in rural areas are higher, more resources are required to address similar levels of need;
- Northern Ireland has lower rates of private health care and a lower proportion of the population meet the full costs of residential/nursing home care. This means that a higher proportion of total need falls on the statutory sector indicating, again, that more resources here are required to meet similar levels of need;
- new therapies and technologies add significantly to healthcare costs;
- many of the cost drivers are determined outside Northern Ireland, but these costs have to be carried within the Northern Ireland budget allocation.

Effectiveness In The Use Of Resources

- productivity in the hospital sector has increased by almost 100% in the last 10 years;
- broadly comparable rates of performance are achieved here relative to GB;
- unit cost comparisons also show broadly similar costs;
- further improvements in productivity are inhibited by delayed discharges from hospital;

- in the community programme there has been a significant increase in the levels of care provided at home or in the community, but there remains an over reliance on the hospital sector;
- management and administrative costs are comparable with GB;
- there has been a strategic focus on improving effectiveness as demonstrated by the development and implementation of a number of strategic reviews; and
- at a local level there are many good examples of changes in the operational profile of services to secure improvements;
- there are also many good examples of management action to improve efficiency; nevertheless
- the analysis identified areas, particularly at the interface between hospital, community and primary care services which could be targeted to improve overall effectiveness.

ADDRESSING THE ISSUES

- 92 Many of the areas identified by the Needs and Effectiveness Evaluation as requiring change, have previously been recognised and work is already underway or planned to address the issues as far as possible given the current funding position. Key areas where work is being taken forward are described below:-
- 93 Performance management processes have been adopted to ensure continuing improvements in the effectiveness, efficiency and economy of the Service. The extension of reference costs and

continued development in the use of benchmarking techniques will be of particular value in seeking efficiency improvements while the implementation of “Best Practice - Best Care” will address the need to deliver and keep up-to-date with increasingly challenging quality and safety standards and ensure that the most effective services are used.

- 94 Decisions in regard to the way forward on The Acute Hospitals Review, should set a framework for a more effective pattern of Acute services.
- 95 The ‘First Report’ of the Review of Community Care has identified a number of innovative schemes and practices which will help Trusts to develop local solutions to the pressures they are experiencing such as schemes for one-stop assessment, hospital at home, rapid response and intermediate care. Recommendations have also been made for seven projects to be taken forward in the next stage of the review. These cover ways of maintaining people in their own homes or other community settings, disseminating good practice, providing practical support for carers, common assessment tools, value for money, agencies and the private/public balance of provision.
- 96 An expanded role for primary care professionals and improvements in the local provision of primary care services are central to the Department’s primary care policies and will be taken forward under the auspice of local health and social care groups.

- 97 The *Investing for Health* Strategy provides an inter-departmental focus for tackling some of the main causes of ill-health.
- 98 The Department is also currently working on a revised regional strategy to draw these various elements together into a single coherent vision for future services.
- 99 Considerable work is also ongoing to improve individual services. For example:-
- a progress on the Cancer Strategy continues and work on the regional cancer centre has begun this year (2002);
 - b the Carer's Strategy aims to identify practical measures that will make a real difference to the lives of carers here. Without the efforts of carers many more older, frail, sick or disabled people would need more intensive support from the statutory services;
 - c implementation of the Cardiology /Cardiac Services Review will reduce waiting times and ensure a whole systems approach;
 - d a service improvement leader, with considerable experience in the field, has been contracted to provide specific advice to individual Trusts on possible changes that could reduce waiting lists. In addition the Department has put in place a Waiting List Framework for Action and individual organisations have developed Waiting List Action Plans. Winter pressures planning to attempt to deal with winter peaks will also continue;

- e the Children Matter Taskforce was established in 2000 to develop a Regional Plan to redress the decline in the number of residential child care places and the virtual collapse of voluntary sector provision. Work is underway to provide a substantial increase in the number of places also greater diversity in provision to deal with adolescents and children with psychological needs or disabilities;
- f a number of ICT initiatives are improving services, particularly for GPs;
- g implementation of the Strategy for People with a Learning Disability, the Mental Health Resettlement Programme and other reviews of policy and service are gradually providing a more effective balance of care between the hospital and community sectors;
- h the implementation of the new GP contract will encourage primary care to take on a wider role in the provision of care;
- i implementation of the Ambulance Review action plan will improve response times and the quality of response.

100 Many of these reviews and strategies have funding requirements and there are also issues, such as the shortfall in capital investment and the need for extra staff projected through workforce planning models, where funding is essential to make progress.

Key Issues

101 The Steering Group identified a range of key issues facing the HPSS which it considered emerged from the report's findings, and reflected the current situation. These could be summarised under

three broad headings and are dealt with in turn in the subsequent section :-

- Dealing with immediate and critical need;
- Getting the pattern right – achieving a better balance between the different areas and demand which make up the HPSS; and
- Investing for Health – addressing underlying health problems now which will show positive gains in future years.

Dealing with immediate and critical need

102 The HPSS has to respond to increasing immediate demands and emergencies. To a large extent, this is what drives the system as is evidenced by the manner in which, for example, winter pressures, can displace elective surgery. Immediate and critical need is a key driver in terms of setting HPSS priorities and in deciding what services must be provided and which ones must give way in spite of the adverse impact on those affected.

103 Access to the system is, however, not automatically open to people at their request. As the interaction model shows (see Annex 3), there are 3 main points of entry. These are through Accident and Emergency Units, GPs or social workers. It is clear, therefore, that effective “gate keeping” has a key role to play in ensuring that entry to the system is properly managed. Similarly, we need to ensure that our Accident and Emergency Units are being properly used. GPs, clinicians and a wide range of primary care professionals have a vital role to play in this.

104 In that regard there are in place sophisticated assessment processes, which are used to provide professional and clinical opinions regarding the most appropriate care or treatment regime for individuals. These are taken forward within existing resource frameworks which can impact on the care path actually recommended. For example increased investment in primary care services could provide for a wider range of care to be delivered in that arena, thus avoiding potentially unnecessary hospital admissions. There has been a trend for more workload to be undertaken at the primary care level – for example as lengths of stay in hospitals have been reduced, greater demands have been placed on the community nursing sector and GPs are taking responsibility for monitoring patient conditions that previously would have required a hospital visit. However, there is a need to provide for the proper resourcing of these developments. The latest negotiations on the GP contract are intended to provide incentives to GPs to take on more responsibility for patients in their care. And under the revised arrangements envisaged for primary care professionals within Local Health and Social Care Group structures the role of the primary care sector will expand contributing to reduction of pressures on the Acute sector and helping to avoid unnecessary admissions and facilitating early discharge.

105 Alongside the need for effective gate keeping is the need to maintain people at home or in the community wherever possible. Acute services represent the most expensive sector so it is

important to ensure that those who are being managed in that sector require that level of treatment. There are also wider quality of life issues in relation to supporting people at home or in the community. The Steering Group concluded that it may be necessary to give effect to a greater range of care options to ensure that people are cared for in the most appropriate environment. The role of informal carers, and how to provide them with the necessary support in that role, is also an important factor given that some 250,000 people in NI are involved in providing some form of care and support to people in need.

Getting the pattern right

- 106 The Steering Group recognised that the fact that the system must be able to respond at all times without delay to emergencies and critical need means that we need to get the balance right between the various parts of the HPSS. As the interaction model shows clearly, the HPSS system involves a high level of complex interaction. The interface areas between the different components are key at every level in ensuring the smooth transition of people from one part of the system to another.
- 107 For example; delayed discharges from hospitals inappropriately utilise capacity that could otherwise be freed up for emergency or elective treatment; accident and emergency units have to see more cases because of difficulties in getting appointments with GPs; older people can require admission to a residential home or hospital because of inadequate support at home or in the

community. The Steering Group would therefore emphasise the importance of addressing problems in a systems-wide way.

- 108 In terms of getting the pattern right, the Steering Group would acknowledge the importance of the potential offered by alternatives to hospital or permanent residential care. Increased investment in primary and intermediate care – in all its forms - could be significant in helping to balance the level of demand for Acute services (the most expensive part of the system) and other types of community care.
- 109 The HPSS is heavily people dependent for delivery of its services, and the human resource issues will have to be actively addressed to ensure that we have the right personnel to run our service now and in future years. The need to invest in additional human resources is a fundamental requirement in terms of future planning for the HPSS. This applies to all levels of the workforce – on the one hand, the training period for specialist medical staff can be lengthy and expertise is in short supply but, on the other hand, the buoyant employment market is making it difficult to attract care workers and other support staff who are essential for the running of our services. In moving forward appropriate arrangements will need to be in place to lever in the future supply of the desired services, so that they are attractive to investors and employees.
- 110 Finally, in terms of getting the balance right the Steering Group recognised that it was important that quality and safety issues should have priority at all levels and that the immediate demands

for care should not displace the need to provide long or longer term care. In particular, we need to ensure that the longer term needs of children and other vulnerable groups are properly addressed and that they are not displaced by the more volatile parts of the system

Investing for Health

111 Prevention is an important factor in getting the future balance of services right. The Steering Group shared the view that we need to take steps now to improve the health of future generations, thereby increasing the general quality of life status and reducing their demands on the service in relation to certain conditions. There is no easy way to determine the level of investment that should be made. The evidence to support initiatives is increasing and it is important that we make what improvements we can now in order to ensure that we are not spending scarce resources later on diseases which are preventable. To that end, the *Investing for Health* programme is laying the foundations, for a concerted and focused campaign to improve the health of the population and minimise the future burden of treatment and care. This will include initiatives from other Departments but there is a continuing case for further investments by DHSSPS in smoking cessation, vaccination, screening, physical activity, nutrition and drug and alcohol programmes.

ANNEX 1

TERMS OF REFERENCE

The terms of reference for the evaluation were as follows:-

- (a) The overall purpose of the Review is to provide an assessment of the needs for and effectiveness of the resources provided for the HPSS in Northern Ireland. This will ensure a better framework for policy decisions, and their link with budget allocations and the achievement of better value for money with due regard to new TSN and equality of opportunity.

- (b) The review will focus on the provision and analysis of information including comparative material. This will include the identification of any constraints on improved performance as well as provide the basis for the subsequent development of policies, which more effectively meet current and future needs. It will assist with identifying those services where allocations of resources would offer significantly improved outcomes.

The review also contains the following detailed terms of reference:-

- i the trends in needs in the Health and Social Services in Northern Ireland relative to other regions in GB;
- ii. the level of resources available in Northern Ireland, including comparison with other regions, and the outputs achieved;
- iii. comparisons of activity levels with GB regions and RoI by service type;
- iv. unit costs and investment per capita comparisons by service type, including trends;

- vi. the performance measures to be used to assess the economy, efficiency and effectiveness of service provision.

CHAPTER SUMMARIES FROM THE MAIN REPORT

This Annex provides a summary of key points from work on specific topics. References to the relevant chapters in the main report are given at the start of each section. Each summary begins with some background information on the services being provided or issues being examined. Apart from the Overview and the summary on assessing population need, key issues on other topics are presented as either relating to "Need" or "Effectiveness". It is possible for an issue to have elements of both need and effectiveness and in such cases the issue has been allocated to the more appropriate heading.

OVERVIEW

[Reference Chapter One Main Report]

Current expenditure on health and social care is £2.5 billion a year. About two-thirds of this relates to Hospital, Community, Health and Personal Social Services (HCHPSS). The other major block of HPSS spending is on the Family Health Services, which makes up some 21% of the overall budget. The HPSS provides a complex and extensive range of health and social care services. These interact, and pressure in one area can have a knock-on effect in others.

Spending per head of population is currently higher than England, similar to Wales and lower than Scotland. The latest figures indicate that the current NI spend per head of population (£1,249) is 10% higher than that in England (£1,136).

Pressures on funds are increasing, with a growing elderly population, and pay and price rises that are higher than inflation. New technologies, treatments and drugs, improved clinical standards and rising public expectations also put pressure on resources.

Many of the HPSS's costs are inescapably driven by developments in England, including Pay Review Body recommendations, drug costs, clinical and other professional standards. The great bulk of the HPSS budget is effectively determined by costs in England and therefore linked to its public expenditure settlement.

Health and social care need can also be affected by the availability of provision from other Programmes, for example, sheltered housing or education and training facilities for disabled people.

The integrated health and social care service in NI has a number of benefits, and avoids some of the problems identified in GB regarding joint planning. However, there remains scope for improved partnership working across professions.

The need for health and social care is determined by the age and gender and socio-economic profile of the population. But other factors too such as rurality; private health care provision; diseconomies of scale; and community tension, affect the need for resources.

The Troubles have had an impact on all aspects of the health and personal social services. In spite of the reduction in violence over recent years, that impact continues to be felt.

Staffing levels per head of population are generally second highest after Scotland, but activity levels are also high. Increased activity due to greater need raises relative costs.

There is a need to invest for the future in improving population health and wellbeing, and the training of new and existing staff.

There are a number of good examples where the Department and the Service have taken steps to improve efficiency and effectiveness. Detailed performance issues are however addressed in subsequent chapters.

ASSESSING THE NEEDS OF THE POPULATION.

[Reference Chapter 2 main report]

Demand for health and social care services will always tend to outstrip the available resources. When these resources have to be split between different populations, it is important to be able to assess what a fair share of the budget would be, given that different populations have different needs.

Assessing a population's need for resources

There are a number of factors that create need for health and social care services. These are: population size and age/gender profile; additional needs generally related to deprivation levels; and extra costs such as those incurred in delivering services to rural areas.

Comparisons of the relative needs of the populations in England, Scotland, Wales and Northern Ireland show the following:

- The NI population is growing more rapidly than elsewhere in Great Britain (GB) because the numbers of older people are increasing at a faster rate. In the 10 years to 2010, the population aged 65 and over is expected to increase by 15% in NI compared to 8% in England and 7% in Scotland and Wales. Growth in the most needy population aged 85 and over is even greater, by 2025 this group is expected to have risen by 72% in NI

compared to 47% in England, 56% in Scotland and 49% in Wales. Although older people here are living longer, by 2025 they will still make up a smaller proportion of the population than in GB.

- NI has a young population with 30% aged under 20 years compared to 25% in England. The birth rate here is still 11% higher than in England but the gap is narrowing.
- The costs of health and social care are high at birth and in the early years and then in the older age groups. For the majority of services, older age groups are the most expensive, particularly the 85+ age group.
- Given the costs of each age group, it would take a 1% increase in resources per year in real terms to meet the additional costs associated with demographic growth up to 2015 and at least as much thereafter.
- Northern Ireland is relatively deprived and has associated higher levels of morbidity and early death. The Standardised Mortality Ratio for persons aged under 75 is a measure of early death and shows that the level in NI is 7% higher than in England. In terms of deprivation, NI has the lowest proportion of the working population in employment (66% compared to 76% in England). The level of income support benefit recipients is 68% higher in NI than England. Also, the proportion of lone parent

households is 38% higher in NI than England.

- There are some 40% extra severely disabled adults under age 65 in NI than in England (Disability Survey). The level of congenital anomalies (inherited conditions) continues to be substantially higher than England.
- NI has to face higher costs in providing the same services to a much more sparsely populated area than is the case in England.
- The low level of private health insurance in NI results in a substantially greater burden falling on public finances. Also a smaller proportion of people fund their own places in nursing homes.
- While the younger population profile tends to reduce the demand for resources, this is more than offset by the increased need associated with a deprived population. The extra costs of providing services in a more rural area and the increased pressure on public funds due to lower levels of access to private provision also have an impact.

IMPROVING POPULATION HEALTH AND WELLBEING

[Reference Chapter 3 main report]

Some £35 million per annum is currently spent on improving population health and wellbeing in NI through a range of activities including immunisation and screening programmes, and health promotion activities. To improve health it is necessary to tackle the underlying causes that are contributing to the development of illness, as well as treating ill people.

Needs Issues

- Deprivation, such as that experienced in NI, is associated with many of the risk factors common to the major diseases which account for the majority of current health spending.
- Smoking is the major preventable cause of premature death and ill health, and heavy smoking is much more prevalent in NI than in GB. There are currently 350,000 adult smokers in NI. Since 1983 the proportion of men smoking has fallen, but this trend has not been matched in women. Two main concerns are: the increase in young female smokers age 16-19 years (increase from 19% in 1983 to 27% in 2000); and the high percentage of heavy smokers here compared with GB (52% of NI males smoking 20+ daily compared to 36% in England and 31% in Wales)

- An increasing number of Northern Ireland drinkers drink in excess of the “safe” drinking levels and this drinking is often concentrated in several “sessions” at weekends.
- There are significant gaps in the development of screening services here compared to GB.
- There are gaps in health development programmes here compared to GB, e.g. GB funds a healthy workplace programme.

Effectiveness Issues

- While the return on investment to improve population health and wellbeing is slow, the benefits of prioritising such work will be evident in the long term.
- Screening and immunisation programmes are successful, and make an important contribution to improving population health.
- Immunisation up-take rates are generally higher than in England and Wales, but lower than Scotland.
- Women between the ages of 50 and 64 years are invited for breast cancer screening once every 3 years and those aged 65 and over can receive breast screening on request. The

uptake of breast cancer screening here in 1998/99 was over 72 per cent, the highest in the UK.

- A recent review of trials of breast cancer screening found there was evidence that mortality rates for women aged 50-69 years can be reduced by 35 per cent if they attend screening on a regular basis.
- The cervical screening programme invites all women aged 20-65 years for a cervical smear every 5 years. The cervical smear test detects changes at an early stage, before any cancer has developed. In 2000, 30 women in Northern Ireland died of cervical cancer yet it can be prevented. Most cases of cervical cancer occur in women who have never attended for a smear test. National guidance recommends that 80 per cent of eligible women should be screened through the programme, but in 1998/99 uptake here was only 68 per cent compared with over 80 per cent in the rest of the UK.
- Evaluations show that public information campaigns are as effective or more effective than those in GB. For example, No-Smoking Day is held annually in each of the four countries, and shows a higher awareness and participation rate here.

- Research demonstrates that smoking cessation interventions are effective. The Department will be publishing a Tobacco Action Plan for consultation.
- Further funding has been secured to develop the Investing for Health partnerships, the pilot of free fruit in schools scheme, a healthier schools initiative and the Investing for Health Communities grants scheme.

ACUTE AND MATERNITY SERVICES

[Reference Chapter 4 main report]

Acute Services, costing £524m in 1999/00, account for around 40% of total expenditure on Hospital, Community Health and Personal Social Services (HCHPSS). Maternity Services, at £49m, (excluding Child Health) represent about 4%. Acute services treat 380,000 inpatients (including day cases) each year, 1.2 million outpatients and 673,000 A&E attendances. Maternity services provide over 30,000 spells of inpatient care resulting in around 22,000 births each year.

Needs Issues

- Hospital capacity is severely stretched at a time when hospitals are having to cope with increasing levels of emergency admissions. As a consequence, the number of patients having to wait on trolleys for long periods awaiting admission, as well as numbers of cancelled operations, have grown significantly, particularly in hospitals with high occupancy levels – over 80% occupancy starts to impact on the efficient running of an Acute hospital. The latest occupancy rate for the General Medicine specialty was 91%. Extra capacity is required.
- The increasing numbers of people aged 65 and over (+54% by 2025) will have a substantial impact on the demand for Acute Services and emergency admissions in particular.

- The birth rate in NI is currently 11% higher than in England, although the difference is expected to narrow over the next two decades.
- Announcements of new expenditure in GB tend to raise public expectations but comparable increases in funding have not been available in recent years.
- The Wanless Interim Report, “*Securing our Future Health: Taking a Long Term View*”, identifies technological developments and new drugs as adding substantially to future hospital expenditure requirements.
- The higher level of deprivation in NI has been shown to increase need for Acute services, particularly emergency admissions.

Effectiveness Issues

- Since 1995/96 the number of Acute Ordinary Admissions to hospital has increased by 14%, while the bed numbers have reduced by 10%. Lengths of stay have reduced by nearly 16% while bed occupancy levels have increased, on average, from 75% to 81%.
- Increases in emergency admissions are producing year-round pressures on key services and directly affecting capacity to deliver

elective treatments. Non-urgent elective procedures are displaced by emergency admissions, which use the capacity originally allocated to planned treatments.

- Despite treating proportionately more people than elsewhere, the NI hospital waiting list is over 60% higher than in England, having allowed for relative population size.
- Reference costs for surgical specialties relate to combinations of diagnoses and procedures (known as HRGs) that are clinically similar treatments and have similar costs. Their use facilitates comparison with England as there is less scope for variation due to the type of patients being treated. The NI average cost for 23 HRGs out of the top 30 fell within the range of 50% of English Trusts, 3 HRGs had an NI average cost above the mid range for English Trusts, and 4 HRGs had a cost below the mid range. Further investigation will be necessary, but NI costs are generally consistent with England.
- The publication of this data in NI represents a significant step in enhancing the accountability of organisations for their comparative costs. Any individual Trust procedure with a higher than average cost compared to an appropriate peer group, will be highlighted so that the organisation can undertake a detailed examination of differences from their peer group. This could potentially lead to improved practice or a better understanding of the reasons for cost differences.

- NI admits comparatively more patients, in line with higher levels of need, and the average length of stay is slightly longer than elsewhere. When this was investigated, there seemed to be a few specific conditions where the situation differed, and these differences contributed disproportionately to the NI average length of stay. In many other areas the position was comparable or better.
- The conditions identified as having long lengths of stay in NI were those requiring lengthy rehabilitation such as Traumatic Brain Injury, Amputations, Multiple Sclerosis (MS) and Strokes. There are indications that such cases are treated in hospital beds within Primary Care Trusts or through intensive community packages in England.
- Most day case rates look similar. Some newer procedures for day surgery are being examined further and discussed with some surgeons. There is some limited scope to increase day surgery further, but where complications can be fatal without quick access to hospital, as in the case of tonsillectomy on children, the use of day case surgery has to be considered carefully, particularly in more rural areas.
- NI is comparable or better on pre-operative lengths of stay and quality indicators such as the absence of surgical deaths or readmission rates.

- The proportion of General Medical admissions discharged in less than 2 days is lower in NI. English hospitals had ready access to MRI and CT scanners and other diagnostic equipment, which facilitated early diagnosis and treatment.
- The private sector makes a significant contribution to service provision in GB (13% of elective surgery) but makes a marginal contribution to Acute care here.
- Overall, Acute services are frequently delivered from ageing buildings with outdated equipment and insufficient staffing levels. These issues need to be addressed if capacity is to meet patient need, and services are to be modernised to deliver the required standards and volumes of care and treatment in the future.
- Maternity Services appear to be more hospital based in NI with mothers staying longer than in GB. There are more small consultant-led units here and this may affect the relative effectiveness of the services. Strategically the Acute Hospitals Review will provide a framework for a more effective pattern of Acute services, within which inter alia, the issues identified in maternity services will be addressed.
- The high caesarean rate, although lower than in Wales, should be explored further as it is a public health issue and contributes to longer lengths of stay.

- An analysis has been undertaken of trends in the use and cost of drugs in hospital, for example, there has been an increased use of cancer healing drugs.

SERVICES FOR OLDER PEOPLE

[Reference Chapter 5 main report]

There are 220,000 people aged 65+ in NI, and the cost of Services for older people (£356m in 1999/00), which includes dementia in NI, is over a quarter of total HCHPSS expenditure. 139,000 older people were in contact with community health or social care services, 12,000 were treated as inpatients and 20,000 as outpatients. The expenditure on domiciliary care (over 15%) refers to approximately 4,600 care managed cases, as well as almost 24,000 people receiving home help. In addition, over 4,000 people were receiving Meals on Wheels. The elderly programme is complex and attracts services from all areas of Health and Personal Social Services.

Needs Issues

- The rapidly growing elderly population impacts markedly on need, given the higher cost of service in this age group. The most expensive age group (85+) is projected to increase by more than 70% by 2025.
- There appears to be a lower level of self-funders in NI (15% compared to 31% in England) and therefore a greater demand for publicly funded nursing home places. It also leads to less flexibility within the market providing independent sector places.

- Comparative figures for home help services indicate a lower level of input per client in NI than in England and Wales. Consultation on the review of community care identified the provision of low-level home help services as an effective method of reducing risk of the need for more intensive services.
- There is a high recorded level of unmet need across all areas of community care evidenced by the fact that there are over 300 people waiting in hospital for a community care package and around 1200 waiting in the community. The stated policy of maintaining people in their own homes, in preference to residential care, is not being delivered.
- Pressures are evident in both the independent residential/nursing home and domiciliary sectors in NI and in other UK regions. The sector argues that fees paid for residential/nursing home care do not reflect the cost of care provision. An additional £3.6m has been allocated towards fees this year to effect an average 5.5% increase seeking to stabilise the sector.
- Intermediate care services, which delay or prevent admission of older people to institutional care or hospital, as well as expediting discharge, receive a high level of investment in England and are more advanced than in NI.

Effectiveness Issues

- Many Trusts are taking forward schemes to reduce inappropriate hospital admissions and to assist with faster safe discharge in the shape of Step-up and Step-down intermediate care. Work is ongoing to replicate schemes, and the funding for the additional 1000 care packages in 2002/03 will be targeted towards reducing dependency through use of innovative practices. The level of use of residential/nursing home care has an adverse impact on rehabilitation.
- The use of nursing homes in NI is disproportionate when compared to the use of residential and nursing home care across other areas. The pilot exercise, carried out in March 2002, on the assessment tool for free nursing care found that 47% of those on which the tool was tested fall into the lowest category of nursing need. On the other hand, consultants providing information on the English position have said that England recognise the need to increase the provision of nursing home places and the use of high quality sheltered accommodation with care, for people who would previously have been placed in residential home places.
- Fees paid in the independent sector in NI are in the lower range of those in England and Wales.
- Charges for domiciliary care have not been introduced in NI but are applied, albeit inconsistently, in GB. This may contribute to a

higher usage of residential care as a cheaper option with Trusts having access to resident's income. It may also encourage people to seek free home care services here, which would be bought privately in England. Of course, more people in NI would be entitled to free services following the required means testing.

- The available data shows a range of reasons for people remaining in hospital after they are considered medically fit for discharge. The largest proportion relates to lack of funding. Resolving the other issues will simply move a substantial proportion of the other delays into the “no funding” category. Some Boards have taken steps to address the issue of choice of home but this requires very sensitive handling and can be rendered impossible where the community divide influences the acceptability of a particular home.
- Informal caring is a major contributor to the delivery of social care services with approximately 250,000 people providing care at some level. The introduction of the Carer's Strategy and allocation of funding for respite care will help to sustain support for carers in the future.

FAMILY AND CHILD CARE SERVICES

[Reference Chapter 6 main report]

There are about 460,000 children in NI, representing 28% of the total population. They experience relatively high levels of social and economic disadvantage. This Programme (costing £72m in 1999/00 – 5.4% of HCHPSS spend) provides a wide range of social services support for families and children. 16,000 children are referred to social services each year, 2,400 investigations are completed under child protection procedures, and 2,400 children are looked after at any one time including some 250 in residential care and 1,500 in foster care.

Needs Issues

- NI has a higher birth rate and a younger population than England, Scotland or Wales.
- Research shows that need for Family and Child Care services is very strongly associated with deprivation. NI has the highest levels of deprivation and therefore greater need for services.
- At October 2000 over 100 families with children in need were awaiting assessment by a Family and Child Care social worker, 68

children were awaiting a residential placement and 290 children were awaiting a fostering placement.

- There is a need to increase the number of places available in residential homes following the collapse of voluntary provision. Allowances for fostering are currently below national levels, and should be increased in recognition of current employment opportunities.
- There is a need to recruit additional Family and Child Care social workers, and to improve their working conditions, to retain qualified staff in this area of practice.

Effectiveness Issues

- Despite the higher levels of deprivation, per capita spend on all social services for families and children in Northern Ireland is lower than in England (which is 35% greater) and Scotland (which is 12% greater), while Welsh spend is similar to that in Northern Ireland.
- Although Northern Ireland has a younger population profile than England, a smaller proportion of the total personal social services budget is spent on families and children.

- Despite our higher levels of disadvantage, a broadly comparable proportion of children are in public care.
- The unit costs of the main children's social services provided - residential and foster care - are lower in Northern Ireland than in GB. Compared with England, expenditure on residential care is 39% less and expenditure on foster care is 25% less. A contributory factor is the higher use in England of more expensive provision in the non-statutory sector.

MENTAL HEALTH SERVICES

[Reference Chapter 7 main report]

It is estimated that some one in six people will suffer from a medically identified mental illness at any one time, i.e. about 282,000 people in NI. Many can be treated by a GP and a smaller number of people, with more complex conditions, require access to services within the Mental Health Programme of Care.

The Mental Health Programme cost £124m in 1999/00, 9% of HCHPSS spend. 10,000 people were treated as inpatients and 85,000 attended outpatient clinics. 560 people were staying long term in hospital and 1,000 were receiving intensive community care packages in a residential setting or at home.

Needs Issues

- Northern Ireland has greater mental health needs than England (estimated as at least 25% greater). Research shows a strong relationship between deprivation and need for Mental Health services. In addition, research in NI indicates the serious impact that the "Troubles" continue to have on psychological wellbeing. There is also a very high use of prescription drugs related to mental illness - prescriptions for anti-depressants are 37% higher,

psychosis and related disorders 66% higher, with hypnotics and anxiolytics 75% higher than England.

- The unmet needs of Victims of the "Troubles" are now recognised.
- A number of initiatives introduced in GB to support community mental health and to provide a better quality of life for service users have not been replicated here. The gap in services is estimated at £26m.
- There is a gap in Forensic Psychiatry services both for offenders and high-risk patients, estimated at £7m.
- There are also unmet needs in Child and Adolescent Psychiatry estimated at £3m per annum, including the assessed need for a further 9 inpatient beds. At October 2000, over 1000 children were on Child and Adolescent Psychiatry waiting lists.

Effectiveness Issues

- Lack of investment in community mental health has resulted in a higher proportion of people remaining in long-stay hospitals than necessary. Quality of life for such service users could be improved.

- Community options 24 hour/365 days a year would also provide an alternative to short-term emergency admissions to hospital.
- There is scope for greater integration of hospital and community based services.
- Mentally disordered offenders are currently detained inappropriately in locked wards, in prison, or in secure hospitals in GB. Forensic services need developed to improve quality, safety and accessibility.
- Services for people with an Eating Disorder could be improved by the development of a regional Eating Disorder Service to provide local treatment. If, as expected, it also encouraged people to seek help at an earlier stage it could prevent the long-term complications of late diagnosis.
- NI spends a higher proportion on inpatients than England but less on outpatients and community services.
- Inpatient and outpatient costs are lower than in GB. The average cost of an outpatient attendance in NI is less than half of that in England but more seriously ill people may get treated on an outpatient basis in England.

- Community costs per capita are lower than in England.
- NI has the lowest “Did not Attend” rate for out-patient appointments. People not turning up for appointments is a particular issue in this Programme and the NI rate of 21% is better than in GB countries.

SERVICES FOR PEOPLE WITH DISABILITIES

[Reference Chapter 8 main report]

Learning Disability and Physical and Sensory Disability services cost some £ 94 m and £45 m in 1999/2000, representing 7% and 3% respectively of total expenditure on Hospitals, Community Health and Personal Social Services (HCHPSS). There were 2,500 inpatient episodes to treat people with a learning disability and 3,500 attendances at outpatient clinics and at specialist learning disability facilities. 470 people are staying long term in hospital and 1,500 were receiving intensive community care packages. People with physical or sensory disabilities benefited from 1,300 intensive community care packages.

Needs Issues

- Northern Ireland has a higher incidence of disability than GB. 17% of adults here have a physical or sensory disability compared with 14% in GB. The incidence of severe disability in adults aged under 65 is some 40% higher in NI than England. There is a higher level of congenital anomalies (inherited conditions) in NI, and this contributes to the need for life long care.
- The “Troubles” are believed to have added to the numbers of people with disabilities who require expensive life-long care.

- The number of people with a disability is growing as a result of the increased survival rates of those with profound and multiple disabilities. People with disabilities also live longer now, impacting on demand for services, and their increasingly elderly family carers also require support.
- Northern Ireland has a higher incidence of road traffic accidents than GB involving young men. These can result in a life-long need for healthcare.
- Survival, rehabilitation and support require increasingly sophisticated and costly interventions.
- Increasing demand for housing adaptations, and the impact of EU legislation on moving and handling, is adding to the pressures on occupational therapy services, and other staff resources.
- Changing social structures and smaller extended family networks are impacting on the role of family carers.
- People with a disability have higher expectations, now underpinned by legislation. The Disability Discrimination Act accessibility provisions will have implications for HPSS organisations, GPs, dentists, opticians and community pharmacists.
- Requirements of Equality, Human Rights and Direct Payments legislation will increasingly be drivers for change and promoting choice and independence.

Effectiveness Issues

- Funding initiatives for these client groups in England and Wales have not been replicated here.
- It is intended that use of hospital beds should be focussed on assessment and short-term treatment. People with long-term needs should have an improved quality of life in the community. The speed of movement from hospital to community, which is dependent on community investment, is much slower in NI than in England or the Republic of Ireland.
- Comparisons of funding in NI and GB are not straightforward because of differences in definition and the scale of need. Relevant professionals consider that NI is less well funded on the basis of need, not possible to provide the same quality of aids, such as wheelchairs, digital hearing aids etc.
- Certain low unit costs in Northern Ireland indicate that there are unmet needs. For example, service users do not have access to day centre facilities for the full five days a week.
- Other Departments and agencies, particularly in the fields of education, training for employment and housing, as well as voluntary organisations, have important roles to play in providing alternatives to day care and residential accommodation for people with disabilities.

FAMILY PRACTITIONER SERVICES

[Reference Chapter 9 main report]

There are four main elements to the Family Practitioner Services, costing in total £454m (cash outturn for 2000/01). These are General Medical Services (£114m) covering 1060 (985wte, the equivalent number of full-time posts) GPs and 156 Locums, General Dental Services (£50m) where 689 (680wte) Dentists provide one million new courses of treatment annually, General Ophthalmic Services (£12m) where 400 (366wte) Opticians provide 310,000 eye tests and 200,000 pairs of glasses annually, and Pharmaceutical Services including the drugs bill, (£278m) where 509 pharmacies dispense 23 million prescriptions a year.

Needs Issues

The need for public funding of these services is impacted upon by deprivation either because it increases demand for services and/or services are provided free of charge to certain deprived groups e.g. GPs workload payments for patients from deprived areas, and the voucher scheme for glasses. Certain age groups are also exempt from various charges.

Effectiveness Issues

General Medical Services

- There is lower expenditure per capita on General Medical Services in Northern Ireland than in all other parts of the United Kingdom. We also have poorer levels of overall health, and poorer ratios of general practice staff to GPs in Northern Ireland than in Great Britain.
- The measures that exist indicate that quality of care in Northern Ireland is probably as high as that in Great Britain.
- Demand for care seems to be running on broadly similar levels, although a specific piece of research shows there is much more pressure on out-of-hours services in Northern Ireland than in Great Britain.
- The current national negotiations to determine a new GP Contract may have significant effects upon the future funding and service delivery of General Medical Services.
- Accessibility to services compares with England and Wales, but is less favourable than in Scotland. Given the level of deprivation and consequent need, GP list sizes should be smaller in NI than in England.

General Dental Services

- The higher costs of General Dental Services here are largely due to greater need and poorer oral health, coupled with better access to services.
- Overall expenditure and average costs per course of treatment are higher in Northern Ireland than in Great Britain- £41.98 compared with £34.79 in England and Wales and £36.78 in Scotland. The lack of fluoridation in NI increases the need for treatment, and leads to an increase in the cost of treating more severe cases.
- Access to NHS dentistry is probably better in NI than elsewhere in the UK. Registration with a dentist, which is an objective of Government Policy, is better in Northern Ireland than in England, e.g. 51% of adults compared with 45% for England.
- There have been improvements in oral health here over time.

Ophthalmic Services

- Expenditure levels are broadly in line with equivalent programmes in GB, and reflect local need.
- As expected, given higher levels of deprivation, activity levels for vouchers towards the cost of glasses are higher in Northern Ireland than in England.

Pharmaceutical Services

- About 29% more items are dispensed per head of population in Northern Ireland than in England, and consequently the cost of drugs per head of population is higher. Some of the higher level can be explained, for example, in NI the community budget bears more of the cost of drugs for people leaving hospital. The higher levels of deprivation in NI would undoubtedly increase demand. The level of drugs prescribed for problems related to mental illness is substantially higher in NI than in GB. Work continues to understand all the differences and close the gap with GB.
- Analysis of the cost per patient of certain categories of drugs also shows wide variations between Northern Ireland and England. The use of ulcer-healing drugs and anti-depressants accounts for about one third of the gap between NI and England.
- The trends in prescribing costs show convergence between Northern Ireland and Great Britain, and the annual growth in the Drugs Bill has been lower in Northern Ireland over recent years than elsewhere. This reflects the success of efforts to promote cost effective prescribing.
- Improved VFM is being achieved by: more effective contracting for drugs; balancing costs of drugs in hospital and community; and assuring a consistent approach through improved management

information for GPs and increased support from prescribing advisers. Improved delivery methods have also been introduced, such as the “managing your medicines” scheme and the investigation of repeat dispensing.

- Northern Ireland is well provided for in terms of access to services, compared with Great Britain.
- In the longer term, beyond the timescale of the current Evaluation, research will need to be done and data obtained to inform future decisions on the delivery of services.

WORKFORCE PLANNING AND GENERAL WORKFORCE ISSUES

[Reference Chapter 10 main report]

There are around 60,000 people employed, either full-time or part-time, in the HPSS at a cost of about £1 billion a year. How they perform in terms of productivity, quality and responsiveness has a key impact on the effectiveness of the Service. Detailed analyses of Administration staff are presented in the next chapter and so they are not focused on here.

Needs Issues

- The HPSS needs more staff, but it also needs to change the way staff work, and to ensure that training and education reflect the changing needs of the HPSS.
- Pay, which represents about 70% of expenditure, is in practice largely outside the control of the HPSS in NI. As pay inflation has been running about 2.5% above GDP inflation on average over the last 10 years, resources are always under pressure. Any increases in funding above inflation have first to meet pay pressures. Growing demands for services have been met to some extent by increased productivity of staff.

- The new Junior Doctors contracts, which pay more money to those doctors who work the most unsocial hours in the highest intensity posts, will add to pay pressures.
- An active workforce planning process covering all professional grades is essential to ensure that the appropriate levels of qualified staff are available to support the effective functioning of the HPSS.
- Professionally qualified staff tend to be mobile so reducing salaries by breaking pay links with GB would only exacerbate the current difficulties in recruitment and retention. The attractiveness of RoI salaries also has to be borne in mind. It would not be secure to plan for the future on the basis of attracting large numbers of nurses from Spain and the Philippines to fill posts.
- Supply of qualified staff is not meeting demands e.g. it is estimated that there will be a 20% shortfall in the number of Radiographers needed to staff hospitals by 2006.

Effectiveness Issues

- Between 1990 and 2001 the highest number of staff were employed at March 1993. The level then dropped by 3,761 to a low point in 1998 and has since increased, but is still over 1,300 below the 1993 level. The overall position masks substantial changes in individual staff groups and some of the net reduction is due to the contracting out of

services. The Ancillary & General group, that includes Ambulance, cleaning, laundry and portering staff, has halved since 1990.

- There were significant increases in a number of the professionally qualified groups. However, in Nursing and Midwifery there were 1,500 fewer WTE qualified staff. While there will have been some shift to management contracts within the senior management group, the majority of the decrease must reflect a genuine reduction in staffing levels over a period when the numbers of people being treated increased substantially.
- The level of hospital and community health staff per head of population here is lower than Scotland, slightly higher than Wales and seems higher than England. However, this does not take account of the higher levels of need and therefore activity in NI compared to England or the fact that England uses a higher level of expensive agency staff that are not included in their figures.
- Certain outmoded systems and variations in access to IT take up staff time. Investing in technology, ICT and more up-to-date equipment could make more efficient use of all staff and reduce the need to increase the numbers of Administration and Clerical staff for the manual processing of information.
- There are higher levels of absenteeism in NI than England. England have invested more in Occupational Health than NI. The Department

has required Trusts to set targets to reduce absenteeism, and results will be monitored centrally.

- Difficulties in recruiting staff have contributed to the rise in sickness absence, as demonstrated during Winter Pressures.
- Skill-mix should continue to be reviewed, along with the benefits of working in multi-disciplinary groups.
- There are more nurses working in lower grades in NI than in Scotland. There are also fewer medical staff in the consultant grade in NI than in Scotland.

ADMINISTRATION

[Reference Chapter 11 main report]

Administrative and Clerical staff account for over a fifth of all staff employed in the HPSS. In September 2000 around 85% (7,800) of all administrative and clerical staff worked in HSS trusts in NI. Of these 7,800 around 4,900 (63%) were estimated to be in grades that provide support to health care or social services personnel. This included support to medical, nursing, social services, medical records, laboratory, pharmacy and paramedical groups etc. The remaining 15% of administrative and clerical staff are working in the Board's HQ's, NI Blood Transfusion Service, Westcare Business Services, Central Services Agency, Ambulance Trust and other HPSS organisations. A number of these also provide support to health care or social services personnel.

Needs Issues

- Effective organisations need good management and must have arrangements for raising and paying invoices, recruiting and paying staff, reconciling accounts, planning and contracting, and other corporate functions.
- In the HPSS many administrative staff work directly with service users to release professional staff from administrative tasks e.g. consultants' secretaries, receptionists, medical records staff and ward clerks.

- There has been a significant increase over the past decade in the amount of paperwork HPSS organisations are required to process in relation to all aspects of their function.
- Although there has been an increase in the number of admin. and clerical staff, clinicians have said that paperwork continues to be a pressure and that more attention needs to be placed on freeing them up from admin. work, which does not require their professional skills or judgement.

Effectiveness Issues

- Evidence shows that the level of administration and clerical (A&C) staff in NI, relative to the size of the workforce (21.7%), is about the same as in England (22.1% including agency staff).
- Using admin. staff to free up clinicians is seen as an effective use of resources.
- Average management costs of the Acute sector in NI represent 4.05% of total trust income. The equivalent figures for England and Wales are 4.07% and 5.0% respectively. The Scottish figure appears to be at least 6% but the sudden increase in 1999 may reflect a quality issue.
- Average management costs across all categories, taken over the same five-year period, represent 4.41% of total trust income in NI, with corresponding figures of 4.68% for England and 4.76% for Wales.

[The information for Scotland is too incomplete to use]. These findings were confirmed in a recent study by the NHS Confederation, which indicates that a significantly smaller proportion of expenditure is devoted to management here than in GB.

- Comparisons of the base pay of Chief Executives, Directors, and of all posts, places the NI public sector median below the UK public sector median in each case.
- The NHS boardroom pay report 2001 shows that median pay of Chief Executives in NI is the lowest in the UK.
- A special exercise to look at the potential savings from the merger of two trusts found scope for savings of only £0.4m, and this did not take account of one off expenses, such as redundancy payments.
- The proportion of costs spent on administration varies depending on the Trust's function. Costs for Acute Trusts are lower than for mixed Acute/Community Trusts or specialist Hospital Trusts. Size of the organisation also has some bearing on relative administration costs.
- The Department is now in a position to issue directions to HSS Trusts on matters relating to pay and conditions. These powers have been used to implement a new pay and grading structure for senior executives, which will provide a fairer and more transparent system of pay and rewards for these key posts.

CAPITAL INVESTMENT/INFRASTRUCTURE

[Reference Chapter 12 main report]

The Health and Social Services occupies an extensive estate. The total floor area is 1.6 million square metres, with 1600 blocks of buildings. The total area of land is estimated at 1.2 million hectares. Equipment ranges from major diagnostic and medical items including linear accelerators, imaging equipment, and sophisticated laboratory analysers to high volume smaller items including beds and simple diagnostic equipment for use in wards.

Information and Communication Technology (ICT) covers all the computers and network cabling (known as hardware) and the programs that make computers and communications function (known as software). Areas that have ICT systems include: finance; supplies; personnel; payroll; patient administration; pathology; radiology; clinical specialties; population screening; population indices; and Family Practitioner payment systems.

Needs Issues

- Much of the estate is outdated, in poor condition and badly located for modern health and social care.
- The total amount of funding needed to bring the HPSS estate fully up to an acceptable standard of performance and physical condition, to replace obsolete equipment and ICT systems, and to create new or

replacement facilities compatible with modern day standards of health care is estimated to be in the order of £1.9bn.

- Significant backlogs of essential estate upgrading and replacement of critical diagnostic and medical equipment and ICT systems have accumulated. The present estimates are over £1800m for estate work, £37m for replacement of imaging and laboratory equipment over 10 years old, and over £30m for replacement of existing outdated ICT systems.

Effectiveness Issues

- The capital baseline, excluding non-recurring and other in-year additions for specific purposes, is in the range of £45-50m per year. Capital projects valued at over £25m have been procured under PFI public-private partnerships and further projects with an estimated capital value of over £100m are under consideration.
- Rigorous arrangements are in place for appraisal, procurement and management of capital projects. Available resources including income from disposal of surplus land and property are used effectively.
- In the NHS in England an increase of approximately 13% in cost allowances has recently been approved to provide the higher standards of accommodation required for modern health services. Unless there is a similar initiative in NI, the Department will not be able to achieve comparable standards in the HPSS.

INTERACTION MODEL

Pathways through the System

1. As the HPSS provides such an extensive and complex range of services an Interaction Model was developed to help describe the different pathways between primary care, community care and Acute services. Recognising the difficulties of creating a map simultaneously covering all care pathways for several client groups, work was focused on the care pathways of normally healthy adults and elderly people – the bulk of service users. The model, including estimates of activity levels, is presented at Figure 1 of this Annex. The main pathways are described below.
2. The model starts with a person being at home or in sheltered housing, and well. If they are unwell, physically or otherwise, most will seek to self-treat or rely on family or friends. Where they are not able to cope they usually visit their GP. The GP assesses their need, often as part of the Primary Care Team, and takes appropriate action, such as: prescribing medication; arranging a further appointment; referring them to Social Services or Community Health Services (including the Primary Care Team); or sending them to hospital, either as an emergency admission or through referring them for an out-patient appointment.

3. Many vulnerable people require both primary and community care. Services may be accessed individually or in a wide variety of combinations, from a short home help visit to home ventilation. Costs may vary from a few hundred pounds to more than £150,000 per annum, depending on the services required and the intensity of their usage. Complex cases are ‘care managed’, following a detailed multi-disciplinary assessment.
4. Where people need hospital care, there are three potential portals into the system, each of which has controlled access. The first, the GP, may refer a person on to A&E, an outpatient appointment or, in some cases, may admit directly to a ward. However there are two other important routes: referral from Social Services, by ambulance or via the GP, where the social care network has picked up deteriorating health in a client; and self-referral, often covering minor injuries, but importantly also feeding in a proportion of emergency admissions.
5. In hospital, the care pathway followed relates to the assessment of the urgency of the patient’s condition, its expected progression, and the demand for the required services. Priority is given to emergency admissions and other urgent cases such as planned cancer treatments. There are many care pathways within the hospital system, reflecting: the various specialist services provided; the available equipment and technology; the expertise and experience of staff; capacity; and the demand for services.
6. Where patients have completed their treatment, their discharge will relate to their condition and need for further services; the availability

of rehabilitation and intermediate beds; the speed of the assessment process; the availability of required services in the community; the resources available to fund community care, either at home or in a residential or nursing home; and the patients own choice, or ability to pay if a residential/nursing home place is required.

Interface Services Between Primary, Community and Acute Care

7. It is possible to identify specific services where increased investment could potentially influence patients flows, to the advantage of the overall service provision. These interface areas are identified in Figure 2 of this Annex and cover:

Hospital/Primary and Community Care Interface:

- **Hospital at Home** – providing some ‘Acute’ services, such as intravenous drips, thus keeping patients out of hospital;
- **Home from Hospital** – Smoothing the return to the community of vulnerable people, thus reducing delayed discharges and minimising potential hospital-related confusion

Hospital/Primary and Community Care/Residential & Nursing Home Interface:

- **Rapid Response** – An emergency ‘holding’ service that puts in nursing and other care quickly for a short, typically 5 day, spell while

other services/assessment is arranged. May maintain people at home or, after assessment, direct them to residential & nursing home care without routing them through hospital.

Primary and Community Care/Residential & Nursing Home Interface:

- **Care Management/Respite** – Already well established, a means of keeping people with more complex needs in the community for longer, as their physical condition declines.

Hospital/Residential & Nursing Home Interface:

- **Rehabilitation** – Hospital patients often need rehabilitation following fractures, head injuries, strokes etc. The balance of provision between hospital and the community could be adjusted to minimise the length of hospital stays and, in some cases, delayed discharges.
- **Intermediate care** – The increased use of intermediate care beds outside of Acute hospitals, where delayed discharges are held in hospital during social care assessment and placement/putting in place services, would ease pressure on Acute capacity.

Result of Interactive Nature of Service

8. Changes in one area can trigger others because of the inter-dependencies. Demands for services can also be initiated or redirected following a change in one service. Consequently, changes are often piloted to ensure that the desired outcome will be achieved. Unmet needs are a particular issue since increasing capacity is often soaked up to a large extent by previously unresourced or unidentified need, and the planned impact on backlogs cannot be fully achieved.

9. When there is insufficient capacity in other services compounded by an earlier lack of investment in improving population health and wellbeing, people ultimately end up as emergency admissions to Acute hospitals. This is an expensive form of care and does not always produce the best quality outcome for a given situation. Older people can be disorientated and take much longer to rehabilitate than if the service had been provided at home. Of course there are treatments which can only be undertaken in a major Acute hospital. Nevertheless, allowing for clinical quality standards, the aim must be to keep people out of hospital, to keep stays in hospital short and to return people to a more appropriate setting as soon as possible.

10. Current difficulties preventing this aim being achieved are:-
 - GPs have not been incentivised to provide intensive medical support in nursing homes or in the community generally;

- Shortage of low level community care, respite care or other carer support can lead to a crisis in an individual's situation which results in the long term use of nursing home care or hospital admission;
- Lack of emergency intensive community support can leave hospital admission as the only viable option;
- Efficiency improvements were sought through reducing Acute bed capacity;
- A number of beds classified as Acute were required for the long term care of people with Traumatic Brain injuries, strokes, MS or requiring lengthy rehabilitation after amputation. This reduced the flexibility to use these beds for short term treatments;
- The growing population, particularly the number of older people, increased demands for all services, especially emergency admissions;
- Emergency admissions must be treated and as occupancy levels rose to over 80%, trolley waits grew and pre-booked elective operations had to be cancelled, adding to the waiting list;
- Shortage of equipment and staff for such things as X-rays and scans causes delays when patients are in hospital and can result in patients being admitted for urgent tests when an out-patient approach would have been sufficient if there were better access from the community;
- People can be delayed in going to a nursing/residential home or back to their own home supported by appropriate community care because of lack of funds. Also, the availability of places in nursing/residential homes is at risk from low profit potential and a competitive market for development land.

- The wages for domiciliary home care workers are becoming less competitive and this is likely to impact on the provision of community care packages.

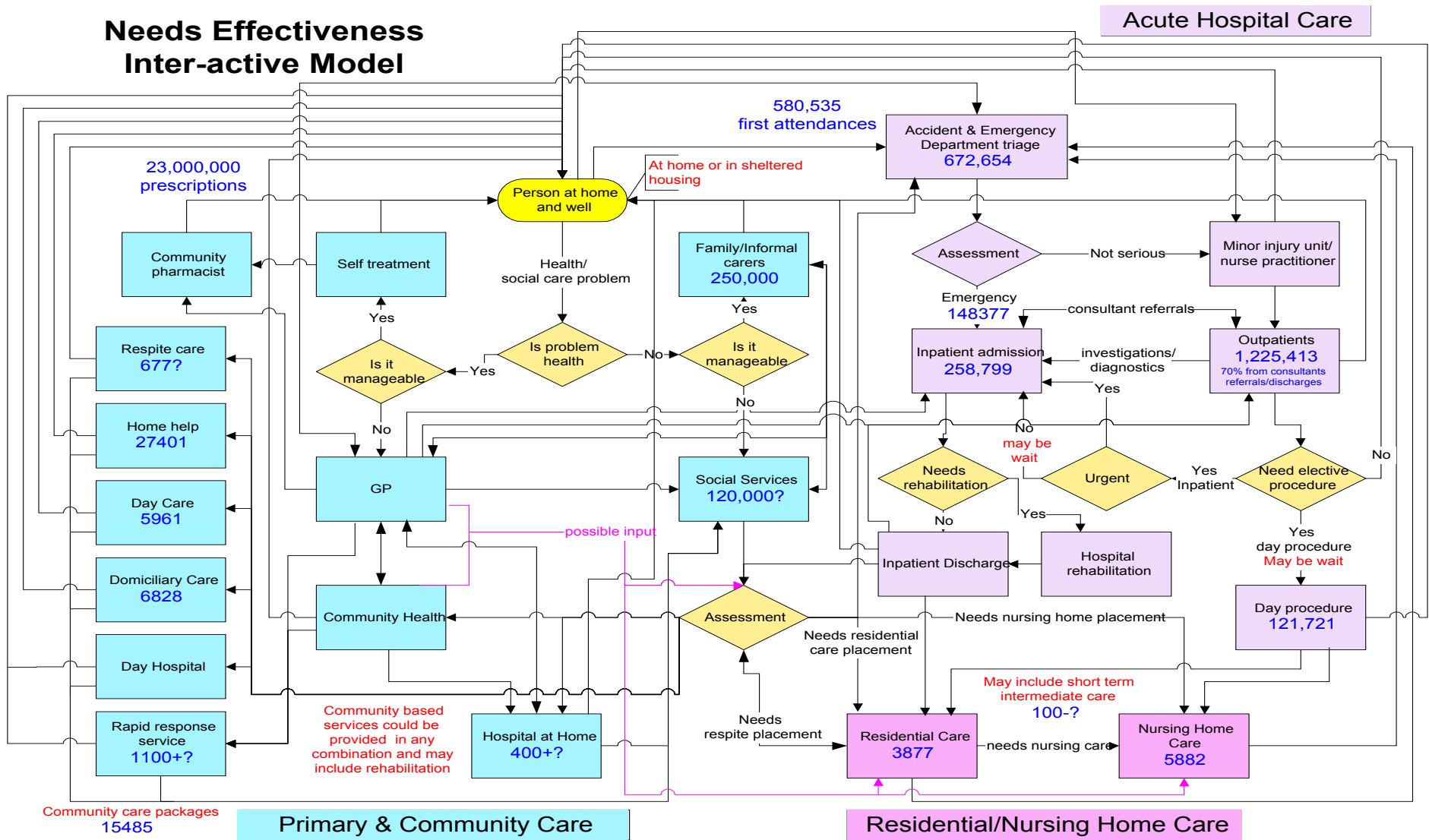
11. It is important to break into this cycle and take some pressure off Acute hospitals. The capacity to treat current emergencies and those with life threatening diseases must be maintained. At the same time investment is required in Primary and Community Care in hospital interface services to minimise hospital use in future and to keep occupancy rates at an efficient level (below 80%). Some investment in access to X-rays, scans etc. perhaps through medical assessment centres and the use of stand alone day case facilities would speed up stays in hospital. Some investment now in population health and wellbeing would help reduce the future levels of demand. Given the projected growth in the older population and the expected reduction in informal carers, any influence which could constrain demand would be beneficial.

Other Services

12. The Interaction Model produced is one layer of a more complex 3 dimensional map, covering all groups. Other layers would display care pathways for maternity; children; and people with learning disabilities, physical disabilities or psychiatric illnesses. Those maps would follow a broadly similar pattern to the Interaction Model but with somewhat different pathways and services.

13. It is important to note that the different layers are not independent of each other and there is a further web of inter-connections between them. For example, whilst people with learning disabilities may draw on special hospitals and community services for their normal service needs, they will still use Acute hospitals when they need specialist surgical services such as appendectomies, or visit their GP when they have flu. The cost of moving people, with relatively complex mental health and learning disability needs, from hospital to more appropriate homes or community settings can be higher than maintaining them in hospital, but it provides a better quality of life.

Needs Effectiveness Inter-active Model



**Needs Effectiveness
Interactive Model - System Boundaries**

