

Facing the Future

**Building on the lessons
of winter 1999/2000**

Department of Health, Social Services & Public Safety

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About this Paper

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Foreword by the Minister

The winter of 1999/2000 challenged Northern Ireland's health and social services as never before. Our hospitals and community services were often under great pressure and, at times, struggled to cope with unprecedented numbers of people needing care. Thanks to the professionalism and commitment of staff, often working long hours in very difficult circumstances, the great majority of those who needed help were treated and cared for, promptly and effectively.

But we cannot ignore the fact that there were shortcomings. Too many people in need of admission to hospital had to wait on trolleys while beds were found for them. Worried patients, some seriously ill, had planned operations delayed. Anxious relatives waited as hospital staff struggled to find available intensive care beds. Confused elderly patients found themselves being moved to and from nursing homes, often at short notice.

We have to learn from this experience. Last winter revealed a number of areas that need to be addressed. Decisive action is needed now to ensure that the problems of last winter do not recur. But this is only the first step in a broader plan to develop and build up health and social services. We must ensure that, in an ever-changing world, our services have the capacity, equipment and expert staff they need to provide modern and effective care to those who need it.

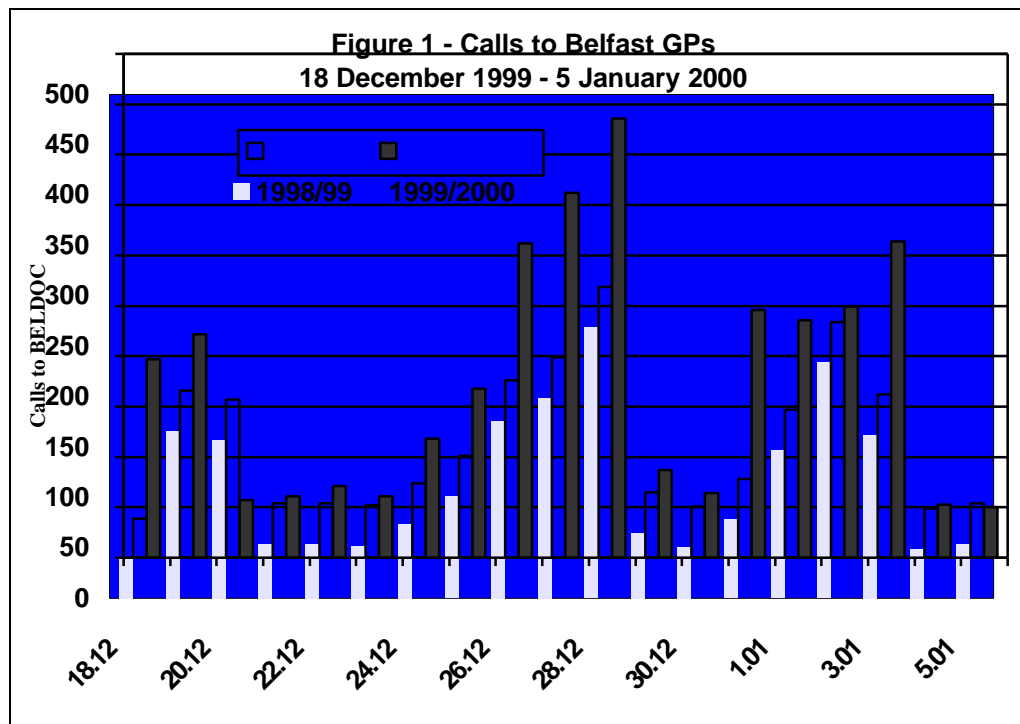
Nationally, the Government has committed substantial additional resources to modernizing the NHS. In Northern Ireland, I am setting in train a parallel modernization programme for the HPSS. This paper sets out the first steps along that path. It outlines what will be done to ensure that our health and social services can cope with the pressures they will face in the new century. It underlines the Government's commitment to ensuring that the health and social services in Northern Ireland are ready and able to face the challenges of the future.

GEORGE HOWARTH
Minister for Health, Social Services and Public Safety

Section 1 – Introduction

Background

- 1.1 Last winter, the health and social services in Northern Ireland faced the most severe challenge they have experienced in recent decades. Over a 6-week period starting in December 1999, hospitals and community services were put under sustained pressure as an unprecedented number of patients sought treatment for severe flu-related or other respiratory illnesses.
- 1.2 Primary Care services, hospitals and community care services came under intense pressure as vulnerable people, particularly older people and children, sought treatment for severe respiratory problems. The numbers of people contacting GP out of hours services in Belfast, for example, rose sharply (see Figure 1)¹.



- 1.3 This report reviews the events of last winter and evaluates the effectiveness of the arrangements that were put in place to deal with the high levels of demand placed on services. It

¹ Figures relate to calls to BELDOC, which covers many of the GPs in North and West Belfast

draws on the lessons on winter 1999-00 and identifies actions required to develop and modernize services to cope with future demands.

1.4 The report:

- Considers the response of Health and Social Services Boards and Trusts to a situation that at times threatened to overwhelm services;
- Examines how the health and personal social services (HPSS) can cope with such peaks of demand for services in the future, and assesses their overall organizational and managerial effectiveness in the light of last winter's problems; and
- Sets out a programme of action for improving the capacity and responsiveness of the HPSS, and for developing their ability to cope flexibly with increasing pressures.

Winter Pressures

1.5 As in the rest of the UK and elsewhere, Northern Ireland's health and social services experience a significant upsurge in demand for services during winter months. At this time of the year, flu viruses and related conditions are at their peak.

1.6 In recent years, extra resources have been given to the HPSS to help them co-ordinate hospital and community services more effectively in winter months; provide extra community care packages; run vaccination and prevention programmes; identify and support at-risk groups of people; and increase hospital bed capacity.

1.7 All four Health and Social Service Boards had plans in place to provide extra beds, increase ambulance cover, make available additional community care packages and other measures. In the Greater Belfast area, the Eastern and Northern Boards were also setting up a new Co-ordination Centre to manage emergency medical admissions. In the event, these arrangements were quickly stretched to their

limits as people with severe flu-related conditions placed unusually high demands on hospital and community care services.

Taking the Strain

- 1.8 The unexpectedly virulent flu virus left hospitals and other services struggling to cope with the volume of demand for care and treatment. From early December, monitoring of hospital admissions reflected a growing problem. In December and January, emergency admissions rose by 2000 a month as flu cases increased. Meanwhile, community care services were under strain too, with 200 adults in hospital waiting for alternative care packages and similar numbers waiting for home help services.
- 1.9 As the numbers of people seeking services continued to rise, it became clear that hospitals were treating unprecedented numbers of very sick patients. Providing emergency treatment had to take precedence and, inevitably, the level and quality of some services suffered. All but the most urgent operations were suspended to make space for treating emergency admissions. With many surgical beds filled with patients from medical wards, normal hospital services were badly disrupted.
- 1.10 At peak periods, acute and intensive care beds were being used to capacity and some very ill patients had to receive care in inappropriate beds. Some patients also had to wait on trolleys for long periods awaiting admission. With many community services also coming under severe pressure, patient discharges from hospital were also delayed, further increasing the demand on beds.
- 1.11 During that period there was a substantial increase in the number of people awaiting delivery of care packages, both in hospital and community settings.

Emergency Action

- 1.12 In response, the then Minister, Bairbre de Brún, announced on 11 January that an immediate £3.3m was being provided to help the HPSS cope. The extra resources supplemented

the £7.6m ‘winter pressures’ money provided in October 1999. The extra funds were provided to cover the costs of additional staff in hospitals; more wards and hospital beds, including high dependency beds in some hospitals; more ambulance services; and more community care packages, to ensure that beds being occupied by patients who did not need hospital care could be freed up.

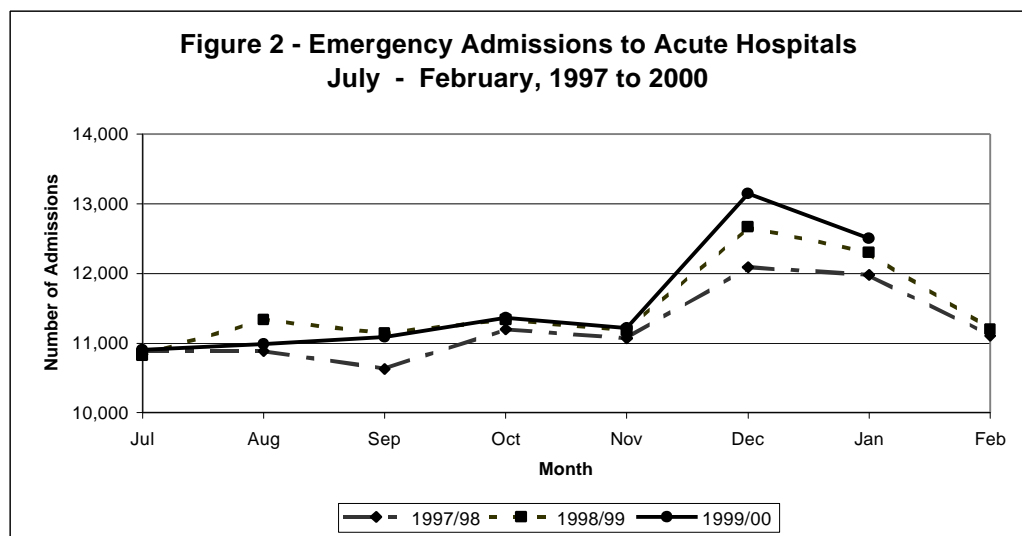
- 1.13 Ms de Brún recognized that, in addition to immediate support, a longer-term strategy was needed to equip the service to handle annual peaks in demand for services in winter, and to respond to exceptional demands where they arose. Accordingly, she asked the Health and Social Services Boards to report on the winter crisis, specifying where problems had occurred, how these had been addressed and what lessons could be learned for the future.
- 1.14 At the same time, the Minister commissioned the Chief Medical Officer to undertake an urgent review of intensive care services, which had come under particular pressure; and asked the Chief Social Services Inspector to review how Care in the Community, and its relationship with the admission and discharge of hospital patients, was working.

Section 2 – The Board Reports

- 2.1 All four Boards reported that, from mid December 1999 until late January 2000, the pressures on hospital beds and on A&E Units were significantly greater than for any winter period in recent years. Hospital activity was often more than 30% above that in the winter of 1998/99 - itself a very busy time. On 5 January, for example, hospital admission rates in the Eastern Board were 47% higher than on the same day in 1999.
- 2.2 High levels of sick leave among key staff over the critical period further exacerbated an already very difficult situation. Up to 25% of some hospital staff were absent through illness at times during the crisis period. Combined with soaring admission rates, staff shortages in vital areas meant that pre-existing plans for managing winter pressures were quickly overtaken by events.

Emergency medical admissions

- 2.3 There was an unprecedented level of emergency medical admissions (see Figure 2). Many were elderly people with serious chest infections and other severe respiratory illnesses, including pneumonia. In many cases, patients had to be admitted to inappropriate beds in surgical wards, because all the medical beds were already full.



Bed availability

- 2.4 There was continuous and heavy pressure on hospital beds. A shortage of intensive care beds in particular was a major concern. High occupancy levels for these beds had a knock-on effect on other services, delaying some surgery where the availability of intensive care immediately after an operation was important to recovery. On occasions, some intensive care beds were also closed as sickness took its toll on specialist staff. As the crisis deepened, people going to A&E departments often found themselves waiting for hours on trolleys before they could be admitted.

Staff Shortages

- 2.5 Staff sickness levels peaked at the height of the busiest time for hospitals. On 7 January, for example, there were 230 nursing staff on sick leave in the Eastern Board area. This was at a peak period when 235 surgical beds were being occupied by patients suffering from flu-related conditions.
- 2.6 Difficulties in recruiting appropriately skilled staff on a short-term basis left Trusts unable to open all of their planned additional bed capacity. Around 40% of additional capacity in the Eastern Board could not be opened. In the Southern Board, a planned increase in bed capacity was halted because of staff shortages.

Community Care

- 2.7 At the start of the flu outbreak, some patients who might more appropriately have been cared for in the community were in hospital. As the winter crisis deepened, community care services came under severe pressure to assess and transfer large numbers of patients to nursing homes and other community provision at the end of their hospital treatment.
- 2.8 In addition, there was an increase in the number of people waiting for assessment and provision of equipment in the community. There was also more pressure on families and carers where the services being provided were below assessed levels, or were not available at all.

Primary Care

2.9 Calls at GP surgeries, contacts with out-of-hours GP services and visits to community pharmacists increased significantly in all areas. In the Western Board, for example, contacts with GP Co-operatives increased by as much as 125% compared to the same period last year. Some GP practices opened their surgeries for extra days during the Millennium holiday period to cope with demand, treating patients who might otherwise have gone to hospital A&E departments. Additional staff were also recruited to help the out-of-hours social work service to deal with extra demands.

Ambulance Services

2.10 There were significant increases in requests for emergency ambulances over the peak December – January period. In the Western Board, for example, there was a 23% increase during the period 23 December and 2 January, in comparison to the same period in 1998/99. This resulted in ambulance service staff having to work excessive hours in an effort to cope with the exceptional demands. Inevitably, response times were, on occasions, adversely affected.

Action by Boards and Trusts

2.11 As the pressure on services increased, Boards and Trusts took a number of measures to meet the high levels of emergency medical admissions. All but the most urgent elective surgery was cancelled to ensure that beds were available for these admissions. Where circumstances permitted, Trusts opened new temporary beds and kept open beds planned for closure over the holiday period.

2.12 Additional A&E teams and ambulance services were put in place as Boards responded to increases in emergency admissions, and looked at ways of reducing delays. For example, the Northern Board piloted an initiative which involved patients being assessed and diagnosed quickly, with many referred on direct to community services rather than being unnecessarily admitted to hospital.

- 2.13 Extra community care packages were also provided for patients whose discharge from hospital was delayed because community care services were stretched. For example, the Eastern Board funded community care places for all patients identified as appropriate for discharge between 17 December and 10 January, thus freeing acute beds for emergency medical admissions.
- 2.14 Community Trusts increased support for patients in the community. This included an intermediate care scheme in the Southern Board area to facilitate hospital discharge and prevent hospital admissions. The Western Board also funded extra staff for such beds and for a rapid-access chest pain clinic. All Boards invested in additional activity in primary care, such as increased District and Treatment Room Nursing.

Lessons Learned

- 2.15 The Boards underline the need for co-ordinated planning between hospital and community care services. Although the remedial actions taken enabled the HPSS to generally manage the winter crisis, Boards consider that a number of issues impeded a more effective response:
- **Funding** – the non-recurrent nature of additional funding prevented the HPSS from addressing problems in a more strategic way. Many community care packages, for example those involving places in nursing or residential homes, require long-term funding. Without this, it is difficult for community Trusts to effectively plan such provision.
 - **Levels of acute bed provision** - bed occupancy is running too close to full capacity throughout the year. Boards report that the effect of this is to leave the system with no flexibility when periods of sustained pressure arise. The point is made that the HPSS must ensure that bed capacity is used appropriately; that plans for coping with peaks in demand are reviewed; and that experience gained by hospital bed managers is built upon.

- **Intensive care and high dependency provision** – the Board reports indicate that intensive care, particularly paediatric intensive care and high dependency beds, were under severe pressure. On many occasions during the winter, patients were being ventilated in recovery areas or in operating theatres because no intensive care beds were available. On one occasion, a 5-month old baby had to be transferred by air ambulance to intensive care in Liverpool because an intensive care bed was not available in Northern Ireland.
- **Recruitment of Staff** – the lack of available appropriately trained staff, particularly nurses, was a problem. Trusts had difficulty in recruiting staff to work in demanding posts on short-term contracts over the holiday period. Even outside of the winter months, Trusts experience difficulties in recruiting and retaining sufficient staff to maintain full capacity in core functions such as general medicine, intensive care and care of the elderly.
- **Community Care** – the Board reports draw attention to a lack of alternatives to hospital admission, and the need for further community care schemes to be developed. During the winter crisis, there was an unprecedented level of demand on community care services, particularly residential and domiciliary care. Demands for occupational therapy were up by 100% in places, with significant increases in the numbers of people awaiting occupational therapy assessment and provision of essential equipment.
- **Staff Vaccination** – two of the four Boards suggest that the issue of a vaccination policy for staff to combat flu should be examined. As noted above, 25% of hospital staff were absent through illness at times. Similar levels of staff illness were recorded in the community and in nursing and residential homes.

Section 3 – The Intensive Care Review

- 3.1 The Department's Chief Medical Officer (CMO) was commissioned to review intensive care and high dependency provision in Northern Ireland in the light of the winter crisis.
- 3.2 Annex B defines intensive care and high dependency provision and contains a full list of the CMO's recommendations.

Approach

- 3.3 The review was carried out by a small team, which looked at: intensive care and high dependency bed provision; paediatric intensive care; associated nursing and medical staff complements; inter-hospital transportation; and intensive care management arrangements in Northern Ireland. The team drew on local, national and international evidence, and built on earlier work by the Northern Ireland Clinical Resource Efficiency Support Team (CREST)².

Findings

- 3.4 The CMO's review confirms that problems highlighted by CREST in the past have not been resolved. The limited progress in implementing changes previously proposed by CREST is a reflection of the high cost of such care and the need to prioritize funding in this area.
- 3.5 The review found that current provision of adult intensive care and high dependency beds has actually reduced over the last two years and is below the recommended minimum in both areas. This is particularly the case for high dependency beds. There are no high dependency beds in Altnagelvin, Antrim, Ulster and in the Royal Victoria Hospital.
- 3.6 The CMO's report confirms that intensive care and high dependency beds are under all year round pressure. Occupancy rates are permanently above the recommended

² CREST is a small team of doctors established by the Department to promote clinical efficiency.

level of 70%, and are rising year-on-year. For example, in 1996 the average occupancy rate across Northern Ireland was 80%. By 1999, this figure had increased to 90% (see Table 1)³.

Table 1 – Occupancy Rates in Intensive Care, 1996 – 1999

Hospital	1996	1998/99
Altnagelvin	66	102
Antrim	92	88
Belfast City	92	89
Craigavon	73	81
Royal Victoria	90	84
Ulster	67	96
Average	80	90

- 3.7 ICUs had to refuse admission on many occasions throughout the year because there were no beds. In these instances patients had their care delayed or were cared for in inappropriate settings, which could compromise their prospects of recovery.
- 3.8 The review also found that the HPSS has difficulty in recruiting qualified nursing staff for some intensive care units. In others, a lack of funding results in inadequate nursing levels. Only three intensive care units meet the minimum standard of nursing cover, and there is an over-reliance (40%) on D-grade nurses, rather than more expert G- and H-grade staff.
- 3.9 In paediatric intensive care, the review found that provision of intensive care and high dependency beds is below the recommended levels because of a lack of trained specialist nurses.

Recommendations

- 3.10 The CMO's review concludes that urgent action is needed. It offers 26 recommendations, building on those previously identified in the CREST reviews, to ensure that the service

³ Data taken from 1998 CREST report *Review of Adult Intensive Care Services*

can better cope with peaks in demand. The key recommendations are summarised overleaf:

- Intensive care and high dependency provision in Northern Ireland can only be managed effectively if it is provided as part of a regional network of care.
- Provision needs to be expanded. Eight new ICU beds and 50 additional HDU beds are necessary to provide the standard of service required by a region the size of Northern Ireland. Paediatric intensive care provision in particular needs to be increased.
- Additional staff need to be recruited, to ensure a safe and responsive service. A range of nurse training and career initiatives should be put in place to facilitate the recruitment and retention of properly skilled nurses. Training programmes for doctors should be revised to enable doctors working in acute specialties to receive training in intensive care.

Section 4 – Review of Community Care

4.1 Recognizing the inter-dependence of health and social services in tackling winter pressures, the Department's Chief Social Services Inspector (CSSI) was asked to undertake a review of care in the community. In particular, he was asked to consider the relationship between care in the community and hospital admissions and discharges.

Approach

4.2 The CSSI's review team asked Boards and Trusts to estimate the extent of unmet need on 14 January 2000. Discussions were held with the Association of Directors of Social Services and the Executive Directors of Social Work in Trusts. Meetings were held in six Trust areas and with the four Health and Social Services Councils. A number of voluntary organisations representing the views of users were also consulted by the review team.

4.3 The review was conducted against the backcloth of Government policy on community care, set out in *'People First: Community Care for the 1990s'*, published in 1990. The aim was to enable vulnerable people to live as independently as possible, for as long as possible, in their own homes or in a homely setting in the community.

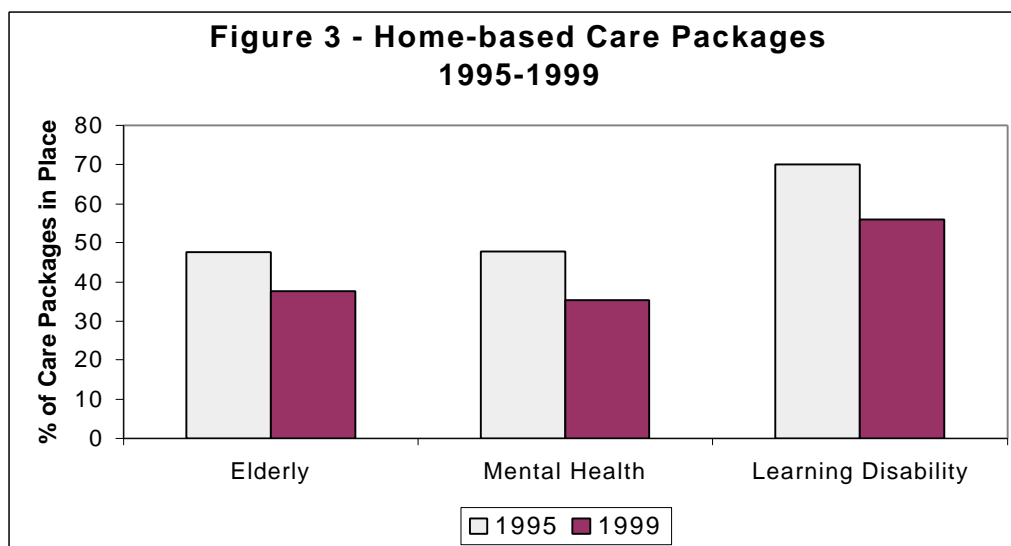
4.4 The review identified current levels of unmet need across the range of community care, focusing on the impact of winter pressures. It also sought information on the responses of Boards and Trusts to these pressures and, in particular: the impact of financial and resource pressures facing Boards and Trusts on community care; the effect of winter pressures on the provision of quality care; and their potential implications for future policy and practice.

Findings

4.5 The review suggests that there are shortfalls in every aspect of community care provision. It reveals that the number of delayed discharges is increasing; that there are increases in the waiting lists for day care, respite care, occupational therapy assessments and provision of equipment; and that

people with disability are inappropriately placed in homes for the elderly.

- 4.6 The report also identifies an unsatisfactory level of integration and co-ordination of care packages by Trusts; that they frequently do not provide holistic assessments of individual need; and that fully integrated professional arrangements are under-developed.
- 4.7 Overall, the report suggests that the core principle of increasing choice for users is not being effectively implemented. Vulnerable people are not being sufficiently supported in their homes. Moreover, it states that ground is being lost, rather than gained, in this area.
- 4.8 The review found that only 43% of all packages of care across Northern Ireland are provided to people in their own homes. In the two largest programmes of care (elderly and mental health), only a third of care packages are being delivered at home. For many elderly people, institutional care is the only option. Apart from physical disability, all programmes have shown a marked reduction over the last five years (see Figure 3):



- 4.9 With this growing emphasis on residential care, the review notes that some nursing homes are finding it hard to recruit qualified nursing staff. This affects their ability to provide care to required standards. On the issue of quality across the

range of community care programmes, the review also confirms that nearly 80% of the social care workforce hold no formal qualifications for their jobs.

- 4.10 The review identifies delayed discharges from hospital as a particular problem. It draws attention to the fact that community care funding has consistently been insufficient to meet demands in recent years. As a recent example, of the £25 million allocated for community care in 1999/2000 only £13.2 million was actually spent on community care. The remainder was diverted, within that year, to meet other urgent pressures in the HPSS.
- 4.11 Nevertheless, in the face of unprecedented additional demands, community care services responded commendably to the winter crisis. During that period they provided an increased range and level of services which included: the greater use of 'rapid response' community teams; the opening of additional community and step-down beds; increasing access to hospital at home schemes; and providing additional care packages.
- 4.12 A notable example of the hospital and community services collaborating effectively during the crisis was the way delayed discharges were handled. Between 20 December and 10 January, around 140 delayed discharge patients were successfully moved from hospital to community accommodation, thus freeing up much needed hospital beds at a critical time.

Recommendations

- 4.13 The review finds that expenditure on community care has fallen short of the amount required to develop and provide services in line with assessed need and existing policy. The care in the community policies have now been in place for seven years and the CSSI proposes that a comprehensive review of community care should now be commissioned.
- 4.14 Such a review would consider how effectively care in the community, particularly as it affects older people, is being implemented. It would focus in particular on the integration and coordination of community care packages and the

interface between hospital, primary and community care services.

4.15 The CSSI's recommendations are set out in full at Annex C of this report.

Section 5 – A Service Under Pressure

Introduction

- 5.1 The reports reviewed in this paper highlight the commitment of professionals and managers and the energy with which they have responded to heavy demands on their services. They acknowledge that last winter's pressures were unprecedented and stress the need for greater investment in key areas, to improve services and ensure that fluctuations in demand are effectively managed. The reports also point to the need for greater co-ordination of services and flexibility of response, to manage such pressures in the future.
- 5.2 This paper does not attempt to paint a comprehensive picture of the care provided by the HPSS. Nonetheless, it provides a valuable picture of pressure points in our services. The evidence shows that some services are increasingly coming under stress all the year round. As the demands on services increase, the capacity of the HPSS is being stretched, at times beyond its limits.

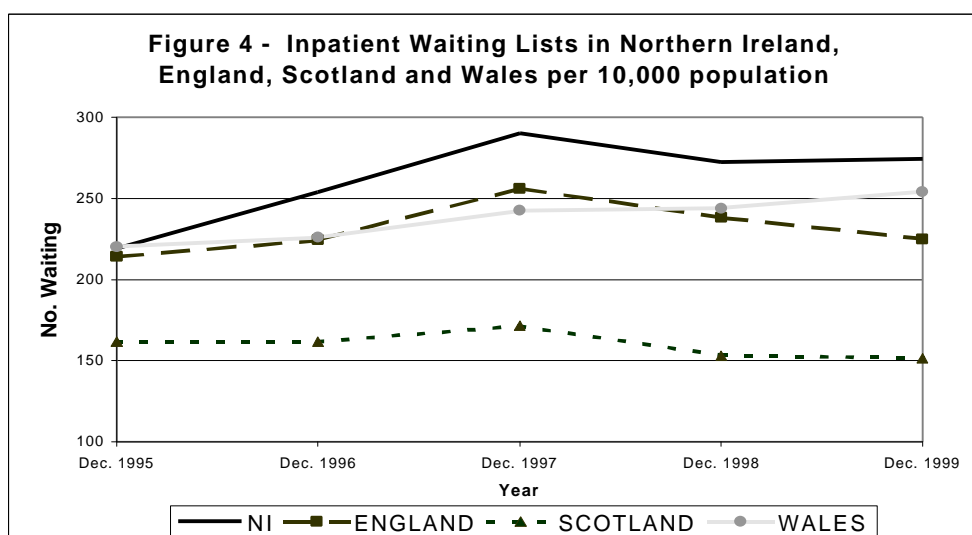
Setting Services into Context

- 5.3 Against this backdrop, it is important to recognize that the general health and social well-being status of Northern Ireland's people is poor:
- life expectancy is among the worst in Europe;
 - we have the 3rd highest death rate in Europe from coronary heart disease;
 - our female lung cancer death rate is twice the EU average;
 - the death rate from breast cancer is the highest in Europe;
 - 43% of people of retirement age have long-standing illness;
 - we have the highest long-term unemployment rate in the UK.

5.4 It is not surprising that demands should be greater on Northern Ireland's health and social services. The underlying high levels of demand place considerable pressure on both its hospital and community care systems.

Shortcomings

5.5 Northern Ireland already has the longest hospital waiting lists in the UK (see Figure 4). The number of excess waiters (people waiting more than the Patient Charter standards for operations) now stands at more than 5,000 – 11.5% of the total. By comparison, there are no excess waiters at all in England. Waiting for care or treatment is not confined to hospital admissions. In a national independent *Casualty Watch* survey on 31 January, two of our hospital A&E departments featured among the top 10 longest waits in the UK.



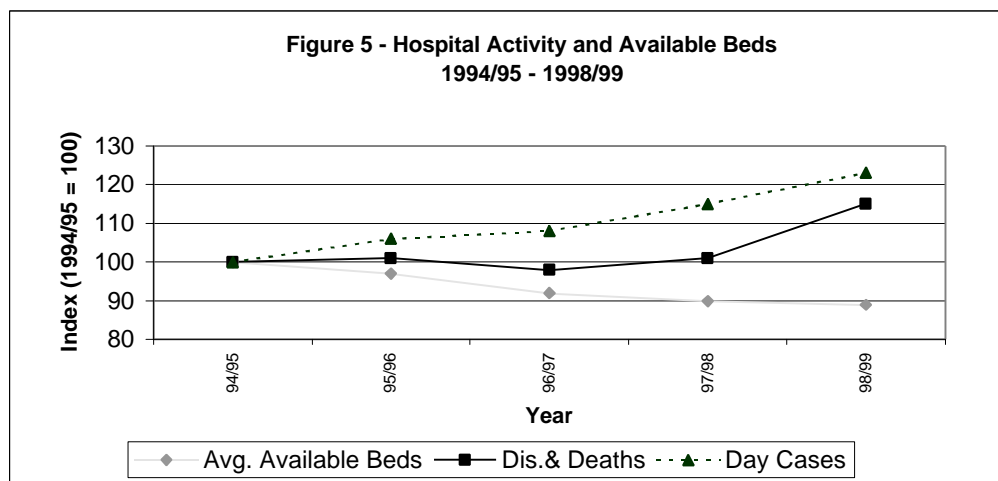
5.6 Patients are sometimes having serious operations delayed because intensive care services are not available for their recovery. Indeed, there are occasions when there are no intensive care beds available at all.

5.7 The situation is no different in community care services. The most recent survey shows that over 300 patients in hospital were awaiting discharge pending the provision of a care package in the community. Again, the number of such people is on the increase.

- 5.8 For those at home, services are often in short supply: nearly 800 adults are waiting for intensive home care; more than 300 people are waiting at home for admission to residential or nursing home care. Nearly 3,000 people are waiting for specialist equipment to support them and more than 200 people are waiting for home help services.
- 5.9 The review of the Northern Ireland Ambulance Service, published in February this year, drew attention to response targets not being met in many rural areas. It pointed to a lack of resources and poor deployment of vehicles potentially impeding the achievement of the new proposed performance standards in the future.

Increased Activity

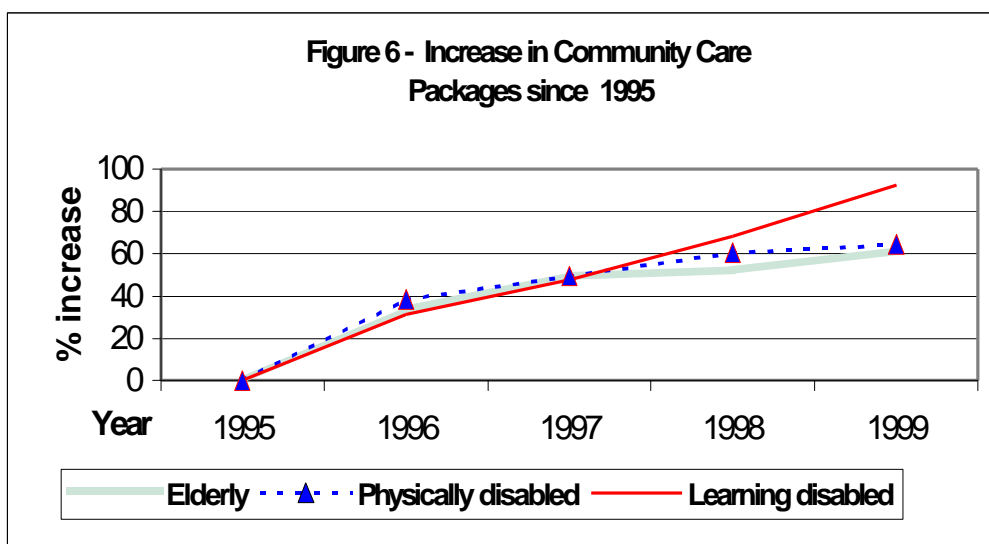
- 5.10 It is not a matter of inefficiency. Current problems are not brought on by any lack of commitment or of effort. In fact, the opposite is true. Nurses here deal with more patients than anywhere else in the UK⁴. Productivity is high and resources are being used at virtually full capacity. No less than 80% of patients are seen at outpatients within 3 months of referral⁵. Between September and December 1999, 77% of inpatients treated waited less than 3 months. Over 95% had waited less than a year. More patients are being treated and more care provided than ever (see Figure 5).



⁴ Survey by Royal College of Nursing, February 2000

⁵ HPSS Performance Tables for 1998-99, DHSSPS, November 1999

5.11 In community care, the number of care packages in the elderly programme of care increased from 6,849 to 11,052 between 1995 and 1999. The physical disability programme of care increased from 708 to 1,163 during the same period, while the number of care packages for people with learning disabilities rose from 684 to 1,317 (see Figure 6).



5.12 During the last 10 years, acute bed numbers in Northern Ireland fell by 30%, while the number of patients treated has increased every year. The decline in beds is not peculiar to Northern Ireland: bed reductions reflect changing clinical practice and improved treatment nationally over the past 20 years. The ‘*National Beds Inquiry*’⁶ published by the Government in February this year, records that bed numbers in the UK fell more sharply since 1979 than in almost any other country.

5.13 There has never been a consensus as to the ‘right’ number of beds. However, there can be no doubt that reductions of this magnitude have significantly diminished the capacity of hospitals to keep pace with the recent unexpected growth in demand for hospital care. Running fewer beds, more intensively, also makes it more difficult to cope with exceptional circumstances when they do occur.

⁶ Shaping the Future – Long-term Planning for Hospitals and Related Services, Department of Health, February 2000

- 5.14 In Northern Ireland, we have also managed with proportionately less money. Between 1983/84 and 1998/99, NHS expenditure per head of population in England rose by 57%, compared to 35% in Northern Ireland. In 1996/97, a 1½% service reduction, equating to £25.6m at today's prices, was imposed on the HPSS by the previous Government.
- 5.15 This reduction increased hospital waiting lists dramatically. While extra resources have been provided for waiting list reductions in recent years, these were allocated on a one-off basis. As a result, waiting lists have followed a 'stop-go' cycle, reducing as money is found and rising again once it was spent. An additional £25 million was earmarked for community care in 1999/2000. However £11.8 million was actually spent on other pressures during that year.

Organization and Management

- 5.16 Despite the best efforts of managers and clinicians, some of the difficulties that have arisen can be traced to the organization and management of the HPSS. Whilst Boards and Trusts seek to minimize these barriers, it often remains difficult for services to operate on a 'whole system' approach. The evidence reviewed suggests that collaboration between hospitals, community care and primary care services is not consistently effective.
- 5.17 By the same token, Primary Care practitioners such as GPs, community nurses, social workers and community pharmacists, are more involved in the planning of services in some areas than in others. Innovations in services that offer alternatives to hospital admission, requiring the relevant practitioners to work together, are often quite localized, with no overall uniformity of approach.

Conclusion

- 5.18 The reports reviewed in this paper have demonstrated the clear need for early action if last winter's problems are to be avoided. For the longer term, we need to begin building capacity to meet demand as well as re-focusing our efforts to manage and deliver our services more effectively all round.

5.19 Such improvement and modernization of our services will call for concerted action on the part of the Department, Boards, Trusts and all others involved in providing health and social services.

Section 6 – Securing a Better Service

- 6.1 Immediate action is required to remedy the service problems identified in this report. But action over a longer time-span is also required. Nationally, the Government has announced a major programme of modernization for the NHS. It is clear that a similar transformation is needed in the HPSS, to equip it for the pressures it is now facing.

Modernizing Services

- 6.2 The Secretary of State announced on 31 March that an additional £700 million would be invested in the HPSS over the next 4 years. A substantial part of these resources will be targeted at modernizing services, and will directly address the service problems highlighted in this paper. This substantial investment will build much-needed capacity in key service areas.
- 6.3 Additional resourcing, while important to address the under-investment of the 1990s, is not the whole answer to service difficulties. The HPSS too must change. It must improve the way it uses its current capacity and work better through an integrated ‘whole system’ approach. It must also embrace modern working practices and effectively exploit new technologies in the interest of patients and clients.

Immediate Action

- 6.4 The additional funding will make an immediate impact on the development of services in Northern Ireland. Much of this will directly support the development and modernization of health and social services. This will cover:
- **Hospital services** – additional resources have been allocated on a recurring basis to provide a flexible response to a range of pressures, including waiting lists, regional medical services and winter pressures. These additional resources will fund the modernisation of cancer services, including community-based care, and will support the phased expansion of intensive care and high dependency services. The resources add to the extra £3m already allocated to this area for 2000/01.

- **Community Care Services** – extra resources have been allocated on a recurrent basis to reflect demand in key areas of service. This will fund additional service capacity in the community, ensure improved co-ordination of care between community and hospital services, and reduce waiting lists for services.
- **Ambulance Services** - Pending final decisions on foot of the recent review, the Department has earmarked additional resources to fund improved communications and the replacement of vehicles this year.
- **Primary Care** - It is important that primary care is equipped to play its full part in the health and social services. The responsiveness of primary care was an important element in dealing with last winter's pressures. Further recurring resources have been allocated to support the capacity of primary care.
- **Recruitment, retention and training of staff** – The modernization of services is dependent on the availability of staff with the necessary skills to support effective health and social services. Additional money has been allocated to fund extra nurse training places, the recruitment and retention of hospital pharmacists, expanded social work training and further reductions in junior doctors' hours.

6.5 Boards have been asked to submit expenditure plans by 19 May, setting out the specific areas in which these extra resources will be utilised. The Department will agree with the Boards firm targets to be achieved in each area funded.

6.6 To improve information, immediate action will also be taken by the Department to put in place a new monitoring system for collecting data on the incidence of flu-like illnesses. This will be in operation in time for next winter and will facilitate the better management of patients.

Reviewing Capacity

- 6.7 It is vital that future capacity is right. The Department will, therefore, commission a review of acute bed provision. The review will examine existing levels of acute bed provision and consider what is appropriate for Northern Ireland. The review will also study the effectiveness of alternative forms of provision and will be asked to report by 30 September 2001.
- 6.8 Alongside this, a review of Community Care will begin later this year and will also report by 30 September 2001. The review will consider how effectively care in the community, particularly as it affects older people, is being implemented. It will focus in particular on the integration and coordination of community care packages and the interface between hospital, primary and community care services.

Improving Performance

- 6.9 It is clear from the evidence reviewed in this paper that co-ordination between hospital, community and primary care can be improved. The reviews of acute bed provision and community care will, therefore, also consider how hospitals, primary care and community care can work together more effectively for those who depend on their services.
- 6.10 Boards, Trusts and others would also benefit from having access to information about innovative schemes that can have a direct impact on the winter pressures problem. These include measures such as rehabilitation and intermediate care initiatives, which take pressure off hospitals. Such work tends to be localized, however, with information on better ways of working often not communicated widely. Potential benefits are not being fully realised. It is vital that good practice is extended where possible. To this end, Boards will be asked jointly to review, by 30 June, the effectiveness of existing winter pressures schemes.
- 6.11 In planning ahead for next winter, it is crucial that plans take full account of the experience of last year. In particular, primary care practitioners, who can do much to prevent unnecessary admissions, need to be drawn into the planning process earlier and more comprehensively by Boards. The

Department will require Boards and Trusts to finalize their winter pressures plans by 30 September this year.

New Technology

- 6.12 There is ample evidence that increased investment in new technology has a direct effect on the care of patients and clients. However, investment by the HPSS in this area has fallen behind the NHS and other European countries in recent years. The HPSS needs to exploit the opportunities offered by information and communications technology to support care services and facilitate modernisation.
- 6.13 During 2000, the Department will develop a new information and communications technology strategy, including a programme for implementation.

Prevention

- 6.14 Influenza immunisation is recommended for those who may be most at risk of serious illness or death as a result of flu. It is effective in reducing the need for hospital admissions. The Department has established a multi-disciplinary group to examine how best to develop this programme further and to review uptake in 1999.
- 6.15 Some of the Boards suggested that staff who work in key areas of the HPSS should be routinely offered flu vaccination. Some Trusts did offer vaccination to staff last winter. Further research is needed on whether routine vaccination of staff this would help to reduce staff sickness levels or the transmission of flu to patients. Discussions are taking place at a national level about this.
- 6.16 The public too have a responsibility to protect themselves. People who are at particular risk should take advantage of flu vaccination programmes. For others, flu should not normally present a serious risk to health and self-medication will usually be effective. For those who have concerns, the GP or community pharmacist can offer advice.

6.17 The Department will run a public awareness programme in the autumn aimed at encouraging vulnerable people to seek vaccination for flu and to promote the most appropriate use of services.

Investing in the Workforce

6.18 Staff are the biggest resource in the HPSS. To deliver effective care, the HPSS needs the right number of staff, with the right skills, in the right places. Many of the actions identified as necessary in this report have staffing implications.

6.19 In many cases, through a combination of additional work and regular staff absences through illness, extra staff are required each winter. This year, with the services heavily stretched, many Trusts found themselves competing against each other for a limited number of private sector staff.

6.20 Boards and trusts will need to have robust, flexible staffing plans in place for next winter. In the longer term, the Department aims to publish a Human Resources Strategy for the HPSS later this year which will provide the framework for workforce planning across the HPSS, particularly the education and training of professional staff.

Accountability

6.21 The evidence reviewed in this report indicates that the Department needs to improve its arrangements for monitoring the performance of the HPSS. To effectively monitor developments, it will require more focused and up-to-date information, to ensure that the health and social services are in a position to meet the needs of people for vital services. The Department will take the necessary steps to ensure that resources are being used effectively and in line with the priorities set by Government.

6.22 The Department will be agreeing with Boards how the additional resources made available this year are to be used, and their targets in the light of this additional investment in services. The Department will closely monitor staff and

service developments, as well as demands on services in the winter months.

Public involvement

- 6.23 It is vital that the public is closely involved in the planning and review of services. In preparation for the Millennium holiday, for example, local newspapers and other media were used to publicise the benefits of flu vaccinations and to let people know about the availability of local services over the holiday period.
- 6.24 This process of public involvement needs to be intensified. People need to be reassured that services will be there for them if they are needed. They also need to be encouraged to use all services, and particularly primary care services, appropriately so that hospital accident & emergency services are available for those who really need hospital treatment.
- 6.25 The Department will expect Boards and Trusts to keep the public informed about their preparations for winter pressures, as well as providing regular information during the course of the winter months.

Conclusion

- 6.26 Key service developments and organizational changes are needed if health and social services are to respond effectively to current and future demands. The Government is allocating extra resources to ensure that services can face the demands of the future. Implementing the plans for action set out above will present service commissioners and providers with major challenges in the coming months and years. The outcome of this sustained commitment to developing and modernizing services must be measured in terms of the capacity of the health and social services to provide modern, safe and effective services 365 days a year.

Action Plan

Immediate Action	Target Date
1. Department to establish immunisation group to consider ways of improving uptake in groups at risk	30 April 2000
2. Department to develop waiting list action plan in conjunction with Boards and Trusts.	31 May 2000
3. Department to agree plans for phased expansion of intensive care and high dependency provision with Boards and Trusts.	30 June 2000
4. Boards and Trusts to complete joint review of existing winter pressure plans.	30 June 2000
5. Recruitment by Trusts of additional staff in key areas	30 September 2000
6. Boards and Trusts to finalise winter pressure plans, including the development of media and public awareness strategies.	30 September 2000
7. Department to commission a public awareness programme to encourage people at risk of flu to seek vaccination.	30 September 2000
8. Department to establish new monitoring system for flu-type illnesses.	31 October 2000

Longer-term Action	Target Date
Review of acute bed provision.	30 September 2001
Review of Community Care.	30 September 2001
Information and Communications Strategy.	31 December 2000
Human Resources Strategy.	31 December 2000

Intensive Care Review – List of Recommendations

Note: The CMO's full report is available from Regional Policy Unit, Secondary Care Directorate, DHSSPS, Room 113, Dundonald House, Stormont, Belfast - telephone Belfast (028) 9052 4166 .

Definitions

***Intensive Care** - The CMO's report defines intensive care as services offering a facility for the diagnosis, prevention and treatment of multiple organ failure. Such services require multi-disciplinary input and the highest possible standard of nursing and medical care. Intensive care is labour intensive and requires full-time medical resident cover and a nurse/patient ratio of 1:1 at all times. It is consequently a very expensive service.*

***High Dependency** - High dependency units offer a standard of care between the acute ward and intensive care, providing monitoring and support to patients with single organ failure or who would require short-term resuscitative measures. Ideally, a high dependency unit should be in close proximity to the intensive care unit as this allows intensive care and high dependency care beds to be used interchangeably, providing a service with the flexibility to cope with peaks in demand. High dependency care normally functions with a nurse/patient ratio of 1:2, but does not require the exclusive services of a full-time resident doctor, as in the case of intensive care. It costs around two-thirds the price of intensive care.*

Recommendations

Additional Capacity

- 1 In the short term (this year) funding should be identified to provide the following additional capacity:-
 - 2 ICU beds in Altnagelvin Area Hospital.
 - 2 ICU beds in Antrim Area Hospital.
 - 2 ICU beds in Craigavon Area Hospital.
 - 2 ICU beds in the Ulster Hospital Dundonald.

 - 5 HDU beds in the Royal Victoria Hospital.
 - 3 HDU beds in the Belfast City Hospital

In addition the 2 HDU beds in the Belfast City Hospital that are currently only funded to operate Monday to Friday 9am to 5pm should be fully funded.

High Dependency Units

- 2 Each hospital with an intensive care unit must have an adjacent high dependency unit. These units allow better management of intensive care beds and provide flexibility in periods of peak demand. Plans need to be put in place to provide the following additional capacity:-
 - 6 HDU beds in Altnagelvin Area Hospital;
 - 6 HDU beds in Antrim Area Hospital;
 - 4 HDU beds in Craigavon Area Hospital; and
 - 6 HDU beds in the Ulster Hospital Dundonald.
- 3 Space needs to be identified for the inclusion of a high dependency unit to be developed adjacent to the regional intensive care unit at the Royal Victoria Hospital. This should have the capacity for around 20 HDU beds.
- 4 Smaller acute hospitals should have high dependency beds and the ability to provide short-term ventilatory support. Clinical staff providing HDU care in these hospitals need to have a close working relationship with clinicians working in the intensive care unit of the nearest area or central Belfast hospital. Such a relationship should include mechanisms for rotational training arrangements and audit within a clinical network of care.

Nursing Staff

- 5 The opportunity for pre registration nursing students to gain experience in intensive care and high dependency units should be considered.
- 6 A regional review of the nursing establishment and grade mix in intensive care and high dependency units should be carried out. One aim of this review would be to reduce the number of nurses in the D grade category and create a career pathway for nurses working in these care environments.
- 7 General induction programmes within Trusts should facilitate nurse's rotation into specialist areas such as intensive care and high dependency.
- 8 Induction programmes within ICUs and HDUs should facilitate nurses remaining supernumerary for at least one month.

- 9 A short programme similar to the ENB 100 should be developed to support nurses in both of these care environments. This programme should be delivered in a flexible way to facilitate the needs of the individual and service and should form a building block to the achievement of the specialist practice programme.
- 10 Rotation schemes should be developed which allow nurses to work for periods in other clinical areas.
- 11 Flexible working arrangements should be developed e.g. job sharing and part time work. These arrangements would help to retain staff in post and encourage staff who had previously worked in the intensive care environment to return to work.
- 12 Plans should be put in place now, and funding identified, to ensure that there will be sufficient trained nursing staff in post when the new intensive care unit in the Royal Victoria Hospital opens in 2 years time.

Medical staff

- 13 There should be an adequate number of appropriately trained consultant staff and a sufficient number of junior medical staff to ensure a safe and responsive intensive care service.
- 14 The postgraduate Council should review the training programmes for future doctors so that doctors, who wish to train in acute medical and surgical specialties, would be offered the opportunity to receive training in intensive care.
- 15 The level of clinical supervision of patients on acute hospital wards needs to be reviewed.

Guidelines and Audit

- 16 Regionally agreed guidelines on admission to, and discharge from, intensive care and high dependency units should be developed.
- 17 All units providing intensive care must subscribe to ICNARC. This should be considered as an essential component of the Trust's clinical governance arrangements. Funding for this should be made available.
- 18 There should be a regional approach to audit in intensive care.

Paediatric Intensive Care

- 19 Every effort must be made to retain, recruit and train sufficient nursing staff to sustain and increase capacity in the paediatric intensive care unit.

- 20 All hospitals admitting children must be able to initiate intensive care.
- 21 Clinical staff should develop a regional agreement on policies for the management of the admission and transfer of critically ill children when the PICU is full.

Inter-Hospital Transportation Service

- 22 Separate inter-hospital transportation services should be established to cater for the separate needs of critically ill adults, children and neonates. These should be based at the respective regional centres and provide a service to the whole region.

Information Systems

- 23 There should be a regional assessment of the information required to monitor demand on the intensive care service. This should facilitate future service planning.
- 24 Information and management systems need to be developed that would allow for better intensive care bed management across the country. Such a system should be piloted to determine its information requirements, scope and utility.

Managing Peaks in Demand

- 25 All intensive care units within Northern Ireland should operate as a single coordinated intensive care service. The service should be developed as a managed clinical network.

Service needs should be kept under regular review. There should be a systematic approach to monitoring and reviewing intensive care services. A further comprehensive review should be undertaken in 2 years' time.

Community Care Review – Conclusions and Recommendations

Note: The CSSI's full report is available from Social Services Inspectorate, DHSSPS, Castle Buildings, Stormont, Belfast - telephone Belfast (028) 9052 0657.

The Minister may wish to commission a comprehensive review of the implementation of community care policy, to include funding and arrangements for the delivery of services in Northern Ireland. Current policy has now been operational for almost 7 years and a review may now be deemed timely and appropriate. In undertaking such a review, account should be taken of the important interfaces between hospital, primary and community care. Account should also be taken of the following:

- the most effective method of funding and strategic planning to deliver community care;
- the infrastructure which facilitates all year round planning and resourcing in order to deliver the most effective use of resources;
- standards set by the Department regarding assessment, care management and discharge arrangements and recommendations of previous inspection reports;
- the need for greater collaboration across Hospital, Primary and community care so as to develop a co-ordinated approach to the planning and management of hospital admissions and discharges to ensure care pathways for patients and clients with appropriate thresholds and settings meet the needs of carers;
- schemes such as “Home From Hospital” and “Rapid Response Service” which prevent unnecessary hospital admissions and facilitate early and appropriate discharges;
- the eligibility criteria and charging policy to provide consistent and fair access to care services for all people in Northern Ireland.
- outcome measures which demonstrate the impact and effectiveness of schemes to address emergency pressures and their impact on the quality of care for patients and clients;
- information systems to enable the Department to more effectively monitor community care and care management arrangements and to inform resourcing decisions. Information on waiting times, costs of referrals, assessments and packages of care in the community should be developed as a matter of priority.
- accountability arrangements which are sufficient to ensure that all recommendations made as a result of inspections are fully implemented.

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