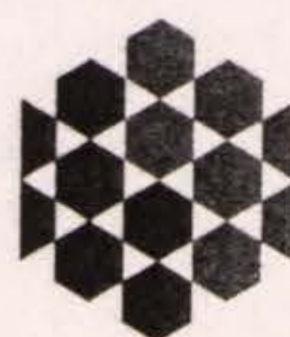


From the Permanent Secretary
Clive Gowdy CB



Department of
**Health, Social Services
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

www.dhsspsni.gov.uk

Professor John Appleby
Chief Economist
King's Fund
11-13 Cavendish Square
LONDON
W1G 0AN

Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
Tel: 028 90 520559
Fax: 028 90 520573
Email: clive.gowdy@dhsspsni.gov.uk

5 April 2005

Dear John,

REVIEW OF THE HPSS IN NORTHERN IRELAND

I must apologise for my inability to fulfil our dinner engagement in Belfast on 14 March because of my illness. I would have welcomed the opportunity to have a discussion with you over dinner, but I know that Paul Simpson filled in admirably and that there was a lively discussion.

I have now returned to the office, although my return will be relatively short-lived as I have decided that I should take early retirement due to my illness. Nevertheless, I wished to let you have some views on the issues which you will be considering in the review. I have therefore prepared the attached paper, which I hope you will find helpful.

I realise that there are different perceptions and different expectations as to the focus and likely outcomes of the review, but I would like to wish you well in difficult task which you face.

Yours sincerely,

Clive Gowdy

D C GOWDY



HPSS REVIEW

Purpose

The purpose of this paper is to provide an overview of the issues facing the HPSS in Northern Ireland and to provide some background context to assist the Review in the consideration of those issues.

Introduction

Like all Health Services across the UK and in the Republic of Ireland, the HPSS in Northern Ireland is struggling under the combined effect of increasing demands and public expectation, rising standards of clinical and social care governance and spiralling costs. Whilst major service improvements in both the volume and quality of care have been implemented and productivity gains have been achieved, Ministers and the public remain impatient for further improvement in both the quality of service delivery and the responsiveness of the system to patient needs.

As a service based on the NHS model, funded entirely from taxation and founded on the principle of delivery on the basis of need rather than ability to pay, the task facing the HPSS is one of balancing demands and expectations against the level of resources Government provides and dealing with the inevitable choices that must be made in identifying priorities. In NI, uniquely in the UK, the system is an integrated health and social care model and we must provide health and social services on the same basis of equity.

The main objectives are to:

- improve the health status and social wellbeing of the people of NI;
- reduce health inequalities across the community;
- provide a comprehensive set of high quality services to meet the needs of patients and clients and secure positive outcomes;
- ensure that health and social care services are appropriate, accessible and effective;
- provide equality of access to services;
- ensure patient and client safety;
- as far as possible, provide person-centred services in communities and in domiciliary settings rather than in hospitals;
- utilise the available resources as efficiently and effectively as possible.

In common with the health services of the other countries in the British Isles, the HPSS faces a raft of pressures:

- the volume of demand continues to grow;
- alongside this growth in demand, there are higher public expectations and lower thresholds for referral – there are no apparent limits to the scope of the health and social care which the HPSS is expected to deliver;
- modern medicine demands greater specialisation, higher standards and greater complexity;
- new drugs, technologies and techniques are creating additional cost pressures;

- modern medicine can do more to prolong life, but this is generating a higher level of need for more intensive, longer term care;
- the growth in long term or chronic diseases and conditions is a major issue for health and social care management;
- patient safety, risk management and clinical negligence are major concerns; and
- there are difficulties in the recruitment and retention of staff, with NI increasingly competing in a global market for skilled health and social care staff.

There is strong political and public attachment to the NHS model in NI. The HPSS is virtually the only provider of health and social care services here. The private sector is small – with, for example, only two small private hospitals – and comparatively few people can afford private health insurance. Figures relating to the uptake of private medical insurance show that in 2002 19% of the population in England were covered by such insurance compared to 10% of NI households.

The value of the HPSS is also demonstrated by the fact that throughout the 30 years of civil disturbance, the HPSS was viewed as an impartial community resource, providing essential services fairly and equitably across the community and political divide. The HPSS dealt with, and indeed continues to deal with, both the injuries and illness directly associated with the conflict and also with the illnesses arising from the economic stagnation, long term unemployment and poverty to which the Troubles contributed.

Fundamental Concerns

While the HPSS continues to provide a wide range of services to people throughout NI, there are difficulties in meeting all of the expressed needs and in doing so both timeously and to the required standards of quality and responsiveness. There are two fundamental concerns which need to be addressed if we are to make a difference in improving the position in relation to health and social care in NI.

First, we need to achieve an improvement in access to treatment and care. This has a number of dimensions to it, but is essentially about having the right capacity, the necessary resources and effective systems and procedures to ensure the proper flow of patients through the treatment and care regime. At present, this is being taken forward through a number of ongoing initiatives designed to ensure a more effective use of the resources already at our disposal. There are undoubtedly opportunities to promote new ways of working and efficiencies which can be achieved to help realise our objective. We look forward to any ideas or assistance that will emerge from the Review in this regard.

Secondly, as with other healthcare systems, we are faced with the difficulties of coping with the ever-increasing pressures on our health and social care services and it is clear that these pressures will become even more acute over the coming years. This will present real resource problems and this issue, which is a problem for health systems world-wide, can not be ignored in Northern Ireland. We need an open and honest political consideration of how these demands should be met.

Improving Effectiveness

The public and the politicians see considerable amounts of money being put into the HPSS but still perceive substantial shortfall in the provision of services. The major problem areas lie in

the lengthy waiting for both inpatient and outpatient treatment, the trolley waits in A&E Departments, the difficulties over access to new drugs and therapies and the lack of residential and other facilities in the community.

These issues have generated a perception that there is inefficiency and waste in the HPSS and that resources are not getting to the front line. There is also a view that substantial amounts of money are eaten up in needless bureaucracy and that the emphasis has been on increasing the number of administrators at the expense of clinical staff.

There are more recent concerns around the issues of patient safety, arising largely from some tragic deaths in both the hospital sector and the social care field which attracted considerable publicity. The growth of hospital-acquired infections and issues of cleanliness and the quality of the patient experience have also given rise to criticism and concern.

Invidious comparisons have also been made in relation to developments in England and Scotland which have not been replicated in NI. These include such things as the introduction of free personal care for the elderly in Scotland and the substantial progress made in England in respect of waiting times, the use of ICT and the role of bodies such as NICE, NPSA, etc.

These are real issues and there is great awareness of them in the HPSS. However, the perceptions of waste and inefficiency are not an accurate depiction of what is actually happening in the HPSS. There are undoubtedly areas where further improvements are required - which is why we have undertaken a challenging programme of reform and modernisation - but overall the performance of the HPSS reflects that of a health and social care system addressing the effects of historical underfunding while dealing with new needs and demands. The reality is that both the perceptions and the problems underlying them will only be dispelled by radical progress in tackling the major problem areas.

The most stark indicator of the HPSS's inability to cope with demand is highlighted by waiting lists and waiting times. The genesis of this problem is to be found in the cut in resources imposed on the HPSS in the mid-1990s. Prior to this, NI was on a par with the best areas of the UK, but the resultant reduction in capacity had an inevitable impact on the numbers waiting. This growth continued until 2002, when the action taken by the Department and the HPSS as a result of the injection of additional resources began to take effect and the numbers have been reducing steadily since that time. The rate of progress needs to be increased and NI still lags behind the rest of the UK on this issue.

The problem of trolley waits is also a public indicator of the state of the HPSS. The perception of sick people lying in hospital corridors and corners of the A&E Department for substantial periods is abhorrent to most people and this has been a growing phenomenon in recent years. The reasons are complex, but there is also a capacity issue involved. The growth in the volume of cases presenting at A&E Departments has been substantial and the occupancy rate in hospital beds has become excessive. Combined with the problems of inadequate capacity in the community and the resultant blockage in discharging frail patients, this has made it difficult to achieve the necessary smooth flow of patients through the system and trolley waits at the entry point have been the result.

The problems of inadequate access to new drug and other therapies have arisen simply as a result of lack of resources and it has not been possible to introduce them in line with public expectation. The public pressure has, however, required some response and the approach has

been to phase the introduction of these new therapies using either non-recurrent monies or cutting into other HPSS programmes. This has been a means of making progress but has not been satisfactory for patients, clinicians or managers.

Leadership and Political Direction

Policy development in health and social services in NI has been blighted by the political uncertainties which have been a feature of life here in recent years. With the on-off nature of devolution, there has been no consistent political agenda for health and social care and officials have had to develop a pragmatic approach which has married care and maintenance with selective development where possible.

Despite the political difficulties, a number of strategic initiatives have been developed. These are summarised in the following paragraphs, but are being taken forward under the umbrella of a new Regional Strategy, *A Healthier Future*. This strategy sets out a vision for the development of our health and social services over the next 20 years and aims to build progress round the needs and wishes of patients. It is designed to be a plan for the achievement of the sort of HPSS we want to see for the people of NI and was developed through a process of widespread consultation with some 1,500 people and organisations. Based on the results of this consultation, it focuses on a series of objectives – improving public health and wellbeing; engaging with people and communities; delivering more responsive and integrated community-led services; promoting new ways of working through more integrated teams; and the delivery of enhanced quality standards. The policies which will be taken forward under the aegis of the Regional Strategy are set out in the following paragraphs.

In line with the poor health status of NI, a new public health strategy, *Investing for Health*, was developed and has been implemented throughout NI. This policy has been praised by the WHO and public health experts, such as Sir Donald Acheson, for its clear and innovative approach. It has also received broad community support as a result of building on the strong tradition of community development here and is leading to many innovative and cross-sectoral initiatives being taken in areas across NI.

Although it took considerably longer than in the rest of the UK, the internal market and GP fundholding policies of the former Conservative Government were replaced with more collaborative arrangements. There was substantial resistance to the ending of fundholding by an influential group of GPs and this was significantly delayed by political lobbying on their behalf. They also refused to cooperate in the new arrangements for primary care development. Progress towards new organisational arrangements which could support this movement has also been delayed for political reasons (see below).

A new strategy for the development of acute hospital services, *Developing Better Services*, was produced and is in course of implementation. It is designed to centre acute services in a smaller number of strategically placed major hospitals and to replace the smaller acute hospitals with local hospitals providing outpatient, day surgery, minor injuries and diagnostic services. This has been strongly opposed in some areas, where most political parties and community organisations align against any reduction in acute services. Nevertheless, the policy is in the course of being rolled out and the planned investment programme in support of it has recently been published as part of the *Investment Strategy for Northern Ireland (ISNI)*.

The problem of reducing waiting lists has been given a high profile and a Waiting List Action Plan was developed, which has been implemented over the past two or three years. In addition, a programme of Service Improvement Projects has been pursued. The projects in this programme have been designed to empower teams to identify local action to improve services and, while the remit of these projects is broader than waiting alone, they are making a real contribution to the reductions in waiting referred to above.

The issues of quality and standards and the need to protect patient safety through regulation and inspection have been taken very seriously and a strategic approach to all of these issues was set out in the policy document, *Best Practice Best Care*. A wide raft of measures have been, or are in the course of being, implemented, including a new statutory duty of quality which has already been placed on Boards and Trusts, new standards and the establishment of a new independent local body, the HPSS Regulation and Improvement Authority.

As in other parts of the UK, there has been recognition of the importance of the role played by primary care. A new Primary Care Strategy has been developed through an extensive public consultation exercise and will shortly be published. It is designed to place primary care in a more central and influential position within the HPSS system and, in recognition of the integrated nature of the HPSS, to produce a collaborative set of working arrangements embracing all primary care professionals. To assist in this, a review of community nursing services is under way and it will deal with the organisation of community nursing to meet the new demands in respect of chronic disease management, first contact care and public health.

A new ICT Strategy for the HPSS, backed by an additional £95m over the next ten years, will see the development of electronic care records, electronic communications and easily accessible e-health information.

The oral health of the NI population is much worse than in other parts of the UK and in the case of our children is the worst in Western Europe. In the face of entrenched political opposition to fluoridation of the water supply, an alternative oral health strategy has been developed and is currently out for consultation. Along with a new Primary Care Dental Strategy, it will influence the future delivery of oral health services.

Although we do not have National Service Frameworks in NI, we have been conscious of the need to develop sectoral approaches and a series of reviews have been conducted to produce frameworks for the way forward in key areas. Such reviews have been conducted and published in respect of Cancer Services, Cardiology, Cardiac Surgery, Renal Services, Pathology, and Lymphoedema. A major review is also under way in Mental Health and Learning Disability and is due to report shortly. One example of the potential impact of these reviews is that of the review of Cancer Services, which preceded the development of a new £50m world class Cancer Centre at the Belfast City Hospital and which has contributed to improved cancer survival rates – although in view of the high rates of cancer in NI, we still have some way to go in this area.

Our annual planning document *Priorities for Action* has reflected the key themes for change in recent years. These have been given renewed emphasis in the 2005/06 document and the HPSS has been tasked with taking forward a number of flagship reforms over the next 2-3 years. This focus on flagship reforms is intended to secure a sharper targeting of investment so that the additionality provided by the resources is not too thinly spread across all services and so that we can achieve tangible improvements from the available resources.

The Building Blocks of Change

All of these policy developments are necessary and will need to be progressed. To achieve this, we will need the following building blocks to be set in place.

One is to change the structure and organisation of the HPSS. The present structure is not fit for purpose in relation to modern needs and modern ways of delivering services. Our current system reflects the internal market approach of the early 1990s and despite repeated attempts over the past 7 years, we have been unable to make the necessary progress because of the wider political difficulties. A more modern structure would be based in the collaborative approach now being pursued in practice to some degree by the HPSS despite the organisational constraints, and would give equal weight to primary, community and hospital services. It would vastly reduce the number of bodies in the HPSS system and would do away with the current separation of commissioners and providers of services. Proposals on these lines have been developed within the context of the work on the Review of Public Administration document which was published for consultation on 22 March.

A second issue is the need to improve the flow of patients through the system. This requires the management of each patient's journey and genuine cooperative working at every stage of the process. Investment is needed in the information technology to support this way of working and in the necessary facilities and equipment throughout the system. (See also the reference to the ICT Strategy above.)

A third issue is to build up the capacity of the system to cope with the demands placed on it, both now and into the future. This requires efficient and effective use of the current resources to ensure that we are getting the best out of them, as well as increasing the capacity where it is necessary to do so. In this latter area, we need:

- additional acute beds;
- additional intensive care and high dependency unit beds;
- additional medical, nursing, AHP and social services staff;
- additional imaging and other diagnostic equipment;
- additional community care packages; and
- additional residential and nursing home places.

A fourth issue is to ensure that care and treatment is being provided appropriately and in an appropriate setting. For example, there is scope to increase the amount of surgery undertaken on a day care basis. There is also scope to increase the number of procedures and the amount of care and treatment undertaken in primary care and in the community.

A fifth issue is to provide more domiciliary care and care in the community to prevent the need for hospitalisation.

Finally, there is the need to manage expectations. The future for the HPSS is one of inexorably increasing demand for services and these can only be delivered if there is a willingness to provide the necessary resources. It raises a number of fundamental issues about the nature of our health and social services system and what it can and should deliver. An informed debate

about how the HPSS should be developed and resourced would be welcome. It is hoped that the review will provide the opportunity for this.

Resources

The resourcing issue cannot be ignored. The resources available to the HPSS do not match the current levels of need and there are considerable concerns about how future demands will be met. The public, however, has not fully grasped this and there is still a view that the inability to meet all the expressed needs is due to inefficiency or bad management.

At one level, there is a view (particularly from some English commentators, including MPs) that NI is very well funded and that the HPSS has more than its fair share of resources. Certainly, the level of funding per head on health shows NI as ahead of England and Wales (although lower than Scotland). For 2002/03, the figures as quoted in HM Treasury *Public Expenditure Statistics Analysis 2004* are :

England	£1085
Wales	£1186
NI	£1214
Scotland	£1262

It is important to note, however, that there are differences in the demographic profile, morbidity and socio-economic status of the populations of the four countries (see below) and it would be wrong to expect that each administration should spend the same per capita. Indeed, the differences between the territories are well within the parameters of difference that are recognised in the English allocation formula (and the NI one) for distributing resources to populations in England after taking account of differential need – for example, Central Liverpool has a needs index of 1.48 compared to an average of 1.0 for all PCTs in GB. It is the contention of the Department that current funding levels do not adequately reflect the greater levels of need in NI relative to England.

Moreover, the reality is that resources for the HPSS have not kept pace with increases in England and the gap will increase significantly under current spending plans. The year on year percentage budget increases in NI and England allocated to DHSSPS and DoH since 1997/98 have been as follows :

	NI	England
1998/99	7.48	7.5
1999/00	11.3	11.9
2000/01	12.5	16.6
2001/02	10.4	11.0
2002/03	10.0	12.0
2003/04	12.7	13.4
2004/05	10.3	9.6
2005/06	9.7	9.4
2006/07	6.8	9.5
2007/08	5.3	9.6

Over the past 3 years, the growth in resources has been 26.25% in England and 24.3% in NI. This translates into a recurrent gap of £66m in the resources available in NI by the end of this

year. Over the next 3 years, the planned growth is 20% in England and 12.5% in NI and this equates to a shortfall in NI of some £250m by 2007/08.

It is also important to recognise that the increases in 2002/03 and 2003/04 included some £50m in respect of the transfer of costs for looking after people with preserved rights in residential/nursing home care whose care was previously financed by the social security system. (Unlike in England, the full increases in the period have not provided for additionality.) Furthermore, the annual budget increase for NI had to provide for the introduction of the Sure Start scheme and the Early Years initiative, whereas this was undertaken in England by a different Government Department. These factors have not been taken into account in the quantification of the recurrent gap in our resources of £250m referred to above.

It is also pertinent to note that in the period 1995 to 2003, the numbers of people whose long term care was financed by the social security system reduced from 5,840 to 1,465 – this reduction of 4,375 funded places had a tangible impact on the resources available to the HPSS, particularly for elderly care services and had an adverse effect on the ability to address delayed discharges.

These comparisons must also take into account the differential levels of need in NI. Different populations make differential use of health and social care services after allowance is taken of “supply induced demand”. Research evidence has clearly demonstrated that differences in morbidity, the age-gender profile and socio-economic factors go a long way to explain different levels of use and hence differential need for health and social care interventions. This is the basis of much work that has been done in developing resource allocation formulae for health and social services across GB (particularly by the University of York). It is also a central feature of the research work conducted in NI to refine the resource allocation formula to target health and social need. (Much of this work was commissioned from the University of York.)

The fact is that there are clear differences in the levels of need in NI and those of England. There are many factors which play a part in the higher levels of demand for services in NI:

- the health status of the population of NI is much worse than England – life expectancy in NI in 2003 was 0.7 years less for males and 0.5 years less for females than in England and, even after taking the different age structure into account, 28% more people in NI reported a long-standing illness and 44% more people assessed their general health as poor in the 2001 Census;
- morbidity and mortality rates for the major disease risks in NI are amongst the worst in Europe – figures for 2001 showed NI to have a 1% higher age-standardised mortality rate for all cancers, 7% higher for circulatory diseases and 16% higher for respiratory disease than England;
- the level of severe disabilities is substantially higher in NI than in England – even when account is taken of the different age structure, the rate of disability in NI is 56% higher;
- the rate of births with a congenital malformation in NI is over twice the level in England and Wales;
- injuries from road traffic accidents and consequential admissions to hospital (particularly involving young males) are significantly higher in NI than in England;

- levels of deprivation are much higher in NI, with associated greater need for health care and social services (Income Support is 66% higher in NI and the number of elderly people on Income Support is 81% higher than in England);
- the proportion of children who are the dependants of people on social security benefits is higher in NI than in England (in NI the figure is 23.5% and in England it is 18.8%; in NI claimants of Family Tax Credit represent 21.6% compared to 11.6% in England);
- NI has a much more rural population than England, with higher levels of poverty and problems over access to services;
- the statutory sector carries a higher burden of care than in England – the private sector plays a more minor role and twice as many people in England (31%) meet the full cost of nursing care privately than in NI (15%);
- there is a substantially higher prevalence of mental illness in NI – the level of need for psychiatric treatment is 25% higher than in England and the level of drug therapies for mental illness range from 37% to 75% higher than in England;
- the NI suicide rate has increased from 7.3 per 100,000 in 1998 to 8.5 per 100,000 in 2002;
- there are much poorer levels of oral health in NI – in 1998 33% of adults in NI had 18 or more sound teeth compared to 41% in England and in 2003 the average number of teeth of 12 and 15 year olds affected by dental decay was more than twice the level for the UK as a whole.

NI also has the overlay of a weak economy and a sustained period of civil strife which had devastating effects on the health and wellbeing of the whole population. Undoubtedly, much of the mental health distress described above is due to the legacy of the Troubles. However, the Troubles and their aftermath have also created long term problems in terms of the number of people who have been left with life limiting injuries as a result of shootings and bombings. These include people with severe brain injury who require 24 hour care, as well as people with injured limbs and organs who require maintenance and replacement of prostheses and/or regular medical and nursing care. There are also long term problems of social care, including the high suicide rate, child protection issues and family disturbance as a result of the Troubles and the more recent emergence of paramilitary criminality and control of local communities by these groups.

It is also the case that the spatial distribution of the population has a differential impact on costs. Research evidence clearly indicates that it costs more to deliver the same level of service in rural communities compared to densely populated urban areas. The spatial distribution of the NI population is virtually unique in UK terms, with a very substantial hinterland to the main conurbation, marked by small market towns and substantial tracts of rural living.

Associated with the sparsity factor is the fact that the service infrastructure put in place historically to respond to patient demands will have differential access to economies of scale. Smaller rural facilities cannot exploit economies of scale available to larger populations, giving rise to increased costs to rural economies. Research conducted for the NI capitation formula has confirmed this.

The only factors which act in NI's favour are the lower proportion of elderly people in the population, who are projected to make up 14% of the population in NI in 2005 compared to 16% in the UK as a whole (although NI has the highest growth rate in the elderly in the UK, with a projected growth of 52% over the next 20 years compared to 41% in the UK as whole);

lower levels of drug abuse (although again that is increasing); and lower levels of sexually transmitted disease.

Despite these few favourable comparisons, it is evident that the levels of need are greater in NI and if we are to provide the same levels of service as elsewhere in the UK, the level of funding will inevitably need to be higher.

Unmet Need

Irrespective of the comparative differences in funding, the reality is that the current level of resources available in NI falls substantially short of that required to meet all of the needs presently facing the HPSS. Major areas of difficulty include the following:

- hospital inpatient treatment – 16,000 people waiting 6 months or longer;
- outpatient treatment – 65,000 people waiting 6 months or longer;
- over 10,000 people waiting for Occupational Therapist assessment;
- 1120 children waiting for first outpatient appointment in child and adolescent psychiatry;
- 594 families with children in need waiting for an assessment;
- 1,275 unallocated cases of children requiring care and protection;
- 1400 cases of vulnerable people requiring care packages – 1040 waiting in the community and 330 delayed discharges in hospital.

Children's services are a particular area of concern. Since 1997, there have been significant changes to the context, policy and legislation underpinning the delivery of services to children in England, much of which has not been able to be resourced in NI. There have been two particular major policy initiatives in England and Wales which have set out the strategic framework for delivering better services to children – *Quality Protects* and *Every Child Matters* – which we have not been able to replicate in NI. Figures in 1999/00 showed that the spend on children's services per head of the under-18 population was 35% greater in England and an additional £885m was committed under the Quality Protects initiative over the five years since then.

Unsurprisingly, outcomes for looked after children have been poor across a range of measures, with two-thirds likely to seek access to mental health services as adults. The numbers of foster carers are declining and the current gap in provision is likely to cause a crisis in foster care within the next three years. Current problems are also creating a crisis in child psychiatric services – gaps in the Child and Adolescent Mental Health Service are resulting in some children having to be inappropriately placed in adult services and in adult wards.

The problem for the HPSS is that these levels of unmet need must also be addressed against a backdrop of rising expectations, growth in demand and the need to provide modern quality standards of treatment and care. It is estimated that the overall annual cost of meeting all of these needs at current prices is of the order of £400m to £500m. A breakdown of the cost factors is shown in **Annex A**.

Financial and Service Planning Framework

Financial stability and good resource management has been a cardinal principle established by the Department for the HPSS in recent years. Although there has been considerable pressure

on resources, the problem of Trust deficits which is currently a major concern in England, and which was previously a problem here, has not been a feature in NI for some years.

The Department has taken steps to impose a tight financial regime and has established a financial and service planning framework for the HPSS. The role of the Department has shifted from that of a "market regulator" in a highly devolved system to that of managing a centrally directed system which provides for the Minister to determine key objectives and priorities and provides clear lines of accountability.

The key steps have included:

- the establishment through *Priorities for Action* of an explicit agenda of targets and objectives for the HPSS;
- the introduction of Board Health and Wellbeing Plans setting out how Boards intend to address Ministerial priorities and to deploy their resources;
- the development of Trust Delivery Plans showing how Trusts will respond to the key priorities within the resources available to them, including measures to make more effective and efficient use of resources;
- the requirement to produce robust recovery plans for those Trusts whose expenditure is forecast to exceed their income by 0.5%;
- the implementation of contingency plans to address immediate financial problems, thus ensuring balance between income and expenditure in year;
- detailed monitoring of how resources provided to achieve PSA targets are used.

The success of these arrangements is reflected in the break even position achieved each year and the high percentage of targets met. The system is severely constrained, however, by the fact that the 3 year public expenditure planning process has been only a 1 year process for a number of years in NI. This contrasts with the position in England where a 5 year above inflation commitment has provided a sound basis for the introduction of the longer term plans necessary to achieve fundamental change in the services provided.

The difficulties of achieving the current sound financial management should not be underestimated. The HPSS faced considerable criticism under the previous local administration for its financial management when the Department had to subject half of the Trusts to formal recovery plans. This "overspending" culture has been reversed and Trusts develop contingency plans to address pressures when they arise. This has ensured the development of a careful approach to financial planning, with no carte blanche to enter into unfunded commitments and a more measured approach to the quantification of the financial consequences of any action.

As a result, the Department and HPSS has not committed ex ante to the scale of improvements targeted in England. In that regard, it is noted that in the current year the NHS may well face in year deficits in the region of £0.5 billion (with potentially larger recurrent deficits) and that there are concerns about the financial position in a substantial number of PCTs. In contrast, the HPSS is expected to break even in 2004/05.

Efficiency and Productivity

Despite the clear difficulties in delivering all that is expected within the current resource envelope, it is acknowledged that resources are scarce and that it is important to get the most

out of the funding available. This is fully accepted by the Department and the HSS Boards and Trusts and a number of measures are in place to address this.

Most of the legal, procurement, IT and Estates services are either already delivered on a shared services basis or have a significant proportion outsourced. In that sense, a number of the efficiency gains that the NHS plans to achieve have already been made in NI. Similarly, the Central Services Agency provides a cost effective system of processing payments to Family Practitioners (GPs, Pharmacists, Dentists and Optometrists) on behalf of all four Boards and a number of other bodies operate bureau services for various support functions on behalf of other HPSS organisations.

In relation to management costs, a detailed study commissioned by NICON showed that these costs across the UK are at their lowest in NI. Expressed as a percentage of relevant expenditure on health and social services, HPSS management costs amounted in 2001/02 to 6.11% - 16% lower than in England, 20% lower than Wales and 27% lower than Scotland. The largest component of these costs relate to Trusts where the 2003/04 Accounts show that costs have declined even further – from 4.25% to 4.07%.

There is a continuous programme of value for money studies and service reviews which act to improve both quality and productivity. The HPSS reference costs are produced annually and their 2003/04 coverage is expected to match that in the NHS. Following publication of the costs, each Trust is formally notified of significant cost variations from its English and/or HPSS peer. Trusts are expected to identify the full range of benchmarking activity planned or ongoing, whether or not initiated as a result of highlighted reference cost variations. They are required to provide regular updates regarding outcomes achieved, either in terms of proven efficiency gains, increased productivity and/or effectiveness and associated service improvements. This system has prompted many Trusts to form clubs to benchmark costs and related information in detail and, individually, to establish mechanisms for unit cost reviews (a process facilitated by reference costs, in conjunction with comparative data from CHKS and other sources).

Among the practical improvements flowing from this activity are those where Trusts have:

- identified actions they will take on discharge management after analysis of certain reference costs in conjunction with other benchmarking information;
- identified changes in capacity/ bed allocation or used reference cost information to identify and address gaps in staffing; and
- linked some of their high reference costs to a decision to construct a day case unit, which frees up operating time.

Over the period since 1997/98:

- the volume of hospital inpatient and day case activity has increased by 17.5%;
- the number of community care packages increased by 36% between March 1998 and March 2004;
- the overall number of beds has reduced by 7.2%, the average length of stay has reduced by 10% and the throughput per bed has increased by 17%;
- comparing 1997/98 with 2003/04, the day case rate has increased from 25.5% to 31.3%;

- between 1998 and 2002, life expectancy has increased in NI by 1.3 years for males and 0.9 years for females;
- levels of oral health, while still generally very bad, have improved in both adults and children – from 1979 to 1998, the proportion of adults without any natural teeth fell from 33% to 12%; and over the past 20 years, the average number of decayed teeth per 12 year old child has dropped from 4.8 to 2.7;
- the recently developed Health Cost Weighted Activity Index has shown a provisional NI estimate of a 4.5% increase in health outputs over the previous year.

Despite these improvements, the relationship between resources and outcomes is not easily demonstrated on an annual basis. There are several reasons for this.

- Annual HPSS inflation is higher than the local economy norm.
- Real increases, beyond HPSS inflation, are required to deal with volumetric increases in demand (eg prescribing).
- Changes to UK-wide contracts of employment have had to be funded before the benefits associated with them have been delivered. Changes to the GP contract and the consequent responsibilities for out of hours work, the consultants contract, junior doctors costs and Agenda for Change have consumed a considerable proportion of the annual uplifts made available in recent years.
- Some of the increases have been associated with the transfer of costs from another part of Government to DHSSPS (eg Preserved Rights) or to fund new initiatives funded by other Departments in England (eg Sure Start).
- Considerable funding has been required to finance residential and nursing home provision at an adequate level – over the past 2-3 years weekly tariffs for nursing home provision have had to be increased from £350 to £420 per week and there remains some way to go before the evidence-based level of funding commensurate with the costs involved is reached.
- Considerable amounts of funding are required year on year to finance recurrently a number of initiatives begun with non-recurrent monies. The subsequent allocation of the recurrent funding does not register any increase in activity.
- Investments in quality and clinical governance have little tangible impact on the response to need.
- Royal College visits can lead to an inescapable requirement to strengthen consultant staffing at local level if existing services and training status are to be maintained. This is particularly the case in respect of small local hospitals.
- Investments made for the future – eg. increases in medical student and nurse training places - have little tangible effect on service delivery in the short term.
- Major capital investment brings with it a requirement for significant additional revenue funding for delivering the same level of service as the latest standards in respect of physical space, equipment, staffing, etc are built into the new infrastructure.

The consequences of these points are that the resources that are available in any one year for 'new' service development are extremely limited. Moreover, when spread across the existing activity levels of, for example, 680,000 A&E attendances, 1.4 million outpatient attendances, 460,000 inpatient and day cases, the marginal improvements possible with the small amount of development money left do not achieve much individual impact. This goes some way to explain why, despite significant year on year increases in resources in overall terms, the HPSS is still seen to struggle to cope with the demands placed on it.

Conclusion

In general terms, therefore, the picture of the HPSS is one of heavy pressure and a number of difficult problems which need to be addressed. Progress has been made in a number of these areas and the perception amongst the politicians and the public of a Service in crisis is not always accurate. However, the reality is still that, while the HPSS is providing essential services across the board to the community, it is falling short on the quality of service it can offer to the public. It has not been possible to meet all of the demands from the public and the worst manifestations of this shortfall have been the lengthy waiting lists for inpatient and outpatient services, the trolley waits in A&E Departments, the inability to provide new drug therapies to all patients who need them or would benefit from them, and the shortfall in community social services to vulnerable people and to children.

Lessons can undoubtedly be learned from other parts of the UK and it is hoped that the Review will provide some new insights and recommendations for action to address the problems. There is also a question of resources - the issues which must be addressed are intimately linked to funding and any consideration of the way forward for the future must inevitably offer some observations on the resource question. DHSSPS will cooperate fully in the work which will flow from the Review.

ANNEX A

UNFUNDED PRESSURES ON HPSS

1.	Additional Medical, Nursing, etc Staff	£101m
	- 300 Consultants x £100k	
	- 250 GPs x £85k	
	- 1000 Nurses x £25k	
	- 500 Social Workers x £30k	
	- 400 AHPs x £25k	
2.	Life Saving Interventions	£15m
	- Cancer Services, Renal, Cardiology, ICU/HDU, etc	
	(NB. This figure excludes clinical staff and drugs costs)	
3.	Drugs	£30m
	- Cancer £8.5m	
	- Anti-TNF, MS £16.5m	
	- Other £5.0m	
4.	Community Care	£30m
	- 1500 Care Packages	
	- Day Care	
	- Fees	
5.	Primary Care	£15m
	CTCCs, Community Pharmacy, Enhanced Services	
6.	Waiting Lists	£30m
	External Providers, New Projects, Community Services	
7.	Childrens Services	£50m
	- Care Packages	
	- Residential Places	
	- CAMHS	
	- Child Protection	
	- Fostering	
8.	Mental Health and Learning Disability	£100m
	Bamford Review Implementation	
9.	Public Health	£10m
10.	ICT Programme (Revenue)	£35m
	TOTAL	<u>£416m</u>
11.	PPP Annual Unitary Payments (Projected)	£125m
	OVERALL TOTAL	<u>£541m</u>