SYSTEMS, NOT STRUCTURES:

CHANGING HEALTH & SOCIAL CARE

Executive Summary

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The Panel would also like to record their gratitude to the many organisations and individuals from across the HSC who gave their time and expertise to informing this work. The report would not have been possible without their involvement.

Introduction

The Northern Ireland Executive invests annually almost £4.6 billion, or 46% of its entire budget, in providing health and social care services for the people of Northern Ireland. If costs rise as predicted, with a 6% budget increase required annually simply to stand still, then we can expect the budgetary requirement to double to more than £9 billion by 2026/27 to maintain the current system. This is clearly not sustainable given the many other public services needed by the Northern Ireland population, many of which also have a significant impact on health and well being by providing employment, education, good housing, and a safe society.

While the need for financial sustainability is indisputable, it is far from the only reason a new service model is required. Generally, people in Northern Ireland are living longer, and with increasingly complex needs that require more support from health and social care services. The health and social care system here (the HSC) is currently unable to meet these needs in a responsive way and maintaining the current configuration of services is tying up resources in the acute sector which would have a greater impact if they were invested in primary and social care.

Moreover, there are still striking health inequalities across Northern Ireland and reducing these in a systematic way will require more investment in the prevention of ill-health and promotion of good health and wellbeing needs. Long term solutions will therefore require a fundamental reshaping of HSC service delivery to put in place a new model of care designed to meet the needs and challenges of today and this century.

Furthermore, the trends in healthcare towards a more personalised, preventative, participative, and predictive model of care will not happen at the necessary speed in the present fragmented and reactive model of care. All four of these essential trends require integrated care and effective system leadership as a precondition.

The stark options facing the HSC system are either to resist change and see services deteriorate to the point of collapse over time, or to embrace transformation and work to create a modern, sustainable service that is properly equipped to help people stay as healthy as possible and to provide them with the right type of care when they need it.

It is likely that additional resources will be required to deliver this transformation. However, if new funding is made available, the system must try to find the right balance between investing in strategic transformation and day to day fire fighting.

This report presents an opportunity for transformation that must be seized and acted upon.

The Burning Platform – An Unassailable Case for Change

The Expert Panel was tasked with producing proposals to remodel the HSC in order to deliver safe, high quality and sustainable services for the population of Northern Ireland.

As a first step in setting about its task the Panel examined the wider socio-economic environment, in which the HSC exists, and the internal dynamics within the health and care system. This examination has been necessary in order to understand the demographic changes of the past 25 years in wider society that are impacting on health and social care and the key underlying features of today's HSC, all of which have rendered the current model of service delivery unsustainable.

By identifying these changes in society and the key features prevalent within the current HSC model, we have attempted to articulate the challenges and opportunities which the proposed new model will address. These are summarised as follows and explored in more depth in the full report:

Demographic Change

- Society has changed dramatically. Patients' needs have changed. Yet the HSC overall still offers broadly the same reactive, acute-centred model as it has provided since the second half of the 20th Century.

Rising Demand

- Demand for health and social care services is increasing and will continue to increase. The system is currently not meeting this demand.

- People in Northern Ireland are disproportionately high users of urgent care, perhaps due to the absence or lack of awareness of alternatives. The emergency and urgent care services in primary, community and secondary care are struggling to meet demand.

- There are too many people in hospital beds who are no longer acutely unwell, but for whom the next step in their care is delayed or is not meeting their needs and choices.

Health Inequalities

- While overall population health has improved, there are still significant health inequalities in the most deprived areas. Less money is spent overall on health and social care in the most deprived areas.

- Waiting lists are the highest in the UK and there are significant pressures in primary care, social care and in emergency departments.
- Expensive new technologies – treatments, medication and therapies – which are proven to be effective, and which are provided in other jurisdictions, cannot be funded here.

Workforce

- A large section of the workforce, clinical and non-clinical, feels disempowered and not properly supported to do their jobs to their full capacity.
- Innovation and quality improvement are subordinate to daily fire fighting and crisis management.
- The current acute model relies heavily on expensive locum and agency staff. The medical workforce can no longer provide the level of 24/7 care required to safely deliver the existing configuration of hospital and primary care. Many services are vulnerable and are struggling to recruit and retain staff. Some of these are very close to collapse.
- The workforce is still fragmented in silos and divided by administrative and professional boundaries.
- There is significant untapped potential in the community and voluntary sectors.

Financial Sustainability

- The system is funded as well as other parts of the NHS, but waiting times for access to urgent and planned hospital care are significantly longer.
- Current service provision and commissioning is overly transactional, based on historical patterns and not on assessed population need. Services are not always planned around patients' needs but rather on filling rotas and maintaining unsustainable models.

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The Panel's Vision – A New Model for Health and Social Care

The burning platform illustrates the challenges the system is currently, and will continue, to face if it does not transform. It is clear that the current model, even if optimally managed, will not be enough to meet future demand.

This will require whole system transformation, involving significant cultural and operational reform. As part of this, it will be necessary to rationalise some, more specialist, services in order to free up resources and invest them more effectively in new delivery models. This is one component of transformation, but the most meaningful, and the most difficult, change will involve moving to a more patient centred, population health model, delivered at a sustainable cost.

The Triple Aim

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The Triple Aim is a well known, internationally recognised framework that is already being used to guide some innovative projects in Northern Ireland. It is characterised by a focus on three objectives:

1. Improving the patient experience of care (including quality and satisfaction);
2. Improving the health of populations; and,
3. Achieving better value by reducing the per capita cost of health care.

The Triple Aim provides a strong focus on optimising these three dimensions equally and is a useful structure for reform.

Given the intrinsic importance of the front line workforce in any transformational change, the panel recommends including a fourth dimension (sometimes called the quadruple aim) based on improving the work life of those who deliver care.

RECOMMENDATION 1

The Panel recommends using the dimensions of the Triple Aim as a framework for reform, including an increased emphasis on the experience of those who deliver care.

Advancing Towards a Local Accountable Care System

The present model of care in Northern Ireland is not delivered on a population agenda. It is struggling to provide continuity of care in an organised way and the organisations delivering it are still operating in silos. There is a need to move away from hospital centred care to a more integrated model.

At a provider level, changes are already being carried out to achieve the size and scale required to better manage and change the current demand for services. GPs are organising themselves into Federations, Trusts are networking across boundaries and there is increased partnership with the community, voluntary and independent sectors. However, this is happening without clear strategic direction, and under outdated contract models and output targets.

This report proposes developing Accountable Care Systems (ACS) to integrate – by agreement rather than by creating new organisations – the provider sector to take collective responsibility. Accountable Care Systems would also provide a structure for better patient engagement, empowering people to become active participants in their own care.

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There are key decisions to be taken and preparatory work to be carried out on the size of the population these systems will serve, their new governance arrangements, support tools they will need, how they will engage with the public, and new cost and quality measures that are measurable, comparable and outcome based.

Under an ACS, providers would collectively be held accountable – under a shared leadership model – for achieving a set of pre-agreed quality outcomes within a given budget or expenditure target, with agreed risk share arrangements and incentives. They would also need to have maximum autonomy to make rapid and sustained changes to improve care and outcomes for the population they serve.

Of course, not all services will be amenable to this model. Some services are so specialist that they must be delivered at a Northern Ireland level. These will require a different commissioning or provider model – set at a regional level – to ensure specialised resources are concentrated on a small number of high volume sites.

RECOMMENDATION 2

The Panel recommends that the HSC should move to:

- Formally invest, empower and build capacity in networks of existing health and social care providers (such as Integrated Care Partnerships and the developing GP Federations) to move towards a model based on Accountable Care Systems for defined population based planning and service delivery; and,

- Regionalised planning for specialist services.

Building on Existing Foundations

Northern Ireland already has many of the key buildings blocks to move forwards on this agenda, perhaps more so than many other places around the world. For example, Integrated Care Partnerships and the majority of GP Federations are already in place, but these building blocks need to be taken to the next level and be fully enabled with devolved autonomy and incentivising funding mechanisms linked to measurable population outcomes.

There has been a great deal of work taken forward which can be developed further to progress this agenda. Key aspects for development include:

- Adding depth to structural integration of health and social care;
- Expanding and investing in eHealth infrastructure;
- Developing the workforce;
- Preventing ill-health;
- Improving quality and encouraging frontline innovation;
- Health and the wider economy

Emerging Processes

There is a shift in other countries from activity based commissioning, paying for activity, to commissioning for value. A value based model in Northern Ireland would need to reinforce an integrated primary and community health and social care delivery model so that more can be done outside the acute setting,

encouraging work across organisational boundaries, as well as a strengthened primary care sector in order to effect a shift in the balance of care.

Finally, there is also now an increasing acceptance that people who use health and social care services will have views on how they should be treated as individuals and as groups. It is now recognised that people should be treated with respect and their views must be acknowledged. Major changes to services should be consulted upon and developed with users. Co-production involves breaking down barriers between professionals and the people they serve, recognising people who use services as assets with unique skills.

The expertise in these areas is rapidly growing and Northern Ireland could develop real capability if it chooses to adopt these approaches as part of reform.

RECOMMENDATION 3

The Panel recommends that the HSC should continue its positive work to invest in and develop the areas listed above.

There should be particular focus on the three key areas of workforce, eHealth and integration:

- As a key enabler of Accountable Care Systems, the HSC should continue to invest in eHealth to support improved self management, care at home and use of information to drive better population health outcomes.
- The HSC should immediately develop innovative primary care based models that will allow non-medical staff to work in a way that makes the most of their skills. (For example, these could be based on the community nurse-led care models being implemented in the Netherlands, or the use of pharmacists in community development here in Northern Ireland).
- Work should be carried out to identify which social interventions are most cost effective in addressing the social needs and improving health for Northern Ireland.
- Any new approach to commissioning should be aligned with the need to build integrated health and social organisations on the ground which target specific inequalities and social groups.

Roadmap for Implementation

Transforming the HSC is an enormous and complex task that will need to be progressed steadily over at least the next ten years.

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These reforms must become the strategy for health and social care and this will need to be led and articulated at the highest level.

RECOMMENDATION 4

The Minister should create, communicate and lead a clear, powerful, long term vision for the Health and Social Care system as a first step in the implementation process.

These reforms must become the strategy for health and social care

Components of Transformation

The Panel has identified three separate components for practical implementation:

1. Driving the system towards Accountable Care Systems
2. Aggressively scale up good practice
3. Rationalisation and stabilisation

These have different life spans, but they are all urgent, they are all connected, and they should all be launched simultaneously.

Driving the System Towards Accountable Care Systems

This is a mid-term agenda, but it must start now. If health system transformation is going to succeed, it will require supportive polices that incorporate longer time horizons, alongside regular milestones to build confidence in the direction of travel.

The HSC has the potential to harness the strengths of different parts of the system, across organisational silos, across sectors and beyond what is traditionally considered to be the health and care sector. However this transformation will need to be conceived and implemented as an integrated package. The panel therefore proposes a series of time bound actions linked to the dimensions of the Triple Aim framework and an additional dimension focused on the Health and Care professional's experience.

RECOMMENDATION 5

Alongside the Minister's vision for health and social care, the Panel recommends that plans, costs and timescales for introducing each of the following actions should be prepared within the next 12 months. It is vital that the implementation of these actions is led by health and care professionals and managers.

Population Health

- Some work on risk stratification has already been carried out at General Practice level. This should be built on to introduce a comprehensive, system wide approach to risk stratification in of the entire NI population.

- Governance arrangements to be developed for new ACS models, including integrated capitation budgets based on the services (excluding the most specialised services) required by the population served by the ACS to be devolved to these new autonomous and accountable provider partnerships.

- Starting immediately, progressively phase in early adopter accountable care systems, bringing together the provider sectors for a defined population into a single accountable leadership. The ACS would be responsible for utilising a capitation based budget across organisational and professional boundaries including local infrastructure to achieve agreed improvements in population outcomes.

- The Programme for Government is moving towards outcome based measures to judge the impact of political decisions and the use of public funding on the population. The success measures for new ACS models should also be outcome focused, and should be measures of population health with priorities for improvement. The Panel recommends the development of a relatively small set of outcome based metrics.

Patient Experience of Care

- The use of co-production as an approach should be mandated in accountable care systems and service redesign.

- Provide the population with individual access to their health and social care information.

Per Capita Cost

- Introduce new cost and quality measures which are measurable, comparable and outcome based.
- Start the process of paying for value and not only paying for activity. By the year 2020, 50% of the budget should be commissioning value.
- As new value based commissioning approaches are implemented and local integrated organisations take form, ensure that the metrics being used include combined social and health indicators.
- Move to a rolling three year budget cycle to allow for more strategic commissioning/planning of services.

Staff Experience

- The Department to lead on the development of an 8-10 year workforce strategic framework, aimed at identifying immediate workforce challenges and planning the workforce to meet the demands of the new delivery model.
- New workforce models to be designed around defined populations and associated care functions. This should include enhanced roles for the skilled but not qualified workforce.

RECOMMENDATION 6

Many of these recommendations will require additional, transitional funding. The Panel recommends that the Minister should establish a ring fenced transformation fund to ensure this process is appropriately resourced.

RECOMMENDATION 7

For this purpose, the panel recommends the creation of a transformation board, supported by the Department, linked to the Executive's health and well-being strategy.

- This board would set the mid-term strategy, oversee the transformation process and would be tasked with creating the right conditions for the local system of care to develop successfully.
- It should help to transform organisational structures and management processes by promoting local decision making, local innovation and scaling up of best practices among the local systems of care.

Aggressively Scale up Good Practice

Northern Ireland has many examples of good practice that are consistent with a move to accountable care systems. Many of these could simply be scaled up and implemented on a regional basis where they will drive the system change and improved population outcomes set out in this report. Some examples of these are set out in more detail in the body of this report. The process of scaling up must however be a managed process.

RECOMMENDATION 8

The system should identify and scale up at least two innovative projects per year where there is clear evidence of improved outcomes for patients or service users.

RECOMMENDATION 9

The Panel recommends that the Minister should adopt a continuous improvement methodology to support the reform of health care towards local systems of care.

To make this actionable, it is necessary to continue with plans to create stronger quality improvement systems. While the exact remit for this will need to be decided by the Minister, the Panel feels that it should be locally owned and tasked with providing support and intelligence to enable new projects at the provider level.

Rationalisation and Stabilisation

There is clear and unambiguous evidence to show that specialised procedures concentrated on a smaller number of sites and dealing with a higher volume of patients, will improve outcomes. Due to the key importance of rationalisation in freeing up resources for transformation, the rationalisation agenda is dealt with separately in the next section.

The significant rises in waiting lists and waiting times in the past year have received significant media coverage. While clinicians and managers have made every effort to ensure that the clinical impact on patients has been kept to a minimum, it is clear that this mismatch between demand and capacity has had a negative impact on the public's confidence in the HSC. Stabilisation will require significant improvements in performance with regard to waiting lists and waiting times. This is necessary to regain public confidence in the system.

RECOMMENDATION 10

The Panel recommends that the Minister takes steps to address elective care performance. However, while this is important, it should not be allowed to overshadow the need for long term transformation.

Leadership for Implementation/Organisational Culture

Changes such as these are not easy to pull off. They will require political, managerial and clinical leadership to come together to ensure that the case for change is fully evidenced, efficiently implemented and effectively communicated.

The model of care proposed for the future in this report will require a new form of system leadership in order to achieve integration of care and true networking among delivery organisations. Top-down command and control will not accomplish this and it will fail to exploit the energy in the organisation. The changes required by the Triple Aim approach will be more successful if they are implemented in a setting which encourages clinician and health professional engagement. Change is everybody's business.

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RECOMMENDATION 11

The Panel recommends that at the strategic leadership level, the HSC should:

- Foster new system leaders by protecting and empowering clinical leaders who take on leadership roles.
- Analyse and eliminate regulatory obstacles which may get in the way of implementing the new networked local health and social care organisations.
- Take the formal decision to empower leadership close to the front line.

Starting the Conversation

If we are to fully support transformation, as well as reconfiguration of services, there is a potential to fully engage with our staff, partners and the public. The new "social movement" approach, currently being adopted in the NHS, provides helpful context.

These new approaches, often underpinned by social media, can act as catalysts for discussion and a way of mobilising communities and individuals to become more involved in the way health and social care is delivered. They offer greater connectivity with voices that might otherwise be hard to reach, opportunities for collaboration, thought diversity, and a culture of openness.

RECOMMENDATION 12

The Panel recommends that the HSC should consider whether there needs to be a platform for a more open and immediate conversation with staff and service users.

Rationalisation

If the model proposed in this report is to be successfully implemented, then it is inevitable that the way services are currently provided will need to change. The evidence contained in the burning platform shows the clear impact of inaction. Furthermore, changing these services is not optional; it is inevitable. The choice is not whether to keep services as they are or change to a new model. Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis.

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Focusing resources on specialist sites means that:

- Patients are seen in the right place and by the right person as soon as possible. Evidence shows that having all the services available on the same site improves the care delivered to the patient and the clinical outcomes;
- Staff have the necessary support and equipment to allow them to deliver the highest quality care to patients;
- It is possible to attract and recruit sufficient staff to deliver a safe, high quality, 24/7 service;
- The services are more stable and there is a better environment for patients and staff;
- There are the right conditions for professional development, quality improvement, leadership, teaching and other activities that are essential to a vibrant workforce expert in delivering care to acutely unwell patients;
- There is capacity for research and a greater ability to engage with academia and industry in generating new solutions and accelerating testing, adoption and introduction of existing solutions; and,
- This achieves the Triple Aim of better population health, better quality care and better use of resources.

However, it is not appropriate for this report to dictate to people in different parts of Northern Ireland what services they should and should not expect to be located in their area or local hospital.

Furthermore, in the course of the many meetings, seminars, events and visits that the Panel has held and attended, it has become clear that clinicians and managers here already have a strong vision of what needs to be done to make services sustainable. The difficulty does not lie in deciding what needs to be done. The difficulty lies in doing it.

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This panel has developed a set of criteria for assessing the sustainability of services. We believe that those taking the decisions on the sustainability of a service should apply the following criteria:

- There is evidence that the outcomes for patients using these services are below acceptable levels either in the services as a whole or in particular hospitals, or where there are safety concerns.
- There is a clear clinical pathway for the patient population. Co-created with patient groups.
- The service cannot meet professional standards or minimum volumes of activity needed to maintain expertise.
- The permanent workforce required to safely and sustainably deliver the service is not available/cannot be recruited or retained, or can only be secured with high levels of expensive agency/locum staff.
- The training of Junior Doctors cannot be provided to acceptable levels.
- There is an effective alternative 'out of hospital' care model or an alternative 'shared care' delivery model.
- The delivery of the service is costing significantly more than that of peers or of alternative 'out of hospital' alternatives due to a combination of the above factors.

The Panel has developed a list of specialties that should be prioritised for review and this should be worked through systematically from this point.

RECOMMENDATION 13

The Panel recommends that the Department should formally endorse the criteria and apply them to five services each year to set out the future configuration of services to be commissioned (or not) from the Accountable Care Systems.

If applying the criteria leads to the conclusion that the service is vulnerable, plans for reconfiguration should be developed and actioned within this twelve month period.

RECOMMENDATION 14

The Panel recommends the identification of a senior leader to lead this process at a regional level.

This process should be collaborative and inclusive and based on the criteria above.

Finally, if these difficult decisions are going to be made, they must be taken and supported by leaders at all levels of the HSC.

This can only work if every part of the system is moving in the same direction and working towards a common goal. Clinicians must identify the evidence for change, managers must ensure that the correct processes are followed, and the Minister, supported by the Executive, must act quickly to take the final decision. All three groups will need to be prepared to defend the decision publicly and openly, and to honestly communicate the need for change with local politicians, the public and individual service users.

Conclusion

There is one overriding message that the Panel has taken away from the many interactions we have had with those working within or in partnership with the system; the HSC and its staff are ready and willing to embrace the transformational change required to deliver not just sustainable services, but services that are world leading in terms of improved health outcomes and better experiences for those receiving, using and delivering services.

We should be under no illusions that transformation will be anything other than a long and difficult road. These reforms are ambitious, and they need to be ambitious. The Panel has no doubt that Northern Ireland has both the people and the energy to deliver a world class health and care system. There is no better time to start than now.

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