Uncertain times

Northern Ireland has integrated health and social care, but it also has the longest waiting lists and significant financial pressures. Seamus Ward looks at how the service is addressing these issues

Looking from the outside at Northern Ireland's health and social care (HSC) services, healthcare managers from elsewhere in the UK must be confused. Across the six counties health and social care has been integrated since 1973 and health is a devolved matter, allowing decisions to be based on local priorities. Spending per head is higher than the rest of the UK and accounts for nearly 50% of the local executive's budget. So why does Northern Ireland have the longest waiting lists and significant financial problems?

The answer is, in part, uncertainty. Since 2011, there have been four major reviews of the structure and delivery of services, met with widespread agreement, but virtually all their recommendations have yet to be implemented. Regular ministerial changes have meant proposals have been set aside, not formally abandoned but left in the pending queue, as each new politician stamps their own imprint on the health and social care brief.

The recent collapse of the power-sharing executive and subsequent election has created further uncertainty. As *Healthcare Finance* went to press, no agreement on a new executive had been reached, with health and other parts of the public sector entering the new financial year without a budget.

To address this, civil servants at the finance department could access up to 75% of the 2016/17 budget and decide how it is allocated. If no agreement is made by the end of July, this sum could rise to 95%.

However, there is a suggestion that legislation could be needed in Westminster for funds to flow to Northern Ireland public services. Either way, there is concern that, at least initially, services face cuts.

Besides the budget, a new minister's in-tray will be topped by a report from a team led by Spanish health systems expert Rafael Bengoa, and the response from former health minister Michelle O'Neill, which broadly accepted the Bengoa vision. These set out a case for a transformed and reconfigured service, with more care provided in the community and the creation of elective care centres and assessment and treatment centres.

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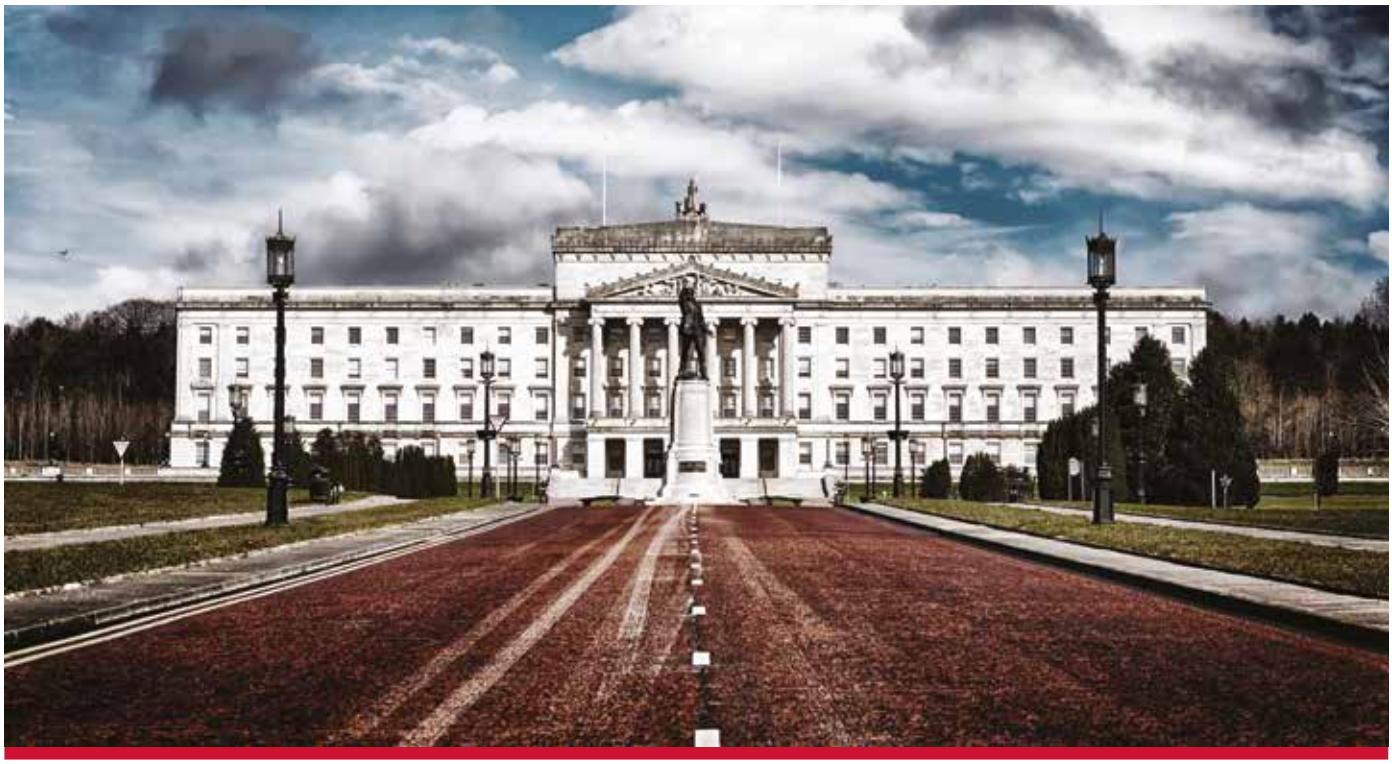
Bengoa set out many of the issues facing Northern Ireland – an ageing population, with rising demand and more chronic illness. It said if costs rise as predicted, a 6% budget increase would be required each year simply to stand still. By 2026/27, this would mean a budget of more than £9bn (currently £5bn) would be needed to maintain the current system.

This system, with its reliance on hospital-based care, had created problems. The report said: '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.'

The report recommended the HSC take the triple-aim approach – improving population



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health, patient experience and value. It said new cost control measures should be implemented, which are 'measurable, comparable and outcomes based', while the process of paying for value, not just activity, should be started. It said that by 2020, 50% of the budget should be linked to value.

Implementing Bengoa would mean moving more care out of hospitals, with services being provided across organisational and professional boundaries, complemented by strengthened primary care. An earlier review had pointed out that, elsewhere in the UK, a population of 1.8 million would be served by four acute hospitals – Northern Ireland has 10. A consultation on the criteria for reconfiguration closed in February.

Managers welcomed the Bengoa approach and many feel the integration of health and social care provides a solid foundation for reconfiguration and transformation of services.

Political pressure

The knock-on effects of the political process are frustrating – without a budget and a minister, health and social care bodies cannot press ahead at pace to implement the Bengoa reforms, according to Heather Moorhead, director of the Northern Ireland Confederation for Health and Social Care (NICON).

'A new minister might change the branding, but we are hoping that there will be no change in the direction of travel, as the current policy has been widely politically agreed,' she says.

'But we will also need the underpinning finances to deliver the transformation. We need to make changes at pace and scale, but the context is not helpful.'

Health and social care have been integrated since 1973, though managers accept that silo working remained entrenched for years. However, the advent of trusts in the mid-1990s saw some of the barriers between health and social care break down.

'I think the biggest benefit of integration for us is that we have been able to move money between health and social care, and therefore, unlike England, we have not seen the big additional pressure on the NHS from reducing council budgets,' says Ms Moorhead.

'However, we have not done as much as we could to integrate services. There has been a good deal of work recently to develop this agenda, shaping services better to support people at home and in their communities.'

The Bengoa reforms will add impetus to this work within a new structure, Ms Moorhead adds. 'Integration must be part of the transformation agenda to improve the efficiency and quality of services.'

HFMA Northern Ireland Branch chair Owen Harkin, who is finance director at the Northern Health and Social Care Trust, says making the most of integration has been a gradual process – particularly with the challenges faced by the HSC in terms of workload, capacity and the ageing population. 'We are all working towards breaking down the barriers even further. In my own trust, for example, we focus on community staff involvement at the front door and in the flow team within the hospital thus enabling our community colleagues to put in place responsive and appropriate packages for patients as they leave hospital.'

For the Northern trust this means greater day-to-day involvement of community care professionals in decisions on discharge. The trust has also restructured, with its six divisions reporting to a single deputy chief executive/director of operations. It also has four localities, aligned with primary care, serving its 450,000 population, each with further local teams to deliver more responsive services.

'We think this is beginning to pay dividends for us. Our community staff, have day-to-day involvement in making sure flow of patients and discharge run smoothly,' he says.

Given the direction of travel on care delivery, Mr Harkin agrees it is vital to strengthen community services. He adds that the trust's reform and modernisation plan (RAMP) is compliant with the Bengoa principles.

He highlights the funding of domiciliary care as a key difference with the English system. Over the past few years an additional £15m to £20m a year has been put into community care across Northern Ireland, despite the pressures in the system with financial shortfalls and long elective waits.

'As an integrated provider of services, and given the Northern trust has the highest proportion of older people in the region, it was important to continue to invest in community services as well as maintain acute flow.'

Generally, more than 50% of domiciliary care providers are in the private sector, where costs are rising. Some trusts are retendering domiciliary care, looking at whether the current payment model is appropriate.

The question, Mr Harkin says, is whether they should be paid for the amount of time carers spend going into clients' homes or on the basis of outcomes.

'Should we be paying them by outcomes – maintaining somebody at home or stopping them going to the ED regularly? We are considering innovative pilot projects to inform

Fact file

- **Population** 1.8 million, projected to rise to 1.9 million by 2024 – while the number of over-65s are expected to increase by 26%, the working age population will rise by less than 1%
- **Waiting times** At December 2016 there were just over 246,000 patients waiting for a first outpatient appointment, including 47,000 for more than a year
- **HSC budget** £5bn, about 46% of the NI executive budget. Health spend is £2,500 per head (£2,000 in England, £2,400 in Scotland and £2,000 Wales)
- **Structure** Five health and social care trusts, providing a wide range of acute, mental health, community and social care services. There is one ambulance trust and one centralised commissioning body, which is slated for abolition with its functions transferred to trusts and the Department of Health

this with a view to developing a more robust model going forward.'

Some areas have too few nursing home places. The Causeway coast area, part of Mr Harkin's patch, has the oldest population in Northern Ireland and a shortage of places, so the trust is considering how it can engage and stimulate the market to respond to need.

The ageing population is just one of the factors putting financial pressure on the HSC. For the past few years it has relied on additional in-year allocations from the executive and non-recurrent measures to balance its books.

Vision for the future

The health minister in the last Assembly government, Michelle O'Neill, highlighted the impact of not addressing the issues when launching her vision for the future. She said: 'The reality is the current model is unsustainable. If we continue to provide services in the same way, using current models of care, demand projections show that ten years from now the HSC will need 90% of the entire executive budget.'

One finance manager says: 'Regionally, we have achieved breakeven over recent years using a range of non-recurrent measures such as slippage on development, technical adjustments and non-recurrent funding in the face of a reducing ability to secure recurrent efficiency savings. The financial challenge is therefore going to continue to grow. In this difficult financial environment it would, however, be important to maintain allegiance to the Bengoa principles to ensure that the health and social care model for the region is as viable and sustainable as possible.'

Attracting and retaining the support of primary care clinicians will be vital to implementing Bengoa, but this sector has its own problems. Many GPs are due to retire in the next five years. And recently, GPs have issued undated resignation letters due to concerns over funding and pressures on the workforce. Some of this is the result of the lack of an agreed budget, and finance managers believe it is important that a strategy, including primary care, is agreed at the earliest opportunity.

Another finance manager, who asked not to be named, adds: 'We need about 6% savings year-on-year but are getting nowhere near that. We are muddling through with non-recurrent measures, but we can't do that much longer.'

Ms Moorhead says the requirement to break even each year has meant that waiting lists have slipped.

NICON members are critical of the year-end balance requirement, which they say leads to a conservative approach to spending in the first three quarters of the year, followed by a rush to spend the remaining funds in the final quarter.

Bengoa recommended moving to a rolling three-year budget cycle to allow more strategic commissioning and planning of services.

A reliance on agency staff adds to financial pressures. Some smaller, more geographically isolated, hospitals have problems attracting enough medical staff, particularly in emergency medicine, paediatrics and acute care of the elderly. With fewer staff, on call rotas can be more onerous than in larger hospitals. As in other parts of the UK, difficulty attracting and retaining staff has led to a reliance on locums, ramping up staff costs and leading to quality and sustainability doubts.

There is also an issue with junior doctors, with most wanting to train in Belfast, as they believe they will get better training. But as a consequence, hospitals outside the capital can be left short staffed. As in other parts of the UK, the difficulty attracting and retaining staff has led to a reliance on locums, ramping up staff costs and putting question marks over safety and quality.

Yet finance managers contacted by *Healthcare Finance* believe that with the North's relatively small size and good road network, hospitals should be able to collaborate to provide cover. 'We are small enough, so I would like to think that we can address this in an innovative way by working together,' one says.

The UK's exit from the European Union is also a significant issue, with Northern Ireland having the only land border between the UK and an EU country. It throws up all kinds of questions about staffing – many members of staff live on one side of the border and work on the other side. Will their ability to move freely across the border continue? NICON's Ms Moorhead says that due to the uncertainty its members are already finding it difficult to recruit from EU member states.

Recent moves to create all-island or even regional cross-border services could also be threatened. For example, there is a cancer centre in the North West – based in Derry and covering the western counties of Northern Ireland as well as Donegal, the most northern county in the Republic – and specialist cardiac services in Dublin for patients from across the island. 'Members believe these have been very positive achievements, which colleagues would seek to build on,' she adds.

Northern Ireland has similar issues to the rest of the UK that it is seeking to address in similar ways. But with the outlook clouded by question marks over its political future and the undetermined impact of EU exit, uncertainty seems to be the only certainty.

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Owen Harkin, Northern HSC Trust