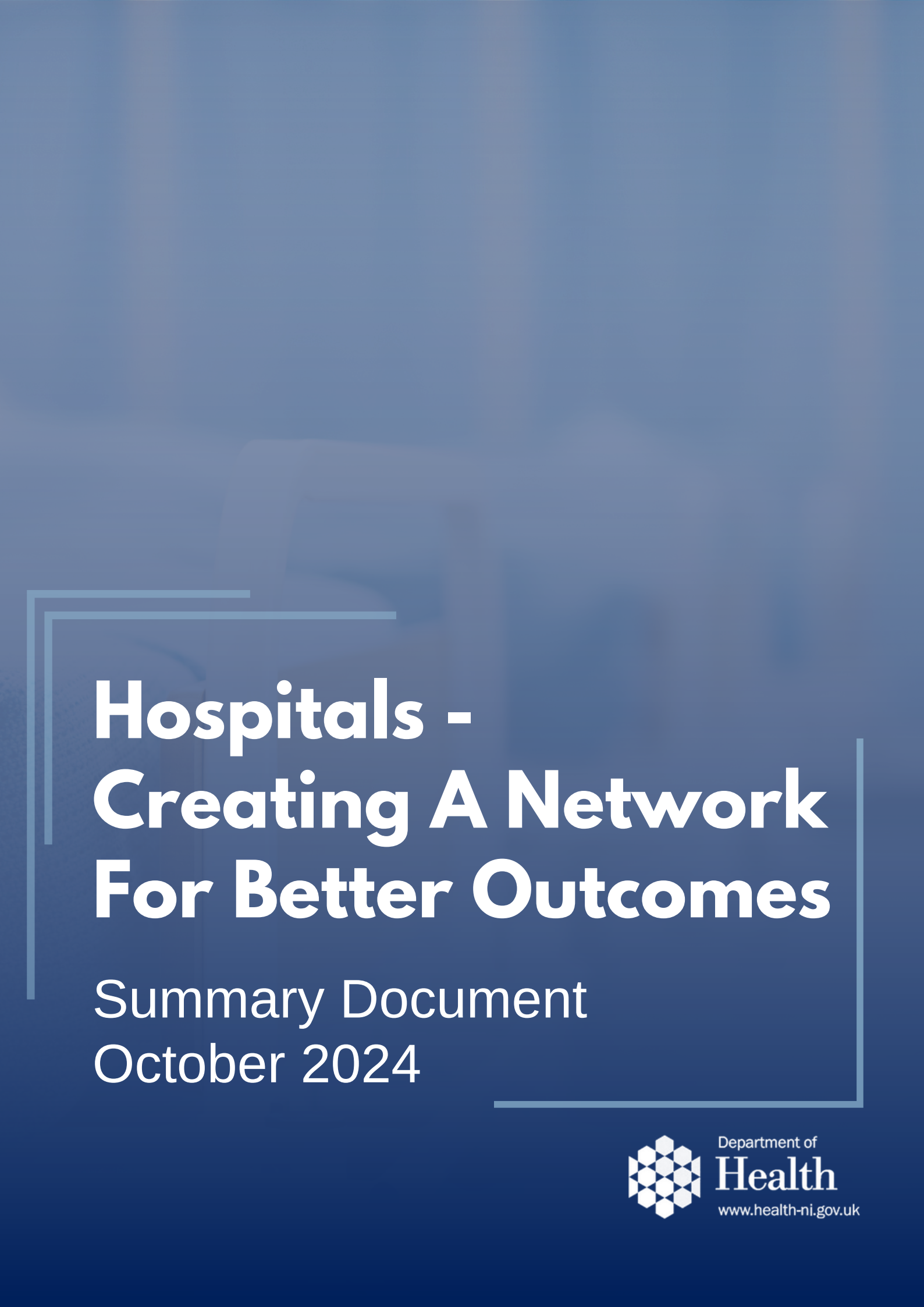

Hospitals - Creating A Network For Better Outcomes

Summary Document
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Department of Health
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1. Introduction

Our health system is on a journey and change is coming. Changes will be based on advances in health and social care and taking account of what the public and health professionals are telling us. The ambition, always, is delivering better outcomes for patients, service users and our wonderful and diverse healthcare workforce. Although health and social care practices have evolved over the decades, the regional infrastructure supporting these services has not kept pace. Balanced by what we can afford, we are committed to deliver for Northern Ireland's (NI) citizens the right treatment in the right place, at the right time. Delivering locally where possible in a person's home, through General Practitioner (GP) services, community pharmacy and centrally (accessible in only one place anywhere in Northern Ireland or limited sites) only where necessary, we aim to deliver safe, sustainable, high-quality health and social care services.

The purpose of this framework document is to support widespread engagement with communities, clinicians, and society as a whole on **Why** we need to reconfigure our Hospitals; **How** we will manage our hospital system as an integrated network; **What** pathways there are for citizens to access hospital services and how they can travel there; **Where** those services are and will be delivered; and **When** future service reviews will take place to inform future reconfiguration. This will become the basis and strategic context for current and future service reconfigurations.

To be successful reconfiguration must deliver:

- Safe and better health and social care services for our population, ensuring best practice becomes common practice across the HSC network.
- A reduction in health inequalities. This will mean that some citizens, depending on their clinical needs and the location of the service that meets those needs, may have to travel further to access quality care.
- More effective and efficient services which maximise productivity and make best use of available funding and our workforce.

- More financially sustainable health and social care services.
- A resilient service that is suitably resourced to keep patients safe, providing consistent good standards of care and reducing the risk that leads to a reduction in reactive safety-related service changes or collapses.

Whilst we recognise that a patient's health journey may span the entirety of the HSC system, this framework document is focused on our hospital system.

Acute Hospitals

This framework categorises hospitals in NI into four specific main types, operating as an integrated network. These types are:

- **Local Hospitals**, which is a diverse group delivering primary, secondary and community services in support of the area and general hospitals.
- **General Hospitals**, delivering defined secondary care services including unscheduled care, geared to a specific, more isolated geographical location. These hospitals also play an important part in the delivery of elective care to the region.
- **Area Hospitals**, delivering a full range of secondary care services, both unscheduled (un-planned) and elective (planned)treatment, to the communities within a geographical area currently defined by the distribution of integrated services delivered by our five geographic Health and Social Care Trusts (HSCTs).
- **Regional Centres**, delivering specialist regional inpatient services for the whole population of Northern Ireland.

For the purposes of clarity, these hospitals are named by category. Some hospitals by nature of their locality or range of services may appear in more than one category:

Local Hospitals: Ards Hospital, Bangor Hospital, Dalriada Hospital, Ballycastle, Downe Hospital Downpatrick, Lagan Valley Hospital Lisburn, Lurgan Hospital, Mid-Ulster Hospital Magherafelt, Moyle Hospital, Omagh Hospital and Primary Care Complex, Robinson Hospital, Ballymoney, South Tyrone Hospital Dungannon, Waterside Hospital Londonderry, Whiteabbey Hospital.

General Hospitals: Causeway Hospital, Daisy Hill Hospital, Southwest Acute Hospital.

Area Hospitals: Altnagelvin Hospital (including North West Cancer Centre a regional specialist service), Antrim Area Hospital, Craigavon Area Hospital, Belfast Hospitals Campus (includes Royal Victoria Hospital, Mater Infirmorium Hospital, Royal Jubilee Maternity Hospital and Royal Belfast Hospital for Sick Children. Given the number of hospitals in Belfast Trust that deliver regional and area services and the overlap of functions, it is more useful to describe an Area Campus of hospitals for the Belfast area) and Ulster Hospital Dundonald.

Regional Centres: Altnagelvin North West Cancer Centre, Belfast City Hospital including the Cancer Centre, Musgrave Park Hospital, Royal Belfast Hospital for Sick Children, Royal Jubilee Maternity hospital, Royal Victoria Hospital, Ulster Hospital Regional Centre for Plastic Surgery and Maxillofacial Surgery.

The Northern Ireland Hospital Network can only be sustained through collaboration. Provider collaboratives can work across a range of programmes of care and represent just one way that providers, such as our HSC Trusts, can collaborate to plan, deliver and reform services. By working effectively at scale, providers can properly address unwarranted variation and inequality in access, experience and outcomes across wider populations, improve resilience in smaller Trusts, and ensure that specialisation and consolidation of services occur where this will provide better outcomes and value.

A key aim of this framework is to identify the core services in each of these types of hospitals, consider the key challenges to sustainably deliver these and then develop an action plan and collaboration mechanisms to support this. This direction of travel means that all hospitals will not do all things. Importantly, this is not about cost cutting or closing hospitals, it is about ensuring effective use of HSC space and resources, managing changes in a controlled and sustained way. Furthermore, it must be recognised that when hospitals have lower patient numbers, this can create significant issues for professionals working in key specialties. These include rota/on-call pressures inherent in smaller clinical teams, as well as insufficient case mix to support specialisation, training and skill development. These issues inevitably have consequences for recruitment and retention.

2. Communication and Consultation

This framework aims to provide greater clarity and information on HSC reform and our integrated hospital network within the broader context of health and social care services. It serves as a platform for informed engagement with stakeholders (key people who have an interest) and an open dialogue with the public. This will facilitate active participation from communities, healthcare professionals, and society at large.

While this document sets out why change is necessary, the Department of Health wants to ensure that the voices of service users who are affected by that change continue to be reflected in the next phase of engagement and consultation. Personal and Public Involvement (PPI) offers a structured approach to engage and consult with service users and their unpaid carers, whose lives may be affected by changes in service delivery. While broader engagement encompasses a wide range of stakeholders, Northern Ireland's health and social care sector has a specific duty within its commitment to PPI, which focuses on service users and their unpaid carers. The PPI framework recognises the critical importance of involving service users and their unpaid carers in health and social care sector decision-making processes.

Throughout this process, there is ongoing opportunity to embed captured learning from the experiences of service users and carers shared through mechanisms such as the Patient Client Experience. This further ensures that all voices are heard and valued and leads to more responsive, patient-centered, and high-quality healthcare services that ultimately benefit all stakeholders. A key section of our community embraces people with direct and often long-term experience of using HSC services.

There are two main ways for making changes: (i) Regional NI wide review of services and (ii) Local individual HSC Trust changes which will require local consultations.

3. Why change is coming

Over the last few decades health and social care in Northern Ireland has changed a lot. Thanks to medical advances, people are living longer. While this is positive, it also means more people may face serious health issues as they age, which increases the demand for healthcare.

We need a health service that helps us stay well for as long as possible, and also helps us live with and manage conditions that do develop. For our hospitals to be able to treat the sickest patients, we will need to enhance both community-based and primary care services. Since 80% of health inequalities can be traced to socio-economic issues, physical environment and behaviours, a focus on reducing these gaps by addressing poverty and promoting healthy habits is essential. Making services more accessible by placing them in communities will help achieve these goals.

Behind every attendance and admission to hospital is an individual. Engagement with our citizens during the Review of Urgent and Emergency Care told us that a shift towards services being provided “out of hospital” within the community is what they want. At the same time, hospital-based medical care – also known as acute care – has advanced quickly, with clinicians becoming more specialised in their chosen areas of medicine and massive advances in technology making treatment more effective.

When hospitals have lower patient numbers, this can cause problems for professionals working in key specialties. These issues include pressures of rota/on-call in smaller clinical teams, and not having enough variety of cases to support specialisation, training and skill development. To address this, we need to develop regional Centres of Excellence or surgical hubs for some inpatient services, especially where the catchment area of our existing hospitals is too small to provide this. Regional Centres of Excellence, rather than small local services in every area, deliver better outcomes for both patients and clinicians. Clinicians are supported and empowered to develop their skills by seeing a good mix of patients and higher numbers of people through a regional centre. Patients benefit because they are seeing the experts with a lot of knowledge and experience who can therefore deliver the highest standards of treatment and care. That approach is necessary to ensure everyone, no matter where they live, can have access to the best possible care.

Myth Busting

Some myths have developed over the years about health reconfiguration and reform.

The first myth is that reform is about closing Acute Hospitals. Contrary to what is claimed, this is not the case. **The reality is that we will continue to need every square inch of current Acute Hospital capacity. The roles of some hospitals will change to better deliver the health needs of the community and keep pace with modern medicine, as well as contribute to regional delivery.** Services may be relocated in some cases from their existing locations, but all hospitals will continue to play a central and vital role in our health service and in their local communities.

Another common myth is that health reform is just about cutting costs. In some cases, reconfiguration will actually require significant additional investment. In other cases, it might help free up funding to allow critical investment; for example, with fewer hospital services overstretched across multiple locations, the need for agency and locum staff cover should reduce, supporting investment in the HSC workforce. While making the best possible use of available funding is clearly important, the overriding aim of reform is not simply to save money. It is about providing services that are both effective and deliver better outcomes and this is what must be at the heart of any consideration of reconfiguration.

Another recurring myth is that nothing has happened on the health reform front; that countless reports have “gathered dust on the shelves”. Of course, the pace of reform needs to quicken, but it should be recognised that a range of important service reviews and reform initiatives have been progressed. This is against a number of key challenges: the global pandemic; budget pressures; the gaps in workforce provision, in the context of increasing demand, due to a growing older population, for health and social care.

We are seeing significant change already taking place, aimed at improving capacity, quality and outcomes both for local communities and for patients regionally. Such changes include creating new day and overnight centres at some hospital sites in addition to rapid diagnostic centres and work to develop an Integrated Care System. Our elective care policy sets an important context for our hospital system. These Elective Care Centres are a means to increase productivity, efficiency and reliability of the service, and are expected to have a significant impact on the number of patients treated. Importantly, the deliberate

placing of Elective Care Centres can be an important means of stabilising and sustaining hospital sites, especially those that have relatively smaller patient populations.

This is reform in action, examples of excellent progress that have been made to improve and strengthen services but there is much more to do. This framework will demonstrate how a collaborative approach can better sustain our hospital network to the benefit of both those who use hospital services and those who work in our hospitals. This framework also sets a strategic direction for future service reconfigurations. It will, of course, be for the Health Minister to take final decisions on any new specific change of services or reconfiguration.

Challenges

It is considered that there are three key areas of challenge, which will need to be advanced in order to successfully deliver effective positive change and the framework proposes some key actions as follows:

- **Workforce** –actions to proactively address challenges in working across HSCT areas including issues around travel, clinical governance, recruitment, retention, inter-Trust competition, equity in the division of workloads across teams etc.
- **Transportation/Travel** (including ambulance services) – creation of a networked system of services necessitates thought around how both patients and staff move between those services and sites. In the 2023/24 Health Survey for Northern Ireland around four fifths (approximately 80%) of respondents indicated that if they needed a routine procedure or non-emergency operation they would be prepared to travel within Northern Ireland if it meant that waiting times would be reduced. As access to public services is broader than health, cross-departmental working alongside other key partners is essential to consider - for example, road infrastructure, public transport networks, and also access to adequate broadband and mobile communication in rural areas for remote access to services.
- **Patient pathways** – patient pathways or a person's route to treatment must be at the heart of system reconfiguration and discussed at the earliest possible opportunity. Pathways must be mapped with serious consideration given to

stakeholders required to ensure pathways work in a seamless way and in the end create a more efficient and effective outcome for both patients and staff.

Meeting these challenges is essential to delivery and can only be achieved by providers working together with a shared purpose.

Change Enablers

The hospital network and future reconfigurations will be supported by some key enablers:

I. **Workforce** – we need to train, recruit and retain sufficient staff of a quality and quantity to enable us to deliver better outcomes. We also need to ensure that our staff are fully bought in to any new service models that we seek to implement. We therefore commit to work with our Health and Social Care staff as we develop new models of care and implement these in any new locations across NI.

II. **Funding** – we have a responsibility to spend the Health and Social Care budget in the most effective way and that will be a key consideration in any reconfiguration decisions. We recognise that in some cases reconfiguration will require additional money to deliver. Importantly, budget constraint is not seen as an insurmountable obstacle to reconfiguration – instead tight budgets impact on the pace of change. We remain committed to delivering reform and will deliver as quickly as we can in the context of available budget and other resources.

III. **Communities and people** – we need to not only make the case for change. We need communities to support, embrace and enable that change – reform and reconfiguration cannot be done to, but must be done with, communities and service users. Importantly, this must also include supporting individuals when travelling to access health care, where this is appropriate.

IV. **Digital solutions** – we will endeavour to make best use of technology and digital solutions as we reform and reconfigure health and social care services. Improved service user experience and better patient outcomes must be at the heart of any digital innovation.

V. **Cross HSC Trust Working** – we recognise that to deliver effective reconfiguration we need to work across HSC Trust boundaries.

This will need cooperation across our HSC Trusts, coordination, new approaches to the commissioning of services and how we manage staff. Provider collaboratives may play an important role in achieving this and we will strive to turn best practice into common practice across the HSC system.

Proposed Actions

The actions identified in this framework document will need to be addressed in the context of the above enablers and in the light of the challenges and identified principles. The proposed actions have been summarised below:

Action 1: The Department will work with the NI Executive Departments to consider carefully the travel support available for our population.

Action 2: DoH to review 2007 Transport Strategy for Health and Social Care services in Northern Ireland.

Action 3: HSC Trusts to continue to consider how their Local Hospitals can best and most sustainably meet local population needs.

Action 4: Consideration to be given as to how in the short to medium term HSC Trusts can work in collaboration to maintain these core General Hospital services.

Action 5: Consideration to be given to designating Causeway as an Elective Care Centre.

Action 6: Consideration to be given as to the most sustainable allocation of resources across Area Hospitals to minimise inequities in access to services.

Action 7: Consideration to be given to moving suitable activity out of Specialist Regional Centres into Area Hospitals.

Action 8: Consider approach to clinical training to ensure that job roles best match current and future population health needs.

Action 9: Consider how the allocation of doctor training places and development of new roles such as advance practice roles can best support service sustainability across the hospital network.

Action 10: Continue with a rolling programme of speciality specific workforce reviews, to encompass all skill mix roles.

Action 11: Review regional specialist services and identify those most vulnerable. Consider how vulnerabilities can be mitigated, for example through strengthening links with GB or ROI colleagues.

Action 12: Define a suitable level of protected bed base, diagnostic and theatre capacity for regional specialist services.
Action 13: DoH to explore with HSC Trusts and NICON how provider collaboration might help to support and sustain the Hospital Network.

We intend to refine these actions based on feedback from the public consultation.

4. Conclusion

In conclusion, the health needs of our population are constantly evolving. We therefore also need a dynamic approach to maintaining our health and social care services, including our hospital network. Importantly, sustaining our hospital network and moving increasingly to a model with Centres of Excellence is better for our population because:

- It provides certainty that all our Acute Hospitals will remain open within the context of current population health need.
- It ensures that our population will have timely access to the best possible safe Health and Social Care services based on the principle that services are delivered locally where possible and regionally where necessary.
- It ensures that our individual Acute Hospitals and entire network remains sustainable and best able to meet population health needs.

However, we recognise that transport to some locations can be a major issue and as part of the actions we commit to working alongside other government departments to consider travel support for those that need it the most. The core hospital services and commitments set out within this framework will be closely monitored both to ensure that they are appropriate within the context of changing population health needs, but also within the context of evolving out-of-hospital services.