

# DEVELOPING BETTER SERVICES – MODERNISING HOSPITALS AND REFORMING STRUCTURES

## INTRODUCTION

1. The Southern Health and Social Services Council was established as an independent statutory body in 1991. The Council has a statutory remit to represent the views and interests of consumers of health and social services in the Southern Board's area; to keep under review the work of health and personal social services, and to make recommendations for improvement where it thinks fit.
2. The Council welcomes the opportunity to respond to *Developing Better Services – Modernising Hospitals and Reforming Structures*. There has been a great deal of uncertainty in recent years about the future of certain hospital services and this has impacted upon residents of the Southern Board area. In 1997 the Southern Health and Social Services Board reviewed the provision of acute hospital services and in June 2000 made the decision to 'temporarily' remove acute services from South Tyrone Hospital at the end of July 2000. This uncertainty and piecemeal approach also occurred in other Board areas and was neither beneficial to patients nor staff working within the service. In the Council's response<sup>1</sup> to the Board's review of acute hospital services it was strongly recommended that a Northern Ireland wide hospitals plan was needed as a matter of urgency.
3. The Council commends the Department of Health, Social Services and Public Safety for producing a consultation document that is clear and easily understood.

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<sup>1</sup> Southern Health and Social Services Council (December 1997). Response to the Southern Health and Social Services Board's Review of Acute Hospital Services.

## THE NEED FOR CHANGE?

1. The Council recognises and acknowledges the need for changes in the way acute services are delivered. The Council agrees that an ageing population, developments in healthcare and medical technology, new ways of working, more stringent training requirements and the need to improve standards all create pressures for change. The Council agrees that these developments provide the opportunity to develop robust modern services which can provide patients in Northern Ireland with the full benefits and highest quality care which modern medicine can offer.
2. It is essential that the changes made to the system and structure of health and personal social services will serve the population of Northern Ireland not only in the short-term but also in the long-term. This means account must be taken of the projected increase in the overall population to 1.8 million by 2015 and of the proportion of older people within the overall population<sup>2</sup>.

## WHAT KIND OF CHANGE?

1. The Council acknowledges that this means there is pressure to concentrate services – but concentration of services must be balanced with accessibility for patients. In a report which examined the views of Southern Board residents of future acute hospital services (SHSSC; 1998)<sup>3</sup> 96% of respondents rated the hospital being close to home as important. When asked to rank the most important aspects proximity to home and up to date technology and equipment were ranked joint first by respondents. Respondents to this survey considered it important to have certain services available locally and were prepared to travel further for others. The vast majority (94%) said they would not like to have to travel very far for routine

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<sup>2</sup> Acute Hospitals Review Group Report (June 2001).

<sup>3</sup> Southern Health and Social Services Council (February 1998). Influencing the Future Pattern of Acute Hospital Services – The Views of Southern Board Residents.

procedures such as screening or diagnosis but 76% considered distance from the hospital less important than quality of care for serious conditions. The balance between concentration of services and accessibility needs to be taken into account if services are to be responsive and have the support of the public.

2. The Council supports the proposal to develop managed clinical networks. This approach to collaborative working opens the prospect of re-focusing services on populations rather than facilities. By providing services across a number of sites a more convenient and accessible service is provided for patients.

## **MODEL FOR FUTURE HOSPITAL SERVICES**

1. As previously stated the Council welcomes the proposals in relation to acute services in the broad sense because it ends the uncertainty that has existed for a number of years. There have been numerous Board wide acute hospital reviews meanwhile the development of a Northern Ireland plan was what was required.
2. The Council welcomes the principles which guide the proposals for the re-organisation of future hospital services:-
  - Current hospitals should be adapted rather than closed.
  - Services should be decentralised where this is possible and sustainable.
  - The range and quality of hospital standards should match the best in Europe.
  - The vast majority of people should be within 45 minutes of access to emergency care and consultant-led maternity care.
  - Refocusing of acute services to allow for concentration of expertise and the delivery of the highest possible levels of clinical care to patients.

3. The Council welcomes the proposal for the provision of a second protected elective centre west of the Bann. Waiting lists have been increasing in recent years. The number of people waiting for inpatient treatment has increased from 49518 in June 2000 to 59674 in June 2002<sup>4</sup>. Not only are there more people waiting but people are waiting longer – the number of excess waiters\* within this two year period increased from 6009 to 8931. This has occurred in spite of the various targets set for reduction and the initiatives taken by the Department, Boards and Trusts. Given this situation, there is an urgent need to ensure that there is protection from emergency pressures because in times of pressure elective procedures tend to be sacrificed. It is the Council's view that nobody should have to wait any longer than 3 months for treatment. And while we very much welcome the provision of a second protected elective centre, the Council questions whether this will be adequate to significantly reduce the number of patients waiting and the length of time they are required to wait. The impact of the measures taken to reduce waiting lists should be monitored very closely and if necessary additional action – such as the provision of a 3<sup>rd</sup> protected elective centre should be taken as soon as required.
  
4. The Council supports the proposal that South Tyrone should be the site for the second protected elective facility. South Tyrone Hospital has a number of attributes in its favour. Dungannon is a central location and is accessible from the Western, Northern and Southern Board areas therefore would be easily accessible to patients from most of Northern Ireland. South Tyrone Hospital has good quality existing hospital and theatre facilities and therefore it would be cost effective to take advantage of these.

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<sup>4</sup> Department of Health, Social Services & Public Safety (September 2000 & September 2002). Information Releases - Northern Ireland Waiting Lists June 2000 and June 2002.

\* Inpatient excess waiters are defined as those having to wait 12 months or more for admission to the Cardiac Surgery speciality and those having to wait 18 months or more to other specialities.

5. In addition, Craigavon Area Hospital and Daisy Hill are serving a large population of 350,000 (approx) and have capacity problems. The Council's Casualty Watch exercises at Craigavon Area Hospital since the 'temporary' removal of services from South Tyrone Hospital two years ago have persistently revealed the year round pressure the Trust is facing. The demand for inpatient beds outstrips the supply and patients regularly have to wait in beds or trolleys on the corridors of A&E for substantial periods of time without privacy and the necessary level of care. This is totally unacceptable for patients, relatives and the staff involved.
  
6. The Council welcomes the roles proposed for both Craigavon Area Hospital and Daisy Hill Hospital. The consultation document proposes the development of full inpatient fracture services at Craigavon Area Hospital and the Council supports the provision of such services within the Southern Board area. In its 1998 survey<sup>3</sup> the Council found that 93% of Southern Board residents agreed that all fractures should be treated by specially trained orthopaedic surgeons. In addition 75% of all respondents throughout the Southern area said it was acceptable for people with fractures to be treated at a specialist unit run by orthopaedic surgeons at Craigavon Area Hospital.
  
7. The Council welcomes the development and active promotion of midwife-led units within or adjacent to consultant led maternity units as proposed in the consultation document. In July 2000 the first midwifery led unit in Northern Ireland was opened at Craigavon Area Hospital. Arguments in favour of midwifery led units include increased development of midwifery skills and levels of confidence among staff. From the patient perspective such units provide more choice to women in how they give birth and tend to have lower rates of interventions. Figures provided by the midwifery led unit at Craigavon Area Hospital indicate an episiotomy rate of 14% which compares

with 42%<sup>5</sup> for the hospital before the unit opened. The development of midwife-led units within or adjacent to consultant led maternity care is in the Council's opinion a pre-requisite for the development of stand-alone midwifery-led units.

8. In terms of the development of two midwife led, stand-alone maternity units, the Council is of the view that more work needs to be done before this model is progressed. As mentioned above the Council believes that the development of midwife led units within or adjacent to consultant led maternity care should be a pre-cursor to the development of stand-alone midwifery units. This staged approach is important because it allows for the development of the confidence and skills of midwifery staff but it also facilitates the gaining of public confidence and support. There isn't enough evidence at present to indicate that a stand-alone midwife led service would be acceptable to women. This is supported by a number of recent reports by the Council. In its 1998 survey<sup>3</sup> 74% of respondents believed midwives have sufficient training to run a maternity unit however 85% believed that maternity services should be in a hospital with other associated specialities e.g. paediatrics. This research also found that 80% considered it acceptable that women with normal pregnancies are cared for in a unit run by midwives *with* consultant back-up but only 35% found it acceptable for these women to be cared for in a unit run by midwives *without* consultant back-up. A later study into women's experiences of and attitudes towards maternity care<sup>5</sup> reinforced these findings. While 84% of women said they felt perfectly safe being looked after by midwives, 83% thought midwives should be allowed to run the maternity unit *with* consultant back-up and only 25% agreed that midwives should be totally responsible for running the maternity unit.

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<sup>5</sup> Southern Health and Social Services Council (June 2000). Women's Voices – Women's Experiences of Maternity Services at Craigavon Area Hospital Following Transfer from South Tyrone Hospital.

9. In the long term the Council supports the development of stand-alone midwife led maternity care – once the development of midwife led units within or adjacent to consultant led care has been rolled out. This should facilitate the building of the confidence and support of women and the change in current attitudes towards the role of the midwife which needs to take place.
10. The Council welcomes the recognition that no matter how hospital services are arranged, dispersed rural communities will be some distance from them and that there is a need to take early additional steps to put in place supporting measures. The Council also welcomes the more flexible interpretation of clinical need which will be applied when considering eligibility for transport to and from hospital provided by the Health and Personal Social Services for people in rural areas.
11. The Council agrees that the aspiration towards collaborative working is in the best interests of patients north and south.

## **THE NEED FOR CHANGE IN STRUCTURES**

1. The Council acknowledges that there is a need for change in the administration structures for health and social services. However form must follow function. It is artificial and unproductive to try to plan what the structures will look like or how they will be organised without first looking at the functions which need to be performed and how these can be performed most effectively and efficiently. By identifying what functions need to be performed, how they can be done most effectively and efficiently should provide better information as to what form the final structures should take.
2. There is a need for whatever structures are put in place to be user focused. Roles should be clear and easily identifiable and understood by consumers. In the Council's research into views on the future

pattern of acute hospital services<sup>3</sup> less than a quarter of respondents (24%) considered that they were either quite or very knowledgeable about the structure of health and social services. Less than half (44%) stated correctly that there were 4 Health and Social Services Boards in Northern Ireland, 37% could not name any Trust in the Southern Board area and a further 20% had never heard the term 'Trust'. The Council considers it essential that there is a public information and education campaign to accompany any change in structures. This campaign needs to simply outline the nature of the changes, who is responsible for what etc... The Council's 1998 research<sup>3</sup> reported that a majority of respondents (55%) were interested in finding out more about the workings of the health service and their preferred option for receipt of this information included leaflets, newspapers and television.

3. The structures also need to ensure that there are mechanisms to take account of and respond to local needs as well as being able to plan at a central level.
4. New structures need to take account of the positives of current administration arrangements. For example partnership approaches such as Health Action Zones, Health Living Centres etc have been developed as ways of working in health and social services and have proved valuable. It is important that these types of relationships and other positive contributions are not forgone for the sake of change itself.
5. In relation to the proposed Regional authority, the Council welcomes the identification of workforce planning as a function that should be performed centrally. Workforce shortages in specialist areas whether nursing, medical or other are a problem at present and a comprehensive approach to good workforce planning is needed as a matter of urgency. It needs to be inclusive of all the relevant stakeholders involved including the Universities.

6. The Council notes that the consultation document proposes a substantial and important role for Local Health and Social Care Groups (LHSCGs) in relation to commissioning - either as commissioning bodies, as commissioning and delivery bodies or as commissioning and delivery bodies with the exception of acute services. Given this important function the Council is concerned over the practicality of this proposal in light of the current difficulties in encouraging GPs to get involved with LHSCGs. In order for LHSCGs to work effectively it is essential to have the support and enthusiastic involvement of GPs.
7. The Council agrees with the proposal that there should be a significant reduction in the number of Health and Social Services Trusts. This should facilitate managed clinical networks by focusing on users rather than artificial administration boundaries.
8. Northern Ireland currently has a largely integrated system (acute and community services managed together), with a number of acute only Trusts and some community only trusts. More evidence is needed on how these configurations have worked in the interests of service users to underpin the discussion on what arrangements should prevail in the future.
9. The discussion on future arrangements should ideally take place in a context where clear objectives are set for what the reorganisation should achieve. We welcome the fact that the current reorganisation is not financially driven. Nevertheless the debate needs to accommodate the widely held public view that the current structures are overly complex for our population size and that a streamlining of governance arrangements would free up funding to improve services.

## CONSUMER REPRESENTATION

1. The consultation document proposes that in the event of the formation of a single Regional Authority the 4 Health and Social Services Councils (HSS Councils) should be replaced with a single statutory health and social services consumer body. The Council supports the notion that arrangements for representing consumer interests should reflect the structures for the commissioning and delivery of services. The Council also takes the view that it is in the interest of service users in Northern Ireland to have effective mechanisms for consumer representation at regional level irrespective of the decision on the formation of a single Regional Authority. It is our opinion that the issue of consumer representation in any new structures warrants a more comprehensive debate than is suggested by the consultation document. The proposal for a single regional consumer body constituted so as to have access to views on local issues represents a serious weakening of consumer mechanisms. As such it runs contrary to the stated intentions of the Department,<sup>6,7</sup> in relation to involving communities and service users in decision-making processes in the Health and Personal Social Services (HPSS).
2. The Council suggests that the question of future arrangements for consumer representation in the HPSS should be the subject of a separate strand of consultation in preparation for the debate on future structures, and that this process should be adequately resourced. There are lessons to be learned from the debate on consumer representation in health that have taken place in England, and under the devolved administrations in Scotland and Wales. The models for consumer representation that have resulted differ across the 3 countries, and no one model will necessarily transfer to the Northern Ireland situation. Cognisance must be taken of the implications for

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<sup>6</sup> Department of Health, Social Services & Public Safety (March 2002). Investing for Health.

<sup>7</sup> Department of Health & Social Services Community Development Working Group (August 1999). Mainstreaming Community Development in the Health and Personal Social Services – Report to the Targeting Health and Social Need Steering Group.

consumer representation of the integrated service in Northern Ireland, and how the arrangements might be expected to contribute to specific objectives relating to the involvement of citizens that are inherent in the Northern Ireland programme for government.

3. Reference is made to the community representation on the (Local Health and Social Care Groups (LHSCGs), and the expectation that this will ensure that issues of concern to local communities will be addressed. The Council has welcomed the inclusion of community and user representatives on LHSCGs, and in common with other Councils, has played an active part in the process of recruitment in its Board area. While we view the presence of community representatives on LHSCGs as a potentially significant element in any strategy for community involvement in the HPSS, the limitations of their role must be recognised. Community representatives have been appointed to make a contribution to the management of the LHSCGs, and *to bring a community user perspective to this task*. There are currently no mechanisms for ensuring that they remain informed of the range of issues concerning the communities served by the LHSCGs, or for allowing the representatives to be held accountable for the specific task of representing community interests. The Council recommends that the department address the issue of the support needs of these community representatives, and the issue of accountability, as part of a wider consultation on HPSS consumer mechanisms suggested at Para 2 above.
4. It is generally accepted that Northern Ireland has been well served by the 4 HSS Councils since their formation in 1991. An important element in their success has been the contribution of the voluntary members who give of their time to serve their communities. While taking the view that we must build on this success, our Council is acutely aware of the need for change. In particular we are aware of the need for strong consumer representation at regional level, and the

necessity to strengthen the voice of the consumer on crosscutting strategic policy issues.

5. While England, Scotland and Wales have had statutorily constituted regional structures with separate funding to support and co-ordinate the work of the local Community Health Councils (CHCs), comparable structures have not been funded in Northern Ireland. The 4 HSS Councils have collaborated successfully to carry out joint research on issues of regional significance and to represent consumers on strategic policy issues but they have done so without the necessary support and within budgets allocated for local activities.
6. Since the HSS Councils were formed in 1991 the expectations in relation to their role in consumer representation has increased significantly, whilst resources available to the HSS Councils have remained static. Devolution has brought with it further increased demands on HSS Councils to respond to regional initiatives and consultation processes again without a corresponding increase in resources. *Investing for Health* has placed specific obligations on HSS Councils in relation to securing the involvement of service users, which HSS Councils have been unable to meet because of resource constraints. The historic under-funding of consumer representation in Northern Ireland should be addressed in the setting up of any new arrangements. The Wales Assembly has agreed a budget for health service consumer representation that is 60% higher per capita than in Northern Ireland. Yet Northern Ireland HSS Councils have the additional responsibility for social care and childcare services, and an additional workload in relation to the provision of public information because of the absence of an equivalent to the NHS Direct. These factors should feature in the debate on funding for the proposed new structures.
7. We have already indicated the Council's view that irrespective of the organisational structure for planning and delivering services there is a

need for a regional consumer body. If the decision is to move to the formation of a single regional authority then the argument for a regional consumer body is strengthened.

8. Our Council takes the view that the Regional Authority and the Consumer body should have a truly regional identity. We believe that this can best be achieved by a choice of location outside the Greater Belfast area. We believe that such a location can make a contribution to achieving a better balance in the structural development of Northern Ireland as a region.
9. However effective a regional consumer body might be it is our view that it cannot maintain contact with local communities without a physical presence at a more local level. The current configuration of the 4 HSS Councils provides opportunities for a total membership in excess of 100. These members represent an important resource in relation to maintaining a watching brief on local services and developing an awareness of local concerns. The dramatic reduction in appointed membership that a move to a single consumer organisation would entail represents a significant loss of resources to the task of consumer representation.
10. The task of a regional body in dealing with strategic policy issues and monitoring the actions of a regional authority represents a development of the role of the current HSS Councils and as such will make different demands of its membership. In addition to fewer overall opportunities for community and user representation such a structure may exclude activists still developing the skills required for strategic policy analysis and lead to the appointment of 'professional' representatives, with consequently fewer opportunities for the representation of disadvantaged communities.
11. The Council takes the view that a single consumer body alone cannot achieve effective consumer representation. Instead we

believe that the regional consumer body should form part of an overall structure that includes provision for locally based groups. This should facilitate greater involvement of consumers at local level as well as allowing community activists to develop the skills and knowledge required to operate at the strategic regional level. Consideration should be given to methods of holding the regional group accountable to the local structures and the local groups accountable in to the communities they serve. In the debate on accountability the role that elected representatives should play in the new structures needs to be considered.

12. The arrangements for local consumer representation should reflect the structures for the management of the services. A balance needs to be achieved between developing structures which are based around recognised centres of population; which reflect commissioning and /or service delivery arrangements; which allow for a local identity yet which are large enough to be viable. In this respect we can learn from the GB experience where in some areas such as Wales Community Health Councils (CHCs) were based on population sizes that gave rise to problems of viability. The current Northern Ireland arrangements in the other hand are arguably not sufficiently local and present particular challenges in terms of community visibility. It is the view of the Council that elected representatives should continue to form a part of structure for representing consumers. The current review of public administration has implications for local government boundaries, a factor which may need to be considered in determining the boundaries of any local consumer structures in which elected representatives are to have a role.
13. Currently the Health and Social Services Councils are only one of a number of mechanisms for involving service users in decision-making processes in the HPSS. The following is not an exhaustive list but includes the key players in relation to promoting consumer activity.

- ❖ The DHSSPS strategy for community development<sup>7</sup> has been interpreted in different ways in different areas. The Southern Board strategy for community development<sup>8</sup> has led to the commissioning of community development teams in each community Trust area and the deployment of a community support team at Board level. A key function of these teams is promoting the involvement of service users in HPSS decision making processes.
  - ❖ The Community Development and Health Network is part funded by the DHSSPS to support and co-ordinate community action on health issues.
  - ❖ Involving communities and users in dialogue with decision-makers in the HPSS has been an important element in the work of the Health Action Zones and Healthy Living Centres. *Investing for Health* places an emphasis on the involvement of communities and service users, and there is the expectation that these constituencies will play a significant part in the Investing for Health Partnerships.
  - ❖ The inclusion of community/service user representatives in the LHSCGs has already been referred to.
  - ❖ Individual projects such as Belfast Healthy City and the former Healthy Communities projects have pioneered the concept of partnership between communities and statutory and voluntary organisations with a remit for health.
14. The debate on structures for representing consumer interests needs to recognise that the current consumer bodies, the Health and Social Services Councils, shares with a wide range of HPSS sponsored organisations the task of supporting service users participation in decision making processes. The role of HSS Councils
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however, is distinct from these other bodies in that they are independent of the Boards and Trusts and have a statutory remit for representing the views of consumers. Consideration of future structures for consumer representation must, however, examine the relationship between the consumer organisations and other organisations promoting user participation in the HPSS. The Council recommends that the separate strand of consultation on consumer representation advocated at Para 2 above should include a review of the relationship between the range of mechanisms for supporting consumer activity, and whether a greater degree of synchronisation is desirable or possible.

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October 2002