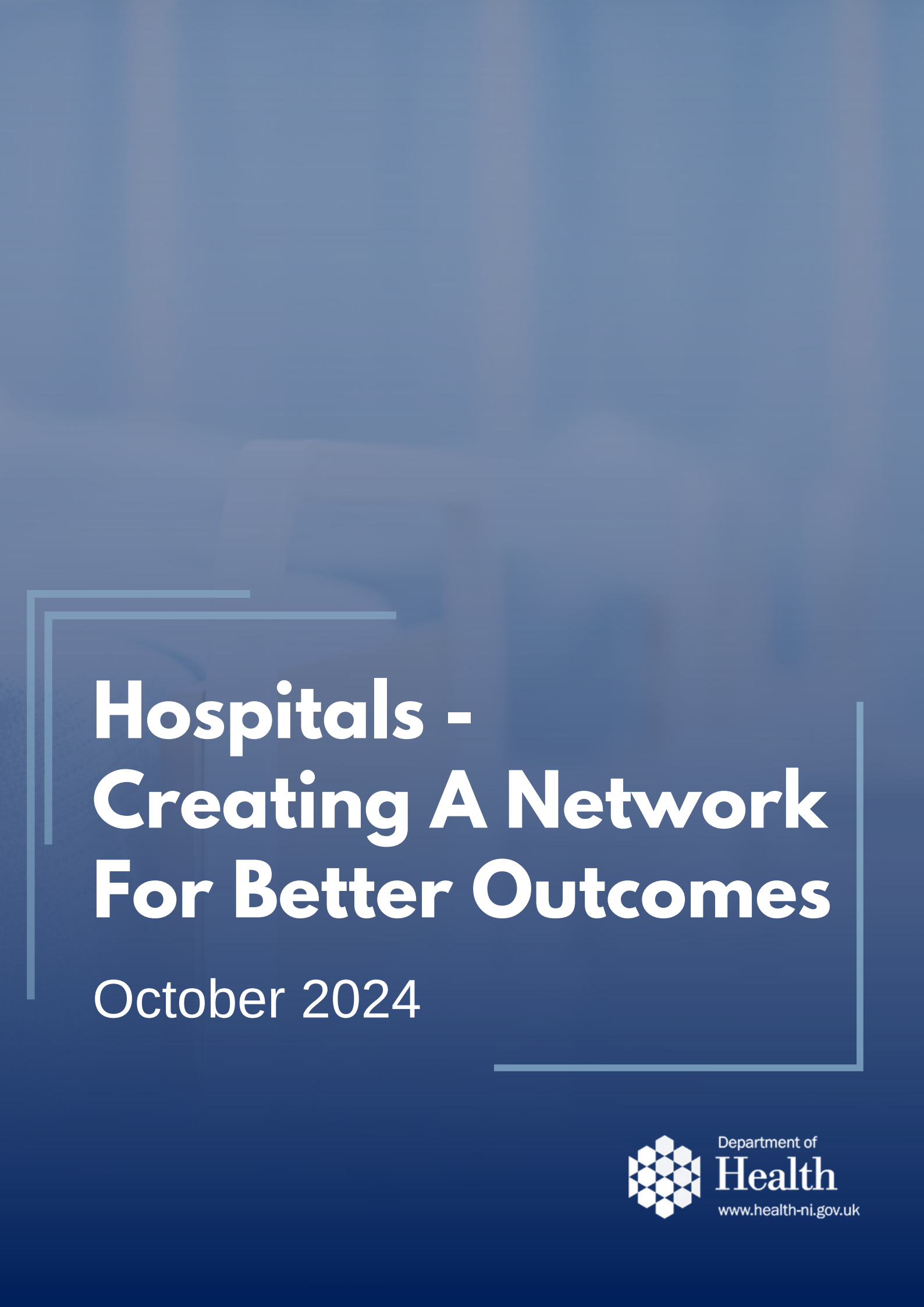


Hospitals - Creating A Network For Better Outcomes

October 2024

Department of Health
www.health-ni.gov.uk

Contents

Ministerial Foreword

We all have good reason to be eternally grateful for the endless compassion, empathy, dedication and professionalism of all those delivering Health and Social Care in Northern Ireland. That said, they deserve better, as do patients and service users.

There are many causes underlying the need for reform: new, life-prolonging medicines and procedures; changing demographics; growing demand; increased acuity among patients presenting for care; and years of underinvestment.

In that context, we must accept that change is necessary, both to meet the needs of our current and future population, but also to ensure the services we provide can be delivered safely and productively. This is the rationale behind launching a public consultation on Hospitals – Creating a Network for Better Outcomes.

From my earliest days in post, I have made clear my guiding light in determining every decision I make will be whether it delivers Better Outcomes, for patients, service users and our wonderful HSC colleagues. This applies to the reform of the delivery of secondary care in our hospitals.

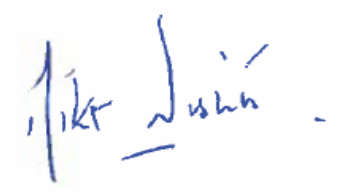
This document aims to describe our hospitals as a network, where all parts work together to deliver services across Northern Ireland, to ensure sustainability and provide clarity of who does what, which will help better achieve those better outcomes.

While not every hospital will deliver every service, leading to an element of reconfiguration, it is important to stress **no acute hospital will close**. Rather, we will further develop Centres of Excellence. I believe patients are prepared to travel to access the best care possible but would like aftercare delivered as close to home as possible. That is my intention with the move to creating a hospital network.

This document is one important piece in the puzzle which delivers a reformed, better fit for purpose HSC system, which will also require focus on population health, social care, primary and community care and mental health and wellbeing.

I am confident we can reform our health and social care system, improve population health and put our entire system on a more sustainable, productive footing. Ultimately, this will require a whole Executive approach.

I commend this document to you and encourage your thoughts and feedback on the proposals within Hospitals – Creating a Network for Better Outcomes.



Mike Nesbitt, MLA

Minister of Health

1. Executive Summary

Our health system is on a journey. Change is coming and indeed, change is necessary both to meet the needs of our current and future population, and to ensure that services can be delivered safely. The ambition, always, is delivering better outcomes: for patients, service users and our wonderful and diverse healthcare workforce. Changes in population demographics, the current fiscal climate and increasing demands for health and care services require us now more than ever to reconsider how we provide services in NI. Although health and social care practices have evolved over the decades, the regional infrastructure supporting these services has not kept pace. We are committed to deliver for Northern Ireland's (NI) citizens the right treatment in the right place, at the right time. Changes will be based on advances in health and social care and taking account of what the public and health professionals are telling us. To meet the changing needs of the population we need to shift the balance of care from hospital to more community-based health and social care services. This will require further enhancements of these services to support this transition and continuing to empower people in their own care. Admission to acute hospitals should only be for acute episodes of care. Delivering locally where possible in a person's home, through General Practitioner (GP) services, community health and social care, community pharmacy and centrally only where necessary, we aim to deliver safe, sustainable, high-quality health and social care services.

The purpose of this framework is to support widespread engagement with our communities, our health and social care workforce 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; **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.

The key outcomes that reconfiguration must deliver are:

- 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, will 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 leads to a reduction in reactive safety related service changes or collapses.

There are five key enablers needed to support the successful reconfiguration of our Health and Social Care (HSC) system - Workforce, Funding, Communities & People, Digital Solutions and Cross HSC Trust Working.

The Bengoa report set out a vision and a set of principles that were agreed through political accord. Since its publication there have been a number of Regional HSC Service Reviews that are already in the implementation phase. Some further reviews are in the development phase while others have been committed to but have yet to commence. Whilst we recognise that patient pathways span the entirety of the HSC system, and effective whole system working is key to meeting current and future population health needs, this framework is specifically focused on our hospital-based services. We acknowledge the need to also take full cognisance of how our whole system across acute, primary and community health and social care works.

Elective Care

Our elective care policy sets an important context for our hospital system. We are moving towards a greater focus on Centres of Excellence or surgical hubs to deliver high quality care for patients. 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, ensuring more patients are diagnosed and treated thus reducing waiting times.

Reconfiguration of elective care into Centres of Excellence will mean that some patients may have to travel a bit further for their treatment. Research suggests that most people are willing to travel if it means they will be seen quicker for a routine procedure or operation. However, there are patients who have concerns about any additional travel time. Importantly, the deliberate placing of elective care Centres of Excellence is essential to improving outcomes for patients, and stabilising and sustaining acute hospital services and workforce. Some of this reconfiguration has already started and this includes Day Procedure Centres at Lagan Valley and Omagh Hospitals, and Elective Overnight Stay Centres at the Mater Hospital, Daisy Hill Hospital and South West Acute Hospital.

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 and elective, 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.

The Northern Ireland Hospital Network can only be sustained through collaboration. Provider collaboratives can work across a range of programmes 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 occur where this will provide better outcomes for patients and efficiency in use of current resources.

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 the changes required. 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.

Furthermore, it must be recognised that when hospitals have lower patient numbers, this can create significant issues for professionals working in key specialties resulting in risks to service provision and patient safety. 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. Strategic Context

Introduction

There is widespread political support for changing the way NI's HSC system is organised. Health reform and specifically service reconfiguration is a constant theme of political and media discussions. While there is a strong political consensus on the need for change, securing agreement on how a reconfigured system will look and how future services should be provided to meet current and future population health needs is not so straightforward. The purpose of this framework is to provide greater clarity and help move reform to a new phase describing both why and how we will reconfigure hospital services and what the reconfigured acute hospital network will look like, where services are already reconfigured and set the framework within which future service reviews will sit and indicate when those reviews are planned. Engagement with communities, health and social care workforce and society as a whole on how we can, through a collaborative approach, better sustain our hospital network will be key.

Why - Change is Coming

The way health and social care is provided in NI has evolved over the last few decades. Medicine has changed dramatically over that period, as have the health needs and demographics of our population. Thanks to medical and technological advances, people are living significantly longer lives. This is obviously something to be celebrated and is a success story for modern medicine. However, with increasing numbers of older people in society, demand for health care inevitably increases and as we age, the likelihood of developing potentially serious conditions grows. **Annex A** details the changes in population by age band over the next 20 years and also shows a map of our most and least deprived areas. So, 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. Furthermore, given that 80% of health inequalities can be traced to socio-economic issues, physical environment and behaviours, a focus on reducing overall inequality, tackling deprivation and encouraging behaviours conducive to better health and wellbeing, will contribute to a reduction in health inequalities. Easier access to services by having them based in the community will be an important part of achieving that aim.

Behind every attendance and admission to hospital is a person. Engagement with our citizens has told us that a shift towards services being provided “out of hospital” within the community is what they want.

Indeed, the evidence shows better patient outcomes and experiences for this approach. Out of hospital care is part of the overall long-term direction to effectively look after an ageing population and an increasing number of people with co-morbidities. We recognise how critical person-centred services are as a means of prolonging or regaining an individual’s independence. As well as the positive impact for the individual, we are also aware of how out of hospital services contribute towards capacity and flows across the whole HSC system. This is not just about better managing the “system” but is in line with what the evidence clearly tells us we need to do.

At the same time, hospital-based medical care – also known as acute care – has been developing rapidly. This has involved greater specialisation among medical and other healthcare clinicians including, for example, specialist nurses, allied health professionals, and advance practitioners. In the past, one team of surgeons would have covered all areas of general surgery whereas now general surgery has five sub-specialisms, all of which require doctors with the skill and experience needed to treat patients. In order to ensure those doctors have sufficient caseloads and case mix to develop and maintain experience and skills, there needs to be a sufficient number of patients requiring that treatment i.e. a critical mass.

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 they live, can have access to the best possible care.

The need for changing health care services in NI was expertly summarised in the Bengoa Report[1] and Delivering Together[2], both published by the Department of Health (DoH) in 2016. Likening the current system to a "burning platform", the Bengoa panel stated: *"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."*

This has been borne out by events since 2016 and a number of hospital services have become increasingly difficult to maintain safely. Spreading key services too thinly over too many sites is at the heart of many of the problems. This makes it harder to recruit and retain specialist medical staff, due to issues like the inevitable workload issues that arise in smaller teams, as well as more limited case mix. This makes some locations less attractive for doctors who want to maintain and develop their skill and expertise. Services have even had to be halted at some sites because safe staffing levels and safe care could not be guaranteed. This is what a burning platform looks like. It is important to emphasise that the Bengoa report had the support of the then NI Executive and was widely welcomed across the political spectrum. As was stated at the report's launch, change has to happen and *"the only question is whether it will happen in a controlled, planned fashion or unfold out of control".*

It is also true that since the Bengoa report, alongside the challenges we have seen in being able to maintain services, particularly in the urgent and emergency settings because of the capacity, skills and staffing issues highlighted above, there has been evolution of our services, particularly on the elective side driven by increasing specialisation, both in terms of clinical skills, but also medical infrastructure which has seen more activity delivered at a regional level.

[1] *Systems, Not Structures - Changing Health and Social Care - Full Report | Department of Health (health-ni.gov.uk)*
[2] *Health and Wellbeing 2026 - Delivering Together | Department of Health (health-ni.gov.uk)*

Myth Busting

Some myths have developed over the years about health reconfiguration and reform. These have been partly driven by the fact that many recent service reconfigurations have been emergency measures driven by lack of workforce resilience.

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. Nor should health reform be seen as a single measure, a button to push or a lever to pull to put things right. It is actually about a series of many different measures, big and small, all based around the overall goal of making health and social care services a better fit for the needs of today and tomorrow. It will not alone solve all the problems currently facing services, and the need for additional investment has been highlighted on many occasions – but the problems will get steadily worse without it.

Another common myth is that health reform is just about cutting costs. In some cases, reconfiguration will actually require significant additional investment – for instance in building up multi-disciplinary teams of care professionals working alongside GPs in primary care. 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”. This claim ignores all the hard

work that has been put into making lasting improvements. 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:

- Lagan Valley Hospital is now a day procedure unit[3], serving a large section of the population.
- Omagh Hospital has been designated as the second of these facilities.
- The Mater Hospital in Belfast, South West Acute Hospital in Enniskillen and Daisy Hill Hospital in Newry have been established as elective overnight stay centres, providing a service for patients requiring intermediate complex surgery, across a range of specialities.
- Rapid Diagnostic Centres for people with potential cancer have been established at Whiteabbey Hospital in Newtownabbey and South Tyrone Hospital in Dungannon.
- The move towards an Integrated Care System (ICS) commissioning framework will assist in delivering a more patient-centred, population health, and outcomes-focused approach.

This is reform in action 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.

[3] The Lagan Valley Hospital includes a Day Procedure Unit, in addition to medical beds, medical day case, outpatient and maternity services

Scope

Health and social care reform requires a whole system approach, involving all providers across hospital and community and voluntary settings. **Figure 1** demonstrates how the HSC looks for the NI population and the broad range of HSC locations that deliver care, whether in the community, at home or in hospital, to ensure right treatment at the right place. The figure is for demonstrative purposes to view the wide range of care. For example, sitting alongside GP practices, there is community healthcare including district nursing, community mental health teams, learning disability teams, community AHPs and prison health care.

Figure 1

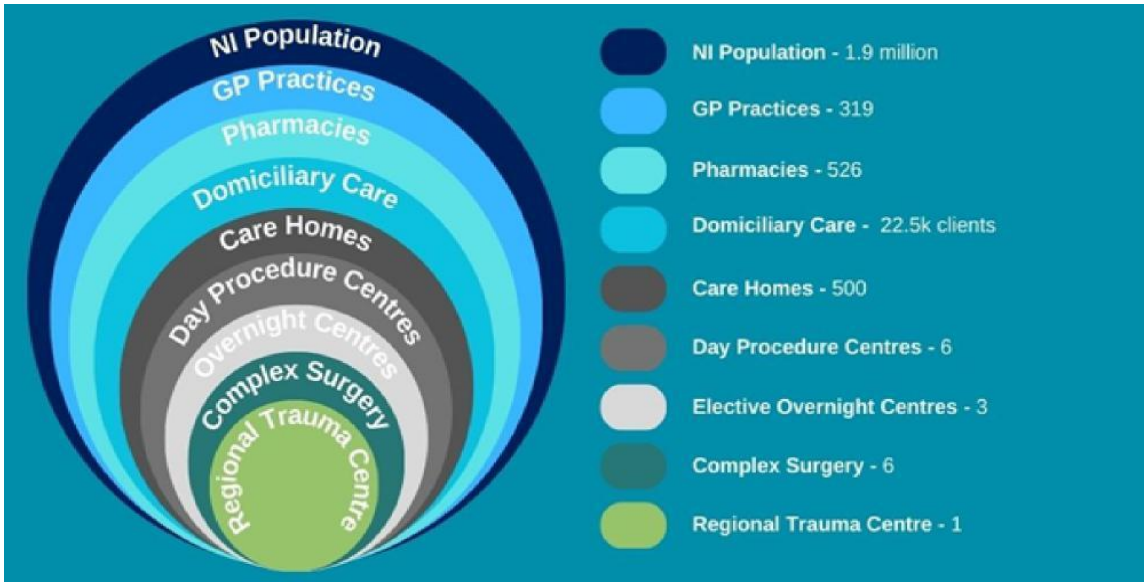
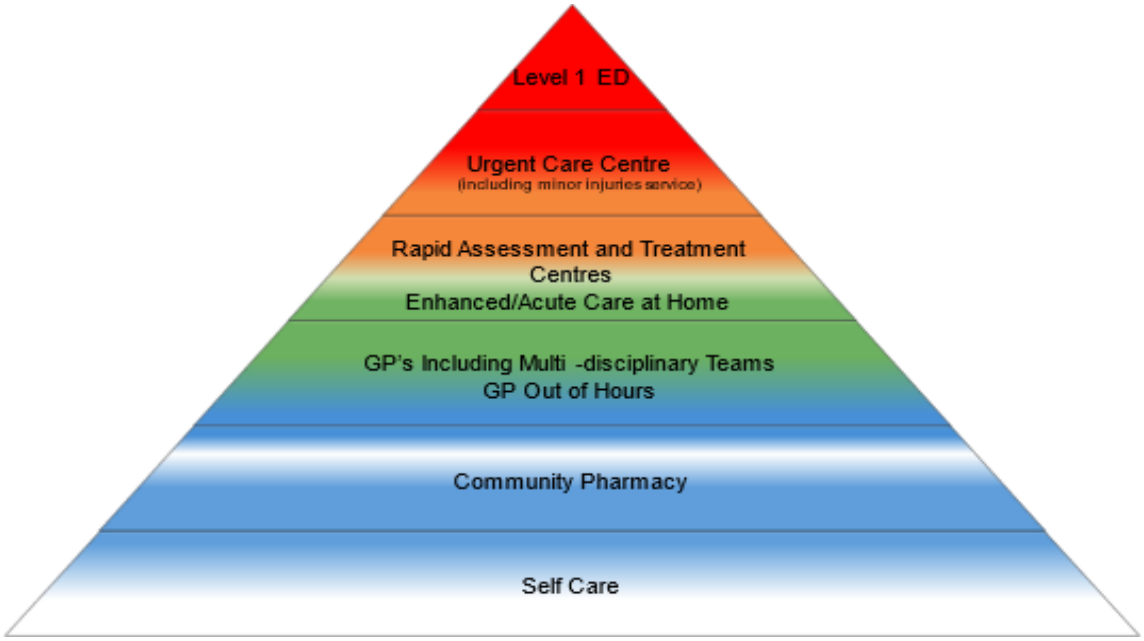


Figure 2

Figure 2 shows the pyramid model of urgent and emergency care. This depicts the various levels of urgent and emergency care available to our citizens, from the importance of self-care and prevention by keeping ourselves well, to local services in the community and hospital services if necessary. Importantly, the vast majority of care is provided at, or close to, the home. Sitting alongside this is also community and primary care. We are working, and will continue to work, as an integrated system. This framework, however, is focused specifically on how we can best sustain our hospital network.



In that context, it is important to note that some specialist services for the NI population (such as specific children's surgical needs) are provided either in England or through North / South Cooperation in the Republic of Ireland. These specialist services are not affected by this framework. The reason that they are provided outside of NI is that they need a critical mass of volume to develop a safe sustainable service and to recruit and retain appropriate clinical expertise. These services tell us that people can, and will, travel to ensure they have access to that specialist expertise.

While not the focus of this framework, it is also vital that we continue to work across the health sector and in partnership with other Departments and sectors to improve health and wellbeing, and prevent ill health, through creating the conditions for healthy lives and ensuring that we intervene at an early stage. Investing in the

promotion of good health and wellbeing, prevention of ill health and early intervention will be key to reducing the demand on our health services in the longer term, and promoting resilience in our population for future challenges, such as pandemics.

The DoH has lead responsibility for the draft Programme for Government (PfG) outcome: *'We all enjoy long, healthy, active lives'*. This means supporting people to take greater control over their own lives, as well as helping to create the conditions and environment to support healthy lives. It also means working with other partners to tackle the root causes of poor health and wellbeing outcomes and to reduce health and social inequalities in NI. DoH also contributes to a number of draft PfG outcomes led by other Departments.

Led by DoH, Making Life Better (MLB) is the Executive's overarching strategic framework to improve health and address health inequalities. MLB was developed on the evidence that health and wellbeing, and health inequalities, are shaped by many factors, including age, family, community, workplace, beliefs and traditions, economics, and physical and social environments. In fact, the international evidence also suggests that, while health and clinical services contribute 20% to improving health outcomes, the population's health is to a much larger extent affected by the economic and social factors (40%) and environmental factors (10%) in people's lives and related lifestyle and health behaviours (30%).

Through strengthened co-ordination and partnership working in a whole system approach, MLB seeks to create the conditions for individuals and communities to take control of their own lives and move towards a vision for NI where all people are enabled and supported in achieving their full health and wellbeing potential. MLB is supported by a number of strategies that are designed to help improve population health and wellbeing targeting areas where health inequalities are often prominent. These include Obesity Prevention; Substance Use; Suicide Prevention; Tobacco Control; Skin Cancer Prevention; Health screening for early detection and early intervention.

The ongoing relevance of MLB is further demonstrated through the development of the ICS NI, where the MLB themes and outcomes will be fundamental to the strategic

direction and planning processes for the new system. We are working closely to ensure that there is a clear alignment between the ICS, population health planning, addressing inequalities, the strategic outcomes framework and MLB. Work is now underway to develop a number of specific collaborative actions across government and partner organisations that can further embed this approach and support the wider reconfiguration of the services. It will also be important that through reconfiguration, and the ICS, the HSC system plays its part in addressing health inequalities and improving health and wellbeing by ensuring equality of access to services, and continuing to develop and support primary, secondary and tertiary prevention.

It is also important to recognise that this framework does not include Mental Health or Learning Disability services as they are outside the scope of this work. Both areas are undergoing significant reform programmes and remain a priority. We recognise there are inpatient facilities in all the Trusts and linkages to the evolving multi-disciplinary teams, but there is a separate process in place, under the Mental Health Strategy to develop a regionally consistent mental health service for the population. A five year implementation plan is in place and this is the mechanism through which any changes to mental health service configuration would be considered in line with existing protocols. This is overseen by a Regional Collaborative Board which will have clear linkages to this wider work to ensure that it is fully aligned.

The Department is aware that people with learning disabilities, particularly those with comorbid Autism, have much poorer mental health outcomes than the general population. It is recognised that for those with complex needs that specialist learning disability inpatient and community services remains the most appropriate way to respond to the current level of need. However, it is also recognised that subject to individual clinical assessment, it may be more appropriate to support people with milder learning disability and need within an adult mental health service.

The challenges faced by these services in terms of increasing demand, pressures on in-patient and assessment and treatment beds, community services and staffing will be considered as part of the wider reconfiguration.

There are clear interfaces and interdependencies with primary care, community health and social care and indeed the voluntary sector. Strong community and primary care health and social care services will be key to ensuring a shift in the balance of care and that acute hospitals are for acute episodes only. Therefore, these services are recognised and not overlooked but have been excluded from the scope of this report. HSC is a network of care providing the right care, in the right place at the right time.

Whilst it is recognised that there is a long-term shift towards a model of care that focuses much more on prevention, proactive management of patients and services increasingly provided in the community, that shift will be addressed elsewhere, and this framework focuses exclusively on our hospital network.

Aims of Reconfiguration

The key outcomes that reconfiguration aims to deliver are:

- Safe and better health and social care services for our population, supported by best practice standards.
- Equal access to health care across NI and a resulting reduction in health inequality.
- A more effective and efficient service which maximises productivity and makes best use of available funding and our workforce.
- A more financially sustainable health and social care service.
- A resilient service that leads to a reduction in reactive, safety-related service changes.

The final point requires some further explanation. Many of the service changes implemented by our Health and Social Care Trusts (HSCTs) over recent years have been in response to concerns about patient safety, primarily arising from a lack of resilience in local specialist workforce and an over-reliance on an unstable locum medical model of cover. This has been a particular problem in our smaller, often rural, hospitals. Proactively reconfiguring services before critical staff shortages crystallise in local hospitals, avoids unplanned emergency

reconfigurations. Likewise, agreeing a set of core services to be sustained through a collaborative approach will help to minimise the risk of future service collapse.

Day to day operational workforce planning (addressing issues such as service delivery, safe staffing levels, operational vacancy management and recruitment) is carried out on an ongoing basis by health and social care employers. The Department is responsible for longer term strategic workforce planning. This aims to secure the workforce and skills supply over a five to ten year horizon and is currently delivered through a regional rolling programme of long-term strategic workforce planning reviews. These reviews, which are aligned to service reform, consider issues such as demographic profile of the existing workforce; anticipated service demand; and workforce design required to support future models of care, including skills mix and career progression pathways that support the delivery of care.

The findings of all strategic workforce planning reviews are currently incorporated into a regional view of workforce need, which informs the Department's annual commissioning of pre- and post-registration training places across the full range of healthcare professions. This is in line with the action in the Workforce Strategy to: "*develop, and by 2026 sustainably fund, an optimum workforce model for reconfigured health and social care services that utilises the findings of our strategic workforce planning to provide a system wide view of workforce requirements.*" However, implementation of the Workforce Strategy recommendations are subject to affordability and the assessment of priorities.

Workforce reviews are integral to strategic workforce planning and they will continue but will be increasingly undertaken at a service level. This is crucially important as they will provide an assessment of the multi-disciplinary skills mix required to deliver specific services going forward and will support the potential development of new roles.

How – Health Care Provider Reconfigurations

We know that well-planned service reconfiguration with extensive community and stakeholder engagement is much better and safer for patients. HSCTs will continue to follow policy guidance on change or withdrawal of services published by DoH, attached at **Annex B**. This guidance emphasises the need to consult service users and the local community in reconfiguration decisions and sets out six criteria to be considered.

In addition to following the guidance on change or withdrawal of services, including the commitment to service user and community engagement, HSCTs will adopt the following principles in future reconfiguration decisions:

- Reconfiguration decisions should take account of population health and the aspirations of individual HSCTs for the longer term, but also provide some short-term deliverables, in keeping with the importance of seeing change on the ground at the earliest manageable point.
- Reconfiguration should be led by patient safety and improving outcomes for service users. Other factors such as impact of social deprivation / health inequalities; regional demand / capacity exercise, including, but not limited to, GIS (Geographic Information System) mapping of demand, capacity planning for inpatient beds and theatres.
- Evidence and findings from regional service reviews should, where possible, be brought to bear in the reconfiguration, even if they have not concluded and/or completed their consultations.
- Reconfiguration should support the need for clear separation of unscheduled and elective patient flows, where possible and should maximise non-complex elective provision at regional elective centres once selected.
- Modernisation of Outpatient services in a hospital setting should be pursued and agreed. Face to face and virtual, or remote, assessment pathways should be established at speciality level based on expert advice and be implemented consistently.
- Decisions on the reconfiguration of services should take into account any impact on other HSCTs, including the potential impact on Northern Ireland Ambulance Service (NIAS) capacity, take cognisance of the full range of HSCT services

including theatres, co-dependent clinical services, Radiology, and other support services, and take account of the need to preserve capacity from smaller hospitals across the region and within their HSCT.

- Reconfiguration decisions for the short/medium term should align with the DoH draft future capital plan and should consider capital constraints and practicalities in delivering a viable service model.
- Reconfiguration decisions should take account of key specialities / interdependencies that are required to sustain safe and effective hospital sites.
- To ensure that tackling health inequalities is a key consideration, service changes as a result of reconfiguration decisions should consider all impacts and be subject to necessary screening (equality/rural needs etc) in line with legislation and HSCT Equality schemes.
- Reconfiguration should take full consideration of current and future workforce requirements including development of new roles and how we maximise workforce potential across all professional groups to meet current and future population health needs for example professional specialist and advance practice roles.

In summary, reconfiguration should be driven by evidence, based on improving outcomes, and consider key policy developments in community services which support the effective operation of hospital services.

How & When - Bengoa Report and Regional Service Reviews

Since the publication of the Bengoa report and 'Delivering Together', the Department has made significant progress on the reform agenda. This is summarised in this section, alongside the key principles underpinning the Bengoa report.

The Bengoa report was accompanied by a political summit involving the main NI political parties. At this summit, political agreement was reached for a vision and a set of principles to guide a new model of health and social care in NI.

This vision was as follows:

"To create a fair and sustainable, including financially sustainable, Health and Social Care system that delivers universal, high quality, safe services that meet the Northern

Ireland population's needs and which deliver world class outcomes for patients and service users."

The Bengoa principles were:

- *The system should be collaborative, not competitive.*
- *The system should adopt a population health and well-being model with a focus on prediction and prevention rather than reaction.*
- *Patients should be active participants in their own care, not passive recipients.*
- *Health and social care is already integrated in NI. Remodelling must build on this strength and take a whole system perspective.*
- *Only people who are acutely unwell need to be in a hospital*
- *Very specialist services can be based anywhere in NI.*
- *The location and composition of resources should be based on meeting patients' needs and achieving the best outcomes.*
- *The real value of health and social care is in its people, not its buildings.*
- *Whole system remodelling is a medium to long term process.*
- *The system must be supported to implement change with pace and scale.*
- *Technology should be developed and adopted where it can support and enable transformation.*
- *The panel will engage constructively with elected representatives when designing and communicating a remodelled HSC. The Panel will also engage openly with HSC staff and the public.*
- *NI can be a world leader in transforming health and social care.*

Following the publication of the Bengoa report and 'Delivering Together', DoH embarked on a programme of service configuration reviews. These reviews have been clinically led, and included working in partnership with those that use the services.

There are several major areas of reform and reconfiguration already underway and in the implementation phase. These are important drivers as to how and when service reconfiguration happens.

Annex C provides website links in relation to the Department's strategies and reviews, where information is publicly available. This includes links to consultation reports, frameworks and recommendations for implementation or action plans and progress reports. Annex C also provides a summary of the current position in respect of each service review. These are grouped under five themes:

- Population Health
- Social Care
- Primary and Community Care
- Mental Health
- Acute Hospital Services

The service review summaries are then followed by information on three key enablers:

- Digital
- Workforce
- Integrated Care System (ICS)

What - Hospital Network Services

The hospital infrastructure in NI ranges from large Area Hospitals to General Hospitals and then Local Hospitals (as defined below). An important aim of this framework is to facilitate more effective integration across the hospital network with Centres of Excellence which allow for sustainable specialisation of services.

In reviewing our existing hospital infrastructure, four categories have been identified. These form the basis of a potentially sustainable network of facilities that will deliver unscheduled, elective and local hospital services and make best use of the existing physical estate. These are:

Local Hospitals

- 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 and elective, to the communities within a geographical area currently defined by the distribution of integrated services delivered by our five HSCTs.

Regional Centres

- delivering specialist regional inpatient services for the whole population of Northern Ireland.

For each category there are different and sometimes competing challenges in terms of sustainability and the delivery of the best possible outcomes for patients. Reconfiguration addresses these challenges, recognising that all our hospitals form part of a single system with critical interdependencies. As stated above, any reconfiguration must focus on outcomes for service users and be guided by the principle of delivering services locally where possible and centralising services, at either area or regional level, where necessary.

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

*No inpatient beds

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
- Ulster Hospital Dundonald

Regional Centres

The majority of our regional services are integrated in our Belfast Centres but also located in the Northwest:

- 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.

*These regional centres also have important dual functions as Area Hospitals for the population of Belfast. Subsequent sections will explore each of these types of hospitals in more detail, their interconnections and how cooperation can improve sustainability of the entire hospital network.

The developing role of Paramedicine and the Northern Ireland Ambulance Service

In addition to the hospitals and their workforce, there is a further element to the network. This is the mobile asset largely provided by NIAS, delivering pre-hospital assessment and care, retrieval, transportation for patient pathways and bypass protocols.

An example of the development of these mobile services is NISTAR (Northern Ireland Specialist Transport and Retrieval), the combined critical care transfer service for NI. By providing advanced resuscitation, stabilisation and inter-hospital transfer of critically ill infants, children and adults, the service ensures patients can be transported to the best place for their care by specialised clinical teams experienced in transport and retrieval.

The Helicopter Emergency Medical Service (HEMS) is another advanced piece in this jigsaw, providing pre-hospital critical care and transportation. By providing skilled assessment and treatment at home, or at the point of call out, and by facilitating transport to non-hospital centres for support and treatment, the Ambulance Service also performs a vital role in ensuring mobility within the system and avoiding unnecessary hospital admission.

North/South collaboration

The importance of established North/South partnerships and collaboration is important in the hospital reconfiguration ahead, and the strategic importance of these linkages should be preserved and if possible enhanced as part of reconfiguration. In this context it should be noted that we have an All-Island paediatric cardiology and cardiac surgery network. In addition, Altnagelvin Hospital, through the Northwest Cancer Centre, provides a major cross border healthcare service to the population of the Northwest of Ireland, through a formal government to government collaboration and formal contractual arrangements. Collaboration on the delivery of an emergency cardiology service to the population of Donegal is also

formally in place. Mutual aid arrangements in the event of emergencies are also strongly embedded on a cross-border basis between the Western Trust and Saolta Healthcare group, particularly Letterkenny Hospital.

3. Elective Care

Our Elective Care policy is strategically important both in terms of sustaining our hospital network and in delivering best outcomes for patients, in the most effective manner. Elective care is scheduled, or planned, as opposed to unscheduled or emergency care. Elective care can take many forms and the patient journey can involve a number of different elements and interfaces; for example, outpatient appointment, diagnostic tests, surgery, review.

In NI, there are over 188,850 patients waiting for diagnostics and 115,929 waiting for elective treatment or surgery[4] (as of 30 September 2023). Waiting for a long time means that patients are living with problems that can and should be treated sooner than they are. This is unacceptable, is bad for quality of life, our economy and can make the treatment more difficult when it is received. We know that we can do better and that we can reduce our waiting lists. This means providing elective care in a smarter, more efficient way and maximising the full potential of all our healthcare workforce. Nuffield Trust reported in 2022 that the cost to deliver elective day case care is nominally 21% higher in NI than in England, with in-patient care 23% higher.[5] If we can drive efficiencies to levels similar to England, we can see more patients within our existing resources.

Going forward, we will address the challenges by reforming how elective care is delivered. There will be more focus on Centres of Excellence to deliver high quality care for patients when they need it – this will allow us to provide better care, to be more efficient when we do so and improve outcomes for patients. Our Centres of Excellence will be shaped as Elective Care Centres. The core of the Centres is to improve patient outcomes. They are a means to increase productivity and efficiency, reduce variation and increase reliability of the service. By doing this we will significantly impact the number of patients treated and reduce our waiting times. By providing services for the region, they also aim to ensure that patients have equitable access to the care they need, regardless of where they live.

[4] Publication of the quarterly Northern Ireland outpatient, inpatient and day case, and diagnostic waiting times statistics - position on 30 September 2023 | Northern Ireland Executive
[5] https://www.nuffieldtrust.org.uk/sites/default/files/2022-09/nuffield-trust-future-funding-and-current-productivity-in-northern-ireland-web.pdf

The evidence from other countries shows that Centres of Excellence work. In 2012, the Health Improvement and Innovation Resource Centre of New Zealand published its summary of the benefits of separating acute and elective surgery. Many of the benefits outlined before were reiterated and noted that "the greatest benefits to the patient are the reduction in hospital-initiated cancellations and improved timeliness of care. Cancellation of surgery creates great hardship for patients, who plan their working and family lives around proposed operation dates. The majority of these cancellations occur with less than 24 hours' notice.[6]

The benefits of Elective Care Centres are well documented, both in terms of patient outcomes and efficiency. They include:

- higher productivity – more patients can be seen in a shorter space of time;
- fewer inpatient stays, and therefore lower risk of hospital-related infections;
- reduced waiting lists;
- a more reliable and cost effective service; and
- low level of complications arising after surgery[7]

For those staff delivering services in Elective Care Centres, professional guidance also suggests there are benefits in terms of resilience, productivity, standardisation of care, quality of service, training opportunities, and a reduced number of avoidable admissions to hospital.[8]

Elective Care Centres are up and running across NI. We have day procedure centres at Lagan Valley and Omagh Hospitals and Elective Overnight Stay Centres at the Mater Hospital, Daisy Hill Hospital and South West Acute Hospital (SWAH) for patients that may require an overnight stay in hospital. In addition, we have cataracts centres at Downe, South Tyrone and Mid Ulster Hospital and an orthopaedic hub at Musgrave Park Hospital which includes the Duke of Connaught Unit, a dedicated orthopaedic day centre.

[6] Strategy 10. Improving elective care through separating acute and elective surgery. Health Improvement and Innovation Resource Centre of New Zealand 2012
[7] Day Surgery – Making it Happen World Health Organisation,
[8] Separating emergency and elective surgical care. Recommendations for Practice. RCS England, 2007

4. Patient Travel

With the increased focus on elective Centres of Excellence, this means that some patients will have to travel further for their elective, non-emergency procedure. This is balanced against more timely access to care and a more efficient service better able to meet the health needs of the entire population. 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 operation they would be prepared to travel within NI if it meant that waiting times would be reduced.

We asked similar questions from the Age Sector Platform and over 80% said they would be willing to travel further if there were benefits such as reduced waiting/procedure times and a lower risk of cancellation. Almost 16% of those asked were either unsure or unwilling to travel a distance to receive their procedures regardless of the benefits.

The evidence suggests that most people are willing to travel if it means they will be seen more quickly. However, it is also clear that there are patients who would have concerns about any additional travel time. Our Service User Advisor Panel has reminded us that there needs to be accessible and reliable public transport for those patients that do not have access to private transport, particularly the elderly. They also highlighted the importance of flexible appointment times, especially for those travelling a greater distance and/or by public transport. The Panel has also raised concerns about the costs associated with travelling further and the potential impact on low-income families.

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.

The DoH has a statutory duty to provide transport to enable eligible patients and clients to access health and social care services. Eligibility for access to non-emergency transport services is based on medical need as determined by a medical

practitioner. NIAS operates a Patient Care Service, which provides non-urgent transport to secondary care locations. This is supplemented by the Voluntary Car Service, whose volunteer drivers will take patients to appointments, especially those who are mobile but require regular treatment, for example, dialysis and cancer treatments, and also on occasion by private ambulance operators and taxis. The Hospital Travel Costs Scheme remains in place and the scheme provides help to those on a low income who are under the care of a consultant and in need of health service treatment at a hospital, health service centre or private clinic.

Those patients requiring treatment will normally make their own way to hospital, either using their own transport, or that of friends and relatives, or by using a number of schemes that exist to help people who have transport difficulties. However, it is recognised that reconfiguration may in some instances impact those who live in rural areas, particularly in relation to potential increased travel times for access to services that will provide better care for our communities in a safe and sustainable way, providing access to the right level of care, in the appropriate setting first time.

While we recognise there are concerns from a proportion of service users, it is our assessment that the move to reconfigure services has a greater overall benefit than the status quo. The excessive waiting times for many awaiting routine surgery need to be addressed and the creation of Elective Care Centres of Excellence is one way to achieve that. Nevertheless, because we recognise that our Elective Care policy may mean that some patients need to travel further to access elective care, we must pay particular attention to the needs of low-income families. We commit to working across the NI Executive Departments to consider carefully the travel support available for our population (**Action 1**). As part of this commitment the Department plans to review the 2007 Transport Strategy for Health and Social Care services in Northern Ireland (**Action 2**), which will include the criteria/assessment of need, promoting volunteer drivers, online non-emergency transport booking system and key performance indicators with performance management data.

Actions

Action 1: The Department will work 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.

5. What and Where: Local Hospitals

We use the term Local Hospitals to describe a widely distributed group of smaller hospitals which currently provide a range of services that may include unscheduled and elective inpatient care, outpatient services, mental health services, rehabilitation, respite care, diagnostics, and disability services. They are also important hubs for accessing community and social care services. Importantly, there are mixed models in operation; some have medical models based on General Practitioners whilst others are managed by hospital grade doctors.

This group of hospitals is less easy to define, and they have already evolved in different ways in response to local need and geographic imperatives. They have effectively developed niche roles that have made them more resilient. There are examples within the group of how a networked approach can sustain a range of unscheduled services. This is illustrated by Lagan Valley and Downe hospitals which maintain inpatient acute medical consultant services, accommodating a service for all patients presenting at the site. This is supported by agreed ambulance bypass protocols whereby a patient is taken elsewhere if deemed appropriate by NIAS, or following discussion between the ambulance service and the hospital clinicians (usually the Ulster or in some cases the Royal Victoria Hospital depending on the initial triage). These hospitals do this in partnership with their Area Hospital (Ulster Hospital), through cross-site working. In reconfiguring the whole system, local hospitals can play a key supplementary role to the work of the Area and General Hospitals. Lagan Valley Hospital is again a good example of this as it has developed a function as a regional Elective Day Procedure Centre, bringing surgeons and anaesthetists from other hospitals to a dedicated facility that is protected from the competing demands of urgent and emergency care - a facility designed to maximise efficiency and deliver better outcomes for patients.

It will be important that HSCTs, continue to evolve their local hospitals to best meet current and future local population health needs (**Action 3**).

Challenges and enablers

Size, and existing infrastructure:

Some sites have already developed their facilities to deliver a range of services that are complimentary to the wider service. For example, the renal dialysis unit at Omagh Hospital and the rapid diagnosis centres at South Tyrone and Whiteabbey Hospitals.

Location and clinical profile:

Some sites by virtue of their relative isolation and clinical profile must tailor their activity to ensure that they can meet extant standards of care. This applies particularly to the more community-orientated sites that provide step-up and step-down care, respite care and rehabilitation.

Cost effectiveness:

Local hospitals can develop roles that are cost effective and of high quality, however it is important to avoid unnecessary replication, or competition for resources. The future of each local hospital must be considered in this context.

Actions

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

6. What and Where: General Hospitals

The three hospitals in this group – SWAH, Daisy Hill and Causeway - share many of the challenges of the Area Hospitals and in reality are competing with them for resources. The issues associated with the reconfiguration of these hospitals are historically the most disputed by local communities. For many reasons these hospitals are the ones that are most vulnerable to unplanned change in service. Their geographical locations and the challenge of maintaining safety-critical medical rotas and wider clinical teams are the biggest issues. They cannot just be small Area Hospitals; the resources do not exist to perpetuate this. It is clear, however, that an achievable and sustainable solution that ensures the future of these hospitals is critical to developing a successful hospital network. These hospitals have a key role in ensuring our system can respond to the challenges of an aging population, delivering a range of acute and rehabilitation services, with the advantage that they are closer to an otherwise more isolated community.

Core Services

What is important is that the emergency departments in these hospitals need to be sustainable on a 24/7 basis, as the Area Hospitals could not cope with their significant workload. This requires acute and diagnostic services on site that include:

- acute and general medicine, accommodating a service for all patients presenting at the site for urgent and emergency care (supported by agreed ambulance bypass protocols either where deemed appropriate by NIAS, or following discussion between NIAS and hospital clinicians)
- radiology, including CT
- laboratory services, (to be defined)
- an enhanced care area with a stabilisation and retrieval team
- anaesthetic cover

It will therefore be critically important to maintain these core services at the General Hospitals. It is expected that General Hospitals will also provide a menu of other services, tailored to meet local population health need. This may include delivery of surgery and other elective care on behalf of the region, consistent with our Elective Care policy (**Action 4**).

Challenges and enablers

Interdependencies

The core specialties and services retained within a General Hospital must work together as a unit and provide a significant volume of the General Hospital services needed by a local population. This is clearly true for the reliance of ED and inpatient specialties on diagnostic services such as imaging and pathology but is also true for planned general medicine specialties such as cardiology, diabetes and respiratory services, as well as Care of the Elderly inpatient beds. As these hospitals evolve, it is important to consider interdependencies around the core services described above.

Elective surgery

To justify the anaesthetic cover and maximise the use of existing theatre capacity (much of which is of a high standard) sufficient elective surgery should be planned and delivered on these sites. This is already helped by the designation of SWAH and Daisy Hill Hospitals as elective overnight stay centres, along with the Mater Hospital within the Belfast campus. In reality, the same profile applies to Causeway Hospital, which could be similarly designated (**Action 5**).

Workforce

General Hospitals must work in partnership with the Area Hospitals in a fully integrated way. A shared or integrated workforce working across sites is going to be critical to their success. Where rotas of medical staff are required, they must be realistic and sustainable. Local variation of services may require a bespoke staffing solution including the introduction of new roles and different skill mix. Maximising the potential of the whole health care workforce across professionals offers more sustainable solutions in some situations.

Critically the General Hospitals may develop in different ways. Outside of the core services described above, they may retain differing clinical services depending on local need. They may also focus on different aspects of elective care. For example, SWAH's theatre specification lends itself to orthopaedic, gynae and general surgery.

Actions

Action 4: Consideration to be given 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.

7. What and Where: Area Hospitals

Area Hospitals are acute hospitals which provide a full range of secondary care services, including inpatient paediatrics and obstetrics, to meet the needs of their population. They are distinct from General and Local Hospitals in that they provide a broader range of specialties and services, have a larger inpatient bed base and more specialised clinical teams. In particular, these Area Hospitals will maintain a 24/7 emergency department, a 24/7 emergency surgery and anaesthetic rota and theatre, and be supported by a critical care unit.

Based on this model, NI can reasonably sustain five Area Hospitals, one in each HSC Trust area. This will however require decisions about other parts of the system, modernisation and the embedding of new ways of working.

The five Area Hospitals are:

- Altnagelvin Area Hospital
- Antrim Area Hospital
- Craigavon Area Hospital
- Ulster Hospital
- Belfast Hospitals Campus– recognising that the Belfast Hospitals provide Area Hospital services for their population across several sites, alongside a wide range of tertiary / specialist services.

It is acknowledged that Area Hospitals in some instances also provide specialist regional services including the regional plastic surgery and maxillofacial surgery service at the Ulster Hospital, the penile cancer service in Altnagelvin, and the recompression unit (hyperbaric oxygen treatment) in Craigavon Area Hospital. These are critical regional services of regional importance and do not impact on the role of the Area Hospital.

Area Hospitals have the potential to be the functional spine upon which the whole network is built. They are the key to ensuring that patient pathways into and out of Regional Centres work effectively. The Area Hospitals also do the bulk of the delivery of unscheduled secondary care. From the perspective of the workforce, staff can both

work in the Regional Centres to develop and maintain subspecialty skills and support regional services, while also supporting the work of the General and Local Hospitals, sustaining rotas and expertise.

Within Area Hospitals there are high levels of interdependency with specialisms working together as a unit. This is clearly true for the reliance of ED and inpatient specialties on diagnostic services such as imaging and pathology, but also in less obvious ways. For example:

- a broad range of elective surgery necessitates strong anaesthetics and Intensive Care Unit (ICU) teams, who in turn support the provision of unscheduled care, emergency surgery and obstetrics.
- the presence of an acute stroke service supports the recruitment of Care of the Elderly consultants, who will then increase the capacity and sustainability of unscheduled pathways in frailty care, inpatient geriatrics and Hospital at Home.

While each individual specialty may not in and of itself be essential to the operation of an Area Hospital, these interdependencies are important for the site to be able to function as a coherent clinical unit, without needing to reach out excessively to other sites for support.

This gives Area Hospitals a level of independence in the provision of secondary care which cannot be sustained in a General Hospital. It should also be recognised that a number of regional reviews are currently underway to consider future service models. These will consider a wide range of issues, including sustainability of workforce, clinical standards, patient outcomes and physical constraints.

Having five Area Hospitals does not always mean providing all existing services five times. Some services may effectively be consolidated and this will be considered as part of future regional reviews. Other services are more critical to providing an integrated acute and urgent care service.

Annex D shows the current distribution of secondary care services across the five Area Hospitals. It can be seen that there is a great deal of consistency across sites,

with approximately 85% of specialties listed being available on all five sites. While there are considerable advantages in having the full range of specialties provided on a single site, and this might rightly be an ambition it is also critical that we take account of the current operating environment in terms of patient safety, funding, service sustainability, maintaining clinical standards, and also future specialty developments, and strive to do the best we can with the available resources. The Getting It Right First Time (GIRFT) Review of Urology highlights the challenges for Antrim of not having onsite urology and offers recommended solutions short of a full surgical and inpatient service. As discussed elsewhere, this presents its own challenges, however, implementation of the recommendations of GIRFT for urology may provide a template for maintaining other important Area Hospital services that experience sustainability issues in the future.

Annex D can be the basis for discussions regarding the services to be expected in Area Hospitals, and how they can best be delivered (**Action 6**). This discussion and future planning must find the means to overcome existing constraints, whether these be funding, workforce, training, the building estate, infrastructure or transport. Adopting new ways of working will be required to deliver a sustainable Area Hospital model.

Inter-dependencies and Area Hospitals

In considering the role of Area Hospitals as being at the heart of the hospital network, their internal and external interdependencies are critical to the success of the whole system:

- **Clinical interdependencies:**

Clinical interdependencies between Area Hospitals operate effectively in specialist areas such as critical care, where capacity across all hospitals is managed as a regional resource and a strong clinically led network (CCaNNI) oversees patient flow through the system.

Other interdependencies are generated by ‘missing’ specialties i.e. where a site does not deliver a service that would normally be considered to be secondary care, an obvious example being orthopaedic trauma and urology which are not provided in Antrim due to constraints around workforce and physical infrastructure.

In this case, patients are transferred to the RVH or Altnagelvin for treatment and then repatriated to the Northern Trust – this is generally considered to be a less than optimal solution but highlights the need for pragmatic collaboration within the current operating environment and optimisation of patient pathways to improve outcomes. The need for secondary transfer and repatriation in these circumstances creates a further interdependency with NIAS.

- **Interdependencies between Area and Specialist Regional Centres:**

There are obvious interdependencies between Area and Specialist Regional centres, as well as NIAS, for tertiary care: patients requiring regional specialist assessment or intervention will be referred on to the appropriate Specialist Regional Centre. Other services such as chemotherapy are provided on a hub-and-spoke model, where clinicians based at a Specialist Regional Centre will provide care on a sessional basis at Area Hospitals. Interdependencies also exist in terms of workforce: there are good examples of clinicians based in Area Hospitals who have regular sessional activity in a specialist regional unit – this helps Area Hospitals to recruit and retain staff who might otherwise not want to work outside of a Specialist Regional Centre.

- **Interdependencies between Area and General Hospitals:**

This largely operates at an intra-Trust level: Antrim-Causeway, Altnagelvin-SWAH, Craigavon-Daisy Hill, and is one of the means of stabilising and sustaining our general hospital sites. The larger, more specialist teams in an Area Hospital can provide support and advice to General Hospital clinicians.

Patients can access a broader range of diagnostics and interventions in their Area Hospital, and services which do not have an inpatient base on the smaller site can run outpatient clinics or provide sessional in reach or virtual advice to ensure access to specialist care for all of the population. It is important that the Area Hospital teams operate an ‘open door’ policy towards their General Hospital and Local Hospital colleagues, with a low threshold to access safe care.

Challenges and Enablers

The five Area Hospitals are broadly resilient, with a good range of on-site specialties and clinical support. With some exceptions, clinical teams are relatively stable and able to recruit and retain staff. They provide a key role in supporting general and local hospitals and their effective management of secondary care helps to ensure regional services are protected for those requiring the most specialist intervention. In line with the developing "area" model of Integrated Care Services (ICS), there is emerging consensus that sustaining five Area Hospitals is important to the delivery of high-quality acute care, as close as possible to local communities. Given the workforce issues already referred to, the sustainability of five Area Hospitals, providing a full range of acute services, presents its own challenges and in itself represents a driver for change through reconfiguration.

It will be important to focus on these hospitals to ensure that they have the clinical workforce necessary to meet best practice standards going forward. This is highlighted in existing reviews, such as the Review of General Surgery in Northern Ireland, the Regional Review of Unscheduled Care, the GIRFT Review of Emergency Medicine, the GIRFT Review of Urology and the GIRFT Review of Orthopaedics. Without reconfiguration and the new ways of working that this requires we will persist with a system of competition for resources that will make it more difficult to meet modern best practice standards.

The key challenges are:

- **Equity of access and specialty profile**:

Annex D shows that most secondary care specialties are available on all Area Hospital sites, albeit there are a few anomalies.

Two questions arise: firstly, can we deliver all these specialties five times on a sustainable basis? If not, either now or in the future, this leads us to the second question: what is the best model to ensure the effective and efficient delivery of these services and to minimise inequity of access? For example, the lack of fracture and urology services on the Antrim site has resulted in access and equity issues and

GIRFT Reviews into both Orthopaedics and Urology have highlighted concerns and offered recommendations.

There is often a rationale for not providing a particular service on all sites: this may be due to clinical standards, patient volumes, workforce constraints, physical infrastructure or a combination of these factors. It should be acknowledged, however, that these inconsistencies can result in delay, inefficiency and increased pressure both on the receiving site and on the Ambulance Service, with potentially poorer outcomes for service users. Where 'times five' is not feasible, alternative models of care must address these points.

- **Specialist Regional / Area balance:**

A number of specialties, such as cardiology or paediatrics, have historically been commissioned and delivered either on a largely regional model, or on a hub and spoke model with more specialist care or interventions delivered on a centralised basis. In some areas, following robust option appraisal, there may be a case for moving some activity out of Specialist Regional Centres and into Area Hospitals (**Action 7**) – this would improve local access for patients, strengthen area-based teams and reduce pressure on specialist regional services. Considerations would, however, need to balance other issues such as recommended volumes per clinician, resilience of clinical teams - particularly out of hours, and any financial impact of losing economies of scale.

- **Workforce:**

There are many workforce-related issues experienced in the Area Hospital network, particularly in relation to medical staffing: competition for clinical staff, over-specialisation in training, the current approach to training doctors and their deployment, under-development of skill mix through roles such as clinical nurse specialists, Advanced Nurse Practitioners, Advanced Allied Health Profession roles, Physician Associates or enhanced administrative support (**Actions 8 & 9**).

A strategic workforce review based on the needs of our population and focused on developing and sustaining strong, multi-disciplinary teams across all acute specialties

will be essential to ensure we sustain our Area Hospitals (**Action 10**).

- **Pathways**

There are pathway challenges for specialist regional services (as per section 8), which places much responsibility on Area Hospitals and NIAS to maintain patient flow to and from Specialist Regional Centres, and from Area Hospitals into the network of services in our smaller hospitals and the community. Alongside the workforce issues, this is possibly the most important challenge to deal with in creating a high performing system.

Actions

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 an 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.

8. What and Where: Specialist Regional Services

This section focuses on specialist regional inpatient services which are delivered for the whole population of NI, generally from a single hospital base. Services are defined as specialist for a number of reasons, for example, they are highly complex, require a specialist workforce or specialist equipment to deliver, or need to be located alongside other highly specialist services.

This is distinct from other services which, in line with Elective Care policy, are delivered for the region in designated hospital sites for efficiency purposes, but which could be located anywhere across the hospital network.
With a population of 1.9 million, NI is a relatively small region in UK terms. This poses challenges in setting up and maintaining specialist services when compared to their equivalents in Great Britain (GB) which usually have much larger catchment populations and bigger more robust clinical teams. There are longstanding commissioning arrangements for specialist regional services within NI, including a wide range of specialties such as neurosurgery, cardiothoracic surgery, plastic surgery and burns, spinal surgery and cystic fibrosis, along with many subspecialties within paediatrics. The definition of Specialist Regional Inpatient Services in NI is shown in **Annex E**.

The great majority (more than 90%) of specialist regional inpatient services are based in the Belfast Trust. Examples of specialist regional services in other Trusts are the regional plastic surgery and maxillofacial surgery service at the Ulster Hospital, the penile cancer service in Altnagelvin, and the recompression unit (hyperbaric oxygen treatment) in Craigavon Area Hospital. Many, if not most, specialist regional services have a time-critical component, with the ability to provide advice to referring units across NI, patient transfer and treatment on a 24/7 basis. Examples with a major unscheduled care component include major trauma, vascular surgery, and neurosurgery. Provision of specialist regional elective care also requires timely access to beds, complex diagnostics or laboratory support, and/or theatres and critical care.

There remain small numbers of patients who have rare or particularly complex conditions and need assessment or treatment which cannot be provided by a NI-based team.

In certain instances, these are delivered by visiting teams from a GB centre, working alongside their NI counterparts; one example is the visiting team from Alderhey for paediatric craniofacial surgery. A small number of patients need to travel for treatment to GB specialist centres, such as the National Amyloidosis Centre in University College London. This is arranged via the Extra Contractual Referral (ECR) process, with patient travel managed by DoH Strategic Planning and Performance Group (SPPG).

Key challenges / Enablers for specialised regional impatient services

There are challenges to the sustainability, quality and safety of highly specialised regional inpatient services, including:

- **Workforce:**

Although certain specialist regional services which are primarily provided in planned (elective) sessions may be able to deliver these with a very small number of consultant staff (one or two), this is vulnerable to unexpected illness or resignation. Where possible, clinicians in such services should be supported to become part of a wider tertiary or quaternary network across GB and/or the Republic of Ireland (ROI) (**Action 11**). Multidisciplinary working is an increasingly essential component of specialist regional care. Depending on the size of the service, this may include attendance at MDTs with colleagues in a wider tertiary or quaternary network across GB and/or the ROI. To ensure best patient outcomes a highly skilled and trained workforce is essential. A prerequisite of this is that there is sufficient workload in terms of patient numbers to develop and maintain these skills. This applies to staff based in the Specialist Regional Centres and staff who may be based elsewhere in the system but work into the Centres both to provide sub-specialist services and to develop and maintain their skills.

- **Protected Capacity and Access:**

These services should not have to compete with non-specialist unscheduled care, therefore there must be an agreed protected bed base, diagnostic and theatre capacity, with separate and protected flow from general unscheduled care pressures (**Action 12**). If this cannot be delivered then these services will be cancelled at times of ED pressure, leading to inequity in the system, patient safety issues, suboptimal outcomes and at times avoidable harm and deaths.

- **Keeping Pace with Innovation:**

It is essential that these teams are linked into supra-regional networks to ensure competency is maintained and training is adequate. Within NI, this work needs to be consolidated in single sites to allow future development and nurture of high performing teams which are able to learn from and challenge each other and are networked into national speciality forums. Modern medicine is constantly evolving so creating the conditions to learn from best practice across the world and bring this back to NI is essential. Strong academic networks are essential to foster leading-edge research in NI which we can then share with the rest of the world, further attracting the best candidates to service and inflow of research monies into our economy which has benefits in the wider economy e.g. iReach and City Deals.

- **Infrastructure and Equipment:**

We must facilitate an environment for innovation to flourish, including the adoption of clinically-evidenced novel techniques which can improve outcomes and are less invasive e.g. robotic surgery, novel interventional radiology techniques etc. Some of these require major investment, such as hybrid theatres and negative pressure rooms. In turn, these techniques can lead to faster recovery and rehabilitation, thus reducing time in hospital for patients.

- **Critical mass and Interdependency of Regional Specialities:**

To ensure the sustainability of regional specialities into the future, it is important to recognise the growing complexity and interdependency of many of these specialties. To ensure the most efficient use of resource in terms of infrastructure, workforce, equipment and training opportunities, it is important that specialist regional

services which need to be delivered alongside others for strong clinical reasons are not disaggregated. For example, hyper-acute stroke care, including thrombectomy (clot retrieval), requires a 24/7 stroke consultant on-call, a consultant specialist neuro-interventional radiologist and imaging, access to a neuro-interventional theatre suite, on-site neurosurgery and on-site regional ICU, coupled with a specialist expanded MDT in support. Similarly, the regional diabetic foot service requires specialist orthopaedic care, vascular surgery, endocrinology, interventional radiology and access to specialist imaging, coupled with a specialist expanded MDT. The same points can be made in respect of the interdependencies of fracture and trauma services.

- **Patient Pathways:**

Patients requiring these services need to have timely access but must also be discharged promptly to their Area or General Hospital or home when they no longer need specialist care so that new patients can be accepted. Smooth discharge requires an appropriate balance of beds in the specialist regional units and area/general hospitals. Beds should be calculated to operate optimally on clinically-agreed repatriation time frames that must be adhered to at all times. The system must collectively prioritise timely flow through these beds, as far as is reasonably practicable. It will be a shared responsibility for the system.

Actions

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 specialist regional services.

9. How: Collaboration Arrangements

Introduction

The actions identified in the above sections should be considered in the context of the principles and learning set out in this section. Collaboration and the establishment of networks is how we will work together to manage the hospital network. This is not a new concept in NI. Various forms of clinical service delivery and planning networks have been tried and tested across NI over the years.

We have a plethora of networks and informal collaborative approaches (there are at least 13 operating within HSC Trusts in NI, such as the Pathology Network, Regional Trauma Network, NI Cancer Programme Clinical Reference Groups, and so on).

Learning from elsewhere

To inform possible collaboration arrangements in NI, the approach taken in Scotland - 'Obligate Networks' - was considered. An Obligate Network is a formalised arrangement between two or more healthcare organisations that secures access to sustainable services for the whole population served by these organisations. Obligate Networks may be strategic between National Health Service (NHS) Boards, who will agree a basket of services to be provided within that arrangement, or they may be at an operational service level between a specialist service and a more generally based service. These networks will provide:

- Access to expert opinion to inform and support local decision making, which may be 24/7;
- Development of shared protocols and pathways;
- Improved discharge planning;
- Transfer Debriefs; Peer Group support, training and education; and
- Rotation for skills and maintenance, this may include joint appointments.

Whilst aimed at clinical service sustainability, Obligate Networks may also provide benefits for non-clinical services. The obligation arrangements may differ between services, the obligation may be limited to ensuring clear pathways of care where more specialist diagnostics or treatments are not locally available.

This may be supported by a visiting service and limited clinical decision support, or it may be more far reaching with the creation of a virtual department with joint appointments. Specific arrangements are agreed on a speciality-specific basis and may require larger departments to make significant changes to current working arrangements.

Scotland currently operates a number of these 'Obligate Networks' based on the principle of formalised arrangements between healthcare organisations and across Health Board boundaries. Furthermore, a review completed in 2022 of the Scottish Health Protect Network (SHPN) contained useful learning for NI. Similar to reconfiguration, health protection is not the realm of any one professional group. A Health Protection Network was initially formed in Scotland in 2005 to coordinate activities across the country. A review in 2012 indicated that wholesale structural changes were necessary and an Obligate Network should be established between relevant agencies to provide health protection services. SHPN was established in 2015 to support professionals and agencies in sharing experience, gathering evidence, embed learning in guidance and support practitioners through audit and research. Parts are obliged to contribute people and time to the network and include Public Health Scotland, Health Boards, local authorities, Food Standards Scotland etc. Other organisations attend on an advisory basis but are not obligate members.

During engagement on the SWAH Emergency General Surgery consultation, the Joint Royal College of Surgeons of England and Royal College of Surgeons of Edinburgh highlighted the concept of Obligate Networks to WHSCT. The Royal College of Surgeons made 'a strong call for the development of managed clinical networks of care, as referenced within the Department of Health's 2022 Review of General Surgery, to ensure equitable access to high quality care both in emergency and elective settings'.

It proposed interconnected systems of service providers that allow for:

- collaborative working,
- clear routes of c**o**mmunication,

- sharing of resources,
- development of common standards of care across the network with agreed thresholds for patient transfer for elective and emergency surgery.

The Royal College of Surgeons indicated that Obligate Networks can *'help with succession planning by providing CPD and refresher training, and support clinicians if unexpected circumstances require that they act beyond their practised competencies. The idea is that the networks should be underpinned by contractual agreements that specify service requirements and outcomes, and they should be appropriately resourced on an administrative and financial basis'.*

Research by Becher et al 2020[9] supports the reasons for the development of a strong and structured networks to support Emergency General Surgery service, not least around patient safety, but also better outcomes. It found that survival rates for non-trauma surgical emergencies were improved when operations were performed at higher-volume hospitals. Research by Nally et al in 2019[10] found that patients undergoing emergency abdominal surgery managed by high-volume surgeons have better survival outcomes.

The Royal College of Surgeons of Edinburgh report 'Standards informing delivery of care in rural surgery (2015)'[11] drew on evidence from the experiences of Scottish Remote/Rural General Hospitals (RGHs) comparable to the NI context. It concluded that patients should be cared for in major trauma centres even within urban settings, and so may bypass geographically closer hospitals even for initial management.

[9] Hospital Volume and Operative Mortality for General Surgery Operations Performed Emergently in Adults - PMC (nih.gov)

[10] Volume and in-hospital mortality after emergency abdominal surgery: a national population-based study - PubMed (nih.gov)

[11] rural-surgery-report-march-2016.pdf (rcsed.ac.uk)

Possible Application to NI

Whilst there may be merit in establishing a new formal network in NI, this would require resource and would take time to establish. At this stage, it is recommended that it would be more beneficial to identify the principles necessary to secure successful collaboration within existing teams and contractual relationships. In this context, it is important to note existing and ongoing local best practice, for example, in cardiology and urology.

It is also considered that it would be beneficial to use models of existing best practice as examples that could be replicated across the system. Therefore, consultation with teams currently operating successful local networks should form part of the action plan prior to considering any new formal framework. **Annex F** summarises some of the key learning from the Obligate Networks.

Provider Collaboratives

Provider collaboratives can be a key component of system working, being one way in which providers can work together to plan, deliver and reform services. The Northern Ireland Hospital Network can only be sustained through collaboration (**Action 13**). By working effectively at scale, provider collaboratives provide opportunities to tackle unwarranted variation, making improvements and delivering the best care for patients and communities. The response to the COVID-19 pandemic most clearly demonstrated how providers can work together effectively at scale and pace to achieve common objectives.

Provider collaboratives are partnership arrangements involving at least two Trusts working at scale across multiple places, with a shared purpose and effective decision-making arrangements, to:

- reduce unwarranted variation and inequality in health outcomes, access to services and experience
- improve resilience by, for example, providing mutual aid
- ensure that specialisation and consolidation occur where this will provide better outcomes and value.

Key Challenges

There are a range of possible challenges associated with successful collaboration, within the scope of reconfiguring the Acute Hospital networking, was considered. These include:

- **Clarity** on the definition of regional/area/local services. Definitions of structures are important, however, it can constrain informed discussion about patient-centred care.
- **Workforce** - there is a need for strategic workforce consideration to address a number of key issues: there are significant issues around supply of and demand on staff; competition between Trusts for staff; and service vulnerabilities which both impact on the ability to retain staff in, and attract staff to, certain locations. There is also the lost opportunity cost associated with travelling to provide services from different locations.
- **Transportation** - significant patient and staff considerations across a regional/ area/ local network. This has a particularly strong impact on NIAS – any decisions which are made around closing services due to vulnerabilities, have a knock-on impact on NIAS for transporting patients from one location to another.
- **Population health planning** – we need to start getting a menu in place for data collection and integrating population health planning into commissioning. For example, the impact of deprivation and the demographic structure in certain geographies has an impact on the demand for particular services from those hospitals. We need therefore to engage non-HSC Partners in addressing this planning challenge.
- **Communication** - requirement for an overall strategy, including cognisance of PPI requirements within legalisation for service redesign. Suggestions have been made around changing the narrative of reconfiguration and successful integration of service users in developing the message.
- **Patient pathways** - learning from the Scottish experience indicates it is important to discuss and include patient pathways upfront in the agreement of collaborative working across networks
- **Requirement to flex and collaborate** - successful collaboration requires all Trusts to “flex” within the system to assist other Trusts – this is core to a collaborative redesign process and solutions proposed as a starting point.

It is considered that there are three key areas of challenge, which will need to be advanced for priority action:

- **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** (including ambulance services) – creation of a networked system of services for a static population and workforce necessitates significant thought around how both patients and staff move between those services. This can create lost opportunity cost for staff and increase patient journeys; however, must be delicately balanced with patient outcomes achieved with operating services at scale.
- **Patient pathways** – patient pathways 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.

Collaboration Principles

Meeting these challenges is essential to delivery and can only be achieved by providers working together with a shared purpose. The following principles can underpin collaboration across our hospital network:

- **Led by patient safety** - reconfiguration at its heart must be patient-centred rather than predicated on achieving service efficiencies for workforce, structures or buildings.
- **Service user and stakeholder engagement** – need to include legal and ethical responsibilities to engage service users and stakeholders in the reconfiguration of services in NI. Need to follow the co-production guidance and best practice to ensure service reconfiguration is co-designed with those on whom it impacts most.

- **Inclusive reconfiguration decisions** -The reconfiguration of services in one part of the system or one area of the province will undoubtedly have an impact elsewhere. Where this is the case, change needs to be planned with anyone impacted. For example, unplanned service reconfiguration within the broader Health and Social Care context can create additional pressures for the ambulance service.
- **Collaboration, not competition** - while the HSC is one of the largest employers in NI, quite often HSC Trusts end up competing with each other in terms of recruiting specialist staff.
- **Evidence based decisions** - service user representatives have advised us that in the past, key reconfiguration decisions were not fully implemented due to political and popular pressure. Decisions should be based on a solid foundation of data and evidence conducting thorough assessments, including patient needs and experience, population health trends, and the impact of reconfiguration on patient health outcomes. Quality Improvement, and the use of best practice research must underpin decisions proposed and taken.
- **Population health informed** - the profile of services and specialties provided across acute hospitals must be informed by a population health planning approach and connected to related strategic drivers such as the ICS and multi-agency discussions ongoing within the emerging AIPBs.

Conclusion

In circumstances where core hospital services identified in previous sections are under threat, solutions will have to be developed. In the long term this may involve additional staffing, new ways of working including digital, additional funding or reallocation of resources. In the short term it may require the HSC system to collaborate to ensure that action is taken to maintain these core services. This may require cross Trust collaboration.

Similarly, where the current hospital configuration gives rise to significant inequalities of access to services, the HSC system should seek to address these in the short term through a collaborative approach, either within Trusts or, if necessary, through cross Trust working.

Actions

Action 13: DoH to explore with HSC Trusts and NICON how provider collaboration might help to support and sustain the Hospital Network.

10. Actions and Enablers

This framework identifies a wide range of proposed actions which will need to be addressed to ensure that our hospital system remains sustainable into the future and continues to provide our population with essential health and social care services. In addition, the hospital network and future reconfigurations will be supported by some key enablers, which have been identified as:

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 is fully involved in the development and provision of 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, reducing waste and ensuring value for money. That will be a key consideration in any reconfiguration decisions. We recognise that in some cases reconfiguration and service innovation will require additional funding 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.

The proposed actions identified in previous sections of this framework document will need to be addressed in the context of the above enablers and in the light of the challenges and principles identified in the collaboration section. The proposed actions have been summarised below and in more detail at **Annex F**.

Action 1: The Department will work 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.

Importantly, it is intended that the proposed actions will be refined following the public consultation, taking account of feedback received during the consultation. Where appropriate relevant stakeholders[12] will be asked to contribute to the refinement of the actions. Following the public consultation process, the Department intends to establish an oversight board tasked with overseeing the implementation of the final actions.

[12] This could for example include service users & carers, Royal Colleges and professional bodies and trade unions.

11. Engagement, Consultation, and Personal Public Involvement

This framework aims to provide greater clarity and information on HSC reform and our integrated hospital network within the broader context. It serves as a platform for informed engagement with stakeholders and an open dialogue with the public. This will facilitate active participation from communities, healthcare professionals, and society at large.

A key section of our community embraces those with direct and often long-term involvement with HSC services. Personal and Public Involvement (PPI) offers a structured approach to engage and consult with service users, their families 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. It establishes a clear mandate for PPI, emphasising transparency, accountability, and responsiveness to the needs and preferences of service users in shaping and delivering change. 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.

In this context, involvement entails collaboration between Health and Social Care (HSC) services, service recipients, and, where applicable, their unpaid carers. This collaboration aims to enhance the overall experience, practice, delivery, and outcomes. In this spirit, the Department seeks to engage with service users, carers, and other vital stakeholders in our community to gather their views and suggestions to further develop a way forward.

While this document sets out why change is necessary, the Department 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. Service users and their unpaid carers constitute a specific stakeholder group with whom the Department will continue to engage as part of the overall involvement process. Their involvement in shaping the future of health and social care in the region has been ongoing and has been evident throughout the development of “Delivering Together 2026”. PPI and coproduction initiatives and approaches have influenced and impacted on this draft framework. Through reviews for elective care, urgent and emergency care, stroke services, general surgery, neurology, and the cancer strategy etc., service users and unpaid carers have been involved in helping shape the way forward for health and social care in the region.

This paper combines approved policies and outlines a vision for our future hospital network. Any future significant specific reconfiguration changes at HSC Trust level will require local consultations. Furthermore, regional service reviews that result in future hospital reconfiguration decisions will require departmental-led public consultations. Therefore, public consultations associated with future hospital reconfigurations will happen either at HSC Trust level or at departmental level.

12. Conclusion

The Bengoa Report and 'Delivering Together' set out **why** we need to change our HSC system. These publications also set out principles in terms of how we should go about delivering reconfiguration. However, the Bengoa report did not set out the specific impact that the reform journey would have on our hospitals.
The long-term direction, as outlined in this paper, is towards greater specialisation, Centres of Excellence and consolidation of services. These factors, alongside the principles and the key implementation enablers will continue to drive future hospital reconfigurations.

The purpose of this framework is to explain **why** we need to change, including seeing our hospital estate as a network, explain **how** we can improve the sustainability of hospital services through greater collaboration and establish the process for making change, explain **what** our network will deliver and **where** and set the context for future reconfiguration decisions. The proposed actions (**Annex G**) set out a programme of work to ensure greater sustainability of our hospital system into the future. It is the intention that following the public consultation these actions will be further refined, incorporating feedback from the consultation, into a more detailed action plan. The Department also intends to establish an Oversight Board tasked with overseeing the implementation of the final actions.

Importantly, sustaining our hospital network in this manner and moving increasingly to a model of elective care 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[13].
- 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.

[13] Reconfiguration is a dynamic process, which should continue to respond to ever changing population health needs.

We recognise that our Elective Care policy may mean that some patients need to travel further to access elective care. We commit to working across the NI Executive Departments to consider carefully the travel support available for our population.

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. The core hospital services and commitments set out within this framework will therefore need to be revisited in the future, 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. We therefore anticipate that this work will be revisited within the next decade to ensure that it remains relevant.

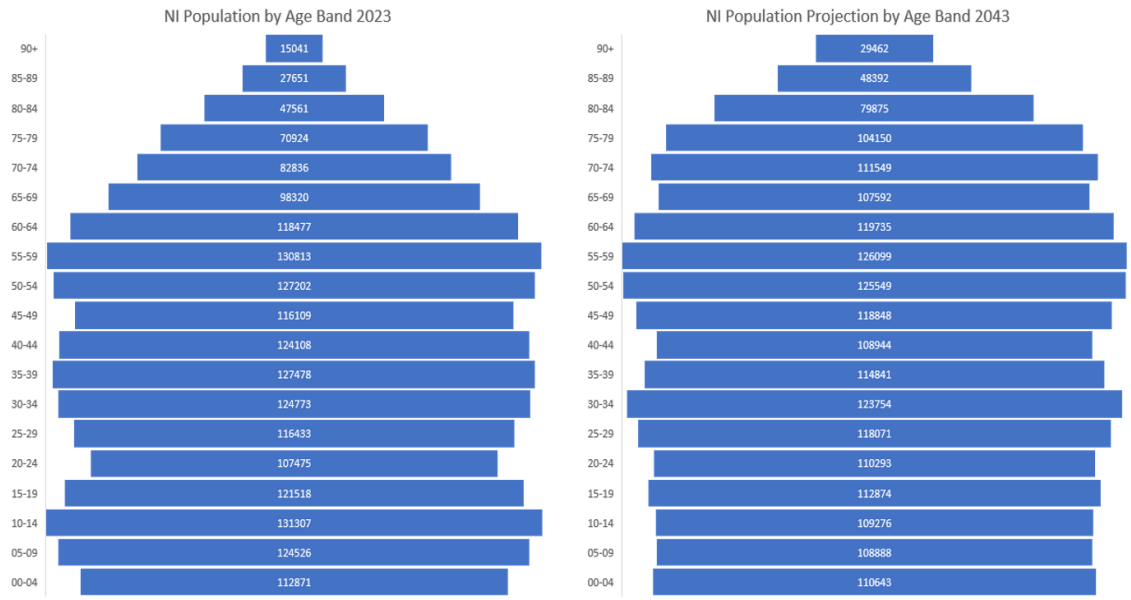
Annex A – Demographic and Deprivation Indices

Key changes in demography will impact on the provision of health and social care, particularly Local and Area Hospital provision. Data taken from NISRA Population Projections highlights a significant projected increase in people aged over 65 and over 85 highlighting new demand requirements in the management of multi-morbidity, including:

- The overall population of NI is to grow by 63,772 between 2023 and 2043 (3% increase);
- Population of 0-14 years olds is to decrease by 11% between 2023 and 2043 (a decrease of 39,897);
- Population of 65 years + to increase by 41% over the period 2023 to 2043 (an increase of 139,047);
- Population of 85 years + to increase by 77% over the period from 2023 to 2043 (an increase of 33,162).

Figure 3.2 below indicates the changes in population by age band over the next 20 years.

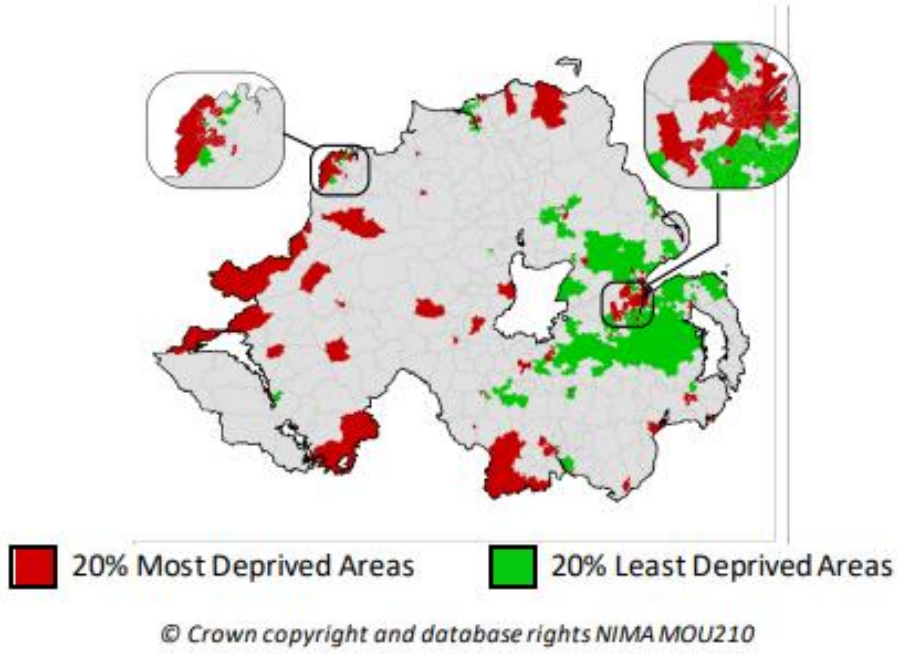
Figure 3.2



The Health Inequalities Annual Report published by the Department of Health utilised the Northern Ireland Multiple Deprivation Measure (NIMDM), produced by NISRA, to define deprivation. The 20% most and least deprived areas are defined according to the NIMDM 2017.

Figure 3.3 below reflects the 20% most and least deprived areas in Northern Ireland according to the 2017 NIMDM. Deprivation should be a key driver in consideration of what services are provided locally.

Figure 3.3



Demography changes and deprivation indices should be key drivers in determining population heath needs and utilised to develop a framework for future management of the delivery of local hospital and community service provision**.**

Annex B - Guidance on Roles & Responsibilities, Change or withdrawal of services

MEMO

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

From: Peter May Ref: SSUB-0446-2023

Date: 30 August 2023

To: HSC Chief Executives

DEPARTMENT OF HEALTH POLICY GUIDANCE CIRCULAR

GUIDANCE ON ROLES AND RESPONSIBILITIES – CHANGE OR WITHDRAWAL OF SERVICES

Introduction

1. The purpose of this circular is to update the guidance on the decision making relating to change or withdrawal of services. The changes reflect recent structural changes across the HSC and intend to provide further clarity on the process of change or withdrawal of services – both temporary and permanent. This circular replaces previously published guidance relating to change or withdrawal of services and is effective from 12 September 2023. This circular does not impact or change any aspects of the obligations and responsibilities with regards to involvement and is consistent with Involvement & Consultation Schemes developed in 2023.

2. The respective roles and responsibilities of all organisations within the HSC system are set out in the HSC Framework Document and in individual Management Statements. However, the Principal Accounting Officer and the Minister are ultimately responsible for the efficient and effective deployment of public money in health, social services and public safety. This means there are occasions when decisions about services will need the final approval of the Department. **Departmental officials will determine if the issue can be approved at official level, or if Ministerial approval is needed.** Where there is any doubt about the threshold, the Minister will be engaged on who the decision maker should be.

3. This scope of this circular relates to all Health and Social Care services including Children's Services, Learning Disability Services, Mental Health Services, Older People's Services and Acute Services.

Role of Department and HSC bodies

4. **The Department** has an overall duty to promote an integrated system of health and social care designed to improve the health and social well-being of the people in Northern Ireland. The Department sets the strategic direction and provides targets for delivery. The SPPG is responsible within the DoH for planning, financial and performance management of the HSC.

5. **The Public Health Agency (PHA)** has lead responsibility for the implementing of Personal and Public Involvement Policy (PPI) across the HSC. This circular does not amend this responsibility and does not provide new advice relating to the PPI policy. HSC bodies that are considering change or withdrawal of service (whether permanent or temporary) may wish to seek guidance from the PHA in relation to best practice on public involvement and consultation.

6. **HSC bodies** are required to provide health and social care services in line with their statutory duties and response to instructions from the Department / Minister. A list of all relevant HSC bodies is attached at **Annex A**.

Involvement with the public, including statutory responsibility to involve and consult

7. *Health and Wellbeing 2026: Delivering Together* states a commitment to ensure that the design of new and reconfigured services is taken forward on the basis of partnership working. Patients, clients, carers and communities should be at the centre of decision making in health and social care. This means that they must be meaningfully involved in the design, delivery and evaluation of their services. HSC bodies are accountable to people and communities for the quality, accessibility and responsiveness of the services they plan and provide.

8. Section 75 of the Northern Ireland Act 1998 and sections 19 and 20 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 impose statutory duties on Health and Social Care (HSC) bodies related to the involvement and consultation process. Nothing in this circular affects those statutory duties or the associated guidance on compliance. Personal and Public Involvement which requires effective and meaningful engagement of service users and carers and/or the public continues to take a critical element of commissioning, service development, delivery and evaluation

9. **It is for HSC bodies to determine if a decision to change or withdraw a service requires a public consultation**. Such decision must be made in line with the Northern Ireland Act and the Social Care (Reform) Act. Public involvement must always take place – whether a public consultation is required or not. The PHA can provide further advice on engagement and involvement with the public on decision making related to change or withdrawal of service.

Permanent change or withdrawal of service: decision making and Departmental approval

10. **HSC bodies are responsible for the delivery of services and can make operational decisions about the service delivery independently**.[14] However, HSC bodies must at all times work collaboratively with PHA, SPPG and other Departmental colleagues and should advice of their intent for a change to, or withdrawal of, a service as soon as practicable.

11. Operational proposals about change or withdrawal of services will not normally require Departmental approval. However, regular collaboration with colleagues in other HSC bodies, PHA and in the Department (both policy colleagues and SPPG) should be normal practice. This may help find alternative solutions with overall better outcomes and will help to determine if a change or withdrawal is major and/or controversial. Such communication can be through formal channels, such as regional programme boards and groups or by direct contact with relevant officials. HSC bodies are expected to exercise judgment about what is major and/or controversial. It is not the Department's aim to take upon itself final approval for all operational decisions about service provision.

12. When a HSC body has determined that a public consultation is required, **the Department (through SPPG) must be formally notified of the public consultation to change or withdraw services**. If the consultation documents refer to regional policies, strategies and standards, the Department must approve such references with a Departmental decision to be processed quickly. The HSC body does not require Departmental approval to start a public consultation. However, as outlined above, some decisions will require Departmental approval after consultation is complete.

13. **If a proposal to change or withdraw a service is determined by the Department to be major and/or controversial or if the proposals are contrary to Departmental policy, Departmental approval to make the final decision on the change or withdrawal is required.** It is not practicable to develop definitive criteria for these terms.

14. If a public consultation has taken place, after the completion of the consultation to change or withdraw a service the HSC body must within a reasonable timeframe[15] furnish the Department with a consultation report and the HSC bodies' proposed way forward which is supported by their Board.

15. If a proposal requires Departmental approval, the Department (through SPPG) will take account of the following factors, based on information provided by the HSC body making the proposal for a change or withdrawal of service:
    a. the extent to which the proposal is consistent with the Minister's priorities and Departmental policies;

[14] This include day to day management of services.

[15] The Consultation Institute have advised that best practice would indicate that such reports should be completed within 3 months or an explanation provided as to why this might take longer.

b. that the proposals are reasonable and the impact they will have on interdependent services or other providers;
c. the assessment of the proposal against the criteria at **Annex B**, where appropriate; and

d. the views of public and local community representatives.

16. The Department (through SPPG) when taking account of these factors will liaise with others in their consideration. This will include policy colleagues and the PHA. It may also include other HSC bodies, or others.

17. In its consideration Departmental officials will consider if a decision to permanently change or withdraw a service can be made by officials or if Ministerial approval is needed. During a period of absence of Minister, officials will follow official guidance whether a decision can be taken or not.

18. A flow chart of the process can be found at **Annex C**.

Temporary change or withdrawal of service: process and decision making

19. **The Department (through SPPG) must be informed at the earliest opportunity and** in advance of major or controversial temporary change or withdrawal to service provision. At all times the public should be involved as far as practicable and in compliance with their policy and statutory responsibilities in relation to involvement and consultation (to the extent determined by the HSC body).

20. **It is for the HSC body to decide whether to undertake a public consultation in advance of a temporary change or withdrawal of service**.

21. If the HSC body has determined that a public consultation is required, but it has not been completed prior to making the decision, it is recommended that a public consultation should be carried out following the decision where the rationale for the temporary change or withdrawal is set out and where the option of re-opening or reinstating the service. Alternatively, if a temporary change or withdrawal has taken place, the Trust can consider a permanent change or withdrawal and (if required) carry out a public consultation on such permanent change or withdrawal without first carrying out a public consultation on the temporary change or withdrawal of a service.

22. A temporary change or withdrawal of service cannot be used as a way to avoid involvement and a public consultation (if determined required by the HSC body). If the HSC body has determined that a public consultation would normally be required, but that the decision cannot wait, the HSC body must involve the public as much as possible prior to making the decision.

23. If the HSC body has decided to carry out a public consultation, and the consultation documents refer to regional policies, strategies and standards, the Department (through SPPG) must approve such references. Sufficient time must be allowed for

the Department to consider the references and provide approval. No Departmental approval is required to start a public consultation.

24. When an HSC body intend to enact a temporary change or withdrawal of service that is major or controversial or if the proposals are contrary to Departmental policy, the HSC body must consult the Department (through SPPG) and must take into account comments received by the Department. When being consulted the SPPG will liaise with and take the view of policy colleagues and the PHA. The views of others may also be sought.

25. **The final decision making on temporary change or withdrawal is always with the HSC body. However, in reaching a final decision to temporarily change or withdraw a service, the HSC body should consider whether or not it has the Departments support to do so. If an HSC body is proceeding to enact a temporary change or withdrawal of service without Departmental support it must be clear on its rational and justification for making the change.**

26. A temporary change or withdrawal of service is intended to be temporary in response to circumstances that require temporary actions. If a temporary change is long standing, it will normally be more appropriate to consider permanent change or withdrawal of service. A temporary change cannot continue indefinitely.

27. A flow chart of the process can be found at **Annex C**.

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Annex A

List of HSC bodies

HSC bodies include all Department of Health Arms Lengths bodies that provide health and social care services.
The relevant bodies include:

- Belfast Health and Social Care Trust (BHSCT)
- Northern Health and Social Care Trust (NHSCT)
- South Eastern Health and Social Care Trust (SEHSCT)
- Southern Health and Social Care Trust (SHSCT)
- Western Health and Social Care Trust (WHSCT)
- Northern Ireland Ambulance Service Trust (NIAS)
- Northern Ireland Blood Transfusion Service (NIBTS)
- Northern Ireland Medical and Dental Training Agency (NIMDTA)
- Regulation and Quality Improvement Authority (RQIA)
- Public Health Agency (PHA)
- Patient and Client Council (PCC)
- Northern Ireland Practice and Education Council for Nursing & Midwifery (NIPEC)
- Northern Ireland Social Care Council (NISCC)
- Northern Ireland Guardian Ad Litem Agency (NIGALA)
- Business Services Organisation (BSO)

Annex B

Criteria for Reconfiguring HSC Services

The Expert Panel's Report "Systems not Structures: Changing Health and Social Care" ('Bengoa') published 25 October 2016 proposed 7 reconfiguration criteria to be used when assessing the sustainability of health and social care services. In parallel, a commitment was given in 'Health and Wellbeing 2026: Delivering Together', to embark on a consultation on the proposed criteria for reconfiguring health and social care services.

A formal public consultation ran in late 2016 to early 2017. Analysis and consideration of representations received during the public consultation resulted in the refinement of the Expert Panel's recommended criteria. The refined criteria were reflected in the Consultation Analysis Report published in April 2019 under the process for decision making during the period of Executive formation.

This resulted in an update to the Department's guidance "Change or Withdrawal of Services – Revised Guidance on Roles and Responsibilities, issued in September 2019. The criteria are:

Criterion 1: There is evidence that the outcomes for people using HSC services are below standards recognised by the Department of Health, or statutory requirements are not met, or safety concerns are evident and impact on the long term sustainability of services.

Criterion 2: There are clear pathways for the patient and client population at local and region wide levels.

Criterion 3: The service cannot meet professional standards or minimum volumes of activity, as recognised by the Department of Health, that are needed to maintain expertise.

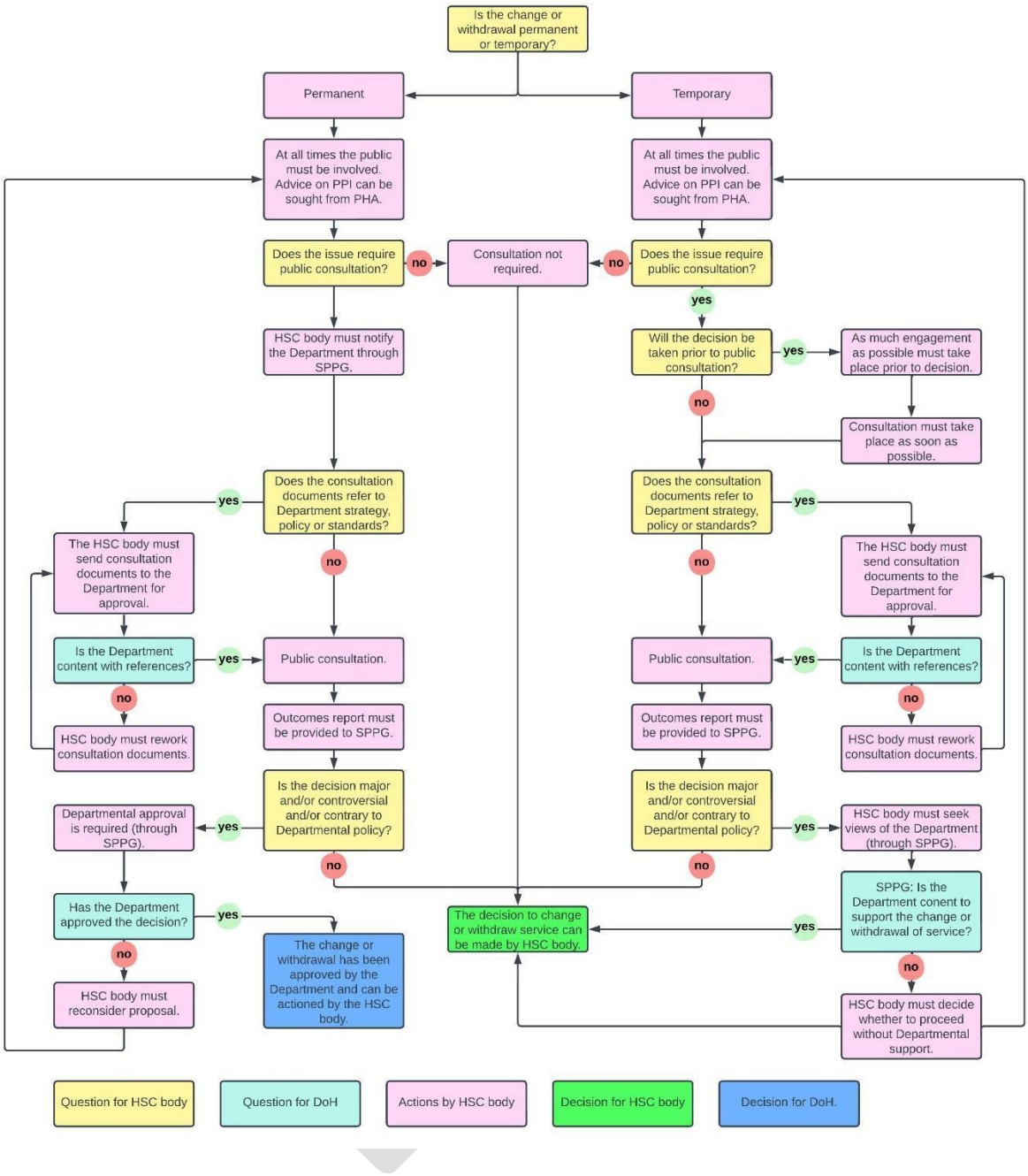
Criterion 4: The workforce required to safely and sustainably deliver the service is not available/cannot be recruited, developed or retained, or can only be secured with high levels of agency/locum staff.

Criterion 5: There are effective alternative care models as recognised by the Department of Health in place.

Criterion 6: The delivery of the service to the required standard is costing significantly more than that of peers or of alternative models due to a combination of the above factors.

Annex C –

Process for change or withdrawal of a service



Annex C - List of Service Reviews and Strategies

Population Health

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
Making Life Better (MLB) – overarching whole system strategic framework for public health in NI	Through strengthened co-ordination and partnership working in a whole system approach, the framework seeks to create the conditions for individuals and communities to take control of their own lives and move towards a vision for Northern Ireland where ***all people are enabled and supported in achieving their full health and wellbeing potential***. The aims of the framework are to ***achieve better health and wellbeing for everyone and reduce inequalities in health.***	MLB Action plan developed focusing on a small number of cross departmental actions.	The aims of the framework are to achieve better health and wellbeing for everyone and reduce inequalities in health.	Monitoring of MLB indicators: https://www.health-ni.gov.uk/publications/making-life-better-key-indicators-progress-update-2023	https://www.health-ni.gov.uk/topics/health-policy-public-health-policy-and-advice/making-life-better
Improving population health and well-being (Prevention strategies): Obesity Prevention; Tobacco Control; Substance Use/Abuse; Suicide Prevention; Skin Cancer Prevention; Breastfeeding					
Substance Use	The vision of ***Preventing Harm, Empowering Recovery - A Strategic Framework to Tackle the Harm from Substance Use (2021-31)*** is: People in Northern Ireland are supported in the prevention & reduction of harm and stigma related to the use of alcohol & orther drugs, have access to high quality treatment & support services, and will be empowered to maintain recovery.	Preventing Harm, Empowering Recovery has a focus on targeting the 3 priority groups identified as being at most risk of harm and death due to substance use – those experiencing homelessness; people who inject drugs; and those in contact with the Justice System.	5 population-level outcomes have been set to improve services for & tackle the harms around substance use.	DoH will publish regular update reports on the implementation of Preventing Harm Empowering Recovery - evaluating progress against SUS outcomes, indicators & actions.	https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-substanceuse-strategy-2021-31.pdf

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
Tobacco Control	The overall aim of the Strategy is to create a tobacco-free society. The key objectives are: fewer people starting to smoke; more smokers quitting; and protecting people from tobacco smoke	Three priority groups have been identified: children and young people; disadvantaged people who smoke; and pregnant women and their partners who smoke	The Strategy did not identify specific targets in terms of health outcomes. Since tobacco related harms occur mainly because of exposure over a sustained period, it is difficult to make direct correlations to the time-period of the most recent strategy. Development of the new strategy includes enhancing reporting of outcomes by which we can measure success.	The action plan is reviewed at every implementation group meeting for progress against key milestones. Any issues are reported back to senior management as they arise on an ad-hoc basis. Reporting to the Department of Health is by way of annual progress reports.	https://www.health-ni.gov.uk/tobacco-control-strategy-and-reports
Skin Cancer Prevention	The overall long-term aim of the strategy is to reduce the incidence of skin cancer and deaths from it among people in Northern Ireland.	Two key target groups have been identified as requiring particular action: • children and young adults; and • people who spend a significant amount of time outdoors including, those who regularly participate in outdoor sports	There are 6 strategic objectives to support delivery of the long-term aim of the Strategy.	A multi-sectoral implementation group for the Strategy, co-chaired by the PHA and Cancer Focus NI, monitors implementation and updates the Department through regular reporting mechanisms. There are also measures in the health survey and YPBAS information in relation to sun safe behaviours and UV awareness.	https://www.health-ni.gov.uk/publications/skin-cancer-prevention-strategy
Suicide and Self Harm Prevention	The two aims of Protect Life 2 strategy are: Reduce the suicide rate in Northern Ireland by 10% by 2024 and Ensure suicide prevention services and support are delivered appropriately in deprived	The Protect Life 2 Suicide Prevention Strategy Action Plan is currently being revised and new priorities will be	A review of the Protect Life 2 action plan is expected to be completed by end March 2024. It is	The Strategy is overseen by the Executive Working group on Mental Health and Wellbeing,	https://www.health-ni.gov.uk/protectlife2

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
	areas where suicide and self-harm rates are highest.	set when this is published at end June 2024. The Strategy currently identifies particularly high risk individuals as those who: • have attempted suicide • self-harm (particularly on a repeat basis) • have certain chronic and painful physical illnesses • are going through divorce/separation 28 • have been bereaved by suicide • have mental illness • misuse drugs and/or alcohol • are incarcerated in the criminal justice system	expected this will contain recommendations for enhanced monitoring and ongoing review of the Strategy. The revised action plan with refreshed outcomes is expected to be published in June 2024.	resilience and Suicide prevention. The Protect life 2 Steering Group meets quarterly and is chaired by CMO and contains representation across the statutory and Community and Voluntary sectors. An annual report is currently published by DoH setting out a narrative summary of performance against each objective within the action plan. The format of this monitoring will be updated once the revised Protect Life 2 Action Plan is published at the end of June 2024.	
Breastfeeding	The overall aim of the Breastfeeding Strategy 2013-2023 is to protect, promote, support, and normalise breastfeeding so that women are able to make informed decisions and are supported to breastfeed; infants are increasingly fed exclusively with breast milk for the first six months of life and, thereafter are fed complementary foods with continued breastfeeding.	Groups requiring specific support, include: • those in areas of low breastfeeding rates; • young mothers; • vulnerable infants (including premature infants and those with disabilities, long term illness and gut problems); • mothers of multiple births;	The Strategy sets 4 strategic outcomes to achieve the overall aim of the Strategy.	Progress on implementation will be monitored through routine accountability arrangements. Successful implementation of the Strategy will help to increase the initiation and duration of breastfeeding and improve public health.	https://www.health-ni.gov.uk/publications/breastfeeding-strategy

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
		• families with inborn errors of metabolism; and • mothers from ethnic minority groups and migrants			
Obesity Prevention	The vision of Healthy Futures - A Strategic Framework to Prevent the Harm caused by Obesity, and Improve Diets and Levels of Physical Activity in Northern Ireland is to create the conditions in Northern Ireland which enable and support people to improve their diet and participate in more physical activity, and reduce the risk of related harm for those living with overweight and obesity.	Consultation on the vision, principles, and themes ran from 23/11/2023 to 1/3/2024. Respondents were asked to comment on potential actions and priorities - these will be developed further through 2024.	Outcomes and action plan to be agreed by end of 2024	DoH will publish regular update reports on the implementation of Healthy Futures - evaluating progress against outcomes, indicators & actions (to be agreed by end 2024).	

Adult and Childrens Social Care

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
Reform of Adult Social Care	A Social Care Collaborative Forum (SCCF) was established in 2023 to implement proposals arising out of the consultation on the Reform of Adult Social Care (RASC).	A 2024/25 Delivery Plan has been developed. It will identify 3 priority headline actions across each of the 8 Programme Workstreams. The activities that the Collaborative Forum will take forward in 2024/25 will seek to maintain a balance between those actions aimed at delivering immediate improvements in the delivery of social care, and those actions that are longer term in nature but which are an essential component of building the foundations for longer term reform. All priority actions are intended to complete by March 2025.	Subject to reform aims being met we would expect to see improvements for adults in receipt of social care services, that will enable them to live as independently as possible, safely, and in a way that as far as possible reflects their ambitions for their quality of life.	Progress against the Headline Actions will be reported to the meetings of the Collaborative Forum in line with the programme governance arrangements agreed by the Forum and reported in the end of year Annual Report.	
Enhancing Clinical Care Framework for NI Care home residents	The aim of the ECCF is to ensure that people who live in care homes are supported to lead the best life possible and that their right to access timely, integrated, equitable healthcare provision is observed.	A review of the Standards for Nursing and Residential Care Homes is currently ongoing. The purpose of this exercise is to review and update the Standards (and relevant supporting documentation) to ensure they reflect the most recent	The central aim is to ensure those living in care homes have access to the clinical and wellbeing support they want and need, to live healthy, fulfilling lives and to meet the daily challenges many will face. The aim is for healthcare support within care homes to	Progress will be reported into the Social Care Collaborative Forum through Workstream 3 which has a focus on Enhancing Care in Care Homes.	

		developments, guidance, policy and procedures, including assisting with implementation of the ECCF.	be increasingly proactive, equitable and planned. The ultimate ambition is to ensure people living in care homes can equitably access the same range of responsive and preventative healthcare available to those living outside care homes, as part of an overarching, holistic approach to their health and wellbeing.		
Review of Children's Social Care Services Strategic Reform Programme	The aim of the Children's Social Care Strategic Reform Programme is to address a range of known service challenges, particularly in relation to the increasing volume and complexity of child and family cases. Implementation of a number of recommendations arising from the Indpenendent Review of Children's Social Care will also be driven by the Programme.	A 2024/25 Delivery Plan is in development. It will identify priority actions across the 9 Programme Workstreams. All priority actions are intended to complete by March 2025.	Subject to reform aims being met, we would expect to see an improvement in outcomes for children known to children's social care services and their families, for those responsible for their care and for the groups of staff working with them at all levels.	The Strategic Reform Programme Board will monitor progress and produce an end of year report. Work has also started on the development of a performance framework.	

Primary and Community Care

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
MDT roll out	Advance the implementation of the MDT model into all areas of Northern Ireland, stabilising primary care services, providing more care closer to people's homes, and reducing referrals to secondary care services	Further implementation of the MDT model is planned in phases over the coming years, with an ambition that rollout will commence in all areas within two years of the recommencement of the Programme.	Providing patients with new, more efficient ways of accessing a wider range of services closer to their homes and communities, thereby reducing the need for provision of care in more expensive hospital settings.	Evaluation of the roll-out to date is underway. The Programme will be subject to full evaluation in due course.	
GP Access project	To improve the patient experience of accessing GP services, and improve the capacity of the system to manage demand effectively, through effective deployment of appropriate technology	Development of guidance for practices in relation to effective management of demand, standardizing workflow and optimising use of technology. Development of a project to test how technology including VOIP telephony can improve management of demand for patients and practices.	Improved capacity for General Practice to manage demand from patients more effectively; improved user experience through consistent application of appropriate technology; improved access to data on user demand and system capacity.	Project will be subject to evaluation in due course.	
GP contract arrangement	Deliver 24/25 GMS Contract as a transitional year with a review of funding and allocation model to be progressed through 24/25 and beyond.	Secure NIGPC agreement on 24/25 GMS contract by 31 March 2024, deliver options following review of funding and allocation model to inform 25/26 contract negotiations.	An agreed 24/25 contract will facilitate improved sustainability of GMS contract provision to citizens. A review of funding and allocation model in 24/25 will provide equitable funding and contribute to sustained	New assurance and quality framework to be developed and implemented.	

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
			delivery of GMS services to citizens.		
New models for management of GP practices	Develop additional contract holding models to enhance sustainability of GMS provision	Deliver new models of alternative GMS Contract holding and delivery models in 24/25.	Availability of additional models for the management of GP Practices will provide additional bandwidth in terms of securing continuing provision of GMS services particularly in at risk areas.	Continued provision of Primary Care (GMS) in at risk areas.	
General Practice Pharmacist Strategy 2030	"GPP NI 2030" sets out a vision where pharmacists fully contribute to population health by acting as the clinical leads for medicines within the general practice team. Implementing a recommendation in the Pharmacy Workforce Review 2020, "GPP NI 2030" sets the strategic direction for the development of general practice pharmacy services over the rest of the decade and outlines six key recommendations for implementation.	"GPP NI 2030" was formally launched by the Minister on 28 Feb 2024. Implementation is being progressed by new governance arrangements led by SPPG primary care, including a new GPP Oversight Board and associated service delivery and service development subgroups.	Implementation of "GPP NI 2030" will fully optimise the contribution of pharmacists in general practice to population health. Outcomes include introducing new clinically advanced pharmacist practitioner roles in general practice, providing opportunities for pharmacists to improve patient health outcomes by consulting directly with patients and delivering high-quality pharmaceutical care, and maximising the whole team's contribution through new pharmacy technician roles.	A plan to implement the recommendations in "GPP NI 2030" will be developed and overseen by new governance arrangements including a new GPP Oversight Board, led by SPPG primary care.	
Transforming Medication	The Transforming Medication Safety (TMSNI) strategy is the Northern Ireland response to the World Health	The strategy was formally launched by the Minister of Health in	Implementation of the strategy will improve safe practices with	A department led Medication Safety Oversight Board was	https://www.health-ni.gov.uk/news/launch-

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
Safety Programme	Organization's (WHO) third Global Patient Safety Challenge 'Medication Without Harm' and provides the opportunity to re-energise our approach to ensuring the safe use of medicines in Northern Ireland. Our response sets out a commitment to improve systems and practice with the safe use of medicines and support a medication safety culture within our population.	September 2020. The key commitments in the TMSNI strategy set out the strategic direction for improvements in medication safety across Health and Social Care organisations. An extensive Programme has been established underpinned by an implementation plan, aligned to the TMSNI Strategy, which will take forward these key commitments. The TMSNI implementation plan contains a number of projects, aimed at enhancing the safer use of medicines within Northern Ireland. Each project falls under one of the four core domains within the TMSNI strategy, namely: 1.Patients and Public; 2.Health and Social Care Staff; 3.Systems and Practices; and 4.Medicines.	medicines and support a medication safety culture within our population. Outcomes to date include the roll-out of the World Health Organization 'Know Check Ask' medication safety campaign to increase public awareness of the importance of using medication safely and support people to be more involved in decisions about their medication. A Northern Ireland Yellow Card Centre was established in 2023 on behalf of the Medicines and Healthcare Products Regulatory Agency to encourage patients and healthcare professionals to report any suspected adverse incidents associated with medicines and medical devices to the scheme. Reducing the burden of avoidable harm from high-risk opioid medicines through the work of a HSCQI Opioid Improvement Programme is due to complete in Sept 2024,	established in May 2023 to provide strategic oversight and ensure accountability for the efficient and effective delivery of the TMSNI Programme. Evaluations of the TMSNI projects will be incorporated as part of the TMSNI programme structure. An evaluation of the 'Know Check Ask' campaign has been completed, with further evaluations in progress, such as the Medicines Optimisation Innovation Centre evaluation of the HSCQI Opioid Improvement Programme. Progress reports and evaluation outcomes are presented to the regional Medication Safety Oversight Board.	new-centre-promote-patient-safety-ni

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
			development and implementation of a patient engagement tool, '5 Moments of Medication Safety', to assist people to manage their medication safely and enable them to get the best intended outcomes. The Pharmacy Schools Programme continues to work with schools and education partners to help equip our children and young people with the knowledge and skills they need to be medication safety wise throughout life.		
Community Pharmacy Strategic Plan 2030	This is a new framework to fully realise the potential of community pharmacy to support better health outcomes from medicines and prevent illness. It sets out the vision and strategic priorities for community pharmacy up to 2030. it outlines how that vision will be delivered through 6 strategic priorities and 4 major reform programmes, to transform community pharmacy's role within the HSC system.	The Strategy will be launched by the Minister in early April 2024. 6 strategic priorities and 4 work programmes to support delivery have been identified; associated milestones for 2023 to 2030 have been identified and this sit alongside the strategic plan to monitor implementation.	The strategy aims to empower community pharmacies to further support and manage patients so that they live longer, healthier lives at home and contribute to a healthier society. the strategy aims to develop more patient-centred community pharmacy services, incorporating independent prescribing and advance practice, to support the goals of the HSC service and meet population health needs.	A number of milestones have been identified for the 4 work programmes underpinning the strategic plan. These will be subject to funding being identified and approved through departmental Business Cases. Implementation will be phased up to 2030.	

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
Advanced Care planning	Advance Care Planning is an umbrella term covering personal, legal, clinical and financial planning. It enables a person to think about what is important to them and plan for their future. It is a voluntary process and helps a person to make known what their wishes, feelings, beliefs, and values are, and to make choices that reflect these.	The Advance Care Planning policy was launched by the Minister in October 2022. Establishing momentum with implementation has been challenging within the context of current financial and resourcing pressures across the Department, PHA and the wider Health and Social Care system. A Task and Finish group, co-chaired by the Department and PHA, was established in January 2024 to take forward planning for the implementation of the Advance Care Planning policy in Northern Ireland. Priority areas for implementation are likely to focus on the clinical aspects of Advance Care Planning Immediate next steps include the establishment of an Implementation Group led by PHA to progress implementation subject to the availability of appropriate resources.	Advance Care Planning is an on-going process of conversations between a person, those important to them and those providing care, support, or treatment. These conversations focus on what matters to the person and what would be important for them to prioritise in the future should they become unable to make decisions for themselves. Advance Care Planning can also help a person consider what is important to them in a situation where, whilst they have mental capacity, they may need to consider their care, support or treatment. If the person wants to make a record of these conversations and share them they should be supported to do so. There are wider benefits for the health care system by helping to prevent unwanted hospitalisations and increasing the utilisation of palliative and hospice services, treating	Baseline information on public understanding of and involvement in Advance Care Planning is available through the Ulster University "Where are we now?" report (2021) undertaken as part of the annual 'Life and Times' survey. Subject to funding it may be possible to recommission this work in the future. It will also be necessary to monitor the level of Advance Care Planning discussions taking place between health and social care staff including in primary and secondary care settings. How we measure success will be a key focus of the Implementation Group.	https://www.health-ni.gov.uk/advance-care-planning-now-and-future

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
			patients with dignity and respect in line with their wishes.		

Mental Health

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
Mental Health Strategy and Delivery plans	To: • Promote mental wellbeing, resilience and good mental health across society. This includes reducing the stigma around mental health, provide early intervention and prevention, and provide support across the lifespan to those caring for people with mental ill health. • Provide the right support, at the right time. This seeks service improvements across a range of services, including; child and adolescent mental health services, old age, community mental health and inpatient services. • - Put in place new ways of working that will support the changes needed across the systems	Delivery of Strategy is being taken forward by way of Annual Delivery Plans. Each year a Delivery Plan is co-produced through engagement with a range of stakeholders which sets expected deliverables and key activities for that year. The initial focus has been on delivery of a number of key enabling actions including the establishment of a Regional Mental Health service, an Outcomes Framework, a Regional Mental Health Workforce Review, and the development of an Early Intervention and Prevention Action Plan. Annual Delivery Plans also provide an update on progress made over the previous 12 months.	If fully implemented, the Strategy will deliver: -a society which promotes emotional wellbeing and positive mental health for everyone with a lifespan approach, which supports recovery, and seeks to reduce stigma and mental health inequalities; - a system that ensures consistency and equity of access to services, regardless of where a person lives, offers real choice, places the individual and their needs at the centre, respecting diversity, equality and human rights, and ensures people have access to the most appropriate, high-quality help and treatment at the right time, and in the right place; - mental health services that are compassionate and can recognise and address the effects of	One of the key enabling actions is the development of an Outcomes Framework for the Strategy. This Outcomes Framework will help inform and improve treatment and care provided, improve service user outcomes through promoting evidence based practice and care, and ensure best use of resources through monitoring and evaluation of services and service developments. A proposal paper for the framework has been developed and arrangements are being put in place to appoint a regional lead	https://www.health-ni.gov.uk/publications/mental-health-strategy-2021-2031

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
			trauma, are built on real evidence of what works, and which focus on improving quality of life and enabling people to achieve their potential.		
Learning Disability Strategic Action plan	To address the challenges in supporting children and adults with learning disabilities. To provide a strategic response to the significant challenges across the programme of care, including health inequalities; growing complexity of need; transition from children's services, over-reliance on inpatient services and accompanying delayed discharges; accommodation gaps; a lack of meaningful day activity; insufficient short break provision and support for older carers.	Throughout 2023/24, the Department has led on an exercise to finalise a service model for adult Learning Disability through Department wide Task & Finish. Trusts, providers and families have been involved in this work to co-design a service model. A revised draft of the LDSM was endorsed by Trust Directors in March 2024 and work is now underway to develop a costed implementation plan and engage widely with the sector and people supported. It is critical that the LDSM is supported by those that use, and those that deliver LD services before developing an implementation plan. Alongside the LDSM, work is progressing to finalise and implement the draft Framework for	Production of a finalised learning disability service model underpinned by a fully costed implementation plan. This will enable better commissioning of the right level and blend of services to support people in the community at an earlier stage, reducing the need for acute inpatient care, high-cost bespoke arrangements and ECRs. The Framework for Children with Disabilities will improve the current offer of early help and community-based support, develop additional effective residential short breaks and short breaks fostering, and rethink the approach to residential provision	Both the Learning Disability Service Model and Framework for Children with Disabilities sets out the vision for the future of learning disability services in Northern Ireland. A Strategic Delivery Plan will set out the key outcome measures and actions outlined in the Service Model and Framework highlighting a number of key mechanisms that will need to be put in place to ensure it is implemented. It will detail how progress will be reported, define lead responsibility, identify resource implications and set timeframes. Delivery will be by a phased approach and will be closely monitored and reviewed to reflect strategic priorities and available resource.	

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
		Children with Disabilities. The Framework has been shared with Trusts for input and work is underway to develop costed proposals and a delivery plan. Subject to Ministerial decision, the service model will be subject to a public consultation in 2024.	and out of home placements and improve transition pathways into adulthood. Additionally, the Framework will be expanded to better meet the medical and therapeutic needs of Children with Disabilities and to better synergise with the ongoing work to support children in educational settings by standardising provision across the region, ensuring that service users and families can access the same pathways and services aligned to assessed needs. It will also provide the Department with a platform to better engage and work with the Departments of Education, Communities, Economy and Infrastructure.		
Autism Strategy	To improve regional pathways of care and enable individuals and families will have access to early intervention and support. To work in partnership to enable autistic people to feel understood and supported		If fully implemented, the Strategy will deliver the aims set out in the	Departments will monitor success through the outcomes-based measures which they have identified for	

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
	throughout their education and experience educational environments which are inclusive to their needs. To seek opportunity to increase understanding of autism in the workplace to enable individuals to feel supported within employment and enhance career opportunity. Through increased understanding of autism, our housing providers will be more equipped to provide supportive engagement and adequately support the needs of autistic people. To work within our community to increase understanding and acceptance of autism and create more inclusive environments to support the needs of autistic people.		commitments of the strategy.	actions within the strategy. Yearly progress reports will also be submitted to the Assembly as required by the legislation.	

Acute Hospital Care

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
Hospital Reconfiguration Framework	The overall aim is to produce a Hospital Reconfiguration Framework document following a programme of targeted engagement and public consultation which will provide an overarching strategic framework within which future hospital reconfigurations decisions can be taken.	(i) Draft Framework with draft Action plan co-produced following targeted engagement (by Sept 24). (ii) Public Consultation (Autumn/Winter 24) (iii) Monitoring and Implementation of Actions.	(i) Description of a NI Hospital network, where each hospital has been identified in a particular tier to build to become a NI hospital interdependent network. (ii) Identifies some core services to be available at each type of hospital and recognises that patient pathways will often flow between hospitals. (iii) How the system works collaboratively to support the network.	(i) A newly established Project Board will monitor the implementation of Actions. (ii) Sustained NI Hospital Network reducing the risk of unplanned change/closures.	
Elective Care Framework (ECF)	The overall aim, as articulated in the ECF, is to ensure better outcomes for patients that need elective care. This will be achieved by leading a strategic, whole system, integrated approach to the delivery of elective care. In practice this will mean better services for patients with reduced waiting times and improved quality and outcomes. The ECF aims to ensure that the HSC system is equipped to deliver an equitable, sustainable high-quality regional service for every adult and child in NI, irrespective of where they live. The six monthly ECF progress reports essentially detail the progress made to date against each of the 55 actions.	Despite the challenging financial position, huge efforts have been made across the system with considerable progress having been made on implementing the actions in the original Framework. Work is ongoing to continue transformation of elective care. Delivery timeframe of ECF - March 2026.	Subject to the necessary funding being made available, implementation of the revised ECF will ensure that people across NI receive the high quality, sustainable and equitable care and treatment they need, when they need it. Driving increased efficiency and productivity across HSC Elective Care Services will deliver a more efficient use of the system and ensure value for money. The total population in	The Elective Care Management Team (ECMT) monitors delivery of the Elective Care Framework, SPPG are responsible for performance management at Trust level.	https://www.health-ni.gov.uk/publications/elective-care-framework-restart-recovery-and-redesign Updated Elective Care Framework - May 2024 - https://www.health-ni.gov.uk/sites/default/files/publications/health/Elective%20Care%20Framework%20-%20May%202024.pdf

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
	In addition, the Department is working with Trusts to increase productivity and efficiency through the use of a wide range of best practice service improvements. Given the changes that have occurred in the HSC operating environment, a revised ECF was subsequently published on 24 May 2024 – this sets the strategic direction for the development and transformation of effective and efficient delivery of elective care services in Northern Ireland over the next five years and details measures needed to address the unacceptable waiting lists here.		Northern Ireland is expected to benefit from the proposals. Delivery of the ECF will see improved quality and outcomes, increased patient throughput, improved life expectancy, ensure better service provision for patients, reduce waiting times, and maximise capacity across the system.		
General Surgery review	The aim of the Review of General Surgery was to develop a safe, sustainable model for general surgery across Northern Ireland. Following its completion, the Review was published by the Minister of Health in June 2022. The Review included the establishment of regional standards for emergency and elective general surgery and actions in the review are now largely complete, including the establishment of a regional General Surgery Network. The Network is chaired by a General Surgeon and membership includes relevant clinicians and managers from all Trusts and DOH officials with relevant policy responsibility.	The Final Report on the Review of General Surgery was published on 24 May 2024. As a consequence, mainstream implementation will be handed over to SPPG/ Trusts.	Safe and sustainable general surgery services across all Trusts in Northen Ireland. Access to treatment through Elective Overnight Stay Centres, and to intermediate support from Post Anaesthetic Care beds for those requiring more care than can be provided on a general ward but who do not require an ICU or HDU bed. Dedicated elective care beds to protect capacity and reduce 'last minute' cancellation of complex elective inpatient surgery for patients with complex surgery or	The development and monitoring of operational measures will be part of the implementation work of SPPG/ Trusts.	Review of General Surgery: https://www.health-ni.gov.uk/topics/health-policy/review-general-surgery Review of General Surgery - Final Report May 2024: https://www.health-ni.gov.uk/publications/review-general-surgery-northern-ireland

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
			complex characteristics. Reduction in general surgery waiting times. The introduction of the National Emergency Laparotomy Audit to all HSC Trusts will enable benchmarking across the region and with England and Wales, directly focused on improving outcomes and experiences of patients undergoing this procedure.		
Urgent and Emergency Care review (including Intermediate Care)	Urgent and emergency care services have been under significant, and increasing, pressure for at least the past decade, with the additional pressures of responding to the COVID-19 pandemic exacerbating the issue. The aim of the Urgent and Emergency Care Review was to improve the service, and improve the service user experience, by ensuring greater accessibility to services and by making it easier to access the most appropriate service as quickly as possible. Access should be in a location most suited to the service user, without necessarily having to attend an Emergency Department, to help protect access to emergency care, whilst providing alternative services/pathways for urgent but not life threatening conditions.	The Review contained three strategic priorities: Creating an integrated urgent and emergency care service; Capacity, co-ordination and performance; and A regionalised approach to intermediate care. A workstream was developed for each of the strategic priorities, which oversee milestones and progress at a local level and report to a Departmental Implementation Board.	Rapid Access Clinics, Urgent Care Centres/Systems and local Phone First services have been introduced across all HSC Trusts, with the intention to launch a Regional Phone First Service, accessed through a single access point - telephone number HSC111 – as soon as possible. This regional service will streamline access to urgent and emergency care for patients, including access to GP Out of Hours (OOHs) services. These services are providing alternatives to ED for	While each workstream will measure success locally, work is ongoing on the development of an outcomes based accountability scorecard for the totality of the work on the implementation of the Urgent and Emergency Care Review. This will include key performance measures, such as: no. of patients utilising UEC services and Phone First; the no. of level 4 & level 5 ED attendances; and the no. and percentage of patients utilising hospital at home and bed-based IC services.	Consultation on Review of Urgent and Emergency Care Services in Northern Ireland | Department of Health (health-ni.gov.uk)

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
			service users, lifting additional pressure from significantly under pressure Emergency Departments and getting service users access to the most appropriate services, first time. The Intermediate Care model has focused on delivery and standardisation of the Hospital at Home and Bed-based Intermediate Care services. The establishment of a more standardised approach to the development and implementation of intermediate care services will ensure better outcomes for patients and greater value for money service delivery. A workstream has been developed to operationalise the IC service improvement recommendations for these two services, ensuring the best outcomes for patients and diverting appropriate patients away from the under pressure acute care setting.		

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
			Improved performance management across urgent and emergency care services will facilitate a restart and embed the recovery of emergency care services in Northern Ireland. This will include improvements in hospital flow and discharge and will, ultimately, reduce delay related harm for patients waiting more than 12 hours in an ED.		
Cancer Strategy	Implementation of the Cancer Strategy for NI 2022-2032 will ensure that everyone in Northern Ireland, wherever they live, will have equitable and timely access to the most effective, evidence-based referral, diagnosis, treatment, support and person-centred cancer care. The aims of the Strategy are threefold: to reduce the number of people diagnosed with preventable cancers; to improve survival; and to improve the experience of people diagnosed with cancer.	The Cancer Strategy contains 60 actions, grouped under 4 themes. Delivery of the strategy will require collaboration across multiple parts of the Department, as well as across the entire HSC. 1. It is essential that the cancer strategy is fully implemented to deliver the required transformational changes within cancer services. 2. Changes to the provision of Breast Cancer Services 3. Development of	A reduction in the number of people diagnosed with preventable cancers. Improved outcomes and survival for those diagnosed with cancer. Improved support services for cancer patients and their families.	Ongoing measurement against existing cancer services performance targets. Monitoring and reporting on progress against the delivery of Cancer Strategy actions.	Designed Cancer Strategy sent to printers Mar 22 (health-ni.gov.uk)

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
		Regional Standards for Adolescent and Young Adult (AYA) Cancer Services in Northern Ireland. 4. Decisions around future of Head and Neck cancer services. 5. North/South collaboration on for the delivery of all island cancer services and research.			
Neurology services review	The identification of the optimum configuration for Neurology services for the next 10-15 years.	Final report to be completed Spring 2024. The report will set out a multi-year programme of recommendations to drive improvement in services.	Improved outcomes driven by workforce and service development which will facilitate improved access to diagnosis and treatment.	A Neurology Delivery Team will be established to develop an implementation action plan including detailed milestones. This will be supported by the development of a Neurology dashboard to support performance management.	https://www.health-ni.gov.uk/rns
Stroke Action plan	Reshaping Stroke Care Action Plan sets out priorities across the stroke pathway to improve outcomes for stroke patients while also improving the sustainability of services.	The Action Plan sets out timescales in respect of each priority action. However, the pace of implementation has been slower than anticipated due to resource and funding constraints.	Improved access to time critical treatments resulting in improved outcomes including lives saved and reduced disability.	The Stroke Sentinel National Audit Programme monitors the performance of all stroke units across the pathway and will provide the basis for measuring the success of implementation.	https://www.health-ni.gov.uk/stroke-action-plan
GIRFT reviews – orthopaedics, paediatric orthopaedics, urology,	Emergency Medicine aims: 1. Produce a live release of a Summary Emergency Department Indicator Table dashboard for Northern Ireland (SEDIT NI) 2. Carry out a GIRFT	GIRFT reviews – orthopaedics, urology, emergency care, gynaecology	The outcomes and benefits from these reviews are similar to the review objectives.	Performance improvement in 4hour Target, Reduction in patient breeches waiting > 12hours, Introduction	Progress update January 2024 - https://www.health-ni.gov.uk/publications/girft-elective-orthopaedics-

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
emergency care, gynaecology	Review of 10 Type 1 EDs NI, 3. Provide a report of local and regional recommendations as stimulus to restart and embed the recovery of emergency care. Orthopaedics To identify proposals for the immediate recovery of the service. The review was undertaken to increase activity in the short term with the overall aim of further developing and maintaining a sustainable and efficient service. Paediatric Orthopaedics - To increase capacity and activity, and achieve improvement in service delivery in the short, medium and long term. Gynaecology - to identify areas where improvements could be made in the extensive waiting lists for gynaecology services, and to ensure that patients are treated as quickly as possible to ensure best possible outcomes. Urology services -facilitate the improvement in the extensive waiting lists to ensure that patients are treated as quickly as possible to ensure best possible outcomes.		Restart and embed the recovery of emergency care services in Northern Ireland. Reduce delay related Harm for patients waiting greater than 12 hours in an ED. Shared Learning in Best Practice from NHSE Maximise capacity in the Health and Social Care (HSC) system to secure sustainable service delivery and more effective patient throughput in line with the Elective Care Framework and the Cancer Strategy. Patients are treated more quickly and resources used more efficiently.	of Same Day Emergency Care Services (SDEC) reducing ED exit times for admission Implementation of reports. Reductions in waiting times for surgery. Improved outcomes for patients due to more timely treatment.	progress-report-december-2023 GIRFT Review of Gynaecology - https://www.health-ni.gov.uk/publications/gynaecology-girft-report-january-2024
Imaging services	The Strategic Framework for Imaging Services in Health and Social Care, published 1 Jun 2018, sets out 19 recommendations to further enhance and modernise the HSC's imaging services over the next 10 years to ensure that Northern Ireland continues to deliver high quality healthcare services and stays at the forefront of technological advances in imaging.	The Framework's 19 recommendations fall under 5 Strategic Priorities: Workforce; Networks of Care; Information and Communication Technology; Investment; and Governance. Implementation is	Implementation of the principles and recommendations in the framework will transform how imaging services are planned and provided, to deliver high quality, safe, effective and efficient imaging services for the	The Regional Medical Imaging Board (RMIB) is responsible for overseeing implementation of the Framework. The RMIB meets quarterly and monitors progress and provides professional advice and support on	

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
	The pace of implementation will be determined by the availability of finance to implement the commitments and actions set out in the plan. Medical imaging services underpin all clinical pathways including unscheduled, inpatient and stroke and cancer care, as well as urgent and non-urgent elective services, for the screening, diagnosis, staging, treatment / intervention stages of the patient journey.	ongoing, with key milestones reached in the following areas: Workforce - development of a NI Imaging Academy. Site-selection via an independent options appraisal process is complete and a business case is being prepared. ICT - All HSC Trusts are now live on NIPACS+ single system for radiology services; with remaining imaging specialities to be consolidated on NIPACS+ by end of Encompass deployment in May 2025. Governance - All Trusts have now attained QSI (Quality Standard for Imaging) accreditation, making NI the first fully-accredited UK region.	population of Northern Ireland, with a more resilient, skilled and multiprofessional imaging workforce, an imaging equipment inventory commensurate to the needs of our population and a service that utilises digital technology and AI to support innovation. Patient benefits are shorter waiting times, faster diagnoses and better outcomes.	issues such as workforce, equipment and strategic planning.	
HSC Pathology Services (Blueprint Programme)	To establish a single regional management structure for HSC Pathology Services.	Phase 1 “Define” – Business Case and associated design of HSC Special Agency to be submitted to DoH for Ministerial approval of the way forward by Autumn 2024.	Benefits for citizens include: • A more efficient, robust and effective pathology service which is sustainably staffed and works in partnership with all HSC organisations to meet evolving clinical service	The Blueprint Programme Board, which meets quarterly, provides oversight. Success will be measured by the Programme's ability to meet its agreed milestones.	https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-modernising-%20hsc-pathology-services-policy-statement.pdf

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
		Phase 2 “Transition” - subject to Ministerial approval and funding, potential for commencement May 2025. Phase 3 “Embed” - will deal with running the service in the new structure and embedding the change – timeline TBC.	requirements into the future; • A clear regional line of sight for commissioners, policy makers, service users and patients. • A stronger regional voice for pathology services to support clinical pathway design and delivery that draws on the latest diagnostic modalities, drives faster translation of research into clinical practice and supports the growth of precision medicine. • HSC Pathology Services being best placed and optimised to address challenges in relation to workforce, training, technology, quality and other regional issues.		
Paediatric	The Child Health Partnership (CHP) is a regional clinically-led network, which is the delivery vehicle for implementing the Department’s two paediatric strategies. In light of challenges of rebuilding paediatric services after the pandemic, in the context of wider HSC system constraints including limited theatre capacity and severe workforce and budgetary pressures, a CHP Programme Board was established in	Priorities are to rebuild and deliver children's hospital and community services and reduce waiting lists. A fuller and detailed workplan will be developed by the CHP Programme Board. The CHP has continued to work across Trusts and other stakeholders to progress its broad	Children will have access to appropriate care in a timely manner and waiting lists will be reduced. Collaborative work with Trusts, established clinical networks and the Department will maximise the capacity for paediatric lists	Waiting lists will be monitored by the CHP Programme Board and Department. In addition, progress on other areas of work will be monitored by Departmental representatives on the Programme Board. ECMT will continue to monitor and investigate	

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
	2023 to support the CHP in leading the rebuild and delivery of children's hospital and community services by promoting greater accountability for its work programme at senior levels across the HSC system and Department. The initial focus has been on redefining the role of the CHP and refining membership, governance and reporting structures within and around the new Programme Board. It is anticipated that the CHP Programme Board will meet quarterly. A new CHP Steering Group will coordinate and deliver an ongoing managed programme of work agreed by the Programme Board in line with strategic objectives and service challenges. A number of sub-groups will cover specific areas including hospital services, primary & community services, palliative care, population health, and professional advice. The role of the voluntary and community sector within the revised CHP structure is under consideration.	programme of work. Constructive clinically-led workshops were held in January and May 2023 to identify solutions in paediatric elective surgery and community paediatrics respectively. A Departmental Child Health Policy Network has been established to draw together the myriad working on child health across the Department eg mental health, social services, childhood cancer, dentistry, primary care, to share information and help provide strategic direction to the CHP Programme Board for its future workplan.	across the region to tackle long waits.	barriers and develop regional solutions to increase activity in paediatric care.	
Maternity and Neonatal	The Department has established a Maternity and Neonatal Services Safety Oversight Group to receive assurance on the safety of maternity and neonatal services for the population of Northern Ireland. This was in light of several recent reports concerning the safety of services for pregnant women, new mothers and	Several workstreams are looking at implementation of recommendations in reports and documents endorsed by the Department and other reports that may contain points of learning - work	The result of the suite of work ensure maternity and neonatal services are safe and appropriate.	Work is already ongoing to measure adherence to reports and guidance. In addition, a single overall action plan will be developed and monitored by SPPG.	

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
	newborn babies, both locally and nationally. guidance, developing a gap analysis of implementation of all relevant reports and strategies endorsed by the Department and other relevant national reports and identifying learning opportunities. Incorporation of the 23 recommendations from the RQIA's Review of the Governance arrangements to support safety within maternity services in Northern Ireland which was published on 30 May. However implementation will be subject to securing any necessary funding.	is ongoing to identify whether Trusts are adhering to these. An overall single action plan will be developed to improve maternity and neonatal services. A broad programme of work is ongoing, including a comprehensive independent review of freestanding midwifery led units and work to inform a consistent approach to the provision of midwifery services, Enabling Safe, Quality Midwifery Services and Care in Northern Ireland, which is being led by Professor Mary Renfrew.		Improved maternity services for mothers, babies and their families in Northern Ireland.	
NIAS Clinical Strategy	There were two objectives: Carry out the preparatory work to develop a new response model for Northern Ireland which will change the way in which calls made to NIAS are categorised, ensuring that the sickest patients are identified and dealt with quickly. Transform the approach to the delivery of Paramedic Education and deliver a comprehensive workforce plan	The project objectives for the Clinical Strategy have been fully met. The key product of the Clinical Strategy was to introduce the new Code Set which was achieved to specification, on time and within budget. The Paramedic Education project has achieved all the	The development of a new Clinical Strategy and the training for EMT's, ACA's and Paramedics are consistent with Transforming your Care and Delivering Together in terms of Investing in our People and ensuring that NIAS has the most effective response model in place to ensure	The new Code Set within the Clinical Strategy has been introduced, laying the foundations on which the Clinical Strategy is built. A comprehensive project report has been produced by the Association of Ambulance Chief	

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
		objectives set out in the original business case and was delivered in time and within budget, including: Successfully developed, gained approval for, recruited to and delivered a new Higher Level Education Paramedic Foundation Degree in Partnership with Ulster University. Commenced and delivered training courses for paramedics, Emergency Medical Technicians and Ambulance Care Attendants.	that people are treated in the right place at the right time. The Paramedic programme was evaluated against, and approved as meeting, the Standards of Education and Training of the Health and Care Professions Council regulatory body. Remaining programmes were delivered in-service by NIAS' own education team. The training has improved standards, knowledge and skill levels for existing and new staff and clearly provides value for money.	Executives, outlining progress against the Clinical Strategy and highlighting a number of key actions which will support in improving operational delivery, the patient experience and response times in relation to the Clinical Strategy model. Provision of in-service training was deemed as cost effective. The training programme has achieved all the objectives set out in the original business case and was delivered in time and within budget.	

Digital

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
Encompass Programme	Encompass is a clinical and operational transformation programme with Epic software at its heart. The flagship programme will see encompass replace or link with the vast majority of clinical systems currently in operation and will replace existing PAS and clinical record systems across HSCNI. It will also include a patient portal (My Care) which will enable patients and service users to take more control over their care than ever before. This programme will bring about change to how staff work at all levels across HSCNI, whether clinical, operational or in supporting roles. The programme is unique in that it incorporates secondary health care, community nursing, mental health and social care. When fully implemented encompass will make a significant contribution to rebuilding HSC services through greater access to virtual platforms for service users and health professionals; replacement of existing disparate systems and functionality; a single patient record; and enhanced data analytics and reporting to provide accurate, real-time reporting and dashboards	The programme went live in the South Eastern Trust on 9th November 2023 and are at an advanced preparation stage for Belfast Trust which went live on June 6th, 2024. Subsequent Go-Lives are set with Northern Trust for 7th November 2024 and Southern and Western Trusts implementing in spring 2025. The programme has entered a new phase of stabilisation and Business as Usual planning with South Eastern Trust including areas such as the Thrive training project and personalisation work to help support staff on the ground using the system. The Go-Live has not been without challenges and a number of elements have been addressed post-live with collaborative work across the Trust, Epic and encompass.	encompass includes a patient portal (My Care) enabling patients and service users to view letters and results, and to take more control over their care. My Care is available as a mobile phone app or through a web browser on a computer. Patients and Service users will be able to access their health and social care records, such as letters, supporting information, lab results and radiology results. They can view appointments and track tasks. The app also has functionality for secure communication with healthcare providers, such as physicians, Specialist Nurses, Allied Health Professionals and Social Workers. It can also act as a secure platform for virtual consultation. It is envisaged that encompass will help	Several mechanisms will be implemented to measure success. The encompass Benefits Board is leading on identifying, baselining, reviewing and measuring core benefits from the implementation of encompass across HSCNI. The system will provide “near real time” data which can be used to benchmark services across Northern Ireland and with other Epic System users in the UK and worldwide. Following the first implementation there has been anecdotal evidence of services seeing immediate benefits in the change including Allied Health professionals having better collaborative working, pharmacists’ reduction in paperwork and Community nurses having access to more information during their interactions with service users through Rovers. A proven process of Go-Live Readiness	https://encompassni.hscni.net/digital-portfolio/encompass/

			HSCNI to work more effectively and efficiently through this regional standardisation based on best practice, and will create better experiences for those receiving, using and delivering services. The single digital integrated record will support the HSCNI vision to transform health and social care in order to improve patient safety and health outcomes.	Assessments was in place at Belfast Trust every 30 days up to Go-Live on 6th June to understand operational readiness and mitigate any challenges. Preparatory work is well progressed at the remaining Trusts to ensure core infrastructure, Training and Operational readiness for their respective Go-Lives.	

Workforce

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
HSC Workforce Strategy 2026 and Strategy Action plans	The Health and Social Care Workforce Strategy 2026: Delivering for our People was published in May 2018. The aim of the Strategy is that by 2026, we meet our workforce needs and the needs of our workforce.	The Strategy's current, and second, action plan was published in June 2022 and covers the period 2022/23 to 2024/25. This includes an ambitious range of strategic actions for progression and contains 34 actions to be delivered through 103 individual programmes of work. Progress is formally monitored by the Strategy's Programme Board on a bi-annual basis.	Delivery of the actions outlined in the Strategy will support the development of a workforce that has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise.	The most concrete measure of the Strategy's overall aim is the extent to which the workforce has stabilised and grown since it's publication in May 2018. Official government statistics on the number of staff employed directly by HSC Trusts report a 15.7% (+8,911) increase in whole time equivalent staff in post across the HSC in Northern Ireland between March 2018 (56,803) and December 2023 (65,714). This includes a 18.4% (+774 wte) increase in medical and dental staff, a 16.8% (+2,539 wte) increase in nursing and midwifery staff and a 21.6% (+1,754 wte) increase in professional and technical staff in post	https://www.health-ni.gov.uk/publications/health-and-social-care-workforce-strategy-2026

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
Nursing and Midwifery Task group	The NMTG report, launched in March 2020, set out a roadmap for the development and enhancement of the Nursing and Midwifery professions over the next 10-15 years. The report contained 15 recommendations, grouped under three key strategic themes: Strategic Theme 1- Population Health; Strategic Theme 2- Workforce Stabilisation; and Strategic Theme 3- Leadership.	Following the appointment of the current CNO in March 2022 a decision was taken to reprioritize the delivery of the outstanding recommendations, ensuring alignment with the CNO Vision (launched in May 2023). A reprioritization exercise has recently been completed alongside an internal audit review of processes. New oversight structures are currently being progressed to support delivery.	The recommendations seek to create the conditions for nursing and midwifery services to deliver the right evidence-based care, with the right numbers, at the right time, in the right place, by the right person, with the right knowledge. Most importantly they seek to deliver the right outcome and experience for people, families, and their communities.	Implementation of recommendations in line with the reprioritized delivery plan will result in achievement of this objective.	https://www.health-ni.gov.uk/publications/nursing-and-midwifery-task-group-nmtg-report-and-recommendations
Pharmacy Workforce Review (PWR) 2020	With our aging population, our Health Service needs to care for increasing numbers of people with complex medical needs taking multiple medicines. The Review contains an analysis of the current pharmacy workforce in Northern Ireland and recommendations to inform the development of the pharmacy workforce over the next ten years.	A PWR steering group has been convened to oversee the progress of the implementation of the 17 key recommendations outlining the HSC pharmacy workforce needs over the strategies 10 year lifespan. An action plan has been developed that outlines indicative timescales for implementing the recommendations contained in the PWR	Pharmacists with their unique set of skills and knowledge are the medicines experts that our Health Service to help ensure that our people get the best possible outcomes from their medicines. In response to the recommendations of Pharmacy Futures NI, the Attract, Recruit and Retain Programme was launched in 2020 to encourage pharmacists to roles in	A number of significant projects are underway including; Pharmacy Futures NI, Introduction of new regulated profession- Pharmacy Technicians (Steering group overseeing the project), Reform of the IET of pharmacists, (Phase 1 introduction of experiential learning completed, phase 2 underway reform of the FTY. It is anticipated that full implementation will take place by 2026).	https://www.health-ni.gov.uk/publications/pharmacy-workforce-review-2020 https://www.health-ni.gov.uk/sites/default/files/publications/health/pharmacy-workforce-review-2019-action-plan.pdf https://www.pharmacyfuturesni.com https://www.health-ni.gov.uk/consultations/i

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
		and will ensure that the pharmacy workforce has the necessary capability and capacity to fully support the transformation of our Health Service in the coming years.	community, hospital and general practice within NI. In March 2022, DOH launched a consultation on the Introduction of Statutory Regulation of the Pharmacy Technician Workforce in NI. The proposal will establish a register and regulated profession and enable the Regulator, the PSNI, to strengthen its role in protecting patients and promoting high standards, so enhancing the public's confidence and trust in the profession. Progress is being made to align pharmacy services to the transformation agenda, but it was clear that pharmacy training pathways are overly long, limiting their universal uptake and constraining service development. On advice from the four UK Chief Pharmaceutical Officers, the Regulator developed the revised initial education and	Reort into the Consultant Pharmacist NI (2023) and currently Advanced pharmacist practice under review (April 2024).	ntroduction-statutory-regulation-pharmacy-technician-workforce-northern-ireland

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
			training standards to prepare all newly registered pharmacists for a prescribing clinical role, capable of working in a multi-sector environment.		

Integrated Care System (ICS)

Programme / Project	Objectives	Milestones	Outcomes / Benefits	Success Measures	Weblinks
Integrated Care System NI Programme	The need for a new commissioning approach has been set out in numerous reviews which highlighted the need to move to a model based on collaboration and integration and not competition. The development of ICS NI signals a move away from a process that was overly bureaucratic, complex, and too transactional for an area as small as Northern Ireland to one that is focused on outcomes and person-centred care. The overarching vision is of one system working in an integrated and coordinated way to plan and deliver health and care services to improve the health and wellbeing of our population and address demand by • placing a focus on preventative measures ie people keeping well in the first instance, providing timely and early intervention ie coordinated care when they are not, and supporting people to self-care when appropriate; and • ensuring we are maximising the resource we have available to deliver the	Autumn 2024 - Roll-out of ICS Model in shadow form	ICS NI will allow planning and delivery of services based on population need and will support people to manage their own health and wellbeing, keeping fit and well in the first instance. It will improve efficiency and optimise capacity, enabling the best use of available resources to support a sustainable service. ICS NI will bring a number of benefits: • an outcomes-based approach to improve the health and wellbeing of our population; • empowering of local providers and communities to work in partnership across traditional organisational boundaries; and	A combination of Outcomes Based Accountability and evaluation from an independent supplier	https://online.hscni.net/our-work/integrated-care-system-ni/

	best outcomes for our population, optimising our effectiveness and efficiency and reducing duplication.		• remove existing barriers to planning and designing care and services that meet the needs of local populations.		

Annex D – Area Hospitals current state (excl. regional / sub-regional specialties)

Specialty	Altnagel-vin	Antrim	Belfast	Craigavon	Ulster
Level 1 ED	✓	✓	✓	✓	✓
Ambulatory / SDEC	✓	✓	✓	✓	✓
Acute / general medicine	✓	✓	✓	✓	✓
Endo / diabetes	✓	✓	✓	✓	✓
Care of the elderly	✓	✓	✓	✓	✓
Acute stroke	✓	✓	✓	✓	✓
Respiratory medicine	✓	✓	✓	✓	✓
Nephrology	✓	✓	✓	✓	✓
Renal dialysis unit	✓	✓	✓	×	✓
Haematology	✓	✓	✓	✓	✓
Chemotherapy	✓	✓	✓	✓	✓
Cardiology	✓	✓	✓	✓	✓
Coronary care	✓	✓	✓	✓	✓
Gastroenterology	✓	✓	✓	✓	✓
Emergency general surgery	✓	✓	✓	✓	✓
Colorectal surgery	✓	✓	✓	✓	✓
Upper GI surgery (benign)	✓	✓	✓	✓	✓
Breast surgery	✓	✓	✓	✓	✓
Urology	✓	×	✓	✓	✓
ENT	✓	✓	✓	✓	✓
Opthalmology	✓	×	✓	×	✓
Orthopaedic trauma	✓	×	✓	✓	✓
Orthopaedic elective	✓	×	✓	✓	×
Intensive care	✓	✓	✓	✓	✓
Gynaecology	✓	✓	✓	✓	✓
Obstetrics	✓	✓	✓	✓	✓
Midwife-led unit	✓	×	✓	✓	✓
Paediatric medicine	✓	✓	✓	✓	✓
Paediatric surgery	✓	✓	✓	✓	✓
Neonatology	✓	✓	✓	✓	✓
Radiology	✓	✓	✓	✓	✓
Laboratory	✓	✓	✓	✓	✓
Pathology*	✓	✓	✓	✓	✓
Outpatient / consult					
Neurology	✓	✓	✓	✓	✓
Rheumatology	✓	✓	✓	✓	✓
Dermatology	✓	✓	✓	✓	✓
Chemotherapy	✓	✓	✓	✓	✓

* all Area Hospitals have a minimum of blood sciences and microbiology

Annex E - Defining Specialist Regional Inpatient Services in Northern Ireland

The following paper sets out an assessment of a range of services and categorises these in terms of eligibility as specialist regional inpatient services. This assessment is the position as at 15 September 2023 and a process is required to review the list on a regular basis.

The information has been constructed based on a number of sources including services commissioned by SPPG specialist commissioning team, services commissioned by other SPPG commissioning team and from templates submitted by the HSC Trusts (Belfast, South Eastern and Southern HSC Trusts).

Principles

- The analysis relates to specialist regional inpatient services.
- The analysis excludes other specialist regional services that do not require inpatient beds e.g. provision of specialist drug therapies or regional laboratory services.
- The analysis excludes Mental Health and Learning Disability inpatient services.
- Inpatient specialist regional paediatric related services are included but identified separately as part of the process.
- The list of specialist regional inpatient services may include sub specialist elements within a larger general service which are deemed specialist as they are only provided by a specific team / or clinicians in one HSC Trust.

Criteria for Inclusion

1. Service requires inpatient bed capacity.
2. Service is provided primarily on a single site or by a single HSC Trust in NI or through a designated centre outside NI.
3. Service accepts referrals on a tertiary or quaternary basis.

4. Service requires specialist skills, facilities, equipment, clinical interdependencies and / or workforce which would impracticable to deliver on more than one or two sites in NI.
5. There is a critical mass of activity required to maintain clinical skills consistent with extant safety and quality standard.

Annex F - Key Learning from the Obligate Networks

Learning from obligate networks:

Taking into account the above reviews, the following outline some pertinent learning points for establishment of a formalised network in NI:

- **Accountability:**
  - Structural review in Scotland has blurred the lines of accountability for SPHN Obligate Networks. It initially was hosted by Health Protection Scotland and is now hosted by Public Health Scotland. At time of review this was a significant issue of accountability. This should be considered a risk in NI if similar Obligate Networks were established.
  - The review of Obligate Networks in NI recommended MOUs with each of the partner organisations.

- **Communication:** if adopting a formalised networking approach, there is a need for efficient communication both vertically (to oversight group) and horizontally (across Local/Area/Regional Hospitals) for the network. This needs linked to partner organisations to help them communicate the reconfiguration to the public and political reps.

- **Direction:** there is a need for a five-year strategic delivery plan. This should be agreed with annual reviews and agreed key performance indicators for each sub-group to enable monitoring and demonstrate performance.

- **Resourcing:** need for secretariat to the Network and consideration of adequate time available for chairs and co-chairs to give due attention to Network business.

- **Focus on outcomes:** review of Obligate Networks indicated that a focus on clinical outcomes was significantly important and communication of this,

rather than addressing gaps, in services was crucial to ensure engagement and buy-in.

- **Four elements necessary for success of such networks:**
  - Investment in Programme Management
  - Quality Improvement
  - Clinical leadership
  - Communication

- **Some simple but important overarching principles:**
  - Coherence
  - Consistency
  - Sustainability
  - Redesign

Annex G - Acute Hospital Reconfiguration – Proposed Actions

Action	Owner	Contributors[16]	Timescale
1: The Department will work the NI Executive Departments to consider carefully the travel support available for our population.	DoH Policy	HSC Trusts / SPPG / PHA	
2: DoH to review 2007 Transport Strategy for Health and Social Care services in Northern Ireland.	DoH Policy	NIAS, SPPG, HSC Trusts	
3: HSC Trusts to continue to consider how their Local Hospitals can best and most sustainably meet local population needs.	HSC Trusts	SPPG / PHA	
4: Consideration to be given to how in the short to medium term HSC Trusts can work in collaboration to maintain these core General Hospital services.	DoH Policy & SPPG	HSC Trusts	
5: Consideration to be given to designating Causeway as an Elective Care centre.	DoH Policy & SPPG	NHSCT / PHA	
6: Consideration to be given as to the most sustainable allocation of resources across Area Hospitals to minimise inequities in access to services.	DOH SPPG	HSC Trusts / PHA	
7: Consideration to be given to moving suitable activity out of Regional Centres into Area Hospitals.	DoH Policy & SPPG	HSC Trusts / PHA	
8: Consider approach to clinical training to ensure that job roles best match current and future population health needs.	DoH Policy / CMO / CNO	HSC Trusts / PHA	

[16] Where relevant other key stakeholders may be asked to help co-produce the final set of actions. This may include service users & carers, Royal Colleges and other professional bodies and Trade Unions.

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.	DoH Policy / SPPG / CMO	HSC Trusts / PHA	
10: Continue with a rolling programme of speciality specific workforce reviews, to encompass all skill mix roles.	DoH Policy	HSC Trusts / PHA / SPPG	
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.	DoH Policy & SPPG	HSC Trusts / PHA	
12: Define a suitable level of protected bed base, diagnostic and theatre capacity for regional specialist services.	DoH Policy & SPPG	HSC Trusts / PHA	
13. DoH to explore with HSC Trusts and NICON how provider collaboration might help to support and sustain the Hospital Network.	DoH Policy & SPPG	HSC Trusts/ PHA	

Annex H – Glossary

AIPB	Area Integrated Partnership Boards
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
DOH	Department of Health
ED	Emergency Department
GB	Great Britain
GP	General Practitioner
HSC	Health and Social Care
HSCT	Health and Social Care Trust's
ICS	Integrated Care System
ICU	Intensive Care Unit
MDT	Multi-Disciplinary Teams
MLB	Making Life Better
MOU	Memorandum of Understanding
NI	Northern Ireland
NIAS	Northern Ireland Ambulance Service
NIMDM -	Northern Ireland Multiple Deprivation Measure
NIMDTA	Northern Ireland Medical & Dental Training Agency
NISRA	Northern Ireland Statistics and Research Agency
PFG	Programme for Government
PHA	Public Health Agency
SPHN	Scottish Health Protect Network
SPPG	Strategic Performance & Planning Group
ROI	Republic of Ireland