

Health and Social Services Reform

22 November 2005

Thank you for coming today.

This is an important day for patients.

And for staff.

Indeed everyone in Northern Ireland who uses health or social services.

Health Service and the RPA

Earlier today the Secretary of State outlined plans for what is a major re-organisation of public administration in Northern Ireland.

Central to the Review of Public Administration is the transformation of local government, from the current configuration of 26 District Councils, to 7 Councils.

As part of that review, but **not dependent** on implementation of the RPA, I will today set out my proposals for health and social services.

And I stress, while related in part to re-organisation of local authorities, they do **not depend** on local government changes to take effect.

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And crucially my reforms will be operating on a different timetable.

The hugely significant changes to Trusts will begin to take effect from early next year.

And only some – **not most** – of these health and social services reforms will require primary legislation.

This programme of reform, modernization and delivering a first class system for patients in Northern Ireland can therefore get underway without delay.

Putting Patients First

If there is a continuing theme to everything I am trying to achieve in health and social services, it is to ensure we **put patients first**.

I have elsewhere signalled my concerns that the **current** organization of health and social services is too cumbersome, too bureaucratic, and inefficient.

That is why I began the first reform in July, announcing dramatic changes to how we handle in patient waiting lists.

To ensure these waiting lists - which only six months ago - recorded **thousands** of patients waiting four or even five years for hip replacements and other surgery, would be transformed by March of 2006.

No-one on an in-patient waiting list would wait more than twelve months from March 2006.

And in three target areas I said we would go further for March of 2006:

- For hips and knees. No more than nine months;
- For cardiac surgery no more than six months;
- And for cataracts. Six months.

You will have read over the last couple of weeks how in Sperrin Lakeland and elsewhere, we have brought in teams of doctors from outside Northern Ireland to give hundreds and people back their sight.

Our job is to find the means to give people back their sight.

As quickly as possible.

To put the system behind them.

Not between the patient and their operation.

So I am working to build a system, which works effectively for patients.

And for staff.

It is very gratifying to hear and read about the nurses and doctors involved in these operations.

Staff obviously deriving huge satisfaction from seeing some of the grinding wheels of the health service move more quickly!

Inequality and Safety

But my proposals for in patient waiting lists were just the start.

The system itself needs to be tackled. Re-organised.

We have excellent staff. Great doctors. Unfailing nurses.

But, in the system's current configuration, our structures actually are failing our patients and our staff.

Creating inequality.

Delays in treatment.

A postcode lottery.

A Trustcode lottery.

I am sure we all agree that we should reform a system which by default creates inequality.

And indeed other bad effects, which are obviously unintended consequences of the system.

Issues of safety and quality.

The case for reform is very strong.

Faster and better treatment.

Efficiency in the service.

Greater patient safety.

Removing inequality.

And these reforms will not only improve care for patients but enable the huge investment we will make in health and social services to produce the real and tangible benefits for everyone.

Investment then to go hand in hand with reform.

I want to see the additional £450 million which was secured in this year's Budget to have impact.

It was a huge increase. Thirteen percent on this year.

£50 million more than previously budgeted.

Health spending in 2007-08 will exceed £3.7 billion.

As well as a £2.2 billion capital investment programme in health and social services.

Developments at all major hospital sites.

Across the entire primary and community care sectors.

The Appleby Review

In bringing forward these reforms, I want to acknowledge the work of others in encouraging these changes.

Earlier this year Professor Appleby of the King's Fund produced his Independent Review of Health and Social Services in Northern Ireland.

He also agreed with me that the system of health and social care is not delivering its best for patients.

He concluded that despite the efforts of excellent staff in health and social services, despite the additional resources invested in these services, the system lacked clarity.

Lacked focus.

And that levels of performance management had huge scope for improvement.

My reforms today of course take on board Professor Appleby's views.

And those of other appropriate parties.

I look forward to relevant consultation on those proposals which will require legislation.

Of course we will take fully into account the views of stakeholders on these issues.

Their views will be important, and they will be considered very carefully.

The Inefficient System

So what of the current system?

Let me deal with the core organisations first.

By core, I mean Trusts, Boards, Local Health and Social Care Groups, the five service delivery Agencies, and the four HSS Councils.

Six months ago I asked,

Why do we need 19 Trusts?

Why 4 Boards?

In England entire regions are organised into single Strategic Health Authorities.

The Strategic Health Authority, which serves my own constituency, Cheshire and Merseyside covers an area of over 1100 square miles.

And a population of nearly two and a half million people.

So why do we need four authorities?

For a population one third smaller?

The management cost of maintaining 19 Trusts is £95million.

The cost of maintaining 4 Boards is £33 million.

Then in addition to the core group, we also have:

- the Central Services Agency;
- the Health Promotion Agency;
- the Blood Transfusion Agency;
- the Regional Medical Physics Agency;
- the Guardian Ad Litem Agency;
- the Health and Social Services Regulation and Improvement Authority;
- the Northern Ireland Social Care Council;
- the Medical and Dental Training Agency;
- the Northern Ireland Education and Practice Council for Nursing and Midwifery;
- the Mental Health Commission.

Of course the role they perform, the services they provide **are** necessary.

The staff who work for each of them **rightly valued.**

But do we need so many?

Most with their own finance, human resources, PR, and senior administration teams.

And what is the cost of all these organizations?

Well, the total **management** cost of **running** these bodies, including the Boards and Trusts, is £155 million every year.

Put that alongside the call on more money for new drugs!

If I could take just one million out of that 155, I could put every MS patient - now on a waiting list for drugs - off that list.

Abolish current waiting lists for MS sufferers altogether.

You will know that last week I announced that I would take the politics out of the prescription of Herceptin.

It should be a clinical decision.

The cost for this drug could be up to £3 million in Northern Ireland.

And what of other cancer drugs?

Or drugs for Alzheimers?

Or rheumatoid arthritis?

Think how if we could get 5% - seven and a half millions -out of this £155 million? Just what that would pay for.

And what if we can get more than 5% out of improved efficiency?

You can see the moral case as well as economic case to drive for these savings and efficiencies.

Patient led health services

This will result in a health system which puts patients first.

Patient led. Patient responsive.

I have seen speculation in the press about my changes today.

Some of it rather too well informed.

Some of it wrong.

So for those who last night told the public there would be more bureaucracy, let me allow you now to clear up your mistakes.

In terms of the core structure, we will move from 47 organisations to 18.

That - by the way - doesn't mean doctors, nurses, or other health professionals aren't going to lead our health system.

But they will be better able to lead on behalf of their patients

We all work for the benefit of patients.

But the system too easily at present loses sight of some patients.

So my proposals today are designed to ensure that in the system, the patient comes first.

The patient will drive demand in the system.

Fundamentally I want to see GPs, nurses and other primary care professionals **commission services on the patients' behalf**, from those delivering the services.

Demand led by patients.

Driven by GPs and primary care professionals.

Commissioning Groups of GPs

I envisage a health system where commissioning of services is structured by a partnership between a single Strategic Health and Social Services Authority and doctors and other primary care professionals, organized into seven Local Commissioning Groups.

And these Commissioning Groups should map against the proposed areas of the 7 District Councils announced in today's RPA statement.

The Strategic Health and Social Services Authority

In essence, the role of the Authority will be to implement the Government's policies for health and social services, and to manage the performance of the system.

And, in conjunction with primary care groups, to commission services in a two way relationship, meeting the demands of patients.

Over the coming months we will develop our model of a single Health and Social Services Authority to replace the 4 Boards.

This will happen in two phases.

In the first, it will work hand in hand with the seven Local Commissioning Groups and develop their commissioning skills.

Initially in this phase, holding the balance of power for commissioning.

In the second phase, within three to five years of bringing in the Local Commissioning Groups, we want to see that balance of power swing to these groups.

In this phase, most services will be commissioned through local, primary care-led structures, backed up by the Strategic Authority.

The idea is simple.

Services need to be multi-professional, co-ordinated and effective.

Economies of scale are important.

But we want to ensure that in the reformed system, local GPs, nurses and other health professionals shape the service, responding to local needs in their area.

Primary Care Commissioning

I am concerned to avoid a big bang approach to these reforms.

Incremental change will ensure that we avoid unnecessary disruption as a consequence of the change itself.

The new primary care commissioning arrangements will take some time to put in place.

And there are a range of important issues which need to be resolved over the coming months.

We need to know how GP and primary care led groups can work together.

With each other, with the Trusts and, in due course, with the Strategic Health and Social Services Authority.

The proposals should be developed and discussed with health officials, GPs, nurses, pharmacists, dentists, social workers, associated health professionals and social services professionals.

This should ensure that the reformed model is efficient.

And truly puts patients first.

Trusts

Five new integrated Trusts will replace 18 of the existing Trusts (the Ambulance Service will continue unchanged) .

Integrated so as to promote links between hospitals and community-based services.

These five Trusts are:

The Western Area – covering Sperrin Lakeland, Foyle, and Altnagelvin HSS Trusts;

The Northern Area – covering Homefirst Community, Causeway and United Hospitals HSS Trusts;

The Southern Area – covering Craigavon Area Hospital Group, Craigavon and Banbridge Community, Newry and Mourne and Armagh and Dungannon;

The Belfast Area – which will amalgamate the Belfast City Hospital, Royal Group of Hospitals, Mater Infirmorum and Greenpark Trusts, and North and West Belfast Trust, part of South and East Belfast Trust and part of Down Lisburn HSS Trust;

The South Eastern Area – covering the Ulster Community and Hospitals Trust, part of South and East Belfast Trust and part of Down Lisburn Trust.

Social Services

Larger Trusts will promote integration within and across Trusts.

Integration across professional groupings.

Integration across geographical areas.

Integration between the health and social services.

...and seamless for the patient.

Networking of services will be core in this.

And we need to join up our system better.

We need to make sure that people who suffer from a long term mental condition receive a joined up service in which their social worker, GP, pharmacist and community psychiatric nurse, can work effectively together to manage their illness.

We need to make sure that people who could be living independently back at home are not stuck in a hospital bed or a nursing home.

We need to make sure that people with a learning disability are supported to live, learn, work and experience a better quality of life.

Patient Representation

An effective system must ensure that the voice of the patient can be heard.

Loud and clear.

The four Health and Social Services Councils will be replaced by a **powerful single** health and social care user's body.

The PCC.

A Patient and Client Council.

The PCC will have a critically important role in engaging with the patient, the client and communities:

- in promoting their health and wellbeing;
- in getting the best from the service; and:
- in providing effective advocacy when the service is not doing what it should be to meet patients' just needs and demands.

Although it will have a regional remit, it will also have a strong emphasis on representing individual patients and local communities.

Agencies

And of the Agencies/agencies I referred to earlier.

The Central Services Agency will remain, but may take on some of the functions currently in the Department.

The Health Promotion Agency will be incorporated in the Strategic Health and Social Services Authority.

The Regional Medical Physics Agency will be incorporated into one of the new Trusts.

This will leave three service support agencies rather than the existing five.

And over the coming months we will carefully examine, case by case, the reasons for maintaining the separation of other agencies.

Regardless, we will expect them to work more closely with each other.

Reducing their management costs.

The Department

In this reorganisation I want to drive down on the bureaucracy which too easily can end up watching over the shoulders of everyone working in it.

The system must be efficient but we should trust the doctors and health staff who we employ to look after patients.

Therefore I envisage a considerably smaller Government Department.

Some of its functions will move into the new Strategic Health and Social Services Authority.

The role of the Department will fundamentally be to set policy.

Develop policy.

And rightly set targets.

And critically to lead the drive for improved performance.

And efficiency.

Efficiency

Taken together, these reforms will begin to transform the health and social services in Northern Ireland.

Into a system which is genuinely patient centred, well governed and continually improving.

Greater efficiency.

And significant savings to reinvest back into front line patient treatments and drugs

- by reorganising the Trusts from 19 to 5, plus the ambulance service;
- by sharing support services;
- by replacing the 4 Boards with 1 Strategic Authority;

The savings from these streamlined structures will be re-invested into front line health and social services.

Resources going directly to meeting patient needs.

What is clear to me is that even a 10% reduction in the cost of running the present health and social services will bring in an extra £15 million to put into drug budgets and services.

But I would hope and want to see substantially greater efficiencies than this.

And in making these efficiencies, let us remember that this is about money where it's needed, into front line services, and the staff to provide these services.

Implementation

In respect of bringing those changes into effect, we will need some primary legislation.

This means that change and reform will be phased in rather than introduced as a big bang.

But I expect to see urgency in implementing these reforms.

We need to get the system better behind the patient and I know from demands made on the health budget, that every penny saved could be spent on drugs or services tomorrow.

Under the Permanent Secretary I will from January 1st 2006 establish a Reconfiguration Programme Board.

This will develop the project. It will oversee and manage implementation.

Including issues of governance, legislation, finance, human resources and communications.

It will first establish in principle and set up the necessary Project management structures for the new Trusts, to be up and running by April 2007.

It will establish in principle and recruit to the new Strategic Authority a Project Board.

It will oversee the establishment and project boards for the new local commissioning groups, to be up and running for April 2008 or sooner if possible.

During the coming months, we will consult with health officials, GPs, doctors, nurses, pharmacists, dentists, social workers, associated health professionals, social services professionals and patient/care groups about practical details for implementing these changes.

We will also explore ways in which we can further **devolve commissioning power** to local, primary care-led groups in advance of

the Strategic Health and Social Services Authority and Local Commissioning Groups being formally established.

I realise that people working in the services will have concerns about the effects of this reorganisation.

I appreciate the concern.

We will work with develop and support our staff to ensure that we have a fit for purpose workforce for the new system.

But we must not lose sight of why we need these reforms

Remember why we are doing this.

The needs of patients.

Patient needs will be at the forefront of everything we do over the coming months.

Decentralisation

I am also conscious of how people often tell me, why is everything organized around Belfast?

They ask us to see how our system functions outside of Belfast.

Whether that is fair or not, you can see the point.

So, I also want to see us move parts of the actual organization of health and social services, out of its Belfast-centric focus.

We should guard against the presumption that all our main bodies should *have to* be in Belfast.

Does the new Strategic Authority have to be in the centre of Belfast?

Why not say Portadown or Antrim?

Or why the headquarters of the new PCC couldn't be located, for instance, in Derry or Omagh?

I will be seeking proposals for all of the new bodies to look at how they could be moved out across Northern Ireland, to ensure a broader Northern Ireland perspective.

Safety

As we carry through these reforms, we must ensure the changes are sustainable and also safe.

Failure to take proper account of sustainability has caused huge problems for our health service.

I don't want to rehearse the problems of Sperrin Lakeland today.

But I am determined the new health and social services structures will learn from the past.

The project boards to implement these changes must also examine thoroughly issues of governance and accountability, to ensure that robust arrangements are established.

As well as effective performance management procedures.

Performance Management

Safety, quality and protection are minimum standards but I expect more from the system.

Patients and the public expect more from the system.

Patients expect an accessible and responsive service.

Patients expect high performance and good quality.

While we take forward these reforms we will expect the service to keep its eye on the ball.

We will be establishing a performance management body, staffed by professionals with skills in health service management, analysis and performance monitoring.

Performance management will go hand in hand with inspection, regulation and improvement.

What is important is that patients and the service know that we will be relentless in driving continual improvements in quality, access times, reducing unnecessary drug costs and other key performance measures over the coming years.

This can be seen in prescribing costs.

Where we have been shown to have costs that cannot be justified in comparison with those in England.

And which are reducing our ability to direct resources to where they are needed most.

There is a lot of good work underway to reduce these costs including Integrated Medicines Management programmes.

The pharmaceutical services improvement programme.

Repeat dispensing programmes and the promotion of more generic prescribing by GPs.

But we need to go further.

As we implement the new structures I will be seeking proposals to give the issue a focus by establishing a specific unit, located in the Strategic Health and Social Services Authority, to take forward the range of measures needed to promote a more effective use of the prescription drugs budget.

Conclusion

I said at the beginning of my remarks, this is an important day for people who use public services.

This is especially the case for patients.

If I can leave you with one message from today, it is that today's announcement further endorses my commitment to put patients first.

A service that will be Patient led.

And Patient responsive.

Reform will not be achieved over night.

But reform has begun.

People are already seeing the results.

Go to Fermanagh and meet the 400 patients whose cataract operation four weeks ago gave them sight again.

Change is happening.

Waiting lists are coming down.

In a few weeks I will set out my proposals to tackle out patient lists.

But we will also begin the process of reforming the very system itself.

The number of Trusts will be reduced

We will make efficiency savings.

We will put that money into front line services.

We have begun the task.

It's time now for us all to join this task.

And together ensure we put our patients first.

ENDS