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# Northern Ireland Healthcare Crisis

The next few issues of the Ulster Medical Journal will contain contributions from a wide of Northern Ireland doctors on the subject of the current crisis in local healthcare.

Previous generations have no doubt felt that the local health service was under pressure, but at no time in living memory have more than a dozen GP surgeries handed back their contracts through difficulty in attracting new doctors, or have acute surgical services been suspended in a large teaching hospital because of inability to attract and retain consultant surgeons. Routine outpatient appointments for some specialties are so long as to be meaningless in terms of the presenting complaint. Patients, doctors and politicians are angry, and there is more than a hint of despair.

I have asked contributors to be frank and honest, conscious of the passion with which many views are held and the pressures under which we now work. I have suggested they might reflect on how their own practices have changed over the years, and what (if anything) we have learned to do better. I have gently inquired if they can provide any note of optimism amidst the general plangency of the media.

The first three contributions are from local medical leaders, but subsequent pieces will hopefully reflect the full diversity of voices across the medical workforce in Ulster. If nothing else, the articles will provide documented proof that in 2023 local doctors really cared about what was happening to patient care, and were concerned to do our best in extremely testing times.

**David J Armstrong, Editor**

## NHS 2023, WHERE DO WE GO NOW?

It goes without saying and without hyperbole that this is the most difficult situation that any of us have ever faced in the NHS in Northern Ireland. We see every sector of the service struggling considerably. In particular in general practice we see the huge effect this is having on our patients; not only on their health, but also on their lives in general, critically including their employment.

General practice itself is doing more and more for less and less. The need for our services is at a level that we have never seen before, and is generated by multiple sources including an ageing population, constant recycling of patients currently on waiting lists who are often becoming sicker, earlier and complex discharges from hospital, a multitude of public health issues and concerns, and a worrying increase in poor mental health and in social stress.

General practice and primary care are absolutely the correct place for many of these patients, and the strategy of shift out of hospital and care closer to home is the right one, but only if we have a strong foundation of funding and staff. Unfortunately, we are a million miles from this.

Perhaps, and the most frustratingly for me, is that we have the reports and the plans that not only predicted the current problems, described as the 'burning platform' in the Bengoa report, but they also suggested and described many of the solutions. There are actually written plans and policy in these areas, but they have not been implemented. Raphael Bengoa himself foresaw the problems when he said that making the plans was the 'easy' bit, actually implementing them was where we as a system recurrently fall short. He was entirely correct.

I am a huge believer in local government, local accountability and local responsibility. Health is and will remain devolved, and we have the flexibility and autonomy to make decisions that are reflective and responsive to our local challenges and local populations. Health of course also involves far, far more than simply health, and a proper, co-ordinated cross departmental strategy is required to not only stabilise our current system, but also to plan properly for the future.

A budget is also critical, not even the exact amount, but the knowledge of what is available to allow for proper planning. The current political hiatus has resulted in full blown crisis management, which is not only expensive, but also fails spectacularly to plan properly for the future. Given the current position, and the huge challenges that we all know we face, there is a real fear that we are moving to an irrecoverable position.

Staff morale is also a major, major problem right across health, and we can see clear evidence of this from the range of industrial action across the country, and I fear that the days of goodwill, that have always been so important to prop up our service, have now gone forever.

No service can run without staff and they need to be valued, respected, paid properly and be enabled to work in a safe and supported environment. Without supported staff our NHS will fail.

I am still a firm believer in an NHS that is free for all and is

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there for all when they need it. We need to fiercely protect this, and I am still optimistic that we can do. We need strong leadership and we need courageous conversations about what our priorities are and about what we can realistically expect from our health service.

We also need strong, mature public conversations about how we pay for it.

We need to trust our staff and trust those that are working in the service who see the problems first-hand every day. I am constantly encouraged in any meeting of clinical staff where solutions and real change can be identified and described often very quickly. This needs to be listened to, enabled and acted on.

I have begun many a talk recently with the words 'if only…', and I still stand by this. We do not need to be overwhelmed or to make things over complicated. We need to understand what we already know; we need to have a clear vision of what we want our health service to look like into the future, and we need to commit to many of the plans that already exist. And we need a Health Minister.

**Alan Stout**
GP Partner, Belfast
Chair, GP Committee BMA(NI)

## UNPLANNED COLLAPSE OR EMBRACE CHANGE

"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".[1]

Words from the Bengoa report of 2016 which unfortunately have come to pass as evidenced by the collapse of emergency general surgical services in two of our hospitals. It is also well recognised that we have the largest waiting lists in the UK with over 122,267 patients waiting for surgery or treatment with 378,411 patients waiting to see a consultant for first time.[2] My own specialty of General Surgery is in the top four of the longest waiters alongside ENT, Trauma & Orthopaedics and Urology. This has been one of the biggest challenges for my colleagues and I over the past number of years. The moral distress, associated with clinicians seeing people and putting them on surgical lists knowing that it may be several years before they receive the treatment they need, is well recognised. My colleagues and I see on a daily basis the impact of such waiting lists with advanced disease presentation, recurrent emergency admissions with the problem requiring surgery (e.g., gallstone disease, incarcerated hernia) and patients no longer able to have the surgery due to a change in their comorbidity. In addition, there is a 'hidden waiting list' of people who have not yet come forward or who have not yet been referred for hospital treatment.

The waiting lists have built over many years, mainly because of rising demand, reduced capacity (particularly during Winter) and lack of predicted recurrent funding of the health service. Previous attempts to reduce by using the independent sector has resulted in brief periods of reduction but once the funding was stopped the lists steadily increased again.

Presently, more than ever we need to unlock the potential of the health service in meeting the needs of patients now and into the future. Patients deserve the right to timely surgery and even more so in a post-pandemic world.[3] The waiting lists are further creating health inequalities where those who have the financial means seek private healthcare whilst others have no choice but to remain on NHS waiting lists. These delays are resulting in conditions deteriorating and management of chronic pain. This contributes to an overwhelmingly negative picture of life described as being 'on hold' or in 'no man's land'[4].

It is also critical to recognise that the landscape of surgery has changed in recent years within the UK. In my own specialty, General Surgery we do not have the General Surgeon of the past who was trained in all aspects of surgery. The future is all about subspecialisation with colleagues providing expert care in one part of General Surgery. Such subspecialisation has brought about the necessity to consider new ways of working (e.g., separating emergencies of an upper GI nature from emergencies of a lower GI nature). Similarly, modern emergency general surgery has much more dependency on the use of interventional radiology and other disciplines. Such circumstances led Minister Swann to commission a Review of General Surgery which I was honoured to chair.[5] The review was an extremely robust, evidence-based process. One of the principal aims was to develop a set of standards for the delivery of emergency general surgery with the recognition that separation from elective practice greatly benefits both aspects of General Surgery. It was particularly evident during the pandemic that the creation of 'standalone' surgical hubs allowed elective surgery to continue despite the pressures on the system.[6] Therefore, if I had the ability to influence one major change in the current delivery of health care in Northern Ireland, I would push on with the creation of 'protected surgical hubs' separate to unscheduled pressures which would allow the increased capacity we so badly need to address our waiting lists and the future increased numbers of people requiring surgery.

It is also becoming very clear that specialist clinicians are increasingly reluctant to take up posts in smaller units with low patient throughput. This has been witnessed across many different jurisdictions for good reason. It's not about Trusts simply "trying harder" to recruit. Smaller units inevitably mean smaller clinical teams, with the burden of punishing work rotas resting on all too few shoulders. As colleagues leave for roles with bigger teams elsewhere, services are increasingly propped up by locum cover, with all the care continuity problems that this entails. Crucially, when patient numbers are lower, clinicians are also deprived of the necessary case mix to maintain and develop their skills and subspecialise in their chosen fields. It is critical to address such situations and in the Review of General Surgery a 'redesign' of the hospital services in Northern Ireland has been suggested with some centres becoming 'overnight stay surgical centres' with the capability to still have

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functioning emergency departments and associated medical interdependencies. Such implementation has the potential to unlock the door to further reviews of surgical specialties all with the aim of ensuring that no matter where one lives in Northern Ireland, they will have access to the same high standard of timely emergency and elective surgical care.

In conclusion change is needed if we are to celebrate our health service in the years to come. It is critical that society grasp this opportunity to implement fully reports such as the Bengoa report[1] and allow changes to hospitals such as fewer emergency centres but with the creation of robust elective centres. Future proofing our health care system has never been more important. Do we have the maturity to embrace change or continue to see collapse?

**Mark A Taylor**
Consultant Hepatobiliary and Pancreatic Surgeon
NI Director Royal College of Surgeons

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## NO BUILDING IS SAFE WITHOUT STRONG FOUNDATIONS.

What is it about general practice that after more than 20 years of work, it continues to keep me interested and invested? It's partly the clichéd *cradle to grave* aspect of what we do but more than that, it is the relationship that we develop with our patients over a lifetime and the stories that we are told that help us understand how illness impacts on them.

Building that picture over time and the impact of continuity is the foundation of good care and better outcomes for patients. It is no surprise that general practice has been described as the foundation or the bedrock upon which the NHS as a whole system is built. The front door or the gatekeeper, an integral part of the system that's function is vital to the health and wellbeing of our population.

Healthcare provision has always been moving towards better care, better outcomes, new advances, and new treatments but with that comes the expectation that the service will provide and need more resource to do so.

General practice has seen many changes over the last 20 years not least the move from a more reactive service to one of improved proactive health care through the introduction of the current contract in 2004. This includes a greater emphasis on chronic disease management and optimisation of care alongside dealing with the urgent and unscheduled. In addition, continuing with health promotion and the vital role we have in screening. That shift to proactivity certainly felt like a positive thing to do for our patients despite the concerns that shifting more care to the community was always going to need more resource to follow and the worry was that such a resource both financially and in terms of workforce would be found wanting. Unfortunately, these fears were realised; austerity, underinvestment, and the lack of a comprehensive general practice workforce plan has been catastrophic in the last decade. However, the challenges we face in our GP surgeries are not isolated as colleagues in every part of our health service are feeling similar impacts as we all try to do more with less and manage patients with increasing medical complexity medical.

That said, given our unique role and proximity to the communities we serve, we see the manifestation of pressures elsewhere in the service daily as we are often the only part of the system that patients can access. The fracture lines that are opening up right across the system are having a catastrophic impact on our foundations. Patients languishing on a waiting list for years with no specialist access are trying to scrape together money to go privately in the hope of being seen. In the interim, the only place those patients can go is to our surgeries and we do our best to support them when they are being failed by other parts of the system.

In my view, there has never been a more difficult time to be a GP. Managing compounding morbidity alongside urgent need is squeezing our proactive care, as something needs to give. There is a growing demand capacity mismatch, and its impact is devastating for patients and general practice teams. Workload is unmanageable and burnout is rife.

But it didn't have to be so. Had we been able to implement transformation that saw a real proportionate investment in community-based care we might have entered the pandemic with some reserves. The fact we did not further compounded the pressures for general practice.

GPs across the UK are now facing intolerable pressure but uniquely in Northern Ireland, we are being let down by a lack of Assembly or Executive at Stormont. When the Executive collapsed in February 2022, so did our first opportunity to

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have a multiyear budget. Having no functioning institutions or political leadership is hugely frustrating and risks our ability to deliver on basic services, let alone take any steps towards vital transformation.

We are fighting a losing battle over access without an adequate workforce and delivery of essential transformation that would see real and sustained investment and support for primary care. That we have seen an unprecedented number of practices hand back their contract in the last 12 months is a stark reminder to all that the foundation of the NHS that was slowly crumbling pre-pandemic, is now facing a seismic shift towards collapse.

It will take years to make the general practice foundation fit to bear the weight of the NHS that sits upon it, but there are ways to help stabilise and support it in the interim. Action is needed to expand our workforce through increased training and recruitment. Urgent support through a region wide roll out of Multidisciplinary Teams and investment in our physical and digital infrastructure, would go some way to tackling unsustainable workload. In addition, a real focus is required on strategies to retain our current exhausted workforce. While none of these solutions are easy and none alone can treat our crisis, our elected representatives and senior leaders cannot afford to continue ignoring the challenges we face because no one can afford for general practice to fail.

**Ursula Mason**
Chair RCGPNI
GP Partner Carryduff Surgery

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