2021

Elective Care Framework

Restart, Recovery and Redesign

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
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MINISTERIAL FOREWORD

I am very pleased to be publishing this framework today - a roadmap for tackling the scourge of Northern Ireland's hospital waiting lists

When devolution was restored in early 2020, waiting times were identified as a major priority for the new Executive.

Tragically, the global Covid-19 pandemic has not only delayed the necessary actions, but has made the situation even worse.

While the pandemic is not yet over, the success of our vaccination programme has brought us to a better place in NI.

We owe to it patients and our great health and social care staff to push ahead with the painstaking process of rebuilding our health service.

That must include a relentless drive to bring down waiting times. These are not statistics, but real life stories of people waiting far too long in pain and discomfort.

We can do better and we will.

This framework contains a range of short term, medium term and longer term actions.

Our waiting list crisis has been building up for some seven years. There are no quick fixes.

The plans detailed in this document include: implementation of "green pathways" with every effort made to keep elected care services entirely separate from any exposure to Covid-19; expansion of the elective care centre model with surgeries provided in ring fenced specialist hubs; a relentless regional NI-wide approach rather than a disjointed postcode lottery system; delivery of megaclinics for outpatient, assessment and pre-operative assessment clinics; improved data, reporting and accountability; continued focus on performance management; ongoing close cooperation with the independent sector; development of in-house HSC capacity

including continued investment in staffing and use of temporary, enhanced rates for targeted shifts.

These are just some of the examples of a suite of initiatives. It will take all these and many more to properly turn the situation around.

I want long waits to have been fully banished by March 2026.

That will require sustained investment in building up the in-house capacity of our health service.

If we don't eradicate the gap between demand and capacity then the backlogs in care will keep re-occurring. Up until 2014, the gap was managed through in year funding injections to facilitate additional activity. Those monies have been in shorter supply since then and waiting times have climbed relentlessly as a result.

Investment and reform are now both required - targeted investment to get many more people treated as quickly as possible; reform to ensure the long-term problems of capacity and productivity are properly addressed.

The required investment will involve more than £700m over five years. I realise this is a big ask at a time when there are many financial demands on our public sector. However, we should have no illusions that this is a crisis that has already dragged on far too long.

The time for talk is over. What we need now is concerted action.

Robin Swann MLA
Minister of Health

ELECTIVE CARE FRAMEWORK – ACTIONS AND TIMESCALES

This document sets out a five year plan to reduce the backlog of patients currently waiting for assessment and treatment.

£707.5 million of additional investment will be required over this period to ensure that no patient waits more than a year for assessment or treatment and to build Health and Social Care (HSC) capacity to meet annual demand for services. Without a commitment to additional investment on this scale, it will not be possible to reduce and sustain waiting times at acceptable levels.

A number of the actions are likely to require investment in infrastructure and, consequently, the associated additional capital funding would need to be provided. These requirements will be assessed as part of the proposals.

5 YEAR TARGETS

- **Subject to a commitment from the NI Executive that the necessary backlog funding will be made available, the Department's clear aim is that, by March 2026, no-one should wait more than 52 weeks for a first outpatient appointment and inpatient/day case treatment; or, 26 weeks for a diagnostics appointment.**

- **Subject to a commitment from the NI Executive that the necessary capacity funding will be made available, the Department's clear aim is that, by March 2026, we will have eradicated the gap between demand and capacity for elective care.**

IMMEDIATE ACTIONS – JULY – DECEMBER 2021

TREATMENT CAPACITY

In order to increase capacity, the HSCB will:

- **Support HSC staff to deliver greater levels of in-house elective care activity by increasing the use of existing bank and on-call arrangements, including the introduction, by July 2021, of temporary, enhanced rates for targeted shifts and priority activities**

- **Make recommendations on medium term contracts to lease theatres to independent providers to address current backlogs. This will include theatre capacity that is not in active use, including use of HSC theatres in evenings and weekends where HSC activity cannot be delivered – by December 2021**

- **Where independent providers can provide value for money and the same standard of service as the HSC, the HSCB will bring forward proposals for multi-year arrangements with independent sector providers to address backlogs – by December 2021 (subject to confirmation of multi-year funding before 31 July 2021)**

The HSC Estate

- **While retaining the ability in the medium term to flip back to a Covid-19 focus if required, the Whiteabbey Nightingale will be repurposed as a regional facility to support advanced rehabilitation – by September 2021**
- **The Duke of Connaught (DoC) Unit at the Musgrave Park Hospital site will be refurbished as a daycase surgery unit for orthopaedics commissioning work is expected to complete by the end of summer 2021**

EXPANSION OF ELECTIVE CARE CENTRES

Building on the success of the elective care centre prototypes in cataracts and varicose veins, and the development of the first Regional Day Procedure Unit, the Department will establish:

- **A new Elective Care Centre Management Team to oversee planning of services at regional elective facilities – by September 2021**
- **The new Team will make recommendations on the next site for expansion of the day procedure programme – by October 2021**

OUTPATIENT REFORM

The scale of the waiting lists means that we need to accelerate reform of outpatients.

- **All HSC Trusts will move to provide a minimum of 25% of outpatient attendances virtually, either by telephone or by video conference by October 2021**
- **The NI Orthopaedic Network will oversee the development of megaclinics for orthopaedic outpatients by September 2021**
- **The HSCB will introduce assessment megaclinics for cataracts by September 2021**
- **The HSCB will oversee the introduction of pre-operative assessment megaclinics by September 2021**
- **Breast assessment clinics for symptomatic patients will move to a regional booking system by December 2021**

ELECTIVE PATIENTS WITH AN URGENT NEED

With the current scale of the waiting lists, it is becoming more common for patients with an elective need to be referred to Emergency Departments as their condition deteriorates. Through the No More Silos network, the Department will invest in specialty assessment units that will be directly bookable and accessed from primary care – by September 2021

IMAGING & PATHOLOGY

- **Extending radiography advanced practice in diagnostic radiography to enable radiographers to report a greater volume of less complex work traditionally carried out by consultants – by June 2022**

- **Services will be developed in line with the recommendations of the Strategic Framework for Imaging Services, 2018 which outlines the future vision for imaging services over the next 10 year period to meet the needs of the population of NI.**

Support the Pathology Network in ensuring that HSC Pathology Services are equipped to support delivery across all relevant Rebuild programmes, in line with the modernisation and transformation of HSC Pathology Services. This will include:

- **Continuing to support delivery of COVID-19 testing across the HSC whilst ensuring routine laboratory services are restored and equipped to support Rebuilding activity across all relevant areas (diagnostics, elective care etc);**

- **Continuing the programme of HSC Pathology Transformation to improve long term resilience through: regional standardisation of laboratory processes; procurement of replacement of Laboratory Information Management Systems (LIMS) by April 2021; implementation of regional digital pathology solution by summer 2021.**

CROSS BORDER HEALTHCARE

The Minister will introduce a new limited administrative version of the Cross-Border Healthcare Directive for the Republic of Ireland for a 12 month period. Applications will be accepted by the Health and Social Care Board from 30 June 2021.

The Republic of Ireland Reimbursement Scheme sets out a framework, based on the Cross-Border Healthcare Directive and will allow patients to seek and pay for routinely commissioned treatment in the private sector in Ireland and have the costs, up to the cost of the treatment to the HSC in Northern Ireland, reimbursed.

The Republic of Ireland Reimbursement Scheme will be open to ordinary residents of Northern Ireland and be managed by the HSCB and all treatments are subject to prior authorisation. Further details will be available in the coming days.

SPECIALTY SPECIFIC ACTIONS

Cancer surgery makes up a significant proportion of all surgical activity. It is estimated that cancer surgery accounts for approximately 26% of all surgery across the region. The actions in this Framework will therefore have significant benefits for cancer patients. In order to address wider cancer services, the Department will publish a Cancer Recovery Plan setting out key actions to stabilise and reform cancer services over the next three years – by June 2021

The Northern Ireland Orthopaedic Network will deliver a recovery plan setting out priority actions and timescales to bring orthopaedic activity back to commissioned levels, and to increase activity as rapidly as possible – by August 2021

The Department will carry out a clinically led review of General Surgery in Northern Ireland. The first phase of this review will include a rapid assessment

of the actions required to stabilise general surgery in the short to medium term. This is likely to have implications for how elective and emergency surgical services are planned and delivered – by October 2021

PERFORMANCE MANAGEMENT

The investment required to deliver these targets over the next five years is set out in more detail in section 4.

To ensure additional investment is used as effectively as possible, the performance management function within the Health and Social Care Board (HSCB[1]) will be enhanced to:

- **Measure and monitor accurate and timely data on theatre utilisation, productivity and efficiency;**
- **Identify underperformance and put measures in place to support improvement;**
- **Learn from international experience to identify best practice and promote adoption and spread of learning;**
- **Identify and invest in high performing services;**
- **Provide monthly performance updates including:**
    - **levels of activity delivered in the HSC and the independent sector;**
    - **Theatre utilisation and productivity for lists delivered through the HSC and productivity in the independent sector, benchmarked against NHS good practice.**

A new Waiting List Management Unit will be in place at the HSCB by summer 2021

HSC Trusts will produce three-monthly delivery plans setting out how they will continue to restore services and reach required activity levels.

[1] By 31 March 2022, the functions of the Health and Social Care Board will transfer to the Strategic Planning and Performance Group within the Department of Health. References to HSCB after March 2022 should therefore be understood in this context.

MEDIUM TERM ACTIONS – JANUARY 2022 – DECEMBER 2022

ANNUAL DELIVERY PLAN

Subject to confirmation of the available budget, the HSCB will produce an annual Elective Care Delivery Plan setting out:

- **Performance in the previous year;**
- **Realistic annual activity targets;**
- **Projected activity for independent sector contracts and in-house additionality;**
- **Overall demand/capacity information for each specialty.**

SEPARATION OF ELECTIVE AND UNSCHEDULED CARE

The new Elective Care Centre Management Team will make recommendations on the development of a regional 23 hr Elective Care Centre – by March 2022

In line with the recommendations in the Cancer Recovery Plan, the Department and HSCB will bring forward proposals for the development of one or more Rapid Diagnostic Centres – by March 2022

The HSCB will bring forward proposals to redesign endoscopy services.

- **This will include the possibility of consolidation on fewer sites delivering a higher volume of procedures – by January 2022; and,**
- **A scoping exercise on the feasibility of a new regional endoscopy centre(s) to deliver high volume scopes – by March 2022**

Taking into account the work of the General Surgery Review, the HSCB will bring forward proposals for the introduction of Post-Anaesthetic Care Units (PACU) at all sites providing complex surgery. This will provide postoperative high-dependency or intensive care for high-risk surgical patients in an area separate from the general intensive care unit (ICU) – by March 2022

New recurrent investment to be targeted at increasing capacity in each of the 15 largest elective specialties.

In addition to ongoing medical, pharmacy, nursing & AHP workforce planning:

- **The new Elective Care Centre Management Team will lead on the development of a multi-disciplinary workforce plan to ensure each centre can deliver its full capacity using the most appropriate skills mix and in line with appropriate professional regulation and standards – by March 2022**

- **The Department will shortly finalise work on a review of perioperative nursing in Northern Ireland that is intended to stabilise and grow the perioperative nursing workforce. As part of the Safe Staffing budget allocation for 2021/ 2022 there will be an additional 30 WTE Band 6 senior nursing posts recruited across the Region and one dedicated Band 7 Clinical Education Facilitator per Trust to support staff development recruited into post by October 2021. This work will also support and promote advanced and specialist practice.**

- **Building on success to date, we will continue our international recruitment programme, as a complement to our ongoing investment in training, and to ensure we have sufficient workforce supply to meet the demands being placed on our HSC system.**

- **In line with the findings of the Regional Imaging Review, the Regional Imaging Board will bring forwards proposals for a new Imaging Academy to deliver training, research and collaboration – by March 2022**

- **Progress and explore options to establish a new single regional management structure for HSC Pathology Services, to underpin the ongoing Pathology transformation programme, better equip the service to**

respond to current and future challenges and improve the quality and efficiency of HSC Pathology Services delivered on a regional basis.

Increase opportunities for skills mix, including:

- **An extended role for orthoptists as assistant in theatre, which would support Consultant Ophthalmologists by September 2022;**

- **Expand opportunities in ENT with Speech and Language Therapists by March 2022;**

- **Introduction of a new multidisciplinary approach to treatment, pre-habilitation and rehabilitation as part of consultant led orthopaedic services – by October 2021**

- **Introduction of a podiatric surgery pilot as part of consultant led orthopaedic services – by January 2022**

- **Nurse led pre-assessment for endoscopy by September 2022**

- **Cross sector pharmacist led medicines optimisation reviews – by March 2022**

- **Development of core roles, including specialist and advanced practice, consultant nurse roles which will enable us to maximise the contribution of nursing to perioperative care and treatment and the expansion of advanced and specialist roles such as advanced practice in anaesthetics, and expanded capacity in nurse endoscopists - as part of a five year plan to develop capacity and capability of staff within the perioperative workforce;**

- **The role of Operating Department Practitioners, including options for a Northern Ireland training programme – by September 2022**

COMMISSIONING AND TARGETS

The introduction of a tariff/incentivisation model is expected to make it simpler to monitor activity, tackle underperformance and reward productivity. The HSCB is currently piloting a shadow tariff model in several high volume specialties. The HSCB will:

- **Carry out an evaluation of shadow tariff models by July 2022**

- **Using the learning from this evaluation, a new tariff/incentivisation model will be developed for elective care services. The HSCB will bring forward proposals for a new funding model by January 2023**

PRIMARY CARE

Where care can be provided appropriately in a primary care setting, this has benefits for patients who may be able to receive their treatment faster, in a more convenient setting, and for our system in preventing unnecessary attendance at our hospitals.

- **The HSCB will continue to develop and expand the delivery of appropriate elective procedures in a primary care setting. Plans for the next phase of this work are expected to be ready by March 2022 and should include activities that can move to be delivered by community pharmacies or other primary care providers to reduce workload pressure in general practice.**

ADMINISTRATION OF WAITING LISTS

Strong administration ensures elective services run efficiently and reliably. As well as investment in the clinical workforce, it is vital that there is investment in the operational and organisational capacity to deliver this.

- **In orthopaedics, the NI Orthopaedic Network will trial a regional booking system for one or two procedures by January 2022.**

- **All HSC Trusts will ensure the introduction of text or voice messaging services to reduce DNA rates for all elective services – by September 2022**

- **HSC Trusts will invest to increase capacity in patient booking teams to ensure that patients are contacted prior to surgery.**

LONGER TERM ACTIONS – JANUARY 2023 ONWARDS

INFRASTRUCTURE

The Department will develop a long term strategic plan for future capital investment, incorporating plans to maximise elective capacity and capability across the HSC. Consequently, when prioritising funding for elective care, due consideration should also be given to funding the associated infrastructure requirements.

TARGETS

In line with the commitment in New Decade New Approach, the HSCB will pilot referral to treatment targets across 5 procedure types.

The Department will oversee the development and introduction of new waiting times targets to reflect the entire patient journey, from referral to treatment.

7-DAY WORKING

In line with increasing HSC capacity, HSC Trusts will move to a 7-day working week for existing theatre infrastructure. There are, however, significant challenges to this. In addition to the necessary investment in the workforce, this will require significant engagement with staff. This is therefore a longer term aspiration and is subject to the delivery of additional recurrent investment.

DIGITAL

There are a number of major digital programmes that will deliver significant benefits to elective care services. These include:

- **Implementation of a Northern Ireland Picture Archiving and Communications (NIPACS+) Programme. The NIPACS+ Programme will provide a single enterprise imaging solution for HSCNI - to support clinical diagnosis, improve clinical pathway planning, improve patient safety and enhance patient care through continued and enhanced medical image sharing and collaborative working.**

- **The introduction of Encompass. Encompass is a HSC-wide programme, working to deliver the digitally enabled transformation of Health and Social Care in Northern Ireland. The Encompass vision is for a digital care record for every citizen in Northern Ireland that better informs and supports their health and wellbeing throughout their life.**

- **The implementation of electronic prescribing in primary care which will reduce workload associated with the management of prescriptions in general practices and community pharmacies.**

SECTION 1. INTRODUCTION

IMPACT OF THE PANDEMIC

The global Covid-19 pandemic has had a severe impact on Northern Ireland's Health and Care system (HSC). Even before taking into account the rising number of patients requiring hospitalisation and treatment, hospital capacity was reduced by the necessity to introduce strict infection prevention and control measures. At the same time, the need for self-isolation of staff testing positive for Covid-19 has exacerbated the existing workforce challenges and has put additional pressure on those staff working in hospital services.

Since March 2020, there have been three periods where demand for urgent and emergency (unscheduled) care has risen to the degree that it has been impossible to maintain planned care while also ensuring all unscheduled patients receive appropriate care and treatment; these are termed surge periods. The first surge period took place in April 2020. Since then, there have been further surges in November 2020 and January 2021.

During a surge period, the scale of the pressures on the HSC are so great that all resources must be deployed to deal with the urgent and emergency patients presenting at hospitals. HSC Trusts have put intense effort into maintaining as much elective work as possible. Regrettably, as the number of patients requiring admission and treatment rises, it becomes increasingly difficult to maintain planned services.

Staff across the system were redeployed to help manage the higher number of patients being admitted to hospitals on an emergency basis and also to allow the system to increase critical care capacity. The majority of routine elective work was also halted during each surge period. Furthermore, as the number of unscheduled patients requiring treatment in critical care increases, this also reduces the ability of critical care to provide dedicated support for the most complex elective surgery. It is extremely concerning that there has been a sustained impact on higher priority elective care during surge periods.

For the past year, rightly and unavoidably, our resources have been directed towards patients requiring urgent and emergency care. However, as the HSC recovers from

this unprecedentedly difficult start to the year, the immediate focus has now turned to how we restart elective activity and ensure that any time critical treatment that was delayed or otherwise impacted by the emergency response to the pandemic is rescheduled and carried out as quickly as possible. At this point we will also need to turn our attention to the growing backlog of patients waiting for assessment and treatment on our waiting lists.

WAITING TIMES PRE-PANDEMIC

Waiting times in Northern Ireland were at an unacceptable level before the pandemic and have been worsening steadily since 2014. Prior to the pandemic, waiting times for elective care were the worst in the UK and among the worst in Europe. Indeed, in March 2019 it was reported that a person in Northern Ireland is at least 48 times as likely as a person in Wales to wait more than a year for care. This is despite Wales being the worst performer otherwise in the UK. Covid-19 has exacerbated a situation that was already reaching a critical point.

This is not the first time that Northern Ireland has faced issues with waiting times. Prior to 2005, hospital waiting times here were the longest in the UK. By 2009, the situation had broadly stabilised and remained relatively stable until 2013. At this point, the wider national financial position led to a suspension of additional activity carried out within the HSC and in the independent sector. Since that time, the backlog of patients waiting longer than ministerial targets has continued to rise.

Waiting times are currently so long in Northern Ireland that Emergency Departments (EDs) and other urgent pathways have increasingly become the default entry point for patients requiring treatment, either due to patients waiting so long that their condition becomes urgent, or because EDs are seen as a faster way of accessing diagnosis and treatment. Fixing waiting times will therefore also help take some of the pressure away from EDs.

In 2017, the Department published an elective care plan setting out proposals for reform and transformation of elective care services. While there has been a great deal of good work carried out to improve how we provide elective care in Northern Ireland, there is still a significant gap between the demand for services and the

capacity of the HSC to meet it. As the experience of 2013 demonstrates, there are limitations to relying on short term funding models for these services. Short term funding will only ever produce short term solutions. Reducing waiting times and keeping them at acceptable levels will require long term investment and a radically new approach to planning and delivering elective care services.

There is no doubt that reform is necessary but, above all, there needs to be a commitment to significant and sustained investment both in the HSC and in the independent sector. Increasing capacity essentially means increasing the workforce. This is true for the independent sector as much as it is true for the HSC. Short term funding simply does not provide the stability necessary to attract and retain staff, or to plan services efficiently.

Ultimately, even if all of the reforms set out in the 2017 Elective Care Plan are to be introduced successfully, the scale of the backlog is so great that this is beyond the capacity of the HSC to resolve without help. There is no doubt that the HSC will need to access additional capacity through partners in the private and charitable sectors for the foreseeable future in order to bring waiting times down to acceptable levels.

TIMESCALE AND INVESTMENT

This Framework focuses on three key phases of this work:

- **Restart – Resumption of activity**
- **Recovery – Systematic backlog reduction**
- **Redesign – Enhance and protect elective capacity**

It is important to be realistic about the time and investment necessary to deliver the actions set out in this plan. Even with the necessary investment, it is expected that it will take at least 5 years to reduce the backlog to acceptable levels and to introduce the longer term reforms necessary to ensure that the HSC is equipped to meet the needs of the Northern Ireland population.

The investment required to fix waiting times can be split into two distinct programmes:

- **Backlog reduction**: multi-year funding earmarked to tackle the backlog of patients waiting beyond ministerial standard – this is likely to be a combination of independent sector and HSC activity;
- **Closing the capacity gap**: additional recurrent investment to increase and reform HSC capacity to meet yearly demand now and projected for future years.

In the first years of the plan, investment will be skewed towards purchasing additional capacity in the IS and HSC. Over time, it is expected that this balance will change as we increase internal capacity to match annual demand. An analysis of the current gap between HSC capacity and demand for services is included at section 5. In total, it is estimated that the HSC will require more than £700m over 5 years to implement this plan. While it will take time to build up internal HSC capacity, it is estimated that the health service will eventually require an additional £121.5m of recurrent funding to close the gap between health service capacity and public demand.

CONCLUSION

The pandemic has cruelly exposed the fault lines in our system in terms of the inability to protect elective care during periods of surge. In spite of the massive efforts of HSC leaders, and the commitment of front line staff, Northern Ireland has had to turn off elective care sooner and for longer than other parts of the UK. This may not come as a surprise to many in our system. Northern Ireland waiting times were at crisis point long before Covid-19.

Many of the actions taken during the pandemic have shown that there is a better way to work. Trusts have collaborated more closely and staff have worked across administrative boundaries to make sure that as much care as possible could be provided to patients. We have learned a great deal about the weaknesses in our system and the obstacles to a better, more efficient way of working.

The steps outlined in this plan represent a completely new approach to how elective care is planned and delivered in Northern Ireland. We will build on the good work that has already been carried out. We will learn from what worked, and from what didn't work. We cannot accept this level of service to patients in Northern Ireland.

This plan is based on the following six principles:

1. **Recurrent investment is required to ensure that the system can build capacity to meet the population's need.**
2. **Additional investment will be required to tackle the backlog of patients waiting for diagnosis and treatment.**
3. **Elective capacity should be fully resourced and protected from unscheduled pressures.**
4. **Elective performance and investment should be closely monitored to ensure productivity and value for money.**
5. **Patients should receive consistent levels of service and quality of care regardless of the centre they are treated in.**
6. **Above all, there must be recognition at local and national level that people in Northern Ireland cannot receive a lower standard of care than in other parts of the UK.**

There is no question that reform is necessary, but it must also be recognised that reform alone will not be enough to fix the problem. Without major sustained investment it will simply not be possible to return waiting times to an acceptable standard and to keep them there.

SECTION 2. ELECTIVE CARE IN NORTHERN IRELAND – DEMAND, CAPACITY, AND CURRENT WAITING TIMES

WHAT IS ELECTIVE CARE?

When we refer to elective care, we mean care that is planned in advance as opposed to emergency or unplanned treatment. Elective care normally involves specialist clinical assessment (generally following referral from a GP or other primary/community health professional), and subsequent care or treatment, including diagnostic tests, surgery, other medical treatments and therapies.

In Northern Ireland, performance against the individual elements of the patient journey for elective care (or stages of treatment) are measured and reported separately, i.e. the waiting time for a first outpatient appointment, a diagnostic test and inpatient or daycase admission is centrally monitored and official waiting time statistics are published on a quarterly basis.

The current waiting time targets are set out in a Commissioning Plan Direction. This Direction is issued by the Minister of Health and sets out the priorities, aims and improvement objectives for Health and Social Care (HSC). For 2020/21 these targets were:

By March 2021:

- 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks;
- 55% of patients should wait no longer than 13 weeks for inpatient/daycase treatment and no patient waits longer than 52 weeks.
- 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

CURRENT WAITING TIMES

Our official statistics show that at the end of December 2020, 323,174 patients were waiting for a first consultant-led outpatient appointment; 275,651 patients were waiting more than 9 weeks and 167,806 patients were waiting more than 52 weeks. 105,159 patients were waiting to be admitted to hospitals in Northern Ireland; 85,883 patients were waiting more than 13 weeks and 56,242 patients were waiting more than 52 weeks.

Pre Covid-19 there was already a significant shortfall in the capacity of the HSC in Northern Ireland to meet the demand for elective care services and this was reflected in the unacceptably long waiting times.

The spread of coronavirus has caused serious disruption to our Health and Social Care system and it was unavoidable that elective care activity would reduce due to the need to redeploy staff to address rising unscheduled demand. Unfortunately, our elective waiting times will be even worse after Covid-19.

By March 2021, 50% of patients should wait no longer than 9 weeks for a first outpatient appointment, and no patient should wait longer than 52 weeks.

There were **323,174 patients** waiting for a first outpatient appointment in Northern Ireland

A **decrease** of **1.2%** on the previous quarter

An **increase** of **6.0%** on the same quarter last year

Source: DoH Outpatient Waiting Times Dataset

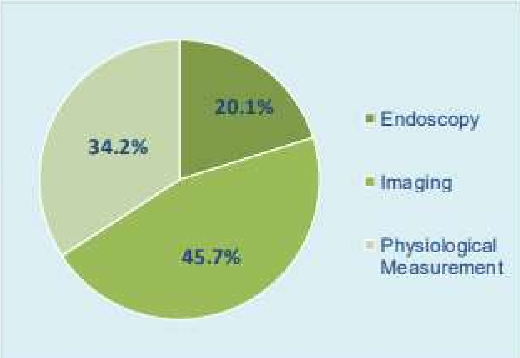
By March 2021, 75% of patients should wait no longer than 9 weeks for a diagnostic test, with no patient waiting longer than 26 weeks.

Total number of patients waiting at 31st December 2020

144,433 patients waiting for a diagnostic service at hospitals in Northern Ireland

decrease of **10.1%** on the previous quarter

increase of **2.2%** on the same quarter last year



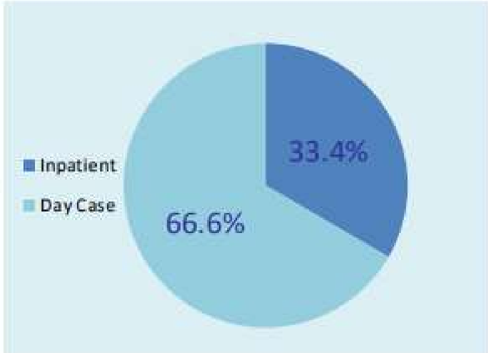
Source: SDR1

Total number of patients waiting at 31st December 2020

There were **105,159 patients** waiting to be admitted to hospitals in Northern Ireland

An increase of **5.5%** on the previous quarter

An **increase** of **16.2%** on the same quarter last year



Source: DoH Inpatient Waiting Times Dataset

HOW DOES THIS COMPARE WITH OTHER PARTS OF THE UK?

Direct comparison between waiting time statistics for Northern Ireland and the rest of the UK is not readily available because in the rest of the UK, waiting time data are no longer collected on separate outpatient and inpatient waits as is still the case in Northern Ireland. Other regions have moved to Referral to Treatment (RTT) time targets, which measure the total time the patient has to wait from referral to treatment. In Northern Ireland, the Department of Health do not measure complete patient journey time from GP referral to start of treatment. Once a referral for a first outpatient appointment has been made, the waiting time 'clock' starts and then stops once they have been seen by a Consultant / specialist. A separate waiting time 'clock' starts if the patient requires inpatient treatment on either a hospital admission or daycase basis, or if they require a diagnostic test.

However, if we look at pre Covid-19 figures for example, in England (total population around 55 million) at the end of November 2019 only 1,398 people were waiting more than 52 weeks on the Referral to Treatment (RTT) pathway to start treatment, whereas in NI (total population around 1.9 million), at the end of September 2019, 108,582 people were waiting more than 52 weeks for their first outpatient appointment[2].

As a relatively crude comparison, the Nuffield Trust has estimated that in March 2019, a person in Northern Ireland was at least 48 times as likely as a person in Wales to wait more than a year for care. This is despite Wales being the worst performer otherwise in the UK, and the Welsh method of measurement capturing more stages of the journey for patients who are admitted to hospital – effectively starting the clock slightly sooner[3].

[2] Waiting lists and waiting times for Elective Care in Northern Ireland: Taking stock - Research Matters (assemblyresearchmatters.org)

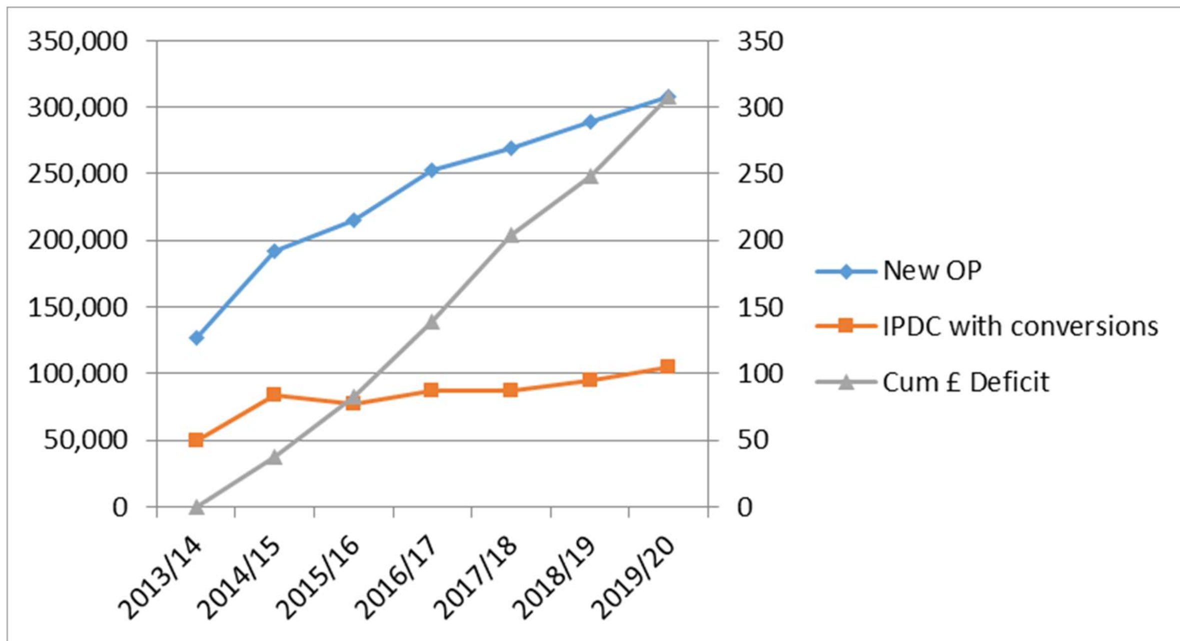
[3] nuffield-trust-change-or-collapse-web-final.pdf

WHY ARE OUR WAITING TIMES SO HIGH?

There are several factors that have contributed to the current levels of waiting lists under-performance. Overall, demand for hospital based elective care services is increasing and this is influenced by demographic changes, particularly a growing, ageing population with more chronic health problems and complex health needs. In simple terms, the longer we live, the more likely we are to require hospital treatment at some point in our lives. Demand for care has been outstripping the ability of the system to meet it for many years. This trend will increase in the years ahead and will only be addressed by action to increase capacity, promote healthier lifestyles and tackle health inequalities.

Addressing the capacity gap is one of the most pressing challenges facing the HSC and, indeed, the Northern Ireland Executive. In practice, where the HSC is unable to deliver the required volumes of treatment, this leads to an over-reliance on buying additional activity, sometimes in-house through an overtime arrangement with HSC employed staff, or more commonly through use of the independent sector to deliver additional waiting list activity.

Since 2015 the annual budget allocated to the Department of Health has not been sufficient to keep waiting times to an acceptable level. The graph below shows how the number of patients waiting has increased as the health service deficit has increased. The fact that the number of patients waiting has not increased as steeply as the deficit clearly demonstrates that while doctors, nurses, other health professionals and managers have made every effort to ensure that any negative impact on patients has been kept to a minimum, waiting times have continued to grow. Waiting lists are now at a level where they will take years to stabilise and even longer to return to their pre-2015 levels. With the pressures of maintaining services in this period, allied to the impact of the pandemic, there is a real risk of burnout among staff. Significant additional investment and new ways of working to deliver services will be needed to achieve the necessary turnaround.



At the same time, our urgent and emergency services are continuing to face significant pressures and the number of acutely ill patients presenting to Emergency Departments and likely to require admission is also increasing. All too often, the result of these pressures is that planned elective procedures, or surgery, are cancelled because hospital theatres, beds or staff are needed for urgent and emergency cases.

Before a surgical procedure can be carried out a range of resources have to be brought together at the right time and the right place: surgical staff, nursing staff, anaesthetic staff, theatre time, beds. Remove any one of these components and the operation has to be cancelled. Where the same staff and resources are required to be available for both elective and emergency care, emergency treatment will always come first – because it is an emergency. The need for hospitals to quickly provide emergency treatment often results in the loss of one or more of these components for planned elective work resulting in the loss of theatre time for patients on elective waiting lists.

The way in which services are organised in Northern Ireland has also contributed to long term issues with efficiency. By attempting to provide 24/7 emergency surgery at multiple sites, we have become overly dependent on locum doctors and agency nurses in order to fill rotas and maintain unsustainable services. This approach combines inefficiency with expense and, above all, could lead to a lower standard of care for patients.

Taken together, these factors have led to a situation where demand continues to increase, while activity levels delivered by the HSC have largely remained static, or in some cases, have not maintained pace with this increase. The administrative and organisational structures we have created to deliver our health and care services can also serve to increase variation of approach. In practice, delivering elective care across five health and social care Trusts can mean that services and resources are not planned regionally, and that patients in different parts of Northern Ireland can experience different levels of service and significantly different waiting times.

Ultimately, if we persist with under-investment and our current outdated models of delivering elective and emergency care services, waiting times will continue to increase, elective capacity will not be able to keep up with demand, and the gap between what patients need and what the system can provide will continue to grow every year.

It also clear that if the system only receives short-term, non-recurrent investment, we will continue to rely on purchasing additional activity rather than investing in long term improvements. It is therefore critical that we balance short term funding to reduce waiting lists with long term investment in new ways of working to increase the in-house capacity within the HSC to meet the population's increasing demand for elective care services now and in the future.

THE IMPACT OF COVID-19

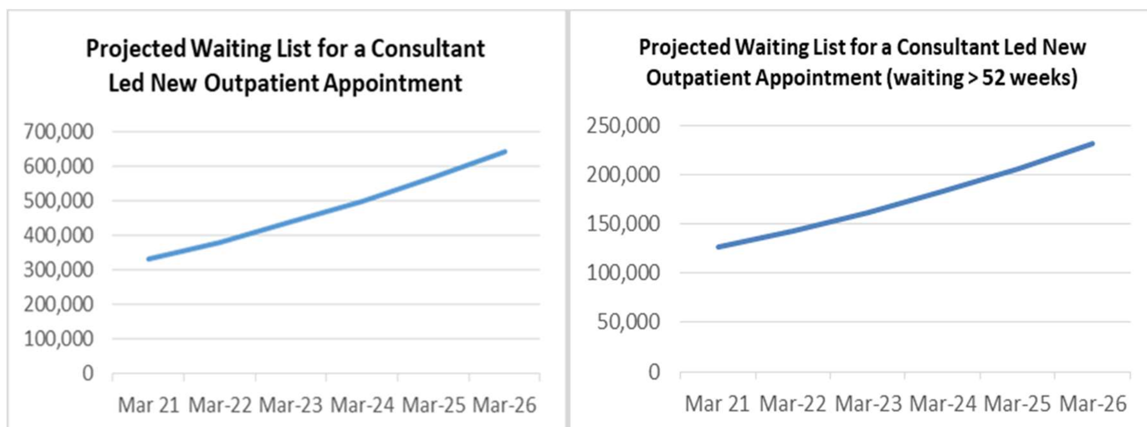
The impact of Covid-19 on the HSC has been profound and will undoubtedly be long lasting. Addressing the backlog will be challenging given the reduced operational capacity across the HSC. Indeed, separating Covid-19 and non-Covid-19 patients, maintaining physical distancing and implementing other infection control safeguards to reduce transmission of Covid-19 (e.g. isolation, use of PPE and environmental cleaning) have meant that hospitals are running at a significantly lower occupancy level than normal, with reduced theatre utilisation that is critical for urgent and elective

work. This has restricted their capacity to deliver patient care and will constrain how quickly hospitals can begin to recommence non-Covid-19 services[4].

Primary care capacity has also been impacted and during the 20/21 year the number of GP referrals for a new Consultant Led Outpatient appointment reduced by approximately 30% from the previous year.

WHAT WILL BE THE LONG TERM IMPACT?

Prior to Covid-19, demand for Consultant Led New Outpatient appointments had been increasing year on year and if demand continues to rise in line with previous years, the waiting list for a New Outpatient appointment is forecast to rise to approximately 640,000 by March 2026, with 232,000 of these patients forecasted to be waiting more than 52 weeks. This reflects the impact of the current gap (approximately 50,000) and an assumed percentage increase in demand each year.



Similarly, by March 2026, the waiting list for Inpatient or Daycase treatment will rise to approximately 306,000, with 107,000 of these patients waiting > 52 weeks. This reflects the impact of the current annual gap (approximately 35,000).

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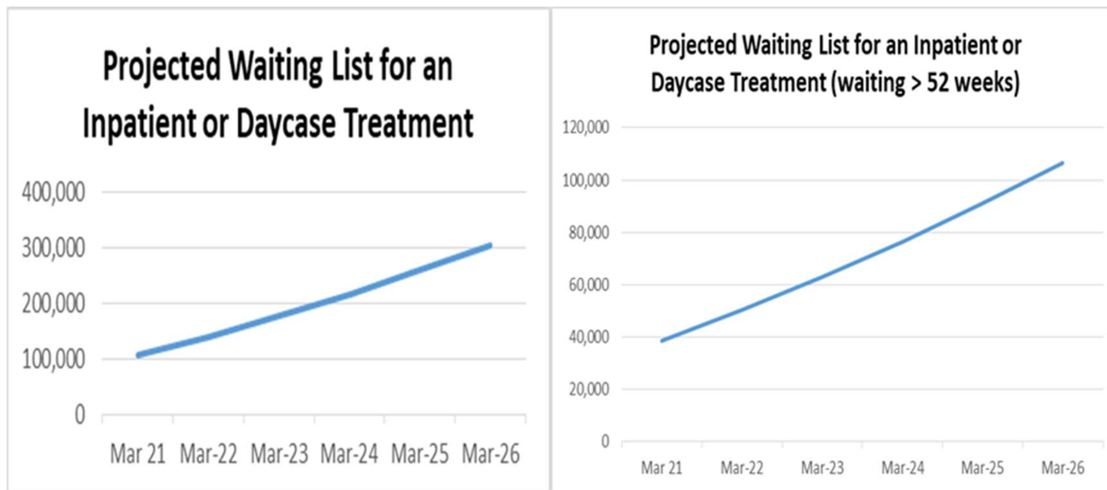
[4] Preparing for a Challenging Winter – July 2020 – the Academy of Medical Sciences



THE POLICY CONTEXT

In October 2016 the former Health Minister, Michelle O'Neill MLA, launched 'Health and Wellbeing 2026: Delivering Together', which seeks to radically reform the way health and social care services are designed and delivered in Northern Ireland, with a focus on person-centred care, rather than on buildings and structures. It is aligned with the aspirations set out within the Northern Ireland Executive's draft Programme for Government, and aims to improve the health of our people, improve the quality and experience of care, ensure the sustainability of our services, and to support and empower staff; but also recognises the challenges that need to be overcome if this is to be achieved.

The *Elective Care Plan* which was published in February 2017 is still a valid roadmap for change. The Plan set out the approach to redressing the waiting list crisis through major reform and transformation to sustainably improve elective care services and build capacity in the HSC. Many of the actions set out in this document were also included in the 2017 plan although the situation has deteriorated much further since then. The collapse of the Northern Ireland Executive was a significant contributory factor to the inability to implement the 2017 Elective Care Plan. While transformation funding was made available, this was only for a two year period, which did not allow for long-term, or even medium term planning.

New Decade New Approach (NDNA) was published by the Northern Ireland Executive in January 2020. It sets out how the Executive plans to transform public services and restore public confidence in devolved government.

There are a number of specific actions relating to waiting times and the delivery of hospital services:

- Introduce a new action plan on waiting times.
- Reconfigure hospital provision to deliver better patient outcomes, more stable services and sustainable staffing. Improvements will be made in - stroke; breast assessment; urgent and emergency care; and daycase elective care - by the end of 2020.
- No one waiting over a year at 30 September 2019 for outpatient or inpatient assessment/treatment will still be on a waiting list by March 2021.
- Consider the scope for changing how waiting times are measured, to reflect the entire patient journey, from referral to treatment, with appropriate targets.

Work on these actions has largely been halted due to the impact of the pandemic and the position with regard to waiting lists has deteriorated. As the number of patients with Covid-19 continues to drop, HSC Trusts are putting in place 3-monthly plans to restart and rebuild elective care activity. Given existing pressures these plans can realistically achieve little more than reducing the rate of increase for waiting times.

DAYCASE ELECTIVE CARE

Much progress has been made on the establishment of Day Procedure Centres and work in this area can be regarded as a success story in terms of maintaining elective services throughout the pandemic.

Day Procedure Centres for cataracts and varicose veins have been operational since December 2018. A policy statement on The Establishment of a Regional Service

Delivery Model for Daycase Elective Care Procedures in NI was published in July 2020 and a Clinical Network was established.

A Day Procedure Centre is currently operational at Lagan Valley Hospital and has been providing much needed support to the region for urgent and red flag daycase procedures in response to the downturn in elective activity in other hospitals during surge periods. A paediatric general surgery day procedure pilot is also underway at the Ulster Hospital to provide time critical surgery for children from across the region.

WHAT IS THE IMPACT ON PATIENTS?

The numbers waiting are shocking, but it is the experience of those patients waiting for care that is unacceptable. In 2018 the Patient Client Council (PCC) gathered information from approximately 700 people, nearly half of whom said their health had deteriorated while on a waiting list. Nearly a third of respondents highlighted worsening pain as a key issue. The negative impact on mental health was also described. Patients also referred to the wider adverse impact on their lifestyle and financial wellbeing.

PHYSICAL IMPACT

"I need my gallbladder removed. I have already had a scan to show stones blocking the neck. I am in constant pain. I live on anti-sickness tablets and painkillers and eat little."

MENTAL IMPACT

"The worry of what the outcome might have been had a knock on effect on my mental health, which resulted in me requiring further services."

SOCIAL IMPACT

"I am unable to make any arrangements or join in for family occasions, I feel bad letting people down which I find very disappointing and it leads to a lot of anxiety."

FINANCIAL IMPACT

I had more days off work with this than I have ever had in my whole life. I don't get sick pay at work only the statutory sick pay from the government and this has a huge impact on everything we do as a family. For example this year we won't be going on a summer holiday as I normally saved throughout the year to pay for this but couldn't this year. My son didn't get to go on a school trip because we really couldn't afford it."

When we describe the scale of the waiting lists in Northern Ireland, the numbers can appear so large that the impact on individuals is lost. In considering the major financial costs associated with implementing this plan, it essential not to allow this to obscure the human costs, not to mention the cost to society, of failing to address this.

SECTION 3. RESTART: RESUMPTION OF ACTIVITY

The pandemic has caused unparalleled disruption to health and social care services and systems. The need to increase intensive care capacity to almost 200% of normal funded beds, allied to efforts to minimise nosocomial infections in health and care settings, have significantly reduced overall capacity. Staff have been redeployed to critical areas and new pathways of care due to testing requirements have resulted in slower flow of patients through the system. For large portions of the three surge periods experienced to date it has been impossible for HSC Trusts to maintain many routine services. At the height of the surges, there has even been an impact on some time critical services.

In practical terms, this has led to an increasing backlog of patients waiting to be seen on top of the existing backlogs pre-pandemic. Following the first surge period, staff in HSC Trusts made enormous efforts to resume elective services and succeeded in rapidly increasing activity over the summer months. Regrettably, from the point that unscheduled admissions began to rise significantly in October 2020, they remained stubbornly high until February 2021 and there has been a prolonged impact on some elective services.

To put this in perspective, Musgrave Park Hospital in Belfast, which provides the majority of the region's orthopaedic surgery, normally runs 10 daily lists for elective surgery. For much of the most recent surge period, this reduced to 1 list as staff were redeployed to deal with unscheduled pressures.

This section sets out the immediate actions that have been taken to restart and increase activity.

APRIL – SEPTEMBER 2021

The restart of elective services has been challenging. The following issues have been taken into consideration:

- A sustained drop in unscheduled occupancy and admissions was necessary before redeployed staff can return to their usual posts;
- Many staff are exhausted, physically and emotionally, and will require a break;

- Measures to prevent nosocomial infection will continue to be required. Capacity and flow will therefore continue to be impacted.
- With delays to treatment and diagnosis, it is likely that there will be an increase in referrals that will need to be treated quickly or as emergency presentations.
- In the restart phase, patients will need to be prioritised by clinical need rather than length of waiting time. Ongoing clinical review of patients on the waiting list will therefore need to be carefully managed.

RESTART: KEY ACTIONS

Since April, the HSC has been working to increase elective activity as rapidly as possible. In this period, the HSC has stood down additional surge capacity that was put in place to deal with the increased pressures on the system since November 2020 and restarted elective services. Some of the key actions have included:

DEMOBILISATION OF REDEPLOYED STAFF

The emphasis has been on ensuring a managed return of staff back to their usual roles and/or services, in particular returning theatre staff from intensive/critical care environments in order to allow high priority urgent elective surgery to recommence. This de-escalation has been carefully planned to ensure that these staff who have been involved in the peak demand period of the Covid surge also have some time to rest and recover.

CONTINUE REGIONAL PRIORITISATION OF THEATRE CAPACITY

Theatre capacity will continue to be constrained in this period across Northern Ireland as admission/inpatient numbers vary across sites in response to local demand. It is therefore essential that capacity is protected regionally for highest priority patients and that this is provided equitably across Northern Ireland.

The HSCB has established the Regional Prioritisation Oversight Group (RPOG) to ensure a clinically led network approach to agreeing relative clinical prioritisation of

cancer time critical/urgent cases across surgical specialties and Trusts. This approach offers a consistent and transparent means of ensuring the optimisation of all available theatre capacity (in-house and in the independent sector) during this period. The role of the RPOG will evolve as the rebuilding of elective services progresses but the overall aim is to ensure an agile and equitable regional approach to the allocation of capacity on the basis of clinical prioritisation.

The RPOG meets weekly to assess and align theatre capacity with agreed priorities. The RPOG provides the necessary oversight and governance to ensure the consistent classification of clinical priorities and this regional approach helps minimise the risk of a postcode lottery and ensures the allocation of theatre capacity on a clinically agreed prioritisation basis.

In order to support this approach, the performance management function within the HSCB will also be strengthened. This enhanced role will ensure that waiting lists are managed in line with the agreed regional clinical prioritisation standards/ process. Where necessary, the team will support Trusts to ensure the effective transfer of patients across Trust boundaries as required. The team will also look at theatre management data to assess utilisation and efficiency and identify examples of best practice that can be adopted across the region.

MAINTAIN ‘GREEN’ PATHWAYS FOR ELECTIVE SURGERY

The aim overall is to confirm and expand the implementation of green pathways. In this context, ‘green’ means that every effort will be made to keep these services entirely separate from any exposure to Covid-19 by ensuring complete separation of elective and unscheduled services.

For a site to be considered ‘green’ there must be complete separation of unscheduled and elective care services in and out of hours. For many sites, this will not be achievable based on current hospital configuration. Therefore, it is anticipated the establishment of ‘green pathways’ within hospital sites is more likely to be achievable during this period.

All Trusts are currently delivering rebuilding plans for the period April – June 2021[5]. Within these plans, there are steps towards de-escalation of surge and development of new pathways to deliver 'green' theatre lists that are separate from unscheduled activity. Capacity to deliver these 'green' pathways should be increased in line with available theatre staff as more surge capacity is de-escalated and staff are able to return to their usual roles at the appropriate time. Scheduling theatre lists 2 - 3 weeks in advance will allow Trusts to remain agile in terms of how they respond to changing levels of unscheduled demand.

While accepting that there are still risks in the system, there is an onus on all organisations to manage this risk proportionally, giving the best opportunity to maximise theatre throughput and patient care. In this context, whilst acknowledging the negative impact on individuals affected, overall it is considered better to cancel patients at short notice, than to lose valuable theatre capacity.

One example of a green pathway is in the Western Trust where a team of orthopaedic surgeons has delivered elective orthopaedic surgery lists in the South West Acute Hospital (SWAH) in Enniskillen. This saw the successful treatment of low complex foot and ankle surgery on patients who had been waiting for years. It is hoped that the success of this pilot can be extended into the future on a regional basis and for the further development of elective orthopaedic, and other, services at the SWAH site.

Plans are also being developed in an area in the Royal Victoria Hospital to support regional flow and ensure equitable access and timely care for neurosurgery, vascular, thoracic and cardiac. The elective and unscheduled bed flow elements of these services will be managed separately.

GREEN SITES

The Lagan Valley Hospital is continuing to operate effectively as a green site for high priority daycase procedures. The unit has responded rapidly to changing regional

[5] https://www.health-ni.gov.uk/publications/rebuilding-health-and-social-care-services-phase-5-plans

priorities and is continuing to work with the HSCB and other HSC Trusts to expedite access to daycase theatre lists.

Northern Ireland's main elective site for complex surgery is the Belfast City Hospital (BCH) and it is important to protect regional specialist elective care at this hospital. The focus is on the development of green pathways within the site with a view to the BCH becoming a green site for complex surgery, serving the region.

HSC TRUST DELIVERY PLANS

As outlined in the Department's *Rebuilding Health and Social Care Services: Strategic Framework*[6], HSC Trusts prepare three-monthly plans setting out how core activity will be restarted, with Trusts currently delivering plans developed for April – June 2021. Following a review of activity projections for April against services actually delivered, Trust plans were revised to increase projected delivery, allowing more robust activity plans for June to be published[7]. The experience of delivering these plans will inform the development of plans that are more challenging and ambitious for the period July – August 2021, with a clear expectation of further increased activity. The intention is that plans from September onwards will have levels of activity matching and where possible exceeding pre-Covid levels. This, of course, will be subject to the future pattern of the pandemic. The position will be kept under review in light of the pandemic and other pressures as further Trust delivery plans are developed during the summer and into the autumn. The clear aim is that delivery of Trust activity will continue to be maximised in the prevailing Covid-19 context.

DEVELOP NEW UNSCHEDULED PATHWAYS

The long waiting times for elective care mean that there is likely to be an increase in the number of patients presenting to hospital later, and with greater acuity. It is therefore essential that there are effective pathways in place for these patients.

[6] https://www.health-ni.gov.uk/sites/default/files/publications/health/rebuilding-hsc.pdf
[7] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-rebuilding-hsc-services-phase-5-data-annexes-revised.pdf

In December, the Department published *No More Silos: COVID-19 Urgent and Emergency Care Action Plan*. Among a number of actions intended to support safe social distancing on acute hospital sites while receiving appropriate urgent and emergency treatment during the pandemic, this work has focused on the development of new pathways of care for patients requiring urgent care but who would not be defined as requiring emergency care.

HSC Trusts have already been working with the network to develop new pathways for cardiac, cancer, orthopaedic and imaging. This work will continue and expand in the coming months. There will be a specific focus on unscheduled and advanced cancer presentations through the Cancer Recovery Plan being developed by the HSCB.

INDEPENDENT SECTOR CAPACITY

Given the impact of Covid-19 on health service operating capacity, the Department has taken steps to secure theatre capacity from local independent sector hospitals. To date, this has allowed many hundreds of urgent and time critical patients to be treated. Provision for continued access to the three independent hospitals had been made to 31 March 2021 initially, however given the significant impact of the most recent surge, dialogue has resulted in a further 112 theatre sessions being made available for HSC cancer and time critical patients. During the period 1 April 2020 to 16 May 2021, approximately 5,500 patients have had their procedures undertaken by HSC consultants in the three local independent sector hospitals. In addition, capacity has been secured from private clinics in Ireland and discussions are ongoing with NHS England for additional capacity for Northern Ireland patients.

In addition to using independent sector hospital providers, there are a number of private healthcare providers providing in-sourcing services. In practice, this means privately recruited teams of clinicians providing services for HSC patients using available HSC infrastructure. This approach is currently being used successfully to deliver endoscopy and cataract procedures at weekends.

With the scale of the backlog of patients waiting for treatment, it is expected that this relationship with independent sector providers will be required for some time.

SURGICAL TRAINING

With low levels of elective surgery taking place and the redeployment of staff to areas of unscheduled pressures during surge periods, the pandemic has had a devastating impact on elective surgical operations. In the most recent surge period, the majority of non-urgent elective operations were stood down in November and have not yet resumed to pre-Covid levels. Unsurprisingly, the suspension of surgical activity has also led to the suspension of surgical training.

The Department is working with the Royal College of Surgeons to identify actions to mitigate this impact as part of this plan to co-ordinate and rebuild services.

EMBED DIGITAL TRANSFORMATION

Throughout the pandemic Trusts have adopted use of technology such as use of telephone and virtual clinics to a much greater extent. Outpatient appointments have, where possible, moved to telephone/virtual appointments, consultations and essential communications. While there were many benefits to this, not least the ability to maintain services that would otherwise have been impossible to deliver, this also provided an opportunity to test the limitations of the virtual approach.

There are many benefits of these technology models, including: reduced travel time and easier access to services for patients; less time spent in hospital for patients; and more flexible working and timetabling for clinical staff. Alternatively, the feedback from clinical teams has also demonstrated that there are of course limitations to this approach, and many instances when a physical examination and assessment is necessary to inform clinical decision making in which a face to face appointment is more appropriate.

Technology will play a significant role in the delivery of elective care going forward and Trusts will continue to use technology where this is possible, appropriate, and where it offers the greatest benefit to patients.

SECTION 4. RECOVERY: SYSTEMATIC WAITING LIST REDUCTION

APRIL 2021 – MARCH 2026

This section sets out two overarching strategic priorities:

- Tackling the backlog
- Closing the capacity gap

Public services in Northern Ireland are mainly funded through two distinct sources. Recurrent funding is funding that is made available to Departments to invest in services that are expected to be needed for the long term. Recurrent funding is required, for example, when recruiting additional staff into the health service. Non-recurrent funding, conversely, is funding that is made available for a specific, time-limited purpose, or which may be made available within the budget period due to underspend elsewhere. Importantly, non-recurrent funding cannot be used to invest in staff or services as there is no guarantee that it will be available after the budget cycle comes to an end.

There has been an acknowledgement for several years that there is an imbalance between patient demand for many elective specialties in Northern Ireland and the available recurrently funded capacity. For many years, the difficulties inherent to this situation were masked by the availability of additional non-recurrent funding in-year. In practice, this meant that the lack of capacity within the HSC to meet patient demand was balanced by the availability of short term funding to purchase additional activity either in the independent sector or within Trusts. This source of non-recurrent reduced dramatically in 2013 and waiting times have continued to rise since then.

HSC DEMAND AND CAPACITY

As mentioned above, the investment required to fix waiting times can be split into two distinct programmes:

- **Backlog reduction**: multi-year funding earmarked to tackle the backlog of patients waiting beyond ministerial standard – this will be a combination of independent sector and additional in-house activity;

- **Closing the capacity gap**: additional recurrent investment to increase and reform HSC capacity to meet yearly demand now and projected for future years.

In order to arrive at an assessment of how much recurrent investment is necessary to achieve a balanced 'steady state', it is essential that there is a clear understanding of the gap between HSC capacity and patient demand.

The following three tables set out details of the level of patient demand by specialty/modality and the corresponding funded HSC capacity for:

- New outpatient appointments;
- Inpatient/daycase treatment services;
- Diagnostic services.

These figures are based on broad planning assumptions at this time.

NEW OUTPATIENT APPOINTMENTS

	Demand Capacity Gap				
	2021/22	**2022/23**	**2023/24**	**2024/25**	**2025/26**
New Outpatient	49,640	55,540	61,868	68,669	75,872

Given that demand is expected to continue to increase, the capacity gap set out above is forecast to increase to approximately 75,900 by 2025/26.

INPATIENT/DAYCASE TREATMENT SERVICES

Intended Management	Demand Capacity Gap				
	2021/22	**2022/23**	**2023/24**	**2024/25**	**2025/26**

Inpatient	7,429	7,962	8,524	9,115	9,738
Day case	30,528	32,537	34,653	36,880	39,232
Total	**37,957**	**40,499**	**43,177**	**45,995**	**48,970**
Excludes Cardiac Surgery and Cardiology					

Given that demand is expected to continue to increase, the capacity gap set out above (excluding cardiac surgery and cardiology and four Endoscopy procedures) is forecast to increase to approximately 49,000 by 2025/26.

DIAGNOSTIC SERVICES

Diagnostics	Demand Capacity Gap				
	2021/22	**2022/23**	**2023/24**	**2024/25**	**2025/26**
MRI	27,797	38,882	50,855	63,785	77,749
CT	54,784	74,939	96,707	120,216	145,606
NOUS	25,412	35,536	46,064	57,014	68,402
Plain Film	39,919	63,266	87,079	111,369	136,144
Endoscopy (4 Scopes)	4,761	5,571	6,432	7,347	8,318
Total	**152,673**	**218,194**	**287,137**	**359,731**	**436,219**

A range of reform and productivity initiatives have been factored into future modelling assumptions, but given that demand is expected to continue to increase, the overall capacity gap set out above is predicted to increase to approximately 436,500 by 2025/26.

BACKLOG

Alongside the investment necessary to balance HSC capacity with annual population demand, it will be essential to tackle the cumulative impact of patients being added to waiting lists where the HSC does not have capacity to keep up with demand.

Where demand needs to be met over and above HSC capacity, this will need to be achieved through funding additional activity. Historically, additional activity has been provided through funding additional sessions above core capacity within HSC Trusts and by entering into contracts with independent providers to provide services to HSC patients either in private hospitals or using HSC facilities where these are not being used to deliver activity.

Working during the pandemic has had a clear impact on HSC staff, many of whom are exhausted after many months of managing the Covid-19 pandemic. It will also take time and sustained investment to train and recruit the staff required to increase HSC capacity. We will need to rely on both delivery methods.

Action is required now to address the growing number of patients waiting for diagnosis and treatment. It will require time and investment to close the capacity gap and eradicate the backlog of patients waiting for diagnosis and treatment.

At 31st March 2021, there were 189,753 (56.6%) and 68,309 (61.4%) patients waiting more than 52 weeks for a first outpatient appointment and inpatient/daycase treatment respectively, and 51,259 (37.4%) longer than 26 weeks for a diagnostic test.

ASSUMPTIONS

In order to estimate the funding requirements a number of assumptions have been made. These are:

- **Backlog** –the backlog will be cleared through funding additional in-house and independent sector activity, including inflationary uplifts.
- **Capacity gap** –
    - There will be an incremental increase in additional funded in-house capacity over the period. The assumed increase in capacity in that time has been costed at internal speciality cost rates.

  - It will take time to increase HSC activity, and as a result there will be an ongoing reliance on funding additional activity to address the residual capacity gap, using a mixture of in-house, waiting list initiative and independent sector capacity.
- **Activity costs** – Historical average mix and cost data per specialty for additional activity and 70% of specialty cost for additional core capacity have been used for the cost model.
- **Existing core capacity** – It is assumed that HSC Trusts will deliver their existing funded core capacity. This may need to be revisited to establish the impact of Covid-19 measures on overall capacity.
- **Capital Costs** – capital costs associated with the installation of additional internal core capacity are not included with the cost model.

The number of patients waiting longer than the targets is several multiples greater than the annual capacity gap. Tackling a backlog of this scale will require ambition and innovation. If we continue to approach the problem as we have in previous years, we are likely to get the same results. Above all, we need to show the same urgency and creativity in tackling waiting times as we have shown in responding to the pandemic. It is clear that this will take many of us, clinicians, managers and elected representatives, out of our comfort zones, but this is where we need to be if we are going to fix the problem.

There has been debate in the past about whether or not the HSC should routinely use independent sector providers to deliver HSC care. We are beyond the point at which this debate is helpful, or even relevant. We are going to need all the additional capacity we can get, whether in-house or in the independent sector for the foreseeable future.

In total, it is expected that the HSC will require more than £700m over 5 years to implement the plan and address the existing backlog and the unfunded recurrent capacity gap.

While there is a clear intention to tackle waiting times as rapidly as possible, we must be realistic about the ability of both the HSC and the independent providers to deliver large amounts of activity without some time to build up services. It will be essential to invest carefully and to grow our capacity to deliver services both inside and outside

the HSC system. Funding requirements therefore will incrementally increase with the increase in both demand and capacity to deliver services.

This Framework sets out the investment required for the next five years. After this period, the position should be reviewed.

Additional Capacity

There will be multiple approaches to commissioning additional activity. These will include:

- In-house additionality – this will involve providing additional funding to Trusts to deliver extended days and weekend working.
- Insourcing independent sector contractors – there is a variety of providers who supply teams to carry out surgical and diagnostic procedures on HSC premises. Where existing theatre space is inactive or inefficient, these should be opened to contractors in priority specialties/services. It is proposed that uncommissioned or inactive theatre capacity will be leased to independent sector providers to deliver agreed activity.
- Outsourcing activity to the independent sector – the independent sector has repeatedly demonstrated its efficiency and productivity in delivering routine surgery. Where services can be provided at or below the cost of delivering these within the HSC, the Health and Social Care Board (HSCB) will develop multi-year contracts.

BACKLOG FUNDING REQUIREMENTS: 2021/22 – 2026/27

The amount of money made available for additional activity above commissioned healthcare services has been dropping steadily since 2013. Between 2009/10 and 2013/14, the HSC received roughly £70-80m per year of non-recurrent funding. By 2019/20, this had dropped to £37m.

While there is a clear intention to tackle waiting times as rapidly as possible, we must be realistic about the ability of both the HSC and independent providers to deliver large amounts of activity without some time to build up services and to ensure value for money. Unlike in previous years, the scale of the backlog in other jurisdictions

(while not comparable with the situation in NI) means that we are likely to be competing with other health services for additional capacity. Similarly, the level of the backlog means that there is already a great deal of activity in the independent sector, which may reduce their capacity to deliver lists on behalf of the HSC.

While none of the actions in this section require long term recurrent funding, they will certainly require a commitment to multi-year additional funding over at least the next five years.

Financial Year	**Funding**	**Target**
2021/22	£70m	By March 2022, we will deliver an additional 70,000 assessments and 24,500 treatments.
2022/23	£80m	By March 2023, we will deliver an additional 80,000 assessments and 28,000 treatments.
2023/24	£95m	By March 2024, we will deliver an additional 95,000 assessments and 33,250 treatments.
2024/25	£110m	By March 2025, we will deliver an additional 110,000 assessments and 38,500 treatments.
2025/26	£120m	By March 2026, we will deliver an additional 120,000 assessments and 42,000 treatments

Total	£475m	

On the basis of a commitment from the NI Executive that the necessary backlog funding will be made available, the Department's clear aim is that, by March 2026, no-one should wait more than 52 weeks for a first outpatient appointment and inpatient/day case treatment; or, 26 weeks for a diagnostics appointment.

CLOSING THE CAPACITY GAP

In 2017, the Health and Social Care Board (HSCB) carried out a demand/capacity analysis of each of the 15 largest elective specialties, namely:

Orthopaedics	Ear, Nose and Throat	Plastic Surgery	General Medicine (including Gastroenterology)
Gynaecology	Oral Surgery	Pain Management	Rheumatology
Cardiology	Ophthalmology	Neurology	Cardiac Surgery
General Surgery	Dermatology	Urology	

Similar work has been carried out in diagnostics, focusing on the seven main modalities of:

MRI inc. CMR	CT	Non Obstetric Ultrasound	Plain Film

Audiology	Cardiac Diagnostics	Endoscopy	

Although this work will need to be updated to reflect increasing demand and to reflect the impact of Covid-19 measures which may have reduced capacity overall, it remains a solid basis on which to plan and target new recurrent investment. The HSCB will lead on identifying immediate priorities and allocating available investment, with oversight from the Department of Health and in line with strategic reform priorities. In future years, recurrent investment will also be targeted towards the reforms identified in this framework.

Additional recurrent spend should be focused on incrementally increasing capacity. Costs will be cumulative as additional staff are recruited. Over time, recurrent investment in the HSC will allow the amount of non-recurrent funding to reduce.

There are a number of limiting factors, besides the availability of funding, to expanding health service capacity.

First and foremost, increasing capacity means increasing and investing in our workforce. Health workers are skilled professionals who require significant time to receive the necessary training and develop the skills needed to deliver these services. To support the delivery of sustainable improvements in waiting times, it will be necessary to ensure that the workforce is of sufficient size and has the necessary skills and support to carry out their roles effectively and productively.

The geographic separation of Northern Ireland from the rest of the UK, and possibly now allied to the implications of the UK's departure from the European Union, means that it can be harder to attract specialist staff to our services. Historically, there are greater benefits to training more staff locally, although there are limits to the number of training places that can be delivered. Recurrent investment is therefore likely to be limited by the number of training places that can be delivered or success in recruiting from elsewhere.

Recurrent investment will be targeted at increasing training numbers; recruiting new staff; sustainability of services; and, moving to seven day working for HSC services.

Financial Year	Funding	Cumulative Impact
2021/22	£1.5m	£1.5m
2022/23	£10m	£11.5m
2023/24	£20m	£31.5m
2024/25	£35m	£66.5m
2025/26	£55m	£121.5m

On the basis of a commitment from the NI Executive that the necessary capacity funding will be made available, the Department's clear aim is that, by March 2026, we will have eradicated the gap between demand and capacity for elective care.

Overall, this comes to a total of £232.5m over five years, with a recurrent requirement of £121.5m per year. This is a significant amount of investment but without additional funding on this scale, there is no realistic possibility of reducing waiting times to acceptable levels.

£707.5 million of additional investment should be made available over a five year period to reduce the backlog of patients and to build HSC capacity to meet annual demand for services. Without a commitment to additional investment on this scale, it will not be possible to reduce and sustain waiting times at acceptable levels.

PERFORMANCE MANAGEMENT

Service users have a growing expectation that the services we design and manage will result in the maximum health gain for the resources that we deploy. Reducing waste, increasing throughput and streamlining patient pathways are all actions which contribute to improved quality of care and delivering a more efficient and productive health service. Value for money and improved patient outcomes are not competing alternatives; they are one and the same thing.

While the HSC has made steady progress in delivering improved productivity there still remains significant scope to release further gains. Service redesign is a key component of the reform and modernisation agenda and the HSC will continue to work closely with local Trusts, to progress this work. Through its performance management function the HSCB will also look at key productivity information to identify and challenge unwarranted variation.

It is important to be clear that the scale of the gap between demand and capacity in each of the areas described in the previous section means that the current ministerial targets for inpatient, daycase and diagnostic procedures are unlikely to be met for some years. The analysis carried out to develop this plan will allow the HSCB to identify and prioritise those specialties with the most significant backlog and the most significant capacity gaps. This will allow funding to be invested in areas where it will have the greatest impact but it will take time and investment to bring waiting times down to acceptable levels.

Alongside recurrent and non-recurrent investment to tackle the capacity gap and the backlog of patients waiting for care, a key element of this plan must be the reintroduction of robust performance management arrangements to ensure that organisations and individuals are held accountable for the delivery of agreed outcomes and funded activity.

In the interim, and in addition to new funding models, the HSCB will bring a renewed focus to performance, quality and productivity, both in the HSC and in the independent sector. This will include an assessment of gaps in existing management information, consideration of new approaches to performance management, and the establishment of new, realistic performance targets until we are in a position to meet the current ministerial standards.

As part of this work, the HSCB will also work to introduce the Referral to Treatment (RTT) waiting times reflecting the entire patient journey, from GP referral up to the point where the patient is actually treated.

The primary objective of an RTT target is to measure and ultimately help reduce patient waiting time over the whole journey of care and not just for discrete stages of

treatment. Any waiting by patients along the ‘patient journey’ should be as a consequence of a decision by the clinical team, and through discussion with the patient, rather than as a consequence of the need to queue for access to clinical services. Such pathways are therefore about improving the patient’s experience and ensuring all patients receive high quality elective care without any unnecessary delay.

Introduction of the RTT would be challenging while the backlog of patients waiting for diagnosis and treatment remains so extensive. Introducing RTT waiting times is likely to be a long term project and will need to be aligned to the introduction of Encompass across the HSC. If it is decided to proceed with the creation of a single delivery body to manage dedicated elective care sites, this could provide an ideal opportunity to test this approach across a number of pathways.

In order to ensure additional investment is used as effectively as possible, the performance management function within the HSCB will be enhanced and strengthened to ensure that it is fully equipped to:

- **Measure and monitor accurate and timely data on theatre utilisation, productivity and efficiency;**
- **Identify underperformance and put measures in place to support improvement;**
- **Learn from international experience to identify best practice and promote adoption and spread of learning;**
- **Identify and invest in high performing services;**
- **Provide monthly performance updates including:**
    - **levels of activity delivered in the HSC and the independent sector;**
    - **Theatre utilisation and productivity for lists delivered through the HSC and productivity in the independent sector, benchmarked against NHS good practice.**

A new Waiting List Management Unit will be in place at the HSCB Care Board by summer 2021

Subject to confirmation of the available budget, the HSCB will produce an annual Elective Care Delivery Plan setting out:

- **Performance in the previous year;**
- **Realistic annual activity targets;**
- **Projected activity for independent sector contracts and in-house additionality;**
- **Overall demand/capacity information for each specialty.**

Performance and productivity gains will only be fully exploited if there is early confirmation of the available budget. Effective advance planning of elective capacity in the HSC and the independent sector requires advance notice of the level of funding to be made available.

SECTION 5. REDESIGN: ENHANCE AND PROTECT ELECTIVE CAPACITY

PROTECTING ELECTIVE SERVICES AND ENSURING EQUITY OF ACCESS

It is too early to state definitively that Northern Ireland has performed less well than other UK countries in maintaining elective services. There are, however, indications that, in order to manage the unprecedented levels of unscheduled care pressures at hospitals, the Northern Ireland HSC has found it necessary to turn down elective services earlier, and for longer, than other parts of these islands.

Nevertheless, the pandemic has also demonstrated what can be achieved within our system when it is required. The incredible commitment shown by clinical staff and managers in the HSC has allowed everyone requiring unscheduled care to receive it. Critical care capacity has been doubled and clinicians and managers have found new ways of working that would not have been thought possible even 18 months before.

However, it is fair to say that the impact on elective services here is reflective of the longstanding vulnerability of our hospital services. Similarly the incapacity of the HSC in Northern Ireland to create truly ‘green’ sites is at least partly due to the systemic problems identified as far back as the Hayes report in 2000 and, subsequently, in *Transforming Your Care*, and *Systems, Not Structures*.

Elective care services in Northern Ireland are under significant pressure; there are long waiting times and large numbers of patients waiting for treatment. As with many services, as a relatively small region we are currently spreading our resources far too thinly across multiple sites. Day procedures, for example, are currently being delivered across five HSC Trusts and around 19 different hospital sites.

As a result of this fragmented system, there is a persistent inequity of service provision. Waiting times vary significantly across Northern Ireland depending on demand, capacity and performance in different Trust areas. In practice this creates a postcode lottery in terms of access to treatment with patients in one area waiting years for treatment while in another area they may be able to access the same treatment within weeks. Moreover, the pressures on services are expected to

increase in future due to a number of factors, including demographic change, new technological developments, and new medical advances.

In addition to the expected clinical benefits of delivering high volumes of treatments on a small number of specialist sites, there are likely to be significant organisational and administrative benefits to delivering day procedures as a single regional service. In a region the size of Northern Ireland, it is not acceptable that people should have such widely different experiences of accessing healthcare based purely on where they live.

It should also be noted that the reforms proposed in this section will only work to their full impact if action is taken to address the capacity gap outlined in the previous section, which will require significant investment. Without this, there will always be pressures and gaps in services and redesign of any scale would have to be carefully managed in order to ensure that it did not destabilise services of higher clinical priority.

SEPARATION OF SCHEDULED AND UNSCHEDULED CARE

The nature of the most complex elective surgery means that it can never be separated entirely from unscheduled care services. However, for the less complex surgery to be as efficient as possible, there is a strong case for attempting to insulate it from unscheduled care pressures. Before a surgical procedure can be carried out, a range of resources have to be brought together at the right time and the right place: surgical staff, nursing staff, anaesthetic staff, theatre time, beds. Remove any one of these components and the operation has to be cancelled. Where the same staff and resources are required to be available for both emergency and elective care, emergency treatment will always come first and will inevitably result in cancellation of elective.

Locally, nationally, and internationally, there are multiple working examples of how efficiently elective care can be provided where there is no competition from unscheduled pressures. From an HSC perspective, it is perhaps unfortunate that in Northern Ireland these are largely in the independent sector. It has been known for some time that clinicians working in independent clinics can deliver 12-13 cataract procedures per list. In recent months, it has also become clear that clinicians working

as an in-sourced team in an HSC hospital can deliver the same levels of productivity. By comparison, clinicians working in their HSC capacity, deliver an average of 7 procedures per list. The experience has also been reflected in current endoscopy services being delivered on an in-sourcing basis in one Trust where productivity rates have also been significantly higher than the HSC average. In many cases, the clinicians working in the independent sector are also employed within the HSC. In view of this, it can only be concluded that there must be other, systemic, factors at play which prevent teams working within the HSC from achieving the levels of productivity they produce when working with independent providers. While some of these, such as the need to provide training to junior staff, may be unavoidable, it is likely that clear delineation of and investment in elective care services that are completely protected from unscheduled pressures would lead to increased productivity.

The approach of improving elective efficiency by separating it entirely from unscheduled can also be replicated within the public sector. The Golden Jubilee hospital in Glasgow has been established as a provider delivering only elective care. Established in 2002, the Golden Jubilee National Hospital is NHS Scotland’s original national elective and diagnostic centre. The Golden Jubilee model has been considered a success story by the Scottish Government and the same approach is now being expanded across the country in order to allow patients to be treated more quickly for planned surgery, taking pressure off hospitals dealing with unplanned and emergency treatment. As well as providing services to patients from the surrounding area, patients from any part of Scotland can opt to be treated in the hospital, for example where they may have to wait longer for treatment locally.

A dedicated elective care body, similar to the Golden Jubilee model, would offer streamlined planning, delivery and accountability, as well as facilitating the separation of elective and unscheduled care administratively as well as physically. The establishment of such a body would require legislation and there would be costs associated in terms of staffing, overheads, boardroom costs etc. although over time this may be offset by higher efficiency and more effective performance management.

While we continue to rebuild services that have been impacted by the pandemic response, this may not be the most appropriate time to create new structures,

although this may be an option that could be revisited as work on regional elective care centres continues to develop. In the sections below we describe how we propose to establish a separate and regional Management Team responsible for overseeing the delivery of Elective Care Centres. In the first instance, this will be taken forward within the existing HSC governance and accountability structures.

Decisions around the future of elective care should also be taken in the context of the vulnerability of General Surgery across the region. General Surgery is a wide ranging specialty with many subspecialties. As one of the largest surgical specialties in the UK, General Surgery plays a key role in the provision of elective and emergency surgery.

Unfortunately, as with other areas of care, the current General Surgery service is struggling as a result of increasing demands for services, increasing surgical specialisation and capacity gaps within the current structure. There is significant variation in practice and in waiting times across the region and, allied to this, there are specific issues relating to the requirement to maintain multiple 24/7 rotas for emergency surgery for adults and children and the difficulties this creates in terms of staffing and meeting professionally mandated standards of care. It is also important to note that some elements of general surgery delivered as planned elective procedures have been particularly impacted by the pandemic.

A new approach is needed to ensure that General Surgery, both unscheduled and elective, can be provided safely and sustainably across Northern Ireland.

The Department will therefore lead a review of General Surgery in Northern Ireland. The first phase of this review should include a rapid assessment of the actions required to stabilise General Surgery in the short to medium term. This is likely to have implications for how elective and emergency surgical services are planned and delivered.

ESTABLISHING ELECTIVE CARE CENTRES IN NORTHERN IRELAND

Last summer it was decided that Lagan Valley Hospital in the South Eastern Trust would become a dedicated elective care centre for the region. While the nature of

the site means that it is most suitable for daycase surgery and procedures rather than more complex work, the complete separation of elective and unscheduled services at the site has enabled services to continue be delivered throughout the pandemic on a ‘covid-light’ pathway. In recent months, the site has delivered red flag and other high priority lists on behalf of the region where these could not be accommodated at the hospital of origin due to pandemic pressures.

The Day Procedure Centre at Lagan Valley has treated 1,588 patients since October 2020 across a range of specialties including plastic surgery, Ear Nose & Throat, General Surgery, Breast surgery, Urology, Ophthalmology.

The success of the model is also dependent on the host Trust protecting the available staff and beds for regional patients. In establishing Northern Ireland’s first regional elective care centre, the South Eastern Trust has proved that this can be done.

Within the same Trust area a regional paediatric general surgery pilot is underway at the Ulster Hospital and clinical teams are also continuing to deliver some cataract operations on a regional basis at the Downe Hospital. Prior to the pandemic, there were also similar initiatives for cataracts and varicose veins in Omagh, South Tyrone and the Mid-Ulster Hospital.

While the overall model for Lagan Valley Hospital is still developing, it has already demonstrated the benefits of having dedicated elective care capacity. Alongside the work to finalise the model at Lagan Valley, it is therefore proposed that consideration should be given to expanding this approach to further sites in a managed process.

These sites will become ‘green sites’ in that every effort will be made to keep them entirely separate from any exposure to Covid-19 by ensuring complete separation of elective and unscheduled services.

As more elective capacity becomes available as pressures at hospitals decrease, it is proposed that we will develop a plan to expand the number of sites providing regional daycase facilities for adults and children as part of a managed process.

With the scale of the backlog of patients waiting for assessment and treatment, and the expectation that this will continue in light of forecast demographic changes and

the increasing population, it is proposed to now move beyond daycase procedure capacity in the next phase of developing elective care centres to include consideration of how a similar model could work in relation to some short stay inpatient procedures.

In the initial phases of this work, the HSC will continue to operate within existing systems and organisations. While it is acknowledged that the system is unlikely to be able to deliver the full efficiency and productivity gains within these structures, they will provide invaluable learning as the system moves to the new model described below.

The development of regionally managed elective care centres for daycase procedures and short stay inpatient procedures will be taken forward on a phased basis. We aim to identify the next suitable centre (Phase 2) by October 2021 and further centre/s (Phase 3) by March 2022.

ELECTIVE CARE CENTRES – REGIONAL MANAGEMENT

In establishing a regional Daycase Procedure Centre at the Lagan Valley Hospital, it was decided to place the governance and management of the centre under the responsibility of the South Eastern HSC Trust. On the whole, this has worked well. While there continue to be some persistent difficulties around the transfer of patients across Trust boundaries, the work at the site has been driven and managed by a small team of committed individuals who have engaged openly and equitably with other HSC organisations.

Nevertheless, as the model is expanded to further sites, it is possible that establishing and managing a new model of elective care centres within existing Trusts would result in all five Trusts being providers of elective services to all other Trusts. This is likely to present a degree of complexity that will be confusing for staff and, above all, for patients. Furthermore, the scarcest and most valuable resources (our staff) would have employment and management processes to overlay on this. In practice it is likely that, under a 5 Trust model of elective care, providers would be dependent on one or two other Trusts for critical resources to deliver services to all Trusts. On this basis, it is not difficult to see how staffing shortages in one Trust

could result in those staff being withheld from Elective Care Centres in another Trust, perpetuating the problems that HSC is facing today.

Performance issues, especially in terms of cancellations or underutilisation of sessions, will impact the delivery of the entire Elective Care Centre plan. Under the arrangement described above, meaningful accountability processes would require a framework involving all Trusts in assessing and addressing underperformance.

In order to deliver this, it is proposed that the Department will establish an Elective Care Centre Management Team. In its initial form, the Management Team will exist as part of a collaborative model, ensuring regional planning and delivery of Elective Care Centre capacity, including the identification of potential new spoke sites. Working within the current governance and accountability structures, it is clear that Elective Care Centres must operate under the accountability of the host Trust. The role and functions of the Management Team may change in response to the closure of the HSCB and as the new HSC planning model develops.

While the Management Team would operate on a regional basis and would have responsibility for allocation of the budget associated with elective care centres, it will work in partnership with HSC leaders and established Clinical Networks to ensure a collaborative approach to the delivery of elective care. The Management Team would be accountable to the HSCB and, ultimately, the Department.

In carrying out its role, the Management Team will ensure that the network of regional Elective Care Centres:

- Responds to changes in demand through effectively managing regional capacity;
- Has local performance management arrangements embedded;
- Meets current and future quality and regulatory requirements;
- Is supported by modern information systems and infrastructure;
- Promotes best practice and standardisation;
- Adopts new ways of working and innovative technologies;
- Has a focus on positive patient outcomes and experience and has systems in place to gather such information;
- Makes efficient use of available resources; and,
- Provides training and teaching opportunities for staff and medical students.

The creation of a new regional elective care Management Team will take 3 months to deliver. In addition to taking on oversight of the delivery of regional elective care services at Lagan Valley, the new Management Team will assume a lead role in planning for future elective care centre hubs across Northern Ireland.

While only applying to a subset of elective care procedures, this proposed approach represents a significant change in the way in which elective care services are currently planned and delivered. It would require a commitment from all Trusts that in sites identified as regional elective care centres, beds and staff would be ring fenced for the delivery of regional elective care with operational oversight granted to the Management Team alongside local operational leads.

The benefits and risks of a regional approach to the operational planning and delivery of Elective Care Centres must therefore be considered alongside the implications of this new approach in terms of accountability, staffing and culture.

Preparation for this will require detailed work on: accountability; governance; staffing models; funding and performance management metrics; structures; case mix; and, ministerial targets.

ORTHOPAEDIC SURGERY

Elective orthopaedic services have been severely impacted by the pandemic. Orthopaedic conditions are rarely life threatening and, as a result, orthopaedic services have been downturned earlier and for longer than many other specialties. However, while they may not be life threatening, the impact of these conditions can be severely life limiting and can have a very serious impact on people's quality of life, their ability to work, or their ability to live independently. As the British Orthopaedic Association has stated, "patients suffer major effects on their physical and mental health as their bones deteriorate and they struggle to undertake everyday activities. These delays really matter. Patients suffer before and after treatment."

Furthermore, waiting times for orthopaedic services were already the longest in the UK prior to the onset of the pandemic and demand for these services continues to increase in line with ageing demographics. Musgrave Park Hospital carries out

approximately two thirds of the surgery in Northern Ireland and plans are already in place for it to operate as an elective care centre. In practice, however, the site is often required to deal with unscheduled pressures which impact on overall elective orthopaedic capacity. It will be a priority to re-establish and protect Musgrave Park Hospital as a regional green site for orthopaedic surgery. At the same time, it will be important that orthopaedic capacity is increased and protected as far as possible at each of the hub sites of Craigavon, Altnagelvin and Musgrave Park in line with the orthopaedic recovery blueprint.

Plans must also be put in place to ensure that orthopaedic surgery can be protected through any future surges. This means that staff and theatres should be protected from unscheduled pressures to ensure that services can be maintained at times of pressure.

Where it is not possible to guarantee the protection of HSC delivered services, we will need to consider whether medium term contracts with independent sector providers – either on an insourcing or outsourcing basis – would provide a more reliable service model in the medium term.

As an immediate next step plans will be put in place to a similar regional model for ring fenced elective orthopaedic services at Musgrave Park Hospital. The Northern Ireland Orthopaedic Network will work closely with the three Health and Social Care Trusts providing orthopaedic services to develop plans for the protection of orthopaedic capacity at sites serving the region.

WORKFORCE PLANNING

Perhaps the most critical aspect of delivering sustainable reform in elective care is the workforce. To support the delivery of long term improvements in waiting times it is clear that the system needs to be fully resourced in terms of having the right number of staff with the necessary skills and support.

It is therefore important that we look at the skills mix required to deliver services. This involves designing the roles and responsibilities of a team, around the needs of

the patient, to ensure staff have got the right skills at the right level to meet those needs. During the pandemic, certain parts of the HSC system, by necessity, radically changed the way they were staffed to ensure sufficient capacity was available to manage demand for essential services. There is much we can learn from this approach to ensure that we have the appropriate skills mix in the workforce to deliver both high quality care and also value for money. For the system to function as efficiently as possible, all parts of the patient journey need to be able to fulfil their role.

- An increase in GP numbers will be necessary to maintain existing primary care services and support the expansion of elective demand that can be managed in a primary care setting, thereby reducing the need for a referral to secondary care services in a hospital setting.

- The response to the pandemic has underlined the essential role played by the nursing workforce in maintaining elective care services, and also the vulnerability of these services due to the current level of vacancies. Substantial expansion of the nursing workforce is essential.

- A significant increase will also be required to the consultant workforce across a range of specialty areas to ensure appropriate staffing levels to respond to both elective and unscheduled care demand and to provide appropriate specialist support to GPs and other staff in primary and community care settings.

- We must also continue to grow and develop new, multidisciplinary roles that will help to support and increase elective care provision. These will include advanced and specialist nursing roles, Allied Health Professionals, operating department practitioners, physicians' associates, and other key roles that are essential to maintain and expand these services in line with appropriate professional regulation and standards.

A key element of any plan will be increasing the number of training places. Recognising the time taken to develop and train individuals, it is likely international recruitment will continue to play an important role in the reduction of HSC vacancy rates. To the extent that these training places and/or other measures to expand the workforce cannot be funded and delivered, it will be necessary to maintain on an

ongoing basis arrangements with independent providers to address any shortfall in HSC capacity relative to patient demand.

REGIONAL WORKFORCE PLANNING

Beyond this, however, as a region we also need to work smarter with regard to recruitment to specialist acute services.

In the past decade, there have been numerous examples of one Trust recruiting to fill medical vacancies, only for the successful candidate to come from a neighbouring Trust, thereby creating another vacancy in the service. In practice, this simply serves to move the problem around Northern Ireland, rather than offering any additional capacity.

In future, there needs to be a greater level of regional planning in terms of the available workforce and recruitment to such posts. Where possible, this should also include a move to a regional waiting list for some specialist services in order to ensure that demand is spread equally and patients have an equitable level of access to services. This would also help to mitigate the impact of any changes to the service profile as described above. The move to a single HSC employer as described in the Health & Social Care Workforce Strategy 2026 will be a key enabler for these changes.

Once established, the new Elective Care Delivery Management Team will support the Department in the development of a multi-disciplinary workforce plan to ensure each centre can deliver its full capacity using the most appropriate skills mix.

Investment in the Elective Care Centre workforce plan must be considered alongside competing workforce priorities to maintain capacity for complex elective and unscheduled care services.

WORKING ACROSS TRUST BOUNDARIES

In establishing the prototype daycase elective care centres for cataracts and varicose veins, perhaps the most important lesson derived from these projects was

the difficulty of planning such services across Trust boundaries. In both cases, there were significant difficulties around issues such as: the transfer of patient notes; workforce governance, pharmacy governance; and, technical or administrative difficulties in terms of setting up and managing regional waiting lists.

While some of the governance issues will only be fully addressed with the creation of a single HSC employer, the prototypes have developed a number of temporary workarounds to tackle these challenges. These are however sub-optimal and add a significant administrative burden to the process. The development of effective governance, administrative and technical solutions is absolutely essential to enable greater consistency, standardisation, and cross-Trust collaboration.

Interim digital solutions will need to be put in place to facilitate regional management of waiting lists in elective care centres and support the development of standardised clinical pathways. These solutions should be designed to inform and complement the delivery of the Encompass programme

COMMISSIONING MODEL AND PERFORMANCE MANAGEMENT

COMMISSIONING ELECTIVE CARE

Commissioning in the context of health and social care can be defined as the process of securing the provision of services to meet the needs of a population. This is a complex process. In practice, it requires the assessment of the population's health and social care needs; the planning of services to meet those needs; the procurement of those services; monitoring of the delivery of services against agreed standards; and an evaluation of the impact of the services that have been commissioned.

The Department's policy statement on the establishment of daycase elective care centres set out the most common approaches to commissioning elective care. These include:

- Capitation: Broadly speaking capitation means paying a provider or group of providers to cover the majority (or all) of the care provided to a specified

population across different care settings. The regular payments are calculated as a lump sum per patient.

- Block Contracts: These are effectively pre-payments that are made by commissioners to healthcare providers to deliver a pre-agreed number of procedures or operations. For example, a hospital could be given a block contract to undertake acute care in a particular geographical area. Generally, the value of the contract is independent of the actual number of patients treated or the amount of activity undertaken.
- Tariff/ Activity Based Funding: This is a system of paying hospitals and other providers for the number of patients that they treat. The idea is that providers will receive a fixed payment – the national tariff – for each type of patient treated. Termed 'payment by results', the policy rewards providers for volumes of work adjusted for differences in case mix.

Historically, commissioning in Northern Ireland has generally focused on a combination of capitation and block contracts. Several reviews carried out in Northern Ireland have made comment on the methods of commissioning and have drawn out the benefits of a tariff model in transparently driving efficiency and productivity.

The policy statement 'A regional Model for Daycase Elective Care Centre in Northern Ireland' published in July 2020 recognised that a tariff based commissioning model would be an appropriate mechanism for daycase elective care to ensure that high productivity is rewarded and also that poor performance is rapidly identified and corrective action taken. The risk of perverse incentives is low as referrals into the service will be driven by clinical decisions. Conversely, increased productivity and efficiency would bring great benefits to patients, and to the wider health and care system in terms of the most effective use of resources.

The introduction of a tariff based funding model will make it simpler to monitor activity, tackle underperformance and reward productivity. Under a tariff model, organisations are only funded for the activity they deliver. Underperformance is therefore reflected in the overall investment in the service. However, this model will take time to implement and may only be appropriate for a subset of the overall elective programme.

The Health and Social Care Board (HSCB) is working to pilot a shadow tariff model in a number of high volume specialties, including cataracts and hernias.

Following evaluation of this approach, consideration may be given to the expansion of tariffs into other aspects of elective care, including appropriate inpatient activity. This should also take into account the experience of the commissioning/payment model in England and best practice in other jurisdictions.

PRIMARY CARE – EXPAND CAPACITY AND CAPABILITY

In addition to the move from inpatient to daycase surgery, this trend has also been apparent in the increasing number of procedures that are being carried out in an outpatient setting or in primary care.

For example this year 1,000 vasectomies will be treated in primary care settings. If carried out in hospitals, these would have required up to 130 theatre sessions as well as a significant commitment from surgical teams across general surgery and urology.

General practitioners and hospital clinicians are currently working together to deliver similar approaches in relation to dermatology, musculoskeletal, and gynaecology patients. These new ways of delivering non-complex elective procedures in primary care have benefits in terms of efficiency and also in terms of patient comfort and convenience. They can also provide opportunities for other health care professionals to broaden their skills and the scope of their relationship with their patients.

There are significant opportunities to better manage patient demand in primary care avoiding the need for a referral to secondary care for a specialist opinion. Through GP Federations and other arrangements, it should be possible in a range of specialties for GPs to work individually and collectively in a way which maximises the skills and expertise within primary care and significantly reduce demand for secondary care services. There are particular opportunities in non-surgical specialties such as rheumatology and dermatology. To secure these opportunities

will require an expansion in primary care capacity and the development of wider skills and capabilities, supported as required through appropriate education.

By taking these procedures out of hospitals, we can free up capacity for the delivery of more complex elective care either in dedicated regional elective care centres treating in-patients or on major acute hospital sites.

Where care can be provided appropriately in a primary care setting, this has benefits for patients who may be able to receive their treatment faster, in a more convenient setting, and for our system in preventing unnecessary attendance at our hospitals. It is recommended that the HSCB should continue to develop and expand the delivery of appropriate elective procedures in a primary care setting.

OUTPATIENTS

Transformation of our outpatient services is key to improving the productivity and sustainability of our elective services. The aim is to ensure that patients are seen by the right person, with the right information, at the right time, in the right place.

One-stop clinics have been implemented in a number of specialties and have contributed to a significant reduction in the number of outpatient appointments required. This has freed up consultant capacity and improved patient experience.

Work continues to change review practice across specialties to ensure those patients who have had treatment and need to be reviewed by the hospital team are seen in a timely manner. This involves no planned specialist follow-up after routine surgery as standard and has already been introduced for a number of pathways. Where a review appointment is necessary consideration should be given to developing non-consultant led outpatient services including nurse specialist, enhanced Allied Health Professional (AHP) services.

We have also developed new and innovative ways to see patients in appropriate settings for example through our enhanced GP services and our Day Procedure Centres. Through these initiatives we are standardising and streamlining patient pathways.

Throughout the pandemic Trusts have adopted use of technology such as telephone and virtual clinics to a much greater extent and this transformation will now be embedded with technology continuing to play a significant role in the delivery of elective care, where possible and appropriate.

Going forward the HSC will also focus on expansion of the e-triage model which allows hospital consultants to electronically triage primary care referrals and either, (i) provide direct advice to the GP on the next steps, (ii) refer directly for investigations, or (iii) invite the patient to attend an outpatient clinic. Direct access for specific tests can be a cost effective way of reducing the time for diagnosis and improving patient access.

The HSC will also take forward the development of ‘hot clinics’ and ‘megaclinics’ which will facilitate rapid access for patients and avoid attendance in ED.

The establishment of Rapid Diagnostic Centres is being considered as part of work on the forthcoming Cancer Strategy. There is a high level of clinical support for the development of Rapid Diagnostic Centres as a means of increasing diagnostic capacity. Implementation of Rapid Diagnostic Centres will however require additional investment in the staff and infrastructure required to deliver them.

The Department, HSCB and Trusts will continue to develop opportunities to consolidate and transform our outpatient services to reduce waiting times and improve patient experience.

INFRASTRUCTURE

One of the key principles underpinning this Framework is that existing HSC infrastructure should be used optimally before recommending a new development.

The analysis carried out through the daycase elective care project suggested that there are opportunities to increase efficiency and throughput in the existing theatre capacity. However, it is also expected that the scale of the gap that has grown

between capacity and demand is likely to require capital investment in additional theatres and, on some sites, additional bed capacity.

Drawing on our understanding of the capacity and capability of each hospital site to deliver the required volumes activity will shape the development of capital plans to maximise the delivery of elective care in line with the recommendations of this framework.

The Department will therefore develop a long term strategic plan for future capital investment to maximise elective capacity and capability across the HSC.

As a principle we aim to maximise the use of our existing theatre capacity. To the extent that additional infrastructure cannot be funded, staffed and delivered, it will be necessary to use Waiting List Initiatives to address any shortfall in HSC capacity relative to patient demand. Waiting List Initiatives include extra clinics in hospitals at nights and at weekends, use of independent sector hospitals and in-sourcing arrangements whereby privately recruited teams of clinicians providing services for HSC patients use available HSC infrastructure.

In order to increase capacity in the medium term, where it is demonstrated that independent providers can provide value for money and the same standard of service as the HSC, the system should consider the viability of longer term contracts to commission services from independent providers alongside those provided within the HSC.

HEALTH INEQUALITIES & PREVENTION

It is recognised that health inequalities and differences in health status are experienced by certain population groups. In particular, people in lower socio-economic groups are more likely to experience chronic ill-health and may die earlier than those who are more advantaged.

Good access to health and social care services has long been recognised as fundamental to people’s health and wellbeing. It is important to have a prompt diagnosis and subsequent treatment. It is also important to be able to obtain quality

preventative care early enough to avoid illness or complications. In a health service such as ours, which is free at the point of delivery to all citizens, it is important that there is equality of access to these services.

Recent work to introduce regional prioritisation of theatre capacity has helped to ensure that there is at least equity of access to high priority services based on clinical need. While this has been a positive step, it does not resolve the issue of access to more routine elective care services. It is also important to bear in mind that while an individual's requirement may not be urgent, this does not mean that it is not extremely important. Routine surgery may be just as life changing as interventions deemed to be more urgent.

With the current scale of the waiting times to access diagnosis and treatment, there are indications that many people are choosing to pay to access these services rather than spend many months or years waiting for them. Under a universal healthcare system, it is not right that anyone should have to pay to access services that should be available through the public system. Furthermore, the very fact that some can choose to do so creates an obvious inequality for those in society who are unable to do so. There is therefore a very real risk that long waiting times could exacerbate, and perpetuate, existing health inequalities.

There is also a potential cumulative impact on wider society. Those who must wait longer for diagnosis or treatment may be more likely to become economically inactive or to have reduced quality of life. In addition to the impact on individuals, it is also very likely that delays to diagnosis and treatment will ultimately lead to higher costs for the health service as patients present with more advanced conditions.

There is already some anecdotal evidence from Emergency Departments that they are seeing an increase in the number of patients arriving at hospital and requiring admission for conditions that should have been dealt with through elective pathways.

The Department will therefore commission work to analyse the impact of long waiting times on health inequalities. Based on the findings of this work, additional interventions may be required to mitigate the impact of this.

The Making Life Better strategy published in 2014 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.

It details that to achieve better health and wellbeing for everyone and reduce inequalities in health, strengthened co-ordination and partnership working in a whole system approach is required.

Delivering Together reaffirmed this, noting that economic, social and environmental factors, and experiences early in life, play a major role in determining not just the health outcomes at an individual and community level, but also their social, educational, economic and other outcomes.

Partnerships and cross-sector collaboration are essential. New services or interventions created, or existing ones that are transformed, will not always be HSC-owned.

As we develop our new integrated care planning model and building on the work taken forward to date, we will ensure that this is underpinned by a population health approach that looks to deliver improved health and wellbeing outcomes for the whole population and reduce the health inequalities which continue to persist in our society.

CONCLUSION

With the experience of Covid-19, health and social care in Northern Ireland has been through a once in a generation crisis. However, as we emerge from the pandemic, it is clear that we face a different kind of crisis.

Waiting times for patients in Northern Ireland are disproportionally worse than in other parts of these islands and this brings with it a serious social and economic cost. There are people on waiting lists who are living in continuous pain. There are people whose condition makes them unable to carry out their jobs, resulting in loss of income. There are people whose overall physical health deteriorates because they wait too long for a simple operation. There are people whose mental health suffers from the anxiety and uncertainty of a long wait for diagnosis or treatment. Even without the context of a pandemic, the waiting lists have been increasing steadily for a number of years. There is already effectively a two tier system in place. Those who can afford to pay for private treatment do so, and those who can't afford it continue to wait.

There are structural issues in the Northern Ireland HSC system that need to be resolved. We need more sites providing dedicated elective services that are entirely separate from unscheduled care. We need to make better use of our theatre capacity on a regional basis. We need to bring a stronger focus to productivity and efficiency. There is still a tendency in Northern Ireland towards professional silos. We need to challenge conservatism in relation to the skills mix of health professionals providing care.

However, it must also be accepted that there are capacity issues that need to be addressed. The HSC does not currently have the capacity to simultaneously provide scheduled and unscheduled services to match the population's needs over the course of the year.

This plan sets out an ambitious, but achievable, plan to bring waiting lists down and to keep them at that level. It requires investment and it requires time. If the investment that is required to deliver this plan is made available, it is important that we resist the temptation to put all of this into buying additional activity. It is clear that

we also need to plan for the future by training and recruiting large numbers of health professionals in key specialties, and by designing the best possible environment to allow them to carry out their jobs effectively. Above all, this plan is about creating better services for two groups of people - those who require treatment and those who deliver it. It is essential that we invest in the future and, while investment in our staff will take longer to bear fruit, in the end it will lead to more lasting change.