Northern Ireland Assembly

Research and Information Service Research Paper

Paper 79/21 10 December 2021 NIAR 171-21

Dr Lesley-Ann Black, Eileen Regan and Marta Cipriano

The unhealthy state of hospital waiting lists:

What we know, don't know, and need to know

Much has been written about the unacceptable length of time people are waiting on a list for elective care in Northern Ireland (NI). "Elective care" relates to outpatient, inpatient, and diagnostic care. NI waiting times have been reported to be the worst in the United Kingdom, and amongst some of the worst in Europe - even before the onset of the COVID-19 pandemic. Figures suggest that approximately one in every four people are now waiting for a first hospital consultation or procedure. Whilst radical change in this area is a must, this Research Paper seeks to unpick two issues for the Committee for Health, specifically in relation to:

- Gaps in how the data is reported; and,
- Gaps in the financing of waiting lists.

Contents

Key Points

- Northern Ireland (NI) reportedly has the worst hospital waiting times in the United Kingdom (UK).

- Local waiting times have been increasing to unacceptable levels for a number of years; well before the COVID-19 pandemic began. These waits have been greatly exacerbated by the pandemic and have also led to extreme pressures on many parts of the healthcare system. Such delays also have implications for patient safety, quality of life and widening health inequalities.

- The Minister for Health has indicated that it could take up to 10 years to resolve waiting lists; and to do so will require significant additional investment.

- Departmental data for waiting times can be difficult to interpret. Unlike the rest of the UK, NI has still not implemented a way to track patients throughout their individual waiting time journeys. This is known as the "RTT" or "Referral to Treatment Time".

- Currently, separate aspects of patient waits are recorded in NI, but these do not link together. For example, data up until June 2021 shows that there were:
    - 184,873 patients waiting more than 1 year for a *first* outpatient appointment;
    - 66,287 waiting more than 1 year for inpatient/day case treatment; and,
    - 48,543 waiting longer than 26 weeks for a diagnostic test.

- Targets associated with elective care waiting times have all been missed, despite them becoming less stringent over recent years. In addition, targets for a first outpatient appointment and for inpatient treatment have rarely been met since 2009. There are no targets for review appointments and no way to gain a more complete picture from available data of the true extent that some patients are waiting.

- Notwithstanding COVID-19, many reasons have been attributed to the deteriorating waiting times. Whilst funding is part of the issue, evidence suggests the need for radical service transformation, which to date has not been realised. In addition, there are: serious workforce challenges; little evidence of accountability mechanisms when Trusts underperform; and rising levels of demand that far outstrip capacity to provide care.

- Within just four years, there have been two Department of Health action plans to reduce waiting lists. The first was an "Elective Care Plan" published in 2017. However, a follow-up progress report (2018) lacks evidence regarding the extent to which the actions in the plan to reduce waiting times were progressed.

- The second action plan is the more recent "Elective Care Framework" (2021). This 5-year plan states that £707 million is needed to reduce the waiting list backlog. Despite timebound actions and governance mechanisms, it remains unclear whether the Framework can be delivered. Many factors will influence this – given the scale of the problem; the need for committed resources; logistics; and the impact of the pandemic on an exhausted workforce.

- Unpicking how waiting lists are funded has been challenging. Despite several requests from the report authors to the Department of Health for information about how much money has been spent tackling waiting lists, this has not been provided. This makes it almost impossible to apply meaningful scrutiny as to how effectively, and where, the money is spent. In going forward, much greater levels of transparency are needed.

1. Waiting lists: a long story

Elective care is typically care that is planned for in advance, as opposed to emergency or unscheduled treatment. Part of this includes semi-elective care - such as planned consultations, diagnostic tests[1] or procedures that can confirm or exclude potentially life-threatening conditions like cancer.[2] Elective care usually takes place in a hospital setting. Current policy indicates that patients are added to a waiting list and treated in clinical priority (urgent first), in order to provide equity of access.[3]

The time it takes for a patient to receive care and treatment is important and acts as a measure as to how the healthcare system is responding to demand for services. Yet, NI is said to have the worst hospital waiting times in the UK, and amongst the worst in Europe.[4] Likewise, it can be said that NI waiting lists have been increasing to unacceptable levels for a number of years, well before the COVID-19 pandemic began.

1.1 Impact of COVID-19

The pandemic has undoubtedly exacerbated waiting times.[5] In 2020, much elective care activity, such as outpatient and surgical services, were cancelled or postponed. This enabled staff to be redeployed. It also created capacity in areas like intensive care for very ill patients with COVID-19, and for other urgent, non-COVID cases. Since then, several surges in COVID-19 cases have occurred. Pressures are still mounting as lockdown measures ease, especially as winter approaches.[6] Indeed, at the time of writing, a number of surgeries are being cancelled.[7] Likewise, Health Officials have stated that it is crucial to keep virus levels low, because increased cases, translate into increased hospital and intensive care admissions.[8] This has resulted in difficulties maintaining planned elective care services.

Furthermore, the ongoing nature of the pandemic means the waiting list backlog will take much more time to resolve, as the number of patients requiring treatment continues to increase. Meanwhile, huge strain is being placed on emergency departments as patients seek treatment via other care pathways.

There are also concerns about the consequences for people who have delayed seeking care during the pandemic, some of whom now require unscheduled acute

[1] These can be grouped as diagnostic imaging, physiological measurement, cardiac diagnostics and endoscopy.
[2] Department of Health (NI) What is elective care? https://www.health-ni.gov.uk/sites/default/files/publications/health/ECP-070217_0.pdf p6.
[3] Clinicians make these assessments and decide the priority for individual patients.
[4] Elective Care Framework (2021) https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf p19.
[5] BMA website. Pressure points in the NHS https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressure-points-in-the-nhs
[6] McKeown, L-A. (27 July 2021) for BBC News NI. Covid-19: Health Trusts cancel surgeries as Covid admissions rise https://www.bbc.co.uk/news/uk-northern-ireland-57991391
[7] BBC News NI 2021 see: Kidney transplants cancelled amid Belfast Trust staff shortage https://www.bbc.co.uk/news/uk-northern-ireland-58065081 and: Covid-19: Belfast Trust to cancel some cancer surgeries https://www.bbc.co.uk/news/uk-northern-ireland-58004195
[8] See Northern Ireland Assembly. Committee for Health. Official Report 11th March 2021. Waiting Lists and Waiting Times: Department of Health; Health and Social Care Board http://data.niassembly.gov.uk/HansardXml/committee-25663.pdf

intervention,[9] as well as those remaining hidden in the system who have yet to seek treatment. These consequences have implications both for longer term population health and widening health inequalities.[10] Evidence also indicates the detrimental impacts that long waits for treatment can have on the physical, emotional, social and financial wellbeing of patients, their families and carers.[11]

1.2 The patient journey

Elective care data from 2017 (pre-pandemic) suggests that annually the NI health service delivers approximately:

- 400,000 first (new) outpatient appointments;
- 600,000 inpatient/day case procedures;
- 1 million review appointments; and,
- 1.5 million diagnostic tests.[12]

However, waits for these services comprise of a complicated and disparate set of measures that *do not* join up the various components (or complete lengths of time) a patient has to wait.

In the UK, NI is the only jurisdiction that does not have a way to join up and track patient data for elective care. This is known as the "Referral to Treatment Time" (RTT). For example, NHS England has been reporting and publishing RTT data since 2007.[13,14,15]

An RTT is broadly described as the time that a patient waits from referral to start of treatment, or, if treatment has not begun, the length of time that a patient has waited to date. The RTT also provides a more complete overview of the patient pathway and is a good way to pinpoint where bottlenecks exist in the system. It can also help clinical teams plan ahead, share knowledge, and make improvements.[16]

[9] See for example BBC News NI 25 August 2021 Covid-19: Health trusts in appeal to off-duty staff https://www.bbc.co.uk/news/uk-northern-ireland-57964603
[10] See for example, the Royal College of Surgeons in England (2021) Northern Ireland Action Plan for Surgical Recovery https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/position-statements-and-reports/action-plan-for-northern-ireland/
[11] Patient and Client Council (2018) Our lived experience of waiting for healthcare https://www.communityni.org/sites/default/files/2018-03/Our%20lived%20experience%20of%20waiting%20for%20healthcare%20-%20Waiting%20Times%20Report%201-3-18.pdf p4.
[12] Department of Health (NI) 2017 Elective Care Plan - Transformation and Reform of Elective Care Services https://www.health-ni.gov.uk/sites/default/files/publications/health/ECP-070217_0.pdf p6
[13] Consultant-led Referral to Treatment Waiting Times https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
[14] The NHS Constitution in England states that 'no-one should expect to wait more than 18 weeks from the time they are referred to the start of their consultant-led treatment, unless it is clinically appropriate to do so, or they choose to wait longer'. https://extranet.whh.nhs.uk/application/files/9814/5639/9534/RTT_Guide_for_Clinicians.pdf
[15] See for example gov.uk. Consultant-led treatment: right to start within 18 weeks https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/464956/RTT_Rules_Suite_October_2015.pdf
[16] See for example NHS Improvement (2014) Seven ways to no delays https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Seven-Ways-to-No-Delay.pdf

In RTT systems elsewhere in the UK, targets are set at specific timepoints to ensure clinical care is delivered in a timely manner. As the RTT is not reported in NI, it is impossible to draw reliable comparisons with its performance against other UK jurisdictions.[17] Whilst implementing any form of RTT system is complicated, the return of investment in terms of having the most reliable set of data, insights regarding performance and tracking of patient flow should far outweigh any reason not to change.

Likewise, calls for an RTT system to be implemented in NI is not new. In 2014 the NI Assembly's Committee for Health recommended that the Department of Health implement a complete RTT system, amongst other measures, to improve monitoring of the waiting list backlog. The Department indicated that it was not possible to track parts of the patient pathway because "*there are elements of the pathway that may not be recorded anywhere*."[18]

Yet in 2015, in a briefing to the Committee for Health, Department Officials acknowledged that RTT targets should be the direction of travel:

> *…because they provide a clear picture of the complete patient journey time and stop patients from being lost in the system, as they are tracked. They also reduce clinical risk….*[19]

Nevertheless, such a system has not been implemented to date, although the new Elective Care Framework (2021) has indicated that some form of RTT system will be progressed after 2023.[20]

1.3. Official waiting times data

Improving data is vital to widening our understanding of the NI waiting lists problem. However, the data available is not always easily understood and can be difficult to interpret. In the absence of RTT indicators, unlinked hospital waiting times are published on a quarterly basis by the Department of Health[21] to provide a snapshot of performance in three areas. These are shown in Figure 1.

[17] According to the Institute for Government - England, Scotland and Wales all measure the time from 'referral to treatment' (RTT) – the time that non-emergency patients wait between first being referred to starting treatment. However, it is only possible to fairly compare England and Wales because they both publish data on 'incomplete' waiting times – the length of time patients *who are currently on the waiting list* have been waiting. Scotland publishes data on complete referral to treatment times (people who have been treated), whereas England and Wales publish data on incomplete referral to treatment times (people who are waiting to be treated). Further Information is available at: https://www.instituteforgovernment.org.uk/publication/devolved-public-services/nhs

[18] As cited in http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2017-2022/2020/health/0220.pdf p5.

[19] Committee for Health Social Services and Public Safety April 2015, Official Report Committee Report on Waiting Times for Elective Care, Department of HSSPS and HSCB, http://aims.niassembly.gov.uk/officialreport/minutesofevidence.aspx?&cid=10

[20] The Minister for Health has committed to introducing an RTT type system as part of the Elective Care Framework (2021)

[21] Department of Health (NI) Publication of the Quarterly Northern Ireland Inpatient, Day Case, Outpatient and Diagnostic Waiting Times Statistics https://www.health-ni.gov.uk/news/publication-quarterly-northern-ireland-inpatient-day-case-outpatient-and-diagnostic-waiting-times-0

Figure 1. Hospital waiting times categories reported for elective care[22]

- A first outpatient appointment[23]
- Diagnostic tests – such as a psychological assessment, diagnostic imaging[24]
- Inpatient care – for those who stay in hospital for at least one night, and day cases who are discharged the same day

In terms of those waiting, the most up-to-date data for June 2021 shows there were:

- 184,873 patients waiting more than 1 year for a first outpatient appointment,
- 66,287 waiting more than 1 year for inpatient/day case treatment, and
- 48,543 waiting longer than 26 weeks for a diagnostic test.[25]

1.4 Waiting time targets

In NI, several targets are attached to elective care waiting time data (for a first outpatient appointment, a diagnostic test or inpatient care). These are set annually by the Minister for Health.[26] However, experts have previously noted that elective care targets in NI are markedly less ambitious than the rest of the UK.[27]

Table 1 shows the most recent targets and performance data available (April-June 2021/22).[28] As can be seen, all targets across NI have been breached:

[22] Hospital performance data is also published for emergency and cancer services by the Department of Health, but are not considered within the remit of this paper.
[23] Outpatient statistics include patients who have first been referred to an ICATS service and been triaged or seen by ICATS teams before then being subsequently referred for a first consultant led outpatient appointment. As cited in Thompson, J. and McKay, K. (2020) footnote 15 - email correspondence from DoH (NI).
[24] Many of these, such as simple blood or urine tests can be performed (and often analysed) in a community or primary care setting.
[25] Department of Health (NI) 2017 Elective Care Plan - Transformation and Reform of Elective Care Services https://www.health-ni.gov.uk/sites/default/files/publications/health/ECP-070217_0.pdf p45.
[26] See Commissioning Plan Direction, as cited in https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf p23.
[27] Appleby, J. in the BMJ. Data Briefing (November 2019) Waiting times compared across the four UK nations.
[28] Department of Health (NI) (2021) Waiting times https://www.health-ni.gov.uk/topics/doh-statistics-and-research/hospital-waiting-times-statistics

Table 1.Current targets and performance associated with elective care (June 2021): [29,30,31]

Targets for 21/22	Target met/not met overall	
First outpatient appointment targets		
50% of patients should wait no longer than 9 weeks for a first outpatient appointment.	Not met - 82% of patients were waiting more than 9 weeks	✗
No patient should wait longer than 52 weeks for a first appointment.	Not met - 53% of patients were waiting more than 52 weeks (1 year).	✗
Diagnostic targets		
Less than 25% of patients should be waiting over 9 weeks for a diagnostic test.	Not met - 52% of patients were waiting more than 9 weeks	✗
No patient should be waiting over 26 weeks for a diagnostic test.	Not met - 33% of patients were waiting more than 26 weeks	✗
All urgent diagnostic tests should be reported on within 2 days	Not met - 82% were reported on within two days	✗
Inpatient targets		
55% of patients should wait no longer than 13 weeks for inpatient/day case treatment	Not met - 81% of patients were waiting longer than 13 weeks	✗
No patient should wait longer than 52 weeks for treatment.	Not met - 66,287 referrals for people waiting over 52 weeks	✗

It is also important to note that targets for a first outpatient appointment and for inpatient treatment have rarely been met since 2009.[32] This is despite those targets becoming more lenient over the past number of years. It is likely that the target parameters have changed because of the difficulty in Health and Social Care (HSC) Trusts meeting them, coupled with the rising demand for care. For example, in 2009 the target for a first outpatient appointment stated that "no patient should wait longer than 9 weeks for a first outpatient appointment"; whereas for the timeframe April 2021/22, the target is that "50% of patients should wait no longer than 9 weeks".[33]

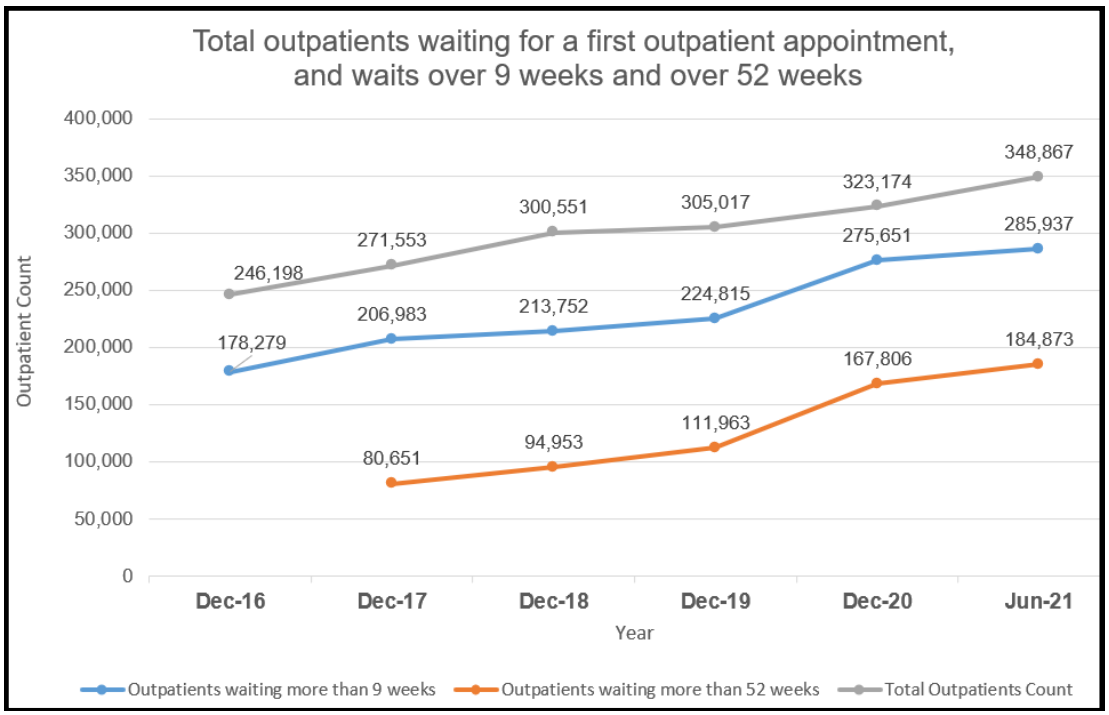
[29] Department of Health (NI) (2021) Outpatient waiting times Quarter Ending June 2021 https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-outpatient-waiting-times-june-2021
[30] Department of Health (NI) (2021) Diagnostic Waiting Times Quarter Ending June 2021 https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-niwts-diagnostic-waiting-times-q1-21-22.pdf
[31] Department of Health (NI) Inpatient and Day Case Waiting Times Quarter Ending June 2021 https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-niwts-inpatient-waiting-times-q1-21-22.pdf
[32] http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2017-2022/2020/health/0220.pdf pp25-26
[33] See Department of Health (NI) https://www.health-ni.gov.uk/articles/outpatient-waiting-times

Comparisons are made even more difficult when the target parameters keep moving over time, are repeatedly missed, and little is known about accountability mechanisms or sanctions for missed targets.

Furthermore, **no** targets or timeframes have been published for the 1 million follow-up review hospital appointments that take place in NI each year, as part of each patient's elective care journey.[34] Again, some form of RTT system would provide more comprehensive data on joining up the patient journey (such as review appointments) and flag areas for improvement within clinical specialities more quickly and accurately.

As can be seen in the following series of graphs, the number of patients waiting has been increasing over the last 5 years for outpatient, diagnostic and inpatient care. The graphs also show the number of waiters - at a given timepoint, against Ministerial targets.

Figure 2. Total number waiting for a first outpatient appointment, including those waiting under 9 weeks and over 52 weeks (52-week data is unavailable for December 2016):[35]



[34] Essentially, review appointments are all appointments that are not 'new' appointments; follow a new outpatient attendance; a previous review attendance; an attendance at an emergency department; a domiciliary visit; or an inpatient admission for the same condition. See https://www.health-ni.gov.uk/sites/default/files/publications/health/ECP-070217_0.pdf p7.

[35] Data compiled by M. Cipriano (RaISe) – data extracted from Department of Health Northern Ireland waiting time statistics: outpatient waiting times June 2021 https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-outpatient-waiting-times-june-2021

Figure 3. Total numbers reported that are waiting for a diagnostic service; those waiting under 9 weeks, and over 26 weeks:[36]

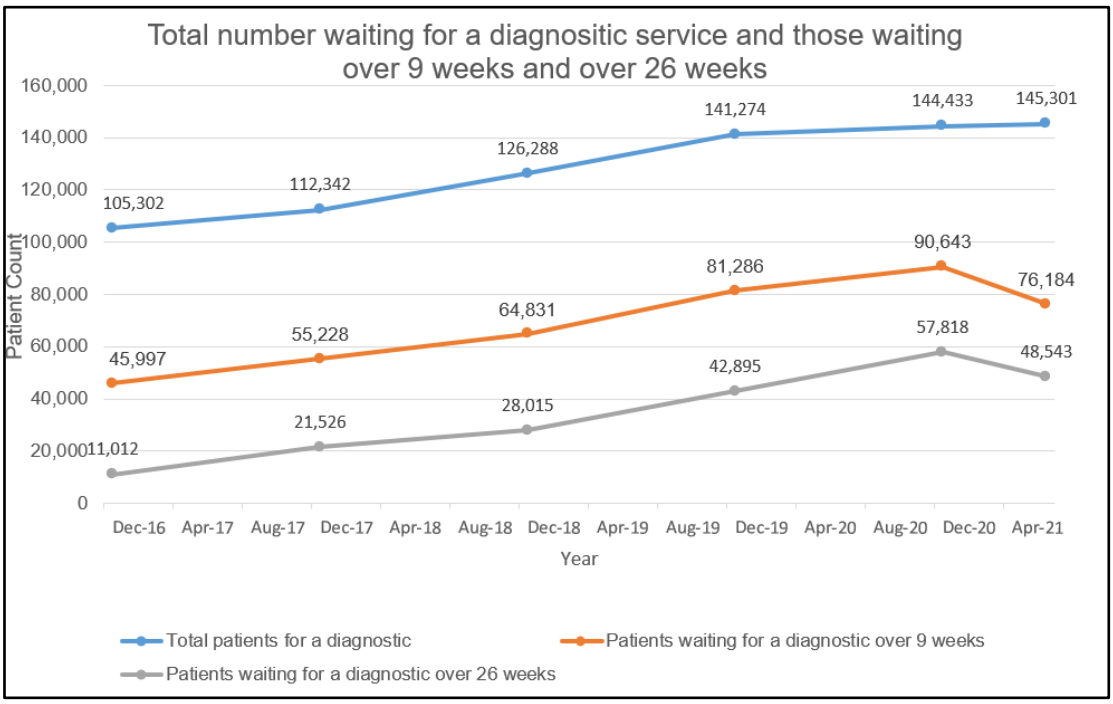
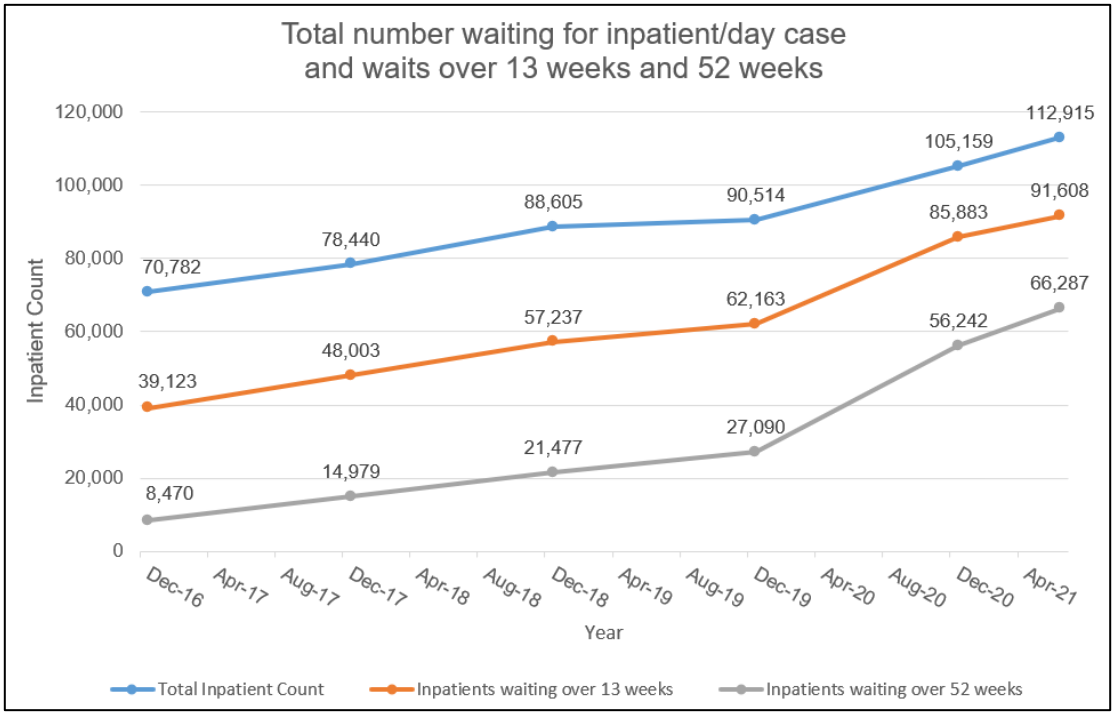


Figure 4. Total number waiting for inpatient/day case admission; and those waiting under over 13 weeks and over 52 weeks:[37]



[36] https://www.health-ni.gov.uk/publications/northern-ireland-waiting-time-statistics-diagnostic-waiting-times-june-2021
[37] https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-niwts-inpatient-waiting-times-q1-21-22.pdf

1.5 Performance and timeframes

Performance against the elective care targets has been described by the Minister for Health as unacceptable.[38] Inevitably, these waits can also have detrimental consequences on patient health and damage patient trust.[39] For example, long waiting times are one of the top areas of patient complaints, according to a study conducted by the Patient and Client Council in 2018.[40]

In regard to recent performance, hospital activity data suggests that during the pandemic reporting period (2020-2021), there has been a 50% decrease in outpatient activity; a 28% decrease in inpatient and day patient activity; and a 46% decrease in theatre activity.[41]

In addition, there is also an unquantified, but likely considerable, level of wasted resources each year and potential delays in treatment due to missed and cancelled appointments. Data for 2020/2021 indicates that hospitals cancelled far more appointments than patients - who either missed, or did not attend their outpatient appointments. In summary:

- Patients missed 89,291 outpatient appointments[42] - a 'Did Not Attend' rate of 7.2%;
- Patients cancelled 72,596 outpatient appointments - a 'Could Not Attend' rate of 5.9%; and,
- Hospitals cancelled 232,902 appointments - a 'hospital cancellation rate' of 16.8%.[43]

1.6 Increasing demand over time

The number of people waiting for a first outpatient appointment has been increasing over the last number of years. In June 2015, there were nearly 86,000 referrals waiting **over 18 weeks** for a first outpatient appointment (those waiting over 52 weeks were not reported as 18 weeks was the cut off target that no patient should wait longer than). Whilst not directly comparable, but to illustrate the extent of the increase, in June 2021 **nearly 185,000 referrals have been waiting over 52 weeks** (the new cut off target) for a first outpatient appointment.[44] Currently, the clinical specialties with the highest number of people waiting over 52 weeks include: Ear, Nose and Throat; General Surgery; Dermatology; Gynaecology; Neurology; Trauma and Orthopaedic Surgery;

---

[38] Black, LA. (2016) Why are we waiting? Outpatient appointments. See http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2015/hssps/12015.pdf
[39] Systems not structures, (2020) https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf p64.
[40] Patient and Client Council (2018) Our lived experience of waiting for healthcare https://www.communityni.org/sites/default/files/2018-03/Our%20lived%20experience%20of%20waiting%20for%20healthcare%20-%20Waiting%20Times%20Report%201-3-18.pdf p4.
[41] Department of Health (NI) (2021) Hospital Statistics: Outpatient Activity Statistics 2020/21 https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-outpatient-stats-20-21_0.pdf
[42] This included Patients missed 54,952 face-to-face and 34,197 virtual appointments, giving Did Not Attend (DNA) rates of 7.3 and 7.1 respectively.
[43] Personal correspondence with Department of Health NI. Minister of Health response received on 19.8.2021
[44] Information Analysis Directorate (2021) Northern Ireland Waiting Time Statistics: Outpatient Waiting Times Quarter Ending March 2021https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-niwts-outpatient-waiting-times-q4-20-21.pdf p11.

and Ophthalmology.[45] In some cases, these figures are quadruple the numbers that were waiting for the same specialities in 2015.

Indeed, the total timeframe that many patients are waiting is likely to far exceed the waiting times reported in official data; with waits for a *first* outpatient appointment of around four or five years not uncommon.[46] Again, this does not include any follow up tests or treatment. However, many patients can be seen within weeks if they are able to pay for private care. They may also be treated by some of the same staff working in the public health and social care system. These realities can further perpetuate the health inequalities that the Department of Health is working seeks to reduce.

To illustrate the extent of the waits being experienced, an article in the British Medical Journal (2019) by economist John Appleby stated:

> *At the Western HSC Trust…patients with an orthopaedic upper limb problem face a potential maximum wait of nearly five and a half years for their first outpatient appointment. They then have the prospect of a further four or more years if they need to be admitted for surgery*.[47]

The article also indicated that the ability to meet such targets:

> …*depends on basic factors such as money, management, commitment, organisational strategies at the front line, and the productivity of the system in converting its budget into activity*.

Meanwhile, others have indicated the length of time people in NI are waiting compared to elsewhere. For example, a report in 2019 by the Nuffield Trust suggested 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*.[48]

It also suggested:

> …*In early 2019, the list of people waiting over one year in England was equivalent to one person per 48,524 inhabitants. In Northern Ireland, it was equivalent to one person in 16*.[49]

[45] Department of Health (NI) https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-niwts-outpatient-waiting-times-q1-21-22.pdf p7.
[46] Dayan, M. and Heenan, D. (2021) Nuffield Trust Seven points of action to help address Northern Ireland's waiting list woes. https://www.nuffieldtrust.org.uk/news-item/seven-points-of-action-which-would-help-address-northern-ireland-s-waiting-list-mess-once-and-for-all
[47] Appleby, J. in the BMJ. Data Briefing (November 2019) Waiting times compared across the four UK nations.
[48] Dayan, M. and Heenan, D. (2019) Change or collapse Lessons from the drive to reform health and social care in Northern Ireland https://www.nuffieldtrust.org.uk/files/2019-07/nuffield-trust-change-or-collapse-web-final.pdf
[49] Ibid, p11.

In 2020, the Institute for Government stated that:

> *…By March 2020, almost 40% of patients on waiting lists in Northern Ireland had been waiting longer than a year just to get an appointment – in England just 0.1% of patients on waiting lists were waiting a year or longer for the **whole journey** from referral to treatment….*[50]

In addition to not knowing how long people have waited so far in their treatment pathway, it is also not known how many patients are waiting for an elective care service in more than one area, or those who are being counted more than once in the figures. It is also unclear how many people on a waiting list are accessing care via Emergency Departments because they have waited so long to see a clinical specialist. Whilst this data may be available in some format to the Department of Health, it is not publicly available.

This raises a number of questions, including:

- How can the true extent of waiting times be quantified?
- Why have the needed changes taken so long?
- How do we know where the biggest improvements can be made?
- How can targets be made more meaningful?
- How can the data for NI be more readily compared - so that lessons can be learned from other jurisdictions in the UK who have historically had much shorter elective care waiting times?

2. What has caused our waiting lists to become so long?

Whilst healthcare systems and elective care waiting times across the UK have been deeply impacted by the pandemic, it is useful to examine some of the factors that have led to the increase in waiting lists on a local level. Over the past 15 years, NI's waiting lists trajectory has been increasing - albeit with some brief periods of stability. This stability was often due to funding injections, combined with initiatives like increased working patterns and the use of the independent sector to reduce the numbers of people waiting.[51]

The Department of Health has cited a number of reasons behind the growing waiting lists, such as:[52,53]

- Financial constraints and over-reliance on short-term funding;
- Rising gap between funded health service capacity (ability to provide services) and increasing patient demand (increased referrals);

[50] Institute for Government (2020) Devolved public services https://www.instituteforgovernment.org.uk/publication/devolved-public-services/summary
[51] Black, LA. NI Assembly paper – Why are we waiting? http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2015/hssps/12015.pdf
[52] Department of Health (NI) 2017 Elective Care Plan - Transformation and Reform of Elective Care Services https://www.health-ni.gov.uk/sites/default/files/publications/health/ECP-070217_0.pdf p4.
[53] Department of Health (NI) Elective Care Framework (2021) https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf

- Workforce issues, such as staff recruitment, retention, use of agency workers;
- Unsuitably configured services, such as acute services;
- Relationship and flow between scheduled and unscheduled care;
- Aging population and higher chronic disease burden; and,
- Impact of COVID-19.

Others have also put forward reasons for the lack of progress, including:[54,55,56,57,58]

- Poor accountability;
- Little motivation or ambition to tackle waiting times;
- A general reactive, rather than proactive, preventative approach to care;
- Lack of strategic planning and published data (for workforce planning, budget, details of how waiting lists are managed);
- A siloed mentality and centralised power structures;
- Political blockages – such as the collapse of the NI Executive (2017-2020); and,
- Difficult political decisions to centralise services repeatedly not being taken.

3. Plans and policies to reduce waiting lists

Over the years, a number of policies and plans have been developed in an attempt to tackle waiting lists.[59] There are two aspects to this: one is to address the backlog of patients waiting, and the other is to address the capacity gap. This needs to be taken in the context that all the while, new patients are continually being added to the lists for various clinical specialties.

In addition to the plans to tackle waiting times, seven major reviews concerning the wider need for transformation of the NI health and social care system have been undertaken in recent years.[60] The overarching messages stemming from those reviews included: the rationalisation of services; creating larger hospitals; regionalising specialist care; and focussing on prevention. However, the sheer number of reviews led to a sense of *review fatigue*, which was acknowledged in the 2016 "Bengoa Report", *Systems not Structures*. It indicated that the NI health service had:

> *…repeatedly spent significant time and resources analysing the challenges it faces, identifying the weaknesses in the current model, making recommendations for*

[54] BBC News NI (19 May 2021) Northern Ireland has 'lost control' of hospital waiting lists https://www.bbc.co.uk/news/uk-northern-ireland-57169143
[55] Dayan, M. and Heenan, D. (2019) Change or collapse Lessons from the drive to reform health and social care in Northern Ireland https://www.nuffieldtrust.org.uk/files/2019-07/nuffield-trust-change-or-collapse-web-final.pdf
[56] BMJ. Griffiths, N. (2019) How the lack of government is affecting healthcare in Northern Ireland https://www.bmj.com/content/364/bmj.l72
[57] Royal College of Surgeons in England in Northern Ireland (2021) Northern Ireland Action plan for Surgical Recovery: 10 steps not 10 years. https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/position-statements-and-reports/action-plan-for-northern-ireland/
[58] House of Commons. Northern Ireland Affairs Committee (2019) Health funding in Northern Ireland. https://publications.parliament.uk/pa/cm201919/cmselect/cmniaf/300/300.pdf p3.
[59] http://www.niassembly.gov.uk/globalassets/documents/raise/publications/2017-2022/2020/health/0220.pdf
[60] Nuffield Trust: Health and social care in Northern Ireland – critical care? https://www.nuffieldtrust.org.uk/news-item/health-and-social-care-in-northern-ireland-critical-care#the-diagnosis-is-clear

*change, but subsequently **failing to enact** the necessary transformation to make these happen.*[61]

In addition to those reviews, Table 2 provides a timeline of plans from the last 5 years, which included proposals or actions to reduce waiting lists.

Table 2. Summary of plans indicating intentions for future delivery of elective care:

Year	Plan or policy
2016	As part of *'Health & Wellbeing 2026: Delivering Together'* the Department of Health stated it would: "Develop a comprehensive approach for addressing waiting lists" in 2017.[62]
2017	This approach was outlined the *Elective Care Plan*.[63] It included 6 commitments to reduce waiting lists, such as increasing patient self-management services, expanding capacity in primary care, and access between primary and secondary care, modernising secondary care services and establishing new service models – for example regional Elective Care and Treatment Centres.
2018	A *Progress Report* on the 2017 Elective Care Plan warns that managing waiting lists with short term funding is not sustainable and that radical change, supported by investment was needed.[64] However, what tangible progress has been made from the original actions is not clearly outlined.
2020	The *New Decade, New Approach* agreement[65] gives a commitment that the Northern Ireland Executive will produce a new action plan on waiting times.[66] This would also seek to change how waiting times are measured to reflect the entire patient journey (RTT), with appropriate targets.
2021	An *Elective Care Framework* - Restart, recovery, and redesign[67] is published. This 5-year plan sets out how to reduce patient backlog and provides a new approach for elective care. It proposes a £700m investment required over a 5-year period. The plan is also based on 6 principles such as: recurrent and additional investment, fully resourced capacity, close monitoring of performance and investment.

Given that there have been two Elective Care plans within four years, the next section of this Research Paper discusses the actions and outcomes that have been outlined in those plans, and any information on progress to date.

[61] Systems not Structures (2020) https://www.health-ni.gov.uk/sites/default/files/publications/health/expert-panel-full-report.pdf p9.

3.1 What actions were in the 2017 Elective Care Plan?

As mentioned in Table 2, the 2017 Elective Care Plan contained 6 commitments and a number of actions to be overseen by a Transformation Implementation Group.[62] The ambition was:

> *…to transform Elective Care services to future delivery models where, when people need specialist healthcare, they have timely access to safe, high quality assessment, diagnosis and treatment; where staff are empowered and supported to do what they do best, working in a service that is efficient and sustainable for the future*.[63]

The Elective Care Plan also wanted to reform in-house healthcare services, in order to reduce reliance on the private (independent) sector.[64] Another commitment set out in the Plan was: "*to reduce the current maximum waiting time for a first out-patient appointment and in-patient/day case procedure to 52 weeks, and for a diagnostics appointment to 26 weeks*." Other actions, many of which were not new, included:

- Strengthening performance management and accountability;
- Reviewing waiting lists by primary and secondary care;
- Renewing focus on improving theatre productivity, e.g. mobile theatres,
- Reducing overnight stays;
- Ensuring treatment occurs in the most appropriate place;
- Consolidating outpatient sites;
- Providing one-stop clinics to reduce number of outpatient reviews;
- Expanding ambulatory care;
- Improving patient 'Did Not Attend' rates and late cancellation rates;
- Increasing nurse-led colonoscopy pre-assessments, nurse-led flexible cystoscopy, and non-medical Gastroenterology Endoscopy;
- Increasing telephone reviews;
- Reducing levels of hospital cancelled clinics;
- Improving imaging services and ways of reporting;
- Improving audiology processes; and,
- Establishing Elective Care Centres, to provide a dedicated resource for less complex planned surgery and other procedures, as well as HSC regional Elective Diagnostic Centre.

However, the scale of transformation needed was caveated by:

> *…the availability of finance to implement the actions and the approval of business cases which will underpin transformation*.[65]

[62] Department of Health (NI) Transformation Implementation Group https://www.health-ni.gov.uk/sites/default/files/publications/health/tig-terms-reference.pdf
[63] Department of Health (NI) 2017 Elective Care Plan - Transformation and Reform of Elective Care Services https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services p17.
[64] Ibid, p17
[65] Department of Health (NI) 2017 Elective Care Plan - Transformation and Reform of Elective Care Services https://www.health-ni.gov.uk/publications/elective-care-plan-transformation-and-reform-elective-care-services

3.2 Progress report on 2017 Elective Care Plan

In 2018, the Department of Health published a progress report on the 2017 Elective Care Plan. Whilst there is some evidence of progress, there is little in the way of timelines/project delivery milestones for when actions would be completed. There are several citations of "plans being developed", or "work underway", but what this has translated into in practice against the original actions outlined in the Plan was not evident in the progress report.

In addition, the commitment "*to reduce the current maximum waiting time for a first out-patient appointment and in-patient/day case procedure to 52 weeks, and for a diagnostics appointment to 26 weeks"* was not achieved. The Department cited the reason for this being due to "*the required level of funding not being made available*".[66]

No further update on progress against the 2017 plan has since been published, and the scale or progress remains largely unknown. Given that this Plan has now in many ways been superseded by the Elective Care Framework, it remains unclear as to what will happen to the actions within the 2017 Elective Care Plan. The new Elective Care Framework does suggest that the previous Plan "…*is still a valid roadmap for change*", but it also states that "…*the collapse of the Northern Ireland Executive was a significant contributory factor to the inability to implement the 2017 Elective Care Plan*".[67]

3.3 What actions are in the Elective Care Framework?

In 2021, the Minister for Health, Robin Swann launched the Elective Care Framework. At the time the Minister stated that it is likely to take up to 10 years to both fully resolve waiting lists and to develop a sustainable elective care service. However, this timescale was deemed to be a "catastrophic assessment" by the Royal College of Surgeons of England, who also published an action plan and recommendations for tacking waiting lists entitled *Northern Ireland action plan for surgical recovery:10 steps not 10 years.*[68] Details of their recommendations are provided in Appendix 1.

The Elective Care Framework is a five-year plan, whereby £707.5 million of additional investment will be required to reduce the backlog of patients currently on waiting lists.[69] The Framework indicates that demand for elective care is also predicted to increase substantially in the next 5 years. When demand goes above HSC capacity, the health service will need to fund additional activity.[70] But the Framework cautions that:

[66] https://www.health-ni.gov.uk/sites/default/files/publications/health/Elective-Care-Progress-Report-February-2018.pdf p3.
[67] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf p31.
[68] https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/position-statements-and-reports/action-plan-for-northern-ireland/
[69] Department of Health (NI) Elective Care Framework (2021) https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf
[70] Ibid, p45.

> *…Without a commitment to additional investment on this scale, it will not be possible to reduce and sustain waiting times at acceptable levels.*[71]

The Framework also contains a more detailed time bound series of actions to be achieved by certain dates, which is to be welcomed. **Appendix 2** of this Paper provides these time bound actions in more detail. At a high-level, examples of these include:

Immediate actions (already underway)

- Enhanced rates of pay for staff working in targeted shifts and delivering priority elective activity;
- A cross-border healthcare scheme to allow patients to receive treatment in the Republic's established private sector and then to seek reimbursement up to the cost of the equivalent treatment to the HSC in Northern Ireland; and,
- The development of "Mega clinics" for orthopaedic outpatients, cataract assessments and for a range of pre-operative assessments.

Medium-term actions;

- Detailed proposals for rapid a diagnostic centre or centres;
- Redesign of endoscopy services, including possible regional endoscopy centre; and,
- Specific focus on reducing missed appointments.

Longer-term actions;

- Movement towards a 7-day working week for hospital theatres;
- A new more transparent, referral to treatment waiting times measurement mirroring the waiting times process in place across the rest of the UK via the Encompass system; and,
- Digital innovations, such electronic prescribing in primary care, will be rolled out in order to deliver maximum benefits to elective care services.[72]

Some of these actions are already well underway or in progress. Having timebound measures will also enable the Department of Health to be held to account as to whether it can deliver on the proposal's actions. However, the longer-term actions, which contain very important aspects of transformation related to elective care (such as the RTT), do not have timebound dates attached to them.

The Framework also introduces another target, subject to a commitment from the NI Executive that the necessary backlog funding will be made available, that:[73]

> *…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.*

[71] Ibid, p6.
[72] Department of Health Elective Care Framework (2021) https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf
[73] Ibid

It remains to be seen if this new target, the most lenient of all outpatient targets (which previously have not been met for many years), will be met in five years' time in 2026.

Also of note is that the Framework has changed direction regarding care that should be purchased from the independent sector, given the operational challenges exacerbated by the pandemic. In turn, the Framework states:

> …*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*.[74]

This is likely to have some cost implications in terms value for money, however, the detailed information on contracts with private sector healthcare providers is not publicly available, and therefore further analysis on this issue is not possible (see section 4.5 for further information on costs associated with funding care from the private sector).

The Framework also outlines the implementation of "green pathways", with efforts to keep elected care services separate from any exposure to COVID-19; for example, Lagan Valley is a "green site" for priority day case surgery. There are also initiatives to improve data, reporting and accountability and a focus on performance management, which is discussed further below. There also will be a focus to provide a minimum of 25% of outpatient attendances virtually, *via* telephone or video conference by October 2021.[75]

In terms of governance, the Framework states that several groups will be established. For example, a **Strategic Planning and Performance Group** will:

- 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; and,
- Provide monthly performance updates.

In addition, it is envisaged that a new **Waiting List Management Unit** will be created, whereby Trusts will produce three-monthly delivery plans setting out how they will continue to restore services and reach required activity levels. In addition, an annual Elective Care Delivery Plan will be published, *if* the budget permits.[76]

[74] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf
[75] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf p8.
[76] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf p54

Furthermore, the Department aims to establish an **Elective Care Centre Management Team**, to oversee planning of services at regional elective facilities, as well as the appropriate workforce planning associated with the elective care centres. The Framework states that the Management Team will be accountable to the Health and Social Care Board, and ultimately, the Department of Health in terms of addressing underperformance.

Again, the exact details surrounding accountability or management mechanisms is unclear, for example, what measures or sanctions may be placed on Trusts or individuals in relation to underperformance?

3.4 Estimated costs to reduce the backlog

It is key that specialties with the most significant backlog and capacity gaps are identified so that funds are spent where they will have the greatest impact. The Framework acknowledges that previous demand and capacity work completed by the Health and Social Care Board in 2017 will need to be updated "*to reflect increasing demand, and to reflect the impact of Covid-19 measures which may have reduced capacity overall."*

In total, the Framework suggests that £707.5 million over 5 years will be required in order to address the existing backlog and the unfunded recurrent capacity gap. Details of the funding estimates, which are based on "broad planning assumptions" are provided in Tables 3 and 4 (totals from each provide the £707.5 million sum). However, it is not entirely clear as to how those figures were estimated, not least given that demand and capacity work described above needs to be updated.

Table 3. Backlog funding required to tackle waiting list backlog[77]

Year	Funding required	Target of procedures delivered
2021/22	£70 million	By March 2022 an additional 70,000 assessments and 24,500 treatments delivered.
2022/23	£80 million	By March 2023, an additional 80,000 assessments and 28,000 treatments delivered.
2023/24	£95 million	By March 2024, an additional 95,000 assessments and 33,250 treatments delivered.
2024/25	£110 million	By March 2025, an additional 110,000 assessments and 38,500 treatments delivered.
2025/26	£120 million	By March 2026, an additional 120,000 assessments and 42,000 treatments delivered.
TOTAL	**£475 million**	

In addition to the monies needed to deliver the activity (£475 million in total), the Framework suggests that additional recurrent spend (£232.5 million) should be focused on incrementally increasing capacity (Table 4). Those costs will be cumulative as additional staff are recruited. Over time, it is envisaged that recurrent investment will allow the amount of non-recurrent funding to reduce.

Table 4. Yearly recurrent funding required 2021/22 - 2025/26[78]

Financial Year	Funding	Cumulative total
2021/22	£1.5 million	£1.5m
2022/23	£ 10 million	£11.5m
2023/24	£ 20 million	£31.5m
2024/25	£35 million	£66.5m
2025/26	£55 million	£121.5m
Total recurrent funding required		**£ £232.5m**

[77] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf p48.
[78] Ibid, p51

It remains unclear if the funding profile required for the Elective Care Framework will be met by a NI Executive Budget commitment, which, at the time of writing, has not been given. It will also be interesting to assess how the Department of Health can achieve the ambitious target to eradicate the gap between demand and capacity, given that there will be resource limitations regarding staff who are already exhausted from the pandemic; combined with a finite number of sites where procedures can take place, and ongoing pressures from the pandemic on both elective and other parts of the healthcare system.

In order for progress to be monitored, it is recommended that the Committee for Health receive regular performance updates and reports on the Framework's status.

4. Unpicking the financing of waiting lists

One of the major reasons cited by the Department of Health for increasing waiting lists is the inadequacy of available funding in meeting current demand. Unpicking the financing of waiting lists is challenging for a variety of reasons. This section examines available information and data, seeking to facilitate the Committee for Health's consideration of funding in this area. It also aims to help inform future potential analysis of waiting list funding, if requested data are made available to the Public Finance Scrutiny Unit (PFSU) within RaISe. The section does this, using the following thematic subsections.

4.1 Financing waiting lists - where does the funding come from?[79]

Simply stated, waiting list funding concerns NI block grant monies, which the Executive receives from the UK Government *via* the NI "Spending Envelope". The Executive allocates those monies to the Department of Health *via* its Executive Budget and in-year financial processes.

4.4.1 NI block grant

Treasury applies the Barnett formula to determine the majority of the NI block grant, including in-year "Barnett consequentials". Also included in the block are non-Barnett determined monies, including, but not limited to, funding relating to, e.g., political agreements such as "Confidence and Supply Agreement"[80] and "New Decade New

[79] Changes have been made to sub-section 4.1 since the initial issuance of this briefing paper. Those changes reflect clarification provided by subsequent government publications on 27 October 2021, including the Chancellor's Spending Review documents, such as the new Statement of Funding for NI: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1030043/Statement_of_Funding_Policy_2021_-_FINAL.pdf

[80] See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/621794/Confidence_and_Supply_Agreement_between_the_Conservative_Party_and_the_DUP.pdf

Approach".[81] The NI Executive receives the block from the UK Government, after the UK Budget is set and then in-year. The block is funded through various sources, including tax revenue collected across the UK by Her Majesty's Revenue and Customs. The NI block comprises "Departmental Expenditure" (DEL), that is both Resource DEL (RDEL) and Capital DEL (CDEL). It, in particular the Barnett-determined block, constitutes the main income source for the NI Executive Budget. Non-ring-fenced, the Executive has autonomy to determine its spending priorities when allocating the block.[82]

4.1.2 Non-block monies

In addition to the block grant, the NI Executive has non-block monies available. Those include, but are not limited to, rating receipts, income from fees/charging and borrowing. [83]

4.2 Budgetary decisions relevant to waiting list financing

In 2021, the Department of Health received almost 50% of the overall Executive Budget - around £6.4 billion in resource funding, as well as £1.7 billion in capital funding. Additional COVID-19 ring-fenced funding streams of over £450 million were also allocated.[84]

A number of budgetary factors are worth noting here. First, the NI Executive agrees the Executive Budget. Second, for some time now, a single-year approach to the Executive Budget has been a key factor impacting the Department of Health's ability to engage in longer-term planning and investment in relation to waiting lists and the wider health and social care service.[85] That single-year budgeting approach arises in part from prevailing financial arrangements under current devolution: budgetary decisions need to be taken at the UK Government level, which in turn help to shape budgetary decision-making at the NI Executive level.[86] This is not unlike other devolved administrations in the UK.

---

[81] See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf
[82] HM Treasury: Block grant transparency, June 2021 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/995939/Block_Grant_Transparency_2021_Explanatory_Note_.pdf p2.

[83] It is worth noting that change could follow in this area in future; currently awaiting the final reports of the March 2021 appointed NI Fiscal Commission. Its final report is due before the May 2022 Assembly elections and will inform future decisions in this area, potentially with implications for income streams available to the Executive; remains to be seen.

[84] Department of Finance https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/Final%20Budget%202021-22%20document%2021.04.21%20-%20accessible.pdf p2.
[85] See House of Commons Northern Ireland Affairs Committee Health Funding in Northern Ireland. https://publications.parliament.uk/pa/cm201919/cmselect/cmniaf/300/300.pdf pp17-18
[86] The Executive does not know its Spending Envelope for a given budgetary period until the UK Government sets the UK Budget, including Whitehall Departmental budgets, which is subsequent to the Chancellor's Spending Review. In recent years, the Spending Review and the UK Budget has been done on a single-year basis.

Second of note are the difficult choices when deciding on spending priorities. While single-year budgeting presents planning and investment challenges like those noted earlier in this subsection, the Department of Finance (DoF) nonetheless acknowledged the need for continued prioritisation of health and social care transformation. It noted that such transformation is the only solution to long-term sustainability of NI's health and social care system, when it reflected in the 2021-22 Executive Budget publication that:

> *The pace, scale and direction of transformation, however, will be informed by work to manage the impact of the virus, the subsequent rebuilding of health and social care services, and the resources available to deliver what is now three systems of care – our normal system, our transformed system, and our COVID-19 system...*[87]

That publication, however, also warned that the 2021-22 Executive Budget:

> *…does not provide sufficient funding for the Department to fully deliver its priorities. In particular, an additional £165 million was estimated to be required to fully meet New Decade New Approach commitments...*

And that:

> *…the Budget will not allow the Department of Health to undertake a transformation programme with any level of ambition.*[88]

More recently, in September 2021, the Minister of Finance, Conor Murphy, responded to an Assembly Question regarding the upcoming Chancellor's Comprehensive Spending Review and UK Budget announcements. Rather than another single-year Executive Budget, the Minister of Finance announced his intention for a multi-year Executive Draft Budget for 2022-2025. He also expressed his view that waiting lists and health transformation should be priorities in the forthcoming Budget, which potentially would require reduced budgets for other Departments.[89] Whether that actually occurs, remains to be seen. The Chancellor's forthcoming announcements on 27 October will be key determinants in whether that occurs, as they will provide the NI Spending Envelope for 2022-25.

The Executive then will need to agree its 2022-25 Budget, including the Department of Health's Budget. This raises a number of questions such as:

- How will the Department's Budget be funded to address waiting lists and health care transformation needs?
- How will the Minister for Health allocate the Department's allocated Budget?

[87] https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/Final%20Budget%202021-22%20document%2021.04.21%20-%20accessible.pdf p62.
[88] https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/Final%20Budget%202021-22%20document%2021.04.21%20-%20accessible.pdf p64.
[89] Mr Matthew O'Toole *(SDLP - South Belfast)* To ask the Minister of Finance what plans his Department has made for the upcoming Spending Review. AQO 2479/17-22

- Will the Minister bid in future in-year monitoring rounds to secure additional funding for waiting lists and transformation, as done in the past?
- If further allocations agreed by the Executive, in what form will it be recurrent or non-current ("one-off")?

The noted series of questions brings us to a key issue regarding the financing of waiting lists, namely non-recurrent funding.

4.3 Department of Health: non-recurrent funding allocations

In the past, managing waiting lists has been heavily dependent on the availability of additional non-recurrent payments through, for example, in-year monitoring rounds. Such funding enabled Trusts to undertake additional activity or to procure capacity from the independent and private sectors, in order to drive down waiting lists. Once such funding has been made available, the approach taken has been treating patients with the highest clinical priority in the first instance, and thereafter, routine patients with the longest waiting times.

However, reliance on non-recurrent funding to support additional elective care activity for waiting lists has been decreasing. For example, between 2009/10 and 2013/14, the HSC system received roughly £70-80 million per year of non-recurrent funding. By 2019/20, that figure had decreased to £37 million.

As stated in the Elective Care Framework (2021):

> *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.*

Part of the problem identified in the Framework is that non-recurrent funding cannot be used to invest in staff or services. This is because there is no guarantee that it will be available at the end of the given budget cycle.[90] While non-recurrent funding does enable Trusts to undertake additional activity in the short-term and can benefit larger patient numbers and reduce waiting lists, it does not provide a sustainable solution to the waiting list problem,[91] especially now with the added complexities and pressures associated with the pandemic.

[90] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-elective-care-framework-restart-recovery-redesign.pdf p42
[91] http://www.hscboard.hscni.net/download/PUBLIC-MEETINGS/HSC%20BOARD/board_meetings_2018/may_2018/Item-07-HSC-Board-Performance-Report-17-18-EOY-Assessment.pdf p23

4.4 Recent Department of Health Bids

During the 2021-22 Executive Budget exercise, the Department of Health made a bid of £30.3 million to address waiting lists. That additional funding bid was unmet. However, the Department did receive COVID-19 Rebuild Funding, of which £40 million is intended to fund waiting list initiatives.[92]

In April 2021, Department of Health Officials gave evidence to the Committee for Health. When asked by the Committee to clarify the costs for addressing the long waiting lists during this financial year,[93] an Official stated:

> *In addition to the provision of elective care in our Trusts, which we know has been constrained and will be constrained at the start of 2021-22, we have set aside £40 million of our COVID-19 funding in order to address waiting list initiatives and other elective developments. Based on our experience in 2018-19, when we invested £30 million of non-recurrent funding in elective care waiting lists, which resulted in around 120,000 additional patients being seen or treated, we estimate that somewhere in the region of 160,000 patients will benefit from the investment of £40 million in 2021-22. That will depend on the case mix and the complexity of the cases, but that is the kind of scale that we expect.*

In terms of funding for future years, the Official continued:

> *At the moment, it is not possible to forecast what we will be able to do in 2022-23. That will depend on the budget that is made available to us. In my opening remarks, I talked about needing an extra £400 million to stand still. That £400 million does not provide any additional funding for waiting list initiatives over and above what is already available in our trusts. We are facing a very challenging position with that investment moving into 2022-23 and beyond. Without the recurrent budget and the recurrent certainty of funding into the future, it is not possible at this stage for us to plan or to comment on what might be deliverable beyond the current financial year.*

At the end of the evidence session, the Chair of the Committee for Health concluded that greater financial data clarity on waiting lists was needed:

> *We need to engage with you on how we might improve the process of getting a clear line of sight and underneath the bonnet of some of the figures that are being presented…. There is also the additional problem that the money allocated by the Department goes to Health and Social Care for commissioning and then on to the Trusts. Sometimes it is described under different headings or whatever.*

[92] NI Assembly Question (AQO2066/17-22) Dr Aiken To ask the Minister for Health whether he made a specific bid for funding to address waiting lists during the 2021/22 budget exercise. Response answered on 18/05/2021.
[93] Northern Ireland Assembly Official Report: Minutes of Evidence. Budget 2021-22 Department of Health http://aims.niassembly.gov.uk/officialreport/minutesofevidencereport.aspx?AgendaId=26197&eveID=13119

It is hard to follow. A key concern in the longer term is that it is hard to track the impact of budget decisions.[94]

More recently, on 30 September 2021, Department of Health Officials briefed the Committee for Health about the Department's October Monitoring Round return, stating the Department was:

…bidding for £30 million of additional funding for elective care. If we are successful, that will all go towards alleviating the waiting list pressures.[95]

At the time of writing, the Department of Finance is scheduled to present its October Monitoring post-statement to the Committee for Finance on 10 November 2021.[96]

4.5 Department of Health spending on independent and private sectors

Another important issue is where the money goes in terms of paying for services within the private or independent sector. Data released by the Department of Health show the level of spend to the independent or private sectors over the past five years, to help reduce waiting lists between 2016 and 2021* (*projected spend).[97] Figures range from £ 8.2 million in 2017/18 to over £20 million both in years 2016/17 and 2020/21, as shown in Table 5.

Table 5. Level of spend on independent or private sectors 2016-2021

	2016/17	2017/18	2018/19	2019/20	2020/21*
HSC Trust	**£m**	**£m**	**£m**	**£m**	**£m**
Belfast Trust	11.0	2.9	6.5	3.2	9.1
Northern Trust	3.4	0.5	0.4	0.5	1.0
South Eastern Trust	6.3	1.7	5.8	4.9	5.1
Southern	1.2	1.5	3.1	0.4	4.6
Western	1.4	1.5	1.4	0.3	1.6
Diagnostics	-	-	-	-	0.6
Total	**£23.5m**	**£8.2m**	**£17.4m**	**£9.3m**	**£22.1m**

[94] Northern Ireland Assembly - Official Report: Minutes of Evidence. Budget 2021-22 Department of Health http://aims.niassembly.gov.uk/officialreport/minutesofevidencereport.aspx?AgendaId=26197&evelD=13119
[95] Northern Ireland Assembly - Official Report: Minutes of Evidence. October 2021 Monitoring Round: Department of Health http://data.niassembly.gov.uk/HansardXml/committee-28681.pdf
[96] http://www.niassembly.gov.uk/assembly-business/committees/2017-2022/finance/forward-work-programme/
[97] AQW 19636/17-22 Mr Gerry Carroll To ask the Minister of Health how much was paid to the independent and private sectors for procedures to reduce hospital waiting lists over the last 5 years, broken down by Health and Social Care Trust. Answered on 23/06/2021

4.6 Questions put to the Department of Health on waiting list funding

Given the lack of publicly available information on funding waiting lists and the wider impact of financial decisions made in that context, RaISe asked the Department of Health for the following:

- The funding provided to elective care, and monies to tackle waiting lists for 2015-2021, including a breakdown of funding sources and when allocated, such as when the Budget was agreed or at a Monitoring Round;
- A breakdown of the financial data into a number of categories, such as the areas of care that funding went to, and other categories, such as private sector monies / monies used for bank staff; in order to track decisions regarding monies spent and to assess whether there is value for money;
- How additional monies would be raised to fund the Elective Care Framework proposals, and when those monies would be released;
- Whether the Department of Health had interim milestones and targets that could reassure the public that the Framework could be delivered.
- When the RTT pilot is beginning and what RTT system model is NI likely to follow – for example, would the Department of Health seek to design its own version of an RTT, or base this on models from nearby jurisdictions?
- What is going to happen if new targets are breached, and more information on accountability.

At the time of writing, the Department of Health had not provided a response to any of the above-noted questions. As a result, an analysis of the requested figures could not be undertaken at present.

4.7 How can greater transparency be established?

Given the absence of the noted data, it is difficult to ascertain what is happening regarding the finances, including whether allocations and spending represent value for money. Potentially, greater data transparency could be influenced by the "Financial Reporting (Departments and Public Bodies) Bill",[98] which is currently at Committee Stage in the NI Assembly.[99] If implemented, that Bill could serve to increase public expenditure transparency and accountability across devolved governance in NI generally, including waiting list funding in particular.

[98] Bill as introduced into the Assembly: http://www.niassembly.gov.uk/globalassets/documents/legislation/bills/executive-bills/session-2017-2022/financial-reporting-departments-and-public-bodies/financial-reporting-departments-and-public-bodies-bill---as-introduced---full-print-version.pdf
[99] www.niassembly.gov.uk/assembly-business/legislation/2017-2022-mandate/primary-legislation---bills-2017---2022-mandate/financial-reporting-bill/

The Bill aims to help "…*create a financial framework that is effective, efficient and transparent and enhances scrutiny by and accountability to the Assembly…*".[100] A key aspect of the Bill, if enacted as introduced, is the inclusion of "designated bodies" within departmental estimates and accounting boundaries; that should bring greater transparency to the public spending received by those bodies. HSC Trusts are amongst those intended designated bodies.[101]

However, while the Bill starts to address long-standing criticism that the present arrangements for reporting and controlling public expenditure are opaque, confusing, and unhelpful, the Bill will not be a panacea. Much work will remain for the Executive and the Assembly - in their distinctive roles - to help increase transparency and accountability in public finance, for example, Department of Health allocations and spending relating to waiting lists. Efforts will need to continue on both fronts, so that there is reduced use of complicated, inaccessible reporting methods that employ poor formats, laden with technical language.

5. Conclusion

The Covid-19 pandemic has made already lengthy waiting lists for elective care even longer. It has also compelled the health care system to work in a different way. However, much is still not known about waiting lists, and many gaps in the data exist - such as the piecemeal reporting of elective care waiting times, and the lack of clarity around funding, in particular, where funds are being allocated and if those decisions represent value for money. It is also well recognised that there needs to be a radical overhaul of health care services in Northern Ireland more widely and a strategic approach required longer term to address waiting lists. Whilst underfunding is one of many reasons for patients waiting longer, there are others as described in this paper. Furthermore, two elective care plans have been developed in the last four years. The most recent, the Elective Care Framework, is subject to a commitment of resources from the Northern Ireland Executive. In terms of transparency, it is imperative that data is made available and that the Committee for Health receives robust and regular evidence of the progress in implementing the new Elective Care Framework. Furthermore, given the scale of the waiting times issue, it is unlikely that waiting times will be at a satisfactory level for a considerable time to come. This in turn is likely to lead to adverse implications in terms of population health.

[100] Written correspondence dated 28 July 2020, from Department of Finance Departmental Liaison Officer to the Assembly Committee for Finance, at para 7.
[101] In a letter to the CfF on 14 June 2021, the Department of Finance provided a list of bodies that would and would not be designated for each Department and reasons why. Included in the DoH list was Trusts. See written correspondence dated 14 June 2021, from Department of Finance Departmental Liaison Officer to the Assembly Committee for Finance, at Annex A: http://www.niassembly.gov.uk/globalassets/documents/committees/2017-2022/finance/primary-legislation/financial-reporting-bill/departmental-correspondence/20210614-dof-response-follow-up-26-may-briefing.pdf

Appendix 1: Royal College of Surgeons in England: Recommendations

Recommendation	Key messages
Investment	The NI government should lobby the UK Treasury to enact a three-year budget cycle to enable strategic and sustainable change. £40m earmarked for the waiting lists falls drastically below what is needed. For NI to clear the elective backlog in 10 years, the Department of Health would require an additional £100m per year for the next decade. To clear backlog in five years, an additional £200m is required.
Waiting lists and elective surgery	Realistic recovery plans: Each Trust should publish a recovery plan for 2021/22 that aims to restore timely access to surgery for patients as per forecasting. Proper demand and capacity planning at specialty/subspecialty level is critical. Imperative that a frank discussion on the reprofiling of hospital facilities takes place with political leaders and the public.
Covid Light sites	COVID-light sites should be accelerated in every trust area to ensure maximum separation of emergency and elective care to prevent a stop start model.
Surgical hubs	High-volume, low-complexity surgery in surgically efficient hubs will accelerate the pace of operations required and will address many long waiters. Continuous validation of the waiting lists should be performed. Building the healthcare capacity to reduce reliance on the (much more costly) independent sector is also critical and requires long-term planning to meet the ever-increasing demands of a changing, older population.
Elective accountability	An annual report should be published setting out the government's response to the waiting times backlog as well as measures supporting long waiters. Introduce & publish RTT and associated targets, including review appointments. The Department should undertake detailed modelling projections to reveal how long it will take to clear the backlog per specialty.
Recruitment/ retention	The wider surgical workforce needs expansion, with focus on perioperative nursing and surgical care practitioners. The NI government should publish a regular assessment of healthcare workforce projections and requirements.
Launch review of surgical services	Plan for a more resilient model of care that can better withstand future pandemics and winter flu outbreaks and the use of technologies.
Wellbeing	HSC Trusts should proactively implement programmes that highlight the benefits of physical and mental wellbeing. Health care workers have borne huge psychological impacts from COVID-19, and many are exhausted.
Support surgical trainees	Surgical training- every elective operation should be considered a training opportunity. There should be an increase in hospital doctors through increased medical school numbers by the end of this NI assembly period (2022).
Collaborate and protect time to learn	Ensure that protected time is built into surgical working schedules to enable communication and learning with colleagues from other specialties.

Appendix 2: Elective Care Framework: Actions and commitments

Immediate actions: July – December 2021.

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

Make recommendations on medium term contracts to lease theatres to independent providers to address current backlogs– by December 2021.

HSCB will bring forward proposals for multi-year arrangements with independent sector providers to address backlogs provided there is value for money– by December 2021.

The Whiteabbey Nightingale will be repurposed as a regional facility to support advanced rehabilitation – by September 2021.

The Duke of Connaught Unit at the Musgrave Park Hospital will be refurbished as a daycase surgery unit for orthopaedics, commissioning work is expected to complete summer 2021.

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

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 via a regional booking system by December 2021.

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.

Extending radiography advanced practice 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; 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 etc by April 2021;

Implementation of regional digital pathology solution by summer 2021.

New limited administrative version of the Cross Border Healthcare Directive for the Republic of Ireland for a 12 month period. Applications accepted by the HSCB from 30 June 2021.

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 will include a rapid assessment 11 of the actions required to stabilise general surgery in the short to medium term by October 2021.

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.

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.

Medium Term Actions: January 2022 – December 2022

Subject to 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; Demand/capacity information for each specialty.

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

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 by January 2022.

A scoping exercise on the feasibility of a new regional endoscopy centre(s) to deliver high volume scopes by March 2022.

The HSCB will bring forward proposals for the introduction of Post-Anaesthetic Care Units at all sites providing complex surgery by March 2022.

New recurrent investment to be targeted at increasing capacity in each of the 15 largest elective specialties. No date assigned.

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, by March 2022.

The Department to finalise a review of perioperative nursing in Northern. 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 a Band 7 Clinical Education Facilitator for each Trust to support staff development recruited into post, by October 2021.

Regional Imaging Board will bring forwards proposals for a new Imaging Academy to deliver training, research and collaboration by March 2022.

Explore options to establish a new single regional management structure for HSC Pathology Services by September 2022.

Expand opportunities in ENT with Speech and Language Therapists by March 2022.

Introduction of a new multidisciplinary approach to treatment, prehabilitation 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.

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

The introduction of a tariff/incentivisation model is expected to make it simpler to monitor activity, tackle underperformance and reward productivity. The HSCB will: Carry out an evaluation of shadow tariff models by July 2022.

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.

The HSCB will continue to develop and expand the delivery of appropriate elective procedures in a primary care setting. Plans expected by March 2022.

The NI Orthopaedic Network will trial a regional booking system for one or two procedures by January 2022.

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

Long term actions – January 2023 onwards

The Department will develop a long-term plan for future capital investment, incorporating plans to maximise elective capacity and capability across the HSC - no date assigned.

In line with the commitment in New Decade New Approach, the HSCB will pilot referral to treatment targets across 5 procedure types - no date assigned.

The Department will oversee the development and introduction of new waiting times targets to reflect the entire patient journey, from referral to treatment - no date assigned.

HSC Trusts will move to a 7-day working week for existing theatre infrastructure but requiring engagement with staff – no date assigned.

Implementation of a Northern Ireland Picture Archiving and Communications (NIPACS+) Programme to support clinical diagnosis, clinical pathway planning, improve patient safety - no date assigned.

The introduction of Encompass- an HSC-wide programme, working to deliver the digitally enabled transformation of Health and Social Care in Northern Ireland to enable a digital care record for every citizen in Northern Ireland- no date assigned.

The implementation of electronic prescribing in primary care which will reduce workload associated with the management of prescriptions in general practices and community pharmacies - no date assigned.