Northern Ireland
Audit Office

Tackling Waiting Lists

Report by the Comptroller and Auditor General

Published
10 October 2023

For further information about the Northern Ireland Audit Office:

Northern Ireland Audit Office
106 University Street
Belfast, BT7 1EU

028 9025 1000
info@niauditoffice.gov.uk
www.niauditoffice.gov.uk

This report has been prepared under Article 8 of the Audit (Northern Ireland) Order 1987 for presentation to the Northern Ireland Assembly in accordance with Article 11 of the Order.

The Comptroller and Auditor General is the head of the Northern Ireland Audit Office. She, and the Northern Ireland Audit Office are totally independent of Government. She certifies the accounts of all Government Departments and a wide range of other public sector bodies; and she has statutory authority to report to the Assembly on the economy, efficiency and effectiveness with which departments and other bodies have used their resources.

Dorinnia Carville
Comptroller and Auditor General

Northern Ireland Audit Office
10 October 2023

Contents

List of Abbreviations

AHP	Allied Health Professional
BSO	Business Services Organisation
DoF	Department of Finance
DoH	Department of Health
DNA	Do Not Attend
ENT	Ear, Nose and Throat
ECMT	Elective Care Management Team
ED	Emergency department
GP	General practitioner
HSC	Health and Social Care
IS	Independent Sector
IPC	Infection prevention and control
ICU	Intensive Care Unit
LVDPC	Lagan Valley Day Procedure Centre
NHS	National Health Service
NDNA	New Decade, New Approach
NICS	Northern Ireland Civil Service
NI	Northern Ireland
NIAO	Northern Ireland Audit Office
NICCY	Northern Ireland Commissioner for Children and Young People
NIPSO	Northern Ireland Public Service Ombudsman
PCC	Patient Client Council
RTT	Referral to Treatment
RPOG	Regional Prioritisation and Oversight Group
RCS England	Royal College of Surgeons of England
T&O	Trauma & Orthopaedic
UK	United Kingdom
VFM	Value for Money
WLI	Waiting List Initiative

Key Facts

Number of people waiting and waiting times

At March 2023: 401,200 people waiting for a first outpatient appointment, with 197,300 (49%) waiting > a year; 121,900 waiting for inpatient treatment, 64,500 (53%) of whom waiting > a year; and 173,200 waiting for a diagnostic test, including 46,500 (27%) waiting > 26 weeks.

HSC waiting lists

Between March 2014 and March 2023 HSC waiting lists have grown by 216% (initial outpatient appointments), 147% (inpatient treatment), and 151% (diagnostic tests). Patient waits exceeding maximum waiting time targets have also increased by 929% (outpatients), 1,396% (inpatients), and 381% (diagnostic tests) (from March 2017). None of the formal waiting time targets achieved since 2014.

Northern Ireland compared to England and Wales

Equivalent of 26.3% of the NI population on waiting lists compared to 12.4% in England and 24% in Wales.

Non-recurrent funding

£98 million of non-recurrent funding (annual average of £19.6 million) provided to address waiting lists between 2012-13 and 2016-17, before falling to £10.5 million between 2017-18 and 2019-20 (annual average of £3.5 million).

Gynaecology and Neurology

59% of patients waiting > a year in Belfast Trust for gynaecology inpatient treatment compared to 30% in Northern Trust. 0% of patients waiting > a year for Neurology inpatient treatment at Southern Trust compared to 100% in Western Trust.

Varicose veins and cataract patients

Since 2019-20, almost 2,100 varicose vein and 18,900 cataract patients treated in new high volume day case centres. NI's first dedicated regional day care centre has also delivered over 10,000 day procedure cases since August 2020.

Costs to implement

Costs of fully implementing a 2017-2022 plan to substantially reduce waiting times estimated at up to £909 million. In practice, only £136.5 million was made available. An estimated £707 million was required just to ensure that by 2026 waiting times do not exceed a year for either an outpatient appointment or inpatient treatment but the Department has now conceded that these targets cannot be met.

"The huge increases in waiting times at the overall NI level since 2014 show how seriously patient needs have not been met, and despite some marginal improvements for lengthy hospital admission and diagnostic test waits in 2023, performance has now reached extremely concerning levels.

The Department and HSC trusts now face immense challenges in trying to address the very concerning situation."

Northern Ireland Audit Office

Executive Summary

Waiting times targets have not been achieved since 2013-14

1. Unlike unscheduled treatment, `elective care' is planned in advance, generally following referral from primary care professionals. It involves initial specialist clinical assessment and subsequent care, including diagnostic tests, surgery, and other treatments. Whilst mainly delivered in hospitals, primary care can also perform routine elective procedures.

2. In Northern Ireland (NI), patient waiting times for elective assessment and treatment delivered by the five Health and Social Care (HSC) Trusts are measured across the separate stages of the patient `journey'. The Department of Health (DoH or the Department) reports waiting times for a first consultant-led outpatient appointment, subsequent hospital admission either as an inpatient or day case, and diagnostic tests, setting annual targets and publishing official statistics quarterly.

3. Lengthy waits place patients at risk of developing debilitating and complex conditions, also meaning more expensive treatment may be necessary. Patients' mental health and quality of life can also suffer. Despite this, the number of people on HSC waiting lists has risen rapidly between March 2014 and March 2023:

- from 127,095 to 401,201, for initial outpatient appointments (216 per cent);
- from 49,341 to 121,879, for hospital admission (147 per cent); and
- from 69,042 to 173,242, for diagnostic tests (151 per cent).

4. These trends show how the HSC sector and its staff have been facing significantly growing demand for care for some time from a population which is living longer. At the same time, trusts' annual budgets have not maintained pace with this. In 2020-21, the demand/funding gap meant that the HSC sector had insufficient funded capacity for 50,000 outpatient appointments, 38,000 hospital admissions, and 153,000 diagnostic tests. This has contributed to DoH not achieving any of its elective targets at the NI level in any year since 2013-14, despite having significantly lowered these. Waiting times have hugely deteriorated since then, with COVID-19 pressures further worsening outcomes:

- **initial outpatient appointments** - waits exceeding nine weeks have risen by 720 per cent from March 2014, standing at 326,200 at March 2023 (81 per cent of patients), with 197,300 (49 per cent) waiting over a year, compared to 21 per cent at March 2017;
- **hospital admission** - waits over 13 weeks have increased by 477 per cent since March 2014 (from 16,356 to 94,300 at March 2023), with 64,500 patients (53 per cent) waiting longer than a year, compared to 14 per cent at March 2017; and
- **diagnostic tests** - waits exceeding 26 weeks have increased by 381 per cent since March 2017, from 9,675 to 46,500 at March 2023.

5. Patient waits have also considerably increased across all trusts[1] and main elective specialisms. At March 2023:

- **initial outpatient appointments** - waits exceeding 52 weeks ranged between 40 per cent (Northern Trust) and 58 per cent (South Eastern Trust), and stood at 56 and 60 per cent respectively for the Dermatology and Neurology specialisms;

1 Variable waiting times across Trusts can be expected to some degree as they deliver different elective specialties.

- **hospital admission (inpatients and day cases)** - between 37 per cent of patients (Northern Trust) and 61 per cent (Belfast Trust) were waiting over 52 weeks across the five trusts. Some 62 per cent of Trauma & Orthopaedic (T&S) surgery and 70 per cent of Ear Nose and Throat (ENT) patients were waiting longer than this; and
- **diagnostic tests** – over 34 per cent of patients in the Southern Trust had been waiting longer than 26 weeks.

6. Unlike NI, the other UK regions report waiting times across the entire `patient journey' through `Referral to Treatment' (RTT) targets. DoH has lagged far behind in introducing this more transparent measurement. Whilst it has piloted RTT measurement for various clinical specialisms, it believes that full and formal introduction will not be achievable until the Encompass project[2] is successfully implemented. Although precise comparison cannot be made, data available suggests England and Wales have significantly outperformed NI in terms of waiting times. At December 2022:

- the numbers currently on HSC waiting lists was equivalent to 26.3 per cent of the NI population[3], compared with 12.4 per cent and 24 per cent of the population on the RTT pathways in England and Wales respectively.
- 51 per cent of those on NI waiting lists were waiting over 52 weeks for assessment or treatment compared to 5.4 per cent waiting longer than this in England on the RTT list, and 33.8 per cent to complete treatment within 36 weeks on the overall Welsh RTT pathway.

7. If people waiting for treatment develop more advanced conditions, the risk increases that they may end up accessing care through urgent pathways. Research shows[4] a quarter of local cancer diagnoses between 2012 and 2017 were made in emergency departments, suggesting peoples' health had already significantly deteriorated. In 2018, almost half of 700 people surveyed stated that their health had worsened while on a waiting list. DoH acknowledges that patients are also increasingly opting to pay for care to avoid prolonged waits, creating health inequalities, with less affluent people disadvantaged.

Waiting times have increased significantly for a variety of reasons

8. DoH estimated in 2019 that under current HSC care models, HSC budgets would have to increase by six per cent annually to meet the rising demand. As this is unsustainable, the demand / capacity gap will continue rising substantially unless HSC models and structures are substantially transformed to better address patients' needs. At this stage, the Department's Elective Care Framework[5] projected that outpatient waiting numbers could further grow by 91 per cent from 335,000 in 2021 to 640,000 by 2026, with inpatient waiting lists increasing by 206 per cent, from around 100,000, to approximately 306,000, in the same period. Whilst demand has not subsequently increased as significantly as these projections, the ongoing growth still underlines why urgent and timely action is required to reduce the already extreme current waiting times, instead of allowing them to continue growing to even further unmanageable levels.

2 The Encompass project is aiming to introduce a single digital and integrated care record for every citizen in NI.

3 This reflects that some people are on more than one waiting list (i.e. waiting for both outpatient and inpatient care). DoH is currently undertaking work on data quality to help it better identify the number of individuals on waiting lists.

4 Research published in April 2022 by the International Cancer Benchmarking Partnership.

5 Elective Care Framework – Restart, Recovery and Redesign (DoH - June 2021).

9. In addition to their annual budgets, trusts can receive in-year supplementary non-recurrent Waiting List Initiative (WLI) funding, mainly through Department of Finance (DoF) monitoring rounds, which helps them address waiting lists through commissioning additional elective activity either internally or from the Independent Sector (IS). However, its availability reduced significantly in recent years. Trusts were allocated an annual average of £19.6 million between 2012-13 and 2016-17, but this fell to only £3.5 million between 2018-19 and 2019-20, meaning use of the IS reduced, and patient backlogs grew very significantly. More recently, £12.1 million WLI funding was provided in 2020-21, and the £61.5 million allocated[6] in 2021-22 represented the highest amount received over the previous decade.

10. WLI funding has limited impact as it only helps address some of the most urgent clinical patient waits, and it cannot be used to strengthen permanent HSC capacity to sustainably reduce waiting times. Its use has effectively only prevented a bad situation from becoming worse.

11. Alongside increased WLI funding, the major systemic pressures arising from rising patient demand need to be addressed through significantly transforming HSC structures, including: making enhanced use of primary care to deliver routine elective procedures; delivering more routine elective procedures as day cases, thereby increasing throughput and capacity; and developing dedicated care facilities which `ring fence' elective capacity from unscheduled care pressures. However, funding constraints have again considerably restricted the Department's ability to progress transformation, including delivering a five-year elective care plan published in 2017.

12. Aside from the general worsening performance, the use of multiple HSC sites to deliver elective day case care means widely varying waiting times have arisen across individual trusts. The report highlights examples of how waits exceeding 52 weeks for the Dermatology, Gynaecology, Neurology, and Urology specialisms vary considerably across trusts. To try and address such variances and maximise available capacity, the Department has commenced important work to move more clinical specialisms to regional waiting lists, including for bladder outflow surgery and stones services. Currently only varicose vein and cataract procedures are managed regionally.

13. Elective capacity has also been reduced further by growing unscheduled care pressures. Dedicated elective facilities can help overcome this but, to date, the HSC sector has developed relatively limited dedicated capacity, with evidence indicating NI is behind the rest of the UK in this area. Varicose vein and cataract prototype day care centres opened in 2017 and 2018, and NI's first dedicated regional day care centre treating various specialisms (Lagan Valley Day Procedure Centre (LVDPC)) has operated since August 2020.

14. These centres worked at reduced capacity during the pandemic, but are now achieving full operational levels. Since the prototype centres were established, they have helped reduce varicose vein and cataract waiting lists from 1,417 to 887 and from 5,556 to 3,131 respectively. However, recent wider waiting list trends still suggest that further expansion of dedicated capacity across more specialisms is needed to more substantively reduce waiting times.

6 In addition to these in-year monitoring rounds, it is important to note that additional Confidence and Supply funding of around £33.8 million in 2018-19 and £22.3 million in 2019-20 was also made available to support elective care waiting lists.

15. In addition to the serious waiting time pressures which had been building for some years, COVID-19 further damaged elective capacity throughout 2020 and early 2021. Routine elective care was frequently halted, and staff redirected towards unscheduled pandemic pressures. Service delivery was further hindered by strict infection prevention and control (IPC) measures, and high HSC staff COVID-19 infection rates. HSC waiting times rose to their highest ever levels, with outpatient and hospital admission waits of over 52 weeks increasing by 62 and 123 per cent respectively between March 2020 and March 2021.

16. Trusts have compiled `Recovery Plans' from April 2021 which include proposals for restoring and increasing elective activity. However, slow progress means the HSC sector had been striving to return to pre-Covid activity levels by March 2023, with DoH setting trajectories for each trust to achieve this. Progress to date has been mixed. For the period July 2022 to March 2023, the level of recorded HSC outpatient activity was 2.6 per cent higher than the 2019-20 pre-COVID position, but hospital admission activity remained 2.5 per cent below this.

17. Our assessment of trust activity and productivity levels since 2013-14 confirms that these have not kept pace with rising patient demand, and that COVID-19 heightened these issues significantly. We found that:

- Annual **outpatient appointments**[7] fell from 1.54 million in 2015-16 to 1.46 million in 2019-20, with only 1.15 million and 1.35 million achieved in 2020-21 and 2021-22. This has increased to 1.41 million in 2022-23 meaning that pre-COVID levels have almost been restored.
- Outpatient appointments which patients **Do Not Attend (DNA)** and which are **cancelled by hospitals** represent lost HSC activity. DNAs remained fairly consistent prior to the pandemic, standing at 129,000 in 2019-20. Although reducing after that due to the impact of COVID-19, 117,000 and 124,900 DNAs were still recorded in 2021-22 and 2022-23 respectively. Whilst hospitals cancelled 167,200 outpatient appointments in 2013-14, this rose to 213,900 in 2019-20 . Cancellations then increased to 231,900 in 2020-21, and have remained high at around 203,000 in 2021-22 and 2022-23.
- Whilst trusts delivered 133,000 **operating theatre procedures** in 2013-14, this reduced to under 111,000 in 2019-20, and to 60,000 in 2020-21. The number of procedures has recovered to 98,200 in 2022-23, but this remains well below pre-pandemic levels. The falling trends partly reflect that long HSC waiting times are resulting in a need for more complex surgery, meaning fewer patients are being treated.

18. **Completed outpatient and inpatient waits**[8] measure patients progressing through key stages of the `patient journey'. The number of outpatient completions remained fairly static between 2013-14 and 2019-20 when they stood at 477,000 but fell to 312,000 in 2020-21. Whilst these had returned to 449,000 in 2022-23, this was again below pre-COVID levels. The 170,900 **inpatient completions** in 2019-20 was 17 per cent fewer than 2013-14 (206,700), reducing again to 93,000 in 2020-21, and only recovering to 133,000 in 2021-22. Similar to other indicators, pre-pandemic performance has not yet been restored.

7 Includes both initial and follow-up outpatient appointments.

8 When a referred patient receives an initial consultant-led outpatient appointment, their outpatient wait is recorded as having been `completed'. Similarly, a completed inpatient wait means someone has received the diagnostic tests and / or treatment required to address their condition.

19. The fact that activity levels have not kept pace with increased demand has clearly contributed to longer waiting times. DoH is working to try and improve HSC performance. However, waiting times will not start reducing meaningfully until activity considerably exceeding pre-Covid levels is achieved.

Previous initiatives to try and reduce waiting times have been unsuccessful

20. DoH attempted to reduce waiting times through publishing an *Elective Care Plan* in February 2017. However, its target of ensuring all patients waiting longer than a year for assessment or care, or 26 weeks for a diagnostic test, would be seen by March 2018, was comprehensively missed, and waiting times instead continued increasing. DoH attributed the non-achievement of this target to only £13 million additional WLI funding being made available in 2017-18, compared to the estimated £31.5 million required to clear long patient waits.

21. The Plan also committed to establishing regional dedicated centres to deliver elective activity. DoH projections in 2017 had suggested that over 133,000 adult and paediatric procedures could potentially be completed annually as day cases if adequate capacity was available. Whilst developing such capacity has simply not proved feasible, the five prototype centres (paragraph 13) treated 2,100 varicose vein and 18,900 cataract patients between 2019-20 and 2021-22. Since August 2020, the LVDPC has also delivered over 10,000 day cases.

22. In addition to more WLI funding, significantly greater longer-term transformation funding would have been required to fully implement the 2017 Plan. DoH had estimated the total costs of clearing patient backlogs and meeting longer-term demand as being between £859 and £909 million. In practice, only £136.5 million was invested in these areas between 2017-18 and 2021-22.

23. The *New Decade, New Approach (NDNA)* document subsequently published in January 2020 committed to introducing long-term funding mechanisms for HSC transformation, and a revised waiting times action plan, as well as improving elective day case care and assessing if RTT targets could be introduced. It pledged to clear long patient waits by March 2021, but the arrival of COVID-19 in NI only weeks after its publication significantly impeded DoH's ability to deliver the documents proposals. In any case, very significant funding would have been required to deliver it, and given previous experiences, there is no guarantee this would have been made available.

24. Within the period broadly between publication of the 2017 Plan and March 2021, waits exceeding 52 weeks for initial outpatient appointments and hospital admission, and 26 weeks for diagnostic tests increased by 257 per cent, 610 per cent, and 429 per cent respectively[9]. Whilst the pandemic contributed to more recent aspects of this deterioration, inadequate implementation of the 2017 Plan also represented a missed opportunity to begin addressing a problem which, whilst already serious, was then more manageable.

9 This analysis excludes Day Procedure Cases.

The Department has already stated that the current Framework will not achieve its waiting time targets by 2026, meaning many patients will continue to endure very lengthy waits

25. DoH published the current Elective Care Framework in June 2021. When published, it aimed to ensure that by March 2026, no-one should wait more than 52 weeks for a first outpatient appointment or inpatient treatment, or 26 weeks for a diagnostic test, and to eradicate the HSC demand/capacity gap and associated patient backlogs. However, these targets mean some patients may theoretically still have to wait up to two years between GP referral and hospital admission. The inability to set much stronger goals highlights how badly local performance had deteriorated at this stage.

26. The Framework's proposed improvements are being delivered through 55 actions. DoH had estimated in 2021 that £707.5 million additional investment would be needed between 2021-22 and 2025-26 to fully implement these. This is notably less than the estimated £859 to £909 million required to implement the previous 2017 Plan, despite waiting lists having considerably grown since then, and DoH acknowledges that the estimate may have to be reassessed.

27. DoH has allocated £192.8 million funding to deliver the Framework up to March 2023 (£183.2 million non-recurrent and £9.6 million recurrent funding). However, the NI Assembly's failure to ratify draft three-year budgets for NICS departments for 2022-25 before the Executive collapsed in February 2022 again created uncertainty over the availability of longer-term funding required to reduce waiting times. In October 2022, the Department conceded that "*without an agreed budget in place there remains uncertainty around the future implementation of the Framework. The ability to plan strategically continues to be hugely limited by the lack of a financial settlement*".

28. Positive outcomes achieved since the Framework's publication include significant additional elective activity delivered through the increased WLI funding provided in 2021-22 and 2022-23, and the ongoing development of further dedicated elective capacity, including establishing Omagh hospital as NI's second regional dedicated day centre, which will deliver around 1,300 additional urology and general surgery procedures annually from July 2023. In addition, three HSC hospitals[10] are to provide elective overnight stay centres, providing intermediate complexity surgery. Phased expansion of 21 new regional Post anaesthetic Care Unit elective beds will also improve patient outcomes and reduce inpatient cancellations.

29. However, in a May 2023 progress review, DoH evaluated 21 of the Framework's actions as having an amber RAG status and 5 as having a red status. More seriously, the review confirmed that as the necessary recurrent funding required to deliver key actions had not been provided, it would not now be possible to meet the Framework's targets as intended by March 2026. Instead, the Department is faced with an extremely challenging situation of having to implement the Framework as fully as possible from limited available and largely non-recurrent resources.

10 Mater Hospital (Belfast), South West Acute Hospital (Enniskillen) and Daisy Hill Hospital (Newry).

30. As paragraph 25 outlined, the Framework's targets could be viewed as relatively modest but achieving these would at least have brought some improvement to the current situation. It is therefore extremely concerning that the Department has conceded that these cannot be met less than halfway into the Framework's lifecycle. The Department also cannot currently set revised targets, as this would require a Ministerial decision. To have fully achieved the Framework's objectives, the significant non-recurrent funding committed would also needed to have been supported by sustained recurrent investment to help address the longstanding issue of demand outstripping capacity. Until and unless a more sustainable HSC funding framework is established, very significant numbers of patients will likely have to continue enduring very long waits.

31. Whilst the Department has conceded that the targets cannot now be met, achieving some improvement in waiting times is still crucial. At March 2023, the numbers on all HSC waiting lists had continued rising compared to March 2021, as had outpatient assessment waits exceeding nine and 52 weeks, and diagnostic test waits exceeding nine weeks. Improvements were however evident in 52 week inpatient waits (a reduction of 8.6 per cent), and 26 week diagnostic test waits (a 9.3 per cent reduction). Whilst this illustrates some impact from the increased WLI funding provided in 2021-22, further improvements are unlikely without a more sustainable funding framework to support HSC reconfiguration and transformation.

32. Our review concludes by assessing what further progress is required across three important themes to help reduce waiting times. We found that:

- A strong and fully equipped workforce is essential to reduce waiting times. Whilst the HSC elective care workforce has grown in recent years, vacancy levels remain high, indicating that further work is required to build a workforce capable of coping with rising patient demand.
- Until the HSC builds sufficient permanent capacity, significantly enhanced use of the IS will be necessary to clear current patient backlogs, but greater clarity is required in defining the nature and extent of its role, and in agreeing longer-term contractual arrangements with IS providers.
- Funding constraints have hindered plans to expand the use of primary care in 2022-23 to treat elective patients, and also threaten further expansion for 2023-24 and 2024-25. If these difficulties cannot be overcome, the various benefits envisaged will not be fully realised.

Conclusions and Recommendations

It is important to recognise the substantial efforts made by HSC staff over the last decade to try and cope with rising patient demand and the severe disruption more recently caused by COVID-19, alongside the tight financial environment trusts have been operating in. Nonetheless, the deterioration in waiting time performance since 2013-14 to a point where significantly increasing numbers of patients risk developing serious conditions and illnesses which damage their daily lives, and which ultimately become much more complex and expensive to treat, represents extremely poor value for money. Given that the Department has now stated that it will not be possible to meet the current Framework's targets by 2026, there is a risk that the current serious situation could further deteriorate, potentially placing the HSC under intolerable pressure. It is now imperative that the necessary funding is allocated as soon as feasible to both clear patient backlogs and drive longer-term HSC transformation. In turn, the HSC must demonstrate how it can use both existing resources and any additional funding provided to maximum effect and achieve the Framework's stated objectives and goals.

Recommendation 1

The very long waiting times across all the main elective specialisms further underlines the range and scale of difficulties facing stakeholders. The Department and trusts should review the key causal factors influencing outcomes across the various elective specialisms and assess if action plans in place to address these need to be radically strengthened. Waiting list pressures are currently particularly acute for Neurology, Dermatology, ENT and General Surgery (initial outpatient appointments) and ENT, T&O Surgery, and General Surgery (hospital admission).

Recommendation 2

To support the introduction of local RTT measurement and targets, DoH must strive to ensure that the Encompass programme remains on course for implementation by its scheduled deadlines, and that it is fully capable of such reporting. In the interim, it should use the December 2022 comparative figures as a baseline and continue regularly monitoring performance on that basis, to determine if the HSC performance gap with England and Wales is narrowing or increasing, and also identify if any best practice there, which has helped ensure performance has not deteriorated to the same extent, can be further implemented locally.

Recommendation 3

Whilst action is underway to try and address issues around trust performance and patient DNAs, and the Department is now trying to centrally drive improvements, the Department and trusts now need to explicitly quantify the increased capacity and activity required to sustainably reduce waiting times, and assess how this can be achieved at each trust, through both improving the efficiency of current operations and progressing HSC transformation.

Recommendation 4

We recommend that the Department identifies the investment necessary to ensure the HSC sector can function more efficiently and sustainably, including reducing waiting times to targeted levels. It should also demonstrate and quantify, in business case terms, if such investment can ultimately secure better longer-term value for money and patient outcomes, and the likely implications of failing to secure such funding. This will help DoH demonstrate how more sustainable funding arrangements can better support its objectives.

Recommendation 5

As DoH and the Trusts seek to incrementally build increased dedicated elective capacity, they should monitor its impact on waiting times, and assess whether the additional facilities are having the desired success and impact. If waiting times are not reducing appreciably, they should assess the extent of further dedicated capacity required across key specialisms.

Recommendation 6

Given the current situation, the Department should firstly confirm the robustness of its estimate of the funding required to fully implement the Framework in preparation for any potential introduction of long-term budgets. Until it has greater certainty on the availability of recurrent funding, it should rank or prioritise the actions likely to have greatest impact on waiting times and allocate available recurrent and non-recurrent funding towards these on this basis. The Department should set revised Framework targets as soon as feasible.

Recommendation 7

The limited implementation of previous strategies means the Department's regular progress assessments on the Framework is welcome. Going forward, these should identify the specific work which must be progressed over the next reporting period to ensure milestones are met, who is responsible for driving this, progress against targets and timelines, and whether emerging evidence means any actions should be redesigned or reprioritised. Progress should continue being publicly reported, setting out why any actions are behind schedule, and whether, and how, this can be rectified.

Recommendation 8

Close working between the various stakeholders involved in workforce-related issues is required, to ensure stronger elective care workforce planning. The stakeholders should now take stock of how their work is progressing and collectively agree the priority areas which require further attention to ensure the HSC elective workforce has the right capacity and capability to drive HSC transformation. Based on the current situation and workforce deficits, revised projections and plans should be developed, together with targets and strategies for achieving these.

Recommendation 9

Increased use of the IS is likely to be necessary for the foreseeable future to address the colossal patient backlog. In preparation for any progress in approving multi-year budgets, DoH should set out its strategic plans for expanding use of the IS, and continue to clarify with the sector the degree to which it can build additional capacity to help clear the backlogs.

Part One:
Introduction and Background

Introduction and Background

1.1 Elective care is planned in advance, unlike emergency or unscheduled treatment. It generally follows referral from general practitioners (GPs) or other primary or community health professionals, and involves specialist clinical assessment and subsequent care or treatment, including diagnostic tests, surgery, other treatments and therapies. Whilst mainly delivered in hospitals and other secondary care settings, primary care can also deliver less complex elective procedures.

1.2 In Northern Ireland (NI), patient waiting times for elective assessment and treatment delivered by the five health and social care (HSC) Trusts[11] are measured across the separate stages of the `patient journey'. The Department of Health (DoH or the Department) monitors and reports waiting times for a first consultant-led outpatient appointment, subsequent hospital admission either as an inpatient or day case (if required), and / or diagnostic tests, and publishes official data quarterly. Formal targets are set annually **Figure 1** shows the current targets.

Figure 1: Current HSC elective care waiting time targets

- at least **50%** of people should wait no longer than **9 weeks** for an initial consultant-led **outpatient appointment**
- **no-one** should wait longer than **52 weeks** for an initial **outpatient appointment**

- **75%** of people should wait no longer than **9 weeks** for a **diagnostic test** and **no-one** should wait longer than **26 weeks**

- at least **55%** of people should wait no longer than **13 weeks** for **inpatient treatment** either through hospital admission or a day case
- **no-one** should wait longer than **52 weeks** for **inpatient treatment**

Source: DoH.

1.3 If patients do not receive timely assessment and treatment, lengthy waits mean they can suffer detrimental impacts, which may include:

- living longer with the consequences of debilitating conditions;
- conditions worsening, meaning more complex and expensive treatment might be required;
- mental health, quality of life and financial wellbeing deteriorating if, for example, people cannot remain in employment; and
- in extreme circumstances, conditions becoming permanent and untreatable.

11 The Belfast, Southern, South Eastern, Northern and Western HSC Trusts deliver elective care internally or can commission Independent Sector (IS) providers to assess and treat patients for them.

Performance trends have deteriorated hugely since 2014

1.4 Despite these potential implications, DoH has met none of its elective waiting time targets at the NI level since 2013-14. The number of people waiting for assessment and treatment and the length of waiting times have grown rapidly. Recent estimates indicate that one in four people in NI are now on a HSC waiting list[12]. At March 2023, over 197,000 people were waiting longer than a year for an initial outpatient appointment, 64,500 were waiting longer than this for hospital admission, and 46,500 were waiting over 26 weeks for a diagnostic test. Waits exceeding these maximum time targets have increased since March 2014 by 929 per cent, 1,396 per cent, and 381 per cent (from March 2017) respectively **(Figure 2)**.

Figure 2: HSC elective waiting lists and waiting times have grown very significantly between 2014 and 2023

Area of care provision	Numbers on waiting list at March 2014 – March 2023 and % increase	Waiting time trends March 2014 to March 2023 (numbers and % increase)
Elective Care - Outpatients	Increased from 127,095 to 401,201 **(216%)**	Waiting > 9 weeks - increased from 39,768 to 326,241 **(720%)** Waiting longer than maximum waiting time – increased from 19,173 to 197,345 **(929%)***
Elective Care - Inpatients	Increased from 49,341 to 121,879 **(147%)**	Waiting > 13 weeks – increased from 16,356 to 94,305 **(477%)** Waiting longer than maximum waiting time – increased from 4,312 to 64,513 **(1,396%)****
Elective Care - Diagnostic Testing	Increased from 69,042 to 173,242 **(151%)**	Waiting > 9 weeks – increased from 10,479 to 89.587 **(755%)** Waiting > 26 weeks – increased from 9,675 to 46,511 **(381%)** (March 2017 – March 2023)

* target was strengthened from 18 weeks to 15 weeks in 2014-15 but then lowered back to 18 weeks in 2015-16 and lowered again to 52 weeks from 2016-17

** target was lowered from 26 weeks to 52 weeks in 2016-17

Source: NIAO, based on DoH published waiting time statistics.

12 One Year Post Publication Monitoring Report `More than a Number' – Northern Ireland Commissioner for Children and Young People (NICCY) October 2022.

Figure 2a: Numbers on waiting list for Elective Care - Outpatients at March 2014 and March 2023

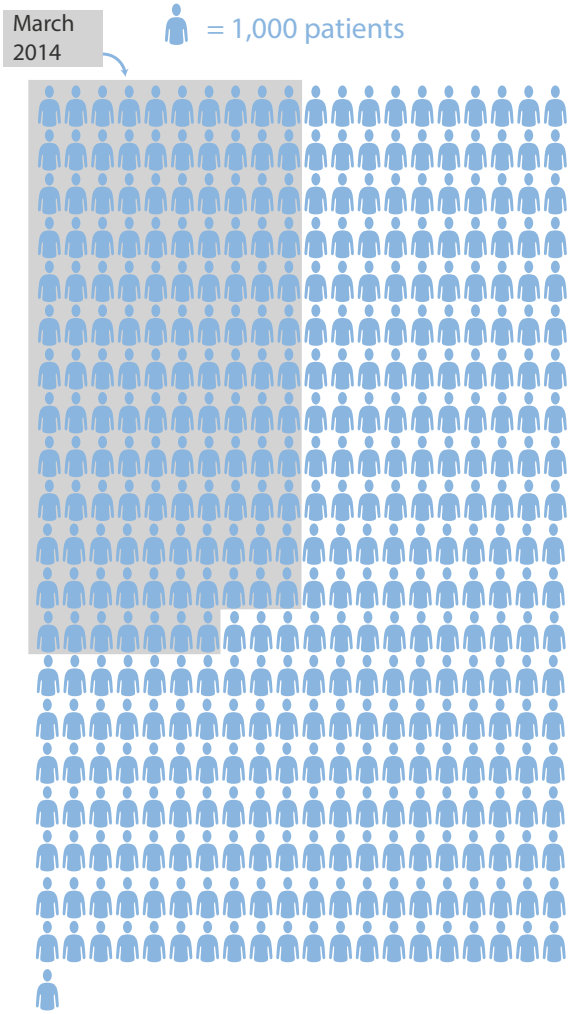


Figure 2b: Patients waiting more than 9 weeks for Elective Care - Outpatients at March 2014 and March 2023

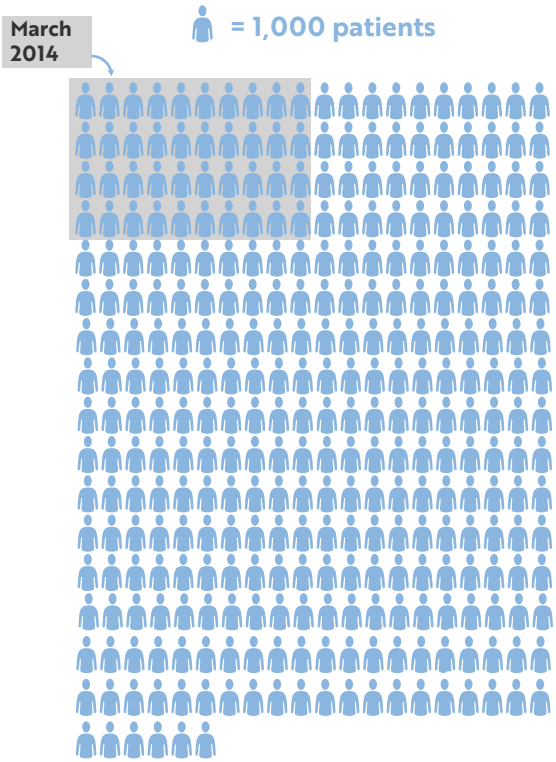
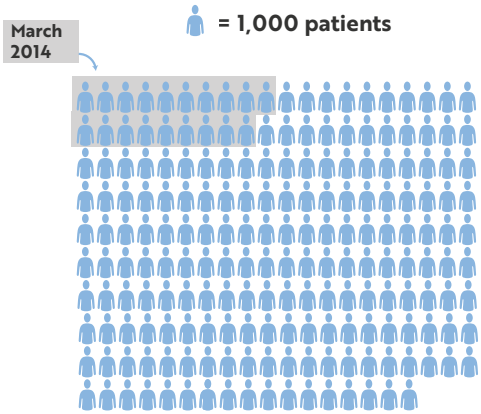


Figure 2c: Patients waiting longer than maximum time* for Elective Care - Outpatients at March 2014 and March 2023



**target was strengthened from 18 weeks to 15 weeks in 2014-15 but then lowered back to 18 weeks in 2015-16 and lowered again to 52 weeks from 2016-17*

Figure 2d: Numbers on waiting list for Elective Care - Inpatients at March 2014 and March 2023

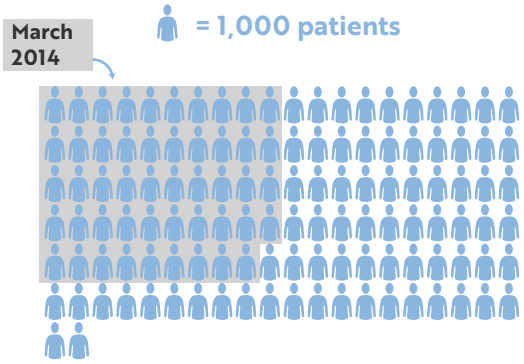


Figure 2e: Patients waiting more than 13 weeks for Elective Care - Inpatients at March 2014 and March 2023

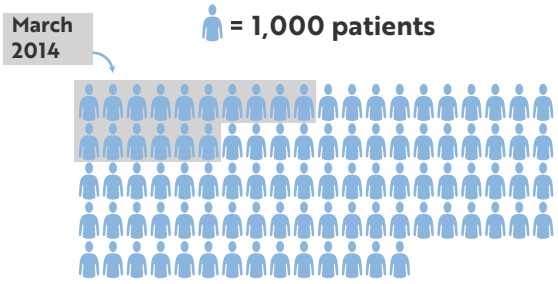
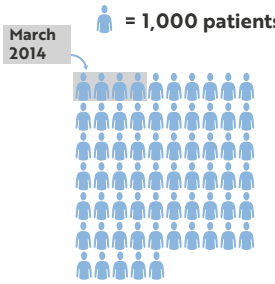


Figure 2f: Patients waiting longer than maximum time for Elective Care - Inpatients at March 2014 and March 2023**



***target was lowered from 26 weeks to 52 weeks in 2016-17*

Figure 2g: Numbers on waiting list for Elective Care - Diagnostic Tests at March 2014 and March 2023

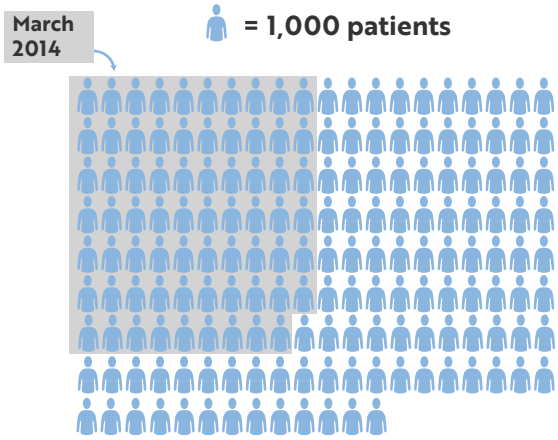


Figure 2h: Patients waiting more than 9 weeks for Elective Care - Diagnostic Tests at March 2014 and March 2023

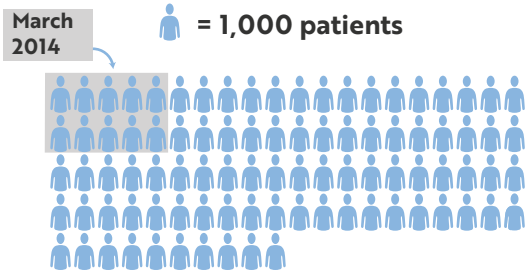
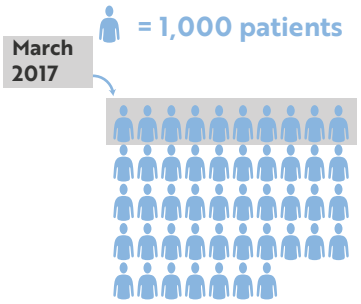


Figure 2i: Patients waiting more than 26 weeks for Elective Care - Diagnostic Tests at March 2017 and March 2023



Source Figures 2 (a) to 2 (i): NIAO, based on DoH published waiting time statistics.

1.5 Waiting times have also increased considerably since 2014 across all five HSC trusts[13], and for all the main elective specialisms, particularly for Neurology, ENT[14], Ophthalmology, T&O Surgery[15] and General Surgery. Significant variances in waiting times also exist for some specialisms across different trusts, illustrating access disparities depending on demand, capacity and performance across the trusts.

1.6 Comparing local waiting times with the rest of the UK is difficult because performance there is measured through more transparent `Referral to Treatment' (RTT) targets which track the time taken to complete the entire `patient journey', rather than the individual stages measured in NI. Nonetheless, available information indicates that NI has had the worst UK performance for some time. At December 2022, 51 per cent of people on local waiting lists were waiting longer than 52 weeks for an initial outpatient appointment or hospital admission, compared to 5.4 per cent waiting longer than this on the overall RTT waiting list in England, and 33.8 per cent waiting longer than a maximum 36 week target on the Welsh RTT pathway.

Waiting times have increased for various reasons, and efforts to improve performance have been unsuccessful to date

1.7 The serious and sustained increases in local waiting times have been significantly influenced by a widening gap between rising demand for care from an increasingly older population which is developing more long-term clinical conditions, and insufficient available funding to ensure existing HSC care models can adequately meet this. Other causal factors include HSC workforce shortages, growing unscheduled and emergency care pressures further reducing available elective capacity, HSC activity levels not keeping pace with demand, and slow progress in transforming and modernising current HSC models and structures to ensure they can better cope with rising demand. COVID-19 further seriously impacted elective capacity in 2020 and 2021, when waiting times reached their highest-ever levels.

1.8 Funding constraints have particularly contributed to the worsening performance. Whilst supplementary non-recurrent funding provided `in-year' helps Trusts purchase additional Waiting List Initiative (WLI) activity internally or from the independent sector (IS), its availability has fluctuated considerably. Compared to an annual average of £19.6 million made available between 2012-13 and 2016-17, this reduced to only £3.5 million between 2017-18 and 2019-20, although the £61.5 million allocated in 2021-22 enabled some of the HSC backlog to be addressed. However, this funding has limited impact as it only addresses immediate pressures. Available funding has also been inadequate to support the longer-term HSC transformation required to sustainably reduce waiting times.

13 The Belfast, Northern, South Eastern, Southern and Western HSC Trusts.
14 Ear, Nose and Throat.
15 Trauma and Orthopaedic Surgery.

1.9 To try and address the serious performance shortcomings, the Department's *Elective Care Plan* (2017), and the 2020 *New Decade New Approach (NDNA)* document[16] both included proposals and targets for eradicating long waiting times, but in addition to funding and organisational barriers, implementation was impeded by the collapse of the Executive in early 2017, and then by the impact of COVID-19. Consequently, neither initiative came remotely close to achieving their targets and aspirations, and waiting times continued growing.

1.10 The number of patients now enduring very long waits means the Department and HSC trusts face huge challenges in rectifying the situation. Significantly increased funding and stronger planning and oversight is required to deliver meaningful improvements. In June 2021, DoH published the `*Elective Care Framework Restart, Recovery and Redesign*' (the Framework), its latest five-year plan for waiting times spanning 2021-22 to 2025-26.

1.11 This was aiming to clear the patient backlog and build sufficient additional HSC capacity to maintain waiting times at `acceptable' standards, so that, by March 2026, no-one should wait more than 52 weeks for a first outpatient appointment or inpatient treatment, or 26 weeks for a diagnostic test. DoH had estimated that £708 million additional funding would be needed over this period to deliver the Framework. However, in May 2023 it announced that the significant recurrent investment required to support this had not yet been provided, meaning the targets could not now be met by 2026. This clearly represents a very disappointing outcome which could have significant implications for the large number of people currently on HSC waiting lists.

What this review examined

1.12 We assessed:

- performance against the elective care waiting time targets at NI level since 2013-14, and across individual trusts and care specialisms since 2017-18, also comparing, where possible, local performance with the rest of the UK (**Part 2**);
- the key reasons why local waiting times have increased so (**Part 3**);
- why previous initiatives aimed at reducing waiting times had limited success (**Part 4**); and
- progress in implementing the current Elective Care Framework, and the key remaining challenges if waiting list numbers and waiting times are to be substantially reduced (**Part 5**).

How we carried out the review (our methodology)

1.13 We completed this review by:

- reviewing performance data for elective care waiting times and for the levels of HSC elective activity since March 2014.
- reviewing key documentation, including DoH and HSC trust waiting time strategies.
- where possible, benchmarking HSC performance with the rest of the UK.
- engaging with local representatives of the Royal College of Surgeons of England, and the NI branch of the Royal College of Nursing.

16 NDNA represented the agreement reached in January 2020 by the main local political parties to restore devolved government in NI.

Part Two:

Waiting time targets and performance

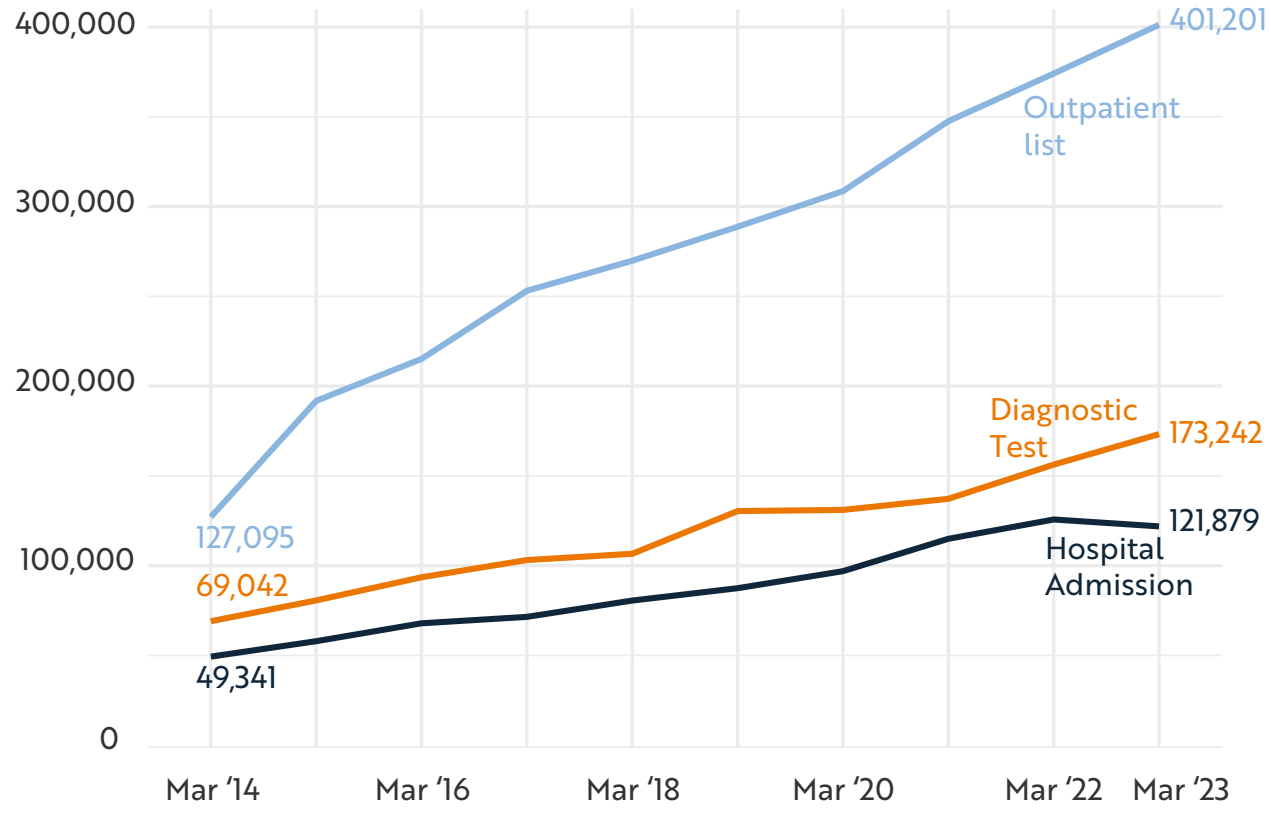
An increasing gap between patient demand and funded HSC capacity has contributed to HSC waiting lists growing sharply

2.1 The number of people waiting for HSC assessment and treatment has risen very steeply between March 2014 and March 2023:

- from 127,095 to 401,201 (216 per cent), for an initial outpatient appointment.
- from 49,341 to 121,879 (147 per cent) for hospital admission.
- from 69,042 to 173,242 (151 per cent), for a diagnostic test **(Figure 3)**.

Figures for the quarter ending June 2023 suggest that the outpatient waiting list has further risen to 416,000, with the waiting list for diagnostic tests increasing to 189,000. There has however been a slight reduction in the waiting list for hospital admission (to 119,100).

Figure 3: The number of people on elective care waiting lists in NI has consistently risen since 2014



Source: DoH.

2.2 Patient demand for HSC services has been increasing rapidly for some time, reflecting a population which is living longer but developing multiple and complex long-term conditions. HSC staff have faced significant challenges in trying to cope with these rising

pressures, and the gap between demand and the funded HSC capacity available to meet it has also grown considerably. In 2020-21 alone, the HSC estimated that it had insufficient capacity for around 50,000 outpatient appointments, 38,000 inpatient and day case admissions, and 153,000 diagnostic tests. This has inevitably contributed to significant growth in both the numbers on HSC waiting lists, and length of waiting times.

Although waiting time targets have been made less challenging, none have been achieved at NI level in any year since 2013-14

2.3 To try and improve waiting time performance, DoH strengthened most of its targets in 2014-15. As waiting times increased, it then revised most targets downwards in 2015-16, and significantly lowered all targets again in 2016-17, to what remain their current levels. However, none of the targets have been achieved at the overall NI level at the March year-end in any year since 2014 **(Figure 4)**.

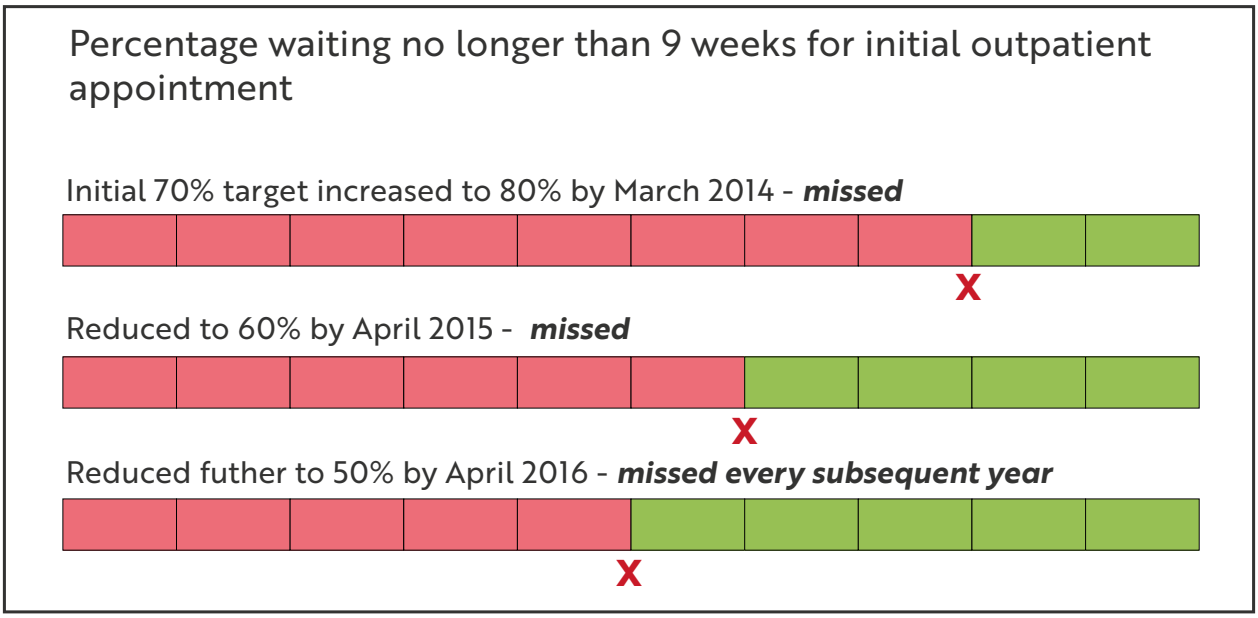
Figure 4: None of the elective care waiting time targets were achieved at NI level between 2013-14 and 2022-23

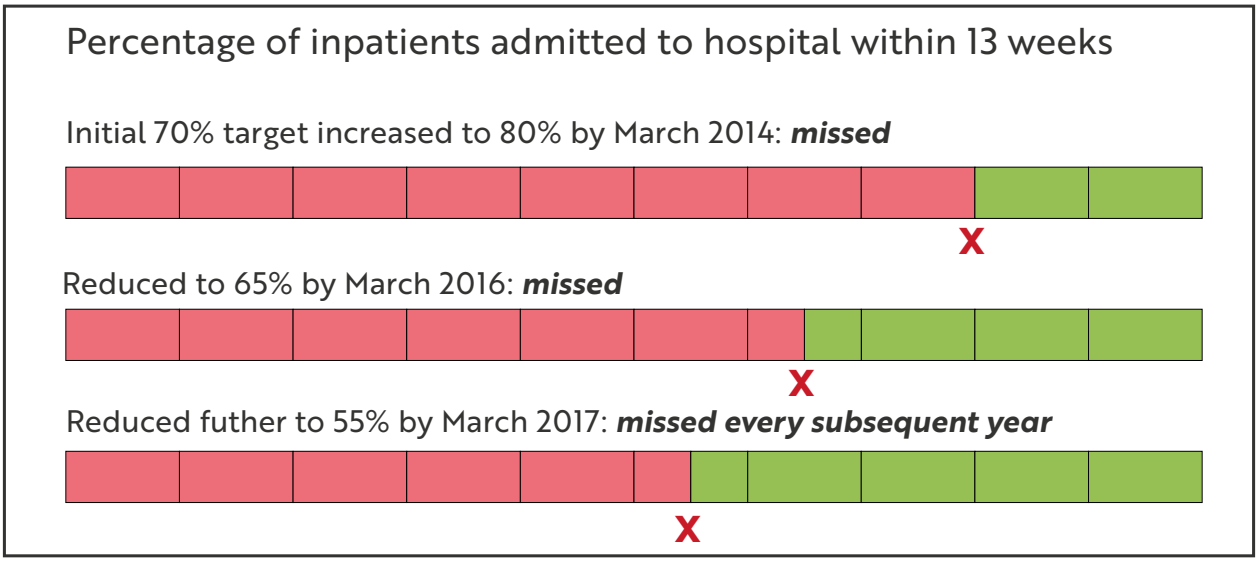
Target details	2013-14	2014-15	2015-16	2016-17 to 2022-23	Target achieved in any year between March 2014 and March 2023
% waiting no longer than 9 weeks for initial outpatient appointment	At least 70% at April 2013, rising to 80% by March 2014	At least 80%	At least 60%	50%	X
Maximum waiting time for initial outpatient appointment	18 weeks at April 2013, changing to 15 weeks by March 2014	15 weeks	18 weeks	52 weeks	X
% of inpatients admitted to hospital within 13 weeks	At least 70% at April 2013, rising to 80% by March 2014	At least 80%	At least 65%	55%	X
Maximum inpatient and day case waiting times	30 weeks at April 2013, changing to 26 weeks by March 2014	26 weeks	26 weeks	52 weeks	X
Diagnostic test waiting times	No longer than 9 weeks	No longer than 9 weeks	No longer than 9 weeks	75% should wait no longer than 9 weeks and no-one waiting longer than 26 weeks	X

Source: NIAO based on DoH published data.

Figure 4a: Performance against elective care waiting time targets at NI level 2013-14 to 2022-23

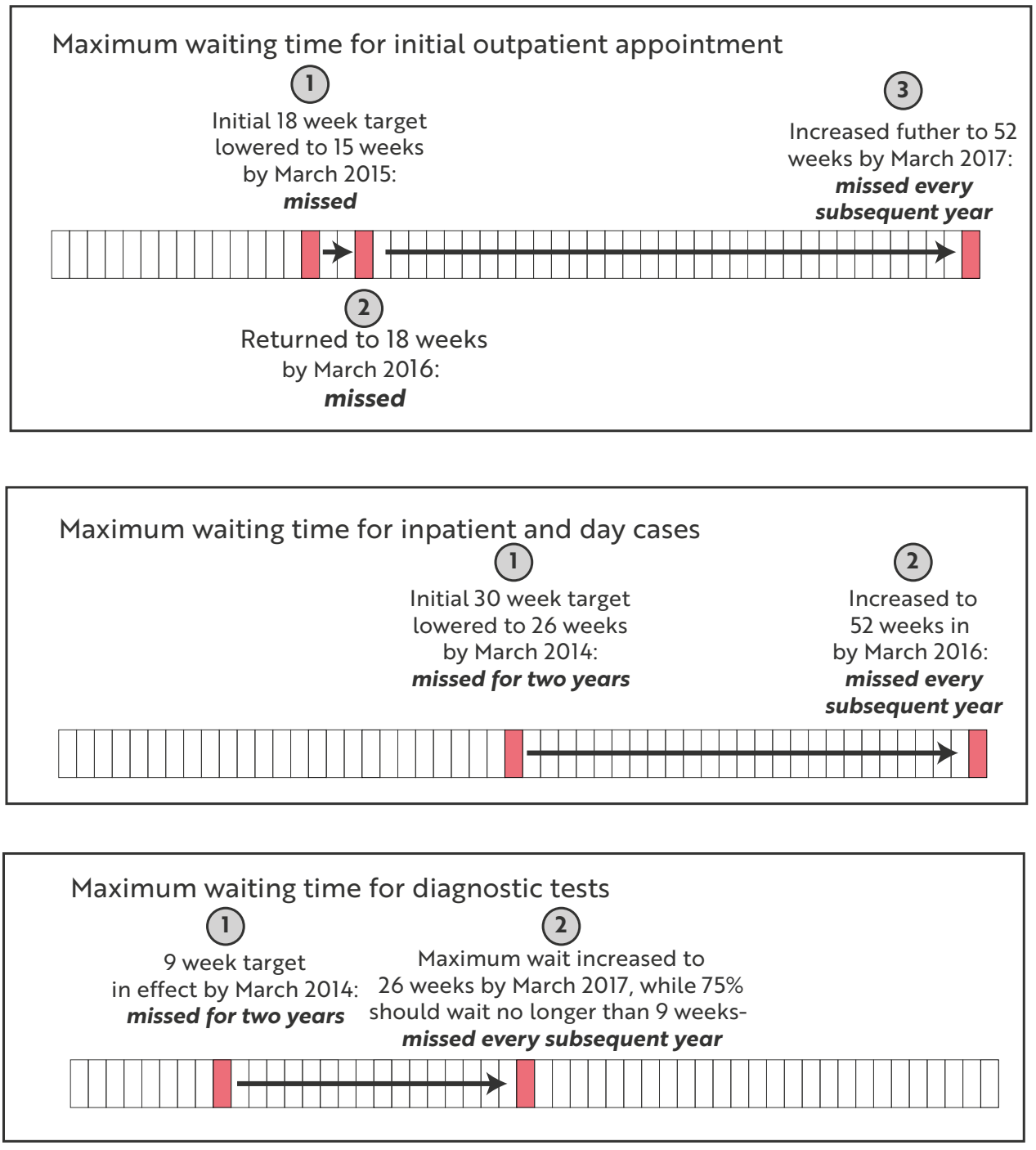
A range of waiting time targets have been adjusted since 2013-14 to make them more attainable - NI Health Trusts have still collectively continued to fail to acheive these revised targets.





Source: NIAO based on DoH published data.

Figure 4a (continued): Performance against elective care waiting time targets at NI level 2013-14 to 2022-23



Source: NIAO, based on published DoH data.

2.4 In addition to the targets being made less challenging, measurement and reporting of waiting times for outpatient appointments currently only focuses on initial appointments, with no formal assessment of review and follow-up waiting times. The Department highlighted that such measurement is problematic as timescales for reviews are set by clinicians and will vary depending on individual patients and their conditions. However, review and follow-ups account for around 68 per cent of outpatient appointments, and little information is currently available on patient waits for these.

2.5 We assessed the following areas of performance:

- overall NI level trends since March 2014 (paragraphs 2.6 to 2.8 and **Figures 5 to 7**).
- outcomes for individual trusts since March 2018 (paragraphs 2.10 to 2.14 and **Figures 8 to 13**).
- waits for some of the key elective specialisms since March 2018 (paragraphs 2.15 and 2.16 and **Figures 14 and 15**).

Our analysis illustrates how badly performance has deteriorated for all indicators, and how this further worsened in 2020-21 and 2021-22, when Covid-19 seriously disrupted the delivery of HSC elective services.

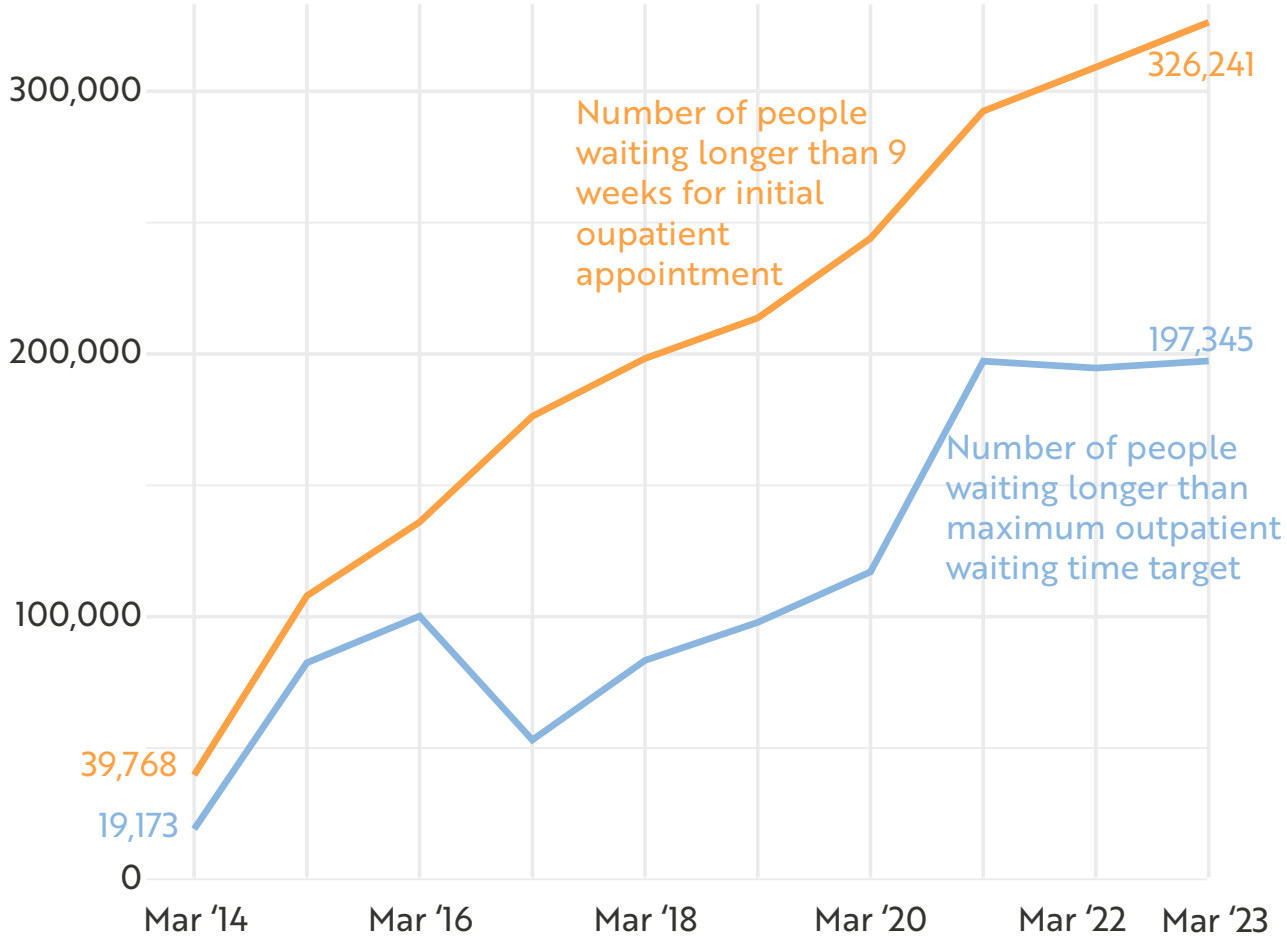
Initial outpatient appointments – NI level

2.6 The number of people waiting for an initial outpatient appointment, and the length of time they have been waiting, has increased very significantly since 2014:

- The number of people waiting longer than nine weeks has increased by 720 per cent, to over 326,200 at March 2023[17] (81 per cent compared to the 50 per cent target).
- The numbers waiting longer than the maximum waiting time target has increased by 929 per cent. At March 2023, over 197,300 patients were waiting longer than 52 weeks (49 per cent compared to target requirements that no one should wait this long) **(Figure 5)**. At that date, 117,400 patients (29 per cent) had been waiting over two years.

17 Analysis based on the quarter ending March for each year.

Figure 5: Number of people waiting longer than 9 weeks and the maximum waiting time for an initial outpatient appointment March 2014 to March 2023



*note – the maximum target was changed from 18 weeks to 15 weeks in 2014-15 but then lowered from 18 weeks to 52 weeks from 2016-17.

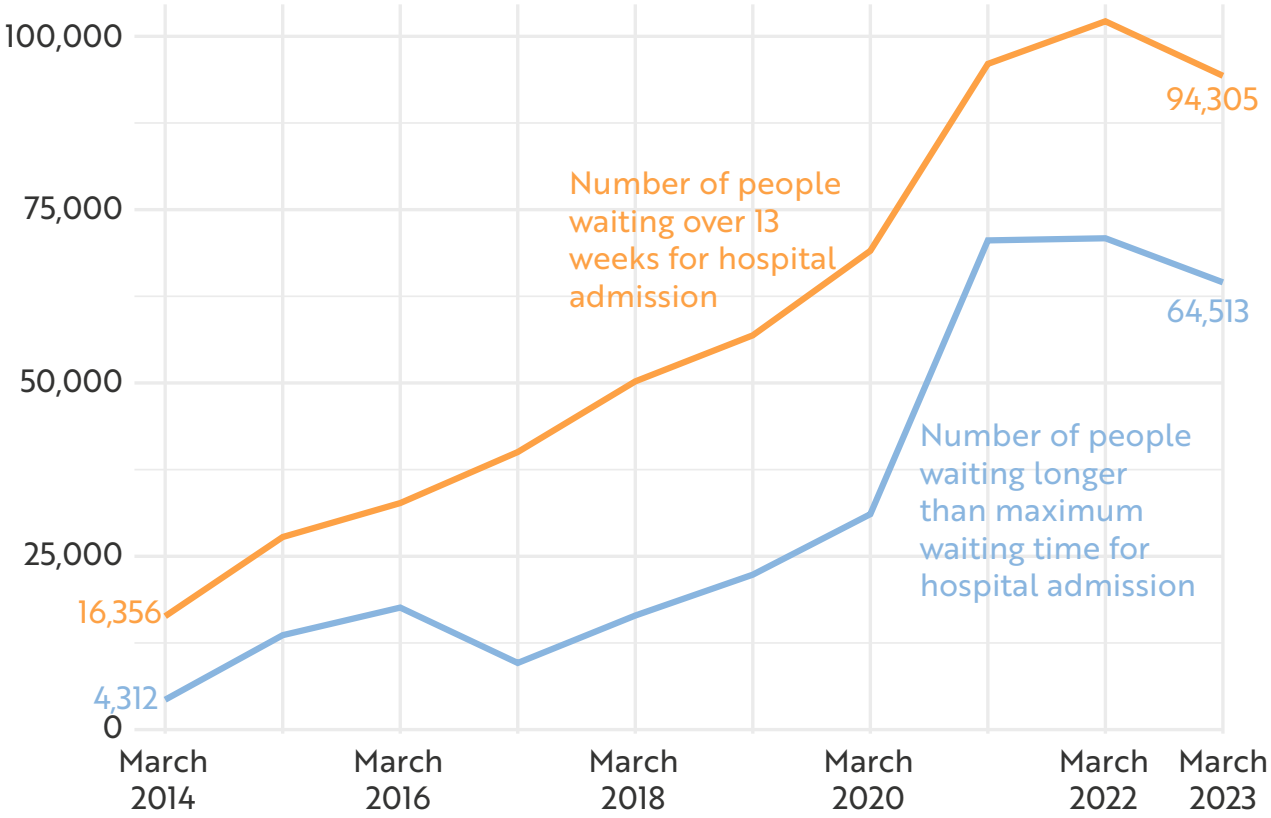
Source: DoH.

Hospital admissions – NI level

2.7 There have been significant increases in the number of people waiting for hospital admission, and the length of waits since March 2014:

- The numbers waiting longer than the 13 weeks target increased by 477 per cent, to over 94,300 at March 2023 (77 per cent of patients).
- Some 64,500 people were waiting longer than a year at March 2023 (53 per cent) **(Figure 6)**. At that date, almost 44,500 patients (37 per cent) had waited over two years.

Figure 6: Number of people waiting longer than 13 weeks and longer than maximum waiting time target for hospital admission March 2014 to March 2023



*note – the maximum target was lowered from 26 weeks to 52 weeks in 2016-17.

Source: DoH.

Diagnostic Tests – NI level

2.8 The number of patients waiting for a diagnostic test, and the length of their wait has risen very significantly in recent years:

- The numbers waiting longer than the nine weeks target increased by 755 per cent between March 2014 and March 2023, when it stood at almost 89,600 (52 per cent compared to the 25 per cent target).
- The numbers waiting longer than the maximum 26 weeks requirement increased by 381 per cent between March 2017 and March 2023, from under 9,700 to 46,500 (27 per cent of patients compared to the target that no one should wait this long) **(Figure 7)**.

Figure 7: Number of diagnostic tests not completed within nine weeks (March 2014 and March 2023) and 26 weeks (March 2017 and March 2023)

	March 2014	March 2023	Overall % increase March 2014 to March 2023
Numbers of tests exceeding 9 week target	10,479	89,587	755%
Numbers of tests exceeding 26 week target	9,675 (March 2017)	46,511	381% *

*supplementary target was introduced in 2016-17 so table shows the overall percentage increase March 2017 and June 2023.

Source: DoH.

Many children experience very lengthy waits for assessment and treatment

2.9 Given the overall performance trends, analysis published by the Northern Ireland Commissioner for Children and Young People (NICCY) in October 2022 unsurprisingly also highlighted stark increases in HSC waiting times for people aged under 18. For example, the number of children waiting for initial outpatient appointments and hospital admission both increased by 45 per cent between 2017 and 2022 (from 26,696 to 38,628 and from 7,178 to 10,371 respectively). Moreover, NICCY highlighted that at April 2022:

- over 15,700 children were waiting longer than a year for an initial outpatient appointment, with over 8,600 waiting between two and four years, and 1,450 over four years.
- over 5,400 were waiting longer than a year for hospital admission, with 3,500 waiting between two and four years, and over 600 waiting longer than four years.

The Royal College of Surgeons of England (RCS England)[18] confirmed considerable problems in this area, telling us that, until relatively recently, a sizeable number of children in NI were having to wait four or five years for routine procedures. A September 2022 Academy of Medical Royal Colleges[19] report highlighted one case in NI in which a 13 year-old boy waited so long for an appointment that he was actually over 18 by the time he was seen, and then had to join another waiting list to be seen by an adult urology specialist.

18 For this examination we liaised with the NI Director of RCS England and his staff.

19 Fixing the NHS – Why we must stop normalising the unacceptable.

Conclusions

The huge increases in waiting times at the overall NI level since 2014 show how seriously patient needs have not been met, and despite some marginal improvements for lengthy hospital admission and diagnostic test waits in 2023, performance has now reached extremely concerning levels. Moreover, the degree to which the targets have been reduced and then missed calls into question their ongoing purpose and relevance. The Department and HSC trusts now face immense challenges in trying to address the very concerning situation.

Trust's performance

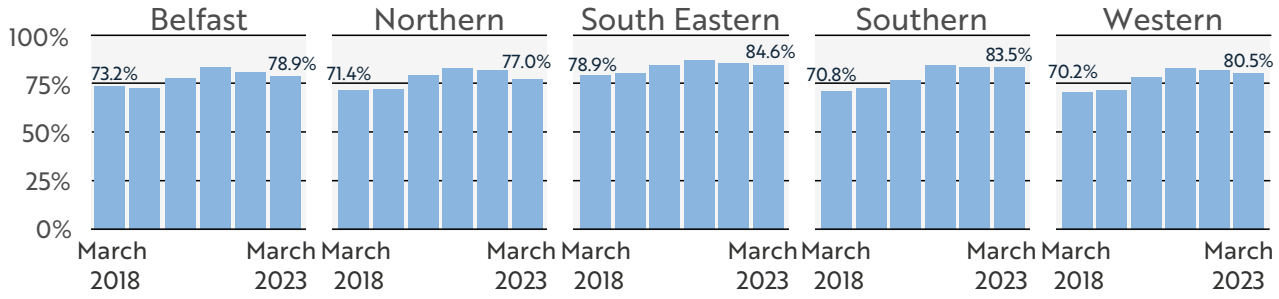
2.10 Our review of performance across the five HSC Trusts showed that none of these achieved any of the lowered elective targets at the in-year `point in time' position in any year since 2017-18[20], with the minor exception of the Western Trust delivering over 75 per cent of diagnostic tests within nine weeks in that year.

Initial outpatient appointments – trust level

2.11 Waiting times have increased significantly across all trusts since March 2018. At March 2023:

- between 77 per cent and 85 per cent of people were waiting more than nine weeks across all Trusts **(Figure 8)**.
- waits exceeding 52 weeks ranged from 40 per cent (Northern Trust) to 58 per cent (South Eastern Trust) **(Figure 9)**.

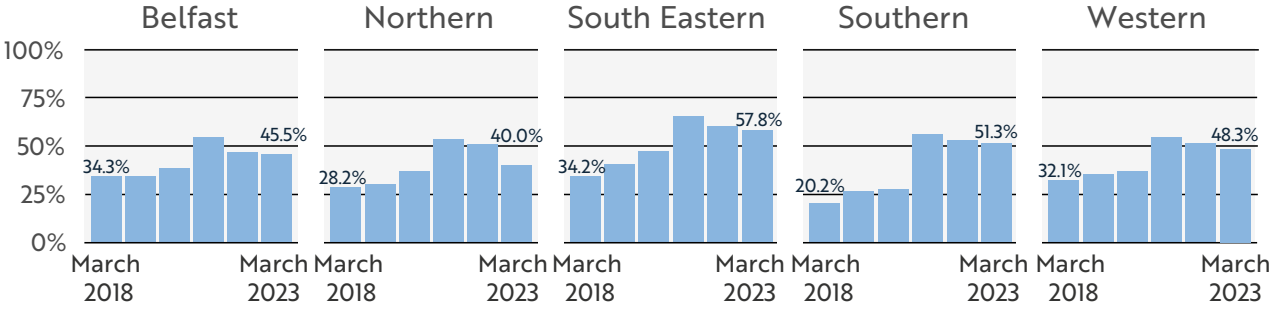
Figure 8: Percentage of people waiting longer than 9 weeks for initial outpatient appointment March 2018 to March 2023 by trust



Source: DoH

20 Analysis based on the year end point in time position i.e. quarter ending March for each year.

Figure 9: Proportion of people waiting longer than 52 weeks for an initial outpatient appointment March 2018 to March 2023 by trust



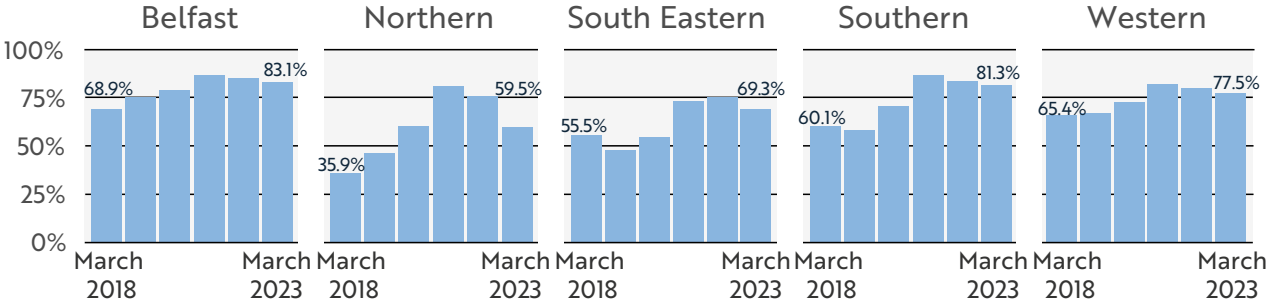
Source: DoH

Hospital admissions – trust level

2.12 Waiting times have again risen sharply at all trusts, and at March 2023:

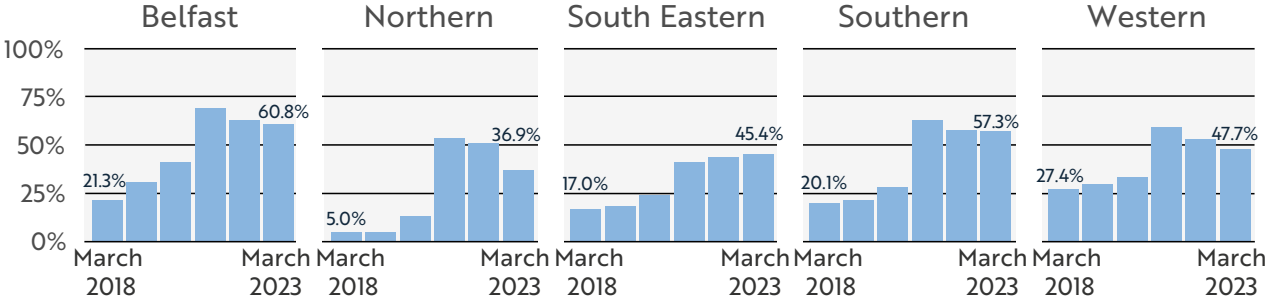
- over 59 per cent of patients were waiting longer than 13 weeks at all trusts, ranging from 60 per cent (Northern Trust) to 83 per cent (Belfast Trust) **(Figure 10)**.
- waits exceeding 52 weeks ranged from 37 per cent (Northern Trust) to 61 per cent (Belfast Trust) **(Figure 11)**.

Figure 10: Proportion of people waiting longer than 13 weeks for hospital admission March 2018 to March 2023 by trust



Source: DoH

Figure 11: Proportion of people waiting longer than 52 weeks for hospital admission March 2018 to March 2023 by trust



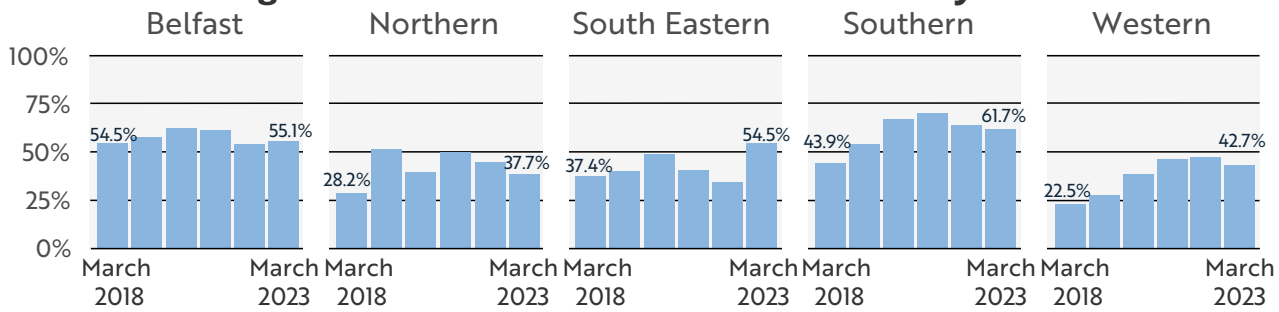
Source: DoH

Diagnostic tests - trust level

2.13 The proportion of diagnostic tests not delivered within the nine and 26 weeks targets has increased across all Trusts since March 2018. At March 2023:

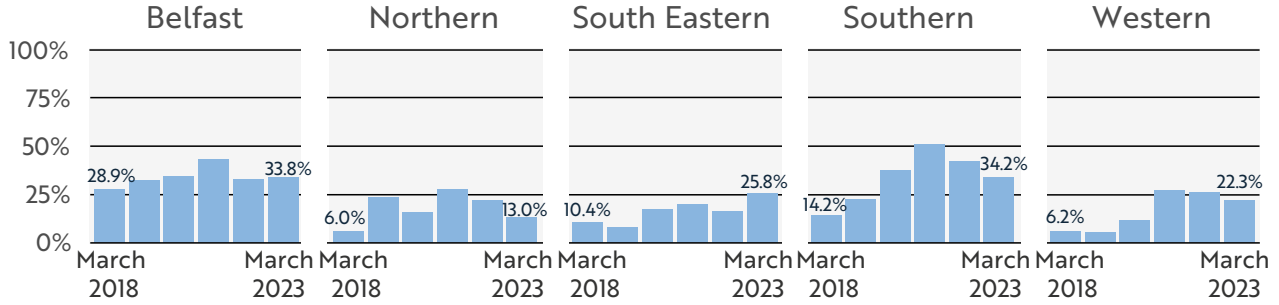
- waits over nine weeks ranged from 38 per cent (Northern Trust) to 62 per cent (Southern Trust) **(Figure 12)**.
- over 34 per cent of patients at the Southern Trust were waiting longer than 26 weeks **(Figure 13)**.

Figure 12: Proportion of people waiting longer than 9 weeks for diagnostic tests March 2018 to March 2023 by trust



Source: DoH

Figure 13: Proportion of people waiting longer than 26 weeks for diagnostic tests March 2018 to March 2023 by trust



Source: DoH

2.14 Whilst DoH regularly monitors waiting times and activity levels achieved by the individual trusts, it has not yet introduced any formal targets which require them to achieve shorter waiting times. It holds the view that setting such targets at this stage could further increase the extent of inequitable waiting times across trusts which are already apparent for some specialisms (paragraph 3.12).

Conclusions

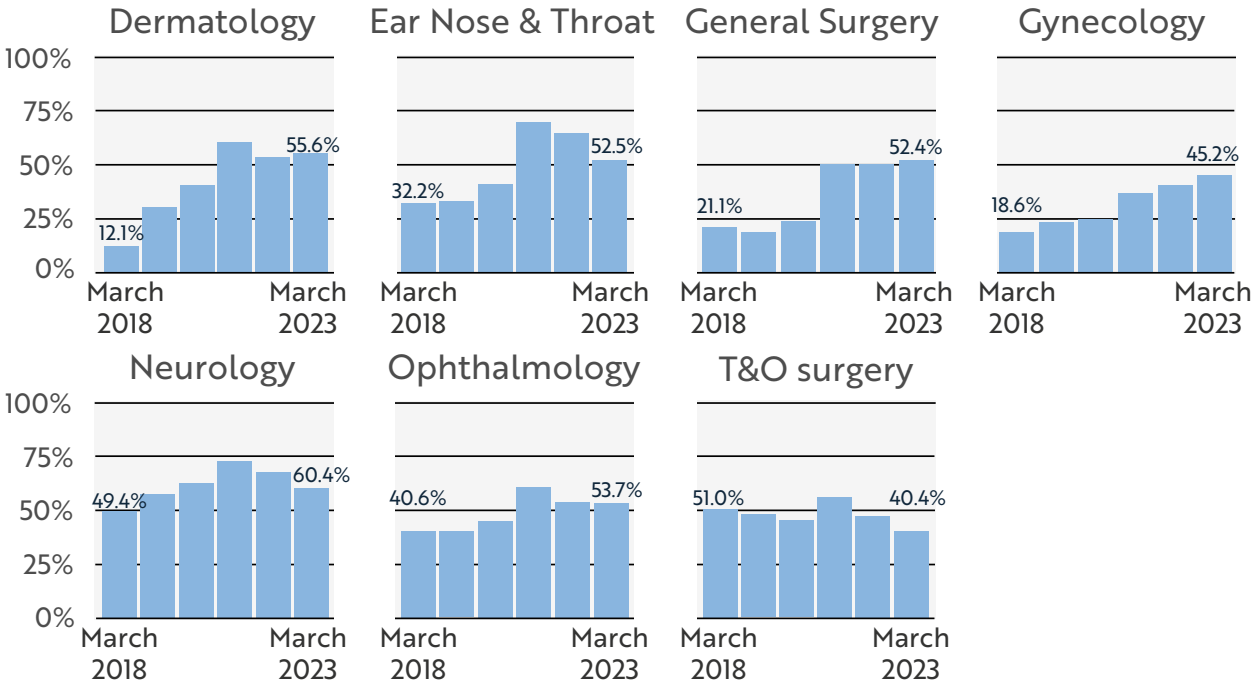
Some variance in waiting times across trusts is inevitable due to differing specialisms, patient demand, capacity and resource pressures, and trust efficiency. However, waiting times have risen very sharply at all Trusts across almost all indicators compared with 2017-18. Whilst all trusts must individually and collectively consider how significant improvements can be achieved, recent data indicates that performance in the Northern

Trust, whilst still notably declining, has not deteriorated to the same extent as other trusts. It also indicates considerable ongoing problems in the Southern Trust (all services), the South Eastern Trust (initial outpatient appointments and hospital admission), and the Belfast Trust (hospital admission and diagnostic testing).

Initial outpatient appointments – specialisms

2.15 For six of the largest volume elective specialisms, the percentage of people waiting longer than 52 weeks has increased considerably since March 2018. The exception to this is Trauma and Orthopedic (T&O) surgery where these have fallen by almost 10 per cent. Nonetheless, the proportion of waits remained high at March 2023 across all specialisms, ranging between 40 per cent (T&O Surgery) and 60 per cent (Neurology) **(Figure 14)**.

Figure 14: Percentage of people waiting longer than 52 weeks for initial outpatient appointment by specialism March 2018 to March 2023

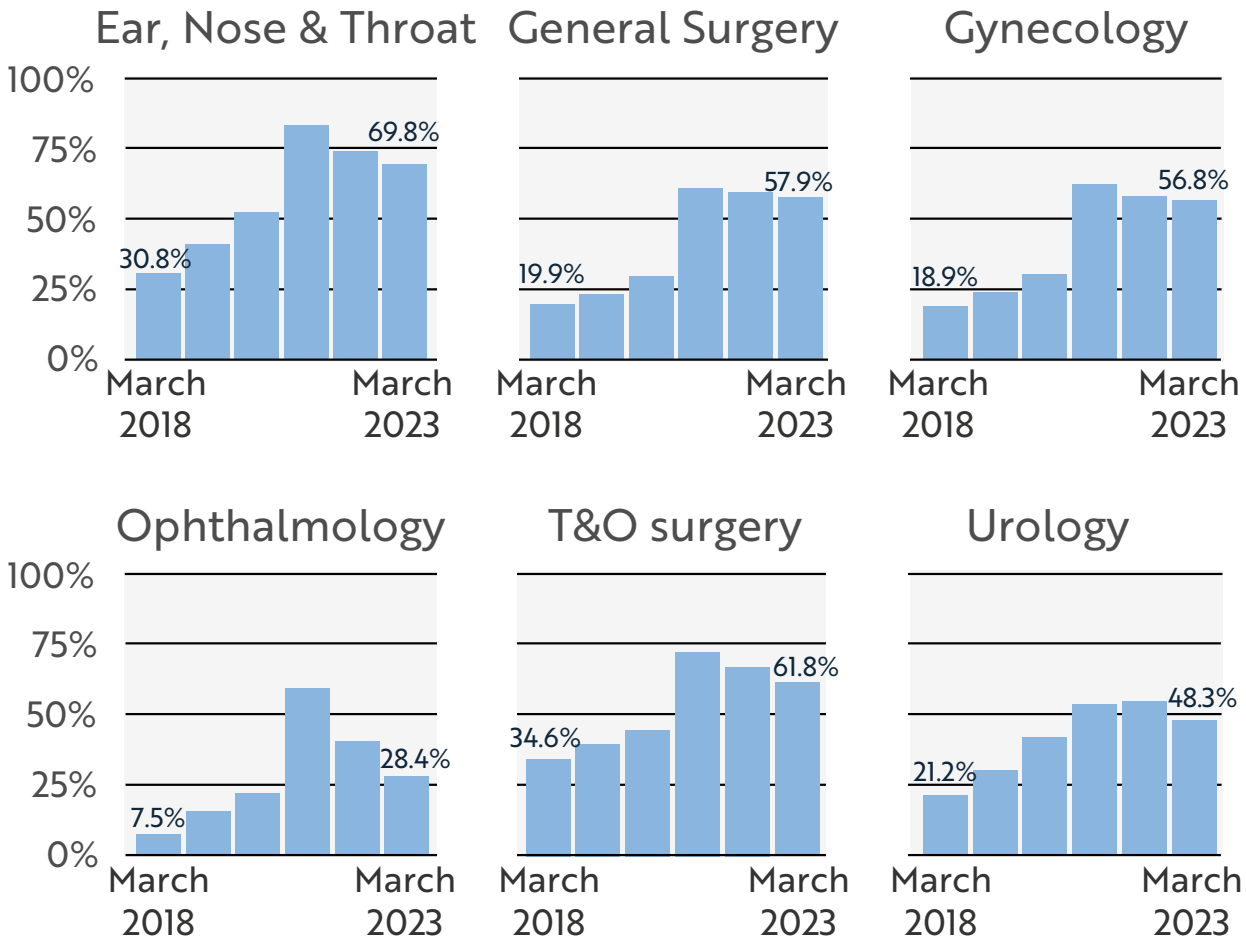


Source: DoH

Hospital admissions – specialisms

2.16 The proportion of waits exceeding 52 weeks has increased very significantly across all main inpatient specialisms since March 2018. At March 2023, such waits ranged from 28 per cent of patients (Ophthalmology) to 70 per cent (ENT) **(Figure 15)**.

Figure 15: Proportion of people not admitted to hospital within 52 weeks by key specialism March 2018 to March 2023



Source: DoH

Recommendation

The very long waiting times across all the main elective specialisms further underlines the range and scale of difficulties facing stakeholders. The Department and trusts should review the key causal factors influencing outcomes across the various specialisms and assess if action plans in place to address these need to be radically strengthened. Waiting list pressures are currently particularly acute for Neurology, Dermatology, ENT and General Surgery (initial outpatient appointments) and ENT, T&O Surgery, and General Surgery (hospital admission).

The rest of the UK measures the time taken for patients to be fully treated, and performance is much better than in NI

2.17 As noted at paragraph 1.2, DoH's elective targets measure waiting times for the individual elements of the patient journey. As such, a `clock' starts once a GP referral for a first outpatient appointment is made and stops when the patient receives that appointment. Separate 'clocks' then measure waits for any diagnostic tests and/or inpatient treatment required. In contrast, the rest of the UK measures the total time patients take to complete the entire elective care `patient journey', by setting `Referral to Treatment' (RTT) targets.

2.18 RTT targets provide more transparent and meaningful measurement, but the local HSC sector has trailed behind the rest of the UK in introducing these. Work on developing RTT targets initially commenced in England in 2004 and in Scotland in 2008. However, in 2014, DoH stated that such an approach would require enhanced linking of hospital patient records, adding that "to make the necessary changes would involve significant cost". These enhancements have not yet been introduced. Although DoH has attempted to pilot RTT measurement for various specialisms, it told us that issues around HSC data quality mean that full and formal introduction is heavily dependent on successful implementation of the Encompass project[21] across all trusts.

2.19 In the absence of RTT reporting, average waiting times, which are also measured elsewhere in the UK, would provide patients with greater clarity on likely waits, but until recently this information was also unavailable. However, in May 2023, DoH launched the "My Waiting Times" web page which provides patients with average outpatient waiting times data by Trust and by specialty. Shortly before publication of this report, the initiative was expanded to ensure that information on inpatient treatment and diagnostic test waits is also now available.

2.20 Whilst obvious scope exists for improving local waiting time measurement, June 2022 data (which showed that 32 per cent of HSC patients were waiting over two years for an initial HSC outpatient appointment, with 39 per cent waiting longer than this for hospital admission), highlight the extent of extremely long patient waits in NI. In contrast, **Figure 16** outlines the more challenging RTT targets and standards established for the rest of the UK.

21 The Encompass project is aiming to introduce a single digital and integrated care record for every citizen in NI.

Figure 16: England, Scotland and Wales introduced `Referral to Treatment' standards over a decade ago

Region	RTT target/standard
England	Separate inpatient and outpatient targets were combined into a single 18 week RTT target in 2004. Since April 2013, NHS regulations have statutorily required that 92% of patients on the waiting list start hospital treatment (or are seen by a specialist and leave the waiting list) within 18 weeks.
Scotland	The Scottish Government moved to a whole journey waiting time target of 18 weeks in 2008, publishing a National Plan setting out how this was to be achieved. It subsequently ruled that an 18 week RTT standard should be achieved for at least 90% of patients, and it has published performance data since March 2011.
Wales	An RTT target introduced in 2011 requires that 95% of patients wait no longer than 26 weeks between receipt of a referral to secondary care and treatment commencing. No patient is expected to wait longer than 36 weeks to receive their definitive treatment.

Source: NIAO, based on research of RTT targets in the rest of the UK.

2.21 Other UK regions have often struggled to achieve these targets, with England not having met its RTT requirements since February 2016. The differing performance reporting also means that local waiting times cannot be fully benchmarked with the rest of the UK, although available data indicates that England and Wales have significantly outperformed NI. **Figure 17** provides a snapshot of respective performance prior to the pandemic.

Figure 17: NI had significantly longer waiting times than England and Wales prior to the pandemic

Region	Waiting time performance before the pandemic
Northern Ireland	38.1 per cent of people waiting longer than 52 weeks for an initial outpatient appointment at March 2020.
England	Only 3,100 people (0.07 per cent) were waiting longer than 52 weeks at March 2020 to complete treatment on RTT pathway.
Wales	Median time to start treatment on RTT pathway at March 2019 was only 8.9 weeks.

Source: NIAO, based on available published data.

2.22 Following this, COVID-19 pressures saw elective waiting times increase considerably across the UK. However, at December 2022, performance in NI remained poorer than England and Wales, with a significantly higher proportion of the population on waiting lists, and a much higher percentage of these enduring very lengthy waits **(Figure 18)**.

Figure 18: At December 2022, NI had a higher percentage of its population on elective waiting lists and a higher proportion of lengthy waits compared to England and Wales

UK Region	Number and % of population on waiting lists (December 2022)	Numbers and % waiting lengthy periods (December 2022)
Northern Ireland (population 1.9 million)	500,678 **(26.3% of population[22])** waiting for either an initial outpatient assessment or inpatient admission.	255,051 **(50.9% of those on waiting lists) waiting longer than 52 weeks** for either an outpatient appointment or inpatient admission.
England (population 56.2 million)	7.0 million **(12.4% of population)** waiting on the overall RTT pathway.	382,090 **(5.4% of those on the RTT waiting list) waiting longer than 52 weeks** to complete overall patient journey.
Wales (population 3.06 million)	735,139 **(24% of population)** waiting on the overall RTT pathway.	248,111 **(33.8% of those on RTT waiting list) waiting longer than 36 weeks** to complete overall patient journey.

Note – Scotland reports completed waits and not numbers waiting at month end and is therefore not comparable. It should be noted that the analysis for NI excludes Day Procedure Cases.

Source: NIAO, based on DoH published data and published RTT data for England and Wales.

Recommendation

To support the introduction of local RTT measurement and targets, DoH must strive to ensure that the Encompass programme remains on course for implementation by its scheduled deadlines, and that it is fully capable of such reporting. In the interim, it should use the December 2022 comparative figures as a baseline and continue regularly monitoring performance on that basis to determine if the HSC performance gap with England and Wales is narrowing or increasing, and also identify if any best practice there, which has helped ensure that performance has not deteriorated to the same extent, can be further implemented locally.

Long waiting times impact negatively on the health and wellbeing of individuals

2.23 Behind the many statistics, long waiting times impact considerably on peoples' daily lives. DoH acknowledges[23] that as people on waiting lists develop more advanced conditions, emergency departments (EDs) and other urgent care pathways have increasingly become the default entry point for patients seeking treatment. Whilst the Department has no formal data to quantify this, research[24] indicates that a quarter of cancer diagnoses in NI between 2012 and 2017 were made in EDs, suggesting many cases were only identified when peoples' health had deteriorated to a stage where they needed urgent attention. As waiting times have further markedly increased since 2017, such trends are likely to have worsened.

22 Although the numbers on HSC waiting lists at December 2022 was equivalent to 26.3 per cent of the NI population, some people will be on more than one waiting list (i.e. people waiting for both outpatient and inpatient care).

23 Elective Care Framework Restart, Recovery and Redesign (DoH - June 2021).

24 Research published in April 2022 by the International Cancer Benchmarking Partnership which was supported by Cancer Research UK and published in the Lancet Oncology. The research used data from the NI Cancer Registry.

2.24 RCS England also told us that the need to prioritise urgent and life-threatening cases in the context of very large waiting lists can result in many other necessary treatments being cancelled or deferred, and that consequential delays in treating these means increasing numbers of `Priority 3' cases have been rapidly escalating to `Priority 2' or even `Priority 1' cases[25]. In 2018, almost half of 700 people surveyed by the Patient Client Council (PCC) stated that their health had worsened while on a waiting list, with almost a third reporting increased pain, and some also reporting impacts on mental health, lifestyle, and financial wellbeing.

2.25 In June 2023, the Northern Ireland Public Ombudsman (NIPSO) published the results of an investigation into communications with patients who are on HSC waiting lists[26]. The NIPSO report concluded that whilst communication with patients appeared to have been previously considered a priority, the focus in these areas had moved away from being patient-centred, with patients all too often provided with little or no communication on their progress on waiting lists. The Ombudsman considered that the issues identified by her investigation amounted to "systemic maladministration".

2.26 As increasing numbers of people could potentially present with more serious conditions, the risk exists that the HSC system will incur higher treatment costs, and long waiting times also create potential health inequalities. In May 2021, DoH reported that patients are increasingly opting to pay for diagnosis and treatment rather than endure prolonged waits. It acknowledged that this created obvious health inequalities, with those unable to pay waiting longer, and more likely to suffer detrimental impacts.

Conclusions

Unless significantly shorter waiting times are achieved, growing numbers of patients will inevitably continue developing advanced conditions and suffer detrimental impacts, and the extent of health inequalities is also likely to widen. This will place the HSC sector under even greater operational pressure, potentially bringing it close to breaking point, and means it will ultimately incur higher costs through having to treat more complex illnesses.

25 The Federation of Surgical Specialty Associations developed guidelines early in the pandemic at the request of NHS England to outline timeframes in which operations should be performed. Priority 3 cases should be performed in < 3 months, Priority 2 cases in < 1 month, Priority 1b cases in < 72 hours, and Priority 1a cases in < 24 hours. As waiting times in NI were so long Priority 2 cases had to be segmented into four lower-level priority rankings.

26 An own initiative investigation into waiting list communications (NIPSO June 2023).

Part Three:

Why waiting times have increased so significantly

3.1 This part of our report assesses why local waiting time performance has deteriorated so starkly. It assesses the following areas:

- the growing patient demand / HSC capacity gap;
- the level of additional in-year funding available to Trusts to address the patient backlog, and the impact of such funding;
- progress in developing `dedicated' elective care centres which seek to protect elective capacity from growing unscheduled or emergency care pressures;
- how COVID-19 impacted on waiting times; and
- HSC elective activity and productivity levels.

Without significant action, the demand/capacity gap will widen and waiting lists will grow further

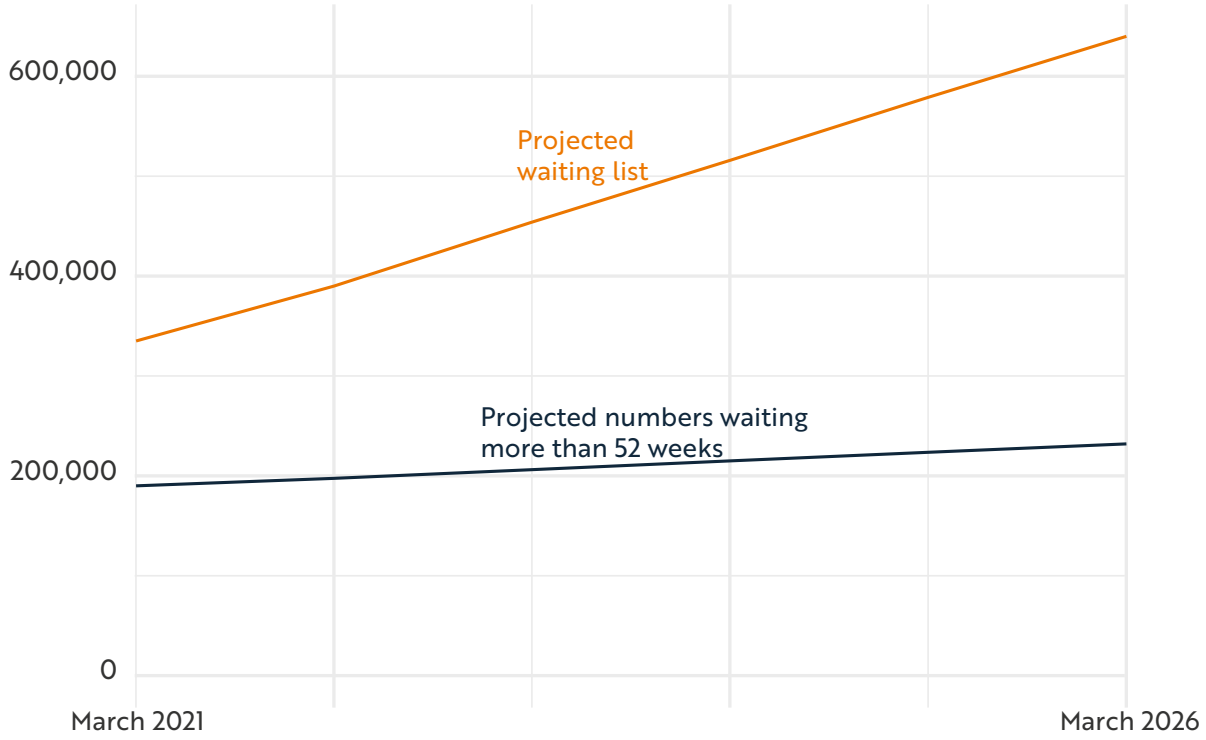
3.2 The annual budget allocated to trusts has increasingly become insufficient to meet rising patient demand under existing HSC delivery models. In 2019, DoH estimated that unless these models were transformed to better cope with rising patient demand, HSC budgets would have to increase by around six per cent annually, which then amounted to around £340 million. The unsustainable nature of such funding levels underscores why HSC transformation is essential, particularly given that DoH had projected in 2021 the following increases in annual demand by 2025-26[27]:

- 49,640 to 75,822 for **outpatient appointments**;
- 37,957 to 48,970 for **inpatient and day case procedures**; and
- 152,673 to 436,219 for **diagnostic services**.

3.3 On this basis, the outpatient waiting list was also forecast to rise by a further 91 per cent, from 335,000 at March 2021 to 640,000 by March 2026, with the number of patients waiting more than 52 weeks growing from 190,000 to 232,000 **(Figure 19)**.

27 It should be noted that the analysis in paragraphs 3.2 to 3.4 excludes Day Procedure Centres.

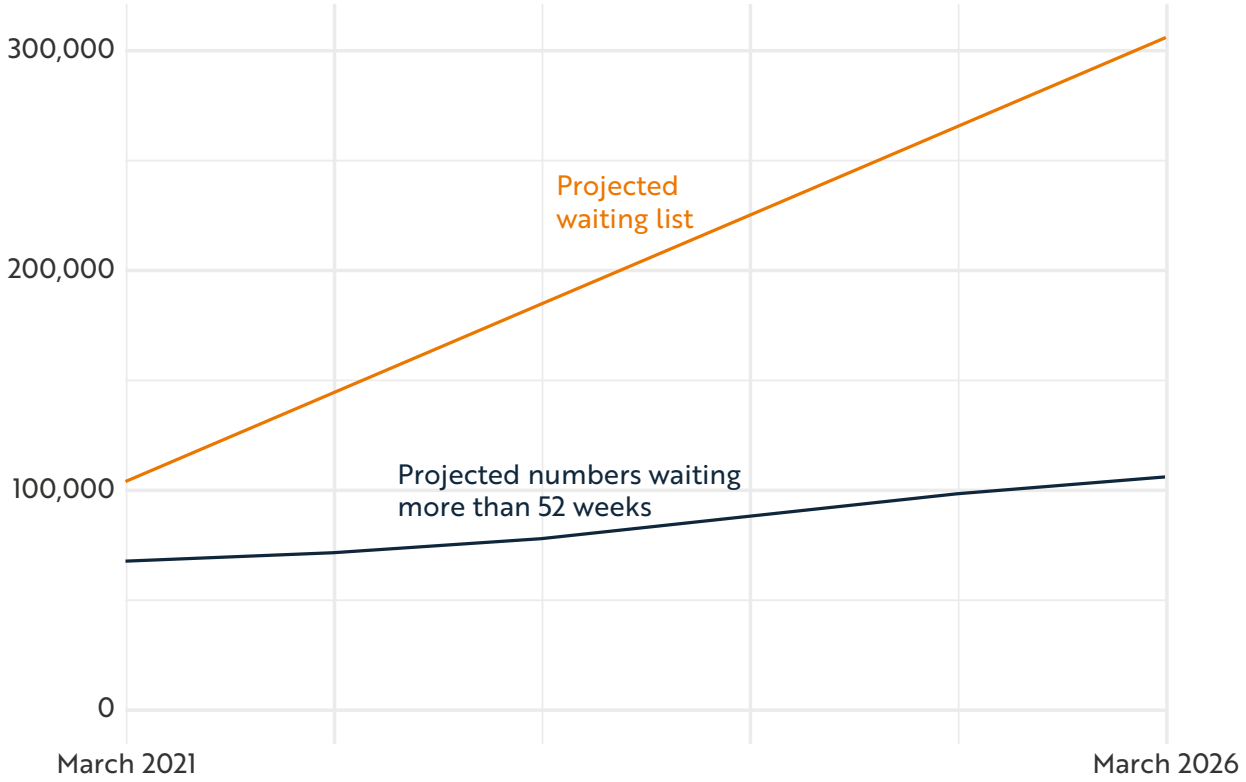
Figure 19: Outpatient waiting list and waiting times in NI are projected to grow significantly by March 2026 without further action



Source: DoH.

3.4 Similarly, the inpatient waiting list was projected to increase by over 200 per cent from just over 100,000 to approximately 306,000 by March 2026, with 107,000 patients waiting longer than 52 weeks, compared to 68,000, at March 2021 **(Figure 20)**.

Figure 20: Inpatient waiting list and waiting times are also forecast to rise sharply by March 2026 without further action



Source: DoH.

3.5 Although DoH highlighted that waiting lists have not subsequently grown as significantly as these projections had indicated, the HSC outpatient waiting list has recently reached over 400,000 and the increases experienced still have potential to place the HSC system under intolerable pressure, highlighting the need for urgent and decisive action to significantly reduce the current extremely long waiting times, rather than allowing them to further increase to levels which would inevitably become unmanageable.

Short-term funding helps address an element of the patient backlog, but it has limited impact, and until 2021-22, its availability was very limited

3.6 In addition to their annual budgets, supplementary non-recurrent funding mainly provided through in-year monitoring rounds, enables Trusts to commission additional assessments and procedures, either internally or from the Independent Sector (IS). Whilst this Waiting List Initiative (WLI) funding helps address some of the patient backlog, its availability can fluctuate significantly, with very limited provision in some years.

3.7 For example, DoH received no WLI funding in 2011-12. Whilst it bid for £250 million funding between 2012-13 and 2016-17, it was allocated £98 million (an annual average of £19.6 million)[28]. This then fell to only £10.5 million between 2017-18 and 2019-20 (an annual average of £3.5 million), which curtailed the trusts' ability to purchase additional activity during this period, and patient backlogs continued growing. However, in 2020-21, WLI funding increased to £12.1 million, and the £61.5 million allocated in 2021-22 was the highest amount provided over the previous nine years **(Figure 21)**. Whilst this analysis reflects outcomes from the in-year monitoring rounds, it is important to note that additional Confidence and Supply funding of approximately £33.8 million in 2018-19 and £22.3 million in 2019-20 was also allocated towards addressing elective care waiting lists.

Figure 21: The amount of additional non-recurrent funding available through in-year monitoring rounds to address waiting lists reduced sharply between 2016-17 and 2019-20

Year	Amount bid for from DoF in monitoring rounds - £m	Amount allocated to elective care by DoF - £m	Amount allocated to elective care internally by DoH - £m	Total WLI funding allocated to elective care - £m
2011-12	15.0	0.0	0.0	**0.0**
2012-13	31.0	19.0	0.0	**19.0**
2013-14	64.0	20.0	0.0	**20.0**
2014-15	70.0	14.0	0.0	**14.0**
2015-16	85.0	40.0	0.0	**40.0**
2016-17	n/a	0.0	5.0	**5.0**
2017-18	7.0	7.0	0.0	**7.0**
2018-19	n/a	0.0	0.5	**0.5**
2019-20	n/a	0.0	3.0	**3.0**
2020-21	11.8	10.3	1.8	**12.1**
2021-22	61.5	61.5	0.0	**61.5**

Source: DoH.

Note – In addition to £61.5 million allocated in-year for 2021-22, Waiting List Initiatives also benefited from a £30 million non-recurrent opening allocation.

28 £93 million allocated by DoF and £5 million internally reallocated by DoH.

3.8 Given HSC capacity limitations, using the IS to assess and treat patients helps the trusts address waiting lists. However, the limited WLI funding available between 2013-14 and 2019-20 significantly restricted the activity trusts could commission from the IS. Outpatient completions[29] and inpatient admissions by the IS fell by 84 per cent and 66 per cent respectively over this period (from 91,400 to 14,100 and from 27,000 to 9,100). Although the increased WLI funding in 2021-22 (paragraph 3.7) supported 31,500 outpatient completions and 20,000 IS inpatient admissions, this remained below 2013-14 levels.

3.9 Most importantly, WLI funding has limited impact on waiting lists, as its availability is heavily dependent on underspends within other government departments, and its non-recurrent nature means it cannot be used to strengthen permanent HSC capacity, to sustainably reduce waiting times. Whilst it helps address the most immediate pressures including time critical treatments, the continual rising demand for care essentially means that the limited amounts provided over the last decade have been insufficient to make significant inroads into patient backlogs and have only prevented a bad situation from further worsening.

Budget constraints means that DoH has been unable to adequately fund longer-term transformation of elective care

3.10 If the current patient backlogs are to be considerably reduced, substantially increased levels of WLI funding will be required over a sustained period. Moreover, the major systemic pressures arising from the ongoing rising patient demand can only be addressed by longer-term transformation of HSC structures. Reforming elective care requires progress in several areas, including:

- enhanced use of primary care to deliver routine elective procedures;
- delivering more procedures as day cases, thereby increasing throughput and elective capacity; and
- developing dedicated care facilities which `ring fence' elective capacity from unscheduled care pressures, and which can deliver large volumes of day case procedures.

3.11 Whilst involving substantial additional recurrent investment, well-planned and managed transformation initiatives would likely deliver major waiting time improvements and better long-term value for money than the limited impact achievable from WLI funding. However, budget constraints have again considerably restricted DoH's ability to fund transformation. For example, whilst it was estimated that a transformation themed five-year elective care plan published in 2017 would cost between £859 million and £909 million to implement, DoH could only allocate £136.5 million towards its delivery. This issue is considered further in Part 4 of this report.

29 These figures related to both initial outpatient appointments and follow-up appointments seen by the IS.

The HSC sector has recently began creating dedicated elective sites, but further expansion of dedicated capacity is required

3.12 The current delivery of local elective day case services over 19 HSC sites has created access disparities depending on demand, capacity and performance at individual trusts. For some specialisms, people can experience major differences in waiting times depending on where they live. Our analysis of June 2023 data confirmed some clear examples of this **(Figure 22)**.

Figure 22: Waiting times vary significantly across HSC trusts for some specialisms

Elective Specialism	% and number of people waiting longer than 52 weeks for hospital admission across HSC trusts at June 2023 (inpatient and day cases)
Dermatology	Northern Trust 0% (0 patients) Southern Trust 49% (368 patients)
Gynaecology	Northern Trust 30% (339 patients) Belfast Trust 59% (1,305 patients)
Neurology	Southern Trust 0% (0 patients) Western Trust 100% (70patients)
Urology	Western Trust 42% (1,037 patients) Belfast Trust 59% (2,215 patients)

Source: DoH.

3.13 The Department is seeking to manage HSC elective waiting lists for more specialisms on a regional basis, rather than by individual trusts, in order to minimise `postcode lottery' situations and maximise available HSC and IS capacity. DoH established a Waiting List Management Unit (WLMU) in August 2021 which is seeking to progress work in this area. Currently, only varicose vein procedures are managed regionally, with cataract procedures partially delivered on this basis. DoH is initially working to try and introduce regional waiting lists for some urology procedures, breast assessments, bladder outflow surgery and stones services.

3.14 The Department has also set up a Regional Prioritisation and Oversight Group (RPOG) which is working with Trusts to redirect patients to other trusts to support equalisation of outpatient and inpatient waiting lists, currently focusing on the longest waiting patients. The May 2023 launch of the "My Waiting Times" web page (paragraph 2.19) also aims to inform patients on average waiting times by trust and specialty, again to try and balance demand across trusts.

3.15 Local elective activity has been further undermined by growing unscheduled care pressures. Clinical procedures require access to surgeons, nursing staff, anaesthetists, operating rooms, theatre time, and beds. Removing any of these to address unscheduled care means operations are cancelled. One way of overcoming this is through establishing regional dedicated facilities which `ring fence' less complex elective surgery from unscheduled care pressures, and which treat high volumes of patients as day cases, rather than inpatients. The increased productivity and efficiency from such centres can help reduce waiting times.

3.16 Case examples A and B outline two dedicated HSC elective care initiatives launched since late 2017-18.

Case Example A – Prototype Day Care Centres for treating cataracts (South Tyrone, Downe, and Mid Ulster Hospitals) and varicose veins (Omagh and Lagan Valley Hospitals)

Cataract activity commenced in 2017-18, with varicose vein activity starting in October 2018 and fully operational by December 2018.

Volume of patients treated – Between 2019-20 and 2021-22, almost 2,100 varicose vein patients and over 18,900 cataract patients (including over 1,600 seen by insourced IS providers) were treated.

Case Example B - Lagan Valley Dedicated Day Procedure Centre (LVDPC)

Established in August 2020 as NI's first dedicated regional day care centre treating multiple specialisms.

The centre treats the ENT, Gynaecology, Plastic Surgery, General Surgery and varicose veins specialisms, and delivers Endoscopy procedures.

Between August 2020 and May 2023, LVDPC delivered over 10,000 day procedure cases.

3.17 Capacity at four of the five prototype centres and the LVDPC was restricted for some time due to COVID-19 pressures, but these are now fully operational. Positively, since the five prototype centres opened, the HSC varicose veins waiting list has reduced from 1,417 to 887, with the cataracts backlog also falling from 5,556 to 3,131.

3.18 Comparing the available dedicated elective capacity in NI with the rest of the UK is difficult, but DoH's Framework document suggests NI has lagged behind. It acknowledged "*the longstanding vulnerability of hospital services*", and in assessing the pandemic's impact, stated that "*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.*" It also identified the inability to create dedicated elective sites as at least partly due to systemic problems identified as far back as 2000. The Department acknowledges that further expansion of this capacity is required to sustainably reduce waiting times, and further ongoing and planned developments in this area are outlined at paragraph 5.8.

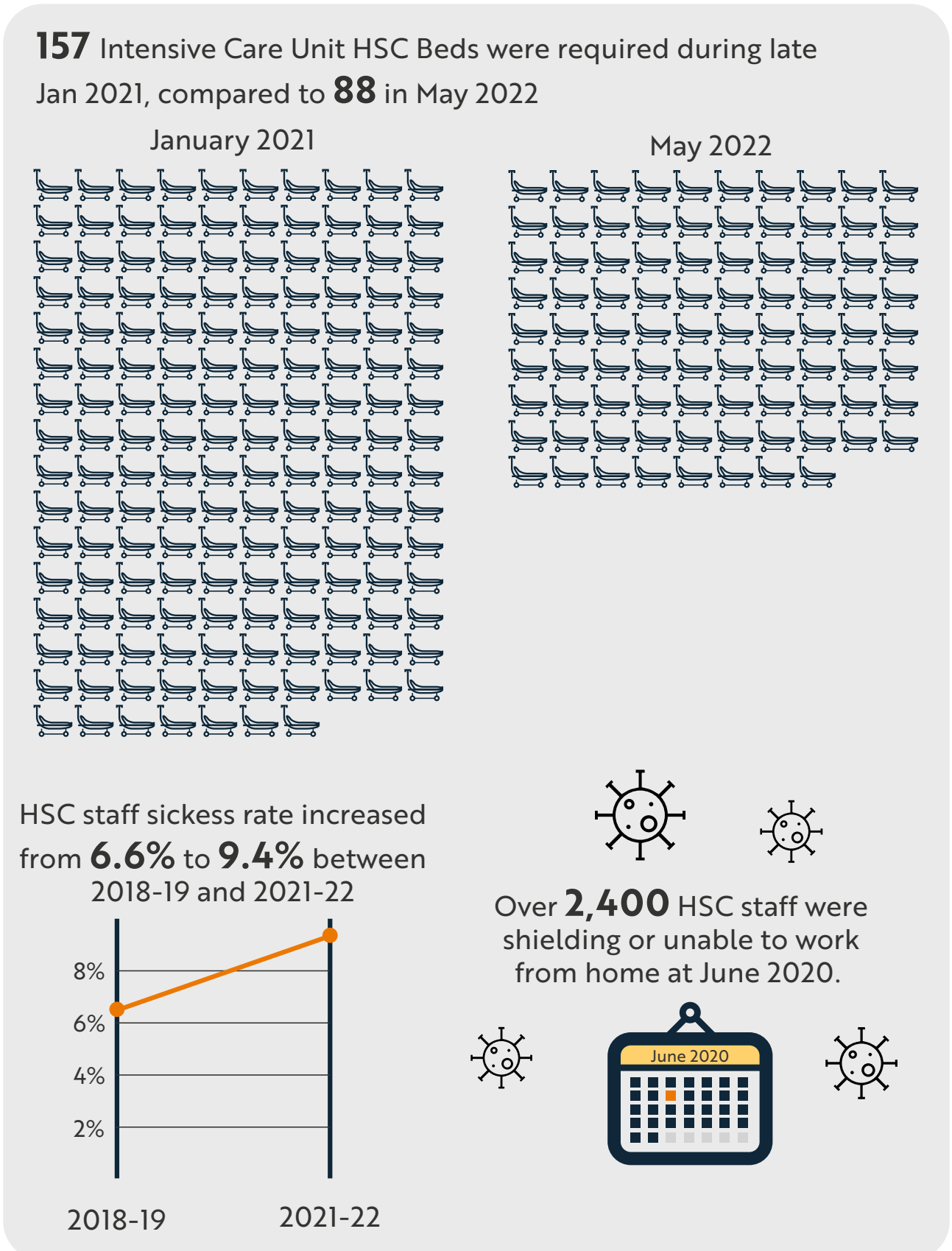
COVID-19 further reduced available elective capacity, meaning waiting times increased even further, and inpatient activity had not returned to pre-Covid levels by March 2023

3.19 The longstanding deterioration in HSC waiting times were compounded by COVID-19, which further restricted HSC elective capacity throughout 2020 and parts of 2021. High infection rates during three `surge' periods (April 2020, November 2020 and January 2021) meant most routine elective care and some complex surgery was halted, and staff redirected towards unscheduled pressures. Strict infection prevention and control measures, and high numbers of trust staff testing positive for COVID-19 further reduced available capacity.

3.20 **Figure 23** visibly illustrates how various operational factors impacted significantly on HSC elective capacity during the pandemic.

- Whilst 157 funded Intensive Care Unit (ICU) HSC beds were required during late January 2021, this had reduced to 88 funded beds at May 2022.
- The HSC staff sickness rate of 6.6 per cent in 2018-19 increased to 9.3 per cent in 2020-21 and 9.4 per cent in 2021-22.
- Over 2,400 HSC staff were shielding or unable to work from home at June 2020.

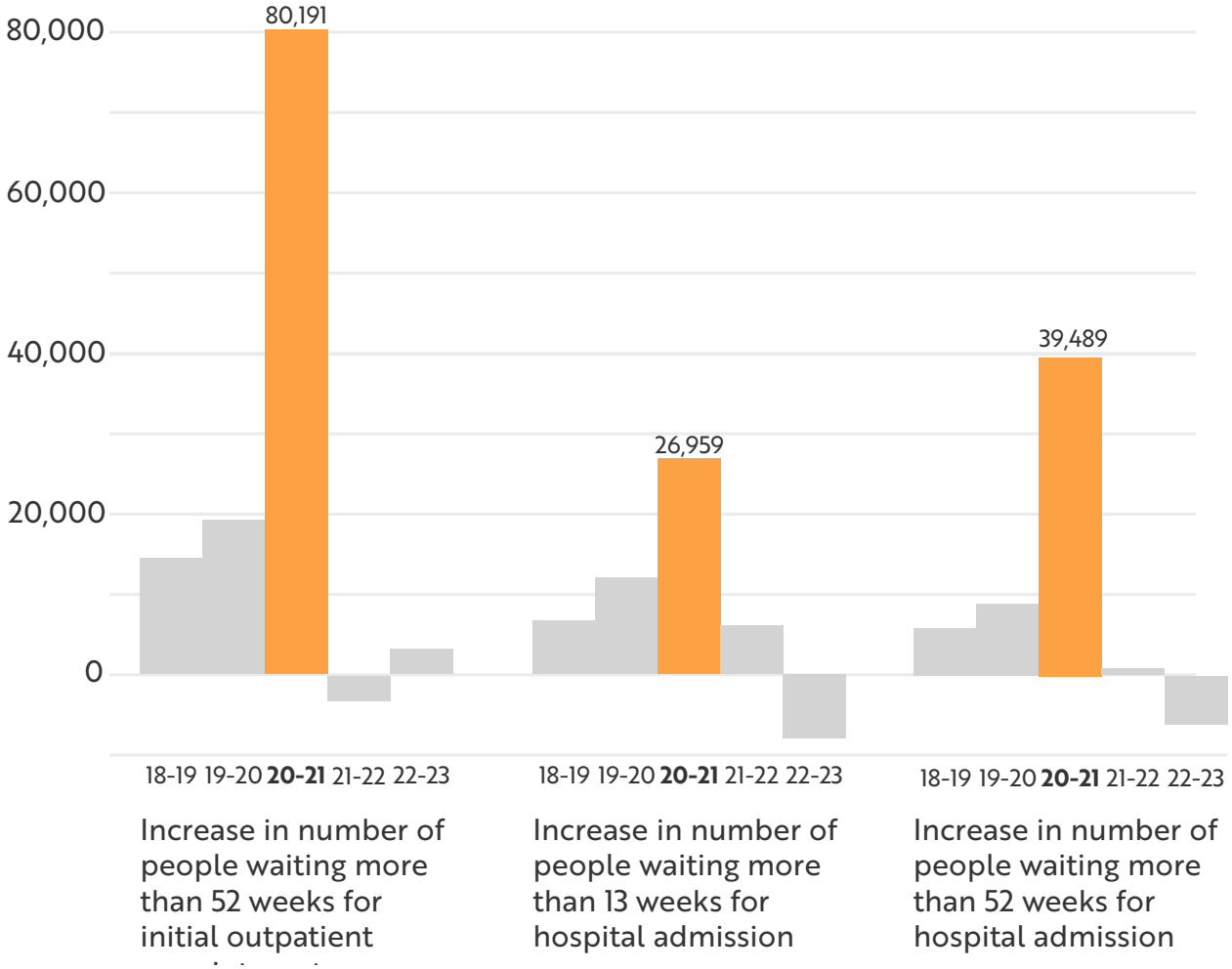
Figure 23: Various operational factors impacted significantly on HSC elective capacity during the pandemic



Source: NIAO, based on information provided by DoH.

3.21 These circumstances inevitably meant that HSC waiting times increased further. Outpatient appointment waits exceeding 52 weeks and hospital admission waits longer than 13 and 52 weeks all increased dramatically at the height of the pandemic compared with previous trends. In 2021-22, the easing of Covid pressures, together with availability of significant WLI funding, helped the trusts commission additional activity, but this mainly only slowed the increases in these areas **(Figure 24)**.

Figure 24: COVID-19 caused waiting times to rise very steeply between 2019-20 and 2020-21



Source: NIAO, based on published DoH data.

3.22 The HSC sector experienced huge difficulties in properly restarting elective care until April 2021, and even then, trusts encountered significant difficulties:

- elective staff could not return to their usual posts until there was a sustained drop in unscheduled admissions;
- many staff were exhausted, and required a break;
- ongoing IPC measures continued to impact capacity and flow;
- clinical review and prioritisation of waiting lists required careful management.

3.23 Trusts began compiling three-monthly `Recovery Plans' from April 2021, which include their proposals for restoring and increasing elective activity, and for establishing dedicated elective capacity. However, progress has been slow and DoH told us told us that the HSC was primarily focusing on trying to return to pre-Covid activity levels by March 2023.

3.24 Progress to date has been mixed. For the period July 2022 to March 2023, the level of HSC outpatient activity recorded was 2.6 per cent higher than the 2019-20 pre-COVID position, but hospital admission activity remained 2.5 per cent below this.

Outpatient and inpatient activity not keeping pace with rising demand, patient non-attendances and hospital cancellations also contribute to longer waiting times

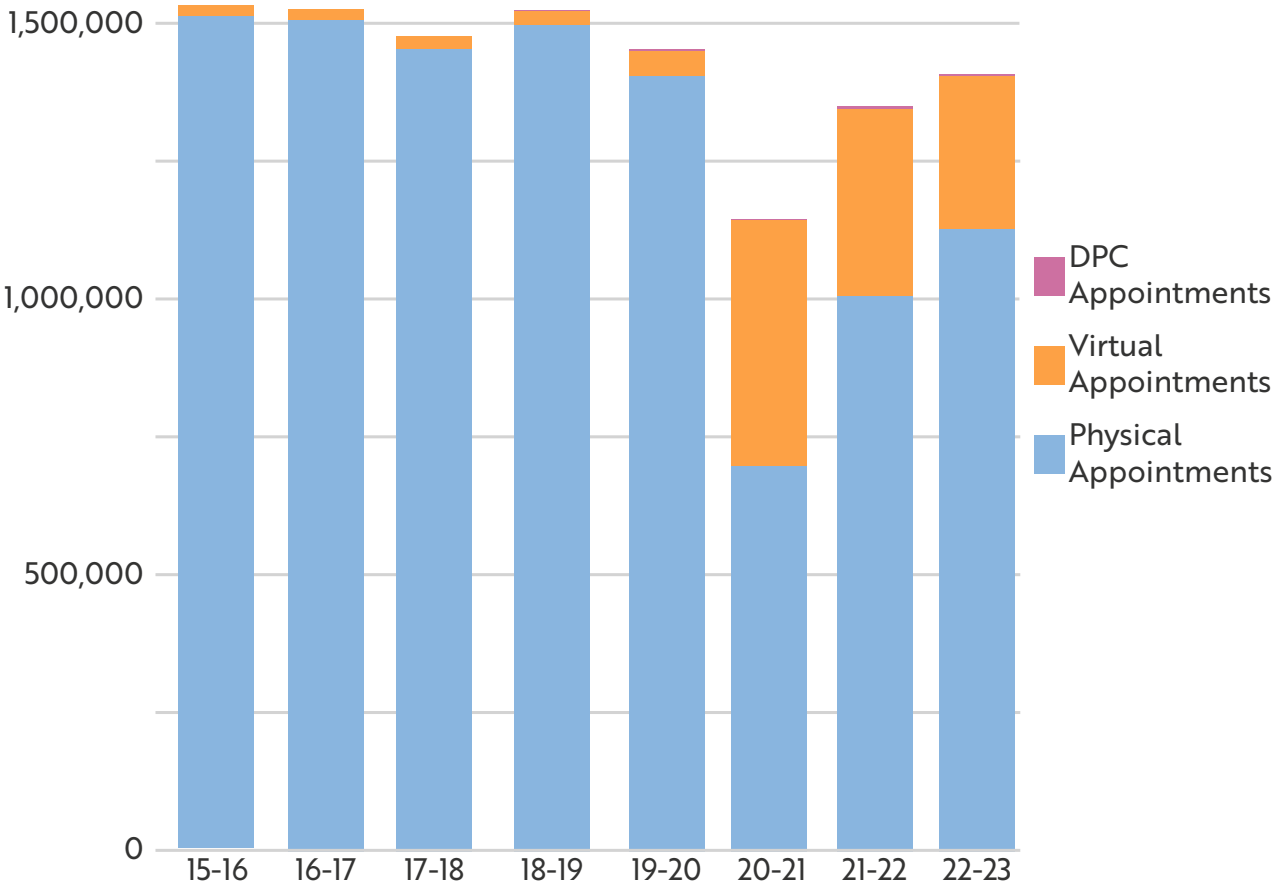
3.25 Given the limited progress in implementing HSC transformation, we reviewed how the HSC trusts have been performing in terms of elective activity and productivity levels. As performance in these areas influences patient waiting times, we sought to quantify the extent of problems which had developed prior to the pandemic, together with the impact of COVID-19 on HSC performance.

3.26 The annual number of **outpatient appointments**[30] delivered by trusts fell from 1.54 million in 2015-16 to 1.46 million in 2019-20. COVID-19 then meant that only 1.15 million appointments were possible in 2020-21. These increased to 1.35 million in 2021-22 and 1.41 million in 2022-23, meaning that pre-Covid levels are close to being restored. The trusts prevented further performance slippage during the pandemic by delivering significantly more virtual appointments in 2020-21 and 2021-22 **(Figure 25)**[31].

30 Includes both initial and follow-up outpatient appointments. Annual outpatient appointments are usually split around 32 per cent (initial) to 68 per cent (follow-up).

31 DoH told us that in recent years there has been a significant expansion of HSC nurse-led activity which is not recorded in these statistics, meaning that outpatient activity levels are higher than these suggest.

Figure 25: The number of HSC outpatient appointments has not kept pace with rising patient demand since 2015-16

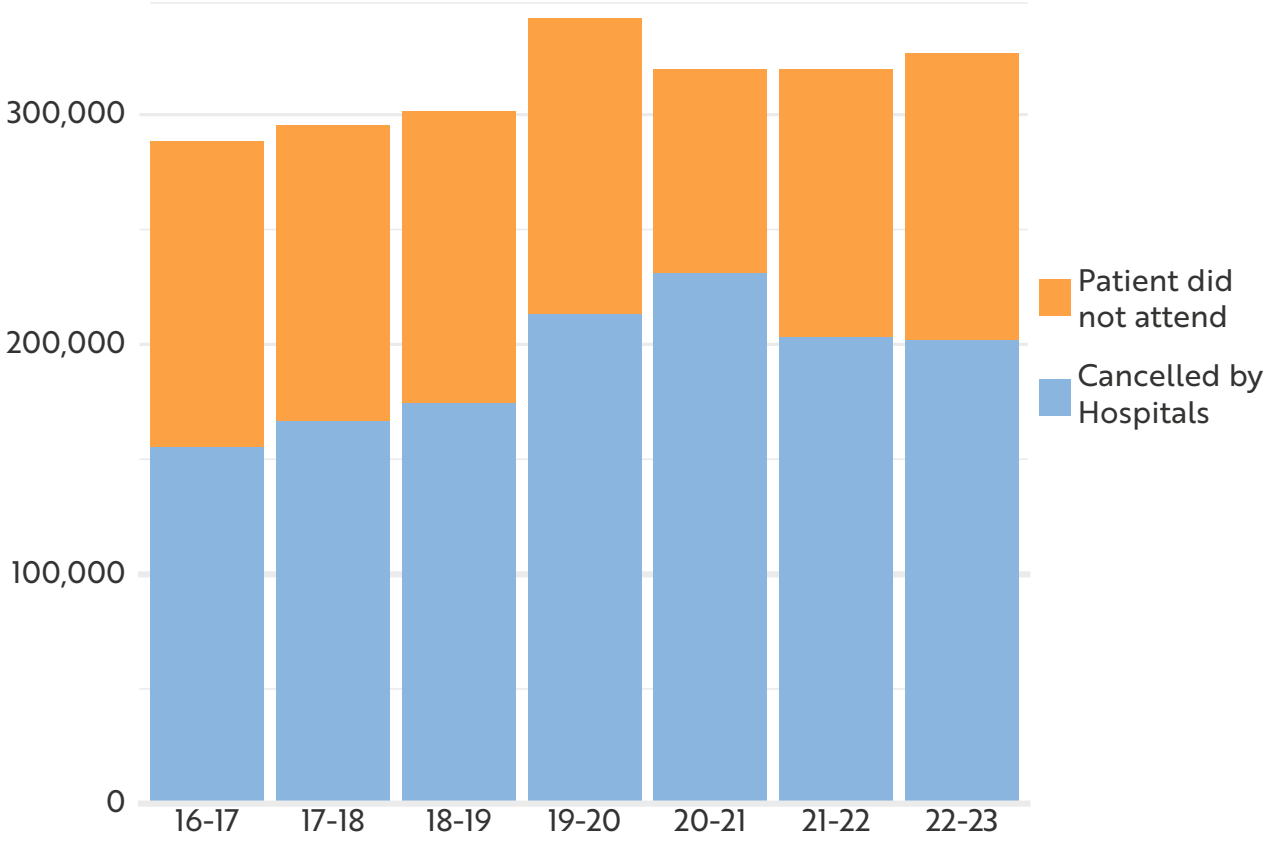


Source: DoH.

3.27 When people **Do Not Attend (DNA)** outpatient appointments, this represents lost HSC productivity, as hospitals cannot reallocate the scheduled slot, due to patients giving insufficient notice, and many DNAs still require future assessment. **Figure 26** shows that DNAs remained fairly constant between 2015-16 and 2019-20. Whilst they reduced notably after that in 2020-21 due to the pandemic curtailing the delivery of elective care, they have begun rising again, with almost 125,000 DNAs recorded in 2022-23.

3.28 The number of **outpatient appointments cancelled by hospitals** is also shown at **Figure 26**. The annual number of cancellations increased from just under 156,000 in 2016-17, standing at 213,900 just before the pandemic (2019-20). These then increased to 231,900 in 2020-21 and have remained high at about 203,000 in 2021-22 and 2022-23.

Figure 26: Patients do not attend a substantial proportion of outpatient appointments and local hospitals also cancel a high proportion of appointments



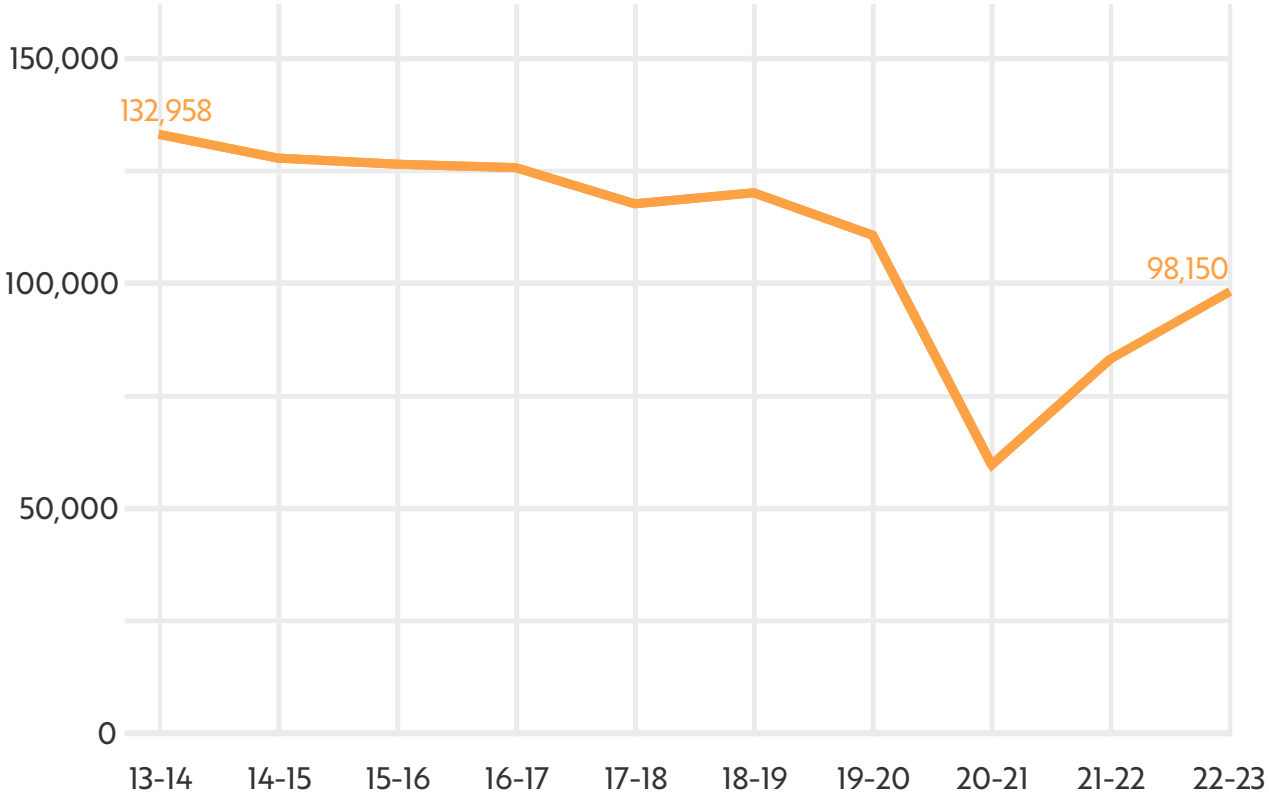
Source: DoH.

3.29 The Department acknowledges the high levels of DNAs and hospital cancellations. It told us that the Belfast, Northern and Western Trusts have commenced issuing text reminders to patients, and that the Southern and South Eastern Trusts are in the process of introducing this for outpatients, and will also focus on extending this to inpatients during 2023. Telephone reminders have also been rolled out across several HSC providers[32].

3.30 **Figure 27** shows that the number of **operating theatre procedures** fell significantly between 2013-14 and 2019-20. Despite some recovery since 2021-22, the most recent 2022-23 figure still remains well below pre-COVID levels. This trend partly reflects the long HSC waiting times creating a need for more complex surgery, thereby meaning fewer patients can be treated.

32 The Belfast Trust, Mater Hospital and Post anaesthetic Care Unit.

Figure 27: The number of HSC theatre procedures has been reducing since 2013-14



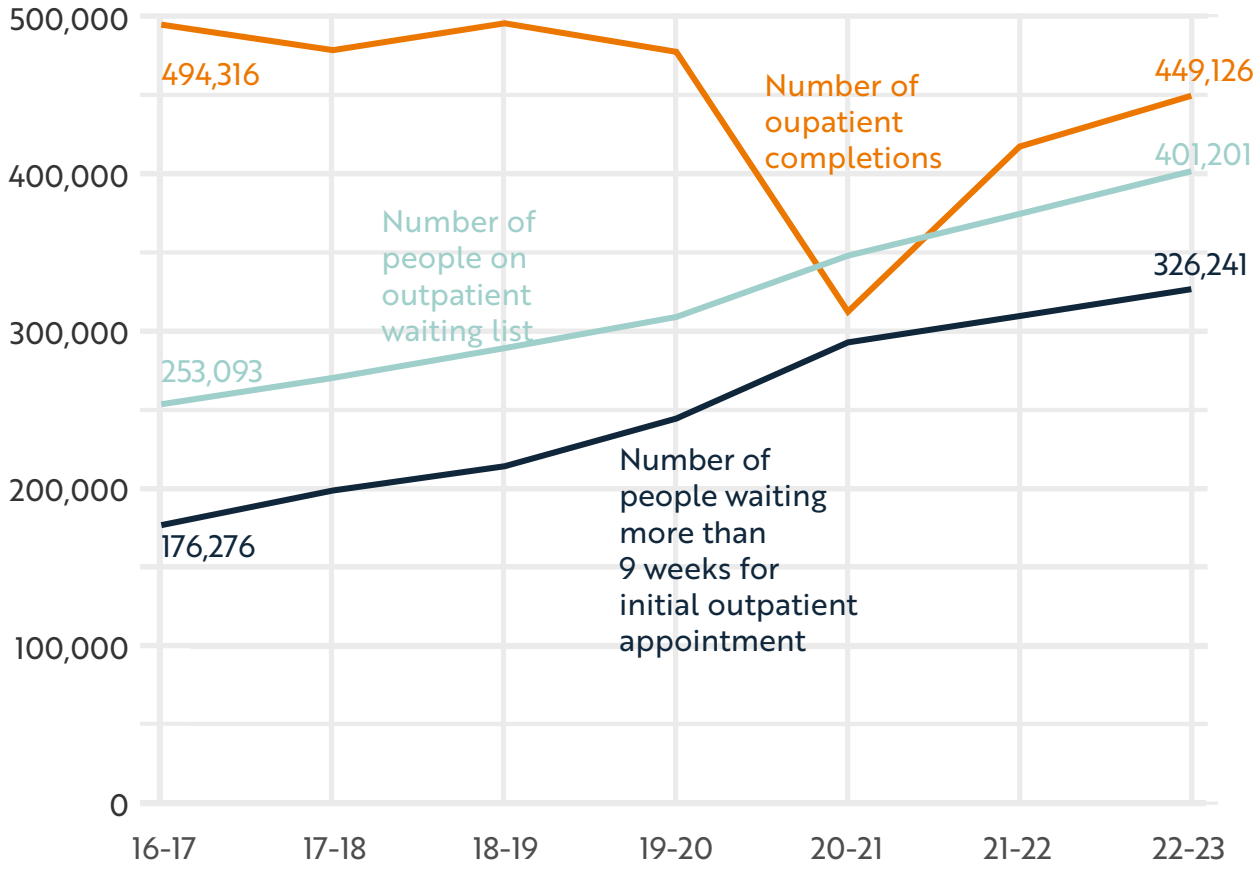
Source: DoH.

Completed patient waits have also reduced during the pandemic and activity has not yet been restored to pre-Covid levels

3.31 Our final analysis assesses **completed outpatient and inpatient waits**[33], which are particularly relevant, as they measure how many people actually progress through key stages of the `patient journey'. **Figures 28 and 29** both show a correlation between static or even falling activity levels and worsening waiting list performance. The number of **outpatient completions** fell significantly during the pandemic. Despite some recovery in 2021-22 and further improvement in 2022-23, the latest figure still remained below pre-COVID levels (**Figure 28**).

33 When a referred patient receives an initial consultant-led outpatient appointment, their outpatient wait is recorded as having been `completed'. Similarly, a completed inpatient wait means someone has received the diagnostic tests and/or treatment required to address their condition.

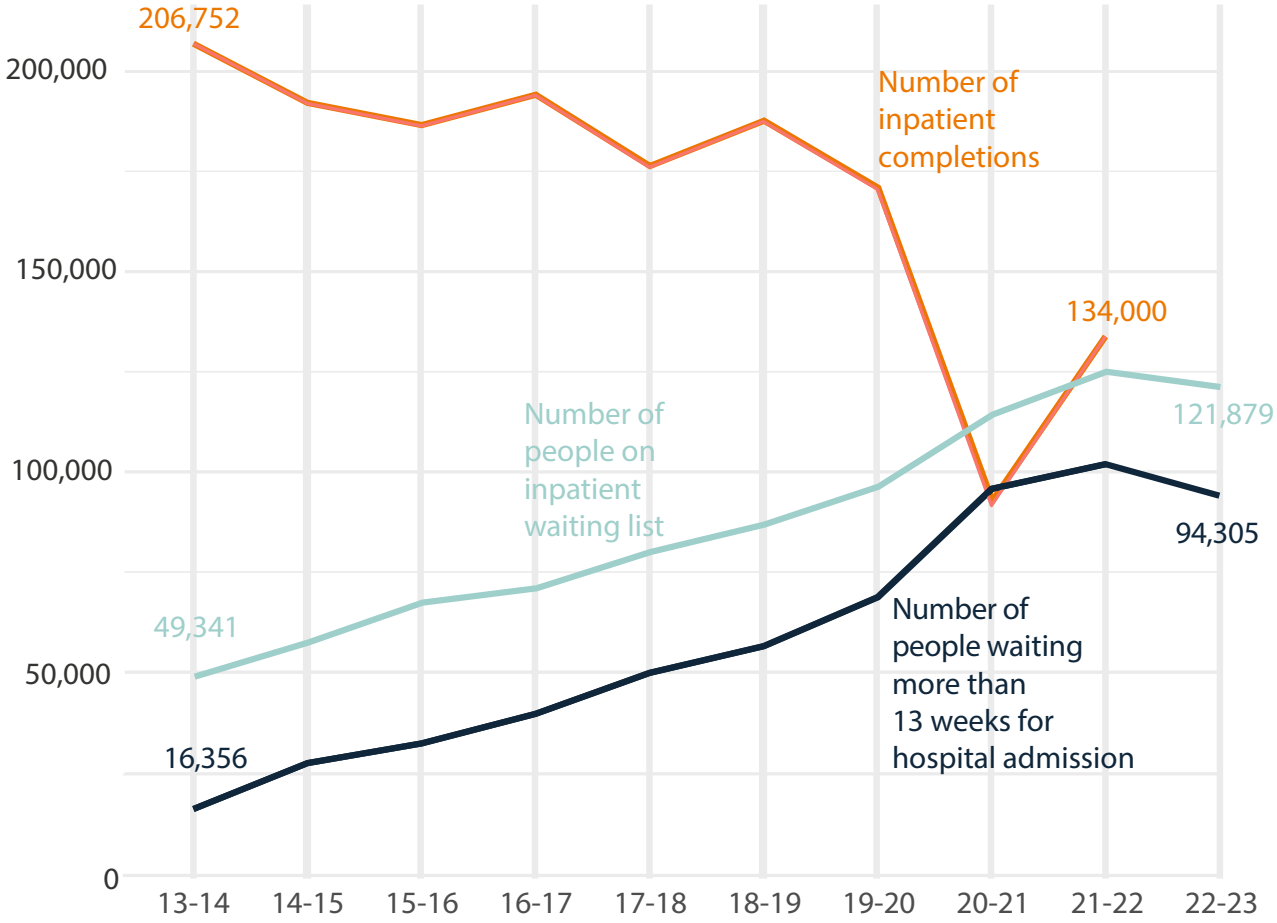
Figure 28: Completed outpatient waits have been reducing since 2016-17



Source: DoH.

3.32 **Figure 29** shows that the number of **inpatient completions** has been falling since 2013-14. A partial recovery in 2021-22 again still left performance well below pre-pandemic levels. We were unable to readily access Inpatient completions data for 2022-23 at the time we published this report.

Figure 29: Inpatient completions have also fallen in recent years



Note - analysis for inpatient completions for 2020-21 and 2021-22 based on provisional statistics.

Source: DoH.

3.33 It is now apparent that the large current patient backlog means waiting times will not start reducing until activity substantially exceeds pre-pandemic levels.

3.34 HSC activity is significantly influenced by the levels of available WLI funding. However, wider issues, including slow progress in transforming the HSC sector and establishing dedicated elective capacity, addressing workforce deficits, and HSC productivity, must also be addressed to achieve substantially shorter waiting times. Using pre-COVID performance as a baseline, **Figure 30** sets out our estimates on how relatively small improvements across key indicators could potentially deliver much needed improvements and make some contribution to achieving shorter waiting times.

Figure 30: Improved activity levels could contribute to reduced waiting times

Area and potential improvements	Approximate potential annual impact
Increasing the number of outpatient appointments by 5% on 2019-20 levels	Additional 70,000 outpatient appointments achievable
Reducing outpatient DNAs from 8.3% (2019-20) to 6%	Prevent around 37,000 booking slots from being lost
Reducing outpatient appointments cancelled by hospitals from 13% (2019-20) to 10%	Additional 40,000 patients assessed
Increasing available HSC beds by 5% on 2019-20 levels	Additional 290 hospital beds
Increasing the number of HSC theatre cases by 10% on 2019-20 levels	Additional 11,000 theatre cases

Source: NIAO based on published DoH data.

3.35 DoH has been examining various indicators focusing where increased performance could generate greater productivity and efficiency across outpatient and inpatient activity. This work includes examining cancellations and DNAs, and measuring and benchmarking trust performance and outcomes to identify and reduce unwarranted variation. It is also reviewing key productivity information, including theatre management data, to increase productivity and efficiency.

3.36 To date, this work has seen varicose vein productivity increase from 3 to 4 patients per list[34], with urology stone lists[35] in one trust now treating four patients per list, compared to the previous two. Whilst productivity across trusts is variable for endoscopy procedures, agreement has been reached that the LVDPC and Omagh centres will initially achieve 10 points per list, which will subsequently be scaled up to 12 points[36].

Conclusions

Since 2013-14, HSC outpatient and inpatient activity has been falling, with fewer completions and theatre cases delivered, and HSC hospitals cancelling an increasing number of outpatient appointments. Most of these trends were already evident before COVID-19 further decimated performance in 2020-21, pointing to an HSC system which, in the absence of sufficient transformation, was simply unable to address the rising demand for care, and which is only now starting to restore some aspects of activity close to the already reducing pre-Covid levels.

Recommendation

Whilst action is underway to try and address issues around trust performance and patient DNAs, and the Department is now trying to centrally drive improvements, the Department and trusts now need to explicitly quantify the increased capacity and activity required to sustainably reduce waiting times, and assess how this can be achieved at each trust, through both improving the efficiency of current operations and progressing HSC transformation.

34 The number of patients who can be seen within a defined period of time.

35 Treatment to address kidney stones.

36 An endoscopy is a test which examines inside a person's body. Within this a point represents a unit of time.

Part Four:

Previous initiatives to try and reduce waiting times

A plan published in early 2017 aimed to substantially reduce waiting times

4.1 *Health and Wellbeing 2026: Delivering Together*, published by DoH in October 2016, is a ten-year strategy to transform local HSC services to provide high healthcare standards whilst also meeting the growing demand. One of its key conclusions was the need for a comprehensive and sustainable approach for addressing local hospital waiting lists. Arising from this, the Department published an *Elective Care Plan: Transformation and Reform of Elective Care Services* (the Plan) in February 2017.

4.2 The Plan included six commitments and 29 supporting actions aimed at delivering sustainably shorter waiting times. It highlighted that whilst previous improvement strategies had focused primarily on increasing elective capacity, it also aimed to maximise resources, so that patients were seen by the right person, at the right time and in the right place. This approach aimed to avoid the traditional pathway of sending almost all patients to hospital, unless this was necessary, by transforming HSC services and making increased use of primary care.

There was limited implementation of the Plan's proposals, and waiting times continued rising

4.3 The Plan's first commitment was that all patients waiting longer than a year at March 2017 for assessment or treatment, or 26 weeks for a diagnostic test, would be seen or treated by March 2018. However, a progress review by DoH in February 2018 acknowledged that this would clearly not be met because only £13 million additional WLI funding had been made available in 2017-18[37], compared to the estimated £31.5 million needed to meet this objective.

4.4 Even if the further £18.5 million WLI support had been provided, there is no certainty that it would have been sufficient to clear the backlog of lengthy waits, and substantial further recurrent funding would also have been necessary to maintain shorter waiting times. The available WLI funding was targeted at the highest priority patients, through commissioning additional IS activity, but instead of eradicating lengthy waits, performance further deteriorated between March 2017 and March 2018:

- the numbers waiting longer than 52 weeks for initial outpatient appointments grew from 53,100 to 83,000, and from 9,600 to 16,000 for hospital admissions.
- waits of more than 26 weeks for a diagnostic test increased from 9,700 to 17,000.

4.5 Some progress was reported for four of the Plan's other five commitments **(Figure 31)**, but several factors make it difficult to firmly conclude on the extent of this. For example, the review did not assess all of the Plan's 29 actions, and an absence of further performance reporting means little clarity exists over how this work evolved, or what outcomes it achieved.

37 This comprised £7 million non-recurrent funding allocated to DoH following the October 2017 monitoring round plus an additional £6 million from unallocated DoH baseline funds.

Figure 31: Some progress was reported in implementing commitments of the 2017 Elective Care Plan

Commitment in 2017 Elective Care Plan	Commentary in 2018 progress report
Commitment 2 – Increase patient self-management services to enable patients with long-term conditions to manage their condition more effectively.	Work delivered and ongoing to support people with some long-term conditions to self-manage these.
Commitment 3 – Increase primary care capacity and capability so that patients can be appropriately managed locally, outside the secondary care setting.	Initiatives ongoing or being developed, including for the Ophthalmology, Orthopaedics, General Surgery, Neurology specialisms, aimed at using primary care capacity more efficiently and effectively to help free up secondary care consultants to see urgent and complex cases quicker.
Commitment 4 – Improve the interface and communication between primary and secondary care to enable more rapid access for patients to secondary care services.	Ongoing work on several fronts.
Commitment 5 – Reform and modernise secondary care services to meet patient demand, to ensure that patients are seen at the right time, in the right place and by the right person.	Initiatives were progressing, including work to increase 'one visit service' models in some specialisms rather than separate outpatient and treatment appointments. Work was also ongoing on imaging services, orthopaedics, and virtual fracture clinics.

Source: NIAO, based on DoH 2018 Progress Review.

4.6 Given the contribution which dedicated capacity can make to delivering elective care more efficiently (paragraph 3.15), the Plan's final commitment was to `*establish regional Elective Care Assessment and Treatment Centres to deliver large volumes of assessments and non-complex routine surgery across a broad range of specialties*'. DoH had concluded in 2017 that potential benefits were achievable from such centres, including:

- enhanced patient outcomes;
- quicker assessment and better management of acute surgical patients;
- more timely and efficient patient throughput;
- reduced waiting lists, due to more efficient operating theatre usage and fewer hospital admissions; and
- savings from reduced hospital stays, and fewer patient complications.

4.7 Following this, the Department stated in February 2018 that, subject to availability of additional investment, it would support the development of a number of regional centres across NI by December 2020 which would deliver elective day case procedures and treat patients across six key specialisms[38].

38 General Surgery, Urology, Ophthalmology, ENT, Gynaecology, and Orthopaedics.

4.8 As paragragh 3.16 outlined, the HSC trusts subsequently established several dedicated elective centres. DoH had estimated in 2017 that if sufficient capacity was available, over 100,000 adult daycase procedures, 25,000 adult endoscopy procedures, and 8,000 paediatric surgical procedures could be performed annually as day cases. Unsurprisingly, it has not proved feasible to build such large-scale capacity. The LVDPC (paragraph 3.16) has delivered over 10,000 day cases since August 2020, and five `prototype' centres across NI have treated almost 19,000 cataract and 2,100 varicose vein patients between 2019-20 and 2021-22.

4.9 Establishing dedicated elective facilities requires careful planning and oversight, and access to sufficient funding. Historical limited progress in this area was compounded by the significant impact of COVID-19 on the HSC sector, which further restricted the ability to develop larger scale capacity. In any case, further expansion of dedicated capacity is likely required to help sustainably reduce waiting times. Part 5 considers more recent initiatives being developed by the Department and trusts in this area.

Implementation of the Plan was hindered by insufficient transformation funding being available

4.10 The 2018 progress review concluded that elective services remained under significant pressure, with waiting times still "unacceptable". It highlighted that insufficient short-term WLI funding (paragraph 4,3), coupled with limited additional longer-term funding had prevented the Plan's fuller implementation, and that additional support of this type was required to achieve meaningful improvements, rather than simply continuing to address current pressures.

4.11 The level of funding available inevitably dictated the progress achievable. DoH had estimated the total costs of fully implementing the Plan as being between £859 million and £909 million over a five-year period (£319 million to permanently clear the patient backlog, and between £540 million and £590 million to enhance HSC capacity to meet future demand). However, this estimate was never publicly disclosed as DoH acknowledges that further work was required to fully confirm its accuracy. In practice, between 2017-18 and 2021-22, only £136.5 million was made available (£71.1 million WLI funding to tackle backlogs, and £65.4 million allocated to elective care transformation).

4.12 This proved inadequate to fully deliver the Plan's commitments, and waiting times continued increasing substantially over this period. This again confirms how budgeting constraints and the many competing HSC priorities mean DoH has struggled to adequately fund transformation.

4.13 Although no further performance reporting was completed on the Plan, DoH's subsequent June 2021 Elective Care Framework confirmed that the "*inability to implement*" it had been attributable to insufficient transformation funding, together with the impact of the collapse of the NI Executive in early 2017 on facilitating key decisions around this area. When the plan was published, DoH had highlighted four other key enablers, aside from funding, as being essential to ensure its timely and effective delivery:

- partnership working between clinical and managerial leaders across primary and secondary care;
- creating a workforce of sufficient size and with the necessary skills;
- infrastructure improvements, particularly around significantly expanding existing HSC theatre infrastructure; and
- improvements in technology and innovation to enhance information sharing for HSC professionals and patients.

Subsequent performance outcomes suggest that progress across these themes was also limited.

Recommendation

We recommend that the Department identifies the investment necessary to ensure the HSC sector can function more efficiently and sustainably, including reducing waiting times to targeted levels. It should also demonstrate and quantify, in business case terms, if such investment can ultimately secure better longer-term value for money and patient outcomes, and the likely implications of failing to secure such funding. This will help DoH demonstrate how more sustainable funding arrangements can better support its objectives.

Further proposals to reduce waiting times in the 2020 New Decade New Approach document were significantly hampered by COVID-19

4.14 The *New Decade, New Approach (NDNA)* agreement was reached in January 2020 by the main local political parties to restore government in NI. It contained the re-established Executive's plans to transform local public services and restore public confidence in devolved government. Its immediate priorities included establishing a long-term transformation funding mechanism for the HSC system. Following the poor progress in implementing the 2017 Plan, *NDNA* committed to introducing a new waiting times action plan, pledging that no-one waiting over a year at September 2019 for HSC assessment or treatment would still be on a waiting list by March 2021.

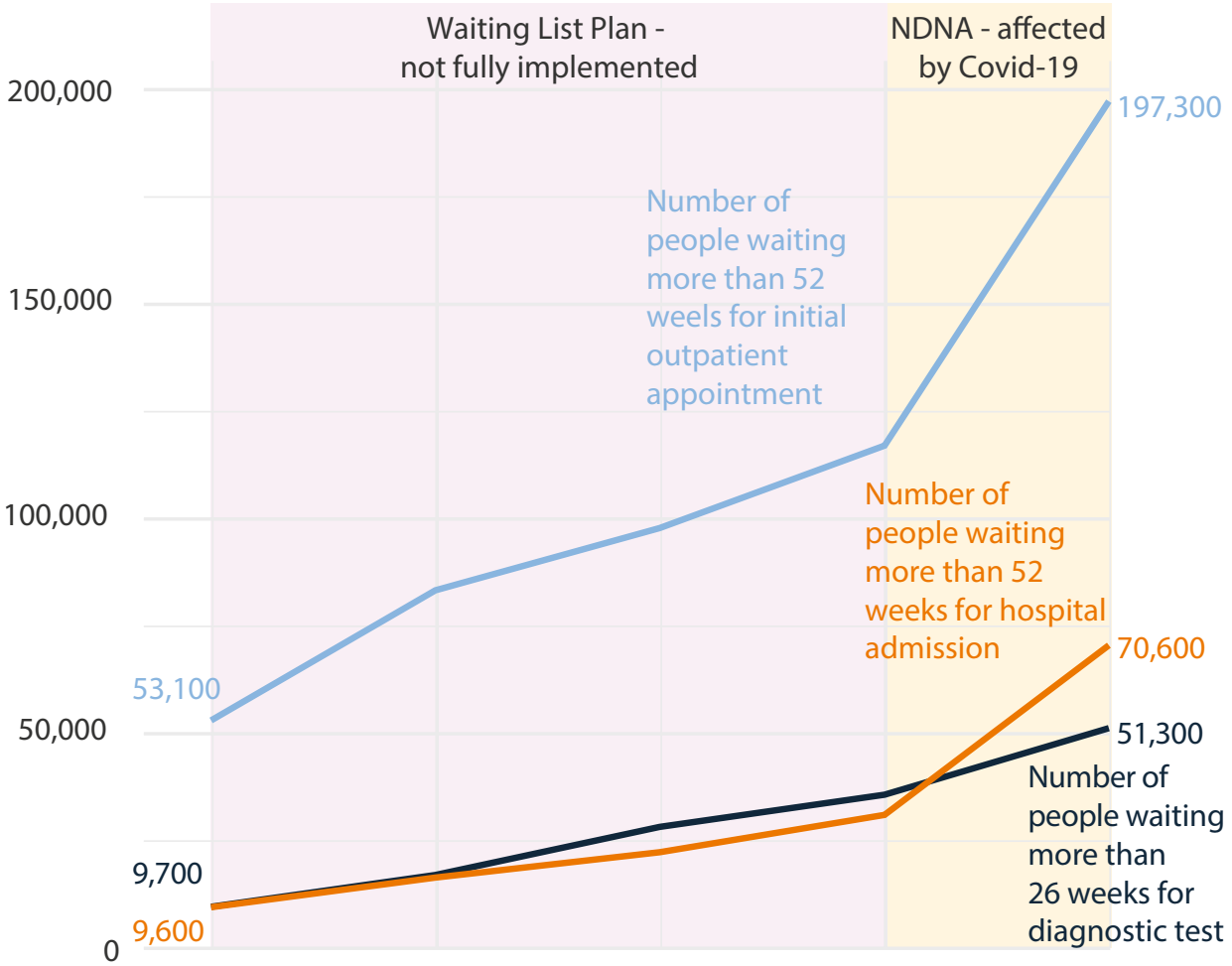
4.15 *NDNA* also outlined several other proposed actions related to waiting times and hospital services, including:

- reconfiguring hospital provision to deliver better patient outcomes, more stable services and sustainable staffing, with improvements in day case elective care by the end of 2020; and
- considering the scope for measuring waiting times across the entire patient journey, with appropriate RTT waiting time targets.

4.16 Only weeks after *NDNA* was published, the first case of COVID-19 in NI was confirmed, and the pandemic curtailed DoH's ability to deliver the proposed actions throughout 2020 and parts of 2021 (paragraphs 3.19 to 3.24). Although the LVDPC opened in August 2020, the unscheduled care pressures arising from COVID-19 significantly disrupted local elective capacity elsewhere, and limited scope also existed for progressing improvement and transformation activities, and waiting times therefore continued rising. However, even if the pandemic had not impacted elective care so significantly, very substantial funding would have been required to deliver the NDNA proposals, and given previous experiences, there is no guarantee that it could have been secured in practice.

4.17 In the period between publication of the 2017 Plan and March 2021 (one year after NDNA was issued), waits exceeding 52 weeks for outpatient assessment and hospital admission and 26 weeks for diagnostic tests increased by 257 per cent, 610 per cent, and 429 per cent respectively **(Figure 32)**. This reaffirms how the limited implementation of the 2017 Plan represented a missed opportunity to begin addressing waiting times which, whilst already growing, were then at much more manageable levels, but which then seriously worsened even before COVID-19 further decimated elective capacity.

Figure 32: Trends for outpatient appointment, hospital admission and diagnostic test waits over period covered by 2017 Waiting List Plan and NDNA



Source: NIAO, based on DoH published waiting time statistics.

4.18 With COVID-19 pressures gradually easing, DoH published the current *Elective Care Framework* document in June 2021, thereby fulfilling the *NDNA* commitment to issue a revised action plan for waiting times. However, when published, this document acknowledged that very considerable challenges lay ahead if the situation which then existed was to be improved and that the huge number of people now on local waiting lists meant DoH may be unable to introduce more transparent local RTT targets for some time. Part five of this report outlines the progress to date in implementing the current Framework, and how significant difficulties have already been encountered in fully delivering its objectives.

Conclusions

The enormous increases in waiting times since March 2014 reflect several factors, including the growing patient demand/capacity gap, lack of progress in delivering HSC transformation, uncertain and largely short-term funding arrangements, workforce pressures, and the recent impact of COVID-19. An acutely critical situation has clearly now developed.

The inability to secure adequate transformation funding to reconfigure the HSC system so it can better meet population needs has contributed significantly to the poor progress, fuelling longer-term problems, whereby the deteriorating conditions of an increasing number of people waiting lengthy periods for care will place unbearable pressures and costs on the HSC sector. Lessons need to be learned from previous experiences, and the Department needs to strive to ensure that the current Framework document is implemented as fully as possible in difficult circumstances. Part 5 considers the latest position in this regard.

Part Five:

The current response

The Department published an elective care Framework in June 2021

5.1 The `*Elective Care Framework Restart, Recovery and Redesign*' (the Framework), published by DoH in June 2021 represents its current five-year strategy to reduce waiting times. When published, it's aim was to ensure that by March 2026:

- no-one should wait more than 52 weeks for a first outpatient appointment or inpatient treatment; or 26 weeks for a diagnostic test; and
- the demand/capacity gap for elective care, and associated patient backlog, would be eradicated.

5.2 Under these targets, some patients could still theoretically have to wait up to two years between GP referral and hospital treatment. The very large patient backlog also means that DoH may be unable to set stronger RTT goals for some time. This clearly demonstrates how badly local performance had deteriorated when the Framework was published in 2021.

5.3 The Framework is seeking to deliver 55 actions across 18 themes, with target implementation dates of December 2021 (short-term), December 2022 (medium-term) or January 2023 onwards (longer-term). **Figure 33** lists the 18 themes.

Figure 33: The elective care Framework is seeking to address 18 themes

Immediate themes (delivered by December 2021)	Medium-term themes (delivered by December 2022)	Longer-term themes (delivered from January 2023 onwards)
• treatment capacity	• annual delivery plan	• infrastructure
• expansion of elective care centres	• separating elective and unscheduled care	• targets
• outpatient reform	• workforce	• seven-day working
• elective patients with urgent needs	• commissioning and targets	• digital
• imaging and pathology	• primary care	
• cross border healthcare	• administration of waiting lists	
• speciality-specific actions		
• performance management		

Source: DoH Elective Care Framework June 2021.

5.4 DoH established an Elective Care Management Team (ECMT) in February 2022, comprising HSC clinicians and senior managers, to lead implementation of the Framework. The Department told us that it is working to develop clear implementation plans, focusing heavily on regional solutions and best practice, and is using information on HSC performance to support informed decision-making on key considerations, including new services, and alterations to existing services, to ensure best patient outcomes. The ECMT's responsibilities include:

- target-setting and deadlines, assigning responsibilities, prioritising actions and taking funding decisions;
- progress and performance monitoring during implementation, and resolving escalated performance management issues; and
- decision-making on actions to ensure targets are met.

Funding uncertainties now clearly threaten the Framework's longer-term implementation

5.5 To fully deliver the Framework, DoH estimated in 2021 that £707.5 million additional investment would be required between 2021-22 and 2025-26 **(Figure 34)**.

Figure 34: £707 million additional funding is required to fully implement the Elective Care Framework

Type of funding	Purpose	Estimated funding required £ million
Non-recurrent funding	Purchasing additional HSC and IS activity through extended and weekend trust working, insourcing IS clinicians to use inactive HSC theatre capacity, and outsourcing activity to the IS to clear the patient backlog.	475.0
Recurrent funding	Additional recurrent funding to increase HSC permanent capacity to meet the increasing demand and sustain waiting times at "acceptable" levels.	232.5
Total		**707.5**

Source: DoH Elective Care Framework June 2021.

5.6 This estimate is significantly lower than the forecast £859 - £909 million required to deliver the previous 2017 Plan (paragraph 4.11), despite waiting lists having considerably worsened since then. Preparing forecasts in this area is complex, and DoH acknowledges that this estimate may have to be reassessed when trusts return to pre-Covid activity levels. Based on this estimate, it projected that this additional funding might: support an additional 475,000 assessments and 166,250 procedures by 2025-26; help strengthen permanent HSC capacity; and support transformation, including increasing seven-day HSC working, and more dedicated elective centres. However, it acknowledged challenges in strengthening services, citing:

- the time required to train and develop staff;
- challenges in recruiting specialist staff;
- limits to the number of deliverable training places; and
- the large investment needed to increase and upskill the HSC workforce.

5.7 An estimated £71.5 million additional funding was required in 2021-22 to begin implementing the Framework (£70 million non-recurrent and £1.5 million recurrent), and DoH actually allocated £91.2 million non-recurrent support. This was intended to be the final year in which NICS departments would operate under annual budgets, as to enhance planning, reform and improvement of public services, DoF had published an initial draft three-year budget for 2022-25 in December 2021. This draft budget was possible as the UK government had completed a three-year Spending Review for this period. The draft three-year budget had allocated the £395 million required to progress the Framework over this period. However, as it was not formally ratified by the NI Assembly prior to the Executive's collapse in February 2022, DoH has had to continue working within the confines of short-term budgets in its efforts to reduce waiting times.

5.8 In 2022-23, DoH allocated £92 million non-recurrent support towards the Framework. It also approved £9.6 million further recurrent funding to establish Omagh Hospital as NI's second regional day procedure centre and to increase elective activity at LVDPC and Musgrave Park and Craigavon Area hospitals, to tackle long waits for several specialisms. The Omagh facility will deliver approximately 1,300 extra urology and general surgery procedures annually from July 2023 onwards (specialities with long HSC waits). In addition, elective overnight stay centres at three HSC hospitals are to provide intermediate complexity surgery across several specialisms[39]. Phased expansion of 21 new regional Post anaesthetic Care Unit elective beds will also improve patient outcomes, with shorter stays, and reduced inpatient cancellations due to the lack of intensive care and high dependency beds.

5.9 Whilst DoH was therefore able to allocate substantial additional non-recurrent funding to the Framework to March 2023, the failure to ratify longer-term NICS budgets meant that uncertainty existed around the availability of the significant recurrent funding also required to fully deliver it. Consequently, in October 2022 DoH acknowledged that "*without an agreed budget in place there remains uncertainty around the future implementation of the Framework. The ability to plan strategically continues to be hugely limited by the lack of a financial settlement*".

Recommendations

As DoH and the Trusts seek to incrementally build increased dedicated elective capacity, they should monitor its impact on waiting times, and assess whether the additional facilities are having the desired success and impact. If waiting times are not reducing appreciably, they should prepare revised projections on the extent of further capacity required across key specialisms.

39 The Mater Hospital (Belfast), South West Acute Hospital (Enniskillen), and Daisy Hill Hospital (Newry) covering the general surgery, urology, gynaecology and ENT specialisms.

Whilst progress has been achieved since the Framework's publication, some key actions are behind schedule, and in May 2023 DoH announced that the targets to improve waiting times by 2026 could not be achieved

5.10 The Department has reported regularly on the Framework's implementation since it was published. This is positive given that implementation of the 2017 elective care plan did not proceed as envisaged. To date it has issued four update reports, highlighting positive outcomes, which included:

- a newly established fracture, orthopaedic, and general rehabilitation clinic which had saved 4,700 acute bed days;
- additional WLI funding in 2021-22 supported 260,000 additional outpatient assessments, diagnostic tests and hospital procedures, 4,200 procedures at the LVDPC, 8,500 GP outpatient assessments and procedures, and 4,500 people treated at specialist megaclinics. In 2022-23, additional funding facilitated almost 321,000 assessments, diagnostic tests and procedures;
- the second regional day procedure centre at Omagh commenced operating in early 2023, with phased implementation of the Mater Hospital as a short-stay patient centre ongoing;
- almost 3,700 patients were treated in the RoI through a relaunched Cross-Border Healthcare Directive[40], between July 2021 and September 2022;
- an orthopaedics day case surgery unit at Musgrave Park Hospital having opened in September 2022; and
- the newly established ECMT (paragraph 5.4) had begun prioritising patients across some specialisms and working on maximising HSC capacity.

5.11 At May 2023, DoH categorised 23 of the Framework's 55 actions as being complete, with a further 6 evaluated as having a green `RAG' status rating . However, 21 other actions were allocated an amber rating and 5 given a red rating. Some actions key to improving longer-term waiting list performance were behind schedule, including:

- expanding use of the IS to deliver elective care and agreeing longer-term contracts with the sector;
- supporting radiographers to complete more work normally led by consultants;
- piloting new commissioning models aimed at improving productivity for some elective specialisms;
- funding an international nursing recruitment campaign; and
- permanently increasing capacity across the 15 largest elective specialisms.

5.12 More importantly, the Department's May 2023 progress report reaffirmed that the recurrent funding required to fully implement the Framework had still not been made available. On this basis, it concluded that even if such investment was provided going forward, it would not now be possible to achieve the Framework targets by 2026.

40 Individuals pay IS providers for this treatment and are reimbursed up to the cost of the HSC treatment in Northern Ireland.

5.13 As paragraph 5.2 outlined, the Framework targets meant that some people could still wait up to two years between being referred for an initial outpatient appointment and hospital admission. Whilst these targets could be viewed as relatively modest, achieving them would still have represented an improvement on the current situation. It is therefore very concerning that the Department has conceded that these cannot be met less than halfway into the Framework's lifespan.

5.14 The Department is currently unable to set revised Framework targets, as this would require a Ministerial decision. It is also now faced with an extremely challenging situation of trying to deliver the Framework as fully as possible using limited available resources. Instead, to fully achieve its objectives, the significant non-recurrent funding committed to date would also have need to have been supported by sustained recurrent investment to help address the longstanding issue of demand outstripping HSC capacity. Unless and until this is addressed, the potential exists that waiting times for some specialisms will remain unacceptably long for the foreseeable future.

Recommendations

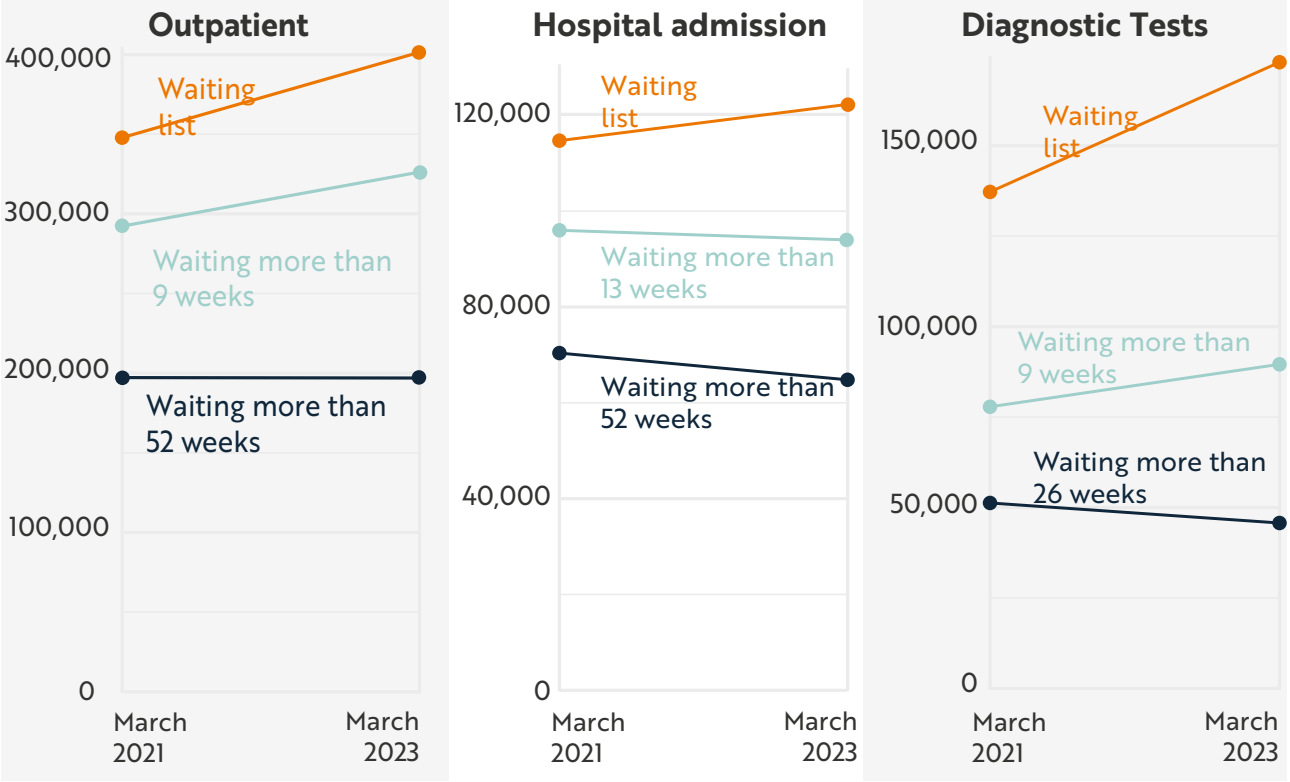
Given the current situation, the Department should firstly confirm the robustness of its estimate of the funding required to fully implement the Framework in preparation for any potential introduction of long-term budgets. Until it has greater certainty on the availability of recurrent funding, it should rank or prioritise the actions likely to have greatest impact on waiting times and allocate available recurrent and non-recurrent funding towards these on this basis. The Department should set revised Framework targets as soon as feasible.

The limited implementation of previous strategies means the Department's regular progress assessments on the Framework is welcome. Going forward, these should identify the specific work which must be progressed over the next reporting period to ensure deadlines and milestones are met, who is responsible for this, progress against targets and timelines, and whether emerging evidence means any actions should be redesigned or reprioritised. Progress should continue being publicly reported, setting out why any actions are behind schedule, and whether, and how, this can be rectified.

Significant additional funding provided in 2021-22 has slightly reduced some lengthy waits, but much more progress is required

5.15 Although the Framework's targets cannot now be fully met by 2026, reducing waiting times remains a crucial objective for DoH. At March 2023, the numbers on all HSC waiting lists had continued rising compared to March 2021, with particularly significant increases for outpatients and diagnostic tests. The numbers of outpatient assessment waits exceeding nine and 52 weeks, and diagnostic test waits exceeding nine weeks have also continued rising. Positively, reductions were evident in 13 week hospital admission waits (1.8 per cent), 52 week hospital admission waits (8.6 per cent), and diagnostic test waits exceeding 26 weeks (over 9 per cent). This illustrates some initial impact from the significantly increased WLI funding provided in 2021-22 (**Figure 35**). However, the wider trends help illustrate why stronger improvements will not be achieved without a more sustainable funding framework to support HSC reconfiguration and transformation.

Figure 35: Waiting lists and waiting times have mainly continued rising since the Framework's publication, although small improvements are apparent in some areas



Source: DoH published waiting time statistics.

5.16 Our current review concludes by assessing challenges which lie ahead to achieve further progress across three key areas identified by the Framework:

- strengthening and upskilling the HSC workforce;
- increasing the use of the IS to clear patient backlogs; and
- increasing the role of primary care in delivering elective treatment.

Key issue 1 – Further efforts are required to build an HSC workforce capable of reducing current waiting times

5.17 Successfully transforming HSC elective care requires a fully resourced and fit for purpose workforce. To try and address serious HSC workforce pressures which had been building for some time, DoH published the *2026 HSC Workforce Strategy* (*the 2026 Strategy*) in May 2018. The document's 24 actions are aiming to ensure the HSC workforce is suitably resourced and skilled by 2026 to ensure local population wellbeing.

5.18 The more recently published Framework also confirmed workforce strengthening as "*the most critical element of delivering sustainable elective care reform*". The Department reported in May 2023 that 10 of the 14 Framework actions directly related to workforce had a RAG status of either amber or red. More generally, the Framework identified a need for:

- increased GP numbers to help shift more elective care into primary care settings;
- further substantial expansion of the HSC nursing and consultant workforces;
- growth in new multidisciplinary elective roles, including specialist nurses and allied health professionals (AHPs).

5.19 Without the necessary workforce, operations are often cancelled or postponed, meaning patients have to wait longer for treatment. Redeploying staff to address unscheduled care pressures also reduces elective capacity and impacts on waiting times. Evidence provided by RCS England to the Health Committee in November 2021 confirms how such problems can arise:

> RCS England highlighted major staffing shortfalls within local perioperative nursing[41] which had been exacerbated by significant staff redeployment to COVID-19 intensive care units during the pandemic. A trauma and orthopaedic surgeon informed the Committee of specific issues at Musgrave Park Hospital, with perioperative nursing staff having reduced from "about 100 or just over 100" at early March 2020, to only 14 at November 2021. He stated that 40 nurses had been redeployed elsewhere, with a further 31 having left, many having "left nursing completely and given up their registration". Even if all the redeployed nurses were returned to Musgrave Park, he stated that only 70 per cent of pre-pandemic capacity would be restored.

41 Perioperative nursing is a nursing specialty that involves providing care to patients undergoing surgery.

5.20 Whilst crucial to reducing waiting times, building a sufficiently strong workforce will prove difficult given intense global competition for healthcare staff, and will require well-managed approaches to training, recruitment and retention. A review of the 2026 Strategy's first action plan up to the end of 2020 identified some progress, including:

- substantial increases in the number of commissioned nursing and midwifery training places;
- an international recruitment programme having appointed over 1,200 nurses over the previous five years, 1,100 of whom remained working in HSC Trusts at August 2022[42];
- workforce planning reviews delivered for several HSC staffing groups; and
- revised processes introduced to reduce HSC recruitment timescales.

5.21 Despite this, the review acknowledged that "*many of the challenges previously identified remain and further challenges have emerged as a result of the pandemic's effects*". In assessing progress in implementing the Framework's workforce-related actions, the Department's October 2022 review (paragraph 5.9) also concluded that this had been "variable", commenting that "*progress has been hampered, not only by the continuing pressures on the service, but by current uncertainty around funding*".

5.22 Prior to publishing the 2026 Strategy, DoH had substantially cut nursing and midwifery training levels, from over 800 places in 2009-20, to only 630 in 2013-14 and 2014-15. However, in more recent years, it has taken considerable steps to address growing staff shortfalls. It progressively increased nursing and midwifery training levels again from 2017-18, reaching 1,325 places annually between 2020-21 and 2022-23. The Business Services Organisation (BSO)[43] has also recently developed a business case to expand international nursing recruitment, targeting up to 3,000 nurses by 2025-26, although the Department has acknowledged that an absence of the necessary recurrent funding means that recruitment will be constrained in 2023-24. DoH has also sought to try and further bolster the wider elective workforce by funding an additional 41 AHPs and 13 medical speciality training places in 2022-23.

5.23 This work has helped ensure that staffing numbers have increased notably across all the main HSC elective care workforce groups since the 2026 Strategy was published (by 9.9 per cent for nursing and midwifery, 17.7 per cent for AHPs, and 15.7 per cent for the medical and dental group). Despite this, vacancy levels remain high across all groups. At March 2022, almost one in ten nursing posts was unfilled, together with 8 per cent of AHP and nursing support staff posts, and almost 6 per cent of medical posts **(Figure 36)**. This indicates that further action is required to build the HSC workforce required to cope with rising population demand.

42 This information was sourced from DoH's second progress review of the Elective Care Framework published in October 2022.

43 BSO provides the local HSC sector with a range of business support functions and professional services.

Figure 36: Whilst staffing numbers in the elective care workforce have increased since 2018, vacancy levels remain high

Staff Group	Staff in post q/e Jun-18	Staff in post q/e Mar-22	% increase since June-18	% staff vacancies q/e Jun-18	% staff vacancies q/e Mar-22	Change in % vacancies
Registered Nursing & Midwifery	17,125	18,819	+9.9%	10.5%	**9.9%**	**-0.6%**
Nurse & Midwifery Support	5,035	5,313	+5.5%	6.5%	**8.4%**	**+1.9%**
Allied Health Professionals (excl Paramedics)	4,520	5,299	+17.2%	9.4%	**8.1%**	**-1.3%**
Medical & Dental	4,552	5,268	+15.7%	4.1%	**5.8%**	**+1.7%**

Source: NIAO based on data supplied by DoH.

Recommendation

Close working between those involved in workforce-related issues is required to ensure stronger workforce planning for elective care. The stakeholders should now take stock of how their various work is progressing, and collectively agree the priority areas which require further attention, to ensure the HSC elective workforce has the right capacity and capability to drive HSC transformation. Based on the current situation and workforce deficits, revised projections and plans should be developed, together with targets and strategies for achieving these.

Key issue 2 – Increased use of the Independent Sector will be necessary for some time to clear the very large patient backlog

5.24 HSC waiting lists at June 2023 included almost 724,000 outstanding outpatient appointments, hospital admissions and diagnostic tests, 319,836 (44.2 per cent) of which had already breached maximum waiting time targets (52 weeks for outpatient appointments and hospital admission, and 26 weeks for diagnostic tests). Until the HSC sector builds sufficient permanent capacity, it will inevitably need to make much greater use of the Independent Sector (IS) to clear the very large patient backlog.

5.25 The IS's role in tackling HSC waiting lists has historically been driven by the level of available WLI funding. Trusts have generally agreed short-term contracts with IS providers to address priority waits, with some also insourcing IS providers to treat patients using HSC facilities. Whilst using the sector may not necessarily represent best value for money (VFM) in purely economic terms, DoH monitors contracts trusts propose to enter with IS providers, and highlighted that trusts will not normally enter these if their proposed costs excessively exceed the NHS national tariff.

5.26 Costs aside, increased use of the sector is now necessary to try and avoid large numbers of patients developing more advanced conditions. Recognising this, the Framework committed to exploring the scope for expanding use of the IS by December 2021. It proposed establishing medium-term contracts to lease HSC theatres to IS providers, mainly using inactive in-house theatre capacity, and developing proposals for multi-year arrangements with IS providers[44]. It envisaged that such arrangements would provide better VFM than the existing short-term contracts with the IS.

5.27 However, DoH has assessed these actions as being `at some risk and requiring corrective action'. Discussions have been held with IS providers on providing weekend day case care, and on agreeing longer-term contracts with the sector, and on what capacity IS providers might be able to allocate to the HSC in future years. However, the absence of a multi-year budget has prevented further progress, with the sector hesitant to develop significant additional capacity, given its potential exposure to financial risk. Consequently, trusts are continuing to use the IS through shorter term contracts, meaning that the benefits envisaged under longer-term arrangements have not been realised. The ongoing absence of multi-year budgets also means trusts have been unable to fund enhanced infrastructure capacity for the largest elective specialisms, which is required in order to insource IS providers on longer-term contracts.

5.28 If multi-year budgets are ultimately introduced, the trusts will need to further liaise and work closely with the sector to identify and agree the extent to which it can further contribute to clearing the backlogs. As the potential level of the IS's involvement has not yet been formally quantified, IS providers will require greater clarity to plan for future potential resourcing and capacity requirements.

5.29 It is also important to highlighted that the need to significantly increase reliance on the IS has only arisen because of the very large patient backlogs which have been allowed to develop, and that these would not have reached such critical levels had much greater progress had been made in introducing more sustainable funding HSC funding arrangements, and successfully delivering HSC transformation. Whilst clearing the backlog is essential, HSC capacity must also be significantly strengthened if waiting times are to be maintained at manageable levels, and excessive longer-term reliance on the IS avoided.

Recommendation

Increased use of the IS is likely to be necessary for the foreseeable future to address the colossal patient backlog. In preparation for any progress in approving multi-year budgets, DoH should set out its strategic plans for expanding use of the IS, and continue to clarify with the sector the degree to which it can build additional capacity to help clear the backlogs.

44 Where the same value for money and service standards as the HSC could be secured.

Key issue 3 – Progress in increasing the role of primary care in delivering elective treatment has largely stalled

5.30 To try and reduce demand on HSC trusts for routine procedures, ensure patients receive treatment faster, in more convenient settings, and free up hospital capacity for more urgent patients, primary care providers began delivering elements of HSC elective care in November 2018. Subsequent expansion of capacity and capability has seen over 40,000 elective referrals received by October 2022 across five clinical pathways[45] by primary care, with over 30,000 patients assessed and treated. These services have mainly focused on patients with routine conditions who typically endure long HSC waits.

5.31 The Framework committed to further develop and expand appropriate elective provision within primary care. Whilst plans for the next phase were to have been completed by March 2022, DoH's October 2022 progress report (paragraph 5.9) also identified this action as being `at some risk and requiring further attention', highlighting that a proposed three-year work plan covering 2022-23 to 2024-25, which had been developed to support this, had not been implemented, again due to insufficient available funding.

5.32 Agreed primary care elective activity levels did not increase in 2022-23 compared with 2021-22 as had been envisaged, and uncertainty exists around whether further planned increased activity for 2023-24 and 2024-25 will be funded. Consequently, around 4,900 additional assessments and treatments planned for primary care may not be delivered. In addition, expansion of further pathways and development of new specialisms has also been deferred.

5.33 Whilst DoH told us that HSC stakeholders were continuing working to try and explore potential additional areas for transformation, successful implementation of any further plans will inevitably again require the introduction of longer-term budgets. To date, however, initial progress made in this area has largely stalled, meaning that the important range of benefits achievable has not been fully realised.

45 Musculosketal (MSK), Dermatology, Gynaecology, Vasectomy and Primary Care Surgery.

NIAO Reports:
2023

NIAO Reports 2023

Title	Date Published
2023	
Planning Fraud Risks	01 March 2023
Public Procurement in Northern Ireland	25 April 2023
Ministerial Directions in Northern Ireland	27 April 2023
Pre-school Vaccinations in Northern Ireland	05 May 2023
Mental Health Services in Northern Ireland	23 May 2023
Reducing Adult Reoffending in Northern Ireland	13 June 2023
Innovation and Risk Management - A Good Practice Guide for the Public Sector	27 June 2023
Developing the Northern Ireland Food Animal Information System	28 June 2023
School Governance - A Good Practice Guide	04 July 2023
The Judicial Review Process in Northern Ireland	04 July 2023
Overview of the NI Executive's response to the Covid-19 pandemic (3rd Report)	27 July 2023
Continuous Improvement Arrangements in Policing	10 August 2023
Approaches to Achieving Net Zero Across the UK - Report by the four Auditor Generals of the UK	15 September 2023

Northern Ireland
Audit Office

Independence and excellence in audit to improve public services

Northern Ireland Audit Office
106 University Street, Belfast, BT7 1EU • 028 9025 1000 • www.niauditoffice.gov.uk

ISBN 978-1-912653-88-1