Department of Health

Elective Care Framework

May 2024

Ministerial Foreword

In June 2021, I published the Elective Care Framework (ECF) – "Restart, Recovery and Redesign" which set out a five-year plan with firm, time-bound proposals for how we would systematically reduce healthcare waiting lists and close the growing gap between capacity and demand. The ECF was developed as a strategic tool to tackle the backlog of patients waiting for assessment and treatment across Northern Ireland. It also set out how we would invest in and transform services to allow us to meet the needs of the population going forward.

That was almost three years ago and there has been significant change across of all of health and social care services during that time. We have seen many aspects of the ECF developed and implemented for the benefit of our patients and our healthcare services. At the same time, however, we have faced some of the most significant challenges to hit the service in a generation. The Coronavirus pandemic not only impacted directly on the service in terms of individuals and families devastated by this deadly virus, but also indirectly on a wide range of elective and non-elective services. Clearly this had a significant impact on our already unacceptable waiting lists and at the same time, the service continued to come under pressure from increasing demographic change.

In Northern Ireland we also have our own set of unique challenges - we have a system that is need of change. This need for changing health care services in NI was expertly summarised in the Bengoa Report[1] and Delivering Together[2], both published by the Department of Health (DoH) in 2016. Further, in common with other Executive Ministers, I have a wholly inadequate draft budget for 2024/25 – while also facing growing need and demand.

While the implementation of the ECF has continued to progress throughout this process, much remains to be done. It is in this overall context that this updated Elective Care Framework has been developed.

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[1] Systems, Not Structures - Changing Health and Social Care - Full Report | Department of Health (health-ni.gov.uk)

[2] Health and Wellbeing 2026 - Delivering Together | Department of Health (health-ni.gov.uk)

This updated ECF sets out a strategic framework for development and transformation for effective delivery of elective care services here. This has been developed on the basis of lessons learned to date and is deliberately set at this strategic level to allow senior decision-makers and clinical leaders within Health and Social Care (HSC) the freedom and flexibility needed for effective implementation of strategic change in a dynamic and complex environment. As such this is not a new ECF, but an updated plan identifying the need to act over the next five years. A number of new actions have been listed within this update, with more scheduled to follow in the weeks ahead after necessary engagement with staff.

It has been developed taking account of the changes that have occurred within the HSC operating environment, both external and internal, the good work taken forward to date under the 2021 ECF and by developing a strategic framework to drive and support the establishment, enhancement and strengthening of service delivery.

To deliver the intended benefits for our patients and wider system, the ECF must be supported by sustainable muti-year investment. I believe that if fully funded for the changes required, the implementation of this framework has the potential to deliver the fit for purpose service that the people of Northern Ireland deserve. I commend it to you.

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Introduction

1. The Elective Care Framework (ECF) was published in June 2021. It set out 55 ambitious actions to transform and improve elective care with the aim to reduce our waiting lists. It identified an investment need of just over £700m over the five years. Three years later much progress has taken place, with 27 actions completed and 21 actions close to being completed or underway. 7 actions are at risk to delivery due to a number of reasons, including lack of recurrent funding, capacity issues and reprioritisation of resources.

2. Even though the ECF has not been fully funded[3], there has been transformation and progress. The work has resulted in treatment waiting times reducing in six consecutive quarters (June 2022 until December 2023). This is the longest sustained reduction since at least 2008. At December 2023, inpatient or day case treatment waiting lists have seen promising improvements. Whilst still at unacceptable levels, there has been an overall 12.7% (14,259) decrease in numbers waiting since the same month the previous year.[4]

3. At December 2023, when compared to December 2022 figures, there have been the following reductions in patients waiting for Inpatient/Day case surgery:
    a. General Surgery – a reduction of 20.8%
    b. Trauma and Orthopaedic surgery – a reduction of 7.6%
    c. ENT - a reduction of 15.9%
    d. Gynaecology - a reduction of 21.6%
    e. Urology - a reduction of 9.6%[5]

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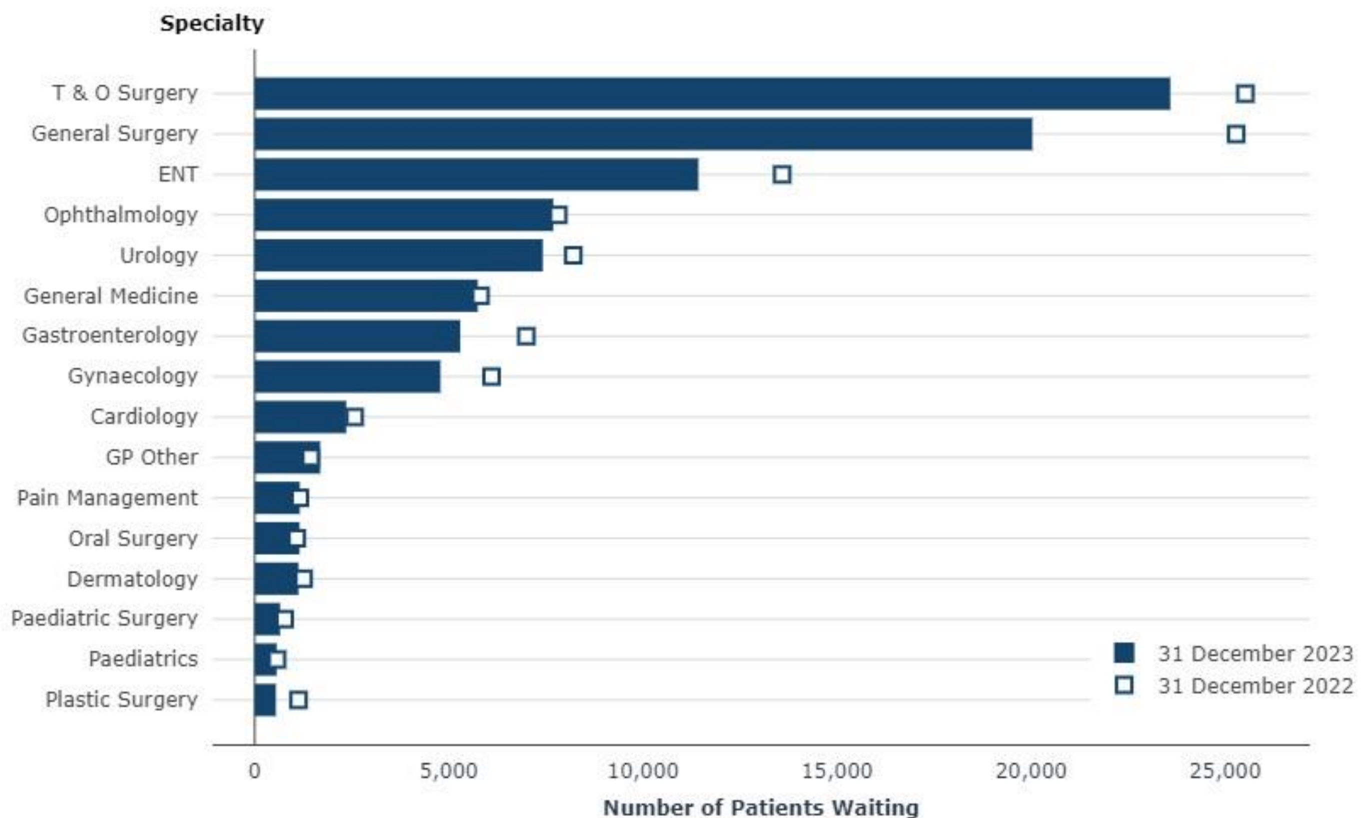
[3] Investment since 2021:
a. £16m recurrent invested in elective care services
b. £252m non-recurrent Waiting List Initiatives funding. However, only approximately £45m of this has been for waiting list reduction, with the remaining invested to plug the gap for red-flag and time critical patients.

[4] NOTE: all figures are adjusted to exclude SET unless otherwise stated. Stats from SET were not available due to implementation of Encompass.

[5] The bar chart shows the number of patients waiting for admission under each specialty on 31 December 2023, with markers comparing numbers on 31 December 2022. Only specialties with at least 500 patients waiting are shown.



4. The most recent report on progress under the ECF, which was published in January 2024, shows that progress has been made against many of the actions with benefits for patients, and the start of small but tangible improvements to the waiting list position.

5. Key examples[6] include:
   a. two dedicated Day Procedure Centres at Lagan Valley and Omagh Hospitals (October 2020 – March 2024, approximately 20,000 patients treated across a range of specialties, including endoscopy);
   b. three Elective Overnight Stay Centres at Daisy Hill, Mater and South West Acute Hospitals (April 2023 – March 2024, over 12,000 patients treated across all three sites);
   c. expansion of 22 Post-Anaesthetic Care Unit (PACU) beds for elective care across all Trusts (November 2023 - March 2024, approximately 600 patients have stayed in a PACU);

[6] Note data provided does not include patient numbers for South Eastern Trust since October 2023 due to Encompass roll-out.

d. three speciality centres for cataracts at Downe, South Tyrone and Mid Ulster Hospitals (Dec 2019 - March 2014, over 18,000 patients treated across all three sites);
e. an orthopaedic hub at Musgrave Park Hospital which includes the Duke of Connaught Unit, a dedicated orthopaedic Day Procedure Centre. (September 2022 to May 2024, over 2,000 patients treated in Duke of Connaught Unit)
f. two Rapid Diagnostic Centres at Whiteabbey and South Tyrone Hospitals;
g. A regional Extracorporeal Shock Wave Lithotripsy (ESWL) centre in Craigavon Area Hospital;
h. Service reviews into general surgery, orthopaedics, urology and gynaecology, to set the direction of travel for improvement;
i. The introduction of mega clinics to maximise patient throughput (January 2021 - March 2024, over 22,200 patients have been treated);
j. Outpatient assessments delivered by GP Federations in primary care settings; and
k. Development of in-house HSC capacity and continued investment in staffing.

6. With the learning from the last three years, it is clear that the ECF needed updated, with a clear plan for further transformation and improvement across elective care.

7. This updated ECF does this, by setting out the strategic direction for development and implementation of changes necessary for delivery of effective sustainable elective care services within the Northern Ireland HSC over the next 5 year period. This ECF has been developed on the basis of changes, both external and internal, which have occurred and which have had or will have an impact on the HSC operating environment. It also builds on lessons learned from the implementation of the 2021 ECF. This Framework sets out a number of strategic themes for service development and transformation. It is deliberately set at a sufficiently high level to afford the necessary freedom and flexibility to senior decision-makers within the HSC to develop and adjust plans as appropriate, within this dynamic operating environment to secure the delivery of Ministerial priorities for HSC services.

8. Within those strategic themes, a number of actions have been set with a focus on the areas where the impact would be the greatest. These actions can only be achieved with appropriate levels of funding.

9. The 2024-25 Budget outcome was extremely disappointing and is likely to have serious consequences for Health and Social Care, reducing our capacity to provide care to red flag and time-critical patients and leading to longer waiting times.

10. Nevertheless, even within this difficult financial environment, it is important that we have a strategic plan in place to set out the actions required to improve and transform elective care services in Northern Ireland to meet the future need and to remove our unacceptably long waiting lists. The ECF highlights a series of actions, some of which can be implemented within our existing resources, some actions that require sustained recurrent investment to deliver and some actions that require targeted non-recurrent investment to deliver.

11. The actions in this ECF are based on three separate waiting lists (new outpatients, diagnostics and day case/inpatient admission). As such, they do not follow the patient from referral to treatment and do not provide a clear oversight of how long patients wait from referral from GP to definitive treatment.

12. The current targets in this ECF represent what is deliverable, considering the significant challenges facing the HSC system. If this updated ECF is fully funded, the excessive waits we currently have will have been in large addressed, at which point it would then be possible to measure a patient's journey from referral to treatment (RTT). At that point, it would also be possible to introduce new, more ambitious targets in line with neighbouring jurisdictions.

13. Going forward, over the next five years, it will therefore be necessary to create an ambitious RTT target, to ensure that the population in Northern Ireland has equitable access to healthcare, similar to those in other parts of Great Britain and

Ireland. We will implement RTT targets on a phased basis building on pilot work carried out since 2021.

14. To reduce waiting lists, it will be necessary to address elective care on three levels; through new sustainable, recurrent investment to increase capacity; through improved productivity and efficiency to increase capacity using existing resources; and through temporary, non-recurrent, investment in activity to clear the waiting list backlog.

15. This will be achieved by carrying out the 10 actions in this updated action plan. However, in order to be successful, the ECF requires funding:
    a. Recurrent funding: £80.5m per year when fully implemented.
    b. Non-recurrent funding: £135m per year for three to five years – totalling up to £675m over five years.

16. This updated action plan focusses on the following seven themes:
    a. Transformation of Elective Services (outpatient and surgery services)
    b. Backlog Clearance
    c. Productivity and Efficiency
    d. Workforce
    e. Independent Sector Engagement
    f. Funding of Services
    g. Patient Communication

17. Implementing many of the actions will require sustainable and recurrent funding. In the current financial climate it is accepted that new recurrent investment is challenging. Nevertheless, the ECF outlines what is required to improve and transform elective care services in Northern Ireland to meet the future need and to remove our unacceptably long waiting lists.

18. In the absence of recurrent funding, work will continue where it is possible, and reports on progress will be provided on an ongoing basis, to stabilise and mitigate the impacts on service of insufficient budgets.

Theme 1: Transformation of Elective Services (Outpatient and Surgery)

Objective:

Through the transformation of services, maximise the provision of care and reduce lengthy waiting times, in line with best practice and Ministerial targets.

Investment:

Action 1: £49.5m per year recurrent

Action 2: no new investment required

Action 3: £20m per year recurrent

19. Over the last three years, there has been progress on transformation of services. Key examples of this progress include the establishment of Day Procedure Centres (DPC), Elective Overnight Stay Centres (EOSC), and Post-Anaesthetic Care Units (PACU). Work will continue in these areas to build on the good work taken forward to date and maximise capacity as far as possible to ensure timely treatment for patients. Confirmation of sustainable funding is required to allow further development of these initiatives and further increase capacity.

Elective Care Centres

- Outcomes:
    - Increased activity in Day Procedure Centres and Elective Overnight Stay Centres.
    - A new Paediatric Elective Care Centre
    - New ways of working across elective care to improve activity
    - Increased public awareness of the Elective Care Centre model.

20. There will be more focus on Centres of Excellence to deliver high quality care for patients when they need it – this will allow the HSC to provide better care to patients and to deliver a greater level of efficiency in doing so.

21. Centres of Excellence will be shaped as Elective Care Centres. The core aim of these centres is to improve patient outcomes. They are a means to increase productivity, efficiency and reliability of the service, and are expected to have a

significant impact on the number of patients treated. By providing services for the region, they also aim to ensure that patients have equitable access to the care they need, irrespective of where they live.

22. There are also benefits for staff in terms of resilience, productivity, standardisation of care, quality of service, training opportunities, and a reduced number of avoidable admissions to hospital.[7]

23. Elective Care Centres are up and running across Northern Ireland with dedicated DPCs at Lagan Valley Hospital (LVH) and Omagh Hospital and Primary Care Complex (OHPCC); EOSCs at the Mater Hospital (MH), Daisy Hill Hospital (DHH) and South West Acute Hospital (SWAH) for patients that may require an overnight stay in hospital; dedicated centres for the treatment of cataract procedures at Downe Hospital (DH), South Tyrone Hospital (STH) and Mid Ulster Hospital (MUH); and an orthopaedic hub at Musgrave Park Hospital (MPH) which includes the Duke of Connaught (DoC) Unit, a dedicated orthopaedic DPC. Each of these centres delivers high volume, low/medium complexity procedures, with high numbers of patient throughput.

24. Going forward, it is intended that a further EOSC will soon be established, creating clear structures for Elective Care Centres across Northern Ireland.

25. The DPC and EOSC model currently focuses on adult services; however it is recognised that there is a need for a similar model for children to ensure they can be treated as quickly as possible in a suitable environment for their needs. In addition to the service already provided at the Royal Belfast Hospital for Sick Children (RBHSC), it is intended to develop this further with a dedicated centre for children. Implementation of this action will require recurrent funding.

26. Activity will be increased across existing Elective Care Centres. This will be achieved through extended working at existing hospitals by using longer days, weekend working and considering the ability to commission new theatre space.

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[7] Separating emergency and elective surgical care. Recommendations for Practice. RCS England, 2007

27. In terms of elective care, Northern Ireland is a relatively small jurisdiction with five HSC Trusts. Each Trust has its strengths, which can inevitably lead to inequitable waits across the region for a single procedure. To prevent this going forward, after the full implementation of the Encompass[8] system, there will be a phased approach to the establishment of a single waiting lists for low and medium complexity procedures. Initial focus will be on single waiting lists for procedures at DPCs and EOSCs.

28. Mega clinics allow patients to be seen quicker in a more effective way, with a reduction in Did Not Attend (DNA) and cancellation (CNA) rates. This transformation will improve productivity and efficiency, ensuring better value for money and more patients being seen within existing resources.

29. £10m investment in mega clinics will allow 31,000 patients to be seen across a number of specialties including breast, urology, macular, orthopaedics, colorectal, gynaecology and fractures, thus reducing time for assessment and diagnosis, and 2,100 pre-operative patients to reduce DNA and CNA rates.

30. The Elective Care Management Team (ECMT) has been working with Trusts to identify key areas for investment to support the effective delivery of elective services. The aim of these measures is to ensure patients can be treated as quickly as possible by building capacity within the HSC system through various ways. This includes, for example, looking at new ways of working through development of Advanced Care Practitioner/Extended Scope Practitioner and other AHP/nursing roles, thus freeing up consultant time; outpatient modernisation measures to reduce cancellations and non-attendance at appointments and expansion of clinical workforce across all specialties.

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[8] Encompass is a Health and Social Care programme that will create a single digital care record for every person in Northern Ireland who receives health and social care. Encompass aims to provide patients and service users with the safest, highest quality of care that is possible. Implementation is ongoing and it will be rolled out across all Health and Social Care Trusts in Northern Ireland by the end of 2025 to create better experiences for patients, service users and staff.

Action 1. Increase activity across Elective Care Centres by extended working, new sites and new service models.

Service reviews

- Outcomes:
    - Increased understanding of changes required at service level.
    - Enhanced transformation across services.

31. Over the last two years, a number of service reviews have been completed, including the Review of General Surgery (2022), the Getting It Right First Time (GIRFT) Review of Orthopaedics (2022), GIRFT Review of Urology (2023), and the GIRFT Review of Gynaecology (2024).

32. These reviews have allowed targeted improvement to service delivery. Thanks to the Review of General Surgery, the service has transformed with a significant reduction in inpatient and day case treatment waiting lists (-20%). The GIRFT Review of Orthopaedics supported the restoration of orthopaedic services post-COVID. Musgrave Park Hospital – one of the three orthopaedic centres of excellence that accounts for approximately 65-70% of all orthopaedic activity in Northern Ireland – is now performing better than both 2018 and 2019.

33. A number of reviews are currently underway, including a GIRFT Review of Paediatric Orthopaedics and service reviews for Neurology and Stroke. A GIRFT Review of Ear, Nose and Throat (ENT) services is scheduled for 2024.

34. Going forward, this service review programme will continue, providing senior decision-makers with a detailed understanding of what transformation is required across the HSC System.

Action 2. Continue the service review programme across elective care:

   a. Complete the GIRFT Review of Paediatric Orthopaedics by September 2024.

b. **Complete a GIRFT Review of ENT services by the end of 2024.**
c. **Continue rolling programmes of service reviews.**

Rapid Diagnosis Centres – pathway expansion

- Outcomes:
  - Faster diagnosis of cancer and other serious diseases
  - One-stop diagnosis and assessment pathway
  - Reduced time to treatment for patients following initial referral

35. Rapid Diagnosis Centres pilot a new approach for the diagnosis of patients. A vague symptom pathway is currently being delivered. This provides a pathway for patients with vague but worrying symptoms that would not meet the criteria for a red flag referral. The model takes learning from similar services that have been developed in Wales and Scotland, which have been positively evaluated.

Action 3. The Department will continue to work with HSC Trusts and Clinical Reference Groups to identify new red flag pathways that would benefit from the RDC model.

Theme 2: Backlog Clearance

Objective:

To reduce the waiting list backlog.

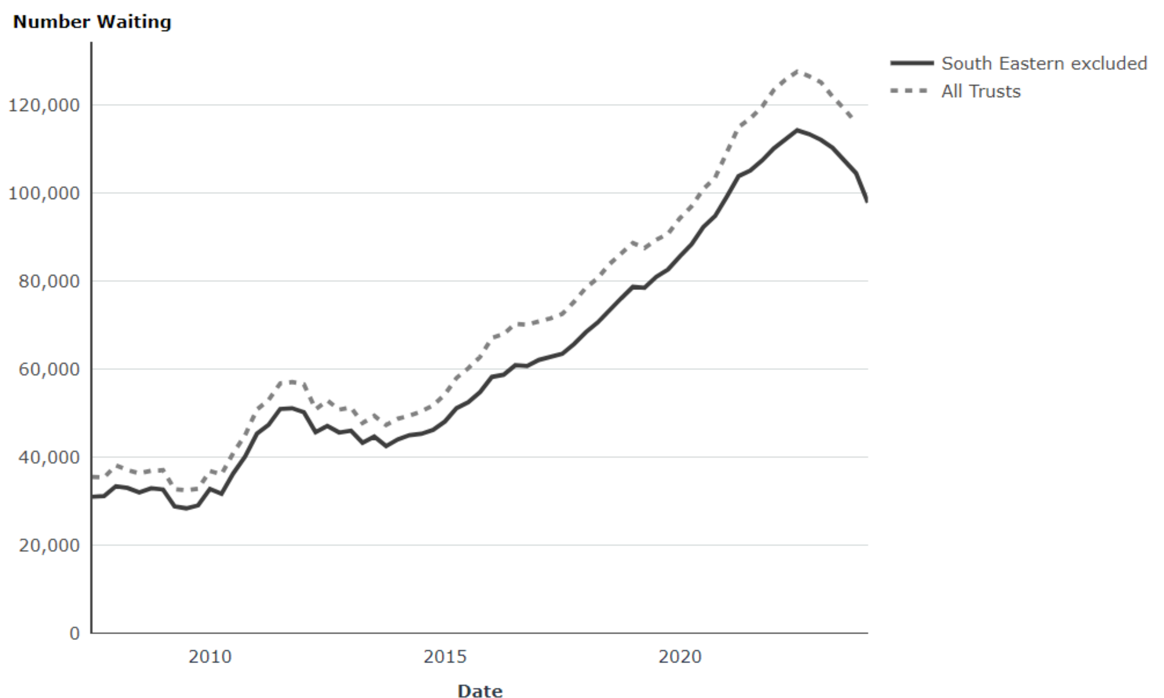
Investment:

Action 4: £135m per year non-recurrent for up to 5 years

- Outcomes:
    - Reduction in waiting lists

36. Waiting lists in Northern Ireland are too long, with too many people waiting above Ministerial targets. The below graph clearly depicts the upward trajectory waiting lists in Northern Ireland have been on since 2013. Despite the beginning of a downturn at the end of 2023, there still remains a significant backlog to address.

Figure 1: Patients Waiting for an Inpatient or Day Case Admission
30 September 2007 to 30 December 2023



This line chart shows that the number of patients waiting rose steadily from 42,435 on 30 September 2013 to 114,222 on 30 June 2022. It has since decreased to 97,794 on 31 December 2023.

37. Many of the actions in this framework focus on creating long-term sustainable capacity to ensure demand is met in the future. Whilst that is a critical component of this framework, there must also be plans put in place to address the large backlog of patients waiting.

38. To address the backlog, there is a need to spend additional resources over and above core demand. This is most effectively done through additionality. It is estimated that it would be possible to spend up to £135m per year in this way, and investments of this level would be required for the next three to five years to clear the backlog and to ensure that no one would be waiting longer than Ministerial targets.

39. This would require an initial focus on those waiting more than three years. In October 2023, there were approximately 47,000 patients waiting over 4 years for an outpatient assessment and 18,000 patients waiting over 4 years for treatment. There are a further 29,000 patients waiting 3-4 years for an assessment and 10,000 patients waiting over the same time period for treatments who will tip into the 4 year waits category over the next 12 months. £135m over a 12 month period would help to clear these patients from waiting lists within 12 months. In the absence of this funding, waiting lists will inevitably continue to grow substantially.

40. Without a budget, however, it is not possible to provide an exact breakdown of what could have been spent. However, below is a planning summary of intended spend:

Specialty/Procedure	Approximate patient numbers	Approximate Cost
Dermatology new outpatient assessment	6,000 patients waiting over 4 years	£2.8m
Cataract procedures	2,800 patients waiting	£5m
Primary hip/primary knee and other long waiting orthopaedic procedures	3,500 patients waiting over 2 years + 900 patients waiting over 4 years	£42m (2 years waits) + £11m (4-year waits)
Laparoscopic Cholecystectomy	1,000 patients waiting over 4 years	£4.5m
Tonsillectomies	1,100 patients (many of whom are children) waiting over 4 years	£3.5m
Rheumatology outpatient assessment	2,100 patients waiting over 3 years	£1.4m

Gynaecology outpatient assessment	4,200 patients waiting over 3 years	£2.5m
Hernia Treatment	800 patients waiting over 4 years	£4m
Colonoscopy	1,905 patients waiting over 3 years	£2.4m
OGD	1,025 patients waiting over 3 years	£0.8m
Other	1,900 patients across a number of specialities	£6m
Scheme	**Approximate patient numbers**	**Approximate Cost**
Reimbursement Scheme	4,000 patients waiting over 1 year – largely orthopaedics	£31m
Primary Care Elective Care	17,000 patients across a number of specialities, including dermatology, gynaecology and MSK	£3m
Mega Clinics	20,000 patients across a number of specialities	£10m
Other including validation		£5m
	Total	**134.9m**

41. The approximate costs set out above are heavily caveated and the exact breakdown of expenditure will depend on a variety of facts, for example, the capacity of Trusts to deliver additional appointments/treatments in a particular specialty and also the capacity of Independent Sector providers to deliver. Furthermore, the cost of delivery in the independent sector will be informed by the unit costs and the ability of the HSC to enter into longer-term contracts, which would allow more competitive pricing. Providers will also need time to adequately plan and schedule the required clinics and theatre sessions.

Action 4. Investment in short-term additionality to clear the backlog of waiting lists.

Theme 3: Quality, Safety, Efficiency and Effectiveness

Objective:

Improve quality, safety, efficiency and effectiveness to ensure highest possible capacity across elective care services, therefore providing better value for money services and increased access to elective care for the population of Northern Ireland.

Investment:

Action 5: no new investment required

- Outcomes:
    - Increased efficiency and effectiveness
    - Increased value for money
    - Increased quality activity within existing resources, thus increase in core capacity reducing the capacity / demand gap

42. There is a need for specific targeted actions to ensure desired outcomes are achieved in terms of transforming services and driving down waiting times. Within this, effectiveness and efficiency are about securing maximum output in line with Ministerial priorities to deliver high quality, safe patient care in Northern Ireland. Inherent within that is the fundamental requirement to deliver value for money.

43. The Department is working with Trusts to increase effectiveness and efficiency through the use of a wide range of best practice service improvement guidance. The focus of this work includes for example:

    a. *New to review ratios* – ensuring that all outpatient review appointments are clinically appropriate; this will be underpinned by the development of alternative models of service delivery including the application of patient initiated follow-up (PIFU);
    b. *Outpatient triage* - using best practice guidance to improve / enhance outpatient triage by streamlining patient pathways and ensuring they are

seen by the right service first time, thereby reducing unnecessary new appointments;

c. *Day surgery* - using the British Association of Day Surgery (BADS) best practice guidance to help develop and monitor the range and volume of procedures carried out as day surgery or as a procedure within the outpatient setting;
d. *Day of admission surgery* – working with Trusts to change booking processes to ensure that admission on the day of surgery is the default position for all clinically appropriate patients;
e. *Theatre utilisation* – using system data to monitor and improve all aspects of theatre efficiency, from the actual booking processes through to the list utilisation. This includes supporting benchmarking comparison by specialty against peer groups;
f. *DNAs / CNAs* – monitoring the number of patients who "Did Not Attend" (DNAs) or cancelled (CNAs) at short notice across assessments and treatments to allow targeted support to help improve current levels. Actions include the implementation and roll-out of patient text reminders; and
g. *Service transformation* – working with Trusts to streamline and improve patient pathways. Actions include the regional consolidation of services to improve patient outcomes.

44. It is anticipated that achievement of the above measures will support effective and efficient service delivery across Inpatient / Day case and Outpatient services to ensure patients can be treated as quickly as possible. There are no costs associated with the implementation of the above.

45. It is accepted that, at times, implementation of effectiveness and efficiency measures can be challenging. Going forward, the Department will therefore systematically review the value for money of services. If appropriate, the Department will move services to providers that can provide increased productivity and efficiency, thus delivering a better value for money service, and ensuring workforce skills are utilised to best effect.

46. In April 2024, the Department evaluated vasectomy services and concluded that the service provisions in HSC Trusts secondary care were not providing optimal value for money. A service with the same clinical outcomes could be provided in primary care at a cost almost 40% lower than in secondary care. The Department therefore decided to move the service from secondary care to primary care throughout 2024, with the full service being provided in primary care in 2025. This allows 1,500 patients to be treated for the same cost as approximately 1,100 patients previously. The Department will start with a consideration of cataract services; other specialities and procedures will then follow as a rolling programme.

47. Going forward the Department will also consider measures to encourage Trusts to meet the efficiency programme targets. Initial focus will be on DNA and CNA rates, where levels are significantly above targets. For example, in Lagan Valley Hospital Day Procedure Centre, the DNA/CNA rate is 12%.[9] This is a slight improvement from 13% in 2019/20, however more work needs to be done. Outpatient DNAs / CNAs have improved overall in the same period, decreasing from 8.5% to 7.9%. Both new and review outpatients have contributed to this improved position. The Department will therefore introduce a shadow costing regime across elective care for DNA and CNA. This means HSC Trusts could be charged a nominal treatment for every patient above the accepted target for DNAs and CNAs. Initially this will be in shadow format.

Action 5. Implement a productivity and efficiency programme and consider value for money across elective care.

[9] DNAs and CNAs happen for many reason. The aim to reduce DNA / CNA is not to apportion blame, but to find areas of improvement in the HSC to ensure most effective delivery of service.

Theme 4: Workforce

Objective:

Transformation of the elective care workforce to meet future requirements and to create effective teams with the right skills mix.

Investment:

Action 6: £10m per year recurrent

- Outcomes:
    - A workforce of the size and type needed to transform elective care services.
    - Better ways of working across elective care services.

48. The transformation of elective services is multi-factorial, and it can only be achieved if it is underpinned by a sustainable workforce. To support the delivery of improvements in waiting times and close the gap between demand and capacity, it will be necessary to ensure that the workforce is of sufficient size and has the necessary skills and support to carry out their roles effectively and productively.

49. Effective workforce planning is critical. The establishment of a robust workforce is not just about filling gaps that exist; it is also about validating the existing workforce to ensure the right number of staff at the right grade are in the right place when needed, as well as looking at new ways of working through extended specialist roles for clinical staff to ensure patients are seen in a timely manner by the right person. In that context, this theme is underpinned a number of strategic objectives.

50. We need to ensure we use the staff we have the best way possible. For example, surgeons – one of the most expensive resources in the Health and Social Care system – spend less time in theatre than surgeons in other jurisdictions. Increasing this will use our resources better, but will require wider workforce changes and new support mechanisms for surgeons.

51. To enable improved activity there is a need for promotion and implementation of new ways of working and the development of new multidisciplinary roles, including advance and specialist nursing roles and advance roles for AHPs. There is also a need to consider wider workforce needs. Going forward there will therefore be a requirement to conduct a workforce review of elective care services.

52. There is also a need to consider different ways of working. This includes using non-surgeons to deliver surgery. For example, at Duke of Connaught at Musgrave Park, Advance Nurse Practitioners are performing carpel tunnel operations and at Craigavon Area Hospital nurses are providing diagnostic services for urology. These models should be explored further and expanded where possible across specialties.

> **Action 6. Working in conjunction with relevant professional bodies, we will develop proposals to transform consultant job plans to maximise time spent in theatres and to work with other professionals to enhance skills mix.**

Theme 5: Independent Sector Engagement

Objective
A clear policy framework for working with the Independent Sector.

Investment:
Action 7: No new investment required

- Outcomes:
    - A clear policy framework to ensure consistent use of the Independent Sector across Health and Social Care – including the development of long-term partnerships as opposed to purely transactional relationships.
    - A clear framework to ensure value for money in IS investments.

53. The HSC alone does not have the capacity to address the waiting list backlog. Not only that, but as new patients continue to be added to the system, the gap between demand and capacity continues to grow, hence the backlog of patients waiting for diagnosis or treatment continues to grow.

54. It is clear that there are opportunities within the Independent Sector (IS) to help address the elective backlog in some areas of treatment. However the extent of that support will need to be fully defined and will also be dependent on the availability of recurrent funding.

55. It may also be that some of the sustainable, recurrent solutions to develop core capacity can be found in the IS through partnership, working across the whole elective care pathway. This means we will work proactively with the IS to improve whole system integration. The starting point is a policy for engagement, setting the scene for effective collaboration.

56. Within that context, there is a requirement for the development of clearly defined policy in this area. IS providers can help to increase capacity in the medium term; however any engagement with such providers must only be taken forward on the basis of clear value for money, and where the same standard of service as the HSC

can be delivered. Any contracts with IS providers must be on the basis of costs with consideration to HSC rates.

Action 7. Development of Policy for Engagement with Independent Sector Providers, which will focus on agreeing rates close to tariff, and confirming the range of clinics and theatre capacity across relevant specialties.

Theme 6: Funding Models

Objective

A funding model that incentivises efficiency, effectiveness, innovation and value for money.

Investment:

Action 8: no new investment required

- Outcomes:
  - A new funding model for elective care services.

57. The effective delivery of elective care services requires recurrent investment to establish and maintain a robust workforce and to build sustainable capacity within the HSC system. There is no doubt that reform is needed to do this, however, without long-term funding, it will not be possible to produce long-term solutions. Short-term funding will not provide the stability needed within the system to attract and retain staff, or to plan service delivery efficiently.

58. In that respect, and in the context of the continuing financially constrained environment, it is critical that consideration be given to looking at new ways of working within existing resources. That said, as waiting lists continue to grow, and the backlog continues to build, there is a clear need for investment to build capacity to ensure patients can be seen as quickly as possible, in line with clinical priority. This framework sets out the basis for how we can begin to build capacity to address that backlog and the growing gap between demand and capacity.

59. It is clear that, in order to build capacity within the HSC, there may be a need to consider other funding models to help exceed commissioned levels of activity. This may include, for example, the need to consider incentive-based activity to build capacity, such as through the funding of additional activity or cost per case. This could also include introducing a targeted approach to a funding model, similar to other parts of the UK. We will need to look at value for money, and how we best achieve that through service delivery.

60. Finally, with growing investment into the IS, consideration must be given to negotiation of deals where HSC surgeons can operate on HSC patients at rates close to HSC rates.

Action 8. Develop a funding model for elective care services that supports efficiency, effectiveness, innovation and value for money, to be developed and implemented in phases starting in 2025 with full implementation by end of 2029.

Theme 7: Patient Communication

Objective

Improved patient communication and support for patients on waiting lists.

Action 9: £1m per year recurrent investment

Action 10: no new investment required

- Outcomes:
    - Improved communication with patients with a resultant reduction in complaints about communication.
    - Improved support to patients who are waiting on waiting lists.

61. Good communication with patients is key, especially when it comes to planned care. This should take place at all parts of the patient pathway, from initial referral by GP right through to discharge from secondary care, so that patients feel confident that they are supported through their healthcare journey. Communication should incorporate information around all aspects of a patient's care, including information around length of time to wait, as well as signposting to support while a patient waits. It is important that patients understand how their care and treatment will be delivered, and that they have the opportunity to communicate with care-givers throughout their healthcare journey.

62. There has been some good progress in this area within the last year. For example, a new online tracking system, 'My Waiting Lists', was launched on 25 May 2023 which will allow patients to check the average waiting times for a first outpatient hospital appointment across the different clinical specialties in each Health and Social Care Trust area. The new "My Waiting Times NI" website now provides detailed information on average assessment and waiting times by specialty and Trust and this information is accessible to both GPs and patients. In addition, the website provides links to support patients' health and wellbeing whilst waiting for treatment, information on travelling to appointments, the Hospital Travel Costs Scheme, Patient Transport Service and advice if treatment is no longer required or if a patient cannot attend for their appointment.

Action 9. Development of patient communication channels to ensure patients are fully informed of all relevant information regarding their treatment and healthcare journey, including appointment and treatment reminders.

Action 10. Trusts to ensure that regular validation of waiting lists are undertaken on a regular basis through communication with patients and clinical.

63. We also need to support patients who are waiting. Development of a policy in this area will aim to ensure people are supported to better self-manage the condition they have been referred for, as well as their wider health and well-being needs, by providing an evidence-based, holistic and integrated whole-system approach. This will aim to ensure patients on waiting lists have the best possible outcomes and, through empowerment and support, ensure that their health is optimised and they are as prepared and as well as possible for their treatment. It is estimated that funding in the region of £500k would be needed for implementation in Northern Ireland.

Implementation

64. To achieve the desired outcomes of this Framework and to ensure ability to spend, longer-term financial planning is required as well as short-term backlog clearing. The scale of the waiting list problem is significant, but transformative work and recurrent investment will address some of the core issues within the system.

65. This will only be achieved with full implementation of the 10 actions set out in this updated Elective Care Framework. However, to be successful, this Framework will require long-term, sustainable funding:
    a. Recurrent funding: £80.5m per year when fully implemented.
    b. Non-recurrent funding: £135m per year for three to five years – totalling up to £675m over five years.

66. Without funding, work will continue with actions which are unfunded. This will continue transformation and improve elective care services. However, without significant additional funding, it will not be sufficient to remove the unacceptable waiting lists within the next five years (if ever).

67. As we move forward, it is important that we acknowledge the difficult financial context in which this updated ECF is being issued. At the time of publication, many actions are subject to confirmation of funding and will therefore require prioritisation, workforce mapping and planning to ensure realistic delivery. The investment required to deliver the updated ECF is significant, is in addition to existing expenditure in elective care services and is also in addition to an identified demand capacity gap for red flag and time-critical services of approximately £75-80m per year.

68. It is not possible to fund implementation from within the Department's existing resources and delivery is therefore dependent on the provision of significant additional funding for the Department. Where it is possible, the Department will also seek to release resources through service efficiencies and reconfiguration – as evident in a number of actions – however, this in itself will not be sufficient to fund full implementation.

69. The pace of change outlined in this updated ECF will also be considered in the context of other service priorities and with regard to the Department's overall financial settlement.

70. Implementation of the updated ECF will require significant work. Work will be led through the Elective Care Management Team and progress will be regularly reported to the public.