Written evidence submitted by the Royal College of Surgeons of England in Northern Ireland, Royal College of Nursing and British Medical Association, relating to the funding and delivery of public services in Northern Ireland inquiry (FPC0030)

Transformation priorities

Royal College of Surgeons of England in Northern Ireland

1 NI's waiting lists are devastatingly high. Approximately one in four of the population are on a waiting list for (a) either a first appointment with a consultant (401,201) or (b) surgery/treatment (121,879). We had a struggling healthcare system before the pandemic and there is no doubt COVID-19 further exposed the fragility of NI's health service in both secondary and primary care. Currently, a lack of government, workforce planning and recurrent budget is hampering efforts to make progress in transformation of HSC. The system needs stability to make sustainable change and this has been lacking for many years. In our elective recovery plan[1] we called for £1 billion to close the capacity gap and address the elective care backlog i.e., £200 million per year for the next five years. DOH plans to cut £34.6 million from this year's Waiting List Initiative allocation is bad news for patients. In parallel to this plan, we know HSC Agency spend will most likely be sky high. For the 21/22 financial year HSC Trusts' combined expenditure on agency/locum staff was £320m, up from £282m in 20/21. We can and must do better. Restoration of the Northern Ireland Executive is essential to allow the necessary strategic issues to be considered & decisions taken.

What are the answers to speed up transformation?

2 **Workforce**: We urgently need a refreshed and fully funded workforce (WF) strategy that tells us what staff we need in the short, medium and long term alongside horizon scanning of population estimates. Staffing shortages are a huge barrier when the system is trying to meet demand and right now we have nearly 7,400 empty posts. Notably the largest % change in HSC vacancies since March 2018 was in the Medical & Dental category, with an increase of 81.6%[2] (+173 vacancies). On top of this government predicts that 25%[3] of the consultant WF in NI are edging close to retirement age and gone. Ensuring we have the right workforce in place is critical as well as the plans to make sure we have a WF that's fit for purpose. We need to recruit into the roles we need, retain the staff we have & look after them better so they stay. We need to look at ways of using our later stage career doctors in the health service.

Finally, any effective WF plan is dependent upon provision of the finance necessary to develop and supply the WF. The current one-year funding cycle seriously constrains assessment of affordability and frustrates the long-term investment in pre- and post-registration education and training required to deliver an optimum WF.

---

[1] RCS England Northern Ireland 10 steps not 10 Years Action Plan for Surgical Recovery https://www.rcseng.ac.uk/about-the-rcs/government-relations-and-consultation/position-statements-and-reports/action-plan-for-northern-ireland/

[2] DOH HSC vacancies March 2023 https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-vacancies-march-2023.pdf

[3] Review Body on Doctors' and Dentists' Remuneration 2022 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1092259/DDRB_2022_report.pdf

3 **Surgical hubs:** We are campaigning for more theatre and operating time to help us address the backlog in NI which is the worst in the UK. Every year the waiting lists grow. Right now we have 121,000 people waiting for surgery or treatment. 5 years ago (March 2018) we had 80,570 patients waiting for surgery. 10 years ago (March 2013) we had 47,689. We need these surgical hubs/spaces/centres & teams protected to help us deliver more life changing and lifesaving surgery away from the pressures of emergency services. We remain of the view that surgical hubs are the best chance we have of reducing long waits.

4 **Budget**: A recurring budget is required to make significant and long-term change. A multiyear budget is crucial especially for health planners. We need sustained time and investment to make good plans to get the best and brightest students in into our two brilliant medical schools; we need time to nurture, train, equip and develop them to the point where they will graduate as surgeons, allied health professionals, GPs and nurses of the future. A 3-year budget could affect real change for good. We must build capacity to meet the needs of tomorrow. We also know surgical trainees have missed out on vital opportunities to train, progress and qualify because of the pandemic. If this is not addressed now we may lose them from the workforce. They cannot indefinitely be re-deployed and miss out on their training.

5 **Reform and transform**: We must keep on with changing how we deliver our health services in NI because for the last two decades demand has risen, not fallen and there is no sign of slowing down. At the same time staff and the way health is delivered is rapidly changing. Clearly we need to move at pace. We've lost around 6 years in the calendar of transformation due to various political impasses and Covid. We can't wait for change any longer. Bengoa predicted unplanned collapse of services if we failed to change and that's what has happened.

Royal College of Nursing, Northern Ireland

6 **Refocus on public health priorities**: HSC transformation began twelve years ago but its original purpose has become diluted to the extent that it has become a synonym for rationalisation and centralisation. Little progress has been made in enabling more people to receive care in their homes and communities instead of hospitals, which is (or should be) the heart of the transformation agenda. There is an urgent need to refocus strategically on building a health and well-being service instead of simply alleviating ill-health.

7 **Immediately prioritise workforce planning**: The main reason for the failure of transformation is that there has been no workforce planning to provide the right numbers of specialist community nurses that are required to bring about this change. The Department of Health estimates that demand for health services increases by

around 6% each year. However, in all areas of specialist nursing, staffing levels have not kept up with demand. If we are serious about building a 'wellness' service as well as one that focuses on treating ill health, workforce planning needs to be addressed urgently. RCN members in community nursing are under unsustainable pressure and short on capacity, yet are being asked to take on more and more, including increased support for nursing and residential care homes, and a spiralling workload due to quicker hospital discharges and poor access to acute services. The Department of Health is committed to publishing a workforce plan by 2026. The RCN believes this delay is unacceptable.

8 **Restore and grow the post-registration nursing education budget**: The education, training and development of the specialist nurses who can and should be driving HSC transformation is dependent upon the post-registration education budget agreed annually by the Department of Health. Restoration of this budget to its previous level was a key element in the safe staffing framework published by the Department in 2020. However, as part of the economy measures announced recently in light of the 2023-2024 budget, the Department has indicated that this budget will once again be cut. This is a false economy. A relatively small level of investment will generate incalculable benefits in driving a transformed and public health-focused service.

9 **Share, support and implement nurse-led service developments**: The RCN believes that the system fails to learn from and replicate examples of how innovative nurse-led services contribute to transformation, promote efficiency and improve patient outcomes. Many of these examples feature in our annual RCN Northern Ireland Nurse of the Year awards. Each year, however, it appears that Department of Health officials and HSC trust leaders are made aware of these innovations but then fail to replicate them. Many of the case studies feature specialist nurses or advanced nurse practitioners. Their impact can be measured in reductions in emergency department attendance and hospital admissions, waiting list reductions, eliminating unnecessary prescribing and tackling infection rates, for example. In an area the size of Northern Ireland, learning from and implementing best practice that improves service efficiency and enhances outcomes should not be challenging. We need to learn from and embed these types of transformative initiatives across the system, instead of regarding them as isolated and temporary examples of good practice.

British Medical Association, Northern Ireland

10 **Workforce**: At the core of the crisis we are experiencing within health and social care in Northern Ireland is a thinly stretched and burnt out workforce and insufficient funding, a lack of strategic forward planning and undue hesitancy in implementing transformation to ensure the survival and sustainability of the service. Workforce data released since our evidence session shows a 90% increase in consultant vacancies between March 2020 and March 2023. We are in desperate need of having a comprehensive and robust workforce plan actually implemented. During our evidence session, Dr Black warned very clearly of imminent hospital service collapses and, within a matter of days, Daisy Hill Hospital announced withdrawal of its stroke service, and warned that inpatient care in general medicine is at risk due to a shortage of

consultants. Investment in the training, recruitment and retention of doctors, nurses and other health professionals is crucial so that we have a workforce fit for the future and a sustainable health and social care system.

11 **Training places**: Plans to reduce or stagnate training places are short sighted and must be reversed across both medical and nursing. The survival of our health system is dependent on having enough highly trained professionals across all areas of the health service and this needs to be treated with urgency.

12 **Pay**: Healthcare staff in Northern Ireland need to be treated equally with their counterparts in GB and pay parity is a big part of that, not only to be fairly rewarded for the work that they do but to place value on the immense contribution they make and help redress crumbling morale. Therefore money needs to be made available to meet the pay review bodies' recommended pay uplifts as well as ensuring that any money arising from Barnett consequentials as a result of pay negotiation in England is not only awarded but is protected and ring-fenced to pay doctors and nurses in Northern Ireland.

13 **Pensions**: Equally, GB pension flexibilities, such as partial retirement and pensionable reemployment, must be extended to Northern Ireland. These are simple and agreed changes that would enable doctors to stay in the workforce longer and there is no reason why their introduction should be withheld as it currently is in Northern Ireland.

14 **GP & MDTs**: In order for general practice to survive, the rollout of multi-disciplinary teams across all areas of Northern Ireland must be completed. Where this investment has been made, it has been hugely successful but the suspension of the rollout has created great inequity and this must be addressed to provide fair and equal access to all patients. Also Northern Ireland is the only area of the UK where GPs have to pay their own indemnity costs which are substantial. This inequity must also be rectified. These steps will go some way towards providing stability for practices making it easier for them to recruit and retain staff.

June 2023