Briefing

Why are waiting times continuing to rise in Northern Ireland?

October 2017

What are current waiting times?

The latest statistics published by the Northern Ireland Department of Health for the quarter ending in June 2017[1] showed further deterioration of both outpatient and inpatient waiting times. All Northern Ireland waiting time targets are currently being breached[2]. Waiting list sizes have also increased; for example, a total of 72,480 patients were waiting for inpatient or day case admission following their outpatient appointment in the quarter ending June 2017[3], a rise of 3.4% from the previous year. Patients are also waiting a very long time for treatment: in June 2017 64,074 patients were waiting longer than a year just for their first outpatient appointment.

How are waiting times measured differently to the rest of the UK?

England, Wales, and Scotland measure waiting times from when a patient is referred for treatment (referral to treatment waiting times). However, Northern Ireland instead measures two stages of treatment: referral to first outpatient appointment and then outpatient to inpatient treatment. This document focuses on inpatient waits but it is important to stress that outpatient waiting times are themselves very long meaning the overall patient time from referral to treatment is far longer than anywhere else in the UK. It is very likely that an unacceptable number of patients will be waiting more than 2 years for treatment from initial referral.

Outpatient waiting times

The Northern Ireland health service target for outpatient appointments is for half of patients not to wait longer than 9 weeks for a first outpatient appointment, with no patient waiting longer than 52 weeks by March 2018.
This target is being significantly missed with no realistic likelihood that the gap will be closed by March 2018. As of 30 June 2017, 71.6% of patients waited longer than 9 weeks for an outpatient appointment. Worse still, 64,074 patients waited longer than 52 weeks for an outpatient appointment – just under a quarter of the outpatient waiting list.[4]

Inpatient 13 week waits

Official 13 week waiting time targets have shifted repeatedly over the last 8 years. In 2009, the Ministerial directive was that 'no patient should wait more than 13 weeks', changing to 'at least 70%' in 2013, with the current target set at 'no more than 55% of patients should wait longer than 13 weeks'. Such frequent changes in the target make it difficult to provide meaningful comparisons over time.

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[1] https://www.health-ni.gov.uk/topics/dhssps-statistics-and-research/hospital-waiting-times-statistics
[2] Northern Ireland Inpatient Waiting Times – DHSSPS QE June 2017 and Northern Ireland Outpatient Waiting times – DHSSPS QE June 2017
[3] https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-niwts-inpatient-waiting-times-q1-16-17.pdf
[4] https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-niwts-outpatient-waiting-times-q1-17-18.pdf

Inpatient 1 year waits

The 2016/17 Ministerial target also states that no patient should wait more than a year to access treatment.[5] The data across the year shows that the percentage of patients waiting more than 52 weeks rose from 9.7% in June 2016 to 15.5% in June 2017. The Royal College of Surgeons (RCS) is particularly concerned by the unacceptably large number of patients waiting over a year for inpatient treatment. In total 11,261 patients are waiting over a year for treatment in Northern Ireland, having risen from 6,787 in June 2016. This compares with around 1,500 patients officially waiting over a year for treatment in England[6] and 3,605 in Wales, despite the fact that England and Wales both have much higher populations.

To stress again: the number of patients waiting over a year from referral to treatment will be far higher given there are more than 64,000 patients waiting over a year for outpatient appointments.

Variation by Trust and specialty

There are large differences in waiting times across individual Health and Social Care Trusts and within specialties. The following table shows the percentage of patients waiting more than a year for inpatient treatment by health trust:

Patients waiting > 52 weeks by Health & Social Care Trust up to June 2017

Health & Social Care Trust	Number (and %) of patients waiting more than one year for inpatient treatment
Western HSC Trust	3471 (22.0%)
Belfast HSC Trust	5027 (16.8%)
South Eastern HSC Trust	1161 (12.8%)
Southern HSC Trust	1393 (12.7%)
Northern HSC Trust	209 (3.1%)

Comparing the number of patients waiting over a year by specialty also serves to illustrate the magnitude of the problem, particularly in General Surgery and Trauma and Orthopaedics, as the table below demonstrates:

Patients waiting > 52 weeks by surgical specialty

Specialty	Number and % of pts waiting > 52 weeks at June 2016	Number and % of pts waiting > 52 weeks at June 2017
Trauma & Orthopaedics	1635 (24.1%)	3960 (35.2%)
General Surgery	2039 (30%)	2199 (19.5%)
ENT	898 (13.2%)	1539 (13.7%)
Urology	1019 (15%)	1080 (9.6%)
Plastics	243 (3.6%)	482 (4.3%)

What are the causes?

Lengthy waiting times characterise almost all surgical specialties, although in some specialties the problems are more severe. The RCS is concerned that this escalating problem is causing significant risk to patients and may result in increased disease and preventable deaths.

Generalised causes include **rising demand**, as a result of an ageing population, which has resulted in major bed pressures in certain specialties. **Growing demand in emergency care** has meant elective care beds are

[5] https://www.health-ni.gov.uk/sites/default/files/publications/health/hs-niwts-inpatient-waiting-times-q1-17-18.pdf

[6] https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2017-18/#Jun17

increasingly being used to care for emergency patients. This is a particular problem during the winter when patients requiring treatment are often more frail and require longer lengths of stay. This has a particular impact in specialties with a higher emergency caseload. These pressures could be reduced in some specialties, such as orthopaedics and neurosurgery, by separating emergency and planned operations, enhancing access to rehabilitation, and improved discharge pathways for the return of patients to their home, to their local Trust for ongoing care or out of hospital care facilities.

The weaknesses of the **commissioning system** have also contributed to higher waits; the problems have been highlighted by the Donaldson Report and the Review of HSC Commissioning Arrangements – Final report October 2015[7]. **Vascular** surgery provides a specific example of the problems that can arise via inconsistency in commissioning. This high volume specialty was subject to a national review in 2012[8] which identified a lack of resources, and a local consultation in 2015[9]. The Northern Ireland Regional Service has undergone dramatic reconfiguration over the last 5 years with centralisation of inpatient arterial services from four units to a single centre in Belfast (Hub-and-Spoke) and that concentration of expertise has improved outcomes and survival for patients. Unfortunately, as central workload increased without sufficient new resources the Health and Social Care (HSC) has seen dramatic reductions in specialist vascular surgery beds (circa 52 to 26), consultant surgeons (13 to 8), vascular theatre lists and vascular nurse specialists. That lack of beds has created a growing planned admissions cancellation rate which over the last 12 months on average exceeded 30 percent (as high as 50 percent) with many urgent admissions cancelled. The effect is the HSC can no longer meet national guidelines for urgent vascular surgery treatment of aortic aneurysm (many waiting 80 days) and stroke (many waiting 20 days). Furthermore, plans to support the main centralised service with local hospital services (which provide outpatient, diagnostic and day-procedure) have not been properly resourced adding pressure and delay to the entire clinical network. Prioritising urgent conditions with limited resources means routine conditions such as varicose veins have an ever increasing wait, with over 1000 patients breaching waiting-time targets and many waiting over 3 years for treatment from initial referral. The Northern Ireland Vascular Review in 2012 identified the lack of resources but these additional resources have not been put in place.

Workforce issues such as insufficient numbers of doctors, nurses and other health professionals, along with recruitment issues and the historical reliance on expensive agency staff, are widely acknowledged as the key causes of delays in accessing elective care in some specialties. For **Oral Maxillofacial Surgery**, the routine waiting time is over 2 years from referral in the Western Health and Social Care Trust and up to 50 weeks for both urgent and routine treatment in the South Eastern Trust. Historical workforce modelling outlined the number of consultants required but the recommendations were not implemented. Waiting times will only deteriorate further as the number of surgeons in this specialty, already insufficient to meet demand, is set to decline in the short term due to retirements and the lack of training posts. Long waiting times from referral in **urology** - some RCS members suggesting the worst waiting time in one Trust of over 3 years and an estimated 90 weeks in another - have been an enduring problem, caused by several factors including the ratio of consultants to patients. This situation is set to worsen as too few trainees are in place to help meet demand, operating capacity is already insufficient and

7 The Right Time, The Right Place – DHSSPS (January 2015)

8 Review of Vascular Services (2012)

9 Consultation on the future commissioning of Vascular Services for the population of Northern Ireland Health and Social Care Board (April 2015)

nurse retention and recruitment is challenging. Capacity and workforce issues in **plastic surgery** relating to staff numbers and mix, along with pressures in dealing with skin malignancy and emergencies delay the treatment of less complex patients leading to ever longer lists. Some 482 patients waiting to access inpatient treatment across Northern Ireland have waited over 52 weeks.

The RCS believes the **reduction in use of the independent sector**, as a consequence of reduced funding for waiting list initiatives over the last 18 months, has had a major impact on waiting times. Historically, the Health and Social Care Board (HSCB) has provided non-recurrent funding for waiting time initiatives through a variety of private care providers, to reduce the numbers of patients waiting for treatment. In 2010/11, the HSC spent around £23M on independent sector treatment. By 2013/14, this had risen to £72M. In July 2014 a moratorium was placed in the use of the independent sector due to financial pressures. While the moratorium was lifted and funding released in 2015, it has not been possible to identify the number of patients treated in the sector in the last year although local surgeons tell us that it has not been on the same scale as before. While there are debates about the merits of using the independent sector in this way, the change has nevertheless negatively impacted on waiting times without being compensated by improved NHS activity.

The **inability to implement reforms**, often for reasons related to political short-termism, as set out in a series of reviews such as those led by John Appleby (in 2005[10]), Transforming Your Care[11], and the Donaldson recommendations of 2015 has led to a piecemeal approach to service improvement which in turn has lacked the joined up approach required to effect system wide change. The reform process has been hampered by the financial situation of the Department in recent years, and more recently by the ongoing lack of devolved government and agreed budget. In **orthopaedic surgery** (e.g. hip and knee replacements) information published by the BBC in May suggested waiting times of 152 weeks for some orthopaedic treatments in the Western Health and Social Care Trust and up to 95 weeks in the Southern Health and Social Care Trust and in the Belfast Trust. The reasons vary by Trust, however, RCS Northern Ireland members have blamed the failure to implement the full recommendations of multiple reports on the rationalisation of service delivery, along with workforce shortages across the wider orthopaedic team. This has been compounded by restrictions relating to equipment and optimal use of theatre space.

The **political instability** of the last 9 months offers little prospect of immediate relief for anxious patients. The additional funds agreed by Westminster in the DUP/ Conservative confidence and supply agreement which were to be targeted at waiting time pressures and support for the implementation of the reform agenda have yet to materialise. With no agreed budget for health, no minister and waiting times deteriorating over every quarter in the last year, HSC Trusts have fought to maintain existing services, with smaller budgets, while being required to make efficiencies. The recent announcement from the Department of Health that Trusts will be required to save £70m and the subsequent release of £40m through monitoring rounds, while welcome, only serves to underscore the problem of political uncertainty. Latest figures from the Department describe pressures of over £430m in 2018/19 which will need to be addressed. Even though

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[10] Independent Review of Health and Social Care Services in Northern Ireland (Professor John Appleby 2005)

[11] Transforming Your Care: A Review of Health and Social Care in Northern Ireland. An overarching road map for change in the provision of health and social care services in Northern Ireland – DHSSPS (December 2011)

the proposed efficiency measures will not be as severe as expected, there will be direct consequences for the delivery of elective care: the deterioration of waiting times is an inescapable consequence of such severe financial pressures.

How can we improve access to surgery?

Improving access to surgery is one of the key priorities set out in last year's Ministerial paper, Health and Wellbeing 2026 - Delivering Together[12]. The former Minister set up a number of working groups to deliver the models that would enable long term, system wide reforms to be implemented. This includes an Elective Care Centre work-stream, which has been established to develop a sustainable model for the future delivery of elective care. While the RCS welcomes these initiatives and the previous Minister's Elective Care Plan, these remain unimplemented in the current intractable political impasse.

The pressing need for change described in Health and Wellbeing 2016 should galvanise all stakeholders. Those who find themselves responsible for developing and implementing policy in the coming year should examine:

- How to rapidly implement the recommendations of the Bengoa Review?
- How a new model for elective care can be co-designed with patients and delivered to meet the needs of the local population?
- How long term policy objectives can be agreed and maintained?
- How new models of commissioning can deliver better services?
- The need to develop a cogent workforce strategy that looks across a wide range of staff and looks to improve recruitment and retention.
- How HSC services and/ or other providers can/ should be commissioned in a more planned and sustainable way to increase capacity in elective care?
- Better protecting elective care access from the pressures of urgent and emergency care by ensuring separation of beds and/or facilities particularly in specialties which don't require access to intensive care facilities.
- A greater focus from the HSC on meeting waiting times targets. We would also like to see some. consistency in the use of targets which have changed numerous times over the last decade.
- How Brexit will impact on existing staffing levels, All-Island and cross border services in Northern Ireland and plan appropriately to address these issues?

Clinical leadership is critical to the development of the right models of service delivery and to the subsequent implementation and the RCS acknowledges the hard work of HSC staff in delivering high standards of patient care. The RCS will continue to seek to participate in all relevant work programmes to shape the service to benefit patients and improve surgical outcomes.

[12] Health and Wellbeing 2016 – Delivering Together (Oct 2016)