Royal College of Surgeons of England
IN NORTHERN IRELAND

NORTHERN IRELAND ACTION PLAN FOR SURGICAL RECOVERY: 10 STEPS NOT 10 YEARS

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EXECUTIVE SUMMARY

Northern Ireland (NI) had a struggling healthcare system before COVID-19,[1] with the worst waiting times in the UK.[2] Outpatient and inpatient targets have rarely been met since 2009.[3] As at December 2020, over 323,000 people are waiting to see a consultant, with 105,000 waiting for admission to hospital for surgery.[4] Together, these figures show over 428,000 patients waiting in a population of 1.8 million. This amounts to roughly 1 in 4 people waiting for a first consultation or a procedure.

The global pandemic has exacerbated NI's already vulnerable health service and has delayed thousands of important, urgent and life-changing surgeries. The Health Minister has stated it will take 10 years to sort the backlog in elective care.[5] This is a catastrophic assessment. The risk of harm because of long waiting lists is already being observed in all surgical specialties. This has important consequences. Those on waiting lists are now having to seek emergency care because their condition has deteriorated and they now require unscheduled acute intervention. This can now be witnessed by the current demands on our emergency departments in the spring months, which is previously unheard of. In addition, there is a 'hidden waiting list' of people who have not yet come forward or who have not yet been referred for hospital treatment.

Restoring timely surgical services should be a collective priority for the NI Executive. While the health system will inevitably experience seasonal shocks, it is imperative that surgical services are not 'stood down' again. COVID-light sites will be key for maximising optimal surgical activity alongside the protection of surgical beds. A regional approach involving patient and surgical teams travelling to surgical hubs holds huge promise for the way forward.

In this publication, we outline 10 steps for surgical recovery that, if implemented and appropriately resourced, could help to deliver better patient outcomes in a more timely fashion. A health system that we can all be proud of requires collective will and effort, not just from systems and staff but all parts of society.

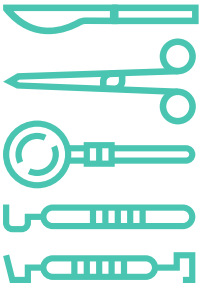
SURGICAL RECOVERY IN 10 STEPS

1	**Investment:** multi-year funding is required to close the capacity gap and address the elective care backlog, estimated by government at £1 billion.[6] £200 million per year for the next five years is required.
2	**Waiting lists and elective surgery:** each trust should publish yearly plans detailing timely access to surgery for patients and committing to the enhancement of efficiency and productivity against any future shocks.
3	**COVID-light sites** in every trust area to ensure maximum separation of emergency and elective care. Such sites in the post pandemic era could become centres of excellence for elective surgery.
4	**Surgical hubs:** high-volume low-complexity surgery in surgically efficient hubs will accelerate the pace of operations required. Patients and surgical teams are ready and willing to travel.
5	**Elective accountability:** the government should publish an annual report setting out its response to the waiting times backlog in NI as well as measures to support patients facing long waits for surgery.
6	**Recruitment/retention:** the wider surgical workforce needs expansion, with particular focus on Perioperative nursing and Surgical Care Practitioners. The NI government should publish a regular assessment of healthcare workforce projections and requirements.
7	**Launch comprehensive review** of surgical services in NI, noting particular digital and technological developments affecting the future of surgery.
8	**Wellbeing:** trusts should proactively implement programmes that highlight the benefits of physical and mental wellbeing. It is essential that every surgeon feels 'psychologically safe' in their working environment.
9	**Support surgical trainees:** No training today no surgeons tomorrow. Systems must maximise opportunities for trainees to catch up on missed training opportunities as soon as possible with bespoke programmes of training that include enhanced theatre time.
10	**Collaborate and protect time to learn:** ensure protected time is built into surgical working schedules to enable communication and learning with colleagues from other specialties and primary care for the mutual benefit of improving patient outcomes.

INTRODUCTION

Seven major reviews into NI's health system over the past 20 years have all called for reform of NI's health system, including Bengoa.[7] The NI Executive's draft Programme for Government 2021–2026 includes the desire for all of us to live long and healthy lives.[8] It is a reality that patients including children are waiting four or five years for routine procedures as a consequence of the longest waiting lists in the UK. In February 2021, RCS England called on the NI government to produce a detailed roadmap for addressing the backlog of both urgent and non-urgent operations.[9] The global pandemic has led to unimaginable consequences for patients. Department of Health statistics for the first wave of the pandemic show how steeply hospital appointments dropped[10]:

- 62% drop in inpatient activity
- 48% drop in outpatient activity
- 40% drop in red-flag cancer cases
- 55% drop in routine outpatient activity
- 34% drop in suspect cancer inpatient activity



Nearly

430,000

people waiting for either surgical appointment or treatment

Presently, more than ever we need to unlock the potential of the health service in meeting the needs of patients now and into the future. Patients deserve the right to timely surgery and even more so in a post-pandemic world. The waiting lists are further creating health inequalities where those who have the financial means seek private healthcare whilst others have no choice but to remain on NHS waiting lists. These delays are resulting in conditions deteriorating and management of chronic pain. This contributes to an overwhelmingly negative picture of life described as being 'on hold' or in 'no man's land'.[11] A recent study found that during the second wave, 40% fewer pancreatic cancer operations were performed nationally than before the pandemic dropped.[12] This is of particular concern as pancreatic cancer is usually an aggressive disease that progresses rapidly if left untreated. The following 10 steps should help guide recovery efforts.

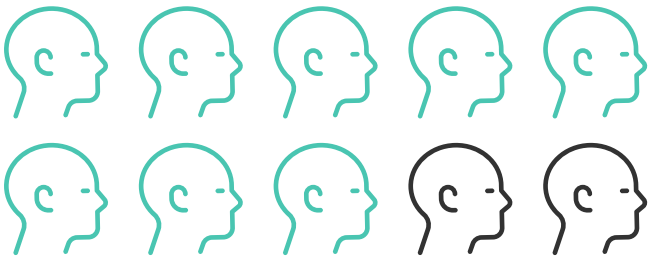
RECOMMENDATIONS

1. Investment

The NI government should lobby the UK Treasury to enact a three-year budget cycle to enable strategic and sustainable change. Government estimates show that tackling the elective care backlog will take £1 billion. For 2021/22, the Department of Health has a £6.6 billion budget, with £40m earmarked for the waiting lists. This drastically falls below what is needed.[13] To facilitate new ways of working, the status quo cannot continue. Transforming old systems requires investment. A financial NI paper on recent spend during 2020/21 showed that the department spent £934.5m on COVID-19 while only £14.5m on transformation projects that produced the 'quickest paybacks'. £10m was spent on using the independent sector to help with elective treatment. This contrasts with NHS England's plans to buy in around £10bn of additional capacity from non-NHS providers over the next four years,[14] and £160m for accelerator elective sites to clear the backlog.[15] If NI wants to clear the elective backlog in 10 years, the Department of Health would require an additional £100m per year for the next decade. To accelerate pace and clear backlog in five years, an additional £200m per annum would be required.

2. Waiting lists and elective surgery

Each trust should publish a recovery plan for 2021/22 that aims to restore timely access to surgery for patients as per forecasting or modelling projections. These realistic long-term plans, supported by trusts, should also 'protect' surgery in the event of any future shocks. These plans should clearly map out what support patients can access while they wait for surgery. There should be senior surgical representation at trust executive teams to ensure the consideration of surgical services at this strategic level. The 2020/21 ministerial target for outpatient waiting times states that by March 2021 at least 50% of patients should wait no longer than nine weeks for a first outpatient appointment, with no patient waiting longer than 52 weeks. Building the capacity of HSCNI is a priority and is the only sustainable option; however, where possible independent sector resources should also be used. Health service appointments in the independent sector are significantly different when comparing figures for 2013/14 (53,010)[16] to 2019/20 (14,132).[17] Proper demand and capacity planning at specialty (and subspecialty level) is critical. The difference in NI's surgical waiting times per specialty is huge (Figure 1). Statistics accessed by the Nuffield Trust show that in the 'Western Health and Social Care Trust, patients with an orthopaedic upper limb problem face a potential maximum wait of nearly five and a half years for their first outpatient appointment. They then have the prospect of a further four or more years if they need to be admitted for surgery'.[18] Cancer figures, show that 55.3% of patients began treatment within 62 days,[19] far below the 95% ministerial target, which has not been met in the past three years. It is vital that we maintain a regional oversight of the waiting lists even after the effects of the pandemic subside. NI's targets have been breached on countless occasions.



Recent NI Survey found

82%

of people thought that a journey time of **up to 1 hour would be reasonable**

Data source: https://www.health-ni.gov.uk/sites/default/files/publications/health/travelling-tables-hsni.xlsx

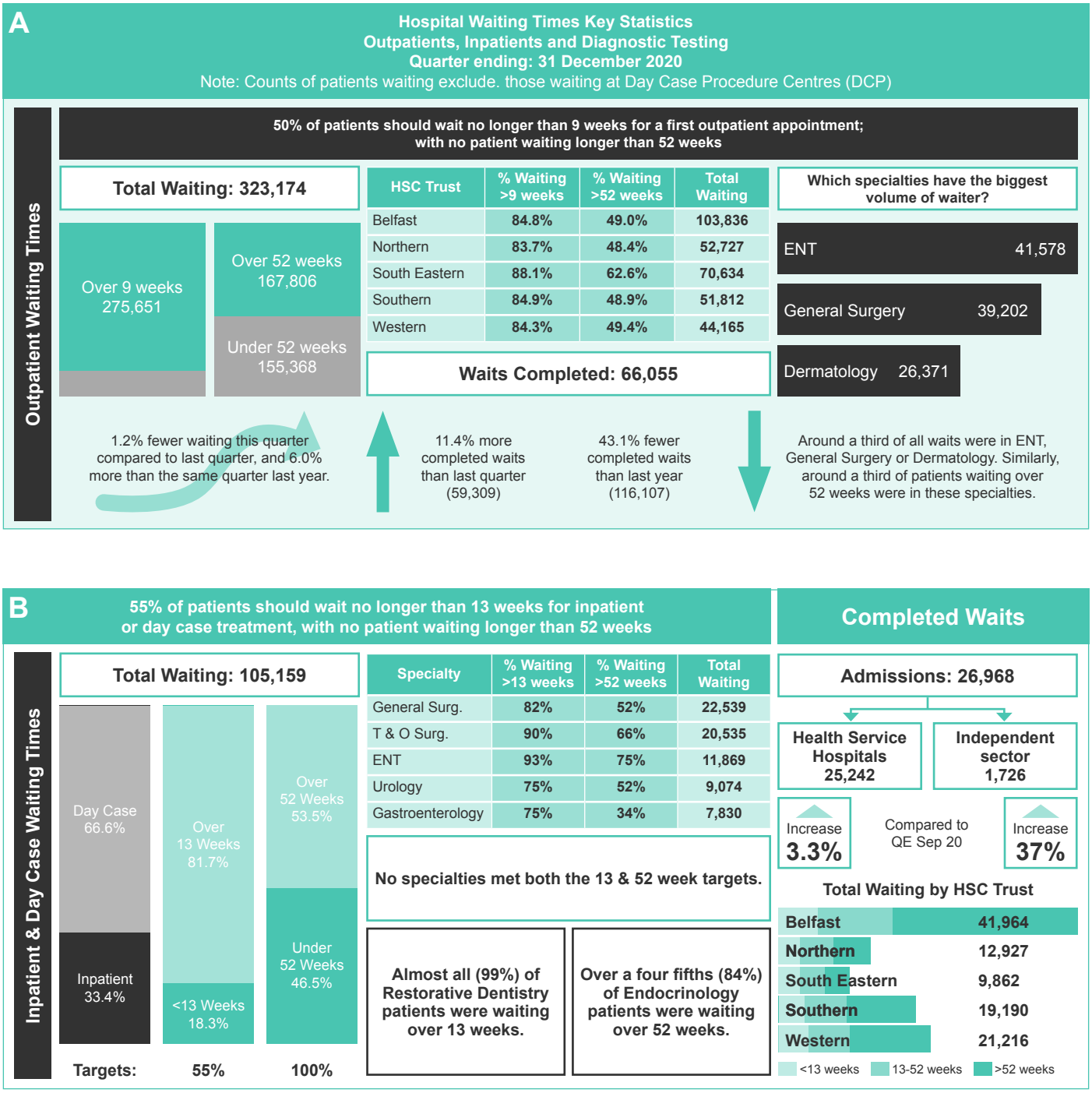


Figure 1 Hospital waiting times for Northern Ireland: a) outpatients; b) inpatients.

We note trust plans for April-June 2021 and the surgical ambitions therein,[20] caveated by workforce wellbeing levels. We welcome the work of the Regional Prioritisation Oversight Group (RPOG) in ensuring patients with the greatest clinical need are progressed.[21]

The creation of accessible community diagnostic hubs will support the surgical journey as part of the pending government cancer strategy 'getting fit for surgery' public health programmes (see 'pre-hab' plans announced by NHS England in May 2021).[22] Pathways of excellence for patient care is our goal.

We need all medical facilities to enable recovery in the fullest sense, not attrition. It will be imperative that a frank discussion on the reprofiling of hospital facilities takes place with both political leaders and the public. We support system-wide change and would encourage all stakeholders to be more involved in co-producing future solutions. A public conversation about the health system is urgently required. Similar to the political health summit that launched the Bengoa health reform work, we believe a similar discussion must take place as a matter of urgency.

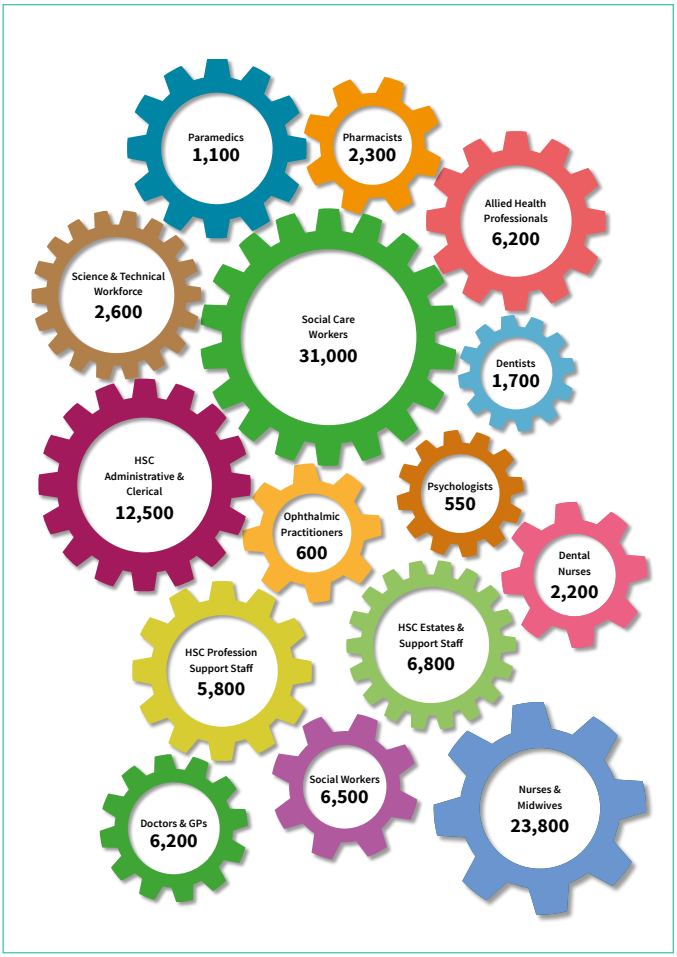
3. COVID-light sites

COVID-light sites (or green pathways) should be accelerated in every trust area to ensure maximum separation of emergency and elective care to prevent a stop start model. During the pandemic, the RCS of England advocated for the establishment of 'green' pathways or COVID-light sites where elective surgery is separated from emergency admissions within and across hospitals. Lagan Valley's success as Northern Ireland's first regional day procedure centre in the South Eastern Trust is tremendous. This centre has been providing support for the region, particularly for urgent cancer diagnostic work. News that Belfast City Hospital as Nightingale is now a green pathway is another very welcome development and will most certainly ease surgical pressures. Regional surgical specialties (for example cardiothoracic, vascular, neurosurgery) should be virtual green areas in their own right and should be unaffected by emergency pressures, repatriation/discharge issues and lack of intensive care.

4. Surgical hubs

High-volume, low-complexity surgery in surgically efficient hubs will accelerate the pace of operations required and will address the conditions of many long waiters. Patients and surgical teams are ready to travel and this concept is being progressed via the Department of Health's regional prioritisation approach. A dedicated survey undertaken in NI in 2017 which found 82% of people thought that a journey time of up to one hour would be reasonable.[23] Supporting colleagues with 'mutual aid' is proving highly successful and surgeons stand ready to play their part. Increased provision of community diagnostic hubs should accelerate the surgical journey across all pathways and should avoid patient bouncing from primary to secondary care.

Trusts should provide support for patients to 'wait well' whilst on the waiting list, as far as possible. Continuous validation of the waiting lists should be performed to capture any change in the patient's condition. Building HSCNI's capacity to reduce reliance on the independent sector is also critical and requires long-term planning to meet the ever-increasing demands of a changing, older population.[24] Reliance on independent sector providers both in NI and elsewhere does not provide the long term capacity required and also is a much more costly option in a system with a limited budget. These sites also have the potential to offer huge training opportunities for surgical trainees.



Overview of NI health and social care workforce

Source: https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-workforce-strategy-2016.pdf

5. Elective accountability

The government should publish an annual report setting out its response to the waiting times backlog in Northern Ireland as well as measures to support patients facing long waits for surgery. As promised in the New Decade New Approach document,[25] and recommended in 2015 by the Health Committee, NI should introduce the Referral to Treatment measure[26] and associated targets so that we, like other parts of the UK, can reflect the entire patient journey from referral to treatment, with appropriate targets. Ministerial targets for inpatient, outpatient and cancer have been breached for years. Clinical benchmarks act as key quality drivers for efficiency and goal setting and assess progress or lack of progress.

Waiting time targets for review appointments should, for the first time, be published. In the New Decade New Approach document, it states that no one should wait over 52 weeks for outpatient or inpatient assessment/treatment.[27] December 2020 figures show that outpatient waiting times are in breach again, with 167,806 on the one year plus wait list.[28] Lengthy waiting times characterise almost all surgical specialties, although some are more severe, such as general surgery, trauma and orthopaedics, ENT and urology. The Department of Health should undertake detailed modelling projections to reveal how long it will take to clear the backlog per specialty. This will enable an honest conversation with patients about how long they will be waiting for surgery.

6. Recruitment/retention

The Health and Social Care Workforce Strategy 2026 requires critical attention.[29] At the strategy's launch five years ago, the report stated:

> The consequences of failure to achieve the aims and objectives of this strategy are grave. The already unsustainable rate of agency and locum expenditure will continue to increase. Waiting lists for treatment will continue to rise. Health and social care services will become unsustainable, and the longer this continues, the more difficult it will be to transform these services.[29]

We are halfway through the strategy and it is unclear how many objectives have been achieved. NI workforce figures show 3,690 whole time equivalent (WTE) medical staff working across the five health trusts and 16,041 WTE qualified nursing and midwifery staff.[30] An expansion of the wider surgical workforce will be necessary to maximise recovery. We need to bolster training opportunities for teams and make better use of the range of professionals that form a surgical team.

Furthermore, although consideration should be given to extending hours of planned surgery and operating at weekends, staff should not exceed recommended weekly working hours. Instead, modified hours should enable flexible working and less than full time working for members of surgical teams. Incentivisation such as allowing staff to leave the hospital if a surgical list finishes early or enhancing training opportunities for each individual in other centres throughout the world will further enhance the effectiveness and efficiency of the surgical team. A cohesive team aware of each other's abilities will ensure the highest patient outcome. Every effort should be made to reduce the amount of redeployment of such staff members during further (possible) spikes of a pandemic. We welcome the department's perioperative nursing group, which aims to improve the career pathway of nurses in that field. The forthcoming new medical college at Ulster University opening in September 2021 will boost the medical workforce in NI in the coming years and will complement existing medical education available at Queen's University Belfast.

7. Launch Review of Surgical Services

Launch a comprehensive review of surgical services in NI, as it is widely recognised that we cannot have all surgical specialties in all district general hospitals. The pathway of care should follow the patient and is of the highest standard irrespective of postcode. This surgical review will also note particular digital and technological developments. We need to quickly plan for a more resilient model of care that can better withstand future pandemics and winter flu outbreaks. We need to grasp and expand on what worked and cultivate a culture of excellence throughout health and social care at all levels. The RCS Commission on the Future of Surgery[31] gazed 20 years into the future to identify advances in medicine and technology that are likely to change surgical care. The future of surgery will bring innovative technologies, enhanced understanding of disease and wider collaboration among experts and innovators to improve patient care. The partnership between patients and clinicians will remain at the centre of healthcare. Technologies such as surgical robots, artificial intelligence, three-dimensional printing and new imaging methods are already changing and will continue to change the way surgical care is delivered. Developments in fields such as genomics, regenerative medicine and cell-based therapies will open new avenues for predicting and treating disease, which were unthinkable only a few years ago.

8. Wellbeing

Health care workers have borne huge psychological impacts of being on the frontline of the COVID-19 battle. Research into psychological impacts of COVID-19 on the NI health and social care workforce shows that, 'Staff are at specific risk of negative outcomes, with challenges such as moral dilemmas relating to inadequate resources, fears about lack of knowledge or experience and the traumatic experiences faced'.[32] During the pandemic, lifesaving surgery continued with surgeons delivering urgent operations for cancer, paediatric or cardiac surgery. Like colleagues from across the health system, the physical conditions were challenging with heavy and restrictive personal protective equipment taking its toll in some lengthy (11 or 12 hour) operations. Surgeons also experienced limited interactions with family and friends because of the virus. Worryingly a recent survey[33] revealed that thousands of exhausted doctors are considering leaving in the next year. One Northern Ireland consultant said:

> 'My team and I are completely exhausted – I can't remember the last time one of us had a break during the working day, and lunch is eaten during meetings or other clinical work. Several colleagues have talked about leaving their current NHS roles, and I personally have considered resigning more than once in the last 12 months. If things continue this way it is inevitable that we will lose staff either through sickness absence or retirement/resignation.'

Credit: Regional Workforce Wellbeing Network: https://bit.ly/3bPYuMK

On top of these personal and professional burdens NI's surgeons, surgical staff and surgical services had experienced years of structural challenges in the health system and the worst elective care waiting times in the UK. As the latest wave of COVID-19 lifts, surgeons are turning to the challenge of reducing NI's lengthy waiting lists and worry about the impact of even further delays on patients. Recovery of surgical services requires the support of anaesthetists and nurses who support surgeons to operate, however we are very aware they are running on fumes after an unimaginably difficult year on COVID-19 wards.

A recent British Medical Association (BMA) report[34] shows the importance of supporting exhausted staff who have been at the forefront. The cost of not meeting mental health strains will be increasing levels of staff distress, absence and potential increased staff turnover generally, all of which places further stress on an already precarious NHS workforce provision. Trust staff management systems should therefore prepare for increased need for psychological care and support to individuals and teams. This includes increased availability of specialist psychological therapies, including trauma interventions, but also particularly for approaches that support moral distress, loss and bereavement, emotional exhaustion and staff burnout, and team challenges. Better practical resources that meet basic needs such as rest spaces, access to food and fluids are low cost solutions but which will create a safe space for teams to maintain wellbeing. RCS guidance Supporting wellbeing of surgeons and surgical teams during COVID-19 and beyond[35] offers advice on what healthcare managers can do to support staff. Ultimately, if we do not support the wellbeing of every member of the surgical team, we risk many more qualified staff leaving the profession altogether.

9. Support surgical trainees

Support surgical trainees to gain experience and complete their training. Surgical training has been severely affected by the pandemic and there is a risk of a lost generation of surgical trainees. Getting elective operations up and running again is essential for the future of the surgical workforce, as limited elective activity has been identified as one of the key barriers to enabling trainees to access appropriate time in theatre. Every elective operation should be considered a training opportunity. Many trainees have been redeployed and the reduction in elective surgery means there has been less experience in outpatient clinics, theatre, ward work and multidisciplinary team meetings. Trainee logbooks show a 50% reduction in operations with trainees as the primary operating surgeon from 2019 to 2020.[36] Over the coming months, every opportunity must be taken to free trainees from non-essential administrative work and to ensure that job planning supports increased theatre time to help speed up the training experience.

We are aware that hospitals are under considerable pressure to reduce waiting lists. However, training and safety must not be compromised by volumes, and incentives to reduce waiting lists should not make hospitals reluctant to support training. There should be an increase number of hospital doctors through increased medical school numbers by the end of this NI assembly period (2022). Every effort must be made to enhance the opportunities for trainees to operate in the independent sector to attempt to bridge the numbers gap as a result of the pandemic. It is unfair to suggest that a trainee performing an operation adds to the time duration of that operation. The use of the independent sector for NHS patients should allow the same training opportunities that exist in the NHS.

10. Collaborate and protect time to learn

A major success story of the pandemic is the increase in communication between primary and secondary care. We must ensure that protected time can be built into the working week of surgeons to enable multidisciplinary and cross-trust teams to come together to learn from one another. Learning also changed, with hundreds of surgeons and colleagues jumping on to lunch time and evening webinars to learn about the latest development, procedure or guidance. The pandemic perversely proved to be an effective force for breaking down institutional and cultural barriers. We must retain and nurture this culture of collaboration to create a more integrated system, which makes smarter use of resources. This entails planning services on a population footprint that runs well beyond a single hospital or health trust. Although changes to structures have a short-term cost because of the disruption brought about by change, over the longer term, if done well, they bring benefits to taxpayers in more efficient use of resources and benefits to patients in improved access to high-quality services. It is important to learn from the challenges of COVID-19 and to understand how we can grow better for the future of surgical practice.

We should consider how the system can adapt, including by taking advantage of new innovative surgical technologies, implementing speedy testing, supporting surgeons and perioperative clinical professionals and reconfiguring care pathways.

Waiting time for orthopaedics in some Trust areas show

80 weeks

for red flag cases and **255 weeks 'nearly 5 years'** for routine procedures

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