Response from the Royal College of Surgeons in Northern Ireland to the NI draft budget consultation[1]. Consultation Period 8 - 25 February 2021.

The Royal College of Surgeons of England is a professional membership organisation and registered charity, which exists to advance patient care. We support nearly 30,000 members across Northern Ireland, the UK and internationally by improving their skills and knowledge, facilitating research and developing policy and guidance.

Members of the Northern Ireland Professional Affairs Board of the Royal College of Surgeons of England are appointed by their respective surgical specialty society. The board comprises leads for general surgery, orthopaedics, ENT, plastic surgery, maxillofacial surgery, cardiothoracic surgery, vascular, urology, paediatrics, neurosurgery, and the school of surgery and trainee representatives. It has a remit to represent all surgeons across all trusts in Northern Ireland (NI), with a focus on improving surgical outcomes**.**

Throughout the course of the COVID-19 pandemic, we have been determined in our efforts to ensure that surgeons and surgical teams are supported in delivering vital patient care and are not exposed to unnecessary risk.

With this in mind, we welcome the opportunity to provide a response to the draft Budget. Please note we are responding to the health implications of this 1-year draft budget only and specifically Questions 1 & 6**.**

Key points

1. A **significant elective surgery backlog** existed prior to the COVID-19 pandemic. A detailed roadmap from government is urgently required.

2. **We must ensure the equitable allocation of nursing staff, theatre staff and anaesthetic staff, to support the continuation of surgery.** Workforce shortages have been a major and consistent theme in survey responses in NI, with particular concerns around nursing staff. In a RCS UK wide September 2020 survey when asked about the key barriers to resuming surgery, **82%** of RCS NI respondents cited a lack of staff compared to **52.9%** nationally. More than ever, we need to re**cruit and**

[1] Consultation Budget https://www.finance-ni.gov.uk/consultations/budget-consultation and also Health draft budget papers: https://www.health-ni.gov.uk/consultations/draft-budget-outcome-consultation

maintain a workforce that has the experience, capacity and skills to meet the challenges of the future.

3. To protect patients and enable urgent surgery to continue through the pandemic, **COVID light sites** should be established at pace. These should be planned strategically and collaboratively across our NI health trusts to ensure a consistent, transparent approach and equity of access for patients. Access to 'COVID-light' facilities in NI is markedly worse than anywhere else in the UK. In NI, **46%** of surgeons report being unable to access such a facility compared to **42%** in Scotland, **30%** in Wales and **19%** in England.

4. Health Trusts should accelerate their plans for the **recovery of surgical services.** Resuming surgery must be a NI Executive priority.

5. Finance should be directed toward **wellbeing**: COVID-19 has had a detrimental effect on the psychological wellbeing of NHS staff working under huge pressure. Support for the mental health and wellbeing for NHS staff must be considered a priority

Question 1 - What services would you prioritise?

A **significant elective surgery backlog** existed prior to the COVID-19 pandemic. We need to recruit and maintain a workforce that has the experience, capacity and skills to meet the challenges of the future. Many patients require surgery in a timely fashion if they are not to suffer from worsening symptoms, deterioration in their condition, greater disability and (in some cases) a significant risk of death. **The delays to surgery already will have resulted in an increased need for complex surgery, as some conditions become more complex to treat if not addressed promptly. (**RCS has produced guidance on how to protect surgery through the surges of Covid[2]).

COVID-19 is expected to give rise to **new hospital services,** particularly in **respiratory and cardiology departments**. COVID-19 will certainly have a long lasting effect on the demand for community services, as patients in long-term recovery will require ongoing treatment and rehabilitation services, alongside existing unmet need for these services from people suffering long-term conditions.

Long COVID will require joined up HSC efforts to meet patient needs. We note the February 2021 report from WHO[3] that states policy makers must (1) implement effective patient registers or other surveillance systems; (2) Develop care guidelines and multidisciplinary services to ensure appropriate assessment and management of the condition and (3) Effective response can only be achieved by involving Long COVID patients themselves.

We wish to assist the NI Executive's collective endeavour via the draft 2021-2026 Programme for Government[4] to ensure 'we all enjoy long healthy active lives'.

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[2] Protecting surgery through a second wave'.
[3] WHO report In the wake of the pandemic: preparing for Long COVID (2021) https://bit.ly/2MsZtZQ
[4] Draft Northern Ireland 2021-2026 Programme for Government

Question 6 Have you any other views for discussion.

We believe that COVID has exposed years of under-investment in Northern Ireland's hospitals and workforce. The draft budget for health 2021/22 shows plans for £6.6 billion. This includes an additional £495 million. The financial allocations, especially for transformational reform, is disappointing when the need to change how we deliver health care is clear.

These deep fault lines within our HSC cannot be easily reversed, but change is possible. Something can always be done if the political will exists. Seven health reports in 20 years have all reinforced the need for transformational change of NI's HSC including Bengoa's report[5].

Waiting lists have been a problem across the UK over the past decade, with each area struggling to meet targets for planned procedures. But they are at their worst, by far, in Northern Ireland. Before the pandemic DOH figures indicated it would take anywhere between £750 million and £1 billion to sort the waiting lists. It is unclear how much it would require now in a post Covid-19 society.

In NI, we urgently need a multi-year budget that can facilitate the scale and breadth of transformative change that the NI health system requires. A 3-year budget cycle would enable Trusts to flex and adapt appropriately as well as instigate/resource meaningful long-term change.

An expansion of the workforce will be necessary to help recover surgical services. We strongly recommend that surgeons, nurses and other healthcare workers who have returned to work should be retained to help manage the backlog of work. We need to keep on those who are willing and able to stay, but also expand the surgical workforce as a whole, bolster training and making better use of the range of professionals that form a surgical team. The NI Executive needs to focus at a policy and financial level, a cogent workforce strategy that looks across a wide range of HSC staff and looks to improve recruitment and retention.

On a UK wide level, the Royal College of Surgeons of England has urged the UK Treasury to invest in a **national strategy to bring down hospital wait times** in a formal submission to the Comprehensive Spending Review process.

Waiting Lists

According to a recent Nuffield Trust report [6]approximately 1 in 12 people in England and Scotland were on an elective waiting list. However, in Northern Ireland the figure was about one in every five.

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[5] Systems Not Structures 2016 report. Bengoa Report.

[6] Heenan D and Dayan M (2020) "Radical surgery on waiting lists in Northern Ireland is long overdue", Nuffield Trust https://www.nuffieldtrust.org.uk/news-item/radical-surgery-on-waiting-lists-in-northern-ireland-is-long-overdue-1

Latest DOH NI figures for waiting lists (up to December 30 2020) show:

- More than 323,000 patients waiting for their first outpatient appointment with a consultant
- Over 105,000 were awaiting admission to hospital
- Nearly 168,000 patients were waiting more than 52 weeks for their first consultant-led outpatient appointment
- Around a third of patients waiting over 52 weeks were in three specialties; ENT, General Surgery or Dermatology.
- **Cancer -** NI has the highest number of cancelled red flag cancer operations in the UK[7].

Waits this long create real risks to patients and may result in increased disease and preventable deaths. Patients are presenting with conditions we have not seen for years like perforated colonic cancers and ruptured hearts.

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.

Targets

NI's targets have been breached on countless occasions. Figures released for October to December 2020 show outpatient waiting times are in breach again. The standard however must remain. A clinical benchmark to assess progress or lack of progress is essential.

In the New Decade New Approach document[8], it has an aspiration that no one waiting over a year at 30 September 2019 for outpatient or inpatient assessment/treatment will still be on a waiting list by March 2021.

In Feb 2020, the Health Minister stated this will require in the region of £50m as part of the 2020/21 health budget. Due to many reasons, not least the pandemic, this goal has not been reached.

Finances

[7] ITV news https://www.itv.com/news/utv/2021-02-11/ni-has-highest-number-of-cancelled-red-flag-cancer-operations-in-the-uk and also BBC NI story with details on 4,280 cancelled procedures from March 2020 - January 2021.
[8] New Decade New Approach January 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/856998/2020-01-08_a_new_decade__a_new_approach.pdf

We welcome plans for a Fiscal Council for NI. A new NI Assembly research paper[9] provides a financial analysis of the government's current spend and particularly in health. This shows that:

- DOH spent **£934.5 million** on Covid-19 including nearly £68 million on Covid capital projects
- £10 million was spent in private sector on reducing the health waiting lists
- A £1.5 million bid to provide additional elective care provision including for cancer treatments was rejected
- £14.5 million on transformation projects with focus on areas producing 'quickest paybacks'

Within the draft health budget, the resource proposed for 2021-22 is (page 55) is 6,451.9 million, which is an increase of 5.7% from last year. The capital outcome for health for 2021-22 is £326.5 million. Central funding for Covid-19, which is unallocated £126.9 million.

We are concerned that the draft budget **will not pay for a range of important areas** including **£75 million for Transformation growth**; £10.7million to Rebuild/Stabilise Cancer, Oncology and Haematology; £0.6 million for Graduate Medical School at Magee; and £20 million for Safe Staffing.

From these pieces of information, it is clear that transformation or ability to address the backlog waiting lists is not a priority, despite NI Executive statements to the contrary. This is deeply worrying. We note that DOH say:

> "We require major investment on a sustained basis to rebuild our struggling services and reduce waiting times. In **particular, increasing the capacity of our elective care system, whether in house or in the independent sector**, requires a recurrent funding commitment to enable us to invest in the staff and infrastructure required to start to make progress. Unfortunately the funding available within our Draft Budget allocation just does not allow us to make any significant headway into this issue, which was already estimated to cost **£750m-£1bn before the impact of the pandemic is taken into account**."

The health budget has highlighted several areas of concern, which states that the NI Executive will have less money than last year i.e. money available for the COVID response has decreased from £3 billion in 2020-21 to £541.8 million in 2021-22.

The economic climate is worrying too and on a UK GDP level is expected to contract by around 11% this year – this will be the largest fall in output the UK has experienced for more than 300 years. Locally, EY forecast NI GDP to fall by 10.9% in 2020, before recovering to 5.5% growth in 2021. Then we have the unknown impacts of Brexit.

Covid Impacts on Surgery

[9] NI Assembly research paper (Analysis of Departmental Bids Relating to Monitoring Rounds and Separate Covid-19 Exercise) published 15 Feb 2021

Following the suspension of non-urgent elective procedures in March 2020 as the first phase of the pandemic took hold across the UK, many surgeons and other staff were redeployed across Health and Social Care (HSC). In almost all hospitals, elective surgery for benign disease was suspended and only emergencies and semi-urgent oncological surgical procedures were undertaken, with the aim of saving hospital and intensive care beds for COVID-19 patients.

In addition, in many hospitals, operating theatres and pre-recovery spaces were converted into intensive care areas to permit the expansion of the intensive care unit (ICU) where necessary supplies, like oxygen and ventilators, were available.

Routine diagnostic services were closed to permit the use of those facilities for testing of patients with a suspected COVID-19 infection, as in the case of radiological services, and to free as many health workers as possible from routine services, permitting redeployment to COVID-19 departments and - in many cases – to intensive care departments.

As infection rates fell, planned surgery restarted in the summer months, with a high degree of geographic and specialty variation. With the arrival of autumn, the anticipated second wave of infection arrived. In the initial COVID emergency, surgical services focused on treating cancer patients, time-dependent surgical patients and patients with urgent but benign surgical conditions. The third wave saw surgery came to another halt.

While it is of the utmost importance to maintain the quality of care needed to provide a COVID service, the system must make every effort to allow as much continuity of other vital HSC services.

In order to achieve this, we need to be flexible, unified in a common goal and agile. Difficulties with capacity and workforce remain significant stumbling blocks but we need to embrace innovative and creative ways of sustaining services. Financially committing resources towards these core elements would represent a positive step in the right direction.