Elective Care Framework

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Implementation and Funding Plan

Introduction

1. The Elective Care Framework (ECF) was originally published in June 2021. It set out the strategic roadmap for tackling the backlog of patients waiting for assessment and treatment across Northern Ireland.

2. An updated ECF was published in May 2024 outlining the strategic direction for the development and implementation of changes necessary for effective sustainable elective care services within the Northern Ireland Health and Social Care (HSC) system over the next 5-year period. It built on lessons learned from the 2021 Framework and set out a thematic plan designed to reduce our waiting lists and increase capacity across the elective care system.

3. The updated ECF was clear that to reduce waiting lists, it would 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.

4. In order to be successful in achieving its objectives, the ECF was clear that the following funding was required:

    - Recurrent funding: £80m per year when fully implemented.
    - Non-recurrent funding: £135m per year– totalling up to £675m over five years.
    - This is in addition to funding required to treat red flag and suspect cancer patients (£85m).

5. Unfortunately, the 2024-25 Budget outcome was extremely disappointing and limited our capacity to provide care beyond red flag and time-critical patients, leading to longer waiting times.

Progress to Date

6. Even against this challenging financial backdrop, there has been transformation and progress. The work has led to a continuous reduction in the number of patients waiting for treatment, with the treatment waiting lists reducing each quarter in 2024/25. This trend has been ongoing since June 2022 and is the longest sustained reduction of treatment waiting lists since the current way of measuring waiting lists started.

7. Key examples include:

- Two dedicated Day Procedure Centres at Lagan Valley and Omagh Hospitals (between October 2020 – March 2025, approximately 17,905 patients were treated across a range of specialties;
- Three Elective Overnight Stay Centres at Daisy Hill, Mater and South West Acute Hospitals (between April 2023 – March 2025, over 18,277 patients have been treated across all three sites);
- Additionally, the two dedicated regional endoscopy centres within Lagan Valley and Omagh hospitals have treated 13,999 patients (as at March 2025) since this regional capacity commenced;
- Expansion of Post-Anaesthetic Care Unit (PACU) beds for elective care across all Trusts improving patient flow;
- Three speciality centres for cataracts at Downe, South Tyrone and Mid Ulster Hospitals (Dec 2019 - March 2025, over 31,866 patients have been treated across all three sites);
- An orthopaedic hub at Musgrave Park Hospital, which includes the Duke of Connaught Unit, a dedicated orthopaedic Day Procedure Centre (between 2021 and 2024, in Musgrave Park Hospital (MPH), more than 18,000 patients have been treated and the newly refurbished Duke of

Connaught Unit (DoC) at MPH has treated over 3,300 patients, since it's refurbishment;

- Two Rapid Diagnostic Centres (RDC) at Whiteabbey and South Tyrone Hospitals. 1,088 patients were treated across the two RDC sites (21 December 2022 to 5 February 2025);
- A regional Extracorporeal Shock Wave Lithotripsy (ESWL) centre in Craigavon Area Hospital;
- Service reviews into general surgery, adult and paediatric orthopaedics, urology and gynaecology, to set the direction of travel for improvement;
- The introduction of Mega Clinics to maximise patient throughput (between January 2021 - December 2024, over 27,068 patients have been treated);
- Outpatient assessments delivered by GP Federations in primary care settings; and
- Development of in-house HSC capacity and continued investment in staffing.

2025/26 Budget Position

8. The budget for 2025/26 remains under extreme constraint, however, the Executive has ringfenced up to £215m in this year's Health budget for waiting list activities – in line with the finalised Programme for Government.

9. This funding for waiting lists and elective care includes some £85m for the expansion of red-flag/cancer/ time critical capacity. Given the critical need for this funding almost all of this expenditure was already part of the Department of Health's plans for the year, as it was in 2024-25. The funding is for immediate and emerging needs during the year and will not target long waiters.

10. Of the £215m investment, £50m is additional funding to the health budget. The remaining £80m has had to be found from within Health's existing

allocation. That will inevitably have unavoidable consequences for wider health and social care provision

11. Reducing waiting lists will not be a quick fix and it will not be resolved in a year or two. Investment at this level or higher will need to be sustained for up to five years to bring hospital waiting times down to acceptable levels.

12. Despite this financial backdrop, the Executive's focus on tackling waiting times in a targeted way is welcomed. Clarity on the funding position has enabled development of this implementation plan for the actions in the Elective Care Framework.

13. Whilst at this stage we are clear as to the general areas where this additional funding will be targeted, it will be important that we approach this in a way that allows flexibility so that we can respond to system changes, where appropriate, to ensure maximum effectiveness in utilisation of the funding. In that context, this is a living document that will be updated as required to reflect the evolving system and financial environment.

Elective Care Framework Themes

14. The Elective Care Framework focuses on the following themes -

- Transformation of Elective Services (outpatient and surgery services)
- Backlog Clearance
- Productivity and Efficiency
- Workforce
- Independent Sector Engagement
- Funding of Services
- Patient Communication

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.

Funding allocated:

- Red Flag/time Critical Capacity Building– £85m (recurrent)
- Other Capacity Building - £80m (recurrent)

This section sets out plans to build core capacity in the HSC across a number of high-risk specialties for red flag and time critical treatments. Over time this investment will help to build capacity in the HSC, make these services more sustainable and reduce reliance on the Independent Sector (IS).

It also describes how we will incrementally build core capacity to tackle the demand/capacity gap for elective care services. This will involve a combination of measures including maximising our existing infrastructure, expansion in core capacity in a range of specialties and partnership working with the IS. Given the scale of the current backlog (both outpatients and treatments), and the time required to establish additional core capacity, the HSC will need to continue utilising IS capacity. While inhouse red flag and time critical core capacity is being developed, the Department will continue to work with Trusts to secure additional Waiting List Initiative (WLI) capacity.

Addressing the current routine capacity gap will therefore require a range of initiatives.

Across both red flag/time critical capacity building and other elective care capacity building, there will be continuous work to change the culture on how we deliver services. We will seek to deliver services as close to the patient as possible at the same time delivering the most effective care to ensure best value for public money.

In practice this means that as we increase capacity in the system, we will maximise the use of our infrastructure. This will be done in a variety of ways, including continuing the shift from in-patient to out-patient care – with more and more patients going home from hospital the same day they have surgery. Not only is this better for patients' clinical outcomes, it also enables us to treat more patients more effectively.

We will also extend working days from the normal two theatre sessions per day to three, meaning greater usage of our theatre infrastructure. This will initially take place with the creation of a regional Hepatobiliary and Pancreatic (HPB) service in the Belfast City Hospital complex elective care centre and at our regional endoscopy centres. Over time this will be rolled out across more and more services. We will also extend working into weekends, ensuring that normal working for elective care is at least six days a week.

This culture shift will require investment in staff and will take time to fully implement. However, as we continue to bridge the demand capacity gap through sustainable investment in core HSC services, operating days will grow longer and there will be more activity during weekends.

Red Flag/Time Critical Capacity Building (£85m)

The £85m earmarked for expansion of red flag and time critical capacity will be used to expand core capacity across a number of high-risk specialties. This investment will help make these services more sustainable and reduce the reliance on IS capacity. The following areas would be prioritised for funding:

i. **Endoscopy (£13m)** – by commissioning vacant core unfunded sessions across Trusts, delivering evening sessions and Saturday sessions, there is the potential to deliver 16,703 endoscopy procedures per annum.

   The plan for expansion of endoscopy capacity has three stages. The first is to commission vacant Monday to Friday sessions by March 2026, the second will see expansion into 50 week working and evening sessions by March 2027, with the third and final stage expansion into weekend working.

   Each phase will see a significant expansion in capacity, with the approach intended to support recruitment of staff in a planned manner as sufficient staff would not be available to implement all stages at once.

   Target: Investment in 21.25 sessions (4,743 patients) to resource all vacant un-commissioned sessions regionally by March 2026. Over time, the patterns of work will change to longer weekday working and working during weekends. Initially this will focus on expansion into extended days and 50-week delivery by March 2027. It will be followed by expansion into weekend working after extended days and 50-week working has been established. This will improve efficiency of the service and help drive the culture change to better access to services for patients.

ii. **Diagnostic Imaging - Magnetic Resonance Imaging (MRI), Computed Tomography (CT) and Non-Obstetric Ultrasound**

(NOUS) (£12m) – based on the current spend, use of existing capital equipment, and if fully staffed by core workforce, there is the potential to close part of the current demand/capacity gap in regional imaging. This will potentially include an additional 5,880 funded CT/MRI sessions and 2,000 funded NOUS sessions per annum.

Target: Investment to potentially deliver an additional 2,940 funded CT/MRI sessions and 1,000 NOUS in hours, evenings and/or weekends regionally per annum by March 2027.

Further expansion of 1,470 funded CT/MRI sessions and 500 NOUS sessions regionally per annum into further extended working days by March 2028.

Expansion of 1,470 funded CT/MRI sessions and 500 NOUS sessions regionally per annum into further weekend and bank holiday working by March 2029.

iii. **Trauma (£11m)** – recurrent funding is required to expand trauma capacity to improve performance against the 24hr Neck of Femur access target. An additional 8 lists will be provided per week to reduce the length of time between assessment and surgery. In parallel this investment will reduce the number of elective procedures cancelled by approximately 35 cases per month (~ 400 per annum).

Target: Increased performance of 65% by March 2026, 75% by March 2027, 85% by March 2028.

iv. **Urology (£7m)** – the expansion of urology specialist nurses will be paramount to reduce the reliance on the IS and improve our cancer waiting times. Only 31% of patients were managed with the 62-day pathway in 2024/25. Providing funding for three additional clinical nurse specialists and two all day inpatient lists per Trust would provide sufficient capacity to deliver an extra 2,000 procedures per year.

Target: Increased performance against the 62-day pathway i.e. 50% March 2027, 65% March 2028, 80% March 2029.

v. **Dermatology (£5m)** – work is ongoing to review the current dermatology pathway to include a review of the nurse led role which could be potentially based in primary care hubs providing the full suite of assessment, diagnosis, prescribing and treatment (3 nurses per hub). This model would enhance the current Primary Care GP led model and would significantly reduce the red flag and urgent demand in secondary care by approximately 9,000 referrals.

   Target: Reduce the number of red flag and urgent dermatology referrals going into secondary care by approx. 9,000 referrals and reduce the overall waiting time for assessment.

vi. **General Surgery (£3m) –** Demand for outpatients, daycase and inpatient red flag and time critical general surgery services is significantly above capacity available. There is a need to expand general surgery capacity regionally to manage these demands and expand capacity across medical, nursing and allied health profession patient pathways.

   Reducing general surgery waiting times for patients waiting for red flag assessment and treatment and time critical procedures will be enabled by completion of a region wide waiting list validation exercise and a demand capacity exercise across all Trusts, with a view to maximisation of existing capacity by utilising vacant theatres. This includes readiness and ability to provide additionality for the region, considering elective overnight stay centres and post op capacity, supported by a regional workforce as additionality during weekends. It is expected that 3,000 assessments and 3500 treatments will be delivered with this investment.

We will create a **regional Hepatobiliary and Pancreatic (HPB) service** at Belfast City Hospital's (BCH) complex elective care centre. We will increase the number of General Surgery consultants in Belfast Trust from 5 to 6 for this service. This will increase the number of sessions per day at the Belfast City Hospital moving complex surgery into three session days. This will address the long waits for this complex surgery and help address long waiters for complex gallbladder surgery. This would cost around £800k and deliver culture change in extending the theatre day at the regional complex elective care centre from two to three sessions per day. It would also deliver an additional at least 200 gallbladder operations per year.

Target: Reduction in general surgery waiting times for patients waiting for red flag assessment and treatment and time critical procedures.

Target: £800k would create a regional HPB service, increase regional HPB theatre sessions at BCH complex elective care centre from the standard of two to three to address waits for complex HPB surgery. It would also deliver at least an additional 200 complex gallbladders per year.

vii. **Plastics (£5m) -** This will incrementally increase red flag and time critical capacity for patients waiting for plastic surgery outpatient, daycase and inpatient services and support clinical interface areas that are essential for delivery service reform. 1,200 assessment and 1,600 treatments are expected to be provided by this investment.

Target: Reduce the plastic surgery elective waiting times relative to the 2024/25 baseline position and ensure equity of access for patients from across NI.

viii. **Vascular surgery (£4m)** – Increasing demand from emergency pressures is having a direct impact on the timely treatment of time critical surgical procedures. There is a clear need to increase the

number of vascular theatre sessions and vascular surgery bed numbers. When fully staffed this investment would allow for additional 5 theatre sessions per week over 50 weeks equating to approximately 300 inpatients.

Target: Reduce the surgical elective waiting times by March 2027 for the following key procedures **-** critical limb, major amputations, carotid endarterectomy and aneurysm relative to the 2024/25 baseline position. Improvements will also include reduced length of stay and a reduction in the number of major amputations.

ix. **Ophthalmology (£3.5m)** Increase outpatient and treatment red flag and time-critical capacity across vitreo-retinal (VR), corneal, macular and glaucoma sub-specialties. This will help to stabilise service provision to meet growing demand for ophthalmology more effectively.

Target: Deliver an additional 300 VR outpatients and 280 additional treatments, an additional 200 corneal outpatient appointments and 150 procedures, and an additional 100 glaucoma procedures.

x. **Gynaecology (£3.5m) -** Demand for outpatients, daycase and inpatient red flag and time critical gynaecology services is significantly above capacity available. There is a need to expand gynaecology capacity to manage red flag and time critical patients and expand capacity in medical, nursing and allied health profession patient pathways. This investment will allow for 4,100 assessments and 900 treatments.

Target: Reduce gynaecology elective waiting times for patients waiting for red flag assessment and treatment and time critical gynaecology conditions. Deliver a reduction in gynaecology waiting lists of 40% by March 2027, 65% by March 2028 and 90% by March 2029 relative to the 2024/25 baseline position.

xi. **Breast Surgery (£5m**) – Additional funding is needed to develop a regional breast pain pathway and address the surgical gap for both the red flag patients and the urgent Breast Cancer Gene (BRCA) patients who are on the waiting list. It is anticipated that at least 3,200 women would benefit from this investment.

Target: Improved performance against the 14-day target i.e. 80% by March 2027.

xii. **Cardiac Surgery (£3m)** – Given the current capacity and demand gap in this specialist service, multi-year contracts (2 years) should be negotiated with the IS to ensure maximum value for money. Based on historical spend, £3m would allow approximately 120 patients to be treated each year.

Target: No one waiting over 9 months by March 2026 and no one waiting over 6 months by March 2027.

xiii. **Systemic Anti-Cancer Therapy (SACT) (£2.5m)** – There is a need to address the substantial resilience issues with regard to the provision of outpatient assessment and delivery of SACT. Additional consultant and nurse led clinics will be required to address this pressure. This funding will close the gap of 20% against stabilisation plans which commenced in 20/21.

Target: In tandem with a range of actions included in this plan, improve overall performance against the 62-day cancer pathway.

xiv. **Ears, Nose and Throat (ENT) (£2m)** - To meet the growing demand for ENT services, the aim will be to provide resilience to subspecialty areas of ENT (head and neck cancer, paediatrics, rhinoplasty, complex airways) for adult and paediatric services across Northern Ireland. To ensure that there is a sustainable Head and Neck Services in Northern Ireland, there is an urgent need to secure medical staffing and theatre

sessions, as well as to develop and standardise approved regional pathways for ENT conditions. 5,500 people will benefit from consultant and AHP input with an estimated further 500 daycase procedures.

Target: By 31 March 2026, secure additional theatre sessions in the Royal Belfast Hospital for Sick Children (RBHSC) to manage complex ENT airway patients, by moving lower acuity cases outside Belfast Trust. 350 Children will receive inpatient procedures as a result of this investment.

By 31 March 2026 significantly reduce outpatient and inpatient waiting lists by 30% against 2024/25 baseline position.

xv. **Cancer Nurse Specialist (CNS) posts (£1.5m) –** To meet the growing demand for cancer services, Trusts have filled posts on a temporary basis using short term charitable funds. As a result, there is an immediate risk to 19 CNS posts across the region. Any reduction in this nurse led capacity would have a direct impact on the 62-day cancer waiting times due to the material loss of capacity to the service and is required to ensure stabilisation.

Target: To ensure that at risk CNS posts are filled permanently by March 2026.

xvi. **Other Specialities (£4m) -** Further work is ongoing to assess the viability of expanding core inhouse capacity across other smaller specialties. This assessment will need to consider current medical vacancies and the opportunities to expand the skill mix of the wider team. Updates will be provided through regular monitoring.

xvii. **Expansions of Rapid Diagnosis Centres** - Work is also underway to develop service principles for Rapid Diagnosis Centres (RDC). Initially this will use RDC capacity in South Tyrone and Whiteabbey Hospitals to support quicker diagnosis of pancreatic cancer through a new RDC pathway. This is expected to involve 500-600 patients who are

suspected to have pancreatic cancer and it is expected improve survival rates where pancreatic cancer is diagnosed. It will also provide a framework for the future expansion of the RDC model to other regional red flag diagnostic pathways for small volume tumour sites.

In addition, we will work in partnership with the Independent Sector to deliver RDCs for suspected cancer patients and cancer services. It is expected that this new way of working will see the establishment of RDCs linked to the Belfast Cancer Centre and North West Cancer Centre (subject to contractual agreements and capital investment at North West Cancer Centre). Each RDC would provide CT, MRI and Positron Emission Tomography (PET) as well as other diagnosis and imaging required for suspected and confirmed cancer patients, enabling up to 17,500 CTs and 10,000 MRIs per year when fully implemented.

Target: Policy principles for the RDC model to be developed by Autumn 2025. Agreement on partnership working with Independent Sector in 2025, with first service delivery in new RDCs in 2027. 17,500 CTs and 10,000 MRIs per year when fully implemented.

The above activity reflects plans for investment, and implementation of these plans will work towards achieving Programme for Government commitments. It must be acknowledged, however, that whilst we are working to build the necessary capacity to deliver on this programme, and the need to ensure continuity of service provision, a decision was taken in Quarter 1 (2025/26) to invest in WLI (in house and IS).

To date £19m has been invested in this way, and it is anticipated that approximately 51,000 red flag and time critical patients will benefit from this.

It should be noted that oversight and monitoring arrangements allow for agility in redirecting between categories if required.

Other Capacity Building (£80m)

To address the current routine waiting times and the associated capacity gap will require an increased focus on demand management, an expansion of core capacity, coupled with an increase in productivity and efficiency. The Department will work across the primary and secondary care interface to ensure that patients are being managed in the most appropriate setting and that capacity is being expanded on a sustainable basis across the HSC.

However, given the scale of the current backlog (both outpatients and treatments), and the time required to establish additional core capacity, over and above the red flag/ time critical capacity referenced previously, the HSC will require a cocktail of initiatives to deliver the expected improvements, including working with the Independent Sector (IS). These initiatives will include:

i. **GP Federations (£2.9m) –** To date, the GP Federation Primary Care Elective Service has the available staff to upscale their capacity in dermatology, minor surgery, and gynaecology. It is estimated that £2.9m would allow the service to see and treat approximately 16,500 patients in 2025/26. This will see activity in gynaecology doubling from 2024/25 levels, including restoration of the primary care led gynaecology service in the Fermanagh area and activity in Dermatology and Minor Surgery will double by end of Quarter 2 2025/26.

   There is also the potential to expand the scope of primary care elective services into other areas where there are long waiting routine patients waiting for assessment. These areas include neurology and urology. Expansion of the Primary Care Elective Service, to include a Basal Cell Carcinoma (BCC) model, is also to be progressed in 2025/26 which will release capacity in hospital dermatology services.

Target - Treat approximately 16,500 patients in 2025/26. In practice this means:

- Activity in gynaecology to double from 2024/25 levels, including restoration of the primary care led gynaecology service in the Fermanagh area
- Activity in dermatology to double from 2024/25 levels by quarter 2 - 2025/26
- Activity in minor surgery to double from 2024/25 levels by end of quarter 2 - 2025/26
- Expansion of the service, to include the BCC model, to be progressed in 2025/26.

ii. **Pre-Operative Assessment (POA) Capacity (£3m)** - Expansion of the POA nursing workforce across the region is paramount if the HSC is to reduce the capacity which is lost in theatres due to short notice cancellations. Expanding this workforce and increasing the access to the anaesthetic led POA clinics, will help increase theatre productivity by reducing the number of elective cancellations compared to the 2024/25 position. This equates to around 35 additional nurses – who could deliver and additional 7,000 pre-op assessments per annum.

Target: Increase the number of consultant led and nurse led POA clinics by March 2027.

iii. **Increasing HSC training places & placement for vulnerable specialties (£6.5m)** - There are ongoing challenges filling consultant posts across a range of specialties including anaesthetics, haematology, vascular, ophthalmology, urology, orthopaedics and general surgery. To address this staffing gap will require an expansion of training places which should be targeted at those Trusts with the greatest recruitment challenges. In addition, there are a small number of trainees due to complete their training programmes in 2025/26 in vulnerable specialties

who will be offered HSC employment to ensure resilience and enhanced capacity.

Target: Incremental increase in posts with an additional 25 appointed by March 2027 and a further 25 appointed by March 2028

iv. **Phlebotomy Hubs (£1m)** – These hubs are essential to ensure that both cancer and non-cancer patients receive their blood work up closer to home and reduces the overall patient pathway. This local model also reduces the footfall at cancer centres for Systemic Anti-Cancer Treatment (SACT) clinics. Phlebotomy hubs will be delivered in line with the RDC model and will – if practicable and appropriate – be co-located with RDCs as they are expanded.

Target: Along with other actions in this plan, this is a core plank to help improve performance against the 62-day cancer pathway.

v. **Expanding Independent Sector multi-year contracts and Expanding HSC Capacity (£65.1m)**– Building recurrent HSC capacity will be subject to recruitment of staff to newly created posts. While efforts would be made to recruit in a timely manner, the ongoing use of available IS capacity would be required while this process is ongoing.

To avoid multiple hand offs, repeat assessments and a build-up of treatment waits, contracts will need to be agreed for the total patient journey including assessment, treatment and post-operative review. This is in line with the direction of travel elsewhere in the UK where demand is managed by the IS, using long term contracts. Specialties where partnership arrangements could be established include Ophthalmology, Orthopaedics, General Surgery, Gynaecology and ENT.

There are a number of HSC sites (Daisy Hill, Causeway and South West Acute Hospital (SWAH) where, in addition to further bolstering HSC

activity, long term IS insourcing is being explored and the blueprint for this hybrid model has already been successfully established using an IS orthopaedic provider in the SWAH.

To help increase the value for money, every effort will be made to expand core HSC capacity across outpatient departments, theatres and beds. While the initial focus will be the expansion of red flag and time critical capacity, the Department will work with Trusts to increase capacity for core services.

In practice, we will seek to establish long term contracts and utilisation of some of the uncommissioned theatre capacity at SWAH for insourcing from IS which could, based on previous working with the IS, provide 30 primary joints or 25 gallbladders (or a combination of similar procedures) per week – thus delivering up to 1,260-1,500 primary joints or 1,050-1,250 gallbladders per year when operational (based on either 42 or 50 week operating model).

Target: At least an 80% reduction, in the March 2025 over 4-year outpatient and treatments waits, will be delivered by March 2028. Incremental reductions will be expected from March 2026.

vi. **Third Sector (£1.5m) –** The HSC has a well-established relationship with the voluntary sector. We will establish two grant funds for the charity sector. A £1m per year grant scheme will be provided for cancer charities and a £500k per year grant scheme will be provided for charities supporting the work on 'Waiting Well'.

The aims of the grant schemes will be to enable charities to carry out valuable work which helps cancer patients and patients on waiting lists avoid seeking hospital care. This will provide a better experience for patients, close to the patients' home, and will free capacity in the cancer and elective care system to deliver more efficient care, thus providing the best use of public money whilst ensuring best patient outcomes.

Target: Two grant schemes, £1m per year for cancer charities and £500k per year for Waiting Well charities, will be established with a call for applications and decisions on funding before the end of March 2026.

Building capacity within the HSC is dependent on the ability to expand existing infrastructure and workforce. The later requires a significant lead in time associated with the desire to have homegrown trainees given workforce pressures which are particularly acute in a number of specialties and competing NHS pressures in other jurisdictions. The profile of spend associated with trainees provides an opportunity to utilise, on a non-recurrent basis, funding to reduce waiting lists.

Theme 2: Backlog Clearance

Objective: To reduce the waiting list backlog.

Funding allocated – £50m (non-recurrent) (against £135m per year requirement in ECF).

To reduce the current backlog will require a package of initiatives, including use of the Independent Sector, expansion of in-house additionality (evening and weekend sessions) and a range of other targeted interventions. These initiatives include:

i. **Waiting List Initiatives** – In-house and IS capacity will be used to address some of the longest waiting for assessments and treatments across a number of general specialties and/or procedures. Funding could also be targeted at some of those specialist procedures where there are long waits impacting women or children - see table below:

Specialty/Procedure	Approximate patient numbers	Cost
Mega Clinics	20,000 patients across a number of specialities including ophthalmology, orthopaedics, general surgery and ENT	**£10m**
Validation	Complete validation of all over 4-year waits (~ 62,000 Assessments and 16,000 treatments)	**£1m**
Primary hip/ knee (900)	Clear over 4-year waits (~3,100 patients)	**£26m**
Lap Cholecystectomy (600)		
Tonsillectomies (400)		
Hernia Treatment (700)		
Colonoscopy (500)		
Waiting List Reduction Reimbursement Scheme	1,400 patients will benefit from the Scheme	**£10m**
		£47m
Other Specialist Procedures (~300 patients)		
Gynae Mesh	Reduce to 6 months	**£3.0m**
Paediatric Scopes	Reduce to 1 year	
Paediatric Squints	Reduce to 13 weeks	
Paediatric Peg Tubes	Reduce to 13 weeks	
Cleft Lip	Reduce to 13 weeks	
Scoliosis	Reduce to 13 weeks	
Total		**£50m**

ii. **Waiting List Reduction Reimbursement Scheme (£10m) –** The establishment of the Waiting List Reduction Reimbursement Scheme will help facilitate the transfer and treatment of long waiting patients, without impacting on core or local IS capacity. The Scheme would initially offer patients the choice of treatment in the Republic of Ireland, expanding to other European Union providers later in the year. To ensure the maximum impact on waiting times, this Scheme will be limited to those patients who have been waiting at least 24 months for their procedure.

Based on the previous schemes, the average cost of £7k per patient has been estimated, this would result in approximately 140 surgeries being funded for every £1m allocated to the scheme.

Target: It is estimated that approximately 1,400 patients could benefit from a replacement scheme at a cost of approximately £10m this financial year.

iii. **Validation (£1m) –** Given the current long waits for routine assessment, it is not uncommon for a patient's clinical condition to change. Undertaking regular validation of the waiting list is important to ensure accuracy of waits and reduce the risk of patient cancellations or Did Not Attends (DNAs). Using both secondary and primary care, there is an opportunity to undertake a targeted validation exercise across a number of specialties and waiting time cohorts. Ensuring accurate and up to date waiting lists will enable more efficient scheduling of activity and should reduce DNAs and Cancellations, thereby improving the overall service productivity. Historically between 5-10% of contacts via validation results in a removal from a waiting list.

Target: Complete validation of all over 4 year waits by 31 March 2026.

iv. **Mega Clinics** – these clinics will be undertaken in all Trusts and will cover a range of specialties including; ophthalmology, orthopaedics, general surgery and ENT. Mega clinics may also be utilised to undertake large scale administrative and clinical validation as this will represent value for money.

v. **Other Specialist Procedures** – whilst the number of patients is small within this cohort there are a number of paediatric procedures which can impact on child development and more responsive waiting times are required justifying the targeted investment. The additional theatre capacity to deliver these volumes are being assessed by Trust colleagues and where necessary other NHS providers may be secured, as is the current contracting arrangement for scoliosis cases.

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.

Funding – No new investment required.

While improvements in efficiency and productivity have been made by Trusts in recent years, there still remains scope to secure further gains, by optimising the resource available to Trusts. Trusts will ensure that appropriate focus is given to deliver service improvements, with implementation of good practice across the patient pathway to help drive improved quality, equity and efficiency. The following actions will be taken forward to ensure we maximise the resources currently available to us:

What?	Why?	Measure / target	Impact
British Association of Day Surgery (BADS) day case rate	To maximise proportion of elective procedures delivered as a day case	As per individual procedure targets	Increase in day case rate reduces patient length of stay and improves hospital flow
Outpatient Did Not Attend (DNA) / Cancellation on the Day (CND) Rate	To maximise available outpatient clinic capacity	New: 5% (max) Review: 8% (max)	Reduction in DNA / CND rate to target would increase attendances and reduce waiting list backlogs
Theatre Did Not Attend (DNA) / Cancellation on the Day (CND) Rate	To maximise utilisation of theatre resource	5% (max)	Reduction in DNA / CND rate to target would increase procedures delivered and reduce waiting list backlogs

Theatre Run Times	To maximise utilisation of theatre resource	90% (min)	Increase in run times can increase the volume of patients treated per list and reduce waiting list backlogs
Theatre Operating Times	To maximise utilisation of theatre resource	Main theatre: 85% (min) Day Procedure Unit: 80% (min)	Increase in operating times can increase the volume of patients treated per list and reduce waiting list backlogs

The above elective productivity measures have been incorporated into the HSC Systems Oversight Metrics (SOMs) and a robust monitoring and reporting process is in place. Where is it evident that sufficient progress is not being made to improve productivity, the service areas will be subject to escalation via the HSC Support & Intervention Framework. In addition to other measures, public messaging is currently being developed to address findings from a recent audit into non-attendance (DNA).

In 2024 a shadow tariff for DNA and cancellations on the day was introduced. This provided a nominal charge for the HSC Trusts for each DNA and cancellation on the day above the agreed national benchmarks. This is intended to encourage HSC Trusts to actively work to meet the national benchmarks. At this point the tariff is in shadow form, with no actual charging of the Trusts.

The shadow tariff will be evaluated in the autumn of 2025. If there has not been significant improvement on Trust performance, with the Trusts meeting the national benchmarks for DNA and cancellations on the day, the Department will consider introducing charging the Trusts the tariff. A final decision on DNA and cancellations on the day tariffs will be taken before the end of 2025.

Theme 4: Workforce.

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

Funding – Will be captured within the initiatives outlined for Waiting List investment and is not shown separately to avoid duplication.

The reform of elective care services is multi-factorial and can only be achieved if it is underpinned by a sustainable workforce. The importance of an appropriately qualified, well equipped and fit for purpose workforce to underpin all aspects of continuity and change in service delivery cannot be overstated.

This is not just about numbers, it is about different ways of working to get the best service for patients from all available resources and having the right staff with the right skills mix, to do that. Work has continued across the system to stabilise, expand and develop the workforce, to support more effective use of staff across different specialities.

This work will continue to ensure appropriate plans are developed for a robust workforce to underpin the necessary transformational and development work to secure a fit for purpose health service.

Work is continuing across specialties to update job plans, where appropriate, to facilitate regional working. In practice this also means we will encourage culture shifts across the HSC workforce. Going forward it is the expectation that consultants will have to travel to the patient and where they are needed. This includes surgeons travelling to elective care centres to provide surgery to regional patients. HSC Trusts will be expected to consider regional working in the annual job plan review of all senior medical staff, with start in 2025/26.

It is also intended that the time consultant surgeons spend in theatre will increase. Today consultant surgeons spend approximately one day a week performing surgery. This does not represent best value for money and does not help us provide better outcomes for our patients. It is the intention that, as we build capacity, the consultant surgeon's time in theatre will increase to at least

two days a week. However, it is recognised that this will take time as other staff will be required to free up consultants to spend time in theatres. In addition, additional theatre capacity will be required, which is expected through expanding operating days and weekend working.

Target: Linking with Theme one above, we will develop a workforce of the size and type needed to transform elective care services leading to better ways of working across elective care services.

We expect HSC Trusts to start considering regional working, culture change and regional strategy in the annual review of consultants' job plans, starting in 2025.

Theme 5: Independent Sector Engagement.

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

Funding – Will be captured within the initiatives outlined for Waiting List investment and is not shown separately to avoid duplication.

A clear policy framework is being developed 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. Development of this framework will ensure value for money in IS investments through development of long-term sustainable partnerships.

We will seek partnership working, where IS delivers core services to ensure best outcomes for our patients.

Target: The policy is currently being drafted and will be published by the end of 2025.

Theme 6: Funding Models.

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

Funding allocated – No new investment required.

Plans for Implementation: Consideration has been given to the model currently used to fund Elective Care activity. Whilst moving to the tariff model used elsewhere in the UK is not regarded as good value for money for implementation in Northern Ireland due to the additional administrative costs it would incur, we continue to explore ways of achieving the same outcomes. This already includes the use of monitoring frameworks to promote greater levels of productivity and efficiency.

Target: Consideration will now be given to the way that the £215m of waiting list money is allocated in 2025/26 in order to better support efficiency, effectiveness, innovation and value for money where possible. The effectiveness of these changes will be evaluated in early 2026/27 to ensure that lessons learned can be applied to future funding.

Theme 7: Patient Communication.

Objective - Improved patient communication and support for patients on waiting lists.

Funding allocated - £500k

Work is currently underway on the development of a 'Waiting Well' policy to provide support to individuals on waiting lists, while they wait for treatment. The policy for HSC Trusts is currently being drafted and will set out the minimum standards/ guiding principles that must be met by Trusts in providing support to patients on waiting lists. This will focus on areas such as patient communication, symptom management and access to support services. Servicer User engagement has commenced to support the development of the policy and will continue throughout the policy development phase.

To support the implementation of the practical elements of the policy, £500k has been ringfenced from the Department of Health budget for investment in a Waiting Well programme as referenced under Theme 1 alongside investment in the charity sector in the form of a waiting well charity grant.

Target: It is anticipated that the policy will be published, and that the programme will be operational by the end of 2025, decisions on grant funding will have taken place by end of March 2026.

Conclusion.

The Elective Care Management Team (ECMT) will be responsible for overseeing this implementation plan. This team is made up of senior policy makers and senior operational staff from the Department of Health alongside Trust Directors.

The ECMT was established in January 2022. The core objective of the team is to ensure better outcomes for patients that need elective care by leading a strategic, whole system, integrated approach to the delivery of elective care services in Northern Ireland as articulated in the Elective Care Framework. ECMT aims to ensure that the HSC system is equipped to deliver an equitable, sustainable high-quality regional service for every adult and child in Northern Ireland, irrespective of where they live.

Progress against the actions in this document will be monitored by ECMT on a monthly basis with formal reporting on progress on a quarterly basis. In that context, the detail of this investment plan will be reviewed on a regular basis and will be updated as appropriate.

A summary of the planned investment is attached at **Annex A.**

Elective Care Framework Implementation and Funding Plan – Summary of Investment

Annex A

Red Flag/Time Critical Capacity Building (£85m)[1]			
Action / Speciality	**Investment (£m)**	**Target**	**Impact**
Endoscopy	13	Investment in 21.25 sessions (4,743 patients) to resource all vacant un-commissioned sessions regionally by March 2026. Over time the patterns of work will change to longer weekday working and working during weekends. Initially this will focus on expansion into extended days and 50-week delivery by March 2027. It will be followed by expansion into weekend working after extended days and 50-week working has been established.	Potential to deliver 16,703 endoscopy procedures per annum.
Diagnostic Imaging	12	Investment to potentially deliver an additional 2,940 funded CT / MRI sessions and 1,000 NOUS in hours, evenings and / or weekends regionally per annum by March 2027. Further expansion of 1,470 funded CT / MRI sessions and 500 NOUS sessions regionally per annum into further extended working days by March 2028. Expansion of 1,470 funded CT / MRI sessions and 500 NOUS sessions regionally per annum into further weekend and bank holiday working by March 2029.	This will potentially include an additional 5,880 funded CT / MRI sessions and 2,000 funded NOUS sessions per annum.

[1] £19m invested in WLI in Q1 25/26 – it is anticipated that 51,000 patients will benefit from this

Trauma	11	Increased performance of 65% by March 2026, 75% by March 2027, 85% by March 2028.	Expanding trauma capacity to improve performance against the 24hr Neck of Femur access target. An additional 8 lists will be provided per week to reduce the length of time between assessment and surgery. In parallel this investment will reduce the number of elective procedures cancelled by approximately 35 cases per month (~ 400 per annum).
Urology	7	Increased performance against the 62-day pathway i.e. 50% March 2027, 65% March 2028, 80% March 2029.	Providing funding for three additional clinical nurse specialists and two all day inpatient lists per Trust would provide sufficient capacity to deliver an extra 2,000 procedures/diagnostic tests per year.
Dermatology	5	Reduce the number of red flag and urgent dermatology referrals going into secondary care by approx. 9,000 referrals and reduce the overall waiting time for assessment.	Reduce the red flag and urgent demand in secondary care by approximately 9,000 referrals.
General Surgery	3	Reduction in general surgery waiting times for patients waiting for red flag assessment and treatment and time critical procedures. £800k would create a regional HPB service, increase regional HPB theatre sessions at BCH complex elective care centre from the standard of two to three to address	Expand general surgery capacity regionally to manage demand for outpatients, daycase and inpatient red flag and time critical general surgery services and expand capacity across medical, nursing and allied health profession patient pathways. To address long waiters for complex gallbladder surgery.

		waits for complex HPB surgery. It would also deliver at least an additional 200 complex gallbladders per year.	
Plastics	5	Reduce the plastic surgery elective waiting times relative to the 2024/25 baseline position and ensure equity of access for patients from across NI.	This will incrementally increase red flag and time critical capacity for patients waiting for plastic surgery outpatient, daycase and inpatient services and support clinical interface areas that are essential for delivery service reform. 1,200 assessments and 1,600 treatments are expected to be provided by this investment.
Vascular surgery	4	Reduce the surgical elective waiting times by March 2027 for the following key procedures - critical limb, major amputations, carotid endarterectomy and aneurysm relative to the 2024/25 baseline position. Improvements will also include reduced length of stay and a reduction in the number of major amputations.	When fully staffed this investment would allow for additional 5 theatre sessions per week over 50 weeks equating to approximately 300 inpatients.
Ophthalmology	3.5	Deliver an additional 300 VR outpatients and 280 additional treatments, an additional 200 corneal OP and 150 procedures, and an additional 100 glaucoma procedures.	Increase outpatient and treatment red flag and time-critical capacity across vitreo-retinal (VR), corneal, macular and glaucoma sub-specialties. This will help to stabilise service provision to meet growing demand for ophthalmology more effectively.
Gynaecology	3.5	Reduce gynaecology elective waiting times for patients waiting for red flag assessment and treatment and time critical gynaecology conditions. Deliver a reduction in gynaecology waiting lists of 40% by March 2027, 65% by	Expand gynaecology capacity to manage red flag and time critical patients and expand capacity in medical, nursing and allied health profession patient pathways.

		March 2028 and 90% by March 2029 relative to the 2024/25 baseline position.	This investment will allow for 4100 assessments and 900 treatments.
Breast	5	Improved performance against the 14-day target i.e. 80% by March 2027.	Additional funding is needed to develop the regional breast pain pathway and address the surgical gap for both the red flag patients and the urgent Breast Cancer Gene (BRCA) patients who are on the waiting list. It is anticipated that at least 3,200 women would benefit from this investment.
Cardiac Surgery	3	No one waiting over 9 months by March 2026 and no one waiting over 6 months by March 2027.	£3m would allow approximately 120 patients to be treated each year.
Systemic Anti-Cancer Therapy SACT	2.5	In tandem with a range of actions included in this plan, improve overall performance against the 62-day cancer pathway.	Address resilience issues in regard to the provision of outpatient assessment and delivery of SACT – additional consultant and nurse led clinics will be required to address this pressure. This funding will close the gap of 20% against stabilisation plans which commenced in 20/21.
ENT	2	By 31 March 2026, secure additional theatre sessions in the RBHSC to manage complex ENT airway patients, by moving lower acuity cases outside Belfast Trust. 350 Children will receive inpatient procedures as a result of this investment. By 31 March 2026 significantly reduce outpatient and inpatient waiting lists by 30% against 2024/25 baseline position.	Will meet the growing demand for ENT services, provide resilience to subspecialty areas of ENT (head and neck cancer, paediatrics, rhinoplasty, complex airways) for adult and paediatric services across Northern Ireland. To ensure that there is a sustainable Head and Neck Services in Northern Ireland there is an urgent need to secure medical staffing and theatre sessions, as well as to develop and

			standardise approved regional pathways for ENT conditions. 5,500 people will benefit from consultant and AHP input with an estimated further 500 day case procedures.
Cancer CNS posts	1.5	Ensure that at risk CNS posts are filled permanently by March 2026.	Improve performance against 62-day cancer waiting times.
Other Specialties	4	Further work is ongoing to assess the viability of expanding core inhouse capacity across other smaller specialties. This assessment will need to consider current medical vacancies and the opportunities to expand the skill mix of the wider team.	Reduction in waits across other specialities.
Total	**85**		
Capacity Building (£80m)			
GP Federations	2.9	It is estimated that £2.9m would allow the service to see and treat approximately 16,500 patients in 2025/26. In practice this means • Activity in gynaecology to double from 2024/25 levels, including restoration of the primary care led gynae service in the Fermanagh area • Activity in dermatology to double from 2024/25 levels by quarter 2 2025/26 • Activity in minor surgery to double from 2024/25 levels by end of quarter 2 2025/26 • Expansion of the service, to include BCC model, to be progressed in 2025/26.	This will see activity in Gynae doubling from 2024/25 levels, including restoration of the primary care led gynae service in the Fermanagh area and activity in Dermatology and Minor Surgery will double by end of Q2 2025/26. There is also the potential to expand the scope of primary care elective services into other areas where there are long waiting routine patients waiting for

			assessment. These areas include neurology and urology. Expansion of the PC Elective Service, to include Basal Cell Carcinoma (BCC) model, is also to be progressed in 2025/26 which will release capacity hospital dermatology services.
Pre-Operative Assessment Capacity	3	Increase the number of consultant led and nurse led POA clinics by March 2027.	Reduce the capacity which is lost in theatres due to short notice cancellations. Expanding this workforce and increasing the access to the anaesthetic led POA clinics, will help increase theatre productivity by reducing the number of elective cancellations compared to the 2024/25 position. This equates to around 35 additional nurses – who could deliver and additional 7,000 pre op assessments per annum.
Increasing HSC training places & placement for vulnerable specialties	6.5	Incremental increase in posts with an additional 25 by March 2027 and a further 25 appointed by March 2028	Expansion of training places across a range of specialities. This will be targeted at those Trusts with the greatest recruitment challenges. In addition, there are a small number of trainees due to complete their training programmes in 2025/26 in vulnerable specialties who will be offered HSC employment to ensure resilience and enhanced capacity.

Phlebotomy Hubs	1	Along with other actions in this plan, this is a core plank to help improve performance against the 62-day cancer pathway.	Ensure that both cancer and non-cancer patients receive their blood work up closer to home and reduce the overall patient pathway. This local model will also reduce the footfall at cancer centres for Systemic Anti-Cancer Treatment (SACT) clinics.
Expanding Independent Sector multi-year contracts and Expanding HSC Capacity	65.1	At least an 80% reduction in the March 2025 over 4-year outpatient and treatments waits will be delivered by March 2028, with incremental reductions from March 2028. Incremental reductions will be expected from March 2026.	Building recurrent HSC capacity will be subject to recruitment of staff to newly created posts. While efforts would be made to recruit in a timely manner, the ongoing use of available IS capacity would be required while this process is ongoing. Long term insourcing arrangements explored for Daisy Hill, Causeway and SWAH.
Voluntary Sector	1.5	Two grant schemes, £1m per year for cancer charities and £500k per year for Waiting Well charities, will be established with a call for applications and decisions on funding before the end of March 2026.	The aim of the grant schemes will be to enable charities to carry out valuable work which helps cancer patients and patients on waiting lists avoid seeking hospital care. This will provide a better experience for patients, close to the patients' home, and will free capacity in the cancer and elective care system to deliver more efficient care, thus providing the best use of public money whilst ensuring best patient outcomes. There will also be investment in this sector to support people on waiting lists, to ensure they remain fit and healthy

			ahead of treatment. This will be underpinned by a 'Waiting Well' Policy.
Total	**80**		
Backlog Clearance £50m			
Primary hip/ knee (900)	26	Clear over 4-year waits	Reduce current backlogs for patients waiting over 4 years by 31 March 2026 (~3,100 patients)
Lap Choles (600)		Clear over 4-year waits	
Tonsillectomies (400)		Clear over 4-year waits	
Hernia Treatment (700)		Clear over 4-year waits	
Colonoscopy (500)		Clear over 4-year waits	
Other Specialist Procedures (~300 patients)			
Gynae Mesh	3	Reduce to 6 months	
Paediatric Scopes		Reduce to 1 year	
Paediatric Squints		Reduce to 13 weeks	
Paediatric Peg Tubes		Reduce to 13 weeks	
Cleft Lip		Reduce to 13 weeks	
Scoliosis		Reduce to 13 weeks	
Mega Clinics	10	20,000 patients across a number of specialities including ophthalmology, orthopaedics, general surgery and ENT	

Waiting List Reduction Reimbursement Scheme	10	Introduction of new Scheme by June 2025. It is estimated that approximately 1,400 patients could benefit from a replacement scheme at a cost of approximately £10m this financial year.	Facilitate the transfer and treatment of long waiting patients (waiting at least 24 months), without impacting on core or local IS capacity.
Validation	1	Complete validation of all over 4-year waits (~ 6,2000 Assessments and 16,000 treatments)	Targeted validation exercise across a number of specialties and waiting time cohorts.
Total	**50**		