

ELECTIVE CARE PLAN
TRANSFORMATION AND REFORM OF
ELECTIVE CARE SERVICES

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HEALTH MINISTER'S FOREWORD

When I took up my post as Minister of Health in May 2016 one of the most challenging issues I inherited was how to reduce the lengthy waiting times for elective care treatment which were being experienced by patients across the North. I have said many times that the current long waiting times are unacceptable. I understand the worry and stress that they cause for patients and their families. This was the subject of my first statement to the Assembly and is the first action listed in '*Delivering Together*'.

I told the Assembly that the root causes of the problem were representative of the wider challenges to the provision of health and social care – increasing demand, financial constraints and a slowness to bring about radical change and reform. I said that my policy would be to adopt a balanced approach, when funding is available, to taking short term action combined with longer term change to radically transform the way Health and Social Care (HSC) services are provided.

My view was supported by the findings in the report of the Expert Panel which highlighted the growing demand for hospital services and the mismatch between demand and capacity. The report noted that while the long term solution is the transformation I have set out in *Delivering Together*, it would also be important to increase public trust in the system by reducing waiting times.

Long waiting times are a product of the rising demand for services set against a current configuration of Health and Social Care (HSC) services that no longer meets the needs of the population. Building a health service that is sustainable in the long term requires us to deal with these factors.

There is no point continually doing more of the same in delivering elective care to our patients. Frontline staff in the HSC are working harder than ever but we are still not meeting the demand for services. We need to do it better, smarter and in a way that will be sustainable. This Elective Care Plan ("the Plan") is a key commitment in '*Delivering Together*', but it is not a stand-alone initiative, nor is it a plan set in stone.

Its strategic commitments and actions must be seen within the broader context of my transformation programme and be taken forward alongside all of the other priorities identified if sustainable improvement is to be realised. It is a high level Plan and the detailed work to develop and implement the Actions in it will be taken forward by the clinically led, managerially supported HSC workstreams established under my Department's Transformation Implementation Group.

The new model of person centred care, described in 'Delivering Together', will in time enable the focus of care and treatment to move from treatment of periods of acute illness and reactive crisis approaches, to one where people are enabled to stay healthy and well in the first place; however when they need care patients will have access to safe, high quality care provided by efficient and sustainable services. For elective care, that means reforming not just the hospital systems but also enhancing opportunities in primary care where services can be delivered differently and closer to the community.

There are several parts to this Plan to improve performance on waiting times. There is the need to provide assessment and treatment for people already on the waiting list; there are opportunities to reinforce the existing good work under way and build on emerging new systems and models; and there is a need to look at new ways of configuring elective care.

We will do this in partnership with the HSC staff who deliver these services and with the people who use them, and who can bring valuable insights to how we can improve. The current consultation on the Expert Panel's proposed criteria for service configuration will be helpful in this respect. The design of new and reconfigured services will be taken forward on the basis of co-design and co-production with staff and service users.

I do not underestimate the size of the challenge in addressing waiting lists or the scale of the transformation that is needed in the long term. Subject to the resources available to my Department the best opportunity we have to achieve this is through the commitments and actions set out in this Plan.

INTRODUCTION

In the Minister of Health's document '*Health & Wellbeing 2026: Delivering Together*', published in October 2016, the Department of Health (DOH) undertook to: "*Develop a comprehensive approach for addressing waiting lists which takes account of the ongoing work of the Health and Social Care Board, as well as the recommendations from the Expert Panel*".

The pressures on the HSC's capacity to respond to demand for elective care services have been building for years. Attempts to tackle this in the past have often focused on short term funding to reduce pressure on the system. The growing number of people awaiting intervention from the HSC to address their health issues illustrates the limitations of such approaches. This document contains the Department's Plan to transform the delivery of Elective Care Services through a process of modernisation and reform to ensure that sustained action is taken to address the root causes of excessive waiting times rather than pursuing temporary approaches.

The actions in the Plan are designed to improve access to services for patients, their families and carers, and to place Elective Care on a sustainable footing resulting in improved waiting times. Alongside the increasing demand for Elective Care services is the parallel demand for Unscheduled Care services. These must be considered together as part of the reform of the whole system of health and social care to deliver better outcomes for patients. They are part of the Minister's wider transformation agenda for Health and Social Care described in '*Health & Wellbeing 2026: Delivering Together*'.

This Plan has therefore been developed to identify the broad range of actions which can be taken to tackle waiting times alongside the reform and modernisation of the delivery of elective care. The actions in the Plan are part of the key building blocks, described in '*Health & Wellbeing 2026: Delivering Together*', required to further integrate secondary, primary and community-based health and social care services. Ultimately we want to ensure that people receive their treatment in the right place

and at the right time with better outcomes and experience for patients, their families, and for the staff who deliver the services.

WHAT IS 'ELECTIVE CARE'?

When we talk about elective care, we mean treatment and care that is planned in advance, as opposed to emergency or unscheduled treatment. A third category that sits between emergency and elective care is semi-elective care. This is planned consultations, diagnostics and/or procedures that must be undertaken urgently to confirm or exclude potential life threatening conditions such as suspect/confirmed cancers.

Elective care entails planned specialist medical assessment and care or surgery including diagnostic tests, medical treatments and therapies, generally following a referral from a primary or community health professional.

Our HSC staff work incredibly hard. On average, each year they deliver more than:

- 400,000 new outpatient appointments;
- 1,000,000 review appointments;
- 600,000 inpatient/day case procedures; and
- More than 1.5 million diagnostic tests.

Altogether this works out as roughly twice as many planned procedures /appointments per year as there are people living in the North of Ireland.

Outpatient services

The vast majority of patients who visit their GP can be managed in primary care but there are occasions when a specialist opinion is required and/or access to interventions or procedures that can only currently be provided in secondary care. In these circumstances, a patient will be referred to secondary care for an outpatient assessment.

This first consultation is very important, and it is well understood that there is significant variability in the nature of referrals which cannot solely be attributed to patient characteristics or their condition. This can vary between different GP practices

and can be influenced by many factors including practice pressures, previous experience, recent updates, and patient demand. The introduction of GP federations provides an opportunity for practices to work much more closely together to start to maximise what is and can be provided in primary care. Increased investment in the primary care workforce will be a key driver to reduce variance in service experience and thus reduce demand on secondary care services. This also provides an important opportunity for different staff to be involved depending on the nature and severity of the condition. The development of multidisciplinary teams involving nursing, Allied Health Professions (AHP) and pharmacy roles within primary care will have a significant impact on the patient experience.

Consultant led outpatient services allow patients to see a consultant or a member of their team for assessment in relation to a specific condition. There are two types of outpatient attendance – ‘new’ and ‘review’:

- A ‘new’ outpatient attendance is the first attendance at a consultant led clinic following an outpatient referral. Most referrals will be seen as a result of a GP request but referrals may also be received from a range of other sources.
- A ‘review’ attendance is an attendance at an outpatient service which might follow a new outpatient attendance; a previous review attendance; an attendance at an emergency department; a domiciliary visit; or an inpatient admission for the same condition. Essentially, review appointments are all appointments that are not ‘new’ appointments.

Inpatient / Daycase Treatment Services

Elective care includes scheduled operations for patients whose clinical condition requires a procedure or treatment with an intended management as either ‘inpatient’ or ‘daycase’:

- ‘Inpatient’ relates to patients who are admitted to hospital for a surgical procedure with the expectation that they will remain in hospital for at least one night.

- 'Daycase' refers to patients who are admitted electively and do not remain in hospital overnight.

Across the north there are 71 inpatient theatres (excluding maternity) and 33 day surgery theatres, located on 18 hospital sites.

Diagnostic Services

When we talk about elective care we also include diagnostic services. A diagnostic test is any kind of medical test performed to aid in the diagnosis or detection of disease and to assist in the management of patient care. Many of these, such as simple blood or urine tests can be performed (and often analysed) in a community or primary care setting. However, those categorised under elective care services usually require specialist equipment and specific training for staff involved in the interpretation of the results, and are usually carried out in hospitals.

There are many different types of diagnostic test but these can largely be grouped into four categories:

- diagnostic imaging;
- physiological measurement;
- cardiac diagnostics; and,
- endoscopy.

Diagnostic services have to balance the planned demand with unplanned demand from unscheduled care, for example emergency admissions or cancer red flag patients and direct referral of patients by GPs.

Waiting times targets/performance for elective care in 2016/17

The longstanding HSC policy is that all patients are seen and treated in clinical priority (urgent first) and thereafter in chronological order to provide equity of access. Clinicians make the assessment and decide the priority for individual patients.

The Department sets targets for elective care performance which are reviewed and set annually. These targets are set to encourage and incentivise performance in the health and social care system. The targets set for 2016/17 are that by March 2017:

- 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks;
- 55% of patients should wait no longer than 13 weeks for inpatient/daycase treatment and no patient waits longer than 52 weeks;
- 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

At the end of September 2016:

- 167,250 patients (68.8%) were waiting longer than nine weeks for a first outpatient appointment and 39,557 were waiting longer than 52 weeks;
- 39,772 patients (56.8%) were waiting longer than 13 weeks for treatment and 7,710 were waiting longer than 52 weeks;
- 40,686 patients (39.9%) were waiting longer than nine weeks for a diagnostic test and 9,675 were waiting longer than 26 weeks.

These waiting times have been increasing for several years due to the factors explained in this Plan. The Minister of Health has made clear that she finds these waiting times totally unacceptable.

THE CHALLENGE

The key challenges which are interacting to create the pressure on elective care services include:

- increasing demand due to the growing and aging population, many of whom have complex co-morbidities;
- the current, unsustainable configuration of acute services; and
- medical and nursing workforce challenges.

If unaddressed through reform and modernisation, these challenges mean that the only available option is to continue investing ever larger amounts of money, although even this will not solve the problem.

The Changing Population

The North of Ireland has a growing population. Some of the key demographic changes are:

- Mid-Year Estimates for 2015 indicate that there were approximately 1.85m people living in the North and current population projections anticipate the population will rise to 1.947m by 2025, an increase of 5.2%;
- The anticipated population increase is characterised by a marked rise in the proportion of older people. From 2015 to 2025, the number of people aged 65+ is estimated to increase by 77,000 to 369,000 – a rise of 26%. By 2025, the number of older people will represent 19.0% of the total population compared with 15.8% in 2015 [Source: NISRA].

The Increasing gap between capacity and demand for elective care

The increase in elective care waiting times is due to an increasing imbalance between demand and capacity. Demand has increased as illustrated by a year-on-year increase in referrals. Staff are being put under more and more pressure, and are doing their best in difficult circumstances, but capacity has been unable to keep pace with this due to: the limited resources available in-year to invest in additional in-house and independent sector waiting list activity due to the wider financial position; an

increased number of acutely ill patients presenting to acute and unscheduled services; and, agreed volumes of funded activity not being fully delivered across a range of specialties.

Waiting times for healthcare are influenced by three overlapping factors. Firstly, the need for treatment – typically surgery, but also prevention, diagnosis, rehabilitation and palliative care. Secondly, the demand, i.e. what treatment is sought by patients. Finally, there is the supply, the healthcare provided, which depends on the level of funding and resources available such as theatres, diagnostic equipment, highly trained staff and inpatient bed availability.

Of significant importance is the interaction of scheduled and unscheduled care on the whole health and social care system in terms of effectively managing and coordinating patient flow to work efficiently. This is particularly important during periods of increased pressure on available beds arising from unscheduled admissions to hospital which impact on the postponement of elective care procedures.

The impact will vary depending on the service area and the respective split of the service between scheduled and unscheduled care. For example, patients who suffer fractures will have an impact on the HSC's capacity to treat patients scheduled for planned orthopaedic procedures. Securing whole system improvement will therefore be an essential element of the transformation of health and social care described in *'Delivering Together'*.

Overall, the trend in demand for hospital based elective care services is increasing, influenced by a growing, ageing population with a greater prevalence of chronic health problems. However, it is not simply that demand is increasing. We are finding, for example, that pre-operative assessment and many operations are taking longer because of the need to consider multiple co-morbidities, and that recovery time for these patients is also increasing. The cumulative impact of this is that in some areas, we are not getting as many operations done as we would aspire to.

The table below clearly illustrates that patient demand for services has increased significantly over the past 5-6 years.

Table 1

Category	Demand 2010/11	Demand 2011/12	Demand 2012/13	Demand 2013/14	Demand 2014/15	Demand 2015/16	Overall % Increase
New Outpatients	432,933	410,115	442,328	463,115	474,572	449,306	4%
Inpatients & Daycases*	134,797	136,146	142,991	143,526	136,451	129,501	-4%
Diagnostic Imaging Services (MRI, CT, NOUS, Plain Film)		1,307,393	1,368,785	1,433,958	1,466,409	1,503,979	15%
Diagnostic Scopes (OGD/Flexi Sig/Colonoscopy/ ERCP)	41,876	40,677	42,972	45,211	47,627	49,350	18%

**Excludes planned activity and all activity in Cardiology and Cardiac Surgery specialities.*

In this period:

- Demand for consultant-led new outpatient assessments rose by 4% between 2011 and 2016, from 432,933 to 449,306;
- Demand for hospital elective inpatient/daycase treatments has fluctuated throughout the last six years and figures for the last two years have shown a reduction on the previous four-year period. However this may reflect slower conversion from outpatients because of growing outpatient waits;
- Demand for diagnostic imaging services has risen more steadily by 15% from 1,307,393 to 1,503,979 over the last five years;

- Demand for diagnostic scopes has risen by 18%, from 41,876 to 49,350 over the last 6 years.

Regionally in 2016/17, it is estimated that there is a gap between funded HSC capacity and patient demand of approximately:

- 63,000 new outpatient assessments;
- 34,500 inpatient/daycase procedures (excluding cardiac surgery, cardiology and endoscopy procedures);
- 172,000 diagnostic tests.

This is forecast to increase by 2020/21 to approximately:

- 83,500 new outpatient assessments;
- 39,000 inpatient/daycase procedures (excluding cardiac surgery, cardiology and endoscopy);
- 300,000 diagnostics tests.

Table 2

Projected Demand	2016/17	2017/18	2018/19	2019/20	2020/21
New Outpatients*	479,000	489,000	498,000	508,000	517,000
Inpatients & Daycases**	162,000	165,000	168,000	171,000	173,000
Diagnostic Imaging Services (MRI, CT, NOUS, Plain Film)	1,563,000	1,612,000	1,662,000	1,711,000	1,760,000
Diagnostic Scopes (OGD/Flexi Sig/Colonoscopy/ERCP)	51,000	52,000	54,000	56,000	58,000

All planned treatments excluded.

**Figures are rounded, high level estimates based on simple projections from existing historical HSCB data. The further forward the forecast is made, the greater the margin of error.*

***Excludes planned activity and all activity in Cardiology and Cardiac Surgery specialties.*

Maximising the available resources

Previous service improvement strategies have focused primarily on increasing capacity. The reform actions in this Plan aim to also address the increases and variances in demand to ensure that resources are maximised so that patients are seen by the right person, at the right time and in the right place. In the future this will avoid the traditional pathway of sending the vast majority of patients to hospital to be seen by a doctor unless this is the best way of addressing their needs. A range of alternative pathways will be available to treat patients out of hospital.

In this context, nurses and AHP have a significant contribution to make both in supporting self-care, early intervention services, pre- assessment services, direct treatments and diagnostic procedures, and in supportive post procedure care.

To maximise this opportunity it will be necessary to prioritise and scale up current service improvement initiatives to maximise the positive impact on elective services. It will also be important to identify and review the best available evidence on role development which supports safe, sustainable service reform in elective care, maximising the contribution of the nursing and AHP workforce.

Medical and Nursing workforce challenges

The delivery of care has also been impacted by increasing challenges in recruiting and retaining the medical and nursing workforce. The Minister has said in *Delivering Together*, that we need to do more to ensure that we are harnessing the skills and experience of the 72,000 individuals working in the HSC family.

Doctors in training

Over the past three years, with an average output from the medical foundation programme of 250 trainees per year, there has been a progressive decline in the number of trainees entering specialty training: 175 entering in 2013, 159 in 2014 and

109 in 2015. Some specialties are impacted more than others, for example, of the 144 available training posts for Core Medical Training, 31 (21.5%) are unfilled. Similarly Emergency Medicine has a 17.6% vacancy rate, with 12 of the 68 available training posts unfilled.

The factors influencing the career choices of medics upon completion of the two-year Medical Foundation Programme are multi-factoral including location of post; a better work/life balance than can be provided through current rotas for doctors in training; a perception that they are not valued, and the ability to increase earnings through locum work. This issue is compounded by the fact that posts are sometimes designated as training posts when they should more appropriately be service posts, which can affect their attractiveness in terms of recruitment.

Consultants and middle grade doctors

The HSC has also been experiencing a growing number of medical vacancies at consultant and middle grade level. Whilst a small number of specialties feature on the UK shortage occupation list, a growing number of grades and specialties not on this list are being reported as ‘hard to fill’. This not only has an impact on waiting lists, but also on the overall cost of elective care, as the amount spent on medical locums has doubled from £22.5million in 2010/11 to £46.3million in 2015/16.

The table below shows the total number of medical vacancies from 2014-15 to date.

Table 3

Year	Total number of vacancies	Consultants	Specialty Doctor and Associate Specialists	Other medical Grades
2014/15	178	114	36	28
2015/16	208	112	59	37
June 2016	227	112.5	115	Not available
November 2016	266	167	129	Not available

In November 2016, a high level data collection was undertaken and identified 266 Whole Time Equivalent vacancies in the medical workforce (excluding doctors in training), representing a vacancy rate of approx 6.7%, with the highest number of vacancies in the following specialties:

Table 4

Consultant vacancies		Specialty Doctor/associate specialist vacancies	
Specialty	No of vacancies	Specialty	No of vacancies
Radiology	31	Emergency Medicine	57.6
Emergency medicine	16	Anaesthetics/ICU	16
Geriatric medicine	13	Acute Orthomedicine	5
Old Age Psychiatry	5	Community Paediatrics	4
General Medicine	9	Paediatrics	4
Acute Medicine	7	ENT	3.5
Anaesthetics	4	Acute Medicine	3
Psychiatry General Adult	4		
Ophthalmology	3		
Paediatric Anaesthetics	3		
Obstetrics and Gynaecology	3		

Nurses and Midwives

The overall number of staff in the Nursing & Midwifery workforce has risen by 8% since 2011. This rise is due to changing service requirements, increased use of nurse led services, service developments, increased service demands and the implementation of “*Delivering Care*”. The increased staff in post since 2011 is reflected below:

Table 5

Staff Group	2011	2012	2013	2014	2015	% Change 2011-15	% Change 2014-15
Qualified Nursing & Midwifery	13,740.1	14,039.3	14,294.6	14,545.5	14,840.0	8.0%	2.0%

Source - Health and Social Care Northern Ireland Quarterly Workforce Bulletin December 2015

Each year since 2011 there has been on average an increase of 275 staff in post. However, the continued growth in demand has impacted on the Trusts ability to continue to recruit at the band 5 entry level. In addition, 32% of the Nursing & Midwifery workforce is aged 50+ with the majority of these holding the opportunity to retire from age 55.

THE AMBITION

The picture is clear. If we persist with our current models of Elective Care services, even with the best efforts of staff, additional investment and efficiency improvements, waiting times will continue to increase, capacity will not be able to keep up with demand and we will simply require more and more elective services every year.

Therefore the ambition in this Plan is to transform Elective Care services to future delivery models where, when people need specialist healthcare, they have timely access to safe, high quality assessment, diagnosis and treatment; where staff are empowered and supported to do what they do best, working in a service that is efficient and sustainable for the future.

A key part of this will be to develop a system which can provide sufficient sustainable elective activity in-house within the HSC to meet the needs of the population. This would reform the current system of routinely relying upon the independent sector to supplement activity on an ongoing basis to meet predicted demand. This approach would also place services on a more stable footing resulting in better planning and use of available resources.

1. Patients currently waiting

There is a significant shortfall in the capacity of the HSC to meet the current and future demand for elective care. At 30 September 2016, 39,557 and 7,710 people were waiting longer than a year for a first outpatient appointment and inpatient/day case treatment respectively, and 9,675 longer than 26 weeks for a diagnostic test. This is an entirely unacceptable length of time to have to wait, so treating these patients is the first commitment in the Plan while continuing to give priority to red flag and urgent patient referrals.

The Department's clear aim is that, by March 2018, no-one should wait more than: 52 weeks for a first outpatient appointment and inpatient/day case treatment; and, 26 weeks for a diagnostics appointment.

Achieving this commitment will be subject to receiving the budget necessary to finance the actions in this Plan.

2. Reform and modernisation

Substantial reform of health care systems is required to make elective care sustainable in the longer term and thus be able to meet rising demand. This will require the transformation of elective care services. The Plan therefore contains five commitments designed to deliver improvement. These are as follows.

- We will increase **patient self-management services** to enable patients with long term conditions to better manage their condition more effectively.
- We will **expand capacity and capability in primary care** so that patients can be appropriately managed locally, outside the secondary care setting.
- We will **improve direct access between primary and secondary care.**

- **We will reform and modernise the delivery of secondary care services.**
- **We will establish new models of provision such as regional HSC Elective Care Assessment and Treatment Centres.**

THE APPROACH

There are a number of enablers which are essential to the timely and effective delivery of our ambition, both to secure the delivery of the necessary reductions in waiting times and to ensure that this improved position is sustainable in the future. These key enablers can be categorised under five broad headings:

- Partnership working/Clinical and Managerial Leadership
- Workforce
- Infrastructure
- Technology/Innovation
- Financial Resources

Partnership working / Clinical and Managerial Leadership

It is recognised that to effectively deliver the necessary reform in elective care will require clinical and managerial leadership from both primary and secondary care. The Department's Transformation Implementation Group, which oversees the implementation of *Delivering Together*, will engage the HSC workforce in the development and implementation of the service improvements required to deliver the reform programme.

GP Federations can provide opportunities for primary care to collaborate and take forward some of the areas of transformation and innovation envisaged in the Plan. With the necessary support in terms of training and capacity building at a local level, it is expected secondary care professionals generally will work more collaboratively with primary care colleagues to improve a range of appropriate patient pathways and services. This would deal more effectively with elective patient demand, and would include more input from primary care to reduce the variance in referrals.

Workforce

The people who work in the HSC are our greatest assets. To support sustained improvement it will be necessary to ensure that the entire HSC workforce is both of

sufficient size and has the necessary skills to maximise their effectiveness. The Department's Transformation Implementation Group has already started the development of a HSC Workforce Strategy. Amongst other things, this Strategy will set out initiatives to recruit and retain the medical workforce and highlight the excellent quality training programmes offered within the HSC. Opportunities will also be taken to introduce new job roles and provide re-skilling and up-skilling in support of emerging systems and patterns of care.

Changes to the nursing workforce need will be addressed through increased commissioning of local pre-registration nurse training, supplemented if necessary by international recruitment over the interim period while students are being trained. Post registration nursing budgets will require further investment in order to train and develop posts with the appropriate skill level to support the development of advanced roles essential to deliver this Plan.

The current configuration of health and care is struggling to sustain services and a significant part of this is due to difficulties in recruiting staff. This is putting significant pressure on the workforce and is not fair to them or to their patients. The reconfiguration of services is therefore essential in terms of providing the best possible environment that will allow professionals to do their job.

Infrastructure

To support the delivery of sustainable improvements in waiting times it will be necessary to significantly expand the existing HSC theatre infrastructure. Regionally there is a gap between HSC Trust capacity and patient demand of approximately 34,500 treatments (excluding cardiac surgery, cardiology and endoscopy). To address a gap of this order within HSC facilities will require capital investment in additional endoscopy suites, inpatient and day case theatres and, on some sites, additional bed capacity. To the extent that additional infrastructure cannot be funded and delivered, it will be necessary to maintain ongoing arrangements with the independent sector to address any shortfall in HSC capacity relative to patient demand. However, the overriding priority is to reduce reliance on the independent sector by building HSC capacity.

Technology / Innovation

Significant steps have been taken in recent years to improve information sharing for health and social care professionals. These improvements aim to support the delivery of high quality health and social care, allowing information to be used more effectively to make better decisions about prevention, treatment and care for patients. These include introduction of the Northern Ireland Electronic Care Record (NIECR) which links core information systems from hospitals and clinics throughout Northern Ireland and includes lab tests, x-rays, appointments, discharge and clinic letters and details of any drugs prescribed and allergies recorded from GP systems. Introduction of the NIECR has led to improved care coordination, reducing delays to treatment and decision making caused by information not being available, and improving patient safety. The Department's eHealth and Care Strategy outlines the future approach, building on the NIECR by moving to fully electronic health and care records and expanding the use of mobile technologies. This has the potential to further improve access to information for both patients and healthcare professionals which would inform better health and wellbeing pathways for patients and their carers. We will expand the range of information and interaction available to citizens, service users and those providing services both online and through apps. This will include building a new patient portal which will allow secure online access to their own health and care information where service users want this.

Financial Resources / Investment

The transformation required to sustainably improve elective care services and build capacity in the HSC will require significant funding over a number of years, as part of broader investment in reform. The pace at which we can progress the Plan will be determined by the availability of finance to implement the actions and the approval of business cases which will underpin transformation.

A key commitment set out in this plan is to reduce the current maximum waiting time for a first out-patient appointment and in-patient/day case procedure to 52 weeks, and for a diagnostics appointment to 26 weeks. It is estimated that some £31m of new investment will be required in financial year 2017/18 in order to ensure that all

those patients waiting longer than this at the end of March 2017 will have been seen or treated by March 2018. The pace at which we can progress this will be determined by the availability of funding within the Department's overall budget settlement. In order to both maintain existing services and take forward transformation it is likely that many of the actions set out in this Plan will require additional, transitional funding.

PLAN COMMITMENTS AND ACTIONS

In summary, this Plan makes the following commitments. Each commitment is described below, together with the related actions to be taken.

Commitment 1: Waiting Times

The Department's clear aim is that, by March 2018, no-one should wait more than: 52 weeks for a first outpatient appointment and inpatient/day case treatment; and, 26 weeks for a diagnostics appointment.

Achieving this commitment will be subject to receiving the necessary budget to finance the actions in this Plan.

Commitment 2: We will increase Patient Self-management Services

Patient self-management services will be increased to enable patients with long term conditions to manage their condition more effectively.

Commitment 3: We will expand capacity and capability in primary care

Capacity and capability in primary care will be increased so that patients can be appropriately managed locally, outside the secondary care setting.

Commitment 4: We will improve direct access between primary and secondary care

The interface and communication between primary and secondary care will be improved to enable more rapid access for patients to secondary care services.

Commitment 5: We will reform and modernise secondary care services

Secondary care services will be reformed and modernised to meet patient demand to ensure that patients are seen at the right time, in the right place and by the right person.

Commitment 6: We will establish new models of provision such as regional Elective Care and Treatment Centres

Regional Elective Care Assessment and Treatment Centres will be established to deliver large volumes of assessments and non-complex routine surgery across a broad range of specialties.

Commitment 1: Waiting Times

The Department's clear aim is that, by March 2018, no-one should wait more than: 52 weeks for a first outpatient appointment (OP) and inpatient/day case (IPDC) treatment; and, 26 weeks for a diagnostics appointment.

Benefits

The backlog of patients waiting more than 52 weeks as at 31 March 2017 will be cleared by March 2018. At 30 September 2016, 39,557 people were waiting longer than a year for a first OP, 7,710 for IPDC treatment and 9,675 longer than 26 weeks for a diagnostic test. It is estimated that some £31.2m of new investment will be required in financial year 2017/18 in order to ensure that all those patients waiting longer than this at the end of March 2017 will have been seen or treated by March 2018. This is a high level costing at historical average and pricing mix based on non-recurrent investment. It should be noted that this applies at a point in time and patients will continue to be added to waiting lists as long as demand exceeds capacity. Further additional investment will be necessary in subsequent years to sustain these improvements and achieving this commitment will be subject to receiving the budget necessary to finance the actions in this Plan.

Actions

1. Enhance performance management and accountability for delivery

Performance Management Arrangements for delivering existing capacity will be further strengthened ensuring that HSC organisations and individuals are held accountable for the delivery of agreed outcomes. Emphasis should always be placed on doing as much as possible within the HSC. The independent sector should only be used when Trusts can clearly demonstrate that sufficient in-house capacity is not available and conditional on plans to reduce dependency on the independent sector in the future.

2. A systematic process will be undertaken to review existing waiting lists by both primary and secondary Care and provide alternatives to referral to hospital where possible.

There is potential for primary care to make a significant contribution to ensuring that patients are seen in the right place within the HSC. Work to date in this area has shown that 50% of gynaecology referrals to secondary care could be managed in primary care through a GP federation with similar numbers for dermatology and between 30-40% for musculoskeletal.

3. Short term additional theatre capacity will be secured via the funding of mobile theatres across a number of acute sites.

Short term additional theatre capacity will be secured via the provision of mobile theatres across a number of acute sites. Plans are already in place to support mobile theatres for Belfast, Northern and Southern Trusts and, subject to the availability of funding, to develop additional permanent theatre capacity at Altnagelvin, Antrim and Craigavon Hospitals.

Commitment 2: Increase Patient Self-management Services

Patient self-management services will be increased to enable patients with long term conditions to manage their condition more effectively.

Benefits

Providing support to facilitate patient self-management can prevent hospital admissions, or where patients are admitted to hospital, it can also result in a reduced length of stay. Patient self-management can also reduce patient demand for outpatient services by educating patients with long term conditions to effectively undertake self-management.

Actions

1. Patient self-management support and services will be prioritised and expanded in order to reduce demand for primary and secondary care services.

Available technology will be used more creatively to support people to live independently and make decisions about their own health and wellbeing as outlined in the Department's eHealth and Care Strategy. E-health service developments are already underway and there is the potential to build on these subject to the evaluation of the existing services and the approval of business cases for any expansion of these developments.

Examples of existing service developments include: the use of remote telemonitoring to enable people with long term conditions to monitor their health from home, with access to clinical and professional advice as necessary; the use of eAT (electronic Assisted Technology), mobile health apps and telecare to enable people to live independently such as the d-Nav diabetes insulin guidance system which allows diabetic users to easily regulate their own insulin; and, also the use of PatientView, an online resource which allows renal patients to monitor their own blood results, weight, blood pressure etc.

2. *Public health support will be expanded and prioritised to promote health and wellbeing.*

Public health interventions targeted at local populations will focus on the prevention of ill health through education and promotion and an increased focus on addressing the social determinants of health. The impact for example of poverty, poor housing, and a poor start in life has a significant impact on the healthy life expectancy of the population. Therefore linkages to the Executive's anti-poverty measures are also central to sustained improvement in elective care outcomes. Also increased investment in social prescribing, effective early intervention initiatives and social prescribing models to improve diet and exercise advice, and other non medical options will be ever more important to the success of this Plan. Social prescribing includes improving the health and wellbeing of older people through signposting pathways such as befriending, lunch clubs, gardening clubs, as an integral part of the suite of interventions available to health professionals across primary care.

Commitment 3: Expand capacity and capability in primary care

Capacity and capability in primary care will be increased so that patients can be appropriately managed locally, outside the secondary care setting.

Benefits

There are significant opportunities to better manage and reduce variance in patient demand in primary care, reducing the need for a referral to secondary care for a specialist opinion. This approach will build on the skills base and expertise within primary care, improve access to treatment for patients while significantly reducing demand for secondary care services. Implementation of the recommendations of the GP-led care review will be important in helping to build the capacity and the structures to deliver initiatives such as these.

Actions

1. Specialist primary care capacity will be increased to undertake high volume, low risk procedures in the non-acute setting.

There are particular opportunities in non-surgical specialties such as rheumatology and dermatology. To secure these opportunities will require an expansion in primary care capacity and the development of wider skills and capabilities, supported as required through appropriate education. A specific example of one such initiative is the introduction of pre-referral testing in primary care to inform decisions on whether a patient needs to be referred to secondary care for a specialist opinion. In addition, the development of General Practitioners with a Special Interest (GPSIs) and specialist nurses will enable more patients to be managed locally, outside the secondary care setting, without the need for referral.

2. The Local Enhanced Service (LES) issued to all GP practices in Belfast in January 2016 to enable GPs to review their own patients on Belfast Trust waiting lists for dermatology, gynaecology and musculoskeletal conditions will be expanded to include other specialities and rolled-out to other HSC Trust areas.

In Belfast 59 practices signed up to the service and 12% of patients were no longer required to remain on a waiting list due to a change in circumstance or condition.

This innovation also showed that up to 50% of patients could be managed by primary care alternatives to referral. This has informed Integrated Care Partnership (ICP) work on the design of new care pathways, including the provision of a clinical medication review to ensure that patients' are receiving appropriate and effective treatment whilst on a waiting list, and is being replicated across the remaining ICPs during 2016-17.

3. *Project ECHO® (Extension for Community Healthcare Outcomes) will be expanded across the North.*

The HSCB is supporting Project ECHO® which uses video conferencing technology to establish a telementoring approach for clinicians. The mission of Project ECHO is to develop the capacity to safely and effectively treat chronic, common, and complex diseases in rural and under-served areas, and to monitor outcomes of this treatment.

The ECHO model is well placed to address the growing demand for secondary care services and is focussed on increasing capacity within primary care through de-monopolisation of specialist knowledge and improving relationships across primary and secondary care. The ECHO model has been shown to be an effective way of addressing the knowledge gap that all healthcare professionals face due to the exponential growth in medical knowledge, reducing demand for outpatient services.

4. *Roll-out of Practice Based Pharmacists will be completed*

The Department has committed to put in place a clinical pharmacist in each GP practice to support medicines optimisation within primary care over the next four years. The Health and Social Care Board commenced commissioning the service in 2016/17 which will be scaled up, year on year. A key objective is to improve the skill-mix within general practice which will release GP and nurse time to focus on other service provision. It is therefore a key part of the enabling infrastructure to support the primary care contribution to elective care management.

The integration of pharmacists within the general practice team will provide additional expertise as patients with complex medicines requirements are managed through transitions of care. They will also provide clinical medication reviews for people on elective waiting lists as part of their patient pathway.

Commitment 4: Improved direct access between primary and secondary care

The interface and communication between primary and secondary care will be improved to enable more rapid access for patients to secondary care services.

Benefits

Facilitating GPs and other primary care professionals to obtain advice directly from secondary care specialists will enable appropriate patients to be managed in primary care rather than being referred into secondary care. There are a number of opportunities to improve communication and sharing of information between primary and secondary care. This includes maximising the potential benefits from encouraging GP federations and primary care professionals to better develop networked working and collaborative approaches and the development of information technology to support decision-making and reduce demand for outpatient services in secondary care. Local clinical leadership, education and peer review are very important factors here, and the closer working between primary and secondary care staff in a population based health model will provide significant opportunities for better patient experience and care.

Actions

1. Use of the Clinical Communication Gateway (CCG) will be expanded.

The CCG allows GPs to make requests for advice to secondary care. Consultants respond directly to GPs and this facilitates, as appropriate, patients being managed in primary care rather than being referred into secondary care.

2. Electronic Triage (eTriage) will be expanded.

Hospital consultants can electronically triage primary care referrals and either, (i) provide direct advice to the GP on the next steps, (ii) refer directly for investigations, or (iii) invite the patient to attend an outpatient clinic. The primary aim is to ensure that patients are seen by the right person, with the right information, at the right time, in the right place – the first time; thereby releasing outpatient capacity for patients who require a specialist opinion. Direct access for specific tests can be a cost effective way of reducing the time for diagnosis and improving patient access.

Commitment 5: Secondary Care Reform and Modernisation

Secondary care services will be reformed and modernised to meet patient demand to ensure that patients are seen at the right time, in the right place and by the right person.

Benefits

This action aims to improve productivity within secondary care by reforming and modernising services to provide improved access to services for patients.

Actions

1. Use of Hospital Theatres – there will be a renewed focus on improving theatre productivity and utilisation.

Under-booking, turnaround times and downtime between patients all contribute to the under-utilisation of theatre capacity. The Audit Commission has indicated that Trusts should aim to achieve an 83% theatre utilisation rate. Based on the 2014/15 Theatre Management System (TMS) data, the HSC achieved a 77% utilisation rate (excluding endoscopy rooms) and there is significant variation in utilisation rates by hospital type – average utilisation rate of 79% for main acute sites compared with 68% for non-acute sites.

This under-utilisation of theatre capacity on non-acute sites is largely due to constraints on overnight stay facilities and the associated clinical risk which is restricting the type of patient and range of procedures which can be undertaken in these theatres.

Restricted access to inpatient beds, out of hours anaesthetic and surgical cover, and ICU beds, are all limiting factors which impact on the volume and case-mix of patients to be treated on non-acute sites. Recent initiatives to address maximising theatre capacity include utilising available day surgery capacity in the South West Acute Hospital to treat routine urology patients from the Belfast HSC Trust.

2. *Reducing Overnight Stay in Hospital - the proportion of surgery that is undertaken without the need for an overnight stay in hospital will be increased.*

This involves reducing the reliance on overnight bed availability by treating an increased proportion of elective patients as daycases. Admission on the day of surgery as the default position for all clinically appropriate patients, will also improve inpatient theatre efficiency.

In addition, it will be necessary to monitor the case-mix going through inpatient and daycase theatres across different sites to ensure that procedures are undertaken in the most appropriate setting and sites. Where necessary, activity will be redirected to other settings such as treatment rooms or outpatient settings.

There is also the potential through GP federations to improve capacity through planned enhanced primary services to help facilitate early discharge, patient management and follow-up out of hospital. A primary care centred approach potentially gives a consistency of care across a population.

3. *Consolidation of Outpatient Services – outpatient services for appropriate specialties will be consolidated on to a smaller number of sites. Clinically appropriate services will also be moved from acute to non-acute/community sites to improve productivity and sustainability of services.*

This approach will simplify the process of accessing services for patients, provide opportunities to co-locate multi-disciplinary staff teams and increase efficiency overall. It will also reduce vulnerabilities in specialties that are managed by small teams across HSC Trusts where there are workforce recruitment and retention difficulties.

4. *One-stop clinics – one-stop clinics for assessment and preparation for elective surgery will be increased.*

One-stop clinics have been implemented in a number of specialties, including urology and fractures, and have contributed to a significant reduction in the number

of outpatient reviews required. This has freed up consultant capacity and improved patient experience.

This action will reduce the number of times a patient has to attend secondary care prior to admission for surgery. These clinics will include initial assessment, further diagnostics (if required), decision on type/risk of anaesthesia or prosthesis (if required), booking of the procedure, explanation of the procedure and what to expect post operatively, including the signposting to other support groups or education.

5. *Ambulatory Care* – will be expanded to substantially reduce the need for traditional outpatient clinics.

Ambulatory Care includes the provision of elective assessment and diagnostic services as part of a single service for planned and unplanned patients. This creates a simpler and better experience for patients.

6. *Pre-op Assessment* – the pre-operative assessment service will be increased to ensure the timely clinical assessment of patients. Information about procedures will be improved to help inform patients about their operation and support their decision making.

Plans are in place to pilot the use of the Clinical Communications Gateway (CCG) as a vehicle to provide procedure information to GPs and patients. The Royal College of Anaesthetists has indicated that Did Not Attend (DNAs) and late cancellation rates should be below 5% for day surgery theatres. Based on 2014/15 TMS data, the HSC had an 11% cancellation/DNA rate for all elective services (excluding gastroenterology and general medicine).

The NHS Modernisation Agency has stated that 30% of all operations cancelled on the day of surgery or the day before surgery could potentially have been avoided by effective pre-operative assessment. All patients undergoing an elective procedure (including endoscopy procedures) therefore will undergo a pre-operative assessment.

7. *Enhanced Skill Mix* – the skill mix of the HSC workforce will be extended across all outpatient services to increase the number of patients seen by clinical nurse specialists or AHPs.

This will release consultant capacity for those patients who need to be seen by a consultant. This is already provided across a range of specialties including ENT, urology and orthopaedics. Examples of potential actions in this area include:

- ***Increasing Nurse-led pre-assessment for endoscopy – nurse-led colonoscopy pre-assessment will be increased.*** This will reduce the need for patients to attend for a consultant-led outpatient assessment and reduce the number of failed colonoscopies due to poor bowel preparation thereby reducing the number of repeat colonoscopies.
- ***Increasing Non-medical Gastroenterology Endoscopy.*** This would increase access to endoscopy. Nurse developed endoscopy services have been in place throughout neighbouring jurisdictions with some Non-Medical Endoscopists, such as Nurse Endoscopists now undertaking up to 20% of the workload in units in England. NHS Improving Quality initiatives have estimated that up to 40% of low risk, high volume endoscopic procedures could potentially be carried out by Nurse Endoscopists. In 2016 Health Education England launched an accelerated pilot training programme for non-medical Endoscopists (NMEs) to help meet endoscopy workforce and service needs following a selection process developed with Joint Advisory Group on GI Endoscopy (JAG),
- ***Increasing Nurse- led flexible cystoscopy.*** This would increase access and timeliness to urology services. Flexible Cystoscopy is the most frequently performed urological intervention across the region. In the late 1990's nurse specialists started to be trained in this technique and in 2000 the British Association of Urological Services (BAUS) set up a working party to develop the role of nurse cystoscopy. Since then nurse cystoscopists have become well established in urological practice in many centres in neighbouring

jurisdictions and in the North currently, clinical nurse specialists within Southern and South Eastern Trusts carry out flexible cystoscopies.

- **Introduction of a regional care model for Podiatric Surgery in respect of foot and ankle surgery.** The Health and Social Care Board has been exploring the potential to introduce a new model of care for podiatric surgery for foot and ankle surgery which has been adopted successfully across other regions. This new model would potentially improve access for suitable patients for foot and ankle surgery reducing the number of referrals to orthopaedic surgeons releasing their time for more complex cases.
- **Development of a one-stop consultant-led Multi-Disciplinary Team (MDT) clinic in Rheumatology/pain management across adults and children's services.** The development of extended roles in Occupational therapy, physiotherapy, podiatry and orthotists within a one stop MDT service model led by Consultant staff will provide a more proactive and efficient model of care to meet the needs of clients. This service will deliver more integrated holistic interventions preventing further deformity or progression of the client's presenting condition and reduce secondary complications.

8. Telephone Reviews – the number of routine follow-ups that are carried out by telephone in secondary care will be increased.

This action will improve access to specialists for those patients who need it the most. It would remove the routine requirement for a face-to-face appointment with a secondary care consultant, thereby releasing consultant capacity to see patients who require a specialist opinion. Telephone contact services also have the potential to provide advice for new patients to prevent a traditional outpatient appointment.

9. Reforming Planned Patient Reviews – the current practice of planned specialist follow-up will be reformed.

Where clinically appropriate, patients will receive a standard approach of providing patients at discharge, after routine surgery, with comprehensive information and a

24/7 helpline they can call if they are concerned about their recovery. Urgent outpatient appointments will be available as required.

This action will increase the capacity available for patients who require a specialist opinion.

10. *Cancelled Clinics* – there will be a renewed focus on ensuring that effective arrangements are in place in HSC Trusts to reduce to an absolute minimum the number of cancelled clinics.

Hospitals cancelled a total of 153,498 appointments during 2015/16, giving a hospital cancellation rate of 9.2%, compared to a total of 168,555 cancelled appointments during 2014/15 (10.1%), compared with a hospital cancellation rate of 9.7% reported for 2013/14 and a rate of 10.9% for 2010/11.

11. *Text or voice messaging service* – will be expanded across all specialties to further reduce the number and rate of patients who Did Not Attend (DNA) their outpatient appointment.

During 2015/16 patients missed a total of 136,899 appointments, giving a Did Not Attend (DNA) rate of 8.3% compared to a total of 147,536 missed appointments during 2014/15, giving a DNA rate of 8.9%, lower than the rate of 9.1 reported for 2013/14 and the rate of 10.3 reported for 2010/11.

While all HSC Trusts have implemented some form of text messaging or voice messaging service to remind patients of their appointment date a renewed focus on a regional basis should provide further improvement.

12. *Imaging Services Reporting Network* – will be established.

This network will facilitate the pooling of reporting skills across the region to address service gaps and improve resilience across all HSC Trusts.

13. *Imaging Advanced Practice Radiography* – radiographers will be enabled to report low level work traditionally done by radiology consultants.

It is anticipated between 20% and 40% of all plain films, depending on case-mix, could be safely reported by a reporting radiographer releasing consultants' time for more complex work.

14. *Single NIPACS for Imaging Services – a single image storage and retrieval system across Northern Ireland will be introduced.*

This single system will further improve safety, quality and enable better pooling of resources across HSC Trusts with resultant productivity gains.

15. *Scanner utilisation – will be improved through the following steps designed to increase efficiency.*

This will involve the pooling of HSC Trust Resources in certain diagnostic modalities and by offering alternative approaches to delivering services such as the hub and spoke arrangements for Cardiovascular Magnetic Resonance (CMR) or a regional reporting network for the reporting of plain film X-rays.

All HSC Trusts will participate in the regional benchmarking network for radiology services. Peer review of performance against key indicators will drive improvement at local, regional and national level.

16. *Audiology – one-fit appointments for assessment and fitting of hearing aids for suitable patients will be increased.*

This model, which would be suitable for approximately 45% of patients referred to audiology, will improve the patient experience, reduce waiting times and release audiology capacity.

Commitment 6: Establishment of Elective Care Centres

Regional Elective Care Assessment and Treatment Centres will be established to deliver large volumes of assessments and non-complex routine surgery across a broad range of specialties.

Benefits

The development of Elective Care Assessment and Treatment Centres, using enhanced HSC facilities, will help to reduce the elective capacity gap currently impacting on the excessive waiting times for elective care.

Actions

- 1. HSC regional Elective Assessment and Treatment Centres will be established to deliver large volumes of outpatient assessments and non-complex routine surgery across a broad range of specialties.**

Given the scale of the gap between current elective capacity and patient demand, and the expectation that this will continue to increase in light of forecast demographic changes as set out in 'Delivering Together', Elective Care Centres will be established to provide a dedicated resource for less complex planned surgery and other procedures.

The development of Elective Care Centres, using enhanced HSC facilities, will help reduce the current elective gap through increased capacity, productivity and the use of new technologies. Hospitals designated as elective care centres will be used for outpatient assessments, diagnostics, day surgery or short stay inpatient surgery uninterrupted by emergency admissions.

The number and location of these centres will be developed in partnership with clinicians and patients and we will bring forward proposals for their location and service specification.

The potential to establish a specific facility to provide assessment and treatment for orthopaedic patients, to address the gap between capacity and demand in orthopaedics, will also be explored.

2. A HSC regional Elective Diagnostic Centre will be established to provide diagnostic services across a range of modalities.

For the foreseeable future, the planned HSC infrastructure will not be sufficient to address the current and future gap between HSC funded capacity and demand for diagnostic services. As a result, an Elective Diagnostic Centre is required to provide diagnostic services across a range of modalities. Again, this centre will be a resource for the region and is expected to operate extended days/weeks.

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List of Abbreviations

AHP	Allied Health Professions
CCG	Clinical Communications Gateway
CMR	Cardiovascular Magnetic Resonance
DoH	Department of Health
DNA	Did Not Attend
eAT	electronic Assisted Technology
ECHO	Extension of Community Healthcare Outcomes
GPSI	General Practitioner with a Specialist Interest
HSC	Health and Social Care
HSCB	Health and Social Care Board
ICP	Integrated Care Partnership
ICU	Intensive Care Unit
IPDC	Inpatient/Daycase
LES	Local Enhanced Service
NIECR	Northern Ireland Electronic Care Record
NIPACS	Northern Ireland Picture Archiving and Communications System
OP	Outpatients
TMS	Theatre Management System