Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

DEPARTMENT OF HEALTH

POLICY STATEMENT

THE ESTABLISHMENT OF A REGIONAL SERVICE DELIVERY MODEL FOR DAYCASE ELECTIVE CARE PROCEDURES IN NORTHERN IRELAND

JULY 2020

Contents

FOREWORD BY ROBIN SWANN MLA, MINISTER OF HEALTH

This document sets out the Department of Health's policy statement for establishing a regional service delivery model for daycase elective care procedures in Northern Ireland.

The 'Health and Wellbeing 2026: Delivering Together' document published by my predecessor in 2016 provides the blueprint for transforming health and social care services in Northern Ireland to better meet the needs of our population. A key commitment in the blueprint is to establish elective care centres to provide a dedicated resource for less complex planned surgery and other procedures. Evidence from elsewhere shows that such centres can reduce waiting times for planned care, and provide a better experience for both patients and staff. The current approach of delivering both planned and unplanned care using the same facilities and the same resources, means that waiting times can be adversely affected when the demand for urgent and emergency care is very high such as that experienced during the Covid-19 pandemic.

My Department has worked with clinically-led task and finish groups over the past three years to develop the regional service delivery model for establishing these dedicated specialist centres. We have tested the benefits of this approach through the cataract and varicose veins prototypes referred to in this document. I have reviewed the evidence presented to me from the prototypes and the other data provided in this document. I believe that this indicates the clear potential benefits which these centres can deliver for reduced waiting times, through improved productivity, improved levels of patients' satisfaction and attractive working conditions for staff. While these centres will incrementally contribute to reducing waiting times I am under no illusion that given the scale of the backlog of patients waiting for treatment significant additional investment is also required to clear this backlog in the years ahead.

Normally at this stage of a service review either the Department, Health and Social Care Board or HSC Trusts would launch a public consultation and engagement process with staff representatives and professional bodies on proposals such as those in this document to inform their final shape. However, due to the adverse impact of the Covid-19 pandemic on elective care waiting times my Department needs to move swiftly ahead of potential further waves of the pandemic to establish this new model as quickly as we can. This is because the dedicated centre to be established at Lagan Valley Hospital will allow us to maintain robust infection control preventative measures at this site to enable daycase procedures to continue during any future outbreaks of Covid-19. While we cannot guarantee that this can be achieved under all circumstances it should however give us a high level of confidence in our ability to continue to deliver this service while other hospitals are treating Covid-19 patients should this occur.

While we have stepped outside the normal consultation arrangements my Department is committed to ensuring that consultation and engagement by HSC Trusts with patients, trade unions and professional bodies will be carried out as part of the planning of the implementation of the new dedicated centre at Lagan Valley Hospital and the new network. This approach reflects a balancing of conflicting responsibilities, made all the more real by the pandemic, to ensure that appropriate consultation is carried out while at the same time continuing to take every available opportunity to rebuild and sustain the delivery of elective care services throughout the period of the pandemic.

I hope that all stakeholders will understand that because of the difficult position facing elective care services, in the wake of the first wave of Covid-19, my Department is taking this approach because we believe that the public interest is best served by this.

SECTION A: ELECTIVE CARE CENTRES. WHAT DOES THE EVIDENCE SAY?

1. WHAT IS ELECTIVE CARE?

1.1 When we refer to elective care, we mean care that is planned in advance as opposed to emergency or unplanned treatment. Elective care normally involves specialist clinical assessment (generally following referral from a GP or other primary/community health professional), and subsequent care or treatment, including diagnostic tests, surgery, other medical treatments and therapies.

2. CURRENT WAITING TIMES

2.1 There is a significant shortfall in the capacity of the Health and Social Care Service (HSC) in Northern Ireland to meet the current demand for elective care services and this is reflected in the current, unacceptably long waiting times.

2.2 The 2019/20 Ministerial target for inpatient and daycase waiting times stated that by March 2020, 55% of patients should wait no longer than 13 weeks for inpatient or daycase treatment, with no patient waiting longer than 52 weeks.

2.3 During the Covid-19 pandemic, elective and diagnostic services have had to be curtailed with adverse impacts on existing waiting lists. At the end of March 2020 there were some 307,000 patients on the outpatient waiting list, almost 94,000 waiting for inpatient and daycase admissions and more than 131,000 patients waiting for diagnostic tests.

2.4 The numbers waiting are shocking, but it is the experience of those patients waiting for care that is unacceptable.

2.5 In 2018 the Patient Client Council (PCC) gathered information from approximately 700 people[1], nearly half of whom said their health had deteriorated while on a waiting list. Nearly a third of respondents highlighted worsening pain as a key issue. The negative impact on mental health was also described. Patients also referred to the wider adverse impact on their lifestyle and financial wellbeing.

3. WHY ARE OUR WAITING TIMES SO HIGH?

3.1 There are several factors that have contributed to the current levels of waiting lists under-performance. Overall, demand for hospital based elective care services is increasing and this is influenced by demographic changes, particularly a growing, ageing population with more chronic health problems and complex health needs. In simple terms, the longer we live, the more likely we are to require hospital treatment at some point in our lives. Demand for care is therefore steadily outstripping the ability of the system to meet it. This trend will increase in the years ahead and will only be addressed by action to increase capacity, promote healthier lifestyles and tackle health inequalities.

3.2 Addressing the gap between current capacity in our hospitals to deliver the required levels of demand for services is one of the most pressing challenges facing Health and Social Care (HSC) now and for the foreseeable future. In practice, where the HSC is unable to deliver the required volumes of treatment, this leads to an over-reliance on buying additional activity, sometimes in-house through an overtime arrangement with HSC employed staff, or more commonly through use of the independent sector to deliver additional waiting list activity.

3.3 Since 2015 the annual budget allocated to the Department of Health has not been sufficient to keep waiting times to an acceptable level. While doctors,

[1] https://patientclientcouncil.hscni.net/the-reality-of-life-on-a-waiting-list/

nurses, other health professionals and managers have made every effort to ensure that any negative impact on patients has been kept to a minimum, waiting times have continued to grow to a level where many believe that they are now out of control, will take years to stabilise and even longer to return to their pre-2015 levels. Significant additional investment and new ways of working to deliver services will be needed to achieve the necessary turnaround.

3.4 At the same time, our urgent and emergency services are continuing to face significant pressures and the number of acutely ill patients presenting to Emergency Departments and likely to require admission is also increasing. All too often, the result of these pressures is that planned elective procedures, or surgery, are cancelled because hospital theatres, beds or staff are needed for urgent and emergency cases.

3.5 Before a surgical procedure can be carried out a range of resources have to be brought together at the right time and the right place: surgical staff, nursing staff, anaesthetic staff, theatre time, beds. Remove any one of these components and the operation has to be cancelled. Where the same staff and resources are required to be available for both elective and emergency care, emergency treatment will always come first – because it is an emergency. The need for hospitals to quickly provide emergency treatment often results in the loss of one or more of these components for planned elective work resulting in the loss of theatre time for patients on elective waiting lists.

3.6 Due to the recurrent budget constraints and workforce recruitment pressures across the UK the HSC has ongoing difficulty in recruiting sufficient staff to bridge the gap between capacity and demand. We have become overly dependent on locum doctors and agency nurses. This has contributed to the instability and pressurised environments in our hospitals and is a further key challenge which needs to be addressed.

3.7 Taken together, these factors have led to a situation where demand continues to increase, while activity levels delivered by the HSC has largely remained static, or in some cases, have declined. The administrative and organisational structures we have created to deliver our health and care services can also serve to increase variation of approach. In practice, delivering elective care across five health and social care Trusts can mean that services and resources are not planned regionally, and that patients in different parts of Northern Ireland can experience different levels of service and significantly different waiting times.

3.8 Ultimately, if we persist with under-investment and our current outdated models of delivering elective and emergency care services on the same sites, waiting times will continue to increase, elective capacity will not be able to keep up with demand, and the gap between what patients need and what the system can provide will continue to grow every year.

3.9 It also clear that if additional short-term non-recurrent investment becomes available and we continue to rely solely on purchasing additional activity from the independent sector, the HSC in-house system will remain vulnerable to deterioration should this funding cease to be available. It is therefore critical that we balance short term funding to reduce waiting lists with long term investment in new ways of working to increase the in-house capacity within the HSC to meet the population's increasing demand for elective care services now and in the future.

3.10 Whilst elective activity declined substantially during the pandemic, the reasons for this decline were pre-emptive and in response to the pandemic rather than in response to the more typical unscheduled care pressure. It has now become evident that these pre-emptive preparations to ensure effective infection control within HSC hospitals have allowed local health services to cope with the initial surge. Health and social care in Northern Ireland is now entering a rebuilding

phase where the continued risk of Covid-19 must be managed alongside the wider healthcare needs of the population, including planned elective care[2].

3.11 The impact of Covid-19 on the HSC has been profound and will undoubtedly be long lasting. Addressing the backlog will be challenging given the reduced operational capacity across the HSC. Indeed, separating Covid-19 and non-Covid-19 patients, maintaining physical distancing and implementing other infection control safeguards to reduce transmission of Covid-19 (e.g. isolation, use of PPE and environmental cleaning) have meant that hospitals are running at a significantly lower occupancy level than normal, with reduced theatre utilisation that is critical for urgent and elective work. This has restricted their capacity to deliver patient care and will constrain how quickly hospitals can begin to recommence non-Covid-19 services[3].

3.12 In June 2020, the Minister for Health published The Strategic Framework for Rebuilding HSC Services which sets out a comprehensive assessment of the impact of Covid-19 across key services and sets out at a strategic level, an action plan for rebuilding services.

4. WHAT ARE REGIONAL DAY PROCEDURE CENTRES AND HOW WILL THEY HELP?

4.1 The establishment of regional day procedure centres aims to transform the delivery of services to increase our Health and Social Care Service (HSC) capacity to meet future demand. This will involve a new way of working by the HSC to deliver hospital services in Northern Ireland. This new approach is already working in other parts of the UK and internationally.

[2] Dr Niall Herity, July 2020

[3] Preparing for a Challenging Winter – July 2020 – the Academy of Medical Sciences

4.2 Essentially the new model will be a regionally planned service delivery model for daycase elective care procedures. There is robust evidence to show that concentrating some specialised procedures on a smaller number of hospital sites, separated from emergency care, and dealing with a higher volume of patients, can improve productivity. The use of similar approaches in other health systems would suggest that such sites can provide a better overall patient experience due to the reliability of the service and the reduced likelihood of last minute cancellations.

4.3 Prior to the pandemic there was a wealth of extant professional guidelines that supported a concerted move towards the delivery of daycase procedures in dedicated centres. There have been numerous guidelines issued from national and international organisations with recommendations on how to resume elective surgical care in the context of Covid-19. The common thread throughout these documents is the consideration of safety for both staff and patients whilst recognising the urgent need for resumption of elective surgery to avoid further detriment to patient health and insurmountable waiting lists.

4.4 For those staff delivering services in day procedure centres, professional guidance also suggests there are benefits in terms of resilience, productivity, standardisation of care, quality of service, training opportunities, and a reduced number of avoidable admissions to hospital.[4]

4.5 It is within that context that the Department of Health has been working with a range of HSC professionals from across the HSC Trusts, HSC Board and the Public Health Agency to develop proposals for the development of a regional model of day procedure centres for Northern Ireland.

[4] Separating emergency and elective surgical care. Recommendations for Practice. RCS England, 2007

4.6 The environment in which daycase procedures will be delivered in future has undoubtedly changed over the past number of months. Day procedure centres are equally, or even more important in the context of the ongoing pandemic.

4.7 The Covid-19 pandemic has further demonstrated the vulnerability of having elective care and unscheduled care co-located on multiple sites. Urgent action is also needed to eliminate as far as possible nosocomial transmission within the health and social care system. Therefore, for infection control purposes there are clear benefits in separating elective care, where service delivery can be tightly controlled, from the more unpredictable unscheduled care.

4.8 As we rebuild services, there are strong benefits to delivering more elective care in facilities which can be protected from both unforeseen and predictable increases in pressures on the health service as a whole.

4.9 The Strategic Framework for Rebuilding HSC Services gives a commitment to exploring the feasibility of establishing dedicated elective care centres to potentially facilitate the continuation of some planned activity in the event of increasing demand for Covid-19 treatment arising from a second wave of the pandemic.

5. WHAT HAVE WE DONE SO FAR?

Current Policy

5.1 In October 2016 the former Health Minister, Michelle O'Neill MLA, launched 'Health and Wellbeing 2026: Delivering Together', which seeks to radically reform the way health and social care services are designed and delivered in Northern Ireland, with a focus on person-centred care, rather than on buildings and structures. It is aligned with the aspirations set out within the Northern Ireland Executive's draft Programme for Government, and aims to improve the health of our people, improve the quality and experience of care, ensure the sustainability of our services, and to support and empower staff; but also recognises the challenges that need to be overcome if this is to be achieved. The report noted

that Elective Care Centres would be established to provide a dedicated resource for less complex planned surgery and other procedures. It also included an action to: “Bring forward proposals for the location and service specification for Elective Care Centres and Assessment and Treatment Centres”.

5.2 The Department subsequently published the Elective Care Plan (‘the Plan’) in February 2017. The Plan sets out six commitments to address the issues currently facing elective care in Northern Ireland. Commitment 6 of the plan concerns the establishment of Elective Care Centres that will provide a dedicated resource for less complex planned surgery and other procedures.

Research and Analysis

5.3 To take forward this commitment under the Elective Care Plan, in 2017 the Department commissioned a clinically led review to:

- Collect and consider the evidence for elective care centres;
- Make recommendations on the type of elective care centres to be established in Northern Ireland;
- Develop proposals on the configuration of elective care centres.

5.4 The group carrying out this review was chaired by Dr Niall Herity, consultant cardiologist. The Chief Medical Officer, Dr Michael McBride, had oversight of the group’s work which included intensive engagement with a wide cross-section of healthcare professionals to secure their support for the proposed new way of delivering elective care. Dr Herity presented the Department with the group’s report and recommendations in November 2017. The final report endorsed the proposal to develop specialised Elective Care Centres of excellence and recommended that:

- The initial phase of Elective Care Centres should focus on ambulatory (another word for daycase) surgical procedures;
- Elective Care Centres should be developed as a resource for the entire region of Northern Ireland;
- Elective Care Centres should become the default location for all patients who have been assessed as clinically appropriate to have their procedure carried out in these centres.

5.5 The report also identified high volume specialties to focus on for the development of an elective care model. This includes six adult surgical specialties, which together account for 90% of all adult daycase practice, and five Paediatric surgical specialties, which account for 87% of all Paediatric daycase practice. A summary of these specialties and associated elective daycase activity is set out in tables 1 and 2 below.

	Ambulatory (Day Case)	**1night Length Of Stay**	**>1 night Length of Stay**	**Total**
General surgery	36493	2796	5396	44685
Urology	21353	1387	2470	25210
Ophthalmology	15436	528	70	16034
ENT	4567	2020	557	7144
Gynaecology	8504	1569	2872	12945
Orthopaedics	5380	1848	4808	12036
Subtotal (top 6)	91733	10148	16173	118054
Other specialties	10335	747	3247	14329
Total Ambulatory Cases	102068	10895	19420	132383
% all elective adult surgery	77%	8%	15%	

Table 1. Summary of the distribution of 132,383 adult elective surgical procedures (including surgical

endoscopy) undertaken in the HSC in Northern Ireland in 2015/16. Source: Hospital Information Branch, DoH.

	Ambulatory (Day Case)	**1 night Length of Stay**	**>1 night Length of Stay**	**Total**
ENT	3077	918	49	4044
Paediatric/ General Surgery	1299	116	154	1569
Orthopaedics	679	294	178	1151
Oral surgery	498	11	20	529
Ophthalmology	412	13	2	427
Subtotal (top 5)	5965	1352	403	7720
Other specialties	846	64	93	1003
Total	6811	1416	496	8723
Percentage of all elective Paediatric Surgery	78%	16%	6%	

Table 2. Summary of the distribution of 8,723 Paediatric elective surgical procedures undertaken in the HSC in Northern Ireland in 2015/16. Source: Hospital Information Branch, DoH

5.6 Some of the findings of this report will be dealt with in more detail later in this document. A full copy of the report is available on the Department's website.

5.7 The group's report was endorsed by the HSC Transformation Implementation Group (TIG), established by the former Health Minister, Michelle O'Neill MLA. The report's findings and conclusions have directly shaped the actions in this document which together provide the basis for the new regional model for day procedure centres.

Action 1 – On the basis of the findings of the clinically chaired task and finish group, the Department will develop specialist regional day procedure centres.

These will be centres of excellence managed and delivered as a regional resource.

6. WHAT ARE REGIONAL DAY PROCEDURE CENTRES?

6.1 'Daycase' or 'day procedure' refers to planned procedures for patients who are admitted to hospital for treatment but do not remain in hospital overnight, i.e. they are admitted and discharged on the same day.

6.2 This differs from outpatients, which refers to a patient who attends for a short consultation, test or a scan, but does not require a bed. Daycase patients generally attend hospital for a more involved procedure, may require some recovery time before discharge and will generally leave hospital on the same day[5].

6.3 Day procedure covers a wide range of surgical and non-surgical procedures in a range of specialties. It includes operations or procedures carried out with no anaesthesia, local anaesthesia or general anaesthesia. It also includes some diagnostic services such as endoscopy. The majority of these procedures are carried out in operating theatres although many can be carried out in procedure rooms.

6.4 Not all patients can be treated on a day procedure basis. Patients with complex or multiple health conditions may not be suitable for a day procedure. In practice, decisions on the suitability of patients for treatment on a day procedure basis will be determined by the team in charge of the surgery or procedure.

6.5 Regional day procedure centres provide a dedicated resource for less complex planned day surgery and procedures. Crucially, and ideally, they operate

[5] https://www.nuffieldhealth.com

separately from urgent and emergency hospital care – meaning they will not be competing for operating rooms and other resources, leading to fewer cancellations of operations. Given the experiences during the pandemic and in light of professional guidance the benefits of functionally separate day procedure centres are clear in terms of managing the risk of cross-infection.

6.6 Whilst the majority of daycase procedures can be delivered in standalone centres, physically separate from major acute hospital sites, there are occasions when it is not clinically appropriate to do this. For example, in some cases it may be a requirement to be close to other specialist services and facilities, so that care can be delivered in a safe and sustainable way. In such cases, a centre that is co-located within an acute site, might be more appropriate. Throughout this process, decisions on the suitability of procedures for delivery on geographically standalone sites will be based on professional guidance and advice from practising clinicians.

7. PROCEDURES SUITABLE FOR DELIVERY IN A REGIONAL DAY PROCEDURE CENTRE

7.1 In 2018, to take forward the next phase of work on the development of regional day procedure centres, the Department established seven clinically driven task and finish (T&F) groups, one for each of the specialties identified in Dr Herity's report as suitable for daycase procedures, namely:

- General Surgery;
- Endoscopy;
- Trauma & Orthopaedics;
- Urology;
- Ear, Nose & Throat;
- Gynaecology;
- Children's Services.

7.2 Each of these T&F groups is led by doctors, nurses, AHPs, service managers and other health professionals from across the Health and Social Care sector. The seven groups are also supported by a reference group of anaesthetists. It should be stressed that those involved with this work have given time to this project over and above their extremely busy workloads. The Department acknowledges and thanks them for their efforts and commitment to improving services delivered to patients.

7.3 Over the last 18 months, these groups have taken forward a significant piece of work in making assessments of both current demand for procedures within their respective specialties, and the projected demand over the next number of years. Building on this information, the groups have also identified which procedures they deemed most clinically suitable to move to a regional day procedure centre as part of a first phase approach.

7.4 Each specialty group has adopted a different approach to this in line with what was appropriate to the nature of their particular clinical specialty, taking account of factors such as demand, patient safety, patient selection, anaesthetic requirements, clinical guidelines, and workforce.

7.5 What this work has shown us is that there are potentially **40,000** daycase procedures annually (including cataracts and veins – section 9) that with careful planning could move immediately to a day procedure centre as part of this regional model subject to securing the necessary investment. Over a period of years, with medical advances and an increase in the number of procedures suitable for daycase, this volume of procedures is expected to increase significantly subject to securing further investment. A list of the proposed procedures has been included at **Annex A**.

7.6 Demand for endoscopy is around 82,000 procedures per year and this work has also shown that up to **60,000** non-complex endoscopy procedures are also

potentially suitable to be undertaken in regional day procedure centres. For more complex procedures and patients, endoscopy services will also still be required on major hospital sites. Again, subject to securing the necessary additional investment, the Department proposes that with careful planning the less complex procedures could move immediately to a regional day procedure centre as part of this model.

7.7 These figures are a starting point on which to build and flexibility will need to be built into the design of any regional day procedure centre to accommodate expansion in demand in the future.

7.8 As well as the transfer of activity into the new day procedure centres, this work will also focus on the patient pathway for each specialty. The pathway is the journey that a patient will take from first contact with their GP or other primary care professional, through referral, any diagnostic tests, treatment, discharge and any required follow-up. At each stage of this process, the patient enters a new waiting list. This means that there are real benefits in keeping the process as streamlined as possible to ensure that the overall time from initial referral to treatment is kept as short as possible.

7.9 In a place the size of Northern Ireland, it is also unacceptable that patients should be treated differently in different parts of our healthcare system. The T&F groups have been developing regional clinical pathways for each of the procedures identified as suitable for delivery in a new regional day procedure centre. These new regional pathways will ensure that all patients assessed as suitable for a regional day procedure centre will follow the same journey for a particular procedure irrespective of where they live.

7.10 The landscape in which this work had been taken forward has however changed significantly over the past 4 months and must now be considered in light of the Covid-19 pandemic. Daycase procedures must now be taken forward in the

context of the continued need to adhere to social distancing and for Personal Protective Equipment (PPE) at volumes not required prior to the pandemic. It will also need to consider the latest emerging professional guidelines and impact of testing and isolation.

7.11 It will not therefore be possible to move the procedures identified by the T&F groups immediately. Rebuilding of day procedures will now need to be taken forward on an incremental and prioritised basis.

Action 2 – Delivery of day procedures will be rebuilt on a prioritised and incremental basis taking account of current constraints.

8. OPPORTUNITIES FOR IMPROVEMENT: REGIONAL VARIATION

8.1 Over the past four decades, there has been a sea change in how surgery is provided at hospitals. Developments and improvements in medicine have resulted in a steady flow of many forms of elective surgery from an inpatient setting to a daycase setting.

8.2 The benefits of day surgery over inpatient surgery are well documented. They include:

- Higher productivity – more patients can be seen in a shorter space of time;
- Fewer inpatient stays, and therefore lower risk of hospital-related infections;
- Reduced waiting lists;
- A more reliable and cost effective service;
- Low level of complications arising after surgery.[6]

[6] World Health Organisation, http://www.euro.who.int/__data/assets/pdf_file/0011/108965/E90295.pdf

8.3 Across the UK, there is wide variation in performance across surgical specialties with regard to time spent in hospital and the levels of procedures carried out as daycase. There are various reasons for this variation, and in the context of daycase elective care, it can be simply due to a difference in hospital policy, where some favour certain procedures to be performed on a daycase basis, whilst others may regard an overnight stay as the norm for the same procedure[7].

8.4 The British Association of Day Surgery (BADS) produces a directory of procedures that provides targets for day surgery rates covering many different procedures. Using this guidance we can identify, at a procedural level, how Northern Ireland regional performance compares to performance across the UK.

8.5 If we look at the list of procedures identified in the *BADS directory of procedures (5th Edition)* as suitable for daycase, 78% of these procedures were carried out on a daycase basis in Northern Ireland in 2017/18. According to BADS, 96% of these procedures could potentially have been carried out as daycase.

8.6 If the HSC had achieved the 96% target, the potential savings are estimated at more than **£14 million** for 2017/18 (Table 3)**.** These potential savings would be manifested in saved bed days, releasing beds so that more patients can be treated, reducing overcrowding and long waits in emergency departments.

8.7 If we take the example of tonsillectomy, BADS best practice suggests that 90% of these procedures should be carried out as day surgery. In Northern Ireland only 40% of tonsillectomy procedures were carried out on a day procedure basis

[7] British Association of Day Surgery (BADS)

in 2017/18. Even more stark is the variation between different hospital sites. Our figures show that in one hospital in Northern Ireland almost all of tonsillectomy procedures were carried out as a day procedure. In another hospital, almost all were carried out as an inpatient procedure. There may be clinical, cultural or infrastructural reasons as to why an operation is carried out in a particular way but, given the pressures on our system, it is unacceptable that we continue to admit patients into hospital unnecessarily. We need to understand this significant variation in practise and to standardise patient pathways to ensure consistency and equity of service provision.

Table 3: British Association of Day Surgery Comparison: Actual Versus Expected

Overall Summary - All BADS Procedures 17/18	Inpatient Episodes	Day Case Episodes	Day case %	BADS Expected %	BADS Expected Day Cases	BADS Expected Inpatients	Actual Cost £m	BADS Expected Cost £m	Potential Savings £m
	14,985	53,846	78.2	96	64,163	4,947	£105.373	£91.174	£14.198

Source: Hospital Inpatient System, Hospital Information Branch, Information & Analysis Directorate, Department of Health, NI.

Action 3: Performance targets for the wider health and social care system (HSC) to achieve improved day surgery activity levels in line with British Association of Day Surgery (BADS) guidance will be considered by the Department and will be informed by clinical guidance and standards.

Equity of Access

8.8 Elective care services in Northern Ireland are under significant pressure; there are long waiting times and large numbers of patients waiting for treatment. As

with many services, as a relatively small region we are currently spreading our resources far too thinly across multiple sites. Day procedures are currently being delivered across five HSC Trusts and around 19 different hospital sites.

8.9 As a result of this fragmented system, there is a persistent inequity of service provision. Waiting times vary significantly across Northern Ireland depending on the performance of services in different Trust areas. In practice this creates a postcode lottery in terms of access to treatment with patients in one area waiting years for treatment while in another area they may be able to access the same treatment within weeks. Moreover, the pressures on services are expected to increase in future due to a number of factors, including demographic change, new technological developments, and new medical advances.

8.10 In addition to the expected clinical benefits of delivering high volumes of treatments on a small number of specialist sites, there are likely to be significant organisational and administrative benefits to delivering day procedures as a single regional service. In a region the size of Northern Ireland, it is not acceptable that people should have such widely different experiences of accessing healthcare based purely on where they live.

9. TESTING THE CONCEPT – REGIONAL DAY PROCEDURE CENTRE PROTOTYPES

9.1 On the basis of the recommendations in Dr Herity's report, the Department decided to establish prototype regional day procedure centres for two surgical procedures in order to test the approach and to learn lessons for regional implementation of a day procedure model.

9.2 Cataract surgery is the most common elective procedure in the developed world, and in Northern Ireland it accounts for around 5% of all elective procedures. The development of varicose veins in the legs is the most common disease of the

veins. At least a third of the population has visible varicose veins and the prevalence rises with age.

9.3 In both cases, the procedure is overwhelmingly carried out on a day procedure basis, making them ideal for a regional day procedure centre. Patients requiring complex surgery were not affected by the prototypes and continued to be treated on major acute hospital sites.

9.4 Therefore, following receipt of the Task & Finish Group's report, the Department established two project teams, co-chaired by a managerial lead and a surgical practitioner, to develop options for prototype regional day procedure centres for cataracts and varicose veins.

9.5 The project teams carried out comprehensive options appraisals on potential sites in which to locate the prototypes. It was ultimately agreed that the varicose veins prototype would be based in Omagh Hospital and Primary Care Complex and Lagan Valley Hospital. For cataracts, the project team decided to develop the service in Mid-Ulster Hospital, Downe Hospital and South Tyrone Hospital. Copies of the options appraisals for each prototype are available on the Department's website.

9.6 The prototype regional day procedure centres for Cataracts and Veins have been operational since December 2018.

10. WHAT HAVE WE LEARNT FROM THE PROTOTYPES SO FAR

10.1 The first patients were treated in the prototypes in December 2018. As such, they are still very much at an early stage and are being evaluated on an ongoing basis so that we can learn important lessons as we implement the regional model for day procedure centres.

10.2 The prototypes have been delivered within the context of the considerable backlog of patients waiting for these procedures. It will take time and significant investment to bring the backlog back to an acceptable level and to allow the prototypes to fully realise their potential. In addition, the cessation of elective surgery during the coronavirus pandemic will only have further added to this backlog.

10.3 Patient feedback from the prototypes has been positive with high levels of satisfaction being reported in patient surveys. Staff are mainly supportive of regional day procedure centres and they agree that it is a good model of care for patients. Many staff agree that it is early in the process and that there is more to learn.

10.4 In terms of performance, in the first 9 months, the Varicose Veins prototype has seen a reduction in waiting times, with a decrease of around 80% in the number of patients waiting over 1 year. The Veins prototype has seen over 50% of an increase in activity when projected over the full year.

10.5 The cataracts prototype is still working towards an increase in productivity and a reduction in waiting times although there are promising signs of improvement. Unlike the veins prototype, the work on cataracts is not focused purely on treatment but has also sought to streamline and modernise the entire patient pathway.

10.6 This is a large scale change for the delivery of cataract surgery and is necessarily more complex. Whilst significant progress has been made in developing a streamlined regional pathway there have been operational (IT, Administrative and Human Resource) issues that have hindered productivity. Work is underway to address these issues and it is anticipated that outcomes will continue to improve.

10.7 The evaluation of the prototypes to date indicates that the concept of the regional day procedure centre model is sound and they can deliver real benefits for patients. Productivity gains in the treatment of Varicose Veins has been highly satisfactory. At this early stage, taking account of the significant backlog of patients, the prototypes are making good progress. There are however infrastructural, Human Resource, IT and administrative issues that come with working across organisational boundaries that are constraining rather than enabling success. The Department is committed to tackling these issues for the proposed regional model for regional day procedures centres to achieve the desired benefits for staff and patients.

10.8 While the impact of the pandemic has resulted in reduced activity for both prototypes, it is worth noting that thanks to the prototype structures, cataracts has been able to restart activity earlier than expected.

10.9 The introduction of the prototypes was made possible by funding through the Confidence and Supply Agreement and the dedicated leadership of a group healthcare professional and managerial staff. These staff have demonstrated their willingness to try new ways of working and are the trailblazers for improving the delivery of these specialties. The Department acknowledges their contribution and dedication to their patients.

Action 4: Taking account of the current constraints associated with the pandemic, the Department will continue to evaluate the performance of the prototypes over the next twelve months with the aim of incorporating them into an expanded regional day procedure centre model.

Case Study - Cataract Patient - South Tyrone Hospital

I had noticed my eyes, both of them, becoming dull or opaque or like looking out of a bathroom window more and more. I went to the optician and he said yes, that left eye needs attention as quick as we can get it. So, they took it from there, and after that I just kept being contacted by Dr Jothi here in Dungannon South Tyrone. I was here then by the end of the year. I came up three times, first for an assessment, then for the pre-op and then for the actual cataract operation itself. I have had two very successful cataract removals, the best possible experience that anybody could have anywhere. As far as we were concerned, it was ideal … the traffic is less dense, you're not as liable to have hold-ups and things as you would to Belfast. I never liked travelling to Belfast anyway, so it was a delight to be coming into the countryside. As far as we were concerned this was a perfect location for anything. There was no problem at all, from reception right through to the consultation with Dr Jothi and her staff, anaesthetist and that kind of thing, I was treated like what I assume royalty is probably treated like in most circumstances.

11. WHERE WE CURRENTLY DELIVER SERVICES

11.1 In section 2, we indicated that initially (pre pandemic) there would be approximately 40,000 procedures that could be transferred recurrently to a regional day procedure centre. These procedures are currently being delivered across 19 hospitals in Northern Ireland, as set out in table 3 below.

11.2 The clinical groups have also identified approximately 60,000 suitable, non-complex endoscopy procedures which are currently being delivered across 16 sites.

Current sites from which procedure delivered	**Speciality**					
	ENT	General Surgery	Ortho	Urology	Gynaecology	Paediatrics
Altnagelvin Area	✓	✓	✓	✓	✓	✓
Antrim Area	✓	✓	-	-	✓	✓
Ards	-	✓	-	✓	✓	-
Belfast City	-	✓	-	✓	✓	-
Causeway	✓	✓	-	✓	✓	✓
Craigavon Area	✓	✓	✓	✓	✓	✓
Daisy Hill	✓	✓	-	-	✓	✓
Downe	✓	✓	✓	✓	-	✓

Lagan Valley	✓	✓	-	✓	✓	✓
Mater Infirmorum	-	✓	-	✓	-	✓
Mid-Ulster	✓	✓	-	-	✓	✓
Musgrave Park	-	-	✓	-	-	-
Omagh	✓	✓	-	✓	✓	✓
RBHSC	✓	-	✓	-	-	✓
Royal Victoria	✓	-	✓	-	-	✓
South Tyrone	✓	✓	✓	✓	✓	✓
SWAH	-	✓	-	-	✓	✓
Ulster	✓	✓	✓	✓	✓	✓
Whiteabbey	✓	✓	-	✓	✓	✓

11.3 In effect, this means that the provision of surgical and endoscopy procedures suitable for delivery in a regional day procedure centre is currently spread across 19 different hospital sites across Northern Ireland. The Department believes that this diffusion of activity, for the relatively small population of Northern Ireland, delivered on sites that also provide emergency care is contributing to the HSC's under-performance compared to the standards achieved in other parts of the UK. As stated above, if we look at the list of procedures identified in the *BADS directory of procedures (5th Edition)* as suitable for daycase, 78% of these procedures were carried out on a daycase basis in Northern Ireland in 2017/18. According to BADS, 96% of these procedures could potentially have been carried out as daycase.

11.4 Therefore, it is anticipated that concentrating the delivery of a large number of suitable procedures on fewer sites will deliver benefits in terms of increased productivity, improved sustainability, economies of scale, reduced cancellations due to staff unavailability, and better opportunities for training. This is the challenge facing the HSC. The Department is therefore proposing that the delivery of these procedures will be concentrated on a smaller number of dedicated and specialised regional day procedure centres serving the entire population of Northern Ireland.

12. SUITABLE SITES FOR DAY PROCEDURES

12.1 As part of its work on the configuration of regional day procedure centres, the group chaired by Dr Herity identified a shortlist of sites defined as either 'stand-alone' or 'self-contained on a bigger campus'. All of these sites are potential locations for regional day procedure centres.

12.2 The full shortlist of sites is displayed in alphabetical order in table 4 below:

Stand-alone Ambulatory Centres	Self-contained on a bigger campus
Downe Hospital	Causeway Hospital[8]
Lagan Valley Hospital	Craigavon Hospital DPU
Mid-Ulster Hospital	Daisy Hill Hospital
Musgrave Park Hospital	Ulster Hospital DSU

[8] Added at the request from the Northern Health and Social Care Trust following consideration of the Task & Finish Group's report

Omagh Hospital and Primary Care Complex	Mater Infirmorum Hospital[9]
South Tyrone Hospital	
Whiteabbey Hospital	

Table 4: Shortlisted sites

12.3 It is estimated that the initial complement of 40,000 procedures (including cataracts and varicose veins) would require approximately 27 theatres or appropriately equipped procedure rooms to deliver annually. The 60,000 endoscopy procedures would require approximately 17 endoscopy rooms.

12.4 Table 5 below sets out the number of inpatient, daycase and procedure rooms available at each of the sites shortlisted above as potential regional day procedure centres.

Name	**Number of operating theatres**		**Endoscopy Rooms**	**Procedure Rooms**
	Inpatient	Day case		
Functionally standalone centres				
Downe	0	2	2	0
Lagan Valley	0	3	2	1
Mid-Ulster	0	2	1	0
Musgrave Park	7	2	0	1

[9] Added at the request of the Belfast Health and Social Care Trust following consideration of the Task & Finish Group's report

Omagh	0	3	1	1
South Tyrone	0	2	2	0
Whiteabbey	0	2	2	0
Functionally self-contained on a bigger campus				
Causeway	3	2	1	0
Craigavon	6	1	1	0
Daisy Hill	4	1	1	0
Ulster	7	4	2	0
Mater Infirmorum	3	2	2	0

Table 5

13. A HUB & SPOKE MODEL

13.1 One of the key principles underpinning the work to date is that existing HSC infrastructure should be used optimally before recommending a new building or buildings for day procedures. As this work has progressed, clinicians involved in the specialty Task & Finish groups have provided feedback that larger stand-alone centres would offer greater benefits in terms of patient safety, service resilience, overall sustainability, and productivity gains.

13.2 Moreover, the reference group of anaesthetists, which includes a clinician involved in establishing and working in a major elective care centre in the USA, has emphasised the significant benefits of providing anaesthetics support in a smaller number of larger centres. With the demands on anaesthetics across the healthcare system, it would be extremely challenging to provide dedicated, specialist support at a large number of sites. Given the importance of anaesthetic

support to safely deliver these procedures at standalone sites, this would impact on the overall sustainability of the service.

13.3 Bearing in mind the theatre capacity required to deliver the full caseload identified as suitable for delivery in regional day procedure centres, it is also clear from the table above that none of the sites would at present have sufficient theatre capacity to deliver the required volume of daycase activity. Even taking a combination of the sites, achieving the initial full capacity of 40,000 procedures and 60,000 endoscopies would require services to be spread over a large number of different sites, contrary to the clinical advice we have received.

13.4 Furthermore, when we compare the number of procedures identified for the first phase with the total number of possible daycase procedures shown in tables 1 & 2 we can see that this very much represents a starting point on which to build. Further advances in medical practice are likely to mean that more procedures will be treated as daycases in future. This means that flexibility will need to be built into the design of any regional day procedure centre to accommodate potential expansion in demand. It is therefore likely that a 'hub and spoke' model will be required.

13.5 Given the urgent need to begin rebuilding daycase elective care procedures and in recognition that this will need to be taken forward on an incremental and prioritised basis, the Department plans to concentrate delivery initially on one 'hub' day procedure centre site

13.6 The 'hub' site is Lagan Valley Hospital (LVH) in the South Eastern Trust and this 'hub' will interact with several hospital sites (the spokes) around Northern Ireland as the model develops.

13.7 LVH has a dedicated day procedure unit and it has demonstrated its ability to successfully deliver a range of daycase and endoscopy procedures. In relation

to the Emergency Department at LVH, the layout of the site means that there are different entrances for patients using the ED and those using the Day Procedure Unit. Importantly the two services can therefore be managed separately without impacting on each other.

13.8 As one of the locations on which the varicose veins prototype was delivered, LVH has proved popular with staff and with patients in terms of accessibility and patient experience. Furthermore, throughout all of the engagement with clinicians involved in developing proposals for day procedure centres, LVH was consistently recognised as a suitable site for an elective care centre in terms of its accessibility for both patients and staff alike. Drive time statistics show that almost 73% of the population are within a 60 minute drive time of LVH.

Orthopaedics

13.9 The Department has also commenced a Regional Review of Orthopaedic Services in Northern Ireland. The key objective of this work is to introduce a new, streamlined end-to-end pathway for orthopaedic surgery, to ensure a reduction in regional variation in clinical practice, and to standardise processes so that patients could have timely access to the same quality of care, regardless of postcode.

13.10 As we now move into the recovery phase of the pandemic, work is underway to develop a phased approach to the re-establishment of much needed elective orthopaedic services in a safe and sustainable manner and to set out a blueprint for long-term transformation. It is appropriate therefore that Orthopaedics day procedures are transformed as part of the wider work on orthopaedics.

14. HOW WILL THE REGIONAL MODEL BE MANAGED?

14.1 Health And Wellbeing 2026: Delivering Together' states that in order to deliver care in a different way, it is clear that the way we plan and manage health and social care will also need to change. This will involve embracing new models of care which has the potential to harness the strengths of different parts of the system, across traditional organisational boundaries, across sectors and beyond what is traditionally considered to be the health and social care sector. Where services are highly specialised, they will be planned and delivered on a region-wide basis. The consultation on HSC structures supported the need to reduce bureaucracy and put in place a more effective streamlined mechanism for how we plan health and social care services.

14.2 The proposals in this document represent the most radical redesign of how we intend to plan and deliver daycase elective care that we have seen in the past 20 years. To ensure its success it will need an appropriate streamlined regional management structure.

14.3 In the current environment there remains is much uncertainty surrounding the type and volume of procedures suitable for day procedure and the timescales for bringing these procedures back online. While we recognise the benefits of a streamlined regional management structure it is acknowledged that this may not be the correct time to establish a new dedicated management structure. The system must adopt an urgent but incremental and prioritised approach to the delivery of day procedures. Therefore the timescales involved in creating a new management vehicle, would prove prohibitive in the fast paced, rebuilding environment. This does however remain something that we will keep under review.

14.4 Lagan Valley Hospital sits within the South Eastern Trust (SET) and it is proposed that the SET takes forward the establishment and management of the day procedure centre model in the first instance. This position will be kept under review as the work advances.

14.5 It is expected that the responsibilities of SET will include for example regional booking, IT solutions, estates, indemnity, finance, operational logistics etc., and will be set out in a Memorandum of Understanding between the Department, HSCB, the SE Trust and the other HSC Trusts. The overall strategic approach in terms of clinical priorities and patient pathways will however be set by the Regional Network described below.

Action 5: Lagan Valley Hospital will be developed as the first regional Daycase Procedure Centre in Northern Ireland. The South Eastern Trust will produce an implementation plan for delivering the day procedure centre by autumn 2020.

Action 6: The current locations of the day procedure centre prototypes for delivering cataract and varicose procedures will continue as at present to be reviewed as the new Day Procedure Centre regional model evolves.

Action 7: The governance of the interim day procedure centre model be hosted by the South Eastern Trust. This will be kept under review as the model develops.

15. A REGIONAL CLINICAL NETWORK

15.1 A clinically led Regional Network will be established to oversee the development of the day procedure centre hub and spoke model based in LVH in the first instance. The Network will drive forward a whole system, integrated approach to day procedures to achieve a real change in quality and outcomes of care for patients. This will be a regional network hosted by the

South Eastern Trust and will report into the Departmental Management Board for Rebuilding HSC Services.

15.2 As this work progresses, the Regional Day Procedure Centre Network will also consider the scope to expand the Day Procedure Centre model to other 'spoke' sites identified by the work of Dr Herity.

15.3 Alongside the work of the Regional Day Procedure Centre Network, Trusts will continue to develop and implement local plans for rebuilding elective procedures, feeding in to the Regional Day Procedure Centre Network.

Action 8: A clinically led Regional Network will be established to drive forward a whole system, integrated approach to day procedures to achieve a real change in quality and outcomes of care for patients.

16. HOW WILL THE MODEL BE COMMISSIONED?

16.1 Commissioning in the context of health and social care can be defined as the process of securing the provision of services to meet the needs of a population.

16.2 This is a complex process. In practice, it requires the assessment of the population's health and social care needs; the planning of services to meet those needs; the procurement of those services; monitoring of the delivery of services against agreed standards; and an evaluation of the impact of the services that have been commissioned.

16.3 In national and international terms, there is no single agreed model for commissioning. Health systems in the UK and Ireland have generally adapted their commissioning model in such a way that complements their specific population needs and health and social care structures.

16.4 Some of the most common approaches to commissioning elective care have been set out below:

- Capitation: Broadly speaking capitation means paying a provider or group of providers to cover the majority (or all) of the care provided to a specified population across different care settings. The regular payments are calculated as a lump sum per patient.

- Block Contracts: These are effectively pre-payments that are made by commissioners to healthcare providers to deliver a pre-agreed number of procedures or operations. For example, a hospital could be given a block contract to undertake acute care in a particular geographical area. Generally, the value of the contract is independent of the actual number of patients treated or the amount of activity undertaken.

- Tariff/ Activity Based Funding: This is a system of paying hospitals and other providers for the number of patients that they treat. The idea is that providers will receive a fixed payment – the national tariff – for each type of patient treated. Termed 'payment by results', the policy rewards providers for volumes of work adjusted for differences in case mix.

16.5 Historically, commissioning in Northern Ireland has generally focused on a combination of capitation and block contracts. Several reviews carried out in Northern Ireland have made comment on the methods of commissioning.

16.6 In 2014, in his report, The Right Time, the Right Place, Sir Liam Donaldson suggested that Northern Ireland could benefit from a tariff model. His report suggested that, under the current commissioning model, Northern Ireland relies too heavily on block grants, which are relatively unsophisticated in terms of achieving value for money.

16.7 Professor John Appleby's 2005 report, 'Independent Review of Health and Social Care Services in Northern Ireland', also suggests that the introduction of a tariff model could potentially be used to drive improvements in efficiency and productivity in regional services. This approach is thought to be very transparent in terms of what is being delivered for the additional performance, and Professor Appleby also acknowledges this as a key benefit of this approach.

16.8 There are valid reasons why a tariff system is not always the most appropriate approach to commissioning across the full range of healthcare services. Used in the wrong way, tariff systems can provide a perverse incentive for providers to seek increased funding by delivering increased hospital activity, rather than focusing on prevention of illness. In the context of unscheduled care, a focus on activity can also lead to providers encouraging attendance at hospitals, rather than considering other, more suitable alternatives.

16.9 There are therefore arguments for and against the tariff model. However, taking into account the points in favour of and against this approach, it would appear to be well suited for the requirements of regional day procedure centres. While quality and safety considerations will always be the most important factors in any new healthcare service, a tariff based commissioning model would be an appropriate mechanism to ensure that high productivity is rewarded and also that poor performance is rapidly identified and corrective action taken. The risk of perverse incentives is low as referrals into the service will be driven by clinical decisions. Conversely, increased productivity and efficiency would bring great benefits to patients, and to the wider health and care system in terms of the most effective use of resources.

Action 9: The development of an activity based funding model to guide the commissioning of daycase treatment to be delivered within a regional day procedure model will be considered as the model evolves.

17. TRAVEL AND TRANSPORT

17.1 It is true that, for some patients, concentrating daycase elective care procedures in a smaller number of sites may mean that they will have to travel further to attend a regional day procedure centre. For the vast majority of patients, attendance at a regional day procedure centre will be a rare occurrence. These procedures are likely to be non-urgent, infrequent events that require a planned surgical intervention. As such, the additional travel will be an isolated event rather than a long term passage of care requiring multiple visits. The clear trade-off for the additional travel will be shorter waiting times for treatment.

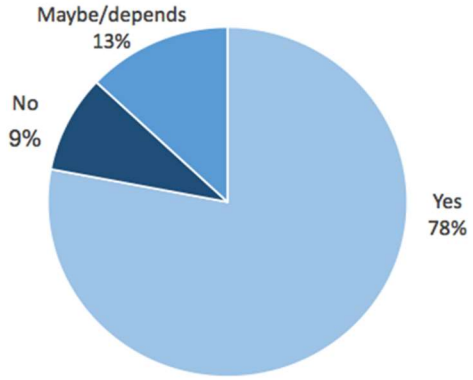
17.2 We recognise that travel and transport are key considerations, particularly for those patients who require additional support. However, as a general principle, patients who are suitable for treatment in a new regional day procedure centre are less likely to require intensive levels of support. Those patients requiring daycase treatment will normally make their own way to hospital, either using their own transport, or that of friends and relatives, or by using a number of schemes that exist to help people who have transport difficulties. In extenuating circumstances eligible patients may be entitled to access non-urgent Patient Care Services (PCS).

17.3 To inform our thinking on transport in relation to regional day procedure centres the Department sought views from members of the public, Age Sector Platform and our Service User Advisor Panel.

17.4 In the 2017/18 Health Survey for Northern Ireland, 79% of respondents indicated that, if they needed a routine procedure or operation they would be prepared to

travel within Northern Ireland if it meant that waiting times would be reduced. 39% of respondents indicated that they would be prepared to travel up to 1hr to a hospital and 27% said up to 2hrs.

If you needed a routine procedure or operation, would you be prepared to travel further than your nearest hospital within Northern Ireland if it meant that your waiting time for your procedure or operation would be reduced?



DoH Health Survey, NISRA, Jul-Sep 2017: 827 respondents (unweighted)

17.5 We asked a similar question of 226 individuals from Age Sector Platform. Over 80% of those asked said they would be willing to travel further if there were benefits such as reduced waiting/procedure times and a lower risk of cancellation. Almost 16% of those asked were either unsure or unwilling to travel a distance to receive their procedures regardless of the benefits.

17.6 This snapshot suggests that most people are willing to travel if it means they will be seen quicker. However, it is also clear that there is a significant minority of patients who would have concerns about any additional travel time. Our Service User Advisor Panel has reminded us that there needs to be accessible and reliable public transport for those patients that do not have access to private transport, particularly the elderly. They also highlighted the importance of flexible appointment times, especially for those travelling a greater distance and/or by

public transport. The Panel have also raised concerns about the costs associated with travelling further and the potential impact on low income families. We gave a commitment to the Service User Panel that we would consider these issues in detail as we develop our plans for regional day procedure centres.

17.7 PCS has for many years met the non-urgent transport needs of eligible service users through a mixed economy of transport provision including the Northern Ireland Ambulance Service, HSC Trust transport fleets, voluntary and community sector organisations, taxi operators and voluntary and private ambulance services. Eligible patients are those whose medical condition is such that they require the skills or support of PCS staff on or after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by other means.

17.8 Requests for non-urgent transport are processed by a medical practitioner. However, the demand for these services often exceeds supply and there is little capacity or consistency in the current system. It is therefore important that appropriate systems are in place to prioritise those patients with the greatest need to ensure they are transported with the least delay. The Northern Ireland Ambulance Service (NIAS) is currently reviewing the provision of non-urgent transport provision to ensure that the service is prioritised for those with the highest clinical priority.

17.9 The Hospital Travel Costs Scheme remains in place and the scheme provides help to those on a low income who are under the care of a consultant and in need of health service treatment at a hospital, health service centre or private clinic. Further information is available on the NI Direct website.

17.10 Transport and access issues now also need to be considered in the context of the pandemic and the South Eastern Trust working with the Regional Network,

the NI ambulance Service (NIAS) and other key stakeholders, will consider transport issues within the context of the current environment.

Action 10: As part of implementation of the new model, the South Eastern Trust working with the Regional Network and key stakeholders including NIAS will consider transport issues within the context of the current environment.

Action 11: As we develop the model for regional day procedure centres we will explore new digital solutions such as intelligent appointment booking solutions that take into consideration a range of factors such as the distance that patients are travelling, the nature of the procedure, and the patient's individual circumstances.

SECTION C: KEY BUILDING BLOCKS OF REGIONAL DAY PROCEDURE CENTRES

18. PATIENT EXPERIENCE

18.1 A positive patient experience, along with positive health outcomes, is at the heart of the concept of regional day procedure centres. All too often, our current system is focused too heavily on the needs of the service with patients expected to fit in with the routines and practices that health and social services feel are most appropriate.

18.2 Patient experience and patient outcomes are key elements of quality, alongside providing clinical excellence and safer care. Patient experience is how the process of receiving care feels for the patient, their family and carers. Patient reported outcomes assess the quality of care delivered to patients from the patient perspective. There is a clear link between patient experience and health

outcomes (i.e. patients who have a better experience of care generally have better health outcomes)[10].

18.3 As we develop the model for regional day procedure centres we are committed to delivering patient-centred care. Reduced waiting times, reduced cancellation rates and more effective management of patients should all contribute to a positive patient experience.

18.4 The regional day procedure centres will have a continual focus on patient experience and patient outcomes and will use a range of new and existing tools, including online user feedback, to capture both positive and negative experiences and outcomes so that they can continuously learn and improve.

Action 12: In line with the Department of Health's Guide to co-production the centres will focus on capturing timely patient feedback and monitoring patient outcomes to rapidly identify what is working well and what requires improvement.

19. DIGITAL IMPROVEMENTS

19.1 The HSC currently uses a number of different systems which cannot, or cannot easily, communicate with each other. Many of these are old and need to be replaced. Issues with inefficient systems such as these lead to delays and cancellations, poor patient experience and a backlog of work for doctors and administrators. Attempting to provide a regional service within the existing digital systems has caused delays and difficulties for the current prototype services for cataracts and varicose veins.

[10] [10] https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Patient-Experience-Guidance-and-Support.pdf

19.2 Effective digital systems that operate regionally also enable a greater degree of consistency of approach and standardised processes. Standardised services make it easier for staff who work across those different services to provide consistently good quality, efficient care. They also provide better value for money by reducing duplication and by enabling the identification of unnecessary steps in a process that do not add value.

19.3 The Encompass programme is a HSC wide initiative that will introduce a digital integrated care record to Northern Ireland. Encompass gives us an opportunity, rather than continuing to rely on paper records and replacing outdated technology system by system, to better use the investment needed in ICT to transform the way we care for people in Northern Ireland[11]. Encompass will begin phased implementation from 2020 and will be rolled out over the next number of years. It will be a key enabler for the successful delivery of regional day procedures centres.

Action 13: The South Eastern Trust will work closely with the Encompass Team to plan for regional day procedure centres. Any interim digital solutions that are required will align with the Encompass programme.

20. THE WORKFORCE

20.1 Among the challenges to be faced, the greatest is likely to be the availability of the appropriate workforce, both in regional day procedure centres as well as in centres delivering unscheduled care, complex inpatient elective surgery and long term conditions care [12]. We believe that, in order to support sustained improvement in Health and Social Care (HSC), recruitment, retention and

[11] http://www.hscboard.hscni.net/encompass/

[12] Elective Care Plan

development of staff is critical. We need to ensure that the entire HSC workforce is both of sufficient size and has the necessary skills to deal with relevant caseloads and maximize effectiveness.

20.2 The Department does not underestimate the impact of Covid-19 on the HSC workforce and the challenges that lie ahead. The HSC workforce has been under significant strain during the pandemic and it will be necessary to consider the implications for staff and to provide appropriate support.

20.3 Prior to the pandemic the delivery of care across the HSC had been impacted by increasing challenges in recruiting and retaining medical and nursing staff. It has also become clear that even when resources have been made available to recruit additional staff, it has simply not been possible to fill all vacant posts. This in turn puts additional pressure on already hardworking staff and has seen the Health Service become increasingly reliant on short term solutions such as locums and agency staff. This not only creates additional expense but has negative implications for the quality of care. It has become a vicious circle which needs to be addressed urgently.

20.4 In addition to this, it is crucial that as we develop a model for regional day procedure centres, the existing workforce is not spread more thinly than is currently the case. Dedicated elective facilities can improve recruitment as many professionals look for stability of specialty and case mix, which in turn may support training, research and development. It is important that the movement of staff to a regional day procedure centre is not permitted to destabilise unscheduled/emergency care at acute sites.

20.5 In the longer term, as the model develops, providing such services may require some recruitment, but it is also likely to present opportunities for redesign of

services and development of professional roles. There is the possibility of real innovation of practice when multidisciplinary teams of experts work together and look across professional boundaries to find innovative solutions to service issues.

20.6 Some clinicians have expressed a concern that concentrating specific elective procedures in a dedicated day procedure centre could potentially de-skill some staff working in the centre. It is therefore important that in planning the new model, careful attention will be given to how the new service will be structured in terms of new roles, rotational posts and multi skilling.

20.7 The Task and Finish groups have been giving initial consideration as to how these challenges could be managed, and are currently exploring options for the realignment and enhancement of current roles as the model develops.

20.8 Ultimately, we want regional day procedure centres to be an attractive environment for staff to work, and one that will deliver a number of benefits, including:

- Improved staff wellbeing and engagement experience;
- A high performance culture;
- New and innovative ways of working;
- Roles in advanced practice;
- Opportunity to work in a safe and efficient multidisciplinary environment;
- Standardised hours of work;
- Opportunities for training and development.

21. WHAT DOES THIS MEAN FOR EXISTING SERVICES?

21.1 In the short term the development or reconfiguration of Lagan Valley Hospital (LVH) as a regional day procedure centre will be carried out in a phased way in order to minimise the impact on existing service users.

21.2 In the longer term, with the wider reconfiguration of the HSC, there will undoubtedly be an impact on the delivery of services from existing hospital sites. In order to maximise capacity and deliver a service that is both effective and efficient, it is likely that some services will be displaced from the existing sites from which they are currently being delivered. This will be subject to engagement and consultation at a local level in line with guidance. For services that are displaced, staff will have the option to transfer to another site with their specialty, but equally if at all possible they will have the option to stay at their current site, with an opportunity to retrain in a different specialty.

21.3 Currently, employment patterns for staff vary widely from Trust to Trust, and this can make it difficult for staff to work across Trust boundaries. As day procedure centres are to be part of a regional model, it is important that these boundaries do not present an issue and new patterns of working will therefore be developed to ensure that the maximum benefits from the new model are achieved for both patients and staff who provide the service.

21.4 Recognising that investment in the workforce is a key enabler to Health and Social Care transformation, the Department has developed a Workforce Strategy which will focus specifically on the retention and recruitment of Health and Social Care staff, opportunities for introducing new job roles; and reskilling and upskilling initiatives. Under this strategy, we will seek ways to make the best use of our resources that promote innovation in skills and workforce development.

22. STAFF ENGAGEMENT

22.1 We can design innovative new care models, but they simply will not become a reality unless we have a workforce with the right numbers, skills, values and

behaviours to deliver[13]. Staff are the heart of any new model of care, and we recognise the need to engage with our workforce as we develop our plans.

22.2 It is within that context that the Department has been working with doctors, nurses, AHPs, service managers and other health professionals from across the Health and Social Care sector to develop proposals for a regional day procedure centre model.

22.3 To date, we have engaged with HSC staff on the delivery of prototype regional day procedure centres for Varicose Vein and Cataract surgery through a variety of channels, including semi structured interviews (face to face or telephone), focus groups and questionnaires. This has provided an opportunity for us to evaluate staff experience, and we will continue to engage with staff and seek their input to inform the future regional model.

22.4 We are committed to working with HSC staff to take their views and feedback on proposals for a regional model, and to continue with ongoing engagement to ensure staff have the opportunity to inform this work.

Action 14: In line with the Department's HSC Workforce Strategy, the South Eastern Trust, working with the Regional Network will produce a workforce plan setting out the staffing levels required to deliver regional day procedure centres with the best possible combination of skills and expertise.

[13] NHS Five Year Forward View

23. PPI/CO-PRODUCTION

23.1 The main change for patients and their carers will be the additional travel time to the LVH Hub and spoke sites counterbalanced by the opportunity to have their procedure carried out more quickly than the current waiting times allows.

23.2 Prior to the pandemic a panel of service users had been helping to inform our thinking on the development of day procedure centres. Learning from and building on this PPI and co-production with patients and their carers on the implementation of the regional day procedure centre model will be meaningfully embedded in the process at Trust level to ensure appropriate consideration of local impacts.

24. IMPACT ASSESSMENTS

24.1 Equality and rural issues will be taken into consideration by Trusts as the proposals are developed with appropriate screening and impact assessments carried out at local level in line with guidance.

25. ACTIONS

Action 1: **On the basis of the findings of the clinically chaired task and finish group, the Department will develop specialist regional day procedure centres. These will be centres of excellence managed and delivered as a regional resource.**

Action 2: **Delivery of day procedures will be rebuilt on a prioritised and incremental basis taking account of current constraints.**

Action 3: **Performance targets for the wider health and social care system (HSC) to achieve improved day surgery activity levels in line with British Association of Day Surgery (BADS) guidance will be considered by the Department and will be informed emerging by clinical guidance and standards.**

Action 4: **Taking account of the current constraints associated with the pandemic, the Department will continue to evaluate the performance of the prototypes over the next twelve months with the aim of incorporating them into an expanded regional day procedure centre model.**

Action 5: **Lagan Valley Hospital will be developed as the first regional day procedure centre in Northern Ireland. The South Eastern Trust will produce an implementation plan for delivering the day procedure centre by autumn 2020.**

Action 6: **The current locations of the day procedure centre prototypes for delivering cataract and varicose procedures will continue as at**

present to be reviewed as the new day procedure centre regional model evolves.

Action 7: The governance of the interim day procedure centre model be hosted by the South Eastern Trust. This will be kept under review as the model develops.

Action 8: A clinically led Regional Network will be established to drive forward a whole system, integrated approach to day procedures to achieve a real change in quality and outcomes of care for patients.

Action 9: The development of an activity based funding model to guide the commissioning of daycase treatment to be delivered within a regional day procedure model will be considered as the model evolves.

Action 10: As part of implementation of the new model, the SE Trust working with the Regional Network and key stakeholders including NIAS will consider transport issues within the context of the current environment.

Action 11: As we develop the model for regional day procedure centres we will explore new digital solutions such as intelligent appointment booking solutions that take into consideration a range of factors such as the distance that patients are travelling, the nature of the procedure, and the patient's individual circumstances.

Action 12: **In line with the Department of Health's Guide to co-production the centres will focus on capturing timely patient feedback and monitoring patient outcomes to rapidly identify what is working well and what requires improvement.**

Action 13: **The South Eastern Trust will work closely with the Encompass Team to plan for regional day procedure centres. Any interim digital solutions that are required will align with the Encompass programme.**

Action 14: **In line with the Department's Workforce Strategy, the South Eastern Trust, working with the Regional Network will produce a workforce plan setting out the staffing levels required to deliver regional day procedure centres with the best possible combination of skills and expertise.**

Annex A

Proposed procedures for transfer to Regional Day Procedure Centres

Specialty	Procedure
General Surgery	Primary Repair of Inguinal Hernia
ENT	Septoplasty Tonsillectomy Adult Glue Ear Turbinate surgery
Paediatrics	Simple extraction of tooth Excision of tonsil Drainage of middle ear Adenoids
Gynaecology	Diagnostic Examination of Uterus - Hysteroscopy Therapeutic Endoscopic Operations on Uterus - Hysteroscopy Other vaginal operations on Uterus Curettage of Uterus. Cystoscopic Botulinum Toxin Injection
Orthopaedics	Puncture of joint Other excision of bone Therapeutic endoscopic operations on semilunar cartilage Other external fixation of bone Other internal fixation of bone Primary excision of lumbar intervertebral disc Release of entrapment of peripheral nerve at wrist Immobilisation using plaster cast Primary open reduction of fracture of bone and extramedullary fixation Primary repair of tendon Other reconstruction of ligament Operations on spinal nerve root Excision of bone Other operations on spine Primary open reduction of fracture of bone and intramedullary fixation Total excision of bone Closed reduction of fracture of bone and internal fixation Extirpation of lesion of bone Primary decompression operations on lumbar spine

	Excision of ganglion Excision of other fascia Diagnostic endoscopic examination of knee joint Other closed reduction of fracture of bone Therapeutic endoscopic operations on other joint structure Fusion of joint of toe Debridement and irrigation of joint Other operations on sheath of tendon Therapeutic endoscopic operations on cavity of knee joint Adjustment to length of tendon Repair of muscle Operations on bursa Complex reconstruction of forefoot Other primary fusion of other joint Other stabilising operations on joint Division of bone of foot Therapeutic endoscopic operations on other articular cartilage
Urology	A trans urethral resection of bladder tumour (TURBT) Ureteroscopy Extracorporeal shock wave lithotripsy Transurethral resection of prostate (TURP)/Laser prostectomy Urolift
Endoscopy	Gastroscopy (OGD) Colonoscopy Sigmoidoscopy
Day Procedure Prototypes	Varicose Veins Cataracts

The procedures listed in this table are subject to clinical approval.