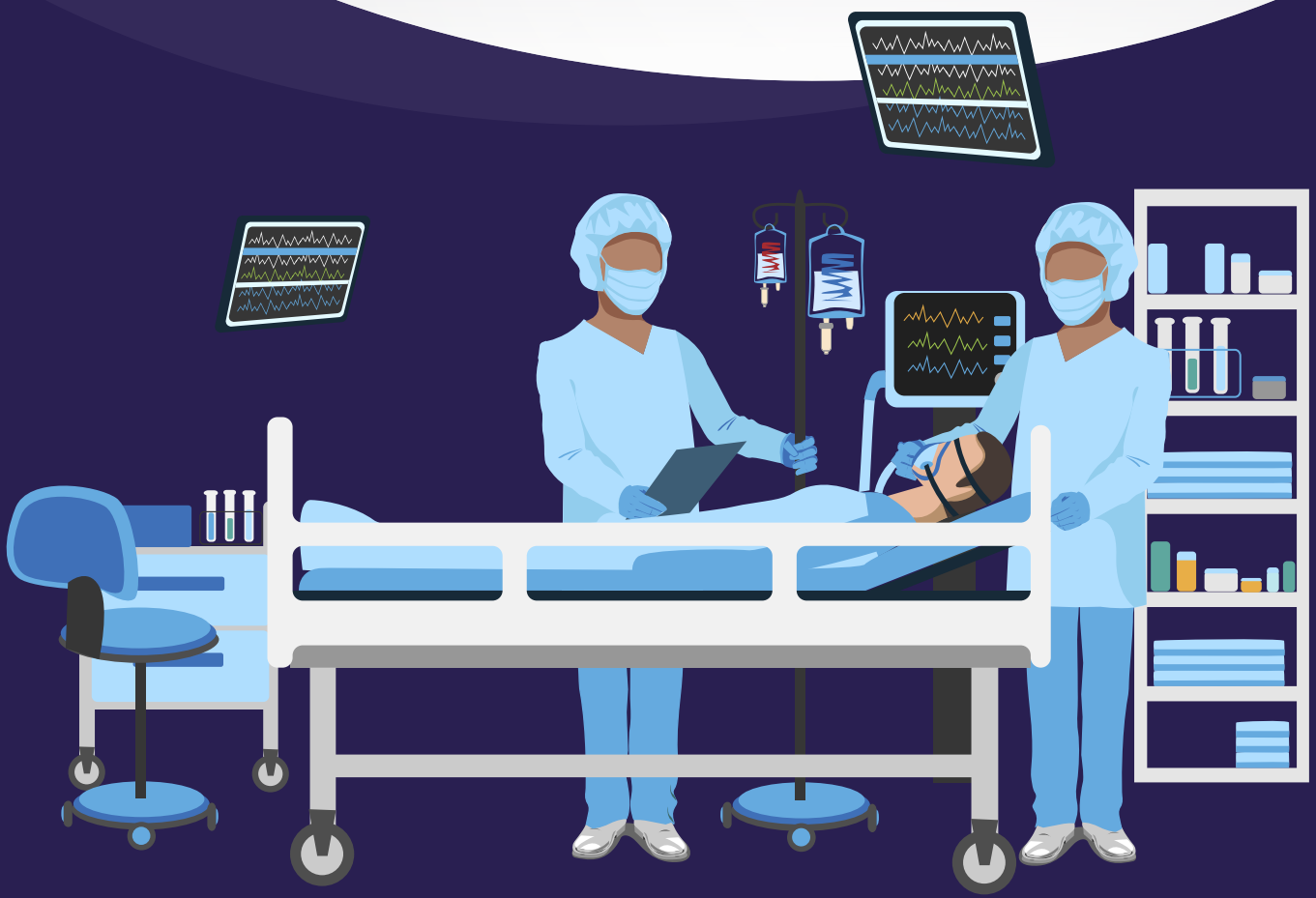
Royal College of Anaesthetists | Northern Ireland

# Northern Ireland's waiting list crisis: the critical role of anaesthetists



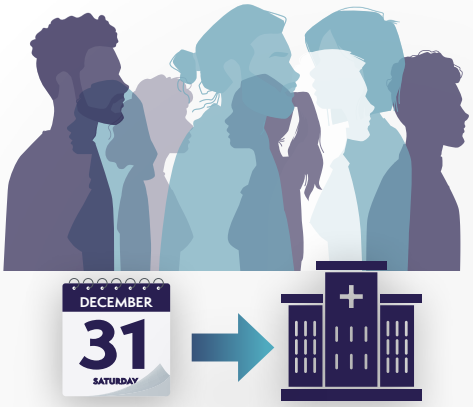
# Executive summary

- Health and Social Care (HSC) waiting lists have grown dramatically. Over 120,000 patients are currently on inpatient and day case waiting lists.
- Most operations require an anaesthetist; however, HSC currently has a 14.6% shortfall of anaesthetists. This severely undermines efforts to get waiting lists down.
- It is vital that workforce shortages in anaesthesia and other healthcare professions are addressed with a comprehensive workforce plan.
- HSC has too many cancelled operations, surgical complications, and extended stays in hospitals – often due to secondary health problems patients face (such as diabetes or obesity) going unaddressed before operations.
- Waiting lists must be turned into preparation lists and the surgical pathway transformed using perioperative care practices.

## The waiting list crisis

Northern Ireland is facing a waiting list crisis, with 120,097 patients waiting for inpatient or day case admission, as of the last quarter or 2021.[1] This is an increase of 14.2% on the same quarter of the previous year.[1] Waiting times are also significantly longer than in the rest of the UK.[1] Health Minister, Robin Swann, has acknowledged that the situation in Northern Ireland has been seriously exacerbated by the COVID-19 pandemic.[2]

To deal with this, two things are necessary: workforce shortages must be addressed (including in anaesthesia), and the surgical pathway must be transformed using perioperative care practices to become more efficient and effective (including by turning waiting lists into preparation lists).

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## Addressing anaesthetic workforce shortages

The anaesthetic workforce is a key part of solving the current waiting list crisis.

Without an anaesthetist, most operations cannot take place. However, while 350 anaesthetists are working in HSC (including consultants and staff grade, associate specialist and specialty – SAS doctors), its own clinical directors say 410 are needed right now – a shortfall of 60.[3]

# Northern Ireland's waiting list crisis: the critical role of anaesthetists

On the basis that the average UK anaesthetist administers 750 anaesthetics per annum, we estimate that the current shortage is preventing 45,000 operations and health procedures from taking place every year in Northern Ireland.[4]

Unfortunately, the **problem is set to get worse**. Due to factors such as an ageing population and increasing demand for surgery, HSC's need for anaesthetists will rise considerably. Furthermore, the number of anaesthetic training places has remained static at 126 for the last three years, which will exacerbate the growing gap between supply and demand.[3,5] Additionally, the anaesthetic workforce in Northern Ireland is itself ageing, with 35% aged over 50, who can be expected to retire over the next decade.[4] The current pension taxation regime also severely disincentivises experienced anaesthetists from remaining in the profession and is a major driver of early retirement.[4]

The current shortfall of
**60 anaesthetists**
is preventing
**45,000 operations**
from taking place every year.

Furthermore, unlike the rest of the UK, HSC does not provide National Clinical Impact Awards (formerly known as Clinical Excellence Awards) – which reward consultants who contribute most to the delivery of safe and high-quality care and the improvement of Health services.[6] These are valuable professional development incentives designed to promote innovative health care improvement and research. The absence of awards in Northern Ireland creates a UK wide pay disparity, as HSC's consultants miss out on NCIA financial rewards ranging from £20,000 to £40,000.[6]

**BY 2040**
Northern Ireland will need
**900**
anaesthetists

It will only have
**500**
anaesthetists
giving a shortfall of
**400**
anaesthetists

This will prevent

**300,000**
operations and health procedures from taking place every year.

It is vital that the anaesthetic workforce is increased. This includes SAS doctors† and consultant anaesthetists, both of which are key to the functioning of every hospital's anaesthetic department.

If Northern Ireland's workforce recruitment and retention issues are not addressed, the incoming Executive will struggle to deliver reduced waiting times for patients. Unless urgent action is taken, our estimates suggest that there will be a shortfall of 400 anaesthetists by 2040,[4] which would prevent 300,000 operations and health procedures from taking place every year.

†SAS doctors include specialty doctors and specialist grade doctors with at least four years of postgraduate training.

It is important to recognise that expanding the anaesthetic workforce alone is not enough. Shortages of other essential health professionals, such as specialist ICM (intensive care medicine) consultants and theatre nurses, will also affect HSC's ability to tackle the waiting list. As of April 2022, there is a shortfall of 12 ICM consultants across HSC hospitals. This means that of the 98 funded ICM consultant positions, only 86 are currently filled. This shortage must be addressed as ICM consultants are a key part of the healthcare workforce.[7] Presently, 93% of ICM consultants hold an anaesthetic training background and the majority of ICM consultants carry out anaesthesia procedures alongside their ICU work.[7]

Nursing staff are key to the delivery of healthcare, and without them operating lists and Intensive Care Units could not function. The Royal College of Nursing Northern Ireland has reported a 'severe shortage' of nursing staff, with 2,666 nursing vacancies in HSC as of December 2021.[8]

The Northern Ireland Health and Social Care Workforce Strategy for 2026 promised to 'sustainably fund an optimum workforce for reconfigured health and social care services,' however, it lacked specific workforce planning projections or targets to recruit and retain staff.[9] This lack of targeted workforce planning has contributed to the insufficient action to meet HSC's current and future workforce needs.

It is imperative that Northern Ireland puts in place and acts upon a comprehensive workforce strategy. This should include clear numerical workforce targets, informed by evidence-based supply and demand projections that cover the period of at least the next two decades.

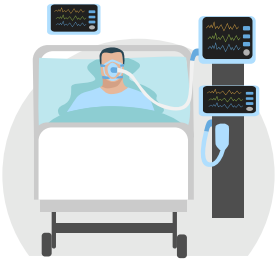
### Northern Ireland needs:

- **A comprehensive health and social care workforce strategy, based on current and projected figures of workforce supply and demand. This should look at both recruitment and retention – and set out specifically how many staff are (and will be) needed, and how those numbers will be achieved.**

## Boosting HSC efficiencies and patient outcomes

In addition to workforce issues, HSC currently faces avoidable inefficiencies in its surgical pathways, which further increase waiting lists and harm patient outcomes.

Across the UK, health services face various problems, including:



10–15% of operations have complications – which are often predictable and potentially preventable.[10]


Within hospitals, 45% of costs can be attributed to 3% of patients – typically those experiencing complications.[11]

Patients often spend one or two days longer than necessary in hospital after surgery due to surgical pathway inefficiencies.

Fortunately, these issues can be addressed. The process of optimising the surgical pathway is often referred to as 'perioperative care.' This covers interventions and processes from the moment someone contemplates surgery all the way to their complete recovery. This timeline includes preoperative care, ie before surgery, intraoperative care, ie during surgery, or on the day of surgery, and postoperative care, ie after surgery.

There are many perioperative interventions, but we will summarise a few key ones below:

## Example 1: turning waiting lists into preparation lists

The healthier someone is before their operation, the lower the chance of last-minute cancellations, surgical complications, or extended postoperative stays in hospital.

Unfortunately, patients' time on waiting lists is often wasted when it could actually be put to good use. Therefore, we recommend the use of 'prehabilitation' programmes. Prehabilitation is a formal programme designed to increase patients' health before surgery through interventions, such as physical exercise, nutritional support, psychological preparation, smoking cessation, and alcohol moderation advice.

Effective prehabilitation can reduce the rate of postoperative complications and a patient's length of stay in hospital. This is of huge importance given the large and growing surgical backlog that HSC faces. An international evidence review commissioned by the Centre for Perioperative Care (CPOC) in 2020 revealed that specific prehabilitative interventions could reduce postoperative complications by 30–80% and reduce the length of stay after surgery by one to two days.[12]

## Example 2: shared decision making

Too often, patients are not included in important decisions about the kind of healthcare interventions they receive or whether to proceed with a certain healthcare intervention at all. This disempowers the most important people in the surgical process, leading to unnecessary operations and surgical regret. In fact, 14% of patients express regret at having an operation,[13] which is bad for them and means that resources which could have been used elsewhere are potentially wasted.

To solve this, HSC should further embed shared decision making into its surgical pathways. This would involve informing patients of the risks and benefits of possible procedures and a discussion of treatment options – including the option not to proceed with surgery.

Research has shown that shared decision making significantly improves patient satisfaction, and many patients decide against surgery following a shared decision making process.[14]

## Example 3: discharge planning

Discharge planning involves a hospital team considering, planning, and in some cases arranging, the support that might be required by the patient upon discharge. Ensuring that appropriate support is available on discharge has been shown to reduce readmissions by 11.5%, which may translate into reduced waiting lists and lower costs for the healthcare system.[15]

# The current situation in Northern Ireland

Northern Ireland has begun introducing perioperative care into HSC, but progress has been limited.

In 2019, two perioperative care regional leads were appointed, and Belfast City Hospital developed a perioperative care fellowship, which has produced three perioperative care fellows. Additionally, in June 2021, HSC cancer care introduced a prehabilitative pathway. However, there is far greater scope for the embedding of perioperative care practices across HSC's wider surgical pathways.

Plenty of advice that HSC could draw on already exists, including the *Perioperative Assessment and Optimisation for Adult Surgery* guidance produced by CPOC.[16]

### Northern Ireland needs:

- **The widespread embedding of perioperative care practices across HSC, including running a comprehensive trial of how various perioperative interventions can be implemented in practice.**
- **The integration of perioperative care into The Regulation and Quality Improvement Authority (RQIA) assessment frameworks to hold hospitals and managers to account on the delivery of services.**

# Summary

We urge all parties in Northern Ireland to adopt our suggestions on how to address HSC's workforce shortages and further embed perioperative care practices into surgical pathways. We believe our recommendations will help HSC tackle some of the key issues it faces, including reducing waiting lists. Taken together, they would benefit HSC as an institution, put its workforce on a sustainable footing, and improve the quality and timeliness of care that patients receive.

For more information please contact advocacy@rcoa.ac.uk

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