Report pursuant to section 3(17-20) of the Northern Ireland (Executive Formation etc) Act 2019

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3 (17): Non-Domestic Renewable Heat Incentive Scheme Hardship Unit

This is a devolved matter. This section of the report is based on information provided by the Northern Ireland Department for the Economy.

Section 3 of the Northern Ireland (Executive Formation etc) Act 2019 requires the Secretary of State to publish a report on the establishment of a Renewable Heat Incentive Hardship Unit in the Department for the Economy.

This section of the report is made in accordance with s.3(17) of that Act which states:

The Secretary of State must, on or before 21 October 2019, publish a report on progress on the establishment of a Renewable Heat Incentive Hardship Unit in the Department for the Economy (unless an Executive has already been formed).

The Northern Ireland Non-Domestic Renewable Heat Incentive Scheme (NIRHI) was introduced in November 2012. The Scheme was designed to increase the uptake of renewable heating technologies by providing ongoing payments to cover the projected difference in cost between renewable heating and fossil fuels, as well as a 12% rate of return on the additional capital cost of a renewable heat boiler.

The original 2012 tariffs and the interim tariffs put in place in 2017 were based on incorrect assumptions, which did not bear out in practice. The Department for the Economy (DfE) commissioned an independent consultant, Ricardo Energy and Environment ('Ricardo'), to undertake a comprehensive review of all the main elements of the tariff and launched a public consultation on the future of the non-domestic RHI Scheme. The review and consultation were used to inform the design of the revised tariffs, which were brought into force by The Northern Ireland (Regional Rates and Energy) Act 2019.

During the passage of the Bill, DfE gave an assurance that it will establish a hardship unit, under an independent chair, that will consider cases of any RHI participant who believes they face hardship as a result of their participation in RHI. DfE repeated its commitment to set up the hardship unit during an evidence session of the Northern Ireland Affairs Committee in May 2019. The following statement sets out the current status and work that has been carried out since that point.

DfE conducted a "Call for evidence" consultation exercise between 17 June and 10 July 2019 to gather information on the nature of hardship experienced as a result of participation in NIRHI, and to seek views from stakeholders on its proposed approach. On 10 October 2019 the Department published its response to the consultation and set out its next steps. This response can be found on the Department's website.

DfE has advised that seventy-eight responses were received, and that the majority of respondents claimed to be in hardship. Only a small minority chose to submit documentary evidence of their circumstances, with many stating that they would prefer to submit such evidence to an independent party rather than to the Department. Many respondents expressed discontent with DfE's proposed approach, and with the limited powers available to the independent chair or panel to offer redress.

DfE has confirmed its commitment to an independently-led consideration of financial hardship as a result of participation in the Northern Ireland RHI scheme. The Department has, therefore, appointed independent energy consultant Andrew Buglass to further consider the issue of hardship.

Mr Buglass will develop a relevant definition of hardship and engage directly with participants to seek evidence of hardship, giving consideration to the individual circumstances of any participants that wish to come forward. Andrew Buglass is expected to report to DfE, with recommendations on any appropriate course of action, before the end of the year.

3 (18): Libel legislation in Northern Ireland

This is a devolved matter. This section of the report is based on information provided by the Northern Ireland Department of Finance.

Section 3 of the Northern Ireland (Executive Formation etc) Act 2019 requires the Secretary of State to publish a report on libel legislation in Northern Ireland.

This section of the report is made in accordance with s.3(18) of that Act which states:

The Secretary of State must, on or before 21 October 2019, publish a report on progress on libel legislation in Northern Ireland and any plans to align Northern Irish legislation with libel legislation in the rest of the United Kingdom (unless an Executive has already been formed).

The Current Legal Position

Responsibility for defamation law in Northern Ireland rests with the Department of Finance (DOF).

Northern Ireland's civil law on defamation, like that of England and Wales, developed over time through common law, supplemented, periodically, by statute. However, the Defamation Act 2013, which changed the law in England and Wales, does not apply in Northern Ireland. Northern Ireland is a separate jurisdiction with its own legislation which chose not to implement the Defamation Act 2013.

As a result, current Northern Ireland defamation law is almost identical to that of England and Wales prior to the 2013 Act. Consequently, in Northern Ireland:

i. Statements alleged to be defamatory are assumed to be both false and hurtful and there is no need for the plaintiff to prove this. (This contrasts with England and Wales where, on account of the 2013 Act, those bringing a defamation action are required to show serious reputational harm or financial loss).

ii. Each publication of a libel is actionable. There is no single publication rule as in England and Wales.

iii. To repeat a defamatory statement is equivalent to having made it. Unlike in England and Wales, there is no limitation of the circumstances in which an action can be brought against a person who is not the primary publisher.

iv. The defences of absolute and qualified privilege have not been extended to cover fair reports of academic conferences or the contents of academic journals.

v. There is some potential for 'libel tourism'—people making a claim for defamation in Northern Ireland, not because it is the most appropriate jurisdiction, but because it is the jurisdiction that might treat the claim most favourably and where the eventual financial settlement might be greatest.

The three usual defences available in Northern Ireland are the common law defences of:

i. Justification—the statement is 'substantially true'.
ii. Honest comment—the statement is a statement of opinion rather than a statement of fact.
iii. Responsible publication on a matter of public interest (the 'Reynolds defence').

In contrast, in England and Wales, the 2013 Act replaced these common law defences with the statutory defences of: truth; honest opinion; and publication on a matter of public interest.

Finally, in Northern Ireland, defamation claims are dealt with by jury trials—a seven member jury. In practice, however, few ever reach full trial and many are, on grounds of complexity, heard by a judge alone. In England and Wales, the 2013 Act removed the presumption in favour of trial by jury.

Steps Currently Being Taken

The Northern Ireland Assembly has not met since early 2017 and there is currently no Northern Ireland Executive. Reform of Northern Ireland's defamation law had been under consideration by the previous Executive and will resume when the devolved institutions are again functioning.

As of 2017, the following steps had been taken with regard to reforming the region's defamation law.

i. At the request of the then Finance Minister, the Northern Ireland Law Commission undertook a twelve week public consultation (November 2014 to February 2015) on the possible reform of Northern Ireland defamation law. This attracted 32 responses, principally from specialists—journalists, lawyers and campaigners—rather than members of the general public. Several respondents (e.g. Google) were not based in Northern Ireland.

ii. A review of consultation findings and the case for reform was undertaken by Professor Andrew Scott, London School of Economics. A report of this review was published in March 2016. It recommended, not a straight replication of the 2013 Act, but a bespoke arrangement drawing on the Act but adapting its provisions to local needs.

The Scott report advised that there was no requirement, under either international or domestic human rights law, to amend current Northern Ireland defamation law. Northern Ireland defamation law, like England and Wales defamation law pre-2013, is fully compliant with the European Charter of Human Rights.

There is no evidence that defamation law in Northern Ireland has inhibited either media scrutiny of local politics or the dissemination of scientific research.

There is little evidence of libel tourism in Northern Ireland. In 2010-2018, there were, on average, 35 Queen's Bench writs for defamation per annum ranging from 19 in 2017 to 54 in 2010. In the period 2014-2018, there were, on average, 30 Queen's Bench writs for defamation in Northern Ireland. As Northern Ireland's current law provides that a claim can be summarily dismissed where no 'real or substantial' tort has occurred, libel tourism would not be straightforward.

3 (19): Protect Life 2 - Strategy for Suicide Prevention in Northern Ireland

This is a devolved matter. This section of the report is based on information provided by the Northern Ireland Department of Health.

Section 3 of the Northern Ireland (Executive Formation etc) Act 2019 requires the Secretary of State to publish a report on the implementation of the Protect Life 2 - Strategy for Suicide Prevention in Northern Ireland.

This section of the report is made in accordance with s.3(19) of that Act which states:

The Secretary of State must, on or before 21 October 2019, publish a report on progress of the implementation of the Protect Life 2 – Strategy for Suicide Prevention in Northern Ireland (unless an Executive has already been formed).

Current legal position

The Protect Life 2 Strategy for Preventing Suicide and Self-harm in Northern Ireland contains actions for a number of Departments and would usually be agreed by the Northern Ireland Executive. In the absence of an Executive, officials applied the guidance on decision making during the period of Northern Ireland Executive formation and concluded that it met the public interest test. Formal agreement was received by Permanent Secretaries across the Northern Ireland Civil Service endorsing the actions and publication of the Strategy. Protect Life 2 was published on 10 September 2019. The Strategy was developed in line with the post-consultation report approved by the former Minister for Health in Northern Ireland in February 2017.

Steps taken to meet the statutory requirement

Protect Life 2 focuses on suicide prevention as a societal issue and seeks to ensure collaborative cross-departmental engagement to address risk factors for suicide and self-harm, as well as engagement across wider society. The strategy sets out what Departments and other stakeholders will do to reduce suicide and self-harm over the next five years and looks at the importance of everyone working together on prevention.

Protect Life 2 contains a range of new and ongoing actions designed to reduce the suicide rate including greater focus on those bereaved by suicide, more support for those who care for others and enhanced working across Departments. Full implementation of the strategy will require additional funding in future years.

The Strategy aims to reduce the suicide rate in Northern Ireland by 10% by 2024, in line with World Health Organisation best practice guidance. Protect Life 2 also ensures suicide prevention services and support are delivered appropriately in deprived areas where suicide and self-harm rates are highest.

Implementation of the Strategy commenced proactively with the launch of three additional programmes through supplementary transformation programme funding.

A Regional Towards Zero Suicide Mental Health Collaborative Programme has been established across all five Health and Social Care (HSC) Trusts. This programme focuses on patient safety to reduce suicide within Adult Mental Health Services.

A Multi Agency Triage Team (MATT) is being delivered in partnership between South Eastern HSC Trust, Belfast HSC Trust, PSNI and the Northern Ireland Ambulance Service and has been operational from July 2018. The project involves two Police Officers, a Community Mental Health Practitioner and a Paramedic working together to respond to people in emotional crisis, aged 18 and over, who have accessed the 999 system.

A Belfast Crisis De-Escalation Service pilot is also underway with community and voluntary staff working directly in Belfast HSC Trust with unscheduled care and Emergency Department teams to accompany clients through the mental health assessment process.

Robust governance arrangements are being set up to drive implementation and delivery of the Strategy. This includes a new Protect Life 2 Steering Group which will initially be chaired by the Chief Medical Officer and thereafter by the Director of Public Health in the Public Health Agency.

Protect Life 2 aims to bring hope, support and clear direction for all involved in suicide prevention in Northern Ireland.

3 (20): NHS waiting lists in NI

This is a devolved matter. This section of the report is based on information provided by the Northern Ireland Department of Health.

Section 3 of the Northern Ireland (Executive Formation etc) Act 2019 requires the Secretary of State to publish a report on NHS waiting lists in Northern Ireland.

This section of the report is made in accordance with s.3(20) of that Act which states:

The Secretary of State must, on or before 21 October 2019, publish a report on an assessment of how much demand there is for elective care services and how this is exceeding health service capacity for both new and existing patients across Northern Ireland, and detailing each of the current measures being taken to reduce health and social care waiting times, as well as those that are planned, and the impact of NHS waiting times on children (unless an Executive has already been formed).

Definition

Elective care is care that is planned in advance as opposed to emergency treatment. Elective care entails planned specialist medical care or surgery, generally following a referral from a primary or community health professional such as a GP.

Demand for elective care services

Overall the demand for hospital based elective care services has increased over the nine year period (2009/10 – 2018/19), however there is fluctuation between individual years:

- Demand for consultant-led new outpatient assessments has risen by 9.3% between 2009/10 and 2018/19, from 483,220 to 527,972. A breakdown by specialty is detailed in Appendix1.
- Demand for inpatient/day case treatment has risen by 2.4% over the same time period, from 247,751 to 253,602. A breakdown by specialty is detailed in Appendix 2.

Even with the use of Waiting List Initiative (WLI) funding, the 2018/19 demand for outpatient assessments exceeded the activity delivered by approximately 22,700 (4.4%). The demand for treatments exceeded the activity delivered by approximately 6,700 (2.7%).

- There is an increasing growth in demand relative to the activity delivered. In 2009/10 the difference between the outpatient demand and activity delivered was approximately 18,000 (3.8%) and the difference in relation to treatments was approximately 3,300 (1.4%)

The core and waiting list initiative activity delivered by consultant led services over this same time period is detailed in Appendix 3 (assessments) and Appendix 4 (IP/DC treatments).

- Consultant-led new outpatient assessments delivered (core and WLI) has risen by 8.6% between 2009/10 and 2018/19, from 465,276 to 505,210.
- Inpatient/day case treatment delivered (core and WLI) has risen by 1% over the same time period, from 244,463 to 246,821. However, it should be noted that this does not take account of the change in casemix and complexity.

Expenditure on elective services for the last two available years averages at £793m.

This activity delivered is less than the demand and as a consequence Elective Care waiting times deteriorated significantly from the second half of 2014/15, due to the wider HSC financial position and the increasing gap between patient demand and funded health service capacity for both assessment and inpatient/day case treatment.

The following table highlights the impact of the capacity and demand gap on waiting lists for both assessments and treatments between 2009/10 and 2018/19.

Table 1: Outpatient and IPDC Waiting Times

Date	NEW OUTPATIENTS				IPDC TREATMENT			
	Total Waiting	Number of patients waiting >9 weeks	Number of patients waiting >26 weeks	Number of patients waiting >52 weeks	Total Waiting	Number of patients waiting >13 weeks	Number of patients waiting >26 weeks	Number of patients waiting >52 weeks
31.3.09	68,755	488	45	not available	32,663	387	47	not available
31.3.10	86,501	8,581	56	not available	36,041	3,252	72	not available
31.3.11	106,206	31,909	6,917	not available	52,880	17,630	4,522	not available
31.3.12	103,029	28,278	not available	not available	50,829	18,109	5,031	not available
31.3.13	99,774	19,764	not available	not available	47,689	14,876	3,309	not available
31.3.14	127,095	39,768	not available	not available	49,341	16,356	4,312	not available
31.3.15	191,777	107,955	not available	not available	57,934	27,780	13,622	not available
31.3.16	215,151	136,036	73,619	24,468	67,898	32,676	17,601	not available
31.3.17	253,093	176,276	113,961	53,113	71,483	40,037	24,553	9,615
31.3.18	269,834	198,296	140,881	83,392	80,570	50,228	33,431	16,454
31.3.19	288,754	213,708	154,234	97,851	87,450	56,871	40,810	22,350

Note: numbers "not available" are due to changes in Ministerial targets and timebands being reported

As indicated above, demand has continued to increase in recent years – significantly outstripping the ability of the HSC to expand capacity to meet patient demand. Regionally in 2019/20, it is estimated that there is a gap between funded core HSC capacity and patient demand of approximately 35,000 new outpatient assessments and 41,000 inpatient/day case treatments.

Measures being taken to reduce health and social care waiting times, as well as those that are planned

Improving waiting times continues to be one of the Department of Health's key priorities. It is accepted that the current model of delivering elective care services in Northern Ireland is not sustainable given the continued increased demand.

The DoH's Elective Care Plan (published in February 2017) sets out the approach to redressing the waiting list crisis through major reform and transformation to sustainably improve elective care services and build capacity in the HSC.

The Elective Care Plan outlines the need for action against 6 commitments. The action plan outlines the need for the development and implementation of new ways of working to meet new intake as well as a focussed effort to reduce the backlog. The scale and pace of action is predicated on additional funding, estimated to be in the region of £750m-£1bn, and available workforce. It is not possible to calculate what additional staffing resource is required across the different clinical teams. The commitments and an overview on progress are set out below:

Improved Waiting Times

- An investment of £30m from the Confidence and Supply Transformation Fund was allocated to the reduction of elective care waiting lists in 2018/19 and a further £16m has been made available this year.
- As result of the £30m investment in 2018/19, approximately 120,000 patients who would otherwise still have been waiting were seen or treated and it is expected that in the region of 64,000 patients will benefit as a result of the additional investment in 2019/20.

Increased Patient Self-management Services

- During 2019, a programme of education sessions has been established to enhance GP/AHP capacity to offer specialist support in a primary care setting, providing up to date and best agreed practice for specific conditions.
- A pain specific section on the MyNI website has gone live to help people self-manage their painful and disabling illnesses.
- Funding for healthy living centres to run support groups for people with painful and disabling illnesses living in socially disadvantaged areas.
- Funding for voluntary organisations to expand the number of self-management courses for people with fibromyalgia in Belfast and Western HSC Trust areas.

Expanded capacity and capability in primary care

- A GP-led non-scalpel vasectomy procedure service has been established in primary care. To date, almost 1,100 procedures, which would otherwise have required a hospital referral, have been carried out.
- GPs are delivering services for photo dermatology triage, gynaecology, muscular skeletal (pain), and enhanced minor surgery, with approximately 7,000 patients treated to date.
- Primary care optometrists are engaged in new initiatives to stem the flow of referrals into hospitals, managing non-sight threatening acute eye problems in the community and carrying out non-complex post-operative cataract reviews, in addition to offering community-based ocular hypertension reviews.

Improved direct access between primary and secondary care

- Clinical Communications Gateway (CCG) allows GPs to both make electronic referrals to secondary care and request advice to facilitate, as appropriate, patients being managed in primary care.
- Electronic triage (e-triage) of referrals allows secondary care teams to provide direct advice on next steps and management, refer directly for investigations or invite patients for an assessment. This ensures patients are seen by the right person, with the right information, at the right time, in the right place – the first time.

Secondary Care Reform and Modernisation

- Work has been ongoing to increase one visit service models in a number of specialties where patients are seen and, where clinically appropriate, have their treatment completed in one visit.
- The development of the Virtual Fracture Clinic has helped reduce demand in fracture clinics by approximately 25% which has helped improve access, reduce waiting times and improve the quality of service provision.

Establishment of Elective Care Centres

- A priority in the transformation agenda is to enable improved access to elective care services by establishing regional centres, known as Day Case Surgery Hubs, to provide a dedicated resource for less complex planned surgery. This new approach will help ensure that patients do not go beyond clinically-indicated review dates, reducing the risk of harm whilst simultaneously freeing capacity in secondary care.
- New prototype day case surgery hubs for varicose vein and cataract procedures have been operational since December 2018 and form part of the long-term plan to reduce waiting lists. In March 2019, the Department announced that the same approach is to be rolled out across a wide range of specialties, meaning the provision of thousands of day case routine operations will be transferred to dedicated sites. This work will help inform a regional model for day case surgery across Northern Ireland.

- It is envisaged this model will be the subject of a public consultation before the end of 2019 and, by December 2020, the aim is to transfer more than 100,000 day cases, 25,000 endoscopy and 8,000 paediatric procedures to the new model.

Impact of NHS waiting times on Children

At the end of June 2019, 8,903 children were waiting more than 9 weeks for a paediatric consultant-led first outpatient appointment. Of these, 2,592 had been waiting longer than 1 year.

In relation to paediatric surgery, at the end of June 2019, 517 children had been waiting longer than 13 weeks and 170 had been waiting longer than a year for inpatient or day case treatment.

The total number of children waiting for inpatient or day case treatment has increased by 494 between 2009/10 and 2018/19, from 276 to 770.

There may also be children waiting to be seen/treated in other specialties; however, these are not published separately.

Appendix 1 - Demand for consultant-led new outpatient assessments

	Fiscal Year									
Korner Speciality	**2009-2010**	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**
Cardiac Surgery	968	1,125	1,086	948	686	683	683	787	730	725
Cardiology	18,694	18,853	18,322	22,103	24,146	24,816	23,980	24,899	24,583	26,812
Chemical Pathology	526	663	624	551	612	533	537	583	538	415
Clinical Genetics	2,563	2,301	1,972	1,584	2,489	2,113	1,737	2,001	1,528	1,925
Clinical Oncology	3,906	3,301	3,711	3,559	3,867	3,390	3,384	3,660	3,752	4,279
Dental Medicine Specialties (Oral Medicine / Restorative)	2290	1560	1391	1610	1548	1551	1157	1486	1425	1299
Dermatology	41,564	40,556	35,733	38,945	40,200	40,181	40,012	41,959	40,544	43,853
Endocrinology	3,044	2,695	2,696	3,718	4,098	4,205	4,958	5,211	5,355	5,357
ENT	50,257	50,045	50,484	52,641	56,029	54,372	50,045	49,992	45,349	44,354
Gastroenterology	*6,750*	*7,953*	*8,977*	*10,620*	*11,872*	*13,590*	*10,409*	*12,810*	*10,957*	*15,279*
General Medicine	*26,718*	*24,197*	*20,493*	*18,756*	*19,009*	*20,430*	*18,730*	*17,195*	*14,840*	*11,285*
Gastro & GMED	**33,468**	**32,150**	**29,470**	**29,376**	**30,881**	**34,020**	**29,139**	**30,005**	**25,797**	**26,564**
General Surgery	71,637	69,527	68,775	70,465	72,401	72,831	71,286	69,683	63,336	67,402
Geriatric Medicine	8,528	7,089	7,309	8,069	8,155	8,715	8,924	8,871	8,737	9,830
Gynaecology	45,799	45,480	46,172	49,099	51,332	49,595	45,414	44,263	43,821	46,553
Haematology (Clinical)	3,562	3,591	3,940	3,995	4,375	4,635	4,445	4,867	4,751	4,914
Nephrology	2,315	2,251	2,391	2,772	2,764	2,839	2,915	2,825	2,767	2,714
Neurology	12,964	12,893	11,688	12,867	14,421	15,659	14,466	14,607	14,501	14,228
Neurosurgery	1,499	1,535	1,489	1,746	1,876	2,101	1,827	2,003	1,916	1,855
Ophthalmology	40,534	39,398	37,166	37,669	40,944	41,671	39,539	39,109	30,868	30,474
Oral Surgery	13,548	13,494	11,795	11,664	13,281	13,147	13,233	12,216	12,542	12,172
Orthodontics	1,712	1,640	1,514	1,576	1,617	1,463	1,551	1,357	1,251	1,289
Paediatric Dentistry	752	605	572	635	786	917	732	732	689	633
Paediatric Neurology	230	278	331	323	264	281	348	442	429	327
Paediatric Surgery	2,691	2,713	2,669	2,635	2,860	2,696	2,397	2,621	2,374	2,301
Paediatrics	17,241	15,338	16,966	21,697	24,890	25,559	26,180	23,174	23,632	22,277
Pain Management	5,485	6,010	6,085	6,022	6,908	7,061	7,821	8,562	6,943	6,724
Palliative Medicine	617	589	570	612	791	873	1,013	679	332	375
Plastic Surgery	7,000	7,376	6,264	6,755	7,617	7,657	7,224	7,712	7,567	7,209
Rehabilitation	1,069	969	494	670	1,049	362	517	473	443	661
Restorative Dentistry	3,708	3,507	3,703	3,654	3,700	3,925	2,720	2,448	2,198	1,892
Rheumatology	10,961	11,384	10,833	12,175	12,265	12,705	11,564	11,079	10,910	11,068
T & O Surgery	56,465	88,454	87,128	91,127	98,522	100,517	99,014	99,727	93,693	99,752
Thoracic Medicine	5,190	5,694	7,586	9,585	9,828	10,343	10,700	11,006	11,551	11,970
Thoracic Surgery	855	721	881	760	632	536	566	635	768	681
Urology	11,578	13,044	13,756	14,140	16,616	13,908	14,727	13,730	11,777	15,088
Total	**483,220**	**506,829**	**495,566**	**525,747**	**562,450**	**565,860**	**544,755**	**543,404**	**507,397**	**527,972**

Appendix 2 - Demand for inpatient and day case treatments

	Fiscal Year									
Korner Speciality	**2009-2010**	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**
Cardiac Surgery	857	781	682	805	815	688	642	880	810	826
Cardiology	9,179	9,934	10,306	10,228	9,750	10,824	10,712	11,268	9,635	10,471
Clinical Oncology	8,338	8,175	7,105	7,303	5,873	4,446	3,190	3,138	3,061	3,591
Dermatology	6,026	5,445	5,636	6,432	6,998	6,364	7,024	6,430	6,364	7,804
Endocrinology	420	404	378	361	339	301	302	330	329	346
ENT	13,336	13,270	13,082	13,670	12,938	12,403	12,590	12,383	11,214	11,588
Gastroenterology	*12,073*	*14,749*	*19,603*	*22,663*	*22,596*	*24,143*	*27,331*	*23,984*	*26,839*	*30,654*
General Medicine	*21,318*	*19,881*	*16,886*	*19,154*	*20,474*	*20,855*	*19,979*	*20,820*	*23,132*	*25,298*
Gastro & GMED								**44,804**	**49,971**	**55,952**
General Surgery	46,818	46,238	46,240	46,802	44,930	45,497	46,183	41,272	41,411	42,491
Geriatric Medicine	-5	-19	6	-10	7	-7	11	-17	-3	3
Gynaecology	17,025	16,014	15,525	14,322	14,682	14,331	14,376	13,604	12,364	12,446
Haematology Clinical	8,626	10,348	10,755	11,236	11,212	12,504	12,035	13,305	12,991	13,903
Medical Oncology	5,766	7,214	5,909	6,375	4,763	2,828	2,570	2,295	2,150	2,001
Nephrology	3,471	4,297	2,515	2,315	2,350	2,378	2,657	2,555	2,415	2,391
Neurology	1,677	1,966	2,285	2,565	2,750	3,032	3,447	3,828	3,393	3,826
Neurosurgery	794	966	1,143	1,178	1,220	1,025	1,159	1,125	1,176	983
Ophthalmology	18,659	17,924	19,811	19,943	18,961	18,791	17,875	17,181	17,080	18,248
Oral Surgery	5,210	4,675	4,700	5,040	4,010	4,441	3,939	3,288	2,997	2,876
Paediatric Dentistry	14	594	268	462	391	471	466	353	373	337
Paediatric Neurology	0	124	112	103	146	122	248	266	312	344
Paediatric Surgery	780	1,667	1,579	1,567	1,372	1,494	1,668	1,475	1,488	1,236
Paediatrics	7,369	1,897	2,149	1,733	2,164	2,386	2,405	2,519	2,416	2,463
Pain Management	4,497	4,273	4,619	5,518	5,777	6,111	5,424	4,128	4,444	3,776
Plastic Surgery	3,937	4,634	3,611	4,523	5,987	5,227	4,287	3,939	4,463	4,830
Rehabilitation	2,512	2,186	1,575	1,550	1,550	1,208	1,001	1,245	1,158	939
Restorative Dentistry	0	0	41	292	217	227	256	282	263	340
Rheumatology	11,265	10,876	10,889	9,345	4,975	4,586	5,192	4,617	4,355	4,480
T & O Surgery	14,869	17,751	15,408	16,987	20,830	19,901	15,957	15,389	15,384	15,506
Thoracic Medicine	1,794	2,086	1,833	1,941	2,185	2,109	2,122	2,080	1,849	1,960
Thoracic Surgery	1,066	1,103	1,116	1,031	1,016	1,091	925	1,005	1,034	1,028
Urology	20,060	21,379	21,446	22,425	25,842	23,986	24,335	25,179	25,327	26,617
Total	**247,751**	**250,832**	**247,213**	**257,859**	**257,120**	**253,763**	**250,308**	**240,146**	**240,224**	**253,602**

Appendix 3 – New Outpatient Activity for Consultant led services

	Fiscal Year									
Korner Speciality	**2009-2010**	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**
Cardiac Surgery	1,001	1,061	1,107	962	694	694	672	781	819	772
Cardiology	17,988	18,364	17,990	21,139	23,331	23,242	23,529	24,537	24,780	24,445
Chemical Pathology	506	685	592	549	599	526	506	564	553	449
Clinical Genetics	2,735	2,328	1,907	1,502	2,227	2,042	1,956	1,906	1,540	1,596
Clinical Oncology	3,921	3,321	3,665	3,527	3,854	3,477	3,371	3,564	3,770	4,234
Dental Medicine Specialties	2,019	1,016	2,009	1,703	1,526	1,509	1,364	1,249	1,082	1,512
Dermatology	40,400	35,636	38,467	40,278	40,374	36,624	41,904	39,099	36,744	37,395
Endocrinology	2,824	2,793	2,570	3,799	3,784	3,907	4,540	5,322	5,529	5,507
ENT	48,245	48,657	48,000	53,277	52,779	46,787	46,823	43,834	42,047	43,208
Gastroenterology	6,340	7,900	8,208	9,567	9,912	9,616	12,709	10,778	10,630	12,819
General Medicine	26,086	23,017	20,970	20,025	19,027	16,649	15,541	15,369	14,385	14,953
Gastro & GMED	**32,426**	**30,917**	**29,178**	**29,592**	**28,939**	**26,265**	**28,250**	**26,147**	**25,015**	**27,772**
General Surgery	70,534	68,744	68,978	69,725	67,764	65,982	68,024	67,207	65,805	65,620
Geriatric Medicine	8,625	7,315	7,074	7,830	8,252	8,447	8,605	8,373	8,544	9,839
Gynaecology	45,066	45,588	46,644	47,568	50,044	44,622	45,848	44,231	43,034	45,140
Haematology (Clinical)	3,475	3,673	3,825	3,986	4,335	4,404	4,481	4,595	4,716	4,608
Nephrology	2,267	2,263	2,392	2,625	2,795	2,763	2,855	2,851	2,825	2,684
Neurology	12,644	10,537	12,275	13,632	12,654	11,767	12,757	11,935	10,864	11,949
Neurosurgery	1,231	1,400	1,860	1,737	1,687	1,810	2,045	2,091	2,004	1,711
Ophthalmology	37,688	35,915	39,641	38,863	36,404	36,117	37,734	32,789	32,230	28,067
Oral Surgery	13,424	10,689	11,799	13,298	12,276	11,626	13,158	9,714	9,440	9,862
Orthodontics	1,697	1,605	1,576	1,522	1,550	1,532	1,461	1,300	1,164	1,296
Paediatric Dentistry	655	538	679	713	552	781	801	626	646	712
Paediatric Neurology	283	277	293	351	231	273	385	432	307	415
Paediatric Surgery	2,676	2,695	2,606	2,618	2,598	2,591	2,771	2,585	2,479	2,217
Paediatrics	16,342	15,245	16,239	21,698	24,388	24,162	24,367	22,092	20,964	21,331
Pain Management	5,049	5,620	6,305	6,045	6,425	6,015	6,661	6,001	6,209	6,896
Palliative Medicine	591	616	550	630	771	875	1,031	675	328	377
Plastic Surgery	6,917	5,625	6,873	7,911	7,576	6,751	6,815	6,209	6,321	7,168
Rehabilitation	1,075	959	485	669	1,047	356	506	469	430	574
Restorative Dentistry	3,802	3,056	3,026	4,431	3,539	3,316	2,884	2,416	1,983	2,498
Rheumatology	10,597	8,926	11,793	13,131	10,919	9,685	10,778	9,533	8,609	9,357
T & O Surgery	51,735	86,563	87,014	88,455	96,079	88,633	92,782	96,325	93,834	99,906
Thoracic Medicine	5,083	5,430	7,152	9,104	8,988	8,938	9,876	9,361	10,184	11,320
Thoracic Surgery	870	722	864	764	601	589	578	595	757	701
Urology	10,885	12,541	12,911	15,093	13,729	11,475	12,380	14,634	14,164	14,072
Total	**465,276**	**481,320**	**498,339**	**528,727**	**533,311**	**498,583**	**522,498**	**504,042**	**489,720**	**505,210**

Appendix 4 - Inpatient and day case activity

	Fiscal Year									
Korner Speciality	**2009-2010**	**2010-2011**	**2011-2012**	**2012-2013**	**2013-2014**	**2014-2015**	**2015-2016**	**2016-2017**	**2017-2018**	**2018-2019**
Cardiac Surgery	826	753	705	796	755	666	794	906	887	741
Cardiology	8,906	9,558	9,561	10,259	10,788	10,194	10,373	10,796	9,846	10,842
Clinical Oncology	8,333	8,173	7,111	7,290	5,870	4,449	3,198	3,110	3,078	3,565
Dermatology	5,651	5,815	5,601	6,339	6,988	6,258	6,770	6,345	6,784	7,512
Endocrinology	425	422	363	360	324	332	306	314	284	298
ENT	13,710	12,501	12,582	13,336	13,256	12,024	11,279	11,015	10,144	9,743
Gastroenterology	*11,532*	*13,508*	*21,440*	*22,356*	*21,528*	*24,025*	*25,153*	*25,798*	*26,610*	*30,019*
General Medicine	*20,918*	*18,820*	*18,950*	*19,741*	*20,573*	*20,135*	*19,413*	*20,992*	*22,400*	*24,969*
Gastro & GMED								**46,790**	**49,010**	**54,988**
General Surgery	46,576	41,939	47,398	47,764	44,920	43,615	43,406	42,488	39,180	41,594
Geriatric Medicine	0	0	0	0	0	0	0	0	0	3
Gynaecology	17,038	14,990	15,200	14,577	14,947	13,975	13,496	13,062	12,639	12,304
Haematology Clinical	8,635	10,345	10,763	11,230	11,214	12,501	12,039	13,285	13,001	13,883
Medical Oncology	5,766	7,214	5,909	6,375	4,762	2,825	2,569	2,292	2,152	1,999
Nephrology	3,493	4,316	2,500	2,317	2,368	2,374	2,630	2,545	2,388	2,390
Neurology	1,625	1,888	2,265	2,612	2,864	2,968	3,233	3,825	3,464	3,748
Neurosurgery	774	942	1,055	1,208	1,247	1,075	1,123	1,206	1,052	958
Ophthalmology	19,053	16,788	18,598	20,055	20,044	18,521	17,011	15,926	14,890	16,986
Oral Surgery	5,111	4,566	4,802	5,063	4,268	3,938	3,756	3,143	3,083	3,110
Paediatric Dentistry	37	508	326	390	467	445	372	395	340	327
Paediatric Neurology	0	124	112	103	146	122	185	299	321	325
Paediatric Surgery	682	1,557	1,485	1,481	1,446	1,464	1,460	1,380	1,327	1,452
Paediatrics	7,392	1,860	2,146	1,741	2,137	2,253	2,477	2,441	2,206	2,448
Pain Management	4,199	3,752	4,405	5,783	5,631	5,132	5,005	4,538	4,409	4,345
Plastic Surgery	3,598	3,756	4,007	5,118	5,927	4,454	4,111	3,878	4,206	4,802
Rehabilitation	2,512	2,185	1,576	1,550	1,549	1,209	1,001	1,245	1,158	939
Restorative Dentistry	0	0	24	244	229	203	242	270	286	295
Rheumatology	11,045	10,615	11,042	9,469	4,955	4,773	5,234	4,554	4,345	4,460
T & O Surgery	14,051	14,538	14,850	16,791	19,029	18,035	16,762	13,304	13,422	14,100
Thoracic Medicine	1,786	2,126	1,827	1,911	2,183	2,107	2,130	2,082	1,838	1,929
Thoracic Surgery	1,077	1,069	1,052	1,062	1,059	1,079	954	961	969	911
Urology	19,712	19,240	21,633	23,683	24,414	24,019	24,012	24,223	24,270	25,824
Total	**244,463**	**233,868**	**249,288**	**261,004**	**255,888**	**245,170**	**240,494**	**236,618**	**230,979**	**246,821**