

A Wait on your Mind?



A realistic proposal for tackling the elective backlog

Robert Ede and Sean Phillips

Preface from Professor Sir Bruce Keogh

Foreword by Rt Hon Stephen Dorrell



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 - Simon Tarry, Managing Director, UK, Ireland and the Nordics, Smith+Nephew;
 - Catherine Wrigley, Policy and Public Affairs Manager, Royal College of Surgeons,

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Endorsements

Dr Charlotte Augst, Chief Executive, National Voices;

Through our 180 members, health and care charities large and small, we hear how desperate the situation is for many people who are waiting for care, and whose lives are often on hold – with impacts ranging from mental ill health, to loss of mobility, to needing to leave work.

This report is a welcome reminder that this issue needs to be taken seriously by policy makers and system leaders – and that the whole health and care system needs to work together to enable access to care, but also to support those people who will unavoidably wait. People need to be supported practically, emotionally and with much better information and communication.

David Hare, Chief Executive of the Independent Healthcare Providers Network;

With the public consistently stating that bringing down waiting lists is their number one priority for the NHS, this timely report from Policy Exchange makes a number of important recommendations on how to improve patient access to care.

And while there's no silver bullet to tackling the elective care backlog, putting patients at the heart of their care and ensuring they can make informed decisions about their treatment, as well as strengthening NHS/independent sector partnerships which have been so successful during the pandemic, will undoubtedly be key to driving down waiting times both now and in the years to come.

Dr Andy Jones, Chief Executive Officer – Ramsay Health Care UK;

Ensuring access to high quality care for patients at the right place and right time is the responsibility of the whole healthcare community not just the NHS, and efficient management of our waiting lists unlocks benefits across all parts of the health system. The scale of the problem is vast and requires immediate action, this report helps to provide realistic proposals for how to tackle the backlog and ensure that the patient is always kept at the centre of the decisions made.

Tracey Loftis, the Head of Policy and Public Affairs at Versus Arthritis;

Versus Arthritis welcomes this report, which highlights the significant impact that waiting for treatment has on the quality of life of people on long waiting lists and the need for Government and the NHS to prioritise reducing the backlog of elective surgery.

In addition, taking better care of those waiting for surgery will help reduce the pressures on the NHS in the long run, especially as longer waits could reduce the chances of future operations being successful.

That is why we are pleased that Policy Exchange has highlighted our call for a package of support for people with arthritis while they wait, which should include clear communication about where people are on waiting lists, advice about pain management, access to physical activity programmes and mental health support.

Professor Neil Mortensen, President of the Royal College of Surgeons of England;

With more than 5.3 million on the waiting list, innovative solutions and investment are sorely needed. Policy Exchange are right to highlight that surgical hubs are one part of the answer. We urge every Integrated Care System (ICS) in England to identify at least one 'surgical hub' where planned surgery can continue, with COVID cases now rising again.

Miles Sibley, Director, The Patient Experience Library;

It is common knowledge that backlogs in elective care are a major problem for the NHS, with more than 5 million people now on waiting lists across England.

So we welcome this report from the Policy Exchange, especially since patient experience emerges as a central theme.

We endorse the report's recommendation that "All GPs should be actively encouraged to access tools such as the new Patient Experience Library waiting time tool". And we look forward to seeing all parts of the healthcare system - with patients - taking up the wider recommendations of this report.

Simon Tarry, Managing Director, UK, Ireland and the Nordics, Smith+Nephew;

With the NHS elective procedure backlog growing, at Smith+Nephew we have been considering how we can assist patients, the NHS and clinicians. Policy Exchange has taken a collaborative solution-based approach and we welcomed the opportunity to provide support.

Andrew Goddard, president of the Royal College of Physicians;

When we asked them a year ago how long it would take for the NHS to get back on an ‘even keel’, 70% of physician specialties said it would take over a year and two fifths more than 18 months. Fast forward to April 2021, and 60% of our members said it would take at least another 18 months — and half of those said more than two years. So the fact the majority of people waiting for care haven’t even been diagnosed is no real surprise. But it does show what we and others have been saying for years: the NHS is significantly under-resourced. Expanding the health and care workforce is key to ensuring that in the long term the NHS can meet patient demand.

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Preface

Professor Sir Bruce Keogh

Chair, Birmingham Women's & Children's NHS Foundation Trust

Former National Medical Director (2007-18)

Tested by the pandemic the NHS lived up to the expectations of the opening paragraph of the NHS constitution:

"The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most."

But while people gathered in the streets to applaud the NHS as it grappled with the biggest healthcare crisis in living memory, many families were quietly worried about when they would get less urgent treatment. Some people sat on evolving symptoms with fear or uncertainty in the absence of a diagnosis, while others lived with pain and discomfort awaiting procedures postponed for an indeterminate period. Whilst a tolerant British public played their part in reducing demand for non-COVID services, that tolerance must be repaid or it will wane with the pandemic, as families pay a very personal price for delays in diagnosis and treatment.

Intolerable waiting lists are back. This is our next big test. We have seen dreadful waiting times before. They were the accepted norm, but they were addressed through a clear set of financially supported policy initiatives in the 1990s and 2000s. Their success allowed the NHS to focus on quality of care rather than simply access to care. Consequently, both the public and NHS staff have now seen better and expect better.

The upside of the pandemic is that it has unleashed innovation in both science and service delivery at a speed and magnitude we couldn't have imagined. This should give us confidence that with pragmatic policy, the right balance between central and local leadership, the application of emerging technologies and harnessing the knowledge and intellectual capital of staff on the front line that the NHS can solve the backlog problem. Achieving the right balance will not be easy. Everyone has a view, with differing perspectives on feasibility, affordability and accountability. This report builds on the lessons and experience of a wide spectrum of people in healthcare and offers some very credible policy proposals and practical suggestions.

I have some particular considerations. Firstly, we must be vigilant to avoid sacrificing quality of care in our enthusiasm to achieve numerical

targets. Secondly, we must not underestimate the personal and professional tensions that will emerge when trying to balance admissions between patients who have waited a long time and some urgent patients, particularly in specialties where waiting lists carry significant risks. Thirdly, if we are to address the social and healthcare needs and expectations of a different population facing a very different set of issues to 1948, we must address the hugely frustrating administrative, financial and philosophical fracture between the NHS and social care. This will have the added benefit of reducing pressure on the NHS by reducing bed occupancy and freeing up capacity for elective care. Finally, if we are to meet the expectations of the NHS Constitution we must be much more compassionate than we were in the 1990s by supporting people as much as possible to “*keep physically and mentally well*” while they wait.

Foreword

Rt Hon Stephen Dorrell

Secretary of State for Health 1995-1997

This report is required reading for anyone who cares about the future of the NHS. As we look beyond the first phase of the Covid pandemic it addresses head-on the next set of challenges which face the service and offers valuable pointers about how those challenges should be addressed.

It responds directly to the challenge set out by Simon Stevens in April when he said that the NHS needs to “think very innovatively, and potentially very radically, about how to redesign some of those care pathways into the health service – rather than just return to the same old ways of doing things”.

That is the heart of the matter.

There are numerous reasons why simply “returning to the same old ways of doing things” is not a workable option.

The first is the question of capacity. Quite apart from its effect on waiting lists, the pandemic has created new demands for both acute and long term care; when that additional demand is linked to the continuing need for effective infection control in care settings and the need to address lengthening waiting lists the capacity issue is obvious.

The capacity issue is compounded by the staffing issue. It is easy to set demanding performance targets and call for additional funding; neither of these “solutions” solve anything for a service whose workforce has been stretched to breaking point by the pressures of the past 18 months and which operates in a sector in which there is a worldwide shortage of skills. While the report rightly calls for the NHS to continue to be a welcoming employer of professional people from abroad (and to continue to contribute to that global talent pool) a realistic elective recovery plan must recognize that dedicated healthcare professionals will remain a scarce and valuable resource.

But the most important reason why “returning to the old ways of doing things” should be dismissed as an option – even if it is realistic, which it isn’t – is that it would miss a golden opportunity to deliver better value and higher quality care,

The key to elective recovery is not working harder, it is working smarter – which in this context means rethinking care pathways to take advantage of the opportunities created by new technologies.

The report rightly emphasizes the role of improved access to diagnostics linked to the changing shape of primary care, coordinated by PCN’s and facilitated by improved digital infrastructure. The precise application of these factors will vary by specialty, and needs to evolve in the light of

experience, but the combination provides a powerful engine of change, and the report offers some valuable insight into the opportunities which they create.

The report also highlights the importance of improved communication with patients. In an age when Amazon can send a message which predicts to within two hours the time of delivery of a parcel sent from the Far East to your home, it is humiliating that the NHS is unable to offer any meaningful guidance on when it will be able to treat your painful or life limiting condition. “Millions of patients are being kept in the dark about when they will be treated and how long they must wait – we cannot let this continue. After Covid, as waiting lists grow, the NHS needs a transparency revolution.

It is this combination of improved care pathways and improved information for patients which lies at the heart of the report. There is an obvious requirement to ensure that proper provision is made for patients with limited or no digital access, but the report is right to argue that these technologies provide an opportunity to address health inequalities which have been significantly compounded by the pandemic.

The report also makes a series of valuable suggestions for improved management process and public accountability – but the essence is its call for the NHS to seize the moment and apply the same open-minded radicalism to rethinking elective care pathways that it has demonstrated in its response to the pandemic.

There are few challenges which are more important – for the NHS or for a Government which will held to account for its oft-repeated promise to “build back better”.

Key Messages

- **The current state of the waiting list in England is politically unacceptable.** Polling on healthcare priorities shows access to routine services is the number one public concern. More than 5.3 million people in England are awaiting treatment, and there are likely to be significant volumes of patients who have not yet been referred. There are also significant divides across the country (both geographic and between groups) in access to high-performing services. With an uncertain winter ahead, things will get worse before they get better. As other countries return to pre-pandemic waiting time performance, the risk is that the NHS becomes an international outlier. Averting this looming disaster will require multi-year investment but should also be characterised as a moment for reform.
- **Prioritising elective care need not ‘hurt’ other parts of the NHS.** Indeed, the inverse can be true. Failing to make headway on the backlog will increase emergency admissions, and place additional burden on services such as mental health and primary care as people experience the trauma of a long and uncertain wait.
- **Operational transparency must improve.** Current clinical prioritisation and waiting times are hidden from patients. Few are informed about their likely wait time, how this compares to their rights as set out in the NHS constitution, or how the new prioritisation methodology (P1-P4) is being applied to their case. The ‘consumer’ of the service is being left in limbo, with limited support whilst they wait. There is evidence that the existing approach is also cementing health inequalities.
- **Out of the current waiting list, more than 4.2 million (80%) are awaiting a decision on treatment.** This represents an enormous unknown clinical risk for the NHS that is even greater than long waiters. One-fifth of all cancer diagnoses are picked up through a non-cancer referral from general practice.¹ The incentives in planned care require urgent adjustment to give adequate prioritisation to receiving a timely diagnosis.
- **Linked to the point above, the NHS must scale up elective diagnostic capacity significantly.** Transformation will require increased capital investment – we suggest that £1.3bn in new funding is made available, which combined with existing commitments would amount to a £1.5bn package bringing diagnostic capacity in line with the OECD average. This should

1. Many of these patients will eventually be diagnosed in hospital following a long delay, by which point their cancer will be more advanced

be viewed as an investment for the future, as aggregate demand for MRI, CT and new types of scanning technology rise over time. The funding would be made available in tranches, commencing at the upcoming spending review, and should be accompanied by service transformation. We must grasp this once-in-a-generation opportunity to push most planned diagnostics into community settings. The remit of these community diagnostic hubs should be expanded over time to include the provision of a wider range of services.

- **An elective workforce plan will be required.** This must begin with a massive expansion of the imaging workforce to staff the new diagnostic capacity – with an additional 2,000 radiologists and 4,000 radiographers required. In the immediate term, additional data managers should also be hired to improve the quality of the data on hospital waiting lists. The Government must also think carefully about how to best reward and safeguard the wellbeing of staff tasked with tackling the enormous backlog of procedures. Wider workforce planning will also be required but is not addressed in this report.
- **The NHS must adopt an innovation-mindset across the elective pathway.** Technologies already exist which can reduce inappropriate referrals from general practice, reduce the time taken to achieve a diagnosis, and speed-up patient throughput. Yet perverse incentives are preventing adoption within the NHS. These must now be rolled out at scale. Current ‘incomplete pathways’ should become a window of opportunity for proven clinical interventions that reduce the risk of condition deterioration. New technologies should be accompanied by shifts in culture behaviour – such as the movement towards self-referral for follow up. Many innovative approaches are being trialled as part of the ‘elective accelerator’ programme. It is important that the successes and failures of this £160m programme are publicly reported so that the best performing solutions can be used widely.
- **Immediate opportunities to innovate exist on the demand side.** We need to empower patients to become demanding consumers. This must begin with giving patients more information and more ability to manage as much of their own patient journey as possible. The NHS should embrace the public appetite for digital solutions, boosted over the past 18 months, by investing in an NHS-led digital offer to support patients on the waiting list. These services should be incorporated within the NHS App and could include appointment scheduling, list status, signposting to wider services to better manage and support patients. The booking system for the vaccine programme sets the minimum expectation. This strategy should include a package to support the digitally excluded, and supplement, rather than replace measures to bring total waiting times down, boosting a consumer-driven approach.

- **The NHS must become relentless in increasing productivity and patient throughput in treatment.** The initial focus for elective recovery should be on meeting ambitious activity targets by using all capacity in this system. Leaders in the NHS should avoid the temptation to produce another strategy or create a working group, as this may distract from the task at hand. Achieving this will require the more effective deployment of the independent sector as part of a national elective recovery plan, with long-term, volume-based contracts negotiated to ensure value for the taxpayer. Surgical hubs should be rolled out for certain clinical specialisms. Regular reviews should be undertaken to ensure that the relaxing of the current infection control and self-isolation requirements at 'green' sites takes place at the earliest moment.
- **The NHS Bill is unlikely to help.** We welcome efforts to better integrate health and social care so that patients receive a more joined up service. But we have concerns that the Health and Care White Paper and subsequent legislation will consume vast amounts of managerial and change capacity in the NHS over the coming 18 months, whilst offering little remedy to the number one problem facing the health service. As the Bill is brought before Parliament, we recommend that specific consideration should be given for elective recovery within upcoming debates and amendments.
- **Targets and performance management need to be deployed carefully.** The challenge facing the NHS is reminiscent of the 2000s, but new tactics are required. Broadly the Referral to treatment (RTT) target should remain, given its importance for maintaining public confidence in the NHS. However, this should become a 'split' 18-week standard to encourage swifter diagnosis within 8 weeks. The new, more ambitious target should be accompanied by a package of support for the worst performing systems, including direct assistance to improve data management. A sanction regime may ultimately be required but must be deployed in a focused way.

Executive Summary

One in ten people in England – over 5.3 million – are now waiting for a routine procedure in the NHS (often described as elective or planned care). For many, that wait will number several months or years and the total number of people waiting will grow substantially over the next 12 months, as a proportion of the 7.5 million people who did not seek treatment during the pandemic are referred by general practice.

The final scale of the challenge remains to be seen. Even optimistic scenarios forecast that the size of the waiting list will approach eight million people by December 2021 and take between five and nine years to be fully addressed.

Tackling the elective backlog represents not just a challenge for the NHS, but a salient political issue, with access to routine services defined in recent polling as the public's number one priority for the healthcare service in the wake of the pandemic. The waiting list has already been identified by the new Health Secretary as one of his top two priorities and will be top of the in-tray of the incoming NHS England Chief Executive.² This has prompted a fierce debate about the policy and management solutions required.

Some are concerned that a focus on the planned care will be to the detriment of the wider NHS agenda. Yet we argue the inverse is true. Failing to make headway on the backlog will increase emergency admissions, which are already experiencing higher than usual demand for summer months. It will also place additional burden on services such as mental health and primary care as people experience the trauma of a long and uncertain wait.

The voice of the consumer – the person waiting for treatment – remains underrepresented in the national debate. It does not have to be that way. We argue that addressing the backlog from the patient's perspective could positively transform our existing approach to planned care – which has remained largely unchanged in decades.

For both the NHS and the Government, the narrative must not be that the backlog was simply addressed, but that opportunities were taken to do things differently, including embracing proven technology-led innovations, empowering consumers, and addressing health inequalities along the way. For there will be no recovery until activity exceeds demand.

This research looks at the entirety of the patient pathway and proposes a package of policy recommendations. These range from how to best address the bottleneck in general practice and diagnostics, to the method of clinical prioritisation, the communication with the patient, the role for

2. Sajid Javid, 'The economic arguments for opening up Britain are well known. But, for me, the health case is equally compelling', *Daily Mail*, 3 July 2021, [link](#)

pre-habilitation, and then finally considers the policy framework which should underpin an expansion in elective care capacity over the medium term.

These recommendations include:

In General practice

- **Primary Care Networks should have a more enhanced role in waiting list management.** New Care Coordinators should support patients facing long waits in pain for elective treatment.
- **GPs should provide more information to patients seeking elective care.** All GPs should be actively encouraged to access tools such as the new Patient Experience Library waiting time tool and the electronic referral system.

In Diagnosis and Treatment

- **The Government should release new capital funding for diagnostics.** The UK Government should announce a £1.3bn package for the diagnostics sector, which combined with existing funding would bring NHS capacity in line with the OECD average. This would be delivered in tranches over the next three years, commencing with £500m at the upcoming Comprehensive Spending Review.
- **The Government and NHS should reform the sanction regime.** The current operational policy standard should be replaced over time with a series of fines for ICSs who are unable to give patients a diagnosis/treatment decision within eight weeks of initial referral.
- **The NHS should better manage and share diagnostic capacity.** A series of short-term, 'mutual aid' measures should be implemented to ensure the optimal use of diagnostic capacity given existing bottlenecks in the system. This could be achieved either through working at provider collaborative or ICS level or by working with independent sector colleagues across geographies.
- **Review Infection, Prevention and Control (IPC) guidance and self-isolation periods at 'green' sites.** A relaxation of the current guidance at 'covid-free' sites will give much greater flexibility; enabling cancellation slots to be filled at short notice by willing patients, whilst also increasing the volume of procedures conducted in theatre. This needs to be balanced by the evidence of continued nosocomial transmission.
- **An expansion of surgical hubs could provide benefits for addressing the backlog.** We believe that surgical hubs may provide part of the answer for elective recovery in certain clinical specialisms where there are already lengthy waits including ophthalmology, orthopaedics, and cancer surgery, and may help to optimise infection control. The expectation should be for these hubs to set up to facilitate three session days and seven-day working and with appropriate transportation provided for patients

travelling the greatest distances.

- **The NHS should ensure the benefits of service transformation are shared equitably.** Hubs for high volume, low-risk activity should not be at the cost of a reduced quality of service for higher risk patients, who are often older, multimorbid and frail.
- **The NHS should make better use of existing independent sector capacity.** Any agreement with the independent sector should be volume-based, comprehensive and give adequate investor confidence and ensure best value for the taxpayer. A long-term approach could include reviewing the current Increasing Capacity Framework, and National Tariff prices to ensure the correct incentives are in place for IS providers to deliver an appropriate proportion of NHS work. The principles of ensuring that treatment remains free at the point of delivery must be upheld.
- **An Elective Innovation Mandate should be established.** Rather than proving cost savings alone, a fund should be established to fast-track solutions which demonstrate the greatest potential to tackle the backlog in high-priority specialisms. This scheme could be modelled on the recently announced MedTech Mandate from NHS England, but would also benefit from being a part of a future DHSC coordinated scheme.

Data, management, and prioritisation

- **RTT figures should be reformed.** Patients should expect to receive a diagnosis within eight weeks (to be known as ‘referral to decision’), before then seeking to commence consultant-led treatment within ten weeks following diagnosis (‘decision to treatment’). This means that the total 18-week target will remain unchanged, but two deadlines will be imposed to incentivise Trusts to shorten the time taken to give every patient a diagnosis. This will be more straightforward to implement than any wider reforms linked to the Clinically-Led Review of NHS Access Standards.
- **Systems with the worst elective waiting times should receive additional managerial support for the next two years.** Whilst unfashionable, investment in appropriate administrative software and additional 100 elective data specialists who are trained in appropriate data and waiting list management will be required to ensure that the waiting list information is of sufficient quality. Evidence provided to this research suggests that 5-15% of data on the waiting list may be duplicate entries or errors, so manual validation is required with quality differing vastly from trust to trust. (details of the wider recommendation are included under ‘workforce’)
- **Greater transparency around the use of clinical prioritisation methodologies is required. This should apply at two levels:**
 - **Nationally.** As part of the monthly RTT statistical release, NHS

England should request for Trusts to include the proportion of patients within each of the current P1-4 categories (or whichever approach replaces this over time).

- **Patient level.** Individual patients should have an informed discussion with their physician regarding their prioritisation level, with the reasoning and methodology explained to them in a way they will understand.

Patient communication and experience

- **The NHS must urgently enhance patient communication.** In a move to greater operational transparency, NHS Trusts should rapidly invest in developing patient-centred information and communication materials. Policy Exchange support the recommendations for better communication as set out in the National Voices report, *Patient Noun, Adjective*.²⁵
- **Greater honesty in conversations with the longest waiters is required.** Where revalidation means a wait longer than 52 weeks, a communication strategy which is candid but sensitive must take priority.¹¹⁸ These communications with patients should set clarify the patient's right and all options, including the right to seek treatment with another provider, and self-funding care.
- **Invest in a priority NHS-led digital offer to support patients on the waiting list.** These services could include appointment scheduling, list status, signposting to wider services, and made available through the NHS App. Mock ups of how this could look are shown on page 56.
- **The NHS should ensure signposting patients to appropriate peer support becomes more commonplace,** drawing upon expertise within the voluntary sector.

Patient preparation and post-operative recovery

- **The NHS should rollout the best digital tools to support patients waiting.** As part of investment in an NHS-led digital offer (to be made available through the NHS App which has had over 1.3 million new registrants since early May 2021) the digital offer should signpost patients to information, exercises, and further support to assist with their preparation and recovery.
- **The NHS should profile and promote best practice in Playbooks.** Emulating the playbook model adopted by NHSx, NHS England should establish a national profile of leading approaches and initiatives, both from within the NHS and beyond such as the resources being developed by the Centre for Perioperative Care (CPOC).

Workforce

- **The NHS and Government should commence a massive expansion of the imaging workforce to staff the new diagnostic capacity** – with an additional 2,000 radiologists and 4,000 radiographers required. In the immediate term, additional data managers should also be hired to improve the quality of the data on hospital waiting lists. The Government must also think carefully about how to best reward and safeguard the well-being of staff tasked with tackling the enormous backlog of procedures.
- **Prioritise training for specialisms with the greatest need in elective care.** The Government and Health Education England (HEE) should work together to ensure training pathways in specialisms currently understaffed or with outstanding need in elective care are adequately resourced and that training places are prioritised. DHSC should look to build upon the £30 million recently made available for HEE to trusts help plan for additional training and to deliver one-to-one training where needed.
- **The Government should bring forward a national workforce strategy.** A holistic, long-term workforce strategy is required which must account for the prospect of experienced staff exiting the profession as well as encouraging new entrants. As part of this, the NHS should remain open to global recruitment.
- **Build up data management skills within the NHS.** 100 additional specialist data managers who have waiting list management skills will be required to ensure that the list information is of sufficient quality. Policy Exchange propose that a fund of £12m is made available for these positions (at NHS Band 8a-8b), which would be on a 24-month FTC basis.
- **Consider how a freeze or cut to the lifetime allowance will impact the medical workforce.** The current freeze on the lifetime allowance has been cited as a causal factor in surgeons and consultants seeking early retirement or reducing their NHS workload. The Government should consider the ‘spill-over’ effects of any changes to the lifetime allowance at the next fiscal event.

Policy, funding and incentives

- **The Health and Care Bill should give adequate consideration for elective recovery.** We are worried that the implementation of the legislation will consume managerial and change capacity in the NHS over the next 18 months, and that the new structures may inhibit the fastest route to elective recovery. The Government should therefore clearly show how the Bill supports the return to the 18-week RTT as set out in the NHS Constitution.
- **The NHS elective recovery framework should be structured based on activity delivered.** A focus on payment-by-results will remain important for the next few years and should be a key negotiation point for HM Treasury at the spending review.

Assuming that IPC guidance and self-isolation requirements can be scaled back substantially, Policy Exchange propose that the upcoming operational planning guidance period from October 2021-March 2022 sets the following thresholds for ICSs:

- **Inpatient activity:** 90% compared to 2019 baseline by October 2021, rising to 100% by January 2022
- **Outpatient activity:** 120% compared to 2019 baseline (reflecting the opportunities for greater use of remote and digital technologies)
- **The Government should offer additional carrots (and sticks) to drive the recovery. These could include:**
 - **Long-term funding agreements for planned care.** The upcoming spending review should include a multi-year commitment towards the recovery of planned care over this Parliament.
 - **Enhanced accountability.** To ensure adequate oversight, NHS England should be required to undertake quarterly reporting back to both Ministers and Parliament outlining the volume and spend of diagnoses, procedures and treatments undertaken.
 - **Additional incentives for meeting the new referral to decision target.** Payments would be made available from the elective recovery fund for ICSs which show substantial improvement in bringing waiting times for a referral to decision down towards the proposed eight-week target.
 - **Uplifting the national tariff for clinical specialisms with the longest waits.** This would reflect the requirement to achieve a 'pincer movement' on both undiagnosed referrals and those waiting 52 weeks plus. This could offer in the region of 120% of NHS tariff prices for a fixed period, to act as an incentive to Providers (including the Independent Sector). Trusts would need to meet the minimum activity thresholds set above to qualify for these payments.
 - **A regular annual inspection regime.** Whilst we believe that a financial settlement for the elective recovery should be long-term, this should be accompanied by annual inspections, and ongoing monitoring to ensure that guidance and policy frameworks from central Government and NHS England are being implemented.

Our elective recovery plan on a page

Phase	General Practice	Diagnosis	Treatment	Data, Management and Prioritisation	Patient Communication, Preparation & Recovery	Workforce	Policy, Funding and Incentives
1	Expand role of Network Care Coordinators in Elective Pathways	Invest £1.3bn in capital funding to boost diagnostic capacity	Review Infection, Prevention and Control (IPC) guidance at 'green' sites	Current 18-week RTT standard should be 'split' with 8-week target introduced for 'referral to decision' to incentivise swifter diagnosis	Urgently enhance patient communication to boost operational transparency	Recruit 2,000 radiologists and 4,000 radiographers to staff additional diagnostic capacity	Agree a multi-year, activity-based elective recovery deal at the upcoming CSR
2	Encourage GPs to make greater use of tools and technology-led solutions to improve the quality of referrals	Introduce 'Mutual Aid' measures to share diagnostic capacity	Expansion of surgical hub model across appropriate specialisms	ICSs with worst waiting times should receive additional managerial and admin support for two years	Expand services offered by the NHS App, such as the ability to access waiting time information and support services	Establish £12m fund to hire additional data managers in NHS to improve quality of waiting lists	Introduce incentives for meeting the new 'referral to decision' target
3		Reform sanction regime, with penalties introduced for failing to reach diagnosis targets	Ensure efficient use of independent sector capacity by reviewing ICF and National Tariff	Greater transparency for patients concerning clinical prioritisation methodologies. Trusts should also report proportion of patients in each P1-4 category	Signpost patients to appropriate support whilst they wait, and draw upon expertise in voluntary sector	Prioritise investment and support for training in specialisms with the greatest backlogs	Uplift national tariff for clinical specialisms with the longest waits
3			Establish an 'Elective Innovation Mandate'		Profile best practices of elective recovery in the NHS (as well as third sector) through Playbooks	Ensure planned care is a priority within a national workforce strategy	Introduce an annual inspection regime and enhanced Ministerial and Parliamentary oversight as part of Health & Call Bill

Introduction

The Scale of the Challenge

One in ten people in England – over 5.3 million – are now waiting for a routine procedure in the NHS (often described as elective or planned care).³ For many of these people, the wait will number several months or years. And the total number of people waiting will grow substantially over the next 12 months, as a proportion of the 7.5 million people who did not seek treatment during the pandemic start to be referred by general practice.

The final scale of the elective backlog remains to be seen. In the 2000s, when spiralling waits for treatment necessitated action, those planning capacity were able to do so with greater certainty compared to the present day. The current environment makes accurate forecasting exceptionally hard. No-one knows how many of the ‘missing’ referrals will return and the impact of a possible third wave of covid infections as restrictions ease remains unclear.

All that we know is that things will get much worse before they get better. Even under more optimistic scenarios, the size of the waiting list will approach eight million by this December and take between five and nine years to be fully addressed.⁴

This has prompted a fierce debate about the policy and management solutions required. Yet the voice of the consumer – the person waiting for treatment or support – remains underrepresented in the conversation. It does not have to be that way, and this report sets out a new approach as part of a detailed proposal for dealing with the elective backlog.

The Consumer is right? Finding the right terminology

In this report we have chosen to adopt the terminology of the consumer when we talk about patients. We think this is useful for two reasons.

1. Too much of the current policy debate about elective recovery is focused on the producers of healthcare services. The ‘consumer’ of the services is side-lined in the conversation.
2. COVID has shattered ideas around realistic expectation of our public services. There is an opportunity to have more grown-up conversations, including between the NHS and the individual. In the context of average waits at historic highs, we need to be willing to move from ‘grateful patient’ to ‘empowered consumer’.

3. As of the latest Referral to Treatment Waiting Times (RTT) which are published monthly by NHS England. Latest figures cover period up to May 2021, [link](#)

4. Rob Findlay, ‘Analysis: the long road to restoring elective care performance’, *Health Service Journal*, 7 May 2021, [link](#)

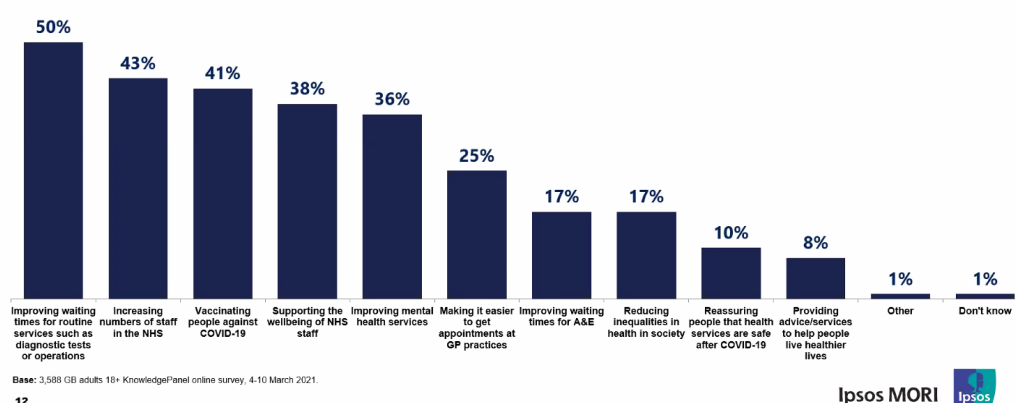
The research looks at the entirety of the patient pathway, from how to best address the bottleneck in general practice and diagnostics, to the method of clinical prioritisation, the communication with the patient, the role for pre-habilitation, and then finally considers the policy framework which should support a return to full elective capacity at the earliest moment. For there will be no recovery until activity exceeds demand. We also explore issues such as workforce shortages and incentives which are likely to be among the biggest constraints.

Chapter One: Can we Learn from History?

Access to routine healthcare services will be the defining NHS challenge in the run up to the next general election. Public polling undertaken by Ipsos MORI for the Health Foundation finds that improving waiting times for services such as diagnostic tests or operations is the number one public concern (see Figure 1).

Figure 1: Public poll of priorities regarding NHS and social care.

Q. Thinking about when the impact of the COVID-19 pandemic has eased, when it comes to the NHS, which two or three of the following do you think should be prioritised?



Source: Ipsos MORI, April 2021

Given the higher proportion of people who are now waiting for an operation – some suggest it will soon be one in eight – the issue will rise in public consciousness. Alongside this, monthly releases of the Referral to Treatment (RTT) figures have created a regular reminder of whether the NHS's performance against waiting times is improving or getting worse.

Over the past eight weeks there are signs of demand starting to return. For the first time since the pandemic, the number of patients being referred onto the waiting list is higher than the equivalent month last year. In the latest figures for May 2021, 1,514,939 people were added to the waiting list (termed 'clock starts') compared to 625,320 in the same month in 2020.⁵

The number of new referrals are still around 15% below pre-COVID years, suggesting that the 'pent up' demand has yet to fully return to the system. This is not cause for celebration. The patients have not

5. Gooroo Ltd (now part of Insource Ltd) analysis of the NHS England RTT Figures

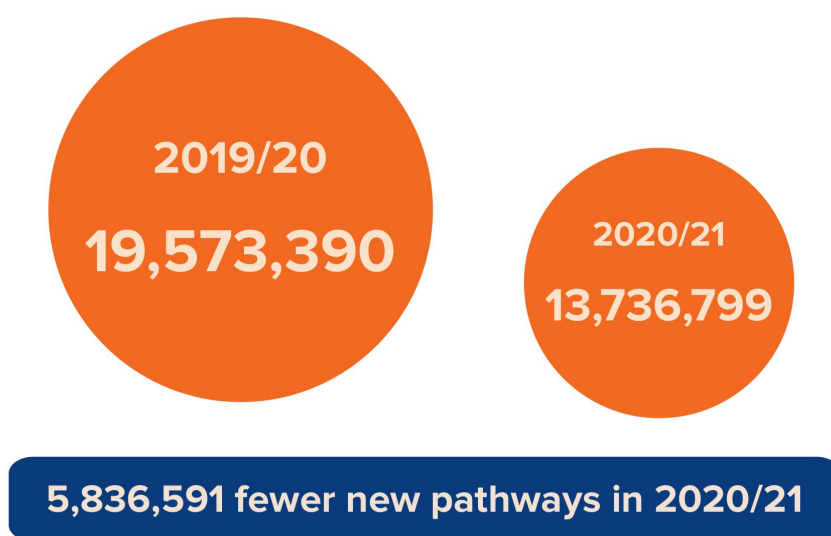
miraculously healed themselves and no longer require consultant-led treatment. Instead, it points to problems upstream. The well-documented challenges in accessing a GP appointment in recent weeks as the sector moves from the 'digital first' approach to a hybrid model indicate that a bottleneck has begun to form in primary care.⁶ Whilst the current polling suggests that GP access is not a top priority (see again Fig. 1) we may see this rise over the medium term.⁷

All things being unequal: the differing impact of waiting times

At the core of the problem are millions of people awaiting treatment, who are gripped by worries of their condition deteriorating.

Those waits are not equal. Certain medical specialities including those which are more clinic-based and have a higher proportion of urgent patients in the case mix have better waiting times [see Figure 3]. This includes thoracic medicine and dermatology, which, for obvious reasons is better placed to embrace the expansion of remote consultation compared to surgical specialisms such as orthopaedics.

Figure 2: Annual difference in new RTT pathways.



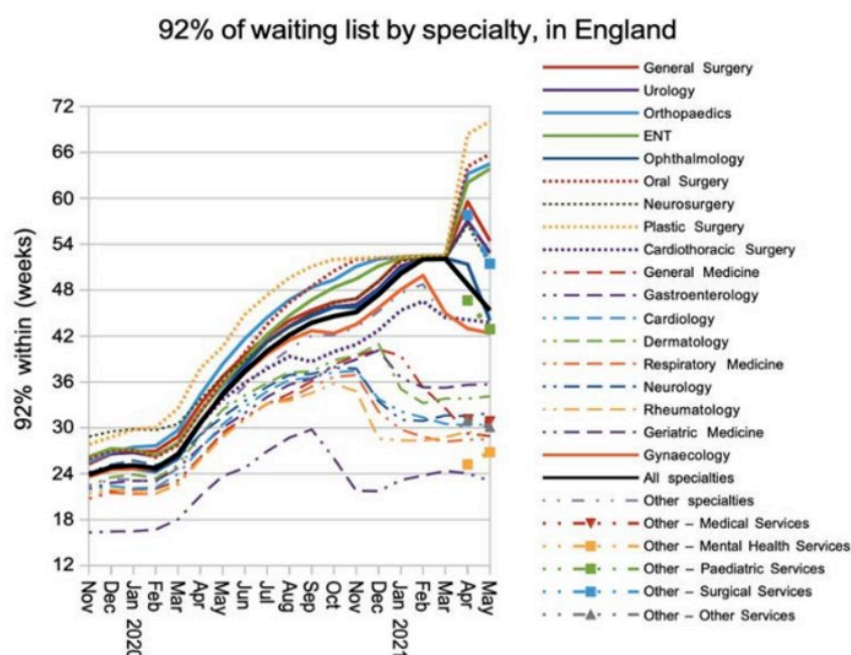
[Whilst this assesses the number of referrals across fixed 12-month periods, the actual number of missing referrals may be closer to 7.5 million, given the very significant reduction in referrals in March 2020 compared to the same months in previous years]

Source: NHS England RTT figure releases

6. GP Access letter, NHS England, 13 May 2021, [link](#)

7. GP Online 'GP patient satisfaction surges despite pandemic pressure' 8 July 2021, link <https://www.gponline.com/gp-patient-satisfaction-surges-despite-pandemic-pressure/article/1721669>

Figure 3: Breakdown showing the different waiting times per surgical specialisms.



Source: Rob Findlay, HSJ

Whilst dermatology activity during 2020 fell by 20% compared to the 2019 baseline, there was a much more severe fall in trauma and orthopaedics where activity fell by 38%. This means that there are going to be longer waits for procedures such as hip and knee replacements. A recent study found that the volume of surgical activity in England and Wales overall was reduced by 33.6% in 2020, resulting in more than 1.5 million cancelled operations.⁸

Differences in outcomes on waiting are also found on the basis of deprivation. Analysis which grouped national NHS Clinical Commissioning Groups (CCGs) into groups based in the Index of Multiple Deprivation (IMD) found that the least deprived CCGs, were able to deliver more treatment pathways in spite of the wider challenges compared to the most deprived CCGs.

There are also disparities at a regional and system level. Ophthalmology is the speciality which had experienced the biggest increase in the number of year-long waiters, but there are huge differences across England. For example, the East of England is now the worst performing part of the country in ophthalmology, with nearly half of patients at one trust waiting more than 52 weeks. Many of these will be waiting for routine cataract surgery – a procedure which remains treatable after several months of delay, but where long waits greater than a year are associated with sight loss. Papers released by West Suffolk NHS Foundation Trust suggest that in part the delay may be caused by limited independent sector capacity in the region, and patients being unwilling to travel longer distances.⁹

8. Thomas D. Dobbs, John A.G. Gibson et al. 'Surgical activity in England and Wales during the COVID-19 pandemic: a nation-wide observational cohort study', *British Journal of Anaesthesia*, 17 June 2021, [link](#)

9. Papers from a Broad Meeting of West Suffolk NHS Foundation Trust suggested that only 50 out of 200 patients had been prepared to travel to Ipswich for ophthalmic appointments/treatment, [link](#)

And finally, is it clear that the current approach to planned care disadvantages certain groups in society. Research published in 2012 found that those living in areas with lower education attainment wait up to 14% longer for care – even when they are being treated in the same hospital as their more educated counterparts.¹⁰

There is evidence that since 2012 further gaps have opened up in access, as total demand for elective care has risen. Research from the Strategy Unit within the Midlands and Lancashire Commissioning Support Unit found that between 2005 and 2018 access to elective care grew at a much slower rate among the most deprived areas in England.¹¹

On the face of it, a smaller number of people living in deprived areas seeking planned care could seem like positive news. But the reality is that this period has coincided with the greatest increases in emergency admissions among people living in these neighbourhoods. Missing volumes of activity in planned care are just filled in A&E.

What is driving these trends? There is likely to be several factors at play. Research has previously shown that areas with higher levels of deprivation are relatively underfunded and under-doctored.¹² Allocations of funding are determined using a statistical formula which tries to account for local healthcare needs – but it may be that these require updating.

Significantly, the most recent studies found evidence that disparities in access to elective care come later in the pathway. Within orthopaedics as an example, patients with hip arthritis living in the least deprived areas are more likely to receive a telephone consultation from a specialist and to receive a hip replacement.

This situation contrasts to the 2000s where people in more deprived areas were on average getting faster access to elective inpatient activity. The issue has been recognised by NHS England, who are now looking for areas to demonstrate how they are tackling healthcare inequalities in order to access additional funding. However, it may be that this simply masks a more fundamental problem with how core funding is allocated. Therefore, more fundamental change may be required if we are to buck the current trend.

The recovery plan so far

NHS England published its elective recovery framework on 25 March 2021.¹³ The framework, issued as part of the 2021/22 operational priorities, set out a series of national thresholds for the scale-up of elective treatment, measured against a 2019 baseline of activity. The plan sets out the requirement for integrated care systems (ICSs, often referred to as systems) to reach each threshold to gain access to the £1bn Elective Recovery Fund (ERF). These monthly thresholds are as follows:

- 70% for April 2021
- 75% for May 2021
- 80% for June 2021
- 85% from July to September 2021

10. Mauro Laudicella, Luigi Siciliani & Richard Cookson, 'Waiting times and socioeconomic status: evidence from England', *Soc Sci Med*, Vol. 74, No. 9 (May 2020), [link](#)

11. 'Socio-economic inequalities in access to planned hospital care: causes and consequences' (May 2021), *The Strategy Unit*, [link](#)

12. Rebecca Fisher, Phoebe Dunn et al., 'Briefing: Level or not? Comparing general practice in areas of high and low socioeconomic deprivation in England' (September 2020), *The Health Foundation*, [link](#)

13. 2021/22 priorities and operational planning guidance: Implementation guidance, *NHS England*, 25 March 2021, [link](#)

Any additional activity above 85% will receive the equivalent of 120% of the tariff, whereas it was determined that there would be no downside adjustments. Activity delivered below a threshold would not be penalised. All elective activity including cancer, outpatient procedures, and outpatient attendances apart from mental health, maternity, and diagnostic imaging fall under the scope of activity.

Meeting these activity thresholds is not the only stipulation. They are accompanied by a series of 'gateway criteria' which each system must hit. The five criteria are 1) Addressing health inequalities 2) Transforming outpatient services 3) System-led recovery 4) Clinical validation, waiting list recovery and reducing long waits and 5) People (staff) recovery.

This includes indicative benchmarking: 40% of outpatient activity that does not involve a procedure should be delivered remotely for instance.

Following the publication of the framework in March, NHS England has subsequently announced a series of pilot initiatives as part of a £160m 'elective accelerator' programme.¹⁴ A dozen systems will be offered between £10m and £20m to devise plans to deliver 120 percent of their pre-covid activity by July.¹⁵ Yet as we move towards August, there has been no confirmation yet that any assessment of the successes or failures of the accelerator programme will be made publicly available.

Is this enough?

Setting targets sits in the middle of an uneasy confluence. Consideration must be given to the impact of infection control measures on patient throughput. Further sensitivity must be shown towards the workforce, many of whom have been pushed exceptionally hard by the pandemic. The possible impact of a substantial increase in Covid infections (coupled with a severe flu season) is also challenging to model for. In Summer 2020, the phase three letter issued by NHS England called for an ambitious return to elective and diagnostic activity which was quickly seen as unworkable as new COVID infections and admissions mounted.¹⁶

We are nonetheless clear that the current framework will not be an appropriate roadmap for elective recovery in the medium and longer term. Setting 85% targets for activity until September means that for every month where referrals are above 85%, the waiting list lengthens. Under this model, admitted activity levels since the beginning of 2020 would run at just over 4 million compared to an expected 6.2 million – a shortfall of 2.2 million admitted procedures.¹⁷

This will be further compounded as new patients are referred for consultant level care. There are ranging estimates on how many of the current 7.5 million 'missing' patients (as outlined in figure 2) will return and under what timeframe. In some modelling, it is assumed that around 20% of these patients may not return, whilst 15% of these missing patients will be removed from the waiting list without being seen. This still means that roughly two thirds of the 7.5 million patients could be added to the waiting list in the coming months.

Most concerningly, millions of people are currently sat on the waiting

14. 'NHS's £160 million 'accelerator' sites' to tackle waiting lists', *NHS England*, 13 May 2021, [link](#)

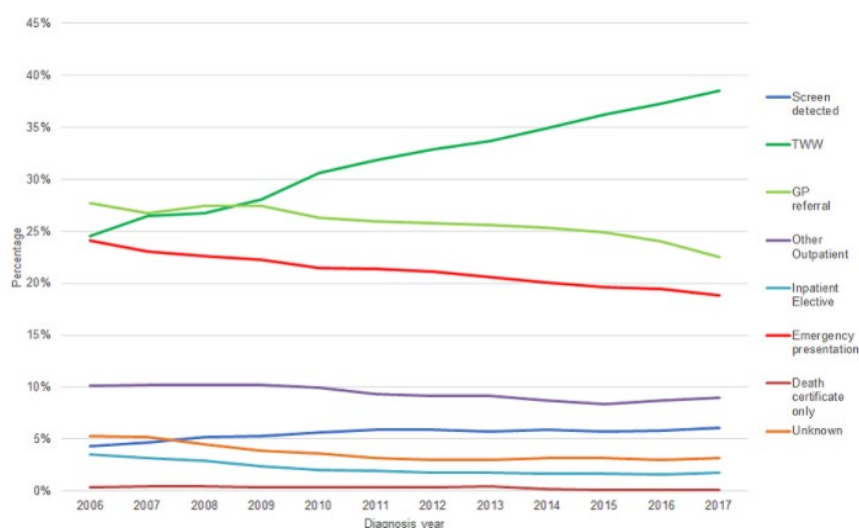
15. Daily Insight: Ready, willing and Abell?, *Health Service Journal*, 7 May 2021, [link](#)

16. Third phase of NHS response to COVID-19, *NHS England*, [link](#)

17. Analysis undertaken by the Independent Healthcare Providers Network in April 2021

list without a diagnosis. Many of these patients will have been referred by their GP as a 'routine,' and therefore, may find themselves at the back of an exceptionally long queue. The statistics show that nearly a quarter of cancers – roughly 90,000 cases every year – are detected in patients who are referred on non-cancer pathways [See Figure 4].¹⁸

Figure 4: Routes to cancer diagnosis, 2006-2017



Source: *Official Statistics: Routes to Diagnosis, 2006 to 2017 results*, GOV.uk Official Statistics Routes to Diagnosis: 2006 to 2017 results

A bold plan is required. This plan must:

- Have a relentless focus on ensuring that unknown clinical risks are accounted for by prioritising patients who currently lack a diagnosis.
- Be transparent about how clinical prioritisation methodologies are being applied to patients.
- Learn the lessons of the pandemic in embracing new ways of working across the NHS, whilst ensuring that the needs of the consumer are respected and listened to.
- Accept we need to adapt the public conversation around NHS performance relating to elective care to make it more candid and open where decisions made are publicly justified, rather than obscured.

18. 'Routes to Diagnosis: 2006 to 2017 results', Public Health England, 14 July 2020, [link](#)

Legislative context

“...that model of health care was designed in a world where the biggest issue was waiting times for elective surgery... and it worked, it did work.”

Jeremy Hunt, speaking about the internal market and the introduction of competition and choice in the NHS.¹⁹

Efforts to address the backlog are taking place concurrently with the passage of the NHS Bill. Laid before Parliament on 6th July, the Bill contains measures to place Integrated Care Systems on statutory footing and fold national Arm's Length Body responsibilities into NHS England.

Many of these proposals were mooted as long ago as 2017. Despite the unique circumstances created by the pandemic, the intention to better integrate care remains the correct course of action. More recent additions to the reform package include measures to strengthen the reporting lines into the Secretary of State for Health and Social Care, a proposal which we cautiously welcome.²⁰

The plans to adapt the market mechanisms in the NHS carry particular relevance to this research. This will reduce the use of volume-based agreements, often termed ‘payment by results’ which will be replaced by block contracts. Alongside this, it remains unclear how consumers of healthcare services will be able to hold poorly performing provision to account under the new structure. Will these measures, if carried into law, make it easier or more difficult to tackle waiting lists?

We have serious concerns that the Bill offers little remedy to the number one problem facing the NHS. Should the Bill be enacted into law, it will also consume a large amount of management and change capacity across the NHS, at the precise moment when the focus should be on treating patients. With an organisation as big and ranging as the English NHS, legislation can only ever be an enabler – but it can disable activity too. We have therefore recommended that the Government should make specific consideration within the Bill for elective recovery.

Doing the time warp again. Are 2000s style approaches valid for dealing with the current backlog?

“People working in the NHS [in the early 2000s] got used to the waiting list. And for some, frankly, it had become something to shelter behind – ‘We’ve got this very long waiting list, so give us more money,’ the implication being that we shouldn’t give it to those who had actually got their waiting lists down. It was only over time that we developed a process, a science so to speak, to get us there.”²¹

Alan Milburn, Health Secretary, 1999-2003

As we look to the current challenge, it is important to consider whether there are transferable lessons from history. Dealing with long waiting lists is nothing new. Indeed, in 1987 the NHS Manager John Yates produced a book entitled *Why are We Waiting* which challenged the notion that long

19. Nicholas Timmins, ‘Glaziers and window breakers: Former health secretaries in their own words (October 2020)’, *The Health Foundation* p. 73

20. Robert Ede, ‘Taking back control? The forthcoming white paper should be cautiously welcomed’, *Policy Exchange*, 9 February 2021, [link](#)

21. Alan Milburn, cited in Nicholas Timmins, ‘How New Labour succeeded with NHS policy’, *The Financial Times*, 12 March 2010, [link](#)

waits were an unavoidable element of care in the NHS.²²

The period in history most synonymous with action on waiting times was under the Blair Labour Government. In 1997 Labour inherited mean waits around 23 weeks, with maximum waiting times of over 18 months.²³ Having initially pursued a policy toward the NHS which emphasised co-operation and collaboration, by 2000 the Government commenced an aggressive, target-based policy as set out in the NHS Plan.²⁴ Described in that White Paper as “the most sustained assault on waiting the NHS has ever seen”, the approach of command and control included:

- A new 12-week maximum wait for outpatient appointments by 2005.
- A six month (24 weeks) maximum wait for an operation by 2005, falling to 12 weeks afterwards.
- A series of ‘carrots’ including a Performance Fund which offered rewards for staff and organisations that reduce waiting times and introduce booked admissions, redesign waiting out of the system and improve the quality of care, including the adoption of local referral protocols based on national clinical guidelines.
- A series of ‘sticks’ featuring robust sanctions for managers who failed to hit the targets, and regular, weekly conversations between Milburn and his successors and poorly performing hospital chief executives.
- A range of other targets beyond secondary care, including a commitment for patients to be able to see their GP within 48 hours.

Among hospital chief executives, the goals were unofficially nicknamed as “P45 targets” as several who consistently failed to meet them got fired.²⁵

Underpinning this was enormous financial investment. The NHS budget grew by 8.7% in real terms from 1999 to 2004, as Milburn won numerous battles with Gordon Brown’s Treasury.²⁶ The Department of Health’s case benefitted from the ballast of the Prime Minister’s commitment to bring spending on healthcare to the European average, enabling the NHS workforce to grow at a rate of 2.5% on average from 1999 to 2004.

Taken together the policy package worked. By 2008, 90 percent of admitted patients, and 97 percent of non-admitted patients were seen within the 18-week referral-to-treatment target.²⁷ The transformation from “18 months to 18 weeks” was complete. That 18-week target endures today. Does this mean that solutions from the 2000s remain applicable?

The relationship between the use of targets and the outcome of reduced waiting times is tricky to untangle. In 2007 a paper by the Centre for Market and Public Organisation at Bristol University suggested that the “terror of targets” was indeed effective.²⁸ The researchers pointed to the NHS in Scotland which received the same funding increase as in England and adopted similar targets but decided against harsher performance management and experiencing only modest reductions in waits. Others

22. John Yates, *Why Are We Waiting? An Analysis of Hospital Waiting lists* (Oxford, 1987)

23. Carol Propper, Matt Sutton et al., ‘Did ‘targets and terror’ Reduce Waiting Times in England for Hospital Care?’, *CMPO Working Paper Series*, No. 07/179, November 2007, [link](#)

24. The NHS Plan (July 2000), [link](#)

25. Gwyn Bevan & Christopher Hood, ‘Have targets improved performance in the English NHS?’, *British Medical Journal*, February 2006, [link](#)

26. NHS Expenditure, *House of Commons Library*, 17 January 2020, [link](#)

27. Anita Charlesworth, Toby Watt & Tim Gardner, ‘Returning NHS waiting times to 18 weeks for routine treatment: The scale of the challenge pre-COVID-19’, *The Health Foundation*, 22 May 2020, [link](#)

28. Carol Propper, Matt Sutton et al., ‘Did ‘targets and terror’ Reduce Waiting Times in England for Hospital Care?’, *CMPO Working Paper Series*, No. 07/179, November 2007, [link](#)

have argued that central direction, supplemented by extra cash since 2000 were critical drivers of success. Others have found any causality between ‘competition and choice’ and waiting times difficult to determine.^{29,30}

History shows target-setting delivers results, and their utility should not be minimised, but the control approach must be accompanied by a comprehensive assessment of the challenge which looks to increase resource (and thereby capacity) so that an improved system emerges.

Not a zero-sum game

Elective care is not the only area to be experiencing the ripple effects of the pandemic. Mental health, cancer, neurological disorders and other often overlooked areas such as addiction and eating disorder services require proportionate focus and energy.

There is nervousness within the healthcare community that aggressive performance management on elective waiting times will divert attention away from these other clinical priorities.

We disagree. Our assessment is that failing to make headway on the elective backlog will hurt other parts of the NHS. The inter-relationship between urgent and elective care is not well understood in policy terms. Yet as mentioned earlier, decreased provision of planned care is associated with higher emergency admissions in deprived areas. A 2021 study found that a wait longer than six months was associated with a clinically significant deterioration in the quality of their life.³¹ These impacts are not merely physical; a recent report from National Voices highlighted the substantial burden placed on patients’ mental health as they wait for services.³²

The NHS must therefore drastically accelerate the rate at which it works through the waiting list, if it is to avoid urgent care being overwhelmed with demand in the next two years.

This report argues it is possible to deal with the elective backlog in a way that progresses action to avoid this nightmare scenario. This will require a willingness from the system to embrace the opportunities to do things differently, echoing the focus that brought waiting times under control in the 2000s, but with new tactics.

The following sections investigate the challenges in each section of the planned care pathway, commencing in general practice.

29. Anthony Harrison & John Appleby, ‘Reducing waiting times for hospital treatment: lessons from the English NHS’, *Journal of Health Services Research & Policy*, Vol. 14, No. 3 (July 2009), [link](#)

30. Anthony Harrison & John Appleby, ‘Reducing waiting times for hospital treatment: lessons from the English NHS’, *Journal of Health Services Research & Policy*, Vol. 14, No. 3 (July 2009), [link](#)

31. Nick D. Clement, Chloe E. H. Scott et al. ‘The number of patients “worse than death” while waiting for a hip or knee arthroplasty has nearly doubled during the COVID-19 pandemic’, *The Bone & Joint Journal*, Vol. 103-B, No. 4, [link](#)

32. Patient Noun Adjective: understanding the experience of waiting for care (August 2020), *National Voices*, [link](#)

Chapter Two: What are the Challenges, and what are the Solutions?

In this section of the report, we examine the specific challenges in the pathway and propose a series of policy solutions.

The research has been underpinned by extensive primary research. A series of one-to-one interviews, a cross-sector roundtable, and two focus groups with people waiting to begin consultant-led treatment took place from January to June. This has been supplemented by a review of secondary literature.

General Practice

Primary care has a critical role as the first port-of-call for many patients, and as a service that those on the waiting list will be predominately interacting with as they await treatment.

There are typically between 25-30 million GP appointments in the English NHS each month.³³ On average every 15 GP appointments lead to one referral for routine consultant-led treatment.

Dependent on the rate of which the ‘missing’ patients return, it is expected that the number of those requiring onward referral may rise substantially in coming months. Modelling undertaken by NHS Confederation suggested that the referrals would have to rise from 1 in 15 to 1 in 12 appointments on average between March and December 2021 to see 63 percent of the ‘hidden’ waiting list return by the end of the year.³⁴

We cannot be sure whether this will be realised, but there are already substantial pressures facing general practice. Recent reports have described a ‘tsunami’ of patients returning to primary care, with an ongoing debate on the role of the current ‘total triage’ model which was introduced during the pandemic and encourages GPs to offer video, telephone, or online consultations prior to face-to-face appointments. A recent study has highlighted positive patient experiences of using virtual consultations during the pandemic, yet two-thirds of patients would prefer face-to-face consultations.³⁵ On 13 May 2021, NHS England set out new standard operating procedures which said that GP practices must all ensure they are making a clear offer of appointments in person.³⁶ The GP Committee of the British Medical Association (BMA) subsequently passed a motion calling the letter ‘unacceptable’ and has since advised practices that the

33. ‘Appointments in General Practice, April 2019’, NHS Digital, 30 May 2019, [link](#)

34. ‘Exploring referral-to-treatment waiting trajectories in 2021’, NHS Confederation, 7 March 2021, [link](#)

35. Stephanie Cliffe & Kay Stevenson, ‘Patient experiences of virtual consultation during COVID 19: A musculoskeletal service evaluation’, *Musculoskeletal Care*, 28 December 2020, [link](#)

36. GP Access letter, NHS England, 13 May 2021, [link](#)

letter has no contractual force.

Far from tangential, these current issues will substantially impact on the elective waiting list.

The Royal College of General Practitioners (RCGP) has found that total triage model results in an increase in consultation numbers overall, with remote consultations also taking longer.³⁷ This will impact on the 'flow' rate of new referrals to the consultant-led pathway. A bottleneck within primary care may in effect shield the planned sector from the scale of the challenge it faces. Rather than being welcomed, this should give those working in the NHS sleepless nights as many of the people they need to help are unable to enter the system.

This row over capacity continues in parallel to the COVID-19 vaccination programme. General practice has done most of the heavy lifting, administering roughly 75% of the vaccine doses to date.³⁸ Ensuring that the remainder of the rollout (and any booster programme) is not disrupted is of paramount importance. We therefore need to embrace the opportunities to do things differently so that dual priorities around core NHS activity and the vaccine programme can be pursued in tandem without either service suffering.

One such area where innovation could deliver short term benefit is in addressing unwarranted variation in the referral rates to elective care. Currently no information is held at a national level on the proportion of referrals to secondary care which are deemed appropriate, whilst there is generally a dearth of evidence about the impact of different approaches to referral management.³⁹

There are clear opportunities to harness digital technologies to give additional information to GPs in making decisions over whether to refer to patient for consultant-led treatment. An evidence review led by the King's Fund in 2010 found that not all referrals are necessary in clinical terms, whilst anecdotally it is believed that only 30-50% of referrals ultimately lead to treatment being initiated.³⁷ Whilst unfortunate in normal times, a high level of inappropriate referrals should be considered wasteful given the broader pressures in the system. In some instances, a patient may be better served being referred to a different type of service within an enhanced community offering. This model has been applied in orthopaedics, where in one CCG the introduction of a single point of access triage, alongside the use of intermediate clinics reduced referral rates by 80% within the first six months, with a QIPP saving of £1.1m in the same period.

We need to be cautious in assuming that this will lead to a massive reduction in the number of referrals, as research has also identified unmet need whereby patients who do need a referral fail to receive one. The consequences of failing to refer are hugely significant for both the individual and the NHS. For example, treating colon cancer at stage 1 costs £3,373, whereas late-stage treatment costs £12,519.⁴⁰

This is a complex area, where any changes to enhance the guidance and information provided to general practice will need to expose under-

37. 'GP consultations post-COVID should be a combination of remote and face to face, depending on patient need', *Royal College of General Practitioners*, 11 May 2021, [link](#)

38. Nick Bostock, 'Basic GP workload far outstrips pre-pandemic level as practices deliver COVID-19 jabs on top', *GP Online*, 29 March 2021, [link](#)

39. Candace Imison & Chris Naylor, 'Referral Management: Lessons for Success (August 2010)', *The King's Fund*, [link](#)

40. Shiona Aldridge, 'Referral management: rapid evidence scan (October 2016)', *The Strategy Unit*, [link](#)

referral as well as over-referral. Better quality data and analytics must underpin any changes to referral behaviour, and this will also require strong clinical leadership in both primary and secondary care.

Finally, the new Primary Care Network (PCN) structure should be offering support toward waiting lists. PCNs are geography-specific clusters of GP practices, covering patient populations of 30-50,000. NHS England wants PCNs to be focused on service delivery rather than on the planning and funding of services, with a remit that includes a set of national service specifications which are agreed each year following negotiation with the BMA's General Practice Committee.

The number of services PCNs have been required to provide has been scaled back because of the pandemic. Looking forward, there may be an opportunity to reconsider the composition of enhanced services from 2022/23. In the most recent contract, an enhanced service on obesity and weight management was introduced, supported by additional funding from Government.⁴¹ With the possibility of up to 10 million on the planned waiting list by Autumn 2021, it would be logical to consider whether various components of planned care can be made a similar priority. This could be supplemented by using the new 'Care Coordinator' roles to help assist with managing and regularly checking in with those facing the longest waits. The opportunities to enhance patient communication, enabled by technology and the NHS App, is explored in greater detail later in the report.

Solutions

GPs have a key role in reducing waiting lists. This could be achieved through efforts to:

- **Harness existing expertise within primary care to improve the waiting experience.** A greater role on elective recovery could be included within the responsibilities for the Primary Care Network Care Coordinators, alongside expanding the role of 'Patient Navigators to plan and optimise elective care pathways.
- **Roll out referral optimisation systems on a more consistent basis across primary care.** All efforts to make the walls of communication between primary and secondary care more porous should be welcomed. This should ideally be a two-way process of discussion between specialist and GP. Examples include electronic advice and guidance (A&G) software for outpatient referrals, whereby a GP can communicate with a specialist to upskill themselves and gain a second opinion before determining whether to refer.⁴² Other examples include Bromley CCG's referral scheme which requires GPs to add essential information and diagnostic test results prior to the referral submission.⁴³

41. 'GP contract agreement England 2021/2022', *British Medical Association*, 20 May 2021, [link](#)

42. Claire Read, 'Improving the quality of the outpatient referral process', *Health Service Journal*, 29 January 2021, [link](#)

43. Dr Rebecca Rosen, 'Transparent processes with a human touch: the essentials of good waiting list management', *Nuffield Trust*, 11 May 2021, [link](#)

Diagnosis and Treatment

Under the current planned care system, there is no additional incentive for ensuring patients receive a diagnosis as quickly as possible.

This is problematic because:

1. Around a **quarter of cancer diagnoses occur following a non-cancer GP referral** to secondary care. Five times more cancers are detected through this route compared to all screening programmes combined. Many of these patients will eventually be diagnosed in hospital following a long delay, by which point their cancer will now be more advanced.
2. The current RTT pathway only ends when a patient commences or declines treatment, dies, or opts for active monitoring. There is **no reward or punishment within the system associated with achieving a timely diagnosis and decision regarding treatment**. Whilst suspended because of the pandemic, the NHS Long Term Plan reaffirmed the policy of issuing fines at a CCG and NHS Trust level for any patient who breaches 12 months waiting for treatment. Whilst this was an appropriate in an era of short waits, we can now conclude that a new sanction and incentive regime will be required to reflect the size of the waiting list.

Addressing this requires two changes. Firstly, the incentives in planned care require adjustment to give adequate prioritisation to receiving a timely diagnosis.

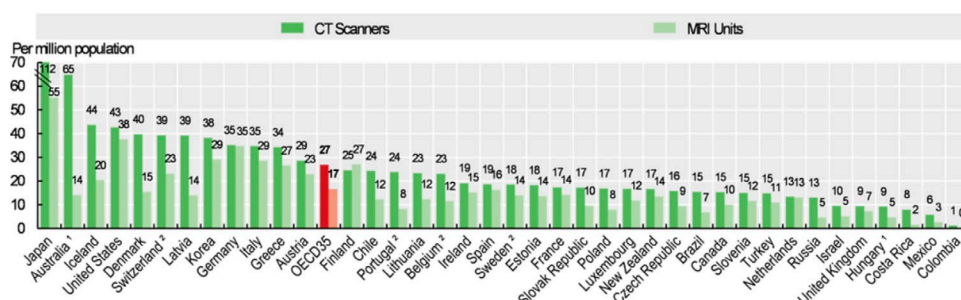
Secondly, the NHS will need to massively scale-up diagnostic capacity.

On the former, there is an emerging consensus that the national conversation around elective recovery is placing too much focus on treatment rather than diagnosis. As highlighted by Barry Mulholland, a waiting time specialist at MBI Healthcare Technologies, patients waiting for treatment can be quantified and plans put in place – but those that have not yet been seen or diagnosed represent a much greater, unqualified clinical risk.

In its initial Elective Recovery Framework, NHS England set thresholds for procedure activity, to run until the end of September 2021. No benchmarks for diagnosis were included. Yet as recently as 2019, the NHS Operational Planning and Contracting Guidance said that “no more than 1% of patients should wait six weeks or more for a diagnostic test”.

Looking ahead, it is expected that pressure will mount on Trusts to be penalised for failing to clear super-long waiters (especially those waiting in excess of 104 weeks). Whilst this may be required to jolt the system into activity, it would be wise to couple it with incentives and sanctions to accelerate the rate at which those on the waiting list without a diagnosis receive one.

Figure 4: CT scanners and MRI units, 2017 (or nearest year).



Source: Jeremy Hurst & Luigi Siciliani, 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', OECD Health Working Papers No. 6,

Whilst the incentive structures can be adjusted relatively swiftly, it will take time for new diagnostic capacity to come on-line. The UK currently has just nine MRI and seven CT scanners per million, putting it in the bottom five countries in the OECD, alongside Hungary, Costa Rica, Mexico and Columbia [see Figure 4]. The UK Government has committed £200m in capital funding towards new equipment, with 78 Trusts across England receiving funding to update their facilities including replacing the oldest CT and MRI equipment. Further resource will be required over this Parliament to meet rising demand: demand for CT scanning (which has wide use across medical specialisms) is likely to increase by 100% over the next five years.⁴⁴ The Health Foundation has estimated that bringing the UK up to the OECD average would require £1.5bn in capital spending.⁴⁵

There is significant scope to roll-out innovative approaches currently being taken to triage and diagnosis. For instance, Triage HF, a monitoring tool for cardiac risk assessment has been used by the Manchester Heart Centre at Manchester Royal Infirmary to identify the most urgent cases, resulting in a 75% reduction in routine scheduled follow up appointments.⁴⁶ The publication of the MedTech Mandate in April 2021 by NHS England as a means to fast-track innovation is a welcome attempt to further scale emerging technologies and to increase their adoption across the NHS. This scheme could be complemented by the establishment of targeted Elective Innovation Mandate to fast-track solutions which demonstrate the greatest potential to tackle the backlog in priority specialisms. This could be modelled on the MedTech Mandate but would also benefit from being a part of a future DHSC coordinated scheme. Over time, emerging technologies in planned care could also benefit from the work of the recently announced 'Multi-Agency Advisory Service' to streamline support and regulation.⁴⁷

44. Diagnostics: Recovery and Renewal – Report of the Independent Review of Diagnostic Services for NHS England (October 2020), [link](#)

45. 'Lack of investment in NHS infrastructure is undermining patient care', *The Health Foundation*, 8 March 2019, [link](#)

46. Presentation by Yinka Makinde on Cardiovascular, 'Digital elective recovery ICS workshop', NHSx, 8 June 2021,

47. A "Multi Agency Advisory Service" has been announced by NHSx as an attempt to regulate AI. The aim of the project is to "make clear the regulatory pathway for safely scaling technologies" and it seeks to "streamline and accelerate what is currently a complex and fragmented regulatory pathway for developers, making it clearer, navigable and robust, whilst maintaining high patient safety standards". The National Institute of Health Excellence (NICE), Care Quality Commission (CQC), Medicines and Healthcare Products Regulatory Agency (MHRA) and the Health Research Authority (HRA) are all participating, [link](#).

Shifting planned diagnostics into the community

Broader efforts are underway in the NHS to transform diagnostic pathways, which have remained unchanged for decades. Up until now, elective diagnostics have largely been provided on acute sites, with patients typically referred by a GP to a hospital consultant, who would then determine whether a diagnostic test would be required after the initial consultation. Having returned for the test, the patient would then be called into the hospital for a fourth appointment to be informed of their test results, with the entire process taking many weeks and often months. The current structure for planned diagnostics is also highly vulnerable to disruption. Due to clinical urgency, many patients admitted to A&E requiring a diagnostic test will need both the test and result very rapidly (sometimes within the hour) and so short-term unexpected surges in emergency admissions can lead to widespread cancellations of elective appointments. This mixed-model is in contrast to countries such as Denmark, which reformed its hospital structure in 2007 meaning that 21 hospitals provide emergency care where all others only provide elective diagnostic and procedures.⁴⁸

The creation of rapid diagnostic centres was first announced as part of the 2019 NHS Long Term Plan in 2019 and are aimed to meet the need for rapid assessment of patients with cancer symptoms or with suspicious results.

More recently, the Independent Review of Diagnostic Services for NHS England led by Sir Mike Richards concluded that new pathways should separate acute and emergency diagnostics from elective diagnostics, to improve efficiency and reduce delays for both sets of patients.⁴⁷ Central to this was the recommendation to establish a series of Community Diagnostic Hubs (CDHs) across England. NHS England has now committed to taking forward this recommendation. Whilst the configuration of CDHs will vary across different integrated care systems, they are likely to include imaging (CT, MRI, ultrasound, x-ray and mammography), physiological measurement equipment (such as echocardiography and blood pressure monitoring) and pathology.

Under the vision set out by the Richards' review, elective diagnostics would be requested by GPs following a virtual consultation, with the specialist then meeting with the patient to inform them of the result and possible action. This approach of 'scan first, engage later' would mean that a sizable proportion of the testing could take place within the community.⁴⁷

New CDH capacity will take several months and potentially years to come online. Julian Kelly, Chief Financial Officer at NHSE recently told the NHS England Board that rollout of a CDH within each system would increase the total diagnostic capacity in the NHS by only 8%. This will need to go further over time, and we welcome recent reports that NHS England will aim for 150 CDHs by 2023.^{49,50} In the immediate term, efforts should therefore go towards operating diagnostic waiting lists at provider collaborative or ICS level. In some cases, it may also be appropriate to use 'mutual aid' to move patients across systems. This will mean that some

48. Terkel Christiansen & Karsten Vrangbæk, 'Hospital centralization and performance in Denmark—Ten years on', *Health Policy*, Vol. 122, No. 4 (April 2018), [link](#)

49. NHS England and NHS Improvement Board Meeting in Common, 24 June 2021, [link](#)

50. James Illman, NHS invites bids for £10bn diagnostic programme, *Health Service Journey*, 1 July 2021, [link](#)

patients will be asked to travel longer distances for diagnostic tests.

A roadmap for planned and outpatient care?

The current approach to planned and outpatient care has remained remarkably unchanged since the NHS was formed nearly 70 years ago. This creates substantial opportunities for innovation.

Organisations such as the Royal College of Surgeons of England (RCS) have advocated for a hub model for elective surgery.⁵¹ This would involve the more widespread use of ‘cold’ elective surgical sites for specialities such as orthopaedics and cancer and are already commonplace in some parts of the country. The South West London Elective Orthopaedic Centre opened in 2004 and performs around 5,200 procedures a year, making it the largest provider of hip and knee replacement in the UK by volume.⁵² Other examples include the ‘race-track’ model deployed by Ramsay Health Care. Ramsay undertakes a third of all NHS elective activity undertaken within the independent sector and has a network of 34 acute hospitals including day case centres in the UK. Ramsay has introduced a streamlined day case pathway which it now models new hospital developments upon. The first hospital which was built modelled on this day case patient pathway in Middlesbrough has meant that 84% of procedures can now be delivered as day cases. Ophthalmology is another specialism which stands to benefit from the hub model, given that a high proportion of cataract surgical procedures are high flow low complexity cases.⁵³

Whilst exciting, there are limits to how widely surgical hubs could be applied. In specialisms such as neurosurgery and geriatric medicine, patients often have a higher risk profile and require on-site anaesthetists and critical care capacity, making it harder for service transformation to venture far beyond the boundaries of a traditional hospital site. Even within specialities such as orthopaedics, there is a cohort of patients who are at high risk of postoperative complications. The recent Royal College of Surgeons report *A New Deal for Surgery* does acknowledge the limitations of the model – stating that it is most appropriate for high volume low complexity procedures.⁵⁴

It will be important to take any steps necessary to increase throughput given the ongoing restrictions around social distancing, including the requirement for surgical teams to wear PPE, and for patients to self-isolate for the fortnight preceding an operation.

A higher-than-anticipated surgical conversion rate may present further challenge. Within orthopaedics this is normally modelled at around 50%, yet it is very possible that the extra delay in many referrals may lead to worse disease states and with a greater proportion requiring intervention.⁵⁵

Solutions

Evolutions to the current approach to diagnosis and treatment of planned patients would involve the following actions being taken:

- **The Government should release new capital funding for**

51. *A New Deal for Surgery* (June 2021), Royal College of Surgeons of England, [link](#)

52. Andrew Haldenby, ‘To clear the post-pandemic backlog, the NHS will need not yet more spending, but improved productivity’, *ConservativeHome*, 6 April 2021, [link](#)

53. ‘Guidance on high volume cataract lists and hubs aims to improve patient care post-COVID’, *Getting it Right First Time*, 30 March 2021, [link](#)

54. *A New Deal for Surgery* (June 2021), Royal College of Surgeons of England, [link](#)

55. Sam Oussedik, Sam MacIntyre et al., ‘Elective orthopaedic cancellations due to the COVID-19 pandemic: where are we now, and where are we heading?’, *Bone & Joint*, Vol. 2, No. 2 (February 2021), [link](#)

diagnostics. The UK Government should announce a £1.3bn package for the diagnostics sector to bring NHS capacity in line with the OECD average. This would be delivered in tranches over the next three years, commencing with £500m at the upcoming Comprehensive Spending Review for new community diagnostic equipment, to support the rollout of Community Diagnostic Hubs. Including existing spending commitments in this area, it would amount to a £1.5bn package for the NHS diagnostics sector since 2019.

- **The Government and NHS should reform the sanction regime.** Whilst suspended, the current operational standard policy as set out in the NHS Long Term Plan is to issue fines to Trusts and CCGs for 52-week breach. This should be replaced over time with a series of fines for ICSs who are unable to give patients a diagnosis/treatment decision within eight weeks of initial referral.
- **The NHS should better manage and share diagnostic capacity.** A series of short-term, ‘mutual aid’ measures should be implemented to ensure the optimal use of diagnostic capacity given the risk of bottlenecks in the system. This could be achieved either through working at a provider collaborative level or by working with independent sector colleagues across geographies.
- **Review Infection, Prevention and Control (IPC) guidance and self-isolation periods at ‘green’ sites.** A relaxation of the current guidance at ‘covid-free’ sites will give much greater flexibility; enabling cancellation slots to be filled at short notice by willing patients, whilst also increasing the volume of procedures conducted in theatre. This needs to be balanced by the evidence of continued nosocomial transmission.
- **An expansion of surgical hubs could provide benefits for addressing the backlog.** We believe that surgical hubs may provide part of the answer for elective recovery in certain clinical specialisms where there are already lengthy waits including ophthalmology, orthopaedics, and cancer surgery, and may help to optimise infection control. The expectation should be for these hubs to set up to facilitate three session days and seven-day working.
- **The NHS should ensure the benefits of service transformation are shared equitably.** The creation of hubs for high volume, low risk activity should not be at the cost of a reduced quality of service for higher risk patients, who are often older, multimorbid and frail.
- **The NHS should make better use of existing independent sector capacity.** Any agreement with the independent sector should be volume-based, comprehensive and long term to give adequate investor confidence and ensure best value for the taxpayer. A long-term approach could include reviewing the current Increasing Capacity Framework, and National Tariff prices to ensure the

correct incentives are in place for IS providers to deliver a high proportion of NHS work. The principles of ensuring that treatment remains free at the point of delivery must be upheld.

- **NHS England should publish Playbooks to profile and promote innovative and effective examples of waiting list management and reduction.** ‘Digital Playbooks’ have been introduced by NHSX to profile specialism-specific examples of innovation. The model should be replicated across the NHS to capture best-practice taking place in waiting list management and reduction.⁵⁶
- **An Elective Innovation Mandate should be established.** Rather than proving cost savings alone, a fund should be established to fast-track solutions which demonstrate the greatest potential to tackle the backlog in high-priority specialisms. This scheme could be modelled on the recently announced MedTech Mandate from NHS England, but would also benefit from being a part of a future DHSC coordinated scheme.

Data, Management and Prioritisation

Whilst the NHS has been compiling waiting list data in some form since 1948, the current reporting regime has been in place since 2007.

Every month over the past 15 years, NHS England has published “Consultant-led Referral to Treatment” (RTT) waiting times. An RTT pathway is the length of time that a patient waited from referral to start of treatment, or, if they have not yet started treatment, the length of time that a patient has waited so far. It is the mechanism through which the media will report on the waiting list, currently listed as being 5.3 million people strong.

Yet this group of five million plus waiters is not uniform. Many patients are at different stages in their procedure – a distinction rarely reported on in public. Who is included in this figure then?

The monthly RTT releases show the total number of patients waiting for an elective procedure from the point they are referred to a consultant for treatment. They are then used as a means of determining the number of those patients who receive treatment within the 18-week target. Following updates since 2007 the data reported now includes:

- “Incomplete pathways” – or patients waiting to start treatment;
- “Admitted pathways” – the time waited for those patients whose treatment started during the month and involved an admission to hospital⁵⁷;
- “Non-admitted pathways” – patients whose treatment has begun but did not involve admission to hospital⁵⁸;
- “Incomplete pathways with a decision to admit for treatment” – where a clinical decision to admit a patient to hospital for treatment has been made but they have not yet been admitted⁵⁹;
- “New RTT periods” –which cover the number of “pathways”

56. ‘Digital Playbooks’, NHSx, [link](#)

57. A useful explanation of this terminology is available at ‘Statistical Press Notice NHS referral to treatment (RTT) waiting times data (April 2021), NHS England, 10 June 2021, [link](#). For instance, “Admitted pathways are the waiting times for patients whose treatment started during the reporting period and involved admission to hospital. These are sometimes referred to as inpatient waiting times. They include the complete time waited from referral until start of inpatient treatment” (p. 8)

58. Ibid. “Non-admitted pathways are the waiting times for patients whose wait ended during the reporting period for reasons other than an inpatient or day case admission to hospital for treatment. These are sometimes referred to as outpatient waiting times. They include the time waited for patients whose RTT waiting time clock either stopped for treatment or other reasons, such as a patient declining treatment.” (p. 8)

59. Ibid. “Incomplete pathways are the waiting times for patients waiting to start treatment at the end of the reporting period. These patients will be at various stages of their pathway, for example, waiting for diagnostics, an appointment with a consultant, or for admission for a procedure. These are sometimes referred to as waiting list waiting times and the volume of incomplete RTT pathways as the size of the RTT waiting list.” (p. 8)

“clock started” – in other words – how many new patients have been referred that month.

Rather confusingly, it is not the case that everyone listed in the RTT figures are actually waiting for surgery, whilst RTT does not cover everyone on a waiting list in the NHS. Instead, it details waits for eighteen “treatment functions”, based on consultant specialisms.⁶⁰ Data for types of treatments that are not covered by these categories are collected under an ‘Other’ category. The data is presented two months in arrears (data released in August 2021 will cover the period up to June 2021 for instance).

Prioritisation process

Prior to 2020, no formal clinical prioritisation methodology was introduced at a national level, with patients determined locally as ‘cancer’, ‘urgent’ or ‘routine’ cases. Choices over the sequence in which patients would be seen would then be determined locally, but the generally agreed priorities of clinical urgency and length of wait have not necessarily translated into systematic processes for booking patients, with the result that patients often booked out-of-turn and some waiting for unnecessarily long periods. In many cases, the time waited proved the next most significant factor used to prioritise patients, regardless of condition severity.

COVID-19 necessitated a complete change in approach. During the initial stages of the pandemic, a ‘Recovery Prioritisation Matrix’ was developed by the Federation of Surgical Specialty Associations (FSSA) as the first nationally consistent prioritisation system for surgery.⁶¹

Category	Urgency	Timescale
P1a	Urgent	< 24 hours
P1b	Urgent	< 72 hours
P2	Soon	<1 month
P3	Routine	<3months
P4	Routine	>3 months

Source: Table adapted from *British Orthopaedic Directors Society Members letter*, 6 May 2021, [link](#) (p. 2)

Two additional categories of P5 (patient wishes to postpone due to COVID-19) and P6 (postponement for non-COVID-19 reasons) were introduced from October 2020 although are excluded from the table above.

Whilst the guidance creates the possibility of adjusting a patient’s level in response to factors which include “psychological distress”, the priority has been given to P1 and P2 patients, with only limited operating on P3 and P4 patients in England.⁶² The capacity constraints within the system have necessitated further reprioritisation within the P2 category. For

60. These specialisms are as follows: treatment of disorders of heart and/or blood vessels (Cardiology); treatment of organs inside the thoracic cavity [generally treatment of conditions of the heart, lungs] (Cardiothoracic surgery or Thoracic medicine); skin, hair or nails disease or injury (Dermatology); treatment of ear, nose or throat related disorders (ENT); treatment of the digestive system (Gastroenterology); treatment of abdominal contents: stomach, intestines, liver, pancreas etc. (General Surgery); head, brain, and nervous system disease or injury (Neurology); Eye injury or disease (Ophthalmology); mouth, teeth, jaw or gum injury or disease (Oral surgery); bone, joint, ligament or tendon injury or disease (Orthopaedics and trauma); reconstructive or cosmetic surgery (Plastic Surgery); disorders of the musculoskeletal system such as the locomotor apparatus, bone and soft connective tissues (Rheumatology); treatment of genitalia or reproductive organs (Urology or Gynaecology).

61. ‘Clinical Guide to Surgical Prioritisation During the Coronavirus Pandemic’, Federation of the Surgical Specialty Associations (FSSA), [link](#)

62. Letter from British Orthopaedic Directors Society to members, 6 May 2021, [link](#)

example, in March 2021 there were around 220,000 completed inpatient procedures nationally (known as admitted pathways). This compares to more than 305,000 in March 2019 – representing a drop of 28% compared to the pre-pandemic baseline.

Information about the number of patients within each category has not been made public, but it is expected that the number of patients rated as P3 and P4 will now be in the millions. Certain clinical specialisms such as orthopaedics have been disproportionately affected by this situation, as a large number of these procedure types fall into the P3/P4 category.⁶⁷

There is now an ongoing debate about how to best manage patients likely to be waiting many more months than the indicative three-month timescale set as the cut off for P3. Moreover, there is the question of how dynamic this prioritisation methodology can prove to be where patients waiting a long time may require re-prioritisation following their initial consultation. There is a wider discussion about whether the P1-4 model is here to stay, or whether it has now run its course as the impact of the pandemic on the NHS lessens.

Within this, there should be a live conversation about what might replace it. Of the patient prioritisation tools previously developed, most focus upon emergency settings with few examples of models which are accepted to be both effective and ethical for use in secondary care settings.⁶³ A recent systematic review of triage systems indicated mixed results on their ultimate reduction of waiting times.⁶⁴ As such, whilst the development of a PPT accepted for use to inform clinicians and patients alike of any prioritisation methodology may be of utility, what is important is that any rationale and methodology applied should be appropriately communicated to the patient.

Can enhanced waiting list management tackle health inequalities?

As highlighted in a recent paper by the Nuffield Trust, the question of how to prioritise patients is relatively uncomplicated during periods of short waiting times.⁶⁵ However, given the potential for long waits and unmet demand, the issue grows in importance. This is especially salient given the potential for the chosen methodology to have unintended consequences for certain groups.

The implementation guidance published by NHS England in March set a series of gateway criteria for access to the elective recovery fund, including action to address health inequalities in planned care. The document calls for ICSs to “identify disparities in relation to the bottom 20% of the Index of Multiple Deprivation and black and minority ethnic population” and to “prioritise service delivery” accordingly.¹² It remains unclear exactly what action should be taken by ICSs, however, with the precise level of prioritisation given to certain groups to be set at the discretion of the ICS.

Some clinicians have argued that the current approach to re-validating the waiting list, as set out by NHS England in October 2020, risks worsening health inequalities.⁶⁶ Instead, it is proposed that reforms are made to the waiting list so that patients are prioritised based upon a

63. These tools include classification systems, sometimes simplified to “high” or “low priority”, whilst others have been designed to assign scores according to a greater variety of factors. See Julien Déry & Angel Ruiz, ‘Patient prioritization tools and their effectiveness in non-emergency healthcare services: a systematic review protocol’.

64. *Systematic Reviews*, Vol. 8, No. 78 (2019), [link](#)

65. Katherine E Harding, Nicholas F Taylor & Sandra G Leggat, ‘Do triage systems in health-care improve patient flow? A systematic review of the literature’, *Australian Health Review*, Vol. 35, No. 3 (August 2011), [link](#)

66. Rachel Hutchings & Dr Polly Mitchell, ‘Questions of fairness: how should the NHS prioritise people waiting for care?’, *Nuffield Trust*, 11 May 2021, [link](#)

67. John Ford, Alex Gimson & Cheng-Hock Toh, ‘Clinical validation of waiting lists—we need to avoid worsening health inequalities’, *The BMJ Opinion*, 28 October 2020, [link](#)

combination of clinical need, but with higher weighting given for those living in disadvantaged areas, to reflect their overall greater health need. There is also a suggestion that if Trusts combine forces to manage their waiting lists at an ICS level, the scheduling of planned care can happen irrespective of place of residence, whilst they will also have the advantage of greater population health data.

Bringing additional factors into consideration makes the clinical picture more complicated. How should providers (and those working at an ICS level) set this information against other important metrics including total length of time waited and age? These are knotty issues, and for all the interest around health inequalities arising from the pandemic, there will be tensions ahead as those working at a national and Trust level consider policies to manage the waiting list through multiple lenses.⁶⁷

Some leading ICSs are making independent progress on this agenda. Within Frimley Health ICS in Surrey, a shared care record is overlaid with population health management tools, enabling the interrogation of information to inform any targeted action. This means that a patient on the waiting list with learning difficulties, or serious mental illness, can be flagged earlier.⁶⁸

If successful, it could pave the way for a conversation on how they can better support and manage these patients. The main challenge will be in ensuring that these examples are translatable to other systems where the leadership and data management may not be currently as strong.

Call for the manager: setting out the need for reform

It has become increasingly clear that the current RTT approach is no longer fit for purpose. The system was introduced to enable effective monitoring of the waiting list at a national level, with the ultimate aim of pushing waiting times down and ensuring the NHS would meet its target of maximum 18 week waiting time for non-urgent, consultant-led treatment. As waiting times have grown, the reporting regime has become increasingly scrutinised both by those working in the system and the wider public.

The opaque nature of the NHS England data releases was often highlighted in our interviews with external experts. Few people – even those with a managerial responsibility for elective care at NHS Trusts can fully make sense of the data. NHS staff report having to spend considerable time digging through the material to find what they are looking for and often must rework the data into a useful format.

Issues at an individual trust level are compounded by a shortage of high-quality managerial capability, and an unwillingness to embrace technological solutions. A focus on reporting data to appear in national NHS performance statistics, rather than active management of the waiting list has meant that much of the information is of poor quality. This is not a clinical issue, but it is one of effective data information handling and management.

The remedy to this will involve new technology, including software

68. Doug Treanor, 'How data will underpin elective care recovery', *Health Service Journal*, 21 April 2021, [link](#)

69. Nigel Foster, 'How we are addressing waiting lists and social inequalities at scale', *Health Service Journal*, 10 May 2021, [link](#)

which can reduce error could be a return to an effective but deeply unfashionable policy idea: more NHS managers.

Successive efforts to streamline back-office functions may have reached the end of the road. Only 1.2% of the total NHS budget goes on administration, whilst managers make up less than 5% of the NHS workforce.⁶⁹ Expanding the number of FTE managers and the use of technology, and incentivising hospitals with the poorest quality datasets to improve the management of their waiting lists, would be one effective first step on the route to revalidation of the current patient cohort and is an approach systems can take with urgency without having to rely upon the introduction of novel approaches alone. A recent report from National Voices emphasised the ways in which poor administration produces significant waste, damages patient confidence and can result in poorer health outcomes.⁷⁰ Being able to demonstrate effective waiting list management in-house would also address the NHS' reliance on consultants, contractors, and temporary staff. Provided the scheme demonstrated an effective return on investment, it could then be aligned to the incentive structure to drive further quality improvement. Further detail on how this could be delivered in practice is provided in the solutions on page 29.

Enhancing the transparency of the system

The current public debate around waiting times is defined in narrow terms. Each month, health correspondents will report on the top-line national figures (often the total number of patients waiting more than the 18-week or 52-week maximum wait time) as a means of characterising the performance of the system as a whole. The original source of this information (the RTT releases) often bypasses patients and their families entirely, who have to rely on the national press headlines. The focus on RTT alone also means that other important areas of the system – such as overdue follow ups – are overlooked.

It is both odd and unsatisfactory that a patient on the waiting list (as well as their families or carer) must interpret what a story at a national level means for their own forthcoming procedure at their local hospital.

Initiatives such as 'My Waiting Time' have sought to make the data more accessible to the user but have never been rolled out across trusts in a systematic way.⁷¹ Privately, some NHS staff members admit concerns that an informed and empowered patient, who knows their rights, could increase the workload and pressure upon admin staff. Ensuring that appropriate feedback loops where patients can review their treatment and help to improve the service should be welcomed.

Whilst this is an important consideration, history provides significant lessons about the value of making national datasets available in a way that the information contained therein can empower patients to advocate for positive systemic change (see box 1).

70. 'Myth four: the NHS has too many managers', *The King's Fund*, [link](#)

71. Paper Works: the critical role of administration in quality care (June 2021), *National Voices*, [link](#)

72. My Waiting Time, [link](#)

Box 1: Case Study - MBRRACE UK



Since April 2013, MBRRACE-UK (short for Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK), a research collaboration between several leading UK universities, Sands and GPs has conducted an annual audit programme which collects information about all late fetal losses, stillbirths, neonatal and maternal deaths across the UK. Its 2019 report found that black women were five times more likely than white women to die as a consequence of pregnancy and childbirth.⁷² Whilst the report didn't determine causal factors, this publicly available data shone a spotlight upon a stark disparity and has encouraged the emergence of campaigns to push for greater awareness. The work of MBRRACE-UK has also stimulated further political debate on the subject, including a Westminster Hall debate on the topic earlier this year.⁷³ There has also been an increased transparency and analysis of the issue from government departments, such as the Office for National Statistics who – as of May 2021 – have begun to analyse data on stillbirth and infant mortality in England and Wales by ethnicity.⁷⁴

Reporting on waiting list data in a way that is accessible and clear to patients can be of use to colleagues working across the NHS, particularly those in general practice. The Patient Experience Library too, launched in June 2021 seeks to serve this dual purpose: assisting patients in understanding more fully how long their wait at the local hospital may be, but also in acting as a tool for GPs who will be able to easily access and interpret the information so they can discuss any potential referral and waiting times with patients “upstream”.⁷⁵ General Practice should also be encouraged to utilise decision support tools, produced by third sector organisations.⁷⁶

A push for greater transparency of late has led to further information being released. In the most recent data release to cover the period up to May, NHS England has reported on the number of 52+ week waiters (and up to 104+ weeks), so we will be able to better understand the number of these long waiters in the system.

Alongside this, one of the existing categories ('Other') has been repeated into subcategories (medical/surgical/mental health/paediatric). Mental health trusts who had not previously reported on their waiting list for example, will now be compelled to do so. This is positive for service users. Whilst the figures may make for sober reading, they will enable a more informed, sustained dialogue to take place publicly about remedies available.

Solutions

We propose a series of changes to the current RTT model and how patients are managed and prioritised at both a Trust and system level. We believe that:

76. Waiting Lists: Get information on waiting times for treatment at NHS Trusts in England, The Patient Experience Library, [link](#)

77. A good example are the series of Musculoskeletal decision support tools produced by Versus Arthritis, [link](#)

73. Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17 (November 2019), [link](#)

74. Including coverage in national newspapers as well as in culture, fashion and women's health outlets, such as Vogue, see Amanda Randone, Black Mothers Are Five Times More Likely To Die During Childbirth. That Needs To Change, Vogue, 25 July 2020, [link](#). For the recent Westminster Hall debate, 19 April 2021, [link](#)

75. Births and infant mortality by ethnicity in England and Wales: 2007 to 2019, Office for National Statistics, 26 May 2021, [link](#)

- **RTT figures should be reformed.** Patients should expect to receive a diagnosis and decision within eight weeks (to be known as ‘referral to decision’), before then seeking to commence consultant-led treatment within ten weeks following diagnosis (‘decision to treatment’).⁷⁷ This means that the total 18-week target will remain unchanged, but in effect two stricter deadlines will be imposed to incentivise Trusts to shorten the current time taken to give every patient a diagnosis. We believe this should be introduced immediately and argue that it will be more straightforward to implement than any wider reforms linked to the Clinically-led Review of NHS Access Standards.⁷⁸
- **Systems with the worst elective waiting times should receive additional managerial and admin support for the next two years.** Whilst unfashionable, investment in information technology and additional data managers who are trained in appropriate data and waiting list management will be required to ensure that the waiting list information is of sufficient quality (further detail is provided in the section on workforce).
- Greater transparency around the use of clinical prioritisation methodologies is required. This should apply at two levels:
 - **Nationally.** As part of the monthly RTT statistical release, NHS England should request for Trusts to include the proportion of patients within each of the current P1-4 categories (or whichever approach replaces this over time).
 - **Patient level.** Individual patients must be informed by their physician of their prioritisation level, with the reasoning and methodology explained to them in a way they will understand.

Patient Communication

Recalibrating patient communication

“It is not that the information is secret...it is available and can be collected providing an individual patient or newspaper reporter has the tenacity to go around two hundred health districts. As the health service has this information readily available, there should be no reason why it cannot be made available to their customers”

John Yates ‘Why Are We Waiting’ 1987

“It’s been no communication, completely on your own, and I know my mental health has deteriorated...I don’t want to talk about it anymore because I feel like I’m just driving my family mad.”

Participant in focus group run by Policy Exchange

A long and poorly managed wait can have dire consequences for mental health, physical health, work, quality of life and relationships.³¹ Some of these consequences will now be unavoidable: many solutions to reduce waiting times will take time and considerable resource.

78. Rob Findlay, ‘Referral-to-treatment waiting time targets have reached the end of the road’, *Health Service Journal*, 15 December 2020, [link](#)

79. Measuring what matters: Update on the Clinically-led Review of NHS Access Standards (November 2019), NHS England, [link](#)

There is one area where immediate, non-clinical changes can deliver a significant benefit for consumers: communication. Whilst there are exceptions of good practice throughout the NHS, it is clear from our research that the way waiting times are communicated to patients, and how these individuals are supported whilst they wait requires reform.

Action here can deliver genuine benefit. Some examples appear obvious, such as the study from the Behavioural Insights Team which demonstrated that regular communication with patients waiting for treatment (for example via text messages) resulted in higher appointment attendance.⁷⁹

We should look beyond healthcare for inspiration: research in Boston, Massachusetts found that trust in the Government increased when the city openly shared information about its efforts to address problems, from potholes to broken streetlamps. Whilst it might appear counterintuitive, these studies suggest that fronting-up to delays and problems can build support and buy-in from consumers.⁸⁰

As part of this research, Policy Exchange commissioned Savanta to run focus groups with patients who had been on awaiting treatment for at least six months. The group represented a spectrum of different clinical specialisms, ranging from orthopaedics to gastroenterology and obstetrics. Most patients reflected the view they felt in the dark about when they might be treated. Many were not updated about likely delays to their treatment and often received news of cancellations at short notice, meaning they felt unable to effectively manage their time waiting. A number said they felt shut out of the process entirely. One participant felt “abandoned”. Most attendees said their experience of waiting was overwhelmingly negative.

This contrasts with their expectations of the NHS. Reflecting on what they considered a ‘good experience’, participants expected clear communication [see table 1]. Yet patient communication is a piece of the elective care puzzle where expectations and experience are substantially divergent.

Table 1: Responses of participants when asked ‘describe what you think when you think of a ‘good experience’ with the NHS’

Responses
“Good communication, respectful, timely and appropriate care delivered with dignity.”
“Responsive, friendly, professional, reliable.”
“Regular communication, keeps me informed about my choices, works with me to help live my best life.”
“Caring nurses, clean hospitals, clear information and communication.”
“Informed and educated care.”
“Safe, caring, friendly, well-informed, educated staff and treatment.”
“Resolving issues the first time”

Whilst our participants had considerable goodwill toward the NHS and

80. ‘How can we support mental health patients on waiting lists? Using text messages to increase engagement’, *The Behavioural Insights Team*, 7 February 2019, [link](#)

81. Ryan W. Buell, Ethan Porter & Michael I. Norton, ‘Surfacing the Submerged State: Operational Transparency Increases Trust in and Engagement with Government’, Harvard Business School Marketing Unit Working Paper No. 14-034, 6 November 2013, [link](#)

an understanding of the pressures facing the NHS, there were signs their patience may wear thin. As one participant claimed, “I’m not surprised or disappointed...nothing has happened in the past year...I think the NHS...have been overwhelmed and overworked. However, I was waiting, already, quite some time before the pandemic started...”.

Recent patient surveys on GP experience may be instructive in gauging the public mood here. According to Healthwatch, by December 2020, around 75% of people who contacted them reported a negative experience. The negative rating was 20% more than the same period in 2019, with a causal link between restricted access to services and negative feedback.⁸¹ It would not be unsurprising to see a similar reduction in satisfaction in planned care in the coming months as already dissatisfied patients are referred from general practice.

A lack of a systematic, transparent approach to patient communication has created a sense of unfairness and growing frustration. This also has the spillover effects beyond secondary care. General practice becomes a first point of contact once patients fail to reach their consultant or relevant departmental staff. As one focus group participant put it, “I’m badgering my GP again... ‘Can you at least let me know whether I’m looking at six months or nine months.’ If I could just know, that would feel better.” Another said: “I’m seriously considering going back to my GP and saying: ‘Look I’m in so much pain, can you get me to [another] hospital and see if I can get the procedure done.’... I don’t want to do it because I feel I don’t want to cheat someone else that’s equally wanting an operation, but I’m putting my life on hold... I dare not go out, because I could end up being rushed into hospital.” With the “total triage” approach being challenged and calls for a greater number of face-to-face consultations to be offered growing, these pressures will not abate in the near term.⁸² Hospital administrative staff also feel the knock-on effect of this communication gap also as they become a first port of call for concerned patients and families. There is a risk of further cementing unfairness through a “he (or she) who shouts loudest” culture if staff feel compelled to address the most persistent patients.

Focus group participants also reflected inconsistencies in the information received in secondary care about their forthcoming procedures. Some were reassured – even empowered – by information their clinicians gave them (often a printed leaflet or website address) with which they could begin to make informed choices at any follow-up consultation or in further communication with healthcare professionals. Others received no information at all.

There is evidence the NHS is working to enhance its communication with patients. The recently updated *Good communications with patients waiting for care guidance* (last updated 26 May 2021) adopts several welcome principles, but the exemplar letters do not contain information to sign-post patients toward materials or services through which they can manage their wait.⁸³

82. ‘GP access review must be part of NHS COVID-19 recovery’, *Healthwatch England*, 22 March 2021, [link](#)

83. Dave West, ‘GPs told to resume booking face-to-face appointments following row over access’, *Health Service Journal*, 14 May 2021, [link](#)

84. *Good communications with patients waiting for care*, NHS England, 21 January 2021, [link](#)

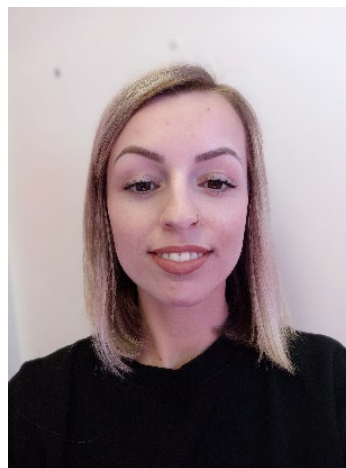
Patient case studies



Samantha – F, 49, Painful back – waiting 18 months for joint surgery

“At the initial consultation... it’s all good. It’s...after that consultation where it all breaks down...when you’re transferred to a theatre list and a specific consultant, but nobody talks to anybody else...it’s very disconnected. Especially if it’s multiple elective surgeries that might be going on...nobody coordinates... you’re just treated as a separate entity for every condition.”

Samantha is currently waiting for two elective surgeries. She has been waiting over eighteen months for surgery on facet joints after previous disc surgery which has left her in constant pain. She also has a prolapsed bladder, the diagnosis for which she paid for privately. She takes multiple prescription medications to manage these conditions. Samantha feels a sense of frustration at communication in both primary and secondary care whilst waiting and reflects a sense that she continually needs to chase staff to try to pin down a date for surgery or for further information



Abigail, F, 24 – waiting 6 months for a laparoscopy for endometriosis

“It would be helpful ...to give you your place within the waiting list. It’s almost like unless the person decides to be sneaky and let you know you’re near the top, you have absolutely no idea. I wonder if there could be a system we could access, or even just that we could call them up and...give us a tier. I.e. 1-10, 11-20, 20-30 etc.”

Abigail is currently on two different waiting lists. Firstly, for a laparoscopy having been referred for surgery in September 2020. The second, for surgery to remove a cyst from her brain for which she initially opted to postpone surgery. Although she would rate her experience of waiting positively, there has been a real disparity in the quality of communication she has received from the NHS regarding the two procedures. Whilst for cyst surgery she was told about the delays and was offered to be put on the short cancellation list, her experience waiting for a laparoscopy has been entirely different, with frustration over amended surgery dates and difficulty in reaching the appropriate hospital staff.

Addressing the communication gap

First, we must consider the information that is most useful to patients and that they are looking for. After all, the aim must be to enable patients to manage their journey through NHS services as far as possible. The success of the current vaccination programme owes partially to an effective and empowering emphasis on patient communication with the public able to book, cancel and reschedule appointments at their convenience using a method of their choosing.

Adopting a strategy which tries to see things from their perspective as much as possible is key, but current approaches are not aligned. For instance, RTT reporting does not reflect the full patient journey. The patient's "clock" really starts when they first see their GP, not when they are referred to treatment by a consultant. From their perspective, they are dealing with multiple waits.

There is an opportunity to do things differently.

Firstly, the NHS should address a common complaint: the lack of a "point of contact".⁸⁴ Having this would prove concurrent with NICE guidance on perioperative care, based upon research which finds that people "place a high value on having information that is consistent and available when they need it. Patients ...stressed the importance of knowing who to contact if they have concerns or queries, particularly after discharge."⁸⁵ Focus group attendees strongly emphasised this point. We have already proposed some potential solutions here, ranging from the use of care coordinator roles within PCNs to expanding the number of managerial staff within the planned sector.

When the NHS does communicate with patients, it needs to ensure the messaging is clear and intelligible. To address inequalities in access to information, this must be translated into relevant first languages and be available in braille and BSL. The NHS needs also to ensure that patients know their rights from the outset. This will include foregrounding information which could be of relevance, such as the freedom to choose a non-NHS provider and to self-fund care. Meanwhile, there is only limited evidence of attempts to describe and to clarify the 18-week standard to patients locally.⁸⁶

The current policy at a national level seems to be to be deliberately vague when it comes to explaining RTT waits. In the set of 'frequently asked questions' for patients waiting for care published by NHS England in October 2020, the first question and proposed response was as follows:⁸⁷

FAQ guidance from NHS England : How long will I have to wait for my operation?

Unfortunately, at the moment we can't be certain. The pandemic has had a big impact on the NHS and we are trying to resume services and keep patients safe at the same time as we continue to treat COVID-19 cases. We are reviewing all patients to see what they want and prioritise those in most urgent need. We are doing our utmost to ensure you get the treatment you require as soon as possible.

85. London Covid-19 Deliberation (July-August 2020), [link](#)

86. 'Perioperative care in adults', NICE guideline 180, 19 August 2020, [link](#)

87. An example of a trust that has outlined what this means is Norfolk and Norwich University Hospitals, see 'RTT 18 Weeks - What does this mean to you as a patient?', [link](#)

88. Clinical validation of surgical waiting lists: framework and support tools, NHS England, 1 October 2020, [link](#)

The NHS should explore ways it can increase ‘operational transparency’, including allowing patients to monitor the in the stage service delivery they have reached. Services such as the Milton Keynes University Hospital “⁸⁸ allows patients to manage their appointments online without needing to call the hospital, reducing the administrative burden on staff and boosting patient choice and control. 80% of the UK population meanwhile now has the NHS COVID app. Utilising existing resources and reach will be useful tools to deliver coordinated communications. These approaches support the expansion of ‘Patient initiated follow up’ and are concurrent with the aims of the Long Term Plan.^{89 90}

Ultimately, addressing this communication gap has the potential to begin to address the lack of consumer-driven behaviours in the system. This should resonate at a senior level within the NHS. The job description for the new NHS England CEO position includes a requirement to shift the national mindset about the NHS to “moving from the “grateful patient” to the “empowered consumer”.⁹¹

During focus groups, Policy Exchange explored a series of policies the NHS could adopt to address the communication gap:

1. Knowing clearly when you would be seen

Focus group attendees overwhelmingly reflected a sense that having clarity over their procedure and knowing the length of their wait was more important than choice over where and who might complete it. Attendees reflected a sense that knowing clearly when their procedure would take place would reduce their anxiety and help them plan their lives waiting.

2. Knowing where you were currently sat on the list

Some attendees liked the idea of knowing where they sat on the list – as patients in Greece for instance are able to learn – recognising how this policy had been effective for the vaccine rollout and the sense of fairness it can create. They reflected however a sense that the variety of conditions, potential for deterioration and re-prioritisation could make the approach both complicated and frustrating if they did not have a sense they were moving up the list, or in such a way they could predict when they may be treated.

3. Knowing the average wait time for patients at the hospital and/or for your specific surgery.

Some attendees reflected that possessing this information would not be useful if they lived too far from other hospitals. Other attendees claimed that the information might be useful if they were facing a particularly long wait. A trial for this approach took place at 12 hospitals across England over 2019 who used average (mean) waits, however no updates on the clinical review of standards have been forthcoming since the pandemic.

89.

90. NHS Long Term Plan, Chapter Three, [link](#)

91. MKUH Patient Portal, [link](#)

92. Position specification: National Health Service, Chief Executive, NHS England, 14 May 2021, [link](#)

4. Being invited for a review if you are a 'long waiter'

Many attendees reflected that they would find more regular monitoring of their conditions desirable – particularly if they were due a long wait for surgery, so that a healthcare professional could divert them to supporting services or to re-prioritise their procedure if required.

The British Orthopaedic Directors Society recently recommended that P3 patients (should receive operation within 12 weeks), should be reviewed after 10-12 weeks if surgery has not been scheduled. For P4 patients they recommend a review should occur every 6 months, with the clinician considering whether an earlier review is required.⁹² These assessments would need to reflect the patient as a whole (their co-morbidities in particular), as focus group attendees reflected a sense that clinicians often viewed them through a particular departmental lens, rather than holistically.

5. Access to peer support

Attendees were broadly supportive of the idea that an expansion of condition-specific peer support networks would be useful as a means of information-sharing between others also waiting for a similar procedure and for building a sense that they were not waiting alone for a procedure.

6. Access to information and technologies to help you understand your procedure and to support you whilst you wait

Attendees reflected disparities in the type and quality of information received – both about their forthcoming procedure and how they might best prepare for it. Some attendees felt well informed and empowered by literature n provided. Others reflected that further information and the option of access to technologies, such as apps, would also be useful in waiting well. Attendees reflected that choice over the format and type of information received would be beneficial.

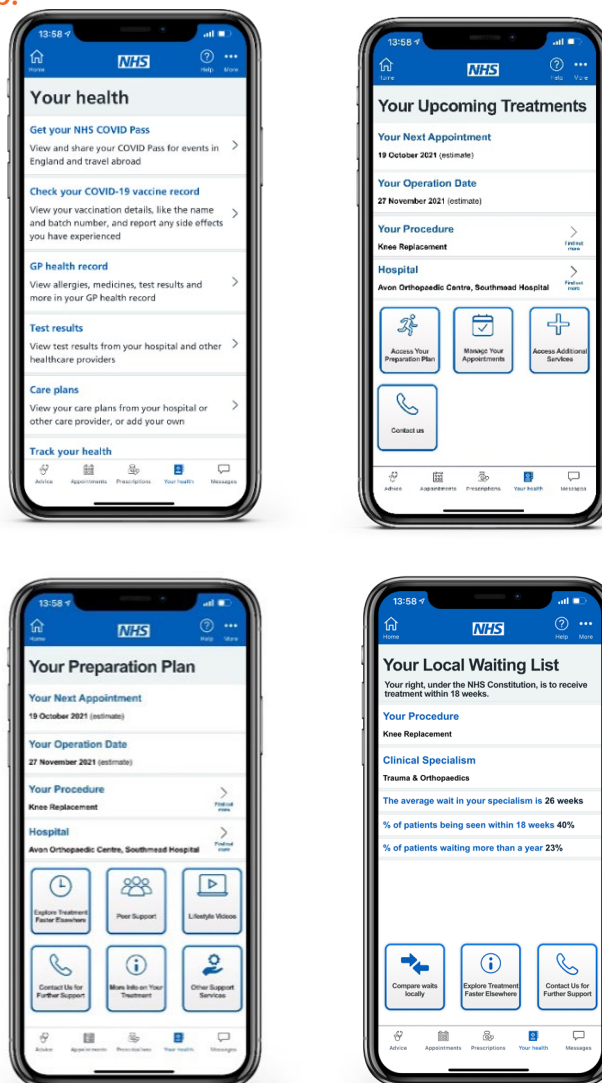
93. Letter from British Orthopaedic Directors Society to members, 6 May 2021, [link](#)

What does good communication look like?

In this section, we suggest ways in which current patient communication formats can be enhanced without significant redesign of the current strategy.

NHS App Dashboard

Figure 5: How waiting times could be incorporated into the NHS app.



Enhancements should be added to existing NHS App and should signpost patients to additional services: from the Your Health dashboard, you should be able to access a section titled Your Upcoming Treatments with the possibility to rebook treatment, ability to communicate with an appropriate member of NHS staff as well as having access to a personalised Preparation Plan (based upon location, procedure type, relevant medical circumstances).

Text messages

The ongoing vaccine rollout has demonstrated that the NHS can effectively coordinate a mass communication campaign with vast numbers of patients in a clear and engaging manner. Despite the uniformity of the procedure for those attending vaccinations, the NHS should look to build upon the lessons of the rollout to optimise its communications with those currently waiting for treatment.

Figure 6: Learning from the vaccine rollout - Harnessing text messaging for those waiting for treatment

You have reached the top of the queue and are a priority for getting a free NHS COVID-19 vaccine. Please book yours now at <https://www.nhs.uk/covid-vaccination> or by calling 119.

Reminder Texts for those on the waiting list

Hello, this is [your point of contact] from Avon Orthopaedic Centre. You're getting nearer to the top of the waiting list and your [procedure] is now just THREE WEEKS AWAY on 27 November 2021 at 10am.

Did you know you could recover more quickly from surgery if you complete our daily exercise videos? GET STARTED TODAY

To confirm you can still make your appointment, [CLICK HERE](#)

If you want further support and want to speak to me or a member of staff, please ring 0123456789 or respond to this message by texting SUPPORT

Can't make this appointment anymore? [REBOOK HERE](#)

Patient letter

The first letter here represents the current template recommended for use by NHS England as part of the latest *Good communication with patients guidance*.⁹³ On the page following it, we recommend enhancements to that letter. These inform the patient of their rights and signposts supporting services, either accessed remotely and in their local area.

94. Good communications with patients waiting for care, NHS England, 21 January 2021, [link](#)

HOW THINGS ARE



Ref: Patient's NHS number

Recipient's name

Address 1

Postcode

Name

Team/Directorate

Private and confidential

Address 1

Address 2

Address 3

Postcode

Dear [patient name]

Telephone

Email address

Important information regarding your postponed appointment

We are writing to you regarding your referral for [appointment].

We are sorry that your appointment has previously been [delayed/cancelled] due to changes we have had to make to our services in response to the COVID-19 pandemic.

Date

It has been our priority to make sure that people needing urgent attention have received the care they need, and our team has been working around the clock to keep services going.

We recognise that many patients have had experienced long waits and therefore wanted to keep you informed about our next steps and plans to restore elective services.

Our team is currently reviewing our waiting list and working through the process of re-scheduling appointments. This will enable us to make sure that those who require an urgent appointment are seen as quickly as possible, followed by those who have been waiting the longest.

We understand your circumstances may have changed whilst you've been waiting for your appointment. We will be in touch shortly to discuss whether you would like to proceed with your appointment or other potential options if suitable.

You can expect to hear from us with within [honest timescale].

If you do not hear from us within the above time, please contact [telephone number and opening hours] or email [email address].

What to do if you have any questions

If you no longer want to proceed with your appointment, or if you are concerned about your condition, please contact us on [telephone number (including opening hours)] or email [email address] so that we can provide you with further advice and support.

Staying safe whilst you are in hospital

We understand you may have queries or concerns about coming to hospital.

It is our priority to keep you, your family, other patients and our staff safe. Because we care, we might ask you to do things differently when you are here.

We're asking patients, visitors and staff to wash hands as often as possible with soap and water or hand sanitiser.

All people in the hospital are asked to always wear a mask (covering nose and mouth). If you can't wear a mask for any reason, please talk to your care team.

People are also asked to keep a safe distance from others.

If you would like to know more about how we're trying to stop coronavirus spreading and keep people safe, you can contact our patient support team via [patient support team contact details].

Yours sincerely,

[Named contact in service/department]



HOW THINGS COULD BE

Ref: Patient's NHS number

Recipient's name

Private and confidential

Dear [patient name]

Important information regarding your postponed appointment

We are writing to you regarding your [condition/treatment required] after you were referred on [date].

We want to sincerely apologise for having [delayed/cancelled] your appointment

Whilst we are working hard to recover our services at [hospital name] following the COVID-19 pandemic, we recognise that you have already been waiting [amount of time].

Therefore, we wanted to clarify when you can expect to be seen and to let you know about services we can offer you to support you whilst you're waiting.

We also wanted to ensure you knew how to contact us if you had further queries about your treatment or wanted to reach a member of our team.

When will my next appointment be?

Based on the current waiting list at [hospital name], the proportion of patients expected to be seen [on x date or within a particular window]. We will be in touch shortly to discuss whether you would like to proceed with your appointment or other potential options if suitable.

Preparing for your treatment

No-one should have to wait for treatment in pain. No-one should feel unsupported whilst they wait. That is why the NHS has created a set of support packages to assist you ahead of your next visit to hospital.

- Have a smartphone? Please download the NHS app, where you can access information about your treatment, your rights, and assistance whilst you wait. Accessible at: www.nhs.uk/nhs-app/
- Interested in peer support? Information about local or national condition-specific peer support group [contact details]
- Did you know about the [name of programme] which provides [type of service locally]?

Who can I speak to?

Your point of contact is [name]. They are available on [telephone number (including opening hours)] and email [email address] to support you.

You can also reach a member of NHS staff via the NHS App.

Have your circumstances changed? – Let us know

We understand your circumstances may have changed whilst you've been waiting for your appointment. If you no longer want to proceed with your appointment, or if you are concerned that your condition has been getting worse, please do contact us using the details above.

Know your rights

The NHS Constitution makes it clear that all patients should expect to commence consultant led treatment within 18 weeks of referral. I am sorry we have not been able to deliver against this target. On behalf of the hospital, I would like to again apologise for the delay.

Yours sincerely,

[Named contact in service/department]

Solutions

We believe that patient communication is of utmost importance. Reforms to communication must be pursued with equal energy to the broader system transformation and elective recovery.

- **The NHS must urgently enhance patient communication.** NHS Trusts should rapidly invest in developing patient-centred information and communication materials and should ensure the Accessible Information Standard is adopted universally. Policy Exchange support the recommendations set out in the National Voices report Patient Noun, Adjective.³¹
- **Improve the transparency of information at patient level.** All GPs should be actively encouraged to access to the new Patient Experience Library waiting time tool, and to use the resource during appointments with their patients to inform decisions around referral.¹²⁴
- **Greater honesty in conversations with the longest waiters is required.** Where revalidation means a wait longer than 52 weeks, a communication strategy which is candid but sensitive must be a priority.⁹⁴ These communications with patients should set clarify the patient's right and all options, including the right to seek treatment with another provider, and self-funding care.
- **Invest in a priority NHS-led digital offer to support patients on the waiting list.** These services could include appointment scheduling, list status, signposting to wider services, and made available through the NHS App.
- **The NHS should ensure signposting patients to appropriate peer support becomes more commonplace.** This should draw upon existing expertise within the voluntary sector.

Preparation and Post Operative Recovery

"I don't know about wasted time but it's just...time that you spend uncomfortable in pain"

Participant in focus group run by Policy Exchange

It does not necessarily follow that the longer the wait, the worse the patient experience. What is clear however is that many that are having to wait for lengthy periods have a poor experience, expressing frustration that time spent on the waiting list is not time used effectively.

Time spent waiting for a procedure should therefore be seen as an opportunity to bring clarity to both the patient and practitioner over any forthcoming procedure through shared decision-making (SDM) which can play a significant role in reducing readmission. Strikingly, research from the Centre for Perioperative Care has found that around one-in-seven patients at present experience "surgical regret," so effectively communicating what a procedure entails and what the result may be is of

95. This is an approach reflected in a recent blog from Dr Rebecca Rosen, 'Transparent processes with a human touch: the essentials of good waiting list management', Nuffield Trust, 11 May 2021, [link](#)

great significance.⁹⁵

In April 2021, Partha Kar, National Specialty Advisor for Diabetes at NHS England wrote in the *British Medical Journal*, that “managing chronic disease well is founded on three basic principles: self-management, peer support, and access to trained professionals. We do not spend enough time and effort on the first two”.⁹⁶ This conclusion is applicable for elective surgery, where there is ample scope to ensure that more patients are able to more effectively “wait well” for their procedure.

To do so would encourage a greater emphasis upon pre-habilitation services. Our research found that several initiatives and ideas have already been established across the country, such as the the ‘Fitter, better, sooner’ website, developed by the Royal College of Anaesthetists.⁹⁷ The Leeds Teaching Hospitals meanwhile have developed ‘Shape Up 4 Surgery’, an initiative fronted by the trust’s consultant anaesthetists.⁹⁸ A host of other initiatives, developed by the third sector meanwhile could play a supporting role, such as Versus Arthritis’ ‘Let’s Move with Leon’ scheme and ‘Joint Replacement Support Package’.⁹⁹ In many cases, these services are conjoined and delivered at an ICS level with links developed between both local councils and the third sector to boost relevant activity groups and peer support, such as the PREP-WELL programme in Middlesbrough¹⁰⁰ and Leeds City Council’s “Active Leeds”.¹⁰¹

The challenge for the NHS is to explore how the most convincing schemes can be scaled nationally. Current provision is patchy (both geographically by clinical specialism). Peer support groups illustrate this point. Maternity services are well ahead of the curve and the types of antenatal peer support available nationally could be embraced more widely as a model to replicate across specialisms.

It is encouraging to see ‘pre-hab’ listed as among the types of innovation being trialled through the £160m elective accelerator programme.¹⁰² Beyond pre-hab, there are an increasing number of innovative remote information and consultation services which can assist patients in both managing their condition and in preparing for a procedure. Many good platforms exist but rolling the best examples out so they can assist more patients is the challenge. For instance, the community health provider Healthshare developed software backed by Innovate UK in 2020, aiming to improve patient literacy, and access to advice, care and self-management support.¹⁰³

Whilst digital platforms can play a significant role in informing patients, assisting with the monitoring of conditions and communication with the service, an emphasis upon digital forms of communication must not be to the detriment of the digitally excluded. A recent report from National Voices wisely points to solutions that can help this risk.¹⁰⁴

To complement these services, there could be an increased emphasis on the role that primary care providers (including GP at Hand by Babylon and Livy etc.) could play in delivering follow-up appointments. Rather than being seen as a distraction in elective service delivery, the rollout of effective preparatory schemes and information must be pursued in

96. Jugdeep Dhesi & Lisa Plotkin, ‘To tackle the backlog, we need to transform how we wait for surgery’, *The BMJ Opinion*, 15 April 2021, [link](#)

97. Partha Kar, ‘Changing the narrative around self-management’, *British Medical Journal*, 21 April 2021, [link](#)

98. Fitter, Better, Sooner Toolkit, *Centre for Perioperative Care*, [link](#)

99. Shape Up For Surgery, *The Leeds Teaching Hospitals*, [link](#)

100. Let’s Move with Leon, *Versus Arthritis*, [link](#)

101. PREPWELL - Community Prehabilitation & Wellbeing, *South Tees Hospitals*, [link](#). For an evaluation of the scheme, see Garry Alan Tew & Robin Bedford et al. ‘A Community-based prehabilitation before elective major surgery: the PREP-WELL quality improvement project’, *BMJ Open Quality*, Vol. 9, No. 1 (2020), [link](#)

102. Active Leeds, *Leeds City Council*, [link](#)

103. NHS’s £160 million ‘accelerator sites’ to tackle waiting lists, *NHS England*, 13 May 2021, [link](#)

104. ‘AI-driven physiotherapy app reduces pressure on NHS during Covid-19’, *National Health Executive*, 8 May 2021, [link](#)

105. Unlocking the digital front door - keys to inclusive healthcare (May 2021), *National Voices*, [link](#)

tandem.

There should also be a renewed emphasis upon post-operative care provision. A recent report from Healthwatch and the British Red Cross has shown that over the course of the pandemic, significant numbers of people did not receive follow-up support having been discharged from hospital, increasing the scope for unmet need.¹⁰⁵ This lack of monitoring simply increases the likelihood that these patients re-enter the system with returned symptoms or new complications post-operation. The provision of Virtual Wards which offer patients the care they need at home, as a virtual in-patient, monitored by a hospital consultant until their treatment is completed should be expanded. The approach can reduce Delayed Transfers of Care (DTOC) freeing up inpatient capacity and further space for elective procedures. In Norwich for instance, as part of NHSx's current elective accelerator programme, 21 patients have been supported at home, saving 179 bed days.¹⁰⁶

Solutions

We propose a series of low-cost interventions to improve how the NHS should communicate with its consumers in elective care:

- **The NHS should rollout of the best digital tools to support patients waiting.** As part of investment in an NHS-led digital offer (to be made available through the NHS App which has had over 1.3 million new registrants since early May 2021) the digital offer should signpost patients to information, exercises, and further support to assist with their preparation and recovery.¹⁰⁷
- **The NHS should profile and promote best practice in Playbooks.** Emulating the playbook model adopted by NHSx, NHS England should establish a national profile of leading approaches and initiatives, both from within the NHS and beyond such as the resources being developed by the Centre for Perioperative Care (CPOC).

Workforce

Balancing Workforce Recovery with Elective Recovery

There is an uneasy inter-dependency between elective and workforce recovery: run the system too hot and you risk stretching a tired and understaffed workforce, increasing the risk of current staff needing to take unplanned leave and experienced staff choosing to quit the service. Hold off too long to let your workforce recover and the backlog could balloon further, increasing pressure on a system as we approach an uncertain winter period. Achieving the optimal balance between these two tensions will be a primary responsibility for the new NHS England Chief Executive.⁹⁵

Any effective elective recovery plan will have to make the existing workforce as efficient as possible at tackling the backlog. One approach

106. 590 people's stories of leaving hospital during COVID-19, *Healthwatch England*, 27 October 2020, [link](#)

107. Statistics based upon data presented at NHSx webinar, 'Digital elective recovery ICS workshop', 7 June 2021

108. 'Vaccine status drives over one million new users to the NHS App', *Department of Health and Social Care*, 23 May 2021, [link](#)

is to incentivise longer and more intense working, through ‘double-shifts’ or by working weekends, but a recent NHS Confederation report, *Putting People First* stresses that “it will not be possible to rely on overtime and weekend working to relieve the current situation, as staff are often not able or willing to work additional hours.”¹⁰⁸ The current trial of ‘Super Saturdays’ as part of the Elective Accelerator Programme for more specialist appointments is welcome and should provide a good evidence base upon which to determine whether the model should be rolled out more widely.¹⁰⁹

A recent report from the Health and Social Care Select Committee notes that “burnout” is a “widespread reality in today’s NHS” with “chronic excessive overload” identified as a key factor.¹¹⁰ A recent British Medical Association survey has indicated that two-thirds of UK doctors over 55, and one in eight aged between 35 and 54 are considering retiring within three years.¹¹¹ For some experienced staff who plan to continue working, and may be willing to complete additional shifts, pension taxation rules have been cited as a contributory factor in consultants choosing either to take early retirement or to reduce their working commitments within the NHS. In a survey in 2019 prior to the changes to the tapered annual allowance, 69% of consultant surgeons reported that they had reduced the amount of time working in the NHS as a direct result of pension taxation rules.¹¹² The Treasury have recently opened consultation to review the cost control mechanism with a view that bringing greater stability to the mechanism may reassure members longer-term.¹¹³

The independent sector has an important role to play in workforce planning and there will be instances where additional capacity to the workforce can be added. Ultimately, a holistic analysis of the workforce is required and there should be renewed conversation of how private sector capacity and its workforce can be maximised. The independent sector cannot however be regarded as a silver bullet to the capacity conundrum however given many clinicians work on both NHS and independent contracts.

Existing issues in workforce planning and numbers have been exacerbated in the past 12 months. Part of this is as a direct result of the pandemic, with training put on hold or staff moved into alternative roles. Part of this is also down to resources. It was recently reported that over 700 anaesthetists at CT2/3 level would be unable to continue their training pathways this Summer, due to insufficient training places.¹¹⁴ Nationally, there are 680 funded, but vacant posts for anaesthetists: 8% of the workforce.¹¹⁵ This is particularly problematic for planned care due to the necessary demand for experienced anaesthetists to assist with surgical procedures.

More positively, there has been evidence that the pandemic has renewed interest in working in the NHS. Applications to nursing courses have risen by almost a third in a single year, whilst university acceptances for courses to become an allied health professional rise by 17.5% in 2020, compared to the previous year.^{116 117} If the long-term funding and certainty

109. ‘Putting people first: supporting NHS staff in the aftermath of COVID-19’, *NHS Confederation*, 21 February 2021, [link](#)

110. Jasmine Rapson, ‘Trusts team up for weekend surgery drive to cut paediatric waiting times’, *Health Service Journal*, 21 April 2021, [link](#)

111. ‘Workforce burnout and resilience in the NHS and social care: Second Report of Session 2021–22’, *Health and Social Care Committee*, 18 May 2021, [link](#)

112. ‘Rest, recover, restore: Getting UK health services back on track’, *British Medical Association*, [link](#)

113. RCS survey on the NHS pension scheme, *Royal College of Surgeons of England*, 7 November 2019, [link](#)

114. ‘Public Service Pensions: cost control mechanism consultation – Proposal to reform the mechanism’ (June 2021), *HM Treasury*, [link](#)

115. ‘Nearly 700 anaesthetists have training interrupted after cuts’, *British Medical Journal*, 12 May 2021, [link](#)

116. ‘Onslaught...’, *NHS Managers.net*, 15 February 2021, [link](#)

117. Megan Ford, ‘Nursing courses see 32% rise in applications during Covid-19’, *Nursing Times*, 18 February, 2021, [link](#)

118. ‘Latest figures show welcome rise in university acceptances to study for the allied health professions’, *Health Education England*, 13 January 2021, [link](#)

can follow from the upcoming spending review, this may form the basis for putting the workforce on a more sustainable footing.

Solutions

- **The NHS and Government should commence a massive expansion of the imaging workforce to staff the new diagnostic capacity** – with an additional 2,000 radiologists and 4,000 radiographers required.
- **The NHS should hire additional data managers to improve the quality of hospital waiting lists.** Policy Exchange propose that a fund of £12m is made available for these positions (at NHS Band 8a-8b), which would be on a 24-month FTC basis. The Government must also think carefully about how to best reward and safeguard the well-being of staff tasked with tackling the enormous backlog of procedures.
- **The NHS should remain open to global recruitment.** Many professions within the NHS are significantly staffed by overseas recruits. Overall, 21% (around 35,300) joiners to NHS hospital and community services in 2020 were not UK nationals – equivalent to one in five of joiners.¹¹⁹ It is not feasible to onshore sufficient levels of staff in the near-term. A National Workforce Strategy should look to boost local recruitment as a priority, but Global Britain demands an openness to global recruitment to secure the recovery in the short-term.
- **The Government and Health Education England (HEE) should work to ensure training pathways in specialisms currently understaffed or with outstanding need in the elective recovery are adequately resourced.** DHSC should look to build upon the £30 million recently made available for HEE to trusts help plan for additional training and to deliver one-to-one training where needed.
- **Consider how a freeze or cut to the lifetime allowance will impact the medical workforce.** The current freeze on the lifetime allowance has been cited as a causal factor in surgeons and consultants seeking early retirement or reducing their NHS workload. The Government should consider whether transferable lessons can be learnt from the Judiciary where a form of exemption on the impact of pensions taxation for Judges was created.¹²⁰
- **The Government should bring forward a national workforce strategy.** Whilst there are some positive signs demonstrating a growing number of young people keen to enter the healthcare profession, a holistic, long-term workforce strategy is required which must account for the prospect of experienced staff exiting the profession on account of the current lifetime allowance as well as encouraging new entrants.¹¹⁹

119. Billy Palmer & Lucina Rolewicz, 'Chart of the week: The contribution of overseas nationals to the supply of NHS staff', *Nuffield Trust*, 24 June 2021, [link](#)

120. 'BMA responds to findings of Ministry of Justice consultation on judicial pensions', *British Medical Association*, 25 February, 2021, [link](#)

Policy, Funding and Incentives

There is substantial interest in the upcoming spending review. The UK Government has so far made an initial £8.1bn available to cover COVID-19 costs facing the NHS in the current financial year with £7.4bn of this available for the first half of 2021/22. In addition, a further £1bn has been allocated to elective recovery, alongside further funding for mental health.

Budgets have not been set for the second half of the year given the wider uncertainty of the pandemic.

Whilst the elective recovery fund was warmly received by the NHS additional funding will be required to meet this multi-year challenge. If the decision to separate the current RTT figures is carried forward as proposed by this report, then modelling suggests that it will take until:

- February 2025 for 92% of patients to receive a diagnosis ('referral to decision') in eight weeks or less.
- September 2028 for 92% of patients to be treated ('decision to treatment') in ten weeks or less.

This modelling uses a relatively 'heavy' estimate in assuming that two-thirds of the missing referrals present for treatment by September 2021. In both estimates it assumes that the rate of activity significantly outstrips 2019 levels, going at 120% activity levels in referral to decision and 115% in decision to treatment, respectively.

A number of interest groups have already begun stating the case for further resource to address the elective backlog over the longer term. The Royal College of Surgeons is calling for a £6bn package over the next six years, to help fund the shift to a surgical hub model. The NHS Confederation has argued that the Government should agree to a 'long-term framework' for the recovery of elective care, whilst also calling for a move away from the current waiting list measurement which it describes as no longer fit for purpose.¹²¹ Reports in the media suggest that internal Government modelling suggests that between £2bn and £10bn will have to be allocated per year for up to four years, on top of core NHS funding.

These unprecedented requests for elective care must also be contextualised by the broader funding demands across NHS and social care.

There is a debate at a senior political level at how to best respond. Some will advocate a long-term settlement for elective care is necessary. It would give the sector greater certainty and pave the way for some of the transformations required to embrace the positive changes from the pandemic, such as community and remote diagnostics.

On the other side of the debate, there is understandable concern within the Treasury that delivering a significant multi-year funding package may not be an effective approach for making rapid progress on the waiting list, especially as the Health and Care Bill may lead to the use of high-volume incentives such as payment by results are scaled back.

There is evidence that the existing policy framework is not resulting

121. 'Building back elective care: a new framework for recovery', NHS Confederation, 11 March 2021, [link](#)

in the effective mobilisation of all available capacity. The RTT figures to March 2021 demonstrate that GP referrals to the independent sector are around 25% lower than 2019 – suggesting inconsistent use of the eRS. This is reflected in reduced numbers of non-admitted completed pathways – meaning that less patients are being seen and treated.

What is the best way forward? We believe that the new Secretary of State should seek to negotiate a multi-year deal at November's spending review. Within this, it is important to maintain the overall 18-week RTT standard, but with adjustments to separate out a diagnosis from treatment, with financial penalties introduced for ICSs which fail to meet them. This reflects the public's priorities regarding access to routine services, and the requirement to get a quick and accurate picture of unknown clinical risk. Incentive structures and support frameworks must be designed with this in mind, to encourage those operating at a hospital and system level to find innovative ways of working through the local backlog in their patch in the most efficient way possible.

Solutions

The recommendations are based upon the premise that the vaccine rollout continues to progress without major disruption, with no variants of concern substantially reducing the effectiveness of the current licenced vaccines, and that the impact of COVID-19 on the NHS is therefore greatly reduced over the coming Winter and Autumn.

- **The NHS elective recovery framework should be structured based on activity delivered.** A focus on payment-by-results will remain important for the next few years and should be a key negotiation point for HM Treasury at the spending review. Assuming that social distancing and self-isolation requirements can be scaled back substantially, Policy Exchange propose that the upcoming operational planning guidance period from October 2021-March 2022 sets the following thresholds for ICSs:
 - **Inpatient activity:** 90% compared to 2019 baseline by October 2021, rising to 100% by January 2022
 - **Outpatient activity:** 120% compared to 2019 baseline (given the opportunities for greater use of remote and digital technologies)
- **The Government should offer additional carrots (and sticks) to drive the recovery. These could include:**
 - **Long-term funding agreements for planned care.** The upcoming spending review should include a multi-year commitment towards the recovery of planned care over this Parliament.
 - **Enhanced accountability.** To ensure adequate oversight, NHS England should be required to undertake quarterly reporting back to both Ministers and Parliament outlining the volume and spend of diagnoses, procedures and treatments

undertaken.

- **Additional incentives for meeting the new referral to decision target.** Payments would be made available from the elective recovery fund for ICSs which show substantial improvement in bringing waiting times for a referral to decision down towards the proposed eight-week target.
- **Uplifting the national tariff for clinical specialisms with the longest waits.** This would reflect the requirement to achieve a ‘pincer movement’ on both undiagnosed referrals and those waiting 52 weeks plus. This could offer in the region of 120% of tariff prices for a fixed period, to act as an incentive to Providers (including the Independent Sector). Trusts would need to meet the minimum activity thresholds set above to qualify for these payments.
- **A regular annual inspection regime.** Whilst we believe that a financial settlement for the elective recovery should be long-term, this should be accompanied by annual inspections, and ongoing monitoring to ensure that guidance and policy frameworks from central Government and NHS England are being implemented.

Chapter Three: Summary of Recommendations

This report has set out the scale of the challenge, but also the exciting opportunities to reform our existing approach to elective care. For both the NHS and the Government, the narrative must not be that the backlog was simply addressed, but that we took the opportunities to do things differently, including addressing health inequalities along the way.

Do the proposals in this document amount to a realistic plan for tackling the elective backlog? That is not for us to determine. However, a summary of the package of policy recommendations across the different sections of the pathway is provided below:

General practice

- **Primary Care Networks should have a more enhanced role in waiting list management.** The role of new Primary Care Network Care Coordinators should be expanded, with their remit to include patients facing long waits for elective treatment.
- **GPs should provide more information to patients seeking elective care.** All GPs should be actively encouraged to utilise the new Patient Experience Library waiting time tool and decision support tools from third sector organisations. These should be used during appointments with their patients to inform decisions around referral.

Diagnosis and treatment

- **The Government should release new capital funding for diagnostics.** The UK Government should announce a £1.3bn package for the diagnostics sector to bring NHS capacity in line with the OECD average. This would be delivered in tranches over the next three years, commencing with £500m at the upcoming Comprehensive Spending Review for new community diagnostic equipment, to support the rollout of Community Diagnostic Hubs. Including existing spending commitments in this area, it would amount to a £1.5bn package for the NHS diagnostics sector since 2019.
- **The Government and NHS should reform the sanction regime.** Whilst suspended, the current operational standard policy as set out in the NHS Long Term Plan is to issue fines to Trusts and CCGs for 52-week breach. This should be replaced over time with a

series of fines for ICSs who are unable to give patients a diagnosis/treatment decision within eight weeks of initial referral.

- **The NHS should better manage and share diagnostic capacity.** A series of short-term, ‘mutual aid’ measures should be implemented to ensure the optimal use of diagnostic capacity given the risk of bottlenecks in the system. This could be achieved either through working at a provider collaborative, ICS level or by working with independent sector colleagues across geographies.
- **Review Infection, Prevention and Control (IPC) guidance and self-isolation periods at ‘green’ sites.** A relaxation of the current guidance at ‘covid-free’ sites will give much greater flexibility; enabling cancellation slots to be filled at short notice by willing patients, whilst also increasing the volume of procedures conducted in theatre. This needs to be balanced by the evidence of continued nosocomial transmission.
- **An expansion of surgical hubs could provide benefits for addressing the backlog.** We believe that surgical hubs may provide part of the answer for elective recovery in certain clinical specialisms where they are already lengthy waits including ophthalmology, orthopaedics, and cancer surgery, and may help to optimise infection control. The expectation should be for these hubs to set up to facilitate three session days and seven-day working.
- **The NHS should ensure the benefits of service transformation are shared equitably.** The creation of hubs for high volume, low-risk activity should not be at the cost of a reduced quality of service for higher risk patients, who are often older, multimorbid and frail.
- **The NHS should make better use of existing independent sector capacity.** Any agreement with the independent sector should be volume-based, comprehensive and long term to give adequate investor confidence and ensure best value for the taxpayer. A long-term approach could include reviewing the current Increasing Capacity Framework, and National Tariff prices to ensure the correct incentives are in place for IS providers to deliver a high proportion of NHS work. The principles of ensuring that treatment remains free at the point of delivery must be upheld.
- **NHS England should publish Playbooks to profile and promote innovative and effective examples of waiting list management and reduction.** ‘Digital Playbooks’ have been introduced by NHSX to profile specialism-specific examples of innovation. The model should be replicated across the NHS to capture best-practice taking place in waiting list management and reduction.
- **An Elective Innovation Mandate should be established.** Rather than proving cost savings alone, a fund should be established to fast-track solutions which demonstrate the greatest potential to tackle the backlog in high-priority specialisms. This scheme could

be modelled on the recently announced MedTech Mandate from NHS England, but would also benefit from being a part of a future DHSC coordinated scheme.

Data, management, and prioritisation

- **RTT figures should be reformed.** Patients should expect to receive a diagnosis within eight weeks (to be known as ‘referral to decision’), before then seeking to commence consultant-led treatment within ten weeks following diagnosis (‘decision to treatment’). This means that the total 18-week target will remain unchanged, but in effect two deadlines will be imposed to incentivise Trusts to shorten the current time taken to give every patient a diagnosis. We believe this should be introduced immediately and will be more straightforward to implement than any wider reforms linked to the Clinically-led Review of NHS Access Standards.¹²²
- **Systems with the worst elective waiting times should receive additional managerial and admin support for the next two years.** Whilst unfashionable, investment in information technology and additional data managers who are trained in appropriate data and waiting list management will be required to ensure that the waiting list information is of sufficient quality (further detail is provided in the section on workforce).
- **Greater transparency around the use of clinical prioritisation methodologies is required. This should apply at two levels:**
 - **Nationally.** As part of the monthly RTT statistical release, NHS England should request for Trusts to include the proportion of patients within each of the current P1-4 categories (or whichever approach replaces this over time).
 - **Patient level.** Individual patients must be informed by their physician of their prioritisation level, with the reasoning and methodology explained to them in a way they will understand.

Patient communication

- **The NHS must urgently enhance patient communication.** In a move to greater operational transparency, NHS Trusts should rapidly invest in developing patient-centred information and communication materials. Policy Exchange support the recommendations set out in the National Voices report, Patient Noun, Adjective.³¹
- **Greater honesty in conversations with the longest waiters is required.** Where revalidation means a wait longer than 52 weeks, a communication strategy which is candid but sensitive must take priority.¹²³ These communications with patients should set clarify the patient’s right and all options, including the right to seek treatment with another provider, and self-funding care.
- **Invest in a priority NHS-led digital offer to support patients**

122. ‘Measuring what matters: Update on the Clinically-led Review of NHS Access Standards’ (November 2019), NHS England, [link](#)

123. This is an approach reflected in Dr Rebecca Rosen, ‘Transparent processes with a human touch: the essentials of good waiting list management’, Nuffield Trust, 11 May 2021, [link](#)

on the waiting list. These services could include appointment scheduling, list status, signposting to wider services, and made available through the NHS App.

- **The NHS should ensure signposting patients to appropriate peer support becomes more commonplace.** This should draw upon existing expertise within the voluntary sector.

Patient preparation and post-operative recovery

- **The NHS should rollout of the best digital tools to support patients waiting.** As part of investment in an NHS-led digital offer (to be made available through the NHS App which has had over 1.3 million new registrants since early May 2021) the digital offer should signpost patients to information, exercises, and further support to assist with their preparation and recovery.¹²⁴
- **The NHS should profile and promote best practice in Playbooks.** Emulating the playbook model adopted by NHSx, NHS England should establish a national profile of leading approaches and initiatives, both from within the NHS and beyond such as the resources being developed by the Centre for Perioperative Care (CPOC).

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- **Prioritise training for specialisms with the greatest need in elective care.** The Government and Health Education England (HEE) should work together to ensure training pathways in specialisms currently understaffed or with outstanding need in elective care are adequately resourced and that training places are prioritised. DHSC should look to build upon the £30 million recently made available for HEE to trusts help plan for additional training and to deliver one-to-one training where needed.¹²⁵
- **The Government should bring forward a national workforce strategy.** Whilst there are some positive signs demonstrating a growing number of young people keen to enter the healthcare profession, a holistic, long-term workforce strategy is required which must account for the prospect of experienced staff exiting the profession on account of the current lifetime allowance as well

124. 'Vaccine status drives over one million new users to the NHS App', *Department of Health and Social Care*, 23 May 2021, [link](#)

125.

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Policy, funding and incentives

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