NHS Confederation

Briefing

Building back inclusively

Radical approaches to tackling the elective backlog

This briefing recommends radical, whole-system changes to tackle the elective backlog inclusively. Aimed at healthcare leaders overseeing elective recovery, as well as policymakers with the levers to effect change, it puts forward ten practical measures to manage the backlog.

It has been informed by a roundtable of senior leaders drawn from all parts of the healthcare sector, convened by the NHS Confederation and Boehringer Ingelheim in July 2021, and a review of the latest waiting list data and trends.

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Key points

- The number of people waiting for planned NHS care in England has grown to record levels, with more than 5.6 million people currently on the waiting list and over 7 million 'missing patients' anticipated to come forward for treatment.

- Inequalities are now becoming evident in the backlog, with evidence suggesting that waiting lists have grown more rapidly in more deprived areas during the pandemic. These areas could face disproportionately large waiting lists per head of population, and deprived communities could also have larger numbers of 'missing' patients.

- There are good reasons to believe that the current approach to elective care, whereby patients are treated in the order they present for care, exacerbates inequalities, worsens health outcomes and perpetuates the inverse care law. If the NHS is to restore services inclusively, radical action is now needed. This briefing sets out a package of measures.

- These include the politically uncomfortable step of proactively growing the waiting list; reforming constitutional standards; promoting active waiting; and developing tools to scan for early symptoms of life-threatening conditions as part of routine interactions with patients, among other measures.

- Alongside this, it will be important for the government to affirm its commitment to openness, transparency and public engagement, being realistic with the public about the demands on the service, the importance of seeking care promptly, and why prioritisation is important to protect the most vulnerable and improve overall outcomes.

- This briefing, informed by a roundtable of senior healthcare leaders convened by the NHS Confederation and Boehringer Ingelheim in summer 2021, recommends systemic action to tackle the elective backlog inclusively.

Introduction

Since the beginning of the pandemic, the number of people waiting for elective procedures has grown to 5.61 million – the highest number on record. Over the same period, 7.42 million fewer referrals for elective care have been made than would normally be expected.

While it is not known exactly how many of these 'missing patients' will eventually present for care, or indeed when, it is clear that the NHS will need to prepare for the number of people waiting to grow considerably higher – and for many to wait much longer than usual.

For healthcare leaders and clinicians, this position does not sit comfortably: patients' conditions may deteriorate over time and could have a significant day-to-day impact on their ability to go about normal life. While our members are innovating and driving service improvement at local level, more support is needed from the government to deal with the challenge ahead, coupled with a radical rethink of the existing framework for elective care.

Our March 2021 report, Building Back Elective Care, set out a policy framework for starting to reduce waiting lists in an effective, equitable and efficient way. But inequalities are now becoming evident in the backlog, echoing the way early COVID-19 cases disproportionately impacted black and minority ethnic and more deprived communities.

Data suggests that waiting lists have grown more rapidly in more deprived areas during the pandemic, and that these areas could face disproportionately large waiting lists per head of population. More deprived communities could also have larger numbers of 'missing' patients. Worryingly, our analysis suggests that the backlog itself is actively contributing to pre-existing disparities in access, experience and outcomes.

Tackling this will require radical approaches to clearing the backlog which ensure that communities disproportionately affected by the pandemic are not disadvantaged during the recovery. But making inroads will also depend on a solid understanding of how health inequalities manifest and interact.

We know, for example, that ethnic minority people have up to three years' lower life expectancy and up to seven years' lower healthy life expectancy compared with white people.[1] The reasons behind this are complex and interrelated – levels of deprivation can explain some of the disparity, but the NHS and partners will need to look more deeply at how deprivation is, in itself, driven by factors such as racism and discrimination.

Health inequalities are systemic and therefore require systemic action.[2] This briefing recommends radical, whole-system changes to tackle the elective backlog inclusively. Aimed at healthcare leaders overseeing elective recovery, as well as policymakers with the levers to effect change, it puts forward ten practical measures to clear the record backlog.

It has been informed by a roundtable of senior leaders drawn from all parts of the healthcare sector, convened by the NHS Confederation and Boehringer Ingelheim in July 2021, and a review of the latest waiting list data and trends.

How the current approach to elective care contributes to health inequalities

In theory, all patients follow a similar pattern when they require NHS elective care. Although a range of healthcare professionals can refer onto the elective pathway, the majority of referrals follow GP appointments. Some of these go to referral management centres, but the majority are handled electronically, typically going straight to a local secondary care provider.

Unless cancer is suspected, patients typically wait chronologically, in the order they were referred. Only after the first outpatient appointment are they grouped into one of four clinical priority groups. Then, after another chronological waiting period, their treatment begins.

In practice it is not quite so neat. First, not all patients in need of care present to their GPs. Competing time pressures, awareness of medical issues, cultural preferences, fear, stigma and many other factors are all well-documented reasons why patients may be reluctant to seek care in normal times. Many of these factors have been exacerbated by the pandemic and COVID-19 has added a new complexity.[3]

Of those patients that do present and are referred, there are increasingly long waits and variation in diagnostic and first outpatient times. This reflects wider waiting time pressures. For example, the backlog in non-admitted cases means that patients who have surgery may require follow-up care in an outpatient setting and are now waiting considerably longer than they might have done pre-COVID-19.

Once prioritised, most patients in lower clinical priority groups receive minimal support, if any, while they wait for substantive treatment to begin. The main exceptions are if they come close to exceeding key thresholds: there is typically a push to begin treatment shortly before 18 weeks and then again before 52 weeks.

Despite the theory of treating patients in chronological queues, with a degree of clinical triaging at first outpatient appointment, affluent and/or patients more familiar with the healthcare system can sometimes use this deeper understanding to access care earlier.

The inverse care law

The inverse care law plays out in this system, whereby those most in need of care are least well served by their local health system. Some underserved communities can face practical or economic barriers in their day-to-day lives that prevent access to care provision. Those who do join the queue tend to join longer queues if they live in areas of greater deprivation, queues which have lengthened more during the pandemic.[4]

COVID-19 has exacerbated existing inequalities in access to elective provision. Although there is a mixed picture across the country, evidence points to:

- increases in admissions for specialties such as trauma and orthopaedics and ear, nose and throat (ENT) associated with areas of less deprivation *
- increases in waiting list numbers associated with areas of greater deprivation, especially in neurology, general surgery and dermatology **
- overall levels of waiting per head of population associated with areas of greater deprivation. ***

* June 2021 RTT data compared to June 2019, correlated with IMD scores where 1=most deprived and 32844=least deprived. Pearson scores of 0.46 and 0.45 respectively

** June 2021 RTT data compared to June 2019, correlated with IMD scores. Pearson scores of -0.31, -0.27 and -0.26 respectively

*** June 2021 RTT data incomplete waiting by STP as percentage of population, correlated with IMD scores where 1=most deprived and 32844=least deprived: Pearson -0.41

Although these figures relate to geographic correlations rather than individual patients, these are broadly consistent with the inverse care law. We know that the ability of patients from low-income households to take time off from work for care is reduced, as is access to cars as opposed to public transport. Conversely, those with more resources and from more affluent communities are more able and willing to engage with NHS administrative procedures and ensure they are seen earlier.

COVID-19 vaccination rates have also been lower and later in areas of high deprivation and among people from black and minority ethnic groups,[5] with a subsequent impact on local health services' ability to maintain elective provision as COVID-19 infections rise.

NHS Confederation members at our roundtable reported greater cancellations and re-bookings from identifiable patient groups, with people from deprived backgrounds more likely to make conscious decisions to delay their care.

Radical action

As detailed in our March 2021 report, the current framework for elective care is widely accepted as not being fit for purpose to resolve growing lists and the increasing backlog. There are also good reasons to believe that treating people in the order they present for care, as per the current chronological approach, exacerbates inequalities and worsens health outcomes.

While there is uncertainty about precisely how large the waiting list will become, it is anticipated that the current list will grow considerably in the coming months. Yet the complexity of care now facing the NHS, threat from new COVID-19 variants and need to operate with infection prevention and control measures will hamper productivity for months to come and make it harder to address the backlog. Attempts to get back to 'normal'/ pre-pandemic levels of activity simply by 'pedalling faster' are likely to be futile. Radical action is now the only way forward.

This section explores ten steps to recover the backlog inclusively, guarding against exacerbating the health inequalities highlighted during the pandemic. For each, we detail why the course of action is needed and how healthcare leaders, national bodies and the government can enact change.

1. Proactively grow the waiting list (in the short term)

By reaching out to people who should be waiting for care and proactively adding them to waiting lists, the NHS can fully understand the scale of the problem and plan accordingly. While growing the waiting list may be politically uncomfortable as it will lead to ballooning figures over the short term, it is a necessary step to achieve equity in health outcomes.

How local and national leaders can enact change

- Use existing local **data and evidence**, aligned with targeted communications campaigns, to **drive increased access**. This should specifically target areas of deprivation, diverse ethnicity, underrepresented socio-economic groups and occupations that the NHS would expect to appear on the waiting list that are currently underrepresented.

  Partners such as Healthwatch, patient groups, the voluntary, community and social enterprise sector, local authorities and primary care are all skilled in getting targeted communications to patients. By harnessing local print and social media channels, as well as engaging with community and faith leaders, the NHS can reach underserved communities.

- Invest in **population health management at primary care network level** – for example, networks could compare actual with expected prevalence (and therefore expected number of patients requiring specific procedures) for a GP registered list.

- Actively **support those who may be avoiding care** to tackle their fears and concerns while taking measures to help prevent them falling through existing gaps in service provision. Integrated care systems (ICSs) should be actively supported to focus on the 'missing' members of their waiting lists.

2. Use tools to scan for early symptoms of life-threatening conditions, such as cancer, as part of routine interactions with patients

Spotting symptoms at an earlier stage will reduce the number of people falling through the cracks, particularly among underrepresented groups, and improve outcomes. Earlier interventions will also improve efficiency by avoiding the need for more complex treatments as conditions deteriorate. The Department of Health and Social Care should fund the development of these tools.

How local and national leaders can enact change

- **Make more of routinely scheduled interactions**, such as vaccinations, existing screening programmes, health checks and repeat prescriptions, by offering additional screening activity that can identify serious, life-threatening conditions.

3. Use diagnostic hubs to optimise resources in deprived populations

Intended as one-stop shops for life-saving health checks, community diagnostics hubs can increase engagement and participation from within deprived communities and demonstrate a commitment to levelling up.

How local and national leaders can enact change

- By **locating new community diagnostic hubs in deprived areas**, integrated care systems (ICSs) can make a clear statement of their intent to prioritise health inequalities.

4. Commit to consistent workforce planning to support population health goals

The NHS entered the pandemic with nearly 90,000 vacancies. This shortfall has contributed to the elective backlog and will continue to have an impact unless there is consistency in the supply and development of healthcare professionals. To enable this and to develop a workforce that can meet community-based population health goals, and provide acute and primary care, the NHS needs to move beyond political cycles and planning workforce around what financial parameters allow us to.

How local and national leaders can enact change

We strongly support amendments to the health and care bill that ensure the health and social care secretary undertakes **detailed assessments of**

future workforce requirements to avoid this situation in the future. These should be:

- based on the projected health and care needs of the population across England for one to five years, five to ten years and ten to 20 years
- undertaken at least every three years in response to changing population needs
- take full account of workforce intelligence, evidence and plans from integrated care systems
- fully available in the public domain.

5. Promote active waiting

Waiting to grade a patient clinically until after the first outpatient appointment is unsustainable, particularly as more missing waiters return. Many ICSs are promoting the principle of 'waiting well,' maintaining a positive dialogue with patients, encouraging health promotion and positive lifestyle choices while patients wait for care.

How local and national leaders can enact change

- Prioritise **rapid access to diagnostics** and smarter triaging.
- Conduct **clinical status reviews** on referral to systematically prioritise patients with comorbidities or whose conditions would significantly worsen with long delays. This includes selecting patients at the highest risk when slots come up at short notice.
- **Support patients with comorbidities to improve their outcomes while they wait**. For example, helping orthopaedic patients to manage their conditions while waiting for surgery with physiotherapy and other health advice and support.

- **Provide ongoing patient advice and guidance during waiting**. These are too often the first thing to go when pressure mounts on services, but they are even more important as waiting pressures develop.

6. Ensure closer working across local healthcare ecosystems and a dynamic approach to lists

COVID-19 has shown how the system can work together effectively across primary and secondary care, independent sector providers and specialist care. It has also exposed the importance of working effectively with social care providers.

Clinical prioritisation must drive the way the NHS manages lists, with a focus on reducing harm to patients, irrespective of the length of wait. The NHS will need to proactively support patients, investing in communications so that care can be expedited or indeed postponed as needs change. Waiting time on its own is an insufficient measure of the success or failure of elective recovery.

How local and national leaders can enact change

- **Support GPs to manage day-to-day pressures with additional resource** to avoid lower threshold referrals as a pressure-release mechanism.

- **Develop peer-review support and closer working between generalists and specialists** to provide direct access to rapid diagnostics and direct to procedure referrals for some procedures.

- **Manage high volume, low complexity work separately** from fast access cancer pathways and pathways likely to be disrupted by further COVID-19 waves.

The key to making this work is to gain the support and active buy-in of clinicians, especially when these reforms change existing working patterns. This is another reason why consistent workforce planning and support are so important.

7. Provide funding consistency and autonomy

To plan, invest and develop new services, the NHS needs consistent approaches to funding and genuine autonomy given to local decision-makers.

How local and national leaders can enact change

- The government and NHS England and NHS Improvement (NHSEI) should **avoid changing or removing promised funding**. Such moves are disruptive and wasteful, damage morale and directly affect patients. There has never been a more important time to avoid these patterns of behaviour.

- **Support local autonomy** – NHSEI should, wherever practical, empower local systems that are best placed to understand their pressure points to make funding decisions, rather than creating specific 'pots' that too often miss their targets.

8. Develop a new commitment to openness, transparency and public engagement

Significant short to mid-term rises in the waiting list are now inevitable. Rather than shying away from the issue, the government should be open with the public about the demands on the health service.

How politicians can enact change

- Communicate the **importance of coming forward** when symptoms worsen.
- Be **realistic about waiting time expectations**.
- Explain how **approaches to prioritisation protect the most vulnerable and improve overall outcomes** to support the NHS in the longer term.
- Support the **production of data disaggregated** by population stratifiers such as ethnicity/deprivation
- Issue **proactive communications to increase patient attendance rates** for booked appointments and procedures.
- Invest to **assess patient experience** of current pathways.
- Publish **data on access and clinical prioritisation** alongside outcomes to avoid unwarranted local variation and support public dialogue.

9. Reform constitutional standards

Current NHS Constitution commitments, to treat 92 per cent of patients within 18 weeks and ensure no waits beyond a year, no longer work for the circumstances the NHS now faces. New constitutional commitments are needed that focus on the quality of care and equity of access, not just in seeing patients as a number.

How local and national leaders can enact change

- Review the NHS Constitution to **include duties to improve outcomes and reduce health inequalities**.
- **Focus resources on deprived populations** to support them entering planned pathways much earlier, thereby reducing non-elective admissions.

- Prioritise **early diagnostics and active waiting** as part of the elective pathway.

- Reduce the elective backlog by **building long-term sustainable capability**.

10. Let local leaders lead

The impact of the pandemic on the backlog will differ across England, meaning that local solutions will be the best course of action. Nationally mandated strategies are unlikely to produce equitable solutions for local communities. The health and care bill 2021 proposes a cultural shift in the NHS that allows local leaders to develop strategies that are right for the people they serve – this has never been more relevant than in the recovery of the elective and diagnostic backlog.

How local and national leaders can enact change

- Support and **promote local strategies to reduce care backlogs**, with **capitated allocations** that recognise the size and scale of the issue in each area.

- Reduce the volume of **central policy directives**.

Viewpoint

Health inequalities are systemic, meaning a systemic approach to tackling them is required. In this briefing, we detail ten actions that will go some way to restore services inclusively. But they will need to be coupled with further action to make NHS leadership more representative, as well as ensuring that health services collect the right data.

It is especially important to recognise that communities are not 'hard to reach' but rather 'underserved', and that effective community engagement is an essential prerequisite to embedding equality in services. The NHS exists to serve all communities equally, and this means using different strategies in different areas and directing greater resource where it is needed to achieve equity. It is not enough to provide the same service for everyone; the NHS must guarantee the same outcomes for all.

Taken together, the radical actions explored here will bolster efforts to reduce disparities in access, experience and outcomes faced by black and minority ethnic and deprived communities. We urge the government to consider approaches to tackling the elective backlog that consider deprivation and equality of outcomes.

References

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3. NHS Confederation (2021) Tackling the elective backlog. [In press].

4. See footnotes on page 5.

5. Sheffield Hallam University (2020), Quarter of adults unwilling to have Covid-19 vaccine. [Web page]. Last accessed 3 September 2021. https://www.shu.ac.uk/news/all-articles/latest-news/quarter-of-adults-unwilling-to-have-covid-19-vaccine

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

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