

Building back elective care

A new framework for recovery

Over the last 12 months the NHS has worked tirelessly to support the country in response to the COVID-19 pandemic. While the NHS has never been a COVID-19-only service, the pandemic has impacted on all aspects of its care, with elective and diagnostic activities among those services that have been disrupted. This has led to a considerable backlog of people waiting for NHS treatment.

Our members, the organisations that plan, commission and deliver NHS services, are clear that piecemeal changes to the existing system will be insufficient to deal with the scale of the challenge facing the NHS.

This briefing explores what lies ahead for the health service and patients, based on our modelling of referral-to-treatment waiting trajectories in 2021. It offers an outline policy framework, drawn up by our members, for starting to reduce waiting lists in an effective, equitable and efficient way.

Key points

- The sustained impact of the pandemic will leave a backlog of care in excess of anything seen over the last 12 years. Although urgent and emergency procedures have largely been maintained, much of the growth in waiting lists comes from low priority, high-volume procedures for conditions ranging from painful bone and joint conditions, to ear, nose and throat and ophthalmology.
- Our modelling suggests that to maintain any sense of control over the NHS waiting list, the NHS will need to increase capacity considerably above levels than have previously been sustained. Our members are embracing best practice, as represented by the Getting It Right First Time programme (GIRFT), and innovating to support waiting list management but will need further support to make inroads into the backlog.
- The existing framework for elective care, which is based around organisations and tariff, is widely accepted as not being fit for purpose to resolve growing lists and the increasing backlog. Without a comprehensive new plan, the government faces the politically unacceptable legacy of hundreds of thousands of patients left on waiting lists with deteriorating conditions for the remainder of the parliament.

- Our members want to see whole-system thinking to manage waiting lists between trusts, and deeper partnerships with primary and community care, supported by real-time patient data. Small amounts of quick capital will help to create 'hot and cold' hospital sites, which will increase efficiency, while funding support for the voluntary sector will help patients to receive more care and support as they wait for their procedures.
- The intensity of the pandemic response has had a marked impact on NHS staff and left the healthcare workforce in a fragile state. In many areas, the same group of staff who have worked through the pandemic, and who are delivering the vaccination programme, will be asked to step up once again to recover backlogs. Any plan that fails to recognise this is unlikely to succeed.
- The additional £1bn agreed in the Spending Review for 2021/22 will not be enough to clear the backlog. The healthcare sector will need honesty from political leaders to help manage the inevitable change in public opinion when there are further delays in treatment.
- By creating a long-term framework for the recovery of elective care that is efficient, patient focused and equitable, the NHS can make fast progress on recovering its elective care position. As part of that, it will be important to rethink the way that waiting lists are measured, as many of the performance standards are no longer fit for purpose.
- This briefing focuses on the elective backlog. Similar pressures will be faced across the NHS, from a surge in demand for mental health support, to increased need for community services and increased demand on primary care.
- While our members are innovating and driving service improvement at local level, more support is required from government in its public messaging. This would help the NHS to clarify priorities and facilitate an honest public debate on the scale of the challenge and the measures to resolve it.

Glossary of terms

Admitted pathways: day case and overnight inpatient admissions.

Incomplete pathways: patients who are currently waiting for their treatment to begin.

New periods: patients who begin their referral-to-treatment pathways during a given time.

Non-admitted pathways: all patients whose pathway has ended for any reason other than an admission. Treatment delivered through outpatient appointments falls into this category, but it is important to note it covers more than outpatient care.

Referral-to-treatment (RTT) pathway: 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.

Background

Throughout this winter, NHS leaders' primary focus has been on keeping patients safe and supporting a workforce stretched to the limit. Staff are juggling a complex portfolio of risk and making decisions to keep as many NHS services running with as much capacity as it is safe to do so. But while the NHS is experiencing the toughest winter on record, many leaders are also thinking further ahead, to later this year and the rest of the government's parliamentary term.

In the early part of the pandemic, elective services were postponed as leaders looked at the experiences of Italy and Spain, emptied hospitals and cleared bed capacity to deal with an uncertain and unpredictable first wave. Over the summer, hospitals recovered as much elective capacity as they could, with enhanced infection prevention and control requirements meaning that operating efficiency was much reduced. Then came the second and third waves of infections over autumn and winter 2020/21.

Although urgent and emergency procedures (priority 1 and 2) have largely been maintained, much of the growth in waiting lists comes from lower priority, high-volume procedures (priority 3 and 4) for conditions ranging from painful bone and joint conditions to ear, nose and throat and ophthalmology.

The existing framework for elective care, which is based around organisations and tariff, is widely accepted as not being fit for purpose to resolve these issues. Our members have told us they need more than piecemeal changes to the system to remedy the issue. They have called for a new policy framework and a comprehensive, long-term and transparent strategy they can work to over the next four years.

But that will only go some way. Equally important is honesty with the public about what lies ahead and a genuine partnership between government, the NHS, patients and carers. Professor Stephen Powis' review of clinical standards is a core part of this discussion. It will need to be supported by a new approach to waiting lists and a new funding and regulatory framework that focuses less on rigid performance standards and more on collaboration, health inequality and patient wellbeing.

Crucially, our members have called for recognition that in many areas it will be the same group of staff who have worked through the pandemic, and who are delivering the largest vaccination programme this country has ever seen, that will be asked to step up once again to recover backlogs of care. Any plan that fails to recognise this is unlikely to succeed.

Without these elements, the government faces the post-pandemic legacy of thousands of patients left on waiting lists with deteriorating conditions for the remainder of the parliament.

This briefing explores what a new elective framework might look like and the issues it will need to consider. It has been informed by engagement with our members, analysis of recent trends in waiting times and modelling of what future waiting lists may look like.

2020: a year like no other

Before the onset of the pandemic there was considerable growth in the number of people waiting on elective pathways. In late 2016, the number rose from around 3.5 million to over 4.3 million by the end of 2019, as the NHS's ability to keep pace was outstripped by increased demand.

2020 saw unprecedented disruption to elective activity. By the end of the year, there were:

- 1.4 million fewer completed admissions in 2020 compared to 2019 (a 39 per cent fall)
- 3.3 million fewer non-admitted pathways compared to 2019 (a 25 per cent fall)
- 32 per cent of patients (1.5 million) waiting longer than 18 weeks
- 21 per cent of patients (970,000) waiting longer than half a year
- 5 per cent of the entire waiting list (224,000) waiting for longer than a year.

This produced the largest official waiting list on record, with 4.52 million people waiting for their treatment to begin in December 2020, up from 4.3 million a year before. Yet despite setting records, this official number is far short of where it could be.

A hidden waiting list

There were 5.9 million fewer new referral-to-treatment (RTT) pathways in 2020 compared to 2019, a 30 per cent fall. This number represents the scale of a hidden waiting list of people yet to join the official queue. The specialties most disrupted are trauma and orthopaedics, and ophthalmology – areas with many conditions that will steadily worsen if left untreated.

Not all patients among this hidden group will eventually join the official list: some will seek care elsewhere while others may never seek treatment. But it is reasonable to assume that many, probably a sizeable majority, will eventually find their way onto the official waiting list.

Longer waits for care

In addition to increased numbers of people waiting, most can expect to wait far longer for care. The figures published by NHS England and NHS Improvement each month include a summary of the number of people waiting for over a year. That now stands at over 224,000 compared to below 1,500 a year ago. However, a closer look at the distribution of time spent waiting shows that 21 per cent of patients (970,000) have waited longer than half a year and 15 per cent of patients (700,293) have already waited 40 weeks or longer.

What could waiting lists look like in 2021?

By examining the different components of waiting list metrics and a hidden waiting list of up to 5.9 million, we have been able to model what future waiting lists may look like. Our modelling is based on assumptions about likely behaviour and the system's capacity to return to normal levels, given enhanced infection control measures, and informed by known activity levels in 2020.

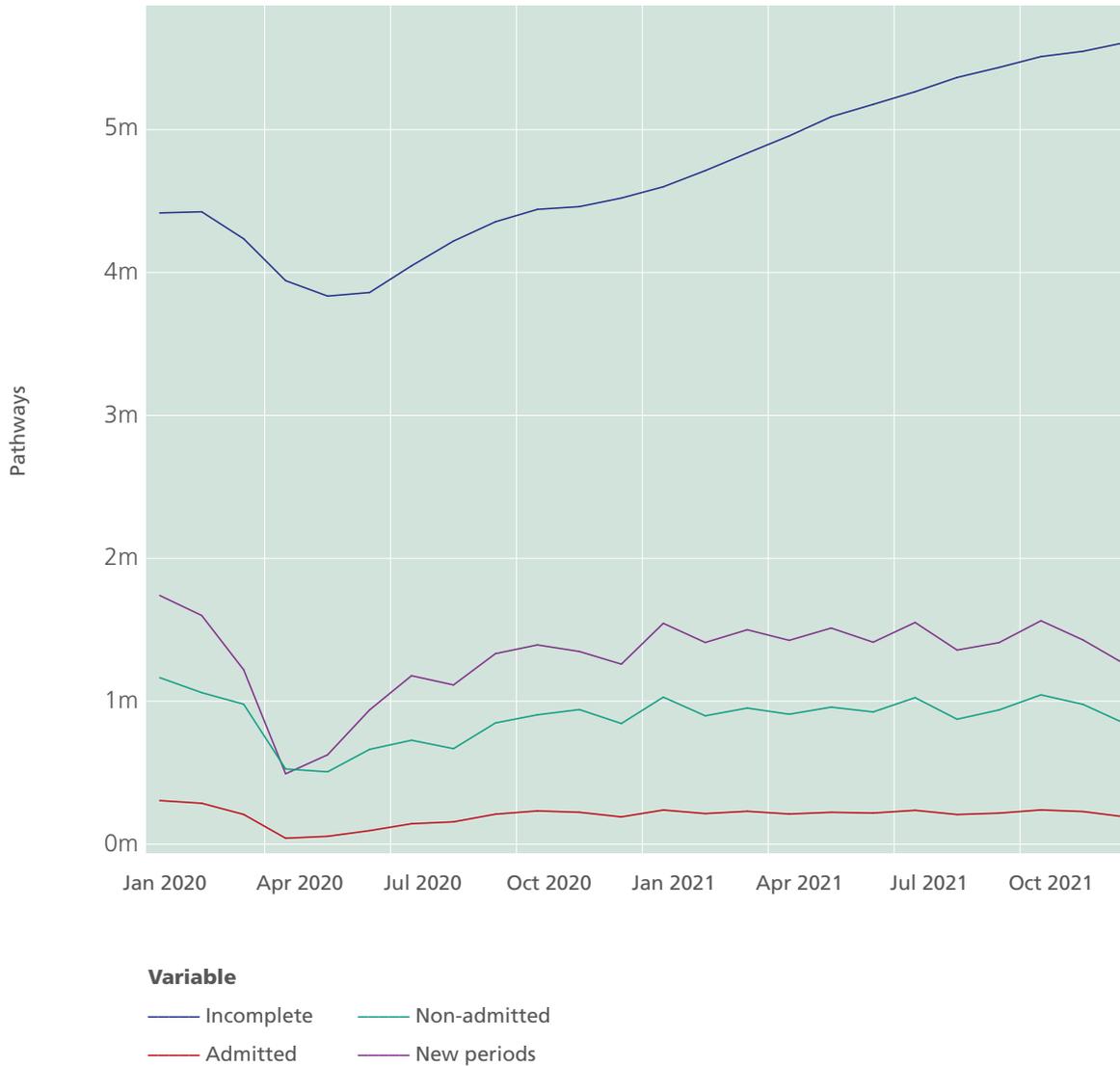
For all models, we take 2019 as our default 'normal' year. There has been a historic trend towards increased demand that exceeds supply leading to a growing waiting list; taking 2019 levels as 'normal' is therefore already an optimistic assumption. Further detail on our modelling is available in our data briefing, [Exploring Referral-To-Treatment Waiting Trajectories in 2021](#).

Model 1: Our baseline assumption

In this model, we assume that all levels of activity remain at the same proportions achieved in December 2020 as December 2019's activity. In that month, completed admitted pathways were 25 per cent lower than in December 2019; non-admitted pathways were 13 per cent lower; and new periods 14 per cent lower. Applying those proportions to the volumes seen in each month during 2019, we could expect waiting figures in 2021 along the lines set out in figure 1.

At current activity and referral levels, we could expect to see a waiting list exceeding 5.6 million by the end of the year. Importantly, the hidden waiting list would also grow significantly, as the NHS would still see fewer patients join RTT pathways each month than it would typically expect. This approach would not be acceptable to government, clinicians, patients or carers.

Figure 1: Forecast waiting numbers assuming metrics stay at current proportions of normal activity

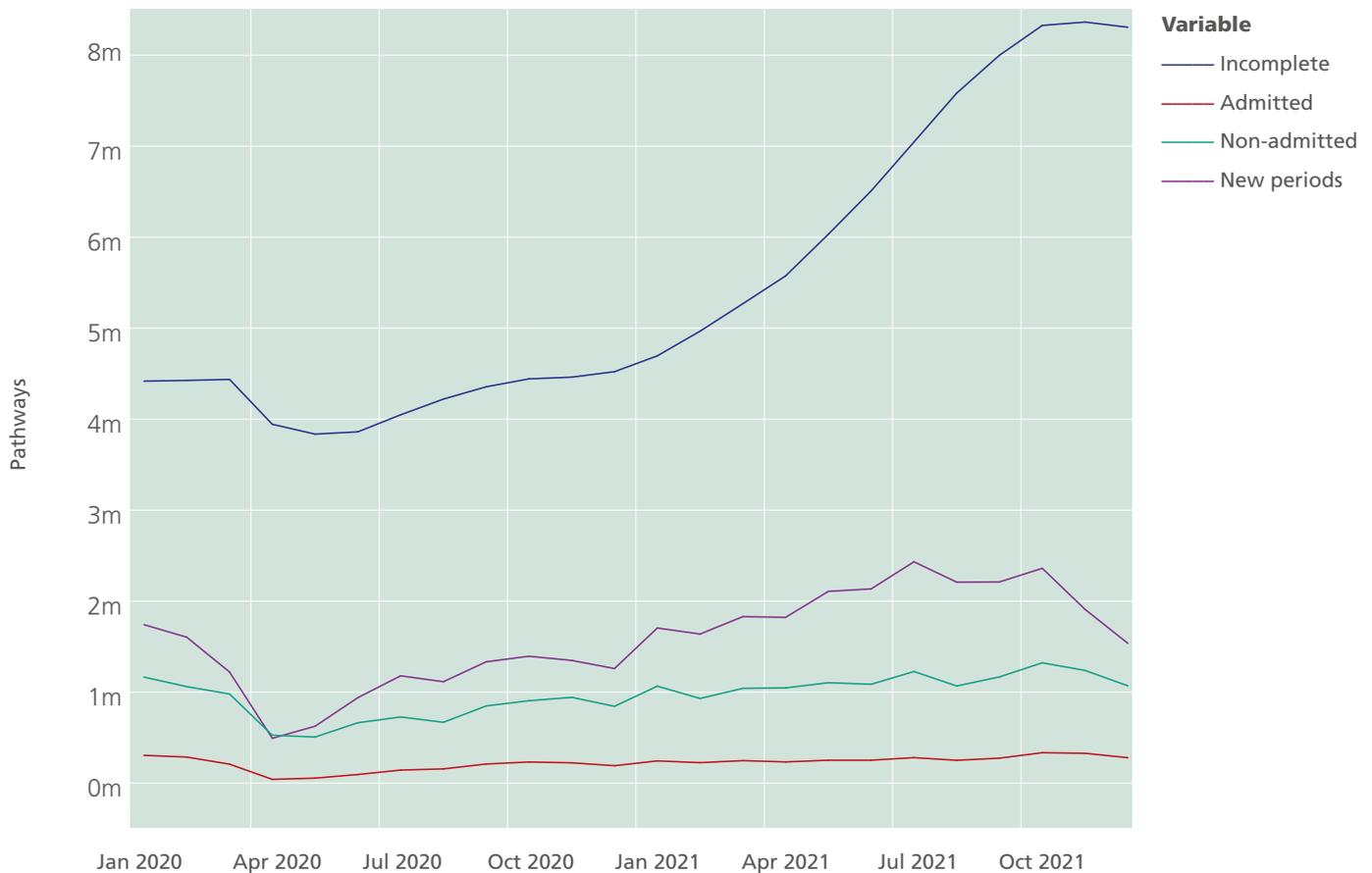


Model 2: A realistic model based on a return in line with vaccination progress

The size of the hidden waiting list is such that if patients are referred throughout 2021 at levels that average 18 per cent above those seen in 2019, the NHS would see 63 per cent of the hidden waiting list join the official waiting list by the end of the year. The impact of such a return on the official waiting list would in part depend on when these patients return. It would also depend on activity levels throughout the year.

Our second model assumes that it takes until the autumn of 2021 to exceed 2019's levels for completed admissions, but that outpatient care begins to exceed 2019 levels by late spring. The model assumes that by the end of 2021, both admitted and non-admitted pathways begin to run at 10 per cent above 2019's levels.

Figure 2: Forecast RTT figures based on realistic improvement

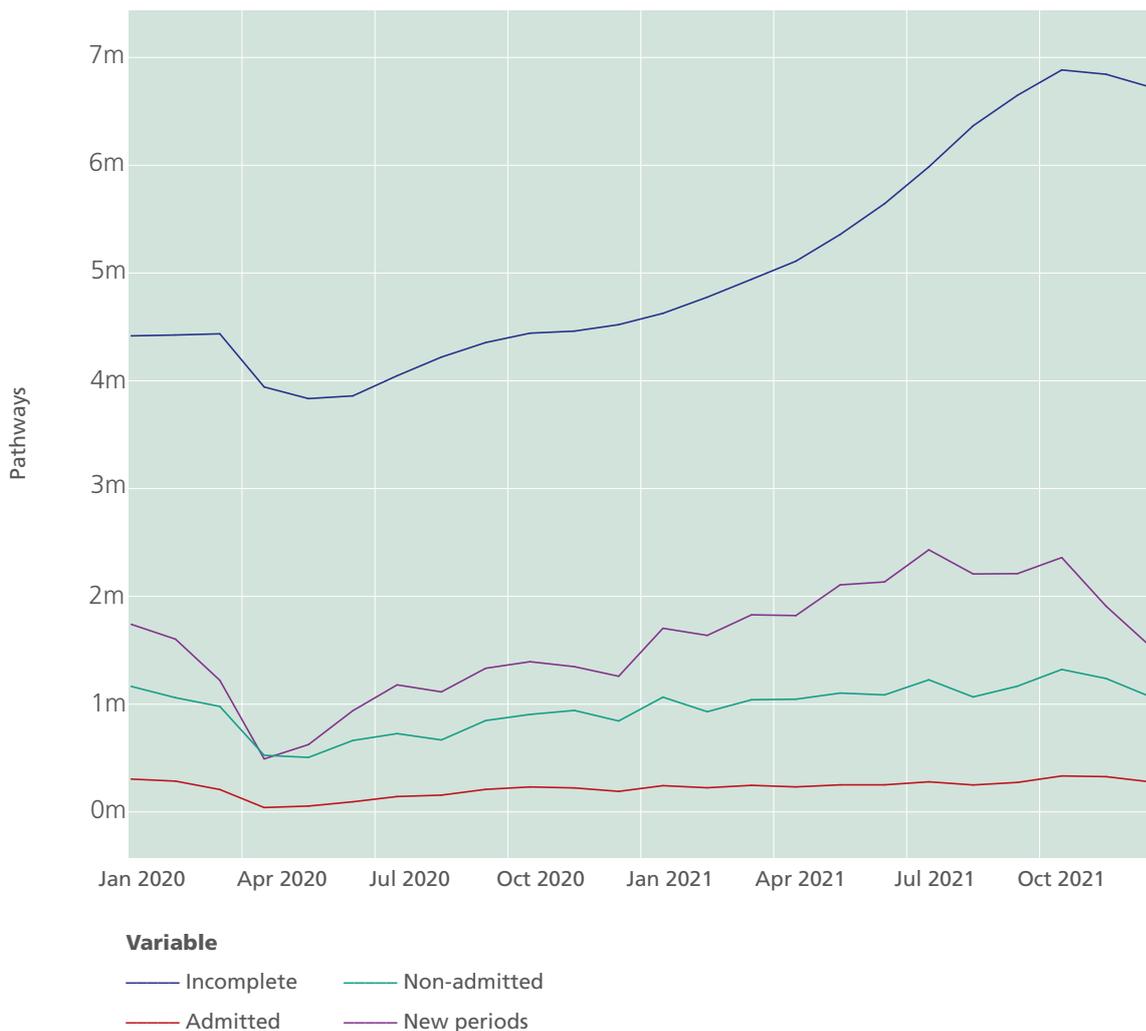


Model 3: A rapid resumption of activity rising to 15 per cent above that seen in 2019 by late summer

Our final model assumes the same rate of referrals as in our second model, but with much more aggressive activity levels. We assume a return to 2019 admission levels by May followed by sustained rises that build to 15 per cent above 2019 levels by August. Completed non-admitted pathways would also return to 2019 levels by February before rising quickly to 15 per cent above 2019 levels by May.

If achieved, these activity rises would be unprecedented in scale, but would still result in a waiting list peak of around 6.9 million by late 2021.

Figure 3: Forecast RTT figures based on rapid improvement of activity levels



The point of these models is not to predict exactly what the official waiting list will be in 2021, but rather to illustrate the scale of the challenge and, crucially, the impact the NHS can realistically achieve. They all suggest that to maintain any sense of control over the waiting list, the NHS will need to increase capacity considerably above levels than have previously been sustained.

A framework for recovery

The independent sector is often the first place to look for capacity, and private and voluntary sector providers will continue to play an important role in helping to reduce the backlog. But there is no simple solution. During the first wave, the government bought independent sector capacity at cost, and some is now increasingly being used to deliver more profitable private work. In addition, the independent sector in many parts of the country is part staffed by NHS staff, exhausted and already fully committed. Undoubtedly, the independent sector should form part of the way forward and there are opportunities to rework the relationship between the sector and the NHS.

Based on our engagement with members and modelling of what future waiting lists may look like, we believe that any new policy framework for elective care in the NHS should be built on ten core principles, which we explore in the pages that follow.



1 Recognition of the impact on the NHS workforce. As the intensity of operational pressures start to subside, it will be important to recognise the collateral impact of an exhausted workforce. With NHS staff stretched and in need of rest, 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. Some capacity will be gained, but it is by no means the solution.



2 Honesty and transparency. The additional £1bn agreed in the Spending Review for 2021/22 will not be enough to clear the backlog.¹ The healthcare sector will need honesty from political leaders to help manage the inevitable change in public opinion when there are further delays in treatment. Clear messaging that the elective situation will not be resolved in 12 months will be vital, as is clarity that waiting times will be managed differently as the NHS recovers from the pandemic. The NHS has seen the impact of COVID-19 denial on staff morale and the consequences of staff pushed to the limit. A lack of public understanding at this next stage will be difficult for everyone.



3 A long-term framework. Meaningful progress can only be made with a transparent, long-term framework for bringing elective care back on track, not a series of short-term plans and targets. Elective care has been creaking for many years and recovery to pre-COVID-19 levels will always be difficult. The NHS should not be measured against unrealistic targets, as this risks creating resentment among clinical staff and local healthcare leadership.



4 A whole-system approach underpinned by real-time data. Any new plan must recognise that only by working at a system level can the NHS maximise efficiencies, allow for mutual aid between trusts and provide a better service for patients. To facilitate this, the NHS needs an agile, real-time, clinically led picture of the state of the backlog in each system. It also requires system-wide waiting lists and a single picture of the truth. This will enable clinically led discussions on prioritisation between primary and secondary care, as well as fluid lists that recognise the individual circumstances of each patient, their co-morbidities and any decline in condition. Additionally, effective discharge arrangements will be vital to support the flow of work through acute and community services. Most of all, any new framework must be resolutely patient focused.

1. In the run up to the 2020 Spending Review, we worked with the Health Foundation to support its analysis of the funding pressures facing the NHS and social care. The analysis concluded that tackling the backlog of demand for elective care and restoring waiting times standards by 2023/24 would cost an extra £1.9bn in each of the next three years. <https://health.org.uk/publications/long-reads/spending-review-2020>



5 Implementation of hot and cold hospital sites. The provision of services through dedicated 'hot and cold' hospital sites, separating urgent from planned care, significantly improves elective performance. The provision of services from dedicated green and red (COVID-19 and non-COVID-19 sites) does the same. Systems and organisations must be allowed to make these changes at pace and expand use of the virtual wards introduced during the pandemic as a way of managing people to 'wait well'.



6 Quick capital. To develop hot and cold sites at pace, our members have asked for access to small amounts of capital that they can access quickly. This would enable them to develop capacity and benefit from system-wide efficiencies. This capital should be allocated at pace and without many of the drawn out and cumbersome bidding and allocation processes seen in the past. As a minimum, existing capital allocations should be brought forward. With low interest rates, additional capital investment will contribute to the government's levelling-up agenda and pay wider dividends to economic recovery.



7 Supporting patients to 'wait well'. By providing social prescribing and community and voluntary sector capacity, patients can be supported to 'wait well' and manage their conditions as they wait for treatment. The impact of long waiting lists will be felt within primary care, which will need to be supported to enable patients to 'wait well' and manage their conditions as they wait for treatment. Our members support preventative investment to help people take charge of their own health and reduce social isolation while they wait for procedures. There is an opportunity to invest in the prevention agenda and shift some work upstream where there is workforce capacity that does not currently exist in the NHS.



8 A relentless focus on patient safety. While systems can provide the infrastructure to manage the backlog, organisations will always provide the safety net and are ultimately accountable to regulators and patients. As a system-level response is designed, it will be important to balance the patient safety and quality secured by organisational governance with the efficiency and equity gains that can be developed at system level.



9 **Concerted efforts to reduce bureaucracy.** To get services back on track, it will be important for regulators and performance managers in national and regional bodies to reduce the demands placed on local NHS organisations. The NHS still spends too much time producing, rebuilding and assuring plans. Instead, a cultural change is needed that gives local leaders a clear framework to work within and lets them manage the complex portfolio of risk and opportunity at a local level.



10 **Learning lessons from the past.** Past history, especially in digital outpatient services, has the potential to stand the health service in good stead, with the measures employed in the early 2000s to deliver significant list reduction highly relevant. The specialist list-management skills used then, and which in some places have been lost, require re-investment and support. The Getting It Right First Time (GIRFT) programme tells us what works and provides a strong clinical foundation. In addition, the NHS will need to increase its use of and investment in digital technology, building on the advances of the last 12 months. Sharing and spreading best practice, such as in how to build high-volume pathways in disciplines like orthopaedics and ophthalmology, will need to be ramped up.

NHS Confederation viewpoint

By creating a long-term framework for the recovery of elective care that is efficient, patient focused and equitable, the NHS can make good progress on recovering its elective care position. As part of that, it will be important to rethink the way that waiting lists are measured, as many of the performance standards are no longer be fit for post-pandemic purpose. We also need to recognise that the NHS still faces a funding gap next year and make decisions on performance grounded in the reality of the Comprehensive Spending Review, which is expected later this year.

As the government builds a Comprehensive Spending Review for 2022-25, it will need to account for these additional costs if it is serious about reducing the backlog. Looking ahead, we should be under no illusions: there will be a political imperative to address this issue that will drive policy, performance and funding for the next four years.

Our members are driving innovation, collaborating and using existing schemes like GIRFT to reduce waiting lists at pace. But they will need further support from the government in its public messaging on what is possible, and a genuine partnership between the government, NHS, patients and carers to resolve the issue.

By being open and upfront, we can acknowledge the scale of the issue and work together to bring waiting lists down in a way that is transparent and equitable, that provides best value for government, equity for patients and looks after the NHS workforce.

About NHS Reset

COVID-19 has changed the NHS and social care, precipitating rapid transformation at a time of immense pressure and personal and professional challenge. One message from leaders and clinicians across the UK has been clear: we must build on the progress made to chart a new course.

NHS Reset is an NHS Confederation campaign to help shape what the health and care system should look like in the aftermath of the pandemic. Recognising the sacrifices and achievements of the COVID-19 period, it brings together NHS Confederation members and partners to look at how we rebuild local systems and reset the way we plan, commission and deliver health and care.

Join the conversation **# NHS RESET**

Find out more at www.nhsconfed.org/NHSReset