The Health Foundation's response to the Health and Social Care Select Committee's inquiry - *Clearing the backlog caused by the pandemic*

September 2021

About the Health Foundation

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Our aim is a healthier population, supported by high quality health care that can be equitably accessed. We learn what works to make people's lives healthier and improve the health care system. From giving grants to those working at the front line to carrying out research and policy analysis, we shine a light on how to make successful change happen.

Our submission

Below we set the Health Foundation's assessment of the key issues related to the elective care backlog in the NHS, with reference to new and already published analysis. We have provided answers to the questions where we have evidence and insight that will be most helpful to the Committee, including new modelling on what it may cost to clear the elective care backlog. We also provide an annex at the end of this submission.

Overview

Given the scale of the backlog, recovery to pre-pandemic levels will take several years, and we welcome the Committee's acknowledgement of the need to look beyond the short-term response. If the health and care system can create and deliver a long-term framework for recovery that is efficient, safe, person-centred and equitable, there is an opportunity to embed sustainable improvements in the design and delivery of elective care. While delivering care to those who need it in the short-term, this could also help to realise some long-term aspirations for the service, including reform of outpatient services, increasing patient involvement in their care and speeding up the adoption and spread of technological and digitally enabled care.

The solutions and approach used for reducing elective waiting lists in the past, which included significant financial investment to expand capacity, and the use of competition, financial incentives and targets to drive additional activity in individual organisations, will need to change to take account of the current challenge and policy context. This changed context includes financial constraints, the capacity and wellbeing of the health and social care workforce post-pandemic, the direction of system reform in developing whole system working to achieve better integration of care, and increased recognition of inequalities in access to care.

The NHS recognises the need to address this wider set of objectives, for example in the approach to payments increased activity levels through the Elective Recovery Fund, which now includes incentives to address health inequalities and support staff recovery. A comprehensive framework, including a clinically informed measurement approach, realistic recovery trajectories, and support for integrated care systems to develop the data,

improvement approaches and systems that enable mutual aid and learning between Trusts, would further help support providers to meet these objectives.

Enabled by a supportive policy framework, the NHS will need to think and act innovatively in how it redesigns pathways to address the elective care backlog. Independent sector capacity will be a part of the answer, although as we describe in this submission, this is not a perfect match for the need, and risks exacerbating inequalities in access to care. The NHS has already established the Accelerator Sites programme, and existing initiatives such as the Getting it Right First Time programme can support sharing of knowledge and approaches across the NHS.

Q. What is the anticipated size of the backlog and pent-up demand from patients for different healthcare services including, for example, elective surgery; mental health services; cancer services; GP services; and more widely across the healthcare system?

Elective care backlog

- **Prior to the pandemic, the NHS had not met the 18 week standard since February 2016 and waiting times had been steadily increasing because increases in activity had not kept pace with growing demand.** Consequently, the waiting list had already grown from 2.92 million at the start of 2015 to 4.42 million by the end of 2019, an average annual increase of almost 300,000. By the end of 2019, 83.7% of patients waiting were within 18 weeks – substantially below the expected standard of 92%.
- **The COVID-19 pandemic has caused severe disruptions to the delivery of elective care, with substantial increases in waiting times and the number of patients waiting.** As of the end of June 2021, NHS England figures show the waiting list for consultant-led elective care was 5.45 million with over 300,000 patients waiting more than a year, despite the number of treatment pathways completed and started having returned to June 2019 levels. Since the start of 2020 there have been 6.1 million fewer completed pathways and 7.4 million fewer new pathways started compared to 2019 levels of activity.
- **There is substantial variation between clinical specialties in terms of 1) the impact of COVID-19 and 2) the challenges involved with addressing the backlog** – compared to 2019, the number of patients completing treatment in 2020 fell by 37-38% for trauma and orthopaedics, oral surgery and ENT (the biggest reductions), while dermatology, thoracic medicine and neurology fell by only 19-20% (the smallest). In general, the specialties where activity fell the most were those where a higher proportion of pathways end with patients being admitted to hospital for a day case or inpatient procedure. This is due, at least in part, to pressures on inpatient and ICU bed capacity during the peaks of the pandemic, as well as more limited opportunities to use remote care to diagnose and treat patients. The specialties where activity fell the least tended to be those where a higher proportion of patients complete treatment in non-admitted (outpatient) settings. Another factor is that some specialties will be slower to recover because they involve more procedures that are riskier from a COVID infection prevention and control perspective e.g. oral surgery is often an aerosol generating procedure so there are heightened risks to patients and staff that need to be managed.
- **Elective care was less disrupted, and recovered more quickly, in regions with generally lower COVID-19 infection rates** – compared to 2019, waiting list activity during 2020 fell by 31% in the North West (the biggest fall), while the South West fell by 24% (the smallest fall). The regions with below average rates of COVID also recovered to pre-pandemic levels of activity more quickly. The major drivers of this are likely to

include: 1) higher rates of COVID cases in the community lead to higher numbers of patients admitted to hospital with COVID (limiting the beds available for elective care) and 2) higher rates of community cases is likely to cause higher levels of sickness absence and self-isolation among NHS staff (limiting the workforce available for elective care). It should also be noted that the regions are large and there is almost certainly as much (possibly more) variation within regions as between them.

- **Patients living in the most deprived areas of England experienced the most disruption to elective care** – compared to 2019, the rate that patients completed treatment in the most deprived areas of England fell by 31% compared to 26% in the least deprived areas. As above, this is likely to be linked to higher rates of COVID cases in the community leading to more pressure on hospital capacity and higher levels of staff sickness absence.
- **While there is uncertainty over when and how many of the 'missing patients' will present, there is some evidence to suggest public willingness to seek treatment – an oft-cited reason for the drop in referrals – is recovering.** Research undertaken in 2020 by Ipsos MORI on behalf of the Health Foundation found unease with using GP and hospital services was highest during the first wave of the pandemic. In May 2020, 20% of people felt uncomfortable about using their local GP and 47% felt uncomfortable about using their local hospital - with concern about COVID-19 the main reason for this discomfort. This fell substantially in July 2020 (with 10% uncomfortable using their GP and 22% uncomfortable using the local hospital) and, despite the increase in cases during Autumn, remained low in November 2020 (12% uncomfortable using their GP and 23% uncomfortable using the local hospital). However, some groups felt significantly less comfortable using health services - including women, people from BAME backgrounds and people living in areas with higher rates of the virus.

Key outputs

- A long read from November 2020 on the impact of COVID-19 on elective care: https://www.health.org.uk/publications/long-reads/elective-care-in-england-assessing-the-impact-of-covid-19-and-where-next
- A long chart from earlier in 2021 updating some of the numbers from the long read and adding an analysis by deprivation: https://www.health.org.uk/news-and-comment/charts-and-infographics/how-is-elective-care-coping-with-the-continuing-impact-of-covid-19
- Research into public perceptions, including attitudes towards using NHS services during 2020: https://www.health.org.uk/publications/public-perceptions-of-health-and-social-care-in-light-of-covid-19-november-2020

Projections of elective backlog need from the Health Foundation's REAL Centre upcoming report

Our upcoming report Health and Social Care Funding Projections 2021 details our estimates of the anticipated size of the elective care backlog and analysis of the costs. A range of estimates are presented as there is uncertainty about: the number of "returning patients" (i.e. those not referred during the pandemic who will be subsequently), the cost of treating those patients, and the policy decisions about how quickly to treat them (which may affect costs in a number of different ways).

The last time the 18-week referral to treatment (RTT) waiting times target was met was in February 2016. Although activity generally increases each year - and so the size of the waiting list for which the 18-week RTT target can be met also grows ('18-week manageable

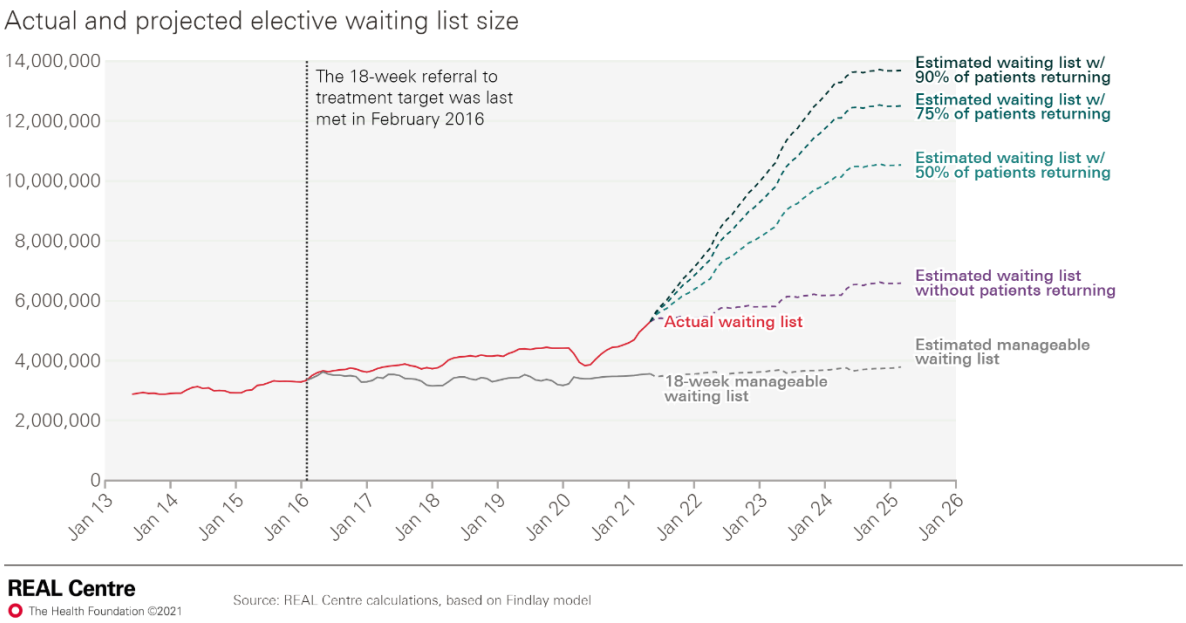
waiting list') - the waiting list ('actual waiting list') has been growing faster than the rate at which the target can be met (Figure 1).

During the COVID-19 pandemic millions of patients who would have been expected to be referred for treatment were not. In our modelling we allow for some growth in referrals year-on-year and estimate the number of 'missing patients' may now be approaching 8 million.[1]

While the size of the waiting list dipped during the pandemic, since then it has grown sharply. As services resume, some of the 'missing patients' would be expected to return but there is significant uncertainty over how many (here we show a range: 50%, 75% and 90%; below we estimate costs for 50% and 75% only) and when. If sizeable numbers of patients do return and activity reverts to pre-pandemic trends[2], we estimate the waiting list could grow to 10.5-13.7 million (with 50-90% of missing patients returning over three years).

The elective care backlog is therefore the difference between the estimated waiting list size and the manageable waiting list size i.e. the total number of patients that would need to be treated to get back to the 18-week manageable level. There is also some recurring activity needed to ensure the list stays at this manageable level (given the waiting list has in recent years been growing faster than activity).

Figure 1 – Actual and projected elective waiting list size



Key outputs: What will it cost to get the NHS and social care on the road to recovery? https://www.health.org.uk/news-and-comment/blogs/what-will-it-cost-to-get-the-nhs-and-social-care-on-the-road-to-recovery

[1] Note, our estimate here includes a growth in referrals of 1.8% year-on-year, which is estimated based on historic data. This may reflect factors such as a growing and ageing population.
[2] Estimated over the period January 2017 -December 2019

Our key findings and modelling assumptions on the cost of meeting the elective backlog as a result of these trends are presented below.

Key information about the waiting list during and before the pandemic are presented in the Annex below.

Impacts on health and wellbeing of waiting for care

- The effects of the pandemic should not be measured in mortality alone. The suspension of routine NHS care has affected people's health and wellbeing – with the significance of this depending on the type of condition or treatment delayed.
- For some conditions, a delay in care will make little or no difference. For others, a delay could lead both to living longer in pain – worsening quality of life – and/or a deterioration in their condition. This analysis explores the implications of this via two case studies – hip replacements and diabetes.

Hip replacements

- **The NHS in England typically carries out 330 elective hip replacements a day. This fell to an average of between one and two a day during March and April 2020.** Recovery began in May 2020, but with marked differences in the pace and extent of recovery in different regions of England – with only London recovering to pre-pandemic numbers by the end of 2020.
- **In 2020, as a result of the pandemic, 58,000 fewer people than usual had a hip replacement** and are therefore waiting. Those waiting are particularly likely to be in certain regions of England (the North West and the South West both have 50% fewer admissions than usual), are slightly more likely to be older and slightly more likely to be living in deprived areas. In London there has been only a 15% reduction in admissions for the least deprived area, compared with 30% for the most deprived.
- **As of January 2021, 58,000 people had waited an average of 25 additional weeks for their hip replacement**. An average individual waiting for an extra 25 weeks suffers quality of life losses during the waiting period equivalent to 80 days in 'perfect health'; and post-surgery losses equivalent to 102 days. This means that, across the English population as a whole, we have lost the equivalent of 29,000 years of life spent in perfect health.

Diabetes

- **In England, there were around 26% fewer new cases of type 2 diabetes in 2020 than 2019, amounting to around 40,000 missed (or delayed) diagnoses**. Referrals to diabetes nurses and education programmes – which help people to manage their diabetes – were also 35% lower in 2020.
- Overall, these impacts are likely to have been less significant than for hip replacements. Missed diabetes care, particularly for those who have been diabetic for some time, does not necessarily lead to a significant deterioration in health or quality of life. We identify three vulnerable tipping points in the diagnosis of type 1 and type 2 diabetes, and in the prevention of type 2 complications, where the risks of missed care are most acute.

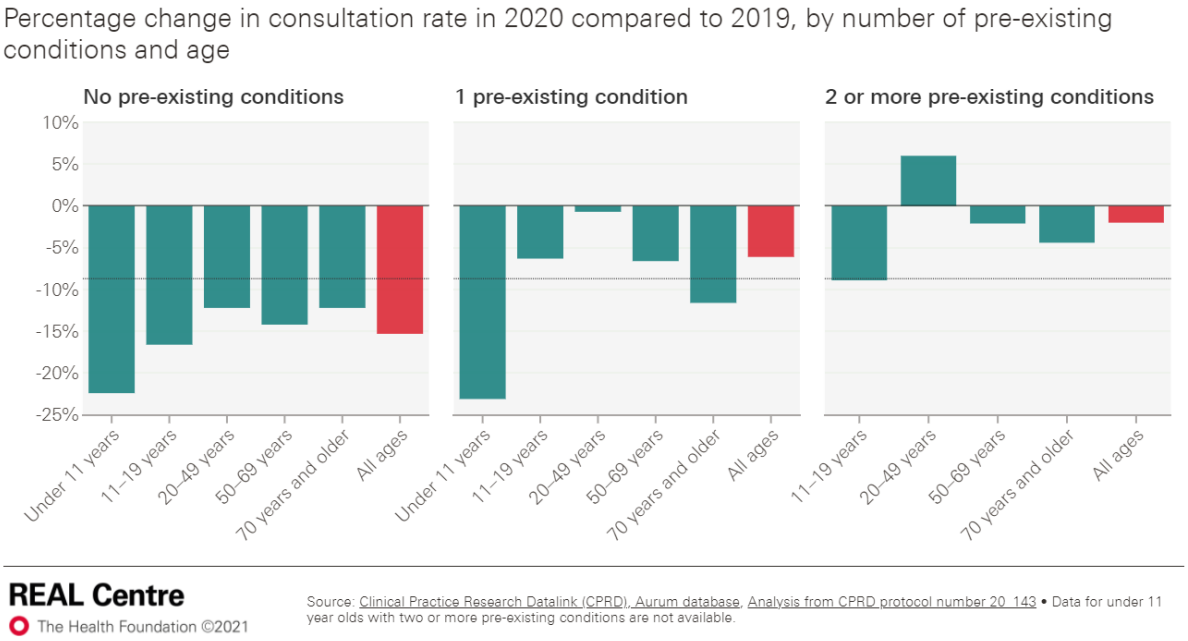
Key output - https://www.health.org.uk/publications/long-reads/waiting-for-care

GP Services

The growth in the elective care waiting list has occurred despite a significant disruption to GP services: a common route of referral to secondary care.

There were an estimated 23 million fewer primary care consultations in 2020 compared with 2019. Almost 16 million (70%) of these were for people who hadn't been diagnosed with common pre-existing non-communicable diseases[3].

Figure 2:

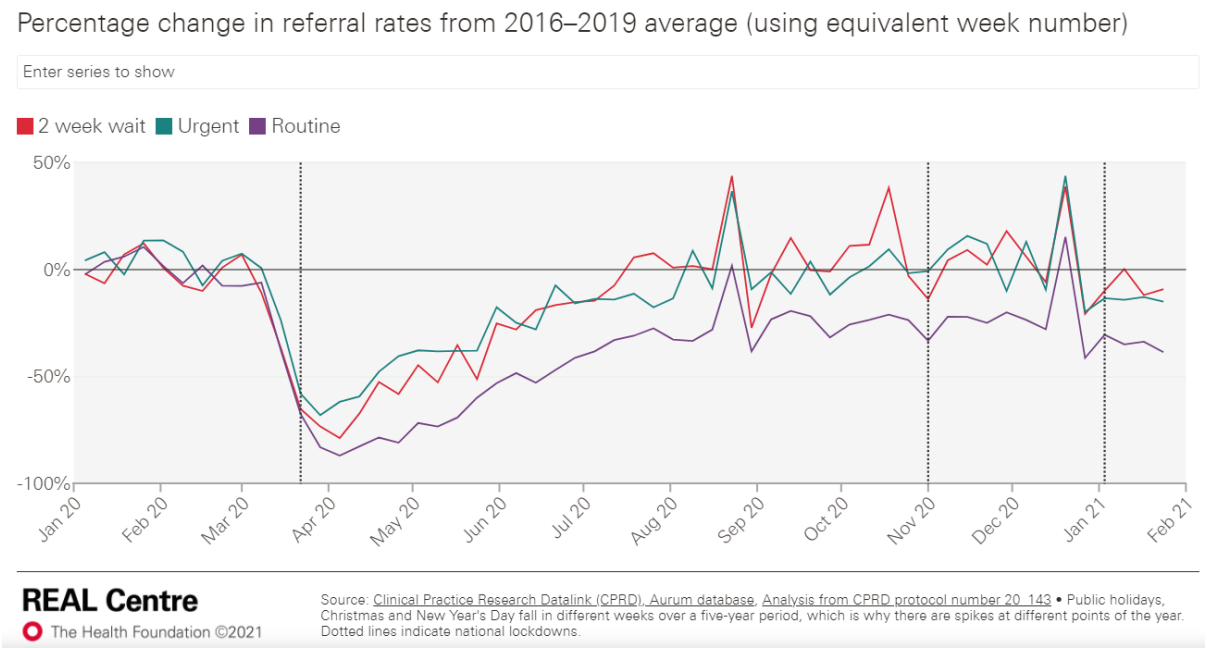


There was a relatively smaller fall in activity for patients with pre-existing non-communicable disease. The largest falls in activity are for young people without illness. Again, this raises the question of how much of this is unmet demand for care, or a fall in need for care.

The disruption to GP services makes unclear the extent to which the current elective wait list is underrepresenting levels of need. Looking at primary care data we observe a clear and sustained reduction in routine referrals.

Figure 3:

[3] AsthmaAtrial Fibrillation, Cancer, Coronary heart disease, COPD, Drepression / anxiety or other neuroses, Diabetes (types I & II), Heart failure, Stroke (T.I.A)



The stark reduction in routine referrals followed guidance from NHS England aimed at relieving pressure on acute care services. Referral rates had not recovered by the end of January 2021, resulting in an estimated 4.5 million missing referrals from 2020 in total.

By autumn 2020, the rates of 2-week wait referrals (for suspected cancer) and urgent referrals were broadly the same as in previous years.

However, 2-week wait referrals did not increase enough to account for the substantial reduction in the first lockdown. Around 250,000 estimated 2-week wait referrals were missing by the end of January 2021.

Key outputs:

Long read on initial impact of pandemic on primary care: https://www.health.org.uk/news-and-comment/charts-and-infographics/use-of-primary-care-during-the-covid-19-pandemic

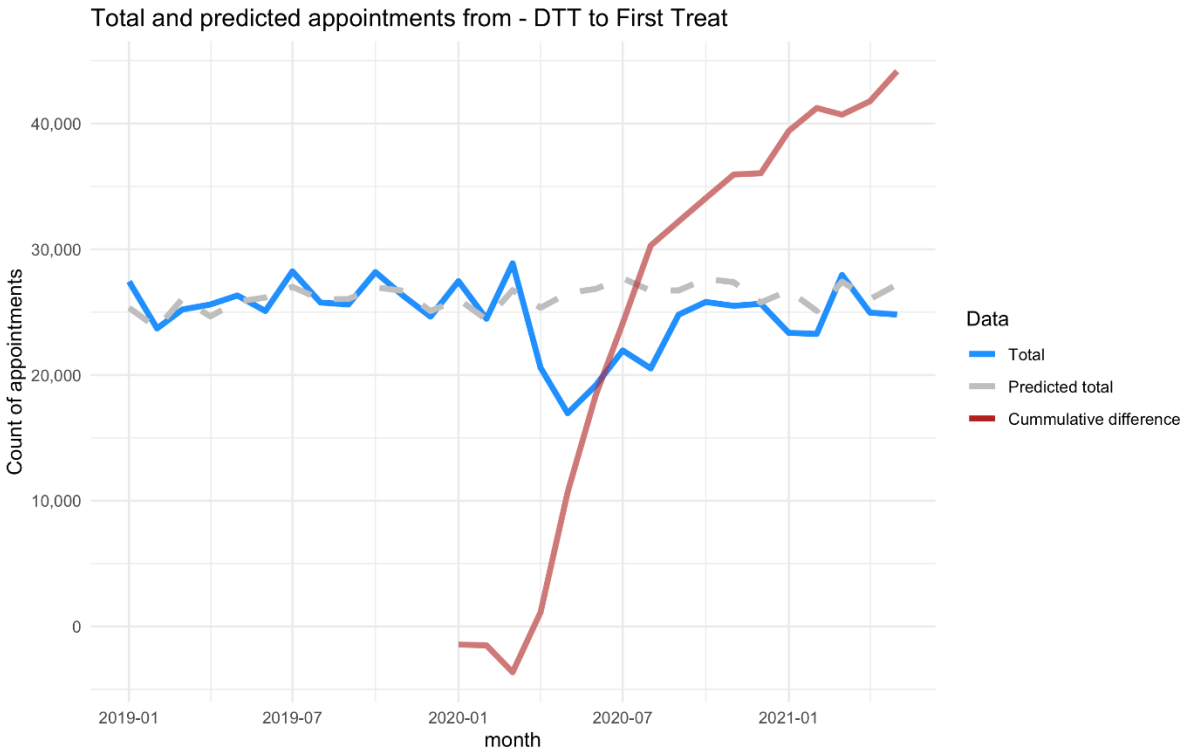
Follow up chart series: https://www.health.org.uk/news-and-comment/charts-and-infographics/use-of-primary-care-during-the-covid-19-pandemic-may-2021

Cancer services

Reviewing cancer waiting times data we can see how the types of activity that has come through the system has been affected by COVID-19.

Figure 4:

Lots of aspects of care and treatments pathways have suffered as a result of the pandemic, but cancer screening has been particularly affected. We analyse the number of patients who have gone from a new cancer diagnosis to a first treatment for cancer.

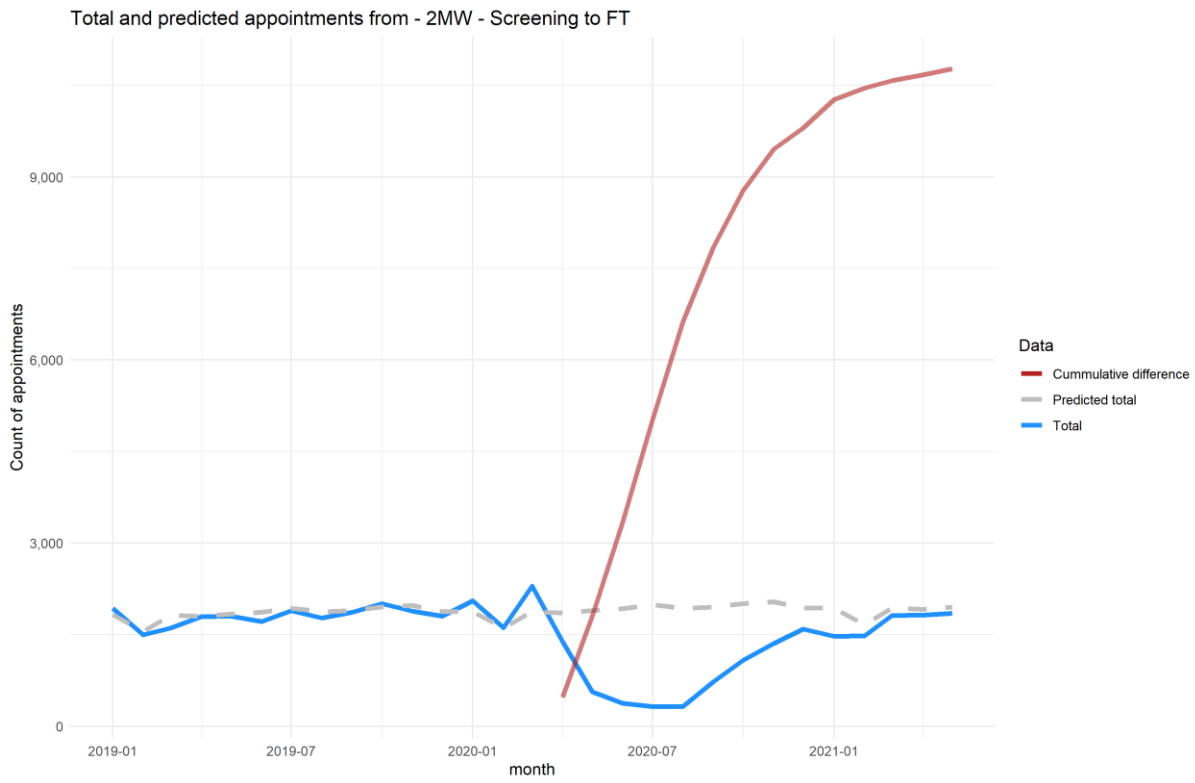


Source: NHS England cancer wait times data, analysis by the Health Foundation's REAL Centre, code for analysis available at https://gitlab.com/tlswatt/cancer-wait-times

The impact of the disruption of the pandemic is clear, by mid-2021 the cumulative difference between observed and predicted first treatments is more than 40,000. This implies there are more than 40,000 patients who are living with undiagnosed cancer, have died with undiagnosed cancer, or have decided not to undergo treatment.

This effect has come from the reduction in consultations and referrals, the necessary pressure on secondary care to focus on the pandemic and a dramatic reduction in attendance of cancer screening. Of this 40,000 plus backlog of missing cancer patients, over 10,000 are missing from the normal diagnosis numbers following a screening.

Figure 5

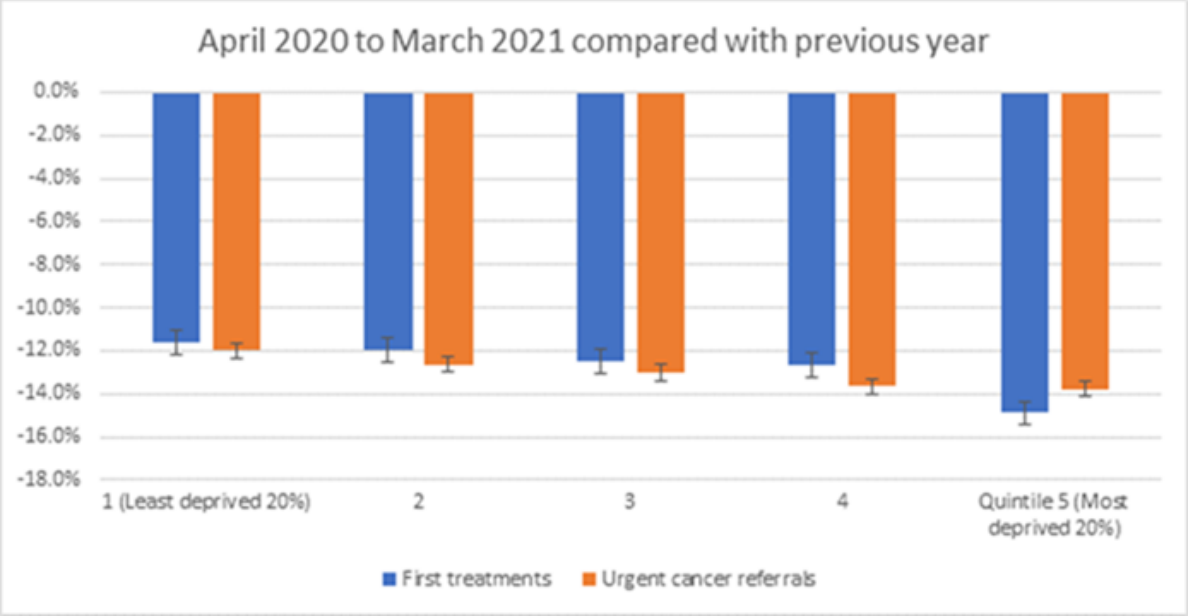


Source: NHS England cancer wait times data, analysis by the Health Foundation's REAL Centre, code for analysis available at https://gitlab.com/tlswatt/cancer-wait-times

Recently published data from the National Cancer Registry and Analysis Service (NCRAS) show clear socioeconomic inequalities in the impact of COVID-19 on cancer.

We know cancer incidence rates are higher in more deprived areas. These data show that urgent referrals for cancer (orange) and first treatments for new cancer (blue) fell significantly more for people living in the most deprived areas of the country.

Figure 6:



Q. What capacity is available within the NHS to deal with the current backlog? To what extent are the required resources in place, including the right number of staff with the right skills mix, to address the backlog?

In 2020 we estimated that to meet the elective backlog an additional 4,100 consultants and 17,100 nurses would be needed.[i] Since then the number of additional treatments needed to meet the backlog as grown.

If 75% of missing patients return, we estimate that meeting the RTT target by 2024/25 would require 13% more pathways to be completed each year than in 2019/20; this equates to an additional 4,440 consultants and 18,310 nurses each year.

Under a more conservative scenario, under which the system is on course to return to 18/19 level of performance by 2028/29, the number of pathways would need to be 7% higher than 2019/20; this would mean an estimated 2,270 extra consultants and 9,370 nurses would be needed each year.

Figure 7 - Estimated additional resources required (75% missing patients returning)

Extra resources needed	Returning to 18/19 levels of performance (2021/22-2028/29)	Meeting the RTT target (2021/22-2024/25)
Consultants	2,270	4,440
Nurses	9,370	18,310

While the independent sector can contribute to addressing the backlog, it is not a perfect substitute for NHS capacity and is not evenly distributed within England.[ii] There are at least four issues with independent sector (IS) capacity that we have identified:

- The IS has historically focused on high volume, low complexity procedures and tends to avoid high complexity procedures and high risk patients.
- The IS also performs more of some procedures than others, and this does not wholly reflect the backlog of need.
    - In 2019, the IS accounted for 20.9% of NHS-funded activity in trauma and orthopaedics (including hip and knee replacements) and 9.4% in ophthalmology (including cataract surgery). While trauma and orthopaedics and opthalmology are two of largest specialties on the waiting list, they only account for 12% and 10% of the total number of patients waiting in June 2021.
    - In contrast, the IS accounted for less than 1% of the total pathways completed in 2019 in geriatric medicine, cardiology, cardiothoracic surgery, neurology, thoracic medicine or general medicine (which collectively account for around 10% of the patients currently waiting).
- Access to IS hospital capacity is not evenly distributed across the country - of the 144 non-NHS providers registered with the CQC as hospitals, 89 (62%) are located in the South East, South West, London and East of England.
- Finally, the healthcare staffing pool is limited and the IS partly relies on staff that also work in the NHS, many of whom may be fatigued post-pandemic and therefore less motivated to take on an increased workload.

Supporting staff wellbeing as part of the NHS recovery:

- In addition to a focus on numbers of staff and how existing workforce shortfalls can be addressed, it is important to recognise the impact of COVID-19 on staff at all levels across the NHS and social care and ensure that staff recovery is prioritised alongside service recovery
- COVID-19 has had a significant negative impact on the NHS workforce including high levels of burnout, sickness absence, increased risk of 'moral injury' and the sustained longer-term repercussions of this.
- Results from the NHS Staff Survey 2020 show that 44% of staff reported feeling unwell as a result of work-related stress, the highest result over the past five years.
- A study conducted after the first wave of covid-19 in summer 2020 found almost half of critical care staff met thresholds for Post Traumatic Stress Disorder, depression, anxiety, or problem drinking. Some staff are likely to have experienced moral injury, the distress arising from being unable to act in line with their personal ethical codes.
- NHS staff form a crucial building block for COVID-19 recovery and therefore more must be done to ensure their health and wellbeing is improved. Improved staff health and wellbeing contributes to improved patient outcomes, reduced costs due to sickness absence and recruitment, and higher workplace productivity. Employment and working conditions are also key social determinants of health and a major contributor to wider health inequalities.

Q. How much financial investment will be needed to tackle the backlog over the short, medium, and long-term; and how should such investment be distributed? To what extent is the financial investment received to date adequate to manage the backlog?

Analysis from the Health Foundation's REAL Centre projections report

Headline findings

Our estimates show that clearing the backlog to return to the 18-week RTT target would cost £11.7bn (50% of 'missing patients' returning) to £15.7bn (75%) over the remainder of this parliament (up to 2024/25). In addition, some recurring cost of around £300m would be needed each year to reach and maintain the 92% target. In all, over this parliament, an additional £12.8bn to £16.8bn in additional funding would be needed.

That funding would enable the NHS to clear the backlog of people waiting for routine elective care – a record 5.5million people now waiting for care – including returning 'missing patients' by treating an additional 1.7milion to 2.2million people a year.

By these estimates, between £3.2bn and £4.2bn a year in additional funding would be needed each year from 2021/22 to 2024/25 to meet the 18 weeks target. However, even with this funding, there may not be capacity to treat this number of patients over the next 4 years. It would mean almost 800,000 extra hospital admissions a year, on top of the [2.5%] growth in activity needed to keep pace with underlying growth in demand.

The NHS was given £1bn for 2021/22 to address the waiting times backlog, considerably less than the REAL Centre's estimate of what would be needed.

How we calculated the figure

As set out above waiting lists were growing prior to the pandemic and a number of "missing patients" who were not referred after COVID-19 may return for treatment (we estimate the number of 'missing patients' is now approaching 8 million). As services resume, some of these patients are expected to present to the NHS needing care, although precise numbers

are uncertain. Our analysis suggests the waiting list could grow to 10.5-12.5 million if 50-75% of people do return and activity continues as usual.

We model two options facing the government: to clear the backlog over the course of this Parliament - which will present significant challenges in terms of boosting staffing levels and capacity – or address the waiting list over a longer time-period. Meeting the target in 2024/25 means bringing the waiting list down to 3.8million by March 2025. Alternatively, by our modelling, tackling the backlog by 2028/29 could mean running with a waiting list of 7-8million (50%-75% of patients returning) in March 2025.

To meet constitutional waiting times standards, the NHS would therefore need to do two things: first, undertake more activity on an ongoing basis to stop waiting lists from growing; and second, clear the backlog for elective care[iii]. The first corresponds to a recurrent or ongoing cost. The second, clearing the backlog, is modelled as a one-off increase in activity to treat those already waiting and returning 'missing patients'[iv].

Costs are based on a weighted average of outpatient and inpatient costs of admission. Only some patients will require a hospital admission. In 2018/19, 22% of all completed pathways were admitted. Looking only at those completed over 18 weeks, a higher proportion were admitted (39%). We assume 39% of those in the backlog, including missing patients, are admitted.[4]

Furthermore, the non-recurrent costs of clearing the backlog are uprated to account for the price premium associated with using more bank and agency staff or capacity in the private sector. The extra costs associated with hiring more temporary staff are likely to be substantial. While bank and agency staff account for around 8% of the NHS workforce on average[5], REAL Centre analysis indicates that they cost on average 90% more than establishment staff per whole time equivalent[v]. We account for the expected higher costs by adding a cost premium to the usual costs of treating patients. We assume this is 50% and 25% cost premium, respectively, associated with clearing the backlog over a 4 or 8-year horizon.

Below, we show two charts:

- 'A', in which the waiting list is cleared over 4 years with a cost premium of 50% for treating the backlog - the average annual cost over 2021/22 to 2030/31 ranges from £1.5bn (50% of patients return) to £1.9bn (75% of patients return). However, the costs fall almost entirely in the next 4 years (from £3.2bn to £4.2bn). There is some recurring cost to meet the target (~£300m).
- 'B', in which over 8 years the waiting list returns to 18/19 levels of performance with a cost premium of 25% - the average annual cost over 2021/22 to 2030/31 is lower (£1.2bn - £1.5bn). However, it is more evenly spread over time; the average cost over the next 4 years would be £1.3 to £1.8bn.

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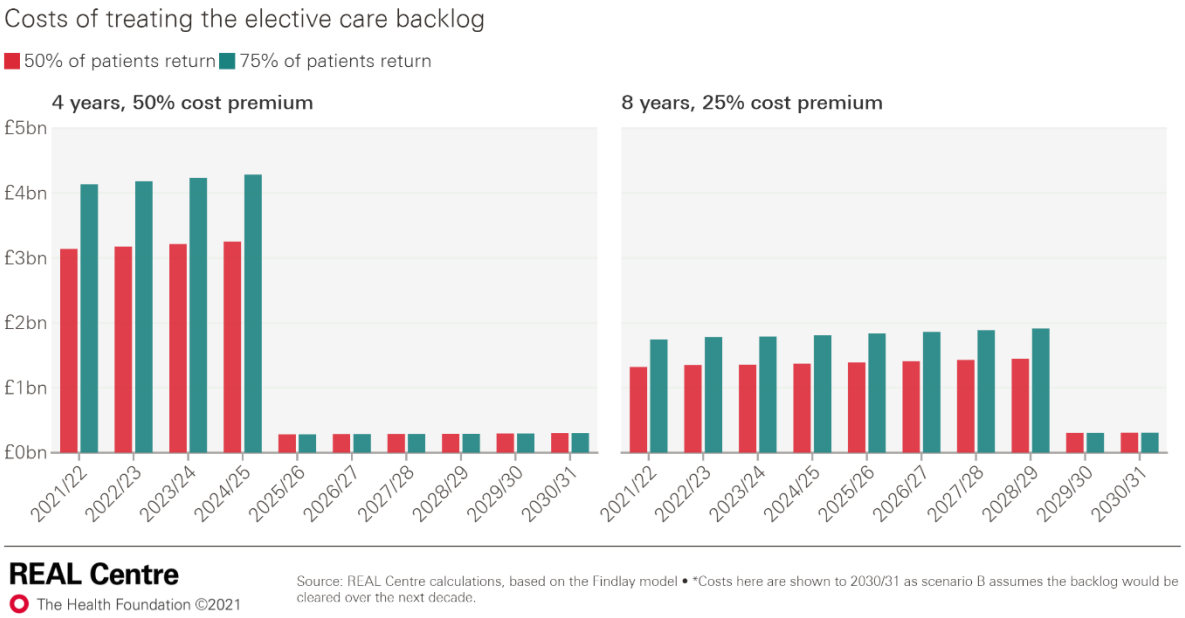
[4] There are several reasons for extending this assumption to returning missing patients. For one, aadmitted patient care fell more significantly than non-admitted patient care during the pandemic. Another is that returning patient are likely to be of relatively high severity, both because GPs are more likely to refer those in greater need and because 'missing' patients, by definition, are being referred later than usual.

[5] This is an estimate based on the fact that vacancy rates for total NHS workforce have averaged 8% since 2018/19 and that most vacancies are filled by bank and agency staff according to latest data.



Note, the costs of meeting the backlog also need to be weighed against the health impacts of delayed care including potentially greater severity and cost[vi] and any wider losses to the whole economy from higher sickness rates.

Q. How might the organisation and work of the NHS and care services be reformed in order to effectively deal with the backlog, in the short-term, medium-term, and long-term?

As we set out in our overview to this submission, recovering elective care services will not only need significant financial investment and support for a tired workforce, but also action on several other fronts. Enabled by a supportive policy framework, the NHS will need to think and act innovatively in how it redesigns pathways to address the elective care backlog.

In this question, we set out work on identifying seven promising models of care and ways of working that could support recovery.

Since April 2021, the Health Foundation has engaged in conversations with frontline NHS staff to determine the key issues impacting and influencing their response to the elective backlog. In June 2021 we held two research sessions with members of the Q community (a network of over 4,000 members with improvement expertise) to explore issues and challenges connected to backlogs and waiting times for health and care services. Through this work and our wider conversations with staff leading recovery efforts, we have surfaced a range of promising solutions being trialled. This is not intended to be a comprehensive overview of all the ways in which NHS services can be reformed.

1. *Supporting patients waiting for care*

Alongside the effective management of waiting lists to ensure people receive care and waiting times are reduced, it is equally important to improve the waiting process. A recent National Voices report described the impact that a poorly managed waiting time can have on peoples' physical and mental health and highlighted the need to understand the importance

of the waiting experience, invest in developing patient-centred communication and information and ensuring people know about and can access support to help them manage their health and care while they wait.

Voluntary, community and social enterprise (VCSE) organisations and their staff have provided unprecedented levels of support to the NHS since the pandemic began. They are now also providing much needed support to different patient groups, particularly those with long-term conditions and those awaiting elective surgery. This is not a free resource. The commitment from the VCSE sector needs to be acknowledged and supported, including financially.

2. *A more holistic approach to elective care pathways*

There is increasing recognition that what happens before and after surgery has significant impact on the quality and efficiency of care. The Centre for Perioperative Care (CPOC) has recently published guidance on preoperative assessment and optimisation for adult surgery.

The guidance calls for the establishment of pre-operative pathways that include optimisation of comorbidities, nutritional status, psychological preparedness or functional capacity (fitness). Viewing 'waiting lists' as 'preparation lists' that optimise patients prior to surgery, has the potential to reduce last minute cancellations, increase chances of a successful procedure, and address longstanding causes of poor health. Embedding shared-decision making (SDM) throughout perioperative pathways is a key component. There is good evidence that when done well, SDM often leads to more conservative treatment decisions, reducing demand for surgery.

3. *Greater use of technology and digital enabled care*

The pandemic has seen increased use of digital technology to support care delivery, which has potential to support elective recovery.

For example, the development of 'virtual wards' aims to support patients to leave hospital earlier, through enabling them to record their own clinical data at home and submit this to their clinical teams via home devices or apps. NHS X has developed 'digital playbooks' advising how technology can be used to deliver more care and advice remotely. It is important these approaches are tested and well evaluated to understand their impact.

4. *Patient Initiated Follow Up*

Reforming outpatient care has long been an ambition of the NHS and Patient Initiated Follow Up (where patients decide when they need contact with their secondary care team rather than attending appointments at arbitrary or fixed intervals determined by the service) is considered a key part of the solution, reinforced most recently in the Long-Term Plan.

Patient Initiated Follow Up has the potential to reduce unnecessary outpatient appointments, providing patients with care when needed the most, and improving patient and clinician satisfaction. For this to be a success, patients need to be supported and given confidence to act on their symptoms and pathways need to be integrated to ensure patients do not get 'lost' in the system. Technology also needs to be thoughtfully optimised to include co-produced questionnaires with patients and clinicians, professional initiated data-led recall, and easy access to information for both patients and clinicians.

5. *Appropriate prioritisation*

Several providers have told us that there is a strong desire to ensure patients are prioritised appropriately, but this is not straightforward. There is often a tension between prioritising

those who have been waiting the longest and a desire to ensure patients are prioritised according to their clinical need. A recent Health Foundation publication exploring differences in waiting times for hip replacements and diabetes care across England highlighted wider factors that may also be relevant, including impact on an individual's quality of life or personal finances or a desire to reduce inequalities. Frontline staff would benefit from national support and sharing of good practice to enable them to balance the moral, financial and political tensions as they prioritise patients waiting for care.

Better data is also needed to aid prioritisation decisions. Further guidance and investment in analytical capability is needed to allow providers to develop local patient databases with detailed demographic and clinical information to allow them to monitor patients on the waiting list and make more informed prioritisation decisions. NHS providers have told us that they are also keen to utilise the formation of Integrated Care Systems to facilitate a system-wide single waiting list and sharing workforce and operating space where possible. This does however require strong leadership, especially where multiple providers within the same region only provide sub-specialist care, and when patients may be unable or reluctant to access care from centres that are further away.

6. *Improving communication between primary and secondary care*

The pandemic has seen an increase in the use of advice and guidance services. This has been of particular benefit to primary care clinicians who are potentially able to seek specialist secondary care advice electronically within a designated period of time, often reducing the need for onward referral. Careful consideration is needed to ensure clinicians in both primary and secondary care have sufficient time to manage this alongside pre-existing clinical commitments.

7. *Innovative use of buildings and estate including community assets*

The implementation of new infection control policies to reduce nosocomial COVID-19 transmission has had a significant impact on the use of NHS facilities and estates. Space has become an important commodity and many NHS providers have rapidly procured new facilities in order to deliver routine procedures. An example includes NHS Nightingale Hospital Exeter which has been purchased by NHS organisations in the South West and is being used to provide diagnostic scans including CTs and MRIs, host a vaccination trial and train international nurses. Royal Devon and Exeter is one of the accelerator sites announced in May 2021 and also pledged to create purpose-built modular units to facilitate an increased number of eye operations in the community. University Hospitals Dorset NHS Trust announced that it would be setting up a "health pop up village" in a local shopping centre as part of its efforts to address backlogs in care.

Whilst acquiring more space is an attractive solution in the short-term as infection control policies remain, this creates additional burden on staff and patients having to travel away from their usual site. It also raises questions about how these sites are governed and regulated to ensure quality and safety standards are maintained.

Key Health Foundation outputs

- Moving past the backlogs: how are Q members improving access to services?
- How can unnecessary outpatient appointments be reduced? The Health Foundation 2020.
- Waiting for care: Understanding the pandemic's effects on people's health and quality of life. The Health Foundation 2021.

- Improving surgical care for patients and their families in Greater Manchester – ERAS+ GM. The Health Foundation and University of Manchester.
- Preparing for surgery: The community pre-habilitation and wellbeing project (the PREP-WELL Project). The Health Foundation 2017.
- Frontline insights on the rapid implementation of video consultations: what's needed now? The Health Foundation 2020
- Video consulting during and beyond the COVID-19 pandemic, Health Foundation supported research project, 2020.
- Scaling up virtual consultations across the NHS, Health Foundation funded improvement project, 2017-2020

Other sources

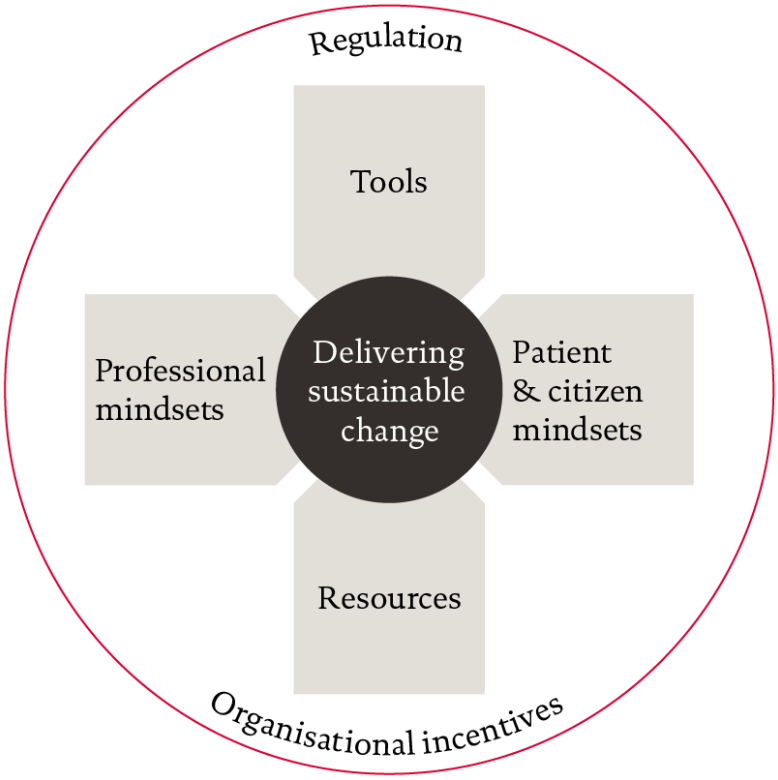
- Advice and Guidance, NHS Digital
- Patient. Noun. Adjective, National Voices, 2020
- Building back elective care: A new framework for recovery. NHS RESET, NHS Confederation 2021.
- Preoperative Assessment and Optimisation for Adult Surgery including consideration of COVID-19 and its implications. The Centre for Perioperative Care, 2021.

Q. What positive lessons can be learnt from how healthcare services have been redesigned during the pandemic? How could this support the future work of the NHS and care services?

The COVID-19 pandemic shone a spotlight on the commitment, resilience and agility of frontline health and care workers.

The pandemic has led to rapid and significant changes in how NHS services are delivered and used. In September 2020 we published a long-read that draws on expertise from the frontline and highlighted enablers and barriers to implementing change within the NHS. We also considered what is needed to sustain these changes and generated a high-level model to depict these (Figure 9).

Figure 9: A high level model for sustainable change



This work was not intended to provide a systematic review of all of the service shifts during Covid-19 (and see work by the Beneficial Changes Network and Accelerated Access Collaborative to understand these shifts more fully) but rather to provide a snapshot of the key shifts (see Table 1) and distil the key enablers of these changes, the potential barriers to sustaining them and to set out a framework to help teams, organisations and system leaders to understand where attention is needed if these changes are to be retained in the longer term.

Table 1: Examples of the service shifts emerging during the COVID-19 pandemic

	Promotion/prevention/ self management	Primary and community	Specialist diagnosis and treatment
Patient-clinician shifts	• Outreach from primary care and mental health for vulnerable groups • Online health promotion resources • Community support networks (health specific and general) • Remote self-monitoring and management tools	• 'Total triage' for general practice • Digital consultations • 'Discharge to assess' • Electronic prescribing • Increase in referral thresholds • Increased skill mix within teams • Community admission avoidance and step down care	• Remote 'Advice and Guidance' for GPs • Virtual outpatients • 'discharge to assess' • Specialist hubs for specific conditions (eg cancer) or elective care • Enhanced 'Call Before You Walk' to A&E • 24-hour telephone crisis care for mental health
System shifts	• Collaborative hubs for locality services in primary care • Leadership roles for Community Trusts in discharge management • Specialisation of services across hospitals (eg hot/cold, elective, specialist networks, downgrading of A&E) • Centralisation of waiting lists across STP		

Source: stakeholder interviews, grey and other literature.

An important lesson from the service shifts that occurred during the pandemic is the need for the right balance of central coordination and guidance with greater autonomy for those on the frontline to lead change – what we describe in our paper as "a combination of top-down clarity and bottom-up agency".

One critical factor in creating that bottom-up agency was freeing up capacity. Staff were released from other duties to concentrate on implementing and delivering change, enabled by a significant reduction in services. As normal services resume, transformation ambitions will once again collide with workforce pressures. If we want the NHS to have the kind of capacity for innovation that we saw during COVID as part of business as usual, there will need to be increases in the clinical and improvement workforce.

Related evidence:

Understanding and sustaining the health care service shifts accelerated by COVID-19, Health Foundation 2020
Securing a positive health care technology legacy from COVID-19: https://www.health.org.uk/publications/long-reads/securing-a-positive-health-care-technology-legacy-from-covid-19
Switched on: How do we get the best out of automation and AI in health care?: https://doi.org/10.37829/HF-2021-I03
Digital transformation in the NHS. National Audit Office. May 2020. https://www.nao.org.uk/wp-content/uploads/2019/05/Digital-transformation-in-the-NHS.pdf

Q. What can the Department of Health & Social Care, national bodies and local systems do to facilitate innovation as services evolve to meet emerging challenges?

As set out above, recovering the backlog will require a comprehensive policy approach, including financial investment, support for the capacity and wellbeing of the workforce, a clinically informed measurement approach, realistic recovery trajectories, and support for integrated care systems to develop the data, improvement approaches and systems that enable mutual aid and learning between Trusts.

Our research on service innovation during the pandemic concluded that the right balance between top-down authority and bottom-up agency and effective dispersed leadership at national, regional and local levels was key to enabling innovation, as was finding ways to build on the shared purpose that drove much of the rapid innovation and improvement during COVID-19. In addition to the policy action described above, there are three things that leaders at all levels of the system can do to facilitate innovation in recovery.

1. *Build capability for innovation and improvement and support implementation*

In addition to funding for specific approaches or “solutions” to address backlogs in care, teams need the capability to implement them well. How successfully reforms like new technologies and models of care are implemented will ultimately be critical to realising their benefits. Key enablers include digital infrastructure, leadership and management capability and Quality Improvement and analytical skills.

This underlying ability to improve is critical in enabling the service to adapt to challenges. A 2020 survey of Q Community members showed that those organisations that had invested in building improvement capability before the pandemic were better able to use improvement skills and approaches to develop effective responses and support strategic decision making during the pandemic. For example, Northumbria Healthcare NHS Foundation Trust had a long history of investing in improvement and prioritising patient and staff experience and were able to quickly adapt a project focused on using real-time staff feedback for improvement to create Corona Voice which they used to make more effective decisions, including on procuring personal protective equipment and supporting staff working from home.

2. *Invest in evaluation of innovative approaches to tackling the backlog*

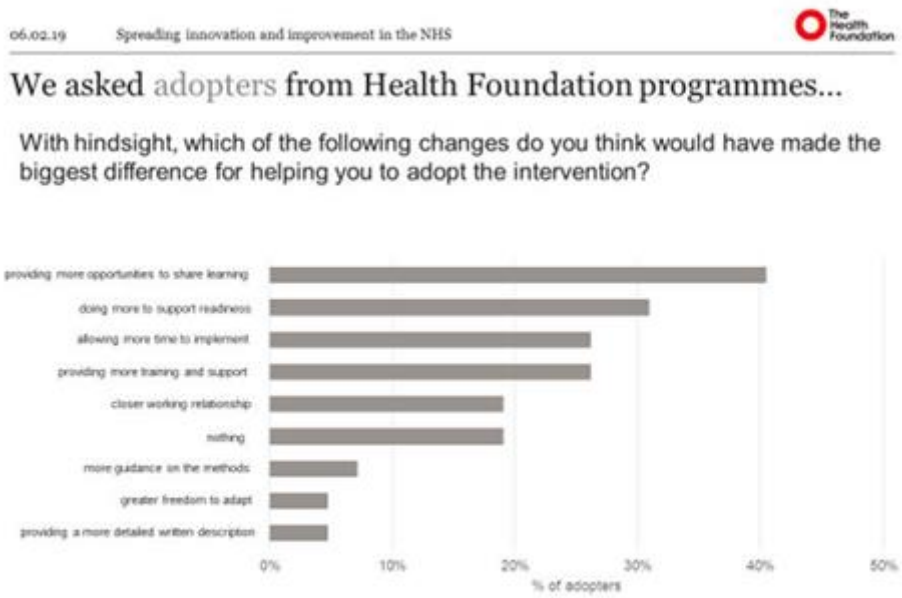
As is clear from the examples in Q4, there are many ways in which frontline staff, teams and organisations are seeking to innovate and redesign services and pathways to address the backlogs in care. It is important that these are evaluated and that learning from the successes and failures is shared transparently and used for further improvement.

However, it is also important that people can learn and act quickly given the urgency of the challenges. Investing in rapid and robust evaluation methods, such as those used by the NIHR funded BRACE and RSET teams, or the Health Foundation's own Improvement Analytics Unit, and building analytical capability across the system must be an urgent priority. As a starting point, NHS England should be clear about how they are supporting evaluation of the Elective Recovery Accelerator sites and what measures it will include beyond a focus on increasing levels of activity, which are important but not sufficient.

3. *Facilitate shared learning*

A clear message from the frontline staff we have spoken to is that they feel there is a real gap around how people can learn from each other about how they are tackling challenges. This is important to ensure that people are not constantly reinventing the wheel, to provide a space for people to share challenges and problem solve collectively and to enable people to learn from an adapt ideas to the specific challenges they face.

In *The Spread Challenge*, our 2019 report on the adoption of spread and innovation in the NHS, we asked teams who had been involved in adopting innovations as part of Health Foundation programmes what would have made the biggest difference in helping them adopt the innovation successfully. Their top answer was providing more opportunities to share learning and experiences with one another.



We have seen a number of individually led initiatives being coordinated and facilitated to try and fill this gap in relation to addressing backlog challenges such the Proud2bOps National Network working with staff leading elective recovery and sharing insights via the twitter hashtag #SharingElectiveStuff and through informal online discussions to share innovative examples and facilitate wider discussion. This is being done on a voluntary basis by staff who are already under significant pressure to address backlogs of care in their organisations or local systems. Many would welcome more national support to facilitate these conversations and shared learning and ensure it reaches a larger audience. Supporting this work at all levels of the system could also help in creating anew a sense of shared mission that was so critical during the pandemic.

The Q Community also has an important contribution to make in connecting improvers tackling the challenges of service recovery and generating and sharing insights. Throughout 2020 and 2021, the Q Team at the Health Foundation, working with our partners, have undertaken a number of workstreams to surface and share learning and insights to support improvers work to respond to the pandemic and address emerging challenges, including backlogs in care. Through the Q Exchange programme, we are also funding 30 teams, led by Q members, focused on embedding positive changes emerging through new collaborations or partnerships during COVID-19. As part of the funding, teams agree to share their learning and insights with the Q Community and more widely.

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Annex A – key waiting times data

Elective waiting time – key facts	
	Estimate
Pre COVID-19 how many patients flowed onto the waiting list each month and how many were coming off?	• 20.2m patients added to waiting list in 2019 – average of 1.7m per month • 16.6m patients completed pathways in 2019 – average of 1.4m per month
During COVID-19 how many patients flowed onto and off the waiting list?	• 23.0m patients added to waiting list from Jan 2020 to Jun 2021 – 7.4m fewer than pre-pandemic (total 2019 plus Jan to Jun 2019) • 18.8m patients completed pathways from Jan 2020 to Jun 2021 – 6.1m fewer than pre-pandemic (as above) • 1,676,342 patients added to waiting list in Jun 2021 – 102% of Jun 2019 • 1,336,376 patients completed pathways in Jun 2021 – 99% of Jun 2019 (95% admitted / 100% non-admitted)
What was the waiting time pre-COVID-19 and during the pandemic?	• 24.9 weeks - 92nd percentile wait in December 2019 • 44.2 weeks – 92nd percentile wait in June 2021
What was the share of admitted and non-admitted patients before and during the pandemic?	• 2019: 21% admitted (3.5m) / 79% non-admitted (13.1m) • 2020: 18% admitted (2.1m) / 82% non-admitted (9.8m) • 2021 YTD: 18% admitted (1.3m) / 82% non-admitted (5.6m) • Jun 2021: 21% admitted (275k) / 79% non-admitted (1.1m)
How much of waiting list is orthopaedics, mental health, eyes and cancer?	• Total waiting list: 4.45m • Trauma & orthopaedics: 668,763 (12% of total) • Opthalmology (eyes): 559,451 (10% of total) Cancer and mental health waiting lists not published on comparable basis: • Waiting list only includes consultant-led care and excludes vast majority of patients waiting for mental health services. • Cancer referrals are included in waiting list but split across multiple specialties and can't be aggregated. Separate waits data is patients seen not patients still waiting. FYI - approx. 2.4m patients urgently referred for suspected cancer seen per year (pre-COVID).

What proportion of those of waiting list are 65 and over, and which regions have the longest list	68.8% of waiting list in England within 18 weeks in Jun 2021 (83.2% in Jun 2019) Regions in Jun 2021 (best to worst): 1. North East & Yorkshire: 74.7% 2. London: 71.8% 3. South East: 71.0% 4. South West: 68.4% 5. North West: 67.8% 6. East of England: 67.5% 7. Midlands: 64.3% 8. NHS England (spec comm): 63.6% Biggest falls in Midlands (2nd best in Jun 2019) and North West (3rd best).
All numbers sourced from: NHS England. Consultant-led Referral to Treatment Waiting Times Data.	

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[iv] NHS England. Consultant-led Referral to Treatment Waiting Times. NHS England; 2021 (https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/).

[v] REAL Centre. Nurse supply model. Projecting the future nursing workforce supply in England [webpage]. *Health Foundation*; no date (https://www.health.org.uk/what-we-do/real-centre/nurse-supply-model).

[vi] Krelle H, Barclay C, Tallack C. Waiting for care: Understanding the pandemic's effects on people's health and quality of life . Health Foundation; 2021. (https://www.health.org.uk/publications/long-reads/waiting-for-care)