

Written evidence submitted by Reform Think Tank (NWT0004)

Inquiry into reducing NHS waiting times for elective care

Reform's 'Hospital of the Future' series is analysing the current problems with the hospital system and how it needs to adapt to the evolving needs of society. This submission draws on evidence gathered for a forthcoming publication in this series, focused on how specialist hospital care can be divorced from the physical building.

This evidence submission sets out key findings and insights that are relevant to the Committee's focus on the topic, to help inform the approach to this vital issue. It will focus largely on the limitations of the current approach on diagnostics and outpatients.

Progress against diagnostic programme

1. The diagnostic programme has the clearest links between its output and intended outcomes. The approach so far has mostly involved increasing diagnostic capacity through Community Diagnostic Centres (CDCs). The approach, while the most impactful out of all the objectives, is not however a straightforward success.
2. In summary: CDCs have been known to create supply induced demand (when creating more service capacity stimulates additional use of services that would not have otherwise occurred); they are often staffed from the core hospital which then dilutes capacity in both settings; and they can also be significantly more expensive to run with little added clinical effectiveness.
3. Some international evidence suggests that diagnostic centres can reduce various waiting times, including time to surgical consultation and time from consultation to treatment.¹ They could also positively impact health inequalities as the volume of diagnostic procedures associated with the introduction of CDCs is slightly larger for those hosted in deprived areas.²
4. However, the evidence is mixed for other wait time outcomes including the time to first visit, time to diagnostic examination and time to diagnosis.³ Evidence also suggests their ability to reduce waiting times is sometimes countered by supply induced demand.⁴
5. They generally increase the *volume* of diagnostic procedures across the board. But increasing the volume of procedures does not automatically lead to faster outcomes for patients.
6. As the supply of diagnostic tests increases, waiting times should fall if demand remains constant. However, while CDCs appear to have been opened in trusts with higher waiting times, there is currently no evidence that this has led to a fall in waiting times.⁵ This suggests that demand has increased commensurate to the increase in diagnostic capacity, which means that more people will be seen, but that waiting times may not fall. This suggests that CDCs should also be introduced alongside a shift in referral behaviours.

¹ Alesha Wale et al., 'The Effectiveness and Cost-Effectiveness of Community Diagnostic Centres: A Rapid Review', *International Journal of Public Health* 69 (23 January 2024): 1606243, <https://doi.org/10.3389/ijph.2024.1606243>.

² Peter Sivey and Jinglin Wen, 'The Effect of Community Diagnostic Centres on Volume and Waiting Time for Diagnostic Procedures in the UK', *Health Policy* 147 (September 2024): 105101, <https://doi.org/10.1016/j.healthpol.2024.105101>.

³ Wale et al., 'The Effectiveness and Cost-Effectiveness of Community Diagnostic Centres'.

⁴ Sivey and Wen, 'The Effect of Community Diagnostic Centres on Volume and Waiting Time for Diagnostic Procedures in the UK'.

⁵ Ibid.

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7. Interviewees for our upcoming paper suggested that CDCs may not be cost efficient; although identifying cost-effectiveness in a relatively less mature innovation is difficult. Nevertheless, in terms of direct running costs, interviewees suggested that CDCs can be significantly more expensive than running the same diagnostic procedures in the hospital setting: economies of scale in a hospital allows for more efficient use of staff and specialist resource.
8. Setting up diagnostic centres in community-based sites is also expensive; not only are upfront costs high, but there are risks associated with private landlords charging more, alongside the cost of relocating equipment.⁶
9. In terms of system-wide efficiency, in theory, with equipment usage focused solely on elective tests and not disrupted by emergency diagnostics, scheduling should be more reliable. This should also be taking away demand from hospitals.
10. Again, the reality is less positive. The Royal College of Radiologists found that 89 per cent of CDCs are staffed with existing trust employees and so rotating staff between the CDC and acute sites might be diluting capacity in both settings.⁷ As a result, specialists from diverse diagnostic fields report that CDCs have introduced a notable increase in workload.⁸ It is unclear whether this is because by increasing diagnostic capacity – irrespective of location – workload increases, or whether this is exacerbated by the CDC not being on the hospital estate.
11. Overall, evidence gathered for our upcoming paper on the future of hospitals suggest that for patients needing varying degrees of specialist investigation, relocating specialist care into the community is not necessarily more clinically or cost effective than attending the hospital estate.
12. This happens due to three reasons. First, providing care outside of the hospital has substantial workforce implications. This requires either splitting the hospital workforce between multiple smaller locations, in turn diluting the staff in the hospital and potentially undermining the efficiency of the hospital services, and/or significantly increasing the workforce in order to provide multiple services in multiple locations simultaneously.
13. Workforce is by far the most significant cost in the NHS, in 2022-23, it accounted for 45.6 per cent of the NHS budget.⁹ The diagnostic workforce already faces significant shortfalls, creating fierce competition among providers to recruit staff.¹⁰ Attempting to increase the size of this workforce will exacerbate these issues.
14. Relatedly, more disparate physical locations for hospitals can undermine economies of scale in specialist infrastructure. One of the primary motivations for the hospital building is the economies of scale in expensive, specialist equipment. If demand is reduced, the unit cost of every diagnostic test executed in a hospital increases.
15. Or alternatively, economies of scale could still be achieved but instead this is achieved by an overall increase in secondary care utilisation. Generally in healthcare services,

⁶ *CDCs Unveiled: Challenges and Triumphs* (All Party Parliamentary Group for Diagnostics, 2024). Ibid.

⁷ *Two Years on, How Are Community Diagnostic Centres Doing?* (King's Fund, 2023).

⁸ *CDCs Unveiled: Challenges and Triumphs*.

⁹ *Key Facts and Figures about the NHS* (King's Fund, 2024).

¹⁰ *CDCs Unveiled: Challenges and Triumphs* (All Party Parliamentary Group for Diagnostics, 2024).

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additional capacity creates supply induced demand and the degree of unmet demand in the health system often means additional services are quickly consumed. This however could be viewed as a positive depending on what outcome is being prioritised.

16. The idea of ringfenced locations to focus solely on diagnostic tests – considering these tests constitute a large part of the elective backlog – was sensible. However, this ringfencing could happen on the hospital estate and overcome some of the system wide inefficiencies of CDCs.

Progress against outpatients capacity

1. The links between the outpatients programme and the outcomes it aimed to achieve have been the weakest of the three transformation programmes. However, one success according to the data released by the National Audit Office has included the Advice and Guidance scheme (A&G). However while the conception of the scheme is sound, its execution has been suboptimal, and there remains significant untapped potential.
2. In July 2023, 209,031 requests were made through the A&G platform, just 18 per cent of overall referrals in that month (1,116,642)¹¹. Some areas use it considerably more than others. Where it has not been used, this is chiefly due to funding, resourcing, and time lag in responses.
3. The introduction of A&G meant GPs have experienced an increase in their workload, without commensurate compensation or the provision of additional capacity.¹² It also puts pressure back on the general practice because they might have to generate another appointment to speak to a patient about what the plan is.
4. There also may be scans or tests that the trust requires before referring, which GPs may not be able to undertake or which place extra pressure on admin teams, without funding for additional capacity.¹³ The A&G £20 per appointment does not sufficiently cover this additional work.
5. The time it takes to get responses to A&G queries is too long – at best one week, but frequently three or more weeks.¹⁴ Patients are kept out of the loop throughout the communication between clinicians. Given failure to refer is one of the biggest reasons for patients to complain about their GP, the time A&G queries take can increase the chance of patient complaints.¹⁵
6. In addition, some GPs have found that they retain clinical responsibility for patients they may not feel comfortable with, without commensurate advice or education to manage these patients – particularly given the lag times for a specialist response.¹⁶
7. Interviewees for our paper highlighted that the A&G is finding a small number of patients where the GP would have referred and the specialist says ‘don’t’, or where the GP had missed something and the specialist says ‘send them to me’. But more often, the specialist is simply confirming what the GP would have done, in turn adding an additional doctor into the decision making process.

¹¹ NHS England, ‘Hospital Outpatient Activity, 2023-2024’, 26 September 2024.

¹² ‘The Agony around Advice and Guidance’, *Pulse*, 27 October 2023.

¹³ *Ibid.*

¹⁴ *Ibid.*

¹⁵ *Ibid.*

¹⁶ *Ibid.*

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8. It is possible an evaluation might say that A&G has added a lot of cost for a small number of patients to be kept in primary care. It might also say that A&G is effective for specific specialties, but not others, and useful if the GP has done the diagnostic tests first, but not if they haven't. The evidence is not available.
9. In short, the A&G scheme lacks sufficient communication infrastructure with hospitals to properly support it and so responses are slow, is not sufficiently targeted towards areas that primary care would be more effective at managing (for example, dermatology or musculoskeletal conditions), and does not pay for the additional resource required to deliver it properly. The scheme has significant potential but it has not yet been realised for these reasons.