Written evidence submitted by Policy Exchange (CBP0040)

Policy Exchange is an independent, non-partisan educational charity seeking new policy ideas that will deliver better public services, a stronger society, and a more dynamic economy.

The Health and Social Care Unit at Policy Exchange looks to tackle the most pressing questions facing the NHS and social care sector today and to ensure that the needs of consumers are placed at the forefront of the national conversation.

We are pleased that the Committee is exploring this important issue. Our evidence submission focuses principally upon the recovery of elective services (also referred to as planned care). This draws upon research conducted and published in a recent report entitled *A Wait on Your Mind: A realistic proposal for tackling the elective backlog*. Elements of our response cover Emergency Care and General Practice.

The submission opens with a list of key messages, followed by direct responses to the questions posed by the Committee. We have chosen to not respond to questions six and eight.

Key Messages

- **Tackling the backlog in elective care is a public priority.** Recent polling on healthcare priorities shows access to routine services is the number one public concern. More than 5.45 million people in England are awaiting treatment, and there are likely to be significant volumes of patients who have not yet been referred. There are also significant divides across the country (both geographic and between groups) in access to high-performing services. With an uncertain winter ahead, things will regretfully get worse before they get better. Averting this looming disaster will require multi-year investment, recognising the current situation as a moment for reform.

- **Prioritising elective care need not 'hurt' other parts of the NHS.** Indeed, the inverse can be true. Failing to make headway on the backlog will increase emergency admissions, and place additional burden on services such as mental health and primary care as people experience the trauma of a long and uncertain wait.

- **Out of the current waiting list in planned care, more than 4.2 million (80%) are awaiting a decision on treatment.** This represents an enormous unknown clinical risk for the NHS that is even greater than those who have been waiting over 52 weeks. We know for instance that one–fifth of all cancer diagnoses are picked up through a non-cancer referral from General Practice, with many of these patients eventually diagnosed in hospital following a long delay. Incentives in planned care therefore require urgent adjustment to give adequate prioritisation for a timely diagnosis.

- **The NHS must scale up elective diagnostic capacity significantly.** Transformation will require increased capital investment – we suggest that £1.3bn in new funding is made available, which combined with existing commitments would amount to a £1.5bn package, bringing diagnostic capacity in line with the OECD average. This should be viewed as an investment for the future, as aggregate demand for MRI, CT and new types of scanning technology rise over time across a range

of specialisms. The funding should be made available in tranches, commencing at the upcoming spending review, and should be accompanied by service transformation. We should also look to grasp a once-in-a-generation opportunity to push most planned diagnostics into community settings with their remit expanded over time to include the provision of wider services.

- **Targets and performance management need to be deployed carefully.** The challenge facing the NHS is reminiscent of the waiting lists of the 2000s, but new tactics are required. The Referral to Treatment (RTT) target should remain, given its importance for maintaining public confidence in the NHS. However, this should become a 'split' 18-week standard to encourage swifter diagnosis within 8 weeks. The new, more ambitious target should be accompanied by a package of support for the worst performing systems, including direct assistance to improve data management. A sanction regime may ultimately be required but must be deployed in a focused way.

- **The NHS must become relentless in increasing productivity and patient throughput in treatment.** Achieving this will require the more effective deployment of the independent sector as part of a national elective recovery plan, with long-term, volume-based contracts negotiated to ensure value for the taxpayer. Surgical hubs should be rolled out for certain clinical specialisms. Regular reviews should be undertaken to ensure that the relaxing of the current infection control and self-isolation requirements at 'green' sites takes place at the earliest moment.

- **The NHS must adopt an innovation-mindset across the elective pathway.** Technologies already exist which can reduce inappropriate referrals from general practice, reduce the time taken to achieve a diagnosis, and speed-up patient throughput. These must now be rolled out. Current 'incomplete pathways' should become a window of opportunity for proven clinical interventions that reduce the risk of condition deterioration. New technologies should be accompanied by shifts in culture – such as the movement toward self-referrals. It is important that the successes and failures of this existing £160m 'elective accelerator' programme are publicly reported so that effective solutions can be scaled.

- **Whilst a long-term workforce plan is required, near-term investment and recruitment could bring substantial service improvements.** We support the recommendations of the Independent Review of Diagnostic Services for NHS England,[i] which propose a massive expansion of the imaging workforce to staff new proposed diagnostic capacity – with an additional 2,000 radiologists and 4,000 radiographers required. Additional data managers should also be hired by Trusts to improve the quality of the data on hospital waiting lists.

- **'Operational transparency' must improve across the NHS.** The 'consumer' of the service is being left in limbo, with limited support whilst they wait for care. Current clinical prioritisation and waiting times are hidden from patients, or presented in such a way that the information is of little use to them. A reformed approach should look to embed 'operational transparency' as a means of boosting understanding and trust whilst the NHS manages an unprecedented backlog in which longer waits will become normalised.

- **Immediate opportunities to innovate exist on the demand side.** We should use this opportunity to empower patients to become demanding consumers. This must begin with giving patients more information and more ability to manage as much of their own patient journey as possible. The NHS should embrace the public appetite for digital solutions, boosted over the past 18 months, by investing in an NHS-led digital offer to support patients on the waiting list. These services should be incorporated within the NHS App and could include appointment scheduling, list status, or signposting to wider services to better manage and support patients. The booking system for the vaccine programme sets the minimum expectation. This strategy should include a package to support the digitally excluded. It should supplement, rather than replace measures to bring total waiting times down, boosting a consumer-driven approach.

- **The Health and Care Bill must be an enabler of elective recovery.** Policy Exchange welcome efforts to better integrate health and social care so that patients receive a more joined up service. We have concerns however that forthcoming legislation will consume vast amounts of managerial and change capacity in the NHS over the coming 18 months, whilst offering little remedy to the number one problem facing the health service. We recommend that specific consideration should be given for elective recovery within upcoming debates and amendments.

Question 1: 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?

It is impossible to say. However, the total number of people waiting will grow substantially over the next 12 months, as a proportion of the 7.5 million people who did not seek treatment during the pandemic are referred by General Practice. Optimistic scenarios forecast that the size of the waiting list will approach eight million people by December 2021 and take between five and nine years to be fully addressed.

It would, however, be unwise to focus solely on the total figure given the different levels of risk contained within the total waiting list of patients for elective care. For example, we know that more than 4.2 million (80%) are awaiting a decision on treatment. This represents an enormous unknown clinical risk for the NHS which is arguably greater than those who have been diagnosed and are facing a long wait.

Question 2: 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?

There are well-documented bottlenecks in capacity, and extreme constraints in the workforce. Policy Exchange have identified the following issues and proposed several specific interventions:

- **Diagnostic capacity is insufficient.** The UK has similar numbers of MRI and CT scanners as Hungary and Costa Rica, putting us in the bottom five countries in the OECD for this metric.[ii] Yet the NHS

waiting list is already greater than the entire 5 million population of Costa Rica. Ensuring timely access to diagnostic and imaging technologies will be critical for gaining a complete picture of clinical risk. Further resource will be required over this Parliament to meet rising demand: demand for CT scanning (which has wide use across medical specialisms) is likely to increase by 100% over the next five years. There are also new types of scanning technology which may open new possibilities in terms of convenience and the Health Foundation has estimated that bringing the UK up to the OECD average would require £1.5bn in capital spending.[iii]

- **The NHS should better manage and share diagnostic capacity.** Given the existing bottlenecks in the system, a series of short-term, 'mutual aid' measures should be implemented to ensure the optimal use of diagnostic capacity. This could be achieved either through working at provider collaborative or ICS level, or by working with independent sector colleagues across geographies.

- **More effective deployment of independent sector capacity is needed.** The RTT figures to March 2021 demonstrate that GP referrals to the independent sector are around 25% lower than the 2019 baseline – suggesting inconsistent use of the electronic referral system (eRS). Whilst we need to be cautious in suggesting that the independent sector is a silver bullet, it needs to be used more effectively.

  Any agreement with the independent sector should be volume-based, comprehensive and give adequate investor confidence, and ensure best value for the taxpayer. A long-term approach could include reviewing the current Increasing Capacity Framework, and National Tariff prices to ensure the correct incentives are in place for IS providers to deliver an appropriate proportion of NHS work. The principles of ensuring that treatment remains free at the point of delivery must be upheld.

- **There are serious concerns about the quality of NHS waiting list data.** Anecdotally it is believed that 5-15% of entries on each list are duplicates, errors, or patients that no longer seek treatment. In some trusts it may be as high as 25%. Investment in cleaning that data and then using appropriate software could deliver quick wins and enable trusts to have a dynamic picture of demand. We therefore believe that the NHS should hire additional data managers to improve the quality of hospital waiting lists. Policy Exchange propose that a fund of £12m is made available for these positions (at NHS Band 8a-8b), which would be on a 24-month FTC basis. The Government must also think carefully about how to best reward and safeguard the well-being of staff tasked with tackling the enormous backlog of procedures.

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

- **An expansion of surgical hubs could provide benefits for addressing the backlog.** We believe that surgical hubs *may* provide part of the answer for elective recovery in certain clinical specialisms where there are already lengthy waits such as ophthalmology, orthopaedics, and cancer surgery, and may help to optimise infection control. The expectation should be for these hubs to set up to facilitate three session days and seven-day working and with appropriate transportation provided for patients travelling the greatest distances.

- **Infection, Prevention and Control (IPC) guidance and self-isolation periods at 'green' sites should be reviewed.** A relaxation of the current guidance at 'covid-free' sites will give much greater flexibility; enabling cancellation slots to be filled at short notice by willing patients, whilst also increasing the volume of procedures conducted in theatre. This needs to be balanced by the evidence of continued nosocomial transmission.

Question 3: 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?

Additional financial investment will be required. Reports in the media suggest that internal Government modelling shows that between £2bn and £10bn will have to be allocated per year for up to four years, on top of core NHS funding.

Most voices are calling for a long-term settlement for elective care. It would give the sector greater certainty and pave the way for some of the transformations require to embrace the positive changes from the pandemic, such as community and remote diagnostics.

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

On balance, we believe that the Secretary of State and NHS England Chief Executive should seek to negotiate a multi-year deal at November's spending review, with around £2bn per year ringfenced for elective recovery. Within this, it is important to maintain the overall 18-week RTT standard, but with adjustments to separate out a diagnosis from treatment, with financial penalties introduced for ICSs which fail to meet them. This reflects the public's priorities regarding access to routine services, and the requirement to get a quick and accurate picture of unknown clinical risk. Our specific recommendation for financial investment is as follows:

- **The Government should release new capital funding for diagnostics.** The UK Government should invest £1.3bn in diagnostic capacity, which combined with existing funding would bring NHS capacity in line with the OECD average. This should be delivered in tranches over the next three years, commencing with £500m at the upcoming Comprehensive Spending Review.

Question 4: 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 outlined in our response to question 3, additional resource will be necessary. But this must also be a moment for reform.

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

Central to all our recommendations in this evidence submission is the need to boost operational transparency, now and in the longer term.

Operational transparency was pioneered in the commercial sector: companies that reveal their process (and efforts) have higher customer satisfaction and perceived value, even if the overall waiting time for that product is longer because it fosters deeper understanding. Research has demonstrated that the concept can be applied to public sector provision. Yet within the NHS it remains untested.[iv]

How would this work in practice? Policy Exchange believes that every patient should be able to access their local hospital waiting times for each specialism. Patients should know their rights and be offered choice. At a senior political level, the UK Government should undertake a monthly press conference on elective recovery, emulating recent coronavirus briefings. These should be led alternately by the PM and Health Secretary, supported by the CMO and new NHS England Chief Executive. Further approaches to reform the existing approach to elective care

- **The NHS elective recovery framework should be structured based on activity delivered.** A focus on payment-by-results will remain important in the coming years and should be a key negotiation point for HM Treasury at the spending review. Assuming IPC guidance and self-isolation requirements can be scaled back substantially, Policy Exchange would propose that the upcoming operational planning guidance period from October 2021-March 2022 sets the following thresholds for ICSs:
    - Inpatient activity: 90% compared to 2019 baseline by October 2021, rising to 100% by January 2022
    - Outpatient activity: 120% compared to 2019 baseline (reflecting the opportunities for greater use of remote and digital technologies)

- **The Government should offer additional carrots (and sticks) to drive the recovery.** These should include:
    - **Ensure long-term funding agreements for planned care.** The upcoming spending review should include a multi-year commitment towards the recovery of planned care over this Parliament.
    - **Ensure enhanced accountability for delivery.** To ensure adequate oversight, NHS England should be required to undertake quarterly reporting back to both Ministers and

Parliament outlining the volume and spend of diagnoses, procedures and treatments undertaken.

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

- **RTT (Referral to Treatment) figures should be reformed.** We believe patients should expect to receive a diagnosis within eight weeks (described as a 'referral to decision'), before then seeking to commence consultant-led treatment within ten weeks following diagnosis (a 'decision to treatment'). This means that the total 18-week target remains unchanged, but two deadlines are imposed to incentivise Trusts to shorten time taken to diagnosis. This would be a more straightforward reform than the implementation of any wider reforms linked to the Clinically-Led Review of NHS Access Standards.

- **The Health and Care Bill must adequately consider the elective recovery.** We are concerned that as the implementation of legislation consumes managerial and change capacity in the NHS over the coming 18 months, new structures may inhibit the fastest route to elective recovery. The Government should look therefore to show how the Bill supports the return to the 18-week RTT as set out in the NHS Constitution.

Question 5: 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?

- **Embrace the appetite for digital solutions. Accompanying the increased uptake of digital tools** over the past 18 months across the NHS, investment should be made in an NHS-led digital offer to support patients on the waiting list. These services should be incorporated within the existing NHS App and could include appointment scheduling, list status, and should signpost users to wider services to better manage and support patients. The booking system for the vaccine rollout should set the minimum expectation. Any reformed digital strategy should include a package to support the

digitally excluded, and supplement, rather than replace measures to bring total waiting times down, boosting a consumer-driven approach.

Question 7: What can the Department of Health & Social Care, national bodies and local systems do to facilitate innovation as services evolve to meet emerging challenges?

- **Systems with the worst elective waiting times should receive additional managerial support for the next two years.** Investment should be made in appropriate administrative software and an additional 100 specialist data managers with waiting list management skills who would be tasked with ensuring waiting list data at Trust level is of sufficient quality.

- **An Elective Innovation Mandate should be established.** Rather than proving cost savings alone, a fund should be established to fast-track solutions which demonstrate the greatest potential to tackle the backlog in high-priority specialisms. This scheme could be modelled on the recently announced MedTech Mandate from NHS England, but would also benefit from being a part of a future DHSC coordinated scheme.

- **Investment should be made in a priority NHS-led digital offer to support patients on the waiting list.** Delivered through the existing NHS App, these services could include appointment scheduling, list status, and signposting to wider services, including those already delivered by the voluntary sector.

- **Show us what works.** Many innovative approaches are being trialled as part of the 'elective accelerator' programme. It is important that the successes and failures of this £160m programme are publicly reported so that the best performing solutions can be more widely adopted. At large, we should look to shift to a culture of trial and error when it comes to innovative solutions.

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

[ii] https://www.oecd-ilibrary.org/sites/eadc0d9d-en/index.html?itemId=/content/component/eadc0d9d-en

[iii] Lack of investment in NHS infrastructure is undermining patient care', *The Health Foundation*, 8 March 2019, link

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

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