NHS0041

Written evidence by Policy Exchange

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 Public Accounts 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*.

The submission opens with a list of key messages, followed by direct responses to the questions posed by the Committee. We have responded to all questions.

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. Six million people in England – one in eight of the population - are awaiting treatment, and there are likely to be significant volumes of patients who have not yet been referred.[1] 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 4.5 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 welcome the recent commitments in the spending review towards diagnostic spending, which should see capacity rise to the OECD average. This

should be viewed as an investment for the future, as aggregate demand for MRI, CT, PET 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 – including at a trust level – so that the effectiveness of the investment can be effectively and openly appraised and the best solutions 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,[2] 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. As the Bill passes through the House of Lords, we recommend that specific consideration should be given for elective recovery within upcoming debates and amendments.

Question 1: Before the pandemic, what were the root causes of the NHS's deteriorating performance against the standards required for waiting times for elective care and cancer services?

It is well known that the waiting list is not just a COVID problem. Declining NHS performance in elective care can be traced back to the early 2010s. The situation began to significantly deteriorate in the winter 2018, when NHS England advised hospitals to cancel all elective surgery following a severe flu season.[3] Specific issues which have precipitated this situation include:

1. **Inherent issues within service configuration**, for example by undertaking both emergency and elective activity in the same locations, increasing the likelihood of elective care being 'paused' during surge events.
2. **A focus on short term financial settlements,** to backfill during periods of system stress (e.g. winters)
3. **Limited capital investment,** which has in part led to a reduction in the total number of beds available.
4. **Poor quality data and strategic planning.** The use of software to intelligently manage waiting lists is inconsistent across the provider landscape. Meanwhile core RTT submissions are often inaccurate – meaning that rather than a 'single version of the truth' there are different interpretations of demand and prioritisation within the system.

Question 2: What did the NHS do well and what could it have done better in providing elective care and cancer services during the pandemic?

The pandemic is ongoing. We therefore need to be cautious in not drawing definitive conclusions in what is a dynamic situation. However, it is possible to look at the first 18 months of the pandemic and set out some early findings and considerations. Two key observations are this point are:

1. **The NHS pause was longer than other comparable systems.** Research from the Nuffield Trust indicates that the NHS had a longer hiatus of elective care procedures during the first wave of the pandemic (43 days) compared to other advanced healthcare systems such as

Denmark (29 days).[4] Denmark also had similarities in terms of fundamental capacity – with similar levels of beds per 1,000 population.

2. **The NHS has since been slower to get activity levels back up to pre-pandemic levels. This includes activity and use of the independent sector (IS).** The RTT figures to March 2021 demonstrate that GP referrals to the IS are around 25% lower than 2019 – suggesting inconsistent use of the eRS. This is reflected in reduced numbers of non-admitted completed pathways – meaning that less patients are being seen and treated. This is reflected in reduced numbers of non-admitted completed pathways – meaning that less patients are being seen and treated.

Question 3: What are the biggest challenges faced by local healthcare providers in recovering performance on waiting times for elective care and cancer services?

One of the most significant challenges will be to restore elective activity whilst at the same time managing the transition to new ways of integrated working under the model put forward by the Health and Care Bill, should it enter into law. Policy Exchange has shared our concerns that the reorganisation 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.

Arguably the move towards integrated care, which is likely to lead to evolutions in the payment and incentive system, could run counter to the activity-led approach of payment by results set under a national tariff which characterised previous assaults on waiting times. A form of 'blended' payment system could bring advantages in meeting wider system goals, but a sensible compromise will need to be found to avoid the transition disrupting progress towards bringing waiting times for elective care under control.

Whilst reorganisations rarely have significant impact on front-line clinical roles, it is NHS leaders which will find themselves focused on a wider set of priorities. It will be important to not lose focus on the public and most pressing clinical priorities in this context.

Question 4: How should DHSC and NHSE support local providers to recover their performance?

As we outlined in our report, DHSC and NHSE must find a sensible balance between 'carrot' and 'stick'. Some proposals put forward by Policy Exchange included:

- **Systems or Provider Collaboratives 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.
- **Additional incentives should be introduced for meeting a new 'referral to decision' target.** Payments would be made available from the elective recovery fund for Providers (or 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. The latest figures show that more than 312,000 patients were waiting more

than 52 weeks for treatment. This proposal would 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 welcome the multi-year settlement for the elective recovery to 2024/25, 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. Ultimately a sanction regime may be required for providers but this must be deployed in a focused way.
- **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.

Question 5: Are plans and funding announced to date enough to help the system recover or, if not, what in your view is still missing?

Broadly we believe that sufficient resource has been provided for elective recovery. Thus far the Government has committed to spend £2bn this year on tackling the elective backlog. In addition, it plans to spend £8bn in the following three years from 2022/23 to 2024/25.[5] This was consistent with the Policy Exchange recommendation which called for a multi-year spending commitment of around £2bn per year over the course of this Parliament.

We also are encouraged by the £2.3bn made available during the spending review to transform diagnostic services, including community diagnostic hubs, and the £1.5bn for surgical hubs. Thise again corresponds with key Policy Exchange recommendations.

The funding is welcome but does not amount to a strategy. We are still awaiting the publication of the elective recovery plan, which was initially promised by the end of November 2021. We anticipate that the plan, the development of which has been led by NHS England, will set out the broader transformation of planned care services. In our view is it important that the forthcoming plan: 1) Initiates a ‘data amnesty’ whereby providers can hand-in their waiting time data for cleaning and refinement, to improve the quality and the transparency; 2) Introduces a package of support to help patients whilst they experience long waits; and 3) Is the first step on a bigger reform of the current 18-week referral to treatment target, to ensure they are fit for purpose and do not lead to perverse incentives in the system.

December 2021.

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[1] NHS England. NHS RTT waiting times data. October 2021. Link.

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

[3] The Royal College of Surgeons of England. A New Deal for Surgery. 2021. Link

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[4] Reed, Sarah. Resuming health services during the COVID-19 pandemic. What can the NHS learn from other countries? July 2020. Link.

[5] UK Government. Build Back Better: Our Plan for Health and Social Care. 3 December 2021. Link.