



Delivery plan for tackling the COVID-19 backlog of elective care

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Foreword

NHS teams have provided expert care to more than 600,000 patients in hospital with COVID-19 since the beginning of the pandemic. Alongside this unprecedented pressure, by rapidly adapting services to ensure the safety of patients, those teams have also delivered over 23 million episodes of elective care, 36 million key diagnostic tests, 4.2 million urgent cancer checks, and over 530,000 first treatments for cancer.

Despite those herculean efforts, and in common with health systems around the world, dealing with the pandemic and its effects has inevitably had an impact across the health service, including on the amount of planned care the NHS has been able to provide, in turn meaning longer waits for many patients and a rapidly increasing waiting list.

The wall of protection that our world-leading NHS COVID-19 vaccination programme gave us over spring and summer 2021 meant that hospitals were able to make good progress on recovering non-COVID care including elective treatment, with many excellent local success stories.

Moorfields Eye Hospital has used surgical hubs to reduce the time cataract patients spend in hospital to around 90 minutes. In Nottingham, as well as other parts of the country, teams have held 'Super Saturdays', performing the same procedure all day to reduce changeover times for equipment and staff. And in Milton Keynes and many other hospitals, surgeons and their teams are using the latest technology, including surgical robots, to deliver more complex surgery with faster recovery times.

These initiatives and many more besides meant that, despite the ongoing limitations of infection prevention and control measures, by November 2021 elective and diagnostics activity levels in many areas had recovered towards, or above, pre-pandemic levels, with an all-time record number of urgent cancer checks carried out.

The emergence of the new Omicron variant meant that the NHS had to rapidly reorient itself in December and January, in particular to deliver the national mission to turbo-charge the NHS COVID-19 vaccine campaign, and identify additional capacity in case the record infection rates resulted in similar surges in hospitalisations.

Even alongside this vital action to protect lives, this winter cancer treatment continued to be prioritised, and partly because of the investment in new services and capacity, early

indications suggest that elective activity has also remained above levels seen the previous year.

But we know that there are still too many people waiting for care, and despite public information campaigns encouraging people to come forward during the pandemic, we understand why fewer people have sought care over the past two years and we still don't know how long people will delay seeking the treatment they need.

Tackling the COVID-19 elective care backlog – alongside addressing additional demand, for example in primary and community care and for mental health services – is going to be a multi-year challenge, and we have welcome recognition of this in the funding agreement from the government covering the coming years.

Our plan – developed with expert input from clinical leaders and patient groups – sets out a realistic but ambitious set of actions and principles which will help local NHS organisations use this investment to build on the momentum they have achieved so far, and go further and faster. There are, of course, risks to achieving these goals should, for example, levels of COVID-19 mean the NHS cannot restore normal conditions and return to much lower levels of staff absence.

This strategy sets out how we will transform services, harness the potential of data and technology, and expand our workforce and physical capacity. But most importantly this strategy has a strong focus on patients, prioritising those in greatest clinical need, and giving them more information and choice about their care, ensuring that we improve patient experience. Crucially, we must also better understand, and then address and reduce, the inequalities in care and health outcomes which have long existed, ensuring the recovery is a fair one for all those who need treatment.

Finally, any solutions for tackling the COVID-19 elective backlog cannot rely on making the same staff – whether in primary, secondary or community care – work ever harder. To succeed, we have to grow and support our workforce, so they can deliver excellent care.

It is the achievements of staff over the last two years which give us the optimism that – as it has in the past – the NHS can overcome this challenge, and at the same time make long-lasting improvements for the patients of the future.



NHS Chief Executive

Executive summary

Elective care covers a broad range of non-urgent services, usually delivered in a hospital setting, from diagnostic tests and scans, to outpatient care, surgery and cancer treatment.¹ The COVID-19 pandemic has had a significant impact on the delivery of elective care, meaning that many patients are now waiting longer for treatment than they were before the pandemic began.

Local systems are working incredibly hard to recover elective services as quickly as possible. However, recovering and transforming the way the NHS delivers planned care is going to require a huge, collective effort from a range of key partners across the system.

This plan, which has been developed with expert contributions from a wide range of partners, sets out a progressive agenda for how the NHS will recover elective care over the next three years. This is in the context of restoring elective performance in the longer term.

It explains how the NHS will take the opportunity to capitalise on current success and embed new ideas to ensure elective services are fit for the future.

This plan sets out a number of ambitions, including:

1. That the waits of longer than a year for elective care are eliminated by March 2025.² Within this, by July 2022, no one will wait longer than two years, we will aim to eliminate waits of over 18 months by April 2023, and of over 65 weeks by March 2024.² Long-waiting patients will be offered further choice about their care, and over time, as the NHS brings down the longest waits from over two years to under one year, this will be offered sooner.
2. Diagnostic tests are a key part of many elective care pathways. Our ambition is that 95% of patients needing a diagnostic test receive it within six weeks by March 2025.

¹ This plan does not extend to the similar challenges facing, for example, primary care, community care, urgent and emergency care and mental health services. These are being addressed by teams across the NHS and social care, and in other such plans.

² Some patients will choose to wait longer, and a very small number of specific highly specialised areas may need tailored plans to tackle the backlog, as was the case before the pandemic.

3. The NHS has continued to prioritise cancer treatment throughout the COVID-19 pandemic and we have consistently seen record levels of urgent suspected cancer referrals since March 2021. To maintain this focus, our ambition is that, by March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.³ This will help contribute to the existing NHS Long Term Plan ambitions on early diagnosis. Local systems have also been asked to return the number of people waiting more than 62 days from an urgent referral back to pre-pandemic levels by March 2023.
4. For patients who need an outpatient appointment, the time they wait can be reduced by transforming the model of care and making greater use of technology. We will work with patient groups and stakeholders to better monitor and improve both waiting times and patients' experience of waiting for first outpatient appointments over the next three years.

The ongoing uncertainties in relation to the COVID-19 pandemic and demand for hospital treatment make it challenging to predict how quickly we will be able to recover elective services. The overall size of the waiting list is likely to increase, at least in the short term. If around half the 'missing demand' from the COVID-19 pandemic returns over the next three years, particularly if this is earlier in the period, then we would expect the waiting list will be reducing by around March 2024. It is vitally important that anybody who has health needs, including those with cancer symptoms, comes forward, and we continue to urge people who need help to seek it.

While the level of this demand that will return – and how this will impact elective services – is hard to know, we will work with stakeholders and researchers to understand this better over the coming months, with a view to being able to provide an update in the summer.

The ambitions for patients are supported with a clear plan, aimed at delivering around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance, and the NHS will continue to work to return to pre-pandemic performance as soon as possible.

³ As part of the Clinically-led Review of NHS Access Standards we will shortly go out to consultation in order to inform the final implementation of this ambition.

This of course depends on returning to and maintaining low levels of COVID-19, enabling the NHS to restore normalised operating conditions and reduce high levels of staff absence.

We will focus on four areas of delivery:

- **Increasing health service capacity**, through the expansion and separation of elective and diagnostic service capacity. The physical separation of elective from urgent and emergency services ensures the resilience of elective delivery, as well as providing service efficiency. This will include a strengthened relationship with independent sector providers to accelerate recovery.
- **Prioritising diagnosis and treatment**, including a return towards delivery of the six-week diagnostic standard and reducing the maximum length of time that patients wait for elective care and treatment.
- **Transforming the way we provide elective care**; for example, by reforming the way we deliver outpatient appointments, making it more flexible for patients and driven by a focus on clinical risk and need, and increasing activity through dedicated and protected surgical hubs.
- **Providing better information and support to patients**, supported by better data and information to help inform patient decisions, and in time, making greater use of the NHS App to better manage appointments, bookings and the sharing of information. We will ensure patients have choice at the point of referral, and this enhanced for long-waiting patients through a national hub model.

This is a national plan that will require a consistent focus to ensure it can be delivered at all levels. However, we know that some places experienced a longer duration of or a bigger impact on services from COVID-19, and even prior to the pandemic, local factors meant patients faced variation in elective services. The different starting point locally will impact on recovery of services and a principle of our approach will be to level-up every area, while supporting those that can to go further, faster.

Our commitment to the public in publishing this plan is to:

1. Increase health service capacity:

- Access to nine million additional treatments and diagnostic procedures.
- Increase support from clinicians who will have more time to care, thanks to new recruitment and technology which reduces the administrative burden on staff.
- More people offered the option of treatment by high quality independent sector providers, free at the point of care.

2. Prioritise your diagnosis and treatment:

- Better prioritisation of treatment if you have suspected cancer or another urgent condition, thanks to enhanced national frameworks on diagnosis and treatment.
- Clinicians working with you to make sure your planned care remains the best option.
- If you are waiting a long time, offering alternative locations for treatment with shorter waiting times, and in doing so tackling the number of people waiting too long.

3. Transform the way we provide elective care, specifically:

- Streamlined care and fewer cancellations, thanks to dedicated surgical hubs and other measures to separate elective care from urgent and emergency care.
- More convenient access to diagnostic procedures and more tests undertaken at the same time, thanks to new community diagnostic centres.
- The scaling up of community and NHS based sites for surgical procedures and convenient, quick diagnostic checks, towards our ambition of a network of surgical hubs and diagnostic centres covering the entire country.
- Greater flexibility in how you access advice and care, enabling more convenient and appropriate care and making the best possible use of clinical time and expertise.
- Using every pound carefully, maximising care and investing for the long term.

4. Better information and support to patients, specifically:

- Better information about waiting for treatment, including greater access to personalised information.
- Greater help in deciding which treatment is most appropriate.
- Targeted, accessible support if you are waiting for treatment, and to prepare for surgery in the best way possible.
- More opportunities to provide rapid feedback to the NHS, which will be used to improve services.

To support elective recovery the government plans to spend more than £8 billion from 2022/23 to 2024/25, supported by a £5.9 billion investment in capital – for new beds, equipment and technology. This is in addition to the £2 billion Elective Recovery Fund and £700 million Targeted Investment Fund (TIF) already made available to systems this year to help drive up and protect elective activity. Under the TIF, the NHS is investing in over 870 schemes across more than 180 hospital trusts to increase capacity through expanding wards, installing modular operating theatres, upgrading outpatient spaces, expanding mobile diagnostics for cancer, upgrading MRI and screening technology, all to tackle cancer and elective waiting lists and reduce waiting times. There will also be investment in technology to improve patient experiences of care and help patients manage their conditions.

The funding committed for elective recovery will be spent on delivering additional activity in an innovative way, enabling the NHS to carry out more checks, scans, outpatient appointments, operations and other procedures up to March 2025. A significant part of this will be invested in staff – both in terms of capacity and skills.

The £5.9 billion capital investment over the same period includes:

- £1.5 billion towards elective recovery services, to include new surgical hubs, increased bed capacity and equipment to help elective services recover, including surgeries and other medical procedures.
- £2.1 billion to modernise digital technology on the frontline, improve cyber security and the NHS's use of data and redesign care pathways.
- £2.3 billion to help increase the volume of diagnostic activity and reduce patient waiting times with ambitions to roll out at least 100 community diagnostic centres over the next three years to help clear backlogs of people waiting for tests, such as MRI, ultrasound and CT scans.

The significant additional funding made available provides an opportunity to transform the way we provide services to patients, as set out in the detailed plan that follows.

1. The impact of the COVID-19 pandemic

The COVID-19 pandemic has placed unprecedented pressure on healthcare systems across the world, including the NHS. The NHS has responded magnificently to the greatest challenge in our history. This is thanks to the determination and ingenuity of our staff and volunteers up and down the country who have cared for more than 600,000 people with COVID-19 in hospitals in England and administered over 115 million COVID-19 vaccinations.

At the peaks of the pandemic, health systems around the world rightly focused on caring for patients with COVID-19 and prioritising urgent treatment like surgery for cancer and other life-saving procedures.

We are now in a new phase of responding to the pandemic. However, there remain significant uncertainties over:

- the trajectory and long-term impact of COVID-19 infections and the response required by the health service, as well as new challenges such as long COVID and new variants of COVID-19
- the number of people who have health needs that were not diagnosed or treated during the pandemic and are therefore likely to require support in the coming months and years, and when those people will come forward.

These ongoing uncertainties about COVID-19 and other demand make it particularly hard to predict how quickly we will be able to recover elective services, but we have set an ambitious goal to deliver around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance.

However, these uncertainties also frame our approach. They require measures that, as far as possible, protect and separate elective care from wider system pressures, and make it important for the NHS to keep adapting as the context changes and we learn more about what works for patients.

A. The waiting list for elective care

The pandemic has placed considerable strain on planned service delivery, which was already under pressure before the pandemic, and understandably deterred people from coming forward for care. Six million people are now on the waiting list, up from 4.4 million before the pandemic.

Patients on the waiting list are at different points on their 'pathway' from referral (usually by their GP team) to treatment. About four in five are waiting for treatment that does not require an admission to hospital, such as diagnostic tests and outpatient appointments. However, some will have complex or urgent needs, such as cancer treatment, cardiac surgery or neurosurgery. These patients typically require more intensive support, including access to an intensive/critical care bed. Demand for these beds increased dramatically during the pandemic and local areas may choose to increase critical care capacity to meet the ongoing response to COVID-19 as well as to recover elective backlogs.

In addition to those already on waiting lists, it is estimated that over 10 million patients who might otherwise have come forward for treatment did not, including a small proportion of these for cancer diagnosis and treatment. There is enormous uncertainty around whether and when these people will seek treatment, making it very difficult to estimate the impact this will have on both their outcomes and the overall waiting list. However, under a scenario where all these people come forward, and with no further action to increase activity levels above pre-pandemic rates, the waiting list could increase to 14 million patients.

Understandably, many people have been nervous about coming forward during pandemic, especially during its peaks. As the NHS has said throughout the pandemic, it is vitally important that anybody who has health needs, including cancer symptoms, comes forward, and we continue to urge people who need help to seek it.

B. The impact on patients

The impact of waiting longer for treatment on individuals and their families and carers is wide ranging. Waiting longer for treatment can mean an existing condition worsens and as a result more complicated surgeries or increased use of medications are required, and recovery is slower and outcomes worse, including reduced quality of life.

Waiting for treatment can also affect other aspects of people's lives, with impact depending on someone's life circumstances. For example, it can make it harder to maintain independence or continue to work or attend school. Long waits before accessing planned care can have life-long consequences on the development of children and young people, impacting their ability to access education and lead full and active lives. For older people, it can make recovery longer and harder, leading to loss of independence.

People living in disadvantaged areas already experience poorer health outcomes. The most deprived people spend, on average, nearly 20 years less in good health than the least deprived. Recent analysis highlighted the disparity in waiting times around the country and a correlation with deprivation,⁴ identifying that on average a person living in one of the most deprived areas is 1.8 times more likely to wait over a year than someone living in one of the least deprived areas.

Supporting local systems with funding, guidance, good information and best practices, as articulated in this plan, will help systems address these issues, begin to recover the backlog for planned care in the NHS and continue to improve cancer care.

C. The impact on NHS staff

The NHS's staff are its greatest asset. The extraordinary achievements of staff over the last two years is a testament to their determination and resilience. Whether leading clinical teams, keeping hospitals clean and safe, transforming service delivery (such as doubling the critical care capacity and rolling out treatments such as dexamethasone) or meeting the increasing demand across primary care, NHS staff have worked with skill and dedication to innovate and prioritise the needs of patients in the face of the continued challenges presented by the pandemic. They have gone above and beyond to provide patients with the best possible care throughout the pandemic, but this has taken its toll on staff.

Before the pandemic, there were workload pressures and workforce shortages across a number of NHS staff professions. While our workforce continues to grow – with around 87,000 more full-time equivalent staff than in October 2019 – demand for services is also very high and will increase in coming years. On average it takes three years to train a nurse and at least 13 years to train a consultant, so targeted action to address the

⁴ <https://www.kingsfund.org.uk/blog/2021/09/elective-backlog-deprivation-waiting-times>

shortages is critical to recovering elective services now, and the sustainability of services over the long term.

The annual staff survey indicates that levels of work-related stress have been rising during the pandemic. This is unsustainable. As well as reducing workload pressures by recruiting and retaining more staff, we also need to ensure health and wellbeing of current staff is prioritised. We will do so by accelerating the adoption of digital solutions and new ways of working that free up time and make the best possible use of staff skills, time and experience. Supporting staff is a key part of the recovery of elective services, recognising that staff need to be looked after so they can look after patients.

D. The impact on urgent and emergency services

Recovery of elective care and urgent and emergency care are intrinsically linked. In order to ensure capacity is available to undertake elective work it is essential that emergency care is effectively managed and emergency patients are discharged into health and care settings beyond hospital as soon as clinically appropriate. This is recognised in our national recovery plans.

The pandemic has seen enormous pressure placed on urgent and emergency care, with significant pressures not just in winter but across the year.

E. Learning from what has worked well so far

The pandemic has shown, and continues to show, how the NHS can rise to major challenges. The people who work in the NHS, public health and social care have worked flexibly and collaboratively to put innovative solutions in place that have had tangible benefits. NHS staff have demonstrated how transformational change can be delivered quickly for patients when needed. In particular, key lessons that inform this plan are:

- Separating elective care facilities from those for urgent and emergency care, to reduce disruptions to care and build resilience in services.
- Increasing flexibility through new ways of working, with NHS staff empowered to lead the changes they know will improve patient care, must and will continue.
- Increasing collaboration across the NHS and beyond through closer collaboration with partners and sharing of resources. A stronger relationship between primary, secondary and community services and local authorities, including social care and the voluntary sector, has throughout the pandemic

enabled more effective hospital discharge and a successful vaccinations programme.

- Systems are now harnessing these relationships to focus on areas that use data to drive better clinical and operational decision-making, and in doing so free up clinical time and reduce barriers to working better together.
- Innovative approaches to cancer diagnosis and treatment, including the use of FIT (faecal immunochemical testing), colon capsule endoscopy and new forms of radiotherapy, offering more COVID-appropriate care, such as treatments with a reduced impact on their immune system.

2. Increasing capacity

We will need to increase the number of patients we can treat if we are to meet demand for services and reduce waiting times. We will increase capacity and reduce disruption to patient care from other pressures in the system by:

- A. growing and supporting the workforce
- B. using digital technology and advanced data systems to free up capacity
- C. working with UKHSA to safely adapt the UK's infection prevention and control (IPC) measures
- D. making effective use of independent sector capacity.

A. Growing and supporting the workforce

Our workforce continues to grow and we now have the highest staffing levels in the history of the NHS, as well as more staff in training. However, demand for services also continues to grow, necessary IPC measures have impacted on productivity, and the strains from responding to the pandemic mean many NHS staff are tired and reporting greater sickness absence than before the pandemic. The pre-existing gaps in our workforce across staff groups, specialties and geographies are now even more critical as we turn to elective recovery. Some are set to widen without further action.

Ambition

We know further work is needed to more systematically train, recruit and retain staff – and that delivering elective recovery will require not just more new staff, but more opportunities for current staff and those returning to practice to work flexibly and remotely, and to develop new skills to progress in their careers. In light of this, Health Education England (HEE), the body responsible for long-term workforce planning, education and training of healthcare staff, which will continue to support new ways of working for NHS staff, will formally merge with NHS England and NHS Improvement, subject to parliamentary passage of the requisite powers in the Health and Care Bill and the appropriate consultation. This will achieve a more co-ordinated approach where service, financial and workforce planning are better aligned. This will be central to recovering elective care.

We will need to target action to narrow supply gaps in priority pathways, specialties and roles across the country to meet the challenges of elective recovery and increase permanent workforce capacity. For example, more training for key allied health professional groups in critical care, enabling them to make an even greater contribution, and greater use of artificial intelligence (AI) imaging software to free up imaging staff time.

We want staff to be better able to support patients across settings, mirroring the flexible approach to other areas of elective recovery. For example, registered nurses working across acute and community services and more cancer pathway navigators to help patients move between services.

Ensuring that staff feel valued, are supported to look after their health and wellbeing, and work in better environments is not only critical to keeping staff well and reducing absence, but also to empowering staff to innovate and improve services for patients. For example, those providers that have systematically focused on looking after and engaging their staff also have lower MRSA rates.

By bringing about these changes now to support elective recovery, we will also be helping to build a bigger, more flexible and more engaged workforce – delivering on the aim set out in the NHS People Plan of having more people, working differently in a compassionate and inclusive culture.

How we will deliver

We will be increasing workforce capacity by identifying and addressing gaps across key staff groups and sectors. We are working at pace to expand workforce capacity, including through targeted plans to accelerate growth of the workforce over the remainder of the year, to ensure that staff can begin the transformation set out in the rest of this plan.

This includes recruiting new staff, with international recruitment of more than 10,000 nurses in total this financial year, in particular those with experience in critical care and theatres, contributing to the existing commitment for 50,000 additional nurses. We will make a more permanent contribution to the workforce if we can retain nurses by providing a positive experience and appropriate professional and pastoral support. This includes encouraging more nurses to take up training grants to support them to become cancer nurse specialists. It also means recruitment this year of 5,000 healthcare support workers, building on the excellent response to domestic recruitment campaigns and

subsequently providing the additional training and skills to further develop this part of the workforce. And ongoing learning from the successful medical support workers scheme, enabling a wider range of doctors to contribute to services and expand the future medical pipeline. Similarly accelerating the introduction of new roles, such as anaesthetic associates and first contact practitioners, and expanding advanced clinical practitioners

It also includes the continued deployment of the more than 17,000 NHS reservists in eight pilots and the programme is now being rolled out nationally, as we develop this new contingency staffing model, allowing us to better protect elective care. This is alongside recruitment to roles showcased in the high profile national 'We are the NHS' advertising and marketing campaign, and all of the more than 350 careers across the NHS.

We are also supporting trusts to make temporary staffing banks more attractive by continuing to make it as easy as possible for staff to take on extra shifts through banks, paying them promptly for working these, and proactively supporting temporary staff, including by offering more permanent employment or development opportunities. We are also ensuring that providers agree more consistent rates for waiting list initiatives, as they have done with rates for collaborative staff banks, and supporting local discussions with the independent sector about pay rates.

In addition, we are running more regional pension seminars to explain how the schemes work and debunk common myths, to enable staff to make informed choices, with a view to supporting them to remain in NHS employment.

Focused work has already begun in partnership with HEE and professional bodies including on strengthening career pathways and increasing supply for theatre staffing, developing the workforce model for Community Diagnostic Centres, and putting in place measures to improve attendance by addressing the root causes of non COVID-related sickness absence.

Alongside these efforts, retaining NHS staff is critical to the recovery of routine care and to do this we need to value and look after staff. This is why we are continuing to support staff to look after their mental and physical health and wellbeing through 40 mental health hubs and free access to a range of self-help apps and helplines, and by supporting local systems to develop bespoke health and wellbeing offers to meet local needs. Taking breaks and annual leave will continue to be important to help people find

a sustainable rhythm of work, as well as having ongoing conversations about health and wellbeing within their teams.

There is a renewed commitment to tackling inequality by ensuring the wellbeing offer is accessible to all staff; this includes tailored support for staff. Work is also being done to increase minority ethnic representation at senior levels across the NHS and to overhaul recruitment and promotion practices.

We are focused on providing support to NHS trusts through our Retention Programme so that they have access to the capacity and skills needed to drive retention by focusing on improving flexible working, workplace culture, health and wellbeing, and supporting staff at the start and end of their careers when they most need it. We will support providers to more consistently manage absence – it is estimated that improving attendance nationally by around 1% could amount to as many as 12,000 whole time equivalent staff.

Finally, we are supporting providers to make effective use of e-rostering, e-job planning, digital staff passports and other workforce optimisation tools to maximise the capacity of the current clinical workforce through effective planning and deployment, and by optimising the skills of multidisciplinary teams and using these across organisational boundaries.

As set out elsewhere in this plan, we have learnt from the pandemic how much difference we can make with better use of staff time by investing in areas like digital pathology, imaging and AI. We will need to continue identifying the best examples of this and finding ways nationally to support their spread and adoption.

We will work together across the system to support local areas to take a more joined-up approach to workforce planning, and tackle some long-standing challenges in understanding workforce requirements, as well as focusing on the most effective ways to recruit and retain staff.

B. Using digital technology and data systems to free up capacity

Many aspects of service delivery in the NHS contribute to capacity, including beds, appointments and how clinician time is apportioned. Digital technology and data systems provide us with the opportunity to release capacity in these areas by allowing us to

deliver services in new ways that more efficiently meet the needs of both patients and staff. This frees capacity for those people whose needs cannot be met virtually, for example tech-supported virtual wards that enable recovery at home for those with COVID-19 have now been extended to a wide range of conditions. Supervising clinicians see data from the home setting and use of virtual wards means more hospital beds are available for those needing inpatient care.

Ambition

We want to make sure that digital technologies that can improve access and flexibility for patients and free up capacity to suit them are scaled across the NHS. Our ambition is to improve core digital and data services in hospitals to ensure we have the basics right, as well as harness and scale innovations that have shown high impact in some areas of the country. We also want to use national digital tools such as the NHS App to provide a personalised route into NHS services for patients, making care more convenient and driven by patients' needs.

In addition, we want to ensure that those in clinical roles can spend as much time as possible treating patients. Greater use of digital technology to assist healthcare workers in completing non-clinical tasks increases the time they can spend caring for patients, which provides a better experience and, ultimately, improves health outcomes. With new technologies based on AI and automation, as well as those we recognise more from our daily lives, like video calls, we are building a digital infrastructure that will ensure the NHS is at the cutting edge of progress for years to come.

We will also use data to drive improvement within the NHS, through using consistent measurement of performance and working with regions and systems to understand and address the reasons behind performance variation.

How we will deliver

As well as improving the experience of surgery and freeing up clinical time, technology can allow people to receive more care in their own home, whether after surgery or as an alternative to admission. This can be much more convenient for patients, their family and carers, speed recovery and increase the number of people treated. This draws on the successful growth of 'virtual wards' during the pandemic and our ambition is to scale these services across the country so many more people can benefit. The feedback from patients is extremely positive with over 2,400 people a week benefiting from this digital home care model. These services also free up clinical time, reduce bed occupancy and improve experience. Our Supporting People at Home programme will continue to work

with systems to implement these technologies across the country so that there are more and larger virtual wards, increasing the numbers of patients benefiting.

“I can’t express how fantastic a service this is. It was like having them in the room with you, at your side. I never felt I was on my own.” Pauline Everidge, whose husband Colin was cared for in Mersey Care NHS Foundation Trust’s digital virtual ward as he recovered from COVID-19.

To help our staff care for patients, we are investing in digital technology that reduces the time they spend on paperwork. For example, Robotic Process Automation has been used to automate patient registration, admission and discharge by enabling effective data upload and transfer to Electronic Patient Records, both saving time on administrative work and helping to clear backlogs of data uploads. We will continue to work with trusts to ensure investment in these technologies, which can rapidly realise productivity savings.

Case study 1: Chelsea and Westminster Hospital use of data

The trust’s digital solution brings together disparate information (eg total number of patients waiting by clinician, theatre scheduling, staff rostering and patient pre-med tests) and makes it available on a single platform, with the aim of improving patient care. Through this platform, clinicians, schedulers and operational staff have new tools to directly improve waiting list data for inpatient elective surgery across several specialties and prioritise patients waiting for treatment, and the technology can dynamically optimise theatre capacity to reduce the burden on staff and ensure more patients are treated faster. So far the solution has enabled a 28% reduction in the inpatient waiting list (both RTT and non-RTT) through validation and better clinical oversight.

Booking lead times have almost tripled, from 6 to 17+ days on average, meaning that patients can be notified to come for surgery in a more timely manner, reducing the number of cancellations due to lack of staff or patient availability. Over the past three month period, theatre utilisation has improved from 73% to 86%.

This success means the solution is now being scaled up as part of the Improving Elective Care Co-ordination for Patients (IECCP) programme, with the waiting list and theatre scheduling elements of the solution to be deployed in up to 30 trusts by March 2022.

An important part of the digital possibilities for elective care is giving patients better access to the information about their care and the ability to communicate more easily with their clinicians. This is covered under section 5: Better information and support for patients, below.

C. Safely adapting infection prevention and control measures

During the pandemic, the NHS has had to take additional steps to prevent and control COVID-19 infection in hospitals and other places where patients receive care, to protect both patients and staff. These measures have included physical distancing, such as increasing the distance between beds on a ward, more intensive cleaning and reorganising hospitals into different zones. These necessary safety measures, along with the number of COVID patients in hospital, have contributed to fewer non-urgent patients being treated over the past two years and more patients waiting longer for diagnostic tests.

Ambition

The NHS is committed to supporting UKHSA to continue to review the measures in place and determine where adjustments can be made that allow services to be delivered in a more productive way that does not compromise patient safety. We want to ensure we protect patients from undue risk while ensuring that we are not slowing the recovery through the sustained implementation of any unnecessary stringent measures, and UKHSA is continuing to consider ways in which IPC can safely be returned to as close to pre-pandemic conditions as possible.

How we will deliver

The NHS is committed to implementing the UKHSA IPC guidance consistently and safely and in doing so move towards delivering services in a more productive way. This will be supported by the separation of emergency and planned care sites described further below: planned care sites will be able to implement pre-testing requirements and ensure they remain COVID-free zones.

NHS hospitals will be given advice on and supported to adopt best practices with learning shared across organisations to help the NHS safely increase capacity.

D. Making effective use of independent sector capacity

Throughout the COVID-19 pandemic and especially during the peaks, the independent sector worked with the NHS to provide additional capacity. This ensured patients could receive the services they needed, even when NHS occupancy levels were reaching unprecedented highs. Capacity was provided by redeploying staff and kit as well as the provision of additional beds. As we tackle the elective backlog, a long-term partnership with our independent sector partners, including charities, will be crucial in providing the capacity we require to deliver timely and high quality care for patients.

Ambition

Our ambition is to ensure that there is a system in place that puts the needs of patients first. To achieve this we need to use all forms of high quality provision as part of a co-ordinated system-wide approach to support patients in the best way possible. Independent sector providers have a significant role to play in supporting the NHS as trusted partners to recover elective services, including cancer, as they have throughout the pandemic. Systems will include local independent sector capacity as part of elective recovery plans and will work in partnership with independent sector partners to maximise activity to reduce waiting times sustainably.

In addition to creating additional capacity for patients, the independent sector can support the NHS's ambition for innovation and efficiency. Elective care boards within each integrated care system (ICS) have been established to bring together local providers, including the independent sector, to agree priorities and solve operational challenges. Systems will work with the independent sector within the context of their broader recovery strategy, population and local plans.

How we will deliver

We will build on the existing patient rights to choice, in relation to choice of first outpatient appointment and also choice of provider if a patient is waiting too long. As we meet our ambitions on reducing long waits over the next three years, we will also reduce in tandem the threshold for our long waits hub, ensuring that patients are proactively offered more choice. We will strengthen the systems and process that enable patient choice, and include independent sector partners as part of those options. This will support patients to understand and access the choices available to them, and they will be given more transparent information to aid their decision.

The development of successful local partnerships between providers and the independent sector will be built on nationally agreed principles ensuring that local areas:

- Clearly articulate how patients can choose their place of treatment at all stages. This will be supported by clear and consistent communication with patients that explains the role of and options for using the independent sector. This will support our ambitions for patients who are currently waiting too long for treatment.
- Ensure patients receive undisrupted and integrated care between local providers.
- Clearly demonstrate how independent sector providers are contributing to overall elective recovery, including for cancer diagnosis and treatment.
- Develop partnerships that are mutually beneficial and sustainable supported by national contractual expertise.

Local areas will be encouraged to develop partnerships with the independent sector that support long-term contracting with sector providers, act at system level to respond to local challenges and allow partners to plan ahead. In addition, joint regular reviews of demand for services and available capacity will support the clinically appropriate transfer of high volume and low complexity conditions, as well as some cancer pathways and diagnostics, to the independent sector. The extra capacity created within the NHS will be used to undertake more complex work such as cardiac, vascular and neurosurgery, with improvements for the most clinically urgent patients. More complex cases can also be treated in independent sector sites that can deliver this level of treatment.

To further ensure value for money, payments should be based on establishing the lowest risk and most effective incentives to increase activity.

To further guarantee the effectiveness of partnership working, systems will have the opportunity to design a joint approach with the independent sector on workforce. This will guarantee common standards of service provision based on opportunities for training and development and use of apprenticeships.

3. Prioritising treatment

As we tackle the elective backlog it is important we continue to focus on clinical need, and not solely absolute numbers on the waiting list. Clinical urgency, the impact of waiting on individuals and potential inequalities created by waiting for care are critical considerations for improving overall health outcomes.

This already happens in the NHS and is a fundamental part of getting the basics right for patients. However, new investment and new technology are revolutionising our approach, helping to focus clinician time on caring for the right patient at the right time.

We will prioritise treatment according to clinical urgency and reduce the longest waits by:

- A. Clinical prioritisation: ensure the order in which patients are seen reflects clinical judgement on need.
- B. Managing long waits: targeting support to reduce the number of people waiting a long time.
- C. Increasing the number of cancer referrals, to ensure we also prioritise those patients who have not yet presented to services.

A. Clinical prioritisation

For this plan to succeed, a consistent approach is required to ensure that those with the clinically most urgent conditions are diagnosed and treated most rapidly.

Ambition

We will support healthcare providers to prioritise their waiting lists based on individual patient needs and ensure they receive the most appropriate care at the right time. Building on good practice before and during the COVID-19 pandemic, the Clinical Prioritisation Programme has supported the management of waiting lists, including by publishing prioritisation frameworks for surgery, diagnostics and endoscopy.

They include steps for clinicians to check a patient's condition, establish additional risk factors and understand their wishes regarding treatment options. Local clinicians will continue to assess their waiting lists and ensure they remain accurate and reflect patients' needs. At the same time, the move to managing waiting lists better across local

areas will help ensure that all communities are benefiting from the restoration and expansion of elective services.

How we will deliver

National and local policies on waiting list management (meaning how people on waiting lists are reviewed to ensure they are seen in the best order) are currently being reviewed and the original prioritisation frameworks amended. We aim to ensure that, across the elective recovery programme, the right prioritisation decisions are being made in a consistent way to deliver the best outcomes for patients on the waiting list.

Understanding and addressing inequalities

As services are restored it is essential that they are opened up to all and resources are distributed fairly according to clinical need.

Systems will be expected to analyse their waiting list data by relevant characteristics, including age, deprivation and ethnicity, and by specialty. The aim is to develop a better understanding of the local variations in access to and experience of treatment, and start developing detailed clinical and operational action plans to ensure treatment is based on clinical need.

The development of a national Health Inequalities Improvement Dashboard will support systems to pinpoint disparities in waiting times based on ethnicity and deprivation, enabling the NHS to take concerted action. This has been released to the wider health and care system and continues to be developed. The next phase is to develop an easy-to-use public-facing version of the dashboard.

Tailored programme for outpatients

A framework and guidance to support the review of patients on the waiting list for an outpatient appointment is currently being developed with support from key stakeholders, including royal colleges, regional teams, systems and providers. This framework is due to be published by March 2022. As part of this work, the opportunity to prioritise access to planned care for children and young people will be explored, due to the potential impact on development for those who cannot access elective services rapidly.

Case study 2: Greater Manchester Cancer Prioritisation

To ensure appropriate prioritisation of cancer patients, the Greater Manchester (GM) Cancer Alliance and the GM acute providers supported the establishment of a cancer surgical hub across GM. This centred on the use of Rochdale Infirmary as a 'cold site' facility where patients could receive their surgery through a new dedicated service, with no risk of resources being diverted to COVID-19 patients. Prioritisation decisions were then made on a weekly basis at joint virtual scheduling meetings, with all waiting lists across GM reviewed by principal surgical officers of the GM Cancer Hub (experienced surgeons from The Christie NHS Foundation Trust and Salford Royal NHS Foundation Trust) to ensure those patients in most urgent need of care were prioritised. A minimum dataset was agreed with all providers, with key information being necessary to determine prioritisation and undertake booking. Around 1,500 patients were treated using this approach in May and June 2020 alone, with very positive patient and staff experience reported.

B. Managing long waits

The impact of the pandemic has meant the number of people on waiting lists for more than two years following a referral has increased to unprecedented levels and the number waiting for more than 62 days from a suspected cancer referral has also increased. This is one of the clearest indicators of the gravity of the challenge of clearing the elective backlog and a central priority of this plan.

Ambition

Addressing such unacceptably long waits must be central to the recovery of elective care. To ensure this, we will bring together providers to work collaboratively and we plan to offer better advice and options to long waiters. This will include ensuring patients understand the choices available to them and that the system supports those choices. We have set the service the ambition of eliminating the longest waits of over two years, except when it is the patient's choice, by July 2022, and reducing the number of people waiting more than 62 days to start their cancer treatment. Following this, the ambition is to eliminate waits of over 18 months by April 2023 and waits of over one year by March 2025, except where patients choose to wait longer or in specific specialties.

How we will deliver

Our delivery focus for long waiters will be on ensuring the accuracy of waiting lists, using available capacity in tandem with patient needs, and developing a network for supporting and addressing the needs of those who have been waiting a long time for treatment. Our approach will build on the duty to offer an alternative provider. We will work closely with general practice teams and the other partners who support patients while they wait. North Central London ICS Elective Recovery Programme has demonstrated the impact of using data to allocate demand to where capacity is available across the system.

Communicating better with patients about their treatment options

We will work with patients to ensure that planned care remains the best option for them, acknowledging that people's circumstances or preferences may change over time. Some patients may have changed their minds about having surgery or the best timing for it.

This should include a focus on interventions identified as of lower clinical value to the patient by the Evidence Based Interventions Programme. The programme, in co-ordination with the Academy of Medical Royal Colleges, NHS Clinical Commissioners and NICE, has identified a number of interventions, based on robust clinical evidence, that do not need to be routinely available to patients unless certain clinical criteria are met, and where the numbers of certain procedures undertaken should be increased, and where the benefit has wider significant impact. We will ensure that the recommendations of the programme are adopted throughout the system to ensure that patients receive the most appropriate care.

Establishing a national network for people waiting a long time

We will establish a new national network for long waiters, managed by the national NHS team and giving systems across all NHS regions a treatment alternative for patients, which will include NHS or NHS-funded independent sector capacity. This may be for patients who are waiting for highly complex procedures, or where significant capacity challenges exist. Patients taking up appointments away from their local hospital will be offered a comprehensive support package, including transport and accommodation where necessary.

Targeted support will be offered to local areas with specific challenges in treating patients waiting for two years or more. This may involve brokering the movement of clinical teams into local systems to undertake complex procedures, or the provision of dedicated support to establish teams to build local management functions to co-ordinate the movement of services and patients. We will design and implement an approach over

the remainder of 2021/22, which will build on the current legal rights to choice, going live by the end of March 2022.

The support provided to patients who have been waiting the longest for treatment will be reinforced. Patients who have been waiting 18 months or longer will now be re-reviewed every three months, as a minimum, until they receive treatment or get discharged. This will be subject to ongoing review as numbers of patients waiting over two years reduce. Reviews should continue to be conducted at least weekly for those waiting longer than 62 days on a cancer pathway.

C. Urgent referrals for cancer

Cancer diagnosis and treatment were prioritised throughout the pandemic, with 4 million urgent suspected cancer referrals made and over 515,000 people starting cancer treatment between March 2020 and November 2021 (95% of whom started treatment within 31 days of a decision to treat). However, some patients experienced changes or delays to their tests and treatment, waiting times lengthened and fewer people came forward with cancer symptoms, meaning fewer people were diagnosed and started treatment than usual. To prioritise the treatment of cancer patients we therefore need to actively encourage those people who have yet to come forward to do so; and we will use the expanded diagnostic and treatment capacity this plan will deliver to provide timely care.

Ambition

The NHS Help Us Help You campaign and extensive work with cancer charities has encouraged people with cancer symptoms to come forward. The NHS has consistently seen record levels of urgent suspected cancer referrals since March 2021, with over 10,000 patients seen per working day. However, there are still patients who have not come forward with symptoms.

Around one in 14 people who are referred with cancer symptoms will go on to be diagnosed with cancer, so maintaining referrals well above pre-pandemic levels is needed to ensure that people who need to can start cancer treatment as quickly as possible.

How we will deliver

We will expand our investment in continued awareness raising of cancer symptoms and risk through Help us Help You. We will focus on the cancers for which referrals have

been slowest to recover, and the systems in which referrals have remained lowest. This is particularly the case for lung cancer, where overlap with COVID-19 symptoms has led to people presenting to their GP later, and prostate cancer, where fewer men coming forward has led to significant decreases in suspected cancer referrals. In these two areas we will go further – partnering with key charities to target communications at high risk groups, distributing awareness-raising material in new NHS settings such as testing and vaccination centres, and using Test & Trace to highlight risks around COVID symptom overlap.

In addition to these national initiatives we will also fund, through Cancer Alliances, more local awareness raising with specific community and patient groups, and tailored approaches for finding the people who have not yet come forward with symptoms. As part of their plan, every system will need to take ongoing action to support general practice capacity where most patients will present.

As more patients who have delayed presenting do come forward, the expanded diagnostic and treatment capacity this plan delivers will ensure they are treated in a timely way. The new 28-Day Faster Diagnosis Standard, ensuring that patients with suspected cancer receive a diagnosis or cancer is ruled out within 28 days, was formally introduced from October 2021 and will allow the NHS to refocus the early stage of the cancer pathway more clearly on what matters to patients – reaching a definitive diagnosis or exclusion of cancer as quickly as possible. This will be made possible by the significant planned expansion of diagnostic capacity, particularly in community diagnostic centres, and the accelerated adoption of stool testing (faecal immunochemical testing) to triage referrals for suspected lower GI cancers – which we are providing immediate additional funding for.

Timely treatment will be ensured by the prioritisation of cancer patients within the overall planned expansion of elective capacity, as well as a continued focus on innovative approaches to treatment adopted by the NHS during the pandemic. This includes new forms of radiotherapy (hypofractionation and stereotactic ablative radiotherapy) to deliver treatment in a more targeted and intensive way, meaning patients spend less time in hospital. For over 40 cancer indications, around 30 alternative cancer treatments have been offered to patients. These ‘swaps’ offer more COVID-appropriate care, such as fewer hospital visits or a reduced impact on a patient’s immune system. Over 12,500 people have benefited from these ‘swaps’ since April 2020.

As a result of this prioritisation within expanded diagnostic and treatment capacity, we have set the service the ambition to see the number of patients on the 62+ day cancer waiting list reduce to pre-pandemic levels.

Case study 3: Help Us Help You campaigns

The NHS Help Us Help You cancer campaigns have raised public awareness of the symptoms that could be cancer and the public's willingness to come forward. The cancer campaign at the start of 2021 increased public awareness by 14% of having a cough for three or more weeks being a potential sign of lung cancer, and the public's intention to act on that symptom also rose by 14%. Our campaign on abdominal cancer symptoms similarly increased awareness by 12%.

To reach people who are most at risk from cancer, Thames Valley Cancer Alliance has partnered with the local authority, local Healthwatch organisations and community faith groups to develop and deliver information about cancer risk, symptoms and testing. The campaign is being delivered through faith venues and community settings to reach key groups such as the Nepalese community and Black men who are at higher risk of prostate cancer (1 in 4 Black men get prostate cancer in their lifetime compared with 1 in 8 other men). The campaign will be expanded next year to reach more community groups and encourage earlier cancer diagnosis.

4. Transforming the way we provide elective care

The challenge of addressing the backlog in elective care also presents an opportunity for our health system. We have the chance to radically rethink and redesign the way that services are organised and delivered, with a constant focus on ensuring the best possible outcomes for patients and delivering an experience that suits their individual needs. We know that service users want flexibility, ease of access and more control over how they interact with healthcare services.

As we have seen throughout the pandemic and continue to see as this plan is being published, services up and down the country are working in extremely challenging circumstances, but during the pandemic have transformed and innovated the way that staff work and the way the NHS delivers care and works with partners. A major challenge has been managing both emergency and routine care. We know how to address this, and over the next three years we will be investing in the physical separation of routine care from the competing demands of urgent and emergency care services where possible.

We will achieve this by:

- A. **Expanding community diagnostic centres** with a focus on ease of access and convenience for patients.
- B. **Increasing surgical capacity through surgical hubs** – separating out many of the low complexity surgical pathways through additional surgical hubs, improving outcomes for patients and reducing pressure on hospitals.
- C. **Improving patient pathways to reduce avoidable delays** by ensuring we are making the best use of the latest technology, clinical time and expertise.

The NHS undertakes 127 million outpatient appointments a year, using patient and clinical time. We want to hand greater control and convenience to patients, by offering telephone or video consultations, empowering people to book their own follow-up care, and working with GPs to avoid the need for an onward referral where possible.

We will achieve this by:

- D. **Improving access to specialist advice** – providing greater flexibility in how advice from clinicians is accessed by patients, enabling more timely, convenient and appropriate care and avoiding the need for unnecessary appointments.
- E. **Making outpatient care more personalised** – giving patients more choice around outpatient care, with options to book their follow-ups and attend video/phone consultations if preferred, simultaneously freeing up capacity for the most clinically urgent. This will include digital innovation through the NHS App.

These are existing examples of best practice designed and implemented by frontline teams across the NHS. This includes personalised patient initiated follow-up pathways for cancer, which are already offering more personalised care for breast, colorectal and prostate cancer patients in many parts of the country. The task is to scale these across the country for the benefit of all our patients, and will require a significant shift in how we work across the health service, including how we interact with patients.

A. Expanding community diagnostic centres

Diagnostic services are critical in making sure the right treatment plan can be put in place for a patient as early as possible, making it more likely that treatment will be successful. They are wide ranging, from an x-ray to a check for a broken bone, using a CT scanner to check for cancer, or having a blood test for diabetes. Sometimes patients need multiple tests before they get a diagnosis, which may be inconvenient for them and expensive for the NHS. Many routine diagnostic appointments have been postponed during the pandemic, leaving a significant number of patients waiting for tests.

Ambition

We want to transform the model for diagnostics, so that patients get tested faster and more conveniently. We are therefore increasing diagnostic capacity and connectivity, transforming how diagnostic services are delivered by investing in more than 160 community diagnostic centres (CDCs) and by creating digitally enabled diagnostic networks nationwide, bringing tests closer to home.

The CDCs are an essential part of the overall aim to more clearly separate urgent and elective care, by taking patients requiring diagnostic services away from acute areas, therefore removing the risk of the estate being reprioritised for urgent work. Separating

clinician time provides better outcomes for both urgent and non-urgent patients, as well as making these services significantly more efficient and timely.

Importantly, they will provide greater access to tests for cancer, allowing both GPs and secondary care doctors to diagnose patients as quickly as possible and in a setting more convenient for patients.

How we will deliver

Forty CDCs were announced on 1 October 2021. This is planned to increase to 66 by the end of 2021/22 and to at least 100 CDCs in the community and on the high street over the next three years. Our ambition is that we will reach a network of more than 160 CDCs across the country. Testing capacity will increase in each of the next three years, to around nine million more tests and checks by 2025 – meaning over a three-year period, patients will be offered around 17 million more diagnostic tests – an increase in capacity of a quarter compared with the three years prior to the pandemic.

Professor Mike Richards recommended the establishment of CDCs in his independent review of NHS diagnostic services in England. CDCs deliver a range of core diagnostic services across imaging, physiological measurement, pathology and, in larger CDCs, endoscopy services. This will significantly increase the diagnostic capacity available for suspected cancer and support faster diagnosis and reduced waiting times. Systems also have the flexibility to include additional optional diagnostic services.

Services are located in community-based buildings, ones that may be purpose built, or in existing underutilised NHS estate. Instead of a potentially long trip to a busy hospital, patients will benefit from dedicated facilities that are often closer to home. Some will be located on high streets; combining a diagnostic test with a shopping trip will be far more common in the future.

The clear focus of the CDCs on diagnostics will enable us to deliver bundles of tests in a single appointment, which as well as being more efficient and a better experience for patients, will protect elective diagnostic capacity from other pressures at acute hospital sites and enable faster diagnosis of cancer and other conditions. We will be investing in digitising cell pathology services across the NHS to speed up turnaround times of tests, and in improving digital infrastructure to ensure test results can be shared across the NHS in patients' digital health records, to reduce duplication, ensure the most efficient use of clinicians' time and speed up care.

Case study 4: Finchley Memorial CDC

The Finchley Memorial CDC, based in North Central London, was established in July 2021. It provides MRI, CT and ultrasound scanning, blood testing and ophthalmology services. As of 14 November 2021, it had conducted 8,333 diagnostic tests, split across five modalities. The CDC aims to deliver a further 31,919 tests by the end of March 2022, split across eight modalities.

100% of MRI patients say that they have had a positive experience. The patient journey time through ophthalmology testing averages 40 minutes, rather than 2-3 hours at hospital sites. The CDC supported sector partners to manage winter pressures by providing a flexible green site resource that they can use as needed.

We are also making best use of existing capacity through digital transformation and growing our diagnostic workforce capacity. Our digital investments will enable, for example, all reporting clinicians in pathology and imaging services to have access to the latest technology for primary diagnosis. This will reduce turnaround times in diagnostic pathways due to instantaneous electronic transmission of images via nationwide networks, enabling rapid access to specialist opinion.

B. Increasing surgical capacity through surgical hubs

In addition to increasing capacity across the system, there are particularly important opportunities to increase surgical capacity and improve the way we manage surgery.

Some relatively simple but important surgeries form a large part of the waiting list for surgical treatment, such as cataract surgery and hip replacement. For example, ophthalmology and orthopaedic patients comprise approximately 22% of those waiting to be admitted to hospital for surgery.

Elective surgical hubs are surgical units that conduct planned, elective procedures only and are often referred to as 'cold sites'. They might exist within a hospital as a distinct unit or ringfenced theatre; or they might have been established on a separate site.

Ambition

We know that many operations can be performed quickly and effectively, with sharing of best practice already leading to improvements in both the quality of surgery and the

number of operations carried out in a day. However, to truly transform surgery for patients, we know we must go further.

Creating a clear separation between the urgent and elective care pathways has a number of benefits and has been an effective way to ensure cancer and other clinically urgent surgeries continued during the pandemic. Staff time and operating theatres can be protected, for example in the event of any future COVID-19 waves. In turn, that makes the planning of treatment easier: enabling more patients to be seen and reducing cancellations. In addition, by tailoring our estate and working practices to particular surgical interventions, we will improve patient experience and reduce the time that patients need to spend interacting with the health system.

How we will deliver

Ensuring that all parts of the system operate as efficiently as possible to reduce waiting times and improve overall patient experience will be achieved through the theatre productivity programme; for example, using outpatient procedure rooms rather than surgical theatres. This will enable clinicians to do more operations per shift, reducing waiting times and improving overall experience.

We are also expanding or establishing a number of elective hubs focused on providing high volume low complexity surgery, as recommended by the Royal College of Surgeons of England, and building on the successful use of surgical hubs for cancer during the pandemic. Surgical hubs, specially designed and built for elective surgery, will increase capacity and resilience.

Hubs can reduce the length of stay needed for these procedures, with more operations done as day cases in outpatient settings, and make it easier for surgical teams to improve care. We will also streamline theatre processes to make them more efficient. Improving the quality and efficiency of surgery will mean patients will be more likely to go home on the same day and less likely to need additional treatment after surgery.

The surgical hubs already being piloted in a number of locations, including London, are helping fast-track the number of planned operations, including cataract removal, hysterectomies and hip and knee replacements, and will be expanded across the country. Additional capital funding has just been approved to enable the expansion of existing hub sites as well as the creation of more hubs in all regions. Each hub is being rapidly developed and staffed based on the needs of its populations and the current

waiting list pressures. Local areas are currently working out how to best maximise activity through these hubs and make sure they work well for patients.

Case study 5: Barking Havering & Redbridge

Barking Havering & Redbridge designed 'Project BONES' (BHRUT Orthopaedics NHS Elective Surgery) to tackle the backlog of patients waiting for surgery due to the COVID-19 pandemic. The system took a fully multidisciplinary approach to planning and delivering a 'perfect week', aiming to perform a high volume of cases, test the system resilience, find the bottle necks in the system and address any hurdles for the future.

The project team included all the clinical and non-clinical members of the team responsible for delivering the service, mapping all stages of the patient pathway and optimising this.

This approach has resulted in sustained improvement in the services – their current activity is 130–160% of their 'business as usual' activity. The learning has been shared with other clinical teams, including spinal, ophthalmology, gastroenterology and paediatrics, who have delivered similar initiatives for the benefits of their patients.

C. Improving patient pathways to reduce avoidable delays

A patient's pathway is a chain of events such as the appointments, tests and treatments they receive following a referral and, for some patients with long-term conditions, may last for many years. Sometimes, it can be more complicated than necessary for patients to get the care they need; they may need to attend multiple appointments and different hospitals for a simple treatment.

Ambition

We want to change this and make processes simpler for patients and their carers, so that they get the right care in the right place at the right time. Working in partnership with patients, carers and those who advocate for people, our new pathway improvement programme will focus on some of the most common types of care, redesigning them for some of the highest volume areas – eye care, cardiac and musculoskeletal services (muscle strains, bones and back pain).

As part of this, increasing the detection and management of long-term conditions, such as heart failure, will help to prevent the need for more complex care and improve the quality of life for people. Increasing critical diagnostics such as spirometry and echocardiography, which have been significantly impacted by the pandemic, will help to prevent the need for further secondary care/hospital admissions.

By designing these pathways better and sharing best practice, focusing on those aspects which benefit patients, we can improve experience and outcomes, while creating extra capacity for elective care.

How we will deliver

This will mean making better use of dedicated surgical hubs: reducing the number of appointments needed, for example with multiple tests being done in one visit in specialist hubs; helping to release time by working more efficiently; and reducing the need for patients to attend hospitals, where appropriate, by building capacity closer to people's homes and making best use of digital platforms.

Working together, regional teams and ICSs will standardise ways of delivering care and adopt best practice, as well as pooling capacity and resources to reduce unwarranted variation to improve patient access and experience. This model of care reduces the risk of planned procedures being cancelled at short notice due to the knock-on effect of operational pressures in the urgent and emergency care pathways.

D. Improving access to specialist advice

Some areas have taken an approach where prior to or instead of making a referral, the referring clinician (often the GP) is able to seek advice from a specialist; or where, after a referral has been made, the specialist is able to review the clinical information and provide advice on the most appropriate next steps without the patient having to wait for an appointment.

Ambition

These services provide timely access to specialist advice to support better care of patients within a primary or community care setting. For patients, providing increased access to specialist advice services helps to ensure care is delivered in the most appropriate setting and supports the management of more patients outside hospital, reducing waiting times and the risk of hospital appointments patients do not need or want.

In addition to the benefits for patients receiving the specialist advice, the service also allows staff to target the most clinically urgent patients.

How we will deliver

Primary care access to specialist advice and guidance will be expanded through continued engagement and support to primary care networks including £10 million through the Investment and Impact Fund, a scheme focused on supporting primary care networks to deliver high quality care to their populations. This will be further supported by the ongoing development of the NHS e-Referral Service to enable the sharing of images to support clinical teams to undertake more effective triage, while improving patient experience. This includes the accelerated adoption of teledermatology services to increase access to specialist advice for suspected skin cancers. In 2021/22 we have invested £2 million in new dermatoscopes so that GPs can take high quality photos of suspicious moles and lesions and seek specialist cancer advice on them, helping speed up referrals and reduce the number of people having to visit outpatient clinics. In 2022/23 we will invest further in these services.

Case study 6: Hampshire and Isle of Wight ICS

Hampshire and the Isle of Wight have been exploring how to maximise the effective use of specialist advice over the last two years. Clinicians in primary care and acute care providers such as Portsmouth Hospitals University NHS Trust have been collaborating to develop and refine the approach. They focus on better supporting patients across a range of specialty areas and pathways. This has allowed 20-30% of those patients with an identified need to be better supported within primary care – with the GP having received advice from a specialist – rather than having to attend an outpatients or hospital treatment.

E. Making outpatient care more personalised

The NHS is giving patients greater control and convenience in their NHS hospital or clinic appointments – by offering telephone or video consultations, empowering people to book their own follow-up care, and working with GPs to avoid the need for an onward referral where possible.

Ambition

As we continue to recover from the pandemic, there is a significant opportunity to accelerate the progress we have already made towards a more personalised approach

to follow-up care in hospitals or clinics. This will ensure people who require a follow-up appointment receive one in a timely manner – protecting clinical time for the most value adding activity. Through this more personalised approach to outpatient follow-up appointments, patients can expect their care needs to be dealt with faster and closer to home where appropriate. This will be done in a way that improves overall efficiency, while not transferring follow-up to capacity-constrained services in the community and general practice without a coherent system plan.

How we will deliver

There are a number of tools that can support us to deliver this ambition, many of which are already in place across the NHS and will be rolled out further and faster for appropriate patient groups. These are:

- **More flexible follow-ups** – giving patients and their carers the flexibility to arrange their follow-up appointments as and when they need them. The approach helps empower patients to manage their own condition and plays a key role in enabling shared decision-making and supported self-management. This can be enabled by simple digital tools (eg telephone, video, online messaging, etc) that support access to the relevant clinical teams when patients feel they need to trigger an outpatient appointment. This should also in time include access to booking and other clinical communications through the NHS App. Non-digital access is also available by calling to arrange a follow-up appointment. Effective self-care at home is supported by increased use of home monitoring tools such as blood pressure monitors.
- **Patient initiated follow-up after cancer treatment** – giving patients more control over their care after cancer treatment by adopting personalised, patient-initiated follow-up for breast, colorectal, prostate and other cancers. Patients are supported to self-manage, with access to specialist advice and support if they have concerns, and continued scans and tests to check for recurrence. This also frees up clinician time for new patients and those with greatest need. Patients have improved experience of care from not having to travel, and reduced anxiety as scan and test results are communicated quickly. A study on patient initiated follow-up in endometrial cancer showed a 94% reduction in the time patients spend travelling and waiting.⁵

⁵ [Patient-initiated follow-up for low-risk endometrial cancer: a cost-analysis evaluation | International Journal of Gynecological Cancer \(bmj.com\)](#)

- **Effective discharge** – every patient should receive the care they need, when they need it. Ensuring patients are assured that it is appropriate and safe to be discharged is vital for all follow-up appointments to provide maximum value for patients and not place unnecessary demand on general practice from patients attending with outstanding concerns.
- **Improving administrative processes** – we will enable effective use of each outpatient appointment, so that clinicians have the information they need prior to an outpatient appointment and do not have to postpone or invite patients for a follow-up due to incomplete information.

To deliver this approach, hospitals across England will be supported to identify the local opportunity, restructure their clinical time and embed the required digital infrastructure to offer this flexible model consistently to patients.

5. Better information and support for patients

Engagement with patient groups in the development of this plan clearly indicated the need to improve communication with people while they wait for planned care. We want to help patients manage their lives around their healthcare needs better. Providing people and their carers with information and personalised support is central to that ambition and our overall recovery plan. We aim to enable people to make informed decisions and be more in control of managing their own care, to reduce the impact of waiting for treatment and supporting recovery after treatment. That includes sharing clear information on their wait and the support available, identifying their needs early so they can best prepare, and signposting them to the most appropriate support for their needs before and after their treatment.

Guidance is available for acute providers to help them deliver personalised, patient-centred communications.⁶ It has been developed with support from key stakeholders including Healthwatch, National Voices, the Patients Association, The Richmond Group of Charities and Versus Arthritis. The guidance aims to improve the experience of care for those who are waiting for treatment. It lays out nine core principles to support the standardisation of clear, concise and timely communications.

We recognise the value in working in partnership with voluntary sector organisations and patients to ensure that patients are supported while they wait for care, including through peer support. We know that actively signposting to trusted organisations can help patients understand their diagnosis, and provide them with access to relevant information, with a particular emphasis on those patients who may have difficulties accessing digital information. We plan to provide this access and support using a comprehensive approach, including:

- A. **Targeted support information for patients, including through My Planned Care** – initially delivering a new platform to increase transparency on wait times and provide a hub of support information for patients covering the entire pathway, before further development to integrate this with the NHS App.

⁶ <https://www.england.nhs.uk/coronavirus/publication/good-communication-with-patients/>

- B. **Supporting patients to prepare for surgery** – by co-developing personalised plans that provide them with the necessary information and guidance to prepare for the best possible outcomes.
- C. **Emphasising the expertise of NHS staff in providing high quality personalised and tailored support to patients**, supported by the latest innovations in technology and improved data sharing.

A. Targeted support for patients

Engagement with patients waiting for planned care has clearly highlighted the importance of providing information on waiting times and what to expect. The inability to plan the rest of your life because you do not know you might be offered an appointment is a source of anxiety for many people.

Similarly, patients who do not have access to the correct information on decision-making and support offers can end up suffering unnecessarily. These issues also disproportionately impact the most vulnerable people in society. Often patients turn first to their GP team for help; this can place an additional strain on primary care services.

Ambition

The ultimate aim is to create a transparent, well-informed process for service users that complements existing local communication channels between the health system and patients. This means the ability to view guidance on self-management of symptoms, targeted support to help prevent deterioration among those waiting to access services, and information on wait times.

There is an opportunity, using our improved data infrastructure and greater digital presence, to deliver this through a series of linked interventions, coalescing around a central platform that will host the information for patients. This will provide a short-term solution and we will explore long-term solutions, such as the NHS App.

How we will deliver

My Planned Care platform

We will provide an open access web-based platform to provide greater transparency to patients. The new My Planned Care platform will provide patients and their carers with access to basic and general information on their elective wait. This system will allow patients and their carers to better understand their expected wait for treatment, and

clinicians to link patients to the most appropriate personalised support. The platform will also include waiting time information by specialty at their provider.

Providers will upload support information by procedural groups to help patients self-manage and signpost to general information on local and community support offers, as well as other sources of support available from the NHS and other routes while they wait. The platform will go live in February 2022, with additional information on local support offers and further guidance for patients added from spring 2022.

The platform will also be accessible via NHS.UK allowing patients, family members, carers and clinicians to all access the information at any point of the pathway. We are currently scoping the timeline to further develop the functionality of the NHS App to supplement that of the My Planned Care platform and offer a more personalised experience while on the elective pathway. This includes providing more personalised information to individuals, making it easier to access relevant support information and signposting to self-management tools and services. This will fundamentally alter the way patients interact with the NHS and how people manage their own health and care, increasing transparency, control and outcomes.

NHS trusts and primary care will continue to play an important and co-ordinated role in contacting patients through other non-digital means such as letters, telephone calls or in-person meetings as an alternative way to get information on waiting times and support.

Support for patients to make decisions

Patients will be provided with the tools and support to decide what treatment is most appropriate for them. Aligning with recommendations from the Paterson Inquiry⁷, providers will be required to adopt two stage shared decision-making across all their admitted non-day case pathways by April 2023, and all admitted pathways by April 2024. Two stage decision-making introduces a short period of reflection for patients into deciding on treatment and giving consent. This allows patients to take the time to fully understand the benefits and risks of treatment and decide whether it is the most suitable option for them.

For the highest volume procedures, tools to support the patient's decision-making will be developed. Clinicians will also be provided with online training on shared decision-making through the Personalised Care Institute.

⁷ <https://www.gov.uk/government/publications/paterson-inquiry-report>

Targeted support for patients who are waiting for care

We will develop guidance to support local health systems to provide personalised and targeted support for patients and their carers to help them manage their symptoms while they wait, prevent deterioration and recover effectively. National clinical groups are developing defined categories of patient needs for the highest volume procedures on the waiting list. Guidance on the categories of need, which will be shared through clinical networks, will support local capacity planning and stratification of the support patients require while they wait for planned care.

National clinical groups are also drafting guidance on high impact support interventions for patients on the elective care pathway, drawing on findings of an evidence-based review of support offers and learning from local pilots. Guidance and patient information material on support offers will be shared with local systems and through clinical networks. Where possible, support offers will also be made available via the My Planned Care platform.

Measuring patient experience

Alongside providing better information, we are committed to giving patients greater voice and acting on the feedback they provide. The success of our plan is dependent on patients' experience of waiting, diagnosis, treatment and care, and how we communicate with people, as well as increasing our capacity. It is particularly important to gather rapid learning on transformative developments such as separating elective and non-elective diagnostics and treatment facilities and providing more flexible outpatient follow-ups to treatment.

We will therefore work with patient charities and other partners to:

- develop better measures of patient experience, including on communications and the nature of care and support, building on leading practice around the country
- use technology to more effectively gather and respond to patient feedback, so that services can quickly build on what is working and take action where improvement is required
- work with partners to ensure that we get a better understanding of the experience of patients waiting over six months – we expect this will draw on feedback from a large number of patients.

B. Supporting patients to prepare for surgery

One third of on-the-day cancellations are due to clinical reasons, such as patients being unfit for the type of surgery or anaesthetic they were listed for. Patients with lower fitness or who struggle to control their long-term conditions are at risk of major complications after inpatient surgery, which can increase average length of stay three-fold or more, and reduced long-term survival and quality of life. Therefore, it is essential that potentially modifiable risk factors are identified and treated early on.

Ambition

From April 2023, providers will be asked to establish Perioperative Care Co-ordination teams. These teams could consist of, for example, care co-ordinators, nurses and perioperative physicians who will assess health needs to proactively inform pre and post-operative care and identify surgical risk factors. They will identify low-risk patients who do not need to attend face-to-face preoperative assessment and patients who could be treated in elective hubs focused on providing high volume low complexity surgery.

This will enable patients to be treated in the place most appropriate for their condition, as well as freeing up capacity for those who require more complex care in a higher acuity setting.

How we will deliver

The teams will work with patients to develop personalised preparation plans. These plans will detail both the clinical and the wider support needs of patients both leading up to the time of surgery and in the post-surgical period. The Perioperative Care Co-ordination teams will be able to refer people for specialist secondary care input where required and, in conjunction with social prescribing link workers, to connect people to the most appropriate community support for them.

We will strengthen perioperative pathways starting at the point of referral or listing for surgery to support patients' preparation. With improved sharing of data and digital tools, providers will enable patients to better prepare for their treatment. Digital patient-led perioperative questionnaires are currently being scoped and will enable the capture of risk factors not traditionally included within health records without additional burden for NHS staff.

The teams support providers to regularly contact those patients on their waiting lists. This contact should collect information on the patient's current condition and overall health and provide an update on likely remaining wait.

Case study 7: Bristol, North Somerset and South Gloucestershire ICS – One Trauma & Orthopaedics Programme

The One Trauma & Orthopaedics Programme is working with the organisation My Recovery to produce a customised version of the Joint School app, which is a programme helping people to prepare for and recover from surgery.

The app is being specifically adapted to deliver information designed for patients awaiting a total hip or knee replacement, as well as anterior cruciate ligament reconstructions.

Clinical teams have produced additional content and videos for inclusion in the app. The information will help the patient's understanding of how to prepare for surgery, what to bring to hospital, as well as post-operative and discharge plans. Furthermore, it will guide them through their pre and post-operative therapy aiding in a quicker return to function.

6. Delivering this plan

The challenge we face in recovering elective services should not be underestimated. It will require a huge collective effort to meet our ambitions. Our approach has been co-designed with stakeholders and patient groups as well as trusts, systems and regional teams across the NHS to build a shared understanding of how the NHS will successfully deliver our commitments to patients and the public. Further details on our approach were set out in the 2022/23 planning guidance,⁸ but our underlying principles are:

Clear accountability for delivery

Integrated care systems will each have plans for their population and for the resources required to recover elective and cancer services. They will work with providers to agree and deliver their plans. Regional and national teams will work together to monitor delivery of plans and provide prompt interventions to drive improvement as required. Cancer performance and elective performance will be managed alongside one another to ensure that capacity continues to be prioritised for cancer patients. Data will be used to drive improvement and identify opportunities for transformation.

Consistent, co-ordinated interactions between national, regional and local teams

Clear communication from frontline clinical teams to systems (including Cancer Alliances), regional and national teams will be vital. This will be supported by a shared understanding of performance and a data-driven approach to identifying and tracking progress, and identifying risks and issues.

An overarching support offer to rapidly share and scale best practice, with targeted support for systems and providers with significant challenges

The case studies in this document show how vital it is to take innovations that are working in one area and spread them, at pace, across the whole NHS. We will particularly seek to spread innovations into systems with the most significant

⁸ [2022/23 priorities and operational planning guidance](#)

challenges and share clinical expertise across system boundaries to accelerate recovery.

Putting reducing inequalities at the core of recovery plans and performance monitoring

We will ensure a 'fair recovery' is at the core of our approach. We will embed a focus on health inequalities in how we hold systems to account for delivery. We will particularly focus on equity of access, experience and outcomes for the most deprived 20% of the population and the five clinical areas of focus set out in 'Core20PLUS5' where we know we can make the greatest difference (maternity, severe mental illness, chronic respiratory disease, cancer and hypertension case-finding).

Collaboration within and across systems to improve access and tackle waiting times

Collaboration has been fundamental to the NHS's response to the pandemic and will underpin our approach to recovery. We will ensure effective collaboration by enabling staff to work across multiple providers, establishing diagnostic and surgical hubs, building effective partnerships with the independent sector and reducing waiting time variation within and across systems.

Being clear on what success looks like and putting in place a payment system that incentivises strong performance and value for money for the public

Longer-term planning will enable us to update and refresh our approach in response to an ongoing assessment of progress, taking into account data on the number of 'missing referrals', the emerging evidence from systems about what works and to reflect the increasing autonomy and role of ICSs as they develop.

Funding for elective recovery will be allocated to local areas to support elective recovery, ensuring that we maximise the impact of the additional funding. Further details on payment mechanisms will be set out as part of the planning guidance for local systems.

Throughout the delivery of this plan we will involve people and communities at all levels. We will work together to ensure regular communications to the whole population.

Acknowledgements

The Elective Recovery Plan has been developed with expert contributions from a wide range of partners, including but not limited to:

- Patient representative organisations including Age UK, Healthwatch, National Voices and The Richmond Group of Charities.
- Meetings with health sector chief executives and chief operating officers, NHS Confederation and NHS Providers, including at a roundtable with trust chief executives.
- The Academy of Medical Royal Colleges and its members including the Royal College of Surgeons of England, Royal College of Physicians and Royal College of General Practitioners.

The plans have been informed by interviews and group discussions with patients, combined with insights from partner organisations. The My Planned Care web platform has been developed with patient and user involvement. We have also benefited from the insights and ideas of staff, including on enhancing staff welfare through the elective recovery process, and from contributions by clinical leaders and NHS provider organisations.

We remain committed to working closely with partners as we deliver these plans, including through an Elective Recovery Engagement Forum (current representatives given below), the NHS Citizen Advisory Group, National Elective Primary Care Clinical Advisory Group and the VCSE Health and Wellbeing Alliance. As the Elective Recovery Plan is implemented insight on patient experience will be enhanced through the new Patient Coalition with independent co-chairs, patient representatives and support from the voluntary sector.

Thank you to all the individuals and organisations who have shared their time, energy, expertise and experience so far.

Membership of the Elective Recovery Engagement Forum (November 2021)

Academy of Medical Royal Colleges	Patients Association
Allied Health Professions Federation	The Richmond Group of Charities
Birmingham City University	Royal College of Anaesthetists
British Medical Association	Royal College of General Practitioners
British Red Cross	Royal College of Nursing
Getting It Right First Time	Royal College of Physicians
Healthwatch	Royal College of Surgeons of England
National Voices	Society of Acute Medicine
NHS Clinical Commissioners	Versus Arthritis