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Still waiting

We revisit a topic addressed in last year's COVID-100 bulletin series – one that has become the number one issue for the NHS.

In last year's COVID-100 bulletin series we looked at the growing issue of NHS waiting times.

Even before the pandemic, waiting time targets were being routinely missed due to the funding squeeze that had been in place since 2010 and the growing complexity of the care needs of the country's ageing population. But COVID-19 took the problem to unprecedented levels – to the point where this is now arguably the most important issue facing the NHS.

So, we make no apology for revisiting the topic in today's illumination – repeating the key questions that boards should be asking and urging them again to consider how this crucial area might be re-engineered in the era of integrated care.

Waiting times matter

As we said last time, waiting times for planned hospital care matter to patients because living in pain and discomfort can have a serious impact on education, employment and mental wellbeing.

They matter to healthcare professionals because keeping patients waiting doesn't sit easily with providing high quality care and many elective treatments can become urgent if they aren't dealt with in a timely way.

They matter to NHS boards because there are NHS constitutional standards and they still matter – don't they?

Unsurprisingly, as a result of the pandemic's impact on hospitals' ability to treat elective patients the total number of people waiting to start consultant-led elective treatment increased to 4.95 million in March 2021, the highest level since records began. This follows a previous fall to 3.94 million in May 2020. In March 2021, 1.8 million people had been waiting over 18 weeks to start elective treatment – double the number from March 2020.

This is obviously bad news for patients, their families and for the NHS. It seems certain now that the gains made in waiting times since 2000 have been lost and we are returning to typical waiting times for 'routine' procedures of more than 12 months.

The number of people waiting over 52 weeks to start consultant-led elective treatment increased to 436,127 in March 2021, the highest level since August 2007. The projections are for this to continue to grow to truly eye-watering numbers, perhaps in excess of one million.

Questions for boards

This is an important and legitimate area for boards to seek assurance. Some questions they may wish to consider include:

- What is the shape of our waiting list now and what do we think it will look like over the next few months?
- Will there be (or is there already) a surge in referrals as fear of COVID-19 subsides, assuming it does?
- For our long waiters, what steps have we taken to ensure there is no harm being done – or at least that it is being minimised – and that patients are being risk assessed?
- What are our processes for patients who have removed themselves from the waiting list, to ensure that they are not coming to avoidable harm?
- What communication has there been with patients and their GPs?
- Are our practices aligned with those of the local system and with commissioners' expectations, and are our regulators and stakeholders aware and supportive?
- What are the processes for stepping up activity, including clinical prioritisation, infection prevention and control, and are they aligned with national guidance?
- What are the financial consequences of scaling up? Can we afford it, will commissioners pay for it, is it all wrapped up in the contract? What are the criteria for accessing the Elective Recovery Fund and will we meet them?
- Are there any consequences for professional staff of such a long pause in practising – particularly for surgeons and surgical teams? Is any refresher training necessary?
- Do our board assurance prompt and corporate risk register capture the risks adequately and are our board committees focused on providing appropriate assurance?

Looking ahead

Then there's the future of waiting list management and the NHS 'elective offer' to consider. Perhaps now is the time to genuinely plan for ICS-wide elective treatment protocols, eliminate procedures of no proven clinical value, improve data quality and patient communication and move to system-wide waiting list management.

How can boards seize this unforeseen and once-in-a-lifetime opportunity to re-engineer a critical part of the NHS?

Illuminations

- There has been a massive growth in waiting times and the number of patients waiting across the NHS as a consequence of the pandemic – and this matters hugely to patients, staff and the NHS.
- Provider trust boards should be assured that their own trusts are doing all that they can to minimise the damage and to recover.
- There are opportunities presented by the creation of ICSs to take a different approach to waiting list management, including the managing planned care capacity across the system.

If you have any questions or comments about this briefing, please call us on 07732 681120 or email **advice@good-governance.org.uk.**