NHS waiting times still matter

Waiting times for planned hospital care matter to patients because living in pain and discomfort can have a serious impact on education and employment and on 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 leaders because there are NHS Constitutional Standards and they still matter – don't they?

The COVID-19 effect

The devastation wrought by the pandemic on waiting times for planned care in the NHS is becoming clear and it isn't pretty.

The latest NHS performance statistics show that more than 200,000 patients are now waiting more than a year to receive hospital treatment, with a record total of 4.52 million on the waiting list. In December 2020, David Maguire, Senior Analyst at The King's Fund, commenting on the figures published back then said:

> *"There have been just under 4 million fewer referrals for hospital care since March this year compared to the same time last year, with more patients having their conditions managed by their GP or in the community. We don't know how many more people will need urgent or routine care next year as a result, but this can only add to the considerable backlog of 4.4 million people waiting for care."*

Since December many trusts have not been able to keep pace with their restoration and recovery aspirations and planned activity levels have taken a further tumble. According to the Health Service Journal, more than 100,000 people were waiting for 'urgent' priority two operations in late January, as planned care rates plummeted amid the COVID third wave:

> *"In the three weeks to 20 December, the NHS was reporting around 110,000 day cases and 18,000 planned overnight admissions each week.*
>
> *"But during January these totals dropped to around 85,000 day cases and 10,000 planned overnight admissions per week. This equates to a reduction of 23 per cent and 44 per cent respectively."*

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 will be lost and that we may return to typical waiting times for 'routine' procedures of more than 12 months.

Cancer patients and services have not escaped the impact of COVID. In its excellent Quality Watch series, the Nuffield Trust noted that:

> *"The number of patients starting a first treatment for cancer was 17% lower in Q2 2020/21 than in Q2 2019/20, due to disruptions to cancer treatment during the COVID-19 pandemic."*

Questions for boards

This is an important and legitimate area for boards to seek assurance. And it is one that they should be mindful of for when the time comes – as it inevitably will – to account for their actions during the pandemic. Some questions boards may wish to ask 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 a surge in referrals as fear of COVID-19 subsides (assuming it does)?
- For our long waiters, what steps have we taken to ensure that 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?
- 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?
- Does our BAF and corporate risk register capture the risks adequately and are our board committees focused on providing appropriate assurance?

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

- Waiting times for planned care still matter hugely to patents, staff and the NHS.
- There has been a massive growth in waiting times and the number of patients waiting across the NHS as a consequence of the pandemic.
- Provider trust boards should be assured that their own trusts are doing all that they can to minimise the damage and prepare 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**