Recovering Elective Care

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Contents

Foreword

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The current backlog in elective care presents one of the most significant challenges the United Kingdom faces in the delivery of effective healthcare.

When elective departments temporarily closed their doors at the beginning of the pandemic, issues in the delivery of routine surgical procedures which had long existed were exacerbated exponentially. It would be impossible to ignore the reports we read and hear almost every day of the devastating impact delays to the delivery of elective care are having on patients, their families, healthcare professionals and the National Health Service.

Prior to my career at Mölnlycke, I spent many years working as a complex wound and ostomy consultant, supporting seven surgical specialties in a large academic trauma center in the United States. At the forefront of my mind, and that of every healthcare professional, is the impact that their care has on the lives of their patients. Every time a surgical procedure is delayed, it is another patient unable to return to normal life or begin their recovery. We know that if the backlog could be resolved by the goodwill and resolve of the NHS's operating theatre teams, there would be no delays, and this report would need not exist.

This country is far from alone in the challenges it faces in the delivery of elective care. Health systems across the globe have been deeply impacted by the pandemic, and the near-universal slowdown in elective care procedures will be felt by us all for many years to come.

As has been so often the case in the last two years, however, we have found that the most seemingly insurmountable challenges bring out new ways of working which would have otherwise been impossible without the restrictions COVID-19 has placed on us. Elective care is no different, and in meeting the demand of the backlog, we must harness the opportunities that the new ways of working under the pandemic has presented, and not return to the 'normal' of before.

As an organisation deeply involved in this field, we know we have our part to play. We understand the need to demonstrate that we are an active partner to healthcare workers, helping them to meet the challenges they face. The Recovering Elective Care roundtable, which brought together leading figures from the NHS, professional organisations and think tanks, is the latest chapter in our own journey. I, and everyone at Mölnlycke, hope that the Recovering Elective Care report, and the roundtable which informed its development, can form a vital part of this conversation. I am deeply grateful to our colleagues from the NHS, professional organisations, and think tanks who gave their time, and shared their expertise, insights and perspectives. We look forward to many more collaborative discussions, as we work together to recover elective care.

"Every time a surgical procedure is delayed, it is another patient unable to return to normal life or begin their recovery"

Executive Summary

With over 7 million on the elective care waiting list for planned surgical procedures,[1] tackling the current crisis in elective care has become the leading national health crisis post-COVID. The impact of the pandemic has been devastating for patients and healthcare professionals alike. Data shows that 6 million fewer people completed elective care pathways between January 2020 and July 2021 than would have been expected based on pre-pandemic numbers.[2] Many of these delays will lead to poorer health outcomes for patients, and lead to further delays and system blockages.

Such is the scale of the challenge faced by the NHS, clearing the backlog will take many years, and cannot be achieved through the contributions of health care professionals (HCPs) alone. HCPs, who have contributed more than most to seeing us through the past pandemic, need support from across the healthcare sector to alleviate these pressures. As a leading supplier of high-quality surgical equipment, technology and training, Mölnlycke recognises that we have our own part to play in supporting HCPs in meeting this challenge and helping operating theatres to become more efficient.

The Recovering Elective Care report, the conclusions of which were informed by a roundtable meeting with clinicians, nurses, and representatives from leading professional organisations and think tanks in Autumn 2021, makes a series of recommendations on how to reduce the impact of the elective care backlog. We at Mölnlycke are grateful to the roundtable participants for their insights which helped inform these recommendations. We hope that they offer a valuable contribution to the debate on how the healthcare ecosystem can support in the recovering of elective care procedures.

The recommendations are:

1. Working groups should be created within hospital trusts to establish new protocols and ways of working based on best practice organisational improvements to elective care departments. This could include supporting measures, technologies and processes that have been demonstrated to drive organisational and operating efficiency, and the working groups should be driven forward by trust leaders.
2. Guidelines on shared decision-making should be developed to ensure greater access to acute surgery, with further consideration given to greater patient choice and participation (in line with the GIRFT report, 'Post-COVID Elective surgery Recovery & Transformation').
3. Surgical skills training and re-acclimatisation programmes should be established to ensure that staff returning to elective teams from critical care are supported in a professional and personal capacity.
4. The NHS should undertake a strategic review of training and development needs for NHS staff working in elective care departments, outlining programmes which can be supported by industry partners.
5. The Government should consider implementing a programme to establish dedicated day surgery units and teams, in line with the recommendations of the National Day Surgery Delivery Pack and GIRFT best practice guidance on hot and cold sites for operations.
6. New guidelines should be established to use shared decision-making to prepare patients in secondary care settings, to support surgical teams to adjust elective care waiting lists in a way that is reflective of patient need.
7. Standardisation of elective care processes should be undertaken at a regional level to allow intra-trust collaboration to reduce elective care numbers.
8. A national NHS Task and Finish group should be established to explore the potential for greater implementation of value-based procurement models in reducing the elective backlog.

The Crisis in Elective Care: Overview

Though undeniably intensified by the COVID-19 pandemic, the crisis in elective care has represented a persistent challenge for the NHS over many decades.

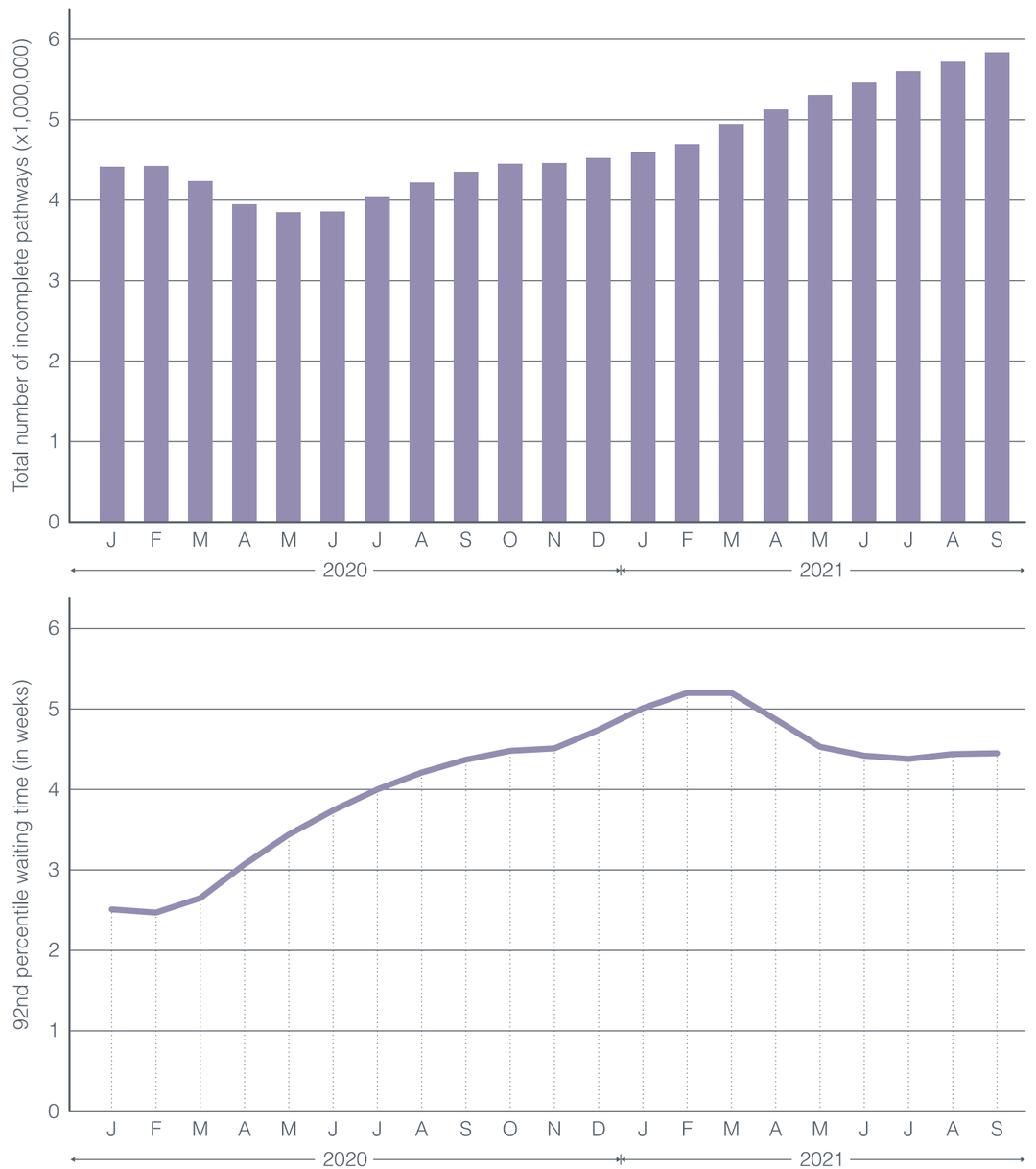
Elective care is defined as care that is planned in advance, such as specialist clinical care or surgery, often following a referral from a primary care provider.[3] Questions of how to efficiently reduce waiting lists for planned surgical procedures have occupied senior leadership for many years, and as a result of surgeries being paused, there are currently 7 million people on the waiting list for elective care.[4] Of this number, NHS statistics show that 293,000 patients have been waiting for a year or more for treatment.[5] While this figure is shockingly high, elective care activity has increased significantly in recent months as the NHS recovers and mobilises from the devastating impact of COVID-19: total elective activity for July 2021 was at 90% of 2019 activity levels, up from 79% in June 2021 and 55% in April 2020.[6]

Nevertheless, restoring the elective care backlog is one of the most significant challenges facing the NHS today, and the Government has announced several measures to ease pressures on the health service, including a £5.4 billion funding package for health and social care. The extra £5.4 billion funding is broken down into: £1.5 billion for elective recovery, including £500 million capital funding to increase theatre capacity and use of technology care backlog.[7] The NHS has appointed two Joint National Clinical Directors for Elective Care, Miss Stella Vig and Mr Ian Eardley, to lead on the elective care recovery at a senior level,[8] and announced £160 million of funding to launch 'accelerator sites' to tackle waiting lists.[9]

Broken down by speciality, the three most affected pathways between January and August 2020 were oral surgery, trauma and orthopaedics, and ophthalmology, which were 42%, 42% and 40% lower respectively than in the same period in 2019.[10] Elective care waiting lists have also varied significantly by region. During the first peak of the pandemic, London had the smallest reductions in completed pathways, at 50%, whereas the Southwest reduced pathways by 58%, and the Midlands, East of England and North West had reductions of 60%.[11] In an effort to tackle this variation, the Government has announced a review of health and social care leadership aims to reduce regional disparities in efficiency and health outcomes across the country,[12] signifying the prioritisation of this issue on the Government's agenda.

The regional variation in elective care has raised concerns among health leaders that it will exacerbate health inequalities, as well as force patients to make financial trade-offs in order to access care.[13] The concern over regional variation was echoed by participants in the roundtable, who noted that different trusts are recovering at different rates, and called for a "coherent" plan for tackling elective care waiting lists at a national level. Participants also noted that it is currently difficult to understand the scale of the issue, when a huge backlog still exists, and staff continue to be relocated.

Looking forward, the pressures of the winter season on the NHS are likely to exacerbate the elective care crisis. The Government has published its COVID-19 Response: Autumn and Winter Plan, which set out a 'Plan B' for measures that could be deployed if needed to prevent "unsustainable pressure" on the NHS.[14] As COVID-19 cases increase and accentuate the impact of flu season, the next few months will see a renewed focus on how to optimise bed space and maximise efficiency across the NHS, in order to ensure that planned elective care can continue.



Recovery of elective care since Jan 2020. Data extracted from: NHS England. 2021. Consultant-led Referral to Treatment Waiting Times. Available at: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

Recovering Elective Care Roundtable

As a long-term partner to the NHS, Mölnlycke understands that we have a duty to elective care teams across the country to help address the current backlogs in operating theatres. Whether through the provision of equipment, technology, or training, we are committed to supporting both the NHS and the healthcare systems of the countries in which we operate to recover from the greatest peacetime health crisis many nations have ever faced.

We have also been in constant dialogue with healthcare professionals across the country to understand better both the nature of the situation they face, and how we can support in alleviating their day-to-day pressures and make practicable recommendations to help reduce the elective care backlog.

In Autumn 2021, Mölnlycke, working in collaboration with the National Health Executive, brought together surgeons, nurses, leading healthcare professionals, in addition to representatives from think tanks and professional organisations for a 90-minute roundtable. The purpose of the roundtable was to discuss how hospital trusts can be supported to reduce the elective care backlog and meet the 18-week referral-to-treatment target. We wanted to understand how surgical teams can be supported to better manage the increasing demand for elective care across the entire patient pathway and ensure that staff have the support they need to drive forward improvements to elective care.

The Recovering Elective Care White Paper provides a summary of the perspectives and insights of those in attendance at the roundtable, and makes eight recommendations across four key themes: learnings from COVID-19, workforce, elective care planning, and innovation and efficiency.

Joining us at the roundtable were:

Dr Steve Feast
Chair

Dr Jag Ahluwalia
Chief Clinical Officer, Eastern AHSN

Maxine Page
Theatre Matron at Princess Alexandra Hospital, Harlow, and AfPP Education Special Interest Group Lead

Isobel Glanville-Pearl
Deputy Director of Nursing, Chelsea and Westminster Hospital NHS Foundation Trust

Professor Scarlett McNally
Consultant Orthopaedic Surgeon and Deputy Director for the Centre for Perioperative Care

Siva Anandaciva
Chief Analyst, Kings Fund

Yinglen Butt
Deputy Chief Nurse, Guy's and St Thomas' NHS Foundation Trust

Dr Tod Brindle
Global Medical Director, Mölnlycke

Learning from COVID-19

"Getting back that process-driven application in operating theatres is certainly going to help, and that adaption where we've managed to do some amazing things in terms of efficiency during the pandemic. When we're scaling up to going back to business as usual it's about getting those processes back into play."

Isobel Glanville-Pearl

Recommendations

1. Working groups should be created within hospital trusts to establish new protocols and ways of working based on best practice organisational improvements to elective care departments. This could include supporting measures, technologies and processes that have been demonstrated to drive organisational and operating efficiency, and the working groups should be driven forward by trust leaders.
2. Guidelines on shared decision making should be developed to ensure greater access to acute surgery, with further consideration given to greater patient choice and participation (in line with the GIRFT report, 'Post-COVID Elective surgery Recovery & Transformation').

There can be no question of the deeply damaging impact that COVID-19 has brought to elective departments, teams, and patients across the country. Nevertheless, it also presented opportunities for new ways of working, collaboration and organisation which would have been impossible to deliver 18 months ago. A key finding from the roundtable was to learn from the adapted ways of working during COVID-19 rather than return to the status quo of before the pandemic. There has been a growing understanding of the new and existing skills staff have developed. For example, advanced nurse practitioners need to be supported and utilised effectively to support surgeons, help meet targets and improve the flow of patients.

Roundtable attendees also stated that there needs to be a continued breakdown of working in siloes across clinical teams, and more widely across acute and primary care settings to ensure patients receive the right care for them. Around 10% of operations have a complication, and 50% of the population aged 65 have two or more comorbidities.[15] For some patients, an operation is not the right treatment decision, and 14% of patients express surgical regret.[16] Therefore, improving shared decision-making across clinical teams within an environment that encourages some challenge and dialogue will better support access to acute surgery based on complex patient needs.

It is also clear that the reduction of infections acquired during or following surgeries, an estimated 60,000 of which occur each year at a cost of £10,000[17] to £100,000 per patient,[18] place further pressure on the elective backlog. Preventing infections through evidence-based preventative steps to reduce the risk of SSIs, high-quality equipment and mandatory surveillance can do much to reduce the impact of SSIs on elective care procedures.

Significantly, the roundtable participants highlighted changes in the attitude of their teams and workforce more generally. The pandemic has brought with it a sense of unity and a breakdown of hierarchy based on titles and seniority, replaced with an increased respect across professions, from nurses to senior clinicians, for the role each member plays and the skills and experiences they can bring to patient care. Throughout the crisis, there was a re-orientation of roles which met the needs of patients rather than rigidly being performed based on titles. This has led to an improved working environment, often emotionally difficult in acute care, and needs to continue to be fostered by trusts.

The pandemic required increasing efficiency in the ways the working and processes within teams are carried out. It also provided a degree of newfound flexibility that allowed people to adapt and work to the best of their abilities in an innovative manner.

Roundtable participants agreed that some of the efficiency-related process should be upscaled when the pandemic is easing, and that a degree of flexibility should be retained before returning 'back to business' and tightly regulating teams once more.

There was also consensus that there was a rush to return to normal, which has not allowed time for staff to consolidate what worked well during the pandemic. Additionally, this has prevented acknowledging that the demographic of patients presenting in acute care has changed. Many patients have more complex needs, which require far more treatment time, as they will have been waiting throughout the pandemic to be seen. In an ideal situation, there would be time to allow staff to ease back in and for teams to stop having to work reactively due to external pressures.

All this internal flux during the pandemic has shown that when teams and trusts work together, they can learn from each other and drive towards better practice. It has helped to change the narrative around the NHS, which is normally seen as 'hard to change', into an organisation that is agile when circumstances necessitate.

"For some patients, an operation is not the right treatment decision, and 14% of patients express surgical regret"

Workforce

"Collaboration between critical care and operating department practitioner nurses has been a huge positive. There's been a huge breakdown of hierarchal barriers… there was a sense of unity with everybody, and this has continued."

Maxine Page

Recommendations

3. Surgical skills training and re-acclimatisation programmes should be established to ensure that staff returning to elective teams from critical care are supported in a professional and personal capacity.

4. The NHS should undertake a strategic review of training and development needs for NHS staff working in elective care departments, outlining programmes which can be supported by industry partners.

When understanding how to reduce the backlog in elective care, one of the most critical components to consider is the workforce. Without a workforce that feels safe and motivated in their place of work, opportunities to improve efficiency in surgeries and on wards are far more limited. Recovering elective care relies on the optimisation of processes across healthcare settings, and fundamentally, it is staff that are responsible for delivering these successfully.

However, there is significant concern about staff burnout in the NHS. A survey conducted following the first wave of the COVID-19 pandemic found that 99% of trust leaders were concerned about the level of burnout among their workforce,[19] and lack of a chance to "reset" from the crisis ahead of the second wave were also highlighted as a key issue.[20] One assessment even suggested that staff working with patients with COVID-19 were 70% more likely to develop both acute and post-traumatic stress disorder or to suffer from psychological distress.[21]

The impact of COVID-19 on the workforce has served as a catalyst for broader action to promote staff wellbeing across the healthcare system. This notably materialised in the NHS People Plan,[22] which was delivered in July 2020 following the first wave of the pandemic. Among its key conclusions, the People Plan called for new flexible ways of working to improve training opportunities, and a supportive and inclusive culture that can ensure staff are safe, both physically and psychologically. In addition to this, the Government has launched a "landmark" review into health and social care leadership, which aims to "foster and replicate the best examples of leadership" and reduce regional disparities in efficiency and health outcomes across the country.[23]

Many of these concerns were echoed by the participants of our roundtable. There was a clear sense that COVID-19 has led to a shake-up across the health service, with significant redeployment across services to manage the stress that was placed on the NHS. In order to effectively recover elective care, participants noted that staff need to mentally return to a position where they can be theatre practitioners again – not only through reacquainting themselves with the skills needed in the operating theatre, but also returning to a point where they feel comfortable in this environment. To achieve this, NHS Providers have called for organisations to be flexible to different working patterns,[24] and have emphasised that hospital management must find ways to facilitate staff who have moved around departments and gained new skills or require re-training. Indeed, roundtable participants stressed that staff wellbeing must be central to any plan for recovery.

This renewed focus on workforce needs is welcome, but it requires support from actors across healthcare to ensure it can best serve the needs of staff, and by extension, the system itself. Trust leaders must continue to engage with HCPs and administrative staff to understand their needs, and any gaps in support. Industry can play an important role here, by providing the educational tools that can give staff the additional training opportunities they need, whilst simultaneously alleviating pressure on the whole system by ensuring that staff feel equipped and comfortable in their roles. For this to be effective, healthcare management and industry must work together to design and create tools with HCPs in mind and integrate these into training programmes across hospitals.

"A survey conducted following the first wave of the COVID-19 pandemic found that 99% of trust leaders were concerned about the level of burnout among their workforce"

Planning for Elective Care

"There's a lot to be done to optimise patients for surgery. We've got evidence that shows we can reduce complications by 30-50% if you prepare patients better, and you can reduce length of stay by 1-2 days."

Professor Scarlett McNally

Recommendations

5. The Government should consider implementing a programme to establish dedicated day surgery units and teams, in line with the recommendations of the National Day Surgery Delivery Pack and GIRFT best practice guidance on hot and cold sites for operations.

6. New guidelines should be established to use shared decision-making to prepare patients in secondary care settings, to support surgical teams to adjust elective care waiting lists in a way that is reflective of patient need.

The current situation provides an opportune moment to consider how hospital trusts and regional system leaders can rebuild the elective care architecture, to maximise their resources and ensure that surgeries are less affected by external circumstances.

One of the ways this can be achieved is through an increased focus on day case surgeries. Participants at our roundtable emphasised the potential that day case surgeries can have in helping to recover the elective care backlog, as they allow hospitals to get through more surgeries in one day. As the peaks of the pandemic thus far have shown, allocating beds to patients can cause significant problems in acute care, particularly at times when COVID-19 hospitalisations are heightened. Therefore, there is a need to optimise both the system pathways for surgery, and the patients themselves. This aims to reduce the chances of complications and distress to the patient, whilst simultaneously decreasing the pressures on beds.

There are several ways to promote day case surgery as a default, and therefore allow hospitals to plan surgeries that are more efficient and reduce risk to patients. One of our roundtable participants, Professor Scarlett McNally, spoke about how hospitals can adjust pathways to plan more effectively for elective care. She argued that "people are seeing [the elective care backlog] as "this is a number of patients who need to be got through a system, rather than seeing how we can adapt the system and adapt the patients to get through better". Further to this, she noted that there is "evidence that shows we can reduce complications by 30-80% if you prepare patients better, and you can reduce length of stay for 1-2 days".[25]

Preparing patients for surgery can be promoted through shared decision-making with secondary care teams and through group surgery schools.[26] As noted by our roundtable participants, optimising patients for surgery is a key aspect of getting elective care back on track: assessing and preparing the patient in a secondary care setting and encouraging shared decision-making can not only improve patient outcomes in the operating theatre but allow surgical teams to adjust elective care waiting lists by patient need. This is where technology can act as a real asset to reducing the elective care backlog, by providing the tools to triage patients based on their clinical need or offer remote support to conduct pre-habilitation for patients.

Returning to the way elective care was managed before the pandemic is not going to drive down the backlog at that rate that is needed to reduce pressure on the NHS and support the COVID-19 recovery. Trust leaders must take a whole-system approach to reducing the backlog, considering how partnerships between providers and the use of innovative technologies can improve surgical efficiency and patient outcomes.

CASE STUDY:

Reducing the backlog at Northumbria Healthcare NHS Foundation Trust

One example of where a trust has effectively managed its elective care backlog to improve patient outcomes is Northumbria Healthcare NHS Foundation Trust, which introduced a successful programme of measures to reduce waiting times for patients. To do so, the trust examined the patients on the waiting list for treatment, prioritising patients by clinical need, as well as using experts on population health and inequalities to ensure resources were directed in the right places.[27] Northumbria also set up enhanced advice and guidance as part of managing waiting lists, to help improve communication between primary and secondary care.

As part of this, consultants' job plans were revised to allow dedicated time to review requests and feedback from patients, ensuring that the patient journey is progressed through advice, not "binary decisions". Data released in June 2021 shows that both Northumberland and North Tyneside Clinical Commissioning Groups (CCGs) are among the 10 CCGs with fewest patients waiting for orthopaedics more than 52 weeks.[28] They also had just one patient who waited more than 18 months and none waiting more than two years–- all of these figures represent among the best in England.

Innovation and Efficiency

"I hope the NHS funding deal provides more conditions for value-based procurement decisions to take place"

Siva Anandaciva

Recommendations

7. Standardisation of elective care processes should be undertaken at a regional level to allow intra-trust collaboration in reducing elective care numbers.

8. A national NHS Task and Finish group should be established to explore the potential for greater implementation of value-based procurement models in reducing the elective backlog.

Another important factor in addressing the elective backlog and reducing pressure on staff is the introduction of innovative technologies and processes across the patient pathway through the operating theatre and into recovery. Innovation can be utilised in a variety of different ways to ensure that surgeries are undertaken more efficiently, in a safer manner, and with better outcomes for patients and staff alike. From using data to help system leaders and clinicians make more efficient choices, through to remote consultations so patients can continue their recovery at home, technology and innovation can have a positive impact for the health system, for clinicians, and for patients.

An example of how technology could support in reducing waiting times for elective care is by decreasing the amount of time surgical staff spend providing face-to-face support or triaging of patients. Remote consultations, used in both primary and secondary care settings from the onset of the pandemic, can play a role in prehab, and free up surgeons' time, which can then be spent operating on patients. Moreover, this technology can also help identify which patient should be operated on, at what time. Instead of a patient being treated based on their place on the waiting list, clinicians could be empowered to make decisions on who to operate on based on clinical need. However, participants at the roundtable were keen to emphasise that shared decision-making must underpin this triaging process.

Technology and data could also be employed across trusts to identify where the longest waits for certain types of surgeries are. For example, it may be the case that a wait for one particular surgery at one trust is six or ten months, the same procedure may only have a two week wait in the same local area. While acknowledging that the introduction of such innovation might not immediately impact on waiting lists, there is an opportunity that over the medium-to-long term technology has a role to play. Technology can't fix everything, however it can help to significantly optimise processes. For this to be effective, roundtable participants agreed there needs to be standardised education and guidelines to empower staff, and make the most of what technology has to offer in reducing the backlog.

There is therefore a clear need to adopt a 'whole system' approach to tackling the elective care backlog, in which every actor in the healthcare system has a role to play. One of the core themes that emerged from our roundtable concerned the need to develop a standardisation agenda, to reduce variation in waiting list times and patient outcomes. This means developing a clear set of guidelines for clinicians based on best practice, so that elective care processes do not differ significantly across trusts. It also means ensuring that procurement teams are purchasing high-quality equipment and technologies that can drive efficiencies in the operating theatre and across patient pathways, alleviating pressures on staff and optimising outcomes for patients.

Participants from our roundtable agreed that increased standardisation of products and services is a crucial step in reducing the backlog. They called for a more nuanced conversation on standardisation, emphasising that this does not necessarily imply greater centralisation, but can instead be led at a sector or local level. Participants also discussed how clear guidance can help to empower healthcare professionals, by giving them clear protocols to follow and ensure that everyone is "telling the same story". Consistent use of high-quality equipment can also facilitate this, and so it is vital that product value is prioritised in the COVID-19 recovery.

While it may be tempting to economise on surgical tools and equipment in order to save money, participants highlighted the need to be less reactive to the crisis, and instead focus on making decisions that will enable safer surgeries in the long term. By prioritising overall product value over cost, and standardising this across hospitals, trusts can reduce local variation and ensure that surgical teams are equipped with the best equipment to improve patient outcomes and, consequently, drive down the backlog of surgeries.

To achieve this, hospital management and industry must work together to ensure that the structures are put in place to facilitate value-based procurement, and that the right tools are being developed to improve efficiencies in the operating theatre. Indeed, roundtable participants noted that the conversation should begin by identifying the problem and designing a solution around it: this is why engagement between trusts and industry is crucial in recovering the backlog, to ensure that these tools are maximised to best support surgical teams and healthcare staff.

CASE STUDY:

Driving efficiencies at the Queen Elizabeth Hospital Birmingham

Industry is uniquely placed to support trusts to reduce the elective care backlog, by working with surgical teams and healthcare staff to understand their needs and where efficiencies can be improved. At the Queen Elizabeth Hospital in Birmingham, Mölnlycke's Operating Room Efficiency Partnership Programme (OREPP) helped teams to identify where efficiency improvements could be made, helping to increase the number of procedures and reduce staff overtime.[29] The use of the customisable OREPP report allowed procurement to identify essential cost and time savings for the hospital, demonstrating how industry can support trusts to recover the elective care backlog.

Considerations for Future Research

During and following the roundtable, several of our participants highlighted areas in which the elective care recovery would benefit from further research investigation. We have outlined our five suggestions for future research below, and look forward to exploring these in greater detail as we collaborate with partners across the health system to recover elective care procedures in the NHS.

- Long-term improvements vs short-terms gains: Many health systems within the NHS are grappling with how to balance the competing demands of a long-term focus on population health improvement and the short-term priority of increasing elective throughput. Further consideration should be given to how elective care services can be restored inclusively so no population cohort is left behind.
- The value of prehab: Prehabilitation services can support patients to be in the best possible physical shape before their procedure to support with post-operative recovery. Further consideration should be given to i) how to embed prehabilitation more effectively into surgical pathways, and ii) the level of patient interaction within prehabilitation programmes – for example utilising new technologies such as an app, or more personalised services.
- Travel for procedures: Roundtable attendees highlighted the potential for suitable patients to travel further afield than their local or planned centre. However, further work is required to gauge patient views on the level of support for this amongst patient demographics, the distance they are willing to travel, under what conditions, and how this could benefit their recovery.
- Sharing best practice: Understanding how best practice can be shared across hospital trusts was one of the key discussion points during the roundtable. Further research is required to gain a greater understanding of how successful elective care teams can support underperforming units to improve care through sharing best practice, and the organisational structures that can most effectively support trusts to do this.
- The Governance of the elective recovery programme: With so many departments and bodies within the Government and NHS contributing to the elective backlog recovery, further consideration must be given to the optimal way to ensure that competing messages, interests and resource funds can work together effectively between departments.

Conclusion

This report has highlighted that there is still much to be done to drive the recovery of elective care. Whilst by no means the end of the conversation, we hope that the findings and recommendations of this Recovering Elective Care report will provide some of the next steps to support the NHS's staff as they work to drive down waiting lists. Stakeholders across the UK, not least at Mölnlycke, have a role to play, from delivering new training programmes, supporting in the standardisation of practices and procedures, delivering high-quality equipment and technology, and sharing best practice across the system. It is essential we all play our part in supporting the health service to recover from one of the most significant challenges it has faced, for patients, staff and future generations.

Based on the evidence reviewed in the report, alongside the examples of best practice and reflections made by leaders in elective care, this report offers the following recommendations to help recover elective care:

1. Working groups should be created within hospital trusts to establish new protocols and ways of working based on best practice organisational improvements to elective care departments. This could include supporting measures, technologies and processes that have been demonstrated to drive organisational and operating efficiency, and the working groups should be driven forward by trust leaders.
2. Guidelines on shared decision making should be developed to ensure greater access to acute surgery, with further consideration given to greater patient choice and participation (in line with the GIRFT report, 'Post-COVID Elective surgery Recovery & Transformation').
3. Surgical skills training and re-acclimatisation programmes should be established to ensure that staff returning to elective teams from critical care are supported in a professional and personal capacity.
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7. Standardisation of elective care processes should be undertaken at a regional level to allow intra-trust collaboration in reducing elective care numbers.
8. A national NHS Task and Finish group should be established to explore the potential for greater implementation of value-based procurement models in reducing the elective backlog.

References

1 NHS England and NHS Improvement. Board meetings in common – operational performance update. 2021. Available from: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/10/Aug22-RTT-SPN-publication-version.pdf

2 The Health Foundation. Longer waits, missing patients and catching up: How is elective care in England coping with the continuing impact of COVID-19? 2021. Available from: https://www.health.org.uk/news-and-comment/charts-and-infographics/elective-care-how-has-covid-19-affected-the-waiting-list

3 Nuffield Trust. Elective Care. 2019. Available from: https://www.nuffieldtrust.org.uk/news-item/elective-care

4 NHS England and NHS Improvement. Board meetings in common – operational performance update. 2021. Available from: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/10/Aug22-RTT-SPN-publication-version.pdf

5 Ibid.

6 Ibid.

7 Department of Health and Social Care. Platform to improve transparency on wait times and provide additional patient support. 2022. Available from: https://www.gov.uk/government/news/platform-to-improve-transparency-on-wait-times-and-provide-additional-patient-support

8 NHS England. New NHS clinical leadership to support post-COVID challenges. 2021. Available from: https://www.england.nhs.uk/2021/09/new-nhs-clinical-leadership-to-support-post-covid-challenges

9 NHS England. NHS's £160 million 'accelerator sites' to tackle waiting lists. 2021. Available from: https://www.england.nhs.uk/2021/05/nhss-160-million-accelerator-sites-to-tackle-waiting-lists/

10 The Health Foundation. Elective care in England: Assessing the impact of COVID-19 in 2020 and where next. 2020. Available from: https://www.health.org.uk/publications/long-reads/elective-care-in-england-assessing-the-impact-of-covid-19-and-where-next

11 Ibid.

12 Department for Health and Social Care. Government launches landmark review of health and social care leadership. 2021. Available from: https://www.gov.uk/government/news/government-launches-landmark-review-of-health-and-social-care-leadership

13 Derbyshire. NHS waits: More people feeling forced into private healthcare. 2021. Available from: https://www.bbc.co.uk/news/health-58680153

14 Cabinet Office. Guidance: COVID-19 Response: Autumn and Winter Plan 2021. 2021. Available from: https://www.gov.uk/government/publications/covid-19-response-autumn-and-winter-plan-2021/covid-19-response-autumn-and-winter-plan-2021

15 National Institute for Health Research. Multi-morbidity predicted to increase in the UK over the next 20 years. 2018. Available from: https://evidence.nihr.ac.uk/alert/multi-morbidity-predicted-to-increase-in-the-uk-over-the-next-20-years/

16 Centre for Perioperative Care. Shared Decision Making Hub Launched. N.D. Available from: https://cpoc.org.uk/shared-decision-making-hub-launched

17. Tanner J, Khan D, Aplin C, Ball J, Thomas M, Bankart J. Post discharge surveillance to identify colorectal surgical site infection rates and related costs. J Hosp Infect 2009;72:243-250

18 Getting It Right First Time. GIRFT SSI National Survey. 2019. Available from: https://gettingitrightfirsttime.co.uk/wp-content/uploads/2017/08/SSI-Report-GIRFT-APRIL19e-FINAL.pdf

19 NHS Providers. The State of the NHS Provider Sector. 2020. https://nhsproviders.org/the-state-of-the-nhs-provider-sector-2020

20 Health and Social Care Select Committee. Workforce burnout and resilience in the NHS and social care. 2021. Available from: https://publications.parliament.uk/pa/cm5802/cmselect/cmhealth/22/2207.htm#_idTextAnchor052

21 The Royal College of Psychiatrists. Written evidence WBR0031. 2021. Available from: https://committees.parliament.uk/writtenevidence/11010/pdf/

22 NHS England. We are the NHS: People Plan 2020/21 – action for us all. 2021. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf

23 Department of Health and Social Care. Leadership for a collaborative and inclusive future. 2022. Available from: https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future

24 NHS Providers. Addressing the care backlog: An essential partnership between primary and secondary care. 2021. Available at: https://nhsproviders.org/addressing-the-care-backlog

25 Centre for Perioperative Care, 2020. CPOC Publishes Major evidence review on the "Impact of perioperative care". Available at: https://cpoc.org.uk/cpoc-publishes-major-evidence-review-impact-perioperative-care

26 McNally, S et al, 2020. Preoperative assessment and optimisation: the key to good outcomes after the pandemic. British Journal of Hospital Medicine, 82(6). Available at: https://www.magonlinelibrary.com/doi/full/10.12968/hmed.2021.0318

27 Northumbria NHS Trust. Focus on inequalities as key part of tackling backlog. 2021. Available from: https://www.northumbria.nhs.uk/media-centre/news-and-blogs/news-stories/focus-inequalities-key-part-tackling-backlog#3d429f05

28 Ibid.

29 Mölnlycke UK. 2019. Driving efficiencies in the operating theatre. [on file]

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