



Centre for
Perioperative Care

Tackling the elective surgery backlog

Perioperative care solutions
to the waiting list

Key findings from polling of health and care system leaders

- System leaders state that it will take at least two years to return elective care waiting lists to pre-pandemic levels if current support and funding levels remain the same. 1 in 5 leaders believe it will take over five years.
- More than three-quarters (77%) agree that integrated perioperative care services will help local NHS waiting lists
- Leaders say the most effective perioperative care interventions at reducing waiting times in their local area will be:
 - increased proportion of routine operations performed as **day cases**
 - implementation of initiatives to **reduce time spent in hospital**
 - promotion of effective **shared decision-making**.
- Only 16% of leaders say their local health system provides **quality** perioperative care across the whole surgical pathway. Even fewer (10%) say their local health system provides **efficient** perioperative care.
- Over three-quarters (78%) believe their local health system needs to improve perioperative care
- Only 9% agree that current funding is sufficient to deliver quality perioperative care in their local health system
- While almost half (48%) agree their local NHS has good multidisciplinary working, almost a quarter disagree (23%)
- Looking beyond Covid, to deliver the NHS Long Term Plan leaders think **joining up primary and community services** (56%) and **improving out of hospital care** should be prioritised (41%).
- Leaders told us that the most important thing their local health system could do to support the delivery of perioperative care is to:
 - Increase **patient empowerment and involvement** in their own care.
 - encourage a greater focus on **patient preparation** before surgery.

Recommendations

- 1** To beat the backlog, we're calling on the forthcoming **elective delivery plan to include dedicated funding for the development of truly joined-up perioperative care pathways**. We propose the funding be dedicated to perioperative care interventions which will most help streamline elective activity, which includes investment in making day case surgery the default option for more routine procedures, implementing initiatives – such as prehabilitation programmes – which will reduce time spent in hospital, and supporting patients and clinicians to take part in Shared Decision-Making.
- 2** Supporting and developing the existing multidisciplinary perioperative team will be essential to the elective recovery. The UK Government and devolved governments should work with Health Education England, equivalents in the devolved nations, and relevant third sector partners, to **prioritise the training and development of the multidisciplinary perioperative workforce**.
- 3** The elective recovery must be underpinned by an NHS-wide commitment to fundamentally **transform the 'waiting list into a preparation list'**. This will allow patients to be fully supported in using the waiting period proactively to improve their health, make informed decisions, and prepare physically and mentally for their operation or other treatment and recovery.

Introduction

'Perioperative services give an efficient and effective way to deliver what the patient needs - right place, right person, right time, right platform.'

Research participant, Health and Wellbeing Board Chair

Perioperative care is the integrated care of patients before, during, and after an operation. It is a highly cost-effective way of improving outcomes for the millions of patients who have surgery on the NHS every year, delivering benefits that matter to them and their families – more patient choice, better quality of care, and extra years spent in good health.

As the backlog of elective care continues to grow to unprecedented levels, there is an emerging consensus that the NHS cannot return 'to the same old ways of doing things' if it hopes to turn the corner on this challenge in a timely, safe, and sustainable way while still striving towards a more personalised, patient-centred service.¹ There has to be a new way forward.

The Centre for Perioperative Care (CPOC) exists to help create that new future through the development and promotion of good perioperative care pathways. At CPOC, we've assembled a coalition of partners working across the entire surgical pathway who are ready to make this change happen. When it comes to the backlog, evidence we've gathered shows that perioperative can accelerate the pace of elective surgery in several important ways - by reducing late or on the day cancellations of surgery, reducing length of hospital stay by on average 1-2 days, reducing time spent in theatre and in critical care wards, and reducing the overall use of surgery.²

Despite pockets of excellence and a strong evidence base about 'what works', integrated perioperative pathways are not yet core practice across NHS organisations or Integrated Care Systems and there is wide variation in delivery. The NHS will not be able to, in the words of the Health Secretary, 'bust the backlog' in a reasonable time frame if it does not fully grasp the opportunities for greater efficiency and more joined-up services that good perioperative care can provide.³

To help us better understand those opportunities and see where potential challenges may be on this agenda, we worked with polling experts Savanta ComRes to interview 79 health and care leaders working across the entire system and in national level leadership positions across the UK. Over June and July 2021, we asked them a range of questions about their system's ability to recover elective services and how they believe perioperative care could most help this challenge in the here and now, as well as in the long-term.

In this paper we present the headline findings from that research, combined with brief analysis and recommendations for future action. With these findings we hope to shape what we think is a very necessary national dialogue about the scale of the backlog challenge ahead and how the NHS, by prioritising perioperative care, could tackle it. As one participant in our research told us: *'There are difficult choices ahead, but now is the time for us to be bold.'*

1 Context – how long will it take the NHS to recover elective services if nothing changes?

There are now over 5.5 million people waiting for surgery on the NHS, with over 300,000 waiting longer than one year. This is about equivalent to 10% of England’s adult population. Worryingly, the number of ‘long waiters’ is now 100 times higher than it was at the start of the pandemic and NHS data is showing that over 300,000 patients have waited more than six weeks for key diagnostic tests, such as ultrasounds or MRIs.⁴

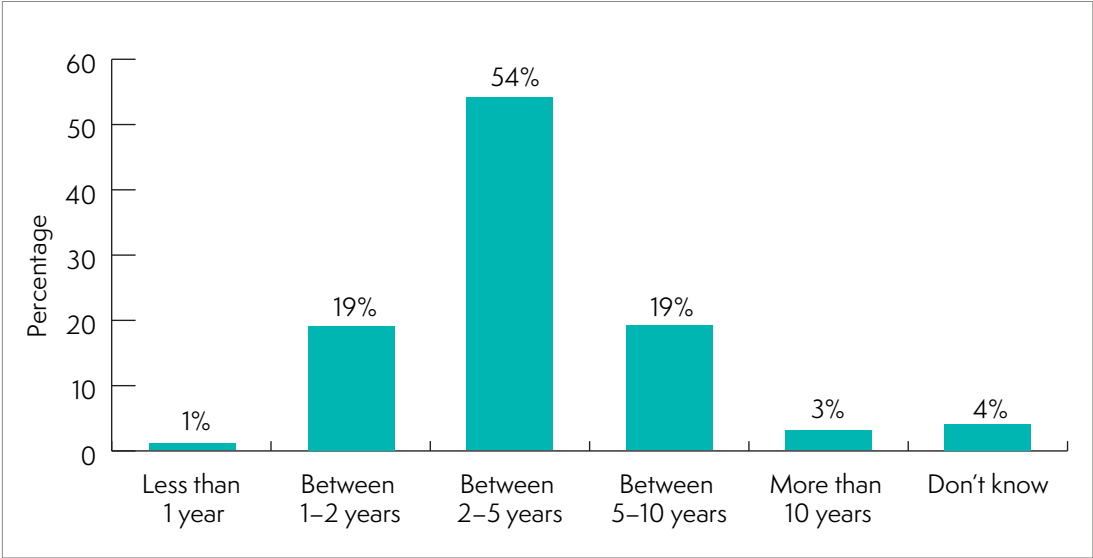
Due to the commitment and expertise of NHS staff, the NHS is making up some ground quickly, with indicators suggesting that elective activity has now reached four-fifths of where it was pre-pandemic.⁵ But since there are so many moving parts and variability across regions, there is now a considerable degree of uncertainty over how long it will take the NHS to recover.

Various organisations, from think tanks to trade unions, have projected that it could take anywhere from two years to over a decade under a range of different future scenarios for services to make up lost ground. The Prime Minister has just tasked the NHS with accelerating elective activity to 30% over pre-pandemic levels in three years – a goal that many believe is undeliverable within current resource and staffing constraints.

We wanted to have a better understanding of what leaders on the frontline of services think when it comes to how long they believe their local system will take to recover their waiting times. The vast majority of respondents to our survey (95%) suggest that, on current trajectories, it will take at least two years at least to return their local elective care waiting list to pre-pandemic levels. Very worryingly, 22% believe it will take over five years.

Long waiting times can do harm to patients, as patients may experience additional pain, distress, and anxiety and their condition can deteriorate. Additionally, with polling showing that addressing waiting times is the number one health priority for the public, a waiting list crisis that lasts for several years is politically intolerable.

Q: With current support and funding levels, how long do you believe it will take your local NHS to return its elective care waiting list to pre-pandemic levels?



2 Perioperative care solutions

We wanted to explore whether or not health and care leaders, regardless of their direct involvement in perioperative care, view delivering better perioperative interventions as something that will help their local system address its backlog. We found that more than three-quarters (77%) of leaders in our poll agree that integrated perioperative care services will help their local NHS better manage elective waiting lists, with only 5% disagreeing.

While there is broad agreement across settings for this idea, those working in adult social care and local authority settings were less likely to agree than those employed directly in trusts. As the system moves more towards place-based planning, this finding suggests that there is more to be done to make the case for the benefits of perioperative care to partners working outside of NHS settings.

Q: To what extent do you agree with the following statement: integrated perioperative care pathways will help my local NHS manage its waiting list

Responses based on work setting

	Overall	STP / ICS	CCG	PCN	Acute trust	Community trust	Mental health trust	NHSE	Local authority	Adult social care
Net: agree	77%	74%	75%	82%	85%	86%	75%	75%	68%	57%
Net: disagree	5%	4%	0%	6%	4%	0%	0%	0%	4%	7%

Which perioperative care interventions do leaders believe can most help tackle the backlog?

Perioperative care involves many components along the surgical pathway, including multidisciplinary team working, shared decision-making between patients and their healthcare team, supporting people to prepare for surgery, examining factors that might increase the risk of complications, using safe and effective processes during surgery, proactive discharge planning, and helping people to recover after their surgery.

We wanted to explore which components system leaders think would be most impactful in helping them get through their backlog over the next 1-2 years. We presented leaders with a ‘long list’ of interventions and asked them to prioritise their ‘top 3’. The top 3 they identified were: increasing the use of **day case surgery**, supporting initiatives that **reduce length of stay** in hospital, and supporting **shared decision-making**.

Q: Which, if any, of the below are likely to be most effective over the next 1-2 years in helping to reduce the current length of NHS waiting lists in your local area? Select your top three

- 1 Increasing the use of day case surgery (54%)
- 2 Supporting initiatives that reduce length of hospital stay (49%)
- 3 Helping patients choose the best option for them through Shared Decision-Making (42%)

For the full list please see the complete survey data tables published by Savanta ComRes, which can be accessed on their website.

Increasing the use of day case surgery

Day case surgery is surgery that is conducted without an overnight stay. Increasing the proportion of day surgery to overall elective surgery is one of the simplest strategies that the NHS can employ to streamline elective services. Currently rates of day case surgery vary considerably by trust, hospital, and surgical specialty – some report only 36%-day case admissions, while others report as high as 77%. In some instances, neighbouring trusts with similar facilities and patient demographics are performing very differently.⁶

Reducing the backlog requires making day surgery the default option for more routine elective procedures across all specialties. We already know how to do this. Implementing new guidance from CPOC, GIRFT, and BADS could halve the numbers of elective patients who currently stay in hospital overnight – this would be transformative for elective capacity.⁷

Supporting initiatives that reduce length of stay in hospital

Perioperative care pathways and their components reduce the amount of time that people stay in hospital after surgery by on average 1-2 days without extra complications, unplanned readmissions or extra burden on primary care or social services. Specific interventions that have an impact on length of hospital stay include good preoperative assessment⁸ (including surgery schools), prehabilitation programmes to help patients physically and mentally prepare for their operation, and the use of enhanced care units to provide an appropriate level of support for patients in the immediate post-operative period.⁹ It is noteworthy that the leading cause of cancellation of surgery on the day is a lack of a bed, so every reduced length of stay benefits all patients.

Shared decision-making

Shared decision-making (SDM) is the process whereby patients and clinicians work together to decide the best treatment option based on evidence and the patient's wishes and values. This may be to select a test or intervention, such as going ahead with surgery. Patients who are effectively involved in making decisions about their care have fewer regrets about treatment, better reported communication with their healthcare professionals, improved knowledge of their condition and treatment options, better adherence to the selected treatment and an overall better experience with improved satisfaction. As 1 in 7 patients experience 'surgical regret', getting shared decision-making right is essential to high quality care.¹⁰ With increasing numbers of patients having multiple medical conditions and at higher risk of complications, it is important that the patient's views are listened to. This requires specific training and work practices.

How effective is the NHS currently at delivering perioperative care?

“Proper perioperative care is underfunded at present and this needs to change.”

Research participant, Associate Medical Director

We asked leaders a series of questions to assess the effectiveness of their local system at delivering integrated perioperative care services. We found that only 16% of leaders say that their local health system provides high quality perioperative care across the whole surgical pathway and even fewer (10%) say that their local health and care system provides efficient perioperative care. Based on these views, it is not surprising that over three quarters (78%) of leaders agree that their local health system needs to improve the quality of its perioperative care services.

We also asked leaders to assess why their local system might be having some a challenging time delivering high quality perioperative care. A lack of funding was identified as a key barrier, with only 9% agreeing that current funding levels are sufficient within their local system. Another key barrier highlighted in this research is leadership and visibility at a local level on this agenda, with only 23% of respondents agreeing that their local system has strong perioperative care champions and just under half (46%) agreeing that perioperative care is core to the services that their system provides.

Looking forward

‘Excellent idea both for patients and the NHS, and our System is keen to implement this, but as always the biggest obstacle is to find the resources (human and financial) to implement what is undoubtedly - the right thing to do.’

Research participant, Clinical lead

These findings show that while perioperative care interventions are widely seen as key parts of the solution to tackling the elective backlog sustainably, most are not delivered as effectively or efficiently as they could be. Leaders have identified which interventions will most help them reduce their backlog but have highlighted that current funding levels are woefully inadequate to enable them to do so.

The Government has just announced a multi-year funding settlement for tackling the elective backlog, allocating an additional £10 billion to deliver around 30% more elective procedures by 2023/25 than before the pandemic. This injection of additional, ring-fenced funding is welcome, but estimates show that it is unlikely to be enough to return waiting lists to pre-pandemic levels. Meeting the Government’s three-year target requires the NHS, and the entire health system, to start doing things differently.

We think the priorities identified by system leaders in our poll present a clear and useful steer for policymakers regarding future investment in targeted elective recovery interventions. We are now calling on the forthcoming elective delivery plan to include dedicated funding for the development of truly joined-up perioperative care pathways, with the patient at the centre.

Recommendation 1

To beat the backlog, we’re calling on the forthcoming elective delivery plan to include dedicated funding for the development of truly joined-up perioperative care pathways. We propose the funding be dedicated to perioperative care interventions which will most help streamline elective activity, which includes investment in making day case surgery the default option for more routine procedures, implementing initiatives – such as prehabilitation programmes – which will reduce time spent in hospital, and supporting patients and clinicians to take part in Shared Decision-Making.

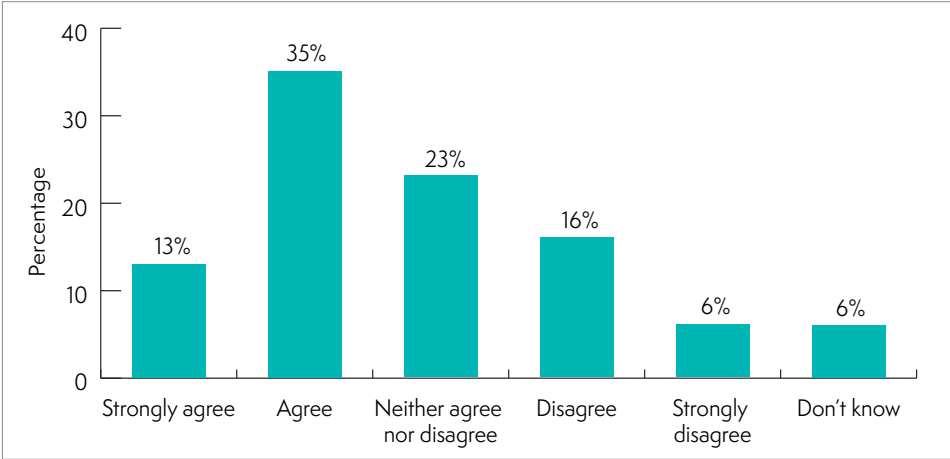
3 Multidisciplinary working

'We need to get better at working together as a team – primary care, secondary care and community care – and take ownership 'this is our problem' not any one individual organisation.'
 Research participant, Clinical lead

Multidisciplinary working, whereby professionals from different specialties and sectors work together to support the patient at every step of their journey, is the cornerstone of effective, high quality perioperative care. Evidence shows that good multidisciplinary working can speed access to surgery (if that is decided as an appropriate treatment plan), improve clinical outcomes, and help people leave hospital earlier – all vital to helping tackle the backlog and delivering a more personalised service.¹¹

When we asked health leaders whether or not they believed their local health system had good multidisciplinary working only around half (48%) agree, suggesting there is a lot more to be done to make this aspiration a reality.

Q: My local NHS and health system has good multidisciplinary working



Barriers and enablers to good multidisciplinary working

We also asked leaders to assess the top barriers and enablers to good multidisciplinary working. Broadly the top barriers and enablers identified directly mirrored each other, with IT systems, leadership, and expectations among team members flagged as essential considerations.

Top barriers	Top enablers
<ul style="list-style-type: none"> ■ Incompatible IT systems (51%) ■ Policy makers, funders, and managers not understanding the benefits of multidisciplinary team working (39%) ■ Unclear or differing expectations about the role of various team members (39%) ■ Resistance to change or lack of buy in from team members (33%) ■ Lack of ring-fenced time (28%) ■ Not including patients as part of the team (27%) ■ Lack of clear guidelines and processes (15%) ■ Lack of administrative support (11%) ■ Lack of robust measurement and reporting to track over time (9%) 	<ul style="list-style-type: none"> ■ Leadership at a systems level and at an operational level (53%) ■ Standard care pathways so that everyone is working with the same expectations (48%) ■ IT systems that allow data sharing across teams (43%) ■ Having pathway coordinators/ liaison people for patients with clear role descriptors (32%) ■ Inclusion of patients and/or patient advocate partners (25%) ■ Training in teamwork and communication (18%) ■ Beginning to work collaboratively within 24 hours of hospital admission (16%) ■ Access to technology for virtual meetings (14%) ■ Clinical governance (9%)

Looking forward

Creating an adaptable, generalist and more multidisciplinary team are key objectives in NHS and health system strategies, ranging from the NHS People Plan, to HEE's Future Doctor report, to a Healthier Scotland. These plans are unequivocal that this aspiration is a 'must have' in order to deliver more joined-up care for patients and is a vital part of how the NHS is going to address its long-standing workforce challenges, including around retention and recruitment.

According to our research participants, there are considerable barriers to multidisciplinary working and only around half believe that their local system is doing it effectively. We welcome HEE's plans to update its existing framework for the long-term development of the health and care workforce as an opportunity to reshape the future health system in a more multidisciplinary mould.¹² In a similar vein, CPOC is also working with HEE to develop a new credential in multidisciplinary working as a first step to supporting the workforce to embrace this new way of working. In the long-term, the NHS will also require a new workforce plan, underpinned by an independent assessment of staffing requirements, for this agenda to be fully realised.

However, in the short to medium term, we believe that HEE and devolved equivalents should prioritise workforce training and development needs directly related to the elective recovery and access to surgery. We encourage the UK Government, and devolved Governments, to work with their relevant workforce bodies and third sector partners, including CPOC, to prioritise the training and development of the multidisciplinary perioperative team.

Recommendation 2

Supporting and developing the existing multidisciplinary perioperative team will be essential to the elective recovery. The UK Government and devolved governments should work with Health Education England, equivalents in the devolved nations, and relevant third sector partners, to prioritise the training and development of the multi-disciplinary perioperative workforce.

4 Transforming waiting lists into preparation lists

'For operations to have the best outcomes, people need to be fit going into them. We need a concerted strategy to keep people more physically active and eating more healthily. Many people cannot do that on their own, no matter how often you tell them, so we have to think of strategies to help. These need to be as diverse as encouraging more active travel (walking and cycling) and stopping fast food outlets from opening.'

Research participant, Local Authority Director of Public Health

At CPOC we believe that while all efforts should be made to reduce waiting times, the elective recovery should also be underpinned by an NHS-wide commitment to fundamentally transform not just 'how long' patients wait, but 'how' patients wait. This ethos is supported by system leaders, who told us that the top two factors they believed most needed to change to support better perioperative care are a **revolution in patient empowerment and involvement** in their own care and an **upgrade in patient preparation**. Without this paradigm shift, system leaders are clear that patients will not have the best outcomes and lags in the system will persist.

We believe that the period leading up to an operation must be used to actively help patients prepare for their procedure and to empower patients to make good decisions based on what matters most to them. This kind of support during the waiting period is vital for the elective recovery for a variety of reasons, including that one of the leading causes of late or on the day cancellations of surgery is because the patient is not fit for their operation.

By treating the 'waiting list' as a 'preparation list' we can help reduce those late cancellations – alongside also reducing postoperative complications, reducing the time patients stay in hospital, and helping people get back home and back to their lives sooner.¹³

We can also help provide the support that patients are saying they would like to have while they wait. A recent National Voices report reveals that patients characterise the waiting period as being 'in no man's land' and say they are 'being abandoned by the system.'¹⁴ In short, patients are not just dissatisfied with the time they spend waiting – they are dissatisfied by the lack of support, lack of communication, and lack of information they receive while they wait.

Recommendation 3

The elective recovery must be underpinned by an NHS-wide commitment to fundamentally transform the 'waiting list into a preparation list', whereby patients are fully supported to use the waiting period proactively to improve their health, make informed decisions, and prepare physically and mentally for their operation and recovery.

Appendix

Polling methodology and sample make-up

Savanta ComRes interviewed 79 system leaders in the UK online, between 9 June and 30 July 2021. Respondents are based across a range of settings, with the most common being PCNs (42%), HWBs (37%), local authorities or councils (35%), NHS Acute / Hospital Trusts (33%), CCGs (30%), and STPs or ICSs (29%). These tend to be board members (29%), clinical leads or consultants (25%), or local/regional directors and deputy directors (20%). A selection of other senior leadership also participated, including clinical directors, HWB chairs, councillors, elected cabinet members and voluntary sector CEOs.

References

- 1 [Nick Kituno, Dave West, 'Elective recovery requires "very radical" service change.' Health Service Journal, 14 April 2021.](#)
- 2 [Centre for Perioperative Care \(2020\), The impact of perioperative care on healthcare resource use: rapid research review.](#)
- 3 [HC Oral Questions, 13 July 2021.](#)
- 4 [As of the latest Referral to Treatment Waiting Times \(RTT\) which are published monthly by NHS England. Latest figures cover period up to June 2021.](#)
- 5 [NHS England » NHS's £160 million 'accelerator sites' to tackle waiting lists.](#)
- 6 Figures from forthcoming GIRFT report into perioperative care – we can provide more information if desired.
- 7 [GIRFT, CPOC, and BADS \(2020\) National Day Surgery Delivery Pack.](#)
- 8 [Preoperative Assessment and Optimisation for Adult Surgery, June 2021.](#)
- 9 [Centre for Perioperative Care and Faculty of Intensive Care Medicine \(2020\), Guidance on Establishing and Delivering Enhanced Perioperative Care Services.](#)
- 10 Wilson, Ana & Ronnekleiv-Kelly, Sean & Pawlik, Timothy. (2017). Regret in Surgical Decision Making: A Systematic Review of Patient and Physician Perspectives. *World Journal of Surgery*. 41. 10.1007/s00268-017-3895-9.
- 11 [Centre for Perioperative Care \(2020\), Multidisciplinary working in perioperative care: rapid research review.](#)
- 12 [Long-Term Strategic Framework for Health and Social Care Workforce Planning.](#)
- 13 [Jugdeep Dhesi and Lisa Plotkin, 'To tackle the backlog, we need to transform how we wait for surgery' The BMJ Opinion, 15 April 2021.](#)
- 14 [National Voices \(2020\), Patient, Noun, Adjective: understanding the experience of waiting for care.](#)



Centre for Perioperative Care

The Centre for Perioperative Care (CPOC) is a cross-specialty collaborative of nine leading royal colleges and healthcare organisations dedicated to the promotion, advancement, and development of perioperative care. CPOC's multi-professional centre is hosted by the Royal College of Anaesthetists.

Centre for Perioperative Care
Churchill House, 35 Red Lion Square
London WC1R 4SG

020 7092 1500 | cpoc@rcoa.ac.uk

cpoc.org.uk

© 2021 Centre for Perioperative Care

Information correct as at September 2021