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The delivery plan for tackling the covid-19 backlog of elective care falls short

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Treating the more than six million people currently on the elective waiting list in the UK is a gargantuan task. There are no easy solutions, and the list is likely to get longer before it gets shorter.[1] But the backlog is also a direct result of a poor national response to covid-19, coupled with an NHS that was under resourced, underfunded, and understaffed even before the pandemic.[2] The NHS lacked the right balance of hardware (infrastructure, finance, workforce) and software (management knowledge, skills, trust) or any necessary excess capacity to respond to the shock of the pandemic.[3] A plan to tackle the backlog needed to start from this foundational point. Sadly, NHS England and Improvement's recent plan: *Delivery plan for tackling the covid-19 backlog of elective care,* does not.[4]

By any measure, the extent of the backlog is a serious failure. Patients are suffering physically and emotionally, which contributes to poorer health. Confidence and trust in the system are weakened, and the economic consequences are huge for individuals and society. How we respond to the backlog is therefore crucial. Getting it right will provide a "resilience dividend" of improved future care in both good times and bad times.[5] The plan acknowledges the scale of the problem, recognises it as an opportunity to transform care, and—importantly—recognises the unequal distribution of waiting times: waiting lists in the most deprived areas have grown by 55% whereas those in the least deprived areas have grown by 36%.[6] But the plan fails to acknowledge the legacy of policies introduced over the past decade. It promises to increase elective activity by 30% by 2024-25, but does not acknowledge that before the pandemic, the waiting list grew from 2.9 million pathways in January 2015 to 4.4 million pathways in December 2019.[7] It would, of course, be politically difficult to make such an admission, but avoiding this means the ambitions of the plan start from the wrong place.

Perhaps what is most problematic about the report is that it never defines which health systems it is talking about. The World Health Organisation's broad definition of a health system is one that "comprises all organisations, institutions, and resources that produce actions whose primary purpose is to improve health."[8] The report often uses phrases like "Systems will be expected to . . ." but the boundaries are never defined. Are they hospitals? Integrated care systems? This is important because without that detail, clear underpinning governance cannot be developed.

Information is a focus, but it is not supported by strong governance. In fact, accountability, and governance feature very little. The structure that will oversee how this plan will be delivered is vague. The plan mentions that "integrated care systems will each have plans for their population and for resources required," but there will also be "clear communication from frontline clinical teams to systems . . . supported by a shared understanding of performance and data driven approaches" and "an overarching support offer to rapidly share and scale best practice."[4]

To increase transparency, a patient platform—"My Planned Care"—will have information on procedures and advice for patients while they wait.[4] The plan rightly recognises that accurate information will be key. Knowing which types of procedures and patients are on the list will guide the creation and allocation of resources. For example, open cancer surgery will require more hardware and is likely to be done by a surgeon. An endoscopy, however, allows the possibility of task shifting to nurse specialists. Effective prioritisation and efficient use of resources is a central part of the plan, but multiple players will be involved—among them, the clinical prioritisation programme, elective care boards in each integrated care system, perioperative care coordination teams—and "systems" will be expected to analyse their waiting list data by relevant characteristics.[4] Trying to treat the most urgent and in-need patients is of course the right goal. But the essence of accountability implies answerability, and it is unclear who is answerable for prioritisation.[9] Further, the real risk is that so many siloed programmes working on the same problem will duplicate efforts and create confusion. Stewardship and leadership are not discussed in the plan—this seems like a serious omission.

Many are upset that the plan does not include a clear path to expanding the workforce.[10] England has 2.8 doctors per 1000 people (European average 3.5/1000), with nursing representing the biggest workforce shortage, so who will do all the extra work to reduce the list, they ask?[11 12] There is a desire to recruit more than 10 000 nurses from other countries this year (with little regard on how this will affect those countries) and to make nursing a more desirable career—but few details are provided other than some vague retention plans to tackle this.[4] Task shifting should have an important role in combating the backlog, but it is perceived as an unrealistic panacea. Proposals include 5000 healthcare support workers, accelerating the introduction of new roles like anaesthetic associates and 17 000 NHS reservists.[4] But no consideration is given to who will train them, how decisions will be made on what tasks can be shifted, and what impact this might have on other staffing levels and human resources. A framework that incorporates machines and patients by van Schalkwyk and colleagues advocates for sufficient

planning, transparency, and resources when thinking about task shifting.[13] None of these seem to have been contemplated in this plan.

The creation of new ways of delivering care through "community diagnostic hubs" that aim to increase access to investigations and "surgical hubs" to increase output through carefully selected low-risk, high-volume procedures is welcomed.[4] But the ends are not tied up—there is no discussion here of task-shifting or delegating or what the boundaries will be or how they will be incorporated without taking resources (such as staff) away from other areas in the same health system.

The private sector is here to stay. As ready made capacity, it should and will have a role in tackling the NHS backlog in the short term. But the aim must be to decrease reliance on the private sector by increasing investment and infrastructure in the NHS. No such goal is included in the plan—in actual fact, it paves the way for more private sector involvement. This is ill-judged, given that most evidence suggests that public hospitals are "at least as efficient as or more efficient than private hospitals."[14] The plan needed to reflect more deeply on the mistakes made early in the pandemic when private sector capacity was bulk bought at huge expense and ludicrously left largely empty.[15] However, it does not. Montague and colleagues propose that instead of constraining the private sector's involvement in the public sector, tools should be used to encourage and subsidise them so that quality of care and a focus on equity becomes part of their incentive structure.[16] The approach promoted by the plan does this well.

A common concern about using the private sector is that the same pool of healthcare workers are used, so outsourcing services makes little sense. The report proposes that "systems will have the opportunity to design a joint approach with the independent sector on workforce," but what this means in practical terms is unclear.[4] Such loose language could signal major changes in workforce planning and training. The plan promotes a "patient choice" approach and recognises that the inverse care law is a problem.[17] 54% of private hospital beds are in the south-east of England, but other areas of the country with fewer choices often have higher burdens of poor health and poverty.[15] In an attempt to tackle this, a health inequalities improvement dashboard will allow disparities to be identified. A national network for "long waiters" (people waiting more than two years), overseen by the national NHS team, will give these patients across all regions a treatment alternative.[4] But any patient on the waiting list might understandably question why they would need to wait for two years for this to be possible.

The NHS backlog figure of over six million people is a cold statistic. What it reflects is patients' suffering, disability, and potentially death. Only a cross cutting, inclusive, and equity based health systems approach that is couched in good governance and better information will be able fairly to reduce the waiting list in the short term, while building resilience for the future. As always hardworking NHS staff will do the best they can with this plan. But it has major gaps that will need to be rethought and developed.

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