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To:
- ICB chief executives
- NHS trust and NHS foundation trust chief executives

cc.
- NHS England Regional Directors

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Wellington House
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25 July 2022

Dear colleagues,

RE: Next steps in the recovery of elective services

As the Elective Recovery Plan set out in February, the NHS's first ambition was to eliminate routine elective waits of more than 104 weeks by July 2022, except where due to clinical complexity or patient choice. The strong focus on this objective and the extremely hard work of NHS staff across organisations has led to rapid progress, reducing the number of long wait significantly, and ensuring we are on course to hit the 104 week wait ambition by the end of July. This is despite challenges such as two waves of COVID-19, the recent heatwave, and ongoing pressures in urgent and emergency care and in discharging patients to social care settings.

Our next two performance ambitions are to return the number of people waiting more than 62 days from an urgent referral for suspected cancer back to pre-pandemic levels (by March 2023) and to eliminate routine elective waits of over 78 weeks (by April 2023), alongside increasing activity to above pre-pandemic levels.

As we move into the second phase of the Elective Recovery Plan and build on the significant success so far, the remaining eight months of the year will therefore require a strong operational focus across both overall elective long waits and cancer long waits. As ever, we need to find a way of delivering this with a combination of tried and tested methods alongside new and innovative approaches, as we have seen so much of over the last couple of years.

Suspected cancer patients waiting longer than 62 days

We understand that the challenge in restoring the cancer 62 day backlog to pre-pandemic levels – a reduction in around 14,000 patients – is unique. We need to reduce long-waiters at a time when referral levels for suspected cancer are as high as 120% of pre-pandemic levels and now constitute 1 in every 4 GP acute referrals. We know that solving this challenge, given the high volume of new patients, will involve carving out recurrent additional diagnostic and treatment capacity.

However, whilst challenging, we also know that reducing the 62 day backlog is critically important for our patients. Clinically, the speed of disease progression in many cases means that days really do matter, and we know that, for those patients who do not have cancer, every additional day kept waiting is a day of understandable stress and worry.

We also know where we need to focus: 85% of patients waiting more than 62 days are awaiting diagnostics and around two thirds of the backlog relates to the Lower GI, Urology and Skin pathways. Whilst progress in reducing the backlog has understandably been challenging in the context of wider pressures, this now needs to be seen as a critical priority for the remainder of the year.

Patients waiting more than 78 weeks for elective care

The next phase of the Elective Recovery Plan will also focus on patients waiting longer than 78 weeks. Building on the fantastic work to eliminate waits of over two years, we need to sustain the momentum and continue reducing waiting times for patients who have waited the longest.

At June 2022, we had more than 1,000,000 patients who need to be treated by April to ensure the 78 week milestone is met. The scale of the challenge is significant, with particular challenges in T&O, ENT and General Surgery as well as more specialist pathways within Spinal surgery and Neurosurgery.

We should acknowledge also that the challenge is not the same across all regions, with disproportionately high 78ww volumes in the Midlands, North West and South West. However, we are confident we have a credible plan able to deliver on this ambition by April 2023, and your delivery on the 104 week challenge can give us all confidence in achieving this. This of course will require returning to and maintaining low levels of COVID-19, enabling the NHS to restore normalised operating conditions and reduce high levels of staff absence.

An integrated approach between elective and cancer long waits

Nationally, we will be evolving our performance oversight mechanisms into an integrated approach across elective and cancer long waits. Both of these priorities will draw on many of the same staff, the same diagnostic capacity and the same theatres, so it is vital that we consider them equal priorities and address capacity challenges in the round.

Sir James Mackey and Dame Cally Palmer will be writing to those Trusts we intend to apply this integrated oversight approach to shortly, and targeted support will be offered to those most challenged providers.

A key component of this work will be engaging the support of those systems and providers that are able to support others, and we will be in touch about that shortly.

All-provider actions

Whilst some trusts will have a specific plan in place agreed with Regional and National colleagues, we are asking all systems, working with their Regional teams, to also focus on the following key universal priorities to address long waiters and increase activity:

1. System and regional level management of long waiting patients, utilising mutual aid and supporting patient choice to expedite patient care where it is clinically appropriate and the patient is willing to travel.
2. Ensuring operational management and oversight of routine elective and cancer waiting lists aligns with best practice as outlined/directed within the national back to basics programme and current Cancer Waiting Times guidance. All patients past 62 days and 78 weeks should be reviewed and the actions required to progress them to the next step in their pathway prioritised.
3. Prioritisation and productivity within surgical pathways through utilisation of evening and weekend capacity, ringfenced elective capacity for cancer patients (particularly P3 and P4 urology and breast patients) and 78ww patients and returning theatre productivity to pre-pandemic levels.
4. Optimising independent sector and NHS capacity via contractual levers including the incentivisation of mutual aid via tariff, utilisation of evening and weekend capacity, full utilisation of any insourcing and outsourcing opportunities (particularly for diagnostics delaying cancer pathways), and applying a co-ordinated approach to increase choice.
5. Ensure best practice pathways are in place for the most challenged cancer specialties, including:
    - FIT is embedded in primary care for use in NG12 patients, in line with British Society of Gastroenterology guidance, and that where patients are referred into Lower GI pathways this FIT result is used within clinical triage to direct appropriate patients to Straight-To-Test colonoscopy, and all others to alternatives such as CT Colonography, Colon Capsule Endoscopy, or safety-netting with advice and guidance to ensure optimal use of endoscopy capacity.
    - Barriers to the full implementation of the Best Practice Timed Pathway for prostate cancer are reviewed, and actions agreed to address the absence of ring-fenced mpMRI capacity and biopsy capacity where this is the key issue.
    - Maximum use is made of teledermatology within Urgent Suspected Cancer Skin services, in anticipation of the usual seasonal surge in referrals occurring this summer.
6. Transforming the delivery of outpatient/non-admitted pathways to free up capacity for longer waiting patients, including appropriate use of virtual appointments, Patient Initiated Follow Up and Personalised Stratified Follow Up, and reducing DNAs. This is having an impact now in some parts of the

country and, importantly, is giving more power and control to our patients. Accelerating progress will be a major factor in this next phase of our work.

7. Prioritisation of 62d and 78w patients through the extra capacity Community Diagnostics Centres are bringing, implementation and delivery of remote diagnostics, and co-ordinated access to available capacity in partner trusts. This should include a review of whether referrals for urgent suspected cancer are being sufficiently prioritised within existing resource, and where this is not the case agreeing actions to provide ring-fenced diagnostic capacity in lower performing pathways.

We know that the challenges of elective recovery and urgent and emergency care are inextricably linked, particularly over winter, and we will write out to you shortly to set out the support available ahead of winter.

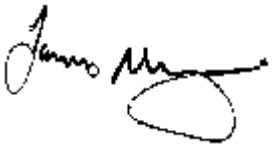
Thank you again to you and your staff for all the continued effort you are putting into elective recovery. The success on 104 week waits has shown exactly what the NHS is capable of when we collectively focus on our highest priorities, and I know we are all committed to sustaining this success as we enter this second, even more ambitious phase of recovery.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Cally Palmer
National Cancer Director
NHS England



Sir James Mackey
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