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The elective care backlog is likely to take years to clear and, with the number of patients waiting for diagnostics and treatment set to increase, waiting times will get worse before they get better. In this context, the All-Party Parliamentary Health Group roundtable on 20th October discussed short- and long-term measures to increase capacity and more effectively use available resource to reduce waiting times and improve the experience of patients waiting for treatment.

The discussion made clear that a multipronged approach will be required to reduce the size and scale of the backlog and the amount of time patients spend on waiting lists. The most important factors in achieving this were identified as **using waiting lists to improve health, use of digital tools, increased pathway efficiencies, service integration and workforce investment.**

Underpinning the response is the pressing need to address inequalities in access, experience and health outcomes. Each of the themes discussed as part of the roundtable must be coproduced and developed with patients, clinicians and the public to ensure success. The measures outlined during the roundtable event all aim to prevent inequality becoming embedded in elective wait times, COVID-19 recovery and the wider health service moving forwards.

Proactively treat patients while they wait

An important concept for tackling the scale of the backlog and ensuring that longer waiting times are less harmful is to proactively treat the waiting list as a period in which action is taken to improve patient's health.

This approach aims to improve a patient's condition prior to treatment. The inclusion of a patient on the waiting list should automatically trigger services to improve physical and mental resilience, prevent a decline in functional fitness, and promote wellbeing. This may be through support to stop smoking, increase physical activity or undertake physiotherapy.

Developing interventions and actions based on individual need should aim to empower patients and assist them to self-manage their conditions. Information and actions must be presented in a way that is accessible and allows for participation without barriers. This may be as simple as considering the patient's home environment or the use of language. For example encouraging patients to increase their physical activity rather than adopt a new exercise can feel less threatening.

Digital tools in Health services

Increasing the use of digital health tools has been an ongoing theme in the government's policy making and strategy in response to the COVID-19 pandemic. Innovation across the health service has allowed for online appointments, virtual wards and mass access to the NHS app. In developing and implementing digital tools as part of the backlog recovery and beyond, coproduction should guide their use. Patients and clinicians can provide practical recommendations at a national and local level on how and when digital is best used and where they should integrate with and support patient pathways.

Speakers highlighted the benefit of digital tools in supporting patients with low acuity conditions. The tools must allow clinicians to provide personalised support to patients to maximise their condition prior to treatment, empowering them through technology and promoting self-management. The use of digital for many patients is considered easy and convenient. This also frees up more clinicians for complex clinical cases and vulnerable patients who may not feel comfortable accessing digital services or who need more support.

Digital tools have the potential to support patients along every stage of the pathway, from offering an alternative to face-to-face appointments, allowing remote monitoring of patients, supporting medication adherence and promoting recovery through tools such as video-based physiotherapy. However, evaluation and regular review of their effectiveness at an individual and broader population level will be important to prevent digital exclusion and ensure investment is used wisely.

Streamlining the Patient Pathway for the benefit of both patient and services

Many patients undergo a complex pathway from first presentation to treatment with a number of different waits for appointments, diagnostics, treatment and review. The roundtable identified opportunities for patient pathways to become more efficient, reduce waiting times and in turn improve outcomes for patients.

At the front end of the pathway, speakers discussed the role of pharmacy in increasing efficiency and managing patients towards the best pathway, thereby reducing the risk of unnecessarily overburdening other overstretched services. Panellists noted that community pharmacy teams see more patients than any other professional group and offer a local, trusted service that is currently undervalued and underutilised. Pharmacy can assist in the drive for better population health through guidance on self-management and personalised support. They also provide minor injuries advice, medicines management and preventative care. Throughout the COVID-19 pandemic pharmacy remained open and expanded its range of services without compromising patient care.

Community pharmacy therefore offers an alternative pathway for low acuity, less complex patients. With investment and innovation, the current role of pharmacy could be further expanded. For example, if pharmacies had the tools and ability to refer patients with red flag symptoms there is the potential to reduce time to diagnosis and identify disease at an earlier stage.

Further along the pathway, speakers discussed the potential efficiencies that could be made in diagnostics. The roundtable welcomed community diagnostic hubs as a useful start in transforming diagnostic provision and wait times. However, their current remit, addressing cancer, cardiovascular disease and diabetes should not be seen as the limit of innovation in this area.

Speakers discussed the need for diagnostics to move from being reactive to proactive. A more innovative approach to diagnostics should involve asymptomatic screening and diagnostics delivered in the community as close to patients and as accessible as possible. Examples such as lung screening services in supermarket carparks, where services are

brought into communities and people who may not normally engage with health services could be reached, represent examples of the ambition needed to shift the diagnostic culture.

Furthermore, the role of primary care in diagnostics was discussed. Increasing minimally-invasive, thorough diagnostics could also assist in addressing the backlog by adding value and eliminating waste through removing the need for the invasive diagnostics delivered in secondary care. Examples of this included conducting a full blood panel prior to referring a patient for an endoscopic procedure.

Integration of diagnostics inputs to streamline patient treatment

Diagnostics are also a good example of an area where integration is still required in order to decrease waiting times, improve pathway efficiency and offer a better patient experience. An area identified as leading to unnecessary delay within the diagnostic pathway is the need for the results of diagnostic tests to be sent to the referring physician prior to any further diagnostic or treatment bookings. If follow-up could be arranged by radiographers or other qualified members of staff, time to diagnosis may be reduced.

Likewise, the fact that some members of health teams cannot refer or see test results or other patient records hampers their ability to work effectively and results in siloes. An example of this is community pharmacy, a group that is offering to do more to integrate with the rest of the health service. Embedding pharmacy records into the health system would allow pharmacists to work more effectively for patients. It would also allow primary and secondary care services to track a patient's engagement with pharmacy, either as pathway to presentation or to track side effects or other over-the-counter requirements between treatments or appointments.

Workforce planning and training for the long term

Underpinning the roundtable discussion was the need for a sustainable workforce based on the current and future needs of the population. Pathway changes require a multidisciplinary team approach with clear and expanded roles across the workforce.

Staff must receive training across their career to ensure that they are working at the top of their profession, increasing workforce wellbeing, retention and efficiency. This applies across the workforce and there are models on which to base this, for example nurse practitioner or prescriber roles could be adapted to offer similar programmes for allied health care professionals. This would not necessarily require long training programmes or the creation of new roles but could be as simple as training physiotherapists to deliver a COVID-19 vaccination.

Ultimately the roundtable discussion supported the need for long-term workforce planning and a clear strategy. Speakers also underlined the difficulty associated with making radical workforce changes such as the creation of new roles during a time in which the NHS continues to be under considerable pressure while simultaneously restructuring. Staff and senior leaders need time to focus on wellbeing and space to evaluate their own pathways and resource needs, to create sustainable change – not a sticking plaster.