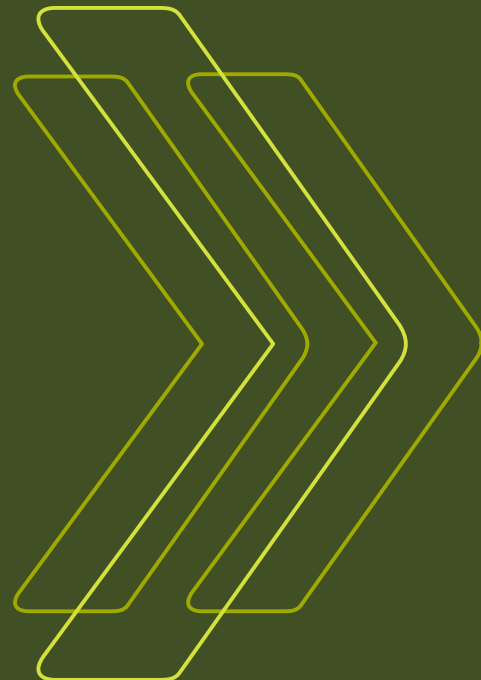


# Tackling health inequalities on NHS waiting lists

Learning from local case studies

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# About this project

This project was funded by The Health Foundation. The views expressed in the report are those of the authors and all conclusions are the authors' own.





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# Key messages

- In 2020, NHS England decided to take an inclusive approach to recovering services after the first wave of the Covid-19 pandemic. It asked NHS trusts and systems to do this by identifying inequalities on their elective waiting lists by deprivation and ethnicity, and prioritising service delivery taking this into account. This marked an important shift in the way NHS organisations were asked to manage their waiting lists, embedding work to address health inequalities into a core operational process.
- Our analysis found that in August 2022, people who live in the most deprived parts of England were 2.1 times more likely to wait over a year for elective treatment than people who live in the most affluent areas. There are structural, economic and social factors that can lead to differences in the length of time people with the same clinical needs wait for treatment, and differences in the impact waiting has on their daily lives. For example, the NHS can be difficult to navigate and appointments difficult to attend; people reach the waiting list in different health states and deteriorate at different rates; and individual circumstances affect whether someone can do things like work or fulfil caring responsibilities while they wait.
- There are examples of successful local initiatives to tackle inequalities on waiting lists that are targeted at particular groups of people, including work to reduce rates of missed appointments ('did not attends', or DNAs), support that helps maintain or improve people's health while on a waiting list (prehabilitation), and the use of artificial intelligence (AI) to prioritise people on waiting lists. This work broadens the range of clinical factors used to prioritise patients, but we did not find examples of wider risk factors such as social demographics being brought into the process.



- Our research did not find evidence that the NHS was systematically taking an inclusive approach to tackling the elective care backlog. This was because of issues at national, system and trust levels that include:
  - a lack of clarity on the case for change, action to be taken and what success looks like
  - operational issues such as poor data and analytical capability
  - fundamental cultural challenges because of different views among NHS staff about what constitutes a fair approach to tackling the backlog, especially to reprioritising waiting lists
  - a lack of accountability and the focus by ministers and national NHS leaders on reducing the overall size of the elective backlog and the headline length of wait, which means NHS staff energies have been focused on this task.
- If the NHS wants to recover elective services effectively and meet its ambition to tackle health inequalities, work to tackle inequalities on waiting lists must be part of that. To make progress, the NHS needs to work with partners to make the case for change, take action, and hold organisations to account for this work.
  - **NHS England** should clarify the case for change and make health inequalities central to its elective recovery plans, support systems to take action and make inequalities part of ongoing performance conversations about elective recovery with ICBs and trusts (this is not currently happening).
  - **Integrated care systems** should set out a local vision for inclusive recovery and goals for what they want to achieve; make this a key part of elective recovery conversations with trusts; engage staff and communities in the vision; bring together data to enable inequalities to be identified at system, trust and specialty levels; and share good practice across their system.
  - **NHS trusts** should engage their board and staff in the vision for inclusive recovery and highlight specific actions that will support change, work with partners to engage people and communities in the vision and in understanding why inequalities on waiting lists exist, and embed inequalities into their performance management systems at divisional, executive and board levels.



# 1 Introduction

## Why we did the research

In the aftermath of the first wave of the Covid-19 pandemic, the NHS decided to think differently about its approach to managing waiting lists.

The uneven impact of Covid-19, which took a higher toll on people from ethnic minorities and more deprived areas, raised awareness of underlying health inequalities and galvanised the government to ‘build back better’, so that the country would emerge from the pandemic as a more equal society (Raleigh 2022; Suleman *et al* 2021).

In the second half of 2020, as part of new plans to ‘recover services’ and start treating the backlog of people waiting for care, NHS England asked local NHS organisations to take an inclusive approach (NHS England 2020a). This meant examining their waiting lists to identify inequalities relating to the level of deprivation and ethnicity, and prioritising service delivery taking this into account (NHS England 2021a). By doing this they brought social demographic factors into the nationally defined approach to waiting list management – a process that was previously only explicit about clinical needs and maximum waiting time guarantees. However, the policy was broad, and left local areas to define their approach.

This novel policy initiative put work to address health inequalities at the centre of one of the NHS’s core operational priorities. The King’s Fund has previously said that progress in tackling health inequalities hinges on the NHS making this work part of its business as usual, rather than an add-on (Chauhan *et al* 2021; Robertson *et al* 2021). We were therefore keen to understand what happened when policy-makers tried to do exactly that.

Three years on from the introduction of that policy, this report looks at how taking an inclusive approach to tackling the elective care backlog has been interpreted and implemented in three case study trusts and integrated care boards (ICBs).



Our findings will be useful for staff working in operational and strategy roles connected to elective performance and health inequalities in trusts and integrated care systems (ICBs), as well as national and local policy-makers looking to develop future approaches.

## Research approach

This research sought to answer the following questions about NHS England's policy on an inclusive approach to reducing elective care backlogs:

- How has the policy been interpreted and implemented by providers and integrated care boards (ICBs) in case study sites?
- How are local ICBs and trusts being held to account for this work and what impact is this having on the approach taken?
- What learning can be identified to inform future work on reducing waiting lists and health inequalities?

The research involved the following:

- An initial scoping phase that explored what was already known about work to take an inclusive approach to tackling waiting lists. This included an analysis of trust and ICB papers, relevant literature and national waiting times data.
- Three qualitative case studies of the progress made in implementing the policy by NHS trusts (two acute and one specialist) and their main ICBs, and interviews with people involved in the use of artificial intelligence (AI) to target and reprioritise elective care.
- A workshop with a range of national and local stakeholders to discuss the implications of our findings.

For a description of our research methodology, see appendix A.



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## Structure of this report

Section 2 sets out background information about tackling inequalities on waiting lists, including a description of the issue and NHS England's policy on it, as well as possible approaches to addressing those inequalities. Section 3 presents findings from our qualitative fieldwork, and section 4 looks across our findings and discusses their implications. Section 5 concludes the report and the final section sets out recommendations for how people working in NHS trusts, ICBs and NHS England can work with other partners in the health and care system to support progress in taking an inclusive approach to reducing elective care backlogs.



## 2 What does it mean to tackle inequalities on waiting lists?

This report analyses the implementation of NHS England's policy that NHS organisations should take an inclusive approach to recovering services after the Covid-19 pandemic, with a specific focus on identifying and addressing inequalities on waiting lists for elective care. In this section we provide context to that research by explaining what an inclusive approach to tackling waiting lists is, including exploring the following questions.

- What are inequalities on waiting lists?
- What is NHS England's policy on this?
- What can an inclusive approach look like?

### What are inequalities on waiting lists?

Health inequalities have been defined as avoidable, unfair and systematic differences in health between different groups of people ([Williams \*et al\* 2022](#)). They can be identified by looking at differences in health status, access to care, experience of care, and clinical outcomes across a population. These differences can be analysed according to various factors that combine and interact to influence an individual's experience. These factors are:

- socio-economic, such as income
- geography
- specific characteristics including those protected by law – for example, sex, ethnicity or disability
- socially excluded groups – for example, people experiencing homelessness.



Wider determinants of health such as income, level of education and the quality of housing are the most important drivers of health and inequalities in health status (Buck *et al* 2018). This means that much of the work needed to tackle health inequalities falls outside of the NHS and relates to things like the development of other public services and the economy. However, the NHS does have an important role to play through its work delivering services (as well as its important role as an employer and major economic anchor in many local communities).

This report focuses on one part of the NHS's role in tackling health inequalities: identifying and addressing inequalities that relate to waiting lists for elective care. As outlined in the next subsection, NHS England asked trusts and systems to focus on this as part of taking an 'inclusive' approach to recovering services following the pandemic – including an ask for them to start to think differently about how they prioritise care. This policy is of particular interest because it attempts to 'hardwire' efforts to tackle health inequalities into one of the NHS's core business-as-usual activities – managing access to elective care.

NHS waiting lists have traditionally been prioritised via clinicians' decisions about clinical need, and the order in which people join the list. During the pandemic, a national approach to clinical prioritisation was introduced for people on surgical waiting lists; however, much is still left to local discretion (see box on pages 10–11).



## How are waiting lists usually managed in the English NHS?

The NHS Constitution states that people can expect to be treated ‘at the right time and according to their clinical priority’ ([Department of Health and Social Care and Public Health England 2015](#)). Decisions about how to prioritise people on hospital waiting lists in England have traditionally been left to local hospitals and consultants. In the past, some hospital admissions policies treated people on a ‘first-come, first-served’ basis according to the order in which they joined the list, whereas others also accounted for the clinical severity of an individual’s condition (Gutacker *et al* 2016). The main piece of national policy affecting waiting list management was the setting of national access targets applied to elective care – primarily that a person should wait no longer than 18 weeks from referral to treatment ([NHS England 2021f](#)). In light of the pandemic and its impact on elective waiting times, the February 2022 elective recovery plan set milestones to eliminate the longest waits for care, starting with 104-week waits and progressively reducing the maximum length of wait for elective care down to 52 weeks by March 2024 ([NHS England 2022b](#)).

Without a national standard approach to prioritisation, variation in practice between different clinicians and different NHS trusts was inevitable. Individual consultants and staff might prioritise people using a range of factors – for example, we heard anecdotally from clinicians that decisions can be affected by factors like a person regularly presenting at their local accident and emergency (A&E) department, or having certain caring responsibilities that they are not able to fulfil while they wait. There is little published evidence about how English NHS trusts actually make decisions on waiting list prioritisation, although one analysis shows that people with more severe symptoms tend to have slightly shorter waits (Gutacker *et al* 2016).

In 2021, NHS England and NHS Improvement published a new framework and tools to support the clinical prioritisation of people waiting for surgical treatment. This was part of their measures to manage the large backlog of people waiting for surgical treatment that built up during the first phase of the pandemic ([NHS England 2021d](#)). It was based on clinical prioritisation work first published in 2020 by the Federation of Surgical Specialty Associations (FSSA) to aid decisions about how work could be prioritised based on clinical need ([Federation of Surgical Specialty Associations 2020](#)).

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## How are waiting lists usually managed in the English NHS?

*continued*

The process included reviewing all people on the waiting list to 'validate' that the list was accurate and up to date, contacting people to discuss their wishes, and using a set of 'priority' or 'P' codes (and an FSSA list that grouped procedures according to their urgency using these codes) to prioritise people who remained on the waiting list. One of the principles included in the document is 'narrowing of health inequalities' and the guidance gives the example of doing this by providing support for people with communication difficulties.

The table below sets out the codes that the guidance initially introduced for clinically prioritising elective surgical treatment (NB: P1 codes, which are not included in the table, typically relate to emergency patients).

### NHS clinical prioritisation codes for surgical care

Code	Clinically appropriate waiting time for the person
P2	< 1 month
P3	< 3 months
P4	> 3 months Delay 3 months possible
P5*	Person wishes to postpone surgery due to Covid-19 concerns*
P6	Person wishes to postpone surgery due to non-Covid-19 concerns

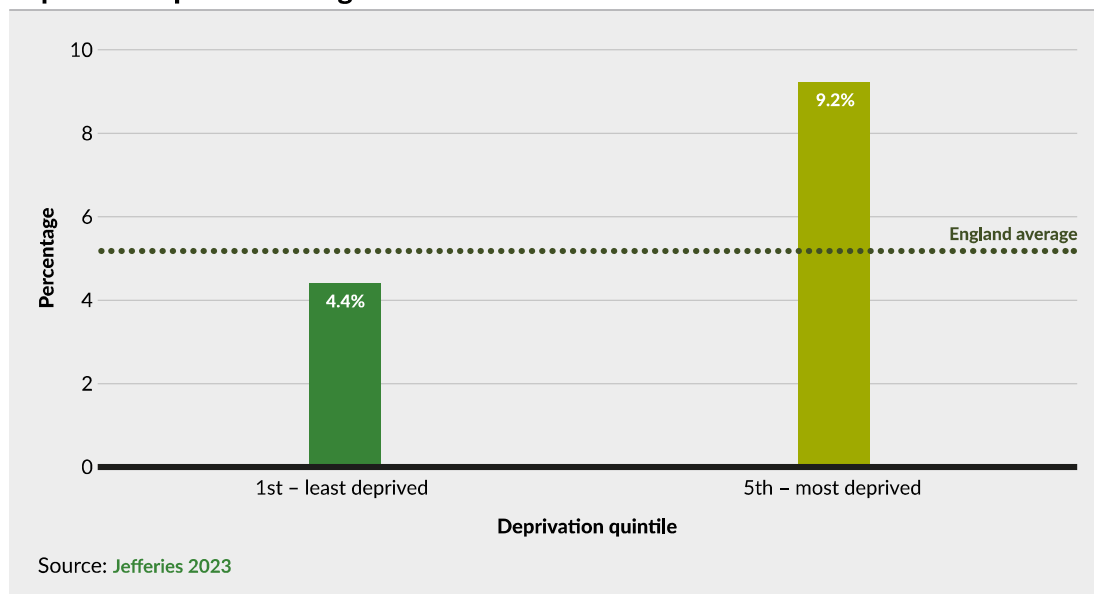
\* no longer in use

These P codes were most commonly used for people that were on a waiting list for planned surgical care requiring admission to hospital. The elective recovery plan does, however, emphasise the need to prioritise *all* people based on clinical priority (reflecting clinical judgement and need) alongside targeting support to address those facing long waiting times ([HM Government 2023](#)). As described in the next subsection, NHS England has also asked systems to look for inequalities in their waiting list data by 'relevant characteristics including age, deprivation and ethnicity and by specialty' and to prioritise service delivery taking this into account, bringing a new set of factors into the waiting list prioritisation process ([NHS England 2022b, 2021b](#)).



There are inequalities in how long people from different groups wait for planned routine hospital care. For example, our analysis of national referral-to-treatment (RTT) waiting times data from August 2022 found that people who live in the most deprived areas of England are twice (2.1 times) as likely to wait for more than one year as people who live in the least deprived areas (Jefferies 2023).

**Figure 1** Percentage of people waiting more than a year for elective care by deprivation quartile in August 2022



This national data shows variation between different parts of the country (the areas covered by different clinical commissioning groups) that have different deprivation profiles, which could be caused by a range of factors, including how resources are distributed and the demand for services. To understand whether this type of inequality is present within local areas, integrated care systems (ICSs) and trusts need to analyse their own waiting lists to identify inequalities and work with people and communities to understand why those inequalities exist. Differences in the length of time someone waits and the impact of waiting on their health and quality of life might occur for a number of reasons:

- **Difficulties attending appointments:** Some people face practical barriers to attending appointments, such as being unable to take time off work or away from their caring responsibilities, having limited or no access to a car or public



transport, or facing a language barrier (NHS Confederation 2021; Beckert and Kelly 2017; Fotaki 2014; Cookson *et al* 2007). This might affect the likelihood of them being referred for elective care in the first place and increases the risk of their treatment being delayed or cancelled once they are on the waiting list, because they miss appointments.

- **The system can be difficult to navigate**, particularly for people living in more deprived areas or for whom English is not their first language. Their access to health services might be affected by a lack of confidence in health care professionals or in their ability to articulate their health concerns and advocate for onward treatment (NHS Confederation 2021; Ford *et al* 2020; Cooper *et al* 2009; McLeod *et al* 2004). Also, there is evidence that clinicians' judgement and decision-making can be influenced by considerations that are not strictly related to a person's health status (McLeod *et al* 2004). For example, onward referral rates and the issuing of prescriptions vary according to economic disadvantage (Wood and Howie 2011, Cookson *et al* 2007). Underlying this inequality are a range of factors relating to the interaction between the clinician and the individual awaiting treatment (and how persuaded a clinician is by the 'case' presented by that individual) as well as clinicians' perception of the availability and constraints of resource and capacity in the local health economy (McLeod *et al* 2004).
- **People reach the waiting list in different states of health.** People from more deprived areas are more likely than other people to have multiple health conditions, to deteriorate quicker, to develop complications while waiting, and to experience worse health outcomes (Illman 2022b; Wyatt *et al* 2022; Cookson *et al* 2007). People who live in more deprived areas tend to come to NHS services with health problems later via urgent and emergency departments – meaning that their symptoms are generally more advanced and more severe than if they had received health care screening or gone to their GP and been referred for secondary care earlier (NHS Providers 2021; Dixon and Le Grand 2006). Typically, more deprived areas are those with greatest constraints on resource and capacity in health care, which means that people living in more deprived areas may experience additional challenges accessing the care they need (Cookson *et al* 2007).
- **Personal circumstances affect the impact of waiting** on someone's daily activities and quality of life – for example, if their condition stops them being able to work or fulfil caring responsibilities (National Voices 2020). A survey of people on NHS waiting lists conducted by Healthwatch found that 39% of



people from lower-income households said that long waiting times affected their ability to work, compared to 29% from richer households ([Healthwatch England 2022](#)).

An approach to waiting list management that is based solely on treating everybody with similar clinical needs equally risks missing other factors that might widen inequalities. These causes of inequalities are likely to coalesce in different ways and to different degrees in different parts of the country and for different specialties – pointing to the importance of a locally tailored approach ([Buck et al 2018](#)). These factors also show why efforts to tackle inequalities on waiting lists may not focus solely on approaches to managing the waiting list itself, but might comprise activities that seek to address the sources of inequality in access, experience and outcomes ([Wyatt et al 2022](#); [Ford et al 2020](#)). Tackling health inequalities on waiting lists is an important part of wider efforts to tackle health inequalities; it is work that supports people to live healthier lives and therefore helps manage demand for health and care services in the long term. This is a critical part of creating a fair and sustainable health and care system.

### What is NHS England’s policy for tackling inequalities on waiting lists?

The NHS has had a long history of policies and government legislation that aim to tackle health inequalities ([Robertson et al 2021](#)). In recent years, this has included a commitment in The NHS Long Term Plan to make action on health inequalities central to everything the NHS does ([NHS England 2019](#)). The Health and Care Act 2022 placed a legal duty on ICSs to ‘have due regard’ to health inequalities and a ‘triple aim’ that asks all NHS bodies to consider the effects of their decisions on the health and wellbeing of people in England (including inequalities in health), alongside quality and efficiency ([HM Government 2022b](#)). However, despite an extensive policy framework aimed at tackling health inequalities, the NHS has failed to make significant progress ([Robertson et al 2021](#)).

### Covid-19 and subsequent NHS England national planning guidance

The Covid-19 pandemic highlighted the need to do more to tackle health inequalities. Coronavirus had a disproportionate impact on people who were already experiencing the worst health outcomes, and exacerbated existing inequalities ([Raleigh 2022](#); [Suleman et al 2021](#)).



NHS England responded by asking NHS leaders to embed action to address inequalities into service recovery plans from the start. In the summer of 2020, following the first wave of the pandemic, NHS England wrote to all NHS organisations setting out its priorities for recovering services over the remainder of the year. This letter asked them to do this in a way that explicitly addressed inequalities (NHS England 2020b).

The letter was accompanied by guidance that set out eight urgent actions that NHS organisations should take to address health inequalities (NHS England 2020a). In the 2021/22 planning guidance, these were distilled into five priority areas (see box) (NHS England 2021a). One of these was a requirement that NHS systems work to take an inclusive approach to restoring NHS services.

### **NHS England's five priorities for tackling health inequalities**

- Restore NHS services inclusively.
- Mitigate against digital exclusion.
- Ensure datasets are complete and timely.
- Accelerate preventive programmes that proactively engage those at greatest risk of poor health outcomes.
- Strengthen leadership and accountability.

(NHS England 2021a, p 11)

The 2021/22 planning guidance also provided more detail on what inclusive recovery work should involve – asking systems to focus on identifying inequalities in NHS performance by ethnicity and deprivation, because evidence suggested that these were the areas where health inequalities had widened during the pandemic (NHS England 2021a).

At the same time, national NHS bodies also made access to £1 billion of extra funding to support elective recovery (the Elective Recovery Fund) partly contingent on systems being able to demonstrate that their elective recovery plans did five things to address inequalities, starting with the use of waiting list data to identify



inequalities by ethnicity and deprivation, and prioritising service delivery by taking this into account (see box).

### **NHS England's health inequality requirements for elective recovery plans**

Access to elective recovery funds was made contingent on systems demonstrating that plans for elective recovery would meet a set of 'gateway' criteria relating to health inequalities (alongside other criteria). The health inequalities criteria were as follows:

- Use waiting list data (pre and during pandemic), including for clinically prioritised cohorts, to identify disparities in relation to the bottom 20% by Index of Multiple Deprivation (IMD) and black and minority ethnic populations.
- Prioritise service delivery by taking account of the bottom 20% by IMD and black and minority ethnic populations for patients on the waiting list and not on the waiting list, including through proactive case finding.
- Use system performance frameworks to measure access, experience and outcomes for black and minority ethnic populations and those in the bottom 20% of IMD scores.
- Evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts.
- Demonstrate how the ICS's Senior Responsible Officers (SROs) for health inequalities will work with the Board and partner organisations to use local population data to identify the needs of communities experiencing inequalities in access, experience and outcomes and ensure that performance reporting allows monitoring of progress in addressing these inequalities.

(NHS England 2021a, p 9)

A specific requirement for NHS boards (covering NHS trusts and integrated care boards (ICBs)) to include in their performance reports waiting list data disaggregated by ethnicity and deprivation was added in further planning guidance that covered the second half of 2021/22 and was reasserted in the following year's guidance (NHS England 2021b, 2021c).



The latest planning guidance covering 2023/24 reasserted the general commitment to inclusive recovery as part of the ‘five priorities for tackling health inequalities’ but did not include any more specifics ([NHS England 2022a](#)).

### **Core20plus5**

At the same time as the publication of the initial policy on inclusive recovery, NHS England launched Core20plus5 – a new approach to help local systems prioritise work on health inequalities by identifying target populations (the most deprived 20% of the national population and other population groups identified at a local level) and disease areas (five clinical areas of focus).

This initiative had a broader focus than elective care but was an important support to actions to take an inclusive approach to restoring services. NHS England also produced a national health inequalities improvement dashboard that is available to NHS staff to support systems to identify inequalities in waiting times by ethnicity and deprivation ([NHS England undated](#)).

### **Elective care recovery plan**

As well as NHS planning guidance, the NHS’s strategy for recovering services is set out in the recovery plan for elective care, first published in February 2022 ([NHS England 2022b](#)). It primarily focuses on reducing the longest waits for care; increasing elective activity by 30%; and clinical prioritisation of people on waiting lists for elective care.

However, the plan does reference ‘fair recovery’ and sets the expectation that systems analyse their waiting list data by ‘relevant characteristics, including age, deprivation and ethnicity and by specialty’ to help them understand variation and ‘start developing detailed clinical and operational action plans to ensure treatment is based on clinical need’. When launching the elective recovery plan in the House of Commons, the then Health and Social Care Secretary Sajid Javid emphasised the importance of addressing inequalities as part of this work. He said:

*I am determined that we tackle the disparities that exist in this backlog, just as I am determined to tackle disparities of any kind across this country. Analysis from The King’s Fund shows that, on average, a person is almost twice as likely*



*to experience a wait of over a year if they live in a deprived area. As part of our recovery work, we are tasking the NHS with analysing its waiting list data according to factors such as age, deprivation and ethnicity to help to drive detailed plans to tackle these disparities.*

Hansard (House of Commons Debates) 2022

Updates and letters about elective recovery continue to assert the importance of taking an inclusive approach and using disaggregated data to inform that (NHS England 2023).

Performance on elective recovery is managed through a tiered system of NHS England support and performance management (NHS England 2021e) and an elective recovery taskforce (HM Government 2022a) that are primarily focused on tackling the longest waiting lists for elective care. However, the most recent implementation plan from the taskforce makes no mention of health inequalities (HM Government 2023).

### **A patchwork of national guidance on inclusive recovery**

This analysis shows that there is no single NHS policy on inclusive recovery or a clear definition of what waiting list inequalities are. We have pieced together the asks from various letters and pieces of operational planning guidance and elective recovery strategy documents.

However, although some details have changed over time, the message – that NHS systems and trusts should work to address health inequalities while they recover services, and focus on identifying and acting to address inequalities in waiting list data that relate to deprivation and ethnicity – has been clear and fairly consistent throughout. This marks a significant change from the way NHS systems were asked to manage elective performance before the pandemic, when the focus was primarily on meeting high-level aggregate national standards for how long people should wait for care.

The policy leaves it open to local areas to decide what solutions to put in place where inequalities are identified. It also avoids explicitly addressing some issues – including whether and how ethnicity and deprivation and other demographic or social factors should be incorporated into decisions about service prioritisation





and recovery plans. It simply asks systems to: (1) better understand how health inequalities manifest on their waiting lists; and (2) take their analysis of deprivation and ethnicity into account when planning and managing services.

Despite the policy message being fairly clear, inclusive recovery is not part of the performance management and accountability structures established by NHS England to manage other aspects of elective recovery. No targets, benchmarks or goals have been set, and the health inequalities dashboard is designed to support improvement rather than manage performance. This means that systems are largely left to self-define what ‘inclusive recovery’ means to them and how to analyse and identify a disparity. This approach sits in stark contrast to the approach to reducing long waiting times for elective care (ie, waits of more than a year or more), which have nationally determined interim performance targets and improvement trajectories and more formal oversight arrangements.

### **Progress so far in delivering the national policy ambitions**

The only published evidence we could find of progress with implementing the policy was a Freedom of Information Act request made by the *Health Service Journal* that asked the 20 trusts with the longest waiting lists whether they had published waiting times data disaggregated by ethnicity and deprivation, as required by the 2021/22 planning guidance (Discombe 2022; [NHS England 2021b](#)). It found that only three trusts seemed to be meeting the requirement in full and the remainder either said they were still undertaking the work, were thinking about how to publish the data, or failed to respond.

But there is evidence that local NHS systems and organisations are making efforts to tackle inequalities on waiting lists. We list some of these examples in the next section.



## What approaches can be used?

The Strategy Unit has developed a useful typology that sets out five different stages of the patient journey at which inequalities in access to elective care can be addressed, and a series of interventions that can be implemented at each stage (Wyatt *et al* 2022).

Below, we set out that typology with the addition of some extra interventions that came up in our literature search. These interventions address inequalities in access to elective care waiting lists (eg, ‘identification and referral of patients’) as well as inequalities that occur once people are on a waiting list (the focus of the policy to take an inclusive approach to reducing the backlog). This work is closely linked and represents different parts of a holistic strategy on tackling inequalities in access to elective care.

We looked for evidence on the impact of these interventions on inequalities in waiting times but found that most of the literature simply described the approaches and their potential impact on inequalities, or provided evidence of their use for different purposes. This is likely to be because NHS efforts to look at inequalities through the lens of the elective care waiting lists are relatively new, and research on the impact of the interventions that are being introduced with this purpose in mind is yet to be published.



**Table 1 Summary of approaches to addressing inequalities in access to elective care**

Stage	Intervention	Example
<b>Identification and referral of patients</b>	Targeted case-finding and screening	Selectively inviting patients with specific characteristics to be seen by a health service professional for initial assessment
	Community and public engagement	Proactive outreach with specific (traditionally under-served) local communities to build relationships and trust, enhance understanding of health and care needs, and identify the most effective approaches to offering care
	Public awareness campaigns	Media campaigns that encourage patients to attend their GP when they have specific symptoms
	Shared decision-making in primary care and use of decision aids	Providing structured information about potential benefits and harms of interventions to support decisions that better align with people's preferences
	Downward adjustment of referral thresholds and eligibility criteria	Changing the criteria used to refer people to make it easier for people in more deprived areas to access services
<b>Pre-treatment assessment and management</b>	Appointment reminders and practical support to attend appointments	<i>See examples 2, 3 and 4 on page 23</i>
	Telephone and video appointments	The option for a remote consultation can remove barriers to some people attending
	Flexible and out-of-hours appointments	Evening or weekend appointments can make it easier for people with inflexible working arrangements to attend
	Appropriate communication methods and options for people	<i>See example 1 on page 23</i>
	Supporting people while on a waiting list/active waiting/ 'prehabilitation'	<i>See examples 5 and 6 on pages 23 and 24</i>

*continued on next page*



**Table 1 Summary of approaches to addressing inequalities in access to elective care** *continued*

Stage	Intervention	Example
<b>Decision to treat</b>	Closer working between primary and secondary care	Dialogue between primary care health professionals and specialists in secondary care to improve the quality of referrals, discuss suitability and potential alternative courses of action
	Carer support	Respite care to support someone the patient cares for while the patient is in hospital
	Patient payments	Paying a patient to stop smoking where this will improve treatment outcomes
	Differential provider payments	Rather than paying a flat fee per patient, payments to health care providers are calibrated to the investment required to achieve equitable outcomes
<b>Waiting list management/prioritisation</b>	Disaggregation of waiting times data according to ethnicity, deprivation and other factors	<i>See example 1 on page 23</i>
	Shared patient tracking lists (PTL)	Creating a single waiting list that can be managed across multiple providers so that patients can be moved for faster/more appropriate treatment when necessary
	Reprioritisation of patients within a waiting list	<i>See example 7 on page 24</i>
<b>Treatment accessibility</b>	One-stop shops/day surgery centres in community-based settings that account for need	Diagnostic clinics located in shopping centres
	Outreach activities and communication as per 'pre-treatment assessment and management'	

Source: Adapted from Wyatt *et al* (2022)



Four interventions came up most frequently in our search of literature about inequalities and waiting times, suggesting that these are the areas getting significant attention in the NHS at the moment. They appeared mainly in grey literature and news articles, with many promoted and shared by NHS England:

- disaggregation of waiting times data to identify inequalities
- targeted appointment reminders and support to attend appointments
- targeted prehabilitation support for people on the waiting list
- the reprioritisation of waiting lists.

Examples of these four interventions happening in the NHS include the following:

1. Calderdale and Huddersfield NHS Foundation Trust analysed waiting list data to identify people with learning disabilities and implemented a range of initiatives and extra support for these individuals. More information at: [www.england.nhs.uk/about/equality/equality-hub/case-studies/how-one-yorkshire-trust-eliminated-the-elective-care-backlog-for-people-with-a-learning-disability/](http://www.england.nhs.uk/about/equality/equality-hub/case-studies/how-one-yorkshire-trust-eliminated-the-elective-care-backlog-for-people-with-a-learning-disability/).
2. University Hospitals of Leicester NHS Trust identified inequalities in 'do not attend' rates linked to deprivation and other factors, and called people to offer extra support to help them attend. More information at: [www.england.nhs.uk/blog/narrowing-inequalities-in-waiting-lists-in-leicester/](http://www.england.nhs.uk/blog/narrowing-inequalities-in-waiting-lists-in-leicester/).
3. The Royal Free London NHS Foundation Trust piloted an approach to reduce missed appointments and increase the rates of ethnicity recording in patient records. More information at: [www.strategyunitwm.nhs.uk/publications/inclusive-elective-care-recovery](http://www.strategyunitwm.nhs.uk/publications/inclusive-elective-care-recovery).
4. Sheffield Children's NHS Foundation Trust used an artificial intelligence (AI) tool to assess a child's risk of not being brought to an outpatient appointment and to target support. More information at: [www.strategyunitwm.nhs.uk/publications/inclusive-elective-care-recovery](http://www.strategyunitwm.nhs.uk/publications/inclusive-elective-care-recovery).
5. Cheshire and Merseyside Integrated Care System used AI to target prehabilitation support to people at highest risk of poor health outcomes from their treatment. More information on page 49.



6. Lancashire and South Cumbria Integrated Care Board developed a prehabilitation intervention targeted at people from more deprived neighbourhoods with known health risks. More information at: [www.strategyunitwm.nhs.uk/publications/inclusive-elective-care-recovery](http://www.strategyunitwm.nhs.uk/publications/inclusive-elective-care-recovery).
7. University Hospitals Coventry and Warwickshire NHS Trust developed an algorithm that helps them prioritise people on the waiting list using a wider set of factors than the date the person joined the list and broad clinical P codes (see box on page 11). More information at: [www.nhsconfed.org/case-studies/tackling-long-waiting-lists-and-health-inequalities-coventry-and-warwickshire](http://www.nhsconfed.org/case-studies/tackling-long-waiting-lists-and-health-inequalities-coventry-and-warwickshire).

It is clear that some local NHS organisations and systems are attempting to tackle their elective care backlog in an inclusive way. But it is not clear how widespread this is and to what extent these actions are in response to, or affected by, NHS England's national policy. Our research seeks to understand in detail how the national policy on taking an inclusive approach to reducing the backlog is being interpreted and implemented locally. The next section sets out findings from case studies of how three local trusts and their main ICBs have responded to the ask.



## 3 What is happening locally?

### Introduction

This section sets out the findings from three case studies that were designed to help us understand how local systems and trusts are approaching work to tackle their elective care backlog in an inclusive way. The section ends with an in-depth look at one specific intervention being used for this purpose – artificial intelligence (AI) tools that reprioritise waiting lists and target support for people while they wait, and a summary of what interviewees told us would help them make more progress.

### Which case studies did we include and why?

We wanted to explore the implementation of the policy in acute trusts and integrated care boards (ICBs) with different levels and types of activity on reducing the backlog in an inclusive way (to learn from the experience of front-runners and those further behind in this work). We also wanted to understand whether the policy worked differently in specialist trusts (which are important as they treat a significant proportion of people on the elective waiting list, but operate over larger areas).

We therefore selected: one trust that we knew from our review of literature and board papers had started work on an inclusive approach to reducing the backlog; one where we had no evidence that work was under way from these sources; and one that was a specialist trust. We selected these trusts to ensure variation in the demographic characteristics of the local population, waiting time performance, trust size and NHS region. Our approach does not allow links to be made between these characteristics and our findings, or for formal comparison between the cases. Rather, we tried to capture as much variation as we could in characteristics pertinent to reducing the backlog to enable us to learn from as wide a range of experiences as possible, within our capacity constraints.

Table 2 on page 26 summarises some key characteristics of our case study sites.

**Table 2 Key characteristics of case study sites**

Case	Primary selection characteristic	Other key relevant characteristics
A	<ul style="list-style-type: none"> <li>Trust known to be taking action on an inclusive approach to addressing the backlog (appointment reminders)</li> </ul>	<ul style="list-style-type: none"> <li>High levels of deprivation and ethnic diversity</li> <li>Poor waiting times performance</li> </ul>
B	<ul style="list-style-type: none"> <li>Specialist trust</li> </ul>	<ul style="list-style-type: none"> <li>Medium levels of deprivation and ethnic diversity</li> <li>Good waiting times performance</li> </ul>
C	<ul style="list-style-type: none"> <li>Did not know in advance what action the trust was taking on an inclusive approach to reducing the backlog</li> </ul>	<ul style="list-style-type: none"> <li>Low levels of deprivation, medium ethnic diversity</li> <li>Average waiting times performance</li> </ul>

(For a more detailed version of this table, see appendix A.)

We had hoped to select a fourth case study that was using AI to reprioritise waiting lists, as this is an intervention that many trusts are considering as part of their work to take an inclusive approach to reducing the backlog. However, none of the trusts or systems that we approached who were using AI in this way agreed to take part in the research. This meant that rather than a case study based around a trust, we took an in-depth look at this intervention by reviewing literature and interviewing stakeholders in various parts of the country and types of organisations involved in this work.

More detail about our methodology is set out in appendix A. We interviewed 39 people across the case studies and AI work between December 2022 and June 2023. To encourage candour, we have anonymised the organisations and individuals we spoke to.





## Findings from our board paper review

Before starting the fieldwork, we reviewed board papers from 13 trusts and their main ICB to explore whether and how boards were considering data on inequalities in their backlog, and to help frame our fieldwork (see box).

### What are ICBs and trusts reporting to their boards about an inclusive approach to reducing the backlog?

One of the key asks from NHS England on an inclusive approach to reducing the backlog was that NHS organisations include waiting list data in their board performance packs, disaggregated by ethnicity and deprivation (see section 2). We reviewed a sample of board papers from 13 trusts in 2022 to see how they were reporting on this to the board, including five that we knew (from our literature review) were taking action on this (see methodology in appendix A for more detail).

We found very few references to the national policy on an inclusive approach to reducing the backlog in the sample board papers. Most boards had set ambitions to tackle elective backlogs and ambitions to reduce health inequalities, but very few reported that they planned to tackle these concurrently. Boards were primarily reporting their progress against actions to reduce longest waits for elective care. Only three of the NHS trust board papers reported that waiting list data had been analysed in line with the policy ask (and one other trust reported that it had undertaken a disaggregated analysis of missed appointments). None of the trusts included the disaggregated analysis in their board performance packs, and none of the ICB board papers included this. Two trusts did mention specific initiatives aimed at taking an inclusive approach to reducing the backlog – for example, reprioritisation of waiting lists and reducing ‘did not attend’ rates.

Within this sample, trust and ICB boards were not monitoring inequalities in their backlog and the majority were not discussing actions to address the backlog in an inclusive way. A wider sample of board papers from different times and from different trusts and ICBs might tell a different story. Also, these findings only represent the response at board level, and specifically discussions at public board meetings. Local ambitions and actions to reduce backlogs in an inclusive way may sit at a different level – for example, in a clinical working group or operational taskforce within an individual trust.



These findings suggest (subject to the caveats outlined above) that in 2022, NHS organisations were yet to respond to the policy asking them to report to their boards waiting list data that had been disaggregated by ethnicity and deprivation. This therefore suggests that the inclusive aspect of reducing the backlog was not a priority for boards. This contrasts with how targets for reducing the longest wait times were reported in board performance reports (ie, frequently, and in a high-profile way).

However, it may be the case that some organisations were taking actions that were simply not reported to the board. The rest of this section of the report outlines findings from our fieldwork in local areas that sought to discover whether this was the case.

### Trust A

- A trust with long waiting times based in an ethnically diverse area with high levels of deprivation.
- Has disaggregated waiting list data, run successful pilots to tackle inequalities in 'did not attend' (DNA) rates, and developed a suite of access projects focused on specific communities.
- Efforts were led by the trust; the integrated care system (ICS) was yet to play a significant role.
- Staff told us they were not able to progress and embed work at scale until long waiting times had been addressed.

### Background

Trust A is a large trust, based in an industrial city with an ethnically diverse population and high levels of deprivation. The trust's long waiting list for elective care puts it in the highest tier for central oversight, which means the trust is closely monitored by NHS England's regional and national teams. Despite these challenges, the trust's executive team spoke with clear passion and drive about their role in tackling local health inequalities. We deliberately selected the trust for inclusion in our research because it is known to have progressed work on an inclusive approach to reducing the backlog, and we wanted to understand what was driving progress.



### What is the trust doing?

In 2020, the trust made an immediate response to NHS England's policy. It set up a health inequalities taskforce to oversee the response, made up of enthusiastic staff from the trust, ICS, and voluntary, community and social enterprise (VCSE) sector who volunteered to be part of the group. It was also one of the first trusts to disaggregate its waiting list data by ethnicity and deprivation. The analysis conducted by the trust identified a range of inequalities, including the following:

- The demographic make-up of the waiting list reflected the demographic make-up of the local population but did not reflect the likely disease burden.
- Black British and Black African people from the most deprived areas were waiting longer for elective care than white people from the most affluent areas.
- People who lived in the most deprived areas were more likely to miss their appointments than people who lived in more affluent areas.

Progress then stalled as ideas about reprioritising the waiting list using a broader range of factors than clinical P codes met resistance from clinicians (for a definition of P codes, see page 11). It was around a year later that the trust took the pragmatic decision to focus on addressing inequalities in its DNA rates.

*So after getting thoroughly depressed and thinking, 'I'm not winning anyone over', I thought, let's try and do something differently. Let's try and change processes that do not involve our clinicians having to do, on the face of it, anything different.*

Trust interviewee

Trust A's analysis showed DNAs of up to four times higher in groups with a range of characteristics, including living in an area with a high Index of Multiple Deprivation (IMD) score, age, sex, and history of missing appointments. The trust piloted an initiative in which (in addition to the standard text message appointment reminders) call-handlers spoke to people at highest risk of not attending, and outlined a range of information and support to help them attend (such as transport routes, reimbursement of transport costs, and access to interpreters). This simple initiative brought DNA rates in the intervention group back down to the trust average, and further pilots also had a positive impact on reducing DNAs. One interviewee reported that people who were called up as part of this pilot were subsequently less likely to miss other appointments at the hospital, as well as the specific appointment they were called about.



The initiative had not been rolled out across all specialties for various reasons. For example, the trust wanted to understand why the telephone intervention succeeded in reducing DNAs (the success might not have been related to the supports people were offered as only two of the hundreds of people who were called actually asked for extra supports to be put in place). There was also a data issue with adding IMD into the analysis (IMD was currently being calculated manually because it was not included in the trust's data warehouse, but manual calculations were not practical when doing the analysis trust-wide). The project was also yet to secure funding for the call operators.

The projects overseen by the trust's health inequalities taskforce grew to around 25. Many of them focused on improving access for specific communities to appointments and drugs by engaging with people and the local community to build trust and understand the barriers people faced to accessing care, then developing an intervention to address them. These included projects like a nurse-run outreach clinic to address the barriers to Black Caribbean and Black African women attending breast cancer appointments. However, many of the projects were at an early stage and we were not able to get data on impact. Some were developed in response to analysis of data on inequalities while others were started by clinicians or other staff identifying issues that needed to be addressed.

The trust was in the process of opening an elective hub that would provide additional capacity for procedures such as hip replacement operations, to help address its waiting list backlog. Interviewees told us that inequalities were being taken into account in the design of the hub – for example, its location and opening hours. However, there was some scepticism from one interviewee involved in planning the hub about whether this would translate into real improvements in reducing inequalities in a way that could be measured.

There was a plan to look again at reprioritisation of waiting lists in the near future and the trust was procuring some AI software to support this work. Some interviewees on the executive team described this as the 'real' work on inequalities that would show they were living their values around addressing inequalities – something that was a key motivator to them at work. They thought the intervention would now be acceptable to clinicians as extra capacity would be used to treat people who were being prioritised, rather than moving anyone 'down' the list.



### What is the ICB doing?

Interviewees from the trust and ICB reflected on the difficulties involved in defining the role of the ICB in work to take an inclusive approach to reducing the backlog and in moving from rhetoric to action on wider work to address inequalities. The particular configuration of the ICS – with one acute trust within its boundaries – made it particularly difficult to identify a ‘system’ role for the inclusive backlog work, which was being led by the trust. Interviewees did tell us that the ICB was usefully providing access to pots of money from NHS England that could be used for work to reduce health inequalities.

*So there’s lots of conversation about what we need to do, but when it comes to committing to the doing, that’s where I see a lack of commitment, and a lack of buy-in. And I think that is just a reflection of how pressured and stressed people are, and the demands that are being made of us nationally, regionally, system level, politically, etc. So I don’t fault people for that. The question I’ve just posed to my system colleagues though is, at some point we are going to have to start doing more doing, because we’re talking a lot of talk at the moment, and we will start to lack integrity unless we start doing more doing.*

Trust interviewee

### How are they being held to account for this work?

Even at this trust – one of the first in the country to disaggregate its waiting list data – they were not regularly reporting disaggregated data to the board, and interviewees questioned whether this would be useful. Some interviewees suggested that in-depth seminars or ‘time-outs’ focused on health inequalities might be a better approach to board engagement. The board did receive general progress updates on health inequalities work.

We heard that the work on health inequalities more generally was not seen as a ‘must do’, in part because the trust’s waiting times performance meant they were focused on eliminating the longest wait times, leaving little room for other priorities. Leaders in the trust and ICB all described a similar picture in which health inequalities were not part of accountability conversations with NHS England.

*So the weekly ones [performance meetings with NHS England] are all about ‘this is your number this week, what’s your number next week, is it getting to where we*



*need it to be?' That type. There will be some [on inequalities] in the quarterly review, but it's probably way, way, way down the list of when it will be discussed, if it's discussed. There's a slide in there about it but you would probably run out of time by the time you'd get to it, if you see what I mean. That's an honest reflection.*

ICB interviewee

Interviewees were also unsure about what accountability for the inclusive part of work on backlog reduction should look like. Interviewees from the trust were resistant to the idea of targets and performance management on this topic as they felt they would do the work anyway and this might restrict them, and the regional team representative queried where they would go for information to do this with.

### **What is helping and hindering this work?**

The trust had started to make progress on taking an inclusive approach to reducing the backlog, despite a challenging performance context. It had analysed its waiting list data, and implemented pilots that had reduced inequalities in DNA rates. It had also started to set up a range of projects – some centrally driven, some initiated by clinical teams – designed to address inequalities in access to elective care (although were not yet at the stage of reporting data on impact). In part, this was due to the striking amount of enthusiasm and passion we heard from interviewees at the trust about work on health inequalities. For many, it was a core part of why they worked in the NHS, and they spoke passionately about its critical importance to the organisation's mission.

*This is just a personal thing. For me – and whether this is the right phrasing or not, I don't know – treating people equally or equitably is the most fundamentally important thing to me in life, full stop. It's who I am, it's how I've been brought up. I've promised myself from day one of working, but also outside of life, until my last breath I will battle against inequalities in every single way possible. And I hope that comes through in what I do.*

Trust interviewee

The progress the trust had made had been dependent in large part on staff volunteering their time, although money for work on health inequalities accessed through NHS England had also supported some initiatives. An above-average completion rate for ethnicity coding was reported to have made the analysis easier than it was for some other trusts.



Despite this progress in identifying inequalities and starting to set up projects to address them, the trust was yet to implement work to address inequalities in its backlog at a significant scale. A lack of clinical engagement had stalled work to reprioritise the waiting list, and clinical engagement was highlighted as a critical facilitator of future progress. A lack of trust on the part of some local communities was also highlighted as a barrier. For example, a project to support people from one local community to access appointments took longer to develop than expected because of a lack of trust in the organisation, and the staff needed to build trust with the particular population group before it could put the intervention in place. A number of interviewees highlighted the time needed for this work and how critical it was to developing and implementing effective interventions.

Some interviewees also questioned whether progress was possible given the long waiting times at the trust. Ideally, this work on an inclusive approach to reducing the backlog would be seen as part of the solution, but it was seen as something the organisation would be able to dedicate more time and resource to once it was on a more stable footing and its waiting times were lower.

## Trust B

- A specialist trust serving a diverse population across a number of ICS footprints.
- Has not disaggregated waiting list data or reported at board level; this work was at an early stage and being advanced by a number of passionate individuals with the support of the executive team.
- Interviewees associated health inequalities with unwarranted geographical variation in waiting times, and efforts to tackle them were focused on addressing this at a regional level by first establishing a single point of access.
- Performing relatively well on waiting time targets but waiting times were still the main measure of performance.

## Background

Trust B is a specialist trust providing treatment in a specialism that constitutes a large part of the waiting list for elective care. It serves a population across a wide geographical area that covers a number of ICS footprints, each with different population needs and service configurations.





### What is the trust doing?

When asked about health inequalities and elective recovery, interviewees described the trust's role as 'equalising waits' for people with the same clinical need, across the ICS footprints it covers. There was a strong sense from interviewees that the trust's specialist status meant it had a responsibility to 'benefit the wider NHS' by addressing this geographical variation.

We heard that since the onset of the Covid-19 pandemic, health inequalities was becoming a thread running through policy and conversations within the trust in a way that it had not done before. This was attributed to a growing awareness of the existence and impact of health inequalities.

*I find it really refreshing and really positive that health inequalities is being messaged and that it's being mentioned at every turn. Because, you know, it hasn't been like that necessarily... it's been an afterthought... It's still in the process of translating. And actually, translating it into a reality is difficult but I think we're having lots of support in finding out about impact on health inequalities... It's definitely being taken into account.*

Trust interviewee

The trust engaged in a major effort during the pandemic to manage its elective care backlog, which left its waiting times performance in relatively good shape. In part, this was thanks to the sustained efforts of clinicians and volunteers who were able to deliver care and treatment safely throughout the pandemic. There was a strong will and drive among clinicians to address the backlog quickly due to fears about the growing risks for people the longer they had to wait for treatment. This initial effort did not, therefore, reprioritise people on the basis of demographic or other non-clinical factors, but solely on the basis of clinical risk.

NHS England's policy on taking an inclusive approach to reducing the backlog had not stimulated action in this trust. The specific requirement for waiting list data to be disaggregated by deprivation and ethnicity was described by interviewees as a 'work in progress' and it was hoped that this work would develop more momentum now that the trust was satisfied it had treated the people who were waiting longest and were at highest risk. Interviewees envisaged that this breakdown of waiting list data would be presented to a number of different audiences within the trust, including the board, clinicians and operational managers, to inform service and





workforce planning decisions. There had not yet been any targeted engagement with patients and the public about this work. As one interviewee put it, consultation on the findings from the data and engagement with any specific groups would come after analysis because ‘you need to know who to talk to’.

The trust’s efforts towards taking an inclusive approach to reducing the backlog had focused on access and the point of referral. This included setting up ‘asynchronous’ diagnostic hubs in high street sites where images and samples are collated and later reviewed by clinicians at another site. They stratified people according to clinical risk and directed them to the next available and most appropriate service and site for ongoing treatment. The trust applied to the Targeted Investment Fund (NHS England funding to support schemes that promoted recovery from the pandemic) for these sites, making the case that the hubs would address health inequalities by offering accessible and convenient diagnostic services to people across a wide geographical area. DNA rates were reported to have ‘significantly reduced’ owing to telephone reminders made by volunteers at the trust, reassuring people that the hub appointment was a ‘real appointment’.

More broadly, building on the legacy of a programme of mutual aid during the pandemic, the trust was leading work to develop a single point of access for its area of specialty, complemented by regional patient tracking lists (broken down at the level of specialty and hospital site). Using this data, clinicians and patients can make informed decisions about the most appropriate site for treatment based on potential length of wait and any accessibility issues, making the best use of available resources. It was hoped that this would allow the trust to collate patient data at a regional level to inform targeted work to address health inequalities in specific places. There was also enthusiasm about the potential to deploy technology and telemedicine services to improve efficiency along the patient pathway – for example, the centralised and automated screening of test results coming in from multiple sites.



### How are they being held to account for this work?

Accountability structures for taking an inclusive approach to reducing the backlog were not established in the trust or in the ICBs they were connected with. Disaggregated waiting list data for deprivation and ethnicity was not yet available, meaning that it was not possible to identify patterns, monitor changes in the data or set a metric to evidence progress. Within the trust and connected ICBs, referral-to-treatment waiting times (and, in particular, the number of people with the longest waits) were the main measures used for accountability, and the relationship with NHS England was characterised chiefly by reporting on the numbers of people with long waiting times.

Given the trust's ambition to establish a region-wide single point of access to equalise access to treatment within the specialty, this raised questions about what the structures of accountability would look like. As one ICB representative put it, in the absence of a blueprint for system- and region-wide ways of working in this area, accountability for taking things forward can be decided simply by 'who blinks first'.

*At the very least, [NHS England] should be specific about which organisation's responsibility it is to deliver these things. So, some things have to be a collective responsibility, but spell it out if it's a collective responsibility. If it's a responsibility for the trusts to do x, y and z, spell it out that it's the trust's responsibility or it's the ICB's responsibility. When you don't have that spelt out it becomes a bit of a vacuum, and then you've got to have a local negotiation about who's going to take a lead on something.*

ICB interviewee

Finally, there was some question about what aspects of addressing health inequalities in waiting lists should the trust be responsible for? For example, one interviewee from the trust told us that the wider determinants of health that drive health inequalities are 'not in our gift to do anything about or influence or implement change'. The role of the trust was therefore felt to lie in ensuring equality in the delivery of its services according to access and outcomes. Participants regarded the ICB as occupying the prime position to co-ordinate efforts to address some of the more 'upstream' drivers of inequality before and at the point of referral to secondary care. This might change, however, if arrangements were made for the trust to oversee and optimise the whole care pathway as a 'lead provider'.



### What is helping and hindering this work?

The work under way in the trust so far was felt to have been enabled by a number of factors:

- Leadership and the sustained efforts of passionate individuals: the trust's executive team consistently voiced their commitment to and support for thinking about health inequalities as part of their day-to-day work. Those leading on specific strands of this work – for example, the disaggregation of waiting list data – said they felt well-supported by the executive team. They spoke about their personal investment and motivation to drive this work forward.

*Persistence is my middle name, and that's my job... It's my professional role and responsibility to raise these issues, ask these questions, provide some evidence, and find platforms to discuss it at.*

Trust interviewee

- A commitment to collaborative ways of working and building relationships across systems and the region as a whole: there was a strong sense that working together at scale was the way forward in order to make best use of the available health care resource to meet demand.

There were also some tensions and difficulties associated with advancing inclusive approaches to addressing the elective care backlog:

- Collating and analysing high-quality data: being data-driven and 'evidence-led' was felt to be an essential place to start with this work. Getting hold of data to disaggregate waiting lists was described as a major challenge (and data quality was an issue too, with around 40% of data on ethnicity deemed potentially 'unusable'). The trust had little analytical resource to produce reports and make sense of the data. The limited sophistication of information technology (IT) structures and interoperability across multiple provider organisations and ICSs was another challenge limiting the sharing of data and the spreading of innovation across systems.
- The bandwidth and backing of clinicians to engage with this work: clinicians had been clear and directive about prioritising treatment of people with the most urgent clinical need and those who were waiting longest. However, it



was not necessarily clear to them how and why they should invest their energy in different ways of working (for example, offering weekend appointments) to facilitate inclusive approaches to elective care recovery. Another example given was that clinicians may not feel it is relevant (and some may not feel comfortable) to ask people for details of their ethnicity, which has ramifications for the availability and quality of detailed waiting list data. As one interviewee put it, there is further work to do to win the ‘hearts and minds’ of the clinical community, whose buy-in will be vital to the effectiveness of inclusive approaches to reducing the backlog.

- The resource and funding needed to sustain this work: we heard that funding for inclusive recovery work is harder to come by now than it was during the pandemic and the costs of establishing new models of care (including community-based diagnostic facilities) can be prohibitively expensive. In general, incentives and payment structures such as Payment by Results (PbR) were associated with siloed and separate ways of working rather than the collaboration envisaged by the trust in its vision for a region-wide model of care for the specialty.
- The impact of the NHS using the independent sector on efforts to reduce health inequalities in waiting lists within the specialty: we heard that independent sector providers focus on high-volume, low-complexity work. This means that people with more complex needs (which might include, for example, whether or not they require an interpreter) are redirected to NHS providers’ waiting lists. It is also the case that people with more complex needs tend to be those living in the most deprived areas and/or belonging to minority ethnic groups.

*Anyone who needs an interpreter, they have to be done by the NHS because it doesn't quite work for [independent sector organisations'] business model of high-throughput, get those people through, anyone who's got a complexity the NHS has to deal with...*

NHS England interviewee



## Trust C

- A trust with relatively good performance on waiting times located in an affluent area.
- Just starting to disaggregate waiting times data and consider developing a co-ordinated approach; progress being made within one specialty.
- Staff did not feel able to progress work until long waiting times had been addressed, although new staff in place with a health inequalities focus should support future action.
- ICS has a clear role on data, convening system partners and capacity management, although this work is at an early stage.

## Background

Before starting interviews in trust C, we did not know from our literature review and review of board papers whether it was doing anything to take an inclusive approach to reducing its backlog. The trust is based in an affluent part of the country, with an average level of ethnic diversity, and has relatively good waiting times performance.

## What is the trust doing?

NHS England's policy on taking an inclusive approach to reducing the backlog had not stimulated action in this trust when it was launched in 2020. In 2023, the trust was only just starting work on the key ask – to disaggregate waiting times data – and this data had not been reported to the board. A trust executive told us:

*I'm nowhere near where I would want to be, and I'm really waiting for our ICB to give us a bit more granular detail around inequality, because I want it cut both at system level, organisation level, and in specialty level, so that then, particularly from an elective recovery perspective, we're able to make decisions according to locality as well as according to demand on particular services and what we might be able to do differently.*

Trust interviewee



In line with this, interviewees acknowledged that work on health inequalities in general and on taking an inclusive approach to reducing the backlog specifically was just getting off the ground, although there were pockets of work under way from proactive motivated individuals.

Some new staff hired to work on health inequalities were expected to accelerate progress in the future. For example, the health inequality funding given to ICBs by NHS England had recently been invested in recruiting health inequalities staff in the trust, council and primary care networks, and a new senior responsible officer for health inequalities recently joined the organisation.

Although NHS England's policy has focused on ethnicity and deprivation as key factors to investigate, the main inequality that interviewees spoke about related to use of independent sector capacity. They were concerned that people with less complex needs could access quicker treatment from NHS paid-for private providers (who only had the anaesthetic cover levels needed to treat lower-risk patients), while people with more complex needs waited longer for treatment at the NHS trust. The way the organisation and system used private-sector capacity to help reduce the backlog was a major focus for elective recovery and central to their debates about 'fairness'.

The most notable pocket of progress came from a divisional director, who had progressed work on health inequalities and waiting times under their own steam. They accidentally found out about the policy on taking an inclusive approach to reducing the backlog through their own research and pulled together data that identified variations in DNA rates of between 10% and 20% among people living in the most and least deprived postcodes. The director secured external funding for a call operator to ring people and offer them support to attend their appointment.

*My approach with my division has just been, it's such a big topic, it's Mount Everest, everyone and their brother is talking about, I don't really know what anyone else is doing about it, so let's just do small interventions in our slice of the pie that will make a difference to our population and our care.*

Trust interviewee

The director also added inequalities monitoring to the trust's divisional performance dashboard and a target to reduce the disparity in DNAs between people from the



most and least deprived geographical areas. Even before implementing the DNA initiative, variation reduced, which was put down to the director taking data on disparities to each clinical lead and discussing it with them – thereby raising the profile of the issue.

Some relevant work was not categorised as tackling inequalities. For example, the trust had improved anaesthetic cover at its elective hub to enable it to treat more people with complex needs and provide greater flexibility about where people were treated; this measure would also address inequalities by improving access for people with more complex conditions. One role for the incoming health inequalities lead was collating and co-ordinating the trust's work on inequalities to provide a clearer picture of what it was doing.

The trust had big ambitions for the future. It had spoken to University Hospitals Coventry and Warwickshire NHS Trust about its work reprioritising people on waiting lists and was in the process of procuring AI software to enable it to do this as well as target prehabilitation work. However, interviewees from the trust and ICB told us that this work could not realistically be progressed until long waiting times were tackled. The trust was planning to pilot the idea of a health inequalities patient tracking list in one specialty to anonymously track people from deprived postcodes. It also had future plans to improve data quality and usage – including using primary care data to verify ethnicity coding in its hospital data, which was currently very poor and a barrier to investigating inequalities by ethnic group.

### **What is the ICB doing?**

The trust is located in a relatively large ICS and its local 'place' has three main acute trusts. Interviewees from the ICB and the trust described their work on health inequalities in general and on the backlog specifically as at an early stage. However, the ICB did have a clear role on data; it was leading work on disaggregating waiting times (and other) data by ethnicity, deprivation and other factors such as age. They were planning to bring analysts, clinicians and managers together from across the system to discuss the data and what should be done in response to it. Interviewees told us that it was difficult to find time to do this because of the pressure everyone in the system was under, but they hoped for some respite over the summer of 2023 that would allow a meeting to take place.



There were also ambitions to develop a shared patient tracking list across the system during the next year, and to use it to support demand and capacity management, particularly managing the use of independent sector capacity.

### **How are they being held to account for this work?**

Elective recovery progress was reported to the trust board and performance and finance committee. Interviewees said health inequalities did not really feature within that. One interviewee reflected on whether mandated reporting of disaggregated data was an effective approach:

*I would say mandating that stuff goes to board, I imagine, has very little correlation with whether you take effective action on it, because I think we've been told we have to take it to board but it makes almost no difference. Plus we get told to take loads of stuff to board.*

Trust interviewee

Work on health inequalities was not part of conversations with the national or regional NHS performance teams. Even in this trust, which had relatively good performance, the focus was still on reducing long waiting times.

The NHS England regional team had initially looked at whether elective recovery plans considered inequalities, but progress was not being monitored.

*So, in our tier conversations [performance management conversations between NHS England and the trust], other than paediatrics, inequality hasn't really come up, as I say. And then we've done some softer stuff about the broader assurance that they are looking at it but it's not something that hits the radar of our elective targeted intervention, because we're being driven by the political targets around long waits over everything else on elective at the moment.*

NHS England regional team interviewee

The ICB had separate governance structures for overseeing system work on health inequalities and elective recovery, although it was starting to think about how it might bring this together across programmes.





## What is helping and hindering this work?

Trust C is an organisation that is just beginning its work on taking an inclusive approach to reducing the backlog, but with ambitious plans for the future. Despite its relatively good performance on waiting times, staff felt unable to implement initiatives that they saw as having the biggest impact on inequalities (such as waiting list prioritisation and targeted rehabilitation) until their waiting lists were shorter.

Several interviewees mentioned the inspirational leadership from Professor Bola Owolabi, NHS England's health inequalities lead. They particularly noted her engaging with people who work outside of health inequalities, in finance and operational roles, and making the case for change in a way that made sense to them – for example, highlighting opportunities to address inequalities while also improving productivity.

Staff who felt passionate about the work were starting to develop ambitious plans for the future, but it was hard to find headspace for this work. Progress was described as being driven by staff using their 'discretionary' time and the work was yet to permeate into the operational divisions. Interviewees acknowledged that more clinical engagement was needed. When a divisional director had taken data to clinicians highlighting inequalities, it was felt to have already started to influence their actions in clinic, even before any specific intervention was implemented.

*I guess, you know, we talk about it [health inequalities] but I guess it's not real for a lot of people. As clinicians, we don't see the impact that it's really having. We might understand that people are waiting a bit longer from certain backgrounds but, you know, a real description of exactly what that is and what that means for different people to make it... you know, to just absolutely drive this message home about how wrong it is that there are these inequalities and what it means would be sort of required in order for, I guess, clinicians to really buy in and really want to make a difference in this, rather than just the trust saying 'this is our priority' and, you know, 'we're doing this'.*

Trust interviewee



The targeted health inequalities funding from NHS England was expected to bring a boost through funded posts focused on inequalities.

Several interviewees raised the issue of culture change, as two different ways of working had to be brought together to blend work on elective performance (immediate, operational) and health inequalities (longer-term, strategic).

Many of the people we interviewed said they could not make real progress until they had disaggregated their data and identified areas for action. Although the data analysis had been done, it was proving difficult to find time to bring together relevant staff across the system to discuss it. The trust also suffered from poor ethnicity data coding, although work was planned to improve this by working with primary care.

An overall lack of funding was also highlighted as a stall on progress:

*...as a trust, it's on one of our, what we call our breakthrough objectives, a real focus. It was on our project wall for a year and a half but nothing moved on because there wasn't any resource to it. If you look at our system strategy, health inequalities are paramount to what we want to do yet still no funding, no investment, and when you are up against, I don't know, discharge at the backdoor and that kind of stuff...*

Trust interviewee

Particularly important at this local area was the impact of independent sector alternatives for NHS care that could treat lower-risk patients. Interviewees told us that system-level tracking and greater control over which patients went where in the system would support efforts to equalise waiting times. The implementation of the patient choice policy was highlighted as something that was inhibiting this work.



## Reprioritisation and the use of AI to manage waiting lists

- Many English NHS trusts and ICBs are considering using AI to manage waiting lists. It can be used to take into account inequalities in the experiences of different people in accessing health care, waiting, and outcomes from treatment, not just waiting time.
- AI tools can be used to gauge the risk that a person's health will deteriorate while they are on the waiting list and their outcomes from treatment – information that can inform decisions about things like that person's position on a waiting list and other interventions to enhance their health while they wait for treatment.
- Early findings from unpublished studies on the impact of this approach indicate that it can narrow inequalities in health outcomes.
- As well as using clinical data to provide a more targeted approach to prioritisation, these tools enable wider risk factors such as socio-demographic data to be incorporated – something that some clinicians and the public have raised concerns about. We did not find any examples where organisations were doing this, and this type of change would require further conversations to make the case about what health inequalities are, how and why they should be addressed, and who has a role to play in doing so.

### Background

As set out in section 2, NHS England asked systems and trusts to think differently about how they prioritise care as part of their plans for recovering elective services after the disruption of the pandemic. Planning guidance for 2021/22 asked systems to analyse waiting list data to identify disparities for people living in the most deprived areas and for Black and ethnic minority populations, and to prioritise service delivery taking this into account ([NHS England 2021a](#)). One interpretation of this is that systems prioritise people on waiting lists not only on the basis of when they joined the list and of clinical need, but according to other factors that are associated with health inequalities.

There is an emerging evidence base for the potential of technology and AI tools to play a role in assessing, pre-empting and predicting the risks posed to a person's health while they wait for care with a high level of confidence ([Pritchard-Jones \*et al\* 2023](#); [Sharma \*et al\* 2023](#)). This risk assessment can then be used to inform clinical



decisions about the duration of the person's wait and their care plan in the interim and beyond. This approach marks a major departure from previous approaches to waiting list management (see box, 'How are waiting lists usually managed in the English NHS?', on pages 10–11).

We were keen to understand more about how this was working in practice and to learn from local efforts to use AI to prioritise care, but unfortunately we were unable to recruit a case study trust where this approach was being implemented. In two of our case study sites (A and C), software was being procured to enable this work in the future, but it was yet to be started.

Instead, we interviewed six stakeholders working in different trusts, ICBs, and academic and support organisations about their work using AI to prioritise care and analysed available literature relating to this approach. This subsection sets out the findings from that analysis.

### **The case for adopting this approach**

Undertaken on a case-by-case basis by clinicians or automated with the use of AI tools, the reprioritisation of waiting lists is a way for people deemed to be in 'greatest need' (however that might be defined) to receive treatment faster than those whose need is deemed less urgent (Rathnayake *et al* 2021). In some systems in England and elsewhere, tools have been developed to take a range of variables into account when prioritising people for care and/or to inform care planning and the delivery of health care services to meet people's needs. Some of these variables might be termed 'clinical' (eg, body mass index (BMI) or blood pressure levels) and some are 'non-clinical' (eg, ethnicity, or ability to undertake activities of daily living or employment) (Pritchard-Jones *et al* 2023; Doshmangir *et al* 2021; Gutacker *et al* 2016; Solans-Domènech *et al* 2013). Some variables (whether clinical, social or functional) may be deemed more relevant and impactful for some conditions than others (Doshmangir *et al* 2021).

However, the separation of 'clinical' and 'non-clinical' factors is less neat than this implies. People living in the most deprived areas or belonging to Black and ethnic minority populations, for example, are more likely to experience more complex and severe health problems (Pritchard-Jones *et al* 2023; Sharma *et al* 2023). One interviewee based in an ICB had found that 47% of those on the waiting list rated as 'high risk' by an AI tool belonged to the 20% most deprived communities.



*What we found is that social determinants of health are strongly correlated with not only the number, but also the severity of comorbidities. And that kind of makes sense... So, essentially, we are capturing things like social determinants of health but based on clinical need as opposed to artificially positively discriminating against particular groups or choosing certain groups based on certain high-level parameters. So, it's based on individual clinical need but also assimilating takes into account social determinants of health. And importantly, we can track what then happens to those patients to ensure that actually the delivery of care, which is the ultimate aim, has been equitable, and that there hasn't been any detrimental impact to any of those vulnerable groups.*

AI systems provider

Although prioritisation of care on the basis of structural, economic or social factors has generated debate among clinicians and the public, we found examples in the literature and in our interviews that value judgements on the basis of 'non-clinical' factors inevitably already influence some clinicians' decisions (Rathnayake *et al* 2021; Solans-Domènech *et al* 2013). It has been argued, therefore, that a standardised tool or an automated approach to prioritisation would allow for transparent and consistent decision-making against a defined set of criteria (Rathnayake *et al* 2021; Solans-Domènech *et al* 2013).

### **What this approach looks like in practice**

Through our interviews, we found that this approach takes a slightly different form in different trusts and/or systems. In the examples that we heard about, AI tools are used to calculate a risk 'score' for each person on a waiting list. This risk score is calculated using a machine learning methodology applied to large datasets that are case matched with the available data for an individual. It takes into account variables relevant to that person's health condition, the proposed intervention and comorbidities. Demographic variables, such as ethnicity and deprivation, do not directly influence the risk score in any of the systems we heard about. Similarly, we did not hear any examples where social factors informed a person's risk score. Some interviewees working in NHS trusts expressed their hope that AI tools will soon incorporate demographic and social factors into the risk score where there is a known correlation between those factors and the health condition in question.

Once this risk score has been generated, different systems adopt different methods to act on the results. In one case the risk score has been used to inform the



order of the waiting list and other clinical decisions – for example, planning for a patient’s recovery following their treatment. In other cases, it has been used to identify people who would benefit from prehabilitation or other interventions to optimise their health condition for surgery and reduce the risk of complications during the procedure (for example, see box). This outreach might comprise ongoing contact to assess and monitor a person’s state of health while they are waiting for treatment, and to offer people support, advice and reassurance to prepare them for treatment. This work has the potential to be delivered by a range of partners (such as hospitals, primary care, community services and VCSE organisations) depending on the person’s needs. In one case, we heard how this approach had facilitated social and economic interventions such as referring people at greatest risk of developing a chest infection following their treatment for financial support with their energy bills, to enhance their quality of life and their care outcomes. It is worth noting, however, that these initiatives rely on people taking up the offer of prehabilitation; and data from one study shows that take-up can be limited (Pritchard-Jones *et al* 2023).

In two systems that are known to be applying variants of this approach, ‘success’ was associated with equity in health outcomes for people who would otherwise disproportionately experience a deterioration or complications with their condition. We heard that these systems are compiling an emerging (yet to be published) and growing evidence base for this approach, which shows:

- a narrowing of inequalities in health outcomes according to ethnicity after using an AI tool to target prehabilitation interventions
- reduced rates of complications and length of stay in hospital among those rated ‘high risk’ by the AI tool.



## Targeted prehabilitation support in Cheshire and Merseyside Integrated Care System

In Cheshire and Merseyside Integrated Care System, 'risk stratification technology' has been used to identify individuals at high risk of complications following their treatment and to provide targeted support while they wait.

The technology combines data from 11 sites (as part of an agreement between the Caldicott Guardians and information governance leads in the ICS and NHS trusts) and the Combined Intelligence for Population Health Action (CIPHA) tool, allowing for the triangulation of people's health data with other personal data. This includes patient-generated data such as questionnaires and outcome measures as well as primary care data from the continuous care record. The data is used to inform holistic 'wraparound' support in the community to improve and enhance people's health.

This support includes offering people a personal health coach via an app called Surgery Hero, which offers one-to-one coaching to help people set behaviour change goals for exercise, diet, sleep and mental wellbeing.

A pilot study of this approach based on 150 'high-risk' patients (those with a greater than 5% risk of a chest infection following their operation) and focusing on post-operative pulmonary complications resulted in the following outcomes:

- an average reduction in length of stay in hospital of four days and a higher conversion of patients-to-day cases in the prehabilitation intervention group than in the control group (35% versus 26%)
- a 65% reduction in post-operative complications and a lower rate of complications arising in the prehabilitation intervention group compared with the control group (6% versus 13%)
- a cost-saving of £2,100 per patient
- an average patient satisfaction score of 8.5/10.

(Carding 2023; Pritchard-Jones *et al* 2023)



### Challenges and opportunities associated with taking an inclusive approach to reducing waiting lists

Perhaps unsurprisingly, given the fundamental differences between the inclusive approach and more traditional approaches to managing waiting lists, the literature and interviews uncovered a number of important considerations in taking this work forward. Chief among these was the reticence – if not outright opposition – to the idea that non-clinical factors could affect a person’s position on a waiting list. This opens up a much bigger conversation about the wide range of expectations of the NHS and notions of ‘fairness’ in relation to waiting for elective care. Critics have raised concerns about the ‘subjectivity’ associated with using social value judgements to determine a person’s place on a waiting list and the risk of ‘replacing one form of discrimination with another’ (Palmer 2023; Illman 2022a).

The buy-in of clinicians and allied health care professionals was identified as something that could make or break this approach in practice. In New Zealand, where prioritisation tools have been developed and used in health care since the 1990s, studies have documented resistance, inconsistent use, and manipulation on the part of health care professionals who questioned the relevance and/or validity of non-clinical criteria in their delivery of patient care (Palmer 2023; Gauld and Derrett 2000). We heard from some interviewees about the necessity of engaging with the clinical community to hear and respond to their concerns about the approach, and to ensure that these were reflected in the design and implementation of the tool itself – a theme reflected widely in the literature (NHS England 2022c; Rathnayake *et al* 2021; Déry *et al* 2020; Bruni *et al* 2010). The literature indicated that decisions about prioritisation might best sit within multidisciplinary teams; nurses, social workers and administrative staff who are perhaps more familiar with an individual’s personal circumstances than a consultant were felt to have a great deal to offer in conversations about what form this approach might take (Srikumar *et al* 2020; Solans-Domènech *et al* 2013).

Alongside this challenge, there is the matter of engaging meaningfully with the public in the spirit of transparency about how clinical decisions are made and in co-designing the tools that might be used to that end (Déry *et al* 2020; National Voices 2020; Hunter *et al* 2018; Bruni *et al* 2010; Sampietro-Colom *et al* 2008).





Recent deliberative research with members of the public in Coventry and Warwickshire found that:

- opinion was divided on the inclusion of non-clinical factors such as impact on ability to work/study/fulfil caring responsibilities in prioritisation decisions
- there was limited support for prioritisation according to demographic factors such as ethnicity, or lifestyle factors such as smoking status and alcohol intake ([Patel et al 2022](#)).

The public's concerns were felt to be rooted in notions of 'fairness' – that is, the potential adverse or unintended consequences for other groups of people who may have to wait even longer for their treatment if others were moved up the queue.

Interviewees described public opinion as a potent force in the way trusts and systems currently use this approach. In University Hospitals Coventry and Warwickshire NHS Trust, engagement with the public had directly informed the design and development of the prioritisation tool to guard against some people's fears that it was possible to 'game' the waiting list and attain a higher priority on the basis of 'less objective' factors that were not specific to a health condition. Specifically, this has entailed the building in of safeguards to ensure that no person waits longer than the waiting time standard stipulates; if that happens, they are immediately prioritised for treatment (Illman 2022a). But we also heard from interviewees about the public's concerns over whether or not demographic factors such as deprivation and ethnicity should influence the length of their wait for care, as well as raising questions about the extent to which it is incumbent on the NHS to venture into the realm of the wider determinants of health. One interviewee shared their impression that the public overall has not fully bought into the idea of health inequalities as a systemic phenomenon worthy of a systemic response; rather, the more common view is that individual choice and lifestyle factors are responsible for people's experiences of health. Given the strong feelings that can abound in this conversation, some stakeholders based within the NHS – despite being passionate about addressing health inequalities – said they were very hesitant to venture into this territory as it is perceived to be a 'can of worms' with the potential to reap reputational damage to individuals and to NHS trusts as a whole.



*There was quite a discussion about whether the NHS should be having to deal with the wider social inequalities that we see in society. And I think that was a really important discussion point, that people wanted a fairer society... They didn't want to see these differences. The question that was raised was, is it right that the NHS is having to do things differently because of those differences?*

NHS trust interviewee

Interviewees spoke enthusiastically about the potential for AI tools in their current form to be applied across entire ICS footprints. Ideally supported by a shared system-wide patient tracking list, the tool would bring together data for individuals living in the area with the potential to inform targeted work to improve the quality of life for 'high-risk' individuals in a number of domains such as housing. In this way, AI tools were felt to offer an inclusive approach to managing elective care waiting lists sustainably and over the long term by potentially addressing some of the causes of health inequalities upstream at their source. It was also argued that this approach would provide oversight of demand and need at a population level alongside the supply and capacity available to meet it, informing decisions about how to make the most effective use of the available resource to treat those with the highest risk of their health deteriorating while they wait.

### What did interviewees say would make a difference?

We asked all our interviewees what additional support would help them address inequalities in their elective care backlog and make the move that many told us they were struggling with – from general ambitions to meaningful and specific actions. Their ideas for what would help included the following.

#### Data tools and templates to help identify inequalities

- A template for the best practice dashboard that every system should use to track inequalities, including in waiting times.
- A baseline dataset that everyone should be looking at from a health inequalities perspective.
- Benchmarking, to help them understand relative performance.
- A single performance measure that would 'crystallise' the ask, and be used to focus the board's attention on the issue and track high-level progress.



### **Support to help them respond to inequalities they identify**

- A support offer linked to performance on the dashboard.
- Case studies that people can look at once they identify an area or issue where they need to take action.
- Evidence about what works (many interviewees told us this was essential to help them get buy-in from colleagues and leaders).
- Other ways to share learning between systems; people mentioned the monthly calls with the NHS England health inequalities team as being very helpful.

### **Guidance to help trusts and systems develop their approach to reprioritising their waiting list, particularly on:**

- the best way to discuss reprioritisation of waiting lists with staff and the community with an ethical framework to help support those conversations
- how to consider social value when organising the waiting list – and clarity on what is ‘within the rules’.

### **National policy changes** *(interviewees mentioned some specific examples)*

- Ring-fenced money for health inequalities, which could not be siphoned off for other things, delivered in a way that gives local systems flexibility to decide how to spend it.
- More alignment of different policies that affect elective recovery. Patient choice policy was highlighted as an example of a national policy that might work counter to an inclusive approach to recovering elective services. Linked to this, some felt that use of the independent sector to reduce waiting lists had the potential to widen inequalities if it was only accessible to people with less complex conditions.
- More clarity on the ‘must dos’ for trusts and systems, and who is accountable for progress. This might include a more nuanced way to track progress with elective recovery that incorporates the experience of waiting and outcomes, as well as length of wait time.



## 4 What have we learnt?

In the aftermath of the first wave of the Covid-19 pandemic, the NHS decided to think differently about its approach to recovering elective services. NHS England asked integrated care boards (ICBs) and NHS trusts to address health inequalities as part of their work to tackle the list of people waiting for elective care (including the anticipated pent-up demand generated by fewer people accessing GP services during the pandemic) (Morris and Reed 2022). This call for an inclusive approach to reducing the backlog was part of a general push to ‘build back better’ – a feeling that the pandemic could be a pivot point after which public services might start to make real progress addressing some of the fundamental inequalities in society, which had been laid bare by the unequal impact of Covid-19 on different population groups.

As we described in section 2 of this report, NHS England asked trusts and ICBs to start work on inclusive recovery by identifying inequalities on their waiting lists by deprivation and ethnicity and then prioritising service delivery by taking this into account. This was a fundamental change in the way the NHS was asked to manage waiting lists, bringing work to tackle inequality into a core NHS operational process – the management of access to elective care. It was also an ask made with little detail about what changes should be implemented or how social and demographic factors such as deprivation and ethnicity should be incorporated into waiting list management.

### Slow progress

Our research looked at how this potentially transformative new policy was being interpreted and implemented locally. In case studies of three local trusts and their main ICBs conducted between December 2022 and June 2023, we found that progress had been slow, and work to take an inclusive approach to tackling waiting lists was at a very early stage. Only one of the three trusts had disaggregated their data and started to act on it. The other two were just starting the process of analysing their data in 2023 – two years after the initial ask. None of the case study trusts or ICBs were regularly reporting disaggregated data to their board (despite



a specific ask in operational planning guidance), while our analysis of board papers from 13 NHS trusts and 13 ICBs from the second half of 2022 found that none of the ICBs reported disaggregated waiting times data to their board and just three NHS trusts reported in their board papers that they had done this analysis (none of them included it in their publicly available board paper performance packs). The fundamental shift set out in NHS England's policy had not yet happened, and in many cases the first step towards working out how to make the shift was still a work in progress. But what did our research tell us about why?

### An unclear ask

The policy ask was diffuse and high level – peppered across different letters to the NHS, planning guidance and elective recovery strategies. Nowhere was it set out in any detail why organisations should take into account wider risk factors when prioritising elective care, other than a couple of sentences stating that ethnicity and deprivation were the areas where health inequalities had widened during the pandemic (NHS England 2021a). The fundamental nature of the change in approach that the policy implied was not recognised in the information published about it. When we spoke to people in local trusts and ICBs who were resistant to the idea of focusing on inequalities in waiting lists, they wanted a clearer articulation of why this work was needed, what action they should take, and evidence about what interventions worked to solve the problem. People we interviewed said that most people had either no awareness or very limited awareness of the policy or the overall drive to take an inclusive approach to reducing the backlog.

### Different views on fairness and resistance to a new approach

We heard two opposing descriptions of a 'fair' approach to reducing the backlog. Some interviewees spoke about an approach based on proportionate universalism – that is, tailoring the way waiting lists are managed to the needs of the people on those lists. These interviewees thought that the best way to tackle inequalities as they present on waiting lists was to prioritise people for treatment based on a wide range of factors, including structural, economic and social factors when they are relevant. Others (who were sometimes equally committed to reducing inequalities) felt that the best way to achieve this was to address long waiting times. They felt strongly that treatment priority should only be linked to a more narrowly defined view of clinical need.



A lack of consensus on the fair and equitable approach to tackling waiting lists was stalling progress. In trust A, plans to start work to reprioritise waiting lists had stalled because of resistance from clinicians, while in trust B and trust C, leaders were concerned about how clinicians would react to the work. All three trusts were wary of public reaction; the results of an in-depth piece of deliberative work with the public in Coventry and Warwickshire suggest that they are right to be wary, as participants did not support the use of ‘non-clinical’ factors to prioritise care (Patel *et al* 2022). In New Zealand, where this type of work on reprioritisation has been undertaken for decades, recent efforts have stalled because of public concerns (Palmer 2023; Gauld and Derrett 2000). The roll-out of an Equity Adjuster tool – used by hospitals to prioritise people who had been waiting more than two years for surgery – was delayed in 2023 pending a review. This followed controversy about the use of ethnicity (alongside a range of other factors) as a factor in prioritisation decisions (Palmer 2023).

### Data issues and the power of community engagement

Data issues were also cited as a major barrier to change. The case study trust that had completed and acted on its disaggregated analysis of waiting times data had unusually good ethnicity coding, whereas the other trusts cited poor-quality ethnicity coding as a barrier (trust C was hoping to improve this through joint work with primary care), along with limited capacity to undertake the analysis. Although looking at data is an essential starting point to help systems and trusts understand who is on their waiting list and the way they progress from referral to treatment, we heard that data issues do not need to completely stall the work. Although ethnicity coding was an issue, many of the useful analyses we heard about looked at other factors such as deprivation. Analysis can be the start of a conversation and can prompt conversations with different communities and groups to help verify and understand the inequalities identified.

A strong message we took from the research was that there are things systems and trusts can do right now that will start to address inequalities on waiting lists. We also heard that data is the most powerful way to help people ‘see’ the issue and understand why action is needed to tackle inequalities on waiting lists. In trust C, talking to clinicians about inequalities on their own waiting list, using their own data, was thought to be already having an impact by influencing clinician behaviour, even before interventions to address the underlying causes were implemented.



## Pockets of success on access to appointments and reprioritisation

Our wider analysis shows that some trusts and systems are taking action. The interventions we read about in the literature (mainly examples showcased by NHS England) and the small number we identified in our case study trusts can be crudely split into two groups: access interventions that make it easier for people to attend appointments, and reprioritisation interventions that prioritise people for treatment (including prehabilitation) based on a wider range of factors than the date they joined the list and broad clinical risk bands. On pages 23–24, we set out what some of these initiatives look like in practice.

In our case study sites, work was under way in the first category (access interventions). Trusts A and C were undertaking work to make it easier for targeted groups of people to attend appointments and trust B was developing a single approach to managing waiting lists for their specialty across the region to reduce unwarranted geographical variation. The process improvements were relatively straightforward to develop and implement, incorporated a range of factors in their targeting (including deprivation), and were starting to narrow inequalities in the time people waited from referral to treatment (by reducing the delays caused by missed appointments between those two points). However, even these relatively simple improvement projects were proving difficult to roll out, although one trust with one of the biggest backlogs of people with the longest waits was making some progress, showing that change is possible even within the current environment.

None of our case study trusts had implemented interventions in the second category, reprioritisation (trust A had abandoned early discussions after resistance from clinicians), but they all saw this as an ambition for the future, and two of the three case study trusts were in the process of procuring software to support them with the work. We spoke to other integrated care systems (ICSs) that have adopted an approach to reprioritising their waiting lists and delivering tailored prehabilitation according to a more detailed assessment of clinical risk using artificial intelligence (AI) (compared to the broad clinical risk assessments that already inform prioritisation; see section 2). They are starting to build evidence that these initiatives offer great potential to improve the experience of waiting and outcomes for elective care patients.





## Social determinants not used to prioritise treatment

The NHS England policy highlighted deprivation and ethnicity as factors that should be taken into account when prioritising service delivery, but did not expand on what this might mean in practice. We did not identify any examples – in our interviews or the literature – of trusts or systems in England who were incorporating these factors into the way they prioritised people on their waiting lists. Nor did we find examples of other factors – such as someone’s job or caring responsibilities – being brought into the algorithms (although it is likely that these are sometimes informally brought into prioritisation decisions by those managing waiting lists). This was seen as a step that would require extensive engagement with clinicians and the public before it could be implemented. Some questioned whether this was the right approach, as they told us that inequalities based on factors such as deprivation could be reduced by incorporating clinically relevant variables with which they correlate (eg, obesity) into the targeting approach.

Our evidence suggests that trusts and systems can make progress addressing inequalities on waiting lists without straying into the controversial territory of prioritising care based on broader risk factors relating to structural, economic and social inequalities. However, as with any improvement project in the NHS at the moment, development and roll-out is difficult due to funding, staff and demand pressures.

## Harness the passion of operational and clinical leaders

During our interviews many people spoke about their passion for addressing inequalities and their desire to thread this through their organisation’s elective recovery efforts. It was these individuals who were responsible for the pockets of progress we saw. We were struck by examples of the critical role played by people in positions one level below the executive team where operational and clinical leaders can do the legwork needed to get staff onside and implement change in a way that is tailored to their specialties. Yet in other cases, the policy on an inclusive approach to reducing the backlog did not seem to have filtered down to people at this level. To make progress, the NHS needs to harness that enthusiasm and give these leaders the tools and ideas needed to make change in their clinical areas.





Part of this is about making the case for change and setting out evidence about what works. We had conversations with clinicians who did not understand what was meant by inequalities on waiting lists and wanted to know more about why they should take action. We also heard from finance and operational leaders who had been inspired by hearing the case for change articulated in language that made sense to them – with opportunities to deliver productivity improvements at the same time as addressing the inequalities that had been identified. The NHS England health inequalities team was mentioned by quite a few interviewees who said their profile had increased and they were starting to get the message across. But to be successful, this work needs leaders at all levels of the system to be making the case and encouraging use of the tools available to take action. We have previously highlighted the potentially powerful role that named health inequality leads on NHS boards can play in this type of work ([Chauhan et al 2021](#)).

### The potential role of ICBs has yet to be realised

Across all three trusts, we did not find the ICBs taking a significant role in an inclusive approach to reducing the backlog. However, there is potential for systems to have a relatively quick impact on health inequalities using their system-wide perspective – to bring together data and people and share best practice to support change. This work could help them to show they are living their values and starting to make progress with addressing inequalities. In one case study trust, the ICB was leading the data work and was in the midst of completing the initial analysis. They were planning to bring together health care leaders in the system to discuss and act on it, but they had yet to do this as it was difficult to find time for people to come together for this purpose. In another case study trust, the work was led by the trust with the ICB providing minimal input; and in the specialist case study trust, the ICB was less relevant because of the trust's large geographical focus that covered multiple ICBs. We heard that ICB work on health inequalities in general was at the early development stage and still being established (although it was a priority for them) – so it is not surprising that work to take an inclusive approach to reducing the backlog was also at an early stage. Interestingly, none of our interviewees mentioned the role of the integrated care partnership (ICP) in advancing this work, despite its focus on population health and collaboration across community partners.



## Competing pressures and lack of accountability

Across our three case study trusts, the most consistent message we heard – in almost every interview – was that progress in taking an inclusive approach to reducing the backlog was not possible because the NHS was focused on addressing long waiting times for elective care. ICBs and trusts told us this was what the NHS regional team was holding them to account for, and was therefore where energies were focused. Although original elective recovery plans had to include information about how health inequalities were going to be taken into account in order to be signed off by NHS England, we heard that they were not tracking progress in fulfilling this aspect of the plan. Some interviewees argued that tackling long waiting times helps to reduce inequalities (and our analysis shows that people waiting the longest for treatment are concentrated in areas of high deprivation). Yet we also heard that some of the initiatives to tackle these long waiting times (for example, use of the independent sector, where only lower-risk patients can be treated) could exacerbate inequalities, as higher-risk patients (often from more deprived areas or minority ethnic groups) had to wait longer for treatment at the NHS trust.

We did not hear about any formal performance management or accountability structures for inclusive recovery within NHS trusts or at ICB level, except for one divisional director who had added a target to reduce inequalities to their division's dashboard and was monitoring progress against it. We heard that the highly developed accountability infrastructure for tackling long waiting times reinforced that this was the 'real' area of priority – and one where failure to meet targets would result in serious repercussions. This is in line with findings from a recent analysis of health inequality accountability structures since 2010, which found that systems for holding the NHS to account for work to address health inequalities have been weak (Allen and Boyce 2023).

Although there is consensus that ICBs and trusts are not being held to account for their work on health inequalities, when we asked what accountability should look like, there were very few ideas on this. Interviewees were uncertain about what a meaningful measure of success would be, and noted that the policy on taking an inclusive approach to reducing the backlog did not set out a clear vision for this. Some suggested that a new 'target' for health inequalities in waiting lists might be needed. Others felt that embedding targets in the performance frameworks used



to oversee ICBs and trusts would stifle local innovation, and that those who were going to act would do so anyway.

Although it will not work on its own, one part of change must be to monitor and hold ICBs and trusts to account for their work on taking an inclusive approach to reducing the backlog. This relies on a robust definition of success being agreed between NHS England and ICBs.

It is worth acknowledging that although formal structures of accountability may give people the ‘permission’ they need to drive this work forward, it is unlikely to be sufficient given the wholesale change in culture and ways of working that will be required to advance the inclusive elective care recovery agenda as a whole.

## Money

Is the solution about money? The initiatives we heard about in our case study trusts had sourced funding from pots of money that were not part of core trust budgets – for example, money from condition-specific networks or NHS England money that was ring-fenced for health inequalities. For this work to be part of the NHS ‘business as usual’ as we hoped it might be when we started out this research, it must be funded from core budgets rather than add-ons, which rely on motivated individuals to apply for on an ad-hoc basis, and is often time limited. In our research we saw a funding picture that is very far from that. And staff time was often being contributed voluntarily to push the work forward – reinforcing the idea that health inequalities work is a passion project for some individuals rather than core business of the NHS.

Current policy has resulted in a stalemate: a broad acknowledgement that it is important to address health inequalities in waiting lists, but a call to action that was poorly defined and has not penetrated existing attitudes, ways of working and structures of accountability. In the next two sections we conclude the report and set out three areas where the NHS must act at national, regional, system and organisational levels if it wants to address inequalities on the still-growing waiting list for elective care.



## 5 Conclusion

Waiting lists are one place where the causes, experiences and consequences of health inequalities coalesce. If the NHS is serious about addressing health inequalities, it needs to address inequalities on waiting lists for elective care as part of that.

The King's Fund welcomed NHS England's call for systems and trusts to take an inclusive approach to recovering services after the first wave of the pandemic. However, our research shows that this vision is yet to be realised, because funding, accountability and performance management structures are firmly focused on addressing long waiting times for care, and are largely ignoring the inequalities that mean that people from some groups wait longer than others. The case for change has not been made strongly or clearly enough to convince clinicians and other staff to consider inequalities. Work to address long waiting times is important and can, in some cases, reduce inequalities (for example, where people waiting the longest are predominantly from more deprived areas) but it takes capacity, resource and staff 'bandwidth' away from the more nuanced action needed to identify and address many of the other inequalities that manifest on waiting lists.

For trusts, our research shows that rather than doing something completely new, a lot of this is about work they already have in train being done in a more targeted way, and using data and community insights to work out what that targeting should look like. It is about identifying inequalities taking into account people's ethnicity and level of deprivation, alongside a range of other factors relevant to a particular condition or situation, and using this to target work to address inequalities. This might be achieved by working to ensure that people do not wait longer for care because they miss appointments, or by supporting people while they wait to be as healthy as possible, so that they can proceed with treatment when they reach the top of the list and get the best possible outcomes.

There are cases where developing an inclusive approach will take more time and resource alongside essential work to tackle long waiting times. The policy is hitting a system that is already struggling to stay afloat because of significant financial



and operational pressures. If the NHS is to play a meaningful role in tackling inequalities on waiting lists then that work needs to become a core part of effective waiting list management now, rather than the system not being able to do so until current pressures subside. To overcome inertia and a lack of progress, leaders at all levels must support staff who are trying to do this work – recognising the value of their actions to tackle inequalities alongside work to tackle long waits. In the long term these approaches contribute to a more equitable health system and healthier communities.



## 6 Recommendations

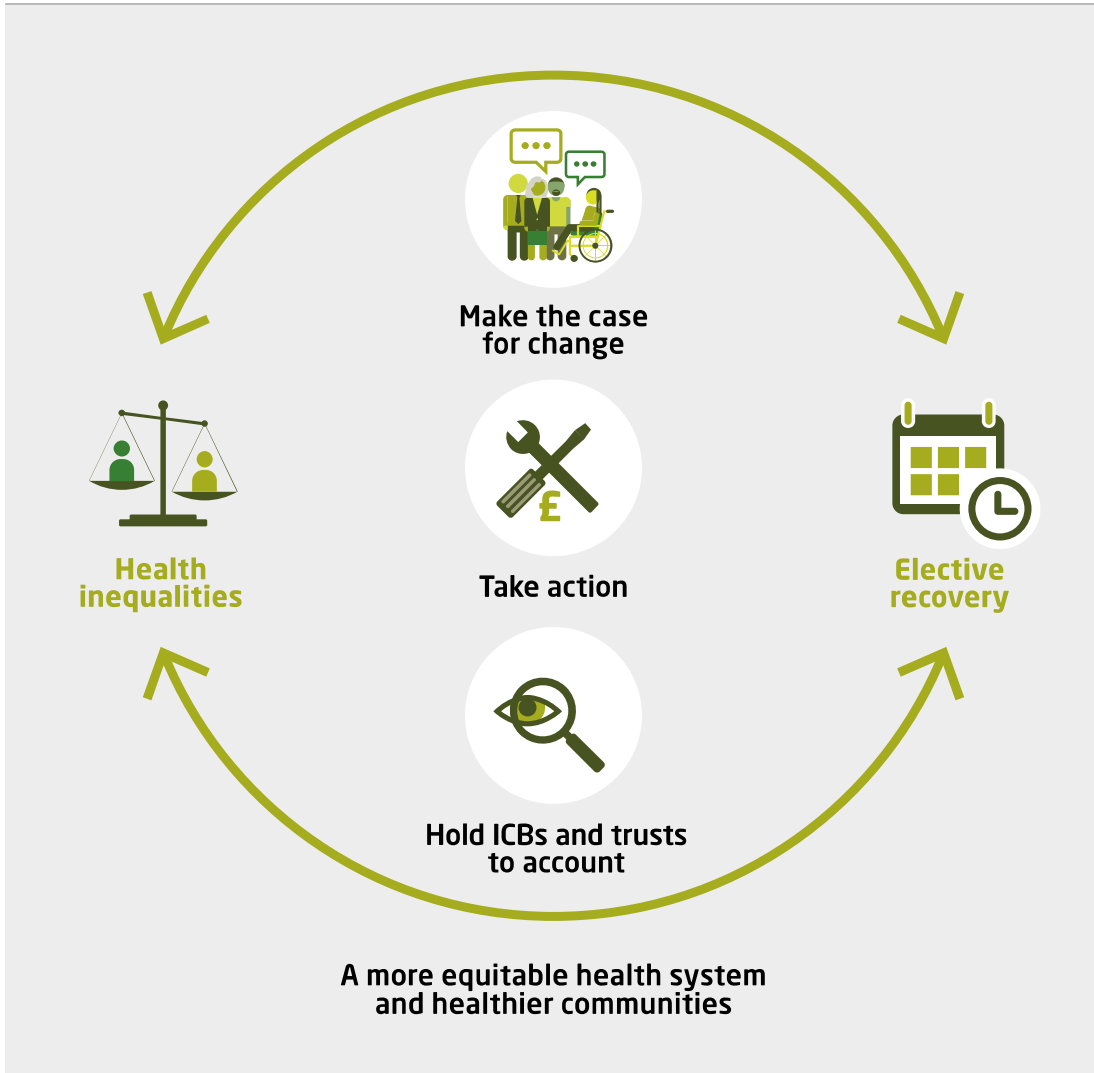
Our research covered just three local areas, so is not representative of action across England, but it included conversations with people from systems and regions about how work was progressing across their patch (and not just in the trust in question). It also included a review of the literature and news reports about local action and a workshop with a range of stakeholders, which included a discussion on whether their experiences matched what we heard in our research. We therefore believe we have developed a clear enough picture of the variation that exists across England to extract some useful learning about what different parts of the system should prioritise for action.

If the NHS wants to realise its ambition on health inequalities, one important part of this is elevating work to tackle inequalities on elective waiting lists. We have identified three areas that bridge the gap between current policy and practice, and between the aspirations to deliver elective recovery and to address health inequalities in waiting lists. These are the areas we believe national, regional, system and organisation leaders need to focus on to accelerate progress in taking an inclusive approach to reducing the backlog. Progress will be based on joint working between a range of organisations across the NHS, the wider public sector and the voluntary, community and social enterprise (VCSE) sector. Here, we set out recommendations for three key actors, including how they should work with others. They are NHS England, integrated care systems (ICSs) and NHS trusts. ICSs include the integrated care board (ICB) and the integrated care partnership (ICP), which both have an interest, duty and role to play in reducing inequalities.

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**Figure 2** Recommendations for bringing work on health inequalities and elective recovery together





## Make the case for change

As we set out in section 2 of this report, current approaches to managing waiting lists (on the basis of clinical need and length of wait) can perpetuate and exacerbate inequalities. To make progress with an inclusive approach to tackling waiting lists, national and local leaders need to clarify the case for change and start a much bigger conversation with the public, health and care professionals and leaders about the relevance, importance and urgency of this work as core to elective recovery and people's health.

### NHS England should:

- **put an inclusive approach at the heart of its elective recovery plans** and set a vision that clearly explains why taking targeted action to address inequalities in the backlog is good for individuals, good for communities and good for the NHS. This vision must recognise the need for local systems and trusts to dedicate resource to understanding their local population's experience of waiting and addressing the inequalities that they identify – work that starts with exploring disaggregated waiting list data. The vision must explain the relevance of deprivation and ethnicity to these questions along with other potential factors. This will send a clear signal on the importance of work to address health inequalities within the elective recovery strategy and provide a call to action that systems and trusts can use to engage staff and the public. The vision will be most effective if developed in partnership with organisations such as the Royal Colleges and patient representative groups.
- **engage the public in this vision.** Waiting lists have a big impact on people's lives and any changes in how they are managed should be implemented alongside engagement with communities to help them understand the changes.

### Integrated care systems should:

- **set out what an inclusive approach to tackling the elective care backlog means in their system** and place it at the heart of their elective recovery strategy. This should include their vision of a fair approach to managing waiting lists, which sets out goals for what they want to achieve locally and how this fits with wider plans to tackle health inequalities.





- **work alongside NHS trusts to engage clinicians, operational leads and communities in this vision.** Local authority and VCSE partners within ICPs have expertise and insights that can support this work. ICS work on health inequalities is still at an early stage but taking an inclusive approach to reducing the backlog could provide a relatively quick way to show they are living their values on health inequalities and having an impact as one part of a broader strategy.

**NHS trusts should:**

- **work to engage their board, clinicians and operational leads and communities** in the vision to take an inclusive approach to reducing the backlog, and develop an organisational view of what success looks like. Trusts should use local data to illustrate the issue and talk to staff about how people are currently prioritised and supported, and what changes might make a difference. Their local joint strategic needs assessment (JSNA) and director of public health, along with local VCSE partners, have significant skills and insights to contribute to this work so should be important partners in it.

### Take action

Our research highlighted some areas where systems can take immediate action. These are 'hygiene factors' integral to the management of waiting lists and the effective delivery of health care, as well as steps towards taking an inclusive approach to tackling waiting times.

**NHS England should:**

- **develop and share guidance, tools and examples** of analysis that identifies inequalities to help systems translate their vision into reality, and work with communities to gather insights as to their causes, and interventions to address those inequalities. Our research highlighted a need for guidance to help systems develop their work on reprioritisation – including an approach and ethical framework to support conversations with the public, and an approach to considering the social determinants of health. This will be best developed in collaboration with partners such as patient representative groups and the Royal Colleges.



- **make long-term, sustainable funding** available to support work on health inequalities, which can be used flexibly by systems (for example, to support project management or strategic support as well as individual initiatives).

**Integrated care systems** should:

- **prioritise and accelerate efforts to develop a quality data source** that allows for the exploration of inequalities at system, trust and specialty level. They should also undertake high-quality analysis of the data, drawing on expertise from local authority public health departments and other local partners as appropriate, and bring together key stakeholders across the ICP to discuss the analyses and decide what actions to take. This work should include analysing who does and does not get access to NHS-funded care from independent sector providers, so that they can take mitigating action if quicker access for some people results in widening of inequalities.
- **share best practice** across the patch – around data analysis and gathering community insights, as well as interventions to address the inequalities identified.
- **provide access to additional funding opportunities** to support implementation when possible.

**NHS trusts** should:

- **highlight specific actions and examples that will support change, rather than focusing on high-level ambitions** – for example, approaches to analysing waiting times and missed appointments to identify inequalities; engaging patient and community groups to help them understand what drives the inequalities; and engaging clinicians and other staff in the data and examples of initiatives that have had an impact, such as the work on ‘did not attend’ (DNAs), prehabilitation and accessibility that has been described in this report.
- **work with local communities and their representative VCSE sector organisations** to understand why inequalities on waiting lists exist in their area, and to develop initiatives to address them, so that the local case for change is centred on an understanding of how and why those inequalities exist.



## Hold ICBs and trusts to account

The potential for performance targets to distort priorities and have unintended consequences is well known. However, the NHS can and must make health inequalities part of the way it holds systems and trusts to account and be included as one aspect of performance management.

### NHS England should:

- **embed health inequalities into its core assessments and performance management processes** for elective recovery in their national and regional teams. This means ensuring that systems and trusts are working to understand inequalities on their waiting list and that they can demonstrate what actions they are taking to address inequalities they have identified. It also means tracking top-level inequalities and ensuring that this data is part of their regular conversations with operational leads. The approaches to this work can be locally agreed but must be robust.

### Integrated care systems should:

- **track inequalities on waiting lists across their system**, ensuring that this is part of their system-wide elective recovery tracking and analysis. As ICBs and trusts develop their accountability relationships, inequalities must be a core part of their conversations about elective recovery. The ICB should be regularly bringing analysis of inequalities on their waiting lists to their ICP so that they can consider where else across their system action should be taken to have an impact on reducing those inequalities.

### NHS trusts should:

- **include performance measures relating to inequalities in their operational performance dashboards**, and monitor inequalities on waiting lists across the organisation. The board must be fully engaged in this work through regular reporting on progress as part of elective recovery monitoring.



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# Appendix A: Methodology

## Scoping phase

Our research started with a scoping phase that mined published information to examine what was already known about work to take an inclusive approach to reducing the elective care backlog. This provided context to our research and informed the design of our fieldwork.

## Literature review

We conducted a non-systematic review of grey and academic literature from England and abroad over the past 20 years, searching major bibliographic databases to identify analyses of inequalities in waiting times, initiatives/approaches used to address those inequalities, and data on their impact. We used a range of search terms related to elective recovery, waiting times and health inequalities.

## Data analysis

We also analysed national referral-to-treatment waiting times data to explore the variation in waiting times for people living in areas with different levels of deprivation. This analysis and its methodology is published separately (see [Jefferies 2023](#)).

## Board paper review

We also reviewed the board papers of 13 trusts and their related integrated care boards (ICBs) to explore whether and how NHS England's call for them to report disaggregated waiting times data to their boards had been implemented in practice and, more generally, what information boards were considering on elective recovery and health inequalities. We selected for inclusion in the review five trusts that we knew from our literature review were taking some action to address the backlog in an inclusive way, and a further eight trusts selected using a stratified random approach to ensure that our full sample included a variation in the ethnic diversity and level of deprivation of their local clinical commissioning group's (CCG) population, waiting times performance, and the NHS region in which they were



located. This gave us an indication of how work to take an inclusive approach to reducing the backlog was being reported in public board meetings in trusts (and their main ICBs) with a range of characteristics pertinent to such work.

For each trust, we reviewed three sets of board papers from meetings conducted between February and September 2022 as well as the most recent meeting papers from their main ICB (the review was conducted in November 2022). In each set of papers we searched for the terms 'Elective'/'planned', 'Inequalities'/'inequality'/'disparities', 'Deprived'/'deprivation' and analysed excerpts of the surrounding text.

### Local case studies

The main part of our research was based around three qualitative case studies of trusts and their main ICB and NHS England regional team. The aim of the case studies was to explore how providers and systems had responded to NHS England's policy on taking an inclusive approach to reducing the backlog, and how they were being held to account for this.

We were interested in exploring the implementation of the policy in acute trusts and ICBs with different levels and types of activity around taking an inclusive approach to reducing the backlog (to learn from the experience of front-runners and those further behind in this work). We also wanted to understand whether the policy worked differently in specialist trusts (which are important as they treat a significant proportion of people in the elective waiting list, but operate over larger areas).

We therefore selected: one trust that we knew (from our review of literature and board papers) had started work on taking an inclusive approach to reducing the backlog; one where we had no evidence that work was under way from these sources; and one that was a specialist trust. We selected these trusts from a long list of those known to have these characteristics so that they would vary in their size, waiting times performance, demographics of their local population (as measured by the level of deprivation and ethnic diversity of the population of their local CCG) and NHS region. Our approach does not allow links to be made between these characteristics and our findings, or allow formal comparison between the cases. Rather, we tried to capture as much variation as we could in characteristics pertinent to work on taking an inclusive approach to reducing the backlog to enable us to learn from as wide a range of experiences as possible, within our capacity constraints.



In each case study we interviewed up to 10 people who were involved in work on elective recovery and/or health inequalities from the trust (including executive team members, managers, clinicians, data analysts and patient representatives), the ICB and NHS England regional team. The interviews took place between December 2022 and June 2023.

We originally hoped to include a fourth case study that was using artificial intelligence (AI) to prioritise care for patients on the waiting list. This was because we knew from our scoping phase that this intervention is being considered by many trusts and systems and we were keen to find out how it was being implemented, and to elicit learning for others considering the approach. Unfortunately, the trusts and ICBs that we approached that we knew were using AI did not agree to take part in the research as a case study site. Therefore, rather than include a fourth case study, we interviewed a range of people who were involved in developing this approach or research relating to it from provider, ICB, support and academic organisations. This allowed us to gain some insights into how AI is being used to prioritise care for people on the waiting list, and the barriers and enablers to this work (our findings are outlined at the end of section 3).

To encourage our interviewees to be candid we have anonymised the case study sites, and although we include quotes, these are only identified using broad categories to provide context on where they are from.

The characteristics of our case study sites are set out in the following table.

Across the three case studies and the in-depth look at AI and reprioritisation, we completed 39 semi-structured interviews online. These were recorded and transcribed, then analysed to extract information on our core research questions

**Table A1** Characteristics of case study sites

Site	Selection characteristics	Interviews
A	<ul style="list-style-type: none"> <li>• Known to be doing some work on taking an inclusive approach to reducing the backlog – appointment reminders</li> <li>• High levels of deprivation and ethnic diversity</li> <li>• Poor waiting times performance</li> <li>• Supra-large acute trust</li> </ul>	Trust: 6 ICB: 3 NHS region: 2
B	<ul style="list-style-type: none"> <li>• Specialist trust</li> <li>• Medium deprivation and high levels of ethnic diversity</li> <li>• Good waiting times performance</li> </ul>	Trust: 10 ICB: 1 NHS region: 1
C	<ul style="list-style-type: none"> <li>• Not known to be doing work on taking an inclusive approach to reducing the backlog</li> <li>• Low levels of deprivation and medium levels of ethnic diversity</li> <li>• Average waiting times performance</li> <li>• Medium-sized acute trust</li> </ul>	Trust: 7 ICB: 2 NHS region: 1
<b>Reprioritisation and the use of AI</b>	<ul style="list-style-type: none"> <li>• To explore AI and algorithm approach</li> </ul>	6

and cross-cutting themes. We also reviewed key background documents on each case study trust and, in the case of AI and reprioritisation, on the intervention.

Following the interview stage of our fieldwork, we held an online workshop to test out emerging findings and discuss their implications. People from NHS England, relevant national representative bodies, ICBs, NHS trusts, academic organisations and think tanks attended the workshop. The discussion provided a broader perspective on our findings from people working outside of our case study trusts on elective recovery and health inequalities.



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**Ruth Robertson** is a senior fellow in the policy team at The King's Fund where she designs and leads research projects on a wide range of NHS policy issues. She is also the programme lead for The King's Fund's strategic priority on tackling the worst health outcomes.

Earlier in her career Ruth spent three years at the Commonwealth Fund in New York researching the implementation of the Affordable Care Act and its impact on the uninsured. She also worked at the Healthcare Commission (a predecessor to the Care Quality Commission) and as a medical secretary at various NHS trusts.

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Nicola joined The King's Fund from North East London NHS Foundation Trust where she practised as an Open Dialogue practitioner and social worker in a community mental health team. It was in supporting the delivery of a clinical trial and roll-out of a new way of working across the service that Nicola gained an appreciation of the necessarily human aspect of facilitating change in systemic structures and processes. Before this, Nicola led on a wide range of research projects (with a particular leaning towards qualitative and ethnographic research) at research consultancy, BritainThinks.

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