

Strategies to reduce waiting times for elective care

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About this report

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Key messages

- Waiting lists now stand at more than 7 million open patient pathways – the highest level since the 18-week referral-to-treatment measure was introduced in 2004. The NHS is routinely missing national targets for how long patients should wait.
- The years following the NHS Plan in 2000 provide important lessons for tackling long waits for planned care successfully. Although there was no ‘silver bullet’, a combination of activities were introduced that were associated with sustained improvements in waiting times performance up until 2009.
- Achieving these substantial reductions in waiting times required a mix of national and local activities that together succeeded in: increasing the supply of health care resources and capacity, including workforce; changing clinical and operational practice; and introducing new ways of managing waiting times.
- A wide range of policies were directly or indirectly applied to tackle long waits for care. National bodies had a key role to play in co-ordinating these policies to ensure that the new approaches to paying NHS providers, regulatory frameworks, and wider government initiatives to improve choice of providers aligned together behind the overall aim to reduce waiting times and improve access to care.
- Improving waiting times was also supported by a clear political focus – the then Prime Minister made delivery of new waiting times targets a personal priority. Central government, including the Prime Minister’s Delivery Unit, routinely gathered granular near-real-time data on performance against national waiting time targets to monitor progress and help direct support towards struggling organisations. The scale of the challenge and the effort required to reduce waiting times depended on countless people in all parts and at multiple levels of the health and care system being engaged and brought along on the journey.
- Performance management played a role in reducing waiting times, and included both challenging *and* supporting local NHS organisations to improve their performance. But care must be taken to avoid unintended consequences of performance management regimes, which could include ‘gaming’ of targets, a culture of fear and low staff morale, and distorting priorities so that only what gets measured matters.



- The factors that affect waiting times (such as the demand for health care and availability of treatments, and the availability of resources to meet that demand) are dynamic and continually changing. The challenge of managing waiting times is never ‘finished’, yet without sustained effort and adaptability to changes over time, any gains in waiting times performance can be lost. With this in mind, care should be taken to ensure that any national and regional infrastructure to tackle long waits for care are not dismantled too soon (eg, national teams with expertise in managing waiting times data and identifying the pinchpoints in a local system that contribute to long waits in the first place).
- The improvement in waiting times performance of nearly 20 years ago took place in a very different political and economic context; a stable government and strong economic performance meant that the NHS received record levels of investment that could be sustained over a decade. It is unlikely that applying individual policy initiatives from the past would be effective today unless shortages of health care staff and physical resources are urgently addressed.
- This very different current context also presents some new opportunities for tackling long waits for care. The introduction of integrated care systems and a renewed focus on tackling health inequalities may allow different parts of the NHS and partners to come together to collaborate, share resources and address long waits in a more transformative and inclusive way.
- The evidence base for activities to reduce waiting times in the published literature does not make a convincing case for any one approach. Studies tend to focus on one specific activity, such as the role of the private sector in tackling waits for NHS care, but it is rarely possible to separate out the contribution of one activity (often amid many others) to bringing down waiting times. Expert testimony from those very close to the design and delivery of waiting times policy in the NHS in the 2000s sheds some light on the activities that were believed to make a difference – although, as experts themselves acknowledged, they each brought their own personal perspective to the question of which activities were more of a ‘game-changer’ than others.



1 Introduction

Context

As at August 2022, elective care waiting lists in England stood at 7 million open patient pathways (NHS England 2022). This figure represents a record number of people¹ waiting for diagnosis of an illness, planned surgery or another type of treatment (Nuffield Trust 2022). For a considerable number of patients waiting for treatment, including the 2,646 people that have been waiting for two or more years, the wait is a source of pain and worry (NHS England 2022). For many people, a delay in treatment could lead to a worsening of their quality of life and a deterioration in the health condition itself (Krelle *et al* 2021).

Health care delays due to the Covid-19 pandemic have contributed to the growth of waiting lists and times. There has been recent debate noting that the official figures do not reflect the additional estimated 3.3 million people who do not yet feature on waiting lists because they did not come forward to seek treatment during the pandemic and whose needs are likely becoming more severe by the day (Nepogodiev *et al* 2022). Nevertheless, even before Covid-19 struck in England, there were 4.4 million people recorded on the waiting list in February 2020. Numbers of people waiting up to 18 weeks and 52 weeks had been climbing since 2009 (Nuffield Trust 2022). The length of waiting lists and waiting times has been attributed to numerous factors, including a sustained slowdown in the growth of NHS expenditure, growing demand for health care, and a chronic shortage in the workforce (The King's Fund 2022b).

Long waiting times for elective care are by no means unique to the NHS in England; they are a longstanding issue in many countries. Analysis shows that all parts of the United Kingdom (UK) have struggled with high waiting times (Dayan and Flinders 2022). Nor is the challenge of reducing waiting times an unprecedented one for the NHS. In the late 1990s, the issue of long waiting times for planned hospital treatment was the focus of various policy decisions and actions aimed at driving down both the high numbers of people on waiting lists and the length of time they were waiting.

¹ An individual may be on more than one treatment pathway and so may appear on the hospital waiting list multiple times.



This study and report

The Department of Health and Social Care commissioned The King's Fund to undertake research on the approaches that have been implemented to reduce waiting lists and waiting times, including their impacts and costs.

The study aimed to explore the following questions.

- What approaches have been used in England and elsewhere to reduce waits for elective care?
- What were the short-term and longer-term impacts of these approaches?
- What lessons can be learnt from those approaches about how to maximise impact and value for money?

We have focused on approaches to tackle long waits for care over the past 20 years because this period is recent enough to provide lessons for the current pressures facing the NHS. Because of this, our findings are more saturated by approaches that were introduced by the 'New Labour' government of 1997–2010. We have also charted what happened with regard to waiting lists and waiting times during the subsequent Conservative–Liberal Democrat coalition government (2010–2015) and the Conservative government (2015 to the present day). Our research has largely focused on learning from the English NHS over this period, but we have drawn on information from other countries where available and relevant.

Our methodology included a non-systematic literature review and interviews with 14 key experts who were very closely involved in setting the policy direction, supporting or implementing approaches to reduce waiting lists and waiting times, as well as those who have academic expertise in waiting lists and waiting times data. The group includes some of the most influential leaders of the time. Their testimonies were critical to understanding what factors enabled the dramatic reduction of waiting lists and waiting times for elective care achieved in the late 2000s, the challenges in sustaining that reduction, and implications and learning for the present day. As far as we are aware, this is the first and only time that the views of a group of experts with such unique insights into the management of waiting lists and waiting times has been brought together. We are grateful to have accessed their first-hand observations of a vital part of the NHS's history.



The experts participated in the research on the basis that their views would be kept anonymous to give them freedom to be open and honest about historic and live initiatives to tackle waiting times – especially as many of the experts are still connected with the NHS in some way today. To situate the findings we present in this report in some context, the broad categories of experts' previous roles include:

- NHS leaders (5)
- senior policy-makers (4)
- leaders involved in the implementation of approaches (3)
- academics or analysts (2).

Due to time constraints and the availability of experts, we were not able to speak to representatives from all parts of the health and care system. In particular, our sample of experts does not include as many clinicians or patient representatives as we had hoped.

For a fuller account of our methodology, please *see* Annex 1.

In this report, we outline:

- the findings of our literature review
- a history of previous strategies and approaches to reduce waiting lists and waiting times in England, including the rationale or hopes for their implementation
- experts' reflections on how strategies were implemented, including the challenges encountered
- the outcomes of the actions taken to reduce waiting lists and waiting times, taking into account any unintended consequences and the impact on the health care workforce
- the implications of our findings for tackling the current backlog for elective care.



2 Findings from the literature review

Our exploration of the approaches that have been used in England and elsewhere to reduce waits for elective care began with an extensive review of published literature. Spanning the past 20 years across 15 countries, the literature afforded us an enhanced understanding of the underlying features and overarching principles of waiting list and waiting time management as well as the specific approaches that have been used to reduce waiting times in a wide range of contexts.

Some fundamental principles of waiting list and waiting time management

Very simply, elective care waiting lists and waiting times are a product of the fluctuations in and disparities between the demand for, and available supply of, health care services ([van Ginneken et al 2022](#); [Ballini et al 2015](#); [Kreindler 2008](#); [Silvester et al 2004](#)). Understanding the root causes of these disparities and taking corrective action to restore balance between demand and supply is therefore considered key to any strategy to reduce waiting times and sustain them at that level.

The forces affecting supply and demand of health care are numerous and broad and change over time; they extend beyond the confines of elective care – perhaps even beyond the health and care system itself. Through our analysis of the literature, we found that these factors fall into three overarching categories.

1. Supply-side factors

Factors in this category are mainly affected by funding and investment in health and social care services to ensure that there is sufficient capacity to meet demand. This capacity takes account of the size and composition of the health and care workforce, as well as the number of available beds, equipment, facilities and technology to deliver health care.



2. Demand-side factors

Demand for health care is influenced and mediated by a range of factors: on the one hand, the health care needs of a population and their propensity to seek treatment to meet these needs; and on the other hand, the availability of treatments for patients, the thresholds/criteria for administering these treatments, and attitudes and approaches of health care professionals to make referrals for onward treatment.

3. Factors impacting the management of waiting lists and waiting times

Within this third category, we have organised the factors documented in the published literature into two subcategories.

- **Cultural and environmental factors**

This subcategory includes factors such as: the political desire and drive to reduce waiting times; central and local leadership of the health care system; the financial mechanisms in place to incentivise and pay for activity undertaken by health care providers; the level of competition and choice within a health care system; and the engagement and buy-in of the health and care workforce to efforts to reduce waiting times.

- **Operational and practical factors**

The factors in this subcategory are those that help or hamper the smooth running of the processes in place to deliver health care. This includes: the arrangement and composition of patient treatment pathways, including the interconnections and 'hand-off' points between different services/parts of the system; the collection and use of waiting times data to understand potential 'pinchpoints' and minimise waste; the processes in place to make and process referrals, book appointments, prioritise patients and issue reminders; and the allocation of roles and responsibilities across different members of the health care workforce.

As these categories demonstrate, waiting lists and waiting times are very dynamic and interact constantly with the context of a given place and time. Effective and sustainable management of waiting lists and waiting times therefore necessitates a system-wide perspective: to understand the interplay between, and forecast,



the forces of supply and demand; and to identify where action is needed to increase supply, manage demand, or address the cultural/environmental and/or operational/practical factors to ensure that any action taken is effective (Siciliani and Hurst 2005).

The literature did not point to any one ‘intervention’ known to reduce waiting lists and/or waiting times; nor are activities targeting ‘supply’ or ‘demand’ in isolation likely to be effective or sustainable over the long term (Siciliani and Hurst 2005). Initiatives that only target supply run the risk of ever-growing investment beyond the point of efficiency or effectiveness, particularly in a health care system that is state-funded and where trade-offs are likely to be needed in terms of how and where to allocate resources (Siciliani and Hurst 2005). Meanwhile, demand for health care services is likely to increase over time due to an ageing population and advancements in the technology and treatments available. Initiatives that focus solely on demand are likely to increase the thresholds or criteria for treatment, thus ‘rationing’ health care further and further, with potentially harmful consequences for patients (Siciliani 2008).

What the literature did indicate was that a combination of activities (combining supply-side, demand-side and other activities) would most likely yield effective and sustainable reductions in waiting times.

Specific actions to reduce waiting times

Before we turn to the specific actions used to reduce waiting times in the past 20 years in England and elsewhere, as documented in the literature, we make the following observations about the published evidence and the conclusions that might be drawn from it:

- The evidence base overall is very weak – that is, we did not find strong examples of evaluated pilots, randomised controlled trials (RCTs) or cost–benefit analyses of strategies to reduce waiting times.
- Where improvement activities were researched, they were often investigated as individual initiatives (eg, the role of the private sector in delivering elective care). Commonly, it was not possible for studies to make any causal links or claims between design/implementation and outcomes – only to draw associations.



- The bulk of the evidence focused on initiatives to reduce waiting times rather than waiting lists – as waiting times are deemed to be the more reliable measure of the size of excess demand in relation to the available supply (Siciliani 2008).

The tables below list all the actions identified in the published literature we reviewed. We have organised these into three broad categories in recognition of the range of factors that conspire to cause long waits in the first place: actions to increase supply; actions to manage demand; and actions that relate directly to the management of waiting lists and waiting times (either via cultural/environmental change or operational/practical measures).

In the interests of time and space, we include here only a short summary of the key themes from the literature. A full summary of the evidence base for each of these actions is published on the PREPARE website: www.york.ac.uk/prepare-reports

Actions to increase supply

Where there is a disparity between the supply of and demand for health care, and there is an acknowledged shortfall in the former, shoring up capacity in the form of staff, facilities and equipment has been associated with increased activity levels and reduced waiting times (Siciliani *et al* 2014; Silvester *et al* 2004). That is not to say that increased funding and resource will necessarily reduce waiting times, or that these increases will be sufficient in and of themselves; rather, the effectiveness of activities within this category rests on the condition that decision-makers have a clear understanding of precisely where and in what format additional funding and resource is needed – investing in workforce numbers, diagnostic capacity and equipment, or shoring up capacity within particular specialties. As one author put it, ‘throwing money at a problem does not work unless you have a very good aim’ (Kreindler 2008).

Table 1 summarises the activities that were identified in the literature to increase the supply of health care and the association between each activity and waiting lists and waiting times.

**Table 1 Summary of evidence about activities to increase supply**

Activities to increase supply	At-a-glance summary of key findings
Additional funding	<p>We found no studies that conclusively establish cause and effect between additional funding and reduced waiting times. Additional funding tends to be accompanied by other policy initiatives (for example, waiting time targets), making it difficult to disentangle its effects from those of other activities (Siciliani <i>et al</i> 2015; Willcox 2007). That said, health systems with the longest waits are those associated with lower levels of health expenditure per capita (Ballini <i>et al</i> 2015).</p> <p>The literature made associations between additional funding and reduced waiting times in England during the 2000s, which culminated in the achievement of the 18-week referral-to-treatment target in 2008. Squeezed funding was believed to be one of the main reasons why the 18-week standard has not been met since 2017 – with further ramifications for workforce shortages and a lack of resource and equipment, particularly in diagnostic services (The King's Fund 2021).</p>
Use of the private/independent sector	<p>We found little empirical evidence that the additional capacity provided/activity undertaken by the private sector in England from 2003 to 2008 contributed to the rate at which waiting times were reduced (Naylor and Gregory 2009). The principal contribution of privately funded facilities such as independent sector treatment centres was instead deemed to be the promotion of patient choice and competition which, in turn, was felt to incentivise and increase activity levels among NHS providers (House of Commons Health Committee 2006).</p>
Expanding the workforce	<p>Waiting times targets in England in the 2000s (which achieved the 18-week waiting time standard by 2008) were accompanied by increases in funding, which was invested heavily in more staff (Department of Health 2000; HM Treasury 2000).</p>
Treating patients overseas	<p>There has been very limited research into this approach, its effectiveness in reducing waiting lists or waiting times, or its cost-effectiveness (Kreindler 2010; Siciliani and Hurst 2005). One paper from the Netherlands found that patients who received treatment abroad in Belgium, Germany and Spain (as mediated by their health insurer) waited an average 1–2 months less than those who did not go abroad (Schut and Varkevisser 2013).</p>



Actions to manage demand

Where it is not possible or desirable to increase the supply of health care in order to balance the available resource to meet demand, a range of activities might be considered to manage and reduce demand. In general, the trend in demand for health care is that of sustained growth; this is the case at least in the present-day context of an ageing population, the proliferation of medical breakthroughs and the availability of new treatments at a faster rate than older or less effective treatments are set aside (Siciliani 2008). That said, the notion of limiting or restricting access to health care can be a controversial one, raising questions of fairness and equity as to which patients should be prioritised for treatment and on what basis (Rathnayake and Clarke 2021; Siciliani *et al* 2014).

Table 2 summarises the activities that were identified in the literature to manage demand for health care and the association between each activity and waiting lists and waiting times.

Activities to manage demand	At-a-glance summary of key findings
Changing the categories/thresholds for adding patients to a waiting list for elective care	We did not find a compelling body of evidence indicating that this approach is effective in reducing waiting times. The most notable implementation of this approach took place in New Zealand in the 1990s; it was associated with reduced numbers waiting for treatment as only those patients categorised as 'urgent' were added to lists although clinicians' allocation of patients to different categories could differ dramatically (Kreindler 2010; Siciliani and Hurst 2005; Gauld and Derrett 2000).
Review/standardisation of referral criteria	We found no studies evidencing a link between this activity and reduced waiting times. Indicative findings included an association between this activity and fewer inappropriate referrals (resulting in reduced numbers of patients on waiting lists), freeing up an estimated 10 per cent volume of capacity (Rathnayake and Clarke 2021; Collins-Nakai <i>et al</i> 2006).
Active engagement with patients on the waiting list	We found no studies assessing the effectiveness of this activity in respect of reducing waiting lists/waiting times, although some sources highlighted the potential benefits of this approach to support patients to manage their health in the community and via primary care and the voluntary and community sector (Rosen 2021; National Voices 2020).



Actions that affect the management of waiting lists and waiting times directly

Activities affecting the culture and environment of a health system

Within this first subcategory, it is worth spending some time considering the differences between, and the potential significance of, the character and form of health care systems in different countries and at different times. People's expectations of and relationship with health care, the structures that support decision-making, and the configuration of services all have a bearing on the actions that might be deemed more or less palatable or effective to reduce waiting times. Similarly, some activities intended to reduce waiting times may influence the culture and environment of a health system as a whole (Siciliani *et al* 2014).

Targets for providers and waiting time guarantees for patients are one of the activities documented in the literature, which we have included within the subcategory of 'cultural/environmental' actions – actions that have the potential to harness the energy of those working in the health care system to reduce waiting times. As those involved with introducing the maximum waiting time guarantee in Canada in 2004 testified, 'transformation is based on attitude, understanding and behaviour' with 'a common vision, shared values, discipline and courage of all within the system to do something differently' (MacLeod *et al* 2009).

Where implemented most effectively, activities to reduce waiting times have been associated with meaningful engagement with the health care workforce, particularly where staff felt that the 'ask' was congruent with their values as health care professionals (Déry *et al* 2020; MacLeod *et al* 2009). Clinicians in Sweden, for example, did not feel that the rationale for the maximum waiting time guarantee aligned with their professional values, hence the guarantee was abandoned in 1998; in addition, some clinicians did not accept that long waiters were placed at significant medical risk while waiting (Hanning and Spångberg 2000).

The role and involvement of patients and their ability to exercise choice in relation to their care is another approach within this subcategory. Patients' ability and willingness to exercise choice, and the extent to which a health care system promotes informed patient choice, has been found to vary between countries and according to a number of enabling/confounding factors. These include: the overarching culture associated with accessing health care; the level of knowledge and attitudes of the referrer; proximity to and accessibility of an alternative



treatment site; and the age of the person requiring treatment. This means that some patients are perhaps more likely and able to take up choice than others, raising questions about fairness and equitability, and potentially exacerbating existing health inequalities (Dixon *et al* 2010; Thomson and Dixon 2006). In England, for example, choice over where to receive treatment was ranked 11th out of 16 factors that patients said were important to them (less important, say, than car parking) (Fotaki *et al* 2008).

A final word is needed here on the risk of unintended consequences of these activities. Specifically, the literature highlighted adverse outcomes associated with the regime of targets in England in the 2000s. These include: a disproportionate focus on targets and areas of measured performance to the detriment of other non-measured areas; prioritising patients on the basis of whether or not the 'deadline' for their treatment was looming rather than on clinical grounds; and deliberate manipulation of waiting list/waiting times data to demonstrate compliance with the target (Mannion and Braithwaite 2012; Kreindler 2010; Dimakou *et al* 2009; Bevan and Hood 2006; Siciliani and Hurst 2005; [National Audit Office 2001](#)).

Although there is some evidence for the effectiveness of performance management as an approach to reduce waiting times (see Table 3), this is also associated with consequences that might undermine attempts to reduce waiting times: specifically, cultivating a culture of 'bullying' leading to the disenchantment of staff, with detrimental impacts on morale and productivity (Mannion and Braithwaite 2012; Harrison and Appleby 2009; Appleby and Harrison 2003).

In addition, the literature makes the case that the contribution of performance management to reductions in waiting times has been misunderstood and overplayed. It indicates that in the absence of additional funding in the resource and capacity necessary in order to meet targets feasibly, performance management on its own does little to reduce waiting times – as evidenced by the steady increase in waiting time duration from 2009 onwards, when increases in NHS funding were reduced ([Appleby 2010](#)).

These points are made here to emphasise once again that no one activity in this subcategory can be held up as a solution to the problem of waiting times – and that the 'how' matters just as much as the 'what'.

**Table 3 Summary of evidence about activities affecting culture or environment**

Activities affecting culture/environment	At-a-glance summary of key findings
<p>Maximum waiting time guarantee (targets)</p>	<p>There is some evidence indicating that waiting time guarantees for patients and/or targets for providers have been associated with reduced waiting times (Kreindler 2010; Propper <i>et al</i> 2008a; Siciliani and Hurst 2005).</p> <p>However, targets have often been introduced alongside other policies (eg, additional funding, patient choice, patient prioritisation), meaning that direct cause and effect is impossible to establish (Kreindler 2010; Besley <i>et al</i> 2009; Propper <i>et al</i> 2008b).</p> <p>The most robust papers on this area suggest that targets are most effective where:</p> <ul style="list-style-type: none"> • they are underpinned by accountability and sanctions/penalties via a performance management regime (eg, the 'naming and shaming' of the poorest-performing providers in England in the 2000s) (Jonsson <i>et al</i> 2013, in Siciliani <i>et al</i> 2013; Propper <i>et al</i> 2008b) • they are combined with payment mechanisms that incentivise activity among health care providers (Kreindler 2010; Siciliani and Hurst 2005).
<p>Remuneration of providers and/or staff for activity to reduce waiting lists/ waiting times</p>	<p>Some studies from Australia and the Netherlands found an association between the payment of providers for activity – both on the basis of <i>volume</i> and <i>mix</i> of activity – to mitigate the 'perverse incentive' for providers to prioritise patient groups that would bring in greatest revenue (Schut and Varkevisser 2013; Rachlis 2005; Street and Duckett 1996). Reductions in waiting times in Spain accelerated following the introduction of financial incentives to providers that undertook additional activity and bonuses of 2 to 3 per cent for staff recognised for their efforts to reduce waiting times (Siciliani and Hurst 2005).</p> <p>The evidence of the one national evaluation of Payment by Results (PbR) in England on whether it boosted volumes of activity and reduced waiting times was not conclusive. It is arguable that the extra activity evidenced in this period would have resulted in any case due to the combination of additional funding and targets (Farrar <i>et al</i> 2010).</p>

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Table 3 continued

Activities affecting culture/environment	At-a-glance summary of key findings
<p>Patient choice of provider (for long waiters)</p>	<p>Overall, ‘the impact of choice on waits is not linear’ (Siciliani and Martin 2007). There is some evidence that increases in patient choice can increase demand and, in turn, waiting times (Siciliani and Martin 2007). All other things being equal, the introduction of the Patient Choice Project in London was associated with waiting times around three weeks’ shorter than the rest of England in 2006 (Dawson 2007). Although take-up of patient choice has been relatively low in some countries (around 10 per cent in Sweden in 2003), it has been suggested that the choice agenda has played a role in reducing waiting times by introducing a competitive dynamic to the health care market – incentivising activity among providers who would otherwise ‘lose’ patients (and money) to other providers (Thomson and Dixon 2006; Hanning 1996).</p>
<p>Workforce engagement</p>	<p>Engagement of the workforce was cited in respect of a range of other initiatives and was deemed to be core to their success – eg, in the design and successful implementation of targets and of patient prioritisation tools (Déry <i>et al</i> 2020; Berry <i>et al</i> 2015; Kreindler 2010; Gauld and Derrett 2000). We found a wealth of literature associating an engaged workforce with a ‘self-improving’ health care system, sparking creativity and innovation with the potential to unlock an approach to reducing waiting times – although this claim was prospective rather than proven (Mailley 2011; Ellins and Ham 2009).</p>

Operational/practical actions that affect the management of waiting lists and waiting times directly

The second subcategory includes activities that transform the delivery of health care ‘on the ground’. These activities are aligned with the principle (as evidenced in a growing number of case studies) that long waits are typically the product of poorly planned and poorly designed systems comprising complex and unnecessary components that lead to ‘traffic jams’ (Kreindler 2010, 2008).

Oversight and analysis of demand and supply at each stage of the patient journey can point towards measures that might realign demand and supply, minimise ‘waste’ and maximise productivity, and ultimately reduce waiting times (Amaratunga and Dobranowski 2016).



The kinds of initiatives that have been used to address these systemic inefficiencies are wide-ranging. They include: changes to the referral pathway (for instance, attaching photographs to referral documents to expedite triage and the screening of referrals); pooled waiting lists so that patients see the next available practitioner in a team or specialty; one-stop shop centres for non-complex yet high-demand procedures such as cataract surgery; and reducing the number of touchpoints a patient has with different people in the health care system from five to two (Dhillon *et al* 2021; Damani *et al* 2017; Blank *et al* 2015). Table 4 summarises findings of the examples of such activities that were documented in some way in the published literature.

The activities within this subcategory might be described as drives towards 'efficiency' in the delivery of health care. As a means of reducing waiting times, ensuring that care is delivered efficiently might well be thought a sensible path to tread. Nevertheless, we feel it is important to highlight some of the other considerations highlighted in the literature in association with attempts to deliver health care in a more efficient way.

- According to the literature, the routine and granular collection of waiting times data was deemed to be a solid starting point for making and sustaining reductions, both in terms of measuring and reporting on performance and as a necessary first step for providers to understand the dynamics affecting throughput and bottlenecks along the patient treatment pathway. It was also felt to afford an opportunity to draw on detailed patient information (including details about patients' clinical needs as well as their socio-economic circumstances) to inform prioritisation, communication and advice to patients to support management of their condition(s) while they wait, and monitor rates of access among different patient groups (Godden and Pollock 2009). This approach has already been used by organisations such as Frimley Health and Care Integrated Care System as a means of tackling waiting times with a view to tackling health inequalities (Foster 2021).
- Where we did come across research that attempted to evidence the cost-effectiveness of activities to reduce waiting times, it tended to be within this subcategory. In particular, approaches such as day-case surgery and electronic referrals have been associated with cost savings to the NHS (Dhillon *et al* 2021; Appleby 2015; Patterson *et al* 2010). In the case of the former, one



study found that only around one-quarter of referrals to one-stop shops were deemed sufficiently low risk/suitable for the service based on the information provided by referrers. Although this may have been a ‘cost-effective’ approach compared with treatment in a hospital, it is important to acknowledge that these savings would only be realised among a relatively small group of ‘non-complex’ patients (Dhillon *et al* 2021). In the case of the latter, although it may cost less to screen referrals electronically as opposed to in-person, the clinical effectiveness and outcomes of electronic referrals were not so strongly evidenced in the literature (Leggett *et al* 2004). The overall cost-effectiveness (indeed, effectiveness in general) of approaches to reduce waiting times is therefore informed by a range of other factors, including the size and type of patient population likely to benefit and the reliability of the approach.

- Some studies flagged the value to patients and to clinicians of the continuity of the relationship they have with each other over the course of a patient’s treatment. In one case, patients reported that they would prefer their treatment to take longer if it meant they could see the same clinician (Damani *et al* 2017; McKessock *et al* 2001). Although some drives towards efficiency propose a shared ‘team’ caseload and/or the sharing of caring responsibilities among multiple professionals in a team in the interests of seeing patients more quickly, speed may not be the only or main priority for those awaiting treatment.
- More efficient services can also benefit patients. Patients receiving care at one-stop shop facilities reported high satisfaction rates, citing shorter waiting times and convenience of the location as reasons for their satisfaction (Dhillon *et al* 2021; Murphy *et al* 2018; Dyer 2013; Salisbury *et al* 2005).

**Table 4 Summary of evidence about operational or practical activities**

Operational/practical activities	At-a-glance summary of key findings
Granular collection and analysis of waiting list/ waiting times data	Hospitals demonstrating greatest success in reducing waiting times in England in the 2000s were those with most ready access to and understanding of waiting list data at the level of specialty and consultant. This data could then be used to detect and plan for variations in supply and demand (Taylor and Shouls 2008; Appleby and Harrison 2003).
Validation/audit/cleaning of waiting list data	We found limited evidence that this approach has been used effectively to reduce waiting times. One study indicated a reduction in waiting time from an average of 76 days to 56, where 51 per cent of patients were found to have been 'inappropriately referred' and were subsequently removed from the waiting list (Chivers <i>et al</i> 2010).
Quality improvement and pathway/process efficiencies	Some studies have shown that quality improvement initiatives are associated with reduced waiting times (from 25 days to 2 days for one MRI (magnetic resonance imaging) service; a reduction of 8 weeks and 10 weeks respectively for a CT (computerised tomography) and an ultrasound service; and improved productivity (one study found that access to MRI scans within 24 hours increased from 53 to 90 per cent). Efficiencies include measures such as: more careful planning of resource to meet demand at different points in the week; creating dedicated non-clinical roles for the management of paperwork; and co-locating equipment so that it can be used/overseen by 'floating' rather than dedicated staff (Bhullar <i>et al</i> 2021; Tlapa <i>et al</i> 2020; Hallam and Contreras 2018; Amaratunga and Dobranowski 2016).
Changes to the referral process (electronic referrals, text-based triage, open access/ combined initial assessment and triage)	We found mixed and inconclusive evidence on the efficiency and reliability of in-person versus virtual triage and its impact on waiting times. Text-based triage, for example, may only be appropriate in between 10 per cent and 50 per cent of cases according to one scoping review (Caffery <i>et al</i> 2016). Some dermatology conditions were found to be less conducive to photographic referrals, with 27 per cent of one study group in an RCT requiring a consultation in order to gain further clarity about the health complaint/diagnosis (Leggett <i>et al</i> 2004).
One-stop shops/ day surgery centres	Despite the rollout of day surgery units in England in the 2000s, their association with higher throughput of patients, and the fact that day surgery cases accounted for the vast majority (78 per cent) of elective activity in 2013, we found almost no robust research of their effectiveness in respect of waiting times (Dhillon <i>et al</i> 2021; Appleby 2015). A pilot project for one-stop cataract procedures at NHS Grampian saw a 30-week reduction in waiting times to a median wait time of 21.4 weeks (Dhillon <i>et al</i> 2021).

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Table 4 continued

Operational/practical activities	At-a-glance summary of key findings
Single entry models/pooled waiting lists	We found mixed and inconclusive evidence for this approach: although some providers adopting a single entry model saw a reduction in waiting times and waiting lists, and generally positive impacts on patient satisfaction (Damani <i>et al</i> 2017; Leach <i>et al</i> 2004), others presented weak evidence about the impact on waiting times (Joseph <i>et al</i> 2014).
Patient appointment reminders	We found no evidence that this activity has effectively reduced waiting times; only that it has been associated with lower rates of non-attendance at appointments and, therefore, more efficient throughput of patients on the waiting list (Rathnayake and Clarke 2021).
Expanded/extended use of existing facilities	We found just one study of extended operating theatre times in an NHS trust in England. Although the 18-week target for surgery was achieved in 93.7 per cent of cases compared with 88.3 per cent at the outset of the study, staff sickness, absence and dissatisfaction all increased (Herron <i>et al</i> 2018).
Separating elective and urgent/emergency activity	Again – and perhaps surprisingly, given the widespread separation of elective and urgent/emergency activity – we found few research studies of the impact of this approach on waiting times. We found one study which indicated that the worst-performing trusts for elective care waiting times in England were those where emergency and elective care resources were shared rather than separated and protected (National Audit Office 2019); and one review which suggested that separating planned and unplanned care increases activity in orthopaedic services – with potential benefits (although not empirically proven) for reducing waiting times (Getting It Right First Time (GIRFT) 2020).
Automated booking of appointments	We found very limited evidence for the effectiveness of this activity in reducing waiting times. The literature comments on the association between inefficient intake, scheduling processes and long waiting times (as well as patient safety) (Harding <i>et al</i> 2018; Findlay 2012).
Waiting list prioritisation (organisation of patients already on a waiting list)	We found no evidence that this approach reduces waiting lists or waiting times – rather, this is a means of ensuring that resources are allocated in a timely fashion to those in most urgent need, concentrating the longest waits among those who are more likely to be able to endure them without significant adverse effects (Déry <i>et al</i> 2020; Siciliani <i>et al</i> 2014). It has also been held up as an initiative that may support efforts to tackle health inequalities by prioritising patient groups with the greatest levels of unmet need (Holmes and Jefferies 2021).

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Table 4 *continued*

Operational/practical activities	At-a-glance summary of key findings
Expanding roles/ multidisciplinary delivery of treatment	We found very little compelling evidence in support of this approach to reducing waiting times. Some papers made associations between nurse- and non-consultant-led services and reduced waiting times (Kelly 2009; Annandale 2008; Clow <i>et al</i> 2002).
Different models of care (virtual appointments, delivering treatment at home)	There was very little published literature on this area of activity and its potential impact on elective care waiting times. That is a shame, as there remains a gap in the evidence about the role of social care reform as a means of enhancing the care and support options available to patients and ‘unblocking’ care and discharge pathways from hospitals. Sweden’s maximum wait time guarantee and the associated reduction in waiting times took place amid broader reforms of social care to facilitate the swifter discharge of older people from hospital into the community. However, the specific impact of these reforms on waiting times is unknown (Hanning 1996).

The limits of the literature, the telling of a story

Although the published literature does not offer anything like a roadmap or tried-and-tested blueprint for reducing waiting lists and waiting times in the present day, it has highlighted a number of key points: the myriad factors that contribute to waits in the first place; the importance of adopting a system-wide approach to tackling these problems at their source; and the value of combining activities that consider supply and demand, the ‘what’ and the ‘how’, of reducing waiting times and sustaining them at that reduced level.

The combination of the most effective actions to reduce waiting times will therefore be unique to the conditions and factors associated with a given time and place. The ability of traditional research methods to determine the ‘effectiveness’ of specific activities in reducing waiting times is, as we found in the body of published literature, very limited.

We therefore supplemented our literature review with interviews with key figures in very senior policy roles, roles at the centre of government, and regional and operational roles, who have all been influential and closely involved in the development and implementation of policies to reduce waiting times.



Their testimony tells a story that helps us to understand the complexities and contextual factors that explain the course of events, and the rationale for – and outcomes of – key decisions to reduce waiting times. This story starts in 1997 with the election of a new Prime Minister, Tony Blair, and a Labour government whose manifesto included a commitment to ‘save the NHS’ and reduce the numbers waiting for elective care by 100,000 ([The Labour Party 1997](#)). The decade that followed saw a number of policy initiatives and a vast reduction in elective care waiting times, to less than 18 weeks.

We tell this story, and describe the specific actions taken within this context, as well as their implications at the time and today, in the remaining sections of this report.



3 A history of strategies to reduce waiting lists and waiting times in England, 1997–2022

The story we heard about the strategies used to reduce waiting times in England from 1997 to 2022 was one of many different but synchronous strands held together as part of a broader direction of travel towards a transformed health service.

If I talk to people who were about at the time now, just about everyone would come up with a different thing... that made the difference on this... I think it was all those different things coming together.

Senior policy-maker

We tell this story in six chapters, each representing a marker, milestone or turning point in the tale of waiting times from 1997 to the present day.

1997–1999: a change in the ‘mood music’

The Labour government came in 1997, came in there with quite a focus on saving the NHS, ‘it’s in the emergency room, we’ve now got to get it out and rebuild the NHS’, and central to that was reducing waiting times... Initially we did it with waiting lists, but then were more focused on times. And that in itself was driven by, it was publicly a very salient thing, so the more staff, better pay, shorter waits was basically what the public were saying, so it’s what politicians were hearing.

Senior policy-maker

The experts we interviewed described a change in the ‘mood music’ in relation to health policy after the election of a Labour government in 1997. The narrative of the health service among the public at that time was recalled as



one of understaffing, under-resourcing, low-paid staff, an excessive number of ‘managers with clipboards’ (as one expert, a senior policy-maker, put it) – and long waiting times.

After an initial focus on reducing the number of patients waiting by 100,000 within Labour’s first term ([Harrison and Appleby 2005](#)), experts close to the centre of government described the shift in focus to reducing waiting times. The experts we interviewed spoke about the immense amount of on-the-job learning that was required to understand and manage waiting lists and waiting times. Waiting list data was not routinely captured or reported at this time, centrally or regionally. In order to support this process of learning, organisations such as the National Patient Access Team were established to offer advice and practical help to hospitals to set up the necessary infrastructure to monitor and manage waiting lists and waiting times.

2000–2003: investment and reform

This period saw perhaps the greatest swathe of reform in the NHS. A number of decisions and actions were taken that the experts we interviewed felt were integral to telling the story of reducing waiting times – even if these initiatives were not systematically evaluated or assessed from a cost-effectiveness perspective.

The year 2000 saw the publication of *The NHS Plan: a plan for investment, a plan for reform* ([Department of Health 2000](#)). This followed an announcement made by Prime Minister Tony Blair on a weekend political programme that the United Kingdom would increase its health spending up to the European Union (EU) average by 2005 ([The Health Foundation 2021](#)). The experts we interviewed also told us that the NHS Plan was borne out of dialogue with senior leaders and clinicians in the NHS itself, making it a popular document with the experts we spoke to.

Chiefly, and as a precondition for further action to be taken on waiting times, the NHS Plan set out unprecedented **increases in the supply and capacity of the NHS**. This saw sustained increases in NHS funding, with:

- an additional £2 billion, bringing the total NHS spend to £54.2 billion as at the financial year 2000/01. This was an increase from £49.3 billion in the financial year 1999/2000 and £45.1 billion in 1998/99



- a commitment to a 6.1 per cent average annual real-terms growth from 2000 to 2004, compared to an average of 3.3 per cent annual real-terms growth since the foundation of the NHS.

We heard, from the experts we interviewed, that this additional investment was overwhelmingly directed towards workforce – not only workforce numbers but also pay and working conditions. The Workforce Directorate within the Department of Health produced the first workforce strategy for the NHS at this time, setting out projections for the composition and size of the workforce as well as a revised pay agenda. Staffing in the NHS would increase by 21 per cent between 2000 and 2004, yielding 7,500 extra consultants, 2,000 GPs, 20,000 nurses, 6,500 therapists and 1,000 more medical school places ([Centre for Public Impact 2019](#)). Hitting these numbers involved renegotiating the training and development pathway for hospital consultants and expanding the remits and responsibilities of junior doctors and nurses in delivering health care.

Investment in the workforce was supplemented by a programme of capacity building, including the delivery of 100 new (additional) hospital schemes, 7,000 extra beds, 500 new primary care centres, modernisation of 3,000 GP surgeries, 250 new scanners, and the modernisation of NHS information technology (IT) systems ([Centre for Public Impact 2019](#)).

Within this context, the NHS Plan refreshed the focus on elective care waiting times by setting a series of phased targets:

- By the end of 2004, the maximum waiting time for an outpatient appointment would be reduced from 18 months to 6 months.
- By the end of 2005, this would reduce further to 3 months (6 months for inpatients).

In demonstrating its commitment to achieving these targets as a priority, elective care waiting times became a central focus of the Prime Minister's Delivery Unit (PMDU), which was established to ensure the delivery of action to improve performance in areas of public service deemed to be 'failing' (education, criminal justice, transport and health care). Monthly 'stocktake' meetings between the



PMDU and the departments responsible for addressing these policy priorities were one of a number of ways that the NHS had to demonstrate that it was on track to meet these targets. Tracking and monitoring progress in pursuit of these policy priorities required the detailed and wholesale **collection and analysis of waiting times data** nationwide. This meant that any providers at risk of missing these targets could be identified and **offered additional support** via the National Patient Access Team and the Modernisation Agency (which became the NHS Institute for Innovation and Improvement in 2005) and the Intensive Support Team (Harrison and Thorlby 2007). Experts who had some involvement with delivering this support spoke of the types of support made available to providers at that time: advice and practical help to collect and analyse data, at a population and a hospital level; reviewing operational data to identify patterns or bottlenecks in supply and demand; and challenging decisions where (for example) a provider was unaware that it cancelled 20 per cent of its operations on the day they were scheduled.

This period saw the introduction of what one expert described as a ‘muscular’ regime of **performance management** against waiting times targets for elective care. This regime was organised and overseen by the Department of Health and was harnessed to a star rating system of performance. The star rating incorporated a number of quality and patient experience measures alongside waiting times and governance/financial management to assess and rate the performance of NHS providers. The first published star rating in 2001 resulted in 12 hospitals being rated zero stars. The chief executives of the lowest-rated providers were summoned to monthly meetings with the Department of Health and the independent quality regulator, the Commission for Health Improvement. We heard how 6 of the initial 12 zero-rated hospital chief executives were sacked in the months that followed.

The NHS Plan of 2000 also set out its vision for the **role of the private sector** in treating patients on elective care waiting lists. The experts we interviewed expressed mixed views about the driving force behind this particular component of the Plan: some argued that the overriding principle of providing patients with timely access to care took priority over who provided that care; others understood this initiative to be part of a bigger plan to ‘ginger up’ the health care system and introduce an element of competition, sending a ‘powerful message’ to the NHS that performance mattered and that poor performance would yield negative consequences (in this case, losing patients – and therefore money – to other



providers). The Plan set out how the private sector might invest in and add to the capacity of the NHS:

- Investment in at least eight independent sector treatment centres (ISTCs) by 2005: a contract was drawn up between the Department of Health and private investors who agreed to build and staff facilities that would provide elective care to NHS patients as part of a ‘take-or-pay’ agreement. This meant that investors were guaranteed a fixed income during their initial years regardless of the volume of care they delivered. The decision as to where these centres would be built was overseen and sanctioned by the Department of Health. Private investors had to demonstrate ‘the principle of additionality’ – that they would source their own staff, not simply poach staff from the NHS for these new facilities.
- Making available spare capacity in existing private hospitals to treat patients waiting for elective care on the NHS: as ratified in the Concordat signed by then Secretary of State Alan Milburn with the independent sector.

The additional investment in capacity and resource, coupled with the sharper focus on waiting times as a policy priority, was followed by a suite of other reforms around the year 2002. These included the creation of **foundation trusts**, a status conferred to NHS providers with good levels of performance according to the star rating system and which granted them greater autonomy over local decision-making and the management of their own funds. The reforms also included **Payment by Results (PbR)**, a mechanism whereby NHS trusts were paid for activity according to a national tariff or rate, meaning that trusts delivering more activity were paid more. Trusts could then reinvest this money in their own staff and equipment, expanding as needed to build capacity to meet demand locally ([Harrison and Thorlby 2007](#)). Ideally, some of the experts we interviewed argued that this model incentivised and stimulated activity, enhancing the efficiency of the delivery of care.

Finally, this period saw the first trial of **patient choice of provider** in London. Hospitals that opted into the scheme could send people who had been waiting for longer (six months or more) to hospitals with shorter waits with no penalty or cost attached. The receiving hospitals were awarded additional funding from central government to treat these patients. By June 2004, a total of 22,500 patients waiting for ophthalmology, orthopaedics or general surgery had been offered



choice, and 15,000 accepted treatment at another hospital (Dawson 2007; Dawson *et al* 2004). Similarly to independent sector health care provision, our experts were inclined to see the patient choice component of reform as a move to incentivise additional activity within the NHS for fear of losing patients (and therefore money) – and, in turn, to reduce elective care waiting times.

Suddenly, miraculously, trusts discovered the capacity to get the operations done, okay? I mean, to be honest, we didn't really need the policy and by the time the actual choice policy was worked out, I don't know that it was much use. It has been used a bit. But the idea was you would compete on quality not on money, and I think at the margins that had a beneficial effect.

Senior policy-maker

2004–2008: a new waiting times target

The view given back by politicians was, 'look, this is a once-in-a-lifetime chance', you've got a government that was very confident that it was going to win, and it did, obviously, win the 2005 election. And so to carry on the investment and reform that had been set off, and so it was a question of, 'look, what would you need to do to take waiting times off the table?' And that's where the discussion began about a much tighter waiting times target. And also a different one.

Senior policy-maker

If the period 2000 to 2004 set the scene for a suite of reforms and the establishment of some momentum to tackle waiting times, the period 2004 to 2008 saw the effort to reduce waiting times cemented as an unquestioned priority in the form of the **18-week referral-to-treatment target**. Initially introduced in the NHS Improvement Plan of 2004, the new target would ensure that 90 per cent of people referred for treatment needing admission to hospital, and 95 per cent of those receiving treatment without an admission, would start their treatment within 18 weeks of being referred (Department of Health 2004). The milestones for achieving 18 weeks were graduated and set out with a lead-in time of several years, with the expectation that the target would be met nationally by 2008. The experts we interviewed described the trajectory of these milestones as challenging but realistic – indeed, the unprecedented amount of funding being invested in the NHS workforce and capacity made it difficult to argue with the ambition of the 18-weeks ask. Some experts commented that, for the Labour government, reduced



waiting times was one indicator that the health service was delivering 'bang for its buck'.

Our experts, particularly those with operational experience of delivering the 18-week target, described it as a 'game-changer'. It covered the whole of the patient journey, from initial assessment and diagnosis through to admission or treatment. It required end-to-end visibility of the patient journey along the care pathway. According to the experts, the infrastructure required to identify and track patients at the different stages of their elective care journey did not exist. What followed was felt to be nothing short of a revolution in waiting list **data collection and analysis** – both at the centre, to gain oversight of and compare providers' waiting times as part of **performance management**, and locally, to map and plan capacity and resource to meet demand.

To this end, experts recalled there being dialogue between central government and providers locally about what **support** providers felt they needed to make the 18-week target a reality. This support took many forms, including a reference group to test ideas and resources (for instance, checking that data capture forms 'made sense' and were 'a doable job' for providers to complete) and 'spread programmes' to instill and disperse learning and good practice among local providers. More intensive support was offered by the National Patient Access Team (later the Intensive Support Team) to providers who struggled to stay on trajectory to hit the 18-week target.

Calculating exactly what capacity you've got is really, really important. So if you get your admin processes right and your capacity right, you're some way to managing your waiting list.

NHS leader

This period of time was also characterised by a continuation of some earlier policies – indeed, the experts expressed the view that it was remarkable for the policy direction to endure over such a long period (politically speaking), changes of secretary of state and, in 2007, of prime minister. These policies included the following:

- Ongoing **additional investment** in the NHS, with £1 billion (as at the 2004 spending review) allocated for extra operations and a further £400 million (as at 2004) to improve access to diagnostic services (HM Treasury 2004).



- Patient choice, which was extended in 2004–2005 so that patients could choose their health care provider (whether NHS or independent sector) via the Extended Choice Network and Choose and Book system.
- Use of private sector capacity and investment, with a modest increase in the number of ISTCs (that is, 25 by August 2005) (Naylor and Gregory 2009).

Describing the years up to 2006, the experts we interviewed spoke of an atmosphere of confidence, where decisive action was taken and the delivery of waiting times targets pursued aggressively with little question that resource would be made available to that end. We heard from our experts who were in central policy roles from 2006 onwards that there was a slight turn in the tide following a £200 million NHS overspend. In general, this overspend was attributed to the over-recruitment of additional staff. This led to financial cuts in areas of public health, community services and mental health. As one expert put it, whereas previously ‘we prioritised delivery over money’, 2006 onwards marked the start of a more cautious and risk-averse approach to investment in the health service.

2009–2014: doing more with less

Inevitably when one’s involved in an initiative that is highly politically charged, once that passes, then the Eye of Sauron then moves on to something else... It went on to money.

Leader involved in the implementation of approaches

In various ways, the period from 2009 onwards marked a departure from the waiting times strategies pursued from 1997 to 2008 – indeed, it marked a significant shift in the political, social and economic fabric of the country as a whole.

For our experts, the tail-end of the Labour government era was characterised by a slightly tired, perhaps even complacent sense of having ‘been there, done that’ in respect of reducing waiting times. Those that had been most closely involved in the efforts to reduce waiting times gradually moved on to other roles, and some of the central machinery that was deemed essential to the successful delivery of the 18-week target (for example, the Access Directorate and the Intensive Support Team) was shut down, resulting in a loss of momentum, expertise and knowledge.



Rival priorities were also vying for political attention, specifically the financial crisis of 2008 and the growing call for the United Kingdom to ‘balance its books’ after a decade or more of enhanced public spending. With the establishment of a Conservative–Liberal Democrat coalition government in 2010, policy shifted towards a drive for efficiency savings and cuts in funding. The Treasury’s budget for that year committed to tackling the nation’s financial deficit in part by reducing public spending to £32 billion a year by 2014/15. The rate of spending on NHS resource would slow to a real-terms increase of 0.4 per cent per annum over the spending review period, from £98.7 billion in 2010/11 to £109.8 billion in 2014/15. NHS capital investment would be cut from £5.1 billion in 2010/11 to £4.6 billion in 2014/15. In a sharp change of direction from the years during which, according to the experts, money was no object when it came to improving NHS performance, the NHS itself was now expected to find £20 billion (at that time) annual efficiency savings by the end of the spending review period in 2014/15 ([HM Treasury 2010](#)).

A new direction for the health service was set in the 2010 White Paper, *Equity and excellence: liberating the NHS*. This document outlined reforms to ‘make the NHS more accountable to patients’, promoting patient choice and control and ‘freeing staff from excessive bureaucracy and top-down control’ to focus on ‘the things that really matter to patients’ ([Department of Health and Social Care 2010](#)). This signalled a slowing of the drive behind centrally set and performance-managed targets. Following the Francis Inquiry into Mid Staffordshire NHS Foundation Trust, which concluded that an overarching focus on ‘targets and finance’ contributed towards failures in the delivery of patient care, experts described a growing emphasis at the centre on the quality of patient care rather than on waiting times ([Mid Staffordshire NHS Foundation Trust Public Inquiry 2013](#)). In the absence of any concerted focus on waiting times, coupled with the mounting demands on the NHS to improve its performance in a number of areas with less resource, waiting times performance deteriorated. After waiting times reduced to their lowest levels, from 2009 they steadily began to grow again ([Nuffield Trust 2022](#); [Appleby 2010](#)). With fast-falling investment, one expert described the waiting times strategy of this period as being one of ‘just try harder’.



2015–2019: from drift to spiral

We have essentially had 10 years of managed decline. This is not a Covid problem. This is an austerity problem.

NHS leader

Although capacity building was not, on its own, felt to be sufficient to deliver the reduction in waiting times seen over the course of the 2000s, experts who remained involved with managing waiting lists and waiting times after 2008 pointed out that the cuts to NHS funding were part of the story of growing waiting times. The period 2015–2019 marked the point at which one expert said ‘we lost control of the money’ and waiting times performance (among other aspects of NHS performance) spiralled. Towards the end of this period, the NHS Long Term Plan ([NHS England 2019](#)), described by one expert as a ‘list of thousands’, set out a £20.5 billion budget settlement for the NHS, part of which would be used to ‘grow the amount of planned surgery year on year, to cut long waits and reduce the waiting list’. Specific strategies mentioned in respect of this effort included: eclinics or digital methods of care delivery; patient choice of provider at the point of referral and (more proactively) after six months of waiting; and the separation and protection of urgent (‘hot’) and elective (‘cold’) resource. The full implementation of the Long Term Plan, however, was never realised, as a threat of a different kind took centre stage for the NHS – indeed, for health systems around the world.

2020 to the present day

We’re all going to be in a financial hole this year, of varying descriptions... Now there’s a lot of money in elective care still, but do I feel now in 2022 like I felt in 2008? No, because part of me is thinking, yes, there’s money, but the growth isn’t that big, and if we burn all this money on that, my goodness me, look at the scale of what I’ve got to do on savings on everything else. And then you get into difficult territory of, well, why are we putting all that money to that priority and not into child and adolescent mental health services or primary care access or whatever it might be... We’ve put great store by clearing this backlog, because it’s a good thing to do and it chimes with the public, but it’s going to take an awful lot of money. And that’s even before we start talking about social care...

NHS leader



The Covid-19 pandemic compounded and added to the challenges facing the health service. The necessary restriction of elective care activity – to enable people with Covid to be treated and to support new infection control measures – resulted in growing delays to the treatment of those who had been referred for planned care.

The discriminate way in which Covid-19 adversely affected people from particular backgrounds (including black and minority ethnic groups and those from low-income households) cast new light on the inequalities that exist in access to, and outcomes from, health care. The academic waiting times expert we interviewed commented on the association between long waiting times and more pronounced inequalities for those who typically experience the worst health outcomes – a point well made elsewhere in the literature ([Propper 2022](#); Mishra *et al* 2021). There is little evidence on the interplay between inequalities and waiting times specifically. However, there is a worrying trend showing that the number of people waiting for more than one year has increased rapidly – particularly in the most deprived parts of the country ([Holmes and Jefferies 2021](#)). Therefore, as one expert (an academic) noted, it is important to collect and analyse the data on waiting times and health outcomes more generally, as well as researching better solutions with regards to waiting times and health inequalities.

In 2022, NHS England published the *Delivery plan for tackling the Covid-19 backlog of elective care*, including new ambitions for elective care waiting times ([NHS England and NHS Improvement 2022](#)). It made a series of pledges to treat people who had waited longest (one year or more) by 2025. These gains would require an increase in levels of activity across the NHS of 130 per cent compared with the period immediately prior to the pandemic. This is an increase of even greater magnitude than that seen in the period 1997 to 2008.

The ability of the NHS's current workforce to deliver this increase was felt to be a key challenge, not least as the pandemic has taken its toll on the health and care workforce itself. A senior policy-maker we spoke to noted that 'we've slightly run out of road on getting people to do extra activity out of hours' and that efforts may be required to attract, engage and invigorate a workforce described as 'burnt out' and jaded.

More than £8 billion (as at 2022) was pledged to support this recovery plan plus £5.9 billion in capital for 1,000 more beds, equipment and technology. Some



familiar actions were proposed (offering patients a choice of provider, drawing on independent sector capacity) and some new ones added (making greater use of technology to deliver care via virtual appointments and to provide information and support to patients while they wait for treatment).

While the elective care Delivery Plan sets out some of the ‘what’, the experts we interviewed remained unclear about ‘how’ the proposed increase in NHS productivity would be achieved; indeed, they questioned whether the plan has successfully engaged and motivated those who will ultimately be expected to deliver it.



4 Outcomes of the actions taken

By December 2008, it was evident that the 18-week target had been convincingly delivered: 96.8 per cent of non-admitted elective care patients and 90.3 per cent of admitted elective care patients were seen within 18 weeks. By 2009, the median wait for treatment was five weeks ([Centre for Public Impact 2019](#)).

Defining success

Looking across our interviews, when asked what happened as a result of the various initiatives described in the previous sections, the experts agreed that success was defined mainly in terms of achieving the 18-week target by the end of 2008. According to one NHS leader, quite simply, 'we delivered'.

It genuinely cut waiting times really significantly. So, from... a time when there were stacks and stacks of over two-year waiters, stretching out to three or four years, in some cases, to get to a time when effectively, we got rid of 12-month waiters, and were heading pretty rapidly towards having six months as your outer boundary. That was dramatic for people.

Senior policy-maker

What was more complicated for experts to describe was: a clear cause and effect regarding the initiatives introduced in the 2000s; how effectiveness was measured (if at all); and, in the face of a number of other outcomes, whether achieving the target was a full-blown success story of the NHS.

One key empirical study in our literature review aimed to determine the impact of the 'aggressive policy of targets coupled with the publication of waiting times data at the hospital level and strong sanctions for poor performing hospital managers' – performance management, sometimes referred to as 'targets and terror' (Propper *et al* 2008a). The study highlighted an association between targets and terror and



the percentage of people waiting for hospital treatment in England relative to Scotland (where targets were not underpinned by a performance management regime). The data from England showed a significant reduction in waiting times following the introduction of the policy, whereas that was not observed in the data from Scotland for another two years. Propper *et al* acknowledge that reduced waiting times does not necessarily mean the policies were ‘welfare increasing’. Further, waiting times statistics do not indicate ‘anything about the quality of outcome’.

It was clear from our interviews that long waiting times for planned care in the late 1990s and early 2000s were perceived as a very poor reflection of the state of the NHS and, to an extent, on the government of the day too. That meant that many different people had a strong, vested interest in bringing waiting times under better control – from the general public, to the government, to policy-makers and people working in the NHS itself. From 1997, we heard that expectations for bringing down waiting times were high and unequivocal; the goal was to take waiting times ‘off the table’ – to reduce them to the point where they were no longer the thing that people thought about when they thought of the NHS.

Our interviews with experts offer an additional perspective: that ‘success’ might be defined in relation to public satisfaction with the NHS, which was riding high in the late 2000s. Analysis of the British Social Attitudes survey data shows that overall satisfaction with the NHS (inpatient, outpatient, accident and emergency (A&E) services and the NHS overall) began to climb from around 2001 (at the same time as dissatisfaction was on a downward trend). The climb in public satisfaction peaked in 2010 (with 70 per cent of people saying they were satisfied with the NHS) and then began to fall ([NatCen Social Research 2009](#)). Levels of satisfaction fluctuated between 2010 and 2019 and have fallen dramatically since then ([Wellings *et al* 2022](#)).



Measuring the effectiveness of activities to reduce waiting times

Our literature review found a dearth of robust studies of waiting list and waiting time initiatives. There is a lack of well-evaluated pilots of specific initiatives and the more robust studies that do exist have limitations, in that it is not generally possible to isolate the study group from the wider circumstances and other variables that may affect outcomes. Waiting list and waiting time initiatives tend to be introduced alongside other initiatives or reform measures, so it was not possible to trace outcomes back to specific antecedents and causes.

Cost-effectiveness and value for money are particularly sparsely captured and reported in the literature, which means that no definitive claims about effectiveness of different initiatives can be made on this basis. We note with interest that no cost-effectiveness or value for money evaluation was commissioned alongside the measures or commitments introduced in the NHS Plan of 2000.

We heard from one expert who was close to the development and implementation of the NHS Plan at that time. They indicated that HM Treasury generally accepted that the commitment to additional funding had been made and the NHS was being given a key opportunity to transform and modernise. Another expert added that there was alignment between the Department of Health and HM Treasury on the government's aims to reduce waiting lists and waiting times. Thus the questions being asked were not whether there would be value for money *per se*, but what was 'the efficient level of resource that's needed to deliver this policy outcome' as one senior policy-maker told us. The debate then moved on to what levels of efficiency or productivity the government could expect for the unprecedented level of financial investment: the maximum waiting time guarantee of 18 weeks was felt by some of our experts to be the main indicator of the NHS delivering value for money.

In respect of the specific activities to reduce waiting times during the period 2000 to 2008, we note the following.

- Looking across the interview data, experts repeatedly pointed to the same activities that – in their view – had the most impact on waiting times: **targets**, alongside **financial investment** and a robust **performance management** regime. Some experts highlighted the importance of **targeted support**, delivered



by agencies like the National Patient Access Team, rather than relying on a punitive system of sanctions for poor performance. As outlined above, targets (which provided a clear focus and direction of travel) required a mechanism to ensure that NHS trusts were performing consistently, as well as additional workforce capacity. In addition, the targeted support was key to focusing on the challenges in different areas and identifying ways to mitigate them.

- According to Propper *et al* (2008a), pro-market reforms introduced in the 1990s ‘were not accompanied by large drops in waiting times’. We heard mixed views from the experts about the perceived effectiveness of reforms that were introduced by the New Labour government and continued under subsequent governments. In general, it was felt that each reform played a part in changing how the NHS could rise to the challenge of tackling long waiting times for elective care.
 - The introduction of **foundation trusts**: The experts that spoke most enthusiastically about foundation trusts were those with a leaning towards the idea that local providers know best how to deliver a high-quality service to their local population. They expressed their belief that some local leaders felt sufficiently empowered and enthused by the foundation trust model to seize the challenges of the day, including bringing down waiting times. These experts believed that the foundation trust model offered a helpful way of engaging and mobilising the workforce, giving them some ownership and satisfaction over the direction of their organisation and their day-to-day work. Part of the criteria for achieving foundation trust status was having low waiting times (Farrar *et al* 2007). That is not to say that experts believed this is what foundation trusts achieved in totality; we heard, for instance, about the controversy surrounding the variability of performance between different trusts and the resulting ‘lottery’ of health care available to people across the country.
 - **Payment by Results**: In 2002, PbR was introduced with the aim to change how NHS hospitals were paid for the type and amount of care provided. The premise was to use a nationally fixed casemix-based tariff to increase activity levels (Appleby *et al* 2012; Farrar *et al* 2007). An evaluation showed that the introduction of PbR in England appeared to have led to more rapid reductions in lengths of stay and in the proportion of day cases than in Scotland, resulting in cost savings of between 1 per cent and 3 per



cent. It was not possible to determine its impact on the volume of activity since the researchers could not disentangle the impact of the tariff from the effect of the rise in financial resources that became available to the English NHS during the same period (Farrar *et al* 2010). A study by the Audit Commission (2008) concluded that PbR had encouraged a more 'business-like approach' to financial management. The experts we interviewed generally agreed that PbR was a good way of incentivising additional activity in contrast to block contract payments that were made irrespective of the amount of work undertaken.

- **Independent sector care provision:** As we heard from an academic with expertise in waiting times research, independent sector provision is a potentially useful short-term measure for dealing with a backlog of care. However, it may not be the most efficient or sustainable way of managing waiting times in the long term in the context of a publicly funded health service. If it is necessary to rely on independent sector capacity to keep waiting times at a manageable level, the same expert argues that this would suggest underinvestment in the capacity of that publicly funded health service. The available literature on ISTCs indicates that they did not treat particularly high volumes of patients and therefore had a minimal impact on NHS waiting times (Kreindler 2010; [Naylor and Gregory 2009](#)). The increase in private sector activity came after 2008, resulting in a surplus of capacity that could be used to undertake a high volume of elective hip and knee procedures ([Arora *et al* 2013](#)).

The experts we interviewed felt that the key benefit of the policy to expand provision was the pressure that a new ISTC might place on other local NHS providers to work differently to hold on to patients by treating them quicker. The experts also commented that the tricky relationship between the private sector and the NHS meant that the amount of activity that was hoped for was not ultimately delivered within these centres – and this was an expensive lesson to learn. They suggested the need for a coherent narrative and strategy on the use of private sector capacity to treat patients – albeit in the face of what one expert acknowledged was a potentially hostile attitude from staff in the NHS. Securing buy-in from primary care trusts and GPs went some way to shifting these attitudes in the past.



- **Patient choice:** In line with the published evidence, the experts we interviewed tended to hold that patient choice had had a limited direct impact on waiting times (Kreindler 2010; Siciliani and Hurst 2005). For some, it was not clear that offering patients the option of receiving their treatment quicker and in another part of the country was either fair or a sustainable way of offering treatment to people in different places.

On the question of fairness, it was felt that patient choice would likely benefit some patients more than others, such as: those living in areas with shorter waits; those able and willing to travel potentially long distances; and those confident enough to take up their right to receive treatment elsewhere. Certainly, the available literature on patient choice indicates a number of conduits and confounders of choice that might adversely affect some patients more than others and potentially exacerbate health inequalities. The role, knowledge and attitudes of the referring practitioner (often a GP, some of whom the experts described as being unsupportive of the patient choice agenda) has also been found to be a mediating factor in the take-up and effectiveness of patient choice. Other mediating factors include the distance a patient would be expected to travel to an alternative treatment site, and the accessibility of an alternative treatment site (for example, via public transport) (Dixon *et al* 2010).

On the question of sustainability, Expert 6 questioned why patient choice would be thought of as an initiative to reduce waiting times; rather, Expert 6 thought of choice as something of an ‘emergency measure’ whereby patients had been waiting for very long periods and capacity was available elsewhere. Instead of channelling energy into the patient choice agenda, Expert 6 recommended planning and increasing capacity in the parts of the system most in need in order to meet demand over the long term.

- The **separation of emergency and elective activity** (‘hot’ and ‘cold’ activity respectively) was highlighted as an effective course of action by two of the experts we interviewed. We found few studies in the literature reviewed to expand on this approach – only a relatively late study that concluded that the worst-performing trusts for elective care waiting times in England were those where emergency and elective care resources



were shared rather than separated and protected ([National Audit Office 2019](#)). We note that since that report, there has been much more of an imperative to mainstream this split of urgent and planned surgery throughout the NHS. There are a few examples where separating urgent from planned services was found to help create efficiencies in surgical services in particular ([NHS England 2019](#)).

Impact and legacy

Experts discussed the legacy of the range of initiatives that were introduced either to tackle waiting times specifically or as part of a wider programme of NHS reform. The legacy can be grouped into short- to medium-term, and long-term effects which themselves yielded a mix of both positive and negative outcomes. Later on in this section, we discuss the impact of efforts to bring down waiting lists and waiting times on the workforce as well as the unintended consequences of some aspects of the targets and performance management strategy.

Short- to medium-term legacy of initiatives

The drive to reduce waiting lists and waiting times created a sense of shared ownership of a common goal among those working in the NHS. We heard from the experts we interviewed that there were small pockets of clinicians who were not as enthusiastic about tackling waiting times or making changes to their established ways of working, but in other spaces there was greater desire and motivation to make improvements to services that would benefit patients and staff alike. Expert 14 (a leader involved in the implementation of approaches) described the role of the National Patient Access Team in facilitating the co-design of services by drawing in the views of patients and staff about what could work better. Ideas about how to reduce waiting times may have differed, but the 2000s saw a turning point in how people (the public, clinicians, NHS leaders and policy-makers) felt about acceptable waiting times for health care.

The significant cash injection to the health service enabled an increase in workforce numbers, especially nurses (through international recruitment) and renegotiating medical school training places and progression pathways to deliver more consultants. As one expert described it, having a positive or more satisfied workforce was felt to be key to patients having better experiences of health care.



According to another expert, the ability to bring waiting times down to below 18 weeks enabled a sense of collective confidence about what was possible if services and the staff delivering them changed working patterns and had what they felt were sufficient resources. In that expert's view, success with regards to waiting lists and waiting times in the 2000s shows what is possible today. Expert 1 (an NHS leader) described how the 18-week referral-to-treatment target became part of 'business as usual' in the NHS, while Expert 5 (a senior policy-maker) described how waiting times were perceived as much more 'manageable' by the end of 2008.

... some of those things just seemed impossible, at the start. How on earth would you ever get rid of people waiting more than 12 months? And building that confidence gave, for a good number of years, a resilience and an ability to tackle ever more challenging access time targets. As part of that professionalising, I think, of... the services which have been a bit of a poor relative, really, not as exciting as doing a lot of the complex surgery, or cancer... And I think we need to be careful not to lose that.

Expert 10, senior policy-maker

However, some experts acknowledged that there was an opportunity cost of the intense focus on reducing waiting lists and waiting times at various points during the 2000s (particularly around 2006 when the NHS slipped into financial deficit). It left less bandwidth for attention – and money – for other areas such as public health, primary care and community health care services. There were some notable exceptions where elective care waiting times were not the sole focus – for example, the introduction of the National Service Framework for Long Term Conditions, the Quality and Outcomes Framework (QOF), and access targets for general practice.

I guess with hindsight, that relentless focus during the 2000s on the elective waiting times [and] A&E meant frankly we had very little focus on anything else. So I think it was so relentless, we let other areas slip... So we didn't necessarily do this in a way that would have helped support a reduction in health inequalities, we didn't invest sufficiently in prevention... We didn't do enough on mental health... So I think... that relentless focus was great in delivering one thing, one objective. What it wasn't great at was doing multiple objectives.

Expert 12, senior policy-maker



Long-term legacy of initiatives

A small number of the initiatives introduced during the 2000s are still visible (albeit in a slightly different form) in the health care system today. For example, targets such as 18 weeks have endured in some way, shape or form in the NHS. There is still a sense of an upper limit to how long a patient should be waiting for care, and 18 weeks from referral to treatment remains the long-term goal. The current Delivery Plan for tackling the elective care backlog has clearly established a fresh set of clinical standards for emergency and elective care and milestones for achievement for the recovery period – arguably working in a similar way to targets. For example, no one will wait longer than two years for elective treatment by July 2022, and waits of over 18 months will be eliminated by April 2023 ([NHS England and NHS Improvement 2022](#)).

Other initiatives that contributed to the reduction in waiting lists and waiting times and that are still present in the health care system today include the continued use of private sector capacity in the form of ISTCs and the physical separation of emergency and elective care. Both of these approaches form part of the Delivery Plan for the recovery of elective care ([NHS England and NHS Improvement 2022](#)).

The impact of initiatives on the workforce

As noted earlier, there were some positive outcomes for the workforce, either directly or indirectly, as a result of some of the actions taken to reduce waiting times. Examples include the expansion in numbers through recruitment, accelerating the careers of junior doctors to grow the consultant workforce, and changing the roles and responsibilities of nurses to increase the number of senior nurses. It could be argued that some of the gains (in reducing waiting times) were made by growing workforce capacity much more sharply – and not by just expecting people to work harder.

There was some positive culture change observed within the NHS workforce as well, such as a sense of professionalism and fulfilment in bringing waiting times down and delivering a good experience (and outcomes) to patients.

Restoring the fundamental disciplines that keep a grip of waiting times and all those sorts of things [is] a work in progress. And it just feels very, kind of, very cyclical... We're having to relearn most of the things... I've heard another colleague describe



how energising that was actually. It felt like they had a purpose again. And it felt like... it does feel like when you get on top of it, it's one of those nice things that you can see progress with. You can measure progress. You can see it.

Expert 9, NHS leader

The impact of the performance management regime

We know that the robust performance management regime introduced in the 2000s had the reputation of creating the 'terror' aspect of 'targets and terror'. We heard about regular (weekly, fortnightly, monthly and quarterly) discussions about performance between NHS senior management and the Department of Health and between the Department of Health and the PMDU. Meetings between NHS chief executives of the worst-performing trusts for waiting times and the Department of Health were described as 'excruciating' by Expert 2 (a leader involved in the implementation of approaches), who had a front-row seat to witness some very challenging discussions:

They [chief executives] looked like they hadn't slept for a month. The ones I knew from before looked physically diminished, and they'd been through a process of ritual humiliation, basically. And at this meeting, one of the excruciating observations, one of them thanked the Department of Health for holding this meeting because these people could meet each other, it was like a support group, really, in going through pain... This is important to understand what people went through... What in the end turned out to be really powerful was this process of naming and shaming those who fail. So that, I think, is a key part of the transformation.

There was also a decision taken by government to put information about hospital performance into the public domain. Experts acknowledged that this was likely to have put considerable pressure on individuals and created a sense of fear about the individual consequences of not hitting targets – both fear of being named and shamed in public and fear of being sacked. Being pulled up in front of officials could either be demoralising and demotivating or a catalyst for action. The 'terror' also created the conditions leading to undesirable behaviours, as we discuss below.

But one has to be really careful about obviously the unintended consequences of this sort of system, because if you inject fear as well as importance to these sorts of



situations, it can be a very high-octane environment, and particularly if you've got a... very highly charged political environment, as we have now, then one needs to be very careful, and the consequence on staff can be huge in terms of stress and strain and also on patients as well.

Expert 14, leader involved in the implementation of approaches

Some of our experts with clinical and operational experience expressed their frustration about the bluntness of the performance management regime as a tool for improving performance. The outcome of this was, in their view, the narrowing and skewing of focus and priorities in the area of elective waiting times as opposed to other potential areas in need of attention locally. Once performance against waiting times seemed to be on track, we heard how the performance management machine would immediately shift its focus to the next area of difficulty.

It's not so much about the performance regime, it's the knee-jerk reaction to it. So rather than getting things sorted properly, it's the centre's inability to focus down and make sure things are sustained. Yes, waiting list was the problem yesterday but what's happening in your A&E today?... And it's that movement that is really difficult to manage locally because you can't take your eye off one to deliver the other, all things need to be delivered and you just need to be able to do it in a systematic way.

Expert 8, NHS leader

Unintended consequences

Several experts (including those responsible for delivering 18 weeks operationally) explained that the pressure to meet targets led some NHS hospital staff to hide or manipulate their waiting times data (otherwise referred to as 'gaming') in order to avoid penalties or sanctions (Mannion and Braithwaite 2012; Bevan and Hood 2006). Expert 4 (a senior policy-maker) told us about how senior management of NHS trusts caught gaming their data were hauled in front of Department of Health officials to be strongly rebuked, if not sacked (as documented elsewhere – see [National Audit Office 2001](#)). Clearly, the political environment was intense and the stakes were high with respect to waiting times. This could create a perverse incentive to deliberately mislead officials regarding performance. As a lesson from the past, Expert 2 argued that it is critical to put in place other measures to counter gaming of data – for example, random and unannounced quality inspections.



So there were a lot of measures directed at service improvement, a consequence of which was a gradual reduction in waiting times. Now, it would be remiss of me not to say that, alongside this, went a certain amount of top-down pressure for bits of the system to hit targets and all that. And that induced a certain amount of bad behaviour, now the sort of thing which is still being characterised as bullying behaviour... Some of the regions got bad reputations for quite aggressively managing down waiting times. And you got the odd case, kept coming up, of waiting lists being found in drawers and all that kind of stuff, as people tried to fudge and fiddle the figures.

Expert 5, senior policy-maker

That is not to say that the experts we interviewed disagreed with the strategy of targets plus performance management. There was agreement that, together, they were powerful levers. The learning from the past is that targets need to be crafted with care to work to their best effect. For instance, in their study of how targets can be made effective in the NHS, Berry, Gardner and Anderson (2015) suggest there should be less reliance on penalties and more focus on supporting commissioners and providers to develop the capacity and capability to make sustainable improvement.

Targets alone aren't terrible things because I can't think of any management system that doesn't set itself some goal or target, or whatever. But often nationally derived targets... which are interpreted very narrowly, haven't served us well.

Expert 11, NHS leader



5 Reducing waiting times: enablers and barriers

We have, by now, explored the different activities that came together in pursuit of the goal of 18 weeks and as part of a concerted effort (or machine) to make this vision a reality. In the context of the 18-week target and the various approaches adopted in pursuit of this goal, the experts we interviewed identified a number of factors that enabled, hindered (or both, in some cases) the effort overall. They also commented on the opportunities and challenges facing the effort to reduce waiting times in the NHS today.

Increased funding and capacity – especially for workforce

One of the most commonly cited enablers and preconditions for success in bringing down waiting times to 18 weeks was the level of investment in the NHS from 2000 to 2008. Chiefly, this investment was geared towards the recruitment of staff and buying equipment (particularly, from 2004, diagnostic kit), without which reaching the 18-week target would not have been feasible. Recalling the financial resources made available in the 2000s, Expert 1 (an NHS leader) described the mindset as one of ‘money isn’t the issue here, let’s get the job sorted because the problem is so big, we need to throw resource at it’.

Our experts were inclined to comment on the investment in workforce specifically during this period as a major factor in reducing waiting times. As one expert put it, bids for funding to support activity to reduce waiting times were questioned less on the basis of value for money and more on the extent to which they accounted for the workforce input that would be needed to deliver success:

The health service is a service, so the workforce needs to be there. So by the time I was working on it full time, as I came in, that was absolutely, kind of, you knew that. So there were periods here where you couldn’t put up submissions



to ministers without a section on the workforce implications. So what are the workforce implications for the submission? How are you going to meet them? Are the Workforce Directorate aware of what you've just said? And so you couldn't put things in to ministers without showing that you'd done it.

Expert 4, senior policy-maker

Experts were more or less agreed that additional financial investment for the NHS and social care is necessary and vital to making a difference to waiting times today.

... making sure that we have an ambition once we recover the acceptable waiting times that unless there is another pandemic or something extraordinary happens, these... waiting times will be delivered, and we need to make sure that we put the resources in place to do that. And... that implies as much to do with social care as it does to do with health care.

Expert 14, leader involved in the implementation of approaches

In particular, it was acknowledged that the size and state of the workforce would likely limit the ambition of the elective care recovery plan and the NHS's ability to meet this ambition. The experts we interviewed commented on this in relation to the need to recruit more staff, but they also noted that additional funding and investment would signal to those already working in the health service that they have grounds to be hopeful and optimistic about the contribution they can make to improving the health of the nation.

Some experts reflected on the current state of affairs of the health and care workforce – a state described elsewhere as one of 'endemic' workforce shortages ([The King's Fund 2022b](#)). The current shortage of NHS staff was believed to pose a major obstacle to reducing waiting times and realising the ambitions of the Delivery Plan for tackling the Covid-19 backlog of elective care:

This big programme to set up community diagnostic centres... there aren't the staff to staff them. We don't staff our current imaging facilities intensively, some of them don't operate at all at weekends, so, you know, that's why the workforce is such an important issue in this.

Expert 5, senior policy-maker



Central direction and oversight

Alongside the unprecedented increases in funding that were pledged to the NHS in the early 2000s, the level of central oversight and involvement in waiting times policy was felt to signal that waiting times were a major priority for central government – indeed, for the Prime Minister himself. If the 18-week target and phased trajectory of progress from 2004 to 2008 conveyed a clear direction of travel for the health service, the input of the Prime Minister and other key individuals at the centre of government was felt to demonstrate a commitment that experts believed was both infectious and unquestionable.

What was exceptional about Blair was he took this seriously and was happy to take four monthly meetings – I don't know, each probably would have taken a few hours – so every month he's spending hours doing this, but that signals to everybody this is the government's top priority because the Prime Minister is interested in it.

Expert 2, leader involved in the implementation of approaches

Consistently, the experts referred to the Prime Minister's Delivery Unit (PMDU) as being integral to the overall achievement of the 18-week target. Crucially, these meetings concentrated efforts on precisely what would be done to achieve the target in practice. By asking the question about precisely 'how' 18 weeks would be delivered, and with a combination of top-down pressure and support (see below), a momentum and confidence was established across the health service that made 18 weeks feel not only feasible but inevitable.

Some of the experts we interviewed had questions about where the primary drive of today's effort to reduce waiting times sits in the new structure for the NHS. The national landscape is now home to NHS England alongside the Department of Health and Social Care, with many of the functions of the Department of Health of the 2000s no longer sitting under one roof. Experts also commented on the establishment of integrated care systems (ICSs) in this context and the opportunities and challenges they present for tackling waiting times. Expert 11 was hopeful for the emergence of altogether different models of care, which might ultimately contribute to a reduction in elective care waiting times while simultaneously delivering against the broader aims of ICSs. As one example, he described GPs and hospitals as 'too separate, sometimes, opposing blocks' – not



always working together strategically to deliver preventive measures to manage demand for elective care. Another expert perceived the role of the ICS as being an ‘enabler’ for hospitals in the area to reduce waiting times.

Performance management and incentives – ‘carrot and stick’

Some experts were inclined to regard the degree of scrutiny and accountability afforded by the performance management framework as the key factor that made the difference in achieving the 18-week target. This included the monthly stocktakes with the PMDU and other meetings facilitated by the Department of Health with chief executives of providers struggling to improve their performance – which, in some instances, led to chief executives losing their jobs. For some experts, including Expert 2 (a leader involved in the implementation of approaches), the ‘brutal’ nature of the performance management regime was key to its success. The fear and shame generated by the publication of star ratings and the meetings that would follow with the Department of Health were a powerful driver for improving performance and reducing waiting times.

Other experts acknowledged that performance management was effective to some degree but that it was not sufficient by itself to deliver the 18-week target. For one thing, they pointed out the increases in NHS funding, which meant that while the 18-week target was challenging, over time belief grew that it was possible. This belief in possibility was what made performance management effective; without that belief, the experts were sceptical that the same approach would have yielded results. Some experts also expressed their conviction that the constructive and supportive relationships between central government and providers regionally were vitally important. This included taking ideas out to test with representatives of strategic health authorities (SHAs) to ensure their ‘workability’ rather than imposing changes with no prior negotiation or discussion.

The thing that worried me in some of the conversations with the NHS in the years that followed [2008] was the overemphasis on performance management. Probably more on the finance side, that you could performance manage trusts to remove their deficits. And you kind of think, how many times have you done this and it's not worked? And it keeps on not working. Whereas when it was done in 2005/6, it did work, but it did work because there was a big budget increase coming the year after



and you could find your way out of it and you had things that you could cut. And so again, there was a plan of how you got out of it, and the plan could be delivered and the plan could be performance managed. Because actually it had some contact with reality. But by 2015/16, these plans had no contact with reality and so they all failed.

Expert 4, senior policy-maker

Offering a different perspective, Expert 5 (a senior policy-maker) pointed out that the ‘carrot’ of incentives to drive productivity can work better than the ‘stick’ of performance management. In his words, ‘... if you really want to... drive efficiency and productivity, the worst way to do it is to bully people, and the best way to do it is to incentivise’. He added that the over-reliance on performance management and the sacking of chief executives or chairs ‘makes no impact on the lives of clinicians’ and that it would be worthwhile giving serious thought to how to ‘incentivise really good behaviours and productivity at a local level’. For Expert 5 and others, this incentivisation could be both financial (mediated by structures including foundation trusts and PbR) and personal (facilitated through engagement with the workforce).

Targeted support

Where performance was identified as being ‘behind the curve’, some of our experts believed that the support offered by the National Patient Access Team and later the Intensive Support Team was a vital part of giving providers the best chance of success – not least because 18 weeks was considered a bold target requiring sweeping changes to ways of working in the health service.

For me, the big and really important step is, so how do you respond when this performance oversight framework reveals that someone’s really struggling, or off the pace? And I firmly believe that simply calling people in for a meeting, and pointing a finger and saying, you know, what’s going on, that is counterproductive. And you did see that in some places, and it’s deeply counterproductive, because not only do you demoralise teams who will be working really hard, but you start putting in an incentive to fiddle the figures. And that’s something you have to really look out for... The right response is, ‘so what sort of help do you need?’ And ‘this isn’t about you, this is about people who aren’t getting the access they need, and you may not have the right resources to do the analysis, you may not have the right operational expertise, we can help with that’... That’s what the National Patient Access Team



was about really, trying to have a response that will be seen to be helpful and impactful in the toughest environments, most difficult places.

Expert 10, senior policy-maker

Expert 14, who was closely involved in the work of the National Patient Access Team, outlined the support process, which was focused on NHS hospitals categorised as either being at high or medium risk of missing the 18-week waiting times target. The team designed a set of standard operating procedures based on the expertise of its analysts and clinicians. The team would visit the high- and medium-risk hospitals and focus on the key data, including historic patterns of commissioning and providing elective care, emergency activity, and the demography of the local population. The data would be shared with the trust, the commissioner and the regional office for sense-checking and to start forming emerging questions.

The team would spend a couple of days at the hospital, meeting with senior clinicians, managers and commissioners to build a picture of how waiting times had been managed in the past. This could, for example, identify the impact of commissioning approaches on waiting lists and waiting times. For instance, towards the end of the financial year, if there was some money unallocated, the commissioning activity would go up and waiting times would come down, but then the situation could almost reverse at the start of the new financial year when commissioners were behaving more cautiously. The point being highlighted was that commissioning patterns could have a real impact on waiting times as well as patient and staff experience.

And there was some often really dreadful examples of episodic commissioning, which meant that some commissioners were seeking short-term answers to long-term questions, which meant that there was a whole bunch of additional mobile operating theatres bought in for a year or two where actually what they'd need to do is to build some substantive operating theatres and to recruit anaesthetists and so on and so forth.

Expert 14, leader involved in implementation of approaches

At the end of the team's visit, an action plan was produced for the hospital along with a report for the Department of Health to help track progress over time.



Leadership and relationships at all levels

The extent to which the 18-week target required changes to ways of working in the NHS was discussed at length, particularly by experts with operational experience of reducing waiting times within a hospital or trust. We heard about the effort required to secure the buy-in and engagement of the workforce to do things differently, whether booking appointments in a more efficient way or changing an operating theatre schedule.

Some experts described work to do in terms of understanding and leveraging managers' and clinicians' motivations and values. Experts gave examples whereby specific locations or sites seemed unwilling and/or unable to transform their culture and ways of working to support the reduction in waiting times. Here, Expert 13 (an NHS leader) highlighted important learning about this with reference to the 18-week target. In his recollection, the target did not readily resonate with all the people who were tasked with achieving it; it wasn't immediately obvious why 18 weeks was the chosen target. The vision had to be 'sold' as a way to help NHS staff do their jobs and get patients access to the care they were paying for (as taxpayers).

In some cases, particular groups such as consultants needed convincing that long waits for treatment were not in patients' best interests – even if long waiting times gave the impression that certain services or individuals were in popular demand. Other experts told us that they encountered resistance in a number of ways: for example, that some consultants regarded long waiting lists as a 'badge of honour'; that some GPs were reluctant to engage with initiatives such as patient choice or referring patients to independent sector care providers (as documented in Dixon *et al* 2010); and that some commissioners found it challenging to plan the allocation of resource to meet demand beyond the annual funding cycle.

For some of the NHS leaders we interviewed, securing the buy-in of their teams hinged on landing the point that 18 weeks was not about delivering government targets; rather, they couched their mission as 'we're there to deliver great outcomes for patients and we're there to deliver safety for the NHS'. This became part of the 'mantra' described by Expert 13 (NHS leader) and was incorporated into discussions with SHAs and NHS trusts. Expert 13 said it was fortunate that, at the



time, 18 weeks would have been approximately the same as average waiting times in Europe for elective care, and that helped staff gauge the performance of NHS services against their international counterparts.

Experts spoke of the importance of ensuring that managers and clinicians felt they retained some degree of ownership and autonomy over their work, so that innovation and changes to ways of working felt as much ‘clinically led’ as ‘managerially enabled’. Asked what could have been done differently, Expert 10 (senior policy-maker) cited earlier involvement of clinical experts – similar to the Getting It Right First Time model ([GIRFT 2020](#)).

If you're trying to manage change in the hospital, you need to take people with you. They need to understand why you're trying to do something. Telling them they've got to do it because the government have told them they've got to do it is never going to deliver the outcomes that you need. So I think you need to be nuanced... and that depends on the quality and the motivation of people who are doing the performance management. In a sense, that was why we had to get the right people into the strategic health authorities to enable us because they, in a sense, were the fulcrum of it. They kind of made it all work.

NHS leader

Mobilising the know-how and skills on the ground

Then there was the task of upskilling staff and distilling/sharing knowledge about how to manage waiting lists in order to hit the 18-week target. As one of our experts put it, the infrastructure and processes required to make 18 weeks a reality was so complex that ‘you need a degree’ to understand how it all worked. It required the input and expertise of all different types of people: people with technical and data analytics knowledge as much as clinical and administrative staff.

So rather than simply having the existing process and getting everyone to do more and more of it and faster and faster, [the team] along with NHS colleagues then ran a series of programmes to support staff re-examining the process of delivering elective care to work out, well, how can we achieve more, better output from the available resources? And as you'll expect, often there were wonderful examples



where staff, when patients, when they were consulted, could say, well, look, we could do this in a different way, do things in parallel rather than in [single visits to] clinics... [This was] often a very helpful device to improve waiting times as well as the experience of patients and staff.

Leader involved in the implementation of approaches

The collection and analysis of waiting times data was revolutionised from 2000 and particularly from 2004; previously, this data was not routinely collected or reported. The experts we interviewed deemed this to be a central component of success in reducing waiting times. It ensured that providers had sight of and could plan supply to meet demand, and it promoted accountability of providers to the centre.

Introducing the 18-week target in particular posed a number of challenges to the collection and analysis of waiting times data. The first challenge was that the target covered the entirety of the patient care pathway from end-to-end rather than as discrete stages. Although this would, in theory, make it 'easier to count' the number of patients waiting in order to anticipate demand, it would make it more difficult to track patients at vital stages of their care journey – especially at the diagnostics stage and the time between diagnosis and the start of treatment (or hospital admission).

The second challenge was that of the consistency and accuracy with which the data was collected. A number of experts gave examples of lost or misfiled patient details – with up to 15 per cent of referrals (according to one expert) believed to have gone 'missing' nationwide every month. Although providers were supported to find solutions to their own unique data challenges, the absence of a common or standardised approach or framework for collecting, processing, storing and using data was felt to lead to potentially dubious practice. Today, it was felt that waiting lists are not managed systematically according to priority and waiting time, leading to what one expert described as 'unsafe and unfair' outcomes for patients.



Wider NHS reform measures: galvanising energy but an opportunity missed?

We heard, from the experts we interviewed, how a combination of ambition and perhaps also ‘impatience’ at the centre of government paved the way for a series of system reforms that were believed to play some role in reducing waiting times during the 2000s. While the direct causal link between, say, the establishment of foundation trusts and PbR and reduced waiting times is tenuous, experts credited these reforms with galvanising and harnessing energy within the NHS itself, believing that they revolutionised the way health care was both delivered and perceived in England and internationally.

Now, during that early period, there was very quickly, as always happens in government, a frustration that, ‘oh right, we’ve given you the money, now why has it not happened overnight, why is this not delivering everything we expected overnight?’ And frankly lots of reasons for that because you’ve got to get capacity in... But feeling probably that in addition – and this feels quite familiar – in addition to money, this wasn’t going to happen without reform and change, we need structural stuff to happen to support that overall policy objective.

Expert 10, senior policy-maker

Although the wider reforms helped energise the national push to reduce waiting times, the experts recognised that there were challenges associated with a multitude of measures in play at the same time. Some described the amount of reform as, at times, ‘incoherent’ and ‘irritating’ – both for the centre to manage and for providers to deliver. Patient choice was cited as one example where the reason and explanation for introducing reform was not clear to all within the system, leading to resistance and inconsistency in how it was applied across the country.

That said, some experts felt that system reform did not go far enough to tackle some of the broader forces that impact capacity and delivery of elective care and contribute to long waits in the first place. We heard how delayed discharges from hospital caused log-jams in the system, as well as the inefficiencies of some patient care pathways whereby they require multiple appointments (with a great deal of repetition and duplication along the way) in order to get a diagnosis. More broadly, it was acknowledged that it was only possible to keep a certain number of ‘plates spinning’ and for the system to contend with a finite number of priorities. For some



experts, this manifested in a number of missed opportunities to think (for example) about the interrelation between primary care and elective care.

One expert spoke about his regret that the period did not see more transformative thinking about the role of general practice and community-based services in preventing, managing and treating health conditions outside of secondary care and hospital settings. This same expert described his hope that the present day presents an opportunity to consider the shape, size and role of general practice in relation to managing onward referrals for elective care and delivering outpatient support. Sharing his personal experience of multiple and duplicate appointments to get a diagnosis for a lump in his ankle, Expert 11 said:

And the reason I've gone on about my own story, which is boring, is because I know that's duplicated hundreds of thousands of times in our health service every bloody day of the week. And it's that what's driven me to say, yes, we're busy but sometimes we're busy doing stuff that we're doing just badly.

NHS leader

There was some question among the experts we spoke to about whether or not the present-day focus on waiting times has truly captured the hearts and minds of those working within the NHS and the public in the same way as 18 weeks did. We spoke to a chair of an NHS trust, who said that his trust was 'operating quarter by quarter' against the 104-week target and it felt like there was 'no sense of vision, no sense of mission, no sense of connecting this with the outcomes we want to deliver and no sense of it building into something'. To capture hearts and minds, it would help to have a sense of the bigger picture – what will be achieved beyond cutting down the size of the waiting list? It would also help to know how the strategy will sustain the proposed reductions in waiting lists and waiting times, so that the same or similar situation does not recur in future.

... the narrative is really important here because you have to mobilise tens of thousands of people to want to make it happen and they've got to believe in it and they've got to feel that they're being backed to do the right thing. At the moment, the narrative is guilt... That's not enough. It's not going to deliver the change that people want. So the narrative, the kind of purpose, why are we doing it, is really, really important if you're going to mobilise everybody to make it happen.

NHS leader



I think [the strategy] should be ambitious, it should set a long-term, bold ambition in terms of access times, and recognising that its achievement inevitably will be a process, not an event. And it should be sliced into, let's say, annual steps which are evidence-based, which encourage and reward innovative practice and the adoption of good practice from around this country and around the world.

Leader involved in the implementation of approaches

And yet the experts acknowledged the pressures facing the health service at this time. They understood the need for goals to be realistic and to have an eye on other challenges facing the health and care sector (the crisis in social care, making integrated care a success, and so on) – not just leveraging waiting times as a politically attractive objective.

The elective strategy is a good strategy, I'm all for it, but I think 18 weeks captured the population... Whereas I think currently the elective strategy has captured the minds of the NHS, I'm not sure it's yet in the conversation down the Dog and Duck on a Friday... [The 18-week referral-to-treatment target] was an easier thing for people to hold on to, I think, because it was a bit more straightforward, whereas now, for a whole host of reasons, it's a little more complex.

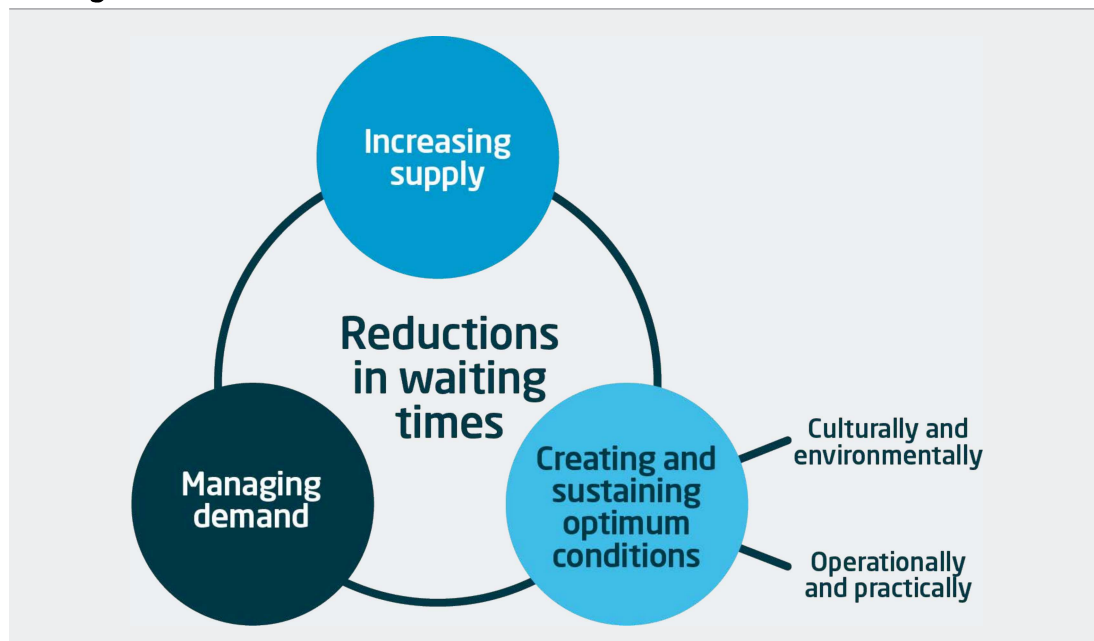
NHS leader

6 Discussion and conclusion

There is no one ‘silver bullet’ that the NHS can use to reduce waiting lists and waiting times. Indeed, what we know from the literature and from the testimony of the experts we interviewed is that the most successful efforts to reduce waiting times tend to comprise a number of activities that simultaneously promote alignment between the supply of and demand for health care, cultivate conditions and optimise practice within the health care system (see Figure 1).

It is worth noting that the findings from our literature review and expert interviews diverge in their assessment of the specific activities deemed to be more or less ‘successful’ in reducing waiting times. In part, this is due to the difficulties of studying a specific activity in isolation from the host of other factors that affect the health care system and waiting times; it is also a matter of perspective and of what matters to those working in health and care – that is, what kind of health and care

Figure 1 The components of an effective strategy to reduce and sustain waiting times





system they aspire to create. What happened in England between 1997 and 2008 was the setting in motion of several chains of events, some of which specifically aimed to reduce waiting times, while others may well have impacted waiting times but via transformation of the health service more generally.

Thinking about the nature and scale of the waiting times challenge facing the NHS today, this research raises some questions for policy-makers and some actions for them to consider.

Increasing supply

The NHS budget saw only marginal increases in funding between 2009/10 and 2018/19 (1.5 per cent per year in real terms, compared to a long-term average of 3.6 per cent per year prior to that) ([The King's Fund 2022a](#)). The growth in waiting times that was under way long before Covid-19 indicates (among other things) understaffing of the NHS. The absence of a comprehensive workforce plan means that it is difficult to know if the changes promised by the Delivery Plan for tackling the Covid-19 backlog of elective care can be realised (Murray 2022).

In this context, the experts we interviewed were both concerned and sceptical about the capacity of the NHS to make meaningful and sustainable reductions in waiting times as per the vision of the elective care Delivery Plan. Although the published literature cannot make any claims about the causal relationship between additional funding and reduced waiting times, there is an acknowledged correlation between the two (Ballini *et al* 2015). Across the board, the experts testified that achieving the 18-week referral-to-treatment target by 2008 would not have been possible without significant increases in funding – in equipment and capacity but also, crucially, in workforce. As one expert put it, 'The biggest single thing of note is, if you visited the NHS in 1997 and then in 2010, there were a lot more doctors and nurses [in 2010].'

Additional funding and expanding the workforce will not be sufficient, by themselves, to reduce waiting times, but they are a vital starting point. Without these measures, as the experts testified, it will simply not be possible to implement the various other components of the elective care Delivery Plan.

As for other measures to increase the supply of health care, paying for capacity within the independent sector might be a necessary short-term measure to reduce



the backlog of care, but investing in the NHS's own capacity would be the best way to sustain reductions in waiting times in the longer term.

Key questions to consider

- Are all the necessary resources – including workforce – in place to meet the vision/aim for reducing waiting times?

Managing demand

The published literature on activities to manage demand and ration access to care did not yield convincing results. Nor was this a category on which the experts dwelled either – except to point towards new and emerging opportunities for wider transformation of the health and care system in the spirit of tackling health and care problems 'upstream'. Whether talking about the role of primary care or ICSs, experts acknowledged that the present-day landscape affords an opportunity to offer new models of care with an eye on population health management and prevention. By working in partnership across traditional organisational and sector 'boundaries', local partners are ideally placed to address some of the social, structural and systemic forces that contribute to elective care waits in the first place. This includes engaging with under-served populations and those with the worst health outcomes, as well as delivering care and support to people at an earlier stage of need and in alternative, community-based settings.

Key questions to consider

- Do we understand the full picture of people waiting for elective care: who they are, where they are and their level of need?
- How does this picture map on to local services, in elective care and in other parts of the health and care system? How can these needs most effectively be met?
- How do local systems manage the balance between delivering elective care to people on the waiting list and retaining a focus on other priorities, including population health management, prevention and tackling health inequalities?



Creating the optimum conditions to reduce waiting times and sustain those reductions

Cultural and environmental considerations

The literature highlighted a number of activities with the potential to focus, incentivise and harness the energy of those working in the health care system to reduce waiting times. We see that there is a need and an opportunity to cultivate this energy in the present-day context, which is typified by workforce fatigue and uncertainty about the vision and priorities for the NHS as a whole and in respect of the 'ask' on waiting times specifically.

In the first instance, this requires a simple and clear message about what 'success' looks like: a message that speaks to and inspires those working in the NHS and resonates with their own values and motivations for coming to work every day. A workforce that feels engaged and looked after (as opposed to disillusioned and under growing pressure) is, after all, more likely to stand a greater chance of delivering the waiting times 'ask' (Mailley 2011; Ellins and Ham 2009).

This brings us to the 'ask', which has historically taken the form of maximum waiting time guarantees for patients/targets for providers. Today, the extent of the elective care backlog is such that providers have so far been asked to tackle the number of long-waiting patients rather than delivering treatment to all people waiting within a stipulated timeframe. As important and demanding as this 'ask' is, we heard from the experts that it is less a vision of 'success' and more about returning step-by-step to performance standards that the public have previously benefited from. The 18-week referral-to-treatment target was not without its problems and had some unintended consequences – yet it offered those working across the health care system a concerted focus and unquestioned priority over many years. With the oversight of the Prime Minister's Delivery Unit in central government and a mechanism that connected those at the very centre of policy to those at the frontier of delivering care, it was possible to establish a roadmap for delivering against the 'ask' while cultivating the relationships that were necessary to do so (between policy-makers, leaders in the implementation of policy, senior managers in the NHS, clinicians, data experts and administrative staff).

Importantly, as ambitious as the 18-week target was, it was deemed feasible in the context of unprecedented levels of NHS spending. Performance management has



received a great deal of credit for achieving the 18-week target, but – as we have seen in the past decade or more – performance management cannot work miracles when it comes to waiting times. Performance can only be managed (and, crucially, improved) where there is sufficient resource and support in place. Even then, it is important for performance management to work alongside support, sanctions for gaming, and inspections both for the quality of care and waiting times performance. There are lessons here for policy-makers today about the design and deployment of targets, the dialogue necessary between the centre and the regions to ensure the feasibility of delivering them, and the value of the ‘carrot’ as much as the ‘stick’.

One final point worth emphasising here is the financial mechanisms that are in place to incentivise activity among providers to reduce waiting times. While the literature offered little conclusive evidence about Payment by Results specifically, our experts tended to feel strongly that the conditions created by a payment-for-activity model were imperative, both for increasing activity levels to reduce waiting times and stimulating creativity within NHS trusts to design and deliver care effectively. It was acknowledged that this resulted in a degree of variability in the performance of NHS trusts and this, too, offers some valuable learning for the present day in terms of: ensuring that sufficient specialist support is available for providers who appear to be struggling; minimising (or, at the very least, not exacerbating) existing inequalities in health care access and outcomes; and recognising the different nature and scale of the challenge in different ICS footprints depending on the needs of their local population and the forces at play within their health economy.

Key questions to consider

- What is the vision?
- What does ‘success’ look like?
- How do we take staff, patients and the public on the journey?
- How will responsibility and accountability for these actions be realised – centrally and regionally?
- What is the roadmap of milestones towards our end goal?
- What actions will take us towards our end goal?



Operational and practical considerations

Aligning supply with demand and, in general, meeting the health needs of the population requires the systematic, accurate and granular collection of data. There is an association in the literature between waiting times performance and the granular collection and analysis of waiting times data (Taylor and Shouls 2008; Appleby and Harrison 2003). We heard from the experts we interviewed that the transformation in data management in the NHS over the course of the 2000s was nothing short of revolutionary – and yet, so much of this learning has been lost. The winding down and eventual closure of support structures such as the National Patient Access Team left a big gap in capability around data analytics, leading to the challenges posed by the inconsistencies and inaccuracies of data collection we discussed in Section 5. As one NHS leader put it while speaking about the lack of standardisation of the management of waiting times data across the NHS: ‘... this sort of chaotic, “let’s just hope”... it just doesn’t work’. As evidenced by the experts we interviewed who were responsible for implementing waiting times policy and support, there is value in building the capability and buy-in of health and care staff (including those who make referrals for elective care), commissioners and patients to unpick and tackle the drivers of long waiting times.

The opportunities for using data in the present day are, in themselves, nothing short of revolutionary. Yes, it is a solid starting point to understand performance, throughput and the bottlenecks that may contribute to waiting times in the first place. But patient data can also be used more sophisticatedly to understand need, demand, and the interplay of socio-economic factors with patient access to health care and outcomes, as well as to deliver tailored communication and support to people in therapeutic and meaningful ways as they wait for treatment (Godden and Pollock 2009). This understanding could unlock learning that enables local systems to find their own approaches to reducing waiting times and prioritising care for those facing the worst health outcomes. It could also enable care to be delivered more effectively and equitably across traditional sector boundaries (such as that between health and social care) to improve outcomes for people whatever the course of their care journey.



Key questions to consider

- Do we know how to capture and analyse waiting times data?
- How can waiting lists and waiting times be managed consistently and fairly?
- Are resources being used effectively?
- Are current ways of working and approaches to reduce waiting times sustainable over the longer term?

The 'how' matters as much as the 'what'

This research sought to understand the strategies that have been used in the past 20 years, in England and elsewhere, to reduce waiting times and their impacts.

At a basic level, the nature of the waiting times challenge is one of aligning the forces of supply and demand. There are a number of specific activities (the 'what') which, although not rigorously supported by the published literature, are associated with reducing waiting times.

Where substantial and sustained reductions in waiting times have been achieved, as in England in the 2000s, this has been linked to a concert of activities (rather than any one initiative). It has also been linked with a clear vision that set out a bold direction for the health service as a whole and, crucially, recognised the importance of creating the right conditions for activities to reduce waiting times to be effective. In an era characterised by unprecedented public spending and unquestioned priority of the 18-week target, the NHS made strides in reducing waiting times with ever-growing confidence and hope. With investment, support and engagement, the health care workforce delivered 18 weeks and more – not simply because they were set a target but because delivering high-quality care in a timely manner was felt to be the right thing to do for people. History offers hope that, with the right tools and the right conditions, the challenge of bringing down waiting times, and sustaining them at lower levels, is surmountable.



Annex 1: Methodology

Background to the research

This study was commissioned in December 2021 by the Department of Health and Social Care to explore approaches that have been implemented in the past to reduce waiting lists and waiting times in the NHS, including their impacts and costs. The agreement was that The King's Fund would undertake a review of the published literature and semi-structured interviews with experts.

Literature review

The purpose of the literature review was to identify approaches that have been used in the past 20 years in England and elsewhere to reduce waiting lists and waiting times. We sought information about the short- and long-term impacts of those approaches as well as cost-effectiveness or value for money. The search focused on published research, policy documents and grey literature mostly related to approaches implemented in England. We limited the search from 2002 to 2022 to cover a 20-year period. We searched seven databases (CINAHL, Embase, Ovid Emtree, Health Management Information Consortium (HMIC), The King's Fund library database, Ovid MEDLINE and PubMed).

In our initial search (carried out by The King's Fund library service), 1,638 references were identified and combined with 10 additional references from other sources as at 25 February 2022. After removing duplicates, we screened 1,222 references and excluded 983 as irrelevant to the study's aims. We then identified 139 references for full review. Three researchers used a red, amber, green (RAG) method to judge the relevance, quality and impact of all of the studies. We then snowballed 141 other references based on themes that appeared important – for example, the role of workforce engagement in approaches to tackling waiting lists and waiting times.



Expert interviews

We were commissioned to undertake up to 20 interviews with key individuals who had responsibility for designing, implementing or studying the identified initiatives from the literature review. We invited 29 individuals to be interviewed, seeking a mix of perspectives: three declined, and it was not possible to trace four others who had changed jobs and/or moved abroad. Eight individuals did not respond to repeated invitations. Therefore, we carried out 14 interviews between May and July 2022.

We acknowledge that our convenience sample of experts was biased towards more policy and managerial perspectives. As highlighted by an independent reviewer, interviewing people employed in clinical leadership positions could have provided an interesting and useful perspective on the implementation and outcomes of the approaches used to reduce waiting lists and waiting times.

We drafted a semi-structured topic guide, asking the interview participant to provide some information about themselves, how they were involved in previous initiatives to reduce waiting lists and waiting times, what they observed happened as a result (including whether this was what they had expected or been aiming for), what could have been done differently in hindsight, and what advice they would give to those tasked with reducing waiting lists and waiting times today. We piloted the topic guide with our first interviewee, who then suggested minor changes for the remaining interviews (specifically, asking a few closed or focused questions at the beginning as a 'warm-up'). The interview with the first interviewee was incorporated into our interview analysis.

Sample

We used a targeted approach in order to obtain further information about the breadth of themes that appeared important from the literature review: funding, targets, performance management and workforce. This gave us a very long list of potential interview participants. We took on board advice about the sample from colleagues at the University of York and the Department of Health and Social Care, and then drew up a short list of 29 people.

We agreed with interview participants (experts) that we would not attribute any quotations to them by name – to enable them to openly share their experiences



and observations. We have sought to de-identify them to the best of our ability in the broad descriptions of their previous roles:

- NHS leaders (5)
- senior policy-makers (4)
- leaders involved in the implementation of approaches (3)
- academics or analysts (2).

Analysis of interview data

Interviews were recorded and transcribed. Researchers developed a coding framework of points that came up repeatedly in interviews in order to organise the qualitative material (for example, barriers and enablers). Transcripts were coded according to the framework using the software analysis programme MAXQDA. The coded interview excerpts were then analysed by researchers for themes, patterns and contradictions. The analysis has been written up in the main report.

Quality assurance

The study was approved by the Health Sciences Research Governance Committee at the University of York at its meeting on 31 January 2022. Two independent reviewers (plus one reviewer from The King's Fund who was not involved in the study) have read a first draft and provided comments.



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Waiting lists for elective (planned) care now stand at more than 7 million open patient pathways – the highest level since the 18-week referral-to-treatment measure was introduced in 2004. The NHS is routinely missing national targets for how long patients should wait.

In the face of these record high waiting times for elective care, The King's Fund undertook research to understand the strategies that have been used to reduce waiting times in England and elsewhere in the past 20 years. Based on a literature review and interviews with those involved in previous efforts to reduce waiting times, the authors found that there is no silver bullet to tackle waiting times. Successful efforts instead need to comprise a mix of activities that focus on managing demand, increasing supply and creating the right conditions to reduce waiting times and sustain that reduction.

Drawing on the experience of reducing waiting times in England in the 2000s, the report highlights that *how* activities are implemented is just as important as *what* the activities are. For the experts we interviewed, the achievement of the 18 weeks target was made possible as a result of: valuing and investing in people working in the NHS; a clear, central vision and goal for waiting and an ambition that those working within health care felt equipped to take on; cultivating relationships and leadership at all levels of the health care system; accountability, incentives and targeted support to encourage performance against waiting times targets and other measures of quality of care; and seizing the momentum of wider NHS reform.

The report concludes by asking policy-makers and health care leaders to consider key questions about managing demand, increasing supply and creating the right conditions to reduce waiting times.

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