GMCA GREATER MANCHESTER COMBINED AUTHORITY

Greater Manchester Joint Health Scrutiny Committee

Date: 18 March 2025

Subject: Elective Recovery Update

Report of: Dan Gordon, Programme Director Elective Recovery, NHS GM

Purpose of Report

The purpose of this report is to update the Committee on the current position for Elective Care across GM, describe the performance of the system in terms of data and trends, highlight driving factors for current challenges and describe the key components of the GM Elective Recovery Plan

Recommendations:

The Committee is requested to:

1. Recognise the improvement made on long-waiting patients and the scale of the challenge to improve access and reduce the waiting list size
2. Support cross-cutting system programmes being taken to improve access across the system and at local provider level

Contact Officers

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Equalities Impact, Carbon and Sustainability Assessment:

N/A

Risk Management

N/A

Legal Considerations

N/A

Financial Consequences – Revenue

N/A

Financial Consequences – Capital

N/A

Number of attachments to the report:

0

Comments/recommendations from Overview & Scrutiny Committee

N/A

Background Papers

The data provided in this report have been calculated from Regional and National performance briefings as well as directly from Waiting List Minimum Data Set submissions from NHS Providers across GM

Tracking/ Process

Does this report relate to a major strategic decision, as set out in the GMCA Constitution

No

Exemption from call in

Are there any aspects in this report which means it should be considered to be exempt from call in by the relevant Scrutiny Committee on the grounds of urgency?

No

GM Transport Committee **N/A**

Overview and Scrutiny Committee **n/a**

Elective Recovery Update

1. Background: context on elective care

Elective care waiting times began to deteriorate across England in the early 2010s, with a marked reduction from around 2015 and were then progressively worsening up to the start of the pandemic. In Greater Manchester (GM) almost 92% of patients began treatment within 18 weeks in December 2015 but by February 2020 this had fallen to 78%, during this time the elective waiting list had increased almost 50% (from 194,000 in December 2015 to 284,000 in February 2020).

The pandemic accelerated this deterioration. At the start of the pandemic doctors and nurses from elective services were trained and directed to support across the hospital, as elective services were stood back up ongoing safety measures meant fewer patients could be seen in outpatients and theatres, and then later waves of COVID led to periods of reduced elective capacity as staff were moved to cover for colleagues experiencing high rates of sickness. Whilst referrals had initially dropped, they recovered to pre-pandemic levels faster than elective capacity and this meant that for eighteen months new demand was higher than elective capacity.

The impact of the pandemic on elective services was more pronounced in GM. The region was impacted more than the England average, spending a longer period in lock-down and with higher rates of COVID than the England average. The GM elective waiting list size increased from 284,000 in February 2020 to 500,000 by September 2022, following some fluctuation it has since stabilised.

Recovery was hampered by the period of NHS industrial action 2022 to 2024. Industrial action led to reduced levels of elective activity through to 2024. Activity in 2024-25 has bounced back and increased by around 10%, and this has led to most hospitals beginning to reduce waiting lists, however, demand has also increased by around 15% compared to 2022-23 meaning the rate of recovery is slower than otherwise would have been.

A number of specialties in GM are particularly challenged with long waiting times. These include but are not limited to Dermatology, Ear Nose and Throat (ENT), Orthopaedics, Oral Surgery, Gynaecology and Paediatric ENT. These follow a similar national and regional trend.

2. Current Performance: data on wait times, comparisons, and trends

GM has driven one of the fastest and sustained reductions in long-waiting patients of any ICB and has moved from being a significant outlier for long-waiting patients to the England average. In January 2023, GM had more than 15,000 patients waiting over a year and a half but this figure reduced to almost zero by March 2024. In August 2023, GM accounted for 1 in 6 (16%) of all patients in England waiting over 65 weeks but we have been able to reduce this to 1 in 25 (4%) with actual numbers falling from 16,000 to a couple of hundred. Patients waiting over a year has fallen 60% over the same period, exceeding the improvement rate across England.

Most patients in GM start treatment within 18 weeks, but despite some improvement our overall performance against this standard is still amongst the lowest in England. As of November 2024, 53% of patients were waiting below 18 weeks. This is the fourth worst of the 42 ICBs in England. However, wait times vary between providers and specialties. 67% of patients in Tameside are waiting less than 18 weeks compared to 48% at Manchester University NHS Foundation Trust (MFT). Across GM 60% of Ophthalmology patients wait less than 18 weeks, compared to Dermatology and Oral Surgery at 44%.

For 2025-26 hospital trusts are required to see at least 60% of all patients in 18 weeks or if already meeting 60%, improve by 5 percentage points. For GM this translates into an overall improvement from 53% to 61% (Table 1) whereas most ICBs need to improve by 5% overall. To meet the government's target of 92% patients waiting less than 18 weeks by March 2029, GM will need to improve at twice the rate of the best performing ICBs for the next four years.

Table 1: 25-26 18 week planning target per NHS provider by March 2026

Provider	Nov-24 baseline performance	March-26 target
MFT	48%	60%
NCA	52%	60%
Bolton	54%	60%
WWL	52%	60%
Stockport	54%	60%
Tameside	67%	72%
Christie	97%	97%
GM	53%	61%

3. Contributing Factors: analysis of causes

GM began the pandemic with a deteriorating elective performance that was worse than the England average and had a worse experience of COVID than much of England. Through this time demand for services has grown, particularly in some of the most challenged specialties. For instance, Dermatology, ENT, Oral Surgery, Gastroenterology and Gynaecology all experienced faster than average increases in demand for suspected cancer referrals - and since patients are treated in the same capacity as routine referrals, this effectively crowds out these referrals who then go on to wait for extended periods. The increase in demand has been exacerbated by other significant issues such as estates/capital constraints and workforce challenges.

Elective recovery has been faster in some specialties than others linked to specific factors impacting different specialties. Paediatric services have not recovered as fast as adult services, with particularly acute issues in Paediatric ENT and Paediatric Dentistry. These are specialist areas with a limited workforce, have experienced growing demand due to external factors such as the lack of access to NHS dentistry and poor oral health in some areas of GM, and significantly reduced activity during COVID due to infection control measures in these specialties.

The Independent Sector (IS) in GM has focused on treating a narrow range of conditions, particularly in Ophthalmology and Orthopaedics, meaning the most challenged specialties had no IS capacity to support recovery. More complex patients who cannot be treated by the IS are seen in the NHS and this impacts the productivity of NHS services (such as through a high short-notice cancellation rate

due to patient ill-health). Further, driven by social and economic inequalities, GM patients typically present with worse underlying health than patients in other regions and this impacts where patients can receive care.

Productivity is a challenge but there are different contributing factors. Whilst elective activity is 10-15% above pre-pandemic level, workforce levels are higher and overall productivity has not kept pace with the national economy (although the NHS had exceeded wider productivity growth in the 2010-2017 period). Under-investment in capital is one driver but other factors such as the changing seniority of clinical staff (due to increased retirement/reduced hours), reduced willingness to undertake discretionary work amongst staff and non-elective pressures are all significant.

Finally, whilst GM has a range of hospital providers, patients typically opt for their local hospital and are not choosing hospitals with the shortest waits. Some of this is driven by a lack of visibility for patients of accurate waiting times through the patient choice process and this is a key area of focus for 2025-26.

4. Impacts: consequences for patients' health and well-being

Research indicates that prolonged waiting times can negatively impact patients' health-related quality of life and psychosocial well-being. Studies assessing the impact of waiting for elective general surgery found that longer waiting periods are associated with worse general health perceptions and more problems in quality-of-life domains. Longer waiting times can lead to disease progression necessitating more complex and costly treatments as well as higher rates of employee absenteeism contributing to decreased economic productivity. Delays in care can lead to other developmental issues, particularly in paediatric patients.

These issues are considered in clinical prioritisation, and whilst patients are treated in wait time and clinical priority order, they aren’t always able to be seen in the clinically indicated time-period. The increase in the proportion of clinically urgent patients and their prioritisation is one driver of the subsequently longer waits for routine patients.

5. Actions Being Taken by providers: overview of current plans and their effectiveness

As part of 25/26 planning, elective funding has been set at a ceiling slightly below 24/25 and despite having a bigger elective challenge than the national average, GM will not receive any further national funding. GM are reviewing elective funding in the round whilst hospitals are working to increase activity through productivity.

Hospital providers are working on a range of plans in line with the Elective Reform Plan and include:

- **Increasing Outpatient productivity** through review of clinic templates, job planning, reduction of Did Not Attends (DNAs) and increased use of alternative pathways such as Patient Initiated Follow-Up (PIFU)
- **Driving overall theatre productivity across all sites** through a focus on pre-op pathways, reducing short-notice patient cancellations and through a GM-wide service to share knowledge, expertise and innovative practice across all parts of the surgical pathway
- **Use of digital to undertake validation of waiting lists** ensuring patients waiting to be seen are waiting for the right care and not waiting unnecessarily

6. Recommendations

To increase access to elective services it is recommended that GM focus on several cross-cutting programmes, including:

- **Development of a single point of access that utilises digital technology for elective referrals in GM** to provide 'air traffic control' functionality, supporting patient choice and optimisation of pathways
- **Development of a GM-wide specialist advice service** to support primary care to continue to treat patients, where safe and appropriate to do so
- **Expanded access to community services using a tiered care model approach** focusing on Dermatology, Gynaecology, ENT and Gastroenterology in 25/26, ensuring consistency of commissioning across all localities in GM
- **Optimising use of surgical hubs and Community Diagnostic Centres** to support treatment of patients across GM

GM localities are asked to support on these areas through local elective programmes of work.

7. Summary

GM has made significant progress on reducing the number of patients waiting a very long time for treatment, improving faster than the rest of England, but still has a lot of work to do on the total waiting list size and the average waiting times for patients.

For GM to return to the constitutional standards for elective care by March 2029 it needs to improve at twice the rate as the best performing ICBs but NHS finances for 25-26 mean GM will not receive extra funding to do this.

The Elective Programme in GM is working on interventions that drive recovery as a system-wide effort, including patients and health care providers at all levels. Hospitals are maximising their elective activity through productivity and incremental pathway improvements. Collectively, this aims to increase the proportion of patients seen in 18 weeks to 60% by March 2026.