Key principles for use of the NHS e-Referral Service (e-RS) for Elective Recovery

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NHS England and NHS Improvement

Background

- **NHS patient waiting lists for elective and cancer care** have been significantly affected by the Covid-19 pandemic as a result of the extreme pressures on critical care capacity, bed occupancy and workforce challenges. This has resulted in a national waiting list of approximately 5 million patients, over 300,000 of whom are now waiting at least 52 weeks for their procedure. Whist the pressure exerted by the most recent wave of Covid-19 is reducing, **the waiting list continues to expand** and there are likely to be significant volumes of patients who have not yet been referred to waiting lists.

- The **NHS e-Referral Service (e-RS)** combines electronic booking with a choice of place, date and time for first hospital or clinic appointments. The benefits of e-RS include shorter referral to treatment times, fewer inappropriate referrals, choice of hospital or specialist, choice of appointment date and time. In most cases, **patients have the legal right to choose** the hospital or service they would like to go to, which includes the independent sector (IS).

- Integrated **partnership working between the NHS and IS** will be essential to support patient care, and ensuring access is equitable taking into account geographic, case mix, capacity and performance factors. This is supported by the principles for embedding IS partners within local CCG/ICS systems as described in the **Getting It Right First Time (GIRFT)** proposal (14 March 2021).

- Waiting list pressures have highlighted tensions in managing e-RS in a way that **protects patient choice** but **prevents scaled health inequalities** based on whether patients choose to receive their care in the NHS or IS.

- Recent discussions with NHSE/I Regional Leads and IS provider CEO/COOs have **highlighted variation** between and within regions, local systems and Trusts in the approach to manage these tensions effectively which has resulted in mixed communications for maintaining access to e-RS, appropriate referral pathways open through the Directory of Services (DoS) and appointment slot availability. It is therefore important that a **set of principles are agreed nationally** to guide greater standardisation and consistency.

- These key principles aim to support the **Q1 21/22 IS planning round** in the immediate term, but also **inform national strategies within the NHSE/I elective recovery programme** when considering clinical prioritisation, patient access, equality of access, waiting list backlogs and system-led integrated planning.

Key principles of using eRS to support elective recovery (1/2)

An options analysis was undertaken to resolve the e-RS challenges identified and articulate the most appropriate solution which helps the NHS and IS respond in an integrated way.

The agreed approach is to have **separate waiting lists managed by providers (NHS & IS) overseen by the CCG/ICS and thresholds established to support 're-distribution' if required**.

1 All providers, NHS and IS, track referrals by Clinical Priority and Length of Wait	• Local systems establish governance and oversight arrangements with NHS and IS representation to monitor waiting times and priorities visible to and reviewed with all providers • Planning incorporates fair and meaningful consideration for the respective needs of NHS Trusts and IS providers • Local partnerships should be established between IS providers and NHS providers and a plan to manage waits should be developed and managed jointly. This is likely to focus on a discrete number of specialties to both improve waits for those specialties and enable the NHS to re-direct resource to other specialties • Data analysis enables specialty & sub-specialty granularity to support decision-making • Full oversight required including data from interface services and trusts assessment services
2 Priority thresholds agreed and maintained which are equitable across all providers	• IS continues to receive, manage and book direct e-RS activity for CCG commissioned activity • Trust and IS agree and jointly manage e-RS flows for Trust commissioned activity (sub-contract) • Agreed minimum waiting time (Outpatient & Inpatient) at specialty/sub-specialty level to minimise inequity of waiting lists – set to be within local maximum NHS wait (e.g. 75th waiting time percentile) • If the NHS is unable to supply sufficient Trust transferred or other additional activity within the agreed 6 week period (see Principle 3), the IS will maximise capacity utilisation by treating patients below the agreed minimum waiting time • The performance and waiting list size should be reviewed on an ongoing basis at a system level by the oversight group. It is expected that waiting times will reduce over time and this process will be withdrawn once waiting times have recovered to BAU

Key principles of using eRS to support elective recovery (2/2)

3 Activity re-distribution and 'swap-in' agreed to mitigate local waiting list pressures	• Local systems should co-produce local plans which allow activity to be 'swapped in' with 6 weeks advance notice, and for IS providers to progress other e-RS activity if these transfer times (patients and information) are not met • Local partnerships should develop indicative plans for 6 months, more detailed plans for 3 months with an 8 week look ahead, so that decisions can be made to either expedite transfers or reduce eRS waits in a timely way • Patient selection criteria set at specialty level, and re-distribution should take into account the type of staff/equipment available at the receiving hospital to ensure this is appropriate and aligned to the Increasing Capacity Framework (ICF) • IS supports prioritisation of time critical cases or long waiters, delaying non-urgent e-RS activity
4 NHS/IS joint management of timely activity transfer	• IS provide clinical/administrative staff to work directly with Trust waiting list teams • All transfers clinically validated and risk assessed jointly by NHS/IS providers with discretion to decline activity • Patient-consultant relationship preserved where possible (but may require reassignment) • Access and sharing of data / patient records clearly documented and agreed • Senior Manager identified in each organisation as "obstacle eliminator"
5 Reporting	• All activity undertaken by the IS provider via CCG contract is reported by the IS provider, and agreement with the Trust for reporting of sub-contracted work • All reporting aligns with the Increasing Capacity Framework (ICF) reporting requirements including relevant ODS registration • All activity completed by IS and NHS feeds into system governance and oversight arrangements • IS provider data will be reported in the IS Dashboard at national, regional and system levels