[What next for the elective care recovery plan?](https://cpoc.org.uk/what-next-elective-care-recovery-plan)

In February 2022, NHS England published its elective care recovery plan. This came on the back of waiting list numbers that had risen substantially even before the pandemic, then exploded when Covid hit.

Alongside the NHS targets that were set to prioritise appointments for people waiting the longest for operations, the [Centre for Perioperative Care](https://www.cpoc.org.uk/) highlighted the importance of giving people support and goals while they waited. The phrase 'preparation time' rather than waiting time gave priority to the need for a step change in how we see the time between diagnosis and treatment. This recognises that healthier, more prepared patients were more likely to have an improved quality of life following planned surgery - if this available time focused on their emotional, mental health and physical needs.

This approach applies to all patients as they wait in limbo, but especially those whose conditions have deteriorated during lockdown, those with the worst health inequality and those whose co-morbidities could lead to compromises in their eventual surgery.

Now, 16 months later, while there has been some confident progress made, as I write this article, 7.42 million patients are still awaiting onward treatment. A record number. This includes 370,000 people who have been waiting for at least a year, often in pain.

**Next steps**

NHSE have now published their priorities, oversight and support for the year ahead for the elective recovery programme, as well as including a checklist for Healthcare Trust Boards to help assure that the key priorities are embedded within the health system of each Trust.

In terms of patient outcomes, CPOC welcomes the five main recommendations that have been put forward that directly support patients as they progress towards surgery. However, a measure of caution should be expressed as the documentation focuses only on in-patient procedures rather than day surgery. This is surprising and something of a missed opportunity as many of the treatments that will benefit both patient outcomes and a reduction in waiting list times, should ideally focus on all surgery.

That said, the following recommendations have the potential to improve the service that patients receive and more importantly, prepare them better for any operations that they may undergo, as they await their admission.  They should also be seen as opportunities to develop and improve communication between patients and clinicians in areas of decision making and optimisation:

1. Patients should be screened for medical and lifestyle perioperative risk factors as early as possible in their pathway.

2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery.

3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months.

4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery.

 5. Patients must be involved in [shared decision-making](https://www.cpoc.org.uk/shared-decision-making) conversations.

While these points are very much welcome and should benefit patients by reducing their risks of surgical complications, it is vital they are implemented in a truly patient centred way.

Take for example, point number 5 regarding shared decision-making. This cannot be a tick-box exercise; decision making must be truly shared. Patients must be informed of the options and risks in terms they understand and included as an informed and active partner.

Most patients are still unaware that they have choices in their decision making towards the treatment options that are available. And unfortunately, medical professionals may also not share full options to patients.

This was highlighted to me recently when I accompanied an elderly gentleman, in poor health, to a consultation to receive a biopsy result for a possible kidney tumour. The consultant started the session by the phrase " although the biopsy missed the area we wanted to biopsy, from the scan, I think we should operate. Would that be alright". To which the patient said "yes".

I felt that it was my responsibility, as an advocate, to discuss with them both the shared decision-making process BRAN - Benefits, Risks, Alternatives as well as not doing treatment. After an interesting discussion, a second biopsy was arranged which resulted in the diagnosis of a harmless cyst, not cancer, and no operation was deemed necessary.

This is why shared decision-making is so important and why we also need to educate the public, patients and healthcare professionals on this next stage of elective care recovery.

If the public and patients can be included in this process, as influencers and knowledge rich individuals, we have a real possibility of improving elective care from a 'bottom up' perspective to complement the other, more top-down recommendations.

And, perhaps, look into how this can be adapted to day case surgery as a priority.

**Lawrence Mudford**

**Patient representative Centre for Perioperative Care (CPOC)**