REPORT TO:	NHS SOMERSET INTEGRATED CARE BOARD ICB Board Part A	ENCLOSURE: F
DATE OF MEETING:	27 November 2025	
REPORT TITLE:	Elective Waiting List Oversight	
REPORT AUTHOR:	Stephen Rosser, Interim Associate Director for Planned Care	
EXECUTIVE SPONSOR:	David McClay, Chief Officer for Strategy, Digital and Integration	
PRESENTED BY:	David McClay, Chief Officer for Strategy, Digital and Integration	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☐
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☐
Discuss	To discuss, in depth, a report noting its implications	☒
Note	To note, without the need for discussion	☒
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

LINKS TO STRATEGIC OBJECTIVES
(Please select any which are impacted on / relevant to this paper)

- ☒ Objective 1: Improve the health and wellbeing of the population
- ☒ Objective 2: Reduce inequalities
- ☒ Objective 3: Provide the best care and support to children and adults
- ☐ Objective 4: Strengthen care and support in local communities
- ☐ Objective 5: Respond well to complex needs
- ☒ Objective 6: Enable broader social and economic development
- ☐ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

None.

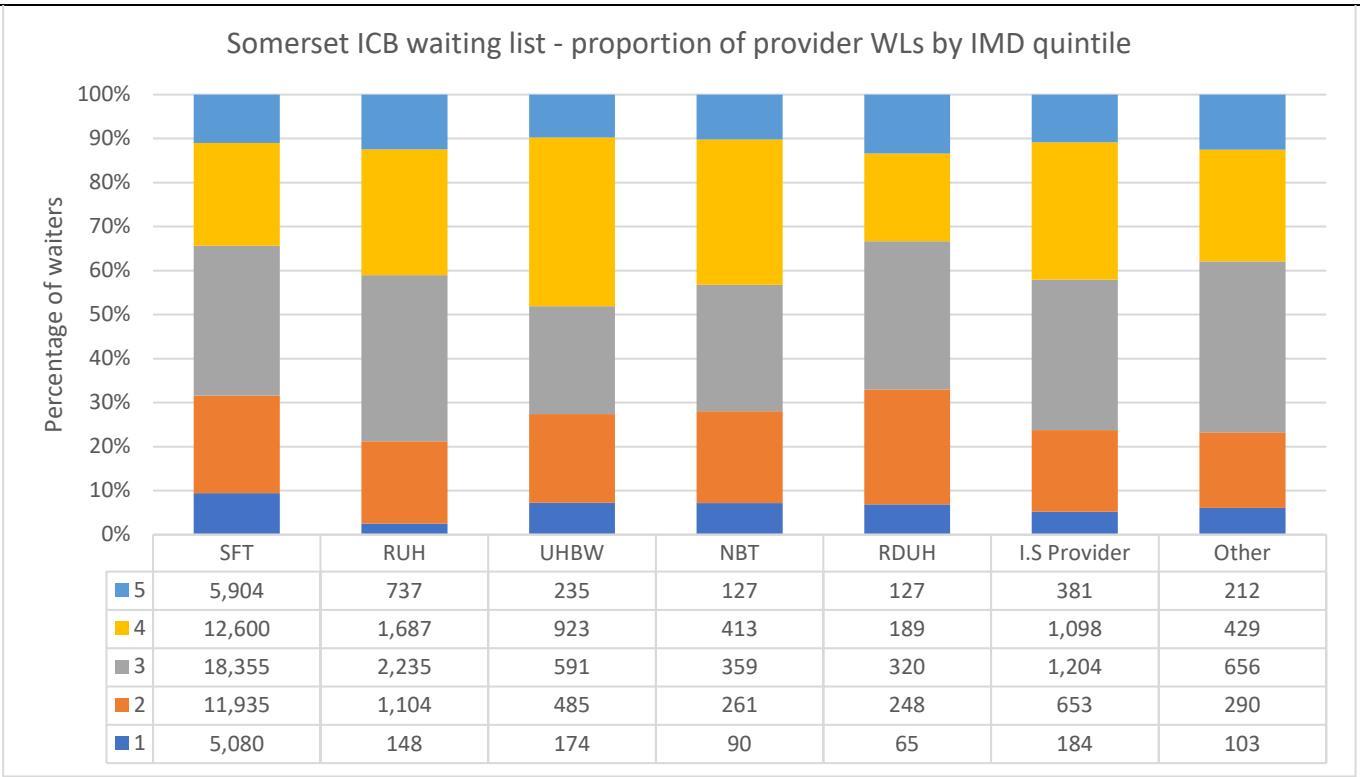
REPORT TO COMMITTEE / BOARD

1. Purpose

1.1. To provide further information and assurance regarding processes by which elective waiting lists are managed with regards to more vulnerable patients and oversight of this at system level.

2. Context

2.1. The ICB monitors waiting lists at system level by provider, and a brief overview of the waiting list position across Somerset providers by deprivation quintile (with 1 being most deprived and 5 the least) can be seen below:



	SFT	RUH	UHBW	NBT	RDUH	I.S Provider	Other
5	5,904	737	235	127	127	381	212
4	12,600	1,687	923	413	189	1,098	429
3	18,355	2,235	591	359	320	1,204	656
2	11,935	1,104	485	261	248	653	290
1	5,080	148	174	90	65	184	103

2.2. The providers managing those patients with the greatest proportion of multiple deprivation are Somerset Foundation Trust (SFT) and Royal Devon University Hospitals (RDUH), however it should be noted that in total numbers of Somerset patients on waiting lists, SFT accounts for approximately 75% and RDUH only 1-2%.

2.3. The two largest providers after SFT are Royal United Hospitals Bath (RUH) and the Independent Sector providers, and these have the least deprived waiting list profiles.

2.4. The overall Somerset system waiting list has reduced over the last 6 months, and the numbers of patients waiting over 52 and 65 weeks has been on a downwards trajectory for the last few months. This is reducing the cohort facing the greatest risk from deteriorating while on a waiting list.

3. Safety netting and prioritisation processes – SFT

3.1. As outlined above the highest priority provider from this perspective is SFT. At SFT for the Musgrove Park Hospital site there exists a robust process for identifying more vulnerable patients, described as follows.

3.2. Patients on RTT waiting lists are given a score. If they score 3 or more, they are flagged to booking teams and managed as if urgent if waiting to be seen in outpatients or managed as the next clinical priority if on a surgical wait list (where capacity allows). For patients with LDs, the LD Liaison Team are also informed so that they can support with getting the patient to the appointment if necessary.

3.3. Scores are as follows:

3.3.1. Patients with a Learning Disability (LD) – 3 points
3.3.2. Looked After Child (CLA) – 3 points
3.3.3. Child under 2 – 2 points
3.3.4. Patient with an open mental health referral – 2 points
3.3.5. Patients living in an area of high social deprivation – 1 point

3.4. This is currently in place for Musgrove, and close to being implemented for the Yeovil site. Broadly speaking, SFT have found that this prioritisation means those patients who meet a score of 3 or more are seen 3-4 months earlier than they otherwise would have been.

3.5. In addition to the initial prioritisation of those at greatest need, there is a known risk that some patient cohorts, predominantly those from areas of greater deprivation, may be less likely to proactively chase appointments or to contact healthcare providers if their condition changes. To manage this risk, there is a subsequent safety netting process in place by which patients are contacted by the Trust as a further means to identify those who are potentially deteriorating or otherwise require urgent action that was not initially identified.

3.6. Patients are sent safety netting letters at intervals according to how long they have waited. All patients are prioritised by clinical need and those awaiting a procedure are assigned a priority number (P1-P4, with P1 being emergency surgery and therefore not used on elective waiting lists). The criteria for sending a letter is as follows for each cohort:

3.6.1. Admitted P2 patients

3.6.1.1. Added to elective waiting list (EWL) > 8 weeks ago (i.e. one month overdue).
3.6.1.2. Not seen in the last month.
3.6.1.3. No TCI (confirmed procedure date), appointment or POAC booked in next month
3.6.1.4. No cancelled op in last month

3.6.2. Admitted P3 patients

3.6.2.1. Added to elective waiting list (EWL) > 26 weeks ago (i.e. 3 months overdue) or already waited more than 52 weeks (from RTT clock start)
3.6.2.2. Not seen in the last 3 months.
3.6.2.3. No TCI, appointment or POAC booked in next 6 weeks
3.6.2.4. No cancelled op in last month

3.6.3. Admitted P4 patients

3.6.3.1. Already waited more than 52 weeks (from RTT clock start)
3.6.3.2. Not seen in the last 3 months.
3.6.3.3. No TCI, appointment or POAC booked in next 6 weeks
3.6.3.4. No cancelled op in last month

3.6.4. Non-Admitted patients waiting for 1st appt

3.6.4.1. Already waited more than 52 weeks (from RTT clock start)
3.6.4.2. No appointment booked

3.6.5. Non-Admitted patients who have had their 1st appt

3.6.5.1. Already waited more than 52 weeks (from RTT clock start)
3.6.5.2. Not seen in the last 3 months.
3.6.5.3. No appointment booked in next 6 weeks

3.7. The letters include a returns form in which patients can inform the Trust if they no longer feel they need to be seen or if their symptoms have worsened. These are received centrally, logged and then sent out to clinicians to review. Clinicians then determine the next steps. These will vary from doing nothing to automatically upgrading their priority on the waitlist.

3.8. Approximately 250 – 300 letters are sent out each month, although this has decreased in recent months as waiting times have reduced. Response rates are fairly steady at approximately 50 per month.

4. IS Providers

4.1. IS provider waiting lists are monitored in the same way as NHS Providers from a commissioning perspective. IS waiting lists are generally considerably smaller and with shorter waiting times than NHS providers; this makes the risk of patients deteriorating while awaiting treatment low. In practice this means that while IS providers will still have waiting list management and safety netting processes, these may be less developed with regards to longest waiters. The IS waiting list for Somerset also contains a lower proportion of patients from the most deprived quintiles.

4.2. ICB contracting changes relating to the IS in this financial year may increase waiting times and require greater safety netting that has not previously been required. This is a recognised risk the

ICB has identified in the Equality and Quality Impact Assessment (EQIA) relating to this work and there are processes in place to monitor any emergent risk and support IS providers with the development of any processes in this regard.

5. Future Developments

5.1. The ICB continues to support scrutiny of waiting list performance and trajectories, and to ensure measures are in place to make sure people from areas of greatest deprivation are not disadvantaged. There are a number of projects underway to support patients accessing healthcare in different ways, particularly within cancer where there are self-referral pathways in place and targeted in those areas of greatest deprivation to support patients who we know may not normally choose or be able to access their GP.

5.2. Further methods for incentivising this kind of activity are being looked at as part of the development of strategic commissioning intentions and a more population health based approach. The below are an indication of the initiatives which we will explore as part of this, subject to consultation with relevant stakeholders:

5.2.1. Full integration with the NHS App to enable patients to view and amend appointment information;
5.2.2. Utilisation of the Federated Data Platform tooling in outpatient and theatres processes (or equivalent);
5.2.3. Widespread use of automated processes to streamline elective administration - including referral triage;
5.2.4. The systemic capability to treat patients according to a wider set of factors;
5.2.5. Full implementation and optimisation of Advice and Refer, which will enable earlier and more informed triage of patients;
5.2.6. The development of the pathway redesign programme to treat demand differently.

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	N/A
Quality	N/A
Safeguarding	N/A
Financial/Resource/ Value for Money	N/A
Sustainability	N/A
Governance/Legal/ Privacy	N/A
Confidentiality	N/A
Risk Description	N/A