Improving Waiting

Evidence for NHS waiting list recovery

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National Waiting List Conference • September 2026

What the National Waiting List Conference examined

Waiting-list recovery must account for what happens to people while they wait.

- The September 2026 conference brought together patients and carers, clinicians, NHS leaders, analysts and researchers.
- Contributors came from NHS England, integrated care boards, hospital trusts, patient charities, universities, HDR UK and the NHS Strategy Unit.
- Patient engagement shaped the central question: how can the NHS shorten waits while responding to people's needs during the wait?

Lorna Allen, Cystic Fibrosis Trust

"Waiting directly conflicts with the ethos of caring about health"

Lorna spoke from lived expertise as a CF parent and involvement leader. Her statement is commentary from a named advocate, rather than an anonymous patient testimony.

Sources: Improving Waiting, introduction and contributors; Day 1–2 conference programmes; Lorna Allen, Day 2, "Survive – waiting to thrive".

Today's discussion

The report's evidence leads to five policy questions and a shared practical agenda.

1. The issues raised by patients and NHS teams across recovery, safety, inequality, technology and measurement.
2. The policy implications that follow from the report's findings and conference discussion.
3. A community of practice on waiting lists: which problems should it address, and how should people share tools and experience?

Question to keep in mind

How do we make waiting shorter, safer and fairer while the NHS clears the backlog?

Source: Improving Waiting, introduction and five policy implications; Day 2 conference community-of-practice proposal.

Five areas in the report

Each area asks a different question about managing NHS waiting lists.

Recovery	Can the NHS return to the 18-week standard and stay there?
Safety	How should patients be protected while they wait?
Inequality	Who is being left behind as aggregate waits improve?
Technology	Where can better data and operational tools improve performance?
Measurement	What needs to be measured beyond elapsed waiting time?

The following five slides follow these sections in the same order as the report.

Source: Improving Waiting, five policy questions and sections 1–5.

Recovery: can the NHS return to 18 weeks, and stay there?

Recovery requires a one-off period of increased activity, paid now or later, with capacity above demand.

The waiting list must shrink by over 3 million pathways

- About 65% of incomplete RTT pathways are within 18 weeks, against the 92% standard.
- NHS England modelling suggests a fall from about 7.3m to below 4m pathways.
- A March 2029 recovery implies roughly 5,000 extra completions per working day, around 6% above current activity.

Added capacity takes time to affect waits

- The report cites evidence that surgical hubs may take about two years to change waiting times. Diagnostic centres show a similar lag.
- Elective activity rose nearly 10% in 2024/25, while completed pathways rose about 4%.
- Capacity must follow the current bottleneck. After recovery, activity needs to match demand to keep waits stable.

Patient insight Long waits bring uncertainty, anxiety and fear of being forgotten. Patients need a credible plan while recovery takes effect.

Source: Improving Waiting, §1. Modelling and forecasts discussed by Tineke Poot, NHS England; surgical-hub evidence in Day 2 slides.

Safety: how should patients be protected while they wait?

Patients need information, support and a clear route to report deterioration.

Waiting creates risks beyond elapsed time

- A data study found substantially more emergency and out-of-hours use before patients entered a defined procedural pathway.
- Focusing on 78- or 65-week cohorts can miss those in greatest clinical need.
- Kidney Care UK's survey of 670 patients found unmet support needs. One in five had a transplant call that did not lead to surgery.

Minimum standards need routine management

- NHS England's planned-care minimum standards describe what patients should expect while waiting.
- The report found uneven awareness and no national system to monitor compliance or respond when standards are missed.
- Standardised reporting and escalation would make the standards actionable.

Patient testimony "The transplant work up is agonising. . . .the whole thing has been emotionally exhausting" — anonymous patient, Kidney Care UK survey, presented by Fiona Loud.

Sources: Improving Waiting, §2; Fiona Loud, Day 1, "The transplant waiting list — waiting in vain?"; Day 2 minimum-standards presentation.

Inequality: who is being left behind?

Aggregate improvements can hide unequal access and unequal burdens of waiting.

The distribution of extra capacity matters

- In a study of NHS-funded private expansion, treated patients had shorter waits. The poorest fifth waited longer and received less private-provider care.
- Private providers treated healthier, less complex patients, leaving more complex cases with NHS hospitals.
- In an England–Scotland comparison of hip and knee surgery, admission inequality grew 2.5 times faster in England.

National averages miss specific groups

- Fiona Loud reported longer average kidney-transplant waits for Black and South Asian patients and geographic variation.
- A linked-data study found the most deprived patients attended A&E almost twice as often while waiting, with about fivefold variation between specialties.
- Monitor access by deprivation, ethnicity, geography, specialty and clinical risk.

Patient testimony “The selection process still seemed like a dark art.” — anonymous kidney patient quoted in Fiona Loud’s presentation.

Source: Improving Waiting, §3; Allyson Pollock, Day 1; Fiona Loud, Day 1; Chris Mainey, Day 2. Study findings are associations and comparisons.

Technology: where can it improve performance?

Operational tools can improve decisions across the pathway, but need a route into routine use.

What conference examples showed

- Tools can validate lists, flag missed follow-ups, link patient journeys, forecast demand and capacity, and improve scheduling.
- One NHS AI application reportedly flagged about 2,000 RTT episodes missed by earlier manual validation.
- Better data can identify where capacity is needed and whether changes improve pathway completion.

What scaling requires

- Staff need protected development time and clearer routes through funding, evaluation, validation and deployment.
- Operational AI needs safeguards for transparency, bias, data quality and data locality.
- Design and evaluation should involve patients and clinicians, with non-digital routes still available.

Policy implication “Operational excellence is not clinical excellence.” Operational technology needs a development route suited to service use.

Source: Improving Waiting, §4; Day 2 conference presentations on NHS data science, scheduling and AI. The 2,000 figure is one reported application result.

Measurement: what are we not measuring?

The 18-week target measures elapsed time but cannot show changing need or the full patient pathway.

Clinical priority needs to be visible

- Waiting lists often lack coded priorities that can be reviewed as patients' conditions change.
- Scheduling by longest wait can divert attention from clinical risk.
- Measure and regularly refresh priority alongside time waited.

The need for care continues after the RTT clock stops

- Patients often need follow-up after treatment. Current RTT measures do not capture these waits.
- NHS guidance requires separate monitoring, but the report describes weaker accountability for follow-up.
- Include clinically important follow-up and minimum standards in performance review.

Patient insight Patients know their baseline and recognise deterioration. Work, caring responsibilities and quality of life should inform how waiting is understood.

Source: Improving Waiting, §5; Rob Findlay, Day 2, on patient tracking lists; Day 2 planned-care minimum-standards presentation.

Five policy implications

The report points to specific changes in how recovery is managed.

1. **Recovery:** Treat backlog clearance as a temporary programme; match capacity to demand once 18-week performance is restored.
2. **Safety:** Make planned-care minimum standards measurable, reportable and actionable.
3. **Inequality:** Track who receives additional care and whether private activity truly adds capacity.
4. **Technology:** Build clearer routes to evaluate and scale operational tools, with appropriate AI safeguards.
5. **Measurement:** Monitor clinical priority and clinically important follow-up, not just the RTT clock.

Source: Improving Waiting, “Five policy implications”; wording condensed from the supplied report.

A community of practice on waiting lists

We are setting up a forum to share tools and improve decisions about waiting.

- Bring analysts, operational managers, clinicians, planners, patients and carers into the same discussion.
- Share concepts, methods, metrics and tools that reveal how waiting lists behave.
- Connect analysis with day-to-day decisions made by the people managing lists.
- Learn from real applications, including what did not work and what changed in different settings.



Scan to register interest and help shape the community.

Source: Day 2 conference community-of-practice proposal slide; exact QR image supplied for this presentation.

How the community of practice could work

Keep the format light and organise it around problems members bring.

Possible format

- Quarterly online sessions.
- Short case studies and practical clinics.
- Masterclasses on methods and tools.
- A discussion forum and shared library.

Questions for the first sessions

- Which measures reveal clinical risk while patients wait?
- How can services find and respond to changing bottlenecks?
- Which tools have improved list quality or scheduling in practice?
- How should patient experience and equity shape evaluation?

Discussion Which problem should the community tackle first, and what evidence or tool could you share?

Format from Day 2 conference community-of-practice proposal; discussion questions adapted from Improving Waiting.

Thank you for listening

Join the Community of Practice on waiting lists

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