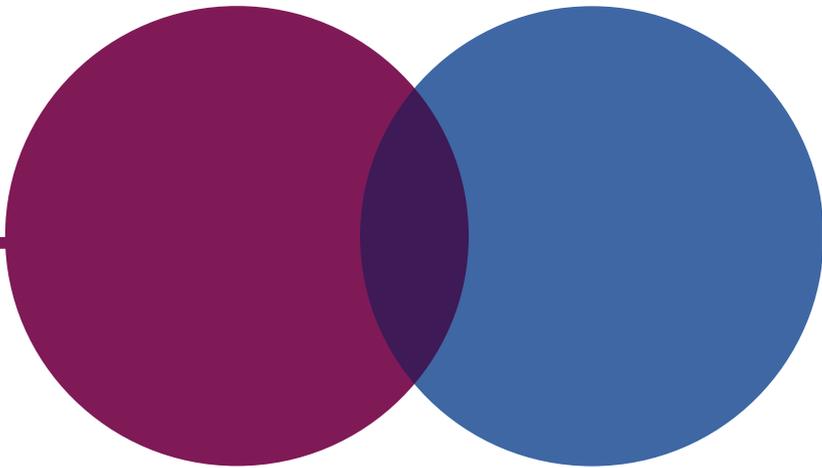




National Audit Office



NHS backlogs and waiting times in England

Department of Health & Social Care,
NHS England & NHS Improvement

REPORT

**by the Comptroller
and Auditor General**

**SESSION 2021-22
1 DECEMBER 2021
HC 859**



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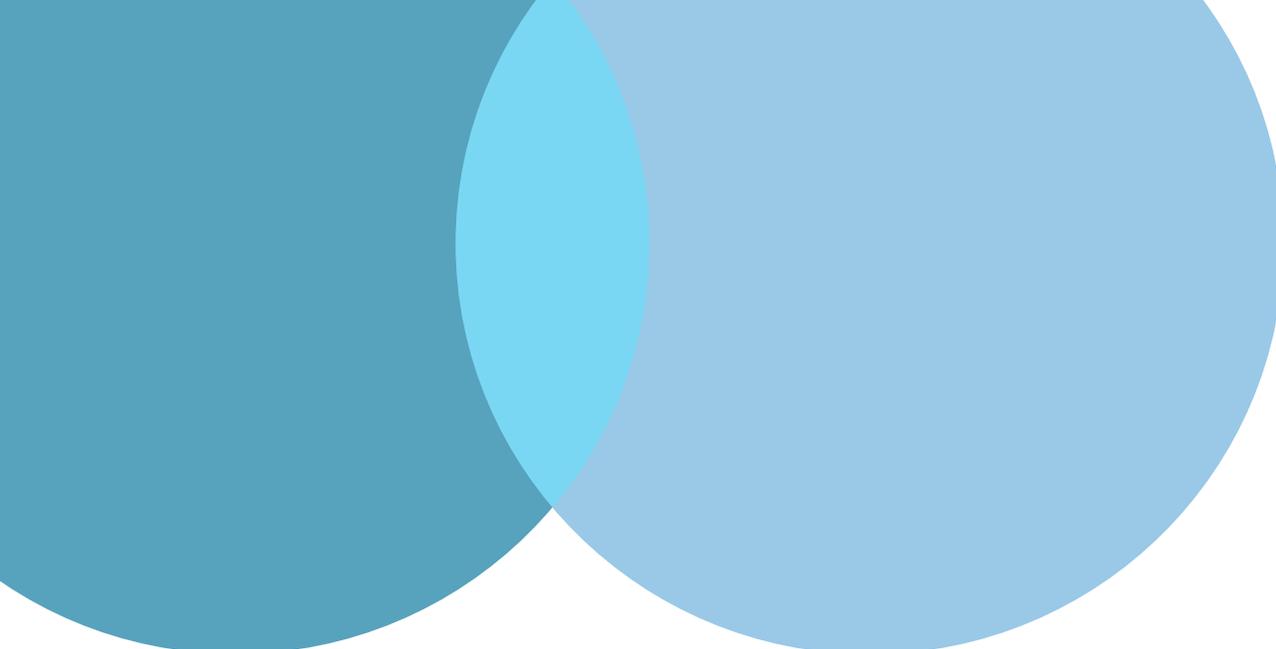
Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

26 November 2021



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Key facts

92%

Percentage of people waiting for elective care whose treatment, by law, must commence within 18 weeks



83%

Percentage of people on the elective care waiting list for less than 18 weeks in February 2020 (3.68 million out of 4.43 million)



66%

Percentage of people on the elective care waiting list for less than 18 weeks in September 2021 (3.88 million out of 5.83 million)



5%

Percentage of people on the elective care waiting list for more than 12 months in September 2021 (301,000 out of 5.83 million)



7.6 million to 9.1 million

NAO estimate of the number of 'missing' referrals onto the elective care waiting list since the start of the COVID-19 pandemic



NAO projection of the size of the elective care waiting list by March 2025:

12 million

If 50% of 'missing' referrals subsequently return and NHS elective activity grows at 3.2% per year (the pre-pandemic plan)

7 million

If 50% of 'missing' referrals subsequently return and NHS elective activity grows to 10% above the pre-pandemic plan

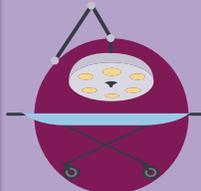
National percentage of cancer treatments within 62 days of urgent referral (10,109 out of 14,866), where the minimum should be 85% (September 2021)

68%



43% to 80%

Percentage of cancer treatments treated within 62 days of urgent referral, worst performing sub-region compared with the best performing (September 2021)



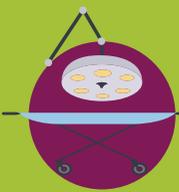
240,000–740,000

NAO estimate of 'missing' urgent referrals for suspected cancer (that is, people who did not present for care) since the start of the COVID-19 pandemic



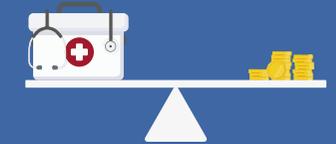
35,000–60,000

NAO estimate of 'missing' first treatments for cancer since the start of the COVID-19 pandemic



£28 billion

Estimated cost of elective care across the NHS in England in 2019-20



Revenue funding the NHS has made available to NHS trusts under the Elective Recovery Programme in 2021-22, additional to normal funding

£2 billion



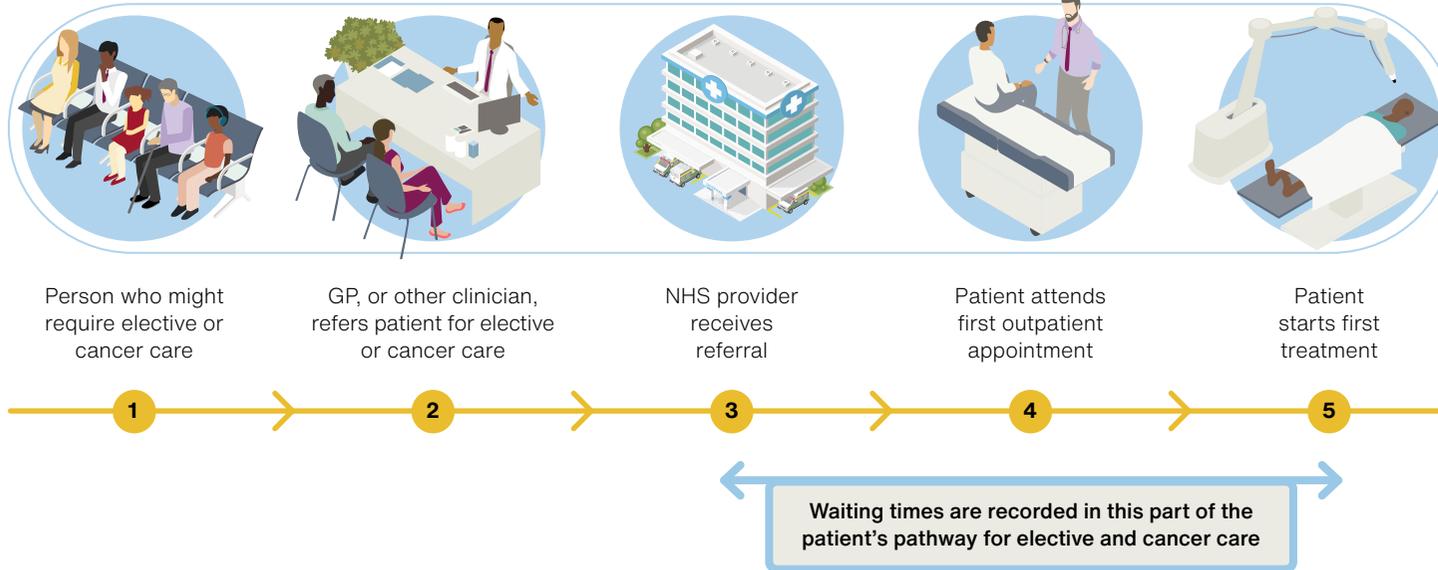
£8 billion

NHS funding for recovery of elective and cancer services announced in September 2021, to be spent over three years from 2022-23 to 2024-25



Key facts *continued*

Overview of elective and cancer care pathways and waiting times



A note on patients and pathways

The elective care system counts the number of pathways which have started but not yet completed, rather than the number of people. Patients may be on more than one elective pathway, so the total number of individuals will be lower than the number of incomplete pathways.

NHS England & NHS Improvement (NHSE&I) estimated that the elective care waiting list of 5.6 million pathways in July 2021 comprised around 4.9 million waiting individuals.

Throughout this report, we follow the convention of referring to 'the number of patients' on the elective waiting list because of uncertainty over how the ratio of pathways to patients may have changed over time.

About this report

This report looks in detail at backlogs and waiting times for elective and cancer care in the NHS in England. It explains how the current increased backlogs and waiting times have arisen, including the impact of the COVID-19 pandemic. We intend to follow this report with a second one, which will describe the NHS's plans to improve this situation and evaluate its early progress.

Part 1 – Trends in waiting lists

Waiting is a feature of public healthcare systems but must be managed to avoid adverse impacts on patients. The NHS sets performance standards for waiting times for elective and cancer care. Its performance against these was deteriorating before the pandemic and has worsened since it began.

This part of the report sets out:

- the potential impact of long waits on patients;
- how waiting times for elective and cancer care are tracked in the NHS;
- how long patients have been waiting relative to the performance standards for elective and cancer care; and
- variations across England.

Part 2 – Causes of backlogs

Waiting times and backlogs tend to grow when there is a mismatch between demand for healthcare and the activity that hospitals can perform. This mismatch was already apparent in the NHS before the pandemic. COVID-19 then caused huge disruption to the NHS's routine services for necessary and unavoidable reasons. Millions of patients' care was disrupted, meaning backlogs increased.

This part of the report sets out:

- the causes of longer waits and backlogs before the pandemic; and
- the disruption caused by the pandemic.

Part 3 – Independent healthcare and the NHS

NHS commissioners and providers purchase services from independent sector providers of healthcare. On behalf of the NHS, NHS England entered into new contracts with independent acute care providers at the start of the pandemic.

This part of the report sets out:

- the elective pathways completed by independent sector providers before and during the pandemic; and
- the national contracting arrangements.

Part 4 – Future challenges and responses

The Department of Health & Social Care (the Department) and NHSE&I have already taken some steps to address the increasing backlogs and waiting times. NHSE&I is developing recovery plans and has an additional £8 billion of NHS recovery funding announced in September 2021. Some backlogs are already visible in NHS systems, but others relate to people who did not present for care during the pandemic, known as 'missing' referrals.

This part of the report sets out:

- analysis of 'missing' referrals during the pandemic;
- forecasts of how the elective care backlog may change in future;
- the Department and NHSE&I's existing measures to address increasing backlogs and waiting times;
- the funding available; and
- the constraints and challenges the NHS faces in making a full recovery.

About this report

Our evidence base

To compile this report we analysed information and data from the Department, the NHS and other sources. We also conducted a wider evidence review and interviewed key stakeholders and experts including the British Medical Association, the Health Foundation, the Independent Healthcare Providers Network, the King's Fund, Macmillan Cancer Support, the NHS Confederation, NHS Providers, the Nuffield Trust, the Parliamentary and Health Service Ombudsman, Dr Rob Findlay, the Patients Association and the Royal College of Surgeons in England. A detailed methodology is available in Appendix One.

Summary

Backlogs and waiting times before the pandemic

Waiting for healthcare

Waiting is a normal feature of public healthcare systems. To receive elective or cancer care, patients typically join a waiting list, or queue, before they are treated. Their wait may be long or short, depending on the number of other patients also on the waiting list and their relative clinical urgency.

Performance standards and the backlog

For some years, the NHS has set performance standards to monitor and manage how long patients must wait. In this report, we use the term 'backlog' to mean the body of work that is preventing the NHS from meeting its performance standards.

Elective care before the pandemic

The main standard for elective care is legally binding and states that 92% of patients on the waiting list should start their treatment within 18 weeks of being referred to a consultant. This means no more than 8% should wait longer than 18 weeks. The number of patients waiting for elective care in February 2020, before the start of the pandemic, was 4.43 million. This included 745,000 (17%) who had been waiting for longer than 18 weeks. Performance against this standard had been deteriorating since 2013. In February 2020, 1,600 patients had been waiting for longer than a year (0.04%).

Cancer care before the pandemic

The NHS has nine principal standards for cancer care. Between August 2018 and February 2020, 495,000 people were diagnosed with cancer and put on a list for treatment within one month. Of these people, 19,000 (4%) had to wait for more than one month (the operational standard) for their treatment to start.

Long-term causes of deteriorating performance

In 2019, we reported in *NHS waiting times for elective and cancer treatment* that rising demand for healthcare, particularly cancer care, had combined with a period of increased financial constraint to cause more patients to have to wait longer. Before the COVID-19 pandemic, the NHS was doing more work year-on-year but the demand for its services was increasing even faster.

As with most advanced economies, the demand for healthcare has consistently increased over time. However, the health systems of the UK have fewer resources – hospital beds, doctors and nurses – than many other European and G7 countries.

Summary

The impact of the pandemic on backlogs and waiting times

A unique crisis

During the pandemic, the NHS redirected many resources away from its normal activities. Staff and beds had to be reserved for COVID-19 patients and many empty beds could not be used because of the need to hold capacity in reserve, or due to infection control measures.

The pandemic's impact on elective care

Initially, the waiting list for elective care fell for three months in 2020 because the number of new referrals of patients to consultants plummeted. After that, the waiting list grew rapidly to 5.83 million by September 2021 as treatment activity remained below normal levels. By September 2021, 301,000 patients on the waiting list had been waiting for more than 52 weeks. During the pandemic, NHS performance against elective care standards dropped to its lowest recorded level.

The pandemic's impact on cancer care

Initially the number of patients completing cancer treatment dropped significantly. In March 2020, NHSE&I asked NHS commissioners and providers to maintain cancer services. However, as the NHS mounted an emergency response to the pandemic it proved impossible to keep performance levels unchanged. By June 2021, NHS cancer services activity had recovered to pre-pandemic levels. However, in September 2021 only 68% of patients requiring treatment within 62 days of urgent referral by their GP were receiving that treatment on time.

Regional variation

There are significant variations in NHS performance across England. In the worst performing area in September 2021, Birmingham and Solihull, 51% of patients on the elective waiting list had waited for longer than 18 weeks, and 57% of cancer patients waited for treatment for longer than 62 days after an urgent GP referral.

The role of the independent healthcare sector

At the beginning of the pandemic, NHS England entered temporary contractual arrangements with a limited number of independent sector providers so that their staff, hospitals and other resources would be available to the NHS to help in its response to COVID-19 and for elective care and cancer services. These contracts cost around £2.1 billion in 2020-21. NHS statistics show that the independent sector had been treating some 110,000 elective care patients per month before the pandemic, but this dropped to a low of around 20,000 in May 2020 before recovering by June 2021. Unusually, some providers' hospitals were used by NHS clinical teams during the pandemic for activity that was counted as NHS provision. This, along with other factors, makes it difficult to compare the relative contribution of the independent sector before and during the pandemic.

Summary *continued*

The impact of the pandemic on backlogs and waiting times *continued*

'Missing' patients who may return

Millions of people have avoided seeking, or been unable to obtain, healthcare during the pandemic. We estimate that there were between 240,000 and 740,000 'missing' urgent GP referrals for suspected cancer during the period of the pandemic up to September 2021. In addition, there were between 7.6 million and 9.1 million 'missing' referrals for elective care over the same period.

How waiting lists and backlogs may change in future

It is uncertain how many 'missing' cases will return to the NHS for treatment, and over what period of time, although clearly many will. It is also uncertain how quickly the NHS will be able to increase its activity. In addition to 'missing' cases, there may be new demand as a result of, for instance, 'long COVID'.

Under two plausible scenarios, however, the waiting list will be longer in March 2025 than it is today. If 50% of missing referrals return to the NHS and activity grows only in line with pre-pandemic plans, the waiting list would reach 12 million by March 2025. If 50% of missing referrals return and the NHS can increase activity by 10% more than was planned, the waiting list will still be seven million in March 2025. The challenge is how to prioritise and manage long waiting lists in the immediate future.

Summary *continued*

The NHS response and the challenges ahead

Immediate responses to growing backlogs

NHSE&I has put various initiatives in place to support the NHS to recover its elective activity levels and address backlogs. The principal ones are:

- £2 billion in 2021-22 to allow higher rates of funding for local NHS providers to incentivise them to make additional efforts to increase their activity;
- £700 million in 2021-22 for investment in reforms to support recovery;
- £350 million in 2021-22 and £2.3 billion more between 2022-23 and 2024-25 to increase diagnostic capacity; and
- a new framework agreement to enable NHS commissioners and providers to purchase elective services from more than 80 independent sector providers. Spend through this framework is estimated to be up to £10 billion between 2021-22 and 2024-25.

Funding for a longer-term approach

The government then announced a new multi-year funding settlement in September 2021, which included £8 billion to support the recovery of elective care in the three years to 2024-25. The NHS spent around £28 billion on elective care activity in 2019-20.

NHSE&I has been developing recovery plans and detailed expectations for 2022-23 and beyond. In return for the extra funding, the government has said that it expects the NHS to deliver some 10% more elective care activity by 2024-25 than it was planning to before the pandemic.

Constraints and challenges

Recovering elective and cancer care performance to the standards the NHS has committed to represents a huge and multi-faceted challenge. It will require the NHS to address a number of problems, some pre-existing and some more recent, including:

- extra beds and operating theatre capacity beyond what was planned before the pandemic;
- longstanding staff shortages being addressed;
- the ongoing pandemic, which may continue to affect bed and staff availability in unexpected ways and at short notice;
- existing health inequalities, which could be perpetuated or exacerbated, for example through some patients being more likely to suffer long waits than others;
- the ongoing pressure on the NHS workforce;

Summary *continued*

The NHS response and the challenges ahead *continued*

- pressure in other parts of the health and social care system, which could reduce capacity, for example by delaying discharges of patients from hospital treatment; and
- the effectiveness of programmes that prevent serious ill health, which could reduce future demand for care.

We have set out our understanding of these challenges in greater detail on pages 42 and 43. We will consider how the NHS's plans address them in our next report.

The challenge faced by patients

Perhaps the greatest personal challenges lie ahead for the millions of patients who face more uncertainty and longer waits for the NHS care they need. Patient representatives and health experts we have spoken to have told us of patients' concerns about cancelled treatment, and that there is a risk that with longer waits patients might "get lost in the system".

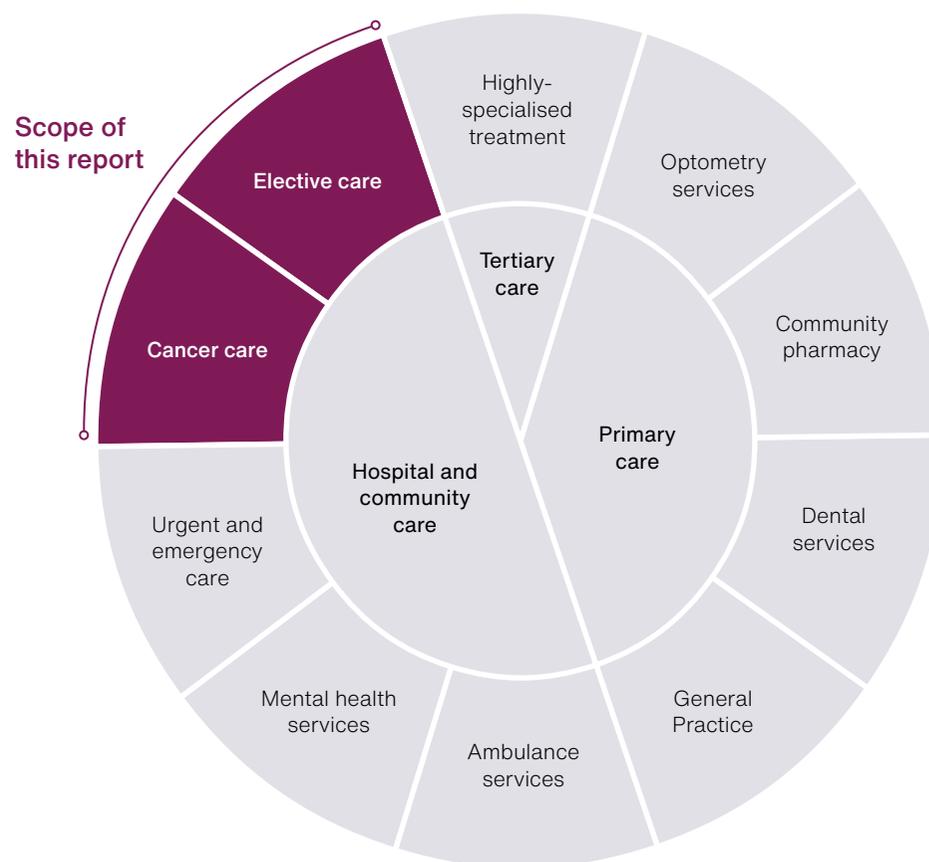
Waiting for healthcare

Waiting is a normal feature of public healthcare systems. A person may wait for most kinds of treatment in England's NHS system, including in-person queues, such as one finds in an accident and emergency department, to longer, more complex waits for the treatment of rare conditions, comprising waits for GP appointments, diagnostic services and planned treatment.

The COVID-19 pandemic has affected the whole of the NHS and has generally had the effect of lengthening waits for care. We are aware of particular strains on ambulance services, urgent and emergency care, general practice, dental services and mental health services, as well as the elective and cancer care systems on which this report focuses.

We have made elective and cancer care our focus in this report because of the scale of the backlogs in these areas and their seriousness for the physical health and long-term life chances of many of the people affected. Backlogs in elective and cancer care are also the most straightforward to report on because there are existing published data collections that we can draw on. However, there are backlogs and waits in other areas of the healthcare system, and these may be exacerbated by the backlogs in hospital and cancer care. GPs, for instance, also often have to offer additional support to patients who are facing long waits. We intend to examine the impact of the pandemic on other NHS services in future.

While it is generally clear what is meant by the term 'cancer care', the term 'elective care' is more opaque. In broad terms, 'elective care' means any non-emergency treatment under the care of consultants, for instance, hip and knee replacements or cataract or tonsil removal.

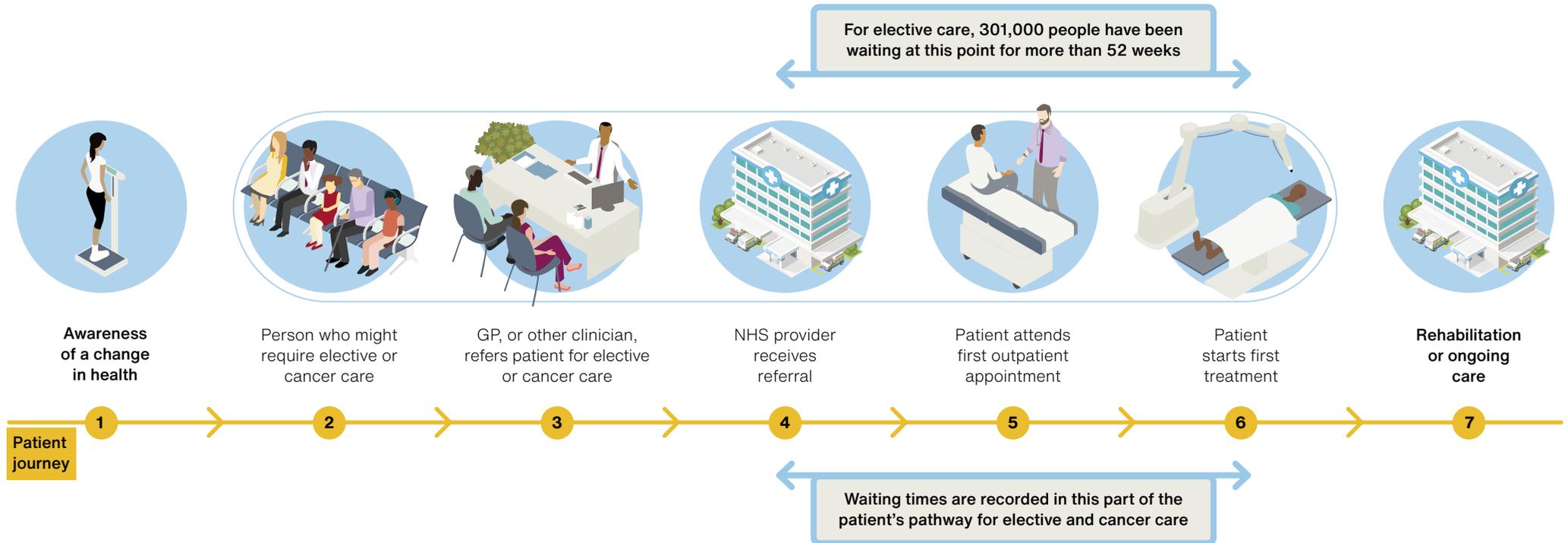


Waiting too long for healthcare

Prompt treatment has clear benefits for individuals. The longer a patient has to wait for treatment, the longer they may experience pain, anxiety or other symptoms. Such effects may temporarily reduce quality of life, prevent people from working, or lead them to seek relief through additional visits to the GP or urgent and emergency care services, placing further strain on the NHS. For a subset of conditions, including but not limited to cancers, undue delay may

cause permanent reductions to life expectancy as once treatable illnesses become untreatable. Clinical negligence claims can result from delays in diagnosis or treatment. Patient representatives and health experts we have spoken to have told us of patients' concerns about cancellations of their treatment and that longer waiting lists can increase the risk that patients might get "lost in the system".

A person's full 'patient journey' is more than the performance-measured part of the pathway



Waiting too long for healthcare *continued*

There is no simple metric to measure whether a patient has waited too long for treatment or to calculate the adverse consequences of a particular length of wait. For elective and cancer care, the NHS has established standards which, alongside clinical judgement, are intended to ensure patients are seen in good time.

The general effect of the longer waits described in this report will be for more people to have adverse consequences, including the likelihood of some people dying earlier than they otherwise would. In a survey by NHS Providers, almost all NHS trust leaders reported the complexity and acuity of new patients had increased since the pandemic. With careful management though, these effects can be reduced.

The Public Accounts Committee has previously concluded that “national health bodies lack curiosity about the impact for patients of longer waits and how often this leads to patient harm” (Committee of Public Accounts, *NHS waiting times for elective and cancer treatment*, HC 1750, Session 2017–2019). Understanding the impact of longer waits will be one important way of managing the risks inherent in the backlogs that have built up.

Backlogs and health inequalities and disparities

We are particularly interested in understanding whether specific groups in society have suffered more than average in terms of waiting longer for treatment, both during the pandemic to date and in future. This could include people with particular health conditions or from certain age or ethnic groups.

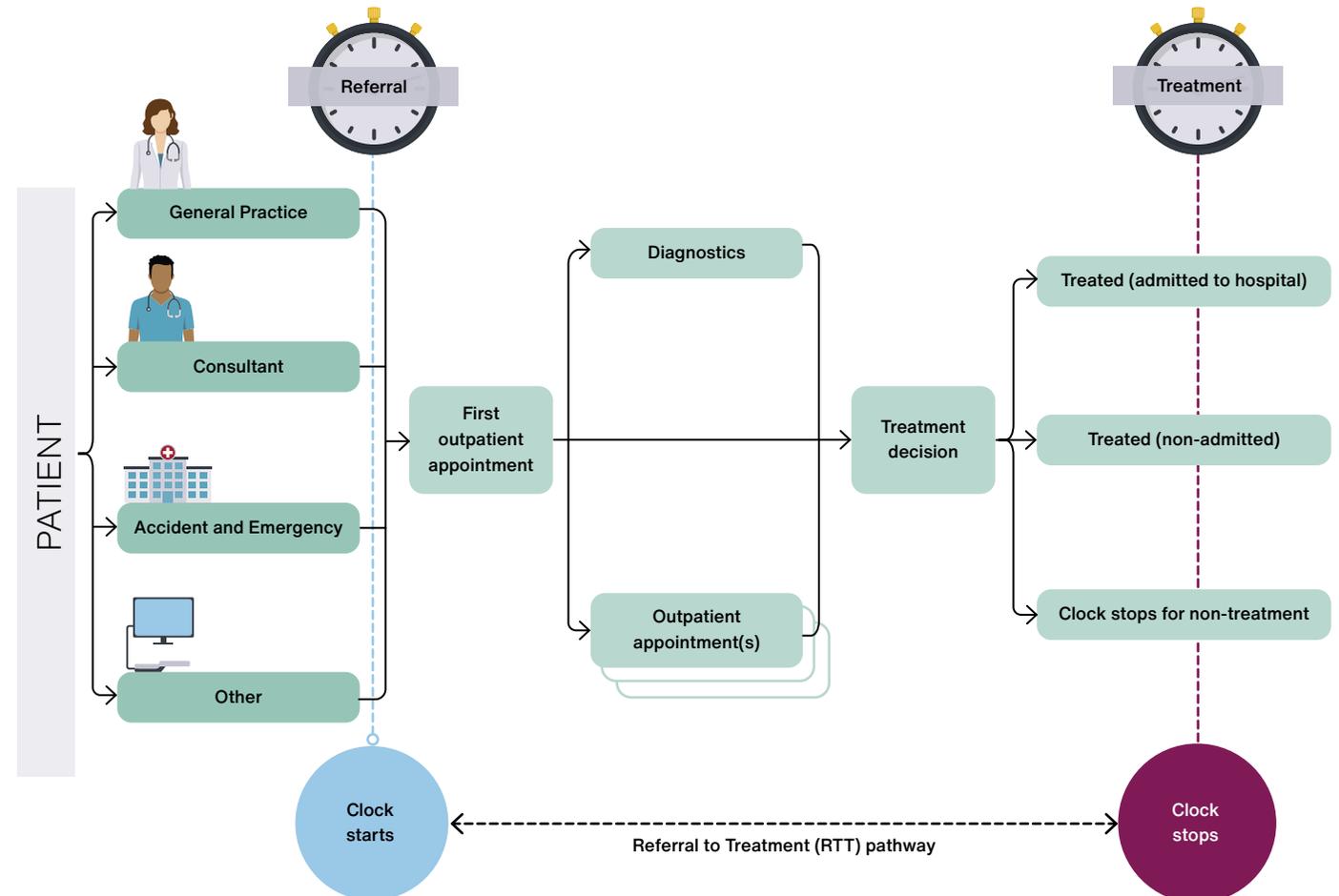
Our initial analysis of the limited data available so far showed that the proportion of people from different ethnic groups who had received elective care treatment during the pandemic was similar to previous years. This does not necessarily mean that there have been no inequalities for ethnic minority groups so far, and other issues may emerge in future, including for those living in areas of deprivation. A survey (by NHS Providers) of 170 NHS trust leaders found that 66% of them were very concerned that backlogs in physical and mental health services would worsen health inequalities. We plan to investigate such variations further, as data permit, in the second report in this series in 2022.

Elective care – the ‘referral-to-treatment’ pathway

A person with a health need that might require elective care is typically referred for an initial outpatient appointment by their GP or another part of the healthcare system, for instance, an accident and emergency unit. This referral starts a clock running in NHS data systems. The clock allows the duration of each patient’s care to be tracked. The period the clock runs for is known as the ‘referral-to-treatment’ (RTT) pathway. It is the key measure of NHS waiting times and backlogs in elective care.

What follows for each patient depends on individual need. It may include one or more meetings with clinicians and/or diagnostic tests, such as x-rays or scans. The clock only stops when a patient receives their first definitive treatment, whether as an inpatient or an outpatient, or when a consultant decides that the patient does not need elective care. About 30% of patients are discharged back to the care of their GP after the first outpatient appointment.

Elective care referral-to-treatment pathway



Notes

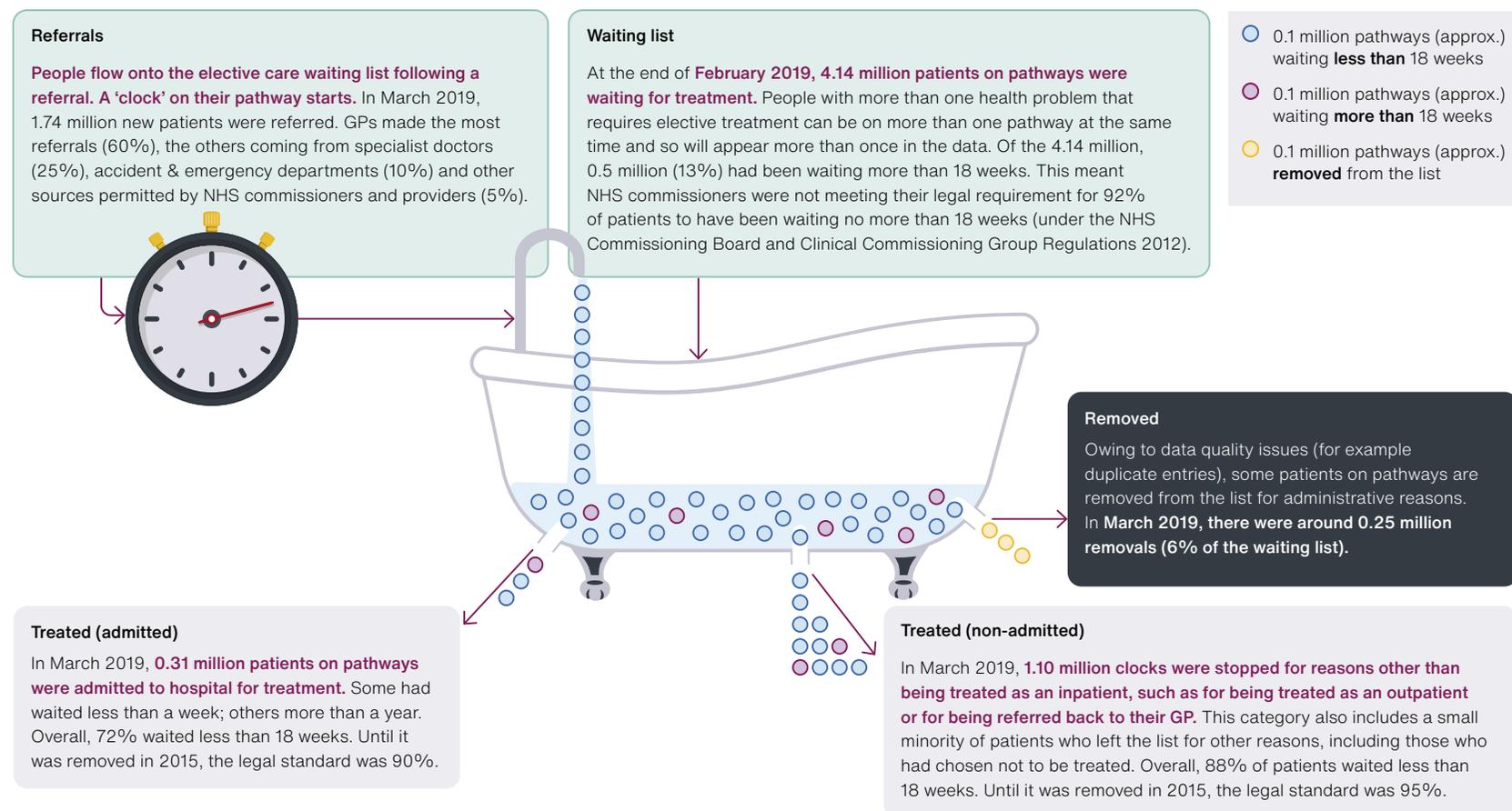
- 1 Consultant referrals occur when one consultant refers a patient to another consultant.
- 2 As well as for clinical reasons, non-treatment includes where the patient declines treatment, does not attend, or opts for private treatment.
- 3 Patients can be referred into services that include a diagnostic alongside or in place of a first outpatient appointment.

Elective care – referrals and treatments in a typical month

In a typical month, more than a million people are referred for elective care, and more than a million people receive treatment. The total number of open referral-to-treatment pathways at a given point in time, for instance, at the end of each month, is the waiting list. The waiting list can be said to be operating with a backlog when the NHS is unable to meet its own standards for timely care. The diagram right shows the waiting list according to a standard 'bathtub' stock and flow model. It uses data from a typical month before the pandemic, March 2019.

Figure 1: Waiting times and performance against waiting times standards, March 2019

When the total flow of patients referred in is greater than the total flowing out, the waiting list grows. By the end of March 2019, the waiting list had grown by 90,000 to 4.23 million



Note

1 Figures may not sum due to rounding.

Source: National Audit Office analysis of NHS England's published referral-to-treatment waiting times statistics

The elective care waiting list, 2007–2021

The elective care waiting list has been published since 2007. This published data show four distinct phases of change (Figure 2).

2007–2009. The waiting list reduced rapidly.

2009–2012. The waiting list was broadly stable with seasonal peaks and troughs.

2013–February 2020. The waiting list steadily increased.

March 2020 onwards. The COVID-19 pandemic affected elective care. First, the waiting list fell for three months as the number of new referrals temporarily plummeted. But then the waiting list rose rapidly as referrals increased again, but treatment activity remained below normal levels.

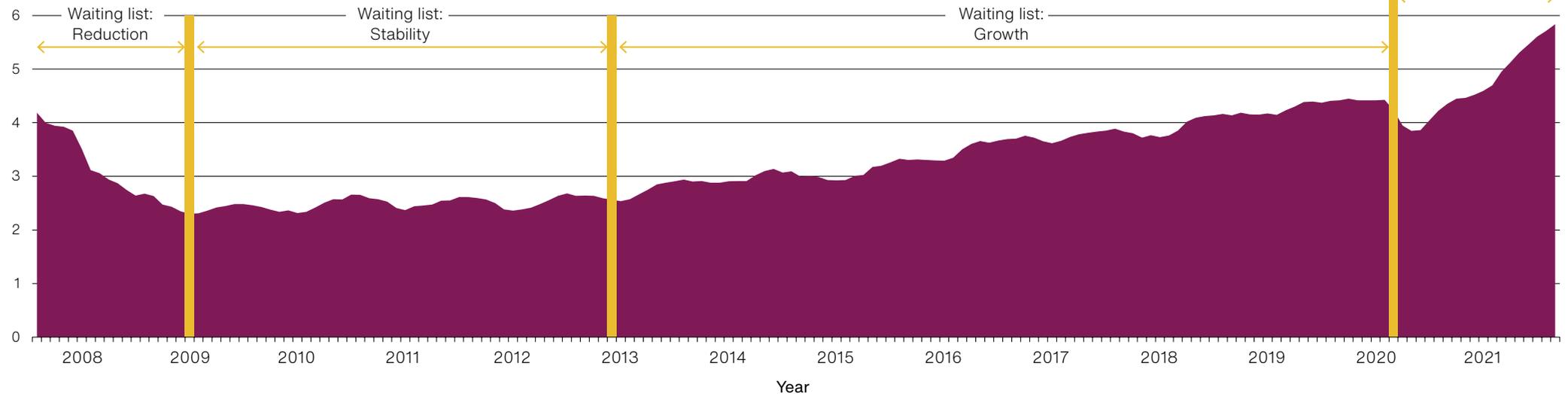
In the 12 months prior to the pandemic (March 2019 – February 2020), the NHS completed 16.6 million elective pathways. In the 12 months during the pandemic (March 2020–February 2021) the NHS completed 11.1 million elective pathways.

Figure 2: Patients on incomplete referral-to-treatment (RTT) pathways (the waiting list for elective treatment), August 2007 to September 2021

The waiting list shows distinct phases of reduction, stability, growth and then the COVID-19 pandemic

Each pathway in this graphic represents a patient. A patient who is on multiple pathways appears more than once in the waiting list statistics. NHS England & NHS Improvement (NHSE&I) estimated that the 5.6 million incomplete RTT pathways in July 2021 comprised an estimated 4.9 million individual patients, or some 9% of the English population. The figures are the monthly total of patients on an incomplete RTT pathway.

Waiting list, millions of patient pathways



Source: National Audit Office analysis of NHS England's published referral-to-treatment waiting times statistics

Referrals and completed pathways, 2015–2021

In recent years, flows onto the elective waiting list have been higher than flows off it, except for three months at the start of the pandemic.

Figure 3 shows how, during the pre-pandemic period, the number of referrals was consistently higher than the number of completed pathways.

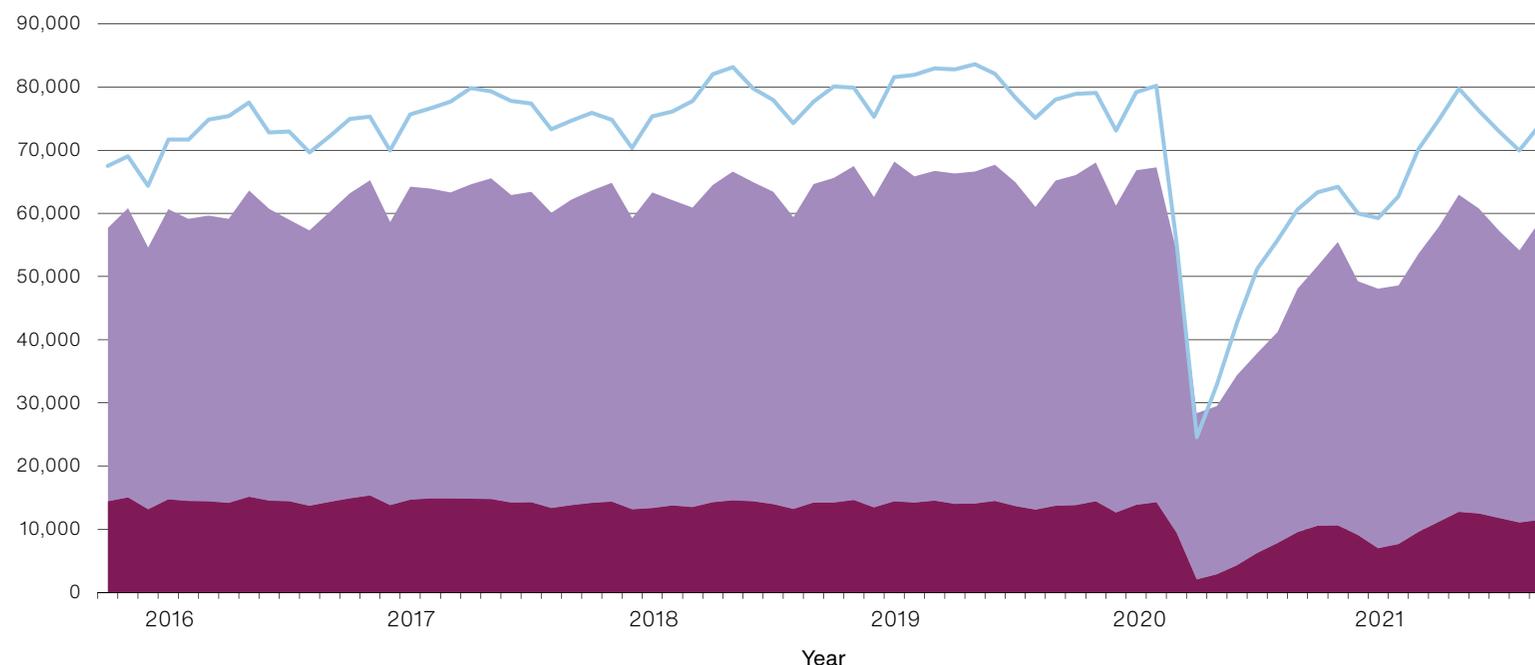
One measure of how unusual the early months of the pandemic were is that March, April and May 2020 are the only months since data have been collected when the total number of new referrals was smaller than the total number of people treated.

We will return later in the report to the subject of these and other 'missing' referrals.

Figure 3: Referrals and completed pathways per working day in each month, October 2015 to September 2021

The waiting list has grown almost every month because more people are referred for treatment than are treated

Referrals and completed pathways



- Completed pathways – Admitted
- Completed pathways – Non-admitted
- Referrals

Notes

- 1 Statistics on the number of elective referrals have been published since October 2015.
- 2 Figures are stated per working day, in order to remove variation due to differences in the number of working days per month.

Source: National Audit Office analysis of NHS England's published referral-to-treatment waiting times statistics

Performance against elective care standards, 2007–2021

The 2004 NHS Improvement Plan stated that by 2008 no one would wait more than 18 weeks from referral to the start of consultant-led elective treatment. Since April 2013, NHS regulations have included a statutory requirement for 92% of patients on the waiting list to start treatment (or to be seen by a specialist and leave the waiting list) within 18 weeks.

Before the pandemic, there was a clear relationship between the size of the waiting list and the length of time patients waited for treatment. As the size of the waiting list grew, so average waiting times increased. The 92% standard was last met in February 2016. During the pandemic so far, performance against the standard has been volatile but always well below levels seen since 2009.

Changes in performance against the 92% standard can be divided into the same four phases as with the waiting list itself (Figure 4).

2007–2009 Waiting time performance improves dramatically but remains below the standard.

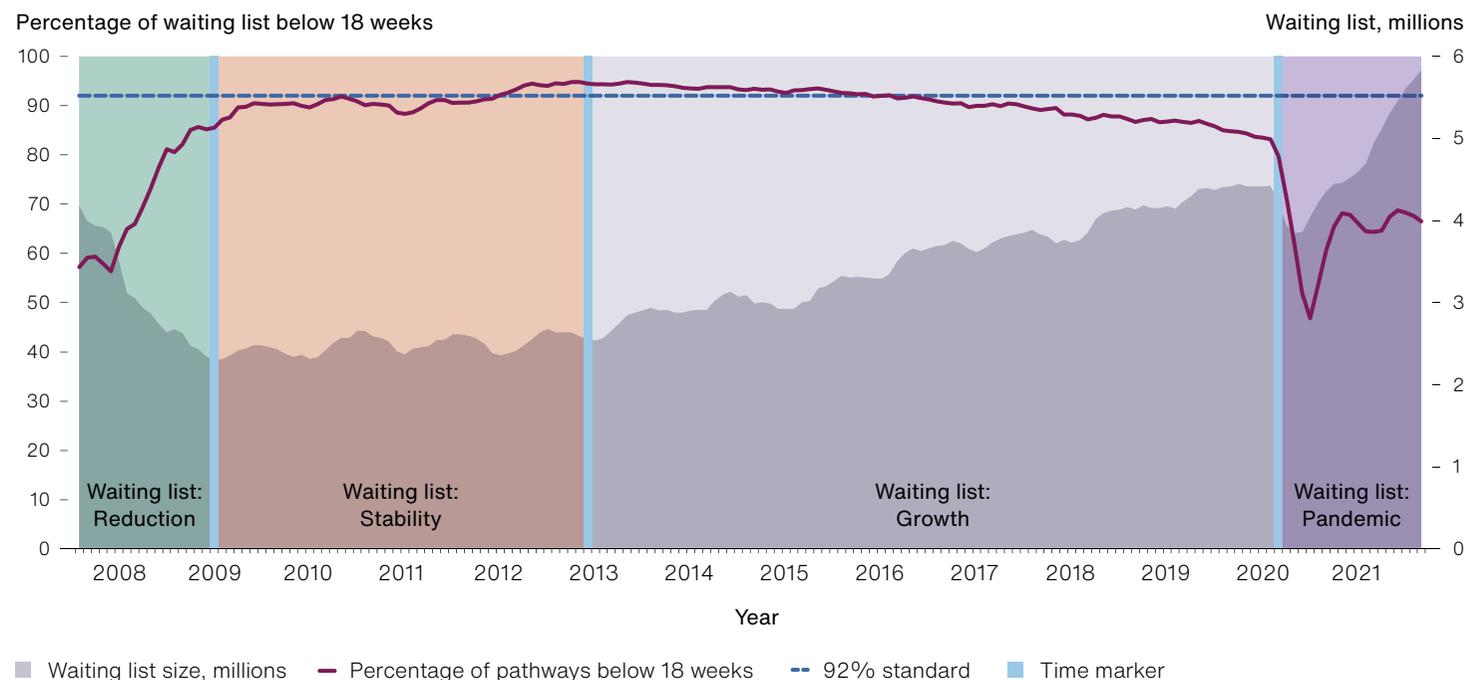
2009–2012 Waiting time performance improves more slowly and achieves the standard for the first time.

2013–2020 Waiting time performance gradually deteriorates as the number of patients being treated or discharged is consistently smaller than the number of new patients being referred.

2020–2021 Waiting time performance plunges rapidly at the start of the pandemic as the NHS focuses on COVID-19 patients. The recovery to date has been only partial, with many more patients receiving their first treatment after waiting for longer than 18 weeks.

Figure 4: Percentage of waiting list below 18 weeks and size of waiting list, monthly from August 2007 to September 2021

Waiting time performance shows four distinct phases as the waiting list reduces, stabilises, grows and then the pandemic occurs



Note: Since April 2013, NHS regulations have included a statutory requirement for 92% of patients on the waiting list to start treatment (or to be seen by a specialist and leave the waiting list) within 18 weeks.

Source: National Audit Office analysis of NHS England's published referral to treatment waiting times statistics

Elective care – patients experiencing long waits, 2007–2021

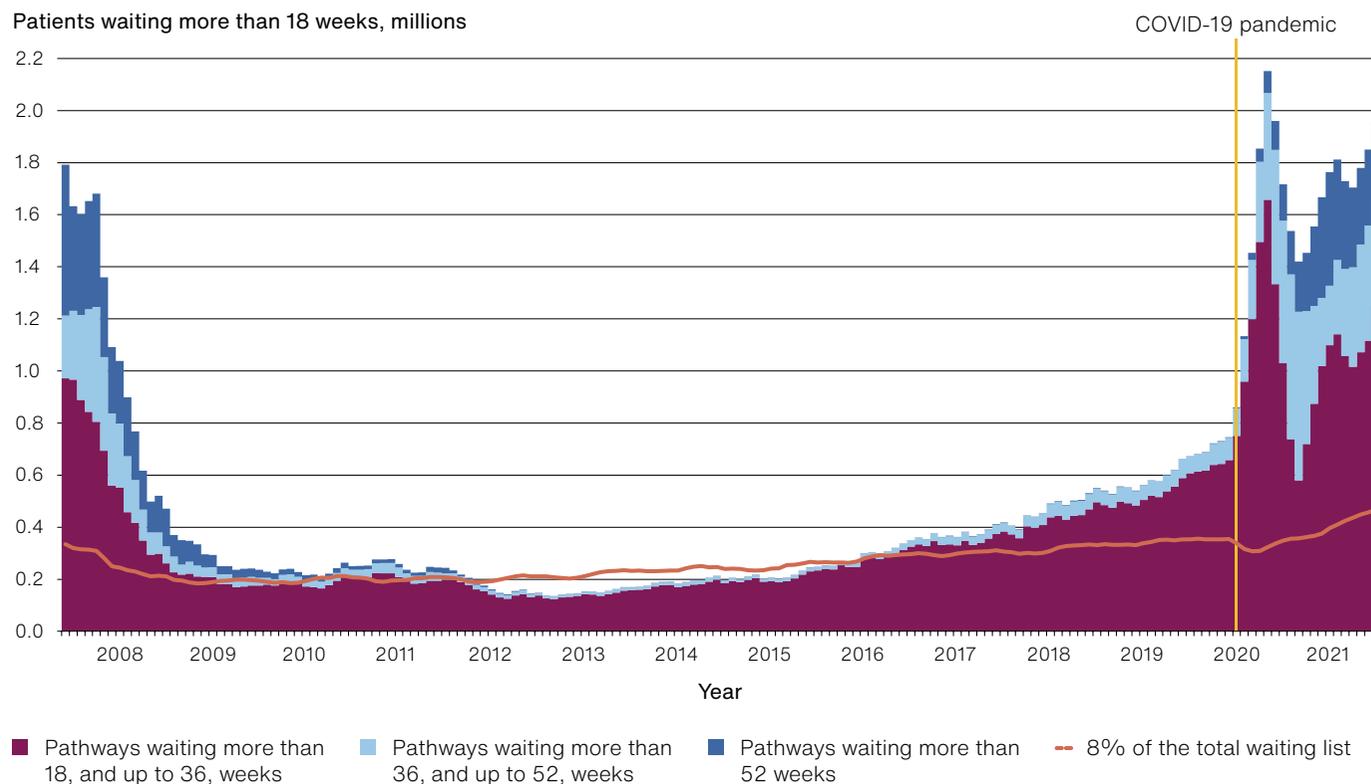
Since April 2013, NHS regulations have included a statutory requirement for 92% of patients on the waiting list to start treatment (or be seen by a specialist and leave the waiting list) within 18 weeks. **Figure 5** shows how the total number of patients waiting longer than 18 weeks has changed since 2007. When the statutory requirement was introduced in 2013, the NHS overall was within the standard because less than 8% of the waiting list (the orange line) had been waiting more than 18 weeks. The requirement was first breached in December 2015 and has not been met since February 2016 as the long waiters gradually built up before the pandemic.

In February 2020, the last month before the impact of COVID-19 was felt, 745,000 patients (of the 4.43 million on the list) had been waiting more than 18 weeks. Of these, 390,000 were outside the standard and 1,600 were waiting more than a year. The latest monthly data, for September 2021, show 1.95 million (34% of the 5.83 million patients waiting) waiting for more than 18 weeks, 1.49 million of them outside the standard.

Inevitably, as performance has worsened, the number of very long waiters has increased. Between 2010 and the start of the pandemic, it was exceptionally rare for a patient to wait for more than 52 weeks for treatment. In the most recent month (September 2021), 301,000 patients (5%) had been waiting for more than 52 weeks.

Figure 5: The number of patients waiting more than 18 weeks, August 2007 to September 2021, monthly totals

The statutory requirement for 92% of patients on the waiting list to start treatment (or to be seen by a specialist and leave the waiting list) within 18 weeks was last met in February 2016



Notes

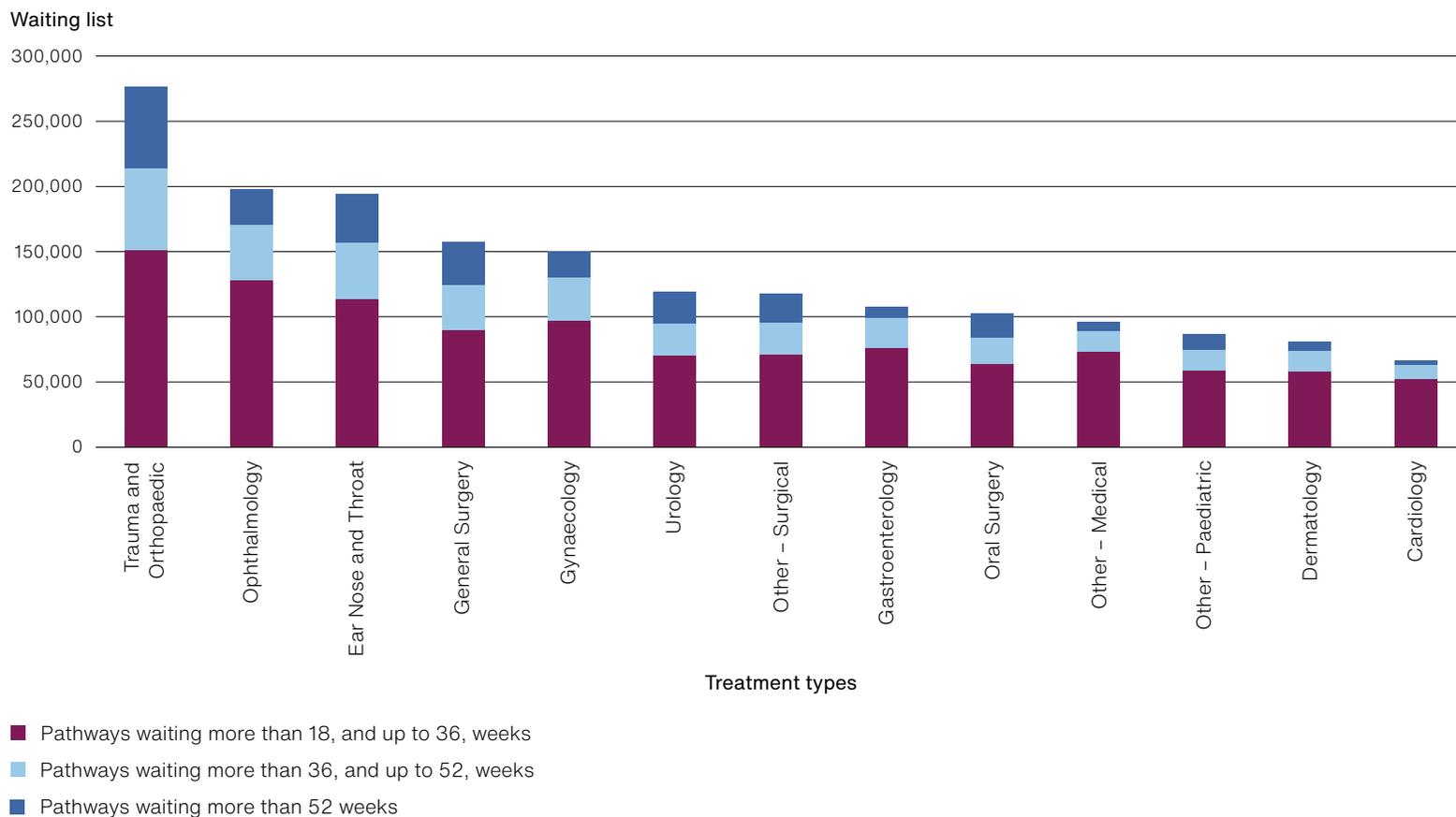
- 1 The 8% dotted line shows the statutory limit for pathways above 18 weeks.
- 2 The vertical line for the pandemic is placed at March 2020.
- 3 Figures for August 2007 – September 2008 based on monthly NHS statistics as initially published and do not reflect very minor subsequent revisions made to these statistics.

Performance against elective care standards, 2007–2021

Statistics on the total elective care waiting list are also provided by the type of treatment patients were referred for. There are 23 treatment types in total and **Figure 6** shows the 13 treatment types with more than 50,000 patients waiting longer than 18 weeks in September 2021.

Figure 6: Treatment types with more than 50,000 patients waiting over 18 weeks, monthly totals for September 2021

The 13 types of elective treatment with more than 50,000 patients waiting longer than 18 weeks in September 2021



Source National Audit Office analysis of NHS England's published referral-to-treatment waiting times statistics

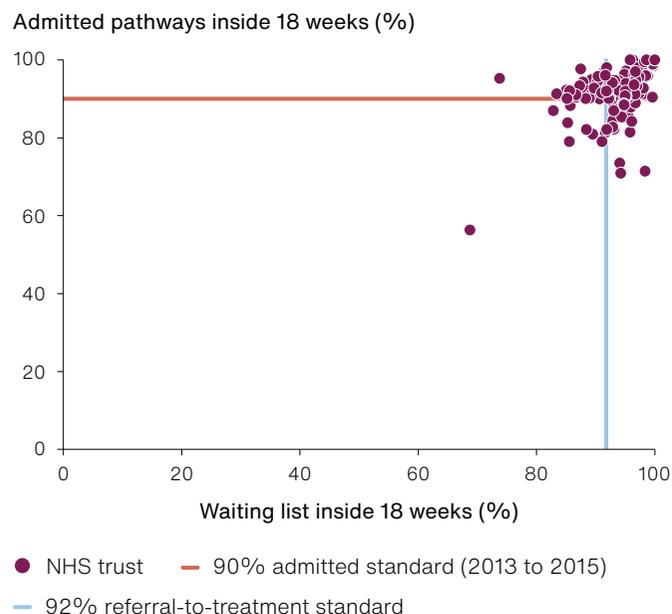
Elective care – variation across England, 2012 to 2021

The deterioration in performance against the 18-week waiting time standard has not happened evenly across England. Looking at the hospitals and other NHS trusts that provide elective care, we see that their performance became much more varied between 2012 and 2020. Variations between trusts mean that some patients are much more likely than others to experience long waits. Since most patients are limited in where they can seek care, this is what is sometimes called colloquially the ‘postcode lottery’. The pandemic then saw some trusts’

performance deteriorate more rapidly than others. Using the same month, February, in three different years (2012, 2020 and 2021), **Figures 7 to 9** show the growing variation between providers. They use two different standards: the overall standard for 92% of patients on the waiting list to be treated or discharged within 18 weeks (the blue line); and a narrower standard for 90% of inpatients to commence treatment within 18 weeks (the orange line). The second standard has been measured throughout the period but was only enforced from 2013 to 2015.

Figure 7: NHS Trusts’ performance, February 2012

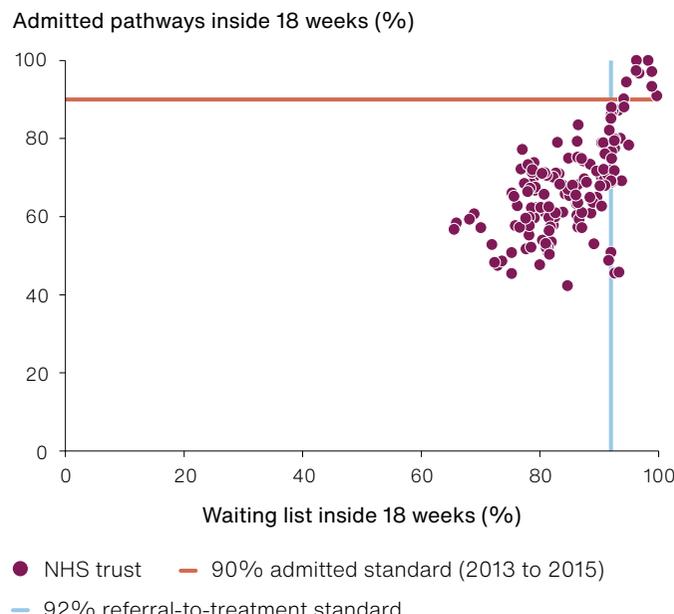
In data from 2012, NHS trusts cluster in the top right of the graph. Almost all providers were meeting both standards. Most of those that did not meet a standard missed it by only a small amount



Source: National Audit Office analysis of NHS England’s published referral to treatment waiting times statistics

Figure 8: NHS Trusts’ performance, February 2020

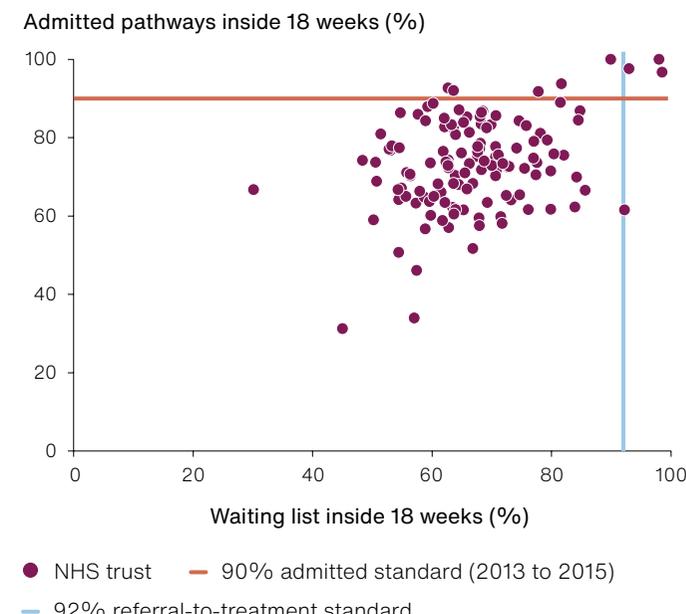
Immediately before the pandemic, NHS trusts’ performance was no longer clustered in the top right of the graph. Most trusts did not meet either standard, and there was a much greater range in their performance



Source: National Audit Office analysis of NHS England’s published referral to treatment waiting times statistics

Figure 9: NHS Trusts’ performance, February 2021

In February 2021, when COVID-19 cases were very high, the NHS’s ability to carry out elective treatment was greatly reduced. Performance generally had worsened markedly since February 2020



Source: National Audit Office analysis of NHS England’s published referral to treatment waiting times statistics

Elective care – variation across England in September 2021

Variation in NHS performance means that, at present, patients in some parts of England are much more likely to experience long waits for elective treatment than patients elsewhere (**Figures 10 and 11**). We examined the waiting lists for September 2021 in each of the 42 sub-regional 'health geographies' that the NHS maintains. It should be noted that variations in the performance of sub-regions might reflect, among other things, differences in their context such as the level of deprivation, the pre-pandemic performance of the NHS and the impact of the pandemic.

The five sub-regions with the highest percentage of their waiting list above 18 weeks are shown in Figure 10 below, while the full list is in Appendix Two.

Figure 10: NHS areas with the highest proportions of long waiting times, September 2021

Patients in the worst-performing sub-region were more than twice as likely as patients in the best-performing sub-region to have been waiting over 18 weeks: Birmingham and Solihull, 51% compared with South West London, 21%

The difference between the proportion waiting over 52 weeks was still greater: Birmingham and Solihull, 12% compared with South West London, 1%.

Sub-regional health geography	Total waiting list	Waits more than 18 weeks (and % of waiting list)	Waits more than 52 weeks (and % of waiting list)
Birmingham and Solihull	183,230	93,108 (51%)	22,479 (12%)
Leicester, Leicestershire and Rutland	109,715	50,807 (46%)	12,068 (11%)
Devon	139,953	61,986 (44%)	11,986 (9%)
Herefordshire and Worcestershire	84,429	36,277 (43%)	8,353 (10%)
Norfolk and Waveney	106,014	44,546 (42%)	12,768 (12%)

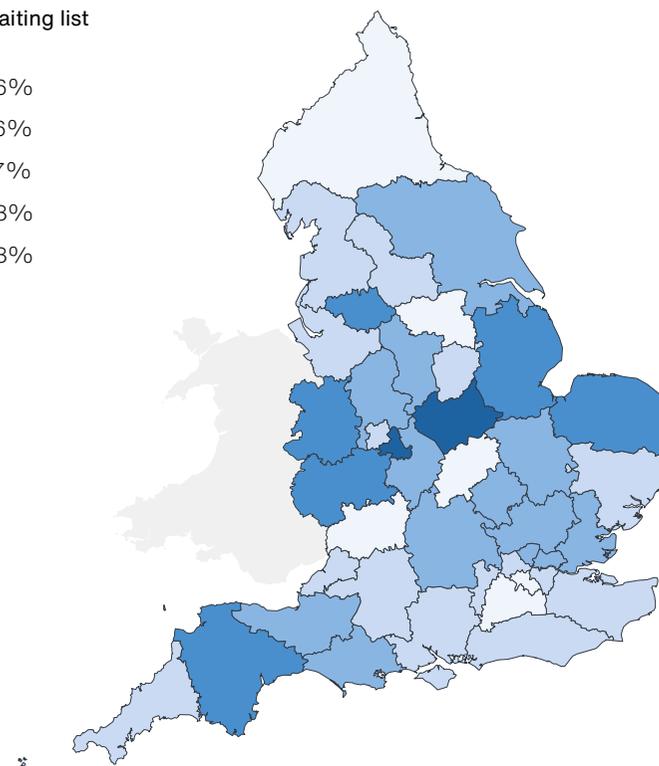
Source: National Audit Office analysis of NHS England's published waiting times statistics

Figure 11: Percentage of patients on the waiting list waiting for more than 18 weeks, September 2021

Patients in some parts of England are much more likely to experience long waits for elective treatment than patients elsewhere

Percentage of waiting list above 18 weeks

- 20.5% – 26.6%
- 26.7% – 32.6%
- 32.7% – 38.7%
- 38.8% – 44.8%
- 44.9% – 50.8%



Notes

- In broad terms, 'elective care' means any non-emergency treatment under the care of consultants, for instance, hip and knee replacements.
- Mapping at latest Office for National Statistics health geography levels, 2021.

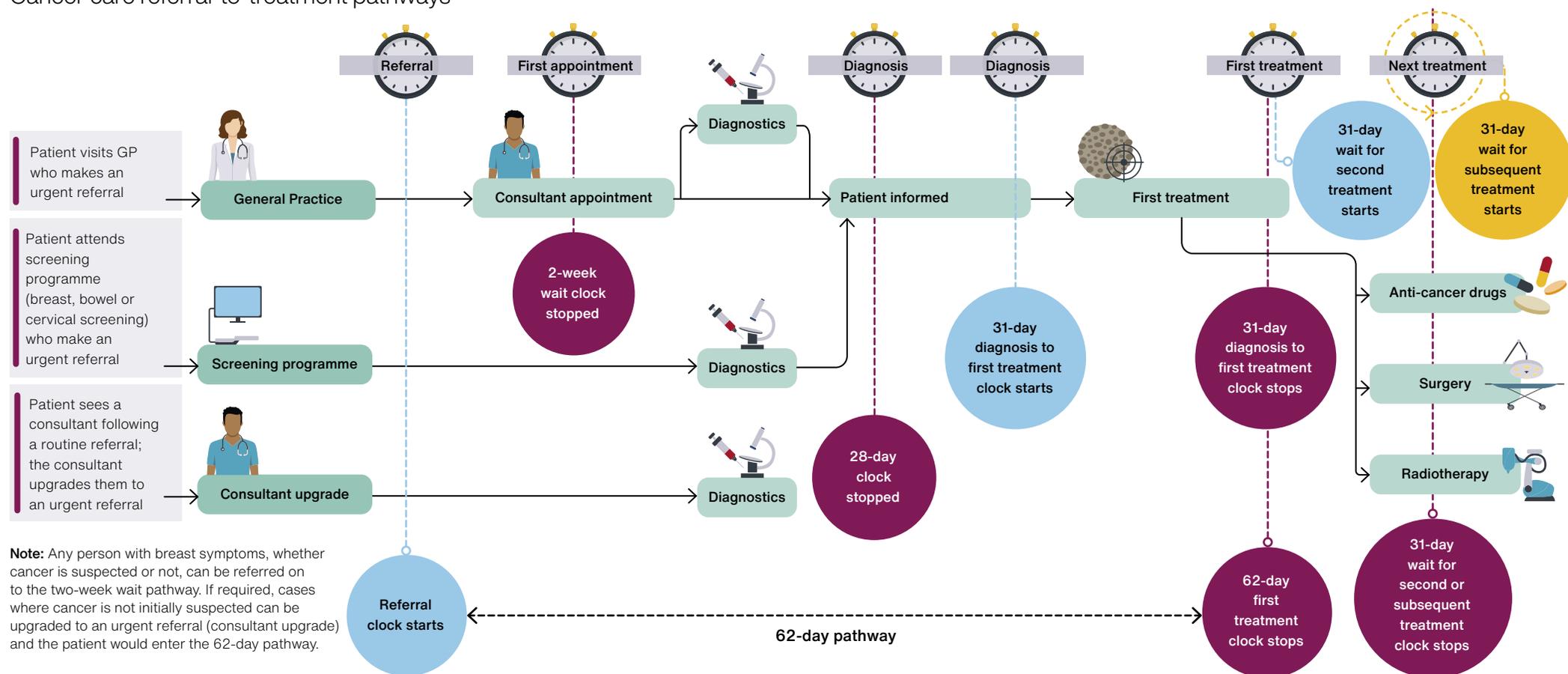
Source: National Audit Office analysis of NHS England's published waiting times statistics. Office for National Statistics licensed under the Open Government Licence v.3.0. Contains OS data © Crown copyright and database right 2021

Cancer care – a brief guide to cancer pathways

A person with a symptom that might be cancer can be referred into a cancer pathway by a GP, a screening programme or a consultant who alters an existing referral for elective care. As with elective care, cancer referrals start a clock in NHS data systems. The referred patient moves through the same broad range of processes as for elective care, according to individual need: consultant

appointments, diagnostic services and treatment. In order to encourage maximum promptness in cancer treatment, cancer services have more performance standards than elective care, meaning that NHS systems measure more clock starts and clock stops for each patient. These standards are also more stretching than for elective care.

Cancer care referral-to-treatment pathways



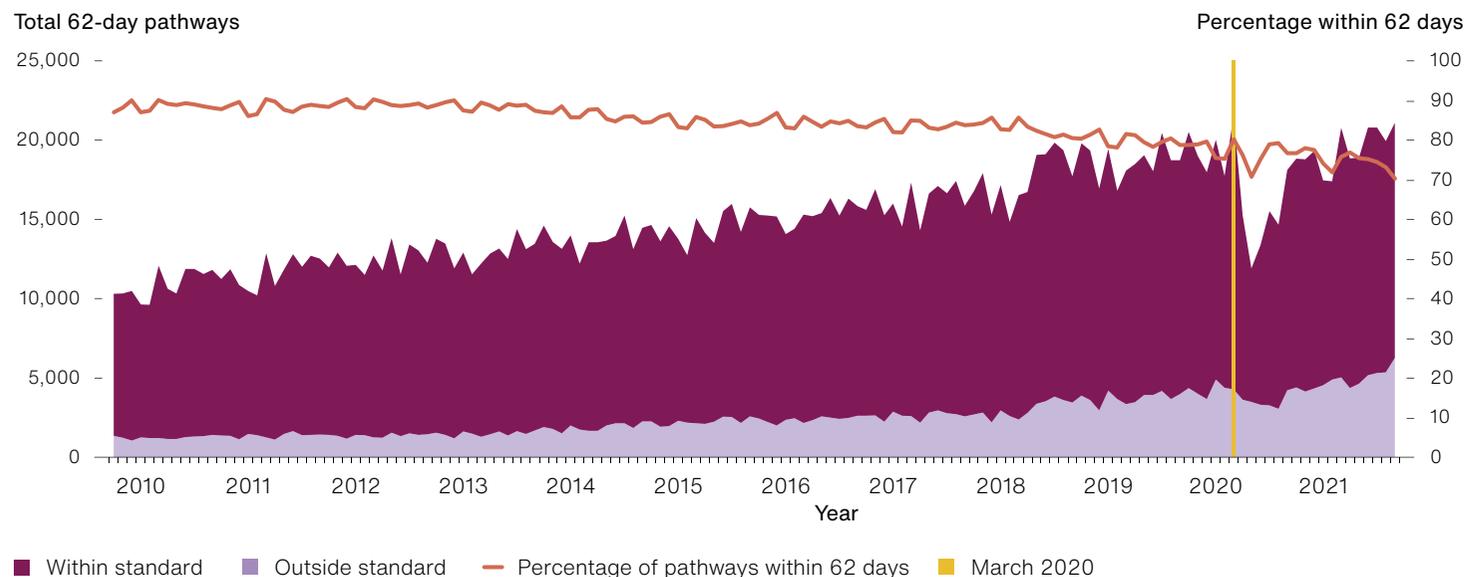
Cancer care – trends in treatment and performance, 2010 to 2021

The number of patients treated for cancer has increased greatly over time. This increase partly reflects greater incidence of cancer in England, but much of the growth is the result of the NHS deliberately encouraging more people to come forward for screening or to have suspicious symptoms investigated. This is seen as important for improving cancer survival rates.

Figure 12 shows patients treated or discharged for cancer who fell within the scope of 62-day performance standards between 2010 and 2021. The number of such patients increased from an average of 11,100 per month in 2010 to 18,800 per month in 2019.

Figure 12: Number of 62-day cancer pathways and performance, monthly, October 2009 to September 2021

The NHS has treated more patients for cancer but has increasingly found it harder to meet performance standards



Note

1 62-day referral-to-treatment pathways for cancer result from an urgent referral from a GP, a screening programme or from a consultant.

Source: National Audit Office analysis of NHS England's published NHS cancer waiting times statistics

As for elective care, the NHS struggled to adjust to this growing workload. Over time, it increasingly found it harder to meet and then missed its own performance standards. (These standards are discussed in greater detail on page 27.)

At the start of the pandemic, the number of patients completing cancer pathways dropped significantly. In March 2020, NHSE&I asked NHS commissioners and providers to maintain cancer services. However, as it mounted an emergency response to the first wave of the pandemic, the NHS treated fewer patients for cancer and a lower proportion of them were treated within 62 days. The reduction in patients treated might reflect a reduction in people with potential cancer symptoms passing through NHS diagnostic services such as screening programmes or going to see their GP.

Cancer services have since recovered to pre-pandemic levels. However, a much higher proportion of patients were receiving their care later than they should have been.

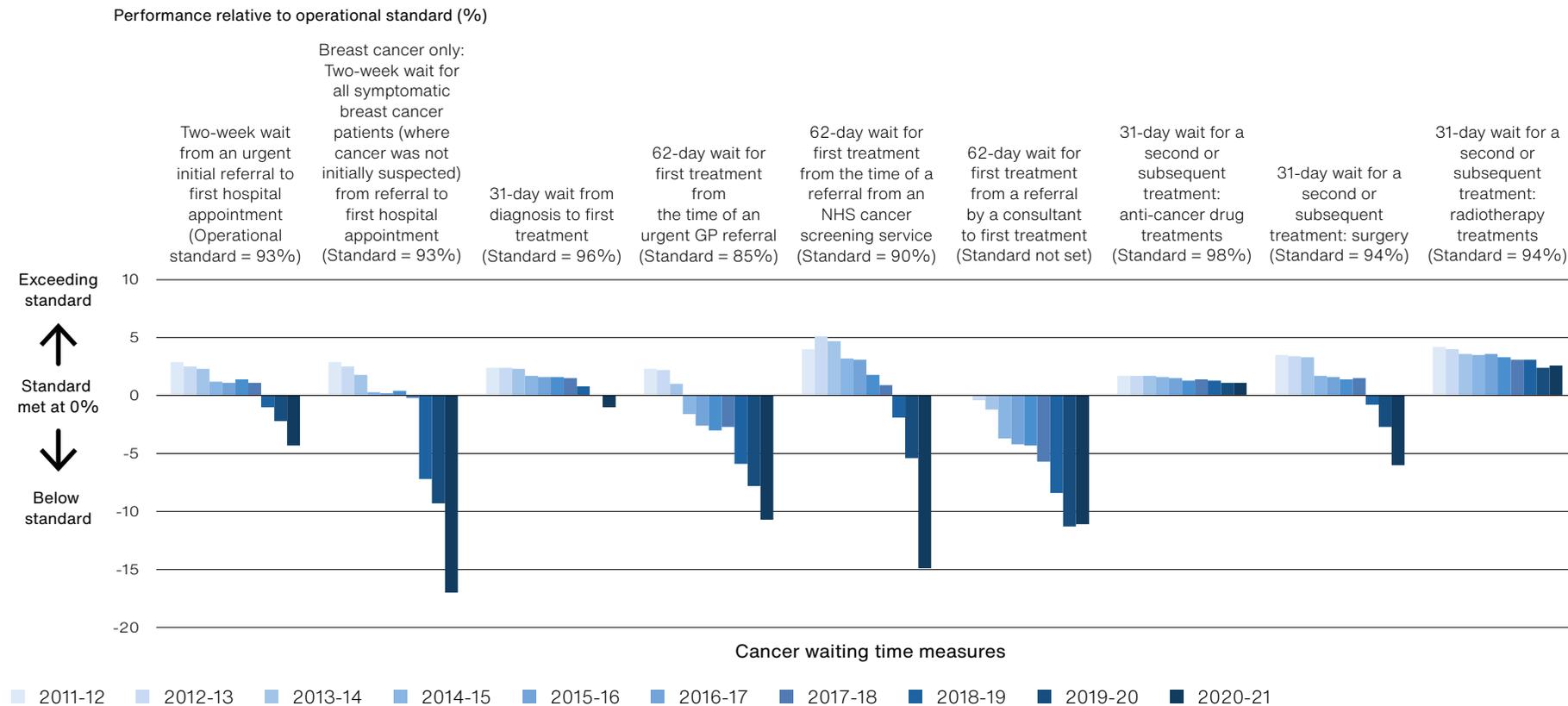
Performance against cancer care standards, 2011-12 to 2020-21

In recent years, the NHS has used nine standards (setting operational performance levels for eight of them) to monitor and manage cancer services (Figure 13). Two relate to the period between referral and first hospital appointment. One relates to the period between diagnosis and first treatment. Three measure

the total time from referral to first treatment, and a further three measure the time taken for a second or subsequent treatment. Performance exceeded all eight operational performance standards from 2011-12 to 2013-14 but began to decline after that. By 2018-19, performance was below five of the eight standards.

Figure 13: Cancer waiting times performance relative to operational standards, 2011-12 to 2020-21

All standards were met between 2011-12 and 2013-14. By 2018-19, five out of the eight operational performance standards were missed



Notes

- The 62-day wait following consultant upgrade of a referral does not have an operational standard, so it is shown above relative to its performance in 2011-12.
- From 2021-22, NHS England & NHS Improvement (NHSE&I) has introduced an additional 28-day standard from an urgent referral for cancer to the date when a patient is informed of their diagnosis. NHSE&I has set the operational standard for this measure at 75% of patients referred.

Source: National Audit Office analysis of published NHS cancer statistics

Performance against cancer care standards during the pandemic

Data are available to show how cancer care has been affected by the first 19 months of the COVID-19 pandemic, from March 2020 to September 2021. We compared this period with the 19 months before the pandemic for all standards (Figure 14).

Performance worsened during the pandemic. In terms of the absolute number of patients being dealt with more slowly than standards permit, this increased during the pandemic in seven out of the nine standards. The biggest drops in performance were seen in the standard specifically related to breast cancer (a 10 percentage-point drop) and the standard relating to screening services (an 11 percentage-point drop).

Figure 14: NHS cancer waiting times standards and performance, August 2018 to September 2021

In percentage terms, performance was worse during the pandemic in seven out of the nine standards and similar in two

Standard	Operational standard	Permitted level outside of standard	Percentage and patients outside of standard (October 2018 to February 2020)		Percentage and patients outside of standard (March 2020 to September 2021)	
	(%)	(%)	(%)		(%)	
Two-week wait from urgent GP referral to first consultant outpatient for all cancers	 93	 7	9	 320,000 out of a total of 3,700,000	12	 443,000 out of a total of 3,600,000
Two-week wait for symptomatic breast patients (where cancer is not initially suspected)	 93	 7	15	 45,000 out of a total of 291,000	25	 54,000 out of a total of 218,000
One month (31-day diagnosis to first treatment for all cancers)	 96	 4	4	 19,000 out of a total of 495,000	5	 24,000 out of a total of 462,000
62-day wait for first treatment following an urgent GP referral for all cancers	 85	 15	22	 58,000 out of a total of 260,000	26	 65,000 out of a total of 247,000
62-day wait for first treatment following referral from an NHS cancer screening service for all cancers	 90	 10	14	 5,000 out of a total of 35,000	25	 7,000 out of a total of 27,000
62-day wait for first treatment following consultant upgrade of urgency of a referral to first treatment	Not set	Not applicable	17	 10,000 out of a total of 62,000	18	 12,000 out of a total of 69,000
31-day wait for second or subsequent treatment: anti-cancer drug treatments	 98	 2	1	 1,000 out of a total of 154,000	1	 1,000 out of a total of 145,000
31-day wait for second or subsequent treatment: surgery	 94	 6	8	 7,000 out of a total of 90,000	12	 11,000 out of a total of 86,000
31-day wait for second or subsequent treatment: radiotherapy	 94	 6	3	 5,000 out of a total of 158,000	3	 5,000 out of a total of 145,000

Figure note: The 'permitted percentage outside of the standard' is the difference between 100% and the operational standard. Where a cell is highlighted red it shows that the performance is outside of this permitted level, and where a cell is green it shows that it is inside this permitted level. Grey is used where a standard is not set. Figures are rounded, percentages based on unrounded cancer waiting times statistics published by NHS England.

Source: National Audit Office analysis of published NHS cancer statistics

Cancer care – variation across England in September 2021

As for elective care, we examined information on patients completing 62-day pathways from urgent GP referral for cancer in September 2021 in each of the 42 sub-regional 'health geographies' that the NHS maintains (**Figures 15 and 16**). It should be noted that variations in the performance of sub-regions might reflect, among other things, differences in their context such as the level of deprivation, the pre-pandemic performance of the NHS and the impact of the pandemic.

Nationally, there is also variation by cancer type, with the following cancer pathways less likely to meet the 62-day performance standard following an urgent GP referral:

- 56% of patients waiting longer than the 62 days for lower gastrointestinal cancers (844 out of 1,515);
- 41% for lung cancers (365 out of 899); and
- 35% for urological cancers (1,104 out of 3,198).

Figure 15: NHS areas with the highest percentages of patients outside of the 62-day treatment pathway, September 2021

Patients in the worst-performing sub-region were more than twice times as likely as patients in the best-performing sub-region to wait longer than 62 days for treatment: Birmingham and Solihull at 57% compared with Surrey Heartlands at 20%. The five sub-regions with the highest percentage of patients waiting longer than 62 days are shown below (full list is in Appendix Three)

Sub-regional health geography	Patients who took longer than 62 days to complete the GP urgent pathway (% of total)	Total patients completing 62-day urgent GP pathways in September 2021
Birmingham and Solihull	145 (57%)	255
Leicester, Leicestershire and Rutland	151 (51%)	294
Norfolk and Waveney	154 (45%)	341
Mid and South Essex	127 (45%)	285
Staffordshire and Stoke-on-Trent	140 (43%)	324

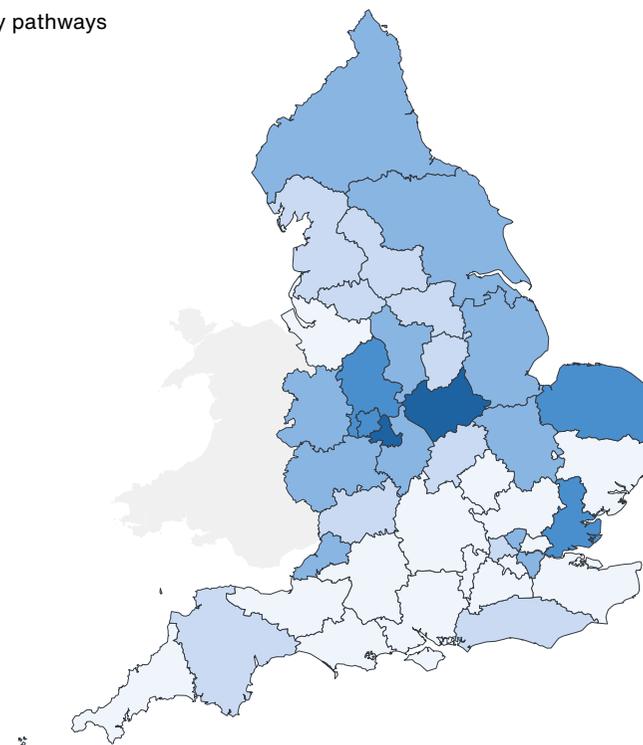
Source: National Audit Office analysis of published NHS cancer waiting times statistics

Figure 16: Percentage of 62-day pathways (from urgent GP referral to first treatment) outside of 62 days, September 2021

At present, patients in some parts of England are much more likely to receive treatment within the 62-day target than patients elsewhere. Nationally in September 2021, 68% of patients were treated within 62 days, meaning it took longer than 62 days to treat 32% of patients. This 32% is 4,757 out of 14,866 patients who completed the 62-day pathway from urgent GP referral to first treatment in September 2021

Percentage of 62-day pathways outside of 62 days

- 19.5% – 27.0%
- 27.1% – 34.5%
- 34.6% – 41.9%
- 42.0% – 49.4%
- 49.5% – 56.9%



Note

1 Mapping at latest Office for National Statistics health geography levels, 2021.

Source: National Audit Office analysis of NHS England's published waiting times statistics. Office for National Statistics licensed under the Open Government Licence v.3.0. Contains OS data © Crown copyright and database right 2021

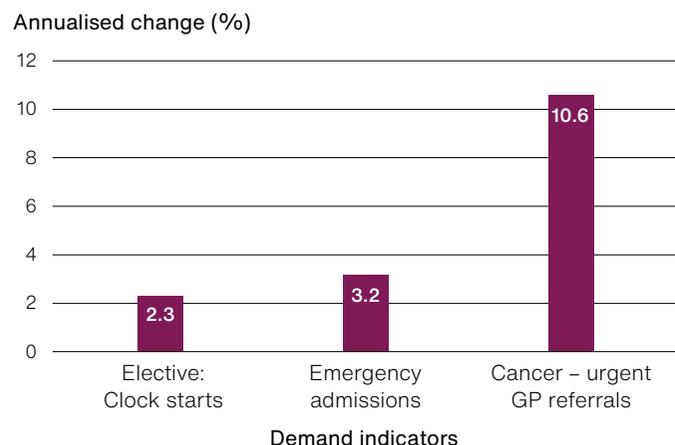
What caused backlogs to increase before the pandemic?

A backlog is an accumulation of work above normal or acceptable levels. In this report, we broadly define the backlog in elective and cancer care as the additional patients the NHS would need to treat in order to begin routinely meeting its own performance standards again. This backlog was already substantial before the pandemic. In 2019, we reported in *NHS waiting times for elective and cancer treatment* that rising demand for healthcare, particularly cancer care, had combined with a period of increased financial constraint to cause more patients

to have to wait longer. The NHS was doing more work year-on-year before the-pandemic, but the demand for its services was increasing even faster. To keep pace, it would have needed either more beds and more staff or a different way of working, or most likely a combination of all three. **Figures 17, 18 and 19** show in more detail how demand, resources and activity changed for a number of key metrics between 2010 and 2019.

Figure 17: Selected annualised changes in healthcare demand, 2010 to 2019

Between 2016 and 2019 (the years for which data are available), the NHS faced average annual growth in elective referrals of more than 2%. Between 2010 and 2019, there was an annual average growth in emergency admissions of more than 3%, and in urgent cancer referrals from GPs of more than 10%

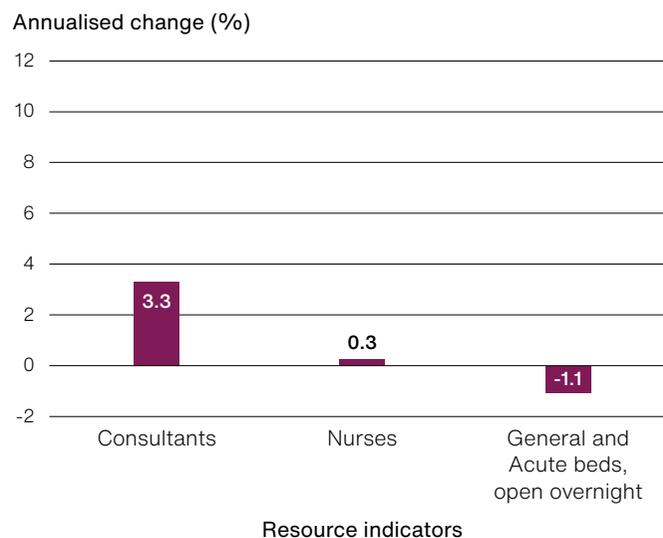


Note: As described on page 26, the large growth in urgent cancer referrals was significantly linked to an NHS policy to encourage more people to get symptoms checked in order to detect and successfully treat more cancers at an earlier stage.

Source: National Audit Office analysis of published NHS statistics

Figure 18: Selected annualised changes in NHS resources, 2010 to 2019

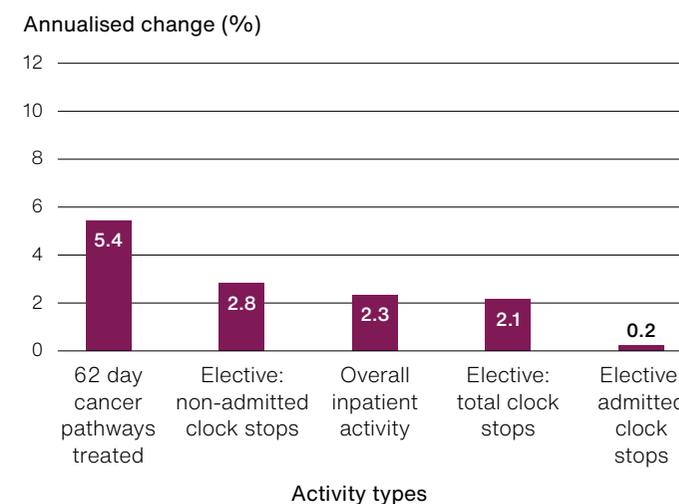
Between 2010 and 2019, the resources the NHS had to deal with demand changed unevenly. There was relatively strong growth in the number of consultants (over 3% per year) but almost no change in nurse numbers and a reduction of 1.1% per year in the number of general and acute beds available for overnight use



Source: National Audit Office analysis of published NHS statistics

Figure 19: Selected annualised changes in NHS activity, 2010 to 2019

Within this context, the NHS managed to treat more patients each year, particularly for cancer. But the level of increase was insufficient to keep pace with demand, and so backlogs grew



Note: Elective: total clock stops includes non-admitted and admitted clock stops.

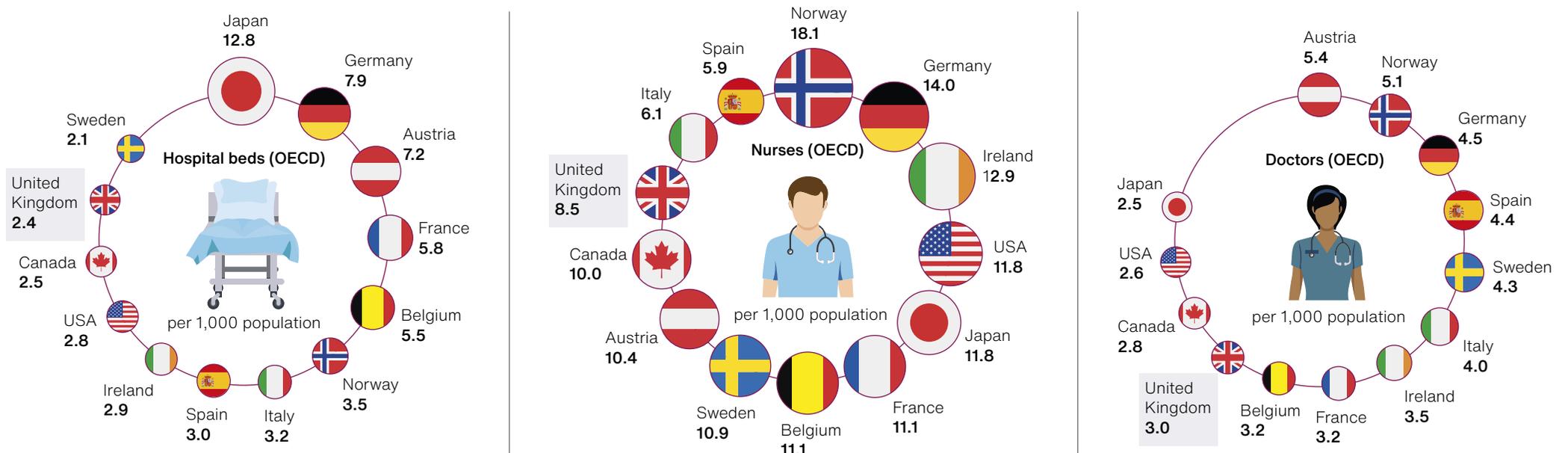
Source: National Audit Office analysis of published NHS statistics

Healthcare resources – international comparisons

It has been a feature of most advanced economies that the demand for healthcare has constantly increased since the middle of the twentieth century, creating challenges for governments that want to control the proportion of taxpayers' money spent on health systems. Within that context, however, the health systems of the UK have fewer resources than many rich nations. The Organisation for

Economic Co-operation and Development (OECD) reports standard statistics from its member countries. These show that the UK has fewer hospital beds, doctors and nurses proportionate to its population, and conducts fewer advanced diagnostic imaging examinations, than many other European and G7 countries.

Healthcare resource indicators per 1,000 population for 13 Organisation for Economic Co-operation and Development (OECD) countries, (2020, or nearest year)



Note: In *Health at a Glance, 2021* the OECD group the advanced diagnostic imaging technologies of computed tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) examinations. For these imaging technologies, any examinations outside hospital are not included for the UK (likely resulting in an under-estimation).

Source: OECD, *Health at a Glance, 2021*, Figure 5.22

Note: The resources include those in both the public and private healthcare sectors.

Source: National Audit Office analysis of published Organisation of Economic Co-operation and Development statistics available at: <http://stats.oecd.org>

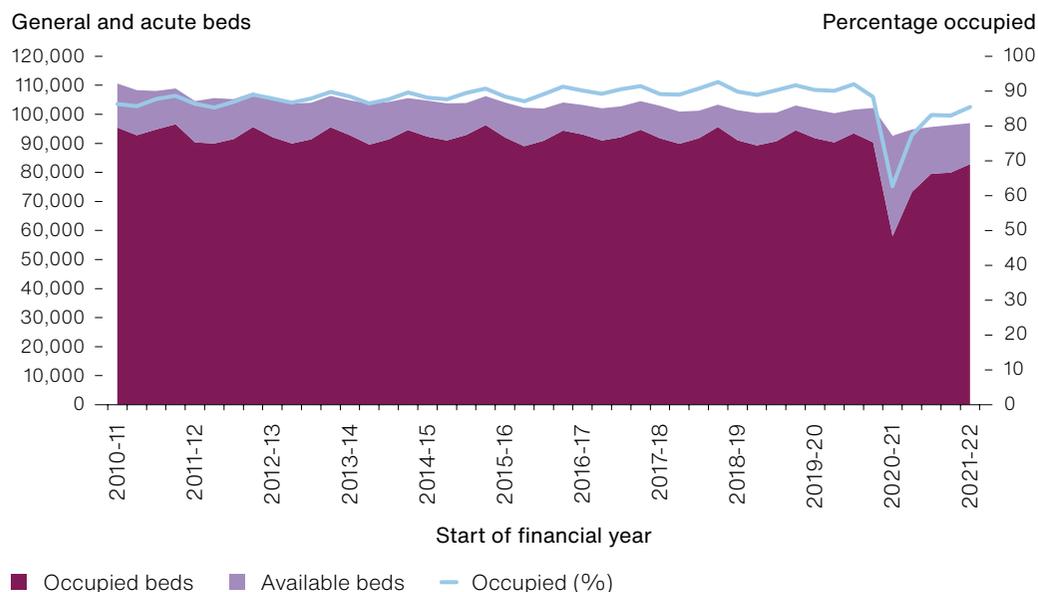
What caused backlogs to increase during the pandemic?

Since the start of the pandemic, the NHS has had to redirect much of its resources away from normal activities. This was both to treat COVID-19 patients and for infection prevention and control. Many staff, operating theatres, clinic rooms and hospital beds were initially put on standby, ready to receive COVID-19 patients. High levels of community transmission of COVID-19 meant that more theatres, clinic rooms and beds have been unavailable because of infection control measures such as social distancing. Staff productivity has reduced due to additional cleaning requirements, isolation and sickness. Outside hospitals, many outpatient services were paused or reduced to allow staff to be redeployed

or to comply with government lockdowns. COVID-19 inpatients rapidly increased from late March 2020 and have since varied over time. Around 90% of medical specialties are classified as general and acute (G&A) when counting beds, and this excludes critical care beds. In January 2021, an average of 24,100 (G&A) NHS beds were being used by COVID-19 patients, and from January to September 2021 an average of 35% of the unoccupied G&A beds were set aside for COVID-19 patients (Figure 21). For a healthcare system that had previously operated at very close to maximum capacity (Figure 20), such disruption was inevitably going to cause a sharp increase in waiting times and backlogs.

Figure 20: General and acute NHS beds, quarterly, 2010–2021

The total number of NHS G&A beds decreased and the level of occupancy increased between 2010-11 and 2019-20. COVID-19 then reduced both the number of beds and the level of occupancy

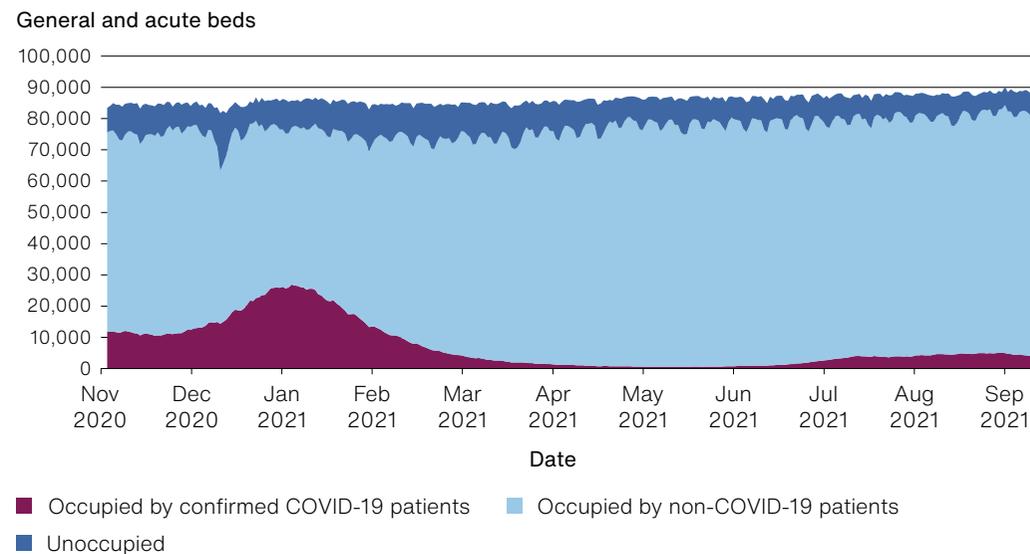


Note: Figure 20 shows the number of available and occupied beds open overnight that are under the care of consultants.

National Audit Office analysis of published NHS bed statistics (KH03)

Figure 21: General and acute NHS beds, daily, 17 November 2020 to 26 September 2021

In January 2021, an average of 24,100 NHS G&A beds (31% of the occupied beds) were used by COVID-19 patients



Note: Figure 21 shows adult general and acute beds. Data is not available prior to November 2020.

Source: National Audit Office analysis of published NHS bed statistics (COVID-19 hospital activity)

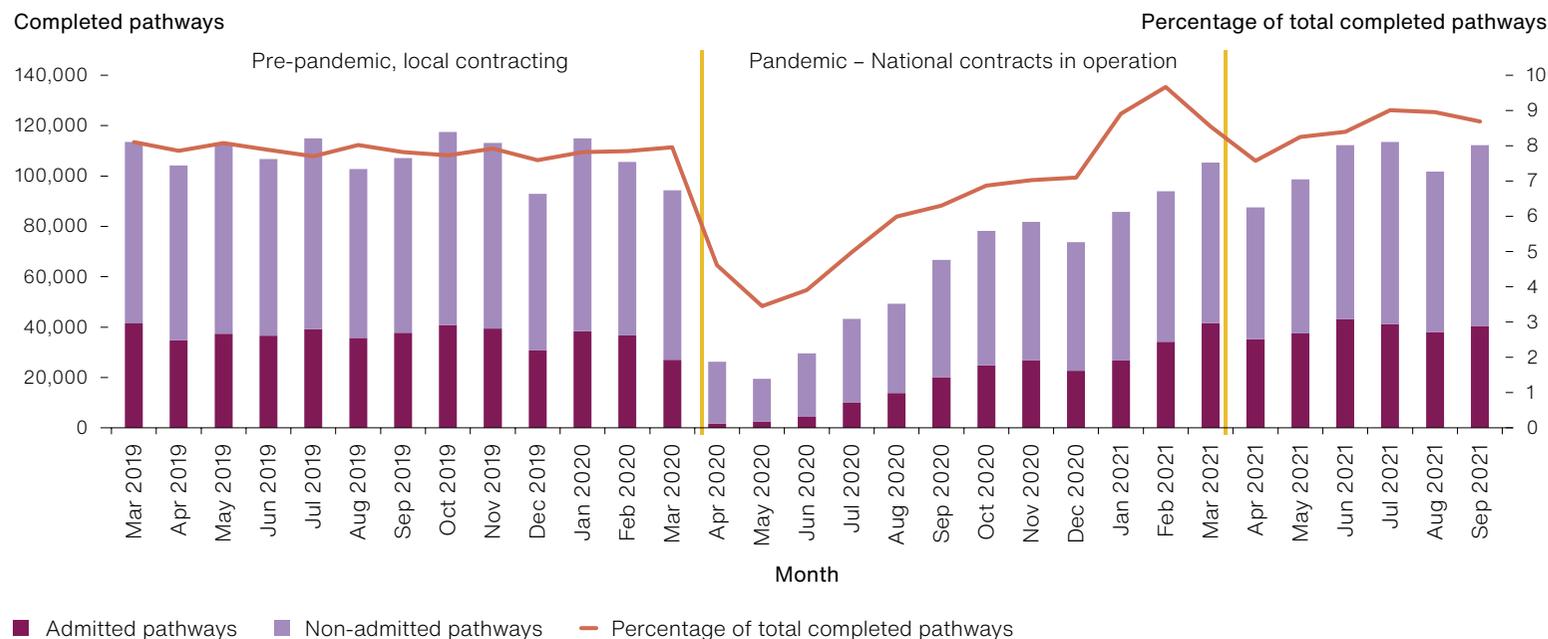
Elective care and independent sector providers, 2019–2021

NHS commissioners and providers purchase services from independent sector providers of healthcare. Before the pandemic, between March 2019 and February 2020, independent providers treated an average of 8% of the total completed elective pathways of NHS patients.

The pandemic caused a sharp reduction in the number of completed elective pathways by independent providers from some 110,000 per month to a low of some 20,000 in May 2020. From June 2021, independent sector providers returned to providing pre-pandemic levels of completed elective pathways.

Figure 22: Completed NHS elective care pathways carried out by the independent sector, and as a proportion of total elective activity, March 2019 to September 2021

There was a sharp decline in the number of completed NHS elective pathways carried out by independent sector providers in April 2020. Independent sector activity recovered during the rest of 2020-21, returning to pre-pandemic levels by June 2021



Source: National Audit Office analysis of NHS England data on consultant-led referral-to-treatment waiting times

There are two principal reasons for the fall in elective completed pathways shown in **Figure 22**.

The first was the NHS’s decision, in March 2020, to postpone all non-urgent elective activity.

The second was a change in how the NHS contracted with some independent providers. In March 2020, NHS England decided to purchase directly the operational capability of 27 independent sector providers.

This included those providers’ staff, equipment and other resources. The capability was to be available, in the first instance, to treat COVID-19 patients should the NHS be overwhelmed but it was also to be available to support elective and cancer care. Under these special national contracts, some elective work was done that did not take the form of completed pathways and was not recorded as such. The types of elective care and cancer care activities undertaken under the special contracts and the total cost of these are described on page 34. There is limited information on the use of independent sector capacity for COVID-19 patients.

The national contracting of independent providers, 2020-21

Independent sector healthcare providers were contracted by NHS England to support the NHS during the pandemic. The initial national contracting arrangement lasted until July 2020, and from September 2020 NHS England started to reduce the number of providers. Between January and March 2021, NHS England contracted with 14 independent providers, including the larger ones, for capacity to deliver a guaranteed minimum number of treatments.

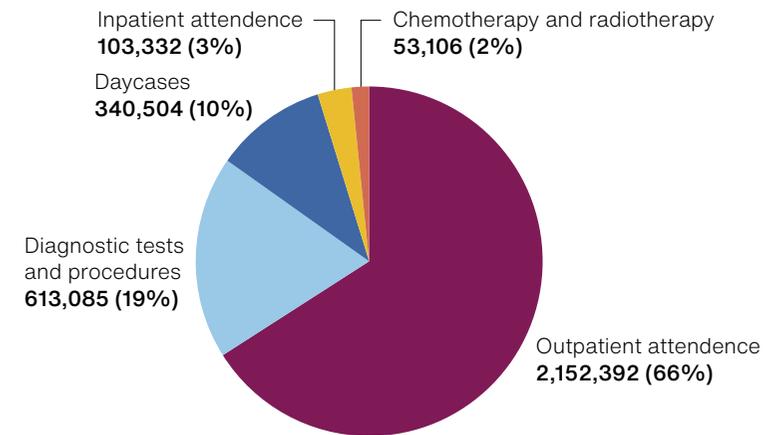
In total, the NHS expects to have paid independent providers around £2.1 billion in 2020-21 under the terms of the special national contracts. In return for this, it told us that 3.3 million activities had been completed (**Figure 23**).

Relatively little of the block-booked independent provider capacity was used directly for COVID-19 patients because the number of COVID patients requiring ventilation or inpatient care did not reach the levels anticipated in government's reasonable worst-case scenario. From March 2020, NHSE&I encouraged NHS commissioners and providers to use independent providers for urgent elective and cancer care and in July 2020, NHSE&I told NHS providers that it expected them to use the full available capacity of the independent sector to support the recovery of elective care.

The special national contracts allowed the NHS to send patients for elective treatment in independent providers' facilities in the usual way, but they also allowed NHS providers to make use of independent provider staff, theatres and equipment as if they belonged to the NHS. NHSE&I told us that this unusual approach had increased flexibility at a difficult time. One consequence of this approach is that data on the use of the independent sector before the pandemic are not comparable with data on its use during the pandemic.

Figure 23: NHS elective and cancer care activities carried out by the independent providers which held national contracts, by type of service, 23 March 2020 to 4 April 2021

Outpatient attendances made up around two-thirds (66%) of the activity delivered by independent providers which held national contracts with NHS England in 2020-21



Note

1 Activities are clinician-patient interactions which are a part of a care pathway but not normally the entire pathway.

Source: National Audit Office analysis of NHS England data on elective and cancer care activities carried out by independent providers within national contracts

Elective care – ‘missing’ referrals and what may happen next

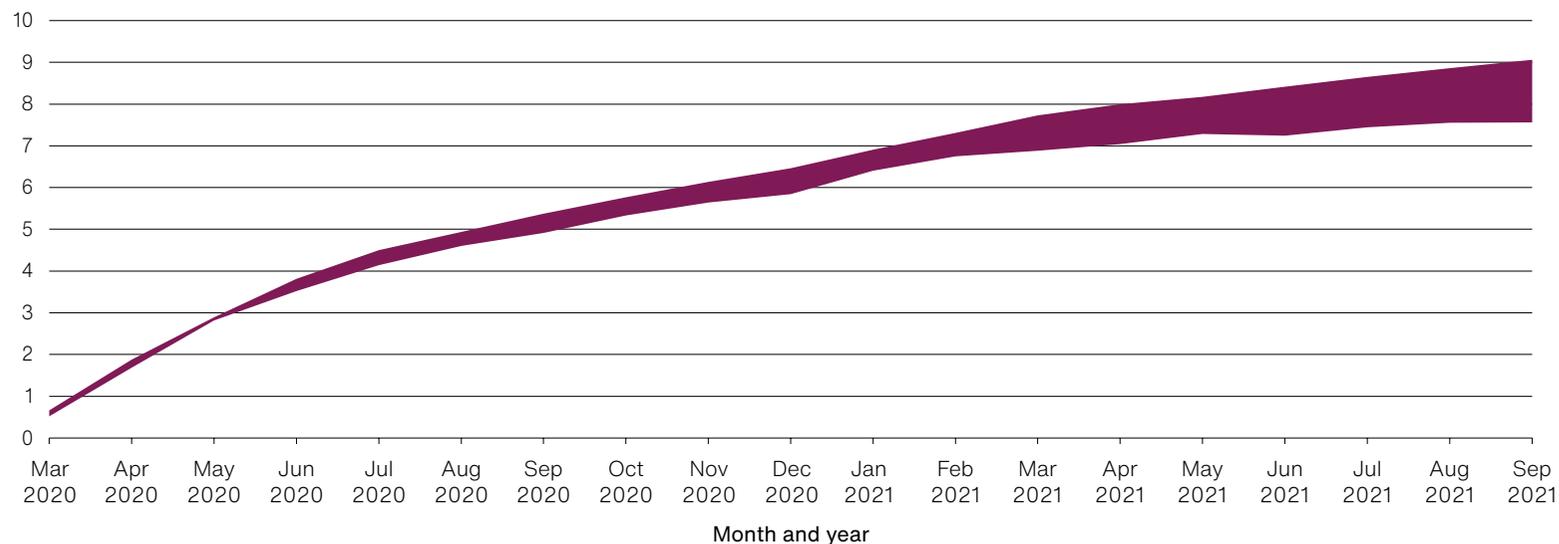
During the pandemic there were fewer referrals for elective care than normal. From March 2020 to September 2021, between 7.6 million and 9.1 million fewer referrals occurred than modelling would have predicted (**Figure 24**). The NHS is working on the assumption, and health experts agree, that many of these patients will present at some point, further increasing the size of the future backlog.

The range in estimates of what we are calling ‘missing’ referrals relates to the different ways of estimating what normal demand for elective care would have been if the pandemic had not happened.

Figure 24: ‘Missing’ elective clock starts since the beginning of the pandemic

Between the start of the pandemic in March 2020 and September 2021, we estimate there were between 7.6 million and 9.1 million ‘missing’ clock starts, compared with the normal demand for elective care if the pandemic had not happened

Estimated ‘missing’ elective referrals, millions



Note

1 These figures present estimates of the lower and upper bound of the range of the ‘missing’ clock starts that would have been expected since the start of the pandemic. The lower bound uses the nearest pre-pandemic month, and the upper bound uses the expected growth associated with the NHS Long-Term Plan of 3.2% growth per annum.

Source: National Audit Office analysis of published cancer waiting times statistics

The lower estimate, 7.6 million ‘missing’ referrals, is calculated by comparing each pandemic month with referral levels in the nearest corresponding pre-pandemic month.

The higher estimate, 9.1 million, is based on assumptions in the NHS Long Term Plan of 2019. As discussed elsewhere in this report, demand for healthcare normally rises. The Long Term Plan assumed that demand would grow by an average of 3.2% per year.

At the time of concluding our fieldwork, the NHS was still seeing lower levels of referrals than would have been expected under either method of modelling. The main reasons for this are likely to be similar to earlier stages of the pandemic: some people may be avoiding healthcare settings because of fear of the virus or to reduce demand on the NHS; others might have had difficulty getting appointments with their GPs or with consultants or diagnostic services.

Elective care – ‘missing’ referrals and what may happen next *continued*

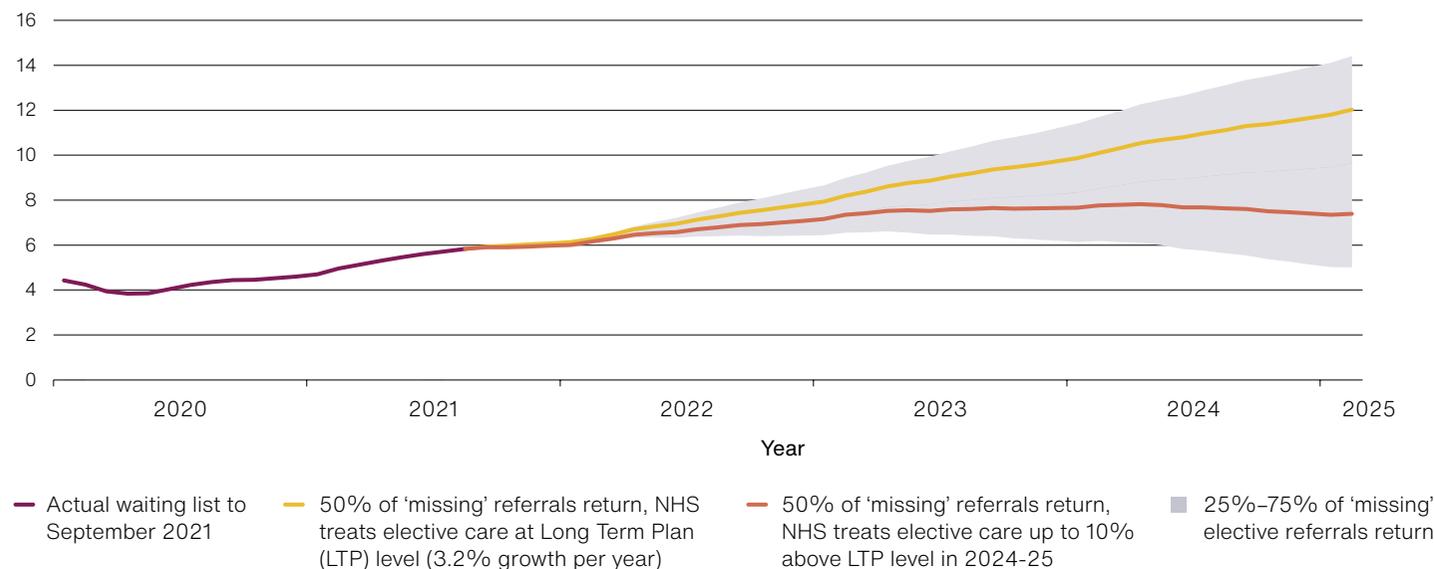
How the ‘missing’ referrals will affect the elective care waiting list over the next few years is highly uncertain. There is uncertainty both about how many of the ‘missing’ patients will enter the system and over what timeframe and about the level of elective activity it will be possible for the NHS to achieve after the pandemic.

To demonstrate how these variables might alter the future waiting list, we have modelled several scenarios. Under two plausible scenarios, the elective care waiting list will be longer in 2025 than it is today, meaning millions more people enduring long and very long waits for care. However, the extent to which the NHS is able to increase activity above pre-pandemic levels will have a very big impact in the future, as the scenarios highlighted in **Figure 25** make clear. Outside this analysis, there could also be additional new demand for elective care, for instance from sufferers of ‘long COVID’.

Figure 25: Actual and projected elective care waiting list to March 2025, monthly

Under two plausible scenarios, the elective care waiting list will be longer in 2025 than it is today

Elective care waiting list, millions of patient pathways



Source: National Audit Office projection based on published referral-to-treatment statistics and assumptions as listed in Appendix One

— The first scenario assumes that 50% of the ‘missing’ referrals return by 2025 and that the NHS achieves the level of activity originally targeted in the Long Term Plan. Under this scenario, the waiting list in March 2025 will contain 12.0 million patient pathways, compared with 5.8 million in September 2021.

— The second scenario also assumes that 50% of the ‘missing’ referrals return but with NHS activity increasing by 10% more than originally targeted in the Long Term Plan. Significantly, this is what the NHS has been instructed to achieve in the financial settlement it received in September 2021 (described on page 40). Under this scenario, the waiting list in March 2025 will increase to 7.4 million patient pathways. The waiting list is long under most reasonable scenarios. The challenge will be how to prioritise and manage long waiting lists in the immediate future to avoid excess demand on A&E and GPs.

The upper boundary of the area of uncertainty (in grey) is based on 75% of missing referrals returning. The lower boundary is based on 25% of missing referrals returning.

Cancer care – ‘missing’ referrals and what may happen next

There have been ‘missing’ referrals for suspected cancer during the pandemic as well. As for elective care, this is likely to be for a combination of reasons: people avoiding healthcare settings because of fear of the virus or to reduce demand on the NHS; people having difficulty getting appointments with GPs, consultants or diagnostic services; and also screening services not operating or operating a reduced service. Early diagnosis and treatment of cancer are very important to increase the chances of successful recovery. The NHS started encouraging people with worrying symptoms to return to the NHS quite early in the pandemic, including through advertising campaigns.

We looked in detail at two performance standards: two-week waits for urgent GP referrals and 31-day waits from diagnosis to first treatment. We estimate that there

were between 240,000 to 740,000 ‘missing’ urgent GP referrals for suspected cancer between March 2020 and September 2021, and between 35,000 and 60,000 ‘missing’ first treatments for cancer over the same period (**Figures 26 and 27**). The range in estimates of what we are calling ‘missing’ referrals and ‘missing’ first treatments relates to the different ways of estimating what normal demand for cancer care would have been if the pandemic had not happened. We recognise that there is inherent uncertainty about these estimates. There is also uncertainty about how many of the ‘missing’ patients will enter the system and over what timeframe. NHSE&I has told us that it is targeting interventions across the country and for all tumour types where there is evidence of reduced diagnoses. It urges all patients with potential symptoms of cancer to come forward.

Figure 26: Two-week waits for urgent GP referrals for suspected cancer, monthly, October 2015 to September 2021

We estimate that there were between 240,000 and 740,000 ‘missing’ urgent GP referrals for suspected cancer between March 2020 and September 2021

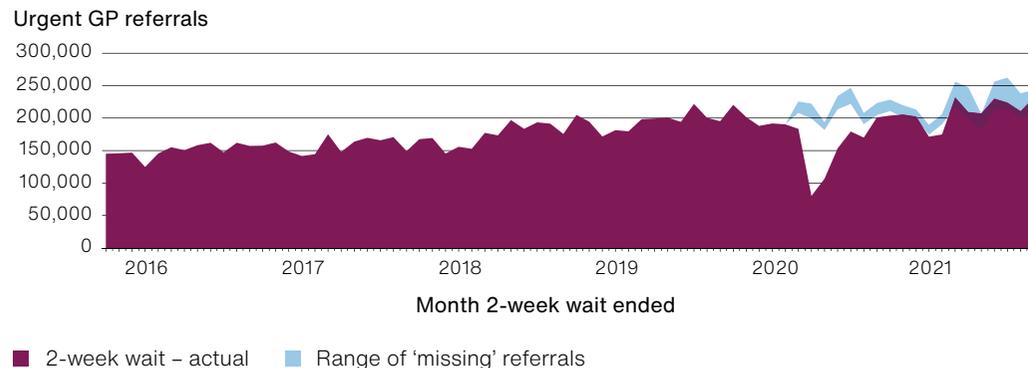
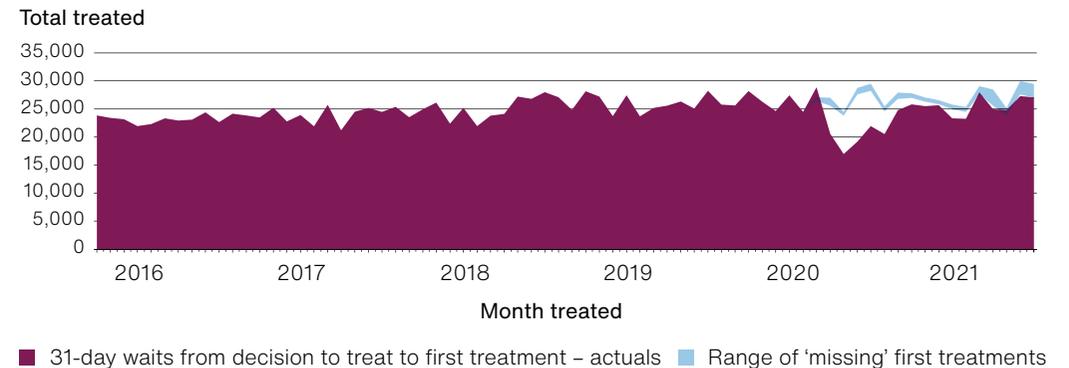


Figure 27: 31-day waits from decision to treat to first treatment for cancer, monthly, October 2015 to September 2021

We estimate that there were between 35,000 and 60,000 ‘missing’ first treatments for cancer between March 2020 and September 2021



Note: These figures present our estimates of the lower and an upper range of the ‘missing’ cancer referrals and ‘missing’ first treatments that would have been expected since the start of the pandemic. Our estimates are based on the trend growth in referrals and first treatments. The lower bound uses the nearest pre-pandemic month (that is, no growth in referrals), and the upper bound uses the trend growth (2016 to February 2020) based on corresponding months and are adjusted for working days. Estimates of the ‘missing’ referrals are rounded to the nearest 10,000 and estimates of the ‘missing’ treatments are rounded to the nearest 5,000, and both are net figures projected from March 2020.

Source: National Audit Office analysis of published cancer waiting times statistics

Addressing the backlog – central initiatives so far

NHSE&I began considering how to address the pandemic's adverse impacts on elective and cancer care towards the end of the first wave of infections in 2020.

Since then, it has used various initiatives to support and encourage NHS providers and other bodies to increase activity levels and make proactive decisions about prioritising patients for care. Some of these are new initiatives introduced since the start of the pandemic and other initiatives were in place before the start of the pandemic (overleaf).

Government announced a new multi-year funding settlement for the NHS in September 2021.

NHSE&I has since been developing recovery plans and detailed expectations for 2022-23 and beyond.

Initiatives introduced since the start of the pandemic, which aim to increase elective or cancer care activity to address the backlog, or make proactive decisions about prioritising patients for care

Initiative	Description	Funding (or value)
Elective recovery fund (ERF)	NHSE&I announced the ERF in March 2021. It aims to incentivise the NHS's integrated care systems (ICSs) to tackle elective care backlogs in their sub-regional health geography. To receive additional funding, ICSs have to deliver elective care at a level greater than 95% (from July 2021) of their 2019-20 activity level.	£2 billion (revenue) for 2021-22
Elective accelerators programme	Twelve ICSs (and a joint paediatric provider group) received funding to implement and evaluate innovative ways of increasing elective care activity to 120% of the 2019-20 baseline level.	£160 million for 2021-22
Targeted Investment Fund	The funding is available to ICSs and individual providers to support investments in elective recovery reforms (such as use of technology), including in systems and providers facing the greatest challenges in restoring elective activity.	£700 million for the last six months of 2021-22 only, of which at least £500 million must be spent on capital
Increasing capacity framework (ICF) with independent providers	NHS England set up this framework agreement with more than 80 independent providers available from April 2021. NHSE&I wants ICSs to use the ICF framework to procure elective healthcare from independent providers (although it is not the sole route for ICSs to do so). The framework value of this initiative does not represent funding to commissioners or providers – these organisations pay from their own budgets.	Spend is estimated to be up to £10 billion between 2021-22 and 2024-25
Waiting list validation and management	Since 2020-21, NHSE&I has required ICSs to carry out a clinically-led review of their waiting list on an ongoing basis, to ensure the effective prioritisation and management of clinical risk.	Unknown, but costs will be borne locally

Addressing the backlog – central initiatives so far *continued*

Initiatives in place before the pandemic that may help increase elective and cancer care activity or address the backlog of care

Initiative	Description	Funding
Increasing and upgrading diagnostic capacity	For new diagnostics equipment and the development of at least 100 community diagnostic centres to increase capacity and throughput as well as improving access.	£350 million in 2021-22 plus £2.3 billion between 2022-23 and 2024-25
Demand management	A range of ongoing initiatives aimed at reducing the demand for elective care. It includes the evidence-based interventions programme (from 2019) and the supported self-management programme.	As this includes a range of initiatives, a funding figure is not available at this point
Transforming outpatient care	Aims to reduce unnecessary face-to-face outpatient appointments and make better use of remote diagnostics, video consulting technology, referral optimisation and patient-initiated follow-up.	£26 million in 2021-22
Getting it right first time (GIRFT) programme	Aims to support elective recovery by developing standardised patient pathways based on best practice and increasing productivity and throughput through surgical hubs.	£11 million in 2021-22

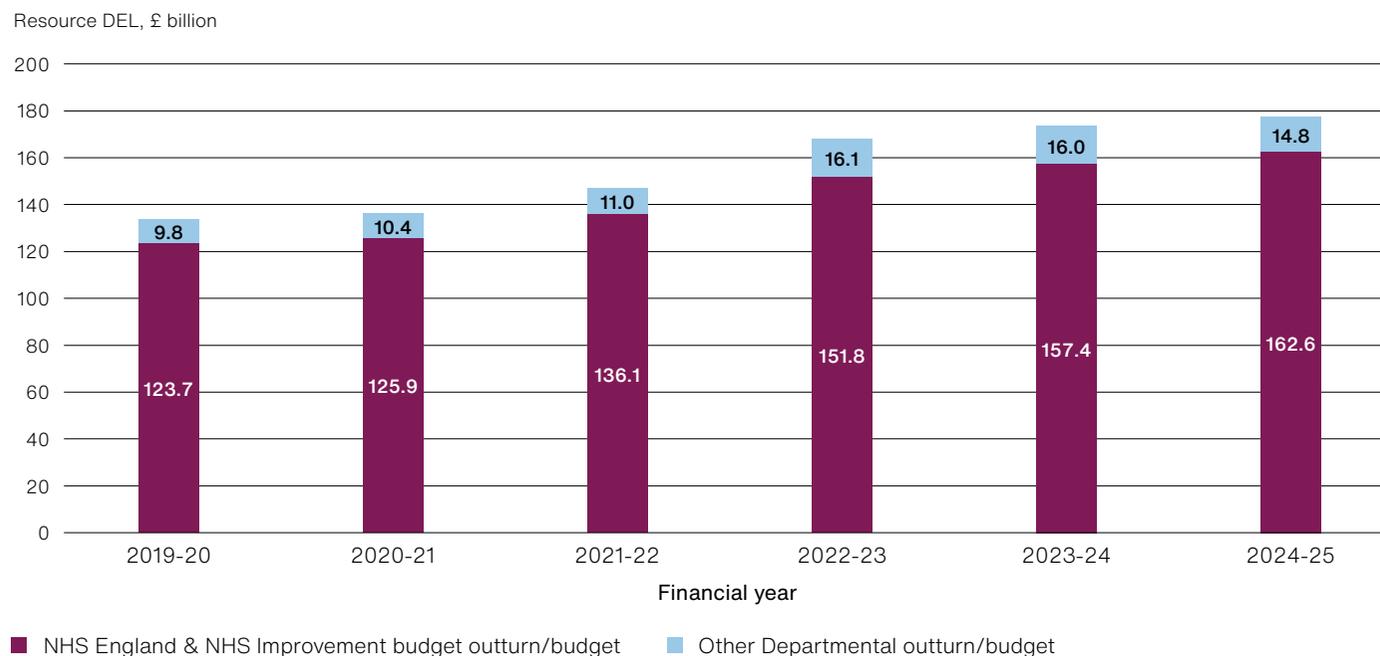
Addressing the backlog – historic and planned spending

NHSE&I's resource spending in 2019-20 was around £124 billion (**Figure 28**).

Of this, around 23%, or £28 billion, is estimated by NHSE&I to have been spent on elective care activity.

Figure 28: Department of Health & Social Care's (the Department's) outturn and budget, 2019-20 to 2024-25

NHS England & NHS Improvement's overall budget in 2019-20 was around £124 billion



Notes

1 These figures do not include Ringfenced COVID-19 Departmental Expenditure Limit (DEL), (£47.4 billion in 2020-21 and £33.8 billion in 2021-22).

2 In addition to Resource DEL and COVID-19 DEL, the Department has budgets for Capital DEL (£9.4 billion in 2021-22, £10.6 billion in 2022-23, £10.4 billion in 2023-24 and £11.2 billion in 2024-25).

Source: National Audit Office analysis of *Autumn Budget and Spending Review 2021*, HM Treasury, October 2021

In September 2021, government announced that an additional £36 billion would be invested in health and social care across the UK over the three years from 2022-23 to 2024-25, to tackle NHS backlogs, reform adult social care and bring the health and social care systems closer together in a sustainable way.

For the NHS in England, this settlement brings additional funding of £8 billion for elective recovery over the period (the additional funding is included in Figure 28). NHS England's revenue funding to 2024-25 will grow by an average of 3.8% a year in real terms.

In return for the extra funding, the government has told the NHS that it expects it to deliver around 30% more elective care activity by 2024-25 than it delivered before the pandemic. This is 10% higher than the increase in activity anticipated by the NHS Long Term Plan (2019), which planned to increase NHS activity by 3.2% per year.

Government has told NHSE&I to set out publicly how it will maximise the elective activity delivered with the available funding, including through what it describes as increased flexibility and embracing innovation.

Addressing the backlog – challenges the NHS faces to increase activity

The government has committed to provide an additional £8 billion funding between 2021-22 and 2024-25 for the recovery of elective care and cancer services. It has said that it expects the NHS to deliver around 30% more elective care activity by 2024-25 than it delivered before the pandemic. Some organisations have suggested that greater funding will be required to clear the known backlog, treat ‘missing’ patients, and return the NHS’s performance on elective care to the 18-week standard. For example, the Health Foundation estimated that almost £17 billion would be needed to achieve these aims.¹

To increase NHS activity, funding needs to be translated into, among other things, increased hospital beds, nurses and doctors beyond the levels already planned for. It can take years to achieve such increases because of the time required for capital projects and for training. In addition, not all NHS providers are starting from the same position, as shown earlier in this report.

Our 2019 report on *NHS waiting times for elective and cancer treatment* used regression analysis to identify typical characteristics of NHS trusts that tended to perform worse when it came to waiting times for elective care.

We found that the poorer-performing NHS trusts tended to be the ones under greater pressure: they had higher levels of bed occupancy, their consultants had to see more patients and their financial deficits were higher. These trusts also tended to perform less well in other services they provided: they saw fewer of their patients in A&E within the standard time of four hours, and fewer of their patients received a diagnostic test within six weeks of referral.

If this remains the case now, it means that the NHS may need to secure the biggest impact in future years from the trusts that have struggled most in the past.

In the second report in this series, we will look at the NHS’s detailed plans for elective and cancer care recovery. We will hope to see fully costed plans by that point that take account of known constraints and are sufficiently flexible to deal with a range of scenarios.

1 The Health Foundation, REAL Centre, Health and social care funding to 2024/25, September 2021.

Addressing the backlog – challenges the NHS faces to increase activity

continued

Based on the evidence we have seen and our analysis to date, including interviews with stakeholders, we think it will be particularly helpful to the NHS if its detailed plans can address the following challenges.

Challenge to increasing activity

Implications for recovery plans

How the NHS will ensure that existing health inequalities are not perpetuated or exacerbated.

NHSE&I will need to ensure a strong focus on all patients in its recovery planning, including assessing how its actions will reduce health inequalities. This includes acting on knowledge of variations in clinical decision-making and operational systems, which can affect outcomes for different types of patient.

How the needs and concerns of long-waiting patients will be addressed.

Local systems will need to maintain good communications with all patients awaiting treatment. They will also need to consider how to communicate their prioritisation criteria.

How best to use GPs without overloading them further.

Local systems will need to work closely with GPs so they use the patient referrals processes optimally and provide appropriate services to patients who are waiting for treatment, while also managing GP workload.

How bed numbers and operating theatre space can be increased quickly in areas with particular shortages.

The Department and NHSE&I need to examine where shortages of beds and operating theatre space will have the biggest limiting effect on recovery and consider whether capital funding and other plans can be adjusted to reduce these shortages before 2024-25.

How elective and cancer care activity can be better maintained if the pandemic and its infection control measures persist or if there are future spikes.

The Department and NHSE&I need to make provision for such uncertainties in the recovery plan. They need to obtain assurance that all local health systems are reserving as much capacity as possible in COVID-free areas for routine care.

Addressing the backlog – challenges the NHS faces to increase activity

continued

Challenge to increasing activity

How staff shortages can be addressed both in the short- and long-term.

How excessive, ongoing pressure on the NHS workforce will be avoided when there is such a backlog of work to do.

How diagnostic services, including screening programmes, can have their capacity boosted, even temporarily, so more of those needing urgent treatment can be identified.

How NHS commissioners and providers can make the best use of the independent sector.

How the interface with the adult social care system can be improved so that patients do not remain in hospital beds longer than they need to.

How expenditure on programmes that prevent serious ill health (for example, smoking cessation, diabetes management) could be targeted better to reduce future waiting lists.

Implications for recovery plans

The Department, NHSE&I and Health Education England need to develop and implement detailed plans to address the shortages in the workforce both over the next 12–36 months and beyond.

A focus on targets or milestones for recovery needs to be balanced nationally and locally with monitoring of the wellbeing of the NHS workforce. This will include using the new People Recovery Task Force.

The plan will need to take account of the lead-in time for increasing diagnostic capacity, and the extent to which increased diagnostic capacity affects the speed with which ‘missing’ patients return to waiting lists.

Having set up a framework to assist procurement from the independent sector, NHS England will need arrangements to monitor carefully how local NHS systems use it, so good practices are identified and shared and unexplained variation and any systemic disincentives are challenged.

The recovery plan needs to place sufficient emphasis and resources on supporting the adult social care sector to receive NHS patients who have been treated and need to be discharged into social care settings.

To be sustainable, the scope of the recovery plan needs to consider additional contributions that existing programmes to improve public health can make to reducing future pressure on elective and cancer care services. This includes engaging in local partnerships with organisations outside the NHS.

Our approach and methodology

We **interviewed officials at the Department of Health & Social Care (the Department) and NHS England & NHS Improvement (NHSE&I)** to understand the respective organisational responsibilities for the elective and cancer care, performance monitoring and how they are developing a response.

We **interviewed Departmental and NHSE&I officials** about health inequalities and the impact longer waiting lists and backlogs have on inequitable outcomes.

We **interviewed the Department's and NHSE&I's** modelling teams about the referral-to-treatment models that they have developed to project the likely size of the backlog.

We **interviewed NHSE&I officials** and the Independent Healthcare Providers Network about the role of independent health providers during the pandemic.

We **interviewed officials** from the Parliamentary and Health Service Ombudsman, and **stakeholders** from Macmillan Cancer Support and the Patients Association about the impact on patients.

We **interviewed leaders in stakeholder organisations** about the operational impact of the backlogs in elective and cancer care and the challenges that the pandemic has brought to the NHS. We **interviewed experts** on healthcare waiting times to gain a greater understanding of the impacts of long waiting times. These organisations included:

- British Medical Association
- NHS Confederation
- NHS Employers
- NHS Providers
- Royal College of Surgeons of England
- Dr Rob Findlay, Insource Ltd

- The King's Fund
- The Health Foundation
- The Nuffield Trust

We **reviewed** the government's white paper proposals for the reform of health and social care, the Autumn Budget and Spending Review 2021, Departmental briefing papers, questions and responses in Parliament.

We **reviewed documents and published literature** from the Department and NHSE&I, and other stakeholders, including the NHS Long Term Plan, the NHS People Plan, clinical guidance, NHSE&I board papers and minutes, official letters from NHSE&I to NHS trusts and foundation trusts, waiting times standards, annual reports, NHS operational and planning guidance, frameworks and tools.

We **reviewed briefing papers and research** such as:

- the Royal College of Surgeons of England's report, *New Deal for Surgery*;
- NHS Providers' submission to the National Audit Office with results of a survey of NHS trust leaders (July 2021) with responses from 170 leaders from 119 trusts;
- The King's Fund research paper, *Cutting Waiting Times*;
- The Health Foundation's briefing paper, *The future of the NHS hospital payment system in England*; and
- The Health Foundation's data analysis on *Waiting for care: Understanding the pandemic's effects on people's health and quality of life*.

Our approach and methodology *continued*

We **analysed data** published on NHSE&I's and NHS Digital's websites. These datasets include:

- elective waiting times;
- cancer waiting times;
- accident and emergency waiting times; diagnostic waiting times;
- bed availability and occupancy;
- outpatient referrals;
- appointments in general practice;
- COVID-19 hospital activity data; and
- COVID-19 daily situation reports.

Other published data that we **analysed** includes government data published on the gov.uk website about healthcare in England (for example, the UK Coronavirus Dashboard) and Organisation for Economic Co-operation and Development (OECD) data on health care.

We **analysed** data from NHSE&I on its use of the independent healthcare sector during the pandemic.

How we **modelled** our projection of the waiting list size:

- We used NHS data about the waiting list size to create two main scenarios.
- **Scenario 1:** the NHS is able to maintain 100% of the activity planned in the **NHS Long Term Plan (LTP) (at 3.2% growth per year)**, written before the pandemic.
- **Scenario 2:** the NHS performs at a 30% higher level than had been delivered before the pandemic and as announced in the **Building Back Better command paper**.
- We then created a range of outcomes by thinking about how many of the patients for whom there had been a 'missing' referral during the pandemic would now present for treatment.
- 'Missing' referrals were calculated as the difference between those referrals that have presented to date and a counterfactual of LTP growth levels of 3.2% per annum, adjusted for working days.
- The number of patients presenting for treatment now and in the future, was calculated to include between one-quarter and three-quarters of **all the estimated number of patients who would have been referred to the NHS if the pandemic had not happened**.
- We looked at the rate of recovery of referrals between August 2020 and July 2021 towards the numbers anticipated under the LTP.
- We then applied this rate of referrals recovery to the projection, which means that the projection shows that the NHS returns to the anticipated LTP levels of elective referrals from April 2022.
- For scenario 2, using government's stated aim that "the NHS in England can aim to deliver around 30% more elective activity by 2024-25 than it was before the pandemic" we assume that this increase builds up as 5% above pre-pandemic levels in 2022-23, 15% above pre-pandemic levels in 2023-24 and 29% above pre-pandemic levels in 2024-25.

Elective waits – variation by sub-regional health geography, September 2021

Sub-regional health geography	Percentage waiting more than 18 weeks	Total above 18 weeks	Percentage waiting more than 52 weeks	Total above 52 weeks	Total waiting list
Birmingham and Solihull	51%	93,108	12%	22,479	183,230
Leicester, Leicestershire and Rutland	46%	50,807	11%	12,068	109,715
Devon	44%	61,986	9%	11,986	139,953
Herefordshire and Worcestershire	43%	36,277	10%	8,353	84,429
Norfolk and Waveney	42%	44,546	12%	12,768	106,014
Lincolnshire	39%	33,358	4%	3,205	85,161
Shropshire and Telford and Wrekin	39%	19,638	8%	3,983	50,227
Greater Manchester	39%	135,023	6%	21,728	345,505
Buckinghamshire, Oxfordshire and Berkshire West	37%	48,484	6%	7,581	130,634
Staffordshire and Stoke-on-Trent	37%	49,499	5%	6,491	134,551
Cambridgeshire and Peterborough	36%	30,100	6%	5,204	84,627
Dorset	35%	24,885	6%	4,246	70,713
North London	35%	51,322	6%	8,175	148,251
Hertfordshire and West Essex	35%	51,087	5%	7,081	147,821
Coventry and Warwickshire	35%	31,859	6%	5,553	92,253
Somerset	35%	17,235	5%	2,559	49,936
Humber, Coast and Vale	34%	49,922	6%	9,402	147,262
Bedfordshire, Luton and Milton Keynes	34%	32,580	4%	3,577	96,923
Derbyshire	33%	30,969	6%	5,781	92,640
East London	33%	64,243	5%	9,894	195,744
Mid and South Essex	33%	42,668	4%	4,788	130,475
Cheshire and Merseyside	33%	74,065	5%	10,801	227,695
Suffolk and North East Essex	32%	28,964	5%	4,134	90,726
Sussex	32%	63,291	3%	6,960	200,600

Elective waits – variation by sub-regional health geography, September 2021

continued

Sub-regional health geography	Percentage waiting more than 18 weeks	Total above 18 weeks	Percentage waiting more than 52 weeks	Total above 52 weeks	Total waiting list
Hampshire and the Isle of Wight	31%	44,747	4%	5,881	142,600
Kent and Medway	30%	51,171	4%	6,093	168,168
Bristol, North Somerset and South Gloucestershire	30%	21,457	5%	3,353	70,914
West Yorkshire and Harrogate	30%	61,990	5%	9,578	205,830
Lancashire and South Cumbria	30%	49,865	6%	9,194	166,038
Frimley	30%	16,277	2%	1,309	54,206
The Black Country and West Birmingham	29%	41,435	4%	5,531	141,311
Cornwall and the Isles of Scilly	29%	14,314	5%	2,271	48,900
South East London	29%	49,021	2%	4,036	168,656
Nottingham and Nottinghamshire	29%	26,013	4%	3,931	90,322
Bath and North East Somerset, Swindon and Wiltshire	29%	20,779	3%	2,108	72,755
North West London	28%	56,680	2%	4,563	203,554
Gloucestershire	26%	15,132	3%	1,621	59,219
Cumbria and North East	25%	69,303	4%	9,836	275,320
Surrey Heartlands	23%	20,345	1%	896	88,660
Northamptonshire	23%	13,171	2%	1,100	57,478
South Yorkshire and Bassetlaw	22%	29,908	2%	2,444	135,026
South West London	21%	27,383	1%	1,322	133,487

Note

¹ The commissioner statistics for elective care in September 2021 include 159,704 pathways where the commissioner is NHS England. These pathways are not attributed to the sub-regions.

Source: National Audit Office analysis of NHS England's published elective statistics

Cancer care – variation by sub-regional health geography, September 2021

Sub-regional health geography	Patients who took longer than 62 days as a percentage of the total	Patients who took longer than 62 days to complete the GP urgent pathway	Total patients completing 62-day GP urgent pathways in September 2021
Birmingham and Solihull	57%	145	255
Leicester, Leicestershire and Rutland	51%	151	294
Norfolk and Waveney	45%	154	341
Mid and South Essex	45%	127	285
Staffordshire and Stoke-on-Trent	43%	140	324
The Black Country and West Birmingham	42%	101	238
Coventry and Warwickshire	42%	107	256
Herefordshire and Worcestershire	41%	99	243
Bristol, North Somerset and South Gloucestershire	40%	98	246
Derbyshire	40%	110	277
Shropshire and Telford and Wrekin	40%	69	174
Cambridgeshire and Peterborough	38%	79	206
North London	37%	90	242
Cumbria and North East	37%	323	883
Humber, Coast and Vale	36%	167	464.5
Lincolnshire	36%	97	271
South East London	35%	115	333
Lancashire and South Cumbria	33%	162	485
Nottingham and Nottinghamshire	33%	102	307
South Yorkshire and Bassetlaw	33%	113	342
Sussex	31%	181	583
Devon	31%	137	442
Greater Manchester	31%	196	642

Cancer care – variation by sub-regional health geography, September 2021

continued

Sub-regional health geography	Patients who took longer than 62 days as a percentage of the total	Patients who took longer than 62 days to complete the GP urgent pathway	Total patients completing 62-day GP urgent pathways in September 2021
Northamptonshire	30%	53	174
West Yorkshire and Harrogate	30%	194	644.5
Gloucestershire	29%	52	178
North West London	29%	102	352
Suffolk and North East Essex	27%	95	356
Bath and North East Somerset, Swindon and Wiltshire	27%	70	263
Dorset	27%	80	301
Bedfordshire, Luton and Milton Keynes	27%	72	271
Cheshire and Merseyside	26%	184	696
East London	26%	68	262
Buckinghamshire, Oxfordshire and Berkshire West	25%	125	499
Hertfordshire and West Essex	25%	81	324
Somerset	24%	52	217
South West London	23%	71	305
Hampshire and the Isle of Wight	22%	118	544
Frimley	21%	41	197
Kent and Medway	20%	109	546
Cornwall and the Isles of Scilly	20%	46	233
Surrey Heartlands	20%	60	307

Notes

- Halves (464.5 and 644.5) are included in the table for two sub-regions because North Yorkshire CCG is listed as a partner of the Humber, Coast and Vale ICS and the West Yorkshire and Harrogate ICS, so its commissioned pathways are divided equally between these sub-regions.
- The commissioner statistics for cancer care in September 2021 include 52 pathways as “Unknown” and 11 as “National Commissioning Hub 1”. These pathways are not attributed to the sub-regions.



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