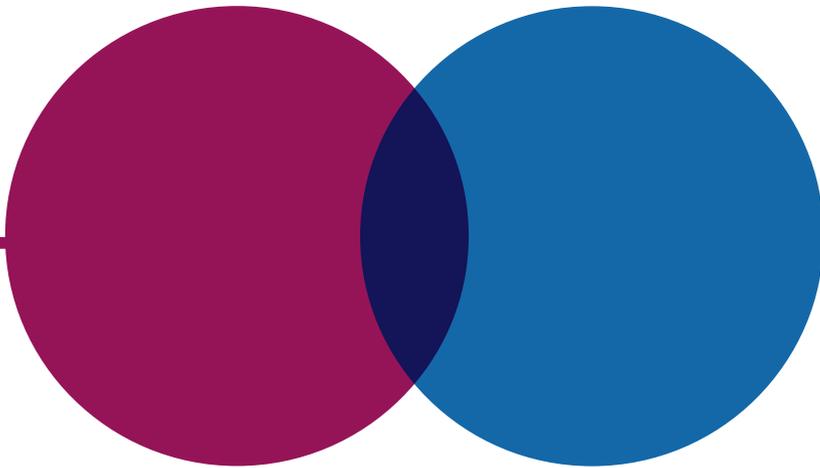




National Audit Office



REPORT

Managing NHS backlogs and waiting times in England

Department of Health & Social Care
and NHS England

SESSION 2022-23
17 NOVEMBER 2022
HC 799



We are the UK's independent public spending watchdog.

We support Parliament in holding government to account and we help improve public services through our high-quality audits.

The National Audit Office (NAO) scrutinises public spending for Parliament and is independent of government and the civil service. We help Parliament hold government to account and we use our insights to help people who manage and govern public bodies improve public services.

The Comptroller and Auditor General (C&AG), Gareth Davies, is an Officer of the House of Commons and leads the NAO. We audit the financial accounts of departments and other public bodies. We also examine and report on the value for money of how public money has been spent.

In 2021, the NAO's work led to a positive financial impact through reduced costs, improved service delivery, or other benefits to citizens, of £874 million.



National Audit Office

Managing NHS backlogs and waiting times in England

**Department of Health & Social Care
and NHS England**

Report by the Comptroller and Auditor General

Ordered by the House of Commons
to be printed on 15 November 2022

This report has been prepared under Section 6 of the
National Audit Act 1983 for presentation to the House
of Commons in accordance with Section 9 of the Act

**Gareth Davies
Comptroller and Auditor General
National Audit Office**

14 November 2022

Value for money reports

Our value for money reports examine government expenditure in order to form a judgement on whether value for money has been achieved. We also make recommendations to public bodies on how to improve public services.

The material featured in this document is subject to National Audit Office (NAO) copyright. The material may be copied or reproduced for non-commercial purposes only, namely reproduction for research, private study or for limited internal circulation within an organisation for the purpose of review.

Copying for non-commercial purposes is subject to the material being accompanied by a sufficient acknowledgement, reproduced accurately, and not being used in a misleading context. To reproduce NAO copyright material for any other use, you must contact copyright@nao.org.uk. Please tell us who you are, the organisation you represent (if any) and how and why you wish to use our material. Please include your full contact details: name, address, telephone number and email.

Please note that the material featured in this document may not be reproduced for commercial gain without the NAO's express and direct permission and that the NAO reserves its right to pursue copyright infringement proceedings against individuals or companies who reproduce material for commercial gain without our permission.

Links to external websites were valid at the time of publication of this report. The National Audit Office is not responsible for the future validity of the links.



Contents

Key facts 4

Summary 5

Part One

Elective recovery plan 14

Part Two

Implementing the recovery plan 26

Part Three

Early results and ongoing risks 39

Appendix One

Our evidence base 54

This report can be found on the National Audit Office website at www.nao.org.uk

If you need a version of this report in an alternative format for accessibility reasons, or any of the figures in a different format, contact the NAO at enquiries@nao.org.uk

The National Audit Office study team consisted of:

Alex Farnsworth, John Fellows, Dounia Foster-Hall and Paul Wright-Anderson, under the direction of Tim Phillips.

For further information about the National Audit Office please contact:

National Audit Office
Press Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

 020 7798 7400

 www.nao.org.uk

 @NAOorguk

Key facts

5.8mn

patients waiting for elective care, September 2021

7.0mn

patients waiting for elective care, August 2022

102%

NHS England's (NHSE's) internal target for completed elective pathways in 2022-23, relative to 2019-20

95%

elective activity actually achieved in hospitals in the first five months of 2022-23, relative to the same months in 2019-20

2,600

number of elective patients waiting for two years or more, August 2022

387,000

number of elective patients waiting for more than one year, August 2022

2,746,000

number of elective patients waiting for more than the legal standard of 18 weeks, August 2022

72,000

number of cancer patients treated following an urgent GP referral in the first five months of 2022-23 (compared with 69,000 patients in the same period in 2019-20)

27,000

number of cancer patients first treated later than the operational standard of 62 days after an urgent GP referral in the first five months of 2022-23 (compared with 15,000 patients in the same period in 2019-20)

129%

NHS recovery plan target for elective activity in 2024-25, relative to 2019-20

62%

percentage of integrated care systems (26 out of 42) whose plans show they expect to miss the elective activity target required by NHSE in 2022-23

88

new community diagnostic centres opened by September 2022

£14 billion

capital and resource funding allocated to support the recovery of elective and cancer services, 2022-23 to 2024-25

3.3%

real-terms annual rate of increase in the overall NHSE resource budget for the period 2022-23 to 2024-25, based on HM Treasury GDP deflators in September 2022

Summary

1 At the start of the COVID-19 pandemic, the NHS in England had not met its elective waiting time performance standard for four years, nor its full set of eight operational standards for cancer services for six years. Due to the pandemic, the number of people receiving elective and cancer care then reduced sharply. Between March 2020 and August 2022, on average there were 8,300 COVID-19 patients in hospital in England at any one time with peaks in this number during waves of infection. Backlogs of patients, both visible on waiting lists and hidden because they had not yet seen a doctor, grew rapidly.

2 In February 2022, NHS England (NHSE) published a plan to recover elective and cancer care over the three years up to March 2025.¹ It has received funding for this recovery, which is taking place at a time when the NHS is managing other major pressures, including ongoing effects of the COVID-19 pandemic, access to primary care, the performance of urgent and emergency care, workforce gaps, and problems with the supply of adult social care.

Scope of this report

3 This is our second report on backlogs for elective and cancer care. The first, *NHS backlogs and waiting times in England* (December 2021), examined how and why backlogs had increased. This report examines:

- the design of NHSE's recovery plan (Part One);
- how the NHS has been implementing the plan (Part Two); and
- the early results, and the ongoing risks NHSE has to manage (Part Three).

The report does not examine the roles of primary care or adult social care in supporting the recovery of elective and cancer care.

4 Our high-level criteria for assessing value for money in this report are that: NHSE's recovery plan should contain clear, achievable objectives; NHSE's recovery programme should be managed as a coherent package of well-designed initiatives; and there should be timely achievement of planned improvements in NHS activity levels and waiting times.

¹ NHS England and NHS Improvement were merged on 1 July 2022 to become a single organisation called NHS England. For simplicity, this report refers to NHS England throughout.

Key findings

Design of the recovery plan

5 The recovery plan for elective and cancer care focuses on reducing the longest waits by March 2025, but even if the targets in the recovery plan are achieved many patients will still be waiting longer than NHS standards say they should. According to the NHS recovery plan, by March 2025 no patient will have been waiting more than 52 weeks for elective care, and by March 2023 waiting times for urgent GP referrals for cancer care will have returned to the pre-pandemic level. Achieving these targets would represent a significant improvement on what patients currently experience but is a long way short of the standards for waiting times set in NHS regulations (paragraphs 1.6 to 1.8, and Figure 1).

6 NHSE is aiming to increase elective activity sharply to reach 129% of the 2019-20 level in 2024-25, which would require a rate of growth not seen in recent times.² At its lowest during the pandemic, between April and August 2020, elective care activity dropped to just 52% of the level in 2019-20. In the first five months of 2022-23, the level of activity had increased substantially but remained below 100%, at 95%. To return to the 2019-20 level and then reach 129% within three years would be an historic feat. For comparison, before the pandemic it took the NHS five years (2013-14 to 2018-19) to increase completed elective pathways by 18%. Ordinarily, such a large jump would require not just better use of existing assets but also sustained increases in NHS workforce and infrastructure, which tend to take years to bring about. Additionally, NHSE has not been able to demonstrate to us that increasing elective activity to 129% would be sufficient to meet the recovery plan's commitments to end the longest waits by March 2025 (paragraphs 1.9 to 1.11 and 3.3).

² A 'completed elective pathway' occurs when a patient who has been referred to a consultant for possible treatment either starts treatment or is discharged where treatment is not considered appropriate.

7 Inflation has eroded the value of both the £14 billion specifically allocated to elective recovery and wider planned increases in the NHS budget; NHS funding is set to grow by less than the long-term average over the next three years. The government announced an additional £8 billion of resource and £5.9 billion of capital funding for recovery between 2022-23 and 2024-25. At the time of the October 2021 Budget, NHSE's total resource funding settlement, including the £8 billion resource funding for recovery, provided for average annual growth of 3.8% in real terms up to 2024-25 (if temporary pandemic-related funding is excluded from the 2021-22 baseline year). This increase was just below the 4.0% real-terms average annual growth in UK health spending between 1999-2000 and 2019-20. However, we estimate, based on HM Treasury's inflation forecasts (GDP deflators), that by September 2022 the same settlement was set to represent average annual growth of just 3.3% in real terms. NHSE has opted not to produce a detailed costed version of its recovery plan to show how it expects all of the £14 billion will be spent. This is because resource funding is devolved to local NHS systems, which submit an annual plan of how they intend to use it. NHSE works with local systems to determine how capital funding is best allocated to deliver national priorities while also addressing local needs (paragraphs 1.15, 1.17, 1.18 and 1.23).

8 NHSE's elective recovery programme partly relies on initiatives which have potential but for which there is so far limited evidence of effectiveness:

- **NHSE wants GPs to handle many elective cases previously dealt with by hospital doctors.** Instead of referring some patients for elective care, GPs manage them within the primary care system after receiving advice and guidance from hospital doctors, who also confirm that a referral is not required. The recovery plan aims for 1.7 million elective referrals to be avoided in this way in 2022-23, rising to 2.0 million in 2023-24. If achieved, this would account for around one-quarter of the planned increase in elective activity over three years. The initiative might mean more work for GPs but the fully-qualified permanent GP workforce decreased by 4% between 2017 and 2022. NHSE told us it is monitoring the impact on different workforces (paragraphs 1.24 and 2.32, and Figure 2).
- **Surgical hubs and community diagnostic centres (CDCs) can contribute to recovery but their impact in the current context will need to be closely monitored.** These two programmes can contribute to elective recovery by improving efficiency and access to services. They may provide resilience by allowing elective care to continue on physically separate 'cold sites' when other parts of hospitals struggle with high rates of bed occupancy or other kinds of patient demand. However, both hubs and CDCs rely on adequate staffing, and key staff could still be diverted to other parts of hospitals at busy times. NHSE currently has limited evidence on hubs' and CDCs' ability to continue operating when their host hospital or wider local area is under significant pressure (paragraphs 1.24, 2.22 and 2.29, and Figure 4).

Implementation of the recovery programme and early results achieved

9 NHSE introduced its recovery plan later than expected in February 2022 and key aspects of governance and oversight have taken longer to set up. A recovery plan was originally intended for publication in November 2021. Its publication was delayed until February 2022, in part because of the Omicron surge in COVID-19 cases. NHSE was slow in building up a centralised programme management office, set up in autumn 2021 but with only seven out of 21 posts filled by the end of May 2022; and it still did not have the capability to report fully on performance in August. In particular, NHSE could only report the current status of 19 out of the 47 indicators in its elective recovery programme dashboard, making it difficult for senior leaders to assess progress and take appropriate action (paragraphs 1.4, 2.4 and 2.7).

10 During 2022-23, the NHS has been operating in a tougher context than the Department of Health & Social Care (DHSC) and NHSE had assumed would be the case. The Omicron variant of COVID-19 and its subvariants put pressure on NHS services for longer than NHSE had allowed for in its plans. For example, NHS staff sickness absence was nearly two percentage points higher from January to April 2022 than it was before the pandemic. The flow of patients through hospitals, and therefore the NHS's ability to treat more patients, has also been restricted by difficulties moving patients both within hospitals and out of hospitals into adult social care. One result of all this has been an increase of one day in the average length of overnight stays in hospital by non-elective patients in 2022 compared with 2019 (paragraph 3.5).

11 By the July 2022 deadline that NHSE set, the NHS had come close to ending waits of more than two years for elective care. At the start of the recovery, NHSE and the NHS as a whole understandably focused on those patients who had been waiting for extremely long periods of time; their efforts have had some success. In February 2022, around 23,300 patients had been waiting for more than two years. By the end of July, this had reduced to around 2,900. Of those still waiting, NHSE judged some 2,600 patients to be "very complex" (including some who had had COVID-19 in the run-up to July) or to have declined viable offers of treatment. The total number of two-year waiters had reduced further to around 2,600 in August. NHSE told us the remaining patients would be treated on the basis of clinical need and patient choice, and that it had not set a new target date for all two-year waiters to be cleared. NHSE accepts that some of the approaches taken to arrange treatment for two-year waiters will not be scalable for subsequent long-waiter targets, due to the much greater numbers involved (paragraphs 1.5, 2.11 and 3.8 to 3.10).

12 The NHS has achieved mixed progress with major initiatives to increase activity.

- **The NHS has successfully increased its use of independent healthcare providers.** Between the start of April and August 2022, the NHS was on track to achieve its target to increase the use of independent providers for elective care, including diagnostics and day-case activity, to reach more than 120% of the level seen in the equivalent period in 2019-20. It is important to note that this remains a relatively small proportion of all NHS elective activity: around 8% in 2019-20 (growing to an estimated 9% if the 120% increase is achieved throughout 2022-23). NHSE has a framework arrangement for contracting with the independent sector, which it expects to be used for around £10 billion-worth of work over the four years from November 2020 (paragraphs 2.23 to 2.26).
- **By September 2022, the NHS had 88 CDCs (with the first opening in July 2021) and there were 89 surgical hubs, but, based on available data, activity in these facilities was still below planned levels.** In May 2022, elective activity for all 'high volume, low complexity' procedures (which includes those carried out at surgical hubs) was at only 85% of pre-pandemic levels. New CDCs have performed a total of 1.8 million tests between July 2021 and the start of September 2022, which is 96% of the planned amount. They will need to carry out another 1.9 million tests to reach the diagnostic target set for March 2023 (paragraphs 2.21, 2.22 and 2.28).
- **According to their operational plans, most local NHS integrated care systems (ICSs) are not intending to meet a March 2023 target for reducing outpatient appointments.** Local NHS officials we spoke to are generally supportive of initiatives to free up clinical resources by reforming outpatient services. NHSE has set a target for a minimum 25% reduction in outpatient follow-up appointments by March 2023. But in the local plans submitted to NHSE only five out of 42 ICSs said they would meet this target (paragraphs 2.30 to 2.32).
- **Better progress than expected is being made in avoiding referrals and replacing them with GP-led treatment under the guidance of hospital doctors.** From April to June 2022, GPs were seeking advice and guidance instead of a referral for 22 patients per 100 first outpatient appointments, compared with a target of 16 patients. NHSE expects this to result in the avoidance of a referral in around half of cases (paragraphs 2.30 and 2.31).

13 The NHS now has a problem with reduced productivity. NHS officials both nationally and locally have expressed concern about reduced overall productivity, meaning the same staff and infrastructure are currently completing less work than before the COVID-19 pandemic. NHSE has estimated that, in 2021, the NHS was around 16% less productive than before the pandemic. Some of this results directly from the pandemic, for example increased sickness absence and infection prevention and control measures. An internal NHSE review has identified a range of other causes, including reduced willingness to work paid or unpaid overtime and reduced management focus on cost control and operational rigour as the NHS sought to maximise activity. It believes that reduced productivity has continued in 2022-23. Some of NHSE's new initiatives, such as surgical hubs and the transformation of outpatient services, are intended to improve productivity (paragraph 3.21 and Figure 4).

14 The overall level of elective activity has remained below pre-pandemic levels and is below NHSE's trajectory for reaching 129% of the 2019-20 level by 2024-25, with more than half of NHS areas not expecting to meet the initial target for 2022-23. NHSE's plan for elective recovery is to reduce the waiting list by increasing the number of people treated, while avoiding as many new referrals as possible where people can be treated effectively by their GP. The goal in 2022-23 was for the number of patients treated (completed elective pathways) to reach 102% of the 2019-20 level. In the first five months of 2022-23, it stood at just 95%. NHSE has developed a new metric for internal planning purposes called value-based activity. This factors in the different costs of different types of elective activity (inpatient and outpatient follow-up, for example) to incentivise the changes NHSE would like to encourage to outpatient activity. For 2022-23, according to this measure, NHSE requires all 42 local NHS ICSs to deliver 104% of the 2019-20 level. In their plans, 26 of the 42 have signalled that they will not reach this target (paragraphs 1.9, 1.12 to 1.14, 1.21, 3.2 to 3.4, and Figure 2).

15 As predicted, the elective waiting list has continued to increase and more patients are waiting more than a year. The recovery plan anticipated that the waiting list was likely to increase in the short term. The elective waiting list has increased steadily from 5.8 million patients in September 2021 to 7.0 million in August 2022.³ By August, some 387,000 patients had already waited longer than a year for treatment, compared with just 1,600 in February 2020 (paragraphs 2.11, 3.6 and 3.7 and Figure 10).

³ The elective care system counts the number of pathways, rather than the number of people. NHS England estimated that the July 2021 waiting list of 5.6 million pathways comprised around 4.9 million waiting individuals. In this report we follow the convention of referring to 'the number of patients' on the elective waiting list.

16 The number of urgent referrals for suspected cancer has increased compared with 2019-20, which is positive, but the NHS is not treating all cancer patients in a timely way and people are experiencing record waits. The NHS has explicitly encouraged people with potential cancer symptoms to visit their GP so those who do have cancer may be identified earlier. Between April and August 2022, GPs urgently referred 15% more people with suspected cancer than in the same period in 2019. However, given that urgent referrals for cancer were increasing annually by 10% before the pandemic, it is still unclear to what extent this means people with possible cancer symptoms who did not go to the NHS in the pandemic have now returned. The welcome increase in patients coming forward has, however, highlighted the inadequacy of current diagnostic and treatment capacity. In 2022-23 up to the end of August, only 62% of patients started treatment within 62 days, compared with a required performance standard of 85% and performance of 78% in the equivalent period in 2019. In the first five months of 2022-23, 8,100 people urgently referred for suspected cancer received their first treatment after waiting more than 104 days (paragraphs 2.13 to 2.16, 3.12, 3.13, and Figure 11).

Future risks and challenges

17 Improving elective and cancer services at the pace and in the way NHSE plans is far from guaranteed, with many risks and challenges threatening to push the recovery further off track:

- **The NHS workforce continues to have high numbers of unfilled posts and morale has worsened.** In February 2022, the NHS had around 90,000 (8%) more full-time equivalent staff than it had in February 2020, but the vacancy rate was one percentage point higher, meaning it was also carrying 17,500 more vacancies in March 2022 than it had in March 2020. Additionally, in surveys staff reported lower morale than before the pandemic (paragraphs 3.18 and 3.19).
- **The recovery plan promises a 'fair recovery' with a focus on reducing health inequalities, but there is a risk of inequalities worsening.** Research covering the period April 2020 to July 2021 indicated that patients in the most deprived areas were nearly twice as likely to wait more than a year for treatment than patients in the least deprived areas. Some groups are also less likely or less able to seek healthcare. For such groups, initiatives to reduce demand for elective care, in particular a move to require patients themselves to initiate certain types of follow-up appointment, could exacerbate inequalities. NHSE is aware of the need to manage this risk (paragraphs 3.25 to 3.27).

18 It is DHSC's job to hold NHSE to account for NHS performance, but some key metrics for measuring the recovery are hard to understand and could be applied inconsistently. NHSE has publicly committed to increase elective activity to “around 130%” of the 2019-20 level by 2024-25 (129% for operational planning purposes), but it has converted this commitment to a 118% ‘value-based activity’ target for NHS ICSs. This new measure includes the different costs of different types of elective activity to incentivise the changes to outpatient services that NHSE wants to encourage, but NHSE does not report the measure publicly. NHSE has also not defined clearly which patients are to be considered out of scope for its long-waits targets, for instance because it regards them as “very complex” cases. In both instances, there is a risk that definitions will be applied inconsistently or even illegitimately across the system, masking the true progress the NHS is making and meaning it is harder to hold it to account (paragraphs 1.3, 1.9, 1.14, 3.10 and 3.28, and Figure 2).

Conclusion

19 The timeliness of NHS elective and cancer care worsened before 2020 and then to a significantly greater extent during the COVID-19 pandemic. NHSE has put in place a recovery plan, with clear objectives. DHSC allocated additional funding and NHSE is implementing programmes to increase both capacity and the efficient use of resources. Local NHS ICSs have a degree of flexibility in how they apply these programmes depending on their circumstances. Officials, clinicians and managers both nationally and locally are committed to improving the service patients experience. Nevertheless, activity so far in 2022 has continued to lag behind the pre-pandemic level and is well below the planned trajectory. To a significant degree, this is due to an operating context that is more difficult than NHSE allowed for in its plans.

20 The NHS's funding package is being eroded by inflation, so that its overall funding up to 2024-25 is set to grow more slowly than the long-term average in real terms. Given progress to date, we are concerned that the 129% activity target and the target to eliminate all waits of longer than 52 weeks by 2025 are at serious risk of not being achieved. There are significant threats to the recovery, including the effects of strain on the workforce, uncertainties about whether new initiatives will be able to deliver results as quickly as NHSE needs them to, and the pressures elsewhere in the NHS and adult social care. If the recovery programme is to deliver value for money NHSE will need to manage the programme in line with best practice. It will need to ensure that all component initiatives are well integrated with one another and that it is agile in responding to results and challenges as they emerge, including supporting local systems to make best use of recovery funding. DHSC has an essential part to play too in holding the NHS to account, providing support and challenge as needed.

Recommendations

- 21** We make the following recommendations to assist DHSC and NHSE with implementing their plans for recovery.
- a** NHSE should improve its reporting indicators so it has a full set in place by the start of April 2023 at the latest. It should develop new indicators to take account of key risks (such as worsening health inequalities or health outcomes) and critical enablers within individual programmes (for instance, workforce availability, which is crucial to several initiatives).
 - b** Before April 2023, DHSC and NHSE should agree and publish guidance that explains clearly and fully how they define and report high-level metrics for increasing NHS activity and reducing long waits to ensure that they are transparent and consistently applied.
 - c** Before April 2023, NHSE should set up independent evaluations of its major elective recovery programmes so that it is actively developing the evidence base for these initiatives.
 - d** In Quarter 1 of 2023-24 NHSE should review the elective and cancer recovery actions it took in 2022-23, to assess progress and any unintended effects. At the same time, DHSC and NHSE should determine whether elective recovery targets and trajectories need to be adjusted, and how to allocate recovery funding, for future years based on actual performance in 2022-23.
 - e** During 2023-24, NHSE should publish a report to improve transparency on the progress it is making with the recovery of elective and cancer care. This should include an assessment of the results of its major recovery initiatives, including its approaches to reducing cohorts of long-waiters, CDCs, surgical hubs, outpatient transformation, and increasing specialist advice and guidance. NHSE should then consider whether the report should become annual for the duration of the recovery.
 - f** In 2024-25, with the benefit of two years of managing elective recovery, DHSC and NHSE should develop a long-term plan for returning elective and cancer services to a state in which legal and operational waiting time standards are met. DHSC should publish the plan so the public can understand at a high level how the recovery will continue after March 2025.

Part One

Elective recovery plan

1.1 In 2020 the NHS in England entered the COVID-19 pandemic after four years in which it had not met its most important elective waiting time performance standard, and after six years in which it had not met its full set of eight operational standards for cancer services. At the start of the pandemic, the number of people receiving elective and cancer care fell sharply. Between March 2020 and August 2022, on average, there were 8,300 COVID-19 patients in hospital at any one time with peaks in spring 2020, winter 2020-21, winter 2021-22 and summer 2022. Backlogs, both visible (7.0 million patients on the elective waiting list by August 2022) and hidden (people with health problems who did not see a GP), grew rapidly.

1.2 NHS England (NHSE) published a recovery plan to improve elective and cancer care in February 2022. This part of the report examines the recovery plan's aims and design. The scale of the challenge was described in detail in our December 2021 report.⁴

1.3 NHSE is an arm's-length body of the Department of Health & Social Care (DHSC), which is responsible for setting the direction of health policy in England and for overseeing the work of the NHS. NHSE is the overall manager of the NHS in England, funding and monitoring the 42 local NHS systems (integrated care boards as part of integrated care systems or ICSs). These 42 ICSs plan and deliver NHS services in their areas, including NHS trusts (which run hospitals) and GP practices. Following NHSE operational requirements and guidance, the ICSs prepare their own operational plans, which reflect local circumstances and needs. They have some flexibility to determine how to engage with the recovery plan, but there are many requirements that are mandatory. The National Audit Office reported on the set up of ICSs in October 2022.⁵

⁴ Comptroller and Auditor General, *NHS backlogs and waiting times in England*, Session 2021-22, HC 859, National Audit Office, December 2021. Available at: www.nao.org.uk/reports/nhs-backlogs-and-waiting-times-in-england/

⁵ Comptroller and Auditor General, *Introducing Integrated Care Systems*, Session 2022-23, HC 655, National Audit Office, October 2022. Available at: www.nao.org.uk/reports/introducing-integrated-care-systems-joining-up-local-services-to-improve-health-outcomes/

Development of the recovery plan

1.4 Government set out its intention to tackle the elective care backlog and improve cancer services in the September 2021 policy paper *Build Back Better: Our Plan for Health and Social Care*. In autumn 2021 NHSE, in consultation with DHSC, developed an elective recovery plan, which included cancer as a subset of elective care. NHSE intended to publish this plan in November 2021 but publication was delayed in part due to the Omicron variant of COVID-19. In February 2022, NHSE published its *Delivery plan for tackling the COVID-19 backlog of elective care*.

Key performance targets

1.5 The recovery plan is centred on clear targets with deadlines for improving the performance of both elective and cancer care up to the end of March 2025 (**Figure 1** overleaf) with a focus on what it calls “unacceptably long waits”.

These targets relate to the speed with which patients should be diagnosed or treated, but are distinct from, and do not replace, the statutory and operational standards which have existed throughout the last decade. Although the plan does not cover primary care and urgent and emergency care, challenges faced in these and other parts of the NHS will affect performance in elective and cancer care.

1.6 Since 2008 (and in NHS regulations since 2013), the standard for elective care has required that 92% of patients on the waiting list should wait no more than 18 weeks to start treatment. For cancer care, performance against targets for eight operational standards has been reported since 2011. In our December 2021 report, we described how performance had declined against these standards before the pandemic. All these standards remain in place. In the case of the 18-week standard for elective care, it is a legal requirement that the NHS meets it.

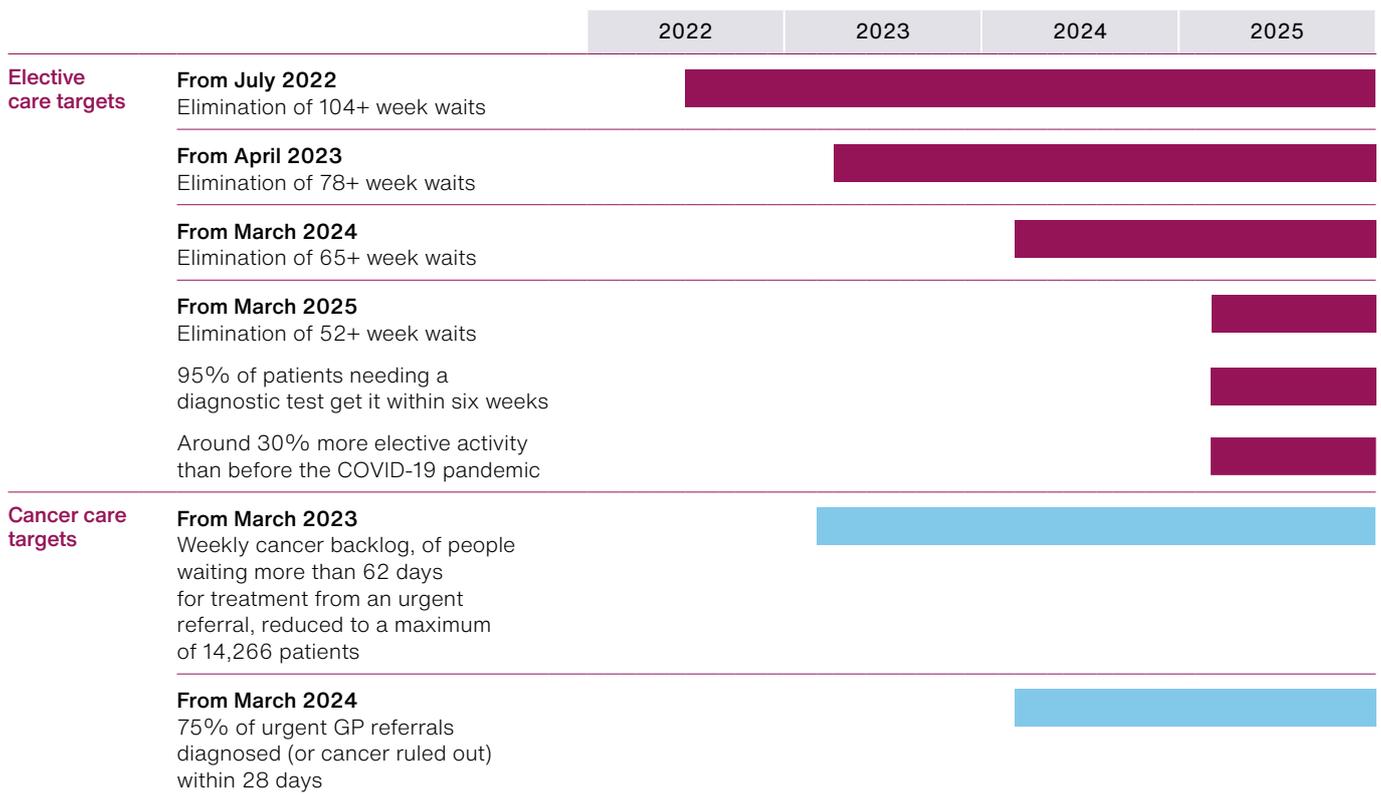
1.7 For elective care, the recovery plan’s new targets focus on eliminating the longest waits that patients are experiencing but do not seek to bring services in line with standards. The targets are graduated, with later targets more stretching. The first target aimed to prevent patients having to wait more than two years (104 weeks) to start treatment by July 2022. The last target aims to prevent patients waiting longer than one year (52 weeks) by March 2025. NHSE told us that it was not possible to achieve the 18-week performance standard within the three-year period that the plan covered.

1.8 The new cancer targets also seek to reduce waiting times without setting a date by which pre-existing operational standards will be met. The first cancer target aims to reduce to the pre-pandemic level the number of cancer patients waiting more than 62 days for treatment following an urgent GP referral. In the week ending 16 February 2020, the number waiting longer than 62 days was 14,123 (which NHSE used to set the target of 14,266 by revising up for missing returns). By the time the plan was published, in the week ending 13 February 2022, it had risen to 25,410.

Figure 1

NHS elective and cancer recovery targets, 2022-23 to 2024-25

The recovery plan includes eight main targets to be achieved and maintained

**Note**

1 Around 30% more elective activity is to be delivered by 2024-25: we have shown it at the latest point at which it could be delivered.

Source: National Audit Office analysis of NHS England's *Delivery plan for tackling the COVID-19 backlog of elective care* (2022)

Plans to increase activity

1.9 To reduce the number of people waiting too long for treatment, the NHS needs to increase the amount of elective care it provides. In the recovery plan and in this report, this is referred to as “increasing elective activity”. At its lowest during the pandemic, elective activity between April and August 2020 was just 52% of the 2019-20 levels (53% if working day-adjusted). The plan states that by 2024-25 NHS elective activity should have increased to “around 130%” of the 2019-20 level (129% for operational planning purposes), which would be equivalent to average annual growth of 9% above the pre-pandemic level over three years.⁶ NHSE counts the 129% in terms of completed elective pathways. A completed elective pathway is counted when a patient who has been referred for possible treatment either starts treatment or is discharged where treatment is not appropriate.

6 In its recovery plan, NHSE states its goal as delivering “about 30%” more elective activity. For detailed planning purposes, however, it is aiming for a 29% increase.

1.10 NHSE has not been able to tell us whether increasing elective activity to 129% will be sufficient to meet the recovery plan's targets to end the longest waits by March 2025. Partly this is because it depends on the number of patients who did not present for care during the pandemic who return by 2025 (so-called "missing patients").

1.11 Many senior officials, managers and clinicians we spoke to agreed that this scale of increase would be very difficult to deliver. We considered previous NHS performance and confirmed that the 129% target required a rate of increase not targeted or achieved in recent times:

- The *NHS Long Term Plan* (January 2019) targeted an increase in elective activity of 3.2% per year over the five years to 2023-24, funded with an average annual real-terms increase in the NHS budget of 3.4%.
- In the five years where comparable data are published, from 2013-14 to 2018-19, the NHS increased elective activity by an average of 3% per year. In 2018-19, elective activity was 118% of the level in 2013-14.
- In the three years from 2002 to 2005, the UK's total healthcare output (based on all health activity, including hospitals, primary care and the independent sector) grew by 22.5%, equivalent to an average annual rate of 7%.⁷

1.12 In recognition of the scale of the challenge, NHSE is seeking to achieve a significant part of the increase without specialist doctors having to see patients. Under the recovery plan, the NHS expects GPs to avoid referring some kinds of patients whom they would traditionally have referred for elective care. Instead, GPs will be able to obtain advice and guidance for such patients from hospital specialists and then manage the patients within the primary care system. For the purpose of measuring performance, NHSE has started to count these avoided referrals as a kind of additional elective activity.

1.13 The NHS's detailed plans aim for there to be 16 specialist advice requests per 100 actual outpatient first attendances in 2022-23. NHSE assumes that around half of these advice requests will be resolved without a subsequent outpatient appointment. NHSE believes that, in total, around 1.7 million outpatient first attendances can be avoided in this way in 2022-23, which is 1.1 million more than were avoided in 2019-20. **Figure 2** overleaf shows how, even after giving credit for this avoided work, the NHS will still need to deliver average annual increases in actual elective activity of nearly 7%.

⁷ Institute for Fiscal Studies, *The NHS backlog recovery plan and outlook for waiting lists*, February 2022. Available at: <https://ifs.org.uk/articles/nhs-backlog-recovery-plan-and-outlook-waiting-lists>

Figure 2

NHS England's (NHSE's) planned trajectory to increase elective activity to 129% of the 2019-20 level by 2024-25

NHSE's plan to increase elective activity (pathways) relies partly on providing more elective care and partly on avoiding referrals through advice and guidance

| Financial year | NHSE estimate of actual completed pathways ¹ | NHSE projection of completed pathways | NHSE projection of additional pathways avoided by advice and guidance | Total projection of pathways |
|----------------|---|---------------------------------------|---|---------------------------------|
| | | (a) | (b) | (a) + (b) |
| 2019-20 | 17.3mn (100.0%) | | | |
| 2022-23 (plan) | | 17.6mn (101.8%) | 1.1mn (6.4%) | 18.7mn (108.1%) |
| 2023-24 (plan) | | 20.0mn (115.5%) | 1.4mn (8.0%) | 21.3mn (123.5%) |
| 2024-25 (plan) | | 20.9mn (120.9%) | 1.4mn (8.0%) | 22.3mn (128.8%) ⁴ |

Notes

- 1 NHSE estimated that there would have been 17.3 million completed pathways in 2019-20 (by including an estimate for March 2020 as if it were not affected by the pandemic). This is a different measure to the published referral-to-treatment waiting times statistics, which show that 16.4 million treatments were started.
- 2 Percentages are stated as a percentage of the 2019-20 activity level.
- 3 NHSE's recovery plan cites an activity increase of "around 130%". But its calculations for operational planning purposes target an increase of 129%.
- 4 NHSE cost-weights the elective activity in the guidance that it provides to NHS integrated care systems, so that it requires 104% of 'value-based activity' in 2022-23, and has modelled 116% in 2023-24 and 118% in 2024-25.
- 5 NHSE told us that the baseline for 2019-20 was around 645,000 pathways avoided by advice and guidance. The table above shows the additional pathways above this baseline so that the total planned to be avoided in 2022-23 is 1.7 million, and in 2023-24 and 2024-25 is 2.0 million each.
- 6 Totals may not sum due to rounding.

Source: National Audit Office analysis of NHS England calculations

1.14 NHSE estimates that around 80% of the elective waiting list experience ends with outpatient services or a diagnostic process. To get as many people as possible off the waiting list it is attempting to change rapidly how outpatient care is delivered, by reducing follow-up appointments and increasing GP involvement. NHSE has translated the annual 108% elective activity required in 2022-23 into a metric called 'value-based activity'. The metric allows NHSE to reflect the different average costs of inpatient and outpatient activity and, it hopes, incentivises NHS providers to reduce some outpatient activity, including follow-ups it considers unnecessary. NHSE is asking ICSs to deliver 104% of value-based activity in 2022-23, compared with 2019-20. NHSE does not currently publish this measure.

Funding

Recovery funding and the NHS budget

1.15 DHSC has allocated £14 billion to NHSE between 2022-23 and 2024-25 specifically for the recovery of elective and cancer care. This comprises £8 billion of resource funding and £5.9 billion of capital funding.⁸ While NHSE has not produced a detailed costed version of its recovery plan, it intends to use the capital funding (subject to its approval of local business cases) as follows:

- £2.3 billion to increase diagnostic capacity, including at least 100 community diagnostic centres (CDCs);
- £2.1 billion for digital technology, and cyber security, and to redesign care pathways; and
- £1.5 billion to increase elective treatment capacity, including new surgical hubs and additional beds and equipment.

1.16 The funding available for recovery should not be considered in isolation from the overall NHS budget. First, this is because the total annual cost of elective care and cancer care far exceeds the recovery funding described above. NHSE estimates that around £28 billion, or 23%, of its resource expenditure was on elective care activity in 2019-20 when there was no additional recovery funding. (It does not have a separate estimate for cancer spending, but much of this also counts as elective care.) Second, many other parts of the NHS, including primary care and urgent and emergency care, have direct and indirect effects on how well elective and cancer services can function.

⁸ In December 2021, the government said that the additional funding for NHS recovery was to come from a new Health and Social Care Levy, a 1.25% increase in the rate of National Insurance contributions from 2022-23. However, the government subsequently announced in September 2022 that this National Insurance rise would cease to exist in November 2022.

1.17 At the time of the 2021 Autumn Budget, the government decided that the overall NHSE resource budget would be £151.8 billion in 2022-23, rising to £162.6 billion in 2024-25 (in nominal terms). This included the resource funding allocated specifically for recovery. The government described this as a 3.8% annual real-terms increase in NHS spending. This real-terms growth percentage was calculated by using the HM Treasury GDP deflators available at that time and by disregarding ringfenced COVID-19 funding which temporarily increased the NHS budget for pandemic purposes. A rate of 3.8% real-terms annual growth was just below the 4.0% real-terms long-term annual growth in UK health spending between 1999-2000 and 2019-20.⁹

1.18 Since the 2021 Autumn Budget, UK inflation has increased, reducing the real value of NHS England's funding settlement. Using the latest GDP deflators (from September 2022), **Figure 3** shows the effect this has had on a like-for-like basis. The real-terms annual increase in NHS funding between 2021-22 and 2024-25 has now reduced to 3.3%. If this level of funding is maintained, it will mean that historically high increases in elective activity need to be achieved with relatively low rises in the NHS budget. The full effect of inflation on NHS finances may be still greater, either because inflation stays higher for longer than current GDP deflators anticipate or because the GDP deflators underestimate the true inflationary pressure the NHS faces. In addition, NHSE has told us that it is spending more than it anticipated in 2022-23 on tackling COVID-19, despite the withdrawal of ringfenced COVID-19 funding (which was worth £16.3 billion in 2021-22).

Funding mechanisms to incentivise recovery

1.19 NHSE passes much of its funding to other NHS bodies, principally via ICSs. It attaches conditions to this funding to encourage particular behaviours. At the start of 2022-23, NHSE allocated ICSs resource funding for the coming year worth up to £2.3 billion specifically for elective recovery. To retain all this funding NHSE told ICSs that they had to deliver 104% of 'value-based' 2019-20 elective activity. Any ICS exceeding 104% will receive additional funding, but any falling short will receive significantly less.¹⁰

9 4.0% UK average annual growth figure between 1999-2000 and 2019-20 is based on NAO analysis of HM Treasury Public Expenditure Statistical Analysis, 2022, table 4.2.

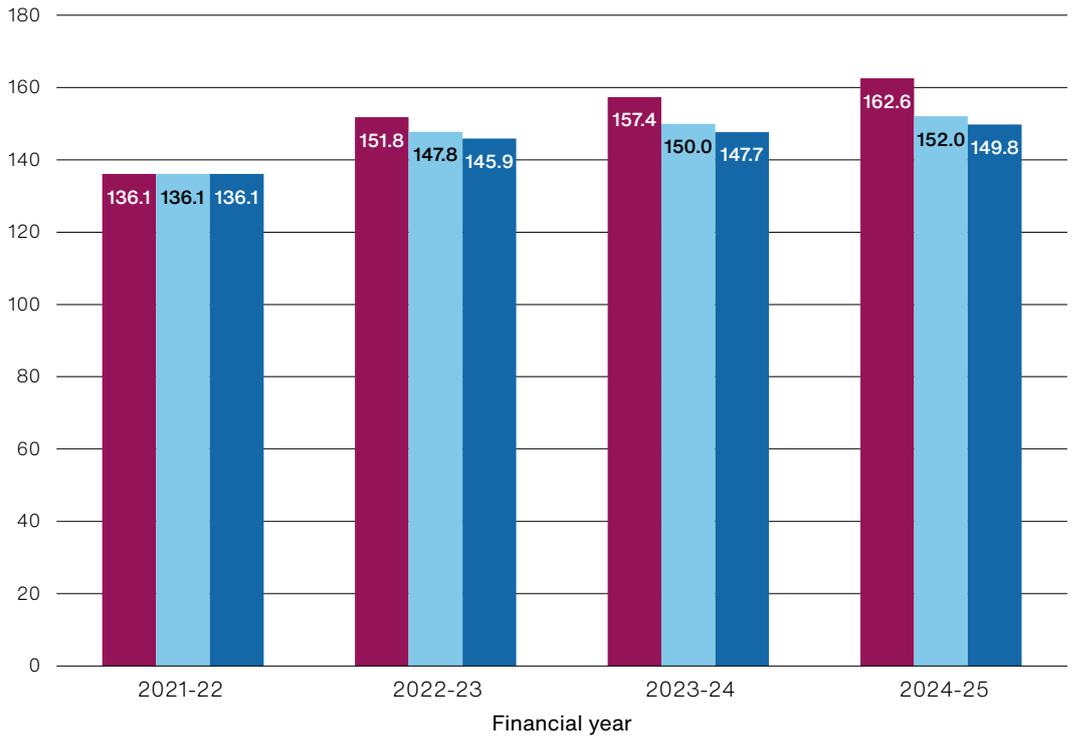
10 Under NHSE's financial rules for 2022-23, a local system (ICS) must achieve 104% activity to retain all of the elective recovery funding allocated to it. If the ICS delivers more than 104% activity, then it receives an additional 75% of the tariff value for the additional activity. If the ICS achieves less than 104%, it loses 75% of its elective recovery funding.

Figure 3

NHS England’s (NHSE’s) resource spending limits, 2020-21 to 2024-25

Inflation is reducing the value of planned increases to NHSE’s resource funding

NHS England RDEL (£bn)



- NHS England RDEL – Budget 2021 (nominal)
- Real terms (using October 2021 deflators)
- Real terms (using September 2022 deflators)

Notes

- 1 Real-terms figures are given in 2021-22 prices using HM Treasury GDP deflators published on 27 October 2021 and 30 September 2022.
- 2 NHSE Resource Departmental Expenditure Limits are taken from HM Treasury’s Autumn Budget and Spending Review 2021, where 2021-22 is used as a baseline (with ringfenced COVID-19 funding excluded) for calculating the real-terms value of subsequent increases.
- 3 HM Treasury excluded ringfenced COVID-19 funding from the 2021-22 total it used, because it deemed this to be funding for a specific circumstance rather than permanent, core NHSE funding. We have used the same approach in the figure above.
- 4 If ringfenced COVID-19 funding is included in the 2021-22 baseline, the real-terms value of increases in subsequent years is reduced. In NHSE’s Board Paper 4.2 of 6 October 2022, NHSE included ringfenced COVID-19 funding and found this resulted in average real-terms growth of just 0.5% per year between 2021-22 and 2024-25.

Source: National Audit Office analysis of Autumn Budget and Spending Review 2021, Financial Directions to NHS England, NHS England Board Papers and the GDP deflator series

1.20 The detailed funding conditions are complex and remained in draft form as late as August 2022. Local ICSs we visited told us that the complexity and uncertainty were consuming unnecessary management time as well as having unintended consequences. Some felt the threat of losing funding later in the year was a disincentive to passing all the work they could to independent sector providers. This is because independent sector providers would need to be remunerated in full for their work, at the level specified in contracts, even if funding was not available to cover it.

1.21 Based on the plans ICSs submitted in the first quarter of 2022-23, 62% of ICS areas (26 out of 42) were planning to miss the 104% target, with an average activity level across the 26 plans of 101%. This would mean that much of the £2.3 billion could end up being clawed back by NHSE, with uncertainty over how it would then be spent.

Programmes within the recovery plan

1.22 The major targets and commitments in the recovery plan are underpinned by more than 100 separate actions. The majority of these are contained within 13 major programmes, grouped into four categories (**Figure 4**). In different ways, most of these programmes were in existence before NHSE published the recovery plan, but it is now seeking to expand or accelerate them. Overall, this is a pragmatic approach to take. Many programmes prioritise making better use of existing NHS infrastructure and workforce; and many are already familiar to NHS managers and clinicians. NHSE is not attempting to implement all the programmes in the same way in every part of the country; rather, ICSs are to varying extents able to tailor an approach to local needs.

1.23 NHSE has opted not to produce a fully-costed version of its recovery plan, showing what it will spend on each of the programmes over three years. Consequently, we have not been able to give costs for the programmes on a consistent basis. It is not yet clear whether their cost will be equal to or greater or less than the overall recovery funding of £14 billion. NHSE requires each ICS to submit an annual plan of how it intends to use its devolved resource funding. For capital funding, NHSE works with ICSs to allocate funding with the aim of both supporting the delivery of national priorities and addressing local needs. NHSE has processes for monitoring the use of funding by ICSs.

Figure 4

Elective recovery programmes, as at September 2022

NHS England (NHSE) is running 13 separate programmes to support elective recovery

| Programme | Aims |
|---|---|
| Increase capacity | |
| Cancer | Increase referrals for suspected cancer, diagnose referred cases faster and increase treatment activity. |
| Workforce | Increase elective care capacity by recruiting 18,000 staff in 2021-22 and hold turnover down to 8%. (Targets for 2022-23 had not been determined by September 2022). |
| Independent sector | Increase local systems' use of the independent sector by 20% in 2022-23. |
| Prioritise certain patients and treatments | |
| Validation and prioritisation | Prioritise outpatient waiting list cases in 2022-23 so they can be effectively managed and, where appropriate, removed. |
| Long waits | Eliminate long waits, starting with 104-week waits and then 78-week waits, through support of challenged local systems. |
| Evidence-based interventions | Reduce medical/surgical interventions that are inappropriate or of limited clinical value. |
| Transform how care is provided | |
| Outpatient transformation | Increase outpatient productivity, including by reducing outpatient follow-up appointments by 25% by March 2023 including through a move to patient-initiated follow-up appointments in some cases; and, avoiding referrals by providing GPs with advice and guidance from hospital doctors for 16 patients per 100 first outpatient appointments. |
| Diagnostics transformation | Reduce diagnostics waiting times, open community diagnostics centres, increase tests, invest in digital diagnostics, set up diagnostic networks. |
| Surgical transformation | Increase productivity and activity for common, straightforward surgical procedures – often using surgical hubs. |
| Targeted Investment Fund | Increase physical capacity of NHS estate through local projects (mainly surgical hubs and new wards). |
| Digital | Improve patient engagement through digital tools, which might also reduce outpatient demand. |
| Inform and support patients | |
| Patient empowerment | Improve information and support for patients who are waiting. |
| Patient choice | Restore access to choice of provider, previously reduced during the COVID-19 pandemic. |

Note

- 1 Most of the £8 billion of resource funding from 2022-23 to 2024-25 is to pay NHS providers for activity under the elective recovery fund and is not part of the budgets for these programmes, even if some of it will be spent through these programmes.

Source: National Audit Office analysis of NHS England internal programme information

1.24 NHSE has expanded some programmes because it judges them to be sufficiently promising, but there is currently only a limited evidence base for their effectiveness. While these programmes may be based on good premises, NHSE will need to monitor carefully whether they are producing results in practice and build in proper evaluations as quickly as possible, being willing to re-direct resources as necessary to where they can have most impact.¹¹

- **Advice and guidance.** NHSE plans that some referrals for elective care will be avoided by helping GPs to support these patients within the primary care system (see paragraphs 1.12 and 1.13). However, it is unclear whether GPs will be able to manage the additional workload that might result and whether databases across the country are capable of sharing and updating patient information efficiently to support this.
- **Patient-initiated follow-ups (PIFU).** As part of the outpatient transformation programme, NHSE wants to move 5% of outpatient appointments to PIFU by March 2023 to contribute to a 25% reduction in outpatient follow-up appointments. However, research by The Nuffield Trust identified 15 studies that examined the effect of PIFU on outpatient activity, but only eight showed that PIFU reduced activity compared with routine follow-up or usual care.¹²
- **Surgical transformation** Both NHSE and the Royal College of Surgeons believe that surgical hubs will increase productivity and capacity, while acknowledging that there is still a need for more evidence. Senior managers in ICSs we visited told us they were also supportive of this programme. But it is as yet unclear how surgical hubs based on hospital sites will function in the current context with other health services under such pressure. To some extent, the same concern applies to community diagnostic centres, in that they may face staffing or operational pressures as their planned activity levels increase.
- **Virtual wards.** In return for £200 million of funding in 2022-23 and an unspecified amount in 2023-24, NHSE expects ICSs to increase their bed capacity by creating 40–50 virtual ward beds per 100,000 population by December 2023. Virtual wards enable patients to live at home while being monitored remotely by clinicians. NHSE has started 10 rapid local evaluations of virtual wards and will commission a national evaluation.

11 National Audit Office, *Evaluating government spending: an audit framework*, 2022. Available at: www.nao.org.uk/insights/evaluating-government-spending-an-audit-framework/

12 The Nuffield Trust, *Patient-initiated follow-up: will it free up capacity in outpatient care?* August 2022. Eight of the 15 studies assessing the impact of PIFU on outpatient activity showed a statistically significant reduction while seven found no difference. Available at: www.nuffieldtrust.org.uk/research/patient-initiated-follow-up-will-it-free-up-capacity-in-outpatient-care

1.25 Well-judged innovation is to be encouraged. Not everything that looks promising will go on to deliver increased value, so careful and timely evaluation is important also. Without it, there is a risk that future allocations of resources to new initiatives will not be informed by reality on the ground. During the pandemic, NHSE allocated significant funding to a recovery project called elective accelerators. It provided £160 million to 12 local systems that it considered could accelerate elective activity rapidly to reach 120% of the pre-pandemic level. The systems then fell short of the planned activity level, in part because of ongoing COVID-19 disruption. None of the systems achieved even 100% of pre-pandemic activity within the timeframe. NHSE has not been able to find its evaluation of the elective accelerators programme so we have not been able to confirm whether it has learned any lessons from it.

Learning from previous experience

1.26 Between August 2007 and August 2009, the number of patients waiting longer than 52 weeks for elective care reduced from 579,000 to 32,000. Many people working in the NHS today remember that time, but when we asked senior officials how they had sought to apply the lessons from it we received evidence only of high-level conversations. Some of the content of those conversations can clearly be seen reflected in the recovery plan. In our view, although there are some differences in the circumstances such as the more limited availability of funding now, DHSC and NHSE could still apply more lessons from this potentially valuable set of experiences and institutional memory. At a high level, several experts advised NHSE that it should try to keep the recovery plan as simple as possible. In our view, NHSE could do more to simplify aspects of the programme, in particular the financial mechanisms it uses to incentivise ICSs to increase activity.

Part Two

Implementing the recovery plan

2.1 This part describes the governance arrangements NHS England (NHSE) has in place for its recovery plan, and progress with implementing six of the programmes in the plan:

- long waits;
- cancer;
- community diagnostic centres (CDCs);
- surgical transformation;
- use of independent sector providers; and
- the transformation of outpatient services.

Governance of the recovery plan

2.2 The recovery is multifaceted and involves many national and local organisations and millions of patients with different needs. It has fundamental uncertainties, including how many of the COVID-19 pandemic's missing patients will return. Good governance allows organisations to deal with complexity and uncertainty, to adapt as they understand more about what is happening, and to address operational risks.¹³

2.3 The Department of Health & Social Care (DHSC) and NHSE have created new governance arrangements for elective recovery. A joint delivery unit, with staff from both organisations, works closely with NHSE to support elective recovery. Within NHSE, there is an Elective Recovery Programme Board, established in late 2021, a national director, and three other directors who all share responsibility for delivery. Sir James Mackey, Chief Executive of Northumbria Healthcare NHS Foundation Trust, works part-time as the senior responsible owner for elective recovery.

¹³ National Audit Office, *Improving operational delivery in government*, March 2021. Available at: www.nao.org.uk/insights/improving-operational-delivery-in-government/

2.4 Most of the 13 major programmes were already in existence before 2022 but they were not previously managed as one programme. Despite NHSE having a draft recovery plan in November 2021 and publishing it in February 2022, the organisation was slow to build up a centralised programme management office to manage and coordinate the 13 programmes: although it was set up in autumn 2021, by the end of May 2022 only seven out of 21 posts in the office were filled, increasing to 18 by the end of September. Each of these programmes also has its own management arrangements. The overall budget for programme management is £31 million in 2022-23, which covers the cost of 97 staff across the programmes as well as non-pay costs.

2.5 The 42 NHS local systems (integrated care systems, ICSs) are responsible for achieving national targets in their area, working with local NHS providers and independent sector providers. The local systems' performance is monitored and supported by NHSE's seven regional offices.

2.6 Governance arrangements were examined in an internal audit report in June 2022. The report noted that the programme had made progress in developing reporting processes but highlighted a number of areas for improvement including:

- there was a lack of clarity over management roles;
- the reporting of risks and dependencies across programmes needed strengthening; and
- performance reporting needed to improve because there were insufficient key metrics, no overarching view of the status of each programme, and no reporting on the financial status or workforce requirements of each programme.

2.7 In response, NHSE is in the process of strengthening its programme reporting arrangements, including selecting additional main metrics and improving existing ones. However, by August, NHSE still could only report the current status of 40% of the indicators in its elective recovery programme dashboard (19 out of 47), making it difficult for senior leaders to see whether programmes were on track and identify actions to address problems. The 13 component programmes vary in their maturity (**Figure 5** overleaf) and NHSE considers it will not be possible to produce a comprehensive dashboard until autumn 2022. In a three-year programme, this half-year delay is an important gap.

Figure 5

Assessment of the status of the recovery programmes, September 2022

Amber, Amber-Green and Amber-Red ratings predominate in NHS England's (NHSE's) own assessment of the status of its recovery programmes

| Programme | NHSE overall programme rating | NHSE programme delivery confidence rating |
|---|-------------------------------|---|
| Increase capacity | | |
| Cancer | Red | Amber-Red |
| Workforce | Amber | Amber-Green |
| Independent sector | Amber | Amber-Green |
| Prioritise certain patients and treatments | | |
| Validation and prioritisation | Amber | Amber-Green |
| Long waits | Amber | Amber-Green |
| Evidence-based interventions | Red | Amber-Red |
| Transform how care is provided | | |
| Outpatient transformation | Amber | Amber-Green |
| Diagnostics transformation | Amber-Green | Amber-Green |
| Surgical transformation | Amber | Amber-Green |
| Targeted investment fund | Amber-Green | Amber-Green |
| Digital | Amber | Amber-Green |
| Inform and support patients | | |
| Patient empowerment | Amber-Green | Green |
| Patient choice | Amber | Amber-Green |

Notes

- 1 NHSE's internal assessment of overall programme and programme delivery confidence is a five-point scale (Red, Amber-Red, Amber, Amber-Green, Green). NHSE bases overall programme ratings on whether the programme is on track to achieve its milestones. Its delivery confidence ratings are based on the quality of plans and level of expectation that programme objectives will be achieved.
- 2 NHSE's assessments of outpatient transformation was made using interim data on the elective recovery programme dashboard.

Source: National Audit Office analysis of NHS England internal programme information

Implementing specific programmes

2.8 In the following paragraphs we consider the implementation to date of six key programmes relating to capacity, prioritisation or transformation. A seventh programme, evidence-based interventions, has recently become more important. NHSE is now seeking to use this programme to reduce the number of new referrals and the amount of treatment activity needed for patients already on the waiting list by withdrawing certain treatments where NHSE and the Academy of Medical Royal Colleges (AoMRC) agree there is too little clinical value. NHSE expects some 1.8 million treatments to be avoided in 2022-23 as a result.

Long-waits programme

2.9 Most of NHSE's recovery programmes seek to reduce long waits, but the long-waits programme itself focuses on the administration and delivery of specific targets. These are to eliminate two-year (104-week) waits for elective care by July 2022, 18-month (78-week) waits by April 2023, 15-month (65-week) waits by March 2024 and one-year (52-week) waits by March 2025.

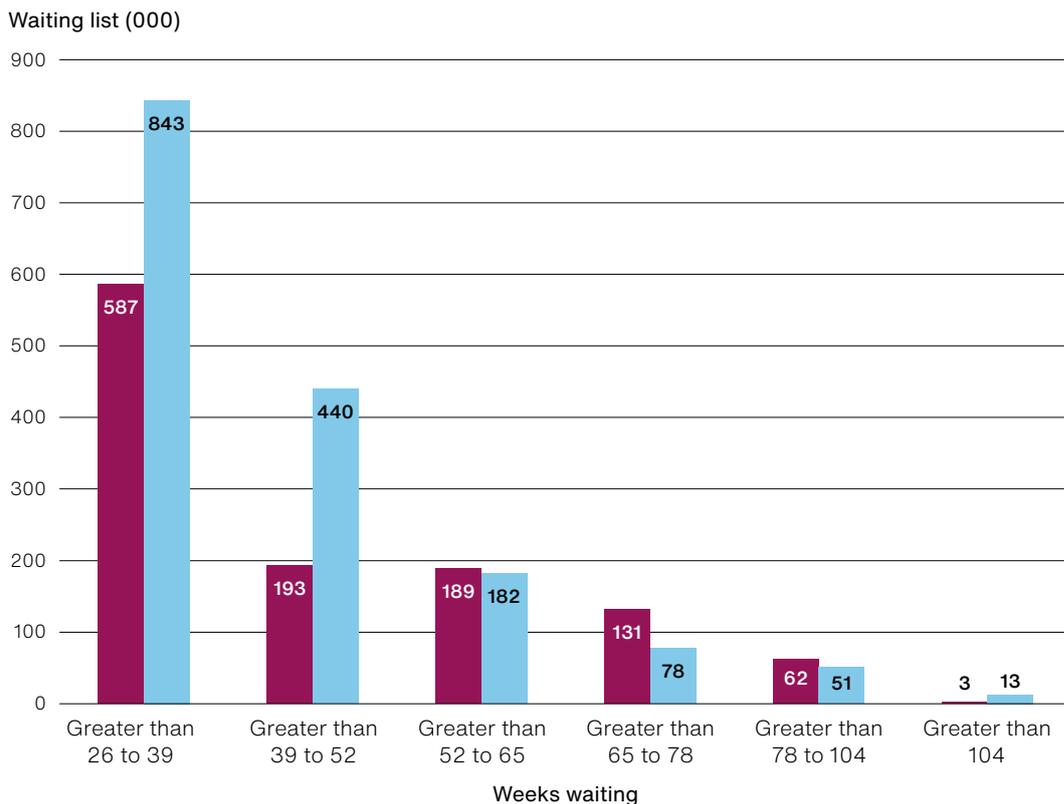
2.10 NHSE's initial focus was on the first of these targets, to eliminate two-year waits. Those managing the national programme divided NHS providers into four tiers according to their likely ability to meet this target. Providers in tier one (least likely to meet the target) received intensive support from NHSE and very close oversight of their performance. They had access to a national offer that their patients could be treated anywhere in the country where capacity existed (known as 'mutual aid'). Local providers in lower-priority tiers received less support.

2.11 In our case study visits, two local systems told us that their senior managers became directly involved in individual patients' cases, as they tried to ensure the first target was met. While this yielded some impressive results for individual patients and almost led to the target being met, they told us that it had had the effect of diverting a significant amount of management time away from other important transformational activity. NHSE's view was that this kind of senior managerial intervention was exceptional action taken in a local context where organisational grip had previously been lost. We do not know whether this type of management response was seen widely across the NHS. In any event, the approach will not be scalable or sustainable when it comes to the subsequent targets, which are by an order of magnitude more challenging. In April 2022, there were 24 times more patients waiting more than a year but less than two years than patients had been waiting more than two years (**Figure 6** overleaf).

Figure 6

Distribution of the elective waiting list above 26 weeks, April 2021 and April 2022

There were 64% more patients waiting between 26 and 52 weeks in April 2022 (1.283 million) than in April 2021 (0.780 million)



■ April 2021
 ■ April 2022

Notes

- 1 The number of patients on the waiting list who had waited no more than 26 weeks was 4.0 million in April 2021 and 4.9 million in April 2022.
- 2 Figures are rounded to the nearest thousand and show the numbers waiting at the end of the months of April 2021 and April 2022.

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

2.12 Additional patients enter the cohorts of long-waiters every day, meaning that snapshot data mask the true scale of the effort needed to meet each target. For instance, in August 2022 there were 51,000 patients who had already waited longer than 18 months but around 690,000 people were due to fall within the scope of the 18-month (78-week) target by April 2023, meaning that they too would require treatment in order for the next target to be met. **Figure 7** on pages 32 and 33 shows how these 690,000 patients are distributed very unevenly across the country. As a proportion of the total waiting list in different areas the range is between 2% and 20%, meaning the challenge to meet the next target will be much greater in some parts of the country than others. NHSE analyses waiting list data on an ongoing basis to understand the scale of the challenge.

Cancer programme

2.13 Cancer care is one of the most important parts of elective care. Many cancer patients are only diagnosed as such after being originally referred with other suspected illnesses. The recovery programmes to increase diagnostic capacity and the use of surgical hubs and the independent sector are intended to improve cancer performance as well as elective care. The cancer programme itself monitors the impact these programmes are having and seeks to increase referrals (through communications with the public and with primary care) and to improve productivity (by improving how treatment pathways are organised).

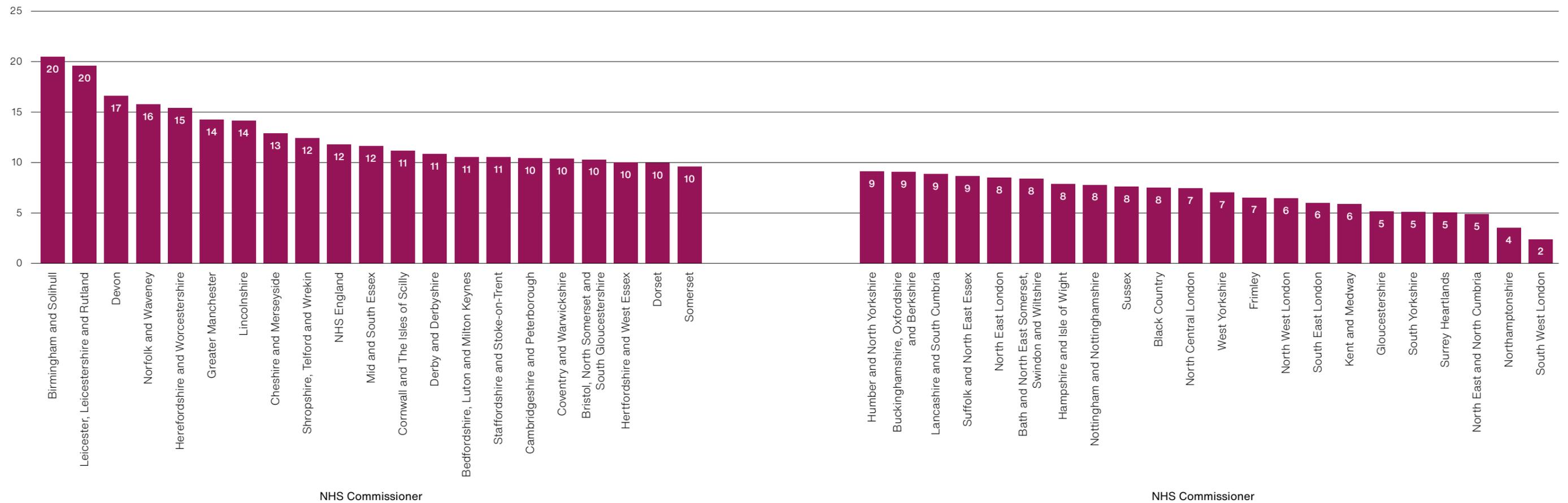
2.14 NHSE's efforts to encourage people with possible cancer symptoms to see a GP (so those with cancer may be identified early) might have contributed to a welcome increase in such cases so far in 2022. The number of urgent referrals by GPs of patients with suspected cancer increased by 15% from April to August 2022 (16% if working day-adjusted), compared with the equivalent period in 2019-20.

2.15 Consequently, NHSE noted in its management reports in August that it considered the cancer referral shortfall to have been closed. NHSE told us that the recent improvement in early diagnosis rates (56% of staged cancers diagnosed at stage 1 or stage 2, as opposed to the more-advanced stages 3 and 4, in both 2019 and 2022 after a drop to 53% in 2021) gave it reassurance that cancer referrals had fully recovered. This may be an optimistic view. Prior to the COVID-19 pandemic, urgent GP referrals had been increasing by an average of 10% per year from 2009-10 to 2019-20 (ranging between 4% and 15%). But when comparing actual numbers of urgent referrals with what should be expected, NHSE does not adjust 2019-20 referrals for any additional growth.

Figure 7
Percentage of waiting list in scope of the 78-week target, by NHS integrated care system, August 2022

Patients who have been waiting for more than 43 weeks in August 2022 will fall in the scope of the 78-week target by April 2023. There is a large difference – between 2% and 20% – between the highest and lowest NHS integrated care systems in the proportion of their waiting list in scope of the 78-week target

Percentage of waiting list in scope of the 78-week target (%)



Notes

- 1 Waiting times are shown by NHS commissioner – the 42 integrated care boards and NHS England as a commissioner of certain specialised services which are commissioned nationally.
- 2 Patients who have been waiting for more than 43 weeks in August 2022 will be in the scope of the target to eliminate 78-week waits by April 2023.

Source: National Audit Office analysis of published referral-to-treatment waiting times statistics (incomplete commissioner)

2.16 It is concerning that cancer waiting times are worsening (paragraph 3.13) at a time when the level of GP referrals is within the range of growth seen in recent years. In our view, there might still be additional patients, above 2019-20 levels, who are yet to return.

2.17 The recovery plan includes two targets for cancer care (see Figure 1 on page 15):

- The number of people waiting 62 days for treatment following an urgent referral should return to the pre-pandemic level (no more than 14,266 waiting longer than 62 days) by March 2023.
- From March 2024, 75% of patients who have been urgently referred by their GP for suspected cancer should be diagnosed or have cancer ruled out within 28 days.

2.18 The March 2023 target is now a major area of focus for NHSE. In June 2022, NHSE identified 17 NHS providers at highest risk of not achieving this. These providers are to receive close national oversight and support from NHSE. Another 13 providers are also considered to be at risk of missing the target, with NHSE's regional teams supporting them to develop delivery plans. While welcome, the increase in urgent referrals so far in 2022 is making the March 2023 target harder to meet, as there is an increasing backlog of patients who either have not had their cancer excluded or have not started treatment.

2.19 The first cancer target is due to be met just one month before the target for no one to wait longer than 18 months (78 weeks) for elective care. NHSE recognises that, with finite resources, NHS providers may need to choose which target to prioritise. NHSE's chief executive wrote to all trusts and local systems in July 2022 asking them to treat the cancer backlog as a "critical priority" and equal to the priority to tackle long waits for elective care.

Surgical transformation programme

2.20 The surgical transformation programme focuses on high-volume, low-complexity surgical procedures, such as routine hip replacements, which are relatively straightforward to conduct and needed by many patients. It adopts the concept of carrying these out in dedicated premises which are supposed to be protected from problems elsewhere in the hospital system, for instance winter pressures or overflowing accident and emergency departments. The intention is to improve productivity and, where possible, ringfence clinicians' and nurses' time, as well as beds and operating theatres, to allow large numbers of procedures to be carried out according to an intensive schedule. The aim is for these services to operate six days a week for 48 weeks a year. The programme also focuses on increasing the use of day-case surgery and improving theatre productivity.

2.21 This programme was set up by the NHS's Getting It Right First Time (GIRFT) team and the London NHSE region and then rolled out nationally. The programme builds on pilot orthopaedic elective hubs set up before the pandemic. In October 2022, NHSE reported that 89 surgical hubs were already open (the first having opened as long ago as 2004), including 18 that were ringfenced (meaning their staff and infrastructure were supposed to be more protected from the impact of pressures elsewhere in the hospital system). DHSC and NHSE told us that an additional 57 hub proposals had passed the first round of the Targeted Investment Fund approvals process and could open through this route by 2024-25. There have, however, been delays in providing capital funding to help local systems to develop them.

2.22 The programme is a promising idea but actual performance in 2022-23 is unclear. NHSE does not yet have a good measure of the activity that is occurring in the surgical hubs. Across all NHS theatre settings (not just hubs), it estimated that activity for 29 types of high-volume low-complexity surgical procedures in May 2022 stood at just 85% of 2019-20 levels, showing how this aspect of NHS care has been particularly difficult to recover. This is likely to be linked to difficulties staffing up operating theatres as well as high levels of non-elective activity and bed occupancy, which lead to cancellations of elective surgery. NHS England is currently working to disaggregate activity that takes place in surgical hubs (whether they are integrated, ringfenced or stand-alone sites) to understand better the activity that is occurring there. According to its risk register for the recovery, NHSE currently sees this programme as very high risk.

Independent sector programme

2.23 The independent sector programme aims to increase the number of NHS patients whose cases are handled by independent sector providers (ISPs). In November 2020, the NHS began using a new framework for independent sector contracts, which NHSE expects will be used for around £10 billion-worth of work over four years.

2.24 Before the pandemic, between March 2019 and February 2020, independent providers treated an average of 8% of all elective patients. NHSE aims to increase independent sector activity to 20% above the 2019-20 level by March 2023. This is a much larger percentage increase than it is seeking in elective activity overall (to 102% for 2022-23), although if it is achieved, the average proportion of elective patients treated in the independent sector will only increase by one percentage point (to around 9%). There is recognition within the NHS both nationally and locally that certain kinds of condition and patient are better suited to the independent sector than others. These include diagnostics and the kind of procedures that are also well suited to the surgical transformation programme. Independent hospitals tend not to be suitable for patients who could require a stay in an intensive care unit.

2.25 The programme is on track to meet its March 2023 target. NHSE estimates that the volume of different activities completed by ISPs had already reached between 127% and over 300% of the 2019-20 level in August 2022. This included very substantial growth in the use of diagnostic facilities, which reached 316% of the 2019-20 level.

2.26 There are risks for NHSE to manage when it comes to increasing independent sector activity. First, many clinicians who work for ISPs also work in the NHS. It is possible that they will do less work for the NHS in future if they do more for the private sector, in effect limiting the net increase in activity and potentially reducing the productivity of NHS assets such as operating theatres. Second, three of the five local systems we visited told us that the draft funding arrangements NHSE had in place had acted as a disincentive to passing even more work to the independent sector. This is because they will have to pay ISPs 100% of the value of this work, even if their wider performance means they do not receive 100% of the funding from NHSE (see also paragraph 1.20). Third, there are perennial tensions to manage, including concerns from some NHS providers that the independent sector is privileged in being able to treat the most straightforward patients, and concerns from ISPs that contracts are too short-term, which discourages them from investing in additional capacity.

Community diagnostic centres (CDCs)

2.27 A major review of NHS diagnostics in 2020 concluded that demand had been rising rapidly for at least five years and was exceeding capacity. It recommended the establishment of CDCs, as hubs where elective care patients could access multiple tests.¹⁴ The shortage of diagnostic capacity has become an even more pressing problem as diagnosis is an essential first step to dealing with the expanded number of people in the waiting list. As part of the recovery plan's diagnostics transformation programme, DHSC and NHSE have allocated £1.5 billion to develop CDCs in the period up to March 2025. By separating diagnostic capacity from main hospital sites, NHSE also aims, as with surgical hubs, to reduce cancellations and waiting times. There are targets for CDCs to deliver 3.8 million diagnostic tests by March 2023 and between nine million and 10 million diagnostic tests by March 2025.

¹⁴ Professor Sir Mike Richards, *Diagnostics: Recovery and Renewal*, 2020. Available at: www.england.nhs.uk/publication/diagnostics-recovery-and-renewal-report-of-the-independent-review-of-diagnostic-services-for-nhs-england/

2.28 By September 2022, nearly a year after the launch of the first sites, 88 CDCs were open. NHSE expects to receive business cases for an additional 81 in 2022-23. Between mid-July 2021 and the beginning of September 2022, CDCs carried out 1.8 million diagnostic tests (representing around 9% of total NHS diagnostic activity) compared with the planned figure of 1.9 million tests in that time. Based on performance to date, the NHS is at 96% of its planned trajectory to reach its target (3.75 million by March 2023). More centres coming online should help to close the gap, but some local NHS managers told us progress with CDCs had been delayed due to uncertainty about the availability of capital funding for the programme.

2.29 CDCs are expanding the diagnostic equipment available to the NHS, through capital investment, but there are also substantial workforce gaps which may limit the impact the centres can have. For instance, a Royal College of Radiologists census in 2021 found a 29% shortfall in radiologists, a gap that it forecast would grow in line with demand for diagnostic services. In July 2022, 28% of patients still had to wait longer than six weeks for a diagnostic test, compared with an average of 2% of patients between 2012 and 2018. NHSE's internal assessment of the CDC programme's progress concluded in July 2022 that all milestones in the CDC programme were on track, but it does not take account of the NHS's total diagnostic activity or the workforce gaps. There is also a risk that some activity in CDCs is not genuinely additional and it is just displaced from other diagnostic sites.

Outpatient transformation programme

2.30 Outpatient activity (known technically as non-admitted referral-to-treatment pathways) increased by 32% between 2008-09 and 2018-19. The 2019 *NHS Long Term Plan* set out a number of measures designed to change outpatient services, including an aim to avoid up to one-third of face-to-face appointments. The outpatient transformation programme builds on this, aiming to hold outpatient appointments by video or telephone where possible; to reduce follow-up outpatient appointments; to move to patient-initiated follow-up appointments in some circumstances; and to increase the amount of specialist advice and guidance to help GPs to manage patients in primary care. Local NHS officials we spoke to are generally supportive of initiatives to free up clinical resources by reforming outpatient services.

2.31 NHSE's data on the outpatient programme are still under development. Based on the information available in September 2022, to date there has been mixed progress:

- By June 2022, 22% of outpatient appointments were being delivered remotely (compared with a target to reach 25% by March 2023), which was slightly below trajectory.
- The local plans submitted to NHSE during the first quarter of 2022-23 showed that only five out of 42 areas were planning to meet the target to reduce follow-up appointments by 25% by March 2023. The latest data showed a reduction in outpatient follow-up appointments of 2% in April to June 2022 compared with the corresponding period in 2019.
- By June 2022, 1.6% of outpatient attendances were moved to a patient-initiated follow-up pathway (compared with the 5% target by March 2023), which was slightly below trajectory.
- In terms of avoiding referrals through GPs being provided with specialist advice and guidance, the NHS seemed to be ahead of target based on data from April to June 2022 only. NHSE wants GPs to be provided with specialist advice and guidance for at least 16 patients for every 100 they do refer. This is with the aim of ultimately enabling GPs to manage around half these cases in primary care, instead of sending them to hospital. According to NHS data, from April to June 2022 GPs were already receiving such advice and guidance for 22 patients for every 100 they did refer, ahead of the target.

2.32 The outpatient programme is operating in the context of an NHS backlog of follow-up appointments, which are not part of the elective waiting list (because the patients have already commenced treatment) but which providers still need to work through. If it is possible to reduce these, it can free up capacity for seeing new patients on the waiting list. We have identified two particular issues with the outpatient programme which may require attention. First, the decision to target a reduction in follow-up appointments has caused concern among some clinicians and managers. Several whom we interviewed for our case studies stated that incentives to reduce the number of follow-up appointments could lead to increased patient harm at a time when more patients might need follow-ups due to the size of the backlog and the complexity of conditions people present with. Second, the advice and guidance initiative might shift work from hospitals to GPs, but the GP workforce is under pressure too. The fully-qualified permanent GP workforce decreased by 4% between June 2017 and June 2022. NHSE told us it is monitoring the impact on both the primary and secondary care workforces.

Part Three

Early results and ongoing risks

3.1 This part of the report assesses the early results of actions taken to recover elective and cancer care and the ongoing risks the NHS faces.

Elective backlogs and waiting times

Activity levels

3.2 NHS England's (NHSE's) plans assumed that services would recover to the pre-pandemic level of activity early in 2022-23 and then exceed that level. The recovery plan stated that achieving the planned growth in activity depended on returning to and maintaining low levels of COVID-19. In our judgement, this assumption may have been over-optimistic when it was made and it has proved so in practice. Another key assumption was that winter pressures would have a minimal effect on activity in winter 2022-23.

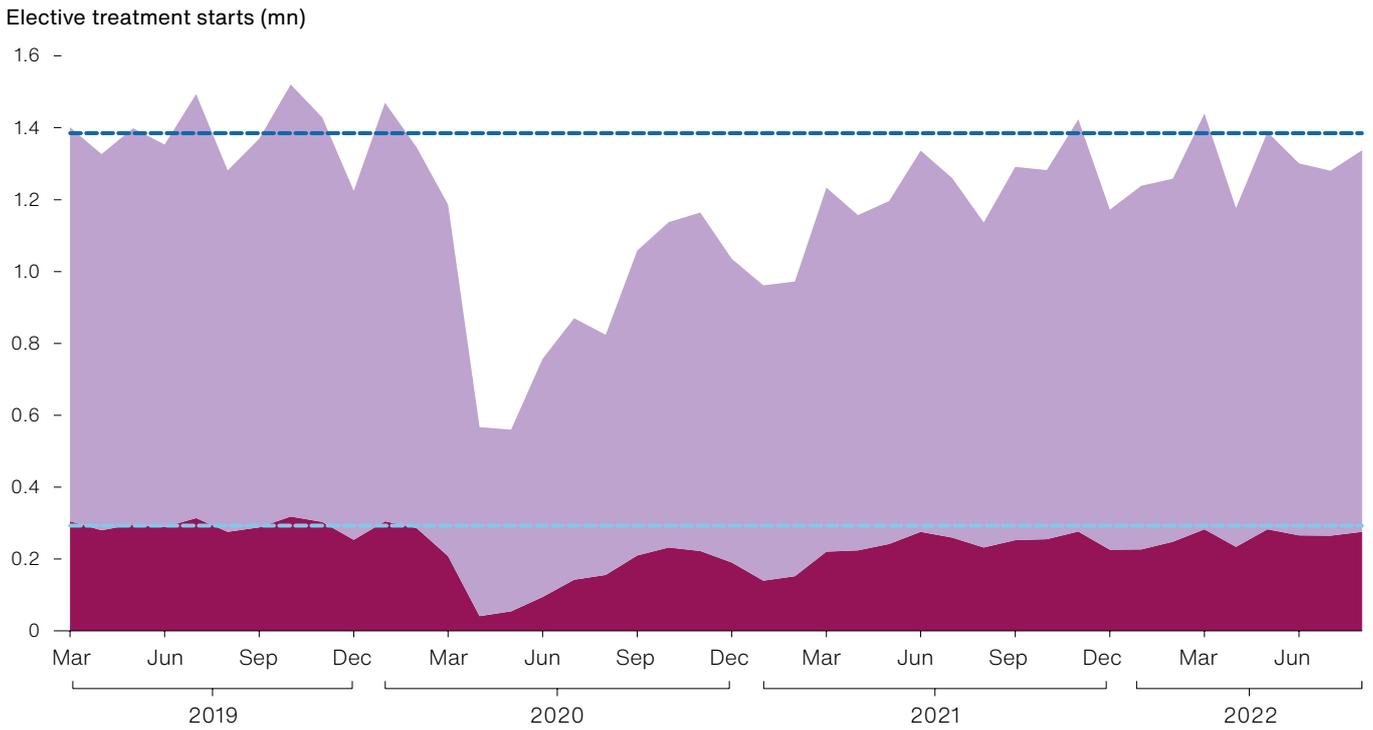
3.3 By August 2022, elective activity (measured as 'clock stops' for inpatient and outpatient elective care) had still not recovered to 100% of 2019-20 activity. On a like-for-like basis, elective activity in the first five months of 2022-23 was 95% of activity in the equivalent months of 2019-20, with outpatients activity running at 96% and inpatients at 91%. On a working day-adjusted basis these figures were 96% for total activity, with outpatients activity running at 97% and inpatients at 93%.¹⁵

3.4 The NHS's target for elective activity delivered in hospitals and in combination with GPs is the "value-based" 104% described in Part One (paragraph 1.14). Taking out activity delivered in combination with GPs, NHSE's internal target was to deliver 102% of 2019-20 activity across the current year (see Figure 2 on page 17). To achieve this now, elective activity will need to average 107% in the seven months from September 2022. **Figure 8** overleaf shows the gap between the 2019-20 level of activity and recent performance. The local systems we visited told us that the large jump to 116% of 2019-20 activity in 2023-24 would be even more challenging.

¹⁵ Adjustment for working days helps with making comparisons between NHS activity in different time periods. In the first five months of 2022-23 there were 103 working days, while in the first five months of 2019-20 there were 105 working days.

Figure 8
Elective activity, 2019–2022

Elective activity (inpatient and outpatient treatment) has not yet recovered to the pre-pandemic average



- Inpatient treatment starts
- Outpatient treatment starts
- - Inpatient treatment starts (March 2019 – February 2020 average)
- - Inpatient plus outpatient treatment starts (March 2019 – February 2020 average)

Note

1 In the elective referral-to-treatment statistics the waiting time clock stops when treatment starts and it is counted as either 'treated (admitted)' which is labelled above as 'Inpatient treatment starts' and 'treated (non-admitted)' which is labelled above as 'Outpatient treatment starts'. Outpatient treatment includes patients being treated as an outpatient or being referred back to the care of their GP.

Source: National Audit Office analysis of published referral-to-treatment waiting time statistics (RTT overview timeseries)

3.5 Some of the likely explanations for the slow start are clear. During 2022-23, the NHS has been operating in a more difficult context than the recovery plan anticipated:

- The Omicron variant of COVID-19 and its subvariants put pressure on NHS services for longer than NHSE had allowed for. There was a daily average of 14,200 people with COVID-19 in hospitals in England in April 2022, compared with 1,900 in April 2021. NHS staff sickness absence was 6.0% between January and April 2022, compared with an average of 4.3% for the same months between 2016 and 2019.
- The flow of patients through hospitals, and therefore the ability to treat other patients, has been restricted by pressure in other hospital departments, for example accident and emergency, and problems with discharging patients to appropriate social care. In August 2022, the NHS had an average of 22,200 people who were ready to be discharged every day but it could only actually discharge 8,800 each day. From 2019 to 2022 the average length of overnight stays in hospital by non-elective patients increased by around one day.

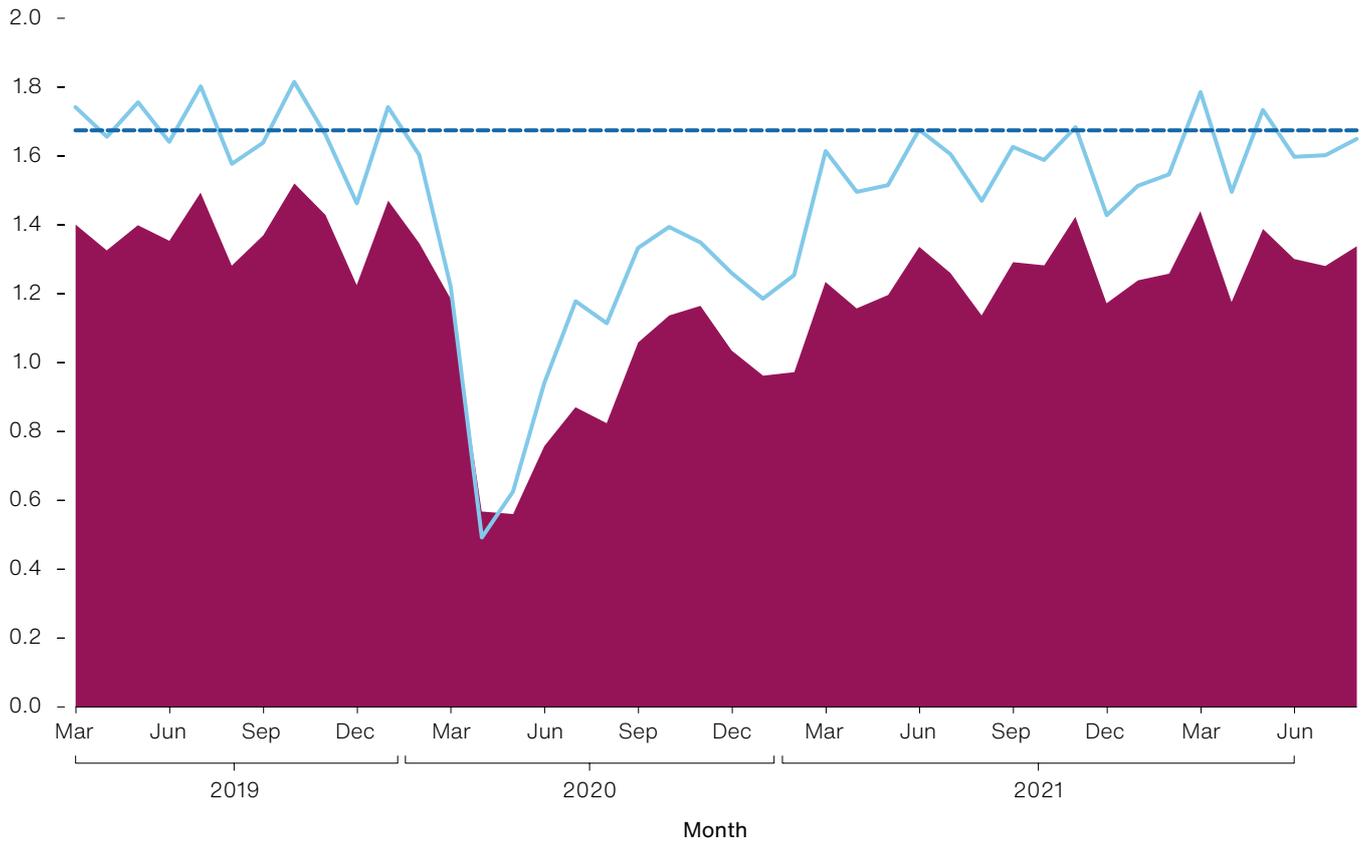
3.6 During the first five months of 2022-23, the average level of new referrals for elective care was at 96% of the pre-pandemic level. New referrals onto the waiting list remained higher than patients coming off by starting treatment (**Figure 9** overleaf), so the waiting list continued to grow. The recovery plan had anticipated that the waiting list was likely to increase, at least in the short term. It stated that if around half of the missing elective referrals from the COVID-19 pandemic returned then the waiting list would start to reduce by around March 2024. (We discuss the return of missing cases in paragraphs 3.22 and 3.23 below).

3.7 With treatment levels still below those before the pandemic, the immediate effect has been to lengthen the elective waiting list from 5.8 million patients in September 2021 to 7.0 million in August 2022 (**Figure 10** on page 43). In our first report on backlogs in December 2021, we estimated that the pandemic had seen between 7.6 million and 9.1 million missing referrals for elective care, as people stayed away from or were unable to be seen by the NHS. Referral levels have not yet grown sufficiently to allow us to say with confidence how many of these missing patients have returned or will return in future. This means there is still a lot of uncertainty about the scale of the waiting list challenge facing elective services through to March 2025. As we stated in our December 2021 report, this uncertainty relates both to how many of the missing patients will enter the system and over what timeframe and to the level of elective activity it will be possible for the NHS to achieve.

Figure 9
Elective referrals, March 2019 to August 2022

Elective referrals have not yet recovered to the pre-pandemic average

Elective referrals and treatments (mn)



- Inpatient plus outpatient treatment starts
- Referrals
- - Referrals (March 2019–February 2020 average)

Note

1 In the elective referral-to-treatment statistics a waiting time clock stops when treatment starts and it is counted as either 'treated (admitted)' or 'treated (non-admitted)' which is labelled above as 'Outpatient treatment starts'. Outpatient treatment includes patients being treated as an outpatient or being referred back to the care of their GP.

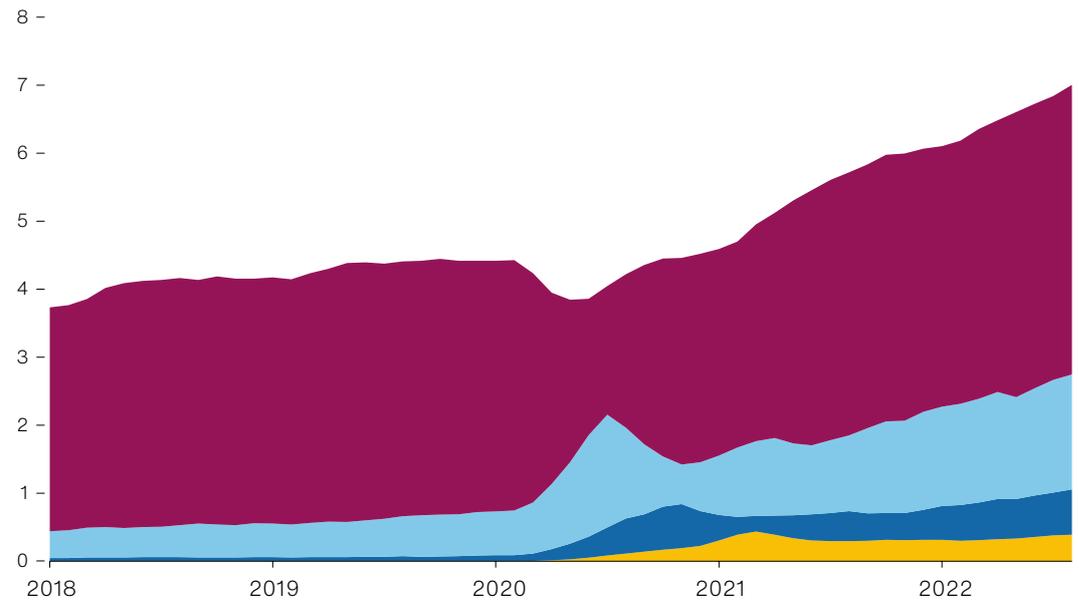
Source: National Audit Office analysis of published referral-to-treatment waiting time statistics (RTT overview timeseries)

Figure 10

The elective care waiting list, January 2018 to August 2022

The elective waiting list is continuing to grow rapidly

Waiting list (mn)



- Pathways waiting up to 18 weeks
- Pathways waiting more than 18, and up to 36, weeks
- Pathways waiting more than 36, and up to 52, weeks
- Pathways waiting more than 52 weeks

Note

1 The elective care system counts the number of pathways rather than the number of people. Patients may be on more than one elective pathway, which in this measurement is the time between referral and treatment starting. NHS England estimated that the July 2021 waiting list of 5.6 million pathways comprised around 4.9 million waiting individuals.

Source: National Audit Office analysis of published referral-to-treatment waiting list statistics

Waiting times

3.8 The first public target in NHSE's recovery plan was to eliminate two-year (104-week) waits for elective care by July 2022. In July 2021, 293,000 patients had been waiting for more than one year and so would, without treatment, have become two-year waiters by July 2022. From the start of 2022-23, the NHS prioritised its available capacity to try to end two-year waits. The number of actual two-year waiters had peaked in January 2022 at 24,000 patients. In the month the recovery plan was released, February 2022, it stood at 23,300. By the end of July, it had been reduced to 2,885. NHSE reported that this meant its target had almost been met because the remaining waiters included 1,000 "very complex" cases (including patients who had currently or recently had COVID-19) and another 1,600 patients who had chosen to wait longer following a viable offer of treatment (for example, because they had a planned holiday).

3.9 NHSE told us that at the time it agreed this target with government, it explicitly excluded 3,000 to 4,000 patients, whom it expected not to be able to treat in time because they needed to see highly-specialised clinicians or because they would choose to wait longer. In August 2022, there were 2,646 two-year waiters. NHSE is leaving it up to local clinical judgement and patient choice to determine when remaining two-year waiters will be seen. NHSE told us it has not set a new target date for clearing the long waiters, but it will need to monitor carefully that the number does not grow. For comparison, just before the pandemic, in February 2020, there were only 1,600 patients waiting one year or longer for elective care.

3.10 In our judgement, NHSE has not clearly defined which patients are to be considered as out of scope for its long-waits targets because of complexity or the rejection of a viable treatment offer. In the absence of clear definitions, there is a risk that such exemptions could be applied inconsistently or even illegitimately.

3.11 The statutory performance standard for elective care is that 92% of patients on the waiting list should start treatment within 18 weeks of referral. Performance before the pandemic was already significantly below standard and stood at 83% in February 2020. It deteriorated further during the pandemic to stand at 64% in December 2021. It has declined further in 2022, to 61% of patients in August 2022, meaning that 2,745,742 patients had been waiting for more than 18 weeks.

Cancer waiting times

3.12 NHSE's recovery target is that by March 2023 there will be no more than 14,266 patients (the pre-pandemic level) urgently referred by their GP for suspected cancer who are waiting more than 62 days for a diagnosis or for the start of their treatment. This is different from the operational standard for urgent GP referrals for suspected cancer, which is that 85% of people urgently referred by their GP who go on to have cancer confirmed receive their first treatment within 62 days. The recovery target of 14,266 patients includes both people who are waiting more than 62 days for a diagnosis, whether cancer is confirmed or ruled out, and people who have received a decision to treat. **Figure 11** overleaf shows how the number waiting has varied since the start of the COVID-19 pandemic, sometimes coming quite close to the pre-pandemic level. However, it has been higher in 2022 and increased by an average of 2% a week between April and August 2022. Of the 32,600 waiting at the end of August 2022, 4,300 had received a diagnosis and were waiting for treatment to start. The remaining 28,300 did not yet have a diagnosis.

3.13 There has been an increase in the number of referrals of people with suspected cancer (see paragraph 2.14). However, the NHS continues to miss its operational standard for treating 85% of these patients within 62 days, where cancer is confirmed. In the first five months of 2022-23, from April to August, only 62% of patients started treatment within 62 days, compared with performance of 78% in the equivalent period in 2019. More positively, the number of people treated in the first five months of 2022-23 following an urgent GP referral was 71,957, which is 4% higher than the 2019-20 level (69,422). However, the number starting treatment outside the 62-day standard over the same period was 27,379, an 80% increase on the number in 2019-20 (15,245). Eleven per cent of these patients (8,084 out of 71,957) were treated more than 104 days after their urgent referral (**Figure 12** on page 47). The pre-pandemic figure (for the same months in 2019-20) was that 5% of patients were treated more than 104 days after their urgent referral.

Ongoing risks for the recovery programme

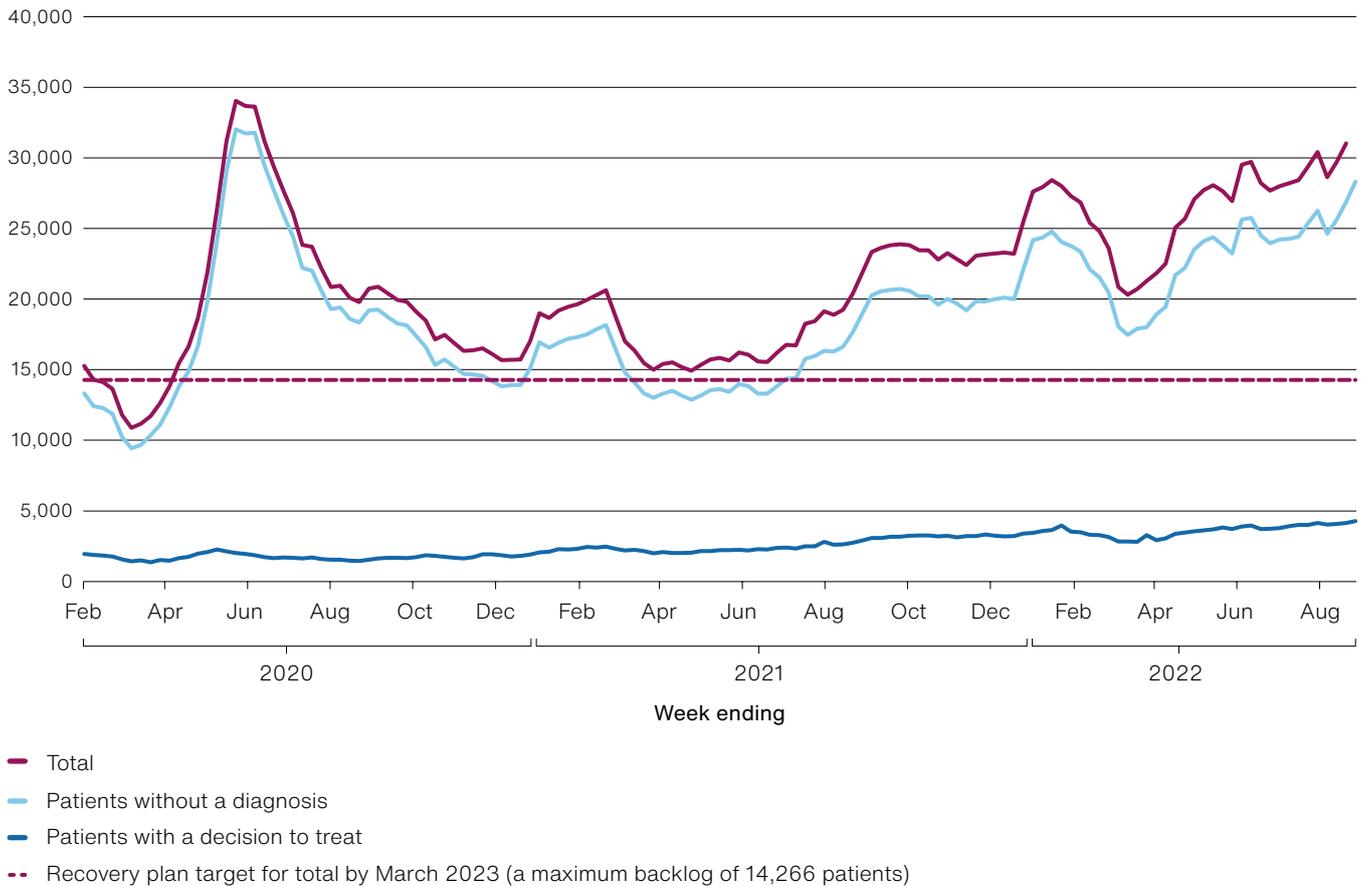
3.14 It is still early days for the recovery programme and many of NHSE's programmes are seeking to deliver improvements over the coming months and years. But there are also many ongoing risks for the recovery programme, which NHSE will need to manage carefully. We discuss what we judge to be six of the main risks below. In addition, the funding committed to the NHS up to 2024-25 is no longer worth what it was, because of the inflationary pressures described above (paragraphs 1.17 and 1.18). This may cause the NHS to have to make difficult choices about where to target its funds for investment.

Figure 11

Number of people waiting more than 62 days for diagnosis and/or treatment following an urgent referral for suspected cancer, February 2019 to August 2022

In August 2022, 4,300 people with cancer were waiting more than 62 days for treatment to start and 28,300 people had cancer neither confirmed nor ruled out

Backlog of patients waiting more than 62 days



Notes

- 1 Data are collected on a weekly basis from hospitals on patients waiting more than 62 days following an urgent suspected cancer referral.
- 2 The total includes those with a decision to treat and those urgent referrals who are waiting for a diagnosis after more than 62 days (the category 'Patients without a diagnosis' above).
- 3 NHS England derived its target of 14,266 by taking the figures for week-ending 16 February 2020 (14,123) and adjusting for three providers that did not submit data for that week.

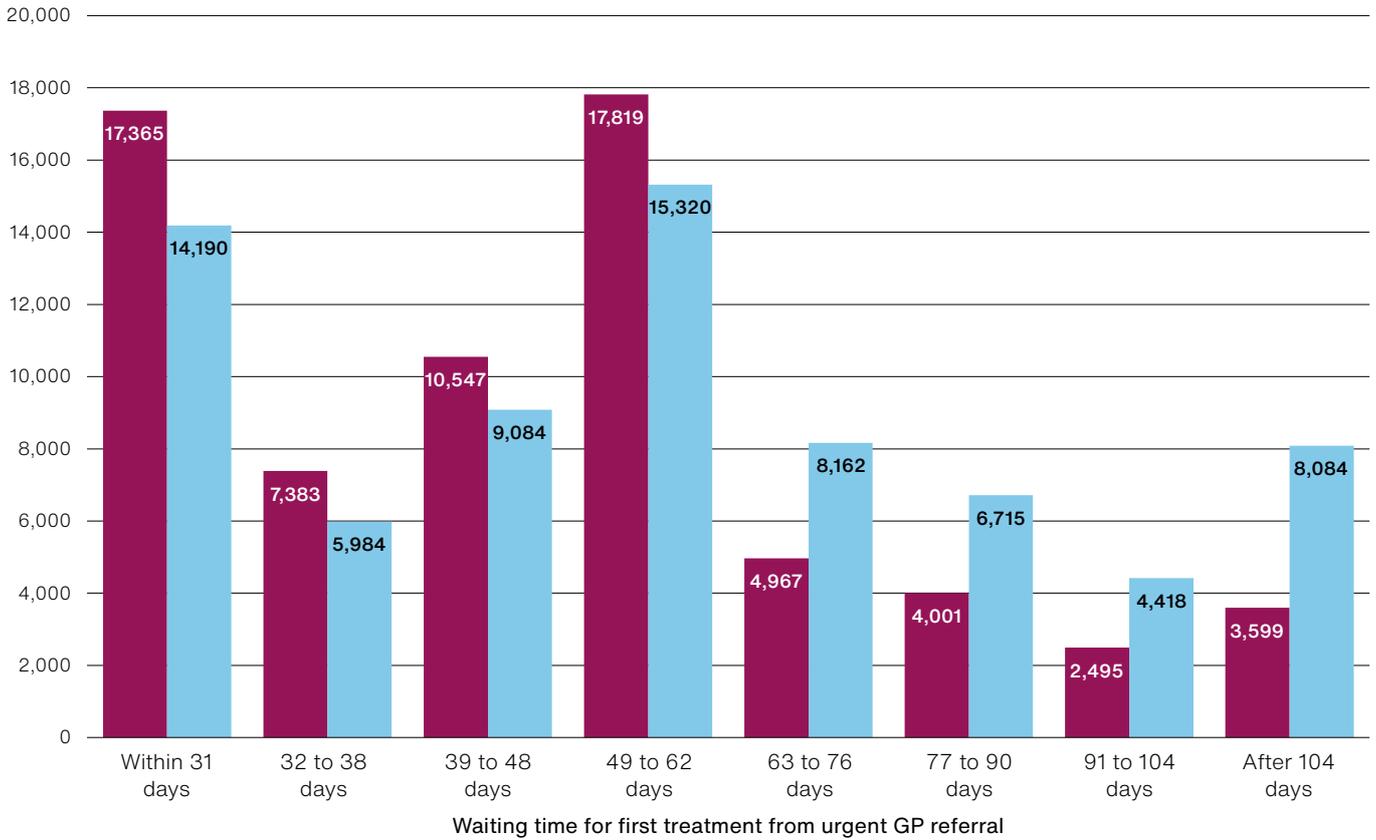
Source: National Audit Office analysis of NHS England's management information on cancer, published on 13 October 2022

Figure 12

Time to receiving first treatment for people urgently referred by their GP, from time of referral, April to August 2019 and 2022

In 2022-23, more patients are waiting longer for cancer treatment than in 2019-20 following an urgent GP referral, with 11% of all patients waiting longer than 104 days between April and August 2022

Number of patients



■ April to August 2019
 ■ April to August 2022

Note

1 For 2019 only, there is a difference of 1%-2% between the published cancer waiting time statistics given for the individual months at which the waiting time distribution is available and the national time series information.

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

Recovery programmes may not have the expected impact

3.15 Many of the programmes in the recovery plan are planning to deliver increases in capacity, productivity and efficiency over the next two and a half years. As described in Part One, new initiatives often have a limited evidence base. As described in Part Two, some have got off to a slower than expected start, while NHSE's systems for monitoring and managing progress are still at a relatively early stage of development.

3.16 If any single programme under-delivers, NHSE will need to be able to identify this quickly and take remedial action, possibly increasing its reliance on other programmes to increase activity. We are concerned also that the dependencies between recovery programmes have not been mapped systematically so they can be actively managed. Finally, identifying the specific impact and benefits of individual initiatives will be difficult when so many different programmes are proceeding in parallel. Doing all this effectively will require strong and focused leadership supported by a high-performing programme office, and with appropriate oversight by the Department of Health & Social Care (DHSC).

Further disruption

3.17 Further disruption to elective and cancer care may come from several sources, with the effect of reducing the availability of clinicians and beds and diverting management time. Potential sources of disruption include:

- Further waves of COVID-19, depending on the infectiousness and severity of the variant as well as vaccine performance. COVID-19 has already hampered NHSE's efforts to stay on its recovery trajectory in 2022 and could do again.
- 'Winter pressures' are a phenomenon the NHS plans for but their severity can vary from year to year. Worse-than-average incidence of hospital admissions from flu, as well as other factors, potentially including the high cost of home heating, could reduce the amount of elective care possible. In this context, it is notable that the operational plans of local systems, perhaps optimistically, do not show a drop in elective activity over the winter months of 2022-23.
- There is an elevated threat of industrial action from certain groups of NHS workers. Several trades unions are balloting their members over the adequacy of pay and conditions.
- Several programmes in the recovery plan rely on additional effort by GPs, but the primary care system is itself under strain.

Workforce

3.18 Having the right workforce in NHS provider organisations will be critical to a successful recovery. In total, the NHS had 8% more staff in February 2022 (1.22 million full-time equivalents) than in February 2020 (1.13 million). However, in March 2022, it was also carrying around 17,500 more vacancies (around 106,000 vacancies in total) than in March 2020. NHSE’s risk register for the elective recovery programme gives high ratings to each of the three risks relating to workforce. It is concerned that the rate of leavers will increase, that it will continue to be unable to recruit to key staff groups, and that staff sickness absence will remain high as result of stress and COVID-19 infections. NHSE is targeting an overall vacancy rate of 8.0% but the actual rate has increased and was 9.7% in June 2022.

3.19 There is mounting evidence of the significant stress many NHS workers feel. The Health and Social Care Committee said in 2021, “Burnout is a widespread reality in today’s NHS [...] There are many causes of burnout, but chronic excessive workload is a key driver and must be tackled as a priority”.¹⁶ The NHS staff survey, to which 648,000 staff responded in 2021, also highlighted concerns. **Figure 13** overleaf shows that only 42% of respondents were satisfied that their organisation valued their work (down from 48% in 2020); and only 27% said there were enough staff at their organisation to do their job properly (down from 38% in 2020).

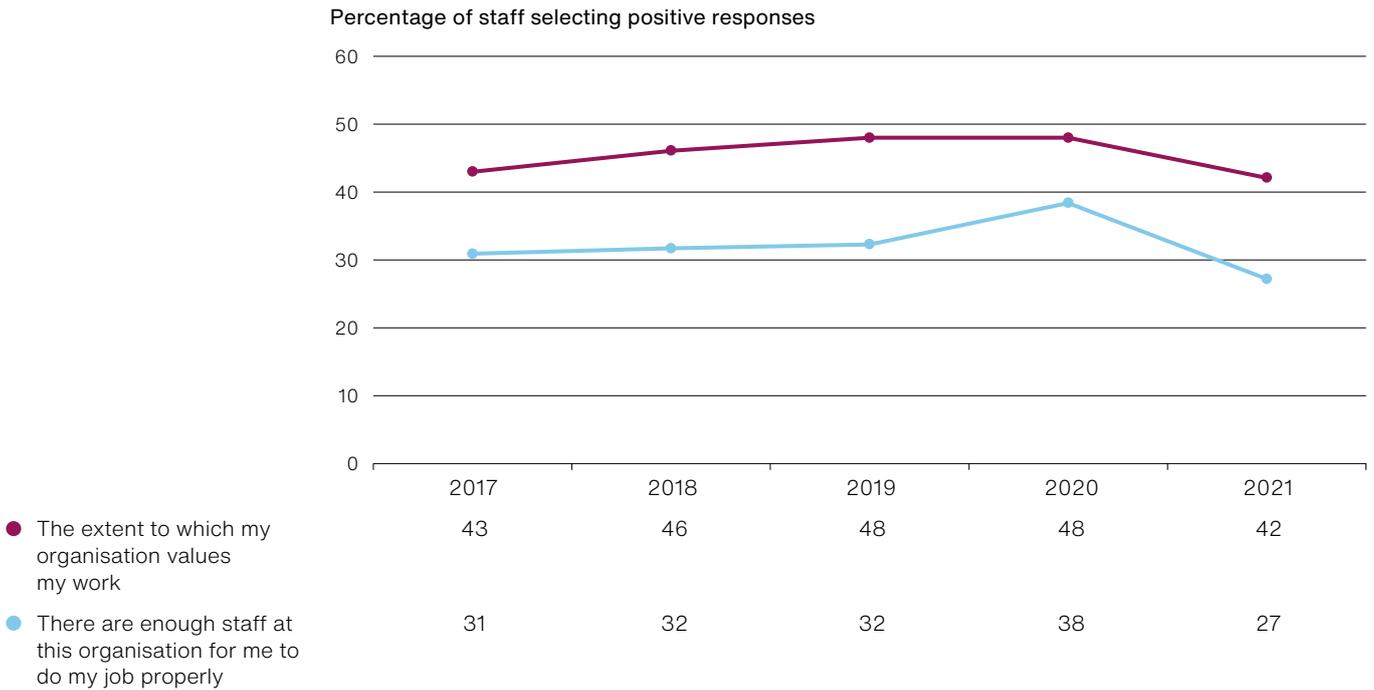
3.20 A further risk is that DHSC and NHSE are unable to resolve issues with tax arrangements for staff whose annual pension accrual is close to, or above, the maximum that is exempt from tax. Senior officials understand that these issues are currently causing some NHS clinicians to be unwilling to work extra sessions because of the large marginal tax rate they would incur. As an indication of the potential scale of the problem, according to the NHS Pension Scheme, 27,400 members (including GPs, consultants and other senior staff) breached their £40,000 annual allowance for tax-free pension accrual in 2020-21. This meant they potentially faced significant additional tax charges as their income increased.

¹⁶ Health and Social Care Committee, *Workforce burnout and resilience in the NHS and social care*, Session 2021-22, HC 22, June 2021. Available at: <https://committees.parliament.uk/work/494/workforce-burnout-and-resilience-in-the-nhs-and-social-care/publications/>

Figure 13

Proportion of NHS staff responding positively about their organisation’s staff numbers and valuing of their work, 2017 to 2021

The latest published NHS staff survey saw fewer staff responding positively about staffing and being valued than in previous years



Notes

- 1 Positive response is answering very satisfied or satisfied to the question on the extent to which their organisation values their work and strongly agree or agree to the question on there being enough staff at their organisation for them to do their job properly.
- 2 Everyone who works in the NHS in England is invited to take part in the NHS staff survey each autumn. The national results shown here are based on data from participating NHS trusts only. The response rates from NHS trusts were 46% in 2017, 47% in 2018, 50% in 2019, 49% in 2020 and 50% in 2021.

Source: National Audit Office analysis of NHS staff survey

Productivity

3.21 NHSE completed an internal review of NHS productivity in April 2022.

It estimated that the NHS was around 16% less productive in 2021 than it was in 2019, both as a result of reduced output and higher costs. This is a major problem, and NHSE believes that reduced productivity has continued in 2022-23. The internal review found that the three main drivers were as follows:

- On average, workers were not carrying out as many procedures as before. Possible reasons included more sickness absence, reduced discretionary effort (less propensity to work paid or unpaid overtime), and the redeployment of staff between teams.
- The impact of COVID-19 infection prevention and control measures continuing to reduce operating theatre capacity and increasing cancellations.
- A reduced management focus by NHS trusts and NHSE on cost control and operational rigour. For example, block funding contracts may have had the effect of removing incentives on trusts to contain costs and some trusts may have prioritised operational considerations over cost control.

NHSE's review went on to identify potential solutions at local, regional and national level to the productivity issue. Examining these is beyond the scope of our report.

'Missing' patients

3.22 Our December 2021 report highlighted that many people did not or could not access NHS services during the pandemic. Between March 2020 and September 2021, we estimated some 7.6 million to 9.1 million 'missing' referrals for elective care and some 240,000 to 740,000 'missing' urgent GP referrals for suspected cancer.

3.23 There continues to be considerable uncertainty about how many of these patients will return to the NHS for treatment and over what timeframe. A high level of returns, or returns that come into the NHS with higher levels of health needs, would substantially increase the risk that the NHS cannot achieve its targets to end the longest waits. From March 2022, NHSE commissioned research to better understand the expected behaviours of the missing elective patients, which between March 2020 and May 2022 it estimated at between 8.0 million and 10.6 million missing referrals. Early results of the research indicate to NHSE that the range of missing referrals that may return for elective care in future is 10% to 50%, which equates to 1.0 million to 5.5 million patients. NHSE plans to publish this work in due course.

Poor health outcomes and health inequality

3.24 Patients face increased risk of poor health outcomes, and possibly harm, due to delays. The NHS can mitigate these risks if it has good information about all patients waiting for care and uses it effectively to prioritise. However, NHSE is aware that for an unknown but sizeable proportion of patients there is no recorded assessment of their clinical priority. This is particularly the case for patients who have not yet seen a consultant. One of the 13 recovery programmes is aiming to validate waiting lists and determine clinical prioritisations.

3.25 The recovery plan promises a “fair recovery” with a focus on reducing health inequalities. The *Health and Care Act 2022* places a duty on each local system to reduce inequalities in patients’ ability to access health services and in their outcomes. However, there is a risk of health inequalities worsening. For such groups, initiatives to reduce demand for elective care, in particular a move to require patients themselves to initiate certain types of follow-up appointment, could exacerbate inequalities. NHSE is aware of the need to manage the risk relating to this initiative.

3.26 Analyses of waiting times in 2021, before the recovery plan was published, show the scale of the task. Calderdale and Huddersfield Foundation Trust carried out an analysis of its elective care waiting list in May 2021 and found that patients from the most deprived areas were waiting 8.5 weeks longer on average for priority two (patients who should receive treatment in less than one month) operations than those from more affluent areas, while patients from minority ethnic groups were waiting 7.8 weeks longer than white patients. Meanwhile, analysis by the King’s Fund in 2021 has shown that people in the most deprived communities are 1.8 times more likely to wait longer than a year for treatment compared with people in the least deprived areas.

3.27 In its recovery plan, NHSE states that reducing inequalities will be at the core of local recovery plans and performance monitoring, with a particular focus on people living in the most deprived areas. But we have seen limited evidence of NHSE closely monitoring this risk so far at the national level: for example, it is not covered in its assessment of local recovery plans, or the recovery programme risk register, or the monthly programme monitoring pack. We have also not seen an impact assessment for any of the component programmes. The chair of NHS England’s Health Inequalities Expert Advisory Group, who at the time was also the chief executive of Calderdale and Huddersfield NHS Foundation Trust, shared elective recovery analysis undertaken by his trust and advocated for other local NHS bodies to carry out similar analyses. NHSE has produced a health inequalities dashboard for two-week wait referrals, segmenting the data by deprivation, age, gender and ethnicity. It plans to publish this at some future point.

Measurement risks

3.28 Some of the NHS's key metrics for measuring elective activity and reductions in long waits are hard to understand and could be applied inconsistently. NHSE has publicly committed to increase elective activity to around 130% of the 2019-20 level, but it is not transparently reporting on the relationship between this target and its new measure of 'value-based activity'. It has also not defined clearly which patients are to be considered out of scope for its long-waits targets, for instance because it regards them as "very complex" cases. In both instances, there is a risk that definitions will be applied inconsistently or even illegitimately across the system, masking the true progress the NHS is making.

Appendix One

Our evidence base

1 The independent conclusions on both the Department of Health & Social Care's (DHSC's) and NHS England's (NHSE's) approach to tackling elective recovery were reached by analysing evidence collected in the fieldwork period between May and August 2022.

2 The analytical framework we used focused on a set of evaluative criteria that fit into three overarching questions:

- Are the national recovery plans realistic?
- Are the plans being implemented optimally at both national and local levels?
- Are early results in line with expectations?

3 We used 20 evaluative criteria to inform evidence collection and assess what good would look like to achieve success from the recovery plan. We used a mixed-method analytical approach to review analysis from the clients and perform our own quantitative and qualitative analysis.

Interviews

4 We conducted 32 virtual interviews with key representatives from DHSC, NHSE and third-party stakeholders to inform our audit.

- **Structured interviews with DHSC and NHSE, including members of the joint-delivery unit.** We discussed issues across the full breadth of our report. We discussed elective and cancer care recovery, policy and strategy, finances, oversight and governance, health inequalities and the impact of longer waiting times on inequitable outcomes. Individuals were selected because of their job roles and relevance to the report. We held regular meetings with the NHSE liaison team for evidence request updates.
- **We interviewed the DHSC's and NHSE's modelling teams about the referral-to-treatment models they have developed to project the likely size of the backlog, and the modelling used for activity forecasts.**

- **Interviews with wider stakeholders.** We interviewed representatives from health stakeholder organisations as well as independent sector providers to understand wider sector views on the NHS's response to elective and cancer recovery. We met with the NHS Confederation, Royal College of Surgeons, Royal College of Radiologists, Independent Healthcare Providers Network and Spire Healthcare.

Document review

5 We reviewed 89 published and unpublished documents as well as literature and email submissions from DHSC, NHSE and local NHS systems. We reviewed these documents to inform our understanding of programme governance, monitoring and evaluation, performance, oversight and financial arrangement and support and guidance provided to newly arranged local systems.

6 These included:

- board papers for the elective recovery programme board, programme-specific deep-dive reports and case studies from NHSE;
- official letters and guidance from NHSE to Integrated Care Boards (ICBs);
- internal audit and risk assessments for component programme delivery;
- operational planning guidance for 2022-23;
- local plans for 2022-23 and evaluation from NHSE;
- internal analytical plans and analysis from NHSE on key components of elective and cancer recovery;
- a walk-through of internal reporting systems for programmes and elective reporting against targets; and
- analytical models used by DHSC and NHSE to test the targets in the elective recovery plan and financial modelling tools.

Case studies

7 We selected a cross-section of integrated care systems (ICSs) with varying levels of performance on elective and cancer care:

- Birmingham and Solihull;
- Devon;
- Mid and South Essex;
- North East and North Cumbria; and
- North West London.

8 We conducted mixed method case study visits for five ICS areas to help us understand and explain some of the observed difference in performance and capacity that exist across England. We also aimed to collect evidence about local actions to deliver the national recovery plan and to illustrate the similarities and differences between NHS local systems. The selection was not statistically representative but included systems with varying performance on waiting times, geographies, levels of deprivation and presence of additional capacity. Two case studies were conducted virtually and three were carried out through meeting in person.

9 For each case study, we held an initial meeting and set up a series of meetings over a selected period with ICS chief executives and ICB chairs, chief finance officers, medical directors, chief operating officers and elective recovery directors, among others. In total we interviewed 38 officials across the five systems. We reviewed and analysed operational plans for 2022-23 for all case study visits. The notes from our meetings were incorporated into our broader evidence base and a comparative analysis was performed to inform our wider conclusions. We are grateful for the time provided from each ICS.

10 For each case study we also interviewed a senior official in the relevant NHSE regional office to obtain their perspective on how the case study ICS was managing its recovery.

Data analysis

11 In Part One of our report, we set out NHSE's planned elective activity trajectory to 2024-25, which is based on modelling provided to us by NHSE. We used the DHSC Budget as stated in the Autumn Spending Review 2021 and HM Treasury's GDP deflator forecast for long-term inflation to estimate the real-terms growth of funding. We audit DHSC expenditure as part of auditing its annual report and accounts.

12 We performed a range of quantitative analyses using data published on NHSE's website. These included:

- **elective waiting times**, which we analysed to show the distribution of patients waiting for different time bands more than 26 weeks, local variation by ICS for patients waiting more than 78 weeks;
- **cancer waiting times** to show changes in the number of urgent referrals and the number of patients waiting to start cancer treatment compared with pre-pandemic years;
- **diagnostic waiting times** to identify the proportion of patients waiting more than the six-week diagnostic standard;
- **outpatient referrals** to compare with 2019-20 data;
- **NHS workforce data** for full-time equivalent staff and vacancy percentage changes; and
- **NHS staff survey** to identify the percentage of staff responding positively to their organisation and valuing their work.

13 Statistics on the numbers of people waiting for elective and cancer care are rounded in the Key Facts and Summary and are given as the actual unrounded numbers in the main body of the report (Parts One to Three).

This report has been printed on Pro Digital Silk and contains material sourced from responsibly managed and sustainable forests certified in accordance with the FSC (Forest Stewardship Council).

The wood pulp is totally recyclable and acid-free. Our printers also have full ISO 14001 environmental accreditation, which ensures that they have effective procedures in place to manage waste and practices that may affect the environment.



National Audit Office

Design and Production by NAO Communications Team
DP Ref: 009311-001

£10.00

ISBN 978-1-78604-451-8



9 781786 044518