National Audit Office

REPORT

Managing NHS backlogs and waiting times in England

Department of Health & Social Care and NHS England

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Department of Health & Social Care and NHS England

Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

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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.