NHS Confederation

NHS Backlogs and waiting times

December 2021

About us

The NHS Confederation is the membership organisation that brings together, supports, and speaks for the whole healthcare system in England, Wales, and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care, and reducing health inequalities.

Summary

The COVID-19 pandemic has resulted in the highest number of people waiting to receive planned NHS care since records began in 2007. As of November 2021, it stands at a record high of 5.83 million people. The National Audit Office estimates this could rise to somewhere between 7-12 million patients by March 2025[i].

Beyond the numbers, health inequalities pervade the backlog with evidence suggesting that many of those waiting or 'missing' from the waiting lists are from deprived and underserved communities[ii]. Services must be empowered to make local decisions which identify the patients most at risk from worsening health inequalities. For this reason, services need to not only allow but actively grow the backlog by reaching out to these people and proactively adding those who need care onto waiting lists. This approach will help ensure we are addressing the backlog in a more equitable way.

The pandemic has exacerbated workforce supply issues and there are renewed challenges in mobilising an already exhausted and demoralised workforce to meet demand across the system. The Government needs to develop and implement detailed workforce plans to address the shortages in the workforce both over the next 12–36 months and in the longer term and strengthen their approach to make sure they deliver on the responsibility of training and recruiting the workforce needed across health and care services.

The existing performance standards for elective care aim to treat 92% of patients within 18 weeks and ensure no waits beyond a year. These standards are not fit for purpose in the

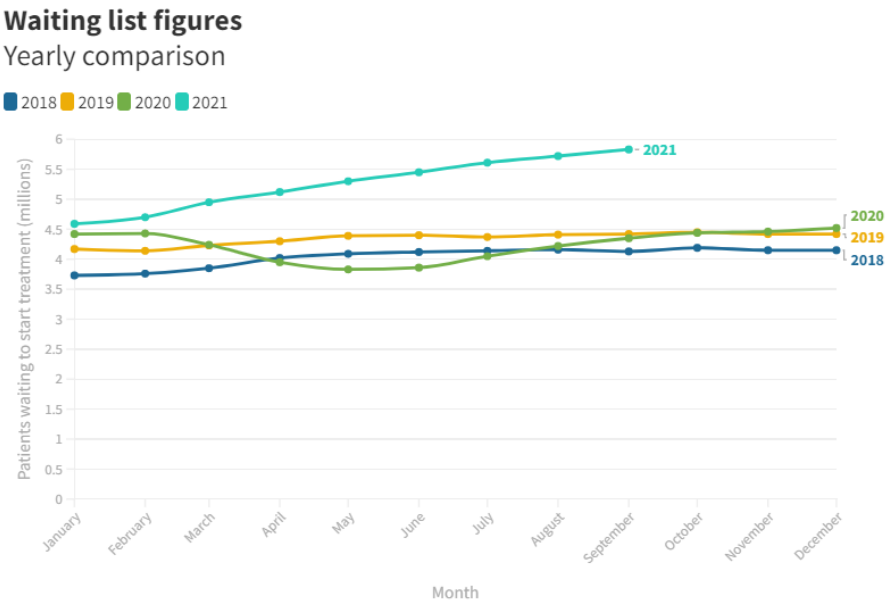
circumstances the NHS now faces. A comprehensive new plan and new constitutional commitments are needed, that focus on the quality of care and equity of access, not just in seeing the backlog in terms of waiting times.

There must be clear and transparent messaging from Government about the sheer scale of challenge faced by the NHS in restoring services. It is imperative that, if we are to achieve a reduction in the elective and cancer backlog, the Government commits to openness, transparency and being honest and realistic with the public about the demands on services, how processes to prioritise care must protect the most vulnerable and improve overall outcomes, and what people on waiting lists should expect.

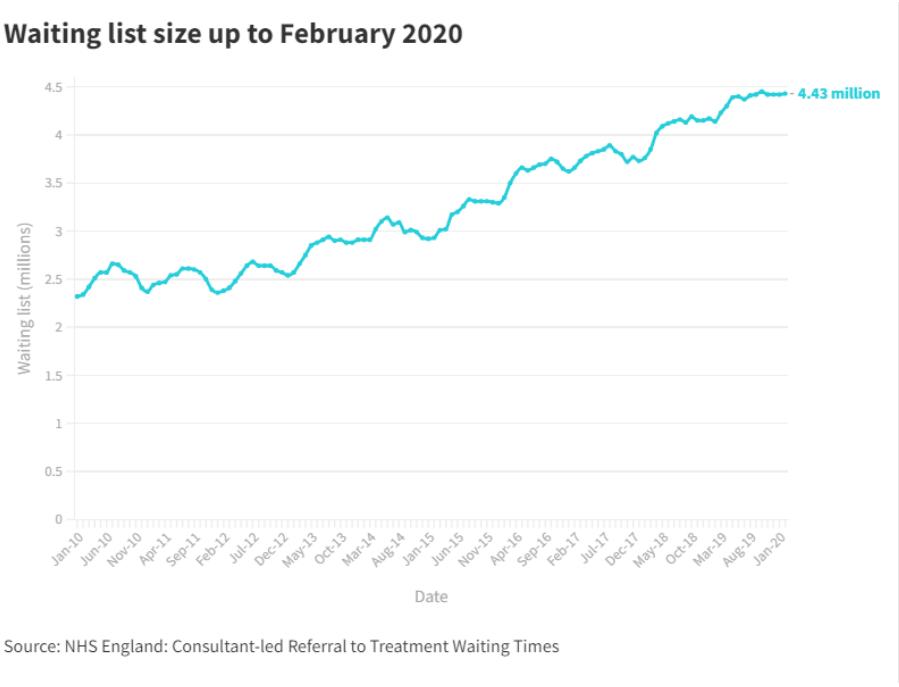
Before the pandemic, what were the root causes of the NHS's deteriorating performance against the standards required for waiting times for elective care and cancer services?

1. The COVID-19 pandemic has resulted in the highest number of people waiting to receive planned NHS care since records began in 2007, rising to 5.83 million in November 2021 [iii]. The National Audit Office estimates that there will be between 7-12 million patients on elective waiting lists by March 2025[iv].

2. Over the past decade the NHS has experienced a rising demand for its services whilst under sustained financial constraints. NHS acute, mental health, community, ambulance and primary care services have continued to experience high levels of demand associated with multi-layered, complex, and long-term health needs from a growing, socially diverse and ageing patient population.



Source: NHS England | Consultant-led Referral to Treatment Waiting Times Data



Source: NHS England: Consultant-led Referral to Treatment Waiting Times

3. NHS core funding has not kept up with high levels of demand. During the period of austerity that followed the 2008 economic crash, the Department of Health and Social Care budget continued to grow but at a slower pace than in previous years. Budgets rose by 1.4% each year on average (adjusting for inflation) in the 10 years between 2009/10 to 2018/19, compared to the 3.7% average rises since the NHS was established[v]. This financial constraint combined with rising demand for both elective and cancer care caused an increase in waiting times even though NHS was doing more work year-on-year. Demands for its services has increased even faster[vi].

4. The availability of sufficient NHS workforce to meet demand has long been problematic with investment in training and retaining of staff not keeping pace with the demand for services, leading to chronic workforce shortages in key areas.

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

What did the NHS do well and what could it have done better in providing elective care and cancer services during the pandemic?

6. Urgent and emergency procedures (priority 1 and 2) have largely been maintained during the pandemic; much of the growth in waiting lists comes from lower priority, high-volume procedures (priority 3 and 4) for conditions ranging from painful bone and joint conditions to ear, nose and throat and ophthalmology. This was due to prioritisation decisions having to be made for elective procedures due to Covid-19 impacts.

7. Despite the immense pressure the pandemic has inflicted on the system, NHS staff have mobilised to implement innovative changes to patient pathways to improve both quality and access to services. Examples include new intermediate pathways for children and young people presenting with an eating disorder to avoid admission; effective use of nurse triage models in rapid assessment areas; same-day access to diagnostics; virtual wards in the community; better use of advice and guidance with generalists and specialists working together to avoid admission; and effective management of patient treatment lists by sharing patient data[viii].

8. Some innovations will be particularly useful for addressing the elective backlog. Given the potential for Covid to disrupt planned care, the accelerated implementation of 'hot' and 'cold' sites to separate urgent from planned care has significantly improved performance across the NHS. Implementation of 'waiting well' models through alternative workforce or digital approaches, also provide an effective system solution for staying in touch with patients on the waiting list. Reduced regulatory pressure has relieved some of the bureaucratic pressures on staff, allowing them additional headspace to respond to pandemic pressure and innovate at scale[ix].

9. NHS staff and teams will need adequate funding and support to scale such initiatives, which will help to reduce the elective backlog more quickly and equitably.

Case studies

Barking, Havering and Redbridge University Hospitals NHS Trust

BHRUT set up a successful initiative to extend elective care to 1,000 more patients between May and September. The Scalpel Project was delivered by the trust's general surgery division and focused on seeing patients that had been waiting longest.

Through a special series of six Saturday clinics, they were able to provide flexibility to patients who are unable to attend a weekday appointment. The trust is now looking to build on this project, to embed the positives of the initiative into the system and share best practice with others across the country facing similar challenges.

West Hertfordshire Hospitals NHS Trust

The COVID-19 virtual care ward established at West Hertfordshire Hospitals NHS Trust saved nearly 300 bed days over a three-week period at the height of the first wave.

A latterly used patient monitoring app called Medopad more than doubled the number of patients monitored at home.

Norfolk and Norwich University Hospitals NHS Foundation Trust is now scaling the virtual ward model to support recovery and beyond. The trust now has almost ten live care pathways and is developing more condition-specific virtual wards, including diabetes and heart failure.

Further case studies can be found at www.nhsconfed.org/case-studies/working-harder-ever-support-patients-and-communities.

What are the biggest challenges faced by local healthcare providers in recovering performance on waiting times for elective care and cancer services?

10. A priority is to understand the 'missing 7.42 million' who did not come forward for care during the pandemic as would otherwise have been expected. We know many of them will be from deprived and under-served groups. This will require the Department of Health and Social Care and NHSEI to empower systems to reach out and identify patients who need care but are yet to present themselves to services and accept that waiting lists will get worse before they get better. Ultimately, this approach will help ensure we are addressing the backlog in a fairer way that doesn't worsen health inequalities as people from deprived and marginalised groups have been more likely to hold back from seeking care during the pandemic.[x]

11. Our analysis of available data has shown a relationship between levels of local deprivation and waiting time trends. Evidence suggests that increases in waiting list numbers are associated with areas of greater deprivation, especially in neurology, general surgery, and dermatology. Increases in admissions for specialties such as trauma and orthopaedics and ENT are associated with areas of less deprivation;[xi] and overall levels of waiting per head of population are associated with areas of greater deprivation.

12. In the same way that COVID-19 cases disproportionately impacted black and minority ethnic and more deprived communities, our analysis of available data has shown a relationship between levels of local deprivation and waiting time trends. Radical approaches are therefore needed to build back fairer, including proactively adding people to the waiting list in the short term to ensure those who need care receive it promptly and to prevent conditions from worsening unnecessarily[xii].

13. The pandemic has exacerbated workforce supply issues and there are renewed challenges in mobilising an already exhausted and demoralised workforce to meet demand across the system. The mental health and wellbeing of staff must be supported through ongoing funding for initiatives like mental health hubs.

14. The need to grow and address waiting lists needs to be balanced with addressing the risk that increased pressure on NHS staff could cause many on the brink of retirement, or burnout[xiii].

15. A recent poll carried out by NHS Confederation of its members showed that the pressure on the NHS is now at unsustainable levels and patient safety and care are being put at risk by staff shortages. Nearly nine in 10 (88%) members said the demands on their organisation are unsustainable. Almost the same number (87%) also say that a lack of staffing across the whole of the NHS is putting patient safety and care at risk.[xiv]

16. NHS Confederation members earlier in the year asked for relatively small amounts of capital funding at pace to manage both elective and emergency pressures over the winter period. NHS leaders warned that receiving funding at short notice would make it more challenging to invest constructively and with more planning investment can be made to reduce waiting times further by expanding their elective capacity. However, they have consistently experienced delays and administrative challenges in accessing the funds in a sufficiently timely manner to make the necessary changes in time.[xv]

17. For the period 1st April 2020 to 31st March 2021, NHS organisations reported that the total cost to eradicate the NHS Estate backlog was £9.2 billion. This is a 2.2% increase since 2019/20[xvi]. We are pleased to see the overall DHSC capital budget increase and systems offered the flexibility to spend it according to their need, but the process for applying for funding is extremely bureaucratic and time consuming, especially at a time when NHS leaders are facing severe challenges.

18. NHS Confederation welcomes the recent announcement of £700 million for the NHS this winter to support NHS leaders invest in capital funding in facilities that will make them more efficient and improve patient care, such as community diagnostic hubs and elective treatment centres. The need for long term approaches to capital investment that support investment in new and more efficient ways of working is crucial[xvii].

19. Our members welcomed the moving of the Elective Recovery Fund threshold of 89% of 2019/20 RTT pathway activity down from 95%. This will allow more providers to access the fund. However, our members have been telling us that rising demand from winter pressures; sustained COVID-19 demand; unprecedented A&E admissions; continued demand and pressure on social care; urgent and emergency care; backlog in ambulance delay handovers and ongoing discharge challenges with patients who are medically fit for discharge but impacted by delayed packages of social care. All these factors are exacerbating an already challenging health and social care system, making it very difficult to access the ERF at this threshold.

20. The publication of the Government's Adult Social Care Reform White Paper has been long awaited and whilst we welcome the White Paper, it does little to address the urgent immediate pressures facing the people who rely on vital social care services, including tackling severe staff shortages[xviii].

How should DHSC and NHSE support local providers to recover their performance?

21. The NHS needs a new approach to waiting lists and a new funding and regulatory framework that focuses less on rigid performance standards and more on collaboration, health inequality and patient wellbeing. By reaching out to people who should be waiting for care and proactively adding them to waiting lists, the NHS can fully understand the scale of the problem and plan accordingly.

22. Reducing the elective backlog must consider all parts of the health and social care system – not just in acute hospital settings. Social care is essential to being able to ensure flow of patients out of NHS settings and hospital beds to free up capacity. Mental health, primary and community providers form an eco-system that helps patients wait well before elective treatment. All require investment and support to play their role.

23. The NHS Constitution commitments, to treat 92% of patients within 18 weeks and that no one should wait beyond one year, no longer work for the circumstances we now face. The pandemic has shown the need to consider equity of experience and outcomes, not simply access, and the need to align performance indicators and incentives to support providers and systems to achieve this shift. Constitutional commitments should therefore include:
    - duties to improve outcomes and reduce health inequalities
    - focused resources on deprived populations to support them entering planned pathways much earlier thereby reducing non-elective admissions
    - early diagnostics and active waiting as part of the elective pathway
    - long-term sustainable capability[xix].

24. Reform needs to be accompanied by clear and consistent messaging from the government that the elective situation will not be resolved in 12 months, that waiting times will be managed differently as the NHS recovers, and what people on waiting lists can expect.

25. NHS workforce vacancies have contributed to the elective backlog and will continue to have an impact unless there is consistency in the supply and development of healthcare professionals. To enable this and develop a workforce that can meet community-based population health goals, and provide acute and primary care, the Government and the NHS needs to develop and implement detailed plans to address the shortages in the workforce both over the next 12–36 months and beyond. Government must strengthen their responsibility and accountability with regard to ensuring we are training and recruiting the workforce needed across health and care services in the longer term.

26. Patient activation is crucial in making gains in the elective recovery plan. Encouraging, empowering, and utilising the knowledge, skills, and confidence a person has in managing their own health conditions is an important lever in bringing down the backlog. Giving patients choice over where and when they attend their appointments; discussing the options available; whether they can attend virtually or via telephone; and what follow-up appointments are right for that individual all contribute to an active decision-making process in outpatient pathways.

    Are plans and funding announced to date enough to help the system recover or, if not, what in your view is still missing?

27. Tackling the elective care backlog and meeting rising demand will mean the NHS workforce will need to grow by almost a fifth by 2024/25.[xx] The Health Foundation estimates this requires HEE's budget to increase to £5.5 billion by 2024/25[xxi]. There needs to a comprehensive long-term plan to address workforce shortages across health and care. Funding will only go so far if we do not keep pace with the right mix of skills and roles needed to transform delivery of care. The NHS Confederation supported amendment to Clause 34 of the Health and Care Bill that would strengthen the duty on the Secretary of State for Health and Social Care to ensure enough workforce are trained to meet the demands on the NHS. We will also support any similar amendments brought in the Lords stages of the Bill's progression.

28. At the time of writing, we are awaiting the Government's Elective Recovery Plan which will include further detail on how the elective backlog will be reduced. We welcome the focus on the increased use of technology and the NHS App; commitment to patient activation; alternative options for patients to access elective care appointments and possibly a single national waiting list. However, it is vital that all these initiatives do not further the already widening health inequalities gap we are seeing in the backlog. Drivers and incentives for reducing the elective backlog must be fully aligned across the system and made clear to NHS leaders that strategies to tackle this enormous challenge is nationally aligned so that we are all working in the same way to achieve the same goal.

29. The government and national bodies need to support the NHS to manage the realities of recovering services, not set unrealistic targets and impose financial penalties. A key part of this is an oversight framework which enables local leaders to lead and innovate.

30. Local leaders are experts on deciding on the most effective interventions locally to manage waiting lists and must be given the autonomy to make local decisions they are best placed to lead on. The Department of Health and Social Care, national bodies and local systems should work with leaders across the NHS to support them to innovate by supplying commensurate funding and workforce.

31. Finally, there must be clear and transparent messaging from Government about the sheer scale of challenge faced by the NHS in restoring services. It is imperative that, if we are to achieve reducing the elective and cancer backlog and provide timely, accessible health and social care services, that the public understands the immense pressure the NHS is currently under and what that means for the people waiting. We therefore call on the government for a new commitment to openness, transparency and public engagement, being realistic with the public about the demands on the service and clear that the prioritisation of care is important to protect the most vulnerable and improve overall outcomes.

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[i] National Audit Office (2021) NHS backlogs and waiting times in England: www.nao.org.uk/wp-content/uploads/2021/07/NHS-backlogs-and-waiting-times-in-England.pdf [Accessed 2 Dec 2021]

[ii] www.nhsconfed.org/news/reaching-out-7-million-patients-hidden-waiting-list-requires-generational-change [Press]

[iii] NHS England (2021) Consultant-led referral to treatment waiting times: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/

[iv] National Audit Office (2021) NHS backlogs and waiting times in England: www.nao.org.uk/wp-content/uploads/2021/07/NHS-backlogs-and-waiting-times-in-England.pdf [accessed 2 Dec 2021]

[v] https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget

[vi] National Audit Office (2021) NHS backlogs and waiting times in England: www.nao.org.uk/wp-content/uploads/2021/07/NHS-backlogs-and-waiting-times-in-England.pdf [Accessed 2 Dec 2021]

[vii] Ibid.

[viii] NHS Confederation (2021) A system approach to the demand crunch: https://www.nhsconfed.org/publications/system-approach-demand-crunch

[ix] NHS Confederation (2020) Lean, light and agile: governance and regulation in the aftermath of COVID-19: https://www.nhsconfed.org/publications/lean-light-and-agile

[x] NHS Confederation (2021) Manifesto for recovery: the health and care system after COVID-19 https://www.nhsconfed.org/sites/default/files/2021-10/Manifesto-for-recovery-0.pdf

[xi] Ibid.

[xii] NHS Confederation (2021) Building back inclusively www.nhsconfed.org/sites/default/files/2021-09/Building-back-inclusively.pdf

[xiii] Ibid.

[xiv] NHS Confederation (Nov 2021) NHS has reached tipping point, warn healthcare leaders [Press]. https://www.nhsconfed.org/news/nhs-has-reached-tipping-point-warn-healthcare-leaders
[xv] https://www.nhsconfed.org/news/government-must-increase-nhs-capital-funding-and-remove-needless-bureaucracy-leading-run-down
[xvi] www.digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/england-2020-21
[xvii] www.nhsconfed.org/news/funding-will-help-secure-care-winter [Press]
[xviii] www.nhsconfed.org/news/nhs-confederation-responds-social-care-white-paper
[xix] NHS Confederation (2021) Manifesto for recovery: the health and care system after COVID-19 [Press].
[xx] The Health Foundation (2021) What will it cost to get the NHS and social care on the road to recovery? [Blog]
[xxi] Ibid.