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Returning NHS waiting times to 18 weeks for routine treatment

The scale of the challenge pre-COVID-19

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Contents

Key points

- Reducing elective waiting times from ‘18 months to 18 weeks’ was one of the English NHS' major achievements in the 2000s. In January 2020, before coronavirus (COVID-19) began to impact on the UK, more than one in six patients were waiting more than 18 weeks for routine treatment. To free up NHS capacity, non-urgent planned care was postponed for 3 months from 15 April 2020.
- Even before the COVID-19 pandemic, to meet the 18-week standard for newly referred patients and clear the backlog of patients who will have already waited longer than 18 weeks, the NHS would have needed to treat an additional 500,000 patients a year for the next 4 years. The pandemic is likely to make waiting lists grow further and the challenge will be even greater.
- At the end of April, the NHS in England was asked to begin a cautious programme to resume some of the routine services suspended in response to COVID-19. Returning the NHS to ‘normal’ is hugely important but poses significant challenges. For example, treating patients with enhanced infection control arrangements will reduce the volume of patients that can be treated relative to normal.
- For planned hospital care, this challenge has to be seen against a backdrop of growing waiting lists and waiting times. In January 2020, before large numbers of COVID-19 hospitalisations, a total of 4.4 million patients were on the waiting list – around 730,000 of whom had waited more than 18 weeks.
- The rates of spending growth, set out in the NHS Funding Bill in February 2020, will not be sufficient to cover the cost of meeting the 18-week standard by March 2024, even before any additional costs and demand arising from COVID-19. The Health Foundation estimates that spending growth would need to increase by a further £560m a year – assuming the NHS can prioritise patients to make the most effective use of available capacity.
- Without a radical intervention to increase capacity, it is unrealistic to expect the 18-week standard can be achieved by 2024 with current infrastructure and staffing levels. Meeting the 18-week standard would require hospitals to increase the number of patients they admit by an amount equivalent to 12% of all the patients admitted for planned care in 2017/18. This would be an unprecedented increase in activity.
- COVID-19 makes the challenge even greater. Over the coming years there will need to be long-term changes to how routine care is delivered, considerable effort at the front line and potentially an important role for the independent sector if the NHS is to return to a position of meeting the 18-week standard. But even with huge efforts, the reality is that longer waiting times for planned care are likely to be a feature of the NHS in England for several years at least.

Introduction

At the end of April 2020, the NHS in England was asked to begin a cautious programme to resume the routine services suspended in response to COVID-19. Over a 6-week period, NHS hospitals in England went from treating no patients with COVID-19 to looking after a daily peak of 19,000 inpatients (confirmed as having the virus) in mid-April. NHS services were transformed to free up beds and manage the spread of the infection: patients were discharged, planned treatment postponed and services shifted online.

Today, the number of patients in hospital with COVID-19 is falling, but many of those discharged will need aftercare and ongoing support – for example from mental health, renal and neurology services, primary and community health services.

Reconfiguring NHS services was essential to meet the anticipated surge in demand for COVID-19 patients in March and April 2020, but there were wider consequences for the health and care system. All non-urgent planned acute care was postponed and – following a 57% fall in A&E visits in April 2020 compared to the same month in 2019 – there were concerns about people not getting the urgent care and treatment they need, including for serious health conditions such as cancer.

Restarting planned treatment is important but will be complex. Patients will need reassurance about the risk of catching COVID-19 in hospital settings, while the virus must now be a factor in clinical judgements about the balance of risk for different care options. Hospitals will be expected to embed infection control arrangements, use virtual consultations unless clinically necessary and physically separate elective and emergency services as far as possible. Asymptomatic patients will be expected to self-isolate for 14 days and, where feasible, test negative for COVID-19 before admission. Enhanced planning and protection will be needed for patients considered 'clinically extremely vulnerable'.

The NHS expects some rebound in emergency demand, but the timing and extent is uncertain. April 2020 saw just over half the number of emergency admissions than the same month in 2019; returning to normal could see emergency patients potentially reoccupying tens of thousands of hospital beds. The imperative to keep patients with COVID-19 separate will prevent the NHS from returning to pre-pandemic levels of bed occupancy, which reached 92% by the end of 2019. There will need to be longer term changes in how planned care is delivered and the independent hospital sector could play an important role, after it was virtually block-booked early in the pandemic to provide additional capacity.

Returning to 'normal' levels of activity is expected to take some time and, even before COVID-19, there were substantial challenges with waiting times. As the NHS looks to start to recover services, this analysis looks at the context in which planned treatment will recommence. Specifically, it looks at what would have been needed – if the NHS were operating within a 'business as usual model' – to return to delivering the standard of 92% of patients being treated within 18 weeks, given the waiting lists and waiting times backlog that had built up by January 2020.

Throughout the NHS' history, providing timely care has been a major challenge for the health service. In 2000, waiting times were among the longest of comparable countries. According to the OECD, in 2001 the median wait for a hip replacement in the UK was 215 days – more than double that of Australia (96 days).

For all the strengths of a taxpayer-funded NHS free at the point of use, long waits were often seen as the inevitable downside of the Beveridge model. Waiting times are routinely identified as an important factor in public satisfaction with the health service and patient experiences of NHS care. Long waits may mean patients experience additional pain, anxiety and inconvenience, and may lead to higher risk of harm and poorer outcomes.

In 2002, the Labour government committed to a major injection of NHS funding with one of the key aims being to dramatically reduce waiting times for NHS elective care in England. In 2004 this crystallised into the ambition to reduce waiting times from '18 months to 18 weeks'.

By December 2008, waiting times for elective care had fallen substantially: 90.3% of admitted patients and 96.8% of non-admitted patients were seen within 18 weeks. And international comparisons showed that the UK no longer had some of the longest waits – the median wait for a hip replacement in the UK fell from 215 days in 2001 to 78 by 2008.

But this transformation has not been sustained and waiting times are now making the headlines for all the wrong reasons. The standard that at least 92% of patients should wait no longer than 18 weeks to start elective treatment has not been achieved for nearly 4 years. This despite it being a legal right under the NHS constitution. And, in January 2020, before COVID-19 began to impact on the UK, more than one in six patients were waiting for more than 18 weeks.

Even without COVID-19, reversing the deterioration in performance against the standard would have required ruthless prioritisation alongside years of hard work, investment and reform. Before we factor in COVID-19's impact, given the gap between current performance and the standard, what would it take for at least 92% of patients to begin treatment within 18 weeks, how much would it cost and is there a realistic prospect of delivery by 2024?

A short overview of waiting times

Waiting lists are as old as the NHS, but targets for waiting times are a more recent phenomenon dating back to the Patient's Charter introduced in 1992. Improvements in performance allowed maximum waiting times to be repeatedly revised down – to 3 months for a first outpatient appointment and 6 months for inpatient treatment in 2000 – as part of a new 'war on waiting'.

But this did not always reflect the reality of how long people waited. A typical pathway involves three stages:

1. time from GP referral to first outpatient appointment
2. time to arrive at a diagnosis and decide on treatment options, and
3. time from that decision to the start of treatment.

The 3 and 6 month targets could be met but, with no comparable measure of time spent in the second stage, some patients still experienced long delays.

The 18-week standard

Introducing the 18-week standard in 2004 fundamentally changed how the NHS measures and manages waiting times. Under the 18-week standard, the clock starts with a GP referral and only stops when the patient starts treatment or is discharged. This demanded a different mindset to the previous 'stage of treatment' targets. Hospitals had to instead look at the whole pathway – managing capacity and tracking patients through outpatients, diagnostics and inpatient services – and align clinical pathways with administrative systems to achieve the standard.

The 2000s were the era of 'targets and terror', but delivery took more than performance management. Delivery of waiting times was also hardwired into system reforms to enable patient choice and competition. The system of Payment by results rewarded trusts for expanding elective activity, and being on track to hit 18 weeks was a prerequisite for applying for coveted foundation trust status. Nationally procured contracts with the independent sector created additional elective capacity, as well as another incentive for trusts to raise their game and avoid losing lucrative extra income. This was all in the context of substantial growth in funding and staff numbers, which meant trusts had the resources needed to act on the incentives the reform created.

The 18-week standard was met in 2008 and performance broadly sustained through the transition to the coalition government. The original standards were based on completed pathways, which created a perverse incentive to treat patients who had not yet reached 18 weeks, over those who had already waited longer, to make reported performance look better. To address this, the coalition added an additional standard for 2012/13 that at least 92% of patients still waiting to start treatment should have waited 18 weeks or less. A few years later, the 'completed pathway' standards were dropped entirely and the 'incomplete pathway' standard became the NHS' single measure of elective waiting times.

The standard was last met in February 2016, when the number of patients who had waited more than 18 weeks was 269,589. By January 2020, the number waiting more than 18 weeks increased nearly threefold to 730,267 in 4 years, while the waiting list has grown from 3.35 million to 4.42 million – and probably more, with several trusts not currently reporting data. Fundamentally, NHS activity to complete pathways and remove patients from waiting lists has not kept pace with the growth in demand.

Waiting times have increased in all regions and specialties. Figure 1 shows the percentage of patients on the waiting list for over 18 weeks by region in January 2020 – this is compared to the 8% (100%–92%) target.

Figure 1:

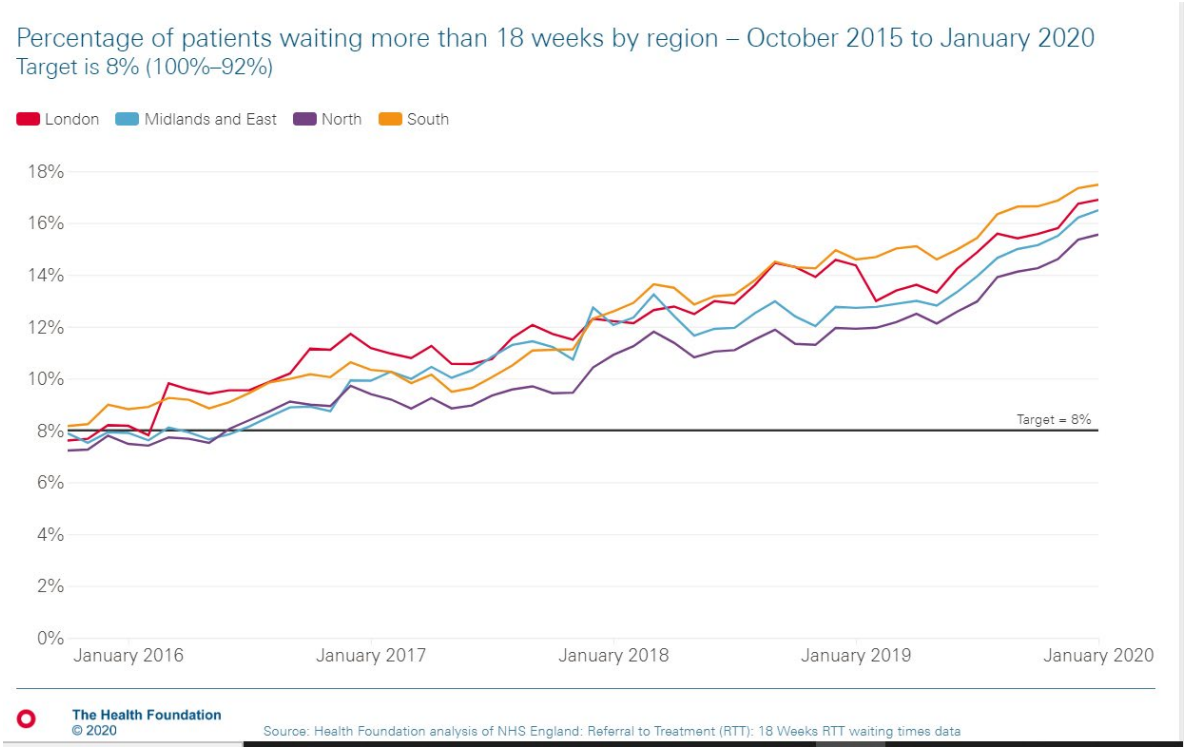
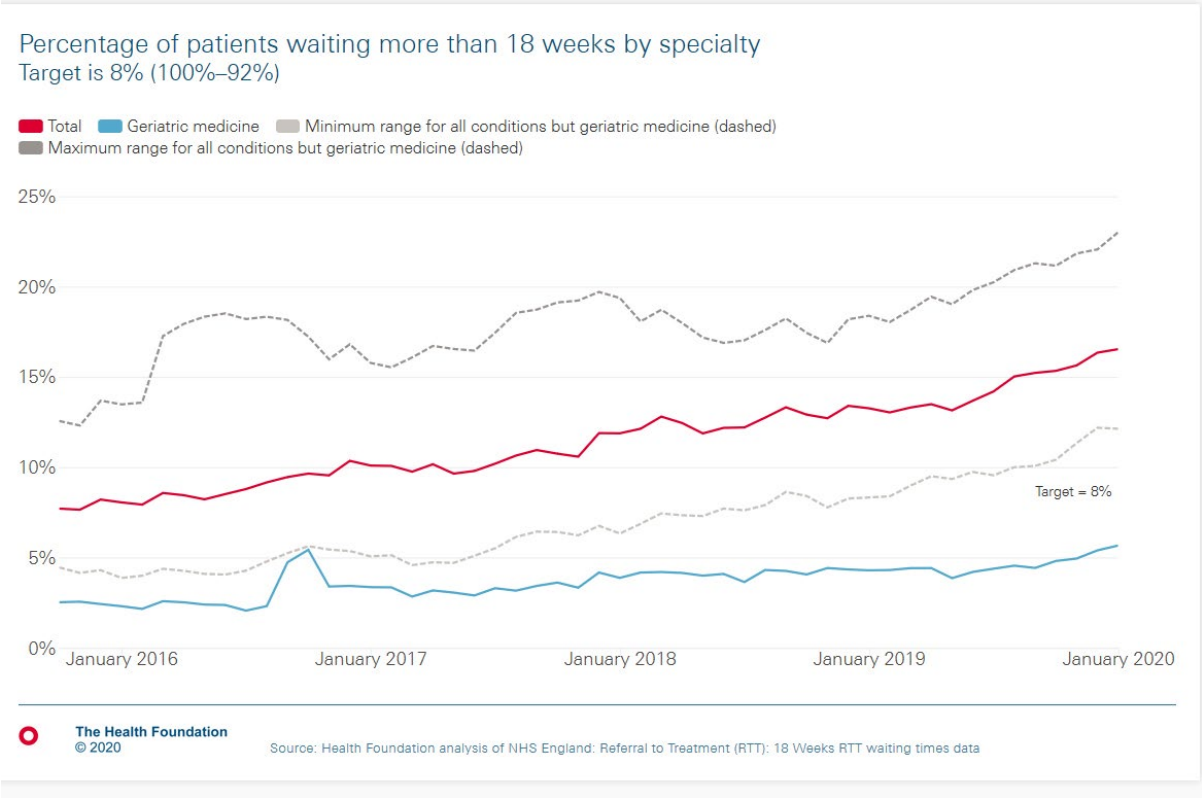


Figure 2 shows the percentage of patients on the waiting list for more than 18 weeks by specialty. All specialties but one (geriatric medicine) have missed the target since November 2018. In some specialities around a fifth of all patients are now waiting more than 18 weeks.

Figure 2:



The Long term plan for the NHS in England (2019) promised extra funding to cut long waits for elective care and reduce waiting lists by 2023/24. Prior to COVID-19, planning guidance expected waiting lists to reduce in 2020/21. This may help to slow the deterioration in performance, but even before the pandemic recovering the 18-week standard looked very challenging.

What would it take to recover the 18-week standard?

In 2017, waiting times specialist Rob Findlay published estimates of the cost of meeting the standard to start elective treatment. At that point, 92% of patients were being seen within 20.3 weeks rather than 18, and the waiting list was 3.83 million. Findlay estimated that the NHS needed to treat an additional 170,000 people per year to keep up with demand and see 92% of new patients within 18 weeks. In addition, he concluded that there was a backlog of a further 600,000 patients who would also need to be treated to recover the standard overall.

Since then, waiting times have deteriorated. In the winter of 2017, 8% of patients were waiting over 21 weeks for their referral; this rose to 25 weeks by the end of January 2020, with 4.42 million people on the waiting list. The number of people being added to the waiting list each year is growing by 3.1% and the NHS is not keeping up with the growth in demand. Findlay recently pointed out that '4 years of waiting list growth would need to be undone to achieve the NHS Constitution standard again'. Using the same methodology, Health Foundation analysis estimates

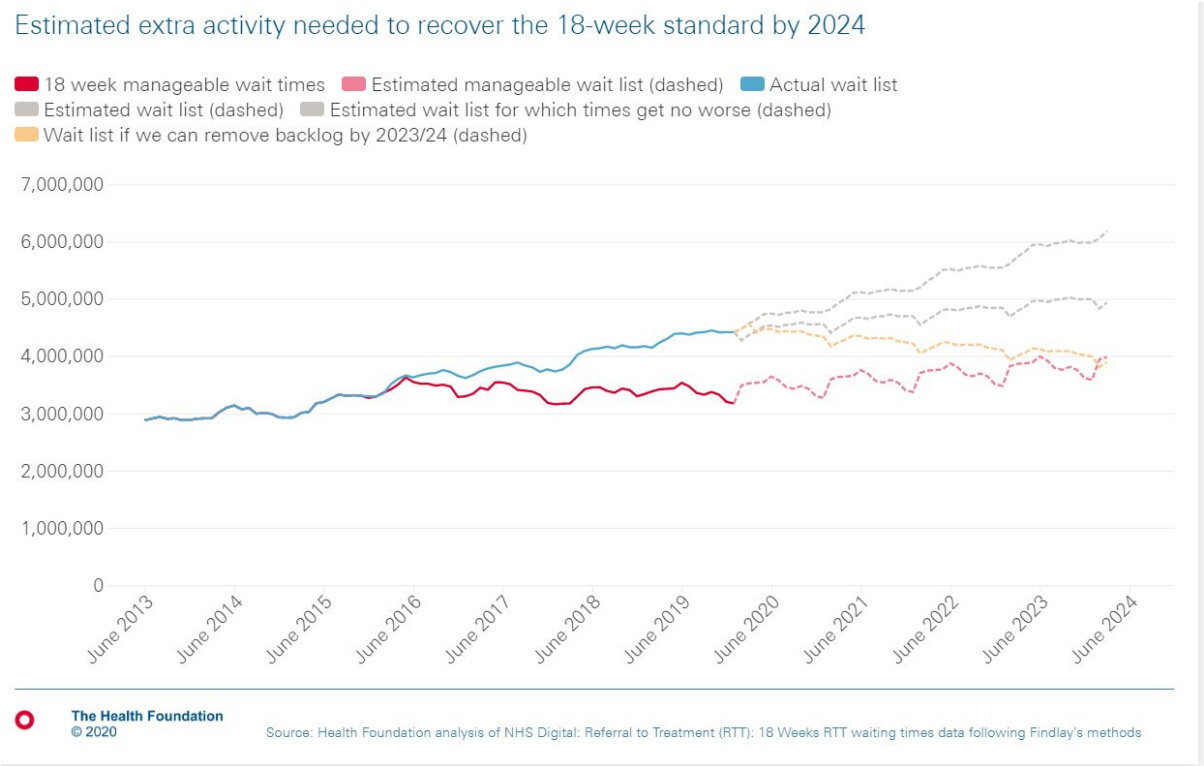
that to keep up with this growing demand and meet the 18-week standard for new patients, the number of additional patients the NHS needs to treat each year has increased to 210,000.

Since 2017 the backlog of patients has also grown. By 2023/24 the NHS must see and treat an additional 1.3 million people over the next 4 years, to address patients already on the list and eliminate this backlog. This is more than double Findlay's 2017 estimate of the backlog.

If the aim is to meet the 18-week standard by the end of this parliament (which this analysis takes as by the end of financial year 2023/24) this would mean the NHS needs to treat over 500,000 more patients in each of the next 4 years.

Figure 3 compares the actual number of people on the waiting list with the size of the waiting list, which would be consistent with 92% of people starting treatment within 18 weeks. It then projects forward current trends.

Figure 3:



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It is important to note that these estimates may be low – they assume that waiting times have no impact on the rate at which GPs refer patients for specialist care or treatment thresholds in specialist care. If GPs responded to lower waiting times by referring more patients, for example, an even larger increase in NHS activity would be needed to meet the standard.

Estimating the cost

Health Foundation analysis estimates the total direct cost of treating 92% of patients within 18 weeks to be £5.2bn–6.8bn, including elimination of the backlog by the end of March 2024. The total direct cost will depend on how efficiently the NHS deals with waiting lists. All financial figures are in 2019/20 terms.

Our base scenario consists of an additional £380m per year for 4 years to keep pace with demand (200,000 additional patients a year being treated), plus £3.6bn to clear the backlog (1.3 million patients). If this were spread evenly over the next 4 years, it equates to a total annual cost of £1.3bn.

Table 1: Estimated cost of returning to the 18-week standard

Scenario:		Base case		High-cost scenario
Year	Annual	by end 2023/24	Annual	by end 2023/24
Recurring				
Extra activity over trend to stop waits growing	210,000		210,000	
Cost per case for recurring activity	£1,800		£2,800	
Cost of stopping waiting time pressures from growing (£m)	£378	£1,512	£588	£2,352
Non-recurring				
Backlog clearance to achieve 18 weeks	1,300,000		1,600,000	
Cost per case for backlog clearance	£2,800		£2,800	
Cost of backlog clearance (£m)	£3,640	£3,640	£4,480	£4,480
Total cost (£m)		£5,200		£6,800

Notes: Health Foundation analysis of NHS Digital: Referral to Treatment (RTT): 18 Weeks RTT waiting times data following Findlay's methods and NHS Digital Reference cost data

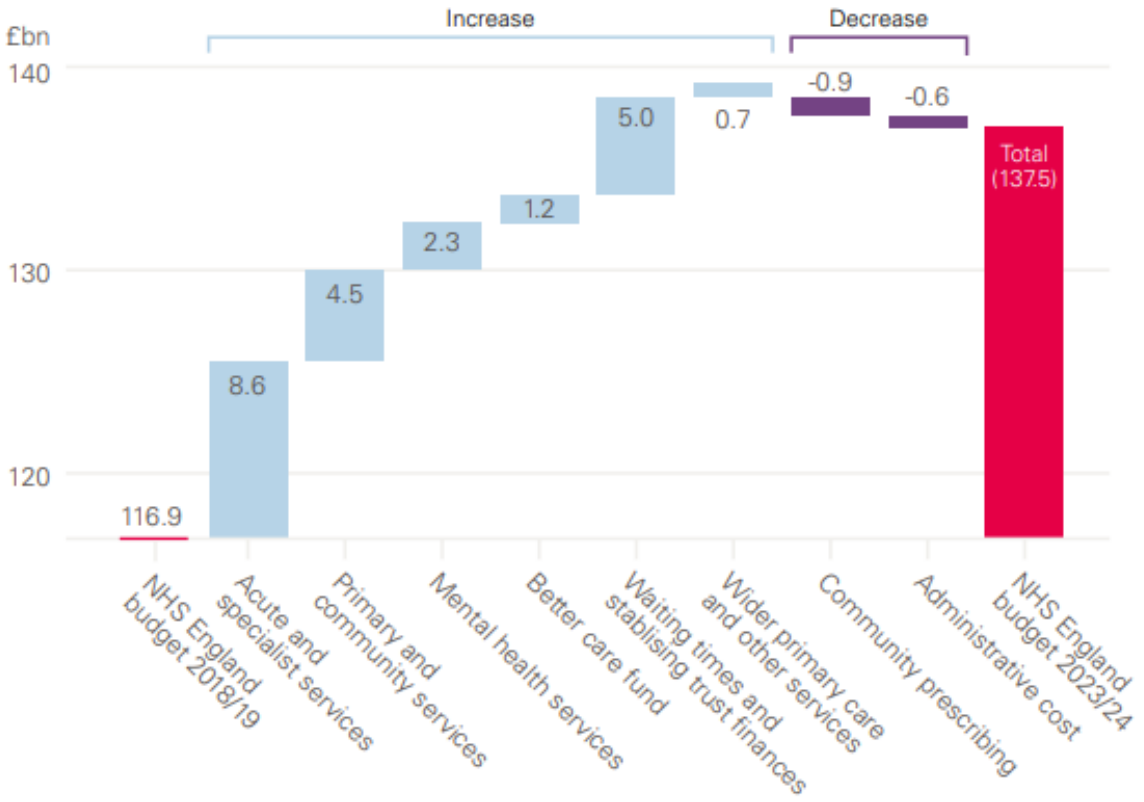
In costing the additional activity needed to keep pace with demand, the Health Foundation calculate a weighted average cost of an inpatient treatment (£4,200) and an outpatient-based treatment (just over £500). This is based on the assumption that just over a third of the extra patients requiring treatment each year will need to be admitted to hospital. (For example, 36% of patients with incomplete pathways over 18 weeks required an inpatient admission in January 2020.) Our estimated cost is £1,800 per patient completing treatment.

For the backlog, following Findlay's methodology, this analysis has increased the average cost by 50% on the basis that these cases will be more complex and, therefore, more costly to treat – leading to an average cost of £2,800 per patient.

Can the NHS afford to meet the 18-week standard?

The government has set out funding plans for NHS England up to 2023/24, showing that spending will increase by £20.8bn in real terms by 2023/24. Alongside the additional funding, in the NHS Long term plan the health service set out a strategy for how to spend the money and improve services. Part of the additional £20.8bn real-terms funding increase between 2018/19 and 2023/24 is earmarked for reducing waiting times. Figure 4 is the Health Foundation's estimate of the planned allocation of NHS funding growth.

Figure 4: Planned and assumed allocation of NHS England funding growth 2018/19 to 2023/24



Source: Authors' calculations; *The NHS long term plan*; NHS England board papers and accounts.

These calculations are based on Health Foundation and IFS projection modelling, which estimates that £5bn would be needed to deliver NHS waiting times standards, including the 18-week standard, and return NHS providers to financial balance. Within this, the delivery of waiting time standards is estimated to cost around £2bn. This figure was based on Findlay's initial estimates of the recurring pressures and backlog of 170,000 and 600,000 patients respectively.

If the backlog of patients waiting more than 18 weeks was evenly distributed across the 4 years (from the start of 2020/21 to the end of 2023/24), the NHS would then need to treat:

- 40,000 additional cases at an average cost of £1,800
- 175,000 (1.3m – 600,000) / 4) cases per year at an average cost of £2,800
- giving a total of £560m more per year at an absolute minimum.

Our analysis suggests that the further lengthening of waiting times since publication of the NHS Long term plan means that the rates of spending growth, set out in the NHS Funding Bill in February 2020, will not be sufficient to cover the cost of meeting the 18-week standard by March 2024. This analysis estimates that spending growth needs to increase by a further £560m a year unless the extra investment planned for mental health, primary and community health services are scaled back.

How well are waiting times being managed?

Our estimates depend on the NHS' ability to efficiently deal with waiting lists. Shifting from 18 months to 18 weeks required funding, but it also involved significant attention to how patients flow through the health care system from referral to assessment for diagnostic tests, and onto treatment. Managing the process efficiently and effectively is critical to reducing waiting times.

Financial penalties for not meeting the 18-week standard were introduced in 2012, which led to more effective prioritisation of cases and management of patient flow. This can be quantified through the index of waiting list management, a measure of how effectively hospitals are allocating their resources and how quickly the NHS can treat a given list of patients. This index improved from 2011 to meet the current standard, but has deteriorated since the beginning of 2016. A key assumption in the base scenario of our analysis and costing of recovering the 18-week standard is that this index will not continue to get worse.

However, the additional measures that will now be needed to deliver planned care – as well as the risk of having to up and downscale activity to manage local outbreaks of COVID-19 – will present substantial challenges to efficiently managing waiting lists. This analysis therefore presents the activity and cost implications of meeting the 18-week waiting time standard if the index returns to 2011 levels. In this high-cost scenario the backlog is estimated to be higher in March 2020 at 1.6 million instead of 1.3 million. It is also highly possible that the cost of the recurring additional activity is higher than the estimated average; here the recurring costs have been inflated to match the backlog clearance (£2,800). This results in a higher cost of recovering the 18-week standard of £6.8bn.

Is there a realistic prospect of delivery?

These estimates relate to the direct costs of treating additional patients. As such, they do not reflect the full scale of the challenge. Realistically, whether this can be done will depend on whether a system already at capacity is able to go over and above current plans.

The numbers above would require almost 2.2 million more outpatient appointments and elective admissions in 2023/24. This may also have capital funding implications in order to provide enough beds and physical facilities. Staffing shortfalls, bottlenecks in diagnostic services and high levels of bed occupancy will continue to constrain hospital capacity, with scope for elective activity to be crowded out by increasing demand for emergency care. This is before the impact of COVID-19 on both demand and capacity is taken into account.

General and acute bed occupancy in England was already at 92.0% – the maximum set by NHS England and Improvement – at the end of 2019 and nursing vacancies were over 40,000. Various measures in the NHS Long term plan should support more efficient delivery of some of the additional activity needed, but are unlikely to substantially reduce demand.

Even if the government is willing and able to increase NHS funding by £500m a year over the next 4 years, delivering the additional activity required to recover the 18-week standard is unlikely to be feasible. Around a third of people on the waiting list will need a spell in hospital. This would require hospitals to increase the number of patients they admit by an amount equivalent to 12% of all the

patients admitted for planned care in 2017/18. This would be an unprecedented increase in activity.

So, even before the COVID-19 pandemic took hold, it was hard to see how the 18-week standard could have been achieved by the end of 2023/24 given the infrastructure and staffing levels. There is more that can and should be done to address the misery of long waits, and the NHS has already made commitments to do so. But until the health service has the capacity it needs to meet demand – and the support of a sustainable system of social care – a promise to recover 18 weeks within this parliament would be putting the cart before the horse.