

Elective care in England

Assessing the impact of COVID-19 and where next

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Key points

- While the pandemic's full impact on access to elective care in England is still emerging, this long read uses routine data on 18-week waiting times for consultant-led elective care to look at what we know so far.
- Before the pandemic, **meeting the 18-week standard** would have required the NHS to treat an additional 500,000 patients a year for the next 4 years – an unprecedented increase in activity, which looked unrealistic before COVID-19 and looks even harder now.
- The number of people waiting for consultant-led elective care was 4.2 million in **August** 2020, around 196,000 less than at the end of 2019 (4.4 million). But this is only the case because the 32% reduction in the number of elective care pathways completed was exceeded by the 34% reduction in the number of new pathways being started.
- From January to August 2020, the specialties with the greatest reductions in new pathways were oral surgery, trauma and orthopaedics, and ophthalmology (42%, 42% and 40% lower respectively than in the same period in 2019).
- The impact of COVID-19, and the response to it, have been felt across the UK but more acutely in **some parts** of the country. Similarly, while the pandemic has already had a stark effect on the waiting list at national level, there are signs that access to elective care has been better in some parts of England than others. This includes regions with lower rates of the virus after the initial peak, which may have also faced fewer difficulties in restarting routine hospitals services.
- With returning to the 'old normal' unlikely to be enough, more radical options are now under consideration. This includes giving full consideration to the role the independent sector can play, while acknowledging the sector is unlikely to be a suitable option for all patients in all regions of England.
- Every day that activity lags behind demand, the backlog will continue to grow. With the government due to announce the results of a Spending Review, the impact of postponing elective care on millions of people, the extent of the backlog the NHS will face, and the new measures needed to address it, should all be taken into account when making decisions about future NHS funding.

Introduction

Early in the coronavirus (COVID-19) pandemic, there was a major risk of intensive care capacity being overwhelmed by a surge in the number of patients seriously unwell with the virus. To help **free up hospital capacity**, the NHS in England postponed non-urgent routine hospital treatment – similar to measures used before to help manage **winter pressures**, albeit with far fewer patients affected than will be by the pandemic. While the full impact on access to elective care is still emerging, this long read uses routine data on 18-week waiting times for consultant-led elective care to look at what we know so far.

The **World Health Organization** declared the outbreak a ‘public health emergency of international concern’ on 30 January 2020. Shortly afterwards, the experience of hospitals in Lombardy, northern Italy – the location of the first COVID-19 outbreak in Europe – showed how rapidly intensive care capacity could be overrun. Lombardy’s **Codogno hospital** reported its first intensive care patient to test positive for COVID-19 on 20 February. Less than a month later, Italian doctors warned hospitals everywhere to activate emergency plans for a surge in demand. The **European Centre for Disease Prevention and Control** similarly warned of the high and imminent risk that health system capacity would be exceeded.

‘Protecting the NHS’ therefore became top priority for the UK government, with a national lockdown to follow as hopes of containing the virus faded. **Freeing up** inpatient and critical care capacity was a major part of the health service’s preparations for the pandemic. All non-urgent elective operations were postponed for at least 3 months. ‘Medically ready’ patients were discharged from hospital, supported by emergency legislation and funding for support packages. Hospitals in the independent sector were block-booked, giving the NHS priority access to around 10,000 additional beds for urgent surgery or COVID-19 patients. Temporary hospitals, built with help from the **armed forces**, created new facilities with space for thousands of additional critical care beds.

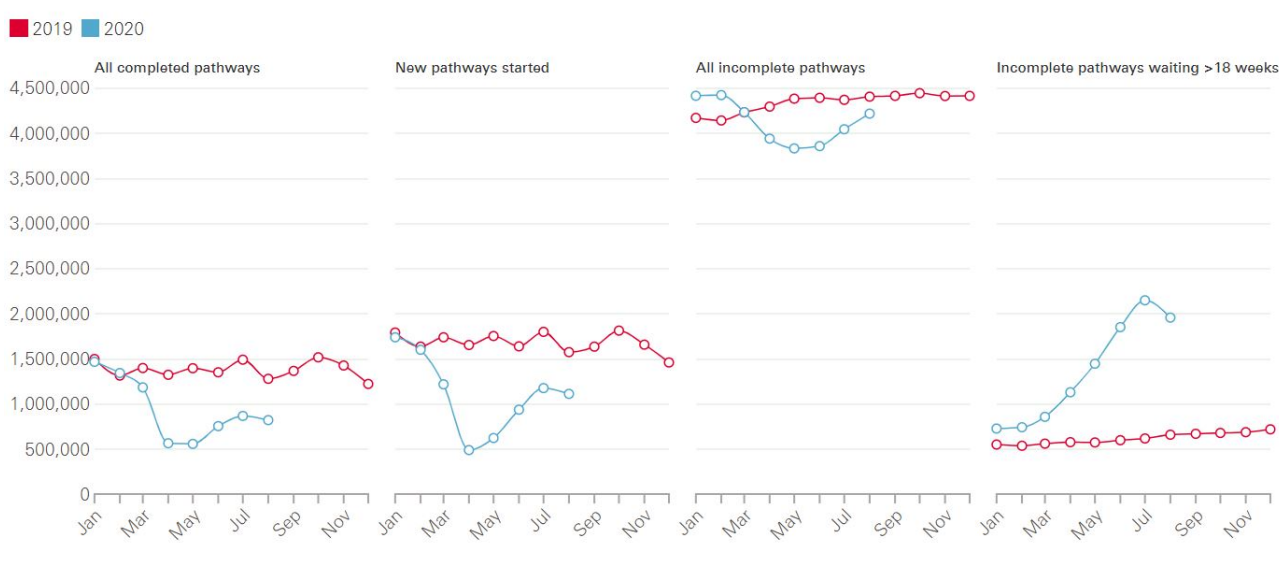
In the initial phase of the pandemic, the number of patients in hospital with confirmed COVID-19 **peaked in mid-April** and intensive care capacity was not overwhelmed – though **some hospitals** reportedly came close. However, enormous volumes of hospital activity had to be postponed in the process which will have **important consequences** for millions of people.

The national picture for England

The number of people waiting for consultant-led elective care (the waiting list) was **4.2 million in August 2020**, around 196,000 less than at the end of 2019 (4.4 million), and well short of predictions of **10 million by Christmas** – but looks can be deceiving. Figure 1 compares the size of the waiting list and the number of people who have waited over 18 weeks in 2019 to 2020 so far, as well as the two main factors that determine the size of the waiting list.

Figure 1:

The number of completed, incomplete and new pathways by month in England in 2019 and 2020



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Source: [NHS England, Consultant-led Referral to Treatment Waiting Times](#)

The first factor is the rate at which clinical pathways are completed and patients are removed from the waiting list – usually when a definitive treatment is carried out, a clinical decision is made that treatment is not required or the patient declines treatment. During the initial peak of the pandemic, the number of completed pathways fell substantially. From January to August 2020, a total of 7.6 million admitted (inpatient and day case) and non-admitted (outpatient) pathways were completed – 3.5 million fewer than the 11.1 million completed in the same months in 2019. By any standard, a substantial reduction in activity – but, given the circumstances, continuing this volume of treatment was a major achievement. Had hospitals been overwhelmed by COVID-19, the reduction would have been even larger.

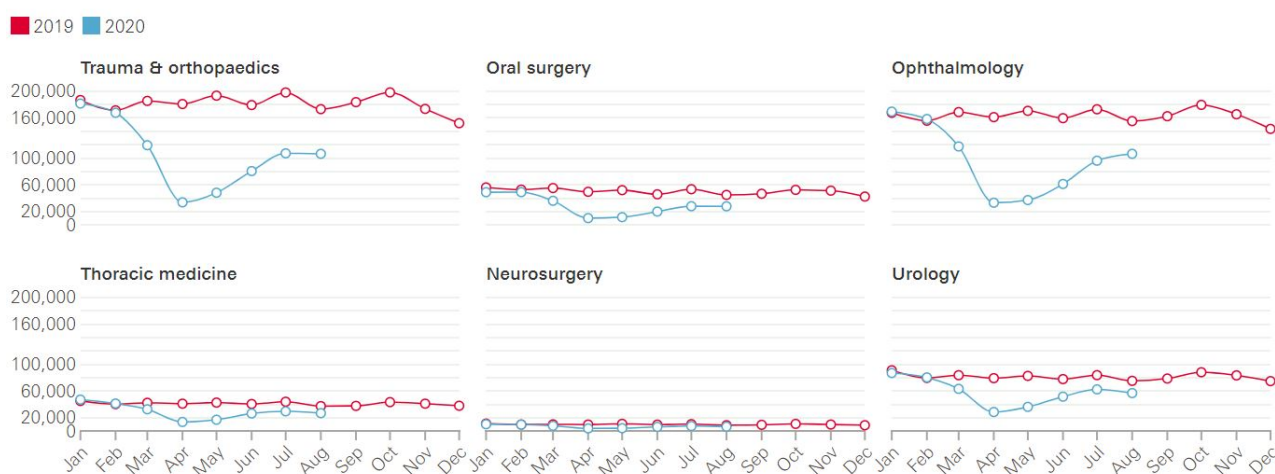
The 18-week standard covers all consultant-led elective care, with procedures reported at specialty level. Figure 2 shows the specialties with the largest slowdowns in the number of new pathways so far in 2020, as well as those with the smallest reductions. From January to August 2020, the greatest

reductions were in oral surgery, trauma and orthopaedics, and ophthalmology – 42%, 42% and 40% respectively lower than January to August 2019. The smallest reductions in completed pathways were in dermatology (24%), neurology (17%) and thoracic medicine (21%).

Figure 2:

The number of new pathways started by specialty by month in 2019 and 2020 during the COVID-19 pandemic

The three specialities most affected during the COVID-19 pandemic are in the top row and the three least affected are in the bottom row



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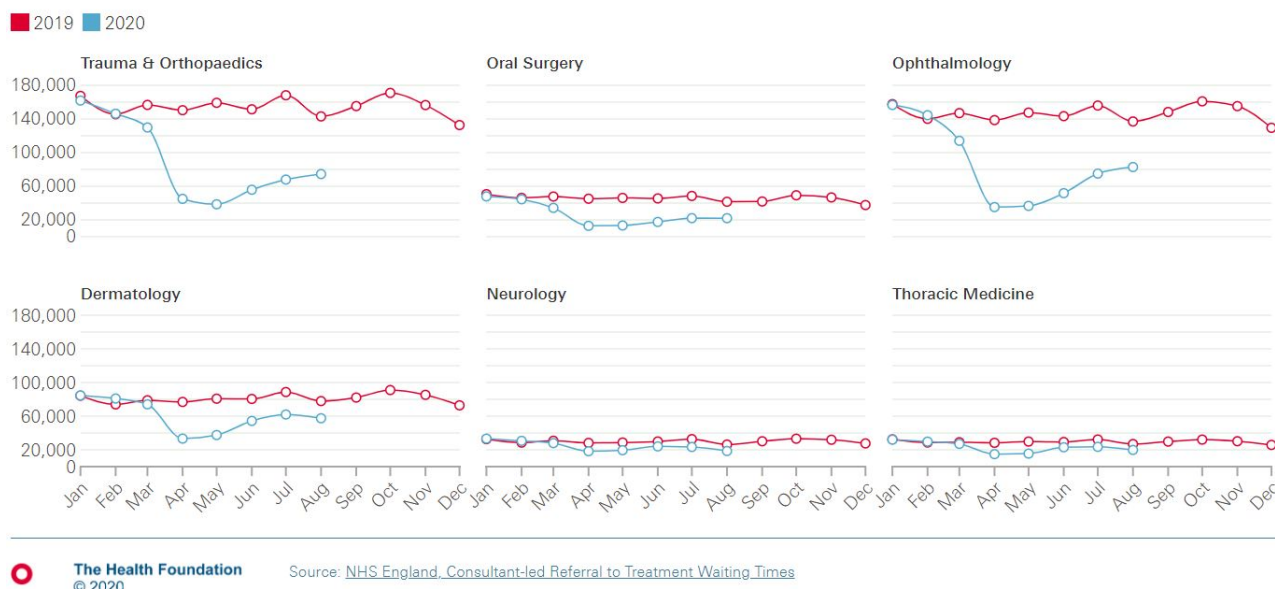
The second factor that determines the size of the waiting list is the rate at which new pathways are started and patients are added to the waiting list – usually via a referral made following a GP appointment. With many hospital services closed to all but urgent referrals, the number of patients starting new pathways also fell sharply during the initial peak of the pandemic. From January to August 2020, 8.9 million new pathways were started – 4.7 million fewer than the 13.6 million started in the same months in 2019.

Figure 3 shows the specialties with the largest slowdown in the number of new pathways so far in 2020, as well as those with the smallest reductions. The biggest reductions were in the same specialties where completed pathways fell the most – oral surgery (43% lower than the same months in 2019), trauma and orthopaedics (42% lower) and ophthalmology (41% lower). The smallest reductions in new pathways were in thoracic medicine (29%) cardiothoracic surgery (29%), neurosurgery (29%) and urology (28%).

Figure 3:

The number of pathways completed by specialty by month in 2019 and 2020

The three specialties most affected during the COVID-19 pandemic are in the top row and the three least affected are in the bottom row



Prior to the pandemic, the waiting list had grown steadily from 3.3 million at the end of 2015 to 4.4 million at the end of 2019. In simple terms, this is because new patients were added to the list faster than those already waiting were being treated. So far in 2020, however, the waiting list is slightly smaller than at the end of 2019 – but only because the reduction (32%) in the number of pathways completed was exceeded by the reduction (34%) in the number of new pathways being started.

This situation is unlikely to last. Patients on the waiting list are already experiencing delays caused by the pandemic – 1,959,684 (46.4%) of those waiting had already exceeded the 18-week standard by the end of August, almost three times more than August 2019. The specialties with the highest percentage of patients who had waited over 18 weeks were oral surgery (68.0%), ophthalmology (58.2%) and ear, nose and throat (56.2%). In total, 1 11,026 patients had waited longer than 52 weeks – compared with just 1,236 in the same month in 2019. In parallel, the most plausible reason for the sharp drop in new pathways is that the pandemic has created new barriers to accessing elective care, which has been the **fastest growing** area of NHS activity for the past two decades.

The health concerns that would, in normal circumstances, have prompted people to seek care and be referred to a specialist have not simply disappeared. The **Care Quality Commission** (CQC) has highlighted the ‘huge pent-up demand’ caused by the pandemic. The big unknown is how much of this demand will return and when. Most new pathways start with a referral made following a GP appointment. GP services remained open throughout the pandemic, but – with most routine hospital services suspended – GPs were unable to refer as many patients as normal. This means **GP**

practices were forced to either hold onto referrals until services reopened, or ask patients to wait and get back in touch later if a referral was still needed.

There is also some evidence that fewer people used GP services during the pandemic. Our public polling with Ipsos MORI, conducted in May, found one in five people felt uncomfortable about using local GP services during the pandemic, mostly due to concerns about catching COVID-19. NHS Digital has also reported a reduction in appointments in general practice, although this may be something of an underestimate as data quality was affected by the shift to remote appointments.

If the ‘missing’ 4.7 million new pathways are added onto the current waiting list of 4.2 million, the prediction of 10 million by Christmas suddenly does not look so farfetched. At least some of this suppressed demand is likely to return – as more services reopen to referrals, as more people go back to their GP, or if people present in A&E because their condition has deteriorated for lack of treatment. Depending on when and how that happens, the waiting list could start growing very quickly.

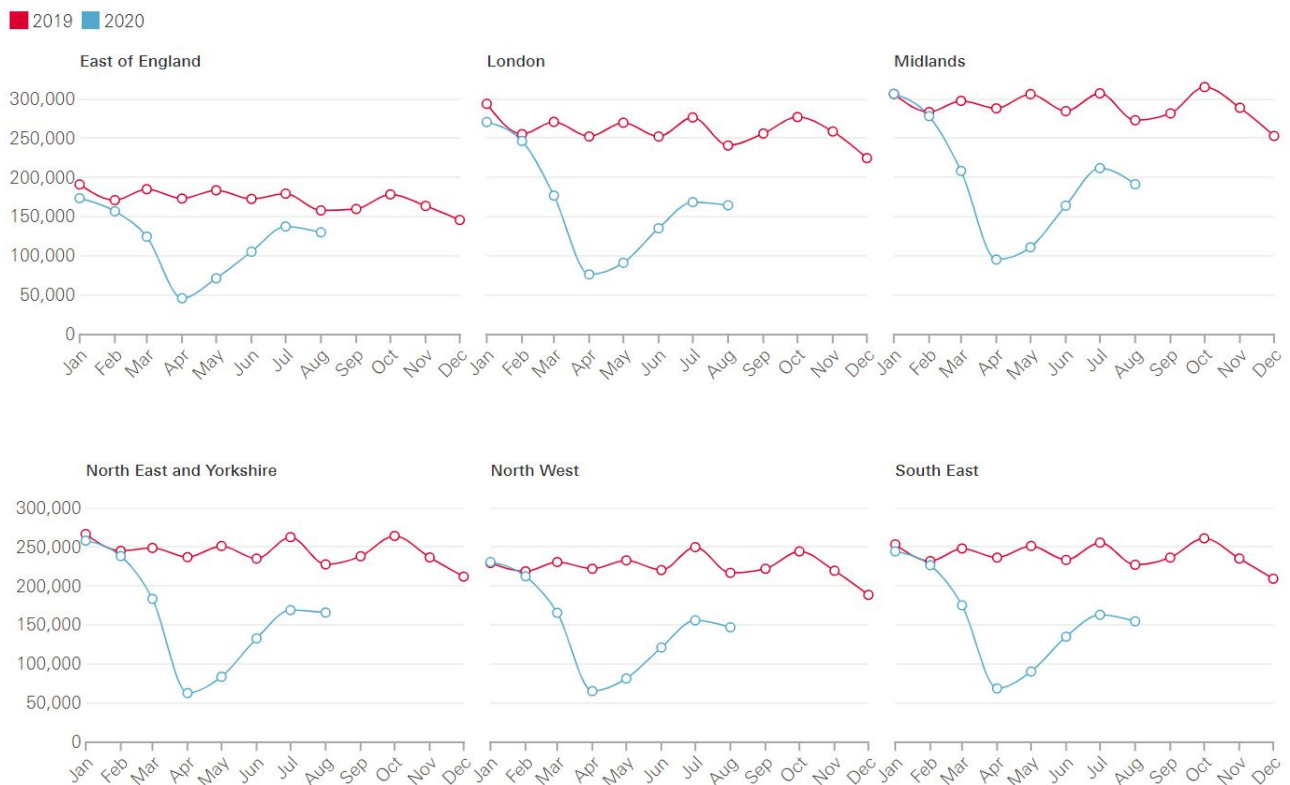
The regional picture in England

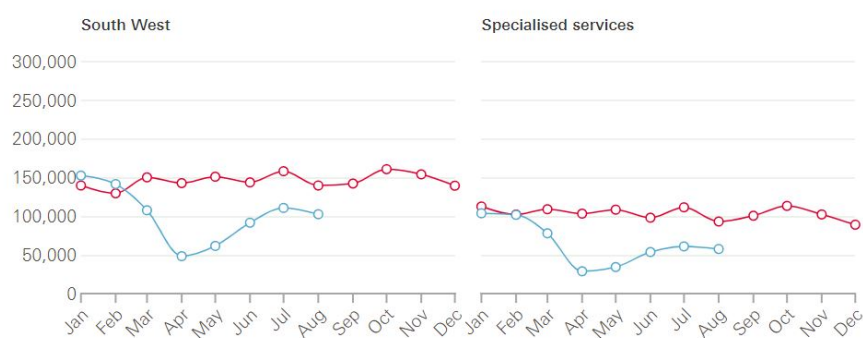
The impact of COVID-19, and the wider governmental and social response to it, have been felt across the UK, but **some parts** of the country have been far more affected than others. Similarly, while the pandemic has already had a stark effect on the waiting list at national level, there are signs that access to elective care has been worse in some parts of England than others.

NHS England publishes data on activity and performance against the 18-week standard, broken down into seven regions plus the **specialised services** for rare and complex conditions commissioned nationally and regionally by NHS England. Figure 4 shows, comparing January to August 2020 to the same months in 2019, all regions in England experienced a broadly similar reduction in the number of admitted and non-admitted completed pathways. This ranged from a 28% reduction in the South West to 34% reductions in the North West and for pathways commissioned by NHS England.

Figure 4:

The number of new pathways started by month in the regions of England in 2019 and 2020





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Source: NHS England, Consultant-led Referral to Treatment Waiting Times • Note: Specialised services for rare and complex conditions are commissioned by NHS England and include patients from all seven regions.

In the initial phase of the pandemic, the number of patients in hospital with COVID-19 **peaked in April**. Although London bore the initial brunt of the first outbreak, the London region had by far the smallest reduction (50%) in completed pathways in April 2020 compared with the same month in 2019. Other regions experienced reductions ranging from 55% in the South East and North East, to 58% in the South West, 60% in the Midlands, East of England and North West. Pathways commissioned by NHS England had the smallest reduction in April with 37% fewer completed pathways compared with April 2019.

Similarly, during the year to date, all regions experienced a comparable reduction in the number of new pathways being started compared with 2019. Figure 5 shows the lowest reduction (29%) was in the South West, which reported relatively lower levels of COVID-19 cases and hospitalisations. Elsewhere, the reduction in new pathways ranged from 33% to 37%. Pathways commissioned by NHS England saw the smallest reduction with 37% fewer new pathways than 2019.

Figure 5:

The number of pathways completed by month in regions of England in 2019 and 2020

■ 2019 ■ 2020





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Source: NHS England, *Consultant-led Referral to Treatment Waiting Times* • Note: Specialised services for rare and complex conditions are commissioned by NHS England and include patients from all seven regions.

Substantial progress has been made in reopening services since April, although activity remains well below the level prior to the pandemic. The South West and East of England are the regions closest to returning to pre-pandemic levels of activity. In the South West in August, the number of completed pathways was 31% below the same month in 2019 and the number of new pathways was 26% lower. In the East of England, completed pathways were 31% lower and new pathways just 18% below the level reported in August 2019.

The North West and South East were the regions furthest away from returning to pre-pandemic levels of activity by August, with completed pathways 38% below those reported in August 2019 and new pathways 32% below. London and the Midlands were the regions next furthest away from pre-pandemic numbers of new and completed pathways. In August 2020, pathways commissioned by NHS England saw a greater reduction than any of the regions with a 43% reduction in complete pathways and 38% reduction in new pathways.

What can the independent sector contribute?

After being block-booked early in the pandemic to provide additional capacity, the independent sector is now being looked to for help **tackling the backlog** in elective care. There is no obvious shift from the NHS to the independent sector. So far the independent sector has accounted for 6.4% of the total pathways completed from January to August 2020, compared with 7.8% in the same months of 2019. The number of pathways completed by the independent sector has increased since April, from a 75% reduction in activity compared with 2019 to 53% in August. However, the increase in completed pathways has been at a slower pace than NHS providers. In August 2020, 6.0% of the total pathways completed were from the independent sector compared with 8.0% in August 2019. However, this could be due to independent sector beds being reserved as surge capacity for patients with COVID-19, or simply a reflection of the time lag from patients being referred or transferred to starting treatment.

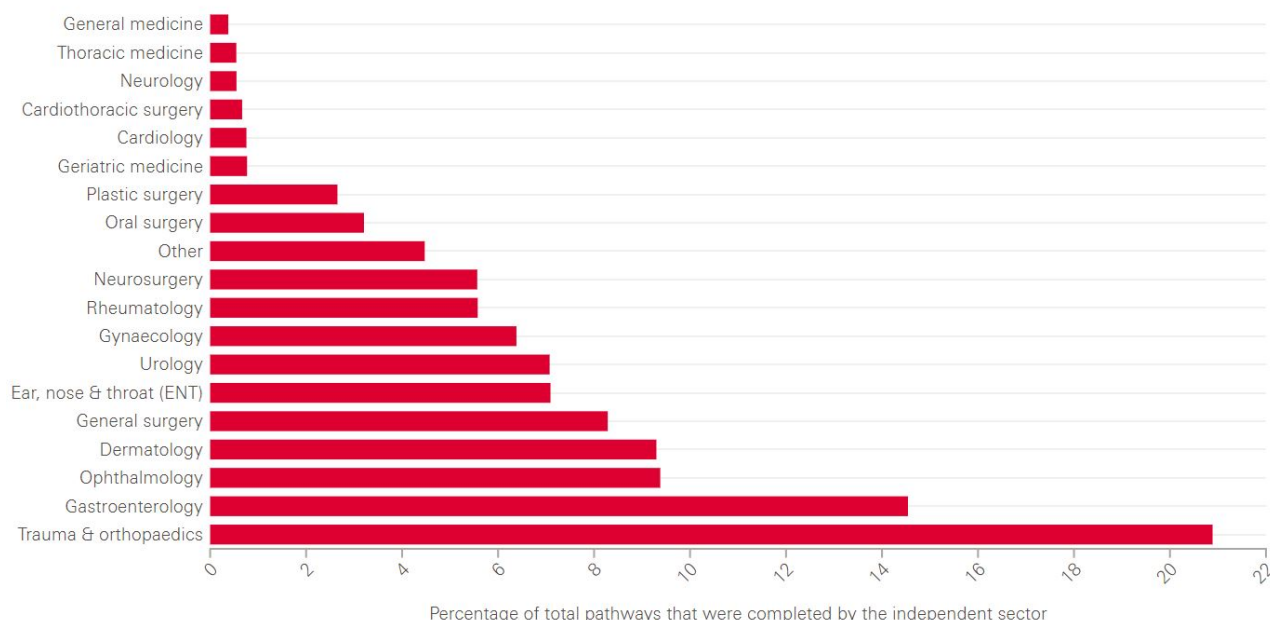
While the Health and Social Care Select Committee **commended** the independent sector for supporting the NHS during the initial peak, it also called on government, NHS England and NHS Improvement to clarify how much capacity the sector is expected to contribute in the longer term. This is apt, as the independent sector differs from the NHS in several ways that are likely to affect the role it could play.

The NHS has a **long history** of purchasing services from the independent sector, but the sector's involvement in delivering elective care **expanded** considerably in the 2000s to help cut waiting lists and deliver the 18-week standard. Prior to the pandemic, independent sector providers already contributed an appreciable volume of NHS-funded elective care with a particularly big impact in some specialties.

Figure 6 shows that independent sector providers accounted for 20.9% of the total pathways completed in 2019 in trauma and orthopaedics and 9.4% in ophthalmology. With some of the biggest falls in activity at national level in these specialties, the independent sector could make a valuable contribution to reducing long waits for common procedures, such as hip replacements and cataract removal. However, this means the sector contributes a correspondingly lower amount elsewhere – including less than 1% of the total pathways completed in geriatric medicine, cardiology, cardiothoracic surgery, neurology, thoracic medicine or general medicine in 2019.

Figure 6:

Completed pathways from the independent sector by specialty in 2019



 The Health Foundation © 2020 Source: [NHS England, Consultant-led Referral to Treatment Waiting Times](#)

While the majority of independent sector providers of acute care are rated ‘Good’ (78%) or ‘Outstanding’ (9%) by the **CQC**, many providers have focused on winning **high volumes** of common procedures for **lower risk** NHS-funded patients. This was highlighted as a common, albeit not universal, business strategy in a 2014 review of the private health care market by the **Competition and Markets Authority**. This means independent sector providers may not all be equipped to treat more complex patients or to deliver the full range of procedures performed in NHS hospitals.

A further consideration is the geographical distribution of independent sector providers. Of the 144 non-NHS providers registered with the **CQC** as hospitals, 89 (62%) are located in the South East, South West, London and East of England. The South East and South West made the greatest use of independent sector providers in 2019, with the sector accounting for more than 10% of the pathways completed in both regions. Location alone, however, does not fully account for regional differences in the use of the independent sector prior to the pandemic. The least use of the independent sector was in London, which may be partly due to the capital having more providers aiming to attract **privately-funded patients** rather than those referred by the NHS. While there are independent sector hospitals in every part of England, the providers willing and able to take publicly funded patients are unlikely to be distributed evenly across the country.

Where next?

Before COVID-19, the standard that at least 92% of patients should wait no longer than 18 weeks to start elective treatment had not been achieved for nearly 4 years – despite this being a legal right under the **NHS constitution**. The health service was not alone in postponing a large quantity of elective care and will not be the only health system facing a substantial backlog. Virtually every other **health system in Europe** took similar measures to free up capacity to treat people acutely unwell with COVID-19. During the initial peak of the pandemic, **28.4 million planned operations** were estimated to have been cancelled or postponed across 190 countries.

This has important consequences for millions of people. Prolonged delays in accessing some types of elective care are expected to have a negative impact on patient outcomes. For example, increased numbers of people who experience **sight loss** and reduced **cancer survival** due to late diagnosis – prior to the pandemic, far more cancers were **diagnosed** following a routine referral than via screening. Longer waits for other types of care may not affect outcomes, but may leave people waiting longer in severe pain or discomfort – some of whom need treatment, such as **hip or knee surgery**, which will allow them to return to work or restore their independence. Fear of being **exposed to COVID-19**, concerns about not getting an appointment or **confusion** about how to access NHS services during the lockdown, may also have led people with an **existing health condition** not to access the regular care they need.

Rescheduling all of the care that has been postponed will put health systems under major pressure for some time to come. Forthcoming work for the REAL Centre will look at what could happen to the waiting list in England under a number of different scenarios. However, exactly how much waiting lists will grow, and how long it will take to clear the backlogs, are likely to be known unknowns – despite all the experience and expertise of the NHS in **modelling and managing** waiting lists.

The challenge of increasing hospital activity

Recovering from the disruption caused by COVID-19 will require substantial increases in hospital activity – to keep up with demand from new patients who are added to waiting lists, as well as to clear the backlog of patients already on the list. In the Canadian province of Ontario, **clearing the surgical backlog** is estimated to take around 84 weeks – but in a scenario where activity resumes at 110% of pre-pandemic levels and is not derailed by further waves of COVID-19. In England, at least, we cannot assume either of those assumptions will hold.

In April, the NHS began a **cautious programme** to resume some of the services suspended in response to COVID-19. Substantial progress has been made, with **NHS England** declaring that some of the recovery milestones had been met in September, but activity remains below the level prior to

COVID-19. The extra precautions needed to make services safe for patients and staff mean hospital capacity is likely to be severely constrained for the duration of the pandemic, again in line with **health systems elsewhere**. Before the pandemic, **meeting the 18-week standard** would have required the NHS to treat an additional 500,000 patients a year for the next 4 years – an unprecedented increase in activity, which looked unrealistic before COVID-19 and looks even harder now.

And, as we approach a winter with COVID-19, there is a risk of losing the hard-won progress made over the summer as emergency pressures surge. The course of the pandemic, including the timing, location and severity of further waves of the virus, is arguably going to be the biggest factor in determining how big the elective backlog will get. Further **suspensions of elective services** are already being reported at the time of writing, particularly by hospitals in parts of England with higher rates of the virus. COVID-19 and the measures introduced to tackle it have already had an **unequal impact** in different parts of the country – the elective backlog may well follow a similar path.

What are the options?

With returning to the ‘old normal’ unlikely to be enough, more radical options are now under consideration. Much has been made of the role the independent sector can play and, while the sector can make an important contribution, it will not be a panacea and is unlikely to be a suitable option for all patients. The NHS already purchases large volumes of some common procedures from independent sector providers, and it remains to be seen how much additional activity the sector can offer without undermining publicly-owned hospitals, such as by competing for the same workforce.

The wider set of options could include refining and expanding the **use of remote consultations**, building on the rapid progress made in the past few months. There may be more effective ways to use existing capacity by taking a different approach to how patients are prioritised for treatment, looking beyond the clinical priority of having a specific procedure to minimising morbidity and mortality in the round. NHS England has already announced plans to establish **community diagnostic hubs**, to undertake diagnostic work outside of hospitals. A further step would be to **consolidate treatment services**, aiming to increase throughput by bringing specialist resources together in regional centres ringfenced from emergency care – albeit at a cost of reduced patient choice and increased travel time.

There is a need to move quickly. Every day activity lags behind demand, the backlog will continue to grow. However, given the trade-offs involved in the different measures that could be used to address the backlog, failing to engage patients and the public in decisions about what should be done – and how change should be implemented – would be a false economy. The government is due to announce the results of a Spending Review. The impact of postponing elective care on millions of people, the extent of the backlog the NHS will face, and the new measures needed to address it, should all be taken into account when making decisions about future NHS funding.