House of Commons

Committee of Public Accounts

NHS backlogs and waiting times in England

Forty-Fourth Report of Session 2021–22

Report, together with formal minutes relating to the report

Ordered by the House of Commons to be printed 7 March 2022

HC 747
Published on 16 March 2022
by authority of the House of Commons

The Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine "the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit" (Standing Order No. 148).

Current membership

Dame Meg Hillier MP (*Labour (Co-op), Hackney South and Shoreditch*) (Chair)

Mr Gareth Bacon MP *(Conservative, Orpington)*

Shaun Bailey MP (*Conservative, West Bromwich West*)

Dan Carden MP (*Labour, Liverpool, Walton*)

Sir Geoffrey Clifton-Brown MP (*Conservative, The Cotswolds*)

Rt Hon Mark Francois MP (*Conservative, Rayleigh and Wickford*)

Peter Grant MP (*Scottish National Party, Glenrothes*)

Kate Green MP *(Labour, Stretford and Urmston)*

Antony Higginbotham MP (*Conservative, Burnley*)

Mr Richard Holden MP (*Conservative, North West Durham*)

Craig Mackinlay MP (*Conservative, Thanet*)

Sarah Olney MP (*Liberal Democrat, Richmond Park*)

Kate Osamor MP (*Labour (Co-op), Edmonton*)

Nick Smith MP (*Labour, Blaenau Gwent*)

Helen Whately MP (*Conservative, Faversham and Mid Kent*)

James Wild MP *(Conservative, North West Norfolk*)

Powers

Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No. 148. These are available on the Internet via www.parliament.uk.

Publication

Committee reports are published on the Committee's website and in print by Order of the House.

Committee staff

The current staff of the Committee are Jessica Bridges-Palmer (Media Officer), Ameet Chudasama (Committee Operations Manager), Richard Cooke (Clerk), Rose Leach (Committee Operations Officer), Heather Nathoo (Chair Liaison), Ben Rayner (Second Clerk).

Contacts

All correspondence should be addressed to the Clerk of the Committee of Public Accounts, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 5776; the Committee's email address is pubaccom@parliament.uk.

You can follow the Committee on Twitter using @CommonsPAC.

Contents

Summary

At the end of December 2021, 6.07 million patients were waiting for elective care, the biggest waiting list since records began. Only 64% (3.87 million) of these patients had been waiting for less than 18 weeks, compared with the performance standard which requires 92% to have been waiting for less than 18 weeks. Similarly, in December 2021, only 67% of patients with an urgent referral for suspected cancer were treated within 62 days compared with a requirement for 85% to be treated within that time.

The Department of Health and Social Care (the Department) and NHS England and NHS Improvement (NHSE&I) oversaw declines in waiting time performance for cancer care from 2014 and elective care from 2016 as they did not increase capacity sufficiently to meet growing demand for NHS services. On top of these previous failures and despite the heroic efforts of the NHS workforce, the COVID-19 pandemic has inevitably caused a further huge deterioration in the NHS's provision of elective and cancer care.

A striking feature of the pandemic was that very large numbers of patients did not present at, or were unable to access, routine NHS services. As of September 2021, there were between 7.6 million and 9.1 million missing referrals of patients for elective care and between 240,000 and 740,000 missing urgent referrals for suspected cancer. People will face serious health consequences as a result of delays in treatment, with some dying earlier than they otherwise would, and many living with pain or discomfort for longer than they otherwise would.

The Department and NHSE&I are now managing a large, growing and diverse set of challenges to elective and cancer care on top of the ongoing pandemic. The Department needs to be better at communicating with NHS staff and patients about what the NHS will be able to deliver in the coming years and it urgently needs to improve its record of holding NHSE&I to account, given the additional £8 billion of revenue funding for elective recovery and £5.9 billion of capital funding. The government has told the NHS to deliver 30% more elective care activity by 2024–25 than it was delivering before the pandemic. We urge NHSE&I and the Department to be clear about what this will mean for patient waiting times and how performance may differ across the country.

Any transparent and realistic assessment of what the Department and NHSE&I expect elective and cancer care services to achieve by 2024–25 needs to include an assessment of the number of staff that will be available, how staff who have been working under intense and consistent pressure will be supported, and how patients will be kept informed about their own progress through waiting lists.

Introduction

Elective care is typically provided to people who require specialist assessment or treatment by a hospital doctor following a GP referral. Common elective treatments include operations such as hip and knee replacements and cataract surgery. The legal standard for elective care exists to ensure timely treatment and states that 92% of people on the waiting list should be seen within 18 weeks. Before the pandemic only 83% were being seen within 18 weeks and this was 64% in December 2021. Of the 6 million patients waiting for elective care, 311,000 have now been waiting for more than a year. NHSE&I intended to publish an elective recovery plan by the end of November 2021 but only did so in February 2022.

Because of the importance of early diagnosis and treatment, there are more performance standards for cancer and more points in the patient pathway where waiting times are measured. One of the most important relates to the proportion of urgent GP referrals for suspected cancer seen within two weeks: the operational standard is 85% but performance in 2019–20 was 77% and this had dropped to 67% in December 2021.

Conclusions and recommendations

1. **The Department has overseen years of decline in the NHS's cancer and elective care waiting time performance and, even before the pandemic, did not increase capacity sufficiently to meet growing demand.** The NHS has not met the 18-week maximum waiting time standard for elective care since February 2016 nor, in totality, the eight key standards for cancer care since 2014. As demand for services rose faster than supply in the years before the pandemic, performance against waiting times standards declined but the Department neither adjusted these standards to realistic levels nor sought to hold NHSE&I to account adequately. This Committee's June 2019 report NHS waiting times for elective and cancer treatment concluded that the Department allowed NHS England to be selective about which standards it focused on, reducing accountability.

   Recommendation: ***The Department must strengthen its arrangements for holding NHSE&I to account for its performance against waiting times standards for elective and cancer care. This should include specific expectations for improving waiting time performance in 2022–23. The Department should write to us alongside its Treasury Minute response to set out the specific and measurable performance indicators for elective and cancer care it has put in its 2022–23 mandate to NHSE&I.***

2. **At our evidence session the Department and NHSE&I appeared unwilling to make measurable commitments about what new funding for elective recovery would achieve in terms of additional NHS capacity and reduced patient waiting times.** NHSE&I will receive an additional £8 billion for elective care recovery and £5.9 billion for capital between 2022–23 and 202425. Government expects that this additional funding will enable elective care activity to be 30% higher than pre-pandemic levels. However, the Department and NHSE&I have not set out in meaningful detail what the money will be spent on. NHSE&I is planning for 566 more elective care beds, but this appears to be a small number compared with the scale of the problem.

   Recommendation: ***In implementing its elective recovery plan, NHSE&I should set out clearly:***

   - ***timeframes, costs and outputs of the components of the recovery plan covering elective care and cancer care to 2024–25;***
   - ***the longer-term investments and plans that are being made now to improve the resilience of elective care and cancer care beyond 2024–25; and,***
   - ***the national performance levels expected in each year between now and 2024–25.***

3. **The NHS will be less able to deal with backlogs if it does not address longstanding workforce issues and ensure the existing workforce, including in urgent and emergency care and general practice, is well supported.** NHSE&I believes it will be 2 or 3 years before there is a material increase in NHS capacity as a result of the changes it plans to elective care. Large numbers of people waiting for so long

presents a huge risk to primary care and emergency services (such as general practice and A&E) because unmet health demand can result in more GP appointments and more medical emergencies. Evidence from the University of Manchester's Voices of COVID-19 project highlights the concerns of frontline NHS staff regarding the public dissatisfaction they face and the NHS's lack of capacity to deal with backlogs of care. The Department and NHSE&I need to ensure the NHS workforce is adequately supported and that its service recovery planning is integrated with its planning for staffing and other types of resources.

Recommendation: ***In implementing its recovery plan NHSE&I's should publish its assessment of how the size of the NHS workforce (GPs, hospital doctors and nurses) will change over the next three years, so that there is transparency about the human resources that the NHS has available to deal with backlogs.***

4. **It will be very challenging for the NHS to focus sufficiently on the needs of patients when it comes to dealing with backlogs, both patients already on waiting lists and those who have avoided seeking or been unable to obtain healthcare in the pandemic.** NHSE&I is concerned about those people who have avoided or been unable to obtain healthcare during the pandemic. This includes the estimated 240,000 to 740,000 missing urgent cancer referrals since February 2020. There is also the huge challenge of communicating effectively with the 6 million people already waiting for elective care and providing them with support that they may require. NHSE&I expects trusts to focus on treating patients who have been waiting the longest.

   Recommendation: ***The Department and NHSE&I must ensure there is a strong focus on patient needs in all their recovery planning, including:***

   - ***measuring the success of all initiatives to encourage patients to return to the NHS for diagnosis and treatment;***
   - ***creating guidance and tools, and setting aside resources, for meaningful communication with patients who are waiting; and,***
   - ***supporting NHS trusts through planning guidance and other means to prioritise patients fairly, so they are able to strike an appropriate balance between clinical urgency and absolute waiting time.***

5. **Waiting times for elective and cancer treatment are too dependent on where people live and there is no national plan to address this postcode lottery.** In September 2021, patients in the worst-performing geographic areas were more than twice as likely as patients in the best-performing areas to have been waiting over 18 weeks for elective care or more than 62 days for cancer treatment following an urgent referral. The difference between the worst and best areas in the proportion of patients waiting over 52 weeks for elective care was around 12 times. NHSE&I is expecting the same levels of improvement across NHS areas but, if this were the end result, it would mean continuing large disparities between these areas.

   Recommendation: ***NHSE&I should investigate the causes of variations between its 42 geographic areas and provide additional support for recovery in those that face the biggest challenges. NHSE&I should write to us in December 2022 on the***

actions it has taken to address geographical disparities in waiting times for cancer and elective care and include a summary of any analysis it has done on differences in health outcomes for elective and cancer care in different parts of the country since the start of the pandemic.

6. **For the next few years it is likely that waiting time performance for cancer and elective care will remain poor and the waiting list for elective care will continue to grow.** The UK has low numbers of healthcare resources per person compared with similar countries and actions taken now to increase its resources will likely take years to be realised. We are concerned that officials are too optimistic about the resilience of NHS services in the short- and medium-term, particularly as NHS staff have been working under continuously high pressure during the pandemic and the system is yet to feel the full effect of missing cancer and elective patients returning for care. The National Audit Office estimates that the elective care waiting list might grow to around 7 million people by March 2025, compared with 6.075 million in December 2021, even if the NHS manages to increase elective activity to its stated aim of 30% above pre-pandemic levels.

   Recommendation: ***The Department and NHSE&I must be realistic and transparent about what the NHS can achieve with the resources it has and the trade-offs that are needed to reduce waiting lists. In implementing its elective recovery plan, NHSE&I should set out clearly what patients can realistically expect in terms of waiting times for elective and cancer treatment. By the time of the next Spending Review at the latest, the Department and NHSE&I should have a fully costed plan to enable legally binding elective and cancer care performance standards to be met once more.***

1 Accountability and planning

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health and Social Care (the Department) and NHS England and NHS Improvement (NHSE&I) about the backlogs and waiting times for elective and cancer care in the NHS in England. We also received and considered written evidence from 40 organisations.[1]

2. The NHS provides elective care, typically to people who require specialist assessment and subsequent treatment by a hospital doctor following GP referral. Common elective treatments include operations such as hip and knee replacements and cataract surgery. The legal standard for elective care was introduced in April 2013. It exists to ensure timely treatment and states that 92% of the waiting list should be seen within 18 weeks. Before the pandemic only 83% of the elective waiting list were being seen within 18 weeks and this had declined to 64% in December 2021. Of the 6 million people waiting for elective care, 311,000 have been waiting for more than a year.[2]

3. The NHS also provides cancer services to assess people with suspected cancer symptoms and to diagnose and treat those with cancers. Because of the importance of early diagnosis and treatment, there are more performance standards for cancer and more points in the patient pathway where waiting times are measured than for elective care. One of the most important cancer standards relates to the proportion of urgent GP referrals for suspected cancer treated within 62 days. This standard exists to ensure that people who present to their GP with urgent symptoms start the necessary treatment quickly. The operational standard is 85% but performance in 2019–20 was 77% and this had dropped to 67% in December 2021.[3]

4. At the time of publication of the C&AG's Report, statistics on NHS performance on elective and cancer waiting times were available up to September 2021. They have subsequently been published up to December 2021. The latest statistics (Figure 1) show that there has been no improvement in the headline percentage waiting time indicators.

Figure 1

Changes in headline waiting time performance (September – December 2021)

Waiting time indicator	September 2021 (from C&AG's Report)	December 2021 (published on 10 February 2022)
Percentage of people on the elective care waiting list for less than 18 weeks	**66%** (3.88 million out of 5.83 million)	**64%** (3.87 million out of 6.00 million)
Percentage of people on the elective care waiting list for more than 12 months	**5%** (301,000 out of 5.83 million)	**5%** (311,000 out of 6.07 million)

1 C&AG's Report, *NHS backlogs and waiting times in England*, Session 2021–22, HC 859, 1 December 2021
2 C&AG's Report, pages 4 and 17; NHS England's published waiting times statistics for November 2021
3 C&AG's Report, pages 27 and 28; NHS England's published waiting time statistics for November 2021

Waiting time indicator	September 2021 (from C&AG's Report)	December 2021 (published on 10 February 2022)
National percentage of cancer treatments within 62 days of urgent referral, where the minimum should be 85%	**68%** (10,109 out of 14,866)	**67%** (9,462 out of 14,132)

Source: C&AG's Report, page 4 and NHS England's published waiting times statistics

Accountability and NHS capacity

5. NHS waiting time performance had declined steadily in the years before the COVID-19 pandemic. The statutory 92% elective care waiting time standard was last met in February 2016. The eight operational performance standards for cancer care were last met in totality in 2014.[4] Five Royal Colleges submitted evidence to us. On the situation before the pandemic, the Royal College of Emergency Medicine told us that elective surgery was compromised every winter due to increased emergency demand and a lack of hospital capacity. It added that many emergency departments experienced crowding and corridor care all year round.[5] The Royal College of Radiologists told us that cancer and imaging services were already overstretched before the COVID-19 pandemic.[6] The Royal College of Surgeons and the Royal College of Pathologists told us of workforce shortages before COVID-19.[7]

6. We asked the Department about the financial constraints the NHS had been operating under in the years when performance was declining. The Department told us that the basic cause of decline in waiting time performance was that the supply of NHS services had not risen as fast as demand for those services.[8] NHSE&I explained that before the pandemic the NHS was in a position where lots of issues needed attention and improvement; it said this was what the NHS Long-Term Plan had been meant to address.[9] Further to this, the Department explained that, just before the pandemic, it had been discussing with the NHS a five-year plan to make best use of additional investment in the hope of recovering or partially recovering the waiting list position. Clearly both the Long-Term Plan and the five-year plan have been thrown off course by COVID-19.[10]

7. But plans are only one part of the explanation for deteriorating performance. This Committee's June 2019 report *NHS waiting times for elective and cancer treatment* concluded that the Department had allowed NHS England to be selective about which standards it focused on, reducing accountability. We recommended that the Department and NHSE&I clarify to the Committee how NHSE should be held accountable, a recommendation with which the government agreed.[11] We heard from the Department that it did not formally change the waiting times standards when waiting times performance declined before the

4 C&AG's Report, pages 20, 27
5 NHS0040 Royal College of Emergency Medicine submission para 2
6 NHS0003 Royal College of Radiologists submission para 3
7 NHS0004 Royal College of Pathologists submission para 2; NHS 0020 Royal College of Surgeons submission para 10
8 Q24
9 Q27
10 Q26
11 Committee of Public Accounts, *NHS waiting times for elective and cancer treatment*, 100th report of session 2017–19, HC 1750, para 2; HM Treasury, *Treasury Minutes Progress Report*, CP313, November 2020, para 2.1, page 159

pandemic but it had accepted that given the pressure in the system clinicians would focus on the clinical priorities of individual patients instead.[12] We asked the Department about how it planned to hold the NHS to account for the additional funding that it is now set to receive for elective recovery. An elective recovery plan had been scheduled for publication in November 2021 but had been delayed.[13] The Department told us it had so far been interrupted from focussing on elective care recovery by the Omicron wave of COVID-19 but that it accepted the need for detailed plans encompassing the necessary elements of funding, capacity, workforce, organisation and clinical decision-making.[14] (The recovery plan was subsequently published in February 2022).[15] The Department also explained that it would continue to set the top-level measures for the NHS through the NHS mandate, and it asserted that waiting time performance standards remained meaningful.[16] Clarity about what and how the Department is measuring NHS performance is vital because it relates directly to how patients experience the NHS.

Recovery planning and funding

8. The C&AG's Report included two plausible scenarios under which the waiting list will be even longer in 2025 than it was in 2021. One of these scenarios assumed that the NHS would achieve the 30% increase in activity that is now the government's stated aim. We asked why more could not be done with the additional £8 billion of funding for elective recovery from 2022–23 to 2024–25.[17] NHSE&I said there was significant uncertainty about the exact size of the future waiting list due to uncertainty over the rate at which missing referrals returned to seek care and the ongoing impact of COVID-19.[18] However, it told us that in its judgement it would be very hard to reduce the size of the overall waiting list by 2025. It explained that it was more confident about reducing the number of very long waiters.[19]

9. We sought reassurance that all additional funding would be well spent and asked for examples of the measurable improvements that we could reasonably expect to see. We heard generally from the Department that with the additional £8 billion recovery funding it wanted to restore activity to the highest level possible and that the £5.9 billion of capital funding would enable a total of 9 million additional health checks, scans and procedures by 2024. More specifically, NHSE&I stated that in the second half of 2021–22 it would spend £700 million to create additional theatres, surgical hubs and diagnostic facilities and to start the separation of urgent and elective care so that urgent care is less able to disrupt elective care.[20] It said these actions together would increase the number of beds available for elective care by 566 by March 2022.[21] This is welcome but very small in scale: for comparison, the number of general and acute beds available daily between November 2020 and September 2021 was on average around 86,000 beds.[22]

12 Q28
13 Health and Social Care Committee, *Clearing the backlog caused by the pandemic*, ninth report of session 2021–22, HC 599, para 5
14 Q31
15 NHS England & NHS Improvement, *Delivery plan for tackling the COVID-19 backlog of elective care*, February 2022
16 Q100
17 C&AG's Report, pages 36, 40
18 Q40
19 Q44
20 Qq 46, 47
21 Q43
22 C&AG's Report, page 32

Recovery planning and workforce

10. Between 2010 and 2019 the NHS saw an average annual growth in emergency admissions of more than 3% and in urgent cancer referrals from GPs of more than 10%. Although there was relatively strong growth in the number of consultants (over 3% per year) during that period, there was 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.[23] We examined the additional capacity the NHS would require to deliver reductions in waiting lists. NHSE&I told us that additional health workers were needed across the NHS and in multiple roles. It explained that a medium-term approach was needed as time was required to recruit and train people and to get them paired with up-to-date diagnostic and other infrastructure, and that it would be two to three years before there was any material increase in NHS capacity. This increase of capacity is a prerequisite for reducing waiting lists.[24]

11. The very large numbers of people who have not presented for healthcare, or were not able to obtain it, during the pandemic, as well as those who have already been on waiting lists for long periods of time present a huge risk to primary and emergency care services. This is because unmet health demand can result in more GP appointments and more medical emergencies as people try to manage or suffer the consequences of their conditions. In a survey by NHS Providers, almost all NHS trust leaders responding reported that the complexity and acuity of new patients had increased since the pandemic.[25] In written evidence, the British Medical Association told us that people who were waiting might seek support from "already overstretched" GPs and that this would have a knock-on effect on the number of GP appointments available to patients seeking an initial consultation, perhaps further increasing the number of missing patients.[26] NHSE&I acknowledged that it was asking GPs to do a lot at the moment.[27]

12. The University of Manchester's Voices of COVID-19 project has interviewed over 2,000 NHS staff to provide a national collection of testimonies in partnership with the British Library. This evidence highlights the concerns of frontline NHS staff regarding the public dissatisfaction they face and the NHS's lack of capacity to deal with backlogs of care. The submission stated that since summer 2021 interviewees had described less tolerance from patients for delays in treatment and appointments, and patients becoming less understanding about the continued impact of COVID-19 on the NHS's ability to provide healthcare.[28] Sadly, there had also been increasing evidence of some patients complaining to and verbally abusing NHS staff. We heard from NHSE&I that it was concerned about how exhausted many NHS staff were and that it was seeking to support staff wellbeing.[29] Specifically for GPs, the Department told us that it was making investments so that GPs could more quickly access specialist advice to help them support their patients.[30]

13. This Committee's September 2020 report, *NHS nursing workforce*, concluded that there was a risk that the NHS was focusing on short-term pressures at the expense of the

23 C&AG's Report, page 30
24 Qq 69, 75
25 NHS0043 NHS Providers submission para 3a
26 NHS0022 British Medical Association submission para 3.7
27 Q103
28 NHS0010 University of Manchester submission para 3a
29 Q74
30 Q102

necessary long-term strategy when it came to staffing.[31] Similar risks exist in the current situation. In written evidence, the King's Fund told us that any plan to reduce waiting times needed to build explicitly from an analysis of existing staff and the potential for workforce growth alongside a realistic assessment of any scope for productivity improvements.[32]

31 Committee of Public Accounts, *NHS nursing workforce*, 18th Report of Session 2019–21, HC 408, 23 September 2020

32 NHS0007 King's Fund submission page 4

2 Meeting the needs of patients and the workforce

14. The Department and NHSE&I are now managing a large, growing and diverse set of challenges to elective and cancer care on top of the ongoing pandemic. We asked how the Department and NHSE&I expected the accelerated and expanded vaccine booster programme, announced on 12 December 2021, to impact on elective and cancer care. NHSE&I told us that GPs would be asked to focus on vaccinations and that people would be asked to forego some routine GP appointments. It stated that there was uncertainty over the size of any COVID-19 wave in January 2022 but that it would only cancel elective care where it had to and that it planned to keep going with high-priority emergency treatments, cancer operations and operations for life-threatening conditions.[33]

Patient needs

15. The number of missing referrals and the size of the waiting list make for a daunting situation when it comes to the needs of patients. Thinking about the recent changes to GPs' workload to allow them to focus on booster vaccinations, we asked how members of the public could know in advance whether a GP appointment was routine or urgent, particularly with regard to potential cancer symptoms. NHSE&I told us that it was trying to encourage an increase in cancer referrals across the whole NHS and that it was most worried about the patients it did not know about. It urged anyone with worrying symptoms to come forward.[34] We agree with this call but it does not answer our question about how patients can tell in advance of seeing a medical professional whether their problem is urgent or routine. The C&AG's Report estimated that, as at September 2021, there were 240,000 to 740,000 missing urgent GP referrals for suspected cancer since February 2020.[35]

16. There are 6 million people on the waiting list for elective care.[36] NHSE&I told us it intends to focus on those with the highest clinical need and priority, and especially in the immediate period, those who have waited the longest time. For long-waiters, NHSE&I stated that its plan for this year would target for treatment those who have waited over two years. Over time, it would target 78-week waiters and then the 52-week waiters.[37]

17. We asked about how patients other than the longest waiters and those with the highest clinical priority would be supported while they waited. NHSE&I stated that GPs had a role in managing these patients and that it was also asking secondary care clinicians to ensure patients were clearly informed about their position on waiting lists. NHSE&I explained that it has been trying to get NHS commissioners and providers to review regularly whether patients' clinical priority had changed and to have conversations with patients. NHSE&I accepted that these approaches had not been working as well as they should in all parts of the system; it said it wanted to build the capacity for more reviews in future.[38] In evidence submitted to us, the British Heart Foundation stated that services should be appropriately resourced to support patients to self-manage and improve their

33 Q32
34 Q76
35 C&AG's Report, page 4
36 NHS England's published waiting times statistics for December 2021
37 Q71
38 Q103

wellbeing while they waited for treatment; this could not just be about patients being left to fend for themselves but meant regular contact, including timely updates on delays, and signposting to relevant services.[39]

Geographical disparities

18. In September 2021, patients in the worst-performing of NHSE&I's 42 geographic areas of England were more than twice as likely as patients in the best-performing areas to have been waiting over 18 weeks for elective care. Patients were also more than twice as likely to have waited more than 62 days for cancer treatment following an urgent referral in the worst-performing area compared with the best-performing. The difference between the worst and best areas in the proportion of patients waiting over 52 weeks for elective care was around 12 times.[40]

19. We asked NHSE&I to explain these disparities. It told us that the COVID-19 pandemic had had a differential effect across the country and that the differences reflected where the NHS had most diagnostic capacity and skilled workforce compared with where these resources were more stretched. It also said that the large disparities reflected different levels of demand for healthcare across the country.[41] The Health Foundation, in written evidence, stated that, on average, the most socio-economically deprived areas of England faced the biggest backlogs and patients in those areas consequently faced longer delays.[42]

20. We asked about very long-waiters in different areas and what action NHSE&I was taking to reduce them. It told us that all areas had had the same expectation placed upon them, to attempt to reduce the number of patients who had been waiting for more than two years by the end of 2021–22. It accepted that some areas of the country would struggle more than others to do this and said that it was working on mechanisms to build additional capacity, modify and change health systems and how areas could help each other across the country – including, for instance, by moving clinical teams or patients between regions.[43] We also heard from NHSE&I that its elective recovery plan would consider how it could help the whole country to recover at a similar pace, even though areas are starting from different positions.[44] The Department considered that transparency of performance data would be a crucial tool in reducing disparities.[45]

Communicating with people and patients

21. Among comparable OECD countries the UK has relatively low numbers of hospital beds, nurses and doctors per 1,000 population and also carries out relatively low numbers of advanced diagnostic examinations.[46] NHSE&I told us that it would take two to three years before there was a material increase in NHS capacity. It said that the NHS needed to be training more staff and that it was considering how training capacity could be expanded.[47]

39 NHS0031 British Heart Foundation submission 28d
40 C&AG's Report, pages 24, 29
41 Q90
42 NHS0044 The Health Foundation submission page 3
43 Q93
44 Q92
45 Q94
46 C&AG's Report, page 31
47 Q69

22. We considered whether officials were planning on the basis of realistic assessments of future demand for healthcare or whether they were being too optimistic. NHSE&I told us that there was lots of risk and uncertainty in the NHS at present because of missing patients and the rate at which they might return but it agreed to do all it could to plan realistically.[48] But it also focused mostly on optimistic scenarios for the future. It told us that if demand was "at the better end of the spectrum" and it "did not have disruptions like those we are going to potentially have in the next few weeks" then the NHS would have "a really good run" at reducing waiting lists.[49] We asked whether enough long-term resilience was being put in place to deal with known and unexpected risks. NHSE&I told us that one of the biggest known risks was annual winter disruption to elective care and that it was working to address this in the current planning process. Longer-term resilience would be underpinned by a workforce of the right size, the right estate and capital support, and digital transformation, as well as necessary reforms to social care.[50]

23. NHSE&I emphasised the flexibility of the NHS workforce, as evidenced throughout the pandemic. It said that this workforce flexibility now needed to continue as part of transforming the NHS for the future and recovering elective and cancer care.[51] In written evidence, the Health Foundation told us that serious staff shortages were compounded by the fact that staff were exhausted by their experience of the past 18 months, with the NHS Staff Survey for 2020 showing that 44% of staff reported feeling unwell as a result of work-related stress, the highest result over the past five years.[52] This is the situation before the health system begins to feel the full effects of missing cancer and elective patients returning for care. Under a plausible scenario of 50% of missing patients returning and the NHS achieving a 30% increase in activity by 2024–25 compared with pre-pandemic levels, the National Audit Office estimates that the waiting list will be 7 million in March 2025, around one million higher than it was in December 2021.[53] As noted by The King's Fund, national leaders will need to decide which areas to prioritise and be honest with the public about the knock-on effects of the care they can expect to receive.[54]

48 Q106
49 Q107
50 Q111
51 Q72
52 NHS0044 The Health Foundation submission page 6
53 C&AG's Report, page 36 and published NHS waiting times statistics
54 NHS0007 King's Fund submission page 5

Formal minutes

Monday 7 March 2022

Members present:

Dame Meg Hillier, in the Chair

Shaun Bailey

Dan Carden

Sir Geoffrey Clifton-Brown

Mr Mark Francois

Peter Grant

Kate Green

Craig Mackinlay

Sarah Olney

Nick Smith

NHS backlogs and waiting times in England

Draft Report (*NHS backlogs and waiting times in England*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 23 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Forty-fourth of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjournment

Adjourned till Wednesday 9 March at 1.00pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Wednesday 15 December 2021

Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; **Matthew Style**, Director General NHS Policy and Performance Group, Department of Health and Social Care; **Amanda Pritchard**, Chief Executive, NHS England; **Professor Stephen Powis**, National Medical Director, NHS England; **Sir James Mackey**, National Director of Elective Recovery, NHS England	Q1–118

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

NHS numbers are generated by the evidence processing system and so may not be complete.

1 Alzheimer's Research UK (NHS0026)
2 Alzheimer's Society (NHS0019)
3 Antoniou, Mr Christopher (NHS0001)
4 Association of British HealthTech Industries (NHS0006)
5 Association of Medical Research Charities (NHS0028)
6 Bowel Cancer UK (NHS0045)
7 British Dental Association (NHS0032)
8 British Heart Foundation (NHS0031)
9 British Medical Association (NHS0022)
10 British Psychological Society (NHS0030)
11 Cancer Research UK (NHS0002)
12 Crohn's & Colitis UK (NHS0038)
13 Diabetes UK (NHS0025)
14 Eli Lilly and Company (NHS0011)
15 Heart Valve Voice (NHS0017)
16 Independent Age (NHS0012)
17 Independent Healthcare Providers Network (IHPN) (NHS0021)
18 JDRF (NHS0008)
19 Lambert, Dr Michael (NHS0042)
20 Macmillan Cancer Support (NHS0024)
21 Medical Technology Group (NHS0015)
22 Menstrual Health Coalition (NHS0013)
23 NHS Confederation (NHS0039)
24 NHS Property Services (NHS0027)
25 NHS Providers (NHS0043)
26 NHS Voices of Covid-19 at the University of Manchester (NHS0010)
27 Nuffield Trust (NHS0037)
28 POhWER (NHS0029)
29 Parkinson's UK (NHS0014)
30 Policy Exchange (NHS0041)
31 Royal College of Emergency Medicine (NHS0040)
32 Royal College of Obstetricians and Gynaecologists (NHS0033)
33 Royal College of Pathologists (NHS0004)

34 Royal College of Radiologists (NHS0003)

35 Royal College of Surgeons of England (NHS0020)

36 Spire Healthcare (NHS0016)

37 Staffordshire University (NHS0005)

38 The Health Foundation (NHS0044)

39 The King's Fund (NHS0007)

40 The Urology Trade Association (NHS0009)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2021–22

Number	Title	Reference
1st	Low emission cars	HC 186
2nd	BBC strategic financial management	HC 187
3rd	COVID-19: Support for children's education	HC 240
4th	COVID-19: Local government finance	HC 239
5th	COVID-19: Government Support for Charities	HC 250
6th	Public Sector Pensions	HC 289
7th	Adult Social Care Markets	HC 252
8th	COVID 19: Culture Recovery Fund	HC 340
9th	Fraud and Error	HC 253
10th	Overview of the English rail system	HC 170
11th	Local auditor reporting on local government in England	HC 171
12th	COVID 19: Cost Tracker Update	HC 173
13th	Initial lessons from the government's response to the COVID-19 pandemic	HC 175
14th	Windrush Compensation Scheme	HC 174
15th	DWP Employment support	HC 177
16th	Principles of effective regulation	HC 176
17th	High Speed 2: Progress at Summer 2021	HC 329
18th	Government's delivery through arm's-length bodies	HC 181
19th	Protecting consumers from unsafe products	HC 180
20th	Optimising the defence estate	HC 179
21st	School Funding	HC 183
22nd	Improving the performance of major defence equipment contracts	HC 185
23rd	Test and Trace update	HC 182
24th	Crossrail: A progress update	HC 184
25th	The Department for Work and Pensions' Accounts 2020–21 – Fraud and error in the benefits system	HC 633
26th	Lessons from Greensill Capital: accreditation to business support schemes	HC 169
27th	Green Homes Grant Voucher Scheme	HC 635

Number	Title	Reference
28th	Efficiency in government	HC 636
29th	The National Law Enforcement Data Programme	HC 638
30th	Challenges in implementing digital change	HC 637
31st	Environmental Land Management Scheme	HC 639
32nd	Delivering gigabitcapable broadband	HC 743
33rd	Underpayments of the State Pension	HC 654
34th	Local Government Finance System: Overview and Challenges	HC 646
35th	The pharmacy early payment and salary advance schemes in the NHS	HC 745
36th	EU Exit: UK Border post transition	HC 746
37th	HMRC Performance in 2020–21	HC 641
38th	COVID-19 cost tracker update	HC 640
39th	DWP Employment Support: Kickstart Scheme	HC 655
40th	Excess votes 2020–21: Serious Fraud Office	HC 1099
41st	Achieving Net Zero: Follow up	HC 642
42nd	Financial sustainability of schools in England	HC 650
43rd	Reducing the backlog in criminal courts	HC 643
1st Special Report	Fifth Annual Report of the Chair of the Committee of Public Accounts	HC 222

Session 2019–21

Number	Title	Reference
1st	Support for children with special educational needs and disabilities	HC 85
2nd	Defence Nuclear Infrastructure	HC 86
3rd	High Speed 2: Spring 2020 Update	HC 84
4th	EU Exit: Get ready for Brexit Campaign	HC 131
5th	University technical colleges	HC 87
6th	Excess votes 2018–19	HC 243
7th	Gambling regulation: problem gambling and protecting vulnerable people	HC 134
8th	NHS capital expenditure and financial management	HC 344
9th	Water supply and demand management	HC 378
10th	Defence capability and the Equipment Plan	HC 247
11th	Local authority investment in commercial property	HC 312
12th	Management of tax reliefs	HC 379
13th	Whole of Government Response to COVID-19	HC 404

Number	Title	Reference
14th	Readying the NHS and social care for the COVID-19 peak	HC 405
15th	Improving the prison estate	HC 244
16th	Progress in remediating dangerous cladding	HC 406
17th	Immigration enforcement	HC 407
18th	NHS nursing workforce	HC 408
19th	Restoration and renewal of the Palace of Westminster	HC 549
20th	Tackling the tax gap	HC 650
21st	Government support for UK exporters	HC 679
22nd	Digital transformation in the NHS	HC 680
23rd	Delivering carrier strike	HC 684
24th	Selecting towns for the Towns Fund	HC 651
25th	Asylum accommodation and support transformation programme	HC 683
26th	Department of Work and Pensions Accounts 2019–20	HC 681
27th	Covid-19: Supply of ventilators	HC 685
28th	The Nuclear Decommissioning Authority's management of the Magnox contract	HC 653
29th	Whitehall preparations for EU Exit	HC 682
30th	The production and distribution of cash	HC 654
31st	Starter Homes	HC 88
32nd	Specialist Skills in the civil service	HC 686
33rd	Covid-19: Bounce Back Loan Scheme	HC 687
34th	Covid-19: Support for jobs	HC 920
35th	Improving Broadband	HC 688
36th	HMRC performance 2019–20	HC 690
37th	Whole of Government Accounts 2018–19	HC 655
38th	Managing colleges' financial sustainability	HC 692
39th	Lessons from major projects and programmes	HC 694
40th	Achieving government's long-term environmental goals	HC 927
41st	COVID 19: the free school meals voucher scheme	HC 689
42nd	COVID-19: Government procurement and supply of Personal Protective Equipment	HC 928
43rd	COVID-19: Planning for a vaccine Part 1	HC 930
44th	Excess Votes 2019–20	HC 1205
45th	Managing flood risk	HC 931
46th	Achieving Net Zero	HC 935
47th	COVID-19: Test, track and trace (part 1)	HC 932

Number	Title	Reference
48th	Digital Services at the Border	HC 936
49th	COVID-19: housing people sleeping rough	HC 934
50th	Defence Equipment Plan 2020–2030	HC 693
51st	Managing the expiry of PFI contracts	HC 1114
52nd	Key challenges facing the Ministry of Justice	HC 1190
53rd	Covid 19: supporting the vulnerable during lockdown	HC 938
54th	Improving single living accommodation for service personnel	HC 940
55th	Environmental tax measures	HC 937
56th	Industrial Strategy Challenge Fund	HC 941