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Committee of Public Accounts

NHS waiting times for elective and cancer treatment

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Report, together with formal minutes relating to the report

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The Committee of Public Accounts

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The NHS treats more and more people each year, and patients have a right to expect to receive treatment within the timescales set out by the NHS Constitution. But more and more patients are being let down by the NHS's continued failure to meet deadlines for waiting times. The percentage of patients treated within waiting times standards continues to get worse for both elective (non-urgent care) and cancer treatment. It is unacceptable that less than half of NHS trusts and foundation trusts (trusts) meet the 18-week waiting times standard for elective treatment, and only 38% meet the 62-day standard from referral to treatment for cancer patients.

Like many areas within the NHS, demand for elective and cancer treatments is growing which risks exacerbating this worsening performance. The waiting list for elective care has grown by one and a half million since March 2013 to 4.2 million in November 2018. NHS organisations are not being sufficiently held to account for ensuring patients' rights to treatment within maximum waiting times for elective care. The NHS does not yet fully understand what is driving the demand for elective care, undermining its ability to plan services to meet patient needs. We are also concerned that the national bodies responsible for setting and managing waiting times appear to lack curiosity regarding the impact of longer waiting times on patient outcomes and on patient harm. Improvement is clearly needed to ensure patients get the treatment they need within the waiting times standards the government has set. The long-term term funding settlement for the NHS, the NHS Long Term Plan, and the current review of waiting times standards present an opportunity to get the NHS back on track in meeting waiting times standards.

Introduction

In England, patients have the right to receive consultant-led elective (or non-urgent) treatment within 18 weeks of their referral (usually by a GP). For patients urgently referred for suspected cancer, they have the right to a first outpatient appointment within two weeks. To ensure patients' rights, the Department of Health and Social Care (the Department) has set performance standards for the percentage of patients to be treated within the maximum time a patient should wait for treatment. For example, 92% of patients should wait no more than 18 weeks for their elective treatment from the date of their referral (if treatment is needed), and 93% of patients should be seen by a cancer specialist within two weeks of being urgently referred by a GP for suspected cancer. The NHS has also pledged that 85% of patients who are subsequently diagnosed with cancer should be treated within 62 days of the date of their original referral, normally by their GP.

The Department holds NHS England to account for national performance against these standards. In turn, NHS England holds clinical commissioning groups (CCGs) to account for meeting the standards for their local populations. CCGs are responsible for enforcing waiting times standards through contracts with service providers, mostly NHS trusts and foundation trusts. NHS Improvement regulates and supports trusts to achieve waiting times standards.

Conclusions and recommendations

1. **The NHS is failing to meet key waiting times standards for cancer and elective care, and its performance continues to decline.** The NHS is treating more people for suspected cancer and elective care than ever before. For example, the number of patients referred for elective care has increased by 17% since 2013–14 and the number of patients referred for suspected cancer has almost doubled since 2010–11. However, the NHS has not met the 18-week waiting times standard for elective care since February 2016. In November 2018, 44% of NHS trusts and NHS foundation trusts (trusts) met this standard. The waiting list for elective care has grown, from 2.7 million in March 2013 to 4.2 million in November 2018. The NHS has not met the 62-day standard from urgent referral for suspected cancer to treatment since 2013, and in November 2018 only 38% of trusts met this standard. In 2015, NHS England committed to us that it would improve performance against the 62-day cancer standard, but performance has further declined since. Between July and September 2018, only 78.6% of patients were treated within 62 days of an urgent referral, down from 83.8% between September and December 2014. Substantial improvement is clearly needed. NHS England and NHS Improvement assert that that they will be in a better position to determine how best to improve performance once local NHS organisations have published their forward plans in September 2019.

   Recommendation: ***NHS England should set out, by December 2019, how, and by when, it will ensure that waiting times standards for elective and cancer care will be delivered again.***

2. **The Department of Health & Social Care has allowed NHS England to be selective about which standards it focuses on, reducing accountability.** Under the NHS Constitution, patients in England have the right to be treated within maximum waiting times. It is important that Parliament and the public can rely on NHS waiting times standards to hold the NHS to account over patients' rights to timely access to care. However, in response to rising demand while under increasing financial constraints, the Department has allowed NHS England to prioritise meeting standards for emergency services and cancer care over elective care. NHS England told us that, in recent years, it has removed sanctions and penalties against NHS trusts for failing to meet elective care waiting times standards, as many of the trusts were already in financial difficulties. We welcome the action taken by NHS England to focus on reducing the number of patients waiting 52 weeks and over for elective care, but we are concerned that the Department is no longer holding NHS England to account for the other service standards that are still in place.

   Recommendation: ***The Department of Health & Social Care and NHS England should clarify to the Committee by December 2019:***

   - ***how NHS England will be held accountable for achieving waiting times standards now and in the future; and***
   - ***what additional support NHS England and NHS Improvement will put in place to help local NHS bodies to meet waiting times standards.***

3. **We are concerned that NHS England's review of waiting times will not be enough to ensure a clear understanding of, and strong accountability over, the performance of the NHS.** We welcome NHS England's current review of standards for accessing NHS services, which includes waiting times standards for cancer and elective treatment. Its interim report, published in March 2019, proposes several changes to cancer and elective waiting times standards. Some stakeholders are concerned that, given the ongoing failure by the NHS to meet the 18-week standard, the review could be used as an opportunity to make the target easier to meet or less appropriate. The review is an opportunity to put patient experience and outcomes at the centre of waiting time standards, but the health bodies involved must ensure that strong accountability for performance remains if standards are being altered. It is also important that the NHS engages with the public regarding any changes that may affect their access rights.

   Recommendation: ***The Department of Health & Social Care should ensure that any changes to current waiting times standards:***

   - ***help to improve patient outcomes and patient experiences;***
   - ***do not water down current standards to make them easier to meet; and***
   - ***are communicated clearly to the public, so that patients understand what they can expect of the NHS.***

4. **The national health bodies lack curiosity about the impact for patients of longer waits and how often this leads to patient harm.** When waiting times are longer, patients may experience additional pain, anxiety and inconvenience. There is also a risk that longer waiting times may lead to patient harm through, for example, the deterioration of a medical condition. Similarly, outcomes for those who wait for more than six months for treatment can be poorer. The NHS has a very limited understanding of this issue. Although trusts collect data on patient harm through an incident reporting system, which is overseen by NHS Improvement, the data cannot be used easily to help understand the relationship between waiting times and patient harm. Individual trusts may carry out harm reviews due to long waiting times, but these data are not collected at a national level. NHS England is aware that some patients have suffered harm due to long waits and that research on the relationship between patient harm and waiting times is not consistent. NHS England relies on the professional judgement of clinicians to ensure that patients do not come to harm because of longer waiting times but accepts that widespread unwarranted variations in clinical practices exist across the country.

   Recommendation: ***The Department of Health & Social Care, together with NHS England and NHS Improvement, should write to us by December 2019 on how they are going to ensure that the data on patient harm due to long waiting times are going to be routinely collected, reported and acted upon.***

5. **Bottlenecks in hospital capacity are having a detrimental impact on how long patients wait for treatment.** There are wide variations in performance against waiting times standards across local areas and hospitals. For example, the proportion of patients waiting less than 18 weeks for their elective care varied between 75% and 96% across CCGs in England in 2017–18. Poorer performance in waiting

times is related to bottlenecks in hospital capacity, including diagnostics and bed occupancy. We have highlighted the persistent lack of capacity in diagnostics services, including shortages in diagnostics staff, in our previous reports. In terms of access to diagnostics, England compares poorly to other countries that have a similar level of income to England. Hospitals now routinely operate with a bed occupancy rate of more than 90%. This can affect elective patient care as patients may have their elective care treatment postponed because the beds are needed for emergency admissions, resulting in delays to treatment. We are concerned that the number of NHS beds has been reduced over recent years but the NHS does not know what the right level of beds is to meet the growing demand for its services. NHS Improvement told us that there is still room to make better use of existing beds through improving patient pathways which may help meet some of the demand for services.

Recommendation: ***NHS England and NHS Improvement should evaluate and report back to the Committee on how the NHS plans to ensure that it has the required diagnostic and bed capacity to meet patient demand in the medium to long term. They should also set out, in the short term, how they will support local bodies to improve their patient flow through the health system and reduce unwarranted variation.***

6. **The NHS still does not understand sufficiently what is driving demand for referrals for elective treatment.** Between the 12 months to March 2014 and the 12 months to November 2018, the number of referrals for elective treatment increased by 17%. Our recent report on NHS financial sustainability, published in March 2019, concluded that the rising demand for NHS services is not sufficiently well understood. The Department asserts that there are three groups of factors which are driving the increase in demand for elective treatment: demography, technology, and patient expectations. NHS Improvement explained that up to 45% of inpatient admissions and 25% of outpatient referrals are due to a growing and ageing population. But the impact of technology and patient expectations on referrals for elective treatment are difficult to quantify and less researched. NHS England expects local commissioners and sustainability and transformation partnerships (STPs) to forecast and develop plans to meet the demand from their local populations. However, we are concerned that each local body carrying out its own analysis will lead to duplication of efforts.

   Recommendation: ***As we recommended in March 2019, NHS England and NHS Improvement should, by September 2019, write to us to set out how they will help local bodies to better understand the demand for care, and to plan their services accordingly to better meet the needs of their local patients.***

7. **NHS England has not yet identified how it will manage the variety of factors that could affect the success of its plans to better manage elective care.** The NHS Long Term Plan, published in January 2019, commits to reducing face-to-face outpatient visits by one-third as part of a wider attempt to manage demand, but NHS England has not set out how this will be achieved. NHS England expects local STPs and integrated care systems to publish plans this autumn, setting out how this will be achieved for their local populations. We are concerned that it will be difficult for these local partnerships to plan effectively when they already face considerable uncertainties, for example, in their local budgets for capital, education and training,

and adult social care. NHS England expects the next spending review to provide clarity on these budgets, but the timing of this is also uncertain. The NHS has not yet published its people plan to support its Long Term Plan. It often takes many years to train key staff such as those working in diagnostics, meaning staff shortages in these areas will continue for at least the next few years. Reducing outpatient appointments through providing more care in the community will also require an increase in capacity for primary care. NHS England told us that it will develop primary care networks that will cover a population of between 30,000 to 50,000 people, but we are concerned that this may not work well for rural areas.

Recommendation: ***The Department, NHS Improvement and NHS England should, by December 2019, clarify to us:***

- ***How they are going to develop a fit-for-purpose workforce to ensure that the ambition to reduce face-to-face appointment by one-third is going to be achieved.***
- ***How they are going to ensure access to care is maintained if the number of outpatient appointments is not reduced as planned.***

1 Delivering NHS waiting times standards for elective and cancer treatment

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department for Health & Social Care (the Department), NHS England and NHS Improvement.[1]

2. The NHS Constitution sets out the principles and values of the NHS in England and the rights to which NHS patients are entitled. The Department and NHS bodies are required by law to take account of this Constitution in their decisions and actions. Since 2010, the Constitution has included maximum waiting times for elective (non-urgent) and cancer treatment as patients' rights. Patients have the right to receive consultant-led elective treatment within 18 weeks of their referral (usually by a GP). For patients urgently referred for suspected cancer, they have the right to a first outpatient appointment within two weeks.[2]

3. To ensure that patients' rights on maximum waiting times are met, the Department and NHS England also set out operational standards for NHS organisations. They do not expect all patients to be treated within maximum waiting times, recognising that, in some cases, it may not be clinically appropriate, or patients may wish to wait longer. These standards currently include: 92% of patients should wait no more than 18 weeks for their elective treatment from referral if they are still on the waiting list; 93% of patients should be seen by a cancer specialist within two weeks of being urgently referred by a GP for suspected cancer; and 85% of patients diagnosed with cancer should be treated within 62 days following their GP referral.[3]

4. The Department holds NHS England to account for national performance against waiting times standards. In turn NHS England holds clinical commissioning groups (CCGs) to account for meeting the standards for their local populations. CCGs are responsible for enforcing waiting times standards through contracts with service providers, mostly NHS trusts and foundation trusts. NHS Improvement, which merged with NHS England in April 2019, regulates and supports trusts to achieve waiting times standards for their patients.[4]

Performance against waiting times standards

5. The NHS is treating more people than ever before. Between March 2014 and 2018, the number of people treated for elective care per month increased from 1.2 million to 1.3 million. Between 2010–11 and 2017–18, the number of urgent referrals for suspected cancer increased by 94%. NHS England told us that the NHS aims to improve cancer

1 C&AG's Report, NHS waiting times for elective and cancer treatment, Session 2017–2019, HC 1989, 22 March 2019
2 C&AG's Report, Figure 1, paras 1.2–1.5
3 Qq 12–13; C&AG's Report, para 1.7 and Figure 5
4 C&AG's Report, paras 3, 1.8–1.10

survival by encouraging more people to come forward for early diagnosis and that the number of people referred for suspected cancer had increased by a quarter of a million to more than 2 million in 2018–19.[5]

6. Performance against waiting times standards has steadily worsened in recent years. The NHS has not met the 18-week elective care waiting times standard since February 2016 or the 62-day standard from a referral with suspected cancer to treatment since 2013. The number of people still waiting for their elective treatment grew from 2.7 million in March 2013 to 4.2 million in November 2018 and the number of people waiting for more than 18 weeks increased from 153,000 to 528,000. The National Audit Office reported that poor performance against waiting times standards is now widespread with most local NHS bodies failing to meet these standards. In November 2018, only 44% of NHS trust and foundation trusts (trusts) met the 18-week standard for elective treatment and only 38% of trusts met the 62-day standard for cancer treatment.[6]

7. We examined progress in improving cancer services and outcomes in 2015. We found that the NHS was failing to meet national cancer waiting time standards for patients, including the important 62-day cancer standard. In response, the Department and NHS England committed to improve performance, but instead there has been a further decline. Between July and September 2018, only 78.6% of patients were treated within 62 days of an urgent referral, down from 83.8% between September and December 2014 when we last reported on it.[7] NHS England assured us that additional investment will be available to help improve its performance against cancer waiting times as part of the NHS Long Term Plan. However, NHS England could not give a commitment as to when the cancer waiting times standard will be achieved again. NHS England and NHS Improvement told us that that they would be in a better position to determine a trajectory for improving performance once local NHS organisations (sustainability and transformation partnerships and integrated care systems) have published their plans in September 2019.[8]

Holding the NHS to account

8. The Government introduced waiting times to help improve patients' satisfaction with the NHS as well as patient outcomes. It is important that Parliament and the public can rely on waiting times standards to hold the NHS to account, to track progress made and, more importantly, to gain assurance over patients' rights to timely access to care.[9] The Department told us that it was very important to have waiting times standards to set out expectations for the public and NHS organisations, to track progress and to send the right signals to the system. NHS England added that it also allows for benchmarking between different countries.[10]

5 Qq 18, 19, 31, 32; C&AG's Report, paras 9 and 12
6 Q6, C&AG's Report, paras 8, 10
7 Qq 18–19; Committee of Public Accounts, Progress in improving cancer services and outcomes in England, Forty-fifth Report of Session 2014–15, 2 March 2015; Treasury Minutes, Government responses on the Thirtieth, the Thirty Fifth, the Thirty Seventh, and the Forty First to the Fifty Third reports from the Committee of Public Accounts Session 2014–15, Cm 9091, July 2015; NHS England, Cancer waiting times national time series – Provider based October 2009 to February 2019 Q4 2008–09 to Q3 2018–19
8 Qq 21–24, 31–35
9 Q 56; C&AG's Report, para 1.2
10 Q 17

9. The National Audit Office reported that, facing rising demand while under increasing financial constraints, national bodies have focused more on emergency and cancer care than elective care.[11] NHS England explained that this reflected the clinical priority of these conditions. The Department told us that it asks the NHS to simultaneously pursue a range of different targets, including heart disease, mental health and older people's services and that the NHS must balance these different priorities when making choices about NHS care.[12]

10. Since 2015, NHS England has gradually removed financial sanctions and penalties against NHS trusts for failing to meet elective care waiting times standards. NHS England's and NHS Improvement's planning guidance for 2018–19 no longer required trusts to meet to meet the 18-week target for elective care. We were concerned that this could imply to local health bodies that these targets are no longer important. NHS England told us that it had removed sanctions because many trusts were already in financial difficulties and additional sanctions would not add anything"[13]

11. We asked whether the 18-week elective care target was a genuine target for the NHS and whether witnesses were concerned that the target was not being met. NHS England and the Department asserted that short waits for routine care do matter to the NHS, but the recent action it described has focussed on those waiting over 52 weeks. The Department told us that it took 'significant management action' when it saw an increasing number of patients waiting 52 weeks and over in order to reverse this trend. NHS England told us that, "to send a clear signal" to people who wait 52 weeks, it was reinstating financial penalties for both providers and commissioners where patients wait longer that 52 weeks for treatment, but not for those waiting more than 18 weeks. NHS England assured us that it will ask CCGs to increase the amount elective care undertaken in the next five years, and that it was taking action to treat more people within short waiting time targets.[14]

Clinical review of waiting times standards

12. NHS England is carrying out a review of NHS access standards which covers waiting times standards for cancer and elective treatment. It published its interim report in March 2019 which proposed several changes to cancer and elective waiting times standards. The main proposed change to waiting times standards for cancer is the introduction of a 28-day standard from a patient's referral to their diagnosis to replace the current two-week waiting time standard from a patient's referral to their first appointment with a specialist. For elective care, the report proposed to explore a number of options, including an average waiting time target to replace the current 92% 18-week standard.[15] We heard from the Independent Healthcare Providers Network and Versus Arthritis that they were concerned that, given the ongoing failure by the NHS to meet the 18-week standard, the review could be used as an opportunity to make the target easier to meet or less appropriate.[16]

11 C&AG's Report, paras 14,17
12 Q 13
13 Qq 10–11, 16–17, C&AG's Report, Figure 7
14 Qq 9–11, 13; C&AG's Report, para 17
15 Qq 3, 36, 37, 56, 57; Versus Arthritis (ECC0004), para 45; Clinically-led Review of NHS Access Standards: Interim Report from the NHS National Medical Director, March 2019
16 Qq 36–46, 56, 57, 94, 95; Independent Healthcare Providers Network (ECC0001); Versus Arthritis (ECC0004)

13. NHS England and stakeholders told us that the review was an opportunity to put patient experience and outcomes at the centre of waiting time standards. NHS England accepted that it will be important that it engages with the public regarding any changes to the current waiting times standards and how they will affect patients' access to care and their rights under NHS Constitutions. NHS England explained that, in carrying out the review, it had consulted widely with stakeholders and patient representative bodies, for example, Healthwatch.[17] The Department clarified that any proposed changes would have to be approved by the Government before being adopted. We asked the witnesses whether any changes to waiting times standards in the NHS Constitution would be subject to consultation. The Department was unable to provide us with details of what specific changes would be subject to consultation but committed to checking the law and clarify the situation with us.[18] The Department subsequently wrote to us to confirm that the Secretary of State has a statutory duty to consult, including with patients, NHS staff and members of the public, on any changes to the NHS Constitution, but that there was no legal requirement to consult on changes to the Handbook to the NHS Constitution. It told us that the waiting times standards were included in the Handbook to the NHS Constitution rather than the NHS Constitution itself so, in practice, there was no legal requirement for it to consult about changes to the waiting times if the NHS Constitution remained the same. However, it confirmed that, regardless of the legal position, it was committed to holding a public consultation if any changes to waiting time standards were proposed as part of its ongoing review.[19]

Patient harm

14. We received written evidence from Versus Arthritis, a charity, who told us that patient outcomes from joint replacement surgery are worse for those who wait for more than six months for treatment. It told us that delaying access to joint replacement surgery can lead to deterioration in an individual's medical condition and "worse overall outcomes, ultimately costing the health and care system more". Versus Arthritis similarly told us that patients who wait longer for treatment experience increased pain and disability compared to those with shorter waits. NHS England told us that for most patients on long waiting lists, such as those waiting for orthopaedic operations, a delay does not impact on survival, but recognised that it could mean that they are in pain for longer. It told us that a review at one trust of people waiting a long time on the elective waiting list found that two cancer patients, out of thousands of patients treated, suffered harm due to their long waits. It asserted that the cause of this had been that these cancer cases had come through an elective pathway rather than a cancer pathway.[20]

15. NHS England told us that findings from studies of the impact of long waiting times on patient harm were not consistent and the relationship is difficult to assess. It also told us that, as the National Audit Office reported, although trusts collect data on patient harm through an incident reporting system, overseen by NHS Improvement, the data cannot be used easily to help understand the relationship between waiting times and patient harm because of the way that these data are currently collected.[21]

17 Qq 20, 42, 56, 57; Breast Cancer Care and Breast Cancer Now (ECC0005)
18 Qq 36–46
19 Letter from the Department for Health and Social Care, 14 May 2019
20 Q 101; Versus Arthritis (ECC0004), para 24; British Orthopaedic Association (ECC0003); C&AG's Report, para 18
21 Q 101; C&AG's Report, para 18

16. Trusts are required to review whether patients have been harmed if they have waited more than 52 weeks for elective care. But these data are not collected at a national level.[22] NHS England told us that it expects clinicians to use their professional judgement to manage and prioritise individual patients to ensure that patients do not come to harm because of longer waiting times. But it also recognised that widespread unwarranted variations in clinical practices exists across the country. We were concerned that patients might suffer harm while waiting for elective care even if they wait for less than 18 weeks for their treatment. As Pancreatic Cancer UK told us, it is possible that some patients suffer harm while waiting to see a consultant due to longer waiting times even when no waiting times standard is breached.[23]

22 C&AG's Report, para 18

23 Qq 59, 91, 93–97, 101; C&AG's Report, para 18; Written evidence submitted by Pancreatic Cancer UK

2 Improving waiting times performance

Bottlenecks in capacity

17. There are wide variations in performance against waiting times standards across local areas and hospitals. In 2017–18, the proportion of patients waiting less than 18 weeks for their elective care varied between 75% and 96% across clinical commissioning groups (CCGs), and from 73% to 100% across NHS trusts and NHS foundation trusts. For cancer, the percentage of patients treated within 62 days following a GP referral varied from 59% to 93% across CCGs.[24]

18. Variations in waiting times performance is closely associated with the diagnostic capacity in the NHS. The National Audit Office found that a higher proportion of patients completing their diagnostic tests within six weeks is associated with a higher proportion of patients waiting less than 18 weeks for treatment. However, it also found there are staff shortages in specific specialties including pathologists, radiologists and radiographers, all of which are involved in diagnostics tests.[25] In our 2015 report on Progress in improving cancer services and outcome in England, we highlighted the lack of capacity in diagnostics services, including shortages in diagnostics staff, and asked NHS England to assess whether the NHS had sufficient diagnostic services. NHS Improvement confirmed that there was still a big capacity issue around diagnostics which required major investment, and pointed out that, for access to MRI and CT scanners, England compared poorly to other OECD (The Organisation for Economic Co-operation and Development) countries.[26]

19. Hospitals with a higher level of bed occupancy are more likely to perform poorly against the 18-week waiting times standard. Hospitals in the NHS now routinely operate with a bed occupancy rate of more than 90%. This can affect elective patient care as patients may have their elective care treatment postponed because the beds are needed for emergency admissions. The number of NHS beds has reduced by 7% (8,000) since 2010–11. We asked whether the NHS had the right level of beds required to manage patient efficiently. NHS Improvement told us that it believed there was still room to make better use of existing beds through improving patient pathways and cutting length of stay in hospitals.[27]

Demand drivers

20. Between the 12 months to March 2014 and the 12 months to November 2018, the number of referrals for elective treatment increased by 17%.[28] A good understanding of what is driving rising NHS activity is needed in order to manage this demand and plan for services in the future. However, as we concluded in our recent report on NHS financial sustainability, published in April 2019, the rising demand for NHS services is not sufficiently well understood. Our report found that the ageing population accounts for approximately half of the rise in demand for NHS services across England, but other

24 Qq 47, 64; C&AG's Report, paras 13, 2.5,3.6 and Figure 2
25 C&AG's Report, para 2.16
26 Qq 64–66; Committee of Public Accounts, Progress in improving cancer services and outcomes in England, Forty-fifth Report of Session 2014–15, 2 March 2015
27 Qq 69–74; C&AG's Report, paras 14, 2.17–2.19
28 C&AG's Report, para 17;

factors that contribute to rising demand are not fully understood, at a national or local level. We also found that wider socioeconomic factors such as housing, employment, and changes to benefits and universal credit, were also contributing factors.[29]

21. The Department explained that there are three groups of factors which were driving the increase in demand for elective treatment: demography, patient expectations and technology, which allowed the NHS to treat conditions which could not previously been treated. NHS England similarly told us that the increase in demand was the result of it expanding the number of interventions, such as cataract operations, knee replacements and hip replacements, and because it was "constantly pushing the boundaries of medical science". NHS Improvement explained that up to 45% of inpatient admissions and 25% of outpatient referrals are due to a growing and ageing population. Both the Department and NHS Improvement accepted that the impact of technology and patient expectations are difficult to quantify and less researched.[30]

22. The Department asserted that the NHS must have a system in place that is able to respond to changes it did not know about yet and needed a workforce that would be able to adapt to new technologies. The Department acknowledged that such a system was not yet in place.[31] We asked whether the NHS is able to model the demand for its services. NHS England explained that local commissioners and sustainability and transformation partnerships (STPs) were responsible for forecasting and developing plans to meet the demand from their local populations. To support the development of local plans by STPs, NHS England committed to setting clear expectations about demographics and other demand drivers.[32]

Long-term plan

23. In January 2019, NHS England published the NHS Long Term Plan. It committed the NHS to reducing face-to-face outpatient visits by one-third over the next five years as part of a wider attempt to manage demand.[33] NHS Improvement told us that the NHS will achieve this through a "clinically-led discussion about a change in clinical practice". NHS England explained that this would be achieved by: maximising the use of "one-stop" clinics, where tests, tests results and treatment plans are all carried out in a single visit instead of multiple ones; integrating primary and secondary care so that patients can be managed in the correct environment first time, for example, treatment by physiotherapists in the community rather than being referred to hospital; and adopting a range of technologies that are used in everyday life, such as video consultations, emails or texts, instead of face-to-face consultations when no physical examination is required.[34]

24. NHS England told us that it expected local STPs and integrated care systems to publish plans this autumn which set out how the aspirations in the NHS Long Term Plan will be achieved for their local populations. It explained that the local plan will set out the STP's "trajectory" for service changes and NHS England will bring them together "in

29 Committee of Public Accounts, NHS financial sustainability: progress review, Ninety-First Report of Session 2017–19, 3 April 2019
30 Qq 58–59
31 Q 63
32 Qq 60, 63, 68, 78
33 C&AG Report, para 22
34 Qq 75, 76

the autumn as part of the national implementation plan for the NHS Long Term Plan".[35] Our report on NHS financial sustainability, published on 3 April 2019, found that there were a number of uncertainties in the budgets for capital, education and training, and adult social care which made it difficult for local partnerships to plan effectively.[36] NHS England told us that it expected the next spending review to provide clarity on these budgets, but there is uncertainty over its timing. The Department stressed that it often takes many years to train clinical staff. NHS Improvement told us that it has yet to publish its people plan and that this would not be finalised until towards the end of the year after the spending review.[37]

25. NHS England told us that it intends to reduce outpatient appointments by providing more care outside of hospitals.[38] For this to happen, it will require an increase in capacity for primary and community care. NHS England told us that it will develop primary care networks for populations of 30,000 to 50,000 people where GPs are supported by multidisciplinary teams, including therapists, social prescribers, physiotherapist, and clinal pharmacists and. It told us that supporting the generalist skills of GPs with a wide range of multidisciplinary staff would allow GPs to "focus on what they do best, which is the complex conditions that they increasingly see with an ageing population".[39]

35 Qq 77–81
36 Committee of Public Accounts, NHS financial sustainability: progress review, Ninety-First Report of Session 2017–19, 3 April 2019
37 Qq 90–91, 99–100, 102–108
38 Qq 53, 54
39 Q 86

Formal minutes

Wednesday 5 June 2019

Members present:

Meg Hillier, in the Chair

Sir Geoffrey Clifton-Brown	Anne Marie Morris
Chris Evans	Gareth Snell
Caroline Flint	

Draft Report (*NHS waiting times for elective and cancer treatment*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 25 read and agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the One-Hundredth 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.

[Adjourned till Monday 10 June at 3:30pm

Witnesses

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

Wednesday 24 April 2019

Sir Chris Wormald, Permanent Secretary, Department for Health and Social Care, **Simon Stevens**, Chief Executive, and **Professor Steve Powis**, National Medical Director, NHS England, and **Ian Dalton**, Chief Executive, NHS Improvement	Q1–114

Published written evidence

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

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

1 Breast Cancer Care and Breast Cancer Now (ECC0005)

2 British Orthopaedic Association (ECC0003)

3 Independent Healthcare Providers Network (ECC0001)

4 Pancreatic Cancer UK (ECC0002)

5 Royal College of Surgeons (ECC0006)

6 Versus Arthritis (ECC0004)

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. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session		2017–19
First Report	Tackling online VAT fraud and error	HC 312 (Cm 9549)
Second Report	Brexit and the future of Customs	HC 401 (Cm 9565)
Third Report	Hinkley Point C	HC 393 (Cm 9565)
Fourth Report	Clinical correspondence handling at NHS Shared Business Services	HC 396 (Cm 9575)
Fifth Report	Managing the costs of clinical negligence in hospital trusts	HC 397 (Cm 9575)
Sixth Report	The growing threat of online fraud	HC 399 (Cm 9575)
Seventh Report	Brexit and the UK border	HC 558 (Cm 9575)
Eighth Report	Mental health in prisons	HC 400 (Cm 9575) (Cm 9596)
Ninth Report	Sheffield to Rotherham tram-trains	HC 453 (Cm 9575)
Tenth Report	High Speed 2 Annual Report and Accounts	HC 454 (Cm 9575)
Eleventh Report	Homeless households	HC 462 (Cm 9575) (Cm 9618)
Twelfth Report	HMRC's Performance in 2016–17	HC 456 (Cm 9596)
Thirteenth Report	NHS continuing healthcare funding	HC 455 (Cm 9596)
Fourteenth Report	Delivering Carrier Strike	HC 394 (Cm 9596)
Fifteenth Report	Offender-monitoring tags	HC 458 (Cm 9596)
Sixteenth Report	Government borrowing and the Whole of Government Accounts	HC 463 (Cm 9596)
Seventeenth Report	Retaining and developing the teaching workforce	HC 460 (Cm 9596)
Eighteenth Report	Exiting the European Union	HC 467 (Cm 9596)

Nineteenth Report	Excess Votes 2016–17	HC 806 (Cm 9596)
Twentieth Report	Update on the Thameslink Programme	HC 466 (Cm 9618)
Twenty-First Report	The Nuclear Decommissioning Authority's Magnox	HC 461 (Cm 9618)
Twenty-Second Report	The monitoring, inspection and funding of Learndirect Ltd.	HC 875 (Cm 9618)
Twenty-Third Report	Alternative Higher Education Providers	HC 736 (Cm 9618)
Twenty-Fourth Report	Care Quality Commission: regulating health and social care	HC 468 (Cm 9618)
Twenty-Fifth Report	The sale of the Green Investment Bank	HC 468 (Cm 9618)
Twenty-Sixth Report	Governance and departmental oversight of the Greater Cambridge Greater Peterborough Local Enterprise Partnership	HC 896 (Cm 9618)
Twenty-Seventh Report	Government contracts for Community Rehabilitation Companies	HC 897 (Cm 9618)
Twenty-Eighth Report	Ministry of Defence: Acquisition and support of defence equipment	HC 724 (Cm 9618)
Twenty-Ninth Report	Sustainability and transformation in the NHS	HC 793 (Cm 9618)
Thirtieth Report	Academy schools' finances	HC 760 (Cm 9618)
Thirty-First Report	The future of the National Lottery	HC 898 (Cm 9643)
Thirty-Second Report	Cyber-attack on the NHS	HC 787 (Cm 9643)
Thirty-Third Report	Research and Development funding across government	HC 668 (Cm 9643)
Thirty-Fourth Report	Exiting the European Union: The Department for Business, Energy and Industrial Strategy	HC 687 (Cm 9643)
Thirty-Fifth Report	Rail franchising in the UK	HC 689 (Cm 9643)
Thirty-Sixth Report	Reducing modern slavery	HC 886 (Cm 9643)
Thirty-Seventh Report	Exiting the European Union: The Department for Environment, Food & Rural Affairs and the Department for International Trade	HC 699 (Cm 9643)
Thirty-Eighth Report	The adult social care workforce in England	HC 690 (Cm 9667)
Thirty-Ninth Report	The Defence Equipment Plan 2017–2027	HC 880 (Cm 9667)
Fortieth Report	Renewable Heat Incentive in Great Britain	HC 696 (Cm 9667)

Forty-First Report	Government risk assessments relating to Carillion	HC 1045 (Cm 9667)
Forty-Second Report	Modernising the Disclosure and Barring Service	HC 695 (Cm 9667)
Forty-Third Report	Clinical correspondence handling in the NHS	HC 929 (Cm 9702)
Forty-Fourth Report	Reducing emergency admissions	HC 795 (Cm 9702)
Forty-Fifth Report	The higher education market	HC 693 (Cm 9702)
Forty-Sixth Report	Private Finance Initiatives	HC 894 (Cm 9702)
Forty-Seventh Report	Delivering STEM skills for the economy	HC 691 (Cm 9702)
Forty-Eighth Report	Exiting the EU: The financial settlement	HC 973 (Cm 9702)
Forty-Ninth Report	Progress in tackling online VAT fraud	HC 1304 (Cm 9702)
Fiftieth Report	Financial sustainability of local authorities	HC 970 (Cm 9702)
Fifty-First Report	BBC commercial activities	HC 670 (Cm 9702)
Fifty-Second Report	Converting schools to academies	HC 697 (Cm 9702)
Fifty-Third Report	Ministry of Defence's contract with Annington Property Limited	HC 974 (Cm 9702)
Fifty-Fourth Report	Visit to Washington DC	HC 1404 (Cm 9702)
Fifty-Fifth Report	Employment and Support Allowance	HC 975 (Cm 9702)
Fifty-Sixth Report	Transforming courts and tribunals	HC 976 (Cm 9702)
Fifty-Seventh Report	Supporting Primary Care Services: NHS England's contract with Capita	HC 698 (Cm 9702)
Fifty-Eighth Report	Strategic Suppliers	HC 1031 (Cm 9702)
Fifty-Ninth Report	Skill shortages in the Armed Forces	HC 1027 (9740)
Sixtieth Report	Ofsted's inspection of schools	HC1029 (Cm 9740)
Sixty-First Report	Ministry of Defence nuclear programme	HC 1028 (Cm 9740)
Sixty-Second Report	Price increases for generic medications	HC 1184 (Cm 9740)

Sixty-Third Report	Interface between health and social care	HC 1376 (Cm 9740)
Sixty-Fourth Report	Universal Credit	HC 1375 (Cp 18)
Sixty-Fifth Report	Nuclear Decommissioning Authority	HC 1375 (Cp 18)
Sixty-Sixth Report	HMRC's performance in 2017–18	HC 1526 (Cp 18)
Sixty-Seventh Report	Financial Sustainability of police forces in England and Wales	HC 1513 (Cp 18)
Sixty-Eighth Report	Defra's progress towards Brexit	HC 1514 (CP 18)
Sixty-Ninth Report	Sale of student loans	HC 1527 (Cp 56)
Seventieth Report	Department for Transport's implementation of Brexit	HC 1657 (Cp 56)
Seventy-First Report	Department for Health and Social Care accounts	HC 1515 (Cp 56)
Seventy-Second Report	Mental health services for children and young people	HC 1593 (Cp 79)
Seventy-Third Report	Academy accounts and performance	HC 1597 (Cp 79)
Seventy-Fourth Report	Whole of Government accounts	HC 464 (Cp 79)
Seventy-Fifth Report	Pre-appointment hearing: preferred candidate for Comptroller and Auditor General	HC 1883 (Cp 79)
Seventy-Sixth Report	Local Government Spending	HC 1775 (Cp 79)
Seventy-Seventh Report	Defence Equipment Plan 2018–28	HC 1519 (Cp 79)
Seventy-Eighth Report	Improving Government planning and spending	HC 1596
Seventy-Ninth Report	Excess Votes 2017–18	HC 1931
Eightieth Report	Capita's contracts with the Ministry of Defence	HC 1736
Eighty-First Report	Rail management and timetabling	HC 1793
Eighty-Second Report	Windrush generation and the Home Office	HC 1518
Eighty-Third Report	Clinical Commissioning Groups	HC 1740
Eighty-Fourth Report	Bank of England's central services	HC 1739
Eighty-Fifth Report	Auditing local government	HC 1738

Eighty-Sixth Report	Brexit and the UK border: further progress review	HC 1942
Eighty-Seventh Report	Renewing the EastEnders set	HC 1737
Eighty-Eighth Report	Transforming children's services	HC 1741
Eighty-Ninth Report	Public cost of decommissioning oil and gas infrastructure	HC 1742
Ninetieth Report	BBC and personal service companies	HC 1522
Ninety-First Report	NHS financial sustainability: progress review	HC 1743
Ninety-Second Report	Crossrail: progress review	HC 2004
Ninety-Third Report	Disclosure and Barring Service: progress review	HC 2006
Ninety-Fourth Report	Transforming rehabilitation: progress review	HC 1747
Ninety-Fifth Report	Accessing public services through the Government's Verify digital system	HC 1748
Ninety-Sixth Report	Adult health screening	HC 1746
Ninety-Seventh Report	Local Government Governance and Accountability	HC 2077
Ninety-Eighth Report	The apprenticeships programme: progress review	HC 1749
Ninety-Ninth Report	Cyber security in the UK	HC 1745
First Special Report	Chair of the Public Accounts Committee's Second Annual Report	HC 347
Second Special Report	Third Annual Report of the Chair of the Committee of Public Accounts	HC 1399