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Committee of Public Accounts

Managing NHS backlogs and waiting times in England

Thirty-Eighth Report of Session 2022–23

Report, together with formal minutes relating to the report

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The Committee of Public Accounts

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Summary

NHS England's (NHSE's) three-year recovery programme for elective and cancer care is very ambitious, relies on innovative but relatively untested approaches, and is already falling short of expectations in its first year. Waiting times for cancer treatment are especially worrying. In the first five months of the recovery period the proportion of people receiving timely cancer treatment has decreased. Only 62% of cancer patients were treated within 62 days of their urgent referral by a GP, when performance should be 85%. It is now clear that the target to reduce the number of people waiting for more than 62 days following an urgent GP referral to the pre-pandemic level will not be met by March 2023. It is also clear that, for elective care, the planned route to increasing activity to 129% of pre-pandemic levels by 2024–25 is unachievable. Being off track means more patients suffering the unacceptable consequences of waiting too long.

Despite the first target for elective care being to eliminate two-year waits by July 2022, in August there were 2,600 patients who had been waiting more than two years. We have serious doubts that the endpoints of the NHS recovery plan—the target to reach 129% of 2019–20 activity and the elimination of 52-week elective waits in March 2025—will be met on time. Assumptions NHSE made about the first year of recovery were overoptimistic, including that there would be low levels of COVID-19 and minimal winter pressures.

The 13 individual programmes NHSE is running to recover elective and cancer waiting times aim for sensible and necessary improvements. But the overall strategy lacks detail on how and when these programmes will combine to create additional capacity and at what cost. There appears to have been a dearth of advance planning to ensure the NHS has the staffing and other resources it needs to deliver additional diagnostic and treatment capacity, much of which was already needed before the COVID-19 pandemic. NHSE's approach too often is to react to these problems as and when they arise, as opposed to making realistic assessments and strategic plans. This is not making the best use of the NHS's hardworking and committed frontline staff. NHSE must act now to improve its management of the recovery programme.

Finally, it is also clear that the success of the recovery programme is reliant on realistic long-term planning in other areas of health and care. There are two areas which most obviously require effective planning to enable elective recovery. The first is at the interfaces between health and care, to increase the capacity of adult social care so that the flow through hospitals improves. The second is the long overdue strategic approach to creating a productive healthcare workforce of the right size, including clarity about how long it will take to reach these levels through sufficient domestic training.

Introduction

At the start of the COVID-19 pandemic, the NHS in England had not met its elective waiting time performance standard for four years, nor its full set of eight operational standards for cancer services for six years. Due to the pandemic, the number of people receiving elective and cancer care initially reduced sharply. Between March 2020 and August 2022, on average there were 8,300 COVID-19 patients in hospital in England at any one time, with peaks in this number during waves of infection. Backlogs of patients, both visible on waiting lists and hidden because they had not yet seen a doctor, grew rapidly.

The expectations for recovery were agreed by the Department of Health and Social Care (the Department) and NHS England (NHSE). The government announced an additional £8 billion of resource and £5.9 billion of capital funding for recovery from 2022–23 to 2024–25. In February 2022, NHSE published a plan to recover elective and cancer care over the three years from April 2022 to March 2025. This planned recovery is essential but in itself only partial. The NHS will still be operating below its legal and operational standards for elective and cancer care even if all targets are met.

Conclusions and recommendations

1. **Cancer waiting times are at their worst recorded level and NHS England (NHSE) will not meet its first cancer recovery target.** 85% of people who have been urgently referred by their GP and have cancer confirmed should start treatment within 62 days. But in the first five months of 2022–23, only 62% of patients met this target, with 11% of patients being treated more than 104 days after an urgent referral. NHSE set a recovery target that the weekly count of patients waiting over 62 days would recover to the pre-pandemic level by March 2023, and in July 2022 the Chief Executive of the NHS wrote to all NHS trusts stating that cancer care was a critical priority for the rest of the year. However, in evidence to us at the end of November, NHSE acknowledged that this first cancer recovery target would be missed.

   Recommendation: ***NHS England should be able to treat 85% of people with cancer within 62 days of an urgent GP referral and no one should ever have to wait more than 104 days for cancer treatment. It is unacceptable that 8,100 people waited over 104 days in the first five months of 2022–23. As a matter of urgency, the Department of Health and Social Care and NHS England should do whatever is required to bring cancer treatment back to an acceptable standard.***

2. **NHS England was over-optimistic about the circumstances in which the NHS would be trying to recover elective and cancer care.** In our first report on NHS backlogs and waiting times in March 2022, we reported our concern 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". The recovery plan, however, continued this over-optimism by including assumptions about low levels of COVID-19 and minimal winter pressures, and that activity levels would recover to pre-pandemic levels early in 2022–23. Between April and August 2022, elective activity was at just 95% of pre-pandemic levels. The reality has been that the NHS continues to manage other major pressures, including ongoing effects of COVID-19, access to primary care, the performance of urgent and emergency care, workforce gaps, and problems with the supply of adult social care. NHSE told us that it would need to "reprofile" the trajectory of the recovery if it was to reach 129% during 2024–25. Macmillan Cancer Support and Healthwatch Suffolk submitted evidence to us with powerful examples of the uncertainty, anxiety and other problems experienced by long-waiting patients.

   Recommendation: ***NHS England and the Department of Health and Social Care should revisit their planning assumptions for the recovery and publicly report any updates to targets so that patients and NHS staff can see a clear and realistic trajectory to achieve the 62-day cancer backlog target, the 52-week wait target for elective care, and, ultimately, the 18-week legal standard for elective care.***

3. **NHS funding has increased, but to deliver key priorities such as elective and cancer recovery it will need to be spent in the most cost-effective way.** The Department has allocated £14 billion to NHSE from 2022–23 to 2024–25 specifically to recover elective and cancer care. This comprises £8 billion of resource funding and £5.9 billion of capital funding. The Autumn Statement 2022 committed an additional £3.3 billion in 2023–24 and 2024–25 to the NHS budget as a whole. NHSE told us this would be sufficient for the NHS to deliver its key priorities. However, NHSE

has opted not to produce a detailed costed version of its recovery plan to show how it expects all of the £14 billion to be spent. Without timely evaluation of its programmes, including surgical hubs and clinical diagnostic centres, there is a risk that the future allocation of resources will not be informed by reality on the ground. Overall, the NHS has a problem with reduced productivity. An internal review by NHS England estimated that the NHS was around 16% less productive in 2021 than in 2019 and said that the immediate effects of the pandemic were not the only cause.

Recommendation: ***NHSE should transparently describe how the additional funds for elective recovery have been allocated. Alongside the Treasury Minute response, it should also write to us providing details of the programmes on which it expects the £14 billion to be spent, the independent evaluations it has put in place to monitor the effectiveness of additional spending, and how it expects additional spending to improve NHS productivity.***

4. **NHS England's elective recovery programme partly relies on initiatives which have potential but for which there is so far limited evidence of effectiveness.** NHSE has expanded some programmes because it believes them to be sufficiently promising, but there is currently a limited evidence base for their effectiveness, their impact on other parts of the health and social care system, and how they will work on a greatly expanded scale. NHSE told us it would ensure that capacity in surgical hubs, community diagnostic centres and the independent sector would be genuinely additional. However, it has more work to do to demonstrate how additional capacity will be sufficiently staffed without detracting from other NHS services. It is also concerning that NHSE could not provide the National Audit Office with its full evaluation of the 2021 elective accelerators programme, on which it spent £160 million.

Recommendation: ***NHS England should know more about the conditions necessary for individual programmes to make the greatest contribution possible to recovery. Alongside its Treasury Minute response to this report, it should write to us more fully describing the real-world impact of community diagnostic centres, surgical hubs, increased use of the independent sector, and the advice and guidance programme. It should set out its understanding of the extent to which these initiatives have so far generated genuinely additional activity, rather than simply displacing activity elsewhere in the NHS.***

5. **NHSE started 2022–23 with a strategy but spent most of the year dealing with tactical issues and its strategic and programme management of the recovery must improve.** NHSE was allocated £14 billion of recovery funding in September 2021 (for the three years from April 2022) and published its recovery plan in February 2022. But it had only filled seven out of 21 programme management posts by the end of May 2022 and still did not have the capability to report fully on performance in August 2022. NHSE told us that it had developed a comprehensive and agile approach to sharing best practice between areas and was supporting and challenging leaders. However, it is unclear whether this approach will be sufficient to address the scale of the challenge in the worst-performing areas, or whether better strategic management is required to address the underlying causes of variation.

Recommendation: ***NHS England must lift its sights and refocus on its strategic duty to offer direction to the whole NHS. This should involve making difficult trade-offs to address historical inequalities between areas, and by having a clear set of actions to improve leadership. To demonstrate progress, NHS England should write to us by the Summer recess setting out the action is has taken to address variation in elective and cancer performance and provide evidence of the impact this has had on patient waiting lists.***

6. **The NHS's recovery cannot succeed without comprehensive, realistic and sustainable plans for the future of the workforce and the capacity of adult social care.** The Royal Colleges of Radiologists, Surgeons, Nursing, Obstetricians and Gynaecologists, and Ophthalmologists all submitted evidence to us stressing the need for strategic workforce planning. In our March 2022 report on NHS backlogs, we stated that "the NHS will be less able to deal with backlogs if it does not address longstanding workforce issues". Deferring action on this means not making the best use of the NHS's existing hardworking and committed frontline staff. It is also clear that the success of the recovery programme is reliant on realistic long-term planning in other areas of health and care, including the capacity of adult social care where this is reducing flow through hospitals. The Department confirmed some of the steps it will take immediately, including to publish an independently verified forecast of the number of health professionals the NHS requires during 2023 and to allocate additional funds to improve hospital discharge into adult social care. These are not end-points, however, and results of this work must be incorporated into realistic planning assumptions for NHS elective and cancer recovery.

Recommendations:

- ***The Department of Health and Social Care should work with NHS England to reassess the achievability of elective and cancer recovery targets following the publication of its workforce plan in 2023, and planned improvements to the discharge of patients into adult social care. It should write to us as soon as possible describing the conclusions of this achievability assessment.***
- ***The Department should publish the underlying assumptions of its workforce projections alongside the forecasts in the workforce plan. This should include quantification of key assumptions, particularly on productivity, domestic training and overseas recruitment and, in full, the independent reviewer's assessment.***

1 Realism about the current situation

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department) and NHS England (NHSE) about NHS backlogs and waiting times in England.[1]

2. At the start of the COVID-19 pandemic, the NHS in England had not met its elective waiting time performance standard for four years, nor its full set of eight operational standards for cancer services for six years. When COVID-19 cases first rose, the number of people receiving cancer and elective care fell sharply. Between March 2020 and August 2022, on average, there were 8,300 COVID-19 patients in hospital at any one time, with peaks in spring 2020, winter 2020–21, winter 2021–22 and summer 2022. Backlogs, both visible (7.0 million patients on the waiting list by August 2022) and hidden (people with health problems who did not seek medical attention), grew rapidly.[2]

3. Government set out its intention to tackle the elective care backlog and improve cancer services in September 2021, and the Department allocated an additional £8 billion of resource and £5.9 billion of capital funding for recovery from 2022–23 to 2024–25. The expected activity levels and targets to be achieved were agreed by the Department and NHSE in autumn 2021 and published in the recovery plan in February 2022.[3]

4. The planned recovery is essential but in itself only partial, as the NHS will still be operating below its legal and operational standards for elective and cancer care even if all targets are met. According to the NHS recovery plan, by March 2025 no patient will have to wait more than 52 weeks for elective care, while by March 2023 the number of people waiting more than 62 days from an urgent GP referral for cancer care will have returned to the pre-pandemic level. Achieving these targets would represent a significant improvement on what patients currently experience but would still be a long way short of the standards for waiting times set out in NHS regulations.[4] For elective care this is that 92% of the patients on the waiting list have been waiting for less than 18 weeks. The operational standard for cancer following an urgent GP referral is that 85% of patients wait a maximum of 62 days and in February 2020 this stood at 74%.

Current waiting times for cancer diagnosis and treatment

5. The NHS is not treating all cancer patients in a timely way and people are experiencing record waits. One of the recovery targets is to reduce the number of people waiting more than 62 days for treatment following an urgent GP referral to the pre-pandemic level of around 14,300 patients.[5] As well as this recovery target, which is based on weekly data collected by NHSE, NHS cancer waiting time performance is also published monthly.[6] Both weekly and monthly statistics show increased waits for cancer care in 2022–23, with the weekly backlog still more than twice the targeted level in August 2022, and with 8,100 people (11% of the total) waiting more than 104 days for treatment following an urgent

1 C&AG's Report, *NHS backlogs and waiting times in England*, Session 2022–23, HC 799, 17 November 2022
2 C&AG's Report, paras 1, 1.1
3 C&AG's Report, paras 2, 1.4, 1.15
4 C&AG's Report, paras 5, 1.6, 1.8, Figure 1
5 C&AG's Report, paras 16, Figure 1, 3.12
6 At: https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/

GP referral between April and August 2022.[7] Only 62% of patients were treated within 62 days in the first five months of 2022–23, against a performance standard of 85%.[8] At the time of our evidence session, performance data was available up to September 2022. This showed that quarter 2 of 2022–23 (July to September 2022) was the worst recorded quarter for cancer waits, with record lows for seven out of ten cancer performance standards.[9]

6. We asked NHSE about the cancer recovery programme, which it has rated overall as 'red' in internal assessments.[10] NHSE told us that performance against the 62-day backlog target had worsened because of a significant increase in referrals for suspected cancer.[11] The National Audit Office notes in its report that, between April and August 2022, GPs urgently referred 15% more people with suspected cancer than in the same period in 2019.[12]

7. In July 2022, the Chief Executive of the NHS, wrote to all Chief Executives of NHS trusts, NHS Foundation Trusts and Integrated Care Boards stating that the 62-day cancer backlog target should be a critical priority for the remainder of the year.[13] This instruction has not led to the results NHSE hoped for. In our session NHSE had to acknowledge that it no longer expected to meet the target by March 2023.[14]

Over-optimism in recovery assumptions

8. This Committee first looked at post-pandemic backlogs in December 2021, publishing our report in March 2022. We noted that officials appeared to be planning on the basis of optimistic future scenarios and also that there was general over-optimism from officials on the short- and medium-term resilience of the NHS.[15] The latest National Audit Office report states that the recovery plan contained over-optimistic assumptions about maintaining low levels of COVID-19 in 2022–23 and suffering minimal adverse effects from winter pressures.[16] It notes that NHSE's internal target for completed elective pathways in 2022–23 was 102% of the pre-pandemic level, but actually elective activity was at just 95% of pre-pandemic levels in the first five months of 2022–23.[17] Put simply, this means that the elective recovery is already off track.

9. We asked NHSE about its optimism at the time it agreed the recovery targets. It told us that its assumption about low levels of COVID-19 had turned out to be "completely wrong". It added that this had resulted in both a higher than anticipated demand for hospital beds for patients with COVID-19 and higher staff sickness absence.[18] The National Audit Office report states that the NHS is also managing other major pressures,

7 C&AG's Report, paras 16, 3.12, 3.13, Figure 11, Figure 12
8 C&AG's Report, paras 16, 1.8, 3.12, 3.13.
9 Quarterly data available at: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/12/Cancer-Waiting-Times-National-Time-Series-Oct-2009-Oct-2022-with-Revisions.xlsx
10 C&AG's Report, Figure 5.
11 Q 44
12 C&AG's Report, para 16, 2.14
13 Available at: https://www.england.nhs.uk/wp-content/uploads/2022/07/B1881_Next-steps-in-the-recovery-of-elective-services_July-2022.pdf
14 Q 44
15 Committee of Public Accounts, *NHS backlogs and waiting times in England*, Forty-Fourth Report of Session 2021–22, HC 747, 16 March 2022
16 C&AG's Report, para 3.2
17 C&AG's Report, paras 14, 3.3
18 Q 11

including other ongoing effects of the COVID-19 pandemic, access to primary care, the performance of urgent and emergency care, workforce gaps, and problems with the supply of adult social care.[19]

10. We shared our concerns about the risks facing the NHS and its ability to deliver the recovery targets and we pressed NHSE on how confident it was that it would meet the target to increase elective activity to 129% of 2019–20 levels by 2024–25.[20] In some ways, this is the most important target because increasing activity is what will enable all the other targets to be met. We noted the importance of reaching higher levels of activity as soon as possible so as to begin reducing the backlog of people waiting for elective care. NHSE told us that it continued to aim for 129% in 2024–25 but that it recognised it would need to "re-profile" its trajectories for getting there.[21]

11. Macmillan Cancer Support and Healthwatch Suffolk submitted evidence to us containing powerful examples of the uncertainty, anxiety and other problems long waits cause patients. Macmillan Cancer Support told us that the impact of cancer care backlogs was being felt by people at all stages of the cancer pathway and that people were worried about a reduced chance of surviving cancer because of the delays.[22] On elective care, Healthwatch Suffolk told us of the wider, often long-term impacts that treatment delays can have, including people having to live with increased pain and experiencing detrimental effects on their mental health, social life, and wellbeing.[23]

19 C&AG's Report, para 2
20 Q 13
21 Q 14
22 NHS0033
23 NHS0008

2 Ensuring effectiveness of recovery plans

Additional spending

12. The Department has allocated £14 billion to NHS England from 2022–23 to 2024–25 specifically to recover elective and cancer care, comprising £8 billion of resource funding and £5.9 billion of capital funding, as described in the November 2021 Budget and Spending Review.[24] The Autumn Statement in November 2022 then, separately, committed additional funding to the overall NHS budget due to financial pressures. NHSE's planned resource limit for 2024–25 is now £166 billion: "£3.3 billion in each of the next 2 years to support the NHS in England in response to the significant financial pressures it faces, and [enable] rapid action to improve emergency, elective and primary care performance".[25]

13. We asked NHSE about whether, in its view, this would provide the NHS with sufficient funding, given its previous comments about the scale of the negative impact inflation had had on its budgets.[26] The Chief Executive told us that it should be enough to deliver key priorities, including elective and cancer recovery. NHSE also listed the continuing risks to recovery, many of which could reduce the value of this latest spending settlement: these include, in particular, risks relating to industrial action, and any increases in the assumed level of inflation.[27] The National Audit Office report notes that NHSE has so far opted not to produce a detailed costed version of its recovery plan to show how it expects all of the £14 billion to be spent.[28]

14. NHSE has estimated that the NHS was around 16% less productive in 2021 than before the pandemic.[29] NHSE's internal analysis indicated that this drop in productivity was not solely due to immediate pandemic pressures, but also resulted from staff being less likely to work paid or unpaid overtime, and a reduced management focus by NHSE and NHS trusts on cost control and operational rigour.[30] In responding to our questions about how it is practically addressing the productivity problem, NHSE said that the work had to begin at the level of individual providers. It told us that a provider should begin by working through available data to understand the specific issues it was facing, in order to come up with a plan to improve productivity. It indicated that it would be leading this kind of process throughout the country during the next annual planning round.[31]

New programmes and initiatives for recovery

15. NHSE's elective recovery programme includes plans for:

- GPs to handle many elective cases previously dealt with by hospital doctors. Instead of referring some patients for elective care, GPs manage them within the

24 C&AG's Report, paras 7, 1.15 ; Autumn Budget and Spending Review 2021, para 2.11
25 Autumn Statement 2022, para 5.57, table 2.1
26 NHS England Board Paper, 6 October 2022
27 Q 105
28 C&AG's Report, paras 7, 1.23
29 C&AG's Report, paras 13, 3.21
30 C&AG's Report, para 3.21
31 Q 96

primary care system after receiving advice and guidance from hospital doctors. The recovery plan aims for 1.7 million elective referrals to be avoided in this way in 2022–23, rising to 2.0 million in 2023–24.

- Surgical hubs and community diagnostic centres which contribute to elective recovery by improving efficiency and access to services. These two programmes may provide resilience by allowing elective care to continue on physically separate 'cold sites' when other parts of hospitals struggle with high rates of bed occupancy or other kinds of patient demand.[32]

16. We asked how confident NHSE was about the component programmes in its plan, particularly those aimed at increasing elective and diagnostic capacity. It told us that it did not have strong evidence for some of its programmes at present, but said it was building evaluation into its programmes on surgical hubs and community diagnostic centres.[33] It said "the basis of a formal evaluation is clearly in place".[34] We hope that NHSE will take this responsibility to evaluate seriously. These are promising programmes but they must prove themselves in practice. We were concerned that NHSE had been unable to find its evaluation of a previous programme, elective accelerators, which provided £160 million to 12 local systems in 2021. The systems were supposed to increase their elective activity but in practice activity still fell short of pre-pandemic levels.[35]

17. Surgical hubs and community diagnostic centres have potential, but success will rely on them being adequately staffed. NHSE currently has limited evidence on hubs' and CDC's ability to continue operating when the wider NHS is under significant pressure.[36] The Royal College of Surgeons also acknowledged the value of a thorough evaluation of surgical hubs, stating that "whilst the underpinning theory for surgical hubs is sound, and there are examples of good practice, we recognise the need for more empirical evidence to confirm the extent to which surgical hubs can increase productivity, and also to consider their wider impacts".[37]

18. We also asked NHSE whether its increased use of the independent healthcare sector might detract from or reduce activity within the NHS itself. NHSE told us that this was a key consideration in decisions about when to use the independent sector. It confirmed that it was working to support NHS and independent sector providers to work as productively as possible together.[38]

32 C&AG's Report, para 8, 1.24
33 Q 61
34 Q 62
35 C&AG's Report, para 1.25
36 C&AG's Report, paras 8, 2.22, 2.29
37 NHS0021
38 Qq 67, 69

3 Improving planning

Improving strategic and programme management

19. We asked NHSE about its programme management of the recovery and its strategic approach to tackling variation in performance between NHS areas. The National Audit Office found that, whilst recovery funding was allocated in September 2021 and the recovery plan published in February 2022, NHSE had only filled seven out of 21 posts in its central programme management office by the end of May 2022. It also reported that NHSE still did not have the capability to report fully on performance, according to the measures it had itself identified, in August 2022.[39]

20. NHSE told us that it monitored performance constantly, with fresh data available weekly, and that it was continually developing the metrics it uses to track performance. It argued that this was a comprehensive and agile approach.[40] We heard how NHSE uses data to place NHS providers into tiers, depending on how on or off track they are against targets. It then seeks to provide greater support to those organisations that are more off track, including sharing best practice from other areas.[41]

21. In response to our question about improving areas that have seen long-term underperformance, sometimes dating back to before the pandemic, NHSE told us that it had sent teams into some areas to support and challenge them.[42] The National Audit Office report showed that the proportion of waiting patients who are in scope of the target to eliminate 78-week waits by April 2023 ranges from 2% to 20%, depending on the part of the country. This means that the challenge of meeting the target is vastly harder for some parts of the NHS than others.[43]

Key dependencies including workforce planning

22. This report is the Committee's second on NHS backlogs, the first being published in March 2022. We stated then that "the NHS will be less able to deal with backlogs if it does not address longstanding workforce issues".[44] For this inquiry we received evidence from five medical Royal Colleges. The submissions from the Royal Colleges of Nursing, Obstetricians and Gynaecologists, Ophthalmologists, Radiologists, and Surgeons all highlighted the ongoing absence of sufficient strategic workforce planning.[45] The Autumn Statement 2022 confirmed that a workforce plan, with quantified workforce projections, would be produced by the Department in 2023: "the government is publishing a comprehensive NHS workforce plan, including independently verified workforce forecasts, next year. This will include measures to make the best use of training to get doctors, nurses and allied health professionals into the workforce, increase workforce productivity and retention."[46] This is a welcome and long overdue step.

39 C&AG's Report, paras 9, 2.7
40 Q71
41 Q72
42 Q 73
43 C&AG's Report, para 2.12, Figure 7
44 Committee of Public Accounts, *NHS backlogs and waiting times in England*, Forty-Fourth Report of Session 2021–22, HC 747, 16 March 2022
45 NHS0002, NHS0015, NHS0019, NHS0021, NHS0026
46 Autumn Statement 2022, para 5.59

23. We asked the Department if it agreed that it was more sustainable to train more doctors, nurses and other health professionals domestically, rather than be over-reliant on international recruitment. It told us that this question would be part of the review that will lead to the workforce plan it will release in 2023.[47]

24. We asked about other key enablers of a successful recovery of elective and cancer care. NHSE told us about the particular negative impact of delayed discharges into adult social care, which had reduced its effective inpatient capacity.[48] The Department confirmed that the additional funding for adult social care announced in the Autumn Statement would be used to help improve "the flow through from hospital to care."[49] The Autumn Statement 2022 committed to "an additional £1 billion of central government funding in England in 2023–24, increasing to £1.7 billion in 2024–25, to get people out of hospital on time and into social care."[50]

47 Qq 106, 108
48 Q77
49 Q111
50 Autumn Statement 2022, para 5.61

Formal minutes

Thursday 2 February 2023

Members present:

Dame Meg Hillier

Dan Carden

Mrs Flick Drummond

Mr Mark Francois

Nick Smith

Managing NHS backlogs and waiting times in England

Draft Report (*Managing 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 24 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Thirty-eighth 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 Monday 6 February at 3.30pm

Witnesses

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

Monday 28 November 2022

Sir Chris Wormald KCB, 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; **Sir James Mackey**, National Director of Elective Recovery, NHS England; **Professor Sir Steve Powis**, National Medical Director and Chief Executive, NHS Improvement, NHS England — 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.

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

1 AbbVie (NHS0025)

2 Alzheimer's Society (NHS0027)

3 Association of Anaesthetists (NHS0007)

4 Asthma + Lung UK (NHS0032)

5 Becton Dickinson UK Ltd (NHS0031)

6 Breast Cancer Now (NHS0018)

7 British Medical Association (NHS0034)

8 Budjanovcanin, Dr Alexandra (Senior Lecturer in Work Psychology and Public Sector Management, King's Business School, King's College London) (NHS0035)

9 CMR Surgical (NHS0001)

10 Cancer Research UK (NHS0023)

11 Company Chemists' Association (NHS0036)

12 Edwards Lifesciences (NHS0017)

13 Glaukos (NHS0028)

14 Healthwatch Suffolk (NHS0008)

15 Independent Healthcare Providers Network (IHPN) (NHS0009)

16 Macmillan Cancer Support (NHS0033)

17 NHS Confederation (NHS0004)

18 NHS Providers (NHS0020)

19 Optical Express (NHS0011)

20 Parkinson's UK (NHS0029)

21 Remedy Healthcare Solutions (NHS0016)

22 Royal College of Nursing (NHS0026)

23 Royal College of Obstetricians and Gynaecologists (NHS0002)

24 Royal College of Radiologists (RCR) (NHS0019)

25 Royal College of Surgeons of England (NHS0021)

26 Spire Healthcare (NHS0003)

27 St John Ambulance (NHS0005)

28 The Health Foundation (NHS0040)

29 The Health Tech Alliance (NHS0022)

30 The Institute for Biomedical Science (NHS0030)

31 The Medical Technology Group (NHS0039)

32 The Royal College of Ophthalmologists (NHS0015)

33 Versus Arthritis (NHS0038)

34 iRhythm Technologies (NHS0042)

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