



National Audit Office

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## **Report**

by the Comptroller  
and Auditor General

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**Department of Health & Social Care and NHS England**

# NHS waiting times for elective and cancer treatment

## Key facts

### Elective care

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**4.2m**

number of patients waiting for elective care at November 2018

**87.3%**

proportion of patients on the waiting list for elective care who had been waiting for less than 18 weeks in November 2018, against a standard of 92%

**44%**

proportion of NHS trusts and NHS foundation trusts (trusts) that met the waiting times standard for elective treatment in November 2018

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**17%** increase in the estimated number of annual referrals for elective treatment between the 12 months to March 2014 and the 12 months to November 2018

**£700 million** estimated additional one-off cost to reduce the 18-week elective care waiting list to the size last seen in March 2018, based on current trends

### Cancer care

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**1.94m**

number of patients with suspected cancer that were referred urgently for diagnosis in 2017-18

**78.6%**

proportion of patients who were treated within 62 days of an urgent GP referral for suspected cancer in July to September 2018, against a standard of 85%

**38%**

proportion of trusts that met the 62-day waiting times standard from referral to cancer treatment in November 2018

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**94%** increase in the number of urgent referrals made by a GP for suspected cancer between 2010-11 and 2017-18

**38%** proportion of all patients diagnosed with cancer in 2016 who were urgently referred, up from 31% in 2010

# Summary

**1** Under the NHS Constitution, NHS patients have the right to receive consultant-led elective treatment within 18 weeks of being referred for treatment (usually by a GP), unless they choose to wait longer, or it is clinically appropriate to do so. Elective care is the treatment of non-urgent conditions. In contrast to emergency care, the treatment is not usually provided at the same time as the decision to treat is made. It covers a wide variety of treatment specialties, including general medicine, neurosurgery, ophthalmology and orthopaedics. For urgent referrals for suspected cancer, patients have the right to a first outpatient appointment within two weeks.

**2** To ensure patients' rights to timely access to care, the Department of Health & Social Care (the Department) has set various waiting times performance standards (**Figure 1**). These describe the percentage of patients that NHS bodies must treat within maximum waiting times. Three-quarters of outpatient referrals, as well as many admissions to hospital, are covered by waiting times standards for non-urgent (elective) and cancer care.

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## Figure 1

### Key NHS waiting times standards for elective and cancer patients

The Department of Health & Social Care has set waiting times performance standards to ensure patients' rights to timely access to care

Scope	Maximum waiting times	Standard
Elective treatment	Patients have a <i>right</i> to start consultant-led treatment within a maximum of <b>18 weeks</b> from referral for non-urgent conditions.	<b>92%</b> of patients
Cancer assessment	Patients have a <i>right</i> to be seen by a cancer specialist within <b>two weeks</b> of a GP referral for urgent referrals where cancer is suspected.	<b>93%</b> of patients
Cancer treatment	The government has <i>pledged</i> that patients should wait a maximum of <b>62 days</b> from urgent referral for suspected cancer to first treatment for all cancers.	<b>85%</b> of patients

#### Notes

- 1 A 'right' is the maximum wait to which patients are entitled under the NHS Constitution. A 'pledge' is the maximum wait to which the NHS has committed to achieving.
- 2 There are a further six cancer waiting times pledges in addition to those listed above.

Source: NHS England

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**3** The Department holds NHS England to account for national performance against waiting times standards, through its annual mandate. NHS England then holds clinical commissioning groups (CCGs) to account for meeting the standards for their local populations. The 195 CCGs are responsible for commissioning elective and cancer care locally. They enforce waiting times standards through contracts with service providers (mostly acute and community NHS trusts and NHS foundation trusts (trusts)). NHS Improvement also has a role in regulating and supporting trusts to achieve waiting times standards for their patients.

**4** NHS England is currently undertaking a clinically led review to consider the current performance standards, which is likely to result in changes to the waiting times standards. We therefore considered that it was a good time to draw together existing evidence and analysis and build on this evidence base to examine the dynamics that affect waiting times performance to help inform the current debate on this topic.

### **Focus of this report**

**5** This review presents data on the NHS's performance against current waiting times standards for elective and cancer care in England, and some of the factors associated with that performance. We chose elective and cancer care because they offer different insights into waiting times:

- for cancer, the health sector has placed considerable focus on improving early referral and diagnosis, leading to more appointments; and
- for elective care, when the health system is under considerable strain, such as during peak winter periods, delays may occur, because the effects of these delays are likely to be less damaging for patients than delays to emergency care.

The report does not cover waiting times standards for accident and emergency (A&E), ambulance and mental healthcare services.

**6** This report draws together existing evidence and analysis by the Department, NHS England, NHS Improvement and other stakeholders. We build on this evidence base with our own analysis to provide added insight into:

- changes in waiting times performance, and variations in that performance;
- the impact of waiting times performance on patients;
- the factors that influence waiting times performance; and
- NHS England's and NHS Improvement's approach to managing and improving waiting times performance.

**7** Part One of the report provides an overview of waiting times. Part Two covers elective waiting times and Part Three covers cancer waiting times. Our audit approach and methods are set out in Appendix One, Appendix Two and Appendix Three, including our approach to data quality issues. Appendix Four provides details of the best- and worst-performing CCGs.

## **Key findings**

### Trends and current performance

**8 The 18-week elective care standard (92%) was last met nationally in February 2016.** Following the introduction of a waiting times standard for elective care there were improvements in waiting times but standards are not routinely being met anymore. The government introduced waiting times standards for elective care in 1991, to improve patients' outcomes and patients' satisfaction. At the time it was not uncommon for people to wait more than 12 months for admission to hospital. In August 2007, when comparable national data first became available, only 57% of patients on the list had been waiting less than 18 weeks for treatment. By 2012-13, this had risen to 94%. However, the 18-week elective care standard (92%) was last met nationally in February 2016. In November 2018, only 44% of trusts met this standard and only 87.3% of patients on the waiting list for elective care had been waiting for less than 18 weeks (paragraphs 1.2, 2.2 to 2.4, 2.7, and Figures 8 and 10).

**9 The elective care waiting list is growing, and patients are increasingly waiting longer for their care.** Between March 2013 and November 2018, the average number of people treated each month increased from 1.2 million to 1.3 million. In addition, the average number of patients treated within the waiting times standard for elective care increased slightly over this period. Despite, these increases, between March 2013 and November 2018, the number of people still waiting for their treatment grew from 2.7 million to 4.2 million, and the number waiting more than 18 weeks grew from 153,000 to 528,000 (paragraph 2.3, and Figures 8 and 9).

**10 Most standards for cancer care have been met until recently.** Although performance against cancer waiting times standards has declined since 2013-14, seven of the eight cancer standards were met nationally until the end of 2017. However, the 62-day standard (85%) has not been met for any quarter since the end of 2013. In November 2018, only 38% of trusts met this standard and between July and September 2018, 78.6% of patients were treated within 62 days of an urgent GP referral for suspected cancer (paragraphs 3.4 to 3.6, and Figures 22 and 23).

## **11 Waiting times performance varies significantly across geographical areas, providers and specialties.**

- **Geographical:** In 2017-18, the proportion of patients waiting less than 18 weeks for their elective care varied between 75% and 96% across CCGs. For cancer, the percentage of patients treated within 62 days following a GP referral varied from 59% to 93% (paragraphs 2.5 and 3.6, and Figures 12 and 24).
- **Specialties:** Trusts are not required to meet waiting times standards by specialty. Some specialties are less likely than others to meet the standards for clinical reasons, such as ease of diagnosis. For elective care, general medicine specialties tend to meet the standards, but many surgical specialties do not. For cancer, performance for lung, lower gastrointestinal, and urological cancers was significantly lower than for other cancers (paragraphs 2.6 and 3.7, and Figures 14 and 25).
- **Demographic groups:** NHS England and NHS Improvement do not monitor waiting times performance across demographic groups for elective and cancer care (paragraphs 2.5 and 3.6).

### Factors associated with waiting times performance

**12 The NHS's inability to keep up with the growing number of referrals is causing performance against waiting times standards for elective and cancer care to decline.** A range of factors contribute to increasing referrals: increasing need from a growing and ageing population; increasing supply of new technologies and new treatment; and NHS policies to improve health outcomes.

- **Elective care.** Between the 12 months to March 2014 and the 12 months to November 2018, the number of referrals for elective treatment increased by 17%. However, for the majority of months since April 2013, the NHS has treated fewer elective care patients than the number of patients referred. We found that a growing and ageing population only accounts for a quarter of the increase in referrals for elective care. What is driving the increase in elective referrals is not well understood.
- **Cancer care.** Between 2010-11 and 2017-18, the number of patients referred urgently for suspected cancer increased by 94%, but the percentage treated within the standard has reduced over time. We found that a growing and ageing population only accounts for around one-tenth of the increase in cancer referrals. The major contributing factor to the increase in cancer referrals is likely to be NHS England's policy of encouraging more urgent referrals to improve early cancer diagnosis (paragraphs 2.11, 2.13, 3.2, 3.3 and 3.10, and Figures 15, 21 and 23).

**13 Waiting times performance is closely associated with constraints on capacity in the NHS.** Of the 43 trusts whose board papers we reviewed, 27 reported constraints on capacity, including lack of finance, staff and beds, as contributing to delays to treatment. Clinicians also reported that 25% of delays to cancer treatment are due to a lack of capacity. We found that, although the number of consultants has broadly gone up in line with activity levels, there have been persistent staff shortages in diagnostic services, and a widening gap between demand for diagnostic services and the number of staff working in this area. Trusts also reported that competing pressures from emergency services have contributed to patient delays. Our regression analysis supports these factors and indicates that trusts tend to perform more poorly on waiting times for both cancer and elective services when, all things being equal, they have:

- a lower proportion of patients seen within six weeks for diagnostic services; and
- a lower proportion of patients meeting waiting times standards for emergency services (**Figure 2**) (paragraphs 2.12 to 2.16, 2.20, 3.9 and 3.10, and Figures 16, 17 and 27).

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## Figure 2

Statistical association between factors relating to trusts' capacity and their performance against key waiting times standards

**A number of factors related to trusts' capacity are associated with their performance against waiting times standards**

Factors related to trust capacity	Elective	Cancer
Diagnostic services	Consistently significant	Consistently significant
Pressure on resources from emergency services	Consistently significant	Consistently significant
Trust finance (deficit/surplus)	Consistently significant	Significant but not consistent
Bed occupancy	Consistently significant	Significant but not consistent
Consultant	Significant but not consistent	Significant but not consistent
Operating theatres	Significant but not consistent	Inconclusive

### Notes

- 1 The factors that we have identified as correlated with performance are based on regression analysis using data from a range of sources, including: waiting times, hospital activity and bed statistics published by NHS England; NHS workforce and Hospital Episode Statistics data from NHS Digital and NHS trusts' financial data from NHS Improvement. We carried out several different approaches to our regression analysis taking account of the data we collected (for example, multiple linear regression analysis and panel data regression analysis). For elective care, the waiting times standard we examined was the standard for patients still waiting for their treatment; for cancer, the standard we examined was the 62-day standard from GP referral to treatment.
- 2 If a factor is significantly correlated with waiting times performance across all the models we tested at a 10% confidence level, we described it as "consistently significant"; if only for some models but not for others, we described it as "significant but not consistent"; if it is significant at a 10% confidence level, but the direction of correlation changes, we described it as "inconclusive". We set out the direction of the association in Figures 16 and 27, which provide more detail.
- 3 Consultants are measured against the level of activity at trusts (see Appendix Three for more details). Diagnostic services are measured by the proportion of patients receiving their diagnostic tests within six weeks and emergency pressures measured by performance against A&E waiting times standards.

Source: National Audit Office regression analysis

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**14 The association between capacity constraints and waiting times performance is stronger for elective services than for cancer services (Figure 2).** Trusts in a poorer financial position or with a higher level of bed occupancy are consistently associated with poorer performance against elective waiting times standards, both across trusts and for the same trusts over time. Although these factors are also associated with cancer waiting times performance, the associations are not always consistently significant in our analysis.<sup>1</sup> Financial difficulties or a lack of available beds can affect elective care waiting times more, as given limited capacity trusts will treat emergency and cancer patients first due to the urgent nature of the treatment. We found that bed occupancy has increased in recent years and an increasing number of trusts now routinely operate with a bed occupancy rate well above 90%. The number of beds in the NHS has reduced by 7% (8,000) since 2010-11. While reducing excess beds may create efficiencies, after a certain point the capacity constraints this will introduce will impact on other resources such as staff and theatre usage (paragraphs 2.14, 2.17, 2.19 and 3.11, and Figures 16 and 27).

**15 Administrative issues or patients choosing to delay treatment are unlikely to be the cause of deteriorating performance against elective and cancer care waiting times standards.** Analysis by NHS Improvement found that the number of appointments a cancer patient has before treatment and whether they have missed appointments are linked to delays in treatment. Around 14% of delays in cancer treatment were reported to be due to patient choice or administrative issues. However, we found no evidence that these issues have got worse over time and therefore they are unlikely to be one of the factors contributing to the falling performance. For example, the percentage of patients who do not attend their appointments has remained stable, at around 9% of all appointments. Several recent initiatives, established by NHS England and NHS Improvement, aim to improve or streamline processes along patient pathways and improve waiting times. These include rolling out e-referrals and introducing rapid diagnostic centres for cancer patients (paragraphs 2.21 to 2.23, 3.11 to 3.13, and Figures 19 and 26).

### Implications and impact of the current standards

**16 For cancer care, an increasing number of urgent referrals has improved early diagnosis of cancer but can have an adverse impact on meeting waiting times standards.** The introduction of waiting times standards for cancer care and the policy of encouraging more referrals more quickly has improved early diagnosis of cancer. For example, the proportion of all cancer patients diagnosed through this programme increased from 31% in 2010 to 38% in 2016 (the latest data available). We found that areas referring more patients through the urgent referral route tend to have better survival rates. However, areas with a high urgent referral rate tend to perform more poorly against the two-week wait standard than those with a low referral rate. This is consistent with recent research which found that meeting cancer waiting times standards did not lead to improved one-year survival rates (paragraphs 3.2 and 3.8).

<sup>1</sup> If a factor is significantly correlated with waiting times performance across all the models we tested at a 10% confidence level, we described it as "consistently significant".



**17 The clinical priorities of emergency care and cancer services means that practically the Department and NHS England have focused more on those than on elective care.** Facing rising demand while under increasing financial constraints, national bodies have focused on stabilising NHS finances and emergency care. While there has been no explicit policy to deprioritise elective care, incentives for achieving waiting times standards for elective care have been weakened or removed over the past few years. This includes, for most trusts, the removal of sanctions for breaching elective care waiting times standards. In *Next Steps on the Five Year Forward View*, published in 2017, NHS England signalled that it expected some provider waiting times for elective care to increase. In February 2018, NHS England and NHS Improvement asked trusts to ensure that in March 2019 their waiting lists for elective care would be no larger than at the end of March 2018, rather than explicitly requiring them to meet the 18-week standard as in previous years. From 2019-20, the NHS plans to reintroduce financial penalties for both providers and commissioners in cases where patients wait longer than 52 weeks for treatment (paragraphs 1.11 to 1.13, and Figure 7).

**18 There is a risk that longer waiting times may lead to patient harm and negligence claims against the NHS but the NHS's understanding in this area is limited.** For many people, longer waits result in inconvenience and the discomfort associated with living with a medical condition. But for others their condition may deteriorate and a longer wait for treatment may cause them harm. The NHS has a national incident reporting system to collect and review evidence of patient harm. However, analysis to show the extent to which patient harm has occurred as a result of long waiting times is not available. In addition, trusts are also required to review whether harm has been caused to patients who have waited more than 52 weeks for elective care, but these data are not collected nationally. A few trusts have reported harm for a small number of patients due to long delays. Given that 40% of clinical negligence claims are brought because of delays in diagnosis or treatment, there is a risk that longer waiting times may lead to an increasing number of future claims (paragraphs 2.8 to 2.10).

#### Action taken and future opportunities

**19 Significant additional investment will be required to meet the existing waiting times standards again.** NHS England and NHS Improvement have taken action to improve performance against waiting times standards, focusing on reducing avoidable referrals, reducing the patient's length of stay to release hospital beds and improving processes. They also publish reports on waiting times performance over time, and variations across organisations and geographical areas; and have developed a range of toolkits to help trusts manage waiting lists. Despite these efforts, performance against waiting times standards continues to decline, and, as underlying demand continues to grow, it is hard to see how the NHS will be able to improve waiting times in the short term without significant investment in additional staffing and infrastructure capacity to support the NHS to see more patients. We estimate that it would cost an extra £700 million to reduce the waiting list to the size last seen in March 2018, based on current trends. The NHS long-term plan notes that some of NHS England's additional funding (a £20.5 billion increase by 2023-24) will be used to increase the number of planned surgeries, to help address long waits, but no details are yet given (paragraphs 1.8, 2.22 to 2.25, and Figures 13 and 19).

**20 The clinically led review provides an opportunity to improve the waiting times standards.** The current review provides the opportunity to make sure that any future waiting times standard ensures that those patients who need access quickly for clinical reasons are seen quickly. However, it also needs to ensure that those who are not a clinical priority do not experience long delays before they are treated (paragraph 1.14).

## **Conclusion**

**21** At a time of financial restraint, the NHS has responded to growing demand for elective and cancer care by increasing the amount of treatment it provides. However, this has not been sufficient to maintain performance against waiting times standards, and some standards have not been met for some years. Cancer performance has been affected by increasing referrals resulting from the desirable choice to improve early diagnosis and survival rates. While increased demand and funding constraints affect the entire system, other factors are linked with differences in performance both over time and across trusts. These include staff shortages for diagnostic services, a lack of available beds, inefficient processes and, in some cases, patient choices.

**22** The *NHS Long Term Plan* commits to reducing face-to-face outpatient visits by one-third. Such a reduction would have a significant impact on elective care performance, as it is currently measured. The plan also commits to increasing the proportion of patients diagnosed with cancer at early stages from 50% to 75% by 2028. The NHS is now preparing local implementation plans for these new commitments. It is hard to see how the NHS will be able to recover its position on waiting times in the near future without significant investment in staffing and infrastructure.

## Recommendations

- a** By October 2019, NHS England and NHS Improvement should clearly set out their objectives for waiting times and explain how they will address declining performance. This should include putting the right incentives and support in place and clarifying how they will ensure that local bodies and partnerships have the right resources and capacities to meet their waiting times objectives.
- b** Our analysis has identified gaps in the understanding of variations in waiting times performance, how waiting times performance impact on patient experience and outcomes, and how waiting times performance is influenced by factors related to hospital capacity constraints. By October 2019, NHS England and NHS Improvement should carry out further research to better understand:
- the impact of waiting times on patients' experience, patients' outcomes and urgent services;
  - variations in performance against the waiting times standards across specialties and across different population groups;
  - the impact of staff shortages by specialty on performance; and
  - the impact of bed occupancy on delays to treatment, and its links to other variables such as staff numbers and theatre usage.