GENERAL ELECTION

What health and care need from the next government

Improving access to treatment

Briefing 4

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nuffieldtrust

The NHS and social care in England are struggling. A combination of the sudden shocks from the Covid-19 pandemic and high inflation, and the longer-term pressures of poor workforce planning, morale problems, failure to deliver promised efficiency savings, and decades of delay to social care reform are all taking their toll. Strain and dysfunction are deeply rooted and will not immediately improve, and the public see this clearly: satisfaction with both services is at historic lows. Credible long-term plans to improve this situation are vital for any political leader who wants to gain the trust of the British people.

This series of briefings sets out particular issues where we believe there is clear evidence that the UK's new government must act in order to meaningfully improve the English health and care system for which it is responsible. This is presented as a series of tests that a policy programme during the next Parliament should meet. They often address less visible, easily overlooked decisions which work behind the scenes to shape the care people experience. We hope these briefings will **inform** the public debate that MPs, journalists, experts and institutions shape over the coming months, and **influence** the policy formation decisions of the national political parties as they draw up a platform to put to the British people.

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Overview

Waiting times for health care are the single biggest cause for public dissatisfaction with the NHS, according to the British Social Attitudes survey. They are rightly a central battleground in the 2024 general election. Delays of months or years in getting treatment which grew over many years before Covid-19 struck, and then worsened alarmingly, strike at the sense of safety people were once proud to feel because they knew the health service was there for them.

Every political party has its own slogans, claims and targets. But when the election is over, the next government will need to select its policies with immense care, learning from long histories of success and failure to deliver and demonstrate the improvement that is needed.

We identify seven tests that must be met, and which should be put to politicians as they battle to convince the public that they have the answers.

1. The English NHS has never delivered all eleven of the targets listed as pledges to patients in its Constitution handbook at once. Even going back to their predecessors it is more than eleven years since it met all those that existed at the time. Having targets that cannot be met is distracting, demoralising, and encourages unhelpful behaviours for moving patients on through the system. The next government must have commitments that are backed up by a clear calculation of how much the NHS can actually deliver based on finance and efficiency.

2. There have been longstanding promises across parties and governments to deliver more care outside hospital, but this has not translated into improving access and capacity. Spending has shifted away from community services like rehabilitation and children's services, and areas of mental health like autism and inpatient care remain overlooked. Waiting times and access are often not even measured. The next government must make these more of a priority.

3. Buildings and equipment in the NHS are in a poor state and limit what it can offer patients, because not enough of the budget has been dedicated to long-term investment over many years. Funding has been repeatedly raided to plug day-to-day deficits. Available data suggests that the UK has unusually few diagnostic scanners compared to other developed countries. The budget raids must stop, and England should spend as much on health care capital as comparable countries do.

4. Initiatives to improve access to care, or improve care generally, work best when they are sustained for the long term. The next government should cut down on small, specific, short-term financial pots for improvement, which make it difficult for the NHS or social care to make big or permanent changes. Fewer, bigger initiatives that do not get raided for cash would be an improvement.

5. There is a systematic inequality where people in poorer areas get worse access to planned care than richer counterparts – for example, the most deprived tenth receive 20% fewer hip replacements than the English average. The next government should set a clear target to reduce the gap in planned care between rich and poor.

6. The next government should not assume that it is easy to improve efficiency and waiting times by closing the gap between 'the best and the rest'. Making different areas do the same thing has often failed, best practice does not spread easily, and blanket requirements for every trust or area in the NHS will be irrelevant to both those who do much better and those who do much worse.

7. Limited data mean it is difficult to tell whether many initiatives to improve access are actually working. Community services data is limited, coding of ethnic groups is not reliable, and information is not fully connected across services. It is increasingly difficult to compare English NHS performance to Scotland, Wales, Northern Ireland, or other countries. These gaps must be addressed.

Test 1 There needs to be a limited number of targets and pledges, based on how much care the NHS can actually provide

The English NHS is currently not delivering nine out of eleven of the waiting times targets set down in the NHS Constitution handbook, which lists the rights the health service should be providing to the English public.[1] The chart below shows performance on these targets, and where relevant the targets that preceded them for the same services, going all the way back to the introduction of the six week diagnostic target in 2012.

The NHS has never delivered on target commitments in all eleven areas at once, with key mental health targets being introduced only after ambulance, A&E and cancer targets had begun to be chronically missed. The last time the NHS met all the targets that existed at the time was in November 2012: the last time it even met most of them was in September 2015.

The fundamental reason in most cases is that the rate of appointments and treatments being provided does not match the demand for them. It is no coincidence that the only constitution targets the NHS still meets are the Talking Therapies target, which has seen huge increases in the number of

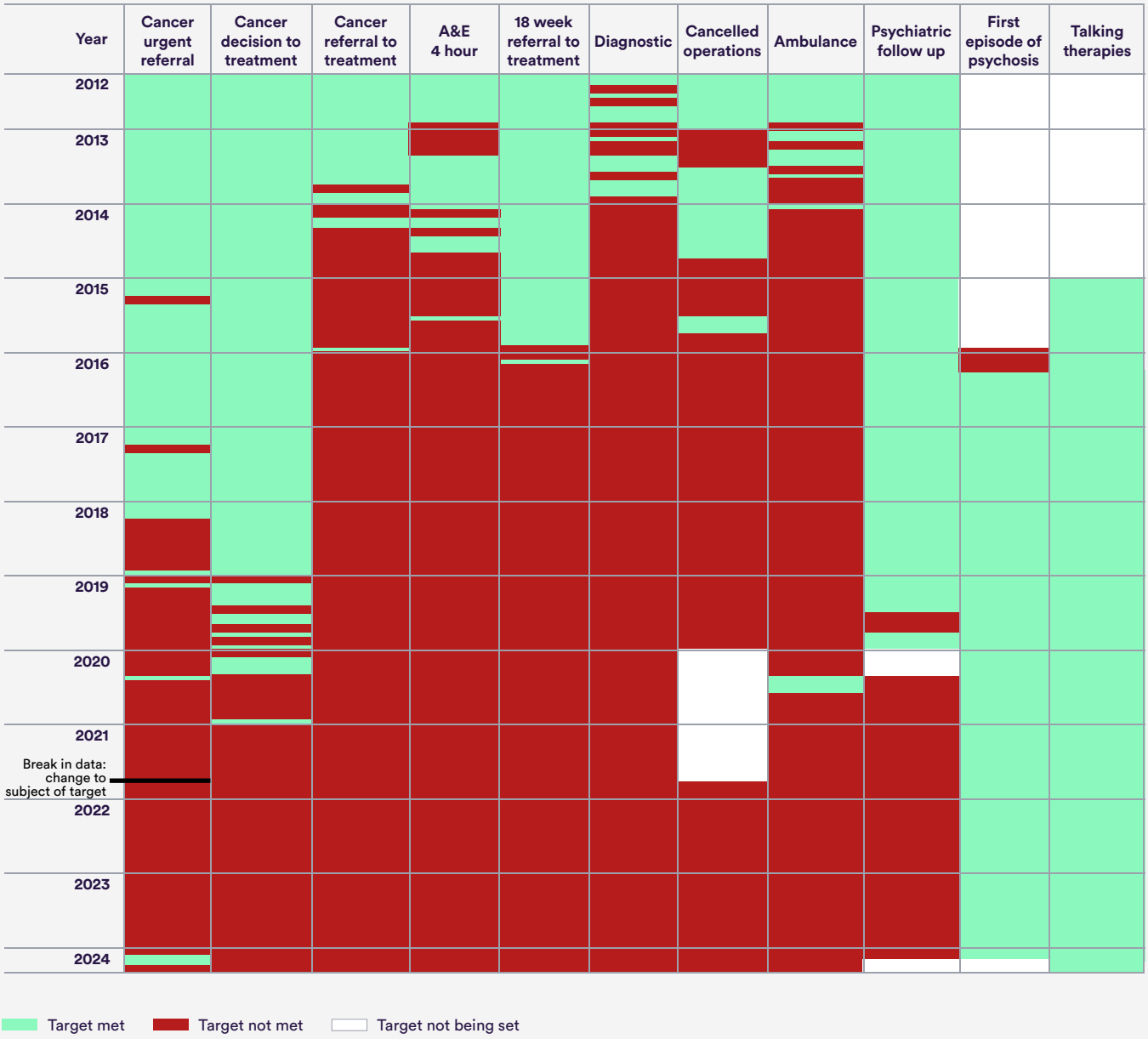
1 www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england#patients-and-the-public-your-rights-and-the-nhs-pledges-to-you

people being treated,[2] and Early Intervention in Psychosis, where the target has been repeatedly delayed or moved downwards so that it stays relevant. These show an alignment of what is possible with what is promised which is lacking elsewhere.

With no spare capacity to do more, a new government will need to be very careful in its use of targets. Recent history shows that targets that are not backed by resources or credible plans to treat people faster have pulled staff away from what was actually a better use of their time and created unintended and undesirable consequences.

2 www.nuffieldtrust.org.uk/resource/improving-access-to-psychological-therapies-iapt-programme

Figure 1: NHS constitution targets and whether they are being hit



Notes: April 2012 start date reflects introduction of diagnostic target for the first time. For detailed information on current definitions of targets listed here and any notable discontinuities during the period studied, please see our appendix 'Notes on NHS treatment targets'.

What happened last time waits fell?

The target for 98% (and later 95%) of people to spend less than four hours in A&E and the target for people to wait fewer than 18 weeks for elective care from the point of referral to treatment are the most totemic NHS commitments, partly because they were achieved in dramatic fashion as a political centrepiece of New Labour's second and third terms.

That success was underpinned by understanding what was possible given the available staff, money, and room for improvement in speed and prioritisation.

On their introduction in 2004, there was a large number of targets and they were unconnected to spending decisions. The Institute for Government have described in a case study how increased realism led to fewer targets, closely connected to spending agreements. The Prime Minister's Delivery Unit, which monitored performance, also provided a feedback mechanism, allowing trusts and local NHS areas to provide evidence and discuss at a high level when targets were genuinely unrealistic or impossible to achieve.[3] The capacity to deliver these targets was outlined alongside the commitment to them in documents from 2002 to the 2004 Spending Review.[4]

Both were achieved and drove a radical improvement in waiting times during the late 2000s. The proportion of people waiting over four hours fell from 22% at the end of 2002 to just 3% two years later, at the end of 2004.[5] But when increased resources and productivity were no longer enough to meet the target in the face of more people needing care, around 2015, NHS trusts had a strong incentive to admit lots of patients just before the four-hour mark, sometimes unnecessarily. NHS England noted that an intense strain to hit the target meant there was no incentive to deal with patients already waiting more than four hours, with very long waits already present in some trusts in 2019[6] and an explosion during and following the arrival of Covid-19.

3 www.instituteforgovernment.org.uk/sites/default/files/case%20study%20psas.pdf
4 www.cepsal.com.ar/improvementexpansionreform.pdf
5 https://webarchive.nationalarchives.gov.uk/ukgwa/20130105020054/http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AccidentandEmergency/DH_087978
6 www.england.nhs.uk/wp-content/uploads/2019/03/CRS-Interim-Report.pdf

The push to reach a target which was barely achievable, then unachievable, encouraged the practice of putting patients into new areas of hospitals which were not full wards – such as 'acute medical units' – even when this may not always have been useful for those patients. A study on elective care, meanwhile, found that while the NHS was meeting or close to meeting the 18-week target, patients close to the target were being squeezed in under it. But once it was unable to meet it, the target ceased to have a discernible effect.[7]

Target clash

Adding new targets or commitments in a situation where existing ones are being missed carries two risks: one to public trust and governments themselves, and another to the ability of the NHS to do its best.

In several recent elections, politicians have promised to meet different or higher targets without dropping those that aren't currently being met for the same thing, and without showing their working on how even achieving the existing target could be possible. This is misleading to the public in trying to give the impression that their access to services will improve, in a context where the limiting factor is not that the NHS isn't being asked to deliver shorter waiting times, but that it cannot do so.

Even targets that seem different can end up relying on the same resources – funding, inpatient beds and nurses, and staff to support patients going home are needed for a wide range of tasks the NHS carries out. In 2006 an initial review of the new wave of targets by Gwyn Bevan and Christopher Hood noted evidence that planned operations were cancelled to help free up capacity to meet the four-hour target when this was measured.[8]

7 https://qualitysafety.bmj.com/content/32/12/712
8 www.ncbi.nlm.nih.gov/pmc/articles/PMC1370980

An excessive number of targets also carries the risk of worsening system management. Many indicators are too complex to be covered by national targets (including most clinical outcomes),[9] so a growing number of targets tends to push focus away from important priorities which are hard to count. NHS trusts and boards can only be meaningfully held to account against a small number of measures in the way that national priorities tend to require.

The 2024 campaign

Parties campaigning in the 2024 general election are not showing that they understand the lesson that waiting times pledges need to be based on a clear understanding of the number or speed of appointments and procedures to meet them, and whether the budget and the workforce will cover this.

Our assessment of manifesto pledges by the major English parties shows that they are consistent with the tightest period of NHS spending in more than the 40 years for which records go back.[10] This seems difficult to reconcile with the need to outrun the demand for care and get back to meeting the 18-week planned care target, as both Labour and the Conservatives are promising.

Labour have a funded commitment for 2 million extra appointments and procedures a year through weekend working. But while it would be valuable to many patients, it is small in the context of the current delivery of around 9 million outpatient appointments and planned procedures each month. The impact on the waiting list will be more modest than the headline number suggests, because most outpatient appointments do not lead to someone leaving the waiting list: patients often need multiple appointments (and sometimes diagnostic procedures) before their treatment starts.[11] The goal of eliminating the backlog in five years would not be fully deliverable without the NHS doing more care above and beyond this to keep up with increases in demand.

9 www.ncbi.nlm.nih.gov/pmc/articles/PMC1370980

10 www.nuffieldtrust.org.uk/resource/health-and-care-finance-tracker

11 www.nuffieldtrust.org.uk/news-item/how-are-strikes-by-health-care-staff-impacting-nhs-waiting-lists

In the past, political parties and governments have often implied that a dramatic improvement in NHS efficiency would arise to resolve tensions like this.[12] It is critical to improve NHS productivity, which dipped sharply during the pandemic and has recovered very poorly. But the NHS has been set efficiency goals which proved undeliverable for years.[13]

The Conservative party manifesto promises a plan for NHS productivity to hit 2%[14] – a laudable but ambitious goal which still awaits NHS England spelling out how it will be achieved. But even if this does take place, with Conservative funding pledges amounting to around a 0.9% overall funding increase the combination of funding and productivity would still not enable the NHS to keep up with regular pressures which have been estimated by multiple sources, including the recent long-term workforce plan, at around 3.6%.[15]

What needs to happen

- **Targets and promises must be justified by calculations** showing how the total number of treatments they require will be delivered, through a combination of funding and productivity.

- There should be no new targets introduced when existing targets in the same areas are being missed, and it should be recognised that even targets in adjacent areas dilute attention, accountability and resources. As a general rule it should be **one in, one out**.

12 www.nuffieldtrust.org.uk/news-item/why-our-conversations-about-productivity-in-the-nhs-are-not-very-productive
13 www.nuffieldtrust.org.uk/sites/default/files/2017-11/the-bottom-line-final-nov-amend.pdf
14 www.gov.uk/government/topical-events/spring-budget-2024
15 www.nuffieldtrust.org.uk/resource/health-and-care-finance-tracker

Test 2 Improve people's access to all NHS services, not just hospitals

Because they are the most visible places at the end of a waiting list, and important centres for towns and neighbourhoods, successive governments have focused targets, money and staff to improve access in hospitals.

Left behind

This focus on hospital leaves many other services underfunded and their patients struggling to get care, and leaves hospitals themselves facing an array of resulting dysfunctions. All main UK political parties recognise this argument in theory, but they have only rarely responded given the short-term political and operational appeal of spending more on hospital care.

Our health and care finance tracker shows barely any increase over the past seven years in the funding trusts received for NHS community services – a category covering everything from district nursing, to children's services, physiotherapy and rehabilitation. Meanwhile hospital services received an increase of 4.4% a year.

When we adjust for the size of the population and their needs based on age and sex, hospital services were again the winner with a 20% increase. General practice rose 10%, community health care was down 4%, and public health down 20%.[16] Reform for social care, meanwhile, has been delayed for more than a decade since an Act of Parliament was passed in 2014.

16 www.nuffieldtrust.org.uk/resource/health-and-care-finance-tracker

Waiting times targets, commitments, and initiatives for improvement currently cluster around hospital care. The list of metrics against which NHS services are overseen currently holds them to account on overall access to planned and urgent hospital care. But for community services, it only monitors a few particular initiatives, like the urgent community response standard, without differentiating by type of service.[17]

The workforce picture in many areas is bleak. The number of health visitors is the lowest it has been in the past 13 years, having collapsed immediately after a political commitment running up to 2015 expired.[18] The number of district and community nurses has fallen by almost half since 2009. There is no national commitment to improve access to most of these services, and as we discuss below, the data which would show us what is happening remains patchy.

A national commitment was introduced in 2019 that "investment in primary medical and community services will grow faster than the overall NHS budget".[19] However, this does not seem to be reflected in the funding received by community trusts. While some of the difference will be accounted for by spending in the private sector, which we did not include, it is also likely that there have been increases in budgets covered by the promise but not actually part of NHS community healthcare – such as 'continuing health care', which is social care funded by the NHS.[20]

The Labour party has criticised this state of affairs strongly, and has committed to extend the 2019 commitment. However, their 2024 manifesto pledges £1.3 billion a year for additional procedures, appointments and scanners in the hospital and diagnostics sector, and no additional funding for general practice, district or community nursing, or social care.[21]

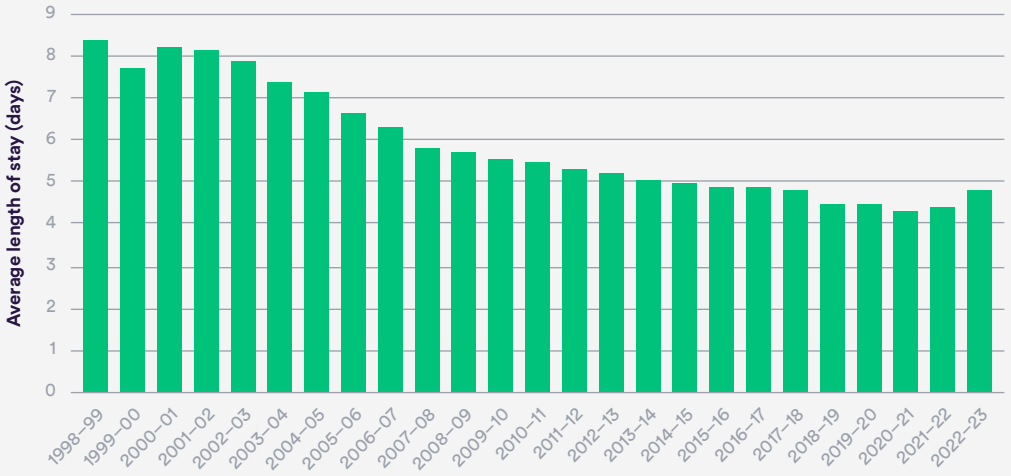
17 www.england.nhs.uk/wp-content/uploads/2022/05/B1378_ii_nhs-oversight-metrics-for-2022-23_June-2022.pdf
18 www.nuffieldtrust.org.uk/resource/the-state-of-community-health-services-in-england-0-0
19 www.longtermplan.nhs.uk/online-version/overview-and-summary
20 www.nuffieldtrust.org.uk/resource/falling-through-the-gaps-a-closer-look-at-nhs-continuing-healthcare
21 https://labour.org.uk/wp-content/uploads/2024/06/Labour-Party-manifesto-2024.pdf

The focus on hospitals can actually make waits for hospitals worse

Apart from the direct effect on patients, when people come to hospital when it could have been avoided, and leave later because there is nowhere for them to go, this limits how much work hospitals can do to clear waiting lists and A&E departments.

Since Covid-19, the NHS has seen the length of time the average overnight patient stays in hospital rise year on year for the first time in over 20 years, and this continued in 2022–23, well after the height of the pandemic. NHS England has noted this as a major cause of lower productivity in their recent board paper. While they state that part of it reflects patients being more unwell, and this reflects a known trend for long length of stay focused among patients with Covid-19,[22] they state that another part of the increase is due to "constraints on out of hospital capacity in particular social care".[23]

Figure 2: Average length of stay in the NHS in England (all providers, excluding day cases)



Source: Hospital Episode Statistics, Admitted Patient Care (NHS England & NHS Digital)

22 www.health.org.uk/publications/long-reads/what-s-driving-increasing-length-of-stay-in-hospitals-since-2019

23 www.england.nhs.uk/long-read/nhs-productivity

The Nuffield Trust recently carried out an international comparison to examine how some other countries which, like the UK, have relatively few hospital beds, but appear able to deliver shorter lengths of stay. These include Denmark and the Netherlands. We found that they typically spent a higher share of their budgets across long-term, preventive and outpatient care. Many had pursued strategies to reduce reliance on hospitals by boosting nursing and social care at home, with some including Denmark moving money away from hospitals.[24]

Mental health: inconsistent focus

The example of mental health spending in recent years shows that it is possible to reroute funding with a tighter and more closely specified commitment. A Mental Health Investment Standard imposed on local NHS purchasing bodies (clinical commissioning groups, then integrated care systems) since 2020 has imposed minimum requirements to increase mental health spend at least as fast as overall budgets.[25] This drove mental health spending up even faster than hospital spending, with a 30% increase relative to the adjusted population noted in our tracker between 2016/17 and 2022/23.[26] The Labour party is also promising further additional funding and staff in its 2024 manifesto.[27]

However, national commitments have been focused towards initiatives for talking therapies and individualised support plans. A succession of goals to improve access to talking therapies from 2015 was highly successful in driving up the number of people starting treatment, even though total targets were missed.[28] Further investment has been promised to increase the number of people seen through this service, with the intention to enable people to get back to work.[29]

24 www.nuffieldtrust.org.uk/resource/building-community-health-and-care-capacity-reflections-from-other-countries
25 www.england.nhs.uk/wp-content/uploads/2022/01/B1297-mental-health-investment-standard-categories-january-2022-1.pdf
26 www.nuffieldtrust.org.uk/resource/health-and-care-finance-tracker
27 https://labour.org.uk/change/manifesto-accessibility/
28 www.nuffieldtrust.org.uk/resource/improving-access-to-psychological-therapies-iapt-programme
29 www.nhsconfed.org/publications/autumn-statement-2023

Those whose condition is more serious, who require more costly or complex mental health procedures, are not considered eligible for NHS Talking Therapies, and do not receive as much scrutiny. The 'early intervention in psychosis' programme is provided to patients over a three-year period, and treats and mitigates the risk of psychosis, delivering savings in the long term by preventing the repeated use of urgent and crisis care services.[30] By 2024, 95% of patients should have started treatment two weeks after a referral was made, but from January to March 2024, only 69% had.[31] This service, while recording data consistently like NHS Talking Therapies, has not benefited from renewed investment to meet targets.

ADHD and autism have received limited attention from central government even though waiting times are poor and deteriorating. Between October and December 2023, people getting a first appointment for suspected autism had a median wait of over nine months since their referral. Over the same three-month period in 2019, people waited a little over four months to be seen.[32] Yet there is no national standard or commitment to address this. There is not even national data published on ADHD referrals or waits.

Services meant to address severe forms of mental ill health, like stays in inpatient facilities, have been facing high demand over the years. Bed occupancy, despite more beds being made available, is well beyond what is considered safe.[33] Individuals end up staying for over a month (39 days) on average (as of 2022/23) because discharge pathways are not well managed.[34,35]

30 www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf
31 https://mentalhealthwatch.rcpsych.ac.uk/indicators/people-with-first-episode-psychosis-starting-treatment-within-two-weeks-of-referral
32 www.nuffieldtrust.org.uk/news-item/the-rapidly-growing-waiting-lists-for-autism-and-adhd-assessments
33 www.centreformentalhealth.org.uk/mental-health-services-in-the-uk-in-2023-what-the-latest-nhs-benchmarking-findings-tell-us
34 www.centreformentalhealth.org.uk/mental-health-services-in-the-uk-in-2023-what-the-latest-nhs-benchmarking-findings-tell-us
35 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2022-23-annual-report

What needs to happen

- The next government should **look to understand why community services spending received by trusts has fallen relative to need and take steps to address this** if they want to make the goal of reducing dependence on hospitals a reality.

- **A comprehensive reform process for England's broken social care system is needed** to transform this into a stable, successful sector which supports people to stay independent and well. Our social care briefing describes what is required in detail, and where a future government should start.[36]

- The next government needs to **give more attention to overlooked areas of mental health**, particularly autism and ADHD services and inpatient care.

36 www.nuffieldtrust.org.uk/resource/what-health-and-care-need-from-the-next-government-2-adult-social-care

Test 3 Invest in buildings and equipment

Clinical staff are what people need access to in the NHS, and it is understandable that they and the NHS trust spending which largely goes towards their wages often receive first call on resources. But this approach has been applied so relentlessly, in a context of budgets often too small to cover everything desired from the NHS, that it has left them without many of the tools they need to do their jobs.

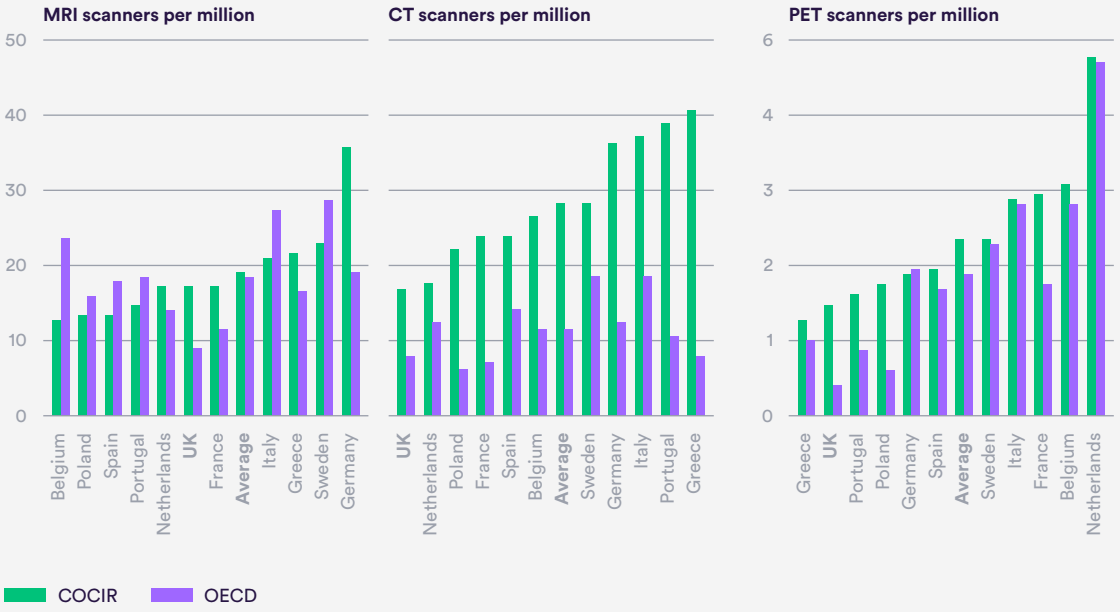
For much of the last decade, the UK spent around 0.3% of its GDP on investment in buildings and equipment, while comparable countries like Ireland, Sweden and Australia spend 0.5% or more.[37] This has resulted in a backlog of almost £12 billion in delayed maintenance repairs.[38] Several hospitals are being forced to prop up roofs made from unstable reinforced aerated autoclaved concrete (RAAC) and left past their safe lifetime.[39] Bit-by-bit purchasing of IT systems leads to problems where they do not communicate with one another, and the NHS has missed national targets to become paperless in 2018 and 2020.[40]

Scanners are crucial to the amount of diagnostic procedures which can be done - a part of the waiting list which is currently backlogged for many people. No perfect international measure exists, as official OECD data for the UK does not include scanners in the private sector to which work is outsourced. But projections of this data by The King's Fund and data held by manufacturers'

37 https://stats.oecd.org
38 https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection
39 www.theguardian.com/society/2023/sep/05/nhs-england-tells-hospitals-to-be-ready-to-evacuate-if-buildings-crumble-concrete-raac
40 www.gov.uk/government/news/jeremy-hunt-challenges-nhs-to-go-paperless-by-2018

association COCIR, which covers most but not necessarily all suppliers, suggest the UK's level of provision is somewhere between below average and very low. The charts below compare the UK with all EU countries with a population above 10 million.[41,42] The gap is least visible for MRI scanners.

Figure 3: Health care diagnostic scanners per million population



From 2020 onwards, the government significantly increased the health capital budget in England, including a commitment across several years at the 2021 Spending Review.[43] At slightly over £10 billion in 2022/23 and finally exceeding £12 billion in 2023/24, this would have been around 0.5% of 'GVA', the measure that is the equivalent of English GDP.[44]

However, this has already been undermined for 2023/24 by a 'capital-to-revenue transfer' shifting £900 million into day-to-day NHS budgets. This practice was endemic over the previous decade, removing over

41 www.kingsfund.org.uk/insight-and-analysis/data-and-charts/what-are-diagnostics
42 www.cocir.org/fileadmin/Publications_2021/COCIR_Medical_Imaging_Equipment_Age_Profile_Density_-_2021_Edition.pdf
43 https://assets.publishing.service.gov.uk/media/61c495ebe90e07196d2b8383/Budget_AB2021_Print.pdf
44 www.ons.gov.uk/economy/grossvalueaddedgva/timeseries/abml/pn2

£4.5 billion in investment.[45] This both erodes the commitment to a more normal level of capital spending, and makes planning more difficult.

Labour has pledged £250 million a year to address the lack of scanners, while the current government announced earlier this year a £3.4 billion pot of investment spread across the coming years focused on digital technologies. These priorities are well advised, but the reality is that almost every area of investment spending has been short-changed, and a lasting general commitment to put the long term first is needed.

What needs to happen

- Beyond specific funding pots to address particular issues, **capital funding for buildings and equipment across the board should be comparable to similar countries**.

- **The capital budget should not be raided** to cover the running costs of the NHS, which stores up more problems for the future. It should be maintained at well above its historic level.

45 www.health.org.uk/publications/reports/failing-to-capitalise

Test 4 Set up long-term programmes for improvement over multiple years and don't raid them

Targets at best set the direction for NHS services, but they do not create the capacity or organisation that makes shorter waits possible. Through NHS history, governments have introduced hundreds of initiatives to achieve this and improve access to NHS services. While no systematic review has been conducted, quality improvement and public service studies tend to suggest that stable, consistent, focused policies generate more legitimacy among staff[46] and more effectiveness[47] – with consistency even being related to higher cancer survival.[48]

The NHS offers examples of this and examples of the opposite. When funding is used in a short-term way in multiple small pots in the doomed hope of 'quick wins', or set up to be raided and removed, it limits the ability to use it to generate significant changes. A focused set of actions supported by stable policy can deliver success.

For urgent care, governments have regularly chosen to attempt initiatives in early autumn each year where several hundred million pounds are placed in the NHS budget to try to improve A&E waiting times during the approaching winter, alongside a local planning process. In recent years, this has been

46 https://onlinelibrary.wiley.com/doi/full/10.1111/padm.12570
47 https://qualitysafety.bmj.com/content/23/2/106
48 https://pubmed.ncbi.nlm.nih.gov/36328024/#:~:text=Cancer%20policy%20consistency%20was%20positively,in%20survival%20for%20most%20sites

accompanied by extra funding for short-term social care to help people to be discharged,[49] dispensed a few hundred million pounds at a time with extensive specific requirements attached.

These have not delivered transformative results. NHS A&E performance is driven by flow through the entire system, reflecting permanent ways of working, staff numbers and bed capacity. Social care capacity takes years to build up, and the private firms who largely run it will not invest without knowing it is worth it in the long term. The integrated care boards, councils and NHS trust boards who run local services cannot plan stable expansions without knowing where funding will be in future either. Apart from their short-term nature, having multiple different pots with specific requirements set by central government means they cannot be used to develop new services or ways of working that achieve wider or longer-term goals.[50,51,52]

Despite failing to deliver several milestones pledged by the Prime Minister, the initiatives in England laid out in the 2022 Elective Recovery Plan appear to have had a potentially more significant effect, with waiting lists stabilising from summer 2023[53] and at least some targets on long waiters being hit. While the impact of changes like the introduction of patient-initiated follow-up and community diagnostic centres is still being understood,[54] there can be no doubt that they have happened on a fairly wide scale.[55] The fact that this recovery plan and the measures it contained were pursued consistently for two years – a relatively long time in the context of the NHS – with a commitment to actual permanent changes in the way things worked probably helped it to have a significant impact.

49 www.nuffieldtrust.org.uk/news-item/getting-the-fundamentals-right-how-to-better-prepare-for-discharge-pressures-next-winter
50 www.nuffieldtrust.org.uk/news-item/getting-the-fundamentals-right-how-to-better-prepare-for-discharge-pressures-next-winter
51 www.careengland.org.uk/from-inception-to-implementation-a-year-of-integrated-care-systems-findings-and-discussion
52 https://assets.kingsfund.org.uk/f/256914/x/ea8416a699/hospital_discharge_funds_2023.pdf
53 www.nuffieldtrust.org.uk/resource/treatment-waiting-times
54 www.nuffieldtrust.org.uk/research/an-evaluation-of-patient-initiated-follow-up-pifu-outpatient-services-in-the-english-nhs
55 www.gov.uk/government/news/community-diagnostic-centres-deliver-more-than-7-million-checks

Like capital investment, NHS funding to improve and reform has also often suffered raids part-way through the year to prop up the general budget. Before Covid-19, the £1.8 billion Sustainability and Transformation Fund originally intended to fund large-scale reform towards joined-up services was essentially rolled into balancing the books.[56] Last November saw £500 million in NHS funding shifted to cover deficits, including some funding which accompanied the elective recovery initiatives, resulting in a slowing down of the level of aspiration to expand planned care. Capital and money for technology were also affected.

What needs to happen

- Short-term initiatives appear to be associated with failure in improvement generally, and give limited incentive to take on staff or change processes permanently. **Policies that set out to improve change should be consistent for several years.**

- Small and inflexible pots of funding make it hard for local services to plan wider improvements. **Fewer, larger pots of funding with more strategic goals** would make more room for developments that actually improve capacity or productivity.

- Repeatedly recycling money for change and reform into the general budget because it is unrealistic has undermined years' worth of NHS programmes. **Money in the NHS budget for improvement programmes should not be relied on to balance the books** because NHS hospitals systematically lack enough funding to match their obligations.

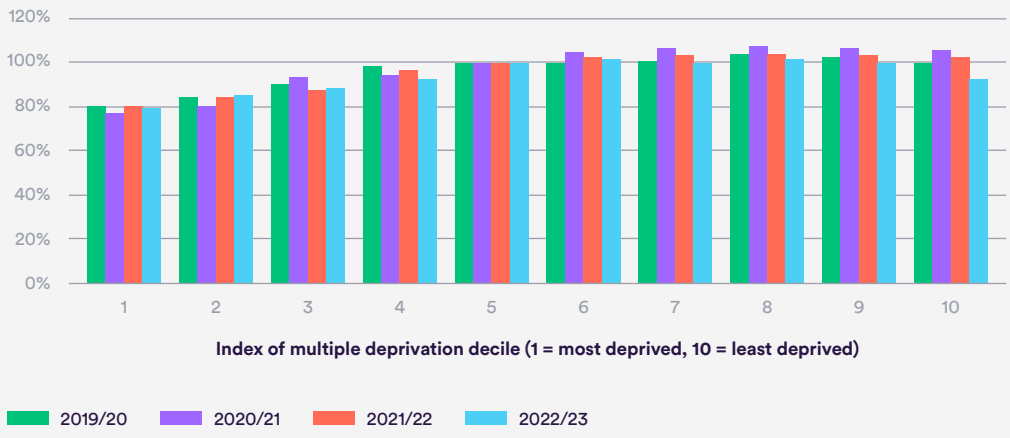
56 www.nuffieldtrust.org.uk/sites/default/files/2017-11/the-bottom-line-final-nov-amend.pdf

Test 5 Tackle the way that planned treatment favours the fortunate

People in wealthier areas of England typically get more planned care than the poorest. An 'inverse care law' exists, as has often been noted for general practice, with more deprived areas of the country having greater health needs yet getting less help.

This is not simply caused by more deprived areas having a younger population. The chart below shows that even standardised for age and sex, people in the most deprived tenth of areas are receiving around 20% fewer hip replacements than those in average or affluent areas. This gap has not changed between 2019/20 and 2022/23.

Figure 4: Directly standardised rate of NHS hip replacement operations relative to the fifth IMD decile



Source: Hospital Episode Statistics data (years 2019/20 to 2022/23). Copyright © 2024, re-used with the permission of NHS Digital. All rights reserved.

Note – for 2021/22 and 2022/23, the denominator used to generate the relative rates used mid-year population estimates for 2020. This is because prior to and including 2020 the population data was published using 2011 LSOAs.

The growing backlog for planned care, exacerbated by the Covid-19 pandemic, has worsened inequalities in access to timely care. Our previous research has shown that people in the White ethnic group receive more planned care, adjusted for age and sex, than those in the Black, Mixed and Asian ethnic groups – almost a fifth more than the Asian ethnic group. There was then a larger fall in care for the Asian group (49%) than the White group (44%) as the pandemic struck. The most deprived groups in the population experienced larger reductions in the planned care they received too. For hip and knee replacements, there was a 13% larger fall in the most deprived group compared with the national average.[57]

NHS England's delivery plan for tackling the Covid-19 backlog of elective care states that "as services are restored it is essential that they are opened up to all and resources are distributed fairly according to clinical need".[58] Services were instructed to analyse and collect data by characteristics including age, deprivation of the area they live in, ethnicity and specialty. While positive, this is only a first step. There is currently no way to measure deprivation at an individual patient level – only by areas. This may create large hidden disparities.

Treating patients on waiting lists by order of clinical need alone is not the solution. More deprived people's health may deteriorate faster, they may be less able to attend appointments at certain times, and they may face barriers like internet access.

There have been staged targets to reduce waiting times, and political parties in this and the previous election have made national pledges on healthy life expectancy and life expectancy gaps. But the NHS has not taken a systematic approach to ensuring inclusive elective recovery. There are no specific national commitments in place to incentivise change.

The next government needs to tackle this issue head-on and ensure that equitable access to planned hospital care becomes a core objective.

57 www.nuffieldtrust.org.uk/sites/default/files/2022-11/nuffield-trust-elective-backlog-and-ethnicity-web.pdf

58 www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf

What needs to happen

- The next government should set a **clear target to reduce the gap in planned care between rich and poor**. This could, for example, use planned care weighted by cost. It should be realistic in terms of capacity and sustained in focus.

- They should look at ways to **measure how wealthy or deprived individual patients are** so that inequalities in care can be truly understood and acted on.

Test 6 Don't fixate on closing the gap between 'the best and the rest'

All incoming governments see that some parts of the NHS achieve all their goals already and assume they can simply spread them everywhere with common initiatives and standards. This is often crucial to initiatives to improve access to care, or the efficiency that enables it. But this is not as simple and straightforward as it seems. A long history of trying to achieve it points to why it is so difficult to get it right.

One size does not fit all

During both waves of the pandemic, NHS England issued procedures and protocols for keeping up work in hospital while managing and minimising Covid-19 infection. Although the expectation was that these would be adhered to in the same way by all hospitals across the country, smaller hospitals were at a particular disadvantage because they had fewer staff and resources (some lacked basic PPE equipment of a certain standard) and had less capacity to respond in the way that bigger hospitals did. Regardless of size, differences in the state of infrastructure meant that hospitals had to take a different approach to separating patients anyway.[59]

Using locally specific solutions has shown success. One of the NHS's plans for improving mental health services is to expand access to physical health checks for those with a severe mental illness. The latest planning guidance for 2024/25 issued by NHS England aims to have at least 60% of people with a severe

59 www.nuffieldtrust.org.uk/sites/default/files/2022-12/1670583154_covid-and-smaller-hospitals-web.pdf

mental illness accessing these checks by March 2025.[60] The implementation tactics used by different regions to achieve uptake so far have been varied. In Manchester, outreach workers offer transport to the GP service, while in Doncaster, home visits are offered to patients unable to travel. Both these services have resulted in better engagement.[61]

Improvement for all

A belief that spreading the best is easy has at times meant actually worsening the divide. A national programme to create 'exemplars' in the use of data and patient records, on the grounds that they would show others the way, ended up with investment and expertise clustering at the best trusts, leaving others behind.[62]

NHS England and the Department of Health and Social Care have recently proposed oversight framework and GP incentive structures that would instead look to make sure each service is improving from where it is.[63,64] There should be evaluation and testing as to the effect of this, but the argument that it will mean there is equal and realistic funding and oversight for areas in the most difficulty is compelling.

60 www.england.nhs.uk/wp-content/uploads/2024/03/PRN00715-2024-25-priorities-and-operational-planning-guidance-27.03.2024.pdf
61 www.centreformentalhealth.org.uk/wp-content/uploads/2024/01/CentreforMHEquallyWell_ReachingOut-2.pdf
62 Why does the NHS struggle to adopt eHealth innovations? A review of macro, meso and micro factors | BMC Health Services Research | Full Text (biomedcentral.com)
63 www.gov.uk/government/consultations/role-of-incentive-schemes-in-general-practice
64 www.england.nhs.uk/nhs-oversight-framework

What needs to happen

- The next government should **not assume that meeting blanket standards, or improving the best so that it spreads, is the right approach**. Different areas and organisations might have different levels of opportunity to improve, and improvement matters everywhere.

- If there is no hard evidence that a single way to achieve a goal is best, **consider allowing local services to decide how they try to deliver set goals**.

Test 7 Improve data collection to understand what works and what is fair

The English NHS, being the universal health service for the whole country, is very well positioned to benefit from data that is routinely collected. This should make it easy for everyone from the government to local leaders to tell which of the health service's countless initiatives to improve access to care are working, and for whom.

Yet the reality is that there are long-standing gaps and failings that often make it difficult to tell whether different ways of providing care are efficient, effective, equitable or safe.

Running blind

Some of these gaps relate to what is collected, and others to whether it is joined up. Rolling out initiatives when not enough data is collected to be sure whether or not they are working leaves uncertainty and makes it difficult to tell whether the right thing is being done.

The rollout of 'patient-initiated follow-up' is an important initiative linked to the NHS Elective Recovery Plan for waiting times. Patients covered by it have to request a follow-up appointment when they need one, rather than following a fixed schedule such as every three months. The aim is to ensure clinicians only spend time with patients who need them, with an intention to help free their time up to clear waiting lists.

However, in our evaluation as part of the NIHR RSET project[65] we were unable to tell the impact on other services because the individuals were not marked in the general hospital data, and there was no connection to GP records. There were issues with trusts being at different stages of rolling out systems, using different systems or ways of categorising information, or having already started doing something similar earlier. Particular conditions people had also could not be picked out – only their specialty of treatment. This made it difficult to assess the impact of the initiative on patients.

Records within hospital are generally strong. But outside the highest profile and most prioritised part of the NHS, there is often less information available or it is collected in different ways, making analysis difficult. Hospices have funding and staffing problems which often prevent them from collecting data. Our research into the role of these services found that a significant proportion were not collecting the data needed to understand who was staying with them and what was happening to them, were not collating it together, or were using different definitions.[66]

Providers of community services in the NHS vary in how they define what a 'contact' with their services is. Interactions with patients are supposed to be counted in a national community services dataset, but currently only a proportion of providers are submitting data returns which describe the type of care received, and which cover all the services provided. When they do submit data there are very few mandatory fields, leading to incomplete returns.[67]

Even where data does exist, the fragmented nature of different NHS services and corresponding dearth of linked data make it hard to track patients moving from one provider to another.[68] The 'federated data platform' announced last year with a £480 million contract is a step forwards, but while it connects data from hospital trusts and integrated care systems, it excludes GP data.[69]

65 www.nuffieldtrust.org.uk/research/an-evaluation-of-patient-initiated-follow-up-pifu-outpatient-services-in-the-english-nhs
66 Support at the end of life (hospiceuk-files-prod.s3.eu-west-2.amazonaws.com)
67 The state of community health services in England | Nuffield Trust
68 www.health.org.uk/publications/long-reads/how-better-use-of-data-can-help-address-key-challenges-facing-the-nhs
69 www.england.nhs.uk/digitaltechnology/digitising-connecting-and-transforming-health-and-care/fdp-faqs/#what-are-the-penalties-for-organisations-that-misuse-patient-data

While most people expect the NHS to be able to join up their health records in order to treat them, there are also understandable concerns about how personal health data is used beyond direct care – for example, for research, planning services, or as part of testing out new treatments or technologies, which could involve sharing data outside the NHS. Addressing public concerns about use of health data will be critical in the long run, to ensure patients' care can benefit from better analysis of existing data.[70]

The NHS data analysts responsible for collecting and understanding this data are often an overlooked staff group, despite the need to compete keenly with other sectors to retain them. The Goldacre review reported that the NHS analyst community is not well managed: there is no formal professional body, clear career progression framework, no best practice handbook.[71]

Making comparisons across countries

Because the English NHS is a single national system, comparing it to other countries is a vital tool in understanding how well it performs as a whole – on waiting times, resources or other outcomes. This applies internationally, but also within the UK where Scotland, Northern Ireland and Wales offer excellent points of comparison with health care that is also largely free at the point of use, nationally funded and based on GP referrals.

Yet these comparisons are becoming ever harder to make. After Brexit, the UK is no longer covered by the EU's Eurostat,[72] and there has been no systematic effort to keep producing comparable information so we can understand, for example, how many health care assistants work in our hospitals compared to our neighbours. The OECD compiles very valuable internationally comparative data, but the UK has not handed in any data on waiting times since 2019, and the data it submits on key resources like scanners misses the large number that the NHS uses in the private sector, as discussed above.

70 www.nuffieldtrust.org.uk/news-item/questions-of-trust-exploring-the-national-data-opt-out-rate

71 www.gov.uk/government/publications/better-broader-safer-using-health-data-for-research-and-analysis/better-broader-safer-using-health-data-for-research-and-analysis

72 www.nuffieldtrust.org.uk/sites/default/files/2024-04/Health%20after%20Brexit_WEB.pdf

Within the UK, we have warned repeatedly that the measurements used by the four countries are drifting apart.[73] Each country counts waiting times slightly differently. Northern Ireland and England start to count inpatient waits at different points in the process, and Wales counts people who don't need to be seen by a doctor while England does not. This makes understanding the differences almost impossible and wastes a perfect natural experiment.

Ethnic disparities in data

Coding of patients by ethnicity is a particular problem area, and undermines efforts to tackle inequalities in access to care. Ethnic minority groups are less likely to have their ethnicity coded consistently over time. An increase in use of the code 'other' when inputting ethnicity has led to reduced detail, and consequently, it is less possible to track different ethnic groups.[74] We also found that people were being coded differently as they used different services: 9.1% of Black Caribbean patients in A&E, and 7.6% of Black African patients had also been coded as 'other Black' by services they had visited recently.

The NHS lags behind other sectors in still using 2001 census categories for recording ethnicity – there needs to be urgent action to implement existing recommendations[75] to address this and other challenges with how ethnicity data is recorded and analysed.

73 www.nuffieldtrust.org.uk/research/the-four-health-systems-of-the-uk-how-do-they-compare
74 www.nuffieldtrust.org.uk/sites/default/files/2021-06/1622731816_nuffield-trust-ethnicity-coding-web.pdf
75 www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities/appendix-f-prioritisation-and-progress-of-data-quality-recommendations

What needs to happen

- The next government must address barriers to wider use **of linked datasets covering community, GP, hospital and social care data** in order to get an overview of health care activity and understand whether many of the highest profile changes actually work. This includes improving trust in data sharing among the public and professional stakeholders.

- The next government should **enable English and UK data to be benchmarked against other countries**, by handing in up-to-date and complete data to the OECD, making numbers that can be compared to EU numbers collected by Eurostat, and sitting down with the Welsh, Scottish and Northern Irish governments to try to reach more shared measurements.

- Specifically, if any initiatives to improve discharge and take care of people at home and in community settings are to succeed, in order to help efficiency and improve access and quality of care, **there must be a plan to improve the usability of the community services data set, alongside ensuring social care providers are supported to fully implement the new client level data collection for adult social care**.

- For the NHS to fully meet requirements to monitor ethnic inequalities in health and care, **recommendations to bring recording of ethnicity within the NHS in line with 2021 census codes must be implemented**, alongside working with NHS organisations and community groups to address concerns about how the NHS uses people's health data.

Notes on NHS treatment targets discussed in Figure 1

Urgent cancer referral

Current definition

Four week (28-days) wait from urgent referral to patient told they have cancer, or cancer is definitively excluded. Standard 75%.

Discontinuity or note

Until September 2021: two-week wait from GP urgent referral to first consultant appointment. Standard: 93%. In constitution now.

Cancer decision to treatment

Current definition

One month (31 days) wait from a decision to treat/earliest clinically appropriate date to first or subsequent treatment for cancer. Standard 96%. In constitution now.

Discontinuity or note

Until September 2023: one-month wait from a decision to treat to a first treatment for cancer. Standard: 96%.

Cancer referral to treatment

Current definition

Two month (62 days) wait from urgent suspected cancer or breast symptomatic referral, screening referral or consultant upgrade to a first definitive treatment for cancer. Standard 85%.

Discontinuity or note

Until September 2023, two separate targets: two month wait from GP urgent referral to a first treatment for cancer. Standard: 85%. two-month wait from national screening service to a first treatment for cancer. Standard: 90%

A&E four hour

Current definition

4 hour wait from arrival to discharge, transfer, or admission. Standard 95%. In constitution now.

Discontinuity or note

No.

Diagnostic

Current definition

Applied from April 2012. Waiting over six weeks for a diagnostic test in one of 15 areas. Standard <1%. In constitution now without specific percentage.

Discontinuity or note

No.

Psychiatric follow-up

Current definition

Maximum 72-hour wait for follow-up after discharge from psychiatric in-patient care for people under adult mental illness specialties on care programme approach. Standard 80%.

Discontinuity or note

Until Q3 2019/20: Maximum 7-day wait. Standard 95%. In constitution now.

Talking therapies

Current definition

75% of people referred to the improving access to psychology therapies (IAPT) programme should begin treatment within 6 weeks of referral and 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral. In constitution now.

Discontinuity or note

Target introduced from 2015 in the NHSE Mandate: https://assets.publishing.service.gov.uk/media/5a7ebc21ed915d74e33f2167/mental-health-access.pdf

First episode of psychosis

Current definition

More than 60% of people experiencing a first episode of psychosis will start treatment within a NICE-recommended package of care with a specialist early intervention in psychosis service within 2 weeks of referral.

Discontinuity or note

Target introduced 1 April 2016 at 50%, aspiration to reach 60% by 2020/21 which was then softened to 56%, until 2023/24 when it is 60%. In constitution now at 56%.

Cancelled operations

Current definition

All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice. In constitution without specific number, rate or percentage.

Discontinuity or note

Target of all patients treated as under 1,000 not receiving.

Ambulance

Current definition

All ambulance trusts to: respond to Category 1 calls in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes; respond to 90% of Category 3 calls in 120 minutes; respond to 90% of Category 4 calls in 180 minutes. In constitution now.

Discontinuity or note

Before July 2017: target of 75% of Red 1 and 2 calls receiving a response within 8 minutes.

18 week referral to treatment

Current definition

Start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. In constitution now.

Discontinuity or note

No.

Nuffield Trust is an independent think tank. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

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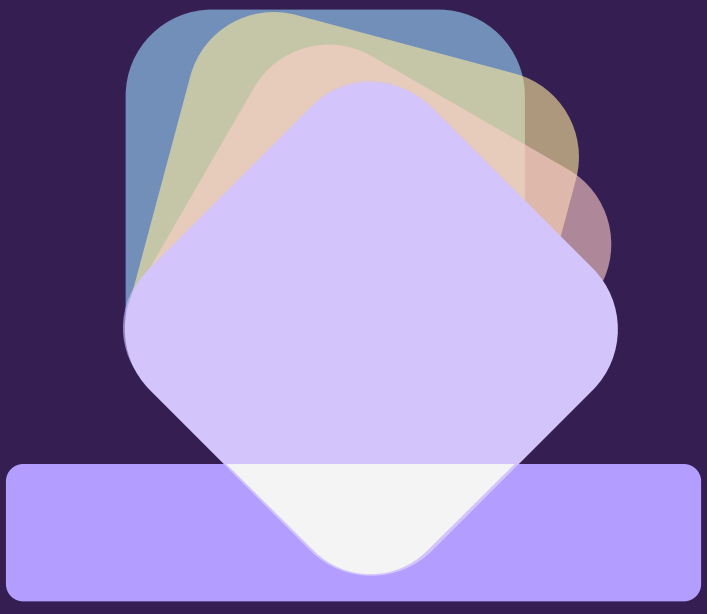

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