



# The NHS crisis

## *Does the Sunak government have a plan?*

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### Summary

The NHS is experiencing the worst crisis in a generation. Ambulance response times and waits at A&E are both at record levels, bed occupancy is above 95%, and the elective waiting list stands at more than 7 million. All of this is happening during a winter that has seen the worst industrial action the service has ever experienced, with nurses and ambulance staff both striking in December and January; medical unions are balloting their members about further action. The implications of this are severe. The Royal College of Emergency Medicine estimates that between 300 and 500 people per week are dying as a result of delays in urgent and emergency care.<sup>1</sup> This report evaluates the government's claims for why this is happening and assesses the likely effectiveness of its response to the crisis.

### Is the pandemic to blame for this crisis?

The NHS crisis was a focus of Rishi Sunak's first speech of 2023.<sup>2</sup> He used that speech to argue that the current crisis is largely due to the pandemic:

"We've significantly increased funding for health and social care... But Covid has imposed massive new pressures and people are waiting too long for the care they need."

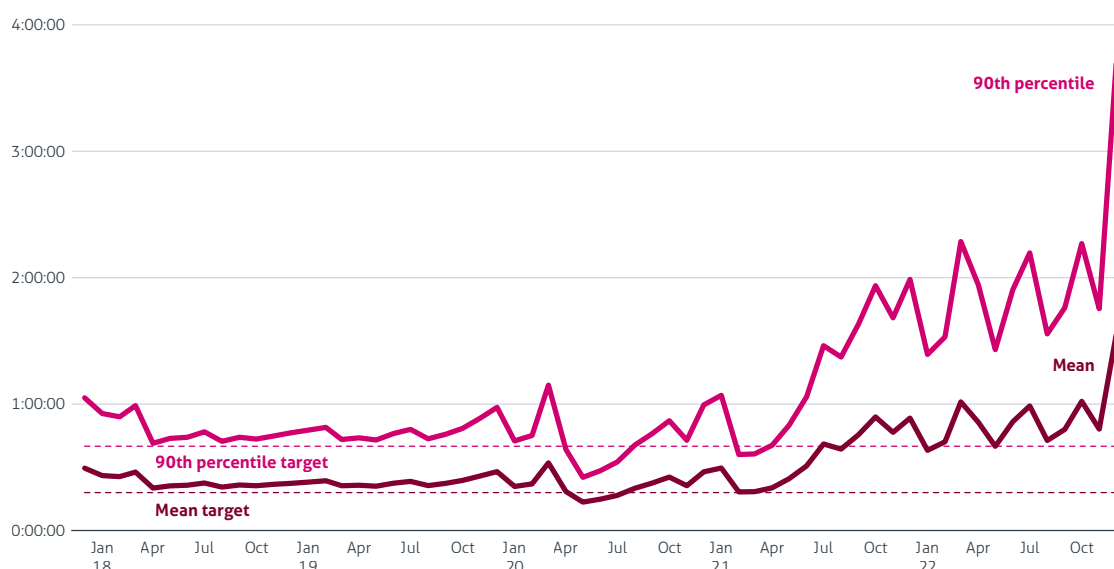
The pandemic has undoubtedly had a big impact on the health service. However, it is only part of the reason the NHS is currently performing worse, arguably, than at any other time on record. Covid hit the health service after a decade in which funding increases fell far below those of the decade before. Throughout the 2010s, spending on health grew by 1.7% per year in real terms, less than a third of the average spending increases in the 2000s.<sup>3</sup>

That trend of lower spending increases meant that capacity could not keep pace with demand for the service – from a mixture of a growing and ageing population, increasing complexity of conditions, and more expensive treatments.<sup>4</sup> The effects of this were already being seen before the pandemic, with cancer referral times, elective wait times, and A&E wait times last hitting their targets in December 2015, February 2016, and June 2013 respectively.

In the question and answer session of his speech, Sunak claimed that areas of the NHS were improving before Covid. He pointed to ambulance wait times, saying that category 2 response times were “just about at target before Covid hit”.

In fact, mean response times for category 2 incidents did not meet the target in any of the pre-pandemic months for which there is a record (January 2018 to February 2020). The only months these hit the target on record was May–July 2020 – exceptional months at the very beginning of the pandemic. Response times weren’t “just about at target” either, averaging 22 minutes 51 seconds per incident, 27% above the target of 18 minutes.

Figure 1 **Response time for category 2 ambulance incidents, December 2017 to December 2022**



Source: Institute for Government analysis of NHS England, ‘Ambulance quality indicators’, (‘Response times’ table), December 2022. Notes: 90th percentile indicates that 90% of response times were faster than this, and 10% were slower. Category 2 responses are for serious conditions, such as stroke or chest pain, which may require urgent transport. Data was not available before 2017.

Performance in the NHS was worsening for a long time before the pandemic, as a result of political decisions made across both the Labour and post-2010 governments. Covid has certainly *worsened* performance, but did not *cause* the crisis now facing the UK – rather, it struck the NHS at a time of low resilience that was the result of repeated efficiency drives brought about by the political choices of successive governments.

## What is the government doing?

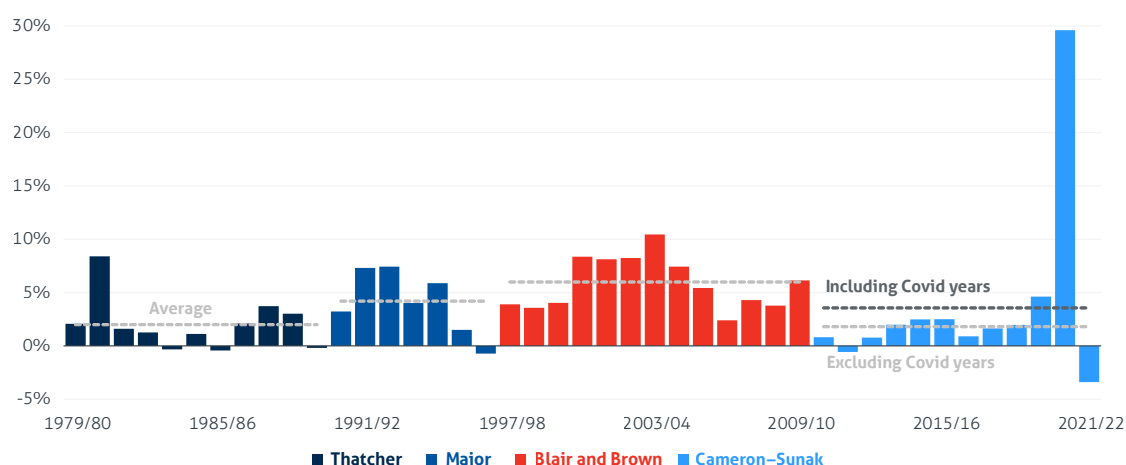
Sunak used his speech to make five pledges, one of which was that “waiting lists will fall and people will get the care they need more quickly”, discussed below. He also used the speech and subsequent question and answer session to outline the steps the government is taking to alleviate the crisis. Below we assess the claims he made for their accuracy and their likely effectiveness.

## Has the government increased spending on the NHS?

### “[The government has] significantly increased funding for health”

Spending on health services increased 1.7% per year in real terms between 2009/10 and 2019/20. This compares to 5.8% between 1996/97 and 2009/10. Spending increased from 2018/19 onwards, as Theresa May’s government provided more funding as part of the NHS Long Term Plan (LTP), which would have seen spending grow by 3.3% per year between 2018/19 and 2023/24 in the absence of Covid.<sup>5</sup>

Figure 2 **Annual change in spending on health, by government, 1979/80–2021/22 (real terms)**



Source: Institute for Government analysis of HM Treasury, ‘Public Expenditure Statistical Analyses’. (‘Chapter 5 tables’), 2021/22.

The government responded to the pandemic by spending more on the NHS. The British Medical Association (BMA) estimates that emergency Covid funding totalled £47 billion in 2020/21 and £34bn in 2021/22.<sup>6</sup> The NHS spent this money on areas such as test and trace, PPE procurement, infection prevention and control, and the vaccination programme.<sup>7</sup>

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Coming out of the worst of the pandemic, the government to its credit recognised that the NHS needed an uplift in spending to help it clear the worst of the backlogs. This was reflected in the October 2021 spending review, which allocated the NHS a 4.1% per year real-terms increase in spending between 2022/23 and 2024/25.<sup>8</sup> This relatively generous settlement was eroded, however, by the subsequent increase in inflation and a higher-than-expected pay deal in 2022/23.

That pay increase was unfunded by the government, meaning that the NHS had to spend £1.8bn more than expected in 2022/23.<sup>9</sup> The current industrial action also means that there is likely to be another higher-than-forecast pay award in each of the next two years, and the potential for a retrospective increase for 2022/23.<sup>10</sup> Inflation is undoubtedly driving up costs for the service. The NHS's chief financial officer estimates that inflation will cost the service £7bn in 2023/24 (this includes the estimate for a higher-than-expected pay award).

The government again seemed to have recognised the pressure that the service is under and provided the NHS with an additional £3.3bn per year in 2023/24 and 2024/25 in November's autumn statement,<sup>11</sup> an amount that is approximately 2% higher in cash terms than the service's allocation in the 2021 spending review.<sup>12</sup> The NHS welcomed this increase,<sup>13</sup> and indeed it was a higher percentage increase than all other services with the exception of adult social care and schools.<sup>14</sup>

But given noted inflation and probable 2023/24 and 2024/25 pay award hikes, the NHS is still likely to experience a lower real-terms rise in spending than forecast in 2021.

International comparisons also show that the amount that the government spends on the NHS is below comparable countries in Europe. Research by the Health Foundation shows that over the last decade the government spent about 21% less per person than the EU14 average.<sup>\*,15</sup> To match that average, the government would have needed to spend some £40bn more per year between 2010 and 2019,<sup>16</sup> far more than the additional £3.3bn a year provided in the autumn statement.

## Will increasing bed capacity help?

***"[The government is] increasing bed capacity by 7,000 more hospital beds and more people cared for at home"***

This measure was previously announced in the NHS's winter plan from August 2022.<sup>17</sup> In that document, the NHS says that it will increase hospital capacity by the "equivalent of at least 7,000 general and acute beds, through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway".<sup>18</sup> There were 97,350 general and acute (G&A) beds available in the NHS in October 2022, meaning that 7,000 more would represent an increase of 7.2%.

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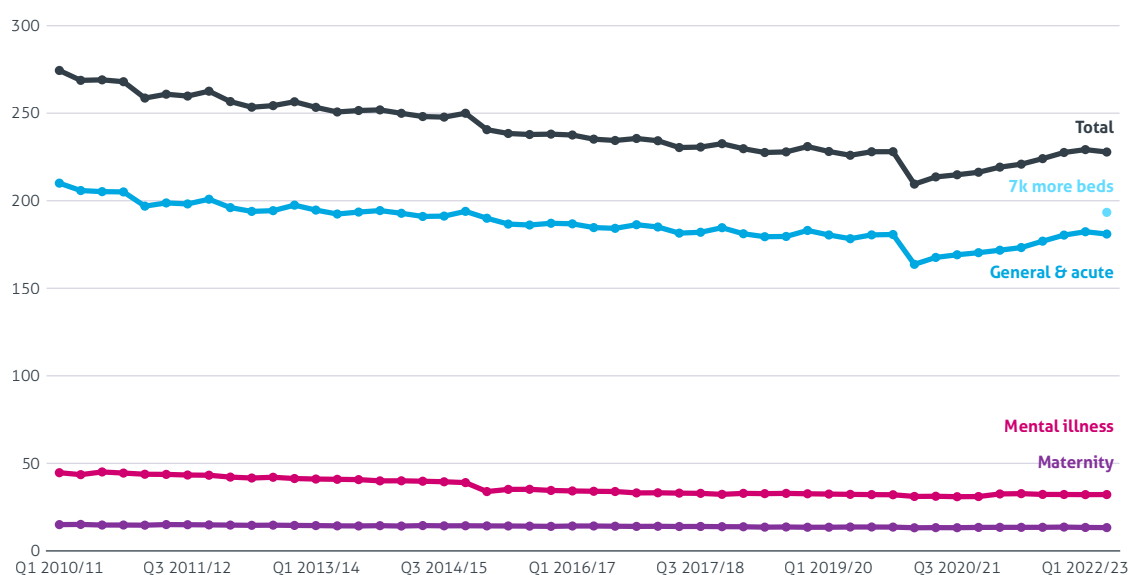
\* The EU14 are the those countries that were members of the EU prior to 2008: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Republic of Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden.

It is, however, not clear that this will be a good way to increase capacity in the NHS. Beds require staff to work on them – a resource that is in short supply, with more than 133,000 roles, or 9.7% of the workforce, vacant in September 2022, as discussed further below. For an example of why solely increasing bed numbers is unlikely to increase capacity, we can look at the 'Nightingale' hospitals opened during the pandemic: despite having a potential capacity of 4,000 beds, the lack of staff meant that very few patients were ever treated in them.<sup>19</sup>

Even if this increase is successful, it would still leave the NHS with fewer beds per person than in 2010. The number of G&A beds per 100,000 people fell from 210.0 in 2010 to 181.0 at the end of September 2022 – a decline of 13.8%. An additional 7,000 G&A beds now would mean that there were still 7.9% fewer than in 2010. To bring capacity back up to 2010 levels would require some 16,423 G&A beds.

The context of these falls is important. Some of the post-2010 trend of reduced beds-per-capita – itself part of a longer trend – was due to positive factors, including improvements in treatment reducing length of stay, and more people receiving treatment in non-hospital settings (again a goal of the NHS, discussed below). At the same time, there is evidence that the balance between efficiency and resilience had not been struck, with at least one in six trusts operating with greater than 95% general and acute bed occupancy by 2015.<sup>20</sup> This high intensity of bed use, continued to the end of the decade, exposed that lack of resilience when the impact of the pandemic and subsequent backlogs in care were felt.

Figure 3 **Overnight hospital beds per 100,000 people, by type, Q1 2010/21 to Q2 2022/23**



Source: Institute for Government analysis of NHS England, 'Bed availability and occupancy data – overnight', ('Average daily available and occupied bed time series – open overnight' table), Q2 2022/23; ONS, 'Mid-year population estimates', ('MYE1 population estimates: summary of the UK, mid-2021').

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'Virtual beds' – an innovation that the NHS made increased use of during the pandemic, which allows staff to monitor patients who stay in bed at home – may appear attractive, allowing the NHS to treat more people without increasing the physical number of beds. But virtual beds face the same problem as physical beds; they need staff to work on them. The *Health Service Journal* (HSJ) reported in December that only half of the 7,000 virtual beds in the NHS were occupied.<sup>21</sup> The reason for this is unclear, but noted staffing restraints seems most likely.

## Will increasing spending on social care solve delayed discharge?

***"[The government is] providing new funding to discharge people into social care and the community, freeing up beds"***

Part of the reason for high bed occupancy is that there are approximately 13,000 people per day who are eligible for discharge from hospital but who remain there at the end of the day. This is for a number of reasons, but a key one is a lack of social care capacity, be that home care, nursing and residential care, or other care in the community. To remedy this, the government made £500 million available to improve discharge as part of the social care discharge fund this winter.<sup>22</sup>

This fund is designed to "be used flexibly on the interventions that best enable the discharge of patients from hospital to the most appropriate location for their ongoing care".<sup>23</sup> The government also used the autumn statement to increase funding for adult social care in 2023/24 and 2024/25, with £400m and £680m of new grant funding in each respective year to improve discharge.<sup>24</sup> It has made other funding for the wider adult social care sector available, which may also help to increase capacity and thus free up space in the NHS.

However it is not just inadequate social care that makes it difficult to discharge patients. Research by the Nuffield Trust shows that 39% of delayed discharge happens because patients are waiting for a place in nursing or residential care, or for care at home,<sup>25</sup> with a further 22% because they are awaiting short-term rehabilitation. But another 39% of people remain in hospitals because of problems in the NHS itself or for 'other' reasons, such as no plan for their discharge or because they are awaiting a medical decision and full discharge summary.<sup>26</sup> So while expanding social care provision is clearly important and the funds welcome, targeting just that will not solve the problem of delayed discharges.

The way funding is allocated is also not conducive to good spending. The Social Care Discharge Fund was announced in September 2022, with the first tranche disbursed in December<sup>27</sup> – too late for the NHS and local authorities (who are responsible for the majority of social care) to put the money to good use over winter. Providing funds on a short-term, emergency basis like this makes it difficult for both to spend that money

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effectively. It is difficult to ramp up social care capacity in a matter of months, as this often requires considered investment by providers. There has been some improvement on this front though, with the government using the autumn statement to make funding available for the next two years.

***"[The government is] investing in the social care workforce... We're introducing career progression for the first time"***

As with the NHS, staffing is one of the key bottlenecks to increasing capacity in adult social care. In its latest monthly data, to the end of December 2022, Skills for Care estimated that 10.8% of roles in the service were vacant,<sup>28</sup> higher than the 9.7% in the NHS. And like with the NHS, retention is the primary driver of these vacancy rates, with 50,000 fewer workers employed in the adult social care workforce in March 2022 compared to March 2021.<sup>29</sup>

There are many reasons for this, of which pay is certainly one. Carers earn less on average than hospitality and retail employees, making moves to those sectors attractive.<sup>30</sup> But it is difficult for the government to directly control the pay of social care staff as the vast majority are employed by private providers; as of September 2021 local authorities directly employed just 7% of the adult social care workforce.<sup>31</sup> One of the most direct levers for increasing the pay of social care workers is the national living wage (NLW), for which many care staff are eligible, but this would require increasing pay for workers in many other sectors too, something the government is unlikely to want to do. The government could legislate to create a minimum wage for social care staff, but that would take time and would also require local authorities to fund the increase – a proposal that many authorities would resist without a funding increase from central government.

Another element that drives poor retention in the service is lack of career progression. The government introduced a Workforce Development Fund during the pandemic to promote continuing professional development for care staff.<sup>32</sup> This was extended into 2022/23, with £500m worth of funding behind it,<sup>33</sup> although with vacancy rates in adult social care at their highest on record it is not clear if it is having the desired effect yet.<sup>34</sup>

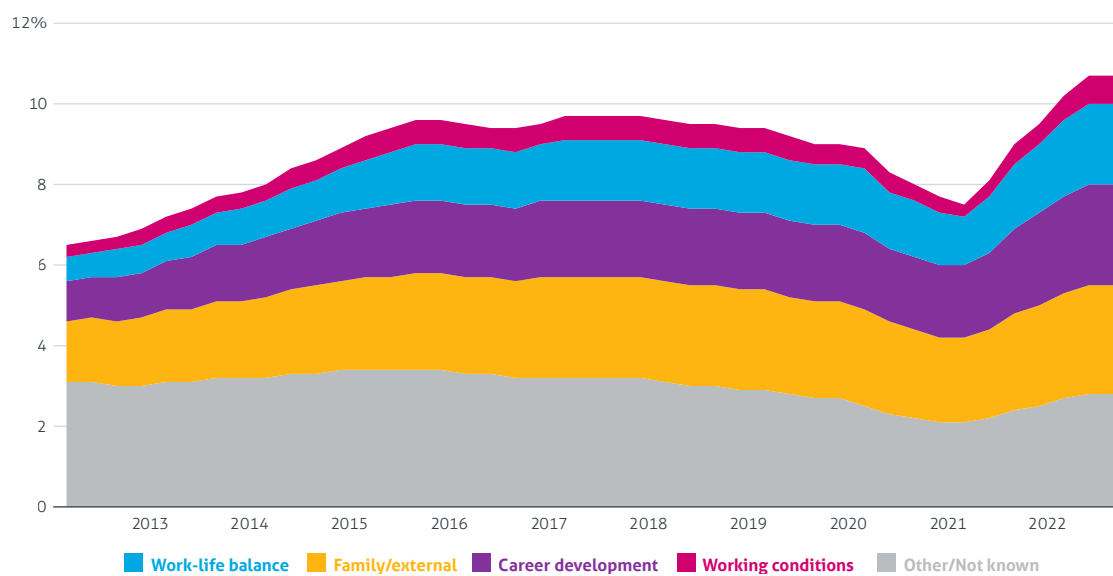
Overall, the crisis in adult social care is largely one of staffing, with vacancies often constraining service delivery. Until the government can stem the flow of carers out of the service, it is unlikely to be able to increase care spaces to the level they need to be to make a substantial difference in the NHS.

## Is staffing sufficient in the NHS?

***"[The government has] recruited thousands more doctors and nurses"***

Answering this question is complex. First, the above claim made by Sunak is correct: there were 27,807 more nurses and 12,027 more doctors working in hospitals in August 2022 compared to March 2019 – an increase of 13.4% and 12.1% respectively.

Figure 4 **NHS workforce resigning in the previous 12 months, by reason, March 2012 to September 2022**



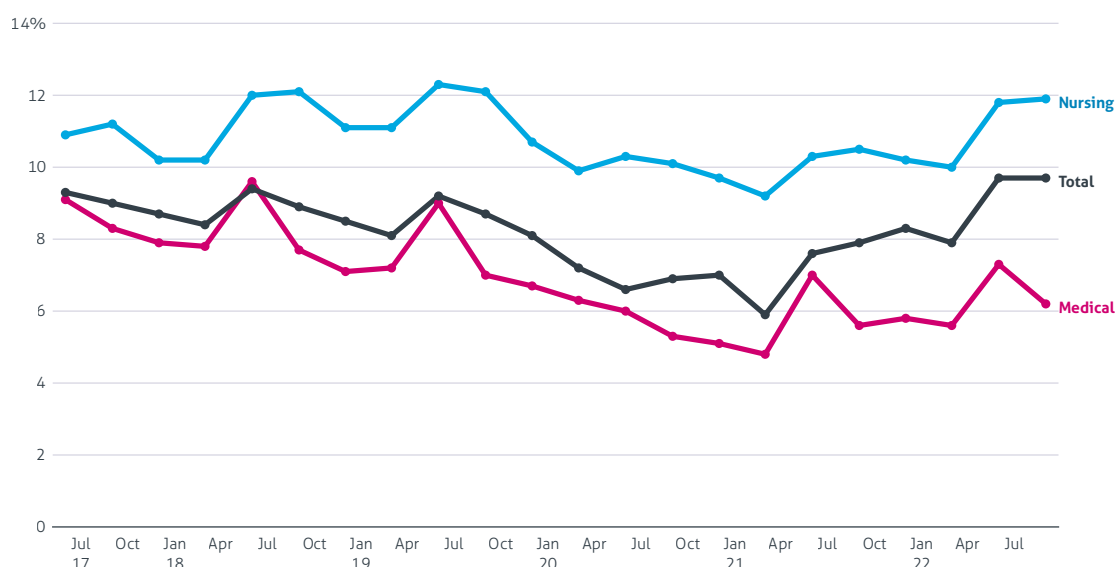
Source: Institute for Government analysis of NHS Digital, 'NHS workforce statistics, September 2022 reasons for leaving', Table 1: Reasons for leaving.

But despite that, there was also the highest level of vacancies recorded in the NHS in September 2022, with close to one in 10 (9.7%) of posts unfilled. This is because even though the number of doctors and nurses has increased substantially, the need for them has increased even more. And even though recruitment has been strong across the service, total staff numbers have not kept pace with that need because of severe retention issues.

In the 12 months to September 2022, a record 148,640 people resigned from the NHS – almost a third more (31.4%) than in the 12 months to September 2019. This isn't just because the workforce is larger, the largest ever proportion – 10.8% – of the workforce resigned in the year ending September 2022, compared to 9.1% in the 12 months to September 2019.



Figure 5 **Vacancy rates by type of role, June 2017 to September 2022**



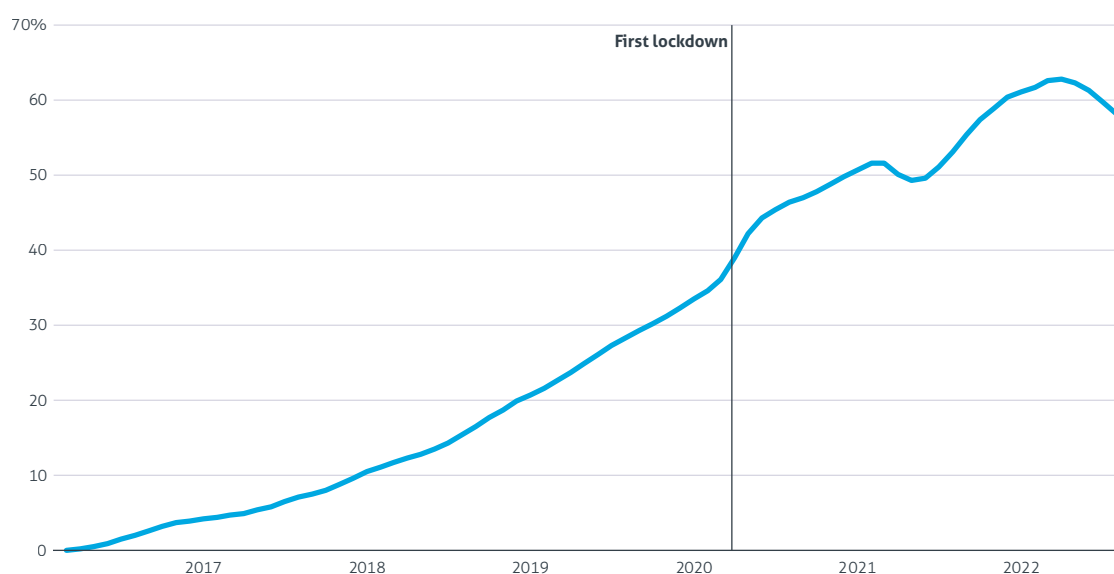
Source: Institute for Government analysis of NHS Digital, 'NHS vacancy statistics England', ('Total 2018 onwards' table), ('Nursing 2018 onwards' table) and ('Medical 2018 onwards' table), September 2022.

There are many reasons for that increase in resignations, but one is that many staff are burnt out after the incredible strain of working during the pandemic. This can be seen in the staff absence data, where the number of days lost due to anxiety, stress, depression or other psychiatric illnesses was almost a quarter higher (23.3%) in the 12 months to August 2022 compared to the 12 months to August 2019.

This is at least in part due to worsening working conditions since the start of the pandemic. The BMA reports that an arresting 96.4% of respondents to their survey on the topic claimed that Covid had exacerbated the risk of moral distress – when “institutional constraints create a sense of unease among doctors from being conflicted about the quality of care they can give”.<sup>35</sup> The leading cause of that moral distress given by respondents was “Not enough staff to suitably treat all patients”.<sup>36</sup> A lack of staff leading to low morale creates a vicious feedback loop: poorly staffed shifts leads to more stress, which in turn leads to worsening retention, which leads to even more poorly staffed shifts.

In a poll carried out by the BMA at the end of 2022, some 40% of junior doctors said that they planned to leave the NHS as soon as they can find another job.<sup>37</sup> The 2021 NHS staff survey also showed evidence in an uptick in intention to leave, with the highest ever proportion of staff saying they will leave the organisation as soon as they have found another job.<sup>38</sup>

Figure 6 **Change in available staff days lost due to mental health, March 2016 to August 2022**



Source: Institute for Government analysis of NHS Digital, 'NHS sickness absence rates', ('Table 2: Count'), August. Notes: This is a rolling 12-month average to smooth out seasonal variation.

Staff are also likely to be leaving because of uncompetitive pay. The tight labour market of the past year has led to some employers in competing industries – for example, the retail and hospitality sectors – paying staff more, which in turn attracts staff (particularly in lower-paid roles such as porters, cleaners and health care assistants, as well as support functions such as IT, HR and facilities<sup>39</sup>) out of the NHS.

Dissatisfaction with pay is most apparent in the number of strikes occurring in the service. The Royal College of Nursing (RCN) claims that nurses' real pay has fallen 19% since 2010 – which it cites as a key reason for its members voting to take industrial action, the first time they have done so in the organisation's history, more on which below.<sup>40</sup>

When staff are absent or have left the service, the NHS fills their roles with bank and agency staff, who are both more expensive and more ineffective than permanent counterparts.<sup>41</sup> This is because filling vacancies with new or temporary staff rarely results in a like-for-like replacement, in terms of experience and efficiency in the role. Research shows that having experienced staff matters: wards with more experienced staff regularly report lower mortality rates.<sup>42</sup>

Overall, while the number of staff in the service has certainly increased, validating at least the language of Sunak's claims, this has been met with the compromise of an NHS operating with more inexperienced, stressed and temporary staff, who are in any case leaving the service in higher numbers than ever – with very likely adverse effects to its productivity.

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## What is the government doing to resolve the ongoing industrial action?

### ***"We're always open to dialogue, the door is always open"***

Arguably before all else, the government needs to resolve the ongoing and potential future industrial disputes in the NHS. Performance in the health service will continue to suffer as long as it is losing millions of staff days to strikes. Sunak repeatedly claimed in his speech that his government was keen on dialogue to resolve the strikes, but negotiations with nurses only began on 9 January.<sup>43</sup> According to reports, little progress was made in that meeting, though the government did 'open the door' to discussing this year's pay<sup>44</sup> – a positive movement, given previous intransigence on this issue. Despite this progress, it does not seem likely that the government and nurses will reach a resolution soon, with the RCN announcing more strikes throughout February.

When defending its decision not to raise staff pay, the government argues that wage increases are unaffordable<sup>45</sup> and that it is following the advice of the independent pay review bodies (PRBs).<sup>46</sup> However, on the first point, the government could choose to increase the budget for the NHS, funded either through borrowing, higher taxation or cuts to non-NHS spending. Not doing so is a legitimate political decision, but framing the increase as "unaffordable" obscures the choice that the government is making.

On the second point, PRBs are to some extent independent, but their independence is highly constrained. Each year, the secretary of state sends the PRB a remit letter, outlining where the body should focus its attention and what constraints the body should consider when setting pay.<sup>47</sup> In Sajid Javid's (then the health and social care secretary) remit letter for 2022/23, he told the PRB: "As the NHS budget has already been set until 2024 to 2025, it is vital that planned workforce growth is affordable and *within the budgets set*" (our italics).<sup>48</sup> The implications of this sentence are clear: the PRB was encouraged to make a pay recommendation that was within the existing spending settlement for the NHS. Otherwise, the government could exercise its veto over PRB recommendations, and instead choose to pay staff less.

Equally, there is nothing preventing the government from looking at the PRB's recommendation and choosing to pay staff more, funded either through borrowing, taxation, or spending cuts elsewhere, as discussed above. It is disingenuous, therefore, for the government to continue to hide behind the PRBs.<sup>49</sup> Worse, this narrative is damaging the credibility of the PRBs,<sup>50</sup> with a range of unions recently announcing that they will not participate in the 2023/24 PRB process.<sup>51</sup>

Reports over the weekend of 21 January indicate that the government might be open to a resolution with rail workers and firefighters,<sup>52</sup> with the hope that this will eventually lead to deals with other sectors. As of 23 January, it is still unclear if this is likely to transpire, but again the shift in tone from the government is welcome.

## Does the NHS have the equipment it needs?

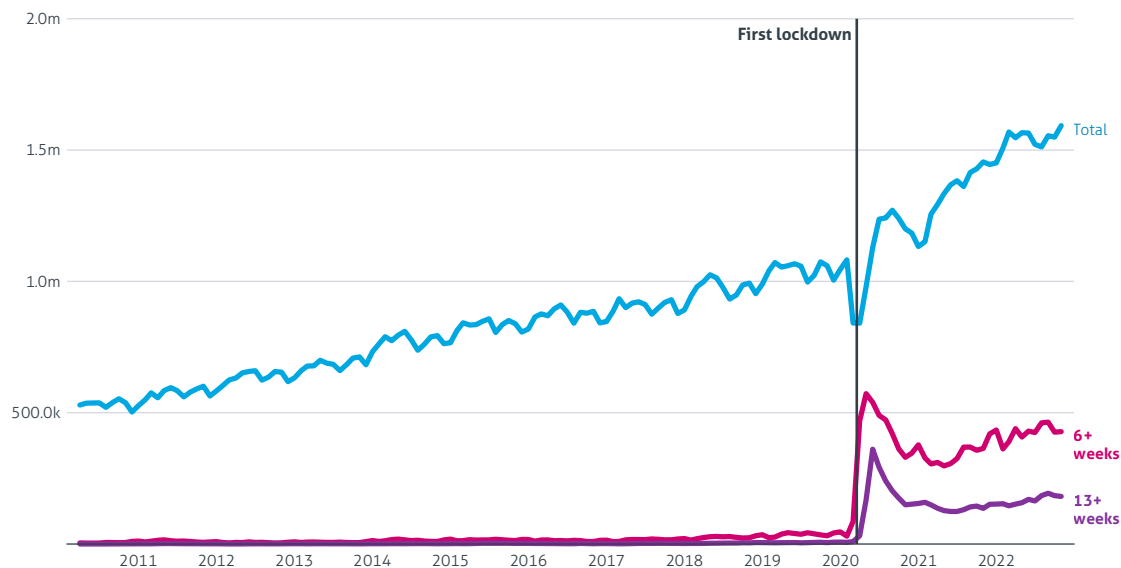
***"[The government has] upgraded hospitals with more cutting-edge technology"***

It is difficult to evaluate this statement for a few reasons. First, it is unclear what Sunak means by "cutting edge". This could refer to new diagnostic equipment, IT systems, innovations such as virtual wards or more. Second, even if any of these are what he means, there is little publicly available data to evaluate whether this is true.

What is known is that NHS capital spending has been below the level of comparable countries in recent history, only exceeding the OECD average in three years (2007–2009) since 2000.<sup>53</sup> The result is that the NHS has the sixth lowest number of CT and PET scanners and MRI units per capita compared to the 37 OECD countries – 16.5 per million people, significantly fewer than half of the OECD average of 44.8.<sup>54</sup>

The consequence of that underinvestment is that it is harder for staff to carry out the amount of activity that they need to. Fewer diagnostic machines per capita means, for instance, that the NHS cannot conduct as many tests as comparable countries, resulting in the largest diagnostic waiting list on record. This has a knock-on effect on other key indicators in the NHS. For example, the longer it takes to conduct a test, the longer it will take to complete an elective pathway.<sup>55</sup>

Figure 7 **Waiting list for diagnostic tests, total and length of wait, April 2010 to November 2022**



Source: Institute for Government analysis of NHS England, 'Monthly diagnostic waiting times and activity', ('Table: Total waiting list'), ('Table: 6+ week waits') and ('Table: 13+ week waits'), November 2022.

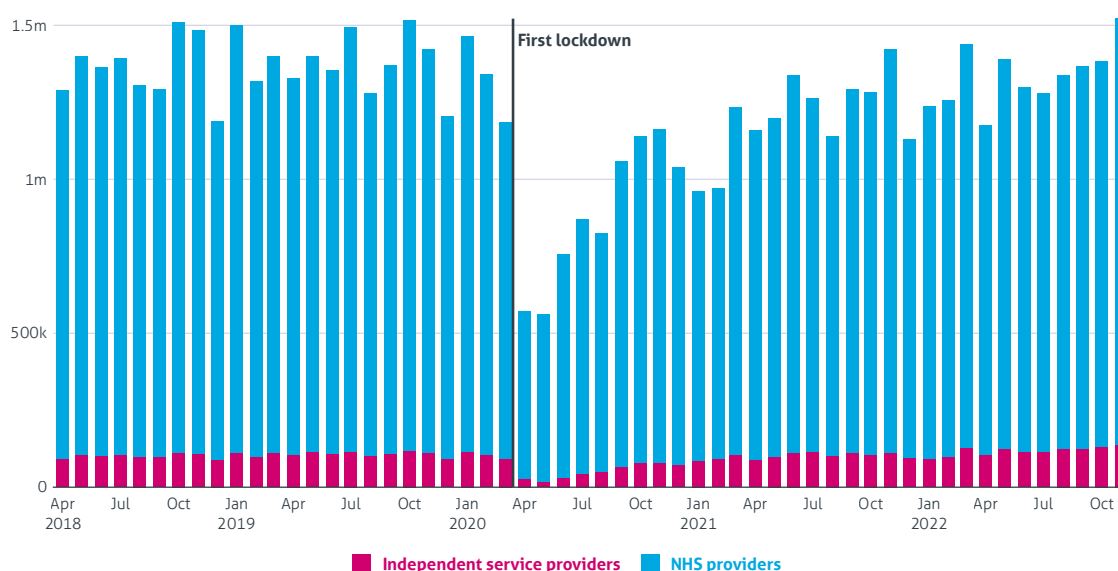
## Will using the private sector boost capacity?

### "[The NHS is] using more independent capacity"

This claim is true. Elective activity in independent service providers (ISP) increased 7.9% in the 12 months to November 2022, compared to the same 12 months in 2018/19. In the same time period, activity in NHS providers declined by 5.6%. But there are a few caveats to this.

First, the increase in independent sector procedures is not nearly enough to compensate for the decline in activity carried out by NHS providers. ISPs delivered 101,674 more procedures in that time period, but this number is dwarfed by the 850,117 fewer carried out by NHS providers. Second, this increase is driven by more activity in one speciality: ophthalmology, where there was a 122.3% increase in activity, equalling an additional 199,116 procedures. This means that excluding ophthalmology, the number of procedures carried out by ISPs in fact *declined* by 97,442 (8.6%).

Figure 8 **Elective procedures, by provider, April 2018 to November 2022**

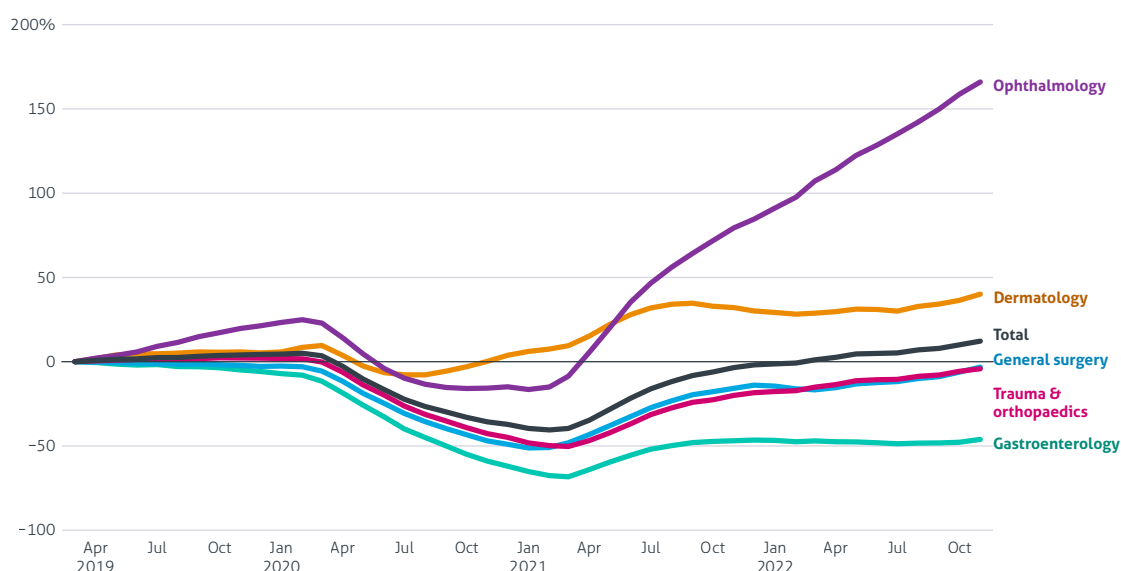


Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' – Admitted Provider and Non-Admitted Provider, November 2022.

There is, however, one way that Sunak is right in this assessment: ISPs are well-suited to routine, low-complexity elective procedures, such as cataract removal,<sup>56</sup> which it could be argued unnecessarily uses NHS capacity. Increasing ISP elective activity for these types of procedures will mean that there are fewer patients occupying NHS beds, which will in turn free up space for emergency admissions. ISPs have taken on more low-complexity care throughout the pandemic, but there is a limit to how many beds this can free up, and the NHS will always be relied on to provide more complex and emergency care.

It is also incorrect to think that there is an unlimited pool of capacity in the independent sector. As with the NHS, the number of procedures that ISPs can carry out is limited by the number of staff they can employ. Given the limited number of health care staff, expanding independent elective activity could come at the expense of activity in the NHS, as they hire from the same group of people,<sup>57</sup> with staff often working for both the NHS and ISPs.

Figure 9 **Change in procedures by independent providers, by specialty, March 2019 to November 2022**



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times' - 'Admitted Provider' and 'Non-Admitted Provider', April 2018 to November 2022. Notes: These are the five specialties with the most procedures carried out in the last year. This chart shows a 12-month rolling average to account for seasonality.

## What other measures did Sunak announce?

***"We're rolling out a new fall service, so that we can save about 55,000 ambulance call-outs a year, by treating people with falls at home"***

This initiative was announced by the NHS in November 2022<sup>58</sup> and aims to treat more patients who suffer the least severe falls in their homes, rather than dispatching an ambulance. This measure is expected to reduce ambulance call-outs by 55,000 per year.<sup>59</sup> This is an interesting innovation and it is certainly better to treat people in the community where possible (although this will not actively reduce demand, which is such that even a full reduction of 55,000 calls would bring category 2 incidents down by a fairly modest 1.2% on 2022).

***"We're creating elective surgery hubs and community diagnostic centres where people can get [the care] they need away from the acute part of the hospital"***

The creation of elective surgery hubs and community diagnostic centres (CDCs) has been one of the government's primary initiatives to increase both elective and diagnostic capacity in the service. Both measures featured in the NHS's backlog

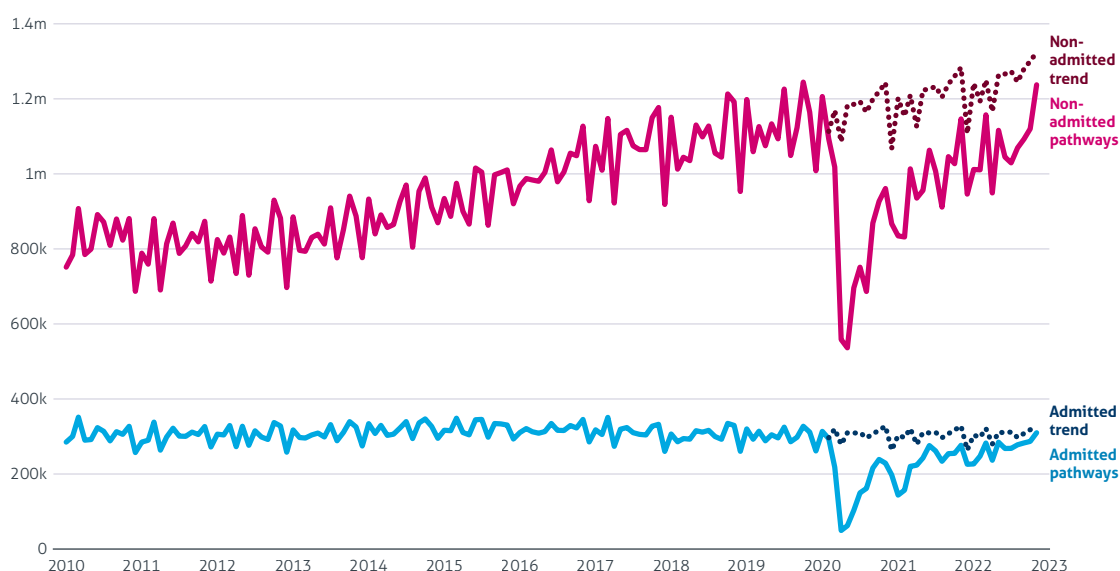
delivery plan,<sup>60</sup> and progress has been made on the ambition laid out in that document. By August 2022, the NHS had opened 91 elective hubs and approved an additional 50 for opening, with an ambition to open 140 in total by 2024/25.<sup>61</sup> By the end of December, the NHS had opened or approved 127 CDCs – more than 80% of its target of 160 by 2025.<sup>62</sup>

The NHS hopes that the hubs and the CDCs will increase the number of elective procedures and diagnostic tests respectively. NHS England estimates that CDCs delivered “over 2.4 million tests, checks, and scans” between July 2021 and December 2022<sup>63</sup> and that elective hubs will deliver “200,000 extra procedures in 2022 to 2023, over 700,000 extra procedures in 2023 to 2024, and 1 million extra procedures by 2024 to 2025”.<sup>64</sup>

It is difficult to evaluate these claims, because there is no publicly available data about the activity carried out in hubs and CDCs. Looking at the total number of diagnostic tests and elective procedures conducted in England in that time period, however, reveals that there were 6.4% fewer elective procedures in the 12 months to the end of November 2022, compared to the 12 months to the end of November 2019; on diagnostic tests, the NHS carried out only 0.7% more in the same period. Given the reported increase in activity in the CDCs and elective hubs, it is important to ask why there is so little impact on the overall level of diagnostic tests and elective procedures.

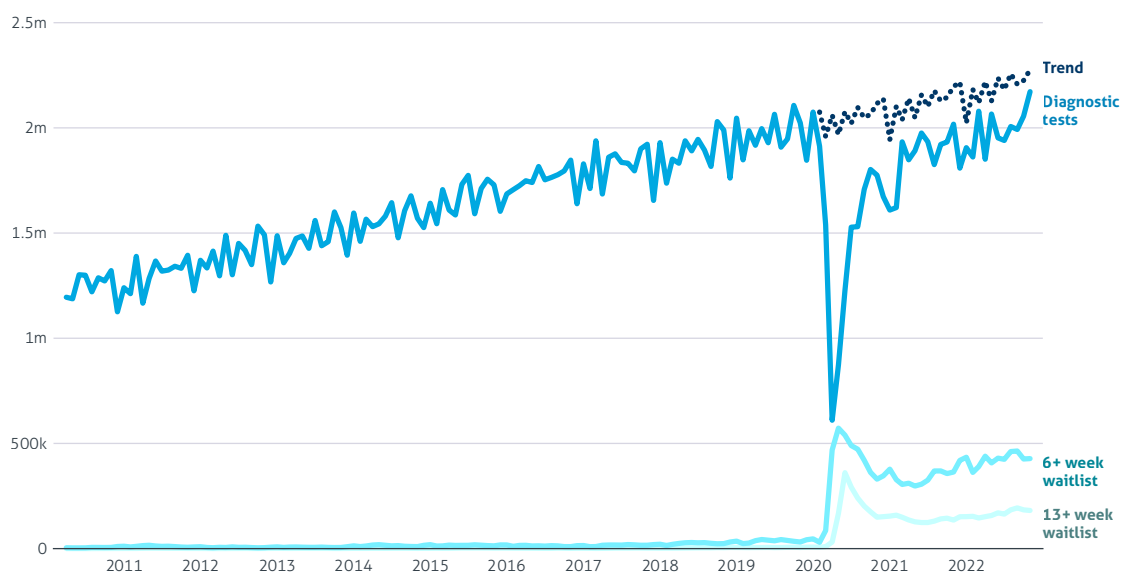
Part of the problem could be – as with other measures implemented in the NHS – that there are not enough people to properly staff the new CDCs and elective hubs. The government should publish data to make it clear how much activity is being carried out in the new CDCs and hubs to allow for better evaluation of their effectiveness.

Figure 10 **Elective activity by pathway, actual and trend in the absence of Covid, January 2010 to November 2022**



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times – Time series', November 2022. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

Figure 11 **Diagnostic tests, actual and trend in the absence of Covid, and waiting lists for diagnostic tests, April 2010 to November 2022**



Source: Institute for Government analysis of NHS England, 'Monthly diagnostic waiting times and activity', ('Total Activity' table), ('6+ week waits' table) and ('13+ week waits' table).

### ***"We need to do a better job at preventative medicine"***

This is true, although at this stage few details on more preventative activity have been made available. The focus of recent NHS policy and spending increases has been on acute services – which provide short-term care when we fall ill or suffer an injury – at the expense of preventative services, which are designed to improve our health over the long term and thus eventually reduce demand for acute services. One way this can be seen is in the decline in money that the government allocates to public health in the form of the public health grant, which the Health Foundation estimates has been cut by almost a quarter (24%) in real terms since 2015/16.<sup>65</sup>

It is positive that the government has recognised this as an issue and it should continue to invest in public health and other preventative measures, but that investment will not help alleviate the immediate crisis in acute care throughout the NHS.

## **How will we know if Sunak has delivered on his pledge?**

***"Cutting waiting lists... They are your government's priorities. And we will either have achieved them or not. No tricks... no ambiguity... we're either delivering for you or we're not"***

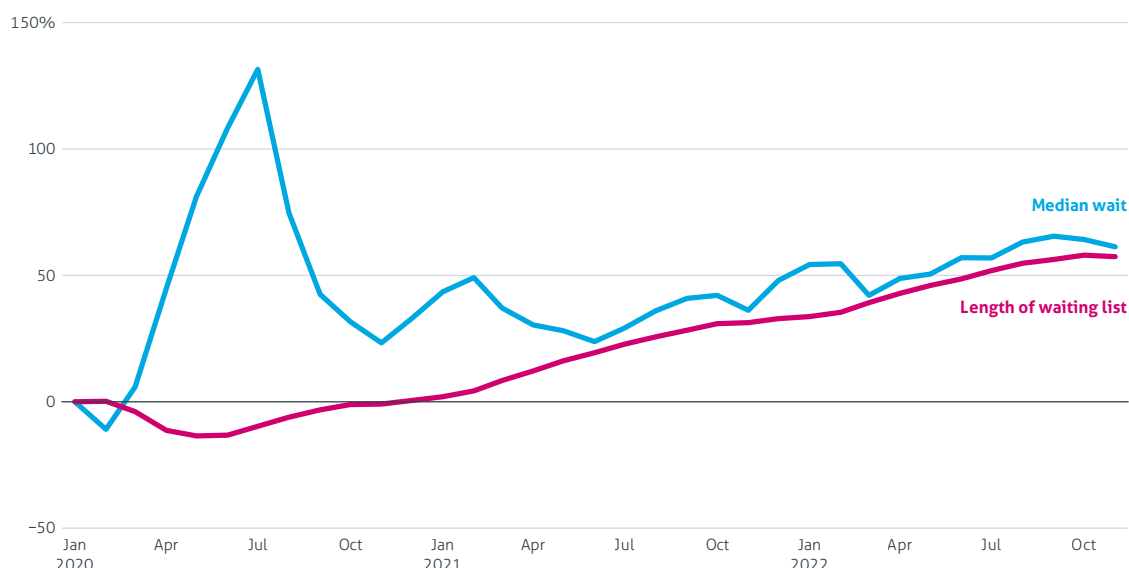
Sunak has made much of the clarity of his government's objectives, and while a straightforward pledge to 'cut waiting lists' seems clear, on further analysis this in fact raises more questions than it answers.



First, there is a complex and diverse range of waiting lists in the NHS, including for elective care, diagnostic tests, cancer treatment, and an ‘invisible’ waiting list for people trying to access primary care in the first place. Even within the ‘elective waiting list’ there are also ‘sub-waiting lists’ of people who are waiting more than 52, 78 and 104 weeks for care.

Second, Sunak appeared elsewhere in his speech to use “waiting lists” and “waiting times” interchangeably. These are not the same things, and conflating the two risks further confusing the discussion. The number of people on a waiting list can fall, while median waiting times increase (as happened in the early days of the pandemic, as shown in Figure 12 below). The opposite can also happen. Referencing waiting times also adds other potential metrics against which to compare this pledge; for example, A&E wait times, ambulance response times, or days between an urgent cancer referral and a first appointment.

Figure 12 **Change in the wait time for elective care and the length of the waiting list, January 2020 to November 2022**



Source: Institute for Government analysis of NHS England, ‘Referral to treatment waiting times – Time series’, November 2022.

Evaluating how achievable this pledge is therefore requires assumptions about what Sunak meant. Given the high profile of the elective waiting list, we will assume this is the one to which the prime minister was referring. Then, as to what “cutting” this list would mean in practice there were two reasonable inferences that could be drawn from Sunak’s statement: either that there will be a fall versus the size of the waiting list as of the day of his statement, or that there would be a fall of any amount at some point before the end of this parliament. The more meaningful commitment is the former so we will start with that.

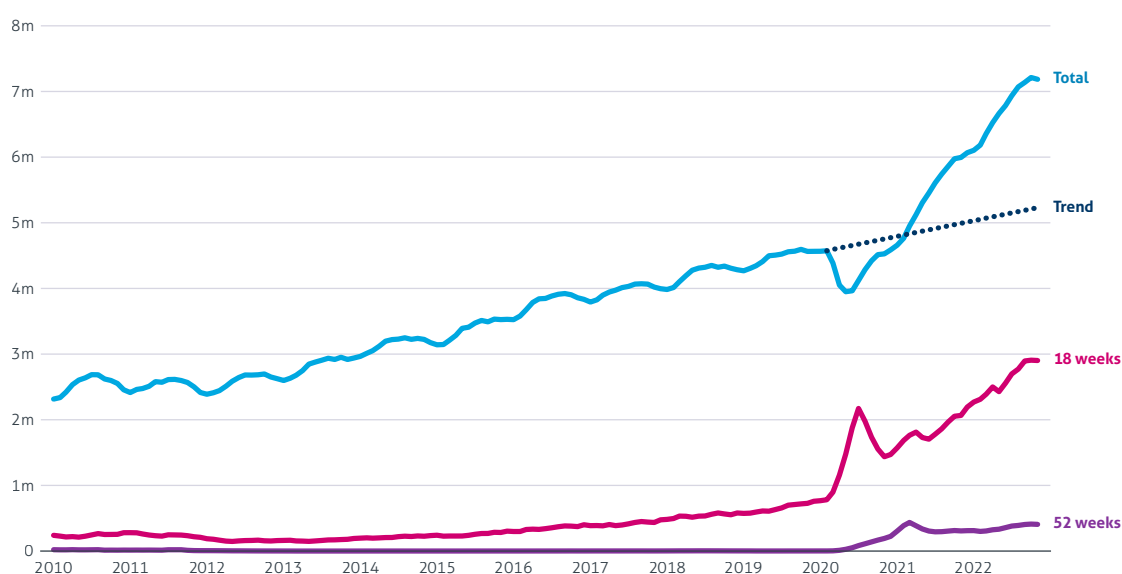
The NHS backlog recovery plan forecasts that “the waiting list will be reducing by around March 2024”.<sup>66</sup> But that forecast is predicated on elective activity increasing to 130% of pre-pandemic levels by 2024/25. This is ambitious. The number of completed pathways in the year ending November 2022 was 6.4% lower than the 12 months to November 2019. Poor patient flow, strike action and high levels of staff absences and vacancies will also continue to hamper elective activity.

This does not necessarily mean that the March 2024 prediction is unachievable. While activity is down, there have also been fewer people coming forward for care than expected.<sup>67</sup> This means that lower activity levels might not prevent a sustained fall in the elective waiting list from March 2024, though whether it will fall to below the level of early January 2023 (Sunak delivered his speech on 3 January) is unclear.

However, there was enough ambiguity in the phrasing of Sunak’s speech for him to claim the second of the options above – that there would be a fall of any amount at some point before the end of the parliament. If so, then the prime minister might already claim success: data released just a week after his speech showed the elective waiting list – unexpectedly – declined in November 2022, from 7.21 million at the end of October to 7.19 million. This was driven primarily by a surge in non-admitted elective activity, the second-highest on record in November 2022, and 4.8% above the level achieved in November 2019.

This is an excellent outcome, but predates the worst of the current crisis in the NHS, and the government should be aware that it could be difficult for the service to maintain that level of activity when urgent and emergency care is performing poorly.

Figure 13 **Elective waiting list length, total and by length of wait, January 2010 to November 2022**



Source: Institute for Government analysis of NHS England, 'Referral to treatment waiting times – Time series', November 2022. Notes: The 'trend' line is a seasonal forecast, using pre-Covid data as the baseline.

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Sunak was ambiguous enough in the wording of his speech that he will be able to point to almost any improvement, anywhere in the service, at any point between now and the election, as a promise kept. But he will rely heavily on that ambiguity to do so – and hope the public are willing to judge his success on his own terms. This is not a given. People’s experience of the health service is often deeply personal and many will base their judgments on a much narrower set of performance indicators than the prime minister’s.

## What did the health and social care secretary announce?

Steve Barclay made an oral statement to parliament on Monday 9 January outlining the government’s plans for addressing the crisis.<sup>68</sup> He opened his statement with a diagnosis of the crisis that focused on immediate short-term pressures, claiming that the crisis was due to a combination of:

- the worst flu season in 10 years, with 5,100 people in hospital compared to just 50 at the same time last year, which has also caused high staff absences
- additional pressures brought about from a wave of Strep A infections
- the ongoing burden of people in hospital with Covid
- more than double the level of delayed discharges than during the pandemic (12,000–13,000 now compared with 6,000 in June 2020).

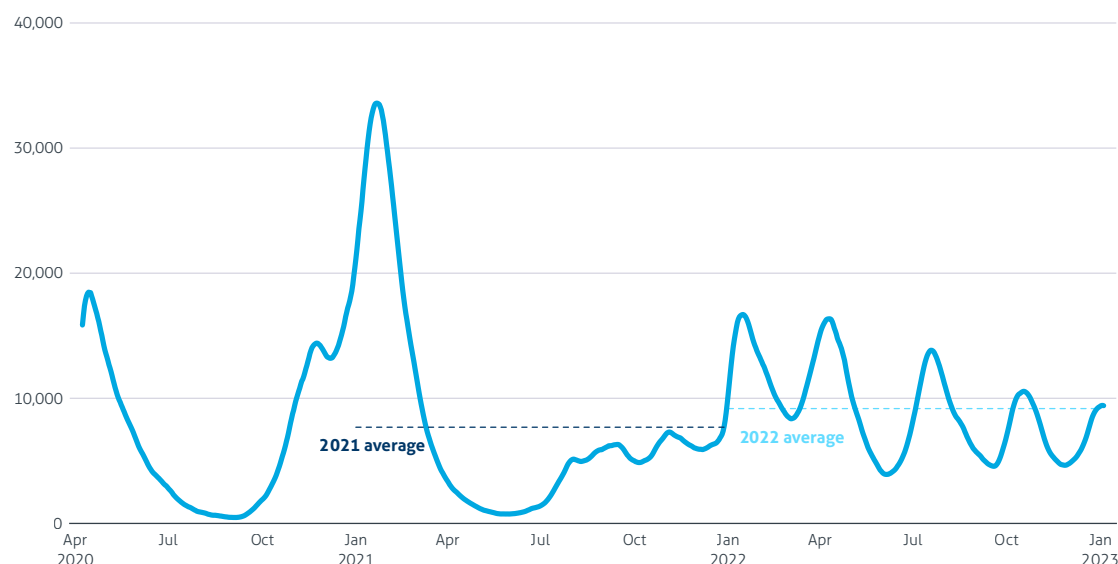
Some of these pressures are certainly worsening the crisis and are fair to raise. It is correct, for instance, that this flu season is particularly bad, and *The Times* supports the claim that it is the worst in a decade.<sup>69</sup>

That said, public health experts have been raising concerns about a ‘twindemic’ – a combined spike in flu and Covid cases – since the early months of the Covid pandemic,<sup>70</sup> so it is reasonable to ask if government could have done more to prepare for it. Indeed, there had been specific warnings that this flu season was likely to be serious based on data from Australia’s winter flu season in 2022.<sup>71</sup> The government did implement some measures – for example, the roll-out of the combined Covid and flu vaccine<sup>72</sup> and the attempted increase of 7,000 beds<sup>73</sup> – but declined to pursue more expensive interventions such as a wider vaccine programme or an increased pay award to improve retention, which would have in turn supported the planned increase in capacity.

Covid unquestionably continues to impose a burden on the service, with more people in hospital per day with Covid on average in 2022 than in 2021 – 9,179 compared to 7,691 respectively. But once again, this is not a surprise. Almost three years through the pandemic the government is aware of what works and what does not in terms of keeping Covid hospitalisations down: if it wanted to prevent Covid admissions there are measures it could have taken, from a booster programme that included the young

to recommending the use of masks indoors. It is a valid political choice not to do those things (or others) but the government must also accept the consequences of these decisions.

Figure 14 **People in hospital with Covid, April 2020 to January 2023**



Source: Institute for Government analysis of NHS England, 'Covid-19 Hospital Activity – Monthly COVID publication', ('All beds COVID' table) January 2023. Notes: This line represents a seven-day rolling average.

Delayed discharge is also a burden on the NHS, as previously discussed. However, choosing June 2020 as a point of comparison is misleading. June 2020 was towards the end of the first wave of the pandemic, when the NHS was urgently discharging patients to free up bed space<sup>74</sup> (a decision described as 'irrational' by judges in 2022).<sup>75</sup> Delayed discharge predates the pandemic,<sup>76</sup> though it is difficult to compare levels now with data released before 2020 due to a change in methodology.

Nowhere did Barclay acknowledge that performance issues in the NHS predated the pandemic or that decisions made over a number of decades – for example, reducing bed numbers or under-investing in diagnostic equipment – might contribute to current issues.

In terms of measures to ameliorate the crisis, Barclay did provide more detail than Sunak. He claims that the government is splitting its response into three phases: steps to alleviate immediate pressures, increased resilience throughout the summer and autumn, and adoption of technology and innovation to keep people away from emergency departments. Measures which have not previously been discussed are examined below:

***"We will block-book beds in residential homes to enable 2,500 [people] to be released from hospitals when they are medically fit for discharge"***

This was the measure that garnered the most attention in advance of the speech and also comes with £200m of new funding. The logic for this is clear: rather than wait for local authorities to assess patients and find places in care for them, the government will book spaces in nursing and residential homes so the NHS can discharge fit patients into them. There are, however, several problems with this approach.

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First, social care capacity is rarely a problem of beds but rather one of staff. As noted above, vacancies in social care are even higher than in the NHS, raising the question of who will care for the people discharged into these residential homes. Second, there is some indication that the government is paying over the odds for this care.<sup>77</sup> While this is low down the immediate list of concerns, it does show how there is poor value for money when the government relies on short-term, emergency funding injections to solve problems.

There are also concerns about support for those discharged beyond the span of this funding. The £200m is expected to pay for care for four weeks after discharge,<sup>78</sup> at which point providers will discharge people into their homes and the community. The government then expects that “discharged patients will be given the care they need [by] GPs, nurses, and other community based clinicians”.<sup>79</sup> This may help with delayed discharge from hospitals but could cause problems in other parts of the health system. In particular, general practice is already facing some of the highest levels of demand in its history<sup>80</sup> and is therefore unlikely to be able to deal with an influx of patients with potentially complex care needs.

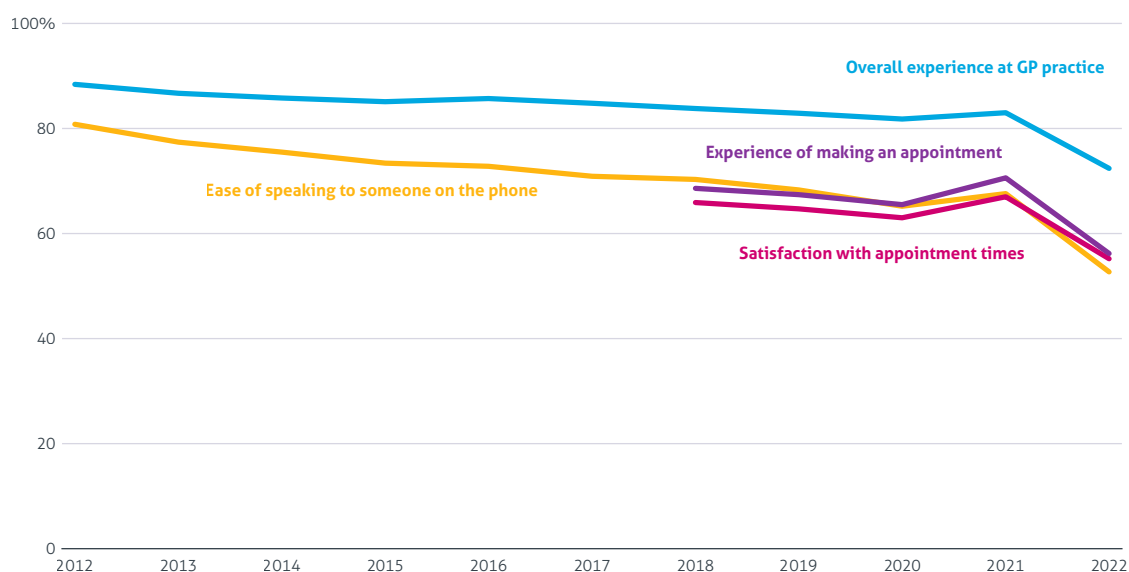
***“Our second investment today is in more physical capacity in and around emergency departments”***

This too came with new money attached, £50m in this case. From Barclay’s speech, it is difficult to know what form this extra space will take. It is worth stressing, though, that problems in the service are not the result of excess demand – there were only 0.2% more attendances at type 1 A&E departments in 2022, compared to 2019. The ‘modular units’ Barclay promises will be used in various ways by hospitals; for example, as a place for ambulances to drop off patients before they enter the main building, or for treatment of patients who would have otherwise been treated in A&E. But as with other interventions designed to increase capacity, the question is one of staffing, and the government needs an answer to who will run these facilities.

***“We are clear there are more things our community pharmacists can support with, which will ease the pressure on general practice”***

This is not a new announcement by Barclay and has in fact been part of government policy since at least the launch of the NHS Long Term Plan in 2019.<sup>81</sup> There are many more pharmacists employed in primary care networks (PCNs) than there were before the start of this parliament – 5,871 in September 2022 compared to 900 in March 2019, a 552% increase.<sup>82</sup> Unfortunately, it is difficult to evaluate their effectiveness at reducing GP workload as the NHS does not publish data on pharmacist activity. What is clear, however, is that even a five-fold increase in pharmacists has not been enough to offset increased demand for general practice, with respondents to the 2022 GP patient survey reporting the worst results on record for accessing the service.<sup>83</sup>

Figure 15 **Patients' experience of general practice, 2012–22**



Source: Institute for Government analysis of NHS, 'GP Patient Survey 2022', questions 1, 6, 21, and 32. Notes: Each time series starts from the first year the question was asked.

Barclay did mention other steps in his statement, but some of these (virtual wards, use of the independent sector, prevention) have already been discussed while others (putting integrated care systems on a statutory footing and 24/7 control centres) are simply long-standing government policy repackaged. Others still (use of artificial intelligence) are too vague to usefully evaluate.

Overall, much like Sunak's speech, many of the interventions that Barclay described come too late to help the NHS this winter. And perhaps the most substantial quick fix at the health secretary's disposal – resolving the various NHS pay disputes and associated strike actions – has been delayed by months due to the government's combative strategy.<sup>84</sup>

It is also fair to question whether the political turmoil of 2022 prevented proper planning for this crisis. Three people held the post of health and social care secretary (including Barclay, twice) between July and October – months when more consistent political leadership could have helped preparations for a difficult winter.<sup>85,86,87</sup>

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## Where does this leave the NHS?

To its credit, the government seems to have finally grasped the extent of the crisis in the service, though this has only come after mounting pressure from health care professionals, the policy community and the media. However, many of the changes that the government is now making will likely be too little, and too late, to solve the crisis this winter.

There is a risk that the government's need to avoid immediate crises means its attention drifts once key indicators – ambulance response times and A&E wait times, for example – start to improve and the NHS is not in the news every day. Next winter will see a repeat of this if the government does not take immediate steps to improve performance in the service by addressing the crisis's underlying causes of poor staff retention, underinvestment in capital, a lack of effective management, inadequate community and social care provision, and a poorly resourced primary care service.

This is a daunting task, but it is achievable. The New Labour era showed that turning around an underperforming health service is possible: the Blair government brought record elective waiting lists down between 1997 and 2008.<sup>88</sup> But that outcome required reform combined with sustained spending increases,<sup>89</sup> in a markedly different economic climate. If Sunak's government is to return waiting lists and performance even to 2010 levels – the year the first iteration of the current run of Conservative-led governments took office – he will require a similarly long-term commitment to higher investment across both health and social care. He will also require sustained political focus to make sure that performance is not allowed to slip once again.

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