Secondary care

This is the 2023/24 edition of State of Care

Go to the latest State of Care.

Key findings

- High demand for services and ongoing pressure in all parts of the system mean that many people, including children, are not getting the care they need when they need it. This is leading to a deterioration in people's health conditions, which then need more intensive support and treatment, and result in longer stays in hospital.
- Although demand has not increased dramatically, overall, the performance of services to meet the need for care is below the expected standard, and in some cases getting worse. By operating continuously in these environments, there is the risk that it becomes normal to accept care that is below standard.

- People are facing long waits for diagnostic tests. As at March 2024, there were around 1.62 million people waiting for a diagnostic test or procedure. And waiting lists are increasing. In total, the waiting list for a diagnostic test or procedure has increased by 52% since 2019.
- People continue to experience delays in referrals and diagnosis for cancer. Figures from NHS England show that the 3 waiting standard measures are not being consistently met, with the exception of the 28-day faster diagnosis standard, which was met for the first time in February 2024. Performance varies considerably between types of cancer and between regional health and care systems.

There is still a high level of demand for services and ongoing pressure in all parts of the healthcare system, which means that many people are not getting the care they need when they need it. This is leading to a deterioration in people's health conditions, which then need more intensive support and treatment, and result in longer stays in hospital.

Although the level of demand has not increased dramatically since last year, the performance of services to meet the need for care is below the expected standard, and in some cases getting worse. By operating continuously in these environments, there is the risk that it becomes normal to accept care that is below standard.

In last year's State of Care report, we highlighted how problems in the wider health and care system were increasing pressure on urgent and emergency care services. This pressure continues to rise, with ongoing high demand for NHS 111 and ambulance services, and people using the emergency department (A&E) to get the care they cannot access elsewhere.

High demand for NHS 111

Evidence of ongoing pressure on the wider system is reflected in calls to the NHS 111 service. The annual volume of calls in 2023/24 remained relatively stable, reaching a high of over 2.1 million calls in December 2023. However, the speed at which calls are answered continues to be below expected standards.

Long waits for calls to be answered lead to delays in people receiving appropriate triage and treatment, which in turn can have an impact on their outcomes. NHS 111 response rates have been consistently poor: between April 2021 and April 2024, the standard of answering calls within an average of 20 seconds was not met during any month, and in 2023/24, calls took on average 2 minutes 59 seconds to be answered.

When people have to wait a long time for their call to be answered, there's a risk that they will either:

- abandon the call and not receive advice on appropriate care or treatment
- seek care from a service that cannot meet their needs appropriately, or face delays in receiving the correct care
- not seek treatment at all.

Between April 2023 and March 2024, on average 10% (over 172,000 calls) to NHS 111 were abandoned each month.

Another safety risk is the delay in people being able to speak with a clinician. Despite a general increase in the number of triaged 111 calls since 2019/20, the proportion of calls assessed by a clinician or clinical advisor has decreased from 53% in 2019/20 to 44% in 2023/24 – this is below the standard of 50%. People are also having to wait longer to receive a callback from a clinician. While 90% of callbacks should happen within 20 minutes, on average only 31% of callbacks in 2023/24 were made within 20 minutes.

People have told us about the impact of delays in callbacks from NHS 111 through our Give feedback on care service:

> "Called [111] for an emergency prescription due to GP errors … Called… at 17:11 [and was told] that my GP would call me back within 2 hours. I advised that my GP was closed. Still had to wait the 2 hours. I then called back after not receiving a call back at 22:50… I woke up [the next day] still no call back. I called back at 9:40am to be prescribed over the phone there and then! I go to [the] pharmacy and was told the prescription was sent the night before [and] the pharmacy closes at 7pm. However, I was [not] informed, and [had been] left in pain all night and not able to sleep due to pain and waiting for a call back that never happened!"

> "I called [111] at 7.30am this morning about my 2-year-old daughter. After the initial assessment I was told that she needed attention within 2 hours of the call and so a clinician could call us back… After 2 hours passed I hadn't heard back so called back again at 9.30am. [The call handler] confirmed we were in a queue and would be called as soon as possible… because I was told multiple times and reassured that we would get a call back, I didn't take my daughter to a walk-in centre. I called again at 5.20pm [as] I had still not received a call… This was 10 hours after the initial call…[I called] again at 7pm – 12 hours after my initial call… Eventually I received a courtesy call at 9.40pm to say that we were still in a queue. I [cancelled the] call now given the time, and [said] that I would need to urgently have my daughter seen the next day at our GP."

Ongoing pressure on ambulance services

The number of calls to the ambulance service decreased by 2% in 2023/24 compared with 2022/23, with 13 million calls made. The proportion of answered calls has fallen over the same period from 76% to 74%, and continued to decline in April to June 2024 to 73%. However, the average time taken for a 999 call to be answered has improved significantly from 39 seconds to 9 seconds, this improvement has continued, with April to June 2024 averaging 5 seconds to answer.

Ambulance response times continue to fall below the expected standard, despite small improvements from last year. On average, ambulances should respond to a Category 1 incident within 7 minutes, and the standard is to respond to 90% of these within 15 minutes. Category 1 incidents are life-threatening events that need immediate intervention and/or resuscitation, such as cardiac or respiratory arrest. Between April 2023 and March 2024, the average response time for Category 1 calls was 8 minutes 27 seconds. Although this is 51 seconds faster than the same period in the previous year, it was still not meeting the standard. But there was better performance against the 90% standard between April 2023 and March 2024 compared with the previous year, with 90% of category 1 calls answered in 15 minutes 2 seconds – just 2 seconds over the 15-minute standard.

The picture is worse for Category 2 calls: these are emergency events that need intervention and/or taking to a hospital, including injuries such as burns, epilepsy or strokes. Category 2 represents the highest volume of calls with increased acuity and therefore more complex care needs. All ambulance trusts should respond to Category 2 calls in an average time of 18 minutes and respond to 90% of calls in 40 minutes. Due to ongoing pressures, in January 2023, NHS England reduced this to a temporary objective to respond to Category 2 incidents in an average time of 30 minutes over 2023/24.

Between April 2023 and March 2024, the average response time for Category 2 calls was 36 minutes 23 seconds, which is 13 minutes 37 seconds faster than the same period in the previous year. The picture is continuing to improve, with a national monthly average recorded of 32 minutes 35 seconds between April and June 2024.

However, performance varies across the country. Between April 2023 and March 2024, the average response time across integrated care system (ICS) areas varied, with only 9 out of 42 areas meeting the interim 30-minute standard. The fastest average response time within an ICS area was 22 minutes 59 seconds, while in the worst performing system, the average response time was 1 hour, 8 minutes and 12 seconds.

The high level of demand is sustaining pressure on services, which is having an impact on ambulance staff. In the 2023 NHS staff survey, 39% of ambulance staff respondents said they often or always felt burnt out because of their work. This was even higher for control room staff (44%), ambulance technicians (45%) and paramedics (45%).

Ambulance handovers

Our State of Care reports from the last 2 years have both highlighted the effects of handover delays – where delays in emergency departments lead to people being held in ambulances outside departments. This affects the care they're able to provide and how quickly they're able to respond to new emergencies.

The NHS Standard Contract states that targets for handovers between ambulances and emergency departments should be:

- 100% within 60 minutes
- 95% within 30 minutes
- 65% within 15 minutes.

We have seen ambulance crews still struggling to meet the required standards. Between October 2023 and June 2024, there were 3.7 million handovers, which took an average of 35 minutes 1 second. During this time, over 900,000 hours were lost due to handovers taking more than 30 minutes.

Nevertheless, as with ambulance response times, handover times have improved, with 72% made within 30 minutes in June 2024 (compared with 67% in January 2024). However, this is still far from the standard of 95%. Between October 2023 and June 2024, the average response time was below the standard of 95% within 30 minutes across all ICS areas, with performance varying from 31% to 93%.

Relieving the pressure on ambulances and urgent and emergency care

Earlier this year, we convened an event for senior leaders and specialists from across England to understand their local experiences around congestion in urgent and emergency care services – and the impact for providers and people using these services. This was an opportunity to learn from their experiences and understand common pressures across systems, as well as sharing experience of what initiatives might work to alleviate pressures.

We know that many people end up in an emergency department when they could be better served in other parts of their local health and social care system. Keeping people away from emergency departments and out of hospital – unless it is the best place to meet their needs – was the focus of many examples from senior leaders and specialists. Some spoke about the tension created among staff when emergency departments were at capacity, but ambulances needed to leave to respond to other emergency calls.

There were some success stories, and specialists explored innovative models and ideas. One of these was an initiative where the ambulance service provided cars to enable mental health practitioners to respond to people having a mental health crisis rather than dispatching an ambulance. The event also explored solutions to the barriers to improving care, such as insufficient integration across systems leading to lost opportunities to make sure people get the care they need without ending up in hospital.

Through our regulation, we have seen evidence of providers taking other steps to address the pressures described above. For example, some ambulance providers have a hospital ambulance liaison officer (HALO) based in the emergency department who works with ambulance crews and hospital staff to enable a smooth handover and reduce the time that an ambulance spends at the emergency department.

Less pressure on ambulances and a faster response to falls

The private ambulance provider Cornwall Ambulance Service Limited introduced an urgent falls response team This alleviates pressure on the NHS emergency ambulance service and meets the needs of patients who do not need an emergency ambulance, but are not suitable for routine patient transport services. The urgent response falls car had attended over 1,300 patients from March 2022 to March 2023.

One of the commitments set out in the NHS Long Term Plan was a new NHS offer of urgent community response to boost 'out-of-hospital' care, and therefore release pressure on secondary care, including ambulance and urgent and emergency care. This support aims to meet patients' urgent care needs at home with a view to improving patient outcomes, preventing avoidable hospital admissions and delivering NHS strategic priorities.

A key component of this commitment is the achievement of a 2-hour urgent community response standard. This response is delivered by a community-based service, typically provided by a multidisciplinary team, to adults with an urgent care need in their usual place of residence, and involves an assessment and short-term intervention.

It is encouraging to see an increase in the number of care contacts delivered by urgent community response support within the 2-hour target following an urgent referral from a GP, NHS 111 or elsewhere. Between April 2022 and March 2024, the number of urgent community response referrals in scope of the 2-hour standard increased by over 3 times – from 17,520 to 54,715. Performance against the response time standard of reaching 70% in 2 hours has improved from 79% in April 2022 to 84% in March 2024.

Reducing the number of admissions to an emergency department

Approaches to reduce ambulance callouts and admissions to an emergency department are being developed. These include the Norfolk & Waveney Unscheduled Care Coordination Hub, made up of multidisciplinary teams from the local health system, which aims to ensure patients get the right care, in the right place, whenever they need it.

If someone calls 999, but they do not necessarily need the skills of a trained paramedic, they are reviewed by the Hub, who then works out what service would be best and facilitates the right response. This could be a 2-hour urgent community response visit to help someone up after a fall, or an out-of-hours GP appointment.

Some people will still need to see a specialist at a hospital, but rather than getting there through the emergency department, the Hub can arrange for them to go in a planned way, with support, freeing-up ambulances to respond to those with more urgent needs.

Increasing pressure on urgent and emergency services

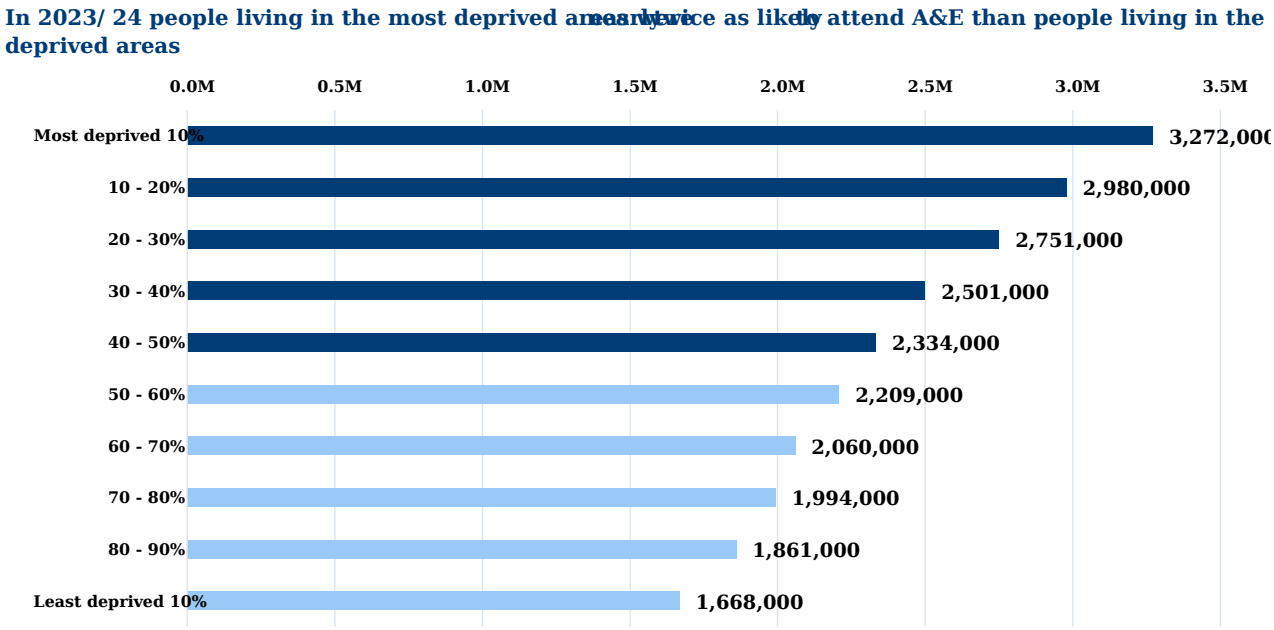
The 3 main types of urgent and emergency care services in England are:

- type 1 – consultant-led 24-hour emergency departments with full resuscitation facilities and patient accommodation (also referred to as accident and emergency (A&E) or casualty)
- type 2 – consultant-led single service facilities for specific conditions, for example eye conditions or dental problems and patient accommodation.
- type 3 – GP-led urgent treatment centres, also called minor injury units.

In 2023/24, the total number of attendances for all types of urgent and emergency services rose by 4% compared with the previous year, increasing from 25.4 million in 2022/23 to 26.3 million. The greatest increase in attendance was seen in type 2 and type 3 services, which both saw increases of 7%. Attendances in type 1 units only increased by 2% in the same period. The pressure on services has continued to increase in 2024, with levels of attendances across all service types 7% higher from April to June 2024 than the same months last year, suggesting pressure remained high on urgent and emergency care services going into the summer.

The level of demand for urgent and emergency care services continues to vary across England. In 2023/24, attendance rates for people living in the most deprived areas were nearly double those in the least deprived areas (figure 11). As we raised in last year's State of Care, and highlight in the section on primary care, we are concerned that these figures suggest people in deprived areas may be more likely to end up in hospital because they can't get the help they need, early enough, in the community.

Figure 11: Number of attendances at urgent and emergency care services by deprivation, 2023/24

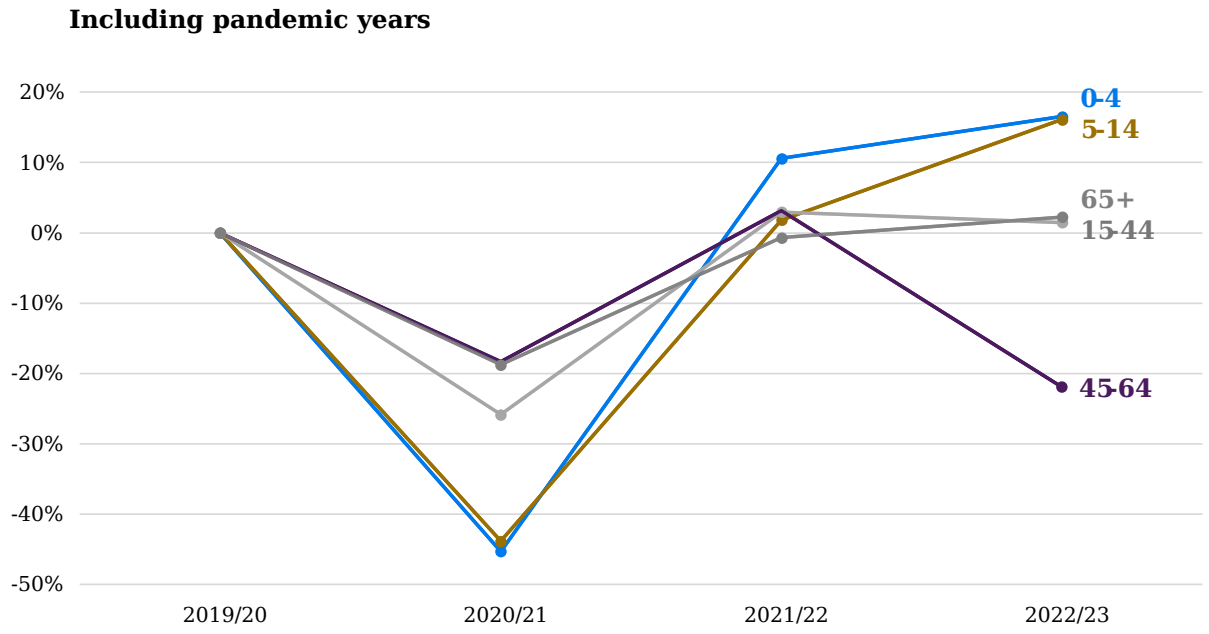


Source: NHS England, Hospital Accident & Emergency Activity

Levels of demand also vary across age groups. In 2022/23, we saw that attendance rates at urgent and emergency care services for children in the age groups 0 to 4 and 5 to 14 years had increased, compared with 2019/20.

In 2023/24, attendance rates for children aged 0 to 4 years had reduced, while rates for the groups aged 15 and over increased. Attendance rates for all these age groups are now approximately 9 to 12% higher than they were in 2019/20. Attendances at emergency departments have remained higher for children aged 5 to 14 years, at 18% above their 2019/20 level (figure 12).

Figure 12: Percentage change of attendance by age category in urgent and emergency care services compared with 2019/20



Source: NHS England, Hospital Accident & Emergency Activity

Waiting too long for urgent and emergency care

Once people have arrived at an urgent and emergency care service, it is important for their safety and health outcomes that they are seen promptly. Delays in getting care in urgent and emergency care services have been linked with increased mortality and illness. For example, a 2021 study looked at the effect of delays in admitting people from an emergency department on patient outcomes; this showed an 8% increased risk of death within 30 days for people who waited for more than 6 to 8 hours.

The NHS Constitution pledges that people should wait no longer than 4 hours from arrival to admission, transfer or discharge in urgent and emergency services. In 2010, operational standards stated that at least 95% of patients should be seen within 4 hours. Due to ongoing pressures, NHS England reduced this to a temporary standard of 76% in December 2022, which was to be met by March 2024. The current objective is that by March 2025, 78% of patients will be seen within 4 hours.

However, the number of people waiting less than 4 hours to be either admitted, transferred or discharged continues to remain below these targets. Across all types of urgent and emergency services, during 2023/24 performance was closest to the standard in April 2023 at 74.6%, and lowest in December 2023 at 69.5%. Performance had improved slightly as at June 2024 to 74.6%.

Type 1 services (emergency departments) tend to have the poorest performance for waiting times. In December 2023, only 54.7% of people attending an emergency department were seen within the 4-hour target. This means that in December 2023, there were over 627,000 people waiting for over 4 hours in a department for a decision to be made about their care. Again, this varied depending where in the country people lived.

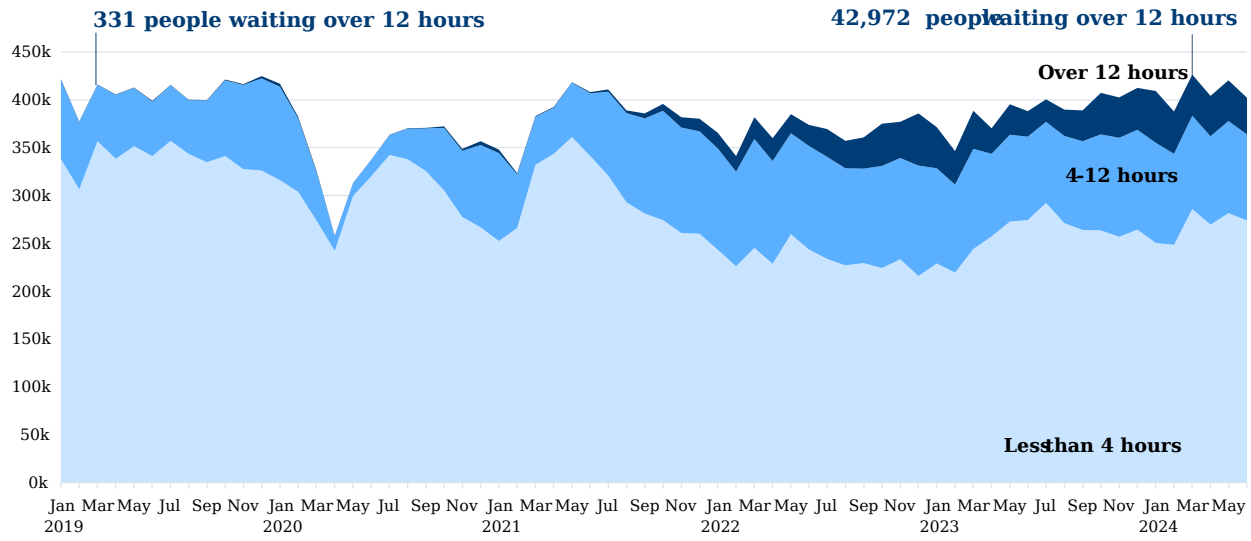
As highlighted in our section on mental health care, research by the Strategy Unit shows that long waiting times are a particular concern for people presenting with mental health issues, with the average emergency department 'pathway' almost an hour longer for mental health patients.

Our analysis of a sample of urgent and emergency care inspections found that challenges for the workforce, including low staffing levels and inadequate levels of core training, is a contributing factor to emergency services being overstretched. Some services did not have enough medical staff to keep people safe. Some inspection reports also described a high degree of risk around burnout and overloading of staff due to the high numbers of patients attending the emergency department. This is supported by the findings of the NHS staff survey, where 30% of respondents said they felt burnt out because of work.

Once the decision is made to admit a patient to hospital, it is important that the resulting action is taken quickly. Not acting quickly enough can increase the risk to patients. The proportion of people attending all urgent and emergency care services who wait over 12 hours from a decision to admit to being admitted indicates how quickly hospitals are able to act. This measure is sometimes referred to as 'trolley waits' and can indicate an inability to admit patients who need care in the hospital. Again, this is a particular concern for people presenting with mental health issues, including children and young people – see the section on mental health.

Since 2019/20, the number of emergency admissions has grown more slowly, at less than 0.1%, than the number of attendances, which has grown at 5%. However, the number of people waiting more than 12 hours from decision to admit to admission has increased sizeably over pre-pandemic levels: in March 2024, nearly 43,000 people (over 10% of people admitted) were waiting more than 12 hours to be admitted to hospital, compared with around 330 (under 0.1%) people who waited this long in March 2019 (figure 13).

Figure 13: All emergency admissions to hospital from urgent and emergency services and time taken from decision to admit, January 2019 to June 2024



Source: NHS England, A&E Attendances and Emergency Admissions

More worryingly, the Royal College of Emergency Medicine (RCEM) has described the 12-hour decision to admit metric as the 'tip of the iceberg', which does not capture the true extent of delays for patients. The RCEM recommended looking at how many people wait longer than 12 hours from the time of arrival rather than the decision to admit.

Using the time of arrival as a measure shows that too many people are waiting too long in emergency departments to be seen, have a decision about their care, and then be admitted. In January 2024, over 174,000 people attending an emergency department waited over 12 hours from their time of arrival. This is over 3 times higher than the number of people waiting 12 hours from a decision to admit to actually being admitted.

The stark difference in numbers highlights that considerably more people are waiting a very long time from arriving in the emergency department before a decision is made about their care, which undoubtedly has a negative effect on their experiences and outcomes. Several people described the impact of long waits in an emergency department through our Give feedback on care service:

> "I was taken to [the emergency department] by ambulance with a clostridium difficile

> infection and severe dehydration. I was extremely unwell. I was put in a cubicle where I stayed for 26 hours. I was on a trolley as I was not allowed a bed as I was not supposed to be there for that length of time."

> "My 95-year-old Aunt was admitted by ambulance this morning after a fall at home... When we got there at 1pm she had not been seen by a doctor and was on a trolley. When we had to leave at 5pm she was in a corridor on a trolley and not once had she been given a drink or anything to eat or asked about her medication that she needs to take (it was left behind by the ambulance staff). She still had not seen a doctor. She desperately wanted to use the toilet, but despite us asking numerous nurses no-one came to her assistance."

> "My [89-year-old] mum was admitted to A&E ... she was seen by the doctor and was informed that she needed to be admitted to a ward in the hospital. I was informed that there was not a bed within the hospital, she was moved into a corridor by the A&E. She was on a trolley in the corridor for 2 days with a nurse looking after 18 patients within the same area... my mum has now a grade 2 pressure ulcer."

These experiences are supported by findings from our inspections of urgent and emergency care services, which have found issues around delays and access frequently reported. An analysis of a sample of our inspection reports identified themes around crowded waiting areas. This led to delays in people being triaged, as well as long waiting times for referral to treatment and arrangements to admit. Delays in accessing services also meant that patients who exhibited signs of deterioration (such as sepsis) were not always seen quickly enough by qualified clinicians. Some inspection reports also described delays in discharge, where patients remained in emergency departments for long periods, due to issues around capacity.

We can also identify changes in the level of demand for services by looking at the proportion of emergency admissions to hospital. In 2023/24, we have seen a small increase in the percentage of attendances at type 1 services (emergency departments) that result in admissions. March 2024 saw the highest numbers of emergency admissions through this route in over 5 years. The increases in attendance and admission figures, while not huge at a national level and compared with the more level long-term trend, are signs of continued pressure on an already stretched part of the system.

Despite all these pressures, evidence from our urgent and emergency care inspections has highlighted how people who used the services, their relatives and carers, said staff had treated them with kindness, dignity and compassion, listening to them, considering their individual needs and offering emotional support when needed. Patients often recognised that staff worked hard to care for patients, despite being extremely busy and having to work in difficult environments.

Hospitals running at capacity

The long delays in urgent and emergency care services have many causes, with pressure on other parts of hospitals and the wider health and social care system contributing to this. This is often talked of in terms of 'flow'.

When hospital beds are available, patients who need to be admitted can be moved out of an emergency department to where they can receive the care they need. NHS England's data on bed occupancy shows that the number of overnight beds in general and acute hospital settings (where patients from the emergency department would often be admitted) has reduced over the long term, from an average of around 109,000 in 2010/11 to around 104,000 in 2023/24.

Compared with other nations, the UK has a very low total number of hospital beds relative to its population. In OECD (Organisation for Economic Co-operation and Development) EU nations, there is an average of 5 beds for every 1,000 people, but in the UK, this is just 2.4 beds.

The number of overnight beds and the level of occupancy is one of the factors affecting flow through a hospital. There are other factors, but in general, high levels of occupancy means that flow is more likely to be restricted. Many of these beds are taken up by people who do not need to be in hospital, but whose discharge has been delayed (see section on discharge delays). Since the beginning of 2022, more than 1 in 10 occupied beds are being used by someone whose discharge was delayed.

While bed occupancy reduced during the pandemic, it has since increased and has remained consistently very close to or above 90% for general and acute beds for the past 2 years. The bed occupancy rate in March 2024 was consistently high across all regions in England, with most integrated care systems (ICSs) reporting occupancy rates exceeding safe levels (above 90%). This varied across ICS areas from 89.9% to 98%.

Bed occupancy is closely related to the length of stay in hospital beds, with longer stays meaning fewer beds available for people. The number of patients staying for 7 or more days increased from around 34,000 (43%) in April 2021 to a peak of around 50,000 (53%) in January 2023. This has reduced slightly during 2023 and into 2024, but is still around 50% on average. The picture is very similar for patients with stays of 14 or more days and 21 or more days, which also saw an increase both in absolute numbers and as a percentage of occupied beds.

Delayed discharges

Delayed discharges are when a person has not been discharged from hospital despite being assessed as being medically fit to leave. While most people admitted to a hospital will be discharged home without any additional support, some may need support from homecare (domiciliary) services, a short-term bed, rehabilitation or a permanent bed in a care home.

As highlighted in our section Spotlight on intermediate care, when intermediate care works well, it can improve flow and discharge from acute and community hospitals, as well as free-up NHS hospital capacity for those who need it most.

However, discharges are often delayed because of internal processes, for example waiting for pharmacy, a diagnostic test or a therapy assessment or treatment, as well as a lack of capacity in adult social care.

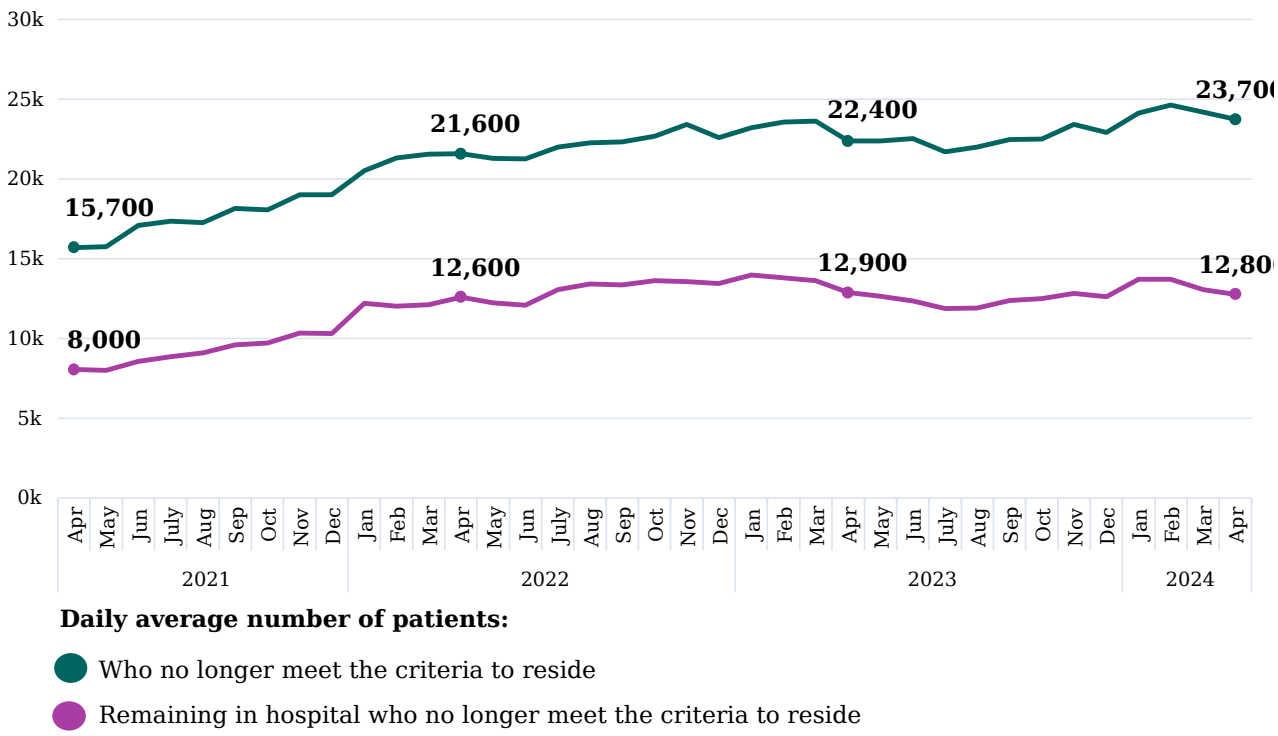
Respondents to the 2022 NHS Adult inpatient survey described challenges around being discharged, including having to wait a long time before all the relevant paperwork and processes were completed, which made the discharge seem poorly organised.

> "...on the 2 occasions I was hospitalised I was told I was being discharged, but it took until the early evening before I received the drugs to take home and the discharge letter."

> "Discharge was poorly handled. Discharge was confirmed at around 8am but paperwork including doctor's signature, physiotherapist comments and pharmacologist information was not completed until 6pm. This also happened for 2 other patients in my ward."

Figures from NHS England show the average number of people discharged from hospital each day increased by 43% between April 2021 and April 2024 from 15,700 to 23,700. However, the number of people ready to be discharged but whose discharge was delayed increased by 59% over the same period, rising from a daily average of 8,000 to 12,800 people (figure 14).

Figure 14: Average daily number of people ready for discharge and of those, the number whose discharge was delayed, April 2021 to 2024



Source: NHS England

Delayed discharges can have a significant impact on people. Longer stays (3 weeks or more) are associated with an increased risk of hospital-acquired infections. There is also an increased risk of people losing mobility and/or cognitive function, which makes it harder for them to regain their independence after leaving hospital and increases their need for care. A quick discharge when patients are medically fit and have an appropriate place to go not only improves flow, but also helps minimise how much people deteriorate, which can make it harder to return to their home or other previous setting.

In the section on 'Waiting for adult social care', we highlight how waits for care home beds and home-based care remain key reasons for delayed discharges. The proportion of delayed discharges attributed to these reasons, for patients who stayed in hospital for 14 days or longer, has increased since April 2021 (figure 4). Lack of community care provision, such as reablement facilities, has also contributed to delays in discharge from hospital (see section on Spotlight on intermediate care).

But, at the same time, many people described feeling that they had been discharged too early, which in some cases had led to them being readmitted to the same hospital, or seeking help from other care providers such as GPs and emergency departments. In some cases, we heard how pressure to free up beds had led people to be discharged without the right support in place. We raised the issue of the increasing pressure to discharge people from hospital and discharging people too early in last year's State of Care, but results from the 2022 NHS Adult inpatient survey show that people continue to report negative experiences of discharge:

> "The discharge process was shocking. The nurses were desperate for the bed. They did not contact social worker to put care in place. They confirmed with family only. Council advised proper process not followed."

> "I felt I was discharged too early after the major surgery. I was discharged the next day but was expecting to stay for 2 more days. I lived alone and did not have any help from social services."

Long waits for care

Waits for diagnostic tests

The pressure being felt in emergency departments as the 'front door' of hospitals can also be seen in other parts of the system. One such area is the long waits for people who need diagnostic tests in secondary care after being referred by their GP. As at March 2024, around 1.62 million people were waiting for a diagnostic test or procedure.

The NHS Constitution sets out that people should wait less than 6 weeks from the point at which the referral is made. However, data from NHS England shows that in March 2024, over 354,000 people (22%) in England waited more than 6 weeks for a diagnostic test or procedure and around 118,000 people (7%) waited more than 13 weeks from the point of referral.

As this is often the first stage in a journey towards treatment, delays after a referral mean people can wait a long time before their concerns are addressed. A delay is not only stressful – it means that people do not get the diagnoses they need within the right timeframe, delaying their treatment and potentially leading to their condition becoming worse and risking poorer outcomes.

This is supported by a recent survey by the Patients Association, which found that of the 1,000 people who responded, nearly 1 in 5 (17%) said their long-term recovery was set back significantly because of delays in diagnostic tests. Many more reported consequences for their mental and physical health, and their wider work and family life, as is illustrated by David's story.

David's story

David is 60 years old and had always been generally healthy and a keen runner. In September 2021, David visited his GP because he was getting back pain. Despite being prescribed painkillers, the pain kept getting worse, leaving him unable to run and keep fit. An X-ray in May 2022 showed multiple historic rib fractures, but to David's knowledge he had never fractured his ribs. As part of ongoing investigations, the doctor sent David for an MRI scan, but the waiting list was 52 weeks long.

By this point, David was taking time off work sick because the pain was getting so bad. He started ringing the MRI clinic daily to see if there were any cancellations and finally got an MRI scan booked in for October 2022. Before this, in August 2022 while waiting for the MRI scan, David requested a blood test from his doctor because he was concerned about the painkillers and the effect they were having on him. The blood tests revealed David had multiple myeloma (a type of bone marrow cancer), which had significantly affected his spine and ribs. David was admitted to hospital where a bone marrow test confirmed this diagnosis. Two days after being discharged from hospital, David went to A&E as the pain in his spine had become so unbearable. Eventually, he had an MRI scan in October 2022, which showed multiple fractures and a wedge collapse. David feels that a lot of the spinal issues would have been detected a lot earlier if the MRI had been done sooner.

(Interview with a member of the public)

Waiting lists for diagnostic tests are getting bigger. In total, the number of people on a waiting list for an NHS diagnostic test or procedure has increased by 52% between March 2019 to March 2024. But, as with other areas of care, the level of increase depends on where in the country people live. While all regions in England have seen an increase, some are larger than others and the size of waiting lists still varies across the country. As at March 2024, 30% of people on the diagnostic waiting list in the East of England region were waiting more than 6 weeks for a diagnostic test or procedure, while in the North East and Yorkshire region, only 17% of people on the list waited more than 6 weeks.

The size of waiting lists also varies depending on what type of diagnostic test is needed. Tests are split into 3 main categories:

- imaging (such as MRI and CT scans)
- physiological measures (such as audiology assessments)

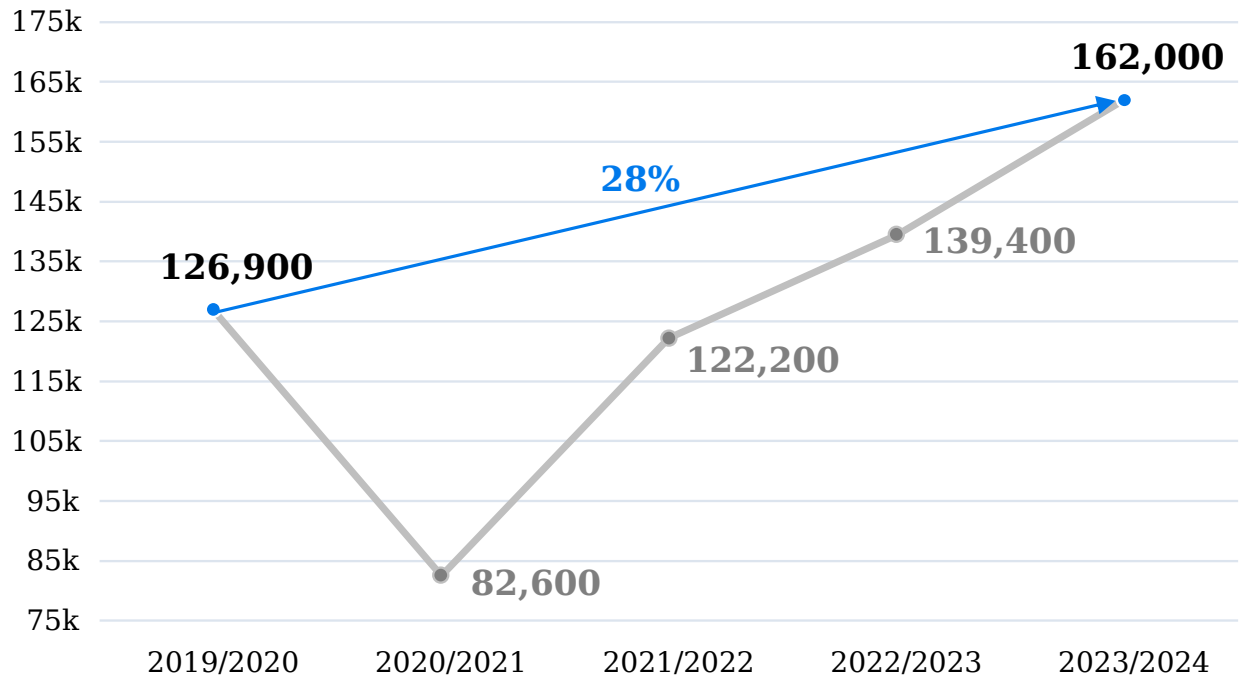
- endoscopy (such as colonoscopy).

More than two thirds of people on the diagnostic waiting list are waiting for an imaging test, with around 190,000 people (17%) in England waiting more than 6 weeks, and around 48,000 people (4%) waiting more than 13 weeks.The waiting list for diagnostic imaging examinations increased by 42% between March 2019 and March 2024 (rising from 784,000 to 1.11 million), with waiting lists in March 2024 varying from around 92,000 to around 220,000 across the regions.

One potential reason for the long waits is the shortage of diagnostics staff, as the numbers of staff in the NHS workforce has not kept pace with rising demand for tests. There are significant vacancies across all specialities. For example, in 2020, the Independent Review of Diagnostic Services for NHS England estimated that 3,500 extra radiographers would be needed by 2025.

Delays in getting NHS diagnostic tests are leading people to seek help elsewhere. Use of private diagnostics services have continued to increase since 2020/21, in line with the increased demand and waiting times for NHS diagnostics. This has continued to rise and is now almost a third higher in 2023/24 (162,000), than 2019/20 (127,000) (figure 15).

Figure 15: Use of private diagnostic procedures 2019 to 2024



Source: PHIN, Volume and Length of Stay datasheets

Again, these figures are supported by the findings of the Patients Association survey. This found that 3 in 5 respondents (60%) would be willing to pay to get a test privately if they faced a long wait or if the test they needed was not available on the NHS. This included patients who did not consider themselves to be 'rich', highlighting how important it is for people to get a timely and accurate diagnosis.

Waits for elective care

Once people receive a diagnosis, they are continuing to face long waits to start treatment. In England, 92% of patients should wait no longer than 18 weeks from referral to treatment. However, as highlighted in last year's State of Care, too many people are still waiting too long for planned hospital care. In August 2023, a record 7.7 million people were waiting for care. While this fell to 7.5 million in March 2024, since then the number of people waiting has slowly started to increase again, with 7.6 million waiting in June 2024.

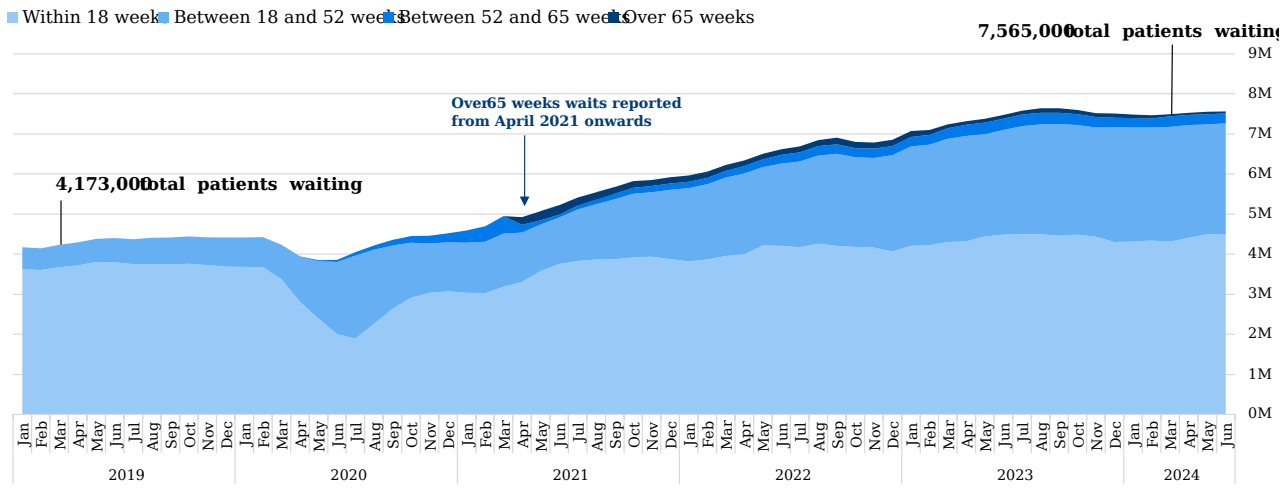
NHS England's Elective Recovery Plan, published in February 2022, set out standards to eliminate waits of:

- over 104 weeks by July 2022
- over 78 weeks by April 2023
- over 65 weeks by March 2024
- over 52 weeks by March 2025.

To support attempts to reduce waiting lists, the previous government made up to £14 billion available to tackle the backlog and speed up discharge. But, despite these measures, performance continues to decline.

Between March 2019 and March 2024, the number of patients waiting for elective treatment increased by almost 80% (from almost 4.2 to just over 7.5 million) (figure 16). Comparing figures from March 2019 with March 2024, there were almost 6 times more patients on the waiting list for longer than 18 weeks, and over 250 times more patients waiting at least 52 weeks.

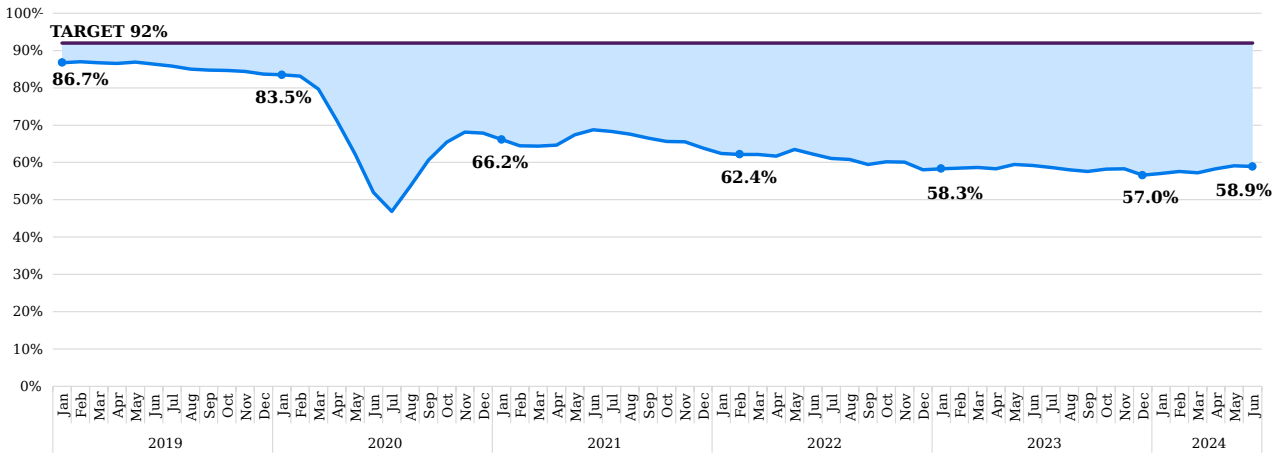
Figure 16: Total number of patients on the elective care waiting list, January 2019 to June 2024



Source: NHS England, Referral to Treatment (RTT) Waiting Times

The standard of 92% of patients waiting less than 18 weeks from referral to treatment has not been met since 2015/16, but this fell particularly sharply during the pandemic and has not recovered. In March 2024, the proportion of people seen within 18 weeks stood at 57% (figure 17). The Recovery Plan's standard of eliminating over 65 week waits by March 2024 was not met either, with nearly 50,000 people having waited over 65 weeks at that time.

Figure 17: Percentage of patients starting treatment within 18 weeks of referral January 2019 to June 2024



Source: NHS England, Referral to Treatment (RTT) Waiting Times

While waiting times for treatment vary significantly by specialty, in March 2024, no specialty achieved the target of treating 92% of patients in less than 18 weeks. The highest proportion of waits over 18 weeks were in the specialties of: ear nose and throat, oral surgery and plastic surgery.

Eleanor's story

We spoke with Eleanor, a 43-year-old mother of two, about her experience of waiting for surgery on her throat.

In October 2021, Eleanor was referred to the emergency department by her GP after presenting with a large bulge on her neck. She described feeling not quite right and finding it difficult to swallow. After urgent blood tests and a scan, Eleanor was told that the bulge in her neck would be removed in 2 to 3 weeks, at which point they would test to see if it was cancer.

By August 2022, Eleanor had not heard anything more, and by this point she could barely breathe, couldn't walk, was struggling to swallow, and found everyday things an effort due to tiredness. She contacted the GP to find out what was happening but was told she would have to speak to the hospital. Despite contacting the hospital on numerous occasions, Eleanor couldn't get through or was told they would ring back. She never received any phone calls back and wasn't given any information about where her case was up to.

Eventually, Eleanor secured an appointment with the Ear, Nose and Throat department at her local hospital after contacting the Patient Advice and Liaison Service (PALS). After this appointment, Eleanor was referred on to another specialist who made the same decision that was made a year earlier in the emergency department – that the growth in her throat would need to be removed. Further blood tests and scans showed the bulge in her throat had grown a further centimetre. This worried Eleanor, as cancer was known to grow, but she had still not been told if it was cancer or not.

Eleanor had the bulge removed in November 2022, a year and 1 month after she had first attended with symptoms. The doctors explained after it had been removed that it had grown so much they were surprised she could still breathe. Eleanor had lived for over a year with the worry it might be cancer, unable to enjoy walking, struggling to eat and swallow, and felt she just wasn't the person she was before.

(Interview with a member of the public)

When looking at how waits have changed over the past 2 years (comparing March 2022 with March 2024), we see the greatest percentage increase in the number of people waiting for:

- respiratory medicine (50%)
- 'other' medical services (37%)
- cardiology services (36%).

The number of people waiting over 18 weeks for these services has grown even more sharply, with all doubling or nearly doubling.

Often, services combine data on waits for children with those for adults. However, we can see some child-specific data under paediatric services. This shows that the number of children on the waiting list has increased by 7% in the past 2 years, with the number waiting more than 18 weeks increasing by 32% over the same period. As highlighted in our section on children and young people's health, delays to treatment for children can have significant consequences.

In last year's State of Care, we stressed how waiting a long time for treatment can have detrimental effects on patients, for example conditions worsening, the need for more complex surgery, increased medication and/or a slower recovery process. It may also lead to more people needing care from their GP or in an emergency.

This is supported by our analysis of free text responses to the 2022 NHS Adult inpatient survey. We analysed responses from a sample of people who reported that their health had become worse while they waited to be admitted to hospital. Some people described suffering physical and emotional pain and stress because of waits and delays. Others described social and economic consequences of waiting. For many, delays and cancellations are an additional trauma on top of their existing issues, as this experience shows:

> "Now, once again, I am on a waiting list [for a gynaecology operation] and I have been on waiting list for 2 years. In the meantime, I continue working with pain. I am a nurse and have worked for the NHS for over 18 years and this is the treatment I get. Recently, due to the increased pain ..., I have not booked more shifts in the hospital. Like me, there are many staff in similar situations."

Cancer care

Macmillan Cancer Care estimates that there are currently more than 3 million people living with cancer in the UK, which it predicts will rise to:

- 3.5 million by 2025
- 4 million by 2030
- 5.3 million by 2040.

With these estimated figures increasing, it is unsurprising that a recent survey of 2,000 people by the University of Cambridge found that cancer is the public's biggest health concern – higher than for any other medical condition, including having a heart attack. People were most worried about late detection of cancer.

In last year's State of Care report, we highlighted concerns about delays for people in getting a GP referral for cancer as well as delays in starting cancer treatment. Analysis of feedback received through our Give feedback on care service shows that access to care – long waits, delays and cancellations – remains the most pressing concern for people.

In October 2023, NHS England revised the standards that cancer waiting times are measured against. There are now 3 waiting time standards that measure performance:

1. **28-day faster diagnosis standard:** people have a diagnosis of cancer or it is ruled out within 28 days of referral (set at 75% and rising to 80% in 2025/26)
2. **31-day treatment standard:** people with cancer start their treatment within 31 days of a decision to treat their cancer (set at 96%)
3. **62-day treatment standard:** people with cancer start their treatment within 62 days of an urgent referral (set at 85%).

Many people who provided feedback through Give feedback on care reported positive experiences, with gratitude towards their GP for taking swift action in following the 2-week cancer pathway. However, delays in receiving a referral and cancer diagnosis were frequently cited, with many people discussing the detrimental effect of this on their health and wellbeing. For example, some people discussed having gone to their GP with symptoms or concerns for suspected cancer, but that their GP had dismissed their concerns across several consultations. In some instances, this dismissal had led to the person's cancer being diagnosed later and spreading.

> "I ended up with stage 3 cancer at the age of 24 because of them ignoring my glaringly obvious symptoms for years and have been through hell because of them."

> "This GP failed on diagnosing my wife's cancer despite her regularly raising her concerns. No tests or scans offered to her. Now it's too late she is stage 4 bowel liver and lung cancer."

As with delays in referral, cancer treatment following diagnosis was frequently found to be delayed. People told us that appointments with oncologists and/or secondary care specialists were often cancelled without explanation. People described how timeframes to start cancer treatment were pushed back without explanation, and how treatment cycles were delayed and rescheduled despite the potential risks.

People described how these delays could leave them feeling anxious, and that there was a lack of care, consideration, and support available to them in both managing their wellbeing regarding their cancer diagnosis and limited care or support for them with their cancer treatment.

People's experience of delays is supported by figures from NHS England, which show that the 3 waiting standard measures are not being consistently met, with performance varying considerably between types of cancer and integrated care system (ICS) areas. We found that between July 2022 and June 2024:

- There were improvements in performance against the 28-day faster diagnosis standard, with the standard being met for the first time in February 2024 (78%). While the majority of ICSs have met the target at some point in the past 2 years, only 12 have met the standard for half or more of the time.
- The 31-day standard has not been met nationally in the period we reviewed. Only 10 out of the 42 ICSs met the 31-day standard at least once over the period, and only 4 of those met the standard more than twice.

- Performance against the 62-day standard is poorer than the others, with a national average of 65% since July 2022, 20% below the target. No ICS has met the standard during this period, and this standard has the widest range between the best and poorest performing ICSs, with the best performing at 79% on average, against the worst at 50%.

A picture of variation

As highlighted, the performance of cancer services varied greatly across the 3 waiting standards and depending where in the country people live. In this section, we explore this variation through measures relating to the 4 most common cancers – breast, lung, prostate and colorectal cancer – which make up over 50% of all cancers.

In England, there are 3 different routes of diagnosis for cancer: National Screening Programme, Urgent Suspected Cancer and/or 'Breast Symptomatic but Cancer Not Suspected'. Depending on the type of cancer, people may receive a referral through different routes. Looking at national figures, we can see that performance against the 28-day faster diagnosis standard varies across the 4 cancer types.

Data shows that between January and March 2024, 81% of people with suspected lung cancer and 89% of people with suspected breast cancer received a diagnosis or were given the all clear within the 28-day target.

However, during the same period, performance against the 28-day target was lower for people with other types of cancers – 62% of people with suspected colorectal cancer and 56% of people with suspected prostate cancer received a diagnosis or were given the all clear within the 28-day target.

Meeting the 28-day faster diagnosis standard also varied depending where in the country people lived. For example, for people with suspected lower gastrointestinal cancer referred through the National Screening Programme, 83% received a diagnosis outcome within 28 days in the best performing ICS area, while in the worst performing area, only 14% received a diagnosis outcome within 28 days.

The picture was worse for the 31-day standard. For January to March 2024, across all the most common cancer types, the target of 96% of people with cancer starting their treatment within 31 days of a decision to treat was not met nationally. This varied across the 4 most common cancer types, with rates for lung cancer closer to target than other cancers at 92% (against a target of 96%). However, between January and March 2024, the biggest variation in performance between ICSs was for breast cancer, with the top performing ICS achieving the target 98% of the time, and the lowest only 72%.

Following on from the 31-day standard, again we see that, nationally, none of the 4 most common types of cancer met the standard of 85% of people starting treatment within 62 days of being referred. Performance against this standard varies between the 4 types, with performance for colorectal cancer again the worst at 54%.

Performance between ICSs also varied for the 62-day standard, with prostate cancer having the largest variation between them (93% for the best compared to 24% for the worst).

The stage at which cancer is diagnosed can have a major impact on prognosis – people whose cancers are detected and treated in the early stages have a better 1-year survival than those diagnosed with late (stage 4) cancer. The previous government set an ambition for 75% of all cancers to be diagnosed early (stage 1 and 2) by 2028. As of 2021, 54% were being diagnosed early.

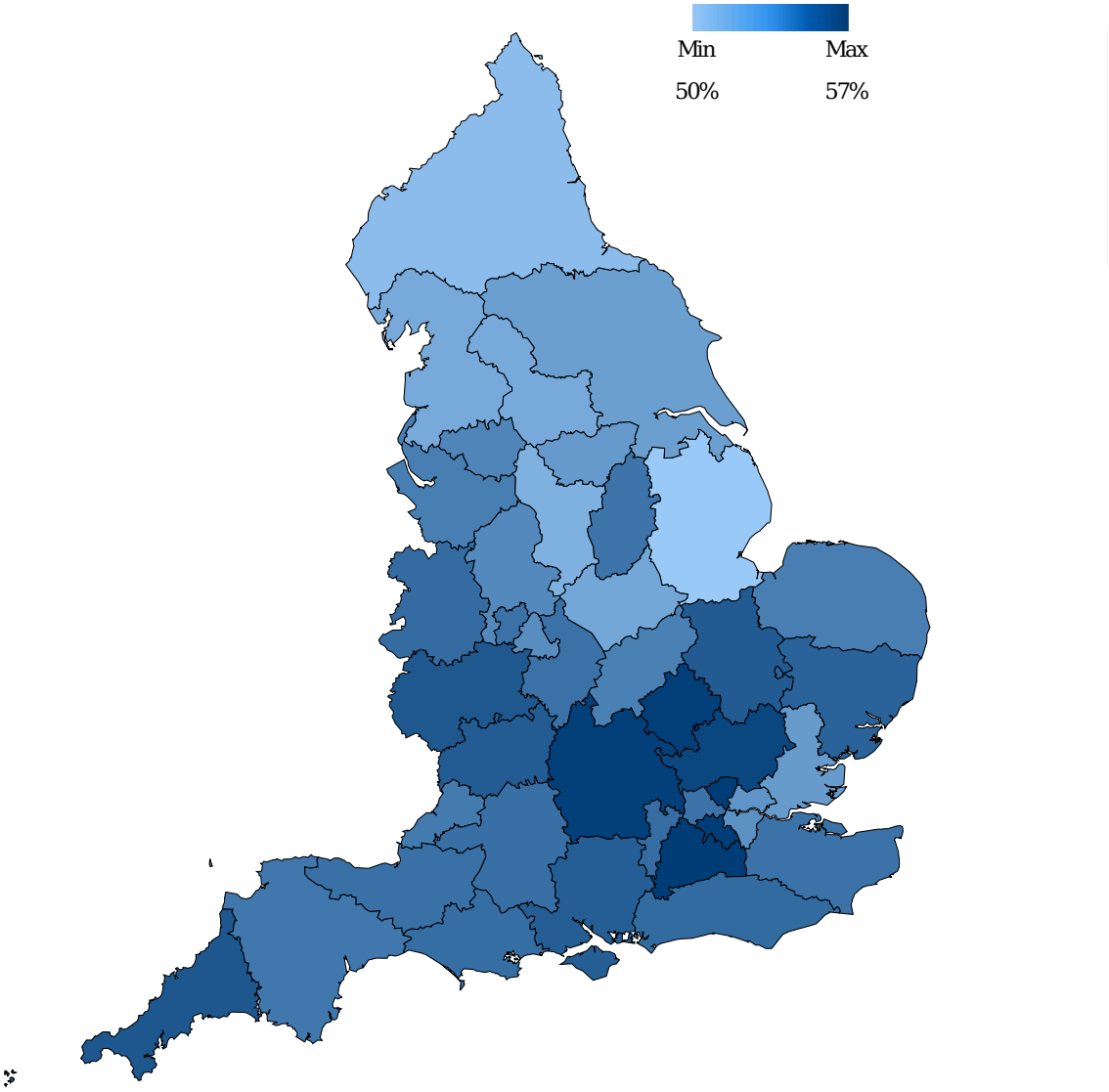
Patients in more deprived areas are more likely to be diagnosed at a later stage. A 2020 report by Cancer Research UK found that over 30,000 extra cases of cancer in the UK each year can be attributed to social and financial deprivation, with survival rates worse for people in the most deprived groups.

As we show in our section on access to GP practice appointments, difficulties in getting an appointment can have adverse impacts on care including cancer screening. Findings from our survey that asked 2,000 adults about their experiences of accessing health and adult social care services shows that access to GPs varies, as people receiving benefits and financial support were more likely to have difficulties with access.

This is supported by recent analysis from the Nuffield Trust, which shows that people living in the least deprived areas have had a consistently higher rate of early cancer diagnosis than those living in the most deprived areas.

Similarly to waiting time standards, the map shows that diagnosis of early stage cancer varies across the country (figure 18).

Figure 18: Percentage of cancer patients diagnosed early (stage 1 and 2) for all cancers, by integrated care system, 2021



Source: NHS England, National Disease Registration Service

Workforce inequalities

In last year's State of Care, we emphasised the importance of having an ethnically diverse workforce that reflects the population it serves – particularly at senior level. This helps to raise awareness of the reality of racism and discrimination, as well as supporting staff to:

- feel equal and represented
- have role models and advocates for progression
- feel able to speak up and raise concerns.

Data on the NHS Workforce Race Equality Standard also shows the vital contribution to the NHS made by staff from ethnic minority groups.

Between March 2018 and March 2023, the proportion of staff from ethnic minority groups increased from 19% to 26%. This upward trend is also reflected at a regional level. Last year, London had the highest proportion of staff from ethnic minority groups at 50%, which has increased to 52% this year. The South West continues to have the lowest proportion at 15%, which is an increase from 13% last year.

However, the 2023 NHS staff survey shows that staff from ethnic minority groups are still considerably more likely to experience discrimination, compared with staff in white ethnic groups. The survey found that they were:

- almost 4 times more likely to experience discrimination from people using services, their relatives or other members of the public in the past 12 months, compared with staff in white groups (19% compared with 4.8%).
- more than twice as likely to have experienced discrimination from a manager, team leader or other colleagues in the last 12 months than staff in white groups (15% compared with 6.7%).

Staff from ethnic minority groups were also noticeably more likely to experience harassment, bullying or abuse, compared with colleagues in white ethnic groups, as the survey found:

- a higher percentage of staff (21%) were harassed, bullied or abused by other colleagues in the last 12 months compared with staff in white groups (16%)

- a higher percentage (28%) were harassed, bullied, or abused by patients, family, or the public than staff in white groups (24%)

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is a set of 10 specific measures for NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

The 2023 NHS staff survey showed that NHS staff with long-term health conditions or illnesses continue to suffer discrimination and have much poorer experiences, compared with staff who do not have such conditions. For staff with a long-lasting health condition or illness:

- 27% said they had felt pressure from their manager to come to work compared with 18% of staff with no such conditions
- 15% said they had experienced harassment, bullying or abuse at work from managers, which was almost twice as high as the proportion of staff with no such conditions
- 24% said they had experienced harassment, bullying or abuse at work from other colleagues, compared with 15% of staff with no such conditions.

An improved and safer use of medicines

Sickle cell disease and access to pain relief

In last year's report, we included a focus on sickle cell disease, which is particularly common in people with African or Caribbean heritage. Knowing that people with sickle cell disease do not always receive high-quality care, we reported on how prepared NHS trusts were to make sure people who experience a sickle cell crisis can access timely and effective pain relief. We found that not all trusts had the right policies to do this, and that there were gaps in the level of knowledge among staff to support people.

This year, we followed up with NHS trusts to understand what progress was being made in this area of risk. We found many had taken actions to make improvements, including:

- reviewing and improving the availability of medicines, providing the most appropriate painkillers and developing a more holistic approach to prescribing
- focusing more on education and awareness, across medical and healthcare staff
- improving policies to support staff, with trusts involving people with experience of sickle cell disease to develop these
- improving collaborative working – for example, one trust was piloting the deployment of community nursing teams to support patients with sickle cell disease in their area, to prevent admissions to hospital.

Although we heard about some excellent examples of improvement, some trusts had a more comprehensive approach to sickle cell pain relief than others. Some non-acute trusts and those in geographical areas with a low proportion of people with sickle cell disease viewed this clinical area as a low priority.

Supporting people who take insulin

Incidents involving insulin are one of the most reported errors in hospitals and can have a significant impact on people's health.

In 2023, we asked chief pharmacists in NHS trusts how their pharmacy teams were supporting patients who take insulin. They told us:

- Electronic prescribing and medicines administration systems have enabled trusts to pre-set safety measures, alert prescribers and nurses of high insulin doses, prioritise high-risk patients, and obtain an accurate list of people's medicines.
- Many trusts had developed bespoke in-house insulin training. One trust had developed a competency framework, which all nurses or staff administering insulin completed.

- Some trusts saw self-administration as an opportunity to support people to gain confidence and maintain independence, and had the potential to avoid incidents. One trust had developed specific self-administration roles who liaised with ward staff to identify patients who would benefit. This had released time for nurses and reduced the workload on district nurses when people were discharged back into the community.

Environmental sustainability

Medicines account for about 25% of emissions within the NHS in England. A small number of medicines account for a substantial proportion of these, particularly gases and nitrous oxide, and asthma inhalers.

We have carried out research through the Regulators' Pioneer Fund to improve our understanding of how health and social care services are improving the environmentally sustainable use of medicines, while improving people's care.

The NHS has committed to reaching Net Zero by 2045.One way hospitals are tackling this is reducing the carbon impact of 2 gases – nitrous oxide and desflurane.

In maternity wards, new equipment is being used to convert nitrous oxide from exhaled air into harmless gases. This has ensured that patients continue to have access to long-established and safe pain-relief in labour, while reducing exposure for staff and protecting the environment by reducing greenhouse gas emissions.

NHS trusts have also reduced or eliminated the use of desflurane – one of the most environmentally harmful anesthetic gases – replacing it with an alternative equally effective anaesthesia. This provides effective patient care while offering large carbon savings.

In general practice, the 2022/23 Investment and Impact Fund took important steps to improve people's respiratory care and, at the same time, reduce the carbon footprint by prescribing lower carbon asthma inhalers and optimising medicines treatment regimes.

Other initiatives include specialist teams of pharmacists and pharmacy technicians working with people living in care homes, their families and care home staff to review people's medicines. This improved outcomes for people by reducing the risk of side-effects, as well as reducing wastage and ultimately reducing the carbon footprint.