

Public Accounts Committee

Oral evidence: Access to emergency and urgent care, HC 1336.

Monday 3 July 2023

Ordered by the House of Commons to be published on 3 July 2023.

[Watch the meeting](#)

Members present: Dame Meg Hillier (Chair); Sir Geoffrey Clifton-Brown; Mr Jonathan Djanogly; Mrs Flick Drummond; Mr Mark Francois; Peter Grant; Ben Lake; Sarah Olney; Nick Smith.

Gareth Davies, Comptroller & Auditor General, National Audit Office, Ashley McDougall, Director, National Audit Office, and David Fairbrother, Treasury Officer of Accounts, were in attendance.

Questions 1 - 135

Witnesses

I. Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; Matthew Style, Director General for NHS Policy and Performance, Department of Health and Social Care; Amanda Pritchard, Chief Executive, NHS England; Professor Sir Stephen Powis, National Medical Director, NHS England; Sarah-Jane Marsh, National Director of Urgent and Emergency Care, and Deputy Chief Operating Officer, NHS England.

Report by the Comptroller and Auditor General

Access to unplanned or urgent care (HC 1511)

Examination of witnesses

Witnesses: Sir Chris Wormald, Matthew Style, Amanda Pritchard, Professor Sir Stephen Powis and Sarah-Jane Marsh.

Q1 Chair: Welcome to the Public Accounts Committee on Monday 3 July 2023. We are here today to talk about the very important issue of access to urgent and emergency care.

The National Audit Office has helpfully delved into this subject, and we know all the reasons why people may seek urgent and emergency care through the various routes available. There has been a lot of publicity over a number of years about the severe strain on this part of the National Health Service, which is particularly related to the discharge of patients who are well enough to leave hospital but who perhaps have nowhere to go and the impact of that on the overall system.

In March this year, our Committee reported that, in the first year of the NHS's three-year plan to recover its services, it was already falling short. We already have a big backlog of cases as well as this issue with emergency care. We want to delve into this in more detail. Since the NAO published its Report, NHS England has published its workforce plan, which we will weave into this hearing. We will not ask specific questions at the top, but we will be asking questions about that important plan and document as we go.

I would like to welcome our witnesses. We have Sir Chris Wormald, who is the Permanent Secretary at the Department of Health and Social Care, and he is joined by, from the Department, Matthew Style, who is the director general for NHS policy and performance. Amanda Pritchard is the chief executive of NHS England, and she is joined by Professor Sir Stephen Powis, who is the national medical director for NHS England, and a first-time visitor to the Committee, Sarah-Jane Marsh, who is the national director of urgent and emergency care and the deputy chief operating officer of NHS England. You just have a little bit on your plate there, Ms Marsh. Welcome to you all.

I want to kick off by summarising the headlines of this Report. We have seen an increase in staff in some places, emergency doctors particularly, an increase in waiting times, an increase in demand and a drop in productivity overall. Perhaps I will start with you, Ms Pritchard. With investment going in, why are we still seeing a drop in productivity as the long-term trend?

Amanda Pritchard: It is great to be here with the Committee today. You are right: this is a really important topic for us to be discussing. Going



HOUSE OF COMMONS

straight into the question you have just asked, it is worth saying that, over not just the period of the pandemic but since then, we have seen record levels of pressure on the NHS.

We have seen by far and away the worst winter I can recollect in 25 years of working for the NHS, but certainly that has not stopped with winter. We have just had the busiest May for A&E attendances ever, and we continue to see pressure not just on urgent and emergency care in hospitals but on GPs as well. We have just completed 12 months where we have seen 30 million more appointments in primary care than pre-pandemic. That is just another indication of the level of demand there is in the system at the moment. The levels of demand are outstripping anything we have had before.

The second point worth mentioning is that we also have a population that is older, more complex and generally also sicker.

Q2 Chair: To be fair, the population has been older and more complex for some time. It has not happened recently.

Amanda Pritchard: No, you are absolutely right. That is a trend that is continuing. Of course, that trend does continue. What that has led to, very clearly, is an impact on the length of time people are in hospital. Some of that is to do with the difficulty in always getting people discharged in the right place at the right time, but some of it is also a reflection of the level of complexity, particularly due to the age profile of the patients who are in hospitals at the moment.

I am sure Steve can say more about that, if that is helpful, but, to bring that to life for the Committee, versus pre-pandemic, every day there are almost 3,000 people in hospital who have been there more than 14 days. That is a significant additional length of stay that we are seeing for patients in hospitals.

The third thing worth saying is that Covid has not ended. It is nothing like the peaks of acute pressure we saw back in 2020-21, but nonetheless even today about 1,000 people are in hospital with Covid. Some of them would have been there anyway, but even those who are in hospital and who might have otherwise been there are more complex. They require particular care to be taken around things like infection control to make sure they are well looked after.

The other impact of Covid that we still have is on our staff. I know we are going to talk a bit about staffing as we go through today, hopefully, but I am sure you will have picked up that we are seeing higher levels of sickness from our staff than pre-Covid. Some of that is particularly in mental health conditions and anxiety. Some of it is directly related to what people have been through over what was an extraordinarily difficult few years. Some of it is also respiratory conditions, one of which is Covid. That continues to have a direct impact on our staff.



HOUSE OF COMMONS

I have already mentioned discharge and flow. A lot of the challenges that we are going to talk about today are about flow.

Chair: We are going to come on to a lot of this.

Amanda Pritchard: Net-net, the NHS is dealing with an awful lot. You are absolutely right. We have had welcome support, particularly now with the support for the workforce plan, which gives hope that we now have a line of sight to a sustainable future staffing model for the NHS, for staff now as well as for those joining us in the future.

We are improving. The final point to make on your productivity challenge is that we are certainly not in a position where we are just observing these challenges. We are absolutely actively addressing them. That is part of what was behind the publication of the urgent and emergency care plan back in January and some of the sustained improvement we have seen since then.

Chair: We might have some discussion about that improvement.

Q3 **Mr Francois:** Ms Pritchard, welcome back to you and your team. You just mentioned the workforce plan, which is highly topical. It was published on Friday. In fact, the Secretary of State is one minute into his statement about it in the House of Commons downstairs in the main Chamber.

It is an impressive document. It is 135 pages long. There is a tremendous amount of detail in here except when it comes to finance. There is one paragraph about how it is going to be afforded, which is paragraph 30, and a few bullet points on page 18. How are we going to pay for this?

Amanda Pritchard: That is a question for the Permanent Secretary.

Q4 **Mr Francois:** You can give it to him, but you are the chief executive of NHS England and you have to execute it. You can start.

Amanda Pritchard: We were absolutely delighted that the Government were clear that they were giving wholehearted backing to the *NHS Long Term Workforce Plan*. Certainly, the Chancellor, the Prime Minister and the Secretary of State have all been clear that that is new money that would be going in. In particular, it provides full funding for the first five years of education and training place expansion. For example, that will allow us to go from currently training 7,500 undergraduate medical students to 10,000 by the time we get to 2028 and 15,000 by the end of this period.

Q5 **Mr Francois:** Apologies for interrupting. When you say "new money", the current NHS budget for England is a bit over £152 billion, from memory. That is over three times the defence budget. You are saying that the money for this plan is going to be over and above that total.

Amanda Pritchard: Yes, that is correct.

Q6 **Mr Francois:** When does that money start to kick in?



HOUSE OF COMMONS

Amanda Pritchard: It is phased over the next few years. Professor Powis will talk about why that is important. In part, that is because we are trying to make sure that, as we bring on additional capacity, most of which is in higher education institutions, we can back that up by having the right clinical education support in hospitals, primary care and other locations in the NHS so that people get really good quality from the experience.

Q7 **Mr Francois:** It is a 15-year plan, so how much new money, how much extra money above that which Parliament has already voted on, is it going to cost to deliver this plan over the plan period, which is 15 years?

Amanda Pritchard: The current Government's commitment has been to fund fully the first five years of that plan.

Q8 **Mr Francois:** That is going to be what—£2.4 billion?

Amanda Pritchard: That is correct.

Q9 **Mr Francois:** That comes out at a little under £500 million a year. You are going to deliver that entire plan for under £500 million over the five years, are you?

Amanda Pritchard: Yes, but that money is specifically for the education and training element. As you will know, clearly having read the plan, that is the bit where there is a new significant commitment.

Q10 **Mr Francois:** Forgive me. That is precisely my question. If the education and training element, which is one part of the plan, is £2.4 billion over five years, how much does the rest of it cost?

Amanda Pritchard: The rest of the plan is a combination of reform and retention initiatives. At the moment, retention is being enabled by other Government actions, such as the changes that have been made to pensions arrangements, which allow us to do things we have not been able to do before, particularly around people who would otherwise be thinking about stepping away at the end of their career. For example, we now have a particular scheme to encourage consultants who might otherwise leave completely to consider staying with us to do outpatient appointments.

Chair: This is not answering Mr Francois's question.

Amanda Pritchard: That does not cost us more money, but it is enabled by—

Q11 **Mr Francois:** I do apologise for interrupting. I do not want to appear rude to anyone, but the nature of the beast is that we always have limited time. I am sorry. It is going to be £2.4 billion over five years just for the training piece. This plan is 135 pages; it is not a small or unambitious document. Are you saying that all of those other initiatives in the plan are ultimately going to be revenue-neutral and you can do all of it for a net £2.4 billion over five years. Is that what you are telling us?



HOUSE OF COMMONS

Amanda Pritchard: That is the basis of the calculations that went into the conversations we have been having about the financial support required. There is other support required to allow those other bits to—

Q12 **Chair:** That other support is costly too. It takes time for someone to train someone.

Amanda Pritchard: Yes, quite. There is cost in relation to regulatory changes and parliamentary time to approve some of that. Again, the Permanent Secretary might want to say a bit more about that. There is cost in relation to the time it takes higher education institutions to stand up additional curricula and things like that. In terms of the actual pound per training place, that is where the big money is.

Q13 **Mr Francois:** What is the total cost to the NHS then?

Amanda Pritchard: In direct costs?

Mr Francois: Some people might say that there is a little bit of smoke and mirrors going on here. Perhaps Chris could help us.

Amanda Pritchard: Can I be absolutely clear? The cost to the NHS has been fully backed by Government and it is that £2.4 billion that we have just been talking about. There are other non-financial enablers that are critical to enable us to do the other parts of the plan.

Sir Chris Wormald: The key to your question is the time period. That is what you are getting at, is it not?

Mr Francois: It is both the amount and the time period.

Sir Chris Wormald: From the existing budget of the NHS, the Government have worked out the addition of this plan, which is what is set out in the figures Ms Pritchard has quoted. In future periods there are decisions for the Government to take about what the total size of the NHS budget is, which will need to take account of the consequences of the plan. Those are future decisions for future spending reviews. There is no smoke and mirrors here. The Chancellor was very clear about that.

Q14 **Mr Francois:** It could end up costing a lot more. One of the challenges the NHS and the Department face—we will explore other aspects of this as well—is that your budget keeps going up and up and up. We are already at record peacetime levels of taxation. There must be some point beyond which the taxpayer cannot go.

The reason we are pressing you hard on this—there is a method to it—is that we are a bit concerned that the true cost of this, because it is so ambitious, is going to be far higher and we may get to a point where, as a nation, we simply cannot afford it.

Sir Chris Wormald: The future budgets of DHSC and, indeed, the NHS beyond this spending review are political decisions for the future, which will have to be informed by all the factors you describe. Government and



HOUSE OF COMMONS

my Treasury friends, particularly the Chancellor and the Prime Minister, have to take overall decisions about the overall burden on the taxpayer and the division of that—

- Q15 **Mr Francois:** This will be my last go and then I will hand back to the Chair because lots of colleagues want to ask questions. The Secretary of State, your boss, said on the Ridge programme yesterday that this was new money and it would be formally confirmed in the next “fiscal event”.

Sir Chris Wormald: He was talking about the direct commitments we have made in the plan for the cash for the training. We have been very clear that the future budgets of the NHS, in terms of future spending review periods, would be settled in the normal way and the Government would take decisions at that point on both what they want the total budget of the NHS to be and how they raise whatever that sum is.

If this plan is successful, we get retention levels up, we are less reliant on international recruitment for our NHS, we use fewer agency staff and we work in the reformed way the plan sets out, there are savings as well as costs. What both the Government and then Parliament, should it approve the budget, would want to weigh is the net of all that.

- Q16 **Mr Francois:** Lastly, is there any reference at all anywhere in this document to the cost of the plan beyond five years?

Sir Chris Wormald: No.

Mr Francois: This is a 135-page document.

Sir Chris Wormald: Those are future decisions for the Government, which take account of all the factors we have just discussed, including the ones you set out.

- Q17 **Mr Francois:** That is great from an NHS perspective. From a taxpayer perspective, it is quite worrying.

Sir Chris Wormald: Just to be clear, the Government do spending reviews in the way they do. That is transparent both to Parliament and to the taxpayer. As I say, what the overall burden of taxation and the investment in the NHS should be is debated at the time.

- Q18 **Chair:** The point is that the plan is going to be delivered over 15 years. Mr Francois is spot on.

Sir Chris Wormald: As I say, there are a lot of decisions to be taken, which will define what the NHS budget is.

Chair: If, in extremis, the decision was made not to fund it any further, the plan would not be delivered.

- Q19 **Sir Geoffrey Clifton-Brown:** I have been listening very carefully to Mark Francois’s excellent questions and I am still not clear what the taxpayer is getting for their £2.4 billion. Can we try to find some clarity



HOUSE OF COMMONS

on that? Does that £2.4 billion provide us with a doubling of medical school places by 2031-32?

Sir Chris Wormald: I might leave my NHS colleagues to answer, but, on that one, yes.

Sir Geoffrey Clifton-Brown: Yes is the answer.

Amanda Pritchard: By which date is that?

Q20 **Sir Geoffrey Clifton-Brown:** The plan sets out a doubling of medical school places by 2031-32, so a 100% increase. Does it give us that?

Amanda Pritchard: The funding is until 2028.

Q21 **Sir Geoffrey Clifton-Brown:** So it does not buy us all that.

Amanda Pritchard: That is why I was trying to clarify exactly which date we are talking about. That takes us beyond the funding period we are discussing.

Professor Sir Stephen Powis: There is a 25% increase in medical school places from 7,500 to 10,000 over the first five years.

Sir Geoffrey Clifton-Brown: That is really helpful, Professor.

Q22 **Chair:** Once they have started, they have to continue doing that.

Professor Sir Stephen Powis: Clearly, those 10,000 do. The doubling, which would be up to 15,000, is for the remaining 10 years, subject to additional funding. It would take the education sector five years to build up to that number, which is back to the phasing question. The money will need to be phased because it will require new medical schools and the expansion of existing medical school places in existing medical schools. That does not happen overnight. We need additional trainers and additional educational staff.

That is why, when it comes to medical schools—you could make the same argument for other professions—the £2.4 billion will be loaded towards the back end of those years.

Q23 **Sir Geoffrey Clifton-Brown:** Professor, allied to that answer, does it buy us a near doubling of adult nursing training places by 2031-32?

Professor Sir Stephen Powis: Yes.

Amanda Pritchard: We train roughly 30,000 nurses at the moment. It would take it up to 40,000 by 2028. By the end of the period, which is further on, it would get up to about 54,000.

Q24 **Sir Geoffrey Clifton-Brown:** Does it buy us a 40% increase in dentistry training places?



Amanda Pritchard: The answer is going to be similar to all of these, which is that it is a step by 2028 and then it is a further step beyond that.

Q25 **Sir Geoffrey Clifton-Brown:** In the report, you estimate that, over a 15-year period, without action, there would be a shortfall of 260,000 to 360,000 staff by 2036-37, by the end of the plan. How far do we get into addressing that shortfall?

Amanda Pritchard: That is a calculation across the whole 15 years. Again, because it ramps up and it takes a while to train people, they will be coming through their training over the course of the 15 years. That is why it is so important that the plan also includes the commitment to retention. Over the period, we would seek to retain 130,000 staff in the NHS who we would otherwise lose.

It is also why the commitment to new roles and to skill mix change is so important because some of those training courses are quicker and they allow a multidisciplinary team with the right skills in place to be able to look after patients' needs in the right way and in a different way.

Q26 **Sir Geoffrey Clifton-Brown:** I am not sure I have totally understood the answer to that question, but never mind. I will look at the transcript. Finally, what does it do to help retain and deal with absences and sickness in the existing staff? It is no good having all these lofty targets about new staff if you are not retaining the existing staff.

Amanda Pritchard: Yes, that is the number I just gave you. We anticipate that the retention initiatives that are described in the plan will allow us to retain 130,000 staff in the NHS who would otherwise be leaving us or would be likely to leave us.

Professor Sir Stephen Powis: Would it help if I gave you some more figures for the first five years?

Sir Geoffrey Clifton-Brown: Yes, it would. It would be very helpful.

Professor Sir Stephen Powis: I have talked about medical training places. Nurse training places will grow by over a third to 40,000 a year. Nursing associates will grow by 40% to 7,000 a year. Advanced care practitioners will grow by 46% to over 6,300. Pharmacy training will grow by 29% to 4,300. GP training places will grow from 4,000 to 5,000.

Chair: We have the Report and the figures.

Q27 **Mrs Drummond:** Ms Pritchard, you mentioned sickness and mental health. What impact does that have on productivity? We started off talking about productivity. Do you record it? As we have said, productivity is going down. Where does that fit in?

Amanda Pritchard: I gave you a list of things at the beginning. Clearly, we have seen the ongoing impact of Covid on our staff. Some of that is physical health, but some of it is also clearly linked to mental health.



HOUSE OF COMMONS

Sickness has gone up. That is one of the reasons we have continued to support things like the mental health hubs for staff as well as all of the local initiatives that are in place to support staff. That is recognised globally as one of the things that happened post-pandemic. Any reason for staff being off sick will clearly have an impact on their ability to care for patients.

Q28 **Mrs Drummond:** Do you have a percentage figure for how much that is affecting productivity, so that we can see what other aspects are impacting on productivity?

Amanda Pritchard: I can come back to you with a specific breakdown of the contributors to staff sickness, if that is helpful. That, musculoskeletal conditions and respiratory illnesses are the three biggest reasons for staff sickness. I can come back with a breakdown, if that is helpful.

Q29 **Mrs Drummond:** From the mental health angle, is that a massive issue as well?

Amanda Pritchard: Yes, those are the three big reasons staff tend to be off sick: mental health, musculoskeletal conditions and respiratory conditions.

Q30 **Mrs Drummond:** It would be great to have a breakdown so we can see what impact that is having.

Amanda Pritchard: Yes, of course.

Q31 **Nick Smith:** Ms Pritchard, I was really pleased to hear that you are hoping to retain an extra 130,000 staff. Having more experienced people looking after patients is absolutely brilliant. I was not clear whether the cost of that was part of your £2.4 billion.

Amanda Pritchard: The big elements of the retention package in the plan—I am conscious that people will have read it and you do not want to hear me repeating it—

Nick Smith: Yes or no is fine.

Amanda Pritchard: It is worth saying that the two big things are about flexibility and continuous career development as well as just knowing you have enough staff to work with, who have the right skills to allow you to do your best work. Some of that, including things like flexibility, as I said earlier, does not require financial support but does require changes—

Chair: It is still cost, though.

Q32 **Nick Smith:** There is a cost to the brilliant 130,000 people who are staying on.

Amanda Pritchard: It is not a new cost over and above the things that people are already aware of.

Q33 **Nick Smith:** It is not in the £2.4 billion.



HOUSE OF COMMONS

Amanda Pritchard: There are not specific costs associated with those things. There is a cost associated with the pension reform, but that has been dealt with—

Q34 **Nick Smith:** Will there be a cost to the extra retention? Will there be a cost to the 130,000 people you are hoping to retain?

Amanda Pritchard: No, not in a sense that there is a specific number. There is a dependency on a whole number of other things. Part of what allows people to stay and to stay well is outside the purview of this plan. Some of this is to do with pension changes, for example, which are not costed here.

In terms of specific initiatives, there is confirmed and continuous funding for continuous professional development. That is not new money, but the plan has reconfirmed that it is going to be maintained. It is not new or extra. There is also a clear set of things where there is a financial cost, but it has been dealt with separately, such as around pensions or flexibility.

A lot of what is in the retention section of the plan is about doing what we know works, doing it systematically and supporting that to be spread across the NHS. For example, we launched an NHS retention programme last year. There are 23 trusts doing it at the moment and it is a systematic application of the things we know matter the most to people working in the NHS. They have seen their rate of improvement double compared with the rest of the NHS.

Q35 **Nick Smith:** Mr Wormald, do you have an assessment of the extra cost to the Treasury of helping pensions and these retention initiatives, please?

Sir Chris Wormald: There is definitely a cost to the pensions. I do not have it with me. I can write to you with the number. That was all costed at the Budget when it was announced.

Q36 **Chair:** Do you know the order of magnitude?

Sir Chris Wormald: Not off the top of my head, no.

Nick Smith: It is a chunky amount of money.

Sir Chris Wormald: Yes, just to be clear, that was a Treasury tax change that was costed by the Treasury. I will get my Treasury colleagues to send you their costings. It is not a cost to the NHS.

Nick Smith: No, but it is a cost to all of us.

Sir Chris Wormald: Yes.

Q37 **Nick Smith:** I have a few questions on delayed discharge, process management and hospital congestion. The first question, please, is to Sarah-Jane Marsh and Professor Powis. Why was the number of patients



HOUSE OF COMMONS

staying in hospital despite no longer needing to higher in the last quarter of 2022-23 compared to the same period last year?

Sarah-Jane Marsh: This is a really important issue to tackle. If we can get people out of hospital in a timely way, it is better for them and it is better overall.

We have been doing lots of different things to try to tackle that. The first is what we can do as an NHS to speed up the discharge process for people. That is making sure they do not need to wait for medications, transport and those types of things when they are waiting to go home, but it is also working with colleagues in the community and in social care for those older people who require more complex discharge packages.

The number you are referring to is the number of patients in hospital who no longer meet the criteria to reside. That is a number that we really encourage all of our hospitals and teams to focus on and look at every day so every patient who can possibly leave does move forward. The thing we are really trying to do is reduce the amount of time between when a person is ready to leave hospital and when they actually do. We have started to see some really encouraging figures there.

There are 7.5% fewer people staying in hospital over seven days from January to March of this year. We have seen that number come down quite significantly. We have seen a 3% reduction in people who are staying in hospital for over 14 days. That is the result of the work we are doing—

Q38 **Nick Smith:** What is the reason for that? Could you crystallise what the reasons for that were, please, so we can understand it better?

Sarah-Jane Marsh: The reason for the improvement or—

Nick Smith: Why was it higher in 2023 than in the previous year?

Sarah-Jane Marsh: Some of it is to do with the needs of the population, the complexities and therefore the packages of care that people need to leave hospital with. We are seeing a need for more and more domiciliary care support and rehabilitation support, as we deal with an older population with underlying and chronic conditions.

As we focus on that, we really encourage people to look at patients in hospital sometimes twice a day and challenge whether or not they should be there. That is helping us to identify more and more ways we can improve. Although we want to see that number come down, the most important thing is that people leave as soon as they have been identified as able to leave. We have seen some improvements in people staying in hospital over a long period of time, but we have a whole lot more to do on this.

Nick Smith: We will come on to that a bit more.



Professor Sir Stephen Powis: It is also important to remember that quarter four of 2021-22 was during the pandemic. The omicron wave was January 2022. Those periods are quite difficult to compare in some ways.

Q39 **Nick Smith:** Late discharge has been an ongoing issue for a long time.

Professor Sir Stephen Powis: It absolutely has. I am just putting a note of caution about making comparisons with the years when we had waves of Covid. We had restrictions in place and health-seeking behaviour was a bit different. Those are hard comparisons to make.

Q40 **Nick Smith:** There is a cost to patients for all this.

Professor Sir Stephen Powis: Yes, absolutely.

Nick Smith: Being in hospital when you are well is bad for you. What are you doing to minimise the adverse effects of delayed discharge on patients?

Sarah-Jane Marsh: For patients in hospital, it is about focusing on their rehabilitation while they are in hospital, so that they do not decondition, as we call it. If they become more unwell while they are there, they will therefore need to leave with a higher package of support than they otherwise would have, if they had left on time.

The therapy and nursing workforce in our hospitals and community hospitals is really focused on optimising people so that, as soon as they are ready to leave, they can go into the right short-term package for them and get back to living the best life they can.

Q41 **Nick Smith:** Is that working?

Sarah-Jane Marsh: We have some really great examples of that working across the country.

Q42 **Nick Smith:** Is it working across the country?

Sarah-Jane Marsh: In most places across the country we have seen significant improvements. There is always more to do. You will be aware of the variation. One of our roles is to bring together the places where this is working really well and where people have new models of looking after people, particularly in the community.

We call it intermediate care. If people have timely intermediate care, it brings people out of hospital and it is really good for the taxpayer overall because it reduces the number of people who subsequently need to go into longer-term care packages in nursing and residential care.

Sir Chris Wormald: It is also important to note that this number peaked in January and it has been coming down. We are down from 14,000 delayed discharges to about 12,000. We can reasonably relate a component of but not all of that directly to the additional investments that Government have made in social care.



HOUSE OF COMMONS

We all think that is not good enough. We would want to see the number quite a long way down from there. We have a lot more to do. We need to do a lot more to make the most of the quite large additional investments the Government are making further in social care.

- Q43 **Nick Smith:** That is good. I do want to ask another question. We all support that and it is brilliant. There was an NAO study on delayed discharge just a few years ago. That study said that a third of the issues that needed to be addressed were related to what is going on in the community, what is going on with domiciliary care and what is going on with social care. However, two-thirds of the problems causing delayed discharge belonged in hospitals.

Give us some comfort, Ms Marsh, that those two-thirds of the problems around delayed discharge, which are the responsibility of hospitals, are being addressed in hospitals.

Sarah-Jane Marsh: That is not the correct figure in terms of the balance between the responsibility of the hospital and more broadly.

- Q44 **Nick Smith:** What would you say the correct figure was?

Sarah-Jane Marsh: About 20% of the issues with people not being able to leave hospital are directly related to something the hospital itself could—

Nick Smith: This is an old study, okay.

Sarah-Jane Marsh: That is still 20% too many. We work really hard inside the organisations on the things that will enable people to go more quickly, so being able to get the diagnostic test at the time they need it, their medicine when it is ready and their transport when they are ready to go. We have a team of people we work alongside, as NHS England, who go out to the places with the biggest challenges and really test them.

Every single part of this needs to come together and make improvements, if we are going to bring this number down overall. From an NHS perspective, for that 20%, we are absolutely committed to continue seeing those improvements.

Nick Smith: Professor Powis, I understand we are running together on Wednesday for the 75th anniversary of the NHS.

Professor Sir Stephen Powis: I am looking forward to it.

- Q45 **Nick Smith:** We will be able to take this session forward then. I wonder whether you could help me, please. What are the main problems and main blockages, coming back to the earlier remarks from Ms Marsh, that prevent the smooth movement of patients between services?

Professor Sir Stephen Powis: This is described in the Report. You have to think of the whole urgent and emergency care pathway as a—

Nick Smith: Hospitals are very often congested.



HOUSE OF COMMONS

Professor Sir Stephen Powis: Yes. If we cannot discharge patients from hospitals and we are running high occupancy rates, that means it is hard to get patients who are waiting in the emergency department into beds in the wards. If our emergency departments are full, it is hard to get patients from ambulances in the forecourts into the EDs. If the ambulances are stuck on the forecourts, they cannot get out to respond to the new calls and that means ambulance response times increase.

Chair: The figures are in the Report.

Professor Sir Stephen Powis: Yes. You see a whole set of pinch points. As we start to decongest that, which is what has been happening since the winter, a particularly bad winter, the first thing we would expect to happen is that those pinch points start to reduce a bit and, therefore, there are fewer ambulance handover delays. That is what we have seen. You are also able to move patients from emergency departments into wards more quickly. What is happening in one part of that particular flow has a direct impact on the other part.

Over the winter, we spent a lot of time working with our staff. If you are on the ward, what is happening in the ambulance service is not immediately obvious, but changes you can make on the ward, such as taking an additional patient or flexing the rotas on the ward, will allow patients to come on to the ward and release ambulances.

We worked very hard, particularly with systems that were struggling, on this concept of spreading risk. The system has to work across the pathway as a whole rather than just focusing on one bit of it. You have to focus on everything, but, as you have just rightly said, if we cannot get patients discharged on time, it does have a knock-on effect all the way down to ambulance response times.

Q46 **Nick Smith:** It is complicated, is it not? We do get that. Ms Marsh, do you have good metrics to measure the movement of this process within hospitals? We understand where the pinch points are, as the professor has identified. Patients are often in great discomfort if they have been in A&E for a long time. They might really need to have an image taken to understand their problem properly. What metrics do you use to understand that?

Sarah-Jane Marsh: We have metrics that we look at nationally. It is really important that these are looked at within the organisations themselves and people are constantly tracking patients through.

As Professor Powis has said, we look at handover delay. We look at the amount of time people are in the department before they are seen, treated and discharged. We look at long waits in an A&E department, where people are waiting for 12 hours or more. We look at length of stay for short-stay patients, so those we would not expect to get a delayed discharge. We look at length of stay overall. We look at the length of time people are staying beyond being ready to leave.



HOUSE OF COMMONS

All hospitals will have an operations centre of some description where they will be monitoring that information and data. As Professor Powis has said, they will be looking to see whether they can open an extra ward, whether they can move patients or whether they can speed up some people's scans to get things moving more quickly.

In some of our organisations we have electronic bed management systems, and we are looking to introduce those in more places during the course of this year so people can see some of this information in real-time. The more we can create that flow and the sense of moving everybody through their journey, with a positive step every day, the better the position we will be in.

Nick Smith: It sounds very fine-tuned.

Sarah-Jane Marsh: It is.

Q47 **Nick Smith:** It demands a lot of local care and attention in these operations centres you talk about. You did not quite answer my question about whether you have good metrics to do it. You talked about electronic management. How many of those systems are in place at the moment?

Sarah-Jane Marsh: Only a handful of organisations at the moment have fully functional electronic bed management systems, but many places have the functionality to do that. We are working with them at the moment to make sure that the functionality and the way the hospital operations centre works come together.

Q48 **Nick Smith:** Exactly how many are there?

Sarah-Jane Marsh: At the moment there are only four places that we feel have all of the component parts to make a first-class electronic bed management system. We are working with a series of organisations, particularly those we are more concerned about, coming into the winter period, to make sure we can increase that number and then increase it year on year.

Everywhere else, where they do not have it, they will be using different electronic systems, with electronic whiteboards and so on. Every hospital tracks patients through. Every hospital knows if there are ambulances waiting outside, if people have been waiting a long time in A&E or if there are people in a discharge lounge who need to go home before the discharge lounge shuts. That is the way hospitals are managed day in, day out.

Matthew Style: On the question of metrics, one of the measures set out in the recovery plan is an improvement in the metrics around discharge, which we have just been touching on. We are developing a new measure that looks in much more granular detail. We will know not only the number of patients who are in a hospital bed and do not need to be there but how long that discharge has been delayed by. We will be able to



HOUSE OF COMMONS

match that data at local authority level. That will increase the transparency. It is a more granular metric, which will allow us to understand better the nature of the problems and better target our action to address them. That metric will be published ahead of the winter.

Q49 Nick Smith: Mr Wormald, which parts of the urgent care system does the Department see as the highest priority for actions and investment to help your colleagues here deal with this tricky issue?

Sir Chris Wormald: We work incredibly closely with the people to my right, and our view would not differ from the NHS view at all. The heart of the system, going into winter, is less about the components of the system than about which local systems—Sarah-Jane has just been talking about this—worry us most. This goes back to your metric questions. Sarah-Jane will be able to describe this much better than I.

There are a series of national metrics with which we identify which local systems are the most challenged. The NHS puts those into tiers and matches its intervention to those tiers. We talk about this—I am not sure how many times a week—at least three times a week: which are the whole local systems we are most worried about and what interventions are going on in that system?

When you look at that analysis—as I say, Sarah-Jane will be able to do this in much more detail—it goes exactly to your point about how the services fit together. It is the whole system from arriving in an ambulance to being discharged, working out what the weak links in those systems are at a local place level and then addressing those. We are not saying, “It is ambulances nationally”, “It is urgent and emergency care nationally”, et cetera. We are saying, “It is these particular places”.

How many places were on your—

Chair: Can we go through the Chair, please?

Nick Smith: Ms Marsh, I was just going to say, from my rugby days, you have been handed a hospital pass.

Sarah-Jane Marsh: There are seven systems across the country where we are worried about lots of different component parts of the urgent and emergency care pathway: the ambulance response time, the way people wait in the emergency department and then some of the issues they may be having with delayed discharge.

We work more closely with those seven places than others, but that is not to say that they need to do different things. It is just that sometimes they need a little bit of extra help and support from us to be able to do that.

Nick Smith: That is me finished. I look forward to our run together on Wednesday, Professor Powis.



HOUSE OF COMMONS

Q50 **Chair:** Can I just go back to the electronic bed management systems? There are four in England. When you say “the country”, I am assuming you mean in England.

Sarah-Jane Marsh: There are four that are completely up to the specification, which means day in, day out, they are able to track every patient in real-time.

Q51 **Chair:** There are four working electronic bed management systems. You want to increase that. Is there a cost to increasing that?

Sarah-Jane Marsh: Can I just clarify? There are four electronic bed management systems that are working in real time and using a particular type of technology that means that, at any point in time, they know when a bed is in use. There are lots of other organisations that use electronic data to manage their beds, but our top-performing organisation, Maidstone and Tunbridge Wells, uses it and gets excellent results.

Q52 **Chair:** Just to be clear, there is this great system. You are clear that, when it is working well, that increases productivity, flow and all those problems we have been talking about.

Sarah-Jane Marsh: Yes. There are 16 trusts in the country where we are going to work to implement the system that we know works really well during the course of this year.

Q53 **Chair:** Who is paying for that? Are they paying for it or is it paid for from NHS England’s central funds or by DHSC?

Sarah-Jane Marsh: The money has been identified from existing budgets, some centrally from NHS England and some from those trusts. That is not new money.

Q54 **Chair:** Have you done an analysis of how much you will spend on that and what the benefit will be in productivity terms?

Sarah-Jane Marsh: That is part of the business case, yes.

Q55 **Chair:** Roughly, what is it going to cost?

Sarah-Jane Marsh: I would prefer to clarify that.

Chair: Yes, absolutely. That is fine.

Sarah-Jane Marsh: The business case is not yet completely approved. I would not want to give you an incorrect figure.

Chair: You have given us some quite clear answers, Ms Marsh, about the challenge of flow. We talk about this a lot. It is not like it is all new. That is a very good and specific example you are giving of something that sounds like it will make a difference. It would be interesting to know the costs and benefits of that for taxpayers and, indeed, for patients.

Q56 **Sir Geoffrey Clifton-Brown:** Between you, you have put a very good gloss on the delayed discharges. You have said that the system is getting



better. If I can take you to paragraph 1.12 on page 17 of the Report, it makes perfectly clear that at the start of March 2023, this year, these delayed discharges had increased to 49,331 staying longer than seven days and 19,337 staying longer than 21 days. The situation is getting worse compared to pre-pandemic rather than better, is it not?

Sarah-Jane Marsh: To be clear, pre-pandemic we did not measure this in the same way. Pre-pandemic it was delayed discharge. That was where health and social care together agreed that a patient met a particular set of criteria that meant their discharge was delayed. Not meeting the criteria to reside, which is the figure you are quoting, is something different. This is a daily analysis of whether there is something we could do to move that patient forward, where this could now be done outside of hospital.

With permission, Professor Powis, I do not know whether you want to say a bit more about not meeting the criteria to reside and why we changed from delayed discharge in the pandemic.

Chair: It would be helpful to know what the change means.

Professor Sir Stephen Powis: We changed at the start of the pandemic because we wanted to help hospitals identify early the patients who were coming up for discharge. We introduced a set of criteria, some of which are physiological criteria, to flag up to teams, "These are the patients who are likely to be ready for discharge". That worked well in the pandemic.

The point is that we want to use a different metric moving forward because it was a very pandemic-specific metric. It has some advantages, but it has some disadvantages as well. That is the metric Mr Style was talking about earlier. I am very happy to talk about length of stay, if you want.

Q57 **Sir Geoffrey Clifton-Brown:** My constituents will be listening to that answer with great interest because for the last two years—Gloucestershire MPs have been complaining about it—Gloucestershire has had twice the average length of discharge compared to the rest of the country.

Interestingly enough, looking at the constituency data, if you add up all the days of delayed discharge and divide them by the number of trusts, it comes out as almost exactly half of what my trust has, 174 days. Does this have anything to do with the workforce plan saying that there are 165,000 posts vacant and that work pressures in adult social care mean that meeting people's needs at home or in the community is challenging? That is what my constituents believe: there is a lack of social care workers who can provide the packages of domiciliary care to enable those people to be discharged from hospital.

Professor Sir Stephen Powis: Yes, there is no doubt that that is part of the challenge we face. We have been very clear throughout that there is



HOUSE OF COMMONS

a challenge in social care. As you have rightly said, the challenge is not entirely in social care. There is work to be done in the hospital sector. We need to be clear about that as well. Workforce issues in social and domiciliary care are challenging, as you know.

Gloucestershire is one of the systems we work closest with on some of these system issues. The problems you have described in your constituency will be replicated across the country.

Sir Geoffrey Clifton-Brown: I hope it is not double the average rate across the country.

Professor Sir Stephen Powis: No, maybe not, but the issues in social care and domiciliary care are undoubtedly plain to see.

Q58 **Sir Geoffrey Clifton-Brown:** I am glad we have a measure of agreement. At least we have an agreement on the problem. That is always a start. How long is it going to take to fix? When will my constituents see a noticeable difference?

Professor Sir Stephen Powis: That might be one for Department colleagues who oversee social care. In the NHS, we focus on working as closely as possible with social care colleagues through integrated care systems. The long-term workforce plan is a plan for the NHS. Some of those colleagues in the social care sector are nurses. This will increase nurses in the round.

There are very specific challenges in the social care sector. I know our colleagues in the Department of Health and Social Care are very well aware of those. I do not know whether Chris wants to say anything.

Sir Chris Wormald: I will not rehearse the challenges of social care because we have discussed them in this Committee a lot. On your specific question, the Government are making significant investments in social care over the next two years. The Chancellor announced that in the autumn statement.

Although the official figures are out next week and I will not pre-judge them, all our reports from both the NHS and local government suggest that the workforce position has stabilised. We now need to see it improve and we need to see those additional investments over the next two years turn into noticeable differences for your constituents and others.

What I said was not in any way contradictory to what you said. We saw delayed discharges peak in January and fall from there, which is consistent with the numbers you gave. We need to see them come down a lot more. I am not saying that the improvement is where anyone would want it to be, but it demonstrates that the Government's investment has already made a difference.



HOUSE OF COMMONS

We therefore need to see the spending power of up to £2.8 billion that local government has this year, and then £4 billion next year, turn into the kind of changes we want to make.

Q59 Sir Geoffrey Clifton-Brown: To clarify that answer, the figures reported by the NAO were to March 2023. We were not able to see any reduction between January and March, as you said.

Sir Chris Wormald: No, but, when you look at the underlying numbers, it peaked in January and has fallen since then, which is entirely consistent with what the NAO has written. We need to see it come down further. As you say, a component of that challenge is the local authority sector care workforce. We need to see that go up.

Q60 Sir Geoffrey Clifton-Brown: The real icing on the cake is that my constituents want to see a long-term plan for the social care workforce. When are we going to get that, so they can be reassured that they are going to get more social care workers to deal with this very difficult problem?

Sir Chris Wormald: The Government have not set out a long-term plan in the same way as the NHS has. Of course, this is not our workforce. They are mainly private employees of independent companies. We cannot plan it in the same sort of way we do for the NHS.

We do take a number of measures on workforce, which I have described to this Committee before and will not go through. As I say, the key to it is that the Government have made some really quite significant investments in this area, which we need to see translated by local authorities into an improved service. As I say, it is not a sector you can plan in the same way as the NHS for the reasons you understand.

Q61 Sir Geoffrey Clifton-Brown: Given that these delayed discharges have such a knock-on effect on the health service—I am going to come on to ambulances in a second—surely you ought to be liaising very carefully with your colleagues in the Department for Levelling Up to make sure we do have a long-term social care workforce.

Sir Chris Wormald: We talk directly to local authorities and employers, but solving this problem and this challenge will involve thousands of individual employment decisions by independent people. We cannot plan the whole system, like we can with the NHS.

It is not an area where I can say, "If there was a nice Government plan, somehow everything would be all right". It comes down to a sector working properly and the interaction of the public sector and the private sector.

Matthew Style: There are steps we have been taking. Over 2022-23, we ran a national recruitment campaign. We have made changes to the shortage occupation list. We have put in dedicated funding to support local areas to improve recruitment practices. We are working proactively



HOUSE OF COMMONS

with Jobcentre Plus to promote social care careers to jobseekers. We provide toolkits to help employers retain and develop their own staff. Where appropriate, there is national action from the Government to support the social care workforce.

- Q62 **Chair:** Can I just check, on the shortage occupation list, if someone is given a visa to come as a social care worker, what the requirements are? Do they have to be very senior? How long are they allowed to stay?

Matthew Style: I would have to get back to you on the specific details, but we have made some changes that have made it significantly easier for employers in the social care sector to operate in the international recruitment market.

- Q63 **Sir Geoffrey Clifton-Brown:** Let us see if we can get another measure of agreement, Professor Powis, on the knock-on effect of delayed discharges on ambulance trusts. If I could take you to paragraph 3.12 on page 39, it says that the mean category 1 incident response time for London was six minutes and 51 seconds, whereas for the South Western Ambulance Service it is a staggering 10 minutes and 20 seconds. Worse still, the best ambulance service for category 2 was 26 minutes and 20 seconds, but in the south-west it is one hour, one minute and 57 seconds.

Those are pretty shocking response times. I imagine that delayed discharge must play some part in that. I accept that the South Western Ambulance Service covers a very large rural area, but it should be able to provide different ambulance stations to deal with that situation. What is the answer to these differences between the very best ambulance service response times and the worst ones, such as the south-west?

Professor Sir Stephen Powis: As you have rightly said, this has to be seen in the context of the entire flow through hospitals. As I said earlier, if you have delays in discharge, that will feed its way through to difficulties transferring patients from ambulances into emergency departments and releasing ambulances to go to their next call.

The response times were not at all where they needed to be over the winter. We have acknowledged that. They have subsequently improved significantly both in category 1 and category 2. That is because the acute flow issues we saw over the winter have improved for a variety of reasons, not least because we have come out of winter but also due to the measures we have been putting in place and the improvement work.

- Q64 **Chair:** How much of it is because we have come out of winter and how much is down to these other measures?

Professor Sir Stephen Powis: Undoubtedly, winter is always the time when we get a lot of infectious diseases. As we acknowledged right at the start of the Committee and as you acknowledged, this winter was a very difficult winter. We had Covid and flu peaking together for the first time. We had a particularly bad flu season. We had group A streptococcus in



HOUSE OF COMMONS

December. There were a whole lot of things last winter. I am very happy to talk about next winter a little later on.

Undoubtedly, some of the improvement is from coming out of winter, but we have also put in a series of measures. We have talked about discharges. We have also been working with hospitals around the ambulance handover part of this. Sometimes that is around staffing models; sometimes it is around putting in temporary accommodation to ensure ambulances can release patients to emergency departments quickly. We have also been working with ambulance services. We have made some adjustments to the category 2 call response mechanism and how that works. A whole host of things have been going on.

You are right: there is variation. You are absolutely right that the south-west and some of our ambulance services that cover large rural areas—the east of England would be another—have particular challenges. In a sense, they get disproportionately affected by some of those flow issues we have been talking about.

Q65 Sir Geoffrey Clifton-Brown: That is helpful. Ms Marsh, can I take you to paragraph 3.9 on page 34? There is absolutely no excuse for this, whether or not it is a rural ambulance trust. That paragraph tells us that, in relation to 999 calls, the best ambulance trust response time to calls was 5.4 seconds compared to 67.4 seconds in the South Western Ambulance Service. It begins to build up a pattern, does it not?

Sarah-Jane Marsh: This is one of the areas we are working on as part of the improvement plan for ambulance services. As we have all described, there absolutely are things that need to happen at the interface with hospitals, but there are lots of things that we know happen better in some ambulance services than others.

For some, it is the way they staff and work their call-answering centres, which you are referring to here, or the amount of hear-and-treat they do. There is quite a bit of variation in those that will treat a patient over the phone as opposed to going to see them, doing see-and-treat and then taking them to hospital.

At the moment, our work is to get those that are doing best to help and support those that are in difficulty. To go back to Sir Chris's description of the tiering system we have, the South Western Ambulance Service is in our tier 1. We are giving it extra help and support this year both financially and with improvement to help it improve. We are starting to see some improvements there.

The big thing we are doing on top, just to help ambulance services, is investing in them directly so that they have a greater percentage of ambulances hours, over 7% more deployed hours, on the road. There were some disparities. The south-west was one of the areas that got a disproportionate amount of the investment NHS England made to support this.



HOUSE OF COMMONS

- Q66 Sir Geoffrey Clifton-Brown:** The support you are giving is good news. Let us hope that flows through into some of the results. I have one final question, again about the variation between the best trust and the worst trust in terms of workforce. We have one of the highest levels of vacancies as a proportion of NHS staff. We have one of the lowest levels of morale in our staff. What can be done in a trust like mine that has some of the worst metrics, compared to the best? How can you bring the worst up to the best?

Sarah-Jane Marsh: People have done lots of things to try to think, in particular, about how teamwork and the way the individual teams within a service can help, support and make people feel valued, like their ideas are listened to and like they can influence the work. In those places that have focused on those team-based models, sickness levels have gone down, morale has improved and turnover has reduced. Again, this is about trying to learn from the places that are doing some of these things really well.

To go back to what Ms Pritchard was saying earlier, if people are asked to do a lot of overtime and to cover gaps in rota shifts, although they are doing it for the right reasons, they can become tired quite quickly and so on. Investing in additional paramedics and paramedic technicians also massively helps because that means there is a larger quantum of workforce overall.

- Q67 Sir Geoffrey Clifton-Brown:** This is a problem that feeds on itself. If you have more vacancies, you are going to ask your staff to do more overtime. They become more demoralised. What can we do about that?

Sarah-Jane Marsh: That is why the majority of the resource that has been available, an extra £200 million of our NHS funding, has gone into ambulance services. It is exactly to address this problem of being able to have sustainable rotas.

- Q68 Sir Geoffrey Clifton-Brown:** I am not talking about the ambulance service here; I am talking about the main NHS trust here.

Sarah-Jane Marsh: The same applies to the NHS trust. As we are able to make sure that we have the right amount of beds, for example, in each of the individual trusts or overall systems, that helps there to be the substantive staffing in place, which supports everybody to feel valued and more likely to stay. If people are asked to work in areas that they are unfamiliar with, or if there are beds in places that we call escalation areas, people do not have as much of an association as if they are working in their regular ward. Again, we have put disproportionate investment into the south-west to try to get both the trust and the ambulance service to have the capacity in place that they need ahead of winter.

- Q69 Sir Geoffrey Clifton-Brown:** I repeat that this is not about the ambulance trust; this is the main NHS trust that I am talking about in terms of morale and vacancies.



HOUSE OF COMMONS

Sarah-Jane Marsh: Yes, but the two things absolutely go hand in hand. We have done some brilliant work through the Integrated Care Boards (ICBs) and the trust. During the course of January and March, we managed to get lots of the long-stay patients out. In the course of that period, we had nobody in hospital for over 50 days in the trust for the first time. There is an awful lot of work going on to focus the energy and attention on those systems that we know need the most help.

Matthew Style: Just making the link between your question and the earlier discussion on the long-term workforce plan, we know that where we train people has a very big impact on where people choose to stay and practise. We have said explicitly that an expansion in training places will have regard to that.

Q70 **Nick Smith:** Ms Marsh, I want to go a little deeper on congestion in hospitals, good process management and what other measures can be taken to help hospitals out. How good are ambulance services across the country at supporting people in their homes so that they do not have to go to hospital? This is about dealing with people on the spot and not having them go to hospital or A&E so that they can receive another form of care. Are ambulance services good at helping with that across the country? Who is good at it?

Sarah-Jane Marsh: Absolutely, this is a big area of focus in the UEC recovery plan, because, if we can stop people going to hospital in the first place who do not need to be there, that is better for everybody. It works well when the ambulance services are working alongside community services, those people who understand how to make the best response to support that individual.

We have lots of examples across the country in all ambulance services, including some of the ones we have talked about that struggle with response times overall. They are good at this. We have talked about getting alongside people. It could be people who have fallen; it could be people who are known to community services. They can call on what we call our two-hour community response teams or come out to people.

Q71 **Nick Smith:** Did you say all ambulance services were good at it?

Sarah-Jane Marsh: All ambulance services work in partnership in their local systems to be able to do this, but we have variation in the way that people do that. We are working to make sure that all people who could get a better response at home, in their nursing home or in residential care get that response there, so that they do not get conveyed to hospital unnecessarily to sit outside when they could have been looked after in their own homes.

Q72 **Nick Smith:** It is brilliant stuff. If you can help people at home, that is fantastic, but you talked about having an understanding and a variation, so who is the best outlier? Which ambulance service is great at helping to keep people at home? What is the difference between the worst



HOUSE OF COMMONS

performer compared with the best performer?

Sarah-Jane Marsh: There is not one answer, because there are lots of different models that people deploy. Some of it is about looking after people in their own homes. The ambulance service works well when the community service provider sits as part of the ambulance services. For example, they do this in the East of England Ambulance Service. When the call comes in to the control centre, instead of the ambulance going in the first place, they can deploy the community response. It is not just about the ambulance going and doing it in people's homes.

Q73 **Nick Smith:** Is there a national metric for this? How do you understand the overall England figure for best-performing ambulance services at helping to keep people in their homes?

Sarah-Jane Marsh: We do not have a metric for the best-performing ambulance services in their own homes. We have a series of metrics for what we call a category 3 ambulance, which is one where we could have had an alternative response, and we look at those to see whether ambulance services routinely take those patients to hospital, whether they can provide services themselves, or whether they have good links with community services that mean they do not need to go to the patients and take them to hospital in the first place.

Q74 **Nick Smith:** How do you know who is good at it?

Sarah-Jane Marsh: We collect some data on the community response times and the number of patients getting an alternative service who are not being deployed to hospital when they are a category 3 or a category 4 ambulance. We do not have a performance measure or standard where we say, "We expect people to hit this particular target or that target".

We spend a lot of time, particularly with ambulance services, just sharing that practice. Some of these are new models. These are things that people started in the pandemic. They are starting to show improvement now. It is about how we share, learn and get people to grow.

Amanda Pritchard: We measure things like hear-and-treat and see-and-treat, to give two metrics. We also measure things like urgent community response, which is both volume of patients and speed of response. We measure things like virtual wards. It is a different kind of model. Again, that is more about the step-up model so that you have community teams looking after people at their own homes to avoid them going in. I think that is what you are describing. There is a range of different things that we measure. At the moment, we do not bring them together into a single metric.

Q75 **Nick Smith:** Might it be worthwhile to bring them together?

Amanda Pritchard: The challenge is exactly the one that Sarah-Jane is describing, which is that there are quite different stages of development across the country. Different models have been established, so it is



HOUSE OF COMMONS

probably a bit challenging to make sure that we have the right currency and we are measuring apples and apples rather than apples and pears. It is a good question, so we can take that away.

Chair: You could pilot it.

- Q76 **Mr Francois:** Ms Marsh, just to prove that we are not only here to pick holes or endlessly talk about money, you mentioned the East of England Ambulance Trust. It has been under great pressure, like all the others, but I have been to its control centre and can vouch for the fact that it is doing a lot better now. It is very well led by a man called Tom Abell, who you may have come across.

Sarah-Jane Marsh: We know Tom very well, yes.

- Q77 **Mr Francois:** Not to say there are not still lots of challenges, but it seems to be doing everything it practically can. While we have an opportunity to acknowledge that in public, I think we should do.

Ms Pritchard, what was the rate of staff outflow from the NHS in the year just gone? In 2022-23, what percentage of your staff left the National Health Service?

Amanda Pritchard: You are talking about staff turnover. I do not have the exact figure to hand, I am afraid, but it is about 9%.

- Q78 **Mr Francois:** That is quite worrying. That is coming on for one in 10. The Ministry of Defence, by contrast, is under a great deal of pressure, but in the last financial year, just ended, its outflow was about 6%, so you are one and a half times higher than the armed forces. The MoD has a system whereby it surveys all armed forces personnel. It is a voluntary survey and they can reply confidentially. It is called the armed forces continuous attitude survey or AFCAS. You will know from our previous discussions that I am not a great one for bureaucracy, but I can see the value of asking people what they think about the organisation they work for. Does the NHS have any pan-NHS system like AFCAS?

Amanda Pritchard: We have a range of things. We have the staff survey, which is an annual survey that gives feedback at individual organisational level.

- Q79 **Mr Francois:** Is that at trust level?

Amanda Pritchard: It is. In fact, that is what Sir Geoffrey was referring to earlier in relation to his own local trust. We also have other surveys that specifically pick up the drivers for why people leave. Hidden in that figure, of course, is that some people go on to be promoted or go to other trusts. There is movement in there. It is not necessarily that people are leaving the NHS; they might be going to other roles within the NHS.

What we do know from that, as we were talking about before with some of the things in the retention part of the long-term workforce plan, are the things that really matter to people. Sarah-Jane mentioned some



HOUSE OF COMMONS

earlier. It really matters to people that they have flexibility; it really matters to them that that flexibility works for patients as well as it works for them as individuals; it really matters that people have a sense of continuous career development so that they have a sense of investment in their own personal futures. Leadership also matters, particularly clinical leadership, so the leadership of the ward or the clinical team that you work on.

Q80 Mr Francois: You have not mentioned pay there.

Amanda Pritchard: Pay also matters. I should have said that.

Q81 Mr Francois: It is fair to say that it does, but it is often also not the only thing. Again, I go back to my MoD experience. When people leave an organisation, they often leave for a combination of reasons. Sometimes there is one thing that is, in normal parlance, the straw that breaks the camel's back, but it is usually a decision in the round.

Look at hospitals now. As politicians, we talk all the time about doctors and nurses. We are used to doing that, but there are lots of other people in the hospital: clinicians, physios, radiographers, cleaners and porters. Without all those different bits of the orchestra, you cannot play the concert, so it is worth putting that on the record too.

Because the NHS is so large, we all have lots of friends who work in it, and I have spoken to some people who have left in the last year or so. Admittedly, this is anecdotal, but often the reason that they say they leave is that they had lost their sense of job satisfaction. They are not enjoying going to work in the way that they did. They give a variety of reasons for that, and one of those is bureaucracy. One person said they left the NHS to become an accountant. I will mention that to the NAO. When I asked the person why, she said, "I was having to fight every day just to do the job that I signed up to do". Why has the NHS become so incredibly bureaucratic?

Amanda Pritchard: Without knowing a bit more about the detail of your friend or colleague's personal circumstances, it can be slightly difficult to give a proper answer.

Q82 Chair: Mr Francois is not asking for a contact. He was using that to illustrate the wider point about dissatisfaction.

Amanda Pritchard: We know that there is a real frustration sometimes with the burden of reporting. We have talked today about metrics, what we collect data on, and whether we can tell which are the best performing or worst performing. Someone has to enter that information somewhere, and that is the kind of thing that people find quite frustrating.

Q83 Mr Francois: Let me try to give you a more specific example. Ms Marsh, you can help us here. At the hospital that person worked at, there are about seven layers of management, some of whom have a clinical role, but most of whom do not, between the senior clinical level, so not doctors



HOUSE OF COMMONS

but band 7 or band 8, and the trust chief executive. Why does it require so many layers of management to run a district general hospital in the 21st century?

I am asking Ms Marsh. With no disrespect, she is a bit closer to the coal face.

Chair: I know that Ms Pritchard was as well.

Sarah-Jane Marsh: I was a trust chief executive for 13 and a half years until I left my trust at Christmas, and I would not recognise there being that many layers. That feels very unusual. You need to collect things into leadership groups because people want to be able to make change together, and that is important, but I would have thought that was quite a lot of layering over and above that which I would know to be typical.

Q84 **Chair:** What was it like at St Thomas', Ms Pritchard?

Amanda Pritchard: We had a clinical leadership model. That is right. Each directorate was led by a clinical director. Mostly, it was a doctor, although not always. Sometimes it was an AHP, a nurse or a midwife. They work with a team of predominantly clinical colleagues to run units that made sense. It might be at ward level; it might be at service level. Mostly, that is to develop the response to the local problem solving and local patients. It allows people to feel real ownership of their roles and thrive in them.

Having said that, there is variation across the NHS. We absolutely acknowledge that. Obviously, each local organisation determines for itself how it is going to be structured.

Q85 **Mr Francois:** We are ultimately talking about productivity for the sake of the patients who use the service. You can get into a debate about when a manager is not a manager. I understand that, but most big organisations, if they are looking to become more productive and more efficient, go through a process of delayering. They take out levels of management. They make the lines of accountability clearer and sharper. The NHS seems to be going in completely the opposite direction.

Right at the top of a massively top-heavy system, you have large numbers of policy officials at NHS England in Leeds and very large numbers of policy officials in DHSC headquarters in Victoria Street. The two do not necessarily always agree on everything. That is one of the reasons why the NHS workforce plan took years to come to fruition in the first place. Do you not realise that you are losing a lot of good people at the coal face because they are part of such a massively top-heavy organisation and a lot of them have had enough of it?

Sir Chris Wormald: No, I do not agree with that.

Q86 **Mr Francois:** Then why are you losing one in 10 of your people every year?



Sir Chris Wormald: No, I am disagreeing with your characterisation of the centre. On most of the international benchmarks, we have one of the lowest percentages of spend on management as opposed to clinical. It was one of the things, as the King's Fund pointed out, on which we benchmark as efficient. That is different from your previous point about layers of management within an organisation where, as Sarah-Jane was saying, what you were describing did not sound like best practice. I would not associate that with how NHS England and DHSC react to each other.

Q87 Mr Francois: If I can find you a hospital with seven layers of management between band 8 and the CEO, you will look into it. Great, that will do.

You make some quite heroic assumptions in your plan about retention. It is the same with the military. There is no point winding the aperture of the recruitment tap if you cannot put a retention plug in the sink, because otherwise you are constantly running to stand still. Even the most mustard-keen new recruit cannot make up for the experience of when a 15 or 20-year person walks out of the door. It is going to take you years to train them. That is just the nature of the beast.

If you wanted to improve that, here is one practical example. You have this state-of-the-art bed management system in four trusts. You said by this year you are going to roll it out into 16 other trusts. Because it is so fundamental to the efficient working of a hospital, why do you not have a crash programme to get that into every single trust this year?

Sarah-Jane Marsh: It is quite a challenge. It is not just about the technology itself; it is about the deployment. It is about having the expertise to get absolute value out of it so that you do not just plug in a system and then carry on working how you were working. You are working in a very different way. We think that is the right number to focus on this year, and then we will get the learning from that.

Q88 Mr Francois: Forgive me if I push back. We all know from our constituency experiences that this issue of patient flow and having enough beds in the hospital is fundamental. It affects the ambulance trusts. As Sir Geoffrey was saying, it affects so many other things.

I am still not convinced by your answer. If you found a state-of-the-art system for doing this better in some hospitals—far better, from what you were saying—than in others, surely logic suggests you should roll that out across the entire NHS as quickly as possible, and then fewer people would be inclined to leave.

Sarah-Jane Marsh: So 16 is the priority for this year. Can I just go back to what I said before?

Q89 Mr Francois: How many district general hospitals are there in England roughly?

Amanda Pritchard: There are 150 with type 1 A&Es.



HOUSE OF COMMONS

Mr Francois: If you extrapolated that, it would take you nine or 10 years.

Chair: Perhaps Ms Marsh might be able to explain the trajectory.

Sarah-Jane Marsh: At the moment, it is only in a handful of places. They are places that have prioritised it and done it themselves. They often have quite unique leadership that has had a vision, and it has been their thing to do.

For this group of 16, we are doing this in organisations that have a whole range of challenges. They are going to be doing lots of other things at the same time, such as putting in extra beds. We want to help and support these 16 places, which are the most fragile, to do this really well, and to give them not just the financial resources but also the expertise to be able to support them. We will then quickly learn the lessons of that and move on to the next stage of the programme, but every system will be doing more work on the data that it is looking at.

We have talked about the hospital bed management, but we also have what we call the system co-ordination centres. It is important that we see not just the beds in the hospital, but community services, services in social care and so on. I would not want you to be left with the impression that this is only about the 16 places.

Mr Francois: You cannot have it both ways. You were making a big thing 45 minutes ago about how brilliant this new system is. Not unreasonably, we say, "Roll it out across all the hospitals", and then you have given me a whole range of reasons why you cannot. Anyone watching this programme who is not an expert or someone high up in the NHS—

Chair: We are not quite a programme, Mr Francois.

Mr Francois: I know, but it is so fundamental to the challenges that face the NHS. I am not saying it is the silver bullet for everything, but you were telling us 45 minutes ago that it was a bit of a gamechanger. Surely you can speed that up.

Q90 **Chair:** What is the trajectory? It is 16 this year. I understand that you are piloting it and trying to get different trusts on board. Is there a plan to roll it out, Ms Pritchard?

Amanda Pritchard: Ms Marsh might be being slightly coy about this. The Secretary of State would absolutely share the ambition to roll out this system and, indeed, many other things that sit in that digital tech space that we know can make a difference, some of it incrementally and some of it more dramatically. It is one of the reasons why, in the workforce plan, we have said, again supported by Government, that continued and sustained investment in NHS infrastructure, but also a significant increase in funding for technology and innovation, is going to be critical.



HOUSE OF COMMONS

If we want to continue to get productivity benefits, there is no doubt that this system is one of the ways in which we can absolutely do that, but not on its own. We need to do all the other things that we have described in the urgent and emergency care plan as well, which means we need to see a continued investment. That is one of the things that we will need to pick up with colleagues as part of budget setting for next year.

Q91 Mr Francois: It is great that you are trying to recruit more people into the National Health Service but, if you cannot stop experienced people leaving, all the time you are running at a standstill. What are the key ways you are going to persuade very experienced staff, be they doctors, nurses, clinicians or other ranks in the NHS, not to leave an organisation that at the moment has a 10% vacancy rate and a rate of people leaving of 9% a year?

Amanda Pritchard: We have covered some of this already. There are things that are outside our control. Pay is one of them. Workload is another issue. We know that that really matters. If you do not feel you can do your best work, that affects people's desire to continue to work in the NHS. Therefore, all the things that we are describing today are hugely important in retention as well as in making sure that we are doing the absolute best we can for our patients.

In terms of the specific offers that we will be making as part of the long-term workforce plan, there are a range of measures particularly focused on flexibility. I have talked about career end, but it is from day one, with flexibility that works for patients, flexibility that works for our staff, as well as continuous career development. This is a package of things that we know works, because in the 23 trusts that are already piloting that range of things, and have been over the course of the year, the rate of improvement in retention has been twice that of the rest of the NHS.

Mr Francois: Certainly, career development is very important. We want you to succeed. I just think some of your assumptions in the workforce plan about retention are bordering on the heroic, but let us hope you can be heroes.

Sir Chris Wormald: You have put your finger on a lot of the very key elements here.

Mr Francois: Thank you for that.

Sir Chris Wormald: Obviously, the pension changes that the Government have made are a very significant intervention, and that is quoted by a lot of senior doctors as being one component. Clearly, the in-hospital management questions about whether we have created the kind of environment you are talking about is key.

The other one a lot of people say was mentioned earlier, but it is very key. It is the hope for the future bit. One of the points of having the workforce plan in the first place is to say that you are not going to be



working in an organisation with very high vacancy rates where you are asked to do lots of overtime and difficult shifts.

It is those three components working together. There is definitely the money aspect but, as I say, a lot of that is locked up in the pension. How is the organisation managed, does it make me want to get out of bed in the morning, and can I see hope for the future?

Q92 Mr Francois: Lastly, during Covid, very many people with medical experience, as it were, reported to the colours. That was an amazing act of collective generosity and even bravery to do that and to bolster the NHS in a time of need, but a lot of those people have now gone because they responded to the emergency. Do you have any proposals in the workforce plan to try to get people who have left the service to come back, as opposed to just trying to keep people who have gone?

Sir Chris Wormald: Yes, and I will ask my NHS colleagues to add, but a lot of that is in things that Amanda was talking about in terms of flexibility. This is true across the entire economy, but certainly in the public services. The very sharp break between being either a full-time employee or retired is clearly not the way the world is going to work.

Now, where you are completely right is on our systems, including the very basics of how pensions work and whether you sacrifice pension by going part time. We need people who are in the category that you are talking about: "I would quite like to do more for the NHS, but I do not want to be on call at 2 am and I do not want a full-time job". We need to be developing the roles. There are a lot of new roles, even doing 111 and those sorts of things. Then we need those practical things about how your pension works and whether you get penalised if you do that, but it is all about flexibility.

Chair: You are waking the panel here, Mr Francois.

Mr Francois: They are fighting to get in. It is normally the other way round.

Sir Chris Wormald: One of the most important questions is whether we can get a structure in the workforce.

Professor Sir Stephen Powis: For the medical workforce, if you are a consultant—it is the same argument for GPs—and you are coming up to your 50s and looking at your later career stages, pensions has definitely been an issue. That is resolved. That will encourage a more flexible work-life balance. This is a conversation that we have already started to systematise with consultants at that age around whether they want to stay on call, or whether they want to move to do more educational work, educational training and all the stuff we talked about in the long-term workforce plan. That is the sort of thing that will encourage people to stay.



HOUSE OF COMMONS

Of course, it requires having sufficient workforce to allow people to have that flexibility, which is why the numbers at the heart of this are important. Then, as you have said, it is about making it easier for people to come back, not worrying about pensions, but also coming back into a range of flexible portfolio careers such as 111. That is what will attract people, as they go through their career, to want to stay or, if they do want to leave, not to leave completely. We do not necessarily need you full time. We would rather have you part time than not at all.

Q93 Mr Francois: It is fundamentally important that these principles will apply to the whole system.

Professor Sir Stephen Powis: Exactly, if you are a ward sister, you arrive on a Monday morning and your ward is not fully staffed, and the staff you have are agency staff who you have not worked with before and you are a little unsure of, that is not an environment that sends your morale sky high. If you arrive on a Monday morning to a ward that is fully staffed with people you have worked with, many of whom you have trained, that is the start of a good week.

That is what the long-term plan is designed to deliver, because it is that sort of satisfaction at work that will ultimately lead people to decide that they want to come to work and to continue working for the NHS rather than think about leaving.

Mr Francois: You put it very well.

Q94 Ben Lake: I know we are pressed for time, so if I can ask for brevity in the answers I would be grateful. The discussion this afternoon has outlined a number of the dependencies on which the success of the plan rests. Ms Pritchard, you have just mentioned the investment in technology and innovation infrastructure. Indeed, the plan says that, for it to succeed, it will require a significant increase in funding. Very simply, how much is "significant"?

Amanda Pritchard: The plan, which has support from Government and, in fact, has been widely welcomed cross-party, which is great, talks about continued and sustained investment. That is the important thing. It is the ability, particularly when we are thinking about technology and digitisation, to think about this as not just a one-year thing but a multiyear set of changes. We have explored some of the very practical benefits already.

Q95 Ben Lake: Are we talking about an increase in funding over a period of time?

Amanda Pritchard: That is what we have talked about in the plan. It is continued and sustained but also, particularly in the area of tech, we would certainly want to see that as an overall increase as well.

Q96 Ben Lake: Is that investment something that is in addition to the £2.4 billion over the five years?



HOUSE OF COMMONS

Amanda Pritchard: That is part of what Sir Chris was talking about earlier when he was talking about the overall settlement for the NHS funding. There is already funding set aside for capital investment that is not included in the £2.4 billion.

Q97 **Chair:** That is partly the new hospitals programme, which we will be looking at. We are dancing around this a lot. There is £2.4 billion for five years. You are putting up a heroic argument for how brilliant that is, and that is great, but there is still this question Mr Francois hit on right at the beginning: what about the next 10 years? You have all put in your pitch that you want this to be supported on a cross-party basis. We hear that. We will all go back to our constituencies preparing for Government and make that message clear to our manifesto writers, I guess.

Professor Sir Stephen Powis: Can I make one other point about the five years versus 10 years? It might be a little bit in the small print, but there is a commitment and an ask of Treasury to refresh the plan every two years, because 15 years is an awfully long time. Technology will advance at increasing pace over that 15 years. Describing the workforce in 15 years with any degree of precision is quite challenging, which is why there are a range of numbers in here, but what we might want the workforce to be doing in 10 years' time in 2033 might be a bit different from our view in 2023.

That two-year refresh is going to be important, not just in establishing the funding requirements, but in making sure that we design a workforce that is the right workforce, because we could easily be designing something for 15 years' time at this stage that is not exactly what we need. Just look at artificial intelligence and imaging. That will be transformed by the time we get to 15 years' time.

Chair: That is the positive side. On the negative side, when we saw a dip in the nursing bursary and then the training spaces, that bulge came through. You all want to be optimistic, but there is a negative side of what Governments might have to do or choose to do in future. Anyway, we could get into the plan again. We have not covered it off, but it is already the subject of much debate.

Q98 **Nick Smith:** Ms Marsh, I have just been pondering one of your earlier answers and I wonder if you could help me, please. You said on delayed discharge that hospitals own 20% of the problem, which says that 80% of the problem lies somewhere else. Could you just let us know, in terms of either other bits of the NHS or councils, where the chunky bits of responsibility for that 80% are, please?

Sarah-Jane Marsh: We look at it in four chunks. We look broadly at the group of patients who are going to go home. If the hospital can do everything it can to get a smooth journey, that will reduce that figure.

Q99 **Nick Smith:** Whose responsibility would that be? If it is not the hospital for that set of people, where does the responsibility lie?



HOUSE OF COMMONS

Sarah-Jane Marsh: In the first group, it is predominantly the hospital leadership's responsibility to have the best processes in the hospital to help and support people to leave in a timely way when they are ready.

Q100 **Nick Smith:** That is the 20% you talked about earlier.

Sarah-Jane Marsh: That is broadly 20% of the numbers. That is just when you are quoting the number.

Q101 **Nick Smith:** I am trying to understand the 80%.

Sarah-Jane Marsh: Many of those people may only wait a small amount of time, such as half a day or a day. That is still too many, but they do not tend to have the very long lengths of stay.

To go back to Professor Powis's point, an example of a patient that would trigger that, though, is somebody who steps down in intensive care. From intensive care, they go to the ward. It would trigger the "not meet". They are not necessarily delayed at this point.

Q102 **Nick Smith:** We understand the difficulties that individuals will have and the complexity of the health service. You do a great job. We are just trying to understand the accountability for that 80% because it is such a big number.

Sarah-Jane Marsh: In the remaining group, there are people who need to leave hospital with a short-term package of care, which is health and social care in partnership. It is normally domiciliary care at home but also with some input from NHS community services, and that is the next-largest group of people.

Q103 **Nick Smith:** That is shared responsibility between NHS and who?

Sarah-Jane Marsh: That is shared between NHS and local government.

Nick Smith: About how big is that chunk?

Sarah-Jane Marsh: It works best when people have models.

Q104 **Nick Smith:** I am sorry to press you. I am just trying to understand the 80%. In terms of the shared responsibility between NHS and council, what chunk of that 80% is that, please?

Sarah-Jane Marsh: That is normally somewhere between about 25% and 30% of people who need a shared solution.

Nick Smith: Call that 50%.

Sarah-Jane Marsh: It changes at any one time.

Nick Smith: I know. This is on the back of an envelope.

Sarah-Jane Marsh: Then there is another group of patients who just need to go into NHS community-style beds. We call that the pathway 2, and that is probably another 25% or so of patients.



HOUSE OF COMMONS

Nick Smith: That is another bit of the NHS.

Sarah-Jane Marsh: That is another part of the NHS. Yes, it is usually in community in-patient settings.

Q105 **Nick Smith:** What percentage would that be, please? I am sorry to press you. I am just trying to understand what percentage that would be.

Sarah-Jane Marsh: If we want to be 100% accurate, we should send you those.

Chair: We are getting the general gist. That is fine.

Sarah-Jane Marsh: Then there is another group of patients, which is small in number, but they can sometimes wait the longest amounts of time. These are people who are waiting to go into nursing or residential care, so they will show as only a smaller percentage, but sometimes can wait four or five weeks from when they are ready to go. They are the broad chunks.

The main thing is that this about the way we do this together across health and social care, using our integrated care boards and what we call the better care fund, which is a way of health and social care being able to pool resource together, to come up with shared solutions, because there are very different percentages in different parts of the country, and very different solutions are needed. Yes, it is a complex picture, but in the main it requires health and social care to work together.

Nick Smith: We have a bit of a better understanding of that now. Thank you.

Q106 **Mr Djanogly:** I would just like to look at some of the factors driving trends in access, starting with 111 calls. Ms Marsh, I heard before what you said on ambulances. However, looking at the NAO Report, paragraph 3.4, the number of calls answered within 60 seconds stayed relatively constant at between 11.2 million and 13.3 million up to 2021, despite increasing call volumes, until falling to 8.4 million in 2021-22 and then 8.1 million in 2022-23. The percentage of answered calls also fell very dramatically. Positive satisfaction rates with NHS 111 have gone down by about 10% recently. What is going wrong here? Why did both the number and proportion of 111 calls answered within 60 seconds decline so rapidly in 2021 and 2022?

Sarah-Jane Marsh: We have seen a massive increase in demand for our 111 services over the course of the last few years. It is not just the overall demand. It is not just the total number of people who are trying to use the service; it is the people who are trying to use it at particular points in the day or at weekends.

Just like other parts of the NHS, we have had some recruitment and retention challenges for people working in 111 call centres, so there are times when we are not able to have all the staff in place that we need for



HOUSE OF COMMONS

the total volumes of calls coming through. Just like other parts of the health service, 111 has been under increasing pressure.

We have been working over the last year or so—and we are going to do more in preparation for this winter—on having as much clinical advice and support as possible so that our call handlers, who are answering the phone, have that ability to draw on clinical help, support and advice and get people call-backs if they are unable to answer their queries in the here and now.

We recognise the challenge and that, if people ring 111 and they do not necessarily get an answer in a timely way, they may go to other parts of the health service. It is a priority to get that number of calls answered in a timely way increased, and then that clinical advice and support to help people.

Q107 Mr Djanogly: You have a huge increase in the number of people working in ambulances, but are you saying that the call handlers are not keeping up with that?

Sarah-Jane Marsh: The call handlers for 111 are not necessarily part of the ambulance service. In some places, 111 services are delivered by or in conjunction with ambulance providers, but in others there is a different range of 111 providers, and we see recruitment and retention challenges. It is another area where we have been trying to learn from what works and why people will stay in some 111 services for longer periods, just like other areas such as flexible working.

Q108 Mr Djanogly: Are you saying that one hand was not talking to the other? As numbers of ambulance staff were going up, people dealing with the call handlers did not realise that they also had to respond to that.

Sarah-Jane Marsh: No. From an ambulance point of view, we have been investing in additional paramedics and paramedic technicians to help and support getting more ambulance hours deployed out on the road. The people who are responding to the 111 calls, the call handlers, are not paramedics. They go through a training period and then they go and work within our call centres. They are able to answer and triage calls using our pathway tools, and they can arrange for a clinician to call back if they feel that the patient would benefit from that. Some of the people who provide that call-back service are paramedics, but it is not the ambulance service per se that delivers the 111.

Q109 Mr Djanogly: I understand that, but clearly they are all part of the same service and you cannot have one without the other. It seems to me that they have not been talking to each other in the way they should have been.

Sarah-Jane Marsh: They are not part of the same service, but we would all accept that, if we can get the call handlers—which is not the same as the ambulance workers—in there and answering the calls, that is beneficial.



HOUSE OF COMMONS

Mr Djanogly: There seem to be increased numbers of people who are being advised to go to A&E by 111 calls. What pressure does that put on A&E services?

Chair: Figure 10 on page 33 is useful in this respect.

Q110 **Mr Djanogly:** Is that being addressed as an issue?

Sarah-Jane Marsh: We know that the most accurate advice is given when we get as much clinical advice and support as we can. We had a big programme of this, particularly in paediatrics, over the winter period. We were able to demonstrate that, if we could get experienced general paediatricians working as part of 111, they were able to give the help, support and advice, and therefore patients were not feeling that they needed to go to A&E. We know that clinical advice and support helps.

We do a lot of work looking back and auditing whether some of the people who were advised to go to 111 were appropriate to go to A&E. Often we can make that decision in hindsight once the patient has been assessed and looked at, but it can be very difficult for the call handlers on the phone with the information that they have. In the majority of cases, 111 is effective and is able to stream people from A&E into alternative services, but it is important that there are alternative services that 111 can signpost people to. That is why the UEC recovery plan is as it is. Ultimately, people are ringing because they want help.

Another example of something that we did last winter that we are going to work on for this winter is acute respiratory infection hubs. We can keep people with acute respiratory infections away from hospital and book them an appointment at an acute respiratory hub, which then prevents them needing to go to hospital. We accept the challenge that some people are told to go, but, of the overall people who ring 111, it is a relatively small number.

Professor Sir Stephen Powis: It is important to understand that, in the scripts and algorithms that underpin 111, there is a fair amount of risk aversion built in, because you want to ensure, if there is any doubt about whether this patient or the member of the public calling up needs to be seen by a healthcare professional, for instance in an ED, that that opportunity is given. There is something around those algorithms. If you alter them and shift that risk aversion, there are consequences in terms of potential missed diagnoses. That is an important thing to say.

That is why Ms Marsh has said that the more clinical judgment you can get in to assist with the underlying algorithms and scripts, the better the quality of decision-making you get, so putting a human component into this. Of course, that is a pool of people that we are trying to recruit in several areas. They could be GPs who are doing additional sessions; they could be other clinicians. We are back to the long-term workforce plan, because there is a bit about trying to use the same workforce to do multiple tasks. We all agree that the more clinical input that you can get



HOUSE OF COMMONS

into the 111 service, the more clinically appropriate decisions you will get. It will take away some of the risk management that inevitably has to be done by algorithms and scripts.

Q111 Mr Djanogly: Ms Pritchard, why is the ambulance service unable to meet response time targets when there are more ambulance staff than ever before?

Amanda Pritchard: That goes back to some of the things we have been discussing before. I have to say that the interdependency between different parts of the system is set out very clearly in the Report. Thanks to the NAO for that. That includes, as Sir Geoffrey was saying before, the challenges with discharge that then mean you have hospitals operating at very high levels of occupancy, which makes it difficult to then admit patients from A&E, which in turn means it is difficult for ambulances to offload patients into emergency departments.

You will have seen the figures in the Report that relate to ambulance handovers. That is quite an important metric of whether the flow through the system is working for ambulance services, and it is therefore a big area of focus around why getting the capacity right is so important. We know that, if we can help to improve flow at the back door, but also make sure that we have the right-sized capacities operating at the right levels of occupancy, the whole system will be more efficient, which means ambulances will be able to hand over more quickly. In turn, that of course means that then they will be able to get to incidents more quickly.

As we discussed earlier, it is not just about ambulance handovers; it is also about making sure that they have the staff and physical ambulances that they need. One of the elements of the urgent and emergency care recovery plan was about additional ambulances, as well as additional ambulance staff and training technicians to support paramedics, so that you have the right workforce there in the round to support response times.

Q112 Mr Djanogly: If I could just move on to looking at the A&E departments' target to admit, transfer or discharge 95% of patients within four hours, Sir Chris, how effective is your oversight of NHSE when A&E departments have not met the four-hour target for the last eight years?

Sir Chris Wormald: As I say, we work incredibly closely with colleagues at NHSE and we have a completely shared analysis of what the challenges and solutions are. The very fact of having an urgent and emergency care plan that is agreed between Government and the NHS, which has in it a set of clear trajectories that the Government hold the NHS to account for, is the absolute heart of that system and is replicated in the primary care plan and the electives plan. There is not a difference in analysis between us.

As we said, at the moment the NHS is on trajectory on that plan, but we recognise all the challenges in doing the next bit. As I say, we talk about



HOUSE OF COMMONS

these things several times a week, but just to be clear about what that conversation is—and it goes with the whole integrated care board philosophy—we are focused on joint problem solving.

There is an accountability element. We expect the NHS to hit the targets that it is signed up to, but our major conversation is, “We have X problem. What is it that we can do between us to solve that problem?” If it is a problem with an individual local authority, it may be on our side of the line to solve. If it is a problem with a particular trust, it will be on the NHS side. There is an accountability element, but the vast majority of our conversation is problem solving.

Q113 Mr Djanogly: Do you have a clear idea now that there are enough beds in the right places?

Sir Chris Wormald: As a component of the plan, as Amanda was describing, there was a right-sizing bit, part of which is adding hospital beds and part of which is virtual wards. The analysis was all done by the NHS, entirely shared with us, and we agree with the assessment.

The challenging bit goes back to what we were saying earlier. It is about those really tough systems. What is the individual plan by a system? Right at this second, that is the conversation between us and our NHS colleagues. We agreed the overall plan. The trajectories are being hit. We agree that we are targeting the right systems, but our shared bit of analysis at the moment is about the answer per system.

Q114 Mr Djanogly: If I could just have a little look at post-Covid-19, in what ways is Covid-19 still affecting access to and the performance of unplanned or urgent care services? I note that the NAO Report says that absence rates in the NHS workforce have been higher following the pandemic than they were before.

Professor Sir Stephen Powis: Clearly, the position at the moment is better than it was during the winter. Amanda has acknowledged that earlier. We have around 1,000 patients in hospital. I do not have the figures in front of me, but staff absences due to Covid are obviously going to be less because, first, Covid is less prevalent in the community and, secondly, we have changed some of the testing regimes that we had in place during the height of the pandemic. There are clearly long-term effects from the pandemic in terms of the well-being of NHS staff, which we talked about earlier. Some of our staff are unfortunately impacted by long Covid as well, so we have some ongoing issues coming out of the pandemic.

Q115 Mr Djanogly: What about the absence rates?

Professor Sir Stephen Powis: I do not have the specific absence rates in front of me for Covid.

Q116 Mr Djanogly: The average rate of absence between April 2009 and February 2020 was 4.2%, compared with 5.1% between March 2020 and



HOUSE OF COMMONS

October 2022, with the rate standing at 5.6% in October 2022.

Professor Sir Stephen Powis: I thought you were asking me about the latest figures, which we have.

Matthew Style: The February 2023 absence figure is 5%.

Q117 **Mr Djanogly:** It is down, but still higher than 2022.

Matthew Style: That is correct.

Professor Sir Stephen Powis: Yes, because we have been seeing some ongoing effects.

Q118 **Mr Djanogly:** How can ongoing effects be worse than what was going on during the pandemic, such that absence would be worse now?

Professor Sir Stephen Powis: As we come out of this winter, we have seen the ongoing effects of Covid infections. I would have to look specifically at the figures.

Amanda Pritchard: It relates a bit to what we were talking about earlier. Within why people are off sick, as I said earlier, there are three big reasons. Musculoskeletal issues has been a longstanding issue across the health service, certainly for as long as I can remember. The things that have gone up specifically are respiratory conditions. That includes Covid, and goes up and down a bit, depending, exactly as Professor Powis says, on the level of Covid circulating in the general community.

The third is mental health. It is worth saying that there was, as we have all discussed, an extraordinary response across the NHS during Covid. Thank you for your comments on this earlier, Mr Francois. People did the most extraordinary things on a personal and a professional level, but that has a long-term impact. That is well understood. It is not just in this country that we are seeing that. We are seeing some of that in the current sickness figures. That is one of the reasons why the focus that we have talked about so much today on how to look after our staff and make sure that they are as well supported as possible is so important. We have lots of work to do on this.

Q119 **Mr Djanogly:** Finally, the NAO Report, at paragraph 7 and 9, looks at the numbers of NHS staff and the spending on the NHS. In paragraph 7 it says, "Full-time equivalent staff in the NHS workforce increased by 32.4% from the most recent low of 963,471 in June 2013 to an all-time high of 1,275,354 in February 2023". I found that, over that period, the population of the country increased by 5%. In terms of spending on the NHS budget, total budget in 2022-23 is £152.6 billion, some £28.4 billion more than in 2016-17. We have had this huge increase in staff and money. It has not been enough to stop the decline in performance, so what else is to be done?

Amanda Pritchard: In terms of what we are doing, it is all the things that we have talked about today. We talked earlier about the fact that, of



HOUSE OF COMMONS

course, the urgent and emergency care recovery plan is not in isolation. There is an elective recovery plan; there is a primary care access recovery plan; we have just published the long-term workforce plan. We have been clear about the areas that were most impacted by the pandemic period.

As I have quoted to this Committee before, Professor Powis said right at the beginning that it was going to be at least a five-year journey from the peak of that very acute level of pandemic response. The recovery was going to take time. We are only partway through that, but we have been clear about the areas that the public rightly want us to prioritise in terms of recovery.

I should say that that does not mean we are ignoring mental health. When we talk about elective, that obviously includes cancer. It does not mean we are ignoring maternity services or children and young people, but we are being very clear about what it is that we need to focus the energy and effort on. We have set out very clearly the steps that we are taking.

There is a huge amount to do, but the good news is that we are on track with the actions that were set out in the plan. At the moment, if we look at the latest figures—we talked about this briefly earlier on—we have seen improvement across the board, not just since winter. If you look at the latest published figures in May against those from May last year, you can see that there has been improvement. We feel that we are now able to say quite clearly that the things we have been doing are beginning to make a difference, but we have a very clear set of actions, for this winter and beyond, to hopefully put us in a more sustainable position over the long term.

Sir Chris Wormald: The bit I would add is the bit that goes beyond the NHS. When we look internationally, demand for health across the OECD goes up at about 4% a year, and it is largely driven, obviously, by how many old people you have rather than the total population. How are you going to meet that? Quite clearly, some of it has to be increasing supply; some of it has to be productivity, as we discussed earlier; some of it has to be public health, reducing that 4% demand; and then some of it has to be technology. If we are going to meet that relentless 4% a year, it is going to have to come out of those four things.

Professor Sir Stephen Powis: We started with the demographics about us getting older. Clearly, we are all getting older all the time, but it is about the underlying trend. In the 15 years that the workforce plan covers, we anticipate—I think this is the ONS figures—a 55% increase in the number of people over 85. That is the part of the population often with more than one condition requiring more healthcare.

Chair: We know the metrics.



Professor Sir Stephen Powis: The international comparison is valid as well. We are not the only system around the world under pressure.

Q120 **Chair:** We are here to ask questions about how you are going to deal with that pressure, so we get that the pressure is there.

Sir Chris Wormald: As I was saying, it is about what exactly the right balance is, but there is not a fifth component. It is going to be in those four spaces.

Professor Sir Stephen Powis: The other thing that we can do, of course, is prevention. The more we can get upstream of some of these conditions and the more healthier years of life we can give people, the less pressure it will ultimately put on.

Chair: We have heard you talking passionately on this before, Professor.

Professor Sir Stephen Powis: Therefore I want to remind you again.

Chair: It is well landed. We share your passion. We like passionate people on this Committee. We also like people who give us answers on numbers.

Q121 **Sir Geoffrey Clifton-Brown:** Ms Pritchard, you have just heard Sir Chris lay out his four areas of improvement. I am going to give him a fifth in a minute, but let us just stick with the four areas. On technology, I think you were present at our hearing on digitalising the NHS and the need to get more people to do that. Specifically thinking about my questions on ambulance trusts, we have had evidence from the NHS providers regarding population health analytics. It says they have heard from one ambulance trust about how it used innovative population analytic methods, allowing it to identify drivers of high demand and work with integrated care colleagues to put in place preventive measures. This builds on the previous example of ambulance trusts using their insight and patient data.

Now, I suspect, when I come on in a minute to ask Sir Chris the difference between the best and the worst health trusts, that this sort of advanced analytics would help ambulance trusts, particularly the South Western Ambulance Service, to come up nearer to the best.

Amanda Pritchard: Thank you for giving time to come back to this. I completely agree with Sir Chris's characterisation, thinking bigger picture about what it is going to take for the population as a whole to be supported to be healthier, and then for us to get our demand-supply flow right.

On tech, that is a critical enabler of productivity. If we want to operate as a modern health system, we are going to need to have not just the technical underpinning. The good news is that we are on track to have nine out of 10 trusts with an EPR—electronic patient record—by the end of the year. The bad news is that that is nine out of 10, not 10 out of 10.



If we are talking about some of the things that you would really like to be able to do, such as AI, as Professor Powis mentioned earlier, you have to be able to build on something that is already digital and not something that is paper. It is a perfectly obvious point. We need to put those building blocks in place and, to your point, have the data. The best ICSs—integrated care systems—are uniquely well placed to operate in partnership between NHS, local government and the community and voluntary sector to understand their population and then to design services that are going to meet their needs.

You have just given a great example around ambulance trusts. It underpins a lot of what is in the urgent and emergency care plan, which is about understanding your population and then being able to put in place those services that are the upstream prevention, but also the community response that prevents people from needing to go to hospital in the end.

Chair: We all know the theory. I think Sir Geoffrey wants to know why it is not happening.

Q122 **Sir Geoffrey Clifton-Brown:** Yes. Why is it not happening?

Amanda Pritchard: It is, but my strong view would be that we need to continue to invest in technology. We need to continue, as we are, for example, with the federated data platform, to invest in putting the data systems in place that are then going to enable us to exploit the benefit of having the data and the technological underpinnings to allow us to become that modern health system. We are doing it. It is already paying dividends, and the challenge will be just to continue that journey.

Sir Chris Wormald: When we looked internationally—and this went into a lot of the thinking that created integrated care systems in the first place—we saw quite a lot of examples around the world of where places had done population health analysis well. What we did not see was people being able to do it at scale. As far as we could analyse, the difference between doing it at scale and the localised examples was all in the data. It was very practical: can you put together the datasets and analyse them at scale, so that you can do the intervention at exactly the right moment?

There are lots of good and bad things about the UK system, but this is one of the areas where we ought to have an international advantage if we can get the data curation right, which is why it is in the federated data platforms and all the things we are talking about. It is not a big philosophical question.

Chair: We went on a visit to Denmark to see how they do data.

Sir Chris Wormald: Again, they do it very well at small scales, as it were. Very few people have succeeded in doing it at the levels that we are trying it at. It is a big challenge, but it is all in the practical bits, not in the philosophy.



Q123 **Sir Geoffrey Clifton-Brown:** Sir Chris, you have just walked into my next question.

Sir Chris Wormald: Am I allowed to retreat again?

Q124 **Sir Geoffrey Clifton-Brown:** Rather timidly, like David and Goliath, can I suggest to you that there might be a fifth category in addition to your fourth?

Sir Chris Wormald: Yes, you can. I would be delighted if there is.

Sir Geoffrey Clifton-Brown: In virtually all the metrics that we have been talking about today, including Mark Francois's bureaucracy—but I would add, critically to that, digital—in every single trust, if we brought the worst closer up to the best, it would completely transform the health service. What can be done about that?

Sir Chris Wormald: I would still say that that is in the four, because that is very central to the productivity question, which is clearly at the heart of this. Tackling variability is clearly one of the biggest priorities and it is how we got to the tiering system in the first place. That is all about the variability and whether we can import the best practice.

Q125 **Sir Geoffrey Clifton-Brown:** We know that. We know that it is all about the variability, but how are we going to solve that?

Professor Sir Stephen Powis: We are going to solve it with specific programmes of work. The core tenet of the GIRF programme, which you will be familiar with—getting it right first time—is absolutely, as you said, about identifying variation and then working hands on with those organisations that are performing less well to get them up to the position of the better trusts.

Similarly, a lot of our improvement work—and we have just launched a new improvement programme within the NHS in England—is around identifying that variation and ensuring that people have the improvement tools that they need to improve. The tiering approach that Ms Marsh mentioned is around identifying those—for this, it is around systems rather than just individual trusts—that are performing at the worst end and putting in the additional support that they need in order to bring them up to the better end.

Of course, the caveat is that there will always be some people below average and some above average. I do not need to tell you that, but moving the whole curve upwards and trying to reduce the outliers is absolutely what we are trying to do.

Sir Chris Wormald: The bit that I would add—again, it goes to the thinking that went into the integrated care systems—is the right balance of national versus local. This Committee has reported a lot on the big set piece “let's do it everywhere” programmes and how that has not worked, for a variety of reasons. There clearly are places for national interventions.



HOUSE OF COMMONS

Chair: One at a time, yes. We understand that. The postcode lottery is both good and bad.

Professor Sir Stephen Powis: The other difference that we have made from probably a year ago is what I have just hinted at, in that we have moved from focusing on specific organisations to much more focus on systems, recognising that, in Gloucestershire, as you are very familiar with, it is not just what the trust does but what the system around it does, including the ambulance service and local government. Our focus is much more on helping systems to increase performance and reduce variability than necessarily just individual organisations.

Sir Geoffrey Clifton-Brown: You have just walked into my next question.

Sir Chris Wormald: As long as he answers it, that is fine.

Sir Geoffrey Clifton-Brown: The better care fund is a lot of money and is designed to do exactly what the professor has just been describing, which is to make different parts of the system work better. Presumably, it is helping the integrated care boards.

Sir Chris Wormald: Yes.

Q126 **Sir Geoffrey Clifton-Brown:** The problem with it is that it is quite a lot of money, but often the different parts of the health service do not receive notification of what they are going to get until rather late in the day. They would be able to plan much better if they could have earlier warning of what they were going to get.

Sir Chris Wormald: I absolutely agree with that. The autumn statement and the Chancellor's announcement around this has, hopefully, given people a clearer planning basis, but I completely agree with the thrust of your question.

Q127 **Sir Geoffrey Clifton-Brown:** Might the better care fund help in terms of the question I was asking earlier, which is the shortfall of 165,000 posts in social care, and what much of the discussion today has been taken up by, which is melding social care better in working with the health service? Is there more that we could do with the better care fund and the integrated care boards to solve this problem?

Sir Chris Wormald: Undoubtedly, yes. The integrated care boards are very new. They are in quite different places, depending upon their history. Some are very mature and the style of working that you are describing is well entrenched. Others are much more in the development phase.

To take your Gloucester example, there are two issues there. First, there is the base funding provided for adult social care, the roughly £21 billion raised by local taxation that goes into the system. Then there is the couple of billion that we put on top, which is normally much more focused on that adult social care/health interface, which is where the integrated



HOUSE OF COMMONS

care boards come in. The base investment in the underlying system is essential to make that work.

While the joint money is very important, what is the base level of the service and, therefore, the Government's additional investments there? If representatives of local government were sitting here, they would say that that bit is considerably more important than the joint bit, because it is about the quality of the underlying service.

Q128 Sir Geoffrey Clifton-Brown: Who is going to be responsible for overseeing the work of the integrated care boards, given that they are not entirely a health creation? They are partly health and partly local government. Who is going to be overseeing their critical work?

Sir Chris Wormald: We have not changed the basic legals, as you know, so social care remains a primary responsibility of local government. The ICBs will certainly work best largely as a joint venture between two independent bodies. Where relations are mature, that works much better.

The thing that we have changed, which was in the Health and Care Act that we have just passed, is that, for the first time, we have inspection oversight of local government commissioning via CQC, and we have compulsory data collections so that we have a much better base knowledge of what is being done in social care.

We have taken steps to create greater national oversight of both the joint work and the base work, but in a system where that money is still the responsibility of elected local councillors. We have not changed that. We have taken as a piece of principle that both we and local government want to see things get better and to solve these problems, and the ICB structure is to give a basis for people who want to work together and to solve these problems to do so. I would not want to suggest that it is a top-down system in the way that we have on the NHS.

Sir Geoffrey Clifton-Brown: I am more worried about the people who do not want to work together, but we will come to that another day, I am sure.

Q129 Mr Francois: So much of this comes down to the quality of leadership at local level. Most trust executives last for 18 months or less now. What are you doing to reverse that, first, to improve the quality of leaders and, secondly, to keep them in place for longer?

Sir Chris Wormald: We had a discussion last time we were here around the leadership review, which, as you identified, has an awful lot of sensible recommendations in it. Do you want to talk about hospital trusts?

Chair: Ms Pritchard, you are atop this system. You were both former chief execs, of course.

Amanda Pritchard: Indeed, yes.

Mr Francois: I was thinking specifically of hospital chief execs.



HOUSE OF COMMONS

Amanda Pritchard: You will be aware that, during the pandemic, we had very little turnover of hospital chief executives. Indeed, across the NHS, people just got stuck in. Since we have now hit the recovery phase, which is extremely hard work, we have seen much more movement in chief executives.

We have two things worth mentioning and then something else. First, there is a real question, which we have been grappling with for many years now, about how to make sure we have the right pipeline of people with real talent. This is one of my favourite subjects. It is not just people who have come up through a general management route, but they might be doctors, nurses, therapists or accountants who have come through.

Indeed, we have many people who come through different routes to chief executive level. We developed a programme a number of years ago called the aspiring chief executive programme, which has been very successful in helping to develop people, so that they have the skills and so that we are setting people up to succeed, rather than setting people up without that support.

Secondly, with the brilliant work that Sir Gordon Messenger and Linda Pollard did in their review, we have a really clear set of recommendations around not just chief executives or, indeed, executive teams, but the whole of leadership and management across the NHS. We have taken those recommendations and are starting in a range of ways, including induction, so at both ends. As an urgent and early priority, we are putting the framework in place to ensure that chief executives have an ability to both self-assess and be assessed about how they are doing, and then to access the support they need. We have an existing structured programme for newly appointed chief execs, but we are enhancing that with coaching, mentoring and buddying with more established chief executives who can help people to make sure that they have somewhere to go if things are proving more difficult.

Mr Francois: We have got the gist of it.

Amanda Pritchard: There is a whole range of things in place there.

Q130 **Chair:** So it is on your mind and you are doing quite a lot to get there.

Amanda Pritchard: Yes. A third thing to say is that this is also where systems matter.

Q131 **Chair:** We have heard a lot about those, and we have got that very loud and clear. I want to turn, if I may, just briefly, before we finish, to Sarah-Jane Marsh and Professor Powis. It is your baby, Ms Marsh. You have come in. You have given up your hospital to come and work in NHS England, so it is a big step, and you are six months on in delivering on this programme. How confident are you that you are on track to sort out urgent and emergency care?



HOUSE OF COMMONS

Sarah-Jane Marsh: You can see that the challenge in front of us is significant. The UEC recovery plan is the right plan for the next 12 months to stand us in really good stead. We have the investment in the additional things that we have talked about—extra beds, ambulances, virtual wards and so on—but also changing the way that we work and trying to keep more people at home rather than bringing them to hospital.

We can see the early signs of success. We have seen improved performance during the year, particularly in April and May, compared to the previous April and May. I do not think that we are remotely complacent about the winter that we have ahead. We know that we are going to face risks. Some of those are known. We do not know what the precise nature of Covid and flu is going to be. We have early indications from the southern hemisphere that it might be a challenging flu season. We also potentially have industrial action, which brings with it some uncertainty.

I feel really confident in the plan that we have set out and the actions that we are taking, but I do not think that it will be plain sailing.

Chair: When it hits the real world.

Sarah-Jane Marsh: When it hits the real world, there is an awful lot of challenge this winter, but the commitment is there to absolutely be focused.

Q132 **Chair:** You have outlined some of the external challenges. Which targets in the plan are most at risk?

Sarah-Jane Marsh: The most challenging one from my perspective is the 30-minute ambulance response time, because the whole system needs to work for that to work. As I say, we are absolutely focused on all the actions that we can do, both inside the ambulance service itself, and in the emergency department and beyond, to do it. I am confident that we will do better than we did last winter. We want to achieve this, but it is going to be tight.

Q133 **Chair:** Is it particularly winter that you are worried about?

Sarah-Jane Marsh: Yes, it is over the winter period and then what does, because the target is measured for the year as a whole.

Q134 **Chair:** So winter is one of your big areas.

Sarah-Jane Marsh: It is just the resilience of winter. It is particularly in the systems that we have talked about here. We might be able to achieve it in England overall, but we need to be able to do that consistently in some of our more fragile systems.

Chair: I am heartened that we are talking about winter in July rather than in November.

Sarah-Jane Marsh: I talk about it every day, to be honest.



HOUSE OF COMMONS

Professor Sir Stephen Powis: To be honest, I thought that you were going to say that Sarah-Jane had given up the hospital chief executive job for the opportunity of appearing before the Public Accounts Committee, but that was another perk.

Chair: I did not think about that.

Professor Sir Stephen Powis: This is my sixth winter coming up since I started in the job. My reflection would be that, this year, we have started earlier than ever before. We started in January and February of this year, so we are well ahead in our thinking. Importantly, systems are well ahead in their thinking as well. We are really focused on getting things in place as much as possible by September or October, rather than a last-minute dash to do it as we go into winter.

We are doing the right things. We have a list of things, one of which is virtual wards, as well as investment in ambulance services and a focus on discharge. They are all the right things. Yes, there is variation, as you said, and we have to focus on supporting those that are doing worse at the moment and getting them into a better place.

Having said all of that, winter will be challenging. Winters are always challenging. The demographics, as we have said, are not going in our favour. Last winter was particularly unusual, because it was the first winter out of Covid and restrictions, so we had group A strep and respiratory syncytial virus out of season. We had Covid and flu occurring simultaneously—the twindemic.

Chair: Yes, we remember the pressures.

Professor Sir Stephen Powis: I hope that this winter will be a little bit less unusual, but we will still have Covid and flu. As Sarah-Jane has said, the season in Australia has been another early season, so their flu season started early in their winter this year. In the last two flu seasons, in 2018-19 and last year, we had a December peak, which is a bit more unusual; it is usually January. We could get an early flu peak again. It could still be a significant peak and it could occur simultaneously with Covid. There is no doubt that that will put pressure on us that we have not seen in the years pre-Covid, and with all those underlying demographic changes, which have not changed.

Chair: So you put in all the caveats and there are still a lot of worries for the winter.

Professor Sir Stephen Powis: We are doing everything that we can, but we will still need a better winter. Of course, the public always do their bit by using services sensibly and getting vaccinated. Let us not forget that the vaccine programmes will start.

Chair: That is a good one to finish on.



HOUSE OF COMMONS

Professor Sir Stephen Powis: On the vaccines side, there is some good news in that there is an RSV vaccine, so we are looking to see, along with colleagues at DH, as and when we can start that.

Q135 **Chair:** So the message is, "Save the NHS and get vaccinated", is it?

Professor Sir Stephen Powis: That is always a message that we end on when it comes to September, October and November: Covid vaccines and flu vaccines if you are eligible. That is what the public can do to help us manage winter.

Chair: For a number of us on the Committee, it is good to be over 50 in terms of vaccines. Never has it been such a good time. Can I thank you very much indeed for your time? The transcript of this session will be available on the website uncorrected in the next couple of days. Thank you very much to our colleagues at Hansard for that. We will be producing a Report on this subject in the autumn.