Lords report on emergency care – Response

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1. Managing pressures in urgent and emergency care

Comment 1: The state of emergency healthcare is a national emergency. The substantial delays that patients face when trying to access emergency health services create considerable emotional distress and unprecedented risk

Comment 9: The crisis of emergency healthcare should be referred to a COBR committee.

1.1. The Government recognises the pressures on urgent and emergency care services. Pressure rises during winter, when demand for hospital beds surges due to seasonal respiratory conditions, higher numbers of elderly patients with higher acuity conditions and longer lengths of stay.

1.2. This winter for the first time we have seen the dual pressures of COVID-19 and flu co-circulating, leading to further demand pressures. In December, A&E attendances rose to record levels with 74,000 patients per day, 4.7% more than December 2019.

1.3. Action has been taken by the Government and NHS England to respond to these pressures. In August 2022, NHS England published their winter plan "Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter"[1]. In October 2022, they expanded on this[2], setting out actions that trusts should take to prepare for winter. These included increasing bed capacity and expanding the use of innovative virtual wards; establishing 24/7 System Control Centres to better manage emergency demand; delivering an integrated COVID-19 and flu vaccination programme; and putting community-based falls services in place in all local systems, helping to free up ambulance services to respond to other emergency calls.

1.4. In September, the £500 million Adult Social Care Discharge Fund[3], was announced. In addition to this, on 9 January 2023, the Secretary of State for Health and Social Care (hereafter referred to as "the Secretary of State"), set out to Parliament[4] the additional support that would be provided to the NHS in England in order to reduce pressure on urgent and emergency services, and enable patients to be seen promptly. This £250 million support package

[1] Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of this winter: https://www.england.nhs.uk/long-read/next-steps-in-increasing-capacity-and-operational-resilience-in-urgent-and-emergency-care-ahead-of-winter/

[2] Going further on winter resilience plans: https://www.england.nhs.uk/long-read/going-further-on-winter-resilience-plans/

[3] Adult Social Care Discharge Fund grant conditions: https://www.gov.uk/government/publications/adult-social-care-discharge-fund

[4] https://hansard.parliament.uk/commons/2023-01-09/debates/DAD854EC-BE5D-48EF-B8EB-99FE327E31D0/NHSWinterPressures

provided £200 million to speed up hospital discharge, freeing up beds for new patients, and £50 million in capital funding to expand existing discharge lounges and ambulance hubs.

1.5. The pressures on urgent and emergency care services this winter are unprecedented, but we need to make sure that the NHS is ready for winters to come. In September 2022, we announced that the government was investing an additional £3.3 billion in each of 2023-24 and 2024-25, to support the NHS in England, enabling rapid action to improve emergency, elective and primary care performance towards pre-pandemic levels. Backed with this funding, on 30 January 2023, the government and NHS England together published the Delivery Plan for Recovering Urgent and Emergency Services[5]. Building on work done this winter, the plan commits to: putting 800 new ambulances on the road, including 100 specialist mental health vehicles; adding 5,000 hospital beds to the permanent bed base for next winter; scaling up innovative virtual wards to support 50,000 patients a month to recover in their own homes; and expanding community services including falls, frailty and community response teams to better support vulnerable people and reduce unnecessary hospital trips.

1.6. The full and effective implementation of this ambitious plan is the work of the Department and the NHS over the coming months, ahead of next winter.

COBR committee

1.7. The government does not agree with the committee's recommendation to refer the current state of urgent and emergency care to a COBR committee.

1.8. The Department of Health and Social care and NHS England have established functions to tackle issues within the health system, including demand pressures, and is taking action on urgent and emergency care, as set out above.

[5] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/

2. A vision for the future

2.1. National oversight

Comment 8: Health systems on a local level cannot be expected to develop a common vision and purpose without a clear national steer on their common purpose. There is no such steer.

Comment 10: Emergency and urgent care services are working to an outdated operating model which no longer reflects the reality of demand or clinical practice. The limited efforts to address this seem to have stalled. Persisting with an outdated model will prevent services from delivering care that patients need.

Comment 13: The Government should consider, consult upon, and establish a bold and ambitious new operating model for emergency healthcare. This operating model must address pressures throughout the system and provide strong leadership to:

- ***reflect increased demand for, and new ways of delivering, emergency healthcare services;***
- ***establish robust accountability arrangements at national, ICS, and service level;***
- ***set clear expectations and arrangements for collaboration with other emergency responders***
- ***establish functional mechanisms to improve the sharing of good practice***

Our plan for the recovery of urgent and emergency care services

2.1.1. The Delivery Plan for Recovering Urgent and Emergency Services (hereafter referred to as the "recovery plan")[6], published 30 January 2023, sets out a vision for the future of urgent and emergency care services nationally, and how we will improve performance – reforming the system and providing a better experience for patients. This plan builds on the investment and actions taken this winter to increase capacity and resilience, by taking steps to embed what works for patients while also creating space for people to innovate. It also builds on the experience during COVID, which brought out the best in the NHS – with new services scaled quickly, genuine innovation focused on

[6] Delivery plan for recovering urgent and emergency care services: https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/

improving patient care, and better working across different types of care provider, centred on the needs of patients.

2.1.2. The recovery plan sets a number of ambitions to support the recovery of performance, including 76% of patients being admitted, transferred, or discharged within 4 hours by March 2024 and improvements to ambulance response times for category 2 incidents to 30 minutes on average over 2023-24. These provide a clear focus for recovery and meeting them would represent one of the fastest and longest sustained improvements in emergency waiting times in the NHS's history. To ensure greater transparency, we will also publish data on 12-hour delays from time of arrival in A&E from April.

Delivery of the plan

2.1.3. Delivery of the recovery plan will reflect the new NHS operating framework[7], with alignment through the national, regional and local level, including the Department and local authorities to ensure full involvement of social care.

2.1.4. Accountability arrangements of the health and social care system are already well established. Nationally, DHSC Ministers are accountable to Parliament for health and social care. NHS England is also accountable to Parliament, via the Secretary of State, for the delivery of the mandate and their statutory functions. As set out in further detail below, local systems – including integrated care boards (ICBs) and NHS providers – are accountable to NHS England and Ministers.

2.1.5. ICBs will be accountable for delivery of the recovery plan across health, able to draw together different partners and provide a cross-system view of the interventions required for delivery. Close working with local government will be essential, for example on improved hospital discharge. All partners will work together to improve flow through increased use of joint working such as care transfer hubs. Local areas are currently developing their plans for delivering the performance ambitions set out in the recovery plan. Delivery of these will be monitored by regional and national teams, providing oversight, support and intervention as appropriate.

Sharing good practice

2.1.6. We agree with the Committee's recommendation to establish functional mechanisms to enable the sharing of good practice. Through national and regional teams, NHS England will work on the ground to support and challenge systems to deliver the recovery plan. This includes identifying and sharing good practice so that all can learn from the best, and providing tiered intervention which will include intensive support for areas struggling the most.

2.1.7. By April 2023 a complementary, clinically and professionally led programme to reduce unwarranted variation will be established by NHS England. This

[7] NHS operating framework: https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf

programme will increase the standardisation of what works across different areas of urgent and emergency care. Subject specific improvement collaboratives will be established to co-develop across systems and share emerging good practice, drawing on teams of experts.

2.1.8. This builds on work undertaken by the national Winter Improvement Collaborative and discharge “100 Day Challenge” this winter. Set up in October 2022, the Winter Improvement Collaborative works with local systems to identify good practice and spread it at scale. The collaborative is clinically led, and all systems were asked to participate supporting teams to identify, evaluate and scale innovation in improving ambulance handover delays and response times, supported by a single set of metrics.

2.1.9. The National Health and Care Discharge Taskforce (NDTF), established to better understand the drivers of delayed discharges, designed a series of 100-Day Challenge initiatives to share and implement best practice throughout the health and care system. The initial 100-day challenge initiative focused on acute trusts. This was designed to help trusts improve flow based on 10 best practice initiatives. We found good progress in systems and providers’ self-assessments against their implementation of the 10 best practice initiatives. The initiative has now been extended to focus on community and mental health providers. Two new challenges were launched in early December 2022, to run until the end of March 2023, with a similar but discrete set of best practices tailored to those trusts.

<u>New models for urgent care</u>

2.1.10. We know that many patients can receive better, safer, more convenient care outside of hospital. The recovery plan commits to expanding and better joining up new types of care outside of hospital, ensuring that patients who do not need to attend hospital receive more appropriate care in the community. NHS England has also begun a programme of work to develop and pilot a new approach to intermediate care, designed to help people move from hospital into more appropriate settings for their needs, with the right wrap-around support for their rehab and reablement.

2.1.11. For example, the recovery plan sets out that, to reduce unnecessary conveyances to hospital, we will (a) implement single points of access for paramedics to provide a single, simple route for referrals to hospitals; (b) increase clinical assessments of 999 calls to ensure that the sickest patients are prioritised for ambulances; (c) extend our urgent community response offer to reduce admissions to hospitals; (d) make improvements to NHS 111 so that it becomes patients’ first port of call, rather than attending A&E or calling 999; and (e) expand the use of ‘virtual wards’ to enable patients to be treated at home, rather than being admitted to hospital.

<u>Collaboration with other emergency services</u>

2.1.12. We also recognise the importance of effective collaboration between the emergency services. Ministers from DHSC and the Home Office are

leading discussions with the services about collaboration between the ambulance and fire services, and where this can be developed further. In addition, DHSC and the Home Office, with the College of Policing, the National Police Chiefs' Council (NPCC) and NHS England are working together to develop a National Partnership Agreement incorporating the principles of the Right Care, Right Person, and operating model followed in Humberside, to ensure people in mental health crisis get the right support.

2.2. Local systems

Comment 11: Integrated Care Boards and Systems have potential to deliver services that address local population need and make significant improvements. There appears, though, to be little understanding of how they will function, or who will be accountable for the delivery of services. We consider it unlikely that ICSs and ICBs will be able to deliver on the high expectations placed on them without further clarity on these matters. They will also need more leadership from the centre than is currently envisaged.

Comment 12: Following the Hewitt Review, the Government must set out accountability and governance arrangements for ICBs and ICSs. These systems must consider how to ensure system accountability where challenges in one service have a domino effect on others.

2.2.1. The Health and Social Care Act (2022), which established Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) in statute was deliberately permissive. This enables Integrated Care Systems (ICSs) the freedom and flexibility to function in the way that best suits their local circumstances and gives them the ability to adapt services to meet local population needs. Legislation gives ICBs responsibility for a range of functions and duties, including, but not limited to, commissioning the significant majority of health services in their areas, holding budgets and duty to co-operate, enabling them to design services and pathways of care that better meet local priorities. We believe that this approach will result in improved outcomes and increased efficiency.

2.2.2. The governance and accountability arrangements for different parts of ICSs are clearly set out in legislation, with supporting guidance[8]. NHS providers are accountable to ICBs for delivery of services and performance. NHS providers' contributions to the system strategy and plan and must be compliant with the provider license and Care Quality Commission (CQC) standards. NHS England holds ICBs and NHS providers to account for delivery of national priorities, and the ICB's statutory functions, and oversees them via the NHS oversight framework[9]. Local authorities are accountable to their local electorates.

2.2.3. Formal accountability of this kind sits alongside, and is reinforced by, other forms of accountability between partners within a system. This is sometimes

[8] See NHS operating framework: https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf and NHS oversight framework: https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf

[9] https://www.england.nhs.uk/wp-content/uploads/2022/06/B1378_NHS-System-Oversight-Framework-22-23_260722.pdf

termed ‘mutual accountability’. This form of accountability often matters most to the successful delivery of shared priorities such as improvements in discharge or meeting the needs of people with learning disabilities in a holistic way. In ICSs, this is achieved through Integrated Care Partnerships (ICPs), where partners across the system work together to develop an integrated care strategy. Before the start of each financial year, an ICB and its partner NHS trusts and NHS foundation trusts develop a Joint Forward Plan (JFP), setting out how they propose to exercise their functions in the next five years. The ICBs must have due regard to integrated care strategies as well as national priorities set by the DHSC and NHSE when making their decisions. The integrated care strategies should have regard to the Mandate to NHS England and any guidance issued by the Secretary of State.

2.2.4. CQC will play an important role in assessing ICSs from April 2023. The intention is for reviews to provide independent assurance to the public and Parliament of how well different partners of the system are working together towards meeting the needs of their local population. They will help encourage service improvement across each system – identifying areas for further support, but also best practice. The Health and Social Care Act (2022) obliges the Secretary of State to set objectives and priorities for ICS assessments, which must include those relating to leadership, quality and safety and integration. After every review, CQC are required to publish its assessment.

2.2.5. The structures and processes in the Health and Social Care Act (2022) are specifically designed to ensure that different partners of an ICS resolve issues together. This is further reinforced by the duties to co-operate placed upon NHS and local authority partners by the NHS Act (2006). NHS England holds the regulatory powers to take necessary formal enforcement action if an ICB or provider has failed or is at risk of failing to perform their duties or meet required standards. NHS England via their oversight framework categorise ICBs and NHS providers on a scale of 1 to 4 and provides mandated support for the most challenged providers and systems. Those in NHS Oversight Framework 3 receive bespoke mandated support from a regional improvement hub. Those in segment 4, with significant financial and quality issues, receive mandated support via the Recovery Support Programme. If there is evidence that established arrangements are not working, the Department – alongside other national partners - will take appropriate action.

2.2.6. ICSs were designed to strike the right balance between system and local leadership, and national support and intervention when needed. The Hewitt review will provide advice on how to ensure national oversight alongside local decision-making. The Department will carefully consider the findings of this review, and plan next steps accordingly. The Department will also continue to take an active interest in the development, success, and challenges of ICSs.

3. Right care, in the right place

3.1. Reducing attendances at A&E through care in the community

Comment 3: In many cases, patients are attending emergency care services because they have – or feel they have – no alternative. The models for primary and community care are broken.

Comment 5: The crisis in emergency healthcare is a symptom of fundamental weaknesses arising from inadequate capacity across primary, community and hospital and social care settings. A new model for primary care is needed.

Comment 18: The Department of Health and Social Care should mandate a greater presence of clinical staff in NHS 111 control centres.

3.1.1. One of the best ways to reduce pressures on urgent and emergency care is by ensuring that patients are able to access care outside hospital. We also know that timely access of community care can lead to better patient outcomes in the long term, avoiding deconditioning and prolonged recovery that can accompany a hospital stay. The recovery plan recognises that up to 20% of emergency admissions are potentially avoidable with the right care in place[10][11]. The plan commits to expanding and better joining up new types of care outside hospital.

Care in the community

3.1.2. Community health services are vital for giving people access to the care that they need to stay well and independent at home, and to manage demand and flow across the entire system. Each month over 1 million people receive care and support from community health services.

3.1.3. Urgent community response services provide fast access to urgent care services at home and are key to enabling people to be treated closer to where they live, avoiding hospital admissions. In November 2022, 82% of urgent community referrals were managed within two hours, providing rapid urgent care to people in their home.

3.1.4. Falls are the number one single reason why older people are taken to the emergency department, and around 30% of people over 65 will fall at least once a year. Care outside of hospital is of particular importance for older people living with frailty, who are much more likely than younger people to be admitted to hospital, and likely to have a longer stay when they are admitted.

[10] https://www.health.org.uk/sites/default/files/QualityWatch_FocusOnPreventableAdmissions.pdf
[11] https://www.health.org.uk/publications/emergency-hospital-admissions-in-england-which-may-be-avoidable-and-how

3.1.5. As part of NHS England's winter plan, and to reduce ambulance callouts and subsequent hospital admissions, all ICBs have now established a community-based falls response. These services operate seven days a week, from 8am to 8pm, responding to adults who have fallen at home or in a care home and have no known injury or illness, or where there is a minor injury requiring further clinical assessment by a healthcare professional.

3.1.6. The recovery plan goes further – the NHS is scaling up falls and frailty services based on the learning from this winter, including consistently meeting or exceeding 70% of patients referred within two hours, with a service that operates for at least 12 hours a day.

3.1.7. In addition to the planned £77 million for community health services in 2023-24, additional targeted funding to support urgent community response winter preparedness will be rolled out from April 2023.

3.1.8. As set out in the recovery plan, the NHS will roll out adult and paediatric Acute Respiratory Infection (ARI) Hubs to provide timely access to same day assessment, preventing hospital attendance and ambulance conveyances. The ambition is that each local area that would benefit has one in place ahead of next winter, learning from those that already exist. These hubs are integrated across primary, secondary and community care and will be a key point of referral for, or to, virtual wards. Patients are identified through remote consultation as requiring face-to-face assessment but not requiring hospitalisation.

<u>Bringing hospital care into the home</u>

3.1.9. One example of better, more convenient care for patients is hospital care at home through 'virtual wards', which are bridging the gap between hospitals and patients' homes. Virtual wards combine technology and face-to-face provision to allow hospital-level care including diagnostics and treatment, using many of the same staff that work in hospitals. In some cases, virtual wards can replace the need for admission, and in others facilitate people being able to safely leave hospital sooner.

3.1.10. The NHS is currently developing virtual wards at scale through investment in community provision for conditions including frailty, acute respiratory conditions and heart failure. The NHS has successfully rolled out 7,000 virtual ward beds, with capacity increasing by nearly 50% since the summer. As set out in the recovery plan, the ambition is to scale up capacity ahead of next winter to above 10,000 with a longer-term ambition of reaching 40-50 virtual wards per 100,000 people, which would mean more than 50,000 admissions a month. As well as continuing to increase capacity, we need to increase utilisation of virtual wards, to make more of the capacity we already have.

<u>Improving access to and awareness of alternative settings to hospitals</u>

3.1.11. NHS 111 helps people to access the right care in the right place, in a timely way. We want to make 111 online and calling 111 the first port of call so that patients can easily access appropriate advice, and be directed to the most effective care, without feeling that they have to go to A&E or call 999. Many patients will need clinical advice, and we are looking to better use clinicians in 111 for the patients who will benefit most. To support this ambition, we will need to grow our workforce. From April 2023, we will launch a promotion campaign for working in NHS 111 and Integrated Urgent Care as a flexible option for clinicians, including returners. We will also provide a route for retiring or recently retired clinical staff.

3.1.12. New technologies should help people to get clinical advice and be directed to the most effective care. Clinical advice to NHS 111 underpins our plan to assess and direct patients to the most appropriate point of care, whether that be self-care, pharmacy, general practice, advice from a paediatrician, mental health crisis centre, an urgent treatment centre, or another setting.

Creating a sustainable primary care system

3.1.1. We recognise that primary care is under enormous pressure. In the Autumn Statement, we committed to publishing a recovery plan for primary care, which is due to be published in the coming weeks. The plan will aim to make it easier for the public to contact their practice, and easier for practices to see patients sooner.

3.1.2. This plan builds on work that is already underway. We are investing at least £1.5 billion to create an additional 50 million general practice appointments by 2024, by increasing and diversifying the workforce. In January 2023, there were on average 1.4 million appointments per working day, excluding Covid-19 vaccinations. Compared to January 2022 (1.29m), this is an increase of 9.3% and compared to January 2020 (1.27m) this is an increase of 10.9%.

3.1.3. Our plan for patients[12], published in September 2022, helps people to make an informed choice about which practice is best for them, book an appointment more easily, and benefit from more options when they need care. By doing so, we aim to reduce frustrations around appointment availability that may lead patients to feel that A&E is their only option to receive care. The plan also sets an expectation that patients who need an appointment with their GP practice within two weeks should get one, and that patients with urgent needs should be seen on the same day. Coupled with this and furthering efforts to improve access, we are supporting practices to put in place more state-of-the art telephone systems to make it easier for patients to get through to their GP surgeries.

3.1.4. Greater appointment availability depends on us having a strong general practice workforce. We are working with Health Education England and the NHS to grow the workforce by boosting recruitment, addressing the reasons

[12] https://www.gov.uk/government/publications/our-plan-for-patients/our-plan-for-patients

why doctors leave and encouraging them to return to practice. There were over 2,000 more full time equivalent doctors working in general practice in December 2022 compared to the December 2019 and a record-breaking number started training as GPs last year. Also, through the Additional Role Reimbursement Scheme (ARRS) and its associated rise in funding, we have recruited over 25,000 additional staff into general practice since 2019, covering a range of non-medical roles, such as physiotherapists and pharmacists. Continued expansion of the ARRS supports doctors and nurses in general practice to focus their attention on those that need them most, and seeks to prevent the escalation of cases that results in patients turning to A&E as a last resort.

3.1.5. The 2023-24 GP Contract was published on 6 March 2023. The changes to the GP contract in 2023-24 set out the requirements of General Practice and Primary Care Networks (PCNs) with the goal of improving patient experience and satisfaction and we recognise that this will require both time and support to assess, review and implement changes. We intend to provide this support in a number of ways, including freeing up workforce capacity through significant changes to the Impact and Investment Fund (IIF) and through the Quality Outcomes Framework Quality Improvement (QI) modules. Further support for practices and PCNs will be outlined in the recovery plan.

3.1.6. Pharmacies also play an important role in preventing emergency admissions to hospital through the discharge medicine service and the new medicine service, which support people with newly prescribed medications to take them optimally and reduces medicine errors on transfer of care between secondary and primary care.

3.1.7. Dr Claire Fuller's Stocktake, on Next Steps for Integrating Primary Care[13], was published in May 2022 and endorsed by all 42 ICS chief executives. It describes an ambition for integrated primary care that provides more proactive and personalised support and advice to patients. It describes an ambition for integrated primary care that provides more proactive and personalised support and advice to patients, including a parallel focus on access and continuity of care, to streamline access to urgent, same-day care and advice, and ensure those that need to most benefit from continuity of care With NHS England, we are considering the recommendations made in Dr Fuller's Stocktake to support more integrated and equitable primary care.

3.1.8. The ambitions of the Fuller Stocktake are reflected in the recovery plan. The intention is for partnerships between acute, community and mental health providers, primary care, social care, and the voluntary sector, to provide more care in the community and prevent escalation to emergency departments. This can only be achieved by bolstering the offer of out-of-hospital care available to patients, making it easier for them to access the right care in the community.

[13] https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

3.2. Enabling people who do not need to be in hospital to be discharged quickly

Comment 6: The Government should introduce further incentives to enable discharge at the right time for patients, freeing up hospital capacity. This could include further use of NHS budgets to cover social care costs.

Comment 7: While the Government's interventions to boost capacity in social care are welcome, they will not be sufficient to fully address the problem.

3.2.1. The government agrees that enabling the safe and timely discharge of patients from hospital into the most appropriate setting is an important part of decreasing hospital bed occupancy, ensuring good flow through acute settings, as well as supporting better patient outcomes.

Improving delayed discharges

3.2.2. This winter, the government provided up to £700 million of funding specifically to help speed up hospital discharge. The £500 million Adult Social Care Discharge Fund, announced in September 2022, was put in place to enable more discharges from hospital into social care, such as purchasing care packages, providing assistive technologies, and improving workforce recruitment and retention. A further £200 million was provided in January 2023, specifically for short-term care. ICBs, working closely with local authorities, have been using this funding to purchase places in care homes and other settings, such as hospices. This has also been used to help fund wrap-around primary and community health services to support patients' recovery. An additional £50 million was made available to the NHS for capital expenditure, which could be spent on measures including facilities for patients about to be discharged.

3.2.3. In line with the recommendation in this report, and as set out in the recovery plan, the government is introducing additional measures to promote the safe and timely discharge of patients from hospital. Over the next two years we are making £14.1 billion available to support health and social care. £3.3 billion in 2023-24 and in 2024-25 will be provided for the NHS to take rapid action to improve urgent and emergency care, and up to £2.8 billion in 2023-24 and up to £4.7 billion in 2024-25 in additional funding will support adult social care and discharge.

3.2.4. Of the additional funding to support adult social care and discharge announced at the Autumn Statement, £1.6 billion in new grant funding will specifically be allocated to support discharge into appropriate care settings - £600 million in 2023-24 and £1 billion in 2024-25. This will be delivered

through the Better Care Fund (further detail below), enabling health and social care leaders to jointly make decisions about how this funding is best spent.

3.2.5. ‘Care transfer hubs’ in every hospital ahead of next winter will mean faster discharge to the right setting, so that people do not stay in hospital longer than necessary. This year, new approaches to step-down care will start to be implemented so, for example, people who need physiotherapy can access care as they are being discharged from hospital before they need to be assessed by their local authority for long-term care needs. Finally, as set out in section 3 of this response, new discharge information will be published with new data collected from this April.

3.2.6. In addition to significant investment, and the commitments in the recovery plan, the government has introduced several measures to support timely discharge for patients.

3.2.7. In January 2022, we set up the National Health and Care Discharge Taskforce, to better understand the drivers of delayed discharges, and the actions that could be taken to improve performance and outcomes. Alongside work to use existing resources and processes more effectively, the Taskforce has taken forward two specific initiatives: Frontrunners and 100 Day Challenges.

3.2.8. This January we announced six National Discharge Frontrunners, which are trialling innovative solutions such as dedicated dementia hubs, new offers of provision for rehabilitative care, and creating effective data tools to help manage demand for discharge of medically fit patients – giving them the help they need to live comfortably in the community after a hospital stay.

3.2.9. The 100-day challenge was designed to help acute trusts improve flow based on 10 best practice initiatives. Over the 100 days we saw improvements in reducing hospital-related delays. The initiative has now been extended to focus on community and mental health providers. Two new challenges were launched in early December 2022, to run until the end of March 2023, with a similar but discrete set of best practices tailored to those trusts.

3.2.10. Hospital discharge guidance has been published which is aimed at senior leaders in NHS commissioning bodies, local authorities, and relevant sectors, such as care providers. The guidance sets out how local areas can plan and implement hospital discharge services. The guidance seeks to support local areas as partners to jointly agree how to use their resources to best effect, to deliver the best possible outcomes for their population. Updated statutory guidance on discharge, incorporating new requirements such as the legal duty on trusts to involve carers in discharge planning, is due to be published shortly.

3.2.11. The National Discharge Taskforce, with membership from local government, NHS England and the Department, will continue to work collaboratively and with regional systems to identify long-term, sustainable

changes which reduce delayed discharges and ensure patients are only in hospital for as long as they need to be.

Capacity in social care

3.2.12. To speed up discharges from hospitals, we know that we have to invest in adult social care. Government investment has already helped local authorities steadily increase their spending on adult social care, which reached £21.4 billion in 2021-22. This is an average increase of 2.5% per year in real terms between 2014-15 and 2021-22.

3.2.13. On top of this historical, sustained investment in adult social care, the government has made available significant additional funding through the Autumn Statement - £7.5 billion over two years for adult social care and discharge. This funding represents a more than real terms increase for adult social care and will put the care system on a stronger financial footing by helping local authorities address waiting lists, low fee rates, and workforce pressures in the sector.

3.2.14. Of the £7.5 billion pounds made available, £1 billion will be new grant funding in 2023-24 and £1.7 billion in 2024-25. This includes the discharge funding referred to in 3.2.4, and £400 million in 2023-24 and £683 million in 2024-25 in new grant funding for local authorities to improve care services. This will be combined with £162 million in each year from the previous Fair Cost of Care Fund and will form the Market Sustainability and Improvement Fund (MSIF). The MSIF contributes to our fundamental objectives of increasing capacity within the adult social care sector across different types of care, and contributing to the reduction of delayed discharges. Local authorities will have flexibility to use the MSIF to drive improvements across a range of priority areas, to best address local sustainability and improvement needs. These include reducing adult social care waiting times, increasing workforce capacity and retention, and increasing fee rates to close the cost of care gap in an area.

3.2.15. We have also listened to the concerns of local government and have taken the difficult decision to delay the planned adult social care charging reform from October 2023 to October 2025. £1.3 billion in 2023-24 and £1.9 billion in 2024-25 in savings from this decision will be retained in local authority budgets to help them meet the current pressures in social care.

3.2.16. We are also giving further flexibility to local authorities on council tax. The government is increasing the referendum limit for increases in council tax to 3% per year from April 2023. In addition, local authorities with social care responsibilities will be able to increase the adult social care precept by up to 2% per year.

3.2.17. We also know that a key part of making sure that people get the social care that they need is by ensuring there are enough social care staff to deliver care. To support local authorities and providers to address workforce pressures, we are backing recruitment at home and abroad. We are running a

National Recruitment Campaign, with continuous activity across jobs boards, video on demand, digital audio, radio and social media until 31 March 2023. In February 2022, we made care workers eligible for the Health and Care Visa and added them to the Shortage Occupation list. The latest data published by the Home Office shows there were 56,900 visa grants for care workers and senior care workers in 2022, showing a strong uptake of international recruitment.

3.2.18. We are investing £15 million in 2023-24 to support international recruitment in the adult social care sector, and are working with the Department of Work and Pensions to promote adult social care careers to jobseekers. We are also funding sector partners to provide support to employers and commissioners to improve recruitment and retention.

The importance of integration between health and social care for discharge

3.2.19. We know that integration between health and social care services are particularly important for enabling timely and appropriate discharges from hospital. The Better Care Fund (BCF), established in 2013, is our existing vehicle for pooling funding between local authorities and the NHS.

3.2.20. It primarily is spent on services at the interface of the health and social care system, including hospital discharge planning, as well as core adult social care services. The pooled nature of the funding allows leaders from across the health and social care system to make joint decisions about how to achieve shared outcomes.

3.2.21. Local areas committed £10.5 billion in total to the BCF in 2022-23, which includes voluntary contributions from the NHS and local government and a £500m Adult Social Care Discharge Fund. Last year, voluntary contributions totalled £3 billion in addition to the nationally mandated minimum, double the figure from 2015-2016. Since 2015-16, there has been an increased amount of spend on adult social care every year from the NHS contribution to the BCF, as recorded in the planning data.

4. Understanding the challenges for urgent and emergency care

Comment 14: The current data published by NHS England on emergency department waiting times inaccurately portray the true waiting times experienced by patients attending A&E. NHS England should publish monthly the number and proportion of patients waiting 12 hours or more from arrival at accident and emergency departments.

Comment 15: There is no clear picture of the type of demand faced by urgent and emergency care providers. This will significantly hinder effective planning and service design.

Comment 16: NHS England must improve the quality and interpretation of data gathered on urgent and emergency caseloads to explain accurately the type of cases faced by ambulances and A&E

Comment 17: NHS England should resume publishing the Delayed Transfer of Care dataset

How data is used

4.1. NHS England has access to and exploits substantial data and information relating to service utilisation. This is regularly published on the NHS England website[14], and includes the urgent and emergency care situation report data collected over the winter period[15]. This data provides a definitive picture of the demand on urgent and emergency care services and allows NHS England to respond to frontline pressures.

4.2. System control centres (SCCs) are a particularly good example of how data can be used effectively in near real-time to make changes on the ground to manage demand. These pioneering centres use system-wide, shared data across a variety of services to enable leaders to make decisions to better manage capacity, flow and performance. In the recovery plan, we have committed to fully embedding SCCs year-round, ensuring that they become sustainable, and are appropriately resourced with autonomous clinical decision making.

4.3. Every year, systems are asked to undertake detailed planning exercises to assess the anticipated demand for services over the coming year, ensuring that plans are in place to respond to these within system allocation and

[14] NHS England Statistical Work Areas: https://www.england.nhs.uk/statistics/statistical-work-areas/
[15] Urgent and Emergency Care Daily Situation Reports: https://www.england.nhs.uk/statistics/statistical-work-areas/uec-sitrep/

service plans. In support of this planning national and local planning assumptions are made based on the activity over the previous years.

Improving transparency of our data

4.4. The recovery plan also set out our commitment to improving transparency – making more data available to the public. This will enable the public to more easily see and compare the performance of their local services.

4.5. From April 2023, the NHS will publish data on 12-hour waits from time of arrival in A&E. We are also working with social care partners on a better measure of discharge to ensure that we are measuring the whole patient journey in hospital.

4.6. Collection of the Delayed Transfer of Care (DToC) metric was paused in 2020 at the beginning of the pandemic, and formally decommissioned in early 2022, following a decision by the Data Alliance Partnership Board (DAPB). In 2016, the National Audit Office concluded that DToCs substantially underestimated the range of delays that people experienced, and the number delayed. In 2022, the DAPB agreed that DToCs should be permanently decommissioned, with the discharge-ready date to be repurposed as the date when patients no longer meet the criteria to reside in hospital.

4.7. From April 2023, trusts will start to consistently record the discharge-ready date for all patients in NHS data systems. In addition to publishing data on overall numbers of discharges and delayed discharges, we will work with local systems to develop a new metric that measures the time from the discharge-ready date to the actual date of discharge. We will publish the new data as soon as possible ahead of next winter following trialling and testing with local providers and patient groups, in support of collaborative actions across the NHS, local government and the social care sector to improve discharge planning and capacity planning. We will work with providers in mental health, learning disability and autism settings to make sure that we develop a metric that can help focus on reducing the longest stays.

4.8. We will use data to help manage periods of high demand and increased pressure across systems and enable urgent system action. ‘Faster data flows’ will bring together data in a way that will reduce burdens on providers, and allow a more granular understanding of patient flow to support improvement. This approach will also require improved collaboration and data sharing across health and social care services to enable joint NHS and local authority capacity planning – identifying capacity requirements and discharge needs to target funding and workforce appropriately.

5. Boosting capacity in secondary care

Comment 2: The emergency healthcare workforce is under unprecedented strain. Without concerted action to address the emergency in the system, many of them will leave the health service.

Comment 4: The Department of Health and Social Care should continue working to increase the number of physical beds in hospitals. This work must ensure that the additional beds are sufficiently staffed.

Increasing capacity in urgent and emergency care

5.1. We know that hospital bed occupancy is too high. In 2022-23, occupancy has consistently been above 95%, which has a significant impact on patient safety and efficiency as flow through hospitals is reduced. The government is committed to increasing the number of physical beds in hospitals to lower occupancy levels. Through the additional funding made available to support the NHS to be prepared for winter in 2022-23, the NHS has already increased the number of staffed hospital beds.

5.2. The recovery plan set out how we will reduce hospital bed occupancy ahead of next winter by increasing the number of staffed hospital beds, supported by £1 billion targeted funding for capacity. Compared to the originally planned levels of beds in 2022-23, there will be 5000 more staffed, sustainable beds in 2023-24. To ensure that this additional bed capacity is in places that will deliver the greatest benefit to patients, all systems will need to conduct appropriate demand and capacity profiling to identify the areas with the greatest need. This will allow any increase in bed capacity to be aligned with other capacity such as staffing.

Growing the workforce

5.3. Over the last year we have seen record numbers of staff working in the NHS, including record numbers of doctors and nurses. We are on target to meet the 50,000 nurses manifesto commitment, with over 38,000 more nurses in December 2022 than there were in September 2019. Compared with December 2021, there are now over 3.7% more full time equivalent hospital and community health service (HCHS) staff (i.e., hospital trusts and ICBs), including nearly 5,000 more doctors and over 11,000 more nurses.

5.4. However, we know that NHS staff have faced significant pressures during the pandemic, and that recovery will impose new pressures. Leaver rates fell during the initial stages of the pandemic before rising, and vacancy rates are 8.9% across the NHS. Demand for staff is likely to continue to exceed supply over the coming years without any action. That's why we are committed to growing the workforce to support the improvement of urgent and emergency services.

5.5. Ahead of the long-term plan, which will be published this year and set out actions to reduce supply gaps and improve retention for the next 15 years, we set out further actions for this year in the recovery plan.

5.6. To ensure that ambulance services remain well staffed, we will continue to ensure that projected paramedic workforce gaps are mitigated through undergraduate student intakes, apprenticeships and a focused retention improvement plan. We will increase the number of emergency medical technicians (who can respond to incidents and support paramedics on ambulances) in 2023-24 to support the planned expansion of the ambulance capacity, with ambulance services developing plans based on local need. These roles provide an entry route to the NHS, and free up paramedic capacity to ensure the most efficient skill mix.

5.7. As set out in section 3.1 of this response, we will take action to increase the number of clinicians in NHS111 and Integrated Urgent Care by promoting it as a flexible option, including to returners. We will also continue to increase the numbers of advanced practitioners and mental health workforce in priority areas including in urgent and emergency care. We will also relaunch the NHS Volunteer Responders programme by April 2023, expanding its remit into social care.

Wellbeing of Staff

5.8. The NHS People Plan and the People Promise pledge to build a more modern, compassionate and inclusive culture in the NHS to improve people's experience of working in the NHS and the retention of staff. The health and wellbeing of all NHS staff remains a key priority and this is reflected in NHSE planning guidance for 2023-24. There are a number of health and wellbeing initiatives which include a wellbeing guardian role, a focus on healthy working environments, empowering line managers to hold meaningful conversations with staff to discuss their wellbeing, and a comprehensive emotional and psychological health and wellbeing support package. Additionally, NHSE have funded an ambulance sector specific Suicide Prevention pathway to provide immediate support for staff experiencing suicidal thoughts.

5.9. Strong leadership across health and social care is an important driver of performance. The Department published "Leadership for a Collaborative and Inclusive Future" in June 2022, that identified seven recommendations to foster and replicate the best examples of leadership. These include improved training, career development and talent management, and embedding inclusive cultures and behaviours within health and care. Implementation is being led by NHSE and Skills for Care.

6. Sharing best practice

Comment 19: Regulators and inspectorates should place greater emphasis on the importance of collaboration between emergency services. This has the potential to enable and incentivise greater collaboration between police, fire and rescue and emergency health services, leading to better outcomes for patients.

Comment 20: The What Works Centre for healthcare is not performing the function of evaluating, sharing and encouraging the implementation of best practice. Other arrangements, where they exist, are patchy and limited, and therefore, abandoned, or not utilised at scale nor as effectively as they should be.

Join up across blue light emergency services

6.1. Ambulance services work locally, regionally and nationally with police services and fire and rescue services to maximise effectiveness and efficiency of resources through training and exercising. The three blue light emergency services have a national strategic lead at chief officer level to represent each sector. These strategic lead chief officers meet with officials on a regular basis through the joint emergency services interoperability programme board

6.2. The Joint Emergency Service Interoperability Programme (JESIP) ministerial board[16] has been reinstated to oversee and support the recommendations and actions arising from the Manchester arena public inquiry. In addition, some local arrangements include co-responding and shared estates.

The National Institute for Health and Care Excellence

6.3. The Department does not agree that the National Institute for Health and Care Excellence (NICE) is not performing the function of evaluating, sharing and encouraging the implementation of best practice in healthcare, but the Government and NICE recognise that there are areas where it can develop and improve.

6.4. NICE plays a vital role in translating the best available evidence into authoritative guidance for the health and care system on best practice. Since it was established over 20 years ago, NICE has earned a reputation as a world leader in its field and its guidance plays a critical role in driving the adoption of best practice and the latest innovations. A key part of its delivery is to use multidisciplinary expert committees of people from health and care services to evaluate available evidence and translate this into recommendations that can be implemented in the NHS.

[16] JESIP Governance Structure: https://www.jesip.org.uk/governance-structure/

6.5. NICE guidelines are embedded in levers across the system that are intended to drive best practice, such as clinical audit programmes, RightCare and CQC inspections. NICE also works with the NHS, local authorities and other organisations to promote a wide range of resources to put its guidance into practice and facilitate implementation activities. These include audit and service improvement tools to help with strategic planning and the delivery of services addressed in NICE's guidance, as well as resource impact reports that summarise how implementation will impact areas such as capacity and demand, training and workforce.

6.6. In addition, NICE's shared learning case studies show how NICE guidance and standards have been put into practice by a range of health, local government and social care organisations.

6.7. NICE also recognises that it must continuously evolve to ensure that it meets the needs of the health and care system and improves patient outcomes. NICE's 5-year strategy, published in April 2021, describes a vision for NICE's future that builds on its foundations and sets out a number of ambitions. As part of the strategy, NICE will improve the usefulness and usability of its guidelines by providing dynamic, living guideline recommendations, combined with a new model of support for adoption of best practice.

6.8. Living guidelines will update recommendations rapidly as new relevant evidence becomes available and provide a guideline methodology that is quicker and more flexible. As well as being timely, NICE's useful and usable guideline recommendations will be easy to find and accessible, getting the right information to the right people at the right time, thereby supporting shared decision making between patients and professionals. At the same time, NICE will make change happen by driving the implementation of its recommendations by forming strategic partnerships across the health and care system to harness the power of collaboration and encourage guidance uptake for the benefit of patients.

6.9. NICE has already taken a number of steps since the strategy was published to fulfil these ambitions, including the introduction of Early Value Assessments that drive the adoption of innovative new medical technologies, and the development of a light-touch, faster evaluation process for new medicines.