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Summary

NHS services for urgent and emergency care have been under pressure for many years. Staff who went above and beyond during COVID have been let down by a system which has seen performance for these services fall far below the standard the NHS says patients should expect and receive. The NHS's own target for A&E waits has not been met since 2015 and its target for ambulance handovers has never been met since it began reporting against this metric in 2017. The quality of service that patients can receive, for example, with regards to the speed of ambulance response or the length of A&E wait, still depends far too much on where they happen to live. There has also been too little progress in tackling delayed discharges, which have serious knock-on impacts throughout the whole urgent and emergency care system, with not enough being done to address the systemic issues with discharges that lie within the gift of the NHS and its hospitals, and which cannot be blamed on external factors.

The poorer performance for patients has been against a background where the NHS has more staff and money than ever before. But NHS productivity fell by 23% over the two years 2019–20 and 2020–21, after it had been improving before the COVID-19 pandemic, and NHS England needs to reverse that decline urgently. Investing in technology will be critical to improving productivity but the Department has not budgeted for this, and NHS England's existing plans lack haste. Given the long-standing declines in both productivity and performance, we are not convinced that the Department is doing enough to effectively hold NHS England to account for making improvements.

The Department and NHS England have set out ambitious plans to recover services and improve patients' access and experience, but there are significant assumptions and uncertainties attached to these plans. NHS England's recently published workforce plan maps out NHS staff requirements for the next 15 years, but only has funding of £2.4 billion confirmed by government to cover the costs of training in the first five years. There are also many other areas of expenditure that will be critical to the plan's success, such as on salaries, estates, and infrastructure, which currently lack any meaningful detail or commitment. In the absence of clarity and assurance on sufficient funding in the medium- and long-term, there is a real risk that the lofty ambitions of the workforce plan may build in unsustainable financial pressure for the NHS in future years.

Introduction

People who need unplanned or urgent care can access several different NHS services depending on the severity of their issue. These services include access to general practice; community pharmacy; 111 calls; 999 calls; ambulance services; urgent treatment centres; and accident and emergency (A&E) departments. These services have been under increasing pressure in recent years, particularly since the start of the COVID-19 pandemic. General practices have seen record levels of attendance, and December 2022 saw the highest number of recorded A&E attendances. Bed occupancy levels were similarly at record levels in the final quarter of 2022–23. In 2021–22 there were close to half a billion patient interactions across these key services. The total estimated annual cost of these services is some £21.5 billion a year.

In January 2023, the government and NHS England published a two-year delivery plan to reduce waiting times and improve patients' experiences of urgent and emergency care services. It is too soon to assess whether this plan is working, but the first indication will be how well the NHS copes with winter 2023–24 pressures on services. In June 2023, NHS England also published a long term workforce plan for the NHS, setting out projections of staff requirements for the following 15 years and how it intends to address these.

Conclusions and recommendations

1. **The NHS has more money and staff than ever before but has made poor use of it to improve access for patients when they are in urgent need.** The NHS is spending more money year-on-year in real terms, with its £152 billion budget in 2022–23 being £28 billion more than its budget in 2016–17. It also currently has record numbers of staff, including double the number of doctors in emergency departments compared with 2009. Despite this, the performance of urgent and emergency care services has been deteriorating for many years and while NHS productivity had been improving before the COVID-19 pandemic, it subsequently fell 23% over the two years 2019–20 and 2020–21. NHS England's projection of future staff requirements in its workforce plan assumes staff productivity will increase by 1.5% to 2% annually but lacks meaningful detail on how this will be achieved. The NHS currently does not have effective metrics to manage patient flows between different parts of the system, and investment in technology and infrastructure improvements will be critical to improving productivity. However, the Department does not appear to have budgeted for any such investment and NHS England's existing plans lack ambition given the scale of the issue at hand.

   Recommendation 1:

   a) NHS England should write to the Committee within six months to set out its understanding of the causes for the fall in NHS productivity after COVID-19 and how it will address them, including how it intends to reduce staff absences.

   b) The letter should also set out how it plans to better capture and manage patient flows across the whole system and, confirmation of what, if any, costed and budgeted plans it has for investment in technology and infrastructure improvements in this area.

2. **NHS England's improvement plans rely on better staff recruitment and retention to address significant shortfalls in the NHS workforce, but we are not convinced that NHS England's current approach will achieve its very optimistic assumptions.** NHS England has identified a potential shortfall of 260,000 to 360,000 staff by 2036–37, compared with a current shortfall of approximately 150,000 full-time equivalents. It intends to address this through ramping up recruitment, improving retention, and reforming work and training practices. NHS staff are currently experiencing very high levels of physical and mental ill health, particularly in the wake of the COVID-19 pandemic, with the most recent 5% sickness absence rate reported for 2022–23 above the long-term average of 4.2%. NHS England estimates that the rate of staff turnover in the health service was 9% in 2022–23. NHS England hopes to retain 130,000 staff who would otherwise leave the NHS over the next 15 years and stated this will be cost neutral. However, the realism of the assumptions underpinning this aspiration seems highly doubtful, given NHS England has identified multiple dependencies on other factors and unknowns.

   Recommendation 2: NHS England should write to the Committee within six months to provide an update on progress with reducing staff shortfalls and improving retention rates. This update should include details of action it has taken and an assessment of whether its original assumptions have proved accurate.

3. **The quality of patients' access to urgent and emergency care depends too much on where they live, particularly with wide variation in ambulance response times.** There is significant regional variation in the performance of services for urgent and emergency care. For example, in 2021–22, average ambulance response times for the most serious incidents varied from six minutes 51 seconds for the London ambulance service to ten minutes 20 seconds for the South-West ambulance service, and average 999 call response times ranged from 5.4 seconds for the West Midlands ambulance service to 67.4 seconds for the South-West ambulance service. The length of stay in the worst performing areas for discharging patients when they are medically fit is over double that of the best performing areas. Local management of systems and digitisation are likely to play a critical part in patients' access to services, but one in ten trusts still lacks an electronic patient record and only four trusts have an electronic bed management system that could be described as first class. NHS England only has plans to upgrade 16 further systems, but it is working with the Department on a business case to expand this capability. NHS England has identified where there is good practice and poor performance but is weak at implementing and rolling out best practice more widely.

   Recommendation 3: As part of its Treasury Minute response, NHS England should clearly set out the causes of variation in performance, and the specific initiatives it takes responsibility for to bring the worst-performing organisations closer to the standards being achieved by the best.

4. **Not enough is being done to tackle delayed discharges, which cause inefficiencies both within hospitals and more widely across the care system.** Delays with discharging patients when they are medically fit for discharge reduces available bed capacity, which in turn slows admissions from A&E departments, which in turn slows the rate at which ambulances can hand over new patients, which then reduces ambulance capacity and therefore the timeliness of ambulance responses. More patients are remaining in hospital when they no longer need to do so. In Q4 of 2022–23, there was an increase of 12% in patients remaining in hospital despite no longer needing to, compared with the same period in 2021–22. Each unnecessary delay is a bed that cannot be released for a new patient. While a proportion of delayed discharges can be attributed to problems discharging older patients from hospital into adult social care, NHS England acknowledges that the challenge does not lie entirely in social care and more work was needed in the hospital sector.

   Recommendation 4: As part of its Treasury Minute response, the Department should set out what it is doing to address delayed discharges caused by constraints within hospitals, problems in NHS community services, and shortfalls in social care.

5. **Given long-standing declines in performance, we are not convinced the Department has sufficiently held NHS England to account for meeting targets and improving urgent and emergency care.** The Department holds the NHS to account for performance in urgent and emergency care. It told us it works closely with NHS England and that, together, they hold a shared analysis of the key issues in urgent and emergency care and an agreed view on the solutions that are needed. However, the NHS has not met targets for ambulance handovers since November 2017 and for A&E waits since July 2015, with wider declines in performance across the board. Against this background, we asked how effective the Department has

been in holding NHS England to account for the declining performance. While the Department was at pains to say how closely it worked with NHS England and had a shared analysis, it did not articulate how it was adding any value in holding NHS England to account for making meaningful improvements to services for patients.

Recommendation 5: The Department must improve how effectively it holds NHS England to account for performance against targets for access to urgent and emergency care. It should clearly articulate the respective roles of the Department and NHS England and set out the key steps the Department takes when its monitoring highlights underperformance.

6. **The unfunded and uncosted NHS Long Term Workforce Plan risks building in unsustainable financial pressures.** The NHS Long Term Workforce Plan drawn up by NHS England only includes a commitment of an additional £2.4 billion to cover training costs for the first five years of the 15-year plan. The plan does not include any estimate of total additional running costs for the significant increase in workers it has identified, such as salaries for an extra 260,000 to 360,000 staff. There is no information available on either the scale or source of how staff costs in future years will be met. Neither is there any cost or funding information on the other enablers without which the plan will fail for patients, such as expenditure on other salaries, estates, technology, and infrastructure. The true cost to the taxpayer of the plan will certainly be far higher than the amounts shared so far, but the Department would not commit to providing us or the NHS with longer-term certainty.

Recommendation 6: As part of its Treasury Minute response, NHS England should provide an update to the Committee on the full cost of implementing its workforce plan over the next 15 years, including ongoing staff costs, training and recruitment costs, and the costs and underlying assumptions of necessary wider enablers such as technology and innovation, social care, and infrastructure.

1 Productivity, accountability and oversight

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health & Social Care (the Department) and NHS England about access to unplanned or urgent care.[1]

2. The Department is responsible for overall health policy in England. NHS England is an arm's-length body of the Department and leads the National Health Service (NHS). NHS England manages the budgeting, planning, and delivery of health services in England, including overseeing their commissioning, either directly or through delegated arrangements with local Integrated Care Boards.[2]

3. People who need urgent and emergency care may need to access one or more NHS services, including general practice; community pharmacy; the 111 service; ambulance services including 999 calls; urgent treatment centres; and accident and emergency (A&E) departments. These services have been under increasing pressure in recent years, particularly since the start of the COVID-19 pandemic.[3] General practices have seen record levels of attendance, and December 2022 saw the highest number of recorded A&E attendances. Bed occupancy levels were similarly at record levels in the final quarter of 2022–23. In 2021–22 there were close to half a billion patient interactions across these key services. The total estimated annual cost of these services is some £21.5 billion a year.[4]

4. In January 2023, the government and NHS England published a two-year delivery plan to reduce waiting times and improve patients' experiences of urgent and emergency care services. The first indication of whether this plan is working will be how well the NHS copes with winter 2023–24 pressures on services.[5] In June 2023, NHS England also published a long term workforce plan for the NHS, setting out projections of staff requirements for the following 15 years and how it intends to address these.[6]

NHS productivity

5. The Department allocated NHS England a budget of £152.6 billion in 2022–23, £28.4 billion more than its budget in 2016–17 at 2022–23 prices.[7] The total amount includes an estimated £21.5 billion that NHS England spends on services for unplanned or urgent care.[8] The number of full-time equivalent staff increased by 32.4% from the most recent low of 963,000 in June 2013 to an all-time high of around 1.275 million in February 2023.[9] The number of doctors working in emergency medicine has nearly doubled over the past 13 years to 9,600 and ambulance staff numbers have increasing by around 50% over the past 11 years.[10] However, as a result of increasing costs and declining activity, NHS productivity decreased by 23% over the two years 2019–20 and 2020–21, following 14

1 C&AG's Report, Access to unplanned or urgent care, Session 2022–23, HC 1511, 21 June 2023
2 C&AG's Report, para 1.1
3 C&AG's Report, paras 1, 1.3 and Figure 1
4 C&AG's Report, paras 5, 6, Figure 1
5 C&AG's Report, para 3
6 NHS England, NHS Long Term Workforce Plan, June 2023
7 C&AG's Report, paras 9, 1.2
8 C&AG's Report, para 1.2 and Figure 1
9 C&AG's Report, paras 7, 1.14
10 C&AG's Report, paras 3.15 and 3.24

years of productivity gains.[11]

6. We asked why, despite increased funding and staff numbers, NHS productivity is continuing to decline and what more needs to be done. NHS England described several factors which have contributed to the decline in NHS productivity, including the COVID-19 pandemic, record levels of pressure on the NHS and a population that is older, with more complex health needs and generally sicker.[12] At the time we took evidence in early July, NHS England told us that there were still around 1,000 people in hospital with COVID-19, leading to particular care requirements, for example around infection control.[13]

7. The pandemic has also had an impact on NHS staff absence rates. NHS England pointed to mental health conditions and anxiety, musculoskeletal conditions and respiratory conditions that were affecting NHS staff.[14] We asked whether NHS England has a percentage measure to assess how far staff sickness impacts on NHS productivity, and it told us that any reason for staff being off sick would have an impact on their ability to care for patients.[15]

8. A key element of NHS England's plans for the NHS over the coming years is the NHS Long-Term Workforce Plan, published on 30 June 2023.[16] Despite the decline in productivity in recent years, NHS England's projections for future staff requirements in its workforce plan assume that NHS labour productivity will increase by 1.5% to 2% by 2036–37. The workforce plan says that modelling to support this productivity improvement assumes that the NHS could deliver a higher level of productivity than the long term trends.[17]

9. The Department told us that when looking internationally, demand for health across OECD countries goes up around 4% a year and improving productivity had to be one of the ways of meeting that demand. Alongside an increase in productivity, increasing the supply of services, improvements to public health in order to reduce demand, and developing new technology would be crucial to improving performance in the NHS.[18] NHS England also told us that effective electronic management systems could improve patent flows within hospitals and increase overall productivity.[19] As an example, NHS England pointed to four organisations in England that have implemented fully functional electronic bed management systems, allowing them to track patients and bed occupancy in real time.[20] NHS England told us that it planned to work with a further 16 trusts this year to implement this system that it knows works well. The initiative will not be funded by new money but will be paid for from capital identified in existing budgets from both NHS England and hospital trusts. We asked whether NHS England had done an analysis of the costs and benefits in productivity terms. NHS England told us that productivity benefits would be part of the business case it is discussing with the Department for rolling out electronic bed management systems more widely, but could not yet be confirmed

11 C&AG's Report, para 4.13
12 Q 1
13 Qq 1, 2
14 Qq 2, 28, 29 and 118
15 Qq 27, 28
16 Qq 3, 4; NHS England, NHS Long Term Workforce Plan, June 2023
17 NHS England, NHS Long Term Workforce Plan, June 2023, page 71 paragraph 8
18 Qq 119, 121
19 Q 52
20 Qq 48, 50

because the business case has not been formally approved.[21] In written evidence after the session NHS England informed us that it expects the main productivity benefit from this system will result from better visibility of bed capacity leading to more informed decision-making, in turn reducing the down time between a bed being available and a patient being moved into it.[22]

Accountability and oversight

10. We raised concerns over the effectiveness of the Department's oversight of NHS England's performance against its targets, including the A&E target for 95% of patients to be admitted, transferred, or discharged within four hours.[23] This target has not been achieved in the eight years since July 2015. In March 2023, the proportion of all A&E departments meeting the standard was 71.5%.[24] The Department told us that it has a completely shared analysis with NHS England and that it was focused on joint problem-solving.[25]

11. The Department recognised that there is an element of accountability in its relationship with the NHS, and said it was holding NHS England to account through the trajectories set out in numerous recovery plans, from primary care to elective recovery. The Department believed that the NHS was on trajectory to meet targets, but this was dependent on meeting ongoing challenges.[26] NHS England confirmed that it was particularly worried about the next winter.[27] When asked whether or not it was on trajectory for recovery for urgent and emergency services, NHS England told us that meeting Category 2 30-minute ambulance response time would be the most challenging as it required whole system-level working to achieve. However, NHS England remained confident that the plan was the right one, that early signs of better performance were visible, and that the NHS would perform better than it did last winter.[28]

12. The Department acknowledged that there were different sides of its approach to holding the NHS to account. It recognised that if there was a problem arising in a local authority it may fall to the Department to address, whereas problems in local trusts would be the responsibility of NHS England.[29] The Department did not accept, however, suggestions that there were too many levels of NHS management, that there was duplication at national level, or that lines of accountability could be clearer and sharper.[30]

13. The Department told us that when compared internationally, the NHS had one of the lowest percentage spends on management compared to clinical roles, making it an efficient organisation when benchmarked. NHS England highlighted the example of a clinical leadership model in one trust led by a clinical member with a predominantly clinical team organised at service and ward level. However, both the Department and NHS England recognised there was variation across the NHS and that each local organisation would decide how it would be structured.[31]

21 Qq 52–55
22 Letter to the Committee dated 19 July 2023 from Sarah-Jane Marsh at NHS England
23 Q 112
24 C&AG's Report, paras 3.20, 3.21
25 Q 112
26 Qq 112, 113
27 Qq 132, 133
28 Qq 131, 132
29 Q 112
30 Q 85
31 Qq 84, 86

2 Service performance

Regional variation

14. We and past Committees have repeatedly expressed concerns about variations in patients' experience of health and care.[32] The C&AG's report highlighted considerable differences in both service performance and access across geographical areas and providers. Proportions of the most serious A&E patients waiting less than four hours in March 2023 ranged from 53.3% in the Midlands to 62.1% in the South-East.[33] We asked, for example, about the average length of discharge delays in Gloucestershire which is double the national figure. NHS England acknowledged that Gloucestershire is one of the areas it worked most closely with in an attempt to tackle systemic issues, but that similar problems will be replicated across the country.[34]

15. In 2021–22, mean Category 1 ambulance response times varied from six minutes 51 seconds for the London ambulance service to ten minutes 20 seconds for the South-West ambulance service, and average 999 call response times ranged from 5.4 seconds for the West Midlands ambulance service to 67.4 seconds for the South-West ambulance service.[35] We asked what could be done to address differences between ambulance services. NHS England accepted that ambulance response times were not at all where they needed to be over the winter. It added that ambulance services covering large rural areas, for example the services in the south-west and east of England, were particularly challenged and disproportionately affected by problems stemming from the flow of patients elsewhere in the system.[36] It also told us that while all ambulances services worked in partnership with their local systems to develop solutions to treat more people in their homes and reduce admissions to hospital, there was variation in how this was being done.[37]

16. There are differences in the capability of individual trusts, including around management, clinical leadership, and technology, that must be addressed to reduce variations in patients' access to and experience of services.[38] We asked witnesses how the worst performing trusts were being brought up to the standards of the best.[39] The Department said tackling variability and importing best practice was one of its biggest priorities and NHS England told us it worked more closely with those systems that it has identified as the most challenged, of which there are currently seven, to provide extra help and support including financial assistance.[40]

17. NHS England described several different initiatives that it had piloted to improve services, for example around electronic patient records and workforce flexibility measures.[41] It also informed us that it had recently launched a new programme of work

32 Committee of Public Accounts, NHS ambulance services, Sixty-second report of Session 2016–17, HC 1035, 27 April 2017; Committee of Public Accounts, NHS continuing healthcare funding, Thirteenth report of Session 2017–19, HC 455, 17 January 2018
33 C&AG's report, para 11
34 Q 57
35 C&AG's report, para 11
36 Qq 63, 64
37 Q 71
38 Qq 52, 84
39 Q 66
40 Qq 49, 65, 124, 125
41 Q 47–48, 88–91

specifically to identify variation and provide tools to make improvements.[42] NHS England pointed to examples where NHS bodies were trying new approaches and identifying good practice, although cautioned that there were limits to the extent and pace at which these could be rolled out more widely.[43] NHS England told us, for example, that there are four places with first-class electronic bed management systems providing information needed to manage patient flows in real-time.[44] We asked why similar systems would be rolled out to only 16 more trusts by the end of the year. NHS England noted that there were several dependencies beyond the core technology, such as the availability of expertise and differing levels of organisational maturity within systems, that made this challenging and said it felt 16 trusts was the right number to focus on for the current phase.[45]

Delayed discharges

18. The different services for urgent and emergency care are highly connected and interdependent, meaning that issues in one service impacts throughout the rest of the system.[46] If the NHS is unable to discharge patients from hospitals when they no longer need to be there it means that people waiting in accident and emergency departments (A&E) cannot be moved into wards, which in turn prevents ambulances from handing patients over to A&E and attending to new incidents.[47] Maintaining the flow of patients throughout and between different urgent and emergency services is critical to ensuring that the system as a whole functions effectively.[48]

19. The number of patients staying in hospital despite no longer needing to be there averaged 13,623 across Q4 of 2022–23, an increase of 1,505 or 12% compared with 12,118 during the same period in 2021–22.[49] We asked NHS England why delayed discharges had increased, and it told us this was partly due to the more complex needs of the population creating greater demand for domiciliary and rehabilitation support.[50]

20. NHS England told us that the reasons why patients might experience delays in leaving hospital could be divided into four categories. For one group of patients, accounting for around 20%, the delays are related directly to activity in the discharging hospital.[51] NHS England told us it was largely the responsibility of the leadership within these hospitals to improve their processes, so patients are better supported to leave when they are ready.[52] Between 25% and 30% of patients leaving hospital need short-term packages of care, which are a shared responsibility between the NHS and local government. A further 25% of patients need to go into NHS community settings, which is another part of the NHS.[53] The smallest group, by number, are patients needing nursing or residential care, but we were told that these people can wait the longest, sometimes up to four or five weeks from when they are ready to leave hospital.[54]

42 Q 125
43 Q 88–90
44 Qq 46–48
45 Q 87, 89
46 Q 111
47 Qq 45, 111, AUEC0001
48 Q 63, AUEC0003, AUEC0005
49 Q 37; C&AG's report, para 1.13
50 Qq 2, 38
51 Qq 44, 98
52 Q 99
53 Qq 102–104
54 Q 105; AUEC0006

21. We have previously noted that the fragility of the adult social care provider market was exacerbating the difficulties in discharging older patients from hospital.[55] NHS England agreed that there is a clear challenge in social care. Different solutions are needed in different parts of the country, but health and social care services must work together to tackle problems with delayed discharges from hospital.[56] The Department noted that social care remains primarily the responsibility of local government, but that recent changes due to the Health and Care Act 2022 had increased its oversight and awareness of the sector, and provided a better basis for shared solutions between local government and the NHS through the move from Clinical Commissioning Groups to Integrated Care Boards.[57] However, NHS England acknowledged that the challenge with delayed discharges does not lie entirely in social care and more work needs to be done in the hospital sector.[58]

22. NHS England told us it had instructed the NHS to speed up discharge processes, for example by minimising waits for supporting services such as transport and medications. It was also asking hospitals to monitor patients more closely to assess whether they needed to remain in hospital. We asked whether this approach was working.[59] NHS England told us that there were some good examples across the country but accepted that there was more to be done, particularly in terms of reducing variations between different places, and ensuring that patients are discharged from hospital to the right place and at the right time.[60]

55 Committee of Public Accounts, Discharging older people from acute hospitals, Twelfth Report of Session 2016–17, HC 76, 22 July 2016, page 5, paragraph 3
56 Qq 57, 105; AUEC0001, AUEC0003, AUEC0005,
57 Qq 105, 128
58 Q 57
59 Qq 38, 41
60 Qq 2, 38, 42

3 NHS workforce

23. We have been raising concerns about the lack of long-term planning for the NHS workforce since well before the COVID-19 pandemic, noting in February 2023 that the Department had repeatedly failed to make good on its commitments to publish a plan to address the issue and that that many areas of the NHS workforce appeared to be in crisis.[61] NHS England published its NHS Long Term Workforce Plan on 30 June 2023. NHS England assured us that the new plan gives hope that there is a line of sight to a sustainable future staffing model for the NHS, for current staff and also those joining in the future.[62]

Recruitment and retention

24. In the workforce plan, NHS England estimates that over a 15-year period, without action, there would be a shortfall of 260,000 to 360,000 staff by 2036–37. NHS England explained that, because it takes time to train people and that they would be completing training over the course of the 15 years, the plan also includes a commitment to retention as well as recruitment.[63] NHS England described the rest of the workforce plan as a combination of reform and retention initiatives.[64] NHS staff turnover in 2022–23 was about 9%, including some people who were promoted or went to other trusts or roles, and people who left the NHS.[65] NHS England said that, over the whole period covered by the workforce plan, it would seek to retain 130,000 staff in the NHS who it would otherwise lose.[66]

25. NHS England added that, in terms of the specific offers that it would be making, the two most significant elements were measures focused on flexibility and continuous career development.[67] It informed us that much of the retention aspects of the plan was about doing what works, doing this systematically, and supporting it to be spread across the NHS. NHS England told us that it had launched an NHS retention programme last year, to systematically apply the measures known to matter the most to people working in the NHS.[68] In the 23 trusts piloting this programme, the rate of improvement in retention was twice that of the rest of the NHS.[69] NHS England assured us there was confirmed and ongoing funding for continuous professional development, which while not new money, contained a commitment within the workforce plan that it would be maintained.[70] Other issues that mattered to staff included leadership, particularly clinical leadership, workload and pay.[71]

26. We asked about the ongoing impact of the COVID-19 pandemic, since absence rates in the NHS workforce have remained higher since the start of the pandemic than the

61 Committee of Public Accounts, Sustainability and transformation in the NHS, Twenty-Ninth report of Session 2017–19, HC 793, 27 March 2018; Committee of Public Accounts, Introducing integrated care systems, Thirty-Fifth report of Session 2022–23, HC 47, 8 February 2023.
62 Qq 2, 3
63 Q 25
64 Q 10
65 Qq 77, 79
66 Q 25
67 Q 31
68 Q 34
69 Q 91
70 Q 34
71 Qq 79–80, 91, 93

long-term average of 4.2% over the previous 10 years.[72] The Department informed us that the absence figure in February 2023 was 5%.[73] NHS England explained that there were ongoing long-term effects from the pandemic in terms of the well-being of NHS staff, and that some staff were impacted by long Covid as well.[74] There were three main reasons why staff were off sick. The first was musculoskeletal issues, which is a longstanding issue across the health service. In addition, respiratory conditions and mental health issues had increased.[75] NHS England wrote to us after the evidence session and informed us that these three conditions accounted for over one million sick days in February 2023, or 55% of all days that were lost.[76] NHS England had also noted during the evidence session that in places which had focused on team-based models of working, sickness levels have gone down, morale had improved, and turnover had reduced.[77]

27. The Department informed us that the government has not set out an equivalent long-term plan for the social care workforce, because they are mainly private employees of independent companies.[78] It told us, however, that there are steps it had been taking. The Department ran a national recruitment campaign during 2022–23 and provided dedicated funding to support local areas to improve recruitment practices. It was working with Jobcentre Plus to promote social care careers to jobseekers and had provided toolkits for employers to help retain and develop their own staff. The Department had also added social care to the shortage occupation list and made it easier for employers in the social care sector to operate in the international recruitment market.[79]

Cost of implementing the Workforce Plan

28. We pressed both the Department and NHS England on how the workforce plan would be paid for.[80] NHS England stated that the current government's commitment has been to fully fund the first five years of the plan.[81] In future periods, there would be decisions for the then government to take about the total size of the NHS budget which would need to take account of the consequences for the plan, but these would be decisions for forthcoming spending reviews.[82] The Department confirmed that NHS budgets beyond the current spending review were political decisions for the future and that the plan, although extending beyond the current funding period, makes no reference to the cost after the first five years.[83]

29. The Department and NHS England told us that government had made a firm commitment of £2.4 billion of new money to fully fund the first five years of additional training places set out in the plan, until 2028.[84] A planned expansion of medical school places up to 15,000 would be for the remaining 10 years, subject to additional funding. This money will also need to be phased, because it requires new medical schools and the

72 Q 114; C&AG's Report, para 1.14
73 Q 116
74 Qq 114, 117
75 Q 118
76 Letter to the Committee dated 19 July 2023 from Sarah-Jane Marsh at NHS England
77 Q 66
78 Qq 60–61
79 Qq 61–62
80 Q 18
81 Q 7
82 Qq 13, 15
83 Qq 14, 16, 21
84 Qq 4, 13, 20

expansion of school places in existing schools.[85]

30. NHS England confirmed that there is no specific funding for staff retention but said that it would be cost neutral. However, there are dependencies on several other factors that are important for retention. Staff wellbeing was outside the purview of the workforce plan and other measures, such as pension changes, were not costed as part of the plan but were instead tax changes costed by the Treasury.[86] NHS England added that, if the plan is successful, so that retention levels increase, the NHS is less reliant on international recruitment, uses fewer agency staff, and works in the reformed way the plan sets out, there would be savings as well as costs.[87]

31. The Department emphasised the most important aspect of the plan was continued and sustained investment and that, particularly when thinking about technology and digitisation, it should be seen as a multiyear set of changes.[88] NHS England added that there was a commitment and request from Treasury to refresh the plan every two years. The two-year refresh will be important, not just in establishing the funding requirements, but in designing the right workforce because aspects such as technology will advance at an increasing pace over the 15 years of the plan. NHS England told us that it would want to see an overall increase in technology investment and that there was already funding set aside for capital investment that was not included in the £2.4 billion.[89]

85 Q 22
86 Qq 34, 36
87 Q 15
88 Q 94
89 Qq 95–97

Formal minutes

Monday 16 October 2023

Members present:

Dame Meg Hillier

Sir Geoffrey Clifton-Brown

Mr Mark Francois

Anne Marie Morris

Draft Report (*Access to urgent and emergency care*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 31 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Seventy-third of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Thursday 19 October at 9.30am]

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Monday 3 July 2023

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	Q1–135

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

AUE numbers are generated by the evidence processing system and so may not be complete.

1 Healthwatch England (AUEC0004)

2 Homecare Association (AUEC0006)

3 McCarthy, Ms Molly (PhD Candidate, Liverpool John Moores Univeristy); McIntyre, Dr Jason; Nathan, Professor Rajan; Ashworth, Dr Emma; and Saini, Dr Pooja (AUEC0002)

4 NHS Confederation (AUEC0005)

5 NHS Providers (AUEC0003)

6 Stroke Association (AUEC0001)

7 The Pharmacists' Defence Association (PDA) (AUEC0007)

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All publications from the Committee are available on the publications page of the Committee's website.

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44th	The Digital Services Tax	HC 732
45th	Department for Business, Energy & Industrial Strategy Annual Report and Accounts 2021–22	HC 1254
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