Written evidence submitted by British Medical Association

About the BMA

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

The BMA welcomes the opportunity to respond to the Public Accounts Committee's inquiry into NHS backlogs and waiting times.

1. Summary

1.1. Since the Committee considered the issue last year, NHS England (NHSE) has published its Elective Recovery Plan[1], the Health and Care Bill has now become the Health and Care Act and departmental budgets have been hit by soaring inflation. Meanwhile, the impact of the Covid-19 pandemic continues to be felt throughout the health and social care system as the NHS prepares to tackle increased pressures over winter.

1.2. The Elective Recovery Plan set out an agenda for recovery over the next three years, but pressures across a vast number of indicators have grown since it was published. Figures for September 2022 show a new record of almost 7.1 million people on waiting lists in England, an increase of 60% since September 2019.[2]

1.3. Waiting lists for surgical care are a visible consequence of pressures within the NHS, but they are a symptom of a more deep-seated problem – the inability to manage the 'flow' of patients through the whole Health and Social Care system, from front door admission to discharge back to the community setting.

1.4. This is evident by growing A&E waiting times, difficulties for GP practices making referrals and increased appointment pressures and delayed discharges from hospital due to pressures within community and social care.

1.5. The BMA recognises the incredibly difficult backdrop the NHS is operating under, created by decades of underfunding and under-resourcing the NHS.

1.6. As the National Audit Office's report[3] concludes, the plan to reduce long waits for NHS elective and cancer care services by 2025 is 'at serious risk', as the funding the Government allocated for recovering services has failed to keep pace with inflation, and the NHS faces 'significant workforce and productivity issues.'

1.7. The report rightly points out that chronic pay erosion, punitive pension taxation, and dwindling staff morale are all contributing to a mass exodus of staff.

1.8. To begin to bring down the backlog and alleviate pressures across the health and care system, we must start to tackle the long-standing challenges facing the NHS as whole including workforce pressures. This must mean retaining existing staff and maximising workforce capacity including by:

- Ending punitive pensions taxation rules driving senior doctors out of the NHS and taking additional measures to maximise workforce capacity.
- Committing to pay restoration for doctors to address over a decade of pay erosion that has left staff feeling demoralised and devalued and considering leaving the NHS. In 2021, almost 10,000

[1] NHSE (Feb, 2022) Delivery plan for tackling the COVID-19 backlog of elective care

[2] BMA Backlog data analysis, available at: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis

[3] National Audit Office (NAO), (Nov 2022), Managing NHS backlogs and waiting times in England

doctors left the UK medical workforce[4] and previous analysis indicates that around half of those leaving plan to move overseas[5]

- The development of a long-term workforce strategy, setting out how many health and care staff we have now and projections on the number needed to meet demand now and in the future, including plans on how to achieve them. We note the Chancellor's commitment at the Autumn Statement to a plan that includes independently verified projections. It is now vital that this plan is backed with the necessary funding and the BMA looks forward to seeing further detail of the Government's proposals.

1.9. It is also vital that the NHS is given the funding and resources needed. The BMA has called for NHS funding to rise above inflation, as essential to protect NHS funding and avoid cuts by stealth at a time when demands and pressures facing the NHS have never been greater.

1.10. While the extra funding promised to the NHS in the Autumn Statement is much-needed, even with this additional investment it represents an increase to the DHSC budget of less than 5% next year compared to this year. This is far lower than inflation, which hit 11.1% in November and is set to remain high.

1. Current position of NHS backlogs and waiting times

The waiting list for consultant-led referral to treatment

2.1 The latest figures for September 2022 show a new record of almost 7.1 million people, an increase of 60%. 2.87m of these patients have been waiting over 18 weeks for treatment, whilst 401,537 patients have been waiting for over a year – this is around 308 times higher than the 1,305 people waiting over a year before the pandemic in September 2019.

2.2 The number of people waiting for more than two years for treatment has however come down significantly. At the beginning of the year, there were more than 22,500 people who had been waiting for two years or more for their treatment, and a further 51,000 who would have breached two years by the end of July. The NHSE Elective Recovery Plan placed a focus on tackling two-year waits and this has undoubtedly been successful with figures from September 2022 showing just 2,239[6] people had been waiting for more than two years.

2.3 Whilst the near elimination of two-year waits should no doubt be celebrated, the comparatively poor performance across other backlog indicators suggest that this could have impacted recovery elsewhere.

The hidden backlog

2.4 The size of the 'hidden backlog' (patients who require care but have either not yet presented or who have had referrals cancelled due to the impact of Covid-19 on the NHS) remains unknown.

2.5 Despite improvements over the last two years compared to the first year of the pandemic, the number of electives and outpatient attendances currently being carried out is still well below pre-pandemic levels. This is storing up significant problems for the future. Delaying treatment is likely to result in worsened conditions further down the line, which will result in even greater demand on health services.

Cancer targets

[4] GMC (October 2022) Understanding doctors' decisions to migrate from the UK
[5] GMC (2021) The State of Medical education and practice in the UK
[6] NHSE (Sept 2022) RTT Overview Timeseries September 2022

2.6 Cancer targets continue to be missed. Although the number of patient referrals has surpassed pre-pandemic levels, the proportion of patients seen by a specialist consultant within two weeks of an urgent GP referral for suspected cancer remains worryingly low. The 93% performance target for patients to be seen within two weeks has not been met since May 2020, and in September 2022 stood at 73% - the lowest on record. Figures for September 2022 show only 60% of patients receiving their first cancer treatment within two months – far below the target of 85%.[7]

Emergency department attendances and waiting times

2.7 Prior to the pandemic, the situation in A&E was already increasingly difficult with demand soaring and the percentage of people being seen within the four-hour target reaching an all-time low over the 2019/20 winter.

2.8 A decrease in A&E attendance during the Covid-19 pandemic led to significant performance improvements, but attendance has steadily increased since the easing of lockdown measures, reducing performance against targets. There were around 2.2m A&E attendances in October 2022 – firmly returning attendances to pre-pandemic levels and showing a slight increase from the 2.0 million in September 2022.

2.9 While attendances have risen waiting times have soared due to a combination of ongoing pressure on services, the care backlog and chronic workforce shortages. The number of patients waiting over 12 hours from decision to admission has increased by 34%, bringing it to a total record high of 43,800 in October 2022 – over 60 times as high as in October 2019.

Pressures in General Practice

2.10 The backlog of care within consultant-led outpatient services has a knock-on effect on primary care and vice-versa. The primary care backlog generates a sizeable proportion of the secondary care backlog because conditions are not being identified soon enough, whilst lack of capacity in secondary care generates additional burden on primary care as patients are cared for by GPs while they wait for access to hospital treatment.

2.11 GP surgeries across the country are experiencing significant and growing strain with rising demand, declining GP numbers, struggles to recruit and retain staff leading to patients having to wait longer for appointments. Despite the Government's commitment to deliver an additional 6,000 GPs by 2024, we now have the equivalent of 1,808 fewer fully qualified full-time equivalent GPs than we did in September 2015 (when the current collection method began). The Prime Minister's omittance of this manifesto pledge from his brief to Health Secretary Stephen Barclay, demonstrates its failure to grow the GP workforce and the urgent need for a focus on solutions.[8]

2.12 Despite these pressures, general practice appointment bookings reached record highs over the winter of 2021 and have remained high since. In September 2022, 28.3 million appointments were booked – a 1.8 million increase since the previous month. In terms of access, around 42% of appointments in August 2022 were booked to take place on the same day, and over 82% of appointments were booked to take place within two weeks. In terms of appointment mode, the ratio of face-to-face appointments continues to increase slightly, with over two thirds (68%) of appointments in September 2022 taking place face-to-face.[9]

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[7] BMA Backlog data analysis, available at: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis

[8] BMA Press Release (November 2022) 'The Government should have the good grace to admit it is not meeting its GP workforce targets says the BMA'

[9] BMA Pressures in general practice data analysis, available at: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice-data-analysis

Delayed discharges

2.13 The significant pressures within community and social care also impact pressures within secondary with delayed discharges. Analysis by the Nuffield Trust shows the most common reasons for delayed discharges are awaiting home care (24%), awaiting short-term rehabilitation (22%) and awaiting a permanent bed in a nursing or care home (15%).[10]

2.14 Recent analysis in The Guardian found that up to one in three patients in hospital beds in England are occupied by patients who are fit for discharge[11], which means that on average 13,600 beds across the NHS in England are occupied every day with patients who are fit to be discharged, equivalent to one in seven beds in acute hospitals in October 2022. In some parts of the country this is even more severe, with one in five beds at 35 acute trusts occupied this way and one in two at North Bristol and Wrightington, Wigan and Leigh NHS trust.

2.15 Implementing a policy of 'discharge to assess' could release up to 6,000 hospital beds and save the NHS £800 million per year[12], but to date such funding to make such a policy change is lacking.[13] The 'discharge to assess' approach, which was widely used during the pandemic and at the time funded by the Government, allows for patients to be discharged more quickly and provided care at home while their longer term needs are assessed.

The role of the private sector

2.16 The BMA continues to have concerns over the proposed approach to enlisting the help of the private sector to reduce pressures on hospitals and help cut waiting lists. We recognise that all options must be considered to ensure patients are getting the care they need, but private sector contracting cannot be a panacea for addressing the pressures on the NHS brought about by deliberate under-resourcing. Limited staffing resources are also often shared between NHS and private sector hospitals, so funding private sector provision often simply shifts staff between sectors rather than increasing overall staffing resource to reduce waiting lists.

2.17 The pandemic has shown that block-booking arrangements do not work well. A BMA survey (September 2021) found that under these arrangements, 60% of private practice doctors who responded were unable to provide care to their patients at the time.[14] The extent to which private hospitals will be able to take on NHS waiting list initiatives going forward is unclear given the increased demand in the self-pay market and the backlog of private sector patients.

2.18 The Government's plans to enlist the private sector risk embedding a longer-term trend of outsourcing NHS contracts and funding to independent sector providers (ISPs) in England. Any arrangements with the independent sector should be time-limited and not a replacement for a credible longer-term plan to increase NHS capacity.[15]

2.19 Public spending on Independent Sector Provider contracts is already high and has been growing year on year. Spend on Independent Sector Providers was £13.8 billion in 2020-21, £2 billion more than

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[10] Nuffield Trust (October 2022) Why are delayed discharges happening? Available at: https://www.nuffieldtrust.org.uk/chart/why-are-delayed-discharges-happening

[11] The Guardian (Nov 2022) *One in three hospital beds occupied by patients fit for discharge*

[12] DHSC Health and Care Act Impact Assessment

[13] https://www.hsj.co.uk/finance-and-efficiency/discharge-reform-could-save-nhs-7bn-claims-dhsc/7033675.article

[14] The BMA Private Practice Survey was launched on 23 September 2021 and closed on 18 October. It was largely open to doctors working in private practice for some or all of their time, with 1,113 responses received

[15] BMA (March 22) Outsourced: the role of the independent sector in the NHS

the £11.8 billion spent in the previous year. Independent Sector Providers delivered 5.2% of all NHS-funded elective activity in 2020-21, compared to just 0.02% in 2003-04. It is essential that if significant public funds are to be spent in this way that the previous trend of the lack of transparency around these contracts is addressed, as there is significant potential for public resources to be wasted.

2. What needs to be done to address the backlog?

Tackle the workforce crisis

3.1 We cannot hope to bring down waiting times, tackle the care backlog or address the pressures that exist throughout the health and care system, if we do not have the staff needed to carry out this work. As highlighted in the Health and Social Care Committee's workforce report,[16] the NHS is in the midst of a chronic workforce crisis, driven by years of insufficient investment in training new staff, inadequate workforce planning, and lack of Government accountability. The result is a vicious cycle of mounting pressures, declining staff wellbeing and poor retention.

3.2 The lack of official, publicly available workforce planning makes it difficult to quantify the full extent of medical shortages. However, recent BMA research has used the number of doctors per 1,000 people in OECD EU nations as a baseline to estimate the size of the gap. This research found England alone would need the equivalent of an additional 46,300 full time doctors simply to put us on an equivalent standard with today's OECD EU average of 3.7 doctors per 1,000 people.[17]

3.3 The BMA is calling for a number of measures to address the workforce crisis and encourage both recruitment and retention:

3.4 **Address the pension taxation trap -** Existing tax and pensions rules – including the annual and lifetime allowance – have been a major factor in doctors choosing to either retire early or to reduce the number of hours they work. A BMA survey from October 2022 shows the number of doctors taking early retirement has more than tripled over the last 13 years and the average retirement age has already fallen to 59. Forty-four per cent of hospital consultant respondents in England plan to leave or take a break from working in the NHS over the next year because of pay erosion and pension taxation arrangements. For surgeons the figure increased to 50%. Among GP respondents, 14% said they plan to take early retirement over the next three years. [18]

3.5 A tax unregistered pension scheme, as introduced within the judiciary in response to similar issues with recruitment and retention, is needed within the NHS to ensure that doctors can work as many hours as possible this winter, without facing major financial disincentives.

3.6 The Finance Act also needs to be urgently amended to correct the impacts of inflation and the impact of negative pension growth in the connected NHS pension scheme, and prevent doctors being unfairly taxed on pension benefits that they will never receive. The Government recently announced some amendments to the NHS pension scheme, but these fail to provide the lasting solutions doctors need.[19,20]

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[16] Health and Social Care Committee (July 2022) Workforce, recruitment, training and retention in health and social care

[17] BMA analysis of OECD Data, NHS Digital Workforce Statistics Note: Data included for available countries only. Includes general practice. Available at: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/nhs-medical-staffing-data-analysis

[18] Ibid

[19] BMA press release (Sept 2022) Government pension solutions 'sticking plasters' and not the long-term fix the NHS needs

[20] See BMA briefing on NHS Workforce and the Pension Taxation Crisis for further information on long-term solutions to pension taxation trap

3.7 **Commit to full pay restoration for doctors -** Since 2008, doctors have experienced persistent and sustained real terms pay erosion, whilst facing increasing workforce pressures and a global pandemic. The Government's pay award of just 4.5% for NHS workers in the face of soaring inflation was another pay cut. Meanwhile, doctors on multi-year settlements, agreed before the pandemic, received nothing additional.

3.8 For junior doctors, this means they received just 2% completely disregarding the sacrifices made during the pandemic and inflation having reached highs not seen for 40 years. The decision to hold junior doctors to the pre-pandemic pay settlement was also against the framework agreement which allows for multi-year pay deals to be revisited if either side request it and the DDRB's informal recommendation to include staff on multi-year pay deals in the wider uplift.

3.9 The continued erosion of doctors' pay has had a significant impact on morale as doctors feel undervalued for the lifesaving work they do. It risks doctors continuing to choose to the leave the NHS for better paid work at home or abroad, which would put greater pressures on already stretched staff and worsen patient care. It also risks industrial action as the Government continues to fail to listen to doctors and other frontline workers' concerns as they fight for fair pay, safe patient care and to protect the NHS. Junior doctors are now in dispute with the Government and will be balloting for industrial action from 9 January. The Government has so far failed to respond to repeated requests to meet with the BMA to discuss the escalating situation.

3.10 The Government urgently needs to commit to full pay restoration for doctors if we are to retain and attract the talented staff the NHS needs.

3.11 The BMA also has longstanding concerns about the effectiveness and independence of the DDRB – concerns which have only been underlined by the Review Body's unwillingness to make formal recommendations on behalf of doctors subject to multiple-year pay deals, and their refusal to recommend steps to address the long-term pay erosion that has happened on their watch. The DDRB must be reformed to restore it to its original purpose, autonomy, and authority.

3.12 **A long-term workforce strategy -** The BMA has long called for a comprehensive national workforce strategy, setting out how many health and care staff we have now and fully publishing modelled projections on how many are needed to meet demand now and in the future.

3.13 The Government cannot hope to address the workforce crisis and plan ahead for the care that patients need without knowing how many staff are needed to safely deliver services. We therefore welcome the Chancellor's commitment to a workforce plan with fully published, independently verified modelling covering the next 5, 10 and 15 years. This is something the BMA and more than 100 other expert health organisations have been campaigning for, for over a year.

3.14 To ensure the plan achieves what it sets out to, it is vital it is backed-up with the necessary funding, training and infrastructure requirements. Further details on the modelling and how the plan will be implemented will be key, and the BMA looks forward to engaging with the process to guarantee we recruit and retain enough doctors to meet the needs of patients now and in the future.

Invest in health and social care and direct resources to where they are needed most

3.15 **Funding to tackle the NHS backlog** - The extent to which the NHS can address these capacity challenges is in large part determined by the resources available to it. The Government allocated additional funding to address the backlog, but this fell short of the Health Foundation projected costs.[21]

3.16 Since then, soaring inflation has eroded the value of both the funding specifically allocated to the recovery plan and the wider planned increases in the NHSE's budget, as highlighted by the NAO report.[22] While the extra funding promised to the NHS in the Autumn Statement[23] is much-needed, even with this additional investment it represents an increase to the DHSC budget of less than 5% next year

[21] Health Foundation (Oct 2021) Health and social care funding projections 2021

[22] National Audit Office (NAO), (Nov 2022), Managing NHS backlogs and waiting times in England

[23] HM Treasury (Nov 2022) Autumn Statement documents

compared to this year. This is far lower than inflation, which hit 11.1% in November and is set to remain high. We cannot hope to clear the care backlog or ensure the NHS has the staff it needs without additional funds made available in the face of rising costs.

3.17 A recent study found a significant and associated link between NHS expenditure and economic productivity, with every £1 spent per head generating £4 of economic growth, demonstrating that spending on the NHS should be regarded as an investment, not a cost.[24] This is particularly important now, as data shows inactivity is rising and more and more people are unable to contribute to the economy due to ill health.

3.18 **Increase NHS capacity** – The Government must set out a credible plan for investing in hospital capacity to ensure the NHS is more resilient and not reliant on the private sector in the long-term. The lack of available hospitals beds is an immense challenge in the UK and one which directly limits capacity and, by extension, efforts to tackle waiting lists and backlogs in care.

3.19 Delayed discharge of patients from hospitals into social care services does play a significant role in reducing the number of beds available within the system. However, the ultimate cause of bed shortages across the UK is a critical lack of bed stock. OECD data shows that the UK has just 2.3 beds per 100,000 patients, compared to 5.7 in France and 7.8 in Germany.[25] The BMA has repeatedly advocated for expansion of bed capacity – with the important caveat that they also need to be properly staffed. The Royal College of Emergency Medicine has also specifically called for a medium-term increase of 7,170 beds across the UK in order to ensure appropriate levels of emergency admissions.[26]

3.20 A further factor in the availability of beds is the condition of NHS estates. The maintenance backlog across the NHS now sits at a total of £10.2 billion in England alone, a significant 11% increase since 2021.[27] As this backlog grows, so does the risk to those who use and work in them, which in a number of hospitals has culminated in the closure of vital clinical space due to safety risks caused by leaks or collapsing roofs. This should never be the case and is why the BMA believes it is essential that capital funding is made available to carry out all urgent repairs to hospital estates and GP premises.

3.21 **Adequately fund social care –** All UK Governments must also ensure social care is properly supported financially, to ensure it is able provide safe, quality care to those who need it, while also helping to reduce pressure on hospital and GP services, including by supporting timely discharge from hospital. The Chancellor has said the social care budget will increase by an additional £2.8bn next year and £4.7bn the year after, paid for by delaying social care reform, increased central government funding and increased council tax. This will include £1bn to directly support discharges from hospital into the community. However, nearly two thirds of the total new money allocated for social care assumes that local councils will increase council tax to the maximum, which is likely not realistic. It is also inequitable. Cuts to social care from 2010 were larger in more deprived areas, where demand for care is higher.[28] These same councils will be the least able to raise enough money from increasing council tax rates. The Chancellor also committed to provide an additional 200,000 care packages next year, yet this pales in comparison to the scale of extra provision needed: Age UK have estimated that there are now 2.6 million people aged 50 plus with unmet needs for social care.[29] It is unclear how

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[24] NHS Confederation, Carnall Farrar (2022), Analysis: The link between investing in health and economic growth
[25] Organisation for Economic Co-operation and Development (OECD), (2021), Hospital beds
[26] Royal College of Emergency Medicine (RCEM), (Nov 2021), RCEM Cares: The Next Phase
[27] NHS Digital (October 2022) Estates Returns Information Collection
[28] IFS (Oct 2022) Does funding follow need? An analysis of the geographic distribution of public spending in England
29 Age UK press release (Sept 2022) 'PM needs to act fast as new analysis finds 2.6m aged 50+ now have some unmet need for social care'

these extra care packages will be achieved given the severe workforce shortages in the sector – there are now the highest number of vacancies in social care since records began.[30]

Collaboration between primary, secondary and community care.

3.22 A holistic approach to tackling the backlog and waiting lists is vital to addressing pressures throughout the health and care system. Over the longer-term, the BMA is calling for increased measures to support effective collaboration between primary and secondary care to improve system efficiency, reduce unnecessary workload and improve care delivery for patients.[31] This will help tackle waiting lists and high workloads and must be supported by measures to tackle the lack of joined up IT and data sharing.

3.23 Our members report that extremely high pressure across the system is also contributing to the inappropriate transfer of workload from different parts of the system to others, and there are measures that both ICS systems and NHS England can take to help reduce such workload transfer, such as ensuring that fit notes for outpatients are produced in secondary care. The BMA has previously published guidance on pushing back on inappropriate workload transfer[32]. Workload shift takes place because systems are struggling due to lack of workforce and high patient need.

3.24 Systems such as Advice and Guidance, a referral system available through the NHS e-Referral Service, and generally used between primary care and a consultant-led service, is a potential solution to help increase collaboration across the interface, and to help manage high workload. However, our members report that in practice Advice and Guidance has led to increased workload in both primary and secondary care and reduced opportunities for primary and secondary care doctors to communicate and collaborate as it reduces them picking up the phone to each other.

Effective use of digital infrastructure

3.25 To bring down waiting lists, digital solutions and remote care can, alongside other measures, support clinicians who are already working at capacity. Digital transformation should therefore be front and centre of health service recovery plans. However, IT hardware and systems are inadequate in many parts of the health service. This will hamper efforts to leverage technology to support recovery and maximise its value in terms of productivity and efficiency.

3.26 Just over 8 in every 10 (81%) respondents to a February 2022 BMA IT and Estates survey[33] say that improving IT infrastructure and digital technology will have a 'moderate' or 'significant impact' in tackling backlogs of care resulting from the Covid-19 pandemic. The scale of transformation within the NHS is, however, impeded by an outdated, archaic IT estate. Responding to our January 2022 Viewpoint Survey, nearly 71% of doctors reported that current IT systems and infrastructure in their workplace "somewhat" or "significantly" increased their workload, with about 59% of doctors reporting losing between 1-3 hours per week due to inefficient IT equipment. This represents potentially millions of lost hours to poorly functioning IT equipment that could be spend on patient care and alleviating backlogs.

3.27 When asked if they had all the necessary equipment to perform their job role, 48% of all of the respondents to our 2022 IT and Estates survey stated that they had it 'only sometimes, rarely or not at all'. A mere 11% of all the respondents reported 'completely' having the necessary equipment.

3.28 Software plays another important part in ensuring doctors time is used effectively and as a result patient safety is maximised and backlogs can be tackled. When asked "To what extent is the software

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[30] Skills for Care (2022) The state of the adult social care sector and workforce in England
[31] BMA (2020) Supporting effective collaboration between primary, secondary and community care in England in the wake of Covid-19
[32] BMA (August 2022) Pushing back on inappropriate workload
[33] BMA (February 2022) BMA IT and Estates survey

you use adequate for you to perform your job and is fit for purpose?", 1 in 3 (30%) of respondents working in both primary and secondary care said that it was 'rarely adequate' or 'not adequate at all', while just under 4% said it was 'completely adequate'.

3.29 One potential way of helping to tackle waiting lists are virtual wards. In England, virtual wards were introduced as pandemic-led pilots across the country developed by local services to reduce admissions into hospital. More virtual wards have recently been announced as a means of increasing bed capacity in the NHS ahead of winter.[34]

3.30 These wards allow clinicians to provide a level of care for patients in their own home and can span several different types of care based on need, with some relying almost entirely on remote care, and others blending remote with face-to-face care.[24]

3.31 Virtual wards hold the potential to deliver some level of care without requiring patients to attend hospital premises, albeit more needs to be done to understand the safety and effectiveness of this model of care delivery.[26]

November 2022

[34] NHSE (August 2022) Next steps for increasing capacity and resilience in urgent and emergency care ahead of winter