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Cite this as: *BMJ* 2023;380:p335
http://dx.doi.org/10.1136/bmj.p335
Published: 15 February 2023

ACUTE PERSPECTIVE

David Oliver: Can NHS England's recovery plan for urgent and acute care deliver?

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NHS England recently published its *Delivery Plan for Recovering Urgent and Emergency Care Services*,[1] with goals and actions for the next two years. Its chief executive, Amanda Pritchard, said that there would shortly be a workforce plan—a "once in a generation opportunity to put the NHS on sustainable footing."[2]

Every part of urgent and acute care is struggling to cope. Ambulance response times, handover delays at emergency departments, overcrowding and long waits in departments, full hospital beds, and delayed discharges of medically stable patients requiring poorly resourced community services have all compounded the staffing problems.[3] It's good to see politicians belatedly acknowledging these challenges and NHS England (equally belatedly) setting out proposals to tackle them, under six key themes:

- "Increase urgent and emergency care capacity" with 800 new ambulances (up 10%, assuming that some aren't just replacements and that they can be crewed) and 5000 new hospital beds (up 5% on our current bed base—low by international and historical standards).[4] Furthermore, the plan is for every hospital to have same day emergency care services at the front door, allowing more patients to be assessed and discharged without overnight admission to deeper wards—but most hospitals already have such services, and adequate capacity is what counts, not just ticking a "we have a service" box. Over £1bn has been allocated, and this includes the cost of building new modular units for a rapid expansion of capacity.
- "Grow the workforce"—which turns out to mean expanding the number of NHS 111 helpline clinicians. This will be done largely by persuading people out of retirement and increasing the number of emergency care technicians, but not paramedics per se.
- "Speed up discharge from hospitals" by putting an extra £1.6bn over two years into home based (or care home based) social care services, while ensuring that all acute systems have "care transfer hubs" to help coordinate capacity and access, monitor delays, and report revised data on hospital discharges and delays.
- "Expand new services in the community," with a focus on NHS care. Suggestions include providing community support and rapid response services for older people with falls and frailty, which may help people to stay out of hospital or be discharged earlier. Another suggestion is increasing the current target of 7000 "virtual ward" places to 10 000 to support (not always frail and elderly) people at home by monitoring them remotely, as some health systems reported success from such work during the covid pandemic. No funding amount has been specified for this, with integrated care systems left to find the resources.
- "Help people access the right care first time" by expanding access to NHS 111 as the "first port of call," while also making it the default route into mental health services.
- "Tackle unwarranted variation" in performance in the most challenged health systems, with a clinically led programme and intensive support.

So, what's my verdict? It would be churlish and counterproductive not to welcome the intentions. Those of us working in emergency or acute general internal medicine, ambulance trusts, or geriatrics would have wanted to see all these things highlighted, prioritised, funded, expanded, and staffed. The themes and priorities seem clinically informed, although the plan overlooks primary care's key role in urgent care services and in supporting people with long term conditions to help avoid crises or plan future care. I have ongoing reservations about how NHS 111 functions and how good it really is at relieving pressure on the urgent care system, but having more trained and experienced clinicians on the line will surely help only if we can recruit them.

It's also good to see mental health crisis support mentioned explicitly, but this needs responsive clinical services to back up the telephone triage and the additional £150m capital expenditure announced.

Patchy evidence

The evidence supporting some of the priorities (such as virtual wards) is still emergent and patchy.[5,6] Such wards may not be a panacea and may be put in charge of patients who wouldn't have been admitted anyway. What's more, they're already established in many systems—for example, same day emergency care—and are therefore nothing new.[7]

Workforce gaps in health and social care are the biggest threat to the service's viability, never mind its expansion. Ministers doing media rounds the day before the recovery plan's publication glossed over the key question of "how will we staff these services?" Yet the Department of Health and Social Care's logo appeared at the top of the plan, alongside NHS England's.[1] The recovery plan says nothing concrete on workforce beyond NHS 111 staff and emergency medical technicians, and the suggestions for expanding all other key clinical workforce groups to make this work are vague, platitudinous, or

non-existent. Any initiative will stand or fall on staff numbers, however much money or however many new builds we supply.

I also worry that government ministers are trying to claim what is clearly NHS England's plan as their own, while simultaneously saying that they'll hold NHS leaders accountable for performance and make them "come clean about A&E waiting times."[8] Crediting yourself for success and blaming others for failure is an easy option.

Finally, it's disappointing that this "sticking plaster" plan is a response to years of underfunding, failure to prioritise community health and social care services, and massive reductions in beds.[9] Prevention would have been better than cure.

Competing interests: See bmj.com/about-bmj/freelance-contributors

Provenance and peer review: Commissioned; not externally peer reviewed.

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