



Public Services Committee

Corrected oral evidence: Access to emergency services

Wednesday 2 November 2022

3 pm

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Members present: Baroness Armstrong of Hill Top (The Chair); Lord Bichard; Lord Bourne of Aberystwyth; Baroness Chisholm of Owlpen; Lord Filkin; Lord Hogan-Howe; Baroness Morris of Yardley; Baroness Pinnock; Baroness Pitkeathley; Lord Porter of Spalding; Baroness Sater.

Evidence Session No. 6

Heard in Public

Questions 41 - 48

Witnesses

I: Victoria Vallance, Director of Secondary and Specialist Healthcare, Care Quality Commission; Sarah Scobie, Deputy Director of Research, Nuffield Trust.

Examination of witnesses

Victoria Vallance and Sarah Scobie.

Q41 The Chair: Good afternoon, everyone. This is another session of the Public Services Committee in the House of Lords where we are looking at the issue of emergency access for the public, when they need it, particularly to the health service, and the role of public services in that. We welcome two witnesses to our first session: Victoria Vallance, who is director of secondary and specialist healthcare at the Care Quality Commission; and Sarah Scobie, who is deputy director of research at the Nuffield Trust.

Where do you feel the problems in the health system lie that cause such pressures on emergency health services? How could those system-wide issues be addressed?

Victoria Vallance: Good afternoon. I am director of secondary and specialist care with the Care Quality Commission—the CQC. May I give a little background about CQC and our purpose before I go into the response? CQC is the independent regulator of health and adult social care services in England. We ensure that services provide care that is safe, effective, compassionate and well led for people who are accessing those services. In the context of urgent and emergency care, which we are talking about here today, that means every single provider across all sectors, be that primary care, community care, the ambulance sector, hospitals or adult social care homes, is registered to us. We have a good understanding of the quality and safety of care across each and every one of those services, and how they come together to provide care across the pathway for people. I hope that is helpful and just sets a little bit of context.

As for the challenges, I hope you have all seen our *State of Care* annual report. If you have not, we are very happy to submit it. In it, we have described the state of care across urgent and emergency care as gridlocked. To your question, there are a number of challenges contributing to that gridlock. I will run through each of those and then I will give a little more detail.

The first is about demand and capacity at every single point, across the primary, community, secondary, ambulance and emergency care sectors and, indeed, the adult social care market.

The second is all about the flow, so how patients are moving from one area of the system to another within and across those services.

The third area of challenge, consistently, is about the pressures on the workforce, the gaps in the workforce capacity and, indeed, the struggle to not just retain but recruit into the workforce in all those areas.

The other area is leadership and culture. We see the best of partnerships and the best of urgent and emergency care where the leadership is robust, where systems and providers are all working together, where

there is a shared vision, a shared approach and shared accountability and management across the pathway, including the clinical risk element. Where we see that working well, there is less of a challenge, but, inevitably, it is a key challenge where it works less well.

Those are the key challenges, as we see them, and we have talked about them clearly as contributing to that gridlock.

Sarah Scobie: I am deputy director of research at the Nuffield Trust, which is an independent health think tank that aims to improve the quality of care through improving the evidence available about health services.

To understand the pressures on urgent care, the front door of the hospital and the situation with ambulances, you need to start at the back door of the hospital and look at what is going on in terms of patient discharge.

We know that around 15% of patients in hospital are already clinically and medically fit for discharge, and so that is a group of people whose discharge is delayed. In about 65% of cases, those people are waiting for community services, whether that is social care or community healthcare services. Their conditions may be exacerbated through staying in the hospital for longer, and it makes it much more difficult for hospitals to admit patients from A&E. The people of particular concern in A&E are those who are waiting to be admitted. That then leads to the problems, of which you will no doubt be aware, of delays in ambulances being able to hand patients over and ambulances spending too much time outside of hospitals, which leads to ambulances taking longer to respond. There is this situation where the whole system is interrelated, and the capacity is not there in the community and in social care to support people coming out of hospital. That is a key factor in the delays for ambulances, emergency care services and emergency health services.

Q42 Lord Hogan-Howe: I have two questions for Victoria. I think the first bit is easy—yes or no—but you might tell me differently. We had paramedics here last time from various sources, and it resulted in a good question from Lord Bichard. He asked, “Is demand increasing?”, to which the answer was that calls are increasing but the number of people carried to hospital has not. You said that all demand had increased right across the board, so I wondered whether you had any insight to that.

The second point is on your assessments of various health bodies. As you explained, you looked at all of the system. I guess you have a standard distribution of performance. I do not know what it looks like but there will be some that are excellent and some that are not very good at all. If everybody was as good as the best, what impact would it have on the problem? Would it get rid of it or halve it? Do you have an impression of what could happen? I have a reason for asking that question, and I am quite happy to share it if you are interested, but those are the two questions.

Victoria Vallance: On demand across the board, the pressure is the greatest it has ever been. What is noticeably different, at this point in time, is the increased demand of the most unwell people, category 1 for example, in terms of the acuity level. The call volume has increased as well but, in terms of ambulances and responses—I know you heard from Daren Mochrie about that—the most noticeable impact on demand is around the level of acuity.

Your second question was whether, if every service were as good as the best, it would solve the problem. We have been really clear that the problem needs attention, in terms of long-term efforts to sustain urgent and emergency care services and, notably, investment in a long-term sustainable workforce. Even with the best leadership, partnerships, governance and everything we would expect when we see things going really well, it will be sustainable only if we see those investments and the effort to support services.

Lord Hogan-Howe: Can I just push you on that? I take the point that you still need to invest even if people improve but what impact, broadly, would it have if everybody was as good as they could be—10% or half? It may be an impossible question, which is fine.

Victoria Vallance: Statistically, I would not like to come to a number but, of course, we would want to see every single patient, person and population group receive the excellent care that we expect people to receive. We hold providers to account to ensure that that is the ambition for the standard of care that is on offer. As you say, unfortunately not all services are providing to that level. The impact for people, which is the main and the important thing, is that then we would feel assured that every single person was in receipt, at the point of entry to any service in the pathway, of really good-quality care. That would be a good, positive outcome.

The Chair: As I understand it, you have done about 10 inspections under the new legislation around the integrated care system, where you particularly looked at this end, and you raised the flag in every single one, did you not? Do you think that the new structure has the potential to come out with a better outcome or do you think people are too concerned about other things, so that this area, which is the one area that you inspected under the integrated system, has not received the attention it might?

Victoria Vallance: You are right that we undertook 10 place-based reviews earlier this year in terms of urgent and emergency care. Practically, that meant that we brought together, and delivered at the same time, a series of provider-level inspections. We looked at primary care services, out-of-hours services, ambulance services and, indeed, the hospital ED services all at the same time. As well as the provider-level view, where we would always hold providers to account, as we are legislated to do, that approach enabled us to give the systems the feedback of the entire pathway of care for people accessing urgent and emergency care in their area, regardless of the entry point. What does it

feel like for people? What does the flow feel like? What do the capacity and the pressure feel like? Importantly, it allowed us to form a view of how those partners work together, manage risk together, govern, manage, and plan services, resources and capacity, and ensure good rigor and governance across the pathway as partners.

As the regulator, we are eagerly awaiting our powers next year to formally be able to hold the system to account, in terms of that duty to collaborate. Then we can see that absolute clear thread, through our insight and our regulatory activity, from the provider level, through the partnerships at different tiers of the system to the ICS level. That will be hugely beneficial for us in being able to hold the right areas of the system to account.

The Chair: Sarah, do you have a view about the new structure being better able to deliver or not?

Sarah Scobie: The integrated care boards most certainly have the potential to bring together providers across a system. There is, though, a lack of clarity about what the levers are for change and improvement. Previously, between the CCG and the providers, there were contractual arrangements that could be levers for improvement, and it is not clear how that is going to play out in an area if one organisation is felt to not be performing. There is just not enough clarity about that.

There is not really, as far as I can see, an effective performance framework for urgent care, because the targets that have been in place for some time have not been met for a very long time. The four-hour time in A&E has not been met for over seven years, for example. It is not really clear how an organisation's performance would be assessed and how patients would know whether their local providers were performing. A new set of clinical standards have been proposed by NHS England, which include what is described as a basket of indicators, but the implementation of those seems to have stalled. It is also not clear what the standards are that each of those measures should be at in order for an acceptable standard to be met. That is another factor to consider.

Q43 **Baroness Morris of Yardley:** It is really difficult to get your head round the figures, not because they are particularly complex but because we tend to get different figures, as they are measured in different ways or whatever. I just wanted a bit of clarity. Victoria, you raised that there had been an increase in people with more serious conditions, category 1 and 2, coming into A&E. If the overall numbers have not increased—they are just about pre pandemic so they are not judged, by some of the evidence we have, to have gone up a lot—and the ones in category 1 or 2 have increased, that logically implies that the ones in 3 and 4 have gone down. That is not the information we get or the picture anyone has described to us. It is quite difficult to work that out. That was the first thing.

Secondly, in a way, you could argue that public behaviour has changed. It does not matter why it has; it has just changed. People with conditions choose to access their healthcare through different groups than they did

five or 10 years ago. Is there an element in the inspection system where we want to squeeze public behaviour back into the system that has been going a fair amount of time? If we think public behaviour has changed, how can we build a system that meets the change in public behaviour? It might be a lot of work, and I am not sure what the answer is, but it might lead us to a better outcome. I just get the feeling that we are on a different page. I do not know whether that is because the public do not want to change behaviour but are being forced to, or whether it is genuinely a change in the way people choose to access care.

Victoria Vallance: Your second point there is a little bit of the answer to the first. We do know that, when people present, be it a 999 call or directly to the emergency department, they are more acutely unwell than they used to be. Either people are waiting longer or they are successfully seeking that support within the earlier stages of care, so primary care or out-of-hours care. You are right that that behaviour change, in part, is what is leading to the increased acuity of the higher-level life-threatening or emergency situations that either ambulances or the ED department are tackling.

Where partners work together and there is a shared approach, even if that is in the emergency department, there can be reduced pressure. For example, through one of the system reviews we have talked about, we saw some really good practice of primary care GPs and professionals co-located at the same place as the emergency department. They could perform quite an immediate assessment of those individuals attending the department. The knock-on impact was to reduce the footfall into the ED department by a third, so there is something to be thought about with behaviour changes. That is probably contributing to the lower demand. But, for those who do, for whatever reason, turn directly to the emergency care department, we have seen some really good practice with good outcomes and impacts on people where primary care has worked together with secondary care.

Baroness Morris of Yardley: Do you think your framework is adaptable enough to allow that change to happen without them failing to meet your targets and objectives?

Victoria Vallance: Yes, we are really keen to see the good positive impacts of creativity and innovation. We have talked about that in *State of Care* and in those reviews. Where we can see that new service models are having a good, safe, high-quality impact, we are fully supportive, yes.

Sarah Scobie: To clarify on the data points, the number of ambulance incidents—so when an ambulance has contact with a patient—is slightly lower than it was pre pandemic, but the number of calls to the ambulance service has gone up, which is probably people calling multiple times because they are waiting. It is worth bearing in mind that the number of incidents is likely to be constrained by the number of ambulance crews and the number of people they can reach.

Q44 **Baroness Chisholm of Owlpen:** You have talked a little bit about this,

but I would like to explore it a bit more. The shared experience is so important, and I want to know how you feel we could better link up with primary, social and mental health services to ensure that only patients with urgent need are accessing A&E and ambulance services. How can we educate people better so that they know the appropriate service to go to when they have a problem?

Sarah Scobie: There has been a lot of focus on the front door of the hospital and trying to reduce demand, and quite a lot of things have been tried. But, to some extent, that focus is in the wrong place. There has not been enough attention on the flow of the patient through the hospital. Things have been tried and it could well be that they have had an impact, co-locating GPs in A&E for example, but the actual impact on reducing urgent care demand has not really been very strong.

We do not know nearly as much about what goes on in primary and community services. We do not have such good data, so assessing the capacity outside of hospitals is much more difficult. One of the challenges for schemes that have aimed to divert people is that it does need somebody in the community to help. If a paramedic goes to somebody who does not need to be admitted to hospital but needs some help that is not available, because it is out of hours or there is not that service in the community, they will end up taking them to hospital anyway. Those community services need to be available.

One or two things have been proposed. There is the idea of booking appointments in A&E, which some minor injury units are implementing. That can have benefits, and they do it in Denmark and some other countries, but it has not really taken off. It was proposed a couple of years ago but only about 3% of A&E appointments are booked. I am not quite sure what has happened to that policy approach.

Victoria Vallance: In terms of people's outcomes and experiences, receiving care in the right place at the right time is incredibly important. To Sarah's point, we want people to be able to get that early intervention and support at either the first point of being acutely unwell or, if it is mental health, the signs and concerns of crisis. We have seen that work really well where there is capacity and investment in primary care and community care.

Again, through our system-based reviews, there will be instances where people, for whatever reason, are not able to, or choose not to, access that earlier stage of support and then end up at a later stage of acuity accessing the emergency care system.

We have seen some really good work—I will use mental health again as an example because I have it in mind—with the mental health team, the experts, the professionals and the clinicians embedding themselves into accident and emergency departments so that they can be available at that point of presentation. The reason I mention that example is that we have seen such poor mental health experiences where providers have not taken that approach. When the clinical expertise and the professional

capability are built in to catch those individuals, if they present in crisis or in a high-acuity state, we have seen some really good positive impacts. Yes, it is about early access in primary and community care, as well as thinking to the opposite end at the emergency department and how those people can be best supported, if that is their entry point to the system.

Baroness Chisholm of Owlpen: Where you talk about best practice, is that then spread to other trusts? I feel it does not go out there. There may be one area where they find really good work. Is data then collected so that that can be shared across the country?

Victoria Vallance: We are trying to take every single opportunity, be it releasing provider-level reports or be it the system narrative. They are not quite reports just yet; we are awaiting those powers, but it is the narrative around systems. We are engaging, influencing and meeting with system partners around those providers, and equally our national reports. We use every single opportunity to share best practice. Yes, we all know as the regulator that it is all about taking action where we find issues and quality concerns, but a big ambition for us is to be driving improvement in a different way and steering that learning and development by sharing best practice and insight. Yes, we are really keen to do that.

Baroness Sater: Picking up on that point, what are some of the tools that you might need more of to make this more effective?

Victoria Vallance: I have mentioned it a couple of times but there is a really great opportunity for us next year when we secure and are able to mobilise our integrated care system assessments because it means we can complete the jigsaw. We will have the view right from the smallest single-handed provider and their individual contribution to care in a system, but we can thread that right together, using the same lines of inquiry and looking at leadership, integration and outcomes for people. That is a huge opportunity for us, in holding the system to account, to support those providers, to support improvement where there is a need for it, and where there is something excellent and outstanding going on to cross-fertilise that within the system.

The Chair: Sarah, the Health Foundation has tried to bring together good practice and knows a bit about who is good at spreading it.

Sarah Scobie: Yes, I am actually from the Nuffield Trust, though, so I had probably better not speak to that.

The Chair: Sorry, but the Nuffield Trust also does bits of that.

Sarah Scobie: We do to some extent. When we do a study, we will aim to disseminate it. We will also engage with relevant clinical networks or groups that meet across the NHS to share evidence and so on. One of the challenges is that the particular local circumstances might be different, as between a hospital with a single site compared to one with three sites, for example, or whether it is a rural area and so on. There might be all sorts of reasons why it is difficult for organisations to pick up good practice and

take it elsewhere. Clearly, there are things that have been shown to be more effective in managing patient flow through the hospital and enabling timely discharge, for example, which could be more widely or systematically adopted.

Q45 Lord Bichard: I just want to come back to the CQC. We started looking at this because we thought it was a sort of national emergency. The previous Secretary of State, if I have the order right, also thought that. You are talking about being able to come out with some findings next year. One of my questions is whether the CQC is giving this enough priority.

I am surprised that you have not developed a model, from all the work you have done, about what good practice looks like. It is all very well looking at individual initiatives but that does not always tell the story. You gave us, in your evidence, Norfolk and Waveney as a good example because it is providing onsite primary care, which I got quite excited about. You said it had meant that a third of the people avoided the emergency department. But we are actually hearing from Nuffield that that did not work very well, so it is a good idea that is probably not going to deliver the solution we want. Should the CQC not be working towards having a model of what really works and treating it with a bit more urgency? In the next 12 months, people are going to die.

Victoria Vallance: We have described it as a gridlock, so we would absolutely be in agreement that this is in crisis state and it needs the support and planning wrapped around it at the system level. It cannot be left to one provider or one area of the system in isolation now to fix, to sort and to ensure a smooth and efficient urgent and emergency care pathway. This needs everybody to work together.

We undertook, as you say, the place-based system reviews. To your point about what else we are doing, at the same time, nationally, we called together clinical expert professionals, system leaders and front-line professionals, and worked with that group to come up with a practical resource, PEOPLE FIRST. I hope the committee has seen it; if not, we can certainly send it through. We recently published that approach. It has principles for ensuring, first and foremost, that urgent and emergency care is person-centred and built around meeting the needs of people in communities and population groups. That requires all those partners to come together. There are a number of chapters in there. It is about managing escalation flow, working together and capacity. I hope systems are taking PEOPLE FIRST into account because there is some really good-quality steering there, born from the clinical opinion and our findings.

Equally, I have talked about the integrated care system approaches. We are not going to wait until then, though. This winter, we will continue to regulate at provider level. We need to do that; it is our duty to do that. At the same time, we will take the approach, because we know it was really welcomed by providers, where we say that we will not look at one GP practice, 111 service or hospital in isolation, but look at these services at the same time to form a view of how they are working together. That

is our ambition again for this winter because we know it is going to be challenging. We need to be out there doing what we can ahead of the powers next year to influence at the system level. It is our intention to share data, share insight and be present early; to flag where we have concerns and risks, and, if that is inclusive of an inspection, to share those findings and any action that we have needed to take; and to call for assurance from the system as well as providers.

Sarah Scobie: The situation is very grave. Throughout the summer, we have seen very long waits for ambulances and for people in A&E. It is very concerning that that happened during the summer, which is usually the time when services can be more responsive. I would reiterate that the very longest waits are for people who are waiting to be admitted. For example, we have recently looked at variation by age in how long people wait in A&E, and it increases as people get older because more people are needing to be admitted. Even for young children, the time people are spending in A&E has really increased since before the pandemic. That gives me a sense that perhaps health systems are just getting used to very long waits and that those waits are being normalised. That will lead, as you say, to greater chances of patients coming to harm. I agree with you that it is a very grave situation.

Q46 **Lord Bourne of Aberystwyth:** Thanks to Victoria and Sarah for the evidence. I want to take us to something that cropped up last week, which is clearly very important, and that is your view of risk management in health and social care. I am not quite sure how we assess that. Clearly, there is a natural tendency to be risk averse when it comes to matters of health. How do we measure that?

Victoria Vallance: Everywhere we look, be it through provider lenses, exploring how you are working with your partners externally or, indeed, one of our place-based system reviews, we see that risk is best managed where it is shared, with partners around the table owning the pressures in the system together, understanding the severity of the risk for their population groups and local communities, and then planning capacity within the service. We are very aware of the extreme challenges and pressures for providers' systems at the moment. We expect providers to be taking risk-based decisions in partnership with each other and with local communities.

Just to talk about winter, it is here and it is fast approaching. We know that there will be ever-increasing and continued risk, and we expect to see people working together across all those sectors, coming together as partners, and planning really very well for how people can have the best experience of their journey through the health and social care system during a time of pressure. As I say, we will be continuing our inspections, not just at provider level but taking into account that wider pressure and risk. We will be exploring it through both lenses. Management of risk is top of our agenda through this winter as well.

Sarah Scobie: One of the fundamental challenges is that, if all parts of the system are stretched, where one part cannot absorb any more

service capacity, that will be squeezed somewhere else. There are models that are looking at this. For example, there is something called a continuous flow model in A&E where patients are admitted into the hospital on a regular basis but that then puts the pressure into the hospital ward. I can send some further information about that because one of my colleagues has been looking at it. There is this challenge that that may help in A&E but it is putting pressure elsewhere with overcrowded wards and not enough staff.

Fundamentally, we need to think about the capacity in the system, the number of staff, and what can be done, going into the winter, to support staff and to reduce stress and sickness, which is having a big toll across the NHS and social care workforce, along with all kinds of other wider economic constraints. For example, in social care there is a real challenge with the workforce. That is going to impact on the care homes' ability to admit patients to their capacity or to support people in their own homes.

Lord Bourne of Aberystwyth: I wanted to go on to look at the issue of regulation. Where regulation is focused on institutions, does that mean we are not looking at the system, which then impacts on patient care and the number of patients being looked at?

Victoria Vallance: Even through our provider-level approaches, one of our key questions is about leadership. Within that, we probe into how you are working with partners and contributing to the approaches and success of the wider system. As I say, we are hoping to look at the wider pathway, but the provider-level approaches do consider the work with the wider system. The benefit, as we have seen through those 10 reviews, of looking into the wider pathway is that we are not just finding the hotspots and the pressures, calling out, for example, an overcrowded ED department. Actually, we can say in our narrative that, when you track this back, there is reduced capacity in primary care, a lack of access at 111 and a high call abandonment rate. Then the patients find their way into the ED department, which is the provider-level approach, and historically we would have had only that area of the story. Now it is really important for us to be able to see the wider picture, particularly given the pressures and extreme challenges to come again this winter.

Are we able to assess the management of systems through the provider level? To some extent, yes, but are we taking steps, even in advance of mobilising with those powers next year, towards looking at the wider system? Yes, we are, and we will continue to do that.

Lord Bichard: Can I ask a very simple question? All the accepted wisdom is that the problem is with social care: not enough places exist in social care for people to move out, and therefore you have these 21,000 people in hospital at any time who could be outside. Has anyone taken a view on whether we cut the number of acute beds too far? We had 299,000 30 years ago and we are now down to 140,000. Is it possible—and does the CQC in particular have a view on this—that we may have gone too far? You will never get to a situation where there is no one in hospital who could not be in a social care bed. Should we increase the

beds?

Victoria Vallance: I will start with your first point about the pressure and the causation being around adult social care. That is a huge and significant pressure on the entire system but a holistic view is needed. Yes, we are calling very loudly for investment in adult social care to increase that capacity but the whole system needs attention. We need to be thinking about access to primary care and out-of-hours care, going back to “right care, right place, right time” for people.

Lord Richard: My question is whether you should be pressing for more acute beds in the NHS.

Victoria Vallance: We have talked about the figure. You presented it as 15%. In September of this year, for example, 22,000 of our hospital beds were occupied by people who did not need to be there. If we secure the flow so that people can get from the ED department into those beds because others have gone out to social care, ambulances will be able to offload patients into the ED department, and so on. By focusing on the flow in the system and increasing its capacity to have the right people in the right place at the right time, we should see some significant, good-quality care and outcomes for people.

Lord Richard: I will ask only one more time. Is the CQC saying that there are enough acute beds in the NHS and that all we need to do, difficult though it may be, is to focus on the flow?

Victoria Vallance: I do not think we are saying that. I certainly do not have a fixed view on how many beds there need to be, but we have a good view on how those beds are being used and how that results in safety and quality of care for people. I do not have a fixed view to offer here today on whether there need to be more or fewer beds.

Baroness Pitkeathley: If you do not have a view about that, do you have a view about the flexibility of the workforce to work across the acute beds into social care and so on? Is regulation of the professions perhaps something of a bar to that flexibility?

Victoria Vallance: There are very clear workforce ambitions around one workforce and one set of core competencies. We would be supportive of every worker, professional and clinician, be they workers in the community reaching into acute or vice versa, having the skills, capabilities and development they need to offer safe, high-quality care in the right place at the right time. If that led to innovative models of sectors working together and sharing resources, which we have talked about working well, we would be supportive.

Sarah Scobie: The question of the number of beds partly needs to be about the workforce and whether there is capacity. The number of occupied beds is lower than it was pre pandemic because there are not enough staff to keep more beds open. It is not just a question of physical space and physical rooms; it is about the staffing. Lessons could be

learned from looking at other health systems, at the extent to which our length of stay and our number of beds is comparable, and at whether those are beds in the acute sector as opposed to beds or services in the community. There are health systems that manage to have a lower number of beds than we do per head of population, but they have better-developed models in the community. The Netherlands would be one example. I can send the committee written evidence on that. That might be worth thinking about.

- Q47 **Lord Filkin:** I have a question about the levers of change and, implicitly, the leadership of that change. Of course, you cannot address that question until you know what change you think is desirable, so we have to go back to Lord Bichard's type of question. Sarah put the weight on hospital flow being fundamental, and that is right. It is known in the Dog and Duck. Everybody knows that, but we are not going to suddenly transform the number of hospital beds and of trained staff, or transform the social care system in five or so years, so it has a flavour of fundamentalism about it. We have to do something more urgently where we can make a change immediately. That is why I am struggling to see what feels like a weak response to where your evidence and our evidence points.

We had very good evidence at our last session. I cannot remember who it was, but it was one of the leadership of the ambulance trusts. When pushed, he said he still thought that you ought to be able to reduce by 15% or more the number of people going to A&E because they did not need to go there. You are explicit on your evidence, which is good, that new models are needed so that people who do not need to go to A&E do not go there.

Whose job is it to develop that model and what leadership will that require? If it is not yours in the CQC—it is clearly not Nuffield's—whose job is it and how do we make them do it? There is not a simple, crude and perfect model, but the need for some model of system change that reduces unnecessary waiting of people who do not need to go into A&E is screamingly obvious at this point. Why do we not get on and do something about it—or am I getting choleric in my maturity?

I will repeat the question. Do you agree that a new model is needed that prevents people going in who do not need to go? Whose job is it to deliver that or design it?

Sarah Scobie: It is not just about preventing people going who do not need to go, because those people may wait a long time in A&E but they will not be admitted.

Lord Filkin: If they are waiting in A&E, they are blocking the queue into A&E.

Sarah Scobie: No, not necessarily, because there will be a triage of people when they arrive at A&E. The people who are coming off an ambulance will need more high-level care than someone, on average, who is walking in. Even if you reduced the number of people who are

walking in, you would not necessarily help the person who is waiting in the ambulance.

Lord Filkin: That contradicts the evidence we have heard both from the CQC and from the ambulance chiefs, who in both cases said that reducing the numbers of people going who do not need to go is a very important change. Can you justify why you disagree with them?

Sarah Scobie: I am not saying that I disagree with them. I am saying that I think the focus needs to be on the people who have the highest needs and are the most severely ill. We have had a number of years of focusing on reducing demand and encouraging people not to go to A&E but, clearly, we would not be in the position that we are in now if all the things that had been tried around that were effective. There is a risk that the system tends to look to create additional services and provide other services for people to use, in order to divert them, but that can have the impact of there being more services that the system collectively needs to deliver.

Lord Filkin: I am still surprised. Lots of our evidence, as well as every friend and neighbour, describes that they are going to A&E because they cannot get services elsewhere. You are saying that that does not really matter.

Sarah Scobie: I am not saying that it does not matter. I am saying that I do not know that that will solve the most serious problem. That is what I would suggest.

Lord Filkin: You did not answer the question. Whose job is it to devise a better system?

Sarah Scobie: Ultimately, the NHS in England is accountable to the Department of Health and Social Care.

Lord Filkin: How do we make them do it?

Sarah Scobie: That might be a question for you as the House of Lords committee rather than for me.

Victoria Vallance: This is everybody's job. I can come on to that but what I wanted to say first, if I may, is that what is needed here—call it what we will; come up with a snazzy model—and what we categorically see as contributing to improvements, better experiences and better outcomes, is true collaboration.

Lord Filkin: That is a slogan. We are always talking about more collaboration and more leadership. I have never touched a public service where those have not been trotted out as what is needed. Of course it is true but just waving that flag is not going to do anything.

Victoria Vallance: There is a really good opportunity through the integrated care systems.

Lord Filkin: So that will sort it. We can sit back and wait because ICSs will sort it.

Victoria Vallance: I would hope to see all partners around that table, importantly with equity of voice and influence, thinking about their local communities and what the services need to look like, planning the resources and planning the capacity. There is an excellent opportunity, since the ICSs came to fruition earlier this year, for true collaboration and partnerships, with a shared vision, shared governance and a clarity of responsibilities and accountability, where everybody is clear as to how the urgent and emergency care pathway partners are coming together for people. As I said earlier, it is about that real sharing of risk, understanding in a live, dynamic way the capacity and the pressures, and recalibrating to ensure that people can access the right care in the right place at the right time.

Lord Filkin: That is the script that we all know and share. We all say “amen” to it, but it basically says that we stand back and let this happen. ICSs have an enormous agenda of change on their plates. You have to apply some sort of focus on this immediate problem if you expect to get any change in three years’ time.

Victoria Vallance: I absolutely agree, and I would expect ICSs to be thinking too, particularly with winter fast approaching, about best partnerships, best models and best use of capacity, expertise, skills and capability that they have within their gift in the system to ensure that safe care is accessible for people.

Lord Filkin: So it is nobody’s job to develop a hypothetical model.

Victoria Vallance: It is everybody’s.

Lord Filkin: If it is everybody’s job, it is nobody’s job. We all know that.

Baroness Chisholm of Owlpen: I want to agree with what you said, Sarah. We heard from Dr Boyle last week, who is a consultant. I cannot remember what his title is now, but he is a head of emergency services. He was saying that the problem is not, as you say—and I certainly know this from when I was nursing—with minors coming into A&E. The problem is the beds within the hospital. Unless you can move the people who do not need to be in hospital into community care facilities, you cannot get the urgent cases off the trollies in the A&E departments into the beds. It is not the minors who cause the problem because they are sitting in chairs and can be looked at by other people anyway, rather than the big trauma units that have to look after serious cases.

Surely, the real problem is getting those people who are in the hospital out of the beds and into the communities. If we can solve that, we can solve the problems of the A&E, which then solves the problems of the ambulances, which solves the problem all round. Would you agree with that?

Sarah Scobie: There is obviously a challenge as to how to do that, but looking at workforce and capacity in social care would be a good place to start.

Lord Filkin: Who could not agree with that? But a system that basically says, "Minor people are going to hospital who do not need to be there and it does not really matter if they wait for six hours in A&E" is a dreadful, dreadful service. As well as getting the flow improved—and let us have the politics and the funding in 10 years to do that—we have to do change where it is possible. It is not acceptable that people wait for four hours even if they have a broken toe and nothing happens to them. Do you not agree that we need to do something to better treat those who could be treated outside A&E elsewhere—yes or no, if possible?

Sarah Scobie: I would briefly mention again the idea of booked appointments if you have something minor.

Lord Filkin: So you book an appointment for when you are going to break your toe.

Sarah Scobie: No. When you break your toe, rather than going to A&E, being put in a queue and sitting on a chair for six hours, you call and they tell you when you are likely to be seen. This happens routinely in Denmark, I believe. It could be considered for that group of patients.

Lord Filkin: Could you send us some evidence on that, please?

Sarah Scobie: Yes.

The Chair: Lots of people want to ask lots of things, but we need to move on to our next question, because we are already over time.

Q48 **Lord Hogan-Howe:** I think this question is worth pursuing, although you might think, "Please don't". One reason for some of the questions is that people have come through and there has not always been agreement about the data or the analysis of it. Michael mentioned—and I think everybody accepts—that social care needs to have more capacity. Victoria, you have brought out the issue about people not getting to primary care, and it sounds like both interests are important. We hear from the paramedics that they are probably carrying half as many people as they used to in a shift because they are spending longer at the scene, which is why people are asking, "What is this new model and how does it work better?" There has not been agreement about that.

To one of the questions that Geoff has concentrated on, if, in a new world with the integrated boards, there will be, as you explained, more accountability and a regulatory opportunity to ask, "Why are you not collectively getting this right?", who has the role of saying, "In that area, this is your job"? Who is going to demand, "As a result of the regulator saying these are the things that are not working very well, that is your role in the new system"?

To give a symptom of it not working in the present system, I would say

that a 95 year-old with a broken hip and a broken shoulder waiting on a floor for 27 hours can never be the answer to a health service that has over 1 million people. It is not only the paramedics. What else did anybody do to prevent that person spending 20-odd hours on the floor? That cannot be the right answer ever. Somebody else should have helped. Who thought it was their job to intervene acutely in that case or system-wide to try to make sure it did not happen again? It may always happen, but you would never want it to happen again.

I may not have represented Geoff's question very well but I would like to understand who is the command and control bit in this. The health service seems to fight command and control. I get that, but who is going to make these levers work?

Victoria Vallance: We have two immediate levers available to us. One is our continued provider-level regulation. Where we find that care is of concern, be it unsafe or not meeting the standards we would expect it to, we will continue to use our regulatory toolkit, in which we have powers to hold providers to account. Where we see significant value in the future, particularly when we can formally assess and form judgments of quality and safety at the integrated care system level, there is another lever for us there.

In terms of accountability, fast forward and imagine that there is a report. I do not know what that will look like but just imagine it. We would then be directing that review of quality and safety to the system chair, and we would be expecting a return on that, an update if necessary, and an action plan. We are still working through the approach and quite what it will look like, but we need an escalation line beyond there. We are working that through because, in the same way that we would call out to NHS England, for example, if a trust were failing to improve, we need to be able to escalate our concerns.

Lord Hogan-Howe: Is it the chair of this integrated board who would be asking, "What are you doing about it?" Would they have a lever to say to GPs, "You've got the capacity to put through 1,000 people a month. You're putting through 600. What can you do about that?" If they are not prepared to do something about it, who would take action? Is it the chair or someone else in that system?

Victoria Vallance: We would be expecting the system itself to reach through and provide support.

Lord Hogan-Howe: This goes back to Geoff's question. The system is not a person or a role. Where can you go in, for example, Monmouthshire to say, "You're being paid to do this better. We expect the GPs"—or whoever it happens to be—"to do their job better. You've got the power to do it. Why aren't you doing it"? I am paraphrasing what Geoff is talking about. In the new model, is there someone tasked and empowered to deliver? I am not sure I have heard that. If there is not, I get that that is not your responsibility.

Victoria Vallance: The accountability and responsibility systems are still working this out themselves. They are grappling with it. What does the governance look like? In terms of our plans and our emerging, shaping up approach, we will be hooking in and delivering our view back to the integrated care system, of which the accountability sits with the chair and the rest of the team around them.

The Chair: Unfortunately, we have run out of time with you and we are going on to the real command and control people later, NHS England. I just want to say thank you enormously to you two. You can tell that we still have lots we would like to explore with you. Thank you, Sarah. You have already said that you will send us information on anything that you think we did not quite get or that you did not get the chance to explain in the way you wanted to. I would also offer the same to you, Victoria. If there is anything that you think afterwards would be useful for us, please let us know. We want to produce a report that will be useful to people and that will inform the area a little better. Thank you very much indeed.