HOUSE OF LORDS

Public Services Committee

Uncorrected oral evidence: Access to emergency services

Wednesday 2 November 2022

4.10 pm

Watch the meeting

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

Evidence Session No. 7 Heard in Public Questions 49 - 58

Witnesses

I: Professor Julian Redhead, National Clinical Director for Urgent and Emergency Care, NHS England; Dr Vin Diwakar, Medical Director for Transformation and Secondary Care, NHS England.

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Examination of witnesses

Professor Julian Redhead and Dr Vin Diwakar.

Q49 **The Chair:** Welcome to this next session of the Public Services Committee in the House of Lords. In this session, we are taking evidence from representatives of NHS England. Both of them are, I hope, in a position to inform the committee of the situation around the sharing and promotion of good practice and innovation, and the systemic challenges of the current system.

We have Professor Julian Redhead, who is the national clinical director for urgent and emergency care at NHS England. I also notice that you have a responsibility at Imperial. We also have Dr Vin Diwakar, who is medical director for transformation and secondary care at NHS England. Welcome to both of you. We are really pleased you are able to join us.

How do emergency services co-ordinate with social and primary care systems to improve patient outcomes and reduce demand for urgent and emergency care? What are the challenges of good partnership?

Dr Vin Diwakar: First, the accountabilities of integrated care boards and integrated care systems are really clear, both in the legislation and in the job descriptions of chief execs and chairs of integrated care systems, which are now statutory organisations.

With particular regard to emergency care, NHS England, working with its partners, has issued guidance to integrated care systems throughout this year, particularly during the summer, on actions that systems should take in order to manage urgent and emergency care over the course of this winter.

We support integrated care systems because they submit plans demonstrating the way in which they are meeting the guidance and instructions we have given them. They are also expected to report progress on those plans directly to their boards and to their chairs through a board assurance framework, which we also assure.

Inevitably, there will be variation—I know you have heard this in previous evidence—in the extent to which integrated care systems are able to deliver. We take a proportionate approach to this. We have a regulatory approach based on something called the system oversight framework. For those systems that are struggling the most, we give them much more intensive and mandated support from subject matter experts, such as Professor Redhead, in urgent and emergency care. For those systems that are doing well, we are gathering good practice from them. We have a variety of ways in which we might spread those practices, which I can expand on later to the committee.

If I could move on to the challenges, the first is the rising demand we have seen across all parts of urgent and emergency care. Again, I know previous witnesses have alluded to that. In primary care, for example, GPs have delivered 345 million appointments over the previous 12

months up to August. In the 12 months prior to the pandemic, in 2018-19, it was 310 million. There is much greater demand on primary care, which we have heard about. Despite those increased appointments, there are real challenges for the public in accessing primary care services.

In urgent care, we have heard already how the number of calls to 999 services has gone up. Even though conveyances have dropped a little, calls are going up. In the 111 service, over the last five years, 111 has taken a million more calls per year. That is a 30% increase over the last few years. On the other side, we have heard about increased demands on mental health services. There has been a 75% increase in referrals to mental health crisis teams. This is across the board.

We might ask, "What are the particular drivers of that increased demand?" Growing complexity is a driving factor. In fact, that is very directly related to urgent care demand. We have an ageing population, and of course age is associated with developing more long-term conditions. The more long-term conditions you have, the more likely you are to receive urgent or emergency care. Your risk is increased three times if you have three long-term conditions and twice if you have one long-term condition.

Over the last five to seven years, the percentage of patients attending an emergency department with more than three long-term conditions has risen from 10% to 30%. The complexity of patients attending emergency departments has definitely gone up. That is reflected in the figures, which I know the committee has heard about, for the proportion of ambulance conveyances that are classed as category 2, which are the second most urgent form of ambulance conveyance, and the relative drop in the percentage that are classed as category 3.

When you put those two things together with the increased numbers of demand and increased complexity, it explains some of the significant demands that are being placed on services across the piece. We have to design services around those factors. It is great news that we have increased life expectancy and that people are living longer in this country. The task, through our strategy, is to develop services in a way that serves the population.

Professor Julian Redhead: I agree with what Vin has been talking about. We are seeing that increased demand on different parts of our system. That is across the system, into social care and all the way through. One of the biggest challenges for us at the moment is making sure we have the right staffing to provide safe care. That is the only thing I would add.

The Chair: You talk about the number of people coming who have long-term conditions. That is clearly a major issue in the demography of people seeking to access care. Are there not better ways of dealing with them? Emergency care will very rarely meet the needs of people with long-term conditions.

Professor Julian Redhead: You are absolutely correct. The ageing population will also get older. The predictions are that the trend will continue. That provides new challenges to our country and to others. It is not just a national problem; the rest of the world is facing this to a greater or lesser degree. We are trying to address that by keeping patients as healthy as possible. It is a preventive strategy, much more than just reacting when patients unfortunately have acute exacerbations of care.

When we look at the long-term plan and the plans we are formulating all the time, they are about working with primary care, the ICS and social care to keep citizens—they are not necessarily patients at that point—as healthy as possible, enabling them to stay active in order to avoid coming into crisis, and looking at how we support them when they are in crisis.

Through Covid, we looked at the idea of remote monitoring for certain groups of patients, where you can step up and have increased monitoring of those patient groups. That would be a good example of how we try to support people more in the community now and not necessarily through an acute system, because we know there are other disadvantages to them being part of the hospital bed system.

Dr Vin Diwakar: The key role for supporting individual members of the public with their long-term conditions sits in primary care. That is important in a range of ways. It is not just about, when you have an established long-term condition such as diabetes, optimising your medication, having regular reviews and supporting you using a variety of tools we have that, for instance, enable you to take your own glucose levels and self-manage your diabetes.

There is also big element for prevention in primary care. For example, we know the early detection of high blood pressure and heart rhythm abnormalities can lead to a measurable decrease in the number of people subsequently presenting with strokes and heart attacks down the line. We have expanded the capability to do that in primary care, as I referred to, but also, for example, through community pharmacies. Community pharmacies can now do opportunistic blood pressure checks, identify high blood pressure early and then directly book patients into primary care.

In mid-2021, we saw a very steep rise in demand for services. That was mirrored across all aspects of the service, including in attendances, ambulance handover delays, problems with complex discharges and the increase in complexity of category 2 calls.

Here is one hypothesis for what might have driven that. During the pandemic, the NHS was largely fully occupied with managing Covid and there were a number of things associated with long-term condition management that could not be done. That was why it was so important for us to get control of the pandemic and then return the NHS to doing the catch-up work that we needed to do in order to optimise condition management.

That is still having an impact on the NHS in driving increased demand. There are not just backlogs in planned care, if you need an operation or an outpatient appointment; there are backlogs in primary care that GPs are still catching up with.

The Chair: I am desperate to come back and ask, "Where is the money in relation to early intervention and preventive care?", but never mind.

Q50 **Lord Bichard:** You will probably pick up during this discussion that there is a degree of frustration around this table. We are trying to find some answers to a problem and we are often hearing, "It's all down to increasing demand", but the data on the increase in demand is not that reliable. A lot of the demand people have talked to us about is actually increased calls, not increased incidence, because people are getting so frustrated when the ambulance does not turn up that they keep calling. Is it demand?

Then we go on to the accepted wisdom that the other problem is the lack of social care beds. We all accept that is part of the problem, but, in the evidence we have received, the longest wait was 33 hours. In a civilised society, this surely cannot be acceptable. Rather than just saying, "We have problems with demand, and there are not enough social care beds", we need to find a model that looks as if it might improve where we are now.

You said there was some guidance you have delivered to the ICBs. I do not know whether we have that. If we do not, it would be really good to have it. That is what we are struggling towards. Is there a model that could make things better? Currently, this is a scandal.

Dr Vin Diwakar: We have three ways of tackling this challenge. I will start with demand. It is absolutely true that calls to the 999 service have gone up, while conveyances have dropped slightly since prior to the pandemic. They were rising prior to that. Ambulance services have got better at avoiding bringing people to hospital. They have increased the number of people they are able to hear and treat, and see and treat. They are carrying fewer people, and that is a real achievement on the part of the ambulance services.

We have three ways of looking at this. The first is all parts of the system working together to reduce conveyances and deteriorations. We have talked a bit about prevention. For example, in our most recent letter, the instructions to the NHS that we issued at the end of August, there is a plan for every integrated care system in every part of England to have a community falls service. Some 25% of category 3 calls are for patients who have fallen. They do not need an ambulance response; they can have what I would call a non-clinical response. They do not need clinical input; they need someone to help them get off the floor and call their community services or their families to come and support them and to assess what the problem is. That could prevent 55,000 conveyances a year when we implement it across England.

Secondly, we have implemented urgent community response. There is a two-hour urgent community response service specification that all integrated care systems have to meet. We are seeing the number of calls to urgent community response services going up. We have more to do in order to extend access to those services, but that is the model that we should have in place for pre-hospital services.

Thirdly, for the 111 service, which is really the entry point for most people into the urgent care service on top of ringing their GP, we have increased the number of call handlers by a significant amount in order to support faster access to 111. We are continuously making changes to something called NHS Pathways, which is the validated system that 111 call handlers use. You describe your symptoms and put them into NHS Pathways, and that gives the call handler guidance as to where the patient should be directed.

For example, about 25% of 111 calls can be resolved over the telephone with advice or by signposting people to the right place. Around 10% need to go to an ambulance service because the patient has called 111 when they needed 999. For those calls, we have senior clinicians working in 111 call centres, who validate those calls to make sure we are not passing those on to the emergency care system when they do not need to be. We have that clinical assessment.

Also, 111 can directly book into primary care and is doing so already. All primary care providers are expected to keep a selection of appointments open that 111 can and does book into. We monitor in NHS England not just the bookings but the uptake of appointments. If not enough bookings are made, we can talk to systems and ask them, “Why aren’t your bookings going up? What’s going on?” That is the admissions avoidance side of things.

Of course, with an ageing population, care homes are a particular area of interest. Just prior to the pandemic, we launched a programme called Enhanced Health in Care Homes. Under their contracts, each care home has to have a lead primary care network and a lead clinician. They are expected to do weekly rounds in the care home in order to optimise care management.

If you get admitted to hospital and you are discharged back to your care home, you have a comprehensive assessment by your GP; you have a personalised care plan developed; and you have a regular medication review to ensure your medications are addressing those problems. Where that has been introduced across England, we saw a 26% drop in the number of conveyances coming from care homes into the emergency care system.

All those things will help not just with admissions avoidance; they will help with discharge as well. But the reality is that the level of demand on the whole emergency care system is rising more quickly than these interventions are having an impact on it. We have a mismatch between demand and capacity, despite the work we are putting in to do that.

That is one of the driving factors behind the levels of care we are seeing at the moment, which no one in the NHS, regardless of whether you work in NHS England or you are a GP, nurse or member of staff, is aspiring to deliver at the moment.

Q51 **Baroness Morris of Yardley:** We have asked everybody about risk and who manages risk in the system. I want to ask you about who manages risk across the system, but before that I will go to complexity, at the other end. I hear what you say about the 111 calls. I can see that the model might work, but the evidence we have received so far from the people who are answering 111 calls is that it is a bit like diagnosis by algorithm, which scares most of us. They do not have the confidence. They do not have the training, the qualification or the experience.

We would all completely understand that you would always make a decision, when it is people's lives, that errs on the side of caution. To save enough time to ask about risk and system change, do you just want to comment on that? How confident are you that this algorithm method, following it through the arrows, is ever going to be as good as it should be? Is it the right system or not?

Dr Vin Diwakar: I will say three things about 111. First, if you are a call handler in 111, you are trained. You have to pass tests and assessments.

Baroness Morris of Yardley: Could you say a bit more about that? Are they at paramedic level?

Dr Vin Diwakar: No, they are not to paramedic level. They are what we would call band 4 staff. They are trained, but not as highly trained as a paramedic. A paramedic is a degree-level course. You have to do three years of training. It is a very advanced skill.

Secondly, the NHS Pathways algorithm was developed and continues to be developed by senior professionals, by the royal colleges and by relevant clinical experts in the field. Because it is a computerised system, we get great data from it. It is constantly being reiterated in order to improve the accuracy of services.

Thirdly, when call handlers are taking 111 calls, a proportion of their calls are supervised and a proportion of them are also validated by senior clinicians. They either listen into the call or the call handler will go through NHS Pathways and say, “We think this is where the patient should go” and a clinician would then review that and say, “Yes, we think that’s the right place to go”. Sometimes clinicians do change where 111 will then direct patients to.

In the survey of people who ring 111, about 78% say they are satisfied with the service, which is still pretty good, but we could do a lot better. I am certainly in no doubt that we need to do more in order to build the public's confidence in the 111 service.

If you look at the number of calls that come to 111, which is going up by a million a year, if those appointments were not being resolved by 111,

they would be going into the urgent and emergency care system. There is work to do to build confidence, but it is a good service and there are good systems both for quality-assuring it and for constantly improving the quality and accuracy of the algorithms.

Professor Julian Redhead: Vin is absolutely correct in what he says about the clinical oversight. The safety of the system is absolutely there.

The online aspect of this also allows patients to access that information and understand where their algorithm could end up online as well. That is good because we do not need additional call handlers to handle those calls, but the patient can access those services themselves.

Baroness Morris of Yardley: Presumably, there is a level of knowledge in the public as to whether to call in the first place. Presumably, that is the first step in the process, is it not?

Professor Julian Redhead: Yes. The algorithms are there to be able to take a citizen through exactly the questions that need to be answered in order to come out with a correct algorithm. The public confidence is in terms of the satisfaction. Most satisfaction surveys demonstrate that patients are very happy with that service and they get the outcomes they would like.

Q52 **Baroness Morris of Yardley:** I want to move on to system-level risk management. Everyone is talking about the integrated care system. It is very new, and I do not know whether it is going to work or not. Who knows? Can you say a bit about who should be managing risk across the system? The temptation is to take the risk based on your own area and your own accountability. That has consequences elsewhere. Professor Redhead, in the new system of integration, where does the responsibility for risk lie and could it be better managed?

Professor Julian Redhead: It is really important. Although the ICSs vary in maturity, during Covid, at the point when the ICSs were forming—they were not accountable then but were certainly part of that—we had to bring all parts of the system together in the response to Covid. A lot of learning came out of that. I was a medical director of one of those ICSs, so I have first-hand experience of how that works.

When we talk about risk management, it is really important that we bring in all parts of the system. You cannot just risk-manage one bit and push the risk on to somebody else. Everyone has to understand the different risks you are facing, and then you work together to come up with a plan that reduces them.

For example, during Covid, we diverted ambulances on a proactive basis because we knew that some hospitals had more Covid cases coming to them than they could cope with, and other trusts did not have as many. Everyone was under pressure—do not get me wrong—but there were relative pressures here. Being able to divert those ambulances proactively was a risk management decision that we took very

successfully to make sure patients had the urgent and immediate care they really needed.

Baroness Morris of Yardley: This goes back to the discussion we had at the end of the previous session. Does somebody clearly have the responsibility to say, "This is what's going to happen"? Is there somebody who can be held accountable and who has ways to make sure that people help deliver it, or does it get lost in an integrated mess?

Professor Julian Redhead: There is an accountable officer. That is usually the chief executive of the ICS. They have the accountability for the care of their population. That includes bringing together social care and all the other leaders to provide that care for that population. That is clear.

I would agree that there is a difference in the maturity of those ICSs and their ability to develop the systems in place to carry out that authority, but that will grow. It is important that it does so.

Q53 **Lord Hogan-Howe:** Let me pursue that a little more. That is a really helpful answer. If you took the example of a GP service, for the sake for argument, that was not delivering the volume or the speed that would be helpful for the whole system, a chief exec could turn round to that part of the system and say, "We need you to do more. I'm insisting that you do something".

You gave the very good example of an ambulance that could be redirected from an adjacent area to help somebody who needs it because there is some capacity there that might be helpful. They can step in and say, in the individual case or across the system, "We're going to change", and they can insist on it.

Professor Julian Redhead: In general it does not come to that. Usually, when you bring everyone together, they start to understand the different parts.

Lord Hogan-Howe: But if they had to—

Professor Julian Redhead: Yes, that person does have that authority to work with the chief executives of the different systems.

Lord Hogan-Howe: You gave us some really reassuring information at the beginning about the demand. It went from 310 million up to 345 million, which indicated more demand but also that the system had responded. You then went on to say that some of that work is preventive. Some of it will be incentivised financially.

Dr Vin Diwakar: Yes, absolutely.

Lord Hogan-Howe: So there is a danger that some of the primary care providers increase their income stream, but the system suffers as a result. I am not saying that is a malicious thing, but it is a possibility.

Dr Vin Diwakar: In the past, NHS England was responsible for commissioning primary care services. What we learned, as a national or regional organisation, was that primary care is local so that is not the right model. Primary care commissioning has been delegated to integrated care systems, so their accountability for the quality of primary care is really clear. NHS England's role is for the strategic leadership in primary care and the provision of data so people can see how primary care varies.

The management of risk is not easy. If I give you my personal example, I was trained as an acute paediatrician. I was trained to look at only the risk of the patient in front of me and the risks I was holding across my patient group in the hospital I was working in. I did not think, 10, 15 or 20 years ago, that the ambulance service was any of my responsibility.

We are now seeing a shift in clinicians. In some of the places that have got very good at managing ambulance handovers, the clinicians have said, "We're here for our community; we're a community asset. This is as much our responsibility as it is the ambulance service's, and we will own this problem". We are seeing increasing acceptance of that by the profession, albeit that we need to work closely with the profession, because it is pretty difficult to accept and manage the risk of patients you cannot see in front of you and you might not feel directly accountable for.

NHS England, in our most recent instructions to the system, created something we have called system control centres. They have been described in the press as war rooms, which is probably a bit of overkill. They have a number of elements to them.

First, operational managers and clinical leaders such as me and Julian will work together to manage risk. That is about us having a real-time view of data that tells us where patients are and where the greatest clinical risks are. We work with operational and clinical managers in acute providers, mental health providers, community providers and local government to ask, "Where can we best place patients, given the scenario we are in, in order to maximise the benefit for the whole population and not just look at risk and argue about risk across different services?"

We have asked systems to set these up, and inevitably there is variation. Some parts of the country have already set them up, which we are learning from, and some are only just starting to do that.

In the letter, we also announced that we would start something called an improvement collaborative, which I am leading. In fact, we had a meeting yesterday with over 200 chief operating officers, medical directors and chief nurses from nearly every provider or system across England. We talked about how we are going to manage risk under these very pressured circumstances in which we find ourselves. "What are each of you doing? What can we learn from what each of you is doing? How can we spread that?"

We will have a very intense focus on that. Over the course of this next winter, we will track the benefits of using the data that we have, for example, on the demand for services. We will assess whether spreading that good practice is having an impact. If it is not, we will need to course-correct and do something else in these quite dynamic circumstances.

These are dynamic circumstances because we are entering winter and the weather is getting colder. We know we have around 8,000 patients with Covid currently in hospitals. There are patients who would not have been there two years ago. We also have the potential for flu, although there are only about 200 patients with flu currently in hospital. We will have to see how demand plays out, manage risk and learn from that effort, because it is early work that we are doing in the NHS and we need to bring people with us on that journey.

Lord Filkin: I have a very quick question. It is one that could be responded to in writing. You gave a very clear description orally of what sounded like an NHS plan to avoid unnecessary admissions. That is very important and relevant to us. Has it been published?

Dr Vin Diwakar: Yes, it has.

Lord Filkin: Can we get it?

Dr Vin Diwakar: Yes. Both are available on the NHS website.

Q54 **Lord Filkin:** Separately—this is not a question for now—what are your systems for monitoring adoption? That would be highly relevant to our inquiry.

The second thing you said, which was pretty honest and clear, was that, despite these performance improvements you are making, the demand was rising more quickly than the benefits. It is explicitly clear: the problem with A&E and access to emergency services is going to get worse because demand is going to continue rising. Any number of House of Lords and other reports show the increase in multiple morbidities and in the proportion of people aged 85-plus. It is going to get much worse, is it not?

Dr Vin Diwakar: First, in response to that, we are only just coming out of the pandemic. We saw demand rising prior to the pandemic, and some demand did drop off due to the odd circumstances we found ourselves in. We do not yet know exactly what the patterns of healthcare utilisation are going to be immediately.

The second point about demand is that we have to optimise the use of the resources we already have. On any given day there are between 10,000 and 14,000 patients in hospital who would be better cared for in their own bed. I am always saying that the best bed is your own bed. We have to work to improve the way we both put together care packages for those patients and discharge them.

We did some intense work with the national discharge task force, chaired by my colleague Sarah-Jane Marsh, one of the local authority chief execs from Birmingham. One of the early things the task force did was to identify 10 things all systems could do that would have a material impact. They were things such as starting discharge planning at the point of admission, having seven-day services with access to senior clinical decision-makers and having an intermediate care strategy so that, when you discharge someone, you have a clear set of services to discharge them into.

For the discharges that are within the control of hospitals, we have seen some improvement in the percentage of patients who could be discharged if, for example, they had faster access to diagnostics or were waiting for a care plan. There has been a small decrease in that. We are continuing to see a very sharp rise in the number of patients in hospital who are waiting for a social care package, a domiciliary care package or access to community services. It is really important that we continue to work with integrated care systems, local government—much of this has to be done at local level—and national government in order to tackle that particular problem. It cannot be right that people are in hospital when they would be better cared for in their own beds.

Q55 **Baroness Pitkeathley:** I want to ask you about good practice, innovation and pilots. Listening to you talk this afternoon, there have been times when I have been thinking, "Where's the problem, then?" It sounds as though things are in place to mitigate this. I was quite glad that you came back to the social care issue towards the end of your remarks. I was thinking, "Why are we doing this inquiry, if these systems are already in place?"

You talked about learning, Vin. What are the barriers to learning from pilots and spreading good practice? Why can we not have a system that everybody buys into and understands is the way to do it?

Dr Vin Diwakar: Uptake is partly driven by the capacity of individual members of staff to take up changes in practice. When I work clinically, I get up in the morning; I go and see a lot of patients; then I come home. The capacity of my full-time clinical colleagues is limited because they are spending a lot of time seeing patients, reducing waiting lists and so on. There is a pace question to this.

Case studies have their place, but they are limited in their impact. We publish and curate large numbers of case studies both internally within NHS England and more broadly, and we have heard how CQC and others publish studies as well.

Baroness Pitkeathley: Are you using the terms "case study" and "pilot" interchangeably?

Dr Vin Diwakar: No. I will come to that. I am using "case study" to describe something where someone is doing something well. We have not necessarily commissioned a pilot, but we have come across it by visiting

the trust or we have heard about it, and then we get them to describe it and we put it there.

We do commission pilots. Our approach has often been to commission them where we have a particular problem to tackle, but we are not completely certain what the right model is in order to tackle that problem. For example, working with the national discharge task force and the department, we are funding six of what we are calling discharge frontrunners. They will test different models in which local government, social care and the NHS can work together, for example, on intermediate care and domiciliary care. Out of that, we should be able to capture some learning that could then be generalised and spread more widely. Until we have done the pilot, evaluated it and drawn out the learning from it, we cannot scale it.

For NHS England, we have a variety of ways in which we can scale innovation. As I say, the pace by which we can scale is limited by the capacity of systems to take it up. For example, one way is creating good case studies and gathering together that evidence into guidance, toolkits, playbooks and so on. Again, the system has limits on the extent to which you can keep reading those, but we do publish them, as do a number of organisations.

The third piece is about publishing data that can demonstrate the variation between organisations. For example, we have a system called the model health system, which has a number of metrics on it that describe the variation between systems. We back that up with clinical peer review by colleagues such as Professor Redhead, who will visit systems in order to demonstrate the degree of variation and offer recommendations. They will often walk alongside people in order to support them in making those changes happen. Spreading innovation is not easy by any means, particularly when the system is so busy, but we have a system in place to do that.

Professor Julian Redhead: Vin is absolutely correct. Whenever you try to do any change management, there is always going to be a percentage of people who are early adopters, who are enthusiasts and who want to get on with it. That is great. There is another large percentage of people who will go along with it because they go with the flow. There are also always going to be objectors who say, "I don't want to do this". You have to go through various stages when you are doing large-scale changes. Some of this is large scale to the individual nurse or consultant who is looking after that particular group of patients.

It is important to recognise that some of this takes time, but it is about looking at the best practice around and how we share that best practice, then adopting it. There is this idea of adapt and adopt. You are looking at the practice and saying, "How could I use that in my system?" Every hospital is subtly different in its estate, the different services it provides and how they are provided. That has grown up over a number of years.

We know there are those variations and we are trying to take out unwanted variation. Where it is helpful, variation is absolutely fine, but it is also important to use best practice to try to drive the things we want to see through the systems.

Baroness Pitkeathley: The ICBs—and this is true across the integrated care system—started at different times and, it must be said, with different levels of commitment. Will there come a point where they are all on one level and you can spread the pilot ideas or the good practice more satisfactorily?

Professor Julian Redhead: Yes, I think there will. It just sometimes takes a little time for them to get the systems in place. Equally, it is about learning from other ICSs that are slightly ahead in certain areas. It is exactly the same process of showing good practice from one ICS and allowing the other ICSs to adopt it. It is all the same mechanism for how we do that change management and making sure we have the right processes and support mechanisms in place for people to go through the different stages of change.

Q56 **Baroness Sater:** We have heard a lot about gridlocks, blockages and lots of people making decisions in different areas. What interests me is the distribution of authority. How much are you looking at that? How much more could you do by using different people to make better decisions and giving them more authority, so that things can be done more quickly?

Professor Julian Redhead: It is interesting. During Covid, one thing we were able to do quickly was to change and adopt things. We are trying to make sure we still have those processes in place.

There needs to be some command and control. We heard that term earlier from your colleagues and I would absolutely agree. There has to be some of that, but we need to be able to delegate decisions to the level where people can make them quickly for their own patients.

If you look at trusts where that happens, matrons are able to take authority over their wards, and consultants are working with other patient groups to make the changes they need, finding out how you get the best innovation from other areas and bringing that in. It is all part of that same conversation.

Baroness Sater: That profile of matron can work better elsewhere as well.

Professor Julian Redhead: Yes. That links to that idea of how we spread good practice within trusts. Most trusts will have ward-accreditation programmes, where they go to different wards and look at good practice. The nurses and medical directors will help to devolve that good practice into other parts of the trust. Other trusts will then look at that good practice and build it from the ground up, which is often what you need for sustainable change.

Dr Vin Diwakar: The Health Foundation published a very helpful evaluation of how we operated in the pandemic, which used the helpful phrase "central clarity and local autonomy". We have thought about this quite a lot in NHS England. We published our operating model a few weeks ago, which exactly describes NHS England's role in setting standards; developing policy and strategy; identifying, spreading and adopting good practice; and using our regulatory powers where we need to step in and do things.

As Julian says, with an ageing population and more long-term conditions, the model of an integrated care system, where we bring health and social care together and understand at a deep level their population and their needs, is vital. NHS England has consistently supported this, in terms of delegating more responsibility for decision-making to a local level, where priorities can be set depending upon the needs of the local population.

As you then start to layer that down, that happens in primary care as well. One of our colleagues, Dr Claire Fuller, the chief executive of an integrated care system in Surrey, was commissioned by NHS England to produce a report looking at better integration at the level of place. One thing she describes is moving away from the current model we have. We created primary care networks more recently. Rather than having lots of practices, each with a population of around 12,000, we move to a model where groups of practices work together on the needs of those populations and share resources to provide better services.

By working with local government and the voluntary sector, primary care actually becomes primary care. It is not just about general practice; it is about working together. They are then much better able to create and work with services that are culturally appropriate and reflective of the way their populations want to use them.

It is about delegation, but we are providing central clarity and standards. Using our powers to spread the adoption of good practice and regulate where necessary is a really important part of the work we are doing, both under the Act and through our integrated care boards and integrated care systems.

The Chair: That is a very interesting report.

Q57 **Lord Bichard:** I want to focus a bit on outcomes. The people waiting intolerable amounts of time for an ambulance or for A&E are not that interested in the processes you have been talking about. I have been there too. They want to see improved outcomes.

There are two parts to my question. First, do we have the right targets? We seem to have difficulty agreeing with witnesses on the data, which is not helpful, but others have suggested that we should have a basket of targets rather than just a crude target. Do we have the right targets?

By the way, why do not we publish the 12-hour target from time of arrival to time seen, rather than from the time a decision has been taken about admission? The difference is 20-fold. Why are we not being

honest—I use the word "honest" because a witness used the same word to us last week—about some of the problems?

The second part of the question is this. It may date me. I worked with Baroness Morris many years ago on trying to improve standards of literacy and numeracy in schools. We had a plan, and people knew what the plan was. We had data on every local educational authority and every school. It came across my desk and her desk once a fortnight. We knew where people were making good progress and where people were not making progress. That enabled us to offer them support. At the end of the day, if we saw that an educational authority was resisting the plan or not making enough progress, we intervened and, in some places, took over the education authority.

I say this because, whether or not you agree that it was the right plan or the right way of increasing literacy and numeracy, most people in this country at the time said it was a national priority. Lots of people in this country are now saying that doing something about waiting times and ambulances is a national priority. Do you have a similar system? Who is this information or data coming to on a regular basis? Can the person it comes to, whether they are the Secretary of State, a Minister or a senior member of the department, intervene and sort out what is going on?

Dr Vin Diwakar: I will take the data question first and then come on to standards. We absolutely do have the data. It is available through, first, the model health system that I described a few minutes ago; we also have our own internal data systems within NHS England. That data is available both to integrated care system chief executives and the chief executives of provider organisations.

We offer different levels of permission into the data. There is a difference between the data we might publish—because, for public confidence, it is very important that that is validated and accurate—and the data we might want to use internally to drive improvement. Using that data, we have a good idea, across a range of areas, of how systems are performing.

Lord Bichard: Who is "we" by the way? Who is this data coming to on a weekly or monthly basis in NHS England?

Dr Vin Diwakar: It is coming first to Amanda Pritchard, the chief executive of the NHS. Then all of her executive team have access to it, as do people such as me, the deputy national medical director, and Professor Redhead. The information is available to us, as well as to integrated care systems and provider organisations, so that all of us are using the same set of data and we have a single version of the truth.

From that data, we know where the systems with the greatest challenges are. We know which systems have the greatest challenges with handover. For those, we are intervening very directly in those systems.

Lord Bichard: How are you doing that?

Dr Vin Diwakar: My colleague Dame Pauline Philip, who is the national director of urgent and emergency care, and Professor Sir Stephen Powis, my boss, the national medical director, speak to those systems on a weekly basis. They have agreed plans with them and monitor to make sure they are being implemented effectively. They work with both the regions and the integrated care systems so they are getting input on a daily basis to track those.

There is a very direct intervention on those organisations with the greatest challenges. We have a regulatory framework called the system oversight framework, using our regulatory powers. If you are in the segment of the system oversight framework in which you are the poorest performer, NHS England can mandate support for you, which includes putting what is called an improvement director into the organisation, agreeing a plan and specific actions to do that.

We do take active regulatory action on those organisations that have the greatest challenges. That data is available to the department and the Secretary of State as well.

Lord Bichard: That is really helpful. I am not sure that we have that information. It would be really useful if you could give us a written description of the kind of process you talked about. We want to be reassured that someone really cares about this, that they are doing something and that things are improving.

Professor Julian Redhead: It is interesting. On the data front, you talk about getting it every week. For ambulances, I can pick up real-time data. I could look up immediately now exactly where there are ambulances waiting outside which hospitals. We have teams of people centrally, regionally and at ICS level looking at that data continuously.

Lord Bichard: You need it over a longer timescale to see whether things are improving.

Professor Julian Redhead: Absolutely, and then we can look at the trends going on from there on a wider basis. I reassure you that there are people looking at that data in real time as well as looking at the trends to try to pick up where a system or a hospital may be coming under increasing pressure, so we can try, regionally or nationally, to help bring about things that could help alleviate the pressure on an individual trust.

Lord Bichard: Why do you not publish the 12-hour target from door to clinician?

Professor Julian Redhead: The four-hour target was put in some years ago. It was really helpful because it really did help everyone understand the pressures within an ED and how we move patients through an ED. There is no doubt that has been really helpful, but it is quite a broad measure. Sometimes it does not pick up patients who have been in

departments for an extraordinarily long time because you get this average time in ED et cetera. It was quite a broad thing.

Clinicians came together under Sir Stephen Powis, the national medical director, to ask whether there was a better way to look at the data flows and help patients with those waits within ED. That is where this bucket of measures came up, one of which is the 12 hours in department. That includes time to assessment, time to admission after referral et cetera. That was going to give us a much broader range. At the moment, together with our partners in DH, we are looking at when we can start to move to that system rather than the four-hour system all on its own.

That is where that comes from. The reason there is hesitation in terms of publication at the moment is partly that taking one measure out of that suite of measures may not be as helpful when you need to look at it as part of everything, given that is where it is. We would also like to publish it. The systems do get that information. Each individual hospital will know what its 12-hour waits are within each part of it. The ICS will know that information as well.

Lord Bichard: You would accept that the public do not realise that, on the 12-hour measure, it is 20 times worse than they believe it to be.

Professor Julian Redhead: We are aware of the rising numbers of patients who are waiting 12 hours in a department. That is why we are working so hard to try to reduce that. It goes hand in hand with the ambulance handover delays.

Lord Bichard: Why not be honest and say, "We are going to measure it from the door to the clinician"? That is what most people out there think we are measuring, but we are not. We publish that statistic only once a year. The rest of the time, we publish the statistic from time to admit to clinician, which is completely different.

The Chair: We are told that Scotland and Northern Ireland publish it.

Professor Julian Redhead: I am not sure about Scotland and Northern Ireland. We are working with the Department of Health around that in terms of how we go about publishing the data we want to publish to improve the care for our patients. That is what we are here for; that is what we want to do.

Dr Vin Diwakar: It is probably worth saying that the decision about what data to publish is not one NHS England can take alone.

The Chair: You get this data. I am impressed that you have the data in front of you all the time and you talk to those who are not doing well, but it is not improving. What is going wrong?

Professor Julian Redhead: Again, we need to understand all the different root causes of the issue at the moment. We have heard from Vin about the problems around discharging patients safely into the community. When you start to be unable to discharge people, the

occupancy in your hospital increases. As your occupancy increases, you are unable to flow patients out of the ED, which is why the number of patients spending 12 hours in ED will increase. At that point, you are going to have trouble getting the ambulances to take patients into the ED, which is already overcrowded, hence the patients wait in the ambulances outside the ED.

You have to start to tackle all the different aspects of this issue. That is what we are trying to do. Through the different plans that Vin has described, we are looking at bed capacity, to make sure we have the right beds in the right places, and the discharge processes internally within hospitals, to make sure they are working. The discharge task force is trying to get that movement, working with all our partners to understand where we can make those improvements around discharge.

Vin spoke about the collaborative we attended that kicked off yesterday. That is going to be looking much more at the internal processes within the hospitals. What can do to make sure we learn from best practice around the country in order to help the movement of patients out of the ED, to enable the patients to come into the ED in the first place and to reduce the 12-hour waits that we know are an issue as well? It is a question of trying to target all the different areas, and that is what we are trying to do.

Lord Hogan-Howe: You gave a very clear answer to the question about command and control, the powers and the levers. The best answer to the questions asked by Lord Filkin, me and possibly others would have been that one, but the Care Quality Commission and the Nuffield Trust did not give that answer. I am not trying to find faults with individuals, but it seems odd that they did not give such a clear answer to what was a fairly stark question.

Dr Vin Diwakar: It is difficult to answer for the Care Quality Commission.

Lord Hogan-Howe: I get that. I guess the open question is whether the system realises that power exists.

Dr Vin Diwakar: For NHS England, we are really clear. It is set out in the legislation what powers NHS England has to regulate. The Care Quality Commission has a long experience of regulating providers. Regulating systems is possibly a newer area for it. As NHS England, we have been working with integrated care for a long time. To go right back to the period before the five-year forward view was first published, we were working with early-adopter sites that were testing and evaluating different models of integration.

I suspect we can bring clarity to it as an organisation because we have been doing this for a long time. We have been developing the model. We played a part in the legislation, and we are very clear about our regulatory responsibilities. We have been responsible for appointing the chairs and chief executives of integrated care boards and managing them

directly. It is difficult for me to answer for other regulators, but, as NHS England, we are very clear.

The Chair: NHSE wrote that part of the legislation and wanted that in the legislation.

Professor Julian Redhead: We are closer to it. The other aspect of this is that we still want the systems to try to sort this out themselves rather than having someone dictating and saying, "Thou shalt". Until you need that, trying to work together is a very—

Lord Hogan-Howe: The question we have been asking is about leadership, not necessarily about command or dictatorship.

The Chair: The question is about accountability, too.

Q58 **Lord Filkin:** You have given us extremely clear and helpful evidence, so thank you. You are going to give us the plan on admission avoidance, where necessary. You have talked about the systems in place to maximise the uptake of that. That is excellent. When you talked about effective discharge, you were pretty clear again that the fundamental issue was social care capacity. We will say that, but the trouble is that it is an incredibly boring thing to say. Everybody knows that.

I am looking for some way that our, I hope, rational evidence can link social care capacity to waiting in A&E. From what you have said, logically there is a very clear chain of connection between those two issues. A note from you substantiating that would help make the case that clearly has to be made: as well as doing all the stuff on admissions prevention, unless we sort out social care capacity, we are going to have appallingly worse increases in A&E.

You have cleverly avoided answering my question, and I understand why. It would be very useful to get some indication of what sort of demand forecasting you do, based on the parameters of demand, so we can look at that and form our view, if not your view, on where it is likely to be in five years. Do you get the point I am making?

Dr Vin Diwakar: I do. The department has convened a national discharge task force; I know some of that work has been done by it. Although NHS England is involved with that, a number of colleagues from the NHS, social care and local government are as well. I am sure we and our colleagues at NHS England can work with the task force and the department to see what could be shared with the committee.

Lord Filkin: It could be very useful to us. It might even be useful to you if we shouted about it.

Professor Julian Redhead: It is also important to point out that social care is under huge pressure here as well. We do not want it to look as if we are saying, "It is all their problem".

Lord Filkin: We are not naïve.

Professor Julian Redhead: They are under the same pressures.

The Chair: It is the community end, not just the social care end, that is important. Thank you. We are really grateful to you and sorry we kept you later than we should have.