



Public Accounts Committee

Oral evidence: NHS waiting times for elective care in England, HC 1002

Wednesday 12 February 2014

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Members present: Margaret Hodge (Chair); Mr Richard Bacon; Stephen Barclay, Jackie Doyle-Price, Chris Heaton-Harris, Meg Hillier, Stewart Jackson, Fiona Mactaggart, Austin Mitchell, Justin Tomlinson.

Amyas Morse, Comptroller and Auditor General, Gabrielle Cohen, Executive Leader, Keith Hawkswell, Director, National Audit Office and Marius Gallaher, Alternate Treasury Officer of Accounts, were in attendance.

Witnesses: Tracey Fletcher, Chief Executive, Homerton University Hospital NHS Foundation Trust, and Dr Sonia Swart, Chief Executive, Northampton General Hospital, gave evidence.

Chair: Welcome. Thank you to both of you for agreeing to give evidence at short notice. Your local MPs are going to ask the opening questions. You both run hospitals in areas that members of the Committee represent. What we are looking for from you—there is no catch to this—are the most difficult issues that confront you at present, or in the past, around meeting the waiting-list targets. That will help us and inform how we challenge and interrogate the accounting officers in this area of health policy.

Meg Hillier: It is welcome to have another Hackney woman in the room.

Chair: Does she live there?

Q1 Meg Hillier: I don't want to discuss those sorts of issues in this room.

It is an interesting Report, and it seems to us that it comes down to the accuracy of the data. For more than half the sample, it was not possible to tell whether it was accurate, and 26% of the auditing records in the Report were wrong. Can you explain from your point of

view of running hospitals what are the challenges to getting the data right, and what are the sticking points that are causing that level of error?

Dr Swart: There are a number of challenges. First, you must understand the national guidance—there are some local interpretations of the guidance—and then you must ensure that all your staff are perfectly trained in interpreting it on all occasions. That is a challenge to start with. A lot of work goes into tracking all the data as it come through. We have a weekly performance meeting run by senior members of staff, in which the list of all patients waiting is looked at and challenged in certain ways. To ensure that every bit of data is accurate, you clearly need a number of different types of information systems.

I have looked at some of the errors identified in the Report as a way of understanding it and tracking it through. Those about starting the clock, as it is called, were simply about interpretation. They were all internal referrals, and we had interpreted those particular ones as having received the referral when the bit of paper arrived in the department and was stamped. In the rules, we should have clocked that as the referral having been made at the point that the letter was dictated and signed. It was just a misinterpretation that added some days to the referral. It would not have caused great harm to the patient. Now that we have had the audit, we have looked at that. If there were complete electronic systems in hospitals that automatically sent it electronically the date would be clocked correctly and you could put a rule in. That is just one example.

Q2 Meg Hillier: Can I put that question to Tracey Fletcher? I know that Homerton has a good track record in electronic management of patient records. Does that mean that you do not have those problems at Homerton?

Tracey Fletcher: Although we have fairly comprehensive electronic patient records, that system does not facilitate an easy link between different points of care within the pathway. Although all the patient's care is recorded on the system and we can access it electronically, if a patient was referred to be reviewed by an orthopaedic consultant for a hip operation, we do not have every point of intervention on the patient linked to a particular pathway. We do not link the diagnostics, the out-patient appointments and the operation all to the same pathway, so there is a degree of subsequent validation. We must ensure that the assumptions that we make at the back-end of the system reflect the pathway appropriately. You have to appreciate that, particularly in a place such as Hackney, patients come into the hospital for numerous reasons at various times. Diagnostics, out-patient appointments, and theatre attendances happen within different pathways at any one time.

Q3 Chair: I don't understand that, I'm sorry. Do you mean that you have different systems to track people through the hospital for different purposes, and because of those different systems you cannot be convinced that you are accurate when you are looking at waiting times?

Tracey Fletcher: What I am saying is that a patient can have an association with the hospital through different pathways. They could be seen through a diabetes pathway and be referred to have their hip remedied. During that they could have a series of interventions that include diagnostics, out-patient appointments and ultimately theatre. When you register the

appointment for the orthopaedic referral it is not given a code that then tracks through ultimately to the admission. You track it as a consequence of assumption around the consortium. It is not absolutely and utterly fail safe within the system. There is a lot of monitoring in the background of that.

Chair: So you have to monitor by hand, not electronically.

Q4 Meg Hillier: What about the other bits of the system?

Tracey Fletcher: You have the dates in the system, but there is a degree of manual monitoring to make sure that your dates in the system are attached and are relevant to the pathway that you are monitoring. There is no golden bullet in information systems at this moment in time that I am aware of that would do this automatically for you. As a consequence there is a degree of work within organisations to make sure you are monitoring the position appropriately.

Q5 Meg Hillier: Clearly there are lots of other bits of the system as well. There is the GP referral. There may be services outside of your hospitals. How do your systems link with that? Is that also all manual or are there any problems there that are causing some of these data issues that we are seeing in the Report?

Dr Swart: GPs input into the system through choose and book—

Q6 Meg Hillier: Do they all do that?

Dr Swart: Most of our appointments come through that, although not all them.

Q7 Chair: They cannot record you shaking your head, Tracey. This is the case with Dr Swart, but not with you?

Dr Swart: There are always manual adjustments that need to be made at that moment with all the systems that you have throughout the country. Most people are trying to get their information systems in hospitals to a point where things can be more easily tagged to this eighteen-week pathway, whether it is the initial choose and book appointment or a diagnostic. We go through this manually and validate it and make sure that it is all correct. In that there is an opportunity for error.

Q8 Chair: We are going to go to Fiona but I just want you to answer the same question, for the record.

Tracey Fletcher: Sorry, I should not have just shaken my head. In the organisation where I work we still have a significant number of referrals coming through on paper. So the electronic process through choose and book, where the GP can initiate the patient booking the appointment electronically and then the referral follows electronically attached to the choose

and book system, happens with a significant proportion but not all. We still get a significant proportion of paper referrals.

Q9 Chair: Why?

Tracey Fletcher: Because that is the GP's choice. That is what the GP would presumably choose to do.

Q10 Fiona Mactaggart: I was interested in your description of the way it goes to pathways. One of the complaints from my constituency, and which in terms of the patient experience is the source of delays, is patients who are complicated because they have more than one thing happening to them, such as diabetes and a broken hip. They get sent back to their GP and their case is reopened. Does that happen in your hospital? Is there any mechanism to stop and to continue someone through and not to go back to primary care at a point when someone is not in an obvious route through, or even if someone wants further treatment following a particular care pathway?

Tracey Fletcher: If I understand the question correctly, there are two answers. First, as an organisation, you have an access policy if at any point the patient repeatedly DNAs. In our access policy we have a rule that the patient's notes get reviewed by the consultant and a decision is taken to discharge back to the GP because the patient is not engaging within the pathway. The second answer to the question I think you are asking is that if a patient is seeing a particular consultant down a particular pathway and requires treatment by a different speciality that treatment is either required as a consequence of the first referral or is something completely different. If it is as a consequence of the first referral—you are going for a hip operation and you need a cardiac opinion—you are able to refer to the cardiologist for a cardiac opinion. If, however, you are seeing the cardiologist and you wish to have your hip replaced, you need to refer back to the GP because that is what our CCG has asked us to do.

Keith Hawkswell: I thought it would be interesting to hear from the two witnesses about their very different experiences of choose and book and the rate at which it is used in their trusts. Does Dr Swart find it helpful that choose and book is used and would Miss Fletcher find it more helpful if choose and book were used more?

Dr Swart: I do think it is helpful. Like any system, it can be continually refined. If it was used universally and if the capacity of the hospital was such that you could use it for nearly everything without having any manual intervention, it would be a good system, because it is all clocked in. Obviously for us, for example, the problem arises because capacity of the hospital is always at the edge. Therefore, you have to keep some slots free so that you can put urgent patients in them. Sometimes you then have the experience where the patient rings up and cannot get an appointment and that has to have a manual intervention to put on extra clinics and so on. But in principle it tells you what kind of clinic you are going to, you are more likely to get into the right clinic and we have some electronic recording of it. So it has had some benefit, but it has not done away with the need for administrative intervention as yet.

Tracey Fletcher: It is probably fair to say that running one system is always better than running two systems. So my preference would always be to run a single-standard system. I don't think there are lots of benefits to the choose and book system. Aside from the capacity issue, which has already been mentioned, one of the issues that we have had with it is making sure that the GPs are following up once they have initiated it. The patient has gone but the appointment they are following up needs a referral letter attached to the choose and book system. Quite often those referral letters come through very late, that is, just days before the appointment or, indeed, slightly afterwards. You really need the referral letter prior to the appointment.

Chris Heaton-Harris: Sonia, I bet you are pleased that you have an MP whose constituency you serve and who sits on this Committee and therefore you get invited in.

Dr Swart: Absolutely delighted.

Q11 Chris Heaton-Harris: Can I take this opportunity to thank you and your staff for the services you provide for my constituents? While we are here highlighting the issue of data we have for waiting times, you do a good job, you are universally liked and while you and I might only correspond on some of the issues that come up, nothing in the NHS is always going to be perfect. So I want to say thank you and if you could pass that on to your staff, that would be welcome.

Conclusion 18 of the Report states: “The current 18-week standards came into effect in 2008, and strengthening them over the last two years, has given NHS trusts a clear focus...The challenge of sustaining the 18-week standards is increasing, and with it the importance of having reliable performance information and spreading good practice”. The thing that stands out for me in this Report—and we will drill down into the data a tiny bit in a second—is why are these national standards, which have been in place for quite some time, being interpreted and implemented quite differently across the system?

Dr Swart: There is the opportunity to have local interpretation, so obviously that gives you the chance to interpret it differently. The “why” probably relates to different local mechanisms and different ways that hospitals are run. It is my impression—I haven't been personally involved in the clocking on and off, but I have been involved in the clinical end of this—is that over the period it has been introduced, it has got incrementally better. So the guidance has been clarified, the interpretation of the guidance is becoming more uniform across hospitals and within the hospital we are getting better at spreading best practice from one department to another. Overall, if you look at it in the round, waiting times are shorter than they were, patients have a better understanding of it and staff have a better understanding of it, but there is a way to go. The Report highlights that. It is basically saying there are still some errors and we must have better data—which clearly we should—and the more standardised we can have systems in the NHS, the easier that will be for hospitals.

Q12 Chris Heaton-Harris: There is a whole section in here about communicating with patients. How does Northampton communicate with patients?

Dr Swart: We have a letter that we send to them with their appointment which explains the 18-week rule, if you like, and signposts them to the NHS constitution. I have to say that partly as a result of this Report, I have looked at all our various bits of information that are available and I think we need to do better. My personal view of this is that we need to make it clearer at the point of referral, which is partly down to GPs. We need to make it clearer in our letters, we need more patient-friendly information on our websites, and we need to engage patients in that. My proposal locally is that we get a Healthwatch to help us to design the information so that patients can be partners in their care. We want them to help us with this, and we want them to understand that when they are referred they are part of a commitment to this pathway, which means that if they are unable to come for their diagnostics, for example, they must change their appointment so that we do not start it all when they are not available. That is one simple thing. Patients need to understand how it works in the hospital, and we need to make that clearer to them.

Of all the issues that are raised with me, very seldom do I have an issue from a patient relating to this. Many issues are raised about other things, but generally speaking this aspect is not the one they raise with me. However, having looked at it, I do not think our access policy is patient-friendly enough, and I think there is a lot more to be done.

Q13 Chair: Can we have an answer from Homerton on that?

Tracey Fletcher: With regard to the information to patients, our access policy is published on our website. Boiling that down to something that is a simple message to patients, we could, like Northampton, probably do a bit better. I guess one of the things that all organisations have to think about is matching the very basic details. Everyone can talk about 18 weeks, but sometimes what you are trying to get through to patients as well is an understanding of some of the interpretations and their responsibilities versus the provider's responsibilities.

The first question was about interpretation of different aspects within the pathway. My view is that the aspects around when the clock starts etc. are probably clearer. As has been described, I guess you cannot ignore the fact that a huge number of people are involved in the process and often very junior people in the organisation are making the first entry in our clinical information systems to record that data. There is quite a lot of training that is forever ongoing with that group of staff.

On the interpretation that is more local, you demonstrate that in your access policies and particularly in how you as an organisation wish to interpret things such as patient DNAs and how many times the organisation will accommodate patient DNAs before referring back to the general practitioner.

Q14 Chris Heaton-Harris: Before I come back with one more question, Keith wants to come in.

Keith Hawkswell: Both witnesses have testified to the importance of access policies in connection with patient communications. We did a census of all trusts and found that only 25% were available online. I thought it was worth setting that in context.

Chair: There was another figure in that paragraph about those that had it.

Keith Hawkswell: In total, we reviewed 118 and found that only 17 covered everything and were up to date.

Chair: Very low.

Q15 Chris Heaton-Harris: Because we have a number of cancellations and although the number is going down, it is still high and it costs a lot of money, so it is in everyone's interest.

Perhaps we can drill down into some figures—figure 6—because it is about clocking on, where it all starts and, more than anything, the veracity of the data. For you, Sonia, 94 cases were reviewed and 53 were correct, which is not bad compared with some others—14 had at least one error found, but there were then 27 incomplete records. How can that be improved?

Dr Swart: I have looked at one or two of those and I think there was some confusion about what was available and what was not. The girl who was doing the work for me brought me evidence that information was in the notes, but we had a combination of paper and electronic systems, and you need to know where to look for lots of different bits to get it for that patient. It is an ongoing issue.

Q16 Chair: Who is “you”? The NAO or any audit should be able to—

Dr Swart: Anyone. I do a lot of case note audit and I have already picked this up as an issue. If I have the paper record, I know that I can look at a system over there and get an electronic discharge notification, which should have been filed in the notes but might not be there. I can look at X-ray results, pathology results echocardiogram results and sometimes day case records. On these particular ones—I can't tell you out of 27, because they were not all put in front of me, but in some of them—there was a sheet in the notes to say that the operation had been done, but it was not written in the front of the notes in the right place with the right type of official discharge notification. That is still an issue, because it is a risk to have two kinds of information systems if you don't formally link them.

Q17 Chris Heaton-Harris: It is an issue for us in many ways, because, as the politicians here, we have set the standard that we would like hospitals to achieve. We are given data suggesting that they are achieving it, but if you dig a bit deeper, you are not sure if they are.

Dr Swart: We have responded to this internally with a variety of measures. Hopefully, as much as possible, we can pick it up through a self-checking mechanism to say, “That's not there.” There is a regular programme of internal and external audit and a report on data quality to our board, so that when they get the 18-week performance report, we will also have a data quality report to go with it.

That kind of need is not just about 18 weeks; it is for everything we look at. As I said, I got interested in it through mortality reviews and picked up the issue of the different kinds of data available and how you can, unless you are quite forensic in it, miss some of them on some occasions. But I couldn't tell you about all 27. The clock-start ones were all about internal referral, because 95% of our GP ones have come in through choose and book, and we have a date on that.

Amyas Morse: When we were coming, people knew that we were coming to carry out these reviews. We asked staff to find the data, and they couldn't find it. That tells you something, doesn't it?

Dr Swart: Again, it is the same problem. It depends on who looks. It shouldn't be; I am not saying it's okay—

Amyas Morse: The chief executive could find it, but we cannot rely on that. On all occasions, can we?

Dr Swart: I think you are right.

Q18 Meg Hillier: I want to ask about non-attendance. In the census that the NAO did, Homerton and 54 other trusts did text-message reminders. Has that made a difference to non-attendance in Hackney, or is it negligible? It is interesting that not everyone does that yet.

Tracey Fletcher: When we first put it in, we did see a reduction in DNAs. That has slightly plateaued, interestingly. That is the position with that. I cannot tell you off the top of my head—

Q19 Mr Bacon: DNA is “did not attend”, just to be clear.

Tracey Fletcher: Yes.

Chair: DNA to us has a different meaning.

Q20 Mr Bacon: You didn't mean deoxyribonucleic acid, did you?

Tracey Fletcher: I'm afraid not. I meant “did not attend”.

We do use the text system, and that is helpful.

Q21 Meg Hillier: Dr Swart, earlier you mentioned local variations to the national guidelines. Could you elaborate a bit more about those and what difference that makes?

Dr Swart: I don't know too much about other trusts in that regard. All I know is that you follow the national guidance and you are able to elaborate the local rules for who puts

things on and off systems, how you count things and so on, so it is not a variation. When we looked at this, we went back to the national guidance for everything. The local access policy should mirror and follow the rules of the national guidance.

Q22 Meg Hillier: So it is not a big variation?

Dr Swart: I don't think so. It's more about which person in what system. Some places have referral centres. We used to have one, but we stopped having that. Some patients have more choose and book, while others have more referral. You would need to put in a system that matched your pattern in your hospital, especially for internal referrals.

Q23 Meg Hillier: If we could recommend one thing that would make life easier for you at the front line—as Chris Heaton-Harris has said, you are doing the hard work really; we just sit here and read the reports—what would it be? What could be done nationally that would make your life easier?

Dr Swart: There is a lot of manual tracking and a lot of industry around this, and the question is whether information systems could help to check things. For example, in our weekly performance meeting, every single patient is gone through and things are checked. If you could have electronic self-checking systems available, it would reduce some of that and make it more accurate. You want to have a more reliable electronic system to reduce human error, basically.

Tracey Fletcher: I guess that having the golden bullet of the electronic system I would agree with; but, realistically, we are where we are, and there's no point in us saying that—I think that is something we are working to, but that is not going to happen over the course of time. I guess for me, it is about standardising one system—and this is not necessarily to provide a comment about primary care—and increasing the proportion of people who use choose and book and standardising the approaches around that help providers, on whose behalf I am speaking.

Q24 Meg Hillier: And for patients.

Tracey Fletcher: Ultimately, absolutely. Dealing with getting patients in easily, without having to chase the GPs or, indeed, change appointments would be helpful from my point of view.

Q25 Chair: Chris has one final question. How long is the guidance? How many pages?

Tracey Fletcher: Which guidance?

Q26 Chair: On this issue; on ensuring that you provide the right data for us to be able to make national—how long is it?

Keith Hawkswell: There is a lot, Chair.

Chair: I am trying to get at that issue. How long is it? Do you know? How many pages?

Tracey Fletcher: Prior to this meeting, I had a look at some of the guidance on the internet, and my recollection is that it was around 28 pages or something like that.

Q27 Chair: Well, I was told that it was 100 pages.

Dr Swart: I have a thick file. I didn't count the pages.

Q28 Chair: There is a lesson to be learned: if you want accurate data, you don't have 100 pages of guidance. Do you know?

Keith Hawkswell: I am told that the rule suite alone, which sits over the guidance, is 36 pages, and then there is the guidance.

Q29 Chair: So we are getting towards what might be one of the issues.

Tracey Fletcher: To be fair, I think that the guidance, which I think is the one I looked at as well, is fairly clear.

Q30 Chair: But you've got that much stuff and you're trying to fill in forms, you get it wrong.

Tracey Fletcher: There are degrees of interpretation, and you're spreading this across the majority of your staff in the hospital.

Q31 Chair: Is there anything else you want to tell us? You have been very helpful.

Dr Swart: I'd just like to say that I think that waiting times have come down as a result of this, and if you ask a patient, they seem reasonably happy with most of the procedures around this at the moment. The hospitals have the task of balancing this with the cancer targets and with the A and E targets. Again, if you ask a patient what is most important to them, they want their heart attack treated quickly first; their cancer treated quickly; and this is the one where, if it is a week here or there, they are not as concerned about it. The most important thing for clinical staff is that clinical priorities are not distorted by this target, and there is an opportunity to match urgent versus non-urgent and to keep that working. It is a challenge for hospitals to balance it; but overall, I think things have

improved, and I don't think we should lose sight of that. What we need to do is use this as a tool for making things even better.

Q32 Chair: And is the pressure of resource constraints putting greater pressure on this bit of your work, excepting your other priorities?

Dr Swart: The biggest pressure is the emergency care pressure.

Q33 Chair: It is the emergency care, rather than here.

Dr Swart: Yes, because, for that, you may have to cancel patients, and that gives you another administrative challenge to move things round. It is not good for the patient if their expectations are not met at that stage.

Tracey Fletcher: First, I echo the fact that waiting lists have come down. Secondly, the correspondence I receive from patients tends to gravitate towards understanding where they are on the pathway and the communication with them more than anything else, and the degree of continuity and making sure that you don't lose the continuity through your pathway management as a consequence of waiting times. Continuity to patients, from what I see and hear, is very important.

Q34 Austin Mitchell: Just quickly, on the fact that you said that it puts pressure on other services if you've got to reach these targets, is the targeting a good idea?

Dr Swart: In general, it is something to aim for, and it has resulted in improvements. Yes, I think it is.

Tracey Fletcher: Yes, I would agree.

Chair: Good. Thank you very much indeed. Thank you for your time, and thank you for coming down, especially from Northampton—the wilds of north of Watford.

Examination of Witnesses

Witnesses: **Dr David Bennett**, Chief Executive, Monitor, **Dale Bywater**, Delivery and Development Director, NHS Trust Development Authority, **Sir David Nicholson**, Chief Executive, NHS England, and **Una O'Brien**, Permanent Secretary, Department of Health, gave evidence.

Q35 Chair: On the whole, a good news story, in that waiting times are coming down, but we will focus on the issue of data, as you would expect. Una, public trust in the NHS is crucial, and when the NAO published its Report, it got quite a lot of coverage across the

media about whether the data were accurate. I just wondered what action you will take to restore people's confidence in the information you give out on waiting lists?

Una O'Brien: Thank you for that question and your acknowledgement of the enormous improvement in the reduction of waiting times. We may touch on that later. As for your question, we agree that there needs to be a concerted effort to improve the accuracy and quality of information. We have a number of defences that we look at in turn to decide where best to improve them. I look at this from four perspectives. The first one relates to the discovery of errors and inaccuracies that are only visible after the event, through audit and data matching—I think you heard something about this from previous witnesses—because of the complex situation in a number of places, where we are marrying electronic and manual systems.

The second is where there is a systematic breakdown in a particular specialty or in an organisation, where large numbers of people are not following the pathway because of some lack of management grip, which becomes visible very quickly. Thirdly, there are issues, thankfully rare, of blatant fraud—one was brought to light recently, and we were very grateful—which is utterly unacceptable. Fourthly, we must decide what to do when fraudulent information is knowingly transferred to another organisation. To my knowledge, that happens extremely rarely, but Robert Francis has highlighted to us the fact that there needs to be very tough sanction against that, and we are acting on that recommendation.

If you take that as the core analysis, the question that I have asked myself, and which we have debated as we consider the Report, is where we need to strengthen the defences. The Report acknowledges that the first port of call is the trust itself, and the evidence from the previous witnesses has borne out the fact that it is essential that the governance and rigour of challenge in systems exists within the organisation, and that there is proper assurance at the level of the organisation. Secondly, it is important that the regulators, Monitor and TDA, are able in their different ways to assure the good governance of those organisations. I am sure that they will echo that. It is not just about the current data, but all the other data, so we need generic, high-quality governance and audit of data collection. That is the second line of defence.

In relation to this data set, which has its own history, there is a role for the commissioner, and there are many references to that in the Report. Fundamentally, what was done prior to the reforms by the Department is now the responsibility of NHS England, in terms of the validation of the data at an aggregate level, using data mining and data comparison techniques, to see errors that are not visible. For example, that may reveal where there are too many clock pauses between zero and three weeks when there should not be any. Those techniques mean it is possible to spot patterns in data, go back to trusts, challenge them and make changes, and we do that. That is the other key line of defence.

Following the Report, what should we strengthen? First, we need to ask ourselves whether there is more we can do on the governance statement that trusts must produce to make transparent the requirement on them in terms of the audit of data. I do not think that that is strong enough or good enough at the moment. For other reasons, as well as this Report,

we are tightening up on the governance statement requirement for the '13-'14 accounts. That is the first point: we do need more transparency in the approach trusts are using on data audit.

I am sure that Dale Bywater, who is here on behalf of David Flory from the NHS Trust Development Authority, and David Bennett will talk about what they can do respectively from the TDA and Monitor. The next question is: are we making the best of the data mining and comparison techniques? They have improved, and I have to give credit where it is due. NHS England have taken that system on.

The final question is an interesting one—I will make this point and then stop. Of course, we had the Audit Commission up to 2010, and they undertook spot checks on this. You would look at that and say, “Well, we haven’t quite got that at the moment.” The Audit Commission is now gone, and I think that for the near to medium term, I should be looking at what role the NHS and Social Care Information Centre could play as a centre of expertise and a validator and spot-checker on the accuracy of data, over and above the defences I have described to you.

Q36 Chair: Okay. I let you give that long answer—I am particularly grateful for the last one. I was going to ask you about the Audit Commission, because it seemed to me that, when it was doing it, at least someone was looking at that. We need to keep that going.

If we go back to governance, which was your first issue, and you look at page 27 of the Report, what is worrying is that in the data submitted in the census done by the NAO, 119 out of the 158 were signed off by the chief executive or the deputy—what were they signing off? It also says that 160 out of 211 were signed off by CCGs, to the extent that they had a role to play. More than half do not bother to have internal or external audits, and you have said that they are important. Then, on page 28, paragraph 2.31 says that even where trust have controls, the data is wrong.

It is all very well having theoretical frameworks and governance statements, but if the information is inaccurate and these guys are just signing it off, we have a problem. This is probably the point at which I turn to the other three witnesses, because I do not think that the statements in themselves, even if toughened up, will be enough if your senior staff do not have systems in place to ensure their accuracy and if there is no audit in more than half the trusts and CCGs. Do you want to start on that, Dale?

Dale Bywater: Sure. We completely recognise the need to tighten up and enhance the audit process for both internal audit and assurance around external audit. That is something that we are doing.

Q37 Chair: Will you insist on it?

Dale Bywater: We will. We have an accountability framework. We oversee all the NHS trusts and we are accountable for all the aspects of delivery within NHS trusts—non-FTs. We transact that through an accountability framework that lays out expectations and requirements, and we have formal monthly returns from organisations, some of which is self-certification against governance standards and so on. We will require all organisations to do

an internal audit within 12 months as a minimum and also look, within a period of up to 3 years, for an external audit—

Q38 Chair: And it will cover this issue.

Dale Bywater: It will cover this issue in that sense. Further to the point from the witnesses earlier, the risk is that we get into the real nuances of audit—we need to do that and tighten that—but that, in a sense, is just one part of the challenge.

The point around rules that seem quite complex is that you can make the rules even more complex and make them cover every eventuality, but they will be very long. You can simplify them and leave even more room for interpretation. As the Report says, the rules have quite good support, and for aspects of them you will see scores of around 90%. The key point here is around the human behaviour of this and the way in which the interpretation happens, and how people understand over time. So there is a big role here, as well as us saying, “You must do an internal audit and an external audit.” We will intervene when we spot problems at all sorts of levels—from our own validation or from external bodies. We will make sure we get staff to understand the rules and the spirit behind them—the fact that there is a patient in the midst of this.

Q39 Chair: And what happens if a chief exec signs it off, and it is wrong?

Dale Bywater: We will hold them to account.

Q40 Chair: And how will you know?

Dale Bywater: First, we will ask, “On what basis have you assured yourself, as a board?” So our first line of assessment will be, “On what basis have you confirmed that you are sure?” We will test that against the internal audit opinion and the other audits and reviews. We will also use the intensive support team, which is a really good resource for going into organisations on the educational development bit, as well as for spotting and responding to problems. We will use a range of means for testing it, as we do with other aspects of quality, safety and financial governance.

Chair: I will go to David Bennett, then David Nicholson.

Dr Bennett: The purpose of the governance statement is to focus the board of the trust on being clear that it has done what it should have done. Everything that is signed off in the governance statement should be subject to an agreement by the internal auditor, and there should be an external audit of that statement as well.

In so far as there are still incorrect data getting through the system, it is obviously not working completely. There are two things that we should do, which are broadly consistent with what Dale is saying. First, we need to be clearer about what we expect from an internal audit of the data. There is also a case for looking at the reintroduction of the sort of external

audit that the Audit Commission used to do. Having an independent overview of whether all this is working is helpful.

Q41 Chair: And what do you do if a chief executive signs it off and it is not true, or is inaccurate?

Dr Bennett: First, we understand what has gone wrong.

Q42 Chair: How do you discover it?

Dr Bennett: How do we discover that there is a problem? That is part of the issue, which is why a degree of external audit of the sort that the Audit Commission used to do is useful. There are other ways of discovering it. A good example is what happened at Colchester hospital. It came to light as a result of a whistleblower that the data were not being recorded properly. There are many investigations going on to discover exactly what happened there. In one of them, we are asking the question, “How come the audit process didn’t internally identify that the data were not being reported properly?”

Q43 Chair: What is the answer, or is it too early to say?

Dr Bennett: We don’t have the answer yet. We would always do that if something such as that came to light.

Q44 Chair: It strikes me that Colchester was awful, but it was pretty extreme. It is welcome that you are talking about an external audit; that is a move in the right direction. People have got to take it seriously in the system, and I can’t quite get where your lever is to ensure that people take it seriously in the system.

Dr Bennett: If you discover that you have got a chief executive who has presided over a system that is either seriously flawed or, worse, subject to actual fraud, there have to be serious consequences for the chief executive, including them leaving.

Q45 Chair: I am going to come back to you in a minute, but let me just give David Nicholson a chance. Some 160 out of 211 of the data sets were signed off by CCGs. If you look at the NAO sample, four out of seven of the NAO case studies were CCGs. Common sense suggests that CCGs were signing it off when it was wrong.

Sir David Nicholson: I take everything that everybody else has said on this. Fundamentally, CCGs do not need to reinvent the arrangements that people have got in individual hospitals. We are not asking them to be responsible for the detail of that. CCGs set out their expectations about standards in the contractual arrangements with the individual trusts. With the support of NHS England, they also do analyses and comparisons of trends, in which we spot lots of issues as we go along. Una gave an example of a trust that had a

particularly large number of pauses within three weeks. When we find those issues, we investigate and challenge the CCG and the trust. We also have an intensive support team, which we can send in to individual organisations, as we have done, to help them get it right. In the vast majority of cases it is simply a misinterpretation of a rule. It could be a movement of staff in the organisation; it could be a new service being set up. That intensive support team helps people get things right.

Q46 Chair: So what do you take from the fact that four out of seven of the NAO case studies were ones where the CCG had signed off? Keith is telling me that I am reading this right. In four out of the seven, the CCG had signed it off with inaccuracies. Four out of seven. I understand, again, your general point, but under your control, in this tiny little sample of seven CCGs, four had inaccurately submitted data.

Sir David Nicholson: Yes. We have been back to them and talked to them about it.

Q47 Chair: Is one of them Leeds, which is awful? In figure 6, Leeds was only 12 out of 95. That is about 13%. Only 13% were accurate.

Keith Hawkswell: And Leeds was signed off by the CCG.

Sir David Nicholson: They were not signing off the detailed way in which those data were collected. They were signing off what they thought they were getting.

Chair: Have you checked elsewhere, David? By chance the NAO chooses seven—goodness knows how—and lands on four CCGs getting it wrong. That is a lot.

Q48 Chris Heaton-Harris: What is the point of the signing process, if they are just being presented with a piece of paper that they just sign?

Sir David Nicholson: They are signing off the data on the number of patients, whether they are achieving their targets and whether that concurs with their experience of what is happening in that organisation. They are not signing off the detailed data capture of those organisations. They are absolutely not doing that. They are dependent on the individual trusts to ensure that, not themselves.

Amyas Morse: First, on CCGs, the rules are clear. They are supposed to check and sign off the data for their commissioned patients. They are supposed to check it, not just sign off. Can I just mention a couple of things? I thought we had excellent testimony. In some ways, we had confirmed what we found in our work.

First, there is inconsistent understanding. We are not suggesting that is deliberate, but there is inconsistent understanding of how to apply the rules practically in each hospital, and that drives inconsistency into the information. Secondly, listen to what we were hearing about what it takes to reconcile the data. You have a system that covers only part of it. Then you have paper systems. If you remember, there is another system over there that tells you something.

No one is going to achieve a high level of accuracy with this quality of information. There has to be a determination. However many phalanxes of auditors you may have, if you are not determined to lift up the quality of the information systems, I cannot see how it is ever going to work. To be honest, it is just not feasible. It is not the fault of the people on the ground; it is the quality of the information they have to work with.

Chair: Who is that question to? Who is responsible?

Chris Heaton-Harris: They all are a bit.

Q49 Chair: I think it is to Una. It is like the guidance—36, 66, 100 pages. You are asking an impossible task. Do you design it?

Una O'Brien: I am clear about that. Let us remember that we are still in the first year of a new system, and actually we are doing okay. We have got a lot of things to improve on.

Chair: 2008—

Una O'Brien: Let me just explain this. Let us take them in turn. I absolutely accept that the guidance could be and needs to be simplified. We accept that and we will do that. In fact, I think there is new, fresh guidance planned from NHS England in 2014.

Secondly, without a shadow of a doubt I will take the point about local access policies. I was disturbed to hear the data on that and I think you did a good job, Keith, in digging that out. We welcome knowing about that and we need to do something, because people need to understand how this works. This is a partnership with the patient. Patients need to understand how they can influence the system and how they can participate in it. Thirdly, my goodness, we have had so many conversations about IT. It is fundamentally important that in the next period of time we are able to make some transformational changes in our health care system. One of them has got to be to go digital. It is necessary and it is fundamental to what patients want and the good running of the system. Getting there will not be easy.

Chair: We are laughing because we are waiting for Richard to explode.

Una O'Brien: I know that Richard has been here before. This is not a hearing about IT systems, but it is where we need to go. We are making an important step this year on this particular point in replacing choose and book with the NHS e-referral system, which will have some features that will be an improvement on what we have had. For example, there will be features whereby the patient can participate more in changing their appointment if it is inconvenient or if a problem arises. There will be opportunities for others apart from GPs to start the pathway, for example physiotherapists and opticians.

It is going to take the best of choose and book. We are aiming for 100% electronic referrals within the next five years—sooner than that if we can make it. That will cut out a lot of these errors. We want to not have the paper letters, and we want the referral back-up material from the GP to be done electronically. This is a major project within NHS England to deliver this change and David can say more about it, but I do think in relation to the

movement of patients who are on these pathways that this system will help. It will have things like mobile apps, so the patients themselves can interact and know where they are on the pathway. It is a challenge to deliver something like this, but all the approvals have been given for the spending and the procurement is currently under way.

Q50 Meg Hillier: Can I ask a quick question about choose and book? We are hearing that there are big variations in how many GPs use it. What power do you have, and have you thought about just directing GPs to use it? The other thing about texting for appointment reminders—we heard that the Homerton had a success at the beginning of that—is that again, it is variable. Only 55 trusts do it. I know that you don’t run every hospital—

Una O'Brien: I try.

Meg Hillier: That is about them saving money. That is a GP decision that is costing the taxpayer.

Una O'Brien: I am not as close to the complexity of why some GPs use that and some don’t. I believe there are elements of that which are a system issue. Part of it is whether there is availability of slots on Choose and Book, and the delivery of how that works varies from one locality to another. You need everybody to participate in that, to make the slots available so that people can use it. If the local providers are not fully participating in it, it is impossible for us—

Q51 Mr Bacon: Sorry, can you translate that into English for the complete avoidance of doubt? What you are saying is: it is not a system issue, it is the behaviour of the consultants in the hospitals not putting their slots up in the system for people to see. Yes?

Una O'Brien: Yes, correct. What I mean is, it is part of behaviour in the organisational systems, not a technical issue to do with how the computer system runs.

Q52 Meg Hillier: So delays in setting up clinics, that sort of thing.

Una O'Brien: No, just not making that knowledge available to the GPs to be able to effect the bookings or having a range of options on there for them to have enough to do it.

Q53 Mr Bacon: Looking at the NAO’s January 2005 Report on patient choice at the point of GP referral—a Report about choose and book from just over eight years ago—it said: “The Department”—that is you—“needs urgently to address the low level of GP support for their plans” and said it should “Press on urgently”. I shall have to turn my phone upside down at this point, I’m afraid, and coax it; by the way, if you get the chance, don’t buy a Samsung. The Report said that the Department should: “Press on urgently with its plans for informing GPs about the implementation of choice at referral”; “Monitor the views of GPs”; and “Consider whether further action is needed to secure the required level of GP support, once GPs are fully informed”. That Report also surveyed GP opinion, and it was very clear that the more GPs knew about it, the more opposed they were. The GPs who knew a lot were

the ones who were most opposed. Basically it was a pants system that did not work. Consultants did not want to waste time sticking information up on a system that they knew the GPs would not use, because it was so clunky and pants, and basically did not work, and you are rowing back from that. Now you are going to replace it. What are you going to do to ensure that the replacement for choose and book doesn't have these problems?

Una O'Brien: There is an excellent team working on this and of course it does not want to replicate problems, but quite a number of the problems referred to there, which is from quite a long time ago, were subsequently ironed out and we achieved a higher degree of participation. We were monitoring the participation, but the policy on monitoring was changed in 2010.

Q54 Mr Bacon: Hang on. Monitoring participation is one thing; if GPs loved it, they would just use it anyway. You would not have to monitor. They would all be biting your hand off for the chance to use it because it was so good, but we just heard from the two chief executives earlier that GPs still were not using it as much as they should. When asked why, I think by Meg, they said, "Well, that's the GPs' choice." They would choose to do it if it was great, wouldn't they?

Sir David Nicholson: First of all, half all referrals go through choose and book, so that is quite a lot. Millions of referrals have gone through choose and book, so while there are problems with it, some GPs absolutely love it.

Q55 Mr Bacon: And did it improve?

Sir David Nicholson: All the time.

Una O'Brien: It did.

Sir David Nicholson: One of the options we looked at and started was giving GPs financial incentives to use it. That didn't work.

Q56 Mr Bacon: I do remember. It was the craziest thing: why don't you take this pants system that doesn't work and we'll pay you some money for using it?

Sir David Nicholson: Obviously some people absolutely loved it and some people absolutely hated it. We got up to 50% of the population, but we concluded that the payments were not incentivising people. Some people just did not like it and did not want to use it, and that is why we have gone through this process of developing the e-referrals system, which has had massive discussion among GPs, and we are still working on all that.

Q57 Chair: I was going to ask a question of the NAO. Are you monitoring the implementation of this new IT—of the whole ruddy lot?

Keith Hawkswell: Yes.

Chair: And you are going to report to us.

Q58 Mr Bacon: What is the timetable for e-referrals?

Sir David Nicholson: I will give you a note on that. The objective we have set ourselves is that everyone is using it by 2017. The question we have to ask, and to get as wide a support for it as we can, is what incentive or penalty system do we need to put in place to ensure that it works? The thing we have heard today is absolutely true: patients are put at a disadvantage if you don't use a system like that, so that will be something that NHS England or the Department—

Q59 Meg Hillier: It is not just patients; it is taxpayers. While GPs are having their moment about this—MPs hate change but we have all had to adjust—isn't it time that GPs were just told?

Sir David Nicholson: But of all our clinicians across the NHS, GPs are the most technically advanced. They have more digital systems than almost anybody. It is not that they are frightened of this; they just don't like the way the system works and affects their patients. They think they want a different way to do it. We have been unable to persuade them of our case. However, I think we are getting to the point, with what we have understood from the implementation of e-referrals, where we want to get a system where we can make it mandatory as we go forward.

Q60 Mr Bacon: Did you make a conscious decision that, despite the fact that there had been incremental improvements to choose and book and the fact that more and more people were using it—you got to a 50% level, which is very significant compared with how it was—it was not worth continuing to make incremental improvements until everyone started to say, "You know what, actually it is really working quite well"? Did you consciously decide that you were going to dump it and have something new?

Sir David Nicholson: No, we have continued the team working, trying to encourage utilisation across the country.

Q61 Mr Bacon: So what is different? It is a new name, but does e-referrals use some of the underlying architecture from choose and book?

Sir David Nicholson: I don't know enough about the underlying architecture to talk about it. All I know is that there has been a lot of engagement with general practitioners and trials with general practitioners.

Q62 Chair: Out of interest, David, can you say what is the different objective, instead of just saying it is a new IT system? What is e-referrals going to do? What is your business demand of it that isn't in the current system? What is so different?

Sir David Nicholson: The major difference is that anyone can refer to anyone. At the moment, for example, referrals can go only to named consultants or groups of consultants in a speciality.

Q63 Chair: Choose and book only goes to a group of consultants.

Sir David Nicholson: Or individuals. It can go to individual consultants. E-referrals allow any GP to refer—and in some circumstances allow self-referral, if that is required—to any NHS clinician. They can refer to physiotherapy, to diagnostics—to a whole series of things.

Q64 Chair: Is that different from what you can do on choose and book?

Keith Hawkswell: Oh, yes. You can book appointment slots through your GP.

Q65 Chair: You said in our pre-meeting that you can go home and self-refer.

Keith Hawkswell: Yes, but the GP gives you a reference number that you can use to access choose and book.

Una O'Brien: If I may, I can give you some examples. At the end of the pathway there is always an issue about information coming back to the GP. This is a system that will allow clinical outcome information or treatment plans to be automatically uploaded into a GP system, so it will allow greater integration. The second feature is that it will give patients more choice of when their follow-up appointments will be, because choose and book is only the first appointment. The third feature is that it will allow the ability to link appointments in a care pathway to ensure that all of them take place in a predetermined order. The fourth feature, as I mentioned earlier, is that it allows for much greater interactivity with modern mobile technology, thereby empowering patients to have more control. One objective has got to be to reduce the number of DNAs and allow clinics to run really smoothly. It is trying to take the best of choose and book, but apply it in a more modern context, given what we have learned about how people interact with the system.

Q66 Chair: Okay. Let's move off the IT, if everybody's happy with that.

Can we look at how you're doing? Everybody has accepted that you are doing well, although the November figures showed a year-on-year downturn. The October figures, which were the basis for the NAO Report, were better than the November figures, which I can read out. In November, the number of patients on the waiting list was 2,590,000. Do you want me to read them out?

Una O'Brien: I know them.

Q67 Chair: You know them. There is a deterioration in the figures all the way through. Can you talk us through that?

Una O'Brien: In the overall scheme of things, if I compare it with 2007, when we had 4 million people on the waiting list, while it is higher than it was as a total number, it is still within an acceptable band that can be managed. There will be more statistics published tomorrow. I cannot comment on them in detail, because they are official statistics, but I do not expect them to show any further deterioration. That shows that these figures can sometimes be down to seasonal pressures as much as anything else.

Q68 Chair: Have you done work around the November figures to understand the change?

Una O'Brien: Yes, we have.

Q69 Chair: What does it show?

Una O'Brien: Well, the fundamental thing that is happening, and I think this is equally revealed in the build-up of pressure on the emergency side, is that there is an overall quantum increase in the number of people being referred for treatment. That is something that is a combination of morbidity in the population and an ageing population.

Q70 Chair: But that would have shown in the October figures as well.

Una O'Brien: I think you will see that it is showing very slightly in the overall numbers, but the other reality that needs to be held on to is that, given this pressure, others might have expected waiting times to go out and, in aggregate, they are not going out. We are still in a position where 50% of people are not only being referred, but are being seen by the consultant, getting their diagnostics and getting their treatment started within nine weeks. That is a tribute to the hundreds of thousands of people up and down the country who make that happen every day. I would not like to suggest for a single moment that we are complacent, because the numerical pressure is there. We are always investigating the causes and modelling what the future would look like, if those different pressures on the system were to continue.

Q71 Chair: There is one other thing about the figures. In the Report, page 16, paragraph 1.15, talks about those trusts that have breached. Everything is average figures, means and all that sort of stuff. There were 58 trusts that breached the 18-week standard for admitted patients, 11 that breached the non-admitted patients standard, and 36 that breached the waiting for treatment standard. Are those the same trusts that have financial difficulties? Is there a pattern there that helps us to understand better what is happening?

Una O'Brien: If I may, I shall ask Dale and David to comment in detail, but I want to emphasise that we are tracking very closely the numbers of trusts that are breaching those

priority treatment times and, through Monitor and the TDA, we are working to understand the causes.

Q72 Chair: Are they linked to financial difficulties?

Una O'Brien: We are not finding any immutable pattern between those. There are areas that have financial problems that do not have these pressures, and there are areas that have these pressures that have financial problems as well. They do not all assemble around a single set of problems. That is the complexity of what we are dealing with. Perhaps I could ask TDA and Monitor to comment in more detail.

Dale Bywater: I guess, in fact, that there is almost an incentive to treat lots of patients who are on your waiting list, if you are a provider, because you get paid for them—you get paid a tariff. So there is almost a financial incentive. I do not think there is necessarily a direct link; it is more a link around operational grip and pressures more generally in the hospital. Those organisations that encounter backlogs—where they have, for whatever reason, not been able to treat patients in the manner required—have to address that. A backlog is those patients who have gone beyond 18 weeks. They need to be treated in turn; that is the driving force.

On the size of the waiting list, one key thing we look at is that size is really important, but so is not creating the incentive actually to let waiting times drift out. There is what we call a tail on the waiting list, so you cannot just focus on the patients who are with you now and are below 18 weeks, in order to keep hitting the target, and just ignore the ones who have already breached and will affect your figures. That does not happen, and it has not happened. The way we test that is the third measure of the national measures—the incomplete pathway—which asks whether at least 92% of the patients on the waiting list have been waiting for less than 18 weeks? That measure has also stood up. That is just one macro, but it is none the less a really important measure—a metric—to understand, so that the result, with a bigger waiting list, is not longer waiting times.

Dr Bennett: The foundation trusts' experience is the same. There is not a systematic correlation between poor performance on waiting times and financial performance. You will get some trusts where the underlying problem is poor operational management, and it can then manifest itself with problems on both fronts, but it is not a systematic correlation.

Q73 Chair: When you look at operations cancelled, again the figure across the system is good: 1%. Is that focused on particular hospitals—is there any sort of correlation—or is it across the system?

Una O'Brien: I do not think we see any significant correlation at national level, but it is important to understand that often an operation is cancelled because of pressure on intensive care. There are a number of operations where the surgeon will not commence the operation unless he or she knows that the intensive care bed will be there, so it can be very local circumstances that have led to a planned arrangement suddenly having to be changed—it can be that micro. My colleagues might know more detail about that, but that is something I have observed in the past.

Q74 Chair: Do you want to say anything on the 1% cancellation—whether there is a pattern either in the foundation trusts, or the non-foundation trusts?

Dr Bennett: The early pattern that we see, which relates to Una's point, is that sometimes the problem can be pressure on emergency care. If you have a sudden surge of demand for emergency care, for whatever reason, the only way to deal with it is to postpone some of the elective care.

Q75 Chair: Do you see a pattern?

Dr Bennett: You do see that pattern, but it is driven by all sorts of reasons why emergency care sometimes has spikes. It might be a problem at a neighbouring trust, for example.

Q76 Meg Hillier: Paragraph 3.14 on page 31 highlights the issue that we heard from the chief execs earlier. The trusts bear the risk of the financial penalties for hospitals, but actually it is not all in their control; that last exchange has sort of demonstrated that.

Have you given any thought to incentivising other bits of the business? Earlier we had a discussion about GPs to ensure that they are not slowing things down. It seems to me that hospitals take the brunt, even if it is not their fault.

Dale Bywater: I can definitely account for what happens in the providers, probably more so than might be appropriate. I think, in a sense, even where there are financial penalties applying—rightly so—from commissioners to trusts, that can sometimes lead to problems still to be solved. Taking money out of the trust or the system does not necessarily get the patient treated. That often results in a discussion on how you are now going to recover the position and on what basis we can use the penalties as one way to support that. It has to be you backing your plan and backing someone you have confidence in.

I don't want to get into the domain around—I have a view, but it is probably more of a view rather than fact. Do you want to—

Dr Bennett: The rest of the system.

Sir David Nicholson: You are absolutely right. You talk about emergency care, and the issue we have at the moment about the cap on emergency income that people can get on the one hand, and then there is no such cap for electives. We are looking at how the incentive system works for emergencies to enable us to be much more open and transparent about the way we do that.

On the commissioning side, the major incentive is that every year, the CCGs are allocated a quality premium based on their performance. Their performance in relation to delivering the constitutional requirements of their local population, which the waiting time is one significant part of, is part of that. They cannot get their quality premium unless they

deliver their constitutional responsibilities. That quality premium can be, at its maximum, £5 per head of population, so it is a significant incentive.

Q77 Chair: You have never implemented it, though, have you? You have never fined them for it.

Sir David Nicholson: No, this is to commissioners. We have never paid it before, because it never existed. This is the first year—

Chair: But there has been no fining or penalties.

Sir David Nicholson: But this is for commissioners, and it is a quality premium.

Secondly, the standard contract gives commissioners the ability to fine people for not delivering on their waiting time targets. I think—is it about half?

Keith Hawkswell: Some 48% weren't fined for breaching the commitment.

Sir David Nicholson: There is an argument that they should be fined irrespective of what the local circumstances are, but we judged that, given particularly what Dale was saying, in some circumstances, just taking money off them would not solve the problem. In fact, it might make it a lot worse. So in some circumstances, people have the flexibility not to make those fines if they come to an arrangement locally.

Q78 Chair: You could say that of anything, couldn't you? You could say that anywhere through the system, so we will never have a penalty regime.

Sir David Nicholson: Yes, but half of them are, so they are used in the system. We think that, at the moment, giving people the local flexibility not to do it if they don't want to is the best thing. In the future, other people might take a different view, but that is certainly where we are at the moment.

Q79 Chair: Do you want to say something on that, Keith?

Keith Hawkswell: Just a couple of things. I understand that, in the future, the standard contract is changing, but at the moment, the fines are mandatory.

It is also worth point out that the quality premium in 2014-15 across all clinical commissioning groups is £270 million. That is a lot of money, but is quite a small proportion of the total funding for CCGs and trusts.

Sir David Nicholson: If you want to give us another £250 million, I'll make it £500 million. Where do you begin? There is no quality premium at the moment. There is no incentive on commissioners in the past to deliver this. This is a new system of providing incentives to commissioners, and I think we should let it work.

Dr Bennett: Just a couple of things. On this issue of looking at the rest of the system and its contribution, I think it is true that we shine a very bright spotlight on the acute sector; we measure quite a lot of what it does quite precisely. We do not shine such an intense spotlight everywhere else in the system. Things like the quality premium are valuable in incentivising nevertheless, so people focus on what is going on in the rest of the system.

On the issue of penalties, I absolutely agree with David that sometimes you are likely to make matters worse, not better, if you take money off a trust. That is not to say that is the only penalty and therefore they escape. If you have a repeat offender, so to speak—someone who is consistently struggling to hit their targets—then either we, for foundation trusts, or the TDA, for non-foundation trusts, will step in, and they will receive attention that will not be terribly welcome. They will be keen to get rid of us by sorting their problems out. They do not get off free, just because they are not fined.

Keith Hawksell: I would not wish to contradict that, but we did say that when trusts were not fined, 46 of them had no conditions attached to not being fined, so there was no direction about how that money was going to be used within the trust.

Dale Bywater: As a provider, you fail this target and may suffer financial consequence for it, but what you definitely suffer is a lot more on the accountability side, which is where we come in, in different guises. There is an absolute holding to account on this. There is no doubt that has all sorts of levels around escalation levels, the way we interface and the level of scrutiny; we may call in external reviews and we may call in auditors. There is a whole raft of armoury. I would not want you to think that trusts are sitting there and not taking this seriously. They see the importance. RTT is up there with the real top operational standards and priorities.

Q80 Chair: Can I talk a little bit about taking it seriously? Are there some unintended consequences that arise? Look at page 20 of the Report: for the acute trusts, it is better to refer back to the GP if the patient does not respond to a letter—presumably a letter—from you. I can think of endless times in my constituency when they have come in with three or four letters that they have not responded to and they then say, “I am not getting the treatment I need,” but pushing it back to the GP means that the clock starts again, so an unintended consequence might be that the patient does not get the treatment they want. I was quite shocked to see, at the bottom of that page, that 2% of trusts allow you only one cancellation before they refer you back to the GP. I know it is a tiny number, but that seems to me to be unreasonable and ought to be stopped by you guys.

The other thing to say about the target is something that happens elsewhere. Somewhere else in the report, you say that most treatments take place within the last week—there is a concentration at the end. With the exception of the first two weeks when most urgent and most straightforward cases are dealt with, a patient is more likely to have the operation or whatever in the final week, so the target drives to the end, rather than doing it as and when. Those are three examples of what I would call unintended consequences, which I wondered whether you wanted to comment on.

Una O'Brien: I would like to reinforce a point I made earlier about simplification and visibility—two very important next steps we need to take. One feature of all of this, looking

both at the data from the NAO and also at our own survey data on public and patient understanding of the NHS constitution, is that it is too low. Not enough people engaged in the system have any idea that they have choice or how the time is being counted. If you are in pain, the time you are waiting, in your mind, is from the time you are in pain. This is an administrative method of evaluating the efficiency and effectiveness of NHS performance. Trying to bring this closer to the patient, help patients and the public to understand what they are entitled to, what they can demand and what the consequences are if you are casual with your appointments need to be sorted. Finally, we must make it a lot easier for patients to interact with the system, because we know that they are much more likely to adhere to appointments that they have chosen. That is why the e-referral system matters. I am sure that others will add to my observations.

Chair: I hear that, and it is good, but my point is really about unintended consequences.

Dr Bennett: In part this is about the difficulty of designing any target system that does not have unintended consequences or worse still, create an opportunity for gaming. You are often trading off simplicity against the risk of unintended consequences, but we are seeing some of the consequences of trying to introduce more detail to avoid unintended consequences which then leads to problems about people not understanding it or not applying it consistently. It is a fundamental problem in any targeting system to get the balance right between something that largely works and does not create too many unintended consequences or opportunities to play games with it.

Q81 Mr Bacon: May I ask Una O'Brien a follow-up to what she said about the public's understanding of the NHS constitution being too low? It calls to mind some sort of vision of NHS bureaucrats berating members of the public for not having done their homework, and it even reminds me of the comment by Bertolt Brecht about the people having failed, and that the obvious answer was to dissolve them and elect a new one. If you are to get the higher understanding of the NHS constitution that you say is required, the people having so far failed to grasp the point, are you going to do it by avoiding at all costs the use of the phrase "NHS constitution"?

Una O'Brien: Maybe given what you have said, we should listen to what is behind your question. Of course, I am using the constitution as shorthand for what it represents, because it is a very significant stage in the history of the NHS. It sets out within a legal framework, backed by all three political parties, what patients are entitled to expect from the NHS. It has been a fundamental feature in the mandate to NHS England, which now has a particular responsibility to gain that understanding, and it has some plans to do so. I agree with you that getting people to say whether they know about a document is meaningless. What we need is patients who are paying for the system to understand absolutely that they are entitled to receive treatment within a certain period of time, and to be an informed user of the system, so that they can use their power to make sure that it works.

Q82 Mr Bacon: You mean to be more demanding customers as it were.

Una O'Brien: Absolutely.

Q83 Mr Bacon: It would be very easy to spend a bit of money on adverts on television saying, “These are your rights. You are entitled to the following, and by the way, if you make an appointment that you have chosen and don’t turn up, here’s what will happen to you: we’ll send you a nice big fine.” You could do that, but if you did, demand would probably go shooting through the roof as people arrived at A and E, saying, “I know my rights.” That is what would probably happen unless you were very careful. How are you going to do this?

Una O'Brien: That is for Sir David, but the health care system is there to provide health and care for people. We are not trying to avoid that. We need people who have seen the adverts, because we are saying, “Come forward when you have a problem.” One of the biggest problems that we have got is that people are presenting too late. A cancer diagnosed in A and E is a disaster. We actually need people, especially men, to go to the doctor when they have a problem and to get it diagnosed.

Q84 Mr Bacon: When you mentioned that example, I wasn’t specifically thinking about the men point, but when we looked at the cancer strategy, there was an eightfold variation in the propensity of GPs to refer to cancer specialists. That was some years ago, so what is it like now? Has there been an improvement?

Una O'Brien: I haven’t got the data in front of me, but it is still an issue, and it is currently on our agenda to see what we can do to get diagnosis earlier. It is something very much on the mind of NHS England.

Chair: We are slightly off the topic, so I am going to bring back Austin.

Q85 Austin Mitchell: I was a bit worried by the snakes and ladders game of going from the head of the snake and falling down again. I see from paragraph 2.7 that “Forty-eight per cent of trusts refer patients back to their GP if the patient has not responded to a contact from the trust to make an appointment.” That seems a high proportion and pretty brutal treatment. You go down to the bottom of the ladder again and start all over, but it pretties up the trust’s performance figures, doesn’t it? Do we know how many cases that refers to, and why the trusts are so brutal?

Dale Bywater: I don’t know the overall number. The rules say that in doing that the trust has to demonstrate that it has made every effort to make the patient aware of the appointment and the patient commitment. That is quite a high number. There are variable practices and the Report refers to that.

I would say that we need to differentiate between vulnerable patients—whether elderly or children—in the way these patients are treated in quite discerning ways in terms of standards. That is the point around local interpretation, which can happen here. We have to ensure that we take the positive of that rather than just look at the negative. So I don’t have the number but I would say that the point is that the trust has to demonstrate that it has taken every step to make a patient aware and that the patient has, in effect, declined the offer.

Q86 Austin Mitchell: Do they keep figures on how many people fall out in that fashion?

Dale Bywater: I don't have the figure to hand.

Q87 Austin Mitchell: A further question on cancellation, which I know is infuriating. According to paragraph 17d, 1.6 million first out-patient appointments were not kept. Other patients could have used those, and that is a substantial cost to the NHS. Are people warned? I get people coming to complain that they were pushed back down the ladder and had to start all over again. Are people warned of the dire consequences if they do not keep the first appointment?

Chair: In 2% of cases they are not—and that is not on.

Una O'Brien: It ought to be very clear. We have already touched on this today. It is the clarity of communication to the patient around the local policies. We have taken that point from the work that Keith revealed through the NAO Report.

Q88 Austin Mitchell: Sometimes they tried to cancel it and it was not heeded. With cancellation arrangements, the number of cancellations allowed by trusts where patients are referred back to their GP and the clock restarted ranges from one to three. Why can't they have a uniform standard on this?

Una O'Brien: The rules overall are national and there is one set of rules. That is one of the very small number of areas where there is flexibility for trusts to have a local policy. It has to do with the capacity that they have to cope with handling re-appointments and trying to get people to adhere to coming to the appointment that they have agreed to. We do accept the points that have been raised by the Report and we will certainly take that away and look at whether we have allowed too much flexibility around that. It is clearly disturbing where people do not know the consequences.

Q89 Chair: We are coming to an end. I was going to ask you one more question and then Stephen Barclay has a question. I am trying to be non-partisan but what is interesting here is that outcome targets, if I can call them that, appear to have had an impact on behaviour in hospitals around getting people treated more quickly. Are you therefore thinking of using a similar mechanism, Una, for example with the poorer outcomes associated with weekend care or the excessive reliance on agency staff? Those are two that particularly impact on the lack of quality in my own health economy.

Una O'Brien: I would need to reflect on that. I think there are big advantages and big disadvantages in these approaches in terms of how you get adherence to best practice. Before I would really want to comment in detail on the appropriateness of targets in either of those cases, I would want to understand the unintended consequences.

Q90 Jackie Doyle-Price: I share the Chair's experience. Once my local trust started tackling the numbers of temporary staff, the performance improved. We have had discussions about outcome-based targets before but, where you are measuring the quality of inputs, numeric measures are perhaps more useful than the outcomes.

Una O'Brien: Yes, they have their place and their time. Often, if you have a particular drive—this was a huge national initiative and everybody knew that the only way we were going to deal with people waiting two years for a first consultant appointment, which is where we started, and get to where we are today was through this sort of approach with a lot of national drive. We want our NHS organisations to be transparent in their performance and for them not to need people nationally to come and dip in to tell them what to do.

Q91 Chair: The only thing I would say to you on the agency staff, if we can take that one, is that every time I look in relation to my hospital—Jackie clearly sees the same—you see poor performance at A and E, and then you look at the use of agency staff, both for nursing and consultants. Then you look at financial problems in the trust and the use of agency staff. Those come up with such a correlation. Rather than giving me yet another chief executive and chair—that would be about the 20th since I have been the MP—that might be a better way of changing the behaviour of the people who work at the trust.

Una O'Brien: It is fair to say that if you look at something like the A and E four-hour target, it has had the biggest effect in terms of the way the whole hospital is organised—almost more than what actually happens in the emergency room—because you can only meet that target if you are looking at the flow through the whole organisation.

I think I understand the point that you are making: if you just take one of these iconic things and use it as the means to drive change, it can be very effective. But these are complex organisations and, when you are pulling out individual things, you can distort the interconnectedness of other things that happen.

Q92 Fiona Mactaggart: But isn't that absolutely one of the reasons why permanent staff, in a complex, interrelated organisation, instead of doing just the things in a box in front of them that agency staff have to do, can have some investment in the whole system? Those of us who have problems caused at least in part by agency and temporary staff can see the difference in the quality of care that our constituents get from people whose futures are invested in that institution as opposed to those on a temporary blip.

Una O'Brien: Let me be clear: I was answering in relation to the use of targets. On the use of agency staff, I completely agree that it is preferable by far to have an organisation staffed by people who are committed to the organisation and who are part of it. The reasons why we have growth in some places in agency staff are often quite complex. I know that there are trusts—Dale knows some of the organisations to which you are referring—who would very much like to have permanent staff and are going to great efforts to get those people. In the meantime, they are not prepared to compromise patient safety by leaving posts

completely unfilled. We definitely share that ambition to minimise the use of temporary staff. I think it is an important point and Dale may wish to comment.

Dale Bywater: There is currently no national standard as such for agency or temporary staff or seven-day working, but it is a big issue for all of us. For us, in our interaction with organisations, an alarm bell rings when we see high rates of agency staff. The point is: “That is very well, Dale, but what is the action and response?” We are getting into this, but the reality is, as Una said, that very rarely do organisations purposely want to have agency staff. This is often a symptom of some other problem, be that the local labour market or the perception of the trust and its reputation. There is a whole range of things that we need to do to resolve that, because that is not a place that anybody wants to be. No organisation wants to have a high rate of agency staff.

Something that has come out of the mortality data and on the back of urgent care is that we are now moving increasingly towards having more seven-day working in the service. We must make sure that other parts of the service, such as social services, can match the hospitals’ ability to work seven days a week, because we are waiting for patients to be discharged on a Saturday afternoon.

Q93 Chair: Just get your act together, and we can deal with the other ones.

Dale Bywater: Precisely.

Q94 Jackie Doyle-Price: It is the use of numeric measures—targets versus indicators. I guess that we are talking about the data as an indicator of something else. Again, it comes back to the quality of the data and the measures in place. The magic ingredient in all this is the quality of leadership in our hospitals. All these things will inform where the deficiencies are. That is where we have to get to if we are going to have the step change in performance that we all want to see.

Una O'Brien: I completely agree.

Q95 Jackie Doyle-Price: So really we should be looking at building a package of measures that will inform a view of the leadership.

Una O'Brien: That is very much what is behind what we are aiming to do with the new inspection regime. I know that a lot is changing in that organisation, but the appointment of the three chief inspectors is a game-changer, as is the approach to the rating of hospitals. Work is being done by those three leaders to really understand what the essential features of a good-performing organisation are, so we can assess that and organisations can know what their rating is. We are determined to get there. Equally, we have to do more to build a cadre of great leaders. These are very difficult jobs to do; we all know that. We all know people who do this work, and we know good people and people who are struggling with it. Our common purpose is to bring on a new generation of people.

Chair: I have to say that my own hospital is back in special measures again. It is about to get rid of the next chair and it is getting rid of the next chief executive. I have asked, “How are we finding a new one?” The same person who sat in the London regional health authority is now the person who is charged with finding somebody, having failed to do that goodness knows how many times before. We on the ground are cynical about whether all that re-jigging of deckchairs on the Titanic is going to achieve a real change.

Q96 Jackie Doyle-Price: Following on from that, Colchester is the most notorious example in this Report. There were issues with leadership in that hospital for a long time, and they were never addressed. We need to have a set of transparent measures that everyone agrees are indicators of good leadership.

Una O'Brien: Yes.

Q97 Stephen Barclay: We have heard about the inaccuracies in the data. Can I raise an issue from our last hearing? Can you clarify whether the NHS stopped paying the chief execs of all SHAs when those bodies were abolished in March 2013?

Una O'Brien: I haven't come prepared to answer that specific question, but I can certainly send you the factually accurate information.

Q98 Stephen Barclay: I have already tabled a parliamentary question, so I would have thought that you were on notice about it. The Department suggested that it did not know, which seemed a remarkable position for the accounting officer to take. I wrote a week ago to NHS England about this straightforward matter, and it has still not answered. Sir David, do you know whether the NHS stopped paying the chief execs of SHAs when they were legally abolished?

Sir David Nicholson: I haven't looked into that particular issue in any detail. I have not come prepared to answer it, but I will answer your letter very quickly.

Q99 Stephen Barclay: Were they not your direct reports?

Sir David Nicholson: Before the end of March 2013?

Q100 Stephen Barclay: Yes.

Sir David Nicholson: Yes, they were.

Q101 Stephen Barclay: So you don't know whether your direct reports continued to get paid beyond March 2013?

Sir David Nicholson: Sorry, let me make that clear. They were employed by their individual strategic health authorities. In that sense, I did not directly line-manage them. Their organisations were accountable to me. I wasn't their direct line manager. I didn't do their appraisals.

Q102 Stephen Barclay: These are the people you are working with. These are the people you know personally. You may even socialise with one or two. You don't know whether any of them continue to get paid by the NHS after their legal entities were abolished?

Sir David Nicholson: I—

Q103 Stephen Barclay: You don't know.

Sir David Nicholson: Before I answered that question I would want to be absolutely sure that I was being factually accurate. I would want to look at the data and the information myself. I would never want to mislead or do anything of that nature.

Stephen Barclay: Perish the thought.

Sir David Nicholson: It would be much safer for me in those circumstances.

Q104 Stephen Barclay: Given that caveat, what do you think is the position?

Sir David Nicholson: It is a hypothetical question. I could not answer that.

Q105 Stephen Barclay: You may recall that I raised a series of questions at our July hearing about my concerns with Mike Farrar, who was the chief executive of the NHS Confederation and the boss of the North-West Strategic Health Authority, which failed to intervene in the Morecambe Bay baby deaths. He worked with Tony Hallsall who failed to pass on the Dame Pauline Fielding report to the regulator. The Grant Thornton report was very critical of him. Mysteriously, Hallsall's secondment to the NHS Confederation for 18 months was agreed three weeks after the draft PWC report, which was very critical, went to Morecambe hospital where the secondment was agreed by the chairman of Morecambe, who was Farrah's former chairman when he was the strategic health authority boss. There is a conflict of interest. I raised that case with you. Could you confirm that Farrah's employment contract did not sit with NHS England after March 2013?

Sir David Nicholson: I couldn't comment on all the dates that you have described because I would need to be equipped to do that. When the SHA was abolished my recollection is that his contract of employment was transferred over to NHS England.

Q106 Stephen Barclay: Indeed. In fact, you wrote to me to say that it was novated to NHS England.

Sir David Nicholson: Yes.

Q107 Stephen Barclay: Could you clarify what “novated” means?

Sir David Nicholson: Transferred over to.

Q108 Stephen Barclay: So the employment contract for Mike Farrar after March 2013 sat with your organisation?

Sir David Nicholson: Yes.

Q109 Stephen Barclay: So in essence you were his employer?

Sir David Nicholson: Yes. His employing body.

Q110 Stephen Barclay: And he continued working until September 2013?

Sir David Nicholson: He was working as the chief executive of the NHS Confederation—

Q111 Stephen Barclay: On a contract with you.

Sir David Nicholson: And they paid him. They paid us for his—

Q112 Stephen Barclay: And the contribution to his very generous pension scheme—where was the money for that coming from?

Sir David Nicholson: It was coming from the NHS Confederation.

Q113 Stephen Barclay: And that is funded entirely by NHS bodies; not a single public donation goes to that organisation.

Sir David Nicholson: I don’t know exactly how they are funded.

Q114 Stephen Barclay: Right. Ms O’Brien, do you accept that the information given to Parliament and the National Audit Office at our last hearing on pay-offs was incorrect?

Una O'Brien: If there is an inaccuracy in the information that we were given we would always put it right. We have had a degree of correspondence since that hearing and tried very hard to give you the best and most accurate information that I have.

Q115 Stephen Barclay: So is that yes or no? Was incorrect information given to the National Audit Office on pay-offs for their last hearing?

Una O'Brien: I can only repeat what I just said. I always endeavour to give honest and accurate information. If I have omitted—

Q116 Stephen Barclay: I was not saying you personally. I am not questioning your personal integrity.

Una O'Brien: Well, I take it personally.

Q117 Stephen Barclay: To be clear, that is not what I am questioning. I am saying: was the information given to the National Audit Office incorrect?

Una O'Brien: If there is an inaccuracy in it then I would accept that there was an inaccuracy but I would need to know what it is.

Q118 Stephen Barclay: You seem surprised. It was carried following a parliamentary question of mine as the front-page lead story on *The Times* just a few weeks ago. Some of the pay-offs were incorrect by up to £200,000.

Una O'Brien: As soon as that information came to light we wrote to you and put that information on the public record.

Q119 Stephen Barclay: You did in a subsequent parliamentary answer to me. The problem with that is our hearing and the NAO report were based on the previous data, which was incorrect.

Una O'Brien: As I say, new information came to light and I have made it available and published it as soon as we became aware of it. I would never knowingly produce misleading information.

Q120 Stephen Barclay: I am not accusing you of knowingly doing so; I am just saying it was incorrect. I would have thought we could get to a yes on that.

Una O'Brien: As I said, as soon as the information was found to be incomplete, we made it publicly available.

Q121 Stephen Barclay: It was only found to be incomplete because of my parliamentary questions, I think. As the accounting officer responsible for value for money, why do you feel it is value for money for Mr Cooper, the deputy chief executive of Yorkshire

and the Humber SHA, to be paid off between £370,00 and £375,000 in redundancy and pretty much immediately start work as director of finance for South London Healthcare NHS Trust?

Una O'Brien: I am not going to comment on the individual case, but I will comment on the general point. I think there need to be changes and there will be changes. The first thing is that the rules as they exist allow people to return to work without repaying anything after four weeks. We have already said that that needs to change and is going to change. I want to say that people are not wilfully seeking redundancy; they are being made redundant as a result of the organisational changes.

Stephen Barclay: But Ms O'Brien, this point was raised by the Health Select Committee ahead of the reorganisation. It was a well-known concern.

Chair: Let her finish her answer.

Una O'Brien: I do need to finish the answer. The change that we are going to make is that if a person is made redundant—and this is not one organisation, it is hundreds—and gets a job elsewhere in the NHS and they have received a redundancy payment greater than 12 months' salary, if they return to work within 12 months they must pay off any excess. If a person, for example, was made redundant, they were only entitled to a three-month redundancy pay and they got a job at nine months or 12 months, clearly they wouldn't have anything to pay back.

Q122 Chair: When is that being implemented?

Una O'Brien: We are implementing it in stages, so we are currently looking at Agenda for Change. We are also in negotiations to see how far we can get in implementing aspects of it with the arm's length bodies. The third group we will come to will be the trusts, because it needs to change across the board.

Q123 Stephen Barclay: That is the jam for the future and it is welcome. My question was, were concerns not raised by Stephen Dorrell's Committee ahead of the reorganisation about this precise issue?

Una O'Brien: Effectively, by the time the reorganisation was announced in 2010, I'm afraid that it was too late to change the 2006 rules for that cohort of people, because they had effectively been announced as redundant. I decided therefore—and I have talked about this in this Committee before—that we must work across the system, because we looked at the cost of the redundancy bill overall in the impact assessment and said it was too big. We spent two and a half years doing it, in order to avoid as many redundancies as possible. Our goal was to bring that impact assessment down—

Q124 Stephen Barclay: It is a separate issue.

Una O'Brien: No, it is the same issue as far as value for money is concerned, for me, because it really mattered that we spent as little as possible on redundancy and where people could be found suitable alternative employment, they were found it.

Q125 Stephen Barclay: The point I am raising is a different one. It is the systemic covering up of embarrassing data. We have seen it with special severance payments and the gagging of whistleblowers, where the data given to the Committee was initially incorrect and the problem disguised. We then saw it with judicial mediation, where Sir David told us it was a one-off, that there was just one case. We then discovered—

Sir David Nicholson: Sorry, no; I said that I had only come across one case in my career.

Q126 Stephen Barclay: You thought it was a one-off. I think that is what the transcript will say. The point was that your deputy had actually used that vehicle, Sir David, and was aware of it, and 70 hospital trusts had used judicial mediation. When it was raised at the Committee, we had raised the issue of special severancing and the gagging of whistleblowers, where it was under-represented. We then raised the issue of judicial mediation, where your evidence to us, as the person leading the organisation, was that you were only aware of one case. We then discovered that 70 hospitals, including your deputy, had used it. We then come to redundancy payments where the figures are out by up to £200,000 and people are going from those sorts of generous payments straight into other jobs. We have the hearing today where, out of a sample of seven, four have incorrect data. So the concern I am raising with you, as the accounting officer, is how can you satisfy the Committee that you really know what's going on?

Una O'Brien: On the data on redundancy, I am in absolutely no doubt whatever that all the information that was relevant at the time went into the 2012-13 accounts. It is true that that digital information came to light in a parliamentary question, but it would also have come to light for me through this year's accounts, because those payments were made in 2013-14. I have an absolute commitment and a requirement through my director of finance that all the information on those redundancies—we do need to take this in turn—will be made transparent in the remuneration reports—any that were missed in the accounts that were due in this calendar year.

Secondly, collectively for the whole of Government, you as a Committee have done an excellent job in shining a light on all these issues, across the whole piece, on payments that were not formally made transparent. Bringing to light the issue about judicial mediation, you have quite understandably then focused on what the Cabinet Office guidance needs to be for all of us to get that right. I refute the suggestion that we sit down and systematically cover up information—quite the opposite. I spend most of my time talking about how we are going to get it out there.

Q127 Stephen Barclay: To be clear, I am not accusing you personally of covering up. What I am saying is the organisation culturally is covering up. It either doesn't know or it

is disguising the data. I am not saying you personally are sat there in Richmond House doing it. I am not in any way questioning your personal integrity at all. What I am saying is, on issue after issue this Committee has looked at, the NAO has either been given incorrect data or the Committee has been given incorrect data. That must raise serious concerns for you as the one who is personally liable as accounting officer.

Una O'Brien: I would say again that I do take it personally. As an accounting officer, that is the nature of the role. We always endeavour, and it is our duty and responsibility, to provide full and honest information to the NAO. Our books are open. We have NAO people at all of our audit committee meetings and we will increase the transparency on these payments. I have undertaken to do that and I am sorry that you were not, I believe, here the last time that David and I were here and answered some questions about the steps we are taking to improve transparency. So it is not about systematically covering up data, far from it. It is about taking the steps to produce greater transparency on all of these matters.

Chair: Finally, Richard wants to ask you something about that.

Q128 Mr Bacon: One quick follow-up to Mr Barclay's line of questioning about payoffs. The public opinion of the NHS, which is obviously a multi-faceted set of views, contains a great deal of love and affection and a great deal of anger. There are probably few things that cause more anger, other than the obvious betrayals such as Mid-Staffordshire, than what Mr Barclay was talking about. People being paid very large sums of money and walking shortly afterwards into other jobs; or going off and becoming "consultants" so they are not on the books and then walking into jobs because everyone in the top levels of the NHS knows everyone else.

Because you thought the redundancy payment amount was too large, you said you were going to deal with it, but in phases. You were going to deal with Agenda for Change, then with arm's length bodies, then with trusts. That sounds to me like providing lots of opportunities for more people to get in under the wire.

I was yesterday with Mr Bywater and the new chief executive of the East of England ambulance trust—the very impressive person, I might say, who has been brought in to sort it out, Dr Marsh. I was very pleased by the way that he had the confidence to say in front of the Minister and Mr Bywater that meeting the national targets was not his top priority. Dealing with extremely long waits, where ambulance crews have watched people dying in their arms after being there for several hours, was his top priority. Only then would he worry about the eight-minute targets for many people for whom, frankly, the eight minutes wasn't relevant. He had the strength and confidence to say that in front of these people, which is a very encouraging sign.

There is a public discussion, and it has been in the press, that this chief executive's predecessor is about to get half a million pounds, and the reason it is still up for discussion is because it is not yet cleared, because there is a possibility he might get redeployed and found another job.

Una O'Brien: Hopefully he will get another job.

Mr Bacon: Hopefully he will. But it seems to me that if your process of changing this is a phased one—you are dealing with the Agenda for Change, then the arm's length bodies, then the trusts—there is much more chance that he and people like him will get, as it were, under the wire, under the ancien régime where these outrageous payments do happen. Then they turn up somewhere else in the multi-faceted NHS because there are lots of management jobs for which they are suitable. That is much more likely to happen if you do it in a phased approach. Why not do it all at once? That is what I do not understand.

Una O'Brien: To do that, I would need legislation, to put it bluntly. I do not want to underestimate the difficulty of doing this. These are legal entitlements that people have under the rules that exist. These are not payments that are outwith the rules. The Government have taken action legally to reduce the overall amount of redundancy payment, were a civil servant to be made redundant. There is now a cap on that—but there are different arrangements in relation to the NHS and as yet there is no proposal to legislate. We have to do that in the best way we can.

Q129 Mr Bacon: Are you saying therefore that this phased approach that you have described is going to happen absent legislation?

Una O'Brien: It is easier to do it for new people coming in without legislation. You can do it by negotiation but it is complicated. The only way, I believe, that you could introduce a cap, cleanly, on the redundancy payment for people who are currently in their jobs, is to legislate. Even that has some complex issues behind it that I would not want to underestimate. I do want to come back to this: if people are being made redundant, it is not against the law to carry on working in the industry that you know. What is unacceptable, and I completely take the point because I feel it myself, is when you have received—even though it is under the rules—a big payment; payments are too large, and you should not then also be being paid in a short period of time afterwards. This new rule about paying back—

Stephen Barclay: It's not—

Chair: I've given you lots of leeway.

Q130 Stephen Barclay: You have, but the point is that of course it is a legal entitlement. No one is disputing that, but what I am saying is that the problem is where performance has failed, people have been criticised and they have moved to avoid accountability, and then they come back in the system. That is the point.

Una O'Brien: I agree. I feel it. I think David might comment on that as well.

Chair: I will let Justin ask his final question and then I think we are finished.

Q131 Justin Tomlinson: It is frustrating that every time we have these hearings we end up being deviated by questions over previous hearings. Miss O'Brien praised the work of the National Audit Office and MPs for highlighting issues, and finding that useful. It strikes me as strange that you are not being more proactive in utilising those MPs who are doing that

research, or the National Audit Office which has clearly done lots of research and can identify issues. As you said, when Mr Barclay raised the parliamentary question, you would have eventually picked up on this because it was part of this year's payment. Why are you not sitting down with those people in advance, being proactive and getting these things resolved? Then, when we have the NHS-related Public Accounts Committee hearings, we would not always have to look at things retrospectively. It seems obvious to me that you have people who can bring that information to you much quicker.

Una O'Brien: Absolutely, and I had thought when we came back last time, two or three weeks ago, that we did give you the information that you needed at that point.

Q132 Justin Tomlinson: So can I get a commitment that you will now start to work with those people who are interested, so we can try and pre-empt this?

Una O'Brien: I would be more than happy to do that.

Q133 Chair: David, very last point.

Sir David Nicholson: The point I was going to make is that I completely support what Una is doing on getting redundancy payments in the right kind of order, publicly acceptable and all the rest of it. The other point is: can we please stop reorganising the NHS?

Fiona Mactaggart: Hear, hear. Did someone say no top-down reorganisations?

Mr Bacon: That was what I was saying in the last election. Stone the crows.

Chair: Okay, thanks very much indeed.