



Health Committee

Oral evidence: Accident and emergency services, HC 923

Wednesday 14 January 2015

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Members present Dr Sarah Wollaston (Chair), Andrew George, Robert Jenrick, Barbara Keeley
Charlotte Leslie, Grahame M. Morris, Andrew Percy, David Tredinnick, Valerie Vaz

Questions 1 - 107

Witnesses: **Dr Clifford Mann FRCP FCEM**, President, College of Emergency Medicine, and **Professor Chris Ham**, Chief Executive, The King's Fund, gave evidence.

Q1 Chair: Good morning and welcome to the Health Select Committee hearing on acute and emergency care. Could I start by asking the panel to introduce themselves to those following the debate at home, perhaps starting with Dr Mann?

Dr Mann: I am Dr Clifford Mann. I am the president of the College of Emergency Medicine and I am a full-time emergency medicine consultant in Taunton, Somerset.

Professor Ham: I am Chris Ham. I am chief executive of the King's Fund.

Q2 Chair: Thank you. Could I start perhaps by asking Professor Ham to give us an overview of where we are now and how that has changed over the course of the winter?

Professor Ham: Yes, thank you. Our view from the Fund, looking at the data and experience across the NHS, is that the recent problems are a result of increasing demand for emergency and urgent care and constrained resources over the last four years. The presenting problem is in A and E around four-hour waits being missed, but the causes are many, varied and complex. We think the most important causes are outside hospital: the underinvestment in services in the community, including in general practice to help people to avoid going to A and E or becoming an emergency admission; equally, the lack of community services to support timely discharge from hospital once people have been admitted. For us, the issue is that we do not have a well-integrated urgent and emergency care system. It is often a confusing system. Patients do not always know where the best place is to go when they need support and help, and, not surprisingly therefore, some patients turn up at A and E when, arguably, they could be more appropriately treated

elsewhere. The solution lies not just in the hospital—and certainly not just in A and E—but in creating a much more joined-up and co-ordinated urgent and emergency care system of the kind that Sir Bruce recommended in his report in 2013.

Q3 Chair: Thank you. Dr Mann, are you able to give us an overview of where we are with the statistics this week and the course of the last few weeks?

Dr Mann: Yes, certainly. If we look at the number of attendances this year—in 2014—it was 14,631,000. That is an increase of 446,049 from the previous year. The interesting thing is that many people will describe that as only a 3% increase in attendances. That is certainly true, but the other way of describing it is to say that that is equivalent to eight or nine extra emergency departments, and, of course, we have not built, staffed or run eight or nine extra emergency departments in the last 12 months. The problem is that both those figures are true, and one of the perennial problems we have with large numbers and statistics around health is that small percentages of large numbers remain large numbers. If you want to diminish the size of the problem you refer to the percentages, and if you want to talk about the impact of the problem I think you should talk about the numbers. Of course, patients are integers; they are not fractions and they are not represented by percentages terribly well. The reality is that 450,000 extra patients have attended our emergency departments in the last 12 months, and, to be fair, the system has responded magnificently in coping to the extent that it has managed to do so.

The other important thing is that that rise in attendances is matched by a rise in admissions of about 7.3%. That is putting huge pressure on the acute medical units of our hospitals, in particular.

The other thing I would like to point out is why these people are attending. They are attending because they have been told to attend. If you look at the 450,000 extra attendances, about 220,000 of those relate to the increase in the number of patients NHS 111 has recommended should attend A and E.

Q4 Chair: Hopefully, we will be addressing that in more detail later on. The thing that has precipitated this hearing today has been the change in the targets and not breaching the targets. Is there any relationship between success and failure against those targets and the quality or standard of care that is delivered to patients?

Dr Mann: That is an incredibly important point and one that has not been well studied. The reality is that there are clearly consequences to unacceptable delays, in terms of accessing care and then being moved properly into a hospital. There is a phenomenon called exit block in our emergency departments and we know that is associated with morbidity and mortality.

The important thing about these figures is twofold. First, there is little difference, from a patient's point of view, if you are in the emergency department for 3 hours, 59 minutes or 4 hours, 1 minute, so we should not get too hung up about that aspect of it. Secondly, even if you are in the department for five or six hours, which is obviously suboptimal, as long as you are seen promptly and the correct treatment has been delivered, following the right diagnostic tests, your care and dignity are being maintained and the activities of daily

living supported, then little or no harm is likely to arise from that. Emergency department staff up and down the country are concerned that, when we see headlines about failing trusts and failing organisations, there is little recognition that the staff in those hospitals are doing a heroic job in delivering timely and high-quality care to the vast majority of patients they see.

Professor Ham: Can I add something on the evidence point because there is not a huge amount of evidence? The research that is usually cited in relation to your question about the relationship between waiting times and patient care—patient outcomes—comes from Australia. We can pick holes in any research project, but my reading of that evidence is that it does show a relationship, whether it is causal or not, between longer waiting times and higher bed occupancy in hospitals and poorer patient outcomes, as Dr Mann has said, in relation to morbidity and mortality. So quick access is not just a matter of patient convenience. If you look at that study, it is related to the outcomes of care for patients.

Dr Mann: To pick up on that again, sorry—not to appear as a double act—the issue here is that the one way in which you can increase the numbers of delays in people getting into hospital is to have a thing called exit block. If you cannot move patients promptly, they are much more likely to end up on the wrong ward. They will just go to the first bed that is available. The best way to increase somebody's length of stay is for them to be on the wrong ward to start with. If you have to be moved from one ward to another, you guarantee your length of stay will go up by at least 24 hours. There is no better way to increase exit block than to increase the length of stay for the patients you have just admitted to the hospital. The phenomenon itself becomes self-perpetuating to some extent, which is why it is such an important area.

Q5 Chair: I know a number of colleagues want to come in, but I have one more question to ask. Once you have a major incident declared within a hospital, can you elaborate on the impact that has on not just the trust in question but also on the rest of the health community, and, of course, further down the line whether you are expecting that to impact on other things such as waiting time targets? Perhaps, Professor Ham, you would like to start.

Professor Ham: A major incident is really declaring to the local community and all the other partners in health and social care that there is a serious pressure within that acute hospital and that they need to be aware of that in relation to referrals of patients and how GPs and others can contribute to reducing that pressure, as well as clearly being a signal within the hospital of “All hands to the pump” and for everybody to help out in very difficult circumstances. We are beginning to see—and there is evidence of this too—that, because longer waiting times and higher bed occupancy are closely linked and also linked to growing numbers of delayed transfers of care, in part because of what is happening in social care at the moment, many hospitals are having to cancel planned operations, planned admissions and people are waiting for cataracts, hips and knee procedures, for example. It is likely, in our view, that that will then have a measurable impact on the other key waiting times—hopefully not on cancer waits because we all see that as being a very high priority—certainly on the 18-week target, which is already under pressure. This reflects that we are talking here—to be a bit technical—about a complex adaptive system in health and social care where changes in one bit inevitably impact on changes in the

other bit. So, today, we might be debating the four-hour target, but maybe in a couple of months' time we will be debating the cancer waits and the 18-week targets.

Chair: Thank you. I know Andrew wants to come in.

Q6 Andrew Percy: I thought Dr Mann's point was important about 4 hours, 5 minutes versus 3 hours, 59 minutes. I had a constituent recently who waited six hours but was very concerned that that was seen as a failure when they had very clearly received excellent care and had not minded about that. It is important.

The point I want to ask about is how many patients are breaching because it is simply not safe to move them. I spent some time in A and E just before Christmas with staff on a shift who said that they are seeing more patients who it is simply not safe to move within the four hours. We had a case of a diabetic collapse of a lady who was being pumped full of fluids and all the rest of it—I think she was on KBA, whatever that means—and consequently they said, "Look, she'll breach, but we can't move her because it is not safe to move her." Are we seeing more breaches because of that, as people are often older and frailer as well, and, if so, do we know what percentage of breaches that relates to?

Dr Mann: We do not have the precise figure that you would like. The first point is that the 95% was introduced so that five in 100 patients can wait more than four hours in the emergency department and that is probably sufficient for the clinical necessity group. You would not expect more than five per 100 people in most emergency departments to require to remain in the emergency department beyond four hours.

The second point is that the data around how many people are breaching simply because we cannot move them on to a ward is much more difficult to extract from the current data because you have to confuse two things. The first is the time a person arrives to the time they leave, which is difficult, shall we say, to interpret creatively—that is the four-hour standard. One of the great values of the four-hour standard is the fact that it is very difficult to game. The other figure you then need is the trolley-wait time. Unfortunately, with the trolley-wait time, while it is clear that the end point is that at which you move from the department to a ward, the starting point is not at all clear because it is the time that the decision to admit was made. In a busy emergency department, when it is self-evident that a person is going to be admitted, people often do not bother to write into the computer that actual time to admission time was 11.14; it was obvious to everybody that this person was going to be admitted the moment they were brought through the door. But if you do a sort of best-guess analysis of that, you can see that about 50% of the patients are breaching the four-hour standard because of what we would call exit block, that is, the inability to move them in a timely fashion from the emergency department when it is safe to do so to a ward, and probably less than 50% are due simply to the numbers of patients presenting at our emergency departments.

Q7 Chair: Just to clarify a final point, is there any danger that hospitals' emergency departments, in order to satisfy the targets, will be putting that ahead of clinical priorities?

Dr Mann: I have not seen any specific evidence of that. There was anecdotal evidence of that. It was not over this winter, but one of the pernicious problems with the four-hour

target, which overall has been a very positive measure for emergency care, is that, again, because it is a percentage target, if you are really struggling to hit the target it makes sense sometimes to devote more resources to patients with fairly minor illness or injury who can be got through in fairly short order and in that way, say, 10 or 20 of those patients might be processed and seen within an hour or two, whereas it would take the same amount of time to see a single or possibly two patients with a major illness or injury. We have always guarded against that as a college by emphasising the fact it is not the target that is the prime driver of what we do in emergency medicine; it is the delivery of appropriate and timely care to those patients most requiring it.

Q8 Andrew George: On the point about the pressure in the service itself—and certainly, Professor Ham, you were talking about the problems from outside the acute hospital itself—the fact is that we have proportionately fewer acute hospital beds per 1,000 of population in this country, significantly less than, about half of, the EU average. France and Germany have significantly more than the EU average. The assumption is that that is not a moveable feast—that somehow that is where we are and nothing can be done about it. The position that we are in is not the result of some kind of accident; it was a conscious policy over the last decade or more. This is the NHS Confederation booklet on “Why we need fewer hospital beds” in 2006. It was a conscious effort to reduce beds. So most acute hospitals either do not have enough acute beds or have just enough so that when a crisis comes they are unable to manage that crisis or end up admitting patients on to the wrong ward, hence resulting in a worse outcome. Do you not think that, as to the overall number of acute hospital beds in our acute hospitals, having surplus capacity rather than just enough or not enough, is an important component part of finding a solution?

Professor Ham: Can I agree and disagree? I agree that there has been a measurable reduction in the number of acute hospital beds over the years, and certainly our numbers are low by comparison with most other comparable countries. But it is not the number of beds; it is how they are used, and particularly it is the flow within hospitals that really matters. If you look at NHS acute hospitals and how they use their beds, there remain wide variations in admission rates and length of stay—delayed transfers of care. If our worst acute hospitals achieved the same standard as the best, then we could probably cope with the number of beds we have at the moment. If the issue is more to do with flow, then we need, yes, to look at the number of beds but also at what are the other services outside the hospital that cause this increase in delayed transfers of care. Social care is one factor; we know there have been cuts in social care in the last four or five years and far fewer people are receiving publicly funded social care support. That is one consideration in explaining the increase in delayed transfers of care. Having said that, the evidence seems to suggest that about two thirds of the causes of delayed transfers are within the control of the NHS itself. There are blockages within acute hospitals because of lack of co-ordination between different specialties. So there is much within the NHS that can be done to improve that too.

Q9 Andrew George: The system cannot be perpetually at the top of the game throughout the whole system itself. Why are we in a situation where we have pursued a policy of cutting beds before we have made sure that the system outside the acute hospital

itself is capable of discharging patients and avoiding unnecessary admissions in the way that, theoretically, people like you perpetually tell us that is how the system should work? It clearly has not. You need to have achieved that before you cut the beds, but you have cut the beds before you have capacity outside the acute hospital system itself.

Professor Ham: That is where I agree with you.

Q10 Andrew George: It is extremely dangerous, don't you think?

Professor Ham: Yes. If you cut the beds without first of all building up sufficient out-of-hospital community and primary care, social care and out-of-hours services, it is a fairly safe prediction that when the pressures increase, as they have this winter, you will experience the problems that we have this winter. I was looking at the numbers yesterday in preparation for today: we have seen a decline in the number of district nurses working in the NHS.

Andrew George: Exactly.

Professor Ham: We hear a lot from the College of GPs about the pressures facing general practice and I have alluded to social care already. We have to look at this as a whole system—that is the only dissent I have—not just looking at the hospital and the number of beds.

Q11 Andrew George: So we should increase beds. Do you agree, Dr Mann?

Dr Mann: I am not an expert on this area. I manage the front door of the hospital, as it were, but I think we were probably coping reasonably well, until this winter, with the bed stock we had and the point that, “We have these delayed discharges means that there is capacity within the system if only we could free it up” is certainly true. The latest figures we have are that for December there were 20,382 bed days lost due to nursing-home placement or availability, which had gone up 6,000 from the same period last year. Clearly, if all those patients had been able to move in a timely fashion to wherever it was we were hoping they would go, we would probably have had sufficient bed stock.

The other point is that most patients who are in hospital who do not need to be in hospital do not want to be in hospital. They would much rather be in their own home or a community care setting and so on. So I would be keen to support a more efficient way in which we can discharge people from hospital in a timely fashion than simply building some more wards.

Chair: There is one final quick point from Charlotte and then we are going to move on to our next questions.

Q12 Charlotte Leslie: This follows on from what Andrew said and I am going to furnish it with a tangible example. Southmead hospital in my area was rebuilt—we had a brand new, great PFI hospital—with fewer beds than it originally had, with a massively growing demographic in the city. Anyone who knew the area at all said, “This is bonkers. We are going to need more beds.” Lo and behold, the minute it opens, there is a massive A and E

crisis. Can you appreciate the kind of disconnect, of what people see on the ground—of course, in an ideal world you would have great community settings and care in the community—between common sense and what people theoretically think needs to happen?

Professor Ham: Absolutely. Unfortunately, neither Dr Mann nor I is responsible for the PFI policy. You may want to ask some of your later witnesses about that. But we know that, in many parts of the country when a PFI hospital has been built and because of the cost of PFI, there has been a big reduction in the number of beds in the new hospital compared with the old hospital, some of which is justified but some of which is driven by a concern to make the cost affordable to the NHS. There are one or two good examples of more innovative PFI schemes. I can think of one in the west of Birmingham, for example, to replace two or three local very old district general hospitals, which is a whole community PFI, so it is an investment in the out-of-hospital services as well as the in-hospital services.

Chair: We are going to come on to the next group of questions with Andrew.

Q13 Andrew Percy: The Association of Ambulance Chief Executives were in the news over Christmas regarding the proposed changes to the eight-minute target. What is your view on that? Is it a sensible move, if it were to happen, or would it put patients at risk?

Dr Mann: It is a sensible move, as a headline statement. We are talking about the red 2 categories, not the red 1—not the immediately life-threatening problems, which would be unchanged. The red 2 category required an 18-minute response time, and for many years that seemed quite appropriate. As the demands on the ambulance service have risen, it is quite clear that the red 2 is a very broad category, and treating everybody in the red 2 category with the same degree of urgency is no longer clinically sensible or logistically possible. There are a number of examples I could give. Each example I could give, I am sure, will cause dismay to a certain patient group, so I say this only inasmuch as there are many examples that could be given but take this as an obvious one.

If you are in front of somebody who is clearly, to you anyway, having a stroke—they have suddenly got a facial droop, lost the use of an arm or leg or the power of speech—it is sensible to dial 999 and for an ambulance to be dispatched immediately. If, however, you are living in a residential or nursing home and when your carer comes in in the morning it is apparent that over the course of the night you have had a stroke, which may have been five, six or 10 hours ago, then, of course, an ambulance needs to come to you and you need to go to the hospital to have the same imaging and stroke care, but the priority to get the ambulance there—the difference between eight minutes and 18 minutes—is no longer of any clinical justification whatsoever. It is about taking a more balanced view. A key thing in the proposal was that they would simply allow themselves rather longer to ask certain questions over the telephone before the ambulance was dispatched. So, instead of being dispatched immediately, they would give themselves 60 to 90 seconds to do a little more triaging, ask some more questions and determine whether this is a stroke that has happened now or one that may have happened at some point in the last 12 hours. That is an appropriate way in which we should use ambulance resources, otherwise we are dispatching vehicles at high speed, with inherent dangers, when the clinical necessity no longer justifies that.

Q14 Andrew Percy: Thank you. One thing we have talked about in the past also is using the ambulance service differently. I was hoping we were going to see some examples of these community paramedicine models that are operating in other parts of the world where advance paramedics are used to treat people at the scene and to discharge to either their home or to refer into other services. We have talked about that in the past and I know it is an ambition of NHS England to achieve a different use of our ambulance services. Do you see that as happening, because the suspicion is probably that it is not happening very quickly, if at all? What are the main impediments, apart from the huge pressure we have had at the moment, to it happening in your opinion?

Professor Ham: My view on that is, yes, that has to be one of the key components of a properly integrated urgent and emergency care system. We have some good examples. The challenge at the moment, certainly in some parts of the country—and London is a good example of this—is recruiting and retaining enough of the paramedical staff who will deliver the service in that way. One of the explanations of the pressures around the ambulance service is the sheer difficulty of doing that.

Dr Mann: We also know there are currently, as yet not entirely explained, differences in ambulance conveyancing rates. If you look at the north-west of England, the ambulance conveyancing rate is in excess of 80% and in the south-west of England it is less than 50%. As yet, we do not fully understand the reasons for that. Supporting paramedics in making front-line decisions is going to be an increasingly important way in which we can diminish unnecessary transfers to hospital, but for that to work—and this will chime with what I say later about NHS 111—we have to give paramedics options. If the only option is to take someone to an emergency department, it is not surprising that people take them to an emergency department. If we give them the options of being able to contact and have available a district nurse, a GP in the community, a mental health team, a Macmillan nurse or a palliative care nurse—whatever it might be—with a realistic prospect of being able to speak to that person and then that person being able to subsequently visit the patient in their own home, that is the way in which patients would want to be dealt with and that is sensible for the whole health care system.

Q15 Andrew Percy: Thank you. There has not been any mention of tariff as an impediment, or indeed skilling up, because for a lot of these more community-based paramedicine models it is these “advanced emergency care practitioners”—I think they are called—who are required. You have not mentioned that at all. Do you see those as impediments at the moment?

Professor Ham: The tariff at the moment intentionally penalises hospitals for treating more patients at the front door. It was well intentioned in its design around trying to create more incentives for commissioners, in particular, to provide the other services that would avoid the flow into the front door, but, clearly, looking at the numbers, that has not happened. Again, this is an issue you may want to explore with some of your other witnesses. I know a lot of work has been going on through NHS England and Monitor to devise a very different way of paying for urgent and emergency care that is not based on paying for activity and certainly is not based on paying 30% for each extra patient over the 2008 threshold coming in, and the faster we can migrate towards a more rational system, aligned with patient needs and patient care, that will get us closer to a solution.

Chair: Robert has a very quick question and then we are going to move on to Valerie.

Barbara Keeley: Can I ask one too?

Chair: Yes, sorry.

Q16 Robert Jenrick: My question has largely been answered, but, as a separate question, one of the frustrations that the public often experience is the sight of paramedics queuing up with, broadly speaking, stable patients. I spent time in an A and E the other day and there were eight teams of paramedics all with patients who were, by appearances at least, stable. Is there anything more that could be done to tackle that apparent inefficiency in the system? I know that paramedics have great concerns about the idea of handing over to another team of paramedics before they could be handed over to A and E because they feel, obviously, that they have a lot invested in ensuring that their patients get the proper treatment and that nothing is lost in the process, but it does seem one of the obvious inefficiencies in the system that you can have in an A and E 12 paramedics waiting with, broadly speaking, stable patients.

Dr Mann: Yes. The paradox here is, given what is currently happening, do you create a system which will mitigate its effects or do you try and sort out the problem so that you do not have this in the first instance? I would much rather we sorted out the problem of flow through our emergency departments rather than trying to hide it by the fact that we discharge the paramedics quite quickly and leave another group of clinicians, or whoever, to act as caretakers before patients can be admitted to a proper emergency department cubicle. At times of particular peak activity, such as we have seen over the last few weeks, it is probably sensible to have a more rational coping strategy, which might mean the ambulance service and the acute trust agreeing to employ more nurses or health care assistants in the emergency department to oversee the care of those patients until they can be put into an emergency department cubicle and therefore relieving the paramedics to return to the front line. But I do not think that should be the standard *modus operandi*, if you like, because that would simply entrench bad behaviour and a system that is not well designed.

Q17 Barbara Keeley: I want to come back to Dr Mann's point about options with the ambulance service and arranging visits of a district or hospice nurse. I understand that we have less than half the number of district nurses—that it has gone down from 12,000 to 5,500. Is what you have said, which sounds very sensible, a realistic option anywhere in the country? I cannot see any part of the country where they have spare district nurses. In fact, it is surely going to take us quite a long time to get back up to anything like 12,000.

Dr Mann: I agree. I was not talking about the current system but what I would hope the system would be. Again, there is little point training emergency care paramedics to a higher standard to be able to make decisions as to what the most appropriate form of care is, only for them to find that there is not that most appropriate form of care accessible, which is exactly the problem that has happened with NHS 111 and the gap in the directory of services that they were supposed to be operating from.

Q18 Barbara Keeley: I understand the issues, but I just know the numbers are such a problem, are they not?

Dr Mann: Yes. With the halving of district nurses, as you say, it is going to take some time to turn that round.

Barbara Keeley: Thank you.

Q19 Valerie Vaz: Can I start by saying thank you to both of you for coming today at short notice, and I know, Dr Mann, you have had to catch an early train having worked last night?

Dr Mann: I did manage to swap the shift so I cannot take credit for that.

Q20 Valerie Vaz: It is good to see you all here. Let us talk about money. Some money has been available. Could you give us a snapshot of your members around the country as to where that extra money has come from, where it is going to and whether it is reaching the right places?

Dr Mann: You are quite right and my college is very exercised by the fact that £700 million winter pressures money was announced last June, it was disseminated to different CCGs and the purpose of the money was to diminish the number of A and E attendances and admissions over the winter period. It is self-evident that that has not been entirely successful, if you look at the figures, and we are also not convinced that the money has necessarily been invested in the schemes that were envisaged in the winter planning guidance “Building Resilience” that was published by the arm’s length bodies back in June. We are so concerned that we are in the process of doing an FOI request for chief executives to find out how much of that money went to their acute trust and, of that money, what was spent in which departments of the hospital, because it is clear that, while some money has certainly got to front-line services, that is a very geographically patchy finding and there are many emergency departments which appear to have seen none of the money.

I agree with Professor Ham that we should not have spent the £700 million entirely on emergency departments—that would be absurd—but the two key things to come out of the figures for this winter show that the real pressures have been in our emergency departments and medical assessment units, similarly moving patients in a timely fashion out of hospital. That is not a surprise; we could have predicted that from what happened last winter, the winter before and the winter before that. I would have thought the vast majority of those moneys should either have gone into front-line services, into EDs or MAUs, or into getting patients in a timely fashion back to a community setting.

Q21 Valerie Vaz: To clarify and expand a bit, is it going to different places? Is it going to CCGs and some of it going to the acute hospitals, or do you absolutely not know? The reason I ask is that the Secretary of State did invite me to give him examples, so I am happy for you to write to the Committee and we can forward that on to the Secretary of State. That would be very helpful.

Dr Mann: I will certainly do that. The money was distributed to CCGs for it to be invested in the local health economy. Similarly, the 70% withheld from the tariff to hospitals for acute care that Professor Ham was talking about was to be returned to the system resilience groups, as they are now called. Again, that money was supposed to be invested in coming up with ways in which we could reduce the numbers of people attending emergency departments and being admitted from them. Again, we are wholly unconvinced that that 70% of withheld moneys has gone into those sorts of schemes.

Q22 Valerie Vaz: Professor Ham?

Professor Ham: I cannot add much to that. I would agree with what Dr Mann has said. The only obvious point to make is that £700 million extra has been put in, which clearly is welcome, at a time when we know the NHS itself is running more and more into deficit. The evidence from Monitor about foundation trusts and the Trust Development Authority on trusts shows a significant proportion of providers, including acute hospitals, that will not balance their books this year. I do not know—I cannot say this for certain—but it will be a surprise if some of that money were not being used to paper over those financial cracks as well as being put into front-line services. But there are other witnesses better placed to give you an authoritative answer to that question.

Q23 Valerie Vaz: To pick up on the tariff point—we had Monitor before us and there was a consultation that went out over Christmas—could we have your comments on the tariffs?

Dr Mann: Yes. The current tariff system is wholly unsuited to the purpose to which it is intended to be applied. The marginal tariff means that each acute trust loses between £1.5 million and £3.5 million a year. The net effect is that acute trusts are about £0.5 billion in deficit because of the marginal tariff. The marginal tariff is particularly iniquitous because it was designed to try and discourage admissions to hospital, but it has created the acute hospital admission as being the cheapest possible option—and often the only available option. The combination of both convenience and low price means that it has not had that effect. If you were serious about trying to reduce the number of admissions to hospital, you would have a marginal tariff not of 30% but 130% and be charging people more for the admissions beyond the 2009 threshold.

The 2009 threshold does not make much sense. It was an arbitrary threshold and the demographics and geographical arrangements of hospitals, particularly their catchment areas, have changed substantially over that time, meaning that some hospitals are particularly penalised by that. The 30% tariff was based on no particular evidence. I have not seen any justification as to why 30% was chosen as opposed to 60% or 75%.

As I said, the other ways in which acute trusts are being penalised is through the ambulance handover targets. Any ambulance handover over 30 minutes can be penalised by financial penalties of £1,000 or more. Again, many trusts have had to pay out substantial sums of money to ambulance trusts to meet those penalty charges. The acute trust, therefore, finds itself being constantly penalised for treating the acutely ill and injured. As I have said before, it is fairly strange that hospitals that were set up in the 14th

century to treat the acutely ill and injured in 2014 are being penalised for doing the same thing.

The only way, therefore, to balance the books is to do something profitable. There are two profitable ways in which you can deliver health care in the NHS. The first is specialist commissioning, which the teaching hospitals do most of; all that money is top sliced. The next way is through elective care. Elective care tariffs generally allow efficient hospitals to make a profit. What the poor acute hospital—particularly if it is not a teaching hospital—has to do is ever more elective care to cross-subsidise the loss-making acute care. The only way to pay for my mother's community-acquired pneumonia is to pay for my father's total hip replacement. That is the way in which it works. Of course, the problem with that is that, if you are doing ever more elective care, you have to have ever higher occupancy rates in your hospital, which diminishes the efficiency of your hospital, but particularly means that there is absolutely no prospect of it coping with sudden peaks in acute activity, which leads to the problems we currently have.

Q24 Valerie Vaz: Great. That is a fantastic essay—wonderful. Can I turn on to locums in relation to this extra money, if you are able to deal with that? I do not know if you have seen the anonymous diary of an A and E doctor in *The Guardian* that was being serialised, but half of the problem about locums is that he—I think it was a he—is taking them through the processes rather than helping them to treat patients. Could I have your comments on how to slightly fix that locum problem in the short term?

Dr Mann: Yes. I have no problem with locum doctors; they have been part of all services in the NHS since it was formed. The problem is the proportion of shifts that are now being covered by locums, so 25% of senior doctor positions in A and E are now covered by locums and £150 million was spent last year on them. That is enough money to fund a doubling of NHS A and E consultants tomorrow and still save money. The problem is that we are spending a lot of good money trying to create a short-term fix to a problem that needs a more sustainable solution. You can add to that—while I am on it—that we have spent £250 million training the doctors who now work in emergency medicine in Australia because there are almost 500 UK-trained emergency medicine doctors in Australia; 95% of them love emergency medicine and plan to stay in emergency medicine, but 92% of them do not plan to come back to the UK to do that. So we have £150 million plus £250 million, and then there is £700 million which we have spent on winter pressures money. That is £1 billion. That is more money than it costs to run every emergency department in the UK for a whole year, including the doctors, nurses, porters, receptionists, trolleys, drugs, equipment, tea, coffee, curtains, the whole kit and caboodle. So we live in austere times, but 50% of the money we spend currently on emergency pressures is not completely wasted but is certainly inefficiently spent because we could spend far less than that and have a safe, sustainable system at lower cost and higher efficiency.

Professor Ham: Could I add a brief rider to that? I asked my colleagues to pull off some figures from the Health and Social Care Information Centre yesterday for today looking at the trends in medical staffing in emergency medicine compared with other specialties in the NHS. These are data from 2002 to 2012. The figures are that there has been a 77% increase in doctors working in emergency medicine over that 10-year period and a 49% increase in all other specialties. I am not denying there are pressures and difficulties in

recruiting in emergency medicine, but there are pressures right through the NHS too, as these figures very clearly demonstrate.

Dr Mann: There are. I would respectfully point out that, again, this is an issue of percentages rather than absolute numbers. When I was working in my emergency department in 2002 there were two of us. So obviously when we got to four we had doubled the number, and when we got to eight we had doubled it again, but there are still only eight of us. Eight doctors trying to provide a service, 16 hours a day, seven days a week, 365 days a year is just about possible and we do that, but if you start with a very low basis, obviously a percentage representation of your increase may slightly flatter the reality, whereas if you have a department of anaesthesia in a general hospital you will have 50 anaesthetists, and in a teaching hospital you might have 200. So if you were to increase that number by 20, you still have only gone up by 10%.

Professor Ham: My only other rider would be that we know more and more, do we not, that if you have senior medical presence at the front door of hospitals, not just emergency medicine consultants but geriatricians and psychiatrists increasingly, that is incredibly important in terms of timely treatment and flow of patients throughout the hospital? The best hospitals already do that. It has to be multi-disciplinary.

Valerie Vaz: Consultants have been available on the end of a telephone rather than being present on those particular disciplines rather than emergency medicine. Thank you both.

Q25 Charlotte Leslie: What are the main barriers to recruiting more A and E doctors? Is there a short answer to that?

Dr Mann: There is a short answer. There is no barrier to recruiting A and E doctors. We have always recruited in year one at 100% and this year we have managed to increase the number of posts with Health Education England and the Department of Health from 220 to 320, and we filled all those. Our problem is retention. Having spent three years in emergency medicine, they take one look at it and say, “To be honest, compared with all the other specialties, the work-life balance here is so poor, the daily work experience is so poor, that I cannot really see myself doing this for another 38 years.” What we have to do is change the way in which we treat acute hospitals so they invest in their emergency departments to make them less stressful places, and we have to give people a contract which does not pay them more money but allows them to have an equitable work-life balance with people who work fewer nights, evenings and weekends.

Professor Ham: I have a small point, and I think we are agreed because we have talked about this before. Increasingly, we know that having GPs co-located in A and E can make a contribution, particularly if you stream the minors from the majors and you have GPs and nurses helping to focus the expertise of people like Dr Mann on those who really need that expertise.

Dr Mann: You will be aware of our STEP campaign. The P of STEP is “primary care co-location”. That is how agreed we are on that particular point.

Chair: Thank you.

Q26 David Tredinnick: I want to ask you about patient demand. Do you think that the problems that A and E are facing at the moment can be attributed to changes in attitudes in society whereby certain patient groups, such as young adults, will not wait to see a doctor in three days' time but just turn up at A and E because they want instant solutions? To what extent is there a change in culture that is aggravating the problem?

Professor Ham: My answer is, yes, in part, but if we think about the big issues—and I will come back to the specific—facing hospitals, they are particularly the growing number of older patients, frailer patients, patients with more complex needs, who really need to be in A and E and then need to be admitted for diagnosis and proper care before they can be discharged back home. I spent a day before Christmas in a very busy A and E department west of London and I saw this with the evidence of my own eyes. Of course there were younger people wanting treatment here and now, not prepared to wait perhaps for a GP appointment, but by far and away the bulk of the patients on that day—and I would say across the NHS—do not fall into that particular category. In so far as they do—and I think there are changes in attitudes and expectations—I do not think, in any sense, we should blame people for turning up to A and E and using it in that way. It may not be the most clinically appropriate thing to do, but given that we have my starting point, a fragmented and quite confusing system, and if people know A and E is open 24/7, and that is the only bit that is open 24/7, why would they not turn up at A and E? If people are choosing to do that, should we not start putting the services there for them, whether they are the GPs, the nurses or the emergency medicine specialists, rather than trying to divert them to more appropriate alternatives?

Dr Mann: I agree. I do not think there is much evidence that there has been a surge in people aged 18 to 30 using our emergency departments. Certainly, given that the real pressures have come since October of this year, I would not have thought that the behaviour of young people would have been any different in June, July or August from how it is in October, November or December, particularly if they are not likely to be the people who suffer with long-term respiratory complaints which might be exacerbated by the weather at that time of year.

This may be an appropriate time to point out that the reason these people are attending our emergency departments is because we have told them to. The NHS 111 figures are very interesting. Of the 450,000 extra attendances in the last year, 220,000 were advised by NHS 111 to come to the emergency department, and for another 220,000 an ambulance was dispatched to them by NHS 111. If you put those figures together, you have more than 95% of the rise in type 1 attendances. So I do not think you should blame people for attending the emergency department when we have told them to go there. It is absurd.

Q27 David Tredinnick: Thank you. I have one more question following on from that. The NHS England recent Board paper on the urgent and emergency care review recommends providing better support for people to self-care, and certainly my generation were taught to try and solve their own problems before they turned up at a doctor's surgery. On Friday at Hinckley in my constituency at the health and wellbeing board which I attend—or it may be called a committee; I forget—we were talking about providing a directory of care, of alternative services, such as exercise classes where people can go and get other

advice before they even get to a doctor's surgery. Is there not a fundamental philosophical issue here that it is not just A and E that we have to stop patients going to, but we have to take the pressure off doctors and use all the range of properly regulated—by the Professional Standards Authority or other authority—services that can assist doctors so that we reduce demand across the NHS?

Professor Ham: Yes. Successive Governments have tried to do that with things like the Expert Patients Programme and particular examples for patients with specific conditions such as diabetes, and there have been public information campaigns about “Go to the pharmacist,” rather than to the hospital or the GP, but we cannot, Canute-like, turn the tide back. If there is that change in expectations and behaviours that is causing people to work in that way, we should not give up providing information and trying to shift people's behaviour, but we should not hold out huge hopes that that will make a big difference.

Q28 David Tredinnick: It is a very defeatist approach, I have to say, Chair, to say, “We can't change it.” It is about change. We are trying to make changes to improve the condition of the people. That is our job as politicians, to use the old-fashioned phrase.

Dr Mann: There are two things here. First, the Commonwealth Fund published a report about 12 months ago looking at the proportion of patients who use an emergency department in all the developed nations' health care systems, and the UK is third from bottom. People in France, Germany, Holland, Spain and Italy all use their emergency departments more than our patients do. So I do not think we can suggest that there is a tsunami of British emergency department patients.

The other problem we have is that we have worked really hard through our public health campaigns. I can tell you the ones which work and the ones which do not. The ones which work are the ones that say, “If you get sudden chest pain, dial 999”; “if somebody thinks you are having a stroke, dial 999”; “if your child has a rash that does not blanch, dial 999”. The ones that do not work are the ones on the sides of buses saying, “A and E won't make it better”, “won't kiss it better”, or “won't put a plaster on it”.

So I agree entirely with Professor Ham here. We do not have an excess of patients. As a front-line emergency medicine consultant, for most of the people I see in my department, I do not think, “You should have gone to an exercise class. You should have gone to your community pharmacist. You should have gone to these various options.” All those have a real part to play in global health care, but not on the acute side or the presentation. Most people present with acute illness or injury, or at least the fear that they have an acute illness. Our college did some work earlier this year—we published it for the Sentinel Sites survey—which demonstrates that 15% of patients across the board could easily be seen by a less acute setting, preferably a co-located primary care centre; 15% does not sound a lot, except that these are big numbers, so that is 2.1 million people. If you took 2.1 million out of the emergency departments of the UK tomorrow, you would substantially decongest them. That is why we are calling for co-location of primary care.

Chair: I am conscious that we have a number of questions to get through, so I am going to come to Barbara next and then have a little wrap-up at the end.

Q29 Barbara Keeley: I want to go back to the issue of the availability of social care. Clearly we know that £3.5 billion has been cut from adult social care budgets, and 90% of councils are now only offering substantial and critical care. In terms of my local area, that means that 1,000 people are losing their care packages this year alone and we can see that that must be having a substantial impact. In fact, both our local hospitals in Salford declared major incidents last week, so my fear about this was that would happen, and it seems to have.

We have touched on delayed discharges and we know that they have increased by 20% compared with the same period last year. Professor Ham, you touched on this earlier and put two thirds of those delayed discharges down to lack of co-ordination between the specialities. But I think poor care or lack of care must surely lead to increased admissions as well as delayed discharges. It is not just a question of exit blocking. Some of those people are there because they were not getting the care that they should have had in the community. Can you say—I think this whole question of social care really hit the news last night in a major way and perhaps it has been ignored a bit too much—what impact you feel the availability of social care is having and should this be more of a policy priority for us now?

Professor Ham: It is having a big impact and of course it should be a much bigger priority. Can I make two or three quick points? One is that we rely on the official definition of “delayed transfers of care”. There is a good debate to be had about how accurate they are. Anecdotally, when I talk to medical directors and chief execs of acute hospitals, they will tell me that the actual number of delayed transfers is much bigger than the officially reported, official definition of what a delayed transfer is. That, I suspect, is behind some of the pressures we have seen recently. Just to reiterate—the point you have acknowledged there—most of the causes, though, seem to be within the gift of the NHS, including of hospitals, to sort out if they were better organised around the flow of patients. Nevertheless, if you have a quarter fewer people today receiving publicly funded social care compared with 2010, that is bound to be one of the factors behind the pressures that we are discussing. We know too, do we not—I worked closely with, though not so much recently—from colleagues in Torbay that they achieved, certainly from 10 years ago for a number of years, good progress in reducing emergency admissions, virtually eliminating delayed transfers of care in Torbay hospital because they had these fully integrated district nurses, social workers and therapists in their locality teams?

Q30 Barbara Keeley: But there are very few places where that works. The problem with focusing on Torbay is that I was talking about Salford, a place where 1,000 people are losing their care packages. Focusing on the best does not help us at the moment.

Professor Ham: I would agree with you and add, too, that Torbay achieved that success when the NHS budget was growing by 7% or 8% in real terms. How much more difficult it would be today if you were starting from scratch in doing it. Clearly, the direction has to be much more integration of health and social care budgets, health and social care services and integrated teams.

Q31 Barbara Keeley: But if you integrate them without increasing them, are you helping? It is going to help a bit.

Professor Ham: If I can invoke Sir Bruce’s boss here, Simon Stevens said—and it may have been to this Committee—that, if you merge two leaky buckets, you should not expect

to get a watertight solution. So it will help, but there is an issue about the quantum of resource we have in the NHS and social care as well as whether we have a single budget. I would argue strongly for more money and a single budget.

Dr Mann: The other point I would make—and I have no expertise in this area other than my personal experience—is that the problems with social care are much greater in terms of timely discharge from hospital than the cause of admission to hospital. My own experience is not that I see elderly people who have ended up in the emergency department because their package of care has been cut or not started. That is not something I see, but I do know from speaking to my colleagues in the hospital that lack of social care packages is a real barrier to timely discharge from hospital.

Chair: Andrew, we are going to have to move on.

Q32 Andrew George: There is an assumption in the system itself that somehow the unavailability of GPs is one of the causes of increased pressure on the A and E service. Especially in the winter months when, contrary, I think, to public expectation, attendances, as I understand it, are lower than in the summer but admissions are higher, to what extent could you say that improving access to GPs, particularly out of hours, would have a significant impact on the pressures that you experience in the A and E departments?

Dr Mann: If I can show you this graphic—I know you cannot read any of it—you can see the spikes. The spikes are the weekends. Those are the dispositions by NHS 111 of patients who called NHS 111 to their local emergency department either by ambulance or they are told to go there. It is not plausible that there is a change in illness on a Saturday and Sunday compared with Monday to Friday. It is slightly more plausible—

Q33 Andrew George: It is possibly alcohol, which you might have a view on.

Dr Mann: There is an issue around alcohol, but that does not explain it. It is plausible that you may have more injuries due to sports and DIY accidents, but I can tell you that they do not account for the whole peak. The reality is that, not just in primary care but throughout the health and social care systems, there is a lack of availability of seven-day services—not completely, but it does mean that accessing those services on a Saturday, Sunday and particularly on a bank holiday are much more difficult than they are on a working day, Monday to Friday. For as long as that persists, there will have to be a default option and currently the default option is the emergency department.

Q34 Andrew Percy: I was interested in something you said, Dr Mann. I have always thought this assumption of social care reductions and a rise in the attendances is somewhat sloppy, given that we have been seeing social care criteria being cut for the last 10 to 15 years. When I was a local councillor in the mid-2000s, we changed our criteria from moderate to severe, and indeed my other local authority has kept it at moderate, and yet we are still seeing the same pressures. That was quite interesting. Throughout the whole session we have heard about a lack of social care, community services and care in the home and all the rest of it as perhaps being drivers, but then you gave the statistic that we have the third

lowest attendance rate in western Europe, or in whatever the basket was that we were being compared with. Does that not really rather suggest that we do not have a lack of alternative provision? Perhaps compared with other countries we have rather more alternative provision. In primary care, a lot of my area has received large amounts of immigration from eastern Europe, and one of the pressures that the hospital has told me of is that they have people coming from countries where it is not normal to access primary care in the way it is here and therefore people access A and E services directly. I cannot quite square how the two can go together—a lack of alternative provision but yet the third lowest attendance rates. Could you tell us what that basket was that we were being compared with—was it European or western?

Dr Mann: It was the Commonwealth Fund and it compared all the European countries, Canada, the United States, Australia and New Zealand. I can get that reference for you. You make a very good point that primary care in this country is world class and we would do well to invest more in it because we definitely need, as a population, to be able to access primary care for a greater proportion of the day and a greater proportion of the week than is currently resourced to be available. One of the ways we think that could be done without simply moving patients or making our life even more onerous for our already hard-worked GP colleagues is a co-located primary care centre—not 24/7 but for the out-of-hours periods—for patients who have an urgent health care problem, not for patients who have chronic disease management, for whom their family doctor is always going to be the best person to go to.

You make a reasonable point about the fact that there are many people in this country now who come from other countries where access to primary care is either simply not available or much less available than it is here, and where there are high populations of patients from other parts of the world then there is an increased use of emergency departments. That is certainly true.

In terms of the attendances, the attendance figure and the admission figure are really very different. When we are talking about social care budgets and the effect that they might be having, that is not likely to impact much on attendances but it is likely to impact on admissions, whereas with the total number of patients it is more about the attendances. I have rambled rather, but what I am trying to say is that about 30% of patients are admitted and 70% of patients are not. So if those patients who have less serious illnesses or injuries form the majority of people who present to an emergency department, and therefore if you are just looking at the raw data—or the summary data, rather—you are going to lose the effect it is having around admissions.

Q35 Chair: We have heard about the importance of all parts of the system working together more effectively and, Dr Mann, you have spoken about co-location of primary care in emergency departments. I had an e-mail from a health professional this week telling me that in their area people who attend the emergency department are then told to leave the building, phone 111 and then come back in again to attend the co-located GP service. Is that not an example of absurdly overloading the 111 service totally unnecessarily? Do you feel there are things like that that we have to address and deal with?

Dr Mann: This is a criminal waste of people's time, effort and money, both that of the patients and the organisations, and it should not be tolerated. There is no plausible reason

why that should be the system you put in place. It manifestly exists not for the benefit of the patients or the staff.

Q36 Chair: Thank you. I will pass on those thoughts and hopefully that will change. Would you agree, Professor Ham?

Professor Ham: I agree with that. I would add here that there is something about how we provide urgent care in primary care in hours as well as out of hours. If at 10 o'clock in the morning, when my GP practice is open, I think I have a serious problem, how does that practice respond to that problem to avoid me just picking up the phone or going into the walk-in centre or turning up at A and E? We have some great practice among some GPs in some parts of the country who make sure that a GP can be available on the telephone, for example, or an experienced nurse, and call you in and keep some vacant slots for that to happen if that is the appropriate thing to do. We need to redesign all parts of the system and how it currently works, both in hours and out of hours, and primary care has to be a big part of that.

Q37 Chair: If you had key recommendations for things you think would make the biggest difference—give us the biggest bang for our buck—what would they be?

Professor Ham: Short term and long term. In the long term, we have to create in every community a single, joined-up, integrated urgent and emergency care system where the component parts work as one, working, I would say, under a single budget. I did not respond to the point about tariff, but tariff is not fit for purpose around A and E attendances and emergency admissions. Tariff is really about planned and elective care and it should not be used for this purpose. I know there is work going on to find better alternatives. That is the vision we should all be aiming towards. We have been talking about it for as long as I can remember. The urgency now is making that happen. In the short term—we cannot wait for the long-term solution—it is about getting more co-location where that is appropriate; it is about the senior medical presence across the specialties at the front door of hospitals; it is about flow within the hospitals. Places like Sheffield Teaching Hospitals and South Warwickshire have shown absolutely that, if you get patients flowing through and flowing out and you keep the bed occupancy at the right level, you can deal with these pressures. Not every hospital has failed on the four-hour target. Many hospitals have delivered. In fact—let us make the point—most hospitals still treat over 80% or 90% of patients who turn up within the four-hour standards, so there is a lot to be proud of as well as concerns.

Chair: Thank you very much. Thank you for your time this morning.

Witnesses: **Professor Sir Bruce Keogh KBE**, Medical Director, NHS England, **Professor Keith Willett**, National Director for Acute Episodes of Care to NHS England, **Dale Bywater**, Director of Delivery & Development (Midlands and East), NHS Trust Development Authority, **Pauline Philip**, Chief Executive, Luton & Dunstable University Hospital NHS Foundation Trust, and **Jim Mackey**, Chief Executive, Northumbria Healthcare NHS Foundation Trust, gave evidence.

Q38 Chair: Good morning. Thank you very much for coming again at such short notice. I should start by saying that I know that, Jim Mackey, you have to leave early because your trust has Monitor visiting. We are conscious of that and understand.

Jim Mackey: That has been changed. So don't worry.

Q39 Chair: So that is no longer the case. Thank you for clarifying that. It does seem rather unfair that there are five of you on one panel and there were two on the last, but we now have more time. Could we start with the panel introducing themselves to those who are following this debate from outside this room, starting with you, Jim?

Jim Mackey: I am Jim Mackey, chief exec of Northumbria Healthcare NHS Foundation Trust. We are an integrated care provider, the most northerly in England. We run hospital services, community services, social care under a partnership agreement in one of our local authority areas, and, soon, primary care as well. Our turnover is about £450 million, we have roughly 10,000 staff and cover 2,500 square miles.

Pauline Philip: Hello. I am Pauline Philip. I am the chief executive of Luton & Dunstable University Hospital Foundation Trust. We are a medium-sized acute hospital. We provide level 1 accident and emergency services. We have a budget of about £250 million. We employ approximately 4,000 staff. Our performance, from a Monitor point of view, has been good for the last couple of years.

Professor Sir Bruce Keogh: I am Bruce Keogh. I am the national medical director for NHS England.

Professor Willett: I am Keith Willett. I am the director of acute care for NHS England.

Dale Bywater: Good morning. I am Dale Bywater. I am director of delivery and development at the Trust Development Authority, which oversees non-foundation trusts.

Q40 Chair: Thank you. Perhaps I could start by asking you, Sir Bruce, to tell us where we are now with the latest figures on performance in A and E and the number of hospitals in emergency measures.

Professor Sir Bruce Keogh: Thank you very much. The figures on A and E at the moment show very clearly that A and E is under considerable pressure at the moment. That is reflected in the fact that for the Christmas week we saw 20,000 more patients in A and E than for the same week the year before. The end result is that, in terms of the four-hour target, if we go back to quarter 2 of this year, it was 94.98%, in quarter 3 it had fallen to 92.96%, and in three out of the last four weeks it has been below 90%, and in fact was 86.7% for the week ending 4 January. Underneath that is also the point that Cliff Mann eloquently made that we have seen a very significant annual growth rate in the demand for accident and emergency services. The number of attendances annually has increased by about 3.2% per year and the number of admissions has gone up by 4.6%.

Chair: Thank you.

Q41 Andrew George: Sir Bruce, can I ask, in view of the increased breach, or the failure to hit the four-hour target, has NHS England made any assessment as to whether this is merely a failure to meet an administrative target and what the consequence is for patient outcome?

Professor Sir Bruce Keogh: Yes. First, we know that the nature of patients who appear at different times of year is different. You will have heard Keith Willett say in previous attendances at this Committee that the number of attendances at A and E tend to be slightly higher in the summer and slightly fewer in the winter. The difference with the winter is that the number of people requiring admissions goes up, and in particular we know that during the summer about 1,000 people a day are admitted for respiratory disease and that goes up to about 2,000 in the winter.

Q42 Andrew George: To save time—I probably did not make the substance behind my question very clear—is it purely an administrative target, a box-ticking exercise, or do you know that this clearly has a detrimental impact on patient outcome? Is it purely an administrative exercise just to satisfy the political classes?

Professor Sir Bruce Keogh: No, I do not think it is a target to satisfy the political classes. We need to set ourselves a target. There is no doubt that people do not like waiting in accident and emergency services, and indeed the College of Emergency Medicine has said before that the target has made a very significant contribution to the way people think about their accident and emergency and about how it fits into the hospital and the whole system in general.

There are two points I would like to make in response to your question. One is that we do know that when people are waiting for services there is a detrimental impact on outcomes, but we do not know which is the chicken and which is the egg and the causal relationship. The second thing I would say about the target is that it has become a barometer. It is frequently misinterpreted as a barometer of just how well an A and E department works, when in fact it is a barometer in many respects of the whole health care economy. The previous witnesses have expounded on that pretty well.

Q43 Andrew George: Can I ask those representatives, perhaps from Northumbria in particular, in relation to your appearing to have very good outcomes and meeting targets, and so on, is this a reflection of the success of the acute side of your service—of the local health economy—or is it more to do with the success of the way in which your community, primary care and, indeed, social care service operates so that it works in concert with the acute side of your work?

Jim Mackey: I would agree with Sir Bruce that this target is a barometer of system health and you cannot look at one thing without the other. We do benefit from generally strong primary care and very good relationships with our local authorities. We run social care in partnership with one of our local authorities, as I said earlier on. So it is much more complicated than just looking at one part of the system. You do require every part of the system to do its bit and to work effectively together, and that has benefited us over the years.

Q44 Andrew George: We have identified—and many people have identified—the difficulties in relation to a system that appears to be failing, resulting in larger numbers of unnecessary attendances at A and E and difficulties in discharge from the acute sector. Can you explain for the benefit of the Committee how your model operates in relation to both of those interfaces, the coming in and the going out, as it were, of the service, and the financial decisions or the financial basis of the decisions that are often the impediment to achieving better flow?

Jim Mackey: The first thing to say is that over the peak period—the last four to six weeks—I do not think we saw lots of people attending inappropriately, so I would agree with some of what was said earlier. There were not lots of people coming to A and E who did not really need to be there. The main cause of our pressure and problem was lots of very frail old people who required admission. So they could have seen a GP before that but they would almost certainly have needed admission anyway. We have managed, mainly because of our partnership agreement with Northumberland county council, to plan better for continuity of service over the working week and the working day. We have a lot of social care presence—a lot more community presence over weekends and evenings than others would normally expect. Generally, we have been trying to work on better primary care access and that has been a bit slower.

Andrew George: Can you speak up a bit, please? I am not the only person—

Jim Mackey: Yes. The primary care access has been a bit slower to achieve, but we are still working on that. Generally, there has been a recognition that services should not shut on weekends and should not close over bank holidays and so on. That has given us an advantage. We have been able to change a lot of things that others maybe have not. That said, we still did struggle over Christmas so we did not achieve our usual high performance standards. We are nearly back to normal now, but it was very difficult for a few weeks.

Q45 Chair: To go further on that, I know, Pauline Philip, your trust does particularly well. Are you able to identify what it is about the system in your area that makes it work better?

Pauline Philip: Yes, and certainly recently we have done a lot of soul-searching to identify those highlights around the organisation, basically because other people have asked us. The first thing to say is that, from a board of directors and a trust management point of view, the A and E target is not seen as a target; it is seen as being around patient safety and that having timely access to care, having that smooth flow through the emergency department and through the hospital, is fundamental to delivering safe care. There is a lot of passion within the organisation around it. It is ED performance, it is the whole hospital performance, but it is also the whole system. It is wider than just the hospital delivery. Clearly, over a number of years, we have been developing better and better processes around the flow of patients, both within the department and through the hospital, and when things break down, when things do not work, we go back, we look at them and we try and learn from them and constantly change that.

We have had an ongoing investment in staff and space within the department, and that is something that the trust has had to pay for and we would not in any way say that the tariff has been able to cover that. We have pretty sophisticated team-working from an escalation and early intervention point of view, so that when things are not working there is rapid escalation within the trust. There is a big focus on discharge planning and trying to stop that exit block. We struggle, we have problems the same as everybody else and we are very happy to talk about that, but one of the key things around the delivery—certainly locally for us and we are not saying that one size fits all—is that we have a range of services co-located on our site. When a patient comes to the site, whether it is by ambulance or whether it is a walk-in patient, we have a range from ambulatory care to a GP clinic on the site, a range within the emergency department, and we are able to cohort patients to the best place. That has been invaluable, and we are doing further work across our health system in how we can make that even more sophisticated and also working with the ambulance service and 111 to see how that can be brought together to overcome some of the issues that we have had this winter.

Q46 Chair: Thank you. To clarify, could you tell the Committee what your performance was against the four-hour targets over the last quarter?

Pauline Philip: It will have been in excess of 98% most of the time, yes.

Q47 Chair: A greater than 98% performance against the target.

Pauline Philip: Yes. I have it in front of me. Yes, it is.

Chair: Thank you.

Q48 Andrew Percy: On this 98%, is Luton council the local authority that serves your hospital primarily?

Pauline Philip: Yes.

Q49 Andrew Percy: What is their social care criteria? Do they intervene at a moderate or severe level of need?

Pauline Philip: I cannot answer that in those terms; I do not recognise those terms. What I can say is that we have an excellent working relationship with both of our local authorities, who are part of the system resilience group, and in particular on a focus around developing integrated care for older people, for people with chronic conditions, and trying to ensure that for patients who are medically fit for transfer we have a system-wide reaction.

Q50 Andrew Percy: I understand all that. It is interesting because a lot of placement on the failure is borne by local government and cuts to local government. Luton council has not been any different, nor has Northumbria—

Pauline Philip: I do not think so.

Q51 Andrew Percy: —to any local authority and presumably have made the same reductions, but that has not borne itself out in a breach of your targets in A and E.

Pauline Philip: Yes.

Q52 Andrew Percy: Given that the two are often put together to create an explanation, I do think it is important that perhaps we could find out that information.

Pauline Philip: Yes, although I would like to say that our local authority colleagues in Luton are certainly concerned about the coming year, but I think that is true for this year.

Q53 Andrew Percy: But they have had four years of spending reductions and you are still hitting 98.5%. Examples are all too often put together when it serves a particular purpose elsewhere, but not here.

The only other question I have on this is that we have not seen any data on how long people are breaching for after the four hours. Sir Bruce, do we have any data on what proportion of patients who breach are waiting an hour, two hours or three hours afterwards? There is a concern that, once you have breached, it does not matter almost because the trust has failed on the target anyway.

Professor Sir Bruce Keogh: I do not have that data in front of me.

Professor Willett: I do not have that breakdown. What is reported, as Dr Mann said, is what is called the trolley wait—the length of time then. As far as we are concerned in the NHS, no patient should be in that position for the 12 hours—which is seen as having a zero tolerance—but there have been some breaches of that in some of the most challenged hospitals over the Christmas period.

Q54 Chair: Thank you. Before we move on to the next question, can I ask Pauline Philip whether you could send the Committee a more detailed note on exactly how you have achieved what you have achieved and what has made the biggest difference? That would be very helpful.

Pauline Philip: Yes. I am happy to do that.

Q55 Charlotte Leslie: To elaborate on targets in the post-Mid Staffs era of hitting the target but missing the point, do you have any evidence that trusts are prioritising hitting that four-hour target over patient care?

Professor Sir Bruce Keogh: I certainly have no evidence of that and I have visited a number of A and Es, speaking to people who would otherwise tell you if that was going on. I am not getting any feedback to that effect.

Q56 Charlotte Leslie: Would the panel be able to provide the Committee with some information on what happens post the breaching of the four hours—what care is like, how long people are waiting?

Professor Willett: Both those data are available and can be demonstrated as a graphic. In terms of your question about whether this is missing the point through getting to the target, we need to put this into context. We have an NHS which is the most cost-effective health care system of the developed countries, according to the Commonwealth Fund, and we also are very proud that we set and try to work to the very highest target standards of anywhere in the world. Emergency and urgent care is all about managing risk, and that is what will be happening. As a clinician, as a doctor, what you worry about is the patient in front of you, doing the right thing for that patient and ensuring their safety. Inevitably, when the system gets very congested, as it has done over the festive period, some people will have poor experiences, but what people will focus on is the safety.

We have to put this into context. A lot of countries now are moving to having targets for emergency admissions. New Zealand have the same target as ours of 95%, but theirs is six hours, not four hours. Western Australia have just set an aspirational target of 90% for the end of this year. If we go to Canada, their admission target is eight hours, not four hours. If we go to Sweden, most health authorities there set 80%, not 95%. We need to be very proud of what the NHS has done: it has managed to stay very close to what it has been asked to do. That is absolutely at the expense of enormous numbers of extra hours and shifts and commitment put in by a lot of staff right through the whole. That is general practitioners and ambulance services, and the ambulance services have had a larger increase in activity than the hospitals—we must remember that—and the group of health care professionals that have had the biggest impact have been the 111 service. Whereas ambulance services and the hospitals went up around 10% over the festive period, the 111 service took a 100% increase for that period. So we have to put it into context and understand how well the NHS has coped.

Q57 Charlotte Leslie: I know that is the case and we are coming to 111 later, but could the panel provide any data on what happens post-breach just so that we know it is not a binary idea?

Coming to Jim, you said that things had been a bit difficult and had not been going so well. Would you illustrate and flesh out the kind of challenges that you are facing and what that means?

Jim Mackey: Yes. In pure performance terms, we would normally comfortably exceed the 95% target—normally 96% or 97%. A couple of weeks before Christmas it started to become really tight, with high levels of admission, and it peaked on about 27 December. I was called in on 27 December.

Q58 Charlotte Leslie: Do you mind if I just cut in? Did you also see a disproportionate increase in 111 admissions?

Jim Mackey: No, not really—just a massive increase in admissions of the frail elderly. We would normally admit about 80 people per day. On that day we admitted 120 or so. We had a few spikes like that. Normally in a year you would have a few days or maybe a

couple of weeks that are hard, but this time it went on for several weeks. The system had to work really hard to manage to get on top of that. There were huge numbers of discharges as well. We mobilised lots of extra people. Somebody referred to heroes earlier on. We had some absolutely heroic shifts from clinicians and managers working virtually round the clock, often coming in unpaid to do what they needed to do.

I would also reinforce that the standard and the target give you a focus, but it is absolutely not the thing you are thinking about when the department is full. When I hear about targets and standards in some of those other countries, the Canadian standard, particularly, at eight hours is a long time if you are 85, frail, frightened and lying on a trolley. It is totally unacceptable and we should never go there.

Also, a full emergency department is quite a scary place. There is a lot of risk there that you cannot see when you get overwhelmed. Our teams just focused on trying to unblock that risk, to get people to the right setting, and we escalated and created lots of extra beds. We are now in the process of trying to collapse that capacity to get back to normal. Since Friday we have been running on about 98% performance again. Every patient, other than one, yesterday was processed within the four-hour standards, which was the first time in quite a long time that we have managed to do that. So there are some signs, hopefully, that it is starting to stabilise, but I would emphasise that the main spike was this massive increase in admissions of the elderly, largely with respiratory problems and largely people who were not going to go home very quickly, so the system just clogged up for a few weeks.

Q59 Charlotte Leslie: Does the panel think perhaps if we talked a bit more about A and E staff going the extra mile that retention of A and E doctors and staff might be slightly easier?

Jim Mackey: We can talk about it. It is their experience that will drive that and it is really hard and quite scary, so we do absolutely need to work on solutions, as has been said earlier on, to decompress the situation and make it more manageable. You cannot work 20 hours a day for very long. You can do it when you need to for short periods. The perception is that it is quite a scary and hard job now. This is not going to be a quick journey. I would add that there are problems with the work force; we are not producing enough people in lots of areas, not just in acute medicine. In our EDs we need to look back at how we are producing and training people to make sure we have a sustainable supply.

Charlotte Leslie: We are coming to that in a bit.

Q60 Valerie Vaz: Can I start by saying thank you all for coming at such short notice, and I know you all have very important jobs to do. I am a bit concerned that people are working in the NHS for nothing—basically they are volunteering—and that is what is partly bringing the spikes down. I am concerned about that and I hope the Department will also take that back.

I want to turn to the winter funding and if you could let us know whether you have the money, how you got it and how you used it.

Pauline Philip: From our point of view, we are still in a dialogue with our two CCGs about winter funding. We have had some earlier agreements before Christmas, but because of this spike in activity that we have seen since Christmas there is an ongoing dialogue taking place. After Christmas, at its peak, we had 53 escalation beds in operation, and clearly that is not something that we predicted as a health care system, so we now need to look at how winter funding is going to be distributed. But it is done through the system resilience group and we have obviously had some experience in prior years as well. Within the system resilience group we have all signed up to winter funding being used in a number of areas. Yes, we need some in the hospital because of the extra capacity that we bring on stream, but we clearly need some of the moneys to be devoted to trying to reduce the number of patients that are part of the exit block who are the “medically fit for transfer” patients. Our CCGs have used some of that money to buy additional capacity outside the hospital.

One of the other very important areas that we have all signed up our winter moneys for is to avoid admission and attendance at the hospital. Through the system resilience group we reach agreement across all stakeholders. This year we obviously have to revisit how the money has been distributed, but last year, at the end of the period, we sat down and looked at how the money had been utilised. Indeed, in a couple of areas where money had been allocated, the money had not been used because the capacity was not available, and so on. We are constantly reviewing and learning from that. Clearly, next year we will have a very different system nationally; that is our understanding. One of the downsides of the winter funding, even though it was announced much earlier this year, is that it is still temporary funding, it is not supporting the long-term recruitment of staff, and the discussions that have taken place nationally have seen that issue and are attempting to address it.

Jim Mackey: Could I add to that? Pauline has made some excellent points and I agree with all of that. We did receive the money but agreed with our CCGs and other colleagues how the money was deployed. It was a little late, and if you look over two years in our system in the north-east we have lost about 300 beds, largely because of the squeeze on the tariff— people having to make financial decisions. If this money had been routed through the normal payment mechanisms with enough time, maybe we would not have all closed those beds. So we had an odd situation this year where many of us closed beds in the summer based on a quiet year last year and financial reasons and then had to open them again later on, and that is really hard to do from a work force point of view. It is very “stop, start” from a planning point of view; it is not sensible. Also as to next year, with regard to the winter money, when it has gone into allocations, we will not receive the same amounts. We will receive significantly less in our system because of the way it has been allocated, and that is a big concern for us.

Q61 Valerie Vaz: How would you want the money allocated?

Jim Mackey: I like the tariff, unlike other colleagues who have spoken earlier. The tariff can be recalibrated to incentivise people to do the right thing. The first thing I would say is let’s not throw that out. It needs to be recalibrated rather than going back to block payments. I worry a lot about block contracts and the disincentives associated with them. Whatever the mechanism is, my view would be that it needs to go to the places that need that money as quickly as possible in the mainstream routine system. When you have lots

of in-year bidding processes, it is incredibly hard to plan and really hard to flex your capacity. You are at risk all the time with making changes in capacity and then finding out a month later that there is some money available that would have meant you would have made a different decision. If we can get back to some order and a system where people have certainty of resource with which they can plan, which is equitably distributed so it goes to social care and primary care, and so on, we can encourage and incentivise people to work together as a system in line with Sir Bruce and Mr Willett's proposals under the emergency care review.

Q62 Valerie Vaz: You are a manager, and obviously we heard from the clinicians that it is not actually getting to the front line and it is causing the doctors who are at the coal face real difficulty when they have to work without being paid. But I am concerned about this dialogue that seems to be taking a long time, and obviously the idea from the Department is that the money gets there as quickly as possible. Could you tell me why the dialogue took a long time?

Dale Bywater: Can I maybe give a national perspective?

Q63 Valerie Vaz: I am coming on to you; I really am coming on to you.

Dale Bywater: Fine.

Pauline Philip: No, I am not really raising it as an issue of concern. I am just setting out that the good planning that has taken place was based on last year and was based on what was likely to happen this winter. We have all recognised that what happened post-Christmas was a real peak in attendances and a corresponding peak in admissions, and so on. It is part of the success of the system that we will now go back and look at how the moneys have been distributed. Some moneys have been held to one side so that we can gauge them on a month-by-month basis through the winter period. I am not really raising it as a concern. It is actually part of the successful planning.

Q64 Valerie Vaz: Okay. You mentioned that some of the money was not utilised. Could you be more specific about that?

Pauline Philip: From memory, for example, some of the money that was going to be used outside the hospital, as far as attendance and admission prevention were concerned—some of the ambitions that the community trust had were not able to be 100% realised because they were not able to recruit the appropriate staff, and so on—was basically put back into the pot and further discussions took place. It is an ongoing dialogue, for us anyway, throughout the winter period and that has been pretty successful.

Q65 Valerie Vaz: Sir Bruce, where do we go next with this allocation? Do you want to add something or is it Mr Bywater who will tell us?

Professor Sir Bruce Keogh: Yes, please.

Dale Bywater: I want to add some context to what colleagues have already described. As Pauline said, this year the money was identified earlier, the planning process started earlier and it was predicated on the experiences of last year, which very much informed it. The easiest thing to do is to allocate money quickly and do it centrally. That was not the approach. It was very locally driven, so the intent, when the guidance was produced in June, was around trying to get away from just winter resilience, picking up Jim's point about more all-year-round operational resilience, which picks up not just urgent but elective care. Although the guidance stipulated some criteria one would hope to see in place, which is best practice within the urgent care and delivery arena, it was essentially up to local systems—system resilience groups—to determine how the spend happened. Of course, as we have said, there is not one sole factor behind delivery in this arena. It brings a multitude of agencies together, so we have acute trusts, community trusts, primary care, social services and so on. The dynamic is very local; it is locally driven, bottom up and within certain criteria. The very nature of that is more discursive and takes slightly longer, but the intent there is to get to the right solution that is evidence based locally and also picking up national experience.

As to the money that went out—the split—we are tracking this monthly now. It sounds a bit bureaucratic—

Valerie Vaz: No, no.

Dale Bywater: —but in terms of understanding what was the proportion of spend actually happening, what sector the money has gone into, acute versus social care versus community care, there is a real focus around that. Is this delivering the things that the local systems said they wanted to do? We know, for example, for the period October to November that £136 million was committed in that period and we are seeing that being evidenced in all sorts of schemes such as beds and staff, but also out-of-hospital care, Hospital at Home, social care, and so it goes. So it is useful to give you the context of the process.

Q66 Valerie Vaz: When are you likely to get some sort of figures? We do not really want an FOI from the College of Emergency Medicine to get that information out, but clearly they are saying that the money is not getting to them. You are saying you are tracking it. Could you give us a time frame of when you would get some sort of idea where the money has gone?

Dale Bywater: Yes. It is tracked nationally by NHS England, so I am one part of that, the non-foundation trust interest in that, but we work very closely with system resilience groups because the intent in June, or subsequent months, as Pauline said, could be refined over time. It could be refined; we intend to have this solution; but actually while they are addressing the problem in current recent weeks it might mean a slight realignment of that. As long as there is a transparency to that, that the money is not just being used inappropriately, we need to bear that in mind in how we track things. I am very clear with the trusts I deal with. I know Nottingham University Hospitals NHS Trust has 71 extra acute beds, it has 48 community beds and 40 more cubicles in its A and E department, and so it goes, and I know Walsall has a 21-bed ward that has gone in just recently. So we are tracking this in quite a granular way.

Q67 Valerie Vaz: By the way, we need an extra £4 million for the other one that was promised to us. Do you have a time frame of when you are going to get this information, before you move on to the next phase of how you are going to allocate the money?

Dale Bywater: We track it monthly. I guess it is something that we manage internally within the NHS. As to the merit of sharing that widely, I am not quite sure of what the plans are on that, if I am frank. I would need to clarify that.

Q68 Valerie Vaz: Could you find that out because it is ridiculous that the College of Emergency Medicine has to do an FOI to get this information, which really we should have in terms of accountability?

Dale Bywater: Yes, okay. I will take that away, look into it and get back to you.

Q69 Valerie Vaz: What is going to happen in the future? You are not going to do these pots of money as and when or in June. What is going to happen in the future? Is there a new system coming out?

Professor Willett: That is part of the urgent and emergency care review, which we have shared with this Committee and the Public Accounts Committee. Part of that was a fundamental look at how the payment system works. We have all talked about—and Chris Ham in particular—the fragmented system, about the confusion, and we have talked about the difficulties at the interfaces between patients moving quickly into what they need. At the moment we have the rather difficult position in that we have general practitioners who are paid basically on the number of patients they have, the ambulance services and 111 services that are paid on activity, but the price is agreed locally; and we have the A and E department that is paid on a tariff without a marginal. For 80% of the patients going to A and E there is no marginal applied, but for those patients who are admitted the marginal rate applies to the tariff. Then we have community services, which are mostly on block contracts, and social care which is on a block contract. Even though we now have in the system resilience groups all those partners coming together saying, “Let’s solve this problem”—and if they really get on as they have done, as has been explained here, and actually start to say, “How should we share the money out, pool it and spend it?”—when they come to do the allocations in the current system the acute trusts have real difficulty in giving up activity because that means they lose money and the community trust that had a block contract at the start cannot take on any more activity because it does not come with money.

So what we have put out for consultation and has been discussed over the autumn is a new payment system which will have common elements to everybody. In essence, we are proposing that, if you are designated to provide a 24-hour service, let us say the ambulance service, you have to have the vehicles and the people. Even if the 999 phone never rang, you have to have that in place. We know that about 90% to 95% of an ambulance service’s costs are fixed even if they do not do any activity. If we look at an acute service in a hospital, about 75% of its costs are fixed and about 25% are based on the activity, which is where the 30% marginal comes from, I might add.

We are looking to say we will have a system in the future where, if you are designated, your core costs are paid for, so that takes that out of the equation. Yes, there will be something around activity, because there will be an effect of activity, but everything will not hang on the activity.

Then we should look at the incentives. The incentives should be in the system to drive the quality and the flow of patients through the system so that the hospitals are incentivised to be able to move patients out and the communities are incentivised to be able to give patients what they want, which is treatment closer to home and expeditiously. That was the model that we put out for consultation and we have asked for pilot sites to try that out over this coming year. In fact, around the health economy, we have some very innovative ideas, and what they have to do there is almost step outside the normal payment systems in order to do that. That is clearly wrong. I want a payment system that tells the patient story and not just an administrative story.

Q70 Valerie Vaz: Absolutely. Patient safety is at the heart of it, if we have learned anything from Francis, so that should be it. When is the consultation going to end and when are you likely to come up with—

Professor Willett: The consultation has been under way already and we have made adjustments in the national tariff document that went out already to start to lay that forward. As we go through the process and look at the incentives for next year, we are already expecting to have some of those built into the system so that we start to link up ambulance services with hospitals and with 111, and start to incentivise that. That will obviously be out for the next financial year. Then over the next year we will be piloting that in those areas. I am sure, given the issues that we have described and the desire for people to work together, we will not have a problem with finding people to do that.

Valerie Vaz: Thank you.

Q71 Chair: Could I clarify—we have heard some examples of very good practice—why the NHS is not so good still at sharing best practice so that we can bring everywhere up to the kind of standards that we have heard from Luton & Dunstable?

Professor Willett: Yes, that is a question that has haunted us for a very long time. One of the difficulties is that sometimes the best practice is most needed when you are under the most pressure because that is when you really need to make those changes. That is also the most difficult time to put your head above the parapet and take a bit of time and see that, and I am afraid that is the stage we are at at the moment. In the longer term, we know that innovations do take a long time to come in, but if we line up all the elements so that everything is pointing in the right direction—which we have not done to date, I would argue, in the NHS—it makes it much more likely. If the clinical model, the management model and the funding models are all directing in the same way, it is much more likely to make it easier for people to adopt those innovations rather than have to sort of get round the system to do it.

Dale Bywater: Can I add to that? There is good practice in emergency care, which the intensive support team, you will be aware of, have. We challenge trusts around this. Some

of these things do require resource. Creating an ambulatory care facility and unit to stream patients so they can be seen on the day and have maybe a rapid test or a rapid outpatient appointment and be discharged and not need to be admitted, as traditionally they would have been, often requires a facility, or at least some space and some people. But there are other things that are more around internal flow and efficiency.

Q72 Chair: That is what we heard from Professor Ham.

Dale Bywater: The point is that we need to be more consistent in the application of those so that we are meeting the standards that Jim and Pauline reach more uniformly. It is things around rapid assessment and treatment for majors in ED; it is also around “see and treat” for minors. But we stream patients, we follow specialty pathways and we are more consistent internally and discharge during the week and at weekends and have early discharges. They are just examples of things you are challenged around. How do we get those consistently applied? That is definitely what we are aiming to do because we need to do those as well as put resource into the problem as well.

Pauline Philip: Could I add to that? On behalf of all our colleagues who are not here today, many of whom are struggling with significant challenges, I would have to say, certainly from our experience, that there is a tremendous appetite within acute hospitals to try and learn from each other and to see what is working better in other places. We are hoping that, through the work that Simon Stevens is doing now on vanguard sites, and so on, that we may be able to construct something that will allow people to test things and then to roll them out further. We are optimistic around all of that, but there is no way we would want the Committee to go away believing that people have their drawbridges up and do not want to learn from others. That is certainly not the case. We are inundated with people wanting to talk to us and I think that is the example.

Q73 Chair: That is good to hear. How much is the success of what you have described down to leadership and culture within the organisation?

Pauline Philip: For us, we would say that it is down to the overall culture within the hospital but also within the wider health system, and it is motivated by a tremendous commitment around patient safety and is about trying to constantly improve clinical outcome. If we were here talking about some other specialty, hopefully it would be a not dissimilar picture. The commitment of staff is just unbelievable. We have been fortunate over the winter period that our staff have been very willing to work through our bank, which avoids us having to use as many agency staff, that we have been able to keep the hospital safe by our own staff working extra hours. They are paid for it. Again, we have to be very careful that, in doing so, we are not putting patients at risk—that staff are not working hours that are excessive.

Chair: Thank you.

Jim Mackey: Just to add to that, clinical and management teams work in a completely integrated way so that you cannot tell who is who in that they work absolutely in the interests of patients at all times. That does happen pretty much broadly across the NHS and you really see it at these times when everybody is stretched.

Chair: Thank you. We will come on to David.

Q74 David Tredinnick: I want to ask you about the impact of the urgent and emergency care review. A lot of this has been covered in earlier questions, so briefly, Professor Willett, I think you told the Committee last year that the current situation was a holding position until this review can be implemented. Is that still the case?

Professor Willett: We have moved forward. Since the last time we discussed this, we have been working with all the people out there who have to deliver this. We have been working through a delivery group, so this is not some central diktat. Problems were identified by the system, by the people working in the system—the nurses, doctors, managers at the front line and the patients—and we helped them come up with the solutions. Now they are also joining us in delivering them.

Over the last few months we have been working up a whole series of what we have called products, but in essence they are ways in which we can help the service make the changes across getting self-advice, advance care planning, how the ambulance service will work differently, how the hospitals can work differently, how 111 will be improved to become a really useful component in the system, how the ambulance services will do more “hearing and treating”, as we call it, and “seeing and treating”, and how the hospitals and the community and the hospitals in an area will work together in networks. All of that is under way, or much of it has already been developed to a significant stage. That was announced in a statement we put out in August. You may be aware that the NHS England Board has approved now to deliver that and that has been welcomed by the Government. That was in December, and that Board paper is certainly part of the public Board papers and gives a list of many of the things that we will be putting out over the next few months.

We have been building these with the clinical commissioning groups. We are intending to use the system resilience groups, which, as we have already heard, are right in the middle and contain all the partners that we need. They will be the people who will be taking these products. They have helped us design them—that is really important—and they are designed in a way that does not constrain them but gives them the best practice models, exactly as Pauline said, that people are wanting to take forward. That has been quite a new experience because the health service is obviously in a different place from where it was a few years ago, and with the statutory responsibility for the vast majority of urgent and emergency care services sitting with the clinical commissioning groups it is absolutely critical that the doctors who lead those clinical commissioning groups have been party to the design. That will all be rolled out over the next 12 to 18 months in particular.

Q75 David Tredinnick: One of the critical weaknesses in the system that has been exposed this morning, I suggest to you, is the muddle over the tariff system.

Professor Willett: Okay.

Q76 David Tredinnick: If tariff talketh not unto tariff, then I concede that this will be right at the heart of the problem, but do you think that if this review is implemented the demand in the winter next year will be better met?

Professor Willett: That is exactly the intention, quite clearly, but we have heard today time and time again that it is not about the tariff and the hospital bit. Actually, this has to be a transformation of the whole system, and we have had numerous examples over numerous years of doing one really good initiative in one part of the pathway and it does not have the effect we expect because the rest of the pathway is sufficiently busy that it can negate the advantage of that. With the urgent and emergency care review, as Chris Ham said, we have to do a transformation of the whole system, with a particular focus on the out-of-hospital services being the way to both reduce demand and also alleviate the issues of congestion within the hospital.

The answer to that is, yes, as we go forward, we have confidence that these products that have been designed by the people who are living and breathing the problems on a day-to-day basis will start to address the issues. But it is not going to be a quick fix. We have said it will take three to five years to get all of these things in place. We have heard about recruitment issues in general practice, acute medicine, emergency medicine and in paramedics. Those things are not addressed over a few months. We also know that the curriculum has to change. We know that we have to have better connectivity around information and better working relationships—and we have to change the payment system. That is not all going to happen inside one year.

Professor Sir Bruce Keogh: May I add that we have tried to do this in a way that engages everybody who is involved in delivering the service? It became clear to us that the service could do better, if you like, towards the middle or the end part of 2012. It was then that we had discussions with the Secretary of State, who agreed that we could do a review. That was announced in January 2013. Keith and his team did an awful lot of work to try and engage everybody and did it in a very public way. All the papers were published on NHS Choices so that people could comment as we went along. The first bit of the review was published in November 2013, and then through 2014 we have done much more work on the delivery side of things.

In answer to the bit of your question about whether we can tell you that next winter will be okay, it would be very foolish to sit here and say this because it is part of a three-to-five-year programme. Last year we had a relatively mild winter. This year the winter has been slightly different. We have seen more flu than we saw last winter and there are extraneous circumstances, which—

Q77 David Tredinnick: More flu, did you say?

Professor Sir Bruce Keogh: Yes.

Q78 David Tredinnick: I will ask you about that later on.

Professor Sir Bruce Keogh: There are extraneous circumstances which influence how the service performs. A new flu virus or some Norovirus can knock us one way or the other, and, of course, it is an adaptive system, as you have heard from others.

David Tredinnick: Thank you.

Q79 Barbara Keeley: On the plan, and particularly around the development of self-care resources, I find this frustrating in that a few years ago my primary care trust in Salford cancelled, for efficiency savings reasons, what was a very successful pilot of active case management of people with long-term conditions. We lost two walk-in centres and that pilot. I know it had an impact because constituents complained to me and organisations like Age UK said what a loss it was that there was nobody working with people with long-term conditions just to try and keep them out of hospital. The stupid thing is that we get into this business of something like that, which was doing good and was going in the right direction, and for short-term savings we just cut them. To reinvent something, to go back to it, to recreate it later feels like such a waste. I wanted to put that to you. Can we stop these silly cuts in things which are obviously heading in the right direction?

My other point was in terms of what Professor Willett has just talked about. We talked earlier about the real reliance there will be on district nurses, hospice nurses and people in the community who can help ambulances work in a different way and provide that care and provide that stop before hospital, but what are the plans to get back to 12,000 district nurses? Where is the plan to have more hospice nurses? As you say, you cannot produce those overnight. Are there concrete plans as part of this review to go back to 12,000 district nurses and to increase the number of hospice nurses? You cannot put more pressure on the people that are there. There are less than half the number of district nurses that there used to be.

Professor Sir Bruce Keogh: While Keith is gathering his thoughts on that, I would like to support Jim Mackey's contention that it would be much easier to have a more sustainable planning approach. That is what we are trying to set out with the urgent and emergency care review. We have tried to deal with all the different components of urgent and emergency care and to set a framework in which local clinical commissioners can deal with specific problems. In terms of the hospital bed stock and what have you, some of that is addressed in the Five Year Forward View and there are opportunities for us to develop multi-specialty community providers and other things. As to the issue of staffing, I do not know whether you have anything to add to that.

Professor Willett: Yes, certainly, and around the walk-in centre issue, this is—

Q80 Barbara Keeley: It was more the active case management. That was a real loss.

Professor Willett: I entirely agree about the idea that in the past decisions have been made in isolation in one part of the system. If there is one thing the urgent and emergency care review is saying it is that we have to do this together, and, if everybody in the system resilience group is looking at that, the advantages and consequences of making decisions become apparent. That is where a payment system and a clinically-led approach to management will be much more beneficial to getting it right in the future.

In terms of the urgent and emergency care review, we absolutely recognise the role of district and general nursing practice in it. In fact, one of the themes and products in the NHS England Board report is that we are working to put together a modern educational

framework that describes what sort of nursing skills are needed and how those nurses are established.

Q81 Barbara Keeley: We need more of them as well.

Professor Willett: Clearly at a local level, how that is then designed as to where they fit in the system will be different. Perhaps in a rural area it becomes absolutely important to have a large number of district nurses because you do not want people moving long distances, and in an urban area people might well find that you also want to design services that are closer and in an urban setting. That will be a local decision about how they do it, but we will be giving them what they have asked us for and we are doing what the CCG medical leads have asked for, which is to give them a framework that says, “These are the sorts of skills that people recognise nationally are the ones we need and the education framework for the nursing staff to be developed to.” We can then take that and apply it in a bespoke way to match our local services. I would imagine, if you talk to our colleagues from the trusts, that that is exactly the sort of thing they want. We do not want to constrain them and tell them; we just need to help them do that.

Q82 Barbara Keeley: But who is helping them fund getting back to 12,000 district nurses nationally? That is more than double what we have.

Professor Willett: As I said earlier, the commissioning responsibility for emergency and urgent care services and the district services all sit with the local CCGs.

Q83 Barbara Keeley: There is no national incentive to do it. It is entirely up to a local CCG whether they increase their numbers.

Professor Willett: They have the statutory responsibility, as you are aware, for commissioning the services that meet the needs of their local population. I do not think they would want me to tell them what to do.

Chair: We will come on to Andrew.

Q84 Andrew George: In relation to the capacity, I know that it is contrary to all of the arguments that have been presented by the health chiefs and gurus over the last decade ever to even consider contradicting this line, which I have shown before—the NHS Confederation’s view that we need fewer acute hospital beds and this mantra that somehow the system will manage to keep people out of hospital or discharge them sooner. But in your plan, Professor Willett, you talk about the importance of the service and that it is about managing risk. Is it not a high-risk strategy to operate the system on the expectation that you can achieve this knife-edge equilibrium and that the throughput of patients coming into the acute system will somehow be managed with there being virtually no surplus beds within the acute system? As soon as there is additional pressure, you are in automatic crisis, as we have seen in recent weeks.

Professor Willett: This is part of the position that we are in on a day-to-day basis where we have a very efficient system, very high standards to work to and the NHS in the middle

is running very hot, exactly as you describe. Efficiency can equate to a lack of reserve, but we know that, despite working under those pressures, if we can achieve the sort of shifts that have been described by the people who have studied this and we understand it, we will create flows that will keep patients treated in the place they want to be.

As to creating reservoirs of extra beds in hospitals with older people in, we know that hospital is really difficult and potentially more of a safety risk for patients, particularly the elderly patients, than being at home. As soon as a patient gets near to a hospital or comes into a hospital, there is an increased risk for them. They are not in their normal environment, so often, mentally, they find it much more difficult to cope, and physically the things that they would normally lean on to get to the toilet, or whatever, are not there. It becomes increasingly difficult to assess them because they are not in their home environment, and that leads to situations where those patients are not really getting the care. For the older patients—and perhaps my other colleagues from the trusts would support this—very often it is the care need which is one of the greatest things to address rather than the medical need. The medical need is often quite a transient treatment, but, once you are past that, then really the right place to assess that patient and the right place for them to be cared for, for them to have the best quality of life and actually achieve what they want, is out in the community. The ECIST team that look at it show that, of those elderly patients who have been in hospital for more than seven days, when they review those in the trust as they go round, 50% would be better off at home but they are currently still in a bed. So I think, yes, we need a capacity in the system, but the capacity is arguably there. We just do not have an efficient flow and that is the thing we have to address.

Sir Bruce in his first report said, and we have said repeatedly, that what we think we have now is an unsustainable system. Building on what we have traditionally done is not going to create sustainability. It is just going to make a bigger system with the same problems.

Q85 Andrew George: Do you think you are going to solve this issue by perpetually having insufficient numbers of acute hospital beds? You are saying that the system is not actually up to operating in the way that you would like it to operate, but you are doing that by putting pressure on throughout the system by there being insufficient acute hospital beds. I have heard this narrative before, but very often—and I am not accusing you of this—those people who advance this narrative, often, when it comes to their own elderly mother would not particularly want them to chance it in the community if they needed emergency senior clinician opinion and diagnostics. You cannot do that at home.

Professor Willett: No, you cannot. If you are seriously ill, need investigation and medical treatment, you need to be in hospital. But you only need to be in hospital for the period that requires that. After that, it is wrong for the patient, it is a risk for the patient and you are creating a situation for them. We still have that in the system.

Q86 Andrew George: Okay, you need to get that right, but still in the system at the moment you do not have enough acute hospital beds in many acute hospital settings—maybe not in Northumbria and maybe not in Luton & Dunstable, but certainly in many hospitals there are insufficient numbers of hospital beds.

Pauline Philip: Maybe I can add a little bit to that and to the question that your colleague asked earlier about work force as well. As acute hospitals, we are becoming more and more sophisticated in being able to look at these issues. All of us across the country are looking at developing integrated care and the work force behind it, and we are doing it as part of the national work force planning work. In answer to the earlier question around district nursing, we are trying to look at what the work force needs to be in three, five and 10 years' time.

Going back to Professor Willett's point, we have very much identified—and this is not just a local issue in Luton—the need for having the skilled educated carer. Yes, there is the need for having district nursing, but also there is the role that acute nurses can play in leaving the hospital as part of Hospital at Home. Indeed, in Luton we have developed basically a virtual ward in the last year. The reason I make that point is that, in developing that ward, we closed beds. But we closed beds in a measured way, constantly looking at whether we will need to bring those beds back on stream in the winter—as indeed we have now had to—if the peak in activity is even greater than we had envisaged. There is a lot of learning taking place across the whole of the acute sector about how to do this in a more sensible way, and it is not just closing beds and ending up with a bed stock that is immature in relation to what is actually happening with integrated care.

Professor Willett: In terms of the beds, we are looking for more step-down type beds, which would be in the community. The ideal step-down bed is the patient's own bed with the service alongside the patient, but clearly we have to get to that and this is part of that process. We have to do this while we are still going along with the pressures. That is what is always tough. We are bringing everybody together so that the focus is clear.

Chair: Thank you. We need to keep answers and questions a little shorter if we are going to get through the questions. Charlotte is next.

Q87 Charlotte Leslie: To slightly build on what Andrew has just said, would you appreciate the frustrations? What Pauline said very much was that an ability to reduce beds is a symptom of getting all the other support services right. But what tends to happen—going back to my new Southmead hospital, which replaces an old hospital, which in a city of dramatically growing numbers, with an ageing demographic, was built from 2006 with fewer beds—is that it impacts, as Andrew said, on the ability to get the support services right, because you get panic discharges as you need to free up the beds, people are not ready to go back home and then get readmitted on something else. Is there any way we can stop this? It seems to be a real obstacle to building the support services that we need to enable people to go back into the community?

Pauline Philip: Part of the “win, win”, as we would see it, is to be able to create a situation whereby we can have wards in our hospital that are not running to full capacity, because, going back to your earlier witnesses this morning, that allows us to get patients to the right bed. Certainly all the evidence is suggesting that that has a real impact, not just on the quality of care but on the length of stay, and then it allows capacity to exist in the system for winter pressures, or any other pressure that the health service might face during the year. I do appreciate that when you are building a new hospital you may not have the same opportunity, but we need to work with the professional bodies, we need to work with our regulators, on how we can have a number of beds available in the ward and be able to

scale up and down our staffing levels rather than have the sort of rigid idea that, “This ward has 30 beds; therefore it needs x number of nurses.” We need to be able to scale that up and down.

Q88 Charlotte Leslie: Is a return to the cottage-hospital system, an intermediate, if the ultimate—

Pauline Philip: Intermediate care beds, yes, and I think not just in the hospital but the whole idea of what we need outside hospital in order to support people really being able to stay where they live, whether it is in their own home, a residential home or in a nursing home. Very often, all they need is more input. For example, our Hospital at Home going into a residential home will be able to give the level of support and expertise to the patient. But, going back to Professor Willett’s point, the idea of having some step-up and step-down beds within the community sector is very valuable—and intermediate care beds.

Chair: Thank you. Barbara, are there any further points on delayed discharge?

Q89 Barbara Keeley: Yes. I take a different view on the impact of social care cuts from my colleague Andrew Percy. It is something that is too little understood and I have a couple of questions. The important thing to say is that I do not know how we are in a situation where we cannot even answer the question he posed earlier. It is not a simple matter, I know. As these cuts have been made up and down the country, it would have been possible nationally to have a look from the social care system into the hospital system as to what impact that had. Now we are reaping the rewards of not having spent time on understanding that. I have a couple of quick questions, and there are probably quick answers to these.

Professor Willett, last year you told us that “categorically” there was a problem with delayed discharge, and the figures show that it has become more serious. Can you perhaps be clear about this? We have heard figures this morning of a third of delayed discharges possibly being caused by exit blocking or social care lack of availability. You have just touched on 50% of patients being better at home. It may be that you do not have the figures, it is just a feel that you have and it changes from place to place, but can you say why there has been such significant growth in the number of patients stuck in hospital?

Professor Willett: Yes. There has been a general increase in the number of delayed discharges. In fact, over the festive period we reached something like 20%. We know that about a third of patients are waiting for social care. Two thirds are waiting on the NHS. It is easier to have a case example than national figures because it does vary. In the Oxford University Hospital that I was in on Friday last week, they had 450 acute beds and 180 delayed discharges. You can see how there are beds in the system but they are occupied. Of those delayed discharges, a third were waiting for a community bed, a step-down bed, a sixth were waiting for a care home, either funded by the NHS or by social care, a sixth were waiting for a home care package and a sixth were for other reasons. One thing that we have in the system now is that, because fewer patients are eligible, as I think we have all agreed, for social care packages, it means they become self-funders, and for families and the patient identifying the care, funding it and selecting the right place takes longer.

So the NHS needs, very often, to put those patients under NHS funding into step-down or intermediate care facilities while that happens.

Q90 Barbara Keeley: My local authority has lost £100 million, and I mentioned earlier—I am sure you heard it—about 1,000 people losing their care package. If we get to January and February where they have absolutely completely run out of money and are unable to fund packages, what is going to happen? Is this problem going to get worse and worse? If their budget is completely exhausted, what happens?

Professor Willett: What we have seen is that the system resilience groups—again there may be local examples—will be looking at the winter resilience moneys and they may well be buying additional capacity; they may well be putting in more community support and they will be buying more beds in care homes.

Q91 Barbara Keeley: So you will have to use NHS money to prop up where budgets have been cut.

Professor Willett: We have to look after the patients; we have to support them. We are looking at many things in this area, but sometimes, while we are waiting to make a decision, clearly the NHS and some trusts are already using some of their moneys in order to place patients while that decision is going through.

Q92 Barbara Keeley: The question, Sir Bruce, really is also going back to this point last year where you said that between 20% and 25% of people in hospitals should not be there. That was in January last year; we are one year on from that, and you said you were working to understand that problem. I made the point that I have argued for a long time, not just in the last Parliament but for two Parliaments, about improving social care. Is there an answer? I have had examples in recent weeks of poor care leading to hospital admissions and into hospitals which could not take those admissions. If you take things like poor catheter care and dehydration, people in a care situation can get to a point where they do end up in hospital. Where have you got to with that?

Professor Sir Bruce Keogh: There are two things. First, that number of 20% to 25% would be widely recognised around the NHS, and some hospitals would claim slightly more than that; Keith has given a pretty good description of what goes on in his own hospital.

The second thing is that we have had a breakdown—you have heard of it from Chris Ham—and that is a pretty fair breakdown, and equally from Keith, but it might be an opportunity to just mention that we see some hope for this in the Better Care Fund and—

Q93 Barbara Keeley: It is not going to fill the gap; it is not new money, is it? Overall, it is not new money.

Professor Sir Bruce Keogh: It is not new money, but it is a transfer of money, in part from the NHS, and it is also pooled money from local government. That comes to about £5.3

billion, of which the areas of spend will be in acute care, mental health, community trusts, some areas of continuing care and some areas of primary care. That is how—

Q94 Barbara Keeley: We cannot waffle round this really. I have described a situation where my local authority has lost £100 million and this year 1,000 people will not have their care packages. They cannot put any more money into a situation to resolve the problem that those cuts have caused, can they? However you merge it, if you do not fill the gap—

Professor Sir Bruce Keogh: No.

Q95 Barbara Keeley: It is the point we had earlier about two leaky buckets being insufficient; they are not going to solve a problem. That is a fair analogy, is it not? However you juggle it round and however you merge it, if it is insufficient, that is the point I am trying to get to.

Professor Sir Bruce Keogh: I would not pretend to have an answer to social care funding, but it clearly is an issue and they have had to deal with some very difficult funding issues.

Barbara Keeley: But in the work you are doing that you talked to us about last January, one year on, given the problem this is causing in A and E, what is going to happen to look at this? It is not sufficient just to say, “It is not my issue,” is it?

Andrew Percy: We heard the evidence—

Chair: We are not here to argue among the Committee. We need to hear the answers from the panel and then to move on to David Tredinnick.

Q96 Barbara Keeley: Could you say what work you will undertake to have a look at it?

Professor Sir Bruce Keogh: The work that we are undertaking is done predominantly at a local level through the health and wellbeing boards.

Q97 Barbara Keeley: So NHS England is not working on it.

Professor Sir Bruce Keogh: Other than having oversight of the Better Care Fund, the answer to the social care funding is not one that I can answer from NHS England’s point of view.

Barbara Keeley: Okay, that is fine.

Chair: Thank you. Now we turn to David.

Q98 David Tredinnick: Quickly, as to access to general practice and other medical services in support of doctors, what additional investment and support can you offer to

primary care in the coming months to help increase capacity and provide alternative routes to health care other than A and E?

Professor Willett: It is clearly important, we recognise, and from the urgent and emergency care review I would like general practice to be conducting that out-of-hospital orchestra because I think they are in an ideal place. We also recognise the recruitment problems, as we have discussed earlier. Within the urgent and emergency care review we are looking at all the alternative support they can have. We have some really good examples and we have made a very strong description of how pharmacists can assist. We know that pharmacists going into general practice alongside general practitioners can take a significant proportion of the work load. That is also true around the nurse practitioners in general practice as well. Part of what we are doing is opening all of that up. We also have to work with general practice to come up with new ways of working so that we are using general practice in the most efficient way possible. Pharmacists, for instance, can deal with medicine optimisation, side-effects, vaccinations and a whole raft of things that would often normally end up with a GP; likewise, specialist general practice nursing.

Q99 David Tredinnick: A couple of weeks ago I was at the Letchworth Centre For Healthy Living, and I talked earlier on about the Hinckley health and wellbeing board looking at directories of support services and other properly regulated alternative practitioners who are out there. Would it not make sense to try and reduce demand on surgeries by making knowledge about other practitioners who are properly regulated in the area more widely available? Then I have one quick question on flu. Do you agree with that?

Professor Willett: The directory of services is an integral part of what we have set for the urgent and emergency care review. A live directory of services that you can book into is absolutely essential to the 111 service, the 999 service and everybody else.

Q100 David Tredinnick: Thank you very much. Sir Bruce, you touched on flu. You may not be aware of this, but will you look at it very carefully? The Canadian Government have just licensed a homeopathic flu vaccine—not one of their agencies, but the Government. Will you look at this and see what potential there is, and possibly write to the Committee with your conclusion?

Professor Sir Bruce Keogh: Yes.

David Tredinnick: Thank you.

Q101 Robert Jenrick: I have a quick question. A lot of people have raised the question of GP surgeries being closed throughout the Christmas period and what impact that might have had, particularly this year given the days on which Christmas and new year fell, and so on. Is that something that you are reviewing and which could be looked into in the future? I know it is a complicated issue, but many members of the general public see it as an issue that could be resolved.

Jim Mackey: The real or perceived access issue for primary care is a problem and it is well recognised. We had two sessions yesterday with both of our CCGs partly about this and partly about new models of care and how we would develop things in the future. To

be fair, one of our CCGs did create quite a lot of extra GP capacity before Christmas. It was a little late and it was not very well publicised, so we need to learn from that in the future, but I do agree with Dr Mann's earlier point that people want to come to the bit that they see as open all of the time. We could certainly benefit from a more robust primary care presence on all of our sites. We do have it on some and it could certainly be expanded. In terms of taking the load off A and E departments, it is a big factor, but it is one of all the other things we are talking about. One of the key things for me this morning is just how complicated this thing is. It is not one silver bullet. It is lots of things that need to work together, but it absolutely does need to be addressed for the future.

A final thing I would say is that we could have had all of that in place and in our patch it would not have stopped the spike of admissions. Most of the people we admitted needed to be in hospital. They could have seen a GP first but the GP almost certainly would have sent them for admission. That was what caused our admissions.

Professor Willett: Across the country everybody, registered or not, at home or not, has access to the out-of-hours urgent GP service 24/7. A lot of the public are not aware of that and how to access it. We know that from the surveys, and part of bringing everything together means that that becomes one of the services that we can use in a much more effective way.

Chair: We move on to Andrew Percy and ambulances.

Q102 Andrew Percy: You heard my comments earlier with regards to how we can use the ambulance services. This is a question I have raised before as I have an interest in this area myself. Eighteen months ago NHS England first started talking about “see and treat” and “hear and treat”. What progress has been made up to now on that?

Professor Willett: One of the early products we will be getting out next year as part of the urgent and emergency care review is something we have been working on with the ambulance services and all our partners there. The guidance around that will be published as one of those products during the early part of next year—sorry, this year; we have moved years.

In addition, there is a large piece of work going on led by Health Education England, our partner in terms of the work force issues. In order to shift the paramedic work force away from what you well know has traditionally been very much a resuscitation and injury-based transfer-you-to-hospital model to one which becomes that mobile community treatment option, it is a curriculum and education change which will obviously take a longer period to come in. Things like the “hear and treat” options and the way in which the systems within the ambulance service and 111 that involve the ambulance service can offer patients treatment and clinical advice without necessarily involving an ambulance directly, or by using paramedics or general practitioners or nurses, are elements within the products we will be bringing forward.

Q103 Andrew Percy: What is the time frame in which we are going to see a radical refocusing of our ambulance services? It is still very much, because of the pressure, a “scoop and carry” service; that is the vast majority of calls.

Professor Willett: In this year there will be changes. There will be changes in terms of the advice and guidance that we have helped them deliver. We will be giving them out to the services and to clinical commissioning groups so that they can start to work through the system resilience groups to make those changes in the service. We hope to have financial incentives in the system that make it very sensible for both the commissioners and the providers to move to that model. As I say, in the longer term, we will set a very clear projection for the ambulance service as to where it needs to take it, how it employs, trains and develops people for the future. In many ways, that is really important because we know that paramedics have been under enormous pressure. As to retaining paramedics, we also have to create for them a viable future.

Q104 Andrew Percy: Can I ask something about 111 with ambulance services as well? In my area, Yorkshire ambulance service provides the ambulance services and also the 111 provider, or, rather, the Yorkshire bit of my constituency, but for the bit that is in Lincolnshire, Yorkshire ambulance service provides the 111 service but EMAS provide the ambulance service. It all seems a bit crazy that the two are separate, and indeed you can even argue about the fact that out-of-hours service is, and Lord knows who provides the out-of-hours service to where I live. I have never had to use it and I am completely confused because it is certainly not the local GP practice. Is there an argument for saying that all of this should just be integrated together? There must be cost and efficiency savings in that. If we are going to have “hear and treat”, that is partly 111’s role already. Yorkshire ambulance service has been able to back up in my area the 111 service with clinical expertise because of what they have available to them, so should we not just be looking to do that everywhere?

Professor Willett: You make a very strong argument for exactly what we have described in the urgent and emergency care review. We have to bring all of those together, and how they are contracted and commissioned is another matter. From the patient’s perspective it has to be seen as one system, a uniform offer which gives the patient what they want and are looking for and addresses their need. That is exactly where we are going with the review. So, yes, if they are all separate organisations, the interface has to work absolutely cleanly.

Q105 Andrew Percy: I suspect—Chair, this is a comment/question—the only concern about all this is that we have been talking about it now for a very long time. When is it going to come to fruition? I know you said that some stuff will happen next year, but I think last year you said something was going to happen this year and, you know—

Professor Willett: We have completed the development year. We are now into delivery; it will happen.

Q106 Andrew Percy: So when you come back this time next year to tell us how everybody has hit 99.9% and how NHS England has been incredibly successful, all this will be in place.

Professor Willett: I will certainly come back next year and tell you exactly what we have developed and what is working.

Professor Sir Bruce Keogh: We can argue about the decimal point.

Andrew Percy: Let us hope that is the argument.

Q107 Chair: That is a good point to finish on, but, just before we go, my colleague David Tredinnick made a comment earlier about homeopathy and I should stress that that was very much his personal view and not the view of the Committee. Speaking myself in a personal capacity, I would be completely horrified if you licensed a homeopathic vaccination for flu, but there we are.

Andrew Percy: It is not a view of Canadians either, as part Canadian myself.

Professor Sir Bruce Keogh: I agreed that I would look into it and write back to the Committee, and I will do so. Before we close, can I take the opportunity, as medical director, to say—and I am sure on behalf of this Committee as well—a really big thank you to the staff in the NHS who have done so much through quite a turbulent period to keep everything afloat, to keep the quality of care as high as they possibly could? Much of that is fuelled on good will, professionalism and a desire to do well for the people that they seek to treat. I am sure we would all want to express our gratitude.

Chair: Thank you, Sir Bruce, and I am sure I speak for the whole Committee in saying that we would absolutely support that view and thank you very much for all you and your staff do across the NHS. Thank you.