HOUSE OF COMMONS

Public Administration and Constitutional Affairs Committee

Oral evidence: Dying without dignity: PHSO report into end of life care, HC 432

Tuesday 15 September 2015

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Written evidence from witnesses:

- Marie Curie (DWD 03)
- Department of Health and NHS England (DWD 06)

Watch the meeting

Members present: Mr Bernard Jenkin (Chair); Ronnie Cowan; Oliver Dowden; Paul Flynn; Mrs Cheryl Gillan; Kate Hoey; Kelvin Hopkins; Mr David Jones; Gerald Jones; Tom Tugendhat; and Mr Andrew Turner.

Also attended: Dame Julie Mellor, Parliamentary and Health Service Ombudsman.

Questions 1-95

Examination of Witnesses

Witnesses: **Dr Jane Collins**, Chief Executive, Marie Curie, **Professor Irene J Higginson**, Head of Department, Head of Division and Director of Cicely Saunders Institute, King's College London, and **Professor Sir Mike Richards**, Chief Inspector of Hospitals, Care Quality Commission gave evidence.

Q1 Mr Bernard Jenkin (Chair): I welcome our three witnesses to this evidence session about end of life care and the report produced by the Parliamentary and Health Service Ombudsman, "Dying without dignity", which was produced earlier this year. Could I ask each of our witnesses to identify themselves for the record, please?

Dr Collins: Dr Jane Collins, Chief Executive of Marie Curie.

Professor Higginson: Professor Irene Higginson, Honorary Consultant in Palliative Medicine and Professor of Palliative Care and Policy at the Cicely Saunders Institute, King's College London.

Professor Sir Mike Richards: Professor Sir Mike Richards, Chief Inspector of Hospitals at the Care Quality Commission.

Chair: We will try to ask short questions and it would be very helpful if you gave short and crisp answers. I will pull you up if I think it is not going to the point and also I will ask my colleagues to remain brief and I will pull them up if I think they are not getting to the point. To start with, how do you evaluate the PHSO's report as a contribution to the debate about end of life care?

Dr Collins: It is very helpful because it pulls out the issues that those of us who work in end of life and palliative care recognise in a very human way, and having those individual stories, which make incredibly depressing reading, brings this to the fore. That is not to say that we did not know that there were problems, but it has been a very effective way of bringing that out. We need to, of course, make sure that there is evidence, more data, sitting alongside it, but these stories are key.

Professor Higginson: I agree with that. The report is very helpful but it does not tell us what we did not know already. It is very helpful to keep it in the public mind and the report has done that. It was helpful that the report also included people who had non-cancer conditions and complex multiple illnesses and also picked individuals who had different problems. But the issue now is to respond to the report and take some action and change things.

Professor Sir Mike Richards: I endorse what has just been said by both my colleagues: very useful stories. The only thing I would say is perhaps some more about the ones that are dying from causes other than cancer because, roughly speaking, three-quarters of us will die of something that is not cancer, so it would be good to have a few more of those.

Q2 Chair: It has to be said that there are some pretty harrowing case studies here.

Dr Collins: Yes.

Professor Higginson: Terrible.

Professor Sir Mike Richards: Absolutely.

Chair: An individual who was obviously dying and he was still being treated as though they were trying to keep him alive; a deaf person who was asked to come in for another GP appointment to be told that she was dying of cancer, she never came and they never followed up the appointment and eventually they told a relative; some really disastrous cases. What strikes me about the report—and it probably was not the intention of the report to go this deep—is why do people behave in this way? Why did GPs fail to do that in that case? Why did a registrar try to put an intravenous drip into a patient 14 times when in fact that patient was dying and could not take an intravenous drip and should have had a subcutaneous injection instead? Why did people walk past beds where people are suffering in pain and not think, "I have to do something about that now" instead of waiting in the queue for the various machinery of various hospitals to whirr into motion of their own accord? Because we are all having this conversation about end of life care—the Select Committee has done a report, there have been lots of reports produced—but none of them seems to get to the point. Why do you think this is the case?

Professor Higginson: Shall I start? You make very valid points and I agree with everything you say and what comes out in this report is hugely tragic. Why does it happen? There is a chronic under-investment in the training in palliative care and in the

provision of services. For example, in undergraduate training, in five years of medical school the average amount of training that a doctor gets in palliative care is about 20 hours. That is far too little. We need far more training for doctors in palliative care. I agree people should not walk past the bed, but one of the problems is that a lot of people do not know what to do or they cannot recognise that somebody is dying, as the report puts out. If you look at what commissioning groups spend on palliative care services, the funding review showed that they spent £186 per person who died. Some commissioners fund that little; some commissioning groups do not even fund palliative care services in hospitals. It is not surprising, with that degree of under-investment in this area, that we have these sorts of problems.

Q3 Chair: That does not explain why somebody walks past a bed.

Dr Collins: Some of it, building on what Irene has said, is that staff now no longer appear to feel confident in looking after people who are dying and obviously that is a significant training issue that you would think would be relatively easy to sort out, but a lot more work needs to be done on that, both at undergraduate and then postgraduate level. We need to link it obviously with some of the other issues that have perhaps come before this Committee in relation to compassion and care. I do think though that when people do not know quite what to do they tend to ignore it, and that is the very worst thing you can do, not only for the person who is dying, but also their family. We have to work out how we can best address this. It is very much down to NHS organisations, but the voluntary sector can undoubtedly play a part in that.

Q4 Chair: Professor Sir Mike, you inspect the hospitals in which people are walking past the beds of people in pain. Why do you think that failure occurs?

Professor Sir Mike Richards: The first thing to say is we at the CQC have given priority to this area for the very reasons that you have already heard about, that it is an area that has not previously had sufficient priority. We have established that assessing end of life care is one of our eight core services that we will inspect when we go into a hospital.

Chair: With respect, that was not the question that I asked.

Professor Sir Mike Richards: No, but that is the context of being able to say that, as has already been said, multiple different factors contribute to this. It is training; it is also the commissioning; it is the fact that we do not have specialist palliative care services on hand seven days a week in four-fifths of our hospitals; it is that we have not done enough to skill up the nurses and the doctors on the wards, as well as having a specialist palliative care team, but that is a thing that a specialist palliative care team can do.

Q5 Chair: But, with respect, I hear Dr Collins saying this is about confidence, we hear it is about training and lack of skill. This is about a sense of responsibility. This is about people on the wards, the registrars, the nurses, the senior staff feeling responsible for what is happening and they clearly do not feel either empowered or responsible. What is wrong in an

organisation that does not encourage people to feel responsible? You are inspecting my own hospital this week.

Professor Sir Mike Richards: That is indeed true, I am, or my team is. The answer again is that I do not think this has been given sufficiently high priority by the health service as a whole—

Chair: But that sounds like a policy issue. I am asking about human behaviour. Why do you think people behave in that way? How do you encourage people to behave in a different way?

Professor Sir Mike Richards: The differences that we see between the very best and the very worst are that in those places that are doing a very good job, and there are some, there it is given priority right from board level. There are trust-wide groups that say, "How are we going to make this happen?" They are skilling up staff on every ward, as well as having a seven-day service. They are making it a priority so that people know who to turn to. If, as Dr Collins has said, they are not feeling confident, they know who they can turn to when they are in need.

Q6 Chair: Let me ask the question in a different way: what do you feel is in the mind of a practice manager or a GP who does not bother to follow up a request for another appointment or in the mind of a nurse who sees someone suffering in a bed and feels that there is nothing he or she can or should do to alleviate the suffering of that patient? What does it feel like to be that nurse? What do you imagine is in the mind of that nurse, that no action is taken?

Professor Sir Mike Richards: In fact, we observe high levels of care and compassion when we go into hospitals, except in certain areas where staff have been spread too thinly and then we see that compassion go. I could take you to the wards—and we have reported them in our reports—where that has happened. This is fortunately relatively uncommon, but it does happen where the staff do not have the skills or there are not enough staff on a ward. We do see it and we then comment on that in each of our reports.

Then can I come on to the general practice side of things, which clearly I am not personally responsible for, but it is a very important thing? The five priorities for care, the PHSO report, the report that I authored on the end of life care strategy some years ago, all start with the fact that people are not necessarily recognising that people are approaching the end of life. If you do not recognise that, that is a major factor. That is the area that we have all identified as the most difficult and one that we need to do more about.

Q7 Chair: What is it you think commissioners, trust boards, trust chief executives need to do, because you referred to that sense of people losing a sense of responsibility for what is happening because they cannot or do not have the skill, or there are not the resources? Even in the case of where hospitals or general practices are under pressure, what needs to happen to make people realise that they are responsible, jointly and severally responsible, that there needs to be a team effort to be responsible whatever the circumstances, whatever their skill levels, whatever their resources? What needs to happen?

Professor Sir Mike Richards: Shall I start on that one? First of all, it does come from board level, there does need to be a board member responsible and not just in name. I can equally take you to places where, let us say, the director of nursing has been given the title, but when you look and say, "What have you done about it?" very little has been done. It does come from the top. Then there has to be the resources put in to make sure that there are seven-day services. There needs to be the mechanisms put in to make sure that pain control is being done well and so that they are assessing it and they do know what is happening. At a very, very basic level in every hospital I go into, the chief executive knows how many births there have been in that hospital in the past year; not every chief executive knows how many deaths there were in that hospital. How can they possibly plan the service if they do not even know that?

Chair: Either of you, just briefly, anything to add?

Dr Collins: Just to agree, and there is also the need, particularly in a hospital, for the consultants in the team, who after all are the leaders of the specialty team, to take a personal responsibility in relation to people who are likely to die. Again from the report, but also other reports, often it is the junior doctors who will be caring for the person day after day and they may have more understanding of what is going on sometimes than the consultant and that obviously needs to change.

Professor Higginson: You need the board level commitment. You need the senior medical and senior nursing leadership commitment to this field. In many hospitals now they organise specific rounds to discuss complex cases that have come up when people struggle with these difficulties. You need palliative care services in hospitals that go around the wards and model the right behaviour. I am a clinician. I do on-call. I get called by doctors at all hours of the day and night about a problem that they see and there are several problems that I observe. They do not know how to assess what is going on or the symptoms and they do not know what to do. If out of hours they do not know to do, they are pressured, they have many things on their plate, they will focus on something else when it is not discussed.

Q8 Mr David Jones: Picking up on Sir Mike's point about seven day a week care, the report identifies 24/7 services as a key issue in improving end of life care. To what extent do you agree with that and could you explain the importance of that?

Professor Sir Mike Richards: It is extremely important. The number of people dying in a hospital across different days of the week is exactly the same. There have been a lot of reports about people who are admitted at different days of the week, but if you look at that same report, Sunday, Monday, Tuesday, right through the week, it is almost exactly the same number of people dying. We need to consider specialist palliative care services as urgent services because, as the report illustrates, people need to be seen within a matter of minutes or very few hours, not waiting 11 hours or more, as in the report. We need to have these services available seven days a week and we need to have access to experts like Professor Higginson out of hours so that people can get the advice as well. We know from various studies that only about one in five hospitals is currently offering a seven-day specialist palliative care service.

Dr Collins: We have a very useful experience as well from Wales, following the Sugar Report, who have introduced 24/7 cover from consultants and clinical nurse specialists and there have undoubtedly been improvements in palliative and end of life care in Wales as a result. That is not to say that everything is sorted, but there have been improvements as a result, so we know it works.

Professor Higginson: We have very good evidence that if you have good intensive home palliative care as well as support in hospitals, then you can double the odds that somebody has of remaining at home and dying at home and you can also halve the odds of somebody coming into hospital and being admitted there. We have research from our unit in the Cicely Saunders Institute that has shown both of those things. The value of extending 24-hour cover would be very great in terms of enabling people to be where they want and also potentially reducing the pressure on A&E departments with people who do not want to come into A&E and could be managed at home. Definitely I agree that we need 24-hour care in the community and in hospitals. The issue is the staffing of it and the resourcing of it, because members of the Association of Palliative Medicine are already often providing this, but there are not enough of them. What they are doing is covering very large geographical areas or many multiple hospitals to be able to do a rota that is possible.

Q9 Mr David Jones: Yes, and I was going to ask you about what practical steps could be taken to improve access to 24/7 services. Have you any views on that?

Dr Collins: We could certainly encourage; again, from the voluntary sector we cannot make things happen. For example, in London, where there are a large number of palliative care consultants, if we could encourage them to work together and work across organisational boundaries, we might be able to create what has occurred in Wales, where the consultants are on—I think it's about one in 25 to provide advice across Wales for palliative care consultants. We could try to do something like that. Certainly in the larger conurbations, where there is a will there would be a way. In rural areas, there are always going to be challenges, so if we were to think about the south-west of England, for example, there would be challenges doing it in that way. But a lot can done through Skype—again there have been a few studies showing that that can be very effective. Of course, telephone advice can be provided anywhere. It may be that you will not be able to get a consultant or a CNS, a clinical nurse specialist, to go out and see the patient.

Q10 Mr David Jones: The Association for Palliative Medicine has suggested and I quote, "There should be Department of Health funded pilots, in perhaps 10 different regions of the country, to ascertain the model that provides most benefit to patients and those important to them, yet is cost-effective". What are your views on that suggestion?

Professor Higginson: That came from the Association for Palliative Medicine, of which I am a member, and I support that suggestion. The issue is that nobody has looked at the best and most effective way of providing: how big should the patch be? Who should be on call? Do you always need to have a consultant, could it be a nurse on some occasions, which might be more cost-effective? The proposal to properly fund and evaluate the cost-effectiveness of pilots would be enormously helpful. To what extent do you need, when

you are on call, home visiting? To what extent can you do it by telephone advice or Skype advice? Some of the extent to which you need to visit a patient or not depends on the quality of the assessment and the information you are given over the phone. If I am given an extremely good assessment about a patient I can give very good advice, but if I am given a very weak assessment by somebody who is trying—as in the case that Mr Jenkin gave—to put in IV lines, it is much more difficult for me to give that person reliable advice because I cannot rely on the assessment. Trying some different models of providing out of hours care, while we move forward doing it, would be enormously valuable.

Q11 Mr David Jones: Have you yet had any response from the Department of Health on your suggestion?

Professor Higginson: I am not aware that we have, sorry.

Professor Sir Mike Richards: I am also a member of the Association for Palliative Medicine, even though I am not acting as a doctor at the moment. What we can also do is build on the differences that we are now seeing between the places that are managing to deliver seven-day services and 24-hour services and those that are not. I do think more evaluation of how cost-effective this is is absolutely needed and I would support that. But we have some very good models of care that we can evaluate and some other places where we know it is not happening yet.

Q12 Ronnie Cowan: You spoke earlier of 20 hours of palliative care in five years of training, which the end measures are appallingly poor. You said sometimes you cannot rely on assessments that have been given to you and you spoke earlier on about the staff levels being stretched and people being stressed. I would simply say here that if the NHS in England had funded more, the amount of training and the staff levels would go a long way to solving these problems.

Professor Higginson: I do not think it is only about money. I see many examples of not very good palliative care existing in the private sector as well as in the public sector and I am aware of problems there too, because some of it is an attitudinal issue about being willing to accept that this is an important part of medicine and prioritising it alongside other things. I do feel that that is a very important thing. Part of the issue about the lack of training is that it varies hugely among different medical schools. For example, in my own medical school we teach medical students in all five years of training. We try to make sure that each medical student visits a hospice and sees at first hand some of the brilliant care that can go on there. But there are many medical schools where they do not either have access to that or they have not prioritised that. That is not an issue for the NHS, in a way it is an issue for the General Medical Council and universities that provide this training, as well as the NHS.

In terms of commissioning the palliative care services, that definitely is an issue for the NHS and definitely it needs to be improved. Some community commissioning groups are supporting it and clearly some are not, with the small amount that they are paying towards specialist palliative care towards each death, which I believe is not necessarily just a

question of money because palliative care has an evidence base and is cost-effective. They could probably support palliative care at no additional cost to what they are doing by realigning their budgets in a better way.

Dr Collins: Maybe an important point—and I do not want this to sound as if I am saying that this is not an important topic, and we are not doing well enough across the whole sector of palliative care, but Marie Curie, over the last few years, has funded something called the "Care of the Dying Audit", which has been carried out by the Royal College of Physicians in London, looking at deaths across hospitals in England. It is clear that 70% of families feel that their loved one had good care in the hospital. Again, that would perhaps suggest that it is not just about money, it is about other factors as well. But we do have to recognise that 70% of people do feel that their loved one did get the care that they would have wanted them to have. We should be focusing, of course, on the 30% who did not and that is the whole point of today, but we have to make sure we see the perspective always.

Professor Sir Mike Richards: Can I just add that I agree that it is not about money, because if it was, we would not see this degree of variation across the country. We are seeing hospitals, that can be adjacent hospitals, can essentially have the same amount of funding going into them having very, very different levels of palliative care and outcomes for patients.

Chair: I am so glad you said that, because that shows it is an issue about behaviour and leadership, it is not a question of resources.

Q13 Kelvin Hopkins: I have not heard any satisfactory answers to the question that the Chairman asked at the beginning. We have heard a lot about training and resources and management, but the simple compassionate feeling of a nurse walking past somebody in pain or distress, that is the interface. If I was a nurse, I must say I would go to somebody and say, "This person is in pain, we have to do something". It is at that level that the problem arises, and even despite pressures on nursing, nurses should feel that compassion and should be able to deal with it at that moment. If you say 70% are satisfied, 30% are not satisfied.

Dr Collins: Yes, quite. It is, yes. But I just wanted you to know there is 70%.

Kelvin Hopkins: Yes, but that is not my question. The most recent published CQC ratings for EOLC services illustrate inconsistency in the quality of the current provision with safety concerns about end of life care services in 50 of the 105 hospitals inspected. That is a lot, nearly half, "There is also inconsistency in the availability of hospice and community services". Why is there still such variability in the provision of quality end of life care services?

Professor Sir Mike Richards: I suppose I had better take that one first. The first thing to say is this is the first time that we have shone a spotlight on it, by making end of life care one of the core services that we always look at and this is where we are seeing the variation. You are absolutely right, we are seeing that variation. Remember that we rate services for safety, for effectiveness, for caring, for responsiveness, for being well led, each one of those gets a rating and then they get an overall rating. There are specific things that we look for under each of those headings. We are finding that variation but we are

also seeing it can be done very well in the NHS. It comes back to the point: if it is given the priority and the leadership, it can be done well in the NHS.

Q14 Chair: Can I just press you on that point?

Professor Sir Mike Richards: Yes.

Chair: You have said something rather astonishing. CQC has for years been involved in inspecting hospitals to ensure there is not unnecessary suffering and you have just said, "We have not been shining a spotlight on this".

Professor Sir Mike Richards: We have not been shining a spotlight specifically on end of life care, that is true, so two years ago—

Chair: Yes, but unnecessary suffering is unnecessary suffering. Why does it take a spotlight on the need for palliative care and end of life care for CQC to notice that there is unnecessary suffering in hospitals?

Professor Sir Mike Richards: This is precisely why we changed our model of inspection two years ago and that is precisely the job that I came in, as far as hospitals were concerned, to do and where we said that our previous approach had not found all the problems. It had found that there were issues to do with cleanliness, there were issues to do with this and that. What we are doing now is taking a much more rounded view of a hospital by sending in a much larger team looking at specific services, the A&E service, the medical surgical services, but also with that specifically putting a focus on end of life care, which, to the best of my knowledge, we are the only place in the world that is now doing that.

Q15 Chair: Perhaps less obsession with whether there are dirty carpets or the fridge temperature log has not been kept properly, more attention to what is happening to people.

Professor Sir Mike Richards: It is not so much less attention on those—fridge temperatures do matter because things like vaccines cannot work if they have been kept at the wrong fridge temperature. Putting that to one side, we are putting much more emphasis on looking at whether people are recognising that they are approaching end of life, the approaches to pain control, whether they have a specialist team, whether the nurses are being skilled up, and whether they are adopting care planning. A whole range of different things that we look at in our inspections now that we did not look at before, which our inspectors were not previously trained to look for.

Q16 Kelvin Hopkins: I am still concerned that there might be inspections where you go away and you write a report and some weeks later somebody comes back. When an inspector can see people suffering in a hospital, particularly elderly people near the end of their lives, on that day they could go to the chief executive and say, "Things are not right. There are people suffering in your elderly care ward now. You should be doing something now to stop that pain happening".

Professor Sir Mike Richards: We do. I can assure you that where we observe that poor care we go straight to the chief executive. At the end of each day of our inspection we will have a meeting with the chief executive. If necessary, we will go earlier in the day if we see something. We do see problems. Where we see those problems we escalate them absolutely straight away.

Q17 Kelvin Hopkins: You talked about leadership and management and there is a question of leadership. Is poor leadership being addressed? One concern I have is that there has been, to an extent, a business model introduced in the health service for managing hospitals. The chair of our local hospital trust some years ago resigned and retired from that job because she felt that the hospital was becoming a business rather than a service for care. But how can we address this poor leadership and how can we get leadership that is more concerned about the patients rather than just the business?

Professor Sir Mike Richards: Because one of the things that we ask about each of our core services, including end of life care is, "Is this service being well led?" We will look both at the trust level: is the senior management of the trust giving any priority to this? Can they demonstrate that they are giving that priority? We also look at the service level, whether the specialist palliative care team, for example, is well led. In many cases, it is the trust level that is the more serious problem.

Q18 Chair: What, in your experience, is the reason that senior leadership in a hospital has not been told about things going wrong in the wards and it takes CQC to come to them and say, "Do you not realise that?"

Professor Sir Mike Richards: This is a question of what is the overall governance within a hospital. Would a chief executive or a director of nursing know which ward was the problem ward? Do they have good ways of assessing this? If you go to somewhere—

Q19 Chair: No, I am asking a different question. What militates against the frankness and openness, because I do not know a nurse who would walk past a bed and see someone suffering and feel okay about that? I suspect there is a desperate sense of their own failure as they do that, but why have they not told somebody about it?

Professor Sir Mike Richards: What happens, and my best explanation for this, is in general the levels of compassion and care are very high.

Chair: Very high?

Professor Sir Mike Richards: But where that breaks down it is almost exclusively where individual wards are understaffed, where the staff are stretched so thin that they lose the compassion. There is one—

Q20 Chair: Except you say yourself that it is not a matter of resources. There is very good practice in some under-resourced hospitals; there is very poor practice in exactly analogous hospitals. Why are you now resting on the resources argument?

Professor Sir Mike Richards: I am not. One of the things is that it is often just an individual ward that may be understaffed and have they recognised that, have they assessed the acuity of the patients—

Q21 Chair: Understaffed is an excuse for less compassion?

Professor Sir Mike Richards: It is not an excuse for it. I am saying it is an explanation for it, so one particular—

Q22 Chair: Understaffing creates additional pressures. Why can the people on the ward not raise the problems arising from those additional pressures?

Professor Sir Mike Richards: They may have raised them before and they did not get any action—

Q23 Chair: Why were they not heard?

Professor Sir Mike Richards: I think that is poor leadership and people just say—

Q24 Chair: What do you need to do to address that poor leadership?

Professor Sir Mike Richards: They first of all—

Q25 Chair: It is about listening and hearing and supporting.

Professor Sir Mike Richards: They need, in the hospitals, the systems in place so that the channels are open so that they do hear what is going on. The hospitals that are well led have an open culture, they encourage people to report when things go wrong. We see that they report more incidents than the hospitals that are less well led because they encourage that, so that they can learn from that. If you go to somewhere like Salford Royal or Frimley Park, they have this very open culture of saying when things go wrong so that they can be put right. That is encouraging culture within the hospital, which again we assess when we go in and also we see it from some of the answers to the NHS staff survey.

Q26 Kelvin Hopkins: That takes us directly to my last question. The Health Committee recently recommended giving responsibility to delivering good end of life care to senior named individuals, both at national and NHS trust level. How would this help improve—I do not know how it would improve it, but I think it would improve it. But is accountability in the system of that kind not vital?

Professor Sir Mike Richards: Yes, it is vital, but it has to be more than just naming an individual. That individual is then going to take the responsibility and that is why we will then ask the questions, "Okay, so it is not just that you are nominated as the lead for end of life care. What have you done about it?"

Professor Higginson: They need to understand that they need to do the right things about it, not just write a report that sits on a shelf somewhere. They need to take action.

Q27 Kelvin Hopkins: Walking around the hospital, if you are at an NHS hospital, seeing patients in beds, making sure you know what is going on and going, if necessary, to the chief executive and saying, "Ward B is not doing a good job now. We must change it, we must improve it".

Dr Collins: In some ways it is easier in hospices because they are smaller, but certainly whenever I go and visit our hospices I will go and talk to the patients and their families, because you need to ask them. Perhaps we have not drawn out the importance of getting feedback. You can get feedback and people want to provide feedback even if they are quite close to death. That is incredibly valuable as well because they will be explaining how they feel. Sometimes the families may perceive things rather differently from the person who is dying themselves. It is important we make sure that we get that as well. That would be the expectation, that the responsible person in the organisation ensured that happened.

Professor Sir Mike Richards: Getting feedback from the patients and indeed from relatives is extremely important. One change that I would like to see is that, when hospitals get complaints, they could be coded in some way to say, "Did this complaint in any way relate to care given at the end of life?", let us say in the last month or last three months of life. That is not currently done, so we cannot very easily look at all the complaints in the hospital and say, "Which ones of those specifically related to end of life care?"

Professor Higginson: Can I make a couple of simple suggestions in relation to your argument? One is that we do know that extremely good care is offered in hospices, of which 25% of hospices in this country are NHS funded and the rest are voluntary funded. These should be used much more as a way of demonstrating how good care can be provided and there should be much closer working between the two.

The other thing is that unfortunately hospices, inpatient hospices, care primarily for patients who have cancer and only 6% of all deaths in this country occur in hospices. Only 4% of people with non-cancer conditions die in hospices and that is not changing. This is not an issue for us for the future, because we have ageing populations, we have more older people who will die of more complex multiple diseases. I do think we need to look hard at how we build better bridges between voluntary hospices and acute hospitals and learn more from them, and also think about what is happening in some other countries where they have hospice-style wards in hospitals that demonstrate within that hospital what happens. You can see this in parts of Europe and in Canada and in North America. I do think that particularly for people who have conditions other than cancer we should start thinking about these sorts of arrangements.

Q28 Tom Tugendhat: What about people dying at home? What is the percentage of people who die at home rather than a hospice?

Professor Higginson: In this country currently about 22% of people die at home.

Q29 Tom Tugendhat: Which is what people always tell me they would prefer to do.

Professor Higginson: Which is what they primarily want, although—

Tom Tugendhat: I am patron of a hospice in Weald, and even people there—and it is a very good hospice—said they would rather be at home.

Professor Higginson: Absolutely. Now about 40% to 50% of people who go into an inpatient hospice are discharged home and will continue their care at home. They go into the hospice and one would use a ward in a hospital in a similar way. One goes into the hospice often to get pain or symptoms or complex problems sorted out or sometimes to help the family get a problem that they have sorted out, and then goes home.

Q30 Tom Tugendhat: Would you include in your 4% those who are still being looked after by a hospice? They happen to be at home but their palliative care is done by hospice but at home; do you include that in the 4%?

Professor Higginson: No.

Dr Collins: They are counted as home.

Professor Higginson: That would be counted as home and it is fair to say that—

Q31 Tom Tugendhat: I am slightly cautious about the way you are using the statistics because they are not quite as clear as you suggest.

Dr Collins: That is why the definition—

Professor Higginson: Inpatient hospices. 6% die in inpatient hospices. Under "hospice services" and "community hospice services", a higher proportion of people with non-cancer conditions are taken than you see dying in inpatient hospices.

Dr Collins: Two additional things, if I may, Chairman.

Chair: Very briefly, yes.

Dr Collins: One is of course that being able to die at home also depends on social care, and that is obviously not something that is drawn out in this report, but social care breaking down is often the trigger for the family or the GP to call for an ambulance and the person ending up in hospital, which is not where they want to be.

The second thing is from work that we have done, particularly in Scotland with patients with heart failure. We found that most of those patients coming to the end of their life with heart failure are able to be looked after at home. They do not necessarily have the symptoms that will need hospice care, and they want to be at home and they can be looked after at home. There are some things that we are learning and we can build on.

Q32 Tom Tugendhat: I would say that comes in proportion with over-medicalising—

Dr Collins: Precisely.

Tom Tugendhat: —and particularly over-medicalising death.

Dr Collins: We will all die.

Q33 Chair: Can I just ask one supplementary question? What consideration is given to using hospices as training providers?

Dr Collins: There are rotations, so at our hospices and indeed all the independent hospices and the NHS hospices, there will be junior doctors rotating through during their training period. I think that is creating some improvements in hospital care. But there is also the recognition that in the hospice it is a quieter, more organised environment than perhaps on an acute ward or in the local A&E, which is where some people sadly still die. In that environment they learn a lot. But clearly, as Irene said, we need to see if we can bring the best of the hospice side more into the hospital. We are beholden, including in the voluntary sector, to do that.

Professor Sir Mike Richards: Just on that point that Professor Higginson raised about hospital wards, there are very few hospitals that have a dedicated palliative care unit. I have just visited one only last week at the Royal Liverpool Hospital, where they are opening one. They have just refurbished it and in a couple of months' time they will be opening that. That will also give opportunities for training and rotations of nurses between the palliative care ward and the rest of the hospital. That is what they are planning right now, and I am sure for junior doctors as well.

Q34 Mrs Cheryl Gillan: I was very struck by one sentence in the "Dying without Dignity" report. In the conclusion it said, "How we die is part of the core business of the NHS and a matter of concern to all". They also concluded that practitioners needed to get better at recognising, first, that people are dying, secondly, making sure that symptoms are properly controlled, which I think of as hard skills, then the soft skills of communicating with patients, their families and each other and the care and compassion. I wondered whether care and compassion can be taught and whether that is not an inherent attribute in each individual. But more importantly, is the end of life care training that we are delivering of sufficient calibre for the sort of care and compassion that we now expect in our community?

Dr Collins: The issue about whether care and compassion can be taught is interesting. I do not know the answer, but there are ways of recruiting people who are more likely to be compassionate. Those are relatively well developed and that can occur at nurse training level, when nurses go to university, at medical school, to ensure that you are looking for the right sort of behaviours. That is well-tested. Can you then encourage them to use that compassionate part of themselves? Yes, I believe you can. Can you destroy that compassion? Clearly you can do that, too. But I do think that we do need to recognise that we need to be looking for the right person at the beginning, because otherwise you have so much shaping to do, you will not necessarily have the outcome you want.

Professor Higginson: Can care and compassion be taught? Certain elements of it can. There is a very good study done by Bruera in the United States that shows that if doctors

sit down beside patients, even if they spend the same amount of time with the patient as they would otherwise, they are judged by the patient as being more compassionate. There are very simple things that we can teach people that have a strong evidence base that palliative care clinicians like myself use a lot of the time that can help the feeling of compassion and what happens.

There are certain attitudinal things that are much more difficult to change and that is about partly selecting the right individuals and also working with people's inbuilt beliefs and their attitudes and what has happened to them in the past, because all staff working on wards are human beings who have a past that has influenced and a culture that influences some of their beliefs, some of what happens. If they have had terrible deaths in their own life in the past, they may have particular personal issues in how they deal with this at that time. The job in training is to try to discover those. I am afraid that sort of thing cannot be taught by a simple online education programme. It needs much more intensive work.

Q35 Mrs Cheryl Gillan: Surely that is where it feeds back into leadership, because whoever is leading within any of the contexts should be able to make that judgment of the staff they are working with.

Professor Higginson: Providing that they also have the right training and ability to do it.

Mrs Cheryl Gillan: Of course.

Professor Sir Mike Richards: We are all agreeing. The word "encouraged" is certainly important, and that is the power of example from the senior doctors or senior nurses that one has worked with. If one has seen compassion in action, that is much more likely to be modelled in the behaviour of the next generation. However, I also go back to the fact that it can be destroyed because we sometimes see that people who have been compassionate have compassion fatigue, if you like. But we have also seen in those same places that when we have taken the stress off them by saying to a hospital, for example, "You have to close a number of beds until you have more staff", within 48 hours there is a change. It is not just me saying you can see a change, the patients on the ward told us there had been a change.

Chair: Sorry, a change?

Professor Sir Mike Richards: For the better. So they said, "You have no idea how much better this place is now than it was 48 hours ago".

Q36 Chair: Because?

Professor Sir Mike Richards: Because the staff were no longer stretched so thin, their compassion was then able to come back.

Mrs Cheryl Gillan: Can I just ask then about the extent—

Q37 Chair: Before you ask that question, may I just ask what destroys compassion?

Professor Sir Mike Richards: If people are overstretched to the point where they are running around unable to deliver proper care, I think they lose their compassion, but it is only temporary. It can then come back when they are put into a better environment.

Q38 Chair: Then what stops people explaining how they feel, that their compassion has been destroyed? What stops people telling the leadership about that?

Professor Sir Mike Richards: They may well have told the leadership and the leadership may not have listened.

Q39 Chair: Why can the leadership not hear?

Professor Sir Mike Richards: I do not think I ought to just know the reason why, but we can point out that they have not heard and that they need to hear.

Q40 Chair: But is that not the most fundamental question: why does the leadership not hear?

Professor Sir Mike Richards: Yes, it is. I agree.

Q41 Mrs Cheryl Gillan: But is it not also important that the leadership observes?

Dr Collins: I was going to say that the ward sister or ward manager needs to be observing the practice of the staff on the ward, and this does not apply just obviously to registered nurses, but also healthcare assistants, who play a huge part in the care delivered to people, so it is that whole group.

Q42 Mrs Cheryl Gillan: That was exactly where my questioning was going. We know who gets end of life care training, but should there not be greater depth? If it is the core business of the NHS, then surely healthcare assistants, even people who clean the wards or deliver the food or what have you, should have some fundamental element of their training before they go into the workplace that takes into account this very important part of our health system.

Dr Collins: Yes, at induction and mandatory training so that, as you say, the cleaner or the people putting out the food, if somebody says, "I am dying" they know how to respond. Those basic things would help enormously.

Chair: A one line question, Mr Hopkins.

Q43 Kelvin Hopkins: One line. A few moments ago I heard the term "compassion fatigue". Is it not the responsibility of managers to see that their staff are under pressure and are suffering from what we might call compassion fatigue?

Dr Collins: Yes, it is.

Professor Higginson: Yes, it is, but the challenge is how they prioritise that among all the other things that they prioritise, and that comes down to making care of people towards the end of life and palliative care a bigger priority in their bundle of things to worry about.

Q44 Mrs Cheryl Gillan: We pride ourselves as politicians on being great communicators and being in the business of communication, but it is obviously—

Chair: Not so good at listening, are we?

Mrs Cheryl Gillan: Well, some of us are. Communications obviously lie at the heart of this. Do you think that the communications training for healthcare professionals is the best it could be? Even we took communications training last week—I was very impressed the Chairman decided we needed it. Do you think we could improve the quality of the communications training right across the board within the health service?

Dr Collins: The short answer is yes. There is also a need of course to make sure that it is done relatively regularly. When somebody goes into a new post, be they a junior doctor or a consultant, then to forget about it for another 20 years or whatever clearly is not adequate. So it does need to be kept up-to-date, and we need to ensure that it is happening. Mike, in a previous life, as the cancer tsar, introduced this for oncologists, which was very effective, but I believe that the funding for that has stopped and that programme is not now universal.

Professor Sir Mike Richards: To the best of my belief, that is true. There is very strong evidence from randomised control trials that, if you provide communications training, communications behaviour does change and for the benefit of patients, and that it lasts a moderately long time, so it is not just a week or two, but for at least a year or more. We know it works. Yes, we were able to provide it for a number of years for cancer clinicians, but I do not think only cancer clinicians need it. I think it is across the board. It can be done better in medical schools—that is now higher up the priority list than it used to be in medical schools. It used to be the training that I enjoyed giving most when I was a practising doctor and involved in teaching in a medical school.

Q45 Kate Hoey: You talked about compassion and it being linked sometimes with the kind of people you choose initially. Just one element, slightly off: in my constituency, I meet lots of people who would love to be nurses, young people. They do not want to go to university, they do not want to have the academic training. They would be wonderful at caring. Do you not think perhaps we should be looking again at how we can use some of those kinds of people to come in and help and become nurses? Just because they do not want to take a degree, they cannot do it.

Dr Collins: Absolutely, and that is happening. There is a recognition that what used to be called the state enrolled nurse as opposed to the state registered nurse role perhaps is one of the missing parts of what is required on wards and indeed in the community. The RCN is involved in a lot of work—I do not know a huge amount of detail, but looking at how those very people can get into nursing. There are ways to go through the healthcare assistant route and do NVQs and then you can get on a practitioner development course. But the idea is that that will be done on a greater scale and that would be most welcome.

Professor Sir Mike Richards: I am aware that there is a lot of work going on between Health Education England, NHS England and the Department of Health. Other witnesses who you are about to talk to may know more about that than I do.

Q46 Kate Hoey: Because compassion is not academic. You do not take a degree in compassion.

Professor Sir Mike Richards: No, you do not take a degree in compassion.

Q47 Kate Hoey: To get back to the question I was going to ask, obviously on the findings in this report, a lot of people have said, "We knew this already. It is nice to have it in a report, but the problem was not a lack of awareness, it was more about implementation", as you have said. How do you think the partnerships that have been advocated in this will make a difference? Would you also say something about the situation in Wales, where they do seem to have slightly got better than what we are doing here in England?

Dr Collins: Shall I start with Wales, because we obviously have services in Wales, which is why I know a bit more about it? Following the Sugar Report there was the introduction of 24-hour, seven-day-a-week consultant cover, clinical nurse specialist cover, and much more co-ordination between the community and the independent charitable sector. That is something that we certainly in the charitable sector would love to have in England. It can be hard to work with the NHS, because we obviously sit outside it. That can make the delivery of services from the patient's point of view as being seamless between hospital and then going into the hospice, for example, or going from the hospice into the NHS community services in the community sometimes a little bit more difficult. They seem to have cracked that there.

It is a smaller population, which makes it easier for working and that is important. We see that across the devolved nations at Marie Curie generally, so Scotland and Northern Ireland are both, in our terms, easier to work with for that very reason. There are still problems though in Wales, so the issue that we all feel very strongly about, and we are all talking about much more, is inequity of access for non-cancer patients. Obviously that is something that needs to be addressed in Wales, so that if we look at what is happening in terms of access to palliative care in Wales, 5% of non-cancer patients will be referred to palliative care and 46% of cancer patients will. You can see there is quite a big difference.

The other thing to bear in mind is that although not a huge amount more, about 6% more people are dying in hospital in Wales than they are in England. There are some areas which I know we will be contributing to and working on in Wales, but the 24/7 cover has been a fantastic success for the care of people in Wales.

Q48 Paul Flynn: How many patients are non-cancer and how many patients are cancer?

Dr Collins: I do not know the actual number—

Paul Flynn: But if your figure is meaningless—

Dr Collins: —of people at end of life. I can get that information for you, Mr Flynn, yes.

Professor Higginson: Do you want it for Wales or are you looking at it more—

Paul Flynn: I would like to see it generally.

Professor Higginson: In the UK there are 470,000 deaths a year, about three-quarters from non-cancer conditions, as Mike mentioned earlier, if that helps. I would also say, just to give you an even bleaker picture for the future, that we are looking at, between now and 2030, an 18% increase in the number of deaths, and deaths will occur at older ages. That is generally a good thing; we all want to live longer. Also they will be more complex in terms of more multiple conditions, so slightly more difficult to manage.

Just coming back to the solutions and your question, one of the other things that has not yet been mentioned is the Bill that has been proposed by Baroness Ilora Finlay, which I think was in the evidence that you received. That Bill is a very important part of the potential solution to many of the issues that were raised in this report in terms of making access to palliative care a more required thing, making research and development, so we can meet the needs of our future population, also a required thing. It would also help tackle this inequity that certainly exists between both cancer and non-cancer patients. There is also a gap in terms of social deprivation, in that people who are in more deprived areas also seem to have less access and that gap seems to be widening slightly.

Q49 Kate Hoey: So you all welcome the Bill, the legislation?

Dr Collins: Yes, we do.

Professor Higginson: Yes.

Professor Sir Mike Richards: Yes. Some aspects of the Bill are in fact already in place. One of the clauses is that CQC should give priority to end of life care. I am pleased to say we already do. But, yes, in general, we are supportive.

Going back to the specifics of partnerships, the drive for seven-day services can help to drive this, because as we talked about for Wales, part of the solution there is networking. It is not just saying, "Let us look at a hospital separately from a community". It is saying, "We need to look across those boundaries" and what we need to look at then is whether that is working across boundaries and bringing the different people together to make sure that there are seven-day services and that there is 24/7 access to advice.

Q50 Oliver Dowden: Just very quickly on this training for compassion, I just wanted your reflections on nurses' training, because one of the criticisms has been that when there was a switch to the more sort of academisation of nurses' training, when you introduced degrees, you lost some of that compassion role from nursing. Do you think there is an issue there to be addressed?

Professor Higginson: I am not a nurse, so I need to be a little careful how I respond because I do not know the full details of what is happening in nursing. But one of the things that does concern me is that in nursing training, just as in medical school training, there is very little on palliative care and end of life care. I do believe that the communication skills and those elements need to be a mandatory part of that training for

nurses and also other professions allied to medicine, such as physiotherapy, occupational therapy and so on. All those are very important in palliative and end of life care.

Dr Collins: I do not believe having a degree stops you being compassionate and I am sure you are not suggesting that.

Q51 Oliver Dowden: No, of course not. One of the wider criticisms is that the shift to having the degree meant that we lost some of that compassion element in nursing. I wonder whether you think that remains a gap that needs to be filled.

Dr Collins: There is such a need, not just in end of life and palliative care, for more nurses and for more nurses across the UK, particularly in London and the south-east. We have to widen the ability for people to get into nursing, even if they do not want to do a degree. By having more people, it would address some of the issues we have been talking about this morning, but it would also bring people in with different skills that would undoubtedly be of benefit. A lot of our care at Marie Curie is delivered by healthcare assistants with NVQs and they provide first-class care for the people they are caring for. Having a widening entry point, if you like, and not excluding people because they do not want to go down the degree route, would be incredibly helpful and will happen.

Q52 Paul Flynn: Professor Richards, how does your claim that the number of people who have died is evenly spread throughout the days of the week square with the claim by the Government that if you are admitted to a hospital at the weekend you are 16% more likely to die?

Professor Sir Mike Richards: Fortunately, the evidence comes from the same academic article in the *British Medical Journal*. Although the people who are admitted on Saturdays and Sundays may be sicker and have a higher risk of dying, they do not necessarily die on the Saturday or the Sunday. The deaths themselves are what are spread throughout the week. If you look across the days of the week at deaths in hospital, it is almost exactly one-seventh on each day of the week.

Q53 Paul Flynn: Can I ask Professor Higginson, where is patient autonomy in palliative care? If a patient wishes to remain clear-headed and articulate in the final precious hours of life, would a patient's views be respected or will he be put into a state of confusion and a state where he is inarticulate?

Professor Higginson: I have never put anyone into a state that they did not wish to be in in any intended way. One of the key things in palliative care, and it should be in all medical care, is listening and understanding and respecting people's wishes. When somebody approaches the end of life and becomes sicker, there are reasons sometimes why people in that position become more confused outside of the drugs and medicines they are receiving, because when you are dying, the electrolytes in your body and other things become imbalanced and that can cause a level of confusion. That, to some extent, we cannot control.

One of the key skills in palliative care and one of the reasons why we do need experts to do some of this is that there is often a very careful titration that you have to do between the medicines you give to manage and alleviate the pain and symptoms. Nowadays we have a greater variety of medicines at our disposal, which is quite helpful, because some people do not respond well to one and so you switch them to another one that gives them fewer side-effects. But there needs to be a very careful titration, so the medicines attack the pain but do not attack the thinking. That is quite a skilled ability. It is not just a matter of saying, "Okay, we give this to this". It is individual and it depends on the person's mix of causes for their pain, which require a careful assessment, because there are some drugs that work better for one pain than another.

Q54 Paul Flynn: Thank you very much. Do you think there is a degree of inhibition in Government in praising what has happened in Wales because of the political agenda, which was that under the socialists in Wales, the health service is poorer than England? Do you think—

Dr Collins: That is a terribly interesting question.

Paul Flynn: —this prevents them from looking fairly at the successes of Wales?

Chair: That is a yes or a no or do not know.

Dr Collins: I would like to say I do not know. I would hate to believe that I could read the minds of Government Ministers.

Paul Flynn: Me, too.

Dr Collins: I have no intention of even trying.

Chair: You have made your point, Mr Flynn.

Paul Flynn: Could we say how nice it is to meet a former tsar? We are all concerned about it, because there was an epidemic of these creatures and we thought they were all wiped out in some kind of October revolution. It is nice to know they survived.

Chair: Thank you very much for coming today. The observation I would make is that a great deal of the thrust of the effort to improve palliative care in this country is directed at policy issues, legal issues, resources issues, when in fact we need to spend more time thinking about the human factors and the behavioural issues and the leadership issues, because if they were addressed more directly maybe it would be easier to get the policy and to distribute the resources more effectively. Thank you very much.

Dr Collins: Thank you.

Examination of Witnesses

Witnesses: **Ben Gummer**, Parliamentary Under-Secretary of State for Care Quality, and **Dr Martin McShane**, Director for Long Term Conditions, NHS England, gave evidence.

Q55 Chair: Thank you very much for joining us. Please could each of you introduce yourselves for the record?

Ben Gummer: I am Ben Gummer and I am the Parliamentary Under-Secretary for Care Quality.

Dr McShane: I am Dr Martin McShane and I am the National Medical Director for Long Term Conditions at NHS England.

Q56 Chair: Thank you. Same injunction upon you as our previous witnesses, short crisp answers, please, and I will pull you up if necessary, and also short crisp questions from members of the Committee.

Mr Andrew Turner: The report, "Dying without Dignity" identified six aspects of end of life care that need improvement. How useful are these six themes in helping to frame policy in this area?

Ben Gummer: Thank you, Mr Turner. The whole report is an extremely welcome addition to what is now an overly-large library of criticism of palliative care and end of life care in this country. The six conclusions are apposite, correct and need to be adopted across the service. Our challenge is to make that happen.

Dr McShane: I would not disagree with that. The report aligns or is supported by the recently-published ambitions for palliative and end of life care, so they create a great framework. I agree with the Minister that we have a long list of publications and policy documents, but it perhaps echoes the issues that exist at ground level.

Q57 Mr Andrew Turner: You used the learning identified in the report to underpin any new ambitions for end of life care. How has the learning from the report underpinned the ambitions framework?

Ben Gummer: If I may say so, the great strength of the report is the simplicity with which it is presented, so you have it page by page. I should pay tribute to Dame Julie for not only her work, but the way she has been able to communicate it. The pick-up from it shows how well she was able to press her point. Page by page, you have simple examples, which unfortunately every one of us can associate with because, whether as Members of Parliament with case work or as relatives, I am sure that we have all experienced poor care in hospitals. The report struck a chord with people across the country who said, "Yes, I identify with that because someone that I know had poor care of that kind". For me, the key is to take what she has done and to replicate that on a systematic basis so that we are picking up patient experience far more consistently and using that to improve performance where it is variable.

What you heard from the previous witnesses was that there is some fantastic practice—we will talk about this in a minute—across the system, there is some extremely bad practice and there is a lot of mediocre practice. Just by raising poor practice up to mediocre and mediocre up to good, we will be able to make a huge change, even without changing policy. The key to that is making sure we know where it is going wrong and that involves listening to staff and to patients and to family in a way that Dame Julie has done in her report.

Q58 Chair: Can you just be clear about who is "we" in your answer?

Ben Gummer: It is a glib way of putting it, it is the whole system, but I cannot answer for previous Ministers or Administrations. This policy area has become of greater interest over the last few years. It reflect a public mood and an increased public interest in end of life care. All I can say is that from my point of view, it is one of my particular areas of policy that I wish to concentrate on, so I am very pleased that this is my first Select Committee appearance, because this is somewhere where we need to make significant progress in a very short period of time.

Q59 Chair: That is "we", the Government?

Ben Gummer: "We" is the Government, yes.

Q60 Chair: What about "we", the matron on the ward, and "we", the hospital executive, or "we", the GPs? How do they use the learning identified in their experiences and in these examples?

Ben Gummer: I was reflecting on some of the answers given by the previous witnesses, and in Baroness Finlay's evidence, she made the important point that death is still a rather awkward subject. It is one of the converse results of improvements in medical knowledge and understanding. If we were having this discussion with medieval people or Victorian people, we would have a far more complex, rich, beautiful understanding of death than we do now. The Ars moriendi is something that was intrinsically understood by everyone, whether literate or not, 600 years ago, but is not understood now. I do not think this is just about nurses and matrons. It is about us as a society. I am pleased to think that that has improved or at least we have an awareness of it now in a way that we might not have done 20 or 30 years ago. Part of it is sensitising or allowing people to feel sensitised to death and being able to speak about it with greater freedom and openness than perhaps they feel now. You heard the previous witnesses speaking about that with some eloquence, I thought.

Q61 Paul Flynn: The 24-hour palliative care is a subject that came up yesterday in debate. There are a number of proposals being given on how to improve this, one by Professor Ilora Finlay, who suggests that we need a Bill in this House. Do you support that?

Ben Gummer: I have some reservations about the Bill, Mr Flynn, for this reason: we have to think quite carefully about legislating for specific clinical areas. At the moment, we do not legislate for any clinical areas so we do not say that someone who has cancer should, by law, have oncological treatment. That is part of the commissioning process and part of the overall architecture of the NHS constitution. It would mean a radical shift in how we construct the NHS and I am nervous about going down that road because it slightly puts commissioners into a relationship with the law that I am not sure is where you want to put them. You want them to be thinking about how to provide great care to people wherever they are, whether they are going to live or die, not just because they are responding to a piece of legislation that you and I have voted on. That is my reservation. But I understand

why, quite correctly, she wishes to see an eradication of the variation. There might be ways of doing that rather more quickly than taking a Bill through the House.

Q62 Paul Flynn: A number of people and organisations are suggesting we should look to a service that is 24 hours a day, seven days a week, rather than just an after-hours service. Do you think this is a practical suggestion and worth pursuing?

Ben Gummer: Some of the best cases around the country—I know that Dr McShane will want to give you examples of that—are indeed services based on a 24-hour service. Noticeably, where they are best, they are joint ventures between Macmillan or Marie Curie or Sue Ryder, so you are seeing that genuine working relationship with partners outside the NHS.

Q63 Paul Flynn: Do you think you can learn from the experience in Wales and Scotland and elsewhere?

Ben Gummer: Absolutely.

Q64 Paul Flynn: Will you approach your appraisal of the services in the spirit of humility?

Ben Gummer: Of course, as I do with much that comes from Wales. The point about what has gone on in Wales, the special strength, is how they have dealt with morality. That is something we need to learn from in our own system here in England.

Q65 Paul Flynn: Do you think the Government might be guilty of politicising these matters in a way that serves their political agenda but causes alarm and confusion in the minds of the general public?

Chair: Yes or no.

Ben Gummer: No.

Q66 Paul Flynn: The Chairman, who urges everyone to have brief questions and answers, has regaled the Committee with more questions than all the other members of the Committee put together. The Under–Secretary should be encouraged to give a longer answer because the spirit of humility is not always obvious in political exchanges, but the experience of scaremongering is. If a headline can be grabbed by criticising the Welsh health service, that was the star example, three front-page stories in *The Daily Mail* appeared last year about the Welsh health service, which was of minor interest to readers and could not be justified on the grounds of newsworthiness—

Chair: What is your question?

Paul Flynn: Wait a minute—but was justified in pushing the lying agenda of the Conservative Party in their attempt to denigrate the services in Wales, causing considerable anxiety among patients.

Chair: What is your question?

Paul Flynn: I am just giving evidence. The question is: can we look to the Minister to change that and not to use the NHS and the fears of people as a political football?

Ben Gummer: Mr Flynn, I was invited here to talk about end of life care. It is an important matter and one I take great interest in, and I know other members of the Committee do. You have introduced the matter of politics to it. I think that is regrettable. This is something there is cross-party agreement on and that I think we will make great progress. There was progress under the previous Administration; there was progress under the coalition. The first paper on this, which is the foundation of the work we are trying to do, was written by Professor Mike Richards, commissioned by a Labour Health Secretary. We will do a great deal for the health service if we do not even try to venture into political discussion, because we will allow the richness of discussion, which will bring a better solution for all the patients we are trying to serve.

Q67 Paul Flynn: Yes, that is certainly one of the joys of Select Committees, that we can escape from the Punch and Judy show outside. But unfortunately I am not apologising for introducing politics into the House of Commons, because I am afraid this is a major influence on our decision.

Could you tell me—this is the final question—we heard about the nature of palliative care and the titration of drugs. At which point do you think it is justifiable to give a patient a dose of morphine that would be lethal to them?

Ben Gummer: Again, you are probably venturing into areas that were not the purpose of this inquiry, but seeing as you have asked the question, it is a free vote on matters of assisted dying. You and I voted on different sides of the House. That is a matter of public record. You will note, Mr Flynn, the number of people working in palliative care and cancer services clinicians who felt this was an important line to draw and supported the position of the majority last Friday.

Chair: Sorry, I think I understand why Mr Flynn asked the question. It was a very moving debate and in fact, Mr Flynn, you made a very moving speech, but we will move on, thank you.

Mr Flynn's question touched on the role of commissioners. Dame Julie, in your report, is there a question we are not asking here that you think we should be asking?

Q68 Dame Julie Mellor: Not from the report. In fact, I wanted to build on Mr Flynn's question about commissioning from what we heard in the previous session from witnesses, because we heard Professor Sir Mike Richards talking about the ability to deliver compassionate care being compromised when people are stretched and therefore stressed, but we heard that the stretched is sometimes because resources in one setting are constrained, but that there is not sufficient scale of provision of palliative care across the system that enables people to have their preference for the kind of care. We heard that this is not to do with the level of resources. If it is not to do with the level of resources, we heard some creative stuff in the previous session about solutions, creative use of digital, more home care, because it is

cheaper than emergency readmissions. My two questions are: why is the commissioning not consistently done to deliver that range and how might Government and the NHS eradicate that variation in commissioning?

Dr McShane: Shall I pick that one up? I would also say that we are almost starting in the wrong place. We are starting too late in the patient journey to have the sort of impact that people are talking about in this room. That speaks to the agenda of the main focus around palliative care having been on cancer, because that is very predictable. A good paper was published in the *BMJ* a few years ago that showed the three main trajectories towards end of life: cancer, which is pretty much a horizontal line and then you die; complex organ decay, so heart, lungs, other systems malfunctioning, which follows a seesaw pattern of gradual decline; and then neurological conditions, which follow a slow inexorable decline. One of the problems we have is that we focused on that which can be predicted quite easily.

What we need to do is to get further back into the system and be able to have a serious illness conversation that identifies and helps people to understand what is wrong with them, what can be done for them realistically and what their options are and what their values and preferences might be. Just to emphasise the numbers behind that, in England in 2012/13 there were 1 million emergency bed days used by the population under the age of 40. In the same year, 7 million were used by the population over the age of 85, and 36% of deaths now occur in the population over the age of 85. We need to have proactive anticipatory care, which creates a care plan in conjunction with the person that is about their values and preferences. That requires continuity of information.

One of the biggest step changes we are making—and it is making progress across the country, and it has been demonstrated with Coordinate My Care here in London and through the Electronic Palliative Care Co-ordination Systems that are being created around the country, and it will shortly be demonstrated through the summary care record—is that when we can make the individual's preferences and have that conversation with them about what they want when their illness becomes serious, it completely changes their experience of care. So more people die at home, more people die with dignity and more people die with their family feeling that they have been properly cared for.

Chair: Thank you. Does that answer the question?

Dame Julie Mellor: No.

Dr McShane: That is what we need to commission—

Chair: Hang on, just a minute. I am asking Dame Julie, does that answer the question?

Q69 Dame Julie Mellor: That is very useful to understand and that is absolutely right. My question though is how do we eradicate the variation in the commissioning that would enable those preferences to be delivered?

Dr McShane: The one thing that we do not have, and this has been alluded to by Sir Mike and by the Minister, is measurement and feedback. We do not have the measurement and

feedback that we need that raises awareness with commissioners of what is happening on their local patch in a way that is timely and informative.

Q70 Chair: This leads very neatly to the next section of questions, which is about leadership, because it seems to me that the commissioners have an unavoidable responsibility as part of the leadership of the system. How are the commissioners going to commission in a way that promotes what you want to be delivered, because they are clearly not commissioning in that way now?

Dr McShane: They are not universally in a standardised way commissioning, but we have examples of where they are commissioning and that is causing a change, and we are using that to help—

Q71 Chair: How do they do that? Give an example.

Dr McShane: One of the examples I would give you is from Midhurst where they have commissioned a community-based palliative care service and it serves 150,000 people across three counties. At the moment it receives 400 referrals a year and they have agreed care plans and 99% of patients are allowed to die at home. They have less frequent A&E attendances, decreased hospital admissions and a halving of in-hospital deaths for that cohort of patients who are receiving that care. We are starting to see that. One of the things that we have set out in the five-year forward view and with the new care models is a recognition that we need to use commissioning to support integrated care across the system, which will help exactly with this agenda.

Q72 Chair: The best example of supported treatment across all the boundaries that now exist in the health service within a trust that I have come across recently, funnily enough for the benefit of CQC and the Colchester General Hospital, was a stroke patient who was taken by a single person from department to department to department so that that patient felt that they had an advocate at each stage of their journey through their treatment for their stroke. Surely the right kind of support for palliative care, as soon as someone is identified as dying or at risk of dying is they have a single advocate to navigate themselves through the system. Patients always feel they are being passed from pillar to post, that the GP refers to a consultant, the consultant refers to another consultant, refers to another department. What can commissioners do to create this kind of joined-up feeling of care of an individual patient?

Dr McShane: The two things that we are endeavouring to create, the ability for local commissioners—because this is commissioned locally in the main by clinical commissioning groups—is first to change the financial drivers in the system so that it supports continuity of care across and between the various components of the system and also to allow the emergence of those new models of care where that that style of management of patients with chronic enduring health problems, relational continuity, which is what you are describing, is seen as very important. To do that, we need to change some of our provider models because they are archaic, which is where the new care models that have been initiated this year, working with creating new models of care that are community-based and much more integrated care with hospitals, is becoming more important. But your navigators, a lot of practices and people are now doing that.

Q73 Chair: Who is responsible ultimately for the end of life care of a patient? Because you commission the GPs, the CCGs commission the acute providers and of course the local authorities commission the social services. How do you join this up?

Dr McShane: If you go back to the original intent, it was that at the very start there should be a joint strategic needs assessment, which defines the needs of a local population and the priorities in that population. The Health and Wellbeing Board then should bring those parties together to create the initiative with the providers so that we are looking at those outcomes and measuring them. We do not have all that in place.

Q74 Chair: It is very interesting. I am inclined to retort that that is a typical NHS answer. I asked about an individual patient; you answer about local populations.

Dr McShane: Sorry, can I answer that? Because when I was a GP I would take personal responsibility for my patients and I did try to help navigate them because that was my role as a general practitioner. There are two things. First, there has been an explosion in expectations and care requirements, and secondly, the complexity of care and the speed at which we do it now requires us to be able to share information in a completely different way from the historical passing bits of paper around the system.

Q75 Chair: But when you were a GP, the implication is that is what you did and it worked. How is the NHS going to commission that kind—because I am absolutely certain that the vast majority of people would love to feel they can go back to their GP for reassurance, for guidance, for advocacy, support. Why do you not commission GPs to do that?

Dr McShane: Because of the complexity, modern medicine is now about a team, and the way people are being commissioned is to say we do need those care navigators, people to support the general practitioners as part of their team to help people navigate the system and have that relational continuity, so someone knows who to turn to when they are in need.

Q76 Chair: I am all for team effort, but the effect of what is happening in too many cases is with too many people being made responsible, nobody is responsible. Nobody feels responsible. Would it not be marvellous if you made it explicit? I do not want to put more burdens on GPs than they already have, and maybe there is a capacity problem there, but would it not be marvellous if you were able to guarantee that someone entering on the phase of the end of their life could be guaranteed the support of their GP throughout the process, who would make sure that the team was operating effectively?

Ben Gummer: Mr Chairman, you will note that we are unpicking some of the disruption to those patient relationships that have happened since the 2004 GP contract, and by returning named GPs to patients, first of all to the over-75s and now to the whole population, we are giving back that sense of personal responsibility, but you are right to say that we need a greater degree of personal responsibility. I think what you have had from both our answers is an indication of the amount of work that needs to be done, but

there is a great deal of policy work going on at the moment and you are absolutely right to point to the need at the core of that.

Q77 Chair: How seriously is the Government taking the Health Committee's recommendation that there should be responsibility for end of life care and there should be a named individual at the national NHS Trust and service provider to deliver that care?

Ben Gummer: We are taking the entire report very seriously.

Q78 Chair: Can I then tax you on what a success regime, like in the County of Essex, is meant to achieve if one of its objectives is not to join up, to get the leaderships of the various bits of the health service in Essex to join up their approach to palliative care?

Ben Gummer: It does not relate just to Essex. It relates to the whole country. One of the lacunas in the current system is that we are not able to judge yet which CCGs are commissioning good services for their patients in a way that Sir Mike does for hospitals. That is why the Secretary of State has launched his scheme for being able to do that through a CCG scorecard. The care of patients in end of life will be one of the focuses in the care of patients of all kinds of conditions. That is one route we can use to be able to have a better grip on where care is good and where it is bad. At the moment, our picture is pretty variable. We know where we have exceptional models of care and we can point to the hospitals. Not surprisingly, they tend to be the hospitals that are brilliantly run anyway and that answers some of the questions you were asking earlier about good management chains—they tend to be a reflection of good management generally. We have some very good examples of community care, as Dr McShane has highlighted, but our picture is incomplete. We hope that through the scorecard and through the changes I would like to make to the VOICES survey, which gives us our most granular impression of what is going on in terms of end of life care, we will know where the problems are and then we can start to do something about it. Then just to go to one move more, if we can get greater detail on what is happening with individuals, we will be able to tighten up care where it is going wrong.

Q79 Chair: Forgive me, but how important do you think it is for CCGs to measure the degree of engagement that the GPs they are commissioning on behalf of feel with the commissioning process?

Ben Gummer: The purpose of the Health and Social Care Act was to engage GPs fully in the commissioning process.

Q80 Chair: What measure of GP engagement with CCGs do you have?

Ben Gummer: If you are suggesting there is a number, there is not.

Q81 Chair: In your Department you do employ an annual people survey to find out the level of engagement of the people in the Department with the mission and work of the Department.

Ben Gummer: That is true and I have to say—

Chair: What equivalent measure do you have for GPs with their commissioning groups?

Ben Gummer: If there is one, I do not know the figure, so I can return to you with that, but you are right.

Q82 Chair: Does this come back to the whole question of what the success regime in a failing health economy like Essex should be like, that you should be looking at why the disengagement and the dislocation exists and how to address the lack of engagement through better leadership?

Ben Gummer: That might or might not be the case. We have had our separate discussions about the success regime and there are clearly problems in the relationship in Essex between GPs and commissioners and providers, as there are in other areas of the country that are subject to success regimes. But specifically around end of life care, I am pointing out that one of the areas we have to work on very hard is to understand where the care is good and bad. Until we have done that, we cannot address the issues that lie at the core of this report, which is that we know there is some very good care, but there is also unacceptably high levels of bad care, especially in hospitals.

One of the things drawn out from the VOICES survey, one of the best bits of datasets the NHS produces on patient experience, to my mind, is that almost half the people who die in hospital we know do not have an optimal experience. That is an appalling statistic. It is not just about the choice of where people die, and we know that has an impact on people's experience of death, but it is also the quality of care that is delivered, especially in hospitals, where it falls most short.

Q83 Ronnie Cowan: On Saturday I was at the funeral of Dr Harry McGilp. Dr Harry McGilp was 88 years of age. He was my GP practically all my life. He was my advocate: he knew my health records; he knew me as a child; he brought me into this world; he was the first person to slap me—not the last. He was in effect my advocate. Had I become terminally ill, Harry would have known my health records throughout my entire life. My current GP, with all due respect, does not know me that well and does not know those records. Did we not have a system that worked, and for some reason we have moved away from that and we now have a broken system?

Dr McShane: The answer is yes and no. We had to move away from it. I trained as a surgeon in the first part of my career and every single operation I did as a surgeon in the 1980s is no longer done. We have advanced beyond those operations. When I started we had a small book that allowed treatment for a number of people. The treatment and the armamentarium now at the disposal and the expectation of what you can do for people in the community is vast. The treatments and the care pathways we have to manage have expanded enormously. The volume of work has doubled in the last 20 years in general practice in terms of societal expectations and consultations. Demographics have changed completely. I am afraid that it was a great time and it was very good, but we could do very little in some ways for people then compared with what we can do now.

Atul Gawande has made it very clear that modern medicine is about a team, so I think there is a need though for people, when they develop serious illnesses, to have their relational continuity—they know who they can turn to—but also to have continuity of information. Having visited Berkshire Hospital a couple of years ago, their A&E department, to do a round with the geriatrician there, 17 patients, all of whom were over the age of 80, admitted in the middle of the night, and that team having no access to the information that would be available in the GP practice made the work very hard. If they had that record, first of all it could have told them who the person is who wants to take responsibility, because they cannot determine that, and what the care plan is. What has been decided in advance that this person, their family, their carers, want the NHS to be doing with and for them? One of the biggest problems we have at the moment in the system is a dislocation of information that follows people around, which we take for granted in so many other aspects of society.

Q84 Chair: In a health system where the headlines around acute services tend to drive resources towards acute services and to squeeze primary healthcare, how can you address that?

Dr McShane: By measuring, and this is starting to happen, what is happening in community services and general practice and demonstrating its value. Being able to give continuity of an individual's information, which they give permission to switch on, is incredibly important. But what we lack at the moment is continuity of information, linking data up across the system.

Q85 Chair: How are you going to build up? The Health 2020 Plan talks about developing MCPs.

Dr McShane: Multi-speciality community providers.

Q86 Chair: How are you going to get commissioners to invest in those services? We are talking about CCGs investing in GP services.

Dr McShane: With two things. One is by looking at the governance of that investment and being able to track the impact that investment is having. At the moment, you are quite right, we predominantly measure what happens in acute hospitals. We also need to be able to measure, so part of the new care model approach is a systematic analysis of what are the contracting mechanisms we need to have? What is the evaluation of those new care models? What is the training and development? That is going into—

Q87 Chair: At the moment the attitude of the CCG in Essex, for example, is to squeeze the community providers in order to support the acute unit. How would you reverse that process?

Dr McShane: Exactly the way I described, demonstrating that by investing in community services and primary care you are able to take the pressure off the acute trust and reverse the trend for increasing—

Q88 Chair: So that the GP can then follow the end of life care pathway of the person, the people we are talking about?

Dr McShane: So that the multi-speciality community provider can have a named person, care co-ordination, continuity of information and know the impact that is having. We have done that through the Electronic Palliative Care and Coordinate My Care. We have demonstrated the impact.

Q89 Chair: Is that what the success regime is intended to create in places like Devon and other places where you have set up success regimes?

Ben Gummer: It is intended to fix a lot of problems, but it would take an entire evidence session to go through those. Just on the end of life care, to answer Mr Cowan's question, yes, as I hope Dr McShane has demonstrated, this is much more complex than it was. But we still need to preserve that named relationship with the GP. I do not know what the arrangements are in Inverclyde or in Scotland, but named GPs were removed in 2004 and we have now reintroduced them for precisely the reason you have tagged.

Q90 Mrs Cheryl Gillan: I have always been very impressed by the work that the PHSO does. This Committee looked into the report on sepsis and I was surprised at the snail-like pace of Government's response to it. I hope that this "Dying without dignity" report will be responded to quickly. One of the things that I have been reading in conjunction with looking at this subject is the NICE quality standard QS13, which is end of life care for adults. Particularly I was looking at the changes, because although it was published in 2011, the only major change that has been made to it was in 2013 after the issues over the Liverpool Care Pathway. Could you, Minister, undertake to look at or have looked at that quality standard in the light of what has been revealed by this particular report from the PHSO and our investigations here and see whether it needs revision?

Likewise, could you also look at the topic expert team that accompanies this NICE quality standard, because if I have read it correctly, although it is full of very eminent people, there does not appear to be anybody from the hospice movement in the UK, which probably predicates against some possibilities of joined-up thinking.

Ben Gummer: I will certainly give you a full response to that. You will understand it is not for me to write NICE standards, but you raise an important point. In referring to the Liverpool Care Pathway, if I can just make two observations. The first is that I think the key lesson to come out of the LCP debacle is that of course that was originally developed as a compassionate and decent clinical response to the need to bring some sort of systematic care pathway to people who are dying, and it became subverted into something that was in many cases extremely unpleasant. The warning I take from that is that what I do not want to do is to pick a particular manner of providing palliative care and try to replicate that across the country by formula, by diktat, by legislation, because we will end up in exactly the same position. It is why I am slightly nervous about going down the pilot and solution route, because I think that might have adverse consequences that none of us intend.

The second observation I would make about the LCP is just to say the distance we have come in the last five years and the work done by Baroness Neuberger and her committee and the changes made to the LCP. The fact that we have been able to move hospital care so significantly away from what was an established part of clinical practice in every acute hospital in the country demonstrates the speed we have been able to move in the last few years on end of life care. That is not to deny the significant amount of progress we need to make in the next five years. I hope—I cannot speak for previous Ministers—to be able to accelerate that and you will not find a snail-like response from me.

Q91 Ronnie Cowan: This section is entitled, "Ensuring competent and compassionate care". I am not questioning, we all want to be competent and we all want to be compassionate, but is there any way in which the Government can help to ensure competent and compassionate care?

Ben Gummer: I know that Dr McShane would like to give a detailed answer specifically in the area of palliative care, but if I can just give you a contextual one about care quality overall. The appalling events at Mid-Staffs exposed some of the problems with having a health architecture that was built around targets, which meant that care was often compromised when you had different financial and care levers. The whole purpose of the reforms we have made, with the significant strengthening of the CQC, which under the Chief Inspector has become one of the best inspectorates of any we have in this country and certainly one of the best health inspectorates in the world, I think he would say there was much more to do, but the journey the CQC has gone under in the last few years has been truly impressive.

To the changes we have made in terms of issuing guidance on staff ratios to board responsibility, all the things that flowed from the Francis Report that we have been implementing, whether it is whistle-blowing, which I know is a particular interest of this Committee, to freedom to speak up, point in the direction of trying to make sure that care quality lies at the heart of what we are doing in the English NHS. You are right to say that this is part of the systemic challenge. It is one I believe we are fixing. You can see that in the improved approval ratings across the NHS, not just from patients, but also from the recommendations that staff would make to their friends and family, they would recommend NHS services to. But the one we have most distance to make up I would argue is end of life care, because you just need to look at the feedback to see that it lags behind almost every other speciality in terms of patient experience and that is why we need to concentrate on it now.

Dr McShane: There has been a lot of work as a result of the Liverpool Care Pathway and other issues with Health Education England, the local education and training boards and putting the wherewithal in place to make it possible for people, professionals, to undertake training and education. That is easy to say, but it is also, as we have had discussions across this morning, about the emphasis being right in not just organisations but across commissioning and across communities to provide the best care and compassion for people towards the end of their life. I think having education in medical schools is important, but as one of my professors of surgery pointed out, we were there to pass finals, we would spend the next 40 years learning about medicine, and he was right. Pretty much everything that I was taught in medical school is now outdated apart from care and

compassion. But I have learnt an awful lot since then from experience, from other people's examples and a little bit form formalised learning.

Chair: Forgive me, the answers are getting awfully long.

Dr McShane: The CNO has led the agenda on this as well with her emphasis on care and compassion and certainly we have examples of Care Makers, of the work that is going on in creating a movement across the system that focuses on care and compassion.

Q92 Ronnie Cowan: At no point we did touch upon training there. Earlier we mentioned the degree qualifications that nurses are getting put into now and there is an indication that maybe that has not been the outcome we are looking for. Is there any move to redress that or should training in communication skills be included for medical staff as well?

Ben Gummer: I have heard the points that have been made in the Committee and they reflect ones that have been made by many people. We are looking at trying to create many different paths into nursing, whether that is through advancing from healthcare associate level or physician associates. There are lots of different ways of trying to deliver healthcare now which are different from how it was 40 or 50 years ago. I hope you will see in the Government's plans in the next few months and years an understanding that training needs to be delivered in a way that is different from the standard, formulaic manner we have all inherited. I take the points from the Committee on board very seriously.

Q93 Oliver Dowden: We have all seen from the reaction to the report, "Dying without dignity" and the evidence to the Committee that there is widespread agreement about the problem and a lot around the solutions. I think a lot of concern still lies around implementation. What are your thoughts on how we can implement this and also how we can entrench the changes so we do not have the situation we often have where there is one problem identified with the NHS, all the focus goes on that, then we have the next problem, all the focus goes on that? How do we make these permanent changes that improve end of life care?

Ben Gummer: I have no idea how you gained that impression, Mr Dowden, but you get right to the heart of the problem in formulating policy on this. The first priority is to measure, and that we are doing poorly at the moment. The policy itself needs to be a substantial one, rather than one that will be undermined the minute that attention is not on this policy area. I hope you will see responses to both that need to measure and that need to implement successfully in the policy announcements we make in the months to come.

Q94 Oliver Dowden: Specifically, and I think you have touched on this a bit already, you have indicated that you do not think legislation is the solution. Do you have anything further to say on Baroness Finlay's proposed legislation?

Ben Gummer: Much of what she has said to me, both personally and also in the submission she has made to this Committee, some of the points that are the thrust of the Bill are worthwhile. She certainly has been part of a great movement in Wales, where

there have been considerable advances in palliative care, so there is much of use there. I have a nervousness—I do not want to repeat myself too much—about enshrining one particular clinical area in legislation. I do not need to tell you what would be the consequence of that.

Q95 Oliver Dowden: Specifically, one of the points that came up in the Committee that I thought was quite compelling was the fact there is only 20 hours of training in this area. Is that something the Government is looking at? Dr McShane, do you even agree with that number?

Dr McShane: The problem is there are 20 hours of formalised training, but as I said before, an awful lot of the training you experience in medical school and subsequently throughout your career is not formalised, but using that formal training in other settings and peer to peer training. Hanging a hook on formalised training as being more important than it is worries me as well.

Chair: I thank our two witnesses. The Minister will not remember when we first met. I was holding him in my arms because he was less than one year old at the time. We have come a long way, but I hope this session will prove both food for further thought and a spur to action, because we do not want to be having another session like this in a year or two's time because nothing has been achieved. That great library of reports you refer to, Minister, the fundamental question needs to be asked, "Why, despite that great library of reports, is there still yet so much to be achieved in this area that is not to do with resources?" I would like to thank Dame Julie Mellor for her report.