

# Health Committee

## Oral evidence: Winter Planning, HC 277

Monday 12 September 2016

Ordered by the House of Commons to be published on 12 September 2016.

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Members present: Dr Sarah Wollaston (Chair); Dr James Davies; Andrea Jenkyns; Emma Reynolds; Paula Sherriff; Maggie Throup; Dr Philippa Whitford

Questions 1 – 78

### Witnesses

Professor Keith Willett, Medical Director for Acute Care, NHS England, and Professor of Orthopaedic Trauma Surgery, John Radcliffe Hospital, Oxford, Pauline Philip, Chief Executive, Luton & Dunstable Hospital and National Director for Urgent and Emergency Care Director, NHS England, Philip Dunne MP, Minister of State for Health, and Lyn Simpson, Executive Regional Managing Director, NHS Improvement.

Written evidence from witnesses:

[Department of Health, NHS England and NHS Improvement](#)

[Department of Health, NHS England and NHS Improvement  
\(supplementary evidence\)](#)

## Examination of witnesses

Professor Keith Willett, Pauline Philip, Philip Dunne MP and Lyn Simpson.

**Q1 Chair:** Good afternoon and thank you very much for coming to this session on planning for winter pressures in accident and emergency. Can I start by thanking Pauline Philip for hosting the Committee to Luton and Bedford last week? It was an excellent visit. Thank you very much to you and all your team. It is good to welcome the Minister to his new role, so thank you for coming. Could I ask you to start by introducing yourselves to those who are following from outside this room, perhaps starting with you, Lyn Simpson?

**Lyn Simpson:** Good afternoon. I am Lyn Simpson. I am the regional director for NHS Improvement in the north. I work closely with Pauline on the overall national A&E plan.

**Philip Dunne:** I am Philip Dunne. I am the Minister of State for Health.

**Pauline Philip:** I am Pauline Philip. I am the chief executive of Luton & Dunstable hospital and I am the national director for urgent and emergency care.

**Professor Willett:** I am Keith Willett. I am the medical director for acute care in NHS England and I am a Professor of Orthopaedic Trauma Surgery in Oxford.

**Q2 Chair:** Thank you. Could I start with an opening question, commenting on the performance of accident and emergency, because I am sure you will all share the concern about deteriorating performance, particularly since 2012? It is obviously of concern to note that only four A&Es are currently meeting the national target and we are now moving into winter. Perhaps, Ms Philip, I could ask you to open by setting out to the Committee how well prepared we are this winter compared with last winter.

**Pauline Philip:** First of all, to set it in some context, I know that we have day-to-day problems as regards the delivery of emergency care within our emergency departments, but if we look at the overall number of patients being cared for within four hours, say, over a five-year period, we will discover that the NHS today cares for something like 2,000 more patients than we were able to in 2010-2011. If you look at that on a year-on-year basis and you also look at the work that NHS 111 is doing, today we deal with 14 million patients a year. So, in the round, how the NHS is coping with emergency care is pretty phenomenal. If you compare us against other countries nationally, our ability to see nine out of 10 patients during a four-hour period is world class.

Having said all that, we are clearly very concerned about the performance of our emergency departments. We recognise, through the work that was done for the NHS review into urgent and emergency care, that society



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has changed. Patient expectation is that you have a one-stop service, irrespective of what walk of life we talk about. Clearly, medicine can do things now that it could not do in the past, and the care that we provide for patients is much more complex.

From an NHS point of view, we have developed the urgent and emergency care plan, and our expectation is that over the course of the next four years we will deliver integrated urgent care, whereby a member of the public who has an urgent or emergency care need, through the development of 111, can receive care outside hospital—very often in their own home—instead of coming to emergency departments.

Having said that, we recognise that we need to do something immediately to help our emergency services for the rest of this year and into next year. So, for the first time ever, we have developed an A&E improvement plan, and that plan was agreed in June. It has five different initiatives behind it and I am happy to talk to the Committee about those initiatives. It is being overseen and co-ordinated by NHS England and NHSI, and overseen by the Department. We can give you the detail on all that.

**Q3 Chair:** We will certainly be exploring the strands of that plan during the course of this session. One of the things that was made clear to us when we came to Luton was that people supported the plan there because they recognised that it was not just about ticking a box but it was in the patients' best interests—and, in fact, the whole system's best interests—for people to be managed and safely assessed within that four-hour period. Therefore, do you share the concern that, although we appreciate there is huge increase in demand, the graphs of patient experience are showing that more people are having to wait significantly longer? Is that something people should be concerned about or not?

**Pauline Philip:** I think every provider and every NHS organisation believes that it is very important to have an emergency department that provides care in a timely manner for patients. Through the work that we are doing with individual providers, if they feel that there are patient safety risks, they can work with them in the overall health system and now within the local delivery boards to address those concerns. Overall, across the NHS, we have demonstrated that even emergency departments that are under considerable pressure can still maintain patient safety. Sometimes, patient experience becomes more compromised, and, clearly, people, when they attend an emergency department, want to be seen as quickly as possible. We have all become aware of those stories, but, from a patient safety point of view, what the service has achieved has been quite phenomenal.

**Q4 Chair:** Can I just pick you up on that point, because, in fact, the people who are most likely to wait more than four hours are the complex patients? They are not the patients who are experiencing some minor inconvenience, and it is the more complex patients who we understand are the key driver for the deterioration in performance. Is that correct?



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**Pauline Philip:** Just to clarify there, we have a standard that delivers 95% of patients being seen within four hours. That standard was set at 95% because every emergency department sees some very clinically complex patients. We and the Royal College of Emergency Medicine would not suggest that those patients should be rushed through the system. Some patients genuinely need to stay in an emergency department for more than four hours. We have not had any concerns or issues with that, nationally. I have never heard of a patient complaining because they were in an emergency department for more than four hours, if they clinically needed to be there. The patients who do become frustrated are patients who feel that they do not necessarily need the care for four hours and they have waited longer to be seen; so there is the difference. Does that make sense?

Q5 **Chair:** Could you set out for the Committee what proportion of these patients are people who are being inconvenienced by a longer stay than it needed to be but they are not really very complicated, and the proportion of patients who stay longer than four hours because they are very complex patients who need to be moved through into the wards and so forth?

**Pauline Philip:** I do not have that information available to me, but can I look to Keith, who may have that information?

**Professor Willett:** If we go back to the 95% standard, 80% of patients we expect not to be admitted. Of a further 20%, we anticipate three quarters of those, i.e. the next 15%, would take about four hours to be seen, assessed and admitted or discharged. The 5%, if you like, which is 25% of the 20%, is the group that we expect to take more than four hours. If you look at the breaches of the four-hour standard, where they have not had their treatment and admission completed, yes, there is an issue there. At the moment, only about 40% of those patients will be admitted within four hours and they spend longer than that in the A&E department. That is not what we would want to see. That is due to the flow through the hospital, and that is when they are on what would be called trolley waits, although, clearly, most of these patients are on beds and not on trolleys, but they may not be in the appropriate environment and they may not be in the specialist area they should be. That is about the flow.

The Health Foundation, other commentators and other people have spent their careers looking at these groups of patients, and we know that the performance in an A&E department is almost wholly dependent on its relationships and its working with the other departments of the hospital and the other providers in the healthcare economy. It is a good measure, in that regard, in terms of the system flow, but it is not something that should be considered to be a judgment of the A&E department.

Q6 **Chair:** The reason I was pursuing the point is that a lot of what we see is focusing on diversion and diverting minors towards GPs, whereas we are also hearing evidence that the focus should be on these more complex



patients.

**Professor Willett:** Could I make a very early point then, I hope for the benefit of the Committee? We need to look at A&E attendances as a different cohort of patients from those who become hospital admissions. If we look at the growth in A&E attendances over recent years, it has been for the less severe conditions—in fact, getting less severe, which is interesting. That growth, predominantly, is in self-referral patients, who make up about 62% of patients who go to A&E, but the group that has grown the most is being referred in by GPs and health professionals. Perhaps we can reflect on why that may be. The growth for people attending A&E, who we would not anticipate being admitted, has been for the increasingly less severe conditions over time.

If we go to the admissions—the patients who are actually admitted to hospital—it is a very different story. There, there is a very strong correlation with an increased complexity in severity of their conditions. That also correlates to the flow within the hospital. So there is a strong correlation between patients breaching the standard for admission and delayed transfers of care. They are a different group of patients. They are older now; they are frail. The average patient who is admitted to hospital now, over the age of 75, has five conditions that they are admitted with. This is the shift we see in hospitals. They are very different.

In terms of the urgent and emergency care review that I have been leading for Sir Bruce Keogh, we have had one big focus on how we help patients and how we take urgent and emergency services out closer to the community, in general practice, in primary care, through urgent care centres, through the paramedics and through 111. The other focus is how we manage the group of patients now who are very complex in terms of their medical problems. Very often, their issue is more of a care need than a health need. Unfortunately, in the NHS, we have a default. If we cannot offer what the patient needs at home or in a locality close to home, our default—even if it is only a care need rather than a health need—is to a higher acuity, usually a higher cost setting, which is not good for the NHS in terms of costs and sustainability, but, most importantly, it is not ideal for the older patients.

**Chair:** Thank you. We are going to explore that in more detail later on. Before we move on, I would like to go to a very topical issue and over to my colleague, Andrea.

Q7 **Andrea Jenkyns:** We are already aware that trusts face a lot of pressure during the winter period. Being very topical at the moment, there are the junior doctors' strikes. To begin with, what impact do you expect the strikes by junior doctors will have on the experience of patients in type 1 emergency departments? We will start off with the Minister.

**Philip Dunne:** Thank you very much for inviting me to the Committee. I would just like to start by saying that this is, clearly, a very timely investigation and inquiry. It is on a topic that is not only topical—I do not



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mean the junior doctors, which is topical, but the topic of the inquiry—but a subject of intense interest and scrutiny from within the Department, to ensure that we are in as good a place as we can be as winter approaches. In that context, the threatened action by the junior doctors is clearly not welcome. It is not only not welcome to the health service but it is not welcome to patients in my view and in the view of the Committee that was negotiating the contract over the last three years. It is perplexing that the current leadership of the Junior Doctors Committee on the BMA is proposing the most significant industrial action in the history of the NHS, I believe, certainly in the last 30 years or so, over a contract that their leadership itself described as fair and safe and recommended to their members. On the Government's side, we have undertaken significant negotiations over a period of years, culminating in over 100 concessions to the doctors, to meet many of their requests and demands. We are now down to two issues, which are both related to pay. It is about pay and nothing else, at this stage.

Q8 **Chair:** Can you address what the impact will be—

**Andrea Jenkyns:** On the emergency departments.

**Chair:** That is our focus.

**Philip Dunne:** I will ask Pauline to respond to that in a second, but the concern that we have now is that we are faced with the potential of 15 days of strike action over two months, in the run-up to Christmas, as winter approaches, and those three actions, over five days each, will put very considerable pressure on not just emergency departments but the hospitals as a whole. It will be much harder than the previous strike actions that have taken place thus far to manage for those people who choose to turn up to work.

**Pauline Philip:** As far as emergency departments and the emergency part of an acute hospital is concerned, clearly we have learned, over the course of the last 12 months, how to effectively maintain safety within our emergency departments during strike times. It is fair to say, as an acute chief executive, that we will feel confident that we would be able to do so, irrespective of the length of the strike. However, my significant concern—

Q9 **Andrea Jenkyns:** Even with the increased demand during the peak winter period.

**Pauline Philip:** Yes, as far as our emergency care is concerned. However, the impact as regards our overall hospital would be significant. In previous strikes, we have maintained most of our elective work and we have properly risk-assessed any elective work that was being cancelled or delayed. If we lose 15 days out of our elective programme between now and Christmas, with every hospital running as hot as it is, that will be enormously difficult. There may be some knock-on impact, as far as emergency care is concerned, because some patients, who would have



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received elective care, may come to the hospital as an emergency. That will be small numbers. From an emergency care point of view, we have good systems in place, both locally and nationally, to ensure the safety of our patients. However, from an overall care point of view, we would be very concerned.

- Q10 **Andrea Jenkyns:** Thank you, Pauline. Back to A&E, are there any aspects of urgent and emergency care that you are aware of that trusts will not be able to provide when strike action commences?

**Pauline Philip:** If I speak for my own hospital and from talking to colleagues, that would not be the case. We would be able to do that. However, our experience so far has been one or two days. Five days will stretch us because we do have a limited workforce overall.

- Q11 **Andrea Jenkyns:** It was not during the busy peak winter period.

**Pauline Philip:** Exactly. At the moment, trusts are already planning, as I am sure you are aware, over the period of 15 days and not just five days at a time, but I do not want in any way to leave the Committee in the belief that this is not going to have a significant impact on acute care overall, because I think it will.

- Q12 **Andrea Jenkyns:** Thank you very much. Given that many trusts are not close to achieving the 95% four-hour standard, how exceptional or sustained does pressure have to be for trusts to request that junior doctors return to work? What is the level that you imagine has been set for them, to get them to return to work?

**Professor Willett:** If I may, I will take that up because we have been through this already and we have reached agreement with the BMA. They have been very accommodating in this regard and so have the junior doctors themselves. As you will be aware, under the licence to practise, any doctor is required to make sure that arrangements are in place that no harm comes to their patients or they are placed at risk. In fact, leading to the last strike, the junior doctors, the consultants, the other doctors, the nursing staff, therapists and the managers in the hospital did a lot of work, before the strike action, to ensure that that was achieved.

- Q13 **Andrea Jenkyns:** Is it not also down to perception, though? I have heard some junior doctors myself, with whom I have been on debates, saying that patient safety is not impacted, but clearly it will be. What measures are you physically putting in place if you have some saying that it is not impacted?

**Professor Willett:** We have agreed that there is an escalation process within the hospitals—that the medical director or an executive of the hospital must be actively involved and take stock. The agreement has been that the circumstances in the hospital need to be exceptional and sustained. In other words, it is something that exceeds what the hospital can manage and it is going to continue for more than a few hours. In those circumstances, through the regional offices of NHS England, they can approach the national co-ordinating centre. We then have an



agreement to speak to the equivalent co-ordinating centre in the BMA for that to be discussed and agreed. Then the BMA, if they agree, will go locally and there will be a request for junior doctors—perhaps it is a specialty—to return to work.

- Q14 **Andrea Jenkyns:** With respect, that whole process, although it seems thorough, does seem quite long and drawn out. If a trust has a massive influx in the A&E department that they cannot cope with, above exceptional and sustained, how long will this process take for them to get more people on the wards?

**Professor Willett:** By the definition of sustained, it means it is going to last for several hours. It cannot just be something that is going to be a very transient event, which means, by definition, you can go up and down that path. That is a very quick path. We are, literally, three phone calls up and down. There is also the agreement that in the event of a major incident being called by an external party—a road crash or something of that ilk—that is an immediate return to work.

- Q15 **Andrea Jenkyns:** How long would the process take, though?

**Professor Willett:** If there was a major incident called, I would imagine that process would be almost immediate. The junior doctors are around in the hospital, and social media gives an amazing ability for junior doctors to communicate, as we have seen. I have no doubt, having been a junior doctor many years ago and knowing all the junior doctors I work with, that they will return to work immediately. I do not think there is any doubt about that in the event of patients being put at harm.

- Q16 **Andrea Jenkyns:** Do you think there are enough safeguards in place to ensure that, though?

**Professor Willett:** We have agreed that with the BMA, yes. I am confident that we have that process in place.

**Pauline Philip:** If I could just add to that, all providers that I have spoken to would say that, individually, they have very good relationships with their junior doctors and that during the previous strike days the junior doctors have remained very close to the management of the organisations.

- Q17 **Maggie Throup:** I have a couple of questions about the role of primary care in relation to winter planning. First of all, can you explain what primary care providers will be expected to do to alleviate the pressures that emergency departments will experience over the winter months?

**Pauline Philip:** I can start. I mentioned earlier that we have established an A&E improvement plan, the purpose of which is to have a co-ordinated national and local response, not just to emergency care but to the winter and winter pressures. We have established, locally, A&E development boards. All providers and commissioners within a local system, including our general practices, are part of those delivery boards. As we approach



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winter and in the development of our overall winter plan, they are going to play a fundamental role. As far as our escalation process is concerned, during the winter period, for the first time we have a new national escalation plan, and, again, they are completely tied into that.

More locally, the answer to your question is that providers within a health system acknowledge the challenges that general practice faces, and, by working together as a single team, we can maximise its ability to see patients in a timely manner by working as a team across the system. Clearly, nationally, we have been supported by initiatives such as the GP Access Fund, which is increasing the number of hours that are available in 57 systems around the country, I think it is, for out-of-hours GP appointments on an evening and at the weekend. That is going to be gradually rolled out over the course of the next four years, to get 100% coverage on that. In general practice, we are all very much aware of the challenges, but by working together as a health system we can maximise the benefits of what we have available today.

**Professor Willett:** Your question was primary care, which is wider than general practice as well. Part of the A&E improvement plan includes increasing the clinical input behind the 111 service and the ambulance service. That would bring in pharmacy, community nursing and others to provide support so that patients who can be managed with minor ailments and minor injuries can be deflected. General practice is under enormous stress, as we all recognise, so it is about using the whole breadth of primary care to create that winter response. The Stay Well media campaign this winter, as was successful last winter, will focus a lot on community pharmacy, where we know there is certainly capacity to take on a lot of that minor illness and injury work.

**Q18 Maggie Throup:** Many of the written evidence submissions we have had showed that patients attending A&E during the winter months are more unwell than during the summer months, so they are more likely to be admitted. Given that fact, what other evidence is there that shows that primary care will be able to reduce demand for the A&E departments?

**Pauline Philip:** It is very clear to the system that during the summer months, although most A&E departments see smaller numbers of patients, the patients are indeed much sicker. With our development, as far as integrated urgent care is concerned, the roll-out of 111 and development of the 111 service, our first ambition is that, if people are unwell, they can be treated in their own home or as close to their own home as possible, and only brought to hospitals—particularly elderly people—with, for example respiratory conditions, UTIs, et cetera. If possible, we will maintain people where they live at the moment—nursing homes, residential homes and so on—but if they have to be brought to hospital, and that is necessary, we are trying to maximise the ability of the emergency department to see them in an effective manner. If they need to be brought into hospital, the focus is on trying to ensure that



their length of stay is as short as possible and that they can return to the supportive environment from which they have probably been admitted.

Going back to the core of your question, by working as a team—with general practice, primary care and the broader primary care staff— that enables us to support the individual patient with their care plan.

**Professor Willett:** I am very aware there is clinical expertise on the Committee and I am a trauma surgeon treading into general practice areas here, but, clearly, within primary care and general practice, there are some really key things. We know that during the winter months we go from 1,000 admissions a day, for respiratory problems, to 2,000 a day. It is the one patient group. Those patients usually have frailty, underlying respiratory problems or cardiac problems. There is a real role there for flu vaccination through primary care, a real role for the rescue pack for medications for patients with chronic respiratory—COPD—problems, and for the role of pharmacists in ensuring that medications are available to those patients, so that, come the bad weather, they do not just run out of whatever they are on. There are some really big things there. This is something that general practice and primary care focus on every year. The media campaigns have been relatively successful in recent years because we have helped to educate the public and the patients to use general practice and primary care in that way.

**Philip Dunne:** Can I add to what Keith said earlier about access? We are now rolling out greater opening hours for GPs. It is at their own initiative where and when they do it, but certainly in my own area we now have GPs 8.00-8.00 on Saturdays, which is an innovation in the last year. That will start to take off across the country and we will see more primary care involvement throughout the year, six days a week.

Q19 **Maggie Throup:** When we were at Luton & Dunstable, one of the witnesses we heard was from the ambulance service. He said that one really practical measure that would be quite easy to implement would be for paramedics, if they are a bit uncertain about what to do with a patient, to be able to get easy access to a medical professional, a GP or somebody in A&E. It is happening in some places. How easy would that be to roll out across the country?

**Professor Willett:** That is part of the ambulance response programme, which is a wider part of the urgent and emergency care review. Within the A&E improvement plan, one of the five things includes an increase in clinical support behind the 111 service and behind the 999 service. You may be a community nurse, a paramedic or a GP in the community who, but for want of a bit more advice, expertise or seniority, could make a better decision for that patient. That is what we are providing them. We know from the areas where that has been running that you can reduce ambulance calls. Ambulance calls are categorised, but if the green ambulance category, which is those that are the least urgent, is reviewed



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by clinicians, particularly by general practitioners, we can reduce the conveyance rate—i.e. we can find something more convenient, as good for the patient, in 60% or 70% of cases. That is a win for both the patient in getting the right care more conveniently but also in terms of the system, because, in general, if you convey an elderly patient out of their home setting and into an emergency department, they are further away from the family, the GP, the people who know them and their medical records. It is extremely difficult for that patient not to become an admission. Once that patient is an admission, you then have a lot of work to do to reassess them, to safely place them and transfer them back into the community. Very often, that is for the want of care rather than medical input, as I said earlier.

**Q20 Dr Whitford:** I wanted to ask the Minister about the rolling out of additional Saturday hours of the GP. As this is now not every practice that is being discussed, is there not the danger that the patient does not really know where to go? It is like when you are trying to work out which pharmacy is open on a Sunday. The moment they do not quite know where they have to go this Saturday, they still just go to A&E.

**Philip Dunne:** You raise a really good point about education of the public and, with the general reforms that are taking place across the NHS, how we make the public aware of where the best place is to go to reach treatment. It has been mentioned already that there are now 14 million people using the NHS 111 number and I am sure we will see that number of people grow significantly. In relation to opening hours for GPs, it will be down to the local area to promote and advertise who is available when. I am not sure how urban your seat is. I suspect it is slightly more than mine.

**Q21 Dr Whitford:** It is a different system anyway. We do not have this.

**Philip Dunne:** Clearly, in very rural areas, we are not expecting individual GPs to be opening for such long hours. They will do so in a hub-and-spoke system. It is going to be a challenge to make sure that the public know where to go. That will be down to advertising programmes and the other ways in which clinicians communicate with patients. It applies to pharmacists as well, as you have said.

**Lyn Simpson:** I would like to make a point on primary care. Over the last 12 to 24 months we have seen the upskilling of staff and the skills transfer, which, if you look at aligning the different parts of the system, has to be in the interests of the patient: the nurse practitioners who work in primary care seeking some of the skills from the emergency care practitioners in the hospital department, the paramedics sharing those skills and a much more fluid workforce that can work across systems so that the patient gets a really good deal wherever they enter the system. Then, eventually, as the number of training posts come on, we see that in primary care they can deliver an enhanced emergency service, and in the emergency department they will deal with the more complex patients as they go along; but it does not happen unless you upskill staff.



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**Q22 Dr Davies:** I understand we have the lowest number of acute beds in Europe per capita. To what extent do you think this fundamentally contributes to the decline in the performance of emergency departments?

**Lyn Simpson:** The overall strategy is to care for patients as close as possible to their home base. Again, that takes some time while they are implementing that strategy, along with delivering care in hospital. So we need to see the shift in the total number of acute beds available and transfer some of that resource to delivering care closer to home, in primary care. If we look at the numbers, it is only a small proportion of acute beds that have been taken out of the service, in totality. What we have seen, though, is a higher proportion of patients in the short-stay 24-hour period. They come in, they are dealt with quickly and then they move back to their home base. I do not think we have seen any significant impact on patient safety or the care that is delivered by the reduction in hospital beds, and you do see the shift as you are moving from one strategy to another.

**Pauline Philip:** I would add to that by saying that, from an acute hospital point of view, we have made significant progress in recent years in reducing the length of stay of our patients. I cannot say that we have done better than other countries, but, certainly, through initiatives such as hospital at home, advances in clinical care in how we treat people, the introduction of short-stay areas, having rapid diagnostics and so on, we are able to use the bed stock that we have in a much more efficient manner.

**Professor Willett:** Perhaps I can just clarify a little on that. We are going to talk about flow and discharge later, but the Health Foundation has concluded, and those who have observed the health service for a long time will conclude, that most of the delays and inefficiencies are not the result of excess demand and capacity but, rather, the way that we use it. The issue we have across the urgent care pathway is that the bit of slack we need across the pathway and the responsiveness across it is very different. We measure our urgent call handlers' performance in seconds, our ambulances in minutes, our emergency departments in hours, our hospitals in days, and we probably measure community and social care in weeks. When you have a surge, the responsiveness you need has to be across the whole pathway and we are not capable of doing that. What happens is that, because we exceed something in a very short space of time, we then make a set of decisions, because we are forced to, which are counterproductive. We start moving patients to the wrong wards; we open escalation beds; we do that sort of thing. We start putting in extra checks, which, if a hospital goes into what I call congestive hospital failure for a few hours—for the clinicians, you will understand the simile—it takes several days to recover. If it goes into congestive hospital failure for a few days, it takes several weeks to recover. If you get into a chronic failure, you cannot get out of it. People just need to reflect on that and perhaps the discussion later on will address some of that.



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**Q23 Dr Davies:** That is all understood, but when we visited Luton & Dunstable you did say that by increasing the number of beds you felt you had reduced the strain on the emergency department, if I understood. While there are good things happening and we understand, to a degree, what we need to do, that implies that perhaps we need to increase acute beds.

**Pauline Philip:** Basically, we told you the story of Luton & Dunstable. Six years ago the department was consistently failing the emergency target. It was very important to us at that point to get our bed stock right and that, by doing so, we were able to avoid all the things that Keith has just described to you. Actually, by getting the bed stock right in the first instance, it has allowed us to do all sorts of things around reducing the length of stay and developing different models of care that we or the hospital had not been able to do in the days when it did not have enough beds. That was part of the turnaround plan for the emergency department and it was very important. From a bed point of view, we do all recognise that we have a problem today with patients who are occupying acute beds, who are medically fit for discharge. You probably want to come on to that issue later.

**Q24 Dr Davies:** In terms of the increase in bed capacity that you brought about, do you think that there is a need for that to be reflected nationwide, or is that difficult to comment on?

**Pauline Philip:** That is a really difficult question, because you would literally need to sit down and look at it hospital by hospital. We put a lot of time and energy into developing the right bed model, and it is constantly under review. Each provider that you talk to will have their own opinions. Some providers, who are not doing well, will say that they believe they do have sufficient beds and they will tell you that there are other problems, but some will say, as you heard from some other providers the day you visited us, that they believe they do not have sufficient beds.

**Q25 Dr Davies:** What kind of leeway is there, for this coming winter, in terms of spare bed capacity? What is the current unused bed capacity?

**Lyn Simpson:** There is not a bed stock that is ready to just switch on because it is unused. In previous years, we have been able to flex the use of beds and bring some additional beds into play for the winter period. This year we have been thinking about how we can use the current bed stock more efficiently. If you look at benchmarking data and efficiencies, there is scope to do more with what we currently have, rather than to bring more into play. There is a lot of good will, as well as reciprocal arrangements, across health economies. If an organisation is feeling under pressure, there is the ability to work closely with a partner and to flex across the system. The old idea of having beds that are mothballed and then brought back into play for periods of time is something that we should avoid and we should use the current bed stock more appropriately.



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**Pauline Philip:** To add to that, one of the pieces of work to which I referred a moment ago that we are doing as part of the A&E improvement plan is looking at this whole issue of discharge and patients who are occupying beds in acute hospitals who do not need to be in acute care. Clearly, there is a significant opportunity there. By working within the local delivery boards, this is one of the first issues that they are addressing, looking at the numbers of patients who are occupying beds in each hospital, who are not just in the original detox category but in the wider medically fit category, and then looking at capacity within the wider health economy, whether it is bed capacity or care capacity. That is probably the opportunity that we would be looking towards this winter.

**Philip Dunne:** Significant improvements can be made by changing the way that we approach the whole patient flow, without necessarily requiring more beds. As an example, I visited Barking last week, who have increased their A&E performance figures by 8% in the last four months for which the data is available by changing the way they do things, rather than by increasing capacity.

Q26 **Dr Davies:** I fully accept that, but if we consider attempts across the country that have not been successful, it is clearly a difficult job, is it not? Would Ministers support a proposal to increase bed capacity, either acutely or step-down rehabilitation beds, as part of the solution to reduce the pressures on A&E?

**Philip Dunne:** One of the things that will come out of the sustainable transformation plan work that is under way across the country is looking more closely at integrating the whole care pathway between, at one extreme, the A&E admission and coming out the other end. As part of that work, we will see the whole healthcare economy players look to develop a more integrated pathway and rehabilitation beds. Intermediate care beds, I am sure, will form part of that.

Q27 **Dr Davies:** This is my final question about beds, you will be pleased to hear. The statistics are currently collected at midnight, when there is usually a dip in occupancy. Do you think that is an appropriate time of the day to measure levels of occupancy?

**Philip Dunne:** That is a new one on me.

**Pauline Philip:** I suppose, again, from a provider point of view, at the moment hospitals are running sufficiently hot that we are all fairly close to that 100%. If we have increased occupancy during the day, it is because we have areas of the hospital such as discharge lounges, which is additional capacity within; so I am not 100% sure that there is a lot to be gained from changing that at the moment.

Q28 **Chair:** Some people do not feel it accurately reflects the pressure because, during the day, there is simply nowhere to move people on to within the hospital and you can get a false sense of security by having lower figures that are measured at midnight.



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**Pauline Philip:** That is probably coming back to the internal flow issue within the hospital. Again, through the A&E improvement plan, we are working with providers to say that, if patients are due to go home, we need to prepare in advance for the patient going home. We need to be able to get people out of our hospitals by 11 o'clock or midday, rather than waiting till 6 or 7 in the evening.

Q29 **Chair:** The question was: would it not be better to measure your occupancy at that time of day, rather than midnight? Is midnight the most appropriate time?

**Professor Willett:** A lot of the measures we have in the system at the moment are very institution or time-based, or spot-based. As part of the urgent and emergency care review, we are generating a whole series of new metrics, with consensus, that measure the system and measure flow, which is what we all need to see, because wherever we put a measure you can work around it or you can game it, or you can do lots of things. We really need to see system-wide metrics and we will be putting those to people in due course.

Q30 **Chair:** That is what we heard. The targets are not really nuanced enough. They are all things that you are working on, by the sounds of it. Would that be fair to say?

**Professor Willett:** Yes.

Q31 **Emma Reynolds:** I have a quick follow-up. I think we all want to see transformation and better integration in the NHS, but there are concerns, Minister, particularly around some of the press coverage of the sustainable transformation plans that we have seen in August that there will be closures of hospitals and therefore there will be fewer beds available if there are closures in the west midlands and elsewhere.

**Philip Dunne:** There have been quite a lot of newspaper headlines and I suspect we will be talking about some of them on Wednesday. I would say it is far too early to be talking in terms of closure at this point. We need to see what plans emerge from the STP programme. NHS Improvement and NHS England will form a view as to whether or not that meets the Five Year Forward View of Simon Stevens, and then they will put them to Ministers, but we are not, at this point, talking about closures.

**Chair:** Thank you. We are going to move on to another section around staffing.

Q32 **Paula Sherriff:** Thank you, Chair. I would like to talk about staffing this afternoon. It is an issue, having had a long history in healthcare management, that I am particularly interested in. If you will allow me, I would just like to contextualise it for a moment. I represent a constituency. One of the health trusts that looks after that constituency is three hospital trusts, and I understand it has some of the highest emergency admissions or emergency patients in the whole of the country



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outside London. I met with the ambulance service last week and they were telling me it is commonplace, several times a week, that 10 ambulances can be waiting outside one of these hospitals, with the patients still in the ambulances waiting for staff to have the capacity to tend to these patients. This started off as an issue that the ambulances are not meeting the targets, and part of the reason is that they are backing up, effectively in a traffic jam, outside Pinderfields Hospital, which is in Wakefield. Then it was established that the reason they are backed up is that there are just not the staff to see to these patients. Obviously, I have discussed this with the trust, and, by their own admission, they are in a crisis regarding staffing. That is straight from the chief executive's mouth.

Interestingly, my local hospital in Dewsbury, which is part of that trust, is shortly going to be downgraded in terms of the A&E department. As it stands, approximately five times a week there is a diversion from Pinderfields, which is the main hospital, to Dewsbury A&E. All blue lights are sent to Dewsbury. The fact that they are still planning to downgrade that in spring next year, really, is beyond parody, I would suggest.

In terms of looking at the STPs—while I am not telling you how to do your job, Minister—perhaps you should think about pausing some of these changes while the figures are not really achieved. Can you tell us what steps trusts should be taking to ensure they have sufficient staffing in their emergency departments? As you will be well aware, when you have problems and an admitted crisis, retention and recruitment is also quite difficult within those trusts. It is very easy to talk about what the trusts should do, but, interestingly, when I met with the trust on Friday, they told me they are still subject to the 2% arbitrary savings target that has been imposed in order to achieve the £22 billion of savings. I would be interested, from a trust perspective, what you think they should do.

**Philip Dunne:** I will start, if I may. You are raising something that has become quite familiar to me since my first week in post. We had an Adjournment debate in Westminster on the subject, and in particular the hospitals in your part of Yorkshire. So it is one of the areas I have spent a bit of time looking at. You are highlighting a challenge. Once an area comes under pressure for either performance or staff morale, or there are traditional recruitment problems in a particular area, it is quite challenging for trust management to turn that around. That is why we have instituted the special measures regime, to try to help trusts, by buddying up with successful trusts with strong leadership, to try to help with the turnaround process. We are introducing that particularly into trusts that have gone into special measures, but we are trying to use a buddying system to deal with specific problems elsewhere.

In relation to emergency department staffing, across the country the picture is a lot better than the one that you are painting locally, in that we have had a significant increase in recruitment of emergency doctors, up over 50% over the last six years. It is running at about a 9% increase in doctor grades. I do not have the nursing figure in my head, but,



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generally speaking, nursing figures are up across the sector as a whole. The specific recruitment challenges of your area, I accept, are difficult, and, to go back to the STP plan again, it is something that needs to be looked at in a coherent whole, with the entire area. I am aware of the challenges in your trust. I hope the STP plan will help to address some of those by looking at more joint working with other healthcare providers in the area.

As to the point about transfer of patients from ambulances backing up in the car park, I am probably not the best equipped to deal with that. It is more to do with patient flow than specifically a staffing issue, but they are, obviously, related.

**Pauline Philip:** I cannot comment on the details of the hospital, but maybe Lyn might be able to say little more about that. With regard to the whole issue that is often presented to us around ambulances sitting on ramps in hospitals, you have to come at that from a number of different angles. When we sit down to work with a hospital that has those issues, the first thing you need to do is to look at the total breadth of services that they are providing. They know themselves what their ability is to recruit and retain staff. When I am talking about the total breadth of services, I am referring to everything from specialist elective work across to emergency care. There may be some specialist elective work that they do not have to do on that site, in that hospital, whereas perhaps they have to do emergency care; so it is a very broad issue. Time and time again, when we come across the issue of these ambulances outside a hospital, it tends not to be about the number of staff within the emergency department but how the emergency department is being organised, the processes that exist—very simple things—and the capacity. We meet departments all the time that do have staff standing there, but they do not have enough trolley space. You have to look at all those issues. Sadly, it is not very straightforward, but I am sure Lyn could say something.

**Lyn Simpson:** I am familiar with the trust itself. It was only two weeks ago that I was there and went round the accident and emergency departments. The good news is that there are some very committed people—

**Paula Sherriff:** Absolutely.

**Lyn Simpson:** There are very capable people who want to do their best for the patients they serve. It is difficult sometimes recruiting staff to the northern part of the region and your area. We have to think a little bit more outside the box and creatively as to how we do that. The Minister mentioned the number of medical staff we have. We have increased nursing staff across the country by 24,000. Unfortunately, we cannot always draw on that for your patch or for the north-east. As I say, we need to think more creatively about that. I am working quite closely with



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the chief executive of the organisation and looking to see where we can bring in some improvement support, because it goes back to the points that Pauline made about maybe doing things a bit differently, looking at those ambulance handover delays. Where is the difficulty in the system? If you can bring somebody in to do that, who is not threatening to the staff but will challenge some of the customs, practices and processes, then we can start to change those processes and improve the flow. It is not easy; it is difficult for the staff, as I say, who want to do their best, but, working collectively, both through the STP and through the improvement resource, we can tackle some of those issues.

- Q33 Paula Sherriff:** Thank you. Can you talk to us about the implications for patients if some EDs are unable to provide consultant cover 15 hours a day, seven days a week? Could you put that in the context that at the moment there are somewhere in the region of 70-odd A&Es, country-wide, that are potentially facing what many call reconfiguration but largely it is downgrades? Often, the argument that is used is that we cannot provide consultant cover, particularly in multi-hospital trusts, so therefore it is safer to send people to perhaps a more centralised location. What are the implications for patients where there is not consultant cover?

**Professor Willett:** Going back to the point that Pauline made earlier on that is the context of this, medicine has changed. As a surgeon in the emergency area, what I used to do in the resus room, the paramedics can now do in an ambulance. What the physicians used to do in a hospital, GPs can now do with a machine in their bag at the house. Medicine has changed dramatically. There is a lot of medicine that we should be taking out to the community and we should be looking at how close we can get urgent care services to a patient's home, ideally if they are elderly, or even to a locality. We also recognise, as medicine has changed, that there are now things medicine can do that it could not do, you just died or you had a poor outcome.

We also know that in the last few years we have shown, in England, to international acclaim, that we have improved the odds of survival for major trauma by 25% in three years. For heart attack, we have increased the survival by 20% at 30 days, in the last few years. For stroke, we have increased the 30-day survival by 17% in those areas.

So there is also an absolute requirement that we should not deny our patients and the public the opportunity to get to specialist centres, and that cannot be provided in every locality. We have this very big shift going on, and, to some extent, I would argue that, although medicine has changed dramatically and our patients, as we described before, have changed a lot, the NHS has not changed its shape. We need to think how we do that, going forward. That is the context of all this.

- Q34 Paula Sherriff:** I am sorry to interject, but there is the whole time and distance argument, is there not, particularly with the golden hour, so to speak?



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**Professor Willett:** There is. If you are severely injured, you are better driving past three hospitals and getting to a major trauma centre than going to the nearest one. Your survival rate chances are 25% higher.

Q35 **Paula Sherriff:** Is there a flip side to that, say, for example, if you had a heart attack, status epilepticus or something like that?

**Professor Willett:** With things like that, that is what I am saying. That is what paramedics can now do in the ambulance. If you are having a heart attack, the paramedic will now do the ECG at the scene; they will see what sort of heart attack you have had. If it is one where your survival chances are increased by going to a heart attack centre and having a stent put in, then they will go to that hospital; they will not stop at the hospitals in the interval that do not have that. That is what I mean about us understanding how healthcare changes. Then we have to design our services to fit that. The original A&E departments, when I trained, had only just started to invent emergency medicine as a specialty. None of them had consultants. Over the years we have grown and grown that, but we have also tied that into saying that if you are an emergency department you have to have X, Y and Z behind it. That is where it becomes unsustainable, because we cannot do all those medical interventions in every hospital. You cannot attract the staff because there is not enough of it to keep the specialist skills up. There are a lot of complex arguments in here, but in general we have increased the emergency medicine workforce considerably, as the Minister has said. We have also grown the nursing workforce. We have done many things to try and create sustainable systems.

Currently, one in five of all the emergency departments that receive children in the hospitals in this country does not have children's services on site. You might argue: how should we manage that? We have to think about that. In the urgent and emergency care review, we are saying, right, this is not about isolated units any more. This is about the whole healthcare system working as a system, so that whether you are the paramedic at the scene or the GP in the home, whether you are the hospital, the urgent care centre, the minor injuries unit or whether you are the small hospital or the specialist hospital, you never have to make a decision in isolation. There is always someone in that system who will help you. As soon as you can identify what is preferable for the patient, we will either take the service to the patient or bring the patient to the right service. That is where we have to get to, so we do need to broaden our thoughts about what the health service will look like over the next 5, 10 or 15 years.

Q36 **Paula Sherriff:** The final question from me is in two parts. Are the trusts that are successfully able to recruit simply depriving neighbouring hospitals of the staff that they may require even more urgently? Again, that is particularly true in my part of the country. Will trusts be permitted to breach the agency spending cap to ensure that they maintain safe staffing levels, particularly over the winter period?



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**Professor Willett:** Were you talking about one hospital poaching staff from the other one? Was that your question?

Q37 **Paula Sherriff:** Potentially, yes, but particularly where morale is low and we have seen an exodus, almost, where there is a neighbouring hospital.

**Professor Willett:** Health Education England is established in terms of workforce. There are local workforce action boards across each local health economy now, which sits under the sustainability and transformation plan banner. They will look at the workforce for the whole local health economy so that you will start to see some more sensible relationships develop, because it is right for the whole system not to be escalating prices through agencies, as perhaps happened before when people were competing, but, if we are going to work as a network and as a system of healthcare providers, we need to look at the workforce needs across everywhere. If there is one hospital that is really struggling with workforce, the impact on that hospital not performing well will be felt in the other parts of the healthcare sector. That is the approach. In terms of the agency cap, I will leave that to others to answer.

**Philip Dunne:** On agency, we all recognise that we need to reduce the dependence on agency staff, not just because they are more expensive but because it deprives them of the need to recruit permanent staff, who will be safer for the patient because they will understand the system better, they will be much more productive because they will not require constant training in where to go, and they will also improve morale for the people who work there. We are very keen to reduce dependency on agency and we are having some success with that. There are various breakpoints so that, if individual trusts get into difficulty and come close to the cap, there are ways of dealing with that. We do not want to give the impression that the measures we are taking to reduce agency usage should be a free-for-all. This is an important thing to drive down within the NHS.

**Lyn Simpson:** Can I add a couple of points there? We need to work in partnerships with the other hospitals in a particular patch, rather than one organisation poaching or being able to attract staff greater than another, so that that partnership arrangement would benefit us all. In terms of the agency cap introduced in October 2015, we have always said consistently, where there are patient safety issues, that a trust can make a decision to breach the cap. Building on what the Minister said, we would like to reduce the reliance on agency and invest that money into substantive staff, because we do know that that improves the care to patients, improves staff morale and greater teamwork, but we will not compromise patient safety.

**Philip Dunne:** In the last financial year, the agency bill was reduced by £300 million. Between October and March that was the impact, which is not an immaterial amount.

Q38 **Chair:** Can we return, briefly, Professor Willett, to the point you made



about paramedics? Are we investing enough in paramedics, given that the strongest evidence we have received from CURE in Sheffield—the Centre for Urgent and Emergency Care Research—was around the use of that “see and treat” model at home for diverting admissions. Are you satisfied enough is going into that part of the workforce?

**Professor Willett:** There are several areas of the workforce that we know are under enormous pressure. The paramedics are particularly under pressure. I would also add the ambulance services. We tend to look at them as a conveyance vehicle structure, but they are probably the area of healthcare that has the greatest opportunity to manage demand for the rest of the health economy.

As to the paramedic workforce, first, I will mention the ambulance response programme at this point because it is very relevant to staff side. A lot of the problem with the paramedics is that we are not recruiting—and certainly not retaining, particularly—experienced paramedics. That is because of the pressures they are under. Fifty-eight per cent of all ambulances in England that are dispatched are dispatched on blue lights and two-tone sirens, to go to an emergency. The number of patient calls that might benefit from a response of that urgency, to get there in eight minutes, is probably less than 2%, and certainly no more than 6%. Fifty-eight per cent of ambulances go out, and that is because they are trying to meet the eight-minute target. In fact, 25% of the ambulances we dispatch never get to the scene because another vehicle has got there first or, it turns out, by the time they have found out what is wrong with the patient that they are not needed. That means we are currently sending multiple vehicles to one call, just to try to meet the standard. We are diverting ambulances that were driving to that old lady who is perhaps on the floor with a broken hip, diverting them away from that call to go to something that has come in as a red call. There is a real issue about the pressures around paramedics. They can spend their lives either driving on blues and twos, as we call it, under enormous pressure continuously, or perhaps waiting to unload because there are handover delays in a hospital. That is very unrewarding. Part of the ambulance response programme is to change the whole way ambulances respond. Where we have started to pilot that, we already have very good staff-side feedback about what it is doing to improve the quality of their working.

In terms of the paramedics and recruitment, there has been a decision, following the PEEP report, to move paramedic training, because of the potential for them to be able to do so much more, to a graduate-based programme. That is coming online. We are about 1,500 paramedics short in the country at the moment. That is probably getting on towards 10% of our paramedic workforce that we are short of. It has now been recognised as a shortage occupation by the Department, so that allows us to look at different ways of recruiting into that. As a result of the PEEP programme and the recognition of what we need to do with the paramedic workforce, that has now gone out and we are now commissioning many more; 2,000 more paramedics will be coming out of



the system by 2020 and they will be graduate paramedics, so there is a significant investment in paramedics. There has been an increase of over 100% in the commission of training places.

Having said that, that is a bit for the future. We do have the short-term initiative. With the ambulance response programme, provided that the pilots demonstrate what we hope they will demonstrate, we will start to see that benefiting the current workforce, which will help us on recruitment and retention. Clearly, the occupational shortage definition now allows us to recruit from others. In fact, the London Ambulance Service has recruited a large number of Australians.

**Q39 Chair:** Just on that point about the pilots, do you have sufficient information to be able to change it nationwide for this winter? It was certainly something that was raised with us in Bedford, and I know there are pilots, for example, going on in the south-west.

**Professor Willett:** As to the ambulance response programme, there are three phases to what we are looking at. This is a root-and-branch review, led by the ideas from the ambulance service clinicians. This is not something that we are imposing. The first thing we have instigated is to pilot some front-line questions at the start of the call coming into an ambulance service, to try to identify those patients who absolutely do need it—they are not breathing, their heart has stopped, or whatever. That is called nature of call. One of the big issues was why so many ambulances get dispatched in a hurry, on blues and twos, and it is because, previously, ambulance services were only allowed 60 seconds from the call connecting to them making a decision. While the call handler is going through the call, as soon as it gets to 60 seconds, if they have not reached what we call a designation—they do not have a disposition that fits the patient—the ambulance service is required to send an ambulance. You can imagine an old lady downstairs, her husband is upstairs trying to work out in a conversation what is wrong, and 60 seconds has gone very rapidly.

We have now allowed the ambulance services to have a longer time to take that call, which means they are much more likely to reach what we call the correct disposition and send out. In the two areas where we have piloted that, over 4 million 999 calls have gone through that. Underlying all of this is safety. We have had no safety instances in those 4 million calls that have been handled in a different way. We have an independent academic partner from Sheffield University that scrutinises that for us and it is very carefully monitored. We have piloted that in six areas. We are piloting that now in the other ambulance services that are—

**Q40 Chair:** It is now being rolled out.

**Professor Willett:** It is being piloted out, because each ambulance service is quite different. We are very cautious about this. Safety is the No. 1 concern, so we are rolling that pilot out now across.



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As to the third phase, one of the big issues that we have is the previous way we dispatched ambulances. What degree of urgency we gave them was determined by expert opinion, looking at what the symptoms might be that the patient has described. We undertook a review of 10 million calls and worked out what those symptoms turned out to be. We are now looking at, and piloting, a way to send ambulances out differently so that, rather than responding to a simple time-based standard, we are making sure that the patient gets the right clinical input and the right vehicle input. Previously you were able to meet the target by sending a vehicle that stopped the clock but was not useful to the patient to convey them. This is very much about focusing on the patients getting the right care, but we know that will also help to deal with the inefficiencies of dispatch. When the targets came in, in the ambulance service, as with the four-hour target, they were very important at the time they came in, but as the system becomes saturated you can end up with a situation where, in an attempt to meet the target, you miss the point.

**Chair:** Thank you. That is a very full answer.

Q41 **Dr Whitford:** Some of the feedback that we had was that the plethora of management groups suggested that there was too much of a focus on commissioning and managing and not so much on what we saw at Luton, which was the practical changes inside an emergency department, to look at the patient flow in that part of the journey. Things changed their names; it was SRGs and now it is A&E delivery boards. We have urgent care networks. Are we, maybe, focusing too much distant from the coalface and within management, rather than in the department?

**Pauline Philip:** That is something that we very much heard from the service earlier on in the year. If you are a provider and you are struggling, and you have hundreds of people coming through your door, each telling you what you should be doing and each checking as to whether you are doing it, it can become very disheartening. So we agreed to establish this A&E improvement plan, recognising that we had the urgent and emergency care review; that to roll out that review in full would take some time; that we would have one system through the A&E improvement plan that would basically bring together NHSE, NHSI, and all the initiatives under one umbrella.

At the heart of the A&E improvement plan are five “mandated” initiatives, basically five things that we want each local delivery board to consider, the local delivery board being where the provider sits surrounded by commissioners, surrounded by other stakeholders, and so on. So it is a single forum, which then links to the regional delivery board, but within the local delivery board we are asking them to consider five things.

First of all, are you making progress on the delivery of integrated urgent care and the scaling up of 111, and are you doing what Keith referred to earlier? As you roll out integrated urgent care, are you looking at the clinicians that you have available for this winter, and are you deciding whether it might be better to use some of those clinicians instead in your



emergency department to bolster 111, or to sit in the ambulance service and to stop some of those patients being brought to you by ambulance who could be directed elsewhere? So the first piece of work is around 111, completely consistent with the review.

The second piece of work is very practical, around how you cope in an emergency department that is under pressure. Do you have the right streams for the patient who appears at the front door of your department? You saw that in evidence when you came to Luton & Dunstable. The first thing that happens is a patient comes to the desk and sees the senior nurse, and we have the ability to say, "Look, your needs can be best dealt with by general practice today or by ambulatory care today and so on," but it is working with departments all over the country to see if they are doing that.

The next area is to look at the flow—how you are actually managing within your department. Do you have the right information systems in place? Do you have the right number of trolleys? How are you phasing your staffing? How are you interacting with the rest of the hospital? What is happening the deeper you go into the hospital and you look at the patient pathway? Are diagnostics readily available, right down to the back door of the hospital?

That leads me on to the fourth initiative, which is around discharge, looking at patients who are medically fit, occupying acute beds.

The fifth initiative is the piece of work that Keith has just talked about around the ambulance service as we roll out these pilots nationally. So it is bringing those five things together into the local delivery board with all the local stakeholders sitting there.

We do understand that some delivery boards will still end up in a crisis situation during this winter. We are asking local delivery boards to work proactively with other local delivery boards so that we do not end up in an escalation situation whereby people are crying out for help at 10 o'clock at night; they work together all the time, but by having a new national escalation plan we have organised that in a fairly systematic way linked into interplanning.

That is a major focus over and above what has happened in previous years, but to try to support front-line providers in a way that they do feel, whether it is ECIP that is coming in to support them or it is a CCG or a region that is having a dialogue with them, it is all joined up; we are not all asking them the same question and we are actually helping in a way that they can accept that help, if that makes sense.

**Q42 Dr Whitford:** You think they will make a difference in the future but we probably do not have much evidence that they have made a difference.

**Pauline Philip:** The change from the SRGs to the local delivery boards is happening as we speak. They are doing a baseline this week so we will be



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able to see where they sit as regards those five mandated initiatives. For example, when we referred to discharge, a piece of work that we were able to launch recently was to go to those local delivery boards and say, "You give us the picture as far as your medically fit patients are concerned so that we can have a dialogue with the frontline and then we can co-ordinate that nationally," which we do once a week. I think that that does have a significant impact on the frontline to feel that they are being supported from a national level down to a local level over the course of a single week.

**Philip Dunne:** We are taking a great deal of interest in this at the centre because we think, as a result of the work that has been done through the professional clinical leads, that we know what needs to be done. It is getting each of the trusts in this dispersed organisation that is the NHS to get the benefit of that learning, and that is quite a challenging thing to do. Hence the national focus from the Secretary of State down, through NHSI and NHSE and these local delivery boards learning best practice to implement these five different standards, and then monitoring the metrics of how that is doing is what we are going to be doing.

Q43 **Dr Whitford:** We have discussed this whole sharing of good practice and not reinventing the wheel many times in the Committee, but certainly from the feedback that we have had from people, not particularly about this project going forward but certainly up until now, there is a sense of project management rather than improvement. So it is about managing the target rather than what we discussed and heard in Luton trying to actually improve the system. Obviously, Lyn you want to come in on that.

**Lyn Simpson:** If I may, there are a couple of things to add to that. This approach is different. It is about how we help organisations to help themselves. We need to differentiate what that improvement offer is to each organisation so that they really get what it is that they need rather than a universal offer. We have a segmentation process whereby we can look at the very best group perhaps but with people in the organisations that are struggling to share that good practice. The organisations that are struggling might require something like an improvement director. The organisations in the middle might just want to pull from the toolkit or guidance advice so that we can stratify what the offer is.

I do absolutely understand that organisations feel there are a lot of people going in and out of their organisations. When you are busy, that is quite frustrating and does not feel as if it is offering a lot of help. So, through the regional teams, we need to make sure that, when we are offering support, it is in a focused way and it is one set of people going in and working with them for a period of time rather than in out, in out.

The final piece, I think, is the bit about the heavy hand of performance management. We do need to hold organisations to account. They do need to make the improvements. They do need to deliver. But the best way to do that, rather than using a constantly top-down, heavy-handed approach, is to say, "You are accountable, but what can we do to support



you to move from where you are on a journey to improvement?" We have some really quite interesting stuff that we are doing, particularly in the north-east. If there is time, I can give you one example; if not, I can come back to it.

- Q44 **Dr Whitford:** You can maybe come back at the end if you want to submit that. Does that mean that the criticism we have heard about daily micromanagement is likely to disappear? Certainly we have heard criticism of people being contacted, conference calls, often more than once a day, which seem to be, in their opinion, more about reassuring managers and even Ministers about what is happening, but it is actually taking people away from dealing with the problem.

**Pauline Philip:** I think that is a really important point, and I think what has happened in the past is that we have been reactive. Basically, you hear the news reports and you read the newspaper. You see that the whole system appears to be in meltdown and people are then reacting to what has happened. We are trying to say through these local delivery boards that we need to be proactive and, instead of having all these calls in the evening and into the night, what we need ultimately is to accept that things will go wrong between emergency departments, but if we can work together in a way that we can support each other, then these types of calls, which were referred to, can become a thing of the past. We can have a new approach to escalation nationally and have some consistency in that, because there were different local approaches. From a provider point of view, my heart goes out to those organisations, because when you are trying very hard to manage a very difficult situation in your own hospital, the last thing you want to do is to spend hours on conference calls. You need people at the front door. That is what we are trying to avoid.

- Q45 **Dr Whitford:** Can I ask you, Minister, whether you would see these disappearing in the short term in that, if people are spending three sessions a day on conference calls to let you know what is happening, then what is happening is getting worse?

**Philip Dunne:** No. We need to get the information to the centre so that we are satisfied that progress is being made, and that is a matter of, essentially, IT getting the metrics right, getting that then reported through the IT system, picking up information that is already existing within the IT infrastructure, rather than creating a whole new raft of bureaucracy. We are not trying to do that.

- Q46 **Dr Whitford:** They also feel that they are being asked for multiple daily data returns as well, which again is taking the time of someone to do that.

**Philip Dunne:** The intent is to find data metrics that can be pulled off the system through algorithms written by software engineers rather than asking senior managers to get on the phone for three hours in the evening. That is absolutely not the intent.



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**Q47 Dr Whitford:** Last summer we had a debate and the Government decided not to report A&E figures weekly any more but on a monthly basis, and then last winter it was monthly but with a six-week delay, which means that we do not get the data for the first week of any monthly period for 10 weeks. In what way is that relating to daily data that is all being gathered, when the data that is published by NHS England is 10 weeks later? It is hard to see the effort going in from people who should actually be doing something useful in A&E.

**Pauline Philip:** What some providers are referring to there is not data per se to tell us nationally what the performance is but data that they were providing locally so that the local system could take the temperature of what was happening. They knew when they were reaching a crisis point and I think that that is what I was referring to earlier.

**Q48 Dr Whitford:** Is that an alternative to the actual software that you had? You obviously had your system that was real time from which you could see if you had had a lot of people in.

**Pauline Philip:** Yes. Looking at that system, ideally, as we move into this winter, we want to try to buddy up emergency departments so that they can share at emergency department level real-time information about what is happening and proactively stop hospitals going into a crisis. I think some of those calls that you are referring to and some of that data is just to feed up the fact that we are having a crisis locally, whereas what a provider wants is to have a solution, and very often that solution will be found locally either by buddying up with other hospitals or working within their local delivery board by the other stakeholders and partners being able to assist them. So it is not feeded up.

**Q49 Dr Whitford:** Can I ask why the members of the panel think that the performance has nosedived so much since spring 2013? Obviously it has the usual ups and downs, but it has been pretty much going down. Since we came away from weekly figures last summer, literally every month, until a recent rebound, it was down. Obviously the Health and Social Care Act came in. Is there any other reason that those of you who are dealing with this think why we lost performance—

**Philip Dunne:** Performance in the last few months has been broadly static rather than continuing to go down. Of course, there is the seasonality effect; so we would anticipate performance would dip as you get into the winter.

**Q50 Dr Whitford:** We muddled through with tough winters, but in actual fact we have drifted down from oscillating around the 95% to 80% to 85%. So those of you who are doing this for a job—

**Pauline Philip:** I would go back to some of my opening remarks there on the fact that the overall system is seeing more patients within four hours; our A&E departments are seeing more patients than they were five years ago within four hours. On top of that, 111 is having 14 million



contacts. How we are communicating this message is obviously difficult because we are just measuring that against the 95%. But the other issue, which we will be completely clear on, is that there are some issues within the system, and in particular the issue around delayed transfers of care, because that has gone up during the same period.

**Q51 Dr Whitford:** We will come on to that later. Working in the system, do you have a particular issue that you felt was contributing to such a change?

**Professor Willett:** Part of the urgent and emergency care review looked at all the evidence behind this. We reviewed it, and, even when we have had those bad winter hits in the past, the best minds in the system from Nuffield Trust and King's Fund have looked at this and there is not a single reason. There is a cumulative effect across all those different elements of the pathway, and it is this business of flow. If one part becomes saturated and becomes a block, then that very rapidly amplifies. Part of the whole of the urgent and emergency care review and why it is going to take several years for the impact of the changes really to be felt is that it will be the cumulative or the compounding effect of the improvements in every element of the pathway right across that will change the system. There is not a silver bullet. When you look at an organisation, even with things like delayed transfers of care, nationally, yes, there is a correlation between A&E performance and delayed transfers of care, but you go into individual trusts and you can find individual trusts that have no transfer of care problem but their A&E performance is poor; likewise, another one has a really big delay transfer of care problem and their A&E performance is good. There is this enormous variability, and it is very easy to try to simplify it and say, "This is what we should do," but the reality is that we have to do everything within the system.

**Q52 Chair:** There are marginal gains across the whole system.

**Professor Willett:** Absolutely.

**Q53 Maggie Throup:** We have been talking about getting everything in place for the winter. I want to find out how you intend to monitor whether A&E delivery boards and individual trusts are applying the guidance that you are issuing in preparation for winter.

**Philip Dunne:** This is going back to the metrics and having consistent metrics across the system. We are working with NHSI and NHSE to develop those metrics and to report those back through to the centre on a very regular basis—not a daily basis but a regular basis. We will be having ministerial-led engagement frequently to keep a track of this as we head into winter and through the winter.

**Pauline Philip:** From an improvement point of view, every week we have a national co-ordination meeting where we sit with our regional PMOs, our regional delivery groups, with the local delivery board, so that we can see on a national basis whether the A&E improvement plan is



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being implemented. Are those initiatives being used? Are all the other things we have talked about today happening? What is happening with performance? It is a very close contact between the centre and the frontline.

**Lyn Simpson:** I have one thing to add to that. At the regional level, we are having monthly deep dives into organisations with consent to understand where they are struggling across those five initiatives, to understand what their performance is and to make sure that we constantly get this wraparound of the improvement support in the right places. Those temperature checks are happening on a very regular basis. There is a governance model wrapped around that so that we can quickly identify if something is not happening that should happen and we are in regular contact with the local delivery board chairs. We meet with them; we have been very clear about what the expectations are; and then we support them in delivering it.

Q54 **Maggie Throup:** Are there any poor-performing trusts who have yet to implement improvements such as using the SAFER bundles to improve their patient flow?

**Pauline Philip:** I cannot absolutely answer that question because this week we are doing the baseline assessment. We are looking at every trust in the country through the local delivery boards to see if any trusts are not using the five mandated initiatives. That is one of them, but we can tell you next week.

Q55 **Maggie Throup:** It would be really good if you could.

**Lyn Simpson:** It builds on things. When you look at the baseline assessment, there is common good practice that every organisation should be adopting, whether it is a SAFER bundle, whether it is sepsis and so on. We could very easily sit and say that everyone is doing it, but we need to make sure that we have the checks and balances in the system to find out whether they are and whether they are applying that on a consistent basis. We have all the material. We just need to make sure that that has been applied and implemented by the organisations.

Q56 **Maggie Throup:** As a Committee, we often hear and see for ourselves some fantastic, really good practice, but what always worries us is why that is not pushed out across the whole of the NHS. I know, Pauline, you have talked about A&Es working in parallel, but it needs more than that. What is stopping good practice being passed on?

**Pauline Philip:** There has been an enormous effort in the last four or five years to do what you have said, but it is a significant challenge. For example, we have the work of ECIP, the intensive care team, who actually go out and work with individual organisations. Lyn referred to how we are focusing their efforts at a regional level with the trusts that can most benefit by their work. There have been several attempts to have buddying relationships as we talked about. I think there is a tremendous motivation in sharing best practice and this is probably one



of the areas in healthcare where we have considered this to the greatest extent.

**Lyn Simpson:** There is something about the psychology of improvement; people need to have an open mind and accept that. It is not something that you do when you have a bit of spare time at the end of the afternoon. It has to be built in, bottom-up and part of everyday work. You constantly question yourself. What can I do differently? What can I do better? What is my colleague doing in organisation X? How can I learn? We need to promulgate that whole psychology throughout the service. There is something about consistency, and when you start to see those improvements and you see patients getting a better deal, we need to ensure that we share that across the service instead of it just being in patches.

Then I think there is something that we need to do—and we have started this, haven't we, Pauline?—whereby we have some real champions. We have four chief execs working across the four regions who are going to help us roll this out. They do it every day. They are responsible for their own emergency departments. They can really encourage, share and motivate other departments who are perhaps not doing it to take on board this good practice and do it in a much better way.

**Philip Dunne:** I should just reassure you that there is a very significant focus on this issue from the most senior elements of the Department from the Secretary of State down, and we are working, as I said, routinely with NHSI and NHSE seeking to ensure that the good practice that has been developed to create the A&E improvement plan gets spread out right across the organisation. There is this balance between intrusive interrogation to check that people are doing it and actually spreading the message across. Nobody is going to be happy all the time, but that is what we are aiming to do and there is a dedicated team now being established within NHSI to promulgate good practice.

**Pauline Philip:** I think it is about getting the balance right. When an overall service is under a lot of pressure, you have to set up a systematic way of making sure that that good practice gets out there and through the A&E improvement plan. That is the core of it really.

Q57 **Maggie Throup:** My last question is about discharge to assess models, which we heard about last week. Will they all be in place in time to deal with the winter pressure? Also, we are hearing about what some trusts have done with domiciliary care organisations. Is that going to be spread out further as well?

**Pauline Philip:** Probably the biggest problem that we face as a service is the issue we have referred to now on a number of occasions—patients who are medically fit for discharge occupying acute beds. It is not good for the patient, it is certainly not good for the system, and we probably would not be sitting here today if we did not have that problem. It is a massive challenge to us as an organisation, but over the course of the



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summer we have been able to bring NHSE and NHSI together, with the support of the Department, to say, "How are we going to understand this issue?" and understand what we can do to change the picture as it exists. Clearly, it is not straightforward.

First of all, we need to start off by understanding the size of the problem out there. We have collected data for a number of years on delayed transfers of care. They do not tell the full picture that you are hearing from providers about patients who do not fall into that category but who are still medically fit and do not need to sit in an acute bed. Just this week we are getting the local delivery boards to get an understanding and a grip of how big the problem is within their patch. We are also asking them locally to tell us what they believe the solutions are. Is there capacity outside their hospitals for patients to go to an intermediate care bed or to receive support at home while they are being discharged for assessment? That work is happening as we speak and we have tremendous support across health to try to tackle it. Underpinning that, we will discover that there are some financial issues, and we are clearly concerned about the impact of social care, budgetary constraint and so on, and we need to understand a lot more about that. But it is at the top of our agenda at the moment.

**Philip Dunne:** It is an important focus of the STP work. By bringing local authorities in with the health and wellbeing board, the primary care community and the acute all working together, part of the objective is to get the patient flow right the way through operating more swiftly. There has been some success. I have a figure in front of me that, in the last year, 41 out of 140 trusts have improved their delayed transfers of care, and a further 27 are better than 3% national targets. So it is not all doom and gloom. Some trusts are really starting to make some inroads.

**Professor Willett:** Some of the context here is that health often does not understand social care in the community. As I have got closer and closer to this as a necessity in looking at the flow, more people are employed in adult social care than in the NHS. The NHS has 7,000 general practices, but there are 18,000 care homes and 8,000 domiciliary services, and the majority of those are family businesses. They are not large corporations. It is a very complex tapestry that we have to work into, and it is fundamentally important that health and social care come together through the STPs and that the local authorities are equal partners with the community and health to understand the issues, because it is not straightforward. This is immensely difficult.

**Chair:** It probably makes more sense to flow into delayed discharges now.

Q58 **Maggie Throup:** You mentioned that one of the issues would be funding. One trust mentioned that they felt to create a domiciliary support service was cheaper than keeping people in the hospital beds.



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**Pauline Philip:** Yes, indeed, and across acute providers a number of us have established these services; we usually call them hospital at home. They have been extremely beneficial in reducing the length of stay of patients in hospital but also in supporting people who then need to go on to further care elsewhere.

**Chair:** We will do funding next because we are already halfway through this piece about delayed discharges.

Q59 **Dr Whitford:** I assume, therefore, you would feel that the fact that acute trusts are funding domiciliary care is representative of the fact that the capacity is not there in the community.

**Pauline Philip:** It is slightly more complicated than that. For example, in my own organisation we have a hospital at home service. Some of that hospital at home service is very much focused on reducing the length of stay, say, for our surgical patients, being able to continue their care into their own home for X number of days and supporting some of the very real clinical needs where they need an acute nurse to be involved. But some of the hospital at home service is compensating for the fact that other forms of care are not available to maintain people in their own residence, whether it is their private home or residential care, and is moving them from the acute bed to allow an assessment to take place elsewhere, and then to have them in the type of supportive environment they need for the future. So it is both.

Q60 **Dr Whitford:** Minister, any time we discuss accident and emergency, we end up with flow and talking about discharge. Can you tell us what the Government are doing to increase the capacity of social care in the community?

**Philip Dunne:** Sure. As you know, last year we introduced the ability for local authorities to raise more funding through increasing the precept specifically to allocate to adult social care and child social care, and 95% of local authorities have taken up that opportunity. That is generating significant resource. It will generate some £2 billion by the end of this Parliament. In addition, the Treasury has allocated an additional £1.5 billion to adult social care again over the course of the Parliament. It will get to that level in the last year.

Q61 **Dr Whitford:** That is not going to come for quite some time. They are back-loaded.

**Philip Dunne:** It is coming in a gradual ramp-up. There is significant funding going into it. In addition, as I have said earlier, through the STP process we are encouraging local authorities to become more engaged in this problem alongside NHS providers and commissioners. We would anticipate that by developing these plans together—not in every area, but there are a number of STPs being chaired by local authority leaders that are very engaged—that will have some impact in sharing the problem.

Q62 **Dr Whitford:** Is not the reduction in funding to local government in



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general an underlying problem? I can totally understand how the STPs could have an impact by joining and integrating people up in the way our integration joint boards in Scotland have been successful, but if they start life with less money, then they are all going to be about shutting and closing and getting rid of, rather than finding better ways of working. Do we, still, just not have enough money in social care?

**Philip Dunne:** I started by saying that we are increasing the money available to the local authorities for this specific activity. They have a statutory duty to provide adult social care. It is one of the services that will be protected as a result of their statutory obligations. We think we are providing the funding that they need.

Q63 **Dr Whitford:** Simon Stevens does not think so. When he was last here, he said that, if there was any money going, even he would suggest it went to social care and not to NHS England. I think people in the business seem to recognise that for the want of a horseshoe nail is social care. The National Audit Office estimated the cost of not being able to get people out of hospital as £820 million.

**Philip Dunne:** As we have been saying earlier today, we recognise it is important to try to speed up the flow out of hospital for the patients, because it is in their best interests to keep them healthy but also to ensure that we can cope with the increasing demands in the system. That is why we are trying to encourage greater working together and closer integration. Some of that will involve taking cost out of the system. If there is less cost being spent within acute beds, the patient flow will allow them to release those beds for other people. An element of the NHS efficiency gain will come out of a more rapid flow of patients, including inter-domiciliary deployment.

Q64 **Dr Whitford:** Do you not need a little bit of investment to be able to move the first piece of the Rubik's Cube? If it is costing £820 million to keep these people in hospital, would it not be worth—even in this coming winter—thinking of commissioning beds that might allow step-up or step-down, rather than patients either coming into or getting stuck in acute hospitals?

**Philip Dunne:** We have touched on looking at intermediate care as part of the STP programme; so it is an integral part of that assessment. As I have already said, we are looking at £3.5 billion going into this sector over the coming years, and some of that started this year.

Q65 **Dr Whitford:** Is that not over the coming four years, with most of it coming in 2020?

**Philip Dunne:** There are hundreds of millions going into the care sector this year.

Q66 **Dr Whitford:** But not to the point of dealing with the problem. The last time the Secretary of State was here he described a 32% increase in delayed discharges. Now that can change. In Scotland, since the



integration joint boards, our delayed discharges have dropped by 9% in getting both sides working together, but you still have to put the money in to allow things to move around, and that money is not there at the moment.

**Philip Dunne:** Forgive me if I get the figures wrong—and I will correct it if the figure I give you is wrong because I am fairly new to this—but my understanding is that £382 million has been raised through the precept this year. I do not have the figure in my head for the Government contribution, but we are talking about hundreds of millions of pounds going into adult social care this year.

Q67 **Chair:** Is it not the case that that is just going to meet the increase in their costs due to the living wage, as I understand it? This does not actually cover an increase in capacity. That was the evidence that we heard.

**Emma Reynolds:** The Local Government Association is saying that most of the money that is raised through the precept will go into additional costs such as the living wage. I agree with the living wage; I am not objecting to it, by the way. But, also, this is against the background of six years of cutting social care budgets by over 33%. If it was the precept in normal times it is a welcome addition, but it is not going to fill the gap that has already been opened up by that cut in social care and the increases in costs that local authorities are seeing.

**Dr Whitford:** Surely we need something transformative. Every discussion ends up at flow, delayed transfers and discharges. Is that not a more cost-effective place to put some of our investment, but sooner rather than later? 2020 is a few winters away—and a few really horrific winters away, I would suggest.

**Philip Dunne:** All I can say to you is what I have already said. We are looking at the STP as an opportunity to provide some solutions to this problem. We are putting more money into the social care system through the precept and from central Government.

Q68 **Dr Whitford:** But not additional to what has been announced previously, though. This is not new money going in, in recognition that we need change.

**Philip Dunne:** We went through the spending review process last year following the election. From an NHS point of view, we have what the NHS asked for. We have £10 billion of money going into the NHS; some of that has already happened. It is front-end loaded, as you know. I am not responsible for the budget going into DCLG that gets allocated.

Q69 **Dr Whitford:** Is not part of the problem—not even getting into local government but within the Department of Health—how budgets are normally reported? We have cuts to Public Health England and Health Education England, and, therefore, the Department increase is only £4.5 billion. On top of that, we have significant cuts that have been going year on year to local government. It might look okay in the NHS column, but



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in the system—and we have talked all afternoon about systems—the whole system is not doing too well and social care has a huge impact on the system.

**Philip Dunne:** The system as a whole has the money that it asked for. In addition to that, we have a significant efficiency challenge to meet; I accept that. But we have the report from Lord Carter, which identified some £5 billion-worth of savings over the period. We had this morning the former Chair of the Public Accounts Committee referring to the fact that even in healthcare in the NHS there are absurdities—which I think was the word she used—in the way that we go about procuring things, for example. There are significant efficiencies we think we can achieve.

**Q70 Dr Whitford:** We recognise those and have taken evidence on them, but, in the Five Year Forward View, the precept of trying to meet the £20 billion- plus savings was on a significant gear-changing approach to public health and dealing with the social care issue. Actually, public health and social care has been cut relentlessly year on year. So, in actual fact, the whole basis of the Five Year Forward View is not there, which means the chances of us saving £22 billion must be pretty thin.

**Philip Dunne:** I will look at the impact of the current social care funding package that we have been talking about and write to the Committee.

**Chair:** That would be much appreciated. It is not just the findings of the Committee from our review of the impact of the spending review, but many of the other major think-thanks. Everything comes back to the fact that social care seems to be a major block in the system. It would be much appreciated, Minister, if you could have a look at that again. We are going to come on to Emma Reynolds.

**Q71 Emma Reynolds:** The last topic is on winter funding and tariffs. Starting with winter funding, could you tell us some more about the impact of rolling winter pressures funding into CCG baselines? We heard in evidence concerns that this funding is not going into emergency care because it is not ring-fenced. What reassurance can you give us that winter funding is being used for that purpose, and what lessons can we learn from the last financial year when it was rolled into the baselines?

**Philip Dunne:** I will start, if I may, but Lyn is the expert here. There was a request coming out of the CCGs in particular that the winter funding element should be put into the baseline rather than developed during the course of the year so that they knew what they would be dealing with. We acknowledged that by providing the winter funding into the baseline for the current year, and that is what we have done. I think Lyn probably can take us through how they then deploy that funding and whether they set some aside for the winter months or whether they use it for other purposes.

**Lyn Simpson:** You are quite right. We used to have nationally prescribed winter pressure funding, which came every year to the service. The providers in a sense relied on that, expected it and managed their service



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in terms of the ramp-up for winter on that basis. Some of those initiatives, though, were fairly prescriptive and did not always meet the local need in how that funding would be spent. Taking it down to a local level and putting in baselines should have meant that people could have an adult dialogue about how that money should be best spent.

We have seen a bit of a mixed bag across the country. Some organisations have come together with the commissioners, the providers, and said, "What do we need to put in now to prepare us for winter rather than doing it September/October time?" I am sure you remember that, even though we brought it forward last year in terms of the allocation of that funding, in previous years it has been very late and often too late to get the staff to put the initiatives in place.

Where it has worked well, there has been a really good adult conversation about what we need to do. Where perhaps it is a bit patchy is that sometimes that conversation has not taken place; perhaps the provider has thought that, regardless of what has been said about it going into baselines, it will still appear late in the day to do some of the things that they have tried and tested.

Looking at it objectively, putting it into the baseline, having that discussion at a local level through the local delivery boards, ensuring that we are doing the improvements in terms of the provider organisations and making the efficiencies, and putting in place the embedding of the good practice, that is the way to ensure that you can cope with the winter. If you leave it and try to do it at the last minute, as we have done it previously, it is not a good solution for dealing with potential increases in patient attendances.

**Q72 Emma Reynolds:** Are you confident that in the areas where it has not worked so well we can improve it this year?

**Lyn Simpson:** I am absolutely confident on that. It goes back to what Pauline, Keith and the Minister were saying. It is not a change in name just to go from the SRG to the local delivery board. It is a complete change in emphasis—a requirement for people to work together on some of these knotty issues, to streamline and ensure that they are doing the best for that particular local service rather than a top-down initiative.

**Q73 Emma Reynolds:** Thank you. On tariffs, we heard in evidence, and indeed during the visit to Luton & Dunstable, that there are ongoing concerns about tariffs. Particularly the so-called easier cases—or elective surgery—are profitable, and there is a lot of cross-subsidisation with the emergency care. With the more complex, very unwell patients, it is very difficult to make those costs stack up. What is the logic of such a lopsided tariff and is it sustainable?

**Professor Willett:** The broader context is that we have a payment issue across the whole of emergency care. We have GPs on a capitation-based payment; we have ambulance services and 111 services on a national



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currency local pricing; we have emergency departments on a tariff without a marginal; we have emergency admissions on a tariff with a marginal; and both community and social care are block contracts. So let's all come together in a huddle and say that it is almost impossible in those circumstances for people to come together. They might all pool their budgets, but when they come to do their allocations, they are stuck with the fact that the hospital does not want to give up activity and the community cannot take it on. So we have a wider problem with this, which we are addressing.

As to the specific tariffs around emergency departments and emergency admissions, the tariffs are derived from the reference across to the returns from every hospital to say what they think each category of patient costs. That is how they are derived and not in a dark room. The reason there is a marginal—there is a limit, if you like, of 70% on emergency admissions—is that, when we have looked at this, we know that within the spend of any single department part of that is essentially fixed in-year, because you cannot change the estate or the fact you need HR support; you cannot turn the lights off and you have probably fixed most of your staffing costs. In an ambulance service 90% is essentially fixed in-year. By the time you have all your paramedics, all your ambulances and you have set up your dispatch, even if the phone never rang, they would almost spend 90% of their budget. When you get to an urgent care centre, it is about 55% fixed in-year. We know that, for an acute area such as emergency departments, medical assessment units and acute medical wards, it is somewhere around 70% to 80%. The marginal would be appropriately around 30%, but we recognise that, because of the pressures in the system, for emergency admissions that was raised.

That is a reflection of how we end up where the money is, but in reality—and Pauline may come to this—within a hospital it is not that every pound you get in labelled geriatrics goes to a geriatric service. There will be separate budgets within the hospital, and a lot of what goes on in emergency departments is not part of the emergency department. It will be the general physicians, the geriatricians and the paediatricians coming in. It is a very complex area.

Yes, there is an attempt at allocating the right tariffs, which is done very rigorously each year and built from within the system, but then there is the application of that in trusts, and that is where we are. Now, the intention is to move forward on that. Between Monitor, before it became part of NHSI, and NHS England, we have proposed a single payment method for the whole of the sector, which recognises the fact that an element is fixed, and we should not be arguing about that because that means that stops people being flexible. There is something that should reflect activity, and then there is something that should reflect an incentive component to drive the flows in the way we want, for instance, out of hospital into the community. But, also, at the moment, with the vanguards across the country—particularly the MCP, PACS and urgent



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and emergency care vanguards—they are all looking at different payment models because they are sat together in the equivalent of the STPs saying, “How do we best divvy up the money we have in a way that is most effective?” They are looking at things like population-based funding; perhaps it is a different way of doing it.

I think we will see over the next few years a very different funding model coming through, and, to be honest, the tariff argument, in my view, is a bit of a distraction at the moment because I do not think it actually plays out for an individual patient, which is what matters. For the care for an individual patient, that is almost an irrelevance.

**Q74 Emma Reynolds:** Is there not a worry in the current system that you are providing a strange incentive for the hospitals to do more elective surgery in order to get the tariffs in for those and then cross-subsidise the emergency department?

**Professor Willett:** That is the assumption that elective is somehow the reference across, that electives are wrong and they are profiting. It is an assumption that, if that is the case, it will have come from the system. Tariffs are looked at every year and are reviewed, based on what hospitals say it costs them to deliver that care. The model is there that that should not be the case, but, as I say within a hospital, Pauline, how it is distributed is—

**Pauline Philip:** You heard when you came on the visit to Luton & Dunstable that all the work that Keith has talked about around the tariff and new models of payment is moving, but maybe it is not moving quite as quickly as some of the service changes that we are making. I think that is the message you were given last week. Because of some of the service changes we have been able to make there, the payment model is not keeping up with it, but we have recognised that and that is the work that is being done nationally and through our vanguards.

**Q75 Emma Reynolds:** The message seems to be that the system is set up not to recognise actual activity but desired activity, and what we are trying to do is move people away from coming to emergency departments—but they are coming. So should we not recognise that that is the reality and design the system around that rather than what we would like it to be?

**Pauline Philip:** I would go back to saying that the fundamental problem, as I know in my own hospital, is the fact that we are making service changes and we are working to a tariff that is out of date now. Clearly, there is the other side of the coin. You could say, “Do you bring in models of payment that incentivise behaviours?” But I think that is not what people were talking about; they were talking about the fact that there is a lag time and they were explaining what it meant for the organisation.

**Q76 Chair:** Could you just clarify when the new tariffs will come into effect?



**Professor Willett:** They are being piloted in the vanguards. Obviously they have to be proven on the ground. We will see some of the population-based funding models come through quite quickly. There is an ability already for vanguards to do that—to look at those models. They will be looking at them; they may well be shadowing them currently. The first exercise that you would do is to shadow. You would pretend that you are doing it just to see how the money might move in a system, how you will go about allocating and assessing. What are the incentives that should be in the system and how do you encourage the flows you are looking for? That is why I say I think we will end up looking at it, but there is no hard date for a new model to come in at this point.

Q77 **Chair:** Do any members of the Committee have any further points they would like to make? Could I raise one last point? Could you comment on the impact of alcohol on accident and emergency departments, particularly over festive periods and so on? How much is this just throwing a spanner in the works of what you are trying to achieve?

**Professor Willett:** As a clinician, the chronic use of alcohol and the drunk person creates a very difficult demand on emergency services. There has been some very good work done in Wales looking at how you can manage this better in the community. There is an agreement to change the way we collect data in the emergency care dataset to include alcohol so that we have a much better handle on what it means. There are patient groups where alcohol is the primary problem—primarily they are drunk or they have an alcoholic disease problem—and there are those patients, which is a much larger proportion, where alcohol is part of the contributing element to their long-term illnesses, which obviously present as an acute component of that.

It has a significant impact on the services. We have to see this very much as a disease. We have to look at the public health issues behind it. The vast majority of hospitals now have alcohol teams in them to pick up these patients and approach them to try to prevent recurrence. Obviously the alcohol and drug misuse services, as part of the Health and Social Care Act, moved to becoming a local authority responsibility, but within the public health grant that goes to them there is a ring-fenced commitment for them to provide those services. Obviously it will depend on local authorities as to what they see as the perceived need to best address alcohol and drug-related issues within their community, and that may be very different from rural to urban areas.

Q78 **Chair:** It would be helpful if you could send us a note on the impact, because certainly the Institute of Alcohol Studies' report last week was not just about the costs of it; it was the impact on staff morale as well.

**Professor Willett:** Absolutely, and we accept that is a very difficult group of patients to manage very often.

**Chair:** Thank you. Thank you very much for coming this afternoon.