

Public Accounts Committee

Oral evidence: Avoiding unnecessary emergency admissions, HC 795

Monday 26 March 2018

Ordered by the House of Commons to be published on 26 March 2018.

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Members present: Meg Hillier (Chair); Bim Afolami; Gillian Keegan; Shabana Mahmood; Stephen Morgan; Anne Marie Morris; Lee Rowley.

Sir Amyas Morse, Comptroller and Auditor General; Adrian Jenner, Director of Parliamentary Relations, National Audit Office; Ashley McDougall, Director, NAO; and Richard Brown, Treasury Officer of Accounts, HM Treasury, were in attendance.

Questions 1-83

Witnesses

I: Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; Simon Stevens, Chief Executive, NHS England; Professor Keith Willett, Director, Acute Care, NHS England; and Ian Dalton, Chief Executive, NHS Improvement.

Examination of witnesses

Witnesses: Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; Simon Stevens, Chief Executive, NHS England; Professor Keith Willett, Director, Acute Care, NHS England; and Ian Dalton, Chief Executive, NHS Improvement.

Chair: Good afternoon and welcome to second part of the Public Accounts Committee sitting on 26 March 2018. In this session, we are looking at the NAO Report on reducing emergency admissions, which we all know is a very significant issue for the NHS. We have discussed this a number of times in this Committee. There are around 6 million emergency admissions a year, costing over £13 billion. Getting that under control is pretty critical to the functioning of our hospitals and other parts of the health service.

In some ways, emergency admissions can be seen as a bit of a failure in some circumstances, where people perhaps should not be in, so one of the issues to look at is what is happening in the community to prevent them, which is part of what this Report looks at. One of the interesting aspects is regional variation—where there is best practice and where that is being learned from.

I will introduce our witnesses and then, Sir Chris, I want to ask you a couple of questions about general issues, which you might not be surprised to hear. We have Ian Dalton—welcome back—the chief executive of NHS Improvement; Sir Chris Wormald, the Permanent Secretary at the Department of Health and Social Care; Simon Stevens, the chief executive of NHS England, who never seems to leave this room; and Professor Keith Willett, the director of acute care for NHS England. So this is very much your territory, Professor Willett.

Sir Chris, we heard some comments by your Secretary of State over the weekend about NHS funding. Will we have an announcement from the Prime Minister this week that the NHS will get an extra £4 billion a year?

Sir Chris Wormald: Announcements from the Prime Minister are a matter for the Prime Minister.

Q1 **Chair:** Were you surprised by the Secretary of State's comments in the media, or is that something you have been discussing with him?

Sir Chris Wormald: His comments in the media are largely things that he has said before. There is obviously a debate going on about NHS funding, and announcements will be made when those debates have been concluded. I only ever expect announcements to be made in the usual way, at Budgets and spending reviews.

Q2 **Chair:** We know there has been a huge debate about the scale of the need in the NHS budget, and you and your finance director have been



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clever at balancing the books at the central level—at great cost, as our Reports over the years have indicated—but we will be interested in watching what happens as a result of what the Secretary of State has said. You won't have heard Simon Stevens' comments earlier, which, I should tell you, were a measure of diplomatic limit, certainly from Mr Stevens, who is not used to limiting himself in these areas about what he needs, but I am sure you are having those discussions elsewhere and we will be having the Prime Minister in front of the Liaison Committee tomorrow, so who knows? It may come up there as well.

I wanted to ask about the pay rise. Obviously, we welcome that the lowest paid in the NHS are getting a much needed pay rise, after the pay cap has been in place for a number of years. The commitment is for three years funding from the Treasury. Can you tell us today whether that commitment will be continued after that and will be part of the base funding of our hospitals and other NHS institutions, to ensure that those staff continue to get paid at that level?

Sir Chris Wormald: It is certainly part of our baseline, the—

Q3 **Chair:** Sorry, it is part or it will be part of the baseline? It is not at the moment.

Sir Chris Wormald: Clearly, the future funding of the NHS is a matter for future spending reviews. None of our money is confirmed past the end of the current spending review. Clearly, the levels of pay and all those issues will be taken into account in future spending reviews.

Q4 **Chair:** Okay. The worry for us as a Committee, having seen the clever magic that you play in the Department of Health and Social Care about how you managed to get the budget to balance, is that you can give money this year, next year and the year after, and then some other part of the budget will be squeezed. For example, our hospital trusts will have to continue to fund pay at that level, which would obviously be quite right and proper, because it has been committed to, but that squeezes other parts of the system. One of the reasons to do all this was to reduce sickness levels and stress in the NHS—there is a real worry about that—so can you give us some commitment today that that will not happen and that this core funding for staff pay will be in those NHS budgets?

Sir Chris Wormald: Obviously, I cannot give you guarantees about what the level in the next spending review will be. The way these things work is that the current pressures on the NHS are taken into account when we set spending review settlements across Government. Then those pressures need to be met from whatever the total is. So we will certainly be taking into account the long-term cost of the pay settlement in how we do spending reviews, just as we do for every pay settlement anywhere in the public sector.

Q5 **Chair:** It was noted that the figure being mooted by the Secretary of State is a potential £4 billion extra funding per year. We will see if that ever materialises, but the deal for pay—



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Sir Chris Wormald: Just to be clear, it was *The Sunday Times* that gave the figure of £4 billion. I don't think the Secretary of State did so.

- Q6 **Chair:** Okay. I had understood that he said it on "Peston", but perhaps, as I am not tuned in on a Sunday morning, I read the reports and believed them. But the deal for pay will cost £4.2 billion, so you can see why we are concerned. The deal for pay will cost that potential figure, and you are saying that figure is not accurate. What is the figure, then, that the Secretary of State has been discussing with you?

Sir Chris Wormald: Obviously, I am not going to discuss that—

Chair: It was worth a try.

Sir Chris Wormald: Of course, in the wider context, a huge proportion of the whole NHS budget is taken up by pay.

Chair: Absolutely. That is why we are concerned about this.

Sir Chris Wormald: That is always, therefore, the biggest conversation in any spending review—how we would ensure that—

- Q7 **Chair:** We have already seen as well the increase in ambulance staff pay, which was, again, necessary to ensure that staff stayed in post and there was the ability to recruit; that came out of the core budget of ambulance trusts. We have the dentists and doctors pay review body looking at pay coming up. Given that differentials matter, will the Government commit to funding future pay increases for doctors and dentists?

Sir Chris Wormald: Ambulance and paramedic staff are part of the "Agenda for Change" group, so they are covered by the announcements we made earlier this week.

- Q8 **Chair:** I was talking about the pay uplift that they had. We won't go into detail, but the previous pay uplift they had was—

Sir Chris Wormald: There was quite a small pay uplift—

Chair: Still quite significant for those trusts.

Sir Chris Wormald: —which was to do with regrading and which did have to be absorbed, one way or another. But they are covered by "Agenda for Change", so—

- Q9 **Chair:** My point is that it's easy for the Department of Health and Social Care to say, "Pay everyone more," but if that is not funded all the way through, as it wasn't with ambulance trusts, it just causes a squeeze elsewhere in the system.

Sir Chris Wormald: That was part of a previous deal that was playing out, and that is exactly why the Chancellor did what he did at the last Budget and committed extra resources, over and above the NHS budget, to fund this pay rise, which went above the Government's previous pay policy. That is exactly why that money was additional.



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Your general point is true, of course. We always—it was one of the reasons for the pay policy in the first place—have a trade-off between what goes into pay for very hard-working staff and what is available for new services, and that is one of the things that we continuously debate. As I say, in this case we dealt with that situation through new money on top of the existing NHS budget, so there would be no effect on other services from the pay rise that we did for the “Agenda for Change” staff. The Chancellor was very specific in his announcement: this arrangement was for the “Agenda for Change” negotiations, not for any other groups; they were to be dealt with in the usual way.

- Q10 Chair:** I am in correspondence with you about the issue of separate service companies being set up by trusts to avoid VAT; that has an effect on pay. Because of the time, I am not going to go into that today, but we are very closely watching pay, because we recognise that one impact of the pay cap is this latent pressure for pay to go up at the same time as there are real challenges for the NHS budget. While I don’t ever begrudge a nurse, healthcare assistant or whoever getting a pay rise after some years of pay restraint, I am concerned that if it is taken from other parts of the budget—I say “I”; the Committee is concerned—this could just cause pressure elsewhere, which would be rather counterproductive.

Sir Chris Wormald: As I say, that was the reason why the Government took the approach it did on this pay rise—to avoid—

Chair: Well, we’ll be watching.

Sir Chris Wormald: One point I do need to correct, and I think was in Ian Dalton’s letter to you, is that you cannot set up a subsidiary company with the primary purpose of avoiding VAT. I think Ian’s letter was very clear on that.

- Q11 Chair:** One of the reasons why we are not going to get into that today is that there is quite a lot of detail that we want to explore with you further on that; we will be raising it at a future session. We have a lot of colleagues around the country who are very concerned about the impact on pay and conditions, and the long-term implications, but I have just written a letter back to you, Mr Dalton, so rather than replaying that here, we will look for a detailed, full response to that letter. So there you are—notice to get back to me quickly, as I am sure you will. We left it unresolved whether doctors and dentists will get a similar deal, but I think you can see my point that there is now going to be pressure on pay across the board, so we are watching very closely what happens in terms of the budget overall.

We will move on to managing emergency admissions to hospitals. As I have said, emergency admissions are a very expensive way of admitting someone to hospital. Sir Chris and Simon Stevens, how have you managed to reduce the impact of rising emergency admissions on hospitals?

Simon Stevens: I think four facts are central to the Committee’s assessment in this area. The first is that over the last five years, as a



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result of looking after people better through their GPs and at home and with community services, your chance of being admitted to hospital as an emergency has gone down by 12%. That is in the NAO Report, citing a piece of peer-reviewed research.

Secondly, the quality of in-patient emergency care has gone up over that period. The evidence for that comes from a range of data sources. We know that if you have major trauma—if you are knocked off your motorbike by a bus—you are taken to a major trauma centre now, which you would not have been five years ago, and your chances of survival have gone up by between 25% and 30%. We know that over the last 17 years, your chances of dying in hospital as a medical emergency have come down from 6% to 3.5%—a faster improvement here than in Scotland—and we know that patients themselves say that their experience of emergency care has improved over the last five years. So we are doing a better job at keeping people out of hospital, and the quality of care has improved.

Thirdly, those who do need hospital emergency admission are being treated in new ways. In particular, they are being looked after as day case emergencies, rather than having to stay overnight.

Fourthly, as a result of those three facts, the NAO is right to conclude that, "The NHS has become more cost-effective in managing emergency admissions".

Chair: It is always nice to pick out the bits that agree with you. Sir Chris?

Sir Chris Wormald: I have nothing to add to that.

Q12 **Chair:** We are quite interested in day case emergencies. We know that with any target there is often a danger that the system will game it. I can see that Ian Dalton will want to come in on this too. How do you know that gaming is not going on? One of the issues is that the tariff can be higher, depending on how it works, for that kind of admission. Professor Willett, do you want to kick off?

Professor Keith Willett: First of all, it is not that day case emergency admissions are some way of reducing cost and chucking patients out quickly. You need to see this in the context of what the day case emergency is. It is one of the steps in trying to manage patients closer to home and in a way that is better for them. To some extent, the bit around emergency day case admissions in hospitals is the last port of call of doing that. The urgent and emergency care review has all been about interventions that support patients to treat them in their home, or as close to home as possible.

Many of the admissions that we call avoidable admissions are not avoidable; they are necessary at the time, because the NHS has not been able to respond further up the pathway of care to give the patients the care they needed. Avoidable admissions are those patients for whom their alternative location, route for treatment or investigation, or very often just prime personal care, was not available.



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What happens is that, because we cannot respond to them, have not put in the prevention around them in the community and have not got a rapid response within community services, those patients migrate to hospital. Once they get to hospital, we do have an opportunity: the emergency day case procedure described by the NAO, which we call ambulatory care. That takes patients who we can, essentially, in a single-stop shop investigate, treat, provide with what they need and get right back home to be cared for in the community, which is the thing that we perhaps failed to do in the past.

- Q13 Chair:** That is the theory. I am sure that is exactly what you intend, Professor Willett, but the NAO has said—I refer you to the summary paragraph 13, which is expanded in paragraph 2.12 on page 26—that there is a difference in how hospitals record patients. An out-patient in some hospitals is a day case emergency care case in others. Those figures can be gamed to ensure the higher tariff. If they are out-patients, a hospital gets paid less than if they are emergency day cases. How are you making sure that—

Professor Keith Willett: We need to understand what the NAO calls emergency day case and what we call ambulatory care. Ambulatory care is not a single entity. Ambulatory care is a series of responses at the front door of the hospital that allow you to achieve what I have described. That can be immediate access to a hot clinic. There is a cardiologist down the corridor running a heart disease clinic; you have a patient with heart problem in front of you; they go straight into that clinic. It can be an ambulatory care facility within the emergency floor, so for patients you think are in that category because they have deep-vein thrombosis or respiratory problems, or have had an epileptic fit, you can move them directly there and wrap around them what you need to get them home. It may be an ambulatory care team that is moving round the acute emergency admission areas in the hospital, or it may be the frailty team. Those are all ambulatory care responses. There is legitimately a variety of ways. Because the dataset has not historically described ambulatory care, they have not been able to record those things. That is a legitimate and difficult process.

- Q14 Chair:** What are you doing to make sure they are recording it? There is quite a difference between someone being seen in a clinic, even as an emergency, and somebody who is admitted.

Simon Stevens: Yes. We think that is a fair comment from the NAO. As Keith said, clinical practice has evolved faster than the standardised classificatory mechanisms. Over the course of the next year, we will be working to harmonise them so that for the year after that we will have a consistent view of what that looks like around the country. We recognise that the changes have arisen in different places at different times, partly because that is the way clinical practice has evolved.

- Q15 Chair:** The challenge for a clinician or somebody sitting there thinking, “How do I clerk in this patient?” is, are they an emergency day case? If it goes straight through to an outpatient clinic that happens to be meeting



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on the same day, are they an emergency? How are you going to make it easy for the people on the frontline? It's great for us to sit here and say, "Yes, do that," because we agree that we want data—

Simon Stevens: We don't want anything we do in our standardised classification to change the optimal clinical pathways. We just want to make sure we are accurately capturing what the actual practices are.

- Q16 **Chair:** My point is that you can define it and explain how you might define it, but people on the ground are scratching their head saying, "Hmm. Some bureaucrat in NHS England has said I need to tick this box or that box." Professor Willett, what is it like for you?

Professor Keith Willett: Clinicians treat the patients in the best way possible. Most clinicians won't have any context about how the tariff is being paid, what pathway it is called in some bureaucratic process and how it is administrated. That is not what the clinician is doing. We have approved an information standard, which was made mandatory in April 2017. In October last year, we introduced across all type 1 and type 2 A&E departments a new emergency care dataset. It is a completely new dataset. It completely replaces what we had before, which was very poorly recorded because it was outdated. It gives us much better information about diagnosis, the source of the patient and what treatment they had—all the elements we want. Within that are the features of ambulatory care, which we are now piloting in six areas around the country to make sure we have got that right. Then we will have a better way, from a funding and an activity analysis point of view, of recording what is ambulatory care. That is all in train as part of the emergency care review.

- Q17 **Chair:** Obviously, the NAO also highlights that the percentage of readmissions is increasing, which relates to the number of people admitted for an emergency and then readmitted after an initial in-patient stay. Clearly, it is better for people to be out of hospital than in, if possible, so you can kind of understand that there might be a trajectory to get people home. Have you done an analysis to see whether people are being sent home too soon because of pressures in hospitals, or are those good clinical decisions that sometimes, because it is a matter of judgment, just do not play out the way they are expected to?

Professor Keith Willett: First of all—to help the Committee here—readmissions are not a bad thing. We must dispel that.

- Q18 **Chair:** For certain things, such as sickle cell, a readmission would be—

Professor Keith Willett: Clearly, there are occasions when patients have been precipitously discharged, the discharge planning has not been adequate, or they have landed in the community and social care, the community or primary care has not picked them in the way that was anticipated. Clearly, we need to identify and address those things, and there is clear guidance around that. This Committee once before was critical of the NHS because we had not progressed an evidence-based pathway—discharge to assess. Discharge to assess absolutely increases your readmission rate. In my unit—I am an orthopaedic surgeon—we

looked at how many days post-admission you were able to confidently predict patients would be safe to go in the pathway you thought was right. For a lot of patients, it takes more than seven days.

We also know that keeping patients in hospital for an unnecessarily long time is absolutely harmful. They are more at risk of delirium, because they have changed their institution, they are more at risk of infection, and they are more at risk of falls. There are a lot of issues relating to that. A week in a hospital bed over the age of 75 is equivalent to 10 years of muscle weakness.

Q19 Chair: We highlighted that in previous Reports, because we were very struck by it.

Professor Keith Willett: It is absolutely important. That means we want to get patients home at the earliest opportunity before those effects happen. That means that if we send 10 patients home and get the perceived advantage for most of them, but for one of them we get it wrong—again, elderly patients with comorbidities in particular do not do what most fit members of this Committee would do. If you have an illness or injury, you will come into hospital, you will have a set of investigations, a diagnosis will be reached, we will start your treatment, we will see your improvement and then you will have pretty much a predicted recovery. It is easy to work out what you need. Elderly patients with complex problems and comorbidities, particularly when they are frail, do not do that. They come in, we do the investigations and we treat what we think is the problem, but then they have a very stuttering recovery. Many of those patients will not do what you want, which is why I said it takes so long to do that. If you hold on to all of them, you have created a problem.

Let's get patients home—we know it is better for them; it means they do not go in at 75 and come out a week later aged 85, which is the alternative—but accept that in a dynamic system like that, readmission is healthy and we should be seeing it. I absolutely agree with you that we need to guard against precipitous, unplanned or unsupported discharges.

Q20 Chair: When you are looking at this data and setting up datasets, are you making sure that there is a proper way of recording that? It is fair enough that clinical judgments will vary. There will be challenges, as you highlight—

Professor Keith Willett: And that is about data linkage—

Q21 Chair: But it is also about watching one hospital doing it particularly well and other doing it badly. If you do not have the datasets, you cannot judge them.

Professor Keith Willett: That is absolutely right. The new dataset has the source of admission—where the patient was before—and the diagnostic issues. The first lot of reporting officially does not start until next month, but we have done some data accuracy checks and even in the early months of the emergency care data set, we had over 80% accuracy of diagnosis when cross-referenced independently. We know we are going



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to be in a very much better place to do the sorts of things you say and clearly demonstrate to the system and to individual trusts where they are at variance from what would be perceived to be good care.

- Q22 **Chair:** So people will see a difference and we will see more—standardisation is perhaps not the right word. Well, it is standardisation, I think. We have seen Ian Dalton—

Professor Keith Willett: A consequence of that is that, for patients who come in with simple problems or problems that we can address very quickly, we can get them home, for the benefit of the patient and the NHS. That leaves us with patients who absolutely need to be in a hospital and have a lot of complex needs. Hospitals will therefore change to having rapid sequence responses at the front door and—there will be a dichotomy—having another group of patients that have a lot of very different problems around care dependency and increasing frailty.

- Q23 **Chair:** How can you be sure you are going to have enough beds for emergency care? How are you planning that into the—

Professor Keith Willett: If you look at bed numbers over time, they reduced year on year over the 20 years through to 2014. Average length of stay has stalled since 2014 at about five days. Most of the reduction in the previous 20 years occurred around elective treatment and moving to day case surgery and day case interventions, but there was a general year-on-year reduction over that 20 years for emergency care as well. We have now seen that continued reduction stall, but these are the ways hospitals are adapting to address that. There are things we are doing this year, learning from past years, around capacity planning across the seasons. We do not do that very well in the NHS. We try to do everything all year round, and we have to get better at that.

- Q24 **Chair:** That brings me to the point about the elective surgery pause, or whatever you call it—cancellations—in January. Does anyone know how many procedures were cancelled?

Simon Stevens: The figures were published as part of the official statistics last month. There were 3% fewer elective operations this January than the January before, which I think represented 22,800 cases.

- Q25 **Chair:** Has anyone done any tracking to see whether any of those elective cases that did not get treated became emergency admissions? We talk about robbing Peter to pay Paul, but you could have that unintended consequence.

Simon Stevens: It is worth underlining a point that Keith made: the most recent data—actually a piece of research that was published subsequent to the NAO Report—shows that readmissions have been going down in England since 2012-13 as a percentage. The paper published in the *BMJ* makes the important point that if, for example, survival rates for certain conditions, such as fractured neck of femur, go up, as they have been, you are likely to see a higher readmission rate, because patients are still alive and at risk, and are subsequently readmitted. The conclusion of the paper



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is: "In fact, increases in readmission rates may reflect positively on the care provided to patients in the NHS."

- Q26 **Chair:** I don't doubt that, but we want to know when it is and when it isn't. From the centre, you need to see when poor-quality judgments have perhaps been made in the first instance on somebody going home too soon and sometimes where it was clinically necessary. You are telling us that you are on that.

Professor Keith Willett: That is what the emergency care data set is all about: understanding a lot more accurately. The old system was really very poor and out of date.

- Q27 **Chair:** I mentioned January because you were talking about the lack of planning over the year and that late funding. We have criticised late funding for, for instance, the winter crisis and so on and those pots of money coming in late in the day. I would say that having to cancel elective surgeries to get the beds you need for emergency admissions is a sign of a failure in how the system is planned.

Ian Dalton: There are a couple of things. First, as somebody who has worked for a long time in hospitals, it is clear that nobody—the patient, the surgeon, the hospital board, the chief executive—wants to postpone an elective operation. A decision is made on clinical grounds, which is obviously the right way to do it. The emergency patient necessarily takes precedent. The elective surgery, which is less clinically urgent but is still very important for the patient, then gets delayed. In some ways, that is the prioritisation process.

The issue for me looking ahead, and the reason we need to have a look much more forensically than we have perhaps done in the past at the calendarisation of work and the capacity of each hospital to deliver that work, including elective work, is that we are seeing bed occupancy levels—we may talk about that later—running in the mid 90s. The consequence of that, as we know, is that elective work gets displaced.

That is a clinically appropriate decision, but it is our job, in working with the system, to ask the questions about capacity, bed numbers and the staffing numbers, in particular, that will be needed to make sure that, across the year as a whole—

- Q28 **Chair:** Do you think it is sustainable to keep bed occupancy at those levels?

Ian Dalton: It is generally accepted that, at levels above about 92% occupancy, the emergency-elective trade-off becomes difficult. Clinicians will always do the right thing for the patients in front of them, but as I said, nobody wants there to be elective postponements. That does not work clinically; it certainly does not work financially for the hospital—it costs them money—and so this is actually about looking at our capacity.

We are engaged in a planning round this year that I think will ask a lot more of those questions. My aspiration is that we plan to reduce bed occupancy significantly from where it is at the moment.



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- Q29 **Chair:** I suppose Simon Stevens will answer this, but what part of that planning will be more of private hospitals doing what you might call the clean surgeries—things like hip replacements and knees? They do one type of operation in bulk, and those patients therefore do not use up emergency facilities, such as anaesthetists and surgeons.

Simon Stevens: We are expecting that the bulk of the extra operations that the NHS is funding next year will be delivered by NHS hospitals, but that does not cut across the choices that patients have had since the mid-2000s.

- Q30 **Chair:** So there will be an increase in NHS hospitals?

Simon Stevens: Yes.

Sir Chris Wormald: I agree with everything that Ian said, but with two additions. Clearly, the NHS faced some pressures this winter that it has not faced in recent winters, around the cold and the length of the cold and then flu, which clearly impact it.

On the planning point, there is not such a disparity between this year's numbers and previous years because in previous years we have seen lots of unplanned cancellations. The decision we took this year, in setting up the NEPP, which is referred to in the Report, was to take a strategic decision about cancellations at the beginning, rather than individual trusts cancelling as they went. It was as much about having that proper plan for both trusts and patients as it was about the level of operations. That is certainly something that we think has been better this year than in previous years.

- Q31 **Chair:** It seems to me that the only benefit of that is that patients across the country knew that their elective surgeries were likely to be cancelled, but I cannot—

Sir Chris Wormald: No, there were two benefits. One is that certainty for patients is much better, if it is going to be cancelled, for it to be cancelled earlier rather than later.

- Q32 **Chair:** But they might not have had it cancelled if they were in a hospital that didn't need to cancel it.

Sir Chris Wormald: Well, no, because the way that the guidance worked was for hospitals that were capable of continuing to do elective surgeries to continue to do so. But the absolutely crucial point is, of course, that if the cancellation happens early, trusts can redeploy staff in other ways to deal with emergency cases. If you are doing it as you go, that is obviously much more difficult.

- Q33 **Chair:** It would be much better if the winter funding were in there in good time—

Sir Chris Wormald: We have debated that before.



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Chair: Yes, we have debated that before, so I will not repeat it.

Ian Dalton: I would also add that it is better for the patient as well, not to be cancelled on the day or the day before.

Chair: Absolutely.

Ian Dalton: So the proactive decision taken by the national emergency pressures panel was clearly the right one in the circumstances, but I do not think that anyone entered into those decisions lightly.

Chair: There was not an air of control when that was announced. There might have been more control than cancelling on the day, but it did not feel very good for people on the ground.

Q34 **Anne Marie Morris:** Moving on to what we can do going forward to reduce the numbers that go into emergency care, NHS England set up four programmes. If you look at figure 8 on page 22, they are clearly set out: we have the urgent and emergency care programme, the Better Care Fund, the new care models and the NHS RightCare and Getting It Right First Time. If those are the key initiatives to look at how we reduce emergency admissions, can we just look at how effective they have been, what learning you have taken from them and what you might do differently going forward?

Looking first at the urgent and emergency care programme, whose initiatives were how you deal with 111, triage and GPs etc, to try to ensure that older patients in particular are not in the system any more than they have to be, could you perhaps comment on which of those initiatives worked and which did not, and why?

Simon Stevens: On 111, I think there are some really significant and impressive changes that are underway in the 111 service, which is handling many millions of calls a year—15 million calls this year. The big change is that we have increased the proportion of calls that are partly dealt with by a nurse, doctor or a paramedic from around 22% months ago to just under half now—46%. As a result of that, we are successfully handling more calls. We looked after 103,000 more calls to 111 during this January compared with the previous January, and we think we are getting the precision of advice better. When people were asked what they would have done had they not had access to 111, 29% said they would have gone to A&E, 16% said they would have called 999 and 35% said they would have gone to their GP, whereas, in fact, 9% of 111 calls are actually diverted to A&E and 13% have an ambulance dispatched. So improving the clinical content and discretion inside 111 is, I think, making a significant improvement to the way in which patients are getting advice.

Q35 **Anne Marie Morris:** Logically that is right, but could it be a matter of marketing and knowledge? A lot of people of a particular generation have never heard of 111.

Simon Stevens: To the extent that we have 15 million calls a year, that suggests that it is increasingly well known.

Q36 **Anne Marie Morris:** Okay. Let's move then to some of the other areas



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you have looked at. With GPs, as I understand it, while the work to provide some triage in the hospitals and the work to include weekend working has reduced the attendance, it has not reduced admissions, which is surprising.

Simon Stevens: We are seeing several things, aren't we? We are seeing a moderation in the rate of increase in attendances to major A&Es and those numbers have been going up by around 1.2% over the last 12 months, compared with 2% the year before, 4.7% the year before that and 5.4% the year before that. So the rate of increase in attendances at major A&Es—type 1 A&Es—is moderating.

Secondly, in terms of what then happens to patients when they are at the A&E or the emergency department, as we discussed earlier the new clinical model means that the increases we are seeing in percentage terms are very substantial—three times more for the same-day day case emergency than they are for the overnight admission. That has not happened by accident.

If I may, I will quote from a research article in this week's *British Medical Journal*, which says it better than I can say it. It says: "we've now designed hospital 'front door' arrangements to ensure that a consultant is present on take so that decisions are not routinely delayed. We have a much greater focus on prompt review by a senior doctor; ambulatory emergency care; rapid, supported discharge home; and quick access to diagnostics, occupational therapy, physiotherapy, and specialist medical opinions...This is good, not bad, medicine...it's bizarre to label a zero day admission 'inappropriate' retrospectively, on the basis of eventual treatment. We shouldn't be labelling good, patient centred medical practice as bad." That was in this week's *British Medical Journal* and I think that represents what Keith described earlier, this big improvement in the management of patients when they are actually in the emergency department.

- Q37 **Anne Marie Morris:** What I hear, Mr Stevens, is some good evidence that outcomes are improving, which is clearly desirable, but I can see very little in what you said that makes a link between what has happened and what the ultimate outcome is. So I will pose the same question as I did with regard to 111. I cannot quite see how you can say that it is what you have done with GPs that has led to that outcome.

Simon Stevens: I do not disagree with that. In a way this was a point of slight divergence of perspective that we had with the NAO on this.

- Q38 **Chair:** It is an agreed Report, so let us continue on that basis.

Simon Stevens: Although the NAO has identified several distinct programmes, the fact is that if you take the 12% reduction in your likelihood of being admitted as a medical emergency, that is a whole combination of things that has been happening around the country. It is pretty hard to disentangle how much of it is this programme or that programme or the other.



- Q39 **Chair:** The problem is you have got these specific programmes, so once again you have a chunk of money for the Better Care Fund and chunks of money here, there and everywhere. If you are going to justify that, you have to then track through what difference that makes, as Ms Morris is saying.

Simon Stevens: Let's look at GP access, for example, covering 55% of the country now compared with the 40% target we had for March and the whole of the country by this coming autumn. That has been shown to lead to a 10% reduction in minor attendances, so that is GP services.

- Q40 **Anne Marie Morris:** It is good that you are tracking that data.

Professor Keith Willett: Can I clarify something? I led the urgent and emergency care regime programme and the new care models and those elements. These were evidence-based programmes. The interventions that we put in were not plucked from the air. In 2013 we published the urgent and emergency care review, which we built in public with all the clinicians in the country and the public. The Nuffield Trust has reviewed all the evidence, as have the new care models programme. We produced the channel shift model as well, which put a cost around it. The Nuffield Trust listed the evidence-based interventions that they expected to see. So GPs having access to specialist care; GPs giving clinical support in care homes; GPs being available for ambulances so that paramedics could triage in the community; and GPs providing continuity for long-term care.

So we knew the elements that needed to go into the extended access to general practice that would change the system, but when you look at—I have said this before in this Committee and in the Health Select Committee—the urgent emergency care pathway, it is a complex set of interventions across the pathway. If you focus and just do one of those interventions, the rest of the system is sufficiently powerful to negate it very quickly. That is why very often the CCG will fund an intervention and it is a no-brainer. The evidence is all there, they put it in, and 12 months later they assess it and it has not worked.

- Q41 **Chair:** You have outlined some challenges.

Professor Keith Willett: So this is a compounding effect of all those interventions. It would be very difficult to go back and say this single intervention had this output. The urgent emergency care review was all about looking right across the pathway, looking at the deficiencies in each element of the pathway, taking interventions that are evidence-based and plugging them in in sequence.

- Q42 **Chair:** So you are saying joined-up—

Professor Keith Willett: Joined-up integrated care will give you what Simon has described. The truth is, something that works in one area might not be needed or might not work in another area.

- Q43 **Anne Marie Morris:** I hear what you say, Professor Willett, and I understand where you're coming from. Where I'm coming from is value for money. While I agree you need more of those interventions, if you do



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not know which ones are the most effective, it is very hard to improve and get the most tax-effective spend. That is really my issue.

Professor Keith Willett: The Nuffield Trust review of the upstream effective interventions was based on cost-effectiveness. There are clearly other interventions that are really good for patient outcome and for patient experience and good for quality of care, but the Nuffield review, which is the list I just gave you, was based on cost-effectiveness. When you get to hospitals, ambulatory care stood out as the most cost-effective intervention.

Chair: We do sometimes think, on this Committee, that this joined-upness saves money as well as being better for patients. So that is kind of where we are driving.

Q44 **Anne Marie Morris:** Let us move on to the second initiative—the Better Care Fund, which is supposed to look at avoidable admissions. We were supposed to be pooling NHS and local government funding. The idea was ultimately more money would go into social care, because there was the assumption that if you did that you would reduce the pressure on emergency care. It is not clear from what I have read that actually it proved to deliver that.

Simon Stevens: We have had discussions about the Better Care Fund in the past, haven't we, and I think our view is that the right way to think about the Better Care Fund is that it is a way of offsetting what would be greater pressures in adult social care were it not for the Better Care Fund transfers that were in place. So the counterfactual is what would have happened without the £7 billion that has been transferred through the Better Care Fund. It is interesting to note that the mandatory budget pooling for the Better Care Fund is £5 billion. Local NHS bodies have chosen to put in another £1 billion on top of that and councils have chosen to put another £1 billion on top of that, so there is £2 billion out of the £7 billion that is not something that has been set nationally. That is what people are themselves choosing to do, because they think it is making a difference locally. So unless we are all going to sit round and say they have got it wrong I think we have to respect some of those judgments.

And I would say that the evidence from this winter is that for the first time in a number of years we do appear now to have begun to turn the corner on delayed discharges, delayed transfers of care—something the Committee also has expressed great interest in. We have seen 1,700 fewer delayed transfers of care in January than we saw in the baseline period of February 2017. That is obviously quite encouraging.

Chair: I am sure Ms Morris will pick this up. Ms Morris, Mr Stevens blinds us with that—

Q45 **Anne Marie Morris:** I think we are going to irritate the Chair unless we keep it a little bit shorter. I hear what you say with regard to discharge but in terms of admissions I do not see the same conclusion. It seems to me that there has not been an improvement there and that the money from the Better Care Fund has been all focused, or most of it, on



discharge.

Simon Stevens: It depends what you think the counterfactual would have been. If you look at the way the Better Care Fund is using its funding it is a whole series of interventions, assistive technologies, carers' services, home adaptations, domiciliary care, support for care homes, primary prevention—all of these—

Chair: In the House of Commons you are not allowed to read out lists, and we think we might institute that.

Simon Stevens: It is just the data.

- Q46 **Anne Marie Morris:** I think my concern is that still this isn't working, and I can tell you when I look at my own authority and the way it is pooled, it is rather more of a game situation, so there is money there and it does not give me any more comfort that each party puts in more money—because we are not talking about any new money here; this is all old money—and what effectively I think you said at the start of your answer is this is about culture more than anything else. I am telling you that when I look at what is happening, certainly locally, I am not seeing more money going on new social care, which seems to me—

Simon Stevens: No, that is what I was saying as well, so I think we are agreeing, because I think this is to some extent partially offsetting what would otherwise have been greater budget cuts in social care. We had this discussion last time round and I think the Committee was critical of that degree of frankness on our part when we said we thought that was what was going on.

- Q47 **Anne Marie Morris:** Mr Stevens, would you agree—this is important not just as culture change but good value for money for the taxpayer—that, perhaps, going forward, NHS England could look more closely at exactly how this better care fund is being spent, because we are still putting more money into it as a means of improving health and social care?

Sir Chris Wormald: When we did the full hearing on the better care fund I think we were reasonably frank that there were things that we thought had gone well, and also things that needed to be improved. The other thing my Secretary of State did last week was make really quite a major speech on social care and the building blocks that he saw—the certain principles he saw—in social care reform.

Chair: Okay, we don't need to repeat that.

Sir Chris Wormald: But the point here is, as we develop the better care fund going forward, and indeed our whole social care policy, those are the things we will want to be looking at, which includes a lot of the issues you are raising. It is quite difficult to track through the exact causation of a particular investment to a particular outcome. A lot of our evidence is about the reports of local players about what effect they see. Certainly the reports we get from local areas don't really match what you get from your area. We do get a lot of reports that this has improved integration and has improved—



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Q48 **Chair:** But the NAO Report, on page 27, paragraph 2.15, on the better care fund—I do not want to cut across, Ms Morris, but it is worth highlighting—says, “Across our case study visits we found local areas welcomed the additional resources from the improved better care fund, but some found the restriction on its use meant they could not spend it in the way they wanted to help reduce emergency admissions.” Ms Morris is not completely estimating—this is something the NAO has had evidence of.

Simon Stevens: In fairness, Chair, what Anne Marie was saying was kind of the opposite of that, which is that we should be more directive about how it is used to ensure that it is doing stuff that is known to work. Those are divergent points of view.

Q49 **Chair:** But it is about how it works, is it not?

Simon Stevens: If we had a critique of the NAO Report, it would be that, despite saying at paragraph 4 that, “The report takes a whole-system approach, and looks...across acute, primary, community and social care systems”, frankly, the Report is, for the most part, mute on the pressures arising in hospital services as a result of pressures on social care.

Chair: That is not entirely its focus. I will keep with Ms Morris on this point. Ms Morris, will you continue on the better care fund?

Q50 **Anne Marie Morris:** Yes, I will carry on with the better care fund. I hear what you say, but I am still far from convinced that there really is pressure to ensure that we know what we are doing and we know what benefit we are getting, and I do not see any appetite for measuring that. I am conscious that we have about 20 minutes left, so I will leave you with the better care fund, and move to the new care models, which I am equally concerned about. You had seven models that you tested in 50 vanguards. My understanding is that those vanguards gave you mixed results. Some of them show that there was evidence that whatever it was the care model was trying to prove succeeded and reduced admissions, but others actually increased admissions. Where are we with the vanguard project and the new models of care? I am not clear that we have any answers, having spent a significant amount of money on it.

Simon Stevens: Figure 9 sets out the answer to your question. It shows that, on average, the vanguards have succeeded hitherto in slowing the rate of growth in emergency hospitalisations quite markedly. With successive quarters, we are seeing that confirmed.

Q51 **Anne Marie Morris:** Yes but, with respect, Mr Stevens, the fact that on average you are getting a reduction does not really help you to work out what you need to do to change things for the better in future. Therefore, you have to unpick these things, and that does not help.

Simon Stevens: We have done that, because we have re-divvied up the money between those that were working best and those that were not. Let us also put this context. We had a discussion on the financial sustainability of the national health service, and looking at the comments you have made on that for tomorrow, Chair, it is less than one tenth of 1% of the



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NHS budget that has been spent on it. For the change that we are beginning to see, that is creating some very important pointers for the future. I would also say that we were a bit disappointed by the way some of the material was represented in the Report, where it talks about—

- Q52 **Chair:** Can I say that this is an agreed Report? If you have an issue with how the NAO has presented it, you need to take that up with the NAO outside the room, because we just have not got time to get into a disagreement about that.

Simon Stevens: It is very pertinent to Anne Marie's question. One of them makes reference to seeing an increase in emergency admissions. As I understand it, the vast majority of that is the zero day "admissions", which is essentially a counting and measurement effect. In fact, I think it relates to South Somerset, where the emergency bed days, as a result of the vanguard, are actually down 2.3%.

Anne Marie Morris: I will leave you and the NAO to argue that out outside the room.

Simon Stevens: We did point that out.

- Q53 **Anne Marie Morris:** My concern is that there are some areas that have not really worked but that are quite critical. Frailty was one of the areas that the new care models were particularly supposed to address. As I understand it, you have looked at the most acute 2%, rather than the 20% of less frail individuals. You have a programme whereby GPs are supposed to monitor the top 2%, but there is not a scheme for the next 20%. In fact, in terms of emergency admissions, that 20% is a much larger part. How come that has not been addressed? Is there a plan to address it in future?

Simon Stevens: The data I have is that, since last year, 2.3 million people have had a frailty assessment. Of those, 570,000 have been shown to have moderate frailty and 295,000 severe frailty—that is about 9% of the over 65s combined. Various interventions have arisen on the back of that, including medication reviews, assessing falls risks and so forth.

Professor Keith Willett: What has come out of the learning on frailty—new care models were all about learning how to land things in the system—is that we agreed to put the frailty assessment into the GMS contract for GPs in October last year. As Simon said, that means that patients who are in the frailty group—either the severe group or the moderate group—and are appropriate for it will get a falls assessment and a medication review, and as part of their enhanced summary care record, which is available to the rest of the system, an advanced care plan is made for them. Those elements have all come, as I said in respect of the urgent emergency care review, from a very strong evidence base. They have been shown to work. New care models were about saying, "How do you best land this in the system?"

- Q54 **Chair:** Is the falls assessment, for example, done by the NHS or by social services?



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Professor Keith Willett: The falls assessment is usually done by the community.

Q55 **Chair:** A community nurse, or—?

Professor Keith Willett: Usually physios or OTs, but it can be nurses.

Q56 **Chair:** But it is in the NHS?

Simon Stevens: Also by the fire service in some places. Greater Manchester was a pioneer in this. When the fire service are doing home fire checks, they are also doing falls assessments.

Q57 **Chair:** My point was about how joined-up it is. If it is all within the NHS there is fragmentation there, but there are also challenges about linking up—

Professor Keith Willett: In getting that service done, obviously the frailty issues relate to the hospital as well, because the frailty response is a really good part of ambulatory care—there are frailty services when the patient arrives in hospital. If we are joining all that up, which is what integrating is all about, then we will see the product down the line. You might not see it immediately in the test sites.

Q58 **Anne Marie Morris:** So how much of this is actually being fed down to the STPs or the 10 integrated care systems? There is not a lot of point in having new models of care and then keeping the results and findings secret.

Simon Stevens: Yes, absolutely. In places like Morecambe Bay, North East Hampshire and Farnham, Gateshead, and Sutton, you can see all these models in practice.

Q59 **Anne Marie Morris:** So everything that has gone through the new care model is in these 10 integrated care systems? That does not sound likely.

Simon Stevens: No, the 10 are eight plus the two devolution areas, and they cover about 9 million patients. They will be going live on 1 April. They have been doing a lot of prior work, but they will not all have the complete package. However, they will be doing so during—

Q60 **Anne Marie Morris:** Okay, but how are you going to measure the results? At the end of the day, one of the issues coming out is, in some senses, what is best practice is self-evident, but we are not measuring whether that is actually true, to be able to clarify exactly how we better spend money.

Simon Stevens: They have got the performance agreement, or an outcomes memo of understanding, which they are entering into with us. That sets out the range of improvements that we are expecting them to generate.

Q61 **Chair:** Can I just bring Ian Dalton in on this? You have a big role at NHS Improvement to make sure that these areas deliver. How are you assessing that, and do you agree with Simon Stevens? I suppose you

might have to, because you are virtually sitting next to him, but do you agree with his assessment that it is all going swimmingly?

Simon Stevens: Which is not my assessment.

Chair: Okay—I am just testing Sir Ian.

Ian Dalton: I agree to the extent that the programmes that are outlined are very important, and have certainly—as I think the value-for-money conclusion of the NAO has recorded—helped the NHS to cope with a continual rise in emergencies. Looking ahead, I think that we need to see, in areas particularly including the integrated care systems where people are working together, them driving these forward at scale. I think it would be fair to say that we are running our hospitals at too high an occupancy level, and we are dealing with a year-on-year increase in emergencies.

I think we have heard so far that the NHS and its professionals are benefiting from the clinical innovations that we have talked about, and coping with that increased demand better than we ever have before. However, going forward we have to factor that into our capacity plans. We obviously should not focus on finance here, but from a financial perspective—we had the conversation about financial sustainability in the NHS—the rising tide of emergencies has a significant financial cost on our hospitals, and is contributing to their overspend situation. This is not a predominantly financial conversation, but we need to see that factored into this as well. We need to see an industrialisation of what we are talking about.

- Q62 **Anne Marie Morris:** That is helpful. The fourth and last area was NHS RightCare and Getting it Right First Time, which is partly a project for the commissioners and partly a project for the hospitals. Do you think that worked? When I look at the map across the UK, it seems to me that there is quite a bit of divergence in what is and is not working. I am far from clear that this is really understood. I don't know whether Mr Dalton or Mr Stevens wants to answer that.

Ian Dalton: We will take a bit each. Do you want to go first and I will do mine second?

- Q63 **Chair:** I don't think you both have to answer at length; let's keep it short.

Simon Stevens: Ian will probably want to talk about GIRFT, but there are three claims made on variation in the Report that it is worth understanding a bit of the context around. The first is in the context of the overall increase in admissions for over-65s. The Report talks about the fact that the over-65s are up by 6.2% between 2013-14 and 2016-17 and emergency admissions are up by 12%. However, three quarters of that divergence is explained by the fact that you have a higher emergency admissions rate if you are an 80-year-old than if you are a 65-year-old, by zero day versus one day plus. The residual is much smaller than is implied.

Secondly, when you look at the comparison year by year that is referenced here in the Report in figures 14 and 15, the NAO is rightly clear and frank



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that those comparisons year over year do not in fact standardise for the known drivers of emergency demand, including ageing and deprivation, for example.

Thirdly, when you get to the cross-sectional chart at figure 13, which might be the one you are most concentrating on, I think that as we are better able to link the data from individual practices and hospital systems, we will find a much more granular understanding that helps to explain away what appear to be some of the unexplained differences here. Finally, to support that point, I will refer to some good research that has been done in your constituency, Chair—

Q64 **Anne Marie Morris:** Very briefly.

Simon Stevens: —in Hackney, Newham and Tower Hamlets by researchers there, who have linked together data for—

Q65 **Chair:** The problem is that you are bringing in information that we do not have access to.

Simon Stevens: It is all published, peer-reviewed data. This is the *British Journal of General Practice*.

Q66 **Chair:** We do some preparation, but we do not read every bit of research—

Simon Stevens: The *British Journal of General Practice* found that the most important independent clinical factors, once you have access to all the medical data, were the number of long-term conditions, which are going up, and smoking status.

Sir Amyas Morse: This is not supposed to be happening.

Chair: I have asked Mr Stevens not to do this.

Sir Amyas Morse: This is really very boring.

Simon Stevens: It is medical research.

Sir Amyas Morse: You have done this half a dozen times now.

Q67 **Chair:** Mr Stevens, could you just finish the sentence, and then we will move on, because we have ground to cover and we are not going to do it in the time we had planned. I warned you at the beginning that we wanted short answers and you just keep adding bits in that we have no access to. Don't give us the reference, because we do not have access to it beforehand. You are just quoting stuff at us that we have not had a chance to look at. It makes it very difficult for us to engage with it.

Simon Stevens: Well, it is peer-reviewed research in the *British Journal of General Practice*—

Chair: Then you can submit it as evidence if you wish, but that is the second time you have read something out in this hearing. We told you we had to finish by a particular time.



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- Q68 **Anne Marie Morris:** I don't think any of that convinces me that we have an understanding of the variations yet, and I think you would agree with that. It seems to me that we need to have much greater clarity about the different start points. You have almost made my point, which I have made to you on several occasions, that we need to look at rural communities, where a disproportionate number of those over-80s live, to look at whether or not the mechanisms of intervention and funding are right. I am grateful for that, but I think more work has to be done to sort this out. I am curious to know what Mr Dalton would like to add.

Ian Dalton: I agree. I would only add that the Getting It Right First Time programme started in the surgical specialties. It is a clinically led programme that looks at variation within hospitals. It is moving into the medical field and I think it will have some contribution to the identification of clinical best practice within hospitals. That is a slightly separate issue from the rate of growth we are talking about.

- Q69 **Anne Marie Morris:** Are you going to try to drill down, then, to find out what the real causes are for these population differences, and not only feed that back, clearly, to your own teams, but make us aware of how you will change things? Unless you are clear about the cause and effect, you cannot roll out best practice.

Chair, if I may, I will cover one final thing, and again, my surprise will not be news to you. Where is the voluntary sector? They are not referred to in any of the work that has been done, and yet the value, if you try to monetise it—as I believe the NAO has done on previous occasions—is £100 million-plus. They are a key part of keeping people out of hospital. Why have they not been included in any of this work in any way?

Professor Keith Willett: They have. There is the urgent and emergency care review and the whole business about what you can wrap around a patient in the community to support them close to home, particularly in that rapid response mode.

I think I was here talking to you about ambulances a few months back, and we talked about the very typical case—it is the subject of 20% of ambulance calls—of an elderly patient who lives alone or in warden-controlled accommodation who has fallen. At the moment, on the opportunities to manage that patient in any way other than to convey them to hospital and for them to become an often avoidable admission, what we said and looked at is that you need a single point of access. The paramedics can contact the single point of access, who can mobilise the voluntary sector rapidly to come in and be with the patient when they clearly haven't got anything that needs conveying to hospital, to prompt community nurse visits very quickly, to wrap around the social care support, to get the general practitioner involved and to generate a full assessment. The voluntary sector was a really important part of that.

- Q70 **Anne Marie Morris:** I hear what you say. In that one part where you looked at the ambulances, yes, it was, but it was a reactive way of looking at the voluntary sector—there was nothing proactive across the



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piece that was actually saying, “What do the voluntary sector do? Where should we integrate them in the overall process of change? And how can they, across all initiatives, actually reduce—”

Chair: For example, could a voluntary sector group in certain areas make referrals that would help ease this into the NHS?

Professor Keith Willett: They could make referrals into the single point of access, and that exists in several parts of the country already. But the voluntary sector also has an established and paid role. The Department of Health has supported the voluntary sector over several years, particularly as part of the discharge to assess model, in making sure that people who go back into the community have support around them. The organisations of the voluntary sector have been an active part of that.

Interestingly, the things that you need to put around a patient to get them back into the community and get them home are the same things you need very rapidly on the night they first fell over or became ill. That has been clear throughout the review.

Q71 **Anne Marie Morris:** You are absolutely right; I am with you all the way. My concern is that you talk the talk, but other than within the ambulance sector you do not walk the walk. I therefore ask you, going forward, to ask NHS England to look far more proactively at the role the voluntary sector can play. You are right, Professor Willett, that there is clearly more that they can do to reduce emergency admissions—which is what we are here to discuss today—in the same way as they have been incredibly supportive in terms of trying to get people out of hospitals quicker. Mr Stevens, will you commit to doing that?

Simon Stevens: Absolutely. If you look at how some of the winter money was used this year, you will see that some of it—a modest amount—went to support the Red Cross with their hospital discharge and support scheme. If you look at the 10 areas that you rightly mentioned a moment ago, you will see that Greater Manchester—one of the 10—has entered into a memorandum of understanding and partnership agreement with nearly 15,000 voluntary organisations across Greater Manchester. Hereford and Worcestershire—

Anne Marie Morris: I am glad to hear this; it sounds like you get the point. We just want to see more of it done more consistently, with it at the top of your overall strategy rather than just inserted reactively in little pieces.

Q72 **Chair:** One of the challenges is making sure it happens at the local level. I will pick up a couple of other points. Mr Dalton, you talked about a 92% bed occupancy rate putting a real squeeze on the system. I knew the NAO had mentioned it, and I found it. On page 8 of the summary, paragraph 14 says, “Our previous work”—that is, the NAO’s work—“has found that bed occupancy above 85% can lead to regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections.” You say 92% and they say 85%, perhaps on a slightly different definition. Do you want to explain the difference?



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Ian Dalton: Professor Willett may have a view, but I am happy to give some initial comments. This is some analysis that we have done, looking at the interplay between reported bed occupancy level through the sit-rep—the management day-to-day data that we get from all our hospitals—and the link between that bed occupancy and the ability to flow patients promptly within the four hours into hospitals from A&E. What we note is that as you move above 92%, you start seeing an increasingly rapid and significant fall-off in the ability to admit patients within four hours.

- Q73 **Chair:** But would you acknowledge that the 85% does lead to what the NAO says it does: regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections?

Sir Chris Wormald: Can I just add something that has changed in what hospitals do? What we have seen, particularly this year, is much more opening and closing of beds to need, which of course changes the percentages. I am sure the NAO was right at the time, but the way that hospitals are managing themselves now is rather different from previously, which I expect explains a fair amount of the gap.

- Q74 **Chair:** If we are talking about moving statistics, we have to be very careful we have the right numbers. We may want to bottom that out outside this hearing. Professor Willett, what about your experience? Both figures can be true; I am not suggesting it is necessarily a dichotomy.

Professor Keith Willett: I think the 85% figure was set when if you went past 85% you were into surges and your ability to react to those meant that you had patients on the wrong ward or outlying patients and some difficulties. Clearly the system has changed in how it responds over winter. As Ian has said, it looks like 92% is accepted as the point at which you start to get really concerned.

- Q75 **Chair:** But at 85% you could still have some of the problems that the NAO has highlighted.

Professor Keith Willett: At 85%, every hospital can cope more than well, and they have done for a good few years, so I do not think that is the case. Also, you have got to reflect as to what sort—that is an average, so I would expect a highly efficient elective unit to be working at 95%-plus without any problems whatever.

- Q76 **Chair:** When they are not going to be knocked sideways by an emergency admission.

Professor Keith Willett: What we are talking about is the reactive acute general medical bed situation, where you want to be able to flex the capacity to absorb the additional patients during surge. If you have not got an ability to flex, then at 85% you will start to take time to recover from surges. Nowadays, we have escalation beds and swing wards. We have a variety of ways in which we respond to that, including seasonal variations in the amount of elective work we do.

- Q77 **Chair:** So both have a truth; it is just that you are saying that 92%—you both agree—is a figure where it really gets very challenging.



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Ian Dalton: It is fair to say that we have seen numbers in excess of that for an extended period of time.

- Q78 **Chair:** That brings me on to the funding issue. We talked about NHS funding earlier, but social services funding is incredibly tight. We have recently seen the National Audit Office's Report on the sustainability of local government funding. We are seeing huge increases in demand for social services and less money after some years of austerity. Do you think it is sustainable, Simon Stevens, to bet the bank in healthcare—not quite the bank, but a large chunk of what we are talking about today—on social services working when local government is facing such financial pressures?

Simon Stevens: No.

- Q79 **Chair:** So would you advocate for more funding for social services as a way of helping to save funding in the NHS?

Simon Stevens: I think it is both. As you know, 18 months ago I said that it would be very important, going into 2017-18 and 2018-19, that some of the immediate pressures on social care were addressed. That is the £2 billion extra that the Chancellor found with the improved Better Care Fund. It was unusual for the head of NHS England to be advocating so directly for social care funding, but I did it because it was the right thing to do, and I still believe that that is the case.

- Q80 **Chair:** So, Chris, you now have a Department that is the Department of Health and Social Care. You have no actual control over the social care budget, but what conversations are you having with your colleagues in Whitehall?

Sir Chris Wormald: We talk about these issues all the time with our colleagues at Housing, Communities and Local Government. The position is exactly as I have described it at previous hearings—we accept that there is considerable pressure on social care and, as Simon said, that is why the Chancellor invested considerably more money in it two Budgets ago, and it is why we need a reform of the system.

- Q81 **Chair:** Let us be clear that with some of that money invested—we have had this come up before, so we need to be clear—a lot of it was about councils being given the power to raise council tax to pay for social care, so it is funded out of the pockets of taxpayers. It is not a chunk of money magically—

Sir Chris Wormald: Council tax is still taxpayers' money.

Chair: Yes, but it is a very different sort of tax in terms of gearing. Let's be clear.

Simon Stevens: I think everybody agrees—as you have said, Chair—that there needs to be a sustainable solution for health and social care funding and that is growing increasingly urgent.

- Q82 **Chair:** Well, it was heartening—it is an early step intervention by the



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Secretary of State to say much the same and we hope that we might get more on that. As you know, 98 Members of Parliament, including 20 Select Committee Chairs, have signed a letter to the Prime Minister, urging her to think about a long-term sustainable solution for health funding.

My final question is: when are we going to see sustained change? Perhaps we will start with Professor Willett. What would success look like in this area? You have painted a positive picture from your perspective of the things that are changing. We can see that might be from your point of view, but we have seen queues of trolleys, increased emergency admissions and elective surgery stopped. They are all things that look like crisis to any ordinary person on the street. You say it is going well, but that does not look good. When will we see a change?

Professor Keith Willett: Let me clarify: I am not saying that things are going well. If it wasn't for the enormous effort of staff in the NHS, we would not be seeing the patient care and the level of patient satisfaction that we are, which is remarkably high, given the pressures in the system.

We need to make multiple changes across the system. When the system is under such pressure, it is very difficult for them to do that. This will be a staged progression, helping the system to identify the points in the pathway that they should work on first, and building that up across time. That is going to take several years. How quick that process is depends on the funding and on a variety of things. Because of the work that has gone on over the last four or five years, we understand what we need to do. I think that the clinicians, managers and those who run the system also have a far better understanding. It will be an incremental change that will have an effect, but it is going to take several more years.

Q83 **Chair:** And you need more emergency care doctors to be the clinicians at the frontline.

Professor Keith Willett: Actually, I would concentrate more out of hospital. We need emergency care doctors in terms of the senior input, because we know that is one of the important interventions to turn patients around quickly and to get the right care with the right early diagnostics, but I would much rather that we caught this upstream, with the responses in the community, our general practice community services, social care and the voluntary sector.

Simon Stevens: I agree.

Sir Chris Wormald: I agree.

Ian Dalton: NHS staff have done a phenomenal job at managing the increasing rate of emergencies, not least over this last winter. You see it wherever you go. I agree completely; we now know what we need to do. We need to recognise that, with an ageing population, increasing frailty and our hospitals operating close to capacity, we need to increase the pace of improvement there. That will take a few years, but that is incredibly important for the sustainability of our hospitals.



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Chair: Thank you very much. The transcript of this session will be on the website uncorrected in the next couple of days, and our report will be out at some point after Easter.