House of Commons
Health Committee

Urgent and emergency services


Volume I: Report, together with formal minutes, oral and written evidence

Additional written evidence is contained in Volume II, available on the Committee website at www.parliament.uk/healthcom

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

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\(^1\) Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).
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Summary

Growing demand

The failure of emergency departments to meet national waiting time targets in the early months of 2013 reflected the ever greater demands that are being placed on the emergency care system. Whilst growth in attendances at emergency departments has been limited, admissions have grown substantially placing more pressure on hospitals and restricting the ability of emergency departments to manage the flow of patients. Beyond this, however, analysing the growth in demand is more problematic. Evidence regarding the profile of patients presenting at A&E is contradictory and there is a pressing need for clearer information which can detail where cases present across the system and the case mix of such presentations.

The problems that have manifested themselves within emergency care cannot be attributed to any one factor or failure within the system. The Committee notes that reduced bed capacity is an important factor in limiting the flexibility of hospitals, but neither this, nor problems with out-of-hours care, or the failures associated with NHS 111 can sufficiently explain why emergency care is operating under such sustained stress.

What we can identify is a broader failure resulting from fragmented provision of emergency and urgent care and a structure that is confusing to patients. A&E departments remain the default option for many patients and hospitals must ensure that they have the flexibility to meet demand by providing sufficient bed numbers.

The Government response

Urgent Care Boards

The Government’s response to the pressure in emergency and urgent care revolves around improving local system management in the short term and restructuring care for the medium term. Urgent Care Boards (UCBs) have been created to implement emergency care improvement plans in local areas. Additionally, local oversight appears necessary to restore a degree of system management removed as a result of the reforms implemented in April 2013. However, the evidence we heard in relation to the Government’s proposals did not persuade the Committee that UCBs will be able to implement reforms and influence commissioning. From the evidence presented by NHS England it was unclear whether UCBs are voluntary or compulsory, temporary or permanent, established structures or informal meeting groups. We believe UCBs have potential to provide local system management but they have no executive power and no clear direction.

The improvement plans which UCBs determine are intended to be funded through the 70% of the emergency care tariff for work over 2009 levels which is not paid to hospitals and, instead, retained by the commissioner. Commonly known as the marginal tariff, this money is already at work and as a result the Committee believes that UCBs will have to identify opportunities for disinvestment elsewhere to fund the appropriate plans. UCBs will be challenged by the fact that they have no statutory role but must exert authority over
Clinical Commissioning Groups in order to deploy resources to support the improved delivery of emergency and urgent care.

We do not believe that the local re-organisation of care can be successfully managed in such a fashion. As they stand, the Government’s plans to improve emergency care and support local changes to the delivery of care require further refinement. Ministers should seek much greater clarity from NHS England regarding their plans for UCBs and either UCBs or Health and Wellbeing Boards should be held to account for plans to improve local emergency and urgent care. We recommend that local Urgent Care Plans should be in place by 30 September this year.

**Commissioning**

An overall lack of authority in local commissioning is concerning. Lines of responsibility and accountability for funding and managing the system have become blurred by the presence of UCBs. They feed into a system which is already built around multiple commissioners and budget holders commissioning providers at regional and sub-regional levels. Allowing providers to work with a single commissioning team can simplify the process, establish key relationships and, importantly, bring providers together to work collaboratively.

**Restructuring**

The bulk of the evidence we received made a strong case for centralisation of treatment for patients with certain conditions such as stroke care, cardiac care and major trauma. When implemented successfully, the creation of specialist centres enhances clinical skills and concentrates resources, with demonstrably improved outcomes for patients. Centralisation, however, is by no means a universal remedy for the ills of emergency care. Service redesign must account for local considerations and be evidence based. Some rural areas would not realise the benefits from centralising services that London has, therefore the process must only proceed on the basis of firm evidence. The goal is to improve patient outcomes – centralisation should not become the end in itself.

**Improving A&E performance**

**The four hour standard**

Performance failure against the four hour waiting time standard has prompted public concern and the eventual publication of proposals to improve emergency care. In this sense the four hour target maintains a degree of intrinsic value as it can highlight when pressure is growing and performance is suffering. Nevertheless, the Committee is clear that the target is not a useful indicator of the quality of care received by a patient.

**Patient flow**

The smooth flow of patients through hospital from their initial attendance at the emergency department to eventual discharge is fundamental to the operation of an
emergency department.

Smooth patient flow can be aided by early senior review of cases. Evidence suggests that the constant assessment and reassessment of patients by junior staff in emergency departments and medical assessment units only breeds duplication and delays authoritative decisions regarding treatment, transfer or discharge. It is imperative that Hospitals learn from best practice in the NHS in order to implement practical reforms that can improve the operation of emergency departments. Increasing the availability of consultants and developing systems of early senior review of patients is at the heart of this.

**Delayed discharge**

It is evident that one of the major contributory factors to the breakdown in patient flow is the inability to discharge patients from hospital. The Committee heard that this is often because places are not available in social care to accommodate patients who have no medical need to stay on a ward. Anecdotal evidence from clinicians and hospital managers identifies this as a fundamental problem which inhibits patient flow, but the official data says fewer bed days are being lost to lack of social care rather than more. The discrepancy between the evidence of people working with patients and the formal data is striking and we find the data incredible. Methods of data collection must be reviewed to ensure that such data provides an accurate picture of the relationship between hospital discharge and social care. Most importantly, data collection must provide system managers with accurate and useable information so they can shape services appropriately.

**Staffing**

Staffing levels in emergency departments are an area of considerable concern to the Committee. They are not sufficient to meet demand, with only 17% of emergency departments managing to provide 16 hour consultant coverage during the working week. The situation is even worse at weekends and consultant staffing levels are nowhere near meeting recommended best practice.

Emergency staffing at all levels is under strain and a 50% fill rate of trainees is now resulting in a shortfall of senior trainees and future consultants. Emergency medicine is not seen as an attractive specialty by young doctors considering their long-term futures. The working environment is uncertain, the conditions are stressful, there is an unsatisfactory balance between work and personal life. Health Education England and local education and training boards must take steps to ensure that emergency medicine is both professionally and personally rewarding.

**Tariffs**

The way in which hospitals which operate emergency departments are remunerated for the services they provide only adds to the challenges that they face. The marginal tariff has failed to encourage the delivery of care outside of emergency departments and penalises them for being open and available to all patients 24 hours a day, 7 days a week. Existing tariffs can provide perverse incentives and do not reflect the need for providers of different services to work together to make sure patients get the best treatment. It is imperative that
tariffs are designed to reward all NHS providers for putting patients on the correct pathway at the first time of asking; however they come in to contact with the health service.

**Alternatives to A&E**

**Primary care**

It is apparent that a significant proportion of emergency department work could more appropriately be classified as primary care and undertaken by GPs. However, we found no evidence that primary care has the capacity to absorb additional work. Walk-in-Centres certainly cater for demand outside of A&E and traditional GP surgeries but the evidence suggests this demand was induced by the provision of additional services.

In principle urgent care can be delivered in primary care but not without substantial restructuring of existing services. No blueprint drafted in Whitehall can deliver a solution for each local health system, and Ministers should look to clinicians to understand what works well and can be replicated elsewhere. The Committee is particularly keen that a new model of integrated primary care should account for the needs of elderly patients. In particular, this would address clinical responsibility for out of hours care, relationships with social care and other providers, and high-quality end of life care. The elderly are too often failed by existing services and many older people end up in emergency departments without any genuine clinical need for this type of treatment.

**Urgent Care Centres**

One way of beginning to instil efficiency and clarity in the provision of emergency and urgent care services is to co-locate Urgent Care Centres with emergency departments on hospital sites. This can offer considerable organisational and patient benefits by concentrating resources and providing a system for quickly directing patients to the correct level of care. We recognise that this model is not appropriate for all locations but UCBs should consider the benefits of this when putting together their improvement plans. The plethora of titles for similar units offering similar services is highly confusing and the purpose of UCCs must, therefore, be clear to patients.

**NHS 111**

It is clear from the evidence presented to the Committee that Ministers rolled out NHS 111 without attempting to interpret the evidence from pilots, which themselves were limited in scale and scope. NHS 111 was launched prematurely without any real understanding of the impact it would have on other parts of the NHS including emergency and urgent care.

NHS 111 is based around triage by a call-handler who is not clinically trained. Call-handlers use the NHS Pathways IT system to assess patient symptoms, but this was regarded by witnesses as excessively risk-averse. In the view of the Committee, NHS 111 does not embody the principle of early assessment by a clinician qualified to a level where they can appropriately quantify and balance risk. We understand the principle of creating a highly recognisable non-emergency telephone service, but believe the process of triage may be so off-putting to patients that they prefer the option of going directly to A&E. In its
current configuration we do not believe that NHS 111 will help to keep people from inappropriately attending A&E. In light of this, NHS England should review the balance between triage and clinical assessment.

**Ambulance services**

Like the emergency departments they often work with, ambulance services are meeting ever increasing demand. In order to enhance the overall system of emergency care in England, ambulance services should be regarded as a care provider and not a service that simply readies patients for journeys to hospital. Increasing the number of fully qualified paramedics can help achieve this. Skilled paramedics can treat more patients at scene, reduce conveyance rates to emergency departments and make difficult judgements about when to by-pass the nearest A&E in favour of specialist units.

Treating at scene and reducing conveyance rates would contribute to alleviating some of the pressures in emergency departments and offer a better service to patients. Particularly in those rural areas where journey times are long and a major consideration, highly skilled paramedics can play a significant role in providing emergency and urgent care. The precise relationship between the development of more highly skilled ambulance crews and conveyance rates and should be investigated thoroughly by NHS England to help ambulance trusts further develop their workforces.

There is more that can be done to support ambulance services in improving the provision of care to patients. UCBs should ensure that ambulance services in their areas have access to key patient data – such information can be crucial in putting together a swift and accurate assessment of a seriously unwell patient. The local implementation of newly developed tariffs designed to reward treating patients over the phone or at scene is similarly important. NHS England should monitor the use of such tariffs in order to understand whether they do provide genuine encouragement to Ambulance Trusts to invest in more high skilled paramedics and treat and discharge patients rather than transporting them on to emergency departments.

Ultimately, the ambulance service has the potential to coordinate other elements of the emergency and urgent care system and lead integration of services. Changing the staff mix, reforming tariffs and ensuring access to patient information are important elements of a process of developing ambulance services in-to care providers in their own right.
1 Introduction

1. In January 2013 the NHS Commissioning Board Authority (now known as NHS England) announced that its Medical Director, Sir Bruce Keogh, would lead a review of urgent and emergency care services in England. The review, which will report in the autumn of 2013, is designed to determine how emergency care can be restructured in order to meet the demands of societal and demographic change. Soon after the announcement of the review evidence began to emerge that the problems facing NHS emergency care departments were becoming more acute.

2. In the first quarter of 2012–13, the majority of A&E departments failed to meet the headline four hour waiting time target. NHS England responded by publishing an improvement plan for A&E in May 2013. The plan set out how local providers and commissioners should respond to the challenges facing emergency care. Introducing the plan, NHS England said:

   Despite much analysis there is no single trend or factor to explain the deterioration and there remains a wide variation in performance both across the country and within the same areas where similar factors apply.2

3. In June 2013, NHS England published an evidence review and 12 design objectives for emergency and urgent care. This is to form the basis of their proposals for reform to be implemented from 2015–16. The review concluded that services are fragmented and that a lack of standardisation in urgent care makes it difficult for patients to understand alternative options to emergency departments. Additionally, it found that emergency departments rely too heavily on junior doctors and that there are insufficient middle grade and senior emergency consultants to meet staffing requirements on a seven day basis.3 The design objectives were focussed on addressing these fundamental flaws.

4. Introducing NHS England’s approach to the problems, Sir Bruce Keogh told us that:

   One thing everybody is agreed on is that the current position of urgent and emergency care is unsustainable and we need to do something. We need to do some things in the short term to address the immediate issues, and then we need to take a longer, more considered and deliberate view about how we address the future. [...] When A and Es were set up a few decades ago, or DGHs (District General Hospitals) came into their own, people could walk in with a problem and most DGHs were capable of dealing with it. But the inexorable advance of medical science means that now there are many common conditions that cannot be treated in an average DGH.4

5. We report on the Committee’s inquiry into urgent and emergency services. We took evidence from Rt Hon Earl Howe, Parliamentary Under-Secretary of State for Quality, Department of Health, Professor Sir Bruce Keogh KBE, Medical Director, Dame Barbara

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2 Improving A&E Performance, NHS England, May 2013, p 1
3 NHS England, the Evidence Base from the Urgent and Emergency Care Review, June 2013, p 11–12
4 Uncorrected transcript of oral evidence taken before the Health Committee on 2 July 2013, (HC 2013–14), HC–119-iii, Q 217
Hakin, Chief Operating Officer and Deputy Chief Executive and Professor Keith Willett, National Director for Acute Episodes of Care, NHS England, Mike Farrar, Chief Executive, NHS Confederation, Dr Patrick Cadigan, Registrar, Royal College of Physicians, Dr Mike Clancy, President, College of Emergency Medicine, Anthony Marsh, Chair, The Association of Ambulance Chief Executives & Chief Executive of West Midlands Ambulance Service NHS Foundation Trust, Mark Docherty, Chair, National Ambulance Commissioners Group, Dr Clare Gerada, Chair, Royal College of General Practitioners and Andrew Webster, Associate Director Integrated Care, Local Government Association.

6. In a separate evidence session the Committee also took evidence on questions related to this inquiry from Rt Hon Jeremy Hunt MP, Secretary of State for Health and Sir David Nicholson KCB CBE, Chief Executive of NHS England.

Terminology used within this report

7. Outlined below are the types of accident and emergency department by the service performed:

i. Type 1: Emergency departments which offer a consultant-led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

ii. Type 2: Consultant-led accident and emergency services which offer emergency care in a single specialty (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.

iii. Type 3: Other types of A&E/minor injury activity with designated accommodation for the reception of patients. These departments may be doctor led or nurse led and can be routinely accessed without appointment. A service which is mainly or entirely appointment-based (for example a GP Practice or Out-Patient Clinic) is excluded even though it may treat a number of patients with minor illness or injury. The category also excludes NHS walk-in centres.

iv. Type 4: NHS walk-in centres which supply a primary care service that does not require an appointment and is not included in the data collection for A&E attendances and admissions.5

8. Type 3 urgent care centres and minor-injury units are often colloquially referred to as 'walk-in centres', but this obscures the differences in purpose between the different types of service. With the exception of quotations, for the purposes of clarity within this report the term ‘walk-in centre’ will only be used specifically in relation to type 4 services.

9. The term ‘accident and emergency’ has become interchangeable with the term ‘emergency department’. In this report ‘emergency department’ will be used specifically in relation to type 1, consultant led A&E departments. ‘A&E department’ is only used to describe type 1, 2 and 3 services collectively or in direct quotation of witnesses.

5 http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/accident_and_emergency_department_type_de.asp?shownav=1
2 A crisis in A&E?

Growing demand

10. NHS England’s improvement plan for A&E acknowledges the extent to which A&E services have been subject to pressure. NHS England say:

A&E performance has deteriorated significantly over the last six months. In the last quarter of 2011/12, 47 out of 152 providers failed to meet the 95% standard for patients being seen and discharged within 4 hours. For the last quarter of 2012/13 this figure had increased to 94 out of 148 providers, double the previous number.6

11. In June, the King’s Fund published a monitoring report examining waiting time data in A&E departments. It found that:

313,000 patients (5.9 per cent) spent four hours or more in A&E in the period January to March 2013, an increase of more than a third on the previous three months and nearly 40 per cent on the same quarter in 2011/12. [...] Data also shows that the proportion of patients waiting longer than four hours before being admitted from A&E to hospital – so-called trolley waits – rose to almost 7 per cent, also the highest level since 2004.7

12. NHS England links this deterioration to a number of factors including:

Increased numbers of patients arriving at A&E. There is a general rising tide with 5.9% more attendances in 2012/13, than in 2009/10. However, the total numbers attending in Q4 of 2012–13 (which is when the significant deterioration began) was 1.7% lower than the previous Q4.8

13. The evidence presented to the Committee about trends in A&E attendances is, however, mixed.

14. John Appleby, Chief Economist at the King’s Fund, has argued that the step change in attendances seen in A&E since 2004 can be explained by changes in the way in which data is collected. Mr Appleby has said:

Until 2003/4, statistics on A&E attendances included ‘major’ A&E units only. But around this time more, smaller units – including walk-in centres (WiCs) and minor injuries units (MIUs) – were introduced with the intention of diverting less serious emergency cases away from the larger, more expensive A&E departments, and the statistical collection was changed to record attendances separately for ‘type 1, 2 and 3’ units. [...]
So, much of the increase in 2003/4 was due to previously unrecorded attendances now being collected, but also additional – but less serious – work being carried out in the new units.

From 2003/4 to 2012/13, attendances in type 1 units have remained more or less unchanged.9

15. The King’s Fund also challenges the notion that attendances in A&E over the past year are unprecedented. It notes that the trend increase over the period November 2010 – April 2013 is around 3.5 per cent – about 1.3 per cent per year.”10

16. In oral evidence to the Committee Dr Clare Gerada, Chair of the Royal College of General Practitioners (RCGP), also questioned whether there had been any real terms growth in emergency department attendances and activity over the last ten years. She said:

if we take away urgent care and look at the number of emergencies—the tariff one—there has been an increase of about 1.7% per year over the last decade. The population has risen by just about the same amount; in other words, it has flatlined.11

17. The College of Emergency Medicine present a somewhat different picture. They argue that the emergency care system is “facing unsustainable workloads”.12 Their research, based on a survey of emergency departments across the UK (not just England), found that:

Attendance rates continue to rise particularly in England. Other work suggests that this is 3–5% year on year although some systems report much higher increases especially out of hours.13

The claim that a growing number of emergency department attendances occur out of hours is not, however, reflected in statistics published by the Health and Social Care Information Centre (HSCIC). They report that in 2007–08 56.5% of attendances were in hours but by 2012–13 the figure was 58.5%.14

18. In oral evidence Dr Mike Clancy, President of the College of Emergency Medicine (CEM) quoted statistics broadly in line with the King’s Fund and RCGP. He told the Committee that type 1 emergency departments attendances had increased by 17% from 2003 – 2011, but added that in the last twelve months there had been a year on year increase of 250,000 attendances in type 1 emergency departments which represented growth of approximately 1%.15 Dr Clancy also noted that there has been little variation

9 http://www.Kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing
10 Ibid
11 Q 184
12 College of Emergency Medicine, press statement, May 2013
13 College of Emergency Medicine, The drive for quality – how to achieve safe, sustainable care in our Emergency Departments?, May 2013, p 10
14 Health and Social Care Information Centre, Hospital Episode Statistics (HES), June 2013
15 Q 2–3
across quarters, arguing that attendance growth was not simply a reflection of specific seasonal demands.\(^\text{16}\)

19. The data detailing emergency admissions to hospital from A&E departments is also important because it illustrates the changing demands on A&E. In the five years since 2008–09 emergency admissions from type 1 departments have increased by over 16% and it is this figure which, in part, helps to explain the pressure under which emergency departments have been operating. Several witnesses reported that more patients with more complex conditions now presented at A&E and the Secretary of State noted that “the kinds of people coming into A and E have more complex and acute conditions than they have had previously”\(^\text{17}\). NHS England reports an “increased number of acute admissions putting pressure on beds”\(^\text{18}\) and say that “there is general consensus (though it is hard to identify the evidence) that patients presenting are more ill and hence more likely to need admission and have longer stays.”\(^\text{19}\)

20. The CEM argued in their oral evidence that it was demand, combined with a more complex case mix, that had resulted in emergency departments struggling to meet the 4 hour target and that type 1 emergency departments “have reached the limits of their compensatory capacity.”\(^\text{20}\) Dr Clancy summarised his view by saying that in emergency departments there are “more people out of hours, more after midnight, more ambulance and more elderly.”\(^\text{21}\)

21. The evidential support for this analysis is unclear. Mark Docherty, Chair of the National Ambulance Commissioners Group, told the Committee that “increasingly, we are finding that some younger patients are choosing to access emergency or urgent services as opposed to primary care.”\(^\text{22}\) Dr Gerada, however, said that:

> the patients who turn up at the emergency department are iller and older and tend to be admitted for longer—it is a cohort. If you look at the patients who turn up at walk-in clinics, they are younger. They are not the sort of patients who turn up at emergency departments.\(^\text{23}\)

22. The BMA presented written evidence in relation to the age profile of patients attending emergency departments. They reported:

> In 2011–12, 43.4% (7,651,005) of all A&E attendances were for patients aged 29 or under and 16.3% (2,875,643) were for patients aged 20–29. This latter cohort tends to be a light user of general practice.\(^\text{24}\)

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16 Q 2  
17 HC 119-iii, Q 240  
18 NHS England, May 2013, p 1  
19 Ibid  
20 Q 2  
21 Q 8  
22 Q 102  
23 Q 183  
24 ES 26, written evidence from the British Medical Association, para 2
Department of Health statistics show that whilst the total number of emergency admissions for patient aged between 20–29 have increased by 6.5% in the five years from 2007–08 to 2011–12, these admissions as a proportion of total admissions have, in fact, fallen very slightly by 0.2%. The number of people aged 65–85+ admitted to hospital as an emergency rose from 1.8m in 2007–08 to 2.1m in 2011–12. This represents growth of 13.5% in five years. Elderly patients now form a larger proportion of emergency admissions than five years ago. In 2007–08 patients aged 65–85+ made up 38.8% of emergency admissions; by 2011–12 this group constituted 40.7% of admissions.

23. The Committee also heard evidence that the demand pressures experienced in A&E were equally prevalent elsewhere in the emergency and urgent care system. The RCGP evidence dealt extensively with the pressure general practitioners now face and Dr Gerada told us that GPs had experienced “an approximately 100% increase in our work load over the last decade.” Dr Gerada went on to describe the degree of stress the under which the primary care system is operating:

I am getting e-mails from colleagues across the country to say that their surgeries are now fully booked by 8.30 in the morning, which is disgraceful. How can we run an NHS where, unless it is an emergency—and by that I mean a dire emergency—you cannot get an appointment with your GP on the day and appointments are fully booked by 8.30? This is not because GPs are going to play golf in the afternoon; it is because they are trying to respond by working 15-hour days.

The King’s Fund analysis demonstrates that it is type 3 urgent care centres and minor injury units that have experienced the most substantial growth in patient numbers. Similarly ambulance trusts have experienced significant year on year growth for their services.

24. The Committee was surprised by the lack of clear evidence about trends in the level and nature of demand for urgent and emergency care. There is a pressing need for clearer information to be produced which can detail where urgent care cases present across the system and the case mix of urgent patient presentations; it is also important to monitor waiting times for urgent and emergency services in order to ensure that services are accessible to patients in urgent need of care. The Committee recommends that NHS England should ensure this data is collected and reported on a consistent basis across the country.

Bed capacity

25. The Chief Executive of the NHS Confederation, Mike Farrar, argued in oral evidence that the problems in emergency department were the result of hospitals finally failing to accommodate ever-increasing demand. He said:

25 Hansard, June 10, 2013, Col 144W
26 Ibid
27 Ibid
28 Q 172
29 Q 175
At the heart of all this, the NHS has the increasing demand, but for the vast majority of the first part of that decade we were able to put resource across the whole of the system. We were increasing the resource available in line with demand. What has really happened since then is that demand has continued to increase but the resource available to increase supply has reduced.30

26. Dr Patrick Cadigan, Registrar of the Royal College of Physicians, argued that there may be a link between reduced bed numbers and the pressures experienced in emergency departments. He said that “the more you reduce the number of beds the more difficult it is to cope with variations and fluctuations.”31 Professor Keith Willett, National Director for Acute Episodes of Care to NHS England, argued that a substantial reduction in bed numbers allied to an increase in emergency admissions was evidence of a much more efficient system. He observed that acute bed numbers had been reduced by a third in the last ten years and that admissions had increased by the same number.32

**Root cause analysis**

27. Attempts to understand why urgent and emergency care services face such substantial pressure have resulted in different parts of the health system being identified as the root cause of the problems. In oral evidence Dr Gerada dismissed the suggestion that renegotiation of the GP contract which transferred responsibility for out-of-hours services from GPs to third parties in 2004 contributed to the downturn in A&E performance. Dr Gerada noted that it was emergency department admissions, rather than attendances, that increased most rapidly, which did not indicate that patients were choosing A&E over out-of-hours services.33 In the general discourse around a ‘crisis in A&E’ it has also been suggested that ambulance services are conveying too many patients and that NHS 111 is directing too many patients to A&E.

28. None of the factors outlined above are irrelevant. The RCGP has itself accepted that the GP contract requires renegotiation; NHS England accepts that NHS 111 provided a poor service in many areas when it was launched; the Ambulance Service accepts that variations in the quality of ambulance response times need to be addressed. But none of these issues by themselves represent an explanation of the developing service pressures which are currently being experienced in urgency and emergency care. The evidence outlined in the following chapters demonstrates clearly that public health advice does not sufficiently facilitate self-care and the NHS 111 service is not yet able to provide timely, effective intervention. Primary care in its current form is not designed to provide urgent care. As Dr Gerada explained, “GPs are trained to deliver care to patients with complex needs and deal with uncertainty in acute condition”. As NHS England has observed, the existing services are fragmented with poor sign posting, meaning that there is little in the way of joined-up

30 Q 13
31 Q 47
32 Q 278
33 Q 194
working. In such circumstances patients are making the rational choice to go “where the lights are on”,\textsuperscript{34} which invariably is the local emergency department.

29. The emergency and urgent care functions of the NHS are undoubtedly working under stress and there is insufficient resilience in the system. Availability of a hospital bed when required is a fundamental part of an emergency care system. Successful delivery of this basic requirement is, however, dependent on the ability of the system to understand the demands made upon it and to deploy its resources in the most effective way. Rising demand for hospital admissions may be as much a symptom of system failure (for example, failure to provide timely care in a patient’s home) as it is of an underlying rise of demand. Until these systems failures are addressed, hospital managements need to ensure that there is sufficient bed capacity available to meet current demand.

30. The system cannot accurately analyse the cause of the problem, still less resolve it, if it continues to “fly blind”. More accurate information about the causes of rising service pressures is not simply a management convenience; it is fundamental to the delivery of high quality care.
3 The Government response

Commissioning

Fragmentation

31. The Committee has consistently argued that multiple services and budgets cannot be brought together if commissioning is fragmented. Creating locally responsive hierarchies of care can only be achieved if strong system leadership is embedded in the local area. Management and commissioning go hand in hand and must incorporate social care if an integrated response is to be achieved. The complexity of commissioning is a fundamental weakness in the system, and the lack of clarity around the purpose and authority of the newly-established Urgent Care Boards (UCBs) risks compounding the problem.

32. NHS England has said that UCBs will cover all ‘communities’ (not necessarily CCG areas) and will include “all key stakeholders from health and social care as well as patient representatives and the appropriate clinical expertise.”\(^{35}\) The role that UCBs can play in implementing local improvements to the emergency and urgent care system is discussed in more depth later on this chapter.

33. Mike Farrar noted the complexity of commissioning and said that:

   I worry enormously that one of the things we have structurally built into the new system is different budget holders for different bits of the budget, social care, particularly primary care, separate from hospital and community budgets, and specialist services.\(^{36}\)

34. The King’s Fund echoed these concerns and said that UCBs may be most useful in providing an additional layer of management to the system. Outlining the commissioning system the King’s Fund’s written evidence said:

   There are now multiple commissioners of urgent and emergency care: NHS England has responsibility for commissioning primary care; clinical commissioning groups commission acute and community services; and local authorities commission social care and housing. Urgent care boards, now being established across the country, may be a useful mechanism for developing system-wide responses, although it will be important to be clear about their role, leadership and accountability if they are not to become just another component in a complex system. We remain concerned that the fragmentation of commissioning and lack of strategic responsibility will make system wide change more difficult to implement.\(^{37}\)

35. Anthony Marsh, Chief Executive of the West Midlands Ambulance Service NHS Foundation Trust and Chair of the Association of Ambulance Chief Executives, described the practical process by which ambulance services are commissioned:

\(^{35}\) Ibid, p 6–7
\(^{36}\) Q 91
\(^{37}\) ES 28, written evidence from the King’s Fund, para 3
You have the core 999 emergency service being commissioned in most parts by a consortium arrangement of clinical commissioning groups across the geographical footprint of the ambulance service, but then, more locally, through the urgent care boards. In most places around the country, those arrangements have existed to a lesser or greater extent—although they may have been called something different—to pull together some more local CCGs to ensure that the service is commissioned locally for their people. In addition to that, sometimes further local arrangements are put in place by clinical commissioning groups for their local population.38

36. The successful provision of emergency and urgent care is a matter of life and death and therefore clarity in commissioning is vital. The Committee is concerned that the lines of responsibility and accountability for funding and managing services have been blurred. The Committee notes the concept of UCBs putting local clinicians and commissioners together to make practical changes and plan service improvement, but it is concerning that new structures are required so soon after the establishment of CCGs and Health and Wellbeing Boards. Health and Wellbeing Boards have made an uncertain start but retain broad support and they are structured to bring all parts of the system together. The current problems should, theoretically, have provided them with an opportunity to develop their functions, but they appear to have been superseded by UCBs.

**Simplifying commissioning**

37. Dr Patrick Cadigan, Registrar of the Royal College of Physicians, said in oral evidence that he hoped that CCGs would be placed at the heart of UCBs because improvements to the system were reliant on better commissioning. He told the Committee that:

> It is very interesting, again, that those trusts that have succeeded best in reducing hospital admissions have been trusts with a single commissioner, so the development of a relationship between a trust and a commissioner, which is capable of constructing perhaps new ways of working financially.39

38. Dr Cadigan’s argument ties in with the view of Anthony Marsh, who told the Committee that in some commissioning areas a single commissioner was taking responsibility for “out-of-hours service, the 999 ambulance service and NHS 111.”40 Mark Docherty, Chair of the National Ambulance Commissioners Group, noted that within existing commissioning structures ambulance services could be rewarded for “advising a patient over the telephone and signposting them to the right service”41 so there was potential to operate a system which promotes a degree of integration.

39. We recommend that CCGs and Health and Wellbeing Boards explore the benefits of establishing single commissioning teams for out of hours care, ambulance services, 999, and NHS 111. A single commissioner can lead across CCG boundaries in the case

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38 Q 98
39 Q 55
40 Q 100
41 Q 114
of services which are most appropriately commissioned on a regional or sub-regional basis. Fragmented commissioning and provision results in a situation where patients are unaware of many available services or are unsure of the most appropriate service. The single commissioning teams for urgent care should take responsibility for signposting patients to available services.

**Solutions**

40. The evidence taken by the Committee suggests that the Government’s proposals to address the failings in emergency are twofold:

i. Alter local system management

ii. Restructure services

**System management: Urgent Care Boards**

41. In May, NHS England published an improvement programme for A&E departments in England to tackle the deterioration in the number of providers meeting the 4 hour standard during the first four months of 2013.

42. In order to facilitate local examination of the systems which determine levels of attendance at A&E departments, NHS England instructed its local area teams to convene Urgent Care Boards (UCBs).

43. In March 2013 the King’s Fund undertook a review of Urgent and Emergency Care on behalf of NHS South of England. The review said that:

> some areas need to do more to provide clear strategic oversight and drive to tackle the main challenges to emergency care systems. Urgent Care Boards have been established in some areas to provide oversight, evaluation, standardisation and communication to all parts of the system, but Boards seem to be at different stages of development and vary in effectiveness.42

44. They also added a note of caution regarding the composition of the boards, warning that:

> Boards appear to be a useful mechanism as long as there is clarity of role, the right people sitting on them (those able to deliver change directly and with a detailed knowledge of the issues), top level sponsorship and methods to hold participants to account. Without this, they have the potential to become somewhat bureaucratic and lead to a proliferation of projects.43

45. We agree with the King’s Fund on both points. UCBs have the capacity, in principle, to contribute to improving coordination of urgent care services, but we are concerned that current plans suggest they are in danger of falling into precisely the trap identified by the King’s Fund.

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42 Urgent and Emergency Care, A review for NHS South of England, The King’s Fund, March 2013, p 4
43 Ibid, p 19
46. Discussing the role of urgent care boards, Mike Farrar, Chief Executive of the NHS Confederation, suggested that they might be in a position to assume some functions that had been lost within the commissioning environment as a result of the implementation of the Health and Social Care Act 2012. He said the creation of a UCB was:

a good move because, effectively, it is trying to replicate someone. [...] If these things are multifactorial and relate to all bits of the system, then a system management approach, where you have somebody who can take that overview, is really important. In the latest reform to the NHS, those kinds of system management roles have been structurally removed so the only way that you recreate them is by volition, where you create something like a board where the parties can come together and actually identify—and it will be different in different parts of the country in different places—where the particular investment or problem is.44

Sir David Nicholson, Chief Executive of NHS England, accepted that UCBs were necessary to provide local oversight and direction. He told the Committee that:

The way the system is constructed is that people will come together in partnership to make it happen, and in lots of parts of the country that is precisely what happens—but not everywhere. It was important that it did happen everywhere, and that was the way in which we thought about urgent care boards to force that system management into the system, which, due to lack of maturity or a whole set of other reasons, was perhaps not quite operating in the way we had hoped.45

47. Explaining their purpose and function, Dame Barbara Hakin, Chief Operating Officer and Deputy Chief Executive of NHS England, told the Committee that, at a local level, it was the responsibility of UCBs to drive performance in emergency care. Dame Barbara said that:

one of the things the urgent care board should do is to identify the use of the 70%.46 For that, we said that the chief executives of the local commissioners, which is the CCG, the area team and all providers—the ambulance trust, mental health trust and acute trust—should sign off the use of that money. That is the minimum group of people who would be there alongside the local authority, because we said there had to be local authority input. Where it is appropriate to have clinicians, they will have many clinicians on them, because the idea of the board is to bring together local experts to determine what they need to do.47

48. This statement, however, contrasts with Dame Barbara’s assertion that UCBs were not part of local governance and management structure, would entail no significant cost to the public purse and would not have staff employed to support their activity.48 Dame Barbara told the Committee that UCBs would be looking:

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44 Q 54
45 HC 119-iii, Q 237
46 Only 30% of the emergency care tariff is paid to providers for activity over 2008–09 levels. The remaining 70% is retained by the commissioner.
47 Q 236
48 Q 239, Q 241, Q 246
at the day-to-day changes they need to make in terms of patient management. How can they work better across primary and social care, and so on? If in a meeting of the urgent care board there is a decision that something major needs to happen, that will have to go back through the formal channels of the CCGs. (Clinical Commissioning Groups)49

49. It was unclear from the evidence presented by the Minister and NHS England how these structures represent a national response to the problems facing emergency care. The number of UCBs remains unclear (with approximately 150 established in England50), they have no executive power but must develop local improvement plans and, despite their responsibilities, no formal structures are in place to ensure they are accountable. Exactly how improvement plans can be implemented if UCBs, CCGs and Health and Wellbeing Boards cannot agree on their content is by no means obvious. The principle is understandable but the execution is unconvincing.

**Funding**

50. It is proposed that UCBs should take responsibility for allocating the 70% of the excess care tariff not paid to acute trusts by commissioners and returned to NHS England (the marginal tariff). In oral evidence Earl Howe referred to this as “extra money”51 but clarified the point acknowledging that this measure released existing money into the system via a different mechanism and could not be regarded as additional funding.52 The Secretary of State told us that UCBs had been given the “specific task to make sure that that money is being used to reduce pressures on A and Es.”53

51. We are concerned about this approach on both procedural and substantive grounds. Firstly, although UCBs are supposed to mandate the use of the marginal tariff, they have no statutory authority to do so and there are no accountability or audit arrangements to track the impact of their decisions; the effective deployment of this resource depends upon local commissioners accepting the recommendations of their UCBs. The Committee regards this as an inadequate basis on which to manage the service reconfiguration which we believe is necessarily at the heart of a proper response to service pressures in urgent care.

52. Secondly, it is unclear how the proposal to develop UCBs relates to the parallel development of Health and Wellbeing Boards. Any coherent plan to restructure the system to meet urgent care needs will need to involve all participants in a Health and Wellbeing Board; it is unclear to the Committee why a second coordinating body needs to be created in parallel with Health and Wellbeing Boards which are not yet four months old.

53. Thirdly, and most importantly, the Committee is concerned about the implication that UCBs will be able to make a difference by re-deploying the marginal tariff. These resources are already being used. There may be better ways of using them, but they do not represent

49 Q 248
50 Q 234
51 Q 225
52 Q 227
53 HC 119-iii, Q 235
“new money”. All UCBs will therefore be required to identify opportunities for “disinvestment” if they are able to initiate any response to current service pressures.

54. The Committee was disappointed with the evidence that was presented about the creation of UCBs. Ministers are relying on UCBs to implement short-term practical changes to improve hospital performance, but the composition, responsibilities and authority of UCBs remain unclear. There is little evidence that any form of national strategy exists beyond the creation of UCBs, and senior figures in NHS England could not tell us precisely how many UCBs have been established.54

55. The evidence presented to the Committee did not persuade us that the structures existed to enable UCBs to implement reforms or influence local commissioning arrangements. The Committee believes that Ministers need to seek much greater clarity from NHS England about its plans for UCBs and ensure that they, or Health and Wellbeing Boards, are required to account for an Urgent Care Plan for their area in the winter and spring of 2013–14. The Committee recommends that NHS England should ensure that these Urgent Care Plans are prepared and agreed before 30 September 2013.

56. It is concerning that UCBs appear to have been created without any senior figure in NHS England being clear whether they are intended to become permanent features in local health systems. We agree with several witnesses that UCBs meet an urgent need to introduce “system management into the system”.55 If that is to be their role, we do not believe it should be regarded as either voluntary or short-term.
4 Restructuring

Specialist centres of care

57. The question of restructuring emergency services is fraught with local sensitivity, as patients and the public value the feeling of accessibility to local services.

58. There is, however, an unquestionable need to restructure the way urgent care is delivered across the health service. Among the most obvious drivers of this requirement to restructure is the recognition that only 17% of emergency departments in England are currently able to provide a minimum of 16 hours per day of consultant cover during the working week. If patients who need access to emergency trauma care are to receive a high quality service it is essential that this scarce consultant resource is used more effectively, and that the system is better at delivering all forms of urgent care, including care that is urgent but non-acute.

59. Professor Willett told the Committee that by regionalising services and bringing together care for particular illnesses and injury in specialist centres the health service “can give not 12 or 16-hour but 24 hour specialist input” which produces a dramatic improvement in the outcome for patients.”56 The Department of Health’s written evidence detailed the clinical benefits of creating specialist units and regional trauma networks based around core trauma centres.57

60. The support for these measures is echoed by the British Medical Association, the Royal College of Surgeons and the Royal College of Physicians and the Committee is satisfied that the evidence base exists to support the Department’s broad objectives in this area. Nevertheless, Ministers and parliamentarians must be aware that it is not possible to make a convincing case for necessary reorganisation unless they are frank about the implications for patients.

61. Regional trauma centres and specialist units catering for specific conditions must be developed as part of the hierarchy of care in each local area. The hierarchy must account for local structures and demand and also make allowances for the distinctions between urban and rural locations. The CEM argued in their written evidence that the benefits of regional centres for patients in rural areas could be entirely negated by increased transport times.58 These observations merely reinforce the requirement for local commissioners to develop a fully integrated service which responds quickly and effectively to patient need.

62. The Committee accepts that a strong case has been made for the centralisation of some aspects of acute emergency care in regional specialist emergency units on the basis that substantial clinical benefits are delivered by focusing skills and resources in single locations. We are, however, concerned that this evidence is not abused; each proposal for service redesign should be reviewed on the basis of the evidence so that centralisation is justified only when the evidence supports it, not as an end in itself. For

56 Q 301
57 Ev 73–75
58 Ev 95
example, in rural areas the benefits of centralising care for some serious conditions could be negated by increased transport times.

63. Some of the evidence submitted to this inquiry drew a distinction between the short-term and medium-term response to the challenges facing emergency and urgent care. A better coordinated response to the current pressure is required to manage the immediate pressures, but in reality this is a continuous process. Medium-term plans for improvement should represent a coherent development of short-term responses while retaining sufficient flexibility to allow them to reflect changing circumstances.

64. Furthermore, there is an urgent need for clearer messaging to improve public understanding of the system and confidence in it. One of the benefits of the NHS should be a clear and familiar national formula for access to urgent and emergency care. The existing system is opaque and must be much more clearly defined.
5 Improving A&E performance

The four hour standard

65. The four hour waiting standard requires all A&E departments to see 95% of attending patients within four hours of their arrival at A&E. It was the deterioration in performance against this standard which prompted NHS England to launch a recovery programme for emergency care. In evidence no witnesses argued that the four hour target should be scrapped. Dr Clancy told the Committee that it was a “process measure and not a quality measure” and that other quality indicators were more useful in explaining how well emergency departments are performing. Mike Farrar explained that whilst the four hour standard was not “a relevant clinical target” it remained a useful indicator of overall performance. Mr Farrar said:

The indicator gives you some sense of the flow through a system. In clinical terms, obviously, if you present with severe chest pain, waiting for three hours and 59 minutes is not right. [...] But it tells you something about how patients are able to be admitted and the capacity of the hospitals. It also gives you a bit of insight into how many people are presenting.

Dr Cadigan sounded a note of caution, pointing out that the target was prone to ‘gaming’. He said when considering the care of a patient in an emergency department:

At the point where there is inadequate capacity and where the right thing to do is to hang on to someone for a little longer in the A and E department, the four hour target forces you to move them—and forces you to move them to an inappropriate place—when it is clinically inappropriate.

66. In Chapter 1 we identified rising admissions to hospital from the A&E department as a key indicator of the changing nature of the workload of the A&E department. In this chapter we examine how the flow of patients through a hospital can adversely affect the work of an emergency department. In oral evidence Dr Gerada linked these two factors and the issue of emergency department staffing (also discussed in this chapter), arguing that the four hour waiting target could drive unnecessary admissions. Dr Gerada said:

With the four-hour target, there are what we call zero-hour admissions, especially children or the elderly, who are so-called admitted but not really admitted. [...] The problem is zero-hour admissions either for observation or because there is not somebody senior enough to make the decision whether or not to discharge. That comes back to the original premise of the College of Emergency Medicine: there are

59 Q 10
60 Ibid
61 Q12
62 Ibid
63 Q 11
not enough senior doctors in the emergency department to make decisions, hence you are clogging up.64

67. In a well-functioning health system the four hour waiting time standard would be met as a matter of course rather than as an objective of policy. The four hour standard retains its value as a basic measure of performance but it does not provide a full measure of service quality. It is prone to gaming and the key indicators of hospital performance should be based on a broader assessment of patient outcome and experience. Waiting times are certainly part of this, but not the whole of it.

Patient flow

Assessment of patients

68. In publishing the evidence base for the Emergency and Urgent Care Review, NHS England specifically acknowledged that:

Timely access is required from supporting specialties to enable appropriate admission and transfer of patients to improve patient flow within A&E departments.65

Further information detailed within the evidence base published by NHS England demonstrates the scale of the challenge that they and the Department face in achieving this objective.

69. The Committee notes the case study of the South Warwickshire NHS Trust which participated in the Health Foundation’s Flow Cost Quality improvement programme and reported in April 2013. The trust decided to analyse the flow of patients from A&E through the hospital after examining the care of one patient who spent an eight day stay in hospital. In this patient’s case they discovered that only 18% of his time in hospital had added value to treatment and the rest of the time in hospital was regarded as wasted.66 The trust undertook a programme of substantial data analysis in attempt to understand why the flow of patients was so inefficient and to uncover the root causes of the problems. They found that:

As in many hospitals, most emergency patients faced delays waiting for an initial assessment by a junior doctor. Once assessed, they then had to wait for input from a senior medic. There was also a lot of duplication (and therefore waste) in the current system. Patients coming through A&E would be seen by a junior doctor first, then by a registrar and sometimes by an A&E consultant. This would often trigger a referral to a specialist team.67

70. The analysis found that there was a four-hour delay between a patient arriving at A&E and then arriving at an assessment unit or ward:

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64 Q 194
65 NHS England, June, 2013, p 12
66 Ibid, p 4
67 Ibid, p 5
The consequence is that although two-thirds of patients arrive during working hours (when senior decision-making staff are available), they are not in the ‘right’ place by the time the senior staff leave the hospital at 6.00pm. [...] As a result of existing work patterns (8am to 6pm, Monday to Friday), on-take physicians and surgeons saw only around a third of patients before 6pm on the day they presented.68

71. In order to resolve this the team in charge of reviewing patient flow hypothesised:

that if they placed senior clinical decision-makers in the MAU (medical assessment unit), when patients presented, they could improve the system dramatically. Having senior medical staff available to assess patients earlier would get patients onto their right care plan more quickly and efficiently.69

The specialists also recognised that if they visited the assessment units after their morning ward rounds (at which time they would have discharged patients), they could ‘pull’ patients from the MAUs to their specialist wards while beds were available.70

72. The new system was trialled amongst cardiologists, who discovered immediate benefits, and it has been extended to other specialities including elderly care. In order to make the new system work consultants had to accept extended evening and weekend working. The presence of senior medical availability until 8pm instead of 6pm:

ensured that patients were being assessed and put on the right care management plan on the day they presented. It took major delays out of the process and, crucially, avoided the need to ‘store’ patients overnight on the MAU.71

73. The King’s Fund analysis in southern England supports the conclusions of the South Warwickshire study by emphasising the importance of access to senior medical staff. They found:

In future rapid access to a senior opinion will need to be the norm. Many hospitals are now developing Acute Medical Unit (AMU) consultant job roles; specialists in assessment and early treatment; networkers across the hospital to conduct patients to the right speciality; and a source of advice to community based clinicians to prevent admission.

In some AMUs the acute consultants are increasingly used by GPs to provide advice on seriously ill patients, developing closer working with the community. For example, in one trust the AMU consultant on call takes GP referral calls directly, preventing 40% from being admitted.72

68 Ibid, p 6
69 Ibid, p 9
70 Ibid
71 Ibid
72 The King’s Fund, March 2013, p 26
74. The written evidence of the Royal College of Physicians emphasised the principle that early senior review could improve diagnoses, eventual patient outcomes and relieve pressure within emergency departments. They said:

emergency departments should consider implementing a rapid assessment and treatment (RAT) model in order to provide early senior review for informed expert assessment, diagnosis, care planning, end-of-life discussions, etc. Senior triage of GP referrals to acute medicine has also been shown to be effective; acute medicine consultant triage of GP phone referrals and the introduction of medical ambulatory care pathways has seen a reduction in community admissions by 37% in the areas served by Royal Derby Hospitals area.73

75. The evidence appears to be strong that quick access to a skilled clinician, rather than laborious ‘triage’ through an ascending hierarchy, delivers care that is both better and more economic.

76. We recognise, however, that in practice there is a difficult balance to draw, particularly when staffing pressures are particularly acute in emergency medicine.

77. Acute trusts must learn from best practice in the NHS. Patient flow studies by the Health Foundation have found that pressure on emergency departments can be relieved by restructuring the assessment of patients and changing working patterns. The management and boards of Acute Trusts should take responsibility for examining their own procedures and identifying whether they are in line with established best practice. In evidence Professor Willett told us that UCBs could help to examine best practice models.74 We agree that UCBs are well placed to undertake this role; successfully disseminating best practice across emergency and urgent care would help to establish the value of UCBs.

78. Accessing early senior review of cases can reduce duplication and accelerate the path of a patient through the system. Senior clinicians are better able to balance risk and make key decisions. We therefore recommend that trusts assess the viability of implementing a rapid assessment and treatment (RAT) model. Additionally we recommend that Acute Trusts operating emergency departments explore the value of effective acute medical units (AMUs) which are designed to incorporate rapid access to senior specialist assessment and the swift development of care plans including a plan for discharge.

Staffing

79. The fifth system design objective of the NHS England Urgent and Emergency Care Review is to improve the patient’s experience and outcomes by “ensuring early senior clinical input in the urgent and emergency care pathway.”75 Improving access to senior clinical opinion can be achieved, in part, by reforming staff rotas and reorganising the

73 Ev 90
74 Q 278
75 NHS England, June 2013, p 6
operation of emergency departments. Nonetheless, the ability of emergency departments to provide swift senior assessment is fundamentally related to overall staffing levels.

80. The CEM argued in both written and oral evidence that emergency departments do not have sufficient specialist consultants to sustainably meet demand. The CEM’s written evidence states that:

Workforce recruitment is in crisis. 3 successive years of only 50% fill rates for Emergency Medicine trainees has resulted in a ‘lost cohort’ of over 200 potential consultants. This loss is permanent and irredeemable. In consequence all UK departments have a significant shortfall in senior trainees, this is compounded by hundreds of vacancies for other middle grade and consultant posts. This shortfall affects service delivery and patient safety on a daily basis. The College has called for a minimum of 10 consultants per Emergency Department and 16 in larger units.

The pressure on those in post is relentless and demoralising. Trainees and Consultants alike struggle to maintain morale when forced to work within and deliver care on the very margins of safety. This creates a vicious circle of recruitment and retention failure.76

81. The Emergency Medicine Trainee Association observed in their written evidence that recruitment problems are also the result of “a failure to retain quality EM (emergency medicine) doctors at the middle grade level.”77 Dr Clancy went on to explain in oral evidence the relationship between patient numbers and consultants:

we are seeing about 15 million patients and that there are in the order of 1,400 consultants. That works out at about just over seven consultants per department. We have grown from four or so in 2007, so there has been an expansion, but there are not enough trained emergency physicians to deliver the care that the public expect.78

82. The CEM’s position is that a minimum of 10 consultants are required in order to deliver a 16 hour presence in emergency departments.79 Dr Clancy told the Committee that existing staffing levels allow for a 12 hour presence 77% of the time on weekdays but only 30% of the time at weekends.80 Only 17% of emergency departments in England are able to provide 16 hour consultant coverage during the working week.81 In order to fill the gaps in staffing rotas emergency departments are making use of locums. Dr Clancy said that:

in the key decision makers the vacancy and locum rate, other than consultants, is about 20% plus and the vacancy in locum rate for consultants is about 17%. Trusts at the moment are spending, on average, per trust £500,000 per annum in locum costs

76 Ev 92
77 ES 21, written evidence from the Emergency Medicine Trainee Association, page 1
78 Q 64
79 Ibid
80 Q 69
81 NHS England, June 2013, p 51
for emergency departments. That is a resource that really should be allocated in the future for substantive, trained doctors who want to do this work.82

83. In regard to the future sustainability of the system Dr Clancy added that:

My major concern for the future of the emergency care system is that not enough doctors want to do this work. [...] The challenge that we face is: how do we value this work more highly than we do now and how do we ensure that we attract doctors into this work, which is difficult and hard, in a career that is sustainable? We are asking doctors to work till they are 67. This is tough work that many doctors migrate away from because it is hard.83

Referring not only to A&E consultants but acute medicine in general, Dr Cadigan said that the specialty is not seen as being glamorous because:

If you are a specialist, you tend to work in a specialist unit: you work in an enclave that you can protect in terms of the sorts of patients you accept into that unit; you work with a consistent team; you work on a group of patients that you know you can deliver good results to. When you move outside that specialist environment into the general medical wards, the wards into which patients are admitted if they do not have a very specialist need, such as a heart attack or a stroke, you find a very different environment where you cannot control the patients coming in; where you do not work with a consistent team and you may be working with a different group of doctors every day; where neither the doctors nor the patients benefit from continuity of care; and where, because of the pressure on beds, patients may move from ward to ward four times within the first 48 hours. That is not a professionally rewarding, safe or educationally good environment.84

84. Earl Howe commented that recruitment and retention of trainees is a concern as “the lifestyle is pressurised and there are fewer opportunities for private work.”85 His view is broadly in line with that of the Emergency Medicine Trainee Association who described “brutal working patterns” and reported that:

It is still not uncommon for some juniors to work seven straight nights in EM usually under intense pressure due to the high volume of patients in the department. It is clear that these rotas are not sustainable over the long term and this is a major reason for many excellent EM trainees are choosing other specialties. [...]It is not uncommon for many ED junior doctors to work through an entire shift without a rest break due to the service pressures or having to cover due to gaps in the rota.

They argued in their submission to the Committee that the specific circumstances of emergency medicine demanded a review of the junior doctors’ contract to improve their terms and conditions:

82 Q 73
83 Q 64
84 Q 67
85 Q 287
the new junior doctor’s contract has to recognise that the needs of acute specialties are very different from the non-acute specialties and that ‘a one size fits all’ approach will be disastrous for the specialties such as EM. We believe that special attention should be paid in defining these needs in terms of workable terms and conditions as well as appropriate remuneration. Junior doctors working in EM currently get the same banding as other specialties who do not work under the same intensity or pressure as those working in EM.

85. In evidence Sir Bruce Keogh agreed with the contention that the existing training regime attracts trainees to sub-specialities which are of less value to patients and the NHS than emergency care. Neither Earl Howe nor the Secretary of State would commit to reforming training in order to drive trainees away from more fashionable sub-specialities and into emergency care, and the Secretary of State was more circumspect than Sir Bruce Keogh, saying:

I am not aware that we are training too many doctors in particular specialties. We need more doctors, full stop. We need them in most specialities because of the increase in demand across the system.\(^\text{86}\)

The Secretary of State said that it was Health Education England’s job “to make sure that we have the right number of doctors and nurses with the right skills in the right areas.”\(^\text{87}\)

86. There is a crisis in the recruitment and retention of trainee emergency department consultants. At present trusts are recruiting too many expensive locums at all levels of seniority. The Department of Health, Health Education England and NHS England must work together to address the concerns of trainees and make a career in emergency medicine an attractive option for more young clinicians.

87. The Committee does not believe that attracting and retaining trainees is simply a question of improved remuneration. Trainees will only join a specialty if they are convinced that it offers the prospect of a career that is both professionally and personally rewarding. It is important that Health Education England and Local Education and Training Boards address these issues in order to make emergency medicine an attractive career option.

**Delayed discharge**

88. In April 2013, the Health Foundation reported on a programme implemented by Sheffield Teaching Hospital NHS Trust which had been designed to improve the flow of elderly patients through the hospital. The report highlighted the problems associated with failing to discharge patients at the earliest opportunity:

A consultant analysed the notes of 23 of the 100 patients with the longest lengths of stay. This review highlighted the difference between ‘possible’ length of stay (based on the first definitive note by a geriatrician that the patient was medically fit to be discharged) and ‘actual’ length of stay. The notes revealed multiple points when the
patients could have been discharged. Opportunities were missed partly because the services involved in discharge were unable to respond quickly enough, as a consequence of a mismatch between capacity and varying demand.

As a consequence of delayed discharge, some frail patients deteriorated while others were transferred to other parts of the hospital. These transfers sometimes resulted in vital information being lost, resulting in further deterioration, re-work and delay. On average, patients spent four times longer in hospital than was initially estimated by consultant geriatricians involved in their care. It is estimated that these 23 patients received approximately £471,960 of hospital care that could potentially have been better spent on more appropriate care in their own homes, or on residential or nursing care.88

The case study reached the clear conclusion that delays in discharge not only incurred unnecessary cost but could also result in poor patient outcomes. Commenting on the pressures in the system which have resulted in some emergency departments failing to meet the four-hour target, Dr Cadigan said "it is flow out of the emergency department that is one of the crippling factors."89

89. In oral evidence Mike Farrar told the Committee that achieving smooth patient flow in hospital was dependent on good discharge planning.90 The NHS England A&E improvement plan acknowledges that problems in A&E may the result of failing to discharge patients because of lack of available community and social care services.91 Indeed, UCBs have been tasked with working with local authorities to ensure that early discharge options are available.92

90. The King’s Fund does not believe that delays in discharge are entirely attributable to lack of available social care provision, but they observe that:

Local authorities have tried to protect social care budgets, but net expenditure on adult social care has fallen in real terms for the past two years. The number of people receiving publicly funded social care through local authorities has also continued to fall – by 7 per cent in 2011/12 and by 17 per cent since 2006/7. Over the same period, the number of people aged 85 years and over has risen by more than 20 per cent. A recent survey of Directors of Adult Social Services by the Fund found that transferred NHS money is being used to promote the closer integration of care but in many cases it is being used to offset general service pressures and councils are finding it much harder to find savings that do not impact on the quality or quantity of care (Appleby et al 2013).93
The King’s Fund do not, however, present evidence that the challenges facing social care have directly resulted in reduced availability of social care places to which patients can be discharged.

91. The Foundation Trust Network presented anecdotal evidence from its members of the problems facing acute trusts in this regard. The FTN identified the relationship between delayed discharge, reduced bed capacity and a lack of flexibility in hospitals. They said:

Many hospitals are also facing an urgent and growing problem of not being able to discharge patients in a timely and effective way because of problems in social care stemming from funding cuts due to reduced local authority budgets. FTN members report problems with ‘hospital back door’ discharge, leading to longer stays and higher bed occupancy rates. This rapidly leads to problems coping with ‘hospital front door’ A&E admissions as beds are not available. Small increases in patient acuity – such as a 1% or 2% annual rise – can lead to increased admission levels that hospitals find it very difficult to absorb when they are running at or close to capacity.94

92. Andrew Webster, Associate Director Integrated Care at the Local Government Association (LGA), however, challenged the notion that delayed discharges in relation to the availability of social care were a major factor in the pressures afflicting emergency departments. He told the Committee that:

Many people focus on the issue of whether people are getting stuck in hospitals—what are described as delayed discharges. Those are actually going down, and those that are attributable to social care are going down faster than those that are attributable to things in the health system.95

Additional written evidence submitted by the LGA bears out this claim. They quote statistics published by NHS which show that:

In 2012/13, the daily average number of delayed transfers of care per 100,000 population (aged 18+) was 9.5, which compares to 9.7 in 2011/12.

On delays attributable to local government going down

In 2012/13 the daily average number of delayed transfers of care attributable to social care per 100,000 population was 3.3, which compares with 3.7 in 2011/12.96

93. Earl Howe told the Committee that:

about 3% of total bed days are due to delayed discharges, with approximately 2% of occupied beds being delayed. So the long-term trend has reached a plateau. It is sticking at around the level of 2,000 acute patients. Before, it was around 7,000.

94 ES 37, written evidence from the Foundation Trust Network, para 33
95 Q 167
96 Ev 112
We, nevertheless, find the disparity between the anecdotal evidence of health professionals and the formal statistics striking. The Secretary of State conceded as much in oral evidence and he observed:

when you talk to chief executives of hospitals and to A and E departments and ask, “What is the biggest single pressure that is a worry for you in terms of hitting your 95% target?”, they say it is the lack of availability of beds in the hospital to admit people who need admitting. In the last few months, nearly all the chief executives have said that they have approximately two wards full of people who could be discharged but they are not able to discharge.⁹⁷

94. The national data available on delayed discharges contradicts the evidence of clinicians and managers across the acute sector. The Committee believes that the data is incredible and we recommend that Ministers swiftly investigate the method of data collection in order to understand whether the available figures genuinely reflect the situation on the ground.

95. More important than national data collection is the delivery of accurate information to local system managers. The Committee received strong evidence to suggest that delayed discharges were a significant threat to patient flow, and therefore to care quality. We recommend that NHS England should require each area’s Urgent Care Plan to include an assessment of the impact of delayed discharges on patient flows and a plan to address the issue.

**Tariffs**

96. The NHS Confederation explained in written evidence that the rationale for the 70–30 tariff split was to provide acute trusts with an incentive to discover new ways to reduce demand.⁹⁸ Mike Farrar described this as having failed because it was “patently clear that supply induced demand is not the driver here”.⁹⁹ The NHS Confederation argued that what the marginal tariff has achieved is to:

substantially increase the already intense financial pressures on acute trusts with emergency departments. Furthermore, the marginal tariff has in practice transferred the risk to providers and has not created a shared imperative for commissioners to actively engage with this issue and make changes to the local health service which will tackle rising demand.

The Shelford Group observed in their submission to the Committee that the problems associated with the marginal tariff were compounded for the largest specialist hospital in a health community. This is because patients in emergency departments “can often by-pass other more local providers to receive care.”¹⁰⁰

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⁹⁷ HC 119-iii, Q 240
⁹⁸ Ev 100
⁹⁹ Q 74
¹⁰⁰ ES 40, written evidence from the Shelford Group, para 19
97. Discussing the way in which the tariff paid to hospitals operates, Professor Willett told the Committee that:

At the moment, we pay a hospital by the admitting diagnosis of the patient and the reference cost set by the average length of stay across the country in previous years. The difficulty is that [...] if the admitting diagnosis happens to be a urinary infection but they have rheumatoid arthritis and had a stroke last year and so on, what determines how long they stay in hospital is not the fact they came in with a urinary infection but that their dependency is much greater than someone who came in who just had that infection.101

The College of Emergency Medicine expressed frustration with the existing arrangements noting that “resuscitation is remunerated at a lower value than a routine out-patient attendance.”102 The NHS Confederation was critical of the way in which payment systems have been developed and said that tariffs must be reformed to:

incentivise better joint working, more focus on intervention and greater investment in community services, all of which would relieve the pressures on urgent and emergency care.103

They concluded that:

The various payment systems, such as tariff, currencies and payment by results, have often been developed in an ad hoc way to address various issues and plug particular gaps across the system.104

98. Dr Cadigan noted that that there are examples of single commissioners successfully working with providers to reduce admissions. He said that those that have achieved this “have dismantled payment by results.”105 Further to this Dr Cadigan explained that:

one of the things that is done in successful groups that have achieved integrated care [...] is that they have reached mutual arrangements to dismantle standard payment by results and gone for shared financial incentives and shared financial risk solutions.106

99. The current arrangements for remunerating A&E departments with only 30% of the tariff for activity over 2008–09 levels is no longer viable. The baseline is five years old and does not account for, or reflect, the pressures that hospitals face. As part of its review of the marginal tariff, Monitor should seek options which minimise the twin dangers of perverse incentives and excessive complexity. Incentivising all providers to direct patients to the correct treatment option, however they come into contact with the NHS, should be the over-riding priority.
6 Alternatives to A&E

Primary care

100. The King’s Fund’s evidence represents a broadly held view that attempts to provide better access to primary care services via the development of walk-in-centres has resulted in an overall increase in demand:

There have been many attempts to divert people from A&E services over many years by providing alternative primary care type services. These schemes appear mainly to increase overall demand, particularly for minor injury and illness, and have also had the effect of creating a highly fragmented system which generates confusion among GPs and other referrers about how and where to access care. There is anecdotal evidence that patients are also confused and turn to A&E services as they have confidence in them and find them easy to access.107

In its evidence to the Committee, the Department of Health does not challenge this view. They recognise that:

there is evidence that the creation of lower acuity facilities, categorised as ‘Type 3’ (Minor Injuries Units, Walk in Centres; Urgent Care Centres), does not reduce the burden on neighbouring A&E departments.108

101. The RCGP challenge this notion and say that walk-in centres (with the term used in the general sense) have managed to relieve pressure on emergency care and GPs. Dr Gerada said:

We saw 160,000 walk-ins at one of our sites. We surveyed them and asked, “If we did not exist, where would you go?” Nearly 40% said they would go to the local A and E department; 6% said they would go to NHS Direct; 9% said they would go to the GP co-op; and 20% said they would go to their own GP—so it is clearly reducing the demand on their own GP. We then have “other”. In essence, what we are picking up—we know this anecdotally, as we ask them where they would go—is that they would go to their emergency department. [...] Increasingly, the GP is being replaced by the walk-in clinic. Rather than saying that we are creating demand, what we must do is simplify the system.109

The Committee does not contest the suggestion that type 3 urgent care centres and minor injury units and type 4 walk-in centres in certain areas limit demand that would otherwise present elsewhere in the system. Equally, we do not believe this argument is inconsistent with the King’s Fund’s analysis, and that of the Department, that the creation of these centres has induced supply-led demand.
102. The Department of Health has yet to illustrate how primary care should be restructured to support A&E, but they do say that “the need to ensure that there is an integrated system with clear points of access is fundamental to the objectives of the Urgent and Emergency Care Review.”\textsuperscript{110} As part of the fourth system objective for the future urgent and emergency care system, NHS England say that possible options to ensure same day access to primary include:

- Same day, every-day telephone, web or email contact to a primary care team integrated with patient’s own GP practice
- A same-day, every-day appointment system for urgent care facilities
- Direct access to community nurse specialists and hospital specialist teams for patients with long term conditions
- GPs/Out-of-Hours teams to have easy direct access to same day opinion from hospital specialists 7/7\textsuperscript{111}

103. The Department of Health’s written evidence argues that A&E attendances could be reduced if patients understood better what services were available:

Primary care could more appropriately treat many of the patients that dial 999 for an ambulance. Until now urgent and emergency care has been fragmented and disconnected, as patients often do not know where they should go when they have an urgent care need that is not life threatening. This has led to inconsistencies in the responses and treatment patients receive. These include preventing cross referral, the need to re-triage at each step using different clinical assessment tools, patients being referred to services that do not have the skills they require or patients simply not knowing where and how they can access urgent care – and as a result dialling 999.\textsuperscript{112}

104. In addition, the Department cites evidence which concludes that emergency departments are undertaking work that can reasonably be regarded as primary care.

The Primary Care Foundation’s report Primary Care and Emergency Departments (March 2010) found that, when it used a consistent definition and a consistent denominator of all emergency department cases, the proportion that could be classified as primary care cases (types that are regularly seen in general practice) was between 10% and 30%.\textsuperscript{113}

Dr Gerada, however, questioned whether primary care had the capacity to undertake additional work, pointing out that excess pressure would always manifest itself and if one part of the system was squeezed the pressure would appear elsewhere.\textsuperscript{114}

\textsuperscript{110} Ev 69
\textsuperscript{111} NHS England, June 2012, p 6
\textsuperscript{112} Ev 68
\textsuperscript{113} Ev 68
\textsuperscript{114} Q 170
105. Dr Cadigan said in evidence that he believed there to be a relationship between the availability of the GP appointments and A&E attendances. He added that there was evidence that continuity of care with a GP is correlated with reduced referral rates to hospital.\textsuperscript{115} NHS England’s review of evidence for the Emergency and Urgent Care Review found that there were correlations between patient satisfaction with GP services and their use of other NHS services. In addition they identified research by the King’s Fund which said that patients who are not satisfied with their GP practice “resort to urgent and emergency care services for primary care needs.”\textsuperscript{116}

106. The School of Public Health at Imperial College London published research in June 2013 which found a link between the availability of appointments with GPs and A&E attendance. The researchers concluded that:

\begin{quote}
the rate of A&E visits for the fifth of practices with the best access was 10.2 per cent lower than the fifth of practices with the worst access. If the bottom fifth had performed as well as the top fifth, the researchers estimate this would have resulted in 111,739 fewer A&E visits for the year.\textsuperscript{117}
\end{quote}

107. In the long term, a transfer of funding from the acute sector into primary care is required. Better signposting for patients is likely to stimulate demand in primary care and this transfer of resource will be required to provide the necessary capacity.

108. The Committee strongly believes that primary care has an important role to play in delivering accessible, high quality urgent care. However the service structure required to deliver this objective is different from the structure required to deliver ‘care to patients with complex needs and deal with uncertainty in acute conditions’. The Committee does not favour a single blueprint from the Department or NHS England. The Committee recommends that NHS England (as the commissioner of GP services) should seek innovative proposals for the development of community-based urgent care services in each area. These proposals should include consideration of step–up and step–down care and they should be properly integrated into the rest of the urgent care system in that area. NHS England should be open-minded about how such a service should be provided.

\textit{Elderly patients}

109. Over the course of this inquiry the Committee has heard consistently that emergency departments are treating increasing numbers of older patients, and this is borne out by the figures referred to in chapter 1. Ambulance providers have told us that nursing homes are very regular users of the service and that they are now looking at ways of reducing call outs,\textsuperscript{118} while Dr Cadigan told us that:

\begin{quote}
115 Q 28
116 NHS England, June 2013, p 23
117 http://www3.imperial.ac.uk/newsandeventspggrp/imperialcollege/newssummary/news_12-6-2013-12-2-28
118 Q 113, Q116
\end{quote}
it would be naive—and this was said by the national clinical director for elderly care—to believe that any time soon there will be a reduction in the rate of acutely ill elderly patients coming to hospital.\textsuperscript{119}

Dr Cadigan observed that some localities did perform better in avoiding hospital admissions for elderly patients than others and there were:

health economies that have a large population of elderly people living in them have better hospital avoidance rates and lower hospital admission rates than other health economies.\textsuperscript{120}

Earl Howe outlined how some GPs work with care homes to help educate them in caring for people with specific conditions.\textsuperscript{121} The Secretary of State, however, summarised the existing circumstances succinctly by saying:

one of the issues at the heart of what is creating the pressure in A and E is vulnerable older people who are going into A and E departments who could be much better looked after in the community.\textsuperscript{122}

110. The Secretary of State told the Committee that older patients are the "group of people we let down the most in the NHS at the moment." We agree.

111. We therefore repeat our recommendation set out at paragraph 108 that NHS England should seek proposals for new models of primary care provision which address directly the needs of this group of patients and which are fully integrated into the requirement to meet all their care needs. The Committee believes that that NHS England should be open-minded about potential providers of these services, but they will need to address at least the following issues:

\begin{itemize}
\item[a)] Clinical responsibility for out of hours care;
\item[b)] Relationships with social care (including carer support), social housing, residential care, hospital services and ambulance services, and
\item[c)] High quality end of life care.
\end{itemize}

\textbf{Urgent Care Centres}

112. The integration of urgent care centres with emergency departments is regarded by witnesses as a positive step in clarifying the organisation of services. The CEM said they acknowledged "the valuable contribution to out of hours care made by minor injury units and walk in centres."\textsuperscript{123} They noted, however, that a "lack of consistent opening hours and
resources (e.g. X-ray facilities) ensure they are sub-optimally used.” The CEM went on to argue that:

where geographically practical these (urgent care centres) should be co-located with the Emergency Department. This allows patients to present, confident that they will be seen by the most appropriate and first available person. In addition duplication is avoided and cost effectiveness is increased. Staff can be easily rotated to enhance skill acquisition and retention.

113. Dr Gerada described the benefits of this approach to the Committee:

Across the country, GP-led walk-in clinics are working very closely with their foundation trusts [...] to develop an integrated approach. For example, you might have a front end of urgent and emergency care [...] that is manned by the same admin staff. At the next stage, where you get triage, they triage to the different parts of the service—left, emergency; right, GP walk-in clinic—with integration between the two, if it is wrong.

Professor Willett noted that:

It is the most efficient model, as patients who arrive at a setting can be triaged into the right pathway. There is also the ability for the general practitioners who are running the urgent care centre and, perhaps, the emergency nurse practitioners to work across both—and for patients to move across both.

He warned however that this model could only operate efficiently in urban areas and that it was often not an appropriate structure for rural locations.

114. The Committee welcomes the development of Urgent Care Centres on hospital sites and accepts the evidence that these units can improve the quality and efficiency of emergency care. We recommend that UCBs should actively consider the development of such centres on acute hospital sites where there do not currently exist, although we accept Professor Willett’s warning that they can be a variety of reasons why the model does not fit every circumstance.

115. The Committee also accepts that the warning of the College of Emergency Medicine that patients will continue to find the organisation of urgent care baffling if similar phrases mean different things in different places. Extensive application of the principles of Urgent Care Centres need to be backed up by clear objectives, clearly communicated.
NHS 111

Implementation

116. The requirement for clear objectives, clearly communicated, is well illustrated by the sorry saga of NHS 111. Commenting on the implementation of NHS 111 the Secretary of State described the benefits associated with the basic principles of the service:

The underlying concept is one that everyone can agree with: it is a simple number that everyone can remember; the fact you are connected directly to a clinician, if you need to speak to one, rather than being called back is something people like; the idea that you are triaged only once and do not have to repeat your story lots and lots of times is a good one; and the fact you can have a service that is broader than the old NHS Direct.

117. NHS Direct submitted evidence to the inquiry examining the operation of NHS 111 which the department says “will get patients to the right place, first time”. NHS Direct observed in their evidence that whilst the intention might be to signpost patients accurately, reducing demand was not at the heart of NHS 111. They said:

As Professor Matthew Cooke, then National Clinical Director responsible for NHS 111, made clear “NHS 111 was not introduced to reduce use of NHS services. It was introduced to simplify and improve access to urgent care services for the public and patients”. It is therefore not surprising that in the NHS 111 pilots run by NHS Direct only about 8% of patients using the service were given advice to look after themselves without the need for onward referral.

118. NHS Direct also provided evidence which compared the skills and knowledge of call handlers in 111 with those in the NHS Direct service. They say:

In the NHS Direct 0845 service, callers are initially assessed by a trained ‘Health Advisor’, with approximately 1 in 2 passed on to speak to a nurse to receive a more detailed clinical assessment. In NHS 111, all patients are assessed by a call handler using the NHS Pathways system, with about 1 in 5 passed on to a nurse who ‘validates’ the outcome reached by the call handler or assesses patients with more complex needs. The clinical content of Pathways deals with the emergency cases such as chest pain and breathing difficulties, but appears less able to support call handlers to signpost callers to an appropriate level of care. As a result of less clinical input a far higher proportion of callers [are] being directed to other NHS services rather than supported to care for themselves.

Their evidence adds that following the roll-out of NHS 111 “the most significant issue was that calls took more than twice as long as expected.” The Medical Care Research Unit at Sheffield University say in their evidence that a possible explanation for the problems

129Ev 68
130ES 31, written evidence from NHS Direct NHS Trust, para 6
131Ibid, para 7
132Ibid, para 24
experienced by NHS 111 in recent months includes “the use of non-clinical call handlers has meant training a whole new workforce.”

119. The Department of Health’s evidence says that it is too early judge what impact NHS 111 has had on A&E admissions. They refer to the pilot programmes for some evidence but note that “the small scale of the pilots, along with inconsistent control sites, and the short time frame that the evaluation was looking at meant the conclusions were limited.” NHS Direct build on this point, questioning the procurement process for NHS 111. They say in their written evidence that:

The procurement process for NHS 111 has led to the imposition of contracts which are contributing to the poor performance of NHS 111 services around the country. [...] In many cases, those responsible for procurement had no stake in the sustainability of the service they were commissioning. Tendering took place in advance of the publication of the evaluation of the pilots and with limited meaningful clinical input from the embryonic CCGs.

120. Supplementary evidence from the Department confirms that in August 2011 Strategic Health Authorities were asked to submit their firm plans to complete the “rollout of the NHS 111 service by April 2013.” The final report of the first four pilot locations was not published until over a year later in October 2012. Earl Howe said that the 111 pilots produced mixed results but he argued that the high degree of patient satisfaction provided sufficient evidence to launch the service. Earl Howe added that issues related to A&E attendance and the effect on demand for primary care were not deciding factors, as the department was “clear that it was a good service.”

121. In written evidence the Medical Care Research Unit at the University of Sheffield explained that it was as a result of a change in Government policy that NHS 111 was rolled out before they were able to complete their assessment of the service. They say that “the decision to roll out the service was taken by a new ministerial team in 2010 – before the pilot sites had gone live.” They agree with Earl Howe that the pilots did record a high degree of patient satisfaction but also point out that “during the pilot sites NHS Direct was also still operational.”

122. The decision to roll out NHS 111 was made before any evidence had been gathered to assess the strength of the service it could deliver. The service was shaped on patchy
evidence despite the results from a small number of pilots questioning the ability of the service to divert demand away from urgent and emergency care services. The Committee concludes that the national deployment for NHS 111 was undertaken prematurely and without a sufficiently sound evidence base.

Assessment

123. Dr Cadigan told the Committee that the NHS 111 IT system is inherently risk-averse. Dr Cadigan said:

I think experience and judgment can trump an algorithm. The algorithms are risk-averse because, rightly, we do not want to get it wrong. It is a big responsibility for the people who are taking those calls, and that is why it is set in that way. One of the consequences of having that approach is that the referral rates, I suspect, will increase. One of the values of having an experienced clinical judgment at the beginning is that you can add more to the judgment than an algorithm.143

Dr Gerada concurred with this argument, saying:

Whereas NHS Direct was a clinician and very good nurse able to triage, we have gone to 111, which essentially is someone trained for six weeks and a computer. The computer says, “Go to A and E,” and that is what happens.144

124. NHS England partially acknowledges this criticism in the design objectives included in the Emergency and Urgent Care Review. They suggest greater clinical input in 111 telephone triage in cases “where hospital transfer is recommended or for complex enquiries.”145 Dame Barbara Hakin cautioned that what was important was to ensure clinical input was available “at the right stage in the patients’ journey”146 and this did not mean that clinicians should be answering calls. Professor Willett added that an enormous amount of nursing time would be wasted if nurses dealt with every call.147 Dame Barbara confirmed that the ratio of call handlers to nurses is 4:1.148

125. The Committee is concerned that NHS 111 did not apply the principle of seeking early engagement by a senior clinician, with the result that many calls took longer than necessary and some patients were advised to attend A&E but did not, in the event, need to be there. We recommend that, as part of its workstream examining the future strategic direction of NHS 111, NHS England attributes a higher priority to the principle of early clinical assessment.

126. In its current form, we do not believe that NHS 111 is in a position to reduce unnecessary A&E attendances. Whilst this is not one of the core objectives of NHS 111, the purpose of the service is to direct patients to the most appropriate care service. Given the

143 Q 41
144 Q 185
145 NHS England, June 2013, p 6
146 Q 342
147 Q 344
148 Q 343
number of inappropriate emergency department attendances, a successful NHS 111 service would, in achieving its own objective, divert patients away from emergency departments. However, NHS 111 must always err on the side of caution and present the patient with the safest option which may compromise attempts to keep patients out of A&E. We are concerned that patients will not value a service which relies on a non-clinical call handler working through an IT-generated script when the alternative option is to visit the local A&E.

127. The Committee accepts that a recognisable telephone led non-emergency service is useful but it is not yet convinced that the balance between “triage” and early access to a senior clinician is right. The Committee recommends that this balance should be actively reviewed by NHS England as part of the ongoing development of NHS 111.
7 Ambulance services

Improving emergency care

Demand

128. It is clear from the evidence presented to the Committee that demand for ambulance services has increased substantially in recent months. The Association of Ambulance Chief Executives (AACE) report that in 2011–12, the total number of emergency calls was 8.49 million; this was an increase of 415,487 (5.1%) over 2010–11.149 As of February 2013, of the 12 ambulance trusts in England, only London, the North East, the West Midlands and the Isle of Wight were meeting the core target of responding to 75% of ‘red 1 calls’ within 8 minutes.

129. The King’s Fund undertook an analysis of the performance of ambulance services in southern England as part of their review of urgent and emergency care. The review found that:

Ambulance services are reporting significant increases in demand across all types of calls. A recent review by South Central Ambulance Service NHS Foundation Trust of ambulance demand over a 3-month period (Sept–Nov 2012, compared to Sept–Nov 2011) found that there was an increase in demand for ambulances, but the range between areas was quite significant (the lowest was 1.94% and highest was 11.6%). The review also found:

- There was uncertainty as to whether 111 is driving up ambulance call outs
- For most areas (but not all) the majority of the increase was in out of hours calls
- In all areas there were only small increases in calls from care homes
- There is a fair amount of variation between areas in the main health conditions accounting for the increase in calls, although psychiatric conditions accounted for 10%+ increase in four areas and falls accounted for 10%+ in three areas.150

Staffing

130. The South Western Ambulance Service NHS Foundation Trust (SWASFT) made the case in its written evidence that the nature of the service determined that staffing levels could not simply be reactive to short term trends in demand. They say that:

The 999 service is described as a “waiting service”. In other words regardless of activity levels (unplanned) sufficient resource must be available to respond to an emergency call whenever and wherever it is received.151

149 Ev 106
150 The King’s Fund, March 2013, p 12
151 ES 05, written evidence from South Western Ambulance Service NHS Foundation Trust, p 1
131. The West Midlands Ambulance Service NHS Foundation trust (WMAS) believes that a workforce predominantly made up of paramedics can alleviate demand in A&E, even if this does not mean an overall reduction in demand for health services. They say that “moving towards a target of 70% of frontline staff who are Paramedic trained” will:

ensure that every patient can be guaranteed to receive Paramedic care which will increase the proportion of patients treated at scene and therefore reduce the number of patients conveyed to Emergency Departments.\(^\text{152}\)

132. Mark Docherty explained the benefits of this in more detail, telling the Committee that:

It is taking time for skill mixes to increase, but in some parts of the country, we are getting close to a 70% paramedic skill mix. The significance of the 70% paramedic skill mix is that with that skill mix you can ensure that every vehicle has a paramedic on board, so that whichever vehicle responds to the patient the first response that gets to the patient will include a paramedic. Up to now, that has not been possible. With a less than 70% skill mix, that will always be a challenge, but most ambulance services are increasing their skill mix fairly rapidly.\(^\text{153}\)

133. Supplementary evidence provided by AACE shows that the current number of paramedics as a proportion of ambulance crews across the 10 mainland ambulance trusts in England stood at 62%. The numbers ranged from a low point of 50% in the East of England to 66% in the West Midlands. Professor Willett questioned the reasoning behind the 70% objective, suggesting that there was no firm evidence base to support the figure.

134. In oral evidence Mike Farrar acknowledged the importance of equipping ambulance services with skilled paramedics who were able to make clinical judgements:

all the evidence is showing that the investment in ambulance services, in having good qualified paramedic support on ambulances, is helping to relieve pressure on both attendances and potential length of stay for people with conditions if they are admitted.\(^\text{154}\)

135. The Urgent and Emergency Care Review acknowledges the significance of utilising paramedics at “key decision points”\(^\text{155}\) and also specifically acknowledges that high quality care can be achieved by bypassing some emergency facilities and instead sending patients:

to specialist centres for stroke, heart attack, major trauma and specialist children’s services; those centres to have consistent network pathways and concentrate expertise to improve patient outcomes and efficiency.\(^\text{156}\)

Mr Marsh built on this, pointing out that new structures in emergency care and the centralisation of some services would require paramedics with greater clinical skill and

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\(^{152}\) Ev 85
\(^{153}\) Q 111
\(^{154}\) Q 82
\(^{155}\) NHS England, June 2013, p 6
\(^{156}\) Ibid, p 7
knowledge. He explained that it was advanced paramedics who would make the decision to bypass local A&E services and to transfer a patient directly to a regional trauma centre.\textsuperscript{157}

136. The Royal College of Nursing, however, warned that numbers of fully qualified paramedics might be falling:

Ambulance services have no control over their patient load, this makes finding efficiencies and financial savings particularly difficult. This means in parts of the country there are recruitment freezes and an increasing ratio of technicians to fully qualified paramedics.\textsuperscript{158}

Unison expressed concern in their evidence that in some trusts staff numbers were falling:

Within the East of England Ambulance Trust there has been a reduction in the number of staff and vehicles delivering emergency response services across the area at a time when demands on the service are increasing and population numbers are rising. During this time the employer had decided to reduce the number of staff and vehicles delivering emergency response services.\textsuperscript{159}

They also questioned whether ambulance trusts were, in practice, moving towards a position where every vehicle would be crewed by a fully-qualified paramedic. They said:

As a result of the drive for efficiency savings, the deployment of double crewed Emergency Care Assistants (ECAs) is becoming an increasing common policy in some ambulance trusts, despite advice from other trusts who have discarded this model due to the clinical risks involved. ECAs receive basic training, are not subject to registration by the Health and Care Professions Council and, unlike paramedics, are unable to administer medication if an emergency arises.\textsuperscript{160}

137. Professor Willett emphasised the importance in rural areas of having a highly skilled ambulance workforce. He said:

What a skilled paramedic can do in an ambulance now is most of what we spent the first 30 minutes doing in A and E 10 or 15 years ago, so the options are very different. One of the things for remote and rural communities is to supply at the scene in an emergency the skill set that is most likely to be able to maintain the patient there or to temporise until the local general practitioner arrives.\textsuperscript{161}

138. Skilled paramedics are trained to make better clinical judgements and administer care more appropriately than ambulance technicians. Ambulance paramedics will increasingly require the skills and knowledge to judge whether patients should be treated at local emergency departments or regional specialist units. Ambulance trusts that service rural areas should also recognise that with sufficient staffing, ambulance crews can treat more people at the scenes of incidents and prevent unnecessary and lengthy journeys to hospital.

\begin{itemize}
\item \textsuperscript{157} Q 105
\item \textsuperscript{158} ES 15, written evidence from the Royal College of Nursing, para 8.1
\item \textsuperscript{159} ES 23, written evidence from UNISON, para 12
\item \textsuperscript{160} Ibid, para 14
\item \textsuperscript{161} Q 313
\end{itemize}
139. Ambulance services must demonstrate a commitment to establishing a ratio of paramedics to technicians which ensures that ambulance crews are able to regard conveyance to an emergency department as only one of a range of clinical options open to them. We recommend that NHS England undertakes research to establish the precise relationship between more highly-skilled ambulance crews and reduced conveyance rates.

**Developing the functions of ambulance services**

140. The King’s Fund analysis in southern England concluded that there was a general consensus that the potential of ambulance services was under-used and could contribute a great deal more to managing demand pressures and the development of new care models. The Department of Health’s evidence emphasised the ability of ambulance services to deliver efficiencies across the whole system rather than within the ambulance service itself. The Department believed that ambulance services could be developed to limit the number of patients conveyed to A&E units:

> There is some potential to further reduce the number of patients transported to hospital by ambulances and to provide more efficient and local care. The number of calls to the ambulance services which are managed through clinical telephone advice has increased significantly over the last five years. Almost 90% of these calls result in no vehicle being sent to the scene (where clinically safe and appropriate). Compared to 1999/2000 levels, there are now 10 fewer patient journeys per 100 ambulance incidents, which reflects the increased use of ‘see and treat’ and other efforts to provide levels of care that meet the clinical needs of the patient.\(^{162}\)

141. The Department’s evidence acknowledged the consensus that a skilled paramedic workforce was central to achieving the ambition of treating and discharging patients at the scene of a call out. They outlined the provision of care by paramedics and explained that:

> Two models of ‘see and treat’ have emerged. Firstly, there are some Trusts with much larger numbers of Advanced Practitioners who require very little clinical field support and act as autonomous practitioners. Secondly, there is a mixed model where, particularly in urban areas (which often do not have good primary care services but greater numbers of acute trusts) existing Paramedics are used to undertake ‘see and treat’ work and are supported by a network of clinical field supervisors.

> Both models can work and a further assessment of their relative benefits will be needed. However there is still considerable variation in conveyance rates between ambulance services, and more could be done to develop and support ambulance clinicians.\(^{163}\)

142. The WMAS say that as a result of a range of initiatives they reduced conveyance rates “from 70% to less than 58% from 2009–10 to the end of 2012–13”.\(^{164}\) However, “despite...
these initiatives WMAS staff are frequently called as a last resort for patients who cannot understand or access the services that are available to them.165

**Integrating ambulance services into healthcare provision**

143. In evidence to the Committee Anthony Marsh, Chair of the Association of Ambulance Chief Executives and Chief Executive of the West Midlands Ambulance Service, made the case that reforms were not simply required in relation to staffing levels and improving the skills mix of ambulance crews. He outlined the case for improving paramedics’ access to nationally-held patient data in order to make more informed judgements regarding a patient’s treatment. He told the Committee that:

> It would also be enormously helpful for front-line paramedics—both those in the control room and responding paramedics—to have access to the national spine, which would enable them to pull down useful and critical information about a particular patient, rather than looking at patients with very limited information, as is very often the case.166

144. As part of the process of ensuring that care is delivered efficiently, objective 9 of the Urgent and Emergency Care Review acknowledges the critical importance of information being available to all those treating a patient. The review suggests making all patient care records accessible and shared amongst all urgent and emergency care providers.167 It should be noted, however, that Mr Marsh did not ask that paramedics have access to all historic patient information, but just the key data that could inform decision making in emergency cases. Professor Willett said it was “inexplicable” that some ambulance crews were unable to access the minimum patient record which showed key information and their most recent medical history.168

145. In addition Mr Marsh demonstrated the need to rectify basic elements of integrated working between the ambulance service and primary care. He said that:

> One thing we have really been pushing for, both locally and nationally, is for ambulance paramedics to have access both to the doctor in hours and to out-of-hours providers, so that you can have that clinical conversation.169

In their written evidence, the CEM said that emergency departments ended up seeing patients who were transported to them by ambulance crews even though:

> “they often recognise that patients could be better managed by GP review in the home (in particular those residing in residential and nursing homes) but cannot get rapid access to GPs.”170

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165 Ev 85
166 Q 108
167 NHS England, June 2013, p 11
168 Q 365
169 Q 141
170 Ev 94
146. An ambulance service that operates as a care provider in its own right can help coordinate the delivery of care by other parts of the system such as emergency departments, NHS 111 and primary care. Therefore, the Committee believes that ambulance services have the potential to drive collaborative working and integration in emergency and urgent care. This is of particular value in rural areas where there cannot be the same concentration of services that would be found in an urban location.

147. **There is still a considerable variation in conveyance rates across ambulance trusts.** NHS England should take the lead in reviewing the various staffing models used by different trusts to help understand which structures are most effective in reducing conveyance rates and putting patients on the correct pathway. This should establish an evidence base for both urban and rural settings to help ambulance trusts determine how they organise their resources and workforce.

148. Ensuring that all ambulance crews have access to national patient data would increase the patient information available and allow for better decisions to be made regarding conveyance and care. The Committee recommends that UCBs take the lead in assessing access to the National Spine for all key parties in the delivery of emergency care and coordinate plans to ensure that the minimum patient record is made available.

**Incentives**

149. The tariff paid to ambulance providers is significant in shaping the service available to patients. Professor Willett told the Committee that the ambulance service tariff was being restructured so that services could be paid for "receiving the call, hearing and treating and [...] seeing and treating. In written evidence the Department said that:

> In April 2012, the Department of Health published a currency for the contracting of emergency and urgent ambulance services, in order to allow locally appropriate ambulance care which may not involve conveyance, where such care is appropriate. The four categories are:

- Urgent and Emergency Calls Answered
- Hear and Treat/Refer
- See and Treat/Refer
- See, Treat and Convey

Professor Willett emphasised that the new tariff was designed to be agreed locally. Sir David Nicholson described his ambition for the ambulance service, saying:

> The priority for us over the next period is to make sure that the payment structures give the right incentives to enable ambulance services to play a much wider role in providing health services.
150. The Department’s evidence also explained how incentives had been used to tackle handover delays between ambulance crews and staff in emergency departments. The Department said that the problem of handover delays was complex and would require a whole system approach to rectify. They added, however, that as part of new key performance measures contractual fines could now be imposed on ambulance trusts for delays of over 30 minutes. The WMAS believed that financial penalties might deliver a short term effect on behaviour but they would not “resolve what seems to be a problem of a lack of resource planning and utilisation in A&E units”. The AACE took a similar view and did not believe that financial penalties were a long-term solution. They attributed delays to:

- ownership by hospital/health system leaders;
- A&E capacity;
- A&E integration with the rest of the hospital;
- timeliness of in-Trust escalation;
- reductions in physical bed capacity within hospitals and the community;
- attitude and behaviour towards handover delays within the hospital; and
- the effectiveness of urgent care pathways keeping demand away from the front door.

151. The Committee believes it is vital that commissioners successfully introduce tariffs which encourage ambulance providers to ‘hear and treat’ and ‘see and treat’ patients. Such encouragement would provide ambulance trusts with further incentives to develop a skilled workforce predominantly made up of paramedics. This would be of particular benefit to patients in rural areas who have only limited access to services.

152. A service that is paid to transport patients will employ technicians to facilitate this; one that is paid to treat patients will invest in recruiting and training paramedics. The Committee therefore urges NHS England to closely monitor the relationship between the use of the new tariffs, conveyance rates and the balance between technicians and paramedics in ambulance trusts.

153. The Committee is concerned that blunt contractual penalties are the main measure that have been applied to improve handover times. Delayed handover is a symptom of the wider demand pressures that exist across the service and most acutely in emergency departments. Unless reforms are implemented across the urgent and emergency care system, delayed handover will be a recurring concern. Emergency and urgent care providers are interdependent and therefore contractual fines targeted at one part of the system will provide only short-term relief rather than a long-term cure.

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174 Ev 73
175 Ev 87
176 Ev 106–107
Conclusions and recommendations

Growing demand
1. The Committee was surprised by the lack of clear evidence about trends in the level and nature of demand for urgent and emergency care. There is a pressing need for clearer information to be produced which can detail where urgent care cases present across the system and the case mix of urgent patient presentations; it is also important to monitor waiting times for urgent and emergency services in order to ensure that services are accessible to patients in urgent need of care. The Committee recommends that NHS England should ensure this data is collected and reported on a consistent basis across the country. (Paragraph 24)

Root cause analysis
2. The emergency and urgent care functions of the NHS are undoubtedly working under stress and there is insufficient resilience in the system. Availability of a hospital bed when required is a fundamental part of an emergency care system. Successful delivery of this basic requirement is, however, dependent on the ability of the system to understand the demands made upon it and to deploy its resources in the most effective way. Rising demand for hospital admissions may be as much a symptom of system failure (for example, failure to provide timely care in a patient’s home) as it is of an underlying rise of demand. Until these systems failures are addressed, hospital management need to ensure that there is sufficient bed capacity available to meet current demand. (Paragraph 29)

3. The system cannot accurately analyse the cause of the problem, still less resolve it, if it continues to “fly blind”. More accurate information about the causes of rising service pressures is not simply a management convenience; it is fundamental to the delivery of high quality care. (Paragraph 30)

Fragmentation
4. The successful provision of emergency and urgent care is a matter of life and death and therefore clarity in commissioning is vital. The Committee is concerned that the lines of responsibility and accountability for funding and managing services have been blurred. The Committee notes the concept of UCBs putting local clinicians and commissioners together to make practical changes and plan service improvement, but it is concerning that new structures are required so soon after the establishment of CCGs and Health and Wellbeing Boards. Health and Wellbeing Boards have made an uncertain start but retain broad support and they are structured to bring all parts of the system together. The current problems should, theoretically, have provided them with an opportunity to develop their functions, but they appear to have been superseded by UCBs. (Paragraph 36)
**Simplifying commissioning**

5. We recommend that CCGs and Health and Wellbeing Boards explore the benefits of establishing single commissioning teams for out of hours care, ambulance services, 999, and NHS 111. A single commissioner can lead across CCG boundaries in the case of services which are most appropriately commissioned on a regional or sub-regional basis. Fragmented commissioning and provision results in a situation where patients are unaware of many available services or are unsure of the most appropriate service. The single commissioning teams for urgent care should take responsibility for signposting patients to available services. (Paragraph 39)

**Funding**

6. The Committee was disappointed with the evidence that was presented about the creation of UCBs. Ministers are relying on UCBs to implement short-term practical changes to improve hospital performance, but the composition, responsibilities and authority of UCBs remain unclear. There is little evidence that any form of national strategy exists beyond the creation of UCBs, and senior figures in NHS England could not tell us precisely how many UCBs have been established. (Paragraph 54)

7. The evidence presented to the Committee did not persuade us that the structures existed to enable UCBs to implement reforms or influence local commissioning arrangements. The Committee believes that Ministers need to seek much greater clarity from NHS England about its plans for UCBs and ensure that they, or Health and Wellbeing Boards, are required to account for an Urgent Care Plan for their area in the winter and spring of 2013–14. The Committee recommends that NHS England should ensure that these Urgent Care Plans are prepared and agreed before 30 September 2013. (Paragraph 55)

8. It is concerning that UCBs appear to have been created without any senior figure in NHS England being clear whether they are intended to become permanent features in local health systems. We agree with several witnesses that UCBs meet an urgent need to introduce “system management into the system” If that is to be their role, we do not believe it should be regarded as either voluntary or short-term. (Paragraph 56)

**Specialist centres of care**

9. The Committee accepts that a strong case has been made for the centralisation of some aspects of acute emergency care in regional specialist emergency units on the basis that substantial clinical benefits are delivered by focusing skills and resources in single locations. We are, however, concerned that this evidence is not abused; each proposal for service redesign should be reviewed on the basis of the evidence so that centralisation is justified only when the evidence supports it, not as an end in itself. For example, in rural areas the benefits of centralising care for some serious conditions could be negated by increased transport times. (Paragraph 62)
The four hour standard

10. In a well-functioning health system the four hour waiting time standard would be met as a matter of course rather than as an objective of policy. The four hour standard retains its value as a basic measure of performance but it does not provide a full measure of service quality. It is prone to gaming and the key indicators of hospital performance should be based on a broader assessment of patient outcome and experience. Waiting times are certainly part of this, but not the whole of it. (Paragraph 67)

Assessment of patients

11. Acute trusts must learn from best practice in the NHS. Patient flow studies by the Health Foundation have found that pressure on emergency departments can be relieved by restructuring the assessment of patients and changing working patterns. The management and boards of Acute Trusts should take responsibility for examining their own procedures and identifying whether they are in line with established best practice. In evidence Professor Willett told us that UCBs could help to examine best practice models. We agree that UCBs are well placed to undertake this role; successfully disseminating best practice across emergency and urgent care would help to establish the value of UCBs. (Paragraph 77)

12. Accessing early senior review of cases can reduce duplication and accelerate the path of a patient through the system. Senior clinicians are better able to balance risk and make key decisions. We therefore recommend that trusts assess the viability of implementing a rapid assessment and treatment (RAT) model. Additionally we recommend that Acute Trusts operating emergency departments explore the value of effective acute medical units (AMUs) which are designed to incorporate rapid access to senior specialist assessment and the swift development of care plans including a plan for discharge. (Paragraph 78)

Staffing

13. The Committee does not believe that attracting and retaining trainees is simply a question of improved remuneration. Trainees will only join a specialty if they are convinced that it offers the prospect of a career that is both professionally and personally rewarding. It is important that Health Education England and Local Education and Training Boards address these issues in order to make emergency medicine an attractive career option. (Paragraph 87)

Delayed discharge

14. The national data available on delayed discharges contradicts the evidence of clinicians and managers across the acute sector. The Committee believes that the data is incredible and we recommend that Ministers swiftly investigate the method of data collection in order to understand whether the available figures genuinely reflect the situation on the ground. (Paragraph 94)
15. More important than national data collection is the delivery of accurate information to local system managers. The Committee received strong evidence to suggest that delayed discharges were a significant threat to patient flow, and therefore to care quality. We recommend that NHS England should require each area’s Urgent Care Plan to include an assessment of the impact of delayed discharges on patient flows and a plan to address the issue. (Paragraph 95)

**Tariffs**

16. The current arrangements for remunerating A&E departments with only 30% of the tariff for activity over 2008–09 levels is no longer viable. The baseline is five years old and does not account for, or reflect, the pressures that hospitals face. As part of its review of the marginal tariff, Monitor should seek options which minimise the twin dangers of perverse incentives and excessive complexity. Incentivising all providers to direct patients to the correct treatment option, however they come into contact with the NHS, should be the over-riding priority. (Paragraph 99)

**Primary care**

17. The Committee strongly believes that primary care has an important role to play in delivering accessible, high quality urgent care. However the service structure required to deliver this objective is different from the structure required to deliver ‘care to patients with complex needs and deal with uncertainty in acute conditions’. The Committee does not favour a single blueprint from the Department or NHS England. The Committee recommends that NHS England (as the commissioner of GP services) should seek innovative proposals for the development of community-based urgent care services in each area. These proposals should include consideration of step-up and step-down care and they should be properly integrated into the rest of the urgent care system in that area. NHS England should be open-minded about how such a service should be provided. (Paragraph 108)

**Urgent Care Centres**

18. The Committee welcomes the development of Urgent Care Centres on hospital sites and accepts the evidence that these units can improve the quality and efficiency of emergency care. We recommend that UCBs should actively consider the development of such centres on acute hospital sites where there do not currently exist, although we accept Professor Willett’s warning that they can be a variety of reasons why the model does not fit every circumstance. (Paragraph 114)

19. The Committee also accepts that the warning of the College of Emergency Medicine that patients will continue to find the organisation of urgent care baffling if similar phrases mean different things in different places. Extensive application of the principles of Urgent Care Centres need to be backed up by clear objectives, clearly communicated. (Paragraph 115)
NHS 111

20. The decision to roll out NHS 111 was made before any evidence had been gathered to assess the strength of the service it could deliver. The service was shaped on patchy evidence despite the results from a small number of pilots questioning the ability of the service to divert demand away from urgent and emergency care services. The Committee concludes that the national deployment for NHS 111 was undertaken prematurely and without a sufficiently sound evidence base. (Paragraph 122)

Assessment

21. The Committee is concerned that NHS 111 did not apply the principle of seeking early engagement by a senior clinician, with the result that many calls took longer than necessary and some patients were advised to attend A&E but did not, in the event, need to be there. We recommend that, as part of its workstream examining the future strategic direction of NHS 111, NHS England attributes a higher priority to the principle of early clinical assessment. (Paragraph 125)

22. The Committee accepts that a recognisable telephone led non-emergency service is useful but it is not yet convinced that the balance between “triage” and early access to a senior clinician is right. The Committee recommends that this balance should be actively reviewed by NHS England as part of the ongoing development of NHS 111. (Paragraph 127)

Ambulance services

23. Ambulance services must demonstrate a commitment to establishing a ratio of paramedics to technicians which ensures that ambulance crews are able to regard conveyance to an emergency department as only one of a range of clinical options open to them. We recommend that NHS England undertakes research to establish the precise relationship between more highly-skilled ambulance crews and reduced conveyance rates. (Paragraph 139)

Developing the functions of ambulance services

24. There is still a considerable variation in conveyance rates across ambulance trusts. NHS England should take the lead in reviewing the various staffing models used by different trusts to help understand which structures are most effective in reducing conveyance rates and putting patients on the correct pathway. This should establish an evidence base for both urban and rural settings to help ambulance trusts determine how they organise their resources and workforce. (Paragraph 147)

25. Ensuring that all ambulance crews have access to national patient data would increase the patient information available and allow for better decisions to be made regarding conveyance and care. The Committee recommends that UCBs take the lead in assessing access to the National Spine for all key parties in the delivery of emergency care and coordinate plans to ensure that the minimum patient record is made available. (Paragraph 148)
Incentives

26. The Committee believes it is vital that commissioners successfully introduce tariffs which encourage ambulance providers to ‘hear and treat’ and ‘see and treat’ patients. Such encouragement would provide ambulance trusts with further incentives to develop a skilled workforce predominantly made up of paramedics. This would be of particular benefit to patients in rural areas who have only limited access to services. (Paragraph 151)

27. A service that is paid to transport patients will employ technicians to facilitate this; one that is paid to treat patients will invest in recruiting and training paramedics. The Committee therefore urges NHS England to closely monitor the relationship between the use of the new tariffs, conveyance rates and the balance between technicians and paramedics in ambulance trusts. (Paragraph 152)
Draft Report (Urgent and emergency services), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 153 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be printed with the Report.

Written evidence was ordered to be reported to the House for publishing on the Internet.

Adjourned till Tuesday 3 September at 2.00 pm
Witnesses

Tuesday 21 May 2013

Mike Farrar, Chief Executive, NHS Confederation, Dr Patrick Cadigan, Registrar, Royal College of Physicians, and Dr Mike Clancy, President, College of Emergency Medicine.

Tuesday 4 June 2013

Anthony Marsh, Chair, Association of Ambulance Chief Executives and Chief Executive, West Midlands Ambulance Service NHS Foundation Trust, and Mark Docherty, Chair, National Ambulance Commissioners Group.

Dr Clare Gerada, Chair, Royal College of General Practitioners, and Andrew Webster, Associate Director Integrated Care, Local Government Association.

Tuesday 25 June 2013

Rt Hon Earl Howe, Parliamentary Under-Secretary of State for Quality, Department of Health, Professor Sir Bruce Keogh KBE, NHS Medical Director, Dame Barbara Hakin DBE, NHS Chief Operating Officer and Deputy Chief Executive, and Professor Keith Willett, National Director for Acute Episodes of Care, NHS England.

List of printed written evidence

1 Department of Health, NHS England, and NHS Trust Development Authority Ev 66
2 Department of Health supplementary Ev 77
3 West Midlands Ambulance Service NHS Foundation Trust Ev 84
4 Royal College of Physicians Ev 88
5 College of Emergency Medicine Ev 92
6 NHS Confederation Ev 96
7 National Ambulance Commissioners Group Ev 103
8 Association of Ambulance Chief Executives Ev 104
9 Association of Ambulance Chief Executives supplementary Ev 107
10 Royal College of General Practitioners Ev 109
11 Local Government Association supplementary Ev 112
List of additional written evidence

(published in Volume II on the Committee’s website www.parliament.uk/healthcom)

1. Dr John Wright
2. Healthcare Audit Consultants Ltd
3. South Western Ambulance Service NHS Foundation Trust
4. NHS Benchmarking Network
5. Beverley Griffiths
6. Pharmacy Voice
7. North East Ambulance Service NHS Foundation Trust
8. Royal College of Surgeons
9. Priority Dispatch
10. Royal College of Nursing
11. The Royal College of Radiologists
12. College of Paramedics
13. Board of Directors of University Hospitals Coventry and Warwickshire NHS Trust
14. Emergency Medicine Trainee Association
15. Janet Egan
16. UNISON
17. Carers UK
18. The Medical Care Research Unit, School of Health & Related Research, University of Sheffield
19. British Medical Association
20. London Ambulance Service NHS Trust
21. The King's Fund
22. Nuffield Trust
23. Dr Timothy Whelan
24. NHS Direct NHS Trust
25. Myasthenia Gravis Association
26. Centre for Public Scrutiny
27. Unite
28. NHS Clinical Commissioners
29. Royal College of Paediatrics and Child Health
30. Foundation Trust Network
31. Dr Daniel Albert
32. Parliamentary and Health Service Ombudsman
33. The Shelford Group
34. Circle Healthcare
### List of Reports from the Committee during the current Parliament

The reference number of the Government’s response to each Report is printed in brackets after the HC printing number.

#### Session 2013–14

| First Special Report | 2012 accountability hearing with the Care Quality Commission: Government and Care Quality Commission Responses to the Committee’s Seventh Report of Session 2012–13 | HC 154 |
| Second Special Report | 2012 accountability hearing with Monitor: Government and Monitor Responses to the Committee’s Tenth Report of Session 2012–13 | HC 172 |
| Third Special Report | 2012 accountability hearing with the Nursing and Midwifery Council: Government and Nursing and Midwifery Council Responses to the Committee’s Ninth Report of Session 2012–13 | HC 581 |
| First Report (yet to be published) | Post-legislative assessment of the Mental Health Act 2007 | HC 584 |
| Second Report | Urgent and emergency services | HC 171 |

#### Session 2012–13

| First Report | Education, training and workforce planning | HC 6-I (Cm 8435) |
| Second Report | PIP breast implants: web forum on patient experiences | HC 435 |
| Third Report | Government’s Alcohol Strategy | HC 132 (Cm 8439) |
| Fourth Report | 2012 accountability hearing with the General Medical Council | HC 566 (Cm 8520) |
| Fifth Report | Appointment of the Chair of the Care Quality Commission | HC 807 |
| Sixth Report | Appointment of the Chair of the National Institute for Health and Care Excellence | HC 831 |
| Seventh Report | 2012 accountability hearing with the Care Quality Commission | HC 592 |
| Eighth Report | National Institute for Health and Clinical Excellence | HC 782 |
| Ninth Report | 2012 accountability hearing with the Nursing and Midwifery Council | HC 639 |
| Tenth Report | 2012 accountability hearing with Monitor | HC 652 |
| Eleventh Report | Public expenditure on health and care services | HC 651 (Cm 8624) |

#### Session 2010–12

| First Report | Appointment of the Chair of the Care Quality Commission | HC 461-I |
| Second Report | Public Expenditure | HC 512 (Cm 8007) |
| Third Report | Commissioning | HC 513 (Cm 8009) |
| Fourth Report | Revalidation of Doctors | HC 557 (Cm 8028) |
Fifth Report  Commissioning: further issues  HC 796 (Cm 8100)
First Special Report  Revalidation of Doctors: General Medical Council’s Response to the Committee’s Fourth Report of Session 2010–11  HC 1033
Sixth Report  Complaints and Litigation  HC 786 (Cm 8180)
Seventh Report  Annual accountability hearing with the Nursing and Midwifery Council  HC 1428 (HC 1699)
Eighth Report  Annual accountability hearing with the General Medical Council  HC 1429 (HC 1699)
Ninth Report  Annual accountability hearing with the Care Quality Commission  HC 1430 (HC 1699)
Tenth Report  Annual accountability hearing with Monitor  HC 1431 (HC 1699)
Eleventh Report  Appointment of the Chair of the NHS Commissioning Board  HC 1562-I
Twelfth Report  Public Health  HC 1048-I (Cm 8290)
Thirteenth Report  Public Expenditure  HC 1499 (Cm 8283)
Fourteenth Report  Social Care  HC 1583-I (Cm 8380)
Fifteenth Report  Annual accountability hearings: responses and further issues  HC 1699
Sixteenth Report  PIP Breast implants and regulation of cosmetic interventions  HC 1816 (Cm 8351)
Q1 Chair: On behalf of the Committee, I welcome all three witnesses. This is our first evidence session on this inquiry into urgent and emergency care, which is a subject that the Committee has received a number of approaches on, both through our constituencies and as a Committee. It is very topical. We are looking forward to what you have to say. Could you briefly introduce yourselves to get the session under way, please?

Dr Clancy: I am Dr Mike Clancy. I am President of the College of Emergency Medicine.

Dr Cadigan: I am Dr Patrick Cadigan. I am Registrar of the Royal College of Physicians, London.

Mike Farrar: I am Mike Farrar, Chief Executive of the NHS Confederation.

Q2 Chair: Thank you very much. You are all very welcome. You will be aware, I am sure, that David Prior, the new chairman of the CQC, has lost not very much time in declaring that the pressure in A and E departments, in his words, is “unsustainable” and “out of control”. Do you agree with that analysis and, if you do agree with it, what do you think are the principal causes? Let us get the discussion under way and start with Dr Clancy.

Dr Clancy: I think a multitude of factors has led to the deterioration in the performance of type 1 emergency departments, which have been under sustained pressure for a long time and in fact have reached the limits of their compensatory capacity. There is a major workforce-workload imbalance within emergency departments and an inability of the whole system at the moment to meet the demand. What is happening in emergency departments reflects the performance and difficulties of the whole NHS as well as within the emergency department.

Looking at the factors that contribute to that, I would like to clarify the issue of increasing attendances and to distinguish between attendances in the system overall and type 1 emergency departments in particular. If we look at all of the urgent care services—emergency departments, minor injuries units and walk-in centres—there has been a 50% increase between 2001 and 2011. For type 1 emergency departments, that has risen by 17% from 2003 to 2011.

From the latest data from the A and E statistics website of the Department of Health, the change between this year and last year is a quarter of a million new attendances. It is helpful if we talk about raw figures as well as percentages. A quarter of a million is five new emergency departments each seeing those patients. So the numbers themselves do not tell the whole story. The numbers are increasing; but, just as those are averages, some departments are reporting substantial increases in attendances. What is happening is that the work load of out-of-hours services is increasing. There is clear evidence that attendances after midnight and at weekends are substantially increased and that more patients are being admitted. Over this year compared with last year, there were 142,000 more admissions. As to patients waiting in emergency departments, there were 152,000 patients waiting more than four and less than 12 hours last year. That is a 34,000 increase. Those are big numbers.

Along with that, more elderly patients are attending, so in the order of more than a quarter of a million more people over the age of 70 are attending who have greater needs. It is also helpful to point out to the Committee that, although winter pressures are a frequently used term, the variation in attendances between quarters is minimal. Therefore, this is a continuous, not a single, problem.

There are other problems beside numbers. There is a lack of clear alternatives to emergency departments that patients trust and want to use. That means that patients are not being cared for in an alternative setting to the emergency department. Emergency department staff shortages are particularly acute, especially out of hours, and this exacerbates the situation because it is particularly difficult to staff departments out of hours. The locum and vacancy rates combined for key decision makers are in the order of 20% and for consultants in the order of 17%. The lack of bed capacity, with occupancy running typically at 100%, means it is difficult to get patients into hospital at this time. The inability to discharge patients means it is harder to get them in and that has led to substantial overcrowding. If you look at the numbers of people multiplied by the length of time...
they spend in emergency departments, that is what is increasing substantially. Overcrowding of emergency departments is one of the major challenges that we face. You should know that that is dangerous: there is an associated mortality and morbidity associated with overcrowding. We know that and are doing our best to control it. Getting rid of overcrowding is one of the challenges because it is something that we know is a substantial risk. Thank you.

Q3 Chair: That is a barrage, if I may say so, of statistics and evidence. Can I start by dwelling on the rise in attendances? I think I am right in saying that you said 250,000 year-on-year total attendances across the full range of emergency departments—this year on last, a 250,000 increase. Did I hear that right?

Dr Clancy: That is for type I emergency departments. For emergency departments that are not minor injury units or walk-in centres, it has increased by a quarter of a million from last year.

Q4 Chair: Could I ask you to reconcile that? I know there are figures around that suggest that year-on-year attendances are down a fraction and with those numbers you are stating they are up. Both propositions cannot be true.

Dr Clancy: Sure. These figures are from the Department of Health’s A and E statistics website that we can all visit and were there, updated, on 17 May. It is because of this ambiguity around numbers that I thought it was important to draw your attention to that. The big increase in numbers is of the whole system combined. Within emergency departments, there has been less of an increase, but nevertheless a substantial increase. That is where percentages can be misleading. We are working with a system that is at the limits of its tolerance and small changes can make big differences to how it functions.

Q5 Chair: That is understood, but can I push you on this? Where does the figure come from that suggests there has been a 1.7%—I think it is, but I do not know the absolute number—decline in attendances year on year for the first quarter of this year?

Dr Clancy: It may be a function of when you choose to measure it—if you are combining quarters in a different sequence, for example—but I have taken the four quarters that constitute 2012–13 against 2011–12.

Mike Farrar: Just for clarity, the 1.7% reduction I think is a comparison of the previous full quarter against that same quarter a year earlier. In aggregate, the total number has been increased over the 12 months, but actually a quarter comparison of the last quarter compared with the year before in that quarter shows that 1.7% rise.

Q6 Chair: So the 250,000 is a full-year number.

Dr Clancy: Yes, absolutely.

Q7 Chair: Taking full-year numbers and accepting that there is not a major seasonal variation, it is a rising trend.

Dr Clancy: Yes.

Q8 Chair: I want to clarify this as the starting point because there has been some discussion about whether the demand pressures are continuing upwards or edging downwards. I want to be clear what the answer to that question is.

Dr Clancy: What I have tried to say is that the numbers per se do not tell the story. It is the case mix, the age and so on, and the time they are attending, so more people out of hours, more after midnight, more by ambulance and more of the elderly.

Q9 Chair: I understand there are several other factors. I am trying to dwell for a second on the numbers in order to try to get that straight. Can I bring in our other two witnesses?

Dr Cadigan: My understanding is that there has been some difficulty in interpreting the figures on the basis of the last 10 years since changes were made in the way they were analysed. The inclusion of emergency care centres’ figures, together with A and E departments, has made it difficult to understand, and I gather there has been some debate about whether the inclusion of follow-up visits has made the figures difficult to understand. Local information from trusts that I am familiar with over this last critical period is that there has been, in the last few months, an increase in the order of 2% to 3% in attendances. At the same time, there has been an increase in length of stay, and it is flow out of the emergency department that is one of the crippling factors. That is something in which our college, responsible for most of the conditions that provoke emergency admissions, is particularly interested.

Chair: Thank you.

Mike Farrar: It is really important to understand what the figure that people are pointing to is describing. This is the number of people in A and E departments who are waiting longer than four hours to receive treatment and be effectively managed. That figure really points to the flow of patients through the system. So, while over the last decade we have seen increases in numbers of people attending, and indeed numbers of admissions, the NHS has, largely, been able to handle that flow. In fact, for the vast majority of the last decade, you saw improvements in the speed at which people were being managed through A and E departments. Over the last couple of years, that has plateaued and is now effectively decreasing in terms of the flow of patients. There are causes within the system as to why we might be seeing that: the inability to return people home into independent living and the inability to keep people well, which means more people presenting by default at the place of last resort, which accident and emergency departments are. We cannot avoid some speculation that the NHS has largely performance-managed this particular target quite heavily for certainly five of the last seven years, but that has lost traction over recent years. In fact, the key thing about this performance-management culture, which people often say has been brought into disrepute, is that it also had preventative aspects. When you saw performance deteriorating around A and E, you were able to put in extra resources to support that. It was not all about saying, “There is a
big stick." There were also some opportunities for support and that system leadership has disappeared. Of course we are also aware—and we do not have data on this, but I am worried—that the resources available through social care support, which very often might have been low-level family support such as respite care, are the kinds of things that were keeping people staying at home longer and may well have been lost with some of the resource cuts to social care. While they are still funding packages on discharge, the loss of preventing people arriving in a state of poor health may well be driving some of this additional acuity when people arrive at A and E services and need admission. So it is multifactorial, but it is a measure of flow. That is important because, if we are going to find solutions, it is not about fixing one bit of it; it is about getting the balance of investment across the system—primary, community, emergency medicine at the front door, general physicians in hospital, general practitioners out in the community. It is about flow and balance of resources.

Chair: That gives us an overview of the issues we are grappling with. Barbara, do you want to lead off on the four-hour wait?

Q10 Barbara Keeley: Yes. First, I am surprised that you are as tentative as you are in saying that it may well be cuts in resources for social care. There have been 27% cuts to local authority budgets. My local authority has moved to “substantial” from “moderate”. I would put it stronger than that. I do not know why we are tiptoeing around this issue. That is an enormous cut to resources, which, as you say, is keeping people out of hospital. So we might as well be a bit more straightforward about it. There are other things too, if I can just reflect, and I am not sure how common this is. Other cuts that were being made in my area were, for instance, to close two walk-in centres and an active case management pilot for people with long-term conditions. They are all things that might have kept people out of A and E. The reason that the two walk-in centres were closed was that they were not judged to be keeping people out of A and E, but in fact the one in my constituency was seeing 2,000 people a month. Those people do not go away, do they? If they are not able to go to the walk-in centre, they are going to go somewhere. It may be that some of these short-term decisions have had those sorts of repercussions. If that sort of decision is multiplied up and down the country, we have gone for the very short-term solution. Let us go back to the waiting time target. We have already covered quite a lot of the ground, but 94 out of 148 providers are failing to meet the target of 95% of patients seen within four hours. Are we at the point where, just having that as a measure—if that is the measure—it is failing almost right across the system? There have been other factors introduced by Dr Clancy, things like overcrowding, which itself is dangerous. Are we at the point where there are other measures that are needed to reveal the performance and quality of care within A and E, or do we still rely on that because the four-hour time limit is important in itself?

Dr Clancy: The deterioration in four-hour performance—which is a process measure and not a quality measure—that I am worried has reflected the pressure the system is under. Organisations are now focusing more on how many people are waiting up to 12 hours and have, in a sense, parked the four-hour target because it is so difficult to manage. That is a reflection of the pressure the system is under. The problem with the four-hour target is that it is convenient but it falsely localises the problem—we have already said that it is a system-wide problem—and organisations such as Monitor have focused on that because it is a convenient thing. But there is a suite of seven other indicators, which have not been adopted, that allude to quality as well as process, and could reflect the quality of care and give a more even representation. Nevertheless, for all its faults, the four-hour target does reflect the problem, which is that it is a system under severe pressure that is struggling to perform.

Q11 Barbara Keeley: What are the other indicators?

Dr Clancy: I am happy to share those with you, but they include, for example, people who re-attend, people who left without being seen, patients whose cases have been reviewed by consultants prior to discharge, and also trying to get a handle on patient experience, which is a really important aspect that we have found difficult to do well on up to now but do have as a priority.

Dr Cadigan: The merits and demerits of the four-hour target were debated in the medical community when it was introduced. The sceptics have had to face up to the fact that it has improved the standard of care in A and E departments up to the point where it reached the buffers in capacity. At the point where there is inadequate capacity and where the right thing to do is to hang on to someone for a little longer in the A and E department, the four-hour target forces you to move them—and forces you to move them to an inappropriate place—when it is clinically inappropriate.

Q12 Chair: That’s gaming, not care.

Dr Cadigan: Yes. It is clinically inappropriate. Of course if the patient moves to the wrong ward and is looked after by the wrong team, they are then handed over to another ward, and every hand-over loses you one and a half days in length of stay. So a target that is inflexible can be damaging. One good thing about the four-hour target, of course, is that it is the measure that has revealed finally, publicly, the extent of the problem, and the reason I suspect we are here today is that the four-hour target has failed in 90% of trusts.

Mike Farrar: I would echo what Mike and Patrick have said. However, it is a useful indicator, but there is a difference between an indicator and a target. The indicator gives you some sense of the flow through a system. In clinical terms, obviously, if you present with severe chest pain, waiting for three hours and 59 minutes is not right. So differentiating between the clinical triaging and making sure the right people get treated quickly within that is more important at one level than saying, “How is our system working?” But it tells you something about how patients are able to be admitted and the capacity of the hospitals. It also
gives you a bit of insight into how many people are presenting, which we have discussed. It is a useful indicator, but I am clear that it is not a relevant clinical target—particularly now when demand is clearly outstripping supply—in the sense that it would be wrong to make sure that everybody got care within four hours but actually the people who need immediate clinical treatment are then being stretched in their time. It is more about getting that right, I think.

Q13 Barbara Keeley: The next point is this. We have covered some of this ground, and clearly we have the increases in demand there, but we have the other factors—more elderly people, out of hours, after midnight and by ambulance. You may not have data on this, but to what extent is the failure to meet that four-hour target demand and how much is it other factors? So many things have changed, haven’t they? Is there a feel for 70% of it being demand and 30% of it being something else?

Mike Farrar: It is worth being quite academic about this. It seems to me that there was a great absorption of increased demand for the vast majority of that first bit of the decade that did not impact on this target. In fact, on that target, we were getting better: the number that was ratcheted up at one time was 90% within four hours and it got to 95%, and that was while demand was increasing. To try and understand what will happen you need to look at, and be clear about, what has happened since we hit our high watermark. There is a resource issue here. At the heart of all this, the NHS has the increasing demand, but for the vast majority of the first part of that decade we were able to put resource across the whole of the system. We were increasing the resource available in line with demand. What has really happened since then is that demand has continued to increase but the resource available to increase supply has reduced. This, of course, brings us back to the great conundrum, which this Committee has sat looking at many times: the only way you were going to continue to be able to meet that demand was actually spending your money more wisely and investing in services that prevented demand. What you are seeing now is an indication that we have simply not been able to do that. My fear is that, because we are still struggling to do that, there is the potential for these figures to get worse. I am sure in the short term there will be a push to put more resources into this particular bit of the system, to look at this particular indicator, but the truth is that that inability to transform the way we provide care is really stretching waiting times.

We will see, I think, elective waiting times struggle as well because a lot of this emergency capacity has taken away the opportunity that the trusts had to do their elective work, which was all about the 18-week target. Also, because financially trusts benefit more from their elective work than they do from their emergency work, it will have a knock-on impact on the finances of the trust. So it is pointing to that inability, that we have had to transform the service and we have had more demand and less resource.

Dr Clancy: The demand-flow equation probably varies in each system. There has been an increase in demand but it is not just the numbers; it is the complexity of these patients. They are more time-consuming to sort out because of the nature of their problems. The flow is a big problem because, if you have 10 patients waiting for six hours, that is 60 hours of patient care. You could have theoretically got through a lot more patients in that time but you still have to get through your patients plus look after these people who are there. The reason we are struggling is partly flow and partly increased demand, but also the time when that demand is made is when it is hardest to provide the service, which is out of hours.

Q14 Barbara Keeley: A point I have made on other occasions is that it is possible to look at the impact that changes in social care resource are having. Because we had 152 different social care systems up and down the country, it would be possible to locate a few where perhaps the changes had been biggest and judge what impact they were having on their local acute services. I do not know why we keep missing the opportunity to do that.

Dr Cadigan: I do not think we have data on that. You are absolutely right to talk about health and social care needing to work very closely together in solving some of the flow problems, both in preventing patients coming into hospital and expediting their discharge. It would be foolish not to face up to the demographics, which I am sure this Committee has heard about on many occasions, that there will be a 50% increase in patients with three or more conditions at the same time by 2018, and by 2030 the number of patients over 85 will have doubled. These patients consume a large number of occupied bed days with high average lengths of stay, so it would be foolish not to look at that demographic and consider the implications for social services as well as medicine.

Q15 Barbara Keeley: But it is possible, it seems to me, to isolate some of the changes that have occurred over the last year or two and say, “This local authority did this; what impact did it have on A and E and acute services?”

Dr Cadigan: I do not have data on that.

Barbara Keeley: No, but I am saying we should be doing so.

Chair: Dr Clancy wants to come in.

Dr Clancy: One of the problems is trying to understand the system, which is complicated, fragmented and with no requirement to report all of its new initiatives. So trying to understand the consequences of these changes and learn from them is quite problematic.

Q16 Grahame M. Morris: With all due respect, Dr Cadigan, you are missing the point. We understand the demographics. What has changed is the resource issue for local authorities. In most cases, they have changed the eligibility criteria so people who would have been supported through the social care system are presenting to A and E. We think that that may be a factor and should be further investigated.

Dr Cadigan: With respect, I do not think I am totally missing the point in that one of the difficulties with very elderly frail patients is making sure that you
adequately meet their medical needs. There is a
tendency—and it is sometimes a tendency among
doctors—to regard these patients as “not coping”,
when there is actually a serious medical problem.
We need to build in structures to make sure these patients
have a proper assessment medically and socially. But
I agree with you entirely that, without the social
dimension being present, the system will fail.

Q17 Dr Wollaston: I have a point of clarification.
Barbara referred earlier to the closures of walk-in
centres pressing up and increasing the numbers of
attendances in A and E. Am I right in thinking that in
fact walk-in centre attendances and minor injuries
units are included in the figures for A and E?
Dr Clancy: Would it be helpful to repeat the figures?
Chair: Not all of them.
Dr Clancy: No. If we combine the whole system
[together—emergency departments, minor injuries
units and walk-in centres—from 2001 to 2011, they
went up 50%]. That is the headline going from 10 to
20.

Q18 Dr Wollaston: But is it not the case that walk-in
centres and minor injuries units were only included in
the figures from 2003–04?
Dr Clancy: Yes.

Q19 Dr Wollaston: So should we just take the
figures from that time onwards?
Dr Clancy: Yes. It would not be dissimilar from what
I have described. There has been a substantial increase
when you take all of those combined. That has to be
contrasted with type 1 emergency departments, where
there has been an increase but it is of a lower order—
say about 17%.

Q20 Dr Wollaston: In the CEM report you suggest
bringing more GPs into A and E departments to deal
with that. But isn’t the danger there that you just end
up attracting even more people to attend an
inappropriate location?
Dr Clancy: If we were a business, we would have
been extraordinarily successful with the numbers that
we were treating.

Q21 Chair: That is assuming you were being paid
for them.
Dr Clancy: Yes. The four-hour target has attracted
people. The issue is with finding a viable attractive
option for patients who could be looked after in an
alternative setting to the emergency department. Our
challenge is to provide something, working with
patients, that they would want to use. The trouble is
that emergency departments are a highly identifiable
brand with a guaranteed service. We need the
alternatives to be equally visible, available and
desirable. That is a challenge. At the moment, the
initiatives of working with primary care, which are a
key component to all of this, are to get the work force
to deal with these patients. But in the longer term
those patients that are best cared for out of hospital
should be cared for out of hospital.

Q22 Dr Wollaston: My point is that you then
facilitate it and make it an even more attractive offer
by putting more GPs within a casualty department, but
would it not be better to put those GPs out in the
community so that people are drawn to the correct
location? Aren’t you going to create an even greater
pull factor?
Dr Clancy: We would be delighted if primary care
and the components of that were able to attract
patients out of emergency departments to be looked
after by them. What you have are these short-term
fixes for a severely pressured system. The longer-term
strategy is that patients who do not need the resources
of an emergency department—it does not serve them
or us well—should be looked after in the community.

Q23 Dr Wollaston: I am sorry to press this point,
but, if as a short-term fix you put more GPs into
casualty departments, aren’t you going to exacerbate
the problem? You are going to have even more people
attending. It is not a short-term fix at all surely.
Dr Clancy: It means that you get more people
attending the same location but looked after by a
different and appropriate professional group, which I
think is helpful. The longer-term strategy should be
about that care being provided in an alternative to an
emergency care hospital setting for those patients who
need that.

Q24 Dr Wollaston: But, if there is a shortage of GPs
and you put them in a casualty setting, you are just
going to end up reinforcing the wrong pattern.
Dr Clancy: Yes, that is one of the challenges that we
face, which is that emergency departments are the mat
upon which everything else that does not quite work
well falls. We need to hold all those other parts to
account to make sure that they work properly; if they
are working properly, those patients do not need to be
there. We would welcome a system that is joined up,
works together and is transparent and accountable. As
to patients who come to us who could have been
looked after by another group, we could work with
that group to help them look after those people.

Mike Farrar: To add a supplementary, one of the
issues about out-of-hours services is that you do not
have the full range of professionals available to you
that you have during in-hours services. At one point
the view was that if you were not treated by a doctor
you could not be managed, but we have gone way
beyond that and many multiprofessional interventions
take place during the day. But when we go to the
out-of-hours period there is much less availability of
a multidisciplinary team. That is one of the problems.
If you are trying to find solutions, more and more
GPs spending more time out of hours dealing with
problems that could be dealt with in a more low-level
and caring way is not a sustainable solution either. So
there is something about getting the 24/7 nature of
healthcare right but seeing that as multidisciplinary,
not just about more doctors.

Dr Wollaston: Thank you.
Dr Cadigan: That is absolutely right. I agree with
both my colleagues that one of the big challenges here
is out-of-hours care. The problem, as Mike Clancy
says, is that A and E is the recognisable brand. That
is where patients will go because they know they will see someone who is expert—who will see them, often within four hours, and they will receive treatment. Patients will go where the lights are on. In many of these alternatives, the lights are not on after five o'clock in the evening or at weekends. We have to face up to the fact that services other than an A and E department are often run on a nine-to-five and elective basis. So the challenge to the entire service—and I think this is a problem for all of us primary and secondary care managers—is to say, “How can we deal as a whole service with this challenge and do we prioritise it? Do we move people resource into that area?”

We have a view that we will have to change the way that physicians work. We have a project called the Future Hospital Commission, which will look radically at the way physicians work to improve patient flow. The challenge to primary care—and we must ask representatives of primary care to talk about this—is what contributions they will make to solving this problem.

Chair: I have a lot of colleagues wanting to come in. Andrew wants to come in and then Virendra.

Q25 Andrew Percy: I want to come back in on the social care issue. I was concerned that there seemed to be a casual link being made between the two, but actually there is no evidence to support it at all because it is important to stress that eligibility criteria for social care services for the last decade have been getting downgraded. I was on a local authority for 10 years and we downgraded the social care services a number of years ago. In my own local authority we took the decision not to downgrade from “substantial” to “moderate”, but we have still seen this huge spike in A and E. It is important to stress that and to tease out from you, which is what I think you have said in your evidence, that there has not been any piece of work done around this, has there? There is no evidence to support the fact that social care service changes and the changing of the thresholds has so far impacted, given that a lot of local authorities have made the decision but have not actually implemented it yet?

Dr Cadigan: I do not know of any evidence of that.

Q26 Andrew Percy: That leads me on to there being other factors at play here. In my own constituency, the biggest issue for people is not accessing GP services out of hours. We all know the history of that. I am wondering whose job it is to take the lead, particularly around this issue of what impact the social care changes will have, because there are statements made around the table about this having such a huge impact but there has not been any study done of this or any evidence to—

Dr Cadigan: The only indirect bit of evidence I know of is that health economies that have a large population of elderly people living in them have better hospital avoidance rates and lower hospital admission rates than other health economies. That suggests to me indirectly that, if you have built up a lot of services for elderly people, then that may work. But I cannot break that down into health and social care. The other thing to say—and again it is harking back to the out-of-hours issue—is that, if an elderly person has a crisis in their home, a fall at the weekend or out of hours, it is very difficult to access social services, primary care and a number of very good things that you can access Monday to Friday, and patients come to A and E. Without a system in place at A and E for accessing intermediate care, for example, those patients will be admitted to an acute bed by default. A and E is the default position.

Mike Farrar: Can I pick up on this point? In terms of changes to eligibility criteria, that is just one element of this. What I was referring to, which is harder to demonstrate, is the community support organisations that are absolutely vital in working with our services to keep people living independently. That is one of the factors.

You point, quite rightly, to the fact that you say, “Eligibility criteria over a decade have seen improvements even while they have been tightening.” But I would say the same of GP out-of-hours services, that, since the changes were made in 2004, the first seven years of that saw improvements in this measure about whether or not people were flowing through the system even after those changes.

The key reason why both the Conservatives in 1990 and the Labour Party in 2002 took decisions on GP out-of-hours services was because you could not recruit GPs. The biggest barrier to recruitment, people said, was the out-of-hours commitment, the out-of-hours responsibility. In our strategic aim of the NHS, which is to create more primary community social care and avoid our hospital services being used, if you cannot recruit GPs, then you are in real trouble. So the out-of-hours changes are a bit of a red herring in some way when we are looking for the significant issues. Improving out-of-hours care is significant and looking at the wide range of services available through social services is a big issue. Eligibility criteria may be a more specific issue and up till recently we have managed to absorb those changes, but now, when there is less resource available overall, we are facing real problems.

Q27 Grahame M. Morris: On that subject, because I think it is really important, Mike you told us earlier that the causes of the increase in attendances are multifactorial—there are a number of aspects to it—but the Secretary of State has said several times in debates, in Health questions, that he pinpoints the prime cause as being the change in the out-of-hours GP contracts. There are other issues around the new GP contracts, our concerns about the change in eligibility criteria putting further pressures on the service, but could you focus in on the Secretary of State’s position in respect of the change of out-of-hours contracts, and perhaps Dr Cadigan and Dr Clancy might have a view on that as well?

Mike Farrar: I remember out-of-hours care before the 2004 change and, basically, the big change that people remember was the one where GPs themselves stopped doing their own out-of-hours care—the image of “Dr Finlay’s Casebook” was there. That was a change in the 1990 contract. After that point, GPs did not have to provide their own out-of-hours care but were

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We have a view that we will have to change the way that physicians work. We have a project called the Future Hospital Commission, which will look radically at the way physicians work to improve patient flow. The challenge to primary care—and we must ask representatives of primary care to talk about this—is what contributions they will make to solving this problem.

Chair: I have a lot of colleagues wanting to come in. Andrew wants to come in and then Virendra.

Q25 Andrew Percy: I want to come back in on the social care issue. I was concerned that there seemed to be a casual link being made between the two, but actually there is no evidence to support it at all because it is important to stress that eligibility criteria for social care services for the last decade have been getting downgraded. I was on a local authority for 10 years and we downgraded the social care services a number of years ago. In my own local authority we took the decision not to downgrade from “substantial” to “moderate”, but we have still seen this huge spike in A and E. It is important to stress that and to tease out from you, which is what I think you have said in your evidence, that there has not been any piece of work done around this, has there? There is no evidence to support the fact that social care service changes and the changing of the thresholds has so far impacted, given that a lot of local authorities have made the decision but have not actually implemented it yet?

Dr Cadigan: I do not know of any evidence of that.

Q26 Andrew Percy: That leads me on to there being other factors at play here. In my own constituency, the biggest issue for people is not accessing GP services out of hours. We all know the history of that. I am wondering whose job it is to take the lead, particularly around this issue of what impact the social care changes will have, because there are statements made around the table about this having such a huge impact but there has not been any study done of this or any evidence to—

Dr Cadigan: The only indirect bit of evidence I know of is that health economies that have a large population of elderly people living in them have better hospital avoidance rates and lower hospital admission rates than other health economies. That suggests to me indirectly that, if you have built up a lot of services for elderly people, then that may work. But I cannot break that down into health and social care. The other thing to say—and again it is harking back to the out-of-hours issue—is that, if an elderly person has a crisis in their home, a fall at the weekend or out of hours, it is very difficult to access social services, primary care and a number of very good things that you can access Monday to Friday, and patients come to A and E. Without a system in place at A and E for accessing intermediate care, for example, those patients will be admitted to an acute bed by default. A and E is the default position.

Mike Farrar: Can I pick up on this point? In terms of changes to eligibility criteria, that is just one element of this. What I was referring to, which is harder to demonstrate, is the community support organisations that are absolutely vital in working with our services to keep people living independently. That is one of the factors.

You point, quite rightly, to the fact that you say, “Eligibility criteria over a decade have seen improvements even while they have been tightening.” But I would say the same of GP out-of-hours services, that, since the changes were made in 2004, the first seven years of that saw improvements in this measure about whether or not people were flowing through the system even after those changes.

The key reason why both the Conservatives in 1990 and the Labour Party in 2002 took decisions on GP out-of-hours services was because you could not recruit GPs. The biggest barrier to recruitment, people said, was the out-of-the-hours commitment, the out-of-hours responsibility. In our strategic aim of the NHS, which is to create more primary community social care and avoid our hospital services being used, if you cannot recruit GPs, then you are in real trouble. So the out-of-hours changes are a bit of a red herring in some way when we are looking for the significant issues. Improving out-of-hours care is significant and looking at the wide range of services available through social services is a big issue. Eligibility criteria may be a more specific issue and up till recently we have managed to absorb those changes, but now, when there is less resource available overall, we are facing real problems.

Q27 Grahame M. Morris: On that subject, because I think it is really important, Mike you told us earlier that the causes of the increase in attendances are multifactorial—there are a number of aspects to it—but the Secretary of State has said several times in debates, in Health questions, that he pinpoints the prime cause as being the change in the out-of-hours GP contracts. There are other issues around the new GP contracts, our concerns about the change in eligibility criteria putting further pressures on the service, but could you focus in on the Secretary of State’s position in respect of the change of out-of-hours contracts, and perhaps Dr Cadigan and Dr Clancy might have a view on that as well?

Mike Farrar: I remember out-of-hours care before the 2004 change and, basically, the big change that people remember was the one where GPs themselves stopped doing their own out-of-hours care—the image of “Dr Finlay’s Casebook” was there. That was a change in the 1990 contract. After that point, GPs did not have to provide their own out-of-hours care but were
clinically responsible for the quality of care of the deputising arrangements, and, as you know, at that point GPs either did their own deputising through GP co-ops or they had commercial deputising organisations. There was a high level of complaints about out-of-hours care compared to in-hours care, as you can imagine, and that has continued over the last two decades.

In 2002, the contractual changes at that point said that GPs no longer had to be responsible for the clinical quality of the deputising services. In practice, not much changed other than we paid more because PCTs, who were supposed to commission then a wider range of services, would commission the primary care out-of-hours service in the same breath as A and E departments, walk-in centres and NHS Direct. The idea was that you had a more coherent strategy for out-of-hours care, but in fact PCTs rolled over previous contracts and just had to pay more because GPs were not obliged to do it. From 2004 to 2010, although that change was in place, improvements in the flow of patients through A and E were going up, with the high watermark being 2009–10, I think, when 95% of patients were going through in four hours. So the question is what has happened since then. I do not think there have been any discernible structural changes to GP out-of-hours services since then.

So I would say—and I think there is room for improvements in every service—that the evidence of a direct correlation between GP out-of-hours care contractually being the requirement of GPs and the A and E performance is not necessarily proven by those statistics.

Q.28 Mr Sharma: Thank you very much. We heard evidence that primary care is also struggling under demand pressure. Is it the case that there is more demand across the board, and pressure in A and E is not the direct result of patients staying away from primary care? Can I add to that, does this indicate that general practice is working very hard.

Dr Cadigan: I cannot speak authoritatively for primary care, but I know that there has been an increase in the rate of general practice consultations year on year, up from something like—I may not have this right—an average of three to an average of five over the last five years. But there has been an increase in consultations and I do not think anyone is disputing that general practice is working very hard. There is evidence that general practice behaviour can influence hospital admissions. There is evidence that continuity of care with a GP is correlated with reduced referral rates to hospital. There is also evidence of very different performance across the primary care system, with some primary care functioning extremely well but with a variability of that quality. That quality is seen—and again I do not have the figures—in that, with out-of-hours care, I think there is a factor of 10 variability in the rate at which patients are referred to hospital via out-of-hours primary care organisations.

That may reflect the availability of other services. What I am certain is—and I cannot speak for primary care—that they should be involved in this discussion as key partners in finding the solution.

Q.29 Mr Sharma: What do you say, Dr Clancy?

Dr Clancy: Just to come back to the contribution of out-of-hours care, I am unaware of any evidence that it has fundamentally changed over the last few years and the deterioration in performance has not corresponded with an alteration in the way out-of-hours care has changed, so its contribution to the present problem is not obvious to me. What I would say, however, is that its contribution to the solution of this problem is very obvious in that they can make a major contribution in looking after patients where they can provide an alternative to emergency departments.

Q.30 Grahame M. Morris: Can I ask a very short supplementary? There was previously a commitment to the delivery of an appointment with a GP within 48 hours, which has been quietly dropped. Do you have any evidence or have you quantified what impact that has had in terms of patients who say, “Well, I cannot get in to see my GP till next week. I know I will be seen at A and E.” So they present there instead?

Dr Clancy: There is a review of the evidence by the urgent and emergency care review, which is in draft form at the moment. I think we are all wary of commenting on another professional group, but there are relationships between availability or performance of appointments and whether people attend emergency departments, as well as social deprivation and other factors. Reference to that document may be helpful in answering that question more comprehensively. But, as to the notion of availability of appointments and their relationship to the use of emergency departments, I think there is evidence to support that.

Mike Farrar: Can I come at this from a slightly different angle, because it is illuminating? Work has been done by a group called Patient Access. Rather than coming at, “Where are the big problems in this?”, they looked at practices—this was largely around Leicestershire and the east midlands—which seemed to have the lowest number of A and E attendances. What they found for some of the top performers—not uniquely, true—was that they have moved from an immediate access, a face-to-face consultation in general practice to an immediate telephone consultation with a GP. They found that the cut-off was 30 minutes. So, if you got a telephone consultation with GPs in 30 minutes, it had a big impact on the face-to-face consultations in general practice. It reduced it by something like 40%. But even though that measure was taken to support primary care work load, it was having a corresponding benefit in A and E. They had not intended that. So, if you come at this from an appreciative inquiry of, “What is happening in those places that are having low A and E attendances?”, it does seem to point to immediate access to medical advice being very helpful in reducing your need then to go to A and E. But you could not do that if it was based on a similar basis of face-to-face consultations because of the available slots. So, one of our solutions has to be about this opportunity around using technology and immediate access.
What we found in the middle of the last decade with some A and E performance in the past was that, if you had a more junior sort of triaging upwards, then you built in a lot of delay, whereas, if you could get access to more senior opinion sooner, you could discharge, take responsibility and then people’s use of the services could be diverted to the right place quicker. I very much support Mike’s point about whether the out-of-hours arrangements and the sort of access issues in play outside of hospitals are material to the solution? I think they are, but it comes back to whether we could use our technology—things like telephone or online consultations—much better. Of course you can do online consultations through the night, and there is a whole set of reasons why you can deal with some problems that way.

Q31 Grahame M. Morris: Didn’t someone introduce NHS Direct following that philosophy?

Mike Farrar: But NHS Direct was nurse-led. NHS 111 is protocol-led and it still takes a while to get to the doctor. That is one of the points I made about having senior decision makers at the earliest point. It seems to have a good impact.

Q32 Barbara Keeley: It is that point, really. In Manchester, we have had total collapse of NHS 111. It suggests it is going to lead very directly to a whole load of people who cannot get access to that medical advice and it is not nurse-led any more so people would not have the confidence in it. It seems to me that it is possible—we have raised the point about looking at places where social care changed a lot and clearly the collapse of NHS 111 in Manchester when it was first introduced—to work out the impact of these things. It seems strange that we have a national picture presented to us and yet we have had examples where things have really gone wrong. The same is true in commercial out-of-hours services in certain parts of the country, where the commercial provider that was brought in has not done a good job, not such a good job as a GP co-operative, and those arrangements have collapsed and caused lots of problems. There should be some case studies on these things to work out the impact they are having. I am surprised that we have this national picture and are not looking at these very specific examples that would suggest what goes wrong. When NHS 111 is introduced and then falls over, what impact does that have? Was there a spike in the A and E figures?

Mike Farrar: I could not disagree with the proposition that we should have more data to understand the consequences, but there is considerable variability. We are talking about case studies and it is often difficult to generalise. We try and present this aggregate figure and give general trends, but it—

Q33 Barbara Keeley: It is not helpful when so many things have changed.

Mike Farrar: No, and certainly I think you can look at case studies such as I have described. It is not just where it is failing, but understanding what is going right that points to what the future might be. Certainly we try to do that with our members and I know others are trying to do that, but we could and should do more.

Dr Cadigan: I think a very important principle was raised by Mike with “early senior review”. Wherever it has been looked at—in whichever setting, in the A and E department, the acute medical unit or in general practice—the fact that you have a senior decision maker available to assess patients and advise them at the point where admission is being considered has proven both to facilitate appropriate admissions and to prevent inappropriate admissions. That senior decision maker in the community could well be a general practitioner, and it would be very important that that general practitioner had access to complete records about the patient and any care plan decisions that had been made. That theme of continuity of care via continuity of information is an important one that we might want to explore when we talk about how the system works, but, if a general practitioner were in that role, then they could certainly function as a senior decision maker. The telephone experience that Mike is describing has the principle called “Doctor First”, where patients have access to a conversation with a doctor first, and that seems to work.

Dr Clancy: I find trying to understand the performance of 111 very difficult because I have not seen nationally collated figures of how the whole system is performing. Therefore, trying to get a balanced picture—such as whether Manchester, for example, is representative of the rest of the country—is problematic.

Q34 Barbara Keeley: I mentioned that because it collapsed when it was first introduced. The complete absence of NHS 111 probably has statistical significance. It might provide a case study.

Dr Clancy: I think the notion of patients having access to a telephone to get advice and guidance is a good one that should not be abandoned because of the difficulties we are experiencing at the moment. Patients have to have access to a resource that tells them what they need to do. It is our responsibility, as a health service, to deliver that.

Q35 Barbara Keeley: There is a question, surely, of whether that has to be a senior decision maker. We do not even have nurses any more on this service.

Dr Clancy: There is recurring evidence that the more senior the input and the earlier it is in the patient journey, the better the patient journey. If you choose alternatives to that, then you have to compensate by having people behind them to pick up the decisions.

Q36 Valerie Vaz: I am seriously concerned about what you are saying about patients having to speak to a doctor. You are sitting there as professionals, but the average patient probably would not know what to say and what to ask. As to this idea that you just ring up a doctor and tell them about your symptoms, I thought medicine was based on observation. I have had exactly the same experience and I have a degree in biochemistry and am a lawyer so can actually articulate it, but the average patient probably would not know what to ask, would they? Do you seriously think that is a good way for patients to be seen?
Mike Farrar: All I can do is rehearse with you the evidence from those practices in terms of the acceptability to patients of speaking to doctors on the phone, the evidence from some of the early telehealth studies where people have been seen on the line, and the fact that in those practices they have reduced the number of people who get face-to-face consultations and it does not seem to have any detrimental impact on outcomes. It is very difficult to generalise about patients. While you might say, “Can the average patient articulate their problems?”, we also have GPs who say the average patient comes in with reams of internet-printed script that they understand far better than they do and how can they possibly keep up with the evidence! Generalising about patients is a problem, but in those practices the evidence seems to be that patients like it and that there is no deterioration in their care as a consequence of getting a telephone consultation within 30 minutes.

Q37 Valerie Vaz: With the greatest respect, you are generalising and saying, “Patients like it”; and you have just based this on—what—the evidence of two practices? I can tell you that I do not like it.

Mike Farrar: Aren’t we both generalising?

Q38 Valerie Vaz: I don’t like being turned away from a surgery.

Mike Farrar: I was pointing to some practices that have actually done this.

Q39 Valerie Vaz: But I am saying we should be very careful and I do not accept what you say, that patients want to speak to a doctor, because you are putting the onus on the patients having to understand what they are being asked and not everyone would know that spewing up, or coughing up, green sputum is a bad thing.

Dr Cadigan: What I would say is that doctors spend a lot of time talking to patients, get pretty good at extracting relevant information and deciding whether that needs to be taken any further by perhaps asking the patient to come in to be examined. Of course what you lose is the face-to-face contact. You lose some of the way you can use your antennae in that way and the ability to examine patients, but, provided you are aware of those limitations, you can behave safely and usefully.

Q40 Valerie Vaz: You could not do that with an elderly patient, who maybe has complex needs, could you? I don’t know.

Dr Cadigan: Ideally that elderly patient with complex needs would have been assessed and you will have access to the information about that assessment. We might come on to that later.

Chair: We have a long list of questions in front of us. Mr George wants to come in and then I am going to move to David Tredinnick.

Q41 Andrew George: I want to pick up on Dr Clancy’s earlier comment that the sooner a patient can be seen by a senior clinician, a doctor, then the sooner the issue can be resolved. In my own area in Cornwall last year, the out-of-hours GP service began using the NHS Pathways telephony logarithm system and it immediately produced a spike in, or larger numbers of, patients coming to the emergency department of the local hospital. It appears from that—and it is backing up a lot of what you are saying—if you use a system with clinicians who don’t know the patients and telephone who are not clinically trained using that system, that it is more risk-averse and seems to produce more patients coming into emergency departments, clogging those departments up. Aren’t there lessons to be learned from that and from a lot else that you are saying, that you need to introduce more familiarity, early intervention of clinicians into the system?

Dr Clancy: What we are saying is judgment versus an algorithm and I think experience and judgment can trump an algorithm. The algorithms are risk-averse because, rightly, we do not want to get it wrong. It is a big responsibility for the people who are taking those calls, and that is why it is set in that way. One of the consequences of having that approach is that the referral rates, I suspect, will increase. One of the values of having an experienced clinical judgment at the beginning is that you can add more to the judgment than an algorithm.

Mike Farrar: It is important to qualify, from our perspective, that the importance of clinical judgment at an early stage is for those for whom there is a serious clinical condition that needs to be managed. There is a place for 111 but it needs to be in the context of other services. Equally, there is a significant place for keeping people well that avoids them having to look for advice and immediate assessment. Patrick’s point about the role of primary care being proactive in terms of managing people with known and chronic problems is the ultimate strategic position that you want to find rather than saying part of the way that we deal with this current crisis is to spend more time on very senior doctors being more available to people who have fairly minor needs. But for the group where there is a likely potential of admission, the access to a senior person sooner is where it is critical. Certainly, the amount of risk that a senior clinical perspective is prepared to manage compared to a junior view is significant in terms of the number of admissions that we have seen.

Q42 David Tredinnick: Specifically on the subject of risk, do you think that clinicians generally have become more risk-averse, particularly since the Francis report, in decisions relating to admissions and discharge? Do you think this could have contributed to the pressures on the system resulting in more trusts missing their four-hour targets?

Dr Cadigan: We are meeting in the shadow of the Francis report and we have been talking, I suppose, more about quantity than quality of care, but it is a very serious issue. Have people become more risk-averse since the Francis report? I do not know of any evidence about that, but the evidence that senior doctors admit fewer patients to hospital probably suggests that there is a confidence factor involved in discharging people. One of the disadvantages of having very junior doctors responsible for those decisions—and that still happens in some trusts—is
that they will be very risk-averse and will admit first of all. So managing uncertainty and risk is part of the essential professional skills, and that develops with time.

**Dr Clancy:** It is really hard to isolate, but people are more comfortable and confident around moving patients when it is to their benefit. As to the gaming issue and the pressures people are under, which we should not underestimate—units are under severe pressure to meet these targets—clinicians, nurses and doctors should feel more empowered and comfortable that, when they witness something that they do not think is right, they do not allow that to happen. That has been something that all of the colleges have encouraged and I know that Parliament has as well. That does translate into a different practice, but I do not believe it is a contributor to the present performance issue.

**Q43 Barbara Keeley:** Pressure to achieve cost savings has led elsewhere to a reduction in bed numbers, with the consequent impact on the ability of A and E to process patients. You talked a lot about flow issues, but at the same time there seems to be this increased demand for acute admissions, in that you said patients are more ill and more likely to need admission. Is there not a simple thing there, that part of this problem in A and E stems from a reduction in bed numbers? What is the evidence that that is a factor?

**Mike Farrar:** Bed numbers have reduced, but so has length of stay. Bed numbers are not the greatest guide. It is more about the use of beds and how hospitals are working. I would be very cautious about saying that the only solution to this is about creating more capacity. One of our problems at the moment, when we are trying to invest more in primary, social and community-based services to prevent people from needing hospital, is that the resource we need is very much tied up in our current expenditure in hospital. If anything, despite the fact that our strategy has been to invest more in primary and community, we have been, in percentage terms, putting more money into more hospital capacity and more hospital care over the recent decade than we have been putting into primary and community care; RCGP figures demonstrate that. So it is a great challenge. The challenge, in talking about bed numbers, is more about the flow of patients who need hospital getting really good quality care—getting the best care when they are in there so that they don’t have to be readmitted—having proper discharge planning when they arrive so that they can go out smoothly and getting the balance of investment in social care right so you are not waiting for access. But I think bed numbers per se is not a great number, and we would have problems if we started to have a political debate in this House that said we are protecting the NHS because we are keeping the bed numbers high. It is not about input; it is about the use of those beds.

**Q44 Barbara Keeley:** My question was opposite to that. There has been a reduction in bed numbers and now you have—clearly, because you have an increased number of more elderly, more ill patients who need admissions—an issue in that they are getting stuck in A and E because you cannot admit them. It is more than the other way round. I am not suggesting—

**Dr Cadigan:** I think that is right and there is an ambition to reduce the number of hospital beds.

**Q45 Barbara Keeley:** But is that the right ambition given that we now have an issue in A and E?

**Mike Farrar:** It is part of that flow.

**Dr Cadigan:** So the number of acute beds has gone down by something like 10% in the last 10 years. We have compensated for that by reducing length of stay. If you look at the length-of-stay graph, that has now started to plateau, so we are struggling to—

**Q46 Barbara Keeley:** But the link I am trying to chase is the link to the process and flow problem you have in A and E in that, if you cannot admit them, they are going to stick there in A and E until you can.

**Dr Cadigan:** Yes, and there are figures from local trusts showing that, this winter, length of stay went up. That is because it becomes more difficult to use that smaller number of beds efficiently. Because occupancy rates are very high, patients are in the wrong ward and they move ward four times, and it is difficult to deal with them in terms both of quality and efficiency of care when the number of beds is small.

**Q47 Barbara Keeley:** So there is a link.

**Dr Cadigan:** The more you reduce the number of beds, the more difficult it is to cope with variations and fluctuations.

**Q48 Barbara Keeley:** Obviously, so there is a link to this A and E problem, to the reduced number of beds.

**Dr Cadigan:** There probably is a minimum number of beds that we can manage with. The demographics of the ageing population suggest that we will have to maintain a certain number of beds. What that number is I do not think anybody knows, but it would be naïve—and this was said by the national clinical director for elderly care—to believe that any time soon there will be a reduction in the rate of acutely ill elderly patients coming to hospital.

**Dr Clancy:** When you are running occupancy close to 100% or more, it is incredibly hard to get patients into hospital. If you do not have some capacity, the turn-around times for these patients becomes more problematic. I am not an expert at flow, but about 85% occupancy, as I understand it, is the ideal level. Once you start operating at a much higher level, it is very difficult and we do not have that headroom to get these patients in and out of the system. That is where, with the bed reduction, in my view—and I have much sympathy for Mike’s argument about increasing capacity—there is some sense of having reached a ceiling here. If you cannot get the patients in easily and it is taking till four o’clock in the morning to solve these problems, do we need more capacity than we presently have?

**Q49 Valerie Vaz:** The majority of admissions at The Manor hospital seem to be elderly people. Would one of the solutions be a proper, integrated look at elderly...
people going straight to a specialist ward, rather than coming through A and E?  
Dr Cadigan: There have been many such solutions tried. Could I point you to the work that has been done in Leicester, by Dr Simon Conroy particularly, where a geriatrician is based in the A and E department and that geriatrician has access to a number of different facilities that can be used—access to intermediate care beds, elderly care psychiatry and to a frail elderly assessment unit? That is a point where you have a senior decision maker, responsible for that particularly difficult and challenging group of patients situated in a place where they can take a decision, and where they have access to alternatives to acute admission. That is a model that has been shown to work, has been shown to reduce admissions and to increase the quality of care. Of course, part of the work we are doing in our Future Hospital Commission is to go round the country looking at units like this. That work is being replicated and trialled in many other parts of country, so I think people are groping their way towards these solutions and might need some help to push it on.

Q50 Valerie Vaz: Where would they get that help from? Who gets a grip of all this? Where do they get that help from?  
Dr Cadigan: How is it paid for?

Q51 Valerie Vaz: No, who gets a grip of it? You said people are going round and there is information swirling around. Someone has to get a grip of all that information. Please don’t say it is the NHS Commissioning Board.  
Dr Cadigan: We are collecting some of that information.

Q52 Valerie Vaz: Right. Are you feeding it into somewhere?  
Dr Cadigan: Indeed. We have a project at the moment called the Future Hospital Commission.

Q53 Valerie Vaz: I know about that and have met representatives, but who would get a grip of all this information in the Department of Health?  
Dr Cadigan: The national clinical director for elderly care would be a good person to look at and there are publications from the Department on this, but I cannot tell you where they are at the minute.

Q54 Grahame M. Morris: I have a question about the kind of multifaceted nature of the increase in demand, but, just to go back to an earlier question, there is something I should bring to your attention, which I am sure you are aware of. We shouldn’t characterise all the increase in demand as being frail elderly. There are 500,000 disabled people under 65 who are falling out of the social care network who are not in the Department of Health?

Dr Cadigan: The national clinical director for elderly care would be a good person to look at and there are publications from the Department on this, but I cannot tell you where they are at the minute.

Q55 Grahame M. Morris: Can I ask your colleagues to reply as well? Could you also give us your thoughts on whether it is best to have a local solution in devising a recovery plan or whether there is undue influence from the centre, from NHS England?  
Dr Cadigan: Another easy question. As to the Urgent Care Boards, we welcome them, but cautiously, because to hand over the most difficult problem in the NHS at the moment to an immature organisation that is working under the aegis of several immature organisations is potentially hazardous. That being said, the idea that commissioning should drive this is an important one. To put the clinical commissioning groups at the centre of it seems to me a key. One of our hopes for the emergence of clinical commissioning is that it would allow sensible conversations between commissioners and providers in solving these sorts of problems. It is very interesting, again, that those trusts that have succeeded best in reducing hospital admissions have been trusts with a single commissioner, so the development of a relationship between a trust and a commissioner, which is capable of constructing perhaps new ways of working financially. Many of the successful projects that have achieved this have dismantled payment by results. It is interesting that Monitor is looking at payment systems at the moment. Collaboration between clinical commissioning groups and local providers with the right clinical advice has the potential for solving this problem. The difficulty is
that they do not have any more levers than we do at the moment and no more money.

Q56 Grahame M. Morris: It is another layer of bureaucracy when part of the concept was a simplification of structures and bureaucracy, yes. I am not putting words into your mouth; it is just a thought. Dr Clancy: I think the Urgent Care Boards are welcome. They are a recognition of the problem, but we have to ask ourselves why they have had to be formed when there is a group already responsible for the delivery of that care. This means that it is a very difficult problem to solve. The clinical care groups may well be the mechanism, but the responsibility and oversight of this whole problem, in my view, has to be central. It is a risk if we devolve this to local responsibility. We have many options, which may or may not be supported by the evidence, to explore. What is clear is that people are seeking guidance as to how to solve this problem because it is a very difficult problem. Unplanned attendances relate to a third of the health service’s activities and half of their budget. To allocate this to embryonic structures that are struggling with a very difficult problem, to me, seems not to be the safest way forward.

Q57 Chair: Do we have any idea, purely as a question of fact, how many Urgent Care Boards are envisaged? What is the process from where we are now? Dr Cadigan: I understand from the documentation I have read that there will be one related to each A and E department. Dr Clancy: I don’t know. I have the document somewhere.

Q58 Chair: Did you say one related to each A and E department? Dr Clancy: It may be each commissioning group, but there is a document from the Department. Chair: I think it is something about which we might seek guidance from the Department.

Q59 David Tredinnick: On these boards, it seems as if you—and I listened to Mr Farrar—were suggesting that there are almost mini-strategic health authorities, and that you lament the fact that we no longer have that oversight. They are certainly smaller, but—I am just trying to work out—I do not think they are quite as small as has just been suggested. Do you think that is fair? Mike Farrar: I would not want to call them mini-strategic health authorities because it is around a particular function. If this is a whole-systems issue and if we have fragmented budgets, which we do—so the spending of money in primary care, social care, community and hospital care, for specialist services and on prevention is all in separate pots with separate budget holders—and if you are trying to fix these things locally, I do not see any other way around getting a group of people who control those budgets together to look at how are they spending them with synergy to get a better service. I am not a great fan of saying you have to have committee structures to do it—I should not say that to a committee, should I?—but the reality is, to align those budgets and get a common purpose around what the solutions are, that you do need to bring people together. If the mechanism in the short term is Urgent Care Boards, then fine. Do they need to be a fixture for ever and a day? Hopefully not, but I think you do need to get them together to resolve it and I do not see any other way around that at the moment.

Q60 David Tredinnick: I have one other question on this, unless anyone else wants to come in through you, Chair. What do you think of the King’s Fund’s suggestion of urgent care networks, please? Dr Clancy: These suggestions, to my knowledge, are evidence-light and we have been subjected to repeated experimentation. I would ask that we do not adopt new things until we know they work. The urgent care centres were an experiment. We do not know whether they worked. They do not uniformly deliver the same service and so on. So I think we really need to ask the question, “Are these good things to do?” before we do them.

Q61 David Tredinnick: This is not strictly related to this, but it came up in earlier questioning. Why do you think there are so many more A and E admissions after midnight? Dr Clancy: It is a mixture of things. There is the issue of what society expects as well as what the patient needs. The concept of discharging somebody who has fallen over, who is elderly and on their own at night and who comes to your department, to send them back to their home with an element of uncertainty about how they will do, is not acceptable in society. The alternatives—

Q62 David Tredinnick: It is a cultural change, is it? Is it, going back to Francis, a risk-averse society that is now overloading the system? Dr Clancy: That is not necessarily related to Francis and was so before that.

Q63 David Tredinnick: It is health and safety. We were always talking about health and safety. Is it now that we have become so risk-averse that this is actually impinging on A and E’s capacity? Dr Clancy: The problem is that the options to discharge, for example, elderly falling patients in the middle of the night are negligible. The services that you can use to make sure that they go back safely are hard to assemble at night. Also, I believe that there were directives that we should not be moving around or discharging patients after midnight as well. So there are demands upon us that society expects of us as well as the clinical needs of the patient.

Q64 Valerie Vaz: I want to ask you, Dr Clancy, something you mentioned in your written evidence about rising demand. You also said “the lack of staff recruitment ensures that the ratio of doctors to patients has steadily worsened.” Do you have a figure for a safe ratio? Dr Clancy: I can tell you that we are seeing about 15 million patients and that there are in the order of 1,400 consultants. That works out at about just over seven
consultants per department. We have grown from four or so in 2007, so there has been an expansion, but there are not enough trained emergency physicians to deliver the care that the public expect. The recommendation of the college was a pragmatic one, which was, “How many consultants do you need to deliver a 16-hour presence”—in other words, up to midnight—“in a department?” The minimum number for that was 10. We are well short of that, but we had made substantial progress. That is not the major concern. The major concern—and this Committee really should understand this—is that junior doctors are choosing not to do this kind of work. This is difficult, unsociable, intense work. The fill rate into our higher training programme is half what it was and we have lost 200 future consultants because of that failed recruitment. The need to recruit more consultants is very evident. We know that, if you have consultants, associate specialists and other trained doctors, the quality of care improves.

My major concern for the future of the emergency care system is that not enough doctors want to do this work. I am talking about the emergency departments, but also the acute medical units and to the general practitioner at two in the morning in a tower block. The challenge that we face is: how do we value this work more highly than we do now and how do we ensure that we attract doctors into this work, which is difficult and hard, in a career that is sustainable? We are asking doctors to work till they are 67. This is tough work that many doctors migrate away from because it is hard. So one of the challenges is that we need—and we have talked about joined-up systems and thinking differently—to enable emergency work to be as valued as much as elective work and not seen as some annoyance to the hospital system that ruins their income generation. You may well come on to the funding of emergency care and the way in which it is inadequate and unfair, but the fundamental challenge that we face is that the future work force is not sufficient to deliver the care that the people of this country expect. The lag time to sort that out is about 10 years and it is not for lack of saying that.

Q65 Chair: I do not think there will be any disagreement in the Committee about the importance of that. Could I ask you for a check-list of three priority areas to address the lack of attractiveness of emergency medicine to young would-be consultants?

Dr Clancy: There would be a sense of commitment and a clear vision to address this problem so that people who are interested in this area could see that there is an intention to sort the problem out. By sorting the problem out, the circumstances under which they work become better because overcrowding starts to be addressed. We need to give them a work-life balance that is achievable. There is a remuneration issue to this, as there is in many walks of life, but we need to recognise the intensity and unsociability of this work to encourage doctors to join us. At the heart of this is a commitment and vision to sort the problem out. That requires a clear expression by all the trusts, Urgent Care Boards and whoever else, that they will solve this problem. If we cannot see the prospect of a solution, then attracting the good and best able doctors—my specialty is the most exciting, as you would expect me to say—will be difficult. The issue is the sustainability of doing this job and we need to look at how we can attract more people into it. It is about work-life balance, intensity, recognition and valuing emergency care more highly.

Q66 David Tredinnick: I find this a really extraordinary response, I have to say. I was lucky enough to be at a dinner last year at the Royal College of Surgeons and they were saying that surgeons who had gone out to Iraq and worked in emergency care regarded that as a huge benefit because they had learned so much in such a short time. I find it extraordinary that junior doctors would not see A and E as a terrific opportunity to improve their skills and actually to be in an extremely exciting place. I do not know what has happened to your marketing, but it seems very strange.

Dr Clancy: I would like to answer that comprehensively. You are absolutely right that this is an attractive, rewarding specialty. We attract our full quota into the training programme; the first three years are fully subscribed. After three years of exposure to this kind of work, half of them elect not to continue with it because of its intensity, its unsociability and the difficulty of delivering high-quality care in the system in which we work. There is no doubt about its value and its value to juniors. The issue is, “How do I carry on working like this in this area for the rest of my life?”

Dr Cadigan: If I may back Mike up, exactly the same is starting to apply to acute medicine, the stage when the 50 patients that have passed through Mike’s department are admitted, acutely ill, to the medical specialties. Recently, we have done a survey of our registrars and the junior doctors at the grade below registrar. The most junior doctors say they look up at their seniors and regard their work load as unmanageable: 80% regard it as unmanageable and they vote with their feet and go into other specialties, specialties with a more pastoral view of life. It is not because the work is not exciting, challenging and professionally rewarding if it is done in the right way, but no doctor finds satisfaction in working in an environment where you cannot behave professionally. If we come back to the Francis inquiry, many of the difficulties doctors had in behaving professionally were because of the working environment, overwork and lack of nursing support.

Q67 Dr Wollaston: I want to clarify something, going on from that. Do you think there is too great a pull factor in some other branches of medicine in that they are more remunerated from, say, the opportunities for private income and the opportunities not to do out-of-hours work? Do you think we need to be much clearer about how we are guiding junior doctors through the system—are we overtraining some specialties and that is hugely wasteful for the NHS as well, isn’t it?

Dr Cadigan: Part of the solution to the problem with acute medicine—and I am not going to talk about A and E at the moment but about acute medicine—is to
try and make it an attractive specialty. How do you make it enjoyable for people to do? It has never been a glamorous specialty, whereas specialties like my own—cardiology—have had a certain glamour over the years. It is not just glamour; it is about the quality of life and the quality of work.

If you are a specialist, you tend to work in a specialist unit: you work in an enclave where you can protect in terms of the sorts of patients you accept into that unit; you work with a consistent team; you work on a group of patients that you know you can deliver good results to. When you move outside that specialist environment into the general medical wards, the wards into which patients are admitted if they do not have a very specialist need, such as a heart attack or a stroke, you find a very different environment where you cannot control the patients coming in; whereas if you do not work with a consistent team and you may be working with a different group of doctors every day; where neither the doctors nor the patients benefit from continuity of care; and where, because of the pressure on beds, patients may move from ward to ward four times within the first 48 hours. That is not a proliferation of rewardingly, safe or educationally good environment. So there are big contrasts between the life you have in a specialty unit and the life you have in the general hurly-burly of the medical wards and the A and E department. We would like to do some work to change that and we have a number of ideas of how it could be done.

Chair: This is a subject, if I may say so, for another day, otherwise we are going to be here till supper time.

Q68 Dr Wollaston: Dr Clancy, if I may, how much of an A and E consultant’s time is spent actually seeing patients? I know across the board in the NHS that very many senior consultants end up spending a huge amount of time actually doing paperwork and relatively little time in face-to-face patient contact? How big an issue is that for A and E?

Dr Clancy: It is not a model I recognise. That was a criticism a decade ago. All the consultants are paid to deliver direct clinical care. The supervision and performance of these departments is very closely monitored and the clinicians are accountable for their performance and where they are. I believe that the consultants are out there seeing patients. That is certainly where I would expect them to be and that is what they are paid to do.

Q69 Dr Wollaston: I have one final point, if I may. In your estimation, how much is the problem with access and waiting times due to the impact of things like alcohol, say, on a Friday and Saturday night in A and E? How big an issue is that?

Dr Clancy: Alcohol is a big issue—it is a contributor—and it varies from inner city to rural areas. The estimates vary from 20% to 30% in some units at particular times of the day, so overnight, for example. Alcohol is a significant contributor to attendances, but it is no worse now than it has been over the past few years. I would draw one thing to your attention, which is about consultant presence—what you rightly asked me about. At the moment, with the number of consultants we have, we are able to deliver a 12-hour presence 77% of the time on weekdays but only 30% of the time at weekends. The challenge for us is how we get that presence there when patients need it. This can be simplistically reduced to doctors working at the wrong time, not doing the right patients need. What we need to do is shift when we work and what we do to address the pressures that the patients are making very clear to us they want addressed.

Q70 Chair: Why is that simplistic?

Dr Clancy: Because there are many factors at play. I think it is a professional challenge as well. As Patrick alludes to, trying to move things around is challenging, and that comes back to our point, which is that we have to make this work—the thing to do for the future that people want to do—to move those curves over to where they need to be.

Q71 Chair: I agree but I was just picking up your word “simplistic”. It struck me that you used the word “simplistic” and then went on to describe precisely what most of us, including, I suspect, you, would want changing.

Dr Clancy: Okay, fine.

Q72 Dr Wollaston: Just simply, if you make more doctors work those hours to provide that cover, you are going to have even fewer people wanting to go into A and E. Is that the challenge that you mean?

Dr Clancy: If we ever get to the situation where we do not need any more people, that is fine, but we are so far away from that. Trying to solve this problem at the rate we are solving it is going to take 17, 18 or 20 years.

Q73 Valerie Vaz: Do you have a percentage of locums in A and E?

Dr Clancy: Yes. There is a survey document, which we will make available to you, that shows that in the key decision makers the vacancy and locum rate, other than consultants, is about 20% plus and the vacancy in locum rate for consultants is about 17%. Trusts at the moment are spending, on average, per trust £500,000 per annum in locum costs for emergency departments. That is a resource that really should be allocated in the future for substantive, trained doctors who want to do this work.

Chair: We need to move on to money.

Q74 Grahame M. Morris: I know there are lots of questions around these issues that you have touched on and in fact I think Dr Cadigan mentioned his concerns about these immature organisations, or the embryonic organisations that Dr Clancy mentioned, the Urgent Care Boards. But just in terms of the money and the suggestion that 70% would be retained from the excess urgent care tariff and somehow used to reduce pressure on A and E departments, NHS England—the commissioning board—is saying that should inform its decision making. What are your thoughts, quite quickly, because I know we do not have a lot of time?

Mike Farrar: Very quickly, the history of that split was that there was a view, probably three years ago,
that part of the reason for that demand in A and E going up was supply-induced demand, that trusts got paid more because of the people who came through. The idea was trialled, effectively—and I think it has been, although it has stuck—that the primary care trusts would pay 100% but only 30% of that would go to the provider. The 70% would go to the strategic health authority—now to NHS England—and the idea was to try and change the incentives around not treating people. The baseline was set at the 2009 level, so anything over and above that contractually was eligible for these arrangements. It is patently clear that supply-induced demand is not the driver here because trusts are now losing significant sums of money on people, but that rule is still in play.

There are two ways you could change that. One would be to scrap it, so trusts get 100% of any payments for people over the 2009 baseline. If you do that, obviously the trusts will be in a better financial position but it may not do anything about changing the direction, the flow, of patients into those services. The alternative is to say, "Well, that 70% that is available should be used to redirect the work. It should be used to redirect patients by providing better services away from the hospital." That is quite an interesting debate about whether you simply accept it has not worked, put all the money still available into the hospital sector—in other words, money follows the patient—or do you try and put the money where you want the patient to go by putting more of that 70% into alternatives to hospital care? I certainly would favour the second, but certainly the way it is working at the moment is that the hospitals are getting the worst of all possible worlds because they have the patients and they are not getting the money. That is not sustainable and it is now punitive.

Dr Cadigan: It is demoralising as well. In addition to the 30% rate, we have the question of ambulance fines.

Q75 Chair: Is there not a problem with this argument that it assumes the 70% is somehow in a bank somewhere and nobody is spending it? It is actually currently being used to pay for other services.

Mike Farrar: It is and you cannot predict it, of course, because it fluctuates quarter on quarter. So, in terms of planning to invest that in alternative services, it is much more difficult. What is absolutely vital is that that money is still available in the local system.

Q76 Chair: It is being used in the local system.

Mike Farrar: It is money that is allocated to the local system. A commissioner in their budget will have a certain amount of resources that they think they have contracted for with the acute provider. If they go over and above that contract, they now pay 30% across and have 70% that is effectively given to NHS England. So it is money that you can deploy but you cannot plan it. It is very difficult to plan it because it depends on contractual performance. This is why there was a big debate about how much actually that money is, whether it is the £70 million to £80 million, which I think NHS England described. But there was a view at one point that it was £300 million to £400 million.

Q77 Chair: The HSJ thinks it is £400 million.

Mike Farrar: It is very difficult to say that we will take that and spend it on a recurrent basis on alternatives. There are things you could do with that money inside as well as outside the hospital to try and move the work through.

Q78 Barbara Keeley: We are moving on to ambulance services now. There has been increased pressure on ambulance services. I suppose that is not surprising given what you have said about increased demand. The number of emergency and urgent calls has increased by 4% every year since 2007–08. So I guess it is just a question of what weight we should give to some of the other things we have talked about, the problems with NHS 111 and the fact that patients do not seem to have the confidence they might have in out-of-hours services. Or is this just a straightforward increase in demand, as you have talked about? Is that the issue? It is the case, I think, that six ambulance trusts failed to achieve the standard of 75% emergency response within eight minutes for the category A calls.

Mike Farrar: First, we have a very narrow window of assessing whether ambulance services are good, which is one very small target, which largely relates to if you have a cardiovascular sort of emergency. Our ambulance service is the best in the world compared with anybody else’s, so we should not forget that. The second thing is that they have had to cope with an additional demand but they have also been modernising. The interesting figure with ambulance services is the conveyancing rate. That is effectively the ability for ambulance services to deploy a paramedic who can immediately treat, support and avoid people coming into A and E. There is quite a good deal of variability in conveyancing rates between ambulance services. The ambulance services sit right at the heart of this and they could be very much part of the solution, but we need to strengthen and support them in this. I am sympathetic to ambulance services who find their capacity tied up sat outside A and E departments. It is not a great place for patients to be, but we also have to support our ambulance services to be a part of the service provision rather than just seeing them as a mode of transport. We can do better in that respect.

Q79 Barbara Keeley: The point of my question is how much is increased demand just straightforward increased demand? Are other factors playing into it such as problems with NHS 111 and lack of
Mike Farrar: First of all I was not suggesting that it was unimportant. I think I said the four-hour indicator is a really good indicator of flow, but it is not clinically relevant. If you have a heart attack, you need to be seen much quicker than that. That is the point I was trying to make. As to the eight minutes—75% within eight minutes, which I was talking about for immediate response—

Q81 Andrew Percy: I am sorry, that is what I was thinking of, not four hours. I meant the eight-minute thing; I was miles away on something else and, in my defence, I am ill.

Mike Farrar: That is an important indicator and for many patients there is the clinical—my colleagues here will know—validity of the eight-minute standard for people who have heart attacks. But eight minutes is not necessarily, again, clinically relevant for everybody; it is particularly key for certain conditions. I am not advocating getting rid of that standard as a way of assessing people. I was saying that there has been a perception that ambulance services in this country are not very good because a number have struggled to hit that 75% target. I was making the point more charitably—and I think quite rightly—that our ambulance services are the best in the world when you take their performance in the round.

Q82 Andrew Percy: I understand. I just worry that, if we lost the eight-minute target, the first thing that would happen is that resources would be moved back to urban areas because that is where the call demand is. The only thing that keeps ambulance trusts maintaining the resources they do in our rural areas is the fear of not hitting the 75%, which my trust, Yorkshire Ambulance Service, has not done. That is about the only thing that has encouraged them to keep resources out in our rural areas.

I am also interested in what ambulance services can practically do to assist with this A and E demand issue. I have been at lots of jobs over the last few months and they are only red 1 or red 2; so I understand they are very serious calls, with the potential of risk to life and all the rest of it. But in pretty much every circumstance, even when it has been perfectly clear that a patient is not particularly ill, because of perhaps being risk-averse and all the rest of it, the first thing that happens is that the person is bundled into an ambulance and taken off to A and E, some 30 miles away in some cases. I wonder what can be done practicably. What is the role for an ambulance service in a rural area like that where there is nothing else for them to be transferred to? How do they contribute to alternative pathways? Is there any good work around the country?

Mike Farrar: Again, colleagues will add their bit, but I think the conveyancing rates vary. Different ambulance services have different services available. In rural areas it may well be that A and E is a very sensible place to take people. The ability to discharge from A and E on arrival, if they are stabilised well at immediate point of treatment or indeed to reduce the length of stay because of any complications that might emerge, can be massively affected by the immediate response. As a first responder, all the evidence is
The broader theme is that, faced with a growing medical manpower crisis, we should use every way we can, that will probably help the whole system.

Dr Cadigan: The broader theme is that, faced with a medical manpower crisis, we should use every opportunity of using other healthcare professionals to help out, skill them up and train them as appropriate.

Q84 Barbara Keeley: I do not represent a rural area—I represent part of Salford—and I think there is really quite a heavy load now put on first responders. Andrew talked about that and clearly they do have a role to play in rural areas, but talking to one of the first people trained as a first responder in Salford I am amazed at how much she gets called. That is a thing that is quite usual—people like that and people like Andrew are being called on really quite substantially, to very serious calls, and they are volunteers. We need to be careful that they are not being overused. They are not a substitute for paramedics, nor should they be.

Mike Farrar: On that point of the growth in major injuries units, there was a big push throughout the early part of the last decade around getting the numbers of paramedics available through ambulance services increased. I suspect that has levelled off with the resources. Again, looking at solutions for the ambulance service, recruitment of paramedics may well be a wise and sensible investment for trying to tackle some of the problems.

Q85 Chair: I want to probe you on this question of differentiated response-time targets. Do you have any formulation that you think would be more appropriate than the 75% within eight minutes?

Mike Farrar: It is worth talking to the experts about the conditions where the eight-minute standard is absolutely about saving lives and others where it is not. Obviously there is the triaging done on the phone in the first instance, about the dispatch of the ambulance, but within the eight-minute frame I have to defer to my colleagues here, I think.

Dr Clancy: I think I know where I can find the evidence for you, but it would be wrong of me to portray it.

Q86 Chair: If you have thoughts on the question of a more refined version of what good looks like in emergency response times for ambulances, the Committee would like to see it.

Dr Clancy: I will try and find that.

Q87 Andrew Percy: On that point about paramedics, I am not saying that the eight-minute target is necessarily perfect. I had a paramedic who said to me once, “If we turn up in seven and a half minutes and they die, that is okay, but, if we arrive in nine and they survive, we are still penalised.” So it does seem a bit wrong. I want to get your opinion on the use of minor injuries units, which are quite important in rural areas. The conveyance rate for ambulance services to minor injury units is incredibly low because of this risk-averse nature, I think, of actually taking someone to an MIU where it may be nurse-led; fortunately, in my town it is doctor-led. It seems to me—and I can only say this from the experience of the many calls I have been to—that there is a fear of taking them anywhere other than A and E, because, if something goes wrong, it is the ambulance service that would be liable. I am not convinced that the training, the pathways or even the processes are in place to support ambulance crews and paramedics in making a decision other than, “We will transfer to A and E.” Minor injuries units seem to be coming under attack at the moment because a lot of trusts are looking at them and saying, as to the figures they present you with, “Oh, well, they are not very well used. Look at these rates overnight.” It seems to me that they should be part of the solution to this, but more and more of them are being downgraded from doctor-led to nurse-led or being closed overnight. Do you have a view on that at all?
Dr Clancy: The point about a wider workforce delivering clinical care over a longer period of time is really important. This is another example of getting the right patient to the right service. There are a number of patients that could be very successfully looked after in minor injuries units that are transferred to emergency departments. That is about holding the system to account. It is that accounting process that, maybe, we do not have developed well enough at the moment. If, for example, patients were unnecessarily transferred to the emergency department, at the moment I do not have any obvious way of feeding back that that could have been looked after at a lower-cost institution, for example; I just carry on and get on with it. It is that lack of joined-up responsibility and sharing of what is happening and how we can improve it that is missing from the system at the moment.

Q88 Andrew George: But you have protocols to deal with this.

Dr Clancy: Yes, there are protocols, but they involve a degree of judgment as well and also there is an overlay at that pressure. Paramedics do not get it wrong—and I acknowledge that fully. I am very sympathetic to the choice to go to a higher level of care. We need to support them is what I am saying.

Q89 Mr Sharma: My question was partially answered, and you both used the response that more skills and resources need to be given to the ambulance crews so that they can provide the service. Do you think that the commissioning of ambulance services can play a part in redesigning to make them more adept at reducing A and E attendances and to bring their incentives and priorities in line with those of other providers?

Mike Farrar: Commissioning has a really important role to play when you have a series of pathways that cross different bits of the system. What commissioning should and could do very well is help co-ordinate the different responses at the different times and get the investment right. Part of the secret of really good strategic commissioning—and I am a big fan of clinical commissioning—is about getting it right—so I am not sure and I acknowledge that fully. I am very sympathetic to the choice to go to a higher level of care. We need to support them is what I am saying.

Q90 Chair: It might be a job for a larger Urgent Care Board.

Mike Farrar: It could be, couldn’t it?

Q91 David Tredinnick: I have some quick questions about influence pre and post the recent reforms. Do you think the new commissioning structures enable the clinical commissioning groups to have greater influence on design and clinicians than the old primary care trusts, under the old arrangements? Do you think the Health and Social Care Act has made a dramatic difference or not? It is a pretty soft question.

Mike Farrar: I am sure Patrick and Mike will have views themselves. One of the big risks—one of the reforms I have already mentioned, so I will just mention it briefly again—is this. I worked for many years to try to unify budgets and all the evidence, I think, of how you get best value out of budgets is that you have a unified budget which you can deploy flexibly to the right areas. I worry enormously that one of the things we have structurally built into the new system is different budget holders for different bits of the budget, social care, particularly primary care, separate from hospital and community budgets, and specialist services. If we are being really strategic, the health improvement spend in another place as well is a big risk. In terms of the new system, I am not worried about clinicians having a greater responsibility—that is a great step forward—but the deployment of fragmented budgets worries me a lot.

Dr Cadigan: It is very difficult to say yet whether it has worked or not, but from conversations with colleagues around the country there are good examples of clinician-to-clinician conversations resolving some difficult problems. As I said earlier, one of the things that is done in successful groups that have achieved integrated care—and I think integrated care is going to be part of the solution to the sort of problems we are talking about—is that they have reached mutual arrangements to dismantle standard payment by results and gone for shared financial incentives and shared financial risk solutions. That seems to be a model that is going to have to be fostered.

Dr Clancy: The college has done a survey recently that was undertaken last year and a third of emergency departments reported that they weren’t directly involved in any discussions with their commissioning groups. Patrick makes the point that when there is good engagement there is progress, but when there is no engagement that could be an impediment. Engagement with those people who deliver the care is of paramount importance and I think that these groups should be mandated, or that involvement of the people who deliver the care should be insisted upon. It should not be an option whether they are engaged or not. A concern for our specialty is that we are not getting the engagement that we need.

Q92 David Tredinnick: If the Health and Wellbeing Boards are anything to go by—having attended a local
one in Hinckley, in my constituency—we are getting a huge level of co-operation between county council, borough council, doctors and all the other associated people there; it is quite an impressive result.

**Mike Farrar:** I think Health and Wellbeing Boards could have a really positive effect on the preventative element as well, supporting people around avoiding lifestyle problems.

**Chair:** Sarah wants the last word.

**Q93 Dr Wollaston:** Before I ask the last question, I will state for the record that I am married to an NHS consultant psychiatrist. We have touched on commissioning services that avoid cases arriving in casualty in the first place, but do you think there is a greater role for commissioning services that act as a diversion once people are there, so, for example, liaison psychiatry, I am referring to, specifically in the role that has in reducing readmissions, services for dual diagnosis once people are in casualty, that kind of area? How important a role is that for us to look at in the throughput through casualties?

**Dr Clancy:** Mental health is the big neglected area. That plays itself out in emergency departments where it is not easy to get the resources that you need to look after these patients. Mental health crosses not only those who are mentally ill but many other patients as well. It is well recognised that that is a serious area where there is inadequate provision. In many ways, emergency departments are not the best location for patients who are psychiatrically unwell to be cared for but they end up there because there is no better alternative. I think we need to recognise that the provision of help for the mentally ill is inadequate.

**Mike Farrar:** There is a specific scheme that was developed around the West Midlands mental health service called RAID. It is a particular model with protocols, which has been seen to be very successful in helping to manage patients with mental illness who appear in emergency departments.

**Q94 Dr Wollaston:** I have seen some figures from RAID looking at up to 30% of re-attendances being prevented.

**Mike Farrar:** “Avoided”, but, basically, for the people for whom this is a relevant service—that is, people with mental health and physical problems—this is a very effective way of avoiding them ending up in hospital, yes.

**Q95 Dr Wollaston:** So why are we so poor in the NHS at rolling out successful projects?

**Mike Farrar:** The holy grail.

**Chair:** Shall we address that on another day? Thank you very much. It is surprising, but then again perhaps not surprising, that almost whatever the inquiry we conduct we end up needing more integrated services. That is one of the strong messages that I think we all take away from what you have said this morning. Thank you very much.
Tuesday 4 June 2013

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Barbara Keeley
Grahame M. Morris
Andrew Percy
Mr Virendra Sharma
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Witnesses: Anthony Marsh, Chair, Association of Ambulance Chief Executives and Chief Executive, West Midlands Ambulance Service NHS Foundation Trust, and Mark Docherty, Chair, National Ambulance Commissioners Group, gave evidence.

Q96 Chair: Good morning. Thank you for coming this morning. Can I ask you to begin the session by briefly introducing yourselves and your posts?

Anthony Marsh: Good morning. I am Anthony Marsh. I am the chairman of the Association of Ambulance Chief Executives and the chief executive of the West Midlands Ambulance Service NHS Foundation Trust.

Mark Docherty: Good morning. I am Mark Docherty. I am chairperson of the National Ambulance Commissioners Group.

Q97 Chair: Thank you very much. I would like to begin by focusing specifically on the question of commissioning. The question is focused particularly on Mr Docherty, but I am interested in both witnesses’ points of view on this. In this session, we are interested primarily in ambulances but only, in truth, in ambulances as part of the ability of the NHS as a whole to respond to needs for urgent and emergency care. This morning, we have press stories about further problems in A and E departments. We have stories with a later witness, Clare Gerada from the Royal College of GPs. Everyone agrees that there are further problems in A and E departments. We have stories with a later witness, Clare Gerada from the Royal College of GPs. Everyone agrees that there needs to be a more integrated capacity for the system to respond to the need for urgent and emergency care. I would like to open the session by asking how the commissioning system is developing to deliver not an ambulance service, an A and E service and a primary care service—different bits that are unrelated—but an integrated, joined-up service. In particular, how is the ambulance service—different bits that are unrelated—but an integrated, joined-up service. In particular, how is the ambulance service being commissioned in most parts by a consortium arrangement of clinical commissioning groups across the geographical footprint of the ambulance service, but then, more locally, through the urgent care boards. In most places around the country, those arrangements have existed to a lesser or greater extent—although they may have been called something different—to pull together some more local CCGs to ensure that the service is commissioned locally for their people. In addition to that, sometimes further local arrangements are put in place by clinical commissioning groups for their local population. Obviously, it is early days—clinical commissioning groups have not been in existence for very long—but we welcome wider clinical engagement. I think that will help and support ambulance services to shift to becoming more clinically focused providers of services and ensure that the services are delivered to meet the needs of local populations, because of course those do vary—one size does not fit all.

Mark Docherty: That would be an ideal, but what we have described in previous work we have undertaken is different levels of commissioning. Commissioning ambulance services for emergency preparedness—terror attacks and things like that—needs to happen on a very large scale, we believe, probably on an England-wide scale, whereas commissioning ambulance services to take patients to alternative pathways of care has to happen on a very local basis, because that can be designed only around very local health care systems. The collaboration has to happen on different scales, depending on the type of ambulance response we are talking about.

Anthony Marsh: You mentioned the urgent care boards. What Mark has just said is absolutely right. You have the core 999 emergency service being commissioned in most parts by a consortium arrangement of clinical commissioning groups across the geographical footprint of the ambulance service, but then, more locally, through the urgent care boards. In most places around the country, those arrangements have existed to a lesser or greater extent—although they may have been called something different—to pull together some more local CCGs to ensure that the service is commissioned locally for their people. In addition to that, sometimes further local arrangements are put in place by clinical commissioning groups for their local population. Obviously, it is early days—clinical commissioning groups have not been in existence for very long—but we welcome wider clinical engagement. I think that will help and support ambulance services to shift to becoming more clinically focused providers of services and ensure that the services are delivered to meet the needs of local populations, because of course those do vary—one size does not fit all.
Q99 Chair: But when we are told—as we have already been told in this inquiry and are regularly told—that the key to effective response to urgent care needs is a joined-up service, who is responsible for delivering that?

Anthony Marsh: Commissioners are responsible for commissioning it and the providers with whom they commission are responsible for delivering it. You are absolutely right. We welcome the integration of ambulance services and the 999 service, out of hours, NHS 111 and other—

Q100 Chair: We all welcome the words. Can we focus on any evidence that anything is happening actually to join up these different silos—including, incidentally, social care?

Anthony Marsh: In some parts of the country—I am not aware of every particular part—there are single commissioners with responsibility for the out-of-hours service, the 999 ambulance service and NHS 111. That is a good start; at least the same individual or teams of individuals within a CCG are working on behalf of the other CCGs within a geographical footprint. In my patch, all 22 across the west midlands together commission NHS 111 and the 999 service. The arrangements are in place to make that happen, but clearly there is an opportunity to strengthen that and really to make sure that it is mainstreamed through the commissioning arrangements.

Q101 Chair: How does that link with the commissioning boards’ responsibility for commissioning primary care?

Mark Docherty: The important thing is that we make sure that all of these commissioning arrangements are joined up. Primary care is clearly an important part of the system that prevents people from accessing urgent and emergency care. For many patients, primary care would be the first port of call.

Q102 Chair: According to the Royal College of Physicians, it would be if the light were on.

Mark Docherty: Yes. The important thing for the ambulance service is that for many patients that will be their first port of access to the health care system. Increasingly, we are finding that some younger patients are choosing to access emergency or urgent services as opposed to primary care. The important thing is that it should not matter how patients access—it is the response we give to that request for access that is important. Increasingly, the ambulance service will send an alternative response or signpost a patient to an alternative, more appropriate service. Anthony’s service in the west midlands would convey a 999 response to about two thirds of the patients it gets; the other third would be directed to places such as primary care, GP out-of-hours services, walk-in centres or community services. The important thing is that we have access to that range of services, irrespective of how the patient has accessed, and what they think is an appropriate way of accessing, the service.

Chair: Okay. We could spend all morning discussing this, but perhaps we should not.

Q103 David Tredinnick: An increasing number of ambulance trusts are failing to meet the Red1 eight-minute response target. In the short term, what do you think can be done to improve that situation?

Anthony Marsh: The Red1 target is a new target; it has only been in existence for just over a year. Most ambulance services are achieving it, and those services that are not are continuing to make improvements. There is a lot of benchworking going on among the director groups to establish best practice and how we can respond even more quickly to those patients with serious and life-threatening emergencies. From speaking to colleagues, I am confident that they have an action plan in place that will enable them to improve on that target, particularly the Red1 target for life-threatening emergencies.

Q104 David Tredinnick: We are getting a lot of media coverage about the increased pressure on ambulance services. Do you think there is any evidence that patient outcomes are worsening as a result of this?

Anthony Marsh: Certainly the ambulance quality indicators and the clinical indicators for ambulance services show an improvement. We have been able to improve in relation to patients suffering from cardiac emergency, stroke and, more recently, trauma, as a consequence of the introduction of trauma networks. Patients are benefiting from those new arrangements and, of course, from the increase in the number of paramedics who are being trained and the additional paramedics who have been recruited to work in ambulance services. You are right, there are occasions when ambulance services are under pressure—the CQC’s recent reports on some ambulance services are evidence of that—but be assured that ambulance staff on the front line and their supporting organisations are doing everything they can to deal with the increase in 999 calls. On average, over the last 10 years, there has been an increase year on year of about 4.5%.

Q105 David Tredinnick: You just mentioned the trauma networks that have been formed. How effective are those? How do you think they are going?

Anthony Marsh: Where they have been and are fully implemented—I am aware that in some parts of the country full implementation may still be being put in place—we have seen substantial numbers of additional lives being saved. The latest evidence that I saw was an improvement of an additional 5% of lives being saved as a consequence of those new arrangements, which enable advanced-trained paramedics to bypass existing emergency departments to take those patients who are most critically injured to a regional trauma centre so that they can get the very best care.

Q106 David Tredinnick: So it is another example of better targeting of resources. Is that right?

Anthony Marsh: Absolutely right—and ambulance staff are well placed to be able to provide those services.

Q107 David Tredinnick: Moving on from that, do you think that the splitting of the category A calls into
Red1 and Red2 has achieved the Government’s aim of reducing the number of inappropriate and, possibly, mischievous calls and the multiple dispatch of ambulances?

**Anthony Marsh:** I am not sure that it has reduced the number of calls—I am not sure that that was one of our objectives—but being able to target the finite resources that ambulance services have and to prioritise those calls more effectively to ensure that we are able to get to the Red1 patients even more quickly is helping patients and, undoubtedly, saving more lives.

Q.108 David Tredinnick: Finally, in your long experience in this service, do you think that generally we make sufficient and effective use of computers in allocating resources? Do you think that the information technology is up to the task, or have you identified problems there?

**Anthony Marsh:** I have no doubt that the extent to which we use computer technology in our control rooms is world class. Could it be better? Yes, it could—I am absolutely sure that there are areas where we can make further improvements—but the progress that has been made is really first class. I do think that the use of technology in ambulance services in the broader sense could be improved. The extent to which we can use electronic patient report forms, rather than having to fill out paper documents for assessing and treating patients, is an area where we could make further improvements. It would also be enormously helpful for front-line paramedics—both those in the control room and responding paramedics—to have access to the national spine, which would enable them to pull down useful and critical information about a particular patient, rather than looking at patients with very limited information, as is very often the case.

Q.109 David Tredinnick: So you very much support the Health Secretary Jeremy Hunt’s idea of getting all the medical records on to a computer?

**Anthony Marsh:** I certainly support access for paramedics to critical information. I am not saying that paramedics need access to all health records for a particular patient, but they certainly need the most critical information in order to make better-informed clinical decisions and clinical assessment for those emergency patients.

Q.110 Mr Sharma: My question is on indicators. What clinical outcome indicators could be included in ambulance services performance measurement to provide a better picture of overall service performance?

**Anthony Marsh:** Good progress has certainly been made on shifting towards a greater emphasis on clinical performance and clinical outcomes, rather than just the speed of response, although that is really important and we should not lose sight of it. Good progress has been made in relation to the key indicators that we put in place for ambulance services a couple of years ago—in relation to patients suffering from heart attacks, stroke, asthma, hypoglycaemia and other indicators—but I think we can place even greater emphasis on those clinical indicators to improve performance, to reduce variation and to provide better training and reflective practice for our paramedics, so that they become even more confident and competent and can provide even better services for patients.

**Mark Docherty:** The important thing in measuring clinical outcomes is that we look at the clinical outcome of the pathway of care and not just the individual sections of the care. We know there are services where one part of the system can produce very good clinical outcomes, but, if a different part of the system is not also producing good clinical outcomes, the net result for the patient is not a good outcome. We need to become more sophisticated at that—for example, by measuring the patient’s unique NHS number as they go through the care pathway. At the moment, we measure the pathway outcome for people who have a cardiac arrest, so we know the patients who leave hospital alive and the ones who are alive up to a month later. We can become more sophisticated at measuring those pathway outcomes.

Q.111 Grahame M. Morris: This issue has been very much in the news—and again today, with the King’s Fund report on the growing pressures on A and Es. In the evidence you have submitted, you indicate that greater use can be made of skilled paramedics who can exercise clinical judgment and that that can have an impact not just in the conveyance of patients to hospital. If that is an appropriate avenue to go down, why is it not standard? Is that an issue for commissioners? Is there a particular reason why that is not the norm?

**Mark Docherty:** If you take the traditional ambulance model from 20 or so years ago, it was predominantly a transport system to get sick people into hospital. That is the background the ambulance service has come from. In recent years, we have seen the development of paramedics, enhanced care practitioners or consultant paramedics, in some parts of the country, so the skill mix in ambulance services is growing at a fairly rapid pace, against a backdrop of increasing demand. It is taking time for skill mixes to increase, but in some parts of the country, we are getting close to a 70% paramedic skill mix. The significance of the 70% paramedic skill mix is that with that skill mix you can ensure that every vehicle has a paramedic on board, so that whichever vehicle responds to the patient the first response that gets to the patient will include a paramedic. Up to now, that has not been possible. With less than 70% skill mix, that will always be a challenge, but most ambulance services are increasing their skill mix fairly rapidly.

**Anthony Marsh:** That is absolutely right. As a consequence of that, we have seen conveyance rates of patients fall from about 70% or more in some parts of the country five years ago to just over 50% now. That number is continuing to reduce, despite increases in 999 calls.

**Mark Docherty:** It is not just about having paramedics. Paramedics are very well trained in saving lives. We are finding that the clinical need of patients is urgent primary care, so enhancing the skills of the paramedic beyond trauma and life-saving care
into the field of urgent primary care is a development that we are starting to see happen more.

Q112 Grahame M. Morris: Is using the clinical skills of the trained paramedic now the norm, or is it just a trend? Is it just part of the solution, not just to relieve the pressure on A and E but to ensure better outcomes, because patients are referred to the appropriate service, which may be primary care? A and E may not necessarily be the best place for them.

Mark Docherty: Some of these patients have really complex needs. It is a difficult environment for clinicians to work in. Even some of the most experienced clinicians will struggle to make decisions in a pre-hospital environment, where your access to diagnostics and a whole range of other things is fairly limited. We have to build the skill of those paramedics so that they have the knowledge, the experience and the expertise. For example, an elderly person with a chest infection may have some quite serious underlying issues; experience may be needed to get to the bottom of those.

Anthony Marsh: You asked about the solution. Paramedics and advanced-trained paramedics are absolutely part of the solution. Paramedics in the ambulance service enjoy high rates of public confidence and are very well placed to be able to expand what is already taking place in many parts of our country.

Q113 Andrew Percy: Following on from Grahame’s point, while the conveying rates and the alternative pathways are important, on Friday I met the chief exec of one of my two ambulance trusts, who explained to me that, perversely, there is a disincentive financially to the trust to reduce call rates. Obviously you have regular offenders, if you want to call them that—nursing homes and care homes, in particular, are very big users of the service, sometimes unnecessarily—but, if the trust were to work to reduce those calls, it would, of course, see a drop in income. Do we need to change the way in which this whole model is commissioned to pay trusts by results on how well they do in reducing call demand as well, through other work in the community?

Anthony Marsh: I am sure every ambulance service does everything it can to provide the best service. I am aware that, almost without exception, every ambulance service is doing some kind of prevention work—nursing homes are a really good example of that—to make sure as best we can that the people who dial 999 for an ambulance service response, although not necessarily an ambulance, are those people who really need an emergency response.

Q114 Andrew Percy: But the trust then loses money, doesn’t it?

Mark Docherty: The answer is that that depends. There is no central edict that determines how the ambulance service is paid. To some extent, that depends on how skilled your local commissioners are and how sophisticated they can make the commissioning process. For example, in the west midlands, the West Midlands Ambulance Service NHS Foundation Trust gets paid for advising a patient over the telephone and signposting them to the right service. The amount of payment is the same as if the patient were taken to hospital. Arguably, there is an incentive not to take the patient to hospital, because the job cycle time for signposting a patient can be much quicker. The answer is that it can work and be sophisticated, but that depends on the arrangement that the local commissioners have.

Anthony Marsh: However, the point that you are making is right. What Mark has described is right for those calls that you receive, but if you reduce the overall number—which is your point—you will receive less income overall, regardless of how much you get for what you do with the patient who does contact you. However, it is absolutely about doing the right thing. As I said, year on year for the last 10 years, the increase in 999 calls has been 4.5%. Ambulance services generally are not looking for more activity.

Mark Docherty: That is the point. There is not an ambulance service in the country yet that has actually reduced activity in any one year. Even though we may have schemes that give alternatives for people to call, in total the ambulance activity is going up year on year—and has done for 20-odd years.

Q115 Chair: If a particular patient’s needs are best met by the primary care service, the social care service or the community health team, are the commissioners able to reward that in the way you have just said they can reward activity by the ambulance service?

Mark Docherty: The word “reward” is often a difficult one.

Q116 Chair: Let us not get into that. Are they able to pay for it?

Mark Docherty: In a sense, the health care system for urgent care should be set up so that the ideal is that the patient gets to the right point of care first time. That is the goal of most of the systems that are in place, although they may have differing effectiveness in terms of whether they achieve that. In terms of the money following the patient, ambulance services have, in differing forms, what we call a payment-by-results system, so if the work goes to an ambulance service, generally the money will go with the patient. Whether that works effectively or not—Anthony Marsh: That is right, but there is also the quality income. Commissioners can set quality indicators alongside the main contract and commissioning arrangements. There are other quality indicators for which commissioners can provide additional funding. Some of those contracts include reducing re-contact rates, particularly from nursing homes; that is a really good example. You can actually attract additional funding by reducing the number of regular callers to 999.

Q117 Barbara Keeley: You may have answered the question that I was going to ask, which was about the mix of paramedics to technicians. We had some evidence to suggest that it was going the other way to what you have suggested. You are saying to us that,
in that ratio, the number of paramedics is definitely increasing.

**Anthony Marsh:** Overall, the numbers are increasing across England.

**Mark Docherty:** That may be something on which we could respond to you following this. We have data on the percentage of paramedics in each of the ambulance services. We could give you that information after this Committee meeting.

**Q118 Barbara Keeley:** That is fine. I want to follow up on the points that you have just been making. We have more questions about NHS 111 in a little while, but I have been gathering evidence locally on what is happening. Are you getting evidence that more people are being taken by ambulance to hospital specifically because early triage from a clinician is now missing and we have computer scripts and non-clinicians at the early stage? There are really a number of things. One is that you do not get the right triage at the early stage or you just get nursing homes phoning up, as we have heard. The other possibility is that there are some services missing. Is there evidence that either or both of those are happening and that that is part of the mix that is causing, we have heard, more elderly and frail people to be taken to hospital than was the case and was expected?

**Anthony Marsh:** Rather unhelpfully, it is all of the above, because we are working in a really complex system. The first thing to say is that, although some of the triage systems are quite risk-averse, even if a call is placed on the ambulance service to provide a response—whether it is an ambulance response or a paramedic in a rapid response car—that does not automatically mean that the patient will be taken to the emergency department. In some cases, they will, but that is a different matter. Very often, the paramedic may be with the patient. They know they do not need an emergency department and recognise that the patient needs some other form of ongoing assessment or care, but either that facility is not available or they are not entirely sure how to access that particular part of the health care system in that very local area, so the default position is to take them to the emergency department. Increasingly, paramedics are able to address that as part of the network. It comes back to one of the earlier points about the ambulance service being part of an integrated system, working alongside primary care, out of hours, mental health and, indeed, social care—being part of that integrated solution. That, as well as the additional training for paramedics, is why we are seeing the overall conveyance rates fall.

**Q119 Barbara Keeley:** I see. That is quite an important point. The evidence I have seen locally seems to suggest the point you have just made—that there are some conveyances to hospital now because a service is missing. Some of the examples I was given were of people who are really on an end-of-life care pathway and should not be being treated in the community, but, if there is a crisis there and that service is missing, they are just taken to hospital. Effectively, people are coming into A and E to die.

**Mark Docherty:** It is a valid point that there needs to be consistency of alternative services. For example, if they close on a weekend, that is not helpful sometimes. I will mention one of the areas where I think there may be scope for us to do more. We find that a lot of the calls from elderly patients, in particular, are falls-related. This is where clinical commissioning groups really come to the fore. For example, Dudley CCG has commissioned a falls car from you, hasn’t it?

**Mark Docherty:** Yes.

**Q120 Valerie Vaz:** You mentioned earlier paramedics talking to patients on the phone. Is that with a view to keeping them out of A and E or to taking them to A and E?

**Anthony Marsh:** To keeping them out. We provide appropriate advice over the telephone that may be able to deal with the patient or signpost them to another part of the system.

**Q121 Valerie Vaz:** Do you feel that there is currently sufficient training among paramedics to enable them to make that sort of decision?

**Anthony Marsh:** Yes, but more could be done. Paramedics are very well trained—and always have been—to deal with very seriously ill and critically injured patients. We are seeing more of that with the networks I referred to earlier. However, working alongside the clinical commissioning groups, in particular, and other parts of the system, we need to accelerate nationally to ensure that more paramedics receive that additional training. It is not instead of the critical end—of course, we still need paramedics to deal with that as well—but we need paramedics to be trained at a faster rate so that they are able to become more confident and competent in dealing with the primary care types of difficulty that patients have, rather than having to take them to an emergency department.

**Q122 Valerie Vaz:** Could you be a bit more specific about the additional training?

**Anthony Marsh:** One example is the extent to which they are able to undertake greater patient assessment and diagnostics, so that they can better understand exactly what is going on for that patient. Going back to a point that I made earlier, access to the national spine that enabled them to have some critical information about a patient would help that decision making. Assessment and diagnostics are really important. Paramedics are now able to administer antibiotics and a wider range of other drugs, which will help to keep people out of hospital. A nother issue
is the extent to which we are able to treat, glue, suture and appropriately dress wounds to keep people out of hospital, to use other diagnostics such as urine testing and to assess patients by ear examination.

Q123 Valerie Vaz: Is dressing wounds something for you or something for a district nurse? Would you ever need to be called in for something like dressing a wound?
 Antonio Marsh: For ongoing care, certainly, the paramedic could make an appropriate referral to a district nurse in primary care services. Initially, when there is an emergency, the patient, the relative or the carer will dial 999. Sometimes, it is easy to make an informed clinical assessment over the telephone, but in most emergency situations it is very difficult to do that. Sometimes, therefore, we will send a paramedic promptly so that they can respond to the patient and make an informed clinical assessment. At that point, in the example that you are framing, if the wound needs gluing, suturing and appropriately dressing, the paramedic can deal with that and then provide a referral to the district nurse, who can pop in to see the patient in the next day or so.

Q124 Valerie Vaz: You talked about an integrated service. Do you think that will work with multiple providers?
 Antonio Marsh: There is no reason why it should not. There is good evidence where it does work well with multiple providers. Clearly, the more providers you have, the more complex—

Q125 Valerie Vaz: Could you give us that evidence?
 Antonio Marsh: Certainly. We can share that with you.

Q126 Valerie Vaz: Do you want to tell me now?
 Antonio Marsh: Of course. Where we have 111 providers, with GP services locally in hours and a different set of arrangements out of hours, the issue is the extent to which those are well connected with paramedics locally and paramedics in the control room. A directory of services draws upon the services that are available in a particular local community, so paramedics working in the control room can connect with the paramedic making an assessment in the patient’s home and provide advice on the services that are in place. There are really good examples of paramedics working alongside GPs and district nurses in local communities and of mental health paramedics working alongside mental health specialists. The difficulty is that that is not standardised. There is not exactly the same practice right across the whole of the west Midlands, let alone the whole of England.

Q127 Valerie Vaz: I am going to put you on the spot slightly; I am sorry, it is a personal thing. I suppose I am trying to go down the road of avoiding the situation that happened at Walsall Manor hospital, when a man was stepped over by paramedics and then died. How can we prevent that?
 Antonio Marsh: That was a very unfortunate incident. It was a very isolated incident. We undertook a thorough investigation, which demonstrated that, and both the ambulance service and the hospital dealt with it. We should not confuse an isolated incident, as serious as it was—and we have dealt with it—with the overwhelmingly excellent care that paramedics and ambulance staff provide every single day of the week right across our country. Treating people with care, dignity and respect and responding to them promptly are at the heart of what the ambulance service does. We are absolutely determined to continue to provide high-quality care consistently.

Q128 Valerie Vaz: I accept what you say and that you all do a great job, but clearly something was missing there in terms of training, perhaps.
 Antonio Marsh: Something was missing there.

Q129 Valerie Vaz: Perhaps it was because he had an alcohol-related problem that people are not picking up.
 Antonio Marsh: We have taken steps to prevent a recurrence of that. We have reinforced the values of the ambulance service both locally and more widely. I am confident that it was an isolated incident, as sad as it was, and we have taken measures to prevent a recurrence.

Q130 Valerie Vaz: How helpful is the eight-minute response time?
 Antonio Marsh: For some patients, it is absolutely critical.

Q131 Valerie Vaz: I mean for you, in terms of your response locally.
 Antonio Marsh: As I said, for some patients it is critical. It does focus the mind. Sometimes we have a substantial number of 999 calls coming into the control room, and it helps us to prioritise those that are in real need. However, I think that some patient groups we are currently trying to get to in eight minutes do not necessarily need an eight-minute response. The difficulty can be that, if there are too many priorities, the patients who are really sick and seriously injured get lost in among some other patients who need a prompt response—maybe 10 minutes—but do not necessarily need a response within eight minutes.

Q132 Valerie Vaz: In the west Midlands, you must cover some lovely rural areas as well. How does that response time help in a rural setting?
 Antonio Marsh: You are absolutely right that one size does not fit all. That is why we tailor the way in which we deliver the services. Almost without exception, every one of the 10 ambulance services has very urbanised areas and very rural parts of its service. The way in which we deliver services varies depending on whether you are in a major city centre or in a very rural county. We use community paramedics who are embedded, working alongside primary care GPs, the out-of-hours service, mental health and the like. Community first responders also do a great job working alongside ambulance services. They are able to provide an immediate response while the paramedics are en route in a response car or
ambulance. In urban areas, of course, they use motorbikes and pushbikes as well.

Q133 Valerie Vaz: Not to carry patients, I hope.

Anthony Marsh: No, to provide an immediate response.

Chair: I have a long list of members who want to come in. Virendra wants to come in briefly.

Q134 Mr Sharma: It is on the training aspect. When you recruit staff, they have a basic understanding and basic qualifications, but then extra training is given. Is a system in place to enable staff to get training from an outside agency or is it training on the job, under the supervision of senior staff?

Anthony Marsh: It is both. We now recruit predominantly from graduate paramedics. As with other professions, these are individuals who have left school, have gone to university, have trained to be paramedics and have then been recruited into ambulance services. Those individuals go to university, but they also have substantial clinical placements within ambulance services to gain their experience, confidence and competence, so that when they graduate from university they are part of an integrated work force within ambulance services. They then go on to do advanced training in trauma, for example, and in the primary care examples we spoke about earlier.

The other route by which staff become paramedics is by being recruited directly into the ambulance service, generally by the student paramedic route. They undertake basic training, core training, emergency driving training and so on. They have a year or so of consolidation before they go back to university to conduct their paramedic training. About two and half years later, they graduate. So there is a mixture of training working alongside other paramedics, training working alongside clinical practice mentors and classroom training in universities. There is also work in hospitals—work in emergency departments alongside nurses, doctors and other clinical staff, and work in theatre, so that they get experience and practice in intubating, cannulating and patient management, as well as in other parts of the system.

Mark Docherty: I want to emphasise the training of a paramedic. At the point of registration, a paramedic may have done just a two-year foundation degree. What we are asking of them in their practice is quite a big ask. We are asking them to make diagnoses, to choose whether to leave patients at home and to choose which patients go to which hospital, so there is real joined-up working alongside clinical practice mentors and classroom training in universities.

Chair: Is there a number of things. The first thing I would say is that the overwhelming experience of patients with the ambulance service is outstanding; the evidence from patient surveys and the like supports that. The point you are making, with which I would agree, is that there needs to be greater integration and more joined-up service across those aspects. In some parts of the country, it works really well and in others it works less well. Our challenge is to ensure that it works the best it can everywhere, while recognising that one size does not necessarily fit all.

While there are undoubtedly patients who do not need to attend an emergency department because their needs can be dealt with better elsewhere or they do not need to be taken to an emergency department, we need to be mindful that whatever alternatives are put in place must be effective, well utilised and cost-effective, otherwise we could end up with a plethora of alternatives that are very good but have a very low utilisation rate in certain communities and therefore do not represent value for money. There is a mixture, which is about the population that you are attempting to serve and the geographical location. I know you understand all of those complexities. What I am trying to describe is a system that we know can work well, because the evidence exists and it happens in many parts of the country, and the extent to which we can level up that variation to standardise those improvements for everybody.

Q135 Mr Sharma: Are we talking about a four-year period?

Mark Docherty: We should not treat it as one-off training. The ongoing development of these professional staff delivering highly sophisticated urgent and emergency pre-hospital care is absolutely critical to the system working effectively.

Q136 Rosie Cooper: Before I ask the question I intended to ask, I want to say that this all sounds wonderful—it sounds really good and as if you have it under control. Why, then, will the public watching this session be sitting there thinking, “It’s not working for me. I am stuck in an ambulance”—perhaps outside an A and E—“and not having people arrive at the right time”? I think the stories are fantastic. You talk about referring people to district nurses, but they are disappearing faster than snow in the summer. You can refer all you like, but it actually has to join up. You are telling us a wonderful story, but the experience of people out there is not the same. What is going wrong?

Anthony Marsh: There are a number of things. The first thing I would say is that the overwhelming experience of patients with the ambulance service is outstanding; the evidence from patient surveys and the like supports that. The point you are making, with which I would agree, is that there needs to be greater integration and more joined-up service across those aspects. In some parts of the country, it works really well and in others it works less well. Our challenge is to ensure that it works the best it can everywhere, while recognising that one size does not necessarily fit all.

While there are undoubtedly patients who do not need to attend an emergency department because their needs can be dealt with better elsewhere or they do not need to be taken to an emergency department, we need to be mindful that whatever alternatives are put in place must be effective, well utilised and cost-effective, otherwise we could end up with a plethora of alternatives that are very good but have a very low utilisation rate in certain communities and therefore do not represent value for money. There is a mixture, which is about the population that you are attempting to serve and the geographical location. I know you understand all of those complexities. What I am trying to describe is a system that we know can work well, because the evidence exists and it happens in many parts of the country, and the extent to which we can level up that variation to standardise those improvements for everybody.

You mentioned handover delays. You are absolutely right that those represent a risk, but the substantial risk is not necessarily for those patients who are waiting in corridors or ambulances.

Q137 Rosie Cooper: It is for the ones waiting to come.

Anthony Marsh: It is for the patients we cannot respond to promptly—which was your second point—because ambulances are tied up and are not able to respond effectively. The good news on that—I am not saying that it is perfect and is all resolved, by any means—is that there have been improvements this year. That has largely been about refocusing and emphasising the importance of prompt clinical handover. There is real joined-up, integrated working between ambulance services and the acute sector to streamline and to speed up that handover. Also, in the national contract this year, penalties have been applied by commissioners that have undoubtedly helped to reinforce the importance of prompt clinical handover
of patients, for the benefit of those patients but, more widely, of the patients who need a prompt response by ambulances.

Q138 Rosie Cooper: Okay. I will go to the question I was going to ask and come back to this in a different way. Ambulance trusts and the Department of Health say that ambulance services are well placed to deliver the efficiencies that are required across the whole emergency care system. You have described a year-on-year increase of 4.5% to 5%. Did you get additional money to deal with that increase? I have heard you describe how you are changing services, but not uniformly, how best practice is not necessarily being used everywhere and how commissioning is doing what it can. You talk about urgent primary care. What does that mean? How can these targets be met continually without additional resources? Understanding that you are changing the mix all the time, there is still that incredible pressure on you and the service around you that is also having to deal with efficiencies and real pressures—district nurses who are not there and things like that. I sit and listen, and the whole range of the work the service is undertaking is that they are not. As money comes out of one part of it, pressures increase somewhere else. You can say, “We will make referrals, stop nursing homes making inappropriate referrals and do x, y and z”—yeah, yeah, yeah—but what is happening?

Anthony Marsh: The first thing to say is that, generally speaking, ambulance services have received some additional funding but not at the rate of the increase in activity, so a lot of the continued improvements that ambulance services have been able to achieve over the last period have largely been about internal efficiencies, the extent to which we can streamline, using technology in the control rooms that we discussed earlier, and the extent to which we have been able to provide additional training for paramedics to enable them to treat and refer or, increasingly, to treat and leave patients at home. I do not want to give you a false impression that more than 40% of the emergencies that we attend are referred elsewhere, because they are not—a tiny proportion of patients are referred to district nursing and others. The bulk of the patients—nearly half—whom we do not convey to a hospital have been treated and discharged by paramedics in the patients’ own homes. We are not reliant on a plethora of other systems. Of course, referrals are made, but they are only a tiny percentage. If you stand back from all of this, the substantial efficiency savings for the ambulance services are the extent to which we can reduce conveyance rates to the emergency department. That is the overwhelming opportunity for the contribution of ambulance services to the £20 billion Nicholson challenge efficiency target, because we know that when patients get into emergency departments they are often admitted—for a whole range of very good reasons, but sometimes when perhaps that was not absolutely necessary. Being able to keep those patients in their homes, treated and discharged by a highly trained advanced paramedic is absolutely the right thing for the overall system. That is why I am confident and genuinely believe that the experience of patients who have come into contact with the ambulance service is overwhelmingly a good one.

Q139 Rosie Cooper: You mentioned referrals into or interface with “urgent primary care”. Can you describe what you are thinking of there? For example, this week I arrived home at lunchtime for my father to tell me that he had not been able to get out of bed that morning. Eventually he was able to get out, but I did not find out about it until lunchtime. I phoned the GP at 2 o’clock and tried to organise an appointment, perhaps for the following morning. The receptionist, who was very helpful, said, “We have an emergency appointment at the end of surgery. I will ring you back.” She phoned me at 4 o’clock, and the response was “There are no emergency appointments. Either come to the open-access wait in the morning or go to a walk-in centre,” which is code for A and E. This is a GP in the afternoon—not an emergency. If that is where we are operating, we’ve got big trouble.

Anthony Marsh: I am sure that in some parts of the country that does happen, but equally—I am not here to speak on behalf of the particular part of the system you are referring to—we know that there are other parts of the country where access is better than that. It goes back to the point I made earlier about trying to level up to where we know it already works. We know it can be delivered, so how do we level up?

Q140 Rosie Cooper: So how do you see urgent primary care? It really makes a big impact on your job.

Anthony Marsh: It does.

Q141 Rosie Cooper: So what do you mean?

Anthony Marsh: For us, it is the ability of the paramedic—whether it is the paramedic in the control room or, increasingly, the paramedic with the patient, very often in their own home—being able to have a clinician-to-clinician conversation with the doctor in the surgery or with the out-of-hours service. One thing we have really been pushing for, both locally and nationally, is for ambulance paramedics to have access both to the doctor in hours and out-of-hours providers, so that you can have that clinical conversation.

Q142 Chair: It sounds pretty basic.

Anthony Marsh: It is.

Q143 Chair: Who says no? What is the obstacle?

Mark Docherty: I think the issue is that primary care—

Q144 Rosie Cooper: No—can you answer that question? That is the core of it. If I were looking after cats and dogs, I would want to speak to whomever. These are human beings. Why doesn’t it just happen? I do not get it.

Mark Docherty: I was attempting to answer the question. The issue is that primary care is very busy itself. One of the solutions I have seen in one area is that GPs collectively pool some of their emergency work. Sometimes the peaks and troughs of the work create an inability to respond at a particular time.
Q145 Rosie Cooper: Okay. I must remember not to have my heart attack at an inappropriate time. This is ridiculous.

Mark Docherty: No. What I am saying is that in some areas I am seeing primary care looking at innovative solutions to enable it to respond to peaks and troughs.

Q146 Rosie Cooper: Out-of-hours doctors—should we have more of them then?

Mark Docherty: The issue is about the system being able to respond to the patient need.

Q147 Rosie Cooper: Okay. You talk about the system responding, but it is not. You are sitting there and my life is in your hands—what is happening?

Mark Docherty: I am sorry. What I am trying to explain is that many GP surgeries work on their own, so when all of their emergency appointments are taken, there is an inability to respond to the patient need. Some areas are working across GP surgery boundaries. Obviously, we have not come prepared to talk about the issues in primary care—

Q148 Rosie Cooper: I appreciate that, but you do not live in isolation. You are a commissioner—what are you doing? Do you not see where it joins up? I have heard lots of lovely warm words, and I love the ambulance service—it is not the problem. The problem I have is that I hear these warm words. You talked about your patient satisfaction. If I went to a hospital, they would give me the same loads of numbers and the same tosh—everybody loves us; nothing is wrong.

Anthony Marsh: I am not saying that nothing is wrong. I think the point you are making is that the cohorts of patients who are seriously ill—you gave the example of your having a heart attack—are well catered for.

Q149 Rosie Cooper: Absolutely. That was a flippant remark in response to what was being said. You cannot have a system that is not able to respond at the bottom as well as at the top. If you are looking for a GP but cannot phone and speak to one, that is just nonsense.

Anthony Marsh: I agree. Your frustration is often shared by paramedics, who are frustrated that they may not be able to get hold of a GP in hours or out of hours either to get some advice—

Q150 Rosie Cooper: So what have you done about it?

Anthony Marsh: We have been very clear, certainly in the west midlands—I have also spoken to colleagues about this—about working with commissioners and, in particular, out-of-hours providers to ensure that paramedics have real-time access to doctors to enable them either to get advice or to make sure that there is a home visit, if a doctor really needs to see that patient and the patient cannot be dealt with appropriately by a paramedic. Those conversations are absolutely going on, and at the highest levels.

Q151 Rosie Cooper: But all I am hearing is “will”, not “is”.

Anthony Marsh: No. It is happening.

Mark Docherty: We can give you examples where the ambulance service does a scheme called “GP in a car”. It works in Tower Hamlets and in Dudley. The issue is that we need to avoid more patients ringing the ambulance service for their immediate primary care urgent need. That is the risk with those schemes, as they are very responsive and very reactive to patient need. Actually, they deliver a really good service.

Q152 Rosie Cooper: So should we put all GPs in cars and send them out?

Mark Docherty: No.

Rosie Cooper: Thank you.

Chair: I think we have covered it. We are running out of time. We have a GP on the Committee who wants to come in.

Q153 Dr Wollaston: I am not going to speak on behalf of GPs, because I know we will hear evidence from the Royal College of General Practitioners later. Just to reflect, when I was in practice, I would sometimes take calls from the ambulance service, so there is nothing to stop the ambulance service calling GPs. Are there some areas where that is particularly difficult? You mentioned single-handed practitioners. In your experience, is that generally the situation in which it is most difficult to get hold of people?

Anthony Marsh: Yes. It has been difficult with some out-of-hours providers as well for the paramedic to have a paramedic-to-doctor conversation about a particular patient. We have made improvements in relation to having that access. I am sure that more could be done to make that mainstream, but it goes back to the point I made earlier. If the paramedic had access to some information from the underlying history for that patient through the national spine and from electronic patient records, it would negate the need for some of those conversations with the doctor. However, sometimes it is appropriate for the paramedic to have a conversation with the doctor. That is in part why we now have GPs working in our control rooms alongside paramedics and other staff either to deal with the patient over the telephone initially or to provide advice to paramedics responding with the patient.

As Mark just mentioned, in many parts of the country we now also have GPs working alongside a paramedic in a car, responding to appropriate calls—no the big emergency heart attack and road accident-type patients but primary care-type patient care difficulties that they can treat appropriately face to face—and taking calls from paramedics dealing with other patients. That is an additional facility that we are putting in place to work alongside paramedics.

Q154 Dr Wollaston: Can I take you back to a comment that you made earlier, Anthony Marsh, about the issue of avoiding unnecessary admissions? Undoubtedly, this Committee would share your enthusiasm for trying to avoid unnecessary admissions, but the flipside to that—and the side that
always makes headlines—is when a patient who did need to be admitted is not admitted. Alongside avoiding unnecessary admissions, are you seeing increasing complaints about patients being left at home who should not have been?

Anthony Marsh: No, not at all. That is largely because of the additional training that we have put in place for paramedics to enable them to make that informed clinical assessment, but also because of the back-up arrangements that we have put in place so that they can talk to a GP in a car who is dealing with another case or in the control room. Sometimes, patients’ expectations are not necessarily met by a paramedic or an ambulance responding to them and a paramedic or GP deals with their case over the telephone. Sometimes patients would prefer to have a face-to-face consultation, rather than a telephone consultation, so we have seen a slight increase in complaints of that nature, but certainly not relating to face-to-face consultation.

Mark Docherty: When there has been a high-profile case, as in London recently, we do see conveyance rates to hospital go up quite significantly, because paramedics feel personally very vulnerable if they make a decision that turns out in hindsight not to have been the right decision.

Q155 Dr Wollaston: So you see a spike in the immediate aftermath.

Mark Docherty: Absolutely.

Q156 Dr Wollaston: How long does that tend to last?

Mark Docherty: It is difficult to say, because we have not necessarily done detailed work on that. Some of this stuff—building the data on non-conveyance, for example—is fairly new. In the particular case that I mentioned, which was in outer London, it happened fairly quickly; from memory, the case was from two years ago. I cannot answer on how long it lasts, but we could look for some information on that.

Anthony Marsh: Fortunately, it does not happen very often, so it would be very difficult to gather any evidence, but we can certainly have a look.

Chair: Valerie wants to come in, followed by Barbara. We then need to move on to the second panel.

Q157 Valerie Vaz: I want to take you back to the handover at the hospital. I would like you to take us through it— as briefly as possible, because obviously we have to hear other evidence. There is some indication that the delay in handover is because the clinicians do not trust the paramedics’ judgment. Could you elaborate a bit on that?

Anthony Marsh: I am not sure that it is about the clinicians not trusting the paramedics’ judgment. Very often, the paramedics will attend the patient when they have had their sudden emergency, whatever that is. Of course, there will be certain occasions when paramedics deal with patients who are unconscious, fitting or, even worse, in cardiac arrest, when the ability of those volunteers who arrive in the very first few minutes to start basic life support and early treatment is crucial. We know that very often, particularly if the patient is unconscious, fitting or, even worse, in cardiac arrest, fitting is when a patient who did need to be admitted is not admitted. Alongside avoiding unnecessary admissions, are you seeing increasing complaints about patients being left at home who should not have been?

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defibrillation is a life saver while paramedics are on route. However, they are as well as, not instead of, the front-line paramedic ambulance service.

Q 161 Barbara Keeley: As I said, the thing that disturbed me when talking to one of them was how heavily that person is used—and I mean heavily.

Anthony Marsh: I understand that. In part, that reflects how busy our ambulance service is. Ambulance services in England deal with more than 25,000 999 calls every single day of the year.

Q 162 Barbara Keeley: But it is a paid job for professionals. Why are we contracting out—at the most serious end of it, it seems?

Anthony Marsh: We are not contracting out anything. They are volunteers, trained in the main by ambulance service staff and equipped to be able to respond to those patients where the first few minutes are vital. If you are unconscious, are not breathing and need early defibrillation, those first few minutes while the paramedics are on their way are absolutely vital. The international evidence demonstrates that the more quickly you arrive at those patients, the greater the chance of their survival while the paramedics and the ambulance are on route.

Chair: We have a first responder on the Committee who would like to ask a question.

Q 163 Andrew Percy: It is sort of on Barbara’s point. As you said, it is not contracting out—it is simply that we can get there more quickly. When you are in cardiac arrest, you are pleased with whoever turns up—or the family are. That is true, isn’t it? My point was not so much about that as about co-responding. We have seen a huge spike in demand for ambulance services over recent years, but we have seen a big fall-off—about 40%—in demand for fire services in the last 40 years. There seems to be quite a lot of opposition in my own area. Volunteer, retained firefighters are prepared to co-respond, but full-time firefighters are not or are prevented from doing so because of their union’s view on this.

This was brought home to me on the first cardiac arrest I went to. I drove past a fire station on the way there and thought to myself, “This is barking mad.” Here I was trotting out, but no one was being sent out from a fire station fully crewed with people who were being called out probably once a day—don’t get me wrong; they do an incredibly important job—with this training and a defibrillator in the building. In that case, the gentleman sadly died. Isn’t it time that we tried to crack this, really got to the bottom of co-responding and said, “We have an emergency service here that is being used less and less. It does an incredibly important job, so we do not want to stop it and take it off the run, but there are trained people here who are being paid by taxpayers and we have to start really pushing co-responding nationally”? What is your view on that?

Anthony Marsh: The first thing to say is that ambulance services and fire services work together incredibly closely on a whole range of emergencies. Co-responding does exist in some parts of our country. Where those co-responding schemes are required, they should be encouraged. One size does not necessarily fit all, so there will be competing priorities for ambulance services and, indeed, other emergency services. Where patients would benefit from closer working, that should be encouraged, but be assured that ambulance and fire services already work very closely on a day-to-day basis on responding to emergencies, training and, indeed, exercising.

Q 164 Andrew Percy: Do you think it should be expanded, as one way of helping to ease the pressure on your service?

Anthony Marsh: I think it depends on the local circumstances. One size does not necessarily fit all. In some parts of the country it would and does work very well. That is not necessarily true in every part of the country. I think it needs to be looked at on an individual basis.

Andrew Percy: So that I do not get accused of wanting to destroy the fire service, I should say that I support that because I think it is actually a way of protecting a publicly funded fire service, by having it expand into other areas.

Chair: I was going to say that I admired Anthony Marsh’s optimistic outlook. Rosie has one very quick question.

Q 165 Rosie Cooper: There is an assumption that volunteers will get there first; that is their raison d’être. I am sure that in a rural area that is great. However, further to Barbara’s point, if a volunteer is used so heavily and gets there first, doesn’t that say that the ambulance service itself is so stretched that it cannot manage and needs more resources?

Anthony Marsh: The important point is that there will always be occasions, whether it is in an urbanised area or in a rural area, when someone may have their heart attack at the point at which the local ambulance or the local paramedic is dealing with another emergency. Community volunteer first responders are trained and equipped to deal with those patients with really life-threatening conditions and have more availability than directly provided paramedic resources of the ambulance service. Because of their immediate availability to respond within the first few minutes to provide basic life support and early defibrillation, they really are life savers. We would want to continue to encourage community first responder schemes across our country.

Chair: We cannot have competition for the last word. Thank you very much for your evidence. You have given us plenty to think about.
Q166 Chair: Good morning. Thank you very much for coming. I am sorry that we are running a little bit late. Could you introduce yourselves very briefly?
Andrew Webster: I am Andrew Webster. I am the associate director for integrated care at the Local Government Association.
Dr Gerada: I am Clare Gerada. I am the chairman of the Royal College of General Practitioners and a GP.

Q167 Chair: As we did with the previous panel, I would like to begin by asking about your experience so far and your views on the future development of commissioning for integrated emergency and urgent care. I know that you were present for at least some of the previous session. Some of the frustrations that were expressed by members of the Committee and, to some degree, by witnesses as well were about the failure of the system to deliver a joined-up service. Do you believe that the commissioning process, through commissioning for ambulance services, the urgent care groups and the different forms of commissioning that now exist in the health service, is fit for purpose to deliver joined-up response to a demand for emergency care? We will start with Mr Webster.
Andrew Webster: That is exactly the point we would like to address. I think there is an opportunity to change it to make it more fit for purpose. I will say something about three broad areas, the third of which will focus on your question.
The first is access—are people getting access to the care they need to deal with emergencies? The evidence from the local government and social care world is that, broadly, they are, because eligibility has remained broadly the same. Reablement, to get people back on their feet, back home and back out of hospital, has been extended; 82% of people benefit from that, and it is well liked. Many people focus on the issue of whether people are getting stuck in hospitals—what are described as delayed discharges. Those are actually going down, and those that are attributable to social care are going down faster than those that are attributable to things in the health system. So access has held up.

Resources are clearly very tight. Social care spending in local government has gone down by 20% over the last three years and will go down further as a result of continued austerity. We have been able to sustain that access by some transfer of money from the NHS—about £900 million in the last year—by great improvements in efficiency and by some increases in charges to people who are eligible to pay. That will continue. I do not need to tell you that demand for the services is also growing and the pressure is increasing; that is evident in the figures and the issues you are looking at.

Our belief is that response to that has to be local, because the reasons for the pressure on emergency care are different in different places. A national prescription will not work. It has to be whole system, because at the moment the work with hospitals is not as closely connected to the planning for services in the community and social care as it should be. The system has to bring how our hospitals are organised, supported and remunerated into scope. We believe that the new health and wellbeing boards, where local government has a lead role in public health and where the leaders of the CCG and the leaders of the local political system are all gathered, are the right places to bring a real focus on planning for integrated care, but that will require them to step up from where they are now into a much stronger and more ambitious lead role.

Q168 Chair: Before asking Dr Gerada to comment, can I ask you to cover in your reference to health and wellbeing boards the relationship between the world you have just described and the urgent care boards that are being developed by NHS England?
Andrew Webster: I think there is good complementarity and that they can work together well.

Q169 Chair: Do you need both of them?
Andrew Webster: Were the health and wellbeing board doing the job that I have just described, I think it would become part of the machinery that the health and wellbeing board used, but I do not think it is unhelpful to prompt people to do that. In so far as it engages the public, local leaders and the hospitals in resolving those bigger system issues, it is a helpful contribution.

Q170 Chair: I turn to Dr Gerada.
Dr Gerada: First, can I apologise for the late submission of our written evidence? I am afraid that, probably like the rest of the health and social care system, we are inundated with work, with all the demands on my team.

With respect to the question you have just asked, of course the answer must be yes. We must make sure that we commission an integrated approach to urgent care. The document that I have here, which is called “Guidance for commissioning integrated urgent and emergency care: A ‘whole-system’ approach", was published in August 2011, had more than 50 stakeholders, is signed off by a number of the major relevant royal colleges and gives an action plan around exactly what you are saying—delivering an integrated approach. I might differ slightly from Mr Webster in that I think that a whole-system approach has to be more than just local. Once we start to look at capacity of some parts of the system to deliver emergency care, as opposed to urgent and unscheduled and routine care, just dealing with local may be too small; of course, it depends on what “local” is.

So the answer to your question is fundamentally yes. The evidence you heard from the ambulance service shows that, if you squeeze one bit of the system, all you are doing is squeezing that problem to another part of the system. With all the debate that has been
going on about emergency departments, I could just as easily put the words “general practice” into there. We are under similar pressures. If one thinks that the floodgates to the NHS, the gates that stop it breaking down, are primary care—I put GP and community care into that bracket—and emergency departments, and those two bits of the system are under serious pressure, it is not surprising that the rest of the system is under serious pressure. I cannot remember who said that for walk-in clinics we should read emergency departments—I think it was Rosie—but they are not. Again, that is a real misconception. Walk-in clinics are predominantly GP-led services, with a much lower tariff. They have to have GPs there, have primary care nurses and other staff and are set up in a way to ease the problems on emergency departments. They are not a proxy for emergency departments. They, too, are heaving.

**Q171 Rosie Cooper:** It was a GP who said that.

**Dr Gerada:** Who said that it was an emergency department?

**Q172 Rosie Cooper:** No, who told me either to wait until the next morning or to go with my father to a walk-in clinic. I took that to mean, “If it’s serious, go to A and E; if not, hang about.”

**Dr Gerada:** I am very sorry that that is what is happening and that general practice cannot deliver the sort of care that I was trained to deliver. A gain, let us get some facts out. We have seen an approximately 100% increase in our workload over the last decade. We are seeing more and more long-term chronic disease. What I do now is what a physician did 10 years ago. What I do now is what a psychiatrist did 10 years ago. GPs still see the majority of urgent care. We do not see emergencies; I think we need to start dissociating that. We do not see fractured limbs, although walk-in clinics and urgent care centres see ambulance cases. But GPs are also the ones who, in hours, over an increasingly long day, pick up the vast majority of the care that presents to the system. The focus on dealing with just one bit of it will push the system to breaking point—which it already is, in all honesty, down the other end of the system.

**Q173 Chair:** Before I invite colleagues to come in, could I ask you to focus? The danger on these occasions is that we all say, “Wouldn’t it be nice if...” and everyone can agree that it is not happening enough—and, perhaps even more importantly, what it is in the system that is inhibiting these developments and what can be done to encourage them.

**Dr Gerada:** Dare I say constant change? Dare I say that it was an emergency department? The thing the Committee needs to focus on is the extent to which it is happening—I guess everyone can agree that it is not happening enough—and, perhaps even more importantly, what it is in the system that is inhibiting these developments and what can be done to encourage them.

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**Dr Gerada:** Dare I say constant change? Dare I say that it was an emergency department? The thing the Committee needs to focus on is the extent to which it is happening—I guess everyone can agree that it is not happening enough—and, perhaps even more importantly, what it is in the system that is inhibiting these developments and what can be done to encourage them.

**Q172 Chair:** Before I invite colleagues to come in, could I ask you to focus? The danger on these occasions is that we all say, “Wouldn’t it be nice if...” and everybody can sit round and agree that it needs to be more joined up. Can you demonstrate evidence of levers being pulled, contracts being written and services being developed on the ground that are breaking down the differences between the ambulance service, the communities and so on?

**Dr Gerada:** Can I put on my other hat, which is my conflict of interests hat? I am a GP at a practice that is one of the largest providers of services in London, including running a number of walk-in clinics which are integrated. Some are at the front end of emergency departments, where there are links to the ambulance service; as I said, we take ambulance cases. We are not unique. Across the country, GP-led walk-in clinics are working very closely with their foundation trusts—or non-foundation trusts, if they are not in a foundation trust— to develop an integrated approach. For example, you might have a front end of urgent and emergency care—let us call it that—that is manned by the same admin staff. At the next stage, where you get triage, they triage to the different parts of the service—left, emergency; right, GP walk-in clinic—with integration between the two, if it is wrong. This is happening across the NHS. I am afraid that I am not an expert on how often it is happening, but it is certainly happening in London and I suspect that it is happening across the country.
the information does not come to them. So there are some very practical things about sharing information, incentivising people and paying for what we want, rather than what we do not want, that could make a significant difference.

Q175 David Tredinnick: It seems to me that you have identified a problem we need to look at closely—the tariff issue, where you have different tariffs. That is something I shall raise later. Dr Gerada, before I get on to the question I wanted to ask, which has partly been answered, you seemed to suggest that one of the problems is the process of change itself. We have just had the Health and Social Care Act, which is a massive change. Surely that is inevitable. We just have to get used to the process of change. There will be difficulties in coordination to begin with, but when you have this kind of change it has to be taken through and is not really an excuse for a situation being unsatisfactory. I put that to you.

Dr Gerada: Dare I disagree with you?

Q176 David Tredinnick: Please do.

Dr Gerada: Come to my surgery and see what is going on, where we do not know who is responsible for certain issues. Come and see what is happening with the issues that do not make the headlines, such as our patients with chronic diabetes, who have had community services pulled, which means that we have to absorb that work. In answer to the question about appointment times, I am getting e-mails from colleagues across the country to say that their surgeries are now fully booked by 8.30 in the morning, which is disgraceful. How can we run an NHS where, unless it is an emergency—and by that I mean a dire emergency—you cannot get an appointment with your GP on the day and appointments are fully booked by 8.30? This is not because GPs are going to play golf in the afternoon; it is because they are trying to respond by working 15-hour days. With the best will in the world, change produces confusion. Change means that you have to rebuild relationships. Change means that you also find that bits that were running well stop running well. I am not using it—I think there are opportunities with the Health and Social Care Act. For the first time, with CCGs now being responsible for commissioning all of out of hours, they can actually start to join up with our fantastic ambulance services, our paramedic services and our social care services and to look at how we can deliver and develop, but you have to give the GPs time. You have to say that this is something that will take time and that an amount of expertise will probably have to be brought in from some of the people who were running these sorts of services before. So I am afraid that I disagree with you.

Q177 Dr Wollaston: Can I follow up on that point about work load? There is a real crisis in GP recruitment and a retirement bulge coming up. How far do you think part of the solution will lie in increasing the skills of those who support primary care? We heard from the ambulance service about increasing the percentage of paramedics. How far do you think that needs to be the answer in primary care?

Dr Gerada: It is a very good question. The answer has to be yes, of course, but you know, as a GP, the skill involves dealing with uncertainty—dealing with risk. We heard from the ambulance service the very telling comment, which should not be missed, that by the time the ambulance crew gets the patient to hospital, in essence, many patients are better. However, there is the fear when you are with the patient, as you do not know how things are going to end. The same applies to general practice. The skill of not sending everybody to hospital is an immense skill that comes with a lot of training. Nevertheless, we must invest in health care assistants, pharmacists, assistants and nurse practitioners. Pharmacists have an enormous role to play. However, these people are not twiddling their thumbs; they, too, have their work force and work load crisis.

Q178 Dr Wollaston: So how are we going to get more doctors to go into primary care?

Dr Gerada: The Royal College of GPs is just about to publish a document called the 2022 vision, which lays out the evidence around the efficacy of primary care and community care. It then says what we need to do in order to continue to deliver and to deliver 21st-century health care, including better-integrated care in and out of hours, better use of telecare and better use of shared decision making. Included in this document is an action plan for how we will engage doctors to become GPs, retain them and then train them throughout their professional lives. We will need your help. Already Mr Hunt has announced in the mandate a wish for 50% of medical students to become GPs. When I qualified, it was 70%; it is now probably about 30%.

Andrew Webster: At the risk of intervening in a GP conversation, it is important from the local government point of view to state that a wider team delivers the care that is planned and organised in the community to keep people at home. Obviously we
need more and more skilled general practitioners, but increasingly social care professionals and public health professionals are working alongside those people in teams for the same groups of patients, managing the same risks. There are real opportunities to get more resources and capability into primary care to deliver some of the things that will reduce pressure on our hospitals.

Q179 Chair: Can I come in there? I would be interested in Dr Gerada’s response to that. Is part of the response to the pressure of increasing demand for urgent care—in primary care, but on the system as a whole—a redefinition of the respective roles within the primary, community and social care teams?

Dr Gerada: Yes. We have to be careful, because over the last decade and a bit we have had more and more bits of general practice taken away from us and put into other individuals who are sometimes quite disparate, away from what I would say would be the medical home of the patient—to the point where we now have district nurses employed by foundation trusts, where they should not be employed. What happens then is that you increase fragmentation, because you increase the number of contacts that you have to have before you get a direct contact with a very good social worker, social care in the community and so on. I think it is the answer—of course you do fantastic work—but it is about bringing it back into primary care and making that the medical home. The second point is around integrated care, which is where I think you are going. Integrated care—shared working across professional boundaries—is difficult. We use this term as if somehow we will all get together like one big happy family when we do not have similar values, as we have come from different professional groups, we do not have similar budgets—some are means-tested and some are not—and we do not have a similar record. Some have confidentiality issues, which means that one bit of the system cannot look at the other bit of the system. Integrated care will work, but it needs time and stability and to be led by GPs. Again, that will need resources. In our 2022 vision, we talk about integrated care—GP-led, multidisciplinary teams with communication that goes beyond the simple exchange of letters—and starting to risk-stratify our high-risk patients, probably from the 5% to 10% group that we know is responsible for about 70% of all health service costs. I think we were writing appeal letters or housing letters. Isn’t it terrible that we are in teams for the same groups of patients, but increasingly social care professionals and public health professionals are working alongside those people in teams for the same groups of patients, managing the same risks. There are real opportunities to get more resources and capability into primary care to deliver some of the things that will reduce pressure on our hospitals.

Q180 Barbara Keeley: I want to clarify an issue that has cropped up for me locally. A GP told me that she had an awful lot of extra work pressures from DWP, effectively, and from other changes. My local health fund is arguing that having more accessible primary care services might actually generate more demand for A and E services. To what extent do you concur that this seems to be driving patients towards A and E departments and MIU services? To what extent do you concur that this seems to be driving patients towards A and E services?

Dr Gerada: Yes, that is what it is saying. And that if walk-in clinics did not exist, that activity would go—
Andrew George: It is simply saying that one of the consequences of the walk-in clinics is that there has been an overall increase in demand for A and E services.

Dr Gerada: In that case, I think it has probably not looked at some of the stats. I have some stats for our organisation. We saw 160,000 walk-ins at one of our sites. We surveyed them and asked, "If we did not exist, where would you go?" Nearly 40% said they would go to the local A and E department; 6% said they would go to NHS Direct; 9% said they would go to the GP co-op; and 20% said they would go to their own GP—so it is clearly reducing the demand on their own GP. We then have "other". In essence, what we are picking up—we know this anecdotally, as we ask them what they would do if they had a problem—are the people who would have gone to their hospital's emergency department. On the whole, when we are frightened—that is to say, when we are ill—we default to what we know. We do not go through a complex algorithm: something I go to 999, 111, walk-in, urgent care or the pharmacist—blah, blah, blah? You tend to remember three things: 999, the local accident and emergency and your GP. Increasingly, the GP is being used by the walk-in clinic. Rather than saying that we are creating demand, what we must do is simplify the system. So I do not agree with the King's Fund.

Q182 Andrew George: I am simply reporting—it does not necessarily follow logically to me. I just wanted to know what your response was.

Dr Gerada: What the King's Fund has not done, which is very sad—I did ask it to do it—is start to collect primary care activity data. We should not imagine that the world begins and ends in a hospital emergency department. If we started to collect activity data accurately across primary care, including walk-in clinics, urgent care centres and minor injuries units, we might start to see what we know already—that is absorbing vast amounts of activity at a much cheaper rate.

Andrew Webster: What we know from the places that have looked at the data in an integrated way is that the people who generate the demand in all parts of the system are the same people. The same people are using lots of social care, visiting their GP a lot, going to the hospital a lot and having lots of support go into their house. The King's Fund is on to a point when it says that, if that were done in a different way, you might be able to reduce the pressure across the whole system. However, I do not think you could argue that the need is created by the service being there, because those were all people who were eligible for higher levels of service.

Q183 Andrew George: Is it that we are becoming a more calamitous, accident-prone nation, that there are larger numbers of worried well or simply that, because of the age of the population, inevitably you get higher levels of illness?

Dr Gerada: It is multiple, isn't it? The King's Fund report showed that the patients who turn up at the emergency department are iller and older and tend to be admitted for longer—it is a cohort. If you look at the patients who turn up at walk-in clinics, they are younger. They are not the sort of patients who turn up at emergency departments—they tend to be younger, with acute illness. Those who turn up at general practice services are a mix of both, but predominantly patients with long-term conditions or urgent problems. Again, we need to start unpicking these data and looking at them. If you design a service that is only for those long-term elderly patients, you will still have this massive group of people who will, for one reason or another, fall ill, stub their toe, cut their finger, have a rash, get worried, have a cough and need to see a doctor. Those are now increasingly being seen by GPs. Regardless of the newspaper coverage that says we are all twiddling our thumbs, that sort of activity is being seen by GPs now and will continue to be.

Q184 Andrew George: Following that pattern of provision and subsequent demand argument, if the King's Fund is right, with fewer A and E services, more A and E services have been closed or downgraded over the last 10 years—one would assume that, because they are less accessible, there would be fewer patients going to them. Of course, that is clearly not the case.

Dr Gerada: That is going to the extreme. Let us look at the facts. It is slightly outside my expertise, but if we take away urgent care and look at the number of emergencies—the tariff one—there has been an increase of about 1.7% per year over the last decade. The population has risen by just about the same amount; in other words, it has flattened. If you look at London, it has actually decreased. As the King's Fund report says, we have had a blip recently, probably since August but most certainly in the last quarter. As I flippantly said on Twitter this morning, that could be because of the publicity provided by that BBC film on a day in the life of an emergency department. It could be something as simple as that—we do not know. It may be because we had a long winter and a nasty flu virus was going around—I do not know.

Q185 Andrew George: Can I move on to the out-of-hours GP service? Dr Gerada, in your evidence you suggested that in fact that seems to be working well, at least, has worked well. I accept that since the changes in 2003–04, and all the studies show there was not a significant increase in A and E attendances at that point. However, many out-of-hours GP services have contracted through competitive tendering to become private companies rather than GP co-ops. They have also adopted pathways where telephony systems, algorithms and telephonists make judgments about clinical need. Certainly in the case studies I have been looking at, as a result there has been a significant increase in the number of patients who have been diverted at a very early stage from out-of-hours GP services to emergency departments. Would you agree that particularly over the last couple of years—the early stages of the 111 service seem to suggest this is going on as well—it is much more prevalent or, on the contrary, is it even less prevalent? Clinicians are not dealing with patients sufficiently early; they are dealt with through algorithms and systems by non-clinically-trained people, and therefore patients are being driven into A and E services. Is that a fair portrayal of the system?
**Dr Gerada:** Yes, it is. If you put a computer at the front end, it will be risk-averse. Computers have to be risk-averse, don’t they? They cannot ask you searching questions. We need to look at what has gone on. In the old days, I went out in my pyjamas and met my colleague from the practice up the road in his pyjamas along the corridor of a housing estate, which I had taken an hour to find. We would meet and think what on earth we were both doing at the same housing estate and why we did not join resources. Those were the old days. It then moved to GP co-ops, which probably ran reasonably well; they had a sense of ownership. In 2008 it was reasonably okay.

We have gone into the current system, where we have competitive tendering with a whole mix and match, with a drop to the bottom in terms of costs. How many patients can you look after in a total population? Factored into that, we have changed the call-handling system from NHS Direct to 111. Whereas NHS Direct was a clinician and very good nurse able to triage, we have gone to 111, which essentially is someone trained for six weeks and a computer. The computer says, “Go to A and E,” and that is what is happening. There have been some changes.

Many GPs across the country want to go back to the co-op system, mainly because we get a sense of solidarity and we want to make things better for our patients. Some are being blocked; others are desperate to do it but feel they cannot with the current work force. We will see another exodus of GPs if they are forced to do it. With CCGs commissioning and the plan to get more GPs, hopefully we can start delivering a bespoke solution for the frail and elderly, the in-and-out patients and those at the end of their lives, and then a solution for the others who may need just an advice service. We also have to be careful that we do not over-egg it. Not much activity in the NHS now, this evening? It is the GP. We deliver 90% of all activity in the NHS in hours and out of hours, but we are not trained to deliver emergency care. You do not want me chopping your leg off in the middle of the night, I promise you. In some countries they do. We are trained to deliver care to patients with complex needs and deal with uncertainty in acute conditions. It is demoralising for my profession to be on the front page of some of the newspapers with our feet up. It is just terrible. I wish we could all work together to sort this out, because we have to do for our patients.

**Q187 Grahame M. Morris:** That is fair, and I fully understand that. I just thought it was important to have it on the record. In respect of some of the targets that have changed—for example, being able to see a GP within 48 hours—has that had a material impact upon people attending A and E, or walk-in centres as an alternative?

**Dr Gerada:** We had the 48 hours’ advanced access target, which I am sure some of you remember, which was what you were saying. Time is the greatest healer. I am not saying that we should be delaying patients because, in terms of your father and the patients who need to be seen, it is really important, but some of the targets created perversity in the system that meant we were seeing people within 15 to 20 minutes of the first presentation of what would be a minor illness and had to see them again anyway, because time will tell. The Health Select Committee might be wise to look at some of the targets right across the system and see whether some might be creating problems further downstream.

**Dr Gerada:** For the record, I am not disagreeing with the King’s Fund report. I think it is a good place to start, and I laud them for keeping the data because they do not have to. I am being just a little critical of the fact that they do not also keep primary care data alongside it.

With respect to your question, Mr Morris, I am on record as saying that I think it is lazy to blame the 2004 GP contract, which is nearly 10 years’ old, for an issue that has become a problem recently, taking into account that we have seen a more or less flatline increase in emergency department attendances, not admissions. We have seen a big increase in admissions. GPs have never stopped delivering out-of-hours care. Who do you think delivers out-of-hours care today, now, this evening? It is the GP. We deliver 90% of all activity in the NHS in hours and out of hours, but we are not trained to deliver emergency care. You do not want me chopping your leg off in the middle of the night, I promise you. In some countries they do. We are trained to deliver care to patients with complex needs and deal with uncertainty in acute conditions. It is demoralising for my profession to be on the front page of some of the newspapers with our feet up. It is just terrible. I wish we could all work together to sort this out, because we have to do for our patients.

**Q188 Grahame M. Morris:** I can give you a practical example from last week of something that happened to me in relation to not being able to see a GP within 48 hours. A close family member rang on Thursday. The earliest GP appointment was on Tuesday. The family member went to a walk-in treatment centre, which was unable to do an x-ray; they went to another centre, with a seven to 10-day wait to see the result; they went to a different centre,
and ended up going to the fracture clinic at A and E. They spent all day doing this on the Friday. It just seemed an incredible waste of resource.

Q 189 Grahame M. Morris: It is my mother actually. Dr Gerada: Your mother—sorry.

Q 190 Rosie Cooper: I would like to thank Dr Gerada for her honesty in telling it like it is. I have a brilliant GP, who is really very good, and I wish that was an exemplar for everybody else. If all those patients who inappropriate present at A and E were to access primary care via their GPs, would there be sufficient capacity in the system to accommodate that additional demand?

Dr Gerada: There has to be inappropriate attendance in the emergency department for it to be safe. If 100% of patients turning up in the emergency department need to be there, I am missing at least 15% of cases. I do not know the stats at hand, but I am very happy to try to find them. There have to be some patients who turn up a little bit like the one you heard about from the ambulance man. He did not know that the patient was going to get better. They had got better by the time they got there, so you can classify that as an inappropriate attendance. It was not; it was appropriate at the time they made that decision. There are some patients who abuse the system; I have no doubt about it. Some patients who are incredibly busy use the emergency department as their place to meet people. I can give you some examples offline. Equally, if general practice had sufficient capacity, rather than finding a way around that, they would be able to deal with it more appropriately. A percentage of patients who turn up at emergency departments should not be there, but we should be able to handle them.

There is an issue around new immigrants not understanding how to use the system, especially people from eastern Europe where there is not a tradition of primary care. But, again, when we audited our so-called inappropriate attendances, it was very little. When we looked at it at the time, not retrospectively—it is very easy to look at it retrospectively—there were very few. It usually amounted to one person doing it once. Even if we wanted to target that person and say, “Don’t do it again,” they are not going to do it again anyway, because the very fact they have attended once and found they should not have means that they have learned. It is a complex issue.

Q 191 Rosie Cooper: Do you know whether in relation to attendances at A and E the big increases are during the day, in the evening or when out of hours are supposed to be in operation? Is that any reflection on what is going on?

Dr Gerada: Isn’t that awful? Using that example, in the days when we had any capacity, what would have happened is that they would have rung up the surgery and spoken to one of the doctors, who would have taken the story. They would have thought, “Is this or isn’t this a fracture?” They would have been seen at the end of the clinic and, if there was a sense that it was a fracture, would probably have been sent up to the local emergency department—probably. What you have now is a mishmash. If you costed out that pathway, it would probably be 10 times greater than the cost the GP gets for the year of care of your friend.

Q 192 Dr Wollaston: Dr Gerada, Jeremy Hunt says the government, where there is even less resource is responsible for out of hours care of their patients. Is that going to be incompatible practically with them being able to do so if the service is put out to tender by the CCG and they have no control individually over that tendering process?

Dr Gerada: And factor into that the move, which is not yet happening but may well do so, to remove geographical boundaries. The patient may be registered with me but does not live in the area and therefore will not use my local hospital, so it is going to be more confusing. But I think Mr Hunt is correct in some ways. Given that more GPs are able to spend longer with their patients in communities, it is important that we provide bespoke care to those who need it most. For those patients, especially the frail and elderly who are in hospital, we should find a way—working with integrated teams, not just GPs—of providing a transition service when they leave hospital. It is hard work, but the best of practices do not need it most. For those patients, especially the frail and elderly who are in hospital, we should find a way—working with integrated teams, not just GPs—of providing a transition service when they leave hospital. It is hard work, but the best of practices do it. If we had more GPs, we would be able to do that in a better way by having micro-teams within large practices, or what we call federations or groups of practices, being able to provide a named person who is responsible for out of hours, not necessarily visiting. If a patient happens to be discharged at 2 am, you can get a call and deal with it, but even in hours you have a named person. We want to do this and make it work. I am asking the Health Select Committee not to focus just on one bit that will increase our workload, which means we are even more unsustainable. I think he is right to flag it up and set it as an aspiration, but we cannot do it at the moment.

Q 193 Valerie Vaz: I have some general questions, picking up on what you said earlier. You mentioned attendances and admissions in to A and E. For Joe Public or Josephine Public, could you clarify for someone who is not in the health service bubble what you mean?
Andrew Webster: What is the difference between an attendance and an emergency?

Q194 Valerie Vaz: You measure attendances and admissions differently, don’t you?
Andrew Webster: Yes. An admission is where someone has been admitted by a consultant into the hospital formally, and an attendance is where somebody goes to the hospital and goes home again.

Dr Gerada: It gets blurred. With the four-hour target, there are what we call zero-hour admissions, especially children or the elderly, who are so-called admitted but not really admitted. If you look at the stats and really look at the figures, it is in zero-hour admissions where we have seen a massive increase.

We have still seen an increase in elderly care admissions, but when we start to try to unpick the system the question is a very good one. If you start to deal with the wrong problem, you will get the wrong answer. The problem is zero-hour admissions either for observation or because there is not somebody senior enough to make the decision whether or not to discharge. That comes back to the original premise of the College of Emergency Medicine: there are not enough senior doctors in the emergency department to make decisions, hence you are clogging up.

Andrew Webster: I do not think that as a patient or member of the public you are that interested in all of that. You want to know that the thing you needed has been done and you are going to be supported thereafter. However we think of this, we should drive it by what happens to the person rather than what happens to the numbers. At the moment we are counting lots of numbers and not very many people, whereas, if we had a system integrated around people, we could track what was happening to them and the outcomes would be the right ones for them. That would be a much better way of measuring how we do it.

Q195 Valerie Vaz: In my questions I usually ask where the patient is in all of this. The current debate is being formed, and the screaming headlines are about numbers. If people are better informed about them, they will not be so fearful about what is happening and they may be underestimating or exaggerating the difficulties.

Dr Gerada: It is important to say that. If you look at the care of the frail and elderly, the biggest problem with respect to discharge is the wait for social care assessments. It is not that they are being massively admitted. The patients being admitted are predominantly young children and some others. It is important to keep the patient in mind but also to get the stats right so that we sort out the right problem and not the wrong one.

Andrew Webster: Can I just correct that briefly? The problem is not primarily that people are waiting for social care assessments; it is that they are waiting for the thing to get them out of hospital. Sometimes that is a social care assessment; more often, it is something else. Whatever it is, there should be less of it and we should be working together to make sure that those things are done much more quickly. They could be if we were operating the integrated teams with clinical ownership by the primary care team that Dr Gerada is describing. There are ways in which we can tackle that issue.

Q196 Valerie Vaz: In the earlier evidence, the ambulance people said that when your patients—or GPs’ patients—went into accident and emergency the GPs did not know about that. How would you improve the system in that way so that you would know?
Dr Gerada: You do not know immediately, but we get a letter back electronically, which we then code.

Q197 Valerie Vaz: But that is usually when they are discharged, isn’t it?

Dr Gerada: Yes, from the emergency department. I do not know how the emergency department does it. I think they fax them all the next day, or press a button, so we do know. What we do not know, and rightly, is the moment at which they have been admitted or attended. Equally, we do not know that a patient of ours is in hospital, because we know only when they have been discharged. Again, we need to sort this out and get it better.

Q198 Valerie Vaz: You mentioned earlier about GP co-ops being blocked. Could you expand on that?

Dr Gerada: I can give you the example of Hackney GP co-operative, which wants to take over that service. I understand they have been told by the local commissioners that they cannot. They wrote to Mr Hunt a while back, and I understand this is now progressing. There are other examples of that, but it is not my area of expertise; it is just that as chair I hear all these things.

Q199 Valerie Vaz: When we are setting up these out-of-hours services, where is continuity of care in the whole process?

Dr Gerada: Exhaustingly and hopefully, with the GP, but, if we can deal with the two big issues facing the NHS, which does it better than most other health services—fragmentation of care, as in the case of Mr Morris’s mother, and continuity of care—and put those two bits right at the front and sort the system out around that, we will end up with a better system.

Andrew Webster: We can put in place practical things through local urgent care boards and health and wellbeing boards that will enable people to do that. It would be very useful to the system if the Committee focused on some of the practical and resource issues that at the moment impede people from doing those kinds of things. I agree with Dr Gerada that the will is largely there and encouragement would be important.

Q200 Andrew Percy: I would like to make a correction from earlier, Dr Gerada. The figures show that 111 has not increased the number of people being referred to A and E—in fact it has halved it—but it has doubled the number of people being sent through to GPs and urgent care. We have heard a lot about how resources in local government are under the cosh, and, indeed, GP services are under extreme pressure at the moment. We know that budgets in England will remain flat for the next few years. In Wales, the
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My local authority was meeting 2% of resources from foundation trusts. The three things are: invest in primary care; invest in community care; and address the social care bed issue. Those are the three things: primary, community care and social care. If you want a fourth—and please forgive me, other royal colleges—you have to examine where the resources have gone over the last 15 years. Predominantly, they have gone in increasing sub-specialisation, which massively increases costs and fragmentation of care, and probably overall decreases quality of care. Please forgive me if you are listening to this, but the solution is to invest in primary care.

Q201 Andrew Percy: But where do we take that money from given that we have not—

Dr Gerada: I have just told you where to take it from.

Q202 Andrew Percy: Yes, but you then apologised for it.

Dr Gerada: 2% of resources from foundation trusts should be earmarked and moved into community and primary care, whether that is real money—i.e. cuts in their services—or people working as generalists across the community: generalist physicians working across the boundaries between primary, secondary and community care. Then you can start to do it. Please don’t cut beds; we haven’t got enough beds, but start to look at step-down beds, such as integrated care beds, which we had moons ago and have all disappeared.

Andrew Webster: The people who are addressing this are doing precisely that. They are looking at how you move the money out of the reactive, expensive hospital end of the system and into the proactive, planned and locally integrated system. There are clearly ways in which that can be done. There are things that Dr Gerada describes—investing in primary and community services—so you can have that capacity. It can be achieved by—

Q203 Andrew Percy: When we went to Denmark and Sweden we saw how they had invested in this, but it led to closures of hospital’s and hospital wards. I am thinking of it from a patient’s perspective. While we may all understand that is perhaps what needs to be done, from a patient’s perspective they will simply disappear. We were in a situation where multiple services reached out to people in the community services, which have also been referred to. Dr Gerada has just said is the answer too. Can we be straightforward about it. It may be that what Dr Gerada has just said is the answer too. Can we be clear about that? In terms of integrated working, if you have fewer social work staff and fewer people to do assessments, if you just have fewer people in the local authority and fewer care packages, however integrated a system you have of working together, you will not be able to handle the increases in elderly and frail people that we are seeing in A and E.

Andrew Webster: What has happened so far is that the people who get services are continuing to get as much as, if not more than, they did before.

Rosie Cooper: That is absolute rubbish.

Andrew Webster: I was very clear in saying that the main thing to mitigate that impact has been the transfer of £900 million from the NHS spend in social care, and, if you want to mitigate that impact further, you have to do more of that.

Q205 Barbara Keeley: You need to stop in what you have just said, because I, frankly, just do not believe that is true.

Rosie Cooper: That is not what’s happening.

Barbara Keeley: My local authority was meeting moderate eligibility needs. Because of £24 million of cuts this year, they are moving to substantial. There is no way, and I know this from—

Andrew Webster: By and large, it is because they have made other savings.

Q206 Barbara Keeley: Fine, okay, but it is not the case that people are getting the same care packages. I am starting to see it coming in in terms of casework. There were two elderly constituents on Friday who were 24/7 carers. They are halfway through the year and they have had no respite care. It is not true that the people who get services are continuing to get as much as, if not more than, they did before.

Andrew Webster: It is certainly true that three or four councils in the last year have made the change you described.

Q207 Barbara Keeley: But 80% of them were on substantial anyway.

Andrew Webster: I am not saying that everything is exactly the same as it was, because clearly there have been reductions in cost and efficiency changes have been made. I am saying that the figures suggest that there are still quite high levels of service going into the support of a slightly smaller number of people.

Q208 Barbara Keeley: The other question is about community services, which have also been referred to. I am more familiar with my own local area. When our PCT was still in existence it closed two walk-in centres. It ended a pilot of active case management and stopped funding other services locally, which also did active case management. We were in a situation where multiple services reached out to people in the
community and checked how they were and dealt with very low-level problems. We were told by the NHS Confederation that, in their view, reductions in the availability of that low-level social care in the community were leading to this increase in A and E admissions. Is that the case, too?

Andrew Webster: We have heard that the things that lead to increases in emergency admissions are many and varied; it is not simply access to low-level social care. For some people that is probably the case.

Q 209 Barbara Keeley: They did not say it was solely that; they said it was one factor.

Andrew Webster: Just under 5% of the social care spend is still going into preventive services that do not have any eligibility criteria attached to them. I think the tenor of my remarks was that we want local health and wellbeing boards to be sitting down with their GPs and local hospitals saying, “Should we change the balance of investment here in order to get a better result?” If the system could make that work, it could have the impact of reducing emergency admissions, but a national prescription of that order would not have that impact.

Q 210 Barbara Keeley: So you are suggesting that the health and wellbeing boards should go to their local acute services and say, “You should transfer money back into social care because we have cut it.”

Andrew Webster: I am saying precisely that, yes; that is exactly what I am saying.

Q 211 Rosie Cooper: Do you believe in fairies as well?

Dr Gerada: Fear and loneliness are the causes, though not always. In my experience, I chair an integrated pilot. When it boils down, it is not constipation or breathlessness; it is fear and loneliness. With respect to low-level care, there is an argument for befriending. If you hear evidence from some of the elderly care charities, you will find that staggering numbers of our elders have no face-to-face human contact in a week. It is fear and loneliness. I am not saying it is a simple solution, but let’s turn it on its head and we will help. The public want this sort of high-tech stuff until you see it. I hear theory, good wishes and all the rest of it, I hit this system and it is 88 with strokes and all the rest of it. I hit this system and Es, the make-up, whether the general public really want to be involved in that and whether it matters, I am talking to you primarily as someone with a history in the health service, but the big thing is that my dad is 88 with strokes and all the rest of it. I hit this system and is looking after stroke patients; it does matter; it does impact on the care they get.

Dr Gerada, I had a conversation with a resident in Liverpool. She was not my constituent but she came to ask me a question. She related a conversation with a doctor in Liverpool. She rang up and said, “Can I have an appointment with the doctor?” The receptionist said, “Is it an emergency?” She said, “No. I need a fit note to return to work.” The receptionist said, “That’s okay; I can do that.” She replied, “No. I need to see the doctor; I need a phased return to work.” She was told by the receptionist, “That’s okay; I can do that.” That is a receptionist. That is the level to which we are sinking. Let’s take the theory and abstract rubbish out of it and talk about what is going on at the front line.

Dr Gerada: I agree with you. For the record, a receptionist cannot sign a fit note.

Q 212 Rosie Cooper: May I very quickly put on record a couple of things? I am on record as saying that as health and wellbeing boards are constituted they are talking shops. They are all very good. As with everything else, it is fantastic in theory, but unless, for example, the clinical commissioning group turns up at those meetings, gets involved and partakes of it, it is just talk. I do not believe you should be sitting talking to the clinical commissioning group; you should be at the table with a vote. If it is anything other than that, you are not having the influence you think you might have, ergo the difficulty.

To refer to an earlier answer about what goes on in A and Es, the make-up, whether the general public really want to be involved in that and whether it matters, I am talking to you primarily as someone with a history in the health service, but the big thing is that my dad is 88 with strokes and all the rest of it. I hit this system all the time. People do not need to tell me about it; I see it. I hear theory, good wishes and all the rest of it, but it is not reality. What goes on in an A and E does matter; it does matter that the consultant in charge of an A and E over a weekend is a specialist in diabetes and is looking after stroke patients; it does matter; it does impact on the care they get.

Chair: We are drawing to a close, but Rosie has a point to make.

Q 213 Rosie Cooper: The resident did not get to see the doctor.

Chair: Thank you very much indeed.
Tuesday 25 June 2013

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Andrew George
Barbara Keeley
Charlotte Leslie
Grahame M. Morris
Andrew Percy
Mr Virendra Sharma
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Rt Hon Earl Howe, Parliamentary Under-Secretary of State for Quality, Department of Health, Professor Sir Bruce Keogh KBE, NHS Medical Director, Dame Barbara Hakin DBE, NHS Chief Operating Officer and Deputy Chief Executive, and Professor Keith Willett, National Director for Acute Episodes of Care, NHS England, gave evidence.

Q214 Chair: We are running a little late and apologise for keeping you waiting. Minister and colleagues, you are very welcome to the Committee this morning. Could I ask you to begin by briefly introducing yourselves? Minister, I think we probably know each other.

Earl Howe: Thank you, Chairman. I am Lord Howe, and I am one of the Ministers in the Department of Health.

Dame Barbara Hakin: I am Barbara Hakin, and since April I have taken over as the interim Chief Operating Officer for NHS England.

Sir Bruce Keogh: Good morning. My name is Bruce Keogh. I am the Medical Director for NHS England.

Professor Willett: I am Keith Willett, National Director for Acute Episodes of Care in NHS England.

Q215 Chair: You are here to give evidence in our inquiry on urgent and emergency care, particularly in the context of the review that we know Sir Bruce Keogh is leading. You have published 12 priorities. To suggest that there are 12 priorities is in itself a dangerous thing to do. Do you think that is at risk of being too blunt a message?

To couple that with a second question, you characterise them as priorities for commissioners in the year 2014–15. Given the press coverage of urgent and emergency care a couple of weeks ago, to be talking about priorities for 2014–15 seems quite a long way away. It is both a very broad range of priorities and quite a long way away.

Earl Howe: The broad range of priorities reflects our view that there is no single cause of the recent pressures on A and E. The causes were many and various. It is difficult to find a word other than “priorities”. It makes it sound as though one is targeting a rather broad front, which we have to do. The reason for looking at 2014–15 is that we are clear we have to address the problems in the short term—perhaps we can come on to how we are doing that—but this is very much a medium to long-term issue. If one looks at the growth in pressure on A and E over the last few years, it is evident that this is not just a short-term problem. One has to look at how the system as a whole works.

You need to look at the way in which primary care integrates with ambulance services; the way that that integrates with acute care; the way that acute care integrates with social care; and again back to primary care. While looking at 2014–15 may seem like a long way away, we need that sort of run-up to have the kinds of conversations that are necessary to make sure that we have a system that is configured properly.

Q216 Chair: In fact, I correct myself. I said 2014–15, but you are looking at 2015–16, are you not, which is very nearly two years away?

Professor Willett: I am sorry if we have not made it very clear. They are not priorities. We put out system design objectives. They were not what we were saying had to be done; they were 12 objectives that we put out there to build in public and to be criticised, discussed, commented on and added to.

This is a medium to longer-term review to look at how we restructure urgent and emergency care from the advice that a patient may get right through to their hospital care. This is a longer-term review. These objectives are, from the patient’s perspective, the system that the steering group, which has started the first phase of the objective, has suggested is the way we should go. That is what we have put out for an eight-week period of engagement, and we are looking for the public, members of NHS staff, experts and people with experience in the field to add to those in order to develop them.

Q217 Chair: To put another pebble in the pool, are you saying that this is medium-term planning and everybody has to do that, but this is not addressing the service pressures that filled the newspapers two or three weeks ago? That is a different stream of work—work that Sir Bruce Keogh is doing is not intended to address those service pressures.

Professor Willett: That is, in part, correct. In terms of the immediate response to pressures—Barbara may wish to speak to this—we have supported urgent care boards in each of the local areas with patient, CCG and local authority involvement to address the issues in the short term. This is a medium to long-term review, which will take over from that.
substantial redesign. We do not need to do a top-down imposition of that, because the issues have been very different in different parts of the country. We are looking to set out objectives from a patient perspective that people can then build on locally to design their services, but we want to do that in public—not as a central dictat.

Sir Bruce Keogh: We are trying to do this in a slightly different way from usual. One thing everybody is agreed on is that the current position of urgent and emergency care is unsustainable and we need to do something. We need to do some things in the short term to address the immediate issues, and then we need to take a longer, more considered and deliberate view about how we address the future.

There are a number of reasons for that. First, there are clear issues, with which this Committee is well familiar. The demands on urgent and emergency care are growing, not necessarily so much in volume but in particular in the nature of the patients who are being presented, so the number of patients who are admitted to hospital who present is going up. We are seeing fragmentation between different parts of the system, which, if it were resolved, could alleviate the problem to some extent.

Furthermore, the practice of medicine has changed. When A and Es were set up a few decades ago, or DGHs came into their own, people could walk in with a problem and most DGHs were capable of dealing with it. But the inexorable advance of medical science means that now there are many common conditions that cannot be treated in an average DGH. A typical example would be a serious heart attack. That requires a degree of expertise and technology, which means that the treatment of it needs to be focused—I hate to use the word “centralised”—in specific centres, and similarly with strokes.

We have demographic and medical practice changes, and that demands that we reconsider things. We have put together an evidence pack that we think illustrates the nature of changing practice and different demands. That is the evidence that we have been able to accrue. It has 300 references, some of them scientific, some based on policy documents and others. We want that out in the open and for people to add to it, subtract from it, to say that these data are out of date and these data could be improved. It is only when everybody understands the case for change, or indeed whether there is a case for change, that we can have an informed debate. We are trying to set the platform for an informed debate about how we organise, configure and deliver services in the longer term.

Dame Barbara Hakin: This medium to longer-term piece of work needs to go on concurrently with the work that we are doing across the system to try to support our overstretched services at the moment. As you rightly point out, we had a prolonged dip in the times that patients waited for treatment in A and E departments. We always have pressure on urgent care over the winter, but generally the majority of our hospital services are able to get back to running smoothly around March/April time.

This year we had a longer dip, which is almost like a barometer of the system, as Bruce has so rightly pointed out, for a variety of reasons, and there are demands on the urgent care services in general across the board, not just in accident and emergency departments. There are more elderly patients with longer-term care needs. When the system is not running efficiently and smoothly, we tend to see it in the time that vulnerable or ill patients are waiting to be admitted to A and E.

The vast majority of patients are discharged from A and E services. Whether they are in type 1 large acute services or in the walk-in centres. Those patients tend to be treated promptly. They are often discharged quite quickly. It is not those patients who wait more than four hours. Looking at the relatively small number of patients out of 100 who arrive and are admitted, if a hospital A and E service is not meeting the standard, which we consider gives the patients their constitutional rights to be admitted in that time, you are starting to talk about patients who are unwell and have been deemed to need admission to hospital having to wait in the accident and emergency department because a bed is not available for them.

We have started to look at how we can support the service particularly for next winter. We are now in a period when the number is going down, but we do need to support the service for next winter. I wrote to the area team directors of NHS England in April, shortly after I arrived, to ask them to bring together all the key players across the health system and support the CCGs, who are the commissioners of A and E, working with their local hospitals, in order to create a plan that would help us through the next few months, and certainly next winter. We know that, where the health economy works and everyone comes together to decide on the holistic care of patients, those are the places that provide the most efficient services.

We are working closely at the centre with Monitor and the Trust Development Authority, which are the organisations that oversee the hospitals, but we need to see local action. Therefore, the three organisations are supporting CCGs, in particular locally, to work across the system to convene urgent care boards—in lots of places those boards were already in existence—to support everybody to be in a better place next winter.

Chair: We are coming on to urgent care boards. Vinendra wants to come in quickly on this.

Q218 Mr Sharma: Briefly, if I understood rightly, these are not priorities but objectives. Professor Willett, you said that you were looking forward to people’s comments on them.

Professor Willett: Absolutely.

Q219 Mr Sharma: Are you saying that it is a mini-consultation?

Professor Willett: It is an engagement, and we are going to build this.

Q220 Mr Sharma: There are two ways of doing it. One is to send it out to the professionals and opinion-formers to seek their views on it, or are you saying
that people, if they happen to read it, can respond to it.

Professor Willett: Let me clarify. It is not a formal consultation because we are not saying, “This is what we are going to do. What do you think?” This is us saying, “We’ve got this far with it with phase 1. These are the ideas that people have come up with; these are some of the objectives we have drawn from the evidence base that we are also putting out there.”

We recognise that the issues of urgent and emergency care cover the full breadth of the pathway for the patient. If we are going to deal with them, we need to draw on the expertise and experience of all the staff in the NHS and the patient experience. You are exactly right: this is out there to engage and help us. We will bring it all back in together and look at it again, and then we will put it out again. That is the intention. So, yes, I want the public to contribute, and the website is set up to do that.

Q221 Mr Sharma: I am not yet clear whether you are sending out the message to the local professionals that they have the opportunity to comment on it.

Professor Willett: Yes.

Q222 Mr Sharma: You are publicly saying it.

Professor Willett: It is being put out publicly; it is on the NHS England website. In terms of the locality, there is an option that as people contribute they can also put it in the first part of their postcode. Not only will we be able to have a national view and contributions, but we will be able to distil that down to give that in a distilled form to local areas, which clearly ultimately will be responsible for commissioning the integrated service.

Q223 Valerie Vaz: Forgive me, but I thought I heard you all saying, “Crisis? What crisis?” You need to answer the Chairman’s first question: what are your priorities for emergency services, given what is going on now? What are your priorities now to sort out the mess?

Dame Barbara Hakin: We are very clear that this is a local issue and that, locally, the CCGs with their providers need to look at what happens to patients before they arrive in hospital. So there is a broad range of things that can be done locally.

Q224 Valerie Vaz: What are your priorities? Just give us your priorities. You must have had a discussion in the Department of Health as to what is happening on the ground. It is not about writing to people. What are you doing now to sort it out?

Earl Howe: Three things. There is extra money.

Q225 Valerie Vaz: Extra money: how much, and where from?

Earl Howe: We are looking at the tariff for emergency care. As you know, the marginal rate tariff introduced under the last Government applies when certain thresholds have been exceeded in terms of admissions to hospital. The marginal rate tariff is 30%. In theory, the other 70% is there to enable commissioners and providers to work together to look at ways of reducing demand. That has not worked very well. We need to mobilise that 70% of the tariff that commissioners have to get those conversations going, hence the urgent care boards, which have been referred to.

In the immediate term, we are looking at how we can prevent another winter like the last one from happening again. Then there is the medium-term work, which Sir Bruce has referred to, looking at the root causes of all of this. The Foundation Trust Network has come up with quite a long list of the root causes, hence the rather long list of objectives that have been defined. We broadly agree with what the FTN said.

As I alluded to earlier, in the very long term we have to look at changing models of care to respond to changing patterns of illness and what we see in local populations. There is a short, medium and longer-term agenda, and perhaps we can help you by refining that a bit more.

Q226 Valerie Vaz: You mentioned extra money: where from, and how much?

Earl Howe: It depends on the area. I look to my colleagues to come up with precise sums, but it does depend on the area you are in. Clearly, budgets will have been used in different ways.

Q227 Chair: It is to do with the 70%, is it not? When you say “more money,” you are focused on how the 70% is being used. Is it being used for emergency care or for something else?

Earl Howe: To be clear, it is releasing money that is already in the system.

Chair: Exactly.

Q228 Valerie Vaz: You mentioned the short term and long term. I was asking for a response to the Chairman’s question. What are the priorities for now? You answered that there were three, but you are giving me short term and long term, are you?

Earl Howe: The priorities for now—

Q229 Andrew George: It is only one that you are doing now, and that is inspecting whether the 70% of the commissioning money is being deployed on the front line effectively. The other two objectives you mentioned were medium and long term.

Earl Howe: Okay, but I think the short-term ones for now are important nevertheless. I should also mention that there was extra money put into the system over the last winter. That was £330 million.

Q230 Mr Sharma: What are the short-term ones?

Chair: Can we have one at a time?

Earl Howe: As I said, the short-term priority has to be to make sure the system is configured so that we do not get similar unacceptable pressures in the system next winter, hence we are looking at how we can mobilise that 70% of the tariff much more effectively. The urgent care boards have been formed in part to do that, but that is not their sole function. Their function is a broader one: it is to get the engagement of all the local players, including social care, to see how people can work better together.
Dame Barbara Hakin: We have been very strong that this is a devolved system and that all the money has gone out to front-line organisations, CCGs led by local clinicians, and the solutions will be local. This is about how, locally, elderly patients are better supported in their own homes, either with medical or social care, so that they do not need to be urgently admitted when they are ill, if they can be and want to be treated at home. This is about local hospitals being able to discharge people quickly, because often the problems are about difficulties with beds; it is about making sure that all the solutions are in place for individuals so that when they are ready to be discharged they can be. The solutions to this will be found by people working together in individual places and understanding what their priorities are.

Chair: Can I say that we are half an hour into this now and we haven’t made much progress yet?

Rosie Cooper: I am losing the will to live.
Chair: Can we move to David Tredinnick, and can I appeal for reasonably focused, brief responses to the questions, please?

Q231 David Tredinnick: Minister, I want to probe you about the current structure. How many urgent care boards are there? Who is responsible for establishing their size and overseeing their composition—the way that they have been put together—and assessing what has happened, assuming you have decided their size, and that it works? How many boards are there?

Dame Barbara Hakin: They are absolutely local. We say that there should be one for every major provider.

Q232 David Tredinnick: Is there?
Dame Barbara Hakin: They are established now, yes.

Q233 David Tredinnick: How many are there? Give me a figure.
Dame Barbara Hakin: We have absolutely left this to local discretion.
Rosie Cooper: So what have you come for? Forgive me, if everything is going to be left to local discretion and you do not know the answer to the numbers, I just do not understand why you are here if you cannot answer these questions.

Q234 David Tredinnick: May I pursue my line of questioning? Can you give me the approximate number of urgent care boards that we now have?
Dame Barbara Hakin: There are round about 150 to map on to the acute providers.

Q235 David Tredinnick: Is it the local providers who establish their size? Is it a very flexible system? Do we have some boards that are enormous and some that are very small, possibly under-resourced?
Dame Barbara Hakin: Yes.

Q236 David Tredinnick: Under-resourced?
Dame Barbara Hakin: Who needs to be on the urgent care board is left to local discretion, but we were clear that one of the things the urgent care board should do is to identify the use of the 70%. For that, we said that the chief executives of the local commissioners, which is the CCG, the area team and all providers—the ambulance trust, mental health trust and acute trust—should sign off the use of that money. That is the minimum group of people who would be there alongside the local authority, because we said there had to be local authority input. Where it is appropriate to have clinicians, they will have many clinicians on them, because the idea of the board is to bring together local experts to determine what they need to do.

Q237 David Tredinnick: I am getting the impression that, at the moment, it is not very clear within the Department how many boards there are and whether they are large or small. It appears to me that part of your task is to find out what you have got.
Dame Barbara Hakin: We are aware; we have the details of them.

Q238 Chair: Could you share them with us?
Dame Barbara Hakin: They are varied as to what people do. We have one for each provider. We have had all the plans that have come in from each pathway—

Q239 David Tredinnick: How many of these are large urgent care boards and how many are small? When the Conservative Government was elected in 1979, the Department of Health had absolutely no idea how many buildings it owned. I am reminded of that period. One of the first things the incoming Government had to do was establish what the Department of Health owned. I am trying to find out the scale of your operation as far as urgent care boards are concerned—and to be helpful.

Dame Barbara Hakin: I just feel that there is a slight misconception that an urgent care board is part of a governance structure, whereas it is a group of people coming together from the locality—the senior executives and senior clinicians—to work out the best way to do things. It is a consensus-building group. Maybe different people attend them at different times, depending on what they are looking at. It is not part of a governance structure where we would keep a formal record of who was on it and how it was constituted.

Q240 David Tredinnick: Okay; fine. We are short of time. I am going to develop this a bit more and then leave it to the Chair. What time frame is attached to the work of the urgent care boards? Are they going to become a permanent feature of local commissioning and management structures?
Dame Barbara Hakin: I repeat that I do not see them as a feature of a management structure.

Q241 Chair: Forgive me and I apologise, Dame Barbara, but in your first answer, in response to the short-term pressures, you volunteered urgent care
boards. Now you tell us they are not an effective part of the management structure of the health service. Which is right?

**Dame Barbara Hakin:** They are not part of the governance structure.

**Q242 Valerie Vaz:** What does that mean? Secret structures?

**Dame Barbara Hakin:** I believe they are very effective in bringing people together. We have had lots of feedback. For the first time, the relevant social care players—the GPs from the CCGs and the clinicians from the hospitals—are coming together to talk about their issues and problems. That is the point of these boards. So, yes, they are an effective part of the structures, but they do not have a decision-making authority.

**Chair:** I am sorry but I have 11 colleagues now, all of whom want to come in. Virendra is closest to me.

**Q243 Mr Sharma:** Are they temporary and not a permanent part of the structure?

**Dame Barbara Hakin:** I can see no reason why they would not remain permanent, simply because why would you not bring together the people who are responsible for care?

**Rosie Cooper:** That is what we have asked you already.

**Mr Sharma:** We are asking you.

**Chair:** Order, order. Could we have one at a time?

**Q244 Mr Sharma:** I am just asking you: is it a temporary or permanent feature of the system? You said it can be permanent, but what are your guidelines for the system that it should be?

**Dame Barbara Hakin:** We have simply asked them to set them up. We have not, as yet, determined whether we would say they could cease, but it seems to me to be a very good thing to do for patients. I hope that they work really well, and why would we not continue with them?

**Chair:** Could we have brief questions on urgent care boards? Then we need to move on.

**Q245 Charlotte Leslie:** I think we are struggling with the formality and the set-up of these things. First, how much public money would you expect an individual urgent care board to take up in its set-up?

**Dame Barbara Hakin:** None. It is a meeting of individuals, all coming as representatives of their individual organisations.

**Q246 Charlotte Leslie:** So there would be no public money in terms of hiring a venue or any logo. You can guarantee that no public money would be used in the setting-up of urgent care boards.

**Dame Barbara Hakin:** Inevitably, when there is a meeting, there will be the people who service the meetings. The people who attend the meetings will be public servants. Their salaries are paid by the public, and it is taking their time. But these are not structures that are designed to have teams of people working for them. It is a meeting of people from the individual organisations.

**Q247 Charlotte Leslie:** Secondly, would any decisions taken or conversations had in those meetings be subject to FOI in the normal way?

**Dame Barbara Hakin:** If there was an FOI for an urgent care board, I cannot see that there would be any reason to withhold the information. It would be subject to normal FOI rules.

**Q248 Dr Wollaston:** Presumably, there is always a cost, because if a surgeon has to cancel their list to attend a meeting, that time has to be replaced. Unless they are meeting voluntarily out of hours, there is a cost, I would suggest. However, this is my main question. We know that system reconfiguration is extraordinarily difficult. If an urgent care board decides there is clearly a problem in the way that the system is operating locally but it has no power, is it going to be a toothless jelly? Is it going to have any power to force through changes where everyone can agree that that is the best way forward?

**Dame Barbara Hakin:** For the most part, we expect urgent care boards to be looking at the day-to-day changes they need to make in terms of patient management. How can they work better across primary and social care, and so on? If in a meeting of the urgent care board there is a decision that something major needs to happen, that will have to go back through the formal channels of the CCGs. We also have health and wellbeing boards. That is really the formal place locally where, if there was any suggestion of major changes to services, that decision would be taken.

**Q249 Dr Wollaston:** So we are talking about minor tweaking within systems in departments in the short term.

**Dame Barbara Hakin:** Yes. I would not like to use the term “minor tweaking,” but the urgent care board is there to look at changes in day-to-day operational issues. How can people work better together to support patients on a day-to-day basis? That is their main aim.

**Q250 Dr Wollaston:** It is rather than reconfiguration.

**Dame Barbara Hakin:** Absolutely.

**Q251 Andrew Percy:** Am I right in thinking that this is simply about getting all the players involved in urgent and emergency care round the table, and, if a locality finds it is working and wishes to continue with that arrangement in the longer term, it will be able to?

**Dame Barbara Hakin:** Absolutely.

**Q252 Andrew Percy:** It is as simple as that.

**Dame Barbara Hakin:** It is as simple as that.

**Q253 Andrew Percy:** I am struggling to find out quite why people have difficulty with the concept of bringing people together. If a locality decides in the longer term that it does not wish to operate in that way, it will not have to have an urgent care board, but if one decides that it is working it will continue to have an urgent care board.
Professor Willett: With the new Health and Social Care Act we are in a much better position, in that just about all the elements of urgent and emergency care, whether we are talking about out-of-hours services, ambulance services, A and E services, or acute services within the hospital, now fall under the clinical commissioning groups. The urgent care boards are making sure that all of those come together with the areas adjacent to them, like the local authorities, so that in this new structure—which is new to everybody—they are talking. That is simply what it is doing.

We know that, if you walk through the patient pathway, there is not one single issue that will solve this problem. In one place it is one thing and in another place it is something completely different. It may be the way the out-of-hours service can relate to local general practices; it may be the way the ambulance service can access patient records in the house when visiting a patient; it may be the way the hospital A and E doctors can find out what medication the patient is on. All these are multiple elements in the system. With the urgent care boards, we are looking to make sure we are optimising the current configuration of services. That is what the urgent care boards will facilitate.

Q254 David Tredinnick: To follow the remarks of my colleague Andrew Percy, looking at the structure and what has happened since the introduction of the Health and Social Care Act, when the chief executive of the NHS Confederation, Mike Farrar, came before the Committee, he told us that the Health and Social Care Act had removed system management roles that would previously have been in place to address the problems in emergency care. Are urgent care boards intended to fill this vacuum in management responsibility, which I believe, from what I have heard, emerged as a consequence of the Act?

Earl Howe: I would simply comment that performance management is rather different from what we have been talking about in terms of the function of the urgent care boards. Mike Farrar is right. Certain layers of administration in performance management have been removed, but, if you are going to find solutions to this, it is about local people agreeing on what the problems are, what needs to be done and taking ownership of those problems. He is correct in saying that we have lost something, but we have also gained something that I believe is potentially more powerful, because it is not people on the ground dealing with the problems as they see them, rather than somebody sitting in a PCT or SHA looking from on high and asking questions.

Q255 David Tredinnick: Your understanding is that the new flexibility is going to deliver better results and that different communities can have more choice. The Government are committed to choice. This is part of the choice agenda, is it?

Earl Howe: Yes, all of that. The new flexibilities in the system are a very important aspect of them. Power is a zero sum game. If you remove a certain amount of power and influence from the centre, ipso facto you devolve it to local areas. The empowerment of local areas is a signal to them that they can be flexible in the way they respond to problems as they arise.

Q256 Barbara Keeley: There is a point of clarification of earlier answers, particularly those of Lord Howe. You tended to say that this was a local issue. We have heard a lot about local problems. You also touched on preventing another winter. We have had a fair amount of evidence so far altogether, and we have already had a debate in the House on accident and emergency. My local hospital trust told me that they have 10% more ambulance arrivals every day; people are sicker; there are more 72-hour or longer stays and fewer shorter stays; there are 25% more triages into resuscitation; and a significant increase in risk and comorbidity. Patients need more attention and support.

As I read it, that is quite common across the piece, and yet you have left me with an impression that you think there are local issues, which tends to suggest that some places have issues that other areas do not. You have also left me with the impression that this is a winter problem. I understand that it is not and there have been problems in every quarter. Can you address those two things before we go any further? I would not want to leave that on the record if that is not correct.

Earl Howe: You are absolutely right to say that many, if not most, areas have certain features in common. You have listed several. The demands on the system from patients who have more complex conditions, particularly elderly patients, have been rising over the last few years in all areas. You are right that it is at all times of year, although winter is a time when the system is under the most pressure, quite obviously. What I meant by variations between different areas is that, where there are blockages in the system, the reasons can differ from area to area. Professor Willett has already alluded to that. It might be that the hospital concerned is perhaps less good than others in seeing a flow of patients through and there is a certain amount of bed blocking. It might be that the local social services are not resourced as they should be; it might be that reablement services are not being commissioned as they should be. There is a variety of reasons why the problems have occurred, but many areas do have issues—the ones you have referred to—in common.

Q257 Barbara Keeley: There is still a lack of clarity about structures. I have a question about the health and wellbeing boards and where they fit in in addressing this. You have talked about some big issues as being the things that need fixing if this situation is going to be improved. We have urgent care boards, CCGs and local area teams all tasked with dealing with this, and yet, Dame Barbara, you just referred to solutions that somehow had to come out of the health and wellbeing boards. Speaking for myself, this is not clear at all.

Professor Willett: That is a clinical perspective because your question was very clinically oriented. If you look at the figures, both nationally and for most
areas, there has been a steady, almost identical rise in the number of people attending an A and E department, the number of ambulance calls and the number of people who are being admitted to hospital. That has climbed at a similar rate for each of those over the last 10 years despite all that has been done, so this is not something that has suddenly happened.

**Q258 Barbara Keeley:** Earlier, reference was made to local issues. It is not a local issue; it is a national trend.

**Professor Willett:** It is a national trend.

**Q259 Barbara Keeley:** It is a national trend that is having different manifestations, depending on the ability of local set-ups to deal with it.

**Professor Willett:** Absolutely. Our current position is that the system we have does not fit. That is because, as Sir Bruce has said, our patients have changed. They are now older and fatter; we have a higher dementia rate; we have a different perspective of patients arriving, but also the public has changed.

**Q260 Barbara Keeley:** That ties in with what we thought was the evidence.

Let's now move back to the question of structures because I think colleagues are really struggling with the structures. You have talked about something that sounds very flimsy and might be temporary or might last. There are other structures that need to feed into it. Dame Barbara, you said that urgent care boards cannot take the decisions; they have to go to health and wellbeing boards. Can anybody on the panel explain how all this fits together? We have even had questions about whether there will be cost involved in this.

Will the issues that you are talking about fix it? How could an urgent care board deal with an issue where a local authority was under-resourced, there was bed blocking and people were staying in hospital longer than they needed to? How could they do that? Where would the decision be taken that the problem is that x, y, z local authority has cut its budgets and there is bed blocking because of that? How do you fix that with the structure we have here?

**Dame Barbara Hakin:** I go back to the description of the urgent care board as local front-line staff coming together to identify what the problems are. That was a very creative way.

That took cost out of the system, but it used money from both systems. If we can create those resources meant that frail, elderly patients were very effectively.

**Q261 Barbara Keeley:** An example might be patients with mental health problems.

For example, in one area I visited, the pooling of resources, which can be deployed very effectively.

**Dame Barbara Hakin:** The urgent care board might identify that as an issue. There may be ways, through people working together, talking to one another and seeing each other on the ground, to improve the way individual patients are managed across health and social care, but, if a decision is to be made about investment, the money for commissioning health care sits with CCGs, and the local authority money sits with the local authority. They come together in a much more formal way than an urgent care board in the health and wellbeing board with specific structures designed to bring together health and social care commissioners and local providers to make the broad decisions.

**Q262 Barbara Keeley:** No; take the problem I have given because Lord Howe referred to bed blocking where a local authority, not being resourced, has to cut back on eligibility and that is causing the problem. How is that going to be fixed by this set of structures?

**Dame Barbara Hakin:** That was a very creative way. That ties in with what we thought was the evidence. That took cost out of the system, but it used money from both systems. If we can create those resources meant that frail, elderly patients were very effectively.

**Q263 Barbara Keeley:** Indeed, but they do not have any power to increase the resources of the local authority. If the local authority has had a big budget cut from central Government and has reduced the money in social care, that board cannot fix it.

**Dame Barbara Hakin:** That is right. The local authority is represented on the board, so it can make decisions about the funding they have.

**Q264 Barbara Keeley:** I understand how it works. We are tripped up now by a lack of resources in the local authority, and it sounds as if it is quite common. The health and wellbeing board cannot change that situation, or are we saying they can—that between these structures they can do something about that?

**Earl Howe:** In so many of these situations you are quite right that money is an issue, but it is not the only way of cracking a problem.

**Q265 Barbara Keeley:** It is the only way of cracking a lack of social care problem, is it not?

**Earl Howe:** If you go round to many areas, and I have been to several, they are thinking very creatively about how they can take cost out of the system—for example, by joint commissioning of step-down care. Social services in Kent are working very closely with primary care providers.

**Q266 Barbara Keeley:** That is fine, but take my local authority. It is making large cuts to social care this year and next because of the budget cuts from central Government. How do we fix a situation that might develop in my local area because of that? How do we deal with that? We do not have step up and step down; all that has gone. We have cut out an awful lot of things that we used to have locally. How do you create step up and step down, which is an excellent solution, when the budget is cut this year and next? If reports are to be believed, there is to be a further 10% cut in Communities and Local Government.

**Earl Howe:** As you can imagine, we are looking very carefully at this area in the context of the spending review, and tomorrow there will be news on that front. I know how constrained many local budgets are. Having said that, there are mechanisms in many areas for the pooling of resources, which can be deployed very effectively.

For example, in one area I visited, the pooling of resources meant that frail, elderly patients were looked after by a mixture of primary care clinicians and adult social care workers in a very creative way. That took cost out of the system, but it used money from both systems. If we can create those
mechanisms, local people can then take advantage of them. I do not wish to give you the impression that this is simple. We were aware at the beginning of the last spending review in 2010 how pressurised local authorities would be, which is why the Department allocated an extra £7.2 billion to local authorities specifically to shore up their resources. The King’s Fund at the time said that that would be enough, assuming a 3% efficiency in local authorities.

Q267 Barbara Keeley: I understand. We have heard evidence from across emergency care of the benefits of working with a single commissioner. There is a point here about how that simplified commissioning can be achieved. We still have a situation where emergency care services extend across CCG boundaries. There might be different local authorities, health and wellbeing boards and urgent care boards. How can we get to that simplification, which seems to make things work where you can utilise it, when in certain areas it is going to be completely different? Earl Howe: We are increasingly seeing CCGs working together, and effectively the net result is joint commissioning by CCGs.

Q268 Barbara Keeley: But then you would have different health and wellbeing boards. Earl Howe: That was always going to be part of the scene. I am not aware that the lack of congruence between local authority and CCG areas has caused a major issue in terms of decision-making. I am wrong about that, please correct me, but I am not aware of it. Barbara Keeley: If I take my local area, Salford is next to Manchester City, which is next to Trafford. There are no longer any decision-making structures that span two or three of those. This is making structures of local government that go across 10 local authorities, but that is not a unit that would work with urgent care boards or CCGs. I think this is a very confused picture.

Q269 Rosie Cooper: I have two questions to ask, but, before that, I want to tie up what I have heard so far this morning and follow on from Barbara’s question about all these differing organisations that will locally cross over and deliver care. I am willing the NHS to do really well, whether it is the Department of Health, NHS England or CCGs—to make the best of the hand that it has been dealt. Our lives depend on you guys enabling people on the front line to deliver. I am still not clear what urgent care boards are about. Dame Barbara, you have described them in a contradictory fashion to me. I am hearing “temporary,” “not part of the structure,” “not decision making,” “they are good,” “people are delighted,” “the first time clinicians got together”—that is a big surprise—and that you hope they work together in the long term. For someone like me, hope is not a long-term strategy. Hope is not a strategy, short or long term.

Is it any wonder that the public out there, looking at this description of what is attempting to deliver the health services on which their lives depend, are fearful that we are in a dreadful mess? It sounds like it is not us in the middle—it is not the Department of Health; it is not NHS England; it is not health and wellbeing boards; and it is not altogether CCGs. We are saying that locally we are all depending on somebody else. We all believe that somebody is waiting for somebody else to sort out the problem. If I was a member of the public listening to this, I would not have any confidence that anybody had a grip of where they are, what their priorities are and how they are going to deliver, whether it is winter or summer pressures or any other pressures. We have gone into a new era and all of this sounds very confused. That is not the question. What assurance can the Minister give people that you can describe this in a fashion that people can understand?

Earl Howe: The simple point to be made is: look at the results. Already we are seeing the system performing to standard. That is a result of local clinicians and others in a local area getting together and making jolly sure that the slippage in performance is corrected in short order. We have had the system performing as a whole up to standard over the last six or seven weeks. That is what we all want to see. I see that as a result of a lot of effort by a lot of people talking to each other, not ducking responsibility but sharing it and making sure that they play their part in addressing the problems.

Q270 Rosie Cooper: In that case, I suppose I would come back and ask what the standard is, but I will go on. The Royal College of GPs and the King’s Fund have said that attendances at type 1 emergency departments have flatlined over the last decade, but the College of Emergency Medicine reports year on year an increase of 250,000 attendances. How could we reconcile those competing claims? If we do not have the full information, how can the Committee hope even to begin to understand what is happening and how the NHS comes up with a solution?

Earl Howe: Attendances over the last three years have most certainly gone up by about 1 million. If one looks at a three-year period, that is an important point to factor in. It depends on what statistic you take about pressure on the system. That is the one we are working to. We believe it is reflective of reality, so I would leave you with that.

Dame Barbara Hakin: To answer that, the biggest rise in attendances has been outside type 1 A and E, and that is where we see some of the difference in numbers. There has been a rise over the decade for type 1 A and E, but the big rise has been in the total numbers of patients who attend A and E, including 2 and 3.

Q271 Rosie Cooper: Is it how we handle that? Can I come to bed numbers in hospitals? Are they now too low to allow trusts to cope with fluctuations in demand while maintaining patient flow through the system? What work has been done to understand how
many beds the NHS really needs to be able to cope with expected demand, or is it the case that we do not have the full information to understand exactly what we need in place? It is a continual problem for somebody like me who has been involved in the health service for years. Every winter we get the same thing over and over again. Is it a continual problem? What is NHS England going to do about it? Or is it the case that we need more beds, which may not necessarily be acute beds, which moves over to Barbara’s point, but the system cannot afford it? My own hospital, Southport and Ormskirk, has to increase the number of beds every year to cope with that demand. To do it, it opens a ward, or does whatever, and that can potentially be a poor way to run a service. It is hard to recruit staff and you end up with agency nurses. It is all very push and shove, whereas this is the health service and we ought to be able to plan for this. Why can we not get it right?

Earl Howe: Perhaps the more appropriate measure to look at, if you are considering beds, is not bed numbers but bed occupancy rates. Of course, bed numbers matter. In my own area, south Bucks, where there has been a reconfiguration of A and E services, Wexham Park hospital was able to expand its bed numbers—two new extra wards and 28 beds—in response to increased demand. It can be done, and it is being done.

If you look at bed occupancy rates, the proportion of beds occupied in the NHS is broadly stable and has been for a number of years. It is around mid-80% on average. That is because, despite increasing numbers of patients being treated, we are seeing many more day cases. Almost 80% of inpatients were treated as day cases in the most recent year, so the system is becoming more efficient. The average length of stay in hospital, setting aside day cases, is coming down. Clearly, each trust is responsible for ensuring that there are sufficient numbers of beds. Hospitals can and do upscale during the winter and downscale during the summer, as necessary. There is money in the system in capital budgets to enable hospitals to present a case for investment, so I would not want to fill you with gloom that the system is inflexible. It is not. There are systems to ensure that it can flex to meet demand.

Q272 Rosie Cooper: You have just said that average bed occupancies are in the mid-80s.

Earl Howe: Over the year as a whole; that is what my figures say.

Q273 Rosie Cooper: But the reality is that at times it is much higher.

Earl Howe: Yes; it is in the 90s.

Q274 Rosie Cooper: Absolutely; so we cannot just not deal with that situation.

Earl Howe: No, indeed; we can’t not deal with that situation, and those figures of 90% during the winter demonstrate amply that the remedies we have been talking about are necessary.

Q275 Rosie Cooper: Forgive me, but are there any signs that those 90% occupancy rates are now spreading more throughout the year?

Earl Howe: I will have to write to you about that. I do not have in front of me a chart showing a week-by-week profile, but we will gladly give you that.

Chair: Andrew George, Andrew Percy and Virendra all have points to make.

Andrew George: Or questions to ask.

Chair: Or even questions—evidence to seek.

Q276 Andrew George: In your answer that bed occupancy levels were in the mid-80%, you were suggesting that that includes the acute sector wards that undertake routine elective work. Perhaps there is again a need to write to the Committee. Is it possible to have a little more detail on that figure? The anecdotal evidence, and certainly evidence we have received elsewhere, suggests that bed pressures have increased over time, particularly on those acute emergency receiving wards in hospitals, many of which are operating at red alert. The received wisdom or mantra about acute hospitals operating with fewer acute beds, on the basis that those hospitals should be operating in a manner that no longer accepts unnecessary admissions and discharges earlier, may be creating some of the pressure that the A and E services are unable to handle.

The first part of the question is: is it possible to have a little more sophisticated information about those that are elective wards and those that are emergency receiving wards?

Earl Howe: We will certainly do our best to supply you with that. It is clearly inefficient for a hospital to keep a whole mass of beds open when they are not needed, so in some instances it could be a case of a hospital not being responsive enough to the rise in demand. There are now quite sophisticated tools for them to predict the demand over the course of a year or even a week. I have seen those systems working. You are right. This could be part of the mix, and if we can enlighten you we will be happy to do so. I am not sure what figures NHS England have, but what they have we will give you.

Q277 Andrew Percy: On bed numbers, there is an issue here. I attended and spoke in the Opposition day debate on this issue and was shocked that Andy Burnham’s introduction made no mention of anything that had happened in the run-up to 2010, which is perhaps not a surprise. But we did lose 50,000 beds and there was no mention of that in that debate. I want to ask a similar question. I think most Members understand why beds have reduced and that hospitals are able to flex over the winter period, but in losing those beds over those 13 years was enough emphasis put on replacing some of them with proper intermediate services: step up, step down and all the rest of it? In part, that was Barbara’s point. Minister, do you have a view on whether or not losing 50,000 beds without a proper strategy around intermediate services is partly behind some of the problems we have seen in the system in the last year or two?
Earl Howe: I certainly would not set myself up as someone to defend Andy Burnham, but this trend has been going on for longer than 13 years, in fact. We have seen a steady decline in beds over more than 20 years.

Q278 Andrew Percy: But we have had a demographic shift.

Earl Howe: We have. I suspect that we have reached the point where deep-rooted questions need to be asked about how much longer that trend can sensibly continue, given the pressures we all know about. I would not want to sit here and give you the impression that I think that trend was mistaken. It was almost certainly appropriate, because we have seen much more serious illness, and it is appropriate to have more care in the community. We have reduced the number of acute beds. That patient group is very different from perhaps 20 years ago. Most of them will be living with one or more long-term conditions. Most people over 60 have two long-term conditions; most people over 70 have three; and most people over 80 have four. That is what the Scottish primary care dataset tells us. These are much more complex patients, often associated with frailty. The dementia rate now is 40%, and it is very challenging to give these individuals the care they deserve. If we are able to interrupt the decisions about getting patients into hospital earlier, we have talked about what general practitioners working with out-of-hours and the ambulance service can do, and how they can work in the community so that they can support the patient in the community. If that demented patient, who has been managing but now just needs a bit more care, can receive care in the community, that patient is not transferred to hospital. But I can assure you that, once that patient arrives in A and E because we have not got that bit right, it is impossible in three hours 59 minutes to identify all the patient’s needs and supply them with what they want; so that patient becomes a guaranteed admission.

Once they are in hospital, it is a strange environment for the patient. It may not have good information about the patient, and that often becomes quite a long stay. We can do things about that, as Earl Howe has indicated. We have reduced the number of acute beds by a third over the last 10 years, but the number of our emergency admissions has gone up by a third. I do not think we can say that we are completely efficient now in dealing with the new challenges in the NHS. There is a lot to be done.

We are now seeing new models where we are bringing senior medical staff, geriatricians in particular and emergency medicine staff, to the front door of the hospital. We are taking a bit longer, perhaps 12 or 24 hours, to assess these patients, bring in general practice and general practitioners, occupational health and physiotherapy, and move the patient back to an environment close to their home, which is supported. That is the new challenge. Things like urgent care boards will start to be able to look at the best practice models, because that is not happening everywhere by any means. There are some real opportunities to change the service going forward. That is why we are doing the urgent care review because we want to seek those good examples and the evidence base out there. Medicine is changing so fast. A lot of that is not published and so cannot be in the evidence base from which we would traditionally work.

Q279 Barbara Keeley: For clarification, we are getting confusing pictures again. You have just made a comment about shorter stays, but earlier I gave you a figure that I got from my local hospital. There has been a 13% increase in admissions of people staying longer than 72 hours. We hear about people being sicker and having to stay longer with a corresponding decrease in the number of people on short stays. We cannot have both. Hospitals and urgent care boards may be working to get to a situation where there are shorter stays, but the trend in patients seems to be working against that.

Professor Willett: I do not have intimate knowledge of your local hospital.

Q280 Barbara Keeley: I do not think that is untypical.

Professor Willett: But we also have some really good examples of where those systems are being put in place and are working very effectively. That is the sort of thing we wish to share and spread around the NHS. I am not suggesting there is not an underlying issue around the number of beds.

Barbara Keeley: We need statistics. It is not my question; it is Andrew Percy’s question, but we cannot leave on the record that you are saying there are shorter stays, when the evidence seems to suggest that patients are sicker and there are longer stays. We must have some statistics on this; otherwise, it is just not clear. There may be a trend of working towards shorter stays, but, if the trend in sickness in patients means that is working against that, we should know which is which.

Chair: Could you write to us about that apparent conflict of evidence? I think Professor Willett’s last response pretty much answered where you were going.

Q281 Dr Wollaston: It is not just about bed occupancy; it is about patients being in the wrong wards—for example, outliers receiving the wrong care—and it is about the knock-on effect on operations being cancelled because there are no surgical beds for patients to come into. How much
will all of this feed into tariff reform? So much of this is about tariffs. Take the role that community hospitals could play in providing step-down care, but often it is an issue of tariff. You cannot split the tariff. How much of that is going to be fed in from urgent care boards and all these people to liaise with Monitor, who need to change the way tariffs are operated?

Professor Willett: The tariff is a very big subject, and we could cover tariff from the ambulance service right the way through. On the specific question you have just raised about the tariff in terms of moving patients into social care and into the community, we have started a piece of work, which I lead on, that looks at disaggregating the tariff a hospital would get. At the moment, we pay a hospital by the admitting diagnosis of the patient and the reference cost set by the average length of stay across the country in previous years. The difficulty is that in the population I have described, if the admitting diagnosis happens to be a urinary infection but they have rheumatoid arthritis and had a stroke last year and so on, what determines how long they stay in hospital is not the fact they came in with a urinary infection but that their dependency is much greater than someone who came in who just had that infection.

We are quite advanced in our work to look at perhaps disaggregating the tariff so that you can identify a section of the tariff that is based on the patient’s needs. That work is ongoing. Many CCGs, and PCTs beforehand, were already looking at releasing moneys into social care and into the community, we have just raised about the tariff in terms of moving patients into social care and into the community.

Q 282 Dr Wollaston: So it can be moved.

Professor Willett: You can feed it in, whatever way your local services are set up. If early supported discharge is the model that you have made work locally, you can feed that in. It may be intermediate care beds; it may be moving patients early into a care home, but those opportunities are created. We are looking to create opportunities so that we can present to clinical commissioners locally who design local services opportunities to do it in the way that they wish for their patient groups.

Q 283 Dr Wollaston: Organisations can talk to each other, but, unless the money follows the patient to the right place, it is difficult to see how we are going to see it work.

Professor Willett: Our expectation is that we will have models worked up for that to test the currencies next year.

Q 284 Dr Wollaston: So next year we should be able to see that.

Professor Willett: I cannot guarantee that because we are working that up, but that is our intention at the moment.

Q 285 Valerie Vaz: Minister, I want to turn to work force issues. Are you the Minister with responsibility for work force issues?

Earl Howe: I am not, actually.

Q 286 Valerie Vaz: Who is?

Earl Howe: It is my colleague Dr Poulter, but I will do my best.

Q 287 Valerie Vaz: You are going to get some questions on work force issues, and I hope you can answer them. I do not know whether you are aware of the evidence given by the College of Emergency Medicine as to the shortfall in trainees for emergency medicine. There are two issues: trainees as well as consultants coming through, and there is a shortfall in both areas. Can you deal with what the Department are doing to address those two issues?

Earl Howe: Yes, certainly. First of all, we were very conscious of this issue as far back as 2010. We asked members of the College of Emergency Medicine to establish the emergency medicine task force, which I think they did in September 2011, to address work force issues in emergency medicine. They published their initial report last year and made a number of recommendations. Those included increased flexibility around core training and the way it is configured and delivered. That included looking at the entry requirements for core training and recognising transferable competencies of trainees currently in other specialties. They were trying to see how one can be flexible in this area, but also how to develop alternative routes into specialty training, such as a parallel run-through training programme. They looked in addition at the expansion of training for clinical nurse specialists and physician associates, trying to define roles rather more precisely, because it is quite clear that the day-to-day delivery of emergency department care is going to depend on the expansion of those kinds of roles.

Health Education England has also set up an expert group, which I think met for the first time in April of this year. That is working in close collaboration with the College for Emergency Medicine and others, to look at what more can be done to ensure there is a sufficient medical work force being trained for the specialty of accident and emergency. We await their advice. It is very much centre stage. Part of the problem here is that it is not an attractive specialty for many trainee doctors for a number of reasons: the lifestyle is pressurised and there are fewer opportunities for private work. To expand the numbers is not a simple matter.

Q 288 Valerie Vaz: Why is that?

Earl Howe: Because of those unattractive features of the life, if I may put it that way.

Q 289 Valerie Vaz: But they gave evidence that this has been happening for the last three years. There is a 50% shortfall in trainees, and therefore consultants, coming through. What is the Department doing? What steps are you taking? There is another task force. I am sorry that you are having to answer questions that are within someone else’s remit, but you must be taking some steps.

Earl Howe: Absolutely. Health Education England is the body that we have charged to take control of this, which they are doing; they are gripping it.
Q290 Valerie Vaz: When will they report?
Earl Howe: I do not want to give you a wrong answer.
I will correct myself in writing if I am wrong, but we expect them to give us some preliminary indications by the autumn on how this can be dealt with.

Professor Willett: Can I add to that because I have been involved in some of it? There are plenty of numbers, in that they are funded and the posts are there. Our difficulty is that less than 50% in three consecutive years have not been taken up. As doctors qualify, they are recruited into core training, which covers a lot of acute areas of health care, including anaesthetics and other areas. At the end of that, a limited number of doctors—I would have to disagree with Earl Howe—do not take emergency medicine. I think it is an attractive specialty.

I am not in emergency medicine; I am a trauma surgeon, but I have lived in that environment for 30 years. There is probably no more rewarding environment, but it is tough. We have to recognise that the nurses and doctors who work in emergency departments are some of the most resilient staff around. When we hear words like “crisis” and “we’re in trouble,” we have to take that very seriously because these people can really take it. These are very special people.

All the training numbers are available; they are just not being selected. It is not that there is not enough money to train them. For every two trainee numbers available, only one is adopted. That is partly to do with the task force. When it made its interim report at the end of last year, it indicated that it had a lot to do with the experience of working in emergency medicine; the amount of consultant support they could get, because everything was just so busy; and clearly there are social issues about working in that type of environment.

Nearly all of the recommendations it came up with have moved forward. It is piloting a change in the order of sequence of training posts that are done in that core training; it is looking at transferable skills so that people who train in another specialty can transfer in with greater ease rather than having to start at the beginning again; it is also looking to deal with non-medical issues around other professional groups that work extremely well and now make up a large part of the emergency work force.

We are looking at recruiting overseas as well and have had some success in India, but emergency medicine is quite a British/American model of care. In a lot of countries they do not have emergency medicine; that is not a structure they use. When you arrive at a hospital, you are either taken directly to a specialist department or the specialist department receives you. One of the other issues we look at is how you are received in the emergency department. We can directly identify some patients who need to be seen by a cardiologist or have other issues, and we reserve emergency medicine for the particular areas they are in to make the thing attractive. We can also link it as a specialty, to take out some of the heat, if you like, with things like critical care—I do not say it is any less hot, but it is more structured—and the pre-hospital faculty of medicine, which has now been approved as a training programme, so that we can move doctors out into the community to work as emergency response teams. All of that makes it attractive.

Q291 Valerie Vaz: I accept all that. You are doing lots of wonderful things, but clearly there has been a crisis, and where you have to get locums in it will cost the NHS much more. I presume this pool of Army doctors who are very used to these kinds of areas will then fit into the National Health Service. I suppose that I am trying to push you into saying what incentives you are actually putting in place now.

Earl Howe: Solving the numbers problem is not going to happen immediately, although one can, as Professor Willett said, look to bring in people from overseas; I think that is being done in certain areas. However, if we are going to have home-grown accident and emergency specialist doctors, we are looking at a period of years before we can ramp up the numbers. Incentives and salary structures are very important; all of that is being looked at by Health Education England. While I cannot present you with an overnight solution and I recognise the problem, we are certainly trying to grip it as tightly as we can.

Q292 Valerie Vaz: I have one quick question about the rate of attrition in A and E compared with other specialties. Do you have the figure for that?
Professor Willett: That would be a Health Education figure. I am afraid I would not have that.

Earl Howe: I am sorry, but I do not have it.

Chair: Can you write to us on that? Sarah wants to come in next, followed by Charlotte and Rosie, but we need to be quick, please.

Q293 Dr Wollaston: Isn’t it also time that we started disincentivising some of the specialties? We are training too many doctors in the wrong specialties. That has been going on for years. Partly it is due to the factors that you have already identified—there are some very popular specialties where there are very lucrative private rewards to be had. Isn’t it time that we just stopped making those the ones people keep going into?

Earl Howe: If you talked to the royal colleges, they would say the same thing. I defer to Sir Bruce here, but increasingly they are recognising that very issue. We know that we have too few GPs. The numbers are going up, encouragingly, but they are not high enough. We do not have enough accident and emergency specialists in hospitals. There are other specialties where we have shortages. So, yes, that is an issue. We can point to a sort of global figure. We now have more doctors in the system—6,000 more, I think, since 2010—which is good, but maybe they are not quite in the right places.

Q294 Dr Wollaston: But it goes right back to medical schools—the way in which medical students are being encouraged to think that there are only some specialties that have value. The emphasis that goes in right through their training is in the wrong specialties.
I do not know whether Sir Bruce also wants to comment on that.

**Sir Bruce Keogh:** My only comment would be to say that I agree with you. The colleges—

**Q 295 Chair:** Do you need to add to that? That is clear.

**Sir Bruce Keogh:** No, I will not.

**Dr Wollaston:** We have been talking about this for years, but still nothing happens. Medical students are still being taught and incentivised in the same way into the wrong specialties after training. When is that going to change?

**Chair:** In truth, it is probably a question for Health Education England rather than for this panel of witnesses.

**Q 296 Charlotte Leslie:** From a number of sources looking at this, a number of doctors have suggested to me that the European working time directive and the disbenefits that that presents, often in making doctors more tired, with the shift rota system, and disturbing patterns of work—so not being successful in its aim—are more acutely felt in emergency services. While emergency medicine may not be a very attractive option because of the pressures, the working time directive makes it even more unattractive. Are you doing any work on that?

**Earl Howe:** The Department for Business, Innovation and Skills is leading our efforts in Europe to try to achieve greater flexibility on the working time directive, as I expect you know.

**Q 297 Charlotte Leslie:** Have you done a specific assessment of how it may be impacting on recruitment to emergency?

**Earl Howe:** Impacting on recruitment—I do not know. I think it might be a good idea for us to take away that question, in conjunction with the question on attrition rates, to see whether we can pin any of the attrition on the working time directive. I do not know whether my colleagues are able to provide the answer.

**Q 298 Chair:** Presumably, what is true is that the Department of Health is doing work to contribute to the broad Government programme on assessing the effect of the working time directive on training programmes for doctors—presumably.

**Earl Howe:** Yes, undoubtedly. We are clear—and we have had this message loud and clear from the health service—that the working time directive inhibits optimum care in many areas and is not necessarily beneficial for doctors in every respect. We have to say that there are some areas of the working time directive that have been very good, because—

**Q 299 Valerie Vaz:** You do not want tired doctors.

**Earl Howe:** We do not want tired doctors.

**Q 300 Charlotte Leslie:** The new deal prevents that, with the 56-hour limit.

**Earl Howe:** But there are inflexibilities in it that I think are unhelpful for all.

**Q 301 Rosie Cooper:** Professor Willett, a short time ago you described some potential changes to A and E, perhaps with people going direct to specialisms. I wonder whether that model of care relies on rationalisation of 24-hour, around-the-clock staffing and, perhaps, a move towards the trauma centre model. Does it? If so, how much have you progressed that work?

**Professor Willett:** Reconfiguration of services and reducing the number of hospitals you have to staff is an obvious way of dealing with the manpower issue. The question is, is that actually what we want? In fact, we know that one of the other specialties we have a problem with is acute general medicine—the physicians behind the A and E, as it were, who will take you into hospital. That is another very challenging area where work intensity and patient numbers are very high, and where we are having difficulty recruiting. So there is definitely a link between the two.

On reconfiguring, we know—and there is good evidence—that, as Sir Bruce said earlier, when we regionalise and bring together certain diseases, illnesses or injuries into specialist centres, where we can give not 12 or 16-hour but 24-hour specialist input, there is a dramatic improvement in the outcome for patients.

We know, for instance, that, if you have a certain type of heart attack and go to a specialist heart centre, your mortality rate is 5% rather than 12%. We know that, if you have a stroke and get to a specialist centre very quickly, your chance of severe disability is half of what it would otherwise be. Today the figures have come out on major trauma, for which we introduced specialist centres last April. It looks like we have a 24% improvement in survival for patients with major trauma. These are some of our most critically injured patients, who are moving past one or two hospitals and arriving at a major trauma centre. It is our responsibility to ensure that we offer those sorts of things to patients.

We also have to balance that with determining what things we should not move away from the locality and which diseases and illnesses should really be managed locally. That is what we are doing in the review. We are trying to put out there the evidence for the things that we know we should regionalise and for which we should have a regional network structure, and for those things that quite clearly should be available to local people in their local emergency facility. That is the discussion we have got to have; it is that redesign that makes us creative. What we have heard, and the evidence you have heard from others, is that at the moment we do not have the right fit. We have patients with the wrong things in the wrong places. It is not the patients’ fault; it is the way we have the system designed.

**Q 302 Rosie Cooper:** When do you think you will fix that bit?

**Professor Willett:** We have done some of them. London has done stroke; the rest of the country is following. We have done most of the heart attack. In vascular surgery, mortality for major aneurism surgery
Chair: Can we move on to delayed discharges?

Again, I think it is instructive to look at those statistics.

Rosie Cooper: Do you have in the Department even a broad blueprint for when you want decisions on each of those to be taken by?

Professor Willett: I am not in the Department— I am in NHS England— but I know what you are saying. We are going out now to have what Sir David Nicholson called the “big conversation” with the public, because this is something that will be very difficult for a lot of people to understand. We have to create a system that presents a very simple, straightforward model to the public so that they know how to access health care by one or two routes— 111 and 999, let us say.

Rosie Cooper: God help them.

Professor Willett: So we will present a very simple system. Behind that, we have the multi-tiered, complex medical model that will respond to their needs, however and wherever they present. That is the redesign that we need to do. I have to say that 111— phoning first—is absolutely critical. When you recognise that, in the system that we have, different things will be available in different sites in the future, it is really important that we can direct patients to the right sites, so that you get the right care, from the right person, with the right equipment, the first time they arrive, which is a phone first phenomenon. That is recognised internationally and is being implemented everywhere.

Chair: Are you really saying that only 2% of NH beds, on average, are occupied by people whose discharge has been delayed?

Earl Howe: Correct. That is the figure I have.

Chair: Is it a figure that a typical NHS trust would recognise?

Earl Howe: Yes, I think so, although obviously that average masks a range of figures, depending on where you are. That is the official figure that I have been given in my brief. Around a third of NHS days delayed are attributable to awaiting further NHS care. The proportion of overall delayed days attributable to social care is coming down and the proportion attributable to the NHS is rising. I think the evidence you have had from the LGA is right, but it reflects a different mix of factors in the equation.

Andrew Percy: It would be helpful if we could have those figures provided to us again, perhaps in writing, with as much detail as possible, because it is regularly thrown at us that it is all because there is a big issue with social care reductions and that is the reason we are seeing these pressures. As I said, I always think that is a bit simplistic, but the figures do seem quite incredible compared with what we have heard from other people giving evidence.

Chair: It would also be interesting to know what the definition of a delayed discharge is in the context of those statistics.

Andrew Percy: My only other question would have been my follow-up on the issue of beds. I was quite reassured, in a way. We have seen a lot of bed reductions in my own constituency, which has certainly had an impact on people’s ability to access local services in a local hospital. As it happens, this has affected mental health beds, in particular, so that now when people go into crisis, the first thing they do is tip up at A and E. If we are going to see bed reductions, because that is something that trusts are able to do themselves, without requiring even the consent of the overview care, which I think is a somewhat simplistic connection to make. However, we heard a different message from the people who are actually delivering social care—from the LGA— when they came. They said that delayed discharges attributed to social care are actually falling. Given that there seems to be this strong disconnect between the argument on one side and that on the other, what actual evidence does the Department or NHS England have about delayed discharges as a result of social care failures?

Earl Howe: Again, I think it is instructive to look at a five-year period. If you look at where we are now compared with five years ago, the long-term trend on delayed discharges has been favourable. Numbers and patients are reducing; they are now broadly stable. On the scale of the challenge and the causes of delayed transfers, about 3% of total bed days are due to delayed discharges, with approximately 2% of occupied beds being delayed. So the long-term trend has reached a plateau. It is sticking at around the level of 2,000 acute patients. Before, it was around 7,000.

Chair: What happens if you are like my dad and you are deaf?

Rosie Cooper: What happens if you are like my dad and you are deaf?

Professor Willett: The system is designed to help.

Rosie Cooper: I am sure.

Chair: Can we move on to delayed discharges?

Andrew Percy wants to ask about the effect of delayed discharges on the service.

Andrew Percy: Barbara Keeley raised the issue of social care and painted a picture from her constituency. In my constituency the picture is quite different, in that there has not been any reduction in social care intervention levels. At my request, the local authority is actually funding free home visits for over-75s, something we saw when we were in Denmark and Sweden. I have asked it to do a pilot, and it is starting that. It is doubling the number of step-up, step-down intermediate beds, with a £3 million investment, fortunately in my own constituency. However, we have still seen the same pressures on the local hospital. While we have not seen reductions in social care, because the council has made the right choices rather than the easy, simple choices, we have still seen big pressures on the local hospital.

The image that is often created is that there is plenty of access through the front door but very little exit through the back door because of reductions in social care. I think is a somewhat simplistic connection to make. However, we heard a different message from the people who are actually delivering social care—from the LGA— when they came. They said that delayed discharges attributed to social care are actually falling. Given that there seems to be this strong disconnect between the argument on one side and that on the other, what actual evidence does the Department or NHS England have about delayed discharges as a result of social care failures?
and scrutiny boards—they cannot even be called in to the overview and scrutiny boards—how will the Department monitor those? I understand the trend and the reasons for it, but I would say that the failure is that we have taken away bed numbers but have not provided proper alternative pathways in every locality. Who takes responsibility for that? What will be done to ensure that, if there are going to be bed reductions in trusts, which trusts seem intent on continuing to pursue, there are proper, alternative and robust pathways in place to replace them—not simply to get you home, so that you probably tip up again at A and E?

**Earl Howe:** There is no single answer to that question, because once again it depends on all parts of the system working together. We get back to the urgent care boards and the work that they are doing. We recognised that, for example, there needed to be extra resources in the system for reablement of frail elderly people. We have put in £300 million over the spending review period to do that, and in many areas that has reaped very valuable dividends. However, we think there is a lot of mileage in GPs working to ensure that we keep people out of hospital when they don’t need to be there; usually they don’t need to be there. Where this has been successful, in a number of areas I have visited, GPs have got together and identified where they need to target their efforts. For example, on care homes, they go to care homes, educate the staff there to ensure that exacerbations in diabetic patients and those with COPD and so on do not happen, and that falls are prevented; there are very simple ways of reducing falls. All those simple things can be done to prevent hospital admissions. That is where the mileage will be seen most over the years ahead.

**Q309 Andrew Percy:** You raise the issue of care homes. Because care homes have come up, I want to jump ahead a little bit to the ambulance service, and it raises the issue of tariff again. I met one of my local ambulance services recently; I have two that cover my area, Yorkshire and East M’lands. One of the chief executives explained to me that there is an awful lot of work they could do with a lot of their regulars in care homes, which are a huge demand on the service; there is no doubt about that, as you have identified. But doesn’t the tariff work against that for the ambulance service, as the fewer people it transports to A and E, the less money it gets paid? Is the tariff being looked at, to reward ambulance trusts for reducing their regular calls? They do not really get a financial reward for that at the moment, do they?

**Professor Willett:** The tariff has been restructured. Rather than an ambulance service being paid just for conveyance to hospital, it can be paid for receiving the call, for hearing and treating—in other words, managing by advice down the phone—and for seeing and treating. Those currencies have been agreed.

**Q310 Andrew Percy:** I understand that. The point is that, if the trust works to negate the necessity for a call at all, there is no financial incentive for them to do that, is there?

**Professor Willett:** The currencies have been worked up. At the moment, those are managed locally, so that is for local discussion. If the CCGs—which, as we have said, are commissioning the whole pathway now—want to utilise it in a way that encourages the ambulance service to do more of that, they can look at that part of the contract; the currencies are available to do that. My understanding is that, at the moment, the prices are delivered locally. Although the currencies have been set nationally, the prices are local.

**Dame Barbara Hakin:** Can I go back very briefly to the previous question about planning? Every year the NHS undertakes a sophisticated planning round, where the commissioning—in this case, CCGs and NHS England—work with all local providers to identify all the initiatives and the number of patients who are likely to be admitted both electively and urgently. They work with the acute providers so that, on that basis, they can determine the number of beds they need. Quite rightly, you point out that, if the planned initiatives to keep people at home do not work swiftly enough, you run into a problem with your bed numbers. But I think it would be wrong if we left without the impression that the NHS goes through a very sophisticated process of planning every year, matching the different services and making sure that the numbers add up.

**Q311 Chair:** Can I bring this back to the discussion we had about delayed discharges? Within that work, it is important not just to look at numbers within existing systems and measures of narrow definition of delayed discharge, but to look at work flow in order to use effectively all the stages in the hospital and community services, isn’t it?

**Dame Barbara Hakin:** I agree absolutely. As I go round the health service, I often find that the provider—I am sure you have been talking to the same chief execs—will say that there are significant numbers of patients in their hospitals who, if only they had the full range of services at home, would not need to be there. We need to look at everything in community and primary care services, not just social care—and the systems within the hospital, because sometimes we hear stories of patients who could go home sooner if something that is going on within the hospital itself were more effective.

**Chair:** A report published by the Health Foundation earlier this year suggested that, for one luckless patient who spent eight days in hospital, 18% of that time was clinically useful.

**Q312 Andrew Percy:** To follow up on the question about mapping, does that mapping factor in at all the experiences, as they may be different for urban versus rural patients? We hear a lot of talk about alternative pathways and how they are the key to all of the problems here, but the reality is that those alternative pathways are much more likely to exist in an urban setting. We heard in the debate in Parliament a couple of weeks ago about urgent care centres, walk-in centres and all the rest of it. For my constituents, who
are largely rural, that is not an alternative pathway at all. Is that considered at all? Professor Willett: This is a really important area. Going back to where we talked about reconfiguring services, one of the disadvantages of regionalising services is that we create more areas that are more rural, if you like, than they were before. We have to look internationally, and we are. One of the things NHS England will do is appoint a national clinical director for remote and rural care and services to focus particularly on this, which we have not done previously in the NHS.

If you look internationally and at the things we will need to look at across this pathway, one thing is to make sure that, when you have an emergency, the sophistication and skill mix of the attending people at the start is higher. One way to keep people at home, to manage them at home or to manage them at the scene of the accident is to have someone such as a paramedic with extended skills attend that scene. They can do a lot of things.

What a skilled paramedic can do in an ambulance now is most of what we spent the first 30 minutes doing in A and E 10 or 15 years ago, so the options are very different. One of the things for remote and rural communities is to supply at the scene in an emergency the skill set that is most likely to be able to maintain the patient there or to temporise until the local general practitioner arrives. The general practitioner services in rural areas are very much more involved in going out to treat their patients.

When we look at remote and rural services for a lot of the follow-on and other care, one of the things the review will need to look at is how we create the right emergency and local facilities that will mean that patients have to travel for the least amount of time that is necessary. So there are certainly things that we will be doing.

Dame Barbara Hakin: Yes, but the mapping services are done locally. While we obviously do national modelling, the key part of planning goes between the CCGs and the local providers, so services will be planned for the specific area, whether it is urban or rural.

Chair: That is a neat link. We need to move on to the next question, which Rosie was going to ask about GPs and primary care, and their role in urgent care.

Rosie Cooper: Are we at question 17, Chair?

Chair: Yes. That is where I am.

Q313 Rosie Cooper: It is something that links in neatly to the rural aspect of Andrew’s question. When commissioners propose the closure of a walk-in centre, what provisions must they make to cater for patients who will then have to seek treatment elsewhere? I have seen the document by NHS England that suggested that walk-in centres and minor injuries clinics should be near A and E departments. What happens to patients who cannot get to those clinics? Many of my constituents cannot travel; the means of travel—buses and so on—are not there, and they struggle to access services. What should commissioners be doing about those people? The question is two-pronged. First, what must you do to cater for the patients who will need to seek treatment elsewhere? Secondly, how do you make sure they can actually do it?

Professor Willett: Again, we are talking about different models for different areas, which is why it is really important that the local commissioners own their services. The comment that was made about urgent care centres being aligned to what are currently traditional A and E departments is based on the fact that we know that that model works very well. It is the most efficient model, as patients who arrive at a setting can be triaged into the right pathway. There is also the ability for the general practitioners who are running the urgent care centre and, perhaps, the emergency nurse practitioners to work across both—

Rosie Cooper: —and for patients to move across both. Inevitably, getting a patient to the right place is a matter of judgment, and very often that may turn out to be wrong. This gives you the opportunity to address that. Quite clearly, that does not apply for rural settings.

You will need to have a local emergency or urgent care facility to deal with the needs of the patient locally. You do not want patients to travel long distances when they do not need to. It is around creating the services that best supply what a patient can have in their home or as close to it as possible.

Q314 Rosie Cooper: What if the local commissioners decide to close one? What provisions must they make for the local population?

Professor Willett: They have to look at the needs of the population and ensure that they can be addressed. You mentioned walk-in centres. The walk-in centres were predominantly an out-of-hours primary care function, not a minor injuries unit or an urgent care centre. This plethora of names is one of the problems that the current system has, which is why it needs to be redesigned. One of the issues is that patients do not know what they can get at a walk-in centre, an urgent care centre and an emergency care centre or minor injuries unit; so they end up going to A and E.

Chair: Do you know?

Professor Willett: Why would I? If I were on holiday, no, I would not. In the locality I might know if I happened to use it, but if I were on holiday or on business I would not. This is why the system needs to be redesigned. We need to start with the patient’s needs. I am afraid that is why a phone first system is essential. Let us give you bellyache, for want of a symptom. If you have that, you do not know whether you need to pass flatus, whether you have a serious abdominal problem or whether you have appendicitis. Why should you— and why should I— as a patient? Rather than have you turn up at a facility, having travelled there, that does not supply it, phoning first and getting some advice so that we can steer you to the most likely point—
Q316 Rosie Cooper: And talk to a pen pusher who does not have a clue either, who has a script, will not listen to you and just keeps following the script—

Professor Willett: No—

Q317 Valerie Vaz: Why have the call centre then?

Professor Willett: Because the pathways that the call centres follow have been designed by the royal colleges. This is all clinically designed. The call centre has a call centre handler, who will refer you on, based on the algorithm. What they make sure of is that they are not missing something serious.

Q318 Valerie Vaz: They refer you to A and E.

Andrew Percy: No, no, they do not.

Chair: Order. This is not a discussion.

Professor Willett: Shall I continue my evidence?

Chair: Please do.

Professor Willett: My evidence would be that the call centre has call handlers who are trained and are following pathways designed by the clinicians, from the consensus group of the royal colleges. If the algorithm that they are following indicates they need clinical advice, they will refer them directly—only occasionally do they need to be called back—to a nurse, who will then take over. That is how it works.

Q319 Chair: With respect, the reason why you were being interrupted was that you set out how “it works.” The question is whether in practice it does work. If it does not, what is being done to ensure that it will work in the future?

Dame Barbara Hakin: I will take over on that. There is no question whatever but that we had serious problems with NHS 111 in the early part of the year. In particular, a couple of providers failed to deliver the service for which they had signed a contract, having given assurances that they could deliver the service. At the time, we had to step in to remove some of the volume of work from them and to support it with contingencies from other areas. Now we are seeing a dramatic improvement in the response times and the call handling. For virtually the whole country, seven days a week, we are seeing the standards met. We have two key standards for answering calls. The first is that 95% of calls should be answered within 60 seconds. Over the last two or three weeks, that standard is being met virtually everywhere in the country. Another one, which I think is really important for patients, is the number of calls that are abandoned—very few calls should be abandoned.

We have now reached a position where, across the country where 111 is operational, the calls are being answered quickly and calls are not being abandoned. We are also seeing much improved transfer times to nurses. The vast majority of calls to NHS 111 are handled by the call handler, so the number of times—

Q320 Rosie Cooper: Is this a secret way of getting everyone to use private medicine, so that you can actually speak to a doctor and deal with real people instead of a pen pusher?

Dame Barbara Hakin: I think it would be fair to say that the majority of our telephone response has not been done by doctors. Doctors do not answer the phone in the out-of-hours services; they do not answer when you dial 999—

Rosie Cooper: That is why people turn up at A and E.

Chair: Rosie, order.

Rosie Cooper: Sorry.

Chair: Can we conclude on NHS 111? We will come back to GP services.

Charlotte Leslie: I know that Sarah had some questions that we have jumped over to come to this section—

Chair: Do you want to go back to general practitioners first?

Charlotte Leslie: I would be very happy to, if Sarah would like to do that.

Q321 Dr Wollaston: Going back to the issue of primary care, we know that, if you cannot get an acute appointment with your general practitioner, you are more likely to turn up at an A and E department, particularly if you live nearby. Could the panel outline what is being done to improve emergency access in primary care, where that is the most appropriate venue for people to be seen?

Dame Barbara Hakin: It is certainly a significant issue. It is sometimes an issue when patients have rung to get routine appointments for things that they do not see as an absolute emergency but where they feel they need to be seen over two or three days and they cannot get an appointment with their GP. Keith described the confusion that exists and asked, “Why wouldn't I turn up at an A and E?” The same applies to patients who cannot get an appointment with their GP—they will go to A and E.

We have a number of things in the GP contract to try to improve and extend urgent access for patients. We measure and check that patients can be seen quickly when they need to be and should still be seen swiftly by general practice. This year we will have another round of negotiations with the general practitioners committee, as we do every year. We will look at a range of things, but doubtless those will include ensuring that patients have good access. As well as looking at the urgent care strategy, one of the areas overlapping with that at which we are looking very much is the primary care strategy. As part of NHS England’s wider look at the future, it is looking at what the future of primary care—general practice, in particular—should look like.

Professor Willett: Can I add something from a clinical perspective? There are various models out there that are already working. You may be familiar with the doctor first model where, rather than everybody having to be seen with an appointment, you phone and speak to a doctor, who will frequently be able to arrange something different or to deal with the issue over the phone. That creates more capacity within primary care, because that appointment takes up a lot less time.

That is also another thing the urgent care boards will be looking at, because they will be looking to accelerate in those areas where currently things are
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not working well. For instance, for all the criticism that has been levelled at 111 services, if they are set up with a very good directory of services, when a patient phones, they can direct them to a pharmacist that they know is open and can deal with that prescription issue, rather than a GP appointment or to A and E, which is what happens currently. Those are the sorts of things that the urgent care boards are doing. In the wider reconfigurations and redesign of the service, those are the sorts of elements that need to be looked at. There are some really good practices out there. Some general practices have really changed the way in which they manage patients. Others have yet to do so, but that is what we are trying to encourage everyone to do.

Q322 Dr Wollaston: Of course, the same work force crisis issues affect general practices. Professor Willett: That is another reason why we have to use the GPs’ time optimally, because they are really important in primary care. As you will be aware, there are something like 300 million primary care consultations each year. Maybe a third of those are urgent. It needs a very small change in that 1% that we know about from the GP survey of patients. We know from that survey that 16% of patients have tried in the last year or so to make an appointment and have not got one. Overall, 1% of those people who were trying to get an appointment end up in A and E. That is actually a very large number out of the 300 million consultations, even if you look only at the urgent care component. That is the sort of thing that may well change a lot of the pressures we see on the ambulance service, then on A and E departments, then on hospital beds and then on social care. That is why it has to be a system-wide redesign.

Q323 Charlotte Leslie: I would like to go back a bit on 111 to get to the bottom of some of its background and birth—who was responsible and how. Dame Barbara Hakin: Probably about 10 years.

Q324 Charlotte Leslie: Congratulations on your new role. When did you apply for your current role? Dame Barbara Hakin: I didn’t—there was not an application for the role.

Q325 Charlotte Leslie: Were you approached? Dame Barbara Hakin: Yes.

Q326 Charlotte Leslie: Who approached you? Dame Barbara Hakin: I have an interim appointment, in that the then Chief Operating Officer, who would have been responsible for all the operations, was leaving at the end of April. I was asked whether I would be prepared in the short term to take on this role. My previous role, which is still my substantive role, was as National Director for Commissioning Development.

Q327 Charlotte Leslie: But who approached you?

Dame Barbara Hakin: Sir David Nicholson asked me.

Q328 Charlotte Leslie: When you accepted the role, did you notify the Secretary of State and introduce yourself in your new role before it was made public? Dame Barbara Hakin: I know the Secretary of State and I had been in meetings with him before that.

Q329 Charlotte Leslie: So you did introduce yourself to him in your new role prior to its being publicly announced.

Dame Barbara Hakin: I do not recall that I actually spoke to the Secretary of State in that time.

Q330 Charlotte Leslie: So you did not introduce yourself to the Secretary of State prior to its being publicly announced.

Dame Barbara Hakin: No.

Q331 Charlotte Leslie: Going back a bit more, were you surprised to be given that role, given that you were facing possible investigation by the GMC? Dame Barbara Hakin: I have always strenuously denied the allegations made against me. I have given evidence to this Health Select Committee that my actions were always in the best interests of patients and always in the interests of ensuring that patients did not wait too long in A and E departments, ill on trolleys. I think it would be unfair to assume that these unproven allegations are correct. I deny them and welcome the opportunity for the GMC to look at this, because I am confident that it will recognise that I always acted in the best interests of patients. I always have done in the 40-something years since I came into health, when I first went to medical school. I think now is a time when experience is really important. It is a difficult time for the NHS. I have been a GP, I have run a PCT, I have run a strategic health authority and I have significant operational experience. I would also suggest that, since I took on the role, 111 has stabilised and improved and we have seen an improvement in A and E. I think it is reasonable that Sir David should choose whom he saw as the right person as an interim appointment. Plainly, if the role were substantive, it would be absolutely different and we would go through a proper appointment process.

Q332 Charlotte Leslie: So you would not be deregistering from the GMC. Dame Barbara Hakin: I would not deregister from the GMC. I am proud of the fact that I am a doctor by background.

Q333 Charlotte Leslie: Who has been the SRO for 111 since its inception—in 2009, I believe? Dame Barbara Hakin: The SRO transferred to the Chief Operating Officer of NHS England in November last year. I became the SRO for 111 as at April—at the beginning of April. I am struggling to remember who was the SRO for 111—Chair: If you do not remember, please write to us and let us know.
**Q334 Charlotte Leslie:** It would be very valuable if you could write to the Committee to say who the SRO for 111 was. When was approval for the 111 number to be used given?

**Dame Barbara Hakin:** I have the details on that, but I will have to look for them quickly.

**Earl Howe:** The original decision that 111 would be the number for this type of urgent call took place under the last Government, in December 2009. We were very clear in our plans when we came into office that we wished to take this forward, which we did. There was no divergence of view in that regard between us and the previous Administration.

**Q335 Charlotte Leslie:** But who was responsible for that decision and its development in the Department?

**Earl Howe:** You will have to forgive me, because I took over responsibility for urgent and emergency care only last autumn, when Simon Burns left the Department. I will have to find out what happened at the beginning, because it was not in my purview.

**Q336 Chair:** But the decision to develop NHS 111 was a ministerial decision.

**Earl Howe:** Oh yes, it was certainly a ministerial decision. Andrew Lansley was very clear that it was a top priority.

**Q337 Charlotte Leslie:** So you inherited it. What was the key intended difference between 111 and NHS Direct designed to be?

**Earl Howe:** If you telephoned the number for NHS Direct, it would give you advice. This is a much broader service. It is much more integrated as part of the urgent and emergency care system, so that not only do you get advice but you can be put through to a nurse, if you want to speak to a nurse, or to a doctor, if you want to speak to a doctor. They can make an appointment and call an ambulance—it is a much broader range of services.

One of the things that the Foundation Trust Network identified was that part of the problem we are dealing with here is poor signposting. As Professor Willett said, people simply do not know where to turn. If we can urge and encourage people to phone before they do anything, it should get through quite a lot of this confusion that they have. So it is designed to be part and parcel of the urgent and emergency care system, rather than just an add-on advice line.

**Q338 Charlotte Leslie:** I will go back to the mechanics of its inception, if I may, Dame Barbara, your own evidence says, “the small scale of the pilots, along with inconsistent control sites, and the short time frame that the evaluation was looking at meant the conclusions were limited.” Given that, why were they rolled out so quickly and the pilots not evaluated?

**Dame Barbara Hakin:** A decision was made by the Department in June 2012 that areas could ask for an extension of the deadline by six months, to October 2013. A letter was then sent to all clinical commissioning groups, which were then sub-committees of PCTs, to say that, if they felt that they were not ready or the services were not ready, they could apply for extensions. In the event, locally, only four small areas applied for deadline extensions. They were Leicestershire, Devon, Somerset, and East London and City. So there was an opportunity, where there were local concerns, for people to extend that deadline.

**Q339 Charlotte Leslie:** So why do you think it still went so badly wrong? I do not think that people can deny that it went badly wrong. Were you not doing any due diligence or monitoring of how this was going before you allowed it to be rolled out?

**Dame Barbara Hakin:** Again, I was not involved at the time. Looking back, I still think that there is no question whatever that certain providers gave assurances that they were ready to take on this service. I have looked at the exchanges between the local commissioners at the time and providers, and the CCGs or PCTs were given absolute assurances that there were sufficient call handlers, adequately trained, to take on the services. You cannot look back at what happened in March and April, when we had real problems with 111, and not say that we must learn some lessons from that. It is not possible to look back and not say that—we did not get the level right.

**Q340 Charlotte Leslie:** When did you first know there was a problem?

**Dame Barbara Hakin:** When did I first know there was a problem? I think I first understood the gravity of the problem towards the end of March, when I was about to take over as the Chief Operating Officer. At that time, Sir David asked me specifically to take responsibility there and then for 111, which I did somewhere around the 27th or 28th of the month.

**Q341 Charlotte Leslie:** And prior to that you had no responsibility whatsoever for 111.

**Dame Barbara Hakin:** I had no direct responsibility for 111, but I was a senior member of NHS England and was previously in the Department of Health.

**Q342 Charlotte Leslie:** The general trend is to recognise that, as soon as possible after presentation, a patient should see a more highly qualified skilled clinician. In that context, who decided that it would be a good idea for patients to be assessed initially by people who are not clinically trained but based on an algorithm, where judgment was not capable of being exercised? Who made that decision and why?

**Dame Barbara Hakin:** The decision in the early inception was to create an efficient service. I think there is a misunderstanding that NHS Direct used nurses to answer calls or that the ambulance service used doctors. What we are saying is that it is absolutely critical that you get clinical advice at the right stage in the patient’s journey very quickly. That does not mean that we have clinicians doing the immediate answering of telephone calls almost anywhere in the health service.

**Q343 Charlotte Leslie:** Forgive me, but does that not feel a bit like what we have seen with the CQC, which...
boasts success because of the number of people it registers? Don’t we see a system where it is all to do with quantity and not to do with quality? It is looking at the number of people going through the system— it is tick-boxing and is not a focus on quality.

Dame Barbara Hakin: No. As Keith said earlier, the algorithm that is used by the call handlers has been designed by the colleges, across the spectrum of the colleges. It is designed to give patients the swiftest and best possible treatment. Unlike NHS Direct, 111 can dispatch an ambulance immediately; it has access to that ability. If the call handler going through the algorithm determines that the patient needs an emergency ambulance, it will be dispatched instantly. The clinical professionals are necessary to come in and support call handlers. On the whole, there is one nurse for approximately every four call handlers.

Q344 Charlotte Leslie: But given what we know about early intervention of clinical expertise, why would you not roll out that principle to your immediate point of entry into the care system in order to sift out those who are not needed? Why would you not put more clinical expertise at the front line?

Professor Willett: If you sat in a 111 centre, an NHS Direct centre or, in fact, a 999 centre and listened to the calls coming in, you would see that the amount of medical or nursing time that would be inappropriately used was enormous. What a patient perceives to be an urgent problem for them may well not be medical. People will phone up because they have gone on holiday and forgotten their tablets; a whole range of things come through. What is appropriate is to have an algorithm, which frustrates people, perhaps, but recognises that there is not a life-threatening event. I know that it is difficult for people when they are standing there saying, “But I am phoning up only because I have forgotten my contraceptive pill,” and you ask, “Are you breathing?” But it is built to be safe and to give you the right medical input—cl inical input or nursing input—at the first point where it becomes appropriate. That is how you manage the millions of calls that come into these systems. That is being worked up now. We are looking at it—there is a group that looks at it the whole time to review the appropriateness of the algorithms. Obviously we may be overcompensating, because it will be built on a cautious system—it will be safe first—but that is the system that has been put in place. Internationally, it is what would be used.

Valerie Vaz: But you are advertising the system as a phone first service. There were also very high levels of approval from people who said that they had had a good or excellent service. There were pilots. One of the key metrics from those pilots was patient satisfaction; 92% patient satisfaction emerged from the pilots. Those were people who said that they had had a good or excellent service. There were also very high levels of approval from people who said that they had been through to the right person first time.

Q347 Valerie Vaz: What about the outcome of their medical problem?

Earl Howe: The outcomes were that problems were satisfactorily addressed.

Q348 Charlotte Leslie: But the Department of Health already says that the conclusions you could draw from the pilots were limited. A further point of concern is that procurement and tendering for the companies to deliver this were done before the results of the pilots had been seen. Why was the Department embarking on procurement before the results of the pilots had been seen? Because of the set of the pilots, the results they produced were also inconclusive; you could draw limited conclusions from them. Why was that?

Earl Howe: On the point about the pilots being inconclusive, I will simply say that there were mixed findings from different pilots as to the effect on A and E, the effect on GP appointments and so on. They were inconclusive in that sense because we had different results coming in from different parts of the country, but there was absolutely no doubt that there was a high degree of patient satisfaction in all the pilots. That is what gave us the confidence to know that this model worked and was efficient and effective. I think that drove the decision to roll the thing out.

Q349 Charlotte Leslie: I think reality has proved differently. If I may go back, why were procurement and tendering taking place for the pilots without the publication of the evaluation? Why were you procuring 111 services from organisations and companies? What due diligence did you do on those? Why was this done before the evaluation of the pilots?

Chair: Can I put the question in another way? What is the hurry? There was NHS Direct. Ministers have
adopted this principle of NHS 111. What is the policy objective that Ministers are seeking to deliver, and why?

**Earl Howe:** The policy objective was to deliver a better, higher quality service for people who did not know where to turn in the NHS. It was not necessarily to save money—it was to provide a much more appropriate series of pathways.

**Q350 Chair:** What were the points of difference that were being sought in NHS 111 compared with NHS Direct?

**Earl Howe:** As I said, NHS Direct was simply an advice line—a helpline. You could not necessarily get through to a nurse or a clinician to talk about your problem. It would not let you know where your nearest pharmacy was and would not call an ambulance for you if you needed that. This is a service that should take the heat off 999, once people are educated into using it, which NHS Direct was never intended to do, but it should also get patients to the right place much more quickly. That was the purpose of it.

**Q351 Chair:** That, in itself, is part of the process of a more integrated urgent and emergency care system—I understand that—and is an ambitious objective. Hence Charlotte Leslie’s question: if that development of urgent and emergency service was what Ministers were seeking to deliver, why didn’t they check that they had a pilot that worked before they rolled it out?

**Earl Howe:** My point is that we did check that the pilots were working in the most important sense—that they were getting patients through to the right service in a very timely fashion. There were a number of pilots around the country.

**Dame Barbara Hakin:** Were they not in the north-east specifically?

**Professor Willett:** They were in County Durham and Darlington, Lincolnshire, Nottingham and Luton. They were evaluated by Sheffield University.

**Q352 Valerie Vaz:** Is there a list of all these pilots on your website—the good and the bad?

**Earl Howe:** Yes, I am sure they are on the website.

**Q353 Chair:** Is it in the public domain?

**Earl Howe:** Yes, absolutely.

**Professor Willett:** The Sheffield university evaluation is in the public domain.

**Q354 Dr Wollaston:** When were the pilots commenced, and when did they complete?

**Earl Howe:** Some commenced in late 2010, from memory. Others started in 2011.

**Dame Barbara Hakin:** The first pilot was in August 2010; it was in County Durham and Darlington.

**Earl Howe:** Then there was a succession of others.

**Q355 Chair:** It might help if you could write to the Committee with a summary of the information about the pilots and where those data can be found.

**Earl Howe:** Yes.

**Q356 Charlotte Leslie:** I am still puzzled as to why, before the pilots were able to be evaluated, the Department embarked on a tendering process for organisations to deliver the scheme. Why wouldn’t you wait until the pilots had been evaluated before embarking upon that, when you could involve the CCGs?

**Earl Howe:** But we had the work of Sheffield University evaluating the pilots. I have explained the sense in which the results were inconclusive. Those areas were not key to our decision as to whether this was a good or an inferior service. We were clear that it was a good service. The respects in which we needed further data were not central to the decision as to whether to roll it out. It was and is a good service.

**Q357 Dr Wollaston:** So is it the case that the primary definition of being a good service was based on patient satisfaction, rather than actually changing the outcome?

**Earl Howe:** No, on the outcome as well.

**Q358 Dr Wollaston:** But you said there were mixed results on that.

**Earl Howe:** Patients were self-reporting on their outcomes, and the reports were very, very favourable.

**Q359 Dr Wollaston:** But in terms of actually reducing A and E attendances or the clinical outcome, there was no evidence from the pilots to show that it delivered a better outcome for patients. Can I be clear about that? There is a difference between a service being popular and a service delivering an outcome.

**Earl Howe:** I totally take that point. In a number of the pilots, we saw A and E attendances go down in relation to the rest of the country. In other pilots—in Nottingham, I think—we actually saw A and E attendances go up.

**Professor Willett:** In Lincolnshire, the number of ambulance incidents rose. A and E attendance went up in some pilots and down in others, but overall—across the four pilots—there was a small reduction in A and E attendance. It was not significant, but the pilot was not designed to do that; it was designed to create a system that ensured that patients got to the right place. The option of a directory of services was a key part of it, which meant that you had the opportunity to direct patients to the right service. It was not intended to reduce A and E attendances; it was intended to put in a much better system for directing patients.

**Q360 Dr Wollaston:** The other criticism, of course, concerns the length of the calls compared with the length of calls in the previous service. Is that an issue you are concerned about?

**Dame Barbara Hakin:** Particularly in the early launches, one of the problems was that, first, there were insufficient call handlers in some places, and secondly, that the call handlers had had not as long in training as they might have had. What we see with 111 specifically is that the call handlers become more experienced and the call time goes down. The average length of call now is about eight minutes, whereas we
were hearing of lots of people being on the phone for 20 minutes to answer questions. We continue to see improvements. In the pilots, patient satisfaction over six months was in the 90% range.

Q361 Dr Wollaston: The other problem, of course, is that some people were waiting excessively long periods for genuine emergencies to be dealt with. Has that now been resolved?

Dame Barbara Hakin: We have seen that 95% of the calls are answered within 60 seconds. We had a lot of reports of patients waiting for call backs. Sometimes those patients were waiting for call backs from the out-of-hours service, because one of the issues is that in most places a local choice was made to integrate the out-of-hours service and to work with it in 111. Sometimes when patients are reporting a very long time to be called, it is when the 111 part of the service is finished, the patient has been handed on to the out-of-hours service and they are waiting for that call back. None the less, there is no doubt that in the early stages there were delays in calls back from 111. We are now seeing a situation where 80% of calls are completed satisfactorily by the non-clinical staff, which leaves 20 out of 100 callers to be passed to a nurse. We have now got the numbers up, so 15 of the 20 are passed directly and do not have to be called back at all. Of the five remaining patients, half are called back within 10 minutes. I agree entirely that, to get the service right, we want to see all patients called back as swiftly as possible.

Q362 Dr Wollaston: So 2.5% of people waiting for a call back from the 111 service itself—not the ones passed on to other people—

Dame Barbara Hakin: Not the ones passed on, no.

Dr Wollaston:—are waiting for more than 10 minutes for that call back.

Dame Barbara Hakin: Yes. Chair: We have run substantially beyond our planned time, but we have not covered ambulance services. Andrew, do you want to ask questions about ambulance services?

Q363 Andrew Percy: Very quickly, because I know we are running over. It goes back and links to the comments we have already made about alternative pathways. We have talked somewhat about this already. We have heard anecdotal evidence about the number of paramedics versus technicians. Can you give me your understanding of where we are at in terms of hitting what I think was a target of 70% of front-line staff to be trained paramedics? Perhaps you could respond to the anecdotal evidence.

Earl Howe: There is a general point to be made here first off, which is that it is up to local ambulance trusts to configure their human resources as they think fit; they are free to do that. Different clinical responses will be appropriate to meet different situations. For example, many trusts deploy paramedics in cars as well as in ambulances. Obviously that makes for better flexibility and improved care. There is no overall target as such. Do we or do we not have enough paramedics? The picture that has been painted for me is that the situation looks satisfactory. The projections by the Centre for Workforce Intelligence show that there is a secure supply of paramedics up to 2016. Currently, there are 900 ambulance technicians who are training to become paramedics, which will result in an increasing number. If one looks at vacancy data, the last figure I have—admittedly, goes back a couple of years—showed that the total number of vacancies for ambulance staff had more than halved; it was recorded as 1.7% in 2010, compared with 4.7% in 2009. So the vacancy gap is shrinking.

Q364 Andrew Percy: What is the national percentage of staff at the moment who are paramedics as opposed to technicians or any other category?

Professor Willett: I think those data are held locally. I do not think NHS England collects them.

Earl Howe: I know that in 2012 the Health and Social Care Information Centre advised that there were 18,645 qualified ambulance staff in the NHS in England. If we can get you a breakdown of that figure, I will be happy to do so.

Q365 Andrew Percy: It would probably be useful, because we have heard a lot about how ambulance services are so important in trying to reduce this demand on A and E and in trying to access these other pathways. Another issue we heard about—I think from the ambulance services themselves when they provided evidence—was paramedics accessing the National Spine and, leading on from that, being able to communicate directly with GPs, to access medical records and all the rest of it. What progress is being made on that? I know that probably the response will be that it is a local matter. I understand that it is, but it needs a real national push.

Professor Willett: You will see that that was one of the key objectives we set out for the review—that information critical to care of the patient should be available to all the professionals in the pathway. We know that is not the case. At the moment, paramedics who are at the scene with a patient who may be a little confused do not have any history, do not really know what is going on and whether or not this is a normal state for the patient, and have to try to contact a GP. So that is quite clearly one of the elements.

Another thing that urgent care boards will be looking at is what is there in their patch, because in a lot of places that is available. We know that in some places the minimum patient record, showing what has happened to them, their key disorders and what has gone on in the last couple of weeks, is not available, but in other parts it is. In some parts of the country, the paramedics and the people in A and E departments can access it, but in other parts of the country they cannot. That is inexplicable and needs to be addressed as part of one of the key themes for patients. Patients cannot understand that. Perhaps one of the things that urgent care boards should ask their membership very seriously is why they cannot do that.
Chair: Perhaps we will not go back to urgent care boards.

Q366 Andrew Percy: To conclude—I suppose it is more a comment, but there is a question in it—the ambulance services seem to be a key component of all of this, but I was surprised at how little interaction a lot of CCGs have had with their ambulance providers. In my local area there are two CCGs, and to a lesser or greater extent they instil me with some confidence. However, they do not necessarily seem to be communicating with the ambulance trust. This is something that will be very patchy.

I know we keep going on about local decision making, but it seems to me that this is a service on which a lot of money is spent and out of which we are not getting best value at the moment. It seems that other providers in the NHS—whether it is GPs, CCGs or even hospital trusts—do not really value it or see the potential for it. I really want an assurance that there will be a big emphasis on this nationally.

Professor Willett: This is a new relationship, because the CCGs, being clinically led groups, are very familiar with working with the hospitals and social care in local authorities but have limited direct contact with ambulances. If the ambulance has gone, they probably have not, whereas if they have gone, the ambulance probably will not—or if it does, it will not be when they are there.

As I said, since April, with the new structure of the NHS, the CCGs will be commissioning all the elements of the urgent care pathway. I think this is one of the areas that will naturally become a focus and that the value of the ambulance services and the impact of congestion in the system at various points—and how it affects the ambulance services and the flow that the Chairman mentioned earlier—will be appreciated.

Dame Barbara Hakin: Just a few weeks ago I met Anthony Marsh, the chief executive of West Midlands Ambulance Service, acting on behalf of the ambulance trust chief executives, to talk through—because I completely agree with you—their experience and how we could support the system, particularly CCGs. One of the things we will be doing in NHS England as part of our support and development for the CCGs is helping them to work collaboratively, because they need to do that for ambulance services. We will work with Anthony and his ambulance trust colleagues to make sure that we get that interaction and that, as part of the CCG development programme, we can support them to be better commissioners of ambulance services, because I agree with you that they have so much to offer in understanding urgent care.

Q367 Andrew Percy: Are we clear that the Red 1 and Red 2 target will remain? A gain, this is something that has been described as unhelpful. I am a first responder with the Yorkshire Ambulance Service, so I know this myself. I know about the response time. As I said at a previous hearing, a paramedic said to me once, “If we turn up in nine minutes and save their lives we do not get any credit, but if they die and we are there within six, seven or eight everything is fine.”

I understand the frustration of that, but it concerned me that there seemed to be a bit of a push from some of the ambulance services to get rid of that target. In a rural area such as a large part of my constituency, it is the only thing that means we have any ambulance resources located in the area. Without it, because of the small volume of calls, we would lose it. So I hope that there will be an assurance that the target is here to stay.

Earl Howe: I am not aware of any desire to remove that target.

Professor Willett: I do not think there is, but one of the objectives that are going into the review is that the quality of my care as a patient should be measured in a way that reflects both the complexity and the severity of my illness. The target was brought in specifically to do that. Clearly, we need to make sure that it is current and is doing what it was brought in to do—fight life-threatening conditions.

Q368 Andrew Percy: Absolutely. We hope that that response time would be to get a paramedic there, but is it ever appropriate for technicians to attend to those life-threatening calls when a paramedic has not been dispatched?

A gain, we have heard anecdotal evidence that this may be happening in trusts around the country.

Earl Howe: It depends on what the call is. The ambulance provider has to make a judgment when a call comes in as to what the need is.

Q369 Andrew Percy: What if it is a cardiac arrest? There was an allegation in my local trust by ambulance crews that EMTs were being sent and paramedics were not even being dispatched. The trust says that this may be happening in trusts around the country.

Q370 Andrew Percy: That is where the 70% figure and how near we are to hitting that target is important. We hear a lot about numbers, but I think—

Professor Willett: As a first responder, you will be aware that what matters is how quickly external cardiac compression commences. It is a matter of what resource you have available that is closest to achieve that first goal. Again, that is a very clinical, individual decision. Clearly, a paramedic would be the ideal, but, if a paramedic is further away than someone who can start compressions in the absence of someone like you, it would clearly be a sensible decision to send them. You will see multiple deployments. From your experience in the ambulance service, you will be aware that it will do whatever it can to get the right resource to the patient.
at the time, as close as possible to where it is happening.

**Earl Howe:** On the response time targets, I would simply say that in the ambulance trusts I have spoken to—and I have also spoken to Anthony Marsh—it is not the targets that are causing most concern but the way in which services are being configured to meet those targets. An ambulance crew have said to me, "We are not in the right place at the right time. It is an organisational issue." They do not argue with the fact that timeliness is vital—quite the reverse—but they think that more could be done to make sure that the targets are met.

**Chair:** Sir Bruce?

**Sir Bruce Keogh:** I was going to ask your permission to talk on a different subject.

**Chair:** Okay.

**Q371 Andrew Percy:** I want to ask just one more question, which is kind of related to this. There will be an opportunity potential through the new social care Bill that is coming forward. It relates to nursing homes. It is slightly off topic, but it is important, because we have heard that they are the source of a large number of calls to the ambulance service. Why don’t we require their staff to be trained in cardiac arrest or for there to be a defibrillator in every nursing home in the country? It is a relatively inexpensive thing to do. Other countries and many US states, such as the state of Texas, now require it. Nursing homes, which are the source of a lot of cardiac arrest calls for the ambulance service, are not required to have that. Why not? Is that something we should be looking at? In the past, the Department seems to have been very anti it.

**Earl Howe:** The British Heart Foundation took charge of this some years ago. I recognise fully the value of defibrillators, and many were actually deployed in public places around the country. To compel a privately run care home, which is what many of them are, to do certain things would require a stipulation in the contract, if the care is commissioned by a local authority or, indeed, by the NHS.

**Q372 Andrew Percy:** We compel them to have food handling qualifications for their staff.

**Earl Howe:** Yes, we do.

**Q373 Rosie Cooper:** Would it be cheaper to give them one?

**Earl Howe:** It might be.

**Q374 Chair:** It would not be cheaper. Whether you do it by giving them one or regulating them to do it at their own expense, surely the question is whether it is a sensible use of resource for patient interests.

**Earl Howe:** I think that is the issue—whether it is a sensible use of resource. The advice I have consistently had is that there is much more mileage to be gained in training people in first aid and in resuscitation skills.

**Chair:** Hopefully, there are one or two of those around in a care home.

**Andrew Percy:** Not always. That is the problem.

**Earl Howe:** No, not always.

**Q375 Andrew Percy:** That is why I think the two should go together as a requirement.

**Earl Howe:** Indeed. We are seeing organisations such as the Red Cross and St John Ambulance doing excellent work on training people in first aid, but—

**Andrew Percy:** It strikes me that these people are making money out of providing a care service and that the very least they should be required to do is to have that potentially life-saving equipment and to have proper first aid training for their staff. We do not seem to do that like other parts of the world do.

**Q376 Charlotte Leslie:** If you are going to organise swimming lessons and are going to use a pool, you have to have a medically qualified, fully-trained lifeguard on site. It seems extraordinary that we do not have the same in a care home.

**Earl Howe:** I agree with you. I think it is something that commissioners need to have at the front of their minds.

**Q377 Chair:** I am not entertaining a distraction here, but it might be something for our friends in the Care Quality Commission.

**Earl Howe:** Quite possibly.

**Sir Bruce Keogh:** They are coming soon, aren’t they?

**Chair:** Indeed.

**Earl Howe:** It is the CQC’s job when it goes into a care home to look at whether the skills that are there are appropriate to the patient mix and the residents who are in the care home.

**Andrew Percy:** It was a little off topic—I apologise.

**Q378 Chair:** Sir Bruce wanted to say something.

**Sir Bruce Keogh:** I would really like to ask for the Committee’s help. If anything has become clear in the course of these discussions, if it was not clear before, it is that this is really complex. We are stuck in a set of new structures and new relationships that are pretty immature in many senses. Those relationships have not matured, and we are working in a much more devolved environment than the NHS has ever experienced before. There are those who believe in the devolution and those who fear it. Nowhere is this seen more than in the area of urgent and emergency care, which is really the bit of the NHS that in many senses people value the most. We are dealing with strong views and concerns about centralisation over localisation.

To improve this system, we have to get better alignment between primary care, out-of-hours services and ambulances, which are grossly underused in my view. We have to understand how the accident and emergency front door, if you like, interrelates with the rest of the hospital. We have to work out how the back door relates to social care, community services, pharmacy and local government. We are trying to have this debate in the face of incomplete evidence; I think our submission to you on the evidence base shows that. We have to have it in the face of changing technology; simply the impact of the mobile phone on health will be very significant. We have the plethora
of names Keith Willett alluded to—a sort of alphabet soup of places you can go to for help—and public concerns over 111. Finally, we have a whole lot of emotion around red-and-white signs and what they may or may not mean as the front door.

It would be really helpful to us, as we embark on trying to conduct our urgent and emergency care review, if you could, please, give some pretty serious deliberation to the evidence base that we have presented and help by asking parliamentary colleagues to have a look at it. We will, of course, do what we can to engage the public and the professions. When that is done, we will reassemble the evidence and adjust our principles accordingly. The difficulty is that we do not know where some of this will lead, because it is a very genuine evidence-based attempt to improve the service.

I suppose this is not a question you hear very often from a witness, but could we come back to the Committee when we have reassembled that and seek your scrutiny—I guess that is the best way of putting it—so that we can then take things back to NHS England to put the right system levers in place to make things work?

**Q379 Chair:** You are certainly right to say that you are the first witness who has asked to come back. One thing all of us in the room are agreed on is the importance that patients attach to early, prompt access to high quality urgent and emergency services. The Committee is taking evidence on this and will produce its own report. Of course we would welcome the opportunity to pursue this subject further. We shall no doubt be required to do so, both by our constituents and by our own internal concerns about this service as we look forward.

**Sir Bruce Keogh:** I think it is an issue that is bigger than just the NHS. How we address this is really a massive societal issue.

**Rosie Cooper:** Sir Bruce, you have my absolute and utmost respect, but what I would suggest you do, when the transcript of this meeting comes out, is you just have a read of it. You will then hear why I, as somebody who has worked in and been part of the NHS for such a long time, just do not have the confidence that the evidence is there. I would not go to the front line for this.

That is really, really sad, because people depend on us to ensure that they are getting the right information. If you look at what is being said out there, nobody understands what has been going on in here today. I understand the direction of travel, but it is not underpinned by real evidence. We are not taking the people with us. I will say that, today, you have not taken me with you at all. That is a really sad place to start.

**Chair:** We will be here for some time if we have closing statements from everybody.

**Andrew Percy:** Nor should we rely just on anecdotes either; we need evidence.

**Chair:** Thank you, witnesses, for your patience with us this morning. No doubt we shall pursue the dialogue, as you suggest.
Written evidence

Written evidence from the Department of Health, NHS England, and NHS Trust Development Authority (ES 01)

Summary of the Evidence

The challenges of urgent and emergency care

— Despite the availability of excellent urgent and emergency healthcare, the system is under pressure and faces a series of long-term challenges. Demand on A & E and ambulance services continues to rise; recent performance in A & E has suffered; and recruitment of trainee doctors in emergency medicine is remains difficult.

The new health structure, mandate and outcomes framework, urgent care review

— The Department is working with NHS England to address these challenges. NHS England is launching an immediate programme to recover standards and a medium term programme to ensure delivery over the next winter period. In the longer-term, as part of a new Vulnerable Older People’s Plan to be published in the autumn, NHS England’s Urgent and Emergency Care Review will look at how to deliver safe and sustainable services.

Evidence on the specific issues raised by the Committee

— A system which includes primary and community models for providing urgent and emergency care would allow the range of patient needs to be met across different geographical locations.

— We are seeing a move towards integrating some primary care services within A & E departments. Therefore, it is no longer representative of what is happening simply to speak of moving lower acuity facilities out of A & E.

— Defining the role of an A & E Department by the cases it is expected to receive and the causal factors in presentations is becoming increasingly difficult.

— There is potential to further reduce the number of patients transported to hospital by ambulances and to provide more efficient and local care.

— The key benefit to the introduction of the NHS 111 service is to improve patient and public experience of the urgent and emergency care system by offering a free-to-call, easy-to-remember number to access urgent NHS services. Many of the NHS 111 sites that launched in February and March have failed to perform as expected. NHS England is working closely with providers and commissioners to resolve the outstanding issues.

— The move to clinical quality indicators is intended to achieve a more balanced and meaningful view of performance for patients and the NHS in regards to quality and safety as well as time measures.

— The situation regarding delays in handover from ambulance services is a complex one, and often reflects the pressure that is being placed on the whole system, including patient flow within hospital and delays in discharge to the community.

— There is clear evidence of the benefit of centralising services and treatment for a number of defined urgent conditions such as major trauma, stroke and severe neurological disorders.

— The Health and Social Care Act 2012 places strong requirements on the NHS England and clinical commissioning groups to make arrangements to involve users of services in the planning, development and decisions that would have an impact on the manner or range of health services available.

— The details of the system of health scrutiny are set out in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (“the 2013 Regulations”). Under the 2013 Regulations, local authorities can review and scrutinise any matter relating to the planning, provision and operation of the health service in their area.

The Challenges of Urgent and Emergency Care

1. The current system of urgent and emergency care in England is under pressure. Patients are confused by the variability in opening times and services offered by unplanned care facilities, whilst they find it difficult to choose and access the right level of urgent and emergency care service. In the absence of advice and guidance, patients tend to go to the facility that offers the widest range of services. There is also poor sharing of information between different providers of urgent and emergency care.

2. A significant rise in attendances at A & E and associated facilities has taken place in the last decade. Demand on the ambulance service also continues to rise. The number of emergency patient journeys rose from 4.2 million in 2004-05 to 4.9 million in 2011-12, whilst the number of 999 calls rose from 5.6 to 8.5 million in the same period. Centralisation of services, which has proven beneficial for patient outcomes from some
serious conditions and injuries, has added to the challenge of maintaining clinical skills and financial viability of smaller A & E units.

3. Long waiting times in A & E departments (often experienced by those awaiting admission and hence ill patients) not only deliver poor quality in terms of patient experience, they also compromise patient safety and reduce clinical effectiveness.

4. A & E departments have faced significant pressure over the last six months. In the last quarter of 2011/12, 47 out of 152 providers failed to meet the 95% standard for patients being seen and discharged within 4 hours. For the last quarter of 2012/13 this figure had increased to 94 out of 148 providers, double the previous number. Despite much analysis there is no single trend or factor to explain the deterioration but these include winter pressures and the increasing acuity of patients presenting at A & E. There remains a wide variation in performance both across the country and within the same areas where similar factors apply.

5. In recent years, poor recruitment of trainee doctors in Emergency Medicine (EM) has raised concerns within the specialty and the medical profession. The specialty in 2011 and 2012 has achieved a lower than 50% fill rate into higher training. The College of Emergency Medicine established the Emergency Medicine Taskforce in September 2011 to address workforce issues in EM. It found that fewer trainees are opting to choose EM due to concerns over the intensity and nature of the work, unsociable hours and working conditions (Emergency Medicine Taskforce Interim Report, 2012). The Interim Report is currently with Health Education England for further consideration. There are also significant manpower issues in Acute General Medicine, General Practice and mental health.

The New Health Structure, Mandate and Outcomes Framework, Urgent Care Review

6. The new health and social care system will ensure that all relevant parties can make the changes needed to the urgent and emergency care system to give it a sustainable future. The Department will work with NHS England, Local Authorities, Public Health England, Monitor, the NHS Trust Development Authority, and the Care Quality Commission to support continuous improvement in outcomes for patients. The Government’s Mandate to NHS England reflects principles in the form of objectives to be met year on year. The NHS Outcomes Framework also sets out the Government’s expectation that healthcare will result in better outcomes for patients.

7. The Mandate and NHS Constitution rights and pledges both set out an expectation on waiting times for patients. They include the following pledges concerning urgent and emergency care:
   - a maximum four-hour wait in A & E from arrival to admission, transfer or discharge;
   - all ambulance trusts to respond to 75% of Category A calls within eight minutes and to respond to 95% of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) to transport the patient in a clinically safe manner; and
   - all ambulance trusts to respond to 95% of Category B calls within 19 minutes.

8. NHS England has been set up to support the commissioning of healthcare which will give the best outcomes for patients, involving them and the public in shaping and monitoring local services. Its role is to oversee the whole commissioning system and to ensure that, working in partnership with CCGs, patients receive the right standards and quality of care. NHS England will support Health Education England to ensure that the urgent and emergency workforce has the right values, skills and training to enable excellent care.

9. Resolving the current situation in urgent and emergency care will require the commissioning system to work with all key partners in hospitals, primary care, and local authorities to create a single national framework to ensure that we see rapid and sustainable improvement. The work needs to be considered in three phases:
   - An urgent recovery programme with significant attention given by local and national commissioners and providers to all factors which can help recover the standards, (including clear performance management).
   - A medium term approach to ensure delivery over the next winter period. This will include care system planning as well as a review of the levers and incentives in the system.
   - In the longer term, the implementation of the urgent care strategy in order to deliver safe and sustainable services.

10. In announcing its Review of Urgent and Emergency Care, on 18 January 2013, NHS England made clear its commitment to equip commissioners with the guidance and tools necessary to help them commission consistent, high quality urgent and emergency care services across the country.

11. NHS England’s Urgent and Emergency Care Review will form part of the Department’s Vulnerable Older People’s Plan, due to be published in the autumn. The plan will cover three areas: improving primary care; the care provided by hospitals, including the role of emergency care; and removing barriers to integration. We want to see real impact on the ground from 2015. We need to find a long-term sustainable solution to improve care for the most vulnerable, particularly the frail elderly and those with long-term conditions. In
doing so, we will tackle one of the principal drivers of demand for A&E services, and ensure that the care people access suits their changing needs.

12. While enabling and supporting commissioning excellence is one of NHS England’s central functions, decisions on how services are configured and provided must remain a matter for the local NHS. An important purpose of the Review is to create clinical consensus on how urgent and emergency care services should be organised. It is then for commissioners to use those guidance and tools to commission for their own localities.

13. CCGs will be vital to this process, as they are responsible for commissioning the vast majority of urgent and emergency care services. NHS England will therefore ensure that the views of CCGs are central to any proposals for service design that come out of the Review.

14. The evidence provided here reflects the new system and coordinates contributions from the Department of Health, NHS England and the NHS Trust Development Authority.

Evidence on the Specific Issues Raised by the Committee:

The role of community and primary care services in the delivery of emergency healthcare, and the appropriate structure for service delivery to meet the demands of different geographic areas particularly sparsely populated rural areas

15. A system which includes primary and community models for providing urgent and emergency care would allow the range of patient needs to be met across different geographical locations, including remote and rural ones.

16. NHS England’s Urgent and Emergency Care Review is considering the issues relating to access to primary and community care services and the consequent impact on ambulances and A&E departments. Primary care could more appropriately treat many of the patients that dial 999 for an ambulance. Until now urgent and emergency care has been fragmented and disconnected, as patients often do not know where they should go when they have an urgent care need that is not life threatening. This has led to inconsistencies in the responses and treatment patients receive. These include preventing cross referral, the need to re-triage at each step using different clinical assessment tools, patients being referred to services that do not have the skills they require or patients simply not knowing where and how they can access urgent care—and as a result dialling 999.

17. Evidence suggests that primary care could play a potentially important role in reducing the number of A&E attendances, for example by changing working practices and improving access. The Primary Care Foundation’s report Primary Care and Emergency Departments (March 2010) found that, when it used a consistent definition and a consistent denominator of all emergency department cases, the proportion that could be classified as primary care cases (types that are regularly seen in general practice) was between 10% and 30%. A&E Departments in rural areas tend to have lower numbers of primary care cases (approx. 10%), whilst those in urban centres have more (approx. 30%). However, it is not clear whether this is related to differences in the way primary care functions in rural and urban areas, the distance that patients have to travel to an A&E Department (i.e. the ease of access) or, most probably, a combination of the two.

18. Alcohol, depression and dementia related events can be key causal factors in emergency presentations. For mental health, there is a well-established, robust international evidence base about safe, cost effective alternatives to hospital care, which, if commissioned well, would reduce burden on the health care system, and on the workload of partners such as the police and community agencies. These also reduce suicides, homicides and deaths in custody. They are: crisis home treatment teams; assertive outreach teams; and alcohol community detoxification services. The Royal College of Psychiatrists and Royal College of General Practitioners have recently publicised evidence-based guidance to support commissioners. The unplanned care pathway for mental health has consistently been identified as one of the top four priorities for commissioning review by the mental health strategic clinical networks.

19. There is no “one size fits all” approach to the delivery of emergency healthcare and different models of care will be appropriate depending on several population factors, including the relative rurality of an area.

20. The key benefit to the introduction of NHS 111 service is to improve patient and public experience of the urgent and emergency care system, by offering a free-to-call, easy-to-remember number to access urgent NHS services. We also hope NHS 111 will be able to reduce inappropriate demand on emergency services, by giving patients an alternative route into NHS services.

21. Research shows that many patients are unaware of their GP out of hours service, or even that pharmacies can offer support without appointments, and a call to NHS 111 will get patients to the right place, first time. Information on the use of these services, collected through NHS 111, will be a vital tool in the commissioning of urgent and emergency care services for physical and mental health in future.
22. It is no longer representative of what is happening simply to speak of moving lower acuity facilities out of A&E. We are seeing a move towards integrating some primary care services within A&E departments. The Primary Care Foundation outlined in its report Primary Care and Emergency Departments (2010) that:

   “Among respondents to our survey it appears that around two-thirds of [A&E] services have primary care staff operating within or alongside the emergency department. This is not representative, as respondents are a self-selecting group including more of those that have tried or adopted such a model. We estimate that around half of the services across the country have some form of primary care service working with the emergency department.”

23. The report also concluded that that if the 10% to 30% of A&E cases were treated elsewhere, A&E attendances could be reduced. However, it is relatively cost effective to treat lower acuity patients in a 24 hour facility. Furthermore, there is evidence that the creation of lower acuity facilities, categorised as “Type 3” (Minor Injuries Units, Walk in Centres; Urgent Care Centres), does not reduce the burden on neighbouring A&E departments.

24. Figures show that, between 2004 and 2013, attendances at Type 1 facilities (major A&E departments) rose from over 13 million to over 14 million, whilst attendances at Type 3 facilities rose from under 4 million to under 7 million.

25. Whether less serious cases are dealt with in separate Type 3 facilities or within A&E departments (possibly by primary care staff based there), the need to ensure that there is an integrated system with clear points of access is fundamental to the objectives of the Urgent and Emergency Care Review. Promoting self-care and publicising “phone before you go” will help to direct patients to the right course of action.

The range, severity and incidence of conditions that can be treated within an accident and emergency unit but not managed at an urgent care centre

26. The role of A&E departments is changing with specialist networks now in place for serious conditions such as stroke, heart attack, vascular surgery and the designation of major trauma centres. This adds to services already regionalised such as children’s intensive care, neurosurgery, and cardiac surgery. Defining the role of an A&E Department by the cases it is expected to receive and the causal factors in presentations is becoming increasingly difficult and advances in medicine, surgery and diagnostics are projected to increase specialist networks.

27. The Department of Health has defined the various types of A&E facility. If a unit is to receive unfiltered 999 blue light ambulances it must be capable of the resuscitation, diagnosis and immediate treatment of all acute illnesses and injuries in all ages. This will range from major haemorrhage from a stomach ulcer to an overdose in a patient with depression to a finger burn in a child.

28. Urgent Care Centres will vary in the patients they are able to manage, and will only accept ambulance borne patients to agreed protocols. They will also have in place protocols for the transfer of patients requiring inpatient treatment. The services they offer may overlap with traditional primary care, but those with x-ray facilities can deal with a wider range of injuries.

29. There is already a variation, in terms of facilities and staff, between different A&E units and in the pre-hospital triage used by the ambulance services to convey patients to the hospital most capable of treating the illness or injury. This is current best practice and patients transported by ambulance will “bypass” the nearest A&E if they need to access a more specialist centre. This occurs whilst there remains a public perception that A&E can deal with virtually any condition. The reality is that patients who self-present at A&E may occasionally require transfer to a facility better skilled and better equipped to meet their needs i.e a specialist centre or mental health specialist service.

30. The Urgent and Emergency Care Review will address how to design services that provide the range of appropriate care across localities, but it is important that it does not try to impose a view on which conditions can be treated by different types of facility. Care should be as close to the patient’s home as their condition allows, but where specialist care is required patients should be able to access this in a timely way. The object is to secure a consensus on service models that will ensure that urgent and emergency care is clinically safe, appropriate and accessible, no matter where you live, and delivered according to a national framework. It must

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1. Type 1—A consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

Type 2—A consultant led single specialty accident and emergency service (e.g. ophthalmology, dental, children’s A&E) with designated accommodation for the reception of patients.

Type 3—Other type of A&E/minor injury units (MIUs)/Walk in Centres with designated accommodation for the reception of accident and emergency patients. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community. A defining characteristic of a service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP practice or outpatient clinic) or one mainly or entirely accessed via telephone or other referral (for example most out of hours and primary care services) is not a type 3 A&E service even though it may treat a number of patients with minor illness or injury.
remain a matter for local commissioners and providers to design a system which meets the needs of the local population.

The prospects for better integration of ambulance services with primary care under the new commissioning regime established in April 2013

31. The commissioning architecture, established by the Health and Social Care Act 2012, provides a unique opportunity for clinically-led commissioning at the heart of service planning and delivering. CCGs are responsible for commissioning the majority of urgent care services for their local population. In considering the most appropriate approach that responds to the needs of the local population, CCGs will be mindful of the opportunity that integrated services can provide.

32. This is particularly true as CCGs are clinically-led membership organisations, made up of GPs, who have first-hand experience of how services work for patients, both the limitations and the opportunities. CCGs are able to take their day-to-day experience and needs of their patients from their consulting room to the clinical commissioning board table.

33. The development of health and wellbeing boards brings all commissioners together to focus on doing the very best for a particular population and the opportunity to take a more system wide approach to commissioning these services. For example CCGs working in collaboration with colleagues from social care and health providers are able to review services in the round as part of the commissioning cycle considering the opportunity of integration, including closer working between health and social care professionals, as a way in improving outcomes for patients.

34. NHS England will not mandate to a health community the approach it should take to commissioning services, but the support, development and assurance processes for CCGs being put into place by NHS England, aim to enable CCGs to become the best commissioners they can be, securing optimal outcomes for the population they serve. Where CCGs, working with co-commissioners, agree alternative approaches will provide the best outcomes for their patients they are able to commission different patterns of care, which may include integrated care.

35. The development of NHS England’s 10 year strategy, incorporating primary care and drawing on the work of the Urgent Care Review, will also contribute to enabling CCGs and their fellow commissioners in NHS England, to commission the most appropriate care for a population, improving health outcomes and decreasing inequalities.

The ability of ambulance services to continue to meet increased emergency demand whilst contributing to the Nicholson challenge

36. There is some potential to further reduce the number of patients transported to hospital by ambulances and to provide more efficient and local care. The number of calls to the ambulance services which are managed through clinical telephone advice has increased significantly over the last five years. Almost 90% of these calls result in no vehicle being sent to the scene (where clinically safe and appropriate). Compared to 1999/2000 levels, there are now 10 fewer patient journeys per 100 ambulance incidents, which reflects the increased use of “see and treat” and other efforts to provide levels of care that meet the clinical needs of the patient.

37. The ambulance service today is characterised by a highly skilled and qualified workforce able to respond to physical healthcare needs, that puts quality and appropriate clinical intervention at the forefront of care. This includes the move to more treatment over the “phone, at the scene and in patients” homes to better deal with the demand placed upon them.

38. Many Ambulance Service NHS Trusts have or are in the process of reviewing and changing the way they respond to emergency calls by broadening both their skill and fleet mix by introducing different types of response vehicle—motorbikes, rapid response vehicles, fully equipped ambulances etc. and by staffing those assets appropriately.

39. Taking Healthcare to the Patient (2005) stated that many 999 patients are still taken to hospital when they could safely receive advice, assessment, diagnosis, treatment and/or care closer to home or over the phone. It identified the need to provide significantly more clinical advice to callers (“hear and treat”) and provide and coordinate an increasing range of mobile healthcare for patients who need urgent care (“see and treat”). This new model of care optimally addresses those in physical health crisis, but has had some consequences for those in mental health crisis. In parts of the country, police services and transport services staff are transporting up to 40% of all those presenting in mental health crises.

40. Two models of “see and treat” have emerged. Firstly, there are some Trusts with much larger numbers of Advanced Practitioners who require very little clinical field support and act as autonomous practitioners. Secondly, there is a mixed model where, particularly in urban areas (which often do not have good primary care services but greater numbers of acute trusts) existing Paramedics are used to undertake “see and treat” work and are supported by a network of clinical field supervisors.
41. Both models can work and a further assessment of their relative benefits will be needed. However there is still considerable variation in conveyance rates between ambulance services, and more could be done to develop and support ambulance clinicians.

42. In April 2012, the Department of Health published a currency for the contracting of emergency and urgent ambulance services, in order to allow locally appropriate ambulance care which may not involve conveyance, where such care is appropriate. The four categories are:
   - Urgent and Emergency Calls Answered.
   - Hear and Treat/Refer.
   - See and Treat/Refer.
   - See, Treat and Convey.

43. This currency was mandated for the 2011-12 reference cost collection and mandated for contracting in 2012-13. Prices will continue to be agreed locally for 2013-14. The four categories were developed and agreed with ambulance trusts and commissioners as the basis for payment.

44. The Urgent and Emergency Care Review will promote the commissioning of services which are better integrated and provide the right care in the right place at the right time. The King’s Fund recently published Urgent and Emergency Care—A review for NHS South of England, which identified a number of areas where change would lead to performance improvement. The NHS Trust Development Authority will incorporate the learning into its work with NHS Trusts to improve their emergency care performance.

Experience to date of the transition from NHS Direct to the NHS 111 service

45. In August 2011, the Department of Health and then NHS Commissioning Board, wrote to all SHA Chief Executives, asking them to confirm plans for the rollout of NHS 111 by April 2013. Responses were received in September 2011, showing that a vast majority of the country would be undertaking procurement exercises to determine the most suitable provider for NHS 111 locally. The plans also showed that contracts would vary between single-PCT/CCG geographic footprints, and larger region-wide footprints, and that a vast majority of sites would go live in February and March 2013.

46. The Department of Health developed a Service Readiness Testing process that each site had to pass prior to launch, including testing call handlers on a range of scenarios, testing the robustness of the clinical governance arrangements in each site, and testing the technical and interoperability processes between call centres, and other “end-points” (i.e. ambulance services, out of hours services etc.).

47. The Department also offered areas that needed it an extension of up to six months to the roll-out deadline of April this year. However, many areas did not take this offer up as their services were able to continue with their existing plans. Sites that launched prior to March 2013 performed well, mostly meeting the National Quality Requirements (NQRs) for calls answered in under 60 seconds (over 95%) and calls abandoned in over 30 seconds (under 5%). However many of the sites that launched in February and March 2013 have failed to perform as expected, with long delays for calls to be answered, and a high rate of abandoned calls. These problems were exacerbated by the long Easter weekend.

48. By 2 April 2013, 39 of the 46 separate NHS 111 sites had been launched—this accounts for around 89% of the population of England. The remainder had been delayed either due to planned late procurement processes, or inability of providers to mobilise in time. In most areas, NHS 111 has taken on calls from GP out of hours, and NHS Direct, in order to simplify routes into urgent care at all times of the day or night. A number of areas—particularly North West, West Midlands and Yorkshire & Humber, have had to switch GP out of hours numbers back on, in order to ensure the service providers could cope with the volume of calls. This has been caused principally by providers failing to deliver on staffing requirements for launch.

49. NHS 111 performance has now stabilized across the country, with all sites running well on weekdays. However several areas, including Kent, Surrey & Sussex, much of the south West of England, Norfolk, and Yorkshire and Humber are still struggling to perform at weekends, primarily because of short-staffing.

50. NHS England took a significant grip on the programme as soon as significant performance concerns were reported. This was just before the Easter weekend. Dame Barbara Hakin led daily SitRep calls with Regional Directors and colleagues from NHS England to monitor and mitigate performance issues. The actions taken quickly regained stability in the service and put in place further actions to improve performance.

51. Regional Directors and Area Teams of NHS England have been made fully aware of their roles in ensuring the service meets the highest possible standards at all times, and are supporting commissioners and holding providers to account to resolve issues.

52. A new comprehensive checkpoint system for sites yet to go fully live has been implemented, to ensure there is senior NHS England sign-off and confidence in each individual site before it proceeds to launch. NHS England has received updated plans from each of the 46 NHS 111 areas describing how the service will grow to full capacity in the coming months. Regional Directors and commissioners are working to ensure these plans are suitably robust.
53. NHS England is developing three workstreams to a) stabilise performance and ensure all future 111 launches are suitable and sustainable, b) review what has happened and what lessons can be learned from this experience, and c) look to the future—to ensure there are suitable processes and mechanisms for NHS 111 going forward, and to look at the future strategic direction of NHS 111.

54. It is too early to say what, if any, impact NHS 111 will have on A&E. The initial four NHS 111 pilot sites in County Durham & Darlington, Lincolnshire, Nottingham City, and Luton, were the subject of a formal independent evaluation by the University of Sheffield. This evaluation looked at the impact of introducing NHS 111 on the local urgent and emergency care system. However the small scale of the pilots, along with inconsistent control sites, and the short time frame that the evaluation was looking at, meant the conclusions were limited.

55. The evaluation found that, while there was a statistically significant change in calls to NHS Direct in pilot sites with reductions in three out of four sites, there was not a demonstrable impact on the rest of the urgent and emergency care system. While there were some instances of statistically significant changes in certain criteria in individual sites, these were sometimes in conflict with each other in different areas, and certainly not uniform across all four sites. The evaluation did find there had been a statistically significant:

- reduction in urgent care attendances in one site (Luton);
- reduction in calls to NHS Direct in three of the four pilot sites associated with the introduction of NHS 111 (Durham & Darlington, Nottingham and Luton);
- reduction in emergency calls in one site (Durham & Darlington) and increase in one site (Lincolnshire); and
- increase in ambulance incidents in one site (Lincolnshire).

56. It is clear that the impact on the current urgent and emergency care system of NHS 111 will be different in different areas, and depends on a variety of factors, including how the Directory of Service has been populated, integration between NHS 111 and urgent care services (whether appointments can be booked for instance), changing demographic needs, and changes in patients’ expectations of what services should deliver.

57. The Minimum Dataset, published monthly by the Department of Health until April 2013, and now NHS England, also provides some information on system impact, presenting rises in A&E activity in NHS 111 sites in line with the national average (2%), and increases in ambulances arriving at scene above the national average (7% compared to 3%). A clinical panel advising the Evaluation reported a high level of agreement that the implication of the shift away from determining the success of ambulance services via indicators based on response time to the new measures designed to assess clinical effectiveness:

- increase in a full set such that improvement action is focused
- increase in quicker response times alone.

59. Clinical quality indicators aim to create a balance between quality and safety of care, service experience and timeliness. Professionals have told the Department that having time targets has in some cases distorted clinical practice. Quality indicators will help achieve a more balanced and meaningful view of performance for patients and professionals in regards to quality and safety as well as time measures.

60. In April 2011, a set of Ambulance Clinical Quality Indicators (CQIs) was introduced, which all ambulance services in England have been measuring and reporting against (See Annex A). These were developed to provide information on the outcomes and quality of care delivered for all ambulance calls in response to concerns that a focus on response times alone had distorted clinical practice. This is particularly important for certain key interventions where time is a major determinant of outcome and requires rapid response by ambulance clinicians to the most serious cases. The Ambulance CQIs are thus intended to:

- encourage a continuous improvement approach in clinical outcomes and patient experience as no arbitrary targets are set.
- provide information that is easier to understand for patients.
- be used by commissioners and providers as a full set such that improvement action is focused against all CQIs rather than response times alone.

61. The measures complement other measures of quality such as the NHS Outcomes Framework and National Institute for Health and Clinical Excellence (NICE) Quality Standards and reflect a whole system focus so that all members of the health economy have a role in the improvement of the patient pathway from prevention to definitive treatment and aftercare.

62. All ambulance trust are required to respond to 75% of Category A8 (immediately life threatening) calls within eight minutes irrespective of location. From June 2012, the Category A8 measure was split into two parts, Red 1 and Red 2. Category A8 Red 1 (immediate time critical calls) cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions. Category A8 Red 2 (serious but less
The causes of delays in handover from ambulances services to A&E or transfer between different levels of urgent care, and actions required to eliminate them

63. The situation regarding delays is a complex one, and often reflects the pressure that is being placed on the whole system, including patient flow within hospital and delays in discharge to the community. Any solutions require a whole system response, with all stakeholders committed to resolving the complex issues. The matter has recently been discussed by Monitor, CQC and NHS England using their “Duty of Co-operation” whilst local and regional summits were held in most ambulance trust areas. CCGs have a key role to play in co-ordinating discussions in the local health economy to find locally appropriate solutions, given that the causes of these delays can be different in different health systems.

64. Any delay in handing patients over from ambulances to A&E or in transferring patients between facilities is a cause for concern. Patients queuing to access space in A&E or awaiting transfers are subject to delays to care, however there is also a significant risk in those patients awaiting a 999 response in the community which cannot be sent due to ambulances being held up elsewhere. The issue also causes severe resource implications for ambulance trusts, which are then compromised in their ability to respond to 999 calls due to ambulances being delayed at A&E units.

65. The following key performance measures have also been developed within the NHS Standard contract 2013/14, to address inefficiencies in ambulance response times due to delays in the handover of patients from ambulance crews to A&E staff:

- all handovers between an ambulance and A&E Department to take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes; with
  - a contractual fine for all delays over 30 minutes, in both situations, and a further fine for delays over an hour, in both situations.

66. These are counterbalanced by the simultaneous monitoring of hospital trusts in their ability of the hospital to perform timely patient handovers for patients arriving by ambulance (time to initial assessment) as part of the clinical quality indicators for A&E departments.

Clinical evidence about outcomes achieved by specialist regional centres, taking account of associated travel times, compared with more generalist hospital based services

67. Centralisation of services has proven beneficial for patient outcomes from some serious conditions and injuries.

68. The King’s Fund (2011) Reconfiguring hospital services document states that there are good evidence-based reasons why, in some services, larger units serving a wider catchment area produce better patient outcomes and are more cost-effective. It discusses the good reasons why consolidation of those services onto fewer hospital sites can be expected to drive up quality and drive down costs. The King’s Fund cites examples including A&E, maternity and neonatal services, hyper-acute stroke units and heart attack centres.

69. Evidence shows that if a patient enters a facility that is unable to provide the optimum care for their need, the time taken to obtain definitive diagnosis and treatment is significantly increased. This is because it takes time to recognise the severity of illness, confirm a diagnosis, arrange ambulance transportation and for the onward transfer. There are then a series of handovers and reassessments, all of which can delay the key interventions that will make a difference to outcome. A recent audit in Manchester identified transfer times of between 5 and 6 hours for patients needing urgent neurosurgery, but assessed in the wrong hospital initially.2

70. Delays of an hour have a significant impact on the outcome for patients with time-critical conditions. A delay of 60 minutes in treating STEMI (a common form of heart attack) means that between 1 and 2 people in every 100 who would otherwise have lived will die instead.3 Similar benefits are seen in stroke, with the odds of a favourable outcome halving if the initiation of treatment is delayed from 60 to 120 minutes.4 Furthermore, stroke patients become ineligible for the newest “clot-busting” treatments if they do not see a specialist and undergo CT scanning within 3-4 hours of symptom onset. Finally, in severe sepsis (infection) the importance of timely treatment is striking: for every one hour delay in starting antibiotics the chances of the patient dying are increased by 7.6%.5

71. Trauma Services: There are approximately 20,000 major trauma cases in England every year. In 2012 a system of trauma care networks, including the development of 26 Major Trauma Centres at existing hospitals (including four children’s hospitals) was established across England. Major Trauma Centres have specialist

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2 Delays in transfer times for patients with extradural haematomas in Greater Manchester, C. M. A. Booth, D. Datta, R. Protheroe, The Intensive Care Society, 2010

3 Mortality Implications of Primary Percutaneous Coronary Intervention Treatment Delays: Insights From the Assessment of Pexelizumab in Acute Myocardial Infarction Trial, Michael P Hudson et al, Journal of the American Heart Association, 2011

medical teams which provide treatment for major trauma injuries 24 hours a day seven days a week and access
to all necessary services on site for the optimal management of patients with severe multiple injuries; including
neurosurgery and neuro intensive care, cardiothoracic, plastic and trauma surgery and trauma rehabilitation
services. The National Audit Office estimated that this system of trauma care could save between 450 and 600
lives per year across England, and patients have a better chance of recovery from their injuries reducing
the risk of serious disability; London, which set up its major trauma system in 2010, has already recorded
fewer deaths.

72. Stroke Services: The radical restructuring of services in London has had a significant improvement on
clinical outcomes while reducing costs. London hospitals had a model of provision of stroke care where all
hospitals provided acute stroke care, however only a few hospitals were delivering high quality specialist care
with access to the clot busting treatment (thrombolysis) 24 hours a day. The majority provided variable, often
poor, acute stroke care. Service reconfiguration was implemented in 2010 reducing the number of hospitals
providing immediate stroke care from around 31 to eight, maintaining access to hyper acute stroke services
within 30 minutes for everyone in London. After implementation the proportion of patients taken directly to a
hospital providing hyper acute stroke care increased from 39% to 69%, with a mean travel time from home to a
hyper acute unit of 17 minutes.

73. London stroke survival is now higher than the rest of England; at 90 days after stroke there are 100
fewer deaths each year for an incidence of 6,400 strokes. There has been a reduction in average length of stay
from 17 to 11 days between 2006 and 2012 with 40% of patients being discharged directly home from hyper
acute care at three days. The London stroke model represents good value for money when costs and benefits
beyond 30 days are accounted for, reducing net costs by £33.5m per year.

74. Cardiac services: Patients with a heart attack should be taken to a specialist centre, and undergo
immediate coronary angiography from a specialist cardiac team; appropriate intervention should be completed
within 4 hours from first contact.

75. Important differences in services between specialist centres and district general hospitals (DGHs) have
been demonstrated. In London in 2008, the mortality rate from heart attack was 5% in specialist centres and
12% in DGHs. Length of hospital stay was ten days in a DGH, but only four in a specialist centre.5

76. Best practice models of care provide clear evidence of a direct causal link between adoption of best
practice and markedly improved patient outcomes. If best practice is adopted, fewer patients die, more patients
make a quicker, fuller recovery, and the patient experience is improved.

Aspects of care which are likely to improve by being located in regional specialist units and the risks
associated with removing services from existing A&E provision

77. There is clear evidence of the benefit of centralising services and treatment for a number of defined
urgent conditions:
— major trauma;
— brain injury;
— chest injury;
— heart and lung injury; and
— major abdominal, pelvic, spine and limb injuries.
— Stroke;
— heart attack;
— major vascular (blood vessel) rupture or blockage;
— severe neurological disorders; and
— severely ill children.

78. As outlined in the previous section, the regionalisation of services has led to improved clinical outcomes
and reduced costs. The smaller number of hospitals in London providing specialised stroke care, for example,
has resulted in a much better survival rate for stroke in London compared to the rest of the country.

79. The urgent conditions listed above constitute a small percentage of the current case mix of a general A&
E department. However, by doing the right thing for the outcomes of these patients i.e. by networking and
centralising services, the resulting reduced number of challenging critically ill patients in some units is likely
to be less of a draw to retaining and recruiting the required number of staff.

80. According to the King’s Fund, achieving the best patient outcomes and patient experience, and narrowing
the quality gap between the best and worst performers, is best achieved by designing reconfiguration to drive
accelerated adoption of best practice models of care in as many services as possible. This in turn is best
achieved by designing reconfiguration along patient pathways involving specialist/tertiary hospitals, district
general hospitals (DGHs) and primary care providers. It requires a significant change in the way emergency

5 Kings Fund, 2005 (unpublished)
and network services are currently provided. Recent successes by PCTs in reconfiguring stroke and trauma services highlight the potential of strong commissioning to bring about markedly improved patient outcomes.

81. It is possible that smaller A&E departments would become less clinically sustainable. Hospital trusts have important interdependencies of services for critical care, radiology, pathology and acute bed numbers. Removing certain groups of patients can therefore reduce the need for these interdependent services. Given the current shortage of medical staff in acute and emergency care, recruitment and retention may also become difficult for smaller units, as staff move towards the larger centres where better care can be delivered. Therefore, any decision to centralise services needs to take into account issues of equality and health inequalities, so that no individuals or groups are disproportionately disadvantaged by the relocation of service and that the benefits of any service change are experienced by whole populations.

82. Delineating and agreeing the optimal model of care for those who present with mental health or behavioural health (substance misuse) unplanned care events, either as the underlying cause of the presentation or the key presenting factors, will also have an important impact on the volume of work in A&E and unplanned care centres.

83. The emergence of networks (hub and spoke) with larger A&E departments working with local urgent care centres is one of the emerging solutions.

The effectiveness of the existing consultation process for incorporating the views of local communities in to A&E service design

84. Through the Health and Social Care Act 2012, the Department has introduce new and stronger requirements on local commissioning organisations to make arrangements to involve users of services in the planning, development and decisions that would have an impact on the manner or range of health services available to those users.

85. Where commissioners are considering a change to services, it is good practice that they involve service users early in the design of proposals, so that these can be shaped by patient insight and feedback. Where commissioners want to seek views on a specific set of configuration proposals, it may be sensible to hold a formal publication consultation in order to gather public opinion on different options. However, it is important that any involvement activity is tailored and proportionate to the nature of the issue under consideration, and that involvement is an on-going activity throughout the lifecycle of a service redesign programme or reconfiguration and that commissioners use a spectrum of involvement activity, rather than only defaulting to formal public consultation exercises.

86. The Department’s policy is that any changes to services must be clinically-led, have a clear clinical evidence base and deliver an improvement in the quality and sustainability of services received by patients and the public. When developing proposals, commissioners should assure themselves, and the communities they represent, that there is strong clinical evidence supporting any change. This would include, for example, being able to demonstrate that safety and clinical outcomes will be improved by relocating services. Commissioners will want to consider a range of evidence and advice including that available from NHS England’s clinical directorates, clinical senates and networks, NICE and Royal Colleges. In reviewing the evidence and the case for change, commissioners will need to consider how high quality and sustainable services are secured in a way that aligns with the principles and values of the NHS Constitution.

87. Reconfiguration is about modernising the delivery of care and facilities to improve patient outcomes, develop services closer to home and most importantly—save lives. The Government’s reforms have put local doctors and other healthcare professionals at the heart of the NHS, making sure that patients receive the very best and safest care. If clinical evidence supports a change in services, it is right that healthcare professionals are empowered to look at how care and treatment can be improved. Any proposed changes to hospital services must involve patients from the start and demonstrate a clear improvement to services and be subject to a transparent and rigorous public consultation exercise.

88. These principles are further enshrined in the Government’s four tests for reconfiguration, which are that local reconfiguration plans must demonstrate:

(a) support from clinical commissioners;
(b) strengthened public and patient engagement;
(c) clarity on the clinical evidence base; and
(d) support for patient choice.

89. There are times when difficult decisions have to be taken. But the Government has been very clear that any such decisions must have a clear clinical evidence base and patients and the public must be involved in that process, regardless of whether a local case for change concerns A&E or any other clinical service.
The ability of local authorities to challenge local proposals for reconfiguration under the revised oversight and scrutiny powers included in the Health and Social Care Act 2012

90. Local authority health scrutiny is a mechanism for ensuring the health service is genuinely accountable to patients and the public, and it helps to bring local democratic legitimacy into the process of service changes. The details of the system of health scrutiny are set out in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (“the 2013 Regulations”).

91. Under the 2013 Regulations, local authorities can review and scrutinise any matter relating to the planning, provision and operation of the health service in their area. This includes NHS and public health services commissioned by NHS England, clinical commissioning groups and local authorities, including those provided by NHS bodies as well as by providers from the private and voluntary sectors (such a body or provider being referred to in the 2013 Regulations as a “responsible person”).

92. Substantial service change might be proposed by a number of players in the new system such as a commissioner or provider of NHS-funded health services. Generally, such “responsible persons” are required in the 2013 Regulations to consult with the local authority on proposals for a substantial development of the health service or for a substantial variation in the provision of such service. The local authority might also offer advice on how the responsible person could shape any subsequent public engagement.

93. It is a requirement in the 2013 Regulations that the responsible person, when consulting the local authority, provides the authority with, and publishes, dates against which the responsible person will decide whether to proceed with the proposal and the date by which they require the local authority to provide any comments on the proposal.

94. NHS England’s position is that effective early and on-going dialogue between NHS commissioners and local authority health scrutiny functions is an important element of good partnership working, and builds on the wider constructive relationships developing between the NHS and local government through health and wellbeing boards. Early engagement of health scrutiny can help to build local consensus on a case for change, and in refining any wider public engagement plans. It is equally important that both the NHS and local authorities are able to provide and review collectively the evidence for change.

95. In the same vein, the Department and NHS England expects commissioners to be able to present strong evidence, it is its view that local authorities have a responsibility to provide robust evidence in case of disputes. Where disagreements occur, it is preferable these are resolved locally without recourse to referral to the Secretary of State—as referral in many ways represents a break down in effective local partnership working. However, the right of referral remains an important part of the wider democratic and accountability framework under which the NHS and local government operates.

May 2013

Annex A

CLINICAL QUALITY INDICATORS, AMBULANCE WAITING TIME COMMITMENTS

The Ambulance Clinical Quality Indicators listed below together with the response times measures form the basis of how Ambulance Trusts are monitored in their performance by commissioners.

1. Outcome from acute ST-elevation myocardial infarction (STEMI)

STEMI is an acronym meaning “ST segment elevation myocardial infarction”, which is a type of heart attack.

2. Outcome from cardiac arrest—return of spontaneous circulation

This indicator will measure how many patients who are in cardiac arrest but following resuscitation have a pulse/heartbeat on arrival at hospital.

3. Outcome from cardiac arrest—survival to discharge

Following on from the second indicator, this one will measure the rate of those who recover from cardiac arrest and are subsequently discharged from hospital.

4. Outcome following stroke for ambulance patients

This indicator will require ambulance services to measure the time it takes from the 999 call to the time it takes those F.A.S.T-positive stroke patients to arrive at a specialist stroke centre so that they can be rapidly assessed for treatment called thrombolysis.

5. Proportion of calls closed with telephone advice or managed without transport to A&E (where clinically appropriate)

This indicator should reflect how the whole urgent care system is working, rather than simply the ambulance service or A&E, as it will reflect the availability of alternative urgent care destinations (for example, walk-in centres) and providing treatment to patients in their home.
6. Re-contact rate following discharge of care (ie closure with telephone advice or following treatment at the scene)

If patients have to go back and call 999 a second time, it is usually because they are anxious about receiving an ambulance response or have not got better as expected. Occasionally it may be due to an unexpected or a new problem. To ensure that ambulance trusts are providing safe and effective care the first time, every time, this indicator will measure how many callers or patients call us back within 24 hours of the initial call being made.

7. Call abandonment rate

This indicator will ensure that we and other ambulance services are not having problems with people phoning 999 and not being able to get through.

8. Time to answer calls

It equally important that if people/patients dial 999 that they get call answered quickly. This indicator will therefore measure how quickly all 999 calls that we receive get answered.

9. Service experience

All ambulance services will need to demonstrate how they find out what people think of the service they offer (including the results of focus groups and interviews) and how we are acting on that information to continuously improve patient care.

10. Category A 8 minute response time

This indicator measures the speed of all ambulance responses to the scene of potentially life-threatening incidents and measures that those patients who are most in need of an emergency ambulance gets one quickly.

11. Time to treatment by an ambulance-dispatched health professional

It is important that if patients need an emergency ambulance response, that the wait from when the 999 call is made to when an ambulance-trained healthcare professional arrives is as short as possible, because urgent treatment may be needed.

Mandate, NHS Constitution and ambulance waiting times

1. The Mandate and NHS Constitution rights and pledges both set out an expectation on waiting times for patients. These include specified standards in ambulance call response times that all ambulance trusts must meet. Commissioners are supported to manage the delivery of these standards through the NHS standard contract, NHS England’s planning guidance for commissioners Everyone counts: planning for patients 2013/14. It is one of the factors that is considered when determining Quality Premium payments for clinical commissioning. Ambulance trusts are also additionally held to account by the NHS Trust Development Authority and Monitor through governance and risk assessment frameworks where response time standards are part of the suite of quality indicators.

2. On the basis that faster response times improve health outcomes and experience for patients with immediately life-threatening conditions, all Ambulance Trusts are required to respond to:

- 75% of Category A8 (immediately life threatening) calls within eight minutes, irrespective of location. This is divided into subcategories - Category A8 Red 1, Category A8 Red 2, defined below.
- 95% of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner

3. From June 2012, the Category A8 measure was split into two parts, Red 1 and Red 2. Category A8 Red 1 (immediate time critical calls) cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions. Category A8 Red 2 (serious but less immediately time critical calls) cover conditions such as stroke and fits.

Supplementary written evidence from the Department of Health (ES 01A)

I presented oral evidence on the 25 June at the Health Select Committee’s inquiry into emergency services and emergency care, alongside from NHS England, Dame Barbara Hakin, Professor Keith Willett and Professor Sir Bruce Keogh.

During my oral evidence session, I promised to write to you on a number of areas and Committee members requested further clarification on some issues.

I have set out as far as possible to answer the Committee’s points of clarification and to provide further detail on where I agreed to write to the Committee in Annex A. At Annex B I have included a series of tables and charts to provide further detail to the information provided in Annex A.
I hope this reply is helpful.

Earl Howe
5 July 2013

Annex A

URGENT CARE BOARDS

1. During the initial stages of the evidence session, questions were focused on short term measures to drive improvements in A&E, and the development of urgent care boards. In May 2013 NHS England, the National Trust Development Authority and Monitor published plans to strengthen performance in urgent and emergency care, which led to the establishment of urgent care boards in many areas. Further information on this work is accessible from the NHS England website at: www.england.nhs.uk/2013/05/09/sup-plan/.

Bed Numbers, Occupancy Rates and Other Factors and Their Effect on A&E

2. Members of the Committee asked me to write to them with facts and figures on factors such as bed numbers, occupancy rates and their impact on the pressures in A&E departments.

Bed numbers

3. The average number of daily available beds has been reducing since 1987. However, while bed numbers have fallen, the bed occupancy rate (for all beds open overnight) has remained relatively stable, rising in the winter months, as we would expect, but remaining between 84 and 88% since 2000. (See Table 1 in Annex B).

4. NHS hospitals need to manage beds effectively in order to cope with peaks in demand. There are higher occupancy rates in winter, when demands are at their greatest. Bed availability fluctuates, but the NHS has practice and experience in managing capacity to cope with both routine and emergency care.

Length of stay

5. The Committee asked for clarification on how increasing reports of older, sicker patients staying longer in hospital could be reconciled with overall reported shorter stays in hospital. There may be local evidence to suggest that some people, after being admitted to hospital following presentation at A&E, are staying longer than average. Where this phenomenon occurs it is largely due to demographic changes, such as the increase in the population of frail and elderly people and the fact that many patients’ needs are now more complex; it may be also be a result of delayed discharge because of issues accessing community services. Nevertheless, the national average length of stay in hospital following an emergency admission has decreased.

6. We do know that many patients admitted are now assessed and treated much quicker than in the past. The latest data shows that, for 50% of emergency admissions, patients are being discharged from hospital the following day or earlier. For those emergency admissions not discharged the same day, the mean length of stay has steadily decreased over the past 5 years. The number of patients treated as day cases has been rising steadily since 2003/04, and now stands at just under 80% of all inpatient activity.

Cancelled operations

7. The statistics for 2012/13 show that the number of cancelled elective operations is broadly low and stable at 0.9% of all elective activity (the same as 2009/10). There were 19,968 cancelled operations in Quarter 4 2012/13, 1.1% of elective activity. The increase in this period is due to seasonality but at just above one%, cancellations remain very low compared to the total number of elective operations carried out. Hospitals should do everything they can to keep last minute cancellations of operations to an absolute minimum.

8. The number of cancelled urgent operations remains very low in the context of the millions of operations performed in the NHS each year. In April 2013, 401 urgent operations were cancelled and 7 urgent operations were cancelled for the second or subsequent time.

9. The Handbook to the NHS Constitution includes a pledge that all patients who have operations cancelled, on or after the day of admission, for non-clinical reasons should be offered another binding date for their operation within 28 days, or their treatment should be finished at the time and hospital of the patient’s choice.

Impact on A&E

10. Overall, we are looking at the relationship between A&E pressures and elective care. Preliminary analysis of historical data suggests that there are no obvious correlations between A&E waits and performance against the referral to treatment waiting time standard for admitted patients.
11. I will now to turning to questions raised by Committee members about delayed transfers of care. In terms of a definition, a delayed transfer of care from acute or non-acute (including community and mental health) NHS care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

   (a) A clinical decision has been made that patient is ready for transfer;

   (b) A multi-disciplinary team decision has been made that patient is ready for transfer; and

   (c) The patient is safe to discharge/transfer.

12. While the figures I quoted to the Committee in terms of total bed days due to delayed discharge and occupied beds delayed (3% and 2% respectively) may be small in the context of a system as large as the NHS, this still translates as 2,000 people every day who are in a hospital care when they would be better receiving care elsewhere and 2,000 beds that could be occupied by someone who is waiting for hospital treatment.

13. The latest available data on delayed transfers of care was published on 28 June 2013. The published data includes a snapshot of the number of patients delayed at midnight on the last Thursday of the month, and the total number of delayed days for all patients during the month.

14. The data shows that, at the end of May 2013, there were 4,200 patients delayed, of which 2,592 were acute patients. There were 120,233 total delayed days during the month, of which 74,324 were in acute care. Sixty-seven% of all delays were attributable to the NHS, 27% were attributable to social care and the remaining six% were attributable jointly to the NHS and social care.

15. The main reason for NHS delays was “patients awaiting further non-acute NHS care”, this accounted for 32% of all NHS delays. The main reason for social care delays was “patients awaiting a residential home placement or availability”, this accounted for 28% of all social care delays. Where both the NHS and social care are attributable, the major reason for delay was “patients awaiting completion of assessment”.

16. The distribution of delays has been changing gradually over the past 12 months. Delays attributable to the NHS now account for 67% of all delays compared to 64% in May 2012, with a similar fall in the proportion of delays attributable to social care.

17. Last week we announced, in the Spending Review, that we have set aside a £3.8bn pooled budget for better integration between health and social care services, with strict conditions that ensure the money is spent where it is needed the most. Better integrated care should improve the transition between health and social care and over time reduce the level of delay transfers of care.

**Workforce**

18. Turning to questions raised about the emergency medicine workforce, I hope it is helpful if I clarify that Health Education England (HEE) is a new arm’s length body responsible for the education, training and personal development of NHS staff. It has a £5billion budget and its remit includes addressing workforce shortages in the short and long term.

19. In September 2011, the Department along with the College of Emergency Medicine established the Emergency Medicine Taskforce to address workforce issues in emergency medicine. HEE has set up the Emergency Medicine Workforce Implementation Group to develop the recommendations made by the Taskforce. The group is planning to set up a number of pilots relating to education and training of emergency department staff.

20. On the issue of attrition rates, the notion of ‘attrition’ is not clear cut in emergency medicine (or in other medical specialties). HEE is currently developing, with its Local Education and Training Boards, a methodology for assessing attrition from medical training. Results will be available later in the year.

21. On the Working Time Directive (WTD), classifying all resident time as working time can mean that immediate compensatory rest is required. However, this aspect arguably has less impact on emergency medicine than on any other specialty, because emergency medicine is the specialty most suited to round-the-clock shift working and handovers are more straightforward and less likely to overrun.

22. The other key aspect is the 48 hour cap on average hours and the impact of the cap on hours (to 56 hours) of the junior doctor’s contract. This has commonly meant that since each doctor’s hours are reduced, more doctors are needed. It also reduces the time available for training and can mean dilution of training opportunities, although the Temple report suggests this should be manageable within the 48 hour limit and other studies agree with this.

23. However, training has not appeared to be a particular issue for emergency medicine, because A&E departments have less down time and the opportunity to make better use of the out of hours period than most other specialties. However, where a specialty has staffing difficulties, they will obviously have more problems with the need for additional doctors.
24. Overall, we would not regard the shortage of emergency doctors as an WTD problem. However, the impact of the WTD restrictions is heightened by the shortage of EM doctors.

NHS 111

25. Committee members also raised questions about NHS 111. I hope it is helpful if I set out for the Committee the history of the introduction and implementation of the NHS 111 service. On the issue of senior official responsibility for NHS 111 services, prior to November 2012, Mark Britnell and Jim Easton held responsibility respectively for NHS 111 services. Ian Dalton took the lead in NHS England in November 2012 and Barbara Hakin took on the lead at the end of March 2013.

26. The Department of Health started work in 2008 on scoping the introduction of a single number to access NHS urgent healthcare services. This included carrying out research with the public that found there was overwhelming support for such a service in particular with a ‘999 style’ memorable number. Research was also conducted to identify which of the available three-digit numbers the public preferred, 111 was by far the most popular.

27. Following this work, the Department asked Ofcom to designate a three-digit number for this purpose. Ofcom launched a public consultation in July 2009 and, following a positive response, announced the designation of 111 as the three-digit number for NHS urgent healthcare services on 18th December 2009.

28. The Coalition Government stated its commitment to a national roll-out of the new NHS 111 service as part of an integrated 24/7 urgent care service in The Coalition: our programme for government and the White Paper Equity and excellence: Liberating the NHS, both in 2010.

29. The Department of Health worked with the Strategic Health Authorities in England to develop the NHS 111 service. Four pilot areas were chosen to initially launch the service in 2010 and to be independently evaluated by the University of Sheffield. Each of these NHS 111 pilot areas developed different operational models for the service, to provide the broadest evidence base possible for the construction of the national service.

30. The Secretary of State for Health, Andrew Lansley, officially launched the first of these NHS 111 pilots on 23 August, in County Durham and Darlington. The service was subsequently launched in Nottingham City, Lincolnshire in November and in Luton in December 2010.

31. In August 2011 the Department of Health and NHS England wrote to all Strategic Health Authority Chief Executives asking them to submit their firm plans to complete the roll-out of the NHS 111 service by April 2013. Responses were received by the Department from each of the SHAs in September 2011.

32. On 1 October 2011 the Prime Minister and the Secretary of State for Health, Andrew Lansley announced that the NHS 111 service would be rolled-out across England. In summer 2012 the Department and NHS England jointly wrote to the NHS offering an extension of up to six months where it was deemed necessary. This offer was only taken up by four areas.

33. The University of Sheffield carried out the evaluation of the pilots, the final report of which was published in August 2012, this can be found at: www.sheffield.ac.uk/polopoly_fs/1.227404!/file/NHS_111_final_report_August_2012.pdf

34. The final report of the University of Sheffield’s independent evaluation of the first year of live operation of NHS 111 in the four original pilot areas was published on the 25th October 2012. The report found that overall the new service achieved its goal of getting patients to the ‘right place, first time’ and had high satisfaction levels among users. The detailed findings of the report show that 93% of callers questioned felt that the advice given was helpful and 86% said they followed the advice they were given. In addition, 86% said that they were ‘definitely clear’ about when to use 111 and 86% said they would use 111 again for a similar problem. The evaluation report also indicated that the introduction of NHS 111 had yet to have an impact on the demand on urgent care services although in one of the pilots there had been an increase in ambulance incidents.

Paramedics

36. Finally, on the issue of paramedics, in 2012, of the 32,076 ambulance staff in 2012, 11,954 were paramedics. Please see table 8 and 9 for current and comparative data on ambulance workforce numbers and for information on paramedics in training.
### Table 1

**AVERAGE AVAILABLE AND OCCUPIED NHS OVERNIGHT BEDS 1997–98 ONWARDS ENGLAND**

<table>
<thead>
<tr>
<th>Period</th>
<th>Total Available Beds</th>
<th>Total Occupied Beds</th>
<th>Occupancy Rate</th>
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</thead>
<tbody>
<tr>
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<td>157330</td>
<td>85.1%</td>
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<td>183826</td>
<td>156933</td>
<td>85.4%</td>
</tr>
<tr>
<td>2003–04</td>
<td>184019</td>
<td>157862</td>
<td>85.8%</td>
</tr>
<tr>
<td>2004–05</td>
<td>180966</td>
<td>154215</td>
<td>85.2%</td>
</tr>
<tr>
<td>2005–06</td>
<td>175436</td>
<td>148465</td>
<td>84.6%</td>
</tr>
<tr>
<td>2006–07</td>
<td>167019</td>
<td>141133</td>
<td>84.5%</td>
</tr>
<tr>
<td>2007–08</td>
<td>160891</td>
<td>135799</td>
<td>84.4%</td>
</tr>
<tr>
<td>2008–09</td>
<td>160254</td>
<td>136860</td>
<td>85.4%</td>
</tr>
<tr>
<td>2009–10</td>
<td>158461</td>
<td>135009</td>
<td>85.2%</td>
</tr>
<tr>
<td>2010–11 Q1</td>
<td>144455</td>
<td>122551</td>
<td>84.8%</td>
</tr>
<tr>
<td>2010–11 Q2</td>
<td>141747</td>
<td>119298</td>
<td>84.3%</td>
</tr>
<tr>
<td>2010–11 Q3</td>
<td>141630</td>
<td>121497</td>
<td>85.8%</td>
</tr>
<tr>
<td>2010–11 Q4</td>
<td>142319</td>
<td>123279</td>
<td>86.6%</td>
</tr>
<tr>
<td>2011–12 Q1</td>
<td>137354</td>
<td>116452</td>
<td>84.8%</td>
</tr>
<tr>
<td>2011–12 Q2</td>
<td>138525</td>
<td>116372</td>
<td>84.0%</td>
</tr>
<tr>
<td>2011–12 Q3</td>
<td>137963</td>
<td>117708</td>
<td>85.3%</td>
</tr>
<tr>
<td>2011–12 Q4</td>
<td>140454</td>
<td>122105</td>
<td>86.9%</td>
</tr>
<tr>
<td>2012–13 Q1</td>
<td>137287</td>
<td>118064</td>
<td>86.0%</td>
</tr>
<tr>
<td>2012–13 Q2</td>
<td>135559</td>
<td>115730</td>
<td>85.4%</td>
</tr>
<tr>
<td>2012–13 Q3</td>
<td>136111</td>
<td>116854</td>
<td>85.9%</td>
</tr>
<tr>
<td>2012–13 Q4</td>
<td>138239</td>
<td>121067</td>
<td>87.6%</td>
</tr>
</tbody>
</table>

Please note that from 2010–11 onwards, the KH03 collection changed from an annual to a quarterly collection. Direct comparisons should not be made with data before 2010–11 as this data was collected annually on a different basis.

### Table 2

**DAY CASE RATES**

<table>
<thead>
<tr>
<th>Year</th>
<th>G &amp; A Day case FFCEs</th>
<th>G &amp; A Ordinary FFCEs</th>
<th>G &amp; A Total FFCEs</th>
<th>Day case rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003–04</td>
<td>3,775,621</td>
<td>1,774,096</td>
<td>5,549,717</td>
<td>68.0%</td>
</tr>
<tr>
<td>2004–05</td>
<td>3,823,067</td>
<td>1,706,601</td>
<td>5,529,668</td>
<td>69.1%</td>
</tr>
<tr>
<td>2005–06</td>
<td>4,052,576</td>
<td>1,709,709</td>
<td>5,762,285</td>
<td>70.3%</td>
</tr>
<tr>
<td>2006–07</td>
<td>4,285,945</td>
<td>1,578,464</td>
<td>5,964,409</td>
<td>71.9%</td>
</tr>
<tr>
<td>2007–08</td>
<td>4,741,728</td>
<td>1,748,601</td>
<td>6,490,329</td>
<td>73.1%</td>
</tr>
<tr>
<td>2008–09</td>
<td>5,071,361</td>
<td>1,674,292</td>
<td>6,775,053</td>
<td>74.8%</td>
</tr>
<tr>
<td>2009–10</td>
<td>5,275,248</td>
<td>1,628,113</td>
<td>6,903,361</td>
<td>75.9%</td>
</tr>
<tr>
<td>2010–11</td>
<td>5,588,136</td>
<td>1,593,215</td>
<td>7,211,371</td>
<td>77.5%</td>
</tr>
<tr>
<td>2011–12</td>
<td>5,868,139</td>
<td>1,598,851</td>
<td>7,466,990</td>
<td>78.6%</td>
</tr>
<tr>
<td>2012–13</td>
<td>6,004,064</td>
<td>1,535,703</td>
<td>7,539,767</td>
<td>79.6%</td>
</tr>
</tbody>
</table>

Source: NHS England Monthly Activity Return, Monthly Monitoring Return
Table 3

LENGTHS OF STAY
Average length of stay, England, 2000–01 to 2011–12

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean length of stay (days) All episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000–01</td>
<td>8.2</td>
</tr>
<tr>
<td>2001–02</td>
<td>8.1</td>
</tr>
<tr>
<td>2002–03</td>
<td>7.9</td>
</tr>
<tr>
<td>2003–04</td>
<td>7.4</td>
</tr>
<tr>
<td>2004–05</td>
<td>7.1</td>
</tr>
<tr>
<td>2005–06</td>
<td>6.6</td>
</tr>
<tr>
<td>2006–07</td>
<td>6.3</td>
</tr>
<tr>
<td>2007–08</td>
<td>5.7</td>
</tr>
<tr>
<td>2008–09</td>
<td>5.7</td>
</tr>
<tr>
<td>2009–10</td>
<td>5.6</td>
</tr>
<tr>
<td>2010–11</td>
<td>5.5</td>
</tr>
<tr>
<td>2011–12</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Table 4

Table 4 shows that 27% of emergency admissions were discharged the same day as admission and 23% were discharged the following day. Together, these figures show that 50% of emergency admissions are being discharged from hospital the following day or earlier.
Table 5

Mean length of stay for emergency admissions not discharged the same day

<table>
<thead>
<tr>
<th>Month</th>
<th>Length of stay (days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td></td>
</tr>
<tr>
<td>2009-10</td>
<td></td>
</tr>
<tr>
<td>2010-11</td>
<td></td>
</tr>
<tr>
<td>2011-12</td>
<td></td>
</tr>
<tr>
<td>2012-13 to Feb</td>
<td></td>
</tr>
</tbody>
</table>

Table 6

CANCELLED URGENT OPERATIONS AUGUST 2010 TO APRIL 2013

<table>
<thead>
<tr>
<th>Month</th>
<th>Urgent operations cancelled</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2010</td>
<td>172</td>
</tr>
<tr>
<td>September 2010</td>
<td>185</td>
</tr>
<tr>
<td>October 2010</td>
<td>173</td>
</tr>
<tr>
<td>November 2010</td>
<td>211</td>
</tr>
<tr>
<td>December 2010</td>
<td>322</td>
</tr>
<tr>
<td>January 2011</td>
<td>222</td>
</tr>
<tr>
<td>February 2011</td>
<td>248</td>
</tr>
<tr>
<td>March 2011</td>
<td>237</td>
</tr>
<tr>
<td>April 2011</td>
<td>219</td>
</tr>
<tr>
<td>May 2011</td>
<td>205</td>
</tr>
<tr>
<td>June 2011</td>
<td>251</td>
</tr>
<tr>
<td>July 2011</td>
<td>203</td>
</tr>
<tr>
<td>August 2011</td>
<td>254</td>
</tr>
<tr>
<td>September 2011</td>
<td>310</td>
</tr>
<tr>
<td>October 2011</td>
<td>301</td>
</tr>
<tr>
<td>November 2011</td>
<td>419</td>
</tr>
<tr>
<td>December 2011</td>
<td>389</td>
</tr>
<tr>
<td>January 2012</td>
<td>322</td>
</tr>
<tr>
<td>February 2012</td>
<td>352</td>
</tr>
<tr>
<td>March 2012</td>
<td>282</td>
</tr>
<tr>
<td>April 2012</td>
<td>229</td>
</tr>
<tr>
<td>May 2012</td>
<td>283</td>
</tr>
<tr>
<td>June 2012</td>
<td>229</td>
</tr>
<tr>
<td>July 2012</td>
<td>250</td>
</tr>
<tr>
<td>August 2012</td>
<td>238</td>
</tr>
<tr>
<td>September 2012</td>
<td>244</td>
</tr>
<tr>
<td>October 2012</td>
<td>301</td>
</tr>
<tr>
<td>November 2012</td>
<td>299</td>
</tr>
<tr>
<td>December 2012</td>
<td>220</td>
</tr>
<tr>
<td>January 2013</td>
<td>316</td>
</tr>
<tr>
<td>February 2013</td>
<td>272</td>
</tr>
<tr>
<td>March 2013</td>
<td>355</td>
</tr>
<tr>
<td>April 2013</td>
<td>401</td>
</tr>
</tbody>
</table>

Source: NHS England
Table 7

<table>
<thead>
<tr>
<th>Patient Snapshot</th>
<th>May-12</th>
<th>March-13</th>
<th>April-13</th>
<th>May-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Delayed Days</td>
<td>119,331</td>
<td>118,186</td>
<td>112,994</td>
<td>120,233</td>
</tr>
</tbody>
</table>

Table 8 and 9

CURRENT AND COMPARATIVE DATA OF NUMBERS OF TRAINED PARAMEDICS NATIONALLY, PROPORTION THEY REPRESENT OF AMBULANCE STAFF AND NUMBERS IN TRAINING FOR FUTURE

<table>
<thead>
<tr>
<th>NHS Hospital and Community Health Services:</th>
<th>Headcount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified ambulance service staff</td>
<td>2006 2007 2008 2009 2010 2011 2012</td>
</tr>
<tr>
<td>Total ambulance staff</td>
<td>28,648 28,471 30,518 32,284 33,163 32,902 32,076</td>
</tr>
<tr>
<td>Qualified ambulance staff</td>
<td>16,176 17,028 17,451 17,922 18,450 18,645</td>
</tr>
<tr>
<td>Manager</td>
<td>614 598 685 692 696 700 657</td>
</tr>
<tr>
<td>Emergency care practitioner</td>
<td>438 646 705 750 780 770 742</td>
</tr>
<tr>
<td>Paramedic</td>
<td>8,222 8,241 9,203 10,089 10,678 11,368 11,954</td>
</tr>
<tr>
<td>Ambulance technician</td>
<td>6,902 7,543 6,858 6,391 6,300 5,853 5,295</td>
</tr>
<tr>
<td>Ambulance personnel (old definition)</td>
<td>.. .. .. .. .. .. ..</td>
</tr>
<tr>
<td>Support to ambulance staff</td>
<td>12,472 11,443 13,067 14,362 14,738 14,238 13,451</td>
</tr>
<tr>
<td>Ambulance personnel (new definition)</td>
<td>4,630 4,537 5,438 6,347 6,444 6,398 6,290</td>
</tr>
<tr>
<td>Trainee ambulance technician</td>
<td>1,829 1,147 1,258 1,415 1,481 1,193 875</td>
</tr>
<tr>
<td>Trainee ambulance personnel</td>
<td>.. .. .. .. .. .. ..</td>
</tr>
<tr>
<td>Clerical &amp; administrative</td>
<td>3,247 3,340 3,882 4,161 4,384 4,303 4,382</td>
</tr>
<tr>
<td>Estates (maintenance &amp; works)</td>
<td>205 166 220 189 226 232 237</td>
</tr>
<tr>
<td>Healthcare assistant</td>
<td>834 992 845 936 960 958 980</td>
</tr>
<tr>
<td>Support worker</td>
<td>1,727 1,261 1,424 1,314 1,254 1,162 695</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Paramedics</th>
<th>Commission Group</th>
<th>Actual 09/10</th>
<th>Actual 10/11</th>
<th>Actual 11/12</th>
<th>Actual 12/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commission</td>
<td>486</td>
<td>633</td>
<td>549</td>
<td>466</td>
<td></td>
</tr>
<tr>
<td>Starters</td>
<td>468</td>
<td>520</td>
<td>570</td>
<td>501</td>
<td></td>
</tr>
</tbody>
</table>

Written evidence from West Midlands Ambulance Service NHS Foundation Trust (ES 04)

1. INTRODUCTION

West Midlands Ambulance Service NHS Foundation Trust (WMAS) is the statutory NHS ambulance service that covers Staffordshire, Warwickshire, West Mercia and the Birmingham and Black Country conurbation, a population of 5.6 million people. The Trust employs over 4,000 staff and responds to around 760,000 999 calls every year. The main measure of ambulance service performance is the time taken to respond to patients who are assessed as potentially life-threatened during the 999 call. The targets are to reach 75% of these patients within 8 minutes and 95% within 19 minutes. WMAS is achieving these targets at 75.5% and 97.3% respectively.

WMAS’s vision is to deliver the right patient care, in the right place, at the right time, through a skilled and committed workforce in partnership with local health economies.

It has four key strategic objectives:

- Achieve Quality and excellence.
- Accurately assess need and direct resources appropriately.
- Establish market position as an emergency healthcare provider.
- Work in partnership.

The Trust was authorised as a Foundation Trust on 1 January 2013.

Key developments include:
— moving towards a target of 70% of frontline staff who are Paramedic trained. This will ensure that every patient can be guaranteed to receive Paramedic care which will increase the proportion of patients treated at scene and therefore reduce the number of patients conveyed to Emergency Departments; and

— Progress towards a Community Based Ambulance Service through the use of a “hub and spoke model” in which ambulances are serviced and equipped centrally and sent out to strategic locations (almost double the number of the previous stations) from where they can respond quickly to predicted need.

West Midlands Ambulance Service NHS Foundation Trust (WMAS) welcomes the Health Select Committee’s inquiry and the opportunity to contribute to the Committee’s thinking. This submission addresses those of the Committee’s questions that are most relevant to ambulance services and outlines opportunities for ambulance services to streamline patient pathways, prevent duplication and improve communication to both patients and commissioners, thereby improving outcomes and reducing inequalities. Through this paper we cover:

— The contribution that ambulance services can and do make to providing urgent and emergency care and treatment in the right place, potentially avoiding unnecessary visits to hospital.
— The scope for more sophisticated commissioning across organisations to lead to improved care and to financial efficiency.
— The potential for ambulance services to work more closely with primary and community care services in ensuring that care takes place in the right place.
— The work of ambulance services in preventing unnecessary admissions and providing definitive care.
— The role of ambulance services in ensuring that seriously ill and injured patients receive the most expert care.

2. Role of community and primary care in delivery of emergency healthcare; appropriate structure to meet demands of different geographical areas

WMAS believes that there is scope for community and primary services to become more involved in the provision of emergency healthcare and in the prevention of medical emergencies. There is huge scope for better integration of ambulance services with primary care. Many 999 patients are frail, elderly, near the end of life or have multiple or chronic complaints eg diabetes and dementia. Good primary and community care can provide support for such patients and prevent the exacerbations of conditions that can lead to emergency admissions. WMAS is involved in a number of initiatives in cooperation with primary care, for example:

— Community Paramedics attend GP practice meetings to ensure that they understand the needs and care plans of particular patients with long term conditions, thus ensuring that they are not admitted to hospital unnecessarily.
— Work with GPs and other providers to review patient pathways and ensure that gaps in provision are identified and addressed. For example, where WMAS has identified a high number of patients who have called 999 following a fall which has not resulted in injury, they have worked with commissioners and other providers to introduce Falls Cars operated by a single Paramedic thereby avoiding deployment of a double crewed, fully equipped ambulance.
— WMAS maintains an End of Life register for patients in Worcestershire to ensure that ambulance crews are aware of patients who are at the end of life and the arrangements that have been made between clinicians and patients. This means that patients’ wishes for their treatment are respected.

Initiatives such as the falls cars described above, GPs in rapid response vehicles and giving Paramedics permission to prescribe antibiotics have all been effective in reducing hospital admissions and conveyance to A&E. As a result of these and other initiatives WMAS reduced conveyance rates from 70% to less than 58% between 2009–10 and the end of 2012–13.

In addition to the treatment of patients, we work closely with commissioners to develop educational material to advise patients who are at risk of accidents and illness about avoidance and management of conditions, through this patients are able to avoid calling for an ambulance or GP visit.

Despite these initiatives WMAS staff are frequently called as a last resort for patients who cannot understand or access the services that are available to them.

The question of how services are structured may be less important than the commitment to work together, whatever the structures. Several services, eg out of hours primary care, district nursing and health visiting have some similar features to ambulance services, such as being mobile and receiving urgent contacts by telephone. The ambulance service has developed region-wide, robust mechanisms for receiving calls, triaging them quickly and sending speedy responses. Learning from the ambulance sector, joint ventures and sharing of resources and information could vastly improve the efficiency and effectiveness of primary care services in responding to patients.
3. Progress towards moving some minor injury and urgent care services out of A&E and into more accessible community settings

WMAS believes that Minor Injury Units serve a useful purpose and should be located where need is greatest, which in some cases may be into more accessible community settings. It is helpful to recognise that the location, nature and volume of need changes according to time of day and day of week. WMAS has had some success with a mobile Paramedic unit that can be located in areas of high footfall and incidence of injury—for example Birmingham City Centre on Saturday evenings.

WMAS considers Paramedics to be well placed to provide minor injury and urgent care services in alternative locations alongside other health professionals. Paramedics are able to triage effectively and have the skills and training to treat a wide range of illness and injury. This initiative could be a key part of providing these services.

4. Prospects for better integration of ambulance services with primary care under the new commissioning regime

WMAS has not yet seen significant change in the way services are commissioned under the new regime, but believes that there is considerable scope for this.

CCGs in the West Midlands have opted for a lead commissioner arrangement for the ambulance service: one individual is jointly funded by all 22 commissioners of the service to develop expertise and lead negotiations although all CCGs are required to sign the contract. This is cost effective and also means that the service receives more expert and concentrated attention.

WMAS believes that there is a need for clearer and more strategic commissioning of integrated services from partnerships of organisations that provide emergency and urgent care. The current situation, in which organisations are commissioned separately, leads to a concentration on reducing cost and increasing productivity within each organisation. This is useful as far as it goes, but an integrated approach would improve patient care and avoid duplication and waste across the system.

Close working relationships and sharing of data and information between ambulance and primary care providers could improve patient outcomes, reduce acute admissions and also avoid the cost incurred in the process of discharging a patient after an avoidable acute admission.

The ambulance triage system, NHS Pathways, generates information that could be used by commissioners and primary care providers. The information can demonstrate unmet need of patients with particular conditions and also where services are not provided at the correct times of day or in the most appropriate location. The Directory of Services for the West Midlands which is a key component of NHS Pathways contains information about all community services, their eligibility criteria and hours of operation. It was developed and is maintained by WMAS. Gap reports are provided for commissioners and these could help commissioners to target resources to the areas and patients with the most need but as yet little action has been taken to act on the information provided.

5. Ability of ambulance services to continue to meet increased emergency demand whilst contributing to the Nicholson challenge

WMAS has delivered savings of between 4 and 5% of turnover in every year since 2010/11 and plans to continue to make similar savings for the foreseeable future. It is funding the increased number of Paramedics from further internal savings, rather than from extra income. High levels of utilisation can be demonstrated for both staff and vehicles and the back office functions of ambulance services are comparatively low for the NHS, typically being about 15% of the costs base compared to 20% in an acute trust.

Nonetheless, 999 demand continues to increase by 4.5% a year in the West Midlands. It will be necessary to continue to respond, usually by sending a Paramedic. WMAS Commissioners have recognised this reality in the negotiations for the 2013/14 contract.

It is unlikely that ambulance services will be able to offer further savings to the Treasury in the short term. But they are a potential source of considerable savings to the NHS as a whole. Advanced Paramedics, who have further training and equipment, are able to provide care outside hospital and prevent unnecessary attendances (and therefore the associated costs). For example in the West Midlands:

- Urinary tract infection: Until recently, most patients with these infections were taken to hospital for the condition to be fully diagnosed. But Advanced Paramedics are now able to carry out a simple test at the scene which allows diagnosis. The patient can then pick up a course of antibiotics from their GP without the need to go to hospital.

- Gluing of wounds: Previously patients with lacerations were taken to A&E to have the wound glued, steri-stripped or stitches applied. Advanced Paramedics are now able to glue and steri-strip lacerations at scene once more reducing the need to take patients to hospital.
6. Transition from NHS Direct to NHS 111

**WMAS** fully supports the national policy for the introduction of NHS 111. However, experience to date in the West Midlands has been poor due largely to inadequate commissioning and implementation. Insufficient focus was placed on the resources required to deliver a safe and effective service at the outset and throughout implementation and this has resulted in a significant shortfall performance which has led to poor patient experience, unnecessary pressures on Ambulance and Emergency services and lack of public confidence in the 111 brand.

7. Shift from indicators based on response time to clinical effectiveness

**WMAS** welcomes the move towards new clinical effectiveness measures and has been instrumental in developing these. A focus on outcomes for a range of conditions means that they receive greater attention. All ambulance services are required to submit performance data and **WMAS** aims for the upper quartile of performance for all of these indicators.

However, fast responses will still be needed for these and other patients, so it has not led to a loss of attention to response time targets.

8. Causes of delays in ambulance to A&E handovers or transfers within urgent care

The causes of delays and transfers are many and varied. **WMAS** has experienced an increase in demand which has an impact on the number of patients being taken to A&E. Once there ambulance crews witness a lack of clarity and/or willingness on the part of hospital staff to engage fully in the handover process which leads to delays. The lack of capacity in A&E units to deal with demand and particularly surges in demand seems to be a factor.

Ambulance services will continue to seek to reduce the numbers of patients they take to A&E departments. This can be achieved through telephone triage and having alternative services to which patients can be referred, through staff having the skills to make the right decisions for patients and through admission avoidance schemes and alternative pathways of care.

As described earlier, **WMAS** has a reduction in the proportion of patients conveyed to hospital by more than 12% in recent years and aims to reduce conveyance rates to 52% by 2015/16, but the rate of reduction is slowing and will continue to do so. In due course it may not be possible to reduce further the proportion of 999 patients that are taken to hospital.

Whilst imposing financial penalties on hospitals for turnaround delays may have a positive short term effect on behaviour, it does not resolve what seems to be a problem of lack of resource planning and utilisation in A&E units.

9. Clinical evidence about specialist regional centre outcomes compared with more generalist hospital based services; aspects of care likely to improve if moved to specialist regional centres

International evidence exists showing improved outcomes for patients with ST Elevation Myocardial Infarction heart attacks if they are taken to places that can provide primary coronary interventions such as angioplasty 24 hours a day. Similarly, survival from stroke improves when diagnosis and intervention is rapid. Major trauma patients benefit from being treated by specialists who are geared up to providing the surveillance and care for patients in recovery. In this case survival rates may be 20% higher.

The Midlands and East SHA undertook a Stroke review in 2011/12. This review recommended the centralisation of a number of current stroke providers to ensure a safe and sustainable 24/7 service within Midlands and East. **WMAS** supports the implementation of any such change by ensuring that crews are trained and empowered to take patients to specialist unit.

The Regional Trauma Network in the West Midlands went live in March 2012. There are four Major Trauma Centres (MTCs) and a network of supporting Trauma Unit hospitals across the region.

**WMAS** has a Major Trauma Desk staffed by Critical Care Paramedics who are responsible for liaising with crews to ensure that trauma patients receive optimum clinical care and are conveyed to the most appropriate treatment centre for their presenting condition. The CCPs are able to offer clinical advice, give support to crews regarding the treatment of patients and advise on the choice of destination hospital. They are also able to put crews in contact with an experienced pre-hospital doctor who will be able to speak to crews, offering advice and support 24 hours a day, 365 days a year. CCPs receive an average of 7 calls per day to the Major Trauma Desk.

May 2013
The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing almost 28,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare. Our primary interest is in building a health system that delivers high quality care for patients.

The RCP welcomes the opportunity to respond to your Inquiry on emergency services and emergency care.

Summary of the RCP's Response

At the start of 2012, the RCP launched the Future Hospital Commission⁶ to review the organisation of hospital care for adult inpatients with medical illness. In September 2012, the RCP released Hospitals on the edge? The time for action.⁷ The report sets the scene for why we must radically review the way we design and deliver acute services for patients. It sets out in stark terms the scale of the challenge facing acute hospitals. The Commission will publish its report in September 2013.

There are many compounding factors that affect emergency services and emergency care, which includes rising demand and the changing needs of an ever ageing population.

Further challenges include:
- Lack of comprehensive, effective alternatives to admission across seven-days.
- Complex discharge issues.
- Handover and flow.
- Recruitment into emergency medicine.

The RCP does not believe there is a “silver bullet” solution to the challenges currently facing emergency care services. The challenges facing Emergency Departments are the most visible manifestation of the pressures facing the system as a whole. As such the solutions lie across health and social care. One of the biggest challenges to emergency services and emergency care is the issue of “exit blocks”. This occurs when patients who could be discharged are not discharged either due to lack of appropriate services to discharge them to, or due to the lack of seven-day capabilities to discharge. In turn, this can lead to patients who need to be admitted facing delays getting on a ward, or being care for in overcrowded conditions, increasing the pressure on “front door” services.

The RCP believes the following fundamental “whole-systems” principles are integral to overcoming the pressures on emergency care services:
- A focus on capacity within the hospital to meet demand. Capacity includes not only beds, but adequate staff levels and appropriate levels of access to diagnostics and treatment.
- Supported early discharge (including adequately equipped and resourced services in the community over seven days, and strong links between in-hospital and community teams across primary, secondary and social care).
- The availability to provide care and discharge on a seven day a week basis.
- Better integration and collaboration within secondary care to ensure smooth flow of patients within the hospital.
- Early senior assessment and review.
- A focus on ambulatory care where appropriate.
- National support for the structured expansion of the physician associate grade.

In our response we have covered:
1. Increasing clinical demand, and the general pressures on emergency services.
2. Compounding pressures on emergency services and emergency care.
3. Whole-system approaches to relieve the pressure on emergency care services.

Increasing Clinical Demand

1. The population of Great Britain has changed substantially since 1948. There are 12 million more people now, living longer, with life expectancy at birth around 12 years longer. People aged 60 or over make up nearly a quarter of Britain’s population,⁸ and half of those aged over 60 years have at least one chronic illness.⁹

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⁶ http://www.rcplondon.ac.uk/projects/future-hospital-commission
⁷ http://www.rcplondon.ac.uk/projects/hospitals-edge-time-action
2. Unsurprisingly, the demographic of hospital inpatients has also changed substantially. An increasing number of patients are older and frail, and around 25% of inpatients have a diagnosis of dementia. At the same time the number of general and acute beds has decreased by a third in the past 25 years, yet during the past 10 years there has been a 37% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75 in the same period (compared with 31% increase for those aged 15–59). The RCP highlighted this in our publication, Hospitals on the edge? The time for action, in September 2012.

3. Addressing the unrelenting rise in emergency hospital admissions is one of the major challenges facing the NHS. This was further highlighted in the House of Lords Committee on Public Service and Demographic Change which warned that the government and our society were woefully unprepared for ageing. Given the continued increase in emergency admissions, the RCP is calling for a radical review the organisation of hospital care if the health service is to meet the needs of patients.

**Compounding Pressures on Emergency Services and Emergency Care**

4. There are a number of compounding pressures on emergency services and emergency care. These can be split into short-term “episodes”, and longer-term factors or “trends” which have been developing over a period of time. Taken together these factors highlight the breakdown in a whole system of care rather than just in emergency departments.

5. Some of the short-term episodes include:
   
   (a) **Extended winter period**—the long winter and cold March in 2013, increasing cardiac and respiratory illnesses
   
   (b) **System transition**—it is vital that there is strong leadership with clear accountabilities, especially at a time of transition.

6. In addition to this there are a number of long-term factors, or “system-wide trends”, which have been emerging over time. These include:

   (a) **Out-of-hours care breakdown**—emergency activity at the weekend is around a quarter lower than during the rest of the week. Patients admitted at the weekend do not get diagnostic tests as quickly as those admitted during the week, there are significant falls in the number of procedures performed at the weekend, including emergency procedures, and fewer people are discharged. This suggests that patients are being “pushed” into the following week. A synthesis of system stress (when admission to hospital exceeds discharge) shows a progressive rise from Sunday to Wednesday and “recovery” (discharges exceeding admissions) from Thursday to Saturday.

   (b) **Handover and flow**—the main cause of delays in ambulance handovers are delays in patient flow through the hospital; which relates to workforce and demand issues at the “front door”, and capacity/flow issues internally through the hospital. The concept of flow is a pre-requisite to efficient, safe and effective care of patients in emergency departments and acute medical units. If patients who require further in-patient care are unable to be transferred out of an emergency department or acute medical unit after their condition has been stabilised both they and subsequent arrivals may be disadvantaged.

   (c) **System fragmentation and lack of alternatives to hospital admission**—despite the high cost of hospitalisation, the NHS has been slow to develop comprehensive, effective alternatives to admission. Patients become acutely ill 24 hours per day, seven days per week. The current drive to seven-day working patterns in secondary care must continue. This drive towards seven day services is not matched in the community. Out-of-hours (OOH) GP coverage has become more fragmented and is supplied by agencies more commonly since the introduction of the new contract in 2004. This compromises efforts to avoid out-of-hours hospital admissions and prolongs the length of stay for inpatients unable to access pathways out of hospital seven days per week, disrupting the capacity to manage new admissions. Integration of primary and social care and primary and secondary care have both been shown to reduce hospital admissions.

   (d) **Complex discharge issues**—the successful discharge of frail older people following an emergency admission to hospital relies on effective joint working between NHS, social care

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partners and the independent sector. In organising discharge pathways, a “whole systems” approach is important. To deliver this, links between primary, secondary and social care must be improved, with greater collaboration in care planning and supported discharge, and better sharing of good practice where this is already happening.

(e) **Financial**—acute trusts have often targeted acute and geriatric bed closures resulting in the UK having lower numbers of emergency beds than other western health care systems to meet savings targets. There is a risk that reducing admissions and beds will lead to a small bed base with high occupancy rates which cannot respond safely to fluctuations in demand.

(f) **Confusing system for patients requiring access to services**—the number of unscheduled care services available may be adding to the confusion experienced by patients when seeking appropriate emergency care. Evidence also suggests that the increase in the supply of newer types of emergency care facilities appears to have led to increased patient demand.

(g) **Recruitment and staffing**—recruitment into emergency medicine is becoming increasingly difficult, with gaps in training schemes, an increasing reliance on locums, and unfilled consultant posts. In addition to this, three successive years of only 50% fill rates for Emergency Medicine (EM) trainees has resulted in a “lost cohort” of over 200 potential consultants. In consequence all UK departments have a significant shortfall in senior trainees which affects service delivery and patient safety on a daily basis.

7. To conclude, we see a number of compounding factors that have created pressures on emergency services and emergency care. What is clear to us is that problems in emergency care services are the most visible manifestation of a “whole system failure” (across primary, community, secondary and social care—and within the hospital itself), and that the solutions must lie across the system.

**Whole-System Approaches to Relieve the Pressure on Emergency Care Services**

8. There is an urgent clinical need to redesign acute services primarily to drive up quality, as well as to deliver effective and efficient services. Problems with emergency services and care are the most visible manifestation of a whole system failure. Solutions to the issue require integration of working (between primary, secondary and community care), but also a more collaborative working approach within the hospital itself. This issue is being addressed by the RCP’s Future Hospital Commission, which reports in September.

9. System-wide solutions include:

(a) **Early senior review**—emergency departments should consider implementing a rapid assessment and treatment (RAT) model in order to provide early senior review for informed expert assessment, diagnosis, care planning, end-of-life discussions, etc. Senior triage of GP referrals to acute medicine has also been shown to be effective; acute medicine consultant triage of GP phone referrals and the introduction of medical ambulatory care pathways have seen a reduction in community admissions by 37% in the areas served by Royal Derby Hospitals.

(b) **Focus on supported discharge on a seven day a week basis**—prioritisation of discharge activities can improve flow in the ED. There is evidence to support the development of generic and disease-specific early discharge schemes that should rapidly respond to patients being designated medically fit; seven days a week. Effective discharge planning can reduce length of stay and readmission, therefore it is a vital element of an effective emergency care process. However, the discharge process has become complex, with patients often requiring a social care assessment, capacity assessment, mental health assessment, best interests assessment and subsequent actions. The current system means that patients are kept in acute hospitals as a “place of safety” while all of these assessments are completed. This could be provided by community services supervised by primary care. A supported discharge relies on effective systems and appropriately resourced services within primary, community, secondary and social care services.

(c) **A focus on ambulatory care services**—the underlying principle of ambulatory emergency care (AEC) is that a significant proportion of emergency adult inpatients can be managed safely and appropriately on the same day, with follow-up for diagnostics and/or treatment, without admission to a hospital bed. Effective ambulatory emergency care is a whole systems approach to...
that is only achieved by re-organising the working patterns of emergency care and diagnostic services. Robust community services are imperative to provide a safety net for AEC.

(d) **Targeted programmes for community services**— although there is weak evidence for the efficacy of broad admission avoidance programmes, targeted programmes for nursing and residential home residents with advanced care plans, frail elderly at home, terminally ill people and some long-term conditions (notably heart failure) may be effective. These require senior decision makers and the capacity within community services to provide immediate care for these groups of patients on a seven-day a week basis.

(e) **Use of acute medical units (AMUs)**— evidence supports the effective use of AMUs to improve the care of patients admitted in an emergency; ensuring rapid, senior, multi-professional assessment and treatment of patients admitted in an emergency, seven days a week is a key principle of AMU care, which is supported by a number of publications from the RCP and Society for Acute Medicine.

(f) **Emergency care boards**— that promote clinical conversations to create shared ownership of emergency pathways and collective problem solving.

(g) **Staffing**— in order to overcome some of the pressures on emergency services staffing, we would recommend an increase in physician associates (previously assistants) who have a shorter training scale (two years), and can offer continuity of care in emergency care services and on wards.

10. There are a number of strategies available to those involved in the planning and provision of emergency services. Often these deal with redesign to the emergency service at the hospital “front door”. However, these redesigns will fail to achieve any improvements in services in emergency departments if wider changes across the system are not also made. This whole system approach must include: a focus on capacity within the hospital to meet demand, supported early discharge (including adequately equipped and resourced services in the community, etc), and the availability to provide care and discharge on a seven day a week basis.

11. Hospitals must deliver consistent, high quality 24-hour services, including a consultant-led service seven days a week. The workforce challenges associated with this are a further driver for reconfiguration.

**Concluding Remarks**

12. Given the pressures on emergency services require a whole-systems approach, the RCP recommends:

(a) A focus on capacity within the hospital to meet demand. Capacity includes not only beds, but adequate staff levels and appropriate levels of access to diagnostics and treatment

(b) Supported early discharge (including adequately equipped and resourced services in the community over seven days, and strong links between in-hospital and community teams across primary, secondary and social care)

(c) The availability to provide care and discharge on a seven day a week basis

(d) Better integration and collaboration within secondary care to ensure smooth flow of patients within the hospital

(e) Early senior assessment and review

(f) A focus on ambulatory care where appropriate

(g) National support for the structured expansion of the physician associate grade.

13. The RCP’s Future Hospital Commission will make recommendations relating to many of these areas and will report in September 2013. The RCP will ensure the Committee is kept informed as work progresses.

May 2013

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26 The RCP has produced a number of acute care toolkits which are a series of resources to help improve the delivery of acute care. These are available online http://www.rcplondon.ac.uk/resources/acute-care-toolkits [Accessed on 15 May 2013]
Written evidence from The College of Emergency Medicine (ES 07)

There are currently four key challenges to Emergency Medicine and Emergency Departments in the UK:

1. Rising demand

NHS England reports a rise in unplanned attendances of 7 million in less than 10 years. Annually rising Emergency Department attendances coupled with the lack of staff recruitment ensures that the ratio of doctors to patients has steadily worsened. Embattled Emergency Department staff encounter episodes of care that is far from excellent. The largest rises in attendances have occurred in patients transported by 999 ambulance reflecting the higher acuity and complexity of the increased caseload.

2. Resources

Emergency Care is currently poorly resourced, poorly regarded and ill served by key stakeholders. The current crisis requires bold decision making to deliver a sufficiently large and well trained workforce. Emergency departments are not an “anything and everything” default option. Failure to address these concerns will result in an existential threat to emergency medicine in the UK with consequent harm to the patients EM doctors trained to serve.

3. Lack of Accessible Alternatives

Narrative reports and research demonstrate a lack of access to community, primary care and mental health services out-with the traditional working day. Medicine is a seven day a week enterprise and timely access requires a greater proportion of doctors to engage in Out of Hours Care.

4. Workforce

Workforce recruitment is in crisis. Three successive years of only 50% fill rates for Emergency Medicine trainees has resulted in a “lost cohort” of over 200 potential consultants. This loss is permanent and irredeemable. In consequence all UK departments have a significant shortfall in senior trainees, this is compounded by hundreds of vacancies for other middle grade and consultant posts. This shortfall affects service delivery and patient safety on a daily basis. The College has called for a minimum of 10 consultants per Emergency Department and 16 in larger units.

The pressure on those in post is relentless and demoralising. Trainees and Consultants alike struggle to maintain morale when forced to work within and deliver care on the very margins of safety. This creates a vicious circle of recruitment and retention failure.

Submission

1. The role of community and primary care services in the delivery of emergency healthcare, and the appropriate structure for service delivery to meet the demands of different geographic areas particularly sparsely populated rural areas

   1.1 The College endorses the notion that primary and community care is where the majority of healthcare is currently delivered and where it should remain. However access is perceived by patients to be inconsistent and uncertain. Patients attend Emergency Departments with conditions that they appreciate are not emergencies as such, but the lack of appropriate face to face alternatives leaves them little choice.

   1.2 Experience and evidence to date demonstrate that education and/or signposting are unlikely to remedy this situation. Furthermore patients have a not unreasonable expectation that they should be able to seek medical advice and treatment without absenting themselves from work.

   1.3 Primary care should be available 365 days per year to all communities—the number of hours provided would be proportionate to population. Provision would vary from a few hours per day in very rural areas to 16 hours per day in urban areas.

   1.4 The College is aware of evidence of significant benefit in the following initiatives:

   1.5 Triage of all attendances to an Emergency Department with “front-door” streaming of patients to primary care or emergency care as appropriate;

   1.6 GPs working alongside Emergency Department doctors and emergency nurse practitioners within the same team.

   1.7 The College is concerned particularly with regard to three vulnerable groups:

   1.8 Patients who are residents of nursing homes are frequently brought to the Emergency Department for assessment and investigation when care may be more appropriately managed in their place of residence. The assessment of 999 calls from nursing homes by a GP prior to dispatch of an emergency ambulance would benefit this patient group substantially.

1.9 The frail elderly are often transported to the Emergency Department by default rather than because such departments best serve their care needs. The provision of seven day community based multidisciplinary teams that could be accessed by the ambulance service would enable more bespoke and patient centred care, reduce 999 transfers and ED attendances.

1.10 Patients with both acute and chronic mental illness attend Emergency Departments seeking help. This help requires both experience and expertise, the former being by far the most important and yet scarce. All Emergency Departments should have access to, and timely attendance of, trained mental health workers.

1.11 The College recommends all service provision and reconfiguration should be evidence based. Whenever such evidence does not exist, schemes should be piloted and independently evaluated.

2. Progress towards moving some minor injury and urgent care services out of A&E and into more accessible community settings

2.1 The College acknowledges the valuable contribution to out of hours care made by minor injury units and walk in centres. Lack of consistent opening hours and resources (eg X ray facilities) ensure they are sub-optimally used.

2.2 Moreover where geographically practical these should be co-located with the Emergency Department. This allows patients to present, confident that they will be seen by the most appropriate and first available person. In addition duplication is avoided and cost effectiveness is increased. Staff can be easily rotated to enhance skill acquisition and retention.

2.3 The College knows that patients attend Emergency Departments for a variety of reasons. Departments should be configured to address these patient needs by streaming them to different providers without the need for a further journey, telephone call or referral. It is unreasonable to expect all patients to self assess the acuity or significance of their illness or injury.

2.4 Currently recruitment and retention of both medical and nursing staff to Emergency Departments is in crisis. Vacancies and locum spend are unacceptably and unsustainably high. Many experienced nurses are taking employment in minor injury units, or as practice nurses where the working environment is more acceptable. Co-location of out of hours services can reduce the burden on Emergency Departments and allow staff rotation to less acute areas to reduce burn-out.

2.5 Where services have been established but without co-location there has been no significant reduction in ED attendances but a significant loss of highly experienced staff. This has occurred in many locations including Manchester and Portsmouth.

3. The range, severity and incidence of conditions that can be treated within an accident and emergency unit but not managed at an urgent care centre.

3.1 Emergency Medicine departments exist to address the medical needs of patients who experience an acute and severe medical condition or symptom. Thus non-acute problems (symptoms present for days) or non-severe (not preventing work, education or activities of daily living) are best assessed and treated in more appropriate settings (minor injury units/GP surgeries/hospital out-patients etc).

3.2 Emergency Departments are tasked primarily with the diagnosis and treatment of time critical interventions; these include, but are not limited to, the assessment of symptoms such as acute chest pain, breathlessness, bleeding, loss of limb function, unconsciousness, severe pain and these in turn reflect conditions such as stroke, seizure, myocardial infarction, haemorrhage, pneumonia, sepsis, major trauma, bone fracture, abdominal and gynaecological emergencies.

3.3 Such conditions represent the majority of admissions from Emergency Departments. Those who are not admitted are discharged and frequently require follow up in out-patients or by their GP.

3.4 This key acute role is predicated on properly trained emergency medicine doctors and nurses, access to investigations (radiology, haematology and biochemistry) 24/7 and the co-location of anaesthesia, orthopaedics, surgery and paediatrics.

3.5 Major improvements in mortality and morbidity arising from stroke, trauma, sepsis and myocardial infarction have been contingent upon Emergency Department participation and leadership in and of rapid assessment, acute care pathways and disease specific networks. The unique skill set of the Emergency Physician is assessing and managing a range of undifferentiated cases and the level of multi-tasking required.

3.6 Emergency doctors are uniquely able to correctly identify who needs admission and who can be safely discharged across the full breadth of acute presentations.

28 Harry Longman Chief Executive of Patient Access
29 http://www.collemergencymed.ac.uk/asp/document.asp?ID=5458
4. The prospects for better integration of ambulance services with primary care under the new commissioning regime established in April 2013

4.1 The time target culture has led to unintended consequences of poor resource utilization. Only a small proportion of 999 calls are transported to hospital using lights and sirens. Moreover there is a complete lack of integration or coordination with community services. Crews often recognize that patients could be better managed by GP review in the home (in particular those residing in residential and nursing homes) but cannot get rapid access to GPs. Ambulance services need to be encouraged and supported in their moves to develop the skills to assess and leave patients and empowered to trigger the attendance of other services eg GP, community nurse, social services.

5. The ability of ambulance services to continue to meet increased emergency demand whilst contributing to the Nicholson challenge

5.1 Ambulance services are struggling at present with demand and need to have the tools that allow them to more effectively triage patients and access support systems that avoid conveyance to an Emergency Department. Some ambulance services achieve non-conveyance rates of almost 50% but there is significant unexplained variation both between and within services.

6. Experience to date of the transition from NHS Direct to the NHS 111 service

6.1 The college supported the concept of NHS 111 as an opportunity to recognise the breadth and depth of local services and ensure patients were appropriately signposted.

6.2 Unfortunately the lack of alternatives to Emergency Department disposition has ensured that the system has added to the ED burden when faced with a demonstrable lack of alternatives or capacity.

6.3 Telephone triage even in expert hands is likely to result in more patients than clinically necessary attending an Emergency Department—especially when there are no credible alternatives.

6.4 To be effective telephone triage requires the patient to speak to the advice giver and requires the patient to make objective assessments of their own symptoms. This substantially disadvantages many patient groups.

6.5 The College repeats its assertion that all process and systems changes should be evidenced based before widely implemented.

7. The implications of the shift away from determining the success of ambulance services via indicators based on response time to the new measures designed to assess clinical effectiveness

7.1 The College welcomes this strategic shift. We welcome the opportunity to review the evidence.

8. The causes of delays in handover from ambulances services to A&E or transfer between different levels of urgent care, and actions required to eliminate them

8.1 There is substantial evidence in the literature that correlates hand-over delays to exit block from Emergency Departments. Hand over delays seldom occur other than when significant numbers of patients have completed their ED care and are awaiting a bed to become available on a ward.

8.2 Reducing the need for conveyance to hospital by provision of alternatives and enabling 7 day a week discharges from hospital are the most effective strategies to enable a patient centred approach to both arrival and departure from hospital.

8.3 The College emphasises the concept of “flow” as a pre-requisite to efficient, safe and effective care of patients in Emergency Departments. If patients are unable to exit an Emergency Department at the completion of their assessment, investigation and treatment both they and subsequent arrivals are disadvantaged.

9. Clinical evidence about outcomes achieved by specialist regional centres, taking account of associated travel times, compared with more generalist hospital based services

9.1 The College endorses the notion that not all services can or should be provided in all hospitals and rationalisation of provision is long overdue. Political realities confound such decisions.

9.2 The associated costs, both direct and indirect need to be factored in to any analysis to ensure money invested in such centres does not disadvantage other patient groups.

9.3 Concentration of expertise in one centre rapidly leads to a loss of specific skills and expertise in smaller units. This phenomenon is seldom researched or evaluated with a consequent risk of bias in the analysis of overall benefits.

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9.4 Over triage of patients is well documented in all the regional trauma centres. This results in patients ending up in hospitals without access to their medical records, and where their care may be paradoxically delayed whilst more severely injured patients are prioritised.

10. Aspects of care which are likely to improve by being located in regional specialist units and the risks associated with removing services from existing A&E provision

10.1 Urban areas are most suitable for centralisation of services. Clinicians can work in more than one unit thus retaining skills, patients are not geographically or psychosocially disadvantaged and economies of scale are maximised.

10.2 In rural areas significant clinical benefit is lost as a result of increased transport times and none of the advantages stated for urban areas pertain.

11. The effectiveness of the existing consultation process for incorporating the views of local communities in to A&E service design

11.1 The Lay Committee of the College is disappointed and unconvinced by recent examples of community consultation eg Lewisham.

11.2 The complexity of the issues relevant to service design are frequently understated and ill considered. Consultation must be informed if it is to be meaningful. Such a process can only be successful if it is presented, conducted and concluded in a non-partisan manner.31

11.3 The paucity of detailed accurate information is a function of the endemic poverty of ED IT systems.

12. The ability of local authorities to challenge local proposals for reconfiguration under the revised oversight and scrutiny powers included in the Health and Social Care Act 2012

12.1 The College is unaware of any examples of this in practice. The College acknowledges that the need for better integration with social services mandates scrutiny of health proposals by local authorities

In addition to the subject headings upon which we were invited to comment the College invites the Select Committee to consider the following points:

13. Financial sustainability

13.1 The College has argued for appropriate remuneration of Emergency Department activity and emergency admission activity. The former is remunerated by a tariff wholly unfit for purpose. Resuscitation is remunerated at a lower value than a routine out-patient attendance. Admissions are remunerated at a marginal tariff of 30% of the full tariff for all admissions above the total recorded in 2009.

13.2 Failure to remunerate appropriately has prevented Acute Trusts from adequately resourcing departments and is further evidence that Urgent and Emergency Care is not valued.32

14. Safety

14.1 Emergency Department overcrowding is associated with increases in both morbidity and mortality. There is increasing evidence of this in all health care systems.

15. The future

15.1 The current “perfect storm” as evidenced by the mismatch of demand and capacity, under-investment (both capital and revenue) and lack of alternatives has exacerbated the problems of recruitment and retention of both medical and nursing staff. Without a workforce Emergency Medicine and Emergency Care will cease to exist

32 http://www.england.nhs.uk/2013/05/09/sup-plan/
33 “The Drive for Quality” The College of Emergency Medicine 2013
15.2. The College has recently published "The Drive for Quality."\(^{34}\) This presents current data establishing the shortfall in service provision and provides evidence based recommendations.

May 2013

**Written evidence from the NHS Confederation (ES 09)**

**Executive Summary:**

- Pressures on A&E services reflect pressures being experienced across the whole system. It is imperative we share understanding of the problem and avoid one part of the system blaming another for strains on emergency services.

- Years ago we warned that the biggest concern facing the NHS would be to sustain massive improvements in reducing waiting times for care, as demand outstripped the funding available to the NHS. We have now reached a point where the cracks are beginning to show and some services are reaching capacity. Swift action must be taken to slow down the trend of over-burdened urgent and emergency care, as demographic pressures mean this is a something which is here to stay.

- There are myriad reasons why A&E departments are buckling under the strain. The rise in demand is particularly concentrated on those with less serious conditions and those over the age of 85. Cuts in social care, under investment in primary and community care and perverse financial incentives in the system are all contributing factors to the rise.

- An overhaul of financial flows in the system to incentivise and change the status quo is long overdue. Our members have particular concerns regarding the marginal tariff for non-elective work. This tariff, while good in intention has not tackled increased demand. We therefore welcome the review currently being conducted by Monitor and NHS England into this matter.

- NHS out-of-hours care is not fit for purpose and successive Governments have so far failed to address this problem. Local NHS organisations now need to look at how they can provide services which are available 24 hours a day, seven days a week. However, this requires a change in working patterns—recognising weekends and evenings as normal working times—and service delivery planning. It is a shift which needs to be driven by quality and safety in patient care, and not overtime rates. Equally, this should not be the responsibility of one profession—out-of-hours care needs to be provided by multidisciplinary services.

- The introduction of the NHS 111 has been problematic in many areas. We fully back the principle of a single portal for people to access healthcare to address the confusion felt by many about where to access care, but we believe so far the 111 service has been a missed opportunity. There are currently significant problems with the service in that it is not properly connected to hospitals and does not have an online equivalent. These issues need to be addressed swiftly if the benefits of the service are to be realised and the public’s trust is to be gained. We understand from NHS England that recent figures show there are some signs of improvement.

- As part of the need to integrate different parts of the system and to relieve burdens on urgent and emergency care, we fully support the objective of using a person’s unique NHS number across health and social care. This would want to give people greater ownership of their number so they can use it to link information to their records and allow the NHS to make targeted interventions aimed at reducing demand.

- Tackling the issues in emergency care will require political courage. We are arguing for more investment in primary, community and social care— as well as a concentration on how to reorganise services so that they are more joined-up and organised around an individual’s needs. We also need to see a change in culture that makes tackling demand a top priority for all parts of the NHS.

1. **Demographic Change and Increased Demand**

1.1 The NHS and improvements to public health have ensured that people are living longer and diseases which were once fatal can now be managed for longer periods of time. For example the population of over 65s is projected to grow by 50% over the next two decades. While these improvements should be celebrated the increase in the number of people living with multiple, long term conditions has led to increased demand being placed on the health service.

1.2 The effect of lifestyle choices, including smoking, alcohol abuse and obesity, on public health and wellbeing have also increased pressures on the NHS. The cost for treating diseases associated with these lifestyle choices is estimated at a cumulative £17.9 billion each year—almost a fifth of the annual NHS

\(^{34}\) "The Drive for Quality" The College of Emergency Medicine 2013
budget. They have also led to an increase in some long-term conditions, for example the rising rate of diabetes—expected to double in the UK by 2025.

1.3 These changes have led to increasing demand for NHS care. Emergency and urgent care is the point where pressure is most intensely felt. For example, total annual attendance at accident and emergency departments in England increased from just over 14 million in 2000/01 to just over 21 million in 2010/11, a 50% increase in 10 years. The increase in breaches of targets which is happening in some areas, such as the 4 hours target in accident and emergency is reflective of increasing pressure elsewhere in the system, rather than within emergency services alone. In addition to this, it is estimated by groups including the National Clinical Advisory Team that around 30% of people attending emergency departments could have been treated elsewhere.

1.4 The demographic changes outlined above combined with the funding pressures on local government have also led to increased pressures on social care. When people’s needs are not met by the social care system they turn to the NHS, which experiences the increased demand for emergency and unplanned work, and delay in discharging people from hospital. Delayed transfers of care already cost the NHS £545,000 per day (approximately £200 million per year). The number of emergency admissions among patients aged 75 and over has increased by 18% between 2006/07 (1.231 million) and 2010/11 (1.453 million). These pressures will increase without action to ensure a sustainable funding solution for social care.

1.5 More work is needed to understand the demand for urgent and emergency services. The way the NHS measures activity has changed in recent years and we need to look at demand in urgent settings (such as minor injury units or walk in centres) as well as emergency departments in order to get a full understanding of the picture. According to NHS England there is a general rising tide with 5.9% more attendances in 2012/13, than in 2009/10. However, we need to recognise that if demand continues to rise emergency and urgent care will reach capacity.

2. A System Wide Approach

2.1 Emergency care is a fundamental issue for all parts of the NHS. To tackle this system wide problem we need a system wide solution. The NHS must avoid one part of the system blaming another for pressures on emergency services. System leadership which brings together all of the parts of the local NHS will be vital to responding to the pressures on emergency services. Currently much of the focus is on the acute and ambulance trusts. However, emergency care is an issue for all parts of the NHS so any approach will need to involve commissioners, as well as acute care, primary care and community services providers. This will require risks and rewards to be shared and organisational interests set aside, for the greater benefit of the local health economy.

2.2 The new commissioning system, and Clinical Commissioning Groups (CCGs) in particular, will have a key leadership role in this, particularly as CCGs are effectively made up of GPs as commissioners who also deliver primary care services. However, it needs to be recognised that CCGs are very new to their role and will need support from the Clinical Support Units and NHS England’s Local Area Teams to do this.

2.3 The new health and wellbeing boards could also play an important role in facilitating this sort of joint approach. However, though significant advances have been made at this early stage of the Boards’ development, there remain considerable challenges to realising this potential. Board members will need strong communication and political skills. While most boards already have a partnership of shared respect and understanding, they will need to go beyond this to become a cohesive, unified body in which overall strategic priorities are put above personal or organisational interests.

2.4 The issue of ambulances handing over patients to hospitals is one example of where a system wide approach is vital to managing the pressures faced by emergency departments. Ambulances stacked up outside of hospitals waiting to handover patients is something which should never be acceptable in the NHS but has become a problem in some areas in recent years. Our report Zero tolerance: Making ambulance handover delays a thing of the past recommends that as delays in handovers are symptomatic of wider pressures, a wider response is needed to tackle them. This involves considering “downstream” issues like timely discharge from hospital to free up beds for emergency admission. It also recommends close working with primary and community care providers, to ensure their critical role in managing urgent and emergency care systems is better understood and developed.

3. Managing Demand: Services Reconfiguration and Cultural Change

3.1 The NHS needs to do more to manage the demand facing the NHS in order to lessen the pressures on the service. We need a change in culture that makes this a top priority for all parts of the system. A key part of this will be greater investment in prevention and early intervention services, which could also be achieved

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through service reconfiguration, specifically through integration between primary, secondary and social care. While local authorities now commission most public health services, there is still a role in this for the NHS.

3.2 This needs to be a whole system effort, where proper management of unscheduled episodes happens along the whole continuum of care, and thus implying well developed communication channels among all the parts of the system. Information gathering and sharing across the system is thus paramount, especially along those fault lines where different parts of the system interface.

3.3 For example, A & E admission rates are affected by limited access to out-of-hours primary care services and management of patient referrals/transfers between acute, primary and community care. This goes hand in hand with a reduced availability of senior acute clinical staff at night and during weekends, with an impact on hospital mortality rates, which are 10% higher at weekends. Providing services available 24 hours a day, seven days a week, throughout the system can help in reducing attendance to emergency departments.

3.4 However, it requires a change in working patterns—recognising weekends and evenings as normal working times—and service delivery planning. It is a shift which needs to be driven by quality and safety in patient care, and not overtime rates. Investing in good-out-of-hours services will help this.

3.5 Another example is the positive impact of proper discharge planning, involving different parts of the system—internal hospital teams, ambulance services, social care and family carers. This has also shown to reduce the risk of re-admission within 30 days following discharge. For example, some NHS organisations, such as in Torbay, have employed a discharge manager who has specific responsibility for ensuring discharge of patients is done as safely and as smoothly as possible.

Case study: Integrated care, Southern Health NHS FT.

The trust is responsible for delivering community and mental health services to 1.2 million people in Hampshire. Operating on a block contract—£350m, 9000 staff—the trust aims to reduce costs, delivering more services for less money; improving clinical outcomes for patients and their families; and improving patient and carer experience.

The focus has been placed on supporting frail elderly people in the community, through creating single Community Care Teams (CCTs), including different levels of care and based around a general practice, serving approximately 30,000 people through 3 sub-teams. Through collaborating with primary care, the FT developed a new, integrated workforce which assesses and proactively plans to meet the needs of vulnerable patients. With acute providers, the FT is creating integrated acute & community elderly care services to reduce emergency admissions and length of stay.

The model showed a certain reduction in A&E admissions of frail elderly throughout the past 5 years of implementation. A key barrier to be broken was the resistance to the cultural shift which achieve integrated care required. Behaviours had to change, in order to enable cooperation through partners that were not necessarily under the same management lines. This shift of relationships across the system, and developing a new set of values, is key in delivering a unified response to urgent and emergency care.

3.6 Significant initiatives led by both NHS providers and commissioners have also strengthened early intervention efforts in areas such as psychiatric liaison, alcohol and falls prevention. We are calling for the introduction of services which aim to take a whole person and community approach to improving health. These could for example include a combination of smoking cessation, weight management, or psychological well-being interventions such as stress management. NHS organisations and local authorities should also work together through health and wellbeing boards to provide wellness services which take a whole person and community approach to improving health. To support this sort of approach, NHS England should design a payment mechanism specifically to support coordination of these sort of services.

3.7 However, our members have clearly stated this sort of work has often been driven by certain individuals and it is not yet something built into the NHS system. We must ensure these initiatives become the norm across the health service.

4. NHS 111

4.1 Another tool to effectively manage the demand for urgent and emergency care, creating a unique contact point and enabling admission triage, is NHS 111. The different points to access urgent and emergency care, such as walk-in centres, and minor injury units can, create confusion in patients, rather than helping to ensure they are treated in the right place. Having one telephone number as single entry point to the health service would certainly help address these concerns.

4.2 While we understand from NHS England that there have very recently been improvements, there are clearly significant problems in some areas of the country as 111 has been rolled out. We have warned in the past about the way that the service were being procured in some areas. However, these problems should not

40 NHS Confederation. From illness to wellness. Oct 2011, (http://www.nhsconfed.org/Publications/briefings/Pages/illness-to-wellness.aspx)
lead to the service as a whole being dismissed. National bodies, particularly NHS England, will need to act to ensure that these problems are overcome and 111 successfully implemented. The roll-out is clearly very variable across the country and does not seem to be related to type of provider. It will be important to analyse the differences between the good and the bad and learn from that analysis.

4.3 National bodies, along with commissioning support units and NHS England’s local areas teams will need to provide support to commissioners in implementing the service. It is concerning 111 has no online counterpart and is not well connected to hospital services. It is paramount for 111 to have systems in place to gather and share information among local care providers and commissioners, including an up to date directory of local services which call handlers can use to help patients makes the right choices about the care they receive.

5 The Role of Ambulance Services in Managing Demand

5.1 NHS ambulance service account for 1.5% of NHS spend but the consequences of their decisions impact on 20% of NHS activity. Ambulance trusts have already been playing a greater role in reducing demand as well as meeting the QIPP saving challenge. For example, our Ambulance Service Network’s document Falls prevention: New approaches to integrated falls prevention services\(^{41}\) sets out benefits, including in terms of making savings, resulting from a falls prevention strategy.

5.2 Non-conveyance of patients, by ambulance crews (ie the decision not to move a patient to an emergency department but to give them alternative treatment more appropriate to their needs) has proven key in managing demand and improving care. Practical solutions, such as improving training for paramedics and providing them with the support needed for making non-conveyance decisions, will promote a culture questioning about whether a hospital is the best place to treat the patient, rather than simply taking them there by default. When redesigning local services, commissioners will also need to find ways to incentivise non-conveyance.

5.3 There is wider scope for better integration of ambulance services with primary health care and community services, particularly for screening, and notifying, people at risk of admission in the community. To both enable this and to enable ambulance services to continue meeting the increased demand for unscheduled care, better information gathering and sharing is particularly important. For example better data can allow the NHS to target frequent attendees in emergency departments and examine if they can receive more appropriate care in a different setting. We need to enable the use of the NHS number as the unique identifier across the health and care system to facilitate this approach.

6. Alternatives to Urgent and Emergency Care

6.1 Properly coordinated, person-centred services can better care for the health of people, rather than dealing with the sickness of patients when they arrive at a hospital. Some progress has been made on transferring care into the community but more must be done. We welcome Bruce Keogh’s review into this issue. There needs to be renewed efforts at national level to enable services other than emergency departments to better deal with unscheduled care episodes, locally and safely. This includes fundamentally reviewing how we organise and fund our services outside traditional hospital settings, the way staff work throughout the whole week, and how we provide effective alternatives to hospital-based emergency care.

7. The Role of Primary Health Care and Community Services, in Relation to Urgent and Emergency Care

7.1 We need to see better utilisation of community care and primary care to take the pressure off emergency departments, making sure people can be treated safely in their own home and avoid unnecessary visits to hospital.

7.2 According to the King’s Fund\(^{42}\), the prevalence of unscheduled hospital admissions for conditions that could be prevented suggests that there is potential to manage patients better in primary care. Primary care needs to work with the rest of the health and social care system to manage the demand on urgent and emergency care. Specifically, limited access to GP’s out of hours and variability in quality is a contributing reason for greater demand on emergency services. In some places there are attempts to address these variations, in order to find innovative solutions that suit local needs. In particular, there is a need to find better ways of sharing and using data to highlight and address variations, especially to better manage the health of patients with long term conditions in primary care. The below example highlights this.

**The Pan London General Practice— A London Strategy to improve quality, access and patient experience in general practice.**

The initiative addresses significant variation in quality across the English capital through:

1. Provide clinicians with the data and information they need to identify and prioritise areas for quality improvement

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41. NHS Confederation, Falls prevention: New approaches to integrated falls prevention services (2012), (http://www.nhsconfed.org/Publications/Documents/Falls_prevention_briefing_final_for_website_30_April.pdf)

42. The King’s fund, Improving the quality of care in general practice Report of an independent inquiry commissioned by The King’s Fund, 2011.
2. Share this transparently at a local level peers to engage general practice in driving care improvement. The project aims at achieving transparency in data at a local level for patients, the public and professional peers through public facing launch of the standards on a web based platform that includes:
   - Intuitive dashboard to present the outcome standards.
   - Public Health Observatory Health Profiles that describe the health of the local population.
   - Practice voice.
   - A patient feedback mechanism.
   - A range of tools and applications for general practice, eg survey templates for achieving DES requirements for patient participation.

As a result, general practitioners took ownership for the quality improvement agenda and delivered a step change in performance for London. Also, unwarranted variations reduced and efficiency savings delivered, contributing to meeting the QIPP challenge by 2014/15.

7.3 As outlined in our 2013 briefing on the role for community healthcare in transforming local care, the community health sector is already driving the transformation of local care systems. Innovative community healthcare providers, including stakeholders such as charity and social enterprises providers are enabling people to stay healthy and independent and avoid crises that lead to unplanned hospital admissions. They enable staff to develop a holistic view of the needs of each individual and provide personalised continuous, rather than episodic, care. This sort of care is much better for the growing number of people with long term conditions and can help better manage those conditions, which in turn will help reduce unnecessary hospital admissions.

7.4 Central to the community health model are prevention, early intervention and enabling timely discharge or transfer from hospital to improve recovery. Community health is moving the focus away from traditional models of healthcare in acute settings to nurse-led rehabilitation in, or closer to, peoples’ homes, the provision of “hospital at home” services such as diagnostics and chemotherapy, and community-based end of life care. Below is an example of where community services have been used to reduce the pressure on urgent and emergency care.

Case study: Birmingham Community Healthcare NHS Trust

Birmingham Community Healthcare NHS Trust has developed a model of care that enables rapid, 24-hour access to community services to reduce emergency hospital admissions. It has established a 24/7 single point of access for urgent and non-urgent referrals, which aims to signpost patients to appropriate care. For urgent care, a rapid response and advanced assessment at home is delivered within two hours. For non-urgent care, multi-disciplined teams respond and manage between four and 48 hours.

A clinician-led telemonitoring service has also been expanded across the city, which allows patients to self-monitor vital health indicators that are automatically relayed, monitored and recorded. This new model of care has allowed 97% of referrals to be responded to within two hours, resulting in a 12% reduction in GP-referred medical admissions to the local hospital. The telemonitoring has facilitated a reduction in emergency admissions of up to 70%, saving an estimated £250,000.

7.5 While there are good examples of innovative initiatives across the NHS more needs to be done to ensure best practice is widely adopted. In order to see this much needed shift toward more care in the community and better utilisation of primary care, NHS organisations will need to redesign services so they better meet the needs of local people and tackle the pressure being felt on urgent and emergency care. Government and national NHS bodies will also need to examine how we pay NHS organisations for their activity to ensure that the necessary large scale change needed is incentivised and adopted at scale and pace across the system.

8. Redesigning Incentives

8.1 Our members have particular concerns regarding the marginal tariff for non-elective work. This was introduced with the intention of penalising acute trusts by paying them a reduced rate (30%) of tariff, (ie the mechanism for paying trusts for their activity) for a rise in non-elective admissions in order to encourage finding ways to reduce demand. While the intention of this was welcome, in practice this policy has not tackled rising demand. What it has achieved is to substantially increase the already intense financial pressures on acute trusts with emergency departments. Furthermore, the marginal tariff has in practice transferred the risk to providers and has not created a shared imperative for commissioners to actively engage with this issue and make changes to the local health service which will tackle rising demand.

8.2 We welcome the review of the marginal tariff by Monitor and NHS England which recognises these concerns. It is vital that the 70% saving from the tariff remains with clinical commissioning groups so they can invest it in changes to local services that will tackle rising demand. This investment must not return to national bodies, the Department of Health or the Treasury, as has happened in the past.

NHS Confederation, Transforming local care: Community services rise to the challenge. March 2013
On a larger scale, more needs to be done to ensure that the right incentives are in place across the system. We need to incentivise better joint working, more focus on intervention and greater investment in community services, all of which would relieve the pressures on urgent and emergency care. The various payment systems, such as tariff, currencies and payment by results, have often been developed in an ad hoc way to address various issues and plug particular gaps across the system.

While this is understandable, we believe that the new NHS system which came on line in April 2013 represents an opportunity for Monitor and NHS England to take a more strategic approach toward incentives in the NHS as a whole. We urge them to develop incentives which will facilitate risk sharing across the system. As part of this, Monitor and NHS England will need to ensure that local leaders are given the freedom to assess what is needed in their area and the flexibility to develop local incentives.

Case study—The North West London Integrated Care Pilot (ICP)

The North West London Integrated Care Pilot (ICP) was launched in June 2011 and brings together more than 100 general practices, 2 acute care trusts, 5 primary care trusts, 2 mental health care trusts, 3 community health trusts, 5 local authorities, and 2 voluntary sector organizations (Age UK and Diabetes UK) to improve the coordination of care for a pilot population of 550,000 people.

The ICP was developed in response to variations in the quality of care and a rising deficit across the local health economy. The clinicians involved decided two areas of focus for integrated care: people older than 75 years and those with diabetes. These groups were experiencing a high level of avoidable admissions and variable care, there was known best practice and improved outcomes would be measurable.

The ICP developed a unique model of clinicians working together in multi-disciplinary groups within a multi-disciplinary system. The multi-disciplinary group (MDG) risk stratified the patients identified for the pilot, developed shared protocols for care across organisations, discussed these protocols and developed care plans with patients, mapped available care and addressed gaps in provision, introduced case conferences for patients with particularly complex needs or significant problems, and reviewed overall performance of the pilot.

£7m investment was provided by London SHA channelling the funds from the 30% marginal tariff on “excess” emergency admissions to hospital. This provided for an operational team, an information tool (to support risk stratification, care planning, sharing of medical information and evaluation), care coordination and incentive for providers to save.

Some benefits have been seen relatively early in the pilot, though it is anticipated the full benefits would become apparent over a 5-10 year timescale. Based on analysis of the impact to date, the ICP hopes to reduce emergency admissions for people over 75 with diabetes by 10%. Patients are also experiencing better coordinated care across different providers. The aspiration for the pilot is to scale up to the whole local population, focusing on the 20% that drive 80% of cost.

9. Redesigning Services

If we are to invest more in prevention and in services closer to home then NHS organisations will often need to redesign local services. In places it will be necessary to close some services or even possibly whole hospitals, with associated staff deployment, retraining or redundancy. In some cases evidence shows that concentrating certain services in specialist centres, such as stroke services in London, significantly improves safety and outcomes for patients. Again this may necessitate the closure of some local emergency departments. The NHS Confederation will shortly be publishing a report which will set out the reasons behind redesigning services and how we can overcome the obstacles to making the right of changes for patients. Below is a case study highlighting the value of centralising certain services.

Case study: Improving quality, safety and outcomes in stroke care

The London Stroke Strategy replaced 32 stroke units across the capital with eight hyper-acute stroke units as the first destination for anyone who has a stroke in the capital. After an initial 72 hours of specialist care, patients are transferred to their local hospital specialist stroke unit. Quality criteria apply to all of the stroke units in London, with the HASUs having to meet specific quality standards associated with delivering 24 hour emergency stroke care.

The model did require extra investment, but that investment has resulted in a reduction in overall costs across London as the average length of time patients stay in hospital has gone down. Early findings show impressive improvements in stroke care across the city, with an increase in the use of thrombolysis to a rate higher than any other major centre in the world and an overall fall in mortality rates across the capital.

We understand how important accident and emergency services are to local people so it is essential that patients, local communities, and their representatives—including local and national politicians—are properly engaged in this debate. Currently many people are sceptical that they will receive the same quality of care in the community as they will in their local hospital. We are calling on the Government, politicians and national NHS bodies to set out a vision for the future of community care. They must demonstrate how patients with
continuing conditions can benefit from being treated in a more convenient location and how this will take the pressure off urgent and emergency care.

9.3 The public are often only aware of the closure of hospital services and not of the subsequent investment in community services or at centralised specialist centres. They need to see that reconfiguration should be about moving care to the most appropriate setting, not cutting services. We recommend NHS organisations have the resources to run services alongside one another in the short term. This will allow patients to be gradually moved from hospital to a community setting.

9.4 Redesigning services requires investment. With central Government funding unlikely to significantly increase in coming years, the NHS will need to make best use of the money already available to it in order to invest in redesigning services. NHS organisations will need to consider redistributing existing funds (for example the 70% saved from the emergency tariff). They should also consider using some of the money currently held in contingency funds. NHS organisations will need to carefully balance the potential risk resulting from decreasing these funds with the urgent need to invest in better patient care.

9.5 Currently the way the health system is organised restricts the ability of local organisations to redesign services. NHS acute trusts are paid for their activity through the tariff while primary care and community care are paid through block contracts, which disincentivises activity. This difference in incentives is an obstacle to redesigning care which urgently needs to be addressed when Government and national bodies redevelop incentives as we outline above.

9.6 A period of stability in the NHS will be crucial in allowing local communities to come together, build strong relationships and develop sound, evidence-based proposals for change. We must avoid another disruptive, structural reorganisation of the health service and we strongly recommend a cross-party agreement on this issue, to ensure a significant period of stability in the future.

10. Legal Challenges Against Reconfiguration Proposals

10.1 There are many legal requirements governing how a reconfiguration should be carried out. It is right to ensure that a strong, transparent process is in place. The rigorous scrutiny from this can be helpful in strengthening proposals. This needs to be balanced against the potential loss of momentum, if changes are stalled by legal challenges. Our recent work on reconfiguration has shown that there is generally good guidance available for many of these obligations, but that strong project management by NHS organisations conducting reconfigurations is important to keep on track of them all. It is important for local NHS organisations to develop strong relationships with relevant bodies throughout the process to help deal with uncertainties as early a stage as possible.

10.2 Following the implementation of the Health and Social Care Act 2012, and the introduction of health and wellbeing boards, the role of local authority Overview and Scrutiny Boards in scrutinising reconfiguration proposals is unclear. We recommend NHS England issues guidance to provide clarity on this.

11 Challenges for Emergency Departments in Rural Areas

11.1 There are particular challenges for rural areas where the quality of urgent and emergency services vary. Again, lessons need to be learned from the good practice which exists across the country so these innovations can be more widely adopted by commissioners. Similarly community services and primary care (such as community pharmacies) can play a greater role in ensuring the health needs of rural communities are better met. In rural areas in particular it will be important for hospital trusts to link their work with local councils, whose public health role can help in managing demand.

11.2 There are also particular issues around staffing emergency departments in rural areas. Staff often cluster around large teaching hospitals and it can be difficult for NHS employers to attract and retain staff. This situation can impact on costs, with some rural services relying on expensive locums, and in turn this can make recruitment even harder. There is no silver bullet to this issue—solutions will need to be found which are appropriate to local areas.

About us

The NHS Confederation represents all types of organisations that commission and provide NHS services. It is the only membership body to bring together and speak on behalf of the whole of the NHS.

May 2013
Written evidence from the National Ambulance Commissioners Group (ES 18)

1. The National Ambulance Commissioners Group (NACG) is a forum for ambulance commissioners in England, formerly hosted by NHS Confederation and now hosted by NHS Clinical Commissioners (NHSCC). Members have primary responsibility for commissioning ambulance services in their areas, and include CCG representatives, clinical leads and experienced leaders of ambulance commissioning.

2. NACG herewith offers its response to the Health Select Committee's call for evidence on urgent and emergency care on the issues specific to ambulance services.

3. As an initial general comment, the introduction of NHS111, utilising the evidence based NHS Pathways and dispositions, offers a real opportunity to help to focus the role of different providers in the system, and will create an opportunity to review/consolidate the role of the ambulance service with other urgent mobile provision, such as GP out-of-hours and community nursing.

4. This could have a significant impact on the requirements for the urgent, rather than emergency aspects of the service.

5. This will need to be balanced against the need for a comprehensive emergency service with sufficient capacity to flex according to demand.

6. In response to specific issues raised by the Committee:

7. The prospects for better integration of ambulance services with primary care under the new commissioning regime established in April 2013
   (a) The new arrangements offer the opportunity but are not yet generally mature or informed enough to understand, plan and execute the necessary integration.
   (b) There is currently no requirement for emergency/urgent care networks to exist in each ambulance service “region”, and therefore there is not necessarily a vehicle in existence to really capitalise on the opportunities for integration. Nor is there a direct overlay between ambulance trust footprints and those of other providers of urgent care.
   (c) Emergency/urgent/out-of-hours care integration action boards (with appropriate sub-regional structures) should be mandated and include all providers—these may be led by ambulance commissioners, who have the oversight of the whole ambulance trust footprint.
   (d) In parallel, ambulance services should identify clear leadership with executive level ownership for urgent care integration and delivery.

8. The ability of ambulance services to continue to meet increased emergency demand whilst contributing to the Nicholson challenge
   (a) To be clear, there is much that can be done to more effectively process activity (the way in which a call is dealt with) through greater integration across the system; however, that will have only marginal impact on demand (the number of calls coming in to ambulance services in the first place). Currently most effort goes into handling activity better, not into reducing demand, which has risen continuously for decades.
   (b) To effectively tackle the issue of increasing demand there must be better and comprehensive sharing of the wealth of information held by ambulance trusts and other providers, in order to identify gaps in the whole healthcare system and to facilitate the appropriate mapping and remapping of care services in order to reduce the need or desire of the public to dial 999. There are a few examples of this being done effectively in local areas.
   (c) There is a critical need for an integrated approach to special patient notes/enhanced care records/anticipatory care plans to enable better management of patients likely to require care
   (d) This process then needs to be backed up by the political will and a major public education process to dissuade people from dialling 999 inappropriately. Current efforts to do so appear to have been ineffective, and the current difficulties with NHS 111 have hampered the potential opportunities of clarifying how the two services are best used.
   (e) If the issues of continuously rising demand are not tackled effectively, ambulance trusts will continue to increase in size and cost as they have done for the past twenty years or more.

9. The implications of the shift away from determining the success of ambulance services via indicators based on response time to the new measures designed to assess clinical effectiveness
   (a) Current time based standards may skew operational configuration and delivery to support RED1 standard compliance. It is also widely recognised that time based standards can impact on comparative performance between urban and rural areas.
   (b) Outcome measures should be prioritised over those relating to process but not at the expense of them. In reality, when assessing patient experience and safety, process and outcome are intrinsically linked. Clearly in some cases delay in initial response will make achievement of high performance against clinical effectiveness more challenging.
The introduction of Ambulance Clinical Quality Indicators (ACQIs) was intended to start a move towards clinically defined standards, however, that momentum now needs to be driven forward. The ACQIs are a useful adjunct to the time standards but cover such a small (albeit important) cadre of patients that are anyway also included in the RED response categories they may have little impact in changing clinical response across the spectrum of ambulance patients. They do however create an opportunity for improvement in training and work on pathways with other providers.

A much broader range of categories of ambulance patient response need to systematically have ACQIs applied to them and have best/acceptable practice parameters defined. This would facilitate a major reduction in the application of “artificial” time standards.

A joint DH/commissioner/ambulance trusts group should be established to consider, prepare, recommend and implement patient experience/clinically focused performance standards for ambulance trusts.

The causes of delays in handover from ambulances services to A&E or transfer between different levels of urgent care, and actions required to eliminate them

There is now a great deal of work going on nationally to address this issue, fuelled by new contract penalties. Solutions rely on intelligent collaboration between ambulance trusts and acute units, but also collaboration across whole system to address underlying patient flows.

NACG, Ambulance Service Network, Associate of Ambulance Chief Executives and the Hospitals Network recently jointly published a briefing document, Zero Tolerance: making ambulance handover delays a thing of the past, which is receiving positive feedback as a valuable resource for addressing the issue of turnaround times.

Written evidence from Association of Ambulance Chief Executives (ES 19)

Summary

The Association of Ambulance Chief Executives (AACE) provides ambulance services with an organisation that influences, supports, co-ordinates and implements nationally agreed policy. It also provides the general public and other stakeholders with a central source of information about NHS ambulance services. AACE’s primary focus is the ongoing development of the English ambulance service and the improvement of patient care.

The Health Select Committee’s inquiry into emergency services and emergency care is welcomed by the AACE. The AACE is pleased to outline its thinking in the areas covered, a summary of which is provided below:

- New commissioning arrangements provide an opportunity for:
  - enhanced integration of emergency and primary and community care, building on current close-working
  - exploration of new and different ways in which the ambulance service can contribute to the wider health system
  - more strategic commissioning of integrated services
- The ambulance service is a key enabler in maximising opportunities to manage demand and increase efficiency; the sector must be embraced as part of the solution to the problem rather than being viewed as part of the problem
- In light of the implementation issues experienced with the NHS 111 service to date, the AACE advocates serious re-consideration of the current arrangements including commissioning
- The AACE fully supports the shift from response time to clinical effectiveness indicators; however, to fully maximise the impact of this, careful consideration should be given to both the benefits and disadvantages of clinical outcomes assuming the position of core performance measure, and Ambulance Clinical Quality Indicators (ACQIs) featuring in the national NHS Provider contract
- There are a multitude of reasons for delays in ambulance to A&E handovers, which the ambulance service is well-placed to advise upon and is proactively seeking to tackle

1. Role of community and primary care in delivery of emergency healthcare; appropriate structure to meet demands of different geographical areas

New commissioning arrangements have the potential to facilitate enhanced integration of emergency, primary and community care. Clinical Commissioning Groups (CCGs) should seek more seamless care provision to improve the patient experience whilst reducing costs (for example, unnecessary A&E admissions).

Commissioning arrangements should be strengthened with more comprehensive Directories of Services and patient pathways, utilised during the day and out-of-hours.

Close working between emergency and community and primary care services already exists. West Midlands Ambulance Service (WMAS) operates community paramedic schemes, which form a central component of its operating model and involve close working with general practitioners (GPs) in relation to patient pathways and identification of gaps in provision. Alongside community and primary care practitioners, ambulance services play a crucial part in the delivery of high quality end-of-life care and in enabling people to achieve what they would consider a good death, as recognised in the Department of Health’s End of Life Care Strategy (2008). The AACE is highly supportive of this integration across emergency and primary and community care, and its expansion where both patient benefit can be derived and cross-system efficiencies gained.

Other opportunities that should be explored include: utilising GP surgeries as potential “hubs” for voluntary community first responder schemes in a collaborative and complementary fashion with the ambulance service; and community and primary care services acting together with the ambulance service to better inform and educate communities about emergency healthcare, including cardiopulmonary resuscitation, to achieve an integrated and holistic response for rural communities. In order for ambulance services to continue to deliver more care in the community and home setting, the local network of community services needs to keep pace and be aligned with the developments in the ambulance service and vice versa; otherwise, opportunities, particularly in rural areas, will continue to be limited.

2. Moving minor injury and urgent care services out of A&E and into community: range, severity and incidence of conditions that can be treated within A&E but not an urgent care centre

Minor injury and urgent care centres serve a useful purpose and can help to ease pressure on A&E; they are best located where need is greatest, which in some instances will be in more accessible community settings. Alongside other health professionals, paramedics are well-placed to participate in the provision of minor injury and urgent care given their triaging and treatment skills. In some areas of England, there is, unfortunately, evidence of enhanced primary and community service provision being reversed. For example, all walk-in-centres across Manchester have been closed over the last 12 months whilst a considerable number of urgent care centre facilities are now located at the front door of A&E departments.

A significant proportion of conditions can be dealt with competently at a well-staffed, equipped minor injury and urgent care centre; examples of those that cannot include conditions requiring a paediatrician, obstetrician or anaesthetist. The major difficulty presented is determining the suitability of an urgent care centre for a patient’s medical needs without the benefit of diagnostic equipment. Experience gained in existing urgent care centres should be sought to help address this.

3. Better integration of ambulance services with primary care under new commissioning regime


However, this commitment and support is underpinned by a number of concerns. Firstly, 2013/14 feels very much like a “transitional year” as CCGs establish themselves and decide what contractual arrangements will exist in the future for ambulance services. Secondly, as CCGs have a different footprint to ambulance services, a system-wide approach is necessary to join up commissioning arrangements, service delivery and funding to support the delivery of integrated care across the whole health system. Finally, whilst the provision of emergency ambulance care is commissioned by CCGs, primary care is commissioned by Local Area Teams. This adds a further layer of complexity to enhanced integration of commissioning and delivery of emergency, urgent and primary care. CCGs must commission collaboratively when appropriate to achieve economies of scale whilst providing a higher performing urgent and emergency care service, particularly in rural settings.

Changes in commissioning arrangements also present a number of opportunities, which ambulance services can play a central role in maximising. The presence of GPs has enhanced the clinical focus at the contract table. The AACE and its member organisations are optimistic that this will shift the focus of future commissioning debate creating opportunities to explore new and different ways in which the ambulance service can contribute to the wider health system. Developments are already being identified locally by ambulance services that can be taken forward in conjunction with primary care. For example, South West Ambulance Service Foundation Trust (SWASFT) is providing an “in-hours” visiting service on behalf of GPs, packages of care, urgent care triage etc, which are all designed to better support the urgent care pathway.

The new commissioning regime provides an opportunity to embrace more strategic commissioning of integrated services. The focus should shift from commissioning the cheapest provider of individual parts of the pathway to consideration of integrated partnership solutions to urgent and emergency care pathways in their entirety. There is considerable scope to reduce duplication and waste, and subsequently cost, whilst significantly improving the provision of joined-up and streamlined services.
4. Ability of ambulance services to continue to meet increased demand whilst contributing to the Nicholson Challenge

The ambulance service is a key enabler in maximising opportunities to manage demand and increase efficiency. Ambulance services are exceptionally well placed to understand the causes of increasing demand and to develop solutions to co-ordinate a proportionate response. Huge increases in demand have been experienced nationally. In 2011/12, the total number of emergency calls was 8.49 million; this was an increase of 415,487 (5.1%) over 2010/11 when there were 8.08 million (www.hscic.gov.uk). Considerable investigation has been undertaken by services locally to understand patterns and changes, which the AACE will build on in an imminent demand management project focused on identifying national trends and determining solutions.

Ambulance services have repeatedly demonstrated their ability to become more efficient whilst saving money, and are committed to the continuation of this through investment in technology, training and transformational change. Utilisation rates are high for staff and vehicles, whilst back-office costs are low when compared to the broader NHS. Reductions in hospital conveyance rates have been achieved consistently over recent years. In 2009/10, 1.60 million patients were treated at the scene and did not need onward transportation; in 2010/11, this increased to 1.76 million; and in 2011/12, 1.81 million (www.hscic.gov.uk). However, this will not continue indefinitely, given the appropriateness of hospital for a significant proportion of patients, and will only be a sustainable trend if emergency capacity does not reduce alongside ongoing demand increases.

Contributing to the Nicholson Challenge in the context of ever-increasing levels of demand certainly presents a major challenge for the ambulance sector. However, the AACE strongly advocates that the sector is embraced as part of the solution to the problem. The ambulance service has the potential to further reduce hospital attendances and admissions through better trained and equipped paramedics delivering more comprehensive care in the community. To fully realise the benefits of this, additional investment will be required. This investment would drive efficiencies in the overall system whilst enhancing the delivery of timely, appropriate care to patients. Unless demand is matched with growth in funding, the ambulance service’s ability to continue to deliver efficiencies at the pace required will be severely limited, particularly given that this will increasingly require fundamental changes to service delivery.

5. Transition from NHS Direct to NHS 111

NHS 111’s recent rollout has seen a mixed reaction, which has been driven by a combination of poor operational performance from some providers leading to significant adverse media fuelled by the inappropriateness of responses. This has been compounded by a significant shortfall in some providers meeting the core performance call-answering metric and high abandonment rates.

Continuing poor and inappropriate performance has the potential to harm public confidence in the 111 service before it has had the opportunity to become a credible offering and is fully embedded. There is now a real and immediate opportunity for the Department of Health/NHS England to act quickly to resolve the continued unease around 111. The arrangements should be reviewed in order to restore public confidence.

Were the ambulance service to assume a more significant role in national 111 provision, the potential benefits would include: confidence in a universally recognised professional, experienced and capable function; whole system effectiveness and value for money; and appropriate management of demand across the urgent and emergency care system. The ambulance service is already held in high regard by the public and is uniquely placed to potentially deliver NHS 111 to ensure high quality service provision for patients and cost effectiveness across urgent and emergency care.

6. Shift from indicators based on response time to clinical effectiveness

The AACE supports the shift to clinical indicators and the drive to promote consistency across the sector. It advocates the simultaneous maintenance of response-time targets, however, because of the value they add as a determinant of outcome and patient experience. There is potential scope for the removal of response-time targets to have a profound impact upon resource efficiency and clinical outcomes. Prior to any move in this direction, comprehensive research and extensive interrogation of the overall impact upon patients is strongly urged.

The commissioning, contract negotiation, management and regulation of ambulance foundation trusts is currently underpinned by a focus upon response times. There has been some move towards combining this with shadow currencies for activity growth in “hear and treat”, “see and treat” and “see and convey”. Thresholds for ACQIs are still agreed and performance-managed by commissioners locally, however. A fundamental shift away from response times to more outcome-based measures would need to see ACQIs featured in the national contract with the standardisation of thresholds for each ACQI to ensure consistency of measurement across all services.

7. Causes of delays in ambulance to A&E handovers or transfers within urgent care

Delays are a major everyday issue for ambulance services. The causes are multi-faceted and vary from hospital to hospital, and health system to health system. Examples include: ownership by hospital/health system leaders; A&E capacity; A&E integration with the rest of the hospital; timeliness of in-Trust escalation;
reductions in physical bed capacity within hospitals and the community; attitude and behaviour towards handover delays within the hospital; and the effectiveness of urgent care pathways keeping demand away from the front door.

Ambulance services are well-placed to provide a range of timely data in relation to handover delays, however, identifying the “softer” issues, such as senior leadership, ownership and operational grip is more problematic. The successful addressing of ambulance to A&E handovers in the past has largely been attributable to strong relationships between clinicians and managers in the hospital and the ambulance service.

Recently, ambulance services have trialled a range of new approaches to deal with the issues faced. These include revision of local hospital handover delay arrangements to include an appendum to the handover escalation protocols (SWASFT); a number of summits for all NHS directors and operational leads across geographical areas to discuss the issues and short and longer term solutions; and the establishment of a local turnaround collaborative in Yorkshire. The introduction of penalties for hospitals failing to manage handover/turnaround activities is likely to improve issues in the short-term, but longer-term solutions will require an assessment of local healthcare provision capacity and demand across emergency and urgent care.

8. Clinical evidence about specialist regional centre outcomes compared with more generalist hospital based services; aspects of care likely to improve if moved to specialist regional centres

There is good evidence of the positive impact of specialist regional centres upon clinical outcomes, including trauma, stroke and STEM1. This has driven the development of vascular centres and current consideration of cardiac arrest centres. If 24-hour-a-day staffing by experienced, competent professionals is to be ensured, there is a requirement for realignment of generalist hospital-based services as more specialist regional centres are introduced.

9. Effectiveness of existing consultation process for incorporating views of local communities into A&E service design

A&E service design often presents too emotive a subject for constructive dialogue to be of value. Processes are reportedly fragmented, bureaucratic and complex. Particular regard needs to be paid to the use of social media and the use of alternative consultation channels to access a broader spectrum of views, including those of young people.

10. Ability of local authorities to challenge local proposals for reconfiguration under revised oversight and scrutiny powers included in Health and Social Care Act 2012

It is still too soon for this to be tested given the very recent introduction of the legislation. However, local authority powers seem appropriate to challenge and review proposed reconfiguration proposals. Local government needs to ensure that the challenge of local versus regional priorities is balanced.

May 2013

Supplementary written evidence from the Association of Ambulance Chief Executives (ES 19A)

It was a pleasure to be able to provide you with my oral evidence at the Health Select Committee of 4 June 2013, and I hope you find the information of help to you and other MPs. As promised, please find attached three pieces of information which Mark Docherty and I agreed to share with the Committee:

— Impact of Serious Incident upon conveyance rates of patients to hospital by ambulance crews following media coverage.
— Workforce skill mix in Ambulance Services.
— Evidence of multiple services working together.

I feel it is really important to also reinforce that the Ambulance Service nationally sees itself as part of the solution to the difficulties currently being experienced within the Urgent Health care system and would very much like to progress some of the good work being undertaken in certain areas across England. However the ability to be able to provide such solutions would be greatly improved with some new innovations to assist progress, for example:

— Access to the NHS Information spine to assist Paramedic clinical decision making.
— Further advanced training for Paramedics.
— Wider access and integration with Out of Hours Services and NHS 111.

The ambulance service is fortunate to be held in such high regard by the general public, and as such this will provide public confidence to the communities we serve with developments as we move forward.
There are already large scale initiatives taking place to drive efficiencies within ambulance services, some of which may be better appreciated when viewed personally.

Anthony C Marsh
Chair, Association of Ambulance Chief Executives
14 June 2013

Annex

IMPACT OF SERIOUS INCIDENT REPORTED BY THE MEDIA (A LONDON EXAMPLE)

28 January 2011 Last updated at 20:06

Ambulance crew suspended over Sarah Mulenga death

Two London Ambulance Service (LAS) Staff have been suspended following the death of a 21-year-old woman they were sent to treat in east London.

Sarah Mulenga, who suffered from sickle cell anaemia, fell ill at her home in Barking on 9 January.

Her landlady said an ambulance crew refused to take her to hospital and other paramedics had to be called.

Miss Mulenga died after her condition deteriorated.

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Conveyance rates prior to incident average at 77%.

Incident happens on 9 January 2011—In the month of the incident, conveyance rates increase to 79.7%.

Conveyance rates peak two months later at 82% (at this point it goes out of the Statistical control limit, so is a significant variation).

After three months, the conveyance rates come back within normal variance.

EVIDENCE OF MULTIPLE SERVICES WORKING TOGETHER—BIRMINGHAM MENTAL HEALTH SERVICES

The Birmingham and Solihull Mental Health Foundation Trust Rapid Assessment, Interface and Discharge (RAID) model was the first of its kind in the UK and ensures patients get help for mental and physical health at the same time—delivering all the care that people need, when they need it in Birmingham’s acute hospitals.

45 http://www.bbc.co.uk/news/uk-england-london-12310658
The government's mental health strategy, No Health Without Mental Health, recognises that mental wellbeing is closely linked to physical health—and the need for mental health awareness to be raised in primary care and acute hospital settings.

Recent research and guidance highlights how important it is for acute hospitals to address the needs of patients who self-harm or misuse substances, recognise the impact of conditions like depression and dementia, and those who present as complex cases with both physical and mental illness, which often result in repeat admissions to acute care.

RAID is a great example of how this new strategy works in Birmingham. The RAID team assesses and treats patients aged over 16, who present at A&E or are already inpatients; getting them the help they need, regardless of age, locality, complaint, severity or time of presentation.

The key to RAID's model is to see everyone referred from A&E within an hour, and all others within 24 hours. This means care for people with mental health problems is initiated early and problems are dealt with swiftly. Staff in the RAID team provide tailored interventions, signposting, follow-up clinic appointments and onward referrals to GPs, and third sector organisations that have been set up to provide on-going help in the community.

Ambulance and hospital staff also receive training on mental health awareness and interventions. This leads to improvements in their practice, in turn improving patient experience, with better detection, diagnosis and therefore earlier treatment.

Now when a patient arrives at the hospital, the RAID team is alerted to provide an assessment prior to admission. The model has shown clear benefits in service delivery, increasing staff and patient satisfaction, rapid response times, delivering high cost savings while improving overall quality.

RAID's primary aim was to streamline the patient journey. In achieving this, RAID has had a positive effect on traditional winter pressures, by reducing length of stay and the number of readmissions.

The number of older adults seen by RAID, who had come from their own home and returned there, almost doubled with 80% returning home compared to 47% pre-RAID.

The team specialises in working with older people with mental health problems, who are embedded in the acute hospital through RAID, can support other professionals to jointly manage the potential risks of discharge and facilitate rapid access to specialist community support.

The close working relationship between the Ambulance service, staff in A&E, the RAID team and the trust's community-based teams, ensures the patient's journey from assessment to treatment is a smooth, straightforward one.

Written evidence from the Royal College of General Practitioners (ES 42)

The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care.

1. Overview

1.1 We welcome the opportunity to contribute to this Inquiry. Patients accessing out of hours, urgent and emergency care are often doing so when they are at their most frightened and vulnerable, and it is vital that health and social care professionals work together to ensure that they receive the right care, in the right place, and at the right time.

1.2 We have the following key points to contribute to this Inquiry:

- We urge the Committee to focus attention on the need for a “whole system” approach to meeting the challenges facing urgent and emergency care, and to move the debate on from “blaming” any one part of this system, as some of the recent media coverage focusing on general practice has sought to do.

- There is no evidence to support the claim that problems within general practice—either in or out of hours—are the cause of the recent additional pressures we have seen in A&Es. GPs should not be seen as part of the “problem” but will be essential to finding a long term solution to improving urgent and emergency patient care.

- GP out of hours services are well regarded by patients who use them and their performance has been shown to be improving. We must move on from debate about the 2004 GP contract and focus on how we can continue to improve GP OOH services and ensure patients are more effectively signposted towards them.

With this in mind, it is disappointing that the implementation of NHS 111 has met with so many problems. Some areas—particularly those run by GP-led social enterprises—have struggled, with increased pressure on existing services.

Rising numbers of patients—often frail and elderly people—are living with multiple long term conditions, and this is placing additional strain on the system as a whole. General practice is facing its own workforce and workload crisis, and in recent years has seen a real terms drop in funding.

We need to redesign services in a way that delivers better integrated urgent and emergency care, including better coordination between the NHS and social care, and promotes more effective self care. Part of this solution must be a shift in investment towards primary care. We also need to avoid raiding the NHS budget to plugs gaps in social care, although with the right safeguards locally agreed budget pooling may deliver more integrated services.

2. Analyzing the Pressures Facing A&E

2.1 Significant public debate has focused in recent weeks on challenges facing A&E departments. Whilst this is an important issue in itself, it must be considered in the context of pressures impacting on the NHS as a whole, both in and out of hours. The factors behind these pressures are complex.

2.2 Whilst overall A&E attendances have risen in the last ten years, the majority of this increase has taken place not in emergency departments, but in Walk in Centres (WICs) and Minor Injury Units (MIUs)—many of which are actually staffed by GPs. Emergency Department attendances have remained relatively stable over this period (rising by around 1-3%) whilst attendances at WICs and MIUs have risen by around 15%. This strongly suggests that an increase in supply (with the introduction of WICs and MIUs) has led to a corresponding increase in demand. We should also be careful about assuming that A&E attendances are constantly increasing; NHS England’s May 2013 A&E Improvement plan notes that total A&E attendances in Q4 of 2012-13 were actually 1.7% lower than the previous Q4.

2.3 In the meantime, the number of acute hospital admissions from A&E have been rising much more rapidly—by around 40% between 2003-04 and 2010-11. This suggests that issues around patient flow within hospitals, including potential unintended consequences of the four hour waiting target, and capacity issues within Emergency Departments are important factors.

3. The Role of General Practice

3.1 Around 90% of patient contact with the NHS—much of which can be classed as “urgent”—takes place in primary care, with GPs dealing with around 300 million consultations annually (based on 2005-2006 activity data published in 2008). GPs’ generalist training means they are ideally placed to support patients with complex needs—such as those living with long term conditions—in the community. General practice can and does play an important role in preventing unnecessary hospital admissions by supporting patients to manage their care in the community.

3.2 However, we have seen no evidence to back the claim that failures in general practice are driving the problems facing A&E at the moment. Rather, we are seeing the effects of rising pressure across the system, caused by a complex set of factors including the UK’s ageing population and the increasing numbers of patients living with multiple long term conditions. It is estimated that by 2025 the number of people in England with at least one long term condition will rise by 3 million to 18 million. In its analysis of the current challenges facing A&E, NHS England has noted that: “There is general consensus (though it is hard to identify the evidence) that patients presenting are more ill and hence more likely to need admission and have longer stays.”

This trend towards increasing complexity of care is being seen across the NHS—causing capacity issues in general practice, A&E and social care in particular.

3.3 As a consequence, general practice is currently facing a workload and workforce crisis. The number of patient consultations rose by 7%, from 171 million to more than 300 million between 1995 and 2008. For the average patient, the number of consultations per year rose from 3.9 in 1995 to 5.5 in 2008, with the biggest increases taking place amongst the over 70s. The Centre for Workforce Intelligence (CFWI) and the King’s Fund have concluded that “the existing GP workforce has insufficient capacity to meet the current and expected patient needs.”

These problems have been exacerbated by underinvestment in general practice in recent years, with just 9% of...
the NHS budget in England being spent on general practice in 2010–11 (compared to 47% spent on A&E and acute care, 19% on other secondary care such as maternity and mental health, and 10% on community care).

3.4 Despite these challenges, patient satisfaction with GPs remains high, and has been consistently higher (74% in the latest British Social Care survey published earlier this year) than satisfaction with A&E services (59% in the same survey).

4. OUT OF HOURS GP SERVICES

4.1 GP out of hours services are well regarded by the patients who use them. According to the GP Patient Survey most patients (71%) say their overall experience was good, with three in ten (31%) saying it was “very” good. Furthermore, 82% of patients say that they “definitely” or “to some extent” have confidence and trust in their out-of-hours clinician. A Primary Care Foundation benchmarking report in 2012 found that “the overall performance of out of hours services is improving... the performance on the most difficult measure of time to definitive clinical assessment is rising.”

4.2 Changes to the GP contract introduced in 2004 transferred responsibility for ensuring that OOH cover is provided to (then) PCTs. This brought an end to an unsustainable situation in which GPs were overstretched, often to the detriment of their own health. The 2004 contract is not in any way responsible for pressures facing A&E over a decade later. There were over 8.5 million calls to GP OOH services in 2007-08 and these services (around half of which are social enterprises run by local GPs) have continued to provide care to patients out of hours across the country.

4.3 However, evidence suggests that not enough patients are aware of the services provided by GPs out of hours, with 42% saying that they don’t know how to contact their local service. This reflects the fact that many patients seeking urgent and emergency care are faced with a range of often confusing and fragmented options. The need for more effective signposting of services was one of the aims behind the introduction of NHS 111, but there have been well-publicised problems with the implementation of this service in many parts of the country (see section 5 below).

4.4 We need to focus on supporting GP out of hours services to continue to improve the care they provide to patients. We also need to look carefully at how these services are commissioned, and how we can ensure they are integrated more effectively with the system as a whole, both in and out of hours. RCGP is concerned that with CCG funding severely restricted, in future social enterprise providers led by local GPs will increasingly find themselves priced out of the market by commercial providers.

5. NHS 111

5.1 NHS 111 must be more effectively supported if it is going to properly direct patients to the most appropriate form of urgent NHS care. The implementation problems of the NHS 111 service are extremely worrying and we are concerned that patients are losing confidence in the new service before it is even fully up and running. The RCGP has also called on NHS England to provide more reassurance about its effectiveness and ability to deliver the necessary standards of care for all patients using the service.

5.2 We believe the overarching principle behind NHS 111—providing patients with a memorable number they can call to access urgent and emergency care services that is “less urgent” than calling 999—is a good idea. If properly implemented, NHS 111 has the potential to make it easier for patients to get “the right care, in the right place, at the right time from the right care professional”. This approach is supported in the RCGP’s Commissioning Guide: Urgent and emergency care: a “whole system” approach.

5.3 In many areas where there have been problems with NHS 111 implementation it has been GP out of hours services which have “picked up the pieces” and ensured that safe care is delivered. Whilst GP-led social enterprises have won some NHS 111 contracts, many have been unable to compete on cost with NHS Direct and commercial providers. RCGP would like to see a move towards more NHS 111 services being provided by local GPs in this way.

5.4 In RCGP’s view NHS 111 was rolled out far too early, with unnecessary pressure placed on some sites to go live before they were ready. We are also concerned about how the service itself is being run—some areas seem to be properly resourced with well-trained clinical staff whilst in other areas it is struggling to cope with insufficient numbers of call handlers, some of whom have received only a few weeks training.

7. A “Whole System” Approach

To successfully meet the challenges of delivering urgent and emergency care in the 21st century NHS we must redesign services based on a “whole system” approach, more effectively integrating care across different parts of the system, and between in and out of hours care. Key elements of this will be:

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34 GP Patient Survey
35 Primary Care Foundation Benchmark Report, April 2012 http://www.primarycarefoundation.co.uk/files/PrimaryCareFoundation/Benchmark4reports/Benchmarkoverview.pdf
36 GP Patient Survey
— **Shifting investment towards primary care**: As noted above, a disproportionately small amount of the NHS budget is spent on general practice, and if current trends continue this will further drop by nearly £200 million in the next three years. In particular we need to focus this investment on increasing the GP workforce, which in turn would enable GPs to spend more time with patients—such as those living with multiple morbidities—who require complex care. The standard 10 minute consultation is not long enough to deliver “anticipatory” care which will help avoid unnecessary hospital admissions. There is also a significant gap in the data around GP capacity and workload—the latest substantive evidence on GP activity and workload is from a Health and Social Care Information Centre (HSCIC) report on consultation rates from 1995 to 2009 and the 2006–07 UK GP Workload Survey. This needs to be rectified urgently.

— **Embedding a multi-disciplinary “care planning” approach within primary care**, with GPs working alongside other health professionals to support patients with long term conditions to self-manage their care. We must move away from reactively treating individual episodes of illness—often in secondary care settings—to better anticipating patients’ needs by planning and managing long term care in the community. Key to this approach is patient empowerment through the promotion of shared decision making and self care, putting patients in control. Major trauma and hyper-acute services should continue to be focussed at dedicated centres with sufficient infrastructure, whilst “urgent” (as opposed to “emergency”) healthcare needs to be developed locally, underpinned by models of primary care working with community services.

— **Improving the interface between primary, secondary care and social care**: Part of the solution in addressing the current difficulties around emergency care is to strengthen the interface between primary care and A&E. There are challenges around discharge planning, shared access to patient records and ensuring A&E departments are aware of services available in the community. This is especially important for vulnerable patients such as the frail elderly, for whom the greater continuity of care and integration of services that general practice can offer are particularly important.

— **Greater integration with ambulance services**: We should work towards greater integration of ambulance services within the system as a whole, including with general practice services both in and out of hours. Ambulance services should continue to develop alternative care pathways, offering treatment and transfer to a range of clinical services without the need to take patients to A&E. Local CCGs could also benefit from more data intelligence from the ambulance service, for example in the identification of particular nursing homes and/or post code areas with high call out rates.

— **Building confidence and awareness of NHS 111**: Part of the problem facing the current urgent and emergency care system is that patients are faced with a fragmented range of options. In principle, NHS 111 has the potential to provide patients with a single, clear access point as an alternative to calling 999. However, due to the problems with its implementation so far in some parts of the country patients do not currently have confidence in the system.

**June 2013**

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**Supplementary written evidence from the Local Government Association (ES 43)**

During our evidence session Andrew Webster stated that although delayed discharges from hospital into social care can be a problem they are, in fact, going down and delayed discharges “attributable to social care are going down faster than those that are attributable to things in the health system.”

The evidence we used for this statement can be found in the report “Delayed Transfers of Care: Statistics for England 2012/13” published in May 2013.

The specific points in the report are as follows:

— On delayed discharge going down
  
  “In 2012–13, the daily average number of delayed transfers of care per 100,000 population (aged 18+) was 9.5, which compares to 9.7 in 2011–12.”

— On delays attributable to local government going down
  
  “In 2012–13 the daily average number of delayed transfers of care attributable to social care per 100,000 population was 3.3, which compares with 3.7 in 2011–12.”

There is additional information available in the “Statistical Press Notice: Monthly Critical Care Beds, Cancelled Urgent Operations, Delayed Transfers of Care Data, England April 2013.”

This report shows that:
— “There were 112,994 total delayed days during the month, of which 70,028 were acute. 68% of all delays were attributable to the NHS, 26% were attributable to Social Care and 6%, where both agencies were responsible”

— “The distribution of delays has been changing gradually over the past 12 months. Delays attributable to the NHS now account for 68% of all delays compared to 63% in April 2012”.

26 June 2013