



House of Commons
Committee of Public Accounts

Emergency admissions to hospital

Forty-sixth Report of Session 2013–14

*Report, together with formal minutes, oral and
written evidence*

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Committee of Public Accounts

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Committee staff

The current staff of the Committee is Sarah Petit (Clerk), Claire Cozens (Committee Specialist), James McQuade (Senior Committee Assistant), Ian Blair and Jacqui Cooksey (Committee Assistants) and Janet Coull Trisic (Media Officer).

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Summary

Many hospitals are struggling to cope with increasing levels of demand for accident and emergency (A&E) services when budgets are coming under increasing pressure. Bed occupancy rates across hospitals continue to rise year-on-year and the ambulance service is also under stress. While all parts of the health system have a role to play in reducing avoidable emergency admissions and helping to manage more effectively those people who are admitted to hospital, financial incentives across the system are not aligned so attempts to ensure patients are treated without coming to accident and emergency departments are not yet working. The improvement of A&E services is hampered by the lack of specialist A&E consultants, the slow introduction of round-the-clock consultant cover in hospitals and a lack of quality performance data. Accountability and responsibility for driving the changes needed remain diffuse and unclear. Without this clarity, the service transformation vital to coping with constrained NHS budgets will not be achieved in the necessary timescale.

Conclusions and recommendations

1. In 2012-13, there were 5.3 million emergency admissions to hospitals, an increase of 47% over the last 15 years. Two thirds of hospital beds are occupied by people admitted as emergencies and the cost is approximately £12.5 billion. NHS trusts and NHS foundation trusts, primary, community and social care and ambulance services work together to deliver urgent care services. Since April 2013, A&E services have been commissioned by clinical commissioning groups, which are overseen by NHS England. However, it is the Department of Health (the Department) that is ultimately responsible for securing value for money for this spending.
2. **It is not clear who is accountable for the performance of local urgent and emergency care systems, and for intervening when local provision is not working effectively.** The Department accepts that it has overall responsibility for the urgent and emergency care system. But it discharges its duties through various arms-length bodies, and both the Department and NHS England struggled to explain to us who is ultimately accountable for the efficient delivery of local A&E services and for intervening when there are problems. Delivery is fragmented, and the health sector does not consistently work together in a cohesive way to secure savings, better value and a better service for patients. Urgent care working groups, which have been established to create better integration, have no powers and are overly reliant on the good will of all those involved. A tripartite group, accountable to the Department and comprising NHS England, Monitor and the Trust Development Authority, is intended to oversee the performance of various aspects of the urgent and emergency care system, including urgent care working groups. However, it is unclear under what circumstances the tripartite group would intervene at a local level.

Recommendation: *In response to this report, we expect the Department to:*

- *Confirm that it is responsible for the overall performance of urgent and emergency care; and*
 - *Set out how it will challenge local performance, step in when this performance is substandard and enforce beneficial local changes to save money and provide a better service when local agreement cannot be reached.*
3. **Financial incentives across the system are not aligned, which undermines the coordination of care across the system.** All parts of the health system have a role to play in reducing emergency admissions, including providers of social, community, primary and secondary care. However the financial incentives to limit A&E admissions are not working across the whole system. Hospitals get no money if patients are readmitted within 30 days and a reduced rate if they admit patients above an agreed limit, but there are no financial incentives for community and social care services to reduce emergency admissions. A new 'year of care' funding model is being piloted that aims to promote the integration of services for patients with long-term conditions by providing funding per head of population for the totality of their care, both in and out of hospital. From April 2015, the £3.8 billion Better Care Fund is intended to ensure better integration between health and social care. However, £2

billion of this funding will have to come from additional NHS savings, mainly in the acute sector, on top of the 4% savings the NHS already needs to make in 2015-16.

Recommendation: *The Department, NHS England and Monitor should review the overall system for funding urgent and emergency care, including the impact of the 'year of care' funding, to ensure that incentives for all organisations are coherent and aligned.*

4. **Neither the Department nor NHS England has a clear strategy for tackling the chronic shortage of A&E consultants.** Many hospitals, and especially those facing the greatest challenges, struggle to fill vacant posts for A&E consultants. There is too great a reliance on temporary staff to fill gaps, which is expensive and does not offer the same quality of service. The Department told us that it was working with the College of Emergency Medicine and Health Education England to increase the supply of emergency medicine doctors. Solutions may include the greater use in A&E of consultants from other departments, mandating that all trainee consultants spend time in A&E, making A&E positions more attractive through improved terms and conditions, and providing financial incentives for consultants to work in more challenging hospitals. But we are not convinced that the Department has a clear vision of how to address either the immediate or longer term shortage of A&E consultants.

Recommendation: *The Department and NHS England should urgently develop and implement a strategy which considers all available options and addresses the immediate and longer term shortages of A&E consultants.*

5. **We are not convinced that additional funding from the Department to support A&E services during winter has been used to best effect.** Trusts receive additional funding from the Department to support the additional workload they face in winter. The Department allocated £250 million to help 53 struggling urgent and emergency care systems prepare for winter in September 2013, and further funding of £150 million was announced in November 2013. The Department acknowledged that the allocation of this funding so close to winter was not ideal as it means that hospitals cannot plan ahead and instead resort to more expensive temporary solutions, such as engaging agency staff to meet demand. The Department plans to release the £250 million winter fund for 2014-15 in the first quarter of that year. However, the Department said it was difficult to assess where the money could best be allocated to address real need rather than rewarding failure.

Recommendation: *The Department should evaluate promptly the impact of additional winter pressure money allocated for 2013-14 and the timing of when the money became available, and use this analysis to inform the early and effective allocation of this fund in 2014-15.*

6. **We welcome the proposed shift to 24/7 consultant cover in hospitals, but are concerned about the slow pace of implementation and the lack of clarity over affordability.** The introduction of round-the-clock consultancy care will start with A&E services, but will not be in place before the end of 2016-17. Round-the-clock hospital services are intended to reduce weekend mortality rates and make more

efficient use of NHS assets and facilities. However, its implementation will rely on the British Medical Association and NHS Employers negotiating a more flexible consultants' contract, and neither the Department nor NHS England has direct control over the timescale or details of these negotiations. The Department and NHS England are also uncertain about the likely costs of moving to 24/7 consultant cover, which early evidence suggests could increase hospital running costs by up to 2%.

Recommendation: *The Department should act with urgency to establish the costs and affordability of this measure and develop a clear implementation plan.*

7. **Commissioners and urgent care working groups lack the quality data needed to manage the emergency care system more effectively.** Those who manage urgent and emergency care services need a clear understanding of demand, activity and capacity across the system. However, performance management is hampered by poor quality data. For example, the NAO reported concerns that the current measure for delayed discharges from hospitals to social care does not accurately reflect the scale of the problem, and figures for the time spent by patients in ambulances upon arrival at hospital before being handed over to A&E departments are not reported consistently. In addition, information across local urgent and emergency care services is not available in one place so that the public can easily make comparisons and hold their local organisations to account.

Recommendation: *NHS England should ensure that reliable information is available across the urgent and emergency care system and that local information is published collectively in one place.*

1 Oversight and responsibility for urgent and emergency care

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health (the Department) and NHS England about emergency admissions to hospitals in England.¹ The number of emergency admissions continues to rise at a time when NHS budgets are under significant pressure. Between 2000-01 and 2011-12 the rate of increase has been much higher in England than in Wales, Scotland and Northern Ireland. In 2012-13, there were 5.3 million emergency admissions in England, an increase of 47% over the last 15 years. These admissions accounted for around 67% of hospital bed days in England, and cost approximately £12.5 billion.²

2. Patients may be admitted to hospital as an emergency through various routes, including from: major A&E departments; single specialty A&E departments, minor injuries units or walk-in centres; referrals by GPs or other health professionals; and referrals following outpatient appointments. In 2012-13, 71% of emergency admissions came via major A&E departments and almost all of the increase in emergency admissions has come through these.³

3. The services which make up the urgent and emergency care system are delivered through a wide range of local bodies and organisations.⁴ When the health system is working effectively, only those with a genuine urgent need to be treated in a hospital should be admitted for emergency care. For everybody else, there should be appropriate services based in primary care or out in the community that help to keep people well, or treat them away from hospital if they do become ill.⁵ All parts of the health system—including ambulance services, A&E services, other departments within hospitals, primary and community health services, and social care services— have a role to play in managing emergency admissions by preventing patients from being admitted to hospital when they do not need to be, making sure those who are admitted stay no longer than is necessary, and ensuring that they are treated in the most appropriate setting.⁶

4. When health and social services are not working effectively the pressure is usually felt by A&E departments having to deal with more patients.⁷ Approximately one-fifth of emergency admissions to hospital are avoidable, and many patients stay in hospital longer than is necessary.⁸ Poor quality access to primary care can lead to more people attending A&E rather than going to their GP surgery.⁹ Shortcomings in social care, primary care and

1 C&AG's Report, Emergency admissions to hospital: managing the demand, HC 739 Session 2013-14, 31 October 2013

2 C&AG's Report, paragraphs 1, 1.9

3 C&AG's Report, paragraph 1.11

4 Q93

5 C&AG's Report, paragraph 1.3

6 Qq27, 72; C&AG's Report, paragraphs 2 & 3

7 C&AG's Report, paragraphs 1.3 & 1.4

8 Qq 36, 47; C&AG's Report, paragraphs 11, 22

9 Qq71-72, 75-76; C&AG's Report, paragraph 2.12

community care can also put pressure on A&E services by delaying the discharging of patients which places more pressure on bed availability.¹⁰ The fragmented delivery of urgent and emergency care services can result in duplication of activities, such as the condition of patients being assessed twice.¹¹

5. It is crucial to have clear accountabilities in a devolved delivery chain like the NHS. The Department told us that it retains overall responsibility for the urgent and emergency care system in England, but it discharges its duties through a large number of arms-length bodies.¹² For example, NHS trusts are accountable to the Trust Development Authority; NHS foundation trusts are accountable to Monitor; and both are accountable to the Department. NHS England is accountable for the commissioning and performance of the NHS, including holding clinical commissioning groups to account for the commissioning of local services.¹³ Foundation trusts are also individually accountable directly to Parliament. However, the Department and NHS England could not clearly explain to us who is accountable for ensuring A&E services are delivered efficiently and how particular failings in local services would be effectively challenged and addressed.¹⁴ In particular, the Department struggled to convincingly set out for us which body a citizen should complain to about a failing local urgent and emergency care service, and what would be done about that complaint.¹⁵

6. The Department said that urgent care working groups had been established to bring together the statutory bodies (clinical commissioning groups, NHS England and local authorities) responsible for the delivery of health and social care services with local care providers to create more accessible and integrated local urgent and emergency care systems. However, while the Department asserted that these groups exert significant influence, it accepted that they had no powers to deliver services and instead operated as a network that relied on the good will of all those parties involved.¹⁶

7. The Department told us that a tripartite group, accountable to the Department and comprising NHS England, Monitor and the Trust Development Authority, would oversee the urgent care working groups. However, neither the Department nor NHS England could clearly explain under what circumstances the tripartite group would step in and who will drive change when local urgent and emergency care systems were not working effectively together.¹⁷

8. The main financial incentives to reduce emergency admissions sit with hospitals, despite all parts of the health and social care system having a role to play. Currently, local clinical commissioning groups pay hospitals a tariff for each patient that they treat. Since 2010-11, commissioners have set limits on the level of emergency activity that they will pay hospitals

10 Q27; C&AG's Report, paragraph 15

11 Qq42, 45, 102-103, 113

12 Qq1-3, 12

13 Qq2-3, 8, 44, 48, 52

14 Qq9-13

15 Qq6-8

16 Qq42-43, 45-47, 52; C&AG's Report, paragraph 3.6

17 Qq42-48, 52

at full tariff, based on the number of emergency admissions at each hospital in 2008-09. When emergency admissions exceed this level the commissioners only pay the hospital 30% of the tariff.¹⁸ NHS England told us that the savings made from the remaining 70% of the tariff were supposed to be reinvested in out-of-hospital care to reduce admissions, but until recently commissioners were often spending the savings on other aspects of care. This equated to removing about £250 million a year out of the acute care system. Since 2011-12, commissioners have also not paid hospitals a tariff for patients who are readmitted to hospital within 30 days of being discharged.¹⁹

9. Since 2011-12 there has been some attempt to expand the range of incentives, when the new GP contract started to include payments for GPs to review and reduce local emergency admissions levels. From 2013-14 NHS England introduced a ‘quality premium’ for clinical commissioning groups to reduce avoidable emergency admissions. However, there are still no financial incentives for community and social care services to reduce emergency admissions.²⁰

10. A new ‘year of care’ funding model is being piloted in eight areas that aims to promote the integration of services for patients with long-term conditions by providing funding per head of population for the totality of their care, both in and out of hospital. NHS England intends that this will encourage hospitals to take a holistic approach to caring for such patients, and it plans to roll-out this funding model in 2015-16.²¹

11. In addition, starting from April 2015, the £3.8 billion Better Care Fund aims to ensure better integration between health and social care, particularly in out-of-hospital care. Local health and wellbeing boards will be responsible for allocating this fund.²² The fund will comprise £1 billion that the NHS already transfers to local government, £800 million from the Department, and £2 billion that will need to come from additional NHS savings, mainly in the acute care sector.²³ NHS England told us that this will be a massive challenge, as these savings are on top of the 4% efficiency savings that the NHS already needs to make in 2015-16.²⁴

18 C&AG’s Report, paragraph 2.23

19 Qq152-153; C&AG’s Report, paragraph 2.24

20 C&AG’s Report, paragraphs 3.8, 3.9

21 Qq155-157

22 Qq63-65

23 Qq125-134

24 Q134-137

2 Meeting demand for urgent and emergency care

12. NHS England agreed that it was essential to have a clear understanding of demand, activity and capacity across the urgent and emergency care system in order to manage the system effectively and to recognise where the bottlenecks are within it.²⁵ NHS England now publishes a winter health check every week that brings together a range of information from across the system, including: A&E attendance and emergency admission numbers; performance against the four-hour A&E waiting time standard (which requires 95% of patients attending A&E to be seen, treated and either discharged or admitted within four hours of arrival); ambulance handover delays; bed occupancy rates; and delayed discharges from hospital.²⁶ NHS England has also started to publish more information about the quality of GP services on its website.²⁷

13. However, performance management has been hampered by shortcomings in the data.²⁸ The NAO reported concerns about the suitability of the current measure for the delayed discharge of patients from hospital, and NHS England acknowledged that the measure may underestimate the scale of the problem. NHS England said there were also some issues about whether ambulance handover times— the time it takes from when an ambulance arrives at an A&E department to when the patient is handed over to the care of A&E staff— are reported consistently. There is a need for a cohesive and harmonised dataset that brings together the various indicators for a particular local area and presents the full picture of what is happening across local urgent and emergency care systems. This would allow both MPs and the public to make comparisons and to hold their local organisations to account.²⁹

14. The urgent and emergency care system comes under particular strain in winter, and in 2013, as in previous winters, the Department and NHS England put additional money into the system to help alleviate this added pressure. In September 2013, £250 million was allocated to help 53 struggling urgent and emergency systems prepare for winter. An additional £150 million was announced in November 2013 to help other health systems prepare for winter. In previous years, this allocation had normally taken place in December.³⁰

15. The Department said that this extra money was not intended to reward failure, but that it was difficult to assess which parts of the country have the most significant challenge, and therefore need extra support.³¹ The timing of these payments, so close to winter, does not enable hospitals to plan ahead sensibly and is likely to lead to the use of more expensive

25 Qq30-31, 84; C&AG's Report, paragraph 3.7

26 Qq32-35, Winter Health Check Reports <http://www.england.nhs.uk/category/winter-hcr/>

27 Q114

28 C&AG's Report, paragraph 3.7

29 Qq33-35; C&AG's Report, paragraph 1.24

30 Qq85-86, 158-164; C&AG's Report, paragraph 17

31 Q164

temporary or agency staff to meet demand.³² The Department and NHS England acknowledged that this situation was not ideal and that this money should be allocated earlier. The Department confirmed that it aims to release the £250 million winter fund for 2014-15 in the first quarter of 2014-15.³³

16. The allocation of additional seasonal monies is a short-term measure. To tackle the underlying problems more fundamental changes are needed. We welcome NHS England's proposed shift to seven-day working in hospitals and the positive changes that this is likely to bring, including reduced weekend mortality rates and more efficient use of NHS assets and facilities.³⁴ NHS England said that achieving seven-day working in urgent care will involve meeting ten clinical standards, which broadly amount to greater availability of diagnostic facilities and better access to senior decision-makers, such as consultants, at weekends. It also explained that not all services will be open seven days a week in every hospital; instead hospitals will work in networks or federations that mean that communities have access to all services seven days a week.³⁵

17. NHS England said that the introduction of round-the-clock consultancy care would start with A&E services, and that it aimed to have at least the first phase in place by the end of 2016-17. To achieve this, NHS England plans to use a number of levers to ensure the necessary changes are made, including clauses in commissioning contracts, the publication of progress in meeting the clinical standards, amendments to training contracts, and the renegotiation of the consultants' contract. However, NHS England was unclear how much the move to seven-day services in hospitals will cost the NHS. It said that early evidence from eight hospitals that had started to introduce seven-day services suggests that the shift will increase hospital running costs by up to 2%, but recognised that more work is needed to better understand the costs. NHS England also said that an organisation called NHS Improving Quality planned to work with 13 early adopter communities to carry out additional economic modelling.³⁶

18. A significant part of the costs will depend on the outcome of the ongoing renegotiation of the consultants' contract. NHS England said that negotiations were underway between the British Medical Association and NHS Employers to reset the consultant's contract with a view to setting the time consultants must work before they qualify for overtime and removing their right to refuse to work at weekends. Following our hearing the Department sent us a note stating that Government had mandated these negotiations in October 2013, and that the target was to have a phased implementation of the new contracts from 2015. However, NHS England told us that neither it nor the Department were directly involved in these negotiations.³⁷

32 Q158; C&AG's Report, paragraph 17

33 Qq158, 163

34 Qq94-95, 97

35 Qq95,167

36 Qq94-95, 119-122

37 Qq95-96, 98-101; Ev. 20 – note from the Department of Health to the Public Accounts Committee, 15 January 2014, p.5

19. The move to seven-day working not only requires changes to consultants' working practices, but also that enough consultants are in post to deliver services seven days a week. There is still a shortage of A&E consultants, despite a 70% increase in A&E consultants over the last ten years.³⁸ In 2011-12, 8% of consultant posts in emergency departments were vacant and 9% were filled by locums.³⁹ There are also major problems in training sufficient numbers of doctors in emergency medicine. In 2012, only 18.5% of ST4 (first year of higher training) posts were filled.⁴⁰ The Department agreed that these vacancies and shortfalls mean that there is too heavy a reliance within hospitals on temporary staff to fill the posts.⁴¹

20. The Department acknowledged that struggling hospitals, such as those placed in special measures, find it even harder to attract and retain candidates for vacant consultant posts. There are currently no mechanisms in place to make working in these hospitals a more attractive prospect, such as providing incentive payments to work there. We raised with the Department the possibility of paying consultants more to work at struggling hospitals.⁴²

21. The Department told us that it is working with Health Education England, the College of Emergency Medicine and the trade unions to examine both short- and long-term options to address the shortage of consultants and trainees. The Department said it was looking at how to make the emergency medicine profession a more attractive option for doctors in the long-term. Both it and NHS England were considering a number of options, including adjustments to annual leave or pensions, examining whether intensive roles need a different structure to achieve a better work-life balance, and making better use of a hospital's entire consultant body to alleviate the pressure on emergency medicine. After our hearing the Department sent us a note expanding on the work to be undertaken by an Emergency Medicine Workforce Implementation Group, which is jointly chaired by Health Education England and the College of Emergency Medicine. However, the Department and NHS England failed to outline a convincing strategy or vision for tackling the immediate or longer term shortage of A&E consultants.⁴³

38 Qq16, 25; C&AG's Report, paragraphs 1.18 & 3.18

39 C&AG's Report, paragraph 3.18

40 Q18; Briefing from the Royal College of Surgeons, <http://www.rcseng.ac.uk/policy/documents/RCSbriefingonemergencyadmissionsforPAC18December.pdf>

41 Qq21, 23

42 Qq16, 20, 22-23, 165-166

43 Qq18, 21-22, 24-26; Ev. 20 – note from the Department of Health to the Public Accounts Committee, 15 January 2014, p.3

Formal Minutes

Monday 24 February 2014

Members present:

Mrs Margaret Hodge, in the Chair

Richard Bacon

Jackie Doyle-Price

Chris Heaton-Harris

Austin Mitchell

Nick Smith

Justin Tomlinson

Draft Report (*Emergency admissions to hospital*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 21 read and agreed to.

Conclusions and recommendations agreed to.

Summary agreed to.

Resolved, That the Report be the Forty-sixth 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 reported to the House for printing with the Report.

[Adjourned till Wednesday 26 February at 2.00 pm]

Witnesses

Wednesday 18 December 2013

Page

Sir David Nicholson KCB CBE, Chief Executive, **Sir Bruce Keogh**, Medical Director, **Dame Barbara Hakin**, Chief Operating Officer, NHS England and **Richard Douglas**, Director General, Finance, Department of Health

Ev 6

List of printed written evidence

1 Department of Health

Ev 20

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

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Thirty-first Report	The Border Force: securing the border	HC 663
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Thirty-fourth Report	HMRC Tax Collection: Annual Report & Accounts 2012-13	HC 666
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Forty-fifth Report	Excess votes 2012-13	HC 1068

Oral evidence

Taken before the Committee of Public Accounts on Wednesday 18 December 2013

Members present:

Margaret Hodge (Chair)

Mr Richard Bacon
Stephen Barclay
Guto Bebb
Jackie Doyle-Price
Chris Heaton-Harris
Meg Hillier

Mr Stewart Jackson
Fiona Mactaggart
Nick Smith
Ian Swales
Justin Tomlinson

Amyas Morse, Comptroller and Auditor General, **Gabrielle Cohen**, Assistant Auditor General, **Leon Bardot**, Manager, National Audit Office, and **Marius Gallaher**, Alternate Treasury Officer of Accounts, were in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

Emergency admissions to hospital: managing the demand (HC739)

Examination of Witnesses

Witnesses: **Sir David Nicholson KCB CBE**, Chief Executive, NHS England; **Sir Bruce Keogh**, Medical Director, NHS England; **Dame Barbara Hakin**, Chief Operating Officer, NHS England; and **Richard Douglas**, Director General, Finance, Department of Health, gave evidence.

Q1 Chair: Welcome. There are the usual conventions: the more succinct the answers, the more quickly we can get through the business, if that is all right with all of you. I am going to start with something I hope will get me a one-word answer, like “me”. Who is responsible to Parliament if an A&E department fails to use NHS money effectively and admits too many people to a hospital for emergencies?
Richard Douglas: The overall responsibility comes back to the accounting officer of the Department, for the overall system.

Q2 Chair: No, that is not what I said. Who is responsible to Parliament if a hospital uses its money ineffectively and admits too many people? I do not want to hear about systems. Who is responsible to Parliament for that?

Richard Douglas: The initial responsibility is with the chief executive of the foundation trust as accounting officer.

Q3 Chair: And for the non-foundation trusts?

Richard Douglas: It would effectively be the Trust Development Authority and through that the Department of Health.

Q4 Chair: Why have we got you guys here?

Richard Douglas: I think it was because we were invited.

Q5 Chair: No. This is always done in co-operation with the Department to ensure that we have the right people here who can be accountable and answerable to us.

Amyas Morse: I would mention to the witnesses that if they think this is the prelude to an afternoon off—

Mr Bacon: Happy Christmas. Thank you.

All witnesses: Thank you.

Richard Douglas: Do you want me to go or stay?

Q6 Chair: It is not very satisfactory. We are here to hold whoever takes those decisions to account. We are not here to be waffled at.

Can I ask another question? Who do I write to as a citizen if I have concerns about a hospital and the way it is admitting people into A&E?

Richard Douglas: You would write initially to the hospital chief executive.

Q7 Chair: Yes, obviously, but I am complaining about the hospital. To whom do I write, as a citizen, to complain about the hospital?

Richard Douglas: As a citizen you should write to the Department of Health.

Q8 Fiona Mactaggart: What would the Department of Health do then?

Richard Douglas: The Department of Health would deal with it, either through direct contact with the organisation or through the relevant arm’s length body: Monitor or the Trust Development Authority.

Q9 Chair: Maybe I have asked these rather tight questions because my hospital was put into special measures today—or yesterday—because of its failure on A&E, with one in five of my constituents and those of neighbouring boroughs waiting more than four hours, and with only seven full-time consultants in place. Given that I have struggled with this hospital

for the past 20 years, who is going to sort it out for my constituents and those of neighbouring boroughs? Whose job is it?

Richard Douglas: Now it is in special measures it will be the Trust Development Authority.

Q10 Chair: What happens if that fails?

Richard Douglas: If the Trust Development Authority fails, well—we will hopefully set up a system where the Trust Development Authority will not fail.

Q11 Chair: Don't tell me that. I have been struggling with this for 20 years. What we are drawing out of this is the lack of accountability. Let us assume that the Trust Development Authority might just fail. Everybody else has failed in the past 20 years.

Richard Douglas: Then the responsibility comes back to the Department of Health again. The Department of Health holds the Trust Development Authority accountable for its role. Part of its role is, when trusts go into special measures, to ensure that the trust takes the action to turn itself around. It will put in place an improvement director; it will agree an improvement plan; it will monitor that and report on it.

Q12 Chair: I have been there before. Okay, so in essence, what you have clarified for me is that in the end, the Department and Ministers are responsible.

Richard Douglas: In the end it comes back to the Department retaining the overall accountability. It discharges that to a number of different bodies. If those bodies fail to deliver, it must ultimately come back to the Department.

Q13 Jackie Doyle-Price: It doesn't though, does it? Frequently, patients just have to accept what they are given. My constituency is also served by Basildon, and neither hospital has covered itself in glory in recent years. They have gone into special measures in the past 12 months, but there has been a decade of underperformance that nobody has got to grips with. We can make as much noise as we like on behalf of our patients, but there is one provider and you get what you're given. We are not going to achieve any improvement in performance unless the Department of Health becomes a lot more challenging in how it deals with these organisations.

Richard Douglas: I think that is one of the reasons why we have established a special measures regime, which we haven't had before, and why we established the CQC and the Chief Hospital Inspector to push us into the position where, when a hospital is clearly failing, someone independently says that. When they have independently said that, then the organisation is put into special measures.

Q14 Chair: This hospital has a deficit; it's bust. It has a deficit of £40 million. Who is going to provide the money to allow it to continue?

Richard Douglas: We will have to look at what the hospital needs to do to turn itself around.

Chair: It will need money.

Richard Douglas: It is about money. Over time, while it is improving, what will generally happen is that the

Department will provide support to allow it to get to a position where it can be financially sustainable.

Q15 Chair: Who will provide the money, Sir David or you?

Richard Douglas: Essentially, while the hospital is in the position of still agreeing a plan and how it will resolve its problems, it is the Department that provides the money.

Chair: You would give them money?

Richard Douglas: During a period in which the hospital is still developing a plan, until the commissioners have agreed what they would be willing to pay for, then the Department underwrites it. We provide the cash support now to organisations that are in financial deficit and cannot finance themselves.

Q16 Fiona Mactaggart: There is a problem with hospitals that are struggling. In the process of their trying to move forward, it is particularly difficult for them to find solutions. For example, Wexham Park and Heatherwood hospital in my constituency advertised vacancies, of which there are more than one, for consultants in accident and emergency. They had only four applications, three of which withdrew before the interview, and the fourth was unappointable. That is common in hospitals that are struggling. What, strategically, are you doing to stop that?

Richard Douglas: Two things: the first is to help hospitals to get out of a position where they are struggling and to try to support them through the special measures regime and others. The other thing is that we are working with the College of Emergency Medicine and with Health Education England to try to increase the supply of emergency medicine doctors. There has been a problem in supply and we are working on it.

Q17 Chair: Is this your responsibility?

Richard Douglas: This is the Department's responsibility, working with Health Education England. Health Education England help us with the supply of staff. The demand is driven by the hospitals themselves, but we have discussions with Health Education England about what is needed.

Q18 Chair: Let's get to the nitty-gritty. I gather you have increased the complement of staff, or the training posts, this morning, but I am not sure that is going to move the world on at all. According to the College of Emergency Medicine, in 2010, 17 out of 82 of the posts advertised were filled. These were higher trainee ST4 posts—whatever that is—which is 20%, so only 20% were filled. In 2012, 25 out of 135 posts were filled; that is less—18.5% were filled. These are figures from the College of Emergency Medicine. This is the nitty-gritty: what are you doing to increase numbers in Fiona's hospital and in mine? Seven out of 19 consultants in A&E—this is costing an arm and a leg, because you are getting locums in. What are you doing to sort it?

Richard Douglas: We have met, I think, twice with the College of Emergency Medicine and with Health Education England together in the last three or four

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weeks to look at what we can do in the short term to try to find people who can fill the posts currently and whether that involves going overseas or other options. We will work our way through that very quickly. The other thing is to look at how the training operates to make it more attractive. Health Education England are putting forward some proposals on that. The final issue is, how do we make this a more attractive career? Again, this is something we are looking at with Health Education England and in our negotiations with the unions.

Q19 Chair: What is the drop-out rate at the moment?

Richard Douglas: I haven't got the numbers with me.

Q20 Fiona Mactaggart: But it is not enough just to make it a more attractive career. While that might mean that hospitals that are thriving can recruit up to a point, the question is, who is doing something strategic in the hospitals that seem unattractive to ambitious consultants because they are in current difficulties? That is surely the role for NHS England or the Department.

Richard Douglas: This, again, is the issue of helping the hospitals get out of the difficulty.

Fiona Mactaggart: Exactly.

Richard Douglas: Fundamentally, it is about how we help those hospitals get out of difficulties. That is why we have created the special measures regime. That will focus attention and support on those hospitals.

Q21 Jackie Doyle-Price: But the issue, going back, is the permanence and the complement of staff. My local trust has gone through a massive improvement in the past year because the new chief executive decided to tackle the whole issue of relying on temporary staff, which, as the Chair said, is more expensive. It is a general behavioural pattern that if someone is part of the permanent side of the organisation, they care more. It then becomes self-fulfilling that performance is better. These are real basics in terms of culture, which the Department and the regulator should be picking up on when performance starts to decline. The reliance on temporary staff is a common feature.

Richard Douglas: You are right that there is too great a reliance on temporary staff. The work that we are doing with Health Education England is trying to get us to a position where we have less of that. You absolutely do not want to be in a position where you continually—

Q22 Jackie Doyle-Price: How are you tackling that, other than just saying it?

Chair: Quite.

Richard Douglas: We have to make the hospitals more attractive by helping to turn them round and increase the supply.

Chair: Nobody in their right mind would come out to Queen's hospital if they could go to any of the London teaching hospitals, which are also crying out for A&E consultants. In an odd way, we have a dispersal of accountability and responsibility and, as Jackie has said, we have no clear idea of what will happen. How are you going to get me from seven to 19 consultants?

Q23 Meg Hillier: On that very point, more is spent, as Jackie Doyle-Price has said, on interim temporary people, who cost more. Is there any ability within the NHS pay structure to provide incentive payments to encourage people to go to hospitals such as the Chair's hospital? Or is that just not allowed under the rules?

Richard Douglas: Under the current contract, I am not sure how that would work, but looking differently at incentives for different roles in different organisations is something we need to do.

Meg Hillier: You give "golden hellos" to maths teachers, but not to A&E consultants in Barking and Dagenham.

Q24 Chair: You need to do it in what time frame?

Richard Douglas: Particularly on the emergency medicine side, some of the conversations that we have had have been with the college. From their perspective, it is not primarily a pay issue; it is about other ways of making the profession more attractive. It is potentially about how annual leave and pensions work and, generally, how more intensive roles might need a different structure for balancing work life and outside life and the later stages of a career. Those are the sorts of things they are asking us to look at.

Chair: I don't think anything you've said gives me confidence that we will get any more permanent consultants.

Jackie Doyle-Price: The reality is that the chief executive has to go and find them.

Q25 Chair: Or, in the old days, everyone had to do a stint in A&E, which they no longer have to do.

Sir David Nicholson: Can I help on this? NHS England and the commissioners have a responsibility to help and support hospitals in trouble and hospitals generally to make things happen. It is worth pointing out that over the past few years we have significantly increased the number of emergency department consultants across the country. It is something like a 70% increase over the past five years.

We have made a big impact over the last period, but for us it is not just about emergency doctors; it is also about the other doctors who are involved in accident and emergency departments. The A&E consultants only do a particular role. They deal with undifferentiated admissions and people where we are unsure what is wrong with them. They are very good at dealing with musculoskeletal problems and they do a lot of assessment. The third thing they do is resuscitation. The rest of the consultant body have a responsibility to provide services within a functioning A&E department, so it may not be that it is just a matter of more A&E consultants. In fact, in some places you might not need more. What you might need is more other kinds of consultants to do that work, so it is slightly more complicated, I think, than just how many A&E consultants. I do not dispute the issue that we need more. Bruce has done quite a lot of thinking around all this.

Q26 Chair: We know, and will come to, the work you are doing on 24/7 and consultants in hospitals. But I just have to say to you that at Queen's hospital

there are seven consultants, out of a complement of 19, in post today. I have no doubt that, apart from anything else, we need more A&E consultants.

Sir David Nicholson: But the issue for that particular hospital—

Chair: I don't think it is on its own.

Sir David Nicholson: I don't run that particular hospital, but it may be that they never get them. In the terms that we are thinking about, apart from locums, they might not get them, so they need to think of an alternative. What I am saying is that there are alternatives available. You can look at enhancing the number of consultants you have got in other specialties to enable you to do it. Or, you can go through the process with the commissioners of completely reorganising the way you deliver urgent and emergency care in that particular part of the world, which I guess is part of the solution here.

Q27 Ian Swales: Clearly, addressing the resource question assumes that the demand stays the same. What the Report and the report of the Foundation Trust Network show is that there are a lot of issues associated with demand and how the system is working. Perhaps Dame Barbara might like to pick this up, because it is very clear from the Report and from what the network says that the failure of adequate social care and the move towards care in the community, and even the home, is part of this problem. What is your view about that?

Dame Barbara Hakin: I agree there is absolutely no doubt that pressure is put on our hospitals and A&E departments if we haven't got the right services out of hospital. It is not only social care; it is community and primary care, general practice—a full range of services which both keep patients well and look after them to prevent admissions when they don't really need hospital care, and which are there to have them discharged quickly. So we have put measures in place in the short term and Bruce's urgent care review will start to look at the longer term, to try to make sure that every single community is bringing together all those key players who can actually have an impact—whether it is the CCG clinical leaders, GPs, hospital consultants, mental health trusts or ambulance trusts—to look at the full range of things which will take the pressure off our A&E departments.

Q28 Ian Swales: We have some data in front of us here—my CCG has the fourth highest A&E admissions in the country—so this is being looked at locally. I have been involved in a number of meetings and it is clear that there are perverse incentives and budgets in different pockets. Also, this Committee's out-of-hours review of Cornwall showed that there is a financial incentive for out-of-hours providers to send people to A&E, rather than deal with them in the community. So what is the NHS generally doing to try to manage those different steps in the pathway? Patients are not interested in who holds the budget, or whatever; they want to be treated in the right place at the right time. How are you trying to incentivise the right kind of behaviour to reduce the pressure on A&E departments?

Dame Barbara Hakin: What is really important is that people have access to the right resources. I don't believe that clinicians alter their behaviour with individual patients for financial resource, but if they are going to keep patients at home and in the community, they need all the resource to do that and it is really important. We have done two things recently which will make a difference. The better care fund is obviously putting in an extra £2 billion—I accept that there is another 15 to 18 months to go, but that is specifically moving money from hospitals into the community and into social care to do exactly that. What we have seen over the last few years is an inexorable rise in the money we spend in hospitals, without the same rise in what we spend in primary and community health. What we know is that, for the most part, if patients don't need to be in hospital, they don't want to be there. NHS England has also identified, through planning guidance released yesterday, additional money for practices and CCGs to use in primary care or community services to support patients to stay at home. There was quite a lot in the GMS contract this time in order to take out some things that we thought were tick-box exercises and were not necessarily helping patients, and to free up time in general practice to look after frail, elderly patients in particular. These are the ones who, if you have the right time with them, you can often save an unnecessary admission.

Q29 Ian Swales: I have a final question. Are you collecting this sort of system data? For example, I met an ambulance driver on Saturday who told me that last Friday he was sitting in a queue of nine ambulances at our local A&E. Somebody was on TV a couple of weeks ago—I don't know whether it was you, Dame Barbara—saying, "Sometimes, paramedics have to deal with them", and so on. It is a nice line but actually, it is all about lack of capacity and, frankly, it might be about the target process. You have all that hardware sitting there and now, in our area, we are having to use private ambulances and, in some cases, police cars because the actual ambulances are stuck at A&E departments.

Dame Barbara Hakin: It was me and I certainly was not excusing it. I was certainly not saying that our ambulances should be waiting; all I was saying was that we always put patient safety first if the patient needed to be in the ambulance to be safe or could not be handed over. It is another symptom. If the A&E department gets too full and too busy, the ambulances cannot hand over and therefore we need to have fewer people in A&E.

Q30 Ian Swales: My question was, are you actually monitoring all of that? As well as the waiting times, do you bring together data about social care, ambulance waiting, the time that people are in hospital when they cannot be discharged because social care is not there, and so on? Do you collect that data?

Dame Barbara Hakin: We do indeed.

Q31 Ian Swales: So you know who the good and the bad people are, and so on?

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Dame Barbara Hakin: We do. In terms of delayed transfers of care, we know which are because of social care problems and which are because of health care problems.

Q32 Ian Swales: Are they published data? Where would we find them?

Dame Barbara Hakin: We now publish a winter health check every week. I am not sure that they are further published.

Q33 Stephen Barclay: It would be very helpful if you published, each month for each hospital, what the turnaround time is and gave that visibility. If you are saying, Dame Barbara, that you collate it, why do you not openly publish it each month? It would be a very useful guide for Members of Parliament to see who the outliers are.

Dame Barbara Hakin: We could certainly do that. There are two other issues before we publish. We have to be really sure that we are publishing meaningful data and we have some problems with delayed transfers of care.

Q34 Stephen Barclay: You wouldn't be collecting data that weren't meaningful, would you?

Dame Barbara Hakin: We collect data about delayed transfers of care and have been doing for some while. It has become apparent that there are a number of patients in hospital who are delayed but do not meet the absolute prescriptive definition of a delayed transfer of care. We think that it is more meaningful to understand about every patient who could be going home and isn't. We are therefore looking at how we can understand that information. NHS England has a responsibility for data standards; we want to review that and make sure that it covers everyone. Similarly, with handovers from ambulance trusts, we need to be absolutely sure that there is an agreement, how that is collected and that it is precise. At the moment there are some issues around that information, but we can publish it because we have official figures.

Q35 Stephen Barclay: With respect, I had the exact debate that Mr Swales was alluding to about ambulance times in the east of England and what the variance was. Will you commit to giving us a note setting down how you will harmonise the data collection and by what date you will be in a position to publish it? I think that they are meaningful data. You can publish with an asterisk pointing to a reason why this particular hospital is at variance with others, and the local hospital can explain if there is anything particular to it. But Mr Swales' point still stands about the ability, particularly of local MPs but also of constituents, to see turnaround times and why some hospitals are at a great variance with others.

Dame Barbara Hakin: Yes.

Q36 Chair: Right. I don't want to lose the point, because you suggest in the report, on page 26, paragraph 1.24, that "Reported data on delayed discharges from hospital suggests that the number of delayed discharges to other parts of the NHS is increasing, whereas those to social care are

decreasing". "Other parts of the NHS" is in your control.

Sir David Nicholson: Yes, that's true.

Dame Barbara Hakin: Yes.

Q37 Chair: So it shouldn't be increasing.

Sir David Nicholson: Well, it is. As you can imagine, all around the country people are doing work on this to work it out. It could be due to delays around assessment when different parts of the NHS assess patients, which clearly needs to be streamlined significantly. It could be due to the availability of community beds, or the availability of teams, psychiatrists or whatever. All those things are part of it, and we need to sort it out. People are working on it through the urgent care working groups to improve the situation.

Q38 Chair: The usual impression in the public domain is that it is always social care and local authorities failing to take action.

Sir David Nicholson: No, it's not.

Q39 Chair: So it is within your control.

Sir David Nicholson: Yes.

Q40 Chair: So it is for you to sort out.

Sir David Nicholson: Yes, it is.

Q41 Mr Jackson: First, Mr Douglas, would it be possible to have a note about the efforts you are making in collaboration with the Royal College to tackle centrally the issue of the availability of consultants in particular? I am slightly unclear about what you meant about the issue of pensions and leave.

Richard Douglas: Yes, we can give you a note on all the things we are looking at with the college.

Q42 Mr Jackson: Right. That will assist us and the NAO when the final Report is published. I get a sense of a willingness to be collaborative and to work together across the different agencies. I get a sense of the carrot—per capita funding, discussions around tariffs and those kinds of things—but I don't get any sense of the stick. What sanctions are available to prevent, for instance, expensive duplication of the things that happen around the transfer of patients from hospital care into social care or primary care? Now that we haven't got strategic health authorities, who is looking out for the generic picture? You will know that at Peterborough hospital, even when we had a strategic health authority it did not do its job properly. Who is insisting on best practice, and who is accountable on a day-to-day basis?

I will give a brief example. An elderly constituent of mine was injured in mid-October. She went to the walk-in centre at our minor injuries unit, spent four hours there and was eventually told that it was an orthopaedic issue so she would have to go to the hospital. She sat for another four hours and was eventually admitted after about nine hours. An X-ray was taken in the first unit and another one was taken in the second unit. The resources used were huge for a relatively minor injury. The reason why I know about that example is that it was my mother.

There is so much going on, and we are not properly co-ordinating the efforts between social care, primary care and urgent care in A&E. It worries me that there is no sanction that can be used centrally to enforce the regime.

Richard Douglas: Shall I kick off on that?

Mr Jackson: Sorry, that was a long question.

Ian Swales: In your answer, can you touch on the financial incentives? The Report at 2.23 says that under the new system, hospitals have a financial incentive to admit people.

Chair: Let's come separately to the financials. There are some big issues around finance, so let's come back to that.

Ian Swales: Sorry.

Mr Jackson: My question is about duplication.

Richard Douglas: The key area is that we have set up urgent care working groups that bring together the different parts of the system. They are tripartite and comprise the commissioning side of our work, the foundation trusts and the trusts. They look at how to plan for urgent care across a locality and how to make each of the different bits of the system work together.

Q43 Chair: They don't have any power. They don't have a budget.

Richard Douglas: They exert significant influence. They are effectively overseen by the three big national bodies. They do exert influence. We have only just kicked off having them. It is early days.

Q44 Mr Bacon: Sorry—just for the avoidance of doubt, when you say “the three big national bodies”, do you mean the Department of Health, Monitor and the Trust Development Authority?

Richard Douglas: I mean NHS England, Monitor and the Trust Development Authority. The Department engages with them, but they are run by those three organisations. I think they are starting to work. There are some things we can do directly.

Q45 Chair: So if this little grouping decides x and it is not implemented, what happens?

Richard Douglas: It depends on who is not implementing and what the “it” is. I know that is not an answer you will like me giving, but it is true. If there are things that a trust should clearly be doing that a trust is not doing then the Trust Development Authority can basically say, “You are going to have to do this.”

Yesterday David Flory, as chief executive of the Trust Development Authority, wrote to all these trusts basically saying that there is a nonsense of dual assessments between two bits of the NHS for someone being discharged. Someone being discharged from a hospital has an assessment within a hospital and an assessment by the community trust. That was clearly nonsense. Two parts of the system were doing duplicate things and were not only duplicating resources but wasting time because you have to wait for the second assessment.

David now says that you have to stop that and there is going to have to be one single assessment. There are things where they can be very directing and others are about influence. Barbara has been engaged with

these from the start and so she can probably add to that.

Dame Barbara Hakin: This is a devolved system. The Health and Social Care Act created separate organisations with separate responsibilities and different oversight mechanisms. One of the main reasons for the Health and Social Care Act was that it was felt that bottom up, people working together, people working out what would work for their local communities and being given a greater degree of flexibility on how that would work, would make services better for patients.

But in May it was obvious that the urgent care system was under strain and that we needed to have really good co-ordination to support it. So on behalf of NHS England I instructed our area directors, who are the most senior people in each locality across seven localities in England, to ensure that every patch had an urgent care board. We called them boards at the time; I apologise for that because I think that using that term gave people the impression that they perhaps had more powers than they did. You are absolutely right. We changed the name because they are much more of a network.

Q46 Mr Bacon: What's the new name?

Dame Barbara Hakin: They are called urgent care working groups. The area directors have responsibility to bring those groups together and to help and support them to be the best they can be. But some parties come to the table in those urgent care working groups which NHS England does not have the power to bring to the table. Local authorities are absolutely key to this group and what they do. In some areas they had them before we suggested that they do this. It was this best practice that made us think that this was a really important thing to do. I think increasingly across the country that these urgent care groups are working well.

Q47 Mr Bacon: Can I just be clear? When you say local authorities have an absolutely vital role to play, I take it that you are not talking about this public health stuff—you are talking about adult social services.

Dame Barbara Hakin: That is absolutely right. I think it is both, but probably the key role in urgent care is social services. Local authorities have an enormous role to play in many aspects of health care.

Chair: But they are doing well. The Report says that local authorities are doing well and that delayed discharges because of social care are decreasing.

Q48 Mr Jackson: Can I press you on a specific point? Someone goes into A&E and the clinician recommends that they are discharged to, say, a mental health partnership trust. If the mental health partnership trust says, “We haven't got any facilities. We haven't got any staff. We haven't got a bed”—basically, “Go away”—who adjudicates between the two? What happens next? Who is accountable for the fact that that patient is betwixt and between clinical needs?

Dame Barbara Hakin: I think as commissioners NHS England has a responsibility to ensure as much co-ordination in the system as possible but we don't have

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authority over, although we commission services from, NHS trusts and foundation trusts. Bringing all parties together around the table in an urgent care working group is where people can identify that, on a certain patch, one of the things that is giving us a difficulty in A&E is, say, that we don't have enough capacity in mental health trusts. Therefore the CCGs on the patch will commission both mental health services and physical services. The CCGs can then commission in a different way—commission additional services from mental health trusts to do that.

In many places, we have now put in additional money over the winter to identify such issues. Every single urgent care group has got an implementation plan. They were asked to do a plan and they are now implementing that plan. Each one has been asked to identify what we call a tripartite group, which is NHS England working with TDA and Monitor, and closely with the Local Government Association.

Q49 Mr Bacon: TD?

Dame Barbara Hakin: That is the Trust Development Authority.

Q50 Mr Bacon: I am just thinking about the poor taxpayer reading this Report afterwards and seeing all these acronyms. TDA is the Trust Development Authority.

Dame Barbara Hakin: The TDA has responsibility for the oversight of NHS trusts that are not foundation trusts. That would be both physical and mental health.

Q51 Mr Bacon: I know what it is; I am just thinking of someone reading it. TD to me sounds like territorial decoration. That is what you used to get after 12 years' service in the Territorial Army. You did not mean that, did you?

Dame Barbara Hakin: No, I meant the Trust Development Authority.

Q52 Mr Jackson: If I can summarise your answer, you are saying that no one is really responsible for adjudicating. It is just a sort of good will thing—that they work together. The next question is: should there be a layer of governance lower than NHS England but higher than CCGs and urgent care working groups to adjudicate and have some sanction? At the moment, if these partners say, "Sorry, we can't do it," no one can compel them to provide that service.

Dame Barbara Hakin: That is why we work closely with the TDA and Monitor because it is not about something between NHS England and clinical commissioners, because NHS England leads the commissioning system.

Say there is something in the implementation plan and it is obvious that one of the partners around the table is not delivering its part of the plan. Because the relative oversight bodies work together at regional and high-level area, we in NHS England would be able to see, for example, if a CCG had said, "We are going to make sure that we put these services in place to support," if that was not happening. We would have oversight of that and deal with it. If it is about the hospitals, it would need to be Monitor or the TDA.

Q53 Mr Jackson: My final question: did it work better when you had the clinical frameworks that were overseen by strategic health authorities? I suppose I am asking whether these urgent care working groups are effectively the same as the clinical frameworks that were in place.

Dame Barbara Hakin: Clinical networks do you mean?

Q54 Mr Jackson: Yes. For example, for IVF, stroke, cancer and so on.

Dame Barbara Hakin: They are slightly different. They are across a larger geography and they look at a broader range things and perhaps have a wider range of partners. They are undoubtedly a network. This is early days in the reform. There are lots of indications that local communities are taking responsibility and doing things really differently.

Q55 Chair: You say early days. How many CCGs are in deficit?

Dame Barbara Hakin: I don't know the exact number of CCGs that are projected.

Richard Douglas: I think it is currently 10 or 11. I can't remember.

Q56 Chair: Out of how many?

Sir David Nicholson: Out of 211. We have got 31 at risk—either in deficit or at risk of being so.

Amyas Morse: I have a question for Sir David. I understand that everybody is working with the best possible intent, but the concern must come when you look at the local government settlement that has just gone through and at the funding pressures on the NHS. Yes, everybody is working together but you are not even on the same platform in terms of level of funding. It may be that the gaps get bigger rather than smaller. Isn't that possible? I am just interested. Is this way of working together adequate to deal with the stresses and strains that may get greater over time? I am not trying to challenge; I am just interested to know what you think about that.

Sir David Nicholson: There are two points. The first is around the urgent and emergency care system and how that works. Then there is the broader question about health and social care in the medium term in terms of the financial position. I presume you are talking about the second of those. There is no doubt that the NHS is under enormous financial pressure. This year, we will deliver what we said we would—a £500 million surplus on the commissioning side and a surplus on the provider side, although there are individual organisations that are having different levels of stress within that. We will, as a system as a whole, be in balance, but it is undoubted that there is stress in all that.

Q57 Chair: How many trusts are in deficit?

Sir David Nicholson: I don't carry that information.

Chair: You have 32 CCGs—

Sir David Nicholson: Sorry, I didn't say that they were in deficit; I said that they were either in deficit or at risk of it—on our risk list. As you know, people are making a set of assessments about what the position will be at the end of March.

Q58 Chair: You cannot say half a billion and then you have all these trusts around the place that are in debt.

Sir David Nicholson: All I can say is that the provider side is in surplus, although some individual trusts are in surplus, and others are in deficit. Overall, there is a surplus on both sides of the equation.

Richard Douglas: At the half-year point—this is not the forecast for the full year—there are 46 trusts in deficit.

Chair: That is both foundation trusts—

Richard Douglas: No, that is just the trusts. There are 41 foundation trusts. What tends to happen—

Q59 Mr Bacon: Sorry. There are 46 non-foundation trusts and 41 foundation trusts that were in deficit?

Richard Douglas: At the half-year point.

Q60 Mr Bacon: So 87 at the half-year point. That is all acute hospitals, is it?

Richard Douglas: No. It is all trusts, so it includes acute hospitals and mental health trusts.

Q61 Chair: And that is out of how many?

Richard Douglas: The total number of trusts is 250.

Q62 Chair: So it is about a quarter.

Richard Douglas: I must stress that that is at the half-year point. What usually happens most years is that the number in deficit is lower by the end of the financial year. It is partly the way the trust savings plan operates, and it is partly the impact of things like the winter moneys going in, which will make a difference. I do not have a prediction for where it will be at the end of the year, but every other year, the number of deficits goes down and the overall surplus goes up.

Q63 Mr Bacon: Past performance may not be a guide to the future.

Richard Douglas: That is a very fair comment.

Amyas Morse: So?

Sir David Nicholson: So there is no doubt that part of the solution to dealing with the financial challenge in the medium term is much more pooling of resources between health and social care, and being less restrictive about the way we use money in that area.

That is why for 2015–16 the Government announced the better care fund, which is £3.8 billion for integration. That money is not new money, but it is money that is pooled between health and social care in a way that can be used to meet the needs of, in particular, out-of-hospital care—the sorts of things that will be prevent admissions. That is being put under the auspices of the health and wellbeing board, so in a sense it is being put under a joint governance arrangement, with power, between health and social care, so in a sense that will reinforce it. There will be a body that is accountable through the accounting officer in NHS England—so it is still under the auspices of the accounting officer for NHS England—and with governance that will be responsible for making the investments in out-of-hospital care to avoid admissions and to get discharges out earlier.

Q64 Mr Bacon: The health and wellbeing boards that sit in the local authorities—that is what we are talking about, yes?

Sir David Nicholson: Yes.

Q65 Mr Bacon: You are saying that they will have the responsibility of spending this £3.8 billion?

Sir David Nicholson: Yes, they will agree the expenditure of that, subject to us signing it off as NHS England, as I am still the accounting officer.

Q66 Mr Bacon: You anticipated my next question. If it is misspent, who do we talk to?

Sir David Nicholson: The accounting officer—me. It is NHS England. In terms of the first year of the better care fund, it is also going to have ministerial sign-off. Ministers in the Department of Health and DCLG will sign off those plans for every local authority.

Q67 Mr Bacon: Is it out of this money that the NHS is now employing social workers, for example?

Sir David Nicholson: The NHS employs social workers through pooled budgets anyway. It is not particularly this fund, but it will grow into this fund over time.

Q68 Mr Bacon: How many social workers are employed by the NHS now?

Sir David Nicholson: I do not have that information.

Q69 Mr Bacon: Can you find it and write to us with it?

Sir David Nicholson: Richard will have it.

Q70 Mr Bacon: Do you anticipate that that figure is going to increase as a result of these reforms?

Sir David Nicholson: They do not have to be employed by the NHS; they could be employed by local government, but they could be funded through the better care fund.

Q71 Meg Hillier: I am very interested in how all this links together. Various studies cited by the King's Fund—we are talking here about GP services—show that poor access to a GP is linked to higher rates of emergency hospital admission, which in a way, I suppose, is stating the bleedin' obvious. Do you think that abandoning the guarantee of a GP appointment within 48 hours has led to an increase in admissions to emergency care?

Dame Barbara Hakin: I don't think there's any evidence that poor access to emergency care has led to an increase in emergency admissions. If a general practice is poor, it will be other aspects of it, rather than immediate access.

Q72 Meg Hillier: But if you are an anxious parent with a sick child and you can't get an appointment at your GP surgery, where else do you go?

Dame Barbara Hakin: What I am trying to say is that what it will lead to is more attendances at A&E. We know that part of it is because a general practice is generally poor—they do not look after patients as well in the longer term, and that can lead to unnecessary, avoidable admissions—but certainly if patients cannot

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get access to a GP, they tend to go to A&E and then get an attendance, but they are unlikely to need admission.

Q73 Meg Hillier: Just too be specific, the 48-hour target for access to a GP was abandoned. Has that contributed to the rise in attendance at A&E?

Dame Barbara Hakin: I think it is very difficult to be certain whether that has had an impact or not. What we do know—

Q74 Meg Hillier: Do you do any monitoring or get hospitals to monitor that aspect and ask, “Why have you come here?”?

Dame Barbara Hakin: What we know is that good access is not a question of “within 48 hours”. We need good access to general practice. Certainly, 48 hours is a long time—if you have a sick child, 48 hours is too long in the first instance—so we know that we need to make a big improvement in some places. Lots of general practices are very good, with very good access, but in some places the standard of general practice is too poor and access to general practice is not immediate enough. Quite often that is in the cities, in urban areas, and of course that is where the A&E departments and our hospitals are sited and therefore those patients, unsurprisingly, go to A&E. We need to deal with that.

Q75 Meg Hillier: But there has been a cut in funding for the extra hour—the out-of-hours of GP surgeries. That will have contributed, from what you are saying, as well.

Dame Barbara Hakin: I am not aware of a cut in funding for GP out-of-hours services.

Q76 Meg Hillier: Well, okay, we recently saw a map of London—I think it was from the NHS Confederation—showing where walk-in centres were. I shall come on to walk-in centres. In my area I can walk to about three; in some areas there are none. It is very patchy. In some areas you have got GP surgeries that are supposedly open seven days a week for long hours. In fact, when it comes to it, you find they are not open those hours at all—colleagues from around London can point to their own one and say, “Well that one’s not open—so there has been something that is stopping GP surgeries opening for longer hours, from 8 to 8, seven days a week. If it is not a cut in funding, maybe I have missed something.

Dame Barbara Hakin: It is not a cut in funding of out-of-hours. What we need to see is increased opening, and we recently announced £50 million—the Prime Minister’s Challenge Fund—which is specifically to deal with GP access. We will be running a number of pilots, which NHS England will be overseeing, to try to work out what is the best way to get the full spectrum of access for patients. Some of it is being open outside routine hours, often because patients work, some of it is being more immediately available—we know that patients complain that they can’t get an appointment, they can’t get through on the telephone—and some of it is about people wanting to access services in a different way. People want to be able to do e-mail and telephone appointments. We

have £50 million going in this year to look at pilots and identify places that can really start to give patients much wider access and, on the basis of our learning from those pilots, I hope that we can roll it out across the country.

Q77 Meg Hillier: What about the walk-in centres? They were not popular with providers. A lot of doctors did not like the idea that their patients might go somewhere else with, presumably, the money following the patient, but they were a way of preventing people going to A&E. In my area, it is next-door to the A&E, so you can go to the walk-in unit or you can be referred to there from A&E. It works very well, but there have been closures and a reduction in walk-in centres. Surely that will have had an impact? We are talking a lot about the hospital bit of it, but if the rest of it does not work, that is when people go where the lights are on and clog it up with things that should not be in A&E. Surely that is one of the biggest problems?

Dame Barbara Hakin: Locating services near to A&E—having good access to GP out-of-hours services or having GPs in A&E—certainly helps to take the pressure off our A&E departments. Some walk-in centres were co-located and some have closed. CCGs have taken over the responsibility for commissioning walk-in centres and some CCGs have determined that it was not necessarily the best use of their money. Some walk-in centres have been very successful and have seen a lot of patients, but for some centres CCGs, as the local commissioners of services, have made the decision that there were better ways of using the money.

Q78 Meg Hillier: GPs are commissioning things that will gain them money. I know there are safeguards—

Dame Barbara Hakin: But the GPs do not lose any money when their patients go to walk-in centres.

Q79 Meg Hillier: I get frustrated, because there is a national crisis and numbers are going up. In my case, we have a busy one. It is not to do with age, because we are quite a young area. We see everyone going to A & E, and whereas we had walk-in centres that were working, they are being allowed to be closed locally. Your job—all of you—is to look at the big picture. What power do you have if a CCG is closing a walk-in centre and A & E is going up? The commissioners can save that money, but the money is being spent by the acute centre. They are sort of commissioning it, but, because of the way it is funded, there is no incentive for them to keep the walk-in centre open.

Chair: Probably around the table we have conversations about CCGs. I am absolutely clear that our CCG wants the money that went into walk-in centres to go into GP surgeries.

Meg Hillier: GP surgeries are reducing their hours in many cases. Walk-in centres and neighbourhood health clinics—they all have different names—that have GP surgeries and services for a wider area are not all open. My colleagues around London tell me that sometimes the one that is advertised as seven days a week does not actually open except on a weekend.

People are expected to go to their GP in the meantime, which might work, but might not.

Sir David Nicholson: The financial incentives are in the right place—

Q80 Chair: You're joking.

Sir David Nicholson: The clinical commissioning groups do not commission primary care, so they cannot use the money from the closure of walk-in centres to put in their own pockets.

Q81 Meg Hillier: They do commission community services.

Sir David Nicholson: They commission community services.

Chair: In their surgeries. We are seeing it, Sir David, for goodness' sake.

Q82 Meg Hillier: It is some time ago, but when I had my last child, I remember complaining, because there were two women being seen at the same time by the health visitors, post-natally. There was no privacy at all. The reason why was because the GP surgeries were not making money. It was not a service they got paid for and they wanted to let the rooms to the services that they got cash for. There are very perverse incentives, and it is difficult for someone outside the system to understand it. We have studied this in Committee, so I am puzzled when you say there are no incentives.

Sir David Nicholson: The argument was that they can somehow move money from the walk-in centre and then they can rely on the A & E department doing it, but the CCGs commission both, so they get no benefit as a CCG from putting people in A & E rather than in a walk-in centre.

Meg Hillier: But are they really looking at the big picture? You can see the big picture from where you are. But in a local CCG area, you might not go to that A & E. It might be that instead of going to that walk-in centre, you go to an A & E somewhere else. In London, you can; you are half an hour way.

Chair: To be honest, our experience on the ground is different from what you think. I can tell you that CCGs are putting services in their surgeries rather than having walk-in centres.

Q83 Mr Bacon: I am amazed if you do not think that GPs will play this new world to their advantage. You have never invented a world that the GPs did not play to their advantage. I have one building in my constituency that has two GP surgeries in it—two different practices. I was being shown round it once and there were a series of pigeon holes and windows you could look through with a person behind them. I said, "What is this one?" He said, "That's the pharmacy." A minute later, I said, "What is this one over here?" He said, "That's the other pharmacy for the other GP practice." They have two pharmacies separated by a corridor less than the width of the gap between the two tables in front of me, because you have incentivised GPs to have pharmacies, so they do. Whatever you do, GPs will find a way to make it work as best they can. You set up this quality and outcomes framework to get more activity out of GPs. I was

googling an old friend of mine who is a GP and the first thing I came up with was QOF optimisation software. This is a way you can pump in the right details into a computer and get out just the right amount to extract the maximum from the system, while doing what is required but not a scintilla more. I am afraid, if you really don't believe that GPs are starting to play the system, I think you should look again.

Sir David Nicholson: I was just making the point about the walk-in centres in the A & E department. There is no benefit; that was the point I was making. You are absolutely right that there are some GPs who are brilliant at all of that.

Q84 Nick Smith: I have a full question to Dame Barbara, and want to talk about 24/7 cover to Sir Bruce.

Dame Barbara, Ian Swales gave an example of ambulances queuing outside A & E, sometimes eight or nine at a time. That seems to be a familiar story in many parts of the country. You promised Mr Barclay that you were going to get better data to understand what was happening with these bottlenecks and how it was affecting ambulances, ambulance trusts and so on, but I wasn't sure that you were suggesting actions to try to make sure that ambulances could get back on the road if this seems to be something that is occurring around the country. What are you doing to get ambulances back out to help people?

Dame Barbara Hakin: To get ambulances back on the road, having handed over a patient safely, we have to improve what is happening in A & E departments. A & E departments have to be able to accept the patients otherwise you will compromise patient safety. All the range of things that we are doing to take the pressure off A & E departments, which we talked about earlier on, to put them in a position to take the patient from the ambulances is the main thing that we will do to help. We have to tackle the problem at the root, not at the symptom. However, there are two other things that we have done.

Q85 Nick Smith: But every weekend evening, I hear tales of ambulances stacked outside A & E departments like planes over Heathrow. That isn't good enough; what are you doing about it now to get ambulances out to people to help them?

Dame Barbara Hakin: Two things were done immediately. The original £250 million went to the hospitals where that was happening the most, because we identified the hospitals where they were having the most distress with A & E. They came up with a range of things which they are now implementing to improve their A & E.

Q86 Nick Smith: Is that working then? Was that £250 million well spent and is it working in those places?

Dame Barbara Hakin: We are seeing changes in some hospitals, although in other hospitals where they had money we have not yet seen an improvement in A & E standards and what is going on. We have recently given some money directly to ambulance services, because we recognise the pressure they are

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under. In the past couple of weeks we have actually given money directly to every ambulance trust in England to help and support them. We are working with ambulance trusts and hospitals both locally and nationally to say “What are all the things that we can do about this to make it better?”

Q87 Nick Smith: That does not sound to me as if you are getting ambulances back on the road.

Dame Barbara Hakin: We are doing everything we can to get ambulances back on the road, but we are coping with a system that is extremely busy indeed. We had more emergency admissions last week than—

Q88 Chair: It is more than not coping; the stats show it is getting worse. I have the figures here: for 2011–12, 2,061 patients waited more than two hours, and in 2012–13 it went up to 3,424. In the east of England, in Stewart’s area, a patient waited 5 hours 51 minutes; in the east midlands, 4 hours 37 minutes; and south central, 4 hours 32 minutes. It is getting worse.

Dame Barbara Hakin: We collect official figures for delayed handovers which actually, so far this year, are not worse than they were last year.

Q89 Chair: Are these figures wrong?

Dame Barbara Hakin: There is a difference between individual ones, the way those are done, and the official figures. We can only go on the official figures that we collect from the trusts.

Q90 Chair: Are the trends in these figures right or wrong? Between 2011–12 and 2012–13 there has been almost a 40% increase in people waiting in an ambulance for more than two hours.

Dame Barbara Hakin: We have to accept that we have a significant problem with ambulances not being able to turn around from acute trusts quickly.

Q91 Chair: And money spent on taxis, because then you haven’t got an ambulance to send out to somebody else. How much is that costing the taxpayer?

Dame Barbara Hakin: I haven’t got an answer to that.

Q92 Mr Bacon: I am not sure that the Department and the NHS nationally is sufficiently seized of this. We in the east of England have this problem. As probably you will be aware, the problem has been very, very acute at Norfolk and Norwich hospital. There have been meetings between east of England MPs from all six counties and the Minister; I was not clear that the information was percolating upwards at some points.

Many of us had ambulance people coming to see us in our surgeries, and we had a meeting in the House with the Minister and 15 paramedics. It took us as MPs meeting the paramedics directly and the Minister to get anyone to realise that there was a problem, to be honest. There was nobody in between who seemed to be listening. That ambulance trust got a lot of stick—some of it, I think, rightly at the senior level, because there were problems there—but also in many

cases because of the issues with the turnaround times, which were nothing to do with the trust itself, but with the acute hospital—the Norfolk and Norwich.

One of the things that I remember being told—and perhaps you would comment on this—was that when you get into the area where you hand over, there is a standard form that you have to fill in. Are you aware of this when you are handing over a patient? I cannot remember what it is called, but it can be done on a tablet. I think the idea is that you can do it en route. I was told that if it is not fixed to the dashboard with a bracket, you cannot use it in case it becomes a missile in an accident. For health and safety reasons the process of filling in the information that is needed cannot start until they are already in the queue at the hospital. Simple things like that ought to be capable of being sorted out. Are you aware of that example?

Dame Barbara Hakin: I am not aware of that example, no. A range of things have been put in place to work with. I know that the East of England and East Midlands trusts—

Mr Bacon: I know there is a new appointment. I think you have just announced the appointment of Anthony Marsh, which is very welcome.

Dame Barbara Hakin: That is not NHS England. The NHS Trust Development Authority oversees these trusts.

Q93 Mr Bacon: Paragraph 2 of this Report says:

“A system such as the NHS needs simple, easily understood pathways”.

It is not obvious to most of us looking at it that it is working as a system. Most of the patients don’t care whether it was the fault of the ambulance trust or of the acute hospital. They want a system that understands itself and that talks to itself, and it is not apparent that they have got that. When you say “We’re doing all we can”, you sound like Al Haig in the White House. It is not very reassuring.

Dame Barbara Hakin: There are more and more patients who are more and more ill. At times such as winter when there is a greater need, it is necessary for us to work very hard together to do the planning across agencies, because there are many agencies and organisations involved in delivering better care for patients.

Q94 Nick Smith: It seems to me that it was a really poor answer, Dame Barbara, about trying to get ambulances back on the road. It wouldn’t surprise me if many of my colleagues, MPs from across the country, return to this time and time again. If you are a local resident and drive past your hospital, you see half a dozen ambulances, scratch your head and think it is just a terrible waste. People don’t get it, and you’ve got to get a grip.

Sir Bruce, can I come on to 24/7 cover? It is fantastic and I was really pleased to hear about your proposal. How long will it take for your announcement to be implemented and realised on the ground? Will it mean a renegotiation of consultant contracts, and what will it mean in terms of extra cost?

Sir Bruce Keogh: First, we aim to have at least the first phases implemented by the end of 2016–17. If I

can take you back on this: the reason that we are doing this is because there is clear

Q95 Chair: The end of 2016–17?

Sir Bruce Keogh: Yes. The second thing is that we know that junior doctors are feeling particularly stressed at the weekend. This might play into that mortality. It also certainly plays into the training of the next generation of doctors. Thirdly, there is the whole issue around how efficiently we use plant in the NHS over the course of the weekend—[*Interruption.*]. Sorry, shall I carry on?

Chair: Yes. But I am shocked by the—

Sir Bruce Keogh: I will come to it. We have empty operating theatres, empty out-patient clinics, and laboratories that are not being used efficiently. In the meantime, we are still paying the maintenance costs for all of those and, at the same time, people are queuing up to see specialists and GPs, patients are waiting for their results and so on.

Based on that, there have been a lot of calls, both from patient groups and from professional groups, to try to address this issue. I was asked as part of NHS England to put a forum together. We have done that and some recommendations have come out of that but, in consultation with the presidents of the royal colleges and the BMA and others, we have agreed that this is a massive issue. It has lain fallow for many years.

The question was where to start, and we have decided to start with urgent and emergency care. We have identified or defined a set of 10 clinical standards which, broadly speaking, fit into two categories. One is to ensure that there is a much greater range of diagnostic facilities available over the course of the weekend. The second is that there is much greater access to senior decision makers—consultants, for instance—over the weekend.

We have several mechanisms for putting that in place. The first is through the contract. For the contract for the coming year, we are asking all organisations to put in place a set of plans that they would use to start bringing this to fruition. Then, over the course of the next two years, we will start to ramp up what we put in the contract with respect to those clinical standards. That is the first thing.

The second lever that we have got is that we will expect all organisations to publish exactly where they are in relation to those 10 clinical standards. The third lever we will use is that we will ask the Care Quality Commission and the chief inspector of hospitals not to give a grade of “outstanding” or “excellent” or equivalent unless those clinical standards are being applied.

The fifth lever that we will apply is through Health Education England. If you accept that having unsupported junior doctors at the weekend is not only bad for patients but bad for their training, then you would say that this is not good training. Health Education England has agreed that it will take that into account when it issues its training contracts.

Then you raise the issue of the consultant contract. Those negotiations are going on at the moment. We believe that there are two imponderables in that. First, there is a clause in the consultant contract, which I do not think bothers most consultants, actually, that

organisations cannot force them to work at the weekend. We believe that the negotiators will be able to have that removed from the contract. The second thing is the amount of time that consultants have to work before they start getting overtime payments. That is clearly going to be a source of discussion in the contract negotiations. How that plays out, of course, will influence the cost of this endeavour.

A lot of the focus has been around cost, and that is quite difficult. We asked the professional association of directors of finance to look at this, and they looked at eight hospitals, all of which were at different starting positions towards seven-day services. There were those that had implemented them—Chesterfield and Salford would be examples—who could do this and make cost savings. Others, to get going, needed some up-front investment. However, their overall impression was that this would cost about 1.5% to 2% of the running costs of an organisation. We are not sure that this is necessarily a reliable sample size, so we are doing two other things. We have identified 13 communities, because, as you rightly pointed out, this is not just about hospitals; this is about the whole community that they serve and the whole system in which they nest. There are 13 different communities working with an organisation called NHS Improving Quality that will be early adopter sites for this. We will use what we learned from them to help us to do economic modelling to understand the real costs, and we will couple that with what we have learned from the eight hospitals. So there is some work that needs to be done on this.

Chair: Can I hurry you up, please?

Sir Bruce Keogh: I have finished.

Q96 Chair: Can you give us a time frame for all this?

Sir Bruce Keogh: I just did—the end of ‘16–’17.

Chair: Is that when it will start or end?

Sir Bruce Keogh: No, it starts next financial year.

Q97 Nick Smith: It is great that you are getting added value out of the real estate and kit. We all think that that is brilliant. You have talked about fairly big systematic changes across the board, and you have talked about a three-year time period for introducing it. Are you confident that you will meet it in those three years, even though to many of us three years sounds a long time?

Sir Bruce Keogh: It is always dangerous to say that you are confident, but what I would say is that I have never known, except on venous thromboembolism, an endeavour where so many people—managerial, clinical and others—have felt that this is absolutely the right thing to do. In my view, when you have got enough people thinking that something is the right thing to do and needs to be done, you have the momentum that enables you to do it when coupled with good, systematic levers.

Q98 Nick Smith: Would it not help, therefore, if you had a time frame on your renegotiation of the contract, because that seems to be at the core of this?

Sir Bruce Keogh: I am not involved in the renegotiation of the contract. That is between the BMA and NHS Employers.

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Nick Smith: Is either of your colleagues here involved with the negotiation of the contract?

Q99 Mr Bacon: After all that stuff that you have talked about, you have just mentioned something that is completely central and said that you have got nothing to do with it.

Sir Bruce Keogh: It is not quite as central as you think. A lot of consultants—let me be absolutely clear about this—are already going in and working at the weekends. A huge number all around the country. That is my first point. My second point is that the other levers that we are putting into the system I think are very powerful.

Q100 Mr Bacon: Do you know if they are doing significantly longer hours because they are doing Saturdays and Sundays where they previously did not?

Sir Bruce Keogh: Yes.

Mr Bacon: Unpaid?

Sir Bruce Keogh: You get a salary.

Q101 Nick Smith: Sir Bruce, what is your estimate on this contract being renegotiated and finished?

Sir Bruce Keogh: I do not know the time frame. It is going on at the moment—

Richard Douglas: I can give you a note on that. It is NHS Employers doing it, working with Department of Health. I have not got the time frame with me, but I can give you a note on it.

Q102 Fiona Mactaggart: This is the question that I want to ask Mr Douglas. He said earlier that he had issued a requirement that people do not have a second assessment when patients are passed between groups. I have heard that there is a sense within the system that sometimes expensive patients are passed out of one budget into another budget, and the assessment says that that is appropriate for them when it might not be appropriate for someone else, because one institution is passing the cost to another's budget. What are you doing about that?

Richard Douglas: What this is doing is saying that there should be a single assessment that both sides agree to, and that you should not have two assessments. That is the aim of the requirement, which was issued not by me, actually, but by David Flory yesterday.

Q103 Fiona Mactaggart: So there is a way that both sides agree to that. How do you make sure it is as fast as having two assessments?

Richard Douglas: You do not need to agree this for each and every patient. You need to agree the discharge assessment that they will use and then both organisations sign up to it and say, "Once one of us has done it in this way, we both accept it." It is just trying to stop duplication and delay in the system.

Q104 Fiona Mactaggart: A better start might be having a single budget, in my view. I am going to ask you, Sir Bruce, to look at figure 16 in a moment, but before that, perhaps I can ask Sir David about occupancy levels. The Report says in paragraph 1.21 that "hospitals with average occupancy levels above

85 per cent can expect to have regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections." I actually looked at all the hospitals represented by members of this Committee, and only one of them has an occupancy level of under 85%. Most of them have a 90% level or more. What are you doing about that?

Sir David Nicholson: I am not trying in any way to suggest that the system is not under enormous pressure. It is, and you can see that in the occupancy rates. We are doing two or three things about that and, as you know, in all the conversations we have had, it is about the way that the whole system works, not just an individual bit of it. In a sense, one bit of the system can start not to work and it has an impact across the whole thing. They are all connected—all of these things that we are talking about are all connected, and that shows in occupancy.

Q105 Fiona Mactaggart: Unfortunately they are not financially connected, so the connections seem to mean that clinicians are spending a lot of time in meetings.

Sir David Nicholson: We are going to have a discussion about finance, aren't we? There is an incentive system here that needs reform, but some of it works very well. Anyway, in terms of the occupancy position that you just described, the first thing is that we monitor the overall position of the number of available beds and the occupancy very carefully—in fact, we have weekly figures that show us that. There are more beds in the system this year than there were last year, and we have allocated another £250 million and a further tranche of £150 million—

Q106 Chair: There is a graph somewhere in the Report showing bed decline.

Sir David Nicholson: Yes, I know. I am saying that when you look at the general number of acute beds available on a weekly basis, this year it is bigger than it was last year.

Q107 Chair: That is not what the graph says—I cannot remember where it is.

Sir David Nicholson: I am giving you the figures from last week.

Q108 Fiona Mactaggart: But you have bumped that up recently, based on winter patients. It is not the same.

Sir David Nicholson: Yes. There are more beds in the system now than there were this time last year, for winter. We are better prepared in that sense.

Q109 Chair: There has been a 30% decrease over the decade.

Sir David Nicholson: I'm not saying there hasn't. There has been a decrease over the period. If you look at any graph like that in any part of the developed world, you will see exactly the same kind of graph. As we drive more day cases, as we shift the model of care, in not just emergency but other services, you are seeing that reduction in beds. The majority of the reduction in beds that you will see will be through elective care—through the shift to day cases. Ten

years ago, 25% of our elective work was done on a day case basis; now it is nearly 80%, and in some hospitals it is 90%. Those are big changes, as well as the pressure overall.

So you have seen that reduction, but on general acute beds being available, the second thing is that we have given more money out this year, and earlier, to enable people to do other things. We have particularly focused people's attention on the use of non-NHS facilities—for example, on the use of the independent sector to provide extra beds and support to organisations. We have done quite a lot to make that run better.

Having done all of that, if you have a problem at the discharge end, it still backs up; if you have a problem with ambulances, it backs up; if you have a problem with primary care, it backs up. Getting the whole system right is what we are currently trying to do, hence the urgent care working groups.

Q110 Fiona Mactaggart: What is a safe level to work at in terms of bed capacity, and how you are going to deliver it this winter?

Sir David Nicholson: The only people who can judge that are the people who run the hospitals themselves. It is quite hard to be able to do that from the centre. There is evidence that it is 85%, but that is not absolutely incontrovertible. At the end of the day, people have to make a judgment about the number of beds that they have available, their financial resources and the activity that comes through the door.

Q111 Fiona Mactaggart: I said to Sir Bruce that I wanted his opinion on figure 16, which is about four-hour admissions. If you look at figure 14, it is quite clear that the four-hour waiting time standard does act as a pressured deadline, but one thing about figure 16 that I am interested in is that it suggests to me that in those places where there is a wait longer than four hours, patients might be more ill. I am not sure whether I am right, and I want to know whether he thinks that that is what the longer stay dates show.

If you look at the longest waits, more than half the patients are staying for three days or more, compared to the group of patients that were seen within half an hour, where less than a third are staying for longer. Am I right in thinking that that pattern might tell me that the people who wait for longer are more ill, or is there a flaw in the hospital's administration?

Sir Bruce Keogh: Our interpretation of that is that many of the sick patients take longer to sort out, so they do tend to wait longer. When I say "wait," that is the wrong term—it takes longer to sort them out, so you would expect to see—

Fiona Mactaggart: They would be having more tests.

Sir Bruce Keogh: Yes. That is our interpretation.

Q112 Fiona Mactaggart: I am very interested in this issue. Very often, those hospitals that are breaching the four-hour limit, or are close to it, are described as "inefficient." However, it seems that that figure implies that something else is going on, and I am wondering whether you have data that backs that up. It is not really the job of the National Audit Office—they have provided us with a very useful table that I

have not seen in this form before—so I am wondering whether you have data about length of time and clinical outcomes that is available for the public, so that we can better interrogate the issue of four-hour waits.

Sir Bruce Keogh: I do not have the data immediately to hand, but your point is really good. The problem of a whole system is manifest in A and E, but the solutions are actually before and after A and E. What we see with many of these hospitals is a congested hospital with people waiting to get into beds, if you like. There are issues around how efficient the hospital is, but also how well it is supported by its community services.

Sitting suspended for a Division in the House.

On resuming—

Chair: Right. We are going to go with Jackie, and then I am going to come in on the money.

Q113 Jackie Doyle-Price: My questions follow on nicely from where Fiona was taking the discussion just before we suspended. Sir David, you mentioned that if you have a weakness in one part of the system, it causes knock-ons elsewhere. I have to say that that is my experience completely; a lot of the problems that I have locally start with poor GPs. The Report says that a fifth of admissions could be more effectively managed elsewhere. Have you developed tools to show where there are particular strains? If you have some measurement tools, you can look at raising the performance of all the links in the chain.

Sir David Nicholson: Yes. There are two things. One of them is that there are lots of ideas about what to do. Indeed, part of the problem that we have had over the past few years is that we have tried almost everything. That is one of the reasons why we have so much duplication in the system—everyone is trying to add something on to it. That is why Bruce's total reform of the system is the right thing to do in the medium term.

When we originally invented the four-hour thing, what we wanted to do was to get a much better urgent care system going. The four-hour target was invented as a sort of indicator of how well the system was working. Don't forget that it is not a waiting target; it starts from when the patient presents themselves at A&E to getting them sorted out—admitted, treated, sent home or whatever. We thought that was a really good way of being able to say, "If we can do that within four hours, the whole system is probably working well." So that was the reason why we did it. It is not just a criticism of a hospital. There are lots of things that hospitals can do, but it is not a criticism of a hospital; it is the whole system. Hence the urgent care working groups and all the rest of it.

We have a whole series of things that have been tried out. In Barbara's letter to the service in May, we set out what good practice was. It is everything from the availability of general practice to out of hours and seven-day social work. It is a whole load of things, some of which are very helpfully in the Report. One of the things we have asked the urgent care working groups to do is to look at the extra money that is coming in and ensure that it is put against those kinds of things so that we can monitor and ensure that they

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are happening. That is the way we are trying to address the whole system.

Q114 Jackie Doyle-Price: Again, it brings us back to patient outcomes. You inevitably end up with measurements that are processy. I am just looking at the statistics for my hospital, which I always enjoy. We have a bed occupancy rate of 97% and, lo and behold, we have a real problem with hospital-acquired infections. The other interesting thing is that the hospital has the second lowest percentage of short stays, but the highest percentage of all trusts for long stays. I suspect that the issues of hospital-acquired infections and long stays are not divisible. Again, it comes back to this point: if more people present themselves at A&E, unless we get the intelligence to tackle that issue of care in the community and GPs, it will all end up in the hospitals in the end, and they are always going to be fighting a losing battle. How do you gather the intelligence to challenge GPs to up their game?

Dame Barbara Hakin: We are doing two things to address that. We are certainly starting to publish a great deal more information about the quality of GP services on our NHS England website. Another thing that has been put in place recently is in the GP contracts, with having a specific focus on hopefully being freed up to look at, as I say, frail, elderly patients in particular. It is those patients who have the most admissions. What A&E and our hospitals will say is that the issue is predominantly about admissions rather than attendances. Those two measures are a start at improving transparency about primary care services.

Q115 Jackie Doyle-Price: Ultimately, it is down to the CCG to monitor the performance of GPs and to ensure that the GP infrastructure is fit for purpose.

Sir David Nicholson: No, that is our job. NHS England does it, not the CCG. Our area teams do it.

Q116 Jackie Doyle-Price: But, essentially, the CCG is going to be playing a role.

Sir David Nicholson: Yes, they play a role.

Q117 Jackie Doyle-Price: This is where I have a problem locally. We have lots of single GP practices and there needs to be a massive step change in the quality. Until there is, we are always going to have a problem with this. I still cannot see how we are going to achieve that without real challenge. I know that the hospital trust is doing its best to try to feed intelligence back to the CCG, so there is some transparency in it, but ultimately how do we do it?

Dame Barbara Hakin: We have the responsibility in NHS England for the oversight of the contracts and ensuring that people fulfil the terms of service, but I do not think that we should underestimate the power of CCGs. The peer pressure on general practice makes a huge difference to professionals. I was a GP for 20 years and I know what a difference it makes when everyone is shown relatively how they are performing on the quality of services. In the majority of CCGs, we are seeing them have a serious focus on helping us to drive up the quality of general practice.

Q118 Jackie Doyle-Price: I accept that and I can see that it would happen in the majority, but as the Chair and I were discussing, we represent constituencies where people have very low expectations. To be honest, the local health infrastructure takes advantage of that and that challenge does not take place. I think we need to get to a position where there is greater challenge from the centre when standards of performance fall below par.

Sir David Nicholson: It is our job to challenge—it is NHS England's job to challenge—general practice in your area and other areas to make that happen. Indeed, in the planning guidance we put out yesterday, we talked about how general practice as a cottage industry simply will not be able to respond to the challenges we have around creating services—out-of-hospital care. We simply cannot; we do not have the capacity. We are looking at how we are going to bring people together into larger groups—it is described as “general practice at scale”—because we think that is the only way to get the quality up.

Jackie Doyle-Price: If you overlaid the map of where you get difficulties with this with the map of health inequalities, they will end up exactly the same.

Q119 Chair: How much more are you going to pay consultants to get them to agree to work 7/7? How much is that going to cost?

Sir Bruce Keogh: I have no idea. I am not part of the negotiating team.

Q120 Chair: Richard and I were discussing it. If you are doing a proper bit of strategic planning to see whether this is an affordable policy, rather than it being just an aim that no one can quarrel with, you must have some idea of the overall cost to the NHS in mind?

Sir Bruce Keogh: I thought I had explained that last time in my last answer.

Q121 Chair: What, 1% or 2%?

Sir Bruce Keogh: I will run through it again. We think that it is of the order of 1.5% to 2% of the running costs of an organisation, based only on looking at eight hospitals, some of which made significant efficiency savings as a result, which they were able to reinvest in other—

Q122 Chair: I understand that if this works well, there may be savings elsewhere in the NHS, but how much will it cost in terms of consultants?

Sir Bruce Keogh: I do not know.

Q123 Mr Bacon: That is being negotiated trust by trust.

Sir Bruce Keogh: No. That is negotiated between NHS Employers, which is an organisation, and the BMA.

Q124 Mr Bacon: On behalf of all the trusts.

Sir Bruce Keogh: Yes.

Q125 Chair: Let me ask another question. See if you can answer this one: £3.8 billion is going out of your budget into local authorities. Where is that money

being found? What health services are being closed on the back of that?

Sir David Nicholson: It was announced as part of the spending review that there would be £3.8 billion—it's now called the better care fund, which has been created in two ways. The first is by money that we currently transfer over to local government. As you know, as part of the last spending review, the NHS transfers about £1 billion this year to local government to invest in rehabilitation and those kinds of services.

Q126 Chair: You transfer it at the moment.

Sir David Nicholson: We transfer it at the moment.

Q127 Chair: And how much of the £3.8 billion is money you currently transfer?

Sir David Nicholson: About £1 billion. About £800 million comes from other sources from the Department, from capital—

Q128 Chair: What does that mean?

Richard Douglas: It is a mix of existing budgets that we have. Effectively the additional amount is £2 billion.

Q129 Chair: Okay. The £800 million must be cuts elsewhere—a mix of budgets we have around the place.

Richard Douglas: No, it is the transfer of budgets that are currently used for the same type of thing. I can give you a list of budgets, but it is not cutting anything; it is transferring the money.

Q130 Chair: What, teenage pregnancy—that sort of stuff?

Richard Douglas: No. I would have to give you the list.

Q131 Mr Bacon: So you say that £2 billion is new money. The £3.8 billion is, as it were, activity that is rebadged because it is driven from elsewhere and—

Richard Douglas: The £2 billion is new.

Q132 Mr Bacon: So the £2 billion is coming from where? The overall settlement with the Treasury.

Sir David Nicholson: The £2 billion will come from our existing investment in health care.

Q133 Chair: So what goes?

Mr Bacon: So that is rebadged stuff as well.

Sir David Nicholson: It is not new money.

Q134 Mr Bacon: I thought Mr Douglas just said that £2 billion of it was new money.

Amyas Morse: Would it be right to see it as a subtraction sum, if I can help?

Chair: Yes, what goes?

Amyas Morse: Would it be right to say that you are minus £2 billion for health care as a result of this?

Sir David Nicholson: Can I say what I was going to say—and tell me if I am wrong, Richard? There is £3.8 billion, right. Some £800 million is coming from sources in the Department, not from the NHS. About £1 billion comes from existing transfers from health

to local government as part of the last spending review, which is spent on rehabilitation and various other things. Some £2 billion has to come from the core funding for the NHS. So we have to find it on top of the 4% we have to find anyway for 2015–16—a further £2 billion of savings from the NHS to put in this pool. That is a massive challenge.

Q135 Chair: Where is it coming from?

Sir David Nicholson: It is going to come, essentially, from either stopping or reducing expenditure in the acute sector—so not allowing the acute sector to grow in real terms, or any terms at all, or taking actual money off the acute sector. The acute sector is broadly going to take the bulk of this resource.

Q136 Chair: Right. So you are going to close some hospitals.

Sir David Nicholson: There are two ways of doing it. One is to drive even more the efficiency in the acute sector, so instead of 4% we might ask for 6% or 7%, which is a big ask—4% is a tough one at the moment. The alternative is essentially to take activity out of the acute sector. This is the challenge. If we work this right with the £3.8 billion we invest in out-of-hospital care through this pooled budget—it is not going to local government; it is going to the pooled budget, which is jointly held—and if we can spend that money and stop a whole load of admissions into hospital, so stop activity in hospital, that is the way we will release the savings into the system.

Q137 Chair: Building on the point that Jackie and Fiona both made, if we are running at 97% to 98% occupancy in the acute sector—

Sir David Nicholson: That is why I do not think you can do it by efficiency. I don't think that driving more patients through the same number of beds is going to deliver it. You are going to have to change how we deliver service. There are lots of examples in here about patients who do not need to be in hospital, or alternatives that could be provided, if they were available. We have to use that £3.8 billion in a way we have never done before to invest in community and out-of-hospital services to stop it happening. All the medium-term sustainability of the NHS depends on our ability to do that.

Q138 Chair: Yes. And the Report says on page 39, at paragraph 3.4, “However, the research is of variable quality and most other interventions”—that is, most of what you have been trying to do—“appear to have no effect on reducing emergency admissions in a wide range of patients.”

Sir David Nicholson: Am I allowed not to accept that? I am not, am I? Okay. I don't quite buy that. Looking at the growth in emergency admissions, when we sat down in 2007 or 2008 and looked at the future of the NHS with little or no growth, as opposed to what we had had before, one of the things we said was that in order to keep the NHS within the resources we had, we had to restrict growth in emergency admissions, because it is quite difficult to stop them altogether. We had to restrict growth—

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Q139 Chair: When did you say that?

Sir David Nicholson: About 2007 or 2008.

Q140 Chair: And what has it been doing since then?

Sir David Nicholson: The long-term trend has shifted. We said that we needed growth of no more than 1.6% over the period. Over the past three years or so, it has been about 1.7%, so actually we have made an impact. There is a debate about what it was that we did that made that impact. Undoubtedly we will come on to that in a minute. We did a whole load of things at that time that all came together to reduce the rate of growth. I think in future we have got to reinforce that. It is not true that we haven't done anything and it is not true that it has not had an effect. It has, but it has not had quite the effect that we needed, and it has not reformed the system.

Q141 Chair: Amyas, did you want to come in on that?

Amyas Morse: I just wanted to ask: as you prepare yourself for the better care fund, I wonder how substitution will work. For instance, if you take a pound of resource from one place and put it in another, I can understand that you can improve, for example, adult social care—a matter of great interest—but what I don't know is how soon that spending has the effect of reducing strain on the health services. Have you any thoughts on that?

Sir David Nicholson: The evidence is mixed. You say in the Report that evidence is mixed about what works. Most other developed health services are trying to this in one way or another at the moment, with varying degrees of success.

As you know, we start from the position of a health service that is extraordinary value for money, in the sense of the amount of money we spend on health compared with most other health care systems and what you get out of it. International comparisons show that. You are starting from that, but nevertheless we believe that there are things that we can do.

The external advice we have had—we have had a lot of people in to help us—is that it is possible to do what we need to do. It is possible to deliver community services, it is possible to deliver preventive services and it is possible to speed up the discharge of patients from hospital. It is possible to do all those things, but the question is whether we can do it fast enough, and whether we can make the changes fast enough. That is the issue that we are grappling with.

Q142 Chair: You can go through loads of the evidence—it is going up. A key fact is that emergency admissions are rising faster in England than in Wales or Scotland. I don't think that Wales has a particularly good record on this, but the rate of increase is faster in England. It is in the Report: rate of increase in admissions is 27% in England, 11% in Scotland and 5% in Wales. You say you are doing things and that it is better, but actually look at the hard facts, Sir David. Your record does not give us confidence, despite your best intent that you are having an impact.

Sir David Nicholson: As I say, you can see in the past three years or so that there has been a big turnaround in how we deliver.

Q143 Chair: But look at this. How do you explain this?

Sir David Nicholson: Do you mean that we are lower than Scotland?

Q144 Chair: No. The rate of increase in emergency admissions through A&E is rising faster in England than in the rest of the UK. This is not even looking anywhere else. Our rate of increase is 27%; Scotland is 11%; Wales is 5%.

Sir David Nicholson: I don't think that shows over the last three years.

Q145 Chair: It does till 2012–13. It goes 1997–98 to 2012–13.

Sir David Nicholson: It doesn't show that. It shows that it is going down.

Amyas Morse: It's on page 16.

Sir David Nicholson: There have been times when they have gone up higher. I know; you can see that.

Q146 Chair: 2011–12. You have one year missing. Come on.

Sir Bruce Keogh: No, it stabilises out at 2009–10.

Sir David Nicholson: We are lower than wherever it is—Scotland and Wales.

Q147 Chair: It is the rate of increase. I don't think the Welsh have a brilliant record. It is the rate of increase that we are looking at.

Sir David Nicholson: I don't think that over the last three years, we are in that place.

Q148 Chair: That is what the facts show, isn't it?

Sir David Nicholson: I don't think they do.

Leon Bardot: For the last few years the rate of increase has slowed down. I think this year emergency admissions—

Chair: I can't hear. Please speak up.

Sir David Nicholson: No, it has not.

Dame Barbara Hakin: It is a 0.3% increase this year to date, which, when you extrapolate that to the—

Q149 Chair: I do hate it with these reports. I just take the facts as you give me in the reports.

Sir David Nicholson: But the facts show that we have stabilised over the last three years.

Sir Bruce Keogh: We have a plateau from 2009–10.

Q150 Chair: It went up in 2009–10. It came down between 2010–11 and 2011–12, to be absolutely clear. It went up. So you have one year showing a bit of a plateau.

Sir David Nicholson: I never said that we would not go up. I said that our plan, our objective, was to get it below 1.6%. That was our objective.

Q151 Chair: And your record in relation to the other nations in the United Kingdom is not good, according to this.

Sir David Nicholson: I think it is fantastic, apart from Northern Ireland. It is much better than Wales or Scotland.

Q152 Chair: No, I am talking about the rate of change.

Okay, let me try you on another one. We will obviously have to agree to differ on that one. Can I talk about the financial incentives in the system? As I understand the tariff, if you go above your A&E record of the year before—correct me if I am wrong—you get only 30% of the tariff. I am not sure why on earth we do that and whether it is having the impact you want. Hospitals don't determine the A&E demand; that is happening outside. But what you are then doing, which brings me back to my own hospital, is putting on financial pressure, because of their having to subsidise A&E out of other budgets because you have cut the money they get for the extra people coming in. You are putting financial pressure on those very hospitals that are already in challenging financial circumstances, where the pressure on A&E is leading to massive bed occupancy rates, ambulance trails and all the other things we have been talking about. So your financial tariff regime is having a perverse effect.

Sir David Nicholson: Can I tell you a bit of the theory and then tell you about the practice? *[Interruption.]* I can see from your face—okay, I'll just get on and talk about it. How this is supposed to work—you are absolutely right—is that we sat down in 2007 or 2008 and said, "Right, we need everyone focused on reducing emergency admissions. How can we get acute hospitals to focus their attention on this?" That is not because they can control it, but because they have a lot of the clinical expertise and knowledge that we need to control it. So how can we do it? An obvious way was a financial incentive. So what we have said to them is, up to a certain level, you get full tariff and then above that level you get the 20%—

Chair: 30%.

Sir David Nicholson: Sorry, the 30% that you described. But the 70%—the other bit of the tariff—is kept back by the commissioner to use on out-of-hospital care. So the idea was that it would make acute hospitals come to the table to discuss how we are going to make it happen, and that we would create a pool of money to enable us to invest in community services. That is the theory and, in the first year, that is exactly how it worked. One of the things we did was that the commissioner could only spend their 70% if the strategic health authority agreed that they could. What happened as that system moved was that the 30% remained, but the 70% got spent somewhere else. So the whole point of having that 70% to invest in out-of-hospital care meant that the commissioners were actually spending it somewhere else—very often in the same hospital, I have to say—on other services. So you got this slightly perverse thing where hospitals were getting only 30% and then did not get access to the 70%. We have put that right now. In fact, the urgent care working groups now have the ability to make a judgment about that 70%, don't they?

But this is only 3% of activity. It is not all emergency activity, but only 3% of it across the country as a

whole that is subject to the 30% rule. It is only a small amount.

Q153 Chair: But for these acute hospitals, what percentage of their income comes from their A&E? I cannot believe that is the case in Queen's—I would think that most of their business comes through A&E, so most of their income will come through patients. I do not think that they have got much room to do elective surgery.

Richard Douglas: On the national aggregate level, the 70% of the 3% is about £250 million. So the money that is lost out of the acute system is about £250 million.

Q154 Chair: But I think that that is just too broad. You have got to look at hospitals—

Richard Douglas: I was going to say that that is at national aggregate level. For individual hospitals, you will see some difference in that. You will see that some hospitals are hit very badly by it, but some are basically not affected by it at all.

Sir David Nicholson: If you look at your graph, you can see that it may have had an impact on at least controlling the amount of emergency admissions that are going into hospitals. It has had an effect. It is quite difficult to measure exactly what that effect was, compared with some of the other things that we did, but we do recognise, and Bruce recognises in his report, that paying for emergency care by case is not going to be the way that we solve this problem.

Q155 Chair: But also it is about control. You want the social care people to get fined if they put people into hospital. You have got to put the financial incentives elsewhere. Or you want GPs, actually, to get fined if you cannot get through on the phone.

Sir David Nicholson: The other issue is that there is a fining system for social care.

Chair: It is a financial incentive.

Sir David Nicholson: I agree, but the point is that paying for emergency care per case puts completely the wrong incentives in the system at the moment. We recognise that and that is why we are doing a lot of work on what is described as the year of care tariffs. The idea would be that an individual hospital would be given so much per head of a particular group of population to look after the totality of their care, both in hospital and out of hospital. In that way, you will get the incentive to look after the total care of that patient, rather than, essentially, clocking-up incentive payments as people move around the system.

Q156 Chair: When will that come in?

Sir David Nicholson: It is not going to come in this year. We are going to continue with the existing system, although we are making sure that the 70% is available to invest in out-of-hospital care. We have, I think, eight pilots going on in relation to that, but the first time you could do it is in 2015–16.

Q157 Chair: Nationwide in 2015–16?

Sir David Nicholson: I will have to give you a detailed note on that.

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Q158 Chair: Okay. The other thing I wanted to ask on money was that in September you found £250 million and then, at the end of November, you found another £150 million that you put in. For the life of me, I cannot see how giving the money that late enables hospital trusts to do sensible planning.

In fact, I would suggest to you that it will be really poor value, because if they are to increase in the end, it will be money spent on people, and they will have to get locums in, who we all know cost much more than other people. Isn't this a mad way of trying to deal with the winter crisis?

Sir David Nicholson: It is not ideal, that is true. But the sources of that money were twofold. First of all, the Chancellor, or the Department, came up with the first £250 million—in fact, they came up with £0.5 billion and have said that there is £250 million this year and £250 million next year, so we already know that there will be £250 million next year.

In a sense, it will not be done late because it has been announced up front. The £150 million extra that we put in is because we had underspend somewhere else, and we judged that it would be sensible to get that out into the system as quickly as we could. For both those tranches, we have put it out earlier than we have ever done before, but I acknowledge what you say.

Q159 Chair: So will we not see this again?

Richard Douglas: The £250 million you will— you will see that going out earlier. The £250 million is already announced for next year. People know it is there.

Q160 Chair: You know which hospitals it is going to. You have allocated it.

Richard Douglas: No, it has not been agreed hospital by hospital.

Q161 Chair: When are you going to do that, so there is time for them to plan?

Richard Douglas: We would aim to get that done a lot earlier than we did this year. It would probably mean the early part of the financial year. I think we should aim to try and get it done in the first quarter. I cannot guarantee you—

Q162 Mr Bacon: Will they all get some?

Richard Douglas: We have to make a decision on that, because this time round, the £250 million was focused on the 53 with the biggest problems and then the £150 million went out, effectively, to everybody else.

Q163 Chair: I do not know why they cannot get it on 1 April, to be absolutely honest. If you think about it logically, you are spending this money on people, aren't you? You are going to spend it on extra people in A&E. That is what you need.

Sir David Nicholson: I agree that we should get it out earlier. I think that the best time to get it out is when you have essentially closed down your winter arrangements for this year. I think in April next year, you will be able to assess how well we did and assess how well that resource did and what worked, and then

make a judgment. I am very happy to say that we should make that money available—

Richard Douglas: In the first quarter.

Sir David Nicholson: In the first quarter of next year.

Q164 Chris Heaton-Harris: I am a bit sceptical about all this, because essentially, you are rewarding trusts for not actually doing the job that you have given them a budget to do in the first place. One of the hospital trusts that looked after my area received some money, but I was not happy that it received some money—I was really concerned that it needed it. I just wonder whether we are now building this into a system and somewhere in hospital management, people will be thinking, "Whether it comes in the first quarter or the last quarter, we are going to be rescued by some sort of intervention from the Department."

Mr Bacon: Or better still, if I were a trust finance director, I could be thinking, "How can I present my numbers such that I come high up your list? I know that they are not going to give it to everybody, but I want to make sure that they give it to me." That would be a rational thing to do, would it not?

Richard Douglas: This is the difficult decision we always have around this. This is not aimed at rewarding failure in some way. What we are trying to do is assess those parts of the country that have the most significant challenge, and that could do with extra support.

It does not just go to trusts, so when we are looking at how that money will be deployed, it will not be £250 million just going to trusts; it will go to some of the other things that we have talked about today. It will not go just to the acute trusts; it can potentially go into some areas of social care, into community, and into the ambulance service. One reason why you would not want to rush to put it out now is that you want to find the best ways of using it.

Chair: But the best way is to use it early—that is one of the criteria. Meg has a final couple of questions, then we are there, I think.

Q165 Meg Hillier: They are quick-fire questions, so quick answers are fine. Earlier, we had a discussion about locums and permanent staff, and the costs for locums being high. I want to be clear: are you looking at, or would it be a matter for NHS employers to look at, a sweetener to entice permanent staff to hospitals where there are big vacancies, such as the Chair's hospital? Who would be looking at that, if it is not any of you?

Richard Douglas: Essentially, that would be an issue for the Department and NHS employers, or for individual trusts themselves.

Q166 Meg Hillier: Okay. Has anyone done the numbers on what that might save and cost?

Richard Douglas: I have not got any with me here. Someone may have done, I do not know.

Q167 Meg Hillier: If someone in the Department has, it would be helpful to have that. On the seven-day-a-week working, Sir Bruce, is there a minimum-size hospital that makes this cost-effective?

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Sir Bruce Keogh: No, I don't think so. What we do not want to create is the impression that every hospital should offer every service seven days a week. In the same way that you know in your town which pharmacy is open, we think that they can be networks, collaboratives and federations that enable people to provide a service for a community. That is how I envisage it.

Similarly, may I add something to getting more consultants into A&E, which came up right at the beginning? Health Education England published something at their board meeting yesterday; I think you will want to see that. Of particular relevance for this is, when we did our review of urgent and emergency care services, we recognised that different A&Es provide different levels of service; there is no doubt about that. So we are keen to institute a set of networks, which would ensure that there are proper transfer protocols, staff rotations and so on to help.

One of the other things that is happening is that, as from this year, we will have 1,800 more specialists coming out of the system, which will help in the negotiations, I guess, on the availability of consultants to help provide seven-day services. That extra 1,800 will go on until 2020.

In the interests of time, I will not run through what the HEE board paper said, but I think you will find some cause for optimism in that.

Q168 Meg Hillier: One final question, if I may. On contracting out, talking to a number of providers locally, we sometimes see NHS organisations bidding against each other for a three-year contract. Has anyone done any modelling in the Department about what the savings would be if that was a five-year contract instead? That would make more sense clinically and would not, I think, damage negotiations over price, but surely it would be cheaper than having bits of the NHS bidding against each other.

Sir David Nicholson: I certainly have not seen any work that has been done in the Department on all of that. But there is quite a lot of controversy and confusion about procurement and competition in the NHS at the moment. I think there is a huge amount of activity that is adding no value to anyone, and the people who are benefiting are the lawyers.

Monitor is putting out its guidance, I think today, on all that. We propose to put out some simple-words-of-one-syllable messages to commissioners about all of this, because if commissioners believe that a five-year contract will be better value for money and better for their patients, they should do it.

Meg Hillier: That is very helpful.

Sir David Nicholson: They should absolutely do it. I think that is a matter for local commissioners to decide, not regulators or anyone else.

Q169 Chris Heaton-Harris: Sir Bruce, you mentioned different networks in that last answer. Does that include allowing more flexibility in existing networks and allowing different bits of the health service to do extra work? For example, if my ambulance service wanted, first, to de-merge from its east midlands thing, but then offer extra services such as GP triage pre getting to A&E, are you encouraging that? How are you going to encourage that?

Sir Bruce Keogh: I will try and be really concise. In our urgent and emergency care review we recognised that people need, on the one hand, a better offer close to home, and secondly, when they have a really serious problem, they need to be able to get to a place where there are proper experts to deal with it.

We also recognised that 50% of 999 calls could be dealt with at the scene, which is often someone's home. We trust paramedics with our lives when we have been run over, yet much of the time they resort to just being drivers. We have a massive opportunity to use them for delivering care outside of hospitals and in the home. So the short answer to that is yes.

Q170 Chris Heaton-Harris: And you would encourage pilots in that area?

Sir Bruce Keogh: Indeed; absolutely. In our urgent and emergency care review, every proposition that we make has been piloted and tested somewhere. But the key thing is, all of these things need to fit together in order to have a whole that is greater than the sum of the parts.

Chair: Thank you. Happy Christmas. See you in the new year.

Written evidence from the Department of Health

PAC COMMITTEE HEARING EMERGENCY ADMISSIONS TO HOSPITAL: MANAGING THE DEMAND—20 DECEMBER 2013

Please find attached notes relating to the Emergency Admissions to hospital: Managing the Demand, hearing requested by the Committee along with the corrected transcript.

The notes are provided in Annex A along with the corrected transcript in Annex B.

I trust the information provided is of help to the Committee.

15 January 2014

RESPONSE TO Q31–35

DELAYED TRANSFERS OF CARE

NHS England publishes monthly data on delayed transfers of care, and this has been done continually (formerly by the Department of Health) since August 2010. The figures can be found on this weblink:

<http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/>

The data use definitions in place since 2003, when re-imburement was introduced.

NHS England also tries to cross validate these data with the winter data to spot any inconsistencies in reporting.

The data collected are:

- (a) Number of patients delayed on last Thursday of calendar month.
- (b) Number of delayed days during the month for all patients delayed (not just those delayed in end month snapshot).

These are split by:

- Acute/Non acute.
- Agency responsible for delay (NHS/Social Care/Both).
- Reason for delay.

NHS organisations submit the data split by local authority, so the figures are presented by trust and by local authority responsible.

RESPONSE TO Q41

Emergency Medicine Workforce Implementation Group (EMWIG)

Since April 2013 the Department has tasked Health Education England (HEE) to joint chair an Emergency Medicine Workforce Implementation Group (EMWIG) with the College of Emergency Medicine (CEM). The group's remit is to address workforce and training issues and is constituted of experts in emergency care and medical education and training.

In order to address shortages in the consultant workforce the group has undertaken programmes of work that will:

- Develop training routes into EM training (including alternative routes).
- Explore the recognition of transferable competences of trainees currently in other specialties to increase the pool of trainees eligible to apply for EM training.
- Support Associate Specialist and Staff Grade Doctors (Specialty Doctors) in their roles to ensure retention and increase work satisfaction.
- Expand training of multi-professional workforce and define their roles in the emergency department.

HEE through EMWIG will continue its work on the emergency medicine workforce and look to its LETBs to support the recommended workforce interventions in order to alleviate the current problems in emergency departments across England.

In October 2013, the Government mandated NHS Employers to enter into formal negotiations with the British Medical Association (BMA) to deliver joint proposals for consultant contract reform. We are keen to see proposals for a renegotiated consultant contract that makes the best use of the medical pay bill, but offers flexibility in the reward mechanisms ie terms and conditions, increased leave and recognising the intensity of work etc, so that specialty-specific issues can be addressed when needed.

RESPONSE TO Q68/9

How many social workers are employed by the NHS now?

Using data from October 2013 it is estimated that between 1700 and 1900 Social Workers were employed directly by NHS organisations. The uncertainty associated with this range is because we are not able to definitively identify those in Social Work roles.

The Electronic Staff Record (ESR) Data Warehouse is a monthly snap shot of the live ESR system. This is the HR and payroll system that covers all NHS employees other than those working in General Practice, two NHS Foundation Trusts that have chosen not to use the system, and organisations to which functions have been transferred, such as local authorities. ESR was fully rolled out across the NHS in April 2008. The ESR fields used for this question have not been centrally validated and so reliability is subject to local coding practice.

This estimate has been derived in conjunction with the “Job Role Verifier” Tool produced by the Health and Social Care Information Centre (HSCIC). The Tool was developed to aid local organisations with Data Quality and shows compatible combinations of Job Role and Occupation Code. More information about the Tool can be found at: http://www.hscic.gov.uk/media/12940/Occupation-Code-and-Job-Role-Data-Verifier/pdf/4_Occupation_and_Job_Role_Data_Verifier_Presentation.pdf.

This method has been selected as while the fields are not subject to external validation they reflect combinations of Job Role and Occupation Code that could be reasonably expected of Social Workers or Approved Social Workers.

A number of individuals also appeared under the “Social Worker” or “Approved Social Worker” but with Occupation Codes not in line with the HSCIC Tool. These individuals emphasise the fact that the estimate is not a definitive figure and may be either an under or overestimate depending on how individuals have been coded at the local level.

RESPONSE TO Q97–101

Consultants Contract Reform

In October 2013, the Government mandated NHS Employers to enter into formal negotiations with the British Medical Association (BMA) to deliver joint proposals for consultant contract reform, on the basis of Heads of Terms (HoTs) agreed by both parties. The HoTs set out key areas where the parties believe there is scope for reaching an agreement, including the facilitation of seven-day services. The HoTs sets out a commitment from both parties to creating a pay system that attracts, retains and motivates the right number and the right mix of medical staff to do all that is required for high quality patient care. The parties will aim to produce a national contract that is responsive to patients’ needs and delivers sustainable improvement in the quality of care, consistently, across the NHS.

The target date for implementation of new contractual arrangements is from 2015, allowing for a negotiating period of 12 months, with a phased period of implementation.

RESPONSE TO Q155–7

Long term conditions year of care funding model

The long-term conditions Year of Care (LTC YoC) funding model programme will develop a new payment system, based on a Year of Care currency and a capitated budget for patients with multi-morbidity (anticipated to focus on around the top 10% of high-intensity health and social care users in a population). The key features of this payment system are that it is:

- person-centred, rather than using the episodic currencies that current exist;
- cross-service (acute, community, mental health, social care and primary care), a currency for the whole patient pathway irrespective of the provider; and
- need-based, rather than a currency for a specific disease or service.

This four-year programme has seen eight Early Implementer teams work towards “shadow-testing” the LTC YoC currency in 2014–15 (Year 3) and, subject to satisfactory testing, national implementation (non-mandatory) in 2015–16.

NHS England plans to share thinking on future plans regarding year of care payments in more detail in spring/summer of 2014. Any proposed new payment models must be tested properly before roll-out, and there are opportunities to build on the work already underway with the “integration pioneers” and the seven-day services demonstration sites. We hope to be able to start the process of implementation of new payment models in 2015–16.