



House of Commons  
Health Committee

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# Winter pressure in accident and emergency departments

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**Third Report of Session 2016–17**

*Report, together with formal minutes relating  
to the report*

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## Health Committee

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

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## Summary

Accident and Emergency departments in England are managing unprecedented levels of demand. On average, over 40,000 people attended a major, or type 1, accident and emergency department each day across the NHS in 2015–16. Over the same period only 87.9% of patients were admitted, transferred or discharged within four hours—well short of the Government’s target of 95%. The variation in performance between providers was also striking, ranging from 64% to 99% in one survey from July 2016.

Achieving safe and timely performance in urgent and emergency care is an increasing challenge primarily as a result of growing and rapidly evolving demand as patients attend with more complex conditions but also as a result of system-wide pressures affecting the ability of the NHS and social care to cope.

The declining level of performance in A&E is a marker of stress across the whole system of health and social care. But performance standards or targets for A&E should not only be viewed as the ‘canary in the mine’ for system-wide pressures. They matter primarily because long waits in A&E affect patient safety and patients’ experience of care.

Traditionally waiting times in A&E increased in the winter because patients attending A&E tended to be older, more unwell and more likely to require admission than during the summer months. To manage this increase, emergency funding would be provided to open more beds and recruit additional staff. Hospitals then experienced a period of relative respite during the summer when, despite generally higher attendances, A&E patients would be less sick or less likely to be admitted.

That pattern no longer applies. For many hospitals demand pressures are high year round and just reach a more intense peak during the winter. Hospitals no longer have additional bed capacity to flex as occupancy rates are at their highest ever recorded levels. It is notable that England has the lowest number of hospital beds per head in Europe. Measuring occupancy at midnight also overestimates the true levels of spare capacity.

Hospitals are finding it increasingly difficult to maintain the flow of patients out of their emergency departments into wards and on to safe discharge. Reduced bed capacity has contributed to this situation, but simply increasing bed numbers would not solve the problem as so many patients are already experiencing delayed discharge. The response has to focus both on managing the patient’s journey through the hospital and on addressing the increasingly inadequate provision of adult social care services available to enable safe discharge.

We conclude that additional investment in community step-up/step-down beds and adult social care is essential to addressing the widespread pressures on A&E. Emergency departments do not exist in isolation and their performance will be supported by investing in services that can prevent admission via A&E and allow swift and safe discharge from hospital. We call on the Government urgently to address the underfunding of adult social care and to evaluate fully the wider impact of this underfunding on the NHS.

Despite the undoubted challenges there are also steps that hospitals can take to improve their own performance by learning from those which more successfully manage flows in similar situations. We support the measures that NHS England and NHS Improvement are taking to tackle variation but call on them to strengthen their processes for spreading good practice.

We heard many examples of good practice which can prevent unnecessary attendances and admission to hospital. We also heard of measures from the first contact with services through to discharge and beyond which can speed and improve the quality of care through the emergency department.

The current levels of variation in meeting the four-hour performance standard cannot be explained by financial challenge, demographics and demand alone. There are also examples of poor performance which have been made worse as a result of inadequate systems which have been allowed to continue for too long.

We call on the Government to make sure that sufficient funding is available to support the infrastructure investment required to ensure that type 1 emergency departments are fit for purpose, and to review the real terms cuts to NHS capital budgets in the Spending Review. We heard evidence of departments that will struggle to transform performance within existing facilities designed to cope with lower demand.

In the best performing hospitals all staff across health and social care will support efforts to meet the A&E performance target, not as a tick-box exercise but because it underpins patient safety and experience. It is in everyone's best interests for this to be the culture in every hospital.

# 1 Winter pressure?

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## Evolving demand

1. Achieving safe and timely performance in urgent and emergency care is an increasing challenge primarily as a result of growing and rapidly evolving demand but also as a result of system-wide pressures affecting the ability of the NHS and social care to cope. The evidence submitted jointly by the Department of Health, NHS England and NHS Improvement (this will be referred to as ‘the Government’s evidence’) said:

On average each day in 2015–16, the NHS saw nearly 63,000 people through its A&E departments, carried out nearly 9,200 emergency journeys by ambulance; and offered over 38,000 NHS111 calls. Overall, in 2015–16, 91.9% of patients attending A&E were admitted, transferred or discharged within 4 hours—that is over 21 million attendances.<sup>1</sup>

2. However, this figure of 91.9% applies to all types of urgent and emergency care provision, which can range from major emergency departments to GP-led walk-in centres. A major, consultant led A&E department which is open 24 hours per day, 7 days per week, 365 days per year is normally referred to as a type 1 department. On average 40,900 patients attended major A&E departments in England each day in 2015–16. The average performance figure for the 176 major A&Es in England is worse than for all types of A&E combined.<sup>2</sup> In 2015–16 only 87.9% of patients in type 1 departments were admitted, transferred or discharged within four hours—well short of the Government’s target of 95%. During the first quarter of 2016–17 85.4% of patients in type 1 departments were seen within four hours. By comparison, for the same period in 2015–16, the figure was 91.1%. The variation in performance between providers was also striking. The Care Quality Commission’s report on the state of care in 2015–16 noted that “in July 2016, the percentage of patients spending less than four hours in major A&E departments ranged from 64% to 99%”.<sup>3</sup>

3. Variation in performance also exists across the United Kingdom with the average performance against the four-hour standard of major A&E departments differing in each nation:

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1 Department of Health, NHS England and NHS Improvement ([WIP 35](#)), para 1

2 NHS England, [Quarterly Attendances & Emergency Admission monthly statistics, NHS and independent sector, August 2016](#)

3 [Care Quality Commission, State of Health Care and Adult Social Care in England 2015–16, HC 706, October 2016, p 17](#)

**Table 1: Percentage of patients spending less than 4 hours in A&E Type 1/major departments only, 2015–16<sup>4</sup>**

England	87.9%
Wales	77.7%
Scotland	93.3%
N. Ireland	71.7%

Source: Department of Health A&E attendances and waiting times data Stats, Wales A&E performance data, SD Scotland Emergency Department statistics, Department of Health NI Emergency Care waiting time statistics

4. The NHS standard contract outlines the penalties that can be applied to trusts that breach the four-hour waiting time standard in England:

Where the number of Service Users in the month not admitted, transferred or discharged within 4 hours exceeds the tolerance permitted by the threshold, £120 in respect of each such Service User above that threshold. To the extent that the number of such Service Users exceeds 15% of A&E attendances in the relevant month, no further consequence will be applied in respect of the month.<sup>5</sup>

Although fines are capped when performance drops below 85%, in some cases no financial penalties will be imposed at all. In July 2016 it was announced that the Department of Health, NHS England, NHS Improvement and the Care Quality Commission would replace national fines with individual improvement programmes for trusts. If A&E performance improved then no fines would be imposed, even if trusts continued to miss the 95% four-hour standard.<sup>6</sup>

### **Attendances & admissions**

5. The increased pressure experienced by emergency departments during the winter months is not directly related to numbers of attendances at those departments, but rather to the complexity of cases and subsequent admissions to hospital. Attendances peak during the summer months but hospitals experience most pressure and struggle hardest to achieve the four-hour waiting time standard (often referred to as the four-hour target) during the winter. The Government's evidence explained how this affects the provision of care:

The change in demand is not simply about an increase in the numbers of people accessing urgent and emergency care, as the average daily number of attendances at A&E tends to be higher throughout the summer months

4 National definitions of type 1 / major emergency departments:

England: 'Type 1': A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients

Wales: 'Major A&E': those departments providing a consultant led 24-hour service with appropriate resuscitation facilities and designated accommodation for the reception of accident and emergency patients

NI: 'Type 1': A consultant-led service with designated accommodation for the reception of emergency care patients, providing both emergency medicine and emergency surgical services 24 hours a day.

Scotland: 'Emergency Department': larger A&E services that typically provide a 24-hour consultant led service

5 [NHS England, NHS Standard Contract 2016/17 Particulars](#), April 2016, schedule 4

6 [NHS England, NHS action to strengthen trusts' and CCGs' financial and operational performance for 2016/17](#), [NHS England](#), July 2016

than during winter. The change in demand is about a greater proportion of people who attend A&E that are sicker and are subsequently admitted as an emergency—27.9% in winter compared with 25.8% in summer. It is this increase in emergency admissions that increases the demand for hospital beds which is evidenced by the increased occupancy rates with highest levels during winter (quarter four) and lowest levels during summer (quarter two) Consequently this affects the performance of A&E departments with the expected dip in performance during winter compared to summer when performance levels are better. [...]

These pressures all need to be put within the context of rising demand in the NHS generally: there were over 6,000 more A&E attendances per day in 2015–16 compared to 2009–10 and Ambulances carried out just under 500 more emergency journeys per day in 2015–16 compared to 2014–15.<sup>7</sup>

### *Seasonality*

6. Our inquiry set out to investigate why winter seems to present such a significant challenge to emergency departments. We wanted to understand why it is that normal seasonal changes seem to precipitate a lengthy period of crisis management within the NHS. In both 2014 and 2015 our predecessor Health Committee took evidence to investigate the performance failings of the urgent and emergency care system during the winter. Winter happens every year, so why do some acute NHS trusts perform so much better than otherwise similar providers in managing this predictable change in demand?

7. We focused the attention of this inquiry on the management, organisation and resourcing of emergency departments. We took this approach as the starting point for the inquiry as we wanted to investigate the issues that hospitals can do for themselves to cope during the winter.<sup>8</sup> We also acknowledge that this is a system wide issue and no inquiry into winter pressure can ignore the compelling evidence on the impact of the deteriorating situation in social care upon NHS performance. It would be wrong to assume, however, that the pressures on social care prevent trusts from taking their own steps to improve A&E performance.

8. As part of the process of informing this inquiry we visited Luton and Dunstable University Hospital NHS Foundation Trust, which has the best performing emergency department in England (judged by performance against the four-hour waiting time standard). In Luton we heard that winter does not represent a substantially more challenging period than any other for their emergency department, and this view was echoed in the evidence we received from other organisations.<sup>9</sup> The submission from the think-tank the Nuffield Trust argued that increasing pressure means that the problems associated with meeting the four-hour target are no longer confined to the winter months:

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7 Department of Health, NHS England and NHS Improvement ([WIP 35](#)) paras 3–4

8 Health Committee ' [A&E winter planning inquiry launched](#)' July 2016

9 Note of Committee visit to Luton and Bedford

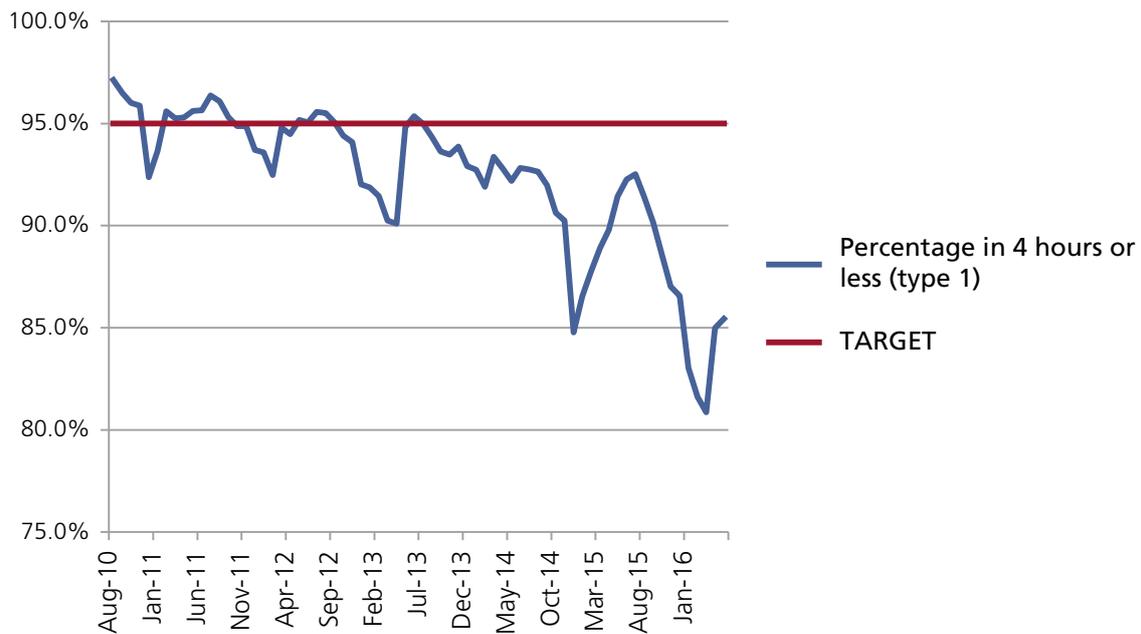
Our analysis suggests that it is increasingly no longer the case that these problems are limited or especially intense in winter. [...] performance has continued to deteriorate in the winter months—but the traditional respite in summer has not seen recoveries back to earlier performance levels, resulting in an overall downward trend.<sup>10</sup>

9. The traditional pattern of intense periods of pressure during the winter with some respite over the summer is less likely to apply. During June, July and August 2016 the performance of English emergency departments was worse than every winter since 2004 bar the winter of 2015–16.<sup>11</sup> For many departments the pressure feels relentless.

**Performance**

10. The challenge now facing the urgent and emergency care system has been underlined by performance against the four-hour target since the second quarter of 2015–16:

Proportion of patients attending Type 1 A&Es admitted, transferred or discharged within 4 hours



Source: Nuffield Trust ([WIP 33](#))

10 Nuffield Trust ([WIP 33](#), para 1.2. See also, for example, the submission from Homerton University Hospital NHS Trust ([WIP 30](#), p 3)

11 NHS England, [A&E Attendances & Emergency Admission statistics, NHS and independent sector organisations in England](#)

Figures published by NHS England in relation to type 1 emergency department performance showed that in July 2016 85.4% of patients were admitted, discharged or transferred within 4 hours.<sup>12</sup> That month Jim Mackey, Chief Executive of NHS Improvement, told the Health Service Journal that performance in the 70–80% range [against the four hour waiting time standard] had become “normalised” in some trusts.<sup>13</sup>

11. Pauline Philip, National Urgent and Emergency Care Director NHS England and Chief Executive, Luton & Dunstable University Hospital NHS Foundation Trust, put existing performance into context by using numbers rather than percentages, noting in oral evidence that more patients are seen within the four hours than ever before. This point was also argued in the Government’s evidence, which said “thousands more people a day are seen within the four-hour A&E target compared to 2010”.<sup>14</sup> Whilst this is true, it is also the case that more patients are waiting longer than four hours in English emergency departments than at any period since the four-hour standard was established. In 2011–12, 700,000 patients spent longer than four hours in emergency departments. By 2015–16 this figure had more than doubled, to some 1.8 million patients.<sup>15</sup>

**12. We are very concerned about the decline in performance of major emergency departments in England. We recognise that hospitals are managing ever growing demands, but the performance of emergency departments against the four-hour waiting time standard is a marker of much wider system pressure.**

### **Impact on patients**

13. The winter of 2015–16 was mild and the flu vaccine worked.<sup>16</sup> We heard of a fear amongst leaders of acute NHS trusts that 2016–17 could be substantially more difficult, something that has also been noted by Professor Chris Ham, Chief Executive of the Kings Fund.<sup>17</sup> It is both significant and concerning that compared to previous years hospitals are working from a much lower base in terms of their performance as we enter the winter period. The decline in performance of emergency departments which is usually associated with winter pressures has become the norm for some NHS trusts. In addition, the Care Quality Commission’s State of Care report showed that the majority of A&E services in England have been rated by the regulator as inadequate or requiring improvement.<sup>18</sup>

14. The impact on patients is the most worrying aspect of this situation. During the seminar we held with leaders of NHS trusts drawn from across England we heard that patients are likely to experience longer waits for emergency care whether they are in the waiting room, a cubicle or ambulance.<sup>19</sup> Evidence to our inquiry from Independent Age reported that people aged over 75 will spend significantly longer waiting for treatment than younger patients.<sup>20</sup>

12 NHS England, [A&E Attendances & Emergency Admission statistics, NHS and independent sector organisations in England](#)

13 Health Service Journal, ‘Mackey: A&E failure is ‘normalised’ at some trusts’, July 2016

14 Q2, Department of Health, NHS England and NHS Improvement ([WIP 35](#)) para 4

15 CQC, State of Care, figure 2.9

16 Department of Health, NHS England and NHS Improvement (WIP 35) Annex D

17 <http://kingsfundmail.org.uk/21A8-4EXIG-BBFNOV17BE/cr.aspx>

18 [Care Quality Commission, State of Health Care and Adult Social Care in England 2015–16, HC 706, October 2016, State of Care, Figure 1.8 \(57% of A&E services\)](#)

19 Note of Committee visit to Luton and Bedford

20 Q6, Independent Age ([WIP 27](#)) para 2

15. In the written evidence submitted to this inquiry witnesses stressed the relationship that exists between good performance against the four-hour standard and patient safety. The Royal College of Emergency Medicine said in its written evidence that “performance against the 4-hour standard is a useful proxy measure of crowding” in an emergency department and crowding “adversely affects every measure of quality and safety for patients & staff”.<sup>21</sup> Commenting on the various challenges a trust may face during the winter which can range from increased demand to high staff absence, University Hospitals of Morecambe Bay NHS Foundation Trust said that in combination these problems can compromise both patient safety and patient experience.<sup>22</sup>

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21 Royal College of Emergency Medicine ([WIP 09](#)) para 39

22 University Hospitals of Morecambe Bay NHS Foundation Trust ([WIP 24](#)) para 3.1

## 2 Pressure & patient flow

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### Patient flow & performance

16. Good performance within an emergency department is dependent on maintaining the flow of patients through hospital. Professor Keith Willett, National Director of Acute Episodes of Care at NHS England, explained the relationship between patient flow and performance against the four-hour standard:

If you look at the breaches of the four hour standard, where they [patients] have not had their treatment and admission completed, yes, there is an issue there. [...] That is due to the flow through the hospital, and that is when they are on what would be called trolley waits, although, clearly, most of these patients are on beds and not on trolleys, but they may not be in the appropriate environment and they may not be in the specialist area they should be. That is about the flow.<sup>23</sup>

17. The Nuffield Trust's written evidence said that "improving inpatient flow is likely to be fundamental to fully addressing the problem"<sup>24</sup> of pressure in emergency departments. Their evidence outlined in more detail the relationship between performance and flow:

Looking across trusts, forthcoming Nuffield Trust research will show that those achieving the 4 hour target have lower bed occupancy across all acute beds. The mechanism by which this happens is not simply that all beds are occupied, preventing any admissions. Rather, it relates to the reduced capacity for patients to "flow" through the system when space is very tight. A certain proportion of free beds is needed to move patients through quickly, due to the need for cleaning, preparation and proper staffing to be put in place. As fewer and fewer beds are left free there is a slowdown. A "one in, one out" dynamic emerges, with queuing causing a back-up in A&E.

18. Dartford and Gravesham NHS Trust's written evidence described the practical problems that inefficient patient flow can create within an emergency department:

Exit block prevents A&E trolley and cubicle space being used to see and treat other A&E patients as these areas contain patients awaiting a hospital bed, significantly impeding the flow through A&E.<sup>25</sup>

We also heard during our visit to Luton and Dunstable hospital that the most complex patients within the emergency department demand a significant amount of staff time.<sup>26</sup>

19. Professor Willett, however, argued that the "delays and inefficiencies" associated with patient flow described above are tied into the way the entire urgent and emergency care system operates and how beds are utilised as a result:

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23 Q5

24 Nuffield Trust ([WIP 33](#)) para 3.2

25 Dartford and Gravesham NHS Trust ([WIP 34](#)) p 2

26 Note of Committee visit to Luton and Bedford

We measure our urgent call handlers' performance in seconds, our ambulances in minutes, our emergency departments in hours, our hospitals in days, and we probably measure community and social care in weeks. When you have a surge, the responsiveness you need has to be across the whole pathway and we are not capable of doing that. What happens is that, because we exceed something in a very short space of time, we then make a set of decisions, because we are forced to, which are counterproductive. We start moving patients to the wrong wards; we open escalation beds; we do that sort of thing.<sup>27</sup>

### **Early senior review of patients**

20. One aspect of care which is regarded as significant in maintaining flow is for each patient to be seen by a senior clinician soon after arriving at the emergency department (commonly referred to as "early senior review"). Our predecessor Health Committee's 2013 report on urgent and emergency care said this could avoid "laborious triage" by a hierarchy of doctors and concluded:

Accessing early senior review of cases can reduce duplication and accelerate the path of a patient through the system. Senior clinicians are better able to balance risk and make key decisions.<sup>28</sup>

The Nuffield Trust's evidence highlighted "a lack of senior decision makers" within some trusts, which could contribute to difficulties in transferring patients to inpatient wards or discharging them.<sup>29</sup> They added that "Senior decision makers should be available early, with an emphasis on resolving cases in one assessment".<sup>30</sup> Their findings are backed by those of the Health Foundation in a study published in April 2013.<sup>31</sup>

21. The Centre for Urgent & Emergency Care Research based at the University of Sheffield, however, observed that the evidence on outcomes for early assessment by senior clinicians is limited:

Early assessment by a senior doctor is intended to accelerate progress through the emergency department. Our systematic review of 25 studies (Abdulwahid 2016) found some evidence that senior doctor triage reduced waiting times and the risk of patients leaving without being seen, but did not find evidence of an effect on adverse events, patient satisfaction or cost-effectiveness.<sup>32</sup>

Visiting Luton and Dunstable trust we heard that early senior review was most helpful for complex patients who were likely to need admission rather than for patients with minor conditions.<sup>33</sup> The Trust continually evaluates the effectiveness of their interventions to improve flow and outcomes for patients and staff in all areas share responsibility for achieving those benefits.

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27 Q22 (Professor Willett)

28 Health Committee, Second Report of Session 2013–14, [Urgent and emergency Services](#), HC 171, para 78

29 Nuffield Trust ([WIP 33](#)) para 2.4

30 Nuffield Trust ([WIP 33](#)) para 3.1

31 Health Foundation, [Unblocking a hospital in gridlock](#), April 2013, p 9

32 Centre for Urgent & Emergency Care Research ([WIP 04](#)) p 2

33 Note of Committee visit to Luton and Bedford

## Conclusion

22. **Both the Nuffield Trust’s and the Health Foundation’s research support the case for early senior review of complex cases. The systematic review cited by the Centre for Urgent & Emergency Care Research, however, reported limited cost and patient outcome benefits from routine use of early senior review of patients. When redesigning systems and processes with the intention of improving patient flow trusts should assess how they are applied and whether they are effective in their local context.**

## National policy interventions

23. The Government’s evidence listed five improvements (“interventions”) which trusts were expected to make in 2016–17, if they had not already done so:

The initiatives that relate to streaming, flow and discharge represent actions that have already been shown to have a positive impact in local systems that have implemented them effectively. This is about implementing these actions everywhere and also about a focus on outcomes and processes.<sup>34</sup>

The five interventions designed to improve flow affect all stages of the patient’s pathway through urgent and emergency care:

(1) **Streaming at the front door—to ambulatory and primary care.**<sup>35</sup>

This is designed to reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.

(2) **NHS 111—increase the amount of clinical input into calls to the NHS 111 number in advance of winter.**

This is expected to decrease call transfers to ambulance services and reduce A&E attendances.

(3) **Ambulances—Dispatch on Disposition and code review pilots; Health Education England increasing workforce.**<sup>36</sup>

The aim is to help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive an appropriate and timely clinician and transport response. The aim is for a decrease in conveyance and an increase in ‘hear and treat’ and ‘see and treat’ to divert patients away from the ED.

(4) **Improved flow—‘must do’s that each Trust should implement to enhance patient flow.**

34 Department of Health, NHS England and NHS Improvement (WIP 35) Annex C

35 As patients enter the emergency department, a streaming system should be put in place which directs those patients who are not sufficiently sick to require emergency care to a service which is better able to meet their needs.

36 Changing the categorisation of calls to the ambulance service so that the process of dispatching paramedics and vehicles can be guided by clinical need rather than meeting target response times (see chapter 5)

This is designed to reduce inpatient bed occupancy, reduce length of stay, and implementation of the ‘Safer Patient Flow Bundle’ will facilitate clinicians working collaboratively in the best interests of patients.

- (5) **Discharge–increase proportion of patients receiving RRR (rehabilitation, recovery and reablement), care in home or community settings mandating ‘Discharge to Assess’ and ‘trusted assessor’ type models and oversee these initiatives, linked to Regional Delivery Boards.**

The aim of RRR is to improve the quality of patient care and outcomes by delivering a seamless RRR service for acute admitted patients. To ease pressure on capacity in acute hospitals and to improve the experience for patients, it is generally more beneficial if patients received RRR care in home or community settings.<sup>37</sup>

24. Commenting on these initiatives, Pauline Philip said they were the central element of the national bodies’ efforts to improve performance and instil resilience as winter approaches:

At the heart of the A&E improvement plan are five “mandated” initiatives, basically five things that we want each local delivery board to consider, the local delivery board being where the provider sits surrounded by commissioners, surrounded by other stakeholders.<sup>38</sup>

25. Ms Philip said that A&E delivery boards should concentrate on applying the interventions related to patient flow that are the direct responsibility of emergency departments and hospitals:

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

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

That leads me on to the fourth initiative, which is around discharge, looking at patients who are medically fit, occupying acute beds.<sup>39</sup>

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37 [Ibid](#) (numbering and emphasis our own)

38 Q41

39 Q41

26. The Minister of State for Health, Philip Dunne MP, giving evidence to us, supported the view that the interventions designed to improve flow can significantly improve emergency department performance.<sup>40</sup>

### Conclusions

27. **It is welcome that the interventions designed for use by A&E Delivery Boards and individual trusts focus on the practical aspects of patient flow throughout a patient's stay in hospital. We support the whole system approach to providing a better experience of care to patients in the right setting at the right time.** This includes care that may be more appropriately delivered within the community rather than in acute beds.

28. The Centre for Urgent and Emergency Care Research, however, has expressed concerns about the strength of the evidence base for some of the interventions which are intended to improve emergency department performance. The Centre is concerned that the solutions being implemented are not fully backed by evidence:

NHS England has produced a guide to good practice (NHS England 2015) with evidence-based principles to deliver safer, faster, better urgent and emergency care. However, the cited evidence consists almost entirely of uncontrolled before-after studies, observational studies and expert opinion, all of which are recognised to carry a high risk of bias and confounding.<sup>41</sup>[...]

The lack of acceptable evidence explains why implementation of the principles has been variable and why implementation has not led to clear improvements.<sup>42</sup>

29. **Ministers and senior officials should acknowledge the reservations expressed by the Centre for Urgent and Emergency Care and re-examine the evidence base for the initiatives being applied within emergency departments.**

30. Applying the principles of safer, faster, better emergency care will be central to winter resilience planning for many trusts.<sup>43</sup> **We recommend that NHS England and NHS Improvement set out how they intend to formally evaluate the effectiveness of the interventions that they have mandated and how they will be encouraging trusts to do likewise. Data collection and evaluation should be built into future programmes from the outset to improve research into the most effective interventions.**

### Practical improvement

31. Whilst acknowledging the importance of national research and evaluation, we were struck by the practical measures applied at Luton and Dunstable University Hospital NHS Trust which has achieved the best performance of any type 1 emergency department in England. As already noted, we were told that the Trust does evaluate their own interventions to measure their impact on performance. The steps taken by Luton and Dunstable which they told us underpin its exceptional performance included:

40 Q25

41 "Confounding" is the presence of extraneous variables which are not controlled for in analysis

42 Centre for Urgent & Emergency Care Research ([WIP 04](#)) p 1

43 University Hospitals of Morecambe Bay NHS Foundation Trust ([WIP 24](#)) para 5.02

- Investing in information technology to provide real time monitoring of bed capacity and demand.
- The use of a two stage triage process at the front desk, first to identify cases requiring an emergency response or to redirect patients to the co-located GP service, and secondly to initiate diagnostic tests.
- Allocating beds prior to final diagnosis for those patients that will require admission. This required early involvement of senior decision maker for patients identified at triage to be at risk of admission.
- The creation of a culture where all medical staff within the Trust as well as the social care team will support the emergency department and are invested in its success. The culture within the Trust and community is that this is because it is in the best interests of patient safety to meet the four-hour standard rather than rather than simply a 'box-ticking' exercise to meet a target.
- This culture extends to all sectors within the hospital who have seen that they can reduce their own pressures and problems with patient flow if the emergency department is managed smoothly.
- The development of an integrated NHS/adult social care discharge team which identifies patients likely to need help at an early stage.<sup>44</sup>

### Conclusion

32. In its report examining urgent and emergency services, our predecessor Health Committee identified the importance of a professional culture which regards meeting the four-hour standard as a sign of good and safe care rather than as an objective in itself.<sup>45</sup> **The ongoing decline in performance of type 1 emergency departments against the four-hour target should be regarded as a matter of patient safety rather than a failure to meet a bureaucratic objective.**

33. **Through the improvement work they are undertaking with trusts, NHS England and particularly NHS Improvement should facilitate the development of the cultural approach we witnessed in Luton, where waiting times in A&E are seen as everyone's responsibility.**

### Flow & delayed transfers of care

34. We recognise that even the best performing trusts cannot continue to manage increasing demand if hospital discharge becomes impossible for those who are medically fit to be discharged. The British Geriatrics Society offered an overview of the effect felt by patients and trusts of delayed transfers of care:

The recently published National Audit Office report on discharging older people from hospital estimates in the past two years 1.15 million bed days were lost due to delayed transfer of care, and that delayed transfers rose by almost a third (31%) between 2013 and 2015. There is inevitably a knock-

44 Note of Committee visit to Luton and Bedford

45 Health Committee, Second Report of Session 2013–14, [Urgent and emergency Services](#), HC 171, para 67

on effect on A&E departments as patients who are assessed as needing admission are delayed [...] if beds are not available. This means they must remain in the emergency department and be cared for there.<sup>46</sup>

35. The Government's evidence provided an overview of the existing position in relation to delayed transfers of care from hospital (often referred to as delayed discharges). The Government put this in the context of increased demand and higher rates of bed occupancy and noted that delayed transfers of care have grown at the same time as bed occupancy has risen "resulting in greater stress upon the whole healthcare system", adding:

The majority of all delays (whilst a small proportion of total beds) are attributable to the NHS, although more recently the proportion of delays attributable to social care has been increasing. In 2015–16, there were a total of 1.1 million delays attributed to the NHS (61.2%), whilst delays attributed to social care were 565,000 (31.2%). This represents an increase of 24,000 delayed days (2.2%) attributed to the NHS compared to 2014–15, whilst the delays attributed to social care increased by 144,000 (34.1%) compared to 2014–15.<sup>47</sup>

36. The Government's evidence noted that "historically the number of delayed days due to social care were relatively stable until February 2015 when they began to steadily increase".<sup>48</sup> Data published in September 2016 showed that delayed discharges as a result of shortages of adult social care had risen by 80% in July 2016 compared to the same month in the previous year.<sup>49</sup>

37. In order to maintain patient flow out of their hospitals some trusts have taken to developing their own domiciliary care services. Oxford University NHS Foundation Trust, for example, has recruited 60 care support workers to provide care in patients' homes following their discharge from hospital.<sup>50</sup> The trust's Chief Executive told the Health Service Journal in July 2016 that 75 beds within the trust had been freed as a result of the initiative and that 50 full time equivalent staff were now providing 1,600 hours per week of care in people's homes. In the seminar we held with trust leaders drawn from across England we heard from one Chief Executive who is launching a similar initiative. He observed that it is cheaper for the trust to recruit staff and to provide care at home than it is to accommodate the same cohort of patients in hospital beds.

38. Pauline Philip told us that a number of acute providers have developed similar arrangements and they have been:

extremely beneficial in reducing the length of stay of patients in hospital but also in supporting people who then need to go on to further care elsewhere.<sup>51</sup>

Ms Philip said that these services had been developed by trusts for clinical reasons relating to length of stay in hospital but, significantly, she acknowledged that:

46 British Geriatrics Society ([WIP 11](#)) para 6

47 Nuffield Trust ([WIP 33](#)) para 5

48 Department of Health ([WIP 35](#)) Annex B

49 BBC, '[Sharp rise in care delays 'piles pressure on hospitals'](#)' September 2016

50 Health Service Journal, '[New Oxford Hospitals chief reveals delayed transfers turnaround](#)', July 2016

51 Q58

some of the hospital at home service is compensating for the fact that other forms of care are not available to maintain people in their own residence, whether it is their private home or residential care, and is moving them from the acute bed to allow an assessment to take place elsewhere, and then to have them in the type of supportive environment they need for the future.<sup>52</sup>

39. We heard from NHS trust leaders that it would still make financial sense for an acute trust to provide a domiciliary care service even if, as in the examples mentioned to us, the local authority may not commission them to do so.<sup>53</sup> The National Audit Office's assessment of the costs relating to the discharge of older patients from hospital said that the daily bed cost to the NHS of delayed transfers of care was £303 per patient. This compared with the daily cost of local authority provided adult home care at just £41 and NHS community services care estimated at £89 per day.<sup>54</sup> This analysis, however, did not account for the costs that may be borne within an acute trust of stalled patient flow, the consequential miss-allocation of beds and the inefficient operation of the emergency department. Furthermore, trusts which free up acute beds by limiting delayed transfers of care can undertake more profitable elective activity.<sup>55</sup>

40. The scale of the problem that trusts face in managing a lack of adult social care was reinforced by the Nuffield Trust's evidence, which concluded that:

The social care system is currently showing signs of serious strain following years of cuts. This is almost certainly linked to rising delayed transfers of care, and presents a potentially serious obstacle to safely discharging many patients.<sup>56</sup>

Building on this analysis, the Care Quality Commission's report on the state of care summarised the extent of the problems facing adult social care and the consequences for NHS providers:

we are concerned about the fragility of adult social care and the sustainability of quality. This is concerning for the continuity and quality of care of people using those services, and for the knock-on effects across the whole health and care system: more emergency admissions in A&E, more delays for people ready to leave hospital, and more pressure on other services.<sup>57</sup>

## Conclusion

**41. It is an indictment of the existing state of adult social care provision that some acute trusts are having to establish domiciliary care services in order to improve patient flow through their hospitals and ease pressure in their emergency departments. This only serves to underline the perilous state of adult social care in England and the fundamental inadequacy of provision in some parts of the country. The Government should undertake an urgent review of the state of adult social care and its impact upon the NHS and the most vulnerable individuals who depend upon both.**

52 Q59

53 Note of Committee visit to Luton and Bedford

54 C&AG's Report, [Discharging older patients from hospital](#), HC 18 Session 2016–17, 26 May 2016 figure 15

55 [Ibid](#), para 1.5

56 Nuffield Trust ([WIP 33](#)) para 3.3

57 [Care Quality Commission, State of Health Care and Adult Social Care in England 2015–16, HC 706, October 2016, p 8](#)

## 3 Maintaining patient flow this winter

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### Increasing bed capacity

42. The relationship between demand, bed capacity and emergency department performance is at the heart of the Royal College of Emergency Medicine's concerns:

The increase in attendances in the last 5 years is equivalent to the workload of 10 medium sized departments in England alone—none of which have been built. Moreover, during the last 5 years the number of beds available for admission of acutely ill and injured patients has continued to fall and we now have the lowest number of beds per capita in Europe and England has the lowest number within the UK.<sup>58</sup>

43. In practice, the College argued that the consequence of limiting bed capacity has been a growth in general and acute bed occupancy from 86.3% in 2010–11 to 91.2% in 2015–16.<sup>59</sup> The College's evidence, however, noted that:

This is the figure recorded at midnight—daytime occupancy rates frequently exceed 100% in many hospitals. Such occupancy levels mean there is no surge capacity, rendering hospitals hostage to fortune.<sup>60</sup>

The British Medical Association (BMA) noted that:

[figures] from January–March 2016 showed the average occupancy rate in acute and general hospitals was 91.2%, with 20% of trusts averaging 95% or above, leaving very little flexibility in the system to cope with a seasonal spike in demand.<sup>61</sup>

University Hospitals of Morecambe Bay NHS Foundation Trust's evidence illustrated the pressure that trusts are operating under:

Medical bed occupancy has been increasing in the last 6 months—as illustrated in the chart below—reaching well over 100% with escalation beds open and outliers spilling into surgery.<sup>62</sup>

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58 Royal College of Emergency Medicine ([WIP 09](#)), para 8

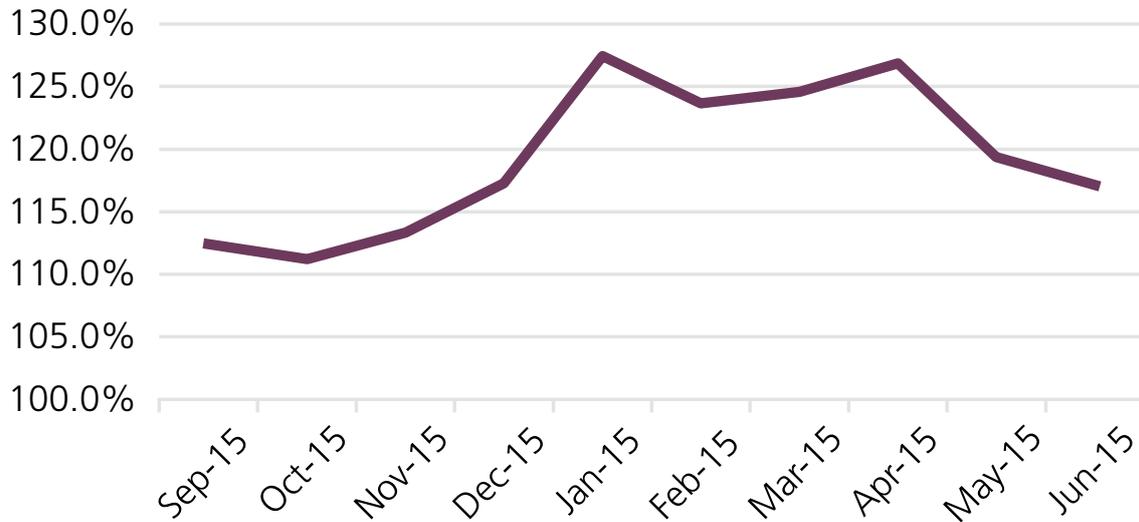
59 [Ibid](#), para 9

60 [Ibid](#)

61 British Medical Association ([WIP 18](#)) para 5

62 University Hospitals of Morecambe Bay NHS Foundation Trust ([WIP 24](#)) p 4

## Medical % bed Occupancy



During our visit to Luton we heard that the first step taken by Luton and Dunstable trust to improve its performance in 2010 was to increase its bed capacity.

44. The Nuffield Trust has assessed the merits of increasing bed capacity to improve patient flow, ease pressure and improve the performance of emergency departments:

One possible solution would simply be to increase the number of beds to return acute wards to a level of acute bed occupancy more conducive to faster flow. Our analysis has shown that this increased capacity accounted for by far the largest proportion of the £650m in additional winter funding money given to the NHS [...] in 2014–15.

However, this did not result in enough capacity to meaningfully reduce occupancy. The issue is in any case increasingly a year-round one. The current strain on NHS finances, particularly capital funding, make it highly unlikely that a large number of new beds will be constructed in the near future.<sup>63</sup>

45. The analysis that there is little respite in the spring, summer and autumn is generally consistent with the figures provided by Morecambe Bay NHS trust. Nonetheless, the peak period for occupancy was during the winter months of 2015–16, which indicates that the growth in admissions during the winter will create additional demands for beds. Whilst year round pressure is now a commonplace feature of the system, for many trusts winter remains the greatest challenge.

46. Comments made in oral evidence by Lyn Simpson, Executive Regional Managing Director for NHS Improvement, reinforced the position portrayed by Morecambe Bay. She told us that there is now very little bed capacity within acute trusts that could be brought to bear this winter:

There is not a bed stock that is ready to just switch on because it is unused. In previous years, we have been able to flex the use of beds and bring some additional beds into play for the winter period. This year we have been thinking about how we can use the current bed stock more efficiently. If you look at benchmarking data and efficiencies, there is scope to do more with what we currently have, rather than to bring more into play. There is a lot of good will, as well as reciprocal arrangements, across health economies. If an organisation is feeling under pressure, there is the ability to work closely with a partner and to flex across the system. The old idea of having beds that are mothballed and then brought back into play for periods of time is something that we should avoid and we should use the current bed stock more appropriately.<sup>64</sup>

### **Funding & staffing additional capacity**

47. Whilst Ms Simpson, like Professor Willett, characterised the challenge facing acute hospitals as being one of making more efficient use of resources, this was not entirely reflected in the evidence we received from trusts. Nottingham University Hospitals NHS Trust said it does not believe it will have the funding in place to increase capacity this winter in the same way it has done in previous years.<sup>65</sup> Similarly, the evidence submitted by Dartford and Gravesham trust highlighted the pressure they face, but they too said it is a lack of funding, rather than the inability to handle a change in approach, that will prevent them from increasing capacity:

The Trust had the third highest level of occupancy of General and Acute beds of any Trust in England in Q4 15–16. The significant rise in population will increase the use of escalation beds over the longer term as there is currently no funding available to increase the inpatient capacity to properly meet this demand. During winter months the impact of the increased demand for beds means that the Trust faces specific capacity problems that manifest themselves primarily on A&E performance.<sup>66</sup>

48. Perhaps most significantly, however, Morecambe Bay NHS trust said that, rather than increasing bed numbers to keep pace with demand, they would have to reduce them because of insufficient staffing:

the Trust has had to take the difficult decision to reduce its medical bed capacity in several ward areas for safety reasons because it cannot achieve the appropriate ward staffing ratios.<sup>67</sup>

49. Another trust described in its evidence plans to free bed capacity during the winter by reducing elective activity. St Helens and Knowsley Teaching Hospitals NHS Trust said that increased non elective activity during the Christmas holiday period was planned for by reducing elective activity. They said that in 2015–16 NHS England:

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64 Q27

65 Nottingham University Hospitals NHS Trust ([WIP 25](#)) para 4.3

66 Dartford and Gravesham NHS Trust ([WIP 34](#)) p 1

67 University Hospitals of Morecambe Bay NHS Foundation Trust ([WIP 24](#)) paras 1.1–1.2

requested a plan to demonstrate a reduction in the elective programme in order to free up an additional 20% bed capacity for NEL [non-elective] demand. This was submitted and achieved.<sup>68</sup>

However, in the seminar we held with leaders from NHS Trusts it was noted that a consequence of this policy is that patients who have had elective procedures postponed during periods of peak demand will, in some cases, present at the emergency department as non-elective cases.

### **Community provision**

50. Whilst increasing bed capacity is not regarded as a viable option by the Nuffield Trust, their evidence identified further utilisation of capacity within the community as being a mechanism for easing pressure in acute trusts. They said that “investment in new rehabilitative ‘step-down’ beds, where patients can recover outside hospital, could deliver substantial gains”.<sup>69</sup> It was therefore encouraging that the Minister said in evidence that as part of the process of developing sustainability and transformation plans:

we will see the whole healthcare economy players look to develop a more integrated pathway and rehabilitation beds. Intermediate care beds, I am sure, will form part of that.<sup>70</sup>

During the seminar we held with national policy experts the point was made that there is often an emphasis on community rehabilitation beds to enable discharge from acute hospital. There is, however, less attention paid to the ‘step-up’ element of community provision which can prevent emergency attendance and admission.<sup>71</sup>

### **Conclusions**

51. The acute bed ratio was 3 per 1,000 people in 2013 compared to 4.1 per 1000 in 2000.<sup>72</sup> We note that ongoing pressure in emergency departments has worsened as the bed per person ratio in the NHS had deteriorated. England has the lowest bed capacity in Europe and our method of counting bed occupancy at midnight provides false assurance. This only serves to widen the gap between Ministers and officials’ perception of pressure in hospitals and the reality facing clinicians at the front line of acute care struggling to find beds for their patients.

52. Acute trusts which host emergency departments are now running too hot. Whilst it may be a practical short term measure given the available resources to postpone elective activity to create capacity for non-elective admissions, the detrimental effect on patients should not be ignored. Postponing elective activity means postponing patient care and results in longer waits for treatment. Furthermore, trusts should heed the warning that in some cases the underlying medical problem for elective patients may deteriorate and they may re-present in emergency care and experience worse outcomes or require more interventions than if treated at an earlier stage. Delaying treatment in order to flex capacity does not necessarily represent an efficient use of scarce resources.

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68 St Helens and Knowsley Teaching Hospitals NHS Trust ([WIP 02](#)) p 2

69 Nuffield Trust ([WIP 33](#)) para 3.3

70 Q26

71 Note of Committee visit to Luton and Bedford

72 British Geriatrics Society ([WIP 11](#)) para 6

53. **Investment in ‘step-up / step-down’ community rehabilitation beds helps to relieve the pressure on NHS beds and can help to flex capacity at times of especially high demand. Nevertheless, acute trusts need to plan effectively for sufficient acute beds as well as access to community beds to improve patient flow.**

### **A&E infrastructure**

54. As noted above, the Royal College of Emergency Medicine’s evidence pointed out that “the increase in attendances in the last 5 years is equivalent to the workload of 10 medium sized departments in England alone—none of which have been built”.<sup>73</sup> Furthermore, the College noted that emergency departments were designed to accommodate far fewer patients.<sup>74</sup> Torbay and South Devon NHS Trust’s written evidence explained the limitations that an outdated emergency department can place on patient care and the ability of a hospital to implement practical changes within their departments that could improve patient flow:

The Emergency Department is not fit for purpose; the design limits flexibility and does not have sufficient cubicle space to meet demand during busy periods. There are limited facilities for children and for the safe management of people who present with a mental health need. There is also limited opportunity to extend ambulatory care pathways for people who are able to be assessed, treated and discharged home on the same day.<sup>75</sup>

55. Emergency department infrastructure must be capable of accommodating the growth in patients and allowing the implementation of practical guidance such as streaming patients to ambulatory care. Simon Stevens, Chief Executive of NHS England, acknowledged this in his evidence to us in July 2016:

It is certainly the case, by the way, that many A&Es have to deal with many more patients than they were originally designed or built for, which is part of the reason why some infrastructure investment would be so welcome as a way of improving those services.

56. Our report, published in July 2016, which examined the impact of the spending review on health and social care reported a reduction in the capital funding available to the NHS:

Capital spending will, however, remain flat in cash terms over the spending review period, at £4.8bn each year. That represents a real-terms reduction of 9% from 2015–16 to 2020–21.<sup>76</sup>

In addition our report concluded that transformation funding which should be used to support the ambitions of sustainability and transformation plans will not be available. We noted that this funding is “being used largely to ‘sustain’ in the form of plugging provider deficits rather than in transforming the system at scale and pace”.<sup>77</sup>

73 Royal College of Emergency Medicine ([WIP 09](#)) para 7

74 [Ibid](#), para 37

75 Torbay and South Devon NHS Foundation Trust ([WIP 31](#)) p 2

76 Health Committee, [Impact of the Spending Review on health and social care](#), First Report of Session 2016–17, HC 139, para 2

77 [Ibid](#), para 128

## Conclusions

57. As identified by NHS England’s chief executive, emergency departments will struggle to manage demand unless additional infrastructure funding is made available. Whilst this would not result in necessary new infrastructure in time for this winter, it would allow the service to improve overall performance and to manage ever increasing background demand as well as predicted spikes in future winters.

58. **It is essential that the Government ensures that sufficient capital funding is available for trusts to develop the infrastructure that will enable them to meet performance levels demanded by Ministers. The first step will be an assessment of the infrastructure investment required to ensure that type 1 emergency departments are fit for purpose, which should be completed through the Sustainability and Transformation Plan process. Once that assessment is complete, NHS England and NHS Improvement will need to ensure that the available capital funding is directed accordingly—we call on the Government to review the real terms cuts to NHS capital budgets in the Spending Review and to protect the transformation element of the Sustainability and Transformation Fund. We emphasise the importance of evaluation of completed projects in order to guide future investment and identify and share best practice.**

## Supporting adult social care to maintain patient flow

### Availability of adult social care

59. As described in Chapter 2, safely discharging patients without delay when they no longer require in-patient treatment is an important step in managing patient flow through a hospital and underpins good patient experience and safe performance in the emergency department. It is for this reason that “[increasing the] proportion of patients receiving [...] rehabilitation, recovery and reablement care outside hospital in home or community settings [and] mandating ‘Discharge to Assess’ and ‘trusted assessor’ type models” is a central element of the guidance designed to improve patient flow.<sup>78</sup>

60. In their written evidence the United Kingdom Homecare Association argued that some discharge to assess schemes have already begun to reduce the length of hospital stays.<sup>79</sup> In addition they said that an evidence base is now developing to support the application of reablement programmes:

Investing in short-term community reablement services can prove to be a cost-effective way of facilitating a timely discharge from hospital and minimising the potential for readmission. HSCIC have reported that 81% of people aged 65 years or over who had received a reablement/rehabilitation package upon discharge had not been readmitted after 91 days at home.<sup>80</sup>

61. Chapter 2 described how some trusts support patient flow out of their hospitals by creating their own services that provide social care in people’s homes. These initiatives,

78 Department of Health, NHS England and NHS Improvement ([WIP 35](#)) Annex C

79 United Kingdom Homecare Association ([WIP 5](#)) para 6 c

80 [Ibid](#), para 6 e

however, have a limited scope and much of the evidence we received emphasised the desire amongst witnesses for greater support to be made available to local authorities for the commissioning of all forms of adult social care.

62. Written evidence submitted by Morecambe Bay NHS trust said that the inability to discharge medically fit patients means that delayed discharges average 120 across each of their hospital sites per day.<sup>81</sup> The trust concluded that the Government could support trusts with type 1 emergency departments by better supporting adult social care as:

it is clear that adult social care funding and social care capacity—packages of care, long term residential and nursing care—and in particular EMI [elderly mentally infirm] nursing care—is woefully short.<sup>82</sup>

The British Geriatrics Society echoed this view, reporting in their evidence that:

The King’s Fund briefing *Deficits in the NHS 2016* provides an up to date analysis which shows that despite transfers of NHS budget to social care it has not kept pace with the increase in demand, and the fall in social care spending between 2010–15 has led to two issues: i. people being unable to access the care they need leading to poorer health outcomes and an increased likelihood of presenting at A&E, and ii. people remaining on an acute hospital ward for longer than necessary, again with an impact on A&E departments, and most critically a negative impact on the health of older people with frailty which deteriorates with every additional day spent on an acute ward. For an older person with frailty the loss of skeletal muscle strength resulting from a hospital stay can make the difference [between] being able to rise independently from a chair or bed and being dependent.<sup>83</sup>

63. Homerton University Hospitals Trust’s evidence outlined some of the more localised and specific consequences of limited funding and a shortfall in resource:

Delays in social care assessments were seen due to vacancies and the difficulty in recruiting substantive staff. Agency staff were often used however their skill mix was poor. Limited suitable care home capacity also led to delays in discharging patients.<sup>84</sup>

### **Cost of delayed transfers of care**

64. It is not only patient well-being and flow through hospital which is undermined by an inability to discharge to adult social care. The BMA’s evidence reported the National Audit Office’s assessment of the financial cost of delayed discharges:

The National Audit Office estimates that around 2.7 million of hospital bed days are occupied by older patients no longer in need of acute treatment which equates to a £820m gross cost to the NHS.<sup>85</sup>

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81 University Hospitals of Morecambe Bay NHS Foundation Trust ([WIP 24](#)) para 4.3

82 [Ibid](#), para 6.2

83 British Geriatrics Society ([WIP 11](#)) para 8

84 Homerton University Hospital NHS Foundation Trust ([WIP 30](#)) p 2

85 British Medical Association ([WIP 18](#)) para 8

65. In our report examining the impact of the spending review on health and social care we explored the relationship between the NHS, adult social care and the financial rationale for further investment in adult social care provision. We concluded that:

We are concerned about the effect of reduced access to adult social care as a result of the cuts to funding and the impact of this on the NHS. Given the evidence of the linkages between health and social care, we were concerned that none of the senior officials giving evidence from the Department of Health, NHS England or NHS Improvement were able to quantify the financial cost of one of the most visible interfaces between health and social care, namely delayed transfers of care as a result of not having adequate social care packages in place. [...]

We recommend that the Government urgently assess and set out publicly the additional costs to the NHS as a result of delayed transfers of care, and the wider costs to the NHS associated with pressures on adult social care budgets more generally. That assessment should be accompanied by a plan for adult social care which demonstrates that the Government is addressing the situation in social care and dealing with its effect on health services.<sup>86</sup>

## Conclusions

66. Ensuring sufficient capacity within community services and adult social care to enable timely discharge is a central element of maintaining flow out of an emergency department and through the hospital. It was encouraging, therefore, that Pauline Philip, Urgent and Emergency Care Director at NHS England, confirmed that this one area where there is potential to improve performance in the coming months:

one of the pieces of work [...] that we are doing as part of the A&E improvement plan is looking at this whole issue of discharge and patients who are occupying beds in acute hospitals who do not need to be in acute care. Clearly, there is a significant opportunity there. By working within the local delivery boards, this is one of the first issues that they are addressing, looking at the numbers of patients who are occupying beds in each hospital, who are not just in the original detox category but in the wider medically fit category, and then looking at capacity within the wider health economy, whether it is bed capacity or care capacity. That is probably the opportunity that we would be looking towards this winter.<sup>87</sup>

67. As outlined above, additional funding may not realistically be available to facilitate additional bed capacity in trusts in the short term, but it could be used to increase the availability of adult social care. The NAO's analysis has delivered an economic rationale for providing additional support to adult social care. The Care Quality Commission's (CQC) report examining the state of care in England made the case in terms of quality. The

86 Health Committee, [Impact of the Spending Review on health and social care](#), First Report of Session 2016–17, HC 139, paras 53, 54

87 Q25

CQC concluded that hospitals will find it “increasingly difficult” to improve their urgent and emergency care services “unless they are able to work more closely with adequately funded adult social care [...] providers”.<sup>88</sup>

68. Better local planning through A&E delivery boards, integrated to work closely with local authorities may help to limit delayed discharges in some cases but we do not believe that on its own this will sufficient to address the scale of the problem. **We recommend that the Government should provide additional funding to increase adult social care capacity. This could substantially relieve pressure on trusts as exit block is a key contributor to winter pressures in areas lacking sufficient adult social care provision.**

69. Discussing the challenges facing trusts of delayed transfers of care, Pauline Philip added that following the national benchmarking exercise that was due to take place in September 2016, A&E delivery boards will have achieved “an understanding and a grip of how big the problem is within their patch”.<sup>89</sup> **The national benchmarking exercise that has been undertaken by A&E delivery boards should inform an assessment of the impact that cuts in adult social care have had on the performance of trusts. We reiterate our frustration that the Department of Health has yet to undertake this assessment and consider it is vital that it does so at the earliest opportunity, particularly given its impact on the performance of the urgent and emergency care system.**

70. Delayed discharges cause exit block in hospitals, which in turn hinders the flow of patients through hospitals and the performance of emergency departments. This has worrying implications for patient safety. **We believe that adult social care is underfunded and this is having an impact on the NHS. The performance of the NHS and social care cannot be viewed in isolation. Adequate funding of social care and appropriate development of the social care workforce are worthy objectives in their own right, but the urgency of action on those two objectives is thrown into even sharper relief in the context of their contribution to the improved performance of the urgent and emergency care system.**

## Utilising primary care to reduce demand

### Case-mix

71. The Royal College of Emergency Medicine’s evidence revealed a degree of scepticism about initiatives to extend access to existing primary care services to reduce demand in emergency departments. The College noted that admissions have increased at faster rate than attendances and consequently:

We are not dealing with ‘more of the same’. The case-mix has shown a significant rise in the proportion of patients whose care cannot be delivered outwith the acute hospital setting.<sup>90</sup>

88 [Care Quality Commission, State of Health Care and Adult Social Care in England 2015–16, HC 706, October 2016, p 4](#)

89 Q57 (Pauline Philip)

90 Royal College of Emergency Medicine ([WIP 09](#)) para 7

72. Outlining how demand may be limited at emergency departments over the winter months, the Government’s evidence highlighted its expectation that primary care will make an important contribution:

Last year, the concern was that where there were extra general practice services in place—they were not advertised early enough to alert people so people still went to A&E. The wider winter planning communication that will go out to the system setting out expectations around a number of areas such as bank holiday planning, elective breaks, marketing campaigns, escalation and, primary care etc will be used to stress the message of better and earlier advertising of available services needed and explore ways for local systems to promote these services more widely. This will also be picked up through assurance of preparations for winter.<sup>91</sup>

73. In their evidence a number of trusts said the availability of primary care will influence how hospitals manage during the winter. Dartford and Gravesham noted that community based services including primary care can influence patient demand in a way which can “confound planning”.<sup>92</sup> Morecambe Bay NHS trust said that one of the biggest challenges they face in their areas is that services close during the Christmas holiday period and the Government should “encourage and incentivise 7-day working by all partners over the festive period”.<sup>93</sup> Evidence from St Helens and Knowsley trust outlined a scheme they will operate which intends to redirect patients into primary care.<sup>94</sup>

74. As noted above, the Royal College of Emergency Medicine (RCEM) has questioned this approach. The Nuffield Trust’s analysis has found

relatively little evidence that factors traditionally thought to increase attendances are linked to the recent deterioration in A&E performances[...] While there is evidence that the availability of GP appointments can reduce A&E attendance, the direct connection to performance against the four-hour target is weak.<sup>95</sup>

75. Addressing the RCEM’s concern that primary care will not be caring for the patients who require admission and are most likely to breach the four-hour standard, Professor Willett, NHS England’s National Director of Acute Episodes of Care, told us that a multi-faceted approach is required to address demand in emergency departments.<sup>96</sup> Professor Willett said that managing the demand placed on the service from those patients that require admission needs a different approach, but the growth in attendances has been driven by self-referral patients with less severe conditions.<sup>97</sup>

76. Professor Willett argued that limiting pressure in emergency departments can only be achieved by making improvements across the entire urgent and emergency care system:

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91 Department of Health, NHS England and NHS Improvement ([WIP 35](#)) para 22

92 Dartford and Gravesham NHS Trust ([WIP 34](#)) p 2

93 University Hospitals of Morecambe Bay NHS Foundation Trust ([WIP 24](#)) para 5.0

94 St Helens and Knowsley Teaching Hospitals NHS Trust ([WIP 02](#)) p 2

95 Nuffield Trust ([WIP 33](#)) para 2.2

96 Q6

97 Q6

There is not a silver bullet. [...]

it is very easy to try to simplify it and say, “This is what we should do,” but the reality is that we have to do everything within the system.<sup>98</sup>

### Extended hours

77. Addressing the specific concern of some trusts that primary care will simply be unavailable during Christmas the Government’s evidence described the extended hours schemes provided by hubs through the Prime Minister’s access fund programme.<sup>99</sup> Philip Dunne, Minister of State for Health, outlined in more detail the Government’s initiative to extend GP opening hours:

We are now rolling out greater opening hours for GPs. It is at their own initiative where and when they do it, but certainly in my own area we now have GPs 8.00–8.00 on Saturdays, which is an innovation in the last year. That will start to take off across the country and we will see more primary care involvement throughout the year, six days a week.<sup>100</sup>

78. We published a report on primary care in May 2016 which investigated the extended hours projects in detail. Whilst improving access to primary care is an important objective we concluded that demand for the type of routine service described by the Minister was limited and that there were potential unintended consequences if the development of extended opening hours undermines the ability to staff existing urgent out-of-hours provision. GPs may not be available to provide the services required in places which are conveniently accessible by patients in rural areas.<sup>101</sup>

### Conclusions

79. There is little evidence that previous attempts to divert patients away from emergency departments and into primary care have been successful. As we approach winter, primary care will only play a limited role in addressing acute winter pressure, as the challenge for the system is managing complex patients that require admission to hospital. **We would like to see further evidence that the Government’s proposals for extended GP hours will limit the demands placed on emergency departments.**

80. Our report of May 2016 described a future primary care system based on practices working in networks and federations, accommodating multi-disciplinary teams made up of GPs, advance nurse practitioners, physician associates, pharmacists and physiotherapists.<sup>102</sup> It was encouraging that Lyn Simpson stressed the importance of different health professionals developing wider skill sets in primary care as this will be central to the new primary care team.<sup>103</sup> **In the long term enhanced and properly resourced primary care shaped around the recommendations we made in our report of April 2016 on primary care will be crucial in helping to prevent the escalation of illness to an extent where emergency admission to hospital is required.**

98 Q51

99 Department of Health, NHS England and NHS Improvement ([WIP 35](#)) para 24

100 Q18 (Philip Dunne)

101 Health Committee, [Fourth Report of Session 2015–16](#), HC 408, Primary care, para 28

102 Health Committee, [Fourth Report of Session 2015–16](#), HC 408, Primary care, paras 103–106

103 Q21

### **Co-location of primary care with emergency departments**

81. Although the RCEM argued that pressure in emergency departments cannot easily be relieved by enhancing primary and urgent care services, the College does believe that co-located services could limit demand in emergency departments. They said in their written evidence that a model should be developed in which the emergency department sits at the centre of a hub and co-located urgent care could deflect cases away from the emergency department.<sup>104</sup> The rationale for this is that redirection and re-education strategies aimed at patients have failed and therefore services should be based around emergency departments.<sup>105</sup>

82. The RCEM said that “more than a third of attendances could be managed without input from an EM doctor”<sup>106</sup> and noted that:

The lack of other services for urgent care needs leads to clinically improbable spikes in attendances at weekends and bank holidays. Establishing an A&E hub model of service provision would ensure that up to a third of patients (almost 5 million per year) were seen by more appropriate providers/ services thereby decongesting the emergency department and improving the care delivered to those most in need of ED clinicians.<sup>107</sup>

83. Visiting Luton and Dunstable trust we heard that the development of co-located primary care allowed patients that did not require care in the emergency department to be streamed to a more appropriate service.<sup>108</sup> The primary care service at Luton hospital remains subject to the four-hour waiting time standard and was regarded as central to delivering good performance and patient care.

84. In 2013, our predecessor Health Committee said that it “welcomes the development of Urgent Care Centres on hospital sites and accepts the evidence that these units can improve the quality and efficiency of emergency care”.<sup>109</sup> The arguments of the RCEM and the practical effect of this measure witnessed in Luton are convincing, but the submission to this inquiry by the Centre for Urgent and Emergency Care Research called into question the evidence base for this practice:

Co-location of these centres with emergency departments has been proposed as a way of reducing the burden of primary care attendances on the emergency department. Our systematic review of 20 studies (Ramlakhan 2016) found little evidence to support the implementation of co-located urgent care centres. Provider-induced demand may lead to a paradoxical increase in attendances. The evidence for improved throughput is poor and any savings may be overshadowed by the overall cost of introducing a new service. A robust evaluation of proposed models is needed to inform future policy.<sup>110</sup>

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104 [Ibid](#), para 24

105 [Ibid](#)

106 [Ibid](#), para 25

107 [Ibid](#), para 27

108 Note of Committee visit to Luton and Bedford

109 Health Committee, Second Report of Session 2013–14, [Urgent and emergency Services](#), HC 171, para 114

110 Centre for Urgent & Emergency Care Research ([WIP 04](#)) p 3

## Conclusions

85. 'A&E' is a widely recognised and attractive brand. Patients understand that if they attend they will be cared for there and then. Meeting national policy experts in Luton we learned that patients are particularly drawn to A&E if they have experience of other countries' healthcare systems where this is the normal route for out-of-hours care or they have previously encountered problems accessing emergency GP appointments or GP-out-of-hours care.<sup>111</sup> Co-located primary care is subject to the four-hour standard—whereas directly accessed primary care is not.

86. Co-location of primary care with emergency departments is theoretically attractive in diverting patients who arrive in A&E who would be more appropriately seen in a primary care setting. This approach may have the unintended consequence of attracting more people to attend A&E in the future rather than contact their primary care service directly. **We agree with the Centre for Urgent and Emergency Care Research that a robust evaluation is needed of proposed models of co-located of primary care with emergency departments. Further research is required to understand the impact on patient behaviour, emergency department attendance and patient outcomes. In particular there needs to be much greater investigation into the risk of creating supply-induced demand. Given the shortfall in GP numbers, it is unlikely to be sustainable to operate several parallel systems for out-of-hours GP access and it is important that commissioners to consider the wider impact on primary care provision for patients as well as for A&E.**

87. Equally, NHS England should be aware that co-location may not be a solution which enhances access in rural areas, and some trusts may simply not have the capacity to accommodate such a service or the capital resource to create it. Models will need to adapt to local circumstances and must be robustly evaluated.

## The ambulance service

### *Potential of paramedics*

88. In both their written submission and their contribution to our seminar with national policy experts, the Centre for Urgent and Emergency Care Research told us that there is good evidence that paramedics are able to reduce hospital transfers and admissions through a 'see and treat' approach at home:

Emergency care practitioners or paramedic practitioners have extended roles that allow them to treat patients without transporting them to hospital. Our review of seven systematic reviews and 12 primary studies (Turner 2015) found that these roles have been implemented in various health settings and appear to be successful at reducing the number of transports to hospital, making safe decisions about the need for transport and delivering acceptable, cost-effective care out of hospital. Our primary studies of paramedic practitioners (Mason 2007) and emergency care practitioners (Mason 2012) confirm these findings in the NHS.<sup>112</sup>

111 Note of Committee visit to Luton and Bedford

112 Centre for Urgent & Emergency Care Research ([WIP 04](#)) p 2

Professor Willett, the National Director of Acute Episodes of Care, summarised the potential of the paramedic workforce by saying that “they are probably the area of healthcare that has the greatest opportunity to manage demand for the rest of the health economy”.<sup>113</sup>

### *Delayed handover of care*

89. Too often, however, paramedics’ specialist expertise is being wasted as a result of delayed handover of patients at emergency departments. The Association of Ambulance Chief Executives (AACE) noted in its evidence that “The most important issue ambulance services face from acute trusts is that of ambulance handover delays at Emergency Departments (EDs)”.<sup>114</sup> The Centre for Urgent and Emergency Care Research reported that in “the year 2015–16 the 10 regional ambulance services in England lost a total of 407,000 hours through handover delays at ED”.<sup>115</sup> Providing the perspective of ambulance trusts, the AACE said:

As an example, one English ambulance trust loses approximately 700 hours every week due to this issue; for some trusts, the loss of hours is greater. [...]

Nationally and regionally, it is worthy of note that there is significant variance between acute trusts in terms of ambulance handover delays. Acute trusts that do not experience as many ambulance handover delays have a distinct ‘zero tolerance’ approach with clear ownership of the issue across the trust, not just within the ED.<sup>116</sup>

90. The comments we heard when visiting the East of England Ambulance Service in Bedford reflected the frustration expressed by the AACE. We heard from East of England Ambulance Service of ambulances waiting for unacceptable periods outside emergency departments and also of huge variation within their geographic footprint between the length waits and procedures for handover.<sup>117</sup> The consequence of delayed handovers of care is that poorly performing trusts tie up ambulances and their crews in their specific area thus reducing the availability of paramedics and vehicles further afield. This is not consistent with the system-wide, place-based approach to managing demand in emergency departments that is being encouraged by NHS England and NHS Improvement.<sup>118</sup>

91. Pauline Philip’s commentary on the challenge of delayed handover reinforced the notion that responsibility for avoiding delays rests with acute trusts. Ms Philip told us that handover delays can be avoided by trusts ensuring they have the correct processes in place and make optimal use of the space available to them:

Time and time again, when we come across the issue of these ambulances outside a hospital, it tends not to be about the number of staff within the emergency department but how the emergency department is being

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113 Q38

114 Association of Ambulance Chief Executives ([WIP 08](#)) para 6

115 Centre for Urgent & Emergency Care Research ([WIP 04](#)) p 3

116 Association of Ambulance Chief Executives ([WIP 08](#)) paras 6, 8

117 Note of Committee visit to Luton and Bedford

118 Q17

organised, the processes that exist—very simple things—and the capacity. We meet departments all the time that do have staff standing there, but they do not have enough trolley space.<sup>119</sup>

92. The incentives created by the four-hour waiting time standard do not necessarily encourage trusts to make best use of their space and prioritise swift handover. The clock for the four-hour standard begins at handover or 15 minutes after the ambulance arrives at the hospital.<sup>120</sup> From the perspective of a trust that is struggling to meet the four-hour standard, whether a patient waits in an ambulance for 5 minutes or for two hours is immaterial as long as the patient does not suffer any adverse consequences and is eventually admitted, transferred, or discharged within 3 hours and 59 minutes. It underlines the pressure some hospitals are facing that valuable ambulance crews and vehicles can, in some cases, be treated by trusts as an extension of their emergency department.

### Conclusions

93. Acute trusts must take responsibility for patients arriving by ambulance so that handover is not delayed. As outlined by the AACE this is dependent upon the entire trust taking responsibility for addressing the problem and speaks to the development of the positive cultural approach described in chapter 2. We heard in Bedford that there are some trusts that will not acknowledge their responsibilities even when a patient is in an ambulance parked on the ramp of the emergency department. NHS Providers' submission pointed to practical steps that trusts can take to minimise handover delays:

The London Ambulance Service has worked with local London trusts to improve ambulance handovers to emergency departments by employing Hospital Ambulance Liaison Officers (HALOs). HALOs act as an initial point of contact for ambulance crews and receive early indications of incoming ambulance cases so appropriate resources can be identified to minimise handover delays and ambulance turnaround times.<sup>121</sup>

**94. Delayed ambulance transfers are an unacceptable waste of valuable paramedic resources and disadvantage patients living in neighbouring areas who may experience longer waits if vehicles are tied up elsewhere. NHS England should urgently address the level of variation to ensure that there is a timely handover of patients.**

119 Q32

120 NHS England, [Emergency Care Weekly Situation Report, Definitions and FAQs](#), April 2014

121 NHS Providers ([WIP 28](#)) para 10

## 4 Further threats to the system

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### Staffing

#### Numbers

95. The evidence submitted by Health Education England (HEE) offered an overview of the measures taken to improve staffing levels in emergency departments:

Working in close partnership with the College of Emergency Medicine since inception, HEE developed practical solutions to workforce pressures based on both current need and longer term sustainable solutions. These proposals include:

- a) Additional ACCS-EM posts (more than 250 over three years);<sup>122</sup>
- b) Piloting and subsequent full adoption of a ‘run through’ training. This means those who enter ‘lower’ training do not need to compete to enter higher training, which enhances the attractiveness of the programme
- c) Creation of the innovative Direct Route of Entry Emergency Medicine (DREEM) training pathway (above);
- d) The “work, learn, and return” initiative whereby training places are offered to overseas doctors to develop emergency medicine skills and gain valuable clinical experience. The programme is up to four years, after which the doctor will return home to use their skills to care for patients and share learning with colleagues.
- e) Rapid expansion of physician associates - a new group of staff to support the medical workforce in Emergency Medicine and other settings. [...] <sup>123</sup>

96. HEE’s submission claimed that there has been significant progress in the development of the emergency care workforce. The examples they highlighted included:

- a) growth in the number of consultants has now been sustained at an average of 9% per year for more than a decade (compared with 3.7% average for all consultants);
- b) the wider EM medical workforce (i.e. trainees and others) has grown at 3.7% per year compared with 2.4% for the wider medical workforce;
- c) in 2004 consultants represented 15% of the EM medical workforce. In 2014 this was 23%.<sup>124</sup>

97. Despite Health Education England’s claim that the expansion of the number of doctors has “relieved pressure on emergency departments”, measures to increase the complement of emergency care specialists have not kept pace with demand.<sup>125</sup> In 2013, our

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122 Acute Care Common Stem training. ACCS is a three year training programme that normally follows Foundation Year 2. It is the only Core training programme for trainees wishing to enter Higher specialty training in Emergency Medicine ([Intercollegiate committee for acute care common stem training](#))

123 Health Education England ([WIP 14](#)) Para 14

124 [Ibid](#), paras 14 - 15

125 [Ibid](#)

predecessor Health Committee noted in its Urgent and Emergency Services report that “Only 17% of emergency departments in England are able to provide 16 hour consultant coverage during the working week”.<sup>126</sup> Reporting on the situation three years later, the Royal College of Emergency Medicine said increased demand has further emphasised inadequate staffing levels in urgent and emergency care:

There are 176 type 1 Emergency Departments in England. Currently there are insufficient consultants in post to provide even one on duty in every department for even 16 hours per day.

Had staffing levels been adequate and kept pace with admissions by 2015–16 there would have been 2516 EM consultants in the NHS in England c.f. 1483. Had the workforce as a whole grown at a similar rate there would now be 8,074 doctors working in our emergency departments rather than, as now, 5,300.<sup>127</sup>

98. It should not be assumed that an increase in the number of commissioned training places will automatically convert into an eventual increase in emergency care specialists. The British Medical Association’s evidence said:

We have concerns that there are a significant number of trainee vacancies across the UK. A recent survey of foundation trainees found that only 52% of foundation trainees in the UK were progressing directly into specialty training. Other research has revealed shortages in fill rates for higher specialty training in certain areas including emergency medicine and acute medicine.<sup>128</sup>

The Royal College of Physicians’ evidence touched on this and said that 21% of consultants have reported ‘significant gaps in the trainees rotas such that patient care is compromised’.<sup>129</sup> Royal College of Emergency Medicine concluded that “the attrition rate from UK training programmes has wasted our most valuable resource”.<sup>130</sup>

99. The Royal College of Physicians’ written evidence stressed the impact that lack of staff will have on the flow of patients through the emergency department (the challenge of which is discussed in chapter 3 above). Their remarks particularly emphasised the impact on the patient experience:

The staffing crisis is impacting on physicians’ ability to swiftly assess patients after they present at A&E departments, to tailor their care plans and to achieve safe and timely transfers of care. This can negatively impact on patient experience and leaves wards unable to alleviate pressures on A&E departments. Targets on A&E waiting times are difficult to achieve unless there is enough staff to transfer patients or discharge them in a timely manner.<sup>131</sup>

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126 Health Committee, Second Report of Session 2013–14, [Urgent and emergency Services](#), HC 171, para 82

127 Royal College of Emergency Medicine ([WIP 09](#)) paras 12 - 13

128 British Medical Association ([WIP 18](#)) para 10

129 Royal College of Physicians ([WIP 10](#)) para 5

130 Royal College of Emergency Medicine ([WIP 09](#)) para 41

131 Royal College of Physicians ([WIP 10](#)) para 6

100. With emergency departments functioning under constant pressure the lack of 7-day 16-hour consultant coverage remains a major concern. Measures to improve patient flow, such as early senior review of patients, cannot be implemented if the requisite staff are not available.

## Recruitment

### *Reliance on temporary staff*

101. There is no quick fix available to alleviate staff shortages. In 2013, our predecessor Health Committee's report into Urgent and Emergency Services noted figures from the RCEM which showed that the 145 trusts in England with type 1 emergency departments were, on average, each spending approximately £500,000 per annum on locum costs for emergency care alone.<sup>132</sup> In their written evidence to this inquiry the RCEM said that the figure now stands at £3 million per week for all trusts in England, which indicated that locum spend has more than doubled in three years.<sup>133</sup> The RCEM, however, has now employed a new methodology for calculating how much acute trusts spend on locums. Their most recent assessment of the cost of temporary doctors in English emergency departments measured the total weekly spend at £13.5 million. This would indicate an average annual spend for each trust of over £4.6 million.<sup>134</sup>

102. Dartford and Gravesham trust's evidence illustrated the difficulties associated with recruitment and the particular challenges trusts are presented with by the agency spending cap and national policy direction which attempts to limit growing staff costs:

Medical staffing in A&E is proving especially difficult as some Trusts are not adhering to the agency caps and are able to outbid us for doctors. With a lack of A&E middle grades there is a seller's market for A&E doctors and the lowest bidder can find themselves struggling to have enough doctors to meet the demand in A&E.

The long term growth in activity also means that this Trust has to increase its staffing levels in other groups, however this is contrary to the national messages requiring us not to do this. Without increasing staffing levels both during winter months and over the long term, safe staffing levels will not be achieved.<sup>135</sup>

103. The growth in spending on emergency care locums runs contrary to the desire of the Government "to reduce the dependence on agency staff".<sup>136</sup> The Minister explained that permanent staff are more productive and "safer for the patient because they will understand the system better". Lyn Simpson reiterated the argument that substantive staff "improve care to patients".<sup>137</sup> We are concerned, therefore, that in the last three years there has been significant growth in a workforce which is regarded by Ministers as sub-optimal in terms of patient safety.

132 Health Committee, Second Report of Session 2013–14, [Urgent and emergency Services](#), HC 171, para 82, Q 73

133 Royal College of Emergency Medicine ([WIP 09](#)) para 38

134 Royal College of Emergency Medicine submission to the House of Lords Select Committee: Long term sustainability of the NHS (NHS0029), para 45

135 Dartford and Gravesham NHS Trust ([WIP 34](#)) p 4

136 Q37 (Philip Dunne)

137 Q37 (Philip Dunne, Lyn Simpson)

## Reforming recruitment

104. We heard informally during our visit to Luton that successful trusts are often able to recruit because they are more attractive employers than neighbouring hospitals that may have poorer reputations.<sup>138</sup> Ultimately, this can serve to reinforce the performance and financial problems struggling trusts often experience. Challenged that trusts are simply denying one another of necessary staff, Professor Willett said that local workforce action boards will sit under Sustainability and Transformation Plans and they:

will look at the workforce for the whole local health economy so that you will start to see some more sensible relationships develop, because it is right for the whole system not to be escalating prices through agencies, as perhaps happened before when people were competing, but, if we are going to work as a network and as a system of healthcare providers, we need to look at the workforce needs across everywhere. If there is one hospital that is really struggling with workforce, the impact on that hospital not performing well will be felt in the other parts of the healthcare sector. That is the approach.<sup>139</sup>

Lyn Simpson, Executive Regional Managing Director for NHS Improvement, concluded that:

We need to work in partnerships with the other hospitals in a particular patch, rather than one organisation poaching or being able to attract staff greater than another, so that that partnership arrangement would benefit us all.<sup>140</sup>

## Changing the model of care

105. Professor Willett indicated that it will not be possible to meet demand by recruiting ever more emergency care specialists. Therefore, the model by which emergency departments provide care will have to change:

The original A&E departments, when I trained, had only just started to invent emergency medicine as a specialty. None of them had consultants. Over the years we have grown and grown that, but we have also tied that into saying that if you are an emergency department you have to have X, Y and Z behind it. That is where it becomes unsustainable, because we cannot do all those medical interventions in every hospital. You cannot attract the staff because there is not enough of it to keep the specialist skills up. [...]

In the urgent and emergency care review, we are saying, right, this is not about isolated units any more. This is about the whole healthcare system working as a system, so that whether you are the paramedic at the scene or the GP in the home, whether you are the hospital, the urgent care centre, the minor injuries unit or whether you are the small hospital or the specialist hospital, you never have to make a decision in isolation. There is always someone in that system who will help you.<sup>141</sup>

138 Note of Committee visit to Luton and Bedford

139 Q37 (Professor Willett)

140 Q37 (Lyn Simpson)

141 Q35

106. We are concerned that trusts informally acknowledge that those that are able to recruit often do so by depriving their neighbours of staff. Similarly, we are concerned at reports that the agency spending cap is being breached which consequently will distort the market for temporary staff. The market for emergency care specialists is failing and shortages of middle grade staff have become a particular problem. The long-term restructuring of emergency care may ultimately re-shape the provision of care and staffing requirements, but this will not address the problems facing emergency departments this winter.

### *New workforce in urgent & emergency care*

107. The evidence from Health Education England said that additional numbers of physician associates will be available to the emergency care workforce.<sup>142</sup> We also heard that trusts are beginning to recruit and train more staff in extended roles to bolster their emergency care teams. Importantly, the analysis by the Centre for Urgent and Emergency Care Research confirmed the positive impact staff in extended roles can have on patient care:

Controlled studies of the nurse practitioners, extended paramedic roles [...] have shown that these are effective, leading to widespread implementation and clear benefit to patients and the NHS.<sup>143</sup>

### *Conclusion*

108. We are supportive of steps being taken by trusts to increase extended roles in emergency departments as part of the wider evolution of emergency care. These measures, however, will not help to alleviate additional pressure that may occur this winter. We are concerned that some emergency departments which are already falling short of the four-hour standard will enter winter with staff levels below those identified as necessary to provide the best possible care. **We recommend that NHS Improvement consider the steps which can be taken this winter to ensure that all emergency departments, but particularly those which are currently performing poorly, are able to recruit the staff which they need to get their performance to an acceptable level.**

109. **In the longer term, we recommend that Health Education England look again at the measures needed to improve staffing levels in emergency departments, and redouble its efforts to ensure that the supply of such staff is sufficient to ensure safe and timely care. It is in everyone's best interest for the prioritisation of the improvement of staffing levels to be the culture in every hospital.**

### *Funding*

#### *Winter resilience funding*

110. The Government's evidence outlined how the distribution of winter funding had been reformed with, they said, the purpose of encouraging better winter preparation. In 2014–15 £700 million additional funding was made available to sustain the urgent and

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142 Health Education England ([WIP 14](#)) para 14

143 Centre for Urgent & Emergency Care Research ([WIP 04](#)) p 1

emergency care system during the winter.<sup>144</sup> It was this allocation that was incorporated in Clinical Commissioning Group (CCG) baseline funding for the following year. The Government's evidence said:

Planning for 2015–16 was earlier in the year with resilience funding included in CCG baselines. One of the key barriers to success of resilience initiatives identified in previous years is funding being released to the system too late in the year, not leaving enough time for proper implementation. This early access means that local health economies can plan and implement initiatives far earlier as they know exactly what resources are available to them.<sup>145</sup>

111. Discussing this reform, Lyn Simpson of NHS Improvement said that under the old system funding would often arrive too late to instigate programmes that could support the urgent and emergency care system during the winter and those reforms that were implemented were “fairly prescriptive and did not always meet the local need in how that funding would be spent”.<sup>146</sup> Describing how the new mechanism has operated, Ms Simpson conceded that there had been difficulties in delivering the benefits expected of incorporating funding into CCG baselines:

We have seen a bit of a mixed bag across the country. Some organisations have come together with the commissioners, the providers, and said, “What do we need to put in now to prepare us for winter rather than doing it September/October time?”[...]

Where it has worked well, there has been a really good adult conversation about what we need to do. Where perhaps it is a bit patchy is that sometimes that conversation has not taken place; perhaps the provider has thought that, regardless of what has been said about it going into baselines, it will still appear late in the day to do some of the things that they have tried and tested.<sup>147</sup>

112. Whilst the focus of NHS Improvement has been on local health economies planning early to use funding, the commentary received in evidence from providers expressed scepticism that, in reality, any further funding would be available to manage the expected increase in emergency admissions. NHS Providers emphasised that this funding was not ring-fenced and called in to question the effectiveness of working winter funding into CCG baseline allocations:

The inclusion of annual ‘just in time’ winter funding in CCG baseline annual allocations was intended to provide greater planning certainty for upfront investments, however, as this funding is no longer ring-fenced there has been a considerable reduction in transparency over how much money is invested in frontline U&EC services.<sup>148</sup>

144 HC Deb, 7 January 2015, [col 273](#) [Commons Chamber]

145 Department of Health, NHS England and NHS Improvement ([WIP 35](#)) Annex A

146 Q71

147 Q71

148 NHS Providers ([WIP 28](#)) para 20

113. Notably, Morecambe Bay NHS trust said in its evidence that the money allocated to them in 2015–16 for winter resilience was less than in previous years when the allocation was made from the specific winter funding pot.<sup>149</sup> Nottingham NHS trust’s evidence called into question the extent to which funding will be sufficient to achieve their objectives related to winter planning:

Whilst there is agreement around fast-track system resilience schemes, we are yet to be in a position to have confirmation on all funded and commissioned activities to support resilience over winter 2016–17. System resilience bids have been developed both independently and collectively by system providers. It is not yet clear whether the financial envelope will allow investment in schemes that will truly mitigate the anticipated pressures on our urgent care system.<sup>150</sup>

They noted in their submission that no funding will be made available for additional bed capacity (the significance of which was discussed in chapter 3), whereas “in previous years this funding was substantial”.<sup>151</sup> In the seminar we held in Luton with leaders of NHS acute trusts drawn from across England it was observed by one participant that funding for winter pressures ‘is not real’.<sup>152</sup>

## Conclusions

114. Our report, published in July 2016, which examined the impact of the spending review on health and social care concluded that there are “acute and increasing financial pressures” in acute trusts and any additional funding available is being used to tackle financial deficits.<sup>153</sup> It is likely in our view that the funding designed to be used to manage winter pressure will have been absorbed in meeting the costs of core activity.

115. There is merit in providing funding for winter pressure much earlier in the planning cycle—but only if this funding is available to be used for the purpose intended. The incorporation of funding for winter resilience into CCG baselines without any form of ring-fence has made it impossible to track whether any additional funding will reach the front line to deal with the challenges that emergency departments and ambulance providers will face this winter.

116. On the other hand, ring-fencing can prevent available funding from being used where it is most needed or can be most effectively spent in a particular health economy. The incorporation of funding for winter pressures into CCG baseline funding not only enabled better long-term planning, it should also, as Lyn Simpson suggested, have enabled local areas to target the funding more effectively.

**117. Rather than introducing a ring-fence on the winter resilience funding that is incorporated into the baseline allocation for CCGs, we recommend that NHS Improvement and NHS England take steps to ensure that there is transparency about**

149 University Hospitals of Morecambe Bay NHS Foundation Trust ([WIP 24](#)) para 4.1

150 Nottingham University Hospitals NHS Trust ([WIP 25](#)) para 2

151 [Ibid](#), para 4.3

152 Note of Committee visit to Luton and Bedford

153 Health Committee, [Impact of the Spending Review on health and social care](#), First Report of Session 2016–17, HC 139, para 168

**the amount of funding which trusts and clinical commissioning groups direct to preparing for winter pressures. Thorough evaluation of the approaches to dealing with winter pressure will require transparency about how they are funded.**

### Tariffs

118. Visiting Luton we heard that the funding mechanism for urgent and emergency care underfunded treatment for those presenting with serious conditions whilst creating a financial incentive to treat minor conditions.<sup>154</sup> We were shown that on an annual basis the Luton and Dunstable trust loses £3 million per annum through the provision of emergency care. It was noted that the patients with minor conditions which attract good remuneration relative to the actual costs of treatment are often sent to the co-located primary care service which is operated by a different provider, thus losing the trust income.<sup>155</sup>

119. Whilst the Royal College of Emergency Medicine did not go so far as saying that emergency departments are paid too much for treating minor conditions, their evidence echoed the comments that were made by Luton and Dunstable trust:

Those patients requiring least intervention, investigation or treatment are remunerated at a rate that enables services to be maintained. However the maximum tariff for the most seriously ill or injured is less than £250. This ensures that treating the very patients emergency departments are established to treat is a loss-making endeavour for a hospital.<sup>156</sup>

120. Professor Willett accepted that the existing tariff mechanism does not successfully reimburse trusts for undertaken urgent and emergency care.<sup>157</sup> He described how each part of the system is remunerated through very different models which function inconsistently and said:

we have proposed a single payment method for the whole of the sector, which recognises the fact that an element is fixed, and we should not be arguing about that because that means that stops people being flexible.[...]

I think we will see over the next few years a very different funding model coming through, and, to be honest, the tariff argument, in my view, is a bit of a distraction at the moment because I do not think it actually plays out for an individual patient, which is what matters.<sup>158</sup>

### Conclusion

121. We are pleased that NHS England and NHS Improvement are pursuing a different funding model, but reform of tariffs should not simply be regarded as a technical long-term objective. **Payment mechanisms should reflect the cost of providing care at each stage of the patient journey and incentivise ambulance and hospital trusts as well as community services to work together in the interests of patients. This means developing payment**

154 Note of Committee visit to Luton and Bedford

155 Ibid

156 Royal College of Emergency Medicine ([WIP 09](#)) paras 36-37

157 Q73

158 Q73

**mechanisms which will suppress demand by encouraging prevention, facilitating early intervention, limiting the escalation of morbidity and helping to ensure that patients are seen by the most appropriate professional at the right time and in the right place. Tariff reform is long overdue and in responding to this report the Government should set out a clear timetable for it to be achieved.**

## Management of the system

### *Performance management or improvement?*

122. The point was made in the course of the seminar we held with NHS trust leaders that there is a difference between performance management and performance improvement. It was generally felt that the emphasis within national organisations such as NHS England and NHS Improvement had been on daily performance management of trusts, rather than providing support and resources to trusts to improve performance. It was observed that substantial senior management time is lost in daily conference calls which, in the view of trust leaders, exist to give national officials and Ministers the impression that things are being done rather than to develop solutions to problems.<sup>159</sup>

123. Homerton University Hospital Trust provided a considered view of the burden placed on trusts by these management demands. They said it is important for patient safety that trust performance is assessed against the four-hour standard, but argued that performance management of trusts should not become more intense just because hospitals are operating under pressure:

Close and frequent involvement of central bodies in the day-to-day operations of acute hospital trusts should cease. This can distract managers and takes them away from the actual task of managing their services at the busiest of times. The level of information reporting should revert to the same levels as routine business-as-usual periods. The combination of twice daily conference calls, 3+ times a day reporting and constant provision of minute detail often adds little value, can undermine managers and lead to little or no action or support from central bodies to assist with the challenges being faced.<sup>160</sup>

We also heard a suggestion during the seminar we held with trust leaders that hospitals could be better helped to learn from their peers if NHS Improvement provided “brokerage of best practice” that could be easily accessed by trusts.<sup>161</sup>

### *Reform of national oversight*

124. Pauline Philip, NHS England’s Urgent and Emergency Care Director, told us that NHS England and NHS Improvement were acting on these concerns and the system would function differently in 2016–17:

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159 Note of Committee visit to Luton and Bedford

160 Homerton University Hospital NHS Foundation ([WIP 30](#)) p 4

161 Note of Committee visit to Luton and Bedford

I think what has happened in the past is that we have been reactive. Basically, you hear the news reports and you read the newspaper. You see that the whole system appears to be in meltdown and people are then reacting to what has happened. We are trying to say through these local delivery boards that we need to be proactive and, instead of having all these calls in the evening and into the night, what we need ultimately is to accept that things will go wrong between emergency departments, but if we can work together in a way that we can support each other, then these types of calls, which were referred to, can become a thing of the past. We can have a new approach to escalation nationally and have some consistency in that, because there were different local approaches. From a provider point of view, my heart goes out to those organisations, because when you are trying very hard to manage a very difficult situation in your own hospital, the last thing you want to do is to spend hours on conference calls.<sup>162</sup>

125. Describing how the central management system should operate in the coming winter, Pauline Philip said that there would be a focus from national bodies on providing assistance to trusts and local health economies as a whole:

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

That is a major focus over and above what has happened in previous years, but to try to support front-line providers in a way that they do feel, whether it is ECIP [Emergency Care Improvement Programme] that is coming in to support them or it is a CCG or a region that is having a dialogue with them, it is all joined up; we are not all asking them the same question and we are actually helping in a way that they can accept that help<sup>163</sup>.

126. Trusts need year round support in redesigning their process both in terms of patient flow into the emergency department and eventual discharge into the community. Therefore it was encouraging that Lyn Simpson of NHS Improvement said:

This approach is different. It is about how we help organisations to help themselves. We need to differentiate what that improvement offer is to each organisation so that they really get what it is that they need rather than a universal offer. We have a segmentation process whereby we can look at the very best group perhaps but with people in the organisations that are struggling to share that good practice.<sup>164</sup>

127. In addition, Pauline Philip said that NHS England and NHS Improvement will be given a baseline assessment of local provision by all A&E Delivery Boards which will tell them if trusts are using the five key interventions which are designed to improve patient

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162 Q44

163 Q41

164 Q43

flow.<sup>165</sup> We regard this as a significant and positive step as there is significant variation in performance of emergency departments and their ability to manage similar challenges posed by demand, demographics, funding and staffing.

### Conclusion

**128. We are concerned about the level of variation in performance between trusts in managing urgent and emergency care. We recognise the pressures hospitals face but there is much that trusts can do to improve flows within their own systems and to learn from the best performing trusts. We support the steps taken by NHS England and NHS Improvement to try to tackle variation. We encourage them to roll out this process as quickly as possible so that other trusts facing similar challenges can overcome their problems.**

129. It is encouraging that NHS England has said that new systems of management will change the demands on trust leaders. We were told that for those working on the frontline the current system appears designed as much to provide assurance to Department of Health ministers and senior officials at Richmond House as to help trusts improve their performance. We do not believe that the system of management has been designed for this purpose, but the frustration that is felt by so many illustrates its inherent flaws. Whether the mechanisms for managing trusts have evolved sufficiently will only become apparent once trusts and local areas begin to experience serious pressure. **Performance management of trusts should not become more intense just because hospitals are operating under pressure. We recommend that the Department of Health should formally evaluate how the central management system which oversees performance against the four-hour target contributes to the maintenance of patient safety and the improvement of performance within trusts.**

### Demand driven by alcohol consumption

130. The challenges faced by the urgent and emergency care system are exacerbated by problem drinking. In October 2015, the Institute of Alcohol Studies reported the findings of a survey of emergency department consultants which found that “alcohol related incidents account for 25% of ED caseload”.<sup>166</sup> In oral evidence Professor Keith Willett, National Director for Acute Episodes, NHS England, described the problems that emergency services can face:

As a clinician, the chronic use of alcohol and the drunk person creates a very difficult demand on emergency services. [...] There are patient groups where alcohol is the primary problem—primarily they are drunk or they have an alcoholic disease problem—and there are those patients, which is a much larger proportion, where alcohol is part of the contributing element to their longterm illnesses, which obviously present as an acute component of that.

It has a significant impact on the services. We have to see this very much as a disease. We have to look at the public health issues behind it.<sup>167</sup>

165 Q42

166 Institute of Alcohol Studies, [Alcohol's impact on emergency services](#), October 2015, p 28

167 Q77

131. Professor Willett observed that caring for patients with alcohol problems can be very difficult for emergency department staff and affect their morale and the Institute for Alcohol Studies (IAS) research underlined this point.<sup>168</sup> The IAS found that 43% of emergency department consultants had suffered injuries from intoxicated members of the public and 35% of consultants said they had been sexually harassed or assaulted whilst on duty.<sup>169</sup>

132. In addition, during our visit to Luton and Bedford we were told that attendees at the emergency department have often consumed alcohol and, at weekends, this is the case for the vast majority of patients. This point was reinforced by those we met at the East of England ambulance service, who described extensive arrangements they have to make to deal with patients who, in many cases, are intoxicated to the state of unconsciousness. The Association of Ambulance Chief Executives said in their written evidence that for ambulance services dealing with alcohol related incidents is a standard part of managing the Christmas period.<sup>170</sup>

133. Some work has been done to mitigate the effects of alcohol intoxication on the emergency services. The Centre for Urgent & Emergency Care Research described Alcohol Intoxication Management Services, which are an intervention designed to limit emergency department attendance:

These services are being piloted in a number of cities as a way of managing people with alcohol intoxication at times of peak incidence without transporting them to the emergency department.<sup>171</sup>

Problem drinking continues to have a detrimental impact not only on accident and emergency departments, but elsewhere in the NHS and indeed wider public services. Winter pressures, especially over Christmas and New Year could be considerably reduced if staff were not having to treat the direct and indirect consequences of excess alcohol.

134. The impact that alcohol has on urgent and emergency care and other public services adds to the growing calls for effective cross-government action to radically upgrade public health and prevention. Our report of September 2016 on the funding, delivery and organisation of public health services concluded that:

Cuts to public health are a false economy. The Government must commit to protecting funding for public health. Not to do so will have negative consequences for current and future generations and risks widening health inequalities. Further cuts to public health will also threaten the future sustainability of NHS services if we fail to manage demand from preventable ill health.<sup>172</sup>

135. Our report noted that the cost of alcohol related conditions to the NHS was £3.5bn per annum. Simon Stevens, Chief Executive of NHS England, said that the consequence of diminished public health services in relation to alcohol is that extra demand presents in the most expensive parts of the NHS such as emergency care.<sup>173</sup>

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168 Q88

169 [IAS](#), October 2015, p 30

170 Association of Ambulance Chief Executives ([WIP 08](#)) para 4

171 Centre for Urgent & Emergency Care Research ([WIP 04](#)) p 3

172 Health Committee, Second Report of Session 2016–17, [Public health post-2013](#), HC 140, para 40

173 [Ibid](#), para 35

136. Local authorities have a key role to play in managing problem drinking in their communities but they struggle to incorporate public health considerations into licensing decisions. As a consequence we urged the Government

to be bold, and make good on its commitment to health in all policies, by enshrining health as a material consideration in planning and licensing law.<sup>174</sup>

### *Conclusion*

**137. Problem drinking is a significant contributor to the pressures in Accident and Emergency departments particularly at weekends and over holiday periods. The Government should take greater responsibility for policy decisions that would help to reduce the impact of excessive alcohol consumption on individuals, families and communities. Local authorities could be well placed to take action and we call on the Government to give them the levers to be able to do so by making public health and the impact on NHS services a material consideration in licensing and planning decisions.**

## 5 Targets in urgent and emergency care

### Four-hour waiting time standard

138. The four-hour waiting time standard is the headline measure by which the success or failure of emergency departments, hospitals, and health systems is judged. Despite the challenging nature of the target and it placing tougher demands on hospitals than in many other comparable countries, we heard broad support for maintaining the standard.<sup>175</sup> Homerton University Hospital Trust argued that benchmarking performance against the four-hour waiting standard is a vital component of ensuring a safe system and positive patient experience. They said that in managing the urgent and emergency care system the Government should

maintain a strong focus on emergency care over winter and maintain the 4-hour target as an indicator of system resilience. Without this there would be a risk of system-wide collapse and patients suffering.<sup>176</sup>

139. Although outright gaming of the four-hour target was thought to be limited, in discussion with the national policy experts we met in Luton we heard examples of where the four-hour target can distort clinical priorities or drive unnecessary admissions to avoid breaching the target—a practice often referred to as ‘admit to decide’. This occurs instead of the more desirable practice of ‘decide to admit’.<sup>177</sup>

140. We heard calls during our visit for more nuanced targets to be developed, for example setting standards for treatment and outcomes for specific conditions across the entire patient pathway.<sup>178</sup> Our predecessor Health Committee’s report of 2013 found that the four-hour target “does not provide a full measure of service quality” and the “key indicators of hospital performance should be based on a broader assessment of patient outcome and experience”.<sup>179</sup>

141. In oral evidence Professor Keith Willett, NHS England’s Medical Director for Acute Care, said that:

the performance in an A&E department is almost wholly dependent on its relationships and its working with the other departments of the hospital and the other providers in the healthcare economy.<sup>180</sup>

### Conclusions

142. As noted in chapter 1, the Royal College of Emergency Medicine has described the four-hour waiting standard as “a useful proxy measure of crowding” and in 2013 our predecessor Health Committee concluded that it “retains its value as a basic measure of

175 Monitor, [International comparisons of selected service lines in seven health systems](#), October 2014, Annex 5

176 Homerton University Hospital NHS Foundation ([WIP 30](#)) p 4

177 Note of Committee visit to Luton and Bedford

178 Ibid

179 Health Committee, Second Report of Session 2013–14, [Urgent and emergency Services](#), HC 171, para 67

180 Q5

performance”.<sup>181</sup> We believe that the standard still serves as a useful measure of pressure in the entire system, an objective for patient safety and a helpful gauge of patient experience. Meeting the standard should be regarded as everyone’s business.

143. Considering the continued value of the four-hour waiting time standard, our predecessor Committee concluded that “the key indicators of hospital performance should be based on a broader assessment of patient outcome and experience”. The evidence we have heard during this inquiry has emphasised that emergency department performance is dependent upon relationships that exist across an entire health economy. Responsibility for achieving good performance in an emergency department lies not just within that department, nor even with the trust alone, but with individuals and teams across the whole health and care system. It is everyone’s business, including those in Government responsible for policy making on public health and prevention. **We support retaining the four-hour waiting time standard in emergency departments. We recommend, however, that evidence-based standards of performance should be developed which allow for a better assessment of the performance of the wider health and social care system in relation to urgent and emergency care.**

### Ambulance service targets

144. The necessity of developing system-wide measures of performance is exemplified by the problematic nature of the response time targets which shape the allocation of resources and working practices of ambulance trusts. The Government’s evidence noted that a pilot scheme designed to review the coding of ambulance calls and dispatch is one of the five interventions designed to help improve the urgent and emergency care system.<sup>182</sup> In oral evidence Professor Willett outlined the failings associated with the existing target mechanisms, which can require attendance by an ambulance within 8 minutes for calls graded at the most serious level (red 1):

Fifty-eight per cent of all ambulances in England that are dispatched are dispatched on blue lights and two tone sirens, to go to an emergency. The number of patient calls that might benefit from a response of that urgency, to get there in eight minutes, is probably less than 2%, and certainly no more than 6%. Fifty-eight per cent of ambulances go out, and that is because they are trying to meet the eight minute target. In fact, 25% of the ambulances we dispatch never get to the scene because another vehicle has got there first or, it turns out, by the time they have found out what is wrong with the patient that they are not needed. That means we are currently sending multiple vehicles to one call, just to try to meet the standard.<sup>183</sup>

145. Professor Willett’s description of the system is aligned with that of the East of England Ambulance service, representatives of which observed during our visit to the Bedford ambulance station that achieving time drives behaviour and not clinical outcomes.<sup>184</sup> In Bedford it was noted that different targets apply elsewhere in the UK and strict time-based targets in England may be driving demand.<sup>185</sup>

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181 Health Committee, Second Report of Session 2013–14, [Urgent and emergency Services](#), HC 171, para 67

182 Department of Health, NHS England and NHS Improvement ([WIP 35](#)) Annex C

183 Q38

184 Note of Committee visit to Luton and Bedford

185 Note of Committee visit to Luton and Bedford

## Conclusions

146. Professor Willett said that part of the ambulance response target includes the requirement that call handlers decide whether a vehicle should be sent within 60 seconds of the call being connected. In reality, Professor Willett said, making a sensible judgement within 60 seconds is often not feasible, so the NHS England pilot scheme has relaxed that aspect of the target, allowing more time for decisions to be made.<sup>186</sup> We consider that this is a wise approach, as the existing target regime for the ambulance service can distort clinical priorities and makes poor use of resources.

147. Neither ambulance response targets nor the four-hour waiting standard in hospital can illustrate effectiveness of clinical decision making across the patient pathway. The challenges associated with handover delay at the beginning of the patient journey and delayed transfers of care at its end illustrate why much broader standards are required to measure the successful operation of the system as a whole, as we have recommended in paragraph 143 above.

148. It is welcome that NHS England has launched pilot schemes to explore how the ambulance service can be utilised more effectively. The pilots should be monitored closely so that initiatives which achieve their objectives can be replicated across all parts of the country as soon as possible. Too often ambulances are despatched inappropriately or are left waiting outside hospitals. This wastes the skills, time and resources available within the service. **Reform of the existing target regime for ambulance providers in combination with tackling handover delays should be prioritised by NHS England. This would help to remove the practical barriers that limit the ability of ambulance providers to ‘see and treat’ patients without having to convey them to hospital.**

## Conclusions and recommendations

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### Evolving demand

1. We are very concerned about the decline in performance of major emergency departments in England. We recognise that hospitals are managing ever growing demands, but the performance of emergency departments against the four-hour waiting time standard is a marker of much wider system pressure. (Paragraph 12)

### Early senior review of patients

2. Both the Nuffield Trust's and the Health Foundation's research support the case for early senior review of complex cases. The systematic review cited by the Centre for Urgent & Emergency Care Research, however, reported limited cost and patient outcome benefits from routine use of early senior review of patients. When redesigning systems and processes with the intention of improving patient flow trusts should assess how they are applied and whether they are effective in their local context. (Paragraph 22)

### National policy interventions

3. It is welcome that the interventions designed for use by A&E Delivery Boards and individual trusts focus on the practical aspects of patient flow throughout a patient's stay in hospital. We support the whole system approach to providing a better experience of care to patients in the right setting at the right time. (Paragraph 27)
4. Ministers and senior officials should acknowledge the reservations expressed by the Centre for Urgent and Emergency Care and re-examine the evidence base for the initiatives being applied within emergency departments. (Paragraph 29)

### Practical improvement

5. We recommend that NHS England and NHS Improvement set out how they intend to formally evaluate the effectiveness of the interventions that they have mandated and how they will be encouraging trusts to do likewise. Data collection and evaluation should be built into future programmes from the outset to improve research into the most effective interventions. (Paragraph 30)
6. The ongoing decline in performance of type 1 emergency departments against the four-hour target should be regarded as a matter of patient safety rather than a failure to meet a bureaucratic objective. (Paragraph 32)
7. Through the improvement work they are undertaking with trusts, NHS England and particularly NHS Improvement should facilitate the development of the cultural approach we witnessed in Luton, where waiting times in A&E are seen as everyone's responsibility. (Paragraph 33)

### Flow & delayed transfers of care

8. It is an indictment of the existing state of adult social care provision that some acute trusts are having to establish domiciliary care services in order to improve patient flow through their hospitals and ease pressure in their emergency departments. This only serves to underline the perilous state of adult social care in England and the fundamental inadequacy of provision in some parts of the country. The Government should undertake an urgent review of the state of adult social care and its impact upon the NHS and the most vulnerable individuals who depend upon both. (Paragraph 41)

### Increasing bed capacity

9. Investment in ‘step-up/step-down’ community rehabilitation beds helps to relieve the pressure on NHS beds and can help to flex capacity at times of especially high demand. Nevertheless, acute trusts need to plan effectively for sufficient acute beds as well as access to community beds to improve patient flow. (Paragraph 53)
10. It is essential that the Government ensures that sufficient capital funding is available for trusts to develop the infrastructure that will enable them to meet performance levels demanded by Ministers. The first step will be an assessment of the infrastructure investment required to ensure that type 1 emergency departments are fit for purpose, which should be completed through the Sustainability and Transformation Plan process. Once that assessment is complete, NHS England and NHS Improvement will need to ensure that the available capital funding is directed accordingly—we call on the Government to review the real terms cuts to NHS capital budgets in the Spending Review and to protect the transformation element of the Sustainability and Transformation Fund. We emphasise the importance of evaluation of completed projects in order to guide future investment and identify and share best practice. (Paragraph 58)

### Supporting adult social care to maintain patient flow

11. We recommend that the Government should provide additional funding to increase adult social care capacity. This could substantially relieve pressure on trusts as exit block is a key contributor to winter pressures in areas lacking sufficient adult social care provision. (Paragraph 68)
12. The national benchmarking exercise that has been undertaken by A&E delivery boards should inform an assessment of the impact that cuts in adult social care have had on the performance of trusts. We reiterate our frustration that the Department of Health has yet to undertake this assessment and consider it is vital that it does so at the earliest opportunity, particularly given its impact on the performance of the urgent and emergency care system. (Paragraph 69)
13. We believe that adult social care is underfunded and this is having an impact on the NHS. The performance of the NHS and social care cannot be viewed in isolation. Adequate funding of social care and appropriate development of the social care workforce are worthy objectives in their own right, but the urgency of

action on those two objectives is thrown into even sharper relief in the context of their contribution to the improved performance of the urgent and emergency care system. (Paragraph 70)

### Utilising primary care to reduce demand

14. We would like to see further evidence that the Government's proposals for extended GP hours will limit the demands placed on emergency departments. (Paragraph 79)
15. In the long term enhanced and properly resourced primary care shaped around the recommendations we made in our report of April 2016 on primary care will be crucial in helping to prevent the escalation of illness to an extent where emergency admission to hospital is required. (Paragraph 80)
16. We agree with the Centre for Urgent and Emergency Care Research that a robust evaluation is needed of proposed models of co-located of primary care with emergency departments. Further research is required to understand the impact on patient behaviour, emergency department attendance and patient outcomes. In particular there needs to be much greater investigation into the risk of creating supply-induced demand. Given the shortfall in GP numbers, it is unlikely to be sustainable to operate several parallel systems for out-of-hours GP access and it is important that commissioners to consider the wider impact on primary care provision for patients as well as for A&E. (Paragraph 86)
17. Equally, NHS England should be aware that co-location may not be a solution which enhances access in rural areas, and some trusts may simply not have the capacity to accommodate such a service or the capital resource to create it. Models will need to adapt to local circumstances and must be robustly evaluated. (Paragraph 87)

### The ambulance service

18. Delayed ambulance transfers are an unacceptable waste of valuable paramedic resources and disadvantage patients living in neighbouring areas who may experience longer waits if vehicles are tied up elsewhere. NHS England should urgently address the level of variation to ensure that there is a timely handover of patients. (Paragraph 94)

### Staffing

19. We recommend that NHS Improvement consider the steps which can be taken this winter to ensure that all emergency departments, but particularly those which are currently performing poorly, are able to recruit the staff which they need to get their performance to an acceptable level. (Paragraph 108)
20. In the longer term, we recommend that Health Education England look again at the measures needed to improve staffing levels in emergency departments, and redouble its efforts to ensure that the supply of such staff is sufficient to ensure safe and timely care. It is in everyone's best interest for the prioritisation of the improvement of staffing levels to be the culture in every hospital. (Paragraph 109)

## Funding

21. Rather than introducing a ring-fence on the winter resilience funding that is incorporated into the baseline allocation for CCGs, we recommend that NHS Improvement and NHS England take steps to ensure that there is transparency about the amount of funding which trusts and clinical commissioning groups direct to preparing for winter pressures. Thorough evaluation of the approaches to dealing with winter pressure will require transparency about how they are funded. (Paragraph 117)
22. Payment mechanisms should reflect the cost of providing care at each stage of the patient journey and incentivise ambulance and hospital trusts as well as community services to work together in the interests of patients. This means developing payment mechanisms which will suppress demand by encouraging prevention, facilitating early intervention, limiting the escalation of morbidity and helping to ensure that patients are seen by the most appropriate professional at the right time and in the right place. Tariff reform is long overdue and in responding to this report the Government should set out a clear timetable for it to be achieved. (Paragraph 121)

## Management of the system

23. We are concerned about the level of variation in performance between trusts in managing urgent and emergency care. We recognise the pressures hospitals face but there is much that trusts can do to improve flows within their own systems and to learn from the best performing trusts. We support the steps taken by NHS England and NHS Improvement to try to tackle variation. We encourage them to roll out this process as quickly as possible so that other trusts facing similar challenges can overcome their problems. (Paragraph 128)
24. Performance management of trusts should not become more intense just because hospitals are operating under pressure. We recommend that the Department of Health should formally evaluate how the central management system which oversees performance against the four-hour target contributes to the maintenance of patient safety and the improvement of performance within trusts. (Paragraph 129)

## Demand driven by alcohol consumption

25. Problem drinking is a significant contributor to the pressures in Accident and Emergency departments particularly at weekends and over holiday periods. The Government should take greater responsibility for policy decisions that would help to reduce the impact of excessive alcohol consumption on individuals, families and communities. Local authorities could be well placed to take action and we call on the Government to give them the levers to be able to do so by making public health and the impact on NHS services a material consideration in licensing and planning decisions. (Paragraph 137)

### Four-hour waiting time standard

26. We support retaining the four-hour waiting time standard in emergency departments. We recommend, however, that evidence-based standards of performance should be developed which allow for a better assessment of the performance of the wider health and social care system in relation to urgent and emergency care. (Paragraph 143)

### Ambulance service targets

27. Reform of the existing target regime for ambulance providers in combination with tackling handover delays should be prioritised by NHS England. This would help to remove the practical barriers that limit the ability of ambulance providers to 'see and treat' patients without having to convey them to hospital. (Paragraph 148)

## Annex: Visit to Luton & Bedford

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### Visit to Luton Hospital emergency department

#### **Background**

The Committee visited Luton and Dunstable University Hospital NHS Foundation Trust (L&D) and the East of England Ambulance Trust (Bedford) on Tuesday 6 September 2016.

Committee members present: Dr Sarah Wollaston MP (Chair); Julie Cooper MP; Dr James Davies MP; Andrea Jenkyns MP; Maggie Throup MP; Dr Philippa Whitford MP.

Representatives of the L&D included: Pauline Philip, Chief Executive, Luton & Dunstable Hospital Trust; David Carter, Managing Director; Mr Dave Kirby, Consultant in Emergency Medicine and Medical Director for Operations & Performance.

Pauline Philip and Dave Kirby provided an overview of Luton & Dunstable's approach to the delivery of the 4hr standard and the systems and processes the Trust had put in place to manage capacity and demand. The Committee was then escorted on a tour of the emergency department (ED).

#### **Seasonality**

The Committee heard that there is a little seasonal effect in Luton and peak periods of demand do not necessarily happen in winter. Equally, attendances fall at certain periods during the summer as Luton is not a tourist destination and the local population decreases as summer holidays are taken. It was explained that a process had been set in train in 2010 to achieve good performance in the emergency department and this is subject to constant evaluation and development.

#### **Factors contributing to good performance**

The L&D said that they had increased bed capacity to improve patient flow but other reforms centred on the management of the emergency department and the organisational culture. A system of streaming patients between the ED and a primary care service had been established. The basic principle that is applied is that if a patient walks into the department, can talk in full sentences and has no obvious condition which requires urgent attention then they will be directed to the co-located primary care service. A small number of risk factors are excluded from the streaming process. This service is not accessible from the street and can only be accessed via the ED. GPs in the primary care service have the same access to services as those in the wider community. Originally, the co-located service had dealt with minor injuries but the ED found that this provided little benefit as a significant number of patients would end up being sent back to the ED. The L&D said that the primary care service, however, had helped reduce congestion in the ED and there is no evidence that the co-located service has increased demand.

### ***Forward planning***

Once a patient is in the ED early senior review of complex patients means that it can be quickly decided (within an hour) if a patient will require admission. This does not mean that a final diagnosis is reached within this timeframe but the point was made that this is not required to know whether a bed will be needed or not. The L&D emphasised that developing this system had required investment in a sophisticated IT system, and the staff to use it. The system allows for anticipatory planning of bed requirements and maps the movement of patients through the hospital.

### ***Hospital wide cooperation***

The cooperation of other specialties within the hospital has been seen as central to maintaining good performance against the four-hour standard. Early on in the process of improvement an agreement was reached with consultants that patient lists would not be cancelled at late notice if they agreed to help in the ED at periods of peak demand. All teams within the hospital recognise that meeting the target is a matter of patient safety rather than a bureaucratic objective. In practice this means that staff can be re-allocated from wards to support the short-term use of escalation wards to increase capacity. The application of IT means that there is a predictive capability to help plan for peaks in demand.

### ***Alternative urgent and emergency care services***

Good performance has been supported by an integrated health and social care team. However, the L&D said that the one aspect of care that they can't plan or adapt for is the lack of adult social care and this posed a major threat to the performance of the ED and hospital. Concern was also expressed about the performance of out-of-hours primary care and the difficulty in accessing alternative urgent care services. It was observed by the L&D's representatives that the performance standards in other urgent care services do not match that of the ED where patients know that they are likely to be seen within four hours. The L&D said that an integrated urgent care service routed through the 111/999 integrated access hub is required—their own audit of attendances had shown that only 58% of patients would attend the ED if there was proper integrated urgent care with a comprehensive service directory.

### ***Financial performance***

The Committee was told that the provision of urgent and emergency care is a loss-making activity for the L&D. Overall, the emergency department loses £3 million per annum. The L&D said the tariff system pays EDs too much for simple cases but too little for complex patients in the ED. It was also noted that the co-located primary care service is operated by a different provider so the tariff for those cases does not reach the L&D.

## Meeting with national policy experts

### *Background*

The Committee held a seminar with a range of national policy experts. Attendees were: Dr Clifford Mann, President, Royal College of Emergency Medicine; Anthony Marsh, Chief Executive, Association of Ambulance Chief Executives; Dr Tom Downes, Consultant Physician and Geriatrician, Clinical Lead for Quality Improvement, Sheffield Teaching Hospitals NHS Foundation Trust and Health Foundation Quality Improvement Fellow; Professor Steve Goodacre, Professor of Emergency Medicine, Centre for Urgent & Emergency Care Research, University of Sheffield; Professor Sue Mason, Professor of Emergency Medicine, Centre for Urgent & Emergency Care Research, University of Sheffield; Corrine Eastes, Emergency Care Improvement Manager, NHS Emergency Care Improvement Programme; Sasha Karakusevic, Senior Fellow, Nuffield Trust.

The seminar opened with a general discussion about performance of the urgent and emergency care system. The point was made that last year the weather was relatively good and the flu vaccine proved effective, but despite this many trusts struggled. It was observed that it has proved possible for some trusts to replicate good practice from elsewhere. Concerns were expressed, however, that short-term decision making can drive actions for the medium and long-term and too much emphasis had, in the past, been placed on improving performance by reforming commissioning processes rather than focusing on service delivery.

### *Effect of the four-hour waiting time standard*

The effect of the four-hour waiting time standard was assessed by the policy experts. The Committee was told that there is little evidence of active ‘gaming’ of the system. In the early days of the target gaming did exist but it is much reduced now. The target is not thought to particularly drive clinician behaviour but it was observed that nurses are under pressure to make swift decisions.

The Committee heard that very few patients are admitted to hospital unnecessarily and even if a patient does not eventually stay overnight in hospital that did not mean that admission was not required when the patient attended the emergency department. There was a discussion about what happens to patients after they are admitted with the point being made that before admission the system is heavily regulated in terms of time but after admission patients can enter a ‘black hole’. Countering this, the Committee heard that good clinical practice means that in reality the approach to patient care does not alter once patients are admitted and the four-hour target is met.

### *System improvement*

Looking at how the system could be improved, it was observed that quite small differences in operational performance can make the difference between a successful and a failing organisation. The importance of community resources was emphasised and the Committee was told that often the discussion around community beds focuses on ‘step-down’ rehabilitative care with little attention paid to ‘step-up’ services which can limit demand for emergency care.

## ***Patient behaviour***

Examining patient behaviour, the Committee was told that in some areas migrant communities will disproportionately use A&E as they have little knowledge or experience of primary care in their countries of origin. It was observed that growing numbers of ambulatory patients are being referred to A&E by other health professionals and problems with out-of-hours services can drive patients to emergency departments. For example, some out-of-hours services will not liaise with paramedics about patient care.

The Committee was told that at present the urgent and emergency care system is defined by managing crises rather than avoiding them. Demand for beds will grow by 9,000 by 2020 so the approach has to change. The Committee heard that the capacity of the system to absorb demand is limited by the available workforce and that patients with complex needs (a group which is expanding rapidly) absorb the most staff time. Moreover the interface between health and social care is 'forming a dam' of patients. It was noted that including a new metric of daily discharge ratios in the Carter review emergency medicine dashboard may have a positive impact.

## **Seminar with NHS trust leaders**

### ***Background***

The Committee met senior representatives of acute trusts drawn from across England all of which host type 1 emergency departments. Attendees were: Kate Slemeck, Chief Operating Officer, Royal Free London NHS Foundation Trust; Nick Hulme, Chief Executive, The Ipswich Hospital NHS Trust & Colchester Hospital University NHS Foundation Trust; Libby McManus, Chief Executive, North Middlesex University Hospital NHS Trust; Rob Cooper, Acting Director of Operations and Performance, St Helens and Knowsley Teaching Hospitals NHS Trust; Liz Davenport, Chief Operating Officer, Torbay and South Devon NHS Foundation Trust; Jenifer Rossall, General Manager for Acute Medicine, Nottingham University Hospitals NHS Trust.

### ***Challenges facing emergency departments***

The seminar began with a description by one trust leader of the specific challenges they face. The trust in question has an ageing population, a significant tourist population and in addition 22% of local children live in poverty. The Committee was told that major problems with emergency care had started to be alleviated by increased recruitment but the fundamental problem faced by the trust was the size of its emergency department. There simply is not the space to accommodate the average number of daily attendees.

Another trust described the challenge of working with three different Clinical Commissioning Groups, all of which have different policies for discharging patients. The trust representative told the Committee that they experienced a 6% annual increase for elective procedures which left them 30 – 60 beds short. Previous winter resilience schemes had focussed on limiting elective activity during periods of peak demand but it was found that some of these cases re-presented at the emergency department.

The Committee heard from a representative of a trust that has encountered very serious problems in the performance of its emergency department. It was noted that some problems

were specific to the trust such as poor rotas of middle grade staff and an inefficient layout of the emergency department. The trust said that their attendances were disproportionately high and attributed this to a lack of GP and community provision.

### ***Consequences of poor performance***

The Committee heard that the consequence of poor performance is that staff begin to give up on ever performing well and a ‘culture of hopelessness’ can prevail. In the following discussion it was observed that Chief Executives in some cases have to tell the staff in poorly performing trusts that they all have to do better.

Although this may be necessary it was acknowledged that it could be high risk. It was agreed that the cultural differences between successful and unsuccessful trusts—and the behaviour and expectations of the staff—are very striking.

### ***New services***

One trust leader described an initiative that had been launched whereby the trust would provide a domiciliary care service. This, the Committee was told, was to make up for a lack of adult social care and because the cost of keeping patients in hospital exceeded the cost of providing care to the same patients in their own homes. Local authorities are reluctant to commission trusts to provide this service as they immediately classify it as an NHS service. Even without local authority commissioning, however, the Committee was told that the service still makes economic sense for the trust. The Committee heard that recruiting staff to this service was easy as the NHS brand is hugely attractive to workers in the care sector. In one area, local authority funded homecare services were described as being ‘on their knees’.

### ***Staffing***

The Committee heard a number of observations in relation to staff from various attendees. The point was consistently made that in some areas it is almost impossible to recruit middle grade doctors and that workforce planning has to apply to entire areas rather than just individual trusts. The Committee was told that the limited supply relative to demand of nurses means that they can carefully choose where they work—they often don’t choose the ED because of the stress associated with it.

### ***Primary care***

Primary care was not seen as contributing greatly to efforts to manage winter pressure. The Committee heard that primary care doesn’t change its offer in relation to winter and doesn’t react to the Christmas and new-year bank holidays when demand can transfer to the ED. The Committee was told, however, that some preventative measures have been introduced such as prescribing prophylactic antibiotics for people with respiratory conditions. This could make a significant difference as 80% of admissions at certain winter periods in one area are for respiratory illness.

## ***Management and funding of the urgent and emergency care system***

The management and resource available to the urgent and emergency care system was discussed with the Committee. The attendees agreed that there had been excessive micro-management of trusts in previous years and the system appeared designed to provide assurance to the centre as opposed to solving problems. It was noted that hours of leadership time spent participating in conference calls during periods of pressure contributed very little to the practical resolution of problems. The Committee was told trust leaders should be able to go to NHS Improvement with specific problems and receive advice on how other trusts had managed to solve the problem that had been identified. This, in essence, would be brokerage of good advice by NHS Improvement.

Funding was said to be very limited and one attendee said that incorporating winter allocations into CCG baseline funding meant in practice that the funding ‘isn’t real’. The Committee heard that even if extra funding was provided to open additional beds it would achieve little as there is no more bed capacity to be used.

## **East of England Ambulance Trust**

### ***Background***

The Committee visited the East of England ambulance centre in Bedford. The Committee was given a tour of the control room and representatives of the East of England Ambulance Service Trust (EAST) discussed the challenges that the ambulance service has to face. Attendees from EAST included: Sarah Boulton, Chair; Robert Morton, Chief Executive; Kevin Brown, Director of Service Delivery; Tracy Nicholls, Head of Clinical Quality; Sandra Treacher, Emergency Operations Centre Clinical Lead; Nikki Ward, Head of Business Development.

The trust told the Committee that they had initiated a process to ‘hear and treat’ a greater proportion of patients which would reduce the need to dispatch vehicles. The Committee heard that all ‘green’ calls are now triaged this way and that they had doubled the proportion of patients being triaged to ‘hear and treat’. The ambition of the trust, they said, is for 10% of patients to be managed by ‘hear and treat.’

### ***Ambulance service targets***

A substantial portion of the discussion examined the problems associated with the existing target regime for ambulance services. The Committee heard that the 8 minute response time was clinically appropriate for some calls but not others and that this can create perverse incentives. In addition the necessity of instantly responding to the target means that crews are regularly despatched and then recalled. The demands of the target, EAST said, mean that behaviour is driven by making time rather than clinical need. EAST argued that targets could be better applied if they covered the totality of care for specific conditions.

It was noted that other parts of the UK such as Wales have different target regimes. In Wales 10% of calls require an ambulance within eight minutes but in England it is 50%. The Committee was told that there may be a capacity gap that is being driven by excess demand. Ireland was cited as an example because it has half the number of calls to the

ambulance service per 1,000 people than the East of England. In addition it was noted that in some systems 40% of patients do not require conveyance to hospital because of 'see and treat' by paramedics. The Committee was told that transport has traditionally defined the ambulance service but it should be only one consequence of the service provided.

### *Handover delay*

The problem of handover delayed was addressed by the representatives from EAST. The Committee was told that there is very significant differences between trusts in the time taken to transfer patients from ambulances to emergency departments. EAST said that at some hospitals delays of over an hour were a common occurrence and waits of more than two hours were not uncommon. The consequence of the delays is that vehicles and crews are unable to respond to emergencies elsewhere and waiting in an ambulance substitutes for waiting in hospital.

# Formal Minutes

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**Tuesday 25 October 2016**

Members present:

Dr Sarah Wollaston, in the Chair

Ben Bradshaw	Maggie Throup
Dr James Davies	Helen Whately
Andrea Jenkyns	Dr Philippa Whitford
Emma Reynolds	

Draft Report (*Winter pressure in accident and emergency departments*), proposed by the Chair, brought up and read.

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

Paragraphs 1 to 148 read and agreed to.

Summary agreed to.

Annex agreed to.

*Resolved*, That the Report be the Third 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.

[Adjourned till Tuesday 1 November at 2.00pm.]

## Witnesses

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The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

### Monday 12 September 2016

*Question number*

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

[Q1-78](#)

## Published written evidence

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The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

WIP numbers are generated by the evidence processing system and so may not be complete.

- 1 Association of Ambulance Chief Executives ([WIP0008](#))
- 2 British Geriatrics Society ([WIP0011](#))
- 3 British Medical Association ([WIP0018](#))
- 4 Bupa UK ([WIP0017](#))
- 5 College of Occupational Therapists ([WIP0020](#))
- 6 Dartford and Gravesham NHS Trust ([WIP0034](#))
- 7 Department of Health, NHS England and NHS Improvement ([WIP0035](#))
- 8 Department of Health, NHS England and NHS Improvement ([WIP0036](#))
- 9 Foundations ([WIP0003](#))
- 10 Health Education England ([WIP0014](#))
- 11 Homerton University Hospital NHS Foundation Trust ([WIP0030](#))
- 12 Independent Age ([WIP0027](#))
- 13 Integrated Care 24 ([WIP0029](#))
- 14 Local Government Association ([WIP0013](#))
- 15 Mr Ben Loryman ([WIP0015](#))
- 16 NHS Partners Network ([WIP0007](#))
- 17 NHS Providers ([WIP0028](#))
- 18 Nottingham University Hospitals NHS Trust ([WIP0025](#))
- 19 Nuffield Trust ([WIP0033](#))
- 20 Optical Confederation and Local Optical Committee Support Unit ([WIP0021](#))
- 21 Royal College of Emergency Medicine ([WIP0009](#))
- 22 Royal College of Nursing ([WIP0032](#))
- 23 Royal College of Physicians ([WIP0010](#))
- 24 Royal College of Physicians of Edinburgh ([WIP0006](#))
- 25 School of Health and Related Research, University of Sheffield ([WIP0004](#))
- 26 St Helens and Knowsley Teaching Hospitals NHS Trust ([WIP0002](#))
- 27 The Royal College of Speech and Language Therapists ([WIP0016](#))
- 28 The Royal Society for the Prevention of Accidents (RoSPA) ([WIP0022](#))
- 29 Torbay and South Devon NHS Foundation Trust ([WIP0031](#))
- 30 United Kingdom Homecare Association ([WIP0005](#))
- 31 University Hospitals of Morecambe Bay NHS Foundation Trust ([WIP0024](#))
- 32 Urgent Health UK ([WIP0026](#))

## List of Reports from the Committee during the current Parliament

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All publications from the Committee are available on the [publications page](#) of the Committee's website.

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

### Session 2015–16

First Report	Childhood obesity—brave and bold action	HC 465 (Cm 9330)
Second Report	Appointment of the Chair of the Care Quality Commission	HC 195
Third Report	Appointment of the Chair of the Food Standards Agency	HC 663
Fourth Report	Primary care	HC 408

### Session 2016–17

First Report	Impact of the Spending Review on health and social care	HC 139
Second Report	Public health post-2013	HC 140