



House of Commons
Committee of Public Accounts

Department of Health: improving emergency care in England

**Sixteenth Report of
Session 2004–05**

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

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Summary

On an average day in the National Health Service (NHS) 34,700 people attend an accident and emergency (A&E) department, 11,700 need urgent transport to hospital by ambulance and over one million people contact their general practitioner (GP). These requests for emergency care take place against a background of four access targets outlined in The NHS Plan in 2000. The Department of Health (the Department) produced a detailed strategy, *Reforming Emergency Care* in 2001, which set the targets in the broader context of increased capacity, reduced fragmentation, wider access and consistency of emergency services, as well as new professional roles and ways of working.

On the basis of a Report from the Comptroller and Auditor General,¹ the Committee took evidence from the Department of Health and the National Director for Emergency Access (Emergency Care Czar) on demand for emergency care, timely treatment for patients and integration of services.

Understanding demand for emergency care

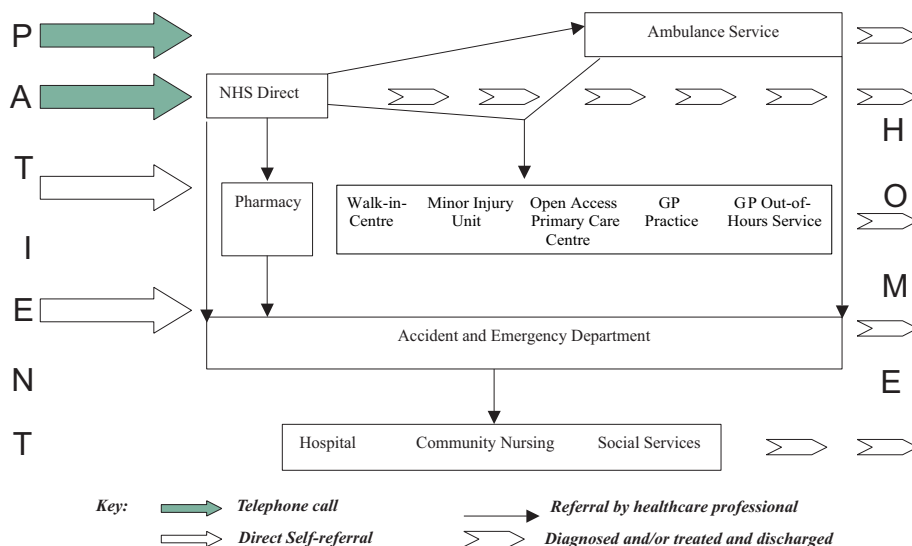
Demand for emergency care continues to grow and the Department has focused on providing services for the convenience of the patient. It has brought in a range of new open-access minor injury and illness services, of which Walk-in-Centres have the highest profile and there are therefore a number of ways in which patients can access emergency care (Figure 1). These alternative services have been positively received by patients but they are mainly addressing previously unmet demand rather than taking pressure off existing A&E services and the relative cost effectiveness of all emergency care providers has not been established.

Sustaining and building on achievements in treating patients without undue delay

Patients identified a reduction in waiting time in A&E as the improvement they would most like to see, and the Department has been pro-actively managing NHS trust performance to ensure that, by December 2004, no one will spend longer than four hours in A&E before being discharged or admitted to hospital, unless clinically appropriate. It has used a combination of programmes to help trusts identify and implement changes, such as the Emergency Services Collaborative and the Improvement Partnership for Hospitals, together with financial incentives to drive improvements. As a result significant and sustained progress has been made towards the target, and published performance data for July–September 2004 showed on average 95.9% of patients across all acute and primary care trusts in England spent less than four hours in A&E. However, a number of trusts still have some way to go since only around 70 trusts had consistently achieved the weekly mark of 98%. From April 2005, the four-hour maximum total time in A&E will no longer be a national target but will be part of the framework of health and social care performance standards which will be assessed by the Healthcare Commission.

1 C&AG's Report, *Improving emergency care in England* (HC 1075, Session 2003–04)

Figure 1: Alternative patient journeys for emergency care



Source: National Audit Office

Some patient groups are much less likely to be seen within four hours. Avoidable peaks and troughs in the availability of beds, waiting for specialist opinion and lack of access to diagnostic services still cause delay. Undue focus on meeting the target could mean less attention is paid to the timely completion of treatment for patients, and a full range of formal measures of quality of care or care pathways provided in A&E departments has yet to be put in place. Obtaining sufficient suitably qualified and experienced healthcare professionals remains a problem and there is no accepted model for staffing A&E departments.

Improving the integration of emergency care services

The modernisation of emergency care requires the redesign of work systems around patients' needs. There are some good examples of collaborative projects, but NHS trust chief executives believe there is the potential to improve joint working. As a means of securing the necessary integration of services, Emergency Care Networks (cross-organisation and multi-disciplinary groups to lead on local emergency care delivery) are a promising development. Nevertheless, many networks are still in their infancy and lack the authority and funding to bring about co-operation across the various emergency care providers. Emergency Care and Emergency Nurse Practitioner roles have been created to diagnose, treat and discharge patients with minor illnesses and injuries, but there is no national competency framework or standard curriculum.

Conclusions and recommendations

- 1. Demand for emergency care continues to rise.** Emergency Care Networks should be given responsibility for reviewing local patterns of demand compared to supply, and emergency care services should be commissioned accordingly.
- 2. The Department is to be commended for expanding access to emergency care through the establishment of new providers, but there is a lack of knowledge about the relative unit costs of these services.** The Department should clarify the methodology for computing costs so that strategic planners for emergency care services can estimate the relative unit costs of the different providers and assess the impact on existing organisations if changes in service provision are made.
- 3. As a consequence of the Department actively managing trusts' performance, the percentage of patients being discharged or admitted from A&E in under four hours has risen from 77% in September 2002 to 94.6% in September 2004.** After the maximum total time ceases to be a national target there is a risk that high level attention to performance in A&E Departments will diminish. To avoid this risk the Department should continue to monitor performance closely and provide support to NHS acute trusts to identify bottlenecks in their systems and help them develop practical solutions.
- 4. Four hours is too long for the treatment of many patients with minor injury or illness, and the proportion of older and vulnerable patients who spend longer than four hours in A&E remains disproportionately high.** The Department should make data available to all emergency care providers so that they can benchmark their performance and monitor their processes to ensure patients spend no more time in A&E than is clinically necessary. In collaboration with other National Directors, particularly the Older People's Czar, the National Director for Emergency Access should promote action to identify ways of reducing the need for crisis emergency care for the elderly and those with mental health problems.
- 5. Treatment would be improved by more efficient use of or investment in diagnostic services, more effective bed management and timely access to specialist opinion.** To reduce variations in patients' experience of A&E services, NHS acute trusts should draw on approaches used by the highest performing departments and hospitals. These include widening staff responsibility for initial interpretation of x-rays, and using up-to-date equipment in diagnostic services, and making use of Departmental checklists for bed management and access to specialist opinion.
- 6. The work on constructing quality standards for emergency care and national clinical audit tools is welcome but overdue.** The National Director for Emergency Access should work with expert groups, such as the Faculty of Accident and Emergency Medicine, to test the reliability, validity and responsiveness of the 36 quality of care indicators which have been proposed. Once a range of performance measures have been agreed the Department should make the data available for patients, clinicians and managers so that they can benchmark the standards of care being provided.

- 7. The current absence of integrated patient records is an acknowledged risk to patient safety.** To prevent the collection of duplicate information and reduce the risk to patient safety the Department should clarify where the responsibility for inputting particulars collected at each stage of the emergency patient's journey will lie. Pending integrated care records which allow emergency healthcare professionals to audit clinical outcomes by tracking patients' progress, the Healthcare Commission should develop more audit tools which allow clinicians to measure the quality of care and benchmark performance across all emergency providers.
- 8. Delivery of high quality care in a timely manner depends on having enough skilled staff 24 hours a day.** The Department should amend its A&E workforce planning model, in light of feedback from its own trials and the recommendations of the British Association for Emergency Medicine, and make the tool available to all A&E service managers. The workforce development confederations of strategic health authorities should then agree regional strategies to address any identified shortfalls in skilled staff.
- 9. Patients are confused by the variety of different emergency care providers.** Strategic health authorities, working with Emergency Care Networks, should rationalise the system of names used for emergency care services so that the purpose of each type of organisation is clarified and standardised across the country.
- 10. Patients need to understand the circumstances in which an ambulance should be called,** when ambulance personnel should and should not be expected to provide a transport service to A&E, and that minor injuries and illnesses can be treated efficiently at emergency care providers other than major A&E departments. The Department should engage in a public education campaign, drawing on best practice from other organisations such as the UK Fire Service,
- 11. The emergency care services of some acute and ambulance trusts are commissioned by more than one primary care trust.** The current method of funding is not flexible enough to deal with differences in strategies to address local health needs or with variations in demand. The Department should evaluate the potential for making Emergency Care Networks responsible for allocating funds for emergency care services in their locality. It should draw on the knowledge and experience gained from Cancer Networks in performing this function.
- 12. The Department's vision for simple local access to emergency care through one telephone call is laudable but staff need sufficient clinical experience and training and local knowledge to provide a safe service.** The Department should expedite its discussions with NHS Direct, the Ambulance Services and GP Out-of-Hours Service providers and conclude on how to handle initial requests for help via the proposed single national telephone number for emergency care. It should also publicise the evaluations of the Out-of-Hours Exemplar Programme to ensure that Emergency Care Networks can adapt best practice to fit the situation in their localities.
- 13. Increasingly, emergency care practitioners and emergency nurse practitioners are becoming responsible for the treatment of patients, but there is no standard training or job description for these roles.** To provide much needed national consistency, and in accordance with ideals of the NHS Knowledge and Skills

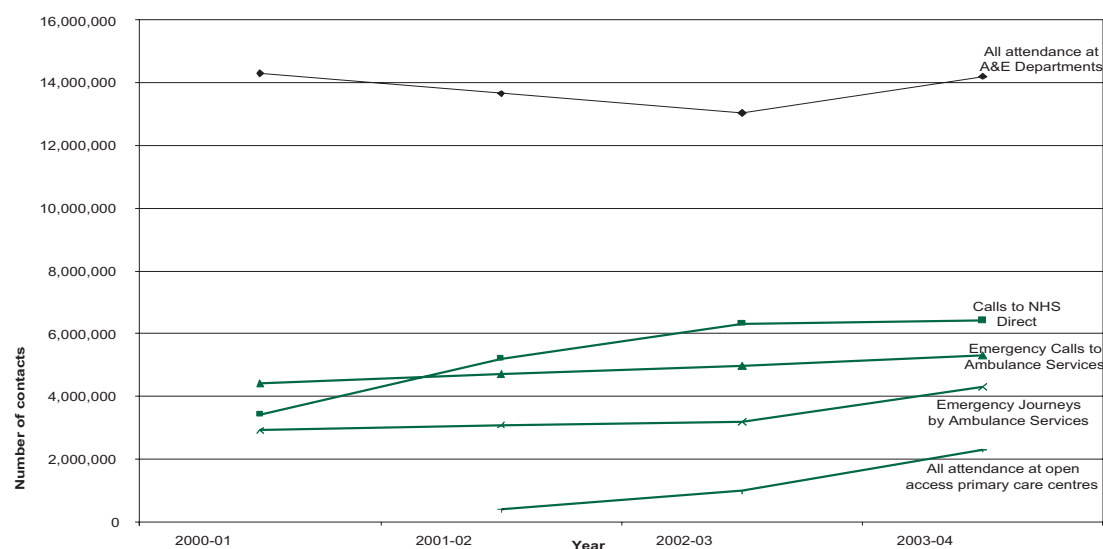
Framework, the Department should clarify the skills and competencies that a person needs to be effective in these posts and define the minimum content for the education curriculum.

1 Understanding demand for emergency care

1. Emergency care, as opposed to elective (planned) care, is a large part of the NHS's work. Major A&E departments in hospitals are only one of a variety of emergency care providers. There is now a growing body of evidence which shows that forecasts of demand for emergency hospital treatment can be made with reasonable accuracy. Demand can only be managed, however, if patient flows, both in and out of A&E, are viewed in relation to the whole healthcare system.²

2. Through the *Reforming Emergency Care* strategy the Department made a commitment to patients that wherever and whenever they contacted the NHS, their needs would be met and the most appropriate response provided. The Department has widened access to emergency care through the establishment of new types of provider such as Walk-in-Centres and NHS Direct telephone helpline and online service. Annual demand for these and ambulance services has been rising year on year. Sixteen million people attended A&E services in 2003–04 (**Figure 2**) and in the first two quarters of 2004–05 the attendances at major A&E services have increased by 5% and 3% on the comparable periods in 2003–04.³

Figure 2: Trends in demand for Emergency Care Services



Source: Department of Health data presented in C&AG's Report, Appendix 2

Notes

1. A&E departments include specialist Type 2 and smaller Type 3 (Walk-in-Centres and Minor Injury Units) services
2. Open access primary care centres are classified as Type 3 A&E services
3. Attendance includes both new patients and follow-up attendances

² C&AG's Report, paras 2.3, 2.13–2.15

³ *ibid*, paras 1.6, 3.3–3.4 and Appendix 2; Qq 2, 42

3. In explaining this growth in demand for A&E services since April 2002, the Department said it was the result of their success in treating the majority of patients within the four hours and not of the reform of GP out-of-hours services, which had not begun then. The Department believed that when systems were running with significant delays, demand for emergency care was suppressed, with patients deterred from seeking treatment in A&E or GPs hesitant to refer. A reduction in waiting would therefore attract some previously unmet public demand.⁴

4. The existence of alternative emergency care providers, such as Walk-in-Centres and NHS Direct, has not reduced the numbers of people going to A&E, suggesting unmet demand. The Department had not estimated the level of this unmet need, or modelled demand for emergency care because of the large number of variables involved. The rate of rise in attendances at A&E had fallen, however, and there had not been a threat to service provision.⁵

5. The Department also expected the new pharmacist contract to contribute to the reduction in the rate of rise in attendances, as the public would be able to access emergency care advice and treatment for minor ailments at chemists. Pilot programmes using prevention and early interventions by health and social workers in the community have been shown to reduce the number of hospital admissions and to improve quality of life for patients with long-term conditions. The use of case managers who check regularly on patients most at risk, co-ordinate multi-organisational care and respond to urgent needs, should therefore reduce the likelihood of patients reaching a crisis situation and reduce the need for emergency care.⁶

6. The Department did not think that increases in A&E attendances were connected to lack of access to GPs. However, there is no systematic picture of where people who present at A&E reside and it was impossible to say whether there were particular primary care trusts or GPs that had high levels of referral. The Department believed that this mapping should be done locally, and highlighted areas that provided services in response to patients' needs. For example in Liverpool, where there is a culture of going to the hospital rather than the GP, the A&E department has GPs working within it. In London GP-led Walk-in-Centres or Minor Injury Services, such as at St Thomas' Hospital, provide access to primary care for people who are registered with a GP elsewhere. In Newcastle-upon-Tyne there is a primary care emergency centre at the front door of the acute hospital to reduce the pressures on local GPs for urgent care.⁷

7. Accurately estimating the overall cost of emergency care is difficult, but A&E services alone cost more than £1 billion annually. Consultation costs differ between emergency care providers (**Figure 3**) and investigations, such as x-rays and diagnostic tests, increase these costs significantly. Attendance at services is highly variable, ranging from single figures at Minor Injury Units to more than 3,000 a week in major A&E departments. This variation increases the disparity in unit costs, and the Department has not determined the

4 Q 2; Ev 14

5 Qq 53–55, 73; Ev 14

6 Qq 53–54; *Transforming Emergency Care in England: A report by Professor Sir George Alberti*, Department of Health, October 2004

7 C&AG's Report, Case Example 9; Qq 2, 11–12, 19–20, 23, 42–43, 70, 75

relative value for money of treating patients at these services. The Department now intend to focus on getting emergency care providers, through Emergency Care Networks, to review their local system and organise their responses in a more collaborative way. Currently there are concerns that primary care trusts are planning to treat a greater percentage of cases of minor injury and illness, and acute trusts will admit more patients via A&E. A joined up approach to providing emergency care services should minimise the incentives for NHS organisations to act so as to make financial gains at the expense of other trusts.⁸

Figure 3: Estimated comparative costs for attendance at Emergency Care Providers

Emergency Care Provider	Costs
General Practitioner	£15
Walk-in-Centre	£25
A&E Department	£60

Source: Department of Health oral evidence, Q 43

2 Sustaining and building on achievements

8. We congratulated the Department on the significant progress made by trusts towards the achievement of the target for 98% of A&E patients to be treated or admitted to hospital within four hours. It used a mix of financial incentives and close performance management, with support for those trusts requiring it. The target was crucial to the improvements, and reduction in variability, between trusts' performance. In line with the national move to simplify and reduce the number of targets, central planning and targets for A&E will however cease from April 2005. The Department said that time spent in A&E would feature in the new Standards for Better Health. The Healthcare Commission would inspect trusts' against this core standard, and trusts would need to ensure that as a minimum they maintained performance at 98% within four hours.⁹

9. At the end of October 2004, around 70 trusts had consistently achieved the weekly mark of 98%. Despite increases in attendances at A&E the proportion seen within four hours has improved month-on-month significantly (**Figure 4**), and the Department was confident that the overall target would be met by December 2004.¹⁰

10. In April 2004, the four-hour target was extended to cover all NHS Walk-in-Centres and Minor Injury Units and their performance was included within data on A&E departments to show overall performance by all trusts providing emergency care. This change in data recording has contributed to the rise in performance by some acute trusts and demonstrates that sufficient facilities and services in the vicinity or linked to A&E departments help to achieve and maintain the 98% level.¹¹

Figure 4: Steady progress has been made by trusts as a whole, but major A&E Departments are still some way behind the target

	Total attendances at all A&E, Minor Injury Units and Walk-in-Centres	Percentage of patients who spent less than 4 hrs in A&E	Attendances in major A&E Departments	Percentage of patients who spent less than 4 hrs in A&E
2004-05 Quarter 2	4,556,695	95.9%	3,381,219	94.6%
2004-05 Quarter 1	4,502,578	94.7%	3,377,850	93.1%
2003-04 Quarter 4	4,009,142	92.7%	3,059,698	90.6%
2003-04 Quarter 3	4,027,622	90.8%	3,106,667	88.3%
2003-04 Quarter 2	4,347,584	90.7%	3,281,186	88.1%
2003-04 Quarter 1	4,132,497	89.9%	3,217,931	87.3%

Source: Department of Health performance data

9 C&AG's Report, para 1.5; Qq 6, 58; Ev 13

10 Qq 3, 5

11 C&AG's Report, para 1.6

11. During a visit to one central London A&E department staff suggested that improving their performance from 96% was causing them great difficulties because of the type of clients they receive, for example people with alcohol or mental health problems and commuters who use the hospital as a drop-in centre. The Department said the 98% target was not chosen arbitrarily and certain categories of patient, such as those with mental ill-health, were included in the clinical exceptions. It did not accept that the costs of achieving these last two percentage points outweighed the benefits. Each 1% improvement nationally was 160,000 more people treated in less than four hours. Widely applicable process changes, which had not required significant investment, had been shown to work.¹²

12. These achievements mask differences for specific groups of patients. Very few children or patients with minor injury or illness spend longer than four hours in A&E. The elderly and vulnerable adults are more likely to breach the four-hour target, however, because of their complex medical and social needs. Improvements to their care had nevertheless been made through the use of clinical decision units and short stay wards where the patients were placed in a proper bed and observed for longer periods whilst appropriate treatment was given or care arranged. The National Director for Emergency Access believed that further improvements would be made, up to and after the December target date, as he had been working with the National Director for Older People's Services (the Older People's Czar) to provide better managed community care programmes for the elderly and multi-disciplinary health and social services teams within hospitals.¹³

13. One fifth of all attendees at A&E departments require admission to hospital, and there remains room to improve their experience as patients. Waiting for a bed on a ward and obtaining a specialist opinion are the commonest causes of delay. The Modernisation Agency provided tools to assist trusts in bed management and improving access to specialist opinion in summer 2004, and the number of breaches of the four-hour target has been reduced, from 50% to 23%, over eighteen months to August 2004. Unless traditional working practices for admissions and discharges are reformed in all acute trusts, however, bottlenecks will persist in A&E and patients will not receive timely care.¹⁴

14. The need for diagnostic tests can be the reason for bottlenecks in A&E. 11% of all stays longer than four hours are the result of delays in diagnostic services. Despite Departmental guidance to improve this situation by extending out-of-hours x-ray services, the National Audit Office found that only just over half the trusts responding to their survey had radiographers available to A&E 24 hours a day. The Department felt it had been addressing these problems since 1997, by initiatives such as an increase in training places and "Return to Practice" schemes for radiographers; but the world-wide shortage of these staff had to be recognised as a contributory factor. Around 3,000 more radiographers will be employed in the NHS by 2008, but in the short-term trusts have been encouraged to make use of new technologies, such as digital imaging, and to expand the roles of other staff to include initial interpretation of x-rays.¹⁵

12 C&AG's Report, para 1.6 and Figure 4; Qq 4-5, 33-34

13 C&AG's Report, Summary para 7; Qq 7-8, 59

14 C&AG's Report, paras 2.14-2.20; Qq 7, 9, 34

15 C&AG's Report, paras 2.11-2.12; Qq 84-88; Ev 13

15. Four hours may be too long, if for example patients may be waiting a disproportionately long time for a simple procedure; or staff may be pressured into making a premature decision about patients who are in danger of breaching the four-hour target. Currently average time is under two hours. The Department accepted that the target had been a blunt instrument, but the aim was to eliminate unnecessary delays for patients in A&E.¹⁶

16. Clinicians and managers generally agreed that the target had focused attention on reducing delays, and consequently had a beneficial effect on performance. In contrast to inpatient services, where national performance data includes more than waiting times, measures of the quality of care provided in A&E departments and national benchmarking are very limited. The Healthcare Commission, with the British Association for Emergency Medicine, has developed three clinical audit tools for paracetamol overdose, pain in children and fractured neck of femur (broken hip) which trusts can use to audit their performance. The Department accepted that the lack of an integrated patient record system made tracking the clinical outcomes for patients who were transferred or discharged from A&E difficult, but it was in the process of making the changes to facilitate this flow of information.¹⁷

17. The increase in A&E attendances has intensified the pressure on hospital staff. Despite extra funding for A&E nursing posts and additional A&E consultants, the National Audit Office found a gap between the number of positions and actual complement in at least 84% of acute trusts in their survey. The Department agreed that more staff, especially practitioners who could act independently, were needed to maintain performance in the future and to improve quality of care further. The strategic health authority workforce development confederations conduct annual exercises to plan consultant numbers, and to an extent nurses and occupational therapists, but the Department does not have a clear understanding of the reasons for the shortages of certain types of staff employed in A&E.¹⁸

18. There is no accepted model for the numbers and mix of types of staff in A&E departments for trusts to use when budgeting for their emergency services, and so in many cases current levels are based on historical baselines. With the increasing use of 'See and Treat' for patients with minor injuries and illnesses, and the need to meet the European Working Time Directive, more input from senior clinicians is vital for A&E departments to function effectively. The Department accepted as reasonable the British Association for Emergency Medicine's calculation that large A&E departments needed eight consultants if they were to provide sufficient cover 24 hours a day, seven days a week. A model based on types of patient, hour of the day and the time needed for consultation by each 'decision making' staff group is currently being tested. This model should allow trusts to develop rotas to cope with demand and meet the needs of patients.¹⁹

16 C&AG's Report, paras 1.9; 1.16; Qq 15, 65

17 C&AG's Report, paras 1.27, 1.29; Q 47

18 C&AG's Report, para 2.25 and Figure 11; Qq 10, 66–67, 77–78

19 C&AG's Report, paras 2.24, 2.27–2.28; Qq 14, 26, 79–82

3 Improving the integration of emergency care services

19. Under its 2001 *Reforming Emergency Care* strategy the Department established the principle that all services must be designed from the point of view of the patient and their needs should be met by the professional best able to deliver the service. The Department therefore recommended the integration of the system of emergency care providers, including the development of Emergency Care Networks to promote and co-ordinate cross-boundary working between primary care trusts, acute trusts, social services, local authorities, ambulance trusts, pharmacies, mental health trusts and voluntary organisations. The Department also proposed that healthcare professionals should be trained and empowered to use their competencies and skills to practice autonomously, so that for emergency conditions which are not life threatening a single practitioner would manage the patient throughout their journey.²⁰

20. To reduce delays further, acute trusts need to look wider than A&E departments and the Department has assisted trusts to identify ‘bottlenecks’ in the patient journey and develop solutions (**Figure 5**). Primary care trusts, which allocate financial resources for emergency care services, have however found it difficult to remove these chokepoints because of funding constraints. The Department acknowledged that the partly historical basis of NHS finance meant allocations to some primary care trusts were probably lower than they should be, but the Secretary of State wanted to address this issue over the coming years.²¹

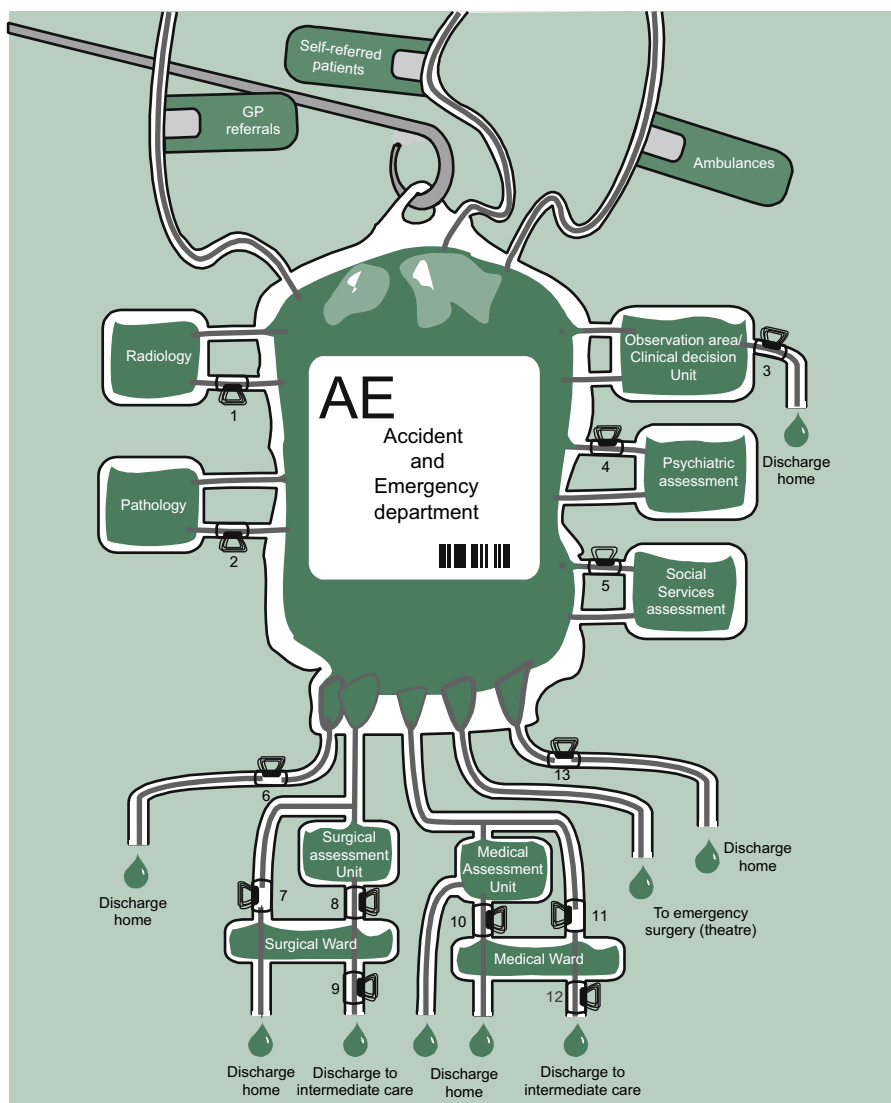
21. Although the NHS has developed new types of provider and co-located services to improve access to emergency care, the National Audit Office found that by and large the public continued to expect provision of emergency treatment through A&E departments. The acute hospital system could therefore become blocked, and capacity could be released if patients were treated in alternative ways. The level of public knowledge about the availability and services of the different types of providers is not sufficient for them to consistently make informed decisions about accessing emergency care. The Department agreed there was confusion and said it would consider renaming services to reflect their function. A good public education policy was needed to ensure patients knew what services were available to them, but it was no longer policy for patients to be educated to go to the “right place” for treatment.²²

20 *Transforming Emergency Care in England: A report by Professor Sir George Alberti*, Department of Health, October 2004

21 C&AG’s Report, para 2.13 and Figure 9; Qq 49–51

22 C&AG’s Report, Summary para 14; Q 71

Figure 5: Potential bottlenecks around an A&E Department



Key

- | | |
|--|--|
| 1 backlogs in radiology delay turnaround or interpretation of results | 7 delay in surgeons accepting admission or no available bed |
| 2 backlogs in pathology delay turnaround or interpretation of results | 8 no available bed in surgical ward |
| 3 waiting for ambulance or other transport; waiting for medicines; waiting for doctor to discharge | 9 no available bed in intermediate care |
| 4 delay in response to request for psychiatric assessment | 10 no available bed in medical ward |
| 5 delay in response from social services for needs assessment | 11 delay in medical staff accepting admission |
| 6 no available bed in intermediate care | 12 no available bed in intermediate care |
| | 13 waiting for ambulance or other transport; waiting for medicine; waiting for doctor to discharge |

Source: National Audit Office

22. The ambulance service is not a free taxi service, and the Department was challenging the perception that an ambulance should always take a patient to A&E. Advertising campaigns about 999 calls have been used, for example in London and Lancashire, and the Department said that public behaviour could be expected to change with experience of being treated at home or being provided with different care pathways by emergency care practitioners, instead of being transported to A&E. The Department was not aware of any direct interventions by trusts, such as letters to inform members of the public about inappropriate use of the ambulance service.²³

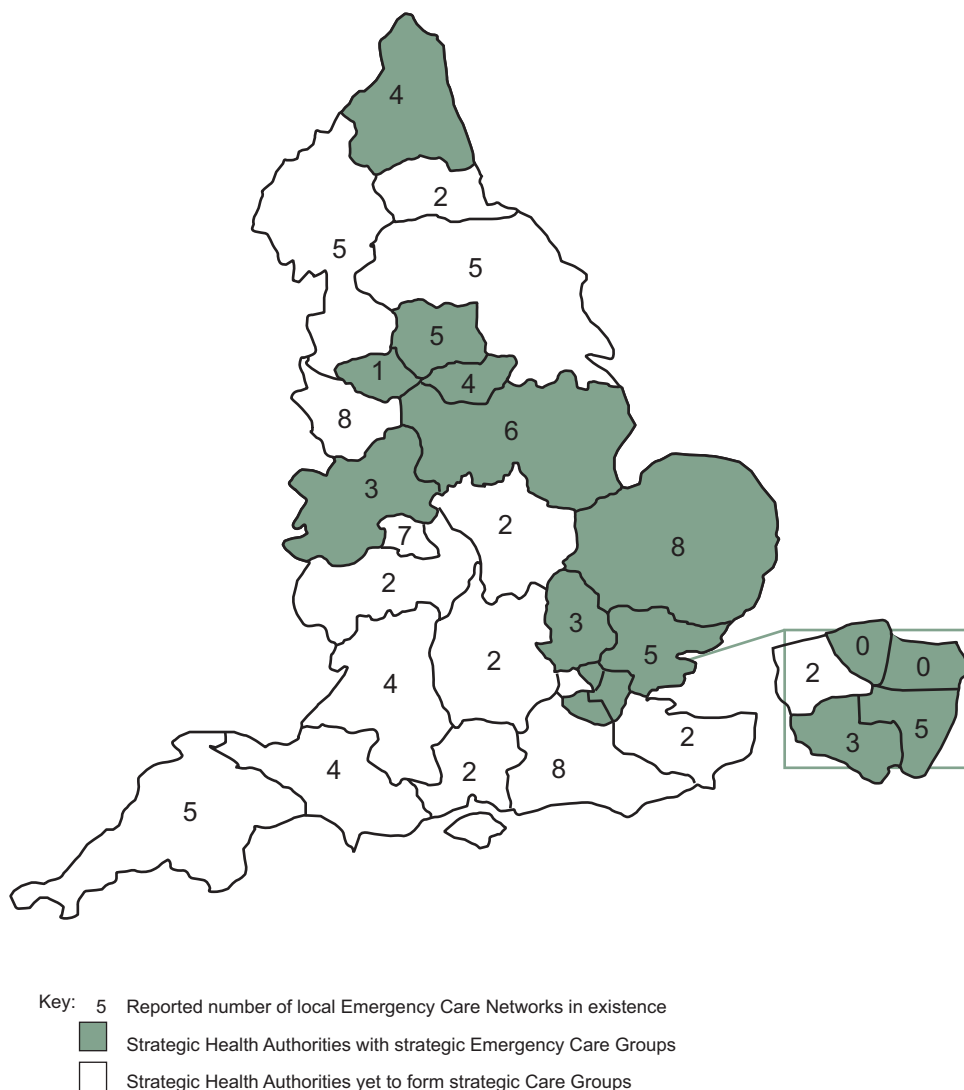
23. Although the Department promoted the idea of Emergency Care Networks as the means of achieving its targets for emergency care in 2001, the National Audit Office still found that many of these cross-organisational and multi-disciplinary networks were still in their infancy (**Figure 6**). Structural reform, organisational boundaries, conflicting performance indicators, and availability of funding and the way it is allocated were obstacles to improved joint working. In its 2004 report, *Transforming Emergency Care in England*, the Department identified strong partnerships as the key to the issue of waiting times. The National Director for Emergency Access believed that if Emergency Care Networks were charged with commissioning all emergency services for a locality, including social service support, improvements would be possible.²⁴

24. The Department believed that the move to a single telephone call access system would provide a more patient-centred response to requests for emergency care. Originally it had envisaged that all services would be linked through a single point of access – NHS Direct – and that a ‘navigator’ would provide assistance to get the patient to an appropriate service as quickly as possible. It remained committed to providing this simple local access to emergency care through one national telephone number, but the organisation to which the enquirer was connected would depend on the locality, and could for example be an ambulance service, a GP co-operative, or NHS Direct. It was also the Department’s intention that Walk-in-Centres, Minor Injury Units and Urgent Care Centres should be integrated with the out-of-hours service. GPs would continue to be rostered, but the talents of nurses and paramedics will be utilised to a greater extent than currently.²⁵

24 C&AG’s Report, Summary para 19; Qq 27, 91–92

25 C&AG’s Report, Summary para 15 and Figures 13, 16; Qq 12, 35–37, 40, 71

Figure 6: Emergency Care Networks in Strategic Health Authority Areas are at different stages of development



Source: National Audit Office

25. The development of emergency care and emergency nurse practitioners has been an important change in the way emergency care is delivered. They are trained to diagnose, treat and discharge patients whose condition is not life threatening, and they are able to determine the most appropriate care pathway for the patient without reference to a medic. The National Audit Office found the skill content was not consistent, and the length of courses varied before the trainee could begin the role. The Department assured us that it was working on agreeing some overall educational standards for competence and skills and a set curriculum for local universities.²⁶

Formal minutes

Wednesday 9 March 2005

Members present:

Mr Edward Leigh, in the Chair

Mr Ian Davidson
Mr Brian Jenkins

Mr Gerry Steinberg
Jon Trickett

The Committee deliberated.

Draft Report (Department of Health: improving emergency care in England), proposed by the Chairman, brought up and read.

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

Paragraphs 1 to 25 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

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

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

[Adjourned until Monday 21 March at 4.30 pm]

Witnesses

Wednesday 3 November 2004

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Sir Nigel Crisp KCB, and Professor Sir George Alberti, Department of Health

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Oral evidence

Taken before the Committee of Public Accounts

on Wednesday 3 November 2004

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Allan
Mr Richard Bacon
Jon Cruddas
Mr Frank Field

Mr Brian Jenkins
Jon Trickett
Mr Alan Williams

Sir John Bourn KCB, Comptroller and Auditor General, National Audit Office, further examined.

Ms Paula Diggle, Second Treasury Officer of Accounts, HM Treasury, further examined.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL:

Department of Health: Improving Emergency Care in England (HC 1075)

Witnesses: **Sir Nigel Crisp KCB**, Permanent Secretary/NHS Chief Executive of Health and **Professor Sir George Alberti**, National Director for Emergency Access, Department of Health, examined.

Chairman: Good afternoon, welcome to the Committee of Public Accounts. I have a very pleasurable announcement to make. Mr Jeremy Colman, who is over there, who is one of our Assistant Auditor-Generals has just been appointed, this afternoon, by the National Assembly for Wales as the Auditor General of Wales. Jeremy Colman has been a great support for this Committee and you have our congratulations. I think it says something for the excellent work of the National Audit Office that they have sought to recruit from the National Audit Office, so congratulations Sir John as well.

Mr Field: In the Sir Thomas Moore film when Rich perjured himself, Sir Thomas said "What's this seal?" Rich said "I'm Chancellor for Wales". Moore said "Why, Richard, it profits a man nothing to give his soul for the whole world. . . But for Wales?". Congratulations.

Q1 Chairman: This afternoon, we are looking once again at the Department of Health improving emergency care in England. We are rejoined by Sir Nigel Crisp who is the Permanent Secretary and the NHS Chief Executive and we are also joined by Professor Sir George Alberti, who is National Director for Emergency Access. I think this is your first visit to our Committee.

Professor Sir George Alberti: It is indeed.

Q2 Chairman: You are both very welcome. I should say that Mr Jenkins and I had a very interesting visit to the Accident and Emergency Department (A&E) at St Thomas's Hospital where we were most impressed. As always, this visit has given us a lot of food for thought and we were very impressed with the efforts that your staff are making. May I start by drawing your attention to some of the points they made to us? You can see this highlighted in the Report of the Comptroller and Auditor General in paragraph 1.6 which you will find on page 10. That

alludes to what we know, what the staff tell us of course, that there has been a 5% increase in attendance at A&E between similar quarters in 2003–04 and 2004–05. How can you explain this, Sir Nigel?

Sir Nigel Crisp: There is a number of reasons for this. The Report actually picks up a 5% increase Quarter 1 to Quarter 1 and since then it has been slowing down, so we have actually seen in the last two quarters a 5% and a 3% rise. The basic reasons for this are that there is a long term trend of increase in A&E, but actually probably the biggest factor is success, that people are actually understanding that you can get treated more quickly in A&E, so we believe we are seeing more people coming in.¹ I know that there is a suggestion in some places that this is connected with the out-of-hours services and GPs, but in fact the rise was before the out-of-hours services started to change and the rise is now starting to tail off, so we do not think that is a contributory cause.

Q3 Chairman: How confident are you that you can meet your four-hour target, given this increase?

Sir Nigel Crisp: We are confident that we will meet it by the end of December, and we are seeing at the moment a month-on-month increase despite this rising workload, which I think is a great tribute to staff.

Q4 Chairman: The point which was made to us very strongly in St Thomas's when we went to visit, was that they were very happy with the 96% target, but they found the 98% target was causing them great difficulties. It is not that they do not want to work harder, but they are having particular difficulties with certain types of clients, people who are drunk, people with mental health problems, people

¹ *Note by witness:* Also improved data quality.

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apparently using St Thomas's just as a drop-in centre because they do not want to go to see their GP and commuters. They are finding great difficulty with this 98% target. What do you say to that?

Sir Nigel Crisp: Firstly, I have great respect for the people at St Thomas's but all the way through this process people have told us that 80% was enough and 90% was enough and now we are hitting 96% people are saying that is enough. The 98% target was not chosen arbitrarily, but we actually looked at how many patients the clinicians thought there was a clinical reason why they should stay in A&E longer than four hours and came up with 0.5%. In order to allow for a margin of error, we went for 2%. The reason why this is important is that in that list of people you gave, the people who concerned me most were the people with mental health problems, who often are the ones who are difficult to place. What it would be very poor to see is that most people got through very quickly, but that we left some particularly deserving categories and I pick them out as opposed to the people who are drunk, in which case you might be able to do something different for them.

Q5 Chairman: Sir George, I should like to put this question to you particularly. There are extra costs involved in this and I wonder whether we are really achieving value for money in trying to get these last 2% points.

Professor Sir George Alberti: It is worth stating that there are around 70 trusts who are now consistently hitting that mark and more and more each week doing so, so it is possible. We have had a few who have been doing this month upon month upon month over the last year, busy, central, big city hospitals, so the same sorts of clientele as we have here. Personally, as a physician, I do not like the idea of anyone waiting and I think it has been pretty bad that we have gone for so long before we started improving things. Each 1% of course is 160,000 people, so we are not talking about small numbers of people. If even St Thomas's were to examine some of their processes, and it is not just any more a question of the A&E department, it is moving people through the whole hospital, I suspect they could squeeze this out without necessarily a vast further input of resource. I think we owe it to our patients.

Q6 Chairman: Sir Nigel, now you have achieved this success with enormous incentives, very tight management, targets: they lose £100,000 from A&E department, they lose their staff status, they are under tremendous pressure. However, you have achieved this with centralised planning and targets. Why are you then moving away from centralised planning and targets?

Sir Nigel Crisp: Something like this, for example, will now become a standard, so this will continue to be inspected on by the Healthcare Commission. We are going to continue to use targets and indeed for the next three years we have about 20; in the previous three years it was 64, but we are bringing them down. What we have brought them down to in this next session is to make sure that we are looking

specifically at important output targets. We are no longer looking at inputs, telling people how many staff they need and so on, we are looking at important output targets. We think that the 20 which cover the whole range of healthcare are the appropriate group of national incentives. They cover everything from the last discussion we had here about MRSA to life expectancy from cancer and coronary heart disease. That does not mean to say that when we achieve this target, we drop it. It will still be inspected against.

Q7 Chairman: Could you look please at page 14, paragraphs 1.19 to 1.20 where you will see there that it is elderly and vulnerable people who still suffer the longest waits. Is this acceptable? How do you propose to tackle it?

Sir Nigel Crisp: The important point here is that this is the group of patients who have the most complex conditions, so they need the most work-up. In fact, if you look at the figures in this Report, you will see that 18 months ago, 50% of people being admitted were not getting in within four hours and that has come down to 23%. So there has actually been a really big increase and improvement in this group, but the basic reason—

Q8 Chairman: But they still suffer the longest waits.

Sir Nigel Crisp: The basic reason why they are staying longer is that they are more complex problems, but perhaps again I can ask Sir George to just illustrate that better.

Professor Sir George Alberti: Again, we are concerned about this obviously and one thing I think we should say straightaway now is that we are in the midst of a continuously evolving improvement plan. We are not saying that we have got to the end of December and that is it. I have been working very closely with my "Older People Czar" colleague on improving processes for older people. First of all, wherever possible, to not have them come in at all and that is part of a big programme of better managed care in the community. Secondly, if they do come in, having a multi-disciplinary team, involving social services, rehabilitation, etcetera, see the patients straightaway; then also, within the hospital getting better flow through the system there.

Q9 Chairman: I am going to stop you there because I am afraid that you will find when you see this Committee, that my colleagues are time-limited therefore we have to have very precise questions and answers. You will have a chance in the course of the hearing to get all your points out. I shall press on because time is pressing and we want to meet our targets. Paragraph 2.15, page 21. We had a considerable debate yesterday when we went to Northern Ireland about consultants and what was happening in the Northern Ireland Health Service. Here we see that how quickly a patient is admitted and discharged seems to depend on the whims of consultants. When will these outdated practices end?

Sir Nigel Crisp: Let me just say that what we are doing, and a lot of the success has been achieved through something we called the Emergency

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Services collaborative, which is actually the different A&E departments working together to share best practice, and one of the things that you do see, again in this Report, is that the variation is getting smaller between different departments. So actually, using those sorts of tools, we are making sure that there is not unacceptable variation.

Q10 Chairman: Will you know look at Figure 11 on page 24, which deals with staff shortages. What we see now is a situation, just to sum up, in which you are meeting your targets. As a result of targets being met, people now know they are going to be seen in A&E, they tend to use you more, attendance is rising, you are now coming up against staff shortages. Are you really convinced that this progress is sustainable? As a supplementary to that, if there is some doubt about that, should you not have a more dynamic kind of leadership, so you can foresee some of these problems which are inevitably going to arise?

Sir Nigel Crisp: I think we do have a dynamic sense of leadership and I think your Committee saw the report from George Alberti,² which I think was circulated to you, which came out last week, which actually describes the fact that we have made real progress in A&E. As George just said a moment ago, we have to make sure that is sustained in the hospital, but actually we have to make sure it is sustained in the community even more so, with the emergency networks and so on. In terms of the staffing issue, we need more staff in order to make sure that we have got this consistently sustainable everywhere, because there is still some variation, but also to keep driving up quality. We want to make sure that we are absolutely the best and we need to keep moving that forward and that is why we need to get more staff in to make sure that it is absolutely sustainable and to continue to improve quality.

Q11 Mr Field: Sir Nigel, you said that the increase in the numbers going to A&E was not due to the GP contracts. I, unlike the Chairman, have been at St Thomas's as a patient rather than on a visit, that is why I did not accompany him. That is the view of the staff there and it seemed to me that one of the advantages for me, and many of the other people there, was that it provided the sort of personalised immediate service that the Prime Minister asks for. Of course I do not want to criticise my own doctor because he will take it out on me when I most need his help, or he might do. However, should we not have been modelling the GP contract on the sort of service which is really increasing, which is the A&E service, when we can seek medical advice, like we can draw on almost any other service in our society, at the drop of a hat?

Sir Nigel Crisp: One of the things we have done, which is drawn out in this report, but more clearly in Sir George's, is we have put in these things called walk-in centres and minor injury units and GP-led services; there is a GP-led service at St Thomas's

which you can actually go into as an alternative to your own GP. Having said that, it is worth noting that 300,000,000 people a year go to use GPs, where as 14.716 million a year use A&E. We still want to make sure that we sustain the GP service very clearly.

Q12 Mr Field: There are lots of things that you go to a GP for, because you can book in advance, your flu jabs and so on, are there not? When you are actually in great pain, you need to go immediately and the appointment system is not so attractive, whereas the A&E is attractive.

Professor Sir George Alberti: We are building up a network of walk-in centres, minor injury or minor illness units—a horrible name—urgent care centres and the intent is that there will be a network of these, but these will be integrated with a GP out-of-hours service. You will have a GP, you will have a nurse-led service and you will then have people we are calling emergency care practitioners (ECPs) doing a lot of the emergency home visits on behalf of the GP, with the GP as the spider in the middle of the web. You will then get the GP service you want, without necessarily having to go off to A&E.

Q13 Mr Field: When we get our walk-in centre, the first one in the Wirral, it was never presented in those terms. Are you not to some extent rationalising a GP contract which is very pro-GP, but not necessarily pro-patient?

Professor Sir George Alberti: I think it is worth saying that for the GP contract, what they have lost is the actual responsibility for the out-of-hours service. The majority of them have not lost the wish to work in the out-of-hours service. I do not think we are rationalising it, but it makes good sense to have an integrated out-of-hours service using all the different people that we have working in little pockets at the moment. I think you will find, if you last long enough, that we will have a better service in the next couple of years.

Q14 Mr Field: Certainly, given the increase in taxpayers resources, I hope we will be getting a better service anyway. Sir Nigel, on the European Working Time Directive for doctors, to what extent was that factored in when you were setting these targets for A&E? I was in A&E for nine hours and I saw three doctors and they were brilliant; they spent extra time in handing me over to the next doctor, but it was three, whereas normally that one doctor would have completed the whole thing.

Sir Nigel Crisp: I cannot answer the first part of your question, because I cannot remember when the European Working Time Directive came out, but we set this target in 2000. I do not know but the European Working Time Directive was presumably before that. It was certainly being factored into our planning so that, for example, for things I referred to like the A&E collaborative, what we look at is best practice in A&E within all the circumstances, which includes the fact that you may have doctors on shifts, you do indeed have doctors on shifts and which also includes the fact that you have the various different

² Department of Health, *Transforming Emergency Care in England—A report by Professor Sir George Alberti*, October 2004.

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specialities of doctors. What has happened in the last two or three years is that you have got more cross-cover between the specialities. I do not know, but your three doctors were presumably three from the same speciality coming through there; I am surprised at three in nine hours.

Professor Sir George Alberti: The other thing is that we are focused very much on liberating the talents of other health professionals. Today we will have several hundred emergency nurse practitioners, very confident people seeing patients, rather than very junior doctors who have not really gone far enough through their training to be independent practitioners.

Q15 Mr Field: It was partly that anyway. My last question is nothing other than to try to draw attention to the pressures that St Thomas's operates under. Not only is there a huge tide of humanity goes through A&E, but the four-hour target was met for me, because I was taken through a door just before the clock of four hours struck and then in a cubicle and then into a temporary ward. Now the service was brilliant, I am not arguing about any of that, but one felt that part of the arrangements were to meet the targets rather than to improve necessarily the services of A&E. To some extent does the service now not just have to respond in this artificial way so that they can meet the targets which politicians and you accept for them?

The Committee suspended from 3.50pm to 4pm for a division in the House

Are all hospitals under pressure to fiddle their figures to meet the targets?

Sir Nigel Crisp: I do not think they are under pressures to do that. One of the problems with targets is that sometimes you can look like you are achieving the target and miss the point. The whole point of this target is no unnecessary delay, because it may well be that your treatment and assessment may take a significant amount of time. That is why Sir George was looking at what was clinically necessary. We have used a target here as a relatively blunt instrument to make change and we would not have got the change that we have made here or in some other areas, if we did not have a target; I am quite sure of that. The other thing is, and I do not know if it was true in St Thomas's when you were there, that actually both George and I have visited a lot of A&E departments and staff actually like this target. The majority of staff, I think it is fair to say, like this target because it has enabled them to make some changes in their department and get the rest of the hospital to take some responsibility for patients. That is where we are.

Q16 Jon Trickett: Is it possible to have an A&E department with no consultants in the hospital at all? Are there any?

Sir Nigel Crisp: Is it possible?

Professor Sir George Alberti: It is possible where they would be on-call from home.

Q17 Jon Trickett: No, with no consultants at all.

Professor Sir George Alberti: There have been a couple of examples.³

Q18 Jon Trickett: No; no, no consultants at all.

Professor Sir George Alberti: It is highly undesirable.⁴

Q19 Jon Trickett: Can you tell me what has been done to look at variations between PCTs in the number of people who present at A&E? I am told in some populations, very large numbers of people go to A&E relative to the average. Is that data available to the Committee, because clearly there are some hospitals which are more under pressure than others as a consequence of that?

Sir Nigel Crisp: I do not know whether we have a completely systematic story, but we know the areas where that is most likely to be true, which are the areas where fewer people are registered with GPs, inner city areas. There is a whole series of areas, Liverpool actually is one, where there is more of a culture of going to the hospital than the GP. It is in those areas that we have done things like put in a GP service in the A&E as well, as we have done at St Thomas's. I am afraid I do not know if we have a completely systematic picture, but we will have it in parts.

Q20 Jon Trickett: I am told that across the three hospitals in the trust which covers my constituency, there are very different patterns of referral. There is a difference in culture maybe between the populations, but possibly also between the GPs. There are three PCTs there. Would it not be advisable actually to do some work, since the cost pressures, really engendered perhaps by GP practice, on some hospitals are greater than others, given the fact that there is more of a propensity among some populations to use A&Es than others, perhaps for cultural reasons, but partly determined by the GPs.

Sir Nigel Crisp: In most A&Es people come in themselves, but there are GP referrals as well. What I would hope, and I can find out, is that in the particular location you are talking about that piece of work has been done locally, but we have not done that piece of work nationally that I am aware of.

Q21 Jon Trickett: Is it not a key piece of management information? If it can happen within Wakefield, just within one district, then across the national presumably there are huge differences?

Sir Nigel Crisp: What we know nationally is that there are variations and that is why we are actually saying that the local system has to be designed to meet the local need and that is why, for example, in areas where a lot of people are not registered with GPs, there is a high turnover of people, which is probably not true in Wakefield.

³ *Note by witness:* There are still a couple of single-handed services.

⁴ *Note by witness:* It is not possible for a Type 1 department.

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Q22 Jon Trickett: No, I do not think it is.

Sir Nigel Crisp: You need a different sort of service than some other areas.

The Committee suspended from 4.05pm to 4.10pm for a division in the House

Q23 Jon Trickett: If you would like to respond, then I want to ask about the financial pressures.

Sir Nigel Crisp: May I ask Sir George to answer, particularly on the Wakefield PCTs.

Professor Sir George Alberti: I have visited your constituency and the trust and PCTs therein and I should say that we have been giving quite a lot of specific support to the health economy there. One of your PCTs has set up a primary care emergency type thing, and that is what is happening in different places where there are more pressures from general practice for primary care type patients, Sunderland is another good example, Newcastle the same, where they have a primary care emergency centre at the front door of one of the hospitals. I just come back to you on what is permissible with consultants. You should not be allowed to be a Type 1 A&E department if you have no consultants at all and that might be something I could follow up with you afterwards.

Q24 Jon Trickett: In private correspondence.

Professor Sir George Alberti: I should be delighted.

Q25 Jon Trickett: I just wanted to pursue this hospitalisation as opposed to “GPisation”, if there is such a word. The consequence of the kind of practice which appears to be going on is that the PCT may well be benefiting financially at the expense of the hospital, since the hospital bearing more of the cost of treating patients and more people are presenting rather than going to the GP with minor injuries. I notice in paragraph 2.27 that a significant number of trusts are not being funded to the expectations outlined there. Maybe you could reflect, rather than try to answer now, on the point I am making about this variation and the differential impact, unless you have anything particular to say about it now.

Sir Nigel Crisp: Where we know there is a particular issue, as there is in Wakefield, because I think the performance is in the low 90s, is it not, then we send in people to help work through the issues and they have to be across primary care as well as secondary care. We can come back to you on the particular Wakefield issues.

Professor Sir George Alberti: We are putting a lot of focus now on the whole system, getting them to work together through the networks.

Q26 Jon Trickett: I do not want to bore the Committee with Wakefield. I think there is a generic issue which I am raising and perhaps we can have a private correspondence about the Wakefield situation. On the question of paragraph 2.27 which is talking about the staffing ratios, is there a minimum point at which an A&E simply cannot

function, I mean a number of patient visits a year? Is there some number where you can say that simply will not sustain an A&E because it is too small?

Sir Nigel Crisp: We do not have an actual number on that.

Professor Sir George Alberti: No, we do not have a number, although once you are below the, you have about 30–35,000 a year, it becomes difficult then to justify fully staffing with all the rotas you need *et cetera* for a type 1 department.

Q27 Jon Trickett: Can I just ask some other questions which relate to sparsity of population? In the event that there are long distances between one hospital and another, one is reliant to some extent on ambulance services in terms of treating patients in A&E. How far is an holistic approach taken to that process of A&E and its inter-relationship with the ambulance service and, again using mine as an example, WYMAS in West Yorkshire is not very good at all in meeting your targets. So here we have an additional problem which is probably a national issue as well.

Professor Sir George Alberti: May I say very strongly that we take this into account. At the back of this, our next steps, that is starting now, and some have already started, are very much to get the whole health economy of that region to work closely together, to do the planning and work out what is needed for your local population. It is absolutely key that that goes on and I have talked to your ambulance service as well and we are encouraging them to work closely with the acute trust and the PCT and the mental health trust and the other partners in that. It is very much on the cards and we are doing our best to promote that.

Q28 Mr Allan: Starting again with a local question. I scanned the league tables and was rather depressed to find Sheffield Teaching Hospital’s NHS trust at the bottom of the table, only meeting 83.7% of patients going through within the four hours according to the tables we have been given.

Sir Nigel Crisp: That is not the figure I have. Sorry, that was Quarter 2 last year.

Q29 Mr Allan: That was Quarter 2 last year, but they are all miserable: 81.7%, 80.1%. It is a miserable performance, is it not?

Sir Nigel Crisp: The last quarter we published, which was the first quarter of this financial year up to June is 92.4%.

Q30 Mr Allan: So they have made a sudden leap up.

Sir Nigel Crisp: They have made a 10% leap.

Q31 Mr Allan: In terms of the old ones, targets, my understanding is that they were a three-star trust which has become foundation status. I am just curious about the apparent disparity between a complete failure to meet the target and—

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Sir Nigel Crisp: The target was on milestones and I think the figure you are looking at is the figure which is about 15 months old. It was a 90% target in April this year and is going to be a 98% target in December this year.

Q32 Mr Allan: My last one was 2004–05, Quarter 1.

Sir Nigel Crisp: The figures should be—

Q33 Mr Allan: That was 83.7%.

Professor Sir George Alberti: That is Type 1 only. Sheffield has a very big walk-in centre and a minor injury unit associated with the acute trust, so Type 1 are getting the really major stuff there, but Type 3, the walk-in centre, is getting the less serious. Between them it works out at 92.4%.

Q34 Mr Allan: Very poor at the serious stuff, but much, much better at the minor stuff.

Professor Sir George Alberti: Not very poor, but under a lot of pressure. Put this in the context two years ago: you took your rucksack with you if you went into A&E in those days.

Q35 Mr Allan: That is helpful. That was the local point, now to move on to the more generic issues. May I ask about the NHS Direct role and whether in the gateways described in Table 1 on page 4 the vision is that if I want a service, no matter what kind of service, the first point of contact will be NHS Direct, that I ring the NHS number, or are we going to maintain a number for the GP co-operative, a number for the A&E units, separate numbers?

Professor Sir George Alberti: I am passionate about simple local access and having a navigator to help someone through the system to get to the right place as quickly as possible. We are now talking with NHSD and the out-of-hours people and the ambulance service about how to handle that initial contact.

Q36 Mr Allan: So it is one number.

Professor Sir George Alberti: One number.

Sir Nigel Crisp: One number gets you into the whole system. Whether it is NHS Direct that takes the first call or is a later call in the system is something that we have still got to work out.

Q37 Mr Allan: At the moment it is a patchwork. I could be in one place and I could be calling NHS Direct because that is a pilot area for that. I could be in another place calling the GP co-op.

Sir Nigel Crisp: Yes. We want, as it says on that page, the patient to make a single call which actually gets you into whichever bit of the system you need to get into.

Q38 Mr Allan: And there is no suggestion that that in itself is not a problem, that people who do not like those kinds of call pathways will just turn up at A&E.

Professor Sir George Alberti: I am sure some of them will continue to turn up at A&E or at this bigger network of walk-in centres that we will have, or maybe at the GP. What we need to do, first of all, is

to have a good public education policy here, bringing people along with what is available to them; the more contact they have, the more they will know; also, not to say anything is inappropriate but to provide services which our patients want.

Sir Nigel Crisp: We have made quite a big philosophical point here, which is actually that we want to treat the patient where they turn up as well. We used to talk about educating them to go to the right place, but actually they are going to turn up. If they turn up in the pharmacy, we need them to be looked after in the pharmacy and be redirected if necessary, but not to be told off for turning up in the pharmacy if I can put it like that.

Q39 Mr Allan: Are you going to do anything to reduce the confusion? I am thinking again of Sheffield. If I am sick, I want to see a doctor, I do not care whether you call it a secondary or a primary care doctor. At the moment in Sheffield, I have a minor injuries unit, a walk-in centre, an A&E and for a lot of people, it is very confusing just to work through that and walk-in sounds funny, it does not sound quite right.

Professor Sir George Alberti: I personally would be renaming them, but I shall have to adhere to advice from my senior.

Q40 Mr Allan: The idea is that you call it all an urgent care centre and if I want urgent care then I go there and you will sort out whom I should actually go to see.

Professor Sir George Alberti: It is not departmental policy yet, but I like the idea.

Q41 Mr Allan: In terms of the other form of interaction, there is the GP booking system with which there is a lot of unhappiness at the moment thanks to departmental targets which mean that you quite often ring a GP now and get told that if you want an appointment, you have got to ring on the day or turn up on the day.

Sir Nigel Crisp: That is only if they are implementing it inappropriately, because actually what they should do, and what most of them do, is allow you to turn up on the day for the actual appointment and you can also book ahead as well. Some people have interpreted it as not needing to book ahead. Both parts are departmental policy. We are very clear about that. Having got the one bit right, which is that you can get to see a GP within 48 hours, we are now dealing with, the unintended consequence that some people dropped having an appointment system.

Q42 Mr Allan: Do you have any evidence of spillover to A&E? If I ring up and get told I just have to turn up at my surgery, I may as well just turn up at the A&E, because it is the same difference.

Sir Nigel Crisp: That is a question which is around and came from St Thomas's, did it not? The figures are not telling us that. Actually the increase in A&E is a relatively small increase and if you think that 300 million people use GPs and only 16 million people

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are using A&E, there is no real evidence that significant numbers of those 300 million are appearing in the figures.

Q43 Mr Allan: Do you have the figures to show what the actual cost is of different patient route through? We hear anecdotally, we are sitting here and we are assuming that going to A&E is the worst thing you can do. But I do not know that, because I do not know what it actually costs. I do not know that it necessarily does cost more for somebody with a sprained ankle to go to A&E rather than go to a doctor out-of-hours service or go to any other kind of service.

Sir Nigel Crisp: We do have some of those costs, but what we are trying to do is do this on the basis of convenience to the patient at this stage. This Committee, about two years ago, had the NHS Direct report in front of it, which did actually attempt to cost the difference between NHS Direct and A&E and to see those effects. We do look at those figures. At the moment the primary issue is to try to make sure that we are providing services out there at the convenience of the patient and not trying to redirect them.

Professor Sir George Alberti: We have some idea of the simple costs. It is £15 for a GP, £25 for a walk-in centre and £60 for A&E. However, if you have sprained your ankle where you need an x-ray, everything gets swamped by the cost of the x-ray and any other investigation. Those are the sorts of figures we are talking about, which suggest, for example, that the walk-in centre is actually quite a cost effective way of doing things.

Q44 Mr Allan: Is our basic assumption that the person with a minor issue who calls an ambulance and goes to A&E is the most expensive still a fairly safe assumption?

Professor Sir George Alberti: Yes, and we are now with those people training our paramedics to leave people at home more or to give them advice or take them to the appropriate place, not automatically to A&E, which was always the case in the past.

Q45 Mr Allan: Do you do any follow-up with people who are using services inappropriately? It seems to me that if somebody calls an ambulance and goes to A&E and goes home again and they never hear from you again, the next time they will call the ambulance and go to A&E. I am not aware that anyone writes to them or gets in touch to say "You really should not have done that".

Professor Sir George Alberti: We are certainly auditing this with our emergency care practitioners and to some extent the ambulance service. I am not sure the patients get written to, although that would not be a bad idea and there are big advertising campaigns, particularly by London Ambulance Service, about appropriate use of service, which cuts that down.

Sir Nigel Crisp: That this is not a taxi service.

Q46 Mr Allan: The people you want to talk to are the ones who are actually using it as a taxi service.

Sir Nigel Crisp: May be should take that one away.

Professor Sir George Alberti: Yes, that is a good thought.

Q47 Chairman: The reference to benchmarking and patients coming back is in paragraph 1.27 which you may wish to refer to. It says here "... a small proportion of patients, for example in review clinics and the lack of integrated patient records means that it is not normally possible to track their progress. You may want to comment on that. You also mentioned the emergency care practitioner and that is mentioned in paragraph 3.15 which you can find on page 33 where you will see "Our survey showed that ... 22 ambulance trusts were in the process of training emergency care practitioners, of which seven already had trained staff in the role. We found varying levels of training were provided". So there is a lack of consistency there as well. I thought I would mention that in the light of Mr Allan's questioning and you may like to comment on that now.

Professor Sir George Alberti: We are now working very hard on getting some overall educational standards for competence and skills, which could then be delivered by local universities, but having a set curriculum for people and that is beginning to come together. We have several hundred ECPs now and many more on the way and these are two thirds to three quarters paramedics and the other ones are nurses. What they do is assess people and initiate treatment at home much more or in a GP surgery, but they do not necessarily take that person to hospital.

Chairman: And would you like to comment on the lack of benchmarking which is dealt with in paragraph 1.27? The patients cannot be sure they are getting consistently good service because there is no follow-up, there is benchmarking, there is no measurement.

Sir Nigel Crisp: As I read this, there are two things here. The first one is that it is difficult to track patients because we do not have an integrated patient record system, which is true, but we are in the process of making the changes which will mean that we will have one of those. In terms of benchmarking of quality more generally in A&E, again we have the Health Care Commission doing inspections against that and we do have certain quality standards in A&E.

Professor Sir George Alberti: Major new initiatives are happening there. The Audit Commission, some part of CHI anyway, have just finished a comparison of fractured neck of femur, paracetamol overdose and something else, three common conditions, and they are now trying to set benchmarks. We shall be developing a whole series of other indicators over the next year to enable people to measure quality and patients.

Sir Nigel Crisp: The very general point here is absolutely right, which is that in hospitals we have tended to concentrate more on the specialist and the inpatient services than in A&E and it is only in relatively recent years with this relatively blunt target that we have made real improvements in emergency care.

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Chairman: I am sure we may want to come back to that in our report.

Q48 Jon Cruddas: I get a weekly, what they call, sitrep report from North East London Strategic Health Authority. It is a brilliant weekly report about all these indicators and how each hospital is dealing with them in terms of the four hours. Our health authority, Barking, Havering and Redbridge, has had some challenging issues.

Professor Sir George Alberti: "Challenging" is a very good word.

Q49 Jon Cruddas: However, from these reports over the last few weeks there have actually been some quite dramatic changes. Talking to them, they generally point to three factors which account for their relative under-performance. First is the physical buildings issue and obviously a new hospital is being planned and they say this will deal with this issue. Second, is the relationship with other intermediary care, GPs *et cetera*, to remove the chokepoints around A&E. I will just deal with that point there. When you investigate that further and you talk to the PCT about it, they say the problem they have in terms of removing those chokepoints is this continuous issue that they raise with me of under-capitation as regards PCT funding. In the index and charts of the relative performance of the health authorities, is there any correlation between under-capitation as regards PCT funding, their ability to provide healthcare that takes people out of going straight to A&E and the A&E performance in reaching the targets designated by your department?

Sir Nigel Crisp: We do not have that piece of information; I do not know. I should be surprised if it were a straight correlation though, because I know of places which are under capitation as much as in East London who are doing well and of course your trust, as you say, is almost at the 98% on the last week's figures that I have seen.

Q50 Jon Cruddas: The third element is the sort of management system approaches within the health authority. They are addressing them, partly with the new management system.

Sir Nigel Crisp: But you make the wider point that some areas are under capitation and our Secretary of State has recently said that he wants, in our next allocations, to try to move people nearer to target.

Q51 Jon Cruddas: Well, funnily enough that was my next question. Even though you do not have the data to see whether or not there is or is not a correlation, would you say intuitively that this sort of rings true? If the PCT does not have enough money designated as the formulas devised by the Department, in terms of their populations, therefore, everything else being equal, they are not going to be able to provide enough facilities to remove the pressure points around A&E and therefore the relative performance of A&E in meeting targets designated by the Department are more challenging than otherwise.

Sir Nigel Crisp: I would only make two pedantic points. It depends how they spend their money. I agree that if they have less money than the formula says they can expect, then somewhere their services will not be as good as if they had more money, but it may not be in A&E; it may actually be in mental health or it may be in some other area. I would only make that point.

Professor Sir George Alberti: I could give half a dozen examples of low capitation areas which have hit 98%.

Q52 Jon Cruddas: Ours does now actually; in the last couple of weeks.

Professor Sir George Alberti: It depends how you distribute your resource.

Sir Nigel Crisp: So there is a local decision. Having said that, clearly if people are as far under capitation as you are and in the North East of England, then we want to try to move them towards capitation as fast as we can.

Professor Sir George Alberti: I would add that our team have spent a considerable amount of time in the hospitals in your area and it is lovely to see things improving.

Q53 Jon Cruddas: I was going to praise the team because that was one of the key factors over the very recent period in terms of the rate of change which is now being recorded. I shall not push that any further because it is a self-evident point that I am making about a priority. Presumably *ceteris paribus* should be the capitation levels to ensure that PCTs have the ability to help the acute sector in achieving these targets. May I ask one other question? Given the increased demand on A&E, do you model the projected demand on A&E? Do you have a peak point in the future, given the trend increase in demand for up to 16.5 million people a year? Do you have that?

Sir Nigel Crisp: We do not actually have a model because there are so many variables here, unless George is going to tell me otherwise. We are seeing the big increase in NHS Direct, there has been a big increase in walk-in centres. This is the point about having an urgent care network so that people will make more use of it. We have just had this new contract, which we are agreeing with pharmacists at the moment, which will actually mean that people will be able to get more advice from pharmacists. We know that six million people a day go into pharmacies. This is a very good place for us to get minor ailments treated and prevention as well. It is a bit too complicated to say that we have a single model for all of that.

Q54 Jon Cruddas: Okay, so you do not have an integrated model of these different variables where you estimate their likely effects and therefore see the trend movement in the number of accesses.

Sir Nigel Crisp: No.

Professor Sir George Alberti: No, we do not and I am determined that the numbers should stop rising through much better use of prevention and pre-emptive strikes, particularly for older people and

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people with mental health problems where I think we really could increase their wellbeing enormously by some regular care before they get into a crisis situation.

Q55 Jon Cruddas: One more abstract point. A few years ago when I started in this job, I quite often collided with the notion that the demand is almost infinite and supply almost creates its own demand. The better facilities you have, the more demand you have, in terms of NHS Direct or whatever. It seems to me that there is a philosophical shift going on in terms of not having that as an underlying model, rather that this is all manageable in the sense of you not working on this continuous positive sum gain in terms of pressures on the system. Is that a fair description of some of the changes?

Sir Nigel Crisp: It is complicated, but one of the things we are trying to do is give people more responsibility for their own health; which they already have of course. That is why actually bringing things like the pharmacy into play means you may actually be getting people to think about health issues before they become health issues. That is where the thrust of our policy is moving towards: to try to get in early and be more preventative rather than worrying too much about the fact that there is potentially an infinite demand at the other end. Having said that, we know that there is still unmet need and in areas like yours we know there is more need. Round different parts of the country there is more unmet need for things like cardiology interventions and so on in different parts of the country. There is still quite a long way to go in what is very clearly, we all agree, need rather than just people wanting.

Professor Sir George Alberti: In chronic disease we have worked on rights and responsibilities of patients in my own previous area of diabetes, so that there are real responsibilities on the patient as well as rights to good care, to access to good care. We need to expand that to the whole public.

Jon Cruddas: I have to say that I thought it was a very good report.

Q56 Mr Jenkins: Sir Nigel, when you read this Report, how did you feel? How did you feel about the Report itself? I know it is a very comprehensive Report and a good Report, but how did you feel about it?

Sir Nigel Crisp: I was happy with this Report; it gives an account of a good platform for moving further forward.

Chairman: That is the same answer you gave to the same question from Mr Jenkins last time.

Q57 Mr Jenkins: He is consistent, very consistent.

Sir Nigel Crisp: I have a very good briefing obviously.

Q58 Mr Jenkins: Any report which says that in the A&E departments there has been a significant and sustained improvement in waiting times and also improvement in the environment for patients and staff and then goes on to say that the reduction in

total time spent in A&E does not appear to have been at the expense of any other objectives and there is evidence to suggest that reducing the patient time spent in A&E has led to increased patient satisfaction, has to be a good Report, as far as I am concerned. I think the Report has highlighted what you probably knew about what the difficulties are and it is an excellent Report. The people in the service should be congratulated.

Sir Nigel Crisp: I think people worked astonishingly hard on this actually and they have taken the opportunity.

Q59 Mr Jenkins: I have met them and one or two said "Will you ask him this?" so I agreed to ask you one or two things. The four-hour wait is a bit of a problem. Although I accept that there is a 2% leeway, you have to understand that if somebody brings in a youngster and the youngster has fallen over and cracked his head and they have brought him down, they are quite comfortable, they have been treated and then they are told that they have to be out in four hours, they say "I would rather not. I would rather just leave the lad there. He is not doing any harm. The parents are quite happy. I do not want to admit him to hospital. I do not want to discharge him. I want to leave him there because I want a bit longer to make sure that nothing is going to go wrong". That is one. Then there is the old-age pensioner who comes in, maybe an elderly, frail person who is rambling a bit and you are not sure whether they fell over, how much damage they have done to their head or whether it is their general condition, so you want to put them into a holding ward. The drunk who has come in after falling over, the mental patient. You are probably going to tell me you do have, but why do we not have a pool area where we can put these people? They have been seen within four hours, have not been moved on for clinical reasons, but they will not count against our four-hour time.

Professor Sir George Alberti: We do, in a word.

Q60 Mr Jenkins: Where?

Professor Sir George Alberti: In more and more of our acute hospitals. It is called a clinical decision unit sometimes or a short stay area where you are in a proper bed. What I do not like is having your old pensioner, for example, on these awful trolleys with people hurtling past in all directions. We have these quiet areas with a nurse supervising, where you are in a bed, you get fed if need be and where you can keep an eye on that person; head injuries, overdoses, a range of things where you just want to keep an eye on that patient.

Q61 Mr Jenkins: Sir Nigel, could you make a point of sending that down to each of your chief executives because I can assure you that staff in the hospitals do not know that. They believe in the four-hour maximum, that if a patient is not out within four hours they will be penalised. They have this dichotomy with regard to treatment. You need to make it perfectly clear that they can go into this pool area and it does not count against them.

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Sir Nigel Crisp: I think Sir George has made it simpler than it is. Actually, for example in children's facilities, there are quite a lot of areas where people bring people in for 12 hours' observation. There are different arrangements in different places and there is not one pool area. For example, somebody comes in with a head injury and you want to keep an eye on them for a period, you put them in what is called an observation ward. There is a series of different things.

Q62 Mr Jenkins: I did not mean one pool area for all people, but that they are placed in a different category, no longer in the waiting time.

Professor Sir George Alberti: If they are in the right accommodation, which I think they ought to be. If it is just a trolley down a corridor, which is what it started as, that sort of thing then . . .

Q63 Mr Jenkins: I thought this was a simple question, but I am beginning to realise that it is not quite that simple. No wonder there is confusion in the service.

Sir Nigel Crisp: I am surprised that they do not actually have the sort of facility we are talking about in Staffordshire.

Q64 Mr Jenkins: I did not mention Staffordshire. It is not in Staffordshire.

Professor Sir George Alberti: We have visited many places where they are absolutely clear about it.

Q65 Mr Jenkins: So for the ones who require treatment you say four hours is the maximum time. Do you think four hours is adequate for someone who has come in with a minor injury, someone who should be treated fairly rapidly, in and out?

Sir Nigel Crisp: The average is much, much quicker than that. I do not know whether we have a latest average figure. We are deliberately not setting a target for an average.

Professor Sir George Alberti: I think it is a little under two hours, that sort of time.

Q66 Mr Jenkins: One basic problem is staff of course; the number of staff in A&E. You do not have sufficient staff in the A&E departments. You suffer from a shortage of staff. What plans do you have in place to ensure that all our A&E departments are adequately staffed?

Sir Nigel Crisp: The first point is that we have increased the number of staff hugely, as this Report says, but we want more.

Professor Sir George Alberti: Two things. One is that there is now a significantly increased number of would-be A&E consultants in training. We shall have a steady increase over the next few years; I am sure you appreciate that it takes four or five years to train them, you cannot just get them off the shelf.

Q67 Mr Jenkins: So you are progressing towards meeting the staffing requirements.

Professor Sir George Alberti: Yes.

Q68 Mr Jenkins: The second thing is the building. Some of the buildings are not adequate for their use today. It is amazing that they were only built 10 or 20 years ago and even the new ones are not adequate because of the demand. What are you going to do about getting the buildings in a fit state to meet the demand?

Sir Nigel Crisp: We have actually already done a lot since this Report. That was a much fairer statement five years ago, whereas actually if you look at as many A&E departments as Sir George and I have done recently, I suspect you will see that every A&E department has had some money spent on it to increase the size.

Q69 Mr Jenkins: The Report says that some trusts spent that money on equipment rather than the environment. I am surprised that they had to do that.

Sir Nigel Crisp: You are talking about the £10,000 which went to *Modern Matrons* which is a different issue. On the big capital stuff, every trust received a bigger allocation and you will see that happening. That does not mean to say that there are not A&E departments which are not good enough; that is a continuing programme. The £10,000 is a slightly different issue. The figure here is that 127 departments told us that they had received the £10,000 but they do not have to tell us actually so that is a minimum figure. We actually think the vast majority has received that.

Q70 Mr Jenkins: It is the growth in minor injuries and walk-in injuries which is starting to block up A&E. One of the people told me that someone walks in, for instance on a Tuesday morning, and says their leg hurts. Is that an accident or an emergency? It must be an accident because it happened while they were playing football on Saturday. It is easier to get into the hospital than to go to see their GP and the hospital is on the way to work because they work in the city centre.

Sir Nigel Crisp: I am sorry; may I just correct you on one thing. A&E departments are not blocking and filling up; they are emptier today than they were two years ago or three years ago precisely because people are moving through faster and you do not have the people stacking up in them. My earlier point was the point that wherever you turn up we should offer you a service.

Q71 Mr Jenkins: The other thing I want to move on to is the ambulance service. In Staffordshire we have a very good ambulance service and we are hopefully moving into emergency care practitioners now. I believe that we are in a position where the vast majority of people could be treated either in the ambulance, or in their home, before being taken to hospital. I think we could do a lot of work to unblock the hospital system by never actually taking them there. We looked at the London Ambulance Service and they showed us how many people were actually admitted to hospital if they are taken in by

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an ambulance. It is a staggering number. If they were treated at home and the number of people taken to hospital was reduced by half, we would release tremendous capacity. If we look at Figure 16 on page 33, if I am reading it correctly, if the public call an ambulance, they expect to be taken to A&E. If they were taken to another part of the hospital 19% found this acceptable. Where did they expect to go? It is the public's perception that is the problem, is it not? This is patients who do not understand that we can deal with them quite easily by not taking them to A&E.

Sir Nigel Crisp: If you take the London Ambulance Service, you know that they have started some pilots in two areas of London to do precisely what you are talking about and as of January it is going to go wider. As people get experience of that service, I think their attitudes will change. You see this in all kinds of big changes in society.

Q72 Mr Jenkins: It is not the experience, it is the knowledge I am more concerned with. We may get repeat users of the ambulance service, but most people use the ambulance service once in a lifetime or twice in a lifetime. It is knowing what to do.

Sir Nigel Crisp: The point about this whole process is that we are moving towards a single phone call. You talk to somebody, a nurse, and they suggest they get an ambulance to you or they get somebody to come to visit you or they suggest you go to your walk-in centre. You get some immediate and personal advice; that is the first thing that we want to have happen. That is something which people will do increasingly. This is a big change for people.

Q73 Mr Jenkins: It is a big change and the one thing which amazed me was that NHS Direct did not actually reduce the numbers going to GPs or A&E, the market just seemed to increase. If we could provide more and more facilities, are we just going to increase the demand? Is there such a thing as a set demand, or does it expand to meet the space available?

Sir Nigel Crisp: Some of the demand will increase, but some of it is unmet need, I have no doubt about that at all.

Q74 Mr Jenkins: I cannot understand that.

Professor Sir George Alberti: I would also make the point that the ambulance service has needed to be empowered, retrained, *et cetera*, so that they are comfortable about leaving people at home. They are on their own, three o'clock in the morning, top of a tower block, dark room, it is tough. What we have now with ECPs, as you have in Staffordshire, is a cadre of people trained to deal with a problem on the spot. As you suggest, that is going to make a very big difference.

Q75 Mr Bacon: I think it was the last time you came to see us, but it may have been before—you come so often—you mentioned something about GPs being placed in A&E departments as an alternative way round. You indicated that it was in the form of an experiment and you were seeing how it went. Could

you say something more about how that has been going and whether you would expect to see it expanded? Going back to some extent to a point made earlier, it is philosophically accepting that is where they are going to end up, but you simply deal with them differently when you get there. How is that going?

Sir Nigel Crisp: It has actually been going on for a little while. I think the first one was in King's about five or six years ago and in fact St Thomas's, where your Chairman went, also has the system. We are seeing this happen increasingly in inner city areas and it is making a difference. It is part of this joining up.

Professor Sir George Alberti: There are two different models: one is the GP actually sitting in the A&E with all the other staff; the second is having a primary care unit as a gatekeeper in front of the hospital or as a separate group there. In both cases, it is having a very big impact.

Q76 Mr Bacon: When you say "as a gatekeeper", do you mean as a pre-triage?

Professor Sir George Alberti: That is one suggestion which is being tested out at the moment. There are lots of local ideas being tested at the moment and we will monitor them, see how well they are working and then make sure that the ones which work well are spread around.

Q77 Mr Bacon: May I ask you about Figure 11 on page 24, which shows the number of trusts which have been reporting shortages compared with funded posts? I was just wondering what analysis you have done of the level of the gap. All this chart shows is that they have reported that there is a shortage compared with funded posts; it does not say how big it is. What analysis have you done of the level and also of the types of gap or the reasons for the gap?

Sir Nigel Crisp: We can talk about the consultants as the easiest base, because we do have a workforce planning arrangement which actually tries to look at what numbers of consultants we are going to need in every specialty over the next five, 10, 20 years and we have one on A&E and another on emergency medicine, because the two things are slightly different. We actually have pretty good analysis of what we think we need in terms of consultants over the next five, 10 and probably 20 years.

Q78 Mr Bacon: Less so for other medical staff and nurses.

Sir Nigel Crisp: We tend to start there, but that same group which looks at that actually looks at other disciplines as well. It will pick out nurses, it will pick out OTs and others as well.

Q79 Mr Bacon: May I pick up that point about workforce planning? On page 3, paragraph 12, it talks about the fact that the workforce is growing across the board, but "... that obtaining sufficient suitably qualified staff remains a problem for many A&E departments and there is no accepted model for staffing them". What I found particularly

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interesting was that “. . . various studies have failed to show a direct relationship between staff numbers in A&E and delays to patients”. If you do not have an accepted model for staffing, how do you plan for the proper number of training places that you actually need?

Sir Nigel Crisp: We have several of these care groups which are looking at the needs in cancer, the needs in A&E, the needs in care of older people and they look at all the models that are around and make estimates of what it is. We have to plan on some figure; we have to make some decision about how many medical students we want. That is how we do it. We take into account the fact that in making improvements in things like waiting times in A&E, there could be a whole series of different things coming together.

Q80 Mr Bacon: Do you think that there are direct relationships, but that the study so far has just failed to show them and you need to do more studies?

Sir Nigel Crisp: I would guess that there will be some direct relationship, but there is also a direct relationship to how you run the place and the systems you use within A&E and how it links in with primary care and those may be more significant in some cases than the number of staff in A&E departments.

Professor Sir George Alberti: There is a workforce model which is being tested at the moment, which is based on how many patients you think a particular sort of health professional can see of a particular case mix, giving us some crude ideas. We have just under 600 A&E consultants at the moment. You can then start doing some sums, if you want a consultant available all the time, which I do, and that starts taking it up to quite high numbers. We are building slowly but surely towards those and you can do the same for emergency nurse practitioners. If we want all our minor units or walk-in centres to be properly staffed at least 18 hours a day, then you can calculate that you need eight as a minimum. You can start building up your numbers. We have done the same for ECPs, where we think by the end of the year we will have not far short of 600 or 700. We need probably many, many times more than that and we can now start working towards it.

Q81 Mr Bacon: The Report refers to the British Association of Emergency Medicine and their recommendations for staffing levels and of course the funding implications of this. Does the Department basically accept the Association’s recommendations?

Professor Sir George Alberti: I have been working on the basis that those are reasonable numbers, but that is me working on that basis.

Sir Nigel Crisp: We do not have a precise answer. All specialty groups identify what they think is needed in every specialty and we always look at them with interest. We do not always accept them.

Q82 Mr Bacon: Are you saying that there is always an element of a wish list about it?

Professor Sir George Alberti: Having come from the other side of the fence, I looked at these numbers very carefully, but to provide a 24-hour service, which is what our patients need, you are into six to eight per department.

Q83 Mr Bacon: How soon do you expect the shortage of radiographers to be eliminated?

Sir Nigel Crisp: Do you mean the shortage generally?⁵

Q84 Mr Bacon: Yes; it is paragraph 2.12.

Sir Nigel Crisp: Is this about diagnostic delay?

Q85 Mr Bacon: Yes, because 11% of all delays are diagnostic delays.

Sir Nigel Crisp: It is worth noting that this is 11% of the people who wait more than four hours.

Q86 Mr Bacon: It does not say that, although I presume it is.

Sir Nigel Crisp: It is actually; it is not 11% of all patients.

Q87 Mr Bacon: I take your word for that, but it is a big, big chunk, is it not, over one in ten.

Sir Nigel Crisp: I think it is the biggest single reason. I think the calculation is 0.2% of patients through A&E.

Q88 Mr Bacon: I am running out of time so can we go back to my question?

Sir Nigel Crisp: I think the answer is probably nearer “as soon as we can”; we have a whole lot of things in process, but I do not think we have yet got absolute milestones for when we will do it.

Q89 Mr Bacon: How many can you see in the pipeline?

Sir Nigel Crisp: I could send you a note on that; I do not know.⁶

Q90 Mr Bacon: If you could, that would be very kind.

Sir Nigel Crisp: Shortage of radiographers is an international issue, as you probably appreciate.

Q91 Mr Bacon: Like lots of other things, as we discovered; like nurses, as we discovered with the United States. One other question which relates to your recent report, Sir George. In the back you talk about—and there is a reference to emergency care networks in the NAO’s Report—all these different stakeholders or partners or whatever the right word is, everything from acute trusts to ambulance trusts to SHAs, to out-of-hours people, to social services and local councils. In your report you talk about breaking down the barriers being a key challenge. What are the biggest existing boundaries? Apart from the fact that they are geographically and institutionally separate, what are the biggest problems that you need to break down?

⁵ Ev 13

⁶ Ev 13

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Professor Sir George Alberti: I suppose finance would be a major element of this, each with its own budget and not wanting to hand over—

Q92 Mr Bacon: We were in Northern Ireland yesterday looking at how health and social care are integrated there and lo, it did not seem to make a lot of difference. There was one guy in front of us who was responsible for both, but it did not seem to solve the problem.

Professor Sir George Alberti: We have examples of that beginning to occur here. We are going to encourage much more of it. What I would see is the emergency care network being charged with commissioning for all the emergency services you require in that patch and that includes the social service support, etcetera. When you get to that stage, then a lot of the problems will disappear. I am very much in favour of health and social services being much more closely integrated.

Sir Nigel Crisp: This is a commissioning model rather than a management model, which is what the one in Northern Ireland is.

Mr Jenkins: Two quick points and you may send in a note, if you would, please. How and when do you intend to get the poor performers up to the best with regard to this 98%?⁷ What do you mean by unmet need? Can you tell me what you mean by unmet need and do you have an estimate for it?⁸

Q93 Chairman: Gentlemen, thank you very much. I apologise for the delays earlier on, but we have managed to make up for lost time. I congratulate you on a good Report. Good progress has been made, but of course we can always do better.

Sir Nigel Crisp: May I pass on your congratulations through a bulletin I send out tomorrow to the NHS?

Chairman: Of course. Thank you very much.

⁷ Ev 13

⁸ Ev 14

 Supplementary memorandum submitted by the Department of Health

Question 83 (Mr Bacon): How soon do you expect the shortage of radiographers to be eliminated?

We have already made considerable progress in increasing the number of radiographers employed in the NHS. There are 13% more NHS radiographers than there were in 1997 and our commitment to grow the workforce further is demonstrated by significant increases in the number of radiography training places. The number of radiography students entering training each year has more than doubled since 1996–97, and this increase will be reflected by future increases in the NHS radiography workforce.

Question 89 (Mr Bacon): How many (radiographers) can you see in the pipeline?

In September 2003, there were 13,344 radiographers (headcount) employed in the NHS, which represents an increase of almost 1,600 or 13% since 1997. As a result of increased training places, International Recruitment and Return to Practise, we project that there will be around a further 3,000 radiographers employed in the NHS in 2008. Along with this increase in radiographers, we are seeking to secure improved productivity and a better skill mix for the benefit of patients.

Question 92 (Mr Jenkins): How and when do you intend to get the poor performers up to the best with regard to this 98%?

All trusts understand they are expected to reach the 98% target to reduce to four hours the maximum wait, for patients, in A&E from arrival to admission, transfer or discharge, by the end of December 2004. The focus on performance management combined with targeted intensive performance support has already sharply reduced the gap between the poorer performers and the best. Two years ago the major A&E range of performance was 36%–99% (source Quarterly Monitoring Accident & Emergency (QMAE) Quarter 2 2002–03). The major A&E performance range July–September 2004–05 was 84%–99%.

The programme of support available to those trusts that are challenged from a national team of experienced managers and clinicians continues to be stepped up and where required intensified as we approach 98%.

The rate at which more challenged trusts catch up with the best continues to increase. Latest management information shows that in early November the weekly average performance was for the first time slightly above 97%.

The four hour target becomes an ongoing standard from April 2005. All trusts are required to meet the target by the end of December and maintain an average of at least 98% there after. The 98% operational standard is embedded in the Healthcare Commission A&E performance rating for 2004–05.

Question 92 (Mr Jenkins): Can you tell me what you mean by unmet need and do you have an estimate for it?

When a system is running with significant delays in accessing care as many areas of emergency care were until recently some demand is suppressed as need is met in sub optimal ways—for example GPs may hesitate to refer patients to a hospital known to be under pressure. As delays in the hospital system are reduced this unmet need for secondary care or advice is released and there is likely to be a transitional period as the system adjusts.

Patients' behaviour also adapts when there are long delays in accessing care. They may seek care later or be put off entirely from seeking care. A reduction in waits will release some unmet patient demand. It is not possible to put a fixed figure on the level of unmet need but the fact that as the NAO Report noted the *rate* of rise of A&E attendances is now falling and the absolute rise is not preventing ever faster progress in cutting delays demonstrates that it is not a threat to service provision.

20 December 2004
