Health Committee – 9 December 2015

Transcript of Agenda Item 6 – Accident and Emergency Care in London

Dr Onkar Sahota AM (Chair): That brings us to today's main item on accident and emergency (A&E) care in London. Can I welcome our guests? Dr Andy Mitchell is Medical Director of NHS England (London). Conor Burke is Co-Chair of the Urgent and Emergency Care Transformation Programme and Chief Officer of the Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs). Lorna Reith is Chief Executive of Healthwatch Enfield and Ian Niven is Head of Healthwatch Brent.

We are expecting Dr Julian Redhead, Chair of the London Region of the Royal College of Emergency Medicine, who gives his apologies for his lateness.

Kit Malthouse AM MP: I just want to kick off with the performance. Obviously, the performance last winter was, I guess, less than ideal. The numbers we have for waiting times were at a ten-year low or high, depending on which way you look at it. I just wondered what steps were being put in place to improve things this winter.

Dr Andy Mitchell (Medical Director, NHS England (London): Yes. First of all, I have to acknowledge that there is considerable pressure in the system. We are anticipating increased pressure even over and above the last year.

Having said that, though, in my experience, having been Medical Director for London now for the last seven years and experiencing winter pressures every year, I would say that this is probably the best prepared that we have been in order to deal with it. We have systems in place from the central office at NHS England (London) in terms of the acute and emergency care taskforce, which will be offering support and advice. We have a much better system of communication with regard to system resilience groups and how they are going to function. We have put in place support to the trusts that we know are high-risk in terms of poor performance.

In terms of getting the message across to the public with regard to how they deal with their own illnesses in terms of self-care, who they present to, whether they go to see their general practitioner (GP) or present to A&E. We have offered a very much more positive message, hopefully, to ensure that the public does not use the system inappropriately, as sometimes happens.

With the move that we have had as well towards urgent and emergency care networks linking into system resilience groups, I just have a sense that we are much better co-ordinated overall than we have been in any previous year that I can remember. Therefore, although, yes, the system is under pressure - we have seen that already in spite of the fact that we have not seen a temperature drop and that could be endorsed by my colleague Conor [Burke] here, who has much more knowledge at a local level of how the system works - I am confident that we are actually dealing with it appropriately.

Kit Malthouse AM MP: In particular, one of the things that struck me was the variation in performance. If you look at Chelsea and Westminster [NHS Hospital Foundation], which was regularly hitting 95% plus being seen within the target time, versus [London] North West [Healthcare NHS Trust], which was down in the mid-60s as a percentage, I wonder if you have got to the bottom of why there was this wild variation in performance.

Dr Andy Mitchell (Medical Director, NHS England (London): I think variation can change from day to day as well. To my mind, it is actually very dependent upon the leadership within the A&E service at the time.

If you have established, solid, good leadership that implements rapid assessment and triage and treatment early on and if you have a system that is then supported by good flow throughout the hospital, performance can be very good. There is so much that is dependent, to my mind, on the leadership skills of the individuals who actually run the service, and the co-ordination that they have with their chief operating officers.

Kit Malthouse AM MP: It is a management issue rather than a resources issue?

Dr Andy Mitchell (Medical Director, NHS England (London): No, resources are under pressure, too, but what we are hoping with our support systems to put in place are consistent management and clinical support systems that enhance patient flow.

Kit Malthouse AM MP: All right. In your first answer, you talked about there being particular A&Es that needed support and help.

Dr Andy Mitchell (Medical Director, NHS England (London): Yes.

Kit Malthouse AM MP: How many do we have in London? Is it 19?

Dr Andy Mitchell (Medical Director, NHS England (London): Yes.

Kit Malthouse AM MP: How many of those are on your hit list?

Dr Andy Mitchell (Medical Director, NHS England (London): It is not just our hit list. There is a national hit list as well and we have identified either five or six trusts in London that we know are subject to quite intense pressure. They have support from the Emergency Care Improvement Team (ECIP), which is a national team, which will be there on a day-to-day basis offering senior experienced support on the ground to those organisations. We are aware of the vulnerable ones.

However, there are also those where there is particular vulnerability because of shortages of consultant staff and A&E staff in general. We are having to work through networked systems in order to support them and see if we can get fluidity and transfer of staff across organisations in order to support them.

Kit Malthouse AM MP: Sorry. When you say you are having to work through networked systems, what does that mean?

Dr Andy Mitchell (Medical Director, NHS England (London): Networked systems basically provide just a much more co-ordinated system of care than we have had hitherto. There has been a national drive - and you may be aware of this - driven initially by Bruce Keogh [National Medical Director, NHS England] to create a much more co-ordinated and understandable system to the general public with regard to how they access care. This means that - just as with stroke, with trauma and with heart attacks - we have networked systems whereby people present to the right place at the right time. We are working hard on other more general illnesses that people present with so that they present at the right place, whether it is an urgent care centre, whether it is an emergency centre or whether it is a specialist centre. What we are hoping to do is to bring much more clarity to the public, and for units to offer mutual support in circumstances where they are under pressure by transferring staff, particularly consultant staff, if required. There is a much more fluid and co-ordinated system than we have had before.

Kit Malthouse AM MP: There will be a central thing that says that the Homerton [University Hospital] can ring up and say -- the Homerton has an A&E, does it not?

Dr Andy Mitchell (Medical Director, NHS England (London): Yes.

Kit Malthouse AM MP: Sorry. I have never been to that. I have three kids and I have been to quite a few. The Homerton can ring up and say, "We are under pressure. Bus some people over from the Chelsea and Westminster"?

Dr Andy Mitchell (Medical Director, NHS England (London): No, not quite like that at the moment. Our aspiration is that the systems will work within sectors and so it would not be transferring staff from the Chelsea and Westminster to the Homerton, but it could be that if they were looking for support we would look for flexibility within the network for other systems that were not under so much pressure to provide a supportive system in which --

Kit Malthouse AM MP: How real-time is that?

Dr Andy Mitchell (Medical Director, NHS England (London): That is our aspiration. That is not something that is in place now, but it would be our aspiration for the future. We are building those network systems currently.

Kit Malthouse AM MP: How predictive can they be? For instance, if you saw that for three Saturdays in a row University College Hospital (UCH) had been inundated with revellers from the West End chucking up and being thoroughly unpleasant in the A&E whereas it had been quite quiet down at Chelsea and Westminster, would you say on the fourth Saturday, "Do you know what? We are going to ship some people over"?

Dr Andy Mitchell (Medical Director, NHS England (London): I do not think we can do it in quite such real time. What I am talking about here is that we know there are systems and I can identify, for example, organisations in North West London where they are under pressure because of staffing shortages. Over a period of months in support of that organisation, we are looking to other, better-staffed organisations to provide support.

Kit Malthouse AM MP: Why? What is the barrier to that kind of real-time dynamic staff allocation?

Dr Andy Mitchell (Medical Director, NHS England (London): You can get quite significant fluctuations in pressure on the service in short spaces of time, and so I do not think it is as predictable as that for us to be able to transfer staff at the drop of a hat like that.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme and Chief Officer of Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups): Also, the resources are thinly stretched in respect of the senior decision-makers who make the biggest difference around flow. It would not be necessarily that easy to move consultants around the system within a fixed amount of time, say 12 hours, because it is very small numbers that make a big difference in respect of flow.

If I use the analogy - and it may not be the most helpful - of motorways, it only takes a very small number of changes in a whole system of flow for there to be blockages in that whole mechanism. It is the same thing with urgent and emergency care. It would be 1% or 2% difference in terms of the demand on the system with a finely-stretched resource to respond to that. If you move, say, 5% of that staffing resource from one bit of the system to another, it will cause the other bit of the system to fall over. It is really very small numbers that make a big difference around the performance target.

Kit Malthouse AM MP: Where are the critical difficulties? Is it the senior consultant staff? Is it the staff further down? Is it nursing staff?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): I can give you the example of my local system, if that is helpful. I cannot talk about Chelsea and Westminster, Imperial or UCH because that is not something I am operationally responsible for. I have a view in a different role as the Co-Chair with Andy [Mitchell] of the transformation board.

However, our system in Barking, Havering and Redbridge - I do not know if any of you are residents - has struggled with this performance target for at least a decade if not more. We have been the worst performing in London for some time and, two years ago, we established what we call a system resilience group, which is equivalent to something like an urgent care board. It takes an operational view of the whole system in respect of the demand that is coming into it, whether it be in primary care, the community or the hospital, and the capacity requirements that we need, the space, the appointments and the resources to fill those across the whole system. We have a very comprehensive measurement dashboard system that looks at all of that, not in real time hour-to-hour but day-to-day and week-to-week and we can generally predict what that looks like.

To cut a long story short, essentially, for the first time in four years, in July 2015, as a result of that hard work, the hospital achieved the four-hour target, which is a fantastic success given that 12 months prior to that it was down in the early 70s. The success of that is not just to do with the numbers of A&E doctors or middle-grades or nurses. It is to do with how the whole system works together.

Valerie Shawcross CBE AM: Demand management?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Demand management but also appropriate response to that demand in the right way across a whole pathway. Therefore, it is really about how we help people to be admitted quickly into a hospital if they need it but then help them out of hospital and back home quickly as well. It is about the whole flow through and enabling that success.

Kit Malthouse AM MP: Yes. It is interesting what you say. If the situation were that in the quiet months you were all hitting your targets and were coming in comfortably and then in the stressed months you were at or around the targets or even dipping below, there would be a rationale for saying that you cannot maintain an A&E at full capacity for the whole year, that it is not efficient to do so and that you have to expect stressed periods.

However, the fact that you are consistently underperforming does point to a structural problem and a management problem. Is that what you are telling us?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): I do not think I was suggesting that. First of all, I do not think there are not quiet months. If I look at my figures day-to-day, week-to-week and month-to-month, they are consistently high in respect of the attendances and the pressures that are on both of my A&E departments in my system resilience group.

Kit Malthouse AM MP: Attendances in the winter months are broadly the same as in the summer months?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Broadly, they are the same. Like I say, there is a marginal increase of a couple of percent in winter by way of numbers, but what you get is more complex patients in the winter because people get sicker and so you might - what we call - 'case mix'. The morbidity of people changes in the winter months due to environmental factors and other types of things, which I am sure you will be familiar with. You might get different ambulance attendance. At the moment, we are getting more blue-light ambulances turn up rather than necessarily people walking in.

That stretches limited resource at a time, when staff are also under pressure because of the same issues around their own health and wellbeing and the fact that a number of them take leave over four-day bank holiday weekends. It is a different way of managing the demand and the capacity.

What I did not say was that we were continually failing. I said that actually we had achieved the target in July --

Kit Malthouse AM MP: You did. Sorry.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): -- for the first time in four years, which is a fantastic success for our local residents, our local community and our local staff, who are very proud of having done that. We still are challenged. If you look at performance this week, which is publicly available, clearly, we are not delivering that at the moment. However, we are considerably delivering better than we delivered last year.

In relation to Andy's [Mitchell] comments about the system being ready, actually, we are performing much better than we have ever performed before at the moment. It is not ideal, but I concur with what Andy was saying. I do not think we have never been better prepared and certainly the focus and the challenge that we are undertaking at the moment - by all of the system, not just the hospital - is really intensive.

Dr Andy Mitchell (Medical Director, NHS England (London): Just to add emphasis to the point that Conor made about the difference between attendances and admissions, it is the admissions that cause the pressure in the system here because they are often frail, elderly patients with complex morbidity who need very specialised and complex care. However, the attendances do not fluctuate as much as the public might have imagined throughout the year.

Kit Malthouse AM MP: Yes, that is a misperception by a lot of people. They think that you are inundated in the winter and twiddling your thumbs in the summer because everyone is on holiday. It is not like that at all.

Dr Andy Mitchell (Medical Director, NHS England (London): It is the level of morbidity and the complexity of the illnesses, particularly in the frail and elderly.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): You are welcome to come and visit Queen's Hospital --

Kit Malthouse AM MP: No, I have been many times. The other thing I wanted to ask about was booze and the impact of alcohol on the whole scene. Do you see a bigger impact during the festive period? I suppose if you are in or around the West End, it is consistent every weekend. Is there more that we can do about alcohol?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): The simple answer to that is yes. If you are in Romford, it is not dissimilar in some respects to the West End on Christmas Eve, not that I have personally experienced that necessarily.

Yes, clearly, parties are things that people want to do and it is absolutely right that they should celebrate Christmas and the New Year. We do anticipate that and expect it to happen and so we do put in schemes to be able to manage that, similar to schemes that run in central London. I think the colloquial term for it is a 'booze bus', where we keep people warm with blankets, we take them to a safe place and then we allow them to detox from that. We avoid them having to go to an A&E department inappropriately and we work with the

London Ambulance Service (LAS) very strongly on managing that whole process. Yes, something that I think we are very good at now is managing that whole piece of surge pressure around detoxification of alcohol.

Kit Malthouse AM MP: In terms of our broad question on performance, you feel better prepared than you have done, Dr Mitchell, since you have been Medical Director. You have these new approaches to co-ordination in place. Broadly, therefore, you are confident that this winter's performance should be better than last winter.

Dr Andy Mitchell (Medical Director, NHS England (London): We are confident that we have the systems in place to facilitate better management than we had, but we cannot say with absolute certainty. Yes, we are confident.

The other point I would also add is that we talk a lot about the four-hour target but that does not mean to say that, if we are not meeting the target, the care is unsafe. The four-hour target is a thermometer in the system. It tells us how hot the system is, but there are other parts of the system that we need to focus on as well as the four-hour target. Provided that we have rapid assessment and treatment systems in place, I think the public can be assured that they are going to receive safe care because those who have serious illness will be triaged out. Not meeting the four-hour target does not necessarily mean that the service is unsafe.

Kit Malthouse AM MP: Just on the four-hour target, is it a four-hour target to be seen by anyone? If I go to A&E and within ten minutes I see the triage nurse and then she sends me back to the waiting room and I have to wait for eight hours --

Dr Andy Mitchell (Medical Director, NHS England (London): No, it is a decision about care and admission, or moving on or discharge into another part of the system.

Kit Malthouse AM MP: All right. How does it work from a monitoring point of view? Is there somebody sitting there with one of those chess clocks who hits it? Is there a computer? I suppose the doctor has to say, "OK, I have sorted this person out". Is there a mad scramble? Is there a clock ticking on each patient?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): I can assure you that there is no chess clock. We have moved into using technology now. It is not --

Kit Malthouse AM MP: Can we sit in A&E and say, "OK, we have these patients. These guys are going towards the four hours. We had better see them now"?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): I do not work in A&E, but I understand the process. When you are clerked in when you go to the administrator and they take your details - and like you say, it sounds like you have been there a number of times with your family - that is when the clock starts because your details are logged on the computer. There will be a way of monitoring the process from that point through by the A&E staff to be able to review through the admin team and also the clinicians exactly where people are in that process.

However, as Andy says, the key priority is not about necessarily the clock-watching thing. It is about clinical safety. It is about providing the most appropriate response to the needs that have been assessed. If you are acutely ill, you are going to be seen really quickly and your life is going to be saved, effectively, within minutes. If you are there with a relatively minor illness, you are triaged in a way so that you are not seen as quickly. That might mean you are breaching the four-hour target, which is absolutely clinically appropriate to meeting your needs, albeit that does not meet the national standard.

Dr Andy Mitchell (Medical Director, NHS England (London): This is terribly perverse, but it is actually a system that is able to function better with the four-hour target the more low-risk cases you have because you can move them along quickly. That is just an anomaly in the system.

Just to emphasise Conor's point, if you are acutely ill, you will be triaged and treated promptly. Fears and worries about exceeding the target are, I think, understandable, but the message I want to get across repeatedly is that it actually does not mean the service is necessarily unsafe.

Kit Malthouse AM MP: Essentially, what you are saying is that if you come within the four-hour target in 90%, it is a by-product of general efficiency rather than targeting the target, if you see what I mean?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): It is an indicator of efficiency, yes, but it is only one of a number of indicators. It happens to be the one that nationally is mandated, but we also measure a whole series of other indicators, like I said, across the whole pathway. We also measure how people are being discharged. There is also a key measure for delayed discharges of care where teams of people - in the hospital, with the local authority, with our community nurses - look at how effectively we can get people out and back home, which is really critical, too. It is about whole-system measurement and the primary indicator is, clearly, the front-door measure.

Dr Andy Mitchell (Medical Director, NHS England (London): This is the importance of the trust dashboard that Conor has mentioned whereby there are a number of indices that are measured on a regular basis and indicate, as close to real time as possible, the flow through the system and where the difficulties are. We have introduced that into a number of trusts across London including Conor's and that will reap dividends in terms of efficiency of practice.

Kit Malthouse AM MP: Thank you.

Dr Onkar Sahota AM (Chair): Thank you. Just to pick up, you were saying that four hours is just one parameter. What other parameters do you use to assess the patient feedback and the experiences of local GPs in the area of the service they are getting from the A&E department locally? How are you measuring that?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): I can answer that, too, if that is helpful. In our system, as I have said, we measure the whole flow and look at primary care, GPs and pharmacists, too, as being an integral solution to the management of the urgent and emergency care pathway.

We have been quite fortunate in the last year or so within what we call the 'BHR health and social care economy' to have been the receivers of a Prime Minister's Challenge Fund award and we had a bunch of money to invest in primary care. The way that we chose to do that was to invest in opening services in the evenings five days a week, and then also on Saturdays and Sundays. We now have six GP hubs open across the community of 750,000 people on that basis. They are for people who want an immediate appointment. They can ring up and within 30 minutes can go to see a GP if they have an urgent issue within six hub centres. We measure the quality of those interactions through a patient survey. Everyone who turns up is asked to complete a survey and rate their experience of that service.

Clearly, then, we have other measures across the system. We have contracts with our out-of-hours provider and our 111 provider and we routinely also measure patient experience of their services. Within the actual hospital environment, there is a specific measure of the Friends and Family Test around A&E services as well as people who are admitted. For my local area, we have been performing poorly on that for 12 months, but in the

last six months we have seen a real improvement in people's experience of care and dignity both within A&E and within the hospital itself.

Dr Onkar Sahota AM (Chair): Thank you. Dr Mitchell, we had a similar hearing last January and you [NHS England] told us that you were very well prepared for winter last year[1]. I am hearing this again that you are well prepared. What have you done differently this year that you did not do last year?

Dr Andy Mitchell (Medical Director, NHS England (London): It is systematising central support, really, to help organisations that are running into difficulties, affording them diverts if necessary and offering expert advice. That is one thing. That is much better co-ordinated. We used to be much more reactive to the system, whereas we are now set up to be much more proactive in offering that support. That is centrally.

I think we have identified and we know those trusts that have a poor track record for various reasons of delivery against the target in terms of their performance. We have channelled the ECIP support that I mentioned, which is expert support and advice from clinicians who have the relevant experience. They have been inserted into those high-risk services.

I think we are, again, being more proactive and are, hopefully, getting more messages out to the public that there are alternatives to A&E. We have talked about the hub centres. They are developing with much greater GP collaboration across London. We are helping people to understand that, as I say, there are different ways of accessing care. People often present because they think that is the final route whereby they will get support. There are alternatives. We are offering videoconferencing for patients. We are offering much more email contact and telephone discussions. There is a whole array of different systems that we have introduced and, hopefully, have been more proactive in letting the public know about these. In North West London, where you have a particular interest, I think we have some defined benefits already in terms of the numbers of patients who have taken advantage of those systems.

Dr Onkar Sahota AM (Chair): Let us talk about North West London, where I have a particular interest. What has been the effect of the reconfiguration of the A&E services in North West London?

Dr Andy Mitchell (Medical Director, NHS England (London): North West London is under as much pressure as any other part of --

Dr Onkar Sahota AM (Chair): As much or worse than?

Dr Andy Mitchell (Medical Director, NHS England (London): No, in some part of better and in some parts it is worse. It fluctuates, but I do not think there are any additional pressures on the A&E services in North West London as compared with the rest of the system following on from the A&E closures.

Dr Onkar Sahota AM (Chair): Really? Have you seen this chart in the Independent Healthcare Commission report by Michael Mansfield QC? It shows the effect of the closures on North West London. Have you seen this report, Dr Mitchell?

Dr Andy Mitchell (Medical Director, NHS England (London): I am aware of the report and I am aware of the work.

Dr Onkar Sahota AM (Chair): Have you read it?

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[1] A link to the transcript of the Health Committee meeting of 14 January 2015 is here.

Dr Andy Mitchell (Medical Director, NHS England (London): I have read the recommendations within the report. However, I think you could mirror that across any part of London and so it is difficult to correlate that falloff in performance with the closure of the A&E services in particular.

Dr Onkar Sahota AM (Chair): Have you had an independent report done on the impact of the closures in North West London?

Dr Andy Mitchell (Medical Director, NHS England (London): Prior to making these closures, there was quite an in-depth assurance process with regard to the safety and the subsequent impact upon patient care. There has been no reduction in capacity. I think what we are doing as a consequence of the reconfiguration is actually to use resources more effectively.

Dr Onkar Sahota AM (Chair): Have you had an independent review done of it?

Dr Andy Mitchell (Medical Director, NHS England (London): It has been subject to review, as you know. It has been subject to consultation --

Dr Onkar Sahota AM (Chair): No, I am asking about the impact of the reconfiguration. Has there been a review of that impact?

Dr Andy Mitchell (Medical Director, NHS England (London): I am not aware of a review conducted independently of this report or any other report that has been conducted.

Dr Onkar Sahota AM (Chair): You are not?

Dr Andy Mitchell (Medical Director, NHS England (London): No, I do not think there has been one.

Dr Onkar Sahota AM (Chair): Actually, North West London told me there has been an independent review done by McKinsey, the very architects of "Shaping a Healthier Future". Are you aware of that assessment? It is not independent, I do not think, but there has been an assessment done of the impact of those closures by McKinsey, the very people who were the "Shaping a Healthier Future" architects as a company. Are you aware of that?

Dr Andy Mitchell (Medical Director, NHS England (London): Yes, I am aware of that particular report and it is the --

Dr Onkar Sahota AM (Chair): I agree with you that it is not independent, although it has been sold as independent.

Dr Andy Mitchell (Medical Director, NHS England (London): No, it was commissioned via the system.

Dr Onkar Sahota AM (Chair): Yes, but that is why I am saying it is not independent. We commissioned McKinsey [and Company] to do an assessment, having had McKinsey do the architectural planning of the thing. Having said that, what were the findings of that, please?

Dr Andy Mitchell (Medical Director, NHS England (London): Irrespective of what those reports say, I think that it is something that would be mirrored across London because we know that there has been a falloff in performance over the last two or three years in the winter-time. That would be --

Dr Onkar Sahota AM (Chair): The point I am making, sir, is that the impact has been worse. The data shows that this is worse than that. Why is it difficult to accept that the impact has been worse in North West London than in the rest of London?

Dr Andy Mitchell (Medical Director, NHS England (London): Clearly, the data in the report is going to be subject to very careful scrutiny by colleagues of mine who have been leading on the reconfiguration exercise. My contention would be that that falloff in performance is actually mirrored in every other part of London and they are the issues that we have discussed. I do not think there is any evidence at all that suggests that North West London is performing any better or any worse than any other part of the system. I do not think it is possible to draw a correlation between the closure of the A&E services in North West London and the falloff in performance that you are demonstrating there.

Dr Onkar Sahota AM (Chair): This is the data here on page 52 of the Mansfield report [Michael Mansfied QC Independent Healthcare Commission for North West London], which very clearly shows that there has been a downfall in the performance in North West London and there are independent comments elsewhere in the report. Also, the McKinsey report shows that there are pressures on it. For example, two weeks ago all the GPs in North West London were sent an email saying, "Do not send patients to Northwick Park [Hospital] because we cannot cope with them. Send them somewhere else", and actually they were told to send them to Ealing Hospital, the very hospital that is due for closure of the blue-lights [services]. There was an email yesterday that came out from Imperial College saying, "We are under stress. Please can you do something about this?"

Dr Andy Mitchell (Medical Director, NHS England (London): By a similar token, there are many other organisations under stress in exactly the same way. My point is that I do not think you can necessarily correlate the pressures in North West London to the closure of two very small --

Dr Onkar Sahota AM (Chair): Then what can you correlate it to? How do you explain the North West hospitals doing even worse? Conor took the credit for the worst; you said that you were the worst in Barking, but you are not. The worst is Northwick Park. What do you think is the cause? Why is Northwick Park performing the very worst out of London?

Dr Andy Mitchell (Medical Director, NHS England (London): My point is that that picture can be mirrored in many health trusts in London. I do not think --

Dr Onkar Sahota AM (Chair): No, it cannot be. It is worse than any other hospital in London. Why is it the worst?

Dr Andy Mitchell (Medical Director, NHS England (London): What I am quite clear about is that when the closures occurred there was no reduction in capacity and that we are using our staff more effectively than we have done hitherto. This will be a system-wide issue. It is not necessarily focused on hospital beds. We are putting support into the North West London hospitals as a trust that we recognise as being a difficulty.

Dr Onkar Sahota AM (Chair): OK. Let me tell you. This was part of the independent survey given in evidence to this report. Tina Benson, who is the Director of Operations at North West London Healthcare National Health Service (NHS) Trust, said:

> *"So there was the risk of knowing we had a capacity challenge at Northwick Park versus the potential of the inability to staff Central Middlesex medically over the winter period and having to do an emergency closure. So we had some ongoing concerns but we felt that we had planned well enough to maintain safety, which was always the key."*

Despite saying that they knew it was happening, they did worse than that. Professor Ursula Gallagher, Director of Quality and Patient Safety for Brent, Harrow and Hillingdon CCG, said:

> *"We planned properly for what we expected to occur and even for a degree of unexpected occurrence. We got something that was completely unpredictable."*

The question is about the system. You thought you could cope with the pressures of closing the A&E departments but you could not. I am just saying that the reason this happened is that there has been the closure of two A&Es and the system is not resilient enough to take over the burden.

Dr Andy Mitchell (Medical Director, NHS England (London): I do not think the evidence necessarily points to that. All I can say is that there was no reduction in capacity in the system. Clearly, the report here raises some specific challenges. These are things that my colleagues, I am sure - who, as I have said, have oversight of the reconfiguration in North West London - will want to scrutinise. If there are identifiable clinical benefits that emerge from the recommendations, I am sure that they will give those due consideration.

However, my belief is that actually this is a pattern that you can replicate in other hospitals, as was the case with the Barking, Havering and Redbridge University Hospitals NHS Trust some years ago. This would be exactly the pattern that we see in other hospitals around London and you cannot correlate that particular data with the closure of the A&E services.

Dr Onkar Sahota AM (Chair): I am surprised, Dr Andy Mitchell, that you take that view and that in the face of data you find it difficult to accept that there are shortcomings in the system.

Dr Andy Mitchell (Medical Director, NHS England (London): I have not actually had the opportunity to see that data. What I am --

Dr Onkar Sahota AM (Chair): I am really surprised to hear that one year on from the closures, but thank you very much for your comments.

Andrew Boff AM (Deputy Chair): I am grateful that we have a register of interests on this Authority.

One of the questions I would like to ask is about the appointment service. You alluded to GP hubs being set up to allow people to be able to access GP services. Could you expand on that a bit more? The impression that certainly this Committee has had over the years is that it is the result of people not using GP services and primary care that contributes in some way towards the workload that the A&E has, in very simplified terms. For us, how you are working on ensuring that more people go to GPs rather than use A&E services is quite significant.

I wonder if you could expand a little on how that works and how the GP booking service might be reconfigured to be able to cope with the demand.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Yes, very helpful. I am happy to do that.

I think we are moving away from a way where we used to blame everybody in the system about who is going to own the blame for the failure of a target to a new way of working about how we as system leaders jointly take responsibility for managing flow across that pathway. Depending where you sit in a local health and social care

system, it could be the hospital's fault, it could be the GP's fault or it could be the local authority's fault around managing this stuff.

The way that we have moved that forward, as I have said already, is through our system resilience group, which is operating very effectively. It has tensions, but we operate collectively together as one system. We have been fortunate enough to have some non-recurrent money, as I have said already, and we tested a new model in primary care and opened these GP hubs, which are around a locality area of about 100,000 people. We have six of them at the moment and we have a seventh opening in the next few weeks covering a population of about 750,000 people in my patch.

The concept was, given the real concerns about accessing GP services at short notice and some evidence to suggest that when people cannot do that they go to the bit that is open 24/7 and easy to access and are prepared to wait four hours at A&E, then could we open some GP services in a hub in the evenings five days a week and could we open them during the day on Saturday and Sunday? We have done that now for probably about 18 months. We have also mainstreamed it. We have proven that it works and patients are satisfied, and so we are no longer reliant on the non-recurrent money and are mainstreaming that through a commissioning budget.

What we are seeing is that in the evenings all of the appointments are full now, probably about 85%, and we do not get any non-attenders, either. A lot of them are children and mums who find it easier between about 4.30pm and about 7.00pm to be able to go to see and take their children. There are also working-age people who come home and want an urgent appointment. It works really well.

We are struggling still, to be honest, with Sunday appointments. Saturday mornings are filling up but people are not tending to use the service on a Sunday. It tends to be about 45% utilisation and so we are in a debate now about what we do about that. It is not a good use of public money but, equally, we want to still maintain that service. How do we promote the service? How do we work with the local authorities and residents to make people aware of that new facility?

That is how it works. The way that they book in, which I think was your follow-up point --

Andrew Boff AM (Deputy Chair): Yes. One of the things I am interested in is how you negotiated with the GPs for them to almost give up a bit of control over their booking systems. That is what you are asking them to do.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): That is right, to an extent. The way that we established the hubs was through GP federations. Federations - and I do not know if you are familiar with that word or that concept - are GPs coming together as a co-operative or as a limited company whereby they can more effectively deliver services at scale. We have three federations, each co-located with each of our boroughs. They have collectively chosen to run the hubs and to fill the rotas between them, acting in a very different way. The model is also reliant on a slightly different organisational form to be able to populate those slots in those rotas. The practices where those are run from have allowed the federation of GPs to run its services from those practices, obviously covering the costs associated with it and whatever that might mean.

In relation to booking, booking is a very interesting one. We tried it just through 111, which you will all be familiar with. If somebody rings up 111, could they be directly booked into an appointment? Our experience was that we were not getting enough utilisation through that and so we opened up access and published a mobile phone number that anybody in the community could ring - not turn up but ring up - and book directly in. That has been much more successful.

Where we want to go into the future is a slightly different place. The other wonderful thing about my local area is that we have also been selected as one of the national urgent and emergency care 'vanguards' through Simon Stevens's [Chief Executive Officer, NHS England] national programme. That happened in July 2015, and it was on the basis of our ambition to completely integrate the local urgency and emergency care pathway. We have painted a picture. If we had a digital platform and if we moved to the next level so that people had one number and were able to call-click, then they could be booked into a clinic appointment in primary care, with a pharmacist or with the urgent A&E department and be given a slot when they will be seen. If we could move to that and create a digital platform, their care record could be available to the providers and the health professionals 24/7. That would be a much better way of relating to people, patients and customers and of managing flow in a much more effective, seamless way than currently happens.

That is something we are actively now moving forward with as a 'vanguard' and as a pilot for London and seeing within the next 12 to 18 months whether we can implement that. It would be effectively you or me ringing and saying, "I am ill", being booked into wherever is the most appropriate location and being seen within an agreed timescale.

Andrew Boff AM (Deputy Chair): I live in Barking and so, hopefully, I can test it for you.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Lovely. Fantastic. You can.

Kit Malthouse AM MP: You said they would be booked into the most appropriate place. When I ring up and say, "I am ill", they will say, "What is wrong with you?" I would say, "My shoulder hurts a bit". Would they say, "You are better off to go over here than you are to there"?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Yes. It would be a little bit more sophisticated than that, but the principle is the same.

Andrew Boff AM (Deputy Chair): All right. That is fascinating. Are you doing a formal appraisal of this innovation?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Yes.

Andrew Boff AM (Deputy Chair): When can we expect to see that?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): It has only just started because it has been a little bit of a process to be able to get to this point. There is a national process and we have to put in what is called a 'value proposition', which is a mini business case, essentially. Assuming that that is accepted, in the New Year we will be actively taking it forward. As part of that there will be a formal evaluation because, clearly, we need to share the learning and any lessons that we have.

Andrew Boff AM (Deputy Chair): I think it is quite an exciting thing, that innovation, and I look forward to seeing what the outcomes are because, as I alluded to, there is a problem with people not using their GP service appropriately. Thank you.

Kit Malthouse AM MP: One of the things that seems to take up a huge amount of time, certainly in my view, is going on the basis that all you want is a referral. Do you think we might get to the stage where I would not have to go to see a GP to get a referral if I say, "My shoulder hurts a bit"?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): I think that is a possibility. Clearly, there are issues within that around clinical safety and risk, but the technology now is moving at such a rate globally to suggest that you could start mapping most diseases through technology and that clinical decision-making could be done in a virtual way, as you are suggesting. The downside to that is the unknowns around clinical safety and risk, and whether people would trust it.

One of the other things we know is that people like going to A&E because they know it, they know where it is, it is open 24/7 and they know they will generally get to see a doctor. In moving to what you are suggesting, while technically it is probably possible to do relatively shortly in the next few years, helping people to adopt that as a trusted solution is probably the most challenging bit of it.

Kit Malthouse AM MP: Also, a certain percentage of time must be taken up with people who are going to a GP for a referral to a private provider, effectively, because private insurance companies make it a condition that you have to have a referral. You cannot go direct to a consultant and then claim it on your private insurance. It seems like an easy one for the health service to say, "We can wave all of these through". It is quite a bit of cost that the private insurance companies are putting on you that you are effectively their triage, instead of saying, "This is a cost you should bear. It is nothing to do with us".

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Yes, potentially. The real growth will be around diagnostics. If you can have more sophisticated diagnostics beyond blood tests and whole-body scans, it will potentially give you your own map of what your needs are going forward for a number of years.

Kit Malthouse AM MP: It is interesting that you should say that. Just as a final thing, I am Chair of the All Party Parliamentary Group for Life Sciences and we were shown a machine that takes a blood spot from you and within four minutes tells you whether you have an infection or not so that you do not have to give antibiotics when there is no point seeing the doctor, and you might as well just go home and get better. It saves about 85% of prescriptions of antibiotics and it is only £2,000 or something for this machine. Is that the kind of thing that you might --

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Yes. Potentially, that is the future. We are seeing a lot of that happen in India where they have leapfrogged and have said, "Do we need people or do we just need very sophisticated diagnostics which at scale become quite reasonably affordable?" At that point, the answer is, "Go here and have this solution", yes.

Lorna Reith (Chief Executive, Healthwatch Enfield): I suppose what I felt was a bit missing was the concentration on what happens to patients once they have reached A&E. We then moved on to looking at what we can do within primary care and, locally, we have a mini experiment on the additional appointments just started.

I wanted to flag up a bit of work that we have done in the Edmonton area, which is the area by the North Middlesex Hospital and which I suspect might be on your hit list because it has been underperforming and is under enormous pressure. That was because people were just not registered with a GP. We had had, as Healthwatch, people coming to us with difficulties registering. We knew that in our neighbouring borough, Haringey, Healthwatch there had done a little bit of work and had discovered an acute shortage of GPs. NHS England has now done a piece of work there and there is an absolute shortage and so there is work to try to open new practices.

We border Haringey and so we decided to look at the Edmonton area. We sent out three teams of volunteers to stop people in the street and ask, "Do you live locally? Are you registered with a doctor locally? If not, why

not? Where would you go if you were ill?" We picked three locations, Edmonton Green station, Edmonton Green shopping mall and Lidl in Upper Edmonton. I did the one outside Lidl. We stood there for a bit under an hour and spoke to 95 people. A quarter of them were not registered with a GP. The figures were slightly lower in the other two locations. This included families with children; it included staff at Lidl.

What people generally said to us was that they had tried to register. There were one or two people who said, "I am healthy. I do not need it", but by and large people had tried to register and had not been able to because they could not provide proof of address. I think this is something that will be replicated in other parts of London where you have a transient population, lots of people in temporary accommodation and lots of people staying with friends or family; none of the utility bills are in their names. What practices were doing was just being very over-strict. People could prove their identities, but they did not have the bills in their names that proved where they lived and so they were being turned away.

On the back of this piece of research, our public health department has launched a campaign with us and there are leaflets going door-to-door in the five deprived wards that cover the area. They advise people about how to register with a GP and make it absolutely clear that they do not need to provide all of that evidence, and that they have a right to register. There is new guidance out from NHS England on that.

Although this was a just a small, what you might call 'quick and dirty' survey in one bit, the whole system is predicated on someone being registered. With additional appointments or whatever you do within the system, you assume that people are registered. If they are not, you have no starting point. When we asked people where they would go instead, they said, "A&E". In fact, one dad with his kids said to me said, "I have been to A&E and they did lots of tests. How do I get the results of those tests?" Of course, he does not because the system assumes that he is registered with a GP.

What I am interested in is what happening elsewhere in London - because I cannot believe that this is a problem that is peculiar to the Tottenham-Edmonton corridor - to ensure that people are registered. We will have a transient population. We will have people coming from countries where their health system is not like ours. Actually, it does not matter whether they have come from Denmark or Somalia; their system will be different. For a lot of people, they go straight to the clinic or the hospital. The role of the GP is a very British thing. You did talk about there being some work done to get this message across, but nobody talked about how we ensure that people are registered.

Dr Onkar Sahota AM (Chair): We will look at GP access and the workforce later on. We realise that that is a different Committee hearing. I will be interested to look at the work, Dr Conor, on how GP appointments do impact on A&E access and attendances. I would like to see the data that GP appointments are a cause of pressure on A&E, given that the workload is constant all through the year. I come from a part of Ealing with a great transient population and there is a requirement to prove residence since these regulations have come in --

Andrew Boff AM (Deputy Chair): Chair, it is not always just because you are transient. I moved to Barking and, after repeated bureaucratic frustrations, it took me a year to register. I tried and I did not have the form. I tried and I could not make that date. I tried for a year.

Lorna Reith (Chief Executive, Healthwatch Enfield): Yes, and you have a command of English and you are literate.

Andrew Boff AM (Deputy Chair): I have a 'command'? OK, it is not too bad.

Kit Malthouse AM MP: From personal experience the GPs appointment system is a driver of people to A&E.

Andrew Boff AM (Deputy Chair): Yes, it is.

Kit Malthouse AM MP: We have been to A&E a couple of times because we cannot get in [to the GP] for three weeks.

Andrew Boff AM (Deputy Chair): Absolutely.

Lorna Reith (Chief Executive, Healthwatch Enfield): You do not have to prove residence.

Dr Onkar Sahota AM (Chair): OK. This is not on GP access. We know there is a shortage of 6,000 GPs in the country and a shortage of 8,000 nurses. We know about that but --

Kit Malthouse AM MP: I am very pleased that we are criticising the largest portion of the NHS in private hands, which is GP practices, right? They are in the private sector.

Dr Onkar Sahota AM (Chair): That is the way the NHS is set up at the moment. I am glad that we will look at that, Kit, but, yes, it certainly is.

Ian Niven (Head of Healthwatch Brent): Around access, I will perhaps pick up a few points that have been made up until now. Going back to Dr Mitchell, he was saying that he feels as if the message of alternatives to A&E has become better and that the system has become better at explaining that.

That is not at all what we are hearing from patients. I have with me two reports done in Barking & Dagenham on why adults go to GPs and why parents take under-four-year-olds to GPs from our own visit to the A&E at Northwick Park and other feedback from places, and a survey done by Healthwatch England. Every single one gives different numbers but all of them say, "I am aware of 111 but I do not know what it does", or, "I am not aware that you could go to pharmacies for certain things". GP hubs were set up in Brent and patients who accessed them really appreciated them, as you have said, but the majority of patients do not know that they exist. Patients do not know the difference between an urgent care centre and A&E or a walk-in, and do not necessarily have confidence. Then other sources and also the report that [Assembly Member] Dr Sahota referred to state that even GPs, both within urgent care and in their practices, do not have complete confidence sometimes about where to go and would refer somebody to A&E.

Therefore, that message and that clarity is not something that we are hearing has gone out at all. What we have seen is the message going out, "Do not go to A&E". Patients can certainly tell us, "I am going to go to A&E. It is my choice and I know it is there and I know I will see a doctor and I will get there".

In Brent, Brent Council's scrutiny committee did a report around GP access and pressures in the system. One of the recommendations, I am glad to say, was that the Brent CCG, the local authority and Healthwatch Brent work together to improve that messaging and the communication out there. At least that is a bit of work.

I do not underestimate the challenge. I always grew up with going to the doctor or, if you were terribly ill, going to A&E. It was nice and simple. The situation is constantly changing. The information that went out a year ago is not necessarily the same services now. It is not that easy. In amongst that confusion, patients will carry on going to A&E.

We want to work with the local CCG in terms of improving that system because if it improves, ultimately, it is good for patients. If we can have confidence, I do not see why we can give out a message saying, "Do not go

to A&E", or, "The A&E is only for life-threatening situations", which is not precisely the case. It is about that positive message of what else is out there.

Kit Malthouse AM MP: Presumably, Conor - sorry to interrupt - this is what your system is about, allocating people to the right place in a timely fashion?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Yes. I do not disagree with anything that Ian [Niven] has said. The system is confusing. The work that we have done both nationally and in London has identified the confusion, the fragmentation and the frustration. That is not just users. It is also staff. Clearly, that is part of the transformation programme that Andy [Mitchell] and I are leading across London. I gave you an example of how we achieved early adoption within BHR. Yes, I absolutely agree that we need to clarify and have a consistent offer and to put that out and that we need to be able to communicate that in a much more effective way. However, it will take time.

Kit Malthouse AM MP: Sure.

Lorna Reith (Chief Executive, Healthwatch Enfield): It is also about breaking down what the different patient groups are. The Barking research around children indicated something slightly different. I think parents with children are a bit risk-averse. They also do not think GPs are particularly good with children and are not really knowledgeable, and so they want to see a doctor. I am quite interested in some of the schemes around rapid access to appointments. If parents knew their child could get an appointment with a paediatrician within 24 hours or 48 hours, it might then impact on whether or not they take them to A&E.

You cannot just treat the patient body as just one group. The reasons why people go to A&E, what alternatives they think are available and how much they trust them do vary. I do not know what work has been done around parents taking children along. It was interesting that your extra appointments seemed to be very popular with parents and children.

Kit Malthouse AM MP: It depends on how many children you have. Your first child gets taken to the doctor a lot more, but two and three do not get taken very often. You learn.

Dr Andy Mitchell (Medical Director, NHS England (London): I suppose Ian [Niven] has articulated what the nub of the problem is. It is that there is a myriad of ways of gaining access to the service. It causes confusion in the public mind. It is fragmented.

Part of the national work that has gone on - as Conor [Burke] has emphasised - was to understand what it is from a patient's perspective; what they want and how they want to gain access to services. We have taken all of that on board. I think there is a huge piece of work yet to be done and it does need to be a collaborative approach in order to make a consistent offer. We have gone through a process of ensuring that places that are designated do offer a specification of services that are understandable to the public. I think there is a huge amount of work yet to be done, but the important thing is that we have acknowledged that we may think we are doing it effectively but clearly not as effectively as we would like.

Dr Onkar Sahota AM (Chair): Good. There are a lot of arguments for having a single hub and someone sorting it out, which is appropriate.

Valerie Shawcross CBE AM: You have done a very good job explaining the complexity and the many drivers of pressure and difficulty and, to some extent now, success for A&E. However, we just want to focus in on the workforce for a few moments and what we have all been hearing about problems with staff shortages.

The opening question is: to what extent are the pressures that A&Es face due to the difficulties of staff shortages and what lies behind those staffing pressures?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): The problem is that we have a lack of A&E trained doctors coming through the system. Of those who do, a proportion are electing to take their work elsewhere, out of the country, into Australia. We know that we are paying about £150 million for locums across the A&Es not just in London, obviously, but across the country. We know that we are losing about £250 million to people deciding to take their expertise to other countries, in particular Australia because the work practice there is more attractive. We know that there are pressures. The seven-days-a-week services and evening services and to a degree some of the work that originally came out with the new contract - we do not know what the new contract will look like for junior doctors - were disincentives for people to go into acute specialities of which A&E is one of the major ones. That is for the doctors. There is also a shortage in nursing.

In London, it is particularly poignant because of the problems with housing and the cost of living within London, and that is true for consultants as well. The training we offer is very good and that is clear, which is why we do get trainees, but trainee numbers are down. As we move towards more and more patients coming through, we need more and more staff to see those patients and that gives us the crisis that we have in terms of staffing. I do not know of an A&E department that does not rely on locum work to fulfil all of its shifts.

Valerie Shawcross CBE AM: We all understand from the work that we have done on other committees and as constituency members the issues around housing costs and the pressures of living in London, but can you tell us a little bit more about why a British-trained critical doctor would go off to Australia? It is not just the sunshine. You said something about the practices. Why is it an unattractive working environment for somebody?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): I am not an expert on the Australian work practice, but my understanding of why people go is because their quality of life in their work environment is much better. They will do fewer shifts within the A&E department for the same amount of money, together with a large amount of support in terms of their training and their clinical professional development (CPD), which comes financially as well. There is attractiveness not just about the country itself that they are going to, but more about how the practice of emergency medicine is there --

Valerie Shawcross CBE AM: The work-life balance, do you mean?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): The work-life balance is important. Whereas in this country at the moment it is just continually increasing out-of-hours antisocial shifts that need to be covered and consultants are doing that at present, in Australia the balance is better and they will have fewer of those out-of-hours shifts because they will have more doctors involved in the care of those patients.

Valerie Shawcross CBE AM: You used some big figures with zeros. For those of us who do not know the service, it would be helpful if you could talk a little bit in percentages and proportions. How much a problem is this?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): I do not have that precise data but I can certainly get back with that type of data.

Valerie Shawcross CBE AM: Give us a sense of the shape of how much of a problem it is.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): We are talking about a percentage. If we take the training numbers, we fill almost 100% of people going into the Acute Care Common Stem (ACSS) training figures, which are those junior doctors who will become either anaesthetists or A&E doctors. The vast majority of those end up going into anaesthetics; it is about 80%. Therefore, where it should be 50:50, we are already losing doctors to a different speciality and that is usually to do with work-life balance. Then another percentage, even if it is only a small 5% of consultants once they are trained, will move to other countries. The net result of adding all of these up means that we do not have the numbers coming through into A&E as a speciality as you may believe in terms of the fill rate of the training scheme positions when they start.

Valerie Shawcross CBE AM: To what extent is that a national problem, really?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): It is a national problem. It is not just located in London.

Valerie Shawcross CBE AM: Is it worse?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): I think it will become worse in London as time goes by, especially if contracts change to not necessarily reward acute specialities, because of London being a more expensive place to live. People will struggle to remain in London and will prefer to take their training elsewhere.

Valerie Shawcross CBE AM: Has there been any progress made in recruitment and retention of urgent and emergency care staff or is it simply getting worse?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): We have done a lot of work to try to recruit and to try to emphasise the positive parts of being an A&E consultant, but my understanding is that still the same figures account for people leaving the speciality.

Dr Andy Mitchell (Medical Director, NHS England (London): Can I draw the attention slightly away from A&E? Notwithstanding the importance of A&E, there is something about the way we train doctors for the future in general terms to meet the need because, traditionally, training has occurred in hospitals when most of the work clinically happens in the community. It is perhaps a different type or genre of doctor that we will need in the future to meet the needs that are going to be predominantly community-focused with long-term conditions, etc. I think there is a big divide at the moment here and a chasm that we somehow have to cross. It is a very big cog to change.

We need to think more imaginatively for the future in terms of developing our specialist primary-care doctors in a sense. That means a change of focus not just for primary care but for secondary care clinicians who go to work in slightly different circumstances in community circumstances. That is going to be a long-term problem, but I think that will begin to ease the pressure on emergency services in the future. There is quite a long way to go with this because there is a big cultural change that will be needed in order to alter the mind-set that currently exists, but it is not appropriate to focus on the A&E service as such. We do need to think a little bit more imaginatively.

Valerie Shawcross CBE AM: What kind of thing would you like to see?

Dr Andy Mitchell (Medical Director, NHS England (London): You could take a specialist in diabetes and set them to work in primary care settings. There are many good models across London. In Whittington, for example, there is a very good community respiratory team looking after elderly patients with chronic

obstructive airways disease. It provides a different emphasis, a different focus and a better patient experience and it is innovative, but it does mean a change in the mind-set for the medical profession.

Ian Niven (Head of Healthwatch Brent): The LAS, I suppose, generally has a concern that it is struggling at the moment in North West London and is struggling in bringing those together. In terms of staff training, it is losing staff to neighbouring counties just outside London in the banding. They are band 5 staff here and band 6 out of London. It goes through an awful lot of staff as well and there is pressure there.

Lorna Reith (Chief Executive, Healthwatch Enfield): I think it is housing and the housing costs. I know the cost of living in London is higher. We were at the LAS's Care Quality Commission (CQC) report back on their inspection and that came through very strongly, that difficulty of holding on to staff in London with staff having to travel very long distances because they were not living in London. They would finish their shifts very late and so on. That will be equally true of those staff working in A&E departments. It is that lack of --

Valerie Shawcross CBE AM: Going back 35 or 40 years, the old Greater London Council (GLC) had a priority housing scheme. Teachers, for example, when there were teaching shortages, would be allocated council housing and so forth. There was tighter employment of the community's resources to make sure that key staff were retained. Is there anymore you would like to say?

Lorna Reith (Chief Executive, Healthwatch Enfield): When my sister trained as a nurse, she was in a nurses' home. I am not suggesting that they would be appropriate now but --

Dr Onkar Sahota AM (Chair): Even nurses now lose their training bursaries.

Lorna Reith (Chief Executive, Healthwatch Enfield): Yes. There was accommodation provided.

Valerie Shawcross CBE AM: Yes, provided accommodation. Is there anything more you would like to see done, Dr Redhead?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): Andy's [Mitchell] points are very salient. How we alter care and how we move to more community-based preventative medicine will undoubtedly have an effect because we are faced with an older population and a population that will have more comorbidities, and will therefore have acute exacerbations of those comorbidities. The more we can identify those early and bring them into expertise in the community, it will certainly ease and help the A&E. However, there will also be that need for emergency care and emergency physicians and I do not see at the moment that those numbers will decrease. I think we can help to control them through those measures, but those numbers appear at the moment to be continually increasing year-on-year. We have to make sure that we have the right workforce to meet the demands of the patients who require those services. Andy's points are very salient to this.

Dr Andy Mitchell (Medical Director, NHS England (London): Yes. I am by no means undermining the role of A&E services and A&E practitioners because they are crucially important to meet the need.

Valerie Shawcross CBE AM: Look at the system as a whole?

Dr Andy Mitchell (Medical Director, NHS England (London): Yes.

Valerie Shawcross CBE AM: Yes, but what about this? We are bleeding out good A&E doctors who are going to Australia. What could be done about that?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): From us at the College of Emergency Medicine, I have a couple of other figures that I have found for you. At the time, about six months ago, we estimated that about 500 doctors were now in Australia working when they had been trained in the United Kingdom (UK) and so there is a definite movement. That figure will be increasing.

I think the problems we have in the UK are how A&E departments are tariffed and how income comes into the A&E departments and that the amount of money coming into A&E does not recognise the work that is going on. A&E in a hospital is seen as a resource that does not make any money and trying to improve things in there is very tricky when you are making out business cases.

We need to understand and get the correct resources going into the A&E departments so that they can identify and produce work-life balances for the staff working there that are correct according to contracts. We need to make sure that the right incentives for doctors to work out-of-hours and into the weekends are there and in place so that everyone recognises the need for that, and the ability to make sure that work-life balance systems are addressed within that system to make sure that that works. Within the working environment of the A&E, with the exit block that we see, which is overcrowding within the A&E departments, again, it makes for a very stressful working environment, which people will tend to move away from if they get that opportunity. Resolving those issues within the A&E departments will help to attract staff into that speciality, which is very important for the community.

Valerie Shawcross CBE AM: Are there some business cases for dealing with this problem based around tackling the extra costs of locums? If you were actually investing that money further upstream in preventing the bleeding-out of doctors rather than constantly paying for more expensive locums, is that business case potentially there or, actually, is it cheaper just to fill a gap quickly with a locum?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): No, I think the business case is there. In certain areas, it is difficult to recruit because there are not enough doctors and so we have to balance this right from the start. We need to attract more people into the speciality and to make it an attractive speciality so that we can fill those positions as they come available. We know that over 50% of senior A&E posts have been unable to be recruited to for over four years. There is a chronic shortage of doctor manpower in order to fill those posts --

Valerie Shawcross CBE AM: Person-power, yes.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): -- and nursing power, yes.

Valerie Shawcross CBE AM: No, person-power. Gender-neutral language: staffing, person-power.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): Yes, absolutely. I apologise. Person-power, absolutely. In A&E, we definitely have very equal sexes within our speciality.

Valerie Shawcross CBE AM: I know you do.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): To me, we have to address this at the root cause by making sure that the trainees that we train are coming through into the speciality and that they are available as a workforce for the future.

Valerie Shawcross CBE AM: Thank you.

Andrew Boff AM (Deputy Chair): We have talked a lot about the link between GP care and the increased use of A&E. Is there an evidence base to suggest that a lack of access to GPs in a certain area might produce this increased attendance at A&E or is this just experience?

Dr Andy Mitchell (Medical Director, NHS England (London): I cannot quote exactly the paper to you but I am aware of evidence that suggests that where there is good access to primary care services, presentations at A&E services are less. There is hard data there.

Andrew Boff AM (Deputy Chair): Is that something that perhaps later you could notify us of? It is an assumption that we are all making but --

Dr Andy Mitchell (Medical Director, NHS England (London): Yes, of course we can pick that up, but I am confident that there is evidence that that is the case.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): The other evidence for this, which I do not have a paper for and so I would not be able to give it to you later, is that there is a variation if you look at GP practices and their patients' use of A&E services. There is a big variation between individual practices and their use of A&E services. How that is linked to access I cannot tell you, but there is a variation.

Dr Onkar Sahota AM (Chair): There is also data showing that if you increase GP appointments, you increase demand for those appointments.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): That is possibly true. I know that anecdotally GPs would say that they put on extra appointments and they are unfilled.

Ian Niven (Head of Healthwatch Brent): It was just that the focus does seem to be on GP access and A&E pressure, whereas a comment was made earlier about the whole system flow. I have never seen anybody been able to put their finger on it and say, "This is where the blockage is in the system". There is a whole series of them. Bed-blocking has been the current one, but it has been recognised that that is not the whole answer, either. It is not just about access to GPs.

Andrew Boff AM (Deputy Chair): Perhaps it is other services as well. We have seen an increase, for example, in people going to A&E for dental services.

Lorna Reith (Chief Executive, Healthwatch Enfield): Yes.

Andrew Boff AM (Deputy Chair): There is some evidence about people going in for mental health issues. Do you see there being a link there between the inaccessibility of other services - not just GPs - and the increased demands on A&E?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): The answer to your question is potentially but we do not know. One of the fundamental problems is that we cannot link the data together. If you ring up 111 today, they will know who you are if you give them your details. What we will not know is what happens to you afterwards, whether you go to see a GP, whether you go to see an urgent care centre or whether you turn up in A&E. Technically - and this is part of our 'vanguard' solution - we will be able to do that. We will be able to track people - in a nice way - to be able to determine exactly what their utilisation of services is. However, there are lots of barriers that stop us doing that around information governance, national legislation, sharing of data and stuff that makes it quite difficult to move forward. Technically the information technology systems can do it today but it is about actually making it happen.

We can all hypothesise about the various different cogs that connect all of this together in a complicated machine that we do not fully understand. Until we get the data that is able to track anonymised individuals, understand populations and stratify those populations - whether it is children, people with drug and alcohol problems, people with mental health needs – I think we are all going to be guessing at the solutions and trying different interventions.

That is going to be one of our key priorities over the next year: how we link the data together to be able to really pinpoint the various different issues and then target the interventions accordingly.

Andrew Boff AM (Deputy Chair): It would be fascinating to see that. One of the things you could look at is that, as we understand, 40% of patients who attend A&E are discharged without requiring any treatment. That is not to say that they should not have been there, but it would be interesting to see an analysis of what they were there for if they are not ultimately getting treatment and where would be the best place for it. Is there any breakdown on that figure at all or any analysis of that 40%?

Dr Andy Mitchell (Medical Director, NHS England (London): I am not aware of any specific breakdown although I am well aware of the figure. What it suggests, of course, is that there could well be alternatives to A&E for that group of people. It could be pharmacy services or it could be GP services ideally, but other ways of providing support for that group that would actually significantly reduce the pressure.

Lorna Reith (Chief Executive, Healthwatch Enfield): Certainly there is research - I cannot remember exactly where - that showed that putting a particularly qualified pharmacist in an A&E department took care of a proportion of patients who had run out of their medication, had taken a double dose without realising, were worried about a side-effect or something and dealt with that. There is evidence out there using that. I have seen figures about people who are turning up at A&E for dental treatment. Either they do not know that there is emergency dental treatment out there or they think they are going to have to pay, and so they go to A&E instead. We do not know. Unless someone goes and talks to them, we are not going to know that.

The other thing is working with care homes and nursing homes where the home inappropriately uses A&E for patients who could have been taken care of within the nursing home. However, night-time staff - not being that well qualified - become risk-averse and dial 999.

Valerie Shawcross CBE AM: Sometimes caregivers can be under instruction to do that.

Lorna Reith (Chief Executive, Healthwatch Enfield): Yes. Again, it is not necessarily in the best interests of the patient. It is looking at all of those different factors that is important, not just what happens in A&E.

Andrew Boff AM (Deputy Chair): What do we know about demographics of A&E use in London? Are there particular groups that are more reliant? We have some indication that the elderly tend to use A&E more than others.

Dr Andy Mitchell (Medical Director, NHS England (London): I think there is evidence that suggests it is actually the younger generations who use A&E services. It is about wanting immediacy of access. There is something about the 'smartphone generation', which expects to be able to look up services and book them in straightaway. There is this mind-set that is developing around the younger population that we could focus on more productively.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): We shared this recently. It is a behavioural insights report that we have done as part of the programme and shared at a

conference that we did across London a couple of weeks ago. It may be of interest for you. There is a whole load of data there reviewing eight A&E departments in London and asking patients exactly those sorts of questions: "Why have you come here today? What gave you the confidence? Why is it that you have been advised to come here?"

It does not actually go into the detailed analytics of different patient segments. However, it gives you a flavour of people being confused and seeing A&E as a point of confidence in the system because they want to be seen quickly, and also the interesting trade-offs that they make around being assured by getting a test done versus waiting four hours. They are prepared to wait four hours if they know they get a test or a product at the end that gives them some conclusion about being well or unwell. There is something also about how we give people that confidence in regard to decision-making about the priority of their ill health. We need to take this sort of data and think of it as a social model as to how we help and give people give confidence around their distress and lack of confidence in the local system.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): From the College's point of view and on a national basis - I do not have figures just for London - there is evidence that UK residents use A&E services less often than most other developed countries. Most other developed countries would have much higher numbers of A&E attendances per capita. It is not necessarily true to say that this is the UK and we are terrible and we all go to A&E. That is not true. We recognise that at least 15% to 20% of those attendances could be dealt with by primary care and I would also add pharmacists, physiotherapists and all of those other services.

We talk a lot about locating primary services. For me, at the College, we do not mean just GP services. We are talking about a hub around the A&E department of all the different facilities that may be required on a local basis: dental if that is a particular issue but certainly a 24-hour pharmacy, access to a GP practice, nurses, etc, as a hub because we know that this is where the patients are going to come to A&E. Trying to divert them has not worked but caring for them in different environments within that hub would make sense.

Andrew Boff AM (Deputy Chair): Is that a model that economically can be rolled out to 19 A&Es?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): The trouble for London is that the A&Es are usually landlocked and as to how you make them bigger in terms of land. Often in parts of London they are in old buildings or brand-new buildings that may not be designed for the numbers coming through these types of services. It would be a challenge to do that. We are clever people. I am sure we could come together to look at the different environments and different departments. However, how would you fund those when we are in a period now where we do not get enough funding correctly through the A&E as it is let alone asking for more money to build on more services where the evidence, they would suggest, may not be there at the moment?

Ian Niven (Head of Healthwatch, Brent): I would like to back that up. Lots of people have solutions to some of these problems but they never seem to get everybody coalescing around one particular model in a strategic way. You mentioned the Mansfield Report, which looks at just North West London. Where is the rationale for the plan? Also, it is funding that you are talking about. Part of that deal was that we needed to have some closures of services and rationalising in order to fund these changes. Unless they are modelled absolutely spot on, it causes another problem somewhere else, does it not? That came out in that report.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): It is chicken-and-egg. This is the problem. If you have to close down services before you have built up the other ones, how do you do this to match demand? That is very difficult.

Andrew Boff AM (Deputy Chair): On a slightly different topic - but it was touched on earlier by Ms Reith - what are the special provisions in place for A&E staff when dealing with people like rough sleepers and homeless persons who have probably not registered? Are A&Es geared up for dealing with the issues related to homeless people and rough sleepers?

Lorna Reith (Chief Executive, Healthwatch Enfield): There was a report that Healthwatch England did probably about a year ago now that looked at what we call 'unsafe discharge'. It did find across the country homeless people being just discharged from hospital without being found somewhere to actually go and so back onto the streets. That was a national one. I do not have the figures for London.

I suspect that highly-pressurised A&E departments are not best placed. For patients who are not registered with a GP, A&E departments should be advising people and helping them get registered. We are aware that they do not do that because they have other things that they need to be doing. They may say to someone, "You need to go and register", but they do not actually get them to the next step.

Andrew Boff AM (Deputy Chair): The last thing on the mind of a rough sleeper is whether they are registered.

Lorna Reith (Chief Executive, Healthwatch Enfield): Exactly. Those people are going to need quite a lot more help. I know some hospitals have set up a homeless unit. University College London Hospitals may have something - it is not my patch - and certainly North Middlesex Hospital did for a while, but always these are the sort of things that get pushed to the margins. I do not know what evidence you have across London.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): We do not have a significant problem around homelessness where I am. It would be more of a central London issue. I cannot really answer the question fully. I think the principle, whether it is homelessness or whether it is people with mental health crises, is that there has been a tendency to not manage them in the most effective way. It comes back to the earlier points around understanding your population or your cohort, and being able to have the most appropriate intervention to be able to more effectively manage that.

We are doing work on crisis care, particularly around people with mental health problems, where traditionally the place of safety has been the police station. It is getting that pathway right for really clear cohort subpopulations and targeting them in the most effective way.

Andrew Boff AM (Deputy Chair): Is it fair to say that it is not so much about access to the A&E but the discharge after they have visited the A&E that is your concern?

Lorna Reith (Chief Executive, Healthwatch Enfield): That is the opportunity to intervene, is it not? If somebody comes to A&E, it is the opportunity to see them as a whole person and to treat whatever the presenting problem is. If you want to make sure they do not come back, come back and come back, you need to go to the next step, which is to get them access to primary healthcare and to get them access to some sort of accommodation.

Andrew Boff AM (Deputy Chair): For somebody who is not homeless, perhaps you might be in contact with some kind of community care support afterwards, but you are saying that is not there for homeless people?

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Traditionally in terms of primary care we have had homelessness-type GP practices where they are much more flexible and much more about going out and supporting patients in the community. We have had those in place and they

have been relatively successful. Again, they vary across London because of different demographics and how that shifts over time. Certainly we have made a lot of approaches to having a very different and flexible model to people with different types of needs.

Ian Niven (Head of Healthwatch, Brent): In Brent, the CCG and the local authority built integrated teams based at Northwick Park, St Mary's and some of the other hospitals to deal with discharges far better. There are joint teams of social workers and health professionals sitting in the same office in the hospital.

Andrew Boff AM (Deputy Chair): We have talked about different economic profiles. Are there any particular communities that have particular problems accessing A&E, perhaps non-English speakers and people like that? How are we addressing those issues?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): A&E is the catchall. We have access to translators. It is a recognised brand and people worldwide would recognise that is where they would go to access healthcare. There are particular groups who come to A&E and will use A&E and it is how we encourage them to use better services for what they require. The care provided by A&E would not be described as deficient for a particular group, including the homeless or people with language disorders, because we are well aware of the multicultural environment that we live in.

Lorna Reith (Chief Executive, Healthwatch Enfield): We have done some work with 12 other Healthwatches in the north central east London area. We trained up people who were deaf British Sign Language (BSL) users because there are never very many in any one area. We trained a group of people and they went off and they did what is called 'Enter and View', which is using statutory powers to go in and look. They went to three A&E departments and a report has been written up. That was quite interesting. Those A&E departments were not very well provisioned for a profoundly deaf person turning up with the support that they had. Language Line is not something you can use if you have someone who is a BSL user. There is a way to go. There are a whole load of recommendations in those reports; I do not need to repeat them here.

A&E is where everybody goes. The main aim is to see if there is somewhere that is more appropriate and can we get them into other systems, but there is still a way for A&E departments themselves to go in meeting needs.

Andrew Boff AM (Deputy Chair): What is encouraging is that you mentioned deaf people. I recently did a rapporteurship about access to health services for deaf people. It is encouraging to know that there is still work going on. You are absolutely right. We still need to go quite a distance in order to resolve some of the problems deaf people have in accessing health services.

Dr Andy Mitchell (Medical Director, NHS England (London): We have a lot of work to do on particularly vulnerable groups who are deprived and having real difficulties. We do not provide the kind of bespoke service that they need. In fact, your report in regard to access for deaf people was discussed in our clinical governors meeting yesterday. It gives us a focus to begin to understand what those population subgroups actually need. We do not do that well enough and there is a considerable amount of more work to be done.

Ian Niven (Head of Healthwatch, Brent): In terms of reconfiguring services again and the impact on different communities, Brent Council had pointed out that closures at Central Middlesex and Hammersmith A&Es, which happen to be in the most impoverished areas in those boroughs, resulted in longer travel times. There are issues there. That is a group of people with a higher level of support needs and health needs. Some people have questioned those very decisions. Putting it bluntly, people have been saying, "Why is it that in this wealthier area the hospitals have been maintained and why in this much poorer area are very good and

recognised services closing? What is going on there in terms of clinical numbers, needs and equality assessments?"

Dr Andy Mitchell (Medical Director, NHS England (London): The only point I would make in response to that - and I certainly recognise the sensitivity around this - is in terms of outcomes. There is not any proof that your outcomes are better if you live in close proximity to a hospital. There is a whole range of other services that can be provided in community settings and which influence outcomes more than just proximity to hospitals.

Murad Qureshi AM: This has been touched on in a number of ways: the wider configuration of urgent care. We know that patients are confused about available alternatives to A&E. It is one of the things that we need to spend some more time on, obviously. What progress has been made in developing new models of urgent and emergency care across London?

Dr Andy Mitchell (Medical Director, NHS England (London): This goes back to Bruce Keogh's report. It is not just a London report. It applies to the whole country. We took on board very clear messages that the public was - and continues to be - confused about the way they gain access to services. In my experience of many of these reviews, this was perhaps one that was conducted the most sensitively in taking on board exactly what it is that patients want from those services.

Part of that, of course, is the work that Conor has just referred to, undertaken by a behavioural insight team. For the first time ever we have tried to co-design services alongside groups of the public to meet specific needs. We are still at a stage where we are beginning to formulate exactly what it is and how bespoke those services need to be for various population groups. Getting that understanding has been critical. We have much better insight as a consequence of that work than we had, say, four or five years ago. A lot of work was done in the review focusing on what it is that patients want.

Secondly, the question was how we design a system that best meets the needs based upon much of the groundwork that had been done. We have derived a system, which are the networks that have been referred to already, whereby there is a more systematic approach to delivering healthcare services so that patients get the care that they want at the point of care that is closest to them and most appropriate. Again, this is a system-wide issue. It is not just an individual issue about A&E services.

We have gone quite a long way in terms of defining and developing systems with specifications that patients will understand - hopefully because they have been designed with them - that will provide a more coherent, easily measurable and higher quality flow around patient care than we have had hitherto. We have learnt a lot in the last couple of years by doing the national debate and by extrapolating that to London. London, to be honest, is actually a little bit further ahead based upon work that we have done over several years. This has crystallised our thoughts about the design of the system. We have launched the specifications with regard to what this model looks like only recently at the meeting that Conor referred to. There has been very wide professional input into this but we have to take on board what patients want throughout the process. Of course, you can never do enough of that and that is part of the problem.

Murad Qureshi AM: There is an example that is close to home for me of St Mary's [Hospital] in Paddington. There is an A&E there and there are also urgent care facilities available at St Charles [NHS Urgent Care Centre]. I have heard locally in the community from those who are in the know that, given what conditions you have, you may well be much better off going to St Charles and being dealt with. It is not locally known that you will save yourself the long queues at St Mary's that there always seem to be at the A&E. People have not made a distinction about where to go when something is desperately urgent and needs to be critically dealt with now,

and when there are other things that need double time that you can be relaxed about and walk into St Charles. Presumably there are benefits to that and that is why it has been set up.

Dr Andy Mitchell (Medical Director, NHS England (London): St Charles may be the only stand-alone urgent care centre in --

Lorna Reith (Chief Executive, Healthwatch Enfield): No, Chase Farm.

Dr Andy Mitchell (Medical Director, NHS England (London): I was thinking about North West London. The vast majority are co-related. What we need to ensure then is that there is appropriate triage and diversion to where the most appropriate care will be received.

What we have tried to do - and we are still in the early stages of refining and finally confirming these specifications - is to produce and define a system whereby patients have a clear understanding of the nature of the service that they will receive if they go to point A as opposed to point B. We also need them to understand that once they are in the system, the networking system will look after their needs no matter what so that they do not get bounced around the system like a pinball, because that is what is very frustrating to patients. We need to make sure that what we put in place actually streamlines patient flow rather than has them ejected from the system at intervals. That is what we are trying to design.

Murad Qureshi AM: I am struck by Lorna's point about pharmacists being in the A&E and dealing with a lot of issues that an A&E nurse may find themselves dealing with as they are usually the gatekeepers. Personally, I go to the chemist rather than my GP for most of my needs.

Dr Andy Mitchell (Medical Director, NHS England (London): Pharmacists probably see more proprietary urgent consultations than any other group. We do not recognise that sufficiently. They are a valuable resource that needs to be tapped into more than we do currently.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): Co-locating those services - the 24-hour pharmacy attached to the hospital hub or urgent care hub – I think would be very important. I think the standards that have been alluded to coming out of NHS London have been very helpful at defining what an urgent care centre should be and therefore now being able to stabilise on one terminology, whereas previously for patients there had been a whole lot of terminology in terms of what the stand-alone centres are called and the services they offer. It is the responsibility of all of us to be helping the public understand what services are out there and the best way to access them.

Dr Onkar Sahota AM (Chair): One of the issues would be that we are then expecting the patient to make the right decision in choosing the right place. What is the rate of transfer from urgent care centres to A&E departments?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): There is a rate. The important thing from the Keogh [report] and from the St Charles experience is that there are good links between that urgent care centre and the central A&E hub. The A&E will be able to provide advice back to St Charles and patients will be transferred to and from, quite correctly so. It is a question of us making sure that the public have the ability to understand their best choice. Where that choice has been incorrect, we can rapidly transfer them back into the correct choice. The specifications certainly help with that. That is an area that was dealt with.

Dr Onkar Sahota AM (Chair): I heard a figure mentioned that of the 75-years-old-plus group attending the urgent care, 40% of them had to be transferred to an A&E department.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): That is not a figure that I would recognise. I do not know where that has come from. Obviously, I will bow down to what research shows.

Dr Onkar Sahota AM (Chair): What is your understanding of the figure, then?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): My understanding is that the stand-alones can usually care for a lot of the patients that come. There will be a few who will be transferred not necessarily immediately but sometimes the next day to be reviewed or brought into separate appointment systems. They integrate very well with us. For the number of patients who arrive who actually have a serious illness and need, the transfer systems are in place to achieve that.

Ian Niven (Head of Healthwatch, Brent): In Brent, we have a stand-alone urgent care system at Central Middlesex and then a combined A&E and urgent care at Northwick Park. Central Middlesex is quite underused. It is a confidence thing. Transfers obviously work very sweetly. There is a triage system as soon as you go to Northwick Park. At Central Middlesex there is no automatic ambulance and transfer. They have to phone up an ambulance to get somebody transferred if they have gone to the wrong place. If it was me who was going or taking somebody, I would go to Northwick Park. I would bear the queues and the waiting to be certain there.

If I give you one patient example from Brent, he fell over and damaged his face and said, "I will not go to the A&E. It is not life-threatening. I will go to the stand-alone. I will walk to the urgent care". He did then get transferred from there to Northwick Park. He got to Northwick Park and they needed to get a specialist from St Mary's to come across.

It is a complex system. The concern for me is that simple clear message of where to go and, ultimately, confidence. It is the confidence of patients that when you go to that service that is what you will get.

Dr Onkar Sahota AM (Chair): People have confidence based upon patient experience.

Lorna Reith (Chief Executive, Healthwatch Enfield): Our urgent care centre at Chase Farm on paper looks very successful. We have heard no poor reports about it. You get seen very quickly, well within the target, with no problem at all. It is open until 10.00pm. I still find people who do not know about it. Given the huge fuss there was when the A&E was closed - because that is always highly controversial - you would think that people would have looked to see what was going on there. However, people do not pick up something until they need it. What people are unaware of is, yes, you can get X-rays there. If your child has fallen off their bike and you think they have broken their arm, do not take them to North Middlesex A&E on a Friday night; take them to the urgent care centre. It is getting those messages out to people. People want to know, "What can I get there? What tests can you get? Can you have a [broken limb] set in plaster? Can they do X-rays?" What people do not want is to go to one place and then be sent off somewhere else.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): I agree with what everyone is saying, but there is a danger if we concentrate on facilities and concentrate on trying to influence patients who are distressed. I know it is only 900 people we have surveyed, but 56% of the people who go to A&E have had advice from somebody else that it is the right place to go, including GPs, including 111, including professionals. It is no surprise then that people end up there.

The confidence thing is important but we also need to provide support to help with that confidence. I go back to my earlier comments that what we are trying to develop is a response. When people are in distress they

know they can call somebody and they can talk through, not a clinical triage decision, but a conversation to say, "This is what I am experiencing. These are my problems. Can you help direct me to the right place to be able to appropriately meet those needs? Can you book me into an appointment at the GP at the urgent care centre or at the A&E?" That is where we need to move to, rather than necessarily expecting people who are actually distressed to make the right decision. Ultimately, if it is me, I am going to end up in A&E. I am going to make that choice for my child because I want the confidence to know that they are not seriously ill. I have done that in the last 20 years with my children. We need to find a different model to give people confidence or to support people to make decisions in a slightly different way.

Dr Andy Mitchell (Medical Director, NHS England (London): There is an important failsafe here that Julian Redhead mentioned. When patients make the wrong choice or receive the wrong advice and end up in the wrong place, the system actually caters for them and, through the integration of the services, deals with them appropriately, sets them on the right pathway and supports them so that they do not bounce around the system. That important failsafe mechanism is crucial.

Murad Qureshi AM: On Ian's [Niven] point about confidence, in some ways I daresay if people knew their anatomy a bit better - I certainly do not; if I said I had a stomach complaint, I would not be sure whether it was my kidney, liver or intestines that was playing up - that plays a role. I am almost advocating that everyone does biology at school.

Valerie Shawcross CBE AM: More health education.

Murad Qureshi AM: Better health education certainly would help. This may be a very central London thing but out-of-hours or 24-hour GP services in places like Soho seem to have quite a good impact, I think. Is that the kind of thing that could be rolled out in other parts of London?

Dr Andy Mitchell (Medical Director, NHS England (London): It is designing the systems that you need with local variation as necessary. GP out-of-hour services have a crucially important role to play. We could highlight their role further. They need to be part of a fully integrated system. They should not be functioning in isolation because they are an important part of the network and they need to be, as I say, linked in. You are quite right that they are important services that we perhaps need to offer a higher profile to.

Murad Qureshi AM: Certainly in Soho they are very keen on it. Coming back to a knowledge question about our own bodies, it is like when Kit [Malthouse AM MP] mentioned his shoulder pain and it could equally have been muscular as much anything that had been cut or broken. If I am wrong it probably means he needs a massage more than going into A&E.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): To me that is why you need this hub. You need the co-location because then patients will have that confidence because they know they have seen health and they have said, "No, this is the more appropriate place for you to go. It is next door and you will get sorted". Then next time you will say, "Last time that happened, but down the road there is the urgent care centre. That is the same as that", because the nomenclature is correct and the standards are there and so they know when they get there that this is what they can do and this is what they cannot. That confidence will then build. At the moment, with the multitude of names for different things and the different services, it has been very confusing for patients and they therefore do not have the confidence.

Valerie Shawcross CBE AM: Lorna and I have both referred to transport a little bit. For a hugely complex set of services, there seems to be scant customer information about how you navigate that service. If the principal access point is GPs - which, if I dare say so, are extremely inaccessible - it is just no surprise that people hit the wrong points or do not hit the right points in the right way. One would have thought that the

NHS itself ought to be - I will not call it a 'journey planner' - looking at a journey planner so that if you want to travel along this complex trip there is something that gives you some basic answers and some basic guidance and gives you some awareness of services that you might not have been aware of before. There seems to be no totality planning about customer access to the system. Perhaps that is because a system that is concerned with financial restraint and closing down, or reducing usage of some services is not thinking constructively about facilitation of access. It seems to be obvious that there is no really good basic 'how you access NHS services in London dot-com' to give you those basic pieces of information.

Lorna Reith (Chief Executive, Healthwatch Enfield): It is "NHS Choices", which is the website that you go to find out about GP practices. The NHS website itself is very good if you want to look up a particular condition or symptom.

Valerie Shawcross CBE AM: I can tell you all about a frozen shoulder. I live in Lambeth and I have some questions. Where do you go? Do you go to the Polyclinic? Do you go here? Do you to King's [College Hospital]?

Lorna Reith (Chief Executive, Healthwatch Enfield): I live in an area where there is an utter shortage of GPs, now recognised by NHS England, which means a lot of my neighbours are not registered because there is nowhere to register and so they have no other options. The NHS has been quite poor at planning across London for population changes with big areas of regeneration, huge population growth, movement of some households from inner London or further out, GPs retiring or whatever. That level of overall planning is incredibly poor.

Valerie Shawcross CBE AM: It is also about empowerment and power, is it not? It is about saying, "We decide where you go", rather than, "We can trust you to make some decisions yourself if we give you the information". You do get that feeling as a patient that you are the one who has to do as you are told rather than actually have some choices.

It is quite interesting that you mentioned culturally that people want instant access. Maybe some of that is unreasonable but, equally, there may be many medical reasons why that is a good thing to have issues dealt with early rather than later, certainly for young people.

Lorna Reith (Chief Executive, Healthwatch Enfield): There is plenty of evidence about, shockingly, the number of people whose cancer is diagnosed in A&E because they have not accessed primary care appropriately beforehand. Certainly, in the more impoverished areas those figures are awful. There will be that mixture of reluctance to go to the GP, fear, one thing and another.

Valerie Shawcross CBE AM: I do not know a young man who does not think he is going to live forever. That is a cultural issue about younger men, is it not?

Lorna Reith (Chief Executive, Healthwatch Enfield): Until they get a cold!

Valerie Shawcross CBE AM: I feel there is an issue about empowerment, information and accessibility on a very large scale.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): I agree. Your journey or route map is absolutely a fair point. If we use technology and had an app that said, "This is how long you will wait at your local surgery", in real time, for younger people that is what they use.

Valerie Shawcross CBE AM: Also, "Your pharmacist is absolutely superb and can do the following things".

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Exactly. It is the technology that we need to move to for those people with relatively minor conditions that can be solved in the system.

Valerie Shawcross CBE AM: Argos can do it. Transport for London (TfL) can do it.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): Correct. I absolutely agree.

Valerie Shawcross CBE AM: Why not the NHS?

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): I agree with that. The other point is that sometimes we have very complex systems even within how to get patients into certain services. It is hard enough for the doctor sometimes to navigate how to get the patient into those services let alone for a patient who knows what they need but just cannot see how they can access it.

Ian Niven (Head of Healthwatch, Brent): Systemically - working with health partners that are here - there is an absence of taking the public on a journey of thinking. I am not suggesting that is easy because, yes, they need a bit of thinking time and there are all different voices. I hear the design of new pathways, for example. This is going to be more effective, more efficient around GP practices and designing them. However, it comes back to that basic point. If patients either do not know about it or do not have confidence in it you are back to the beginning again. What worries some patients is if GPs are under quite a lot of pressure to send people down a particular pathway that denies them their right to choose. They will go down that pathway if it works, if it is better and if it makes them and their families well. That is the only basis upon which they will do that. There is a disjoint all the time between what strategically sounds like a good plan and a good idea and, like you were saying, how they actually behave.

Murad Qureshi AM: It is the big idea from the meeting: a NHS London journey planner for IT systems.

Valerie Shawcross CBE AM: There are some parallels but you do not necessarily know what your final destination is with this one.

Dr Andy Mitchell (Medical Director, NHS England (London): I could just say thank you very much. This has been a very helpful debate.

I did want to come back about your comments with regard to the culture of a medical practice very briefly. You are quite right that historically in the past - and I recognise that in myself even in my own clinical practice - we tend to adopt a paternalistic point of view. Many things have changed with that. What we are trying to do is really take on board what it is that patients want and to engage them in any decision and planning process. We have a long way to go, but the philosophy underpinning the changes we are making really genuinely have patient understanding, patient needs and patient empowerment at their core. That is something very genuine that I can speak to. I hope that reassures you that we are moving in that direction.

The idea of a journey planner is crucial. What we have tried to emphasise today - and we started off with performance - is that this is a whole system problem. It may be that there are difficulties at each stage. It is a multifactorial problem. There are multifactorial answers to it. We have to collectively own the issues, which is what the system resilience groups are attempting to do.

I come back to the point that I am confident in the approach we have adopted to the planning of care, to the specifications of the service and to the support systems we are putting in place - that we are in the right direction. What we have more to do about is this issue of patient education and supporting their behavioural change where it is necessary to do so.

Conor Burke (Co-Chair, Urgent and Emergency Care Transformation Programme): I have nothing further to add.

Lorna Reith (Chief Executive, Healthwatch Enfield): One of the things about the NHS is that people talk to other people in the NHS. I suppose it is quite refreshing to at least hear people say that it is very confusing for the patient out there. That is where we come in. We are Healthwatch. It is very confusing for us and we are supposed to be signposting people. The individual member of the public just does not understand how that whole system works and who does what.

Valerie Shawcross CBE AM: No, we are not told. It is not available to us.

Lorna Reith (Chief Executive, Healthwatch Enfield): It is also that you do not think about it until you need it and so it is quite hard to get messaging across. A move to something that is a simpler way of telling people where they should go for what - and maybe even the idea of co-locating things more on the basis that, if people go there, you would have your pharmacists there and so on - makes sense.

Ian Niven (Head of Healthwatch, Brent): I have probably made my point many times. Dr Mitchell, you and I share a slightly different view of - that is fundamental to me from today - your confidence around empowering patients. I completely agree with you that I see health professionals and the local CCG doing everything within their power and being completely committed to improving patient care. There is no question in my mind about that whatsoever. It is still - as Lorna says - health people talking to health people a lot and then going out and trying to give the message and that becomes the education. By that time, the patients are hacked off or those ones who are keen and interested. Then you have a battle on your hands because a decision has been made. Empowerment and engagement starts right at the very beginning of the conversation. That culture needs to change.

Dr Andy Mitchell (Medical Director, NHS England (London): I take that message on board. I fully agree that there is a lot more to do.

Dr Julian Redhead (Chair, London Region, Royal College of Emergency Medicine): For me, my colleagues in A&E would feel I was remiss if I did not raise this issue. I know the contract negotiations are ongoing and we do not know what the final contracts for the new doctors are. I think there is a great worry that if that contract has disincentivised doctors to enter into emergency medicine or does not encourage them to come into acute specialities, then London will be disproportionately affected and the recruitment crisis that we see across London will get worse. We need to be very careful and watch very carefully what is happening with those negotiations.

Dr Onkar Sahota AM (Chair): Thank you, Julian, and thank you to all the witnesses for your contributions. If you remember that there was something that you wanted to say, if you have forgotten to add something or if there is some evidence that you have said you can provide to us, please do so. Write to the Secretariat and we would be delighted to look at that evidence. Can I thank all the guests for their contributions?

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