



Health Committee

Oral evidence: [Urgent and Emergency Care](#), HC 960

Tuesday 21 January 2014

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Members present: Stephen Dorrell (Chair); Rosie Cooper; Andrew George; Barbara Keeley; Charlotte Leslie; Andrew Percy; Mr Virendra Sharma; David Tredinnick; Valerie Vaz

Questions 1-159

Witnesses: **Professor Sir Bruce Keogh**, Medical Director, **Professor Keith Willett**, National Director for Acute Episodes of Care, and **Emma O'Donnell**, Deputy Director for Acute Episodes of Care, NHS England, gave evidence.

Chair: Welcome back to the Committee, to discuss a subject you have spent a fair amount of time on in the last few months and years. Could I ask you to briefly introduce your two colleagues?

Professor Sir Bruce Keogh: Certainly. This is Professor Keith Willett, previously professor of trauma and orthopaedics in Oxford and now full time in NHS England as director of acute care, and Emma O'Donnell, an NHS manager, who is Keith's deputy.

Q1 Chair: Thank you very much. You are all welcome. I would like to begin, if I may, with yesterday's announcements on tariff changes. The Committee would like to understand where the thinking is about changes in the tariff. There is clearly a recognition that the previous structure was impeding efficient use of resources, response to demand and so forth. Should we see the changes announced yesterday as a long-term change or are they a fix to get us through the short term?

Professor Sir Bruce Keogh: Can I just give you some background to the thinking, Chair, because I was part of the NHS management board that considered these originally? Admissions had been rising at 4% to 4.4% per year for about eight consecutive years, and we felt that acute trusts had no real incentive to help keep people at home who didn't need to be in hospital. So we agreed to split the tariff in such a way that anything over the 2008-2009 baseline in terms of activity would only be paid for at 30% of the tariff rate; the remaining 70% would be put into a pot and the trust would engage in discussion with commissioners on how that 70% could be used. That became effective in the operating framework for the NHS in 2010-2011. Monitor subsequently reviewed that strategy to see whether it had any impact. What we saw almost immediately was a very rapid reduction to less than 1% in the growth of admissions.

What has been a bit more tricky, frankly, over the last three years during the transition has been to really work out whether that money has been actually used for that purpose. We are embarking on new measures to radiolabel that in a way that makes it absolutely identifiable.

In May last year Barbara Hakin, as director of operations, wrote out to the urgent care working groups saying that they should have responsibility for ensuring how that money is used. You will recall from discussions last time that the urgent care working groups are, if you like, groups of people who have a vested interest in ensuring that local urgent care works properly—local authorities, commissioners, providers, NHS England, Monitor and the TDA. or 2014 we have clearly identified this money in the CCG budgets. We have determined that it should be used by the urgent care working groups, and that will be assured by NHS England.

One of the misconceptions that are around is that all emergency admissions are being paid at only 30% of the rate. What it really amounts to in real terms is only 3% of the urgent admission activity. So, for the average trust, we estimate that that would work out broadly in the order of about £1.5 million. This is not something new and we will be looking at it over the course of the coming months.

Q2 Chair: Let me just be clear. What is the scope, therefore, of this tariff if it is only 3% of admissions? This is not a tariff around emergency admissions.

Professor Sir Bruce Keogh: The idea was to try and reduce growth. Hospitals were already fully funded for activity at the 2008-2009 level, and the idea was to try and stunt that growth so that it would not grow any further.

Q3 Chair: I understand that. Your point was that only a comparatively small proportion of the revenue of an individual acute unit was affected by this split-rate tariff. I was looking for clarity about which admissions were affected by that split-level tariff if it is only 3% of admissions. I thought it was actually related to accident and emergency activity.

Professor Sir Bruce Keogh: No. Do you want to come in?

Professor Willett: Yes. When we talk about activity in hospitals—there is clearly somewhat of a confusion here, and it always exists, particularly in the media—when we talk about A and E, we are talking about people attending, many of whom, 80%, will go home. When we are talking about acute admissions, we are talking about all the unscheduled patients who come in through the A and E department or through other routes as urgent cases. That is the cohort of patients we are talking about to which the tariff is attached. They took the baseline at 2008-2009. That is still paid at the full level, or the tariff level, for this year. It is just the increase on that which is affected by the marginal rate, so it is a relatively small amount of money; but, as Sir Bruce says, it is the 70% which is the bit that has caused concern. One of the changes that have been indicated going forward is that the CCGs, working with providers, where they agree the baseline is now inappropriate—and that may be because service configurations have changed or individual services have changed—in those circumstances can reset the baseline to make it more appropriate. So, for some of those trusts that were perhaps unreasonably penalised, that can now be corrected.

Q4 Chair: Going back to my original question, is this simply a relatively minor change of an existing process—

Professor Willett: Yes.

Q5 Chair: —or is it a rethink? It is not the rethink that the urgent care review was promising.

Professor Willett: No.

Professor Sir Bruce Keogh: No, certainly not. We will come on to that, I hope.

Chair: Thank you.

Q6 Charlotte Leslie: Thank you very much for coming. The public are understandably concerned that our A and E system needs to be resilient to meet a winter crisis. Can you give reassurance to the public that the system is more resilient than it was last winter?

Professor Sir Bruce Keogh: I think we can. The first thing that I think was different was that this year we started planning for winter much earlier than we had done for previous years. We started planning in May. The second thing that we have done as part of this is put urgent care working groups into place, and I have already alluded to that. The next thing that we have done is put national oversight on to those urgent care working groups, so that we have Monitor, the TDA, the Association of Directors of Adult Social Services and so forth, who will tackle problems that have been identified by the urgent care working groups. They also provide oversight of local plans for those groups.

What we have also done differently is that we have given the winter moneys somewhat earlier this year. Normally they are given out towards the tail end of the year. This time we have given two lots. The first lot we gave in September, which was £250 million, and then that was subsequently supplemented in November by another £150 million. What is different with the moneys this time is that they have been given to those communities where we think the patients are most at risk of problems in winter. That money is not being given just to the hospitals; it is being given to the communities that are served by those hospitals. So £371 million of that £400 million has been given to communities; £15 million has been given to help beef up 111 in anticipation of additional calls; £14 million has been given to ambulance services; and £7 million has been given to specialised services because there are some specialised services which come under particular pressure over winter. Obvious examples would be adult intensive care unit, neonatal intensive care and ECMO, which is a pretty complicated process for putting oxygen into people's blood when they can't breathe on their own.

The other thing that we are doing which I think is different this year is being utterly transparent about the data. We are putting it out on a weekly basis in a way that we have not done before, so that the public, the media and, most importantly I think, local communities can scrutinise it. We have also started to look at how the private sector might be engaged in the event of a surge through hospitals coming in through A and E. One of the issues under consideration is that, when the going gets rough in winter, often one of the big impacts is on elective care, so waiting lists start to drift out; could elective care be shifted more into the private sector? Also, Barbara Hakin has had meetings not only with the private sector but also with the voluntary sector to see what they can do to help.

I think we are certainly better prepared than any winter that I have been involved with before, but I think it would be foolish to be complacent because there are always things that can pop up like outbreaks of flu or norovirus or something.

Q7 Charlotte Leslie: Let's just hope the sun keeps shining. Often, to be honest, in most emergency departments during winter they consistently miss the four-hour target. Do you think that that four-hour target becomes meaningless, in a sense, in that you cannot expect departments to meet it during a winter crisis? Has it lost its purpose?

Professor Sir Bruce Keogh: As medical director, I can never say a target is meaningless because the moment you say that people stop aiming for it. There has to be an ambition and people have to try and meet it. I am glad to say that we tend to regard the target on a longer-term basis. This year we are at week 41 into the year and we are at 95.8%, so we are doing pretty well. The target has become a source of pejorative discussion at times, but we have the most exacting targets, both for our A and Es and for our ambulances, of anywhere in the world. It is something we should be proud of and I think we should strive to meet that target, because when patients have to wait, either to be dealt with or admitted, it is not fair on them. But we should also not forget that the average waiting time in A and E is only 50 minutes.

Q8 Charlotte Leslie: We have seen previously that some problems arose because of people hitting the target and missing the point. What penalties are applied to those units that consistently fail to meet the target, and are you concerned that the penalties may be tackling the wrong things? You may be beating a horse with a stick when actually you need to look at the underlying causes of them not meeting those targets, and, particularly if there are financial penalties, they can make a difficult situation worse and lead people to try and hit targets and incentivise them to miss the point.

Professor Sir Bruce Keogh: To answer the latter part of your question, there has been quite a bit of controversy about the distribution of the winter moneys this year. There are those who feel that the winter moneys have been directed to those who have apparently failed in delivering the targets, which is why I said a few moments ago that we have tried to direct that money to the places where the patients are most at risk. That is something that we have done differently. There is a debate around the four-hour target, but you may be interested to know, for example, that most states in America and many places in Europe have no idea what is going on in terms of these targets. Australia, which has got some grip on it, is only meeting, I think, 64% for their four-hour target and only 29% for four-hour admissions, and their ambition is to hit 90% by the end of 2016.

Q9 Charlotte Leslie: I have one final question which I have been asked to ask by some concerned constituents; it is to do with patient safety. My constituency borders Wales and there are obviously differences in the healthcare system there. Was the Keogh mortality review helpful in finding out where there were big gaps in care and—obviously it is difficult for you to give an opinion—would something like that be helpful in Wales, do you think? I have been asked to ask this by a concerned constituent.

Professor Sir Bruce Keogh: Yes. I know that is a source of discussion in Wales at the moment and I know there are differing views among colleagues in Wales about whether this would be helpful or not. My view is that the process of review itself stimulates improvement. I tried to conduct those reviews in a different way—and I won't go into it in

detail—but one of the things that had bothered me about so many of the other reviews that had gone on was that people went into somewhere and said, “You’ve got a problem,” and somebody else came in and said, “You’ve got a problem,” and of course the trusts knew they had a problem. What they needed was help. Any review process of organisations that are struggling—and there are some issues with access times in Wales—that offers a significant chance of improvement is worth pursuing.

Q10 Barbara Keeley: I did not want to leave the point that you made, Sir Bruce, about allocation of funding because, broadly, you have allocated this extra funding to areas which have failed in the past.

Professor Sir Bruce Keogh: Yes.

Q11 Barbara Keeley: My local authority, my local hospital, did not get any of that funding, but the point is there is a kind of future thing as well. The LGA in their evidence to us said that only 7% of the initial £250 million was earmarked for adult social care. What is happening while you sit there with the allocations that you have made is that, across the country, local authorities are changing the position by changing their eligibility—a lot of them because of the central Government cuts. My local authority is just about to remove social care funding from 1,400 vulnerable or disabled people. What will that do to the position in our local authority, Salford, when those 1,400 people suddenly do not have social care? It seems to the LGA and to me grossly inequitable to go on the past. It is constantly fighting the last battle, isn’t it? “Look back. Where have we failed in the past? Give them the money.” You need to look forward as well. Somebody somewhere needs to be keeping an eye on what local authorities are being pushed into doing by central Government budget cuts and say, “What happens there?” What happens when 1,400 people in one area suddenly lose a care package? You can put two and two together, the same as I can.

Professor Sir Bruce Keogh: Can I just say thank you for that? I can’t answer it, but I can certainly take it away.

Q12 Rosie Cooper: Can I ask what happens if you don’t put that money into A and E? Do people just die?

Professor Sir Bruce Keogh: I am sorry but I do not quite understand the question.

Q13 Rosie Cooper: If you do not allocate the money to failing A and Es or to A and Es that are not coping, what are we saying—that we don’t allocate the money and people should therefore suffer harm?

Professor Sir Bruce Keogh: I don’t think I said that.

Q14 Rosie Cooper: No, no, no, but, if you take Barbara’s question and your question, there is not enough money in the system. I am saying that, if you are going to allocate it to local authorities, then what is going to happen is that the crisis in A and E will be even worse.

Professor Sir Bruce Keogh: Thank you.

Q15 Valerie Vaz: I just want to pick up on some of the comments you made about this additional funding. I don’t know if you have had an opportunity to have a look at some of the written evidence. The Royal College of Physicians of Edinburgh says that the money that you

are allocating needs to be looked at for the long term “rather than the current reactive response.” The Royal College of Nursing is talking about it as a sticking plaster, and I think the NHS Confederation also is concerned about “sticking plaster solutions for emergency care.” I know that you are very excited about giving this money and it sounds very good, but this actually isn’t new money, is it? It is an underspend from the savings that many of these providers have had to make.

Professor Sir Bruce Keogh: In addition to that, the winter moneys became so routine that people wrote them into their baseline budgets and used them for whatever they felt was most appropriate according to their priorities at the time. So I think your points are absolutely correct, which is why one of the work streams as part of the urgent and emergency care review—and I will ask Keith to say a couple of words about this in a minute—is to try and introduce a more secure footing for funding. Another area is to think about how we can alter the way hospitals handle different work streams during different seasonal demands, and how we can alter the tariff in such a way that hospitals actually get the money to deal with what they need. And a point that is really important is that A and E is where the problem is manifest, but the problems lie, I think, as Barbara Keeley has said, in social care, primary care and community services. We need to look at smart ways of providing funding that enables us to link all of those up. I think Keith has some early thoughts on those.

Professor Willett: I think Sir Bruce is absolutely right in saying that this is temporary money, based on what has been done in the past, to deal with an issue. The issue is not around people dying, I would say. A and E departments, the emergency services, are all about managing risk; that is what they do. If they are insufficiently funded, then what happens is the quality goes down. Risk does go up, but they will protect that.

We want to look to the future. We have to have a system that will work going forward. This is very much a holding position. That is what we are in. I think the evidence we gave last time was that the system was unsustainable; we do what we can, using the efficiencies in the current system, to make it last.

Going forward, we have inherited a commissioning structure which is very fragmented. Not only is the clinical care fragmented, which is what your constituents will tell you—the GP does not know what the hospital is doing and the out-of-hours hospital services don’t know what the paramedics are doing—but we have inherited a fragmented system as well. General practitioners are commissioned on a capitation basis and the number of people they look after; ambulance services are commissioned in a different way; the hospitals are commissioned on a tariff basis by activity; and then community care is a block contract. We are in a position where, even if we try to bring everybody together to share outcomes for patients so that we can commission a whole pathway of care that our patients and your constituents would understand, when we try to do that and come to allocate the money, again we are still stuck with those methods.

One of the large pieces of work stream that we are doing within the review will be to look at that whole funding structure, and there are different ways we could fund such that we could plan to support what we have asked for in the review, which is to support more activity out in the community. The ideal place to treat most people is as close to their home as possible with the support they want. If we are going to need to move money in

that way, we have to be able to have incentives in one place with an activity change that fits that.

Q16 Valerie Vaz: With the greatest of respect—and I know there are lots of members who want to come in—I want to focus on this particular thing, and we will come on to the review. Could I point you to a graph from the House of Commons Library? They are saying that the non-winter A and E attendances have gone up rather than the winter ones—and everyone seems to think that this is a mild winter so the problems really haven't hit us yet—so is there going to be more money available?

Professor Sir Bruce Keogh: The decision as to whether money is available is a decision made by the Department of Health, not by NHS England.

Q17 Valerie Vaz: But you are aware of this graph, are you?

Professor Willett: Perhaps I can answer that. I think there is a misconception. The two quietest months for A and E attendances are January and February every year. January and February are the quietest months every year for A and E attendances. The problem is not A and E attendances.

Q18 Valerie Vaz: I don't know what you are saying. Are you saying that the House of Commons graph is wrong?

Professor Willett: I have not seen the graph. What I am saying is that, every year since we have had records, A and E attendances—the number of people turning up at A and E—is lower in January and February than at any other time of the year. The issue in the winter is not the numbers of people attending; it is that in the summer, because of daylight hours and everybody is active, a lot of people will turn up who are younger with minor injuries or minor ailments. The majority of those are seen in A and E and then sent home. In the winter, the activity in the general population goes down. People don't fall over in the ice and snow; that is a misnomer. What we see in the winter is a doubling in the number of people, usually with long-term conditions, who are frail elderly, particularly with respiratory problems such as asthma or bronchitis. That number of patients doubles. All of those patients, unlike the summer people, are people who are elderly, who need a stretcher, a trolley or a bed, and that is what logjams the A and E departments.

Q19 Valerie Vaz: Who is attending now? What is the cause of these massive attendances? Do you say it is a majority of elderly people?

Professor Willett: It is the same; the pattern is identical year on year.

Q20 Valerie Vaz: Moving on to discharge—and certainly this is something that has been raised by the hospital in my area, Manor hospital—do you see that there is a problem with delayed discharge?

Professor Willett: Yes; categorically, there is. The numbers that are measured are, I think, unrepresentative. That is because the marker that was put down was really designed, when it was thought about in the Department of Health originally, to be something that might be a marker of social care function. It has never actually gone as far as that, but it has been retained. But there is little benefit for the hospitals to record it, and actually it does not mean very much, because if you have a community that can support patients with quite

high care needs we could move a lot of patients out very quickly. If you have a community that can support only low needs, then obviously patients have to get a lot better.

Q21 Valerie Vaz: Are you saying that they are not being supported now?

Professor Willett: No. What I am saying is that the opportunity is now to move—

Q22 Valerie Vaz: Is there a problem with delayed discharge?

Professor Willett: If the community services were better—

Q23 Valerie Vaz: Yes, so my next question is, rather than a lecture—

Professor Willett: —we could move more patients out.

Valerie Vaz: You have said there is a problem with delayed discharge, so is the problem related to a lack of social care and cuts in social care budgets?

Professor Willett: Not on the current figures. In fact, the delayed discharges appear to be as important in terms of moving patients across any—

Q24 Valerie Vaz: You seem to be disagreeing with the House of Commons Library a lot because, apparently, there are cuts of £1.8 billion in adult social care. Are they wrong?

Professor Willett: No, but they have been managing them very well. The published figures would suggest that the bigger problem has been moving patients into other environments, including within the NHS. The social care delayed discharge numbers have come down. That would show that they have been—

Q25 Valerie Vaz: So you say the numbers have come down, like Sir David Nicholson has said.

Professor Willett: Yes; those are the published figures.

Q26 Valerie Vaz: But the Secretary of State says they haven't.

Professor Willett: I don't know what—

Q27 Valerie Vaz: The Secretary of State told us in evidence that the problem is he has been talking to chief executives and they have approximately two wards full of people who could be discharged but they are not able to discharge.

Professor Willett: I agree, but what I am saying is the social care element does not seem to be the biggest problem.

Professor Sir Bruce Keogh: Can I try and help?

Valerie Vaz: Please, thank you.

Professor Sir Bruce Keogh: I think there is an element of this that we don't quite understand. If you speak to most people who work in a hospital, they will say that somewhere between 20% and 25% of people should not be there. As part of a national medical director's clinical fellow scheme, I have junior doctors who have gone in and looked. It seems as though there is that sort of proportion of people that don't need to be

there. What we have not dissected out—and this is something that we are working on—is whether those people are there because of social care or inadequacies of social care, whether they are there because we can't get them into other parts of the NHS, whether they are there out of convenience or whether they are there for some other reason. So we need to work on that. But, in any event, there are delayed transfers of care out of hospital.

Q28 Valerie Vaz: You say that you need to work on it, but should you not be doing that now and what are you actually working on?

Professor Sir Bruce Keogh: We are doing it now.

Valerie Vaz: Could you tell us what you are working on?

Professor Sir Bruce Keogh: But we perhaps should have done it a long time ago.

Q29 Valerie Vaz: That doesn't matter; you are working on it now, but what are you actually doing?

Professor Sir Bruce Keogh: Well, we have started some work in the operations department to try to identify exactly what the delayed—it has only just started so I don't—

Q30 Valerie Vaz: You can't give us a taster of what the problems are?

Professor Sir Bruce Keogh: No, not yet, I am sorry.

Q31 Valerie Vaz: Do you know when you are likely to?

Q32 Chair: Can I interrupt you for a second? It is an extraordinary thing to say that serious work into the causes of delayed discharges has only just started, is it not?

Professor Sir Bruce Keogh: Well, there has been some work which—

Q33 Chair: It is hardly a new theme.

Professor Sir Bruce Keogh: No, but I think whenever you start it will be too late. I mean, we have started.

Q34 Chair: Are you inviting the Committee to believe that none of your predecessors ever did any serious work on the causes of delayed discharges, because I really do find that quite hard to believe?

Professor Sir Bruce Keogh: No, we know about the causes of delayed discharges that Keith has referred to. What we are not clear about is some of the other causes of delayed discharges. That is what I am telling you.

Q35 Chair: Would Professor Willett like to comment?

Professor Willett: I was just going to say that the work that is going forward is on the money that has been allocated from the healthcare budget over the next two years—the integration transformation fund; it is that £3.8 billion. We will be looking at that interface. That is about how we move patients out of the hospital environment in particular and back into the community. That is money that will be used in that way. There is a lot of work going on now around the process by which the CCGs, the local authorities and the

provider trusts work together to ensure that that money is spent in an appropriate way to move those patients out, to support the social care sector or the community sector. That is the big piece of work that is going on. As to the analysis of who can't go where, to some extent we need to solve the problem rather than just go back and look at that analysis.

Q36 Valerie Vaz: I have one other thing. I know that Gus O'Donnell, when he was head of the civil service, was suggesting it to civil servants all the time, and I know Jeremy Hunt, the Secretary of State does it: it is fine if you are sitting in Richmond House, but you need to go down to the coalface and actually talk to the chief executives and front-line staff, so can I please suggest you do that? The College of Emergency Medicine know the reality of it. Can I suggest you do that rather than move paper around?

Professor Willett: We do.

Q37 Barbara Keeley: This is around the same issue really. I just think we need to say, in terms of the work of this Committee, with regard to the anecdotal evidence we heard—and it does tie in with what the Secretary of State told us—as to the causes and impact of delayed discharges, that the official statistics contradict what we heard anecdotally. We heard again and again and again—and it is here in the LGA evidence—that social care, lack of social care, lack of assessments and not being able to move forward on those were the issues. It wasn't just one person; we heard it repeatedly, and we heard it from the Secretary of State. There is a problem with the statistics, I have to say, and it is interesting that you say that you are just embarking on work on this, because the official position that you put to us is that that cause for delayed discharges is declining. It appears it is not. In fact it would be counterintuitive if it did because £2.68 billion has come out of adult social care. It contradicts what you have just said. How on earth can you be speeding up changing and improving the situation when all that is happening is money is coming out of adult social care? I have described to you what is happening in my local authority, which has lost more than £100 million in three years and is to lose another £75 million over three years. Adult social care is 40% of their budget. What do you think is going to happen? I just can't get my head round how you think this is going to improve unless you put in money of a similar order. In fact, that is not happening. What is happening is that money is going out of social care this year, in the coming months and even in the tail end of this winter. Is that not something that keeps you all awake at night, because, to be honest, it would keep me awake at night?

Professor Sir Bruce Keogh: Yes, it does bother us and I think it bothers everybody. We are trying to maintain a stable and improving service in the NHS at a time that our colleagues in social care are taking a massive hit to their baseline. Of course, the provision of services in the NHS is utterly dependent on having a joined-up health and social care system, and I think your points are very well taken.

Q38 Barbara Keeley: My local authority and lots of other places are faced with this yawning gap that is going to open up and there is nothing to be done about it, because the LGA told us that, of your extra funding that you put in, only 7% went to social care. When we discussed this with the Minister at this Committee—when you were talking about urgent care boards and your planning for winter pressures—I raised this question then. There was no answer and there is still no answer. Now you are months down the road and you say you have plans, and the position isn't better—it's worse. The position is actually worse.

Professor Willett: As to the winter pressures money and the 7%, what you are talking about there is the £400 million that was put in for the winter pressure. The money I was talking about was the £3.8 billion, which is the integration transformation fund.

Q39 Barbara Keeley: That is not new money either. That covers things like carers' breaks and adaptations. Only half of that is not previously-announced money. You are taking money that local authorities already have—the carers' respite breaks and the adaptations money—out of the money you have already announced. That is not new money. Also, I understand from the Care Minister that that is going to cover the new responsibilities for local authorities from the Care Bill. You are spending that money again and again and again, and half of it was spent anyway. So I don't think we can be in a situation where we keep on pointing to that one fund and saying, "That's going to cover everything."

Professor Sir Bruce Keogh: I think these issues might be better addressed by someone from the Department of Health.

Barbara Keeley: You should be raising it with them.

Q40 Andrew Percy: I just want to bottom this because we hear a lot about social care. I have two local authorities affecting my area, one of which changed its criteria a number of years ago—six, seven or maybe eight years ago now. There was not quite the outrage when that happened that we hear now from certain quarters. The other one has made a decision not to change its criteria. They are served by different hospital trusts, different acute trusts, but the demand for A and E services in both trusts has gone up the same, so can we just bottom? Is there any evidence that the changes in social care tariffs on the ground have made any difference at all to A and E admissions?

Professor Sir Bruce Keogh: I don't know of any, but we can send you a note on that.

Q41 Andrew Percy: Okay. It would be interesting to know because we hear it a lot—the link is made—but I would suggest, from my own area, that we have seen similar pressures in both hospital trusts despite the different social care criteria. My local council discussed changing the criteria and they decided to get rid of people earning over £100,000 instead and used that to provide the care. So there are solutions available to local authorities if they have the leadership to take them.

Moving on, when we had the LGA here, they made quite a bold statement in which they stated that actually delayed discharge wasn't an issue. I really want to echo what we have heard from other colleagues that there does not seem to be any clarity here. The LGA, who came before us, if you remember—and I have always found it a little unbelievable—stated that there was not an issue with delayed discharge and actually the situation had been improving in recent years. I would make the appeal that we do need to get some clarity on the data around us, because we are completely at a loss as a Committee as to who to believe, I think, as we do hear things anecdotally, and, similarly anecdotally, there are good things happening on the ground as well. There is this inability for us to really know—and it concerns me that you as NHS England don't seem to really know—what the pressure is in terms of delayed discharge and the impact it is having. That work needs to take place post-haste, I would suggest.

Professor Sir Bruce Keogh: Yes, I agree.

Q42 Valerie Vaz: Where are you getting the data from then?

Professor Sir Bruce Keogh: I will have to give you a note on that because it is not being done in my directorate.

Valerie Vaz: Okay.

Q43 Rosie Cooper: Can I take a point that Andrew has made, and you may not be in a position to answer this but it is just an interesting thing? I don't know of any local authority that does not almost charge/means-test people who take up the services they provide in a social care setting. Do you know of any local authority that just gives free social care willy-nilly to anybody without doing a means test?

Professor Sir Bruce Keogh: No.

Professor Willett: No.

Q44 Rosie Cooper: So this £100,000 is just not relevant then.

Professor Sir Bruce Keogh: Like I say, we are from NHS England. The way that social care operates is a matter for the Department of Health.

Q45 Andrew George: I have a couple of questions to follow up. One is a supplementary on the issue of the four-hour waiting time and the other is on the measurement of readmission. On the matter of the four-hour target, it was quite clear that you are suggesting or implying that obviously this is going to be here to stay. You are also implying that it is there as a guide, not as a straitjacket in terms of—

Professor Sir Bruce Keogh: No, I am not implying that. We have a target and we have to use it.

Q46 Andrew George: It is a straitjacket then. In that case, to what extent are you able to measure or receive advice from clinicians on the ground that the target distorts clinical priorities and has an impact on patient outcomes and patient safety? It is quite clear that the anecdotal evidence suggests that it does have a consequence for patients in A and E because of the obsession with the four-hour target to the detriment of patient care. Would you accept that that might be a possibility?

Professor Sir Bruce Keogh: I will ask Keith to say a few words on this in a moment, but I think it certainly introduces an element of stress for people who are working in accident and emergency departments, and, whereas that stress was primarily focused on managers previously, it has now become increasingly felt by medical and nursing staff. But Keith has worked in a trauma service and A and E for the whole of his career, so he is probably better equipped to answer.

Professor Willett: The bit of history that is important is this. If you talk to the College of Emergency Medicine and to emergency medicine clinicians, they would not get rid of it because it was the one thing that really changed their lives. As to this cycle of A and Es coming into difficult places, we have been there before and that was the thing that undid the problem in very short order. It is a very valuable way to focus the whole of the hospital—that is, the in-patient services, the managers and everybody—on making sure that A and E is given a priority. The difficulty we have, and this will be part of the review,

is that we will look at all of these elements, but the A and E standard that we look to is four hours. Now, that is four hours to complete your treatment and be out of the door, to be transferred to another hospital if that is what you need, or to be admitted to an in-patient bed if you are one of the 20% or 25% that needs admitting. It is not a four-hour wait to be treated but four hours to have completed the whole of that episode. That is quite an achievement, and, as Sir Bruce has said, it is the highest level of requirement internationally. The difficulty is that it is 95% of attendances.

Across the country, if you go to A and E for an injury or an illness and you are then discharged straight home again, most patients complete that in under two hours. If you are admitted to hospital, the average is three and a half hours to be got into a bed. The difficulty is, because we use attendance as the denominator, and I talked about that seasonal variation where there is a lot of activity in the summer, which is a single illness or injury that goes home, it is relatively easy to hit the 95%. In the winter, when that activity melts away because people have stopped being so active and the number of elderly and frail patients and those with respiratory disorders climbs, the denominator has gone down but the numerator has climbed a lot, so it is very difficult to hit the 95%.

That means that, going forward, we will have to look at things that are much more important to patients and clinicians other than a single target, which is what we have at the moment. Part of the review is that we will be working to look across the whole healthcare system to come up with measures that are far more meaningful and important to patients, to take away what can be some almost perverse incentives to perhaps deal with patients in a way that doesn't feel right. Clinicians will always do what feels right for patients, but it does create pressures and I would fully accept that. So, going forward, as part of the review, we have to change the standards we set so that they are broader and more patient and medically sensible.

Q47 Andrew George: In answer to my earlier question, you are suggesting there is an extremely useful and rather rigid guide, but not a straitjacket, which might have a consequence.

Professor Willett: No, I think it is really important because it does drive the system at the moment, but we need to replace it with things which are better than we have now.

Q48 Andrew George: You know that there are a lot of hospitals which have this sort of netherworld where you are not quite admitted; you are on an admissions ward where the staffing levels are often threadbare and the patients will be in a much more dangerous position in order to meet the four-hour target, effectively on trolley wards.

Professor Willett: No, I agree, and, if we look around, all the developed countries are in the same place—Canada and Australia. Everybody is trying to do the same thing and looking to come up with a suite of measures—metrics—that they can really measure accurately, that do reflect patient and clinical importance, but, more importantly, taken as a whole, do reflect the whole patient pathway. You take away some of those elements that could be distorting which you do not want to be present.

Q49 Andrew George: You are primarily looking at outputs rather than inputs, so you have no view on staffing levels and safe staffing.

Professor Willett: We want to look at outcomes rather than outputs and inputs. It is outcomes that really matter. There will be different ways to achieve those. There will be guidance going forward. That is what we are doing with the review. We will be looking at the clinical standards that patients should expect to be able to receive. We should be looking at the sort of skills that should be available to address that. So there will be some things around inputs and process, but it is outcomes we need to get to.

Q50 Andrew George: You won't address the issue which has been raised by the RCN and others in the evidence to us to say that there is a serious issue of understaffing in many of these settings and that clearly has a consequence for patient care and safety.

Professor Willett: I would agree that we have to look at the skills that are available and the amount of people. But, again, in the review what we have to do is decompress the A and E departments to give us the headroom to do the proper assessment. That is about supporting patients out in the community. When you read the phase 1 review, that is what we have got consensus on from all the patient groups and from the clinicians. When we went out to public engagement we had enormous support for those. In fact there was a 97% mandate that the system had to change in that direction to support people out in the community.

Q51 Andrew George: Yet you have no view as to whether a lot of the A and E settings—the emergency department settings—are unsafe in relation to the staffing levels.

Professor Willett: There is local incident reporting on all the safety issues, so that is in place. They are reported and addressed locally. Clearly, when you are in an environment that is a high-risk environment, the safety elements become apparent very quickly. What clinicians will always do is to prioritise those patients at greatest risk, and the result of that is that the experience of care for some patients who perhaps are not at risk goes down. That is something we have to improve.

Q52 Andrew George: So you are going to side-step the issue of safe staffing levels.

Professor Willett: It is not about staffing levels. It is about the skills that are available. You can have as many people as you like, but if they don't have the right skills you won't have a safe environment. We can put care-support teams in and whatever, but we need the right skills—skills that matter.

Q53 Andrew George: That sounds like management babble to me.

Professor Willett: No, I am a doctor; I am not a manager. I am a clinician and I have worked there for 30 years. I know exactly who I would want. I would know which nurse—

Andrew George: Maybe you have drifted into management.

Professor Willett: —and which doctor I would want to treat me.

Chair: Let us get back to staffing levels.

Q54 Andrew George: On the issue of readmissions, I understand that tariffs are set to penalise hospitals which experience patient readmissions within, is it, 30 days? Is that also used as a good measure by which you can assess the extent to which there are readmissions, and what is that telling you in recent years in terms of readmission levels?

Professor Willett: The concept behind the readmission is that, if you are assessing your patients properly, you are doing a full discharge and you judge all those things right, your readmission rate should be low. In other words, you have supported patients correctly in the community. It is a judgment about that interface. As medicines move forward again, although that is something that is important as a marker, it, again, is a process point, and as we move into a situation where we do a lot more of what we call rapid assessment, treatment and discharge, for a lot of older patients—particularly the frail and particularly now that 40% of our older patients have dementia—the hospital environment is not the ideal place for them. So a lot of those patients we would like to very quickly assess and move back into the community with the support they need. That is much better for them if we can provide the support. That is where we would be looking to go with the review and that is the sort of thing we are working on. But, as you do that, some of those patients—and there is a lot of art in here as much as science—will require readmission. If you have a very dynamic relationship in that you are trying to hold as many patients out in the community, a readmission may be quite an important part of that process because you would expect to have a certain number. So, going forward, we will be looking at that as well as to whether that is a proper indicator of good care.

Q55 Andrew George: But my question was about the pattern in recent years of readmissions. On a factual basis, what is the penalty level, in terms of a readmission within 30 days? What is the penalty?

Professor Sir Bruce Keogh: You don't get paid for it.

Professor Willett: You are not paid.

Professor Sir Bruce Keogh: We went through a process—

Q56 Andrew George: You are not paid, so it is a zero tariff.

Professor Sir Bruce Keogh: This is a separate issue to the emergency admissions put through A and E. We went through a process when this was being discussed, which was quite widely shared with the clinical community about what is and is not reasonable to expect. For example, people who have to come back for chemotherapy who would clock in as admissions on the administrative database don't count. So we have a significant series of inclusions. The other area that was debated is that, if you are making a drive to have day-case surgery, for example, the more day-case surgery you do, then the greater the proportion of readmission, as you might expect; and we are starting to see that.

Q57 Andrew George: So readmissions have increased in proportion and number in recent years.

Professor Sir Bruce Keogh: I think we are at about the same level that we were, yes.

Q58 Chair: I want to bring in David Tredinnick and move on to ambulance services, but, before I do, can I take you back, Sir Bruce, to some answers you gave earlier on about the responsibility that you have in NHS England for the delivery of NHS services? To several questions you answered, "Well, that is a matter for the Department of Health," implying that there was a very sharp divide between NHS services delivered by NHS England and social care services delivered by social care authorities responsible, through a different line, to the Department of Health.

Your report on urgent care stressed, as this Committee has done as well, the importance of breaking down that distinction—first point. The second point is that through the better care fund, whether or not it is new money, that certainly gives to the NHS an instrument to engage across that divide so that the issues that Barbara and Valerie were raising are no longer entirely matters for the Department of Health because they are matters within which NHS England should mix it, are they not?

Professor Sir Bruce Keogh: But NHS England does not set the budget for social care. What we are trying to do in NHS England is to bring parties around the table. We accept that there are very serious problems with funding in social care, so we take that as read. The place that we try and do that is through the urgent care working groups where we have people from providers—from NHS England, Monitor, the TDA, social services, local government and so forth. The aim of those groups is to identify where the problems lie for local delivery of, in particular, urgent care services, and in some cases it may be that things are stacking up at the front door because you can't get people out of the back door of the hospital, and there are complex mixes that create different scenarios. The idea is that those groups will identify where the challenges lie and use, in particular, some of the 70% of the tariff that is held back for those readmissions to try and address those issues. Of course, some of the issues can simply be addressed by having the right people around the table.

Q59 Chair: I am going to have one more go. What you describe I accept as far as it goes, but the implication then is that a spending decision by a social care authority in the local government context is something which the NHS has to accept as a given. Surely the whole point about the better care fund is that that is not the case and that it ought to be a negotiation and not limited to £3.8 billion either.

Professor Sir Bruce Keogh: Those are two important points. The first is that the better care fund is not up and running yet. So the better care fund, I think—

Q60 Chair: The principle is, is it not?

Professor Sir Bruce Keogh: The principle is, but there are several issues. First of all, we need to understand that the £3.8 billion that is going to be put into the better care fund is not sitting in a bank vault somewhere unused. It is already being used for delivering services. That is the first point.

The second point is that there has been a lot of discussion about the rules that have to be put around the application or the use of the better care fund. In particular, as medical director, I am interested in two particular areas. One is the provision of social services seven days a week to help us to get people out of hospital; I have forgotten the second one—

Q61 Barbara Keeley: Can I stop you there? That is really fantasy. I don't know what I have to say to impress upon you, but we are talking about £2.68 billion being taken out of it. We have had this in debates with the Secretary of State in health questions downstairs in the Chamber. As to the notion of applying a seven-day working week to social services when it is being cut left, right and centre, and my colleague has said some local authorities do not have to cut, I am afraid my local authority had to cut because £100 million cannot be found out of the non-social care budget—it cannot—particularly not when there is £75 million more to

come. As to the notion of any extension of social care across the weekend, my local authority is just about to cut 300 posts from its staffing. All that we are having is fewer care packages and less staff to do assessments and less staff to work on this.

Professor Sir Bruce Keogh: I rest my case—

Q62 Barbara Keeley: We have even got less director time.

Professor Sir Bruce Keogh: I rest my case about why that should be addressed to the Department of Health, Chair. I think Barbara Keeley has made the case extremely well.

Barbara Keeley: But it is your issue, though. You cannot deal with the issues that you need to deal with and that we are talking about here unless we can bottom this issue. Ministers are just in denial about it all the time.

Q63 Rosie Cooper: You are basically saying that integrated care and the whole package that you are the front door of is a joke and a charade because integrated care means it has to work right across the piece. You are accepting, “This is the bit we can do and everything else is over there. We actually believe it should be delivered,” but when they can’t deliver it you say, “Oh, well, oh, dear, we have this small amount of money in integrated care.” I do accept you are going to grow that phenomenally to £50 billion, but that is just going to cause other parts of the health service to collapse; you know it as well as I do. How can you sit there and not in your heads join it all up? Can I just ask you a question about urgent care boards?

Professor Sir Bruce Keogh: Can I come back to you, please? The second thing is that this will be used to try and reduce the demand on accident and emergency care, but we need to be absolutely clear because there is a great scepticism in the NHS that this money will be used for those purposes. There is a fear that the labels will be taken off the money and that it will be used for filling in potholes and other significant things.

Chair: Rosie, can I—

Q64 Rosie Cooper: Chair, what I don’t get is this. When you came and we had a Select Committee on urgent care boards, that was one of the most unsatisfactory meetings we have had. We did not get any answers. It was all woolly, and today it is still woolly. I would like to pose you a really simple question: are those board meetings public, are the minutes public, and can everyone else see what woolly nonsense is going on?

Professor Sir Bruce Keogh: I don’t know whether the meetings are public, but I can let you know.

Q65 Rosie Cooper: But why can’t they be?

Chair: Sir Bruce says he does not know so perhaps we can find out. It is a question of fact about which we should be able to get an answer relatively easily.

Professor Sir Bruce Keogh: We will make sure you get an answer.

Chair: We are at risk of spending all afternoon talking about this and I think we might make a passing reference to this part of the conversation in our report.

Q66 David Tredinnick: We are ready to move on to the performance of ambulance services and, in particular, handover delays. By coincidence, I am going out with Hinckley ambulance service on Friday in my constituency. Is it right that the handover delays between ambulance crews and emergency departments have been reduced but, unfortunately, trolley waits have gone up? Is it the case that addressing delays in one part of the emergency system simply pushed the pressure on to another part of the system so we actually do not have an improvement?

Emma O'Donnell: The first thing is yes, it is true that, from the published statistics, ambulance handover delays have decreased. From the latest figures that were published, they are down about a 1,000 overall on the same week last year. You have made a very good point as well about the urgent and emergency care system as a whole. So, when we look at part of the system in isolation, we can measure a certain part of it, but, inevitably, patients are on a pathway in that system and there are a variety of services that they pass through. One of the things we have tried to say as part of the urgent care review—and Keith may want to come in after I have spoken—is that we need to look at the system as a whole and not just look at one component part of it, in terms of how we make improvements across that whole system to make it better for patients.

Q67 David Tredinnick: Professor Willett, earlier on you were talking about a ward with trolleys—a huge waiting area, in other words. Is this the reality then, that, overall, there is not an improvement? I am not clear from the answer whether things are better or not.

Professor Willett: I think we are broadly where we were last year. If we look across the piece, some of the figures are slightly up and some are slightly down, but, in general, we are where we were last year. Having said that, there has been a 0.6 to 0.7% increase in admissions, so we are where we were despite the annual climb that we have seen for the last three years in work load. So we are in a holding position. I think last time we were here we were saying the system is unsustainable and we will do what we can within the current constraints. But, going forward, we have to change the system more radically.

Q68 David Tredinnick: Just so I am absolutely clear, are you saying that it is much the same—

Professor Willett: Yes.

Q69 David Tredinnick: —but you have taken care of the increase in demand, or it is much the same and you have not taken care of the increase in demand?

Professor Willett: We are at week 41 and I would be foolish to say in January that we have done it, because this is not the end of the winter season, for sure. I would say at the moment—

Q70 David Tredinnick: You have already told us that January and February are the slackest months.

Professor Willett: For attendances but not admissions. They are the busiest months for admissions, and that is the problem. A and E has to shift from seeing lots of patients who can go home to one that has to hold and admit a large number of patients. That is the issue at this time of the year. So I would say we are broadly where we were last year, and we have accommodated the slight increase in activity that there has been to date.

Q71 David Tredinnick: Thank you. Moving on to the fines that are levied against acute trusts that delay handover, are you intending to reinvest those in ambulance services? Is that the plan?

Professor Willett: The fines system that is there is used by some commissioning CCGs and they commission ambulance services. The idea of the fines is not to make the fines. The idea of the fines really is a way to make people aware and to concentrate on looking at the pathway, and that is something that I would imagine for most urgent care working groups. Where we have attended those, I think those are really impressive groups. It is where the CCG chairing the group sits down with the local GPs, the patient representatives, the local authority, community health, the ambulance service and the acute trust providers. Everybody is in that room. I have to say, from a clinician's point of view, that this is the first time that has ever really happened in health care in my career. It is a big step forward, and that is where people are now not talking so much about penalties and money, because, to be honest, there isn't any new money that is moving around. What they are talking about is how they defragment the system and how, as mutually accountable organisations, they can help patients move through the system. They were put in to address the winter pressures, but I have to say I think they have been a very impressive organisational structure that has come in and sets in good stead what we will want them to do for the urgent emergency care review going forward, because they are new discussions.

Q72 David Tredinnick: I accept and quite understand that getting people round the table improves things—"To jaw-jaw is always better than to war-war"—but I am still not clear from your answer as to whether you as a clinician want the fines money to be reinvested in ambulance services.

Professor Willett: You can invest it where you think the problem is locally, and that is what the Health and Social Care Act has given the opportunity to do. Local commissioners will be able to decide where the blocks are in the local services and best spend the money allocated.

Q73 David Tredinnick: Last year the clinical commissioning groups that commission ambulance services were given an extra £14 million in December. Why was that given to them at such a late stage in the year, please?

Professor Willett: Winter pressure moneys in general have been given late and that is why this year it was done very differently; it was done early, and the moneys were allocated much earlier. This year there was £15 million allocated much earlier in the year.

Q74 David Tredinnick: I know perhaps, through you, Chair, that colleagues want to come in on this, but earlier on the Chair, I think it is fair to say, expressed some astonishment at the lack of monitoring that had been going on in the Department in respect of something else, but can you tell me what monitoring does NHS England undertake to try and understand how its funding is being used and what has proved effective in alleviating pressure on the ambulance services? How do you keep a track of all this is the simple question?

Professor Willett: You asked about the monitoring.

Q75 David Tredinnick: There are two questions. How do you monitor what is going on? Have you got effective systems in place? I suspect that they are not very effective, as we have already heard from Sir Bruce that he is putting in systems that I think many of us around this table would have expected to have been in place already. I share the shock of the Chairman.

Professor Willett: Some data metrics are reported nationally from the ambulance service performance and some are reported locally, so we know the ambulance response times are nationally reported and those are published. Locally, there are care quality standards as well that are requirements of the ambulance service and they are reported locally to the commissioners. The CCGs—the local commissioners—as I have said, are commissioning just about all the elements now of the urgent care pathway. So they do commission ambulance services, 111, out-of-hours services, A and E services and the acute hospital services. The reporting is done locally and they have the statutory responsibility for commissioning ambulance services. There are national figures that are published, which are available to everybody, and there are local standards that are reported to the CCGs and they will be performance-managing the contracts they have with the ambulance services.

David Tredinnick: Thank you very much.

Chair: Andrew Percy, I think I am right in saying, is the Committee's only first responder.

Q76 Andrew Percy: Yes—20 hours of duty every weekend with Yorkshire ambulance service, including this last one—a part-time MP, yes. What concerns me whenever we talk about ambulance services is that I don't really think we value them in the way that we should. The conversation always tends to be as to how quickly they are getting somebody to hospital and how quickly they are handing somebody over. We still see it very much as a scoop-and-carry service. We have been running an advanced paramedic trial in Goole, which I was quite vocal in trying to get for the town because we had terrible response times, and in the first six weeks of that trial—we actually had the Secretary of State in Goole this last week to hear about it—they saved 56 double-crew man hours, and 23 people who would have had to have been conveyed some 25 miles to Scunthorpe A and E were instead treated in their own homes.

I have been looking at models around the world and I was in communication with the Paramedic Academy of British Columbia, which has been looking at this, and I know a lot of work has been done in the States on community paramedicine, as they call it. We don't value it enough. What is the actual agenda, and who is going to drive that for a proper community paramedicine role? Whenever I talk to anybody, everybody kind of says, "We need to make better use of it," but at the end of the day, for the CCG, it still comes down to the targets because that is what they are paying the ambulance service for, and, for the acute trust, it is how quickly they can get them back out. I don't see anything about dealing with that. Particularly in rural areas, the Joint Committee on Rural Emergency Care in the US has looked at this, and in a rural setting in particular, where we never had walk-in centres and we don't really know who our out-of-hours GP provider is, we need to do more about this. But the money that came this year came very late to ambulance trusts and went to acute trusts—again, CCGs and all the rest of it. When is somebody going to grab this issue and really develop community paramedicine?

Professor Willett: We are grabbing it now. We have had no end of chances to talk about the review. You will have read the review and seen that the paramedic profile was very high in the review and in what we planned. One of the eight work programmes we have is around ambulance service and paramedics. We have talked exactly about that, about moving paramedics away from the public perception of their role, which has been around predominantly assessing and conveying—the scoop and run—to one in which we wish to turn paramedics, or a portion of the paramedic service, into a mobile community treatment service. So they will be part of the treatment response in maintaining patients at home, and we don't have to go to British Columbia: actually, one of the best examples is in the south.

Andrew Percy: I'm quite happy to, though.

Professor Willett: Yes, I am sure. One of the best examples is in the south-east coast ambulance service, where they now have enhanced paramedics who are working with GPs in primary care. When a call comes in that sounds like it is a frail elderly patient or a patient with a long-term condition, they have a priority dispatch to one of those trained paramedics, who will assess that patient, which is not something the paramedics traditionally have included in their curriculum. Their curriculum has been much more around resuscitation and injury-type response; this is a different expertise for them. The paramedic will then contact the GP and work with the GP practice to initiate treatment in the home, bring in whatever support is needed from the community or from the GP practice in order to manage that patient at home. That is the model we want to go to. It is one of the things we have specifically put in the report and the working group is now into the delivery phase of working up.

Q77 Andrew Percy: Just to follow up on that, the tariff system was often criticised in the past for incentivising against that kind of model. Has that been addressed adequately yet, and do you think the targets which we have, which are obviously still the main focus, are potentially damaged developing that model too?

Professor Willett: My view on that is that, as we go through the review, we are building the review around what we want as the best patient clinical model for the new service. That includes paramedics, how ambulances respond, the medical support and the paramedic support when they are at the scene so that they are not there in isolation. One of the things we have said about the review is that no patient or clinical consult should occur in isolation; there should always be somebody else to support you so that, if you have a concern that you think you are going to have to move the patient to a higher level of care, you can get advice. Having built the clinical model—we have the clinical standards in place and are working with Monitor closely on this—what we will do is look at all the tariffs, the incentives and the quality metrics that go with that that the patients and the clinicians believe best portray the service that they want to see. To our mind, in terms of the review, over the next 12 months we will be looking at all of those things and I would expect many of them to change to something that fits what we need in the new system.

Chair: Barbara, do you want to come in on winter pressures?

Q78 Barbara Keeley: I can do, yes. We have been round the £400 million funding and the further £250 million extra that is being made available. Is it not the case now, in terms of all the points you have discussed, that, without short-term additional funding now being made available every year, urgent and emergency care systems will not actually meet demand? Are

we now in a situation where we need this additional money and more than this money to cope? If you take it away, how will we get through?

Professor Sir Bruce Keogh: We are working within a constrained envelope, and one of the things that we want to tackle and address as part of this review—and Keith will say a couple of words about this in a moment—is really to address the funding system of the way we deliver urgent and emergency care. That has to be coupled with how we deliver urgent and emergency care. If you look at the review that we have conducted, there is a spectrum of things that we have to do, which starts with encouraging people to do more self-care, ensuring that we get appropriate advice to people at the time that they need it. Part of that is beefing up 111, ensuring that people get to the right place when they need care, ensuring that that right place for conditions which are not serious is as close to home as possible. We think that there is more that we can provide close to home. Using paramedics to deliver care in the home is an example of that, rather than simply using them as transport agents. Finally, we need to link all of these urgent care centres—for want of a better word—together in a network. At the moment we have quite a confusing system. For people who are interested in these kinds of things, there are 22 different names for walk-in centres—minor injuries units, urgent care centres, GP-led this—so we need to standardise that. We need to ensure that they are linked into—

Q79 Barbara Keeley: Could I stop you at that point? There was a heart-rending report of a baby who died because his parents did not know the difference between the differently named centres. They turned up at a hospital and lost the time that they needed. With tragic cases like that, surely you look at this mishmash—you find it confusing—

Professor Sir Bruce Keogh: Absolutely. I think every—

Barbara Keeley: If we are having deaths attributable to people just not understanding the different statuses, clearly you have a problem.

Q80 Rosie Cooper: Or you could keep A and Es open. That would be a revolutionary thing, wouldn't it?

Professor Sir Bruce Keogh: One of the things we need to be clear about is that not all A and Es are the same.

Q81 Barbara Keeley: The public are not clear about that.

Professor Sir Bruce Keogh: No, and it is interesting how we have got there. If you go back to when DGHs were set up in the early 1970s, at that time most DGHs could treat most patients with most conditions to a reasonable or good standard of the day and it was something that the NHS was very proud of. But then medical science advanced in a way which meant that not all places would either have the expertise or the expensive kit for dealing with complicated things. We have now got to a position where, for example, major trauma can only be dealt with effectively in certain centres; heart attacks, similarly, can only get the best care if there is the best expertise and the best facilities available; and similarly with strokes.

Q82 Barbara Keeley: But don't you worry that the public doesn't understand this?

Professor Sir Bruce Keogh: Indeed. One of the things that we propose in this review is categorising A and Es. We see a scenario where there are major centres which can treat particularly complex things. Keith was involved, for example, in reorganising trauma services for this country when he was a national clinical director in the Department of Health. Within the first year of implementing that, there was a 20% increase in survival for people with major trauma. We have also seen that the reorganisation of stroke services in London, from 31 centres down to eight, has resulted in a much lower mortality rate, with more people returning to independent living, a shorter length of stay and considerable savings in terms of tens of millions of pounds. So we know that we need to reorganise our A and E services for serious conditions, but we also need to provide a much better offer, I think, than currently exists locally. By that, I mean we need to provide a good kind of portal of entry into the urgent care system, and you are quite right to point out the confusion that people have. We also need to provide a service which takes demand, if you like, off A and Es. I do not know whether, Keith, you want to run through the kind of steps that we will—

Barbara Keeley: We may have to stop soon for a vote.

Professor Sir Bruce Keogh: Oh, I'm sorry.

Q83 Barbara Keeley: I just think there are issues with what you said. I noted that the BMA chair said in his new-year message that in the post-Health and Social Care Act nobody was in charge, and the difficulty about these reconfigurations you are talking about is that it feels impossible to get to where you want to go to.

Can I also touch on this? You have mentioned NHS 111 in passing because that is said to be part of the solution for alleviating pressure on emergency departments, but I note that, even with a small thing like getting the new-look question summaries out to GPs, GPs have said that they are still useless. That is something I read over the weekend; you change information that you send out to GPs after NHS 111 has been used and GPs are still unhappy with it. It does not seem to be improving; it does not seem to be getting to where you need it to be, which is part of the solution and not part of the problem.

Professor Sir Bruce Keogh: I think most people are signed up to the concept of 111 as being a good thing, the fact that you can—

Rosie Cooper: Not all.

Barbara Keeley: Not at all, I am afraid.

Professor Sir Bruce Keogh: Okay.

Rosie Cooper: It is nearly as bad as the ambulance service, “Are you sure you are dead?”

Q84 Barbara Keeley: Not in this House. There are very bad experiences across the piece.

Professor Sir Bruce Keogh: The concept, I think—

Q85 Andrew Percy: It is the clinical back-up behind it.

Professor Sir Bruce Keogh: 111 got off to a rocky start, but we are in a much better place now, after a number of ventures—and I will ask Emma to say a few words—where calls

are being answered quickly, and 88% of people are satisfied or very satisfied with the service, which, coincidentally, is exactly the same percentage number of people who are happy or very happy with their GPs.

Q86 Barbara Keeley: There is a different purpose here. This has to guide people to A and E or not, does it not?

Professor Sir Bruce Keogh: Indeed. The original idea of 111 was that it would guide you to wherever you needed to be. It would guide you to A and E if that was the appropriate place, to your GP if that was the appropriate place, or to mental health or dental services if those were the right places. Consequently—

Q87 Barbara Keeley: You don't need to tell us. We know how it works. We used to have something called NHS Direct that did the job quite well before you replaced it with something which does it less well. What evidence is there that it is now moving in the right direction?

Emma O'Donnell: I think what we are seeing from the latest figures is that 98% of calls are answered within 60 seconds. The abandonment rate is under 1%. It is sending approximately 11% of patients to 999. It is actually sending only around 7% of patients to A and E. If you compare that, when patients are asked what they would have done if they had not phoned 111, 24% said that they would have gone to A and E. So the fact it is only actually directing 7% to A and E shows that it is influencing patient flow.

Q88 Barbara Keeley: How does that compare to NHS Direct?

Emma O'Donnell: I do not have the figures with me in terms of NHS Direct, but what we know from 111 is that approximately 25% of patients do in the 111 call speak to a clinician and they do that within the actual call as it occurs. They are not called back. NHS Direct used to work on a call-back model whereby a patient would wait to be phoned back by a nurse. We know that, if patients suffer from delays, if they are sat there waiting to be called back, they will often make another decision and attend another service because they are anxious and they don't know what to do. If they are offered the opportunity within the actual 111 call to speak to a clinician, there is more chance that they will get to the right service or get an appointment within that call and not go elsewhere.

Q89 Andrew Percy: Quickly on this, I have just had a letter from a constituent who was very happy with 111, which is not what you expect. I know it is only one, but it is a start considering where we were. I have three quick points on them. When we did our review of urgent care services we talked about the sense in possibly bringing together the commissioning of ambulance services, 111 and out-of-hours GP services. In my patch, Yorkshire ambulance service provides the 111, which is great because they also provide the ambulance service in part of the constituency, but not in the rest. Has any progress been made on that because it would seem that there is some value to that?

Professor Sir Bruce Keogh: As you know, we have gone out to some interim providers and 111 was given, under those circumstances, to a number of ambulance services. Those ambulance services that are doing that feel that there is a synergy because they use the same software, they are under the same management system and they are under the same governance, which is an important point. Furthermore, the times that 111 is busy tend to

be the times that 999 is not and vice versa, so there are some economies that can be had through that. We will be going out to re-tendering services in 2015. Do you want to add anything to that?

Emma O'Donnell: Yes. The point I was going to make is that, as Bruce says, the NHS Pathways clinical algorithms, which are used in all 111 services, are used by the majority of ambulance services nationally as well to triage their calls. In terms of the way we set out in the review a vision for 111 in the future, it is the ability to book into more services so that patients have the opportunity to have an appointment at the end of the call, access to the care record and the ability to speak to a wider range of professionals. I think, as NHS England works to develop that specification, that will be put out there and it will be for commissioners to take a view in their local economy, looking at their services, to procure against that specification and see what model fits appropriately in their area in terms of who would best provide that service.

Chair: May I interrupt for a second? I am told there is going to be a vote sometime in the next five or so minutes. I am in the hands of the Committee as to whether we want to go at a gabble rate through the key questions or whether we want to come back. I would suggest we would, in truth, come back. That is fine. When the bell goes, we shall depart and come back 10 minutes later.

Q90 Andrew Percy: I won't be able to; I have a meeting about flood insurance, so I won't be back, but it is nothing personal.

Are we convinced, though—it is the same question on this as one of the issues that, when we did our review, we looked at and were concerned about—as to the clinical back-up to this use of algorithms? I will give you an example. On Friday night I went to a job. I happened to be outside when I was called to it; it was a 111 job. So I was there in 30 seconds, but the individual I went to had a chest infection. The call came through and obviously it went all the way through 111 as chest pain, difficulty breathing and all the rest of it, so it immediately became a red 1, red 2, or whatever. We got there, and in the end it was three ambulance assets there. Actually, the paramedic in that case did do a discharge from the home and all the rest of it, so that side of it worked well. But this got all the way through 111 and required a paramedic in an RRV and a double-crewed ambulance to appear. Are we really convinced that these algorithms work properly and that there is the clinical back-up there? Who made that assessment, when actually the first question should have been, “Have you been coughing up phlegm recently?” “Oh, yes, for the last two days.” “Well, guess what?” One of the big criticisms we have been getting or we have heard and talked about in our review is about the clinical back-up.

Professor Sir Bruce Keogh: The algorithms which are used are those of NHS Pathways, which is a set of algorithms which are approved by a group chaired by the Royal College of Physicians. They have quite significant—not “quite”; they've got incredible clinical support, but they are subject to continuous review. Do you want to add any more about the process?

Emma O'Donnell: Yes. They are subject to review, and, as Bruce says, that committee looks at them. The thing to bear in mind, as you will appreciate working as a first responder, is that when a patient makes a call the algorithms obviously do have to err on the side of caution in terms of sending a patient to a service which appears appropriate. As

you will accept, when the crew get there, what may transpire might be different from what has been the case on the phone. But I think there has to be that degree of caution there.

Q91 Andrew Percy: It is less of an issue if we have proper community paramedicine, of course.

Professor Willett: In terms of reviewing, what we are recommending going forward is around the concept of supporting everybody. 111 would, we believe, benefit from having more clinical support, the sort of support I saw when I visited the Yorkshire ambulance 111 service—very impressive. What they have already done is to bring in quite a lot of clinical support. So they have got medical support and nursing support. They desperately need mental health support because that is a big requirement for 111 services, and dental, particularly over weekends, so the ability for someone phoning up who has jaw pain or toothache to be able to speak to a dental nurse, to get advice and to be booked into an emergency NHS dental slot the following morning. For most people, that would satisfy them so that they would not then subsequently seek A and E because they have got the definitive care they need in a package.

What we are proposing in the review and working on in the groups now is to come up with those recommendations. Clearly, all of those have to have a cost impact assessment and whether or not they would deflect it, but certainly the analysis we have of 111 activity would certainly support that as being exactly what we need to do. There is a logic then in that that support could come from out of hours—the GP service as well could be part of that—and many of the CCGs have commissioned 111 and out of hours together because it makes sense to combine the two, and also the medical support and the 999 ambulance service dispatch desks, because they could do with mental health, dental and maternity support. This all has to come together and this is what we were talking about with “defragmenting the system.” Rather than having these bits working and being commissioned in isolation, we want them seen as a whole and in a way that manages the patient as close to home as possible with the right level of resource. Clearly, what you describe with three ambulance assets turning up is over the top.

Q92 Rosie Cooper: Emma, you mentioned that at the end of the call you might get an appointment—an appointment with whom? What have you got available?

Emma O'Donnell: I am sorry, do you mean in terms of what we are proposing in the review?

Q93 Rosie Cooper: No. I am asking you about what you just said before—that that call may actually end with getting an appointment. An appointment with who, what, where and why?

Emma O'Donnell: At the moment with 111 it depends what has been commissioned locally in terms of the availability of appointments and what sort of services are in the—

Q94 Rosie Cooper: Yes, but what kind of—

Emma O'Donnell: You could get an appointment with the GP out-of-hours service. Some urgent care centres run appointments. What we are talking about in terms of the review in the future is opening up a much wider range of appointments for 111 to book into. That actually may be an appointment at your own GP practice.

Q95 Rosie Cooper: Why can't I phone up my own GP? Why do I need you?

Emma O'Donnell: You could phone up your own general practice, but some patients may not—111 is about access in to urgent care services and it is around, "Phone 111 if you are not sure." It may be that a patient knows that they are ill but not what service they need, so 111 guides them through that to take them to the service that best meets their needs.

Rosie Cooper: So this could be a shortcut to getting a GP appointment when everybody else is hanging on the phone. Is that what is going to happen?

Chair: That is a partially rhetorical question and we are invited to go and vote, so we will be back in either 10 or 20 minutes, or rather more than 20 minutes if it is two votes.

Sitting suspended for a Division in the House.

On resuming—

Chair: Our next question is in the hands of Mr George.

Q96 Andrew George: Thank you very much. I will certainly be taking the word "defragmentation" away with me; no, that's fine. It is very helpful and it is a very helpful image as well, and a very agreeable image too. The £250 million funding which has been put forward with the intention of alleviating or allegedly to alleviate winter pressures, according to the theme of the questions that have been raised, might be described as rewarding failure. I know that, of course, one of the intentions of that funding is also to assist with the additional resources going into primary care and the management of long-term conditions. I want to draw our inquiry into the other side of the early discharge and then avoidable admissions—avoidable urgent episodes—coming into the acute sector in the first place by putting investment in to primary care. Apart from lots of warm words—and everyone seems to be repeating them, that we want to avoid unnecessary admissions and avoid unnecessary emergency episodes coming through the front door of the emergency departments—I cannot see any actual actions going on. I want to get an impression from you as to what is going on to achieve this avoidance of emergency episodes in the first place, and whether there are very good examples or blueprints of this type of activity going on.

Professor Sir Bruce Keogh: The longer-term game, of course, in all of this is that CCGs commission services, which—

Andrew George: Can you speak up slightly, please? We will shut the door.

Professor Sir Bruce Keogh: The longer-term game is that we start to implement the changes which we have put in the urgent and emergency care review. In the meantime a lot of CCGs are doing really good things in terms of developing much more local services close to home. One example might be the Corby urgent care centre, which is very well-equipped: it is adjacent to a general practice; they have the facilities for doing blood tests and x-rays; they see their patients within, broadly speaking, about 15 minutes, and by doing that they have been able to reduce the number of overnight stays for adults—in other words, unnecessary admissions to the local Kettering hospital. When I was there last, it was reduced by about 30% and I know they had aimed to get to 50%, which they thought was entirely feasible.

Q97 Andrew George: So, sorry, they still come through the front door of the urgent care centre; it is just that they do not stay overnight. There is avoidable admission—

Professor Sir Bruce Keogh: And they don't have to go to Kettering A and E, which is further away. Similarly, they have done the same with children. Often, children get admitted simply for observation, but they provide an observation facility within their urgent care centre. There are numerous examples like that around the country where new and innovative ways of delivering local urgent care closer to people's homes are being implemented.

Professor Willett: Do you want me to add something in terms of what we are doing?

Andrew George: Yes.

Professor Willett: The review is going forward, having put out the report in November. If you go to that report, you will see that we talked about how we could improve self-care. A lot of people don't want to bother the NHS but they often don't have a route to get information otherwise; so we have put examples in there. The way we have gone about describing the self-care, the ability to get a rapid contact with someone for advice, how to better use a pharmacist and all of these things, has come from the groups. We have pulled together over the last year all the groups that live and breathe these problems. They are the patients, the clinicians, the nurses, the GPs and the paramedics. We have had them all there saying, "Look, what is it that works? Where were the blocks in the system?" Just about everything that we have described in the report as things we want to do exist already somewhere in the NHS and are working, and many of them have an evidence base behind them. What happens almost nowhere is anybody has put all of them together. If you defragment the system and put them in a place in a whole community, then we will start to get what we want to do, which is to avoid patients migrating to the A and E department, which in essence is currently the victim of its own success because it is always there and the lights are on.

The sorts of things we talk about are improving very much, particularly in the digital age, how people can get advice in terms of using the internet or by telephone advice. The campaign we have started at the moment publicly, which you may have already seen, is around getting earlier access to advice and the role of the pharmacist. The biggest interaction in the NHS around urgent care is with community pharmacists—over 400 million. That compares with only 20 million A and E attendances. There are 300 million GP attendances compared with only 20 million A and E attendances. What we are describing all the way through the review is how do we support the patient to get what they need at the earliest opportunity, without defaulting through a system? We have talked already the paramedics and how we can use them better.

Also, we have some real anomalies in the system. For instance, you go to your GP on a Thursday morning and you have a problem—a long-term condition, as you have suggested—you and the GP have been struggling to sort it out for a few weeks and it is still not working well. The GP makes a decision. On Friday evening you are unwell again and the out-of-hours doctor is called in. Very often the out-of-hours doctors have no relationship with the GP surgery so they don't know your records. You immediately don't have so much confidence, but also they are disadvantaged in the decision making, so it is much more likely for you to be moved to hospital. Perhaps they do sort you out on the

Friday evening, but by Sunday you are really unwell and then an ambulance is called, but the paramedic does not know what the out-of-hours doctor did or what the GP did. It is almost impossible for them not to take you to A and E.

It is linking those together and the information base, but also, importantly, what we have said in the review is—and, again, there are good examples of this—that we want the hospital specialists to be available to support the GPs, the paramedics and the out-of-hours teams in the community. That is, as I said earlier, about there being no patient or specialist consultation going on without support. It is a diabetic patient who had the problem on the Thursday morning and it is a diabetic issue on the Friday evening. What the situation really needs is for the GP to be able to phone the diabetologist at the hospital and have a one-to-one and say, “What do I do?” He will say, “I suggest we do this for the weekend and I will see them urgently in my clinic on Monday morning,” or whatever is appropriate. We need to get that definitive point of response to satisfy the patient’s medical needs but also to give them confidence in the decision making. That would alleviate one or two more elements of the pathway being used and the patient arriving in A and E for what is something that really could have been sorted out in a better environment were the system not fragmented.

Valerie Vaz: I am just staggered by some of your responses.

Rosie Cooper: It is just—

Valerie Vaz: An urgent diabetic response would be—

Q98 Andrew George: Before you ask, can I finish on my questioning just so that we can stress these issues? In terms of understanding what is going on, clearly, as you have heard from Andrew Percy, we can, of course, in retrospect, in a number of cases interpret the chest pain as a common cold or something, rather than as something cardiac, but I guess there are certain symptoms that one has to treat with great seriousness and it is only in retrospect that you discover it is a relatively—pardon the expression—trivial and less significant issue. However, in looking at long-term conditions such as diabetes, asthma and other respiratory conditions, once again—and this is how the theory at least goes—surely the better management of the long-term conditions avoids acute episodes happening.

Professor Sir Bruce Keogh: Yes.

Q99 Andrew George: We keep hearing the mantra that that is obviously what the system is intending to do, and we have heard that for years during the previous Government and the present. But to what extent is that now happening with some of those long-term conditions, and is there good practice which provides a blueprint, which is then being disseminated effectively to primary care and commissioners around the country? So there are those two questions.

The final one is that of the resources necessary to do this. At a time of financial stringency when the whole system is continuing to seek to make efficiency gains, still the mantra is that we need to be concentrating on better resourcing the primary care sector to avoid pressures on secondary acute care. To what extent can that still happen? Can we frontload primary care when every time there is a political crisis politicians tend to throw money at A and E rather than at primary care? The last question may indeed be a political

question that you cannot answer, but certainly in terms of addressing these issues I think you understand where I am coming from.

Professor Sir Bruce Keogh: It is a really good point. The first part of your question was about what is happening in terms of dissemination. Much of that dissemination will happen through professional channels. That will be probably more important than any other channel. To give you an example of how things progress, diabetes used to have to be admitted to hospital to have the diagnosis and to initiate your treatment and you had to see a consultant. Then it moved out into primary care, into the GP arena. Then it moved into an arena where specialist nurses could take control, and eventually it is a combination of patients and support from their primary care services. This is starting to happen in other areas.

The treatment of patients in hospital is much more expensive: 50% of our budget is in secondary care. Primary care commissioners will have a vested interest in improving their services in a way that they can treat people out of hospital. We hope that a combination of those two will be quite a strong driver. I don't know if anyone else wants to comment.

Professor Willett: Also, the clinical world recognises that what we have is unsustainable at the moment. Nobody can do their job properly because it is really very difficult in the current environment. We are in a position now, which we have not been before, to bring all the clinicians together to agree that. So, when the GPs are expressing their frustration about not being able to get a hospital specialist's advice, we can now work in that environment and look to commission across the whole pathway so that those specialists do make themselves available to GPs. In the same way, the GP practices are available to support the paramedics or the hospital. A patient, let's say, with a mental health disorder is very difficult to assess, and an elderly patient with dementia who does not have a carer with them is very difficult to assess. We need to put all those things back together again, because, inevitably, the less information you have about the patient, the less knowledge you have, the more likely you are to default to a higher level of care setting, which can be inappropriate for the patient as well because hospitals are not the best places to be for patients who don't need to be there.

Andrew George: Thank you very much.

Q100 Valerie Vaz: We have a bet on the Committee about how long it takes to mention Torbay and you have something there that exists, where they are doing exactly what you think is just being invented at the minute, but I want to come back to what you were saying earlier. You talked about a diabetic event. A diabetic event which leads to an emergency admission is probably because the person has passed out, not because they have just got diabetes and they think, "Oh, I must go to accident and emergency because I want someone to"—

Professor Willett: I was not suggesting that. Most of the diabetic problems are around managing diabetes to keep your blood sugar at a stable level. They are getting recurrent infections; they may be having other problems, which, because their diabetes is not managed well—

Valerie Vaz: With the greatest respect, we need to ask the questions. I don't know where we are. I don't know if we are talking about urgent care—

Chair: You were asking a question to your choice.

Professor Sir Bruce Keogh: And perhaps Keith could have a chance to answer.

Q101 Valerie Vaz: Can I just go back to the winter funding? Maybe, Sir Bruce, you are the person to ask about the winter funding allowance. There are two sets, aren't there? There is £250 million for the hospitals and £150 million for the CCGs. Is that right? Is that where it has gone?

Professor Sir Bruce Keogh: No. Both tranches have gone into communities and they have been sub-divided, so some are given to CCGs and some of the money has gone—

Q102 Valerie Vaz: You said “communities,” but could you be a bit more specific?

Professor Sir Bruce Keogh: Yes, I was earlier on. I will just reiterate that it has gone to 371 areas. That £15 million has gone to 111. The urgent care working groups decide among themselves how the money is divided. So they are the people with the best local knowledge. I am sorry, but I had not answered that specifically earlier—my apologies.

Valerie Vaz: No, that's okay.

Professor Sir Bruce Keogh: The idea is that they will determine how that money is shared out because they know where the problems are.

Q103 Valerie Vaz: So £15 million is going to NHS 111 and the rest is all going to the urgent care working groups.

Professor Sir Bruce Keogh: Yes, £371 million.

Q104 Valerie Vaz: In terms of accountability for that money, how are you satisfied that that money is actually going to, say, for example, primary care or community care, rather than just paying locums to sort out the problems, which is what some of the written evidence has said?

Professor Sir Bruce Keogh: I am sure there is an element of that.

Q105 Valerie Vaz: Do they have to be accountable to you?

Professor Sir Bruce Keogh: No. They are accountable to a tripartite group, which is TDA, Monitor and NHS England. They submit plans that are reviewed by the tripartite group. That gets to the heart of some of the difficulties of the accountability because some parts of the system are accountable directly to NHS England and—

Q106 Valerie Vaz: Which bits? Tell us.

Professor Sir Bruce Keogh: CCGs would have their plans assured by NHS England, but, in terms of the delivery of urgent and emergency care services, some of those services are delivered in a hospital and NHS England has no jurisdiction within hospitals. That has to be dealt with by the TDA if it is not a foundation trust and Monitor if it is a foundation trust. To try and get around that, we have this so-called tripartite oversight to try and join things together.

Q107 Valerie Vaz: You just give the money. You would give the money but you would not be sure that that was not being spent on locums, for example, rather than, say, for example, community care—long-term sustainable solutions.

Professor Sir Bruce Keogh: I think we can only be sure on how it is being spent now. The long-term sustainable solutions need to come out of those urgent care working groups in the longer term. They have only recently been established, and Keith mentioned earlier that they are starting to prove their value.

Q108 Valerie Vaz: But they were the urgent care boards previously, were they not?

Professor Sir Bruce Keogh: We have just changed the name. I think in the light of the discussion—

Q109 Valerie Vaz: So they were the urgent care boards before. Is that right?

Professor Sir Bruce Keogh: Yes, because the urgent care boards gave a sort of grandiose impression.

Q110 Valerie Vaz: But the urgent care boards had to be set up because there was a gap under the Health and Social Care Act—is that right—because of the reorganisation?

Professor Sir Bruce Keogh: You can describe it as a gap, or you can describe it as—

Q111 Valerie Vaz: You would not have instigated them if there was not a gap.

Professor Willett: They were done directly really to respond to the winter pressures.

Q112 Valerie Vaz: I am sorry, can I ask Sir Bruce?

Professor Sir Bruce Keogh: They were set up to deal specifically with winter pressures, but the key thing about them is that there are different parties responsible for different parts of this system, and the urgent care working groups are a really important tool in joining those up, both financially and clinically.

Q113 Valerie Vaz: You mentioned this tripartite group of people with lots of different roles. Is there one person who is the accountable officer who will report back for this use of public money, or do they just talk among themselves and give out the money to whoever they want?

Professor Sir Bruce Keogh: There are different levels of groups. We have a tripartite group at a regional level and that would report back through the regional director of NHS England.

Q114 Valerie Vaz: Ultimately it will come back to you.

Professor Sir Bruce Keogh: Yes.

Valerie Vaz: Thank you.

Chair: Rosie, you wanted to come in on this.

Q115 Rosie Cooper: Thank you. Would what you call the regional director of NHS England be what I would formally understand to be the local area team?

Professor Sir Bruce Keogh: No. We have 27 local area teams and then we have four regions. The local area teams are nested within a region, and then we have a regional director for the region.

Q116 Rosie Cooper: Do you know who the regional director for Lancashire is, and the north-west, I suppose?

Professor Sir Bruce Keogh: Richard Barker.

Q117 Rosie Cooper: Richard Barker—never heard of him, which is really cool. Did any urgent care working group fail to produce an assurance plan to the satisfaction of the tripartite grouping?

Professor Sir Bruce Keogh: I don't know the answer to that. We will have to go back and ask our operations directorate.

Q118 Rosie Cooper: Okay. Let's say that happened. Who at local level would lead developing the plan that would have to follow to deal with winter pressures?

Professor Sir Bruce Keogh: That would be co-ordinated through NHS England.

Q119 Rosie Cooper: So that would be the—

Professor Sir Bruce Keogh: The regional directors.

Q120 Rosie Cooper: —invisible regional director who we have never seen or heard of. Can I just ask you how LATs fit into your structure—the local area teams—and the people you have running those?

Professor Sir Bruce Keogh: We have 27 local area teams, and, broadly speaking, they have a director, a medical director, a director of nursing and—

Q121 Rosie Cooper: Where do they fit in?

Professor Sir Bruce Keogh: They are part of NHS England.

Q122 Rosie Cooper: Do they report to the regional director?

Professor Sir Bruce Keogh: Yes, they do. They report to the regional director and then the regional directors are part of the senior team.

Q123 Rosie Cooper: If there are only four regional directors, would it be fair to say that, at a local level, if the urgent care working group did not have a functional plan, the director of the LAT would probably be the person closest?

Professor Sir Bruce Keogh: Yes, absolutely, because he would sit on the urgent care working group.

Q124 Rosie Cooper: In that case, I have to say to you, Sir Bruce, the answer terrifies me because I have never met Richard Barker—he is Mr Invisible—and I am hopefully quite close to what is going on. In Lancashire we have a director of the LAT who is from local government, and, frankly, he hasn't got a clue; he's hopeless. I have asked him questions about the future of Southport and Ormskirk hospital—we had a meeting—and in terms of

emergency care, which is what we are talking about today, and the future and the robustness of the plans to do with that, he said, “Oh, well, Southport and Ormskirk,” he assured me, “would have an A and E or something close to it.” He did not understand that that response sent me into orbit. I asked him, “Would ‘close to it’ mean the hospital would have intensive care or high-dependency?” He hadn’t got a clue, and this is the man who is developing or would be responsible for the local plan. He also told me that, for example, Southport and Ormskirk, while it deals with my constituents in west Lancashire, would be looked after by the director of the Mersey LAT. I do accept that she has got a much better handle on things and I have far more confidence in her.

But we are back to this. You are talking about fragmentation all the time today, and now we have a hospital which the director of Merseyside is in theory going to look after because he has defaulted, and yet the CCG—i.e. the primary care—will be dealt with by Lancashire and him. How does that fit in with your, “We are going to defragment all this nonsense and make it all tie in together”? He obviously doesn’t understand.

Perhaps I can put a question to you. Define the difference between a major emergency centre—for me, a trauma centre—and an emergency centre? Does an emergency centre have an intensive care or high-dependency? Does this guy have a clue?

Professor Sir Bruce Keogh: The way our thoughts are merging in terms of the difference between an emergency centre and a major emergency centre is that an emergency centre will be very similar to what most people consider an ordinary A and E at the moment. There are three things that really are important to deal with as an emergency because they kill people: one is trauma, and that particularly kills young people; the second is heart attacks; and the third is strokes. I have already alluded earlier that not all hospitals are fully equipped to provide the most modern treatment for that. We want to be absolutely transparent about that because I don’t think every member of the public knows that. They think all their A and Es are the same. What we want to do is to try and understand which of those hospitals can provide those services—it does not have to be all three of them—and we will regard those in a public and transparent fashion as the major emergency centres. We will link them through a network to the remaining emergency centres.

Q125 Rosie Cooper: Absolutely great. I have been involved in the health service for thousands of years. They are, to me, trauma centres, exactly what people have been planning for 20 or 30 years. I get that. Tell me about emergency centres. Is my local hospital going to have an A and E, or is your emergency centre, ergo, not going to be an A and E of any real description because it is not going to have intensive care or high-dependency beds? That is the real question. Is that what this fool was telling me?

Professor Sir Bruce Keogh: First, I cannot speak for your hospital because I don’t know the details of your hospital.

Q126 Rosie Cooper: But it’s got an A and E.

Professor Sir Bruce Keogh: What we will do is we will run through the principles of what we need to underpin what would be a necessary set of supporting services for an urgent care centre. Would you like to do that, Keith?

Q127 Rosie Cooper: Hang on. So you have a major emergency centre, which is my trauma centre. Are you now saying that anything that is not a major emergency centre, as you call it—a trauma centre, as I call it—is no longer going to be an A and E?

Professor Sir Bruce Keogh: I did not say that at all.

Q128 Rosie Cooper: No, but that is what I am asking.

Professor Sir Bruce Keogh: Perhaps if you could let us finish and let Keith explain some of the principles that are underpinning our thinking, it will help.

Professor Willett: Part of the reason for this, as Sir Bruce has said, is that currently what is called an A and E is very different around the country. One in seven does not have on site one of the essential services that would be recognised to be part of an emergency hospital, and one in five does not have children's services on site. The definition is that an emergency centre—and we use “emergency centre,” but it is not a term we have fixed on and we are coming to a decision about what the names are—looks very much like what you are calling an A and E at the moment. An emergency centre is an acute hospital that is set up to receive all types of patient. A major emergency centre is one, similarly, that receives all types of patients but also takes specialist referrals from other centres that do not have the specialist capacity. Those will be things, as Sir Bruce has said, like major trauma, stroke, primary coronary intervention for heart attacks, vascular surgery and plastic surgery, etc. It will be more than the major trauma centres because some of those are not related to trauma. That is why we have envisaged at the moment that there will be a number of hospitals—probably somewhere between 40 and 70—that will have those specialist services on site, which are taking those specialist cases which make up less than 5% of activity from the other hospitals.

It is also important to clarify the difference between receiving and treating. If you go to a very rural area of the country, it will be important, because of the geography, to have a facility that is capable of receiving all patients. Whitehaven is 47 miles from Carlisle. We have no choice, if you like, in a situation like that. A rural community has to have an emergency-receiving facility, but the number of people in that area will be too small to justify, or even make safe, having critical care services or surgical services, because there will not be an activity to make that safe or to keep staff there. So we would describe it as a hospital that has to be able to receive everything, but for those patients who require the more specialist care, over and above what the critical mass of the population can support as a hospital. Those patients will be moved on and that is part of the emergency network. It is not just receiving; it is the very rapid and safe identification and transfer of those patients.

As you move towards a more urban area, your critical mass of population increases and the number of services that will be in the hospital will also increase, so the number of patients who will need to be transferred—rather, they will be assessed and treated on the site—will reduce for two reasons. One is because the service may now be on site because the hospital is big enough to support it, or, secondly, because you are now in a run time, in terms of the ambulance travel distance, to enable the paramedics to do the assessment and convey that patient very appropriately to the specialist centre, be that a major trauma centre or a stroke centre. That is the configuration that we are describing. So there is one

thing around receiving, assessing and initiating treatment and either transferring, or receiving, initiating treatment and actually taking them to hospital.

Q129 Rosie Cooper: The question is will every emergency centre, however described—emergency centre or major emergency centre—have intensive care and high-dependency facilities?

Professor Willett: We will have to have a facility that will be able to manage those patients. What we are now doing in the delivery phase, having agreed where the review is going and having the consensus achieved from the clinicians and from the patients in phase 1—we are now into phase 2—is defining the clinical standards, defining exactly what that means for each of the centres and what the options are. There will need to be options because what happens in a rural setting will be different, necessarily, from an urban setting. At this stage—

Q130 Rosie Cooper: I'll tell you what. Yes or no? Will every emergency centre have intensive care and high-dependency—yes or no?

Professor Willett: It will have the—that is the work we are doing now. How that is delivered—

Q131 Rosie Cooper: I think the country needs to stand up and listen to what you are doing and saying. There was the young boy in the *Sunday Mail*, or whatever it was yesterday, dying, and what this fool has alerted me to is that you are up to closing a lot more A and Es, and we will have the Secretary of State and Tory MPs campaigning to save their A and E, while you are sitting there saying, “The closure has nothing to do with us.” It is absolutely outrageous.

Professor Sir Bruce Keogh: No. Can I ask, have you read our review?

Q132 Rosie Cooper: I have not read your review.

Professor Sir Bruce Keogh: Then I do not think you are in a position to make those kinds of remarks.

Q133 Rosie Cooper: Okay. Let me say this, Sir Bruce—

Professor Sir Bruce Keogh: Chairman—

Rosie Cooper: —I will make sure I go and read that review.

Professor Sir Bruce Keogh: Thank you.

Rosie Cooper: But the bottom line is that, if you cannot say whether an emergency centre is going to have intensive care or high-dependency, it is not going to be an A and E of any description.

Chair: Okay, Rosie, I have given you time. This is Parliament. This is where the people's views should be heard. Quickly, because we are running out of time, I think, Barbara wants to ask questions about staffing.

Q134 Barbara Keeley: Yes, because staffing is such an important issue. We have touched on it, and obviously there is a chronic shortage of both consultants and higher trainees in emergency medicine, and we have talked about the use of locums. You said, Sir Bruce, I think, that consultants will be required to work at weekends to ensure that care quality does not dip outside the working week. But what is being done to address the problem that the majority of emergency departments, as we reported earlier following an inquiry we did, cannot provide 16-hour consultant coverage during the working week, let alone at weekends? It seems a peculiar thing that you have tried to stretch the existing consultant cover to weekends when we are not even covering the vast majority, does it not? I think it was only 16% or 17% that were reaching the desired levels of staffing.

Professor Sir Bruce Keogh: There are two components to that. The first is the issue of emergency medicine doctors. The second is the issue of trying to provide safe comprehensive services for the citizens of this country seven days a week. They are related in some ways but not completely. When David Sowden was director of medical education at the DH in 2010, he alerted me to the issues of training of emergency medicine doctors. So we established a group to try and look at those problems. Since then, we have increased the number of consultants by 300 and we have doubled the number of trainees. That task force reported and the work to try and address those issues has been taken up by Health Education England. I think we are getting into a much better position in terms of recruiting doctors to emergency medicine. We have—

Q135 Barbara Keeley: Can I stop you there because I do not believe that is true? I asked Ministers a written question about this, about the fill rate for higher trainee posts, and it has tailed right off. In the last round of recruitment with 193 higher trainee posts at ST4, you filled 37 out of 193. The fill rate has been low anyway, but the latest round of recruitment was worse. We have been told—I think we have talked quite extensively about this in earlier inquiries—that people are voting with their feet. I know cases of people who are now GPs, who have left emergency medicine because they cannot stand the stress of it. It is confusing me if you say that we have solved the trainee problem because the figures I got from Ministers suggest that is not the case.

Professor Sir Bruce Keogh: I am sorry if I gave the impression that we have solved it. I think that is wrong.

Q136 Barbara Keeley: It is actually getting worse, is it not?

Professor Sir Bruce Keogh: What I said was—well, the projections from Health Education England imply that it is getting better.

Q137 Barbara Keeley: Not at the higher trainee levels, which is what you need. You can fill trainee posts, but it is a long training, and if they get put off at the point of—

Professor Sir Bruce Keogh: Shall I explain? There are two points of entry into training for emergency medicine doctors. One is really junior and the other is at about year 4, as you alluded to. For those that come in at a very junior level, the recruitment rate is very good, but we have about a 25% attrition rate for those. For those that come in at a more senior level, we have not been able to fill the posts that well and there is still an attrition level.

Q138 Barbara Keeley: That is where the problem is, isn't it?

Professor Sir Bruce Keogh: It is; it is. There will be a delay before we get to a really good position on this. What Health Education England is trying to do is to increase the number of trainees that enter at a lower level in order to mitigate the attrition rate that occurs higher up.

Barbara Keeley: I have to tell you from the figures I have in front of me, which I got from Ministers, that it does not seem to be working, because the vacancies number goes up but the number entering at that level does not seem to increase in proportion at all. So, as I said—

Q139 Chair: Rather than having a contest at short notice about figures that most of us have not seen, could we ask for the Department—Sir Bruce has said he thinks this is trending in a better direction—to substantiate that with its own figures?

Professor Sir Bruce Keogh: We could ask Health Education England as they have just produced a paper to their board a few weeks ago that addresses this.

Q140 Barbara Keeley: It is probably timely to say after this meeting today that, when you come to talk to us about this important topic, which is one of the most important issues facing the country at the moment, it is important that we don't have a series of things which you cannot answer or—

Professor Sir Bruce Keogh: I am trying to answer.

Barbara Keeley: Yes, I understand that, but—

Professor Sir Bruce Keogh: And I have the details, but it is just that you have a different set of figures from me.

Q141 Barbara Keeley: I got those by asking a parliamentary question of the Health Minister. If the Health Minister can't tell me what the situation is—in fact, other people have made clear to us that they were losing trainees at that point. I have brought that into it, but my question overall was, how can you stretch a situation which is full of vacancies and has a very high attrition rate—actually, is it going to make things worse—by asking those consultants to work weekends, when we haven't got the coverage now? I don't think we have solved the trainee problem. How can you move forward on this when it is such an issue now?

Professor Sir Bruce Keogh: I think that “weekends” conflates two issues. The emergency medicine doctors are already providing seven-day services. Where we are asking for additional input at the weekend is from other consultant colleagues. We have a set of 10 clinical standards, which have been drawn up by colleagues in London, that define what good practice looks like in terms of assessing a person who is newly admitted to hospital; it defines the time to assessment for both—or it defines the access to diagnostics, which is important for making the diagnosis; and then it defines the time to a senior decision maker seeing those—

Q142 Barbara Keeley: So you are using non-emergency medicine- trained people.

Professor Sir Bruce Keogh: Yes.

Q143 Barbara Keeley: That does lead us to the next question, which is my final question. The Royal College of Physicians has warned that hospital trusts are using nurse practitioners

and physician associates to deliver emergency care. Clearly, with the position of the shortfall of senior staff and the financial pressures, it is understandable, but the feeling from the evidence they gave us is that that is actually using those junior staff in an inappropriate way. Could you comment on that aspect of what they told us?

Professor Sir Bruce Keogh: I am really sorry, but I did not get that.

Q144 Barbara Keeley: Clearly, it is understandable that hospital trusts would start using nurse practitioners and physician associates, because they were so short of staff and because they were under such pressure, but the view expressed to us is that that is an inappropriate way to use junior staff—that it is not appropriate to do that.

Professor Sir Bruce Keogh: Last Saturday I was in Ipswich where they have nurse practitioners; 30% of all the patients that come in through their A and E are seen only by the nurse practitioner. 85% of those patients are sent home and they have been—

Q145 Barbara Keeley: So you think that is fine. You think it is fine to use the staff in that way.

Professor Sir Bruce Keogh: I will just finish. They are trained up to treat quite significant conditions, such as broken wrists and dislocated shoulders. They do significant suturing, they catheterise patients and, yes, this is appropriate. It is all down to the level of training that people get. It is the direction of travel in other parts of the world. I don't know if you would like to add anything to that.

Professor Willett: Yes. Emergency nurse practitioners are highly qualified. They have gone through extensive training and there are groups of patients who come to A and E that fall certainly within that skill mix and, in fact, if anything, arguably get a better response than they would because the doctors find that those doctors are tending to migrate to the more complex patients. Emergency nurse practitioners have been in the NHS now for over 20 years. They are very advanced in their training. It is a core part of the service and using that multidisciplinary team. So there would be nurses who have mental health expertise, nurses who have physical injury expertise, and there will be children's nurses. That makes up part of the normal complement. It is an important part of addressing the gaps that there are in the medical work force.

Barbara Keeley: It sounds as if you need to convince the Royal College of Physicians of that because they have given—

Chair: We will have one question from David Tredinnick and then I think we will probably have exhausted our time.

Q146 David Tredinnick: Actually I have two questions, but I have been quite quiet here, Chair. I want to ask you, historically, whether there ever was a greater involvement of consultants at the weekend, and you have explained that A and E consultants are on standby. Is it something that has drifted over the years? Was it such that when the national health service was set up there were still levels of consultants serving at weekends and that has just disappeared?

Professor Willett: It is quite interesting. Most people will perhaps not realise that emergency medicine did not even exist as a specialty 30 years ago. So the front door of the

hospital was always served by the inner-hospital specialties coming forward. The whole of the emergency work force was junior staff, and it was appropriate because the cases that were presented on the whole were relatively straightforward; they were not as complex and elderly as they are now, and medicine was not advanced. For a heart attack 30 years ago, basically, the patient had morphine, they were admitted to hospital, put on a monitor and you took your chances. The mortality rate reflected that. Things have changed now. With the advances in medical care and the complexity of the patients, we now have a very different need. We also had the Working Time Directives come in, which have reduced the experience overall that the junior doctors have. We have a different demand and a different asset available, so there is this inevitable drive to requiring more consultants. I do not think the consultants have drifted away. What has happened is that the requirements that now are needed in urgent care are very different from the health care—what medicine can do and what the patients need.

Q147 David Tredinnick: My last question is something slightly different. We live in an information technology age where we are all carrying electronic kit and we have video used in court rooms. In the health service we have advice services down the line using 121 and other services and 999, where people can categorise and make decisions. Have you looked or are you looking at the possibility of having consultants on duty at weekends who are available by video link from a centre to a range of hospitals? There must be many times where a junior doctor is faced with a decision that does not require the consultant to be present, where there is some issue about the relationship of one drug to another or something that just needs a feel. Are you looking at that?

Professor Willett: That is very much part of the review. Making the hospital specialist available to whoever in the network needs to support them is what we are doing. Some of that already goes on. A lot of the on-call consultants will now take the urgent phone, so the calls don't come through from another hospital to junior staff. A lot of the reporting of scans and x-rays is done remotely now rather than having everybody in a hospital, and the technology will certainly allow it. That is part of one of the information work programmes that we have going forward in the next stage of the review.

Q148 David Tredinnick: Why not have a room of senior consultants on duty and a red button in accident and emergencies where, if they really get stuck, they can at least talk to somebody who is experienced? Surely, that is a good use of IT? I read no IT in this briefing. Surely there must be some connection between the health service and what is going on in data, in cyberspace. I sit on the Science and Technology Committee as well and we are doing Big Data in a couple of weeks' time—this extraordinary phenomenon of everybody being informed about everything all the time—and yet I don't see it in my notes here.

Professor Willett: It is in the review; so we have put it in.

David Tredinnick: I apologise.

Professor Willett: It is in the review and we had one of the eight work packages entirely around information and knowledge transfer and that support. We have talked about how the network will support each other and that will be one of the mechanisms. You are right that in remote America, in Dakota, they have exactly what you have described. So we are aware of all these things. What we need to do is to bring them in. In Dakota, they run their

peripheral hospitals with one doctor and a team of consultants, who are a paediatrician, a surgeon and a radiologist all in a remote setting.

Professor Sir Bruce Keogh: The precedent exists and has done for some time, for example, in neurosurgery, where CT scans are transmitted down the line in between hospitals so that an expert neurosurgeon and neuroradiologist can inspect them. So we agree with you entirely.

Chair: Valerie has a final question.

Q149 Valerie Vaz: I have just a few quick ones, Sir Bruce, about the review. This is completed, and I just wanted to know what the time frame is. Is it now decided that there are going to be emergency centres and major emergency centres? Is that still up for grabs or is it just the review that has decided that?

Professor Sir Bruce Keogh: Well, I think one of the reasons we are here is that we are still listening.

Valerie Vaz: Okay.

Professor Sir Bruce Keogh: So we have put this out. We have tried to conduct everything that we have done here absolutely in public so that people can feed into it. It is published. Everything that we have done as we have done it we have published on NHS Choices and on the NHS England website, so thoughts that the Committee have would be really gratefully received.

Q150 Valerie Vaz: In addition to the ones you have heard already.

Chair: In a slightly more refined form possibly.

Professor Sir Bruce Keogh: No, absolutely. Keith is leading on the sort of delivery side of things and has several work streams. Do you want to talk about that?

Professor Willett: All those work streams are happening there. Some of the things will happen very quickly because the urgent care working groups are out there wanting them. Some of the things around the tariff and how we change the funding will come in over the next year or two.

Q151 Valerie Vaz: It would be helpful—I know you say some of the things and you know it, it is in your head, etc.—and it would be nice if you could just write to us and tell us what the work streams are.

Professor Willett: The last part of the report is about the timetable to implementation; it is in there.

Q152 Valerie Vaz: Okay; so that is fine. That is under way. I am quite keen to know what time frame you are working towards.

Professor Willett: The overall time frame is three to five years because this is a whole-system change. But some of the things will be—

Q153 Valerie Vaz: For what?

Professor Willett: For the whole-system change. This is the whole network construct, all the changes. Some of the things like paramedics changing their curriculum and learning how to manage patients is a curriculum change, so that will take the longest—somewhere around five years. Some of the things about teams working together, sharing information, can happen now. Thirty-two million patients have a summary care record and we just have to link that up now. Some of the things can happen very quickly. The 111 service changes—the specification—comes in for April 2015. All of those are laid out in a timetable.

Q154 Valerie Vaz: Is there a danger that people won't do anything—local commissioners won't do anything—while they are waiting for this review?

Professor Willett: No; it is on the contrary. We have been working with all of them. We have the CCGs and we have a working group with the NHS Commissioning Assembly and with clinical commissioners. We are working with them, with the area team directors, so they are fully informed. We have told people to keep going. That is why we are feeding them as much as we can because they are doing this at the same time as us.

Q155 Valerie Vaz: What are they doing? I am getting confused. Are they working towards major emergency centres and emergency centres? They are working towards that.

Professor Willett: At this stage we are coming up with the specifications and the standards that those centres should be capable of delivering.

Q156 Valerie Vaz: I just want a yes or no. You are dragging this out—yes or no.

Professor Willett: Yes.

Q157 Valerie Vaz: Are they working towards major emergency centres?

Professor Willett: Yes, they are working towards organising their networks at this stage.

Chair: Valerie, one more question.

Q158 Valerie Vaz: Are all the reconfigurations that are currently ongoing going to stop while this review is going on?

Professor Willett: No.

Q159 Valerie Vaz: So there are still going to be reconfigurations and you are still working towards major emergency centres.

Professor Willett: In the review, we have indicated that reconfigurations will proceed, and they will take on board the advice, the guidance and the commissioning structure, as we produce it.

Chair: I am sorry, but I now have an inquorate Committee. Before my colleague departs, I want to say thank you to you for your patience with us. We shall take account of what you have said in our report.