HOUSE OF LORDS

Public Services Committee

Corrected oral evidence: Access to emergency services

Wednesday 12 October 2022

3 pm

Watch the meeting

Members present: Baroness Armstrong of Hill Top (The Chair); Lord Bichard; Lord Bourne of Aberystwyth; Lord Filkin; Lord Hogan-Howe; Baroness Morris of Yardley; Baroness Pinnock; Baroness Pitkeathley; Lord Porter of Spalding; Baroness Sater.

Evidence Session No. 1 Heard in Public Questions 1 – 11

Witnesses

I: Professor Peter Murphy, Director of the Public Policy and Management Research Group, Centre for Economics, Policy and Public Management, Nottingham Business School; Professor Leo McCann, Professor of Management at the School for Business and Society, University of York; Professor Inga Heyman, Associate Professor, Policing and Public Health, Edinburgh Napier University.

Examination of witnesses

Professor Peter Murphy, Professor Leo McCann and Professor Inga Heyman.

Q1 **The Chair:** Good afternoon, everyone. This is the first public session after the Recess and of the Public Services Committee. Today we are with three people who work in academia, who have knowledge of and do work on the emergency services systems, and so on. I am really keen that we get ideas about the broader issues, so the questions today are about the broad issues, but we will as we go through in subsequent sessions narrow down on the issues and get to more detail. What is it that is going on? How do we compare with other places? It is those sort of questions that we are dealing with today.

We are very pleased to welcome three witnesses. In the room, we have Professor Leo McCann, from the University of York, which has a long history in working on issues around the health service. We are pleased to see you and grateful to you for travelling. I know it well, and it is normally a straightforward commute to York. We also have Professor Peter Murphy on the screen. He is at Nottingham Trent University. Our third witness is Professor Inga Heyman, from Edinburgh Napier University. She is particularly working on public health and policing. It is really good to welcome all three of you.

Inevitably, we have a series of questions, and colleagues may well come in with supplementary questions which you have not been warned about. They just want to make sure that we know as much as we can at the end of this session, to set the context for our inquiry into access to emergency services. The first question I want to ask is this: what do you see as the key issues facing first responders to emergencies in the United Kingdom?

Professor Leo McCann: Thank you so much. My expertise is in NHS ambulance services, which are now in a situation of prolonged and severe operational crisis. This has been brewing for over 10 years. The last two or three years have been exceptionally challenging, for all kinds of different reasons, but it is important to make the point that the COVID-19 pandemic has exacerbated trends that were already there. The service was already facing quite profound difficulties, even leading up to 2019-20.

There is a whole range of problems, as we see on the news regularly; pretty much every week, we see stories of very long waits for ambulance callouts, from category 1, which are the most urgent and potentially life-threatening emergencies, through to category 2, which are potentially serious incidents, through to categories 3 and 4. All four categories have regularly missed their standards and targets; the data are widely available publicly and have been for quite some time.

My own research has looked at the human side of all this trouble, and the operational difficulties that they have had. My most recent work involved qualitative interviews with paramedics, ambulance service managers and

other ambulance responders of various kinds, and some observations of their work as well. The work that I did was in 2015-16, and even in that period, five or six years ago, the strain they were under was very severe. So to see it continue to deteriorate is a real problem for patients and staff.

The Chair: Thank you. Inga, if you want to say something about your general work as well as answering the question, that would be fine.

Professor Inga Heyman: My work is focused on the intersect of policing and emergency services. It is about people who come to the attention of police and health services, particularly those with mental health distress. I work with other areas where there is that intersect between policing and health for lots of different reasons, such as around violence—that is one example, but also around custody.

I am interested in how the systems connect and respond to services, but also how the people working within those services work—that human element of it. One of the biggest challenges for emergency services is that the needs of people who come to the attention of the emergency services are frequently multidimensional. Although there is often a well-being, health or safety component for the police, when there is a call for support it almost always has a social component.

One of the challenges is around how systems are set up. In the case of health, whether ambulances or the police, the biomedical response and the criminality response are only two responses. We assess and treat, and in the case of police we safeguard or triage people onwards, but when we transfer people on to the emergency department, wherever it is, it does not really address that social component. So there is almost a missing service, which perpetuates the swing between emergency services, particularly out of hours.

We see people coming frequently to the attention of services. We keep moving them through, but this area of their life is not really addressed. It is not an emergency social service necessarily—there are some elements of that, but not to the extent that can be responsive in a timely mater in the same way as ambulances, police or the Emergency Department, the ED. There is a missing service there. We are working between these two-dimensional services which do not hit the needs for people. We do not really ask people what they actually need.

Professor Peter Murphy: I tend to deal with the performance of public services more generally, so a bit wider than the other two witnesses. I would sum up the current position we have got into with emergency health as a perfect storm. This is not to take anything away from what Inga said about multiple morbidities or social determinants of health, which is quite right, or what Leo said about the ambulance services having been in an increasingly impossible position in terms of demand for more than 10 years. However, in general terms, the risks that the emergency services are facing are getting greater and more complex. Even the fire service, which had for a time been reducing its number of

incidents, turned up to a greater number of incidents prior to the Covid pandemic.

The risks we have been facing recently, whether the pandemic or wildfires, are tending to be greater and more complex. The demand on services is increasing. There are a number of reasons for that, which we can go into. The resources to address the consequences of those two phenomena—more and increasingly complex risks—are consistently being reduced. More of a recent phenomenon is that those resources are increasingly being spent on short-term responses rather than acting upon root causes.

This is exacerbated—just to make it all worse—by similar trends, not only in emergency services, to move towards response rather than long-term causal issues. Key partnering services, both at the local and national level, whether welfare services, social care, housing, health and safety—this occurs whether they are provided by the public sector, private sector or third sector—are increasingly moving to response and short-term services rather than addressing root causes. At some stage we can go into any of those in particular, if you want. We have done a lot of research on the priorities and tackling short-term responses, rather than fundamentally tackling long-term prevention and protection.

This shift in resources towards response rather than protection and prevention is despite continuing policy intentions and presentations and protestations to the contrary. A greater proportion of a reducing investment pot is being dedicated to those response services. That is despite policy over the last six Governments saying, 'We are going to prioritise preventive and long-term causes'. That has become rhetoric; the reality is the opposite.

Q2 **Lord Hogan-Howe:** Thank you, everybody. I am interested in the demand side—Peter, you said you might be able to talk a bit more about that. One of the graphs we received is about the record waiting times in A&E of more than 12 hours. We get figures only from January 2020, but it really seems to take off in July 2021. Could anybody help us understand what changed in July 2021? By the time we get to July 2022, it has risen to 30,000, having been down to just the odd thousand. Covid, which may be a precursor, started back in 2019, so does anyone know what suddenly changed in July 2021?

Professor Leo McCann: I would not be able to answer that directly in terms of that specific time. From the point of view of the crews out on the road I have spoken to during my research and since then, they described a situation where it was quite hard to predict how a shift was going to go. Throughout the summer and up to now, people have been telling me that very often their shift involves spending an awful lot of time at the hospital, unable to hand over the patient.

It seems that we not only have delays at the front end, with perhaps a long wait for the ambulance response to arrive, but once that ambulance has picked up the patient and transported them to A&E, they are also

facing very long waits there. Once you transfer the patient, they are also having a trolley or corridor wait for many hours. This is now fundamentally unsafe for the patient.

The NHS ambulance model was based on a 1960s or 1970s rapid response emergency medical services—EMS—model. The idea is that you call for an ambulance, it arrives quickly and will stabilise the patient, and will then transfer them to definitive care at the hospital. With the greatest respect in the world for foundation trusts, hospital trusts, A&E doctors, nurses and all the professionals working there, the situation for a patient has become unsafe in terms of the ambulance service wait and the hospital wait. I do not know exactly why this spiked so badly in the summer, but the problem has been building for quite some time.

When I was finishing writing my book, news stories were appearing. Before Covid, in the build up to it in November and December 2019, stories emerged of 24 ambulances outside Worcester hospital, and other stories of that nature. The build-up of very slow handover times has been growing. It will fluctuate over time, and it is quite hard to find specific reasons.

Going back to the original question, when you speak to crews it is very strange. You ask them how their shift has been and sometimes they will say 'I spent eight hours with one patient'; 'I wasted that shift'; 'I did nothing useful in that shift' or 'I was in a vehicle for eight hours, a corridor for two hours and responded to two calls'. Others will say that it was a shift that was more useful. It used to be that you would have maybe eight, nine or 10 call outs in a 12-hour shift. You occasionally still get those shifts which go reasonably well. It is a bit of a mystery quite how any individual shift and any individual month's statistics will go.

There have now been seven or eight months of terrible performance measures when looking at the waiting times and operational data. The last seven or eight months have been as bad as it has ever been, particularly with these tail waits in the 90th percentile. I cannot tell you exactly why it spiked in July, but it has been growing for a long time.

Lord Hogan-Howe: I just wonder whether Peter or Inga might be able to help.

Professor Peter Murphy: The only thing I would say is that you can track the spikes locally. I would know where the spikes were in my local hospitals in the East Midlands. Interestingly, they have been bunching more; for instance, our biggest hospital did not have its spike until some time after. The cause of that spike was that we got more capacity in A&E about 18 months previously, which meant that we delayed the spike but, lo and behold, soon enough our local hospital was declaring a problem. It was about three months after that period simply because we put lot of extra capacity in A&E just before Covid hit. It is very variable across the country, but I definitely agree with Leo that there was a continual build up in the demand on ambulance services. It was inevitably getting worse.

Other things might have come into play. We were starting to get the return of delayed operations across hospitals. Delays in every clinical intervention had built up over the Covid period. We had started to get people going back to those and then it suddenly got to gridlock. I suspect it built up over time and then one trigger made it noticeably worse around July 2021.

Professor Inga Heyman: I cannot talk directly to that spike but it is worth looking at the bigger picture, as Leo said. We are feeling the accumulation of people being tied up in A&E. Think also about who is bringing people to emergency services: it is the police, particularly with mental health related calls, and they will get tied up there too. Frequently, mental health distress is not a time-critical emergency. The literature is really strong in saying that these people will spend way beyond four hours in an emergency department, particularly if they are intoxicated as it might be difficult to assess somebody.

To go back to what Leo was saying, ambulance services sitting there for eight hours with one person will frequently have a knock-back effect on the police, who will become *de facto* ambulance drivers, bringing people to the emergency department, and then they will be sitting there for eight hours with somebody as well. There is a knot in the system that can leave all the emergency services tied up unless there is a different pathway. One of the issues is the limitations on that in the current system.

Q3 **Lord Bourne of Aberystwyth:** My question is a follow on, principally from what Leo said, probing a very important area in relation to transfer. No matter how much we spend on ambulances, if they are not able to transfer people then we are clearly not going to get anywhere. On what you said about spikes, was it in the same hospital trust that suddenly they were able to make 12 visits within a shift and then just one in the next? If it was the same trust then that is even more surprising.

Professor Leo McCann: My work is predominantly with ambulance trusts, which are regional. The ambulance responders can drop their patients off at many different hospitals depending on how much they travel in a shift. What they experience will differ individually but, overall, last year in particular the issue of long handovers has become the critical issue they are facing.

Lord Bourne of Aberystwyth: To what extent have we studied other similar countries in Europe? Do they have the same situation? Is it because we are not using our resources sensibly in hospitals and have become obsessed with the number of beds being used so there is no slack in the system? What is the experience in France, Germany or Spain?

Professor Leo McCann: I am not really qualified to comment on that in any huge depth. What I know is that the number of beds is seen as far too low in Britain, and in England generally. It is a major problem of bed and staff shortages.

Lord Bourne of Aberystwyth: So unless we crack that, we are not going to crack the whole cause.

Professor Leo McCann: The major bottleneck at the moment is ambulance crews being effectively stranded at A&E and unable to go back active. Until that is solved, the ambulance trusts are hamstrung.

Lord Bourne of Aberystwyth: I do not know if Inga or Peter have anything on that. The area Inga is looking at is very interesting, but it is such a massive tableaux to look at and this is our last inquiry. It would be very good in a way, because it would mean that we could carry on, but if we start to look at all of it, we would be here for ages.

Professor Inga Heyman: One of the problems is the limited number of pathways; it is all to the emergency department or out-of-hours. For a lot of people, that is it, so we should not really be surprised there is a bottleneck. If there was an alternative pathway for non-time-critical emergencies which were not quite so multidimensional, it would be easier. It is not always about piling more people into more beds—although I agree with Leo—but about thinking about not bringing people to the emergency department in the first place if they do not need to be there.

The Chair: I think we will come back to that later.

Professor Peter Murphy: I can confirm that hospital capacity in terms of beds per person is much more of an issue in this country than in most of Europe or in the United States or Canada. Therefore, bed occupancy is much higher. If you get over a certain level of occupancy it causes problems.

We did some work a few years ago on system dynamics—what was causing bed-blocking at one end of the system, too many people in A&E who could be better treated in other healthcare settings, and fewer people going to A&E than could have gone had those other people not been there. We found multiple problems and a particular group of people who were not efficient in their use of A&E. In other words, there are groups of people who go to A&E when they do not need to. We also found big problems at the other end of the system with bed-blocking. The biggest problem was inadequate social care and discharge to appropriate housing.

All of that is complicating the problem for ambulances, which can only operate if they can get people into triage systems, whether in A&E or somewhere else. Our poor old ambulance services are in a pretty unique situation, as they have very little control on either the demand for their services or where they can go with them. They are stuck when there is gridlock in the system.

Q4 **Lord Bichard:** My question is on the same point, but I will persevere. This is such an interesting and complex problem because there are so many variables. We have touched on quite a few already. It is possible to

just get caught up in the variables. However, there is one basic fact: the number of acute beds available in the UK has dropped from something like 300,000 in 1987 to 141,000 now. There are reasons for some of that, and some of us around this table have said that the number should have reduced. I want to be clear on how significant you think this is in the problem we are dealing with. Is this the elephant in the room? Has it got to be dealt with if we are to make any progress?

Professor Leo McCann: Yes, along with several other things that also need doing. If there is a way of improving the number of staffed acute beds, then the NHS is absolutely crying out for that.

Lord Bichard: I am not suggesting that it is the only thing; I am asking how significant it is in your view.

Professor Leo McCann: It is very significant. The ambulance triaging system and the four categories of call also need looking at. Perhaps we will get to that later, but there are problems there as well. It is very significant and it is vital that you have raised that.

Lord Bichard: Do Inga and Peter agree?

Professor Peter Murphy: Undoubtedly.

Professor Inga Heyman: Undoubtedly, but I do not think it is the only problem.

Lord Bichard: We have to start somewhere though.

The Chair: I do not think anybody is suggesting that. Part of our problem is that this can go off in all sorts of different ways. As you are talking, I am thinking about what I keep hearing a lot: that it is about patient flow. Because there is not effective patient flow, there are bottlenecks all the way through. However, that is another issue.

Q5 **Baroness Morris of Yardley:** Thank you very much, and good afternoon everyone. I want to move away from the problems of the emergency services for a minute. Could you explain the model used to deliver emergency health services in the UK? What principles underly it? At some point someone must have had to make a decision about what kind of emergency health service we would have.

I am not asking what it would look like if it was brilliant, but rather what were those principles which underly our current system? It may be helpful to include what choices other people made. What were the alternatives when those decisions were made?

Professor Inga Heyman: I am really sorry; I lost half the question.

Baroness Morris of Yardley: I will sum it up. Moving away from the problems, could you describe the principles that underly our model of delivery of emergency services? Presumably when we set it up, it was based on some principles. Other countries might have used different ones and set up something different to solve the same problem. Could you talk

a little about that?

Professor Inga Heyman: It is really interesting that we have chosen a medical model for our health service. It sounds odd to say that, but who decided what healthcare should look like? Did we actually ask people? In other countries—for example, the Netherlands and Australia—they asked people what they thought their emergency healthcare needs would look like. However, we have decided what it looks like for people. I do not think that what we think people need is always what they are asking for, particularly with out-of-hours care.

I know you said you wanted to move away from problems, but my answer probably shows that that is a bit of a problem. Whoever decided what emergency health systems would look like had a fairly strong political view on that. Healthcare problems do not change every four years. We will not get them sorted in my lifetime. My career will never unknot the general problems. We need to ask people, as has been happening in other countries, particularly the Netherlands. They have been asking people what they need, rather than us deciding. I do not know if that is the answer you were looking for.

Baroness Morris of Yardley: It might be helpful if you could give us an example of, having asked people what they need, what the Netherlands has got that we have not.

Professor Inga Heyman: Mental health triaging. People do not want the police knocking on their door; they do not want the lack of dignity, the embarrassment or having to explain to neighbours why the police have been there while they have been in mental distress. The Netherlands has looked at changing the look of the ambulance or police car that comes so that it is not so publicised—not the blue flashing lights—so people can be treated with dignity.

Another examples is in Chicago, where they have asked people about their experience with mental health distress. When sitting in the emergency room, in front of everybody, when you are in mental distress, there is publicity. They have developed a back or side door to their emergency department, which has an emergency psychiatric room that looks completely different and has a social component to it. It is not about the medicalisation of mental health.

Those are two examples of when the experiences of people using the services were listened to. One of the big challenges is the significant dearth of literature around people's voices and what they want for health services. That voice is missing. It is always practitioners' experiences or strategic decisions; we are very poor at asking people what they want. Maybe that is what some elements have done well.

Baroness Morris of Yardley: Thank you. I move to Peter.

Professor Peter Murphy: I emphasise just how clinically and medically focused the whole thing is. When we were sent the second question, I

looked up the recently released NHS *Transformation of Urgent and Emergency Care: Models of Care and Measurement*. This was supposed to build on the long-term plan and learnings from the first part of the pandemic.

The report states 14 actions. I am not going to go through them all, but every action is wholly inward-looking to health provision and is always transactional. For example, we will build a bit more of this, we would like capacity here, we will get another emergency number. It would increase and improve current organisations and initiatives to increase capacity. However, I also did a simple word search and did not find any of the following anywhere in the document: police, fire and rescue, local authority, welfare, or housing. There are only five mentions of social care throughout it.

We know from evidence from as long ago as the Marmot review that the conditions of people's lives consistently have a big impact on their health. Their homes, financial resources, opportunities for education and employment, access to other public services, and the environments in which they live have the greatest impacts. Yet we have a model that is not taking those matters into account.

The other thing is that the emergency telephone numbers model is similar throughout the world. You have an emergency number which transfers you to a control room of one of the three emergency services—although in some parts of the world they have two of the three emergency services provided by one organisation, such as Dublin's fire and rescue and emergency ambulance service. You then go to individual control rooms. There is very little academic evidence assessing those control rooms, but it appears to be a fairly consistent model. It is at the stage of triaging from taking the call that differences emerge in where and when it is done and who can get the triaging into the appropriate circumstances and services.

Q6 **Baroness Morris of Yardley:** That is really helpful. It feels quite recent, but it was probably years ago, that more numbers like 111 were introduced, where people are expected to do their own triaging in terms of who they phone. Has that made a difference? Is that a good idea? Do other countries do that as well? We seem to be talking about 999 at the moment, so just say a bit about the 111 and 101 services.

Professor Peter Murphy: Funnily enough, this tends to happen in a lot of countries at roughly the same time. We will get on to the transformation of what a paramedic does at some stage, but it is interesting that health seems to be an incredibly joined-up research and practice area. When it happens in one country, it happens rapidly in another.

I think the 111 service and out-of-hours services developed about 20 years ago, roughly at the turn of the century. Other countries have been using them for the same purposes. I do not want to repeat myself, but is the 111 service actually getting people into alternative clinical settings or

is it defaulting to A&E too much? If in doubt, it sends them to A&E or calls an ambulance. There has definitely got to be a question mark over that.

As to whether other countries use alternative numbers, they started using them at around the same time that we did. Some of them are slightly better at triaging.

Professor Leo McCann: I guess we are talking about system design here. What we have has evolved for all kinds of complex reasons and was maybe not designed in the way it has now unfolded. As I said, it has its roots in a rapid response EMS model. Over time, that has dramatically changed. Paramedics now, as Peter was hinting at, have outgrown that model to a large extent. The paramedic is now a much more versatile clinical resource than 30 years ago.

Other reports in the past, for example the 2005 report *Taking Healthcare to the Patient*, have talked about how we can design an ambulance service that will work with a lower conveyance rate. Can we bring the conveyance rate down, treat more patients in the field, at home or at the scene, and without necessarily having to convey them? That is clearly useful and something that is happening. The conveyance rate now is around 59%, so it is still quite high.

The ambulance service gets around 14 million calls per year, which has grown about 80% over 12 years. There has been a huge growth in calls and an enormous growth in calls at the lower end of the acuity scale—categories 3 and 4. These patients need some kind of intervention; they need looking after. As Peter and Inga said, these are interrelated issues—it might not be a health emergency, but some kind of chronic issue that has defaulted to becoming an emergency because there is nowhere else available. They might be unable to get a GP appointment, or a nurse-led walk-in centre might not be open. There are all kinds of out-of-hours mental health crises as well.

The ambulance service now is effectively dealing with three different types of call. There is the traditional emergency such as a high-acuity trauma, stroke or heart attack. When it works well, it is brilliant at dealing with those calls. It is dealing with unplanned primary care, which is partly by design but partly because it has fallen into that area of business. Should it be doing unplanned primary care? It can do it very well, but is the delivery system through 999 a sensible way of doing that? The same is also true of psychiatric and mental health crises. As Inga was saying, does it make sense to deliver that kind of care through a 999 blue-light ambulance response model? Sometimes it does, but a lot of the time it does not.

We have a design, but the system has outgrown that design and no longer reflects the reality on the ground.

Baroness Morris of Yardley: Where does the decision get taken? If it is not something that paramedics ought to deal with on site, presumably the decision should be taken before they are involved or at the point they

triage. How can we reduce that number? I suppose it is about co-ordinating with other services at the point of phoning in.

Professor Leo McCann: It is partly that. Ambulance crews are often quite critical of 111 and say it is too risk averse and escalates too many calls to 999. Even when the patient has not asked for an ambulance, they are often told 'Wait for help to arrive', and that is where you get 15 or 17 hour waits as they end up as a category 3 or 4 call.

I am not a clinician, and it needs looking at in a very detailed way, but I think that triaging is not correct on 111 or 999. Many crews say that category 2 is too broad. Category 2 is for potentially serious calls with a default response time average of 20 minutes. It is so broad that what you get could be almost anything.

The Ambulance Response Programme of 2017 changed triage to four categories. That has helped a bit, because they are given a bit more time to assess the call before they are dispatched, but it still seems that the four categories of call plus 111, are not quite designed correctly for the resources we have. A very detailed study will be required to look at that because there are issues of clinical risk to look at in depth.

Q7 **Lord Porter of Spalding:** I raised my hand to speak on Inga's response. The things you mention would clearly give better care to the patients. I do not think anybody around this table would try to defend the condition of mental health services in this country, given the absolute car crash of a service that it looks like to most people, despite the extra money that has been pumped in. Would better care—obviously it would give better outcomes—put less pressure on the call in the first place? If rather than a police car to the front door of A&E, a taxi turned up and took them to the back door, it would be better, but would it be 'instead of'?

Professor Inga Heyman: In defence of our mental health service, as a mental health nurse, there are elements that are done incredibly well. Regarding Leo's point, if somebody is in need of a service right there and then, we are really good at doing clear-cut mental health care in some levels.

Lord Porter of Spalding: I would have to disagree with you. I was dealing with one over the weekend. We had about eight or nine interactions and still did not get anywhere. Every one of those interactions is a wasted resource.

Professor Inga Heyman: In saying that, we do not necessarily need to take people to hospital. Even saying a 'back door to A&E' sounds wrong at every level because it is like it is not the same level of importance. I do not mean that; I mean it from a perspective of dignity. The way our safeguarding legislation is set up sees people who are in mental distress, under mental health legislation, taken to a place of safety which is the emergency department.

The majority of people are sent home. They are not admitted to hospital and nor should they be. Sometimes we do more harm admitting people

to hospital. Is there a different way which means we do not bring people into services? Could we come to people in their homes, sit with them and have a much more compassionate response?

Lord Porter of Spalding: Was that not the point of the crisis team?

Professor Inga Heyman: Not every service has a crisis team. Who is in the crisis team? It tends to be a medicalised model.

Lord Porter of Spalding: That is not my experience in Lincolnshire.

Professor Inga Heyman: It goes back to a medicalisation of mental health distress, which has a social element to it. It is not and should never have a medicalised approach to it. Expecting a medical crisis response is just the wrong service coming.

A good example in Scotland is the distress brief intervention teams, which pick up people very quickly. They can be referred from the police, emergency departments or GPs. It is a really flexible, collaborative service and it runs across the whole of Scotland now. It has just been formally evaluated and had a very good evaluation. That is an example of something that looks different to transporting people on a regular basis.

We need to think in a different model. We need to be brave about that and not always think we need to fit people into our current system and transport them but think about a different approach.

Baroness Sater: Picking up your point on those who are having to make decisions at the very beginning, do you think they are too restricted? Do we need to empower them more to be able to make decisions? Do you think there needs to be more training to allow people to be freer and to be able to make quick, more effective decisions?

Professor Leo McCann: Yes, the crews complain bitterly about triaging, call prioritising and dispatching. We have to be a bit sceptical sometimes about what they are saying as it is just from their perspective. They see what comes to them and may be frustrated by what they get. A call comes to them at a certain level, they might respond and say, 'Why was that prioritised as category 2—it was nowhere near serious enough?'

They talk a lot about needing more clinical skills in the emergency operations centre, which is run by the ambulance trust as the control centre. There is quite a lot of clinical experience on the dispatch side. You cannot have huge levels of skills at every level, so on the call-handling side, you are basically following a tree of knowledge computerised system. There are questions over how well that works and that has always been part of the topic.

It could be improved; I suspect that there could be more clinical capacity in the Emergency Operations Centre. Almost certainly, there could be more in 111 as it is very risk averse and does not have the clinical capacity to make difficult decisions, so it defaults to making what it sees as the safest decision. Ultimately, that might not be safe, because if you

are stacking up hundreds or thousands of low-acuity calls you are tying up the service and it cannot get to the category 1 calls. The risk management is not right, and to get it correct you need a lot of clinical ability at triage level.

There is more when they respond as, when the paramedic arrives, they have more autonomy and clinical training to make better decisions now than they had 20 years ago. It is much better there, but we do not necessarily have that at the start of the call. I think it needs looking at.

Q8 **Lord Bichard:** Is there more we can do to ensure that the right staff with the right skills get to cases? Can I ask a supplementary question, as you have teased one out of me? You three are quite frequently in touch with emergency teams. My experience of organisations is that the best way of finding how to improve it is to talk to the clients or the front-line staff. What else are you picking up from front-line staff? What do they think we should be doing? How do you get the right skills to cases, and are the front-line staff giving you some clues as to what we should be looking at?

Professor Leo McCann: They complain in depth about call prioritising and categorisation. They think it needs looking at again. The 2017 Ambulance Response Programme has helped a bit but has not stopped the problem. It might need looking at again in terms of rethinking clinical risk and improving clinical capacity in the EOC and particularly in 111.

I have also heard people complain about the staffing levels of 111 not being where they would like them to be and about its capacity. It is basically too easy for them to transfer it to 999 and they will do that. If there is any risk, they will naturally transfer it to another organisation. The level of clinical risk that they have been asked to shoulder is perhaps incorrect. That is talked about a great deal.

They talk about other much more mundane things as well, such as very poor standards of leadership in the service. They complain about a bullying culture and a lack of a clinical learning culture in the ambulance service. There is a lot of literature and reports on this. Day-to-day morale is very low. I was shocked at some of the things I have heard about how people are treated in the ambulance service as professional clinicians.

They talk quite highly about the people they share the station with but worry a great deal about the structure further up—the mid-level and senior management and incentives it has for designing and operationalising that service. For example, there is an obsession with hitting time targets, a lack of training and lack of time for training, for clinical debriefs and to think about what they are doing. There is a lot of frustration about the service as an employer. Employment issues, low morale, poor standards of leadership and a lack of direction are complained about all the time.

Lord Bichard: While we are on my supplementary, are you picking up the same messages, Peter and Inga?

Professor Peter Murphy: I can add numbers because I would be stronger on what Leo has said. On the annual staff survey, the highest levels of vacancies and of presenteeism throughout the NHS are in the ambulance services so there is stress on the individual. The percentages of vacancies, absence and presenteeism are greater than any other part of the NHS and they are going up.

I would be even stronger than Leo in terms of what you could do to improve triaging in control rooms and 111. Triaging in other places of treatment by clinical staff had to be tried over Covid outside of A&E. That was relatively successful, and we should investigate that for improvements.

The other thing that is worth mentioning at this stage is that there has been a long time in which the three emergency services argued about the need for increasing the professionalism of the service, particularly paramedics. Not much progress was made in any of the three of them until about 20 years ago, and there is still not much progress in the police and fire services. However, the long-term professionalisation of paramedics, not only in this country but in the USA, Canada, Ireland, parts of Europe and Australasia, has been nothing short of transformational in the last 10 years. However, we are slower than other countries.

In terms of developing paramedics as a profession that can undertake clinical skills, the world is waking up to the potential for using them. The move to a mobile pre-hospital care system, rather than a delivery service as quickly as possible, has been aided by better clinical skills in front-line paramedics. That has resulted in more interventions and more options to treat, which ultimately leads to fewer journeys to A&E. One thing you could do as a Committee is accelerate that professionalisation. I was delighted over the summer to look at the number of courses being offered by universities, which has increased exponentially.

I would really like to see a course offering degree-level training with a common first year followed by a specialisation in one of the emergency services. When we teach at executive and masters' level, the courses are considerably improved by mature students from different public services who learn from each other. One thing we could do is accelerate that, because that is a good trend.

Lord Bichard: Are other staff telling you the same thing? I am glad I asked this question, because there are really important points in all of that.

Professor Inga Heyman: Certainly, from the police officers' perspective, I think they get frustrated because, where do they hand people on to? They feel that perhaps they are not doing their job as police officers. There is conflict there because police officers are there to keep people safe, and there is a health component there as well, but there are also frustrations for police officers around some of the technological solutions—information sharing in live time, with other

emergency services and what gets in the way there. They might know only a certain part of what is happening for that individual, whereas there is actually a better picture.

Equally with police not being able to hand on to emergency services, there are definite information-sharing challenges for individuals and what the individual wants. Police officers get frustrated about that because they do not know what that individual's voice is in the middle of all that. So they are tired; police officers are tired and frustrated.

Going back to what Peter was saying, something we hear so often from police officers is that they are trying to understand and learn with the other emergency services so they can better understand them, why their response is that way and the challenges they face. Because it is usually just at the emergency department door that they learn about each other, as they hand people on and up. We need a system that allows people to learn together. We just got a new undergraduate programme around public health and policing, bringing that together. So, it is starting, but it is definitely an area that we need to develop, as live services, to work together, understand each other, learn together and debrief together.

Q9 **Lord Hogan-Howe:** I suppose I shall pursue a similar area, which is about governance and leadership and how that can support better outcomes for emergency services. We have been brought back a couple of times, but we have tended to concentrate, for understandable reasons, on ambulance and health, but some of these things apply to policing as well.

I was just struck, and I made a note of five different things that made me wonder about whose job it is, in the health service and the health process, to decide who does what. We have cases such as the guy who lies on the floor for 26 hours, and no one says, 'There are 20,000 people working in the health service in this area; you can go and help today'—now, not wait 26 hours. The 111 can task the ambulance, but it does not appear to be able to task the GPs, so if somebody needs primary healthcare, the first one is a paramedic. It came out really powerfully from what Leo said: the paramedics can be held at the scene, because they are providing care, which also delays it for someone else, I guess.

Whose job is it to sort out the car park of ambulances at A&E? Because there is someone inside the hospital who is tasked with getting people into a bed, to cut through the nonsense—not so much nonsense, but there are things that need to be prioritised. You do not have sharing of call handling; everybody answers their calls and nobody says, 'Actually, you can go to this; we'll go to this together.' Everybody makes an independent decision. It goes back to the fundamental question of how could the governance and leadership of the services, either together or individually, be improved.

Professor Inga Heyman: Can I talk to that?

Lord Hogan-Howe: Yes, that is my fault. I left it open. You are quite right: I should have been more like a leader.

Professor Inga Heyman: I am going to speak from the perspective of Scotland, but of some of my international colleagues as well. That strategic relationship has been really well developed in Scotland between Police Scotland and Public Health Scotland. From a strategic perspective they are talking together and planning together, and their leadership is now formalised and firmly connected. They are starting to have these fantastic conversations about a really interesting public health approach to policing and attacking some of these really difficult challenges we have.

So, from a strategic perspective, things are really starting to move in Scotland and, again, we see that happening in other countries as well. There is starting to be this much more collaborative leadership and I think as it develops further there should be strategic hubs around police and public health, but also social care, so that they are talking, and getting academia embedded in that as well. I think that is the vision within Scotland, that is where we are going, to really work on all the problems where there is this intersection of services. I think there is hope there and it is quite a good model that is happening in Scotland—we are not there yet, obviously.

On that point, about the emergency services, there is a trial in Scotland at the moment, having mental health nurses embedded in the police control room. It is not fully evaluated as yet, but the Scottish Government funded a piece of work that has great promise; it is about the right person getting the right call at the right time, rather than sending out two police cars and perpetuating the A&E scenario that we have all been talking about. Actually, that call could be dealt with very differently, with a different group of people.

Lord Hogan-Howe: Just quickly, I know there is one Police Scotland. How many ambulance trusts are there?

Professor Inga Heyman: Oh, goodness. Well, there is the Scottish Ambulance Service—

Lord Hogan-Howe: So, there are two partners to agree things?

Professor Inga Heyman: Yes, and that is a helpful model.

Lord Hogan-Howe: I would agree.

Professor Inga Heyman: And we have the Scottish Fire Service.

Lord Hogan-Howe: Peter, you are indicating, so I will take you next.

Professor Peter Murphy: Okay. There is undoubtedly a contrast in what is happening either side of the border. As Inga said, there is much more of a strategic relationship and they are moving towards more integration. They are not there yet, but they are definitely moving that way. We have done some comparative research on England and Scotland, particularly in the fire and rescue service, in my case, and there is no doubt that for the

last 10 years, we have been moving away from a joined-up and integrated service more to a fractured, silo-type approach.

Each of the blue-light services in the UK is driven by different departments, different leadership and governance and different management accountability arrangements. I will not go through them all, but remember that the emergency services are responsible to different departments, and then you have different arrangements in the three devolved Administrations. There is no common national performance framework, and they have relied upon multi-party statutory obligations to collaborate here and there, assisted by past practice, where people know each other and have the same values in what they are trying to do.

They have relied a bit on civil contingency arrangements, ultimately, emergency services, local resilience forums and we have a JESIP— a joint emergency services interoperability programme—arrangement. They tend to operate in silos, rather than being holistic, integrated or at least mutually reinforcing. And that comes right down from the top, where we have not got a set of objectives that are common to the different emergency services. The problems are that the arrangements in the three devolved areas are moving away from the English arrangements. Its boundaries are unlike those in Scotland, Wales and Northern Ireland, where there is only one boundary for all three services; it includes them all. There are three fire and rescue and four police in Wales, so it is not quite the ideal, but they have a common outer boundary.

Our board model is increasingly moving, particularly in the NHS foundation trusts. Scotland, Wales and Northern Ireland have unitary boards, where executives and non-executives sit on a single board, but in foundation trusts you have a council of governors, which can be up to 50 people, and a board of directors that is a combination of execs and non-execs. Recent research has shown that there is too much turnover in boards of directors, particularly at executive levels, and this has led to too much poor attendance in the health boards. They also recommend that there should be an increase in the number of non-execs on the board.

The last thing that we do not get in a single place is the opposite of the leadership: the risk registers and civil contingencies co-ordination. We still have national and local resilience risk registers, emergency plannings and co-ordinated response, but we have lost the co-ordination, the risk registers, and the response, at the regional level. If you look at emergencies that have gone relatively well in terms of the response, they tend to be at the local level. If you look at ones that needed to pool resources from a wider field—Grenfell would be an example, as would some of the wildfires—we have lost co-ordination at the geographical level of a region. In this case, I am thinking of Scotland and Northern Ireland being the equivalent of regions. We have lost that natural regional co-ordination that they have. They have aligned all their boundaries.

Lord Hogan-Howe: That has been incredibly helpful. You have sketched

out how clear Scotland is. You were very brave to call Scotland a region.

Professor Inga Heyman: You are.

Lord Hogan-Howe: You explained very clearly the problem of the complexity of the governance and the lack of overlap of boundaries. That was really helpful.

Professor Leo McCann: Peter mentioned the accountability arrangements, which are important. What are the incentives for the top managers in ambulance trusts? What are they trying to achieve? Is it primarily hitting response-time targets, or all the range of other things that they do? You can say the same thing about police Chief Constables. What is their primary incentive to achieving what is set out for them? Like the NHS, they are commissioned services, but it is a mystery to me exactly who does the commissioning and what the commissioner's role is in all this. Who sets these incentives? What are they trying to achieve?

There is a whole range of clinical and operational indicators generated daily. If you walk into an ambulance station or an HQ you will see these things on a screen, like a stock-ticker of hourly real-time performance data, but what are we doing with that? What is that data for? What is the objective? Organisations will try to achieve that objective. The top management's jobs are on the line for hitting those targets and incentives. We do not know quite what they are. Historically, the ambulance service was judged according to time of response. That is increasingly problematic because they are also collecting clinical outcome data. That seems to have very limited traction in terms of discussion. You do not really see it talked about. When you think of the ambulance service, you think, 'rapid response', and if something goes wrong, it is all over the newspapers—a 15-hour wait for an ambulance. These are important, of course. Time of response is important. However, there are a whole range of other things that the ambulance must consider, particularly clinical development, debriefing, professionalisation and the kind of things that Peter was mentioning. The police may have an even broader remit for what they should be doing. It is quite confused.

It is interesting to hear what Inga was saying about Scotland, which sounds a lot more encouraging. In England, as Peter was saying, it is very diffuse, very confused. What is the strategy? What is the top-level vision for an ambulance service that is fit for the conditions that we are putting it through? We have not answered that question.

Q10 **Lord Hogan-Howe:** I have just one final question. It is not really in this area, but it runs through a little of it. Obviously, one thing is to get through on the phone to get the help. You could email, but essentially you must communicate with the services that you want. All the evidence seems to be that people are taking longer to get through. One thing that seems antagonistic to a quick answer is a long conversation, and of course, 111 and 101 are more of a conversation, 'Tell me about your problem and I'll try to direct you to the right place'" What research has happened around whether that has improved the whole process? It helps

for the person on the phone, but the ones in the queue presumably do not know that they will be answered, and some of them do not get answered. What research is there about that process?

Professor Leo McCann: I do not know a great deal about the mechanics underlying all that, but the ambulance service will triage some of its calls and not send a response. They call it 'hear and treat'. Sometimes they will send a vehicle, and it is 'see and treat', so they will arrive but there will be no need for further transportation. There is more flexibility, and the ambulance response programme attempted to enhance that.

The knee-jerk reaction used to be, 'send whoever's nearest'. That is not necessarily the right use of the resource, so they have modified and finessed it, but the problem is not particularly long waiting times on the phone. A lot can be done via the phone. Often the EOC call handler will remain on the call for quite some time, and whoever has made the call can, to a degree, assist with the call, in real time. We come back to the shortages issue. The bigger issue is the chronic lack of availability of vehicles and crew, because of where they are and them being tied up.

Lord Hogan-Howe: It may be a different answer for 101, because the average time was about 10 minutes, which is diabolical. Thank you.

Q11 **Lord Filkin:** It is fascinating if somewhat grim listening. I guess that it will get worse because the demand looks to continue to rise, given demography and the slower pace of capacity. It is fundamental to us to decide where we focus. We have limited time to take evidence and above all, we want to have an impact. We must struggle with answering the question of where to focus: influencing the public, policy or practice?

There is a big dichotomy, a big choice, facing us explicitly. We know that the ambulance service, or the emergency response service, is the fall guy for capacity problems downstream. There is insufficient capacity in primary, secondary and social care, and the connections between them. That is very well known, very well documented and very serious. Unless it is sorted, you will not sort out the ambulance problem.

However, if you spend all your time there, you disappear into it, because it is an enormous topic and very well ploughed by everybody else. The alternative might be to focus on what performance improvements could be made to the emergency service itself. We have had very interesting suggestions by all three of you, of mobile hospital care, better triage, et cetera. That will not solve the problem unless you solve the capacity problems downstream, but it looks more realistic in a few weeks' time and has the potential to say something new. It is a slightly loaded question, but only slightly. What do you think?

Professor Leo McCann: It is such a hard question to answer because I am also somewhat in the dark about the role that the Committee wants to play. It is wonderful to be here—thank you so much for the invitation. It is nice to be able to say a few words about what the problems are, but without knowing so much about your organisation and what it thinks that it can do—

Lord Filkin: It is to have a public impact, so that people suddenly say, 'This is a really big issue, we need to think about it, and here are three things that we can do about it.' It moves politics to public debate.

Professor Leo McCann: Can I have a moment to think? Maybe we can hand over to Peter and Inga.

Lord Filkin: You can even call a friend, if you like.

Professor Inga Heyman: In non-regional Scotland—I should not say that—you are right that we need to reconfigure that process upstream so that we are not creating that demand. So I suggest thinking about how that could look differently, without taking people to the emergency department or putting a demand on people. It is that upstream bit that we need to think about.

But you need to ask the public what they expect of our emergency services, not consider what we think people want. I do not think that we have got that right, or else we might not be in this situation. We have just decided what it should look like, but it could actually look quite different when we ask. That could even be the case if we asked ourselves what we would expect from an emergency service, if one of our loved ones were in that situation—what would that look like?

Lord Filkin: If there is any such evidence of what people want, please send it to us.

Professor Peter Murphy: I definitely do not think you want or need to get lost in the capacity problems; they are pretty obvious. Although the improvements to the services' performance are very tempting, my plea is to also do something about the long term. How do we join up and better integrate policy delivery and the assurance of services? How are services, whether they are services or individual organisations, going to become more resilient, financially and organisationally, in this challenging context and into the future? As well as looking at what we can do immediately, I ask people: how are we as a society going to benefit from more resilient emergency services into the future?

Professor Leo McCann: I absolutely reinforce what Inga and Peter said. As Peter said, the second part of your leading question is absolutely correct: things like bed capacity and social care capacity are known, so, if you want to make more impact, you should look at the overall vision for the system design. We have outgrown that vision.

Ambulance services only joined the NHS in 1974; their roots lie in local government first aid and transportation. They have changed dramatically since that time, but we have not yet fully grasped or set out a new vision for what ambulance services could be, connected with all the joined-up things that Peter and Inga were saying. So I suggest consulting on and asking about what we want an ambulance service to look like in this very complex, interrelated and demand-heavy environment.

Lord Filkin: Has that not been done by either the practice or DHSC to

date?

Professor Leo McCann: It has just been piecemeal.

The Chair: What has come across for me—and this is a bit of an obsession of mine at the moment—is that nobody really knows what the levers of change are. Someone talked about bullying, which is frequently what people talk about in terms of the health service: they say that their main lever of change is someone at the top telling people what they have to do, and, if they do not do it, they shout. The real levers for getting change that benefits the patient are really not clear in the structures and everything else.

As you were talking, I was thinking that 111 came in largely when the GPs stopped doing emergency services. At the same time, the Government established what you were calling the nurse-led clinics—they had a special name—but they then largely disappeared under the coalition Government. They were a victim of austerity. So the structure that was put in, which was meant to handle greater demand, has largely not worked, and that has put a lot of pressure on the others.

We do not want to go into the history too much, but we need to think about how we get the change that we are looking for. You have helped us enormously in thinking through the problems and through where we are. This is just the beginning of the inquiry, and Leo is right to challenge us on our role. This is a relatively new Select Committee for the House of Lords, but it is trying to look at how we effect change across the public sector, rather than just in silos, which is how it has traditionally worked in Parliament. That is our challenge in this inquiry.

So I thank all three of you very much. I hope that you will send us anything that you later think we should have looked at, whether it is research, work that is going on or a good example of what you think is working. I also hope that you will keep an eye on what we are doing and call Sam or Tom, our officials, to let them know what else we should be looking at.

Lord Filkin: I want to reinforce that. When we have decided on our focus, we will communicate it to you and then have you as active contributors, in terms of capturing the knowledge, evidence and ideas that might address it.

The Chair: Thank you very much.