



Public Services Committee

Corrected oral evidence: Access to emergency services

Wednesday 19 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. 2

Heard in Public

Questions 12 - 17

Witnesses

I: Pam Kelly, Chief Constable, Gwent Police; Dennis Keeley, Chief Fire Officer, Dublin Fire Brigade; Daniel Elkeles, Chief Executive Officer, London Ambulance Service NHS Trust.

USE OF THE TRANSCRIPT

This is a corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witnesses

Pam Kelly, Dennis Keeley and Daniel Elkeles.

Q12 The Chair: Good afternoon, everyone, and welcome to this meeting of the House of Lords Public Services Committee, which is looking at emergency access to public services. Inevitably, at this time it means that we are doing a lot around health but also the other emergency services to see how the system works, where the problems are and what we ought to be saying about them.

Our first session is on both collaboration and innovation in services and what we can learn from that. We have three witnesses. Welcome to Pam Kelly, chief constable of Gwent Police. We have Dennis Keeley, chief fire officer of Dublin Fire Brigade. We particularly asked you, Mr Keeley, because of the collaboration and joint working between you and the ambulance service. Again, we extend a very warm welcome. Daniel Elkeles is here in person. He is the chief executive officer of London Ambulance Service NHS Trust. We are really pleased to see all of you.

We are trying to understand what we need to know about structures, systems and what is going wrong, because clearly at the moment there is a lot of anxiety. We would not be doing this inquiry if there was not concern about services. We want to get to the bottom of what is happening and where system change and our recommendations around system change may make a difference.

I will ask the first question. Perhaps when you answer, each of you will say a little about your own role and respond to the question as much as you are able to.

All of you have been invited because your services are doing something interesting in innovation or working with other public sector organisations to deliver improved outcomes for patients and service users. I want to ask you first to outline some of the things that you are doing that you think are making a real difference. I will go to you first, Pam.

Pam Kelly: I am chief constable of Gwent Police. I am also the National Police Chiefs' Council lead for workforce co-ordination, so I am very interested in how we work as people across policing and the interface with other public services.

From a Welsh perspective, I want to set the scene. Policing is not devolved to the Welsh Government, so how we work together as a non-devolved sector is really important. It does not matter whether you are devolved; what is really important is how you work together for the greater good of the public. For me, it is really about leadership and relationships. That is what actually makes things work in managing the increasing demand that we are all seeing.

To put that into perspective—I know I speak for other forces—our demand has increased by about 20% to 30% since Covid. It is not a matter of demand decreasing and staying down since Covid; that demand has been there. To put that into perspective, probably only 30% of

policing demand is core policing business because of the demand that other agencies are facing and all of us having to pull together to try to meet that demand. The reality is that it is not sustainable because we need to be delivering core policing functions and business to safeguard our communities.

As for some of the things that we are doing at a strategic and operational level, we have a joint emergency services group. Fire, ambulance, Natural Resources Wales, the military and the Welsh Government—everybody who is a key stakeholder—get together monthly and look at the demand across the services.

We cannot wave a magic wand because the demand is still there, but what we are trying to do is to understand each other's demand and what we can do to mitigate that. Sometimes that is technology; sometimes it is a triage service. For example, we are looking at bodycams that can be used at scene so that the first blue light facility that attends can go back to force control rooms and check which is the right agency and how many services can attend so that we are not all attending that immediate situation that communities are facing.

The challenge is also around mental health. Some of our communities have been struggling with mental health during Covid, and now post Covid we are seeing a significant difference. What we are trying to do with the health service and social services locally is constantly to triage from control rooms what is the right service to attend, but I have to say that it is based on relationships and a can-do approach. We have reduced a lot of demand as a result of that through triage, looking at the service that we deploy and using really good technology. If there is anything that we need to do, it is to invest in cross-sector technology, not just looking at policing. There is absolute opportunity in technology at scenes and in force control rooms, and that leadership intent, to try to take away some of that demand.

I will go through some of the other challenges, if I may, in the next questions, but it is about leadership, intent and true collaboration. It does not matter whether or not you are devolved; it is about being there for your public. Technology, leadership intent and investment in that are absolutely essential going forward to meet the increasing demand that we are all facing.

The Chair: Thank you very much, Pam. Let us go to Dublin and Dennis.

Dennis Keeley: Thank you, Chair, and the rest of the committee for the invitation and opportunity to attend and discuss these issues today.

I am chief fire officer with Dublin Fire Brigade and ambulance service. Chair, as you pointed out, one of the main reasons I am here today is that we run a joint fire and ambulance service, which is unique in Ireland and the UK. It is not new. Our fire brigade was formed in 1862 and the ambulance service in 1898, so we provide a long-established service to the community.

That evolution over such a long time has put us in a place within the community where there is a level of trust. The challenges that we face, very much like those faced by the previous speaker, Chief Constable Kelly—the strain on our resources, particularly after Covid but having come through Covid—are quite considerable, causing us to take a step back and reconsider how we are delivering our service.

At a basic level, we believe that the fact that we are running a fire EMS—fire and ambulance service—means that opportunities exist because we are a fire EMS. At the moment, we are very heavily driven towards our ambulance service in terms of the community. Our fire calls have reduced over a number of years for many reasons, similar to the UK, but we are seeing a significant increase in the requirement to deliver pre-hospital emergency care.

On that basis, the fact that we have and operate a fire EMS system means that we have huge resilience in the number of paramedics, EMTs and advanced paramedics that we have the opportunity to devolve to the service.

We have a very high utilisation rate for our ambulances. Essentially, the ambulances never stop: they can return to the station and swap crews. It also means that in particular as we come through Covid there is less burnout of staff, so they are not constantly dealing at the front line of an ambulance; they are sharing that workload with their work as firefighters. I believe that that level of diversity assists in maintaining a good, healthy mental state for our crews.

Beyond just fire and ambulance, we are fortunate enough that we manage our control centre—our emergency call centre. We take the call and incident right from the start to delivery at the hospital. We have staff who have had experience dealing at the front line as paramedics and firefighters, a percentage of whom are in our control centre. That level of experience has allowed us to move to a strong triage regime and work with colleagues in the National Ambulance Service.

A number of initiatives are under trial, particularly in relation to our elderly population, trying to keep them as much as possible in their homes. We are triaging those calls and dispatching an advanced paramedic with other occupational therapists, physiotherapists, et cetera, who may be in a position to treat and advise patients in their own homes and transport them to an emergency department, with all the difficulties that go with that for all of us, never mind those who are elderly.

Those initiatives have been very successful and they will continue. The idea is to keep people away from emergency departments where possible and not to tie up ambulances but to keep them for emergencies when they are needed.

The other opportunity is the deployment of fire tenders to support the ambulance service. We see complex cases—cardiac arrests, respiratory arrests and falls in difficult environments—where ambulances, with the

staffing levels, would have difficulty. We have the opportunity to mobilise fire engines to support ambulances in dealing with those cases. That aids and assists the casualty but also provides great assistance to the crews who have to manage it.

Where we have the ECHO or most serious cases, as you can imagine, the demand on ambulances is extremely high. Where we have long delays for the dispatch of ambulances, we have the opportunity to mobilise fire tenders, which carry a range of life-saving equipment such as defibrillators and some drugs.

In terms of the challenges, it is very much more about capacity on the medical side; it is a way of clever working and pushing these alternative pathways for the treatment for casualties, triaging effectively and efficiently, and working more broadly with occupational therapists, et cetera, to try to keep those who can stay at home, where it is more comfortable and safer, to be treated in their homes. That is just a broad spectrum of the kind of work we are involved in.

The Chair: Thank you very much. Daniel.

Daniel Elkeles: Thank you for inviting me. London Ambulance Service is the only capital-wide healthcare provider. I have been privileged to be the chief exec for just over a year. I am not a paramedic or ambulance person by background; I am a hospital manager, mostly. I think I have brought quite a different take to the ambulance sector because of that.

Last year we answered 2.2 million 999 calls and 2.2 million 111 calls. The volume is extraordinary, and, as the other two witnesses said, demand goes up quite relentlessly. Of those calls, only about 10% are what you would normally think of as a life-threatening emergency, which is what you would think an ambulance service was for. About 10% of the patients we deal with jointly with the Metropolitan Police and less than 5% with the London Fire Brigade.

Our collaboration with the Mayor of London, the Metropolitan Police and London Fire Brigade is really strong. There are lots of ways in which we work together, both in training and practice for major incidents, and in how we share things. We discovered that the Metropolitan Police had a brilliant occupational health service. We have adopted the same occupational health service provider, for example.

I think you asked me here to talk about innovation. We have some brilliant innovations going on in the space that Dennis has just touched on. As the paramedic profession has grown, both in numbers of paramedics and in skills, paramedics can do more to keep patients at home, but to do that we need to work in collaboration, mostly with other parts of the NHS. We have lots of examples of how we are now bringing the NHS to a paramedic to do lots more.

As an example, we have mental health joint response cars. That comprises a paramedic and mental health nurse. We piloted that a couple

of years ago, going to the 10% of people who phone 999 and have a mental health illness or condition. We used to convey half of them to hospital. When we send a specialist mental health nurse and an advanced paramedic, the conveyance rate to hospital goes down to 15% because they are able to treat on scene so many more patients. I am pleased to say that we now have recurrent funding to have six of those cars in operation across London every day by January.

There is a whole heap of schemes that I would call 'phone a friend'. In north-east London, a paramedic can be in someone's house and phone an A&E consultant and have a clinical conversation with them about the right place for that patient to go. That means north-east London has the lowest ambulance conveyance rate in London. If you are in north central London, you can phone a geriatrician or stroke consultant. They do FaceTime, so literally you bring the consultant into the person's home and they do a full consultation there and then. That makes a huge difference.

Literally two weeks ago in south-west London we launched community joint response cars. The equal biggest callers to 999 are mental health patients and frail elderly people, generally who have fallen but often with other conditions too. Generally, the conveyance rate to hospital is 80%. In south-west London, where we have been piloting this for two weeks, we take a community nurse and paramedic in a car. In the first two weeks of operation we have saved 71 ambulance conveyances and made 33 referrals into the new urgent community response services that the NHS has funded. The patient experience of staying at home and being looked after well is fantastic.

This morning I asked how it was going and got a great story about an elderly person who had fallen during the night. We went this morning and gave them pain relief. We made the patient and the house safe, and the patient is being referred to a community team, who will come round to do a full assessment tomorrow. That person would have gone to A&E and probably would have been admitted; now they do not need to be and they can stay at home.

A lot of our innovation is about how to bring all the parts of the NHS together to keep as many people at home safe and well cared for rather than taking them to hospital, because the opportunity is really big in that space.

Q13 Lord Porter of Spalding: The cynic in me says that is going really well and so we will not bother to do that anywhere else; we will not roll that out because it is going too well for the public sector to say it will adopt that. That is not where I want to come in; I want to come to Pam. We have a track record in this country of having best practice and then ignoring it and not sharing it. That is something that others might want to explain later.

Pam, do you know whether your figures for Wales are comparable with those for England?

Pam Kelly: There are very similar themes across the board in England and Wales.

Lord Porter of Spalding: Do you know what percentage of your call-outs are to mental health patients?

Pam Kelly: Obviously, that changes, but generally it is around 15% to 20%. As a force—I know that other forces are adopting the same practice—we have mental health co-ordinators within our control room who have access to social services and other medical records. We work with other agencies on what is the best response so that we are not sectioning people and taking them unnecessarily into custody. We do not want to be doing that. There is an awful lot of police business, including incidents involving firearms linked to people who perhaps are struggling with mental health where serious issues of violence creep in. A significant amount of our work is linked to people struggling with mental health. Sometimes we can spend up to four to six hours with people waiting for the right service to come along, especially at 2 am or 3 am, which is not what policing is here to do.

Baroness Morris of Yardley: I just want to follow up a point Gary made. I do not want to jump to later questions. When we read the papers and listen to you, obviously a lot of innovation is going on. Is there one central place where you can look at what other organisations are piloting and experimenting with so that you do not reinvent the wheel? I have an overall impression that it gets lost in the ether. This is a very direct question: is there a central body that holds current innovation and trials and feeds back to you—across all three services? Let us make it difficult.

Daniel Elkeles: The NHS has NHS England, so there is a national part of the NHS. It is increasingly focusing on its improvement arm. Currently, there are several national places you can go to to get the evidence, but I am pretty certain it is on a mission on how to get it in one place.

Baroness Morris of Yardley: There is no website, phone number or person you can go to and say, 'Just let me know what is going on elsewhere'.

Daniel Elkeles: There is a national team for urgent and emergency care that knows an awful lot of good practice. On the cars I have just spoken about for the community, yesterday a new winter letter came out from the NHS that set out, 'These are the things that are really important'. There was a whole annex explaining how a falls service should work, with examples from around the country of good practice, and, fantastically, our service was in it.

The Chair: It is a revolution.

Lord Bichard: To follow up the two points that Estelle and Gary were making, it is a joy to hear you go through those examples; it really is. I am not being disrespectful when I say they are not rocket science. The question I am asking myself, setting aside Gary's scepticism, is: what are

the barriers to that happening elsewhere? It is okay having a central body, but central bodies have a dodgy record in getting best practice shared around the place. I have been involved in one or two. What are the barriers to these innovations happening?

Daniel Elkeles: In the ambulance sector, it has been a bit unclear for quite a long time whether we are an emergency service or part of the NHS. Traditionally, leadership in the ambulance sector has come from ambulance people through and through. What is clear is that the ambulance sector has to collaborate really well with the other emergency services for a part of its work, but it is really part of the NHS. When you bring people like me into leadership, you think, 'We've had 25-odd years of what good integrated care looks like', and you discover that, traditionally, it does not involve the ambulance sector; but we are the front line for the public for most urgent and emergency care. I think we have a whole new philosophy going on about how we properly make the ambulance service part of the NHS and bring the best of all the other parts of the NHS to people's front doors with paramedicine.

Part of the answer for me definitely is: how do we do that? I have two adages. One is: steal with pride. If you see a good idea somewhere, you think, 'Why can't I just do that too?' The chief exec of the NHS, Amanda Pritchard, has a nicer way of putting it, which is called 'adopt and adapt'. But we have to get into the idea that good practice does not have to originate from you; what you have to do is say, 'There is good practice there. How do I do it in my place?'

The Chair: Everybody wants to ask a question. I have to move on to the next one because we have two panels today. Lord Bourne.

Q14 **Lord Bourne of Aberystwyth:** Thank you very much to the panel. Listening to you has been fascinating.

Developing what we have been looking at, we have been hearing totally positive stories, which I am sure is a lot of the totality, but there must be a downside. Can we have examples of where this has not worked so we can perhaps think about tackling that? This question is addressed largely to Pam, but to others too. We are looking at this in an urban environment. Does this work in Dyfed Powys where you were previously, Pam? Is the same thing true in rural areas or are there different challenges there?

Pam Kelly: There are always different challenges across different forces. For me, where it does work is where people work together in an innovative way on a regional basis. Across the four forces in Wales we meet regularly, discuss the challenges and find solutions together. The question just asked was about innovation nationally. It is not there across agencies. Where pockets of good practice take place, especially at regional level, we make it happen.

I know that funding and money are short at the moment and will be in the future, but my honest answer is that, unless we start to have funding streams available so that across emergency services we have the money

to access technology and the like to help us to be more innovative, it is really difficult. Ultimately, we are struggling to get funding to provide our own service at the moment to make sure that our own service runs. We need a pocket of money available so that emergency services can work together innovatively and know that the money will be there to help us to reduce some of this demand. We cannot fight for both. We want to deliver the service today, but we need the money to be made available so we can deliver the service in three to five years' time.

Let us be frank: that demand is only going to grow. If we are not careful, we will have a real problem in retaining staff. Those on the front line dealing with this demand are the ones who need praise at the moment. Sometimes the demand on the ambulance service is respected and appreciated; the demand and the increased demand that the police face are often not spoken of. Unless we see this as a collective public service demand, invest in today's service, yes, but where we put the money so that we can shape the future service together and not on an individual basis is essential.

Lord Bourne of Aberystwyth: Could I come in briefly on that before the question goes to the others? Is there ever a stage—this is a leading question—where you feel that the police have to do the work of the ambulance service, putting it in very crude terms? Is that something that ever happens?

Pam Kelly: Of course. The first principle of policing—Lord Hogan-Howe is here today—is to save lives. If a member of our community is at risk and an ambulance is not available, the police service will attend. If the life of a member of our community is at risk, any emergency service has a duty to be there.

What we are facing—in my own force I see this regularly—is that, because of the demands on the ambulance service, more and more we are being called to save lives, and when somebody dies and a police officer has attended we have to refer that incident to the Independent Office for Police Conduct because it is a death following police contact. That goes into the IOPC. Officers are under investigation just because they have attended when another emergency service was unable to attend. Yet those referrals are taking place. In my view, this is having a huge impact on morale and the well-being of good emergency workers who just want to be there for their communities. It needs to be looked at seriously.

Lord Bourne of Aberystwyth: Thank you for that; it was very interesting. I do not know whether Dennis or Daniel have any points on this as well.

Dennis Keeley: Collaboration will not happen in a vacuum. There is a variety of levels, but I think Pam has summarised the coalface of response quite well. We have responders who want to do the right thing, but they do come from different organisations. It needs leadership, proper governance arrangements and funding to be agreed. I cannot

speak in relation to our own police service here, but the fire service is often left at the scene of an incident waiting a considerable time for an ambulance. There is a cost factor to that. There is also a detriment to the provision of fire services if a fire tender is effectively tied up.

Pam referred to relationships and leadership, but at a higher level some policies have to be fundamentally agreed in terms of funding streams, consolidating what I believe are opportunities, particularly for our fire service to provide to the community that extra piece of medical assistance. For my service, it is much more streamlined. We happen to have a fire and ambulance service—that is not the case everywhere—but for that model to become more valuable all of what I have said needs to happen. Both the policies and funding need to be put on a solid basis and for that it needs leadership and proper governance.

Lord Bourne of Aberystwyth: I suspect it is not easy to do. Daniel, I do not know whether you have anything to add.

Daniel Elkeles: I would add two points. In the ambulance service, can we meet demand? This is the first job I have done in the NHS where the workforce is not our constraint. Lots of people want to come and train to be paramedics. The London Ambulance Service has become the NHS's biggest apprenticeship provider. We have 723 people on apprenticeships and two state-of-the-art training centres in London. You can do a degree through the London Ambulance Service, which we pay for, so recruitment is really strong. My current funding for this year is a good level of funding and should mean we can deliver the response.

The 'however' is that there is huge burnout going on with the workforce in paramedicine, which I am sure you will hear, because part of the job has become really difficult. Waiting with your patient in a hospital to hand over is completely soul-destroying for the clinician; it is also an awful patient experience and it is taking up a huge amount of time. You would normally expect a paramedic to be able to treat six patients on a shift; in some parts of London, on some days of the week and at some times of the day, it is one or two. That is really bad and is causing a huge amount of distress. You can see it all over the media, because that is not right. We have to fix that. We must never normalise that hospital handover delays are acceptable. As we have just heard, it has an impact on both the police and fire brigade because then the ambulance service is not always as available when it needs to be to get to the really sick patients.

The Chair: Do you find there is a difference in those innovations? For example, in north-east London, when the A&E consultant says, 'No, they don't need to go and this is the alternative', are your paramedics enjoying that? 'Enjoy' is not the right word, but are they getting better job satisfaction from that than from the normal ambulance work?

Daniel Elkeles: It is huge job satisfaction. People become clinicians because they want to look after people. We are increasingly giving the clinicians more skills and more ways they can use their skills to keep people well and at home. The real positive is that. We have loads of

clinicians who are really hungry to develop themselves to be able to do more so that you can change the paradigm. Why would you convey someone to hospital and potentially be in a handover queue if, actually, you could give them much better care at home and get other parts of the NHS to come to them? It is one of those virtuously good things. That is good for professional development; it saves the NHS money, but it is also a much better patient experience, and that is what we are all here for.

The Chair: I want Dennis to think about job satisfaction too from some of the things he was saying. Can I come back to you, Daniel, about the system? As you say, you are the one NHS organisation that covers the whole of London. You have different projects going on in different areas. Because it was on the local television and I have heard from other people, I know the challenges in the north-east in trying to keep the funding going because the commissioners just saw it as an expensive thing and were not talking about the savings being made. How are you working to try to make sure that the system works across London and that what works is picked up in other areas? Are you able to do that?

Daniel Elkeles: We are getting increasingly better at it in nearly all the innovations that I have just shared with you. If you take the mental health joint response car, it started out as one, and now all of London will be doing that. The phone-a-friend scheme was started in north-east London. We now have north-west and south-east London wanting to do it. The joint response cars for the community have been going for only two weeks, but I now have interest from most of the rest of London to say they would like to do it. I see our role as the only London-wide provider, and we do work with the London region, as having a real ability to spread good practice because we are in all of London and part of all of the ICSs. Spending all the time on relationships is time-consuming, but to make change happen is a relationship thing. I think we can do it; it is definitely possible.

The Chair: Dennis, let me give you the chance to answer on workforce.

Dennis Keeley: I mentioned burnout earlier and the opportunity for our paramedics to have that variety of work across a working shift. I think that has got to us in terms of the work/life balance, if you like, but that is becoming increasingly challenging. There is a huge element of frustration among staff with the handover delays at hospitals in relation to triaging. It has always been so. We are not very different from London inasmuch as it has always been the case that the ambulance service responds to non-emergency calls, but nevertheless it is left in a position where it transports the patient to an emergency department, despite the fact you know this really is not necessary.

Looking at the empowerment we have given to our highly trained paramedics and advanced paramedics, we are in a very interesting time in pre-hospital care where devolving that responsibility into the decision-making at the clinical [*Inaudible.*] that they offer is an exciting time for those responders. They welcome that. We need to provide all the

protection they need to ensure that we do not put them in a vulnerable position.

As for the workload, the enjoyment and the role of the firefighter paramedic, in many ways we have the best of a lot of the aspects in terms of being happy with the job now at this crossroads for pre-hospital care with different disciplines. I am excited to hear about the extra initiatives that London is providing, but whether it is community first responders, of whom we have a large number in the Dublin area, where we have the community responding as part of the whole response mechanism, whether it is our community paramedics or trauma paramedics who are responding, our job now is to empower them and give them the tools to bring the hospital to the patient and to assist them to be the decision-makers. That is the next step in keeping staff satisfied in their role; I think that is the next natural step.

The Chair: I need to keep moving on here. You can tell that we have lots of questions and want to keep going, but never mind.

Q15 Baroness Pincock: It has been fascinating so far. My question is about collaboration between services. I have never thought about the ambulance service not being an integral part of the NHS, as Daniel has described. Would that be helpful? Are there unseen problems? You will have thought about them. Are there any unintended consequences from such collaboration? Does it happen already? Where could it be developed?

I would quite like to start with Daniel because he has been explaining how great the integration is going on within the NHS, but what about the other emergency services?

Daniel Elkeles: We work closely with the police and fire brigade. To give the example of the police, we are the only ambulance service that has a dedicated IT link between our control rooms and the Met control rooms. Literally, between 600 and 800 messages a day pass between us to enable us to provide the best care between both sets of services. That is a pretty advanced form of collaboration. It requires a lot of trust that the information you are sharing is right and appropriate.

As for the fire brigade, we need a new estate strategy, because we have not had one for a very long time, and it is natural that we go and talk to the London Fire Brigade (LFB) about whether we can cohabit some of our ambulance stations with the fire brigade. That happens quite commonly in the rest of the country. We have only one shared location between us and the LFB currently. That collaboration between the emergency services in London is well established, no one would like to unpick it, and we work well together.

A whole new collaboration is emerging between an ambulance service and primary care, which is also worth investigating. GPs are allowed to employ paramedics as part of their workforce, and in parts of the country that has meant paramedics have gone from the ambulance service to GP practices. In London, we have a massive scheme where we do joint appointments between primary care and the ambulance service. In some

of the London boroughs, the paramedics are on a 50:50 rotation. That is really brilliant because they get upskilled in primary care, do not lose their front-line experience and we do not lose them from front-line care either.

We are now exploring lots of ways of how an ambulance service, or 111 provider, can support GPs to deliver lots more care when people phone on the day to say they need an appointment with their GP and there simply is not the GP capacity to do it. We are thinking about how we can help to provide capacity to primary care so that can actually happen. If you have seen the document called *Fuller Stocktake: A Vision For Integrating Primary Care*, it has a big section on urgent care, which begins to talk about the relationship between primary care and the ambulance and 111 services. There is lots to talk about in that space.

Baroness Pinnock: There is, is there not? I would quite like to hear the thoughts from other parts of the country. Dennis, would you like to tell us what happens in Ireland?

Dennis Keeley: We mentioned earlier the importance of relationships. Collaboration hinges on people. We can have all the technology and systems we want, but ultimately it boils down to people. Relationships are so important. Nevertheless, I think collaboration can break down where the accountability of each agency is not quite clear. It is important that, despite the good relationships and communications that you might have with the current equivalent in another agency—at times it is about personalities and individuals—you need to consolidate that with very strong governance arrangements so that it is quite clear on both sides what the expectations and working arrangements will be.

For ourselves and the National Ambulance Service as an example—the two services operating in the Dublin region—we operate a virtual joint desk. Likewise, we will have hundreds of communications back and forth during the day, trying to manage queueing and delays at EDs in terms of handovers. As in London, that level of trust and integration is growing all the time. It is a significant part of that collaboration between our two agencies, the National Ambulance Service and Dublin Fire Brigade. There are lots of opportunities that are hugely important for collaboration with other agencies, such as our police force, the Garda Síochána, at regular inter-agency meetings at local level, regional level and national level, each informing the other of the various programmes of work that are being undertaken.

I suppose that one of the challenges and difficulties that may exist in that can be around the expectations and whether they are realistic. They can be about not having the shared vision, which I think is fundamental, that, when they are going to collaborate, each agency understands and agrees a shared vision in what is attempted to be achieved and that clarity exists.

Those initiatives are the opportunities for joint meetings and the parity of esteem between the agencies, which is also critical, so it is not seen as a

power struggle or grab for resources. These matters are not rocket science, as was said earlier; these are fundamental pieces to the esteem of all our organisations.

Baroness Pinnock: That is very helpful. I turn to the police in Wales.

Pam Kelly: Perhaps I could bring a different perspective to that. First, on collaboration in terms of procurement, purchasing of furniture, vehicles or whatever, that is an absolute must, and certainly on a regional level and across policing we are exploiting that because it will release money that we can put back into front-line services. For me, that is common-sense collaboration. Across the sector many of us are doing our best to release money, because we are big purchasers as public services and we need to use that to best effect.

Of course, our front-line services collaborate really well. On a day-to-day level, they collaborate really well. However, we need to be careful and bear in mind that, certainly in my case, probably about 65% of my front-line officers have less than four years' service and are very young in terms of age and experience. We are trying to develop skills in policing; that is, public order skills, how to deal with cybercrime, neighbourhood crime, firearms, sexual assaults and violence against women and girls. We cannot have front-line officers who are specialists in everything too soon. I think that is dangerous territory. What we do is burn people out and public expectations are too high. We need to work on it carefully in a very much together approach so that when there is an emergency, and we know that from what we see regularly in crises, our public services work well together.

One other thing is that across departments in government each of us as an emergency service have different performance measurements and targets. If we really want to serve our public in a one public service approach, we have to be careful that those targets, scorecards or whatever people want to call them do not pull apart collaborative working; it should be pulling them together. This is a real barrier for us. As money becomes tighter and there is much more of a focus on performance targets, will that undermine what we do together when our communities need us most and demand is at its highest? There is collaboration at a number of levels that I think we need to look at and work through together.

Baroness Pinnock: That is such an interesting answer. Thank you very much.

Q16 **Lord Filkin:** We have had some fascinating evidence on both this and the previous question. Could I ask a question on collaboration for system transformation?

Daniel, you and others have talked essentially about system transformation. Put crudely, in the past the measure of success was how quickly an ambulance could take somebody to A&E. Now we are certainly identifying an urgent need not to take people to A&E like you said,

because that will have enormous benefits to the person and the system.

I have about three or four questions. If there is not time, could you send a note afterwards, because it is pretty on the money of what we are interested in?

First, is the data from all the ambulance services of non-admission by categories? If so, can we have a look at it, and how has it changed over time?

Secondly, is there now a consensus about what a normative model would look like of good practice in not sending people and what sort of system needs to be developed to achieve that? You have given some very interesting illustrations of things that sound as if they are highly relevant to doing that, but we are groping to see that brought together with some numbers saying that, on this scale of demand, these are where the big hits are, the big gains, and this requires a re-engineered system with PCTs, or whatever, to reduce demand into A&E and for patient benefit.

If that is pulled together it does not have to be a long note, but at least a very clear one and an illustration of who needs to do what to mobilise such a system transformation and the collaboration or incentives that will be required to make it happen. Clearly, it will be different in 10 years' time because that is how life is, but we have to get on fairly fast with some of the system transformation that you have painted a picture of; otherwise, it will all drown very badly. It does require a vision of what good looks like. It is not good to get people fast to A&E if they are just stuck in a queue. It is good to get more people treated.

Daniel, is that an impossible piece of homework, or have you already done that?

Daniel Elkeles: You could ask those questions of some of the witnesses sitting behind me and you would probably get a better answer than from me.

Lord Filkin: I do not mind having lots of different answers; let us just have a look at it.

Daniel Elkeles: It is very interesting to look at admission rates into hospital by category of patient because you do not discover what you would normally expect. Ambulance patients fall into categories one to five where in theory one is the sickest and five is the least sick. The highest admission rate is in category three, predominantly because that is where elderly people get categorised when they phone up and they are ill. The admission rate is skewed by how old you are rather than by category. We can show you that, if you like.

Lord Filkin: Please.

Daniel Elkeles: That is what the data shows.

Is there an agreed model of good practice? I think the answer is not yet because we are in a place where there is a huge amount of innovation happening right across the ambulance community. One of your witnesses

later in the week is Daren Mochrie, the North West Ambulance Service chief executive, and loads of good things are happening there too. We are working on how you design the best system that means that you get taken to hospital only when you really need to go there. I have given you some examples of things you can do to look after people at home, and there are many others.

We need to systematise that. What is the vehicle to do that? We have the new structure in the NHS called ICSs—integrated care systems—of which there are five for London. They are designed deliberately as a collaboration of what were the commissioners and providers, but all sitting round one table together to talk about how to use their collective resource, workforce and endeavour in the NHS to provide better care for the people who live in the geography of that ICS. That is all a new way of working.

Lord Filkin: But they will be very busy and they have a number of transformations. Does it require somebody like you at least to put forward a hypothesis with some data and say, 'I think this is at least a debating model of where we should be going'?

Daniel Elkeles: Yes. In London, we now have an urgent and emergency care board that brings together the five ICSs with the region and the ambulance service. That is exactly the point of the board, which is to say, 'Let's not try to do things five times over if we can agree that there is one model for the region that works'. All these structures are quite new, but the good will from people not to compete, which was the old regime, but collaborate in the interests of patients is really strong.

Lord Filkin: It would be great to get a note as well, if we can.

Q17 **Baroness Pitkeathley:** I know we are very short of time. To some extent my question, which is the 'not invented here' question, has already been addressed by colleagues. I refer to the difficulty of getting pilots embedded in the mainstream in public services, which we have found constantly in this committee. I must say I feel quite cheerful about that today given the evidence we have heard.

If Pam and Dennis have any brief examples of the barriers to moving pilots into the mainstream, perhaps we could hear from them. I want to ask you specifically, Daniel, about the new schemes you talked about that you have in different areas. One is collaborating with orthopaedics; another is collaborating with community services. Obviously, they are going very well, but where did that initiative come from? Did it come from the orthopaedic department—in other words, the clinicians in the hospitals—or from your ambulance service itself and your paramedics?

Daniel Elkeles: Most of the things come bottom up from clinicians. My experience, not just from the ambulance service but from previous jobs, is that you do not try to design a governance system to deliver integration, but if you get clinicians from lots of different disciplines together and say, 'How would you look after this person? What would you do?', they will all get there very quickly. They will say, 'I've got this skill.

You've got that skill. This is what the person needs, and this is what we would do'. Then you say, 'If that is the outcome we want to get to, now let's design a system that enables those decisions to be made effectively'.

In my previous job a hospital ended up taking on community services and primary care because we said we could keep lots of people out of the hospital if we worked together. In a way, I brought that into the ambulance service and said, 'What happens if?' How we ended up with joint response cars for older people was that we did a piece of work with the five community providers in south-west London and my team, and said, 'What does good look like?' The clinicians said, 'It looks like this', and then we made it happen.

Baroness Pitkeathley: Was that because the need presented itself more acutely in that particular geographical area, or did it just happen to be certain relationships between individuals?

Daniel Elkeles: To get people together you have to have some relationships. We chose south-west London because that was where I was a hospital chief exec, so I knew quite a lot of people. But when you say to the clinicians, 'What would be the best care for a frail elderly person who has fallen?', they would say, 'It looks like this'. Then you say, 'Let's do that then'. The idea has to come from the people who are actually providing the care. By the way, it is quite good to talk to patients as well. We have a very active patient council in LAS. We asked them what they thought about the new model of care and they said they would support it.

Baroness Pitkeathley: Perhaps I could extend to Dennis and Pam the opportunity to talk about that consumer angle. If your consumers or clients wanted to design your service, what would you expect them to say? Do you want to start, Pam?

Pam Kelly: From a policing perspective, we seek a number of different views. For example, victims of sexual assault have designed the approach we take to rape and sexual assault investigations. The important thing for me is: what are our communities telling us about the service we are providing as single agencies but across emergency services as well?

I know we do not have much time, but I am very passionate about a futures approach. During times of austerity we often take money away from predictive work. For me, that is the time we need to invest in future thinking, innovation of thought and having some of the younger people in the service working alongside our communities so that we plan for the future and develop leaders of the future on that journey.

Our communities and agencies will be struggling financially over the coming weeks and months. My worry is that that innovation, which now needs to be working at maximum speed, will be culled because of the money, and the capacity will not be there to deliver. That is a real passion of mine. That is our biggest barrier.

Let us continue to work with our communities. What is it that our communities need? It is not just: what is it that emergency services have to provide? It worries me that some members of our community are injured and we are unable to attend because of that demand. That is not acceptable. We have to work much more innovatively, but the money and capacity need to be there. I think the innovation will come from that.

Baroness Pitkeathley: That is a very timely warning. Dennis?

Dennis Keeley: I appreciate that you are tight for time, but I would build on all that Pam has said. There are challenges for our services and for the delivery of our services. It is extremely important that when people dial 999, or 112 in our case, they have every right to expect that they will get a timely response from whatever service they need at that moment because for them that is a crisis.

We work hard to engage with our users. We have opportunities for surveys where we get feedback. Generally, the feedback is quite positive. We are seeing an increase in complaints and an increase in people being dissatisfied with the service they are getting. This may be linked to Covid, but it is certainly linked to the expectations of the public of the service they want. That is predominantly around a rapid, courteous and professional response. That continues to be a challenge for us particularly and never more than it is at the moment.

The Chair: I know that my colleagues have lots of other questions they would want to put to you. This has been a very useful and fascinating session. Thank you to all three of you for coming. Your jobs are really important for people out there who are anxious and concerned about their future, their relatives, their families and communities. Thank you enormously for giving us your time, experience and insight this afternoon.