

Public Services Committee

Oral evidence: Access to emergency services

Wednesday 19 October 2022

4.05 pm

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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. 3

Heard in Public

Questions 18 - 23

Witnesses

[I](#): Miriam Deakin, Director of Policy and Strategy, and Deputy Chief Executive (interim), NHS Providers; Dr John Martin, President, College of Paramedics; Lisa Elliott, UK Deputy Director of Nursing: Workforce, Professional Practice, and Quality, Royal College of Nursing (RCN). Examination of witnesses

Miriam Deakin, Dr John Martin and Lisa Elliott.

Q18 The Chair: Welcome to the second session today of the Public Services Committee here in the House of Lords. We are very pleased to have, again, three very interesting witnesses. We have Miriam Deakin, interim deputy chief executive and director of policy and strategy at NHS Providers; Lisa Elliott, deputy director of nursing for workforce, professional practice and quality at the Royal College of Nursing; and Dr John Martin, president of the College of Paramedics. We are really pleased to have all of you here.

In this session we are looking particularly at leadership, autonomy and regulation, inevitably all these things coming together. In the last session, certainly some issues around regulation came in as to whether or not people can collaborate effectively, and leadership was at the core of everything that people talked about.

I want to open up by asking you how you see and describe the balance of authority between NHS trusts, integrated care boards, NHS England and central government. We heard about ambulance services too, which have more recently come into the NHS. We are interested in systems and governance too.

Do you think that coming out of that mixture, some of which I have just described, local leaders feel they have the authority and the capacity within the role to take the decisions that are necessary to deliver the high-quality services that everybody wants to provide? Who wants to start? Miriam, I will take you. You are in the middle.

Miriam Deakin: I will make a start. Thank you for inviting us to speak with you. As you said, I am director of policy at NHS Providers. We are the membership body for trusts. We represent all the ambulance trusts in England as well as mental health, community and acute trusts. We aim to speak on their behalf.

As you rightly described, I think the health and care landscape is very complex. People generally accept that there are roles for national bodies to fulfil—for example, setting national standards, national targets, the response times that we have in the ambulance sector, a national policy framework and regulation. People accept that there is a valid role for the department and NHS England in that regard.

As you mentioned, we have new integrated care boards and integrated care systems on a statutory footing. That presents a huge opportunity for integration and integrated services. It does present some unique challenges for the ambulance sector because the ambulance services are operating on a larger geographical footprint than any individual integrated care system. So that is quite interesting.

Legally, in NHS trusts, whether a foundation trust or an NHS trust, the trust board is accountable for the quality and safety of the services delivered. Theoretically, legally, trust chief execs and clinical directors have autonomy and authority. However, a number of factors lie outside the control of any individual trust at the moment. Some of those warrant government attention—things like looking at longer-term workforce planning, looking at the impact of inflation on the service and ensuring that people can get access to enough capital, which is a huge challenge, and looking at social care, which is a cross-government issue.

Some of those issues sit outside the gift of any individual trust. For the ambulance sector, it is particularly interesting that the challenges we see presenting perhaps at the front door of a hospital in handover delays also lie out of the immediate control of any individual trust, which I think you heard from previous witnesses. That points to working very differently in systems and it points to a case for greater investment holistically across the piece, perhaps in primary care and mental health community services as well as looking at our acute bed base.

Theoretically and in legal terms, trust chief execs and trust boards have that autonomy. They are certainly accountable for the quality and safety of the services they deliver. The solutions to the challenges that we see lie in collaborative working and likely in investment in other services—perhaps more in community services, mental health services and primary care.

The Chair: Thank you. Lisa.

Lisa Elliott: I am the deputy director of nursing for workforce, professional practice and quality at the Royal College of Nursing. I would like to follow on from what Miriam said.

The Royal College of Nursing has close to half a million members across the UK, and I think the system at the moment is under real pressure. One of the real pressures that you have is workforce. We are running at a nearly 12% vacancy rate within nursing at the moment. If you want the system to run effectively, you need to have the workforce and the nurses for that to happen. At the moment, we have such a high vacancy rate that the system is not working and is impacted. Nurses are integral to every single part of the system. If you do not have enough nurses, the system is not going to be able to flow.

The wait to be able to hand over in the emergency department is a great example. You need to have the nurses there to be able to hand over to. If you do not have enough nurses in your emergency department, that is a delay. You are also going to get that delay because you have patients in the emergency department waiting to go to a ward, so you need to have nurses on the wards to accept that patient and to facilitate the discharge of patients out of hospital and into the community.

You also need to have the community nurses to accept and deliver the care there. You also need nurses within primary care and public health to possibly prevent people needing to come in. We are running at such a high vacancy rate at the moment that this is impacted along the way, and patients at the centre are being affected.

I also want to add that we are struggling now with retention. We are seeing nurses leaving. That is because of the vacancy rate, the impact of not having fair pay at the moment and the way that nurses feel that they are not valued and they are not listened to. It is difficult to retain. We need to be able to retain the nurses. We are not in a position where we can afford to lose nurses at the moment, but we are seeing a struggle.

I talked to a ward sister last week, who told me that she was consistently having to come in on her days off because they do not have enough staff, and that was happening really regularly. She told me that she was feeling burnt out and that she was exhausted. These nurses have suffered two years of a pandemic. They have gone through that, but the pressure has not gone now that the pandemic has stopped. We are still seeing a high workload pressure and hospitals at high occupancy rate, and that is now impacting the well-being of our nursing staff and how they are feeling. For me, if you do not have the workforce there, you are not going to get systems to happen and you are going to be in crisis management all the time.

The Chair: Thank you, Lisa.

Dr John Martin: Good afternoon. I am the president of the College of Paramedics. We represent 21,000 members across the United Kingdom. I am also a practising paramedic, so I see patients every couple of weeks on a clinical shift. I hold a post in the London Ambulance Service as chief paramedic, so I am an executive director within the NHS.

In terms of your question about the system, you have already heard that there are 10 ambulance services in England—and more if we include Scotland, Wales and Northern Ireland—and there are 42 integrated care boards, so there is a mismatch. What we see when we practise as paramedics is having to get down to a real local level with our primary care colleagues and social care providers. We need to explore what happens at a big level, what happens at a small level and how those interact to allow practice to occur. That, for me, is some of the change we are seeing that Miriam has outlined in this new structure. How do they come together?

I think you also heard in the last session—and I can say this probably because I have worked in acute and community and mental health in my career—that ambulance services have been a bit of a bolt-on in the NHS. Increasingly bringing them into the fold where we see ourselves as part of the NHS—because we are all seeing the same patients—is a key component of the future and being able to put the patient at the centre of what we do.

A last point I would like to make is that, although I am going to talk probably a lot about ambulance services because I know that is the focus of the committee, paramedics now work in all sorts of fields. They are also in the emergency department, in primary care and working in community services across the country.

The Chair: Good. At some stage, we would appreciate you saying a little bit more about that and how you see that developing.

Lord Hogan-Howe: One quick point of clarity if you do not mind, Chair. Lisa, you said very clearly there is a vacancy rate of about 12%, and that was the majority of your evidence.

Lisa Elliott: The exact figure is 11.8%.

Lord Hogan-Howe: What is causing that 12%? If you have the money for the budget, why are they not getting employed? I say 'you', but I mean collectively.

Lisa Elliott: We are not producing enough nurses domestically. We are not training enough nurses to fill those posts. We have a huge reliance on international recruitment, but that is not sustainable. We know that globally there is a huge shortage of nurses. We are not producing enough and we are not retaining nurses.

Lord Hogan-Howe: They are slightly different problems, are they not?

Lisa Elliott: We are seeing nurses leaving in droves as well.

Lord Hogan-Howe: I thought you said that the vacancies were causing the lack of retention—that is people getting overwhelmed.

Lisa Elliott: They are both. The fact that you do not have nurses—

Lord Hogan-Howe: What I am trying to get to is this. What has changed? You always have a vacancy rate—

Lisa Elliott: No, this has been a long-standing problem. Pre-Covid, we had a high vacancy rate above 12%. We saw that fall during the pandemic because there was a real push on the temporary register, nurses were encouraged not to retire, and we brought in nurses who had retired. We saw our vacancy rate fall a little, but it is now back up again. It has gone from 9% during the pandemic to 11.8%. That is because we are not recruiting enough and we are not retaining enough. The fact that we are not retaining nurses, or the fact that we have this vacancy rate, makes it harder to retain nurses because they are working in a very stretched way.

Lord Hogan-Howe: Basically, they are not producing enough students to fill the regular jobs.

Lisa Elliott: We do not have enough students. There is a challenge. We are seeing a decline this year in the number of people applying to be student nurses. We saw a bit of a rise in that during the pandemic. We have seen a drop-off of that again now. It is about attracting people into the profession and keeping them when they are in the profession.

Lord Hogan-Howe: Thank you.

Q19 **Lord Porter of Spalding:** Miriam, earlier you said that people further up organisations are empowered to use their judgment to do things differently within the set parameters. How far down organisations does that go? Do you feel that people at the front end are empowered enough sufficiently to be able to make decisions based on what is best for patients, even in the control rooms? I do not know whether they still do it, but they used to say, 'Hello, 999. What service do you require?' 'Something that is fast and efficient.' I am not sure whether the call handler is better placed to decide what service the person requires once they have been given the problem.

Do you feel that people on the front line have enough empowerment to do stuff, and are they trained enough to make the right call on behalf of patients?

Miriam Deakin: Those are really good questions. I might bring in John as well if that is okay. My sense is that, particularly in the ambulance service, call handlers, who are paid a very modest wage, and paramedics are carrying a lot of responsibility. They have a lot of clinical autonomy. It is quite an unusual service in terms of the paramedic feature because you are literally out on the road in very small, compact teams, and you carry a lot of responsibility to take decisions in the moment depending on what you are faced with. It is the same for call handlers, who have clinical

guidelines and clinical supervision, but when they take that call there is some burden of responsibility on them.

I feel that in the NHS that level of clinical autonomy certainly filters down. As Daniel said, in terms of innovation, the kinds of groups you want to make sure we are always hearing from are clinicians, front-line staff and, of course, patients—the patient community voice in what we are shaping as well. I do not know if I can pass to you to add to that, John.

Dr John Martin: Absolutely. In terms of clinical autonomy, that does move down. We might talk a little later about regulation and maybe how we might practise defensively depending on how that is there. Certainly, as a paramedic, I do have the ability to make decisions in the best interests of patients. I will be following guidelines and best practice though, and that is absolutely an advantage.

Because there are only 10 ambulance services, there is quite a restricted, 'This is the best way to do it', which allows for less local variation. There are probably positives to that as well as a question to be asked about whether it means further down that it does not meet the local needs. Certainly, as a clinician, that ability to practise within guidelines is there.

Regarding call handlers, there is some good evidence that following quite a rigid script around that allows us to identify certainly patients in cardiac arrest very quickly. If you allow someone like me on the end of the phone, I will deviate in various ways and take longer, so there is some sense in some things having to be quite highly protocolised for emergencies.

Lord Porter of Spalding: This is not related to my question but to a comment you made earlier about ambulance staff starting to be seen as part of the health service. From a patient's point of view—from Joe Public's point of view—I do not think we have ever seen ambulances as anything else other than the core part of the health service that gets most of us to it when we really need to get to it. I do not know how the organisations have just decided they are all of a sudden part of what we all thought as a country you already were.

Somehow, we need to make sure that the service understands that the public sees the health service as an entirety, not as bits of it, and certainly the ambulance service is integral. You would have seen from the previous evidence that we are increasingly seeing the police service as part of the health service and the fire service as part of the health service. If anything, somebody needs to start marshalling where all the blue lights sit in the health service rather than still having those departmental silos that allow people to think they might be higher up a hierarchy because they are from a different thing.

Certainly, in the bit of the world I look after, the public see all of it as the health service. There is no hierarchy in it. It was not a question, just more of a statement following on from that. It is just a bizarre thing.

The Chair: It is what we are struggling with. It seems to me that one of the pieces of evidence that we kept hearing about before is the real problem of the ambulance service for handover, for treatment, which Lisa mentioned, and for moving.

We have also heard particularly in our previous inquiry into workforce that professionalisation has sometimes created barriers so that there are associate medical people who really ought to be able to prescribe who cannot. If you go to A&E you may be given two painkillers, but you then have to be sent somewhere else to be given a prescription for them, for example.

It seems that, looking at the thing as a whole, there are restrictions that need to be got rid of as well as looking at whether the boundaries are too tight, so that “No, that is not my job” becomes too prevalent. Do any of you experience that, particularly once it gets to the hospital?

Miriam Deakin: Hopefully, we are seeing some of those boundaries broken down a little bit now. When we talk about bringing the ambulance sector into the health service, we are perhaps thinking about how integral the ambulance service is, and particularly the growth around urgent care, rather than just seeing the ambulance service as a sort of blue-light response. Increasingly, ambulance services are an integral part of supporting the public with urgent care demands as well, and that means having a mixed-model workforce. I know other panel members will be able to say more about that.

We have a number of examples of innovation. In the north-west, we now have community paramedics, and they are able to socially prescribe. They are often dispatched to support people who certainly are in need but may not even have a primary medical need and will not benefit from conveyance to ED. They can offer social prescribing and signposting into voluntary sector support—a much broader range of help.

Lots of hubs are focused on people who have fallen, who may or may not warrant conveyance to ED, and some services focus on the needs of older people in particular, and quite often they will have a mixed multidisciplinary team. We have very mixed models now in call centres. Midwives, district nurses and all kinds of people can be on call in a call-handling centre.

Similarly, some interesting models are emerging of paramedics situated half-time in primary care so that they are rotating through different clinical settings. Not only do they learn more about that setting in developing themselves, but they are passing on their knowledge to their colleagues in those settings as well. That kind of breaking down of the barriers and moving to more of a mixed-workforce, mixed-skills model is developing.

Lisa Elliott: I would like to add to that. I think that nurses see themselves as very much part of the multi-professional team and are very used to working with a range of professionals. We need to have a

level of caution, though, about the substitution of non-professional nurses because there are not enough. We need to make sure that we are not trying to fill a gap with people who do not have that level of training and that level of expertise.

A lot of research is out there that we are happy to share with the committee that shows that you need to have the right number of substantive registered nurses in order to provide safe care. When you do not have the right number of nurses, patient care is affected. There is something about breaking down the barriers and working in a very multi-professional way, but making sure that we are not trying to fill gaps where they are with a pair of hands; I suppose that is what I am saying. We need to make sure that we have the people with the right skills and the right knowledge in order to provide safe care.

Lord Porter of Spalding: In the absence of people with the right skills, surely in some circumstances a pair of hands is better than no pair of hands. If people have fallen on the street and are lying there for 12 or 14 hours because the ambulances are all chewed up with people who have been dropped off to a hospital that does not really want them there because they are already under the cosh because they do not have enough nursing staff to handle the people in the ambulances, surely a big room with another pair of hands in it so that those ambulances could offload and get back out again would be better than not having that extra pair of hands.

That is not in an ideal world. In an ideal world, everybody has all the skills they are ever going to need and if I have to go to a hospital I have 110% of trained people looking after me. Lying on a street for 12 hours is not a preferred option if it could be somewhere safe and warm. That surely is a preferred option.

Lisa Elliott: What I am trying to say is that we want a workforce plan that looks at how we are actually going to fill these vacancy rates. Nursing is a safety-critical profession. You need to have the right number of nurses in order to provide safe care. No one wants to be on the floor for 12 hours waiting for an ambulance, but at the same time you do not want to be a patient in a hospital without having a nurse to look after you. You need to have the right number of nurses with the right skills also to get the patients effectively through the system so that you prevent that backlog in the first place.

It takes skill to plan an effective, safe discharge out. It takes skill to make sure that patients do not deteriorate when they are in hospital. In order to get patients through the system safely and provide that safe care, we need to have the right number of nurses with the right skills, and we are lacking that at the moment.

Baroness Morris of Yardley: Can I follow that up? I do not disagree with you. It is a really highly skilled job. If I am ill, I want to have a person with the right skills. Things change. A nurse's job now is not what it was if you go back 20, 30, 40 or 50 years. In every occupation, we

have to change everything depending on what we learn and what technology says. How good are you at matching that wish to preserve the nurses' skills when they are needed with being innovative and looking at a new workforce for new times? I can think of a whole host of examples, which you can as well.

To be honest, it sounded a bit as though you were saying, 'Nothing can ever change. It's always got to be the nurses.'

Lisa Elliott: No, no.

Baroness Morris of Yardley: Can you say a bit about how you see a new workforce, because we know new things and the service is different and we are looking for different aims? It has to be give-and-take a bit, does it not? It has to be saying that, if we have a new workforce, it is me who needs to change as well as everyone else. Can you say just a little bit about that?

Lisa Elliott: Nursing does innovate and has adapted. You are right: we are not where we were. I have been nursing for over 20 years now, and it is not the same role as it was 20 years ago. It is a very professional, degree-level profession now that we are in, but the research shows that if you do not have enough nurses—and nurses are integral—patient care is affected. We work in a very multi-professional way. We work very closely. We are adapting and changing in the roles, and the positions and skills of nurses change, but what I am saying is that, because we are integral across the whole of the patient journey, if you do not have enough nurses, the patient is the one who is impacted and affected, and the patient flow is impacted and affected going through the system.

Baroness Morris of Yardley: Equally, if one of your colleagues elsewhere is not a nurse, the way their job changes is to do some of the things. Are you happy to discuss that? That is part of creating a new workforce as well.

Lisa Elliott: It is. What I am saying is you cannot substitute a safety-critical professional with someone who is not.

Baroness Morris of Yardley: No, I agree.

Q20 **The Chair:** We could have lots more questions, and I am aware we have not brought you in on that, John. There are issues too around the changes in paramedics. However, we wanted to ask about good leadership. What does good leadership in emergency services look like?

Dr John Martin: I do not think it is any different in emergency services from the rest of what good leadership is. What is missing in my experience, having been in the profession for over 20 years, is an understanding of what good leadership looks like and the evidence base for that. In my clinical practice, I am expected to stay up to date with the latest research to understand how drugs have changed and to understand how practice has changed. That is a common part of clinical understanding.

I would say my experience in the ambulance service, although it has been changing in more recent times, is not that. I climbed quite a way up the hierarchy without any understanding of what leadership was, what the evidence base was and what the research was underneath it. It turns out as I started to study it and became a student of leadership that what I thought it was and what I observed in the ambulance service is not actually what good leadership is. I know you have seen some of the reports coming out of the Care Quality Commission recently. You emulate what you see above you, whether you think that is good or bad potentially, if you do not know better. The crux of this is getting to the heart of what good leadership looks like and what the research shows.

I will just give you one study, but as a committee there are lots of studies you could look at. Goleman's study back in 2000 said that there were six different leadership styles, four of which were good for morale in the long term and two that were not. The two styles that were not were 'coercive and commanding' and 'pacesetting'. My experience in the NHS, often with the pressure of the demands and making sure that we are providing a service, means that those two are the dominant styles. They are used more often when people are frustrated about delivery and cannot get there. We know from that study that it drops morale in the long term. Although it gives you immediate results, it does not give you long-term sustainability.

As we come out of a pandemic where we had to take a quite commanding approach, saying, 'This is what we are going to do. This is the order we are going to need', I think we need to reconsider some of the other styles such as coaching and visionary leadership in our basis, to use that as an example. If we looked at bad leadership, it would be overuse of the wrong styles.

I often think about this in relation to my children and the frustration I sometimes have with getting them to put their shoes on. I can try coaching for a bit. I can say, 'Let's take you out to the park. Let's do this or do that', but once the time pressure comes, or in this case maybe the regulatory pressure, I get angry, I shout, I turn into 'coercive' and say, 'You must put them on right now', and we know that that is bad in the long run. We need to get to what is the evidence base for good leadership for sustainable services outside a crisis.

Miriam Deakin: I agree with John that the qualities of leadership that we are looking for are consistent across the NHS. Leaders in the current world have to be highly collaborative. We have talked about many of the solutions to the challenges the ambulance service faces sitting outside the gift of any individual leader. They have to be highly collaborative; they have to be inclusive; they have to be able to talk to staff, patients, clinicians, stakeholders and colleagues; and they have to be innovative.

As John alluded to, it is worth probably remarking on the level of resilience that we are asking of our leaders in health and care at the moment with the current level of operational pressures. It is also worth emphasising a point John made there. The leadership qualities we ask of

trust leaders or clinical leaders are important to emulate at all levels of the system, whether that is through regulators or other national bodies.

Lisa Elliott: I do not disagree with anything that has been said. I would add that it is very challenging to lead during a crisis, and for nursing there is a crisis. There is a workforce shortage at the moment, so it makes it very challenging. When you are in those challenging situations, it is very hard to be visionary and to be a role model. It is very hard to take people with you when you have a demoralised and exhausted workforce. It is extremely challenging at the moment to lead within the systems that we have.

- Q21 **Lord Filkin:** In a sense, I am inviting you to go back to some of the topics we explored in the last session, particularly with Daniel, about the leadership for system change. Could each of you speak from the perspective of your own organisation, your own role, about what you think you need to do to mobilise the sort of system change that may be necessary to empower those who will no doubt operationalise it?

I am still on the same broken record—but please challenge it—that one of the most important issues is trying to reduce the number of people who get taken to hospital when they do not really need to, and it would be better for them and the rest of the system. We do not have much data on that, but I would assume if it can be maximised it makes a pretty big impact on delays and on patient dissatisfaction. It is pretty urgent to get some data on that.

Put that to one side, though. If you agree that that is a critical goal, do you agree that we need to articulate what are the key components of such a new model, which obviously will evolve through time, so that people have some sort of idea of what evidence-based good looks like to reduce those admissions that ought not to be going there? Perhaps you would like to answer those two questions and address the third one about what you think you should be doing about it in your role.

Dr John Martin: Shall I start with patients going to hospital? Back in 2005, the Department of Health published a report called *Taking Healthcare To The Patient*. That very much set ambulance services and the profession on a journey. It changed the way paramedics were educated. It changed how we practised, fundamentally.

You mentioned data. Back then, when I was practising, we were taking 77% of patients to hospital. Today, it is about 51%. That is what the latest year shows. Yes, that has taken a chunk of time—quite a number of years—but that is how you professionalise a workforce.

How have we managed to do that over that time? It is a change in education and it is a change in our practice. It has required huge collaboration in terms of working with other professions. The autonomy that comes with making the decision to not convey a patient to hospital is very much predicated on education and on what the safe pathways are around that.

There are some patients who do not need any onward referral and do not need any support, but there are lots of patients who require other services out in the community. As mentioned earlier about whether paramedics do or do not feel part of the system, one of the bits we have come up against in the past when we tried to make a referral is that some parts were very good at accepting referrals and other parts would say, "Who is a paramedic to be doing this?" That has been changing over the years, but there is further to go. Are there more patients who could be safely cared for in the community? Absolutely. As we continue to collaborate—

Lord Filkin: Can you give us a number?

Dr John Martin: Can I give you a number?

Lord Filkin: A rough ballpark as to where we should be hoping to go.

Dr John Martin: We are talking about 50% at the moment; 50% are not being conveyed to hospital. I reckon another 15% to 20% of that could come off with appropriate support.

Lord Filkin: That is pretty big.

Dr John Martin: We are talking about virtual wards. We are talking about understanding frailty much better. We are talking about how we link in with primary care clinicians to ensure that over a number of days, often, a patient who has had a deterioration will get better, but they need that support in the community. It requires infrastructure to happen. I also think it might require a bit of a change in public perception.

It is not unusual when I arrive that the patient absolutely does not want to go to hospital. I do not want them to go to hospital unless they need to go, but the relatives might well want them to, and some skill is required from the paramedics to have that conversation where multiple people are advocating with different views. I think, even with the pandemic, hospitals are still seen as the safe place to go to get care, but probably for quite a group of patients it is not the best place for them to go.

Lord Filkin: That is very helpful. Please send us the data, would you, by time and by the 10 regions to show how that non-admission has changed? If there is anything you want to say further about your 15% to 20%, not now, that would be very helpful. That would give us something to get our hands on, and we can then quantify what that means and what a system to deliver it would look like. Thank you.

Lord Hogan-Howe: I will say this very quickly. John, you have excited me about the data, so please let us know if there is any data to add on there. I have three quick questions, and I do not expect an answer.

You mentioned the 71% down to 50%. It would be interesting to know how many patients were affected because obviously there would be more demand. Is it 50%, the larger number? That is one question.

The second one is, with a reduced number of people going to hospital, if that is what it means, how long are paramedics spending at the scene, and has that changed?

The third one, which I would say of the police but I cannot say of paramedics, is that there is some evidence that there is a larger number of units attending an incident because of more specialism skills potentially—I do not put it any stronger than that. I see a lot of cops deploying to one incident when probably two could have dealt with it had they only managed it differently. I would be intrigued by those three pieces of data if it is available.

Dr John Martin: The first one is certainly available. I cannot do it off the top of my head. Demand has been increasing, but not at the rate we might think it has. It is up certainly in the last five years, 2018 to 2021—across that period, when we changed some of the measures—with about 500,000 extra incidents across that. We have seen a decline in conveyances. Fewer patients go to hospital both as a proportion and as a count.

What we referred to as time per patient is definitely up, and that is for two reasons. When we look at how we split that—I work in London but I have looked at the national data as well—one is the on-scene time. That is certainly up for patients we do not take to hospital but also for patients we take to hospital. That is as a result of a changing skill set for paramedics.

When I started, to give you an easy example, we were not allowed as paramedics to do 12-lead ECGs. The technology did not really exist out of hospital and we were not trained or educated to do it. We now have that, so that means on quite a group of patients I take a 12-lead ECG. I did not when I started. It is up because we are doing more interventions. If you are not going to take a patient to hospital whom I would have historically taken to hospital, you want to be sure that your clinical decision is right; you are taking a greater history and you are recording that.

The second element is hospital handover delays. On the data, if we take you to hospital, for that group that is up very clearly. To give you some indication—we will send you some data on this—when I started practice as a paramedic back in 2000, in a 12-hour shift, it would be usual for me to do 10 to 12 patients. The average now is five to six.

Lord Filkin: I will ask Miriam to respond to the question about the leadership of system change as well.

Miriam Deakin: As Daniel alluded to it, the introduction of integrated care systems is complex for the ambulance sector because, as we said, they are covering a much bigger geography. Ambulance colleagues have to grapple with working with a number of systems, and we are seeing the formation of an emergency and urgent care board across multiple ICBs to inform the commissioning of the ambulance service. There is an

opportunity for the ambulance sector to influence clearly at that level, which will match their own geographical footprint.

It is very challenging, though, for the ambulance leaders to influence every individual system. If you think about the additional investment we have said that we might need in mental health pathways or in the community sector, those decisions are taken at those individual system boards.

Lord Filkin: That is exactly the nub of my question. While there may be a consensus among paramedics that that is what is needed—and even in A&E—unless there is some force that drives the other bits of the system that need to change, it will not happen. How is that going to happen?

Miriam Deakin: There is consensus that we need to invest more in preventive measures and alternative pathways. To build on what John said, this winter we would expect to see a real push on virtual wards—different forms of support for people in the community. We are expecting a big push on support for people who might fall to check that they can be put on the right pathway rather than necessarily be taken to an A&E department, which might not be right for them. There is consensus around the direction of travel.

To be completely transparent, in the current context where finances are constrained and the operational pressures are high, some of these issues will be challenging to resolve fully.

Lord Filkin: Exactly. I do not think what you have said convinces me that it is going to happen in the current climate even though people might privately think it ought to, because everybody has their own agenda.

Miriam Deakin: It is worth looking at the data because that shows movement. As John said, only about half the people are currently conveyed to hospital, and I think we will see that move. It is also interesting—we can dig out some data—that demand for category 1 calls has leapt up pre-pandemic. Although we are seeing the pressures, the ambulance service is dealing with an increase in demand along certain pathways in particular. If we pull some of that together, you might see the movement, except it might not be going—

Lord Filkin: It is a great story and it is cheering.

The Chair: Hang on. We still have a question to do.

Lord Filkin: We need a collective vision; otherwise the other bits of the system are not going to engage it, are they?

The Chair: I am just anxious that these are not the witnesses who will be able to deal with that, and we need to think of witnesses who can. It may be interesting, for example, to think about asking Liam Donaldson to come, who is chairing the ICS in the north-east, because it is the biggest in the country and covers the same region as the ambulance service. He

is a system leader from many years ago. I just do not want these people to think we are interrogating them on things they are not actually going to be able to deliver. I want to go to Lord Bichard.

Q22 Lord Bichard: You always want to stop me speaking! We need to talk about regulation and inspection, but before we do that I want to give you a chance to re-educate me and tell me I am wrong.

When you are faced with resource problems—you have always been faced with resource problems, and, my word, it ain't going to change in the future—sometimes you have to redesign your service. I do not always find when I talk to the National Health Service, at quite senior levels sometimes, that there is a willingness to do that. That is the first thing. Tell me I am wrong.

The supplement to that is that, when an attempt is made to redesign the service, I hardly ever see real involvement of patients and clients. I see them being consulted usually after something has been decided and there is a wish for them to tick the box. I do not often see them being brought to the table right at the beginning and saying, 'Right, how could we do this differently?' Am I wrong on both counts?

Dr John Martin: I will start with patient involvement. I do not think you are. I do not think it happens consistently. I have seen some fantastic examples of bringing a patient in right at the start, asking, 'What is their problem?', often around specific conditions. We might be redesigning a pathway for a specific clinical condition and bring it in. Does it happen consistently in all service design and all service change across the National Health Service? No; that probably poses a question about where patients fit in our governance structure. In the London Ambulance Service, which I work for, we have a patients council. Daniel mentioned it in the last session. They are there. We will take stuff to them. Are they integral at the beginning?

Lord Bichard: There is a difference in having them involved in the governance in that way. You have had Healthwatch down the years. That is different from having someone sitting around the table with you, looking at a particular part of your service, and you saying to them, 'Look, can we do this differently? Would it better meet your needs? We know that we are going to have to be flexible', but I do not see much of that.

Miriam Deakin: I agree; it is variable. There are areas where it could be done better. All trusts have quite vibrant patient groups who are involved in service transformation and reconfiguration. All trusts boards will regularly hear from patients. You would expect board members to be out on the wards, whether they are executive or non-executive. There is good practice out there, but I agree with the point underlying your question that there probably is variability out there as well.

Lord Bichard: It is so important, is it not? I was so pleased to hear one of the previous witnesses today say that that came out of discussions with patients/clients. When I ran the Benefits Agency, it always told me it

was in Grimsby, and I went running up to Grimsby to find out. It was indeed happening in Grimsby but it did not happen anywhere else. They got rid of me for a day, and I can understand that. It should not just be inconsistent; it should be the way we do things, should it not? Okay.

I will come on to regulation and inspection. What do you think of the current system of regulation and inspection? Does it actually help the service to change the way it does things for the better? Does it help empowerment within your services? Maybe it has exactly the opposite effect. Does it look at the whole system, which various Members today have pointed to, or is it in danger of looking at one narrow part of the organisation and its targets and forming an assessment? Is it a positive force or is it not? I do not know. Lisa.

Lisa Elliott: From a very personal perspective, when I was a matron and had CQC inspections, it just told us what we already knew. When they came in and they would tell us that we did not have enough nursing staff, I knew that as a matron. At the moment, the five questions that the CQC asks in its fundamental standards are core to what we want to achieve and provide for safe care, but the system is under such pressure that it will be difficult to achieve those, especially when you are looking at the standards around having adequate workforce.

I do not think I can answer the question wholly from the position of the Royal College of Nursing, but from a personal perspective it is very challenging and very stressful as a member of staff when you are inspected by the CQC. I do not know if it delivered the changes that were hoped for, but that is a very personal perspective.

Lord Bichard: Miriam, from the providers' viewpoint.

Miriam Deakin: Both the Care Quality Commission and NHS England are in the process of adapting their frameworks to this new world of system working so that they can take into account new collaborative arrangements. What providers tell us is that they fully agree with the aspirations set out by the regulators as to their direction of travel, but they are still experiencing a gap between that rhetoric, or that aspiration, and what happens on the ground, which is what Lisa is describing there.

They tell us that they want the regulators to take the context of operational pressure better into account. They want them to take the context of system working better into account, because there is often no point making recommendations to one organisation in the current climate; you have to bring people together and encourage them to work together. I think there are changes to be made.

It is an interesting question how far regulation ever drives improvement. Certainly, there is a role for regulators to identify and share good practice, but our experience would be that that improvement is driven from the front line, from staff, from the bottom up, and the trusts that are most proficient at that tend to have an agreed quality improvement methodology and to take it quite seriously. What we want regulators to

do is an interesting question, given that they are resource constrained as well, and often all you are getting is a snapshot on a particular day of their experience.

Lord Bichard: Down the years—I hate to say this, Baroness Morris—whether you are looking at schools or whether you are looking at health services, there have been two approaches to inspection. One is to identify the things that are wrong and leave it to the service to put it right, and the other is to try to identify the good practice that you have talked about and try to get it shared across the piece. Do you think in your world at the moment enough time is spent on trying to identify the good practice and get it shared?

Miriam Deakin: I think both the Care Quality Commission and NHS England share what they identify. An example is a helpful document called *PEOPLE FIRST*, which is focused on urgent and emergency care, which the CQC published recently trying to share a series of case studies of good work that it had come across. I think it is difficult for regulators to bring that alive. We are often talking about paper documents. It is really at the front line and with investment in training support facilitation that you can get staff around the table and get the momentum behind some of the improvement initiatives that are needed.

Dr John Martin: The Care Quality Commission has changed its approach recently; it is doing more system inspections. Most of my time in the NHS they have been individual inspections and have been very focused on the provider. We most recently had one that looked across the system. However, honestly, when the report landed, the first thing I did was go to all the references to my part of the service to understand that, which underpins your question about whether it picks up the good examples as well as the areas that need improving. The answer is yes: when you look through the reports, they highlight areas of good practice and areas where we need improving. It is therefore less about the inspection, which is around understanding good information and data.

It is always useful to have a pair of eyes that is going to look differently as a service, including patients, as the CQC does, within that. It is when the report lands and the culture, and how you feel as a leader within that, that is driving, I believe, some of the behaviours that come out of that. That is less about the regulator, which is doing the observing and coming up with the recommendations, and more about how it feels as a leader when you have some bad things in your report, how psychologically safe you still feel as a leader on that, or is your job now on the line, and what leadership behaviours you then take to correct the areas you have seen for improvement.

Information is good. If you want to improve as a clinician, feedback is always useful. It is how that report lands and the culture and expectation of the outcome of the report that drives leadership behaviours, and that is probably why you do not get the change you expect from the regulation.

Lord Bichard: That is in the organisation as a subject of the inspection, but it does not need to be like that in the other nine ambulance authorities.

Dr John Martin: Yes.

Lord Bichard: The question is whether they are looking to learn and to encapsulate what they need to change. I have to say without being too provocative—this is on the day of the East Kent maternity inquiry, which I was reading before I came in—that the same issue was being identified for a long time and appears not to have been dealt with. That suggests to me that the culture of learning is not readily available within the health service at the moment.

Miriam Deakin: That is a fair point in terms of the NHS as a whole. We have repeated instances like that which are unacceptable and where it is clear that we have not learned from past incidents. I think the commitment there is to shift the culture. NHS England is sponsoring an improvement collaborative this winter to collect learning more effectively and share it. There are good initiatives in play, but your fundamental point about whether we are communicating enough and whether leaders have the headspace and the support to really share good practice enough across the NHS is a very valid one.

Lord Bichard: That is honest. The reason I raised it in this context is that there are only 10 ambulance authorities, and some of the things you have said are not consistent. You would have expected by now that perhaps they ought to have been if there was a culture of learning.

Dr John Martin: One thing we have, because there are only 10, is an Association of Ambulance Chief Executives. That means more so than other parts of the NHS that we meet regularly. The quality directors get together, the operations directors get together and the medical directors get together. Therefore, we share best practice and learning around that.

I do not know whether we are learning consistently. There is some fantastic work coming out of Harvard from Professor Amy Edmondson around psychological safety and how you create learning organisations. A lot of the time the way the NHS is structured and formed means that we are not particularly psychologically safe. That pushes us into either the anxiety zone, where we do not make decisions, or the apathetic zone, which we do based on your East Kent reading. We need to understand how to create psychologically safe organisations and do that consistently across the NHS and understand the role that each of the bodies can play in doing that.

Q23 Baroness Pitkeathley: Can I just extend it to talk about professional regulation—the regulation of the professions themselves? We have talked a lot today about innovation, co-operation and so on. Is it your view that some of the ways the professions are themselves regulated, often very separately from each other, stifle some of that innovation and the ability to work flexibly?

Lisa Elliott: It is an interesting question that I had not considered before. My first reflection is that professional regulation is setting the standards and the expectation for your profession, so I suppose I would say it should not stifle or innovate because it is setting the framework around which you as a profession should work.

Dr John Martin: It is an interesting question. Paramedics are regulated by the Health and Care Professions Council—the HCPC. I am not sure that I can demonstrate that that has stifled our ability to develop. We have recently acquired independent prescribing for paramedics if you undertake the appropriate qualification. Our scope of practice is broad and generalised. I do not think the regulation is stopping the collaboration.

Does regulation change the way we practise, going back to the fear and the consequences? That is a different question. I cannot pinpoint that the HCPC means that we have not been able to develop as a profession and collaborate.

Miriam Deakin: It is important for professional regulation to keep pace with where people want roles to develop without diluting any of the standards of current roles. For example, if you wanted a district nurse to go out with a social work qualification as well, or if you wanted to blend roles over time, you might experience some barriers. I really agree with Lisa. It is not about diluting standards but it is also important that the professional regulators keep pace so that we can evolve.

Lisa Elliott: It is interesting because there is about to be a period of regulatory reform and they are starting to look at that. That process is going to happen as well.

The Chair: We are going to have to finish now. We can go on questioning and exchanging views for a long time, but you have busy lives and we have other responsibilities to attend to. Can I say an enormous thanks? As I say, the work that you and your organisations do is very important for folk out there who are anxious about their families, their communities and their own futures, so we appreciate you giving us time in the middle of all of that work. Thank you very much indeed, and I now formally end this session.