HOUSE OF LORDS

Public Services Committee

Corrected oral evidence: Access to emergency services

Wednesday 26 October 2022

3.05 pm

Watch the meeting

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

Evidence Session No. 4 Heard in Public Questions 24 - 30

Witnesses

I: Len Richards, CEO for Mid Yorkshire Hospitals NHS Trust, and CEO member of West Yorkshire Association of Acute Trusts; and Daren Mochrie, Chair, Association of Ambulance Chief Executives.

Examination of witnesses

Len Richards and Daren Mochrie.

Q24 **The Chair:** Good afternoon, everyone, and welcome to this session of the House of Lords Public Services Committee, where we are looking at access to emergency services. I am very pleased to be able to welcome one witness on screen and that is Len Richards, who is representing West Yorkshire Integrated Care Board. He is also chief executive for Mid Yorkshire Hospitals NHS Trust, and CEO member of West Yorkshire Association of Acute Trusts. Welcome. We also have here in the room Daren Mochrie, who is Chair of the Association of Ambulance Chief Executives. Welcome to you, Daren.

We are looking in this session particularly at ambulance services, at how our systems deal with emergency services, both in and out of hospitals, and the challenges of good practice: the partnership between ambulance services, the new integrated care organisations and NHS trusts. The session will also consider leadership approaches to risk and demand management in emergency health services and the root causes of what is going on there.

I will open with the first question. When you come to answer, if you could just say a little bit about your role, that would be very helpful. Considering the significant challenges there are throughout the health systems at the moment, what changes are needed to address the high levels of demand and capacity challenges in urgent and emergency care? Who do you think needs to push forward these big changes?

Daren Mochrie: Thank you for the invite this afternoon. I am the Chair of the Association of Ambulance Chief Executives. That is a membership body not too dissimilar to the national police chiefs and the national fire chiefs councils. I am also the Chief Executive of the North West Ambulance Service NHS Trust, so covering the whole of the north-west, about 7.5 million in population. I wear two hats today but principally my AACE hat.

In terms of the current challenges with regards to emergency and urgent care, I think it is fair to say that, if we look at the ambulance sector first of all, just before the pandemic ambulance services were meeting many of their response times. Under the new ambulance response programme, which were the new standards that were introduced—they were not just about speed of response but about clinical outcomes—ambulance services were doing much better than they had been doing.

However, since Covid, and coming out the back end of Covid, it is fair to say that a lot of ambulance trusts, not just in the UK but internationally, are struggling with that increased higher-acuity demand and challenges of flow through hospital, and releasing ambulance crews at the front door to respond to the calls waiting in the community.

It is also probably worth saying a little bit about ambulance trusts in the UK—we have 14, because AACE covers the devolved Administrations as

well. Ambulance trusts do not just do the 999 side of things; many like my own in the north-west have an integrated model, so they run the 999 service, the 111 service for a whole region, and the patient transport service. In among all that, they have specialist assets for major incidents.

The big challenge now is demand and capacity and being able to get ambulances freed up to respond to the patients waiting in the community. The other thing we have noticed is that the acuity is much higher than it has been in the past. That is the type of calls that we receive, so we are seeing more category 1 and category 2 patients coming into our triage system, which we obviously have to then respond to.

As we all know, workforce has been a challenge for us with Covid. We have had higher absence rates than we would ordinarily have and would like. We are working hard with our staff, unions and others to look after the mental health and the health and well-being of our staff. Perhaps we can touch on some of that later on.

The big challenge for the ambulance sector now is how we get ambulances freed up to respond to those patients waiting in the community. We are working very closely with the new integrated care systems. I spend probably most of my week working with NHS England colleagues as well. We are looking at different ways to address some of those challenges, whether it is hospital handover delays, frail and elderly falls patients—which you heard Daniel talking about last week—or mental health patients. There is a high demand coming into the ambulance service that we did not necessarily see many years ago.

Len Richards: I am Chief Executive of Mid Yorkshire Hospitals NHS Trust. That is quite a large district general hospital service, with a hospital in Dewsbury and a hospital in Wakefield, which is our large acute centre. We also have a hospital in the Pontefract area. In addition to that, we run community services for Wakefield and districts. It is quite a complex environment.

I will just build on what Daren said around some of the real challenges in the system at the moment. I would echo everything he said. That also applies in the acute sector: challenges with workforce, challenges with demand, higher-than-normal levels of demand at this time of the year and significant challenges of acuity, so the illness of patients.

In answer to the question, what changes are needed? Daren touched on close working relationships between ambulance services and acute hospital services, but I think we have to go further than that. I will come back to relationships as we go through this session. We need to focus on prevention. I know that is easy to say and very difficult to do, but there are many good examples of focusing on preventative services to try to reduce the demand of patients attending the accident and emergency department. I am thinking in particular of falls services and support for people to live in their communities, so particularly around high-risk adults and the elderly with frailty. Through our Core20PLUS5 approaches, it is

also about focusing on those who live in deprived areas or who have, by nature of their background, disadvantage in one way or the other. There has to be a real focus on prevention.

In addition to that, we need to find resilient alternatives to emergency departments. In a sense, the default position becomes the accident and emergency department. That is sometimes because there are no resilient alternatives. When we look across the world at some of the systems that work a bit better than us—although emergency services across the world are experiencing the same sort of demand as we are—and at the areas of best practice, we see that there are alternatives where ambulances can take those lower-acuity emergency patients to be looked after.

The third thing is behavioural change. Communities see the accident and emergency department as the default position. It is there 24 hours a day, seven days a week. It is always open. Therefore, if there is an option between a walk-in centre that might close at 10 o'clock and an accident and emergency department that is always there, I think people take the option of the A&E department because it has doctors, it has nurses and it has diagnostics. It has all the things that you might need for a minor-type injury or some of the most extreme-type emergencies. I think people go to that default position. A behavioural change programme of communications around what is best for patients and how they can access those services is required.

Those are just three things that come to mind in answer to the question of what changes are needed. Who should push these things forward? That is all about roles. The ICB has a significant part to play in engaging with communities around those behaviour change-type processes, but we do as well in hospitals. Our clinicians do as well, because they are a trusted source of information.

As for developing alternatives, there are alternatives through acute hospitals. There are alternatives that the ambulance service can run, and which occur in some systems. There are alternatives where we can combine across organisations. I am talking particularly about my experience in Wales, where mental health nurses accompany ambulance services to manage mental health crisis in the community. That is a combination of one or two different organisations.

To be completely honest, I think this is all of our business. It is so overwhelming at the moment that it will require a range of things to be done that we all have to take ownership of, and individuals and organisations will lead on different things.

The Chair: Thank you, that is very interesting.

Q25 **Lord Bichard:** Could one or both of you clarify for me a couple of issues around data? I am finding it quite difficult to be clear about just what the demand levels are and how we measure access to A&E. On demand, which you both said is increasing, are we measuring that on the basis of cases or are we measuring it on the basis of the number of calls you

receive? There are situations where someone calls, does not get an ambulance, calls back, does not get an ambulance and calls back. Is that one or is it three? That is the first question.

Secondly, from the research that we have had done, I am quite interested to hear how you think we are measuring waiting times for A&E. I have always assumed that they were measured from the time you entered the building to the time you were seen. That seemed a fairly reasonable way of doing it. It is suggested to us that that is not the case, however, and the published figures are about how long you wait from the time it is decided to admit you until the time you are seen. I think the public assume it is the first. If it is the second, that is quite a serious issue, because the difference is a factor of 21. Can you help us on those two issues of data? We have to get the data straight before we start thinking about what recommendations we want to make.

Daren Mochrie: In terms of 999 activity or demand, you are right, we do measure two aspects of that. We measure the actual call volume, the 999 call volume, which could include duplicate calls that you just described there, or indeed it could involve five calls to one 999 call because it is maybe a road traffic collision on a motorway. That is 999 activity around call volume. What we then do is we look at our incident count, which is the actual incidents where we send an ambulance resource or clinicians to the scene. That is certainly how we measure it from an incident and a call volume point of view from the ambulance sector.

Lord Bichard: It would be quite interesting to have access to both of those.

The Chair: Have both been rising?

Daren Mochrie: Call volume has been rising; incident demand historically rose 5% year on year, but just after Covid it has plateaued out. Something has happened with Covid with the overall demand for incidents being stable but call volume is up.

Lord Porter of Spalding: So demand has not gone up then. It is nuisance calls that just keep clogging up the system. It is demand failure that is causing that work.

Daren Mochrie: It could be multiple calls for one incident; it could be duplicate calls coming in for the same incident because people are looking for an ETA, estimated time of arrival, for the ambulance arriving on scene. The actual incident demand has flattened, which is unusual, because year on year—and we were looking at some of the statistics the other day—over the last 10 years it has historically risen by about 5.8% per annum.

That could be to do with a lot of the initiatives that we have put in place. I think the Committee heard last week about 'hear and treat' and 'see and treat'. Hear and treat is where we resolve patients' clinical concerns over the phone without an incident; that is, sending an ambulance. See

and treat is when we have sent a clinician to the scene, but the clinician sees that patient in their home, or in the community, and discharges them without transport to ED. That has gone up quite a bit over the last five years. We now resolve about 12% of patients over the phone with hear and treat, and about 32-33% through see and treat. That should be taking some pressure off our emergency department colleagues, because those patients have been managed elsewhere.

Lord Bichard: If Len agrees with that answer—and it looks like he does—this is quite a significant point. Lots of people are telling us that the demand has increased and that is one of the problems that the services face. What you are telling us is the demand has not increased. What has increased is the number of calls. In other words, the incidents have not increased significantly, but we are getting a lot more calls, and that may be because we are not responding quickly enough to the original call. Is that what you are saying?

Daren Mochrie: Within the demand, we also have the type of acuity, so the severity of the category. Category 1, 2, 3, 4 and 5 is how we grade the calls, as you heard last week. Category 1 and 2 demand has gone up. Category 3 demand has gone down. That could be because we are resolving a lot more over the telephone, through hear and treat, and doing a lot more signposting and managing patients to the right place first time over the phone rather than sending an expensive ambulance.

The Chair: That does not count as an incident?

Daren Mochrie: That does not count as an incident. The workload is still there. We are just dealing with it in a slightly different way, if that makes sense.

Q26 **Lord Bichard:** That is very helpful. The other question was about waiting times in A&E. Len is probably the better person to answer this because he is the Chief Executive of a trust. I must say I found this very worrying, because I think the great British public believe that it is from the time you walk in the building until the time you are seen, not from the time you are admitted. Is that the case, Len?

Len Richards: There are two questions you asked, one about demand. We are seeing attendances at our accident and emergency increase. That is not always conveyed by ambulance. People walk into our accident and emergency departments but, overall, while it fluctuates on a day-to-day basis, we are seeing an increase in the number of attendances there.

With waiting times, it is fair to say that there are a number of measures, but my measure and the one that we report on is time in the department. Therefore, the clock would start when—if they are coming from an ambulance—they are handed over or, if they walk in, when they arrived in the accident and emergency department. We look at time to triage; we look at time to be seen, and then, if there is also a decision to admit the patient into the hospital, we look at the time from them arriving until they are admitted into the department. There are a number of measures,

but it is time in the department and, therefore, I think less concerning than the second point that you raise.

Lord Bichard: That is commendable, but is that how it is being done on a national basis, because we are all used to having news reports about the A&E waiting time? Nationally, I understood that NHS England bases it on time from admission to being seen. Is that your understanding?

Len Richards: No, it is time from arrival until the point at which you are either discharged from the A&E department—because some patients go home from there—or until you are admitted in the organisation, if that was the decision that was made for you.

Lord Bichard: We may need to double-check that.

The Chair: Is the time someone waits in the ambulance outside part of the time?

Len Richards: That is a controversial area.

Daren Mochrie: That is why I hesitated.

Len Richards: That does not count. It is time from once you enter the department and we receive handover. That is when it starts to count.

The Chair: It is not when the ambulance arrives in the grounds of the hospital?

Len Richards: Daren might want to comment on that, but my understanding is that it is from when they enter the department and are handed over.

Daren Mochrie: Yes, the way the ambulance service measures it is when we trip the satellite tracking of the ambulance as it comes into the emergency department. That is us at hospital. We measure it by inputting that information on to a hospital screen in the department, as the clinician does the handover with the nursing staff or the doctor.

We then measure a second aspect to that, which is when the crew gather all their equipment, clean the vehicle and then book clear with the control room. We have two measures but, Len is right, if a patient waits in the ambulance outside and the crew do not get into the department, for whatever reason, I do not think the waiting time clock will have started in the department.

Lord Bichard: Targets are very important in the incentives and the messages they send. I am a sceptic. I could interpret your answers to mean that there is a real incentive on the hospital to keep as many people as possible in the vans because then they do not appear on that target. It is a bit like the railway system. Len is saying no.

Len Richards: Respectfully, I do not think there is. I do not think the clinical teams work to those incentives that you have described. I think there is a reality about what you say; that could be perceived. Clinical

teams do not work like that. We certainly—and I will come on to it as we go through today—have done a huge amount of work to minimise the times that patients stay in ambulances, because we recognise the risk in our local community that exists if an ambulance is not able to go and pick up the next category 1 or category 2 patient.

We do a lot of joint work with the ambulance service to respond to that and, actually, what that has meant for my A&E department is many more patients in it, and it has meant that my organisation is one of the best in the region for ambulance handovers, but it is not so good when you talk about length of time in the department. That is caused by a different issue, which is flow of patients through the hospital.

I just offer that as an example to try to counter that point of view that targets drive clinical behaviour in the way that was described. I do not think it does and I have real-life examples in my organisation, and across West Yorkshire. Leeds Teaching Hospitals also has a very positive approach to unloading patients from ambulances, yet what that does is create congestion in the A&E department. That is a safer place for the patient to be than be at home with a potential heart attack, stroke or what have you and an ambulance not turning up for them. Those risk discussions are really important and I think people see that perspective.

Q27 **Lord Hogan-Howe:** It has been an interesting debate about the data, but one thing we have not talked about is the patient's experience because they will not count it in the blocks in which we have discussed it, important as they are for managing it. The patient experience is a critical one, I suspect. My question is: what is your view of risk appetite in urgent and emergency care and the wider health system? How could risk be better managed?

Len Richards: This is very important issue. The wide range of patients who attend an A&E department—it could be with broken ankle, a cut hand, a potential heart attack, a potential stroke and so on—drives our clinicians to be risk averse. They are focused on finding out exactly what is wrong with the patient, using all the diagnostic tests available to them, to reach a diagnosis before a decision is made. I think that creates that risk-averse environment.

I hinted at this in response to the last question. We did a piece of work with our ambulance service because we recognised that we were seeing greater risk in the community because of patients not getting access to an ambulance. We discussed risk appetite with ambulance service staff and with our clinicians together. As a result of that discussion and as a result of some service improvement approaches, we streamlined our handover process. There as an agreement that our clinical teams in A&E would do their utmost to unload patients and receive handover of patients from the ambulance, so that that ambulance was released back to the community.

When we look at that process—and as I said earlier, I think we are one of the best performers in this—it was the discussion around risk appetite

and recognition of where the risk to the patient lies that drove most of that improvement. While we did speed up handover, and we talked a lot about how to make that easier for the ambulance staff and our clinicians, it was that acceptance that there was greater risk outside of the department that drove a lot of the improvement. We have seen that improvement sustained now probably over the last three to four months. I think risk appetite is a critical issue when we are looking at these particular points.

We need to expand on that in risk appetite between congestion in our A&E department and the wards, and discharge of patients into the community to free up beds. That is a different debate. It is driven by the same sort of thing, a risk-averse nature. What that has led to in my organisation is congestion that sits in the A&E department and, therefore, patients waiting there longer than they should be. However, they are being offloaded from ambulances. We have been able to deal with that part of the process.

Lord Hogan-Howe: Obviously, a lot of the risk assessment takes place based on the patient's account or somebody's account of the patient's symptoms. Someone has to do this perhaps over the telephone and perhaps more and more by video now. A paramedic might attend and then someone has to make another assessment in A&E. Has someone done some objective assessment of the position whereby, regardless of how they declared themselves, which might have sounded like a category 1, the patient is actually a category 4, had they not misdescribed their symptoms or had we listened more? Has someone worked out where either the biggest risk is or the biggest opportunity to reduce the number of people being carried?

Len Richards: Again, we have liaison staff from the ambulance service. We feed back to them where we think, after diagnosis, a patient has not been classified in the right risk category. My sense is that the only way you can truly determine the risk category of an individual patient is when you reach a definitive diagnosis on what is wrong. It is at that point—

Lord Hogan-Howe: I get that, but has somebody looked at that and then compared the end with the beginning?

Len Richards: Sorry, I did not catch that.

Lord Hogan-Howe: At the end, they conclude they are having a heart attack, and that sounds like a pretty serious outcome, but at the beginning they may have said, 'It sounds like a heart attack to me' and the alternative is obvious. I am trying to work out whether when somebody is logged from end to end, from the call to the diagnosis eventually, where the biggest discrepancy is, or is there a discrepancy that is worth worrying about?

Len Richards: My sense is that the discrepancy—and Daren might have a different perspective on this—is not that significant. My issue, and I think where we need to focus our attention, is offering alternatives to

people who are classified right at the outset in those lower-risk categories. If there is no other alternative, they will come to the A&E department.

Lord Hogan-Howe: You made that point at the beginning. I get that.

Len Richards: I think sufficient are categorised in those lower-risk categories. However, you have to also bear in mind that in an A&E department probably two-thirds, if not more, walk in, so they classify themselves. Therefore, we either need alternatives that we can direct those patients to or be able to reach a diagnosis quickly and discharge them.

Daren Mochrie: We do do that. In the north-west, we ran a series of handover hospital collaborative work, and that was not done just by the ambulance service. We recognised that to identify that risk and share it, we need to all be in it together and we are all in it together; we work very well with our acute colleagues and the new integrated care boards and systems. As part of that hospital collaborative work, we got the staff on the ground together—the matrons, the nurses in charge, the doctors, the paramedics and the local ambulance managers—and we looked at six different hospital sites in the north.

We asked whether if we could open up more alternative pathways in the community, it would mean that we could successfully resolve more patients over the phone—so right care, right time, right place. Could we do the same then for our ambulance clinicians when they arrive on scene and have many more alternative pathways available to them? It is all very well saying, 'This patient has gone into ED inappropriately', but you do not know what was happening at the scene. The ambulance crew may have had no option but to transport that patient to hospital because there was no alternative pathway from a safety net point of view. We want to continue to do that. This hospital collaborative work is being rolled out at scale across the country to see whether it can make a difference to other areas that are more challenged. As Len Richards says, that north and east area of Yorkshire is pretty good in terms of hospital handover delays, but we know that it is not the same across the country.

I want to say one other quick thing about hospital handover delays. It is not just about the impact on a patient. The impact on staff worries me as much as the impact on patients. We might come to talk about culture and challenges in the ambulance sector, and perhaps sickness rates and so on, but this is also having a big impact on our workforce and our staff.

To understand the appetite for risk, it has to be shared. We need to explain to hospital colleagues what it means when patients are waiting with chest pain for two, three and four hours in the community for an ambulance. Similarly, we need to understand the pressures that hospital colleagues are under when they may have five 'majors' patients waiting to get into a resuscitation room and they do not have the capacity. If we do not do that joined-up thinking and work together, we will miss the point and not understand the risk.

Lord Hogan-Howe: You are both saying that, in terms of risk assessment, it is not obvious that one part of the system is handing all the risk over to the A&E department, be it the call handler or the ambulance staff. I thought Len was saying that people were risk averse, but I do not hear the evidence for that.

Daren Mochrie: We could sit here and talk about all different parts of the healthcare system. I think we all have our part to play. It might be primary care, in being able to triage patients on a Monday morning when patients phone up at 8 o'clock, because if they had more capacity or availability, perhaps not as many patients would not call 111 and perhaps some of them would not then end up in the 999 system and so on.

For me, it is about looking at access, having reliable services in place and having alternatives for patients, with hopefully patients then choosing the right pathway first time. That will be very much part of the urgent and emergency care strategy that NHS England is developing. I have been involved in that as part of one of the workstream leads. We are looking at flow, access and how the whole system comes together. Integrated care boards are new. They have been around only since July. Certainly, in the north-west—I know from some of my chief executive colleagues—we are very much firmly embedded in the integrated care system and provide the collaboratives, where acute, mental health and community services come together. We try jointly to solve some of these problems.

Lord Hogan-Howe: You are saying that risk aversion may be part of the problem, but it is not the majority of it. It is more about demand and flow through the system. That makes the second part of the question a bit more difficult. The next part of the question was: do you think that regulation and inspection drive risk aversion? However, I do not hear either of you saying that risk aversion is the major problem. It may be a problem, but it is not the major one.

Daren Mochrie: I suppose it depends on how much we want to get into the technical details of what the future might look like. For example, one thing we are doing from an ambulance perspective is having many more clinicians working in the control centres. What that is about—and it is no different from policing or the fire service when calls are coming in—is how you triage those initial calls to get the right response first time.

Traditionally, not just in the UK but in Australasia, the USA, and Canada, there tends to be an algorithm triage-based platform; a series of key questions generates an outcome. In the UK, we have recognised that, on its own, that is no longer going to meet our needs for a lot of the urgent activity that we now see coming into ambulance trusts. That might have been okay 10 years ago when it was predominantly emergency activity coming in to us, but ambulance services are now much more of a mobile healthcare provider, covering lots of stuff, as the committee has already heard.

We are now looking at whether our triage algorithms and tools are still fit for purpose. Two main ones are used in the UK. The second piece of the

jigsaw for me—and we have been doing this as part of the UK ambulance services—is introducing many more clinicians to augment the algorithm triage tool. That is why we are getting so good here in treat rates now.

To answer your question about risk aversion and taking the calls, we could go a step further and maybe take more risk in how we triage calls.

Lord Hogan-Howe: Has inspection and regulation had an impact or not?

Daren Mochrie: Regulation and inspection focus chief executives' and provider organisations' minds on things such as quality, safety, governance and systems and processes. What the CQC—the Care Quality Commission—is doing now, and I agree with this, is not just looking at one organisation in a silo but looking at a whole-system inspection process.

Lord Hogan-Howe: So improving?

Daren Mochrie: If you look at organisations in silos, you miss the point. We have touched on that in terms of handover delays.

Lord Hogan-Howe: Len Richards, two points. One, is the risk and regulation point but you also have experience of Australia, I think, so if you wanted to feed that in, this might be the time.

Len Richards: I think regulation does drive risk aversion. I take the point that Daren just made about regulation starting to look at how we can regulate systems rather than individual organisations, but the heat of regulation at the moment is on individual organisations and, therefore, when the CQC comes in and looks at my organisation, it will talk about congestion in the A&E department; it will not talk about the assessment that we made around there being a greater risk in the community if we did not offload ambulances.

My second point—and I think this is all related—is that the discharge of patients out of hospitals into care homes and nursing homes is often delayed because of the regulatory requirements in those care homes and nursing homes, which is a different part of the CQC. We had some challenging times over last winter. We asked nursing homes and care homes to take patients. They could not take them beyond a certain limit because it would put their accreditation at risk.

We had every single bed open, two wards of surge beds, 40 patients in our A&E department waiting to be admitted and so on, and we could not discharge because the care homes would risk their accreditation. We went to the CQC to try to create some flexibility. I have to say the perspective was very much that of an independent regulatory body that would look at the organisation, not the system. There is a long way to go there.

Q28 **Baroness Morris of Yardley:** That is very interesting. To some extent, you have begun to answer my question but that always happens as a discussion goes on.

You mentioned partnership, and you have made it clear that what happens in emergency services is dependent on what happens elsewhere. Would you say something about the mechanisms you feel are available in the NHS to deliver changes that might help the emergency health services?

I get the feeling, from what you have said so far, that there would not be any ill will but there is not that seamless discussion about changes throughout the service that would help you at the sharp end. It is a question not so much about what as leaders you can do by yourself. The point you just made about the inspection system was very well made. They do concentrate on inspecting individual institutions rather than the networks. Tell me a bit about the mechanisms you think are in place across the NHS that would help you.

Len Richards: I think the mechanisms we have had in the past are very focused on individual departments and organisations. I think the development of the integrated care systems, the ICB model, the place-based systems, which we work with in West Yorkshire, has encouraged cross-agency working. I think I said this at the beginning. I believe relationships between organisations are what will enable us to improve the system and not individual techniques applied in departments or particular areas.

Therefore, a lot of our change management has to focus on system working. A lot of our leadership and our capability to lead need to change from being about how you manage a department to how you manage a service which spans more than one organisation. That is a different skill set. My sense is that we have to develop that capability. In some places, and I put West Yorkshire in this, we have a long history of working at place level, not at an ICB level in terms of West Yorkshire but at a place level—an example of that would be Wakefield and district. Another example would be Kirklees, where we, the acute hospital, work actively with social care, the ambulance service and community services on improvement processes. We need to get better at that but that is the direction of travel.

Baroness Morris of Yardley: Tying that in with the inspection and accountability frameworks—it is quite an important point—I suppose the reason they focus on the departments is to make sure that people are held accountable for their own actions and cannot hide underperformance across an institution. Now you are working in the integrated care system, what is your view on the likelihood of the accountability system catching up with the changing working practices that you are hoping to introduce?

Len Richards: I am hopeful that that happens. In the health and care services you have to remain hopeful in these situations, and I am sure Daren would agree. I think the whole system is changing—sorry about the use of the word 'system' too many times—and changing to one that says, 'Let's look at the way patients access their services and let's improve that journey rather than the bit of the journey that I am accountable for'.

In one sense, we have to make sure that that does not dilute accountability. In another sense, it may mean that we have to look at the whole process of care if we are going to make an improvement. Coming back to my situation at Mid Yorkshire, we are one of the best at handovers from ambulances, but we are struggling with congestion in our A&E department as a result, because we cannot get discharge out of the hospital into our communities as effectively as we want to. Unless we can unlock that discharge end, we are going to have problems somewhere in our journey, so we have to focus on all that process, not just one bit of it.

I was heartened earlier this year, in March and April, when the CQC did a review of our system and particularly our unscheduled care system. It looked at us, at the ambulance response times, discharge into the community and so on, and created a narrative around that. I do not think it was a regulatory report in the way that it would produce it around my particular organisation, but at least we have now taken that step. I think the next step is regulation at a system level. I do not underestimate the challenges in that, but I think we have to get to that lest we create the perverse incentives that we talked about earlier.

Baroness Morris of Yardley: Thank you. Could I go back to the first question, Daren, and get your comments about what mechanisms there are across the NHS to deliver change that would help the emergency services?

Daren Mochrie: NHS England is slightly different from Scotland, Wales and Northern Ireland because health boards tend to operate in those jurisdictions and it is usually coterminous with police and fire—not always, but a smaller number of police and fire. The introduction of the integrated care boards has made it much easier for me, as a chief executive covering a big area, to work with Len and other colleagues to make sure we drive change forward. In the past, I had to deal with 30-odd clinical commissioning groups for example. Now I have only five integrated care boards to liaise with and five police and fire, and it is much more manageable.

Nevertheless, ambulance services are still spread across a bigger region, but I think they have to show system leadership and come up with structures within that make sure we are at the table, because we have to be at the table to have these really difficult conversations. I think we can also put a lot of solutions on the table. As you heard Len say a minute ago about some of the challenges, it is not so much hospital handover delays and patients coming in from ambulances, but other factors. Perhaps the ambulance service in his area could help with some of those challenges. That is why it is so important that the ambulance service works closely through our integrated care boards and provider collaboratives—that is where chief executives and other directors and staff get together from the acute mental health community and so on, and primary care perhaps. We have a national joint ambulance improvement board in NHS England. We focus on things from a national perspective to see if we can drive that at scale across all the ambulance

services, not just through individual organisations or at a local level. There are lots of different things going on just now in terms of how we spread improvement. The Association of Ambulance Chief Executives – the AACE – also had a big role to play in that.

Baroness Morris of Yardley: Can I ask you about workforce culture? You have both mentioned it and we have heard about it in previous sittings. Would you say that, on the whole, it is caused by systemic failures, the system making life very difficult for people and causing a culture problem? Or is it more about one-to-one working relationships? Or can you not look it that way? Is it six of one and half a dozen of the other?

Daren Mochrie: For the ambulance sector, I am not sitting here saying that every leader in the ambulance sector gets it right every day and makes sure that the right culture exists across the organisation. Obviously, some leaders will need development, and some will be more experienced, and so on.

Having been in the ambulance sector for 34 years now, I believe that some of it is about the working conditions. If I were back in an ambulance now, starting a shift at 7 am, not getting time to check my vehicle and my drugs, being sent out to one patient after the next, standing in a hospital corridor for six or seven hours, only seeing one patient and not doing the clinical role that I am employed to do, missing meal breaks, not getting breaks and being kept late every night of the week because I am stuck wherever I am stuck, not seeing my family—all that would grind me down, and it will grind staff down.

Every time I go out to a station and talk to the staff, the single issue they tell me about is handover delays. They cannot cope much longer with handover delays. That is not me having a dig at our acute colleagues, it genuinely is not, but it is the reality. That is how staff are feeling, and I think that impacts culture. Managers are under pressure and cancel training, appraisals or any CPD opportunities, because we have to treat patients. It is a vicious cycle. Staff feel as if we are not looking after them from a development, appraisal or training and education point of view, and that is not what I, as a leader in the ambulance sector, want. We need to find a balance and get back to how we invest in and look after our staff.

Baroness Morris of Yardley: Len Richards, do you want to tell us about culture? You have already brought it up.

Len Richards: My experience is similar but slightly different from what Daren said. I think what is driving the culture in our urgent and scheduled care is purely the demand issues. We find it very difficult to stay in control of what is happening. I already mentioned that at times our A&E department can become overwhelmed, and when that happens organisations move into a command and control-type model to try to manage safety and get control of what is going on.

My sense of that is that it disempowers our clinical staff in their areas, and it is not the style of leadership that they want or respond well to. Therefore, we somehow have to create an environment where our clinical leaders drive the culture in their areas, and we empower them to respond but we empower them to work at a system level through collaboration and working across agencies rather than just seeing risk as being in their own purview and management areas. My sense is also that we move to command and control because of the situation, but that that is a disempowering environment, which leads to disaffection and therefore to some of the issues we see.

Some of the best developments and improvements that I have seen are when you get clinical staff together, cross-agency, pose the question, pose the problem, give them some tools and techniques to work on that problem, and they can come up with some quite spectacular changes. That is the sort of leadership we need to drive—it is what we are trying to drive here in West Yorkshire—a clinically led, empowered workforce, but the demands can create the opposite of that.

The Chair: Thank you. You can tell that we have a very empowered workforce here.

Q29 **Baroness Chisholm of Owlpen:** We know that if you have a heart attack or an accident, the ambulance service is the first and the best place to go for the best response. However, a lot of people have had a lot of conditions for a long time, and perhaps calling an ambulance is not the best way to go. How can we ensure that the first response is the best response? Ought we to be thinking out the box a bit so that people can go to pharmacies, for instance, to get help if A&E is not the best place to go?

Len Richards: We have to create more information about how our systems are working and how patients access them. Currently, our information and our data are very organisation-centric. I know all there is to know, and if there is anything I want to ask, I can ask our A&E department. I can get the statistics out, I can get all of that. What I cannot find out is whether patient A has been to their GP three times in the last month or has called 111 and then called the ambulance and come into us.

If you think about information as the ability to learn about your system, my sense is that we do not have shared information at a macro level and, therefore, we do not learn as a system. That is the route to having a more effective response at every point in the journey, because we need to understand our patients more. I would include social care in that. A lot of patients end up in an A&E department through whatever route—housing plays a part in it, social care plays a part in it, other support mechanisms play a part in it. However, we do not know any of that. We see the patient when they attend the A&E department.

We will have access to records that tell us about the last time they attended the A&E department and the last time they spent time in the

hospital. We are starting to get GP information, but we do not get that rounded sort of understanding or the kind of understanding on which we can plan initiatives. We have it on a patient-by-patient basis, but we do not have it at a system level to understand how our systems work. That is one of the deficits. We need to move away from organisationally bound systems to a system-level approach.

Baroness Chisholm of Owlpen: Daren, would it be helpful if more ambulances had clinicians with them when they go out, or practice nurses, so that more patients could be treated at home without having to be taken to hospital?

Daren Mochrie: We have many more advanced paramedics working in the ambulance service than we have ever had. As you heard from Daniel last week, we have mental health nurses, occupational therapists and multidisciplinary clinicians now working in ambulance services. Without repeating what Len Richards has already said, it is first and foremost about access. If people can access the right service the first time, they will not repeat-call or phone another service.

It is also about the availability or responsiveness of some of the services they call. If a person calls, say, the pharmacist, which somebody mentioned as an example, but the pharmacist does not get back to you for eight hours, in that eight hours they will probably be concerned and will have phoned somebody else, somebody else and somebody else, and there will be all those duplicate calls.

Len Richards made a point about technology, shared records and electronic transfers. It does not matter what number a patient calls, they just want help. If they phone 999 and it is not necessarily a 999 call, that patient needs to be seamlessly transferred to other services. They should not have to know much about it. The phone call deals with their needs. We need to use technology, shared records and electronic intelligence better.

Baroness Chisholm of Owlpen: That is really about data sharing.

Daren Mochrie: Yes, and prevention. Len Richards mentioned that at the beginning. We are doing a huge amount of work on that in the ambulance sector, and we know how successful the fire service has been over the years with fire prevention. We are looking at that to see what more we could do in the NHS and the ambulance sector.

The Chair: Lord Bourne, I will ask you to put your question, because it is very important, but perhaps respondents will say a little bit and then send us some more information in writing.

Q30 **Lord Bourne of Aberystwyth:** We have not heard so much today about pilots, but we heard a lot about them last week and we have written evidence. Clearly they are important. We were a bit concerned last week that perhaps the information on effective pilots was not getting out in the way we had hoped; that it and was not being rolled out effectively.

Particularly when we have devolved Administrations in Scotland, Northern Ireland and Wales—we also took evidence from Dublin last week—it is important that that information gets out. How could that be better addressed? We had evidence about mental health specialists and community nurses going out and so on. That might have been rolled out more effectively, but there were other things as well. Can you give us some views about that?

Len Richards: This is a problem for the NHS. There are many areas of very good practice, but they stop in that area or in the ward the practice was developed in.

In West Yorkshire, we ran a spread and scale academy, a sort of teach-in where different teams with ideas about different pilots could come together to say, 'How do you design that with two things in mind: first, to test its effectiveness; and, secondly, to scale it up across the environment?' We worked with a company called the Billions Institute, the founder of which, Becky Margiotta, worked with homelessness in New York, did a good job of that and was asked to go to a number of other cities across America to do the same thing. Her learning was that the same things do not work in different contexts, but the core does. Therefore, design the improvement around the core, but allow it to be contextualised in different areas and you will get greater take-up of those pilots and different approaches. We have done that across West Yorkshire. We had about 30 teams and 30 different initiatives, and we will measure the impact, particularly from a scalability point of view, so that we can get over 'pilot-it is'—the pilot that runs in one place, but does not spread.

Daren Mochrie: There is a lot going on across the devolved nations, including with our English ambulance services in their joint response with the police in Kent, co-responding with the fire service in some parts of the country, or tri-service stations with police, fire and ambulance. There are lots of examples. The exam question is: how do we embed them at scale not just in England but across the country? That is the challenge.

With the integrated care boards coming on stream, it will be easier for us. One challenge when it came to local commissioning was that those pilots were sometimes not a priority and money was put into something else. So how do we get the evidence that says that these things are worth doing for patients, and how do make sure that we have the right level of resource to put into those pilots and roll them out at scale? AACE has a huge role, along with other national organisations such as NHS Employers and the NHS Confederation, to help to support providers to roll these things out at scale—if it is the right thing to do, of course.

Lord Bourne of Aberystwyth: Is there a role for NICE in the evaluation of these pilots? There was some suggestion that NICE is not looking at this, but somebody needs to evaluate pilots. Who should be doing that? Perhaps you could respond briefly and maybe follow up in writing if you have anything more to add.

Len Richards: I am not sure that NICE should be doing it. NICE is doing lots of things. My sense is that there needs to be careful structuring of evaluation in each case, and that is part of the presentation and part of the selling point. Evaluation is very important, and it should be system evaluation—impact on the system, not impact in the department, the ward or a particular service.

Daren Mochrie: We use universities. It would not the first time we have used a university to do a piece of research on whether a pilot or a piece of work has added value. NICE, or SIGN guidelines in Scotland, tends to be more about clinical practice and procedures and drugs. The Joint Royal Colleges Ambulance Liaison Committee looks at procedures and medications, drugs and so on, and NICE and SIGN also tend to support us on things like that.

The Chair: Thank you to both witnesses. Following up on the last question, we would be grateful if you could send us any useful studies that you are involved or have seen and think we should be aware of of some of the pilots that you think may be working. It is one of the areas we are trying to look at in some depth.

Thank you, both of you. We could have gone on questioning you for another hour, but we have other witnesses who we need to bring in, so this session is now concluded.