HOUSE OF LORDS

Public Services Committee

Corrected oral evidence: Access to emergency services

Wednesday 26 October 2022

4.10 pm

Watch the meeting

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

Evidence Session No. 5 Heard in Public Questions 31 - 40

Witnesses

I: Dr Adrian Boyle, President of the Royal College of Emergency Medicine; Professor Julia Williams, Professor of Paramedic Science and Associate Dean (Research), University of Hertfordshire.

Examination of witnesses

Dr Adrian Boyle and Professor Julia Williams.

Q31 **The Chair:** I welcome you to the second session today of the House of Lords Public Services Committee on access to emergency services. We have two further witnesses now, Dr Adrian Boyle, who is president of the Royal College of Emergency Medicine—welcome, Dr Boyle—and Professor Julia Williams, who is professor of paramedic science and associate dean of research at the University of Hertfordshire. Welcome to both of you. You will have seen that we are trying to get to the bottom of what the systems deliver in the United Kingdom, but particularly in England, and how we affect systems in order to ensure more effective emergency access for patients.

We are grateful to you for coming along. We are particularly looking in this evidence session to explore concerns that we have heard about, those systemic issues leading to challenges in emergency services in hospitals and ambulance services, alongside training, skills, best practice and learning and changing demand. Some of those things were covered in the last session but we want to look at them with you too.

I want to open the questioning by asking: considering the challenges throughout our health systems, what changes do you think are needed to address the high levels of demand and capacity challenges in urgent and emergency care? Who should be pushing forward these big-picture changes?

Dr Adrian Boyle: We have a number of issues. The reason why we are seeing these very long delays to offloading ambulances and handover delays is that our hospitals are full. It is not because demand has gone up, and it might be worth trying to unpick some things from the previous session and explain some of the demand.

The Chair: That would be helpful.

Dr Adrian Boyle: Hospital episode statistics about the number of people going to emergency departments do show an increase. However, the majority of that increase is in type 2 and type 3 emergency departments. These are urgent treatment centres, eye units, minor injuries units. The number of people going to type 1 emergency departments—what you and everyone recognise as the major emergency departments—has stayed pretty static for about the last two or three years. There are areas where it goes a little bit up, where you have population growth or where there has been a merger at the hospital. The problem is really not to do with increased demand.

Our big problem is with the length of stay within emergency departments and the inability to admit people into hospitals. The problems are largely all about the flow through emergency departments. I was very interested in the discussion in the previous session about waiting times.

There is a problem—particularly in England to a great extent and to a lesser extent in Wales—with the recording of very long stays in emergency departments.

The monthly reporting performance statistics that come out of NHS England include something called a 12-hour decision to admit metric. That is taken from the time when a clinician decides that a patient should be admitted to hospital and this has been often several hours after the person arrived. I agree with Lord Bichard and pretty much everyone who thinks about this problem in any way that it is clear that it does not matter when that decision to admit is made. What really matters is how long the patient has been waiting in the emergency department. This has been routine for a number of years in Northern Ireland and Scotland, and it is a much more robust measure.

The consequence of using a DTA metric—the decision to admit metric—is that it underestimates and conceals the true scale of the problem. We think it underestimates the scale of the number of people who are suffering long stays in emergency departments. In August 2022, 10% of all attendances to type 1 emergency departments spent longer than 12 hours from the time of arrival. The DTA metric was 2%, so it is underestimating it fivefold.

This metric is collected. It is reported centrally to NHS England but is not published routinely alongside other performance statistics. It is only published once a year. We have campaigned for a long time on meaningful metrics, because they provide better operational intelligence and a better appreciation across the system of the level of risk, demand and problems within the system.

The Chair: Crikey. That was very clear.

Lord Bichard: What you have just said is pretty devastating because the great British public thinks it is one thing but it is far worse.

Dr Adrian Boyle: Yes, it is. We are also in a situation now where people are spending a lot longer in emergency departments than we have ever seen. In 2015, a 12-hour DTA was so uncommon. Yes, people used to get very excited about it but it was not that much of a problem because we were not having these long 12-hour stays.

It is important to recognise that the situation we have with handover delays is a relatively new problem. Certainly, it is new at this scale. The problems that led to this were there before Covid. I do not think it is reasonable to suggest that this is entirely driven by Covid. A lot of problems were already there but Covid accelerated the situation.

Behind this, we are running our hospitals fuller, our acute hospitals fuller, than we have seen ever before. In September, we recorded the highest level of occupancy we have ever recorded since records began, at 93.6%. It is fairly clear from international comparisons that hospitals should aim to run their capacity with an uncontrolled system at about 85% capacity.

In the UK, we are particularly bad at using our capacity well because we have an addiction to open bays, which means the capacity can be used less flexibly. We do not put women next to men in hospitals—that is quite right—and if we get an infection control outbreak, Covid or flu or winter vomiting virus, that bay can be used much less flexibly. The open bays in our hospitals are a particular problem for capacity.

I heard in the previous session there was a bit about demand. There is a particular area of demand where we think there can be improvements. That is around the NHS 111 and the systems within NHS 111, and the risk that is carried and shared or exported by NHS 111. NHS 111 is a little bit too siloed. It would be much more effective if it was given better access to clinicians to support.

If you have an untrained call handler or an unsupported non-clinical call handler, inevitably they will call an ambulance or they will direct somebody to an emergency department or general practice. Triage is a difficult, valuable clinical skill that I think we need to value more. Making those decisions over the telephone can be quite difficult and requires experience. There is reasonably good evidence where, if you get a clinician into an NHS 111 call centre, you can reduce a lot of referrals to higher levels of care.

Professor Julia Williams: I think Adrian has covered quite a lot of what I was going to say. While I work in the University of Hertfordshire, I have been involved in pre-registration and post-registration education of paramedics since 1996. I have a joint appointment because I am also a paramedic and I work in South East Coast Ambulance, where I head up research and undertake clinical shifts.

Over the last three weeks, you have been hearing about the diversity of roles of paramedics. I do want to stress that, while we are talking a lot about ambulance services, we have paramedics working in urgent care centre, EDs, heart attack centres, hospices. We have started to see specialities, such as paramedics working in frailty, which I think is particularly significant in terms of the sort of things we are trying to achieve throughout the whole healthcare system and social care. We cannot divorce social care from some of the challenges we are having today.

Since the 1980s, the paramedics have moved from an ambulance transport system to a system of determining what happens to the patient based on their need, so diagnostic reasoning, and that involves education. It has been a slow process, as you would expect in a transition, to becoming a point of entry now A, B or C. That is something that will advantage the situations we are in because, as Adrian was saying, something like telephone triage is incredibly complex. I have done it myself and I would far rather see my patient face to face.

There are real skills that we are largely giving to an unregistered workforce. By bringing in specialists from whatever profession—and at that point it could be nursing, it could be medicine, and it certainly could

be paramedic because our advanced scope of practice, at the moment, is quite dichotomised either into critical care or into more primary care in the ambulance service. That is not the same outside of the ambulance service where we have some fantastic clinicians developing as advanced clinical practitioners, who are hopefully adding to minimising the problems with the work flow through the hospitals.

We have a role right at the front end. We have a role in terms of, as you heard Daren say, 'Hear and treat' and 'See and treat'—again, those are advanced skills that have to be developed. It is those practitioners who are supporting our front-line ambulance staff who will—that is why they came into the job, is it not? They are attracted to undifferentiated presentations and that sort of environment. Of course, what we have seen—and that is what we are talking about today—are the challenges of then moving from perhaps spending anything from 20 minutes to two hours with the patient, depending on where you are working in the country. Because obviously you have much longer run times in rural areas.

To move that to 12 hours and maybe only seeing one of your patient groups in one or two per shift does require a transition. It is great to hear that there are. Hopefully we will talk about this notion of pilots later on because, for me, absolutely, evidence base and research is the way forward and it depends on what we are talking about when we are saying a pilot. Since 2003 we have had community care paramedics, we have had research where a district nurse goes out with a paramedic in a vehicle. Some of these things are not new. They have just not been developed.

In terms of the district nurse going out with a paramedic or a community nurse, as is now, you have to question whether you need two practitioners of that level doing that. Absolutely, mental health is totally different; midwifery is totally different; and so is working jointly with the police services—so a police officer and a paramedic in a car. What we do not want to do is duplicate expertise. We do not want to see two highly-qualified practitioners going to the same patient when one person could probably do that.

The other area I think we need to look at is care homes because there are significant calls that are related to elderly people who have fallen in care homes, and you will see horrifying statistics of how long they have been left on the floor. I think we have to look at the risk ratio and the risk benefit there as to how we develop staff in care homes to perhaps manage a non-injury fall. I say that cautiously because, for me, you still have to have the skills to be sure that they are a non-injury. You cannot just whip them up off the floor. Maybe we need a greater use of technology and video to have some of our experienced clinicians who are in the hubs seeing that patient and then helping to do that sort of thing. That is the areas of research that are going on. Unfortunately, research takes such a long time and maybe that is how we have to expedite some of those things.

Q32 **Lord Porter of Spalding:** I declared all my interests at the start of these sessions but, for not losing track of it, I am a non-executive director of a company that does have a lot of care homes. It is not their main function but it is one of their functions.

Professor Julia Williams: I need to talk to you then.

Lord Porter of Spalding: We would not be letting staff willy-nilly handle people like that, because we would end up with a bunch of angry relatives coming and trying to sue us for everything we are worth because that is the litigious nature of the world we live in at the moment. There would have to be something that made sure that the staff and the organisations were properly insured against that risk, and I am not sure that that would stand up to that.

Professor Julia Williams: I am not suggesting that we would do anything like that; whether we work with the fire service authorities or our community first responders, there has to be clinical governance packed in around that because it still has to be safe. That might mean maybe a better working relationship with some of the care homes. It may not be possible but it is areas that we have to look at.

The Chair: They are the primary care people working.

Professor Julia Williams: Absolutely.

Lord Porter of Spalding: I do have one at the back of where I live now and that basically has an ambulance there all the time. It is constant. They will be getting people for one reason or another, blue-lighting it down there.

Q33 **Lord Bichard:** It has been suggested to us in one piece of evidence that the real problem is the length of time that is being spent out there on an incident—I am just repeating this to you so you can say it is a load of rubbish or, conversely, that we should be on to something. The problem with that, of course, is that ambulances are out on one call longer than they used to be, and therefore they are not available to get back and start another call. It is not so much a level of demand, as we were hearing before, but it is the time spent at an incident. Do you agree with that or do you think it is a load of rubbish?

Professor Julia Williams: I do not think it is a load of rubbish, but I do not agree with it in terms of taking it as a face-value statement. It depends on what is being done at that call. If I go there as a clinician and I am doing full patient history, full patient assessment, with a view, because none of us want to take people into hospital unless they need to go. There is a proportion of patients that have to go to hospital in a time-critical incident—obviously, stroke, heart attack, some of those sorts of presentations.

Lord Bichard: The time taken has increased over the last five years.

Professor Julia Williams: It has, but what we have to look at is: in doing that, have we safely left a growing number of people at home? From the statistics that have been given to you over the last couple of weeks, it is varying between 50% and 70%; you always have to ask 50% and 70% of what.

If we are successfully either directing patients into a more appropriate care pathway or safely leaving them at home with community support, that is not something that we can do in 20 minutes. At one point we were given an average of 20 to 25 minutes per patient.

Q34 **Lord Hogan-Howe:** This question came up last time and it is not a judgment of the length of time people spend there, because it may be that better outcomes medically are achieved, and we can see that. The challenge is the system does not seem to acknowledge that, if you spend twice as long at an event, you will probably attend half the number of events. The system does not seem to have compensated. It is great for the person who is treated, but it may not be for the person who is lying on the floor for 23 hours, as the worst-case example.

Dr Adrian Boyle: The reports that I see from various ambulances around what they call—with no sense of irony—the wasted patient hours that they spend outside emergency departments would easily pay back that time for a little bit more investment. If there was flow into the emergency departments and through the emergency departments, we would be able to free up ambulances, and then they could go and spend double the amount of time.

Lord Hogan-Howe: I get that, but that suggests there was double the capacity they needed before this started deteriorating.

Dr Adrian Boyle: I think all that has happened is the queue has got longer.

Lord Hogan-Howe: That is not what the demand curve says.

The Chair: You did say that demand was not the issue, but anyway we need to move on.

Q35 **Baroness Pinnock:** We have had a fascinating session, and last week as well, hearing about good ideas for improving service from different providers—be it the ambulance, the chief executive we have heard today, or yourselves and last week as well. There are lots of these pilots and good ideas around. You have brought up one or two today about a clinician within the call centre. The challenge is: how do you evaluate them and then, if they are a goer, how do you get it out so that everyone can benefit?

Dr Adrian Boyle: I think you have hit on an important problem for the NHS. Certainly, I have seen a number of pilots—quite important big pilots—that have been done that have had a lack of commitment to evaluate.

The Chair: We have to go and vote.

Dr Adrian Boyle: I will have a perfect answer for you when you come back.

The committee suspended for a Division in the House.

The Chair: We can now start again. You were just starting to answer the question when we were taken away.

Dr Adrian Boyle: The question was about how we share good practice and what works. There is a problem within the NHS about how we identify whether something is properly evaluated and then rolled out. There are two aspects to this.

A lot of pilots are conducted and do not have a built-in evaluation. That is problematic for a number of reasons. For instance, there were two pilots we have been involved with in emergency medicine. One was the NHS 111 First. This was an idea that people who were deemed to be low acuity attendances at hospital would be encouraged to phone NHS 111 and go away and be directed to alternative care. We entered into this in good faith but with some scepticism, because we work in a complex system and often we do not know about unintended consequences. We have never seen results from that pilot. We do not know whether it works. We do not know whether it does not work. We expect, because we have not seen any evaluations, it probably did not work. We do not know.

Likewise, we took part in a pilot on understanding a series of new performance metrics under the clinical review of standards; 14 hospitals took part in a national pilot. They were exempt from reporting information into NHS performance figures during the conduction of the pilot. We see those 14 hospitals are now exempt from all levels of reporting. No one has said whether the pilot has stopped. It is just those hospitals are in a performance vacuum. We have not any information around whether this has been helpful or harmful.

When pilots like that are done and we do not see the results of taking part of it, we are uncertain as to whether they take effect. We go and create our own data and we do our own evaluations as a specialty, but that is inordinately time-consuming and it should be part of routine business.

NHS England has bits of its organisation that are devoted to doing this. Julie will say, as a university professor, trying to get research through a university is inordinately time-consuming, and that is right and proper. NHS England has something called the strategy unit based in the West Midlands. It has access to all sorts of data. It can do evaluations quickly, but we do not feel it has been used nearly to its full potential.

Baroness Pinnock: Those are formal pilots that are organised.

Dr Adrian Boyle: They may provide either an evidence review, or they may say, 'You have done this; we will tell you whether it worked—yes or no.'

Baroness Pinnock: Julia, with your university hat on, you will obviously do some of the research and evaluation of different ways of working in terms of breaking the mould of how things have always been done. How do you see bringing innovation and rolling it out as good practice?

Professor Julia Williams: As Adrian said, there are different ways of doing it. From a university perspective, largely we would be involved in research as opposed to a pilot. I think some of this is about what we mean by a pilot and a feasibility study. The ambulance service that I am in does a lot of pilots, but they may not have an evaluation built into it. There will be governance wrapped around it. They will monitor it. There are some very good things that have happened because of it. Is that a pilot? Are we evaluating the impact on patient care? Those are the sorts of things that we need to get better at within the ambulance service.

The ambulance service is phenomenal at collecting data. There is a vast amount of data out there, whether you are looking for time targets or outcomes, within the ambulance service. We do have issues linking that across, and that is some of the stumbling blocks to seeing whether what we are doing in one area makes an impact in another.

I think the time factor to do research is one of the challenges because it can, as we know—there are papers published on this—take seven years from coming up with the idea to getting funding to doing it and then getting that out into practice. I do not think the NHS is very good at that.

One of the things that comes to mind, which was set up by Health Education England, was looking at something called the rotating paramedic. This was having one employer, which was the ambulance service in this particular pilot. We had four sites, and the paramedics were rotated around different areas, into GP practices and into control. They repeated that pilot probably the year after and again. Still, although the evidence was quite strong that it made a lot of difference to retention of staff in the ambulance service—one of the worries is that people are leaving the ambulance service, so what we are ending up with is a fairly inexperienced workforce that is doing the front-line work, if you use that term.

Pilots on their own are not enough without then saying—the biggest block for getting that in, to be honest—was who will pay for it. There were issues around commissioning the rotating paramedic—hence why we have probably part-time contracts with people working in the ambulance service or people working in primary care. It is difficult and it is about having a centralised place where everybody knows, but that is only as good as the people looking at it. We do have duplication, but I do not believe that is unique.

Dr Adrian Boyle: We are desperate to know that stuff does not work. We all have good ideas, but being told that stuff does not work is valuable for us because then we move on and do not waste effort and time. We welcome that commitment to evaluation and subsequent application.

Q36 **Baroness Pitkeathley:** My question is about training, but it relates to what you were saying about rotating paramedics. Do the staff who respond to health emergencies, from wherever, have access to the right kind of training, and the opportunity to develop skills, which is another way of tackling retention, as we know? Perhaps you could couple that with saying whether there are more opportunities for integrated training, more shared training across the services. Julia?

Professor Julia Williams: It is a huge question. By responding to emergencies are you talking about our acute patients or all our patients?

Baroness Pitkeathley: We are looking at the whole of the way that the emergency services work.

Professor Julia Williams: If we are looking at the whole picture, we are talking about needing to educate and skill up our workforce to manage birth to death from high acuity to low acuity, including mental health and social care. If you ask any paramedic or anyone in the ambulance service or outside of it, continual professional development is hard. It is hard to find time to do it because you are working at capacity. It is hard to find clinical supervisors or mentors because growingly there are less of those, and we are going to mention the ambulance service for that.

Pre-registration, we are trying to get students to be potentially the lead clinician on scene at the point of registration in three years. To cover all of that, I think we must say that it has taken us a long time—probably 12 years—to get to the point of recognising that it needs to be a degree entry profession.

For people who are already registered, it is difficult and it changes across the trusts. Some trusts might allow two days a year for upskilling, some maybe four. During Covid virtually everybody had none, because with the demand out there with staff sickness that was the first thing that went.

We are totally for interprofessional working and there are a lot of areas that we all could learn from, each of our professions, but it needs to be targeted.

Regarding the other emergency services, I think that is probably more limited to specific things around sharing resources, maybe having simulation with the fire service or the police or mental health or fires or traumas and things such as that, but we would have to be careful about diluting, if you are talking about sharing a degree programme with other emergency services. There may be some commonalities, but we need to ensure that we are equipping the registrants with the confidence and competence for day one. They need clinical supervision and mentorship. We have a newly qualified paramedic scheme, but it needs work.

Dr Adrian Boyle: It is disproportionate across the professions. We have a very good training programme for our doctors. I oversee the training programme for emergency medicine in this country and I think it is one of the best trainings that I have seen in the world. During the pandemic and over the last couple of years the time given to training has been nibbled at and it is a red flag for me when I hear that training gets cancelled.

We have a rigorous programme for training nurses and paramedics who want to train as advanced care practitioners. We have embraced that and it is the right thing to do, but it is a rigorous, time-consuming credentialling process. That is good. I feel very strongly for our nursing staff who work in emergency departments: emergency medicine is very much a team game, and their opportunities for professional development are considerably more limited. When matters get tight, when rotas get tight, their training gets cancelled and it is an own goal in terms of managing the staff, because it contributes to burnout, and it makes life much harder for them.

Baroness Pitkeathley: It is very much a false economy but, as you rightly say, it is always the first thing that goes when there is a crisis.

Dr Adrian Boyle: Training in teams is a lovely idea but it is a time-consuming and difficult thing to set up.

Baroness Pitkeathley: I will leave it there, Hilary, with some rather depressing answers.

Q37 **Lord Porter of Spalding:** Do the remits, the priorities and the approaches of emergency services accurately reflect the types of demand that emergency service workers will be picking up on the ground? This is about the culture of how the organisations work through and the reality of what the people at the sharp end are experiencing. Does the comfort blanket of the organisation around them work in that way?

Dr Adrian Boyle: From my perspective, certainly one of the areas we are struggling with and that you heard about in the previous session is lack of alternative access, so that a lot of people do come to an emergency department because it is the only place they can access services.

We have a number of patient groups. It is absolutely right and proper that people who are seriously ill or injured come to emergency departments. There is a big group, and now probably our dominant patient group of what we call the majors—ambulance patients who walk in but are not trivial cases. They may not be quite so time-critical. They may be somebody who presents with a bit of chest pain that may or may not be a heart attack and until they have been properly looked at and evaluated we will not know, so that major ambulance group is taking up an inordinate amount of effort. I am not sure those patients always need the services of an emergency department, but this is around access to alternative care, and that is often quite poor.

In particular, mental health patients are a group who struggle with access to mental health care. It seems to be the only way that a lot of people can access mental health care is by going through an emergency and a crisis. We can probably do better as a country with that.

Lord Porter of Spalding: I have a few bones on that particular area, given that Theresa May stuck in £2 billion to deal with a lot of the stuff, which seemed to get siphoned off into other priorities inside the system—largely paying down debt by trusts as opposed to going to front-line patient care.

The Chair: We cannot hear you at this end.

Lord Porter of Spalding: That was probably just as well. I was complaining about people who I might need to come and fix me when I break something. That is the trouble with being critical on anything on this. We have been told that 10% of the demand is GPs not seeing patients. That is 10% of the call-out load that paramedics will be dealing with. We have another 15% to 20% that has gone through on mental health call-outs where, if you had sent two mental health nurses, they would probably have done a better job for the patient and would have been a cheaper solution for the country.

Professor Julia Williams: That is one of the issues. When we say 10% have not been seen and that is why we are getting them, was the GP the right facility in the first place? Are there other healthcare professions, particularly in the allied health professions and nursing, who could undertake those roles and develop those areas? Certainly, in my profession the advanced scope of practice clinicians—and Adrian referred to the ACPs, which are in the hospitals but are moving into more primary care—have advanced education, and that is exactly the sort of thing that they are doing and they are taking patient caseloads and developing. That takes time, and it takes more education and development, so these are largely master's level and beyond.

Is our system most appropriate now? Are there other ways that we can supplement what was classically the only way that people would go? That requires a lot of public education as well on how to use the services.

Lord Porter of Spalding: It is a straightforward thing at the moment: 'Go to your doctor, but if you cannot get to a doctor, go to the hospital.' If your clever people come up with something that is a better solution, you would have to spend the next 50 years educating people that that was the route through. Sorry, I am rambling again.

Q38 **Baroness Chisholm of Owlpen:** Thinking about that, there need to be other places where people can go outside of the A&E department. I was an A&E nurse, but it was a long time ago—before either of you were born, probably—and obviously even then back in the 1980s you were seeing people in A&E departments who did not need to be there, but there was often nowhere else for them to go. Do you think we utilise places such as pharmacies enough? In pharmacies, when you are

standing in line waiting to get whatever it is, you hear them give a lot of care to various people who come up with problems. Could we not have those as hubs, where perhaps you have practice nurses or mental health nurses or even a clinician who could take some of that work away from A&E departments?

Dr Adrian Boyle: This is a question that comes around frequently. In a way, we could do all those things, but it would not make any difference to the problems we are seeing with ambulance handover delays, because our problem is all around the patients who need to be admitted to hospital. I see lots of plans to try to prepare emergency departments, and I am very sceptical of anything that is based around demand management. People who turn up with low acuity problems can usually be turned around fairly quickly and fairly efficiently. They do not need hospital admission; they probably do not need the investigations that we do to them. They may get a bit of investigation but that is not the big problem that we are suffering with. That is not what is causing the problems for the paramedics waiting outside and the awfully long waits we have in our emergency departments, in the long stays and the consequences that has on mortality and health. We could, but it would not be the answer.

Professor Julia Williams: The only thing I will add to that—and I totally agree with everything that Adrian has said there about how it is not going to impact on the delays—is the other part of our calls, which are 'Hear and treat' and 'See and treat'; it is possible that would reduce the load there. I cannot say it would; there are several universities that are building into the pharmacy programme patient assessment modules, and the students are quite resistant to that. I taught on one a few years ago and they said they did not come into pharmacy to do that role. So it might impact on some of our workload, but without a doubt would not impact on yours.

The Chair: That is interesting. Would it mean that the A&E would not be as crowded and distressing?

Dr Adrian Boyle: Yes, you might have a few less people in your emergency department and your waiting room, but the problem that you have, and the problem that drives all the problems we are seeing with ambulance handovers, is the people on trolleys. You do not see that when you go into an emergency department, because trolleys are around the corner in cubicles. I feel quite strongly that this is an invisible group.

The Chair: Yes, it is about patient flow, which we have been saying for some time. Any other follow-ups on that? If not, I will come to Lord Bichard.

Q39 **Lord Bichard:** I have been asked to ask the impossible question, but I will ask it anyway. What one intervention really would make a difference? While you are thinking about that—and I suspect you have already thought about it—I would like to add a genuine question. We are a Select Committee. We identified this as an issue that we thought was important

as a public service and that was causing a lot of distress to a lot of people. We work on the basis that we ask a lot of questions and come to some conclusions.

What I think we are finding is that we are asking questions of people who are asking questions. I am slightly perplexed that no one is coming here and saying to us, 'There is a vision that I have that is going to resolve this.' Okay, it might have slight differences around the country, given regional issues and that sort of thing, but we are talking to a lot of people who are asking the same questions that we are talking about, and it seems to be a circular process.

What is the one intervention that would make a difference? Dr Boyle, I will start with you. Do you have a vision and would you share it with us?

Dr Adrian Boyle: Yes. I want an emergency system that is fit for purpose, by which somebody with a severe illness or injury can be responded to quickly by an ambulance, which brings them into an emergency department where they are treated quickly by a skilled clinician who identifies their need for ongoing care. If we start by focusing on that high-acuity pathway, that is the vision that we need. Because of all the other problems, that particular part of the pathway is broken at the moment.

My first ask to try to get there is meaningful trustworthy metrics. That means honest 12-hour data, so that we understand what we are dealing with, we have system oversight and risk sharing across the system. Reform the difficult interface between acute hospitals and social care, so that we do not congest our hospitals with people who can be got out. Then long-term we need to look at the model of beds that we have in our hospitals to try to support flow. We are running our hospitals far too hot, far too tight, and that is having all the knock-on effects.

Lord Bichard: On that last point, what did we have in 1986? We had 300,000 acute beds. We now have 144,000. Do you think that is at the heart of some of the problems we are experiencing?

Dr Adrian Boyle: Yes, particularly since at least 10,000 of those beds are occupied by people who can be transferred to another level of care. We are harming those people by keeping them in hospital.

Lord Bichard: I do not want to put words in your mouth, but when you talk about the data you are saying by highlighting that we are in denial, and we are hiding the true extent of the problem. If you ever hide the truth into the problem, you never get to a solution.

Dr Adrian Boyle: I think the 12-hour DTA metric is a fundamentally dishonest way of reporting data. It is hiding and doing our patients a disservice by minimising a very serious problem.

Professor Julia Williams: I absolutely agree with Adrian. Ideally, that is what you want for your emergency service. You do not want people having the delays and having the stress. You do not want staff being

stressed because they cannot deliver an appropriate level of care as they see it.

The biggest risk at the moment is the handover delays, because that has a knock-on effect to all our other areas. For the ambulance service there still needs to be a recognition that there is so much more going on to prevent people going to an inappropriate destination, for lack of a better word. We need to make sure that is being done safely, and that we are capitalising on the experience that we do have within the service, fundamentally from paramedics but also from other healthcare professionals.

It needs to be an integrated approach and then, as we said before, for the other part, utilising not the emergency department access but other healthcare professionals and other healthcare pathways. I think it is improving, but it is not improving across the board. You hear of areas where it is improving, where we have access to other healthcare routes that are more beneficial to the patients than ED. It is a complex picture of course, but for the handover delays that must be about flow through.

Q40 **Lord Hogan-Howe:** These are two narrow questions, and it may be a longer answer but a narrower question. What has become clear from talking to various witnesses—I speak for myself as a lay person—is that we do not understand the complexity of what the data shows and what it may be counting, always for good reasons, but sometimes it can be at the least inaccurate. What would you suggest is the best source of data with some analysis that says, 'Broadly, this is what has happened over the last 20 years'?

On that point, for example, I think we had some data in our first meeting about how the waiting times at A&E shot through the roof in about July 2021 with no clear explanation of what changed. Something did, but I do not think it was entirely Covid. It would be interesting if there was something that succinctly says, 'In the health service, in this area, this is the data and this is going to explain the complexity of it.'

That was point one. The second one—and it is a bit of a challenge, but it is in the way that Lord Bichard said—is that I think it is almost possible to say that NHS is a misnomer in saying that it is national. I am left wondering who is in charge, either locally or nationally, who says, 'This is not working. It is not a command and control issue—"I am telling you what to do"—but, broadly, we have decided this is best practice and we are going to give it a try until somebody comes up with best practice.' Whose responsibility is it to say we are going to improve the system either nationally or locally. Those are two questions, on data and leadership.

Dr Adrian Boyle: There are several good documents. We published a series, an *Acute Insights Series*, which gives you an idea about the various flows of information and we have submitted a number of these to this committee to try to support their decision-making. The Nuffield Trust is also very good at producing information around urgent and emergency care activity, waiting times and beds within the NHS. They have a bed

tracker that is updated every month about the number of beds, and you correctly identified the nearly threefold loss of beds over the last 20 years.

In terms of who is in charge, it is a dynamic landscape at the moment, with the establishment of the ICBs, and there is a variable level of maturity and engagement from ICBs while they try to figure out what their responsibilities are.

Lord Hogan-Howe: You say that is a committee that meets every so often. That still comes back to: who is in charge? Not to be pejorative about them, but when somebody says, 'The system is not working and we need to work differently', who thinks it is their responsibility to do that?

Dr Adrian Boyle: Certainly, my local experience working on the ground is my executives have very good working relationships with their local ambulance service trusts, so if you are thinking the acute hospital working with their ambulance trust. They are the people who feel they have ownership of the problem.

Lord Hogan-Howe: If they said to the GPs, 'Look, part of the issue is that you are not seeing enough people when they need to be seen and, consequently, they are self-selecting and turning up at A&E when they would hopefully go somewhere else', could they say to a GP, ;We need you to think about how you would address that'?

Dr Adrian Boyle: I do not know if they would do that. I do not know the answer to that question.

Lord Hogan-Howe: That is just one example. Across the whole system, if the GPs are an element of demand control or service delivery, if the system cannot if not direct but advise—because otherwise people just keep coming back and saying that the GPs are an element of it, the 111s are another element and A&E has to think about their contribution.

Dr Adrian Boyle: From my understanding, there should be some delivery arm of an ICB or an ICS that is responsible for that. They are still bedding in, and I do not know how that works in practice.

Professor Julia Williams: I echo that, but also say that, from the ambulance service perspective, you will find that many of the medical directors are GPs. Well, a few of them are, but you have a GP and each ambulance service operates slightly differently. SECAM, South East Coast Ambulance Service, is in constant discussion with GPs around the service delivery, so it is an interesting one. As you said, the ICBs and ICSs are too new to say, but presumably that is what their target role is. If it is not, we want to know why.

Lord Bichard: Probably one of the problems is that we have been in dynamic transition for the last 30 years. We always hope that the latest dynamic transition is going to take us to a happy place and very rarely does it do that. That may be one of the things that we want to say that

others have said. Surely when we are all identifying this as a systemic problem, but all the parts of the system are within the NHS, someone within the NHS, not locally but nationally, has the responsibility for doing something about the problem that we are trying to examine. Ultimately, it may be the Secretary of State but in terms of the executive?

Dr Adrian Boyle: I think you raise an important point about where the accountability lies. You would have to ask NHS England and the DHSC where they think that lies. I suspect they will tell you that this lies with the ICBs, but how that is organised I am not clear.

Lord Hogan-Howe: It may be inconsistent. It may be locally focused, I guess.

The Chair: Julia, do you have a view?

Professor Julia Williams: I was just thinking, though, that the work group, which I cannot remember the name of and I am hoping you can—

Dr Adrian Boyle: NHS England UEC, which I think is giving evidence later.

Professor Julia Williams: That is part of the remit and the discussions around accountability development, but I would not say that they necessarily have the responsibility.

Lord Hogan-Howe: The structures vary around the country. We heard from Daren earlier—he is from the North West Ambulance Service—that not everywhere has a regional ambulance service and we have these different trust structures within different geographies.

Professor Julia Williams: In terms of ambulance services?

Lord Hogan-Howe: With everything. London is—

Dr Adrian Boyle: The ambulances are the biggest trusts within the NHS. There are nine in England.

Lord Hogan-Howe: Then we heard from Len Richards from West Yorkshire, who had an arrangement with certain hospitals. However, if I understand it correctly, the ambulance service has different structures. It has a regional one in some places.

The Chair: Yes, the ambulance services are much more regionally based.

Professor Julia Williams: We have 10 in England, but we span different geographies and that is the problem.

The Chair: Yes, they are not coterminous. It is only in the north-east that they are coterminous, and they are nearly coterminous there.

Professor Julia Williams: It only has five boards.

The Chair: Yes, a bit goes over into Cumbria, which is not really in the

north-east. I think that there is not the coterminosity around and that sometimes allows for lack of things. We are about to have another vote and so we need to finish. Adrian, you were talking about your vision of the high acuity getting quick access to emergency services and then through to appropriate treatment. Do all the people who are eventually getting into hospital need to be there, or is it sometimes that we do not have the right means of looking after some of them?

Dr Adrian Boyle: With these long delays that we are getting in seeing patients there are a number of elderly patients who you might be able to discharge during the day, but you feel very uncomfortable about discharging late at night. I would feel quite uncomfortable about discharging somebody in their 80s, who had multiple problems, who I might be able to get home at 8 am, get a physiotherapist to see them, walk them around the department and to have someone to try to evaluate whether they are safe to go home. At 10 pm that would be hard, and it might feel quite risky.

When we get these very long waits there is an effect where you end up admitting some patients a little bit longer. Increasingly, those patients are just waiting in the emergency department overnight and people are having a pretty grim experience while they spend a long time because there is not a bed to admit them to, and then you start trying to do it all over again and try to get them home first thing in the morning, by which time they are deconditioned. They may have become a bit confused. They may be a bit delirious and they have had a pretty miserable time of it.

The Chair: Thank you very much. We have a lot of thinking to do around some of these issues, but we are grateful to you for giving us that evidence. If there is anything that occurs to you that you think we have missed, or you want to reinforce, please let us know and we will very happily take on additional information.