



Public Services Committee

Corrected oral evidence: Access to emergency services

Wednesday 9 November 2022

3.05 pm

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

Evidence Session No. 8

Heard in Public

Questions 59 - 70

Witnesses

I: Will Quince MP, Minister for Health and Secondary Care, Department for Health and Social Care; Matthew Style, Director General for NHS Police and Performance, Department of Health and Social Care; Dr Vin Diwakar, Medical Director for Transformation and Secondary Care, NHS England.

Examination of witnesses

Will Quince MP, Matthew Style and Dr Vin Diwakar.

Q59 The Chair: Good afternoon, everyone. We are in the session of the Public Services Select Committee in the House of Lords and today we have Ministers. The first is from the Department of Health and Social Care, Will Quince MP. With him is a doctor from NHSE, who we met last week, and a civil servant. Welcome to you. I know that you are in a new department, only a week or so in. We thought that this session was not going to happen, so we are very impressed that you are here today.

We are dealing with issues around access to emergency services and there is a large amount of concern. I know that when you come to a Select Committee you want to paint the department in the best light and so on. You are a new Minister and we are looking for what you see the challenges are. We want to be able to acknowledge that there is a real problem out there and what are the best ways that we can assist the department and the Government to find ways through this to give patients and the public more confidence in their access to emergency health services.

In that light, I will ask the first question. What do you see the system needing to produce? What sort of picture do you have of what emergency services should look like? We know that there is a challenge around mental health services now, particularly post Covid, and primary care, which historically were not seen as being responsibilities of the emergency services. How do you see what should be there and what do you think about these other things that seem to be taking up time?

Will Quince: Thank you, Chair. It is a pleasure to be before your committee again. You probably know me well enough to know that I will not sugar coat and if things are not as they should be I will say so. Perhaps being only seven or so days into the job, I am more *au fait* with some of the challenges and problems than I am with some of the solutions, although I will talk about that a little bit later.

Where we are is not where I hope we would be, in that people are currently waiting too long for accident and emergency and they are waiting too long when an ambulance is called. If you look at the provision of ambulance services, we have 11 trusts serving 124 accident and emergency departments in hospital or acute trusts around the country. They are under considerable pressure. To be frank, when people call for a cat 1 or a cat 2, cat 1 being life threatening, where we want to see people receive an ambulance and have a response within seven minutes, it is in excess of nine minutes. To me, that is not acceptable or where we want and need it to be. We would expect cat 2, which is an emergency, to be around 18 minutes and it is currently over 40 minutes. Again, that is not where we need it to be.

I have to be a bit careful because I do not want to be overly critical of our ambulance services. I think that the 11 trusts do a fantastic job and it is very easy to look in isolation and say they are not turning up on time and

it is all the fault of the ambulance service. In many cases that could not be further from the truth. I think paramedics and ambulance technicians have the most unbelievably difficult job. I would not and could not do it. Ambulance services cannot work in isolation and the pressure that they are under is largely down to broader health ecosystem pressures.

My analysis in seven days in the department is that when an ambulance collects a life threatening or emergency patient they arrive at a hospital. Hospitals are a bit like—for want of a better analogy—a tube, which starts at one end and fills up with water. At the end we currently have a giant bung and that bung has a pinhole in it. The problem is that you have ambulances arriving at accident and emergency and we would expect an average handover to take 15 minutes but it is taking well in excess of that, which is the biggest problem. That is not the fault of the ambulance paramedics or technicians; it is the fault of the system in that A&Es are clogged up because there is high bed occupancy rates in the hospitals. That is largely due to pressures on adult social care, which means that the system and patient flow through the hospital is not working as it should. The system is very heavily clogged up at the back end and, as a result, it gets clogged up at the front end.

I completely get the frustration, because paramedics and ambulance technicians desperately want to get back out on to the next call. They want 15 minutes and then another 15 minutes maximum to make any preparations to the vehicle, get back out on the road and go and see another patient. That is not happening and that is causing them huge frustration. Yes, there are changes that we can and probably should be making at ambulance trust level. The biggest changes we need to make, certainly for this winter and beyond, are around patient flow and bed occupancy through the hospitals, which will in turn take the pressure off the ambulance service and enable them to get back out on the road and get to patients quicker.

Q60 The Chair: Do you think that there are too many patients ending up at A&E who should not be there?

Will Quince: That is undoubtedly true. I was at an accident and emergency department last week, and I have heard this before. Doctors will tell you that many people are arriving at A&E who do not need to be there. I suspect that is more walk-in than it is conveying through ambulances. Conveyance through ambulances has dramatically decreased over the past few years as more people are either being treated in the community or through community health services and others and ambulances have not been necessary to convey them. I think that the fall is about 50% but I will defer to experts in Health who will be able to confirm that.

We also should not underestimate the pressure there is more broadly on accident and emergency through people arriving. The number of trust chief executives who say to me that A&E stands for “accident and emergency” not “anything and everything”, and there is a real challenge there. People are turning up at A&E because they know they will be seen.

I am not going to criticise any patient for doing that. I know, as a parent of young children, if you think your child is ill you want to see a doctor or clinician or paediatrician as quickly as possible and get a diagnosis and the validation or reassurance that your child is okay.

We have to work out—and this is what I will do with my counterparts in the department—GP access, community healthcare services, what we can do about walk-in centres, to make sure that there are other options, for example NHS 111. If somebody falls over at home, do you need a paramedic to attend or could it be community health services? Some of the most innovative trusts are already doing that work. They are diagnosing and analysing on the phone what service needs to be provided and if it does not need to be an ambulance and they do not need to be conveyed to hospital. I have yet to meet somebody who wants to go to hospital, unless of course they are very sick. Most people would much rather receive the treatment and care, as clinically appropriate, at home or in a community setting than going into an acute.

Q61 Lord Filkin: Thank you, Minister, for your time in coming. A simple but perhaps difficult question: will it get better or will it get worse or does the department not know?

Will Quince: I can tell you the steps that we are taking to try to ensure that it gets better. The first is that last year we put an extra £450 million into 120 accident and emergency departments to increase their capacity and flow to improve the service that they can provide. This year we are putting an extra £150 million—or NHS England is—directly into ambulance services. It set up the national ambulance co-ordination centre, so we have that national oversight at NHS England level. Local ambulance services have put in place 24/7 control systems, so they have a bird's eye view of the situation across their regions. We have contracted with St John Ambulance to provide an extra 5,000 hours of surge capacity and we are increasing hospitals this winter by 7,000 additional acute and other beds. About 2,500 of those will be virtual ward beds. The final ones are further investment in NHS 111 call handling and 999 call handling.

Probably the most important one, focusing on the point I made at the beginning about the bung with adult social care, is that we are putting £500 million into a social care discharge grant, which I think will be announced later this week. That will go out to integrated care systems to be used flexibly to try to tackle some of those issues. They know best how to spend that money to improve patient flow through their acutes and help people into social care.

Lord Filkin: That is all good and necessary. We have heard that evidence and it is to be commended. The question then is whether that will be sufficient.

Will Quince: We have to keep a very close eye on it. There are more and broader changes to adult social care. I am not the responsible Minister for adult social care, but inevitably, when I am looking at patient

flow and elective care and accident and emergency, I have to work very closely with my counterpart. I think so much of this hinges on adult social care. I suspect that we will come on to collaboration later, because it is a very important point. I mentioned earlier that you cannot just say it is an issue for ambulance trusts because it is about the wider health ecosystem. That is why integrated care boards and integrated care systems more broadly are so important because for the first time you have an holistic approach to the whole health ecosystem.

Where I have seen this done really well is Swindon Hospital, where in one room in the hospital trust there is a paramedic who sits there looking at the stack, so as calls come in they think, "Does that really need a paramedic or could that have someone from community health to go and check in on the patient?" They make that analysis and decide who needs to come into hospital. In the same room they have clinicians but also people from every ward who look at every single patient in the hospital every day and say, "Do they need to be here; what treatment have they been provided; can they be treated at home; can they be treated in the community; what are the barriers to them leaving the hospital?" In some cases it is adult social care, sometimes it is things as simple as occupational therapy or even transport, so they are improving the flow through the system. But the critical thing is that also in the room sits Swindon Borough Council and Wiltshire County Council, because of course they have responsibility for social care and they are helping to address some of the barriers to people getting out of the hospital and into the community.

Lord Filkin: I have a final question on this. We have received quite a lot of evidence about the generation of demand, for demographic reasons, social trends, inaccessibility of primary care, out of office hours, or mental health services, and the public almost getting habituated to knowing that they use A&E. The generation of demand plausibly looks as if it will be greater than the system improvements. We are very clear that the system improvements are essential and fundamental, but by their very nature they are very slow to come on stream. You do not build a hospital quickly; you do not transform primary care quickly. These changes, even with the best will in the world from the Treasury, will take five or 10 years. In the meantime, there is lots of evidence that demand will keep on rising. Do you disagree?

Will Quince: I think that is a fair question. I broadly agree with what you are saying but the statistics do not agree with it. Before the pandemic we had a long-term growth trend on access to accident and emergency and ambulance use. That has been disrupted by the pandemic. In the 2021 figures, A&E attendance was down 8.5%, ambulance incidents down by 11.5% and conveyance by ambulance to hospital down by about 50%. Where you are absolutely right is that more people are looking to urgent care or accident and emergency because they want a quicker outcome and they want to see a doctor, and I get that.

There are two ways we can address that. You can either say let us just increase capacity in our acutes, and some are doing that. Many now are moving to the model where at the front of a hospital you have a left and a right—you have an urgent care or walk-in centre and you have an accident and emergency. You are triaged at the point of entry and they say A&E or urgent treatment centre, and that model works. But at the same time we need to say you can either drive behaviour change and invest in primary care, so we invest in primary care and we try to drive behaviour change and that is one way of doing it. The other way of doing it is you accept that this is the way that people want to transact with the health service now and then you have to look at other ways.

Do we massively invest and improve the NHS app, for example? I think that we should and that is what we are doing. Do we invest in other services like GP on Demand, which will not work for everyone, where people want to see a GP over their smartphone or tablet? Do we invest in pharmacy? If you have an ear infection or a urinary tract infection and you need antibiotics, at the moment you can only go and see a GP. Should you be able to go to your pharmacy and see a pharmacist and they are able to prescribe? They are doing it in Wales and Scotland, and I think we should be doing it in England.

We have to make it easier for people to access NHS services, which I think will divert them away from our acutes. We do that by making it available and through NHS 111 and the app. People will assess their own health situation and be directed to the services that are available in their community. I think that is the better way, much better than driving behaviour change. You make it easier in the community for people to access health care.

Q62 Baroness Morris of Yardley: Good afternoon. I am interested and pleased to hear the last few words you said about trying to build a system that suits changing needs or changing requests from the public. Prior to that I had the impression, from the response to the Chair's opening question, that it was about making the existing system work. I am not persuaded, and I do not think I ever will be, that relatively small amounts of money in adult social care or in bits of the system will ever get us out of the problem. The scale of investment that would need to be driven through is not on the cards at the moment and I do not think we should pretend otherwise.

The question I was going to ask against that background is: how adept do you think you are at adapting to changing practice? Something I have been interested in—it is only a little thing but it is an example—is the ambulances that deliberately stay longer with somebody they have been called out to because they do the treatment and the patient never gets to the hospital, but neither the waiting times nor anything else are adjusted. It seems from the nodding that that is good practice, yet when you look at their statistics they will just show that they took ages to deal with that case. If that was the case, the ambulance was potentially tied up for longer than you might previously have thought. What changes have been made to the number of ambulances and the structure of the service to do

that? It is all right saying we ought to change to the different demands of the patients but I am not sure that the whole health service seems able to do that at the moment.

Will Quince: That is a fair question. I will defer to my colleagues because I have said a lot already. I think you are absolutely right that it is not binary. We should not just try to address issues in community health services and primary care and access in the community. We have to focus on the acutes, too. I think the key to this is integrated care boards and the broader integrated care system. We have to empower local system leaders to do what is right in their own individual areas.

Some Ministers love top-down targets. I am not one of them. I think that they can help in driving the behaviour and change that you need to see at a local level but, at the same time, you do not want targets that drive adverse or perverse behaviour. For example, I would not want a paramedic or an ambulance technician to not stay with the patient if then it would lead to a conveyance to hospital that was unnecessary, which more often than not, I hasten to add, leads to an admission into hospital whether or not it would have been necessary if the intervention at home had worked. I would not want them making the wrong decision. You have to empower systems and leaders at a local level to make clinical decisions that are in the best interests of the patient not in the best interests of meeting targets that we set in Whitehall.

Baroness Morris of Yardley: I agree. I can absolutely see that you would not want to set specific targets for specific parts of the health system, but leadership is about saying that this is the nation's direction, we have an accountability to the public, this is what we want to see, so this is where we want to see improvement. I will go back to my little example: who in the system will say should we look at what we measure so that the ambulance person who stays there solving the problem does not feel bad because they have made the statistics for their group worse by the end of the month?

Matthew Style: On the very specific example, we and the leaders of all ambulance trusts are very clear that an increasing incidence of what we call see and treat, or hear and treat where you do not even despatch an ambulance in the first place, is very much a positive development. I would be surprised that anyone felt that the performance management regime that is in place is discouraging that. Indeed it is quite the opposite because we actively monitor the extent to which ambulance services are promoting the use of those models. Absolutely, it is our job to make sure that there are targets in place that are driving exactly the right behaviours, and we keep a very close eye on that.

To your broader point about our needing to change the nature of the services we are providing, as the Minister said, integrated care boards will be absolutely at the heart of that. I point to the work commissioned from Dr Claire Fuller on the reform of primary care to ensure that people can get faster access to support in primary care when they need it. Integrated care boards are at the heart of working out how to implement

that in their own areas. We are increasingly seeking to ensure that community services are providing faster access to care so that when needs are identified, they get a rapid response from community services and people are not always relying on an ambulance-led or paramedic-led service to meet those rapid needs in the community.

- Q63 Baroness Pitkeathley:** Minister, it is very good to see you when we know you have so many problems, many of which you set out in your first answer. They have been brought to us by witnesses about the problems for A&E and ambulance services and elsewhere in the system, as you have pointed out to us: a shortage of beds, difficulty in discharging patients and limitations with social care. I appreciate that you are not the Minister for Social Care but one place where social care and healthcare very much meet is at the point of discharge of patients. I would like you to expand more on the money being made available for hospital discharge and how the discharge process will be better managed. We had a very interesting question for your ministerial colleague in the Lords about this yesterday, pointing out that if discharges are made too suddenly without, for example, relatives being prepared, the patient does not get proper care and has to be readmitted, so it is a waste of time, energy and money. Could you expand on how the money will be spent and how you expect to improve discharge procedures?

Will Quince: Thank you. It is a very good question. I am conscious that I am not the Minister for Social Care but my understanding is that the £500 million fund will be announced either tomorrow or Friday. The idea is that that fund will be made available to integrated care systems to use flexibly to target the areas facing the greatest challenges and to strengthen their sector's ability to recruit and retain staff. That goes hand in hand with two other things we are doing, which is a national social care recruitment campaign and a £15 million investment in international recruitment into social care. One of the biggest challenges in social care is recruitment. The good news is that anecdotally I have been told that international recruitment for social care is very promising indeed and I hope that we will be able to update the committee at a later point.

We are very careful not to be overly prescriptive with local integrated care boards about how they should spend the funding, because they are the ones that know best and every area has specific challenges. To give an example, the funding could be used to create more capacity in home care. People could be discharged to home with something like an interim care package, but while they are waiting for a full assessment, which you rightly point out would involve family and friends and others to offer wider support, it almost bridges the gap. We are largely going to leave it to the experts on the ground. I do not know if either of my colleagues would like to add anything to that.

Matthew Style: We see it as absolutely critical that there is a discussion locally involving the local authority, not just NHS colleagues, on how those resources are deployed. That is so we can ensure not only that those resources are used to have the maximum impact on discharge over

this winter but they are also deployed with an eye on what the longer-term sustainable solutions are to the resilience of local social care.

If I may, Baroness Pitkeathley, I will pick up on the point you made on thinking about avoiding readmission and so on, and you referred to avoiding sudden discharges. Our guidance is very clear that good practice is that, when someone is admitted to hospital, you start planning for discharge then and you set an expected date of discharge when someone is admitted and you start involving family and the care and support network in that conversation right from the point of admission. I will not pretend that that happens routinely everywhere but we have been trying, across all our acute trusts, to focus people on some of the good discipline of what good discharge practice looks like and the actions that need to be taking place in acute trusts as well as that those outside in local government in the social care system are all happening.

Baroness Pitkeathley: Nobody could disagree that planning for discharge as soon as the patient is admitted is good practice, but time and again, as you and the Minister will know, discharge is sudden because there is such a pressure on beds and suddenly on a Friday afternoon somebody has to be discharged. Patients and carers mostly complain about the lack of communication; "Nobody told me, they just dumped my father at my door", is what they say.

Will Quince: It is a fair point. I will come back to Swindon, which I think is a really good model because they are looking at every patient every day and they are looking at their flow and journey through the hospital and all the different barriers that they might have to getting home or into a care home. I think that model is a far better one. For example, there is more join-up around, "We are not going to send Mr or Mrs X home because they have not had the occupational therapist go in and put in railings and steps and all the other things that would be appropriate for them to be able to go home. Have we sorted out transport?"—all those sorts of things. It is a good model if you have everybody in the room thinking about every single individual patient as they flow through the hospital and it leads to you not having the sudden, "Oh my gosh, we need a bed. Who can we discharge from the hospital today?"

- Q64 **Lord Hogan-Howe:** On the beds issue, we have been told that the number of beds has dropped over the years and that is probably a good thing because perhaps there was an overcapacity, but the average rate I think is about 85%, 87% across the country. The risk is that there are not enough beds where they are needed because you are never going to have perfection in terms of social services access. Is any work being done to see whether there is a correlation between high occupancy—higher than 85%—or lower than 85%, and what impact that has on either discharge rates or on A&E waiting times? It is said that that is the main reason, yet there is no clear evidence that someone running at 95% and someone running at 66% bed occupancy is having an impact on the waiting times.

Will Quince: It is a fair question. I will hand over to Matt for a response.

Matthew Style: Vin may want to come in as well. He is much more expert in these matters than I am. There is a very strong correlation between the level of bed occupancy and handover delays at the front door of the emergency department, which then feeds into delayed ambulance response times and so on. It is absolutely critical. In recent weeks occupancy has been running much higher than the sorts of benchmark levels that we would have aimed for traditionally and to which you referred. Tackling discharge and bringing down occupancy is absolutely central to what we are trying to achieve for better patient flow and better ambulance response times.

Lord Hogan-Howe: The counterargument is that you need more beds as well—not necessarily a doubling but some more capacity. I do not know what the optimum level of occupancy is.

Matthew Style: As the Minister said, part of the plan for this winter is the equivalent of 7,000 more beds, so we are doing as much of that as we can within the resources available. As you said, there is a balance here because part of the productivity story across the NHS is that we have used our acute estate very efficiently and we have not had wasted capacity over time.

Dr Vin Diwakar: I completely agree that there is a direct relationship between flow and backlog and bed occupancy. I am an acute paediatrician and I can say that when the trust I was working at was running at 95%-plus bed occupancy, it was jolly challenging. We had patients waiting longer and longer in the emergency department who we could not get into a bed even if we had a list of the patients that needed to come in.

The optimum level in the international evidence is about 85%; whether that is achievable is another question but certainly somewhere between 85% and 90% bed occupancy is the optimum level. We know that below 85% the productivity drops down and the level of gain you get for every percentage point rise probably is not there in the use of beds. I think that bed occupancy is a key issue for us but the solution to that has to be in reducing the 10,000 to 14,000 number of patients on any given day who are in a hospital bed and would be better cared for in their own home, who are waiting for a social care package and so on to be given, even when discharge planning starts early.

On discharge, the real advantage of integrated care is the way in which community services as well as local authorities work together with the acute trust on assessing patients for their care package at home. Prior to the pandemic we knew that, speaking as an acute paediatrician or an acute physician, when we had a complex child I did not really know, as a hospital doctor, the home circumstances that the family were living in, and that is the same if you are an adult physician as well. People working in hospitals tend to be risk averse and tend to make assumptions about it. When the patient goes home we know that there are some care packages that community services can scale back because they understand the circumstances they are living in. The real beauty of the

type of system that the Minister mentioned in Swindon is that you can get services working together with general practice so that you get a balanced view of risk and optimising the discharge of patients in that way. Certainly there should be no surprises.

One of the other things I think we have to do on discharge is to be able to offer services seven days a week. You hear lots of stories from acute trusts where, on the acute trust side, clinicians are going around every day making discharge decisions, all the clinical care has been delivered that can be delivered in a hospital setting, and the community services or local authority care or the care home cannot accept the patient on a Saturday or Sunday. That variation in discharge rates over the course of the week causes as many problems in flow because, as the Minister said, we are trying to maintain continuous flow over a seven-day period. Flow is just as important and the seven days is important as well.

The Chair: I need to move on now. I shall just a comment that what we were talking to you about last time, workforce, is the key issue here. Even in the north-east, key issues in social care are lack of staff and the inability to recruit staff, even in areas where traditionally you would have been able to. I think that it is much bigger than any of us have been acknowledging today. I will ask our Swindon expert to ask his question.

Q65 **Lord Bichard:** I am delighted to hear you speak so warmly about Swindon. I do not come from Swindon but I also have been impressed by what they are doing and I hope we might be able to visit them and pick up on that experience. I completely agree with that.

I want to ask you questions about workforce, which you seamlessly tried to take me towards, but before I do that can I pick up on some of the conversation we have had until now? I want to come back to the demand and supply issue because this discussion has largely been about supply. I accept how important that is, but I wonder if we are doing enough around demand. I know it is very difficult to change individuals' behaviour, but are we analysing where the demand is coming from?

We have had quite a few examples of care homes calling for an ambulance to help them pick somebody up off the floor. I do not know whether that is a significant percentage but I think we ought to know. If it is a significant percentage, we ought to be getting into care homes and educating them on how to deal with that situation and when they should really use the emergency services. As an example, the fire service has done tremendously well over the last 25 years in reducing demand by prevention and education. Do you know enough about the demand to be able to target activities that might reduce it?

Will Quince: I think it is a fair question. At integrated care system level they certainly do and there is continual work to move wherever possible and where it is clinically appropriate to do so to have that urgent care outside of hospital. You are right about care homes: there is an issue. If somebody falls over, some care homes have a policy that they do not lift regardless. They are care professionals and they should be able to make a judgment as to whether it is the right thing to do to move the

individual. If it is not, of course calling an ambulance is the most appropriate thing but if you know that an ambulance will take some time, it may be that the individual will deteriorate because they may be on the floor. I know that at integrated care system level they are doing far more work with care homes on things like lift policy and that when they do call an ambulance there is a clinical or medically trained professional on the other side talking to them. There are now lots of tools available. For example, there is an inflatable lift that care homes and others can use to help.

Lord Bichard: Is that available in every care home now?

Will Quince: It is not. We have not, as the NHS, made them available.

Lord Bichard: Do you think it would be a good idea if you did?

Will Quince: I am seven days in but it has already crossed my desk and I am exploring it. They are about £1,000 each. We will be doing that analysis on whether there are care homes that regularly call ambulances for things such as falls. We have set up a falls response service, so it would not have to be a paramedic who attends. It could be someone from community health care who is a specialist in falls—that sort of urgent community response.

The other thing that we have not touched on yet but is significant is mental health. That is not just a large use of the police and the ambulance service but anecdotally I hear from those working in A&E that very often they spend the longest time in A&E, especially before being able to be moved on to specialist mental health provision. We now have mental health professionals in ambulance control rooms and there are mental health practitioners who go out on ambulance crews as well. We are looking to do a lot of this work. It is why in part conveyance to hospitals has reduced by 50%, but wherever it is clinically appropriate to do so we want to get people the care that they need in either their homes or the community.

Matthew Style: We have asked every integrated care board, as part of their assurance ahead of the coming winter, to specifically look at what is called—and I do not want this to sound like a pejorative phrase—high intensity users to identify the population who are most at risk of needing to call 999, have an ambulance called out, be admitted to hospital and have specific proactive plans in place for identifying those cohorts and ensuring that they have the right almost preventive services in place. Of course you cannot do that for every single member of the population, but taking a data-led approach to identifying those people might mean that you identify a care home where the requirements of the enhanced health in care homes specification from general practice are not being met. You need more support to make sure that they are getting the clinical input to support them to keep patients in the home rather than picking up the phone. It is part of the plan.

Lord Bichard: I am told that the first reaction of some schools is to get

an ambulance. Those are people you can talk to and educate and hopefully get them to behave more sensibly. Are you doing that?

Will Quince: I confess that I am not aware of a specific initiative focused on schools, but we should take that away.

Q66 **Lord Bichard:** On workforce, Minister, you said earlier that it is an unbelievably difficult job—I could not agree more—and you talked about the significant pressures that exist at the moment. We are hearing stories about staff who are burnt out and frustrated because they do not feel that they can provide the service that the clients deserve. Can you tell us a bit about how you are going about providing better support for staff, perhaps some of the innovative ideas that you may be looking to progress? Also how are you boosting workforce numbers in this particular area? I am not talking about social care at the moment; I am talking about ambulance services.

Will Quince: I will talk about the numbers first. I believe that paramedics are up by 40% since 2010. I do not have the figures since 2019 but Matt or Vin might. Health Education England are mandated to train 3,000 extra paramedics every year. That is part of the issue because burnout also comes from not having enough people, so that is the first step.

The second is the more challenging one, which is making sure that people feel valued. One of the challenges, again anecdotally from what I hear speaking with medical professionals, is that they become a paramedic because they want to be out on the road treating patients and saving lives. They do not want to be sitting outside a hospital in a queue, waiting for the patient that they have to be admitted, who very often is deteriorating. I completely understand the frustration and it would be remiss of me at this point not to put on record my huge appreciation and thanks to all those who work in the ambulance trusts and the NHS.

Supporting staff largely falls under the purview of NHS England, but there is the NHS People Plan. I had a meeting yesterday with the Secretary of State and a number of acute trust chief executives and the NHS England head of people—I think that was the title—to talk about retention. It is all well and good us looking at recruitment but it is equally, if not more, important to ensure that we retain the very best people who have the experience and entered the profession for all the right reasons. I do not want them going off, wherever possible, to work in Aldi or Lidl or even retiring early. That is a key point.

Some of the measures we have put in place are things such as well-being guardians to focus on healthy working environments and empowering line managers. Line managers are critical in the NHS. Often intent is set at Whitehall and policy intent is set at trust level but we must ensure that it is implemented. It is interesting how many people tell me they do not leave trusts, they leave line managers. Culture and leadership are important and I know that NHS England is encouraging and fostering, especially in ambulance trusts, them talking to each other about best

practice and sharing what measures they can put in place around well-being.

For example, in my local trust, the East of England Ambulance Trust, which has its faults, the new chief executive put in place a number of well-being vans. These are at a hospital and they have—I know it sounds like a simple thing—tea, coffee, healthy snacks, less healthy snacks, available for paramedics in between trips. It is sometimes little things that show, “We value you and we know you want to be straight back out on the road. We have got a wait but do take some time out to speak to colleagues and help yourself to something to eat and drink.” These sorts of things—if trusts speak to each other, just to show those who work there that they are valued—are important.

Q67 Baroness Chisholm of Owlpen: Thank you for coming after you have been in post for only a week. It is greatly appreciated. I was thinking about the workforce and you said that there are more paramedics coming into the profession now but there is difficulty retaining them because they get burnt out. Have you thought about having more auxiliary staff who are not trained paramedics but who can go out and do the work that paramedics are doing now that they do not really need to do but could be done by lesser trained people, whether it is ambulance people on bicycles or going to houses for less urgent emergency cases? Then the paramedics would not feel so exhausted.

Will Quince: It is a fair question. For cat 1 and 2, you cannot really replace the paramedics—they have those exceptional skills—but for other things, yes. With community healthcare services and the fall response teams at local levels, we can absolutely do that. I know that Ministers get criticism for talking about the voluntary sector, but I think that Community First responders do the most incredible job. They are largely trained up by ambulance trusts. I would love to see an expansion of that and I know that many trusts are looking at that too. Likewise, we should not be afraid, and we are not, to use other experts in the field such as St John Ambulance, which is providing the 5,000 hours of surge capacity at the moment.

I will take away the point that you make, particularly with things around drivers but also more around community health services and the falls service and what more we can do in that sphere.

The Chair: Can I quickly get to my next question? Lord Hogan-Howe, we have two questions to do in 10 minutes.

Lord Hogan-Howe: Okay, I will take the hint.

Will Quince: I think that it is my fault for verbose answers.

Q68 Lord Hogan-Howe: No, I am sure not. My question is about the new system—the integrated care boards—which sound like a great opportunity, and whether they have sufficient powers or levers to deal with the problems we are describing. We have heard that there are three chronic problems. One is demand, where the only people in the system

who seem able to say no are providers of primary care, with the appointment system. They can stop the demand, which forces it into, as you say, self-selection. We have heard about the issue that Estelle mentioned, which is more time spent by an ambulance at a scene for a better outcome, which is more effective but less efficient if you have effectively halved the number of ambulance spaces, and whether there need to be more ambulances, even if there was no more demand. The third issue arises on arrival at hospital, with the blockage with social care.

Those three things have come up time and time again. The acute symptom of that seems to be people spending a long time on the floor. I think the worst case we heard was 33 hours, and probably 20-odd hours for a person of 95 with a broken hip—I will not go on. It is an awful story.

Will the integrated care boards have the sufficient levers to intervene at the chronic level, to say to a GP, "We need to shift the balance of your preventive work to more reactive work. We are rewarding you for that preventive work as it happens but we need you to shift that because we need more capacity"? Will they be able to intervene with an ambulance trust and say, "We need you to get more ambulances"? There may be an issue of funding—I get that.

On the acute ones, I have not heard of someone in the system who says at four hours, "It is not good enough that that guy is still on the floor. We are either going to get an ambulance from the adjacent trust, 15 yards away because it is only a border, or we are going to get a physiotherapist or a GP. We do anything other than leave somebody on the floor for 33 hours." Someone has the power to intervene. Is that down to the integrated care board in the case of an acute problem? If not, who is it? I accept you may not be able to answer it but I am not being reassured on either level yet that the integrated care boards have the powers that they might need.

Will Quince: It is a really fair question and I will bring in Matt. On the direction of travel of where we want to be, that is exactly it. You have touched on one of the issues, which is around primary care and general practice in that we have the GP contract but a lot of people do not realise that within the NHS—and I do not blame them for it because it is all free at the point of use when they go and see their GP—that GPs are all businesses. They are individual private companies, microbusinesses, individual sole practitioners, partnerships or set up in other structures. We do not have the same levers over general practice in the way that we do with our acutes and the ambulance trusts, because they are through NHS England.

ICSs are the commissioners of the services, which is the first point, so they have the levers over who gets the contracts and the money, which is usually one of the big drivers. The second is that for the first time you are taking a bird's eye holistic view of the whole system. If I am the chief executive of an ambulance trust—not that that would in any way be appropriate—I will be concerned only about my staff and my ambulances and conveying people to hospital and treating people at home, whereas if you are the acute trust, you are thinking about entirely different things.

For the first time, through the ICS and the ICBs, you have someone looking at the whole system and then ensuring that, to be frank, heads are banged together when they need to be, and you are making sure that everyone is working in tandem not against each other. I will bring in Matt.

Matthew Style: I completely agree. On the one hand, of course, integrated care boards are new statutory organisations and some will still be finding their feet. I want to be realistic about that, but I think it is very powerful, as the Minister said, to bring responsibility for commissioning all these services together in one place and have the governance in place where those people are represented around the table with no one else to look at and point to. They are around the table making decisions about the services they want to provide locally. They also have much greater financial flexibility at that level than ever before. Effectively, the NHS pound for their geography is in their hands and they have much greater flexibility to deploy that in a way that will have the most impact for their patients locally, and indeed support the evolution of the services being offered in exactly the way that Baroness Morris and others have suggested.

To go to the more operational end of your question, in a recent letter sent out to integrated care boards about their preparedness for the winter period, we have asked every single integrated care board to have in place what we have called a system control centre, 24/7. The integrated care boards should have an holistic view of demand and capacity across urgent and emergency care, primary care and social care 24/7. Then they are able to make those decisions and see where the risk is popping up across the system and how most appropriately to balance that, given the resources available to them. That will not be a silver bullet but I think it will help.

Lord Hogan-Howe: I think the bit you added, Matthew, is the 24 hours bit. I do not think we have heard that before, so that is more reassuring.

I have a final question, on the contract. The Minister mentioned the contract, but is it not within the Government's gift either to change the contract or, presumably, give more local flexibility in how it is deployed?

Will Quince: We are just entering into the last year of the GP contracts and then we will be looking ahead to 2024. Yes, to some extent, but I think that has always been national.

Matthew Style: There is a national contract for the provision of general medical services, but not all the primary care budget is tied up in that general practice contract. Integrated care boards have the flexibility—this is critical to the implementation of the fuller vision I talked about earlier—to commission additional primary care services outside that core contract. We are trying to increase that flexibility so that they can make good choices locally.

Q69 **Baroness Pinnock:** Apologies for the late entry. There were technical

difficulties at my end. Minister, thank you so much for the clear answers you have been giving. My question is about collaboration between the various emergency services. During the course of our investigations we have heard, for instance, that data sharing between ambulance, fire and police is not as good or as easy as we may expect it to be. The same can be said for communications between the three when there is an incident. We heard, I think from the fire service, about legislative barriers to it getting more involved in direct care of 999 calls, for example. How about unblocking the blockers?

Will Quince: It is a great question and I am very keen to do that. I am also acutely aware that the ambulance trusts are very different from the police and the fire service. They are almost impossible to separate out from the NHS because of the natural conveyance to and the interaction and interoperability with acute hospital trusts. Nevertheless, there is so much more that we could and should be doing. In parts of the country, there is a lot of work around sharing estates, control rooms and back office functions and there are plenty of examples of where that works well. The picture you paint of a US-style model whereby you call an ambulance and it turns up saying "Fire Department New York"—we are not there and I am pretty sure the fire service would be pretty opposed to doing that, but the fire services in parts of the country are doing far more of this. One of the fire services I know of is doing some work around lifts and helping people who have fallen over, for example.

I must admit that I am not aware of the data point and I will take it away and look at it. If there is an issue around data sharing and communication breakdown between the trusts, it is worth me taking it away and exploring further.

Baroness Pinnock: Thank you for that. On the data sharing, I think we heard from the fire service who said, "If only we knew who were the most vulnerable people in our community, we could do the prevention education programme for their issues", which they have done with reducing domestic fires. There clearly is a lack of data sharing—and who knows how that has unravelled?—but that seems to me a point.

The Chair: May I come in on the back of that? We heard that during Covid all those restrictions were lifted and each ambulance trust got the list of vulnerable people, so they were able to monitor them. If they were doing visits about fire alarms or whatever, they could also check on other things. As soon as Covid and the regulations finished, they were not allowed to do that and they had to go back to negotiating those things locality by locality.

Will Quince: Understood. I will take that away and look at it. That is less an issue with ambulance trusts because they would not hold that data, but I assume at primary care level, for community health services and general practice, they would have that data. To me it seems eminently sensible that if you are going to a home to do one thing and you are a trusted professional, you can do many more things too. I will take that away and explore it.

Q70 **Lord Filkin:** Minister, you know better than we do why this matters in human terms and politically. If, in two years' time at the general election, the public still see that access to primary care and emergency health services is as bad as it is now, they will rightly conclude, will they not, that the Government, of whatever party, has failed to protect the NHS? Is that a fair comment?

Will Quince: I think the public are also realistic in that they see the pressure that the NHS is under and they can see the record investment. I think that it is over £162 billion. If you compare that to 2010, which was about £100 billion, there is significant investment going in. I think it is fair to say we have a lot of work to do. If you ask me to come back to the committee in six months or 12 months' time and ask what is my goal in this—what is my priority—it is to work with colleagues to ensure that we are unclogging the system as much as possible, improving patient flow through our hospitals, ensuring that people are treated in the most clinically appropriate setting and way, that we prioritise rapid response to the very sickest patients and that all patients receive a clinically appropriate response by the ambulance service in the right timeframe. That is something that I, and the Government, will understandably and rightly be held accountable for.

Lord Filkin: We hope it succeeds.

The Chair: Thank you very much indeed, Minister. We have lots more we could go through with you but I am afraid our time is over and your colleague is waiting outside to talk to us more particularly about collaboration. Thank you very much and we will keep at you and keep holding you to account, I hope. Thanks to your two colleagues.