HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Ambulance delays and strikes, HC 984

Tuesday 20 December 2022

Ordered by the House of Commons to be published on 20 December 2022.

Watch the meeting

Members present: Rachael Maskell (Chair); Lucy Allan; Dr Caroline Johnson; and James Morris.

Questions 1-56

Witnesses

I: Rachel Harrison, National Secretary of the Public Services section, GMB; John Martin, President, College of Paramedics; Daren Mochrie, Association of Ambulance Chief Executives; and Professor Julian Redhead, National Clinical Director for Urgent and Emergency Care, NHS England.

Examination of witnesses

Witnesses: Rachel Harrison, John Martin, Daren Mochrie and Professor Julian Redhead.

Q1 **Chair:** Thank you ever so much for joining us this morning for our first session on a particularly topical issue. Today we will be looking at the ambulance service, ambulance safety and the industrial landscape. I am Rachael Maskell, and I am standing in for Steve Brine today, who sadly cannot be with us. First, we need to declare any interests. I am a member of GMB and Unite, and I used to be head of health at Unite. Does anyone else have anything they wish to raise? No? In that case, we will go straight into the first of our two sections.

We will look at ambulance safety first. Welcome to the panel. We have four witnesses today. We have John Martin, who is the president of the College of Paramedics. Online, we have Daren Mochrie from the Association of Ambulance Chief Executives. We also have Professor Julian Redhead, the national clinical director for urgent and emergency care at NHS England, and Rachel Harrison, who is the national secretary of the public services sector of the GMB. Welcome.

According to the British Heart Foundation, 230 deaths every week are now associated with the crisis we are seeing in emergency medicine. What has gone wrong, and why are we in this situation? May I start with you, Julian Redhead?

Professor Redhead: It is important to understand how the whole system is working together at the moment. The first point is around demand. Demand in our emergency services is up to phenomenal degrees, especially at the moment. We have also seen increases in flu and covid admissions, and we have the cold snap—we know that cold weather is associated with ill health. We have seen rises from those as well, not just now but sustained over a period of time.

The other side is the constraints that we have around flow and therefore occupancy within our hospitals. Our occupancy levels are higher now than at most times of the year. We are running at about 98% occupancy across our trusts. The reason we are running at those levels at the moment would appear to be mainly due to discharge. We are struggling to discharge patients into alternative care positions. We know that we have a large number of patients who meet what we call the criteria to reside. Those are a way that we can identify patients who may be better cared for in different environments. We know that we have a large number of those patients in our beds as well.

What we are trying to do is to understand all those flow systems, to make sure that we can respond to our most vulnerable and sickest patients. The trouble is that when we have very high occupancy in the hospital, the A&E services themselves become overcrowded as patients wait in the ED to come into beds. That causes difficulty with us being able to bring

ambulance patients off the ambulances and into the A&E departments, which increases the number of ambulances outside an A&E department. That then has a consequence on the ability to answer calls, because the call handlers get multiple calls against the same incidents, as people are ringing back to say, "When can I expect my ambulance?" Our response times are in difficulty there as well.

All those things are interrelated across the whole pathway. What we are trying to do at all times is to find solutions and ways that we can make the system more productive—that is, get patients through our systems as easily as possible—and to work with our partners in social care, community care and mental health care to try to move as many patients at the correct time to meet the needs that they have during their care period.

That is the important background information that we need to have. Undoubtedly, that means that our response times are difficult for the ambulance service at the moment. I know that they are doing everything they can to try to improve those response times—both internally and, again, working with partners and especially with the integrated care services—to make sure that we bring everyone together to try to find the solutions that we need. That includes increasing bed numbers, which is what we have been trying to do across the NHS as well. There is an ambition to put 7,000 more beds in for this winter. We are on track to achieve those, with both real beds and virtual beds, because it is important that we look at new technology as well. Those plans are there, but it is not just a question of new beds, because if we can't discharge, we are going to fill those beds, so we have to have process change at the same time.

We are working really hard to try to improve those ambulance turnaround times, so that we can keep the ambulances on the road and bring the patients who are most vulnerable from the community and into where they need treatment, which will be into our hospitals. That includes heart and cardiac patients. We have also worked hard to try to protect services such as cardiac and stroke services. We know that those patients have time-critical interventions that will help them in the long run. The ambulance service themselves have done a lot of work on this and on making sure that we have the right codes and the right patients in the right category, so that we can respond to those who are most sick as quickly as possible. I am really grateful for the support that our colleagues have given around that work as well. We know that the call handlers themselves want to help those patients that they know need those time-critical interventions. So what we are trying to do is to help them as well, to make sure those ambulance response times improve. But it is demand and flow that is our problem at the moment.

Q2 **Chair:** Thank you very much for your answer. John Martin, I would like to ask you a question in the light of the increase that we are seeing in demand on the service—my own ambulance trust has seen a 16% increase in demand since 2019. How is the ambulance service keeping up

the supply of workforce to be able to address that demand? Clearly, one thing we do know is that waiting times for patients to receive vital care are increasing.

John Martin: Good morning. Yes, it is really difficult at the moment. Those waiting times have got longer, and we can see that in the national data. That is partly about demand, as we have outlined. You have mentioned a figure of 16%. I looked back over the last five years nationally, and in England demand has gone up by 18%, but really importantly, it has gone up much more significantly in the higher acute category. What we call category 1 is way higher than it was previously: there has been an above 50% increase over the last five-year period. So we are seeing a sicker population, who are calling us more often.

Paramedic members of the college up and down the country are working extremely hard to meet the needs of patients, but we are seeing less patients in a shift than we did previously, and that all comes back to the flow and demand that Julian has already outlined. A number of years ago, we would see more patients. We are seeing less patients. That causes a problem. Actually, for our members—paramedics, like me—working up and down the country, that is having a big impact on us, our morale, our ability to care for patients and our ability to do what we need to do to keep patients safe.

Q3 **Chair:** Daren Mochrie, is there now a call for a further reconfiguration of services, to be able to address this crisis? It doesn't seem to be abating anytime soon; it has been building for a substantial time, as we have just heard. Is there a need to look again at how the flows work within the system, to ensure greater patient safety but also to ensure that people are seen in a more timely way, which is clearly life-critical?

Daren Mochrie: Good morning, everybody. I will not repeat what John and Julian have already said, but I will just pick up on a couple of things. In terms of reconfiguration or looking at the current models that we have across England, I have been working, as the chair of the Association of Ambulance Chief Executives, very closely with Julian and the national NHS England team. We are looking at a revised or a new urgent and emergency care strategy. You can think about what Julian said earlier about "hear and treat" and "see and treat". Hear and treat is when we treat more patients over the phone and signpost them to more appropriate care or, indeed, send a paramedic out to those patients and then manage them in the community without needing an emergency department attendance. That is very much part of what we want to continue to do, because if you look at the figures year on year, we have been really successful in doing that. What we want to do is to work with our partners across the whole system, as Julian says, and continue as much of that as we can, as long as it is safe and effective for those individuals. That will be very much part of the urgent and emergency care strategy going forward.

The other thing that the Association of Ambulance Chief Executives has been working with NHS England on more recently is how, in the new world post covid, we right-size our ambulance services in England to make sure

that they are capable of doing what we need them to do. If I think back 31 years to when I joined the ambulance service, we now spend a lot more time on scene, which is the right thing to do, because that is us trying to make sure those patients are managed more locally and in the community. But, equally, hospital handover delays, because of the flow issue that Julian described, have gone up probably six or sevenfold since when I worked on the road. That is obviously eating into our availability to then be able to respond to patients in the community. The piece of work that I am working with NHS England on now—and the point you were asking about—is, what model do we need going forward, and how do we right-size ambulance trusts for the future to meet the needs of a post-covid world?

Q4 **Chair:** When can we expect to see that new strategy? There is clearly a crisis now. Are there international examples of really good practice that we need to aspire to?

Daren Mochrie: NHS England, or Julian, is probably best placed to talk about when that strategy will be finalised and launched, because it is an NHS England strategy. In terms of best practice internationally, believe it or not we still have a lot of best practice internationally. I sit on the Australasia—so, Australia and New Zealand—meetings, on the federal meetings out in the USA and on the Paramedic Chiefs of Canada meetings as well. A lot of those countries still look at the UK for best practice, particularly around hear and treat and see and treat.

The big challenge we now have in the UK, which other countries have as well, to be fair, is the flow, the hospital handover delays and that vicious cycle of then not being able to respond to those patients in the community. You just need to look in the newspapers over the weekend and you will see it in Australasia, certain parts of the US and in Canada. They all have this challenge around flow. As John said, patients are much sicker than they were before, and it is that perfect storm post covid that we are experiencing now.

Q5 **Chair:** Thank you. Julian, quickly, when are we going to see the strategy?

Professor Redhead: The strategy is being written. The important thing about the strategy is that we have been engaging with people from all over the different parts of the service, right down to the consultants and nurses at the shop front to make sure that they understand and get a chance to talk about the strategy. That is true for the ambulance service as well, to make sure we have got the right strategy going forward. That is also going to be linked to the recovery plan for the UEC, which we are hoping to get out in January to ensure that everyone understands how we can recover that.

Daren is absolutely correct when he talks about international comparisons, because, on the strategy, we have looked internationally to say what is best practice internationally, and I have been talking to a number of partners in different countries as well. We do need to look around at all the different potential innovations and changes we need to make over the

next five to 10 years, because the strategy needs to look at that sort of timeframe, although the recovery plan will be much shorter. How do we implement that? How do we go through those?

So there is a lot that we are learning from our international partners. It is an international phenomenon. I am an A&E consultant, and I talk to my colleagues in other countries as well, and they are all struggling with this overcrowding, in EDs especially. It is that flow issue, which I talked about already.

Q6 **Chair:** A date? When are we going to see it?

Professor Redhead: I have not got a date, but obviously we can try to get one back. It is being written up at the moment, so we are working together to get that written up.

Q7 **Chair:** Early next year, do we think?

Professor Redhead: Oh, yes. Definitely.

Q8 **Chair:** Thank you. Rachel Harrison, what is the impact on your members—the staff on the frontline and those taking the calls—of these delays?

Rachel Harrison: Good morning, everybody. It is absolutely having a devastating impact on our members—frustration, stress, burnout, exhaustion, low morale and poor mental health. Our members are tired of going to work every day and, in some cases, spending the whole of their shift sat on an ambulance outside an A&E department with the same patient. We have had examples where our members have clocked off at the end of one shift to return the following day to the same patient being on the ambulance with the crew they had left them with the night before.

Our members went into this profession to become healthcare professionals, to help the public and to provide patient safety. They feel they are being physically prevented from being able to carry out their jobs today. That is because of this knock-on impact with handover delays, waiting times and the fact that patients cannot be safely discharged into hospitals. When our members eventually get to a job, and they can see on the monitor that somebody has been waiting hours and hours for this call, they don't know what situation they are walking into. They don't know if that individual will still be alive. They have friends and families that are screaming at them, as if it is their fault. These are the very individuals who are not to blame for this situation.

So our members have taken the steps that they have—to vote for action—and this is one of the central parts as to why they are doing this, because we have been raising these issues for years and we have been ignored. As early as last year, we wrote to this Committee, and we had a very supportive response. We wrote with a copy of a letter we sent to the Government, highlighting, "We have come out of the pandemic. We are heading into the worst winter pressures, which our members are reporting to us." That fell on deaf ears—nothing was done. Those issues are even worse now. Our members are exhausted.

The highest sickness level among all categories of workers in the NHS is in the ambulance service, and that is because of the terrible conditions they are being expected to work in. This isn't just the frontline paramedics, technicians and emergency care assistants. This is the call centre people that are having to deal with this influx of calls and screaming family and friends that are frustrated. There is also the massive increase in mental health calls that they are having to deal with, because there is significantly reduced access to community and mental health services. So the whole impact across the workforce is massive, and our members are pleading with the Government to do something about this now.

Chair: Thank you ever so much. I think the NHS workforce survey has demonstrated that, in every single category, ambulance staff have the lowest morale and the greatest pressures being placed on them.

Q9 **Lucy Allan:** I wanted to follow up on what you have been saying. As local MPs, we work closely with chief executives of our local ambulance service. I am a west midlands MP. Since the start of this year, I have heard exactly what you have been saying. I have been passing that on to the Government, via Ministers. West Midlands ambulance service experienced 44,000 lost hours in one month waiting outside hospitals. What has really frustrated me is that, like you say, no one has been listening. You have explained how you have tried to get the voices of your members heard. Professor Redhead, are you hearing that message? Do you understand what Rachel is saying? Do you understand what I am saying about what is happening on the frontline?

Professor Redhead: I absolutely do. In my own A&E department, when I talk to paramedics who come in, I can see exactly those effects on them as well. Obviously, I talk to the medical directors of each of the ambulance services. Absolutely, I understand that, and it's about how we make sure that we get the right investments in the right areas to improve in the right timeframes. That is what we are trying to do.

Q10 **Lucy Allan:** Sir Anthony Marsh, the chief executive of West Midlands ambulance service said, at the start of the year, that by August/September, West Midlands ambulance service would start to fail. What then happened? When you get a message like that, what action is taken that would prevent us from being where we are now, with members quite understandably saying, "No one is listening. We have to take strike action."?

Professor Redhead: Obviously, I work very closely with Anthony because of his role nationally as well. Action has been taken. What we have tried to do is to increase the number of call handlers, because some of the problem originally was around call handing and being able to make sure that we can answer the telephone call. We have increased the number of call handlers by over 300 from where they were a year ago. That is also for 111, because there is a link between 111 and 999 calls. We have also got to increase the number of call handlers so patients can get the advice they need through 111, and those have been increased, by about 5%. So

we are trying to keep up with that level of demand around the call handling as well.

We have also put in more focus in terms of those handover delays, because that is really what is causing the issues for the ambulance crews themselves—they don't want to be outside the ambulance; they want to be able to help people. We have been working with individual trusts that have got real issues with this.

Q11 **Lucy Allan:** Is this trust-specific? If I look at data for the whole of the west midlands, I can see that Telford and Wrekin, which is where I am from, has the worst waiting times. Is it because the hospitals in that region are less good at discharging patients than other hospitals, or is it something more complex?

Professor Redhead: It is always going to be more multifactorial, but there are hospitals that are more challenged than other hospitals, and those are the ones that we have targeted to get those improvements. We have also put in work with all trusts across the country to improve that handover situation.

We launched a winter collaborative, in which we are working with each trust on eight different factors that we believe would help to improve the services as much as we can, although I go back to discharge being the No. 1 thing that we need to do. We have the discharge taskforce, which is led by Sarah-Jane Marsh, and a new board set up within NHSE led by Lesley Watts to look at this work around discharges.

The discharge taskforce has had some success, working with the parts of the discharge process that they have the most control over. We have seen improvements in the numbers of patients from that clinical reason to reside. We now have a specific challenge out with community trusts and local authorities to help that position. Also, the Government have released more money into local authorities to help with those discharges. Work is ongoing all the time to improve those situations.

Q12 **Lucy Allan:** John Martin, what would you like to happen on delayed discharges and the other factors that are preventing ambulance paramedics from doing their work?

John Martin: Talking to our members, hospital handovers is right at the top of the list of their issues. If we look at the situation report most recently published by NHS England, on 11 December, 4,232 hours were lost in one day outside hospital. That equates to 176 ambulances. Our members are really struggling, because as Rachel said, they can spend the whole shift outside hospital waiting to hand over a patient. That has a huge impact on paramedics who are in the back of the ambulance, on the family and on the patient themselves.

Going back to international comparisons, we pride ourselves on having great paramedic education in this country. We are considered world-leading in our degrees, in how we create paramedics, so it is really frustrating not to be able to use those skills on patients over the course of

the shift because paramedics are with one patient, waiting outside the hospital.

It is also true that our training is about emergency care, urgent care and providing that in the community. That is quite different from the education for looking after someone for hours at a time outside hospital. This is having a huge impact on morale and patients. Everyone is frustrated, including the ED doctors we hand over to.

Q13 **Lucy Allan:** Is that the real underlying driver of tomorrow's strike?

John Martin: We are a professional body, not a trade union, but from what our members are telling us, the frustration is that they are worn out and tired, and they want to get back to being good paramedics.

Q14 **Lucy Allan:** Daren, what else would you like to happen to improve the situation that we just heard so eloquently described?

Daren Mochrie: In the short term, we have to find a way to unblock the flow and to get ambulances handing over their patients. That is easier said than done. As you allude to, some areas can do it better than others. The work I am doing with the Association of Ambulance Chief Executives, Julian and others is on how we share that best practice across all parts of the country, to see if we can reduce some of the unwanted variation. There is a big push to do that.

Even the trusts or ambulance regions that have had relatively good handover delay figures over the past few years—including the North West Ambulance Service, where I am chief executive—are starting to get worse and worse as well, because of the flow issue. For me, it is about how we get ambulance crews freed up quickly so we can respond to the next patient. That is in the short term.

A big piece of work—a lot of work—is going on about frailty, falls and mental health, because those are now a huge volume of work in the ambulance sector. Again, we are working with NHS England and colleagues on how we can ask mental health trusts and community trusts to do more to support some of those lower-acuity patients who are phoning 999 because they do not feel that there is an alternative. That would take some of the pressure off the ambulance sector, to allow us to get to the heart attacks, strokes and patients we talked about at the beginning of the meeting. In the longer term, or the medium to longer term, we have to right-size the ambulance sector for the future, continuing to look at innovation and international best practice.

Our staff and our patients deserve that. I heard what Rachel was saying about how staff are feeling, and I hear that every single day I go out to do either a clinical shift as a paramedic or station visits. It is soul-destroying for our staff just now.

Q15 **Lucy Allan:** In the short term, do you foresee that the situation will continue to deteriorate?

Daren Mochrie: Yes. I cannot see how, in the next few weeks and months ahead, the situation will improve.

Lucy Allan: Thank you, Chair.

Q16 **James Morris:** I want to ask about response time targets. They were introduced three or four years ago, and I don't think they have been met consistently since they were introduced. Would it be useful to not have targets? Have targets been a complicating factor?

John Martin: Targets have an interesting effect on paramedics. They have changed a number of times in the 20 years I have been a paramedic. We pride ourselves on providing good care, and you need to have a way of monitoring that. At the beginning of the session, we mentioned the British Heart Foundation report. For some conditions, time is a huge factor, and therefore monitoring time is absolutely important. Is it the only thing that we should monitor and get hung up on? The answer to that is no. Paramedics will tell you that time is important, but it is not the only factor.

Q17 **James Morris:** What else should we be putting into those? At the moment, it is purely to do with response time and whether we are hitting it or not. That has an effect on public perception, too.

John Martin: NHS England—Julian might want to comment—have another set of indicators, the clinical quality indicators. If we take something like a heart attack where someone is phoning up with chest pain, we look at the response time. We also look at whether the paramedic gives analgesia—pain relief—once they arrive. Do we take the patient to the right location? Often, for patients who are having a heart attack, it is not to the local district general hospital; it is somewhere else. So there are other bundles that are used. They are often not reported on, but time still remains a factor in that. I think you have to have both.

Q18 **James Morris:** Do we need targets? Would it be better if we got rid of them?

Professor Redhead: It is important to remember where the targets came from. They came from a process—colleagues will know more about this than I do, so I will do my best, but correct me if I am wrong. There was a clinically led position where lots and lots of different ambulance calls were reviewed in, I think, 2015 through a long process of looking at what the target time should be for different types of categories. The category 1 response time of eight minutes is important because that is how fast we need to get to patients, who might have a cardiac arrest, to increase survival times. That is also true when we look at some of the category 2 response calls as well. There are conditions that rely on that time. It is important that the public have confidence—as best we can to give them that confidence—that they will get the responses that they expect.

Q19 **James Morris:** If the targets have been consistently not met over a long period of time—you might argue that they are calibrated wrongly—does that not undermine public confidence unnecessarily in that it sets an expectation that the system is simply not going to meet?

Professor Redhead: I understand your point, but it is also important that we continue to strive to improve our services all the time. Where time-critical interventions are required, we need to make sure that we meet those. I think the time standards are right. It is always nice to look at some outcome measures as well, but that is sometimes very difficult when the public want to know exactly what they could expect, and that can sometimes be complicated if we go into more complicated types of monitoring for those.

Q20 **James Morris:** Rachel, what do your members think about targets?

Rachel Harrison: Unfortunately, because of the staffing crisis and the demand on resources, targets are just a number now because they know they cannot meet them. Regardless of how much effort they put into their working day, they know they are being prevented from meeting the targets. The reason is that demand for ambulances has risen 10 times faster than the level of resources, so it is becoming impossible to meet all the demand that the public want from their ambulance service. We have seen call volumes go up by 80% since 2010. When you have 133,000 vacancies across the entire NHS, the individuals are just not there to be able to respond to all the calls that are coming in.

The increase in cat 1 calls was mentioned earlier. Well, category 2 calls have gone up as well. They have gone from 25 minutes to an average of 48 minutes in two years, and that is leading to more deaths during patient transport. We are going to write to the Secretary of State about some information we have on that. The delays are impacting on patient deaths, and we have to tackle the root cause of this, which is the workforce issue, which ultimately comes down to their pay and working conditions.

Q21 **James Morris:** A number of you have spoken about the changing nature of demand. Let me ask Daren: is it possible that we are categorising too much into category 1 and category 2 when we are triaging calls? So even though demand is going up, the composition of that demand is being skewed because of decisions at the triage point—what do you think of that hypothesis?

Daren Mochrie: Just before I answer that point, I want to come back on the last question you asked, around the targets. It is probably fair to say that if you look at just after the Ambulance Response Programme—the new targets that Julian referred to, which I think started to be looked at in about 2015—just prior to covid, many ambulance trusts were achieving those standards. In fact, in the north-west, there were a couple of weeks throughout the middle of covid when demand came down, we had extra resources on, and we actually met all of our targets for a day or a couple of days. But unfortunately, that has not been able to be sustained, for all the reasons we just spoke about.

As Julian says, a lot of work was done trying to look at having clinically appropriate targets in terms of response times, and also at the ambulance quality indicators, which look more at the clinical outcomes. In terms of triage, there are two primary triage systems used in the UK: one is NHS

Pathways, and one is MPDS, which is an American product. I think it is about half and half in terms of the use of those two products by ambulance services in the UK. We have been looking at how we continue to refine those products, to try and make sure that with our non-clinical call handlers, who do an amazing job under relentless pressure, as we have heard from Rachel—

Q22 **James Morris:** Daren, sorry, can I just interrupt? On that, do you think the pressure might be leading to the easy categorisation of calls into categories 1 and 2? Is that a consequence of the pressure?

Daren Mochrie: No, I wouldn't say that, because the call handlers are trained to follow the algorithm and to go through the script. They would not deviate from that unless they were told to by a clinician in the room, but even at that, they are likely to go through the whole script, because they are audited on that. I know you are not saying this, but nobody is doing a shortcut to try and triage calls differently.

What I think we are seeing—one of the witnesses said it earlier—is much more, sicker patients. We are seeing a lot more, sicker patients in that category 1 and 2 basket, which is driving up those numbers, if I am being honest. In addition to our highly trained call handlers, we have also introduced many more clinicians into control rooms as well over the last few years—that could be mental health nurses, midwives, paramedics or general nurses—with a view to supporting our call handlers to triage those patients the best we can.

We are putting a lot of emphasis and support into the call centres, but it is not enough with the volume of calls that we are receiving just now, and the knock-on effect of the duplicate calls is causing the problem. If we cannot get the vehicles freed up at the hospital to respond to patients in the community, we may take several thousand additional duplicate calls, which is blocking the whole thing up.

Q23 **James Morris:** There were a couple of references to the fact that there is an increased number of calls related to mental health of a variety of sorts. How do you think they should be handled? How does it work at the moment if somebody presents through the call system with, say, an acute mental health issue in crisis? Does that get triaged out somewhere else, or is it handled directly by the ambulance service? Are they in kind of a grey area?

Daren Mochrie: Sorry, is that still a question for me?

James Morris: Yes, Daren—sorry.

Daren Mochrie: No problem. We will triage mental health, frailty and falls the same as we would with any other call that comes in through the 999 system. Our call handlers would take them through the particular card on the call-handling triage system, and they would come out with certain dispositions at the end of that. It might be that there is an immediate threat to life, it comes out as a cat 1 call, and we would immediately dispatch an ambulance. It might come out as a lower-acuity call, in which

case we might ask one of our clinicians in the clinical hub within the control centre to look at that call—take a mental health patient as an example—and maybe phone the patient back.

Increasingly, however, a lot of the calls coming into the ambulance service for frailty, falls and mental health could be dealt with more appropriately by other parts of the system. What we are working really hard on with NHS England and our other acute mental health and community partners is how we can signpost those patients much quicker to mental health crisis lines, mental health community teams, falls teams and community services. If we can't do that, it overwhelms the 999 ambulance service and then we can't respond to those high-acuity patients. A lot of work is going on—perhaps Julian could talk about this in a minute—to see what more we can do to set up and establish something much more robust. When I say robust, what I mean is something that is available 24/7 and responsive, so that when we need them, they can respond and so on. That would take a bit of the pressure off the 999 system.

Chair: Thank you. There has been a suggestion of a specific emergency number for mental health, so that may be one of the solutions.

Q24 **Dr Johnson:** I want to ask John a question, but before I do, I have to mention that I have been out in ambulances before as part of my paediatric work, mostly on neonatal and occasionally on paediatric transfers, as the clinician in the back of the ambulance.

John, you talked about 176 ambulances being lost to time waiting outside A&E. What sort of timeframe is that over, and what proportion of the overall ambulance stock in that particular shift would that be?

John Martin: I took the latest situation report published by NHS England on 11 December. The figure was 4,232 hours lost over a 24-hour period, so I just divided it by 24 to get to 176 ambulances. Arguably, we could say that is across the country, but I think Lucy pointed out earlier that it ranges around the country. I think we would need to ask Daren about the total number of ambulances on.

What we do know is that 176 ambulances will see circa 2,000 patients between them, because we know that you'll see five to six in a 12-hour shift—you can do the multiplication there. The frustration for our members is being stuck, because they want to be back out there, helping, and that is exacerbated with the demand coming in. We in ambulance services rightly then do what is called a general broadcast, so, as a paramedic, you can hear that there are patients waiting. That has a real impact—you might call it moral injury, if you look at some of the literature—on people who want to be able to leave one patient and start with another. They are hearing those calls waiting and being held. That is having a huge impact. It has an even bigger impact on those working in our emergency operations centres, because they are seeing the stack of patients waiting. We have just talked about clinical triage and how difficult that can be in those situations.

Q25 **Dr Johnson:** I understand the frustration of waiting—that must be an

awful experience. Is 176 in this context sufficient to resolve the problem? In other words, if we resolved the flow problem, would the 176 ambulances that you are losing cover the calls that you need to provide a really good service? Is the ambulance service well resourced, with the issue being caused by the flow problem, or is it a joint problem? That is the question I am getting at.

John Martin: I don't think it is the single solution to the problem. There are 176, so using basic maths gets you to 2,000. Multiply that out across the month and you probably get to about 60,000. The increase we've seen in the past five years is about 100,000 extra incidents in a month, so it would still be short.

The other important thing about flow and response times is that you absolutely need some spare capacity. We need that with beds and emergency departments, and that is because variation happens during the day. If, when we go shopping, four of us turn up at the shop at the same time and there is only one cashier, it will take us longer. If we go in one by one, there will be shorter response times. That variation has to be played in, so, certainly, part of the solution would be to free that up.

It takes three years to train a paramedic via a degree route. We have a good recruitment pipeline—lots of people want to be paramedics in this country, so we don't have a problem recruiting people into the profession, but it takes a while to recruit them. We have seen an increase in the number of paramedics over the past 20 years, and certainly in the past decade. There are more paramedics than there have ever been, working both across the NHS and outside it. There is a very positive story about what paramedics have become, but dealing with the handover delays is one part of the solution.

Q26 **Dr Johnson:** That is really interesting, thank you. Part of the strike planning has been about asking what we do and how we replace capacity, because I don't think anyone wants to see people lying on the pavement suffering in the cold because there is no ambulance, as the ambulance people are on strike. One of the suggestions I have read is that some ambulances would be replaced with taxis, and I wonder what your thoughts on that are. In an ambulance, you get two members of staff—your paramedic and technical staff—and you have a whole box of really quite clever kit in the back. If you can replace that with a taxi during a strike, does that mean that some of the people who are using the bells and whistles—the whole kit—do not actually need it? Can we replace that kit with taxis at other times, enabling paramedics to be freed up to see the patients who really need the whole works?

John Martin: You cannot replace a paramedic with a taxi. Paramedics are registered professionals who have a whole range of drugs, equipment and monitoring capabilities for patients, as well as the ability to provide a clinical assessment. What will happen when putting a patient in a taxi is, presuming that they do not need a critical intervention there and then, they will be conveyed to a hospital where it may be a paramedic who sees

them and does the same scope of practice as would have been done pre-hospital. That will have a huge impact on hospitals.

We know that over the last five years our conveyance rates have dropped. Paramedics working in the ambulance service are essentially taking the same number of people to hospital as they were previously, whereas demand overall has gone up. That is because of our see and treat rates—how often we do not convey people to hospital because we have done an assessment. Obviously, someone in a taxi is not going to be able to do that assessment, the patient is going to get taken to hospital and that will put more demand on overwhelmed emergency departments.

I do not think it is replaceable. The question is what is the model: do we want paramedics out there seeing a whole range of patients with conditions from life-threatening to those needing urgent care? We are trained and educated to assess those in the community—and that is what we are doing. That keeps ambulance conveyance rates from growing exponentially in the way 999 calls have.

Q27 **Dr Johnson:** Just to clarify, you think that at the moment all those people who go in an ambulance to hospital need the whole ambulance to go to hospital? It is not simply about physically moving a person from one place to another because otherwise they could not get there.

John Martin: Those who are taken to hospital where a paramedic has assessed them, I believe do need to be taken to a hospital in our current setting. That is because they will need further tests or examination, and they will often need to stay in hospital. Is there more that we can do in terms of our education of paramedics? That has been happening in recent years and will continue to happen to bring the conveyance rate down.

Q28 **Dr Johnson:** Is the plan to use taxis unsafe?

John Martin: I have been asked that a lot of times in recent days. We like to frame safety as a binary concept: safe or unsafe. You will know, because you work in clinical medicine, it is not either safe or unsafe. Do I think taxis are far less safe than using a paramedic in an ambulance? Absolutely. For some patients it might be okay, but a group of patients are not going to get assessed, they are not going to get analgesia—pain relief—and they might be conveyed unnecessarily to hospital, whereas we would have been able to look after them in the community.

Q29 **Dr Johnson:** Professor Redhead, I want to ask you about the flow issue. When people get an ambulance, they are queued up. Sometimes I look out of my office window when I am doing a clinic and I can see the queue of people waiting—I work at Peterborough Hospital. It is very frustrating for staff, and it is cost and labour intensive. You may have a patient who has slipped and fallen in the street and needs treatment having banged their head—some gash that needs sewing up again. That patient has two members of staff and a whole box of tricks in the ambulance, and they might be queuing for many hours.

Are there any alternatives? I know that we have talked about social care and the issues of overall flow, but are any other alternatives being used—for example, saying to one ambulance crew to come into the hospital building and then handing over to another, so you have two crews looking after one patient. One-to-one is routine for ITU, and most of these patients are not that sick. Are there other ways of using these paramedic experts better, perhaps just inside the hospital but not handed over to the hospital teams, to get more of the 176 ambulances back on the road?

Professor Redhead: The answer is yes. That is something that the ambulance service does in conjunction with hospitals, but the difficulty is when you have a very overcrowded A&E department and space becomes absolutely critical—

Dr Johnson: Physical space?

Professor Redhead: The physical space to be able to place patients in a safe environment. Again, it is the risk balance between the different safety factors of being in the back of an ambulance, being in a corridor, being in an overcrowded A&E, being on a ward and putting more patients on wards. There is always the factor of balancing those risks across the system, which we need to do, and the ambulance service helps us with that, as it can. We will always try to release crews. I know that every hospital wants to release the crews. It is not something that they want to do. Certainly, the staff within the hospital do not want that position either.

Some of this also has to do with how we can get alternatives to A&E, so that ambulance crews can go to other calls. We have heard about the falls service and care for patients who have no injuries as a result of their fall, and use of the urgent community response teams, which was encouraging. There is also the work that we are doing around SDEC, which is same-day emergency care, where patients can go directly when we understand what their treatment needs are. They are less likely to be admitted by going through that sort of process, so there is a number of different factors that we try to put in place to try to avoid those situations. We have heard about some of them in mental health as well, and some of the work and investment that the ambulance service is quite correctly doing around mental health.

Q30 **Dr Johnson:** One of the things that you have not mentioned is pharmacy. I watched my mother's admission to hospital earlier in the year and watched her wait 12 hours for her drugs to come up. As a clinician myself, I have seen how long it takes sometimes for drugs to come up for patients. To what extent do delays in pharmacy TTOs, as we would call them, contribute to the flow problem through A&E and therefore to the ambulance backlog?

Professor Redhead: It is going to vary between different hospitals. I think most hospitals now would have situations where you do not necessarily need to wait. The patient can go home, and the drugs can follow, in terms of being able to deliver the drugs to patients. Obviously,

we are encouraging, as you know, our junior doctors and ourselves to make sure that we have the TTAs written up in a timely manner to make sure that we get those discharges.

A real focus for most hospitals at the moment is around discharging patients before 12 o'clock, especially those patients we know can go home the same day. It is exactly for that reason: what we want to do is to release the beds to be able to bring patients through and make sure that we are not getting those unnecessary delays around TTAs. That is something that each hospital is absolutely focused on.

Q31 **Dr Johnson:** Lincolnshire has a thing called LIVES volunteers, an absolutely fabulous service of people who go out in paramedic-like cars, essentially, providing first aid and first care to patients. I do not know whether that is widespread across the country, or how much that can help to support the ambulance service.

John Martin: I am happy to comment first. Daren might also want to comment. Community-first responders are used up and down the country. That is because for cardiac arrests it is really important that somebody gets there quickly who can do CPR and can use a defibrillator. That does not need to be a paramedic. You need to be followed up by a paramedic once you have had that initial response, and that is what is happening. Every ambulance service in the United Kingdom uses a scheme similar to LIVES, and they are very much there for critical patients where minutes and seconds make a huge difference. The immediate intervention is not from the paramedic; it is from someone who is trained in that immediate life support.

Chair: I think we will move on unless there is anything urgent.

Dr Johnson: I was going to ask Rachel about pay.

Q32 **Chair:** We will come to the industrial situation next, so if you can hold that thought that would be wonderful. I am going to come to Rachel Harrison next as we move on to look at the industrial situation. Tomorrow, 10,000 workers are going to walk out on strike. The unions have said that they want to talk, to negotiate over pay. This afternoon, the unions will meet with the Secretary of State over the industrial dispute. What do you want to see as the outcome of that meeting?

Rachel Harrison: Unfortunately, we do not expect an offer to be made on pay today. We have been given half an hour to meet with the Secretary of State to discuss emergency cover for tomorrow, which considering our strike starts at midnight is a bit late in the day. Those agreements have already been reached at a local level, so unless the Secretary of State is willing to talk to us about pay today those strikes are set to go ahead. What we have been calling on him to do is to come to the table, talk to the unions, and make us an offer on pay that we can take back to our members. They will be the ones who determine whether it is a good or bad offer. That is the quickest way to resolve this dispute.

We have been calling on the Government and the pay review bodies to recognise NHS workers for many years now. For the last two years, we have entered into that process in good faith under an extremely delayed timeline that actually meant that the lowest paid in the NHS this year had to have a top-up to their wages to prevent their employers from breaching national minimum wage rates. Due to the timeline that has been given to the PRB again this year, we will be in the same position. The national living wage has now gone above the minimum pay of these people working in the NHS. These could be your call handlers or your patient transport workers. They are your porters, possibly. They are your cleaners and your caterers. These are people who carry out crucial jobs within our NHS. The dated and not fit-for-purpose pay review body process, which significantly delays getting money into people's pockets, and the approach of this Government towards public service cuts and austerity, mean that we have members working right across the NHS on low pay, and that is the exact reason we are seeing them leave.

Our plea to the Secretary of State is: talk to the unions about pay and make us an offer. GMB is refusing to engage with the pay review body this year because we believe the Government have hidden behind the recommendation made back in the spring of this year. We believe that what we actually need to see is true reform of the PRB process where the remit given does not tie the PRB's hands into existing budgets that have already been set and existing bank accounts that the trust are already struggling to manage. There needs to be independence on that panel, and they need to be free to make recommendations that consider things like the true cost of living and the impacts on the workforce. That is why we are calling for reform.

We are asking the Secretary of State to come to the table. In the past, the Government have moved away from the pay review body process. We had pay negotiations in 2016 and in 2018, at which the employers and the Department of Health were represented. Jeremy Hunt himself in 2014 chose to ignore the recommendation of the PRB, so the Government can step away from that recommendation. We are calling on the Government to talk to us and make us an offer that we can take back to our members, because our members do not want to strike. They have been forced into this. The Government have it within their control to resolve this issue, and they could do that today.

Q33 **Chair:** Thank you. We constantly hear Government Ministers saying that the pay review body has set the process, stressing their independence. However, the Government appoint the members, set the remit, define terms of affordability and control when and how the recommendations are published. Within this situation where we clearly have a disparity in expectation between Government and the workers, the independent pay review body does not seem to have the ability to make recommendations of what needs to be done to resolve this dispute. Julian, do you see a mechanism or a way forward to address the issue if the pay review body does not have that power?

Professor Redhead: Those are really questions for Government rather than for myself as NHSE. Obviously, they are the ones who define those parameters of pay, so those questions would need to be to the Government. What all of us, including the GMB, are concentrating on is trying to ensure that we keep our patients as safe as possible during any industrial action. Obviously, we respect the right for people to take industrial action, but we are all there to make sure that the public has confidence and is safe during those periods. I am sure that that is something we all want to do.

Q34 **Chair:** If I may ask John and Daren, we have heard that low pay and the current pay dispute is having a massive impact on recruitment and retention. Do you concur with that? As a result, what else needs to be done to address the issues of recruitment and retention?

John Martin: The College of Paramedics is a professional body rather than a trade union, so I will not talk specifically about terms and conditions. As I said earlier, we do not have a problem attracting people into the profession. There are a good number of people coming in. Retaining them in the profession is much harder. For those who are in ambulance services, that is partly—our members tell us—due to the impact this is having on them, as we have talked about these last few minutes, but also because there are lots of opportunities in the profession for paramedics now. We have them working in primary care. We have them working in emergency departments. I think that is good for individuals. It is good for career longevity. It is difficult to be a frontline paramedic into your 60s, whereas working in other settings may be possible. We primarily have a retention problem. Some of the salaries outside the ambulance service are higher and more attractive.

Q35 **Chair:** Daren, do you agree that retention is a major issue, and is pay a factor in that?

Daren Mochrie: That is one of my biggest concerns. I know it is a concern for all the chief executives as well—the fact that it is not just about pay, as we have already heard. It is about the conditions that ambulance staff are working in. As John says, we do not necessarily have a problem recruiting and training up paramedics across the country. The challenge we have in the ambulance sector is that paramedics now no longer want to continue to work in that sector; they want to go and work in primary care, perhaps in other departments and disciplines, as opposed to working in the ambulance sector. It is down to the hospital handover issue. I think it is one of the single causes of that. I would argue that it is not just about pay—but to be fair, everybody has said that.

Q36 **Lucy Allan:** If I may start with you, Rachel, about the impact on patients tomorrow in terms of patient safety but also the longer-term impact on the backlog that is already there. How do you think the action tomorrow will impact patients?

Rachel Harrison: First of all, I give GMB's assurance that our GMB reps and local teams have been working around the clock for the last couple of weeks with local employers to agree derogations and exemptions and to

make sure that essential cover is in place. We have entered into all of those conversations in good faith. I believe most agreements have now been signed off. We are doing our role in communicating to our members what they are and encouraging them to adhere to the exemptions that have been put in place. The cover does vary by service. The reason for that is that unions feel the correct people placed to make the decisions as to what care is needed in local communities are the people working in those communities. That is why we may see variances in what those arrangements look like.

Life and limb cover will be provided. The last thing our members want to do is put patients in harm's way. The reason we have ended up in a position of dispute now is because they feel they are prevented from delivering patient care. We have to realise that right now, today, people are not getting ambulances. They are taking themselves to hospitals in a taxi, because they cannot get an ambulance. People are dying, waiting to be handed over at A & E departments. That is happening today. That is one of the very reasons that has driven us to this dispute. We will do everything within our power to ensure that communities are safe during this action. The Government have to play their part: they have to come to the table and talk to us. Our members want a resolution to this.

Q37 **Lucy Allan:** Professor Redhead, what steps are being taken to reassure the public that all cat 1 and cat 2 will definitely be responded to tomorrow?

Professor Redhead: Obviously, we are very grateful to the members of staff who will come to work and use their derogations to do that. It is important to recognise that, as part of their strike action. We have concentrated with our unions to make sure that we have the services available for the sickest and most vulnerable patients to have the response they require. Those in general will be in category 1 and category 2 call-out categories. There are others where there may be elderly patients who are on the floor for some time as well, who also may need care. That is why we are working very hard with the unions to get those derogations. Obviously, we have also tried to support those services by, in some instances, bringing in the military. There are other clinicians who are going to try to help to make sure that we maintain those safeties and the unions are aware of those and are working with us to make sure that they are integrated into the care of our patients.

The overarching message is that emergency care will continue. We have heard about the life and limb emergencies and that should not discourage us from dialling 999 if the public feel that they need that service. They will be answered and an appropriate response will be available when that is required.

Q38 **Lucy Allan:** Will patient safety be affected tomorrow?

Professor Redhead: We are doing everything we can to maintain patient safety and that's what we're concentrating on all the time. And none of

us—I don't think any member of staff I know—and a lot of paramedics would also say this: nobody wants to see public safety be harmed by this.

Q39 **Lucy Allan:** John, can I ask you about that—about the public's safety tomorrow and what your perception of it will be?

John Martin: Yes. As I said earlier, I don't think safety is black and white; it's not one or the other. Right now today, we're seeing long delays for patients; there are lots of patients waiting at the moment for an ambulance response. On Wednesday, even with the derogations, that's likely to be worse. But with this life and limb cover, paramedics up and down the country will absolutely want to keep patients safe.

I think the important bit to note in that, though, is that the category 1 calls—the ones that come in at the time that look like they are life and limb—will get a response and the unions are working very hard on how that will occur.

It's the group who are in category 2 and below who maybe don't start off at life and limb, and this is what we're seeing today, let alone Wednesday, who will deteriorate over time and eventually they will become a life or limb emergency. Obviously, at that point then they do fall into that category, but it's whether or not that— But that's happening today. So let's be really clear: that's happening today and that's what we see for the category 2 response times. Rachel mentioned earlier that 48 minutes was reported in November's figures nationally; that's twice as long as it was a number of years ago. And it's those patients who are waiting and some of them are deteriorating.

We are seeing that they then get upgraded; so, you call back and you say, "This has happened to me." And that probably explains some of the shift in the category 1 numbers when we say incidents are up. So, I think we need to be clear that those who are in a life and limb—it's the ones who I think our members are worrying about that are going to deteriorate over time, and whether something can happen with them. But that's happening today, right now, before we even get to industrial action on Wednesday.

Q40 **Lucy Allan:** Darren, can I just ask you a final question about addressing the issue of morale and burnout among paramedics? What do you feel should be done to try and assist?

Daren Mochrie: Yes, I think it's really, really difficult just now, isn't it? I think about the 31 years I have been in the ambulance sector and the 34 years in the NHS, and I would say that this is the most difficult time I have experienced, and I know that a number of my chief exec colleagues have experience as well, and I know that's how the staff feel, because I speak to them day in, day out.

I think it has been absolutely exacerbated on the back of covid. There has been no respite whatsoever. Normally, we would get respite in between the peaks of the winter periods and a little bit of respite before winter—the busy summers and then back into winter. But if you think about covid,

we've just had no respite whatsoever and I think that's what is really seriously affecting the morale of our staff.

That's why I'm really desperate to continue to work with NHS England and the Minister about right-sizing ambulance trusts, so that we can have the right level of resources to respond to the new levels of demand, with the new pressures that we see across the ambulance sector—continuing to do all the good things that we have been doing, with regard to hear and treat and see and treat. And I would like to see us build in some of those rotas and patterns—some more protected time to look after our staff from a continuous professional development point of view and from a health and wellbeing point of view, as well, because that's what we need to be doing and that's what I'll continue to work with NHSE colleagues and Ministers on, going forward.

Chair: The NHS Staff Survey said that 80.2% of ambulance staff are experiencing burnout, so it's a really important issue. James, can I turn to you?

Q41 **James Morris:** Rachel, having listened to what you said about the driver for the dispute, I can't work out whether it's about pay; I think you said that it's about your members being prevented from doing their job. Which is it?

Rachel Harrison: The legal dispute is fundamentally about pay. Ambulance workers' pay has been slashed in real terms; I think the average is 13% that it's been slashed. And I mentioned earlier about those in the call centres and patient transport services who have fallen below the living wage. So this is absolutely about pay at the heart of this and it will be an offer on pay that can resolve this dispute.

However, the reason our members have chosen this year to vote for industrial action is a build-up of everything that we've discussed today, because it's not just GMB members who have said, "Enough is enough." All you have to do is look at the 14 health unions that are recognised across the NHS and how many of those have balloted their members this year, because they've been asked to ballot their members by their members, and how many of those have secured mandates for industrial action. That tells you the strength of feeling across the entire NHS and ambulance service workforce.

So, patient safety standards are at the heart of this—

Q42 **James Morris:** But strength of feeling about what? We have a health system that will be funded by £180 billion by 2025. We have never had so much money. Everybody recognises that covid presented huge challenges to the health system, which were outside the control of the Government. The Government have committed a huge number of additional resources to the NHS at a time of severe challenges in terms of recovering from the backlog. Is this not a completely inappropriate time for unions to be considering industrial action?

Rachel Harrison: No. This is the ideal time. This is our members saying, "Enough is enough," now. They will continue to leave the service in their thousands if we don't start to do something to address their working conditions and their take-home pay.

Q43 **James Morris:** Which is agree to your pay demands? Is that right? It is about pay, so if the Government this afternoon—

Rachel Harrison: We want to keep members in the service—

Q44 **James Morris:** If the Secretary of State were to agree to all your demands this afternoon and we were to all walk away from this, then all the issues that we have been discussing today would be resolved?

Rachel Harrison: No, absolutely not. The service is still in crisis. There is no overnight solution. But one issue that would be resolved is that our members would feel rewarded and valued, not only for the last two years during the pandemic efforts. They went to work and many of them didn't go home because they had insufficient PPE; this Government wasted money on contracts. They were sent to the frontline without protection. Rightly so, they have had enough. Yes, pay is the crucial thing and that is the legal dispute. We have hospitals setting up food banks. How can our pandemic heroes be having to access food banks and be unable to put fuel in their cars just to attend work? The dispute is about pay.

Q45 **James Morris:** What is the bottom line of your pay deal? What do you want?

Rachel Harrison: At the time that we put in our PRB submission, GMB asked for an inflation-busting increase, along with the majority of the unions.

Q46 **James Morris:** What does busting mean?

Rachel Harrison: Above whatever inflation was at the time. We asked for an immediate plan to restore a decade of lost earnings with a down payment. What we are asking for now is an immediate solution on pay. Make us an offer. We will take that offer back to our members, and they will be the ones to determine whether it is sufficient. We are not making a demand. We are saying, "Make us an offer."

Q47 **Dr Johnson:** Rachel, what you and others have said about the frustration of paramedics wanting to do their job but being stuck waiting outside A&E in an ambulance is a very powerful, emotive response. But like James, I am somewhat confused. You said earlier that it is not about pay, but about the response. You have then said that if you are given an offer on pay today, you will call off the strike. The Government only have so much money. Say that £700 million pays 1% on "Agenda for Change" bands. If the Government found £700 million, would you want them to give that to your union members in pay, or would you want them to invest it in perhaps additional space in A&E so that paramedics can more effectively do their jobs by getting back on the road quicker?

Rachel Harrison: As we have said, there is no overnight solution to the crisis in our health and social care service. Absolutely not. It needs a lot of investment and a credible plan. At the centre of that though is the workforce. What we are seeing—and it has been said today—is that we cannot keep staff. Not only has their pay been eroded in real terms, but their working conditions have been severely eroded. Earning capacity on things such as unsocial hours has been taken away from 2018. People are leaving because they can go to primary care or to GP services, where the pressures are a lot less demanding, there are no unsocial hours, and they don't have to spend their entire shift in the back of ambulances.

Q48 **Dr Johnson:** Sorry, but you didn't really answer the question as I understand it. Say the Government have £700 million. They could spend it on investments in A&E capacity, flows in social care or things that will make the working lives of your members less frustrating so they are less likely to get stuck outside A&E, or they could spend it on an extra 1% pay. Which should the Government choose? Which do your members want more: a less frustrating job or more money?

Rachel Harrison: They want to be able to do their job, so you absolutely have to—

Q49 **Dr Johnson:** So are you saying that the Government should invest not in pay, but in stuff that makes the job easier to do?

Rachel Harrison: They need investment in their pay if we are to keep them. There is no point having extra beds and extra services if there are no staff to run the ambulance service and the NHS. We need investment in the workforce now, and at the centre of that is pay, because if we continue to lose the existing staff, all the recruitment drives that are happening at the moment are pointless. If we cannot hold on to our existing staff, there will be no NHS and there will be no ambulance services, so we have to invest right now in the workforce. We need to sit and have a proper conversation about how we tackle the crisis, and that has to involve social care as well, because we cannot get people out of hospitals if the care isn't out there in the community.

Q50 **Dr Johnson:** Okay, so it's pay. Do you support nurses' requests for 19.6%? Is that the sort of pay rise that you are looking at?

Rachel Harrison: GMB did not ask for 19%. I am conscious that at the time RCN put their submission into the pay review body, they asked for RPI plus 5%. As I said earlier, we have not asked for 19%. We have asked for inflation busting, and what we are asking for right now is a conversation on pay and to make us an offer.

Q51 **Dr Johnson:** So you are not happy with the independently verified offer—the independent review offer—and you want a better offer. I understand that. The media talk about nurses' pay, ambulance drivers' pay and paramedics' pay, but, actually, all this pay is one scheme, isn't it? You have the "Agenda for Change" bands, and if you are not a doctor, a dentist or an extremely senior manager in the NHS, you are all paid in one of nine bands. There is some division of band A, but essentially there

are nine bands. A newly qualified nurse and a newly qualified paramedic are both pay band 5, so there is no capacity to pay paramedics and nurses differently unless you change the bands that they are in. If you are not asking for as much as the nurses and you support the nurses' request, do you think that paramedics, ambulance technicians and call handlers are in the wrong "Agenda for Change" bands at the moment? Do you think their work is more equivalent to work in a higher band, or do you think their banding is right but the pay for each banding is wrong?

Rachel Harrison: I think there is a huge issue with pay banding across the whole NHS in all the professions. There is a large piece of work being undertaken at the moment with the ambulance service profiles and the nurses and midwives' profiles, but that will not solve the issue. The real issue is that, regardless of their job, people are expected to work under extremely different circumstances from when their job was initially evaluated. What we are also seeing is that those people who have stuck with the NHS are having to pick up the workload of the 133,000 people who are not there. All the workers in the NHS are working under extreme pressures, and we would be calling on all employers to review all of the jobs, because we definitely recognise that people are not being paid the correct rate for the job in all professions.

Q52 **Dr Johnson:** The "Agenda for Change" bands have been in place since they were negotiated in 2004 by the last Labour Government and the unions themselves. The unions wanted them at the time because they felt that they could then make sure that equivalent jobs were paid the equivalent money. Are you suggesting that your members would now want to see the dismantling of "Agenda for Change" so that paramedics and ambulance staff are paid in a different set of negotiations from nurses, managers, porters, cleaners and everyone else, or do you want the bands to stay?

Rachel Harrison: No, we are not suggesting walking away from "Agenda for Change". What we are saying has happened is that the jobs have changed drastically since they were initially revaluated, so it needs a whole refresh and a whole evaluation. We are not suggesting walking away; we are still supportive of "Agenda for Change", and that encompasses all the professions within it.

Q53 **Dr Johnson:** So it is more a case of you thinking the bandings of the jobs are not quite right any more.

Rachel Harrison: People are not being paid the correct amount. A healthcare assistant is a good example. We have a lot of healthcare assistants who are paid at band 2, but more and more medical treatments have slipped into their job roles, which means they should be getting paid at band 3. In many places, we are struggling to get them uplifted to band 3, to truly reflect the job that they are now being required to perform.

Q54 **Dr Johnson:** Okay, fair enough. The other thing is you talked about a decade of lost earnings, and I was confused by that. I have some figures looking at bands 3, 5 and 6 between 2005, which is essentially just after "Agenda for Change" came in, and 2021. In all cases—band 3, band 5

and band 6—the proportion of median earnings that is earned by each of those people is higher now than it was in 2005.

When we ask taxpayers to pay the salaries of over 1 million people on "Agenda for Change" pay—the Government say that 1% on an "Agenda for Change" pay band is £700 million—that £700 million has to come from the wider population in taxes. When we do that, we take it from people whose earnings have risen in line with private sector wage increases. We can look at the median—the middle—salaries and the wholetime equivalent of median and gross earnings. Actually, for bands 3, 5 and 6, which are the ones that we looked at—a call handler, a newly qualified paramedic and a fully trained paramedic who has been there for a while—the median earnings that they earn now are higher than they were a decade or more ago. Where is the decade of lost earnings if your members' wages are reasonably increasing in line with the wages of the general populace—faster than the general populace?

Rachel Harrison: I have obviously not seen the statistics you are referring to there, but on the calculations we have done, real-term earnings have not kept up with inflation. Every single pay review body recommendation that we have had since 2010 has been below the level of inflation, so in real terms our members' pay is not keeping up. In the ambulance service, it is an average of 13%.

What is generally not included in statistics like the ones you are quoting at me is an acknowledgment of the fact that, for our ambulance service members, a lot of their take-home pay is built around their unsocial hours, which were cut in 2018. A lot of them rely on overtime. To be fair, ambulance services cannot function without the good will of our members who do overtime.

It is difficult to comment on statistics like that because they don't necessarily take account of the full picture of what our members are earning. Our members are seeing real-terms losses because of inflation and the cost of living. They are taxpayers themselves, so any increase means that they will be paying more tax back to the system.

Q55 **Dr Johnson:** I understand that. What happens if the Government say, "Look, even for 1%—£700 million—we can't select paramedics or nurses as it is 'Agenda for Change' pay bands, so the whole NHS has to be paid that amount of money across the board. It is unaffordable"? Are you going to continue to strike? Are patients going to have to suffer? What will you do if they say, "No, I'm sorry; we just don't have the money to afford this"?

Rachel Harrison: Our members will be the ones who decide. They are the ones who voted for action. They are the ones who determine what action we will take and when we will take it. We will continue to say to the Government that our door is open to talk about pay. Our members will be the ones who decide on any pay offer that is made. If no pay offer is forthcoming, we will continue to have that conversation next year as we head towards the next round of pay discussions.

Q56 **Dr Johnson:** Thank you. I will ask this to Daren and John, who are paramedics. If the Government has £700 million to invest, does it invest 1% in your and your colleagues' pay, or does it invest £700 million in A&E capacity, social care capacity and other things that make the job a more rewarding and fulfilling experience?

Daren Mochrie: In terms of the 1% uplift, or whatever it may or may not be, that is really a matter for the pay review body and the Government. I can give an opinion about what I think it should or shouldn't be. We know what has happened in Scotland. I used to work there for many, many years, so I have a lot of contacts up there. I think it is very difficult. From the Association of Ambulance Chief Executives' point of view, I keep coming back to the work that we are doing with NHS England just now on right-sizing our organisation. If there is some money available to go into the ambulance sector to do just that, that will help all our ambulance sector colleagues and staff. Pay is really a matter for the Government and the pay review body.

John Martin: Our members would definitely say that working life would be better if there were fewer hospital handover delays, and if, when they went to refer a patient in the community, the service was available. That would make a huge difference, but I'm not sure this is an either/or choice. At the same time, not retaining paramedics in the ambulance sector and other parts of the NHS that paramedics work in is a problem. If pay is important to retention—as I have pointed out, we are a professional body, not a trade union—to lose our experienced paramedics, either to not being a paramedic any longer or to other parts, is hugely damaging. You might well have better referral pathways and fewer handover delays, but you won't have a workforce left. It is for the Government to decide which choices we make, but our members would definitely say that they want a better ability to deliver care as paramedics.

Dr Johnson: Thank you.

Chair: Thank you ever so much for coming along today, John Martin, Daren Mochrie, Professor Julian Redhead and Rachel Harrison. It has been a really enlightening session. We hope the talks this afternoon are constructive, and we look forward to seeing the national strategy when it is published. We hope that is soon.