



HOUSE OF LORDS

Integration of Primary and Community Care Committee

Corrected oral evidence: Integration of primary and community care

Monday 12 June 2023

3.10 pm

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Members present: Baroness Pitkeathley (The Chair); Lord Altrincham; Baroness Armstrong of Hill Top; Baroness Barker; Baroness Finlay of Llandaff; Lord Kakkar; Baroness Osamor; Baroness Redfern; Baroness Tyler of Enfield; Lord Watts; Baroness Wyld.

Evidence Session No. 17

Heard in Public

Questions 165 - 173

Witnesses

I: Professor Catherine Evans, Professor in Palliative Care, King's College London; Dr Salwa Malik, Vice-President, Royal College of Emergency Medicine; Dr Alex Thomson, Vice-Chair of Liaison Faculty, Royal College of Psychiatrists.

Examination of Witnesses

Professor Catherine Evans, Dr Salwa Malik and Dr Alex Thomson.

Q165 **The Chair:** Good afternoon and welcome to the Integration of Primary and Community Care Committee. Two of our members are online, Baroness Redfern and Baroness Tyler, and we have apologies from Baroness Shephard. We are fortunate to have with us Dr Malik, vice-president of the Royal College of Emergency Medicine; Professor Catherine Evans, professor in palliative care at King's College London; and Dr Thomson, vice-chair of the liaison faculty at the Royal College of Psychiatrists. Welcome to you all.

As you know, we will take it in turns to ask you questions and my colleagues may leap in with other questions if they catch my eye. May I come first to Dr Malik and perhaps to other colleagues after that? To what extent are patients presenting at hospital who could be cared for more effectively elsewhere? Why is that happening, and would better integration of services avoid that happening?

Dr Salwa Malik: Thank you for having me today. It has to be acknowledged first that patients who have mental health problems are three times more likely to come to the emergency department anyway and five times more likely to require an emergency admission. From 2008 to 2019, the number of attendances of those with mental health problems increased by 133%; for children specifically, it was 341%, which is extraordinary.

In the last few years, we have seen a much slower decline. On average, those with mental health issues account for 3% of attendances coming through the ED. However, there are some significant outliers. In some cities, for example on the coast in Brighton, this can be up to 12% of attendances, which is a complete outlier and, as you can imagine, quite overwhelming for the service down there.

It has to be acknowledged that only a small proportion of those presentations could have been seen elsewhere. Those cases include patients who come with anxiety, low mood, insomnia. They are what we call the bread and butter of primary care physicians, and they can absolutely be seen and turned around in the emergency department.

The problem with the emergency department is that the patients who are turning up now are far more complex. Although the attendances over the last few years have not accelerated as they did previously, the intensity and complexity of their condition has definitely accelerated. As we all know, the environments of the

emergency departments are now pressure cookers. It is not a safe or conducive environment to deliver that sort of care.

It is important to acknowledge that patients who come to the emergency department with this level of acuity are twice as likely to stay more than 12 hours in the emergency department. In surveys with our clinical leads around the country, a good 80% have said that the wait for a mental health bed is more than 24 hours, and 40% say that these patients will wait more than 72 hours. It is not unrealistic now for patients to wait almost two weeks for mental health beds in an emergency department. Only the other week, there was a patient in an emergency department cubicle waiting for admission for 31 days.

This is happening because of community. There are services available, but I question the effectiveness of them, and maybe the staffing and resources given to them. It is a shame that there are no GPs on the panel.

The Chair: We have had quite a lot of evidence from primary care, as you will appreciate.

Dr Salwa Malik: On asking them, the waiting list for getting into an ADHD clinic is 13 years. A CAMHS referral for a child is two to four years. These patients are unfortunately not getting the care they need in a timely manner, and in the meantime they are deteriorating and then pitching up to the emergency department in a worse state.

There are examples of good practice that have been used and probably should be used across the board, nationally if possible. The first response service in Cambridgeshire, for example, is used with 111 to try to reduce the number of conveyances to the ED, and it has managed to do that. In London, they implemented the mental health joint response crisis cars, which also helped to reduce conveyances. There are initiatives and schemes out there. Since the pandemic, there has been an increase in the number of 24/7 hotlines and crisis cafes, et cetera, but they have not been evaluated, so we do not know their effectiveness.

The Chair: If you could send any examples like that to the committee, we would be very grateful.

Dr Salwa Malik: Yes, I am sure we can find that for you.

The Chair: Can we move on to hear about integration and whether it would alleviate this position?

Professor Catherine Evans: Particularly in terms of the why and what the priorities are, we know, for example, that adults near the end of life have increasing use of emergency departments. Some 83% of adults who die with dementia will have had an unplanned admission in their last year of life. The use of emergency departments increases with nearness of end of life, so in the last three months of life we see increasing use of emergency departments.

In terms of solutions, we know that adults whose palliative care needs have been recognised by the GP or by the community services, or adults who are receiving specialist community palliative care, are far more likely to remain at home or in their care home. That is because there is multidisciplinary anticipatory planning in place, and the services, care and treatment are in place to keep up with the individual's increasing distressing symptoms and deterioration as they near end of life.

Dr Alex Thomson: It is important to acknowledge that the majority of patients with mental health crises who are referred to liaison psychiatry in emergency departments also have concurrent medical needs. Sometimes I hear a narrative that perhaps these patients should be diverted or better cared for elsewhere, but it is not possible to create a parallel network of alternative provision. An emergency department that is well served by an integrated mental health service is the most appropriate place for the initial assessment.

The challenges are as you have already heard. Once a patient has arrived and a decision has been made to admit or to arrange onward care, the service capacity may not permit the timely arrangement of onward care. Similarly, the service capacity of community treatment may not allow timely preventive care in the first instance. From a mental health perspective, we need to support the emergency departments, but we also need to ensure that we have service capacity before and after.

The significant challenges relate particularly to children. We have a programme through NHS England to invest in and to resource adult and old-age liaison psychiatry to a minimum standard for the whole of the UK, but we do not yet have a similar programme of investment for paediatric liaison psychiatry.

Lord Watts: I just want to talk from my own experience. People receiving palliative care were often in and out of hospital accident and emergency units for what seemed to be no good reason whatsoever. They ended up back in the ward that they left some weeks ago. Is there any reason why people who are in palliative

care, who are having an episode of something or other, have to go through the accident and emergency units again every time they are not feeling too good?

Professor Catherine Evans: The use of the emergency department for palliative care patients is often out of hours, so at weekends and at night. Some 90% of patients who are known to palliative care teams use unplanned health services, and a third of those happen again in their last three months of life.

You are absolutely right: with nearness of end of life, there are increasing distressing symptoms, particularly things like breathlessness, and increasing concerns. Many emergency departments will run an emergency oncology provision, so people who are presenting with an oncological emergency, such as a spinal cord compression, would be fast-tracked through the emergency department.

You want to remember that most patients who are end of life have non-cancer conditions. They are individuals with dementia, heart failure or chronic respiratory disease, and many of them are not flagged as being a palliative patient even though they might well be in their last month or year of life.

It is about improving the care out of hours. The NHS long-term plan indicated a requirement for a 24/7 telephone line for all services for palliative care patients, but only one-third of commissioners have implemented that. That was from our *Better End of Life Report* funded by Marie Curie. So although we have had a 10-year policy imperative for that, only a third of commissioners have put that in place. If a palliative care patient deteriorates at night or on a weekend, who do they call? If they have to phone 111 because they have severely distressing symptoms of breathlessness and they cannot access help and support, they will escalate to the emergency department, as the health service they can access timely, expert, skilled care through.

Q166 **Baroness Redfern:** I want to pin you down a little. What are the three main barriers to the kinds of integrated work in the primary and community care sector that will avoid hospital admissions? In particular, can I hear about commissioning services, because they are a focal area for helping to overcome barriers?

Dr Salwa Malik: When we talk about barriers, we have to think about emergency medicine. Emergency medicine is emergency medicine. We like to have a service where you can try to admission avoid or attendance avoid if possible. That relies on the resources available in the community. Unfortunately, because of lack of

staffing and resources, as I said, these services are not available for mental health patients. Therefore, the alternative is to come to the emergency department, where they can find help because it has an open-door policy, 24/7.

A robust follow-up service in the community is also important. I like to think that our psychiatry colleagues are quite good at providing that. We have home treatment services, and there are crisis support teams, but, again, they rely on staff and bodies. We have to remember that mental health is do with people's emotions. Those are very subjective and to do with what they have experienced in their life and what is going on in their physical health. It is not a number that we can simply treat, which is perceived as easier; it is very complex, relying heavily on resource—personnel.

The Chair: We are really seeking the changes that have to be made.

Dr Salwa Malik: Well, it is the staffing. That is the change.

Baroness Redfern: On staffing, how do you think GPs and community nurses interact? Is there an issue there?

Dr Salwa Malik: I could tell you quite a bit about that.

The Chair: Could we perhaps hear from one of the other witnesses?

Dr Salwa Malik: Yes, of course.

Professor Catherine Evans: On the point about staffing, we have seen a drastic reduction in the number of community nurses, particularly a loss of experienced nurses, the individuals with a specialist practice qualification in district nursing. It is not just about how many staff you have, but about the level of clinical expertise of those individuals.

On the interaction with mental health services, as with all these things, the integration between physical and mental health is absolutely something to improve on. One of the main challenges and quick wins is probably improving the use of shared electronic patient records—so digital solutions. Again, that varies across the country and relates to GPs sharing records with community services, acute hospitals giving view-only to the community, and similarly with mental health. A quick win would be improving the shared electronic patient records.

Dr Alex Thomson: The three priorities are workforce, funding resources, and estates.

On the workforce, we are seeing increasing vacancy rates in the existing workforce, so it is becoming increasingly challenging to staff our existing services, let alone to expand services. To address that, we need to think about working conditions and about programmes for training and skills to encourage new staff to work in all the different disciplines in mental health services, and to consider support for the retention of staff.

On estates, which I also want to emphasise, in both primary care and secondary care the mental health facilities are often segregated and are not colocated with other health facilities. For example, you will often see integrated community centres that have primary care, community diabetes, physiotherapy and many other services under one roof, but the mental health centre will be in a separate building up the road. We talk about having a one-stop service where you get your eyes checked, you get your feet checked and you have your scan, but why do we not have mental health as part of that integrated community centre?

Similarly, in secondary care and the emergency department, it is quite right that, where people do not have a medical need, they could be seen in a specialist mental health crisis centre. But given that most people presenting in mental health emergencies need a medical evaluation and may also need some medical treatment, if they have to make a road journey to transfer from an emergency department to the mental health centre, many people will just stay put. So having colocated, integrated estates is important.

Baroness Redfern: Is there work going on on integrated estates, then, if this is one of the real barriers?

Dr Alex Thomson: There is increasing development of mental health crisis centres and crisis facilities, but that tends to be in the estate that we have. Those are developed opportunistically. If there is space on an acute hospital site, they may be located there, but if there is space on a psychiatric hospital site separately, they will be located there. Where new hospitals are built, we need to consider the extent to which we should be specifying mental health facilities as an integrated part.

Q167 **Baroness Armstrong of Hill Top:** Good afternoon. It seems to me that there are lots of models operating around the country. In a sense, we are trying to find not one model, but what really will work in the future. Talking about the integration of emergency care and mental health, two of you have said that you think there needs

to be better integration at the emergency access level. I wonder whether you can say something more about that. What are the other services that need to be integrated or would benefit from integration at that level? Then, perhaps, we can think about what commissioners should be doing about other things.

Dr Salwa Malik: I will echo what Professor Evans has said, in that IT integration is key. You cannot integrate if you cannot communicate. I cannot care efficiently and effectively for my patient if I do not know everything about them. That underpins everything. Having what we call the core 24 liaison service is fantastic, and I know that it has improved and increased throughout the country as a service for acute hospitals. It would be really good if you could have enhanced and comprehensive services alongside that for the bigger trusts. By that I mean consultant-led care with specialists in alcohol and drug misuse, to support patients who are really challenged with that. That is the bulk of what we see; the physical health side of things that goes alongside that.

Then there is the high-intensity user who comes to the emergency department. A high-intensity user is a patient who will attend ED more than five times in a year. It is usually a lot more frequent than that, but that is where the cut-off is. We need to see as a priority early intervention from a multidisciplinary team to try to meet that underlying need for those patients. That could be a social care problem, a long-term chronic pain problem. Using that sort of a service and having that robustly evaluated would really help to support what happens in the emergency department.

Baroness Armstrong of Hill Top: I was involved in a project on homeless people and frequent fliers, as they called them. Rather than tending to them at the hospital end, we employed a community nurse who tended to the physical and mental health and addiction work way before they got into the emergency system. Are you saying that there should be both?

Dr Salwa Malik: It depends on the demographic for your area. There are places where homelessness, for example, is rife and is a real problem, and they do not have access to healthcare. So what you suggest is absolutely correct. In certain societies, we need to see an increase in those sorts of services to try to support them best and to prevent them from coming to the hospital, because we know that if they do not get that service, they decline. That is why they attend, in physical and in mental health.

Baroness Armstrong of Hill Top: I go back to my original question. Professor Evans.

Professor Catherine Evans: What is important is the upstream work, which is what you were alluding to when you talked about the homeless team. It is important that we implement models for which we actually have evidence that they make a difference. My expertise in palliative care and mental health is in dementia. We know that adults who receive both specialist palliative care and a palliative care approach are more likely to be able to remain in their nursing home, care home or at home when near end of life.

It is about upstreaming and putting in that multidisciplinary anticipatory care early, and recognising dementia as a terminal condition and that the person will be deteriorating and will have increasing needs. The care and services need to be in place to keep up with those, and at the very least a conversation needs to have been had with the family, and with the person if they are able, in order to understand what it means to live with a progressive terminal condition such as dementia and what will happen at the end of life, so that the family, the person and the services can be prepared to manage that.

At the moment, the person declines but no anticipatory planning has been put in place, so that is seen as a medical emergency because there is no understanding of why that person has declined. They are then escalated to the emergency department, which, as individuals with dementia and their families will tell you, is the last place they want to be. They want to be in their usual place of care, but that can happen only if that anticipatory multidisciplinary planning has been put in place and there has been a recognition of their nearness of end of life.

The Chair: Dr Thomson, could you just mention the ICSs and the PCNs?

Dr Alex Thomson: I will mention three things: frequent attendance, emergency pre-hospital response, and the ICSs.

I have done a lot of work on frequent attendance, both in clinical services and in developing guidelines. There is very little hard, researched evidence and no really unified model or gold standard recommendation for practice. I think that is because attending an emergency department frequently is a characteristic not of individual patients but of systems. Risk factors for attending an emergency department frequently include mental health conditions, addiction conditions, poverty, marginalisation, being a victim of abuse. Those are things that the health and social care system does not necessarily do well in an integrated way.

Most of the evaluations of services have focused on case managing the individual or trying to get a key worker for individual patients. My opinion, based on experience, is that we need to be using the characteristics of people attending emergency departments frequently as intelligence and data in order to guide the development and commissioning of community services. We cannot predict which people with those characteristics may end up frequently attending an emergency department, but we can be confident that there are a number of conditions that mean that you are more at risk of attending an emergency department. We need to consider developing services in that area. We need a joint approach of case management for individuals but we also need to use that information to better develop clinical services.

That probably goes to the question about how the ICSs can improve things. It is by looking at where the gaps in services are, based on the reasons for attending an emergency department.

Professor Catherine Evans: On the ICSs, for one of the challenges we did some documentary analysis of their strategies and looked at what they were prioritising in the services that are commissioned based on population need, which you talked about.

Baroness Finlay put forward the requirement in the Health and Care Act 2022 that all ICSs had to include palliative care in their strategies. In our review of all those strategies in 2022 we found that, on the whole, the detail on palliative care is either not there or is very weak. Again, there was a clear requirement in that Act, a requirement that has clear evidence and rationale as to why that needed to be put in place and the difference it would make, yet that has not been implemented in those strategies. There is a need to understand what makes a difference and what the population needs are, but on the whole that has not been reflected in the priorities of most of those strategies.

The Chair: Your view is that the ICSs ought to be following that up.

Professor Catherine Evans: Absolutely. Baroness Finlay did a fantastic job of getting it included in the Health and Care Act, and it is a requirement for those strategies. As I said, we looked at the strategies and, on the whole, they are weak.

Q168 **Baroness Tyler of Enfield:** I just want to pursue a little further this issue about people turning up in emergency departments with acute mental health crises. We have already covered it quite a bit today in this session, but I would like to focus on two or three specifics.

First, what is your best assessment of the impact this has on other patients, particularly when people with mental health problems are, as the evidence says, having to hang around for a long time?

Secondly, how well integrated are liaison psychiatry services with the emergency department, and to what extent, particularly in relation to children, are they having to make up for lack of out-of-hours CAMHS provision to do assessments and the like?

My third point of interest is the recent Metropolitan Police announcement, which I suspect came rather out of the blue for many, that it was no longer going to attend mental health emergencies in A&E, with fairly short notice. I just wondered what impact you thought that is likely to have.

Dr Alex Thomson: I will start with the police issue. You may be aware that the Home Office has announced a national partnership agreement between the police and the health services, which sets out the intention for the police to reduce their involvement in mental health care, with a view to health services taking over. This is based on a local arrangement in Humberside that had a two-year lead-in and now is in its first or second year of implementation.

There is appetite, and there is absolutely a need for health emergencies to be dealt with by health services. The concern is about the timescale and perhaps the lack of patience from the policing side. The other concern is that, at the moment, this seems to be led by the police, with a withdrawal of service. From my perspective, I would be much more comfortable if this was led by health and was about healthcare services wishing to take over and to receive additional resources and staffing in order to move the police out of this space. The direction of travel and the spirit can only be positive, in that if you call with a health emergency, you get a health response. The concern is about the detail and timescales of how it is implemented.

The Chair: Could you address the other questions that Lady Tyler put to you?

Baroness Tyler of Enfield: They were about the impact on other patients of having people with severe mental health crises for long periods in A&E, and how well the liaison psychiatry service was working particularly in relation to children.

Dr Alex Thomson: As well as the impact on others, I am concerned about the impact on the patient themselves. You have come for help, you are in need, and you end up being told on the one hand that you are so unwell that you need to be in hospital and

on the other that there is no bed available for you and you have to wait until someone is discharged before you can come in.

Beyond the needs of trying to care for someone in an emergency department who may be unwell and may be very visibly distressed, I am left thinking about how it feels to be told that you are so unwell that you need to be in hospital, and yet there is no bed and no hospital for you to come into. It affects everybody. It affects the patients with mental health needs, the staff and, of course, other patients.

On liaison psychiatry, we have been really pleased with the commitment from NHS England to invest in and develop liaison psychiatry services. Over the last 10 years, we have gone from about 20% of English hospitals with emergency departments having a minimum staffed liaison psychiatry service to approaching about 60% now. There is an intention and a commitment to roll out services so that 100% of acute hospitals with emergency departments have a minimum staffed liaison psychiatry service. That means that you have a psychiatry service that is on site and will respond within the hour to patients in an emergency department, and within 24 hours to patients admitted to a medical or a surgical ward. For hospital inpatients, we will provide concurrent joint medical and mental health care. We will do the same in an emergency department.

The challenge then is what happens next. If we can arrange home-based treatment—if we can discharge someone and arrange a follow-up—we will do so. There is a reasonable provision of community follow-up and intensive community support, but where somebody needs to be admitted is currently the pinch point in the urgent emergency care system.

The Chair: Lord Watts, Lord Kakkar and Baroness Barker all have questions.

Q169 **Lord Watts:** I think the health approach is the right one. However, I worry that, in some circumstances, the police will be required. I would not like them to think that it is the end of their responsibility and they can pass it on to the medical people. How safe will this be unless there are sufficient beds and significant increases in support for medical interventions? You say that there will be a psychiatrist on site. That is fine if one person turns up, but if there are two you are in trouble. I wonder how safe it will be for the general public and for the staff who work in those units if that back-up is not readily available from the police, if required.

Q170 **Lord Kakkar:** I have a broader extension of the question about

police. It is very clear that other services are required to support the needs of these patients, beyond those that are traditionally provided by the health service. How content are you that there is proper co-ordination across all the agencies and bodies that need to be available to ensure that such vulnerable patients are properly protected and provided for? From a health point of view, you fully recognise the health needs, but those health needs extend far beyond what the health service can provide and there is a need for other agencies to be present to support that. How is that effectively achieved?

Q171 Baroness Barker: When we considered the draft mental health Bill in another committee last year, we spent a lot of time focusing on the legal status of A&E departments under the Mental Health Act and the need for A&E departments to have a specific area in which patients could be held under different laws, according to their needs. Could you perhaps follow this up in writing with examples of where that distinction has been drawn and whether that has been beneficial in enabling patients who show up at A&E in a very distressed state to receive the appropriate physical and mental health treatment?

The Chair: I know we have bombarded you with questions. If you want to follow up Lady Barker's point in writing, we would be happy with that, but do your best to answer now those that have been put to you, including Lady Tyler's.

Dr Alex Thomson: On the point about liaison psychiatry teams in acute hospitals, I work in Northwick Park Hospital, and we have a minimum of three psychiatric liaison nurses on duty 24 hours a day, and we have on-call doctors to support them. We have a team of junior doctors. We have three consultant psychiatrists working across a hospital with 650 beds and around 90,000 emergency department attendances a year. We also have an integrated multidisciplinary team with additional nurses and psychologists in the daytime. It is not a case of just having a single consultant on site. We have a full service.

On the policing issue, I can perhaps give two scenarios where it should be fairly clear that one is a police matter and one is not. One scenario is where a patient does not attend a mental health clinic appointment. Their community nurse calls them, cannot get them on the phone, calls the police and says, "I don't know where this person is. Would you mind going around, knocking on their door and checking that they're safe and well?" That kind of thing is framed as a concern for welfare check. The question the police could very well ask is, "You don't have an immediate emergency concern. You don't have any evidence of a life-threatening

emergency. You should be going round. You should have staff available to knock on their door and check”.

Another example is if someone has called their family and said, “I’ve gone out. I’m going to kill myself. I’m not going to tell you where I am. I just want to call to say goodbye”. Only the police would be able to track that person’s mobile phone, locate them and bring them to a mental health service.

It is fairly clear that there are situations where it is questionable whether the police should be responding, and situations where it is very clear that only the police should be responding. We need more dialogue between agencies to agree the terms and the boundaries. There is work at the moment between NHS England, the Department of Health and Social Care and the Home Office to discuss those boundaries.

It is in the very early stages, and my concern is that the practice on the ground may move more quickly than the policy and the guidance. We do not yet have a gold standard model for pre-hospital mental health care. In some areas, there are joint cars with mental health and police officers who will go to emergencies; in some areas, there are joint cars with mental health staff and paramedics going out; in other areas, there are mental health staff going out by themselves. A review is needed of how decisions are made about who should be dispatched, as well as planning or modelling to consider, “Well, if we are going to send out mental health staff to all the calls that the police or ambulances are going to, how many mental health staff do we need?”

Q172 Lord Watts: How can primary, community and social care work better together to ensure that people have a dignified death in the place of their choice? What progress has been made in this respect and what changes can the Government make to ensure that multidisciplinary working in the community is the norm for palliative care? Is providing this service realistic, given the shortage of resources?

Professor Catherine Evans: It is absolutely realistic, and it is a policy priority in our last Health and Care Act. To make it a reality, we need to implement the things that we know work and to recognise, for example in primary care, that the person is living with a terminal condition, that they are nearing end of life and that they have palliative care needs. Better use could be made of the primary care end-of-life care register that all GP practices hold. At the moment, it has only patients with cancer and some neurological conditions such as MND. Part of the reason for that is that those

are conditions where there is a clear trajectory of nearness of end of life.

It is also a way for the primary care teams, just as you have said, to manage the volume of patients who require palliative and end-of-life care. Remember that the main cause of death is dementia and that most people who die are in old age, most of them multimorbid. It is about strengthening the identification of patients who need palliative care.

When I say palliative care, I mean both the palliative approach provided by GPs, community nurses and care home staff, and the provision of specialist palliative care for individuals with complex needs. We have a good evidence base on how to do that and that it makes a difference in improving patient outcomes. We did some work on a model called short-term integrated palliative care, which was delivered to older adults who were frail, with multimorbidity, and severely affected by their non-cancer conditions. The provision of palliative care for a short period, up to three visits, working in an integrated way with the GP and the community nurses, reduced the distressing symptoms for the person and enabled them to remain at home, and it was demonstrated to be effective as well as cost effective. Those are the sorts of models of care that our commissioners could be implementing now.

Lord Watts: If I go back to my own experience, when a person enters a hospital with terminal cancer, the care is often not as good as it should be. The Macmillan home services are not that good. It is only when they get to a hospice that they seem to have the level of staff and expertise to manage that process. There is a stark difference between the kind of care that individuals have in those three sections. One is excellent and the other two are not good.

Professor Catherine Evans: Individuals who are receiving hospice care or specialist palliative care have very complex needs. Often the aggressive nature of their cancer is causing increasingly distressing symptoms as it progresses and, equally, psychological distress for the person and the family.

Our hospices in this country are fantastic in what they do, but they have limited reach. The majority of them are funded in part by charities. The proportion of their funding that comes from charities varies, but that means that there is huge inequity in provision. If you live in a very deprived part of the country such as Hull, there is very little hospice provision. I live down in Sussex. In Sussex and Surrey, we have fabulous hospice provision because we are living in a wealthy part of the country. So I completely agree.

The hospices are an invaluable resource and you need to think about the components. They are multidisciplinary. Across all services, whether mental health or palliative care, you have to have multidisciplinary teams if you want to meet the needs of a person across health domains. They are skilled practitioners, so they have skilled specialist training. Palliative medicine is recognised as a medical speciality. The nurses are specialised as well. They have the level of expertise to manage very complex presentation.

They also have much more discrete caseloads than a GP or community nursing service, for example, would have. You can see the difference. If you have a skilled, multidisciplinary team at a workforce level that can meet the patients' needs, just as you have described, they can provide excellent care. We want that for everybody, not just individuals who are in the privileged position of living in an area where there is a hospice and able to access it. There is not enough of that multidisciplinary, highly skilled expertise for everybody who requires palliative care provision.

The Chair: The committee has received that message loud and clear. Thank you.

Q173 **Baroness Wyld:** I have the wrap-up question today. What one change would you like the Government to make that would better integrate services?

Dr Salwa Malik: I wish I could have a chance to comment on the emergency medicine stuff that you asked the other people. I had a lot more to say on that.

To pick one thing, I could give you a solution to the Metropolitan Police problem, which would be standardised hospital security training. Make it mandatory that they have mental health training and are skilled in de-escalating and in having to restrain—if, indeed, they need to—in a safe manner, so that they do not have to depend on calling the police service. Can I throw in another one really quickly?

Baroness Wyld: That would be two. Go on.

Dr Salwa Malik: We love standards in A&E. I would like a one-hour standard to be introduced from the time of referral by the emergency department physician to mental health liaison services seeing the patient. That is important for the timely assessment and timely management of the patient. Can I have another one?

Baroness Wyld: Do we have time for extra comments?

The Chair: Yes, go on.

Dr Salwa Malik: I will make it very concise. On the impact on the patient, I want to give an example from two weeks ago, when 22 out of 24 cubicles were occupied by mental health patients. I can hear you asking me, "But where were your other patients cared for?" They were cared for in the corridor. That is one impact.

A lot of these patients are frail. They are utterly terrified of what they see and witness, because they witness it in the corridor. There is no curtain around those patients to give them dignity and confidentiality in their care, but there is no privacy for the other patients either. You can imagine that pressure cooker effect.

The other impact, as Alex has mentioned, is on the patient themselves. The combination of a long wait and the emergency department's complete inability at the moment to offer a suitable environment essentially means that the patient's mental health deteriorates. They become more agitated. They try to abscond. They attempt suicide, even though they have that one-to-one or sometimes two-to-one specialist care. Their volatility increases. They become violent towards themselves, other patients and staff, and unfortunately that means that we have to resort to restraining and using sedatives.

Unfortunately—I cannot believe I am going to say this—there have been recent cases of patients being successful in committing suicide in the A&E department and its surroundings, which is unbelievable. As I said, the police can play a role there.

Baroness Wyld: I am sorry, but the clock is against us.

Dr Salwa Malik: That is fine. I just wanted to get those points in.

Baroness Wyld: Thank you so much.

Professor Catherine Evans: My one change is to implement what we know works. We have good evidence of what makes a difference to patient outcomes, such as recognising palliative care needs, having excellent palliative care, not using emergency departments, and, in particular, focusing that energy on providing care out of hours. As I said right at the beginning, only a third of ICSs have commissioned the 24/7 palliative care line that was in the NHS long-term plan over 10 years.

Baroness Wyld: Thank you. That is very helpful.

Dr Alex Thomson: Number one is a commitment to expansion of paediatric liaison psychiatry that mirrors the expansion of adult

liaison psychiatry. We did a survey in 2019 and found that only 46 out of the 170 acute hospitals with an emergency department had some form of paediatric liaison psychiatry service in the hospital. Of those, only two had a comprehensive or adequately specified paediatric liaison psychiatry service. There is a long way to go in the care for children, even behind the challenges with adults and older adults.

I would support the introduction of a one-hour standard. I believe that NHS England is piloting that. It might have got lost in the pandemic, but the intention is there and we would support that.

I would request that we try, where possible, to use nurses for the observation of patients in emergency departments, rather than defaulting to security guards.

Can I add another?

The Chair: That is considerably more than one, but you can add one more, quickly.

Dr Alex Thomson: Integrated and colocated estates will be vital to better integration of services.

The Chair: Thank you very much indeed and apologies that we always have to work against the clock. If there are things that you would like to have said to the committee but have not been able to, please feel free to communicate them to our committee clerks, who would be more than delighted to receive them.

Baroness Finlay of Llandaff: Chair, if we are asking people to write in, the one thing nobody has referred to is the relationship to 111 and the impact out of hours, so it would be really interesting to hear about that.

You have all mentioned the physical estate, but none of you has come up with a solution. Should we be totally redesigning emergency departments not just to be the front door to the hospital but to have multiple doors in? It would be really helpful if you could write along those lines. I should declare my interests. Professor Evans has referred to some of them in palliative care, but I am also an honorary fellow of the Royal College of Emergency Medicine.

The Chair: Thank you very much indeed. That is more than several essays for you to write in to us. May I, on behalf of the committee, thank you very much for your evidence to us today? It is extremely useful and we are very grateful to you for giving your time on this very hot afternoon. I apologise that the Palace of

Westminster does not go in for air conditioning. I must now bring this public session to a close.