HOUSE OF LORDS

Public Services Committee

Corrected oral evidence: Ambulance services and A&E capacity

Wednesday 15 April 2026

11.10 am

Watch the meeting

Members present: Lord Bradley (The Chair); Baroness Coffey; Lord Faulkner of Worcester; Baroness Hollins; Lord Mohammed of Tinsley; Baroness Nichols of Selby; Baroness O'Neill of Bexley; Baroness Pidgeon; Baroness Watkins of Tavistock.

Evidence Session No. 1 Heard in Public Questions 1 – 13

Witnesses

I: Jason Killens KAM, Chair, Association of Ambulance Chief Executives (AACE); Dr John Martin, CEO, South Western Ambulance Service NHS Foundation Trust; Sarah Walter, Deputy Chief Executive and Director of the ICB Network, NHS Alliance.

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Examination of witnesses

Jason Killens KAM, Dr John Martin and Sarah Walter.

Q1 **The Chair:** Good morning. This is the Public Services Committee. I am Keith Bradley, Chair of the committee. I welcome you to this meeting and ask you to please introduce yourselves and your positions.

Dr John Martin: Good morning. I am the chief executive of South Western Ambulance Service in the south-west of the country. I am also a paramedic and the immediate past president of the College of Paramedics.

Jason Killens: Good morning. I am the chief executive of the London Ambulance Service and I chair the Association of Ambulance Chief Executives, a membership body representing ambulance services across the UK.

Sarah Walter: I am deputy chief exec of the NHS Alliance, which is an independent membership organisation representing the health sector across England, Wales and Northern Ireland.

The Chair: Thank you for joining us remotely, Sarah. We will start the questioning and I will open by asking you to give us an overview of the level and type of demand being faced by ambulance services and accident and emergency departments. Please also explain what you think is driving that demand from your point of view.

Dr John Martin: I will cover the south-west and Jason will pick up the national position. Some 20% of England is covered by the south-west: Dorset, Devon, Cornwall, Wiltshire, Somerset, Gloucestershire and Bristol are all in the area that I am responsible for. Over the last 10 years—from 2016 to 2026—we have seen a 25% increase in 999 demand. That is against a population increase of 8%, so although the population is increasing, the number of 999 calls coming in is disproportionately going up.

Covid was obviously in the midst of that 10-year period, and that caused quite a lot of variation. During Covid we saw call rates drop, and then immediately post some lockdowns we saw an increase in activity of 11%, so more calls were coming in. That probably reflects that there were conditions that were exacerbated during that lockdown period that then required emergency ambulance services. In more recent years—looking over the last three—our activity is back to about a 5% to 6% increase in growth year on year.

In terms of what is driving that demand, Covid clearly had an impact after the lockdowns. As I say, we are seeing more calls coming in than the increase in the population. Given the access to alternative pathways, people are choosing to call 999 or access us via 111. We believe some of that demand is because they cannot now access other services in the community that they may have historically accessed.

Weather—hot and cold—also affects our call demand in the south-west and I am sure nationally; we are seeing some variation in the way climate is affecting that. We also have a big increase in population in the south-west during holiday seasons, especially in the summer when millions of people come on holiday there. We saw a summer impact during Covid as well; when you could not travel outside the country, more people stayed inside the country so we saw an increase there.

There are two other bits I will add for why we are seeing this increase in activity. The first is an ageing population. For us in the south-west, 36% of our 999 calls come from people over the age of 75, but they make up just 11% of the population so there is disproportionate use of the ambulance service over the age of 75. Not unsurprisingly, as we get older we have more health conditions that might mean that we are calling for an ambulance, but with an ageing population—and certainly older people moving to the coastal regions in the south-west—we are seeing that disproportionate increase.

Deprivation is the other area. We know we get more calls from deprived areas, and as deprivation in the country changes we see that 999 calls go up from those areas more than from the non-deprived areas. Some focus on how we keep that deprivation down would have an impact on our demand.

Jason Killens: The picture across England is largely similar to that which John has described for the south-west. The 10 ambulance services across England respond to just under 30,000 999 calls each day. In February this year, just under half of those were conveyed to emergency departments, with other options for our crews across the country seeing 25% to 26% of the calls and patients we respond to being managed by way of what we call "see and treat". That is where a clinician from the ambulance service provides care in the patient's home or the place where we find them and safely discharges them there. Just under one in five calls on average across England is now dealt with remotely by way of what we call "hear and treat", where a clinician in a contact centre provides advice over the phone or refers that patient to another part of the system.

The reasons for the rising demand that John set out for the south-west are consistent across the rest of the country: an ageing population, often with complex comorbidities and frailty, and gaps in some places in other services such as primary care and mental health. For argument's sake, in the last two years we have seen a 97% increase in patients presenting with mental health conditions here in London, a significant rise. The picture is perhaps not as steep as that but consistent across the rest of the country. John touched on deprivation and socioeconomic issues driving our demand. It is fair to say—John will certainly feel this, as will other services around England—that rural and remote geographies also have different challenges to them and sometimes use our services very differently.

Sarah Walter: I agree with all of the above and do not have a huge amount to add to that, other than the fact that the ageing population increases the complexity of the health needs of that population. As Jason and John have described, the overall population demographics and the impact of deprivation, frailty and complexity within the population have a significant impact here.

Q2 **The Chair:** I should have declared no interests before I started, so I will do that now. On the point you made about ageing but more complex, has that influenced the recruitment and training of your staff to have to deal with those difficulties in adverse points of contact?

Jason Killens: It has. John might want to pick up on some more of this, but trusts and ambulance services across the country have certainly changed their workforce model in recent years. In addition to paramedics who finish university with a three-year degree, we also now have large numbers—it varies across each service—of what we call advanced practitioners, who focus on either urgent, emergency or primary care. These are colleagues who have gone on to do an additional master's education, many of whom are now paramedic prescribers as well. That offers us the opportunity to manage many more complex patients in communities and avoid conveying them to the emergency department where it is safe and appropriate to do so.

Dr John Martin: You will hear a future session from the Royal College of Paramedics, but there is a curriculum guidance that is set. That has certainly changed over the last couple of decades in response to the sort of calls that paramedics attend. While we are talking here about paramedics working in ambulance services, they work in other settings as well. When we start talking about whether patients are going to the emergency department, this group who are frail and complex require both a knowledge and skill base and management of risk. Typically, ambulance services are thought of in relation to critical care. Critical care patients go to hospital, so we have to get it right on scene and have the right skills and knowledge to do that.

When you are taking responsibility for a patient who you are going to discharge at scene and have an alternative to taking them to an emergency department, that requires both a knowledge and experience base and an understanding of risk and how that can be managed in the community for these patients. I still practise clinically, and most patients who are older in life do not want to go to hospital unless they need to. If they need to go, they are very happy to hear that from a paramedic, but actually if we can work with them to keep them in their home setting, for the majority that is their preference.

Baroness Pidgeon: I have no interests to declare.

Baroness Coffey: Can I just ask a follow-up question on that? I have no interests. Dr Martin, you referred to 36% of your calls being from people of 75-plus. What proportion of those calls are then conveyed to an emergency department as opposed to being either seen and treated or

heard and treated?

Dr John Martin: Our conveyance rate in the south-west for the whole population is 42%, which is the lowest in the country. It is relatively consistent for that older patient group as well. About every other patient we will not be conveying to the hospital. That is the group who will also be having strokes and—

Baroness Coffey: So in your experience there is no difference in terms of age in whether they get conveyed or not?

Dr John Martin: Yes, in my experience. I can get you the statistics if required.

Q3 **Baroness Hollins:** It is really interesting. Among the older people, I wondered what happens when somebody is dying at home. I am interested in the algorithms for somebody who is dying at home and wants to die at home but there is no community support. How do ambulance crews deal with that? Anecdotally, here are people who are being told they have to go to hospital when they do not want to because they want to die at home, but there is no local support. How do paramedics deal with that?

Jason Killens: The situation will vary across the country, depending on the partnerships they have with other organisations. Some ambulance services across England, and certainly in the devolved nations across the UK, have developed specialist paramedics in end-of-life or palliative care for precisely the reason that you describe. In one devolved nation, paramedics work in community end-of-life teams supporting patients in communities at the end of their lives to avoid the conveyance to an emergency department, for precisely the reasons that you set out. In England, there are similar schemes working in some ambulance services but not all. It is an area that we continue to develop our practice in, and specialist paramedics continue to be trained.

Dr John Martin: In the south-west we have specialist paramedics who have end-of-life care training and additional drugs and medications and will support that. I guess in that group we are talking about those in the last few hours of their life and we will do everything we can to keep them there. There is this other group who are in the last couple of weeks of life; we really rely on access to community services to be able to support the dying wishes of that group of patients.

Q4 **Baroness Watkins of Tavistock:** I am afraid I have a bit to declare here. I chaired paramedic grandfathering, was deputy chair of the South Western Ambulance Service trust and am a fellow of the Royal College of Nursing. I want to pick up the issue you referred to with mental health patients. This is not a criticism of the police, but has the change in the police directive directly impacted you?

Dr John Martin: In the south-west, we support what is called the Right Care, Right Person scheme. We know that police were picking up a gap that was in health, so we support that. It pretty much came in during

Covid so there might be multiple factors going on here, but in the south-west our 999 calls for mental health pre that were 4% and are now 7%, so we have seen an increase in our total 999 calls being mental health presentations. Historically, a number of them would have been dealt with by the police but probably inappropriately, which is why the scheme exists, and they would probably have gone to emergency departments with police officers. That could have been dealt with in different ways.

Jason will pick up on this for his service as well, but in the south-west we have mental health practitioners now working on 999 vehicles and will do our best to manage patients where it is safest to do so. That might be in an emergency department; quite often it is not, but it requires someone with the right skills.

Jason Killens: Just to build on that if I can, I would echo John's points that while we have seen an increase in patients across England presenting with mental health conditions following the implementation of Right Care, Right Person, this is about providing healthcare to these patients. Of course, while enforcement may be necessary in a small number of cases, the vast majority of this is about providing good care for people so we certainly support the direction of travel.

Just to build on John's point about how we respond to this, it varies across ambulance services in England. Some have mental health practitioners in 999 contact centres, so in control rooms, and responding on the streets. When you look at how patients are managed, about 40% of patients presenting with mental health conditions can safely be closed without a response when there are specialist mental health clinicians in our contact centres. There are varying ways we can respond to this, but without doubt we have seen a pretty steep rise in patients presenting with mental health conditions in recent years.

The Chair: Just a very quick follow-up from me on that. Would it be helpful to you as a service if there were a continual growth of crisis care units alongside A&E departments so that you could direct the patient into that facility rather than going into accident and emergency and being part of a more generic group of people?

Jason Killens: The simple answer to that is yes because often a busy, noisy emergency department is completely the wrong place for a patient in mental health crisis. It is important that as those facilities are developed, they are both consistent and available for our clinicians to be able to make referrals into. By consistent I mean the hours of operation and the types of patients they will take so that our clinicians can refer into them.

Dr John Martin: To add to that for the south-west, I absolutely support the point. Alternatives to emergency departments for patients in mental health crisis are really important. You are going to hear in a future session from an emergency department doctor. It disrupts not just that patient but patients across the department.

I will add in the rurality factor. I would agree with Jason that we want consistent pathways and open access, but the number of miles you have to travel to get one plays a big factor in the south-west. You cannot have lots of them, but enough to make that a good pathway for patients and our clinicians would be important.

Q5 **Baroness Pidgeon:** Maintaining the quality of those is going to be really crucial there. I want to pick up the issue around capacity and performance today, because we all have anecdotal stories and see stuff in the news. What is the situation today in terms of the performance of ambulance services and that interaction with emergency departments? The issue we particularly always hear about is the handover times, and that seemed to be in the press a lot a year ago. Can you just give us a flavour of what the current situation is? What are the capacity and demand challenges?

Jason Killens: Shall I kick off with the national position? I can share February's data, which is the latest month that is complete. The committee will likely be aware that emergency calls in England are categorised in one of five buckets of work for response. For category 1—the most serious patients—across England we responded within seven minutes and 50 seconds in February, so slightly outside the seven-minute mean expectation there. For category 2 patients, it was 28 minutes and 57 seconds, which is a significant improvement on recent years. There is variation across the 10 services in England across both category 1 and category 2 performance, but significant improvement is being delivered right across the country in both.

In terms of the interface with emergency departments—this is a real, live issue for John in the south-west—the single biggest contributor to pressure, if you like, at the interface between the ambulance service and the emergency department is what we call handover delays. This is a clear symptom of pressure right across the urgent and emergency care pathway. It is not just an issue with the emergency department; it is right across the patient pathway. The standard here is that patients will be handed over within 15 minutes. In February that was 32 minutes nationally across England, which is driven in part by a small number of regions. There is pretty good performance in some regions, very good improvement in others, and a couple of regions that continue to be challenging, particularly in the West Midlands and east of England.

Baroness Pidgeon: Then it is another 15 minutes to get the ambulance and the crew ready to go out on another call, so that is obviously having an impact on being able to respond to calls.

Jason Killens: It does because our data demonstrates there is a direct correlation between emergency department handover delays and our ability to respond, particularly to category 2 patients when they need a response.

Baroness Pidgeon: John, can I just come to you? Then Sarah, I would like you to think about whether there is anything you have to add on the

emergency department side.

Dr John Martin: For the south-west, I have been in post for two years and I moved from the London Ambulance Service. While London had handover delays, I was quite surprised at the extent when I moved to the south-west. I obviously did my homework before I took the post up, but the handover delays were significant and in fact the longest in the country.

We have seen improvement across the last two years and it is very much about partnership working. I want to recognise that the patients move into the emergency department, which can increase the crowding and that has a risk that goes with it, but there is a significant risk to patients who were waiting in the community. At times we could have hundreds of patients waiting for an emergency response while the ambulances were outside the hospital waiting to hand over.

At its peak, 20% of our resource—one in five of our ambulances—was waiting to hand over, but we have seen a significant improvement. We are now at pretty much the mean level of the country so about 30 minutes for a handover, though still longer than the standard we are aiming to achieve. That has been very much about partnership working.

The other factor for me, having moved from London, is that Cornwall, for example, has one hospital in it. You cannot move patients to other hospitals; that is the hospital. If it is busy and overwhelmed, it is still where the patients need to go. That ability to flow patients is a really important factor for rural areas.

Our improvement in handover delays has had similar improvements in our category 1, 2 and 3 performances. Category 1 has improved by 42 seconds to nine minutes from nine minutes and 42 seconds. For category 2, there is an 11-minute improvement from 45 minutes to 34. Category 3—some patients who are low acuity but quite often the frail, elderly ones we are talking about—has improved by about 35 minutes from 2 hours and 23 minutes to 1 hour and 47 minutes, as well as that increase on "hear and treat" that Jason mentioned. Are we able to use alternative pathways?

I talked earlier about our non-conveyance rate being the lowest in the country, so we are least likely to take patients to hospital. The handover delays have supported our clinicians in really thinking broadly about whether we can do the right thing for patients, because the hospitals were very busy and overwhelmed in the south-west.

Q6 **Baroness Pidgeon:** Sarah, in the wider NHS that you represent, can you talk through what hospitals are doing to help with this? As John says, it is partnership working; it cannot just be the ambulance side making improvements. What are hospitals doing? What innovations are happening to actually help tackle this management of capacity and demand?

Sarah Walter: I would broaden it out from what hospitals are doing to looking at the wider system. As John and Jason have described, there can be that issue around handover delays and the impact on hospital flow issues. Evidence from our membership is that there are clearly things that can be done within trusts to improve performance and productivity. There is also a more fundamental thing about how the system as a whole operates, where patients are going and how we support better system navigation. Both Jason and John have described some alternative routes instead of going into hospitals, looking at the development of more local and neighbourhood health arrangements, the role of primary care, wider support services and use of the voluntary sector. There is a broader point here around the need to improve the flow within NHS trusts but also to look at that broader picture.

The 10-year health plan that was published in the summer described that shift towards a more neighbourhood health-based service and trying to shift more resource out of hospitals and into community services. There is a real opportunity there for us to have a more fundamental rethink about how the system as a whole operates and the role of ambulance providers and hospitals within that. It really requires a more fundamental rethink of the system. It is an opportunity for all partners within the system to be able to play the part that they can uniquely play and ensure that patients are getting the appropriate care and support that they need in order to get the best use out of the system we have.

Baroness Pidgeon: Theoretically, I agree with what you are saying; that might be where we want to be. But practically today, do you have any good examples of hospital trusts or primary care mental health working well with ambulance services that are good models that we could be looking at?

Sarah Walter: We have all kinds of examples around the role that ambulance services can play in system navigation and alternatives to A&E. Part of the question when ambulance providers are involved is how many of those calls are conveying patients into a hospital. As John and Jason have described, a significant proportion of those calls can actually be directed elsewhere with the use of hear, see and treat approaches and improved GP access so that fewer people attend A&E.

We need better system navigation if we think about the NHS’s three main front doors—general practice, ambulances and emergency departments, and the way those systems are working together. We have examples such as collocation of alternative treatment centres with A&E. The Hull Royal Infirmary City Health Care Partnership, which is a CIC, has operated an urgent treatment centre next to the type 1 emergency department, so there is active deployment of staff within the hospital to help redirect patients. We have examples across the country where this can be improved. As Jason described, we know that the performance varies across the country.

There is also an opportunity to learn from effective practice within different provider organisations and to look at how that can be

developed, notwithstanding the challenge that John has described around particular geographies, challenges of rurality and purely the number of trusts that can be provided, for example. As I say, there are clearly examples of good practice that we can build on, but I guess it is also about how we move from that incremental change to something more systemic.

Baroness Pidgeon: Perhaps afterwards we could get some more practical examples; that would be really helpful.

The Chair: We will come back to that. Baroness Hollins, do you want to come in again? If you do, can you just declare whether you have any interests or not?

Baroness Hollins: I do not have any interests. I just want to ask you about category 2 patients. How often is capacity insufficient to be able to respond, with patients asked to try to make their own transport arrangements? Jason, could you comment on that from a national perspective?

Jason Killens: It is difficult to give you a precise answer as to how often demand outstrips supply. By definition, if the response standards are longer than the expectation we have, the sufficient capacity is not available to respond to patients. While we have seen an improving picture for category 2 in every service across the country in recent years, as I described, we still have a way to go to get back to the 18-minute constitutional standard or expectation for a response time for category 2 patients. There is an improving picture; it will vary across each service and trust by hour of day and day of week. Regrettably, some patients in that group will be waiting longer than we would like, simply by definition and the fact that we were at some 28 minutes in February rather than 18.

Q7 **Lord Faulkner of Worcester:** I have no interests relevant to this inquiry to declare. I would like to ask you each to look at the service from the point of view of the patients your members are picking up. First, are they given proper information about how long it may take for an ambulance to arrive for them? Secondly, are they alerted to the possibility that they may be in a queue in a car park waiting to get into an A&E department because of congestion? If so, how do you deal with the anxiety that must be created in both those situations?

Dr John Martin: Both nationally and locally, when a 999 call is made we pick up the phone very quickly; less than 10 seconds is the average to pick up the phone. We will triage the patient by asking them or their relative—depending on who made the 999 call—a number of questions. We work out what category the patient is going into. If it is category 1, a life-threatening emergency, you are getting the nearest resource; that is about 10% of our demand. For all the others, if we are busy we highlight that to the patients.

We will not give specifics about how long it is going to be because that changes minute by minute; as other calls come in, we move resources around. We highlight that we are busy when we are in states of escalation, so we handle that up front with patients. At that point a number of them say, "Don't worry, then; I'll make my own way", and decide to self-convey, which is why Jason alludes to the fact that we do not count that. Our call handlers will be reassuring and give advice over the telephone. We will look to support people, but we are honest and tell them when we are busy without giving a specific time.

When we arrive on the scene for patients we do not manage over the telephone via "hear and treat", our clinicians work through the options with the patients and the family and relatives who are there. As we have said, about half the time that means they are not going to hospital because we are able to keep them in the community. The other half of the time, we will explain why we believe it is in the best interest of the patient to go to hospital. If they have mental capacity, they have the choice. Some still say, "I know you're advising me as a paramedic to go to hospital, but actually I don't want to go". That is okay; it is part of the Mental Capacity Act and a choice that individuals can make. If you do not have mental capacity, we will obviously make that decision for you.

Our clinicians are well versed in what is happening locally, so they are likely to say, "It might be a while before we get into the emergency department", but we are giving the advice based on the fact that you need to be in an emergency department. We will not say to our patients that they need to go when they do not need to go. We are advising that they need to go for an assessment, a test or treatment, depending on what that is.

That anxiety is there in patients. Certainly in the south-west—it was probably true when I worked in London during the Covid period—patients were very anxious. We quite often see pictures in the media of the number of ambulances waiting outside, and they say, "I don't want to go there". A lot of our patients, especially at the frail end, have had experiences relatively recently. They will say, "Two months ago you took me in and I had to wait 12 hours in the car park before I went in". Where they are still able to make that choice, that is then affecting whether they want to do it, so experience plays a part. Our clinicians are good at working with people to explain the options, but that anxiety is there for patients.

Jason Killens: I will build on a couple of points. John took you through the call-handling process. The other thing to say is that where a call is being held in one of our control rooms awaiting a response—there is not an ambulance to send—our clinicians or other staff will often maintain contact with that patient by ringing them back periodically or providing advice over the phone, so welfare checks are made to maintain contact with those patients.

Just to draw out on car park care—as it is sometimes known—the other point is that of course, as John has described, our clinicians will be

advising patients to go to the emergency department when they believe it is in their best interest. That is what they need to do given their clinical presentation. We do all we can to avoid that car park care. Part of the role our clinicians can play in supporting flow across the entire urgent and emergency care pathway is to ensure that we convey to the emergency department only those patients who really need to go there.

That is a key development that the ambulance sector has seen nationally in the last 10 to 20 years. As we touched on very briefly earlier, with the creation of specialists and advanced clinicians, we are now able to do much more as an ambulance service in our communities than simply convey patients to an emergency department. Our clinicians can provide great care to patients in their communities and often discharge them into the care of another part of the health system without conveying them to the ED. That is an area of growth for the sector to ensure that, overall, patients get a better experience and better care and we are conveying to the emergency department only those who really need to go there.

Lord Faulkner of Worcester: What is the typical size of an ambulance crew?

Jason Killens: Two.

Lord Faulkner of Worcester: Are they equally skilled?

Jason Killens: It varies across the country. Generally there will be one paramedic, who is a registered healthcare professional, and then one other person, either an emergency medical technician or an equivalent grade and title. It is generally one registrant and one other.

Lord Faulkner of Worcester: One obviously has to be a driver.

Jason Killens: Indeed. Both will drive.

Dr John Martin: Both can usually drive. There is a clinician—a nurse or physiotherapist—who is a paramedic registered with the Health and Care Professions Council. There may be another paramedic but quite likely it is going to be an assistant, for want of a better term, who has skills and can drive, help and do clinical things but is under the guidance of the registrant in the vehicle.

Lord Faulkner of Worcester: That is really helpful—thank you. Sarah, is there anything you would like to add?

Sarah Walter: No, not on that point.

Q8 **Baroness Nichols of Selby:** I do not have any interests to declare other than I have been a public sector worker for over 40 years but in local government rather than health. I have probably represented people with my union head on.

We have talked about the patients and the impact on them but there is obviously an impact on the staff. Nobody goes into public services if they do not want to help people and their communities. Often people live

around where they work, as well. I wonder what the impact is on staff when they cannot get there quickly enough. Are there frustrations around that and what kind of support do they get? The answer is probably yes, but are the changes that are coming in actually helping them so that they are able to treat more people in the community, which is what people want?

Jason Killens: I will start and John clearly will add to it.

There is a significant impact on our people when they are unable to provide great care to patients. As you say, that is what we all join the public sector for: to help people when they need it most. The experience of emergency department handover delays is deeply frustrating for our people on a number of fronts. First, they cannot provide the care that they have joined to give to the individual patient who is in front of them. They are in a setting where they are not equipped or skilled to manage that patient for a protracted period of time in the back of the ambulance. Secondly, there is then the patient in the community who we then cannot get to, who in many cases suffer avoidable harm as a result of our inability to respond. That is a significant impact for our staff too.

The third area is that, often, as a consequence of that pressure, our people can be late off their shift, so a 12-hour shift becomes a 14-hour shift. That become a real issue, particularly for those with caring responsibilities—young children, elderly relatives and so on—because they cannot plan what they are doing.

You have moral injury occurring in two or three places here for our people: their inability to provide great care for the patient they are with; the harm that they know is occurring to others in the community who we cannot get to; and the disruption to their own lives outside work, particularly if they have caring responsibilities.

Dr John Martin: To add to what Jason said, it has a massive impact on our staff, all of whom join because they want to make a difference to patients.

To contextualise it, two years ago, when I joined south-west in the winter, the longest handover delay in my first week was 34 hours. Generally, ambulance staff do 12-hour shifts, so the moral injury—as Jason talked about—is you start your shift, you are there for the whole 12 hours, you go home, someone takes over for 12 hours, you come back and you see the same patient. That has a big impact on you psychologically. We actually are a country that does care for our people. We have seen significant improvements in handover delays, which has had an impact on our staff's well-being and the moral injury that is there, but it all adds to the stress.

The other element is when we respond to patients in the community. Our response times were extended, so there were hours and hours of waiting. We are the first people to arrive. When we knock on the door we are often starting our interaction with a patient who is saying, "Thank

goodness you're here", by having to apologise, as clinicians, that it has taken three, four or five hours to get there when the expectation of a member of the public and a patient is a quick response from the ambulance service.

One more group I would like to mention while we are talking about staff is our students. We are creating new paramedics and the assistant roles that we mentioned earlier all the time. It has a big impact on them. If your whole shift is one patient outside the hospital, that is very different from the experience you were expecting, of seeing lots of patients and having variety. It has had an impact on our student experience as well.

It is improving—we have seen handovers improve around the country—but if we take a five-year look at this, we see that there were real impacts on staff injury.

Q9 **Baroness Coffey:** The purpose of this inquiry is to understand how ambulance services can support A&E departments. What impacts are government and NHS policy having on ambulance and emergency department capacity, performance and patient outcomes?

Jason Killens: I will start with just a couple of areas. John and I were actually discussing outside that we can see and feel improvement occurring across the country. One example would be the rollout of same-day emergency care facilities—SDEC—where some 200,000 more patients have been managed through those facilities in the last 12 months. I touched on the fact that we have seen improvements in category 2 response performance as a result of improvements across the system releasing capacity that was otherwise not available to us to respond at the emergency department where the delays we were just talking about occurred.

We also have increased visibility and accountability for what is happening at a regional level through the national oversight framework. We are able to see where there are improvements, learn from and share those across the country, and adopt them at scale and pace to deliver better services and access to services for patients. We can see and feel improvement occurring as a result of some interventions that have come online.

Dr John Martin: To add to that, in the 10-year plan for health we are seeing the shift from hospital to community. As a policy direction, that allows those pathways to be there. It would be fairly safe to say that these are early days in neighbourhood provision. If that comes to pass as is written in policy, we would expect, over time, to see more options for our clinicians to be able to refer in the neighbourhood, which obviously would mean that their patients are safely not going to emergency departments.

On the shift from analogue to digital, for some patient groups who have complex needs, are frail or have long-term conditions, we have seen that the policy direction of being able to access summary care records from our clinicians is a change. Instead of starting all the history from scratch,

we can see what else is happening. There is more to do as well, as we shift into that space. We are seeing some policy directions coming through.

The other thing in more recent years is that we have seen in the annual planning cycle from NHS England that it is to be clearer about the standards for handovers. We are often talking about the backstop; we know the standard is 15 minutes but we are improving that and it has been incrementally coming down over recent years.

Jason Killens: To build on that a bit more, I will give you two tangible examples. One is the policy position to manage more patients remotely by way of hear and treat. While it is at 18% nationally at the moment, we see some trusts and organisations achieving close to one in four 999 callers now being managed by way of remote telephone advice or video consultation. That is a significant improvement and frees up ambulances to respond to patients who need them.

Another really good example is in the digital area that John alluded to. A couple of organisations, including my own in London, have now deployed ambient voice technology. We are using that to support clinical assessments remotely. It is giving us about a 15% productivity improvement, enabling us to see and manage more patients within the existing resources.

Baroness Coffey: Should it be government NHS policy that that tool is used in every single ambulance service?

Jason Killens: It already is. We are working as a sector nationally to roll it out across each service.

Baroness Coffey: Can I press a little further about the government NHS policy?

The Chair: Can we bring Sarah in, in case she would like to respond to your first question?

Baroness Coffey: I can inform Sarah that, four years ago, she did not seem to know about improvements that could be made, some 50% of hospital ambulance handover delays were in 10% of trusts, so changes can be made.[1] It would be interesting to see what they have learned since then.

The Chair: Sarah, would you like to respond to that?

Sarah Walter: To the point around government policy and the improvements that are happening, as Jason and John have described, there is a lot within the 10-year health plan that we can support, particularly around shifts to neighbourhood care and analogue to digital.

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[1] This refers to analysis undertaken by DHSC regarding the performance of NHS trusts. After the session, Sarah Walter clarified that she and Lady Coffey had not discussed this topic or met previously.

There is more opportunity for us to ensure that the ambulance sector is properly represented within those.

Take the neighbourhood working plan as an example. There has been very little involvement and focus on the role of ambulance trusts in thinking about that neighbourhood health provision. The opportunity to think about things holistically is there but is not always enacted in the way that we might hope.

One of our observations as NHS Alliance, working with members across the country at the moment, is on this balance of recovery and reform. We have talked a lot today about the improvements that can be made and we have examples of where those are happening. There is clearly a role for incremental improvement and recovery, and NHS England has been focused on that space. The 10-year health plan is much more about fundamental change and reform in how the health system operates. We are seeing less of a focus on that, or maybe less progress in that direction, given the performance and financial challenges that the NHS is facing.

It goes back to my earlier point that we know that there are improvements that can be made, but ensuring that the health service can be sustainable over the longer term is about a more fundamental shift in the delivery model.

One area to note is the role of commissioners in this space, and we may come on to this in a bit more detail. There is clearly a role for integrated care boards in how the ambulance services are commissioned and in thinking about how the urgent emergency care pathway is commissioned more fundamentally. Again, we know that there is work to be done around ICBs’ role as strategic commissioners and building up their capability.

In the last 12 months, ICBs have experienced a very turbulent period, with a 50% reduction in running cost allowance and significant clustering and mergers. That will have had an impact on their capability and capacity to focus on commissioning in this area. That is settling somewhat now, but there is quite a task in hand. I know NHS England will be investing in a development programme for strategic commissioning that can help to support this.

I wanted to make a point about the role of the NHS commissioners within this area, ensuring that they are established and able to support the effective strategic commissioning of urgent emergency care and thinking about the role of the ambulance sector as part of that.

The Chair: We may come back to this in a further question.

Baroness O’Neill of Bexley: Jason and John made reference to the use of ambulances. Although I appreciate that there is a triage system, I wonder if the Government could do more around comms. My background is that I was leader of the London Borough of Bexley, and therefore I had

a lot of communications with the local ICB, et cetera. We did a bit of work around a road map to care, to encourage our residents, through local communications, and tell them where the right front door was.

We all hear experiences of people calling ambulances—indeed including 111—where they may not be required, and obviously the fewer callouts you get, the more effective you can be and the less stacking up you are going to have. Is there more that can be done around communications to the wider public, not just to us wonks who are interested in policy care?

Jason Killens: John, I will start, but please jump in.

The stated position, or the strategy position of the Association of Ambulance Chief Executives, is the view that there is not really a wrong front door for the patient, if I can describe it like that. What I mean by that is increasingly ambulance services are the providers of 111 services too. Where there have been established relationships between the 999 and 111 provider over time, you see those services beginning to come together. For the patient, asking the public to determine whether they have an emergency or an urgent care need—do they ring 111, do they dial 999, or do they go to their emergency department?—becomes quite complicated, because what is an emergency for me is probably not going to be an emergency for you or vice versa.

Our view as a sector is increasingly to make the contact and, where services provide both 111 and 99 services, we can then understand the specific patient's presentation and need and direct them to the appropriate care for their condition. You have fewer hand-offs—the patient ringing 111 and then being told to ring 999 and then go here and do this—it is more joined up and connected, and, ultimately, the patient gets a better, cleaner experience. We would also argue that it is more efficient and effective for the overall health system to have those services joined up.

There is always more that can be done on comms, to your specific question, but it is more about making it simpler for this patient to access care.

Baroness O'Neill of Bexley: Can I just clarify the point you made there? Presumably not all areas have joint 999 and 111 services.

Jason Killens: That is right. Ambulance services can bid to operate 111 services on contracts—some operate them, some do not.

Baroness O'Neill of Bexley: Can you give us numbers?

Jason Killens: Roughly half.

Dr John Martin: In the south-west we do not run the 111 service; we just run the 999 service with other providers. We see variation between those providers. To Jason's point, I am not necessarily saying that it all needs to be run by the ambulance service, but there is an opportunity to

make sure that together we work as a single front door for those who are accessing urgent and emergency care.

To support what Jason said, there have been a number of research studies in the past, which maybe the clerks could look up, of trying to analyse why patients call 999. They pretty much concluded that, when you call 999, you think you are having an emergency. Through the communications, you have to change people's perception, which is very difficult to do. These studies often analyse what a paramedic or doctor might think is an emergency compared to what a patient has deemed to be, but actually, when you get into the psychology of it, they thought they had an emergency. You and I might not think it is an emergency but they do, and therefore the communication change is quite difficult.

Q10 **Baroness Hollins:** Sarah has already addressed part of the question about commissioning. I want to say at the beginning that a lot of my concerns are about the needs of people with mental health issues and learning disabilities, having been a psychiatrist for most of my career, so I will have that in my mind when I am asking my question. How do NHS governance and commissioning arrangements affect ambulance service design, performance and outcomes? How do the lead ICBs work with the other ICBs in their ambulance trust area and how satisfactory do you think that approach is?

Jason Killens: Ambulance services operate, in essence, on a regional model as we have touched on; there are 10 across England. Commissioners work on a lead commissioner model, as you have set out in your question. There is one ICB that will lead for a number—sometimes up to around five—across a region. We operate as a sector on what are known as block contracts, which is quite a blunt contracting arrangement, essentially funding for a set of activities. What that lacks is sophistication, particularly around incentives to drive different behaviours and manage patients in a better and more effective way.

That said, we welcome multi-year settlements, which are now becoming clear, enabling trusts to plan a bit further ahead. Historically, we have been on annual financial settlements, which makes it very hard to plan and transform services. The position of AACE—the Association of Ambulance Chief Executives—is that we would favour moving towards commissioning on a regional level rather than the current ICB and lead commissioner footprint.

Dr John Martin: For the south-west, we currently have seven integrated care boards; there were 12 previously. We are moving to three in the new cluster model imminently. We have a lead commission model; that works well, in the sense that there is a single block contract that we work through, as Jason has said.

Picking up your background of psychiatry, there are lots of local initiatives. Mental health response cars would be our highlight. Across my seven ICB areas, they do not all fund that in the same way, which means that you can end up with variation in provision. That might be the right

thing for the local population; the amount of money needs to be split based on the needs.

At times, it makes it more difficult for us to run a regional ambulance service because we do not work on ICB borders. If you are on the border of Somerset and Devon, we will move the ambulances up and down and across, because we go where the patient need is. There is something about recognising local funding and local decisions around that and helping ambulance services have regional schemes so that we can provide consistent care and make it easier in our operating model. It becomes more confusing, especially on the borders, for our staff working to move the ambulances around.

Jason Killens: The other thing we currently see as a challenge is inequity in access, where we have differential access times for patients across regions. Again, our view of moving to a regional commissioning model would be supportive of reducing the inequity we see for patients.

The Chair: You mentioned the national oversight framework. Will the introduction of regional directors of the Department of Health covering a number of ICBs help or hinder that local provision?

Jason Killens: Regional directors for NHS England already exist.

The Chair: But they are going.

Jason Killens: They are going. I do not think it would be right to say it would necessarily hinder. The stated direction of travel brings in clearer lines of accountability, which is helpful, but the regional footprint will still remain in the department instead of in NHS England. As the transition starts to take effect, it is becoming clearer now where those lines of accountability are. At the moment, our position as a sector would be that we welcome and support the changes, but it is yet to be seen once it is settled.

Baroness Hollins: Can I ask a follow-up question? Earlier, you spoke about the need for better joined-up services. Given what we have heard about patient flow and communication between emergency and community services, what is the role of the lead ICB to somehow lead on improving the local co-ordination of services? It seems to me that there is potentially a bit of a gap there.

Jason Killens: That may be a question that Sarah might want to comment on.

Sarah Walter: I am very happy to. As described, the current model with the lead or co-ordinating ICB can operate effectively but there are some challenges around that. It is incumbent on buy-in from all the ICBs within the region and ambulance trust footprint to work comprehensively together. As we have described, looking ahead, it is likely that ambulance commissioning will transfer to the newly established offices for pan-ICB commissioning across the seven regions. There is an opportunity there to strengthen some multi-ICB collaboration across an ambulance patch.

We have seen a huge amount of change within the ICB geography, responsibilities and accountabilities since ICBs have been established. There has been pretty consistent change and churn for commissioners, and inevitably that does not help from the point of view of developing partnership arrangements and collaboration arrangements. In particular, when thinking about investment within the ambulance sector, being able to invest in digital solutions and the strategic direction of ambulance services, that amount of change within the commissioning context can hinder things.

We are hopeful that there is a stabilisation of the commissioning infrastructure as these offices for pan-ICB commissioning establish themselves. We hope that we get into a better place, with more strategic opportunity to think about urgent emergency care and the role of ambulance trusts within that, alongside the development of local pathways and a shift to neighbourhood health. That is where everybody wants to get to. There has probably not been as much capacity to be able to focus on that in the last 12 months, given the amount of change within the sector.

Baroness Hollins: There are challenges we have not touched on. What the ambulance trusts are concerned with is health, but often it is a lack of social care support that leads to a crisis. Many ICBs are trying to develop joint commissioning approaches with their local authorities, but this becomes very complicated.

Sarah Walter: It absolutely does. Think about the amount of change within the NHS, in particular for commissioning organisations, and change within local government happening on multiple levels, through local government reform and the development of strategic authorities. NHS and local government partnership is hugely important when we are thinking about population health and how we support people to be able to live healthily. The NHS and local government arrangement is fundamental. Again, the amount of instability across both the NHS and local government is a significant cause of concern at the moment.

Baroness Hollins: As is its impact on emergency services.

Q11 **Baroness Watkins of Tavistock:** I want to pick up one issue that has been in the press a lot recently in relation to commissioning. Regional centres often appear to have longer waits for ordinary patients, as it were—for example, a neurological centre or a burns centre. I wonder whether you could comment on that and whether we have the commissioning right around those issues.

Dr John Martin: There is a small group of patients that we do not take to the local emergency department. For your part of the world, that would be Plymouth. For cardiac conditions, we will often bypass the local emergency department for a specialist centre. Neurological conditions, such as strokes and bleeds on the brain, and trauma are the others where we routinely will not go to the local emergency department. The reason for that clinically is that the outcomes for you are better if you go

to a super specialist centre. We will drive further, manage your condition en route and use interventions to make sure that you are in the best place you can be when you arrive at the specialist centre.

In the south-west, we have seen that some specialist centres have also struggled with handover delays. That is because you have your normal footprint coming in through the front door and then we will bring in a trauma patient. It is probably a question to ask of the emergency department team when they come at a future point in the inquiry. Having said that, it is not universal; there are hospitals that are able to do both and get the flow running. That is probably for the emergency department team to answer.

Q12 **Lord Mohammed of Tinsley:** My question is trying to tease out the one reform that is needed to enable ambulance services to have the greatest impact on both urgent and emergency care for patient experiences and outcomes.

Jason Killens: Just one reform.

Lord Mohammed of Tinsley: I would go for one—you can go for two, if you want. My question is to all three of you: what could you do or what could we demand of Government?

Jason Killens: The single biggest thing the sector would argue for is time. What do I mean by that? As we are currently judged, our success is based on time. While time is an important part of reflecting the overall patient experience and the service they receive, it increasingly inhibits our ability to do the right thing for the patient.

The reason I say that is the role of the ambulance service sector has changed significantly over the last 10, 20 or 30 years. If you go back 20 or 30 years, we were essentially a transport organisation responding to 999 calls, picking patients up and taking all of them to an emergency department. Today, one in five patients is dealt with by way of remote hear and treat advice with our clinicians in contact centres. We have specialist paramedics who are degree-educated. Twenty years ago they did a six-week course on top of a vocational entry programme. We now have registered healthcare professionals who are degree-educated, and specialist and advanced paramedics with master's degrees specialising in certain areas of care, many of whom are independent paramedic prescribers, able to write a prescription for you in your community and keep you safe and well at home. A model judged solely on the time that it takes us to respond inhibits our ability, in some cases, to provide the best care for patients.

To your point about one reform, it would be to increasingly measure outcomes—patient experience and satisfaction and clinical outcomes—alongside time. Time is still an important feature, but not necessarily the primary feature for the majority of the patients we now go to.

As a provider of clinical care and healthcare in our communities, to touch on a previous question, we should be aspiring for a 95%, 98% or 100%

conveyance rate rather than a lower conveyance rate, but only the patients who need to go should receive an emergency ambulance. Therefore, the conveyance rate should be much higher because we are using our clinicians and the skills and education our people have to provide different care for patients in communities, rather than simply conveying them to the ED. Time is the reform that would be most helpful for us.

Dr John Martin: I will add a second one. I support what Jason said about time, but if we are going to use that for patient benefit and maximise keeping patients away from emergency departments where that is safe to do so, what we need another reform. We have heard a lot about alternative care pathways, but how do we increase uniformity in access to patient information for all our clinicians, and access to those services not just geographically but at different times of day, weekends, nights, et cetera?

I will put on the table respect for paramedics as clinical professionals to be able to refer to those services. We still have examples where another clinical professional—often a doctor, but that is not universally true—can make a referral but when a paramedic tries to make a referral they are told that they cannot. To utilise the time more effectively to keep patients from the emergency department, we need access to these pathways for all our clinical professionals as uniformly as we can across the country.

Sarah Walter: To build on both those points, there is a focus on the left shift and the proportion of funding that goes into acute hospital care as opposed to primary and community care. A lot of what we have spoken about today is around alternative pathways and ensuring that support is available within the community, with appropriate services. We have been talking about people who present with mental health conditions, including children and young people. We know that a lot of the current environment is a result of those services not being in place.

The Darzi review, which the Government commissioned 18 months or so ago, highlighted that acute hospital care spend had increased from 49% to 58% between 2002 and 2021, and the 10-year health plan talks extensively about reversing that shift and having a focus on neighbourhood health. Doing that will not happen, as I have said multiple times. It is about a more fundamental reform in how the service operates, rather than incremental performance changes. It is about being able to take a more radical approach to how we deliver care within the NHS and the types of services that are available. That then would have a knock-on impact on much of what we have discussed today.

Lord Mohammed of Tinsley: I should have said that I have no interests to declare.

Q13 **Baroness Pidgeon:** I just have one small point, and it might be something you can write to us about. The conversation we have been having has been really useful, so thank you all. We talked about older people and social care earlier. A lot of callouts are for older people who

have fallen at home. I know you need to pick them up, check they are okay and whatever, but are there any good examples—you can write to us about them—of places in the country where there is a model that has another team that can deal with those calls? I have seen it over so many years, and it seems to me a waste of that valuable resource, when it is about picking someone up, making sure they have adaptations and getting those in quickly so that they can live safely at home.

Dr John Martin: Up to one in five of our 999 calls are for falls, which is somewhere between 17% and 20%. That is what they come through on the phone as. Sometimes, when you arrive, falls are not just falls, and people can get it wrong—they may have had a stroke and be on the floor, which looks like a fall but it is not. When we arrive, a clinical assessment needs to happen.

In the south-west, we have a number of alternative falls provisions, and people who go and do that. For our own service, we have 600 community first responders, partly because of our rurality. They are volunteers who work in the community. They are primarily set up to go to cardiac arrests, because time makes a real difference in those cases. They can use a defibrillator and are trained lay volunteers. We have started using them for falls, where it is non-injury—where it sounds over the telephone like we just need to get someone up off the floor. If they arrive and speak to the patient and the patient is in pain, we will obviously back them up with a clinician. We are seeing some of that for our local services.

Some of our community services have falls pathways. It goes back to my point about consistency. They are not always available, as they are not there all the time. People fall at all times of day and night and the default tends to be 999.

We can send you something in writing, but there are opportunities here for the group who look like they are low acuity—unlikely to require a paramedic assessment—to have alternative provision.

Baroness Pidgeon: There are some people who fall and you are called out several times a week.

Dr John Martin: Absolutely. Unfortunately, if you start falling, the likelihood is that you will continue to fall, even with all the extra interventions that occupational therapy and physiotherapists will make.

Jason Killens: To build on John's point, community first responders are often used in services in England. In Wales—I know it well because I came from there, after seven years—there is a dedicated falls response service that the ambulance service subcontracts and operates, and an additional role for community welfare responders who support vulnerable patients in communities. There are different models around the UK. The Association of Ambulance Chief Executives can point the committee to those models, if that would be helpful.

Sarah Walter: I want to make the point about prevention in this space as well. We are talking about when people have fallen, but it should be part of a proactive health service that we identify people who are at risk of falls, undertake medication reviews and put in place adaptations to try to prevent falls occurring in the first place. That comes back to the point about primary community services and use of the voluntary sector to get us into a position where we are trying to prevent falls in the first place before they come through as a 999 call.

The Chair: What I am hearing very loudly is that there is lots of good practice going on in different parts of the pathway but no consistency to level up all the services and make connections between the partners within that. It is about having a mechanism to get a national standard properly embedded in the service, not stifling local innovation but using good innovation to improve the service for everyone, rather than within silos around the country. Would that be a fair comment?

Dr John Martin: Yes, it is about consistency. To your inquiry question about support to emergency departments, the variation in the rate of conveyance between ambulance services is 10%. In the south-west, we are the lowest in the country. There is another ambulance service in the country that takes 10% more patients than the emergency department. I suspect that if they were here giving evidence, they would be talking about access to pathways and how it is structured and set up. That variation probably should not be there. We should all be working as hard as we can to avoid ED where that is safe to do so.

Lord Faulkner of Worcester: If I can just add a comment on that. It would be good, too, if the service could perhaps blow its own trumpet a bit more and demonstrate where the good practice is and give examples of it, because we have heard some great evidence from you three this morning.

The Chair: Thank you all very much indeed. Your contribution to the inquiry is a very good start for us. There will be a transcript for you to correct if you think it does not properly reflect what you said, and there will be an opportunity for us to come back to you for further information and clarification if needed. Thank you for your time this morning.