



Public Services Committee

Corrected oral evidence: Ambulance services and A&E capacity

Wednesday 22 April 2026

11 am

Watch the meeting

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

In the absence of Lord Bradley, Baroness Pidgeon was called to the Chair.

Evidence Session No. 2

Heard in Public

Questions 7 - 20

Witnesses

I: Dr Ian Higginson, President, Royal College of Emergency Medicine; Tracy Nicholls, CEO, Royal College of Paramedics; William Pett, Head of Policy, Public Affairs and Research, Healthwatch England.

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Examination of witnesses

Dr Ian Higginson, Tracy Nicholls and William Pett.

Q7 The Chair: Welcome to this session of the Public Services Committee. This is our second oral evidence session on the role of ambulance services in supporting A&E department capacity. I welcome our guests. One is remote and two are here in person. I will start off the questioning, then we will take it in turns to ask further questions and follow-ups. First, can you introduce yourselves and your organisations?

William Pett: Good morning, everyone. I am the head of policy, public affairs and research at Healthwatch England.

Tracy Nicholls: Good morning. I am the chief executive of the Royal College of Paramedics.

Dr Ian Higginson: Good morning. I am currently the president of the Royal College of Emergency Medicine. I work as an emergency physician down in the south-west of England; it is probably worth noting that I also work as a voluntary doctor with the South Western Ambulance Service through BASICS and as a critical care doctor with Cornwall Air Ambulance.

Q8 The Chair: Wonderful. Thank you very much indeed for coming along today. From your organisations' perspectives, what is the current position of ambulance services and emergency departments? How are you seeing pressures and so on change over time?

Tracy Nicholls: We have seen an increase in demand over time. Since 2010, ambulance service demand has gone up by something like 60%. Covid had quite an impact on the ambulance sector and our colleagues in emergency departments. We saw quite a fall-off in demand but, obviously, that was predicated by very sick patients. We were navigating this novel virus and understanding how to continue to do our jobs in that situation.

As we emerged from Covid, 2023 was when we started to see what we would now describe as systemic delays across the ambulance sector. Some of that is because Covid did change society. We saw people who had potentially ignored some of their symptoms through Covid, who had become quite sick and who had not dealt with their medical issues as they would have done if Covid had not been around. That has carried on for us in terms of demand. It is only recently that we have seen demand start to fall slightly. Some of that is policy, driven by the Government; some of it is ambulance services really honing how their operating models work.

However, the demand is still there. The ambulance service in particular is run very hot. We represent paramedics who work not in the ambulance sector but in hospital departments, primary care, military offshore, et cetera. Everyone is feeling that pressure. It seems to be easing slightly, but we cannot afford to be complacent.

The Chair: The evidence we heard last week was that numbers still seem to be going up. When you say that it is easing, is it patients being treated either at home or via the phone that is easing the pressure?

Tracy Nicholls: It is some of that. There are a lot of mechanisms in place. I am sure that Ian will talk about the same-day emergency care system and how hospitals are changing their methodologies for treating patients. From the ambulance service's perspective, it is trying to do a lot more here in the treatment of patients. It is trying to signpost and navigate patients through from their 999 call. There is a lot of work going on that is just holding it together, but it varies from region to region, location to location, hospital to hospital and ambulance trust to ambulance trust.

The Chair: That is very helpful. Ian, can you give us an overview, please?

Dr Ian Higginson: Of course. I will talk about emergency departments. Our speciality over the past 20 years has changed beyond recognition in terms of its development. We are a relatively new speciality: we are only just over 50 years old. The skills that we bring are increasing, and we now have a cadre of highly skilled doctors and nurses available in emergency departments.

However, as far as our emergency departments are concerned, things have been on a downhill trend for the past 10 years or so. Our EDs remain overcrowded and fundamentally under-resourced. We are probably still able to deliver proper care to the sickest patients because we prioritise them. As I say, we can bring considerable skill sets to bear for those patients, but, for patients who fall in the middle—typically elderly, frail patients with complex disease who have something on top of that, which has led to them coming to us—the situation is awful in many departments. I am on record as saying this, and I will keep saying it: where we currently are is a national scandal, to be honest.

From my perspective, we have a precious resource in our emergency care system. It should be the jewel in the crown of the NHS; it was, actually, when I came back from New Zealand 20 years ago. It was a pleasure to help it develop, but it has really degenerated. It is an indictment of what has happened within the political and in leadership.

I can give some headline statistics, just to give you a flavour of that; I can talk in more detail later about the impact on patients and staff for some of your other questions. Back in the late 1990s, there were some 13 million to 15 million attendances. Now, it is 27 million; it has probably doubled. The stats are not easy to understand because of the way in which things are counted, but, when we say “doubled”, that is to the extent of another 14 million or 15 million people coming. That is a lot of people. Resourcing simply has not kept pace with demand, whether we are talking about EDs, hospitals or the other bits of the system that keep things going. We also have a very low bed base.

On overcrowding, in 2025, 1.7 million patients waited more than 12 hours in our departments, and 500,000 waited more than 24 hours. Many of those will have been elderly or suffering from, for instance, mental health problems. That is an extraordinary number of patients. One in five patients, in a snap study released this year, was treated in escalation areas such as corridors. Importantly, in 2024—we are working on the 2025 data—something like 16,000 patients in England died in association with long waits in emergency departments.

Frankly, I remain completely baffled as to why this awful statistic is not talked about more. My feeling is that politicians tend to talk about it when they are in opposition rather than when they are in government, sadly. In any other sector—or, indeed, any other part of the NHS—this would be regarded as an unmitigated disaster, and we would see proper accountability, but this just does not seem to cut through. It seems to be accepted as normal, though I cannot accept it as such. I am really pleased to be able to talk about it with you today.

The Chair: William, do you want to come in from the patient perspective and on the work that you do?

William Pett: There are too many acronyms in the NHS, but I am going to talk about the four Ds that summarise the patient feedback we receive on urgent and emergency care.

The first D is delays. It is welcome that category 1 ambulance times have stabilised and have started to see some modest declines in recent years. The NHS was also extremely close to hitting its headline urgent and emergency care progress targets in March, but it has now been five years since most constitutional ambulance targets were hit. There is significant variation by postcode and there are often delays to each part of a patient's journey, from waiting for the ambulance and getting handed over to a hospital to waiting for a bed once they get to A&E and being discharged. We hear from patients across England about the impact of these long waits. One person told Healthwatch Nottingham and Nottinghamshire, "At 10.15 pm, my wife's replacement hip popped out, leaving her in agony. I called an ambulance. It came at about 7 am. A nearly 75 year-old lady was left in agony for more than eight hours. This is unacceptable".

The second D is decisions. In your evidence session last week, you heard that, although ambulance services will inform a 999 caller when they are under periods of particular pressure, they are unable to give specifics on how long the wait for an ambulance might be. So alongside the long waits are the often impossible decisions that patients face about whether to wait for an ambulance or to self-convey. One person told Healthwatch Staffordshire about their experience of driving to hospital themselves due to long delays: "I had a nightmare journey to hospital in rush hour, believing that my father was having a heart attack. I had to watch for him losing consciousness as I had been told he may need CPR".

The third D is disarray. We know from our feedback that busy and chaotic waiting areas, particularly in A&E, cause discomfort and distress. Healthwatch Cumberland, for example, recently reported that a man took his mother to A&E and was appalled by the conditions. There were not enough seats for all the patients. It felt cramped and there was no ventilation. They left after waiting for a few hours, having not managed to be seen by anyone. Other common concerns that we hear about in A&E include lack of access to basics, such as food, water and pain relief. We hear about unclean facilities and people feeling unable to pop out for air for fear of missing being called by staff. These issues are, of course, particularly problematic for people who present to A&E in mental health crisis; I hope that we will return to that subject later.

The fourth and final D is arguably the most important: dedication. Despite all the challenges I have just outlined, a golden thread runs through all the feedback that we receive on urgent and emergency care. It is the incredible commitment and professionalism that NHS staff demonstrate every single day. This dedication does not go unnoticed. We hear about plenty of problems from patients, but around a third of the feedback we receive is positive and even the negative feedback often highlights the amazing job that staff do under significant pressure. One person told Healthwatch Leicestershire that they received a fantastic service when their husband had a seizure: "The paramedics were reassuring, calm and supportive in what was a stressful situation. They even made me laugh". I hope that I can elaborate on those four Ds a bit more in this session today.

Q9 Lord Mott: I am conscious of the stats you gave, Ian, in terms of 27 million patients presenting to A&E. Do you have any breakdown within that 27 million on what I would call repeat patients? Are they 27 million individual patients or is a proportion of them referred to A&E on a regular basis, suggesting that there are other issues at play there?

Dr Ian Higginson: I do not have the statistics for you to hand but we know that there is a small group of patients who will return to emergency departments on multiple occasions. There are various acronyms used to describe that group of individuals but they tend, on the whole, to be very vulnerable individuals, often with a number of chronic health conditions. It is possible to have an impact on this group of people. The current terminology tends to be "high-intensity users of services".

There will be another group who attend less frequently, often as a result of a disease or disease progression. Then there is another group who attend infrequently. You hear that the majority of the UK population will come through an emergency department at some stage every few years, either as a family member or as a patient. So emergency departments are a common experience for a large percentage of the population. For a smaller percentage of the population, they are a very common experience.

I am sure that you are not doing so, but I would not be blaming the increase on that relatively small group of patients, although they tend to have a relatively high impact where they present repeatedly.

Baroness O'Neill of Bexley: I come from the background of having been a council leader until last November. The conversations that I had regularly with the local NHS were more about discharges than about people at the front door. If people did not present to start off with, you would not be discharging them in the end. The reality was that I was quite interested in the sorts of things that you have said there, especially around that number. Does the number that you quoted include the urgent care centres or urgent treatment centres as well, which would perhaps be dealt with in a different way to A&E?

Dr Ian Higginson: Yes. To keep that stat consistent, because of how it has been counted over the years, I use the total number of attendances—27 million in total. If you keep it to type 1 attendances, currently there are approximately 17 million a year. Type 1 attendances would be patients who are attending major emergency departments and not urgent treatment centres. In the old days—10 or 15 years ago—all these patients would have attended the same department, but now there is such an array of alternative settings that it has become much harder to count them.

Q10 **Baroness Nichols of Selby:** Ian, I was really interested in your comment that you came back from New Zealand 20 years ago and things have changed so much. Is this about the impact on the other parts of the NHS—GPs, et cetera? Their contracts have changed, they do not do emergency callouts any more, none of them is on call. Could that potentially have an impact on what is happening in A&E? In my area, people tend to go up to the emergency unit when they could be dealt with in another way, but that service is not there any more.

Dr Ian Higginson: Yes, but no—this is a complex problem. I used to be a GP in another life; I used to do home visits and was on call for my local population. It was very rewarding and valuable. The problem of overcrowding—the long-wait problem—paradoxically is not linked to what comes in at the front door. One of the unfortunate things is that most of the solutions that people instantly go to are aimed at the front door. The answer is often, “Well, let’s reduce the demand”.

Patients who come in with a sore throat, a cough or something relatively less serious do not need to come into hospital. They are not the ones in our corridors or who are suffering from this increased mortality rate. The problem is essentially one of a failure to keep up with the times—a failure to invest in the health service, particularly around how our hospitals work and how we can support patients to leave hospital once they are ready to do so in the community and social care sector. We also have a smaller bed base in our hospitals than most other comparator countries.

The problem that we face in our emergency departments is getting patients who need to be in a hospital bed into those beds. Those are the

patients who lead to overcrowding. Regrettably, this is a difficult strategic problem that requires thought and investment; it will require cross-party collaboration and long-term investment. It is often in the “too hard” basket. People tend to look at the easier stuff and go for demand management. That will not solve the problem that we face.

We are gradually trying to bring politicians and other leaders with us, to say, “We’ve got to do all that stuff at the front door, it’s important, it’s all about improving quality of care”, but it will not fix the problem that I am describing. As we will go into later, I am sure, the problem of full hospitals and overcrowded emergency departments will then have a knock-on effect on the ambulance service.

Baroness Nichols of Selby: This is probably for all three of you and I probably know the answer to it in certain areas. How resilient is the urgent and emergency care system?

Tracy Nicholls: I would not use “resilient”. I would use “fragile”. Resilience for me is where a system can cope with seasonal variation influxes such as major incidents or epidemiological issues, where it can bounce back quickly, where there is no cascade failure. The ED is overcrowded; therefore, the ambulance is delayed; therefore, the patient in the community cannot get an ambulance; therefore, harm is coming to the patients in the corridor and response times flounder.

If it was resilient, you would not see that whole cascade that we have seen for years. It is not my role to build the resilience but, as Will alluded to, the efforts of the staff who work in all these different points is, quite frankly, heroic at times. You cannot rely on those people to keep a system going. It takes other input.

William Pett: I consider a resilient system to be one where patients get good and timely care even when that system is under severe pressure. As we look ahead, how effectively the system can eradicate corridor care over the coming months will be an important litmus test on how resilient the system is.

Our evidence points to patients waiting as long as 28 hours in an ambulance, as long as 40 hours in a corridor and just sitting for many hours before they are even triaged. The statistics nationally bear this out. There were nearly 47,000 waits of more than 12 hours from decision to admit reported in March 2026. Encouragingly, this is down from over 70,000 in January, but we are still talking about a significant number of patients. Our core message, fundamentally, is that corridor care must be treated as a failure of care—a failure of dignity and safety, not a reasonable response to pressure.

We are somewhat reassured that the Government seem to understand this. It is welcome that NHS England guidance sets clear expectations on privacy, communication and clinical oversight, and we welcome that there will be publication of national data on corridor care from next month. However, this is long overdue.

Dr Ian Higginson: I wrote, "It depends how you define resilience". To some extent, I am with Tracy. The system already does not provide reliable, high-quality emergency care for many of our patients. You could say that it has already fallen off and demonstrated that it does not have resilience. We are running the system much too hot for it to have resilience in it.

There are a couple of facts to back that up. A ~~???~~UNCORKED study earlier this year showed that, at a spot time, between 10% and 25% of departments had no available resus bed. You want to keep at least one of those beds free—I try to do it all the time when I am on duty—for the next really sick patients and not have to juggle beds whenever someone comes in who is in cardiac arrest or critically ill.

There was another paper by a group that showed that only 9.5% of departments which were surveyed felt that they could clear their ED if faced with a major incident. Only 15% were confident that their ED could respond to a major incident in current, overcrowded times.

I would like to talk about our staff here, under resilience. They have shown incredible resilience. It is good to see that reflected in the comments from our colleague from Healthwatch England. However, progressive overcrowding and chronic underresourcing has left a high proportion experiencing burn-out. Already something like 30% of our trainees and something like 25% of their trainers in a GMC survey showed hard signs of burnout.

Also, 97% of EM leaders who we surveyed prior to another committee hearing in March felt that things were unsustainable in the long-term. That is due to the overcrowding and underresourcing, but increasing violence, aggression and racism are adding to that burden, along with a strong sense that our staff feel undervalued compared with other groups. There is a myth that they are expected to put up with conditions that no other staff group in our health system would be expected to put up with. Imagine asking a surgeon to operate on one patient, on the next one before he has finished and then to look at the one in his anaesthetic room and, while he is at it, do this—with the wrong nurses and patients unable to leave the operating theatre. It simply would not be tolerated, yet we tolerate it in our emergency departments.

Our staff have shown incredible resilience, but I am not sure how long that can continue. We are seeing experienced nursing staff leave for more sustainable work, so we are losing a lot of our experienced nurses. Our resident doctors are going to Australasia, where they feel more valued. Our senior doctors are going to Australasia, the Middle East, Ireland and Canada. At times it is amazing that our services are still standing. It is frustrating for me to see these brilliant people ground down with these emerging problems that we are talking about. I really worry about the resilience of our staff. The cracks are more than starting to show. We must be very careful to look after our emergency care system, or we will not have the staff to look after us when we are critically ill.

Q11 **Baroness Coffey:** I think I met Dr Higginson once when I was Secretary of State for Health. Hopefully he will remember that I insisted that we kept the four-hour metric instead of whatever NHS England was recommending.

I have two questions linking Dr Higginson and Ms Nicholls. The *HSJ* article said that it had identified data internal to the NHS that 50% of conveyances to A&E did not need major care and were not transferred to other sites. At the same time, I want to get a sense, in particular from Tracy, of the relationship between 111 and 999 and whether there are any changes there. I may be wrong and am happy to be corrected, but my understanding is that if 111 says that an ambulance has to go, that cannot be challenged by the Hear and Treat or See and Treat. I wanted to get a sense of that, as our main focus is on how we make the best use of resources to reduce the pressure on A&E.

Tracy Nicholls: Thank you for that really astute question. Paramedics tend to convey around 47% to 50% of the patients who dial 999. Of those patients whom they can find no alternative care pathway for, some do end up at ED as a default destination rather than the right destination. We may cover that later, so I will not go into that in detail.

The relationship between 111 and 999 is dependent. You heard last week from John that not all service providers have a 111 and a 999 system. Where they are joined—where they are co-located—they have better success at not sending an ambulance, but there is a “warm transfer” with 111. If you meet certain criteria on the algorithm and there is no clinician overseeing that 111 call, an ambulance is sent. Paramedics feel a sense of despair sometimes going to 111 calls because they do not know what is going to be at the end of it. It is probably not as acute as with someone whom they know is waiting in the 999 queue. I hope that answers the question.

Baroness Coffey: Would you like to see any changes to the process that is allowed for the individual ambulance service to be able to follow up further?

Tracy Nicholls: I would certainly like to see the integration of those systems. There was a 111 review some time ago. I have never seen the output of that, but I would like to see it. There is much more that can be done in that space.

Baroness Coffey: Does Dr Higginson have any thoughts about the percentage that the *HSJ* revealed in that regard? The NHS is very proud that it had fewer beds for a while because it was saying that it could get people out on the same day after having an operation—that they did not need to stay overnight. However, I understand your point about issues of discharge with social care involvement.

Dr Ian Higginson: Steering away from bed availability and the question around this, it is very hard for us to say because we receive the patients. You cannot use the data that we have access to—acuity data, whether a

patient ended up being admitted or their diagnosis—to tell you that. You could be critically ill having an epileptic seizure and be leaving our departments four hours later having recovered from that seizure, or you could have a broken ankle and end up needing to come into hospital with it. It is very hard data for us to interpret.

Anecdotally, however, we know that our patients are often very frustrated, both ways. They are frustrated sometimes that they are sent an ambulance when they felt that they did not need one and were just trying to get to the right place. They called 111 and ended up getting an ambulance. Also, the data will be skewed by many of them now having such long waits for ambulance that they come in cars.

However, there are groups of patients who clearly could be better served by not coming to hospital for whom ambulances are commonly called. Tracy will know this much better than me, but the ones who spring to mind for me are those nearing the end of their life and often already on established pathways, patients who could be treated at home or in alternative environments if the right stuff was there, with the right capacity, when you need it and with it being easy to get hold of.

Finally, patients with mental health problems are often brought to the emergency department. It is not the right place for them either. We certainly do not get it right. More could be done out there. Focusing on that as the solution for ED overcrowding is the right thing to do but it will not solve the problems that we face, which then have that knock-on effect back on the ambulance service.

Q12 **Baroness Watkins of Tavistock:** I need to declare that I am a fellow of the Royal College of Nursing and I chaired the paramedic grandfathering years ago. I want to come back on the major accident issue, Dr Higginson. It used to be common for people to rehearse major accidents. Have we stopped doing that? Would it expose the extent of the problem that you referred to?

Dr Ian Higginson: I cannot give you a fact-based answer on this. My feeling is that we are rehearsing for major incidents much less, for lots of reasons. Our departments are now so rammed, and everyone is so rushed off their feet, that finding the time to train and the space to run these exercises is proving difficult. This is something that I want to investigate further as part of my presidency. It is one of the priorities that we are going to start working: where are we with our EPRR work? Are departments are prepared as they should be?

In the current context, you will be aware of the warnings that we have had about the potential for conflict in Europe, but also the climate crisis and the increasing number of incidents that we are seeing for that and the potential for a future pandemic. All that comes together for me as the need for a system that is able to deal with all these challenges. Although I cannot give you hard data to back this up, I am not convinced that we are in a state where we can say that we are ready for anything. We are

currently under such a level of stress that we are not where we should be in this particular area.

Q13 **Baroness Shawcross-Wolfson:** I do not have any conflicts to declare. I was really struck last week by Jason Killens telling us that, 30 years ago, ambulances were largely seen as a transportation service and that this had changed immeasurably. We have heard a little bit today already about how fewer than 50% of people who call for an ambulance ended up being taken to hospital. Can you dig in a little bit to what patients feel about that, patient expectations when they call 999, and the degree to which people are happy with See and Treat and Hear and Treat? As the ambulance service evolves to patients understanding expectations and experiences of the ambulance service, how is that tracking as the service itself is changing?

Tracy Nicholls: It is an interesting question, and I am sure Will has a lot to say on it as well. The difficulty when you turn up in an ambulance is that some members of the public think that you will have a look at them, do a clinical assessment, make a diagnosis and convey them somewhere. That is why some of those early conversations through the operations centre in the ambulance services are key. Some people genuinely do not know what they want. They are anxious. They are frightened. It is their worst day, their worst evening. They, their family or their loved ones are unwell. They have seen something happen in public and just want someone there to be able to navigate through that crisis in the moment. The paramedics and ambulance clinicians are highly skilled in having a conversation with patients and saying, "We think you can be treated at home. If we make some arrangements through your GP practice or through services that are local to you, you can be seen there". They describe the alternative, which is that there is at least a four, five or six-hour delay at hospital. You will be waiting with everybody else. Particularly if you are an elderly patient or a young person, that is not the place you want to be, as Ian has alluded to, certainly not when you are in palliative care at the end of your life. There are lots of avenues that we explore, both on the phone and when you are face to face with patients about what is right and acceptable for them. Some patients will insist on coming to hospital and that is a difficult conversation, but the paramedics are suitably skilled to have those conversations.

William Pett: Your question requires clinical judgment, and I do not want to exceed my remit too much on that front. But some of the evidence that we hear tells us that the public highly trusts and has high confidence in paramedics. We hear that consistently. They value ambulance staff but are often not getting the best overall experience, due to A&E pressures. Therefore, enabling paramedics to provide more direct care without the need to convey patients to A&E is something that patients would welcome.

Dr Ian Higginson: I have little more to add except the broken record that trying to do all the alternative stuff is brilliant and is what patients want, but it will not solve the problem of our full hospitals. The other thing is that the optimal role of ambulance services is to respond to

emergencies. Ambulances bring paramedics who are highly skilled professionals in dealing with emergencies. Their role is not to make up for failings and deficiencies elsewhere in the system. That, sadly, is happening too much. Whether those deficiencies are around general practice, as you have already eloquently described at times, dentistry, mental health services, social care or end-of-life care, Tracy would agree that a lot of the time emergency ambulances are being used to deal with urgent care rather than necessarily emergency care. What the majority of them are really for is emergency care. That is what they were set up to do. That is one of the big changes we have seen over the last period.

Baroness Shawcross-Wolfson: That is helpful. I am keen to push on what the service is for and the degree to which we heard about paramedics getting increasingly skilled, having high-level practitioners, and people who can prescribe. That suggests that ambulance services are being used to provide more care in the community. This is a really interesting question. Is that what we think ambulances should be doing versus the old model of having transportation to hospital in any emergency? Is that what we should be going back to? I should love to hear your views on that.

Tracy Nicholls: It is classed as an essential service. It is not an emergency service and is funded as an essential service, but it is considered as one of the three emergency services—fire, police and ambulances. That is well embedded in in people’s psyche. However, the ambulance sector in itself has always been there for emergencies. As Ian has alluded to, society has changed. The health and care system has changed. Paramedics have developed into this sort of catch-all: catching the unmet need, catching people who are in underserved communities, and they have had to develop around that. But those paramedics who do not work in the ambulance service support primary and urgent care through virtual wards, through same-day emergency centres, et cetera. They have a more defined role but if you are in the ambulance service, you are suddenly trying to do everything. I do not see that changing any time soon. It is better, but if you have ruled out there being a life-threatening emergency, then what? If you have ruled out that someone does not need to go to hospital because there is something like a heart attack, a stroke, fitting, then what? We are just layering what the professionals can do in that space.

Q14 **Baroness Hollins:** I should say that I have been a psychiatrist and a GP in my past life, and a family carer. I am interested in the public understanding of the role. It is a bit confusing if you are providing urgent care, which perhaps other people might be expected to be providing, and you are providing an emergency service. There is room for a huge amount of confusion among the public as to exactly what they are doing when they call 999. For example, when my husband was dying, and the first time we thought he might be dying, the GP insisted on calling an ambulance. It did not come, so it was self-conveyance and a 12-hour wait. It was a disaster. Next time, we were told to dial 999. We did not want to. But, actually, it might have been quite a good idea because he

was dying. We just wanted somebody to be there who might have been able to do something. Do you see what I mean?

I suppose what I am interested in is: what kind of role do paramedics find themselves playing at the end of life when somebody wants to stay at home but they might need a little extra help, and there are no community services available to do that because there is a lack of co-ordination, poor commissioning or whatever? How, from the paramedic point of view, do you deal with end-of-life issues? It sounds like an awful lot of people end up being whisked off to hospital in an ambulance, then die in an ambulance or A&E, when really they wanted to die at home.

Tracy Nicholls: First, can I say how sorry I am to hear about your husband?

Baroness Hollins: He died peacefully and it was lovely.

Tracy Nicholls: On end-of-life care, I know a lot of paramedics and do not know one paramedic who would want an end-of-life care patient going to hospital. They will do everything in their power to keep that patient at home. They will look at the documentation and [RespectSPECT](#) forms.¹ They will speak to the families if they can. Sometimes, it is the family's concern that the ambulance is called and arrives because, despite all the brilliant work that the Macmillan nurses and Marie Curie do, sometimes just that moment renders people paralysed. So, if we arrive, a lot of the time is used to sort out what is required: what is the situation? How can we help? How can we do our utmost to keep that patient at home? How can we console the family? This goes to your point about that not being a traditional paramedic role, but our role is to help people through their crisis.

Baroness Hollins: That is the bit that I do not think people understand—and I did not understand, actually. If I dialled 999, I did not want him whisked away. Do you see? I think there is a confusion about the role, which is really important.

Tracy Nicholls: People do end up in EDs, as I am sure Ian will attest to, but that will probably mean that everything else has been exhausted. There may be something that the paramedic maybe cannot prescribe or administer to the patient, or something may be distressing them at the end of their life.

Baroness Hollins: That point about needing to broaden the range of things that you can prescribe seems quite important.

Q15 **Lord Mohammed of Tinsley:** I need to declare that my son is a paramedic with the Yorkshire Ambulance Service in Sheffield, and I do not know whether he has taken part in any of the surveys you have asked for. My question is around how appropriate the targets are currently, what effect they have on the services that you provide and how

¹ [Note from witness: ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment.](#)

that affects feedback to Healthwatch. The supplementary to that would be: what would you want changed?

Tracy Nicholls: There is no doubt that time targets have saved lives and continue to do so. But we have to recognise that in some cases they have also caused unintentional harm. Time targets sit at a faultline between improving care and distorting it. Where time targets are really helpful is where they guard against dangerous delay, where a patient's condition—cardiac arrest, choking, et cetera—is such that any delay would be absolutely deleterious to their health. But the time targets must be really closely linked to clinical benefit.

There has to be clinical benefit as to why you have put that time target there and that sits alongside the experience and outcomes that Will has probably seen through his work. They fail when they become proxies of quality. If you get to someone in time, the care you give is equally important. The time target should not override professional judgment because you may have a category 1 call, which is deemed to be immediately life-threatening. You get to the patient. It turns out it is not immediately life threatening. You cannot judge a paramedic on the fact that they do not convey that patient to hospital, even though it was a category 1. Their clinical judgment is such that they have exercised it. Time targets can lock the ambulance sector into a defined transportation role. They are an easy headline and are easy to measure but it is not the whole space. For me, a blended time target plus measuring paramedics on how well they treat people in their place is important. Do people recontact health and care within 24, 48 or 72 hours? What is their experience and, importantly, what is their clinical outcome? Paramedics never get to know what has happened to their patients. How do we learn from that?

Lord Mohammed of Tinsley: We heard last week of exactly the same the outcome. It is important for staff morale as well that they went and did everything possible—and then not necessarily knowing, once the patient enters the emergency department, what has happened to them.

William Pett: Tracy outlined some important caveats to this but I should say that, from a patient perspective, targets are important because they set out what the public should expect from the services that they fund. They help to stop unsafe waits becoming normalised. They are simple and easy for patients to understand, although I appreciate the points that Tracy has made. Our evidence is full of stories showing why long delays cannot be accepted as business as usual.

I should say, however, that targets must be complemented by measures that capture some of the issues that patients really care about: issues around privacy, dignity or communication. Those will not be captured by time-based performance targets. The Government have committed in their neighbourhood health framework to reforming patient-reported experience and outcome measures. Having these for emergency pathways could potentially be helpful. They could allow us to capture more real-time information about how patients are experiencing services

and their outcomes, rather than just what we have at the moment, which is a large-scale patient survey repeated every two years.

The last thing I should say is that we specialise in qualitative evidence, and members of the committee will be aware that there is reform at the moment to Healthwatch and how we collect patient experience in the future. I hope that, in the new world, qualitative evidence will be valued because it is going to be essential to have mechanisms for patients to tell their own stories and give their views in their own words.

Dr Ian Higginson: This has been a rich discussion and I agree with everything that has been said, particularly about the link between process and outcome-based targets. With one exception in this domain, we do not need more targets, just the right solutions focused on achieving the current ones. The other thing that has not been mentioned around time-based targets is that they can be gamed, or you can try and achieve them in the wrong way. An example of this is around the ambulance service's efforts to meet its response-time targets. You may be aware of rapid release protocols. W45 is one of the common acronyms whereby patients can be moved from ambulances into overcrowded emergency departments at a defined time in order to free up ambulance capacity. In our survey in March, two-thirds of our clinical leaders reported that that policy has indeed reduced ambulance waits, which looks good on paper and then makes for good optics and press releases, but has actually increased overcrowding in emergency departments. We have shifted the problem from one part of the sector to another.

The other thing I should like to highlight on this is that we know that improving handover times at hospitals—the delay from once ambulances have arrived to being able to bring the patient in—makes a contribution towards achieving response-time targets, which can be and are important for patients and, at times, for outcome. We know, however, that the way in which to do that is to reduce overcrowding in our emergency departments. The most pertinent target relating to that is the four-hour standard, which, as we have already heard, has not been achieved for a number of years. If the four-hour standard—a constitutional standard—was achieved, we would not have overcrowding in the majority of departments.

That standard is directly linked to occupancy in hospitals. If you were to ask whether there is one standard or target that you might think about focusing on in order to improve overcrowding in emergency departments, our ability to stop holding patients in ambulances and our ability to free up ambulances to get out there to patients—and everything else we have talked about—it would be on hospital occupancy. We wonder whether we should be thinking about defining an accepted standard for hospital occupancy for people to shoot for. It is probably going to be around 85% if we did that. We currently sit up in the low 90s on average in the UK. That is behind many of the problems we see. That is the only new target we would really want to see. We would much rather be focusing on getting to grips with the old targets that we used to achieve. When that

happened, the whole system that we are talking about worked much better for patients. For staff, it was a much better place to work in as well.

- Q16 **Lord Mott:** I just want to put on record that I have no interest to declare in this inquiry. I aim this question initially to you, Tracy, but Ian and William can come in, too. We have touched upon parts of this, anyway. What proportion of patients conveyed to emergency departments by ambulances do you believe are best treated in this way? How appropriate is the emergency department environment for people experiencing mental health crisis?

Tracy Nicholls: To answer your second question first, it is not. An ED is the worst place to experience a mental health crisis. I am sure Ian would agree with that. As I alluded to with Baroness Coffey, the ambulance service will not convey around 47% to 50% from the 999 call. Some of the recent studies—Ian, you may have more current data—show that one in five of patients who are brought in walks away with no treatment whatever. But that does not tell the story of why they had to come to the ED. What was not in place in the community that made the paramedics take them to the ED?

If you are an elderly patient—particularly if you are alone—a child or young person having a mental health crisis, or if you have any sort of mental health issue, ED is not the place for you, currently. We have seen so many cuts in other areas of the service. Right Care, Right Person has had an impact on where mental health patients go. Mental health is a health issue but some mental health services have been drastically cut. There is nowhere specifically to go. There used to be Section 136 suites. There used to be places where you could take mental health patients. Paramedics are talking some people down from an acute situation. People may be seriously planning to take their own lives at that time. There absolutely are alternatives to ED but, if you are on a four-day bank holiday or it is Friday at 11 pm, Ian and the ambulance sector are the only two organisations that are working 24/7.

William Pett: Perhaps I may add some comments, particularly on the second part of your question. For patients who are attending A&E with a mental health condition, we know that long waits and chaotic environments simply increase agitation and distress. We have heard from patients reporting mental health conditions who describe typical A&E departments as “horrible and off-putting”. Those are some of the words used. Healthwatch England co-chaired one of the working groups to inform the 10-year plan, particularly on access. We highlighted the need for better emergency support for people in mental health crisis, and were pleased that this led to the announcement of dedicated mental health emergency departments co-located within typical EDs. However, there are structural issues to iron out here, which Ian has alluded to.

We know that among admitted patients, people with mental health complaints generally wait for longer—from decision to admit and then eventually to be admitted. We know that the waits there are due to beds

not being available in mental health wards, which in turn is due to patients having specific housing needs or social care services not being available. Mental health emergency departments might potentially improve the conditions within which mental health patients are waiting for the care that they need, but it will not improve the waits and the waiting times for those patients, as Ian has described.

Dr Ian Higginson: We covered the first part of the question earlier: it is hard to say who would have been best treated on the datasets that we have, although the anecdote is all there. Regarding mental health, the ED is clearly not the right place to come for patients who are experiencing a mental health crisis and have no medical problems that need emergency treatment. It must not be forgotten that some patients will present to us having taken, for instance, an overdose or with some self-inflicted trauma, who need medical treatment. However, for patients with mental health problems, we are not the right place. We would love to be the right place. These are a significant proportion of our patients, and we are trained to deal with them.

In 2025, around 27.6% of patients with mental health problems waited 12 hours or longer. That is more than three times the incidence for other patients. This group suffer more than other groups from long waits. Over the same period, 10% of all patients with mental health problems waited over 24 hours in our departments. That is largely because of inadequate services being available for them to be assessed—particularly those waiting for Mental Health Act assessment or mental health beds.

I invite the committee also to consider adolescents with mental health problems. This group is particularly poorly served. We are seeing an enormous increase in the number of children who we are now starting to term “abandoned children”, which tells you how bad it is, who end up in our departments for days because no one will pick up responsibility for their care—or those facilities are not available to them. The poor patients are caught in the middle of arguments about social care or psychiatric care and left in our departments.

Why are we the wrong place? It is not because we are horrible people. You have heard already that our staff are gifted professionals who care deeply about these patients, but these are brightly lit, busy, noisy and confusing environments that are designed for patients with physical illness rather than mental health problems. Our staff are often unable to give the time and space to very distressed patients who are stuck with us.

There are additional problems. The recent HSSIB interim report suggested that the right legal frameworks are not in place. I completely agree with Tracy that Right Care, Right Person has increased pressure on the ED and the ambulance services, because the police have rightly said, “We are not the right people to deal with the needs of these patients either”. That has happened in the absence of saying, “If the police aren’t, who is?” and these patients defaulting to our services as well.

This group of patients need particular attention. I am sure that my colleagues from other royal colleges would agree, particularly those from the Royal College of Psychiatrists and the Royal College of Paediatrics and Child Health.

The Chair: There are lots of people who want to come in on this before I move on—Baroness Hollins, Baroness Coffey and then Lord Mohammed.

Baroness Hollins: I have two points. First, I would be worried if an emergency service saw itself as concerned only with physical health, given that mental and physical health are supposed to have parity, if part of it is about helping people to find the right service.

Secondly, and key, there is the risk of diagnostic overshadowing, if somebody's presentation is of a mental health or behavioural disorder but they also have concurrent physical health problems. For example, there is the amount of cardiovascular disease in people with severe depression, diabetes in schizophrenia or psychosis, or drug-related issues. These cause difficulties which are not due to self-harm but are related to the mental health condition. People with autism or learning disability may find the emergency department extraordinarily difficult yet have an undiagnosed physical health condition. It is about the skills and preparedness of an emergency service which must cover the whole range of patient need.

Dr Ian Higginson: I would not have wished in any way to imply that our departments do not regard patients with mental health problems as being part of our core business. It is a fundamental part of emergency medicine practice and something that we do very well. What we do particularly well is the management of either co-existent physical illness or occult physical illness. That is what makes this group of patients a really challenging group but at times a very rewarding group to deal with, because we can manage both their physical problems or their mental health problems and at the same time work out what is going on.

The issue for our patients is that, once we have sorted all that out, we are not the right place for them to end up for long waits of 12 hours, 24 hours or days at a time. These are not the right places for these patients, who predominantly in their long waits are waiting for mental health assessments. The terminology is "medically fit" or "medically clear". That is when we are happy that we have dealt with all the co-existing stuff and worked out the diagnostic dilemmas that you describe. Those patients who are left with a need to be assessed by mental health services or onward care are the ones who are particularly poorly served.

Baroness Coffey: I want to move away from the mental health side to talk about Hear and Treat and See and Treat. I have one question for Healthwatch England specifically. You mentioned qualitative evidence, but have you done any research about patients' experiences and satisfaction? If you have, could you share that?

My second question, for Tracy, is probably a bit more detailed. Thank you

for the written evidence that you put in. I do not know if they are called advanced care practitioners or clinical critical care practitioners, but I mean people who have done the master's level. It is not straightforward. I have not been able to find information from an ambulance trust. Have you got any correlation or causality evidence that this helps with the Hear and Treat, in order to appropriately reduce conveyance? I have a question about skills which may come up later, but I wanted to get a sense of that first.

William Pett: I am happy to start with the first question. I do not have to hand direct experiences from patients on Hear and Treat and See and Treat. Generally across our feedback we hear about fairly high levels of trust and confidence in NHS staff and paramedics. That lends itself to a belief that generally patients are happy to be treated in those ways. However, I do not have those experiences to hand. I will analyse our database and get something a little bit more concrete sent over to you and the committee, if that is helpful.

Tracy Nicholls: The career framework for paramedics is that from paramedic you go to specialist or enhanced paramedic and then advanced paramedic, which is, as you rightly say, Baroness Coffey, through master's-level education, and consultant paramedic. This is within our scope of practice—not trying to be doctors, so let us not get into that argument.

Similar to if Ian and his department were putting senior clinicians nearer the front door, you would see a different set of decision-making if you had not got that there. The ambulance services will have that data. I will ask on your behalf, Baroness Coffey, for that data. The royal college does not have that data. They have much more experience, much more skill and have done a lot of education and training to support the area of work that they are in—which might be in the operations centre, might be out on the road and might be supporting mental health.

For example, if I draw Yorkshire Ambulance Service in as an example, it has advanced paramedics working on a mental health service for patients where there is a group of multidisciplinary clinicians who go out and support those mental health patients in a very different way. The crews can call them from scene. It gives that specialist knowledge of that entire team to be able to support that patient.

Baroness Coffey: Would that sort of thing cover Hear and Treat or See and Treat? Is that how the mental health response you have just mentioned would get categorised?

Tracy Nicholls: Yes, sometimes it comes through from a phone call and they determine in the control centre through discussion with either a mental health professional that some ambulance services have in their operations centre or through a senior clinician like an advanced paramedic, who would say, "I think this is for the mental health team. Let's send them out." Once you have sent crews, you are losing

productivity and efficiency, and you need to send the right clinician to the right patient at the right time.

Lord Mohammed of Tinsley: I want to go back to Ian. I know some ambulance services often operate a 45-minute rapid release in trying to hit their targets. I was particularly concerned around how that would impact if that was a mental health patient, and whether that is the sort of target that we would not want because it ticks the box for the ambulance service but creates huge problems, particularly if it is a mental health patient. Do we have any data on how many rapid releases have taken place when it is a mental health patient? If that is not available, is there any chance, Tracy, you or others in Healthwatch could get that information because I would be really interested in it?

Dr Ian Higginson: I am sorry to say that I do not have data around that. I should reiterate that rapid release protocols are the sort of thing that make sense on the face of it and are invariably well intended because they are simply designed to release ambulance crews to respond to emergencies in the community. There is nothing worse for me as an emergency department consultant in charge of a department than when I hear every radio go off among the paramedics in the department for what is called a general broadcast, saying, "Any ambulances available to attend a category 1 in X?" I know they are all in my department stacked up outside. So we all share the common thing. But as I suggested, the flaw with this idea is that many of the policies were introduced according to our two surveys of our clinical leads in a perhaps less collaborative fashion than might have been desirable. The changes that were required to support them at the back end of the hospital were not implemented. Essentially, what has happened in many departments is that, when these protocols are enacted, it is always because the system is under stress. It can make overcrowding worse in departments at the same time as releasing ambulances.

The difficulty is that we do not know where the greatest harm is. If you are having a cardiac arrest or there is a major emergency in the community, you are at risk. But those 16,000 patients who die are, we believe, in excess of what would be expected in association with long waits. We genuinely do not know if these patients are coming to harm because they are waiting for ambulances, or they are waiting in our car parks, or they are waiting in our emergency departments, or because they end up staying in hospital too long as a result of all this, or because the hospitals are not functioning well enough and that is what is causing the problem in the first place. We just know that this whole system is not working well and patients are coming to harm as a result. That particular protocol is just getting at one bit of the problem without trying to solve the rest of it.

Q17 **Baroness O'Neill of Bexley:** I have no declarations to tell you of, but I want to explore the avenue of whether there are sufficient alternative care pathways and interventions available for the ambulance service and the paramedics to use. Where there are, do they have problems

accessing them? Do you think—this probably will be for you, Tracy—that the ambulance services, their knowledge and expertise are used in commissioning services for healthcare?

Tracy Nicholls: The honest answer is no. There are not enough alternative care pathways. There are not the right ones, and they are not available at the appropriate times when patients need them most. In our survey—literally for five days, we opened a survey prior to me coming here—we had over 880 respondents. Some 75% of those described the lack of alternative services as one of their biggest frustrations. As I said before, if you are coming up to a four-day bank holiday or just a normal weekend, it is our view that patients suffer in that time, because the alternative then is about what you do with that patient. You have to be absolutely sure as a paramedic, as an ambulance clinician, that leaving that patient at home is safe. Otherwise, you have no alternative but to take them to ED or same-day emergency care somewhere that probably is not as appropriate. But to leave them at home is less appropriate than taking them somewhere. That is the risk decision-making that you are trying to weigh up in that time.

Where there are alternative care pathways that work, they are great but they are not consistent, either. It is no good a service running every Wednesday and every second Friday. That is not helpful. Alternative care pathway services operate differently as you cross borders as well. Ambulance sectors have three, four or five ICBs that they cover and each has different funding for different alternative care pathways. It is detective work for paramedics on scene to try and figure out, “Is there a service, are they open, will they accept my referral?” As John alluded to in your last session, for some reason, paramedics referring into some of these systems is not accepted. It is not deemed to be clinically appropriate enough or paramedics are not considered to be of a significant gravitas to be able to make a referral into some services. That is a real shame. I would love to see that changed because the paramedics are walking that line in between policy and reality, and we need to keep patients safe.

Baroness O'Neill of Bexley: If 75% thought that there were not, then 25% thought there were alternatives. Is there a way of capturing that best practice to feed that into future policy and direction? Does that happen?

Tracy Nicholls: It does not happen. It has happened. We had directories of service and all these mechanisms, but they are updated so frequently that they become outdated almost the minute they are available to staff. Paramedics and ambulance clinicians will normally try once or twice. If they do not get any result, they deem that the service is not useful and will do something else. But I absolutely think that, where we have exemplar alternative care pathways, there could be scalability in those.

To your second question on commissioning expertise, I met the national ambulance service commissioners yesterday. They are a passionate, engaged group of people. There is one paramedic on that group. But

where it starts to become diluted is with the decisions made higher up through those services. The ambulance service has been described as a Cinderella service. It functions and carries on. As Ian said, the staff just absolutely make sure that their services are there for patients when they need them. But in terms of “Is it from a strategic point of view important?”, I do not see that. The commissioning group, absolutely, but further up than that, I have less confidence.

William Pett: Your question refers to alternative care pathways being available to paramedics. I should also challenge, to ask the question: are those alternative care pathways available to patients in the first place? Often, either those care pathways are not available to patients or there is simply a lack of trust in them among patients. Again, you have to look at the results of the CQC’s urgent emergency care survey, which shows that of patients that went directly to A&E, 20% did so because they lacked confidence that their GP practice would be able to help. Similarly, while patient experience surveys of NHS 111 have shown some modest improvements on experience in recent years, we continue to hear frustrations about it. Healthwatch Leeds published a report earlier this year on the use of 111, particularly for mental health patients. That found, first, low levels of awareness about the 111 service and, secondly, that three-fifths of people did not find the support they received through 111 helpful. The Government are looking to roll out neighbourhood health services. We support that, but working with patients to understand the existing barriers to alternative local pathways to A&E would be a good starting point.

Dr Ian Higginson: From our perspective, I completely agree with everything that has been said. We see variability in access to services. As emergency medicine clinicians, we hear the frustrations of our paramedic colleagues, who arrive saying, “I know this patient either doesn’t need to be here or could be treated elsewhere, but I couldn’t get hold of X, which is all I needed to get them home”. That is often in the evenings, at weekends and over long holiday periods.

We get so many patients who are really frustrated, having tried to navigate their way around systems. They find themselves being bounced from pillar to post. I think it was Theresa May—forgive me if I am wrong—who referred to it as “patient pinball”. Those alternatives are either hard to access or not available where they are needed.

There are increasing moves to potentially use the expertise of emergency medicine clinicians as part of the alternative care pathways, along with other key groups such as general practitioners. But my big worry about that is: first, this is a new thing that will require training; and, secondly, there is generally an expectation with that sort of thing that you can do it within existing resource envelopes, and I am particularly concerned that if, for instance, my colleagues are going to be asked—many of whom are really keen to get out there into the community—the workforce planning goes behind it so that we are not adding another thing for an overstretched group of people to do.

Finally, as far as commissioning goes, I obviously cannot speak for the ambulance services, but if there is anything like the limited involvement of emergency medicine specialists in the commissioning of emergency care, the answer is going to be very similar to the one that Tracy gave.

- Q18 **Baroness Watkins of Tavistock:** What do you see as the optimum role for ambulance services and paramedics in the urgent and emergency care system? You kind of differentiated them in your discussion. What would be the most significant reforms that would help you? I would like to add one issue. I am quite impressed with the patient record—I now have mine on my phone—but I know that it can be read if I go to A&E here in London but not if I go to some A&E departments near my home. Do you think that will revolutionise how paramedics can work?

Tracy Nicholls: If we were to optimise the profession, paramedics would see the emergency department as a destination of necessity, not default. Certainly, as Jason Killens alluded to last week, you would like a 100% conveyance rate to the ED, because they are the right patients to go. We have a long way to go for that. But paramedics are first-contact clinicians. I know that there is a lot of nomenclature in some of the GP contracts around first-contact practitioners, but we really are the front door in a lot of these services. We can work effectively in the ambulance service, in neighbourhood care, in community care and in virtual-ward environments. I would really love to see paramedics working in mental health services, frailty and other areas.

The ability to improve how we prescribe within our scope of practice would definitely help, and how we then integrate within that neighbourhood team to keep people in their place and integrate with those systems is key. We can support reduced conveyances as a patient safety issue—taking patients who do not need to be in the ED is a patient safety issue in the long term. As was beautifully alluded to, we guard the trust that patients have in us very dearly, but we are great public health messengers as well. Thinking about the Making Every Contact Count campaign—

Baroness Watkins of Tavistock: Can I just bring you back to what you think the optimal role is? For many years I was a community mental health nurse, and I would hope that, with the AI patient record, you might be able to think, “I can call that team”. Can we just come back to the absolute optimum role?

Tracy Nicholls: Absolutely. Digital is one of the left shifts of the Government’s 10-year healthcare plan. Many paramedics and ambulance clinicians are making decisions about patients without a full understanding of the patient’s condition, so digitisation is certainly crucial for better clinical decision-making. To get the systems to do that, we will be on this for a little while. We are all trying to get some uniformity around that, which will massively help. We are also trying to understand what the community capacity is through that digitisation. If you are trying to refer someone through the community and you know that there is capacity within the system, you can refer them. If there is no capacity,

you have to think of something else. It gives you options and allows you as much information as you can get to help the patient in front of you.

Baroness Watkins of Tavistock: Yes. My final push on this is a long question: what is the optimal role for your services in urgent and emergency? Would you say it is emergency before urgent, for example?

Tracy Nicholls: It is difficult, because it is what we have become and it will be very difficult to disassociate that. It used to be that 80% of paramedic training was about 20% of the jobs—it was trauma and cardiac-arrest based. That has changed. We have had to flex our curriculum to incorporate urgent care. If that is not what the future holds, the ambulance service will need to redefine itself, but we do not just have paramedics working in there. As you pointed out earlier, it is confusing for the public that paramedics have become a safety net.

Dr Ian Higginson: May I come in on the bits that I feel able to speak about? The way things have evolved is largely a result of failures in the system. As Tracy pointed out, that makes it very difficult to row back from many of the changes. But we have to take a big step back and look at how urgent care is commissioned, particularly around minor illness—at the moment, the commissioning frameworks are confusing to me, to say the least, and I suspect not particularly well defined—and around such things as dentistry, mental health services and community and social care. A lot of the stuff that should be a safety valve, such as what the ambulance service and emergency departments do, is actually acting as a safety net for failures in the system, and that is creating problems.

But remember: it is not all about demand. We require other reforms to tackle overcrowding in emergency departments. I am not just talking about corridor care; I am talking about long waits, because you can also wait for a long time not in a corridor. That needs sorting out. It will help free up ambulances and, in particular, paramedics to do what they are meant to do.

Thinking of other reforms, picking up on the earlier theme, I genuinely think that emergency preparedness needs reviewing, given the climate that we are now in. We need to take a good, long and hard look at where we are, how prepared we are and what needs to be done to get us where we need to be. Those are the major reforms that I would be looking at.

Q19 **Baroness Coffey:** I am going to go back to Tracy. It is quite a recent phenomenon or policy change that paramedics are required to have degrees. You also talked about a master's level of training. I will be open: I am a bit sceptical about that. I am conscious that many paramedics do not have a degree. This is quite recent, so I want to go back to what level of skills people need. I fully understand that the more skills you have, the more different ways you can be deployed, but I am conscious that lots of students are having to do apprenticeships that go on for a long time or incur a lot of debt and, frankly, they will never earn the same amounts of money that resident doctors who become consultants can earn. I am trying to get a sense of whether we are, if not overeducating people,

making the barrier too high to a really important way for people who are not doctors to be able to contribute to Hear and Treat and See and Treat, as well as the more traditional role of emergency treatment on deployment to the right place for the patient.

Tracy Nicholls: My personal view is no, we need the academic rigour behind that. You are asking paramedics to do a very different job today than you were 20 years ago. I spoke about why paramedics maybe are not trusted healthcare professionals to make referrals. Some people still see us as a vocation for driving to a patient, picking them up and taking them to hospital. That simply is not the case. To be able to discern some of that risk stratification, that clinical decision-making needs much more thought and rigour behind it. Because to leave a patient at home who comes to harm is the worst thing you could do, not only for the patient but for you being responsible for that decision without making sure that you have explored everything, within not only your own scope of practice but have sought to seek advice from other healthcare professionals at the same time. Our nursing and medical colleagues have been fantastic allies in that.

If you want a vocational service, you will get what you asked for, but if you want a service that is going into the future, you need paramedics to understand and appreciate the system's complexity, integration, risk stratification, where risk lies and where it sits with you and other organisations, and how you play a part in that. You mentioned people leaving with degrees. Actually, we estimate at the Royal College of Paramedics that 45% of paramedics this year will not have a job. There are no vacancies. So that is something to look at. HEIW in Wales this week announced that it will no longer fund places in 2026, and the Welsh Ambulance Service is not employing any paramedics this year. That will be replicated across England and Scotland, and probably Northern Ireland.

Baroness Coffey: What percentage of your current paramedics would have a degree today?

Tracy Nicholls: It is over half, Baroness Coffey. I can get the figures for you.

The Chair: That would be really helpful. Thank you.

Q20 **Baroness Shawcross-Wolfson:** I wanted to follow up on Baroness Watkins's question. I understood from what you have said, thinking about ambulance services specifically, not about paramedics as a wider class of healthcare professionals—I am keen to make sure that I have understood this properly from Tracy and Ian—that you think that, in an ideal world, ambulances would only be dispatched when a patient needed to go to hospital—that is the 100% conveyance rate—and we should not be looking at ambulances as a means of providing care in the community. In an ideal world, there would be other means by which patients should be cared for. Urgent care patients who could not leave their homes could be cared for by other professionals. Have I understood that right? This goes

back to the optimisation point. I know that paramedics play other roles, but I am thinking just about paramedics in ambulances and the ambulance service itself.

Tracy Nicholls: I would not speak on behalf of the ambulance service because we have paramedics that work the breadth of the health and care system. However, having been a paramedic for 30 years, I should say that you cannot always define an emergency. Patients will define the emergency. They are ringing 999. That is their emergency. To differentiate from that and to have only an emergency service means that you would ignore everything else. That is not possible. It is too nuanced, complicated and sophisticated. I have a slightly different view to Ian in terms of society needing support from healthcare professionals more than ever at the moment. If police only responded to what were known to be criminal activities, and fire and rescue responded only to fires, what would happen to all that other work that we all do outside that? It is not an answer but it is much more nuanced, I am afraid.

Baroness Shawcross-Wolfson: That is helpful. Thank you.

Dr Ian Higginson: In my own defence, I think Tracy and I completely share a view here. I go back to my point that I do not think the role of ambulance services is to make up for failings and deficiencies elsewhere in the system and see patients who other healthcare professionals or other services could better see and treat. But there is a lot more nuance to this. As you say, you never know when you go out on a job—I respond regularly in two other different roles—what you are going to face at the other end, and often you only know when you are there and can make an assessment. Remember, ambulances are transport platforms that carry dedicated skilled healthcare professionals on them. What you are really doing is bringing a skill set to the patient, and then an ability to transport that patient to another place if you arrive in an ambulance. Sometimes, all a patient needs is a transport platform and does not need a paramedic with it. That can be confused and, tying in with Baroness Coffey's thoughts, this stuff is not easy. It is really difficult. Having highly trained people doing that work is essential.

It also offers them career and professional development. Asking these skilled professionals day in, day out, to do the same work under difficult circumstances, which is emotionally and physically draining over a career, is also difficult, so it is important to offer professional development. I work with a talented group of critical care paramedics as part of a critical care service. My word, they are skilled and teach me something every time I go on a shift with them, rather than the other way around. Again, it is a nuanced picture out there. The trick is, as best you can, to use the ambulance service for the patients who will benefit from their particular skill set. There is always going to be grey around it but you should not make up for the failings elsewhere in the system. That would improve the system as a whole, not just ambulance services, because that impacts on emergency departments and all sorts of other services.

The Chair: I am going to draw the session to a close now. Can I formally

thank our guests William Pett, Tracy Nicholls and Dr Ian Higginson? You have given us a lot of evidence and a lot of things to think about and to follow up. There are a number of bits of data that we asked you for, so please submit those. If there is anything that you wanted to say that you did not have the opportunity to, please submit that in writing to help us with our inquiry. The deadline has passed and we have received a lot of written evidence, and more will be circulated to members shortly. I declare the public session closed.