



HOUSE OF LORDS

Public Services Committee

2nd Report of Session 2022–23

Emergency healthcare: a national emergency

Ordered to be printed 16 January 2022 and published 19 January 2023

Published by the Authority of the House of Lords

Public Services Committee

The Public Services Committee was appointed by the House of Lords on 13 February 2021 to consider public services, including health and education.

Membership

The Members of the Public Services Committee are:

[Baroness Armstrong of Hill Top](#) (Chair)

[Lord Bichard](#)

[Lord Bourne of Aberystwyth](#)

[Lord Filkin](#)

[Lord Hogan-Howe](#)

[Baroness Morris of Yardley](#)

[Baroness Pinnock](#)

[Baroness Pitkeathley](#)

[Lord Porter of Spalding](#)

[Baroness Sater](#)

[Lord Willis of Knaresborough](#) *

* Lord Willis was unable to take the Oath of Allegiance due to ill health and as such did not participate in this inquiry

Declaration of interests

See Appendix 1.

A full list of Members' interests can be found in the Register of Lords' Interests:

<https://members.parliament.uk/members/lords/interests/register-of-lords-interests>

Publications

All publications of the Committee are available at:

<https://committees.parliament.uk/committee/430/public-services-committee/publications/>

Parliament Live

Live coverage of debates and public sessions of the Committee's meetings are available at:

<http://www.parliamentlive.tv>

Further information

Further information about the House of Lords and its Committees, including guidance to witnesses, details of current inquiries and forthcoming meetings is available at:

<http://www.parliament.uk/business/lords>

Committee staff

The staff who worked on this inquiry were Sam Kenny (Clerk), Tom Burke (Policy Analyst) and Claire Coast-Smith and Aimal Fatima Nadeem (Committee Operations Officers).

Contact details

All correspondence should be addressed to the Public Services Committee, Committee Office, House of Lords, London SW1A 0PW. Telephone 020 7219 6154. Email: hlpublicservices@parliament.uk

Twitter

You can follow the Committee on Twitter: [@LordsPublicSCom](https://twitter.com/LordsPublicSCom).

CONTENTS

	<i>Page</i>
Summary	3
Chapter 1: Introduction	5
Box 1: How should it be?	5
Our inquiry	6
Box 2: An action plan for emergency health services	7
Chapter 2: A national emergency	8
The extent of the problem	8
Figure 1: Patients waiting 12 hours or more from decision to admit to admission	9
Figure 2: Ambulance response times to category two calls	10
Box 3: Experiences of the emergency healthcare system	11
Impact on the workforce	11
Chapter 3: What has gone wrong?	14
Demand	14
Increasing demand for emergency health services	14
Figure 3: A&E attendances graph	15
Figure 4: Ambulance incidents	15
Figure 5: 999 and 111 calls	16
Type of demand	16
Unmet need in primary care	17
Figure 6: Percentage of patients who felt they had seen NHS mental health services often enough for their needs in the last 12 months	18
Figure 7: Elective treatment waiting list	18
Figure 8: GP waiting times	19
Bed capacity	19
Patient flow	20
Availability of social care	21
Chapter 4: Leadership	24
Leadership and vision	24
COBR	25
Service model	25
Demographic change in the UK	25
Model for delivery	25
Targets	27
Integrated Care Boards and Systems	29
Box 4: Integrated care	30
Systemic challenges	30
How ICSs will affect change	32
Chapter 5: Clarity of published data	34
Waiting times	34
Figure 9: Number of patients waiting 12 hours or more from decision to admit (DTA) and time of arrival (TOA) in the last 12 months	35
Demand for emergency health services	35
Level of demand	35

Type of demand	36
Delayed discharge	37
Chapter 6: Right place, right time	38
NHS 111	38
More effective triage	39
Chapter 7: Collaboration	40
Potential for collaboration	40
Measures to encourage collaboration	40
Joint Emergency Service Interoperability Principles	40
Policing and Crime Act 2017	41
Role of regulators	41
Chapter 8: Best practice	43
Learning from each other	43
Machinery for sharing best practice	43
“What gets measured gets done”	45
Summary of conclusions and recommendations	47
Appendix 1: List of members and declarations of interest	49
Appendix 2: List of witnesses	51
Appendix 3: Call for evidence	55
Appendix 4: Summary of engagement event, 3 November 2022	59

Evidence is published online at <https://committees.parliament.uk/work/6918/access-to-emergency-services/> and available for inspection at the Parliamentary Archives (020 7219 3074).

Q in footnotes refers to a question in oral evidence.

SUMMARY

Emergency access to healthcare is in crisis. Unmet need in primary and community care and low capacity in hospitals and social care has left the emergency health services gridlocked and overwhelmed, unable to provide safe care. Waiting for care, patients experience distress and lengthy delays, leading to substantial clinical risk. Emergency healthcare, a key component in the national health service, has been allowed to degenerate, and it is likely to get worse. We see no sign that there is an adequate plan or the necessary leadership to address this.

Patients struggle to access care in the community, so feel they have no option but to use emergency services, attending Accident and Emergency departments (A&E), and calling ambulances. Hospitals are overcrowded and under-staffed, and so ambulances are stuck outside hospital waiting to hand over their patients, unable to respond to additional calls. Inside A&E, there are substantial delays before being treated or admitted. At the end of the experience, when ready to be discharged, patients often wait for community or social care to become available, remaining in beds that cannot then be accessed by other patients. While many patients experience only one delay along this chain, for others the process is a long waiting game at each stage.

In A&E, this waiting game has been widely underestimated. The number of patients waiting 12 hours or more in A&E is around five times higher than the number most regularly used. The data published monthly on waiting times exceeding 12 hours does not reflect the patient experience because the clock only starts when a clinician has made the decision to admit a patient to hospital, rather than when that patient entered A&E. This was described to us as “a fundamentally dishonest way of reporting data”. To demonstrate, in August 2022, 133,286 people waited in A&E for over 12 hours. Of these, over 100,000 were not reflected in the data published monthly.¹

The scale of the challenge is substantial, and demographic change means that it will get worse. The problem is also complicated, created by unmet need at every level of the health and care services. Leadership is fragmented and under-ambitious, and there is no sign that the Government is adequately addressing the problem.

We need decision makers to work together to address this emergency, providing the system with the necessary resources. This means cross-government attention, and accountability from the Prime Minister down. In the short-term, therefore, we have recommended that a COBR Committee be assigned the responsibility to address the crisis in emergency healthcare.

In the long-term, we are clear that a substantial overhaul is needed, one which sets out a bold new operating model for the system as a whole, and which is backed by equally bold leadership.

Our action plan, which encompasses our recommendations, is set out in chapter 1.

Chapter 2, ‘A national emergency’, sets out the extent of the problem. It ends with the inescapable conclusion that many staff in emergency healthcare—

¹ [QQ 31, 39](#) (Dr Adrian Boyle). See chapter 5, ‘Clarity of published data’.

recognising, as we have come to, that emergency healthcare is in crisis—will vote with their feet and leave the health service, compounding the problem.

Chapter 3, ‘What has gone wrong?’, examines how we reached this point. It considers unmet need, and failure to invest in preventative services. It also demonstrates the blockages caused by a failure to move patients through the system. There are far fewer beds in hospitals than a decade ago, and they are filling up with patients who cannot be discharged because there is inadequate provision of social care.

Chapter 4, ‘Leadership’, is where our key recommendations can be found. The Department of Health and Social Care and NHS England are deferring to extremely new structures (Integrated Care Systems) for solutions which these structures are not equipped to provide. We call for a bold new operating model, and strong, ambitious leadership from central Government.

Some problems have clear solutions. Alongside the long term shifts we have set out, we have made some more specific recommendations which, if implemented, would make a substantial difference to the parts of the emergency services to which they are relevant. They cannot stand alone.

In chapter 5, ‘Clarity of published data, we identify specific questions which require clarity, and how to address them. Chapter 6, ‘Right place, first time’, moves our focus to triage, and recommends a higher clinical presence within the non-emergency helpline, NHS 111. This would mean that fewer people would be sent to hospital from an abundance of caution: there would instead be informed clinical decisions and more patients empowered to care for themselves, at home. Chapter 7, ‘Collaboration’, looks at how police and fire and rescue services—the other ‘blue-light’ services—could be better supported and incentivised to collaborate with emergency health services. Chapter 8, ‘Best practice’, looks at how to empower and encourage the spread of interventions that have been proven to work. Currently, innovative methods of delivering emergency health services are trialled but rarely evaluated; and abandoned rather than celebrated. The ‘What Works Centre’, which could perform this function, does not do so.

The state of emergency healthcare is a national emergency. It requires an emergency response from the Government. Our action plan sets out how, in the short-term, the Government can address some immediate challenges, and in the long-term can begin developing a new model for emergency health services which are fit for purpose.

Emergency healthcare: a national emergency

CHAPTER 1: INTRODUCTION

1. Access to emergency healthcare is in crisis. The situation is a national emergency. Delays and overcrowding are putting patients in danger and posing a serious risk to the sustainability of the National Health Service. There are two key causes of this: at the front door of hospitals, and the back. At the front door, demand on emergency services, including for the high-acuity (high-risk) cases, has risen dramatically over recent years. There has been an upswing in cases presenting at Accident and Emergency (A&E) which should have been addressed elsewhere, with substantial unmet need in primary and preventative care. At the back, it is very difficult to discharge patients into community or social care (these services either are not available or do not have capacity), so patients remain in beds which cannot then be used for A&E patients. This means ambulances wait longer to unload their patients and respond to the next 999 call.

Box 1: How should it be?

In a functioning health system, patients should be able to obtain reliable care at the “right place, right time”,² accessing care in the community through, for example, their GP, a health visitor, or a pharmacist.

When needed, patients should be able to access first aid or advice from services, including in the evenings and at weekends. Patients should be able to call a non-emergency service staffed by clinicians who could make a balanced judgement on what care was needed, not sending people to A&E or sending ambulances unnecessarily.

Those who do need to access ambulances, or to visit A&E should be able to do so in a reasonable timeframe and be assured of safe treatment and swift admission into hospital if required.

2. Fault for the current situation in emergency healthcare does not lie with the staff. Health and care workers, wherever they are working, are doing challenging work for relatively little reward. The situation leaves staff overwhelmed and frustrated, with low job satisfaction; meaning they are more likely to leave and find work elsewhere.³
3. We set out on our inquiry to establish how the health service could ensure that decisions made at every level always had the welfare of patients at the forefront. We found an emergency service that was fragmented and lacking leadership, with a service model that no longer fits the reality of demand or clinical practice. This is characterised by outdated targets, a lack of clarity throughout the system, an over-cautious approach to triage, and missed opportunities to spread good practice and collaborate with other services.

2 ‘Right Care, Right Place, Right Time’ is a regularly used phrase in healthcare discussions. See for example NHS Providers, *Right Place, Right Time: Better Transfers of Care: A Call to Action* (November 2015): <https://nhsproviders.org/media/1258/nhsp-right-place-lr.pdf> [accessed 30 December 2022].

3 See chapter 3 of Public Services Committee, *‘Fit for the future?’: Rethinking the public services workforce* (1st Report, Session 2022–23, HL Paper 48)

Above all, we found an unwillingness to take the action that is now absolutely necessary: to create a new operating model which takes account of how patients move through the health system and addresses the fundamental flaws which have created the situation we are currently facing.

4. Along with many others in the country and among civil society, this report makes recommendations which address the health system as a whole. We call for strategic leadership and a new operating model. These solutions will not be in effect overnight, but they must be begun now. We also encountered some specific areas where smaller changes could make a substantive difference, and have made recommendations on these, too. As has become ever clearer over recent months of media coverage, action on both are necessary.
5. Our last report, *Fit for the Future? Rethinking the public services workforce*, highlighted substantial staff shortages across the public sector, and looked at the need to develop a solid plan for the future workforce. We found then that efforts to address the problem were at far too small a scale. This inquiry has reaffirmed those findings.⁴

Our inquiry

6. We launched our inquiry on 22 September 2022. In addition to taking oral and written evidence and holding a private seminar, we held an online engagement event with front-line emergency staff and some senior leadership. We are grateful to all who helped us with this inquiry.
7. We began with the intention to examine the role of all emergency responders, and to establish what role collaboration between services could play in ensuring that decision making at every level always kept the interests of the patient paramount. As we progressed it became clear that the most acute issues were in emergency healthcare. Our report therefore reflects this, although some later chapters cover emergency services in general.
8. As our inquiry covers largely devolved matters, our recommendations apply primarily to England, although recommendations on policing in particular will be relevant in Wales. Others will be of interest to the devolved administrations more widely.

4 Public Services Committee, *'Fit for the future?': Rethinking the public services workforce* (1st Report, Session 2022–23, HL Paper 48)

Box 2: An action plan for emergency health services

- **An emergency response:** Recognising this is a national emergency, the Government should refer the crisis in emergency health services to a COBR Committee.
- **Deliver care at the right place, right time:** In the short term, boost the number of clinicians in 999 and 111 services so that patients are being directed to the right services at the right time.
- **Unlock the gridlock:** Incentivise faster safe discharges from hospitals and increase capacity in hospitals and social care to make sure people can move through the health system and do not end up stuck in ambulances or at A&E.
- **Understand the problem:** Data on A&E waiting times do not accurately reflect the patient experience. Performance data should accurately report the true waiting times experienced by patients so that decision makers have a clear picture of the problem, and so the public can hold them to account.
- **Address unmet need:** Boost capacity in hospitals and social care. Make it easier for patients to get care in the community both before they reach crisis point (preventing admissions) and following discharge.
- **A new model for emergency health services:** The Government must develop a new model for emergency health services which recognises the current crisis, the type of demand services face and clinical best practice and, for accountability purposes, sets out appropriate performance measures.

CHAPTER 2: A NATIONAL EMERGENCY

9. Emergency health services are facing a crisis. Patients are delayed at every stage of trying to access emergency healthcare, with some left without clinical support for hours or overnight—exacerbating existing health problems and posing an unacceptable risk. Stories of ambulances being stuck outside of hospitals, unable to hand over patients and respond to further calls, have become common. In recent months there have been multiple reports of people dying while waiting for ambulances, and the number of people waiting to be seen in emergency departments has significantly risen.⁵

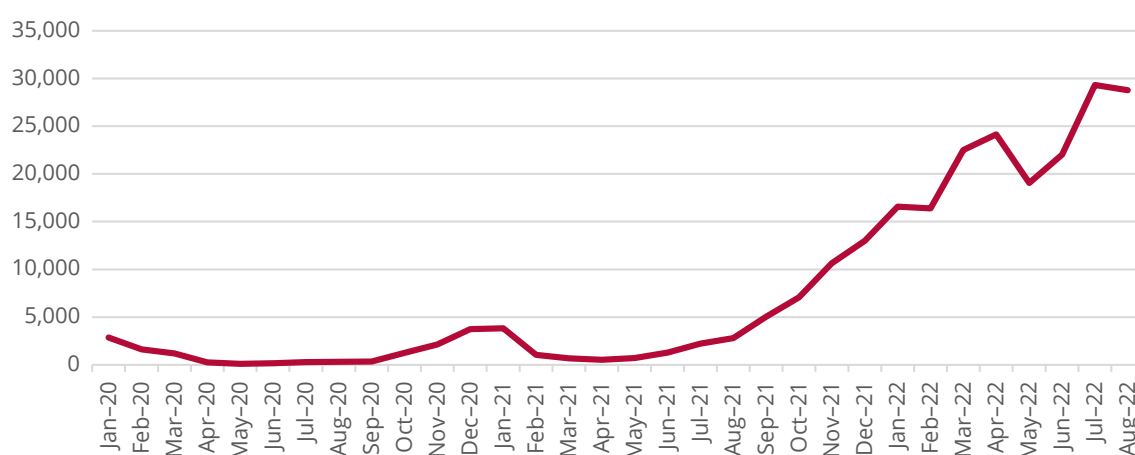
The extent of the problem

10. Barriers to accessing emergency healthcare have led to “a decline in public confidence”, with fewer than 40% of people saying they were confident in being treated in A&E or by an ambulance in a reasonable time.⁶ The figures prove the public right.
- In the West Midlands, the number of people dying waiting for ambulances has risen from one in 2020 to 37 between January and September 2022.⁷ Looking nationally, ambulances have been missing the target response times in almost every category every month since May 2021, with average response times for the second highest risk calls more than doubling since then.⁸
 - Between 14 November–11 December 2022 an average of over 3,500 hours of ambulance staff time were lost every day to ambulance handover delays.⁹

-
- 5 See for example, ‘Gloucester: NHS boss says people have died waiting for ambulances’, *BBC News* (November 2022): <https://www.bbc.co.uk/news/uk-england-gloucestershire-63656082> [accessed 29 December 2022], ‘Patient dies after waiting almost two hours for ambulance following operation’ *Mirror* (November 2022): <https://www.mirror.co.uk/news/uk-news/patient-dies-after-waiting-almost-28493210?amp%3Bamp%3B> [accessed 29 December 2022], ‘Patient died waiting an hour for ambulance to come to life-threatening call’ *East Anglian Daily Times* (November 2021): <https://www.eadt.co.uk/news/health/21269912.patient-died-waiting-hour-ambulance-come-life-threatening-call/> [accessed 29 December 2022], ‘Man died after 2.5-hour wait for ambulance, Cornish inquest hears’ *The Guardian* (November 2022): <https://www.theguardian.com/uk-news/2022/nov/21/man-died-after-two-and-a-half-hour-wait-for-ambulance-cornish-inquest-hears> [accessed 29 December 2022], and ‘Ex-teacher, 92, spent four hours on floor waiting for ambulance before her death’ *Stoke Sentinel* (November 2022): <https://www.stokesentinel.co.uk/news/stoke-on-trent-news/ex-teacher-92-spent-four-7766880> [accessed 29 December 2022].
- 6 Written evidence from Healthwatch England (AES0006) Healthwatch are the independent statutory champion for people who use health and care services. Every area of England has a local Healthwatch.
- 7 ‘Big rise in numbers dying after West Midlands ambulance delays’ *BBC News* (December 2022): <https://www.bbc.co.uk/news/uk-england-shropshire-63885374> [accessed 29 December 2022]
- 8 Ambulance callouts are categorised on a scale of one to four, with one representing the highest acuity (highest risk) cases. The increase in waiting times for category two calls is set out in a graph in this chapter. Categories one and two have average (mean) and 90th centile response time targets, while categories three and four only have 90th centile targets. Almost all of these targets have been missed every month since May 2021, with the only exception being the 90th centile target for category one calls, which has been missed every month since June 2022. Association of Ambulance Chief Executives, *National Ambulance Data, Data to the end of October 2022* (25 November 2022): <https://aace.org.uk/wp-content/uploads/2022/11/National-Ambulance-Data-to-October-2022-FINAL.pdf> [accessed 21 December 2022]. See also NHS England, *Ambulance Quality Indicators* (8 December 2022): <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/12/20221208-Statistical-Note-AQI.pdf> [accessed 21 December 2022].
- 9 NHS England, Hospital arrivals and ambulance handover delays (15 December 2022): <https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fstatistics%2Fwp-content%2Fuploads%2Fsites%2F2%2F2022%2F12%2FAmbulance-Collection-Web-File-Timeseries-2.xlsx&wdOrigin=BROWSELINK> [accessed 21 December 2022]

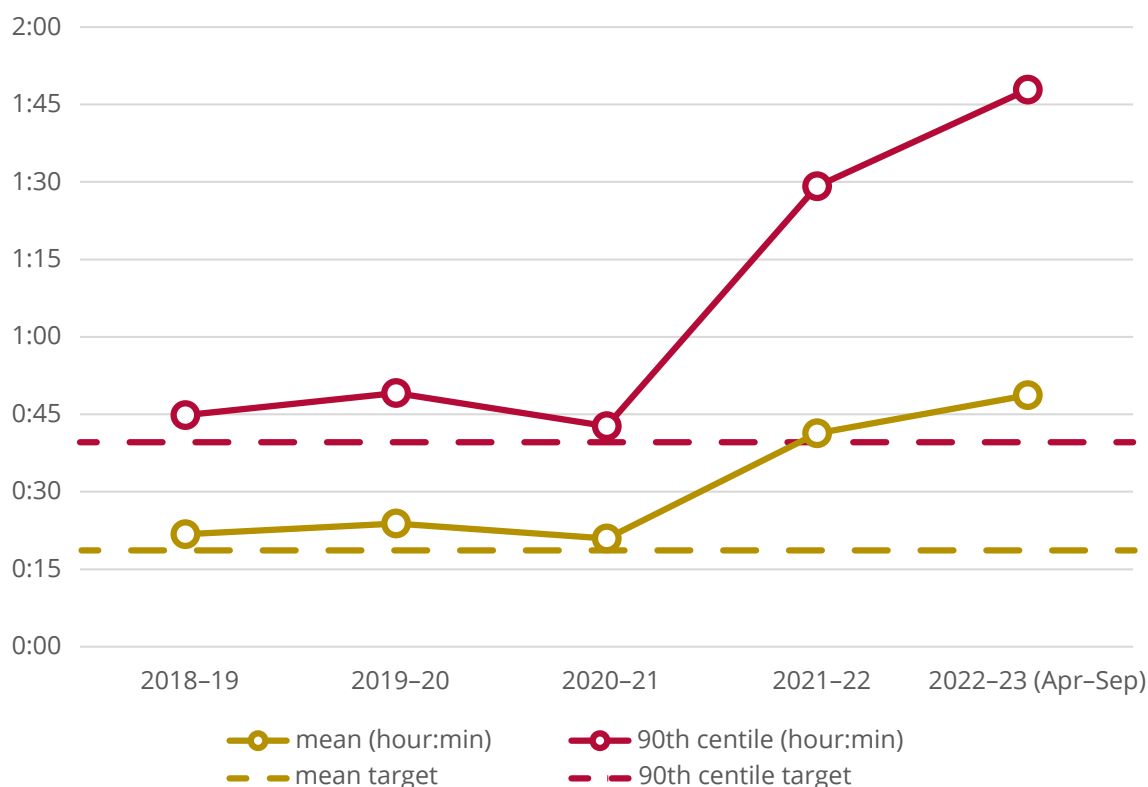
- In October 2019, just 2% of patients handed over from ambulances to A&E waited over an hour. In October 2022, it was 18%: 52,000 patients.¹⁰
- In October 2022, 45% of patients waited longer than four hours in A&E. NHS England stated this was “the lowest reported performance since the [data] collection began” in June 2015.¹¹
- In November 2022, 37,800 patients waited 12 hours between the decision to admit them into A&E and being admitted. The real number of people waiting 12 hours or more in A&E is likely much higher (see chapter 5, ‘Clarity of published data’.)

Figure 1: Patients waiting 12 hours or more from decision to admit to admission



Royal College of Emergency Medicine, ‘Data & Statistics’: <https://rcem.ac.uk/data-statistics/> [accessed 9 January 2023]

-
- 10 Association of Ambulance Chief Executives, *National Ambulance Handover Delays* (November 2022): <https://aace.org.uk/wp-content/uploads/2022/11/National-Ambulance-Handover-Delays-Data-to-Oct-2022-FINAL.pdf> [accessed 21 December 2022]
- 11 NHS England, *A&E Attendances and Emergency Admissions October 2022 Statistical Commentary* (October 2022): <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/11/Statistical-commentary-October-2022-cftrel.pdf> [accessed 29 December 2022]

Figure 2: Ambulance response times to category two calls

NHS England, 'Average daily number of available beds, by sector, England 1987–88 to 2009–10' (29 July 2010): <https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fstatistics%2Fwp-content%2Fuploads%2Fsites%2F2%2F2022%2F12%2FAmbSYS-time-series-ending-20221130.xlsx&wdOrigin=BROWSELINK> [accessed 9 January 2023]. This graph shows the averages (mean) waiting times and 90th centile waiting times for category two ambulance responses only. The target response time for these calls are for the mean response time to be 18 minutes, and the 90th centile response time to be 40 minutes. The graph shows that neither target has been met in the timeframe shown.

11. Delays create significant clinical risk. In June 2022, the Healthcare Safety Investigation Branch stated that delays handing over patients from ambulance crews to A&E were “causing life-threatening harm to patients.”¹² The Association of Ambulance Chief Executives put it starkly: “some people are dying because we cannot reach them in time, others are experiencing worsening condition and poorer outcomes when treatment has been delayed”.¹³ Martin Flaherty, the managing director of the Association, has stated:

“These crippling delays are a twin threat—they cause significant harm to patients who are forced to wait in the back of our ambulances, while our crews are stuck and therefore unable to respond to patients who need us out in the community ... patients are dying and coming to harm as a result on a daily basis.”¹⁴

The Healthcare Safety Investigation Branch published an interim bulletin in November 2022. It found that “extended ambulance response times and

12 HSIB, *Interim report calls for immediate action to reduce harm to patients from handover delays* (June 2022): <https://www.hsib.org.uk/news-and-events/interim-report-calls-for-immediate-action-to-reduce-harm-to-patients-from-handover-delays/> [accessed 29 December 2022]

13 Written evidence from the Association of Ambulance Chief Executives (AES0024)

14 ‘Patients dying as ambulances face crippling delays in England’, *BBC News* (November 2022): <https://www.bbc.co.uk/news/health-63743383> [accessed 29 December 2022]

delays in transferring patients to the right place of care ... are impacting on patient safety throughout the healthcare system.”¹⁵

12. The emotional impact of long delays in treatment is considerable and our evidence reflected that, repeatedly referring to fear, distress and suffering for patients.¹⁶ We have outlined some case studies below.

Box 3: Experiences of the emergency healthcare system

A care home patient with a fractured hip was categorised as being “in a place of safety”, and care home staff were told not to move the person. They were left on the floor for over eight hours before an ambulance arrived, with little beyond paracetamol for treatment.¹⁷

An 87 year-old man with prostate cancer waited 15 hours for an ambulance to arrive after a fall. Delays and advice from call handlers not to move him meant he was lying outside overnight, in a makeshift tent his family built using items including a football goal and an umbrella. His injuries included a fractured pelvis and seven cracked ribs.¹⁸

A case study shared during the inquiry set out someone’s experience of calling an ambulance for their mother: “My Mom had a fall at home. I called an ambulance and Mom was left on a cold kitchen floor for 21 hours until the ambulance came the following day. Even though I telephoned 999 five times and basically told them that I thought Mom had fractured something I was told stop ringing unless anything changed in her condition ... Mom has osteoporosis of the spine, hips and knees and I advised them of this but she was still left on the floor.”¹⁹

13. **The state of emergency healthcare is a national emergency. The substantial delays that patients face when trying to access emergency health services create considerable emotional distress and an unprecedented clinical risk.**

Impact on the workforce

14. The emergency health workforce faces significant challenges, including shortages,²⁰ low job satisfaction and retention rates,²¹ and poor health.²² Ambulance staff were described as “overwhelmed”,²³ and “fatigued and depleted”.²⁴ In the NHS as a whole there is a vacancy rate of 9.7%, amounting to over 133,000 vacant posts, the highest vacancy level in the last five years. Within ambulance services, there are over 3000 vacancies, a 6% vacancy

15 Healthcare Safety Investigation Branch (HSIB), *Interim bulletin 2 Harm caused by delays in transferring patients to the right place of care* (November 2022) <https://hsib-kqcco125-media.s3.amazonaws.com/assets/documents/hsib-interim-bulletin-harm-caused-by-delays-in-transferring-patients-to-the-right-place-of-care-1718NOQ.pdf> [accessed 29 December 2022]

16 Q14 (Daniel Elkeles) and written evidence from His Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (AES0012), the Stroke Association (AES0025) and Dr Alison Porter (AES0034).

17 Written evidence from the Care Quality Commission (CQC) (AES0023)

18 ‘Man, 87, forced to wait 15 HOURS for ambulance as family says ‘system is broken’, *Mirror* (August 2022): <https://www.mirror.co.uk/news/uk-news/man-87-forced-wait-15-27778288> [accessed 21 December 2022]

19 Written evidence from Healthwatch England (AES0006)

20 See paragraph 95.

21 Written evidence from NHS Confederation (AES0010), Association of Ambulance Chief Executives, (AES0024), and Andrew Newton (AES031). See also Q 35 (Julia Williams), Q 18 (Lisa Elliott).

22 Written evidence from GMB (AES0021)

23 Written evidence from Unison (AES0039)

24 Written evidence from the Association of Ambulance Chief Executives (AACE) (AES0024)

rate, and in acute care settings there are 90,967 vacant roles (9.1%).²⁵ The resulting overwork may help explain the finding of the 2021 NHS staff survey that 67% of paramedics had felt unwell as a result of work-related stress in the last 12 months.²⁶

15. We heard that retention in emergency health services is a major issue, with staff leaving for other roles as the problems in the service negatively affect staff.²⁷ Daren Mochrie, Chair of the Association of Ambulance Chief Executives, gave a compelling explanation of why.

“If I were back in an ambulance now, starting a shift at 7 am, not getting time to check my vehicle and my drugs, being sent out to one patient after the next, standing in a hospital corridor for six or seven hours, only seeing one patient and not doing the clinical role that I am employed to do, missing meal breaks, not getting breaks and being kept late every night of the week because I am stuck wherever I am stuck, not seeing my family—all that would grind me down, and it will grind staff down.”²⁸

16. Pay concerns were also repeatedly raised, not only by union bodies but by organisations representing leadership, such as the Association of Ambulance Chief Executives.²⁹ Frustration about pay and terms and conditions of work has also been demonstrated through ambulance staff strikes at nine of the ten ambulance trusts in England³⁰ and the first ever nationwide nurses’ strike.³¹ In November 2022, the Nuffield Trust reported that all NHS staff have seen a 4.5% pay cut in real terms since 2010.³²
17. This is no surprise to us. Problems in retention, wellbeing, job satisfaction and pay exist across the public services workforce, as we explored in our report *Fit for the Future? Rethinking the public services workforce*.³³ That report also highlighted unacceptable levels of bullying and harassment in the workforce; borne out by the NHS staff survey which found that 27.5% of staff had experienced bullying, harassment or abuse in the last 12 months from patients, service users or other members of the public. 11.6% had experienced it from managers, and 18.7% from other colleagues.³⁴

25 NHS Digital, *NHS Vacancy Statistics England April 2015–September 2022 Experimental Statistics* (December 2022): <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---september-2022-experimental-statistics> [accessed 21 December 2022]

26 Written evidence from Trades Union Congress (AES0030)

27 Q 28 (Daren Mochrie). See also written evidence from Deb Saunders (AES0005).

28 Q 28 (Daren Mochrie). See also appendix 4, ‘Summary of engagement event’, Q 35 (Prof Julia Williams), and written evidence from NHS Confederation (AES0010) and Deb Saunders (AES0005).

29 Written evidence from the Association of Ambulance Chief Executives (AACE) (AES0024), Trades Union Congress (AES0030), GMB union (AES0021), MedTeams (AES0049), Anonymous 3 (AES0045), Unison (AES0039) and NHS Providers (AES0027)

30 ‘Strike: What will ambulances respond to on Wednesday’, *BBC News* (December 2022): <https://www.bbc.co.uk/news/health-64037440> [accessed 21 December 2022]. See also written evidence from the Trades Union Congress (AES0030)

31 ‘Nurses across UK back strikes in pay dispute’, *BBC News* (November 2022): <https://www.bbc.co.uk/news/health-63561317> [accessed 29 December 2022]

32 The Nuffield Trust, *Chart of the week: What has happened to NHS staff pay since 2010?* (November 2022): <https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-what-has-happened-to-nhs-staff-pay-since-2010> [accessed 21 December 2022] See also written evidence from the Trades Union Congress (AES0030).

33 Public Services Committee, *‘Fit for the future?’: Rethinking the public services workforce* (1st Report, Session 2022–23, HL Paper 48). See, in particular, chapters 3 and 5.

34 NHS Survey Coordination Centre, *NHS Staff Survey 2021* (March 2022): <https://www.nhsstaffsurveys.com/static/1f3ea5c952df62a98b90afcf3daa29ac/ST21-National-briefing.pdf> [accessed 21 December 2022]

18. **The emergency healthcare workforce is under unprecedented strain. Without concerted action to address the emergency in the system, many of them will leave the health service.**

CHAPTER 3: WHAT HAS GONE WRONG?

Demand

19. We heard that there has been significant long-term growth in demand for emergency health services.³⁵

Increasing demand for emergency health services

20. There is a long-term increase in the number of people accessing A&E and ambulance services:
- The number of incidents ambulances responded to grew from 8.4 million in 2018–19 to 8.9 million in 2021–22, an increase of 6%.³⁶
 - A&E attendances have increased by 13% in the last ten years, from 21.5 million (2011–12) to 24.3 million (2021–22).³⁷
 - Alongside this, there has been a sharp increase in demand for emergency (999) and non-emergency (111) phone services:
 - The number of calls to ambulance control rooms has increased by 20% since 2018–19.³⁸
 - NHS 111 services are answering 31% more calls than they were six years ago.³⁹

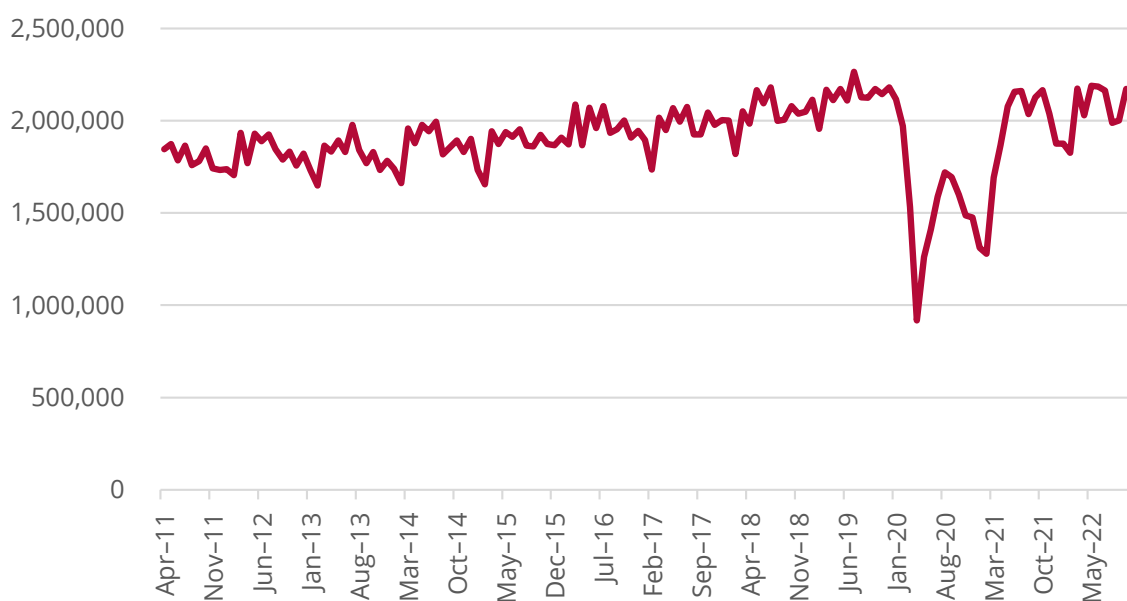
35 Written evidence from the Department of Health and Social Care ([AES0014](#)), [QQ 1–2](#) (Prof Peter Murphy), [QQ 12, 24, 26](#)

36 Written evidence from the Department of Health and Social Care (DHSC) ([AES0014](#)). Comparisons with data before 2017 are difficult due to changes in how cases were recorded.

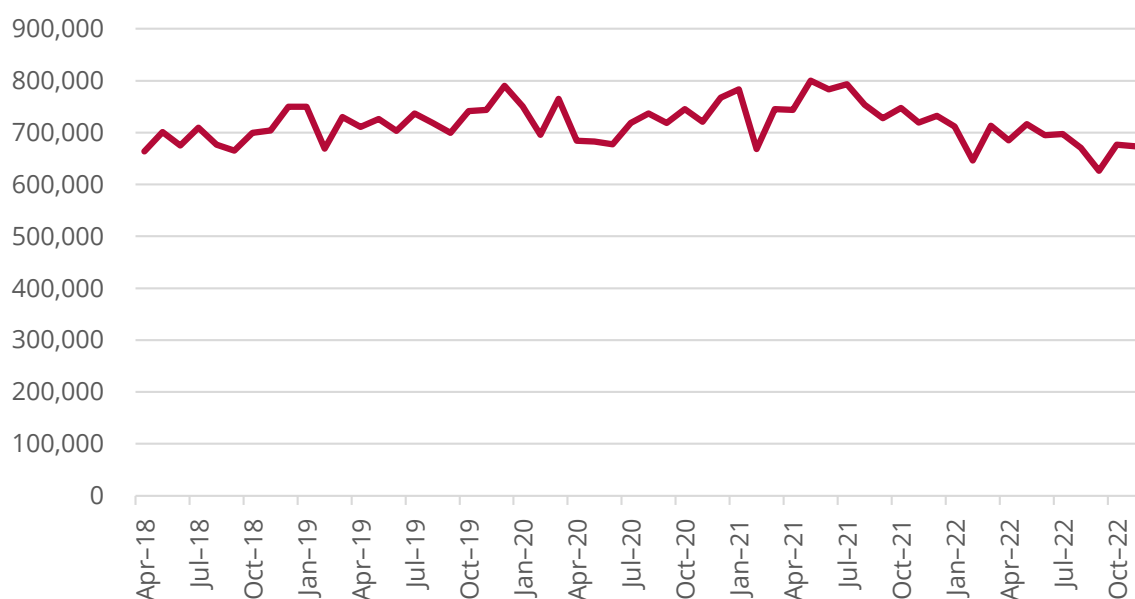
37 Written evidence from the Department of Health and Social Care (DHSC) ([AES0014](#)). Attendances peaked in 2019–20 at 25 million, before dropping to 17.4 million in 2020–21, the first year of the COVID-19 pandemic.

38 NHS England, *Ambulance Quality Indicators Data 2022–23* (December 2022): <https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2022-23/> [accessed 21 December 2022] Callers are directed to ambulance control rooms when they call 999 and request an ambulance.

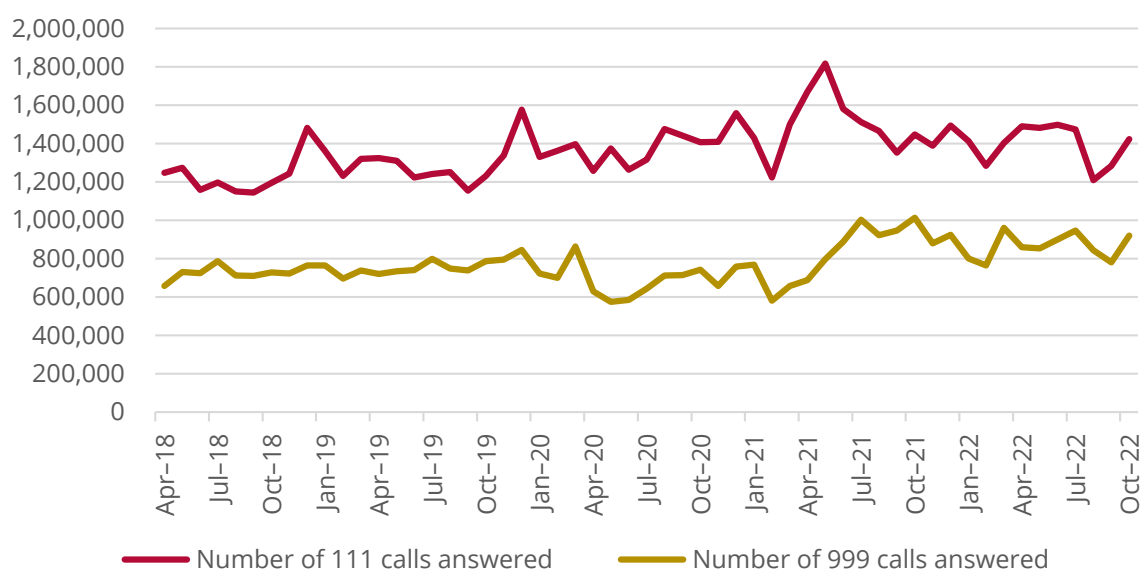
39 NHS England, *NHS 111 Minimum Data Set 2020–21* <https://www.england.nhs.uk/statistics/statistical-work-areas/iucadc-new-from-april-2021/nhs-111-minimum-data-set/nhs-111-minimum-data-set-2020-21/> [accessed 21 December 2022] and NHS England *Integrated Urgent Care Aggregate Data Collection (IUCADC including NHS111) Statistics Apr 2022–Mar 2023* (December 2022): <https://www.england.nhs.uk/statistics/statistical-work-areas/iucadc-new-from-april-2021/integrated-urgent-care-aggregate-data-collection-iucadc-including-nhs111-statistics-apr-2022-mar-2023/> [accessed 21 December 2022]. See also [Q 49](#) (Dr Vin Diwakar).

Figure 3: A&E attendances graph

NHS England, 'A&E Attendances and Emergency Admissions': <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/> [accessed 9 January 2023]

Figure 4: Ambulance incidents

NHS England, 'Ambulance Quality Indicators': <https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/> [accessed 9 January 2023]

Figure 5: 999 and 111 calls

NHS England, 'Ambulance Quality Indicators': <https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/> [accessed 9 January 2023], NHS England, 'NHS 111 Minimum Data Set 2020–21': <https://www.england.nhs.uk/statistics/statistical-work-areas/iucadc-new-from-april-2021/nhs-111-minimum-data-set/nhs-111-minimum-data-set-2020-21/> [accessed 9 January 2023], NHS England, 'Integrated Urgent Care Aggregate Data Collection (IUCADC including NHS111) Statistics Apr 2022–Mar 2023': <https://www.england.nhs.uk/statistics/statistical-work-areas/iucadc-new-from-april-2021/integrated-urgent-care-aggregate-data-collection-iucadc-including-nhs111-statistics-apr-2022-mar-2023/> [accessed 9 January 2023]

21. The long-term increase in demand is not enough to explain the step-change in waiting times seen in the 12–18 months prior to December 2022; the number of ambulances waiting for an hour outside A&E is five times higher than two years ago.

Type of demand

22. The number of patients with severe conditions who urgently need to be seen (high-acuity patients)⁴⁰ has increased by 11% over a two year period.⁴¹ There is also a substantial rise in the number of mental health attendances to A&E—an increase of 133% between 2009–10 and 2018–19.⁴² This was described to us as “unplanned primary care” and it had, we were told, increasingly become a feature of ambulance services’ work.⁴³

40 NHS England, *Guidance for emergency departments: initial assessment* (August 2022): <https://www.england.nhs.uk/guidance-for-emergency-departments-initial-assessment/> [accessed 21 December 2022]

41 This means that A&E departments are seeing 11% more patients classified as having the highest risk category than they were two years ago. See NHS England, *Ambulance Quality Indicators*: <https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/> [accessed 9 January 2023]. NHS England data demonstrate that in 2019–20 there were 449,600 category 1 incidents, but in 2021–22 there were 514,400, an increase of 11%. See also [QQ 24–25](#) (Daren Mochrie), [Q42](#) (Victoria Vallance), written evidence from Dr Alison Porter ([AES0034](#)) and NHS Providers ([AES0010](#)).

42 Written evidence from the Royal College of Emergency Medicine ([AES0017](#))

43 [Q 6](#) (Prof Leo McCann)

Unmet need in primary care

23. Several witnesses suggested that an increase in demand for emergency services has arisen because of barriers in accessing care elsewhere, including primary care and mental health services.⁴⁴
24. Preventative health services have seen significant cuts. The Health Foundation report that the Public Health Grant⁴⁵ has been cut by 24% on a real terms per person basis since 2015–16, with greater cuts falling in more deprived areas.⁴⁶ In October 2022, one in five patients, over six million people, faced a wait of over two weeks between booking their primary care appointment and attending it, whilst almost 2 million people waited over 28 days.⁴⁷ Similarly, a third of people in contact with mental health services saying they had not seen their care providers often enough for their needs.⁴⁸
25. These barriers to accessing care drive demand for emergency care. Dr Adrian Boyle, President of the Royal College of Emergency Medicine stated: “a lot of people do come to an emergency department because it is the only place they can access services.”⁴⁹ This has been borne out by the GP Patients Survey 2022, which found that more than 1 in 10 people who could not get an appointment at their GP surgery went to A&E.⁵⁰ The Frequent Caller Action Network described frequent callers to 999 services as “a vulnerable patient cohort who present with multiple unmet complex physical health, mental health and/or social care needs”.⁵¹ Even when patients do not go straight to emergency services when they cannot access primary care, they may still need to attend A&E or to call 999 if their conditions deteriorates.⁵² The same is true of patients facing long waits to access elective care.⁵³

44 For primary care, see: written evidence from the College of Paramedics (AES0016), and the NHS Confederation (AES0010), and Health and Social Care Committee, *The future of general practice* (Fourth Report, Session 2022–23, HC 113). For mental health, see: Written evidence from the Royal College of Emergency Medicine (AES0017); Open University Centre for Policing Research and Learning (AES0011) and HM Inspectorate of Constabulary and Fire & rescue Services (AES0012).

45 A grant from the Department of Health and Social Care to local authorities to improve health in local populations.

46 The Health Foundation, *Public health grant* (October 2022): <https://www.health.org.uk/news-and-comment/charts-and-infographics/public-health-grant-what-it-is-and-why-greater-investment-is-needed> [accessed 29 December 2022]. See also Q 1 (Prof Peter Murphy).

47 NHS Digital, *Appointments in General Practice, October 2022*, (November 2022): <https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/october-2022> [accessed 29 December 2022]

48 NHS Digital, *Mental Health Bulletin, 2021–22 Annual report* (November 2022): <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2021-22-annual-report/main-findings#changes-since-march-2020> [accessed 29 December 2022]

49 Q 37 (Dr Adrian Boyle)

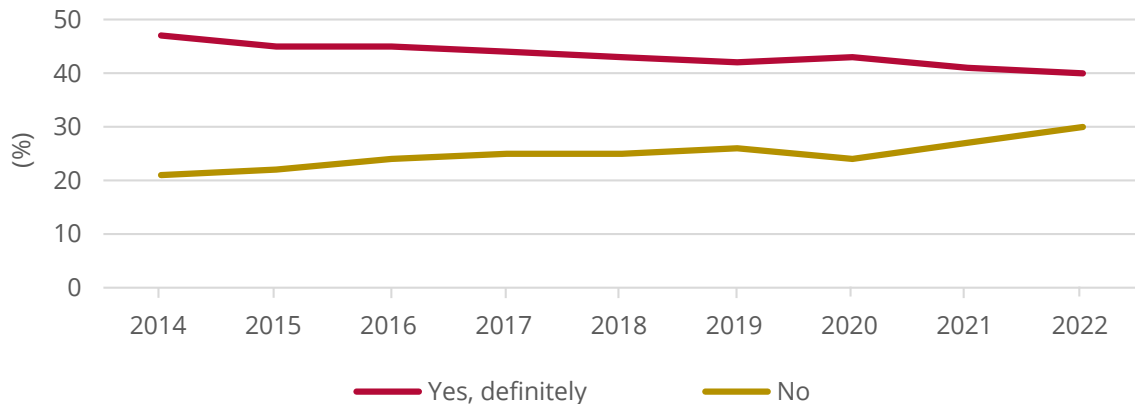
50 NHS, *GP Patient Survey*: <https://gp-patient.co.uk/> [accessed 29 December 2022]. See also written evidence from the Open University for Policing Research and Learning (AES0011).

51 Written evidence from the Frequent Caller Action Network (AES0008)

52 Q 37 (Dr Adrian Boyle)

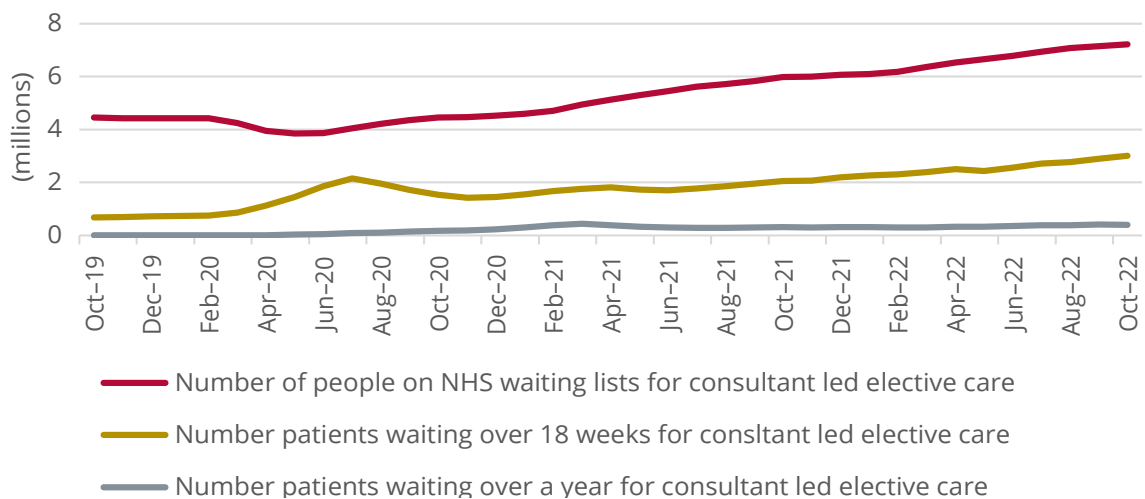
53 Written evidence from Unison (AES0039)

Figure 6: Percentage of patients who felt they had seen NHS mental health services often enough for their needs in the last 12 months

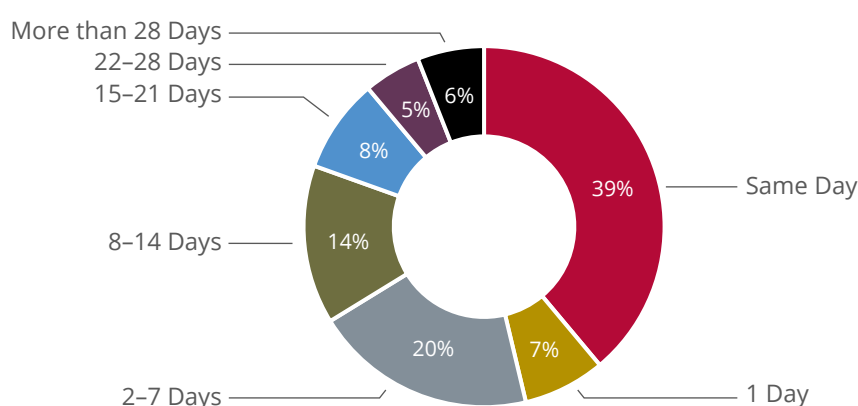


Care Quality Commission, 'Community mental health survey 2022': <https://www.cqc.org.uk/publications/surveys/community-mental-health-survey> [accessed 9 January 2023]. The number of people who answered "yes, to some extent" has remained consistently around 31%.

Figure 7: Elective treatment waiting list



British Medical Association, 'NHS backlog data analysis': <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis> [accessed 9 January 2023]

Figure 8: GP waiting times

NHS England, 'Appointments in General Practice, Experimental Statistics October 2022' (November 2022): <https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/october-2022> [accessed 10 January 2023]. The number of appointments categorised 'unknown / data quality' was 27,238, which amounts to less than 1%.

Bed capacity

26. The number of beds available in hospitals is an important factor in care capacity. The Royal College of Emergency Medicine report:

"The gradual loss of acute beds within hospitals is a key contributing factor: since 2010, over 29,000 hospital beds have been removed from the system, despite no reduction in demand. The UK has one of the lowest numbers of beds per capita [among] OECD nations."⁵⁴

27. The King's Fund report that "the total number of NHS beds has more than halved over the past 30 years."⁵⁵ The total number of beds has dropped from around 299,000 in 1987–88 to 128,800 in 2022–23. The latest NHS data shows that, within this, the number of hospitals beds for general and acute care has fallen by 43% from 180,900 to 102,300.⁵⁶
28. Ideally, we were told, there should be an 85% occupancy rate for acute beds (with 15% unoccupied). This would allow patients to move effectively through hospitals and reduce overcrowding.⁵⁷ In September 2022, 93.6% of acute beds were occupied in England—some significant way from the stated ideal.⁵⁸
29. The bed capacity problem is clearly recognised by the Government. The Minister for Health and Secondary Care, Will Quince MP, stated: "We are increasing hospitals this winter by 7,000 additional acute and other beds."

54 Written evidence from the Royal College of Emergency Medicine (AES0017)

55 The King's Fund, *NHS hospital bed numbers: past, present, future* (November 2021): <https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers> [accessed 29 December 2022]

56 NHS England, *Average daily number of available beds, by sector, England 1987-88 to 2009-10* (29 July 2010): <https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fstatistics%2Fwp-content%2Fuploads%2Fsites%2F2%2F2013%2F04%2FBeds-Time-Series-%25E2%2580%2593-1987-88-to-2009-10-XLS-34K.xls&wdOrigin=BROWSELINK> [accessed 10 January 2022] and NHS England, *Average Daily Beds Available and Occupied Beds Timeseries* (24 November 2022): <https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fstatistics%2Fwp-content%2Fuploads%2Fsites%2F2%2F2022%2F11%2FBeds-Timeseries-2010-11-onwards-Q2-2022-22-GHVBN.xls&wdOrigin=BROWSELINK> [accessed 10 January 2023]

57 Q 31 (Dr Adrian Boyle), Q 64 (Dr Vin Diwakar)

58 Q 31 (Dr Adrian Boyle)

About 2,500 of those will be virtual ward beds”.⁵⁹ However, virtual wards are not additional beds in hospitals, but “remote health services which support patients to remain at home”.⁶⁰ They do not represent a physical bed in a hospital, although hospital doctors may monitor patients at home remotely.⁶¹

30. Even with these ‘virtual ward’ beds included, the planned increase leaves the NHS 22,000 beds short of 2010 levels and does not provide a longer-term boost to capacity. Increasing the number of available beds will mean little if the staffing issues outlined in chapter 2 are not addressed. Sarah Scobie, Deputy Director of Research at the Nuffield Trust, argued that “there are not enough staff to keep more beds open. It is not just a question of the physical space and physical rooms; it is about the staffing”.⁶²
31. **In many cases, patients are attending emergency care services because they have—or feel they have—no alternative. The models for primary and community care are broken.**
32. ***The Department of Health and Social Care should continue working to increase the number of physical beds in hospitals. This work must ensure that additional beds are sufficiently staffed.***

Patient flow

33. Several witnesses highlighted problems in how patients moved through and out of hospital. Of the patients who arrive in A&E, some are admitted to hospital wards and most will ultimately need to be discharged.⁶³ Dr Adrian Boyle, President of the Royal College of Emergency Medicine, argued:

“The reason why we are seeing these very long delays to offloading ambulances and handover delays is that our hospitals are full ... the problems are largely all about the flow through emergency departments.”⁶⁴
34. Patients are often not being discharged when they are clinically ready, remaining in hospital for longer than they need to (with associated risk of infection).⁶⁵ This leads to a shortage of available beds in hospital wards for patients to be admitted from A&E, leading to crowding and long waiting times.⁶⁶ One patient described their experience with this:

“[I] was considered ill enough for admission. No bed. Treatment [was] sporadic and a total of 24 hours spent in A&E finally requesting to be allowed home as was in too much pain and discomfort to remain sitting on a hard chair any longer. Traumatic experience.”⁶⁷
35. Overcrowded emergency departments may be unable to accept patients from ambulances, which are often then stuck with patients outside hospitals⁶⁸ and

59 [Q 61](#) (Will Quince MP)

60 NHS England, *What is a virtual ward?*: <https://www.england.nhs.uk/virtual-wards/what-is-a-virtual-ward/> [accessed 30 December 2022]

61 See chapter 8 ‘Best practice’.

62 [Q 46](#) (Sarah Scobie)

63 Written evidence from the Care Quality Commission (CQC) ([AES0023](#)) and [Q 41](#) (Sarah Scobie)

64 [Q 31](#) (Dr Adrian Boyle)

65 Longer stays in hospitals can also worsen patients’ health, see [Q 41](#) (Sarah Scobie).

66 [Q 57](#) (Prof Julian Redhead) and written evidence from the Department of Health and Social Care (DHSC) ([AES0014](#))

67 Written evidence from Healthwatch England ([AES0006](#))

68 [Q 57](#) (Prof Julian Redhead),

unable to respond to other callers.⁶⁹ As Sarah Scobie, Deputy Director of Research at the Nuffield Trust, said, “To understand the pressures on urgent care, the front door of the hospital and the situation with ambulances, you need to start at the back door of the hospital and look at what is going on in terms of patient discharge.”⁷⁰

36. The scale of this problem is significant. The Institute for Government estimated that on an average day between 29 November 2021 and 31 August 2022, 12.4% of general and acute beds in hospitals in England were occupied unnecessarily: patients clinically ready for discharge, but with nowhere to be discharged to.⁷¹ Data for April 2022, obtained via a freedom of information request, indicated that 65% of delays in discharging patients were due to waits for services such as social care or community healthcare to be available, to ensure the discharge was safe.⁷²

Availability of social care

37. Health Education England noted the difficulty in making discharge decisions: “one of the most complex decisions a health care professional has to make is whether someone can be safely maintained at home”.⁷³ Others highlighted concerns about sending a patient home when other clinical support may not be available, such as late at night or on weekends.⁷⁴ Dr Vin Diwakar, medical director for transformation and secondary care at NHS England, said:

“You hear lots of stories from acute trusts where ... all the clinical care has been delivered that can be delivered in a hospital setting, and the community services or local authority care or the care home cannot accept the patient on a Saturday or Sunday.”⁷⁵

38. A lack of social care capacity has been widely reported. 90% of directors of adult social care do not believe there is the funding or workforce to meet the care costs of older and disabled people in their area.⁷⁶ The Government recognises the importance of this for healthcare settings. The Minister for Health and Secondary Care, Will Quince MP, stated that “much of this

69 Written evidence from the Department for Health and Social Care (DHSC) ([AES0014](#))

70 [Q 41](#) (Sarah Scobie)

71 Institute for Government, *Performance Tracker: Hospitals* (17 October 2022): <https://www.instituteforgovernment.org.uk/publication/performance-tracker-2022/hospitals> [accessed 29 December 2022]. See also written evidence from Care England ([AES0009](#)).

72 [Q 41](#) (Sarah Scobie). The Nuffield Trust, *Hospitals at capacity: understanding delays in patient discharge* (October 2022): <https://www.nuffieldtrust.org.uk/news-item/hospitals-at-capacity-understanding-delays-in-patient-discharge> [accessed 29 December 2022] shows that 15% await a permanent bed in a care or nursing home, 22% await short term rehabilitation, 24% await home care and 5% await a community care agreement on discharge plan.

73 Written evidence from Health Education England ([AES0036](#))

74 [Q 40](#) (Dr Adrian Boyle); see also written evidence from HM Inspectorate of Constabulary and Fire & Rescue Services ([AES0012](#)), Royal College of Paediatrics and Child Health ([AES0041](#)).

75 [Q 64](#) (Dr Vin Diwakar)

76 Association of Directors of Adult Social Services, *Autumn Survey Report 2022*: https://mcusercontent.com/83b2aa68490f97e9418043993/files/0c1fb681-8955-aab3-9c2f-f9a3979ea32c/ADASS_Autumn_Survey_Report_Publication_15_November_2022.pdf [accessed 9 January 2023]. See also Skills for Care, ‘The state of the adult social care sector and workforce in England’ (October 2022): <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx> [accessed 9 January 2023]. We have previously highlighted staffing issues in social care, reporting significant challenges in recruitment and retention, with concerns including low pay, lack of recognition, poor wellbeing, and lack of career progression. See: Public Services Committee, *‘Fit for the future?’: Rethinking the public services workforce* (1st Report, Session 2022–23, HL Paper 48)

hinges on social care”.⁷⁷ The Parliamentary Under Secretary of State at the Department of Health and Social Care, Lord Markham, has stated that lack of capacity in social care “is what is behind the 13% of beds that are blocked”.⁷⁸ An additional complexity is that regulation prohibits care homes from accepting patients past identified levels: Len Richards, Chief Executive of Mid Yorkshire Hospitals NHS Trust, shared examples of care homes refusing admissions from over-full hospital wards because it would put their accreditation at risk.⁷⁹

39. **The crisis in emergency healthcare is a symptom of fundamental weaknesses arising from inadequate capacity across primary, community, and hospital and social care settings. A new model for primary care is needed.**

Short-term measures to support social care

40. The Government has taken steps to support swifter discharges into social care. Action includes a £500 million Adult Social Care Discharge Fund which will be distributed between local authorities and integrated care boards (see paragraphs 67–78). This funding is expected to be pooled into the Better Care Fund, which aims to ensure “greater join up of health, social care and housing services” to “enable people to stay well, safe and independent at home for longer”.⁸⁰ Alongside this, in January 2023, the Government announced an additional £200 million for NHS services to “immediately buy short-term care places to allow people to be discharged safely from hospitals”.⁸¹ Given demographic change and the resultant need for further capacity in social care (see paragraph 52), this join up between health and social care funding is welcome. A similar join up occurred during the COVID-19 pandemic, when the NHS was able to use funding to pay for follow-on costs in adult social care or home care costs for up to six weeks after discharge from hospital. This aimed to support social care providers to be able to accept patients from hospitals.⁸²
41. The Adult Social Care Discharge Fund, however, is not new funding: it comes from existing health and care budgets.⁸³ It is also a short-term measure, with funding released in December 2022 and January 2023. The Government has stated that the discharge fund can be used “to boost general adult social care workforce capacity through staff recruitment and retention”⁸⁴ but little information is available about how new staff, including agency staff, recruited

77 [Q 61](#) (Will Quince MP)

78 HL Deb, 9 November 2022, [cols 634–637](#) [Lords Chamber]

79 [Q 27](#) (Len Richards)

80 Department of Health and Social Care, *Press release: Better Care Fund framework 2022 to 2023 published* (19 July 2022): <https://www.gov.uk/government/news/better-care-fund-framework-2022-23-published> [accessed 30 December 2022]

81 Department of Health and Social Care, ‘Up to £250 million to speed up hospital discharge’ (9 January 2023): <https://www.gov.uk/government/news/up-to-250-million-to-speed-up-hospital-discharge> [accessed 12 January 2023]

82 Department of Health and Social Care, ‘Press release: More than half a billion pounds to help people return home from hospital’ (21 August 2020): <https://www.gov.uk/government/news/more-than-half-a-billion-pounds-to-help-people-return-home-from-hospital> [accessed 30 December 2022]

83 HSJ Intelligence, ‘No new money in Coffey’s £500m winter social care fund’ (22 September 2022): <https://www.hsj.co.uk/finance-and-efficiency/no-new-money-in-coffeys-500m-winter-social-care-fund/7033210.article> [accessed 30 December 2022]

84 Department of Health and Social Care, ‘Letter to the health and social care sector from the Minister for Care’ (18 November 2022): <https://www.gov.uk/government/publications/adult-social-care-discharge-fund/letter-to-the-health-and-social-care-sector-from-the-minister-for-care--2> [accessed 30 December 2022]

using that funding will be paid once the discharge fund ends, which suggests that progress may halt after that time. The Adult Social Care Discharge Fund has been described by the Association of Directors of Adult Social Services as “too little, too late”.⁸⁵ While the £200 million announced in January 2023 appears to be additional funding, stakeholders have criticised the timing of the decision, with the NHS Confederation arguing that “the government is playing catch up” during a crisis.⁸⁶

42. ***The Government should introduce further incentives to enable discharge at the right time for patients, freeing up hospital capacity. This could include further use of NHS budgets to cover social care costs.***

Longer term support

43. Within the Autumn statement, the Government has announced a funding increase for the social care sector. This was an increase of up to £2.8 billion in 2023–24, and £4.7 billion in 2024–25.⁸⁷ While additional support for social care is welcome, it does not meet the £7 billion annual increase called for by the House of Commons Health and Social Care Committee in 2020.⁸⁸
44. **While the Government’s interventions to boost capacity in social care are welcome, they will not be sufficient to fully address the problem.**

85 Local Government Chronicle, ‘Discharge fund roll out ‘too little, too late’, warns Adass’ (12 November 2022): <https://www.lgcplus.com/services/health-and-care/discharge-fund-roll-out-too-little-too-late-warns-adass-21-11-2022/> [accessed 30 December 2022]

86 NHS Confederation, ‘Government playing catch up on NHS crisis, say health leaders’ (9 January 2023): <https://www.nhsconfed.org/news/government-playing-catch-nhs-crisis-say-health-leaders> [accessed 12 January 2023]

87 HC Deb, 17 November 2022, cols 844–893 [Commons Chamber]

88 Health and Social Care Committee, *Social care: funding and workforce* (Third Report, Session 2019–21, HC 206)

CHAPTER 4: LEADERSHIP

Leadership and vision

45. Our witnesses called for change, a sense of urgency, and leadership from central government. When asked about the role of the Government in addressing the structural problems affecting emergency healthcare, the Minister for Health and Secondary Care Will Quince MP seemed to devolve responsibility. He said:

“You have to empower systems and leaders at a local level to make clinical decisions that are in the best interests of the patient, not in the best interests of meeting targets that we set in Whitehall.”⁸⁹

Similarly, the National Clinical Director for Urgency and Emergency Care told us that NHS England stressed the importance of allowing local health leadership to address challenges, including those in emergency health services, saying NHS England “want[s] the systems to try to sort this out themselves rather than having someone dictating and saying, ‘Thou shalt’”.⁹⁰ NHS England’s operating model stresses the importance of “empowering local leaders to make the best decisions for their local population”. It states that NHS England will “agree the mandate for the NHS with government” and “set the national direction.”⁹¹

46. Our witnesses called, though, for mandate and direction from the centre. This, we were told, should come alongside a clear, holistic view and a set of expectations for what should be delivered. The Care Quality Commission told us that:

“a common vision and purpose, shared between leaders in a system to work together, is ... needed to meet the needs of people who use services, their families and carers. System leaders need to move away from reactive ‘quick fixes’ ... and to address the enormous gap in resources and capacity.”⁹²

47. Others agreed. Professor Paresh Wankhade, Professor Peter Murphy and Dr Geoffrey Heath argued that “strategic delivery plans” relating to different government commitments for emergency health services were “conspicuously absent”. They called for “a national strategy” led by NHS England which brought together and prioritised government plans to improve the situation and includes regionally focused plans for emergency health services.⁹³ Similarly, GMB stated that “without serious strategic and joined up action led by government and across the healthcare system [the situation] will become even more devastating”.⁹⁴
48. **Health systems on a local level cannot be expected to develop a common vision and purpose without a clear national steer on their common purpose. There is no such steer.**

89 [Q 62](#) (Will Quince MP)

90 [Q 57](#) (Prof Julian Redhead)

91 NHS England, ‘Letter to the health and care system from Mark Cubbon, NHS England Chief Delivery Officer’ (12 October 2022): <https://www.england.nhs.uk/long-read/letter-to-the-health-and-care-system-from-mark-cubbon-nhs-england-chief-delivery-officer/> [accessed 30 December 2022]

92 Written evidence from the Care Quality Commission (CQC) ([AES0023](#))

93 Written evidence from Prof Wankhade et al ([AES0028](#))

94 Written evidence from GMB ([AES0021](#))

COBR

49. We are concerned that neither the Department of Health and Social Care, nor NHS England, seem prepared to deliver the leadership required with the urgency required. We therefore considered how to ensure that the situation would be addressed at the highest levels of policy making. We are attracted to the idea of referring this issue to COBR, the civil contingencies committee which deals with matters of national emergencies or major disruption.⁹⁵ This would have the benefit of securing cross-government attention, including that of the Treasury and the Prime Minister. We have set out in chapter 2 the extent to which the situation of emergency healthcare fits the criterion of “national emergency”, and we lack any confidence in the existing structures to ensure the leadership this issue needs. Referring the matter to a COBR Committee would enhance accountability and bring public attention to the severe state of affairs.⁹⁶
50. *The crisis of emergency healthcare should be referred to a COBR Committee.*

Service model

51. Our evidence was clear that the current model for emergency health services is out of date and unfit for purpose.

Demographic change in the UK

52. Shifting demographics have, as we noted in our report, *Fit for the Future?*, changed the nature of demand for health services.⁹⁷ Increasing numbers of older people and those with multiple health conditions place different and more complicated demands on health services. We have not identified evidence that demonstrates that the model of service provision has evolved to fit current population needs.

Model for delivery

53. Dr Andrew Newton, former Chair of the College of Paramedics, argued that ambulance services were “stuck in a previous era”.⁹⁸ Professor Leo McCann agreed with the College of Paramedics that the commissioning model for ambulance services is “outdated”.⁹⁹ Both argued that the emergency health model focuses on a swift response and conveyance to hospital. This, they said, does not fully recognise that significant amounts of treatment can be delivered on scene or over the telephone, and that this may be better for patients: a focus on swift response does not indicate enough focus on obtaining the right outcome for patients. Miriam Deakin, Director of Policy and Strategy at NHS Providers, argued that it was important to stop “just seeing the ambulance service as a sort of blue-light response”.¹⁰⁰ Due to increased demand in urgent but not emergency cases (meaning high-acuity

95 Institute for Government, ‘COBR (COBRA): What is COBR or COBRA?’ (12 October 2022): <https://www.instituteforgovernment.org.uk/explainers/cobr-cobra> [accessed 30 December 2022]

96 See chapter 2, ‘A national emergency’.

97 Office for National Statistics, ‘National population projections: 2020-based interim’ (12 January 2022): <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2020basedinterim> [accessed 30 December 2022]. See also Public Services Committee, *‘Fit for the future?’: Rethinking the public services workforce* (1st Report, Session 2022–23, HL Paper 48).

98 Written evidence from Dr Andrew Newton (AES0031)

99 Q 6 (Leo McCann); Written evidence from the College of Paramedics (AES0016)

100 Q 19 (Miriam Deakin)

cases which are not time sensitive), services needed to have “a mixed-model workforce” including specialists such as midwives or district nurses being placed in control centres.¹⁰¹ Daniel Elkeles, Chief Executive of the London Ambulance Service, spoke about the move to a model that is “more about [paramedics] making clinical decisions for their patients”, which had been made possible by an expansion of skills in the paramedic profession.¹⁰²

54. This focus on conveyance to hospital does not reflect the fact that only 50% of cases that ambulances respond to result in conveyance to hospital. Instead, paramedics treat people over the telephone (‘hear and treat’ approaches) or on the scene (‘see and treat’ approaches).¹⁰³
55. The President of the College of Paramedics, Dr John Martin, believed that conveyance rates could drop as low as 30%.¹⁰⁴ An approach focused away from conveyance would, we were told, allow appropriate care to be provided *in situ* and would reduce unnecessary hospital admission and attendance.¹⁰⁵ The Director General for NHS Policy and Performance at the DHSC, Matthew Style, noted that more patients being dealt with through ‘hear and treat’ and ‘see and treat’ approaches, and a corresponding lower proportion being taken to hospital, was a “positive development” which the department encouraged.¹⁰⁶ When we asked ambulance leaders what models paramedics were encouraged to follow, we heard that there is “no consensus on a non-conveyance model.”¹⁰⁷
56. This lack of consensus also means that the extra time ‘see and treat’ approaches take—keeping ambulance crews on the scene for longer and meaning they take longer to respond to the next case, may not be being recognised or planned for effectively.¹⁰⁸
57. Dr John Martin, President of the College of Paramedics, provided a possible explanation for this lack of central steer. He said that ambulance services had traditionally been seen as a “bit of a bolt on”.¹⁰⁹ Ambulance services developed separately from other NHS services. They were only brought into the NHS in 1974, having developed within local government and having aligned with other emergency services for some of their operation.¹¹⁰ Within their areas, Integrated Care Boards and Systems¹¹¹ cover all NHS services; however, ambulance trusts operate on a different, larger geographic basis covering multiple Integrated Care Systems.¹¹²

101 [Q 19](#) (Miriam Deakin)

102 Supplementary written evidence from Daniel Elkeles ([AES0044](#))

103 NHS England, *Transforming urgent and emergency care services in England: Clinical models for ambulance services* (November 2015): <https://www.nhs.uk/nhsengland/keogh-review/documents/uecr-ambulance-guidance-fv.pdf> [accessed 30 December 2022]

104 [Q 21](#) (Dr John Martin)

105 [Q 25](#) (Daren Mochrie), written evidence from NHS Providers ([AES0027](#))

106 [Q 62](#) (Matthew Style)

107 Supplementary written evidence from Daniel Elkeles ([AES0044](#))

108 Written evidence from MedTeams ([AES0049](#))

109 [Q 18](#) (Dr John Martin)

110 Written supplementary evidence from Dr John Martin, College of Paramedics ([AES0046](#))

111 For further information on Integrated Care Boards and Systems see Box 4 and NHS England, ‘What are integrated care systems?’: <https://www.england.nhs.uk/integratedcare/what-is-integrated-care/> [accessed 30 December 2022].

112 [Q 18](#) There are 42 integrated care boards in England, which cover NHS services such as hospitals and primary care in a specified area; however there are only 10 ambulance services in England, which generally operate on a regional basis.

Targets

58. We heard that the targets emergency health services work to have not kept up with changes in the nature of demand, and do not reflect how services are now accessed, delivered and used.¹¹³ The College of Paramedics argued:

“The current targets are only fit for purpose for around 10% [of] all calls. They are ‘time driven’, as opposed to linked to improving patient outcome”.¹¹⁴

59. Some argued that that the targets were irrelevant because they were rarely, if ever, met on a national level. Sarah Scobie, Deputy Director of Research at the Nuffield Trust, said:

“There is not really, as far as I can see, an effective performance framework for urgent care, because the targets that have been in place for some time have not been met for a very long time. The four-hour time in A&E¹¹⁵ has not been met for over seven years, for example. It is not really clear how an organisation’s performance would be assessed and how patients would know whether their local providers were performing.”¹¹⁶

We heard similar arguments from frontline staff. A student paramedic and call handler stated “targets are not seen as either achievable or important, in weekly bulletins it is normal to see every targeted response time has been missed.”¹¹⁷

Ambulance Response Programme

60. In 2017 the Department of Health and Social Care introduced a new performance system, the Ambulance Response Programme (ARP). The DHSC said this “sought to address ‘target-chasing’ behaviours ... [by] installing a clinically led model that prioritises the sickest patients and drives efficient and clinically led responses ... [so providing] a clinically appropriate response to different kinds of 999 calls.” The programme was largely aimed at moving away from time-centred targets to targeting based on ensuring the appropriate clinical response.¹¹⁸
61. The ARP received some praise from witnesses, with Daren Mochrie, Chair of the Association of Ambulance Chief Executives, describing it as “the biggest substantial change in operating practice in England for 40 years”¹¹⁹ and arguing that under the ARP standards “ambulance services were doing much better”.¹²⁰ He added that while “it will take several years for the system to bed in ... as at May 2018 the ARP has been successfully implemented across all ambulance services”.¹²¹
62. Other witnesses were less positive. Professor Wankhade and his co-contributors stated that while the introduction of the ARP “led to some improvement in the evaluation of ambulance performance”, time-focused

113 Written evidence from Wankhade et al ([AES0028](#))

114 Written evidence from the College of Paramedics ([AES0016](#))

115 The target that 95% patients attending A&E should be admitted, transferred or discharged within four hours.

116 [Q 42](#) (Sarah Scobie)

117 Written evidence from Anonymous 1 ([AES0001](#))

118 Written evidence from the Department of Health and Social Care (DHSC) ([AES0014](#))

119 Written evidence from Daren Mochrie, Chair, Association of Ambulance Chief Executives ([AES0047](#))

120 [Q 24](#) (Daren Mochrie)

121 Written evidence from Daren Mochrie, Chair, Association of Ambulance Chief Executives ([AES0047](#))

targets “continue to be predominant in ambulance performance metrics despite research showing the need to focus more on quality and outcomes.”¹²² The College of Paramedics argued that the clinical quality indicators introduced measures of processes as opposed to outcomes and suggested that “more work needs to be undertaken to align emergency health provision to outcome-based measures”.¹²³

Clinically led review of urgent and emergency care standards

63. In December 2020, NHS England published a consultation on new metrics for urgent and emergency care, with responses published in May 2021. The response to the consultation demonstrated broad support for a “proposed new bundle of standards for urgent and emergency care” including reducing avoidable trips to emergency departments by ambulances, the percentage of patients spending more than 12 hours in A&E and the percentage of ambulance handovers within 15 minutes.¹²⁴ Implementing these new standards would mean removing other performance metrics, such as the target that 95% of patients attending A&E should be admitted, transferred or discharged within four hours.
64. It is not clear whether these new measures will be implemented. Sarah Scobie said “the implementation [of the new measures] seems to have stalled”.¹²⁵ Healthwatch reported that “there has been no further detail ... on whether the review’s recommendations will be adopted.”¹²⁶ NHS England selected 14 pilot sites to test the new metrics, but the Royal College of Emergency Medicine told us: “there has been a lack of transparency about the data and no consistent instructions to the pilot sites about how to implement the proposed framework.”¹²⁷ They argued that uncertainty around the future use of the four hour target and the implementation of new standards from the clinical review means the urgent and emergency care system in England is “operating in a performance vacuum”.¹²⁸
65. Professor Julian Redhead, National Clinical Director for Urgent and Emergency Care at NHS England, stated that NHS England was, with the Department of Health and Social Care, “looking at when we can start to move to that system”.¹²⁹ When questioned on A&E and ambulance targets in the House of Lords on 22 November, Parliamentary Under Secretary of State at the Department of Health and Social Care Lord Markham stated that “we are making sure that we look at the performance measures that really matter”.¹³⁰ Neither NHS England nor Lord Markham indicated a timeline for introducing such measures, and Lord Markham did not reference the metrics suggested in the review.
66. **Emergency and urgent care services are working to an outdated operating model which no longer reflects the reality of demand or**

¹²² Written evidence from Wankhade et al ([AES0028](#)), see also written evidence from Prof Leo McCann ([AES0043](#)).

¹²³ Written evidence from the College of Paramedics ([AES0016](#))

¹²⁴ NHS England, *Clinically led review of urgent and emergency care standards: measuring performance in a transformed system* (26 May 2021): <https://www.england.nhs.uk/wp-content/uploads/2021/05/B0546-clinically-led-review-of-urgent-and-emergency-care-standards.pdf> [accessed 30 December 2022]

¹²⁵ [Q 42](#) (Sarah Scobie)

¹²⁶ Written evidence from Healthwatch England ([AES0006](#))

¹²⁷ Written evidence from the Royal College of Emergency Medicine ([AES0017](#))

¹²⁸ Written evidence from the Royal College of Emergency Medicine ([AES0017](#))

¹²⁹ [Q 57](#) (Prof Julian Redhead)

¹³⁰ HL Deb, 22 November 2022, [col 1267](#) [Lords Chamber]

clinical practice. The limited efforts to address this seem to have stalled. Persisting with an outdated model will prevent services from delivering the care that patients need.

Integrated Care Boards and Systems

67. One of the topics on which we heard some optimism was the emerging role of Integrated Care Boards and Systems (ICBs and ICSs). These were established in statute in July 2022 and aim to bring together different organisations in the governance of the health and care systems in local areas. The introduction of ICBs and ICSs and the opportunity they provide to further a more integrated, holistic approach was welcomed by witnesses,¹³¹ due to their potential to address the systemic issues causing challenges in emergency health services.¹³²

131 [Q 16](#) (Daniel Elkeles), [Q 21](#) (Miriam Deakin), [Q 28](#) (Len Richards), [Q 30](#) (Daren Mochrie) [Q 47](#) (Victoria Vallance), written evidence from Care England ([AES0009](#)), College of Paramedics ([AES0016](#)), Royal College of Emergency Medicine ([AES0017](#)), Association of Ambulance Chief Executives (AACE) ([AES0024](#)), and NHS Providers ([AES0027](#))

132 See chapter 3, ‘What has gone wrong?’.

Box 4: Integrated care

- Integrated Care Systems (ICSs) are “partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.” Their responsibilities include bringing partner organisations together to improve health outcomes, tackle health inequalities, enhance productivity and value for money, and “help the NHS support broader social and economic development.” 42 ICSs were established across England on a statutory basis on 1 July 2022.¹³³
- Each ICS has an Integrated Care Board (ICB), a “statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area.” These replaced clinical commissioning groups.¹³⁴ ICB membership must include a chair and chief executive, and representatives from NHS trusts, primary medical services, and local authorities, with additional members who do not hold roles in health and care organisations within the ICS.¹³⁵
- Each ICS also has an integrated care partnership (ICP), which is a “statutory committee jointly formed between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.”¹³⁶ ICPs have elected chairs, and chairs of ICPs may also be chairs of ICBs. Some ICPs have a shared or rotating chair model.¹³⁷ Membership of ICPs is determined locally and can include but are not limited to social care providers for adults and children, regional UK Health Security Agency teams, police and crime commissioners, and voluntary, community and social enterprise alliances.¹³⁸

Systemic challenges

68. Part of the problem in addressing the challenges emergency health services face is that the causes of those challenges often do not sit with the service addressing them. Miriam Deakin, interim deputy chief executive and director of policy and strategy at NHS Providers, noted that “many of the

133 NHS England, ‘What are integrated care systems’: <https://www.england.nhs.uk/integratedcare/what-is-integrated-care/> [accessed 30 December 2022]

134 NHS England, ‘What are integrated care systems’: <https://www.england.nhs.uk/integratedcare/what-is-integrated-care/> [accessed 30 December 2022]

135 ICB membership must include: a chair; chief executive; Director of finance; Medical Director; Director of nursing; at least three Partner Members from NHS trusts and foundation trusts; primary medical services; and local authorities. There should be at least two ‘non-executive’ members, who are not employed by the ICB nor who hold roles in a health and care organisation in the ICS area. Additional partner and non-executive members may be appointed.

136 NHS England, ‘What are integrated care systems’: <https://www.england.nhs.uk/integratedcare/what-is-integrated-care/> [accessed 30 December 2022]

137 NHS England, ‘Integrated care system leadership and websites’: <https://www.england.nhs.uk/integratedcare/ics-leadership/> [accessed 30 December 2022]

138 For a non-exhaustive list of potential members suggested by DHSC, see Department of Health and Social Care, ‘Statutory guidance: Annex A: people and organisations to consider involving’ (29 July 2022): <https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/annex-a-people-and-organisations-to-consider-involving> [accessed 30 December 2022].

solutions to the challenges the ambulance service faces sitting outside the gift of any individual leader.”¹³⁹ The Royal College of Emergency Medicine agreed that “The siloed nature of [Urgent and Emergency Care] means that it is difficult for system leaders to identify and share risk equitably across the system.”¹⁴⁰

69. The Department of Health and Social Care expects that Integrated Care Systems will deliver a holistic, system-wide leadership for health and care services, improving collaboration to address issues for which (like those in emergency health services) problems in one service arise due to problems in another.¹⁴¹ Because they bring together leadership from hospital trusts and local authorities who are responsible for social care provision and public health functions, ICSs should provide a mechanism to develop the “shared vision” for local health and care which the Care Quality Commission calls for.¹⁴²
70. ICBs present an opportunity to approach risk management in the health system from a systemic perspective rather than considering risk solely in individual services. Victoria Vallance, Director of Secondary and Specialist Healthcare at the Care Quality Commission, spoke positively about this, saying “risk is best managed where it is shared, with partners around the table owning the pressures in the system together, understanding the severity of the risk for their population groups and local communities, and then planning capacity within the service”.¹⁴³
71. ICBs operate on a larger geographic basis than the clinical commissioning groups they replace. Witnesses thought that this should allow for easier collaboration between Integrated Care Systems and ambulance trusts. London Ambulance Service’s Chief Executive Officer, Daniel Elkeles, told us that it was easier for the London Ambulance Service to collaborate with five ICSs than the larger number of clinical commissioning groups, and that working with ICSs had been more collaborative and less competitive compared with working with clinical commissioning groups.¹⁴⁴
72. However, there is still a mismatch between ambulance trusts and ICBs—there are 42 integrated care boards and 10 ambulance services in England, with individual ambulance services covering a larger area than individual care boards.¹⁴⁵

139 [Q 20](#) (Miriam Deakin), see also written evidence from NHS Providers ([AES0027](#)).

140 Written evidence from the Royal College of Emergency Medicine ([AES0017](#))

141 Written evidence from the Department of Health and Social Care (DHSC) ([AES0014](#)). Examples of challenges in other parts of the health and care system affecting emergency health services, such as social care capacity, are set out in chapter 3, ‘What has gone wrong?’

142 Written evidence from the Care Quality Commission ([AES0023](#))

143 [Q 46](#) (Victoria Vallance)

144 [Q 16](#) (Daniel Elkeles) Before Clinical Commissioning Groups were replaced by ICSs there were 106 CCGs in England, with 32 in London - roughly one per borough.

145 [Q 18](#) (Dr John Martin) Ambulance services tend to map to the former government office regions, with the exception of the South West and South central Ambulance services. For a full list of ICSs and relevant leaders see NHS England, ‘Integrated care system leadership and websites’: <https://www.england.nhs.uk/integratedcare/ics-leadership/> [accessed 30 December 2022], and for a full list of ambulance trusts see Association of Ambulance Chief Executives, ‘Structure of the UK ambulance services’: <https://aace.org.uk/uk-ambulance-service/> [accessed 30 December 2022].

*How ICSs will affect change**Improving services*

73. There is little clarity on how ICSs will hold services to account if the services perform poorly. Victoria Vallance stated that the Care Quality Commission would expect “the system itself to reach through and provide support”.¹⁴⁶ It is unclear to us what this means, or how it would happen. Sarah Scobie, Deputy Director of Research at the Nuffield Trust, referred to:

“a lack of clarity about what the levers are for change and improvement. Previously, between the CCG and the providers, there were contractual arrangements that could be levers for improvement, and it is not clear how that is going to play out in an area if one organisation is felt to not be performing.”¹⁴⁷

Victoria Vallance stated that “The accountability and responsibility systems [between ICSs, ICBs and individual services] are still working this out themselves. They are grappling with it. What does the governance look like?”¹⁴⁸

74. Dr Vin Diwakar, on the other hand, stated that ICB and ICS accountability was “really clear”.¹⁴⁹ The NHS England operating model states that NHS England will “agree oversight arrangements for place based systems and organisations”.¹⁵⁰ NHS England representatives said that ICS accountable officers would be empowered to intervene in specific services.¹⁵¹ However they also acknowledged that some ICSs may not yet be in a position to make such interventions.¹⁵² NHS England Chief Delivery Officer Mark Cubbon has acknowledged that the framework now in place “does not contain all the answers at this point” and that accountability and responsibility systems continue to be developed “as other aspects of policy are confirmed”.¹⁵³
75. The Government have announced a review into Integrated Care Systems (‘the Hewitt Review’), which will “explore how to empower local leaders”. Specific areas of consideration for the review when it was announced were to ensure that “new ICSs are held robustly to account” and “the relationship between ICSs, and central bodies”.¹⁵⁴ The terms of reference of the review however indicate that it could result in “a significantly smaller number of national targets” for ICBs to be held accountable to.¹⁵⁵

146 Q 48 (Victoria Vallance)

147 Q 42 (Sarah Scobie)

148 Q 48 (Victoria Vallance). See also Q 22 (Miriam Deakin).

149 Q 49 (Dr Vin Diwakar)

150 NHS England, *Operating Framework for NHS England*, (12 October 2022), p 10: <https://www.england.nhs.uk/wp-content/uploads/2022/10/B2068-NHS-England-Operating-Framework.pdf> [accessed 30 December 2022]

151 Q 52 (Prof Julian Redhead)

152 QQ 52–53 (Prof Julian Redhead)

153 NHS England, ‘Letter to the health and care system from Mark Cubbon, NHS England Chief Delivery Officer’ (12 October 2022): <https://www.england.nhs.uk/long-read/letter-to-the-health-and-care-system-from-mark-cubbon-nhs-england-chief-delivery-officer/> [accessed 30 December 2022]

154 Department of Health and Social Care, ‘Press release: Independent review of integrated care systems’: <https://www.gov.uk/government/news/independent-review-of-integrated-care-systems> [accessed 30 December 2022]

155 Department of Health and Social Care, ‘Independent report: Hewitt review: terms of reference’ (6 December 2022) <https://www.gov.uk/government/publications/hewitt-review-terms-of-reference/hewitt-review-terms-of-reference> [accessed 30 December 2022]

76. **Integrated Care Boards and Systems have potential to deliver services that address local population need and make significant improvements. There appears, though, to be little understanding of how they will function, or who will be accountable for the delivery of services. We consider it unlikely that ICSs and ICBs will be able to deliver on the high expectations placed on them without further clarity on these matters. They will also need more leadership from the centre than is currently envisaged.**
77. *Following the Hewitt Review, the Government must set out accountability and governance arrangements for ICBs and ICSs. These systems must consider how to ensure system accountability where challenges in one service have a domino effect on others.*
78. *The Government should consider, consult upon, and establish a bold and ambitious new operating model for emergency healthcare. This operating model must address pressures throughout the system and provide strong leadership to:*
 - *reflect increased demand for, and new ways of delivering, emergency health services;*
 - *establish robust accountability arrangements at national, ICS, and service level;*
 - *set clear expectations and arrangements for collaboration with other emergency responders; and*
 - *establish functional mechanisms to improve the sharing of good practice.*

CHAPTER 5: CLARITY OF PUBLISHED DATA

79. The step-change required for urgent and emergency care will need to be based upon a solid understanding of the situation: leaders need data on which to base policy. And yet the data situation within emergency healthcare, and emergency services more generally, is poor. It lacks clarity, and much that is gathered it is not necessarily used or understood by decision makers. Some of it is simply misleading. Addressing problems in data will not fix the wider problem, but they cannot be ignored.

Waiting times

80. The long waiting times highlighted in chapter 2, ‘A national emergency’, demonstrate that patients face serious delays in accessing emergency healthcare. We heard that the way waiting times are published on a monthly basis diminishes the scale of the problem.
81. The data NHS England publishes monthly show the number of patients who wait 12 hours or more after a ‘decision to admit’, when a clinician decides a patient should be admitted to hospital, but not the number of patients who wait 12 hours or more after arriving at A&E.¹⁵⁶ The data on 12 hour waits from arrival are gathered and shared with NHS England and Integrated Care Systems, but are not published alongside other monthly data, instead being published annually.¹⁵⁷
82. The Royal College of Emergency Medicine report that in August 2022, over 133,000 patients waited more than 12 hours from arrival at A&E—a figure five times higher than the 28,000 reported by NHS England.¹⁵⁸ Dr Adrian Boyle, President of the Royal College of Emergency Medicine, argued that this manner of reporting waiting times was “a fundamentally dishonest way of reporting data. It is hiding and doing our patients a disservice by minimising a very serious problem”.¹⁵⁹

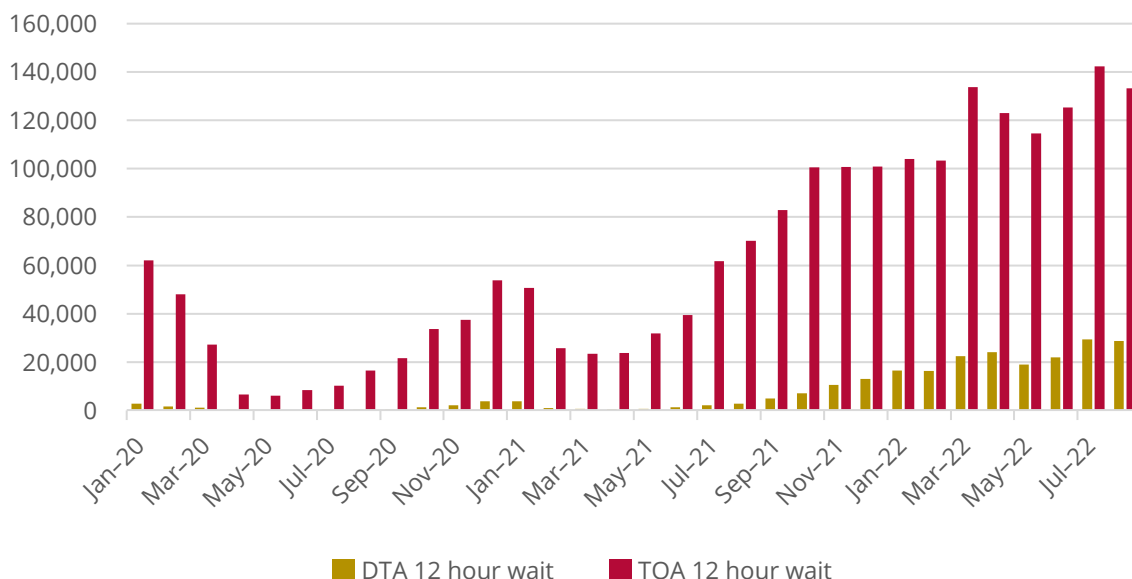
156 NHS England, *A&E Attendances and Emergency Admissions November 2022 Statistical Commentary* (November 2022) : <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2022/12/Statistical-commentary-November-2022-cftre1-1.pdf> [accessed 10 January 2023]

157 [Q 57](#) (Prof Julian Redhead)

158 Flourish, *Emergency Department attendances of 12 hours or more, measured from patient’s time of arrival*. (November 2022): <https://public.flourish.studio/story/1724303/> [accessed 29 December 2022]. See also [Q31](#) (Adrian Boyle).

159 [QQ 31, 39](#) (Dr Adrian Boyle)

Figure 9: Number of patients waiting 12 hours or more from decision to admit (DTA) and time of arrival (TOA) in the last 12 months



Royal College of Emergency Medicine, 'Data & Statistics': <https://rcem.ac.uk/data-statistics/> [accessed 9 January 2023]. The 'decision to admit' (DTA) is when a clinician has seen the patient and decided they should be admitted to A&E. The 'time of arrival' (TOA) is when a person walks through the door at A&E.

83. In July 2022, the Office for Statistics Regulation wrote to NHS England arguing that there was a “clear need for more frequent figures” and requesting that the 12 hour from arrival data be published monthly.¹⁶⁰ When questioned on this, Dr Vin Diwakar stated “the decision about what data to publish is not one NHS England can take alone.”¹⁶¹ Professor Julian Redhead indicated that there was discussion between NHS England and the Department of Health and Social Care on this topic, noting that it was “one measure out of a suite of measures” that was being considered.¹⁶² As noted in chapter 4, ‘Leadership’, these measures appear to have stalled.¹⁶³
84. *The current data published by NHS England on emergency department waiting times inaccurately portray the true waiting times experienced by patients attending A&E. NHS England should publish monthly the number and proportion of patients waiting 12 hours or more from arrival at accident and emergency departments.*

Demand for emergency health services

Level of demand

85. The Committee heard conflicting views about how demand for emergency health services is changing, with some arguing demand had seen a recent significant increase while others argued that the increase was more long-

160 Office for Statistics Regulation, *Ed Humpherson to Chris Roebuck and Mark Svenson: Statistics on patients waiting more than 12 hours* (July 2022): <https://osr.statisticsauthority.gov.uk/correspondence/ed-humpherson-to-chris-roebuck-and-mark-svenson-statistics-on-patients-waiting-more-than-12-hours/> [accessed 29 December 2022]

161 Q 57 (Dr Vin Diwakar)

162 Q 57 (Prof Julian Redhead)

163 Q 42 (Sarah Scobie), written evidence from Healthwatch England (AES0006) and Royal College of Emergency Medicine (AES0017)

term.¹⁶⁴ This was perhaps best encapsulated by the Minister, Will Quince: when it was suggested to him that demand for emergency health services would continue to rise, the Minister replied, “I broadly agree ... but the statistics do not”.¹⁶⁵ While the pandemic has apparently impacted the growth in demand for emergency health services, the reasons for demand growth such as demographic change and unmet needs elsewhere in the health system indicate that it will continue to increase.¹⁶⁶

Type of demand

86. We heard disagreement about the type of demand emergency services face. The Open University Centre for Policing, Research and Learning stated:

“All services currently focus on limiting demand and restricting access to services rather than meeting demand ... most public services have a poor understanding of the underlying demand in the system ... [and] develop strategies that either refuse requests from the public, limits who receives service, or pass demand to other services (often even less well equipped, resourced or skilled to meet this demand).”¹⁶⁷

87. We heard that the number of high-acuity cases has increased.¹⁶⁸ We also heard that “life-threatening illness and injury” make up just 10% of emergency calls,¹⁶⁹ that emergency services were regularly responding to “unplanned primary care”¹⁷⁰ and that patients with mental health problems were increasingly presenting at A&E.¹⁷¹ DHSC Minister Will Quince stated:

“[NHS Trust] chief executives ... say to me that A&E stands for ‘accident and emergency’ not ‘anything and everything’.”¹⁷²

88. We were told that the reports of more high-acuity cases were due to cases being inappropriately categorised as high risk,¹⁷³ including by NHS 111.¹⁷⁴ This will be further explored in chapter 6, ‘Right place, right time’.
89. We also heard that some groups or organisations were making up a disproportionate amount of calls, including specific vulnerable children,¹⁷⁵ adults with multiple unmet mental health, physical health, and social care needs.¹⁷⁶ Professor Julia Williams noted that a significant number of calls came from care homes about elderly people who had fallen.¹⁷⁷ However, it is

164 For contributors who argued that demand was rising significantly in recent months, see [Q12](#) (Daniel Elkeles), [QQ 24,26](#) (Len Richards), written evidence from Unison ([AES0039](#)). Conversely, NHS England data show demand is only 1% higher than pre-pandemic levels, see written evidence from the Department for Health and Social Care (DHSC) ([AES0014](#)).

165 [Q 61](#) (Will Quince MP)

166 See chapter 4, ‘Leadership’.

167 Written evidence from the Open University for Policing, Research and Learning ([AES0011](#))

168 [QQ 24–25](#) (Daren Mochrie); [Q 42](#) (Victoria Vallance); Written evidence from Dr Alison Porter ([AES0034](#)) and NHS Providers ([AES0010](#))

169 Written evidence from the College of Paramedics ([AES0016](#)); see also written evidence from Dr Jamie Miles and Steve Scholes ([AES0029](#)) and [Q12](#) Daniel Elkeles.

170 [Q 6](#) (Prof Leo McCann)

171 [Q 12](#) (Daniel Elkeles), written evidence from the Association of Ambulance Chief Executives (AACE) ([AES0024](#)), NHS Confederation ([AES0010](#)), and the Royal College of Emergency Medicine ([AES0017](#))

172 [Q 60](#) (Will Quince MP)

173 Written evidence from Anonymous 1 ([AES0001](#))

174 Written evidence from Dr Jamie Miles and Steven Scholes ([AES0029](#))

175 Written evidence from the Association of Paediatric Emergency Medicine ([AES0033](#))

176 Written evidence from the Frequent Caller National Network ([AES0008](#))

177 [Q 31](#) (Prof Julia Williams)

difficult to quantify from the data where trends in frequent calls are occurring, and whether these are appropriate or inappropriate calls, undermining the ability to target interventions.

90. **There is no clear picture of the type of demand faced by urgent and emergency care providers. This will significantly hinder effective planning and service design.**
91. ***NHS England must improve the quality and interpretation of data gathered on urgent and emergency caseloads to explain accurately the type of cases faced by ambulances and A&E.***

Delayed discharge

92. As established in chapter 2, there are substantial numbers of people medically fit for discharge but who remain in hospital. Authoritative data on the reasons for this is collected, but it is not publicly available. In February 2020, for capacity reasons at the beginning of the COVID-19 pandemic, NHS England paused publication of the relevant dataset, the Delayed Transfer of Care dataset.¹⁷⁸ NHS England states that they will “keep the paused collections under review to establish at which point further collections should be reinstated”.¹⁷⁹ As with the other data points noted in this chapter, a lack of information hampers decision makers. Information that is available, but not to the public, impedes scrutiny, challenge and accountability.
93. ***NHS England should resume publishing the Delayed Transfer of Care dataset.***

178 NHS England, *Delayed Transfers of Care Statistics* : <https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/> [accessed 29 December 2022]; NHS England, *COVID-19 and the production of statistics* : <https://www.england.nhs.uk/statistics/covid-19-and-the-production-of-statistics/> [accessed 29 December 2022]

179 NHS England, *COVID-19 and the production of statistics*: <https://www.england.nhs.uk/statistics/covid-19-and-the-production-of-statistics/> [accessed 29 December 2022]

CHAPTER 6: RIGHT PLACE, RIGHT TIME

94. Because the stakes are so high in emergency care, it is natural that clinicians will want to avoid risk; making the safest decision for patients at every stage. We heard that each point of care has a tendency to refer up the chain, in preference to holding any risk at that level. We heard of schools, for example, calling ambulances for every child who had bumped their head (including when parents could have driven the child to A&E).¹⁸⁰
95. The Royal College of Emergency Medicine noted the dangers that can arise from overload in call centres, ambulances and wards: “an overwhelmed system marked by high levels of crowding may increase the risk of significant adverse events, errors, complaints, and litigation”.¹⁸¹ Overload can undermine improvements made elsewhere, with Professor Leo McCann saying a programme’s improvements “appear to have been offset by continued demand overload and the intensification of chronic shortages”.¹⁸² As outlined in chapter 3, an overloaded system creates a vicious circle:

“High occupancy prevents patients being admitted from A&E quickly. This increases waiting times and crowding in emergency departments, driving further delays in ambulances handing over their patients to A&E. In turn, this causes ambulance queuing, which reduces resource available to respond to incoming 999 calls, driving longer ambulance response times in the community.”¹⁸³

NHS 111

96. NHS 111 is a telephone line for people who think they “need medical help right now”.¹⁸⁴ It aims to direct people to the right place to care for them. It might advise callers to call 999, to treat themselves safely at home or to a range of options in between. One study found that around 80.2% of callers were advised to attend A&E within 1–4 hours and only 0.3% were referred to self-care.¹⁸⁵
97. The service was repeatedly described as transferring people to an emergency service when they did not need to be there, with witnesses describing it as “risk-averse”.¹⁸⁶ Professor Leo McCann, among others, said that there was a practice of escalating callers to 999: “If there is any risk, they will naturally transfer it to another organisation”.¹⁸⁷
98. Decision-support algorithms are used to classify cases (with a call handler asking questions on the telephone) in terms of acuity. These algorithms, we were told, can identify “high acuity” patients (those with the highest risk) “with near perfection, but it will also class 94.1% of the mid- to low-acuity

180 Written evidence from Deb Saunders (AES0005). See also appendix 4: ‘Summary of engagement event’.

181 Written evidence from Royal College of Emergency Medicine (AES0017)

182 Supplementary written evidence from Prof Leo McCann (AES0043)

183 Written evidence from the Department of Health and Social Care (DHSC) (AES0014)

184 NHS, *When to use NHS 111 online or call 111* November 2022): <https://www.nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-use-111/> [accessed 30 December 2022]

185 Basav Sen et al, ‘Impact of Emergency Medicine Consultants and Clinical Advisors on a NHS 111 Clinical Assessment Service’, *Emergency Medicine Journal*, vol. 36, (2019), p 208: <https://emj.bmj.com/content/36/4/208> [accessed 21 December 2022]

186 Written evidence from Dr Jamie Miles and Steven Scholes (AES0029) and Prof Leo McCann (AES0043)

187 Q 8 (Prof Leo McCann) and written evidence from Anonymous 2 (AES0004)

patients as high.”¹⁸⁸ This could mean that someone having a panic attack is sent to A&E, because the call handler at NHS 111 cannot rule out the possibility that a racing heart, difficulty breathing and tight chest may be a heart attack.

99. When a patient is referred to 999 or an A&E department, this increases the caseload of these services: there are more people in the queue or the waiting room. Not all of these patients need that service. The Association of Paediatric Emergency Medicine noted a sharp increase in “low acuity presentations that could have been seen outside of emergency departments”.¹⁸⁹ We were told that “paramedic crews still regularly complain about what they see as risk-averse call prioritising and dispatching”.¹⁹⁰
100. Changing triage to ensure that people are sent to urgent and emergency care settings only if it is necessary for them to be there could have a dramatic impact. NHS England was keen to emphasise that clinicians generally should ensure that they are not sending people to urgent or emergency services unnecessarily. Professor Julian Redhead argued that “you cannot just risk-manage one bit and push the risk on to somebody else”.¹⁹¹ Dr Vin Diwakar told us that treating patients who had fallen outside emergency care “could prevent 55,000 conveyances a year”.¹⁹²

More effective triage

101. Call handlers in the NHS 111 service have training significantly below that of paramedics or other medical professionals.¹⁹³ Clinical oversight in the call centres varies depending on the day and time. This, according to some of the paramedics we spoke to, meant that they were often sent to lower-acuity cases at weekends, when there were fewer clinicians available in the call centres to prevent these calls being referred to 999.¹⁹⁴
102. Several witnesses reported that an increased number of clinicians in the call centres would help. Dr Boyle told us that NHS 111 “would be much more effective if it was given better access to clinicians to support”. Clinicians, we were told, can ‘close’ calls more quickly, shortening the patient journey and reducing the proportion of patients passed to emergency or urgent care services.¹⁹⁵ In a study conducted between July 2016 and February 2017, calls classified as high acuity by call handlers in one 111 centre were passed to a clinical adviser. After review, there was a reduction of 75–81% in cases advised to attend A&E.¹⁹⁶
103. ***The Department of Health and Social Care should mandate a greater presence of clinical staff in NHS 111 control centres.***

188 Written evidence from Dr Jamie Miles and Steven Scholes ([AES0029](#))

189 Written evidence from Association of Paediatric Emergency Medicine ([AES0033](#))

190 Supplementary written evidence from Prof Leo McCann ([AES0043](#))

191 [Q 52](#) (Prof Julian Redhead)

192 [Q 50](#) (Dr Vin Diwakar)

193 [Q 51](#) (Dr Vin Diwakar)

194 See appendix 4, ‘Summary of engagement event’.

195 [Q 31](#) (Dr Adrian Boyle). See also [Q 6](#) (Prof Leo McCann), [Q 27](#) (Daren Mochrie) and written evidence from Anonymous 3 ([AES0045](#)).

196 Basav Sen et al, ‘Impact of Emergency Medicine Consultants and Clinical Advisors on a NHS 111 Clinical Assessment Service’, *Emergency Medicine Journal*, vol. 36, (2019), p 208: <https://emj.bmj.com/content/36/4/208> [accessed 21 December 2022]

CHAPTER 7: COLLABORATION

Potential for collaboration

104. We heard of unacceptable delays in healthcare assistance arriving. Often, other services respond instead. We received lots of evidence about police officers attending mental health crises because an ambulance would take too long to arrive, which can take officers away from their core duties.¹⁹⁷
105. Both the Home Office and the Department of Health and Social Care acknowledged the “vital”¹⁹⁸ role of collaboration between blue-light services, with the latter saying that it: “presents a real opportunity for emergency services to maximise available resources, enhance local resilience and improve the service delivered to the public.”¹⁹⁹ There is potential for more collaboration when an incident is called in. This could, for example, help agencies to determine which would attend or to provide a swifter response when one is facing delays. An IT link between the London Ambulance Service and the Metropolitan Police enables between 600 and 800 messages relating to emergency response to be shared per day. Daniel Elkeles, Chief Executive of the Ambulance Service, said that this enabled both agencies to “provide the best care between both sets of services.”²⁰⁰ Collaborative approaches such as shared training and co-locating of estate, control rooms and shared back-office functions could also assist.²⁰¹

Measures to encourage collaboration

106. Measures to increase collaboration between the blue light services were criticised by some witnesses as “patchy”²⁰² and “totally inadequate”.²⁰³ Professor Peter Murphy thought that arrangements “tend to operate in silos, rather than being holistic, integrated or at least mutually reinforcing”.²⁰⁴ Some pointed to the London Bridge and Manchester Arena terrorist attacks as examples of ineffective collaboration.²⁰⁵

Joint Emergency Service Interoperability Principles

107. The Joint Emergency Service Interoperability Principles (JESIP) “form the foundation for all emergency service joint working in the UK, including between emergency health services and the other emergency services.”²⁰⁶ However, the five principles in JESIP²⁰⁷ appear to be geared towards supported services when responding to incidents rather than in service design and planning. For example, it is not common practice for responders

197 Written evidence from the Open University Centre for Policing Research and Learning (AES0011), HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) (AES0012), Police Scotland (AES0038), Police Superintendents’ Association (AES0040), Q 8 (Prof Leo McCann)

198 Q 71 (Chris Philp MP)

199 Written evidence from the Department of Health and Social Care (DHSC) (AES0014)

200 Q 15 (Daniel Elkeles)

201 Written evidence from Association of Ambulance Chief Executives (AACE) (AES0024)

202 Written evidence from Open University Centre for Policing Research and Learning (AES0011)

203 Written evidence from Fire and Rescue Services Association (AES0007)

204 Q 9 (Prof Peter Murphy)

205 Written evidence from Open University Centre for Policing Research and Learning (AES0011), the Home Office (AES0042), and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) (AES0012), Q 9

206 Written evidence from the Home Office (AES0042)

207 JESIP, *Principles for joint working* (October 2021): <https://www.jesip.org.uk/joint-doctrine/principles-for-joint-working/> [accessed 30 December 2022]. The principles are: “co-locate; communicate; co-ordinate; jointly understand risk; and shared situational awareness”.

from different agencies to co-locate despite one of the JESIP principles being colocation.²⁰⁸

108. A Ministerial Board, responsible for “supporting the multi-agency approach to the embedding of JESIP and providing strategic direction to the portfolio”, was established in 2021, but as of 9 November 2022 it had met only twice.²⁰⁹

Policing and Crime Act 2017

109. The Policing and Crime Act 2017 introduced a “new statutory duty to collaborate on the police, fire and emergency ambulance services where it is in the interests of efficiency and effectiveness. The duty to collaborate is non-prescriptive and locally enabling”.²¹⁰
110. The Act enables some forms of collaboration, but with caveats. The Act allows Police and Crime Commissioners to take on responsibility for fire and rescue governance where a local case is made. There are four areas where this has occurred.²¹¹ It also enables the Police and Crime Commissioner to sit on a local Fire and Rescue Authority with full voting rights, but this is subject to the consent of that authority. There are only two examples of this.²¹²

Role of regulators

111. We were told that the duty imposed by the Act to collaborate “is rarely examined by inspectors.”²¹³ Inspectorates exist to “ensure standards are achieved, good practice is spread, performance is improved, and the public are engaged and assured.”²¹⁴ In His Majesty’s Inspectorate of Constabulary and Fire & Rescue Service, the PEEL programme is an assessment of the effectiveness, efficiency and legitimacy of police forces in England and Wales. The assessment criteria include no reference to the duty to collaborate or adherence to the JESIP principles.²¹⁵ The Care Quality Commission will soon have power formally to hold the system to account on collaboration, but this will cover Integrated Care Systems and the Commission will have little role in commenting on services delivered by the police or the fire and rescue services.²¹⁶
112. Inspectorates and regulators could, though, provide a powerful incentive and potential levers for change. The Open University Centre for Policing Research and Learning thought that inspection could be a part of the answer for collaborative approaches, recommending that “Inspection bodies should

208 Written evidence from Anonymous 2 (AES0004)

209 Q 75 (Jae Samant)

210 Written evidence from the Home Office (AES0042). See also Police and Crime Act 2017, Policing and Crime Act 2017, Section 2.

211 These areas are Essex, Staffordshire, North Yorkshire and Northamptonshire. See written evidence from the Home Office (AES0042).

212 These areas are: Norfolk and South Yorkshire. See written evidence from the Home Office (AES0042).

213 Written evidence from Open University Centre for Policing Research and Learning (AES0011)

214 Written evidence from HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) (AES0012)

215 Q 75 (Jae Samant). See also His Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), *PEEL CDI judgment criteria* (April 2021): <https://www.justiceinspectorates.gov.uk/hmicfrs/publication-html/peel-cdi-judgment-criteria/> [accessed 30 December 2022] and His Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), *PEEL assessments 2021/22* (March 2022): <https://www.justiceinspectorates.gov.uk/hmicfrs/peel-assessments/what-is-peel/peel-assessments-2021-22/> [accessed 30 December 2022].

216 Care Quality Commission, *Statement from Dr Rosie Benneyworth on the Government’s Amendment to the Health and Care Bill* (20 October 2021): <https://www.cqc.org.uk/news/stories/statement-dr-rosie-benneyworth-government%E2%80%99s-amendment-health-care-bill> [accessed 30 December 2022]

have an increased remit to highlight good practice and challenge other organisations to justify their approaches where partnership and collaboration is less evident.”²¹⁷ The Fire Sector Federation addressed the remit difficulty identified above, saying that the Care Quality Commission could have overall responsibility for driving best practice (including in collaboration) but with a clear duty to collaborate and work with other inspectorates. The federation thought that a “broader single collaborative assessment could be done by the inspectorates collaborating on a thematic inspection”.²¹⁸

113. **Regulators and inspectorates should place greater emphasis on the importance of collaboration between emergency services. This has the potential to enable and incentivise greater collaboration between police, fire and rescue and emergency health services, leading to better outcomes for patients.**

²¹⁷ Written evidence from Open University Centre for Policing Research and Learning ([AES0011](#))

²¹⁸ Written evidence from Fire Sector Federation ([AES0018](#))

CHAPTER 8: BEST PRACTICE

114. Collaborative approaches to emergency services delivery, as outlined above, are patchily distributed. They rely on the initiative and drive of individual leaders. This is symptomatic of the wider problem of a lack of leadership. Where good practice develops in emergency and urgent care, there is not enough in place to ensure that it is widely shared, evaluated or adopted.

Learning from each other

115. Many organisations take different approaches to providing care which could be spread more widely, with organisations learning from others' ideas. Daniel Elkeles said that organisations should aim to “adopt and adapt” good practice from elsewhere, saying: “steal with pride. If you see a good idea somewhere you think, ‘Why can’t I just do that too?’”²¹⁹
116. Many examples were provided to us; we have listed only a few.
- The Ambulatory Care Experience “provides an alternative to hospital referral or admission for children and young people with common acute illnesses like asthma”.²²⁰ Children and young people (who meet the criteria and are referred from primary care or A&E) are looked after at home through contact with a paediatrician and nurse.²²¹ There are several “pathways” for this, whereby children with some conditions can be treated at home. An example of this is for children with infant jaundice: phototherapy lamps will be used by a community nursing team to treat children in their homes.²²²
 - Falls Services provided by St John Ambulance in London and Wolverhampton. St John staff attend people (usually the elderly and frail) who have fallen at home. Some 90% of dispatches are managed without needing an ambulance and calls are responded to in 20 minutes.²²³
 - Pre-hospital video triage is being piloted in different areas in England. This allows patients displaying symptoms of a stroke to speak to a stroke clinician. This “can identify patients who do not need stroke treatment, and allows emergency services to use their resources more efficiently.”²²⁴ Paramedics can communicate with stroke doctors at the hospital to make the final decision on whether the patient is having a stroke.²²⁵

Machinery for sharing best practice

117. Witnesses referred to a difficulty in sharing and learning from good initiatives. We were told: “Innovative ways of working are often not taken past trial

219 See for example [Q 22](#) (Dr John Martin) and written evidence from Unison ([AES0039](#)).

220 NHS Bradford Teaching Hospitals, ‘Welcome to the ACE Service: Information for professionals’: <https://www.bradfordhospitals.nhs.uk/the-ace-service/information-for-professionals/> [accessed 30 December 2022]

221 Written evidence from Royal College of Paediatrics and Child Health (RCPCH) ([AES0041](#))

222 NHS Bradford Teaching Hospitals, ‘Award-winning ACE Service now treating jaundiced babies at home’ (November 2019): <https://www.bradfordhospitals.nhs.uk/award-winning-ace-service-now-treating-jaundiced-babies-at-home/> [accessed 30 December 2022]

223 Written evidence from St John Ambulance ([AES0019](#))

224 Written evidence from Stroke Association ([AES0025](#))

225 Written evidence from Stroke Association ([AES0025](#))

stages despite showing patient benefit”.²²⁶ Len Richards, Chief Executive of Mid Yorkshire Hospitals NHS Trust, thought that the many areas of good practice, “stop in that area or in the ward the practice was developed in.”²²⁷ The College of Paramedics thought that there was a cultural element and that consideration of best practice was viewed as “an optional ‘bolt-on’.”²²⁸

118. It is not simple to disseminate information about good practice, nor is it always easy for organisations to “adopt and adapt”.²²⁹ In relation to spreading good practice, the Minister for Crime, Policing and Fire referred to the “institutional machinery ... that facilitates or allows this kind of work to happen; you cannot necessarily assume it will happen spontaneously.”²³⁰ The Royal College of Paediatrics and Child Health described the current machinery as “fragmented”.²³¹
119. Ten ‘What Works Centres’ aim to support more effective and efficient services across the public sector. This includes the College of Policing, which produces authorised professional practice, and the National Institute for Health and Care Excellence (NICE). According to the organisation’s website, NICE’s role includes: “encouraging the uptake of best practice to improve outcomes for everyone.”²³² Our witnesses seemed to suggest, though, that NICE’s role was limited to clinical practice, procedures, and drugs. It was not, in the views of our witnesses, the right place for sharing best practice: when asked, Len Richards, the CEO for Mid Yorkshire Hospitals NHS Trust, stated that, “I am not sure that NICE should be doing it. NICE is doing lots of things.”²³³
120. Professor Julia Williams, Professor of Paramedic Science and Associate Dean of Research at the University of Hertfordshire, said that sharing best practice was: “about having a centralised place where everybody knows”.²³⁴ A White Paper, ‘Reforming Our Fire and Rescue Service’ was published in May 2022, and proposes the establishment of an independent College of Fire and Rescue to support improvement within the fire and rescue sector. This could, the consultation suggests, consider “research; data; leadership; ethics; and clear expectations for fire and rescue service.” Such a body could have a role in disseminating best practice within the sector, but it would be limited to the fire and rescue service.²³⁵ While there are other potential structures for sharing best practice—the Association of Ambulance Chief Executives; the National Ambulance Coordination Centre; and the Care Quality Commission—these largely focus on their own particular sectors.
121. On best practice covering collaboration between different services, Home Office Minister Chris Philp acknowledged that there lacked “a set of best practice guidelines that cover that whole system and how those systems

226 Written evidence from Anonymous 2 ([AES0004](#)). See also written evidence from College of Paramedics ([AES0016](#)).

227 [Q 30](#) (Len Richards)

228 Written evidence from College of Paramedics ([AES0016](#))

229 [Q 44](#) (Sarah Scobie)

230 [Q 75](#) (Chris Philp MP)

231 Written evidence from the Royal College of Paediatrics and Child Health (RCPCH) ([AES0041](#))

232 National Institute for Health and Care Excellence, ‘About’: <https://www.nice.org.uk/about> [accessed 30 December 2022]

233 [Q 30](#)

234 [Q 35](#) (Prof Julia Williams)

235 Home Office, *Reforming Our Fire and Rescue Service*, CP 670, (May 2022), p 18: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1074948/DRAFT_WP_consultation_HO_template_110522.pdf [accessed 2129 December 2022]

interact with each other at the boundaries”.²³⁶ Several witnesses suggested that Integrated Care Systems would be well placed to play this role.²³⁷ Care England reasoned that responsibility for driving best practice was “shared between health and social care, sector stakeholders, local and central government, and the regulators” and that the ICSs were therefore well placed to identify and implement good practice.²³⁸ ICSs, though, are geographically limited.

122. Health Minister Will Quince stated that the government tries to organise trusts to talk to each other.²³⁹ NHS England has a role to “mobilise expert networks” and “enable the spread of best practice”,²⁴⁰ but its operating framework, published in October 2022, details no specific actions or processes to do so.

“What gets measured gets done”

123. Many contributors thought that there was limited evaluation of whether pilots had worked, and that this hampered attempts to share them between services.²⁴¹ For example, one trial, where a paramedic could call a consultant for assistance, looked promising but no formal evaluation was commissioned. There is, we were told, no way to know for sure whether it was effective, nor much evidence on which to advocate a national roll-out.²⁴² Dr Adrian Boyle noted another example, where people with low-acuity attendances at hospital would be encouraged to call NHS 111:

“We have never seen results from that pilot. We do not know whether it works. We do not know whether it does not work.”²⁴³

124. As the Director General of Public Safety noted, in public services, “what gets measured gets done”.²⁴⁴ A lack of evaluation may therefore explain the tendency identified by Daren Mochrie that pilots “were sometimes not a priority”.²⁴⁵ There were calls for more evaluation of where pilots have taken place, to determine what effect they have.²⁴⁶
125. The Royal College of Emergency Medicine cautioned against investing in demand management interventions which were “poorly evaluated” as they may not achieve their stated aims.²⁴⁷ Conversely, they might be under-utilised, or used in a less efficient way than they might be. One of these interventions could be the use of ‘virtual wards’. The Nuffield Trust reported on their use during the COVID-19 pandemic, “further evidence is still needed on

236 Q 71 (Chris Philp MP)

237 Q 55 (Prof Julian Redhead), Q 68 (Will Quince MP), Q 30 (Daren Mochrie) and written evidence from the Stroke Association (AES0025)

238 Written evidence from Care England (AES0009)

239 Q 66 (Will Quince MP)

240 NHS England, *Operating framework for NHS England* (October 2022): <https://www.england.nhs.uk/wp-content/uploads/2022/10/B2068-NHS-England-Operating-Framework.pdf> [accessed 29 December 2022]

241 Written evidence from Royal College of Emergency Medicine (RCEM) (AES0017) and Stroke Association (AES0025)

242 Supplementary written evidence from Daniel Elkeles (AES0044)

243 Q 35 (Dr Adrian Boyle)

244 Q 75 (Jaec Samant)

245 Q 30 (Daren Mochrie)

246 Written evidence from Anonymous 3 (AES0045), Q 30 (Len Richards)

247 Written evidence from the Royal College of Emergency Medicine (RCEM) (AES0017)

... whether they work.”²⁴⁸ The Institute for Government, similarly, has said “there is not enough evidence to evaluate their effectiveness.”²⁴⁹

126. There have, though, been some promising results from early trials. A rapid evaluation conducted in Croydon found that the model used there in July 2020 was able to:

- “appropriately deliver care in patients’ homes for 65 per cent of virtual ward patients (all of which were acutely unwell);
- manage a cohort of up to 30 patients at one time using only a small team of clinicians; and
- deliver a service that patients were largely satisfied with.”²⁵⁰

As we outlined in chapter 3, ‘What has gone wrong?’, virtual beds form a substantial part of the Government’s plan for bed capacity. The results indicated above suggest that they might have the potential to be central to a positive step-change in the provision of urgent and emergency care, but without leadership and robust evaluation, we simply do not know where they would be best used, and most effective.

127. **The What Works Centre for healthcare is not performing the function of evaluating, sharing, and encouraging the implementation of best practice. Other arrangements, where they exist, are patchy and limited, and there is a lack of urgency in driving best practice. Innovations are often, therefore, abandoned, or not utilised at scale nor as effectively as they should be.**

248 Nuffield Trust, ‘Virtual wards and Covid-19: An explainer’: <https://www.nuffieldtrust.org.uk/resource/virtual-wards-and-covid-19-an-explainer> [accessed 21 December 2022]

249 Institute for Government, ‘Performance Tracker 2022: Hospitals’: <https://www.instituteforgovernment.org.uk/publication/performance-tracker-2022/hospitals> [accessed 21 December 2022]

250 Health Innovation Network, *Rapid Evaluation of Croydon Virtual Ward Model* (December 2021), p 5: <https://healthinnovationnetwork.com/projects/rapid-evaluation-of-croydon-virtual-ward-model/?cn-reloaded=1> [accessed 21 December 2022]

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

A national emergency

1. The state of emergency healthcare is a national emergency. The substantial delays that patients face when trying to access emergency health services create considerable emotional distress and an unprecedented clinical risk. (Paragraph 13)
2. The emergency healthcare workforce is under unprecedented strain. Without concerted action to address the emergency in the system, many of them will leave the health service. (Paragraph 18)

What has gone wrong?

3. In many cases, patients are attending emergency care services because they have—or feel they have—no alternative. The models for primary and community care are broken. (Paragraph 31)
4. *The Department of Health and Social Care should continue working to increase the number of physical beds in hospitals. This work must ensure that additional beds are sufficiently staffed.* (Paragraph 32)
5. The crisis in emergency healthcare is a symptom of fundamental weaknesses arising from inadequate capacity across primary, community, and hospital and social care settings. A new model for primary care is needed. (Paragraph 39)
6. *The Government should introduce further incentives to enable discharge at the right time for patients, freeing up hospital capacity. This could include further use of NHS budgets to cover social care costs.* (Paragraph 42)
7. While the Government's interventions to boost capacity in social care are welcome, they will not be sufficient to fully address the problem. (Paragraph 44)

Leadership

8. Health systems on a local level cannot be expected to develop a common vision and purpose without a clear national steer on their common purpose. There is no such steer. (Paragraph 48)
9. *The crisis of emergency healthcare should be referred to a COBR Committee.* (Paragraph 50)
10. Emergency and urgent care services are working to an outdated operating model which no longer reflects the reality of demand or clinical practice. The limited efforts to address this seem to have stalled. Persisting with an outdated model will prevent services from delivering the care that patients need. (Paragraph 66)
11. Integrated Care Boards and Systems have potential to deliver services that address local population need and make significant improvements. There appears, though, to be little understanding of how they will function, or who will be accountable for the delivery of services. We consider it unlikely that ICSs and ICBs will be able to deliver on the high expectations placed on them without further clarity on these matters. They will also need more leadership from the centre than is currently envisaged. (Paragraph 76)

12. *Following the Hewitt Review, the Government must set out accountability and governance arrangements for ICBs and ICSs. These systems must consider how to ensure system accountability where challenges in one service have a domino effect on others. (Paragraph 77)*
13. *The Government should consider, consult upon, and establish a bold and ambitious new operating model for emergency healthcare. This operating model must address pressures throughout the system and provide strong leadership to:*
 - *reflect increased demand for, and new ways of delivering, emergency health services;*
 - *establish robust accountability arrangements at national, ICS, and service level;*
 - *set clear expectations and arrangements for collaboration with other emergency responders; and*
 - *establish functional mechanisms to improve the sharing of good practice. (Paragraph 78)*

Clarity of published data

14. *The current data published by NHS England on emergency department waiting times inaccurately portray the true waiting times experienced by patients attending A&E. NHS England should publish monthly the number and proportion of patients waiting 12 hours or more from arrival at accident and emergency departments. (Paragraph 84)*
15. *There is no clear picture of the type of demand faced by urgent and emergency care providers. This will significantly hinder effective planning and service design. (Paragraph 90)*
16. *NHS England must improve the quality and interpretation of data gathered on urgent and emergency caseloads to explain accurately the type of cases faced by ambulances and A&E. (Paragraph 91)*
17. *NHS England should resume publishing the Delayed Transfer of Care dataset. (Paragraph 93)*

Right place, right time

18. *The Department of Health and Social Care should mandate a greater presence of clinical staff in NHS 111 control centres. (Paragraph 103)*

Collaboration

19. *Regulators and inspectorates should place greater emphasis on the importance of collaboration between emergency services. This has the potential to enable and incentivise greater collaboration between police, fire and rescue and emergency health services, leading to better outcomes for patients. (Paragraph 113)*

Best practice

20. *The What Works Centre for healthcare is not performing the function of evaluating, sharing, and encouraging the implementation of best practice. Other arrangements, where they exist, are patchy and limited, and there is a lack of urgency in driving best practice. Innovations are often, therefore, abandoned, or not utilised at scale nor as effectively as they should be. (Paragraph 127)*

APPENDIX 1: LIST OF MEMBERS AND DECLARATIONS OF INTEREST

Members

Baroness Armstrong of Hill Top (Chair)
 Lord Bichard
 Lord Bourne of Aberystwyth
 Baroness Chisholm of Owlpen (from 26 October 2022 to 27 November 2022)
 Lord Filkin
 Lord Hogan-Howe
 Baroness Morris of Yardley
 Baroness Pinnock
 Baroness Pitkeathley
 Lord Porter of Spalding
 Baroness Sater

Declarations of interest

Baroness Armstrong of Hill Top
Husband is employed in various consultancy work for NHS bodies and is Chair of Advisory Group for management consultancy PPL; and Care City, a social care Community Interest Company.

Lord Bichard
No relevant interests to declare

Lord Bourne of Aberystwyth
No relevant interests to declare

Baroness Chisholm of Owlpen
No relevant interests to declare

Lord Filkin
No relevant interests to declare

Lord Hogan-Howe
Non-executive director, Cabinet Office
In receipt of policing pension
Retired police officer

Baroness Morris of Yardley
No relevant interests to declare

Baroness Pinnock
Councillor of Kirklees Council

Baroness Pitkeathley
No relevant interests to declare

Lord Porter of Spalding
Leader of South Holland District Council
Non-executive director, Norse Group
Non-executive director, Department for Levelling Up, Housing and Communities
Chair, Building Safety Competence Foundation
Chair, Clean Streets
Chair, Effective Governance Forum

Baroness Sater
Chair, Taskforce on physical activity and sport, Alliance of Sport in Criminal Justice

Specialist Adviser, Professor Suzanne Mason

*Professor of Emergency Medicine, School of Health and Related Research,
University of Sheffield*

*Honorary Consultant in Emergency Medicine & Clinical Director for
Research and Development, Barnsley Hospital NHS Foundation Trust*

*Deputy Director and theme lead (urgent care), National Institute for Health
and Care Research, Yorkshire and Humber Applied Research Centre*

*Author of a report by NHS Confederation, 'Re-envisioning urgent and
emergency care'*

APPENDIX 2: LIST OF WITNESSES

Evidence is published online at <https://committees.parliament.uk/committee/430/public-services-committee/publications/> and available for inspection at the Parliamentary Archives (020 7219 3074)

Evidence received by the Committee is listed below in chronological order of oral evidence session, and then in alphabetical order. Those witnesses marked with ** gave both oral evidence and written evidence. Those marked with * gave oral evidence and did not submit any written evidence. All other witnesses submitted written evidence only.

Oral evidence in chronological order

**	Professor Leo McCann, Professor of Management at the School for Business and Society, University of York	QQ 1–11
*	Professor Inga Heyman, Associate Professor (Policing and Public Health), University of Edinburgh	QQ 1–11
*	Professor Peter Murphy, University of York	QQ 1–11
*	Dennis Keeley, Chief Fire Officer, Dublin Fire Brigade	QQ 12–17
*	Chief Constable Pam Kelly, Gwent Police	QQ 12–17
**	Daniel Elkeles, Chief Executive Officer, London Ambulance NHS Trust	QQ 12–17
	Miriam Deakin, Director of Policy and Strategy and Deputy Chief Executive (Interim), NHS Providers	QQ 18–23
*	Lisa Elliott, UK Deputy Director of Nursing Workforce and Quality, Royal College of Nursing (RCN)	QQ 18–23
**	Dr John Martin, President, College of Paramedics	QQ 18–23
**	Daren Mochrie, Chairman, Association of Ambulance Chief Executives (AACE)	QQ 24–30
*	Len Richards, CEO for Mid-Yorkshire Hospitals NHS Trust and CEO member of West Yorkshire Association of Acute Trusts	QQ 24–30
*	Dr Adrian Boyle, President, Royal College of Emergency Medicine	QQ 31–40
*	Professor Julia Williams, Professor of Paramedic Science and Associate Dean - Research, University of Hertfordshire	QQ 31–40
*	Sarah Scobie, Deputy Director of Research, Nuffield Trust	QQ 41–48
*	Victoria Vallance, Director of Secondary and Specialist Healthcare, Care Quality Commission (CQC)	QQ 41–48
*	Dr Vin Diwakar, Medical Director for Transformation and Secondary Care, NHS England	QQ 49–58 QQ 59–70

★	Professor Julian Redhead, National Clinical Director for Urgent and Emergency Care, NHS England	QQ 49–58
★	Will Quince MP, Minister of State (Minister for Health and Secondary Care), Department of Health and Social Care (DHSC)	QQ 59–70
★★	Matthew Style, Director General for NHS Policy and Performance. DHSC	QQ 59–70
★	Rt Hon Chris Philp MP, Minister of State (Minister for Crime Policing and Fire), Home Office	QQ 71–75
★	Jae Samant CBE, Director General, Public Safety, Home Office	QQ 71–75

Alphabetical List of Witnesses

	Anonymous 1	AES0001
	Anonymous 2	AES0004
	Anonymous 3	AES0045
	Tristan Ashby, Chief Executive Officer, Fire and Rescue Services Association	AES0007
	Association of Paediatric Emergency Medicine	AES0330
★	Dr Adrian Boyle, President, Royal College of Emergency Medicine (QQ 31–40)	AES0017
	Care Quality Commission (CQC)	AES0023
	College of Paramedics	AES0016
	Professor Jeremy Dale, Professor of Primary Care, University of Warwick	AES0013
★	Miriam Deakin, Director of Policy and Strategy and Deputy Chief Executive (Interim), NHS Providers (QQ 18–23)	
	Department of Health and Social Care (DHSC)	AES0014
★	Dr Vin Diwakar, Medical Director for Transformation and Secondary Care, NHS England (QQ 49–58 and QQ 59–70)	
	Sir Liam Donaldson, Professor of Public Health, London School of Hygiene and Tropical Medicine)	AES0013
★	Professor Adrian Edwards, Professor of General Practice, Cardiff University	AES0013
★★	Daniel Elkeles, Chief Executive Officer, London Ambulance NHS Trust (QQ 12–17)	AES0044
★	Lisa Elliott, UK Deputy Director of Nursing Workforce and Quality, Royal College of Nursing (RCN) (QQ 18–23)	
	Fire and Rescue Services Association	AES0007
	Fire Sector Federation	AES0018

	Frequent Caller National Network (FreCaNN)	AES0008
	Phil Garrigan Chief Fire Officer, Merseyside Fire & Rescue Service and Vice Chair, National Fire Chiefs Council	AES0048
	GMB	AES0021
	Professor Martin Green, OBE, Chief Executive, Care England	AES0009
	HealthWatch, England	AES0006
	Dr Geoffrey Heath, Keele University	AES0028
*	Professor Inga Heyman, Associate Professor (Policing and Public Health), University of Edinburgh (QQ 1–11)	
	HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)	AES0012
	Home Office	AES0042
*	Dennis Keeley, Chief Fire Officer, Dublin Fire Brigade (QQ 12–17)	
*	Pam Kelly, Chief Constable, Gwent Police (QQ 12–17)	
**	Professor Leo McCann, Professor of Management at the School for Business and Society, University of York (QQ 1–11)	AES0043
	MedTeams	AES0049
**	Dr John Martin, President, College of Paramedics (QQ 18–23)	AES0046
	Robert Graham Mason	AES0003
	Dr Jamie Miles, Clinical Research Fellow, University of Sheffield	AES0029
*	Daren Mochrie, Chair, Association of Ambulance Chief Executives (AACE) and Chief Executive, North West Ambulance Service NHS Trust (QQ 24–30)	AES0024 AES0047
*	Professor Peter Murphy, University of York & Nottingham Trent University (QQ 1–11)	AES0028
	Dr Andrew Newton	AES0031
	NHS Confederation	AES0010
	NHS Providers	AES0027
	Justin Partridge, Visiting Research Fellow, Open University Centre for Policing Research and Learning	AES0011
*	Rt Hon Chris Philp MP, Minister of State (Minister for Crime Policing and Fire), Home Office (QQ 71–75)	
*	Will Quince MP, Minister of State (Minister for Health and Secondary Care), Department of Health and Social Care (DHSC) (QQ 59–70)	AES0053

- Professor Julian Redhead, National Clinical Director for Urgent and Emergency Care, NHS England ([QQ 49–58](#))
- ★ Len Richards, CEO for Mid-Yorkshire Hospitals NHS Trust and CEO member of West Yorkshire Association of Acute Trusts ([QQ 24–30](#))
- Royal College of Emergency Medicine (RCEM) [AES0017](#)
- Royal College of Paediatrics and Child Health (RCPCH) [AES0041](#)
- St John Ambulance [AES0019](#)
- ★ Deb Saunders, Investigations Officer, South Western Ambulance Service NHS Trust [AES0005](#)
- Steven Scholes, Consultant Paramedic, NW Ambulance NHS Trust [AES0029](#)
- ★ Sarah Scobie, Deputy Director of Research, Nuffield Trust ([QQ 41–48](#))
- ★ Jae Samant CBE, Director General, Public Safety, Home Office ([QQ 71–75](#))
- Stroke Association [AES0025](#)
- ★ Matthew Style, Director General for NHS Policy and Performance. DHSC ([QQ 59–70](#))
- Trades Union Congress (TUC) [AES0030](#)
- Unison [AES0039](#)
- ★ Victoria Vallance, Director of Secondary and Specialist Healthcare, Care Quality Commission (CQC) ([QQ 41–48](#))
- Professor Paresh Wankhade, Edge Hill University [AES0028](#)
- Chris Welsh, Community Protection Manager, Hertfordshire Fire and Rescue Service [AES0032](#)
- ★ Professor Julia Williams, Professor of Paramedic Science and Associate Dean - Research, University of Hertfordshire ([QQ 31–40](#))

APPENDIX 3: CALL FOR EVIDENCE

The House of Lords Public Services Committee has launched an inquiry into access to emergency services.

The call

This is a public call for written evidence to be submitted to the Committee.

Evidence will, along with a programme of oral evidence, inform the Committee's inquiry. In the new year, we plan to publish a report with recommendations to Government. The Government must respond, and there will in due course be a Parliamentary debate.

Submission guidance

Submissions should be kept short and concise. The evidence will be used to inform our recommendations to Government so, where relevant, please outline what you want the Government to do, and the evidence supporting this recommendation. Submissions will usually be published, so please ensure that they are pitched at the interested non-expert and, as far as possible, avoid jargon.

The process for making submissions is set out in Annex 1, but if you have any questions or require any adjustments to enable you to respond, please contact the staff of the Committee at hlpublicservices@parliament.uk.

Evidence should be submitted by 26 October.

Background

The Public Services Committee is responsible for scrutinising public services, including health and education.

The Committee's first report established eight key 'principles for public services reform' which have underpinned the Committee's work since the report's publication. These are:

- the Government and other providers of public service should recognise the vital role of preventative services in reducing inequalities;
- central Government and national service providers should improve the way that they communicate and cooperate with local-level service providers if they are to deliver effective public services;
- charities, community groups, volunteers and the private sector should be recognised as key public services providers, and given appropriate support to deliver services effectively;
- the resilience of public services to the challenges posed by the COVID-19 pandemic and ongoing demographic changes will require a fundamentally different, vastly more flexible approach to the sharing of data;
- the integration of services to meet the diverse needs of individuals and the communities in which they live is best achieved by public services providers working together at the local level, and should be supported by joined-up working across Government departments at the national level;
- local services and frontline workers should be given the resources and autonomy to innovate and improve the delivery of public services, while

mechanisms to ensure the accountability of local service providers should be improved;

- advances in digital technology should be used to increase access to public services, particularly for hard-to-reach groups, but should be applied intelligently. Online services should never replace face-to-face services if to do so would disadvantage the service user;
- users should be involved in the design and delivery of public services.

Inquiry focus

In light of numerous reports of challenges in accessing emergency health services, with long wait times and delays, the Committee is now launching a new inquiry into the challenges facing emergency health services in the UK.

In particular, the Committee would like to explore leadership, governance, and regulation in emergency services at both a strategic and frontline level, reflecting on how emergency services can be organised so that the welfare of service users is always at the forefront of decision-making.

The Committee is interested in submissions on the challenges emergency health services are facing, and how decision-making at local and national level could improve outcomes for service users and achieve greater efficiency. We are interested to hear whether local providers, NHS Trusts and Integrated Care Boards have the right level of autonomy and responsibility to deliver high quality services.

There have been examples of creative practices to improve services, and the Committee would like to hear about different models and practices of delivering emergency services, and the challenges to these being shared and implemented across the UK, alongside where regulations or targets create a barrier to supporting service users.

The Committee is also interested in hearing how collaboration between services might support the NHS deliver better outcomes for those accessing emergency health services, alongside barriers or problems with such collaboration.

We seek evidence on the following areas of interest: it is not necessary to answer all questions.

Areas of interest

Alongside information about where emergency services are facing issues due to funding issues or staff shortages, the Committee is seeking recommendations on how emergency services could be transformed to achieve better health outcomes and boost efficiency such as through different models of delivery and prioritising different areas of work to reduce demand (such as preventative services).

The situation

1. What are the main challenges facing emergency health services in the UK? How are these challenges affecting service user?
2. How have the type, and volume of demand for emergency services changed over recent years?
 - (a) How could demand on emergency health services be reduced or limited? Who should be responsible for decision-making to drive forward this work?

3. Where and when should decisions of whether someone should receive an emergency health response be made? Who should be making those decisions?
 - (a) How effectively are frontline workers enabled and empowered to make decisions on emergency care?
 - (b) How can we ensure that emergency responders are equipped with the right skills and authority to address the situation they arrive at?

Governance and leadership

4. What would be the appropriate levels of autonomy, responsibility, and accountability for those leading delivery of emergency services?
 - (a) How far are the targets set for emergency health services helpful for driving good practice and processes which benefit service users?
5. What impact do regulations and inspections have on decision-making in and for emergency services?

Best practice and innovation

6. How would you describe the UK's emergency service model, and decision-making and planning processes? How could they be improved to secure better outcomes for patients?
 - (a) What other models of emergency health response might be effective in the UK? What is the role of other emergency services in supporting responses to health emergencies?
 - (b) Can you share examples of innovations or best practice which have improved outcomes for emergency service users?
7. How can emergency health services better collaborate with other emergency services, and who should be responsible for driving this collaboration? Can you share examples of innovations or best practice which have improved outcomes for service users?
 - (a) What unintended consequences could increased collaboration have on different emergency services?
8. Who should be responsible for identifying, driving, and implementing good practice in emergency health services across the UK?
 - (a) What are the mechanisms for sharing good practice, both in the NHS and other emergency services? How effective are they, and how could they be improved?

Annex 1: Guidance for Submissions

Short submissions are preferred. A submission longer than six pages should include a one-page summary. Paragraphs should be numbered.

Evidence that is accepted by the Committee may be published online at any stage; when it is so published it becomes subject to parliamentary copyright and is protected by parliamentary privilege. Submissions that have been previously published will not be accepted as evidence.

Diversity comes in many forms and hearing a range of different perspectives means that committees are better informed and can more effectively scrutinise public policy and legislation. Committees can undertake their role most effectively when

they hear from a wide range of individuals, sectors or groups in society affected by a particular policy or piece of legislation. We encourage anyone with experience or expertise of an issue under investigation by a select committee to share their views with the committee, with the full knowledge that their views have value and are welcome.

All submissions made through the written submission form will be acknowledged automatically by email. We would be very grateful if you could submit the diversity monitoring form sent with this acknowledgement.

Once you have received acknowledgement that the evidence has been accepted you will receive a further email, and at this point you may publicise or publish your evidence yourself. In doing so you must indicate that it was prepared for the Committee, and you should be aware that your publication or re-publication of your evidence may not be protected by parliamentary privilege.

Personal contact details will be removed from evidence before publication but will be retained by the Committee Office and used for specific purposes relating to the Committee's work, for instance to seek additional information.

Substantive communications to the Committee about the inquiry should be addressed through the clerk of the Committee, whether or not they are intended to constitute formal evidence to the Committee.

Written submissions should be made online by clicking the "Start" button below. We would be grateful for submissions by 23:59 on 26 October.

For any questions, please contact the Committee staff at hlpublicservices@parliament.uk or by telephoning 020 7219 8654.

You can follow the progress of the inquiry at: <https://committees.parliament.uk/work/6918/access-to-emergency-services/>

APPENDIX 4: SUMMARY OF ENGAGEMENT EVENT, 3 NOVEMBER 2022

Summary of engagement event held on 3 November: Note by the Clerk

Background

As part of their inquiry into Access to Emergency Services, the Committee was keen to meet with those who had experience team delivering urgent healthcare services, including emergency responders from the fire and rescue service, within A&E, and paramedics. The Committee secretariat worked with the Select Committees Engagement Team to seek attendees to a virtual roundtable event on 3 November 2022. The advertisement for the event was also published on Eventbrite and the public were invited to sign up.²⁵¹ <https://www.eventbrite.co.uk/e/access-to-emergency-services-online-engagement-event-tickets-435741623927>

Several Members of the Committee attended the online event, along with participants with experience delivering public services. Participants were a mix between those “on the ground”, and more senior people, with several Chief Officers joining. Roles included:

- Chief Fire Officers
- Chief Executive of NHS Trust
- Senior managers in the ambulance service
- Frontline paramedics
- Staff in 111 control centres

Following a welcome and introduction from the Chair, participants were assigned to breakout groups. The Chair of the Committee explained that the session was not being transcribed, and that no comments would be attributed for individuals, but that quotes and views might form part of the Committee’s consideration and report. Discussions within these breakout groups were chaired by a Member of the Committee and some suggested questions guided the discussions. Participants had been sent these questions ahead of the session.

This document provides a non-attributed record of the themes arising in the event and in follow up conversations with the Secretariat.

Demand: ambulance service and urgent care overloaded

There was an agreement among front line urgent healthcare workers that there was serious pressure on ambulances and A&E. This had a significant impact on staff wellbeing as well as on patients themselves. It was noted that timely responses to emergencies were very difficult.

Attendees noted that a difficulty in discharging patients created a backlog of beds being blocked and therefore unavailable for new patients. This is particularly difficult at night-time: “People are being discharged from hospital because they are clinically well—there is no further need for them to be there—however, they then return home with no social care. A&E will discharge you at 2:00 o’clock in the morning if need be but social care services aren’t available 24/7”.

²⁵¹ Eventbrite, Access to Emergency Services—online engagement event (3 November): <https://www.eventbrite.co.uk/e/access-to-emergency-services-online-engagement-event-tickets-435741623927> [accessed 20 December 2022]

Urgent care versus emergency care

Handlers and paramedics reported an increase in repeat calls, and an increase in “urgent care” over “emergency care”. Monday, the Committee were told, is particularly bad for calls as people had been unable to get to their GP following the weekend.

One paramedic said they took around 40% of patients they saw into A&E. This, they said, showed that the majority of incidents they responded to did not need an emergency response, but rather needed signposting or a referral to other services.

Many attendees referred to falls as non-emergency situations that still required a responder. This was identified as an area where ambulance services were failing: people were often left for hours, increasing the likelihood they would require hospital admission. There were many calls from nursing homes where a patient had fallen.

This was noted as an area where different people than the traditional responders could act, as long as there was support. This would reduce pressure on hospitals.

There was a perception, however, that only paramedics were willing to make the decision to lift a patient due to a low risk appetite or internal policies.

“I’ve had GPs and doctors say ‘no, leave them there and let the ambulance services get to them’ and we’re sat there going ‘no, get them off the floor’. I will try and coach people over the phone. [...] People are unwilling to do it because they’re so frightened that someone’s going to sue them; they’re going to end up in court.”

Fall teams run by fire & rescue services (FRS), where they were in place, were commended.

There was a concern that where FRS responded, they might then be stuck at the scene until an ambulance arrived (if one was required), but a suggestion made that communication with the ambulance services could allow an FRS responder to leave in some circumstances.

It was also noted that training would be required for this to work.

Lifting equipment within nursing homes and in other community centres could help.

There had also been a lot of people calling with mental health concerns/needs.

Availability of other services

Healthcare workers noted that very unwell patients (not in an emergency) could (and should) be addressed outside of an emergency response. Some front-line staff felt that people should be reporting more concerns to their GP and pharmacists—with one paramedic referring to a “perception” of a lack of availability for other services.

There was strong support among all attendees for a move into emergency services being more community focussed. It was suggested that the system of Integrated Care Systems (as opposed to multiple Clinical Commissioning Groups) had potential to ease the process of collaboration and help with unlocking local agreement. It was suggested that a redrawing of the boundaries of ambulance jurisdictions in line with those of the ICSs could assist further with this consolidation.

Front line health workers thought that there was an overlap and lack of clarity in what should be dealt with by 111 or by GPs. People often call 111 that need out of hours GPs. This was worse at the weekends. When asked for one recommendation which would improve the situation, one attendee called for every GP surgery to have an open surgery in the morning.

Triage

111 was noted as being confusing to the public, who didn't quite understand what it was for: although there was acknowledgement that 111 provided information, advice, and clinical assessment which could not be obtained from a GP or a walk-in centre. People, the Committee were told, called 111 for permission to call 999, and there were cohorts of people calling one number when they should be calling another.

Some paramedics thought there was a need to educate people on when to call for emergency care. Some thought that there was an increasingly high expectation on services. One believed that patients thought it was a cultural issue where there was a belief that "well, they're going to come out anyway". Those people who called GPs but hadn't got through occasionally called 999 as they felt the need to speak to someone. There were others who stated that, if someone bumped their head at school, an ambulance was regularly called as a matter of school policy, including where the parents could have driven the child to A&E. There was a discussion about whether patients could attend an ED in a personal car or a taxi, rather than waiting hours for an ambulance.

There was an increasingly complex call load for 111 handlers who were dealing with physico-social issues, and chronic conditions.

Frontline urgent healthcare workers felt that there was a problem of over triage: where health emergency calls would be categorised as Category 1 too regularly, and inappropriately. Paramedics felt that this led to the wrong people receiving ambulance support. There was some disagreement on this—one paramedic felt that the categorisation was correct, but that there was no resource to respond.

There were strong calls for more clinicians to be present in 111 handling centres to better triage. This may be the place where clinical involvement would have the greatest impact.

There was disagreement on the way that 111 triaged.

"They have a very set algorithm and questions that are asked. There is no scope to go outside of the boundary; there's no scope to be an autonomous clinician. Within the ambulance service you can go outside of your normal scope as long as you're doing something safe that's in the best interest of the patient."

Others felt that NHS pathways (a decision supporting algorithm in 111) allows for a holistic approach to calls and better information gathering from patients than other available models.

It was felt there was a need to invest in technology to allow call handlers to work from home.

Training

There were calls to have fire and rescue responders trained to a higher standard of medical knowledge. While the fire service could perform basic first aid, they couldn't do other things, such as lift someone with a broken pelvis from the floor.

There was also a call for an in-between role which could help upskill emergency care assistants to become, eventually, paramedics. There was appetite for an apprenticeship type role to improve the response that non-clinical staff could provide.

Appetite for collaboration

There was very strong appetite from fire service leaders, and frontline workers, to assist with health emergencies. One leader described this approach as “an absolute no-brainer”, and it was acknowledged that there was an untapped capacity within the fire service to respond to some health emergencies. One leader referred to the need to “switch on that capability”.

Examples were given to demonstrate the point that: “there will always be a fire engine closer to a victim [than an ambulance] at some point or another”. Many stated that outcomes improved the faster a responder arrives: “it doesn't matter which agency it is as long as someone gets there quickly”.

A car accident resulted in a teenage boy trying to resuscitate his father for 44 minutes, awaiting an ambulance. The father died. A fire station, with all the relevant medical equipment, was four minutes away from the scene.

The fire service was described as a “can do” and “get on” organisation. Leaders emphasised that fire fighters often join the service to save lives, and that dealing with health emergencies would be attractive to staff. One leader (who got in touch after the session) expressed that where fire fighters dealt with health emergencies, staff retention was high.

Benefits of collaboration

One example was provided where a fire service had facilitated the delivery of COVID vaccinations. It was noted that the fire service were the most trusted profession, seen as advocates for local communities within which they were based. It was felt that the brand enabled them to reach communities who may be unlikely to engage with the health service.

Barriers to increased collaboration

It was noted that where new things were tried, or pilots launched, there would need to be evaluation frameworks built in from the beginning, as it was difficult to prove “what worked” or “value added”.

Funding from other agencies for projects was occasionally withdrawn without consultation—as in the case of the fire service providing COVID vaccinations outlined above. On another point the Committee were told:

“We have this scattergun effect of little trials that produce great results [...] but then the funding dries up from the CCG before it spreads out to the greater area and then it all falls flat.”

Comments on union opposition were phrased carefully by service leaders—who had given some pushback to additional duties. Leaders felt that there was no lack

of willingness to firefighters “stepping up” but that unions wanted recognition for staff member. This could best come, leaders felt, in the form of a role re-grading. It was noted that there was “a culture journey to go on” and a need to build a strong foundation for increased collaboration.

It was noted that the fire service was inspected on the fulfilment of their statutory functions, and that this could allow good services/practices to be de-prioritised if they did not fit under these functions. Fire leaders felt that there was an opportunity for regulators to look more broadly at the work of the service.

Some front line staff felt that commissioning bodies made collaboration exceptionally complex.

Data sharing

There were strong calls to standardise data, and to share more widely within and between emergency services. An ongoing challenge was the difficulty in collating information together, and that there were many different versions of data, in different forms. A leader from one fire service noted that the three ambulance services in their area used slightly different sharing systems.

NHS England has rich data which it shares, but the extent of this was patchy - “very hit and miss depending where we are in the country” - and it can be cumbersome to access. It also depended, to an extent, on relationships between leaders in different services. One fire service leader said: “nationally we’re being starved of data from the NHS”. It was noted, though, that there had been additional access to NHS datasets during the pandemic.

Fire service representatives noted that many health risk factors were also risk factors for fires. Leaders noted that, often, fire deaths occur to people who could have been identified (through health data sharing) as being vulnerable to that danger. One leader noted that: “the more we understand what vulnerable people we have, the more we can review our own plans and put in the right resources”. A “fall service” run by one fire department was described as a “free referral service” for becoming aware of those at risk of fires. Data sharing was described by one fire service leader as a “tangible fix”.

Leadership

Political leadership was criticised by leaders in the fire service. Service leaders called for a discussion about the role of the fire and rescue service and how it could assist/offer health services, and a need for cross-governmental support: “the block is at the very top”. There was strong agreement that there was a need to define the role of the fire service. Service leaders called for a resolution to the Fire White Paper.

A lack of leadership resulted, the Committee were told, in a “policy vacuum” and a “postcode lottery” for where health services were delivered. One stated that:

“we all spend an inordinate amount of time doing local agreements ... it’s such a waste of money to do this patch by patch.”

The role of the National Fire Chiefs’ Council was commended as having matured as an organisation and a function—becoming a good place to share best practise.

Culture & workforce experience

Attendees noted that sitting in ambulance queues was demoralising and horrible for paramedics as well as patients: ambulance queueing was becoming very normal, and some thought that the NHS survived on the good will of the staff: “the NHS] has survived on the goodwill of the staff and I’m concerned about the staff. In a run of four days off I’ve done two extra days”. Paramedics stressed they regularly stayed past their shifts.

There were serious wellbeing concerns voiced by front line paramedics. While the traditional culture was viewed as macho or militaristic, this had developed, so there was more acceptance around showing emotions. This, though, was limited by the high levels of demand: people felt they simply had to move on to the next job—long term this can lead to burnout, mental health concerns, and stress.

The fire service was noted as very white and male and it was suggested by one front line fire worker that it was difficult sometimes to get staff to do more. Service leaders reported that there was a need to recruit fire officers differently. It was noted that the addition of a health responsibility/focus could increase the diversity of those applying: “We’d open the door to hundreds if not thousands of people who don’t at the moment see us as an employer of choice”.

It was noted that paramedics were increasingly young, and that while they were often fantastically skilled clinically, there was a perception that they could lack the social or communication skills to interact with the public. Some felt that a paramedics role was no longer one for life:

“People come for two years and then they just disappear to go off and do beauty injections [...] why shouldn’t they go somewhere else, get more money, and more training that’s paid for.”